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MIDTERM EVALUATION OF THE FAMILY PLANNING SERVICE EXPANSION AND TECHNICAL SUPPORT (SEATS) PROJECT (936-3048)

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MIDTERM EVALUATION OF THE FAMILY PLANNING SERVICE EXPANSION AND TECHNICAL SUPPORT (SEATS) PROJECT (936-3048)

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Glossary

ABBEF	Association Burkinabe pour le Bien-Etre Familial (Burkina Faso National Family Planning Association)
ABPF	Association Beninoise pour la Promotion de la Famille (Benin Association for the Promotion of the Family)
ABSF	Association Burkinabe des Sages-Femmes (Burkina Faso Midwives Association)
ACNM	American College of Nurse-Midwives
AIBEF	Association Ivoirien pour le Bien-Etre Familial (Ivory Coast Association for Family Welfare)
A.I.D.	Agency for International Development
AIDAB	Australian International Development and Assistance Bureau
AIDS	acquired immunodeficiency syndrome
AMEG	American Manufacturers Export Group
ANE	Bureau for Asia and Near East (A.I.D.)
APHA	American Public Health Association
ATBEF	Association Togolaise pour le Bien-Etre Familial (Togo Association for Family Welfare)
AVSC	Association for Voluntary Surgical Contraception
CA	Cooperating Agency
CAFS	Centre for African Family Studies (Nairobi)
CBD	community-based distribution
CDC	Centers for Disease Control
CERPOD	Centre d'Etudes et de Recherche sur la Population pour le Development (Center of Studies and Research on Population for Development
CHU	Benin Centre Hospital Universitaire (University Hospital Center)
CIP	Clinic Improvement Project
CPFH	Center for Population and Family Health, Columbia University
CTO	cognizant technical officer
CYP	couple year of protection
DFMH	Division of Family Mental Health (Cameroon)
DICSS	Direction de l'Inspection des Services Socio-sanitaires (Burkino Faso Directorate of Inspection of Socio-Sanitary Services)
DISS	Directorate of Inspection of Social Services for Burkina Faso
DOH	Department of Health
DOHH	Department of Occupational Health and Hygiene
DSF	Direction de la Sante de la Famille (Burkina Faso Family Planning Division of the Ministry of Health)
ESA	East and Southern Africa (REDSO)
ESARO	East and Southern Africa Regional Office (SEATS)
FEMEC	Federation des Eglises et Missions Evangeliques du Cameroun (Cameroon Federation of Churches and Evangelical Missions)
FHI	Family Health International
FHS	Family Health Services
FISA	Family Planning Association of Madagascar
FP	family planning
FPA	Family Planning Association (IPPF)
FPAU	Family Planning Association of Uganda

FPIA	Family Planning International Assistance
FPLM	Family Planning Logistics Management (project)
FPSD	Family Planning Services Division (Office of Population)
FY	fiscal year
GTZ	German Technical Cooperation Agency
HIV	human immunodeficiency virus
HPN	health, population, and nutrition
IEC	information, education, and communication
IMA	Islamic Medical Association (Uganda)
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JSI	John Snow, Inc.
MCH	maternal and child health
MIS	management information system
MOH	Ministry of Health
MOL	Ministry of Labor (Uganda)
MoPlan	Ministry of Plan
MoPop	Ministry of Population
MOU	memorandum of understanding
NE	Bureau for Near East (A.I.D.)
NFPP	National Family Planning Program (multiple countries)
NFWC	National Family Welfare Council
OB/GYN	obstetrics/gynecology
ONAPO	Office National de la Population (Rwanda National Office of Population)
ONFP	Office National de la Famille et de la Population (Tunisia National Office of Family and Population)
OPTIONS	Options for Population Policy
OST	L'Office de Santé des Travailleurs (Occupational Health Care Office, Burkina Faso)
OSTIE	Organisation Sanitaire Tananarivienne Inter Enterprise (Madagascar)
OYB	operational year budget (A.I.D.)
PATH	Program for Appropriate Technology in Health
PCS	Population Communication Services Project (Johns Hopkins University)
PNG	Papua New Guinea
POP	Office of Population (A.I.D.)
POPCOUNCIL	Population Council
PSI	Population Services International
PVO	private voluntary organization
R&D	Bureau for Research and Development (A.I.D.)
REACH	Resources for Child Health Project (JSI)
REDSO	Regional Economic Development Services Office (A.I.D.)
SEATS	Family Planning Service Expansion and Technical Support (project)
SOMARC	Social Marketing for Change (project)
SP	South Pacific
SPAFH	South Pacific Association for Family Health
SSK	Soysal Sigortalar Kurumu (Turkish Social Security Institute)
STD	sexually transmitted disease
TA	technical assistance
UMATI	Ugandan Family Planning Association

UNFPA	United Nations Population Fund
UPMA	Uganda Private Midwives Association
USAID	United States Agency for International Development (mission)
VSC	voluntary surgical contraception
WARO	West Africa Regional Office (SEATS)
WCA	West and Central Africa (REDSO)
YPPU	Yemeni Physicians and Pharmacists Union
ZNFPC	Zimbabwe National Family Planning Council

Project Identification Data

1. **Scope:** Worldwide

2. **Project Title:** SEATS (Family Planning Service Expansion and Technical Support project)

3. **Project Number:** 936-3048

4. **Contract/Grant Number:** DPE-3048-Z-00-9011-00

5. **Critical Project Dates:**

Contract Signed:	July 10, 1989
Project Assistance Completion Date:	July 10, 1994 (end 5-year contract) December 31, 1999 (end 10-year project)

6. **Project Funding:**

5-year Contract Amount:	$43,466,378 (estimated $16 million from buy-ins and OYB transfers)

7. **Mode of Implementation:**

A.I.D. Central:	Contract between the Office of Population, Family Planning Services Division (FPSD), and John Snow, Inc.

8. **Contractor:**

John Snow, Inc.
210 Lincoln Street
Boston, MA 02111

9. **Subcontractors:**

Columbia University Center for Population and Family Health (CPFH)
Program for Appropriate Technology in Health (PATH)
American Manufacturers Export Group (AMEG)

10. **A.I.D./Washington Project Manager:**

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Washington, D.C. 20523

11. **Previous Evaluations/Reviews:**

Management Reviews conducted by FPSD in February 1991 and March 1992.

Executive Summary

Project Background

The Family Planning Service Expansion and Technical Support (SEATS) Project was designed to expand the development of, access to, and use of family planning services in countries of low contraceptive prevalence — primarily in sub-Saharan Africa plus selected countries in Asia, the Near East, and the South Pacific. The first five years of this 10-year project are being implemented through a $43.5 million contract between the Agency for International Development (A.I.D.) and John Snow, Inc. (JSI) ($27.5 million from Office of Population and the remaining $16 million from USAID missions or regional bureaus and operational year budget (OYB) transfers). This 10-year effort has a completion date of December 31, 1999. This report contains a midterm evaluation of the project and covers the first three and one-half years of project activities.

Project Design

The SEATS project design is broad and flexible, enabling SEATS to play three major roles: 1) development and implementation of service delivery subprojects, 2) technical assistance geared toward institutional development in management, and/or planning to strengthen country systems or programs, and 3) assumption of specialized tasks until a mission develops a bilateral program ("bridging"). The design has given SEATS the reputation of offering the opportunity for "one-stop shopping"; its wide variety of financial, technical, and human resources have enabled the project to support family planning programs in such diverse areas as project development, contraceptive logistics, quality assurance, management information systems (MIS), training for service delivery skills (clinical and non-clinical), information, education, and communication (IEC), health care financing, evaluation, and commodity procurement.

At the time of the evaluation, the total $27.5 million that was expected to be provided by the Office of Population to the SEATS project had been obligated, but there were fewer buy-ins than expected. SEATS' ability to easily utilize central core funding has been a major strength and has enabled the project to move rapidly in developing programs.

After the 1991 decision of the Office of Population to focus its activities in 20 "priority" countries with large populations and high unmet need, SEATS added two priority countries to its portfolio — Morocco and Turkey — but, at the same time, has continued its focus in low prevalence, non-priority countries. Currently, 6 of the 19 countries in which it has its principal operations are Office of Population priority countries.

Program Implementation

Strategic Planning and Program Development. Insofar as possible, SEATS develops country programs on the basis of a strategic planning process that includes needs assessments and is in concert with country family planning strategies. In some cases, however, SEATS has undertaken isolated activities requested by the USAID mission or inherited from other Cooperating Agencies (CA). This has helped SEATS achieve its required outputs for subprojects (43 out of a required 40 to 50 subprojects to date) but has also resulted in some activities that do not fit well with SEATS' mandate.

Subproject Implementation. SEATS's subprojects on average have been funded at a lower level than anticipated but still tend to serve substantial populations, as they are relatively large-scale and encompass multiple sites. They represent a wide range of activities, some have used

innovative service delivery networks, others have expanded access to a wider range of contraceptives, and some have helped national family planning programs develop. Most are located in urban areas. Over half the subprojects are with private sector organizations, a considerable accomplishment given the tendency of many CAs to work with governments. Many of these subprojects are among the project's most successful.

Some subprojects have design flaws, either because of inadequate linkage of outputs to family planning service delivery or because of inputs that may not result in the desired outputs. The documentation of some subprojects is weak, perhaps a reflection of the emphasis on contractual over programmatic aspects of the written forms themselves.

Project staff are confident that the project will meet the stipulated goal of over 1 million couple years of projection (CYP), but performance to date (only about one-third of the goal) raises questions as to the final outcome. Far too much emphasis has been given in the project to CYP. Although CYP is one useful measure of SEATS' aggregate achievement, it should not be the primary, and certainly not the only, indicator in establishing service delivery targets or evaluating performance at the subproject level.

Cost effectiveness of subprojects is hard to judge, particularly this early in the life of most of them. The differences among projected costs per CYP is great, ranging from as low as $2 per CYP to as high as $33. Likewise, achieving sustainability appears a distant goal and SEATS recognizes that too much emphasis in this direction could be counterproductive from a service delivery standpoint. SEATS has not given sufficient technical assistance in subproject management information systems and thus, subproject service statistics are inadequate. SEATS has done good work in developing MIS systems at headquarters but has not yet transferred these capabilities to the field.

Technical Assistance. SEATS' heavy reliance on regional population professionals to provide technical assistance has been a prime factor in establishing project credibility. In Africa, these professionals, both those from the two African field offices and the project's resident advisors in-country, have provided long- and short-term assistance in program design and planning, training, IEC, MIS, clinical areas, and management and institutional development. On the whole, satisfaction has been high with the quality of their work.

Expenditures for technical assistance have been unexpectedly high, reflecting the lesson learned during project implementation that in the poorest low-prevalence countries, more technical assistance than anticipated would be needed for the institutional development necessary to initiate services. In some cases, institutional development has not been well linked with service delivery. Other problems that have arisen in the area of technical assistance include some criticisms regarding inadequate time and intensity of the assistance provided; occasional inability to match skills with needs; and inadequate attention to skills transfer, although this latter problem must be viewed in the context of frequent host country inability to provide counterparts and absorb assistance. Both host countries and USAID missions call on resident advisors for assistance outside SEATS' scope of work, a propensity that will increase as the numbers of USAID technical field staff decreases.

Management

SEATS' decentralized management structure has allowed for the flexibility needed to respond to a wide variety of country conditions and needs. The two large regional offices in Africa are staffed by individuals with good technical skills in specific areas of family planning (IEC, clinical services), although their experience in the more general field of project development and general implementation may need strengthening. Resident advisors play a significant role in managing some of the SEATS-assisted institutions, a major negative consequence being time lost from transfer of

technical skills. Some problems have arisen with regard to supervision and monitoring of the resident advisors.

SEATS' performance in procurement of equipment and supplies, an important project activity in part administered by a subcontractor, the American Manufacturers Export Group, has been the problem most frequently noted by missions, host organizations, and other CAs. The delays reflect a variety of causes, some well beyond SEATS' control. Consequences can be serious, in part because of time wasted, but more particularly because failure of equipment to arrive on time has disrupted project activities. SEATS has effectively utilized its two other subcontractors — Center for Population and Family Health at Columbia University and the Program for Appropriate Technology (PATH) — to supply field staff skilled in training, medical issues, and IEC.

SEATS has worked well with many other CAs. Although inevitably there have been a few problems in coordination, working relationships have developed well and are amicable. SEATS' capacity to provide equipment and technical expertise has been useful and likewise, SEATS has benefited from staff time from other CAs. A clear need exists, however, for A.I.D. to develop administrative mechanisms that will clarify procedures and simplify collaboration among CAs.

Follow-On Project

The need for a general purpose family planning CA like SEATS will clearly continue beyond the duration of the current contract, particularly to assist with the needs of low prevalence countries. Many USAID missions were particularly firm that SEATS-type assistance should be continued. Given the time required for project start-up and the loss of momentum and disruption of activities should a new contractor take over after this five-year period, it seems unwise to require a rebid. Funding should be approved through the 10-year project authorization. In addition, given SEATS' prime mission of working in low prevalence countries, particularly in Africa, at least 50 percent of the funds should be reserved for low prevalence countries that are not Office of Population "priority" countries.

The project design should remain essentially the same, retaining the current broad project purpose, substantial core financial resources, and decentralization of responsibility for subproject design and implementation. In the next phase, more emphasis should be put on efforts to increase family planning services and less on institutional development unrelated to services and to bridging activities. The Office of Population and the Africa Bureau need to develop new approaches to enable the Bureau to access and channel central funds for country-specific population assistance without being dependent upon bilateral agreements. The current project's component that calls for strengthening the institutional capacity of U.S.-based private voluntary agencies is inappropriate and should be dropped. An AIDS prevention message should become an integral part of all family planning packages.

A list of all the recommendations in the report is provided in Appendix F.

1. Introduction

1.1 Background

The Family Planning Service Expansion and Technical Support (SEATS) Project #936-3048 was developed by the Office of Population, Bureau for Science and Technology - now Research and Development (R&D/POP) — and approved for 10 years with a project assistance completion date of December 31, 1999. The project was developed at a time when interest in and commitment to family planning were growing in countries of low contraceptive prevalence, particularly in Africa, but when existing Agency for International Development (A.I.D.) mechanisms were considered inadequate to meet the increasing need. Funds for the first five years are $43.5 million, with the Office of Population providing $27.5 million and anticipated buy-ins or operational year budget (OYB) transfers totaling $16 million.

The current five-year project is implemented through a contract with John Snow, Inc. (JSI), a private public health consulting firm based in Boston, Massachusetts. The contract was signed on July 10, 1989 and is scheduled to end on July 10, 1994. JSI has subcontracts with the Center for Population and Family Health (CPFH) of Columbia University for training activities; with the Program for Appropriate Technology in Health (PATH) for information, education, and communication (IEC) services; and with the American Manufacturers Export Group (AMEG) for procurement.

This report is a midterm evaluation of progress up to this point (see Appendix A for further discussion). Although termed midterm, this evaluation is occurring approximately three and one-half years into the five-year project.

1.2 Project Description

The project purpose is to expand the development of, access to, and use of family planning services in currently underserved populations and to help ensure that unmet demand for these services is addressed through the provision of appropriate financial, technical, and human resources. The project is to focus its efforts in sub-Saharan Africa and selected countries in Asia, the Near East, and the South Pacific. This focus was consistent with the Office of Population's strategy (at the time) to expand services in sub-Saharan Africa, especially in countries without bilateral population programs. The project is designed to support quality family planning services; to strengthen management and planning capabilities of subprojects; and to place emphasis on assisting implementing agencies to develop cost-effective, sustainable service delivery systems.

The major project outputs are included in the contract's scope of work and shown in Table 1 on the next page. The scope of work for the contractor is specific on the steps to be taken to accomplish these outputs, including designation of the Washington, D.C. area as headquarters, establishment of regional offices in anglophone and francophone Africa, and the type and level of experts to staff these offices.

A list of "emphasis" countries is to be updated annually and these countries are to receive priority for services, although the contractor is not precluded from working in non-emphasis countries subject to approval of the A.I.D. cognizant technical officer (CTO).

Table 1

Progress Towards Achievement of Project Outputs

Type of Output	Contract Requirement	Status
Operational service delivery subprojects with public & private institutions	40-50 subprojects in up to 20 countries	43 subprojects, plus three buy-ins
Family planning users and resulting CYPs	Approx. 1.3 million users/over 1 million CYPs	320,408 CYP through 1992 900,000-1.2 million CYP projected
Monitoring and TA visits to each subproject	Quarterly by regional TA teams, JSI hdqts & short-term consultants	Monitoring and TA visits made.
Long-term TA in countries with large SEATS investments or country needs	4-6 long-term TA advisors	16 to date, 12 at present. (SEATS has combined long-term TA and advisors)
Long-term program/policy advisors	Up to 15 policy advisors	
Subproject management information system	Operational MIS in all subprojects	Under development
Subcontracts with in-country and U.S. firms	Local training or management firms; U.S. specialized TA or service delivery	Several contracts executed
Training modules in FP program development and management for subproject staff	5-8 modules in English, French, possibly Arabic or Turkish	8 completed, including CBD, program management and cost recovery. awaiting distribution
In-country training and regional seminars in FP program development and management	40-50 training programs & 3-5 regional seminars	80+
Study tours or short-term training for directors or managers of subprojects	40 participants to US or 3rd countries	40+
Workshops to examine progress to date, lessons learned and identification of problems, special needs and resources	2 multi-regional workshops	2

Source: SEATS

A major project intent is to offer missions rapid access to a relatively wide range of technical and advisory services from one Cooperating Agency (CA) ("one-stop shopping") as opposed to specialty services from a variety of specialty CAs.

1.3 Midstream Change in A.I.D. Office of Population Strategy

In 1991, two years after the SEATS contract had been signed, the Office of Population adopted its "Priority Country Strategy." Between the mid-1980s and 1991, the Office had accorded low contraceptive prevalence countries, such as those that SEATS was designed to assist, a relatively high claim to family planning resources. During this period, however, the need and demand for assistance were increasing faster than were available resources. In an effort to "focus and concentrate" its resources, the Office of Population identified 20 priority countries which were assessed to have the greatest need for assistance, based in part on the size of their populations.

SEATS responded to the Priority Country Strategy by adding two priority countries to its portfolio — Morocco and Turkey. At the time of the evaluation, SEATS was providing assistance to six of the Office of Population's priority countries — Kenya, Nigeria, Tanzania, Uganda, Morocco, and Turkey — but the project has also continued its focus in low prevalence, non-priority countries (see Appendix B for a listing of 18 countries in which SEATS has carried out subprojects; in addition to these, SEATS has provided considerable technical assistance in Nigeria).

As noted in Section 1.1, about two-thirds of SEATS' funding was expected to come through core funds and the other third, through bilateral funding. The Priority Country Strategy is designed to affect use of core funding only. The strategy anticipates that activities in non-priority countries will be funded primarily through buy-ins or OYB transfers from bilateral agreements between A.I.D. and host governments. Thus, in Africa, where SEATS has activities in 13 countries (most of which are non-priority countries), the strategy anticipates that over time, most of its activities will be financed through bilaterals.

At the time of the evaluation, the total $27.5 million that was expected to be provided by the Office of Population to the SEATS project had been obligated, but there were fewer buy-ins than expected. As will be discussed below, the project's ability to use core funds has been one of the major reasons for its successes to date. In countries that were in the process of developing bilaterals, these funds have enabled SEATS to fund "bridging" activities that helped the establishment of a family planning infrastructure while the bilaterals were being put in place. In countries with bilaterals, SEATS has been able to access core funds far more expeditiously than the more cumbersome bilateral process would allow. Core funds, for example, have been used to expand activities included in bilaterals or to undertake activities that were not included in the original agreements. For example, in Zimbabwe, SEATS is providing technical and financial assistance to three post-partum family planning projects and an employee-based family planning clinic associated with Union Carbide that were additive to the family planning activities funded by the bilateral program. In addition, core funds have been used to fund most resident advisors, the country population professionals for technical assistance who have been a prime factor in rapidly initiating project activities and establishing project credibility. Designing and implementing bilateral activities are slow processes. SEATS' access to central funds has allowed it to move rapidly in providing technical and financial resources to the low prevalence countries that it was designed to assist.

2. SEATS Project Performance

2.1 Overview of Implementation

2.1.1 General Assessment

As an A.I.D. worldwide family planning project, SEATS is still in its infancy. Both service delivery and technical assistance activities have been under way for too short a time to assess meaningfully their impact either in terms of increasing contraceptive use or strengthening institutional capacity.

SEATS staff do, however, have a number of important achievements to their credit. SEATS had a positive image in four of the five countries visited and in most of the countries responding to an A.I.D. cable concerning this evaluation. With a few exceptions, SEATS has established favorable working relationships with host country personnel, other A.I.D. CAs, and USAID missions.

The SEATS staff deserves substantial credit for moving at a very rapid pace to develop country programs despite disruptions in project implementation caused by the Gulf War in 1991 and by political turmoil in several countries in Africa where SEATS has initiated activities. (The withdrawal of the SEATS West Africa Regional Office [WARO] from Togo because of civil disruption was occurring during the field visit portion of the evaluation.)

Cabled responses from USAID missions and the fieldwork component of the evaluation confirmed that technical assistance provided by SEATS at the country level also generally is valued by both host country institutions and USAID missions. SEATS has been skillful in identifying and placing highly qualified, committed, and dynamic family planning professionals who have been able to gain the confidence of host country officials as its in-country resident advisors. In several countries where SEATS is providing broader institutional support, resident SEATS personnel are strategically positioned to have a significant influence over national family planning programs. Training programs have received high marks. The project is on schedule in achieving its quantifiable outputs (see Section 2.1.2).

On the other hand, some subprojects appear to have design flaws, either because of inadequate linkage to family planning service delivery activities or because of inputs that may not result in the desired outputs. Couple years of protection (CYP) is overemphasized as an indicator of subproject performance, and management information systems (MIS) for subprojects are weak. In addition, the project has committed a smaller proportion of its resources to subprojects than anticipated in the original design. Technical assistance has sometimes fallen short in terms of its length and intensity, the appropriateness of the skills of the advisor, and the attention to skills transfer, although this last must be viewed in the context of host country difficulties in providing counterparts. Inadequate attention has been given to developing and implementing an evaluation system to track the results and assess the impact of technical assistance interventions. Procurement of equipment has sometimes been a problem, disrupting project implementation.

2.1.2 Program Performance

The SEATS project is on schedule in meeting most of the quantifiable outputs specified in the A.I.D./JSI contract. These outputs and progress in achieving them to date are listed in Table 1.

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2.1.3 Project Design

The broad and flexible project design has enabled the project to play three major roles:

1. development and implementation of service delivery subprojects;

2. development or strengthening of country institutions or systems; and

3. assumption of specialized tasks until a mission develops a bilateral program ("bridging").

In most countries, as typified by Uganda and Cameroon, SEATS has developed a portfolio of **subprojects** aimed at expanding and strengthening family planning services. Subproject activities include support to a broad range of clinical, community-based, and employment-based family planning activities, as well as technical support, training, IEC activities and provision of equipment.

SEATS has also been called on to provide **institutional support** to an extent unforeseen in the original project design. Such activities do not directly generate CYPs. In these cases, SEATS has provided management and technical assistance to national institutions rather than funding subprojects not directly providing services. In Tanzania, Morocco, and Zimbabwe, in particular, USAID missions have assigned SEATS a central role in institutional development and technical support within the context of USAID bilateral programs.

With regard to **bridging** activities, in Tanzania and Zimbabwe, during the design of new bilateral family planning projects, USAID assigned SEATS a role of providing management and technical support to the national family planning institutions in these countries. In Madagascar, SEATS played a bridging role by financing activities prior to the initiation of a USAID bilateral family planning project. These activities can be either through subprojects or institutional support, but tend to fall in the latter category.

Table 2 shows the distribution between subproject and institutional development/technical support.

In all three of its roles, under the "one-stop shopping" concept, SEATS has provided support for family planning programs in such areas as project planning and development, contraceptive logistics, quality assurance, MIS, training for service delivery skills (clinical and non-clinical), IEC, health care financing, evaluation, and commodity procurement. This broad mandate has provided a flexible response capability for SEATS.

2.2 Strategic Planning and Program Development

SEATS' broad scope of work has provided flexibility and resulted in the project's having quite different roles in family planning efforts in various countries. The project paper anticipated that, when responding to requests for assistance from individual countries, SEATS would develop a country strategy based on a systematic process of needs assessment and strategic planning. Activities which resulted from this process were intended to support quality family planning service delivery or strengthen management and planning. In all instances, emphasis was to be placed on developing cost-effective, sustainable, national-level service delivery systems.

Table 2

Pattern of SEATS Assistance in Key Countries

Country	Subprojects	Institutional Support
West Africa Region		
Benin	x	
Burkino Faso	x	
Cameroon	x	
Cote d'Ivoire	x	
Rwanda	x	
Togo	x	x
East Africa Region		
Madagascar	x	x
Malawi	x	x
Tanzania		x
Uganda	x	
Zimbabwe	x	x
Kenya (CAFS*)		x
Asia/Near East		
South Pacific		x
Morocco		x
Papua New Guinea	x	
Turkey	x	
Yemen	x	x
Tunisia	x	

Source: Evaluation team, constructed from SEATS documents

*Centre for African Family Studies

In many countries, SEATS has followed this approach to program development. In Uganda, for example, SEATS carried out a comprehensive planning exercise that led to agreement among USAID/Kampala, the Ministry of Health, and SEATS that SEATS had a comparative advantage in working with the private sector, and this led to development of innovative service delivery subprojects.

In some countries, however, SEATS' activities did not result from this planning process. Rather, USAID missions have tapped the SEATS project to accomplish mission ends, usually (as noted above) in the context of initiating a new bilateral program of family planning assistance or in the form of an *ad hoc* requests for some activity with which the mission needed assistance.

In other countries, SEATS was asked to assume support for "inherited" subprojects previously funded from other sources. In Burkina Faso, SEATS was requested by the USAID mission to assume funding for activities previously supported by the Enterprise Project, Family Planning International Assistance (FPIA), and the Columbia University operations research project. SEATS also agreed to fund certain activities for which the USAID mission had been unable to obtain host country approval for funding under the bilateral project. The mission's identification of these activities enabled SEATS to establish a substantial portfolio of activities very rapidly but resulted in a program that includes some activities that do not fit well with the SEATS' scope of work (e.g., the integration subproject with the Direction de la Santé Familial, in which the family planning dividend is far removed — see Section 2.3.3 below for further discussion).

The strategic planning process has proven valuable in ensuring a focus on an integrated country-level program of activities rather than on a diverse, unrelated set of interventions. SEATS country programs appear to have greater coherence and to support service expansion more directly in countries in which SEATS has taken the initiative, with program development based on strategic planning (e.g., the SEATS effort in Papua New Guinea — see Section 2.4.2), as compared to countries in which SEATS' role has been delineated by USAID.

Recommendation:

1. **Needs assessment and strategic planning should remain the guiding principles for further development of SEATS' country-level activities. In countries in which SEATS' assistance is written into USAID bilateral family planning projects or in which USAID missions otherwise define the scope of SEATS activities, SEATS should negotiate appropriate and meaningful interventions consistent with the SEATS country strategy and its worldwide mandate for service expansion.**

2.3 Family Planning Subprojects

2.3.1 Subproject Characteristics

As originally conceived, the largest single component of the SEATS project, representing 42 percent of total funding, was to be support for the development and implementation of up to 50 new family planning services subprojects, in accordance with the project purpose of expanding high-quality family planning services. By the end of 1992, project expenditures totaled $23.1 million, of which $5.1 million (22 percent) was attributed to subprojects. This reflects the higher-than-anticipated expenditures for technical assistance, which resulted in fewer funds for subprojects (see Section 4.3.3).

The SEATS project appears to be on target in developing the number of subprojects and reflecting the regional balance of activities specified in the contract scope of work (i.e., focus on sub-Saharan Africa). SEATS management moved very rapidly to initiate subprojects, responding in a flexible manner to the expressed needs of both USAID missions and host governments including, as noted above, taking over former FPIA activities when the Office of Population terminated support to FPIA. Several USAID missions noted the quick and efficient manner in which SEATS was able to assume funding for these activities.

Three and one-half years into the five-year project, a total of 43 subprojects have been initiated in 16 countries. Of these subprojects, 20 are in West Africa; 16 in East and Southern Africa; and the remaining 7 in the Asia/Near East Region.

In the project paper and contract with JSI, subprojects were expected to be multi-year, large-scale activities averaging $300,000 to $450,000 each over a three-year period. Under the project, the typical subproject budget has been considerably lower, averaging around $120,000. Budgets typically range between $100,000 to $750,000, with the smallest an $18,248 effort for a small employment-based subproject in Zimbabwe and the largest, a $3.3 million outlay for the major SEATS initiative with the Social Security Institute (SSK) in Turkey. As anticipated, SEATS subprojects are of relatively long duration, with an average subproject life of approximately 24 months.

The general pattern has been for SEATS to fund several mid-size subprojects in a country, rather than one large program. Sometimes this was because subprojects were started in both the public and private sectors. At other times, it was necessary to initiate multiple discrete projects because no single public or private sector institution had the infrastructure or absorptive capacity to mount large programs.

SEATS subprojects encompass a wide range of activities, usually providing inputs related to the delivery of family planning services. Subprojects incorporate a wide array of approaches to service delivery, including through community-based distribution (CBD) and employment-based activities. Many of the subprojects emphasize static clinical facilities. A small number of subprojects have been somewhat indirect in their support for expansion of services, focusing instead on development of the policy institutions. For example, SEATS subprojects have supported key staff and activities of the National Family Welfare Council in Malawi, a fledgling organization responsible for developing family planning policy, and the implementation of a situation analysis in Zimbabwe, which was jointly funded with the Population Council through the Africa Operations Research/Technical Assistance project.

SEATS subprojects tend to be relatively large scale and to involve multiple service sites. In Burkina Faso, for example, the SEATS integration subproject with the public sector health system is designed to assist 93 health centers. In Uganda, SEATS is training between 150 and 200 private midwives. A few activities, primarily those inherited from FPIA and Enterprise, tend to be smaller scale and more personalized, such as the project in Burkina Faso with the Midwives Association that supports two free-standing clinics in Ouagadougou and Bobo Dioulasso.

Although subprojects may provide some coverage in rural areas, they primarily serve urban populations. The urban concentration of activities appears appropriate given the fledgling stage of family planning efforts and weak rural health infrastructure in most of the countries in which SEATS works. In any case, whether the project focuses in urban or rural areas is not the issue; the issue is to ensure that all subprojects, during the remainder of the current project and in any follow-on activity, should be viable, effective efforts with the potential to serve significant numbers of clients.

SEATS seems to have had particular success in the area of support for the expansion of private sector family planning initiatives, with over half of SEATS subprojects involved exclusively with private sector organizations. Not only have many other CAs had difficulty bypassing the government to work with the private sector; many of the private sector subprojects appear to be among this project's most successful. Private sector organizations include groups as diverse as International Planned Parenthood Federation (IPPF) affiliates, missionary health networks, associations of private midwives, and private commercial enterprises. The smaller number of subprojects that work with the public sector has usually sought to strengthen the integration of family planning within existing government health networks, as in Togo, Burkina Faso, and Cameroon. A handful of subprojects are working with both the public and private sectors.

See Appendix C for a complete listing of subprojects by region, country, type, cost, date of start and completion, and collaborating agencies.

2.3.2 Potential Impact and Strategic Importance

SEATS has made a major effort to develop activities with potential impact and strategic importance. It has moved to break out of the small-scale pilot project mode, which involves unrealistically high levels of funding that cannot be replicated on the wider scale through which most A.I.D. service delivery CAs have traditionally functioned. As noted above, it has launched services in multiple service sites and it has also identified innovative networks for the provision of contraceptive services, especially in the private sector. Subprojects are training significant numbers of family planning service providers. SEATS is also making an important contribution in broadening contraceptive choices and especially in expanding the availability of long-term clinical contraception. Some of its subprojects have contributed to the institutional development of national family planning programs.

Serving Substantial Populations

The SEATS project paper and contract include the stipulation that subprojects "should have the potential to demonstrate broader feasibility for implementation in a nationwide family planning program, i.e., demonstrate replicability." SEATS has modified this mandate, aiming rather to support interventions geared to moving countries as a whole toward national-scale quality family planning programs.

As noted above, SEATS wants its subprojects to provide large-scale services. In addition to Burkina Faso and Uganda, SEATS has undertaken subproject activities in several other countries that have the potential to serve significant populations.

> **Turkey, where SEATS is working with a network of over 100 hospitals of the SSK and expects to provide a total of 400,000 CYP, representing a very large number of family planning clients.** In the first few months after services were initiated, the project reported 53,645 CYP.
>
> **Papua New Guinea, where SEATS is strengthening the delivery of family planning services in five provinces.** SEATS' efforts are expected to produce a total of 107,000 CYPs; 24,591 CYP had been reported through December 1992.
>
> **Cameroon, where SEATS has developed projects with the two largest private sector church health networks.** SEATS estimates that its program of assistance in Cameroon in the public and private sectors has introduced family planning at 118 additional health facilities and will also eventually reach 279 retail outlets through the social marketing activity with Population Services International (PSI). According to a cable response from USAID/Cameroon regarding this evaluation, the activities of SEATS and two other CAs have resulted "in a doubling of family planning service delivery sites and estimated contraceptive use in Cameroon since 1990."

Innovative Service Delivery Networks

SEATS has been effective in identifying innovative networks for service delivery:

> **In Uganda,** SEATS has drawn new groups into family planning service delivery, including the Uganda Private Midwives Association and the Islamic Medical Association.

In Burkina Faso, SEATS is working with the National Family Planning Association (ABBEF, an IPPF affiliate) in an activity to establish special contraceptive and sexually transmitted disease (STD) counseling and services for adolescents in two major cities.

Training

In Papua New Guinea, SEATS has trained 30 mid-level managers from seven provinces, and with the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), has provided training of trainers to 20 nurses who, with SEATS' support, have provided family planning training to 1,000 family planning service nurses.

Expanding Access to a Range of Contraceptive Technologies

SEATS deserves considerable credit for the emphasis it has placed on expanding access to a broader range of contraceptive technologies. The following are some examples of contributions SEATS is making to improving quality of care and method mix:

With regard to clinical methods, SEATS is playing an important complementary role to efforts of the Association for Voluntary Surgical Contraception (AVSC) in a number of countries by expanding the number of professionals trained to provide these long-term methods. In Rwanda, SEATS is expanding provision of voluntary sterilization from the three prefectures where AVSC has been working to the country's remaining seven prefectures.

In Turkey, SEATS has made major strides in promoting vasectomy within the SSK project.

In Cameroon, SEATS' assistance will add pills, injectables, and IUDs to the current social marketing of condoms by PSI.

In Burkina Faso, a SEATS subproject is the site for Norplant introductory trials sponsored by the Population Council.

Institutional Development of National Programs

Some SEATS subprojects have helped in institutional development of national family planning programs:

In Cameroon, SEATS has designed and established a contraceptive logistics management system that is being used by both the public and the private sectors.

In Malawi, a SEATS subproject is supporting key personnel and activities of the National Family Welfare Council.

Some capacity-building interventions have been of lesser significance. For example, SEATS' assistance for computerizing the central compilation of health services data in Burkina Faso is unlikely to have a meaningful impact unless there is a more comprehensive effort to improve the quality of data collection.

2.3.3 Subproject Design

Subproject development has been the primary responsibility of the SEATS regional offices. Many activities visited or reviewed reflect favorably on the expertise and competence of SEATS staff

responsible for their design. In some subprojects, however, the technical contribution of SEATS staff during design appears to have been inadequate.

In the SEATS **integration subproject** with the Direction de la Santé Familial, the IPPF affiliate **in Burkina Faso**, for example, more imaginative technical assistance might have increased the importance of family planning in 93 newly integrated maternal and child health (MCH) health centers. This Burkina Faso subproject, with a financial commitment of about $775,000, builds on a former Columbia University operations research activity and has had very little design input from SEATS. The subproject aims to integrate delivery of MCH services, including family planning, within the existing public health system, by making all services available at all times instead of only at specific days and times, as was the case previously. Major SEATS' inputs include clinic equipment, renovation of facilities, and support for a two-week training course in the management of integrated MCH services for personnel from the 93 health centers covered by the project, along with follow-up activities relating to the reorganization of services.

The emphasis on family planning appears minimal, however, and the linkage between inputs and expected outputs appear weak. In part, this reflects that half of project costs go to provision of clinic equipment and renovation of facilities. In addition, the management training course does not appear to include special emphasis on family planning. At the only health center visited, the total number of family planning clients served monthly was low and had increased only slightly since the recent "integration" of services. SEATS staff do not appear to have played a major role in the development of the training curriculum nor to have proposed alternative approaches for integrating services (such as targeted IEC, clinic outreach, and increased clinical training) which could potentially have sharpened the focus on family planning and increased the client load.

A similar situation arose in **Malawi**, where the mission asked SEATS to help write a strategy for creation of the National Family Welfare Council, which coordinates all child-spacing activities in the country. The donor community had reportedly identified a need for a service delivery organization whereas SEATS' assistance contributed to the creation of an institution that focuses to a considerable extent on policy. SEATS' support to the Council is no doubt of central importance to the development of a national family planning effort. In not being able to develop a service delivery role for the Council, however, SEATS may have missed an opportunity to shape a more effective and useful institution.

Design Documentation

Subproject documentation represents the understanding between SEATS and recipients of SEATS' assistance with regard to the purpose, objectives, nature, and scope of each subproject. SEATS has opted to use a subcontract format, with the contract describing the terms and conditions of SEATS' assistance as the key document, to which are appended the subproject descriptions. This format emphasizes contractual obligations over proposed subproject family planning objectives. It allows for flexibility and speed in developing the document but has the disadvantages of providing insufficient detail and of serving as a poor mechanism for transferring project design and development skills.

The quality of subproject scopes of work is uneven. Some scopes are comprehensive and detailed, as for example, for SEATS' training activity with the Family Planning Association of Uganda. In this case, the clearly stated objectives and detailed workplan reflect a high standard of technical input by SEATS in the design process. On the other hand, scopes of work in some subproject subcontracts are less comprehensive and/or specific and thus do not fulfill their potential as a management tool for subproject implementation. For example, although almost half of the budget for the Burkina Faso integration project was intended for equipment, no detailed list of equipment to be procured was included in the subproject document. Other subproject subcontracts lack vital management tools,

such as time-line implementation plans or organizational charts describing key relationships. Moreover, at new subproject sites in Zimbabwe, key project personnel did not appear to have a clear understanding of proposed objectives or the mode of subproject operation, raising questions regarding the extent of their involvement in the design process (see below, Section 2.4.3).

In another case, USAID staff noted a weakness on the part of SEATS staff in the area of developing comprehensive service delivery subproject documents, specifically noting that several proposals lacked sufficient detail. In this case, the health, population, and nutrition (HPN) officer commented that although SEATS had staff highly qualified in a number of specialized areas, what seemed to be lacking were staff with generalist family planning backgrounds and design skills (see Section 3.1.3 below).

Subproject Review

SEATS has developed a four-step mechanism for internal subproject review. When a subproject proposal is received from a regional office, a program associate first reviews it for a minimal non-technical level of acceptability (i.e., whether it includes all requisite information such as name and address of implementing agency, budget, etc.). The second stage is a preliminary review by a technical officer to determine whether the proposal contains sufficient technical information to warrant a committee review. The third stage is a committee review, which normally results in a set of questions that are referred to the regional office. The final stage is a second committee meeting, at which a decision is made, based on responses from the regional office, as to whether the project should go forward to the project CTO and to the A.I.D. contract office for final approval. Although the process itself seems thorough, the standards applied to the proposals seem to be somewhat lax with too little attention to inclusion of such elements as timeline implementation plans, job descriptions, equipment lists, etc.

Recommendation:

2. **SEATS management should review the format used for subproject development and documentation and SEATS' internal standards for subproject review, in order to strengthen quality control in subproject preparation and to ensure that subproject documents consistently provide adequate detail.**

2.3.4 Goal-Setting for Subprojects

Project/Country Performance with Respect to CYPs

The project paper and contract set an objective for the SEATS project to provide just over 1 million CYPs over the period 1989-94. This number was based on the arbitrary assumption that SEATS should be able to provide 10 percent of the total CYPs required to meet the United Nations medium variant fertility projections for each country in which it worked.

As required, SEATS has set CYP targets for each of its subprojects. These are not set according to any consistent formula, however, and many may prove to be on the high side. If all were met, the total CYPs generated from the project would be nearly 1.5 million, considerably above the contractual requirement. As of January 1993, the project had generated around 343,000 CYP, based on the conversion formula in effect at the time of the start of the project, or only about 289,000 CYPs, based on the currently operative formula, which on the whole requires a higher level of performance

to achieve a CYP.[1] Overall, SEATS country programs have not achieved expected CYPs, with the possible exceptions of Turkey, Papua New Guinea, and Côte d'Ivoire, which have made reasonably good progress to date[2] (Côte d'Ivoire discussion below). At the subproject level, of the only two completed subprojects, one, in Burkina Faso, had exceeded its target whereas the other, in Madagascar, had not even achieved 40 percent of its CYP goal. Promising beginnings were reported in some of the larger subprojects, including in Papua New Guinea and Turkey (see Section 2.3.2). In these cases, which, like most of the subprojects, will not be completed until 1994, it is hard to predict what the final performance will be. In fact, the lagging achievement to date primarily reflects the relatively recent initiation of most subprojects, the time required for start-up and training of personnel, and in some cases, delays in implementation of project activities. Although SEATS project staff express confidence that the project will generate the total suggested by the subprojects by the end of the project, the assumptions upon which they base these projections are debatable and it is unlikely that SEATS will achieve its CYP targets during the limited time remaining. (See Appendix C.)

Subproject Objectives Measured in CYPs and Other Indicators

In addition to setting a specific project-wide goal for CYPs, the contract called for SEATS to set specific "measurable objectives" for each subproject. The only required indicator was to be projected CYPs although, in many cases, the "number and type of users to be served...." could also be used. For example, the contract estimated that 1.3 million users would be served in order to reach 1 million CYPs. SEATS, however, does not appear to have established a consistent methodology or approach for establishing service delivery objectives for subprojects. In Burkina Faso, for example, although most subprojects established service delivery targets in terms of both new and continuing clients *and* CYP, some subproject documents express service delivery objectives *only* in terms of CYP. For example, documentation for the integration subproject expresses service delivery objectives exclusively in terms of CYP (but lacks any analysis as to how the target of 85,000 CYP was derived). Similarly, documents for several new subprojects in Zimbabwe dealing with voluntary sterilization services express service delivery objectives exclusively in terms of CYP, although other indicators such as number of clients and age and parity when sterilized (female) would also be useful.

CYP as an Indicator

Overall, far too much emphasis has been given in the project to CYPs. Although CYPs can be a useful tool, especially in the context of activities like social marketing for which other measurement of service outputs is difficult, the reliance on CYP as the *sole* indicator of subproject performance

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[1]During late 1991, A.I.D., in conjunction with the Centers for Disease Control, developed a new set of conversion factors for contraceptive methods. Except for IUDs, they required a higher level of performance than did the earlier set. Specifically, the factors are as follows: for temporary methods, 15 cycles of oral contraceptives = 1 CYP; 150 condoms and 150 cycles of vaginal foaming tablets = 1 CYP and for long-lasting methods, sterilization provides 10 years of protection and IUDs provide 3.5 years of protection. CYPs derived from the more recent conversion factors are used in the text above.

[2]Questions regarding the validity of CYP data reported by SEATS were raised by USAID/Abidjan staff. The 104,674 total CYPs reported for its two subproject activities in that country represent about 36 percent of the total CYPs reported for all SEATS activities. The questionable aspects of attributing CYPs to the Population Services International (PSI) subproject is discussed in the text below. Regarding the approximately 59,000 CYPs attributed to the clinics funded through the national IPPF affiliate, AIBEF, it was not possible to determine the validity of the data reported. The low level of family planning activity at these sites reported in subproject quarterly reports, however, puts into question the accuracy of the CYP figures.

is inappropriate. This is true, both because of the inadequacy of the measure itself and because of the difficulty of accurate counts.

With respect to the adequacy of the measure itself, CYP is an indirect and conceptual indicator, one not always easily understood by service providers responsible for implementing subproject activities. In addition, CYP does not capture important qualitative aspects of family planning services such as the contraceptive method mix or the level of continuing clients for non-permanent methods. To be sure, CYP could be broken down to illuminate these various other aspects; the project, however, does not call for any information but the base CYP number.

Arriving at an accurate count of CYPs generated is an equally complicated issue. In particular, it is difficult to isolate the impact of SEATS' interventions when SEATS and other CAs collaborate (when, for example, SEATS funded renovation or equipment of public sector clinics in which the Program for International Training in Health [INTRAH] trained personnel or when SEATS built on voluntary surgical contraception [VSC] training activities initiated by AVSC). In such instances, the result may be some double-counting of service delivery outputs by SEATS and other CAs.

The accuracy of CYP counts may be further compromised because of the pressure SEATS management feels to achieve its CYP goals. For example, subprojects tend to take credit for all services provided in clinics assisted by SEATS, even in cases in which some level of family planning services was available prior to the SEATS intervention or in which project inputs do not directly support the actual delivery of services. The latter situation was illustrated in the Côte d'Ivoire, where SEATS provided funds ($100,000) but no technical support to assist Population Services International (PSI) develop a media campaign to promote condoms. Even though SEATS did not provide any technical inputs to the campaign itself, SEATS and PSI agreed, with A.I.D. approval, to attribute all 45,000 CYPs reported from increased condom sales toward SEATS' CYP targets.

Some USAID, host country, and CA representatives also question whether pressure on SEATS for rapid CYP generation has encouraged it to work with the same groups as other CAs and take credit for all CYPs. In Malawi and Zimbabwe, for example, SEATS has chosen to work with the same institutions with which AVSC has had a long-standing involvement.

To conclude, if properly calculated and attributed, CYP is one useful measure of SEATS' aggregate achievement. It should not be the primary, and certainly not the only, indicator in establishing service delivery targets or evaluating performance at the subproject level, however. Additional objective criteria for establishing service delivery goals for subprojects are needed, such as service statistics on new and continuing clients.

SEATS is working on indicators that measure progress in service accessibility, quality of services, management capabilities, and sustainability of programs. Additionally, SEATS participates actively in an Office of Population working group charged with developing indicators for worldwide family planning programs. Thus, it would seem that SEATS would be in a strong position to develop new indicators for its own subprojects.

<u>Recommendations</u>:

3. **If CYP is to be used as an evaluation indicator of project performance, A.I.D. must establish rational and consistent mechanisms for attributing the CYP and should intensify efforts (in collaboration with the EVALUATION Project) to develop other qualitative and quantitative indicators to measure project progress in both service delivery and institution building.**

4. **SEATS needs to establish a consistent process for establishing service delivery objectives for subprojects. Indicators for measuring the attainment of objectives for all service delivery subprojects should include numbers of new and continuing clients and data on method mix. At the subproject level, CYPs should be used only as a complementary measure.**

2.3.5 Management Information Systems

Given SEATS' strong reliance upon CYP as a subproject performance indicator, the project takes a somewhat laissez-faire approach to collection of family planning service statistics. SEATS guidelines permit recipients of assistance to use any reporting format they wish, as long as it provides the minimum information needed by SEATS to monitor subproject performance. Where recipients request more technical assistance in client reporting, SEATS recommends, but does not require, a format developed by the Centers for Disease Control (CDC), which includes two measures, "new clients" and "revisits." Subprojects compile data from service delivery points and submit them to SEATS on a quarterly basis. No work has been done on developing in-country capacity for data clean-up or analysis. Data are aggregated and analyzed at the SEATS regional offices and forwarded to headquarters.

This casual approach contributes to a high degree of unreliability in the MIS and also to the difficulty experienced during this evaluation in validating controversial CYP figures in some countries (see footnote 2). Many SEATS subprojects do use the CDC format, but a review of several completed forms indicated frequent errors and differing interpretations of key definitions. Data from the East and Southern Africa Regional Office (ESARO) appeared to be somewhat more reliable than those for West Africa Regional Office (WARO) activities, reflecting the relatively more advanced state of family planning activities in the ESARO regions.

SEATS has done some good groundwork at headquarters in developing MIS capability, including developing extensive MIS documentation that provides background information on SEATS' MIS objectives and guidance in application. None of these materials has been applied in the field as yet. When they are, they should be helpful in assisting the host country institutions to establish an MIS.

<u>Recommendation</u>:

5. **In order to improve the quality, comparability, and reliability of client reporting and feedback, SEATS should provide sufficient technical assistance for each family planning service delivery subproject to establish an MIS at project start-up and then periodically follow through with hands-on technical assistance until the host country personnel can operate the system reliably.**

2.3.6 Subproject Implementation

In countries with a number of subprojects, resident advisors are recruited and assigned to monitor subproject activities and assist in implementation. Depending on the nature of the subproject and its objectives, the resident advisor might provide technical assistance for specific tasks or call for outside help. Regional office staff have the capability to provide much of the required technical assistance, but, if necessary, may call for help from headquarters or other sources. Regional staff typically help subproject managers set up financial reporting systems, conduct workshops for subproject staff, organize and in some instances conduct regional or local training for key personnel, and provide specialized technical services such as the development of IEC strategies. In addition to regular reporting on the progress of each subproject by the resident advisor, regional staff conduct regular monitoring visits.

The degree of involvement by the resident advisor in the day-to-day management of subproject activities varies widely. It depends on the objectives of the subproject to some extent but frequently is determined by the interest, abilities, and institutional strength of host country managerial personnel. In the few countries visited, the family planning infrastructures were relatively weak and the resident advisors generally were quite involved in day-to-day subproject management (see below, in Section 3.1.4, for further discussion of the resident advisors).

A key factor in smooth working relations between the SEATS resident advisor, the USAID mission, and the host country institutions is the degree of understanding that each has of the objectives of the SEATS activity and the part each is to play. In several instances, there were serious gaps in understanding on the part of one or more of the players which either delayed progress or, more seriously, jeopardized achievement of subproject objectives. Typically, in these cases, written agreement of the precise responsibilities of each group did not exist.

Recommendation:

6. **For both subproject implementation and technical assistance activities,[3] in every SEATS-assisted country, USAID, SEATS, and the host country agency should use a memorandum of understanding or similar instrument to spell out the responsibilities of each and the communication channels agreed upon to resolve differences.**

2.3.7 Cost Effectiveness and Sustainability

The contract requires SEATS to provide an analysis of cost per CYP and cost per new acceptor as part of the subproject design. This analysis can be based on a small sample basis collected over a short time frame. The project paper and current contract also envisioned that SEATS would assist subprojects in the development of sustainability plans that would address issues such as plans for phaseout and the avoidance of high recurrent cost burdens.

Cost Effectiveness

Given the recent initiation of service provision in many subprojects, it is clearly premature to make any estimate of the actual cost of CYP reported to date. SEATS, however, has data available on projected cost per CYP. A cursory review of subprojects suggests a very great diversity in these costs. In the East Africa region, for example, they ranged from as low as $2.20 for the Chitungwiza post-partum activity in Zimbabwe to $33.60 for the proposed Seventh Day Adventist project in Uganda. Even within the same country and for similar subprojects, the projected costs sometimes differ greatly. For example, the SEATS activity with the Malamulo mission hospital in Malawi is anticipated to yield 18,823 CYPs at an average cost of $12 while a similar activity at the Ekwendeni hospital is projected to yield 4,824 CYPs at a unit cost of $24. This diversity may arise from different country and project conditions but it also stems from the lack of any consistent methodology in projecting cost per CYP, reflecting in turn the lack of any consistent formula for setting CYP goals.

In general, the expectations for subproject "productivity" (i.e., intensity of client load) differ greatly but overall appear low for multi-year activities. For example, subprojects in Malawi include 487 service delivery "outlets" (mostly CBD workers), which are expected to generate 23,647 CYPs over the life of the project, or only 48 CYPs per outlet. In Uganda, on the other hand, 346 outlets (again mostly CBD workers) are expected to generate 73,917 CYPs, or 213 CYPs per outlet over the life of the project, a respectable number for a CBD project. In Côte d'Ivoire the USAID mission has

[3]The need for this recommendation as applied to technical assistance activities is discussed below in Section 2.4.3.

questioned the potential cost effectiveness of the AIBEF (the IPPF affiliate) clinics, assisted by SEATS, based on their low projected client load.

Sustainability

With regard to the stipulation that SEATS assist subprojects in the development of sustainability plans, SEATS has taken this mandate seriously, while recognizing the inherent trade-off between expanding services and enhancing sustainability. SEATS' approach to financial sustainability has been to identify organizations at the design stage that have the capacity to maintain their activities without indefinite SEATS' support. Consistent with A.I.D. policy, SEATS has been reluctant to support inputs involving heavy recurrent cost burdens such as salaries, choosing instead to emphasize activities such as training, equipment, and clinic renovation that do not involve heavy recurrent cost burdens. Except in the case of a few smaller private sector subprojects, SEATS has not provided support for recurrent costs such as personnel.

SEATS does not appear to have developed sustainability plans or provided technical assistance in cost recovery to the extent anticipated by the project paper. Most subprojects include some minimal cost recovery through user fees. SEATS headquarters has also developed some excellent guidelines on user fees, "User Fees for Sustainable Family Planning Services: Background Discussion for the Program Managers' Handbook," and "Designing a Family Planning User Fee System: A Handbook for Program Managers." These tools have yet to be field-tested and transferred for use in the field. The project director at one SEATS subproject, for example, wanted to charge more for services but was not sure how to determine user fees. With regard to these requirements, it is important to recognize that in many of the countries where SEATS is working, too much emphasis on cost recovery and financial sustainability may be premature given the nascent stage of service delivery activities.

Recommendation:

7. **SEATS needs to develop a consistent process for projecting cost per CYP and over time, to monitor the actual cost per CYP and compare this indicator to original projections.**

2.4 Technical Support Activities

2.4.1 Characteristics

The project provides a diverse range of technical assistance, both long- and short-term. Technical assistance has been provided in program design, training, IEC, MIS, and clinical areas such as the introduction of VSC. SEATS also has provided technical support in strategic planning and management, institutional development, quality assurance, cost recovery, and sustainability.

One of SEATS' strengths is its pool of dedicated and experienced staff, consultants, and advisors. Many of the staff professionals are native to the area in which they work. SEATS has found that the use of such professionals is extremely useful in establishing credibility and influence with counterparts, particularly in Africa.

Short-term technical assistance is provided by resident advisors and their associates, headquarters staff, and less often, by non-SEATS consultants. Long-term technical assistance is carried out by resident advisors and their staff associates, with help as needed from the regional offices. Togo and Zimbabwe probably receive additional undocumented attention because of the presence of the regional offices.

Regional office staff have primary responsibility for overseeing their regions and each staff member backstops a specific country. Depending on the particular needs of a given country, SEATS regional offices might also tap into the expertise of other resident advisors (rarely), use staff cross-regionally, or use assistance from headquarters, external consultants, or another CA.

Ideally, the specific areas of technical assistance to be provided are determined as part of the strategic planning and project development exercise described in Section 2.2 above, but at other times tasks are determined by the USAID mission or are developed in response to *ad hoc* requests. Whether the form of assistance reflects strategic planning or a request from the USAID mission, best results are obtained when SEATS, the host country, and the USAID mission jointly develop a workplan.

In some countries, SEATS has invested heavily in technical assistance for institutional development that does not directly generate CYPs. Examples are Kenya, Madagascar, Malawi, Morocco, Tanzania, Tonga, Yemen, and Zimbabwe (see Table 3). In these, the technical assistance was felt necessary either to start programs, to improve training (Kenya), or help move programs toward a national level. Many of these activities were not tied directly to service delivery.

Table 3

SEATS' Major Technical Assistance Efforts
Not Directly Generating CYPs

Country	Activity	Dollar Amount
Kenya	Centre for African Family Studies	$465,000
Madagascar	Bridging Funds in All Sectors	$1,700,000
Malawi	National Family Welfare Council	$69,000
Morocco	Ministry of Health	$2,900,000
Tanzania	Family Planning Unit (MOH)	$2,300,000
Tonga	South Pacific Association for Family Health	$400,000
Yemen	USAID FP/MCH Bilateral with REACH	$1,600,000
Zimbabwe	Zimbabwe National Family Planning Council	$336,000
Total		**$9,770,000**

Source: SEATS

SEATS has done a good job in collaborating with other CAs in providing technical support.

2.4.2 Appropriateness and Potential Impact

SEATS' technical assistance efforts have been intended to advance family planning programs to national levels, increase access to service or improve quality of services, strengthen management, or promote sustainability. Some examples of the appropriateness and potential impact of SEATS' technical assistance activities will help demonstrate the effectiveness of these interventions.

In Papua New Guinea, SEATS' assistance paved the way for a much larger World Bank project. Here, SEATS used its resources to develop an embryonic family planning infrastructure and to test service delivery implementation patterns in preparation for the design and implementation of the World Bank project, scheduled to begin in the spring of 1993. SEATS trained large numbers of service providers in basic family planning, rehabilitated model clinics in the five provinces in which the project was operating, developed and tested simple service statistics and contraceptive logistics systems, provided a resident advisor to launch a contraceptive retail sales program, and participated in developing improved health planning and management capabilities. All the interventions have been effective and this precise combination of activities will be expanded in the upcoming World Bank project.

The Malawi government, which traditionally has taken a very conservative stance with regard to family planning, continues to ask SEATS to provide assistance to its newly established program based on the acceptability of two initial efforts. This is an impressive achievement, given the government's historic position on family planning. SEATS' main effort has been in relation to the National Family Welfare Council. SEATS' technical assistance helped train Council staff and assisted in the development of a five-year strategic plan, a 1993 workplan, and a budget. In addition, SEATS assisted church hospital networks to develop CBD programs that include distribution of oral contraceptives.

In Zimbabwe, SEATS' work has been much appreciated. Here, SEATS assisted in the revision of national medical standards and guidelines for family planning services. This work required both technical skills and the ability to develop a consensus among the diverse players in family planning on national standards. Representatives of the Ministry of Health, the Zimbabwe City Health Council, and the Zimbabwe National Family Planning Council all were pleased with the caliber of SEATS' assistance and viewed it as extremely important to improving the quality of the national family planning program.

In Kenya, the resident advisor to the Centre for African Family Studies (CAFS) in Nairobi was given high marks in terms of his technical capabilities and his interpersonal skills. Specifically, a number of individuals commented that the CBD course developed by this advisor was exceptionally well done.

In Tanzania, where SEATS is providing management and technical assistance to the Family Planning Unit of the Ministry of Health, it received high marks from the mission. Mission staff noted particularly that SEATS, whose resident advisor had assisted the unit in the development of an annual workplan and a computerized accounting system, had won the unit's confidence and trust. They also noted that SEATS had helped the unit convince the Ministry of Health to provide it with good additional, qualified staff, helping it make difficult decisions. These initiatives have helped increase the prominence of the national family planning program.

2.4.3 Implementation Problems

Although personal and cable feedback on short-term technical assistance generally was highly favorable, instances also existed reflecting a variety of problems. Some of the criticisms were general in nature. The USAID mission in Rwanda noted that technical assistance appeared to be SEATS' "greatest weakness," reflected in its inability to recognize when and how much technical assistance was needed. In Tanzania, where SEATS provided short-term technical assistance to the Family Planning Unit of the Ministry of Health to develop a MIS, the unit staff complained that the assistance they received from Washington was too brief and too theoretical and that there had not

been sufficient follow-up. More than concept papers, the staff said, they needed practical help in the application of the concepts. This is a typical need in low prevalence countries, where MIS frequently is the least developed component of the subprojects, and points to the need for SEATS to ensure that sufficient technical assistance is provided to each activity to solidly establish the MIS.

In Zimbabwe, the problem was different — namely, that the requirements of the country did not match the skills of the technical assistance provider. The need specifically was for assistance in health care financing but this need was filled by the country backstop in the regional office, who was an IEC specialist. Elsewhere, an MIS specialist backstopped a CBD project. The alternative would have been to provide technical assistance from SEATS headquarters or through a consultant.

Another issue is that some technical assistance activities have been linked only weakly to service delivery. For example, SEATS' assistance to CAFS was originally justified in terms of training support for subproject personnel. SEATS' assistance to date, however, has led to very few subproject personnel trained at CAFS, although it has enhanced the overall training capacity of an important regional institution. Similarly, in Tanzania, SEATS' technical assistance to the Family Planning Unit was only in management.

A final issue is that SEATS does not always pay close attention to the importance of skills transfer as part of technical assistance. The director of CAFS criticized SEATS for having abruptly eliminated the position of resident advisor, with the result that CAFS did not benefit fully from the transfer of his skills. Also, as noted in Section 2.3.3, in Zimbabwe, questions arose as to the extent of involvement of key project personnel in the design of subproject activities.

The issue of counterpart involvement has two sides, however. One of the difficulties faced by SEATS in providing technical assistance is that counterpart offices and personnel may not contribute adequate levels of effort or assume commensurate levels of responsibility or involvement. For example, in the CAFS situation mentioned above, there was no counterpart when SEATS withdrew its resident advisor. Because many countries have very little absorptive capacity, they are tempted to view SEATS as a supplementary human resource to be called upon for any purpose, without regard to the scope of work. (This is true for some USAID missions as well.)

A failure to spell out clearly the scope of work, specification of roles, responsibilities, and modus operandi of the technical assistance and counterparts may also contribute to the low level of counterpart activity. This situation is reminiscent of that in subproject implementation, when no documentation exists defining the roles of the SEATS resident advisor, the USAID mission, and the host country institutions (see Section 2.3.4 for pertinent recommendation).

2.4.4 Costs and Cost Effectiveness

Technical assistance costs represented approximately 78 percent of SEATS' spending through FY 1992 (as compared with only 22 percent for subprojects). The breakdown of these costs is shown below in Table 4. This was very different from the expectation at the inception of the project, which envisioned 42 percent of project funds being allocated to subprojects (see Section 2.3.1). Technical assistance costs include administration costs and the costs incurred at headquarters such as the costs associated with the placement of resident advisors, the time of other SEATS staff and consultants, subcontracts, travel and per diem, and all other direct costs associated with the technical assistance provided.

Table 4

Project Expenditures:
Subproject vs. Technical Assistance (through FY 1992 in $'s million)

	Subprojects	Technical Assistance
Administration		$3.39
Projectwide Activities		$2.81
WARO Countries		$4.55
ESARO Countries		$4.73
Asia/Near East Region		$2.46
Total ($23.06 million)*	$5.12	$17.95

Source: SEATS
*Total differs from sum of subprojects and technical assistance because of rounding.

Expenditures for technical assistance have been much higher than originally estimated. This is primarily because SEATS found in the low prevalence countries in which it has worked that much more intensive, long-term technical assistance has been necessary than planned to lay the groundwork for service expansion. This has required significant investment of both money and time. Even where service delivery has been started, much additional technical assistance is still required in infrastructure-poor countries. In addition, money has gone to technical assistance because countries were often found to be weak in their ability to conduct subprojects.

Although from a qualitative standpoint, almost all technical assistance provided has been timely, of high quality, and well received, the project contains no indicators that would permit evaluation of the cost effectiveness of technical assistance except as a level of effort. Not measured are the quality of technical assistance nor the impact of technical assistance. If appropriate indicators are developed, it is likely that a cost effectiveness study would be most useful if undertaken several years after full implementation.

Recommendations:

8. **SEATS should develop an evaluation instrument by which missions and host countries can systematically provide feedback on the quality and amount of technical assistance received from any SEATS source.**

9. **A.I.D. and SEATS should develop ways to evaluate quality and impact of technical assistance.**

2.5 Cross-Cutting Issues

2.5.1 Procurement of Equipment and Supplies

SEATS' performance in procurement of equipment and supplies (including of contraceptives) is the problem most frequently noted by missions, host country organizations, and other CAs. This is a

serious issue because resident advisors have spent an excessive amount of time monitoring equipment and commodity shipments and because lack of attention to sequencing of all project inputs, including provision of equipment, represents a serious implementation problem for subprojects.

The provision of equipment and supplies has been a significant component of SEATS' assistance. The American Manufacturers Export Group (AMEG — see Section 3.2.2 below) handles a portion of U.S.-based procurement, mainly of clinic equipment and supplies required for SEATS subprojects. Additionally, SEATS headquarters has done considerable direct procurement and SEATS field personnel have helped in procurement funded through bilaterals. Most items are procured from the United States, although an unknown portion may be procured in-country by missions, with SEATS' assistance.

Several examples can be cited of how failure of equipment to arrive on time has disrupted project activities. In Uganda, for example, SEATS had agreed to supply clinical equipment to 71 Ministry of Health clinics whose service providers had been trained by INTRAH. A series of delays was encountered, however, the result of which was that six months after INTRAH's training had ended, some participants were still without equipment. INTRAH finally had to step in and provide additional kits. The background was that the SEATS resident advisor had initiated direct procurement in early 1992 from a manufacturer in Kenya. This supplier, however, was unable to provide the standard clinical kits available on the international market. Delays occurred while equipment lists were redone by line-item, and more delays ensued while the individual items were reassembled into kits after arrival in Uganda. Some items were missing and then had to be ordered from the U.S.A. through AMEG; procurement was still in process at the time of the evaluation.

Burkina Faso offers another instance of how lack of timely provision of equipment derailed the planned sequencing of inputs, including technical assistance, training, and contraceptive supplies. In this country, personnel in the integration project health centers received training, but the centers were not yet renovated or equipped. Likewise, the Burkino Faso National Family Planning Association's youth project had begun service delivery, but neither clinical equipment nor contraceptives shipped by SEATS had arrived in-country and the Association was forced to use contraceptives and equipment acquired on a stop-gap basis from IPPF-funded programs. Only a small stock of contraceptives was available at the Bobo Dioulasso clinic, and the inadequacy of supplies, especially condoms, threatened the effectiveness of program activities (see Section 3.4.1 below for further discussion).

In Tanzania, a considerable amount of resident advisor time was used in trying to track a major procurement of vehicles for the bilateral project. Delays in procuring the vehicles have been variously attributed to an initial delay in placing the order, difficulties encountered by JSI and the Japanese auto manufacturer in working out the details of a mutually acceptable advance, questions relating to responsibility for insurance during shipment, and Japanese address errors in mailing key shipping documents. Trying to sort out all these processes was a time-consuming task that contributed little to SEATS' primary role in Tanzania.

Procurement of equipment and commodities for development projects is a notoriously complicated and often problem-ridden process. Frequently changing A.I.D. regulations make procurement for overseas projects a particular challenge. Some delay is almost inevitable in procurement of U.S. commodities for new projects. In the instance of procurement of contraceptives, many SEATS subprojects, such as the one in Burkina Faso described above, are probably too small and serve too few clients to justify special shipments of contraceptives from the United States. In such cases, a more efficient system might have been to use contraceptives that were already available in-country through countrywide contraceptive procurement.

Expanding family planning programs to national levels will require more, not less, procurement of equipment and commodities. Steps should be taken to improve the process, especially in light of the substantial share of project resources that has been spent on equipment, the excessive time resident advisors currently spend monitoring equipment and commodity shipments, and the disruption of subproject activities when equipment arrives late (see Section 2.5.1).

Recommendations:

10. **SEATS should institute an immediate and thorough review of its procurement procedures and performance and make adjustments as necessary to be more responsive to field needs. SEATS and A.I.D. should give consideration to adding professional procurement expertise at the headquarters and/or regional office level to coordinate and streamline the procurement of equipment and commodities. SEATS should also explore with A.I.D. the feasibility of SEATS' warehousing some standard equipment to speed field supply.**

11. **USAID missions should integrate SEATS' contraceptive needs into projections of national contraceptive needs prepared for central procurement and assist SEATS in obtaining contraceptive supplies from in-country sources.**

2.5.2 The Special Project Fund

SEATS has created a $3 million Special Project Fund for initiatives to assist U.S.-based private voluntary organizations (PVO) that conduct health-related development programs to increase their institutional capacity to carry out family planning by adding or expanding family planning activities in their portfolios. SEATS has provided assistance to two organizations through this fund: the American College of Nurse-Midwives (ACNM), which is working with the Uganda Private Midwives Association, and PSI, which is financing elements of social marketing efforts in Côte d'Ivoire and Cameroon (see Sections 2.3.2 and 2.3.4). A third activity is proposed involving U.S. Save the Children.

Both ongoing activities are playing a useful role but neither is designed to increase the institutional capacities of either ACNM or PSI. Rather, SEATS is essentially providing a resource transfer, particularly in PSI's case, considering its considerable technical expertise in the area of social marketing. SEATS is recommending that the second phase of the project include $10 to $15 million for an expanded version of the fund, which would support subproject funding, training, study tours, and technical assistance, including the possibility of placing resident advisors in U.S. PVO headquarters, regional, or country offices. This seems like a poor idea. Strengthening the institutional capacity of U.S. PVOs to work in family planning is a more appropriate role for A.I.D. than for SEATS (or any other CA). One danger is that the attention to PVO institutional development will detract from field-level service delivery activities. Collaborative activities *at the field level*, which should be strongly encouraged, can be achieved through other mechanisms such as subcontracts.

Recommendation:

12. **No further SEATS funds should be used for the Special Project Fund. If there is a follow-on project, the fund, as currently proposed by SEATS, should not be continued.**

3. SEATS Project Management

3.1 Project Management Structure

3.1.1 Overview

Organization of the SEATS project is decentralized, with lines of authority emanating from the headquarters office in Rosslyn and the two regional offices — the West Africa Regional Office (WARO) for francophone West Africa and the East and Southern Africa Office (ESARO) for anglophone East Africa.

Responsibility for overall project management and implementation lies with the project director who is also responsible for assuring project development, provision of technical assistance, and all tasks related to the achievement of SEATS project outputs. Each of the regional offices is headed by a regional director who has the same set of responsibilities in his respective region. The regional director for Asia/Near East and the Pacific is based in the headquarters office. According to the organizational structure, each of the regional directors also supervises the resident advisors within his region (see Appendix E). At the central level, a program associate is assigned as the primary point of contact and support for each regional office and resident advisor, maintaining daily contact and ensuring effective communication in both directions.

The decentralized management structure, coupled with a broad mandate for country-specific programming, provides the flexibility needed for developing national-scale family planning programs in the different countries in which SEATS operates. SEATS management reinforces these characteristics by operating a flat non-hierarchical organizational structure which attempts to minimize bureaucracy. This management structure places both a great burden for supervision and coordination on the project director and the regional directors and a resulting wide span of control. The approach results in minimal supervision of the resident advisors and regional technical specialists and requires that each technician be self-directed. At the subproject level, this sometimes results in technical assistance that is perceived as being of insufficient duration, depth, or quality (e.g., in Zimbabwe, when an inappropriately trained individual provided technical assistance — see Section 2.4.3). SEATS has attempted to control for this by instituting a number of formal procedures and informal practices that support the decentralized structure. These include the assignment of the program associate mentioned above as a point of contact for each regional office and resident advisor, the establishment of a small project fund, and a rapid system of proposal review and approval.

3.1.2 SEATS Headquarters Office

SEATS headquarters is located in Rosslyn, Virginia, within easy reach of A.I.D. technical and administrative offices. Its staff consists of 11 senior professionals and 7 junior associates (see Appendix E). The SEATS deputy director has assumed a resident advisor's position in Morocco but still retains the title of deputy director. In his absence, the senior professionals rotate responsibility for serving as the acting director when the director is out of the country or otherwise unavailable.

The senior professional staff have excellent professional credentials and are experienced and respected members of the international family planning community. The program and staff associates largely have had professional training and some international experience, but are mid-career level.

3.1.3 SEATS Regional Offices

The requirement that SEATS establish two regional offices in sub-Saharan Africa was to ensure that a pool of technical assistance specialists from SEATS would be available as close as possible to the countries in which they would be needed. The vast geographic expanse of the region, the communication and logistics difficulties in developing countries, and the broad linguistic differences in sub-Saharan Africa made the requirement for two offices both reasonable and potentially cost effective.

The project established WARO in Togo in late 1989, almost immediately after the project was started. Following significant delays in obtaining USAID approval, it established ESARO in 1991 in Zimbabwe. The Lome office has experienced severe disruptions in its operations due to the political and security situation in Togo. At the time of the evaluation, the situation had deteriorated to the extent that it was virtually impossible to operate from Lome.

ESARO has a total staff of 13 and WARO, 14. Both offices have technical specialists in the areas of program development, training, IEC, MIS/evaluation, financial management, and medical issues (see Appendix B). Each office is headed by an African professional with years of international family planning experience.

Although specific technical skill areas are well covered, several USAID missions found the SEATS staff somewhat deficient in the areas of project implementation and service delivery project development. Staff themselves corroborated this perception, with none reporting skills in implementation of subprojects and several reporting that they had experience in service delivery and in project development, but not in these skills together (see Table 5). SEATS personnel have the ability to transfer successfully specific technical skills to host country personnel. What sometimes is overlooked is assistance in how to use these specific technical skills during implementation. This approach has sometimes resulted in a subproject development process containing specialized technical assistance inputs but lacking the overall design quality that would aggregate these inputs into a successful family planning service delivery subproject. Furthermore, during project implementation, each subproject is backstopped at the regional office level by one of the technical experts, rather than by a generalist with implementation skills (see Section 2.4.3).

Table 5

Selected Technical Skills of SEATS Staff, as Reported by Each Staff Professional

Skill	Central	WARO	ESARO
FP Service Delivery	7	2	2
CBD	3	2	1
Clinic Management	3	2	1
Project Development	9	4	4
Program Monitoring	9	5	4
Total Number of Staff Reporting	10	7	6

Source: Excerpted from "Background Analysis for SEATS Mid-Term Evaluation Scope of Work." John Snow Inc., Feb. 1993, p. 61.

Recommendations:

13. **The regional office staff in Africa should include more service delivery program development and general family planning service delivery expertise in order to improve provision of technical assistance to host country institutions for project development, design, and implementation.**

14. **SEATS should continue to maintain two offices in sub-Saharan Africa in order to ensure continued effective support its activities in the region. In view of the political situation in Togo, immediate attention should be directed to relocating the WARO office.**

3.1.4 Resident Advisors/Country Offices

Description

SEATS has been very successful in recruiting highly qualified and experienced family planning professionals as resident advisors, particularly Africans in sub-Saharan Africa. The long-term assistance they have provided has been useful and its quality has been good, according to observations, interviews, and cabled responses from USAID missions. Of the 12 resident advisors now in place, 8 are assigned to sub-Saharan Africa and 4 are assigned in Morocco, Papua New Guinea, Turkey, and Yemen (see Table 6 on the next page). Most resident advisors are assigned to a country for at least two years.

Initially, it had been expected that the project would have two types of staff who would provide long-term technical assistance: 1) 4 to 6 resident (or technical) advisors assigned to countries with large or numerous SEATS subproject activities and 2) up to 15 long-term program/policy advisors who would be assigned at the request of missions to assist in strengthening components of national family planning programs (see Table 1). SEATS has treated these as one category, primarily because it was found that the advisor performs both functions to some degree, although one role is usually predominant. Of the 16 resident advisors who have been placed during the project life, 10 are or have been primarily concerned with subproject development, implementation, and monitoring (i.e., they fit the job description of the original resident advisor) and the other 6 are closer to the expected role of the second category, that of program/policy advisors (i.e., they are less concerned with CYP-generating subprojects and spend more time working on "bridging" activities or on institutional development, management and general support). All but three have been funded either in full or in part through core funding, reflecting the ability of the project to access these funds for low prevalence countries. If the Priority Country Strategy, which calls for core funding to go only to priority countries, were to be rigorously enforced under the follow-up project this could lead to a possible disruption in SEATS' activities in some low prevalence countries.

Major Responsibilities

In many of the countries in which SEATS works, health and family planning infrastructures are so poorly developed that resident advisors must serve as key components of the host country institution's management structure. Although the scope of work of each resident advisor is individually developed and negotiated so that it is specific to the country in which he/she is placed, in some instances as much as 25 percent of the resident advisor's time may be taken up in day-to-day administrative matters that are of no technical assistance benefit in terms of development of systems or transfer of management and coordination skills. Because by definition the resident advisor position is an expensive and highly visible one, such use of time, however justifiable under the rubric of "management support," reduces the cost effectiveness of the resident advisor and creates a degree of dependency as in Tanzania (see Section 2.5.1).

Table 6

Main Functional Role and Source of Funding of Resident Advisors

Country	Role A[1]	Role B[2]	Source of Funding for RA
Burkina Faso	✓		Core
Cameroon	✓		Core+Buy-in
Cote d'Ivoire	✓		Core
Kenya/CAFS (now ended)		✓	Core
Madagascar (now ended)		✓	OYB Transfer
Malawi		✓	Core
Morocco		✓	Core
Papua New Guinea	✓		Core
Rwanda	✓		Core+Buy-in
Tanzania		✓✓	Buy-in
Turkey	✓		Core
Uganda 1	✓		Core
Uganda 2	✓		Core
Yemen 1 (now ended)		✓	Core
Yemen 2	✓		Buy-in

Source: Evaluation team analysis

[1]Role A = Service delivery program development, monitoring, and coordination.

[2]Role B = Institutional development, management strengthening, and general support.

Supervisory Structure

Consistent with the decentralized nature of SEATS management, the resident advisors are expected to report to regional directors and are to receive most of their support and backstopping from the regional office. Almost all technical assistance required by the resident advisor is supplied by the regional office, including most assistance for IEC, training, MIS, financial administration, and medical aspects of contraception (see Section 2.3.4). In Tanzania, on the other hand, the resident advisor reports programmatically directly to SEATS headquarters without any apparent loss of effectiveness. In that particular case, the communication difficulties between Dar es Salaam and Harare and the specific technical assistance required for implementing the SEATS' scope of work in Tanzania make this direct relationship with headquarters a rational decision. The regional office can reasonably be expected to provide only partial administrative support in a timely manner from its pool of technical

expertise. For example, all financial and contractual issues relating to the resident advisor including salary negotiations are handled directly with SEATS headquarters. This works well.

In some instances in Africa, the amount of support provided to the resident advisor from the regional office has been called into question. In Burkina Faso, the resident advisor seemed to have received very little technical backstopping from the regional office. In Tanzania, because of his extensive family planning background, the resident advisor found that the regional office had little to offer. Clearly, when technical backstopping is found insufficient, part of the explanation can be found in the difficult and inefficient communication in sub-Saharan African countries. Another part of the problem, however, is related to the wide span of control of the regional directors and the consequent difficulties they experience in supervising all the technical specialists at the regional office and at the same time providing direct supervision and support for the resident advisors. Consequently, in instances of conflict or tension between the USAID mission and the resident advisor (as in Tanzania and Côte d'Ivoire, the latter touched on in footnote 2), it has been difficult for the regional director to play a role in resolving the dispute. A few missions (especially Tanzania) have the perception that the regional office is not essential to the functioning of the resident advisors.

Visits by regional directors to resident advisors provide the director with an opportunity to monitor overall progress of SEATS' activities, to provide supervisory support to the resident advisor, and to assess the strengths and weaknesses of the resident advisor. The annual performance appraisal of SEATS resident advisors includes self-appraisal and regional director comments but has no input from either USAID or host country personnel.

The supervisory span of control of the regional director could be reduced if day-to-day supervision of the technicians in the regional office were assumed by another staff member, preferably a generalist with implementation skills, thus allowing the regional director to focus his supervisory responsibilities in the field. The program development officer position in WARO and the program director position in ESARO could be given the additional responsibility for supervising regional office technical staff. The current incumbent at WARO has general family planning expertise and currently has broad responsibility for subproject development and for coordination of the inputs of the technical specialists, although his prime skill is general family planning expertise. The newly recruited program director at ESARO, who will have a similar role, is a family planning generalist, with broad skills in design, implementation, and women's issues.

Recommendations:

15. **In addition to regular monitoring and supervision visits by the regional director, SEATS should develop appropriate mechanisms for incorporating the comments of USAID missions and host country counterparts in the annual performance appraisal of resident advisors.**

16. **SEATS should review the organizational structure of the regional offices with the objective of reducing the span of control of the regional director to enable him/her to provide more effective supervision and support to the country resident advisors. An alternative, more effective structure would have the technical specialists reporting to the program directors.**

3.1.5 Cost Effectiveness of Field Advisors

According to a simple cost analysis undertaken by SEATS in preparation for this evaluation, it was found to be more cost effective to provide technical assistance locally and regionally than from central sources. This analysis was carried out by comparing the costs of transportation of central staff with costs of basing many advisors in their native countries. Although this comparison found that it was

less expensive to use technical assistance based in-country, the more important issue is that of quality. Here, too, a strong case can be made for continuing to locate resident advisors in Africa.

Qualitative factors favoring on-site resident advisors include the speed and range of responsiveness made possible by a country-based advisor familiar with local circumstances and his/her ability to pursue a problem to completion. This ability to stick with an issue, particularly in the infrastructure-poor countries of Africa, cannot be matched by technical assistance from the U.S., no matter how technically sound the technician. The on-site presence also provides opportunities to react to targets of opportunity that might go unnoticed in the absence of an in-country presence. Moreover, the continuing decline in numbers of HPN officers as well as other support personnel in USAID missions creates an increasing need for on-site, non-A.I.D. technical resources to assist the missions in program guidance and monitoring, a role that SEATS resident advisors can comfortably fill because of their professional capabilities.

On the issue of sustainability, the sub-Saharan African countries in which resident advisors are assigned are some distance from being technically or financially self-sustaining. Although SEATS has not been as active as anticipated in the areas of sustainability and cost recovery in subprojects (see Section 2.3.7), resident advisors and regional office staff do have an opportunity on a broader scale to encourage recipient countries, especially in sub-Saharan Africa, to start moving toward sustainability in the area of family planning. One example is SEATS advisors' making countries clearly aware early on of the long-term advantages of introducing long-acting contraceptive methods, whose greater effectiveness will result in reducing overall costs of contraceptives and thus freeing funds for additional efforts in family planning. Another way in which SEATS resident advisors and regional office staff encourage technical sustainability is in the area of identification, selection, and mentoring of candidates for participant training. SEATS' participation increases the likelihood that those selected for training will be individuals who are committed to family planning and thus will contribute to promotion of fertility reduction. Since in many countries, resident advisors must serve as key components of the host country institution's management structure, it could be argued that SEATS' involvement is detracting from the opportunity for host country staff to take the lead in family planning activities. In view of the mostly nascent family planning infrastructures in most SEATS countries, however, it will be well beyond the ten-year span of the SEATS' activity before the presence of resident advisors or the regional offices will slow or interfere with sustainability.

3.1.6 Evaluation Mechanisms

Monitoring and evaluation tools used by SEATS include financial reports; subproject and resident advisor reports on activities and progress towards objectives; and monitoring visits and MIS systems for tracking CYP and other quantitative outputs. SEATS and the A.I.D. CTO also conduct an annual management review which focuses on predetermined areas of project interest. As called for by the contract, quite extensive internal management reviews were conducted by the Office of Population and SEATS in February 1991 and March 1992. In September 1992, SEATS conducted its first annual program review, examining some of the same questions that this present external midterm evaluation is charged to examine. SEATS used a newly developed protocol for program review which involves joint visits by headquarters and regional office high-level personnel to a subproject in each of three SEATS regions and an intensive document review of three other SEATS countries. The program review examines progress towards achievement of SEATS' project outputs; country progress towards developing national programs; overall progress toward SEATS' project purpose; and soundness of the project design. Additional reviews are planned.

3.2 SEATS Subcontractors

3.2.1 Center for Population and Family Health and the Program for Appropriate Technology in Health

The SEATS project has two major cost-reimbursable subcontractors, the Center for Population and Family Health (CPFH) of Columbia University and the Program for Appropriate Technology in Health (PATH). Both provide full-time core staff for the African regional offices. CPFH provides one medical advisor and four training advisors, two per field office. (The resident advisor at CAFS was CPFH-funded, but that position was not renewed at the end of his contract [see Section 2.4.3].) PATH's two full-time staff are responsible for technical assistance in IEC; one is assigned to WARO and the other to ESARO.

All subcontractor staff are supervised by the regional directors and are functionally indistinguishable from the other technical specialists in the field. Both subcontractors confirmed that SEATS maintains excellent relationships with the two organizations and has instituted periodic subcontractor meetings at which project implementation is reviewed. In addition to these full-time personnel, other personnel from these subcontractors have undertaken specific technical assignments for SEATS, an example being development of the CYP Target Model by a member of the CPFH.

3.2.2 American Manufacturers Export Group

SEATS maintains a procurement services subcontract with AMEG for the procurement and shipment of commodities and clinic equipment. The current SEATS procurement mechanism using AMEG involves a field office assessment of the equipment needs for a subproject during the subproject development process. A list is compiled and submitted to SEATS headquarters where it undergoes an internal review process before a request is made by the contracting officer to AMEG for price quotation. AMEG requests bids for the equipment before submitting estimates to SEATS. If the estimate fits within the program budget, a task order is issued to AMEG, which then procures the equipment and arranges shipping and forwarding through its shipping agent, MATRIX International. When the estimate does not fit within the initial program budget, the field office is contacted and requested to make decisions regarding the equipment funding. To date, AMEG has obligated a total of $600,000 for 25 task orders.

3.3 SEATS' Relations with Other Organizations

3.3.1 Office of Population

Relations between the Office of Population and SEATS are excellent and SEATS is very well regarded at A.I.D. SEATS' efforts to establish and maintain open and frequent communication channels with A.I.D. from the beginning of the project have facilitated project implementation and ensured that SEATS remains an effective mechanism for implementation of Office of Population strategies. The SEATS' strategic plan, annual workplans, and the annual management review exercise all provide important opportunities for feedback and dialogue with A.I.D., as do the routine quarterly financial and progress reports submitted to A.I.D. This dialogue has played a key role in enabling the SEATS project to respond to the Office of Population's Priority Country initiatives (see Section 1.3).

In its approximately 44 months of existence, SEATS has had six CTOs for an average of seven and one-half months per CTO. This frequent turnover might have had very serious effects, given the differing opinions of population professionals about the competing priorities of international family

planning assistance, the interpretation of SEATS' broad mandate, and the roles and responsibilities of SEATS, the Office of Population, and the USAID missions, to say nothing of the scope and complexity of the project itself. As a result of the caliber of the CTOs, however, this high turnover has only occasionally slowed the pace of project implementation. More slowdowns have occurred because of the repeated turnover of contracting officers responsible for SEATS. Once the inevitable learning curve has been passed, the contracting officers have been very helpful. Ultimately, however, such turnover is part of the price of doing business with A.I.D. and SEATS has been fortunate to have weathered these changes with little or no disruption to its operations.

3.3.2 USAID Missions

In general, SEATS maintains very cordial relations with USAID missions. Many missions have welcomed SEATS' flexibility and "one-stop shopping" approach because of the potential for reducing the management burden involved in dealing with a large number of CAs working in a country. The Tanzania mission noted in particular that SEATS had "reduced the ordeal of working with so many contractors and Cooperating Agencies," and the Zimbabwe mission also expressed appreciation of the way SEATS had facilitated coordination of activities implemented by the many CAs in that country.

This appreciation is complicated, however, by the occasional misunderstanding of what "one-stop shopping" means in terms of SEATS' role. As noted in Section 2.4.3, missions tend to view SEATS as a "supplementary human resource," and this has led to some missions' asking SEATS to do everything from coordination of other CAs (the role of the "lead CA") to procurement of large quantities of equipment to provision of management support to host institutions or technical assistance for specific family planning interventions. Expectations of some missions have been unrealistic, and SEATS itself may have contributed to these unrealistic expectations by its marketing of its "one-stop shopping" mission. Failure to be "all things to all people" has led to SEATS' being assessed critically by some missions. SEATS has been faulted in Tanzania for not having lived up to USAID's expectations regarding its ability to manage and replace other CAs. The mission there contends that an A.I.D. design team member oversold the "one-stop shopping" capabilities of SEATS and that senior mission management is disappointed that it is not getting from SEATS the range of technical assistance it expected and must therefore still draw on other CAs. Likewise, in Rwanda, the mission indicated its view that SEATS' scope of work seemed "too wide and varied," questioning whether a project could be expected to have staff "in adequate numbers — with solid expertise in the wide range of skills required" to do all that the scope implied.

Furthermore, the actual roles and responsibilities that SEATS is expected to fill in a specific country are often vague and general. Again, in the case of Tanzania, SEATS was requested by the mission to procure 26 vehicles (see Section 2.5), provide management support to the Family Planning Unit (see Section 2.4.2), and assist in the implementation of the bilateral program by providing technical assistance (see Section 2.2). This broad and general scope of work led to conflicts between SEATS and USAID which had not been completely resolved at the time of the evaluation.

Most likely, more attention to strategic planning and to spelling out roles of all parties would ease these problems (see Sections 2.2 and 2.3.5 for recommendations designed to improve missions' understanding of SEATS' role).

3.3.3 Host Country Institutions

In the countries visited, relationships between SEATS and host country organizations were generally cordial and appeared to be based on mutual respect. As observed in Côte D'Ivoire, Burkina Faso, and Tanzania, SEATS resident staff have forged close working relationships with high-level host country counterparts. Cabled responses from USAID missions either were silent on this question or

complimentary, with a few minor exceptions. For example, the Uganda mission noted that, except for training activities, SEATS lacked a formal mechanism for coordinating its private sector activities with the national family planning program of the Ministry of Health. In Tanzania, the mission noted the Family Planning Unit's disappointment with SEATS' technical assistance (see Section 2.4.3). Overall, however, given the multiple host country organizations with which SEATS deals, relationships appear to have been solidly established and beneficial.

3.3.4 Other Population Agencies

SEATS collaborates with a long list of population organizations and projects including CPFH, PATH, AMEG, PSI, Pathfinder International, INTRAH, AVSC, JHPIEGO, Population Communication Services (PCS), and the Population Council (see list at end of Appendix C). Although inevitably a few problems in coordination have arisen, working relationships have developed well and are amicable and all expressed their satisfaction with the working arrangements that had been established with SEATS. Indeed, relationships between these organizations and SEATS appear to be remarkably free of expressions of turf concerns. Even reports of difficult situations often turned out to be less problematic than thought, or to be untrue. For example, even though the Director at CAFS had expressed disappointment that SEATS had "unilaterally" discontinued its resident advisor (see Section 2.4.3), he indicated he was looking forward to further collaboration. Rumors of problems in Tanzania between INTRAH and SEATS, and in Rwanda between SEATS and AVSC, both turned out to be incorrect.

Although a spirit of cooperation is visible in all SEATS countries, in Africa, in particular, the sense of urgency arising from the huge job facing the development community has contributed to facilitating relationships among the CAs involved there. Instances of collaboration are many and varied. For example, SEATS has participated in over 10 percent of the Population Council's Africa Operations Research/Technical Assistance subprojects including several situation analyses.

SEATS staff time is frequently made available to other agencies. For example, in Papua New Guinea over an eight-month period, one-third of the time of the SEATS resident advisor was contributed to social marketing activities supported by the Social Marketing for Change (SOMARC) project; in Rwanda, SEATS contributed four person months to INTRAH training activities and four person months to AVSC training; and in Cameroon, under its bilateral project, SEATS is hiring a financial advisor to oversee all A.I.D.-funded CA projects in that country. Likewise, other agencies make their staffs available to SEATS. In Yemen, for example, JHPIEGO donated the time of one of its trainers to a SEATS project.

SEATS also provides support in the area of equipment and supplies. In Uganda, SEATS worked, albeit somewhat unsuccessfully, to procure clinic equipment for family planning service sites staffed by INTRAH trained personnel (see Section 2.5). In other places, SEATS has paid for printing of materials developed by the PCS project. In Tanzania, SEATS provided funds to INTRAH so that trainers of family planning personnel could have additional training abroad.

SEATS' capacity to provide funds to other CAs for unexpected equipment needs and other activities has been cited as being exceedingly useful. Moreover, this collaboration has enabled each CA to exhibit its strengths, i.e., to permit a broad-based SEATS to complement the work of other CAs which have more specialized missions. The result, in the words of the SEATS director, has been "more effective field activities which deploy disparate resources more coherently."[4]

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[4]Memo from Nancy P. Harris to evaluation team member Shanti Conly, entitled "Collaboration/Coordination/ Subcontracting," dated March 9, 1993.

Bureaucratically, these collaborative activities have been more problematic. Most are arranged at the country level and do not require A.I.D. approval. The problem, however, is that there are no standard mechanisms for one CA to access expertise from another, as, for example, when SEATS wants to "buy" the services of the other specialty CAs. In addition, no resources are explicitly available for such cooperative ventures, nor have any guidelines been drawn up to spell out at which juncture in subproject design or implementation SEATS could or should seek such collaboration.

Multiple arrangements do exist, however, to exchange funds and personnel for mutually planned activities, and SEATS has resorted to these various *ad hoc* mechanisms in implementing the collaborative efforts described above. Most commonly, a kind of "barter" arrangement is used: In Papua New Guinea, SEATS billed all SOMARC-related travel, per diem, and incidental expenses through SEATS and then subsequently billed SOMARC. Increasingly, particularly for more formal or multi-country interventions, a formal memorandum of understanding is prepared. Such a memorandum has been developed for a cooperative venture with Georgetown University, which will train professionals from SEATS countries, including two SEATS staff members, in lactation management and post-partum care. The written agreement covers clear delineation of cost attribution and supervisory arrangements for Georgetown technical staff in the field. In some instances, however, no mechanism could be found: For example, in some countries, SEATS sought to draw in other specialized CAs, but was unable to, since these agencies had expended all funds available for use in that country for that year.

Although SEATS is committed to continuing these collaborative efforts, simpler standard mechanisms for collaboration would help assure timely help from other CAs.

<u>Recommendation</u>:

17. **SEATS and A.I.D. should seek to develop simpler financial and procedural mechanisms to permit SEATS easier access to technical assistance expertise available through other CAs.**

4. Follow-On Project

4.1 Justification for a Follow-On Project

The need for a general purpose family planning CA like SEATS will clearly continue beyond the duration of the current contract, particularly to assist with the needs of low prevalence countries. Many USAID missions were particularly firm that SEATS-type assistance should be continued. That core funds of the current SEATS project are fully programmed is further indication of the demand for the kind of services it provides (see Section 1.3).

Given the time required for project start-up, SEATS is only now gathering momentum and beginning to provide services on a substantial scale. The requirement that the contract be rebid after five years could potentially lead to a significant loss of momentum in the final year of the contract, just as project interventions are beginning to yield results. Moreover, a change in contractor for the follow-on project would almost inevitably cause some level of disruption of service delivery activities.

Recommendation:

18. **The SEATS project should be extended an additional five years when the current contract expires, this period being consistent with original project design. A.I.D. should begin the redesign immediately to maintain existing momentum and minimize interruptions or delays should the project be rebid.**

4.2 SEATS' Comparative Advantage and Niche

Three characteristics make the SEATS project design particularly appropriate, setting it apart from most other centrally funded family planning projects and giving it comparative advantages in its range of activities and its ability to respond rapidly and flexibly to requests for specific assistance.

The first characteristic is the **extremely broad project purpose** of the project paper, which provides an opening for SEATS to consider responding to nearly any request for family planning assistance (see Section 1.2). Few other CAs have enjoyed similarly comprehensive mandates; even those that have, had similar but somewhat more constricted scopes (Pathfinder and, in the past, FPIA). More typically, family planning CAs are designed to provide state of the art technical assistance and support in highly segmented specialty areas, such as VSC, IEC, family planning logistics, and operations research. From a field standpoint, the downside of calling on these many CAs is the management time necessary to select, monitor, and coordinate their activities, an increasing concern given ever-diminishing numbers of USAID professional population and health field personnel. The broad mandate of SEATS allows it to respond to a much wider range of requests for family planning assistance. A medical analogy for SEATS would be to liken it to a highly trained family physician who calls in more specialized assistance (other CAs) when needed. A stronger analogy would be to liken most CAs to uni-purpose specialty clinics and SEATS to a full-service hospital.

A second characteristic providing a potential comparative advantage is the considerable **financial resources** available to SEATS. The original plan — to focus attention in low contraceptive prevalence countries, many of them with populations of 10 million or less and with somewhat limited absorptive capacities, and to provide a funding mechanism that combines core funds and capacity to accept buy-ins — has assured that there have been sufficient resources to respond to special, sometimes costly, situations. Mention has been made earlier of how the project's access to generous amounts of central core funds allowed for an early start to activities while regional or mission funds were being put in place and permitted missions to implement family planning activities for which they did not have

sufficient funds. Other CAs typically must husband and pre-program their funds much more strictly for designated activities in specific geographic areas.

A third characteristic that gives SEATS a potential comparative advantage is the **decentralization of responsibility for subproject design and implementation.** Project personnel, both regional and country-based, are given an unusually wide latitude to design and select activities or subprojects that respond to identified needs and to take the initiative in negotiations within a given country. Because the staff are largely seasoned professionals who are thoroughly familiar with SEATS' policies, they undertake these tasks with considerable assurance that they will receive strong backing from SEATS management.

In addition, the SEATS' ability to work imaginatively with the private sector is not easily matched by other CAs and is a strong argument for retention and continuation of the SEATS organization.

In particular, it is the existence of these characteristics *in their totality* that sets the SEATS project apart and makes it uniquely useful among A.I.D.'s CAs.

Recommendation:

19. **Access to high levels of core funding for support of technical assistance and subprojects in low prevalence countries should be maintained in a follow-on project. At least 50 percent of the funds should be reserved for low prevalence countries which are not Office of Population "priority" countries.**

4.3 Design Issues

4.3.1 "One-Stop Shopping"

Particularly in low-prevalence, non-priority countries, the "one-stop shopping" approach to technical assistance offered by SEATS is the most appropriate approach. Such countries are not able to utilize assistance from specialty CAs as effectively as can countries with more mature programs. Rather, they need assistance at a more rudimentary level, guidance on how to get started in all the key facets of a young family planning effort, including technical assistance for service delivery, training, IEC, and MIS.

On the other hand, the use of the term "one-stop shopping" itself needs to be rethought. As happened in Tanzania (see Section 3.4.3), this phrase conjures up unrealistic expectations, suggesting that SEATS can carry out all the activities in family planning that the mission decides upon. This may be possible when these activities are few and limited, but especially in priority countries where demands are many and heavy, it is clearly impractical. Pathfinder and FPIA (in its day) both offered a wide range of technical capabilities but never used the "one-stop shopping" phrase. SEATS' reputation as a source of a similarly broad range of technical assistance options is well established. This is sufficient; use of the term "one-stop shopping" has no precise definition, means different things to different people, and has resulted in misunderstanding and ill will in some situations.

Recommendation:

20. **Although the follow-on project should retain the "one-stop shopping" characteristics of SEATS I, it should drop the "one-stop shopping" term to describe its capabilities.**

4.3.2 Relevance to Country Programs in Africa

The follow-on project will most likely continue to include a mix of core and buy-in funding. As the Priority Country Strategy continues to be introduced, in Africa a greater proportion of Office of Population core funds can be expected to be absorbed by the priority countries; this is because most of them, e.g., Nigeria, Tanzania, Zaire, have a very low level of contraceptive prevalence, implying a multiplicity of costly needs. Concentrating project funds in these larger countries is a sound strategy; however, SEATS may now be the Office of Population's major contributor to the non-priority countries. Therefore, the need will continue for funds to supplement SEATS' core funds for the many low prevalence, non-priority countries for which SEATS' assistance was designed.

The project has shown that core funding allows a more expeditious response to mission and host country needs than have bilateral agreements. Thus, a new way needs to be found that will enable the Africa Bureau to channel some funds centrally rather than through missions. The Africa Bureau and the Office of Population have not maintained effective communication channels for the development of a population strategy for Africa that enables the Africa Bureau funding to access Office of Population technical assistance. It is important that under SEATS II, the Africa Bureau work more closely with the Office of Population on developing a coordinated approach to meeting needs of all countries in that region.

Recommendation:

21. **The Office of Population and the Africa Bureau should develop a coordinated strategy that addresses the technical assistance needs in family planning of all countries in the Africa Region. The Bureau should consider providing funding to Office of Population CAs, including SEATS, to assist and expedite population activities in non-priority, low prevalence African countries.**

4.3.3 Mix of Project Activities

Under the current project, subproject expenditures have amounted to only 22 percent of the total, rather than the 42 percent called for in the contract budget (see Section 2.3.1). The other 78 percent has gone to technical assistance related to institutional development (see Section 2.4.5). Current projections suggest that, over the life of the project, subprojects will account for 31 percent of expenditures, with technical assistance absorbing the other 69 percent.

Expenditures on technical support costs — particularly the costs of resident advisers, staff travel, allowances, and other direct costs — have been higher than anticipated. To a certain extent, this reflects the decision by some missions to call on SEATS for institutional support. A high level of intensity of technical assistance appears necessary to support service delivery activities in low prevalence settings, and the project has invested considerable time and effort in establishing the basic systems needed to enable services to function effectively. SEATS' tendency to use a staff-intensive model of technical assistance has added to costs (see Section 2.4.3).

As noted in Section 2.4.3, technical assistance to strengthen infrastructure and develop institutional capacity has not always been well linked to the provision of services. Although technical assistance will continue to be important to strengthen infrastructure and develop institutional capacity, attention needs to be directed to ensuring that such activities are more closely linked to the provision of services. Moreover, a stronger focus by SEATS on service expansion would give project management the basis for saying "no" to mission proposals that SEATS become involved in more peripheral activities, such as those "inherited" projects described in Section 2.2.

Recommendation:

22. **SEATS II should operate under its current broad and flexible mandate in order to maintain its flexibility to respond to A.I.D. requests for expansion of family planning service delivery, and to a lesser extent, for bridging activities and institutional development. Resources allocated for institutional development activities should be clearly tied to service delivery and directed to currently supported institutions that have made the most progress.**

4.3.4 Emphasis on Collaborative Approach

As noted in Section 3.4.5, although SEATS has done an excellent job in collaborating with other CAs, its efforts have been made more difficult as a result of lack of standard operating procedures for collaborative efforts among CAs. Creating a special mechanism to draw in other agencies raises many difficulties. Providing SEATS with the resources to support the activities of other CAs raises sensitive issues and is likely to be resented to a certain extent by other CAs. A.I.D. contracting regulations tend to discourage subcontracts with other U.S. CAs, except as essential to the project design, because of inefficiencies such as double overhead. The increasingly competitive atmosphere surrounding both mission and worldwide procurement also represents a deterrent for specialized agencies to share their technical expertise with a potential competitor, and serves to keep general purpose CAs and more specialized agencies apart. Nevertheless, if SEATS is to be responsive to low prevalence countries, particularly non-priority countries in Africa, a formal mechanism for the transfer of resources must be built into the follow-on activity.

Recommendation:

23. **The design of a follow-on project should give special attention to the interface between SEATS and more specialized CAs. The project design should incorporate a functional mechanism that would enhance SEATS' ability to access other CA expertise, while meeting A.I.D. bureaucratic requirements with respect to subcontracts. The project design should also establish the criteria on which SEATS should base the decision to draw in other more specialized CAs, and to the extent possible, create incentives to do so when appropriate.**

4.3.5 Trade-off Between Impact and Sustainability

As noted in Section 3.1.4, SEATS has taken seriously its mandate of assisting implementing agencies to achieve financial sustainability while recognizing the inherent conflict between expanding services and enhancing sustainability. Among its various efforts to promote sustainability, the only one that needs serious rethinking under SEATS II relates to the project's reluctance to support inputs involving heavy recurrent cost burdens such as salaries. SEATS deserves credit for attempting to identify activities with the potential for long-term sustainability independent of SEATS' support. In the early stages of program development in very poor low prevalence countries, however, the assumption that short-term support for a few discrete inputs will result in sustainable family planning services in public sector projects is probably unrealistic in the absence of some support for recurrent costs, including on occasion temporary partial salary support. In the follow-on SEATS project, reluctance to provide such supplements may result in subprojects with host country counterparts who are unwilling or unable to devote the time and effort necessary to accomplish subproject objectives.

Recommendation:

24. **A.I.D. and SEATS should reexamine the possibility of temporary provision of some recurrent costs, including salary costs, in public sector programs in those countries ranked in the lowest 25 percent by per capita gross national product.**

4.3.6 Integration of AIDS Education into SEATS

In many of the countries in which SEATS is working, the prevalence of AIDS/HIV and other STDs is very high. Despite the many linkages between family planning, AIDS, and STDs, neither SEATS nor other CAs appear to be addressing key issues related to the provision of family planning services in this new environment.

This may reflect the position of the Office of Population, which reportedly has been reluctant to promote a more integrated approach, apparently from concern that more emphasis on AIDS could dilute the focus on family planning. Condoms financed from the AIDS and population accounts are currently tracked separately, illustrating the current vertical approach to AIDS and family planning programming and making condom-counting and attribution necessary.

It is imperative that the AIDS prevention message become an integral part of the family planning package. The need is urgent to develop guidelines and protocols for protecting both family planning clients and staff during clinical procedures and to provide family planning counseling and services for women at risk of, or suffering from, AIDS/STDs. For example, service providers need to promote condoms more aggressively, and need to be provided guidelines as to when they should advise women to use condoms in addition to more effective family planning methods.

SEATS has recently created a new post of women's health advisor, and the incumbent is expected to address many of these issues. The challenge for SEATS will be not only to develop the conceptual framework for addressing these issues, but also to establish effective mechanisms for their transfer to field-level programs.

Recommendation:

25. **A.I.D. should address the interface between family planning, AIDS and other STDs in the SEATS project and in all of its family planning programs and activities. Issues of the source of funding for these activities should be settled within A.I.D. sooner rather than later.**

Appendices

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Appendix A

Description of the Evaluation

Purpose and Methodology of the Evaluation

This evaluation was conducted by a four-person team from February 1 through March 1, 1993. The team's scope of work was to "assess project performance to date, assess the project's effectiveness in achieving its purpose, and provide information and recommendations on whether there should be a follow-on project and, if so, to recommend any adjustments, improvements, or changes in the design, focus, strategies, interventions and emphasis of any follow-on project." A.I.D. also asked the team to examine the conflicts, if any, between the population strategy existing at the time the project was designed and the present and to assess how useful and relevant the concept of "one-stop shopping" appears to be to USAID missions. The scope of work appears as Attachment 1 to Appendix A.

The team was comprised of three external consultants and a member from A.I.D.'s Africa Bureau. The team leader was Dr. Merrill M. Shutt, Associate Professor in the Department of Community Medicine and Rural Health at the University of North Dakota and a former A.I.D. health and population development officer. Team members included Dr. Ayo Ajayi, the Population Council's senior representative for East and Southern Africa; Connie Collins, public health nurse and since 1991, the HPN Officer for A.I.D.'s Office of New Initiatives in the Africa Bureau; and Shanti R. Conly, Director for Policy Research and Analysis at Population Action International (formerly the Population Crisis Committee). The CTO, Bonnie R. Pedersen, joined the team as an ex-officio member for part of the field work.

After being provided some preliminary background material, the team assembled in Washington on February 1, 1993, for a series of briefings from SEATS, various A.I.D. offices, SEATS subcontractors, and other CAs. It then embarked on a three-week visit to Burkina Faso, Côte d'Ivoire, Zimbabwe, Kenya, and Tanzania, reassembling in Washington on March 1 to begin drafting the report and to brief A.I.D. and SEATS. During the field visits, the team met with the Lome Regional Office Director and some of his staff in Ouagadougou because of the civil unrest in Togo. Given the family disruption and concerns of the regional office staff, the team was particularly grateful for their inputs. The Malawi resident advisor was interviewed in the Harare regional office and the team met the Ugandan resident advisor and senior technical advisor in Nairobi. The resident advisor for Cameroon participated in the SEATS briefings in Rosslyn.

A list of documents reviewed and persons interviewed in connection with this report are provided in Attachments 2 and 3 to this appendix.

Problems with the Evaluation

The time allotted for this evaluation was inadequate to sufficiently evaluate the project with the degree of confidence team members normally experience. In part this reflected the complexity of the project itself: the diversity of project activities (e.g., service delivery subprojects, institutional development subprojects, special purpose subprojects, technical assistance, training, manual development, etc.), their vast geographic spread, the few objectively verifiable indicators in the project/contract, and the embryonic nature of the service delivery subprojects visited. In particular, it would have been helpful had SEATS developed a better MIS for field activities that would have provided reliable information on services and technical assistance.

Other problems related to the design of the assignment. The short five-country field work itinerary permitted the team to see active service delivery subprojects in only one of five countries visited, namely Burkina Faso. Team members did visit service delivery subproject sites in Zimbabwe, but services had not yet been initiated. The balance in the types of activities and the limited sample of service delivery subprojects selected and approved by A.I.D. and approved by the missions for team visitation represented a major methodological

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weakness in the evaluation, significantly limiting the team's ability to draw conclusions with any confidence, particularly in terms of project impact. One improvement would have been if more time had been provided at the start for review of basic documentation and at the end, for further debriefings with SEATS and intra-team meetings. Field visits in regions other than Africa would have provided a better sample of project activities. Finally, one key member arrived late and departed early because of late recruitment.

Appendix A-Attachment 1

Scope of Work

A. Achievement of Project Objectives and Outputs

The contract specifies contractual deliverables for the SEATS project.

1. Is the project on target for attaining contractual deliverables? If not why not? What corrective measures are being taken?

2. Are the contractual deliverables appropriate for achieving the purpose of the project? appropriate to the level of funding?

3. How is CYP calculated?

4. How has the adjustment in the R&D/POP emphasis since the development of the project affected the SEATS project? Has the project responded appropriately to new initiatives?

5. What qualitative inputs have contributed to moving programs to a national scale? Is there a mechanism to determine the potential quantitative output or generative capacity of qualitative inputs?

B. Performance and Implementation

The SEATS contract was specifically designed to enable the project to have sufficient flexibility in implementation to respond strategically to individual needs in particular field situations.

Based on contract and technical directions from A.I.D., the project has engaged in activities that may be categorized as follows: (1) multi-faceted assistance to small to medium size "emergent" countries; (2) policy and managerial support to national programs mainly in A.I.D. Priority Countries; and (3) other activities, such as discrete technical assistance, assessments and projects with U.S. based NGOs.

The technical approach of the SEATS project is characterized by: programming resources in a strategic manner responsive to local needs rather than attempting to implement one particular model or work in one functional area; attempting to advance countries towards national scale family planning programs; and addressing both public and private sectors.

1. How has the technical approach prescribed in the contract/project paper contributed to the achievement of project objectives and purpose?

2. How has the contractual flexibility evolved and contributed to implementation of activities to achieve the project's objectives and purpose?

3. Is the mix of activities appropriate and contribute to the attainment of the project's objectives and purpose?

4. To what extent have the SEATS interventions (e.g., training, service delivery and commodities support, IEC, etc.) been effective in advancing national family planning programs?

5. How much is the choice of intervention influenced by often conflicting deliverables (e.g.) CYP and sustainability, and what is an effective balance?

6. Is the scope of activities in given countries too broad or diverse (or too narrow) to foster a cohesive national program? To what extent do the activities flow from a strategic planning process?

The contract emphasizes intensive technical assistance, particularly through resident advisors and regional offices, as well as the range of activities necessary to develop service delivery capacity. This approach places a high premium on the quality of the staff.

7. What is the caliber of SEATS staff?

8. Is the mix of staff skills appropriate for achievement of the objectives and purpose of this project?

9. Has the decentralization to regional offices and resident advisors produced the desired results? How has it affected the management of personnel?

10. Is the mix of technical assistance and direct service projects effective in meeting project objectives?

11. What types of technical assistance have been most useful?

C. Effectiveness of Unique Project Characteristics

1. How effective has the emphasis on national strategic planning been given the array of CAs, donors present in any one country?

2. At what point in strategic planning or implementing an intervention does SEATS call for the assistance and collaboration of other CAs; is it timely appropriate and effective? How has SEATS drawn on specialized CAs such as PCS, FPMD, PAC IIb?

3. How effective has the emphasis on urban, peri-urban programs been in moving the country programs to national scale?

4. How effective has performance based contracting been in low prevalence countries?

5. What lessons have been learned in moving programs to a national scale with the flexibility of working in all functional areas and sectors?

D. Soundness of Project Design and Future Directions

1. Is the concept of "one stop shopping" effective in increasing access to quality family planning services? in promoting sustainability? in improving management of programs? Is the mandate too broad? Are there technical/programmatic areas that should be expanded, reduced (e.g., U.S. based NGO projects, resident advisors, etc.)?

   1a What should be the balance between CYP, TA and sustainability?

   1b Is the cost of Resident Advisors and Regional Offices worth the results? Are there other mechanisms for achieving the same? How do RAs/RO facilitate or take away from sustainability?

   1c What has the SEATS experience been in the procurement of equipment, supplies, vehicles and contraceptives? Should this be a function of any follow-on project?

2. What has worked, not worked and why? What should the focus, emphasis and features be of any follow-on project? Should a follow-on project target certain types of countries or geographic regions?

3. What changes, service delivery outputs, improvements have taken place in access, quality management capability and sustainability that can be attributable to the SEATS project as measured by the indicators developed by SEATS? Can these be included in any follow-on project?

4. What is the SEATS projects comparative advantage, niche? Is it meeting a unique need that existing projects could not do? How does it fulfill the needs of the USAID mission and country needs?

5. How much emphasis should be placed on institutionalization?

6. What modifications to the current SEATS project strategies and activities would increase the effectiveness or efficiency of the current effort? What modifications should be made in any follow-on project?

7. Are the interventions being employed for low prevalence countries effective? applicable to other countries? applicable to priority countries?

Appendix A-Attachment 2

List of Persons Interviewed

BURKINA FASO

USAID/Burkina Faso

Thomas Luche, Director
Jatinder Cheema, HPN Officer
Perle Combary, Population Officer

SEATS Burkina Faso Office (Ouagadougou)

Meba Kangone, Resident Advisor, Burkina Faso

SEATS West Africa Regional Office (Interviewed in Ouagadougou)

Sahlu Haile, Regional Director
Paul Sossa, Program Development Officer
M'Baye Seye, IEC Advisor (PATH)
Andrew Fullem, Finance/Administrative Manager

Ministry of Health

Leonard Tapsoba, Secretary General

Directorate of Family Health

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Appendix A-Attachment 3

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Appendix B

List of Subprojects

Asia/Near East (ANE)		Principal Geographic Focus			Sector		Service Delivery				Technical Support Activities							Cost	Level of Effort Person-months	Dates		
		Urban	Rural	Mixed	Public	Private	Clinic Based	CBD	VSC	Post-Partum	Clinical Trg.	Mgmt. Trg.	Equpmt. & Rehab.	IEC	Quality Assure.	Cntrct-Commod.	Other	Budget	Actual	Begin	End	Collaboration
Morocco	Regional Advisor																		5.25			
	Buy-in/Memo of Understanding (MOU) (209)			x	x		x					x	x	x	x	x		2,925,252		05/92	07/94	MOH
PNG	Regional Advisor																		25.9			10,11
	MOU (411)																	425,000		07/91	06/94	
	DOH			x	x		x		x		x	x	x	x	x	x						
	FPA			x		x						x										
	Lutheran Medical Services			x		x	x	x	x				x	x	x			19,972				
Tonga	SPAFH (425) South Pacific Association for Family Health			x	x	x	x	x			x	x	x	x	x		x	400,000		05/92	06/94	12
Tunisia	ONFP (408) Office National de la Famille et de la Population					x	x										x	132,000		05/91	07/92	
Turkey	SSK (421) Soysal Sigortalar Kurumu			x	x		x	x	x	x	x	x	x	x	x	x		3,367,950		01/92	06/94	1,5,19, 21
Yemen	Regional Advisor																		30			20

Asia/Near East (ANE)		Principal Geographic Focus			Sector		Service Delivery				Technical Support Activities							Cost	Level of Effort Person-months	Dates		
		Urban	Rural	Mixed	Public	Private	Clinic Based	CBD	VSC	Post-Partum	Clinical Trg.	Mgmt. Trg.	Equpmnt. & Rehab.	IEC	Quality Assure.	Contrct-Commod.	Other	Budget	Actual	Begin	End	Collaboration
Yemen	YPPU (793) Yemeni Physicians and Pharmacists Union	x			x	x					x							84,574		03/92	07/93	
	CIP (791) Clinic Improvement Project			x	x	x	x	x			x	x	x	x	x			246,822		09/90	02/92	
	Flipchart Development				x	x								x			x					

ESARO		Principal Geographic Focus			Sector		Service Delivery				Technical Support Activities							Cost	Level of Effort Person-months	Dates		
		Urban	Rural	Mixed	Public	Private	Clinic Based	CBD	VSC	Post-Partum	Clinical Trg.	Mgmt. Trg.	Equpmnt. & Rehab.	IEC	Quality Assure.	Contrct-Commod.	Other	Budget	Actual	Begin	End	Collaboration
Kenya	Regional Advisor			x	x	x	x	x	x		x	x		x	x				23.2			4
Madagascar	Regional Advisor																		14			
	OSTIE (724) Organisation Tananarivienne Inter-Entreprise						x		x		x	x			x			48,011		11/90	12/92	
	MOU (209) (Bridging Activities)											x		x			x	1,668,000		11/91	11/92	
	MOH											x		x								
	Special Project: Bibliography of Family Planning																x					
	Population Policy (MOH, MoPlan, MOPop)																x					
	Special Project: Review of Family Planning Laws																x					
Malawi	Regional Advisor																		7.2			17

ESARO		Principal Geographic Focus			Sector		Service Delivery				Technical Support Activities							Cost	Level of Effort Person-months	Dates		
		Urban	Rural	Mixed	Public	Private	Clinic Based	CBD	VSC	Post-Partum	Clinical Trg.	Mgmt. Trg.	Equpmt. & Rehab.	IEC	Quality Assurc.	Cntrct-Commod.	Other	Budget	Actual	Begin	End	Collaboration
Malawi	NFWCM (409) National Family Welfare Council of Malawi	x		x								x	x	x				56,354		08/91	08/93	7 & other gov't
	Ekwendenni Hospital (412)			x		x	x	x	x		x		x	x				117,456		09/91	06/94	7 & other gov't
	Malamulo Hospital (755)			x		x	x	x	x		x		x	x	x			58,395		11/90	12/91	17
	Malamulo 2 (430)		x			x			x	x	x		x	x	x			220,017		08/92	06/94	1
Uganda	Regional Advisor																		14.2			
	ACNM (402) American College of Nurse-Midwives			x		x	x			x	x	x	x	x	x		x	715,052		08/91	07/94	
	FPAU (414) Family Planning Association of Uganda			x	x		x		x		x	x	x	x	x		x	170,720		10/91	06/94	
	IMA (415) Islamic Medical Association	x					x		x		x	x	x	x			x	334,520		10/91	06/94	

ESARO		Principal Geographic Focus			Sector		Service Delivery				Technical Support Activities							Cost	Level of Effort Person-months	Dates		
		Urban	Rural	Mixed	Public	Private	Clinic Based	CBD	VSC	Post-Partum	Clinical Trg.	Mgmt. Trg.	Equpmt. & Rehab.	IEC	Quality Assure.	Cntrct-Commod.	Other	Budget	Actual	Begin	End	Collaboration
Uganda	MOL/DOHH (416) Department of Occupational Health and Hygiene			x			x		x		x	x	x					312,571		10/91	06/94	8,18
	MOH, Equipment Drop (422)				x		x		x				x					100,000				
Zimbabwe	Regional Office			x		x	x	x	x	x	x	x	x	x	x	x	x		221.6			14
	Mutasa Chitepo PostPartum (427)			x		x	x	x	x	x	x	x	x	x	x			65,609		09/92	06/94	1,9
	Chitungwiza PostPartum (431)			x		x	x		x	x	x	x	x	x	x			132,485		09/92	06/94	9,1,7
	ZNFPC Situation Analysis (403) Zimbabwe National Family Planning Council			x		x											x	49,652		05/91	11/91	9
	Harare PostPartum (43)	x				x	x		x	x	x	x	x	x	x	x		70,127		12/92	06/94	9,1,7
	Doma, Commercial Farm Workers (426)		x			x		x	x		x			x				18,248		05/92	06/94	9

ESARO		Principal Geographic Focus			Sector		Service Delivery				Technical Support Activities							Cost	Level of Effort Person-months	Dates		
		Urban	Rural	Mixed	Public	Private	Clinic Based	CBD	VSC	Post-Partum	Clinical Trg.	Mgmt. Trg.	Equpmnt. & Rehab.	IEC	Quality Assure.	Contrct-Commod.	Other	Budget	Actual	Begin	End	Collaboration
Tanzania	Regional Advisor																		16.87			7,14
	Buy-in (207)			x	x		x					x	x			x	x	2,183,851		09/91	06/94	2,7,13, 14

WARO		Principal Geographic Focus			Sector		Service Delivery				Technical Support Activities							Cost	Level of Effort Person-months	Dates		
		Urban	Rural	Mixed	Public	Private	Clinic Based	CBD	VSC	Post-Partum	Clinical Trg.	Mgmt. Trg.	Equpmt. & Rehab.	IEC	Quality Assure.	Contrct-Commod.	Other	Budget	Actual	Begin	End	Collaboration
Benin	ABPF/424 Association Beninois de la Planification Familiale	x				x	x	x			x		x	x		x	x	119,196,100		05/92 24 months	04/94	
Burkino Faso	Regional Advisor																	150,000	9.3			3
	DSF I/MIS (404) Direction de la Sante Familial	x			x		x					x	x					38,000		06/91	03/94	3,13
	DSF II (420)			x	x		x				x		x		x	x		775,045		05/92	07/94	
	ABBEF (417) Association Burkinabe pour le Bien Etre Familial	x				x	x	x					x	x				328,913		10/91	06/94	
	ABSF (423) Association Burkinabe des Sages Femmes	x				x	x	x	x		x		x					35,929		06/92	03/94	
	DICSS (419) Direction de l'Inspection des Services Socio-sanitaires	x			x		x						x					221,646		10/91	06/94	
	OST (406) Office de Sante des Travailleurs	x			x		x	x			x	x	x					103,568		8/91	6/94	

WARO		Principal Geographic Focus			Sector		Service Delivery				Technical Support Activities							Cost	Level of Effort Person-months	Dates		
		Urban	Rural	Mixed	Public	Private	Clinic Based	CBD	VSC	Post-Partum	Clinical Trg.	Mgmt. Trg.	Equpmt. & Rehab.	IEC	Quality Assure.	Contrct-Commod.	Other	Budget	Actual	Begin	End	Collaboration
Cameroon	Regional Advisor																		11.7			
	MOH (401) Ministry of Health			x	x		x	x	x		x	x	x	x		x	x	617,927		10/91	02/94	1,2,4,5
	Ad Lucem (418)			x		x	x				x	x	x			x	x	226,493		03/91	09/93	
	Djoungolo (756)	x				x	x			x	x	x	x					44,481		11/90	10/91	
	FEMEC (433) Federation des Eglises et Missions Evangeliques de Cameroun			x		x	x				x		x					448,600		11/92	04/94	
	PSI (429) Population Services International			x		x		x						x	x	x	x	363,347		08/92	06/94	
Côte d'Ivoire	Regional Advisor																		25			3
	AIBEF 794/726 Association Ivoiriene de la Bien-Etre Familial	x				x	x				x	x	x	x				553,738		11/90	10/93	13
	PSI (410)			x		x								x				100,000		08/92	03/92	
Rwanda	Regional Advisor																		0			

WARO		Principal Geographic Focus			Sector		Service Delivery				Technical Support Activities							Cost	Level of Effort Person-months	Dates		
		Urban	Rural	Mixed	Public	Private	Clinic Based	CBD	VSC	Post-Partum	Clinical Trg.	Mgmt. Trg.	Equpmnt. & Rehab.	IEC	Quality Assure.	Contrct-Commod.	Other	Budget	Actual	Begin	End	Collaboration
Rwanda	ONAPO (202) Office National de la Population			x	x		x	x			x	x	x	x		x		627,190		08/91	07/94	
	ONAPO (413) (VSC)			x	x		x		x		x	x	x					695,502		09/91	07/94	1
Togo	CHU (405) Benin University	x				x	x				x		x					59,000		08/91	06/94	1,10
	ATBEF (744) Association Togolese de la Bien-Etre Familial	x			x		x				x		x					433,276		01/92	12/93	
	DSF (428) Direction de la Sante Familial	x			x		x				x	x	x	x	x			651,236		06/92	05/94	
	Regional Office (751)			x	x	x					x	x	x	x	x	x	x		344			14
	GTZ Video (Special Project Fund/041)			x										x				16,000				15

Source: SEATS. "Background Analysis for SEATS Mid-Term Evaluation Scope of Work." Appendix 1.

Legend for Collaboration

1. AVSC
2. INTRAH
3. Centre d'Etudes et de Recherche sur la Population pour le Development (CERPOD)
4. CAFS
5. PATH
6. Options for Population Policy (OPTIONS)
7. MOH
8. Muslim Supreme Council
9. ZNFPC
10. JHPIEGO
11. SOMARC
12. Australian International Development and Assistance Bureau (AIDAB)
13. Population Council (POPCOUNCIL)
14. FPLM
15. GTZ
16. Family Planning Association of Madagascar (FISA)
17. NFWC
18. FPAU
19. PCS
20. Resources for Child Health Project (REACH)
21. Pathfinder

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Appendix C

Target and Reported CYP By Country and Subproject
(through January 1993)

Region/Country	Project/No.	Duration	Target CYP	Reported CYP[1]	Reported CYP (based on revised CYP factors)[2]	Country Target	Total Country CYPs[3]
WARO							
Benin	ABPF 424	May 22, 1992 - May 21, 1994	14,950	0	0		
						14,950	0
Burkino Faso	OST 406	Aug. 1, 1991 - June 30, 1994	21,000	11,023	10,962		
	DSF 404	June 1, 1991 - Sept. 30, 1992	N/S	0	0		
	DSF II 420	April 1, 1992 - July 9, 1994	85,000	0	315		
	ABSF 720	Nov. 1, 1990 - Oct. 31, 1991	4,050	5,661	4,150		
	ABSF II 423	June 1, 1992 - May 31, 1994	14,351	2,685	2,176		
	ABBEF 417	Oct. 1, 1991 - June 30, 1994	9,854	182	444		
	DICSS 419	Oct. 1, 1991 - June 30, 1994	49,679	0	0		
						183,934	18,047
Cameroon	Djoungolo 756	Nov. 1, 1990 - Oct. 30, 1991	N/S	0	0		
	MOH DFMH 401	March 1, 1991 - Feb. 28, 1994	50,000	25,239	21,854		
	Ad Lucem 418	Oct. 1, 1991 - Sept. 30, 1993	8,000	0	0		
	PSI 429	Aug. 17, 1992 - May 31, 1993	77,692	0	0		
	FEMEC 433	Nov. 1, 1992 - April 30, 1994	43,000	0	0		
						178,692	21,854

Region/Country	Project/No.	Duration	Target CYP	Reported CYP[1]	Reported CYP (based on revised CYP factors)[2]	Country Target	Total Country CYPs[3]
Côte d'Ivoire	AIBEF 794	Nov. 1, 1990 - OCt. 31, 1993	59,800	68,593	59,434		
	PSI 410	Sept. 15, 1991 - March 14, 1992	30,000	74,334[4]	45,240[4]		
						89,800	104,674
Rwanda	ONAPO/CBD 202	Aug. 15, 1991 - July 9, 1994	51,000	15,494	14,524		
	ONAPO/VSC 413	Sept. 15, 1991 - July 9, 1994	75,000	0	0		
						126,000	14,524
Togo	ATBEF 744	Jan. 1, 1991 - Dec. 31, 1993	35,000	22,596	16,567		
	CHU OB/GYN 405	Aug. 1, 1991 - July 30, 1994	44,150	357	311		
	DSF 428	June 1, 1992 - May 31, 1994	65,978	9,559	7,391		
						145,128	24,269
ESARO							
Madagascar	OSTIE 724	Nov. 1, 1990 - April 30, 1992	6,200	2,796	2,380		
						6,200	2,380
Malawi	Malamulo I 755	Nov. 1, 1990 - Dec. 30, 1991	50,000	4,131	3,268		
	Malamulo II 430	Aug. 1, 1992 - June 30, 1994	18,800	1,973	1,619		
	Ekwendeni 412	Sept. 1, 1991 - June 30, 1994	4,800	1,553	1,263		
	NFWC 409	Aug. 15, 1991 - Aug, 14, 1993	N/S	-	-		
						73,600	6,150
Uganda	UPMA 402	Aug. 13, 1991 - July 9, 1994	43,000	869	721		
	IMA 415	Oct. 1, 1991 - June 30, 1994	13,565	592	520		

Region/Country	Project/No.	Duration	Target CYP	Reported CYP[1]	Reported CYP (based on revised CYP factors)[2]	Country Target	Total Country CYPs[3]
Uganda	MOL 416	Oct. 1, 1991 - June 30, 1994	17,352	753	753		
	FPAU 414	Oct. 1, 1991 - June 30, 1994	N/S	10,646	11,071		
	Kisekka (SPF)	Oct. 13, 1992 - March 31, 1993	1,514	337	320		
						75,431	13,385
Zimbabwe	Sit. Anal. 403	May 15, 1991 - Nov. 15, 1991	N/S	-	-		
	Doma CBD 426	May 1, 1992 - June 20, 1994	7,500	1,009	850		
	Chitungwiza 431	Sept. 1, 1992 - June 30, 1994	53,000	0	0		
	Chirepo 427	Sept. 1, 1992 - June 30, 1994	7,102	0	0		
	UoZ OB/GYN 434	Dec. 1, 1992 - May 31, 1994	13,000	0			
	Union Carbide	Feb. 1, 1993 - May 31, 1994	3,800	0	0		
						84,402	850
ANE							
PNG	MOU 411	July 19, 1991 - June 30, 1994	100,000	21,685	24,591		
	Luthern 432	Aug. 1, 1992 - June 30, 1994	3,000	0	0		
						103,000	24,591
South Pacific	SPAFH 425	May 1, 1992 - June 30, 1994	N/S	-	-		
						N/S	-
Tunisia	Priv. Sector 478	May 1, 1991 - July 31, 1992	0	0	-		
						0	-
Turkey	SSK 421	Jan. 1992 - June 1994	400,000	56,380	53,645		

Region/Country	Project/No.	Duration	Target CYP	Reported CYP[1]	Reported CYP (based on revised CYP factors)[2]	Country Target	Total Country CYPs[3]
						400,000	53,645
Yemen	Declzd App 791	Sept. i, 1990 - Feb. 29, 1992	N/S	1,949	2,127		
	YPPU 793	March 1, 1992 - Aug. 31, 1993	N/S	0	0		
						N/S	2,127
OTHER							
Training Activities			N/S	2,825	2,260		
			1,481,137	343,221	288,756		
						1,481,137	291,016

[1]Indicates calculated according to factors in force at time SEATS contract was awarded.

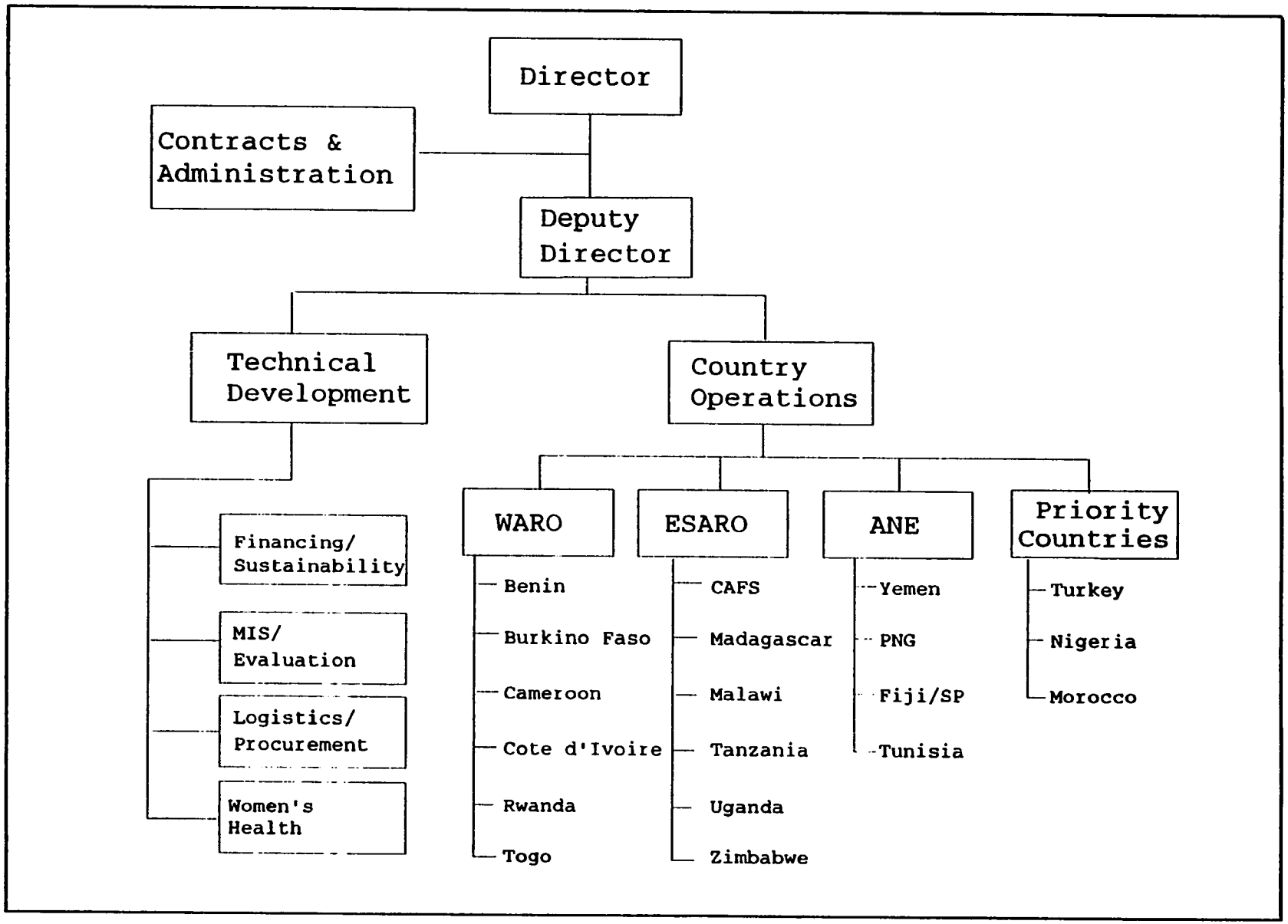
[2]Indicates calculated according to revised CYP factors as recommended by the A.I.D. Population Projects Indicators Working Group.

[3]Totals based on reported CYP (based on revised CYP factors).

[4]Indicates this amount includes CYP generated subsequent to the conclusion of SEATS funding (May '92) resulting from SEATS support, and not reported by other cooperating agencies.
N/S Indicates "not specified" in project document.

Appendix D

SEATS Organization Chart



Appendix E

SEATS Project Staff Positions

Headquarters - Washington, D.C.
- Director
- Administrator
- Regional Director/Asia NE
- Contracting Officer
- Financial Manager
- MIS Evaluation Specialist
- Senior Technical Advisor
- Senior Technical Advisor
- Senior Technical Advisor
- Women's Health Advisor
- Resident Advisor At-Large
- Program Associate
- Program Associate
- Program Associate
- Program Associate
- Program Associate
- Staff Associate/ESARO, Asia NE
- Staff Associate/WARO

East Africa Regional Office
- Regional Director
- Program Director
- Training Specialist
- Training Specialist
- IEC Advisor
- MIS Evaluation Specialist
- Medical Advisor
- Finance/Administrative Manager
- Financial Manager
- Administrative Assistant
- Staff Associate
- Staff Associate
- Driver/Messenger

West Africa Regional Office
- Regional Director
- Program Development Officer
- Medical Advisor
- Training Specialist
- Training Specialist
- IEC Advisor
- MIS Evaluation Specialist
- Project Coordinator (Fellow)
- Finance/Administrative Manager
- Financial Manager
- Administrative Assistant
- Secretary
- Receptionist/Secretary
- Chauffeur

Resident Advisors (see table 7 for countries of assignment)

SEATS In-Country Staff

Burkino Faso
- Staff Associate

Cameroon
- Staff Associate

Madagascar
- Program Associate

SEATS-SSK Turkey
- Deputy Director, Training Coordinator
- MIS Specialist
- IEC
- Financial Manager
- Program Associate
- Secretary
- Messenger/Clerk

Yemen
- Program Associate

Morocco
- Intern
- Administrative Assistant

Tanzania
- Finance and Administration
- Administrative Assistant
- Program Assistant

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Appendix F

List of Recommendations

Current Project

1. Needs assessment and strategic planning should remain the guiding principles for further development of SEATS' country-level activities. In countries in which SEATS' assistance is written into USAID bilateral family planning projects or in which USAID missions otherwise define the scope of SEATS activities, SEATS should negotiate appropriate and meaningful interventions consistent with the SEATS country strategy and its worldwide mandate for service expansion.

2. SEATS management should review the format used for subproject development and documentation and SEATS' internal procedures for subproject review, in order to strengthen quality control in subproject preparation and to ensure that subproject documents consistently provide adequate detail.

3. If CYP is to be used as an evaluation indicator of project performance, A.I.D. must establish rational and consistent mechanisms for attributing the CYP and should intensify efforts (in collaboration with the EVALUATION Project) to develop other qualitative and quantitative indicators to measure project progress in both service delivery and institution building.

4. SEATS needs to establish a consistent process for establishing service delivery objectives for subprojects. Indicators for measuring the attainment of objectives for all service delivery subprojects should include numbers of new and continuing clients and data on method mix. At the subproject level, CYPs should be used only as a complementary measure.

5. In order to improve the quality, comparability, and reliability of client reporting and feedback, SEATS should provide sufficient technical assistance for each family planning service delivery subproject to establish an MIS at project start-up and then periodically follow through with hands-on technical assistance until the host country personnel can operate the system reliably.

6. For both subproject implementation and technical assistance activities, in every SEATS-assisted country, USAID, SEATS, and the host country agency should use a memorandum of understanding or similar instrument to spell out the responsibilities of each and the communication channels agreed upon to resolve differences.

7. SEATS needs to develop a consistent process for projecting cost per CYP and over time, to monitor the actual cost per CYP and compare this indicator to original projections.

8. SEATS should develop an evaluation instrument by which missions and host countries can systematically provide feedback on the quality and amount of technical assistance received from any SEATS source.

9. A.I.D. and SEATS should develop ways to evaluate quality and impact of technical assistance.

10. SEATS should institute an immediate and thorough review of its procurement procedures and performance and make adjustments as necessary to be more responsive to field needs. SEATS and A.I.D. should give consideration to adding professional procurement expertise at the headquarters and/or regional office level to coordinate and streamline the procurement of equipment and

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commodities. SEATS should also explore with A.I.D. the feasibility of SEATS' warehousing some standard equipment to speed field supply.

11. USAID missions should integrate SEATS' contraceptive needs into projections of national contraceptive needs prepared for central procurement and assist SEATS in obtaining contraceptive supplies from in-country sources.

12. No further SEATS funds should be used for the Special Project Fund. If there is a follow-on project, the fund, as currently proposed by SEATS, should not be continued.

13. The regional office staff in Africa should include more service delivery program development and general family planning service delivery expertise in order to improve provision of technical assistance to host country institutions for project development, design, and implementation.

14. SEATS should continue to maintain two offices in sub-Saharan Africa in order to ensure continued effective support its activities in the region. In view of the political situation in Togo, immediate attention should be directed to relocating the WARO office.

15. In addition to regular monitoring and supervision visits by the regional director, SEATS should develop appropriate mechanisms for incorporating the comments of USAID missions and host country counterparts in the annual performance appraisal of resident advisors.

16. SEATS should review the organizational structure of the regional offices with the objective of reducing the span of control of the regional director to enable him/her to provide more effective supervision and support to the country resident advisors. An alternative, more effective structure would have the technical specialists reporting to the program director positions.

17. SEATS and A.I.D. should seek to develop simpler financial and procedural mechanisms to permit SEATS easier access to technical assistance expertise available through other CAs.

Follow-On Project

18. The SEATS project should be extended an additional five years when the current contract expires, this period being consistent with original project design. A.I.D. should begin the redesign immediately to maintain existing momentum and minimize interruptions or delays should the project be rebid.

19. Access to high levels of core funding for support of technical assistance and subprojects in low prevalence countries should be maintained in a follow-on project. At least 50 percent of the funds should be reserved for low prevalence countries which are not Office of Population "priority" countries.

20. Although the follow-on project should retain the "one-stop shopping" characteristics of SEATS I, it should drop the "one-stop shopping" term to describe its capabilities.

21. The Office of Population and the Africa Bureau should develop a coordinated strategy that addresses the technical assistance needs in family planning of all countries in the Africa Region. The Bureau should consider providing funding to Office of Population CAs, including SEATS, to assist and expedite population activities in non-priority, low prevalence African countries.

22. SEATS II should operate under its current broad and flexible mandate in order to maintain its flexibility to respond to A.I.D. requests for expansion of family planning service delivery, and to a

lesser extent, for bridging activities and institutional development. Resources allocated for institutional development activities should be clearly tied to service delivery and directed to currently supported institutions that have made the most progress.

23. The design of a follow-on project should give special attention to the interface between SEATS and more specialized CAs. The project design should incorporate a functional mechanism that would enhance SEATS' ability to access other CA expertise, while meeting A.I.D. bureaucratic requirements with respect to subcontracts. The project design should also establish the criteria on which SEATS should base the decision to draw in other more specialized CAs, and to the extent possible, create incentives to do so when appropriate.

24. A.I.D. and SEATS should reexamine the possibility of temporary provision of some recurrent costs, including salary costs, in public sector programs in those countries in the lowest 25 percent of gross national product.

25. A.I.D. should address the interface between family planning, AIDS and other STDs in the SEATS project and in all of its family planning programs and activities. Issues of the source of funding for these activities should be settled within A.I.D. sooner rather than later.

POPTECH'S REPORT-AT-A-GLANCE SERIES

MIDTERM EVALUATION OF THE FAMILY PLANNING SERVICE EXPANSION AND TECHNICAL SUPPORT (SEATS) PROJECT (936-3048)

(1989-1994; A.I.D. Funding $43.5 million)

SUMMARY

The Family Planning Services Expansion and Technical Support (SEATS) Project provides a wide variety of financial, technical and human resources ("one-stop shopping") to expand access to and use of family planning services in underserved populations of sub-Saharan Africa, Asia, the Near East, and the South Pacific. It assists implementing agencies to develop and carry out service delivery subprojects or to improve institutional capacity for management and/or planning. The project has recruited an excellent professional staff, particularly host country population professionals in Africa, and is on target in terms of numbers and types of subprojects developed and most other indicators. Private sector subprojects generally have been more successful than have those in the public sector. The project most likely will not meet ambitious targets for couple years of protection (CYP) during its first five years. Some technical assistance is only very weakly linked to service delivery. Funding should be approved through the 10-year project authorization, with at least 50 percent of the funds reserved for low prevalence countries which are not Office of Population "priority" countries.

FACTORS AFFECTING PROJECT PERFORMANCE

Facilitating Factors

- SEATS' heavy reliance on country population professionals for technical assistance has been a prime factor in rapidly initiating project activities and establishing project credibility.

- Project decentralization for management and implementation allows the project to be highly responsive to host country needs.

- Field access to generous levels of SEATS core funding has allowed USAID missions to begin family planning activities before undertaking the time-consuming development and approval of bilaterally funded projects.

- SEATS' development of country strategies based on systematic needs assessment and strategic planning results in well-planned subprojects with high potential for success.

- SEATS' ability to develop collaborative relationships with other Cooperating Agencies (CA) has facilitated cooperative programmatic approaches and husbanding of resources.

Constraints

- Low prevalence countries often have institutional bases so poorly developed they are incapable of effectively using SEATS assistance to initiate service delivery without first developing the necessary institutions.

- Subprojects which are requested by USAID missions or which are "inherited" from other CAs are less likely to contribute to achievement of SEATS' goals than are those developed as a result of strategic planning.

- Slowness in developing reliable management information systems for subproject service delivery data results in delayed and/or weak subproject reporting and loss of the benefits of this tool to policymakers, managers, and administrators.

- Lack of timely procurement of equipment has hindered subproject implementation.

- Reliance on the CYP as the primary or sole indicator of subproject progress results in projects' not establishing intermediate goals.

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LESSONS LEARNED

- A general purpose CA like SEATS, which has a broad purpose, considerable financial resources and quick access to central funds, and flexible, decentralized management, will remain an essential component of the Office of Population portfolio. Low-prevalence, non-priority countries require a SEATS-type project, one that provides guidance on how to get started in all the key facets of a family planning effort in the early stages of development.

- Family planning programs in the poorest low prevalence countries require large amounts of technical assistance to prepare institutions to deliver services.

- Catchy nicknames used to capsulize the role of complex projects can lead to confusion and misunderstanding. In the case of the SEATS project, the term "one-stop shopping," meant to capture its character as a project with multi-specialty family-planning professionals, is an imprecise term with the potential to create erroneous or overly high expectations.

- Easy access to central core family planning funds permit a rapid response to mission and host country needs while longer-term programs are developed.

- Missions, increasingly understaffed in the areas of health, population, and nutrition, will inevitably use any auxiliary assistance they can find. In the case of the SEATS project, this has resulted in missions' calling on SEATS resident advisors to provide assistance for any number of activities related to national family planning programs, from procurement to management.

- Although in some settings CAs have tended not to develop working partnerships with each other, in Africa the sense of urgency arising from the huge job facing the development community has contributed to enhancing the spirit of cooperation and facilitated relationships among CAs.

- In view of the ever-widening health crisis represented by AIDS and the many links that exist between family planning, AIDS, and sexually transmitted diseases (STD), SEATS could and should develop guidelines and protocols for protecting both family planning clients and staff during clinical procedures and for providing family planning counseling and services for women at risk of or suffering from AIDS/STDs.

- Although measurement of CYP can be a useful tool, especially in the context of activities like social marketing for which other measurement of service outputs is difficult, the reliance on CYP as the sole indicator of subproject performance can result in diminishing the use of equally important intermediate goals.

- Strengthening the institutional capacity of U.S. private voluntary organizations to work in family planning is a more appropriate role for A.I.D. than for SEATS (or any other CA).

Source: *Midterm Evaluation of the Family Planning Services Expansion and Technical Services Support (SEATS) Project (936-3048)* by Merrill M. Shutt, Ayo Ajayi, Constance L. Collins, and Shanti R. Conly. 1993. POPTECH Report No. 92-186-150.

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August 24, 1993

SUBJECT: 1) *Midterm Evaluation of the Family Planning Service Expansion and Technical Support (SEATS) Project (936-3048)*
2) Report-at-a-Glance

Enclosed for your information are copies of the above-referenced publications prepared by Merrill M. Shutt, Ayo Ajayi, Constance L. Collins, and Shanti R. Conly.

Yours truly,

Malven E. Schneider
Director, POPTECH

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