

FINAL REPORT

Mid-Term Evaluation of the
Romania Family Planning Project

(Project No. 186-0002)

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Prepared by:

Amil Kumar, Nancy Langer, Dr. Louise Tyrer

Submitted by:

DATEX, INC.

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The views and opinions expressed herein are those of the evaluation team, and are not necessarily those held by Datex, Inc., nor USAID.

ACRONYMS

BTB	Breakthrough Bleeding
C&L	Coopers & Lybrand
CDC	Centers for Disease Control
CEDPA	Centre for Development and Population Activities
FPMV	Family Planning Movement of Vrancea
GP	General Practitioner physician
IE&C	Information, education & communication
IPPF	International Planned Parenthood Federation
IUD	Intra Uterine Device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
MIS	Management information systems
MOH	Ministry of Health
MSCI	Margaret Sanger Center International
NGO	Non-Governmental Organization
NIS	Newly Independent States
Ob/Gyn	Obstetrics & Gynecological physician
OC	Oral contraceptive
PCS	Population Communication Services
PVO	Private Voluntary Organization
RFP	Romanian Family Planning Project
RHS	Romanian Health Survey
SECS	Society for Education in Contraception and Sexuality
STD	Sexually transmitted disease
TA	Technical assistance
TOT	Training of trainers
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
USAID/ENI	USAID/Bureau for Europe and the Newly Independent States
USAID	U.S. Agency for International Development
WHO	World Health Organization
WIM	Women in Management

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EXECUTIVE SUMMARY

Project Background

Romania was ruled by the Communist regime of Nicolae Ceausescu for 24 years from 1965 to 1989. His strongly pronatalist government outlawed abortion and family planning. These policies prompted widespread illegal abortions. The abortions were inexpensive but dangerous and resulted in the highest maternal mortality rate in Eastern Europe. Following Ceausescu's assassination, "Western" reporters were invited into the country. The maternal mortality rate and vast numbers of institutionalized children prompted international horror and the U.S. Congress immediately earmarked \$3 million, \$1.5 million for each of these problems.

In 1991, The Centre for Development and Population Activities (CEDPA) was awarded a \$1.5 million grant by the U.S. Agency for International Development (USAID) to implement the Romanian Family Planning (RFP) Project (Grant No. EUR-0002-G-00-1016-00) for eighteen (18) months. The goal was "to establish a pilot family planning service delivery system in the private sector"¹.

The project purpose was to "improve the health and well-being of the women of Romania through family planning service delivery"². It was determined that objectives would best be achieved by funding existing family planning Non-Governmental Organizations (NGOs) to establish model family planning clinics. The grant was ultimately extended to \$4.9 million for five (5) years, to go through early 1996.

CEDPA currently funds three Romanian NGOs, the Society for Education in Contraception and Sexuality (SECS), Family Planning Movement of Vrancea (FPMV), and Youth-for-Youth. SECS is the largest NGO and runs ten clinics throughout Romania, seven of which are funded by CEDPA, the other three funded by International Planned Parenthood Federation (IPPF). FPMV is smaller and runs one clinic, they receive almost all of their funding from CEDPA. Youth-for-Youth has only recently begun receiving support from CEDPA. They are still very new and very small.

The project, active now for two and one half years, was evaluated by Datex Inc. A four person team of independent experts conducted this mid-term evaluation. The team was comprised of a Team Leader/Program Management and Evaluation Expert, a Family Planning Program Specialist, a Marketing/Financial Expert, and a Clinical Services Delivery Expert who is an Ob/Gyn (Obstetrics and Gynecology) physician. The team conducted document, program and management reviews in Washington, D.C. and at various sites in Romania. They reviewed programmatic and administrative documents from USAID and CEDPA headquarters and field offices, as well as at subgrantee offices and clinics in Romania. They reviewed relevant reports from various sources including the World Bank and the Centers for Disease Control (CDC). On-site clinical evaluations were also conducted. While individuals on the team had primary responsibilities for certain areas, the team members assisted each other in all areas of evaluation.

Report Structure

Section One of this report is the Introduction which provides background on the social, economic and political climate surrounding this project, and other forces leading to its development. It details the

¹ CEDPA Grant Agreement document

² *ibid.*

formation of this project and its activities. The evaluation methods used by the team to reach their findings are also outlined.

Section Two, "Programmatic Development", details the evaluation of the quality of clinical services that are being carried out by the subgrantees. This assessment was primarily carried out by the Family Planning Program Expert and the Clinical Services Delivery Expert. It looks at how effectively project objectives of model family planning services are being met. This section also outlines important new programmatic activities and areas that should be developed by the project in its remaining half.

Section Three, "Project Management Systems and Processes", details the examination that was primarily conducted by the Program Management and Evaluation Expert. The management tools and processes, and the administrative procedures used to oversee the project, were investigated. The relationships and communication methods between the various project entities was explored. The institutional development and professional development at the subgrantees was also analyzed.

"Financial Management and Analysis" is Section Four. This assessment was principally conducted by the Marketing/Financial Expert. Several components of financial management, financial reporting, and financial analysis were investigated at all levels of the project from CEDPA through to the subgrantees. The technical assistance provided to the subgrantees in financial and commodities management was reviewed. This section also explores two key issues connected to this aspect of the project: sustainability, and currency management and recognition of inflation.

Section Five outlines "Future Grant Activities" for CEDPA, other contracting organizations, USAID, and other donor organizations.

Main Findings

The Team's findings indicate that, while the project should continue, the various activities need to be re-defined. The project is clearly at a crossroads and a re-alignment of remaining monies is needed to achieve re-defined emphases. To this end monies should be set-aside to organize a meeting with USAID, CEDPA, the subgrantees and other significant potential donors and players. A major discussion point should be coordinating cooperation on project activities between the various entities so that defined objectives are met collaboratively. This meeting should be facilitated by an external consultant.

Overall, the problems with the project tend to be in its management both as it relates to general and financial management.

The evaluation team found that the quality of clinical services being provided by the CEDPA subgrantees was very high. There was an adequate choice of methods being offered, and the information provided on these methods was good. It is important that this component of the project be maintained. However, the program has the opportunity to do much more. The subgrantees are eager to expand the breadth of their activities in order to become more oriented towards public outreach and education. This focus would also increase the impact of this project, because these clinics currently serve a very small population. Towards these ends, it is recommended that CEDPA expand the project objectives to include a large information, education and communication (IE&C) component.

There were problems with the management of the project. Some valuable management tools and processes, such as needs assessments and scopes of work for technical assistance, were not fully utilized. Project relationships, particularly between CEDPA and the subgrantees have been unclear and, at times, troubled. Significant technical assistance should be carried out by specialized expert external consultants to focus on more institutional development for the subgrantees.

Financially, the project, as it stands, is not sustainable and will not be sustainable in the near future. In order to approach sustainability, the project needs further inputs of TA in several areas. The technical assistance in financial management has been haphazard, overdue, and of poor quality. Further assistance in the area needs to be carefully planned. Particular emphasis should be placed upon financial analysis, management information systems and cost accounting. CEDPA and USAID should standardize policies regarding currency: both as to the statement of the subgrants and the treatment of gains on exchange and inflation. This issue is causing significant problems with disbursement of funds, analysis of expenditures, and monitoring of project funds, and should be clarified as soon as possible.

SECTION ONE: BACKGROUND

1.0 Romanian Social, Economic and Political History as it Relates to the Romanian Family Planning Project

The communist regime of Nicolae Ceausescu in Romania, spanning the years 1965-1989, was notorious for its abuse of women and children. In order to increase the nation's workforce to 30 million by 1990, Ceausescu outlawed abortion in 1966 for all women save those with five children at home. The state also limited access to contraceptives, and in the 1980s import of contraceptive commodities was banned outright, women were checked at work sites to see if they were pregnant; taxes were imposed on childless couples; and mothers with five or more children were given medals from the state.

Romania, a country with a rich peasant heritage, had always placed a high value on children and on women's fecundity. Nonetheless, in 1966, Romania's birthrate had fallen to a low of 14.3/1000, then the lowest of any country in the world. Like its neighbors throughout Eastern Europe, the birth rate in the 1960s had fallen as a result of a number of factors, principally universal education, the collectivization of agriculture (which removed much of the incentive to produce children as farm labor) - and liberal abortion policies.

The "pronatalist" policies backfired. The population smuggled in black market contraceptives from Hungary, the Soviet Union, and elsewhere, but most women resorted to the cheap, albeit more dangerous, method of illegal abortion. Some trained practitioners, including Ob/Gyns, provided the illegal service in their off hours. But for the vast majority of women, such medical procedures were too expensive, and back alley abortionists plied their trade with disastrous result.

By December of 1989, when the Ceausescu regime was overthrown, the country's population had not substantially increased, but maternal and infant mortality rates had risen higher than any other in Europe. In addition, Romanian parents were institutionalizing their children at three times the normal rate; by 1990, 150,000 children were found warehoused in state institutions.

The country's new party rulers, led by Ion Iliescu, immediately instituted a host of political reforms, including legalizing abortion and the import of contraceptives. In 1990, U.S. Congressmembers, citizens, and press visited the country and pressed for aid to improve the appalling state of women's and children's health. In FY 1991, Congress earmarked the first aid to the country -- \$1.5 million for institutionalized children and \$1.5 million for family planning.

Congress suggested that IPPF and the United Nations Population Fund (UNFPA) might be possible recipients of the family planning funds. Due to administration policies regarding abortion³, however, these organizations could not receive U.S. Government family planning funds. In March, 1991, USAID awarded Grant No. EUR-0002-G-00-1016-00 to CEDPA, an international women's empowerment organization. CEDPA's "woman to woman" development approach seemed suited to the project purpose, which was to establish a pilot family planning service delivery system in the private sector.

At the inception of the CEDPA program, any ethos of volunteerism among professionals -- even the term "volunteer" -- had been distorted and discredited by years of imposed "volunteer" labor performed for

³ Throughout the Reagan and Bush Administrations, no U.S. aid could be distributed to any programs and projects that practiced abortion or even counselled on abortion. This policy at USAID became known as the Mexico City policy.

Ceausescu's uncivil society. Struggling under the weight of this legacy, newly formed Romanian family planning NGOs had not yet absorbed the concept of volunteer, private, non-governmental organizations⁴.

But perhaps the most important constraint faced by the CEDPA program, was the state of family planning. After years of Ceausescu propaganda cautioning women against modern contraception, women overwhelmingly choose abortion over more expensive modern contraception. In 1990, abortions in Romania exceeded one million, or three abortions for every live birth. Meanwhile, the powerful Ob/Gyn community had developed a strong economic interest in providing abortions, for their low government salaries were augmented by fees and "tips" for performing the service.

As for developing family planning in the private sector, at the time CEDPA launched its program Romania had a negligible private sector. What little private sector experience had been gained was limited to the underground economy. Inflation was rising, from 1 percent in 1980 to 200 percent in 1991. A chaotic political climate, including violent struggles in the nation's capital, kept the Iliescu regime in constant flux. Consequently, the leadership within the Ministry of Health (MOH) changed frequently, as did the Ministry's commitment to family planning.

In addition, in 1991, neither USAID, the United Nations Development Programme (UNDP) nor the World Bank had representatives or offices in the country. The Romanian government and the World Bank had not yet finalized terms and conditions for a \$150 million loan, including a \$27.5 million component devoted to reproductive health care services and commodities purchase.

The Romanian family planning project is currently funded at \$4.9 million through a five year grant to CEDPA. The project is being implemented directly by CEDPA through a series of sub-grants to three Romanian NGOs: SECS, FPMV and Youth-for-Youth. It is also being implemented through subcontracts to contractors, consultants, and NGOs providing specialized technical assistance (TA).

Currently, the goals of the project are to improve the capability of Romanian health care personnel to provide family planning services and information and to enhance the ability of private Romanian organizations to promote and market voluntary family planning services. The project purpose is to train general practice (GP) physicians and other health care personnel to counsel women and to provide safe, high quality comprehensive family planning services.

One of the major policy related issues and program constraints faced by CEDPA revolved around the limitations imposed by USAID's Mexico City Policy. The policy forbade funding of NGOs engaging in abortion-related activities, including pre and post abortion counseling as well as linkages to MOH clinics which provided abortions. Another policy issue and constraint involved USAID policies prohibiting "topping off" government employees' salaries; since almost all of the trained medical personnel in the country were MOH personnel, access to qualified clinicians and laboratory technicians was hindered. Very few high status professionals were willing to give up the security of their government jobs with the MOH to work with fledgling and unsure NGO family planning clinics.

Inevitably, with SECS, CEDPA's principal sub-grantee, strongly allied with the Europe-based IPPF -- an organization that had been adamantly opposed to the Mexico City policy -- tensions developed between CEDPA and IPPF, SEC's two major donors.

⁴ A note on terminology: not-for-profit organizations incorporated in the U.S. who register with A.I.D. after meeting certain standards are called private voluntary organizations (PVOs); similar non-U.S. organizations who have not registered with Missions are called non-governmental organizations (NGOs). Thus, in the context of this report, the Romanian organizations (SECS, FPMV, and Youth-for-Youth) are NGOs. CEDPA is a PVO.

Within this daunting social and political context, CEDPA, USAID/Europe and USAID/Bucharest struggled to jump start a system of model, quality, private sector clinics. Other areas like IE&C, as well as working with the public sector and pursuing the feasibility of social marketing, were determined to be of lower priority.

The implementation of the project purpose has been hindered by more than the social, political and economic climate in Romania. USAID's Mexico City policy forbade funding of NGOs engaging in abortion-related activities. The CEDPA-funded clinics could not be linked to or located within Romanian MOH clinics, since the MOH clinics were now providing abortions. The "topping off" prohibition continued to be harmful in the search for trained medical personnel, qualified clinicians or lab technicians. Very few people were willing to give up the security of a position with the MOH to work with such fledgling and unsure clinics.

The Romanian domestic economy, in common with those of its reforming neighbors of the Newly Independent States (NIS), has been spiralling into decline. Inflation is currently estimated to be running at levels of 400 percent. The Romanian Lei continues to devalue against Western hard currencies at an alarming rate further exacerbating the situation. During the nine day period, November 1, 1993 through November 9, 1993, the official (bank) rate rose from 1050 Lei = \$1.00 to 1074 Lei = \$1.00, a devaluation of 2 %.

Privatization of the economy is hampered by the sheer size of large scale industrial establishments, the dismantling of which into viable and saleable units is a complex operation. However, the period 1990 through 1993 has seen a rapid increase in small scale businesses, consisting in the main of one person operations, and the private sector is now estimated at being anywhere between 15 and 24 percent of GDP.

NGOs are a new concept in Romania. There is no legislation covering NGOs and they are treated as trading corporations subject to taxation on turnover. However, the situation remains unclear, and attempts are being made to recognize the difference between not-for-profit organizations and trading corporations. In the event that NGOs do trade by selling services and/or supplies, the income thus derived may be subject to taxation.

2.0 Evaluation Methodology

Five of the eight project-funded clinics were evaluated for quality of care. Evaluation emphasis was placed on SECS as it operates seven of the CEDPA-funded clinics. The Family Planning Program Specialist evaluated the clinics using an internationally accepted standard clinical assessment tool developed by Margaret Sanger Center International (MSCI). The tool obtains data on the six elements of family planning quality: choice of methods, information given to clients, clinical (technical) competency, interpersonal relations, mechanisms to encourage continuity and follow-up, and organization and location of services. The Clinical Specialist conducted an independent review of three clinics. Due to limited time, it was not possible for these specialist team members to assess the clinic at FPMV. The clinic evaluations also included interviews. A total of seventeen SECS clients were interviewed to obtain anecdotal accounts of the level of patient satisfaction. In-depth interviews were also conducted with clinical personnel (see Annex 3, People Contacted).

The management of this project was evaluated based on a wide number of factors, including the use of a standard set of internationally accepted management tools and processes. The management tools and processes are the following:

- Needs assessment
- Definition of measurable objectives and/or logframe
- Initial and annual work plans

- Organizational chart for project structure
- Job descriptions for staff
- Scopes of work and reports for technical assistance
- Subcontractor contracts
- Reports from subcontractors
- Quarterly reports and annual (72) reviews and reports
- subgrantees quarterly and annual reports
- Contracts and reviews for field staff

The institutional development, communication systems and reporting systems of the family planning NGOs were examined.

To evaluate the financial components of this project, the Financial/Marketing Expert evaluated the financial reports and documents available at CEDPA headquarters and at the field office in Bucharest. The financial documents and reports submitted by the subgrantees were also examined.

SECTION TWO: PROGRAMMATIC DEVELOPMENT

2.1 The Quality of Clinical Services

2.1.1 Major Findings (Results)

2.1.1.1 Choice

All clinics evaluated were offered a voluntary choice and range of methods. In all clinics assessed, three oral contraceptive methods, two barrier methods, the Copper T 380-A IUD (intra uterine device), and spermicides were available. Depo-provera, the 3-month-long acting injectable was not available. (See Annex Five, Evaluation of Medical/Clinical Services, for more detailed information).

GPs reported that on occasion logistical problems of supply have narrowed patients' choice of methods. There were no policies limiting the choice of unmarried or adolescent clients. Clients expressed satisfaction with the SECS clinics' lower prices for oral contraception.

GPs interviewed reported a high degree of satisfaction with the methods and pills they are prescribing, with one exception, Regividon, an imported Hungarian pill⁵ (See Annex Five, Evaluation of Medical/Clinical Services). Both clients and staff expressed the desire to be able to choose from American contraceptives which are not yet licensed in Romania.

2.1.1.2 Dissemination of information

All of the clinics that were evaluated offered accurate, appropriate information on family planning methods. Patient brochures, demonstration models, and wall charts were found in all evaluated SECS clinics. Client records were maintained and in good order. Clients had a fair level of knowledge about the methods they were using.

⁵ The Hungarian pill also poses unique disadvantages to family planning in Romania due to the fact that the people of Romania have a long standing prejudice and dislike of anything Hungarian. This effects clients' perceptions of the pill, regardless of medical information.

2.1.1.3 *Quality of clinical care*

The quality of medical services provided by clinicians was excellent. Upon acceptance of oral contraceptives (OCs) or IUDs, patients are counseled about use, and potential disadvantages and advantages. Usually patients are queried as to their risk for sexually transmitted diseases (STDs), instructed on breast self-examination and given a breast examination. Weight and blood pressure are taken. A pelvic exam is usually performed. Some clinics take pap smears, while others must refer out for this and other services.

There was an especially high quality of client-provider relations in the clinics. GPs generally spend between 10 and 30 minutes per client, providing counseling and information. Clients reported that SECS GPs are user-friendly, helpful and respectful. However, using physicians as family planning counselors is a costly, time-intensive approach to practice (see Annex Five, Evaluation of Medical/Clinical Services). FPMV uses nurses as counselors with good results.

2.1.1.4 *Organization and location of clinical services*

All SECS clinics evaluated are located in fairly convenient, safe locations. Throughout the entire first half of the project (until March 1993), however, the Mexico City Policy prohibited SECS from locating clinics linked to MOH clinics providing abortion services. The Policy hampered continuity of comprehensive women's reproductive health care and volume of clients, since women would have to go to more than one place to receive their women's gynecological health and basic health care. The Leu University clinic, for example, which exists within a general MOH facility (non-abortion providing) for students, is the highest volume clinic in the SECS system. This and other sites are well maintained, and SECS facilities are clean and attractive. However, services available in the clinics do not include testing for chlamydia and gonorrhea, nor treatment of STDs. There is a lack of necessary equipment, commodities, and on-site, non-public sector staff to provide these lab services. Clients are often referred out, reducing continuity of care and follow-up.

A number of additional difficulties further limit follow-up and continuity of care. Some of these are due to the fact that the mail and phone system in Romania are inefficient at times. There is also a lack of uniform policies in the clinics regarding the scheduling of patient follow-up and revisits.

2.1.2 **Significant Accomplishments and Impacts**

The NGO clinics that CEDPA has funded and developed maintain a very high quality of patient care. The information on modern family planning that is being disseminated is comprehensive and accurate. Patients are being provided with a solid choice of family planning options.

2.1.3 **Conclusions**

The choice of family planning methods at subgrantee clinics is comprehensive, with high quality information dissemination regarding the various methods. However, there are still some important gaps to be addressed.

- Depo-provera (a highly-effective injectable contraceptive with a less than 1% failure rate) is not provided. The World Bank loan currently categorizes it as only for use for mentally retarded women or those who experience failure with other hormonal methods. This has caused stigmatization of Depo, even if the World Bank's categorization may only be due to cost considerations. However, it is a viable option and clients should be given adequate balanced information on this method.

Clinicians do not have sufficient information regarding how to prescribe the low-cost Hungarian generic pill Regividon to avoid breakthrough bleeding (BTB). The pill has been purchased as part of the World Bank loan. Additionally, Romanian prejudices toward all things Hungarian, combined with instances of BTB, damage clinician and patient attitudes toward Regividon. (See Annex Five, Evaluation of Medical/Clinical Services.)

With government policy unclear about restricting trained GPs from inserting IUDs and little public education about the broad benefits of Copper T 380-A IUDs, the method does not have many acceptors.

Pre and post abortion counseling takes place unofficially in SECS clinics, but SECS and FPMV have not yet received official, written notification of Amendment 3 (the reversal of the Mexico City policy). Although CEDPA has told the subgrantees that the Mexico City policy has been lifted, neither CEDPA nor the subgrantees can act upon this policy change without formal written notification. It is essential to further strengthen linkages between the providers of modern contraception and the providers of abortion care in order to improve the conversion rate from the option of abortion to family planning. (At another internationally funded clinic in Bucharest, the Marie Stopes clinic, they provide both abortion and family planning services on site, but conversion of abortion patients to family planning is only 10 percent). Much more needs to be done in this area, and such work depends upon a clear understanding by subgrantees in the field of the change in USAID's abortion policy. Subgrantees should receive formal, written notification of Amendment 3.

CEDPA's principal sub-grantee, SECS, is providing quality preventive family planning services to approximately 12,000 women attending seven USAID-funded clinics in Romania. These "young" clinics with less than 15 months of operation report a trend toward increasing numbers of clients. It is an impressive accomplishment. Of course, small NGOs such as SECS and FPMV are not now, nor will they soon become, an alternative delivery system for the 5.3 million Romanian women of reproductive age. However, these pioneering programs provide an essential quality of care preventive model that the public sector could replicate. Whenever possible, clinical services should be augmented by increased linkages with MOH providers, including providers of abortion.

2.1.4 Recommendations

1. The CEDPA project should continue to provide information about the utility of the Copper T 380-A IUD and Depo-provera as mainstream methods of contraception to MOH and family planning NGO decision makers. Donors and the World Bank should coordinate efforts to ensure adequate information, supply, and fewer undue restrictions limiting client access to these methods. Efforts should be undertaken by USAID and CEDPA to reverse the World Bank's policy on Depo-provera.
2. Clinicians need additional technical assistance to strengthen existing follow-up and continuity of care mechanisms. In order to strengthen the skills of family planning clinical staff, training in sexuality within the family planning context should be provided.
3. Plans for CEDPA-funded NGO clinic facilities do not yet include the assumption that services will expand. At a minimum, space needs to include the capability for two examining rooms to be used simultaneously for efficiency and impact purposes.
4. In order to increase the future efficiency of clinics and decrease costs, training a cadre of non-physician family planning counselors should be encouraged. If subgrantees concur with such a major change of GP responsibilities, CEDPA should provide funding and TA for a three phase training of counselors (see Annex Five, Evaluation of Medical/Clinical Services).

2.1.5 Lessons Learned

The anti-abortion stance on the Mexico City Policy complicated cooperation between the NGOs and the MOH, which offered abortions, as well as among donors. The policy prevented an open and honest dialogue with European peers and obstructed collaboration with the European community, and IPPF in particular. It is imperative that the subgrantees receive official notification of the repeal of the Mexico City policy. Until they are able to deal openly with abortion, their impact and effectiveness with most Romanian women will be restricted.

Sustainability of clinical services within a five-year time frame where donors cover salary, rent and other major costs is generally not feasible (for further discussion of the sustainability issue, see section 4.3).

Modern methods of family planning will need to be consistently available, trusted and effective to achieve widespread use as an effective alternative to abortion. Safe and legal abortions are used by women in Romania as a cheap and effective family planning method. Legalization of abortion has lowered maternal mortality significantly.

Private sector family planning will need to expand, cooperating closely with the MOH and others, sharing facilities, training, staffing and other resources, in order to have an impact on large numbers of Romanian women.

High quality clinical services can be supplied by NGOs. These can be supported and improved by management systems development, analysis of clinical and MIS data (see 4.2.1.2), and expansion of IE&C (see section 3.3).

When more than one donor is supporting an organization, as in this case with IPPF and CEDPA both supporting SECS, a threat exists that the donor agencies will compete rather than cooperate. Personnel sensitive to these issues must utilize interpersonal relations skills and conflict resolution skills to maintain a mutually supportive relationship among donors.

Innovative reproductive health care programs threaten the status quo of the establishment, specifically the "guardians" of women's health, the Ob/Gyns. These obstacles must be recognized and addressed by incorporating public information, legal reform, citizen action, and advocacy campaign TA to support NGOs struggling against a hostile public climate.

2.2 New Programmatic Activities and Areas to Develop

2.2.1 Information, Education & Communication

2.2.1.1 Findings

CEDPA originally conducted an initial spate of focus group activities in 1991/92 as the groundwork for technical assistance in the area of IE&C strategy. However, SECS declined CEDPA-sponsored research and strategic TA by the Population Communication Services (PCS) in November, 1992. By that time SECS was tying itself as closely as possible to IPPF, and preferred to follow their methods and strategies. CEDPA's planned IE&C TA and training activities have been stymied since then.

Funding of SECS public education activities comes, in large measure, from the European Community and other sources. TA in this area remains a need of the NGOs. With limited funding and experience, SECS has produced clinic brochures, posters, pins, and community events and has pursued radio and television appearances. As yet, the organization has not had funds to present public education spots on

TV or radio. The other NGO, FPMV, has also actively produced IE&C materials and events with little TA and funding from CEDPA. A major opportunity exists in this area to expand the NGO's IE&C work. New data provided by the Romanian Reproductive Health Survey (RHS), funded in part by the CEDPA project and carried out by the Centers for Disease Control (CDC), could lay the groundwork for such IE&C work. (Specialized TA will have to be provided to enable subgrantee managers, including IE&C staff, to make use of the data in their IE&C strategic planning.)

The USAID Health Officer in country has discussed, and a SOMARC study has explored, the feasibility of launching social marketing in Romania, to expand the reach of family planning. SECS leadership agrees with the concept of social marketing, but disagrees with the term "social marketing." The WHO representative, World Bank/W personnel and others agree in principal with social marketing. However, the CEDPA Project Manager views social marketing as outside of the project's essential mandate. CEDPA's vice president has stated that "social marketing does not address women's needs for comprehensive health education, counselling and services and is not viable in a rapidly deteriorating economy with no existing demand for contraception." (Results from the RHS, conducted by the CDC, show demand for contraception exists, as does the history of black market pills under Ceausescu. Further, even in a "deteriorating economy" the Romanian private sector is growing and gaining an economic foothold). In addition, a number of focus groups, two studies as well as the extensive RHS, have produced information sufficient to launch a public information campaign dispelling myths and misconceptions about family planning. If social marketing is defined in the future as "linking a major public education effort about family planning with distribution of family planning through private pharmacies," it should substantially clarify the issue and generate greater consensus.

2.2.1.2 *Conclusions*

SECS has undertaken pilot public education activities, working in radio and TV, print media, and community education. Reconceptualization of the CEDPA project should provide support for an explicitly connected set of activities: model clinical services, IE&C, and public advocacy, rather than focussing only on support for CEDPA-funded clinics.

2.2.1.3 *Recommendations*

1. Existing and future subgrantees should receive major funding and TA support to expand their public IE&C activities.
2. USAID should further explore the feasibility of broadening information about family planning by using social marketing to distribute contraception via private sector pharmacies within grant funding or with additional funds.

2.2.3 **NGO as Public Advocate**

2.2.3.1 *Findings*

The role of an NGO in a civil society includes that of a public advocate educating public sector decision makers. USAID's policy of supporting the emerging Eastern European private sector limited CEDPA's TA to the public sector. However, a courageous CEDPA decision at the start of the program to strongly support GPs rather than Ob/Gyns in the new USAID-funded clinics led to a broader public advocacy role for SECS.

SECS has wrestled with a major question of legal reform in the last two and a half years over who will provide family planning in Romania. The issue has revolved around certification of practitioners. It was

CEDPA's philosophy that due to a scarcity of Ob/Gyns -- only 1,200 in the country -- and their proclivity to provide more remunerative abortion services rather than contraception, that female GPs should also provide family planning, including IUD insertion. In 1991 laws and policies regarding certification for family planning providers were unclear. CEDPA contracted Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) to train an initial cadre of 5 GPs and one Ob/Gyn to provide family planning, including IUD insertion. Once JHPIEGO certified the trainees, SECS requested the MOH to grant formal certification, but the MOH has not done so. Nonetheless, SECS moved ahead; its CEDPA-funded GPs joined IPPF-funded GPs to train MOH GPs interested in family planning and IUD insertion.

At present, there is a legal question as to whether private practice, trained, and competent GPs can insert IUDs and whether they can prescribe family planning methods such as oral contraceptives. These legal uncertainties create a difficult climate for private sector family planning practice in Romania, and encourage a stranglehold on the practice of quality family planning services by the Ob/Gyns and the MOH.

SECS has taken the position that GPs, under the rubric of their private practice license, can prescribe oral contraceptives. Many Romanian practitioners have informally gone further, privately taking the position that competent, NGO-certified GPs, working under the internationally established guidelines provided by IPPF, can also insert IUDs.

Training to competency level has been established internationally as the most appropriate model for physicians in practice. The Romanian government's new mandated training for practicing physicians (6 weeks for Ob/Gyns and 3 months for GP doctors) will likely delay program development and expansion of family planning in Romania.

2.2.3.2 *Conclusions*

Because the MOH does not presently have a leadership environment that strongly supports family planning or private practice family planning providers, SECS is acting appropriately and within the confines of international norms. It should be noted that as advocates for change, some Board members have been promoting family planning among influential MOH Ob/Gyns. In addition, the CEDPA-supported annual conferences have drawn Ob/Gyns to listen to papers on such topics as "Family Planning: Prevention vs. Cure." Such education and public relations campaigns are essential at this juncture.

SECS has played an important leadership role in pressing the MOH to broaden the number of professionals certified to provide family planning. CEDPA's philosophy of supporting GPs as providers of family planning provided an important catalyst for SECS's growth as a public advocate of family planning clients and GP providers.

Given the current climate in Romania for family planning, the amount of government regulation in this sector is not productive. The appropriate governmental role in family planning is the development of guidelines for training of providers for the public sector. Ideally NGOs and Governmental agencies will collaborate in the guidelines development process. At present such collaboration does not exist and the fluctuations within the MOH continue.

2.2.3.3 *Recommendations*

1. The Ob/Gyn community should be targeted for more intensive public relations campaigns to increase their awareness and support for family planning. The education could be included as

part of World Bank or as future CEDPA project efforts. Possible events include evening programs hosting internationally recognized experts (for example, the developers of Norplant); a newsletter for Ob/Gyns on contraceptive technology; and study tours for selected, influential leaders.

2. The CEDPA program should build a capacity within the NGOs to improve the public climate for family planning in general. Additional project TA should be provided in the area of public policy analysis, legal reform and citizen action to strengthen the NGO's capacity to work with, and educate, policymakers within the MOH, the MOH National Council for Family Planning, the Romanian Institute for Post Graduate Training for Doctors, the Ministry of Education, and other key leaders. A major goal should be developing genuine collaboration between NGOs and governmental agencies without forsaking the independence of the NGO community.

SECTION THREE: PROJECT MANAGEMENT SYSTEMS AND PROCESSES

3.1 Management Tools and Processes

Quality family planning projects require strong management competence, tools and processes. Although this project is relatively small, originally funded for only \$1.5 million and 18 months, and still only at \$4.9 million for 5 years, there are still a recognized basic number of management tools and processes that should be used to adequately develop and manage a project of this size.

The standard management tools and processes are the following (see also Annex Six, Management Tools and Processes):

- Needs assessment
- Definition of measurable objectives and/or project framework
- Initial and annual work plans
- Organizational chart for project structure
- Job descriptions for staff
- Scopes of work and reports for technical assistance
- Subcontractor contracts
- Reports from subcontractors
- Quarterly reports and annual reviews and reports
- Subgrantees quarterly and annual reports
- Contracts and reviews for field staff

3.1.1 Findings

3.1.1.1 *Needs Assessment*

The extent of the needs assessments carried out for this project have been limited. A CEDPA preproject fact finding visit in April 1991 provided a brief assessment of the Romanian situation and needs. It discussed the one potential NGO known to exist in the family planning area at that time (SECS), and examined its capabilities, leadership, and experience. This analysis did not discuss significant country background, family planning data, or issues. After project start-up, the needs assessment was updated and presented in the October 1992 trip report. This report was reviewed and found to be a well written report. It detailed project activities carried out, but the extent of the needs assessment was narrow. There was no evidence that other CEDPA needs assessments were done. CEDPA HQ had discussed the Trust Through Health document, which

was an early needs assessment conducted for Romania by a USAID team of experts, however, the information was not directly incorporated into CEDPA's own needs assessment.

3.1.1.2 *Definition of Measurable Objectives and Development of Framework*

USAID never required that a framework be developed for the project or that measurable objectives be defined. It is the opinion of the team that these should have been carried out anyway in the interests of more thorough and effective project management, but CEDPA did not pursue this opportunity. In the initial grant document and later amendments, most of the six key objectives are not measurable. Project development was rapid in 1991. There was opportunity to define measurable objectives at the third or sixth month as part of a project implementation plan (PIP) or project framework, but it was not taken advantage of by USAID or CEDPA.

3.1.1.3 *Initial and Annual Workplans*

Workplans were developed throughout this project, however there have been gaps of four to five months between the plans that were not explained. The workplans reviewed were composed of lists of activities and dates. Their effectiveness was hindered by a lack of explanation and rationale for the relationship between the significant project components and project activities. Monitoring of project activities is difficult because there is little classification and breakdown of types of activities into the programmatic areas and components.

3.1.1.4 *Organizational Chart for Project Structure*

The subgrantees have no organizational chart that defines their relationship to CEDPA, which has caused ambiguity and difficulty between CEDPA and the subgrantees. In its organizational relation to subgrantees, CEDPA alternately identifies itself as providing assistance and also as directly implementing parts of the sub-grant.

A project organization chart should graphically present the structure, titles and relationships of staff within a project and with subprojects, this should also clearly relate to position descriptions. CEDPA developed an organizational chart, but not until around two and one half years after project start. It seemed limited since it only presented a project manager, project associate and field representative. No other CEDPA staff supporting the project are included. The relationships, especially between the project manager and field and support staff, are not clearly defined.

For the first two years of the project there was a blurring of the management responsibilities between the Project Manager and a Senior Technical Advisor. The Advisor position was ultimately eliminated and that situation was resolved. The Project Manager is located in the Washington office. The CEDPA Field Representative is also presented as Project Manager on her business card, which creates further confusion.

3.1.1.5 *Job Descriptions (JD)*

Job descriptions were developed for all key positions, but some blurring of management responsibilities existed, and there have been some problems with the description and responsibilities of the Field Representative in Romania.

The job description presented for the Project Manager (Washington office) includes responsibilities for the development, implementation and evaluation of the project and provision of TA. The responsibility for identification and coordination of short term specialized TA is not specified. Rather, the project manager is to be responsible for directly providing the TA for developing the counselling, service delivery, data collection, financial management, program monitoring and community based information/education systems. The project manager has also,

in effect, come to absorb the responsibilities of the Senior Technical Advisor position that was eliminated.

The job description for the CEDPA Field Representative is confusing because it details administrative support and interpreter responsibilities, yet she is presented as a Project Manager in Romania. Although this may seem like just a question of semantics, it is causing confusion among the Romanian subgrantees. Additional responsibilities have recently been developed and agreed upon, such as "establishing reporting criteria for subgrantees" (these were included in the future responsibilities portion of her 9/93 annual performance review). The team does not consider these highly technical responsibilities as appropriate additions to the essentially administrative and support responsibilities of the role and job description. There is additional concern over this situation due to the Field Representative's absence of family planning experience prior to this current position.

The CEDPA Director of Programs is responsible for supervising the Romania Project, assuring the quality of programs, monitoring division and program budgets, and providing TA to division directors. Although most of the job description refers to tasks related to the overall CEDPA program, the evaluators assume that these selected tasks refer also to the Romania project.

3.1.1.6 *Scopes of Work (SOWs) and Reports of Short Term TA*

The scopes of work for the TA provided to the subgrantee, which define the purpose of the TA and the responsibilities of the TA advisor, should ideally be discussed and drafted jointly with subgrantees. SOWs presented by CEDPA consisted primarily of brief task descriptions. Some of the SOWs presented to the evaluation team appeared to be taken from the consultants' reports, which were written after the consultancy had been performed. Multiple consultancies were carried out using one SOW from the initial trip. This SOW was not revised or supplemented for the follow on activities. Subgrantees stated that until the past few months, the scopes of work for TA Advisors were not jointly developed.

There has been a breakdown in the distribution of the TA reports. The subgrantees stated that they did not receive TA advisors' reports during the first two years of the project, while CEDPA stated these reports were distributed. However, the team did not encounter them.

3.1.1.7 *Quarterly Reports and Annual Reviews and Reports*

The grant agreement required CEDPA to present quarterly progress reports, but no annual reports were required. Quarterly reports should contain a structured presentation of progress in the major areas of activity and their prime components measured against established project objectives. Quarterly reports ended up being written almost like trip reports. No quarterly reports from 1993 have yet been presented to USAID.

There was an internal CEDPA Annual Review conducted in July 1993. This was the first such review conducted and was designed to review the project and subgrantee progress. No copy of this internal CEDPA review was available for team review.

CEDPA requires quarterly reviews from the subgrantees, but no quarterly reports from subgrantees were available. There were monthly records of NGO clinic statistics. However, no other programmatic information was reported by the NGOs. Subgrantee monthly and/or quarterly financial reporting was submitted independently from other reports. The process of review of information from the subgrantees within CEDPA was not clear.

3.1.1.8 *Contracts and Reviews for Field Staff*

There was confusion between the Field Representative and CEDPA over the question of whether the status of her employment was as a contract employee or as a full time exempt permanent employee. The job description was in conflict with how HQ was classifying her position.

3.1.2 Conclusions

Although the project has initiated the development of management capacity and systems within the NGOs, the use of only a limited number of standard management tools and processes diminished the efficiency and quality of project management and management systems of the grantee and the NGOs. The project has supported the development of management and technical skills through the training of some 22 people in U.S. based training and through presentations at international and Romanian conferences. Some literature has been provided on management development. The NGOs have also begun to develop their own management systems. Implementation of efficient and effective processes continue to be critically needed by CEDPA to structure and support future project activities.

Some confusion regarding roles and responsibilities of various people throughout the project does still exist. There is a need for CEDPA to clarify position titles and responsibilities further in order to avoid any unnecessary confusion. An Organizational Chart with clear titles reflecting responsibilities and the reporting and support relationships with staff and subgrantees is important to the future management of the project.

A general breakdown in communication exists between CEDPA and the subgrantees. There are many factors contributing to this situation, but the bottom line is that this problem must be addressed. A productive relationship and efficient project management is going to be difficult to achieve without adequate communication between these parties. Such things as receipt and distribution of reports should not be in doubt. Both parties need to understand the purpose and scope of their respective activities and responsibilities.

3.1.3 Recommendations

1. CEDPA should conduct an in-depth review and restructuring of the project management. This should be done as a first step to the management of the second half of this project. External expert management TA should be contracted by CEDPA, with the review and approval of the Bureau Project Officer, to assist in this process on an initial and regular periodic basis. A formalized structured report and sharing of this review and redesign should be provided to the Bureau and the USAID Representative/Romania. Changes in management systems, tools and processes should be communicated to the subgrantees.

3.2 Management and Programmatic Relationships and Communication

3.2.1 Findings

CEDPA assistance in management and programmatic areas has encountered a pattern of significant resistance from the two major NGO CEOs and Boards. There were periodic signals that basic aspects of the relationship between CEDPA and the NGOs were in danger. The CEDPA President responded by making one trip to Romania. The NGOs, despite some difficulties, remain interested in continuing to work with CEDPA. However, there is a need to address basic issues of relationship and communication.

Between subgrantees and CEDPA, communication channels and reporting schedules have been developed without any kind of applicable institutional history or previous mechanisms. Channels and requirements

for communication between the NGOs and CEDPA needed to be explained and clarified, and the delivery of reports needs to be routinized. Financial reporting was routinized early, although programmatic reports have not generally been routinized. Difficulties arose when CEDPA essentially bypassed the central management and CEOs of the NGOs and communicated directly to clinic staff, soliciting data from them and inviting them to participate in training.

Communication was frequent between CEDPA and the USAID Europe Bureau, and quarterly reports were specified in the grant. CEDPA responded to Bureau requests for project information for the most part. However, as stated above, quarterly reports were not provided for the past three quarters. USAID has also been remiss in not pursuing the matter.

Communication between CEDPA and the USAID Romania Representative and Health Officer was not mandated by the grant, so lines of communication and reporting have been unclear. CEDPA provided them with some reports, although the Bureau did not direct CEDPA to provide reports to the Representative or Health Officer. The Representative has expressed to USAID/ENI a "need to get copies of quarterly reports as stated in the PIO/T... previous arrangements have not worked." This is a situation that should be resolved by USAID. The Representative has also suggested that, "in the future CEDPA be mandated to work under the general supervision of the USAID Representative/Romania."

There has been consistent communication between the involved parties at USAID. A number of e-mails were sent on program issues, between the USAID Representative, the USAID Health Officer, and the Bureau for Europe. Communication between the Bureau and the Research and Development Bureau (R&D/POP) has not been formalized, but there is an opportunity to use that office's expertise.

IPPF, as the other major donor organization for SECS, has a role to play in the project communication. SECS has declined TA assistance from CEDPA in certain instances (as detailed below) in favor of IPPF assistance. IPPF and CEDPA have communicated throughout the length of project activities. However, there is no regular communication among these parties. The roles of these two organizations are mutually supportive, and both duplication of effort and gaps in assistance must be avoided. This can be prevented if they work together and have frequent and cooperative interaction.

3.2.2 Conclusions

Future success of the project will require efforts to redevelop a productive working relationship between CEDPA and the NGOs.

Clear lines of communication and reporting could strengthen project management and processes among CEDPA, USAID, and the subgrantees. It is also important to maintain good communications with the MOH, and other public sector entities. This also could facilitate the sharing of information. The team interviewed CEDPA, subgrantees, and USAID/Romania and identified and graphed relevant communication channels and processes.

Breaks in the appropriate lines of communication during the first two years of the project were considered by subgrantees to be counterproductive to creating a functioning organization; they also weakened subgrantee management development. Communications among almost all parties had to be developed without previous mechanisms or procedures. Inappropriate CEDPA attempts to communicate and receive reports directly from clinics caused concern from subgrantee leadership attempting to manage and assure accuracy of data. Limited inclusion of the USAID/Romania Representative, Health Officer, and R&D/POP limited their inputs and valuable insights.

3.2.3 Recommendations

1. The project should fund and conduct a joint CEDPA, NGO, USAID, IPPF and other active or potential agencies (e.g. AVSC) workshop of two or more stages to jointly plan future project activities (see section 3.1.3). An expert external trained facilitator should be contracted expressly to facilitate this meeting. The facilitator must be skilled in conflict resolution. This meeting will be especially crucial for the first stage of CEDPA-NGO discussions to resolve any difficulties and to help the parties in moving positively forward on strategic planning. The second stage should then continue strategic planning activities, cooperatively restructuring the project's key family planning components: programmatic (IE&C, clinic, etc.), management and finance components for the second half of the project.
2. It is recommended that USAID utilize the R&D/POP liaison officer to communicate with IPPF to encourage more collaboration with CEDPA.
3. CEDPA should review and revise approaches to communications and reporting with subgrantees, respecting appropriate lines. Communications between the Bureau, the USAID Representative, USAID Health Officer and R&D should be reviewed and revised to make appropriate use of valuable inputs and insights to assure cross fertilization of expertise and experience.

3.3 Institutional and Professional Development of the Family Planning NGOs

3.3.1 Findings

CEDPA's long term project manager and senior technical advisor were to provide significant TA in this area. This TA was reviewed; it did not provide a structured, constructive approach to the development of the NGOs. Consequently, little specialized institutional development short term TA was provided by the project.

The three family planning NGOs vary in their length of time in operation, size and institutional capacity. Currently most full-time staff are paid by the project; board members and "volunteers" donate time and considerable energy to the project. Perceptions of their role of collaboration with the MOH and GOR varied from active, de facto cooperation and cordial relationships to a sense of rivalry. Fortunately, CEO leadership has clarified a pragmatic and collaborative role as their goal. In the MOH Family Planning Unit discussions, officials expressed interest in cooperation in training, clinical protocols development, and family planning supplies procurement.

3.3.1.1 Professional Development

CEDPA's written plan articulates a TA approach aimed at developing a cadre of competent family planning clinicians and a growing group of family planning Master Trainers. At the project's mid-point, the written plans have not been fully realized.

3.3.1.2 Training

CEDPA provided an initial phase of training, a six-day introductory training on women's health care philosophy, counseling, and IE&C, to the first SECS clinical staff in September, 1991. The training was simultaneously translated into Romanian.

Next, a CEDPA-funded JIPIEGO course focused on IUD insertion, with some training on other methods of family planning clinical practices. There were some problems when the JIPIEGO course lectures

were not translated into Romanian, since not all of the trainees were English proficient. The trainees were then sent to various practice sites. Due to a lack of eligible IUD acceptors, the trainees had very limited supervised IUD insertion practice. JHPIEGO followed-up twice on the training (six months apart) by making site visits and assessing trainee competence. All trainees were examined and found competent.

There was a 10 day training workshop held in Cluj in September 1992, training 30 GPs in IUD insertion by JHPIEGO. A follow up Training of Trainers (TOT) was held in November 1992 with 15 GPs attending. Beginning in 1992, SECS declined additional CEDPA offers to provide in-country clinical training and TA. Instead, IPPF provided an Ob/Gyn trainer to SECS for monthly TA visits.

With the initial CEDPA inputs, and the ongoing inputs from IPPF, a cadre of strong practitioners has been developed. But a cadre of Master Trainers, with both advanced training skills and mastery of contraceptive service delivery, is not yet fully developed. SECS now has 14 people who comprise a potential cadre.

3.3.1.3 *Standardization of terms*

Training requires some degree of uniformity in clinical terms, as does accurate reporting and recording. Uniform terms and definitions (such as "dropout", "clinic visit") were not clearly defined. However, CEDPA sponsored a SECS Standardization Meeting in October, 1993 that established uniform terms and definitions. Two IPPF clinical consultants provided technical assistance at the meeting.

Reports received by USAID/W from CEDPA have need for other clarifications and elaborations. For example, the 12,830 "consultations" reported for the Bucharest Leu University clinic actually merged MOH clinic statistics; the correct number was closer to 6,000. This has made client and service analysis more difficult, particularly assessment of the SECS clients drop-out rate.

3.3.1.4 *Development of clinical manuals and curricula*

Part of CEDPA's TA plans were to develop various clinical manuals and curricula. However, when SECS received an associate affiliation with IPPF in mid 1992, the organization began to rely on IPPF, declining to use CEDPA TA in the area of medical and counseling training, as well as standard-setting. Since IPPF is clearly an internationally recognized, reputable health and family planning provider, there is no problem adopting their standards. However, as a result, "medical manuals on each of the contraceptive methods" have not as yet been developed, printed, or disseminated to either SECS private sector clinics, policymakers at the MOH, or members of the MOH Family Planning Unit. In their stead, SECS has opted for the quality of care standard found in IPPF's manuals and books, translating a key volume into Romanian, printing copies, and distributing them to its clinics. Standards for quality of care and quality control, as well as the philosophy of emphasizing counseling and prevention, are an important part of these IPPF materials.

3.3.1.5 *Resources and literature*

There is relatively little access for the subgrantees to resources and technical materials from the international community. There is a high degree of enthusiasm for these materials after decades of restrictions on foreign medical and scientific literature during the Ceausescu regime. The Project Manager has hand carried numerous academic papers and distributed them to clinics, but there is no system in place for steady distribution. During the evaluation, the present library resources at CEDPA's in-country office and its subgrantee offices were examined and found to be extremely slim. A system should be implemented to allow clinics not only to independently receive assorted papers, but to order

magazine subscriptions and books on a routine basis. Given the high level of interest, this lack of assistance represents a significant missed opportunity for strengthening the NGOs.

Access to international literature on developing NGOs is crucial to effectively helping subgrantees create NGO organizational structures. Much progress has been made by the NGOs even without the benefit of this literature. However, there is a need and desire for the subgrantees to have access to international literature on a steady and reliable basis.

3.3.1.6 *Study tours and international training*

Study tours enable key CEOs and Board members to maintain access to peers and to provide an opportunity to explore such issues as NGO development, management, policy, and donor coordination. This tool has been utilized, however, there has been little involvement of the subgrantee executives in either the selection of candidates or the participation in the training and tours. One policy maker from the public sector was taken on a foreign trip; more could be done in this area. There have been some inappropriately chosen individuals for other international trips and training.

The purpose and desired results of study tours and training need to be carefully examined and determined before people are sent to undertake them. The efforts aimed at developing the NGOs were lacking in exposure of key Board members and Chief Executive Officers (CEOs) to "study tour" visits to other family planning NGOs internationally. Tours would provide these Romanians access to other Boards and CEOs with advanced experience for examples and for exchange of ideas.

International training should expand the medical, scientific, and programmatic knowledge of clinicians. A total of 28 SECS and FPMV staff and volunteers have been sent for training in the United States. One doctor received training in IE&C at PCS. Two SECS volunteer leaders were sent to a Training for Trainers course in Santa Cruz. But the vast majority of training involved CEDPA's Women in Management (WIM) Training (11 trainees attended the WIM course). The CEDPA course is "specifically tailored to meet the needs of women managers who have never had a role model." While the SECS Executive Director did not participate in the CEDPA WIM course, two SECS secretaries did.

3.3.2 **Conclusions**

CEDPA project management procedures have not been adequately developed to support project activities. The project's management at the headquarters or field level has essentially not used the basic management systems, tools and processes such as establishing measurable objectives, developing adequate workplans, establishing organizational structures, defining lines of communications and reporting, clarifying job descriptions etc. These were critically needed and continue to be critically needed by CEDPA to structure and support future project activities.

Solid basic education and the ability to conceptualize allows the NGOs to absorb quality TA in the areas of NGO development, family planning clinical and counselling skills, IE&C, general, financial and information systems management and others. TA and resources (computers, literature, equipment) and seasoned TA will assist them to rapidly join their theoretical base with practical skills. The capacity exists for additional well defined TA to be absorbed by the NGOs and shared with the MOH.

The need to assist NGOs with institutional development as new entities was not adequately provided by CEDPA staff or by short term specialized TA. Nevertheless, significant progress has been made by the NGOs. More exposure to study tours, literature, and specialized TA would have improved progress. The first phase of training and study tours was focussed primarily on women's empowerment and

somewhat less on family planning programmatic knowledge. The need for these inputs continues to be a priority.

The project was funded to assist the project subgrantees to develop their NGO organizations, including boards, constitutions, bylaws, and administrative and management structures and processes. This component of the project could have benefitted from short term TA specializing in NGO startup, organizational development of family planning NGOs, constitutions, and bylaws. This approach has been used with other USAID funded NGO institutional work in Romania, with documented success.

3.3.3 Recommendations

1. Specialized TA, study tours, and international literature on NGO development, and, specifically, family planning NGO development should be provided in a structured approach to the three current and any future NGOs. In section five, Future Project Activities, the role of CEDPA and other contractors is defined.
2. Study tours should be considered for Executive Directors who have not yet received them, for Boards of present and future subgrantees, and for key government decision-makers. In addition, practicing clinicians and key staff should continue to receive foreign training and study tours.
3. In cooperation with IPPF's Master Trainer, strengthening a cadre of Master Trainers should be a top priority. (See Annex Five, Evaluation of Medical/Clinical Services) To achieve greater training efficiency, the vast majority of Training of Trainers (TOT) and clinician training should take place in-country.
4. A major initiative to increase the library stocks of subgrantees should take place. Subgrantees should be consulted about their areas of interest. Experts in family planning professional development should be consulted to ensure the purchase of essential references and periodicals from Europe and the U.S. A system for the acquisition of these resources should be developed and institutionalized.
5. Senior representatives with significant family planning credentials should be chosen to represent Romania at the UN Cairo Population conference in 1994.
6. Future sustainable assistance should include all the above areas. NGO sharing (with the MOH) of clinical sites, staff and equipment and supplies should significantly lower costs and move toward sustainability (see 5.1, #3). In addition, TA to expand private practitioners with revolving loans for start-up equipment and supplies can be explored. Finally, TA to expand public education and commercial marketing may not be immediately sustainable but was identified by the Romanians as critical and should be included.

3.4 Significant Accomplishments

CEDPA has initiated the development of some tools and processes to manage the project. They have also initiated the management and programmatic relationships and communications for project management and monitoring, and the building of institutional capacity of three family planning NGOs.

The Project has supported the development of management and technical skills through the training of some 22 people in U.S. based training, presentations at international and Romanian conferences. General TA was provided by CEDPA in institutional development especially during the first two years.

Technical assistance has been provided in the areas of clinical training, IE&C, policy advocacy, financial management and MIS and general management, and institutional strengthening.

The project has funded an initial assessment of the potential to expand IE&C and social marketing as a basis for future project activities.

3.5 Lessons Learned

The legacy of the Ceausescu security system still affects Romania. To assist in institution building, the leadership of family planning agencies would benefit from exposure to other countries' systems, and to models and international literature. Considerable absorptive capacity exists in NGOs and in the MOH. Development of Romanian Boards, Executive Directors and senior staff requires advanced TA specialized in institution building.

Use of a simple set of project management tools and indicators will assist USAID, the contractors, and the Romanian NGOs to plan, implement and monitor projects for the most effective use of resources. These can be incorporated at the mid point of the project.

SECTION FOUR: FINANCIAL MANAGEMENT AND ANALYSIS

4.1 Financial Reporting and Financial Management

4.1.1 Findings

4.1.1.1 Expenditure Levels

Review and analysis of CEDPA's internal reports, for the period from project initiation through September 30th, 1993, show the following expenditures:

	Budgeted		Expended		% Expended Over Budgeted (e)
	\$'000s (a)	% (b)	\$'000s (c)	% (d)	
Subgrants	1,635	33.4	310	17.0	18.9
Subcontracts	921	18.8	265	14.5	28.7
CEDPA Expenses	2,344	47.8	1,252	68.5	53.4
	4,900	100.0	1,827	100.0	37.2

The analysis above indicates that expenditures on CEDPA-related costs are being incurred at a far greater rate than expenditures on subgrantees, the focus of this grant. At the mid-point of the 5 year grant, five dollars is spent in the U.S. for CEDPA and subcontractors for each dollar spent on subgrants in Romania (column c).

The table further shows, in column e, that while CEDPA expenditures amount to 53% of the amount budgeted for the project period, subgrant expenditures are less than a fifth (18.9%) of the amount to have been expended.

While the low levels of expenditure on subgrantees could be partly due to the massive devaluation of the Lei, a significant portion of this "gain" on exchange will have been offset by the hyper inflation in Romania. Similarly, amounts on subcontractors are being underspent even though they are not subject to the devaluation of the Lei. Subcontractor TA activities should be utilized

The amount of subgrant expenditures is constrained by the limited number (three) of project NGOs and the activities funded by CEDPA within these NGOs. However, these NGOs do have the capacity to absorb assistance in the areas of training of trainers, IE&C, financial management, and training. In addition, CEDPA could have funded and provided more TA to advance family planning within the bounds of the Project. This would have expended more funds on in country activities. There is still a need for these TA activities.

4.1.1.2 *Financial Reporting and Analysis as a Management Tool*

Financial reports are effective management control tools. The caveats are that they should be accurately assembled on a timely basis and effectively utilized to help the reader understand the transactions that underlie the numbers. Program information should tie in to the trends depicted by the numbers; together, these qualitative and quantitative data provide management with control mechanisms.

CEDPA's financial reports are submitted to USAID independent of their program progress reports. Thus, while CEDPA's *financial* reports have been regularly submitted at quarterly intervals (the most recent submission being on November 15, 1993), CEDPA's quarterly *progress* reports only cover the period through December 1992. Furthermore, the financial report format used by CEDPA is USAID's Financial Status Report (Short Form SF 269-201), which reports outlays in total and identifies the Federal share of such outlays. This format allows little meaningful analysis. While CEDPA is required by the grant to provide "quantitative data...related to cost data for computation of unit costs" (paragraph 1E.2.(b)(1)), no such analysis has been attempted.

CEDPA produces an internal monthly financial report, showing expenses by line item and reporting actual cumulative expenses against the total project budget. CEDPA's primary use of this report is to determine the allowability/disallowability of expenses charged to the project. The significant value of financial reporting with analysis is thus lost to CEDPA's management. By analyzing internal reports, CEDPA management should be alerted to areas of expenditures which are significantly under or over budget, not merely in total, but in the relevant proportion for the period covered by the report. By reviewing the reasons for these variances and going "behind the numbers," financial analysis can make a substantive contribution to the overall successful implementation of the project.

For example, analysis of CEDPA expenses through September 30, 1993 indicates that at the project midpoint, while total expenses are more or less on target at 54% of the project budget, some line items are significantly overspent, e.g. travel at 69% and fellowships at 82% (see 3.3.1.6 for further elaboration). Analysis of the overspent line items would enable CEDPA to determine the justification of these expenses. Additionally, an analysis of person time charged to the project indicates that the two most senior staff members of CEDPA related to the project had at that point exceeded the person-time allocation budgeted for the grant period through September 30, 1994.

4.1.1.3 *CEDPA's Analysis of Subgrantee Financial Reports*

CEDPA requires quarterly financial reports from subgrantees. However, it has not made an effort to standardize the quarters; thus, subgrantee reporting quarters do not coincide with each other nor with CEDPA. Consequently, a consolidated picture is difficult to establish. These financial reports are used almost exclusively by CEDPA to generate remittances to them after they are reviewed in Washington for arithmetical accuracy and internal consistency. No attempt is made to link financial performance with the underlying program achievement.

Further, CEDPA has failed to utilize simple controls over remittances to subgrantees. For instance, CEDPA's Terms and Conditions of Grant to subgrantees specify that disbursements will be on a reimbursement basis, i.e., after the initial advance, subsequent remittances would be made on the basis of monies actually disbursed by the subgrantee. Remittances thus should equal costs incurred as reported by the subgrantees: this, theoretically, gives the subgrantee an "imprest" float of a known amount at all times. However, actual remittances to subgrantees continue to be on a round sum basis. CEDPA makes no obvious linkage between funds expended by the subgrantee and remittances made to them. (Annex Four lists disbursements made to the three Romanian affiliates. The dates and amounts present no perceptible pattern in these remittances).

CEDPA has taken steps to establish future cash needs of subgrantees. Reporting forms have recently been amended to include subgrantees' forecast of cash required. However, the early forms returned by subgrantees indicate that these forms are not clearly understood, very little training has been given, and they have not been correctly filled out.

Having set up a cash forecasting methodology, CEDPA's response to forecasts have been mixed: on at least two occasions, subgrantees ran out of funds and had to revert to using funds from other donors (subsequently repaid) to meet program requirements. In one instance, where the subgrantee did not have access to other donor funds, their program was curtailed pending the receipt of the next CEDPA remittance. The reason for delays in remittances was not clear.

4.1.1.4 *Subgrantees' Analysis of Their Own Financial Reports*

SECS: Financial management at SECS consists of maintaining accounting records, extracting and submitting reports to donors, and submitting reports to the Executive Director and the Board.

Separate books of accounts are maintained for CEDPA funded activities and other donor activities. At the end of each accounting period (monthly), accounts and reports are manually merged to prepare consolidated board reports. The separation of records extends to maintaining separate petty cash boxes and records. All records are maintained manually and, although some computers have been delivered to SECS, these are presently envisaged as being for clinic client records and user statistics, not for financial reporting and analysis.

Problems that occur relate to the merging of ledgers to produce institution wide reports. The volume and complexity of transactions is such that the system in use is at optimum levels. The addition of any further activities is likely to overload the system, potentially leading to its collapse.

The nature of reporting required by donors varies, with CEDPA requiring cumulative reports, incorporating total project/sub-grant Receipts and Payments reports from inception of project to date, while IPPF requires calendar year Income and Expenditure accounts. (CEDPA requirements were recently changed from individual sub-grant reports to cumulative reports incorporating all sub-grants made).

FPMV: As with CEDPA and the other subgrantee, SECS, financial reports within FPMV are viewed exclusively as an accounting requirement, and reports are not used for any form of management control. Since FPMV only operates one central clinic which is located in their headquarters building, the timely receipt of incoming clinic financial reports is not a problem. All financial transactions apart from minor petty cash transactions related to the satellite clinic at Faltinceni are also handled by the Finance Director.

Income to the FPMV is almost exclusively from CEDPA apart from some minor donations received locally. In recent months the institution has received donations of contraceptive supplies. These have not been reported since CEDPA has not required non-CEDPA financial receipts to be included in routine reports. Since currently all major funding is attributable to CEDPA, the need to maintain separate records does not arise. The extent to which FPMV will also be burdened by repetitive manual systems as the institution grows and has multiple sources of funding was of concern.

Financial reports are routinely and regularly submitted to CEDPA by fax. This was documented by FPMV records at the same time that CEDPA reported that financial reports were not prompt.

Youth-For-Youth: This is a new subgrantee, consisting at the moment of an unpaid volunteer Board. CEDPA is currently assisting in recruiting a Project Director, responsible for project implementation. Although the Board is aware and concerned about reporting requirements, no concrete action has been taken by CEDPA or the subgrantee to identify or satisfy financial requirements. As of the date of this report CEDPA has made one remittance to meet financial obligations for rent and renovations of premises.

4.1.2 Conclusions

Field related project expenditures are being incurred at a significantly slower rate than planned, but central CEDPA expenditures continue to be incurred at budgeted rates. This results in a significant imbalance in expenditures at project mid point. The opportunity continues to exist to expand the type of activities funded within the current NGOs.

Financial reporting is being used exclusively, by CEDPA and its subgrantees, to meet accountability and remittance needs. No meaningful analysis nor linkage to progress reports exists. Thus, a critical management tool, which could assist in meeting project objectives, is not being utilized. This has also led to inappropriate overspending of certain line items by CEDPA (see 4.1.1.2).

There is no consciousness raising nor training geared towards the institutional strengthening and sustainability of subgrantees. This is manifested by a lack of TA in teaching subgrantees the importance of linking financial and program reports, of understanding the financial ramifications of programmatic thrusts, and, then, of fine-tuning both aspects for optimal results. Further, TA provided to date has not facilitated the preparation of consolidated, institution-wide accounts (which would give subgrantees an overall picture of their fiscal position). The focus of the TA, thus, has been on achieving CEDPA's requirements rather than enhancing SECS' skills.

4.1.3 Recommendations

1. CEDPA should identify, in conjunction with subgrantees and other donors (such as IPPF) and USAID, how best to reprogram and accelerate the spending of remaining monies for the optimal development of the NGOs in Romania and for attaining grant objectives (see also 3.1.3). Clearly, a need exists for greater in-country TA on such matters as financial management training, IE&C and public education, commodities management training, enhancement of the MIS, etc. CEDPA should also look to fund activities of other organizations who will assist in meeting program

goals/objectives, e.g. an Association of Pharmacists who might be interested in mounting a Social Marketing campaign.

2. CEDPA should conduct an extensive review of its internal financial management procedures related to the project, and ensure that financial reports are linked to program reports, with variance analyses explained in both financial and programmatic terms. Corrective action to address variances should be taken. These matters should be covered in reports to USAID so that it is kept apprised.
3. CEDPA should review the need for budget reallocations in instances of over/under expenditures. Such budget reallocations should be formally processed, thus ensuring that adequate financial resources are available as the project approaches each stage of completion.
4. CEDPA should require subgrantee financial reports in conjunction with quarterly program reports. Reporting periods should be standardized throughout. Reports should be reviewed promptly and matching dollar remittances made to assure that programs continue without interruption. The cash requirements section introduced recently should be clearly described in writing and training provided to subgrantees. Forecasting should be done in U.S. dollars to account for inflation. TA should also be provided to subgrantees so that they begin to link financial and programmatic performance for a better understanding of their own operations.
5. Adequate TA should be provided to assist subgrantees to develop and manage a simple computerized financial reporting and analysis system which would assist in preparing consolidated accounts and tailored reports to different donors. Financial reports should be routinely and systematically analyzed together with progress reports to establish those activities requiring reallocation of financial resources needed to ensure the project objectives. Variances should be investigated and explained. Budgetary reallocations should be made as appropriate.

4.2 Technical Assistance in Financial and Commodities Management

4.2.1 Findings

TA funded by CEDPA in the area of financial management and commodities management within the subgrants was provided primarily by external subcontractors and consisted of:

U.S. Consultants

Financial Management (Ron Geary CPA, Oct/Nov 1991 and Jul/Aug 1992)

Management Information System (Hubert Allen, Jan. 1992, Oct. 1992, and Nov. 1993)

Commodities Logistics Training ⁶ (Tim Minor/Suzanne Hurley, Sep/Oct 1993)

Local Consultants

Legal and Accounting (Coopers & Lybrand, from Nov 1991)

⁶ CEDPA did not fund the Commodities Logistics Training TA itself, but the in-country training costs. The TA was provided by Centers for Disease Control (CDC) through a PASA funded by the Europe Bureau, USAID/W. The first CDC visit was in May and was requested by USAID/Bucharest.

In October 1993, almost 30 months after the award of the grant, the CEDPA HQ Field Auditor made a field trip to assist subgrantees in getting their accounting records ready for an external audit. (In CEDPA parlance the "Field Auditor" does not perform audits, but provides TA).

4.2.1.1 *Financial Management*

The financial management TA advisor's two assignments were apparently aimed at providing basic accounting systems to be implemented by both subgrantees. The financial management TA advisor's visits were perceived (and indeed were described as such by the CEDPA Program Manager) as being "internal audits" conducted by and for the benefit of CEDPA. To exacerbate this confusion, his reports (which included formats, descriptions of systems to be used and books of accounts to be maintained) were not made available to the subgrantees⁷. The value of this technical assistance was therefore considerably diluted. The result is that the NGO system currently in use at SECS (the larger of the two grantees) was designed and implemented by the current Finance Director.

4.2.1.2 *Management Information Systems (MIS)*

Software Development

The MIS, which CEDPA proposed as a strategy in the initial project proposal dated 1991, has been in the process of design since January 1992. The subgrantees, particularly SECS strongly requested that their own system be designed and developed as opposed to implementing an off-the-shelf version. Software has finally been developed in 1993, and with the recent availability of computer hardware, is now in the process of being implemented. The system was developed with continuous clinic management involvement, but there were large gaps in TA, diluting and hindering the development and its impact.

The system has been devised to produce data on client statistics, methods used, and contraceptives issued. While the system has been designed to be expandable as more services are provided, the obvious need for linkage to inventory forecasting, and to income recording has been ignored. Importantly, the MIS is geared towards patient information and service records: no attempt has been made to include financial management, fund raising, and other applications that would assist in managing the NGOs as going concerns. Emphasis has been put on development of a specially designed computerized program when perhaps an off-the-shelf package could have been adapted more effectively. However, the system that has been designed is of good quality.

Data Collection

As from October 1992, clinics were required to manually record client information on forms which would ultimately be used for data input. It was also planned that each clinic would use these manual records to extract summary data that would later be produced by the computerized system when installed. In practice, none of the SECS clinics have used manual data to prepare summary information for their own use. It would appear that clinic managers perceive the system as an imposition required by the donor. It is possible that when computerization is implemented, and data is more readily available, managers will use it to improve their management of clinics. At this stage, however, insufficient TA has been provided to use the data available.

⁷ While CEDPA maintains that these reports were given to SECS, we did not find any evidence of it, nor has SECS been using the formats recommended (which further supports their contention that reports were not given them).

Hardware

Hardware has been slow in coming in. An IBM workstation and printer were given by IPPF to SECS in July, 1992, 3 more PC/printer groupings were given by IPPF in May of 1993, and 6 groupings were given in August of 1993 by CEDPA. Details of these are in Annex Nine, List of Hardware and Software. CEDPA also gave one grouping to FPMV.

4.2.1.3 *Commodities Logistics Training*

Commodities logistics training did not take place until late 1993. The TA consultant's report of September/October 1993 was not yet available. However, the training appears to have been well received by NGO participants. This training coupled with commodity forecasting training provided by IPPF as a part of their Planning, Programming, Budgeting and Reporting Workshop assisted SECS to manage this area. Given the uncertainties in the flow and availability of contraceptive supplies in Romania, this training was long overdue. The extent to which the TA and training attempted to include MOH personnel, who have identified commodities management as a critical area of need in the training is not known. The needs within the MOH, with the responsibility for forecasting contraceptive needs for the MOH/WB loan remains critical.

4.2.1.4 *Coopers & Lybrand, Local Consulting*

Coopers & Lybrand (C&L) was commissioned to audit the (then) two subgrantees following the first financial management TA visit (Geary's visit, 11/91). C&L provided TA in the area of legal matters at the early stages but have since been less active in the affairs of the subgrantees. Effectiveness of TA provided by C&L was difficult to assess, since the Scope of Work does not specify the tasks to be done.

C&L were also hired by CEDPA to audit the subgrantees for the period of May 1, 1991 through September 30, 1992. These were not issued until April 21, 1993. They have submitted quotes for auditing the subgrantees for the year ended September 30, 1993 but to date CEDPA has not made a final decision.

4.2.2 Conclusions

TA in Financial Management has been haphazard, overdue and ill-planned, and of poor quality. The absence of adequate briefing and debriefing caused unnecessary misunderstandings, with TA being perceived, and in one case explained, as audits. CEDPA did not attempt to involve the higher levels of NGO management to accept the training provided, considerably diluting its potential.

The MIS system needs to be implemented. A great deal of time and money has been spent on the development TA for the MIS, and the result has been a good system, although it is important that its capability be expanded to include financial management, inventory forecasting, and income recording.

TA in Commodities Logistics, only recently begun, is on the right track. It is very important that future TA in this area be very carefully planned.

4.2.3 Recommendations

1. Future TA in the areas of Financial Management and Commodities Logistics should be carefully planned, with the continuous involvement of top NGO management from all three NGOs. This planning should ensure that comprehensive SOWs are drawn up; that all three parties (CEDPA, the recipient, and the TA contractor) are uniformly aware of objectives and outputs; and that TA provided is complementary to that provided by other donors (IPPF, etc.).

2. The Chief financial officers of NGOs should be provided with TA in the area of Fund Accounting systems.
3. Urgent attention should be given to the Clinic MIS being implemented to link this to inventory control and accounting. Training must be carried out for appropriate clinic staff to learn the MIS system to strengthen the financial and project management of the clinics and the subgrantee organizations.
4. CEDPA should provide TA in cost accounting to NGOs to provide information to management on pricing mechanisms and the cost effectiveness of clinic operations.

4.3 Sustainability

4.3.1 Current Context and Progress to Date

The Romanian domestic economy, like those of reforming neighbors of the Newly Independent States (NIS), has spiralled into decline. Inflation is currently estimated to be running at levels of 400 percent. The Romanian Lei continues to devalue against Western hard currencies at an alarming rate. During the nine day period that the team was there, in November 1993, the official bank rate rose from 1050 Lei to 1074 Lei for \$1.00: a devaluation of 2%.

Privatization of the economy is hampered by the sheer size of large scale industrial establishments, the dismantling of which into viable and saleable units is a complex operation. However, the period 1990 through 1993 has seen a rapid increase in small scale businesses, consisting in the main of one-person operations and the private sector is now estimated at providing anywhere between 15 and 24 percent of GDP.

NGOs are a new concept in Romania. The first NGOs to be formed and registered in Romania were Trade Unions, followed rapidly by other NGOs. There is no legislation covering NGOs and they are treated as trading corporations subject to taxation on revenues. However, the situation remains unclear, and attempts are being made to recognize the difference between not-for-profit organizations and trading corporations. In the event that NGOs do trade by selling services and/or supplies, the income thus derived may be subject to taxation.

As of November 1993, SECS has established 10 clinics in 8 cities in Romania. Seven of these clinics are funded by CEDPA and three by the European Community through IPPF. The major difference between these clinics is that at the IPPF funded clinics, discussion of, and counselling on abortion is done. Clients seeking services pay fees for counselling and supplies based on their ability to pay. e.g. any unemployed person is provided with services free of charge although they may be required to pay for any contraceptives that are issued.

In May/June 1993 USAID/W commissioned a review of clinic sales and pricing policies, to establish whether clinic services could be self-sustaining. It is likely that the fee structure will be amended upwards, but it is increasingly obvious that fees earned and monies generated from sales of supplies are unlikely to produce income sufficient to defray the costs of maintaining the clinic services in the foreseeable future.

Since both NGOs need to continue to maintain some clinic-based activities, it will be necessary for them to establish a secure and regular source of income to defray clinic costs.

4.3.2 Findings and Constraints to Sustainability

Family planning humanitarian assistance, designed as short-term emergency intervention, should not be burdened with the longer term objective of sustainability. Sustainability of family planning services without the addition of more remunerative abortion services, is rarely accomplished in the short term, especially in countries with adverse economic conditions and high inflation.

The main constraints to achieving a break-even position (sustainability) are:

- The volume of "sales" generated is and will remain insufficient to cover expenses.
- Supplies of contraceptives are haphazard and not assured.
- Neither NGO has developed a business strategy to cope with the continuously changing market-place. (e.g. Pricing levels require the acquiescence of the National Council which only meets twice a year).

The SOMARC review commissioned by USAID and conducted in May/June 1993 concluded that even with NGO clinics operating at capacity, the "selling price" for services and supplies would have to be pitched at levels unacceptable to the market for clinics to be self sustaining. Thus, for the foreseeable future, if the clinics are to continue to offer services, these would have to be subsidized, either in the form of subventions from donors or as donated contraceptive supplies.

The availability of supplies has, at best, been inconsistent. Contraceptives are available in local pharmacies, but the "margins" are augmented by the Government if the supply is made against a medical prescription. Pharmacies are less concerned about the consistency of supplies since they offer a range of products other than contraceptives. The availability of this range spreads the pharmacy's overhead over a broad product spectrum, allowing the pharmacy to better cope with inconsistent supply of a narrow range of product.

In an environment where the currency is devaluing daily, and inflation is rampant, a service provider must be able to increase prices based on market forces. Until such time that these forces are better understood in Romania, and until the private sector grows to constitute a larger proportion of the total market, price flexibility is a factor that will not be available to organizations in the NGO sector. Additionally, there is an inherent contradiction in creating a market for family planning services and pricing the product out of the market place. If contraception services are priced too high, the consumer will revert to abortion as a family planning method, thus defeating the strategy. Alternately, if the price of abortions can be increased to make them economically unattractive and contraception consequently more feasible, it is still likely that this will encourage the creation of a back street abortion service and a consequent fall in the standards of abortion services.

The SOMARC report suggested that one solution would be to expand the range of products sold at clinics to include cosmetics. However, the report also observed that this was not the long range answer to the sustainability issue.

Another option suggested was to include family planning related services, such as pregnancy tests, in the range of products offered. While this would be in keeping with the overall objectives of the non-profit organizations, revenues thus generated would be insufficient to attain self-sufficiency.

A further option is for clinics to provide abortion services in their range of services. The Marie Stopes Foundation is an example to be followed. Since its formation three years ago, this foundation has achieved self-sufficiency by providing a high quality service at a price above the Ministry of Health

outlets. However, in spite of the availability of pre and post abortion counselling, the number of abortion clients who become family planning acceptors remains well below 10%.

In the case of SECS, the Board does not see itself as a service provider in the long term. Rather this NGO sees itself as a source of information and education, using a limited number of clinics as standard setters for other service providers, and using the provision of clinic services as a source of credibility to its voice in the anticipated debate on family planning issues.

4.3.3 Conclusions

Clinic services will not be self-sustaining in the foreseeable future.

In the immediate future, the only feasible method of an economically viable distribution system of contraceptives in the private sector will be through a network of pharmacists.

Any sharp increase in the price of abortions will not achieve the desired effect of increasing the acceptance of temporary family planning methods, but instead is likely to drive the illegal abortion market into greater activity.

It is essential to address the issue of obtaining and maintaining a regular and consistent source of contraceptive supplies.

4.3.4 Recommendations

1. USAID should support a social marketing campaign aimed at increasing the level of acceptance of contraceptives, using any existing private sector Pharmacists association. If necessary encourage the development of such an association.
2. Both the organizations currently funded under the CEDPA grant should be encouraged to seek funding for clinic activities from other International donors.(e.g. International Foundations). The organizations should also seek to reduce costs by reviewing expenses such as full time staff vs. part time staff.
3. Mount an information and education campaign to disabuse potential users of family planning methods of any misgivings about modern contraceptive methods, thus creating an increasing demand for these services. At the same time, appropriate technical assistance in areas such as marketing and accounting should be provided to ensure that service providers are cognizant of balanced business practices, including but not limited to pricing policies and the costing of sales. In conjunction with the Ministry of Health, public and private clinics should be encouraged to increase the price of abortions slowly over a period of time to make alternative methods of family planning more and more attractive. But, this must only be done as public awareness and accessibility to preventive family planning methods increases, so that any punitive effect on Romanian women is limited.

4.4 Currency Management and Recognition of Inflation

4.4.1 Findings

Two important financial issues raised repeatedly during project implementation remain unresolved. Both relate to currency.

4.4.1.2 *Grant Denomination*

Subgrantees (and the Project Manager) are unclear as to whether the grant commitment from CEDPA is a US\$ commitment or a Local Currency (Lei) one. CEDPA grant documents indicate the value of each amendment, and the new revised total commitment in Lei, and then state the total cumulative value of the commitment in US\$. Since rates of exchange are not specified in these grants it is not possible to establish rates used for any specific amendment. However, since the total cumulative amount is expressed in both Lei and US\$, the exchange rate obtained from these total amounts is a composite average rate over the life of the project. In view of the substantial devaluation of the Lei against the US\$, this composite average rate is a valueless management tool. (The last amendment issued on August 20, 1993, extending the grant to cover the period May 1, 1991 through September 30, 1994 results in an average rate of Lei 412 = 1 US\$. The rate of exchange during November 1993 was Lei 1074 = 1 US\$).

4.4.1.3 *Effects of Inflation*

Clause 2.4 of CEDPA's Terms and Conditions of grant that indicate gains arising from fluctuations in the exchange rate will be treated as overpayment and deducted from subsequent remittances. While the exchange rate is not specified in the grant, the rate shown in the most recent budget attached to the grant is Lei 430 = 1 US\$. Should CEDPA choose to apply this condition the subgrantees would have to reimburse 60% of local currency amounts generated from US\$ remittances currently being received from CEDPA, with the amount increasing with each subsequent devaluation.

4.4.2 **Conclusions**

Clearly, CEDPA has to provide accounting and reporting guidance to the subgrantees on the management of currency fluctuations and also clarify the value of the grant.

4.4.3 **Recommendations**

1. For ease of reporting to USAID, the CEDPA subgrants should be stipulated in US dollars.
2. Currency translations should be as per the guidelines set down by the Financial Accounting Standards Board (FASB). Basically, this recommends translations of transactions during the year at an average rate (composed of actual rates obtained when dollars are translated by the bank), and a conversion of balance sheet items at rates prevailing on that date. Any gains or losses through currency fluctuations would be plowed back into the grant total.
3. In order to acknowledge rising costs through inflation, the subgrantees should be allowed to flexibly re-state their budgets, for CEDPA approval, based on current costs, say, every six months. Any currency gains arising out of #2 above should be used to offset increased costs arising from inflation.

SECTION FIVE: FUTURE GRANT ACTIVITIES

5.1 Overall Findings and Recommendations

1. No project activities should be discontinued.
2. Significant restructuring should be done in the second half of the project. Project objectives should be reclarified to expand the Non-Governmental Organization (NGO) role. The most important step in this restructuring process should be to hold a meeting between the Centre for Development and Population Activities (CEDPA), U.S. Agency for International Development (USAID), the subgrantees, and other active and potential donors and contracting agencies. This should be externally facilitated by an independent consultant who is skilled in conflict resolution. The meeting should address ways in which all of these organizations can cooperate and coordinate their efforts to achieve the most benefit from this project.

There should be multiple results of this meeting. Ways and means to improve current project activities should be worked out among all parties. The amount of funding remaining needs to be determined relative to the scope of future activities. It is then imperative to determine the priorities for all of the project activities, new and old, for the remaining time of the project. Responsibility for all of the project activities must be clarified. Project objectives should be discussed, redefined and agreed upon. The final result of this meeting should be a definite action plan for the remaining years of the project. The action plan can then be the guide for project activities, utilized by all of the parties involved with the implementation of any activities. It is important that everyone be involved in this effort, but that there is particular cooperation and coordination between USAID, CEDPA, the subgrantees, and International Planned Parenthood Federation (IPPF).

3. Key issues of the project include the following:
 - The need to reexamine the sustainability of NGO family planning activities. The current project's family planning NGO model is not sustainable. Other options for continued project funding must be explored (see section 4.3).
 - The provision of significant additional specialized technical assistance (TA) oriented to the areas of training and training of trainers (TOT), advocacy, institutional development, financial management, management information systems (MIS) and clinical skills will be needed to continue to strengthen the subgrantees and to adjust and reorient their role. CEDPA will need to reorient and expand its provision of TA, implementing the TA through use of specialized expert TA contractors to meet NGO needs. Project TA should be reoriented to be shared with other private sector parties and the Ministry of Health (MOH) whenever feasible.
 - The opportunity to expand family planning through sharing information and resources with the public sector. The impact of this project will remain limited without more involvement of the public sector. Expanded NGO and MOH cooperation should be developed, including close connection with MOH staff, sites, and supplies when possible (e.g. locate the family planning clinics as close as possible to, and in cooperation with MOH clinics so that clients have easier access to the laboratory, gynecological, and other basic health services available through the MOH). NGOs should reorient and/or expand activities to emphasize training and sharing of family planning information with MOH staff, medical doctors (MDs) who can provide public and private family planning services, and private pharmacists, nurses, etc.

The grant's second half builds on the Project's lessons learned and accomplishments. Cooperation with the public sector is key to increasing coverage of family planning services. Private sector family planning will need to train, advocate and cooperate with the public sector, which currently has major donor funding for family planning from the World Bank loan.

To expand family planning in Romania, specialized TA is increasingly required for clinical, information, education & communication (IE&C), training, management, financial management, MIS, procurement and social marketing. The following allocation of responsibilities to CEDPA and to other agencies is based on the current and future needs for specialized expertise. Increased CEDPA use of specialized subcontractors is essential. Future project activities should emphasize joint planning by CEDPA, the NGOs and other TA agencies.

5.2 CEDPA Activities and Responsibilities

CEDPA should continue to provide funding and support to the subgrantees, actively promoting their continued institutional development and provision of high quality clinical services. The clinics serve the dual purpose of increasing the respectability and credibility of the subgrantees as reputable family planning organizations in the eyes of the public sector. CEDPA must address methods of influencing the public sector providers of basic health care and family planning if this project is going to have a widespread effect on Romanian women. The following activities should be specifically addressed:

- Provide TA by specialized external consultants in management practices, financial management, MIS, family planning counselling, and additional areas of institutional development.
- Develop more routinized NGO institutional development activities such as access to international literature and resources, and international study tours for appropriate NGO personnel.
- Expand the family planning clinics' service provisions to include basic gynecological services wherever possible.
- Expand project approach to cooperate more fully with the MOH in training activities, and sharing of their staff, facilities and supplies whenever possible, within USAID regulations.

5.3 Other Contractors' Activities and Responsibilities

Other contractors should be utilized to provide the majority of the project's TA. Where needed, TA in each area should be developed by the specialized contractors who have specific expertise in those areas. This is particularly important for the TA in the areas of sustainability, development of a cadre of Master Trainers, IE&C activities, contraceptive legislation and logistics management, and development of financial management systems.

5.4 USAID Activities and Responsibilities

USAID needs to actively plan and participate in the recommended meeting among the major actors of this project and family planning in Romania. It will then have the responsibility to ensure that future project activities are carried out according to the plan developed.

The USAID Bureau of Europe and Newly Independent States (USAID/ENI) should ensure that it monitors the project activities according to the grant documents and be sure that reporting requirements are being met.

USAID needs to clearly express to CEDPA what direction and focus it wants the project to have for the remaining two and one half years. Indicators should be developed and reported on so that monitoring and subsequent potential adjustments of project activities are simplified.

USAID is also responsible for ensuring that USAID/Romania remains apprised of project activities. Its proximity to project events provides USAID with a valuable resource for guidance on developing issues surrounding the project.

USAID should work to influence the Government of Romania (GOR) and the World Bank in retaining the family planning component of the World Bank's loan to Romania. There is a danger that this component could be reduced as trade-offs on other issues. However, this component is extremely important, and USAID should reinforce that fact to the World Bank and the GOR.

5.5 Funding for Remaining Project Activities

The current project is not sustainable, and there is very little chance that it will be in the near future. In addition to the activities detailed in Section Four (4.3), other donors should be sought out to continue funding this project after USAID assistance has run out. CEDPA should draw on its resources, namely access to international donor directories and networks, and assist the subgrantees in soliciting future funding for this project.

5.6 Other Donor Activity

Time limitations did not allow the team to collect extensive information on other donor activities in population and family planning. However, interviews revealed the other donor family planning support activities and identified areas of possible collaboration.

Other donors in family planning in Romania include the World Bank, World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations Development Program (UNDP), IPPF and others.

The most active donor in the area of Romanian family planning is the World Bank. As discussed above, the World Bank is providing a \$27.5 million family planning component within its \$150 million Health Rehabilitation project with the GOR. This provides for equipment and contraceptive supplies; pre- and in-service training and development of the MOH's Family Planning and Sex Education Unit; and the Institute for the Mother, Child and Adolescent.

IPPF has provided TA and salary support to its Romanian affiliate, SECS, in areas of institutional development, training, clinical skills development and IE&C. This review identified a need for communication and collaboration between IPPF and USAID at the donor level, and between CEDPA and IPPF at the operational level (see section 3.2). A strong working relationship has not yet been forged with IPPF at either of these levels.

UNDP has a resident advisor, who is also the acting UNFPA resident advisor. He has provided some technical support to the development of family planning equipment lists, contraceptive supplies, and training of medical personnel. The advisor is also working at obtaining funding for the purchase and supply of contraceptives. The resident advisor advocates broad community education programs with teachers, parents groups, mass media campaigns, and social marketing.

At the policy level, donor collaboration is important to address opposition and/or indifference to family planning within the MOH and GOR. At the operational levels, donor cooperation would maximize technical inputs and offer consistent and complementary technical support and information to Romania, while avoiding some potential for competitive assistance. USAID should promote increased donor communication to encourage coordination. Areas of policy dialogue, effective provision of adequate family planning supplies and expanded family planning educational efforts should receive priority.

Annex 1

Scope of Work

SCOPE OF WORK

Mid-Term Evaluation of the Romania Family Planning Project (Project No. 186-0002)

I. BACKGROUND

For nearly thirty years beginning in the mid-1960's, Romania suffered extremely restrictive family planning laws. During this period, the efforts of Romanian women to control their fertility and family size led to unusually high rates of maternal morbidity and mortality - the highest in Europe - and also resulted in a large number of abandoned and institutionalized children.

At the end of the Ceaucescu regime, the prevailing situation in reproductive health in Romania was unusual even within Central and Eastern Europe:

- In spite of the antiabortion laws, Romanian women had achieved total fertility rates of about 1.9, comparable to other Eastern European countries. This was managed primarily through the use of natural family planning methods and widespread illegal abortion.
- In 1990 there were 400,000 live births and between 800,000 and 1,200,000 abortions (numbers were inexact due to under-reporting), in a population of 23.5 million, with about 5.6 million women of reproductive age.
- Health status indicators for Romanian women and children compared unfavorably to other countries in Europe: the infant mortality rate was 22 per 1,000 live births; nearly a quarter of all reported newborns suffered from low birth weight; maternal mortality - at 160 per 100,000 live births - was estimated to be higher than in other European countries by a factor of 10; there were also high rates of sterility and ectopic pregnancies.

These data suggested that a family planning program would be an important focus for external humanitarian aid in Romania.

After the fall of the Ceaucescu regime, one of the first acts of the new government was to legalize abortion and family planning. Early in Fiscal Year 1991, the U.S. Congress earmarked funds to be used for services to institutionalized children and for voluntary family planning programs in Romania. Shortly after that, in March of 1991 the A.I.D. Romania Family Planning project began.

II. INTRODUCTION

The Romania Family Planning project is currently funded at \$5 million through Grant No. EUR-0002-G-00-1016-00 with the Centre for Development and Population Activities (CEDPA), for a total of 5.5 years. It began in March, 1991 and ends in September, 1996.

The project is being implemented by CEDPA both directly and through a series of sub-grants to Romanian private voluntary organizations, and U.S. PVOs and consultants providing specialized technical assistance.

The goals of the project are to improve the capability of Romanian health care personnel to provide family planning services and information; and to enhance the ability of private Romanian organizations to promote and market voluntary family planning services.

The project purpose is to train general practice physicians and other healthcare personnel to counsel women and to provide safe, high quality, comprehensive family planning services.

Project implementation to date has included the following activities:

- Support for the organization of the first two private voluntary family planning organizations in Romania;
- Establishment of eight private family planning clinics in five cities in Romania;
- Provision of training, technical assistance, equipment and supplies for the operation of the family planning clinics;

At present, despite significant achievements there are some challenges facing the family planning program in Romania. To some degree these are inherent in the country's stage of economic and social transition. These challenges are:

- Low acceptance of modern contraceptives in Romania. Even the grant-supported clinics that have been providing modern contraceptive services for up to one year are experiencing uneven client acceptance and relatively high drop-out rates.
- Commodities. There has been a chronic problem with ensuring continuous supply for the clinics, in part because the responsibility is shared among Romanian NGOs and among donors, in-country logistics are problematic and the market for contraceptives remains undeveloped.

- Sustainability. Total revenues in the clinics are low. The project has had to struggle with maintaining a private sector activity in a country where the general economy is weak and the private sector is far from fully developed. A.I.D. is not expecting a fully self-sustaining program during the next few years. On the other hand, it would be reasonable to expect an efficiently managed, cost-effective program having a minimal dependence on continued donor support.

III. SCOPE OF WORK

A. Purpose

The Contractor will provide an objective, formal, external mid-term assessment of the Romanian Family Planning project (186-0002).

B. Issues for the Strategic Evaluation

The Contractor's overriding objective is to document historical and present assistance activities utilized by A.I.D., the Cooperating Agency (CA), Nongovernmental Organizations (NGOs), external donors, and the Romanian Government in family planning since the fall of the Ceaucescu regime in 1989 -- and assess their impact. This information is crucial in order to concentrate and reorient A.I.D. assistance if, and where, it may be necessary to do so.

Within this overall objective, there are four main elements to this evaluation: 1) the Contractor will analyze socio-economic and other factors to determine whether A.I.D. assistance in family planning is being targeted to ensure the most effectiveness of limited resources; 2) the Contractor will identify positive and successful elements of A.I.D., CA, NGOs, external donors and the Romanian Government assistance to date along with quantitative and qualitative impact indicators (i.e., acceptance of modern family planning methods by individuals in urban areas, whether the existing A.I.D. "model" provides high quality family planning services, etc.); (3) the Contractor will assess local institutional capacity and resources to determine the most appropriate role for future sustainable assistance; and (4) the Contractor will examine the lessons learned in the country to determine if A.I.D. assistance should be redeployed or reallocated.

In completing this assignment the team should particularly consider current understanding of root causes for low use of modern contraceptive methods, marketing factors, issues of financing, and ability of various proposed interventions to meet the program's goals for Romania.

C. Team Composition

The team will consist of three people. All team members should possess superior written and verbal communication skills. Overseas experience, preferably in Eastern and/or Western Europe is desirable. At least the team leader is required to have experience participating in previous A.I.D. evaluations and/or project design activities.

The following expertise is required:

- (1) a contractor with A.I.D. program management and evaluation expertise who will serve as the team leader;
- (2) a family planning clinical service delivery expert with international experience; and
- (3) a marketing/financial expert with appropriate skills and experience to assess program sustainability and the country context.

D. Methodology

Prior to departure, the Contractor shall:

- (1) review background documents, including
 - o legislation on voluntary family planning assistance to Romania;
 - o report by Jordan and Gibson (USAID), Fall 1990;
 - o "Women's Health, Family Planning, and Institutionalized Children in Romania," by Trust Through Health, Inc. (USAID), March 1991;
 - o grantee trip reports and quarterly reports'
 - o consultant reports; and
 - o documents prepared by UN and World Bank consultants.
- (2) conduct interviews and hold briefings with USAID and CEDPA staff in Washington. Key resource persons include A.I.D. Bureau for Europe staff and CEDPA's senior and project management staff. Interviews should also be held with relevant World Bank staff to gain insight into the World Bank project in Romania.

During the field work, the Contractor shall conduct an extensive field program review in Romania, including meetings with U.S. Embassy and A.I.D. Representative officials, meetings with grantee and Romanian NGO staff, visits to not less than six operating clinics (out of eight), and meetings with other donor representatives active in family planning in Romania.

E. Schedule

The evaluation will start in October 1993, dependent on availability of consultants. The entire assignment will take place over a three month period which will include one week in AID/W for collection and review of documents, briefing and team building; two weeks in Romania for field project review; a week in AID/W for debriefing and draft report preparation; and a week after receipt of A.I.D. feedback for final report preparation. In addition, four weeks will be allocated for the preparation of a follow-on concept paper for future women-centered health programs and summary of previous written materials. The detailed work plan for this activity will be developed by the Contractor based on the activity findings and submitted to EUR staff for approval prior to other work on the concept paper.

F. Logistical Support

All logistical support will be provided by the IQC contractor, including travel, transportation, secretarial and office support, interpretation, report printing and communication as appropriate.

G. Deliverables

Prior to departure, Contractor will submit a draft work plan to EUR/PDP/PA for concurrence.

The Contractor will propose measures for testing the impact, effectiveness, and efficiency of assistance delivered and test them against the cases sampled.

The Contractor shall produce a report which includes the following:

- (1) identifies successful activities or accomplishments stemming from A.I.D.'s approach to date;
- (2) calls attention to problem areas;
- (3) recommends types of assistance that should be continued or expanded;
- (4) identifies types of assistance that should be discontinued or postponed; and

(5) where appropriate, recommends new initiatives or complementary assistance to be undertaken in the future to ensure impact on project objectives.

The goal is to better match program service delivery with country-specific assistance needs at this point in the family planning process. In addition, the Contractor will assess the extent of in-country and AID/W coordination of activities. The Contractor shall propose mechanisms for streamlining of this project where overlap exists and improved coordination where needed. The Contractor's objective is to ensure that maximum benefit will be derived from the expenditure of future U.S. resources in this sector and country. Specific questions to be addressed by the evaluation team are included in Attachment A.

Immediately after return from the field, draft summary findings and conclusions will be presented to EUR staff at a preliminary meeting. A draft final report will be submitted not later than 14 days following the the team's return to the U.S. for AID/EUR review. A.I.D.'s and the grantee's comments will be given to the Contractor within approximately three weeks following receipt of the draft final report. The Contractor will then prepare and submit a final report, that responds to A.I.D.'s and the grantee's comments, within ten days. Thirty copies (29 bound and one loose leaf) of the draft final report and the final report, not to exceed 25 pages (including an Executive Summary of findings and conclusions not to exceed three pages) will be submitted by the Contractor to EUR/PDP/PA for distribution. Additional material may be submitted in Annexes, as appropriate; e.g., bibliography of documents analyzed, list of agencies and persons interviewed, list of sites visited, etc.

The Contractor's report shall provide a concise, analytical examination of these issues for Romania in the context of the host country environment, and an examination of NGO/grantee management styles and effectiveness.

The specific questions that the Contractor will answer include:

1. Has the programmatic structure of the project provided an effective vehicle for the project purpose achievement?
2. Are the project objectives being met? If so, have they been achieved in a cost-effective and timely manner?
3. Has the project been sufficiently flexible to respond to the policy and other changes in the context for family planning in Romania?
4. What are the key issues which have emerged during project implementation which ought to be addressed through project reorientation?
5. Are there outstanding legal or regulatory framework policy issues which need to be addressed by A.I.D.'s dialogue in-country to ensure the success of the project activities?
6. What new direction or goals should be considered for the remaining life of the project activities or follow-up activities?
7. Have external factors influenced the program's service delivery? If so, what types? Have they been positive or negative? Are there any positive or negative unanticipated influences on results from project activities?

Annex 2

Documents Reviewed

Annex 2 Documents Reviewed

- . USAID Strategy Papers. LPA Revision, (October, 1993).
- . United States Seed Act Assistance Strategy for Romania. (1993-95).
- . "The New Romania," New Yorker Review. (October 25, 1993).
- . Congressional Correspondence 1990-91, re: Romania Family Planning Earmark.
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- . World Bank Health Rehabilitation Project. (September, 1991).
- . "Contraceptive Supply in 3 Districts of Transylvania." MSF Survey, (August, 1992).

- AVSC. Project Proposal. (October, 1993).

- Bruce, Judith. "Fundamental Elements of the Quality of Care," Population Council Working Papers. No. 1, (May, 1989).

- Campenu, Pavel. "National Fervor in Eastern Europe: The Case of Romania," Social Research. Vol. 58, No. 4.

- CEDPA Romania Project. "Mid-term Evaluation, Oct/Nov 1993." (document including AID grant documents, background graphs, staff details, training information, clinic data, disbursements to sub-grantees, Youth for Youth proposal, IPPF trip report, CEDPA workplans, Sub-grant budgets, list of consultants used, consultant trip reports)

- CEDPA. Status of AID/CEDPA Supported Family Planning Clinics in Romania. (undated graph).

- CEDPA. Trip Reports.

- CEDPA. Quarterly reports. April 1 to June 30, 1991; July to September, 1991; October to December, 1991; January 1 to March 31, 1992; April to June, 1992; July to September, 1992; October to December, 1992.

- Coopers & Lybrand. Audit Reports. SECS - Period to September 30, 1992; FPMV - Period to September 30, 1992.

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Hord, Charlotte, David, Henry, et al. "Reproductive Health in Romania," Studies in Family Planning. (July/Aug 1991).

Hough, Richard. Program Progress and Accomplishments-Romania. USAID/Romania.

Johnson, Brooke, Horga, Mihai, Andronache, Laurentia. "Knowledge, Experience and Perceptions of Contraception and Abortion in Romania." IPAS Research.

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Micka, Mary Ann. CEDPA Grant File/Romania.

Minor, Tim, et al. "Framework in Support of a Draft Strategy for Health, Population and Humanitarian Assistance in Romania."

Nester. The Romanian Revolution.

Schwartz, Karl. Action Memo for the Deputy Assistant Administrator, Bureau for Europe.

SECS. Documents for Evaluation: Job Descriptions, Newsletters, Public Information Bulletin, Grant Correspondence, Monthly Clinic Reports.

Somarc III. Trip Report. (May-June 93).

Annex 3

People Contacted

Annex 3

People Contacted

The Centre for Development and Population Activities:

Hubert Allen, Consultant
Adrienne Allison, Program Director
Lucy Ankiewicz, Chief Financial Officer
Peggy Curlin, Chief Executive
Daniela Draghici, Field Representative, CEDPA/Romania
Mary Luke, Program Director
Roseanne Murphy, Project Manager
Stephen M. Slampyak, Field Auditor

Society for Education in Contraception and Sexuality:

Adriana Baban
Alexandru Burlacu
Adrian Ciocan
Constanta Dragne, Chief Financial Officer
Dr. Albu Dinu Florin
Anca Gabriela Ghinea
Ion Hogea
Mihai Horga
Maria Jinga
Dr. Borbala Koo, Executive Director
Aurora Liiceanu
Valentin Nastase
Ana Oltean
Sorin Puia, Chairman of the Board
Rodica Doina Savescu
Andreia Valter

United Nations Development Program:

Bernard H. Fery, Resident Advisor, UNDP/Romania, acting UNFPA Resident Advisor
Corlos Bendito Prieto

Ministry of Health, Family Planning Unit:

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Laviniu Buligan
Doina Bologna
Marius Cazacu
Doncia Cornelin
Cristian Jianu, MOH Tirnu Severin

United States Agency for International Development:

Rodica Furnica, Romania
Richard Hough, USAID Representative for Romania
Mary Anne Micka, Health Officer, USAID/Romania
Deborah Prindle, Program Division Chief, Ofc. of Program Devel. & Planning, USAID/ENI
Julia Terry, Project Officer

The World Bank:

Robert Castadot
Richard Florescu (Romania)
Sabrina Huffman

International Planned Parenthood Federation:

Richard Cooper, Management Accountant
Lynn Thomas, Regional Director

Family Planning Movement of Vrancea:

Diana Manea, President & Executive Director
Lili Scirlet, Nurse
Constantin Stratula, Medical Doctor
Tatiana Tiganus, Nurse

Centers for Disease Control:

Leo Morris
Florina Serbinescu, CDC/Atlanta and Institute for Maternal and Child Health

Other Organizations:

Fiona Bristow, Director, Marie Stopes Clinic/Romania
Phyllis Buttar, Area Director, AVSC

Dr. Henry David, Child Care/Romania
Irina Dinca, Board Member, Youth for Youth
George Flowers, Economic Advisor, Embassy of the United States of America/Romania
Charlotte Hord, IPAS
Heather Macleod, World Vision/Romania
Bogdan Serbanescu, UNESCO
Charles Unwin, Partner, Coopers and Lybrand/Romania

Annex 4

Project Disbursements Made

Annex 4
Disbursements Made to
Subgrantees

April 1991 through September 1993

Date	SECS	FPMV	YFY
Apr 91	\$16,000		
May 91			
Jun 91			
Jul 91			
Aug 91		\$27,800	
Sep 91			
Oct 91	\$10,000		
Nov 91			
Dec 91			
Jan 92			
Feb 92			
Mar 92	\$10,000		
Apr 92	\$6,000		
May 92	\$10,000	\$10,000	
Jun 92	\$18,000		
Jul 92			
Aug 92			
Sep 92	\$18,000	\$6,000	
Oct 92			
Nov 92	\$14,000		
Dec 92	\$14,000		
Jan 93			
Feb 93	\$14,000		
Mar 93	\$15,000	\$10,000	
Apr 93			
May 93	\$25,000	\$15,000	
Jun 93			
Jul 93	\$20,000	\$10,000	\$6,000
Aug 93	\$15,000		
Sep 93	\$20,000		
Total	\$225,000	\$78,800	\$6,000

Annex 5

**Evaluation of Medical/Clinical
Family Planning Services**

Annex 5

Evaluation of Medical/Clinical Family Planning Services

Summary

This annex was prepared by the Ob/Gyn physician who served as the Clinic Services Delivery Expert on the evaluation team. This contains a detailed technical evaluation of the medical and clinical services provided at the SECS clinics. A general assessment of the clinical services is in Section Three of the main body of the report. The purpose of this is to provide a more comprehensive analysis of the family planning services provided.

The quality of medical/clinical services provided in the clinics reviewed is excellent. However more efficiency can be achieved without diminishing quality care. Ways to do this are detailed in the document and referenced to a set of ten (10) recommendations which flow from the content.

A review of the recommendations will provide insight into appropriate courses of action for consideration.

Introduction

Unintended pregnancy continues to be a significant problem for Rumanian women. Preliminary results from a recent (Sept. '93) reproductive health survey being conducted in the country with technical assistance from the US Centers for Disease and Prevention Control found that "71% of the most recent pregnancies were unplanned, including 55% that were unwanted" and 60% requested more information about contraceptive methods. Myths continue to flourish about risks associated with modern contraceptive methods. Further, in a meeting at the Rumanian Ministry of Health with the physician in charge of the Family Planning Division we were advised that there continues to be a significant number of deaths associated with abortion. These data clearly provide the rationale for enhancing efforts to expand contraceptive use in Romania. Doctors continue to supplement their incomes through provision of abortion. Presently there is little linkage for patients receiving abortion care and access to contraception. See Recommendations #1, #2, #3.

Review of Medical/Clinical Services

Site Visits to the following clinics were conducted:

Nov. 10/1993 - SECS Mures, Tirgu Mures

Nov. 11/1993 - Polyclinic at the University

Nov. 12/1993 - SECS clinic Has Deu, Bucharest

Clinic Sites, Facilities, Services and Flow

All clinic sites were inconspicuously located, yet readily accessible by public transportation. Each was identified by a small, but visible SECS sign. Each was clean, nicely decorated with a warm hospitable atmosphere. They were in renovated or remodeled quarters, with inadequate space for any expansion. All had waiting areas, but the one at the polyclinic catering mostly to students only provided hard benches in a cold hall. The waiting area for the Tirgu Mures clinic was very small, accommodating only 3 persons (they plan to move to other quarters in 1994).

Facilities consisted of a reception area in or near the waiting area, a consultation room, a bathroom, an examining room and a utility room. The utility room often housed the supplies, commodities (under lock and key), microscope, reagents, instruments, auto and clove, sterile packs and often also the sink for disinfecting instruments. Careful attention was given to ensuring appropriate infection control. It appeared to be adequate. Recommendation #4.

Services provided are always voluntary, and as a minimum in each clinic include counseling by a physician about all methods of contraception. A chart is opened for each client. Upon acceptance of OCs or IUDs the patient is given detailed counseling about its use, potential disadvantages and advantages. She is queried as to her risk for STDs. The patient is instructed on breast self-examination and an examination performed. Weight and BP are taken. A pelvic is performed. Some clinics take pap smears while others refer for this service. If the choice is an IUD she is rescheduled for an insertion at a time when an OB/Gyn physician can be on site as per governmental regulations and also to coincide with

the woman's menstrual period. This type of regulation is counterproductive, rather individual competence is the prime issue. Patients were followed through the entire process who accepted OCs, IUDs and condoms. All patients were provided an additional second method, E.g. condoms or diaphragm, when they chose a primary method, e.g. OCs or IUDs. Recommendations #5, #6.

Clinic Flow is cumbersome since facilities were not designed to serve as clinics. Since the doctors do all the counseling individually it can take up to 45 minutes before the examination is initiated. In one case the client could not stay for the examination, leaving the clinic with condoms only despite the fact she requested OCs. She made a return appointment, which may or may not be kept. This individualized physician-performed counseling is cumbersome, inordinately slows down clinic flow and, from experience in other countries, can be significantly modified and still be highly effective. Most clients are walk-ins, since the phone systems are not adequate. Revisits are scheduled by appointment. See Recommendation #4.

Staffing Patterns were adequate for the volume served at the time of the team visits. Clinics had 2-4 staff members on duty during sessions. These consisted of a receptionist/secretary/cashier person, a doctor and, in some situations, an administrator. In the University based Polyclinic sometimes they see as many as 49 clients in a session and staffing is woefully inadequate.

All staff were sensitive and user-friendly. The clients like the staff and when queried responded with positive comments about their experience. The staff functioned competently in each of their areas of expertise, except for one secretary/cashier at the Has Deu Clinic who had only been on the job for a few days, and once it was decided she would be a permanent employee she would be oriented by SECS headquarters staff. In the interim, the doctor also acted as cashier.

Client Mix consisted almost exclusively of young married women, with or without children, except for the University Polyclinic where unmarried women also attended.

Quality of Care was the paramount concern of all staff. In the view of this evaluator, the quality of medical services provided by clinicians was higher than average for the usual family planning clinic. In fact, a better balance needs to be struck between expeditious service and quality care. This can surely be achieved without compromising the essentials of quality care. See Recommendations #4, #5, #6.

Clinical Training and Competency Issues -- Governmental and Non-Governmental Agency Roles

The medical expertise of the physicians providing the clinical services of history taking, physical evaluation and provision of contraception was deemed to be excellent. An IUD insertion was observed, performed by a family practice doctor under the direct on-site supervision of an Ob/Gyn specialist. The patient was 29 years of age and had one child. At her initial visit a pelvic exam was done, confirming a retroverted uterus, along with a pap smear, which returned negative. She was deemed to be at low risk for STDs. The insertion

of a Copper T-380 IUD was uneventful. The patient was given doxycycline to take for 10 days. Since the program does not have the capability to test for chlamydia and gonorrhea this approach is appropriate. This physician and other family planning practice doctors who insert IUDs received the JHPIEGO training in family planning -- a short course that included training in client selection (e.g. low risk for STDs.), IUD insertion and clinical management. Their capabilities to screen candidates and insert IUDs were subsequently evaluated by a JHPIEGO trainer and they were certified and a document of certification was issued to them. Training in family planning technology to meet an approved and predefined level of competence is essential for all clinicians in order to provide such clinical services. Such training insures an acceptable level of competence, when back-up by more experienced Ob/Gyn providers is available for management of problems.

In the opinion of this evaluator, training to competency level is the most appropriate model for physicians in practice. Government mandated extended periods of training for practicing physicians (e.g. 6 weeks for Ob/Gyns and 3 MOs for General Practice doctors) is not only practical and costly but would likely obstruct program development and expansion in family planning in the country. Few doctors could afford to take the time for such training. My perception of the governmental role in training is to develop guidelines for content of training. The role of PVOs is to ensure that government standards and regulations do not inhibit program development and service delivery while at the same time ensuring that providers meet an acceptable level of competency. PVOs can serve as models for service provision and training centers. See Recommendation #7.

Government should also ensure provision of reproductive health care, including family planning services, for the public sector. In this situation, since government will necessarily pay for training and service delivery, if they decide it is appropriate to require a certain level of training to attempt to ensure competence they have the authority to do so. However, even in such a scenario, the ultimate factor requiring evaluation is clinical competence. This assurance can only be achieved through monitoring. See Recommendations #6, #7.

Standardization of Terminology and Record Keeping

Great strides are being made to develop standardized definitions and terminology in family planning. Although this should have been done early in the genesis of the program, with the introduction of computerization it became apparent this was an essential task. The meeting of October 24, 1993 was a landmark step in the right direction. Clinicians must have an efficient record keeping system in order to function efficiently, and data must be collected to document the progress of the program.

Supply Issues

Without exception all providers complained that their service provision was hampered by inadequate supplies of equipment and/or irregular access to contraceptives, particularly changes in OCs formulations. Donor agencies need to develop a consistent schedule for delivery of equipment and supplies to ensure that clinics do not run out and patient services not be interrupted. See Recommendation #8.

With regard to OCs, the most common and consistent complaint related to breakthrough bleeding (BTB) problems was with the Hungarian pill Regevidon. This pill contains 0.03 mg of ethynlestradiol (EE) and 0.15 mg of levonorgestrel. Further, since it is a generic, there are concerns about the quality control of its potency. Since it is available at no cost, its use is encouraged, but with little acceptance by providers. It is my recommendation as a solution to the problem that new acceptors of OCs start on a 0.05 mg EE pill and after 6 months, when BTB is less of a probability, patients be switched to the 0.03 mg EE pill. See Recommendation #9.

Depo-provera, the now available 3 month injectable contraceptive which has been shown to have a high rate of acceptance as a mainstream method, needs to be available as a contraceptive option for all women requesting hormonal methods. It must not be stigmatized as limited to use for the mentally retarded and those experiencing failures with other hormonal methods. See Recommendation #10.

Recommendations

1. There needs to be a massive campaign to educate the population at large as well as health professionals about the health benefits of modern contraception. A carefully planned and well executed public information campaign is long overdue.
2. Changes need to occur within the health care system so that doctors will not need to supplement their income through provision of abortion services, a practice which can act as a disincentive to provision of modern contraception.
3. It is essential to link counseling and provision of modern contraception with abortion care to reduce the need for abortion.
4. Plans for facilities need to include the assumption that services will expand. As a minimum, space needs to include the capability for two examining rooms to be used simultaneously for efficiency purposes.
5. It is inefficient and unnecessary that the counseling about all methods, or even the details about benefits and risks and how to use the method chosen, be done by a physician. Competence can readily be gained by a non-physician health professional so long as the content of the counseling is approved by the medical advisory arm of the agency and the performance of the counselor is monitored. Inefficiencies in the system make it break down and reflect adversely on patient satisfaction.

It is essential that decision makers, physicians and the public know about the importance of the IUD as a contraceptive option. The Copper T 380-A can provide long-term (8 yr) very low cost contraception.

6. Approval of physicians to select appropriate clients, perform IUD insertion, and manage ongoing uncomplicated care should be based on training to a level of competence acceptable to a master trainer, and the accessibility of a back up physician capable of managing IUD problems. Once competence is assured, on-site supervision by an Ob/Gyn physician should not be required. Such a requirement is too limiting and medically unnecessary. Ongoing monitoring of charts with periodic performance review is indicated.
7. The governmental role is perceived to be that of the development of standards and guidelines for training of providers for the public sector. These guidelines can be used by the PVOs for ensuring that their providers achieve competence, which can be demonstrated to monitor in the event the PVO receives government funding for service provision. Ideally PVOs and Governmental agencies will collaborate in the guidelines development process.
8. Develop a system for consistent availability of supplies and equipment.
9. Clinicians' concerns about the level of BTB with the free Hungarian generic pill that

contains the lowest doses of EE and a progestin need to be addressed. A likely solution is to start new patients on a pill containing 0.05 mg of EE for the first six months, then substituting the lower dose 0.03 mg EE containing OC. The built in bias against all things Hungarian must also be considered as significant.

10. Depo-provera (DMPA), the 3 month long acting injectable, is the most highly effective method of hormonal contraception, with use effectiveness rates comparing favorably with those of sterilization, i.e. well under 1% failure. Further, in many countries it has shown a high level of acceptance and user satisfaction, despite the irregular bleeding that often occurs in the first 6 months of use, once women are counseled to anticipate this effect. Therefore, it is essential in order to avert an image problem, that Depo-provera should not be limited or categorized for use only for mentally retarded women or those who experience failure with other hormonal methods as has been done by the World Bank in their contraceptive supply agreement. DMPA is a mainstream method as are OCs and needs to be so positioned.

Recommended Future Issues to Enhance and Expand Romanian Family Planning

Suggested Training Activities

All training needs to focus on Training of Trainers (TOT). All training should be provided in country.

I. Training in Provision of Family Planning Services

- **TOT Training**

A cadre of master trainers need to have a 3 day didactic practicum course in how to train other doctors to provide appropriate family planning. There are models for TOT. A meeting with the various high level groups, e.g. representatives from the Ministry of Health advisory group in family planning and leaders from various PVOs for planning purposes would be appropriate (e.g. 5 planners) No more than 25 high level, highly committed physicians from various parts of the country who agree in advance to the TOT concept should be selected to attend.

- **Trainers providers**

Similar regional training sessions need to be held, involving local doctors in planning the training so that their needs can be met.

- **Role of funding agency for TOT and provider training meeting.**

- set up meetings of planning groups.
- Facilitate the planning process to ensure that the family planning agenda remains paramount;
- Logistical support for meeting planning, including translations of materials to be used for lectures, slides and handouts to participants.

II. Training of Counselors in Family Planning.

- **Phase I - Convene a mixed group of competent people from various disciplines to determine the content essential to teach trainees to learn in order to be able to counsel potential clients about the various methods of contraception, their benefits and risks and appropriate use. The group should include family practice providers who presently provide such counseling, sexologists and some clients/students who can convey what they perceive they need and want to know.**

- **Phase II - Conduct a TOT session similar in structure to that for Trainers in contraception.**

- **Phase III - Develop a Manual that trainers can use at local sites for training counselors. Such manuals exist, but need an in-country imprimatur.**

III. Training in Sexuality in the Family Planning Context

Follow the model for training of counselors for phases I through III.

Phase IV - Develop a media strategy for public consumption and implement.

IV. Training in Permanent Methods of Contraception

This training needs to follow the model detailed for training in provision of Family Planning Services. An additional module would be hands on training in female and male sterilization techniques, including sessions on male involvement.

V. Training in Management of Family Planning Programs

This needs to include facility design, patient flow, how many, how much, who, when, where, why, financial management, data collection and analysis, monitoring, evaluation, etc.

Annex 6

**Management Tools and
Processes**

Annex 6 Management Tools and Processes

The following is a brief explanation of the various management tools and processes that are considered to be standard instruments for effective project management. These instruments and procedures are discussed in relation to the Rumanian Family Planning Project in Section Three of the Final Report.

The management tools and processes are the following:

- Needs assessment
- Definition of measurable objectives and/or logframe
- Initial and annual work plans
- Organizational chart for project structure
- Job descriptions for staff
- Scopes of work and reports for technical assistance
- Subcontractor contracts
- Reports from subcontractors
- Quarterly reports and annual reviews and reports
- Sub-grantees quarterly and annual reports
- Contracts and reviews for field staff

Needs Assessment: This tool and process provides an elemental baseline of the situation and needs in the area where a project will be established. It serves as the starting point on which to build the project's approach and activities. The analysis should discuss significant country and/or regional background, and relevant sectoral issues or data. After project start up, the needs assessment should be updated as a basis for the continued development and adjustment of project approach and activities.

Definition of Measurable Objectives/Logframe: Measurable objectives are used to determine the progress being made by a project. It is important to periodically assess the effectiveness of a project, and it is important to have concrete means of doing so. A logframe graphically presents project objectives, often in a time line, in order to facilitate this procedure.

Initial and Annual Workplans: Workplans present a schedule of project activities that list the planned actions and set dates for their performance. The workplans are most effective when they include narrative to explain the rationale and relationship between the significant project components and the activities. It is difficult to monitor a project's major areas of activity when workplan activities are not defined by programmatic areas.

Organizational Chart for Project Structure: An organizational chart for a project should graphically present the structure, titles and relationships of staff within a project and with any

sub-projects. It is important that this chart is developed as soon as possible after project start. The relationships among the organizations and the personnel must be clearly defined, or it leads to confusion and miscommunication of roles and responsibilities. It is particularly important for management responsibilities to be clearly described and designated, for confusion over responsibilities at these higher levels affect the entire project. An organizational chart with clear titles reflecting responsibilities and the reporting and support relationships with staff and sub-grantees is essential to the management of a project.

Job Descriptions (JD): Clear Job Descriptions define responsibilities and lines of reporting. Key project job descriptions must be carefully developed and presented.

Scopes of Work (SOWs) and Reports of Short Term TA: SOWs should be used as a management tool to clarify tasks for specific short term TA assignments. When applicable, they should be discussed and drafted jointly with sub-grantees, defining briefly the purpose of the TA and responsibilities of the TA advisor. Consultancies involving multiple visits should revise and/or supplement the SOW for all or the follow on activities.

Reports from short term TA provide feedback regarding the success and perceived results of the assignments. It is important that the recipients and the sponsors of the TA receive these reports.

Quarterly Reports and Annual Reviews and Reports: Quarterly and annual reviews and reporting are to be used to help project management make periodic internal assessments and redirect the project as needed. Quarterly reports should contain a structured presentation of progress in the project's major areas of activity and its prime components against established project objectives. They are to address problem areas, budget reporting, and briefly define planned future activities.

Annual Reviews and Annual Reports are to be used to help project management staff to conduct and report out a structured, more comprehensive process of review of project and sub-grantee progress.

It is also very useful, if it is at all possible, if programmatic information is reported in conjunction with monthly and/or quarterly financial reporting. The review of these reports can then proceed to analysis of project spending as it relates to the most effective project activities.

Contracts and Reviews for Field Staff: Since these personnel are often isolated from the project management headquarters it is very important that the documentation of the duties and responsibilities for these people is very explicitly detailed. Their contracts must be clear and concise, and a review schedule should be established from the outset.

Annex 7

**Summary of Grant History and
Documents**

Annex 7 Summary of Grant History and Development

Grant No. 186-0002

Period of Grant: March 12, 1991 to September 30, 1992.

Amount: \$ 1,499,907

Strategies

1. Establish a model women's reproductive health clinic to provide quality services on a sustainable basis.
2. Train physicians and clinic staff, counsellors, and community outreach workers in methods and motivation.
3. Initiate a prototype monitoring system to provide rapid feedback on program performance, clinical safety, user preference and compliance.
4. Explore the feasibility of establishing additional satellite counselling and/or service centers.
5. Develop women-to-women community based private initiatives through management training for women with a strong emphasis on institution building.
6. Establish a reliable resupply system for contraceptives for trained providers. (If necessary, supply contraceptives in the short term through the Ministry of Health).

Possible additional strategies

7. Collect baseline data on the knowledge and willingness of health personnel to provide contraception, and on the KAP of fertility regulation among potential clients.
8. Teach promotion, inventory and marketing skills for contraceptives, particularly condoms, and establish a supply, stocking and distribution system.

Program Implementation

Phase I

Months of March 1, 1991 to September 6, 1991)

assign a team of family planning specialists with experience in designing and implementing community-based, private sector service delivery programs to:

1. Identify counterpart individuals and organizations
2. Establish a private sector model family planning clinic
3. Train clinical and counselling personnel
4. Provide quality services
5. Determine the need for supplying contraceptives to previously trained medical

personnel, if necessary.

Phase II

Months of June 1, 1991 to June 6, 1992)

Explore and implement:

1. Development of family planning education materials
2. Establish additional satellite clinic centers, and expand outreach.

Collaborating Agencies

JHPIEGO To train clinicians and write service delivery protocols

PCS Development and printing of brochures and ToT for counsellor training

PSI Marketing of condoms

AVSC Training in surgical contraception

FHI KAP study

HUMANA Provision of quality services in a culturally sensitive way.

WVRO & Case Western University In every possible way

Management

Oversight CEDPA President and Program Director

Project Director

A skilled family planning manager with extensive international experience, fully familiar with USAID procedures and reporting requirements

Physician/Epidemiologist

Expert in maternal health and women's affairs

Bilingual technical assistant, fully familiar with USAID requirements.

Quarterly progress reports; trip reports within 15 days of completion; Annual audits of CEDPA and all sub-contractors

Evaluation

Continuous, supplemented by an evaluation of the entire project in month 9 (December 1991). Second comprehensive evaluation in August 1992. Additionally each project component evaluated every three months.

Documentation will receive a major significant emphasis.

Amendment No. 1

Reiterated and added further prohibitions against using project monies to do anything connected with abortion.

Amendment No. 2

Period of Grant Extended to September 30, 1994

Amount Increased by \$1,500,000 to \$2,999,907

Program to date

1. Strengthened two organizations
2. Established 6 clinics
3. Trained initial cadre of physicians in counselling and the provision of modern clinical services (Orals and IUDs).
4. Obtained acceptance by Ministry of Health for using general practitioners to provide clinical services.
5. Held two national conferences on family planning knowledge, acceptance and service delivery
6. Trained seven women in management skills for family planning programs.

Other achievements

Institution building

Successfully initiated process in SECS and FPMV, but more work required to enable understanding of Board/Staff relationships, and issues such as the difference between oversight and micro-management, and to fully develop administrative, financial and personnel procedures manuals.

MIS

Initial site visit completed. System being tested, and modifications suggested. System will be refined during extended grant life and installed in all grant-supported clinics.

Quality Control

Obtained Ministry of Health approval to license general practitioners to provide clinical contraceptive services.

Planned activities

1. Expand SECS clinics to ten cities.

2. Expand FPMV to three cities.
3. CEDPA will keep Ministry of Health informed as appropriate.
4. Establish Medical Oversight Committees.
5. Create medical manuals on each of the contraceptive methods.
6. Conduct an IEC campaign with emphasis on:
 - Focus group research
 - Teenage health education
 - Media
 - Hotline
 - Community outreach

Support

1. Renew yearly sub-grants
2. Provide clinical, audio-visual and office equipment for an additional 15 clinics.
3. Contraceptives in sufficient quantities for the CEDPA supported NGOs.
4. Develop a cadre of trained Rumanians who can train other professionals in the basics of family planning service delivery.
5. Establish a small field office staffed by one identified (approved) host country national. This will reduce the number of person-months of short term expatriate TA.

Amendment No. 3

Repeal of the Mexico City policy ban on abortion.

Amendment No. 4

Period Extended to March 31, 1996

Amount Increased by \$1,899,972 to \$4,899,879

Key Objectives

1. Comprehensive, high quality reproductive health care
2. Health care to include pap smears and breast examinations
3. Target gypsy population
4. Develop operations research; Heighten awareness and support for family planning; Feasibility study of selected surgical interventions & post-abortion counselling.

Strategies

1. Institution building
2. Fine tune and install MIS.
3. Support creation of high quality, culturally sensitive and medically sound manuals on each of the contraceptive methods (offered).
4. Develop overall media advertising plan and increase community outreach efforts;

Undertake operations research to establish why women over 30 years of age are less likely to use services of family planning clinics.

Components of IEC

Focus group research

Teenage health education program

Media efforts

Hotline services

Community outreach

Annual meetings, seminars for NGO community

Pre and post abortion counselling

Support

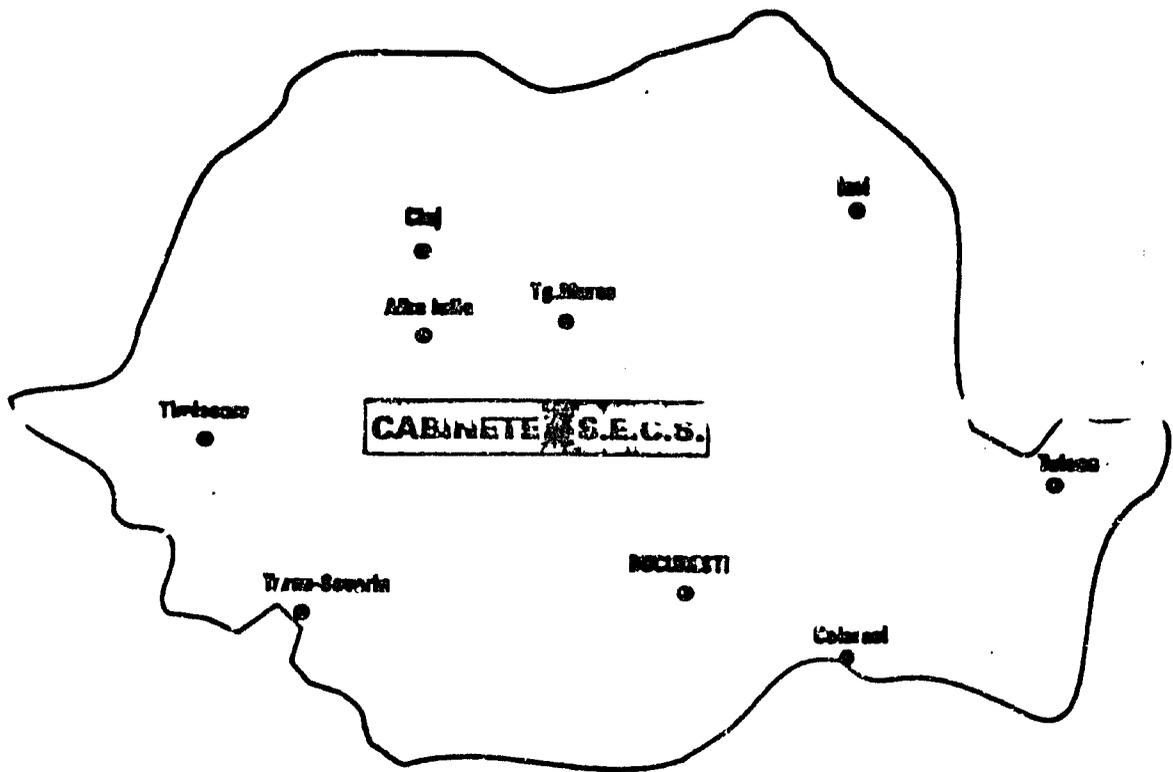
1. Renew annual sub-grants to two existing sub-grantees
2. Equip up to 15 clinics with clinical, audio-visual and office equipment
3. In conjunction with IPPF provide contraceptives (barriers, hormonal and IUDs). Resolve problems related to supply of contraceptives.
4. Continue to develop a cadre of trained Rumanians with special emphasis on logistics training. Also training of selected public sector staff.

Annex 8

Map of Romania



Map of Romania
Sites of SECS Clinics



Annex 9

List of Hardware and Software

Annex 9
List of Hardware and Software

Computers Available at SECS:

<u>Date</u>	<u>Hardware</u>	<u>Software</u>	<u>Source</u>
July, '92	1 x IBM PC and 1 Laser Printer	Windows WP 5.1 Quattro	IPPF
May, '93	3 x Act Brave PCs and 3 Laser Printers	as above	IPPF

These were used for management, medical and financial reports, and general correspondence.

Aug., '93	6 PCs and 6 Printers	WP 6.0 EPI Info 5.1 MS Dos 6.0 Quicken	CEDPA
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1 PC and 1 Printer were for CEDPA's local field office.

1 PC and 1 Printer are located at H.Q. and the other 4 units have been transferred to clinics located outside Bucharest (input of data for these clinics will be made at H.Q.). Data will be transferred from clinics to H.Q. by floppy disks physically carried from clinics to H.Q. and back.

Annex 10

List Of Recommendations

Annex 10

List of Recommendations

Programmatic Development

1. The CEDPA project should continue to provide information about the utility of the Copper T 380-A IUD and Depo-provera as mainstream methods of contraception to Ministry of Health and family planning NGO decision makers. Donors and the World Bank should coordinate efforts to ensure adequate information, supply, and fewer undue restrictions limiting client access to these methods. Efforts should be undertaken by USAID and CEDPA to reverse the World Bank's policy on Depo-provera.
2. Clinicians need additional technical assistance to strengthen existing follow-up and continuity of care mechanisms. In order to strengthen the skills of family planning clinical staff, training in sexuality within the family planning context should be provided.
3. Plans for CEDPA-funded NGO clinic facilities do not yet include the assumption that services will expand. At a minimum, space needs to include the capability for two examining rooms to be used simultaneously for efficiency and impact purposes.
4. In order to increase the future efficiency of clinics and decrease costs, training a cadre of non-physician family planning counselors should be encouraged. If Sub-grantees concur with such a major change of general practitioner responsibilities, CEDPA should provide funding and TA for a three phase training of counselors. (See Appendix Five, Evaluation of Medical/Clinical Services).

New Programmatic Activities and Areas to Develop

1. Existing and future Sub-grantees should receive major funding and TA support to expand their public IE&C activities.
2. USAID should further explore the feasibility of broadening information about family planning by using social marketing to distribute contraception via private sector pharmacies within grant funding or with additional funds.

NGO as Public Advocate

1. The Ob/Gyn community should be targeted for more intensive public relations campaign to increase their awareness and support for family planning. The education could be included as part of World Bank or as a future CEDPA project effort. Possible events include evening programs hosting internationally recognized experts

- (for example, the developers of Norplant); a newsletter for Ob/Gyns on contraceptive technology; and study tours for selected, influential leaders.
2. Rather than abandon all work with the public sector, the CEDPA program should build a capacity within the NGOs to improve the public climate for family planning in general. There are numerous models of family planning groups laboring under such odds to "make a dent". Additional project TA should be provided in the area of public policy analysis, legal reform and citizen action to strengthen the NGO's capacity to work with, and educate, policy-makers within the MOH, the MOH National Council for Family Planning, the Romanian Institute for Post Graduate Training for Doctors, the Ministry of Education, and other key leaders. A major goal should be developing genuine collaboration between NGOs and governmental agencies without forsaking the independence of the NGO community.

Management Tools and Processes

1. CEDPA should conduct an in depth review and restructuring of the project management. This should be done as a first step to the management of the second half of this project. An external expert management TA should be contracted by CEDPA, with the review and approval of the Bureau Project Officer, to assist in this process on an initial and regular periodic basis. A formalized structured report and sharing of this review and redesign should be provided to the Bureau and the USAID Rep/Romania. Changes in management systems, tools and processes should be communicated to the sub-grantees.

Management and Programmatic Relationships and Communication

1. The project should fund and conduct a joint CEDPA, NGO, USAID, IPPF and other active or potential agencies (e.g. AVSC) workshop of two or more stages to jointly plan future project activities. An expert external trained facilitator should be contracted expressly to facilitate this meeting. The facilitator must be skilled in conflict resolution. This will be especially crucial for the first stage of CEDPA-NGO discussions to resolve any difficulties and to help the parties in moving positively forward on strategic planning. The second stage should then continue strategic planning activities, cooperatively restructuring the project's key family planning components: programmatic (IE&C, clinic, etc.), management and finance components for the second half of the project.
2. It is recommended that USAID utilize the R&D/POP liaison officer to communicate with IPPF to encourage more collaboration with CEDPA.
3. CEDPA should review and revise approaches to communications and reporting with sub-grantees, respecting appropriate lines. Communications between the Bureau, the USAID Representative, USAID Health Officer and R&D should be reviewed and revised to make appropriate use of valuable inputs and insights to assure cross fertilization of expertise and experience.

Institutional & Professional Development of the NGOs

1. Specialized TA, study tours, and international literature on NGO development, and, specifically, family planning NGO development should be provided in a structured approach to the three current and any future NGOs. In the section five, Future Project Activities, the role of CEDPA and other contractors is defined.
2. Study tours should be considered for Executive Directors who have not yet received them, for Boards of present and future Sub-grantees, and for key government decision-makers. In addition, practicing clinicians and key staff should continue to receive foreign training and study tours.
3. In cooperation with IPPF's Master Trainer, strengthening a cadre of Master Trainers should be a top priority. (See Appendix Clinical Evaluation.) To achieve greater training efficiency, the vast majority of Training of Trainers (TOT) and clinician training should take place in-country.
4. A major initiative to increase the library stocks of sub-grantees should take place. Sub-grantees should be consulted about their areas of interest. Experts in family planning professional development should be consulted to ensure the purchase of essential references and periodicals from Europe and the U.S. A system for the acquisition of these resources should be developed and institutionalized.
5. Senior representatives with significant family planning credentials should be chosen to represent Romania at the UN Cairo Population conference in 1994.
6. Future sustainable assistance should include all the above areas. NGO sharing (with the MOH) of clinical sites, staff and equipment and supplies should significantly lower costs and move toward sustainability. In addition, TA to expand private practitioners with revolving loans for start-up equipment and supplies can be explored. Finally, TA to expand public education and commercial marketing may not be immediately sustainable but was identified by the Rumanians as critical and should be included.

Financial Reporting & Financial Management

1. CEDPA should identify, in conjunction with sub-grantees and other donors (such as IPPF) and USAID, how best to reprogram and accelerate the spending of remaining monies for the optimal development of the NGOs in Romania and for attaining grant objectives. Clearly, a need exists for greater in-country TA on such matters as financial management training, IE&C and public education, commodities management training, enhancement of the MIS, etc. CEDPA should also look to fund activities of other organizations who will assist in meeting program goals/objectives, e.g. an Association of Pharmacists who might be interested in mounting a Social Marketing campaign.

2. CEDPA should conduct an extensive review of its internal financial management procedures related to the project, and ensure that financial reports are linked to program reports, with variance analyses explained in both financial and programmatic terms. Corrective action to address variances should be taken. These matters should be covered in reports to USAID so that they are kept apprised.
3. CEDPA should review the need for budget reallocations in instances of over/under expenditures. Such budget reallocations should be formally processed, thus ensuring that adequate financial resources are available as the project approaches each stage of completion.
4. CEDPA should require sub-grantee financial reports in conjunction with quarterly program reports. Reporting periods should be standardized throughout. Reports should be reviewed promptly and matching dollar remittances made to assure that programs continue without interruption. The cash requirements section introduced recently should be clearly described in writing and training provided to sub-grantees. Forecasting should be done in U.S. dollars to account for inflation. TA should also be provided sub-grantees so that they begin to link financial and programmatic performance for a better understanding of their own operations.
5. Adequate TA should be provided to assist sub-grantees to develop and manage a simple computerized financial reporting and analysis system which would assist in preparing consolidated accounts and tailored reports to different donors. Financial reports should be routinely and systematically analyzed together with progress reports to establish those activities requiring reallocation of financial resources needed to ensure the project objectives. Variances should be investigated and explained. Budgetary reallocations should be made as appropriate.

Technical Assistance in Financial and Commodities Management

1. Future TA in the areas of Financial Management/Commodities Logistics should be carefully planned, with the continuous involvement of top NGO management from all three NGOs. This planning should ensure that comprehensive SOWs are drawn up; that all three parties (CEDPA, the recipient, and the TA contractor) are uniformly aware of objectives and outputs; and that TA provided is complementary to that provided by other donors (IPPF, etc.).
2. The Chief financial officers of NGOs should be provided with TA in the area of Fund Accounting systems.
3. Urgent attention should be given to the Clinic MIS being implemented to link this to inventory control and accounting. Training must be carried out for appropriate clinic staff to learn the MIS system to strengthen the financial and project management of the clinics and the subgrantee organizations.

4. CEDPA should provide TA in cost accounting to NGOs to provide information to management on pricing mechanisms and the cost effectiveness of clinic operations.

Sustainability

1. In conjunction with the Ministry of Health, clinics should increase the price of abortions slowly over a period of time to make alternative methods of family planning more and more attractive. At the same time mount an information and education campaign to disabuse potential users of family planning methods of any misgivings about modern contraceptive methods, thus creating an increasing demand for these services. At the same time, appropriate technical assistance in areas such as marketing and accounting should be provided to ensure that service providers are cognizant of balanced business practices, including but not limited to pricing policies and the costing of sales.
2. USAID should support a social marketing campaign aimed at increasing the level of acceptance of contraceptives, using any existing private sector Pharmacists association. If necessary encourage the development of such an association.
3. Both the organizations currently funded under the CEDPA grant should be encouraged to seek funding for clinic activities from other International donors.(e.g. International Foundations). The organizations should also seek to reduce costs by reviewing expenses such as full time staff versus part time staff.

Currency Management & Recognition of Inflation

1. For ease of reporting to USAID, the CEDPA sub-grants should be stipulated in US dollars.
2. Currency translations should be as per the guidelines set down by the Financial Accounting Standards Board (FASB). Basically, this recommends translations of transactions during the year at an average rate (composed of actual rates obtained when dollars are translated by the bank), and a conversion of balance sheet items at rates prevailing on that date. Any gains or losses through currency fluctuations would be plowed back into the grant total.
3. In order to acknowledge rising costs through inflation, the sub-grantees should be allowed to flexibly re-state their budgets, for CEDPA approval, based on current costs, say, every six months. Any currency gains arising out of 2 above should be used to offset increased costs arising from inflation.

Overall Findings & Recommendations

No project activities should be discontinued.

2. Significant restructuring should be done in the second half of the project. Project objectives should be reclarified to expand the NGO role. The first step in this restructuring process should be to hold a meeting between CEDPA, USAID, the sub-grantees, and other active and potential donors and contracting agencies. This should be externally facilitated by an independent consultant who is skilled in conflict resolution. The meeting should address ways in which all of these organizations can cooperate and coordinate their efforts to achieve the most benefit from this project. Additionally, the new strategies and objectives of the project should be established within this collaborative framework.

