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**EVALUATION OF THE FAMILY
PLANNING MANAGEMENT
DEVELOPMENT PROJECT (FPMD I)
(936-3055)**

POPTECH Report No. 94-003-004
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by

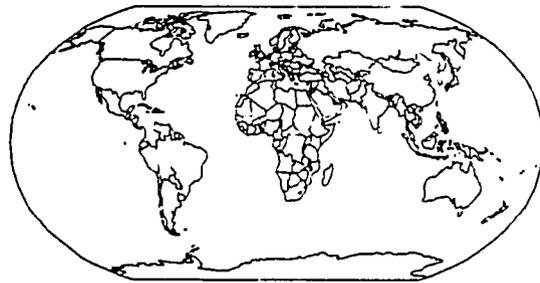
Bill Trayfors
Michele Andina
Karen Lassner
Rodney Powell

Prepared for

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Edited and Produced by

Population Technical Assistance Project
1611 North Kent Street
Suite 508
Arlington, VA 22209 USA
Phone: 703/247-8630
Fax: 703/247-8640



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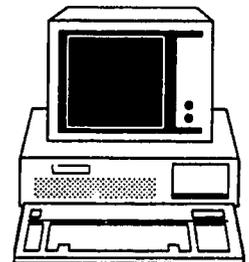
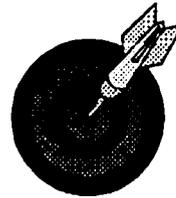
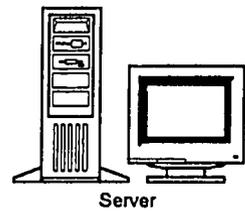
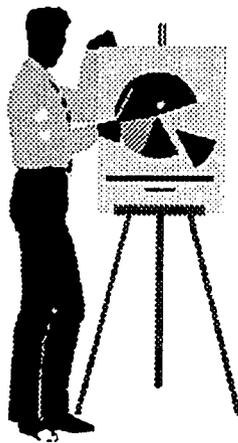
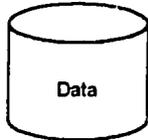


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ABBREVIATIONS

AMS	Activity Monitoring System
AVSC	Association for Voluntary Surgical Contraception
BDG	Bangladesh Government
C	Coordination (FPMD Intervention Code)
CA	Cooperating Agency
CAFS	Centre for African Family Studies, Nairobi
CAR	Contraceptive Acceptance Rate (used in Bangladesh by BDG/MOH)
CBD	Community Based Distribution/Distributor
CBHC	Community Based Health Care
CCS	Diocese Maseno West/Christian Community Services
CD	Curriculum Development/Training Skill (FPMD Intervention Code)
CEDPA	Centre for Development and Population Activities
CHAK	Christian Health Association of Kenya
CHW	Community Health Worker
CIES	Centro de Investigación, Educación y Servicios
CNS	Caja Nacional de Salud
CORAT	Center for Operations Research and Training
CPR	Contraceptive Prevalence Rate
CQI/TQM	Continuous Quality Improvement/Total Quality Management
CSW	Community Service Worker
CYP	Couple Year Protection
DA	Development Associates, Inc.
DFH	Department of Family Health
DFP	Directorate of Family Planning
DGPF	Dirección General de Planificación Familiar
E	Evaluation (Subproject/Country Level) - (FPMD Intervention Code)
ELCO	Eligible Couple
ET	Evaluation Team
FEMAP	Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo Cumonitáριο, A.C.
FG	Financing (FPMD Intervention Code)
FP	Family Planning
FPAB	Family Planning Association of Bangladesh
FPAK	Family Planning Association of Kenya
FPCVO	Family Planning Council of Voluntary Organizations
FPIA	Family Planning International Assistance
FPLM	Family Planning Logistics Management (JSI Project)
FPMD	Family Planning Management Development
FPMT	Family Planning Management Training
FPSTC	Family Planning Services and Training Centre
FRAC	Francophone Regional Advisory Committee
FWA	Family Welfare Assistant (BDG)
FWV	Family Welfare Visitor (BDG)
G/PHN/POP	Office of Population, USAID
GOB	Government of Bangladesh

GOK	Government of Kenya
GOM	Government of Mexico
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HQ	Headquarters
IEC	Information, Education, Communication
IMSS	Instituto Mexicano de Seguridad Social
INOPAL	Investigación Operacional en America Latina
IPPF	International Planned Parenthood Federation
ITP	In-Country Training Program (LIP)
IUD/IUCD	Intrauterine Contraceptive Device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU/PCS	Johns Hopkins University/Population Communication Services
JSI	John Snow Inc.
LAC	Latin America and Caribbean
LIP	Local Initiatives Program (Bangladesh)
LOG	Logistics (FPMD Intervention Code)
LOP	Life of Project
M	Marketing (FPMD Intervention Code)
MCH	Maternal and Child Health
MDA	Management Development Assessment
MEXFAM	Fundación Mexicana para la Planeación Familiar, A.C.
MIS	Management Information Systems
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare (Kenya, Bangladesh)
MSH	Management Sciences for Health
MYWO	Maendeleo Ya Wanawake (Kenya)
NCPD	National Council on Population and Development (Kenya)
NGO	Non-governmental Organization
NRHP	National Reproductive Health Program
OD	Organization Structure/Personnel/Supervision (FPMD Intervention Code)
ODC	Other Direct Costs
OP	Operational Planning (FPMD Intervention Code); also, USAID's Office of Procurement
OR	Operations Research
OST	Observation Study Tour (LIP)
PCU	Publication and Communications Unit
P/FP	Population/Family Planning
PHC	Primary Health Care/Center
PPFA	Planned Parenthood Federation of America
PVO	Private Voluntary Organization
Q	Quality of Care (FPMD Intervention Code)
QES	Quality, Expansion, Sustainability
QIT	Quality Improvement Team
QOC	Quality of Care

REDSO	USAID Regional Development Support Office
RTI	Reproductive Tract Infection
SCBD	Senior Community Based Distributor
SD	Service Delivery/Design (FPMD Intervention Code)
SDA	Seventh Day Adventist, Rural Health Services
SP	Strategic Planning (FPMD Intervention Code)
SSA	Secretaria de Salud
SWOT	Strengths, Weaknesses, Opportunities, Threats
TA	Technical Assistance
TAF	The Asia Foundation
TAI	Technical Assistance, Inc.
TDY	Temporary Duty
TIE	Training Impact Evaluation
TQM	Total Quality Management
USAID	United States Agency for International Development (refers to a Mission, e.g., USAID/Kenya, or Washington Headquarters, USAID/W)
USAID/W	U.S. Agency for International Development/Washington, D.C.
UTI	Urinary Tract Infection

EXECUTIVE SUMMARY

THE PROJECT

Purpose and Methodology of Evaluation. The present evaluation comes in year four of the current five-year contract period of FPMD I (1990-95). Its purpose is to assess progress to date, and to make recommendations for the next five-year period (FPMD II).

Four public health specialists were chosen for the evaluation, each having broad international health and family planning experience and bringing complementary skills to the team effort. The team spent one week in the U.S. (USAID/Washington and MSH/Boston), then divided to evaluate FPMD activities in Mexico, Bolivia, Kenya, and Bangladesh, spending one week in each country. The team reunited in Washington for a final week for debriefing and writing.

Over 250 persons were interviewed during the month-long evaluation; several hundred project-related documents and publications were consulted.

Project Design. FPMD was originally designed as a follow-on to the earlier five-year FPMT project. It built upon experiences under FPMT to fashion a new long-term effort in management improvement through a series of targeted *management interventions* directly with client organizations and with CAs and regional organizations and through training. Focusing on strategic and operational planning, organizational structure, and management systems required to efficiently implement programs in the field (e.g., MIS, financial management, personnel management), FPMD was designed to impact on the availability, quality, and accessibility of family planning services provided by client organizations worldwide. FPMD is designed as a ten-year effort (divided into two equal segments, FPMD I and FPMD II, of five years each) with a total cost of \$70 million. It was envisioned that 60% of the project costs (\$42 million) would be centrally-funded, while 40% (\$28 million) would come from USAID Mission and regional buy-ins. Core costs were estimated at \$31.5 million (45% of overall costs), TA/Training at \$26.6 million (38% of overall costs); materials and equipment at \$7.7 million (11% of overall costs); and inflation at \$4.2 million (6% of overall costs).

Expected End-of-Project Results (EOPS). The Project Paper identified three conditions indicating the achievement of project purpose:

- "institutions are better able to define objectives, to meet targets on schedule, and to operate efficiently while maintaining or improving program quality, coverage, and accessibility;
- institutions implement mission statements, structures, strategies, and systems that support quality service provision; and
- institutions are increasingly sustainable over time."

The project design further called for the development early in the project of "*measurable indicators of the management development process*"; these were to become a part of all management development plans (MDAs).

Project Components. FPMD project components include: TA, training, and relatively small amounts of materials and equipment. Unlike other USAID CA projects, FPMD was designed specifically to EXCLUDE, with relatively minor exceptions, the provision of financial and material assistance. FPMD does not, in the main, provide financial support, commodities, contraceptives, or other forms of material assistance to client organizations. Rather, it concentrates on the provision of high-quality technical assistance.

Except in Latin America and the Local Initiatives Program (LIP) in Bangladesh, TA is provided primarily by Boston-based MSH staff and consultants. The project makes good use of in-country staff in countries where it has numerous activities; both expatriate and local consultants are used.

Training activities are conducted primarily outside the U.S. (in-country and regionally); however, some U.S.-based short-term training is also provided. Long-term participant training is not supported (as contrasted with FPMT, which supported both long- and short-term training).

Contracts and Amendments. FPMD Phase I (1990-1995) is being implemented by MSH under two contracts with USAID, including a Core or "C" contract (# DPE-3055-C-00-0051-00) and a Requirements or "Q" contract (# DPE-3055-Q-00-0052-00). Both contracts were executed on September 28, 1990. Under the "C" contract, MSH is to provide 1,509 total person-months of labor over the five-year contract period for a total cost of \$23,029,471 including salaries, consultants, overhead, travel and per diem, nonexpendable equipment, ODC, subcontracts, and fixed fee. Initial funding of the "C" contract totaled \$2,337,000 ... about 10% of the estimated LOP cost.

TEAM FINDINGS

Responsiveness to Mission Needs. In general, FPMD has demonstrably gone the extra mile to be responsive to USAID mission needs and requests. This is a consistent finding across countries and regions, reflected in interviews with Mission personnel and in cabled replies. In the few cases noted where FPMD has not been seen as fully responsive (Nigeria, REDSO/ESA, Bangladesh), there were clear misunderstandings either of what FPMD was all about, or what it could and could not technically or legally do. In the cases of REDSO/ESA and Bangladesh – despite earlier misunderstandings -- both missions are now very pleased with FPMD's work to date. The Nigeria case is complex and remains to be fully resolved.

Project Management. In its early years FPMD developed the reputation of a "troubled" project, due both to internal factors (those related to project staffing, leadership, contracting) and to external factors such as the Gulf War. In the estimation of the Evaluation Team (ET), a more appropriate label might be "troubling", since the project raises as many questions about USAID management as it does about MSH management.

On the MSH side, there has been an uneven and somewhat disruptive pattern of leadership, staffing, and management practices. On the USAID side, most problems appear to stem from the mode of contracting chosen for the project, i.e., the aforementioned "C"/"Q" contracts, but also from shifts in policy and in project monitoring styles and practices within the Office of Population. A related factor has been the frequent changes in USAID monitoring personnel, both in Washington and in the field. The degree to which these factors have impacted on project implementation is difficult to estimate, but is believed to be considerable. That the project has managed to accomplish as much as it has in the past four years can be attributed to Herculean efforts both by MSH and by the Office of Population to make the best of a sometimes uncomfortable situation. An important finding is that the impact of these problems at the field level has been markedly attenuated as compared to their impact in Boston and Washington.

Contract Deliverables. FPMD's progress toward meeting its contractual requirements (as renegotiated with the Project Office) is highly satisfactory. Although contract deliverables are an attempt to "quantify" management interventions and thus are not truly reflective of the broad scope of FPMD activities, contractor performance to date in terms of "deliverables" is more than adequate.

As of May 1994, FPMD has provided assistance of some sort in a total of 37 countries. Subprojects (N=37) have been developed in 16 countries (see Figure 5). In addition, FPMD has worked with four regional organizations in Africa (CAFS, CERPOD, FRAC, IPPF). Five subprojects have been completed; 32 are ongoing, involving some 147 different interventions.

Areas of Concern. Given the variety and extensiveness of FPMD's subproject activities at present -- and its potential for the future -- a few areas of concern were identified:

- Difficulties communicating what FPMD really does and with whom it should best do it. The broad and sweeping scope of activities makes it difficult for FPMD to either "niche" itself in a particular domain, or to efficiently "market" its product; nevertheless, this must be done with a view to influencing the choice of client organizations and subproject activities.
- Need to include field perspective, especially at the service delivery level, in FPMD management interventions, and to collaborate more closely with service-providing CAs.
- Need for documentation of all management interventions so client institutions can replicate and share expertise gained from FPMD.

Factors That Have Aided or Impeded Implementation. A number of factors have both aided and impeded project implementation. These include the following:

Factors which have aided:

- USAID mission support and guidance: USAIDs have generally been very supportive of FPMD;
- Growing recognition of the importance of management interventions: such recognition has occurred among USAIDs, CAs, regional organizations, other donors, and host country institutions alike;
- FPMD's design which emphasizes holistic assessments of management needs, TA and training interventions (and not other forms of support): FPMD is universally seen as an organization with little to offer other than good advice.....it has no axe to grind, and does not "buy" entry into organizations it assists;
- Wide appreciation of and respect for the high quality of FPMD TA;
- FPMD's flexibility in approach, tailored to institutional needs and abilities; and
- The high quality and utility of FPMD publications such as *The Family Planning Manager* and the *Handbook*.

Factors which have impeded:

- The "C"/"Q" contract mechanism and its attendant complications;
- Personnel changes: in MSH headquarters and USAID personnel changes;
- A tendency toward micro-management, both on the part of USAID/Washington (largely the result of the contracting mechanism) and MSH (highly centralized decision-structure);
- USAID tendency, on occasion, to use FPMD to "fill gaps" rather than as a strategic tool;
- Some loss of overall direction and focus: the result of the four above-listed factors;
- Limited ability of FPMD to choose/influence choice of subprojects; and
- The Gulf War and attendant disruptions in travel.

RECOMMENDATIONS

Overview. In FPMD II (and III), the overall project goal and purpose should remain the same. However, certain long-term strategies need modification or redirection. The Evaluation Team is NOT recommending five more years of the same approach taken by FPMD I. In its next phases, FPMD needs to move toward a more proactive selection of its client organizations, and toward building collaborative partnerships and empowering local TA capacity as has been done in Bangladesh (vs. what has been a heavily centralized operation under FPMT and FPMD). Also needed is a broadening of targeted levels and activities in client organizations, extending to all management and service delivery levels from top to bottom. This reorientation needs to include strategic materials development & dissemination. It will also require a modest but critical change in overall management style from a highly centralized one to an approach more supportive of distributed decisionmaking.

FPMD should be thought of as a 20-year effort at institutional strengthening (now in its ninth year), beginning with the FPMT project in 1985 and continuing through FPMD I (1990-95), FPMD II (1995-2000), and FPMD III (2000-2005 -- yet to be authorized). This is a sufficient time period in which to develop and apply management interventions which will help to build sustainable family planning management institutions in many USAID-assisted countries. See Figure ES-1.

Detailed Evaluation Team recommendations are included in Section 5.0 and are summarized in Appendix I.

FPMD CONCEPTUAL FRAMEWORK

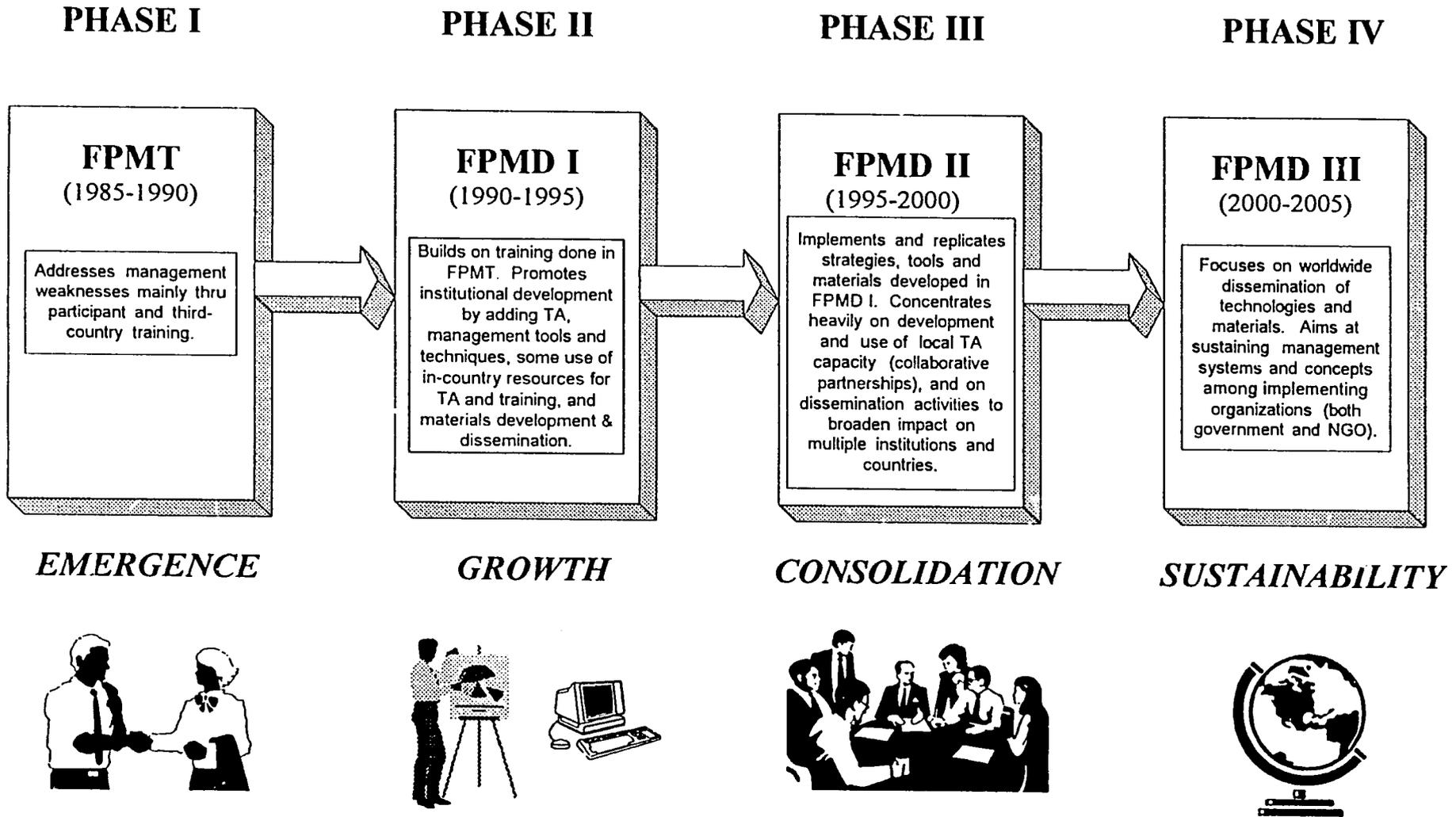


Figure ES-1

1. PROJECT BACKGROUND AND OVERVIEW

1.1 The Problem

The FPMD Project Paper identified *family planning program management weakness* as the central problem to be addressed by the project. Citing several advances made in past decades (e.g., in method mix and CBD), and challenges for the decade of the 90s (increasing numbers of clients due to demographic variables, need to increase CPR to impact on population growth rates, and the withdrawal of donor support from the more advanced developing countries), the case for improving the management effectiveness of family planning programs is clearly set forth.

1.2 The Proposed Solution: Management Interventions

Drawing upon earlier work under the five-year Family Planning Management Training Project (FPMT, #936-3039, 1985-90), and upon lessons learned and recommendations contained in the 1989 evaluation of that project, the FPMD project design centered squarely on the objective of *organizational development*, i.e., strengthening the management of family planning organizations through institutional development interventions.

The FPMT evaluation concluded:

"The FPMT project clearly addresses a major need in the family planning field. The project does something that other A.I.D. projects do not do, and it thereby occupies a significant niche in A.I.D.'s overall population program. Having a project that focuses on management improvement as its single purpose is a very appropriate strategy."¹

The evaluation concluded, however, that the FPMT project design fell short of what was needed to meet the objective of strengthening the leadership and management of family planning programs. The FPMD project design was intended to correct this deficiency.

1.3 Project Design

FPMD was originally designed as a ten-year follow-on to the earlier five-year FPMT project. It built upon experiences under FPMT to fashion a new long-term effort in management improvement through a series of targeted *management interventions* and training directly with client organizations and with CAs and regional organizations. Focusing on strategic and operational planning, organizational structure, and management systems required to efficiently implement programs in the field (e.g., MIS, financial management, personnel management), FPMD was designed to impact on the availability, quality, and accessibility of family planning services provided by client organizations worldwide.

The LOP funding for the ten-year effort was set at \$70 million, including \$28 million in buy-ins. The project is being implemented in two five-year segments (FPMD I and FPMD II), the first of these through contract arrangements with Management Sciences for Health (MSH) in Boston, MA.

¹ Wickam, Robert; Pillsbury, Barbara; and Logan, David, "The Family Planning Management Training Project External Interim Evaluation", Dual and Associates, Washington, D.C., Spring 1989.

1.4 Expected End-of-Project Results (EOPS)

Three conditions indicating the achievement of project purpose were identified:

- "institutions are better able to define objectives, to meet targets on schedule, and to operate efficiently while maintaining or improving program quality, coverage, and accessibility;
- institutions implement mission statements, structures, strategies, and systems that support quality service provision; and
- institutions are increasingly sustainable over time."²

The project design further called for the development early in the project of "*measurable indicators of the management development process*"; these were to become a part of all management development plans (MDAs).

1.5 Purpose and Methodology of Evaluation

The present evaluation comes in year four of the current five-year contract period of FPMD I (1990-95). Its purpose is to assess progress to date, and to make recommendations for the next five-year period (FPMD II). The Scope of Work for this evaluation is given in Appendix A.

Four public health specialists were chosen for the evaluation, each having broad international health and family planning experience and bringing complementary skills to the team effort. The team spent one week in the U.S. (AID/Washington and MSH/Boston), then divided to evaluate FPMD activities in Mexico, Bolivia, Kenya, and Bangladesh, spending one week in each country. The team reunited in Washington for a final week for debriefing and writing.

Over 250 persons were interviewed during the month-long evaluation; several hundred project-related documents and publications were consulted. These are shown in Appendices B and C, respectively.

² Project Paper, page 23.

2. PROJECT DESIGN

2.1 USAID Project Design

The FPMD project paper outlined a conceptual framework for the "Stages of Program Development". Drawing on work by Vriesendorp, Sylvia, et. al., under the FPMT project, the PP set forth a framework for organizational development consisting of four stages: (1) emergence; (2) growth; (3) consolidation; and (4) sustainability. The management components of these four stages were further examined in terms of four dimensions each: (1) mission; (2) strategies; (3) structure; and (4) systems.³ Separate models were developed for public sector institutions and for private sector (NGO) institutions. These models describe both the theoretical stages of development of family planning organizations, and the areas for management interventions under the FPMD project.

The project design also includes two major focus areas: (1) management effectiveness; and (2) quality of care (QOC). These are included in a theoretical framework which posits QOC as a key outcome of effective management. QOC dimensions cited in the project paper included the following:

- increased knowledge on the part of the acceptor;
- increased satisfaction with services;
- increased contraceptive use;
- decreased fertility; and
- better health of the acceptor.

Thus the project design clearly delineates the theoretical linkages between management improvements on the one hand, and QOC outcomes on the other.

Project strategies to achieve the desired outcomes are described for each of three geographical regions: Africa, Latin America/Caribbean (LAC), and Asia/Near East (ANE). In general, the FPMD strategies are geared to contraceptive prevalence levels in the target countries, thus taking account of the varying stages of family planning services development. As an example, the strategies for mid- to high-prevalence countries include: "coordination of decentralized service delivery; expansion into the private sector; MIS for large-scale family planning programs to be integrated into primary health care systems; computer-based MIS systems that integrate service statistics and cost data; coordination of service delivery in a complex situation of public, PVO, and commercial sector service providers, and financial sustainability."⁴

Other project strategies include: decentralization, sustainability, MIS, contraceptive methods (esp. new), regional training institutions, and management assistance to other USAID cooperating agencies (CAs) and donors. **Methodologies** to be used included five principal components:

- "management development planning;
- institutional development through technical assistance and training to help organizations implement management development plans;

³ See esp. Tables 4 and 5 on pages 19-20 of the FPMD Project Paper (936-3055) dated March 1990.

⁴ Project Paper, page 27.

- development, adaptation, use, and dissemination of training materials;
- evaluation of project-assisted activities; and
- preparation and dissemination of materials that capture and synthesize the project's experience in supporting organizational and management development of family planning programs."⁵

Magnitude of Inputs. FPMD is designed as a ten-year effort (divided into two equal segments, FPMD I and FPMD II, of five years each) with a total cost of \$70 million. It was envisioned that 60% of the project costs (\$42 million) would be centrally-funded, while 40% (\$28 million) would come from USAID Mission and regional buy-ins. Core costs were estimated at \$31.5 million (45% of overall costs), TA/Training at \$26.6 million (38% of overall costs); materials and equipment at \$7.7 million (11% of overall costs); and inflation at \$4.2 million (6% of overall costs).

Contract Outputs. Anticipated FPMD I outputs were originally quantified in the first five-year contract in several categories as follows:

- diagnostic and needs assessment reports for 48 institutions;
- management development plans for 48 institutions;
- TA and training for 73 institutions;
- 80 short-term in-country workshops and 20 short-term U.S., third-country, or study tours
- curricula and teaching exercises for 13 management content areas adapted or developed and field tested by end of year three; two handbooks;
- management indicators developed during year one; ongoing program evaluation to include an average of ten subprojects per year; and
- issues papers and working papers (six per year); FRAC meeting each year; three international conferences.

This listing of outputs was later modified and submitted to USAID's Office of Procurement as "contract deliverables" and became the subject of a re-negotiation between the contractor (MSH), the Office of Population, and the USAID contracts office. This modification is still awaiting contracts office approval.

2.2 The Design as Implemented by MSH

2.2.1 Project Framework and Operational Context

Framework. The technical proposal submitted by MSH in June 1990 closely parallels the design parameters laid out in the USAID Project Paper. It reflects a deep understanding of (and agreement with) the basic project design, including its conceptual framework, organizational and geographic strategies, methodologies, and project components. As MSH had been the implementing organization for the predecessor FPMT project, its background and experiences under that project were directly relevant to the new FPMD project. Indeed, some management interventions under FPMD were to be carried out with organizations previously assisted by MSH under the FPMT project.

⁵ Project Paper, page 24.

The overall framework within which the FPMD project operates can be understood in terms of the Conceptual Framework of Family Planning Supply Factors (**Figure 1**). This framework, developed under USAID's Evaluation Project, depicts the systems and structures which ultimately impact on family planning service delivery outputs. The FPMD project operates principally within the two areas shown as shaded 3-D boxes: FP Organizational Structure and Operations. It does not, for example, operate principally upon such factors as External Development Assistance or the Political and Administrative System (as does, for example, the OPTIONS Project).

Operational Context. The FPMD project can also be thought of in terms of its interaction at various levels of: (1) the family planning services infrastructure; and (2) the management infrastructure. This interaction is depicted in **Figure 2**, again highlighting in the shaded 3-D boxes the principal levels of FPMD focus.

2.2.2 Project Components

FPMD project components include: TA, training, and relatively small amounts of materials and equipment. Unlike other USAID CA projects, FPMD was designed specifically to EXCLUDE, with relatively minor exceptions, the provision of financial and material assistance. FPMD does not, in the main, provide financial support, commodities, contraceptives, or other forms of material assistance to client organizations. Rather, it concentrates on the provision of high-quality technical assistance.⁶

TA is provided by Boston-based MSH staff and consultants, and is increasingly augmented by the use of local staff and consultants⁷. The project makes good use of in-country personnel in countries where it has numerous activities; both expatriate and local consultants are used.

Short-term training activities are conducted in-country, regionally (as in the case of the FRAC), and in the U.S. Long-term participant training is not supported (as contrasted with FPMT, which supported both long- and short-term training).

2.3 Contracts and Amendments

FPMD Phase I (1990-1995) is being implemented by MSH under two contracts with USAID, including a Core or "C" contract (# DPE-3055-C-00-0051-00) and a Requirements or "Q" contract (# DPE-3055-Q-00-0052-00). Both contracts were executed on September 28, 1990.

Under the "C" contract, MSH is to provide 1,509 total person-months of labor over the five-year contract period for a total cost of \$23,029,471 including salaries, consultants, overhead, travel and per diem, nonexpendable equipment, ODC, subcontracts, and fixed fee. Initial funding of the "C" contract totaled \$2,337,000...about 10% of the estimated LOP cost.

⁶ There are a few exceptions. FPMD sometimes provides computers and software and, in the case of LIP/Bangladesh, other limited forms of assistance.

⁷ Except in Latin America where TA is provided almost exclusively by in-country local consultants or consultants from other Latin American countries, and in Bangladesh where the LIP contractor is wholly staffed by local personnel.

Conceptual Framework of Family Planning Supply Factors

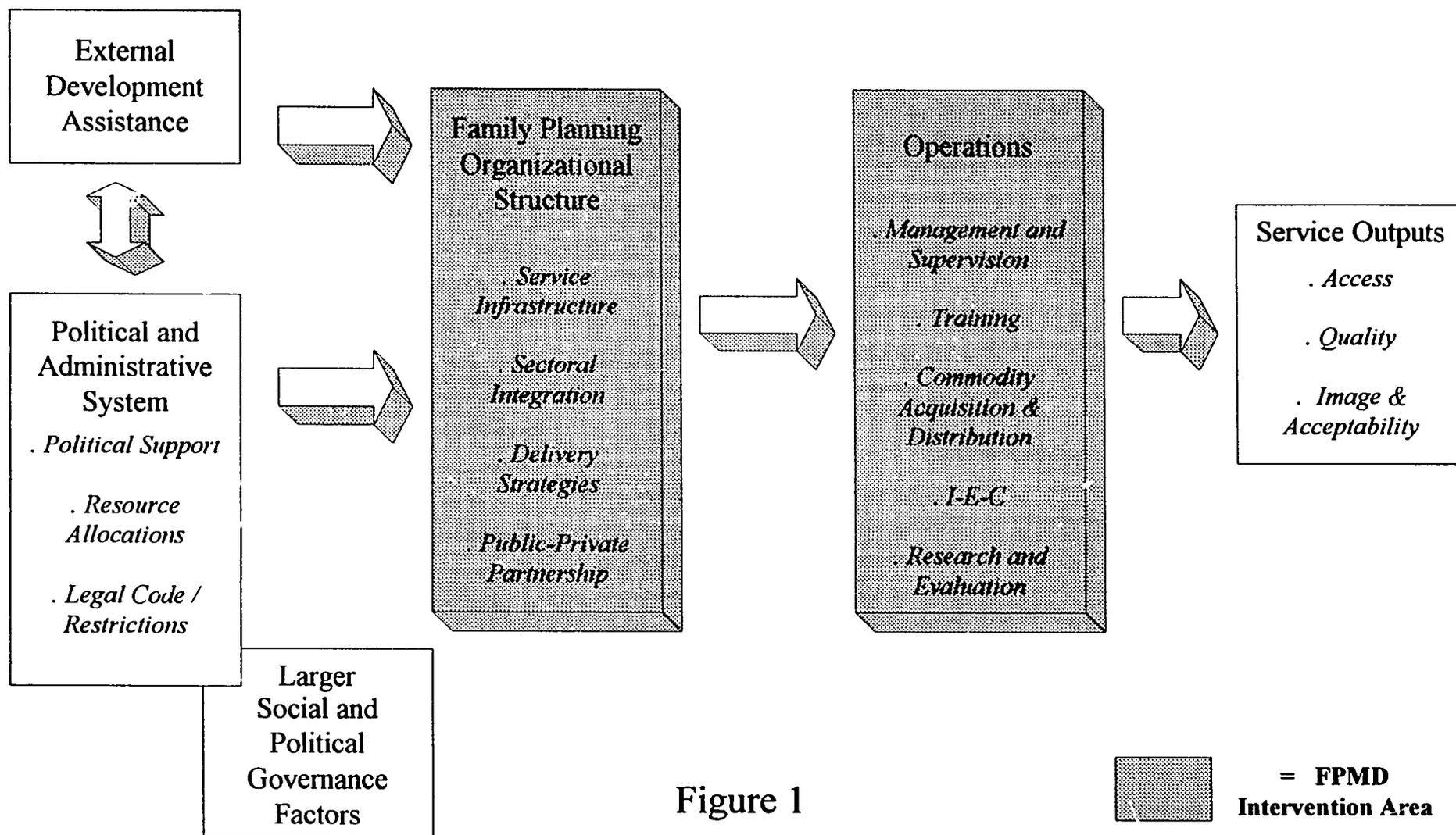


Figure 1

SOURCE: *Handbook of Indicators for Family Planning Program Evaluation*, (Bertrand, Magnani, Knowles), AID/RD/POP 1994.

CONTEXT OF FPMD INTERVENTIONS

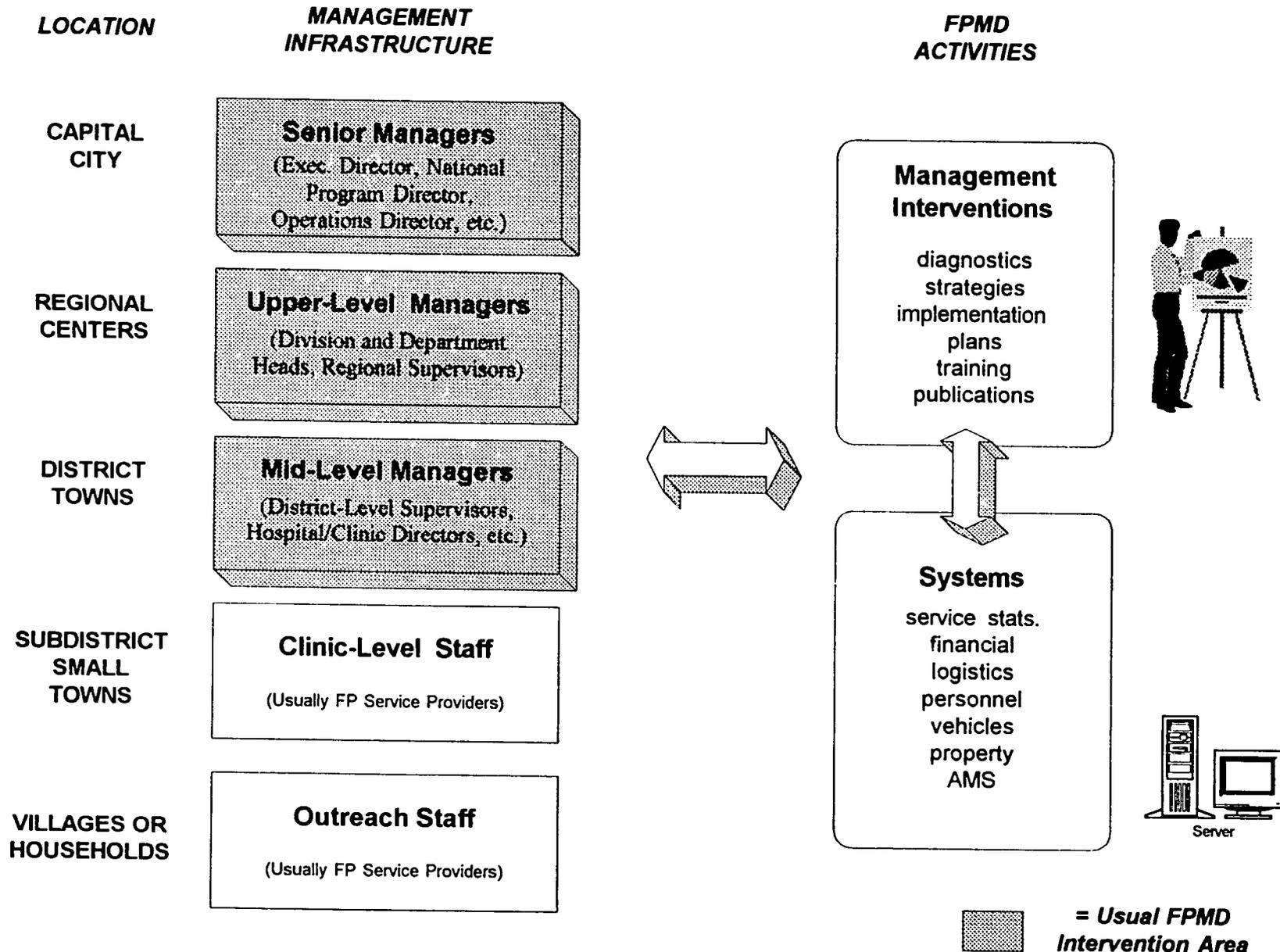


Figure 2

Section C of the "C" contract includes a 23-page description of work, mostly drawn verbatim from the Project Paper. Included is a listing of "Anticipated Quantified Contract Outputs" (page 32). The 105-page contract contains specific language covering contractor activities, coordination with USAID and other organizations, country selection, staffing, level of effort, reporting requirements, conceptual framework, strategies, outcomes, training materials, and virtually everything imaginable related to the implementation of the FPMD project. It also includes an "Estimated Implementation Schedule by Major Activity and Deliverable" table on page 40.

The "Q" contract was issued as "a companion contract" to the "C" contract, in order to "fund ad hoc intermediate and intensive country-specific institutional development efforts when adequate bilateral funds are available".⁸ The "Q" contract contains a description of work identical to the "C" contract, with the added notation after major sections, "This contract is to be utilized only in conjunction with contract number DPE-3055-C-00-0051-00". The "Q" contract established no ceiling on buy-ins, and appeared not to recognize the relationship between potential buy-ins and their impact on core funding.

Both contracts were executed in some haste at the end of FY1990. These factors were significant in two respects: (1) the contractor had no previous experience with the C/Q contract mechanism and its many sequelae; and (2) international travel was heavily restricted during the months of FPMD startup (due to U.S. involvement in the Gulf War). A third intervening factor during the first years of FPMD was a shift in strategic directions in the Office of Population ("Big" country to "Priority" country). As a result of these factors, MSH in August 1993 submitted a 25-page letter to the Office of Procurement requesting a "major modification" to the Prime contract, following on "extensive discussions with the Cognizant Technical Office and Project Manager". The proposed changes, inter alia, involved a modification of the work statement and quantified contract outputs. As of early May 1994, these changes have not been finalized by OP. Nevertheless, MSH and the Office of Population have proceeded with contract implementation on the basis of the proposed changes.

⁸ "Q" contract, page 2.

3. CONTRACT PERFORMANCE

3.1 PROJECT STRATEGY

3.1.1 Strategic Goals

The Project Goal, stated in the original Project Paper, is: "(1) to enhance the freedom of individuals in less developed countries to choose voluntarily the number and spacing of their children; and (2) to encourage a population growth rate consistent with a country's goals for economic and social development."

The Project Purpose, from the same source, is: "to promote institutional development and strengthen the management capabilities of public and private (non-profit) family planning organizations, to enhance the quality and sustainability of their services."

The project purpose has been later interpreted as including both "quality" and "quantity" factors (i.e., enhanced availability as well as enhanced quality of services). This intent is made clear in the Project Paper itself, viz. Table 5 on page 20.

3.1.2 FPMD's Conceptual Framework

MSH's Technical Proposal submitted to USAID in July 1990 took basic institutional concepts and constructs from the USAID Project Paper and developed them into an overall framework for project orientation and implementation. The evaluation team (ET) believes this framework is technically sound and appropriate to the intended strategic goals of the project. MSH clearly demonstrated in their proposal an in-depth understanding of the issues to be dealt with, and they clearly delineated their approach to operationalizing the conceptual framework.

Drawing on the five years of experience with the FPMT project, MSH set forth five key components to management development which they termed the "MSH Strategy for FPMD":

- close collaboration with USAID, CAs, and donors;
- targeted assistance to organizations with a commitment to change and development;
- strengthening organizational leadership;
- sufficient time to enable change of the organizational culture; and
- consistent, high-quality technical assistance and mutual respect between the (client) organization and FPMD.

Thus at the outset in 1990, there was a clear understanding on the part of USAID and the prospective contractor of the long-term institutional development objectives of the project, and of strategies and modalities to be employed in pursuit of these objectives. In the opinion of the ET, some of this clarity and focus was subsequently undermined by a series of unanticipated events having to do both with USAID itself and with the contractor. These events are examined in detail in later sections (see esp. pp 17-20, Sections 5.6, 5.8, 5.9, and Appendix K).

Impact on Services. The FPMD project aims at improving access to family planning services and at improving the quality of family planning services by strengthening the overall management capability and practices of organizations, both public and private, which provide such services. While to many persons this charge appears to ignore the many intervening variables between

management interventions on the one hand and **improved FP service availability and quality** on the other, in fact the designers of the project were mindful of these intervening variables and the many relationships they imply.

The Evaluation Team (ET) believes it is not necessary -- and not really possible -- to prove, in a scientific or quantitative way, that specific management interventions provided under this project have resulted in specific service outcomes. Rather, it seems more appropriate to consider FPMD management interventions in relation to the question: "Is it conceivable that desired service outcomes (increased availability and quality) could be achieved broadly and sustained **without** improvements in the management of service-providing organizations? The answer, clearly, is no. Improved management is a key factor in improved service delivery. As one CA respondent in Kenya put it, "Now (given the state of development of FP service delivery programs), management is everything."

3.1.3 Interventions, Modalities, and Outcomes

While management may be "everything", it is in some ways an obscure and even esoteric concept. In order to make it less so, and to operationalize an approach to impacting on the many management systems involved in FP service delivery, FPMD has formulated and used a set of *management interventions* (which may be thought of as FPMD tools or technologies) which are to achieve specific *institutional outcomes*.

Unlike many USAID population CAs, FPMD was not designed to include comprehensive support to collaborating institutions (commodities, financing, contraceptives, etc.). Rather, FPMD interventions are mostly in the form of technical assistance delivered through its core staff and consultants, in-country staff and consultants, and thru learning modalities such as training, observational tours, workshops, materials, and publications. On the whole, this design strategy has proven to be workable and an asset: FPMD is not seen as "buying" entre or favor from host institutions; it has only TA to offer.⁹ In a sense, this posture represents a very good starting point in working with new clients, as they are expecting to benefit primarily from FPMD's management expertise. However, on occasion FPMD's operational mandate has been misunderstood by the USAIDs and potential collaborating institutions (e.g., the case of Nigeria where a large OYB transfer was made in the expectation that FPMD would be providing significant material assistance as well as TA to the Family Planning Association).

Management Interventions. TA is provided under 13 types of "management interventions". These categories are shown below, together with their codes used for activity tracking purposes:

- C = Coordination
- CD = Curriculum Development/Training Skill
- E = Evaluation (Subproject/Country Level)
- FG = Financing
- FM = Financial Management

⁹ This is generally the case, but there are a few exceptions, i.e., situations in which FPMD provides some hardware and software and other forms of material assistance. LIP in Bangladesh (a USAID/Dhaka buy-in) is an exception in several ways, as described later in this report.

LOG = Logistics
M = Marketing
MIS = Management Information Systems
OD = Organizational Structure/Personnel/Supervision
OP = Operational Planning
Q = Quality of Care
SD = Service Delivery/Design
SP = Strategic Planning.

As of May 1994, some 137 FPMD management interventions were active in 14 countries and in five regional organizations worldwide. The relative frequency of these interventions is shown in **Figure 3** (codes same as above).

FPMD assists public sector, private sector (NGO), CAs, and regional organizations serving both public and private sector entities. The regional and sectoral distribution of FPMD's management interventions is shown in **Figure 4**.

Desired Institutional Outcomes. FPMD's management interventions are designed to result in specific institutional outcomes, i.e., in organizations which:

- Define Objectives
- Operate Efficiently
- Implement Systems
- Meet Targets on Time
- Maintain or Improve Program Quality, Coverage, and Access
- Implement Sustainability Actions
- Implement Mission Statements, Structures, and Strategies

The above interventions and desired outcomes are individually tailored to the situations and needs of client organizations with which the FPMD project engages. They are chosen at the beginning of a new collaboration, and are expanded, contracted, and otherwise modified as the relationship develops. Herein lies the real strength of FPMD: its ability to flexibly engage in a collaborative management improvement effort with a client institution -- large or small, public or private -- at virtually all management levels and intensities. The ET has repeatedly seen evidence of this flexibility and strength.

FPMD's chosen approach is not without inherent pitfalls. Chief among these is the temptation to use FPMD resources in a piecemeal fashion to address single management problems or issues. Such use could well result in diverting FPMD resources from more important pursuits (this has in fact happened on occasion). Sometimes, however, such "diversions" actually result in more important interventions as FPMD is able to convert single interventions to more comprehensive work with strategically important organizations.

**FPMD INTERVENTIONS BY TYPE
(N=137 ACTIVE WORLDWIDE AS OF MAY 1994)**

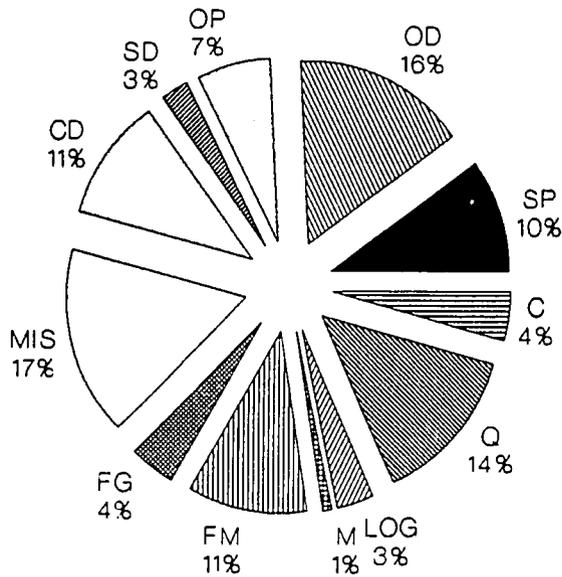


Figure 3

**FPMD INTERVENTIONS BY SECTOR
AND BY REGION (MAY 1994)**

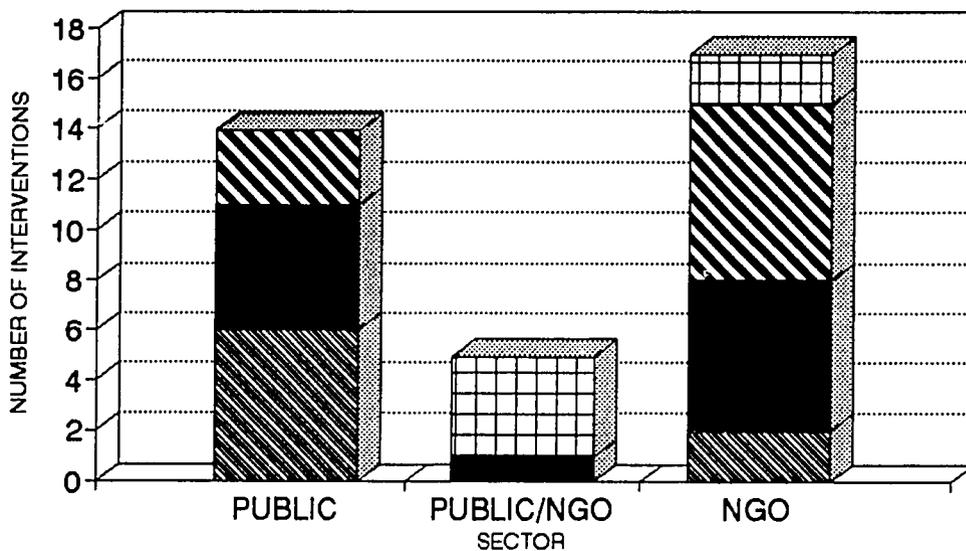


Figure 4

ASIA-NE
 LAC
 AFRICA
 REGIONAL

3.1.4 Regional, Country, and Activity Selection

Based on expressions of interest from USAID missions which responded to a worldwide request, the core contract included a listing of potential countries for FPMD work. This listing included a total of 36 countries (including 12 "new" ones which had not benefitted from FPMT assistance) plus six regional organizations (including two "new" ones). Also included in the contract was a listing of subject-matter areas ("activities") for each country, based on their cabled responses. This listing represented the notional "targets" for FPMD assistance over the next five to ten years.

As of May 1994, FPMD has provided assistance of some sort in a total of 37 countries. Subprojects (N=37) have been developed in 16 countries (see **Figure 5**). In addition, FPMD has worked with four regional organizations in Africa (CAFS, CERPOD, FRAC, IPPF). Five subprojects have been completed; 32 are ongoing.

The current FPMD subproject portfolio includes five countries in the Asia-Near East region (Bangladesh, Nepal, Philippines, Turkey, Tunisia), six countries in the LAC region (Bolivia, Ecuador, Honduras, Jamaica, Mexico, Peru), and three countries in the Africa region (Burkina Faso, Kenya, Nigeria).¹⁰ The ET was only able to visit four of these 14 countries (Bangladesh, Bolivia, Kenya, Mexico), but reviewed numerous project documents pertaining to all FPMD countries.

The Selection Process. In practice, most selection of FPMD countries, clients, and activities is heavily influenced by the USAID missions. Some self-selection by clients also takes place, particularly among the CAs seeking FPMD assistance. The contractor has not been free to seek new country and institutional engagements worldwide. In 1993, FPMD requested a modification of the "C" contract to reflect this reality (this request is pending final approval by the contracts office).

The fact that FPMD has only limited control over the choice of its institutional collaborators ("subprojects") is an important limiting factor in the project's potential impact worldwide. As FPMD cannot always ensure that its work is centered in organizations having strategic importance -- or that its interventions are those which could have the greatest impact -- some of its potential is lost. Moreover, the contract mechanisms chosen for FPMD ("C" and "Q" contracts) place quantitative requirements on the contractor for "deliverables" which, though not inconsistent with overall project objectives, tend to focus attention on quantifiable products or actions and away from overall strategic objectives.

Thus, there is the built-in tendency to "get the numbers up" to comply with contract deliverables rather than focus on the overall impact of project interventions. The ET believes that together, these country/activity selection and contracting factors represent a one-two punch which undermines the original intent and the overall impact of the FPMD project.

¹⁰ Needs Assessments have also been conducted in Cambodia, Egypt, India, Indonesia, Morocco, and Sri Lanka.

FPMD INTERVENTIONS BY CATEGORY AND BY REGION (ACTIVE AS OF MAY 1994)

Total Interventions = 137

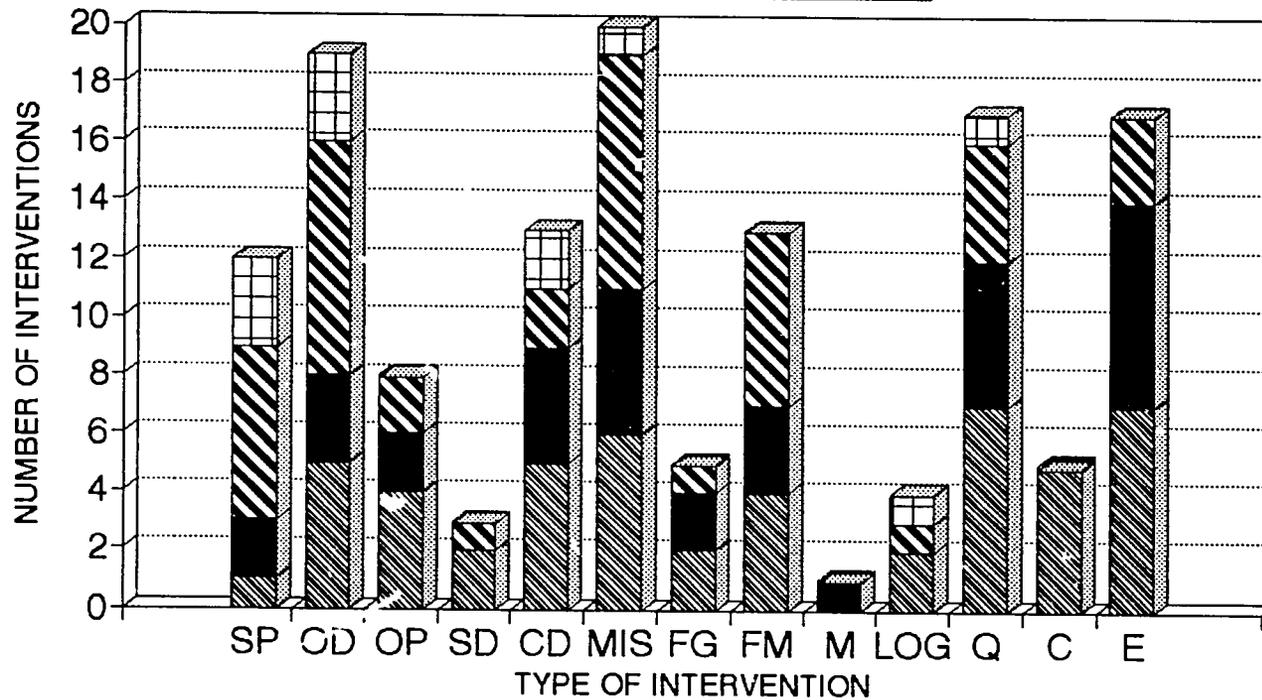


Figure 5

ASIA-NE
 LAC
 AFRICA
 REGIONAL

14

3.1.5 Responsiveness to Mission Needs

In general, FPMD has demonstrably gone the extra mile to be responsive to USAID mission needs and requests. This is a consistent finding across countries and regions, reflected in interviews with Mission personnel and in cabled replies. In the few cases noted where FPMD has not been seen as fully responsive (Nigeria, REDSO/ESA, Bangladesh), there were clear misunderstandings either of what FPMD was all about, or what it could and could not technically or legally do. In the cases of REDSO/ESA and Bangladesh -- despite earlier misunderstandings (over Scope of Work, timing, and what FPMD could legally do) -- both missions are now very pleased with FPMD's work to date. The Nigeria case is complex and remains to be fully resolved.

To avoid future misunderstandings, both USAID and FPMD need to take effective steps to ensure that USAID Missions, other USAID CAs, and potential client organizations fully understand the context in which FPMD operates.

3.2 Project Administration

3.2.1 Project Management

In its early years FPMD developed the reputation of a "troubled" project, due both to internal factors (those related to project staffing, leadership, contracting) and to external factors such as the Gulf War. In the estimation of the Evaluation Team (ET), a more appropriate label might be "troubling", since the project raises as many questions about USAID management as it does about MSH management.

On the MSH side, there has been an uneven and somewhat disruptive pattern of leadership, staffing, and management practices. On the USAID side, most problems appear to stem from the mode of contracting chosen for the project, i.e., the aforementioned "C"/"Q" contracts, but also from shifts in project monitoring styles and practices within the Office of Population. The degree to which these factors have impacted on project implementation is difficult to estimate, but is believed to be considerable. That the project has managed to accomplish as much as it has in the past four years can be attributed to Herculean efforts both by MSH and by the Office of Population to make the best of a sometimes uncomfortable situation.¹¹

A troubling aspect of FPMD project management is the degree to which both USAID and MSH managers have tended to micro-manage. Micro-management by MSH seems primarily related to its highly centralized decision-making structure, but also is conditioned by the nature of its contract arrangements with USAID. These same contract arrangements have tended to encourage (or require) close USAID involvement in virtually every aspect of FPMD project implementation, including relatively minor actions. The Office of Procurement, the Office of Population, and the USAIDs have all been (sometimes unwilling) partners to this cumbersome management style.

FPMD was designed to be a long-term institutional development project. As such, one would have reasonably anticipated a procurement mechanism suited to this purpose (e.g., a Cooperative Agreement which recognizes the stages of institutional development and contractor actions required

¹¹ It should be noted that the impact of these problems at the field level has been markedly attenuated as compared to those in Boston and Washington.

to move through them). Unfortunately for all concerned, not the least for USAID itself, a different contract road was chosen. It has proven to be a bad choice.

Nevertheless, and despite a few lingering signs of earlier project management problems, the ET found the situation in May 1994 to be much improved. In January 1993, MSH appointed a senior officer of the corporation with strong management skills to head up the FPMD project (Catherine Crone Coburn, who had previously headed the FPMT project team). In the past 16 months, she has built a strong senior staff whom the ET found to be very impressive indeed, both in their professional expertise and in their approach to project implementation. In addition, Coburn has set in motion a series of actions designed to recapture the project's strategic positioning and thrust, some of which had been eroded in the first years of FPMD. While continuing to pursue numeric targets -- both contractual and programmatic -- FPMD staff is now actively engaged in reviewing subproject activities from a strategic perspective, asking hard questions about what is and is not being done by the project and seeking opportunities to maximize the impact of supported activities. These changes bode well for the final year of FPMD I, and will help set the stage for FPMD II and beyond.

3.2.2 Project Staffing

The level-of-effort for core staff and consultants under FPMD I was contractually set at 1,509 person-months. This total included 32 core professionals plus nine supporting staff positions in the U.S. No explicit provision was made for in-country staff, except for "long-term resident advisors" which might be funded through buy-ins under the companion "Q" contract when "there is an opportunity to work on a 'cutting edge' program issue or when the project has a substantial number of activities underway in a country."¹²

At present, approximately 50% of overall FPMD staff consists of Boston-based¹³ personnel; the remainder consists of in-country staff and consultants located in a total of 18 countries.

Current staffing of FPMD in Boston is shown in **Figure 6**. Boston-based staff is allocated both by geographic region (Africa, ASIA/NE, LAC) and by cross-cutting functions (operations, financial, publications/communications, research/evaluation, etc.). As noted above, the ET was very impressed with the quality and professionalism of the headquarters staff. A consistent finding of this evaluation was the high quality of technical professionals employed by FPMD (as seen by the USAIDs, by client organizations, and by other CAs). This finding applies both to FPMD staff and consultants from MSH headquarters and elsewhere, including locally recruited consultants in the field.

¹² "C" contract, page 64.

¹³ The FPMD project headquarters is actually located in Newton, MA -- a few miles outside Boston. The headquarters office of MSH is located in Boston.

Catherine Crone Coburn FPMD Project Director

FPMD Unit	FPMD Staff	
Africa	Susan Aradeon Michael Hall Peter Kibunga Peter Savosnick Katie Sears Marjorie Smit Annie Thairu Barbara Tobin Cynthia Veliko Sylvia Vriesendorp	Project Coordinator, Nigeria Senior Program Officer, Africa Technical Advisor, Kenya Senior Technical Advisor, Kenya Program Assistant Regional Director, Africa Program Officer, Kenya Program Administrator, Kenya Program Assistant Organization Development Specialist
Asia	Alison Ellis Paul D. Fishstein Carol Gomez Taryn Vian	Regional Director, Asia/Near East Senior Program Officer, Asia/Near East Program Assistant Resident Advisor, Philippines
Latin America/Caribbean	Nancy Murray Cunningham Maribel Diaz Edgar Necochea Wendy Wise Sandra Wilcox	Regional Director, Latin America/Caribbean Senior Program Assistant Senior Program Officer, Latin America/Caribbean Program Assistant Resident Advisor, Bolivia
Evaluation	Walter Mertens Donna Monahan	Director of Evaluation Senior Program Assistant
Publications	Claire Bahamon B. Jacki Forbes Janice T. Miller Jill Shulman Linda Sutenfield James A. Wolff Dierdre Wulf	Program Officer, Publications Production/Graphics Specialist Senior Publications Manager Senior Program Assistant Senior Publications Specialist Director, Publications and Communications Senior Publication Specialist
Technical Unit	Marc D. Mitchell Deborah Ruhe	Technical Director Senior Family Planning Advisor
Operations	Elizabeth S. Abbott Susanna Binzen Robert Burns Dana Chehayeb Bryan Constans Denise Daly Ellen Freedman Carla Goncalves Diane Midura Melanie Powers Susan Purser-Haskell John Taylor	System Support Specialist Special Projects Associate Contracts/Finance Director Information Specialist Program Assistant Assistant Project Accountant Contracts Analyst Senior Program Assistant Project Accountant Director of Operations Senior Program Assistant Accounting Assistant

Figure 6: Current FPMD Staffing

- 11 -

Many among the current professional staff in Boston are relative newcomers to the project, reflecting one of the past problems FPMD has had: staff turnover. The ET did not attempt to concern itself with a blow-by-blow account of turnovers; rather it attempted to assess the impact of these changes on project implementation in the past and, especially, the immediate future. It would appear, from all respondents queried in the field, that staff turnover was more a problem in the U.S. than a real problem impacting on field operations.¹⁴ In the opinion of the ET, staff turnover had a more insidious effect: when combined with the twin factors of turnovers in FPMD leadership and an awkward USAID contracting arrangement ("C"/"Q") which had the effect of focusing inordinate staff time on "mechanical" rather than substantive issues, staff changes resulted in a subtle but still apparent erosion in the clarity of project framework and purpose, certainly when contrasted with the very clear vision expressed in MSH's original technical proposal in 1990. A further contributing factor was the inability of the Evaluation Unit of FPMD to lay out a practical plan for subproject monitoring and evaluation. This latter problem has been rectified and, as previously noted, present FPMD leadership is moving decisively to recapture the overall project vision in a practical operational context.

Project Location. An issue raised at the beginning of FPMD and throughout its first four years is whether or not the project should be, in whole or in part, Washington-based instead of Boston-based. The ET explored this question with FPMD project staff, with AID/W personnel, and with staff members of other CAs based in Boston and New York¹⁵. There are certainly advantages for MSH and for its implementation of the project to having FPMD's location in the Boston area. The disadvantages are related primarily to AID/W feelings of being "out of touch", as well as to real problems of interfacing with OP and G/PHN/POP on implementation issues and problems. The ET was able to identify communication difficulties at both ends.

Nevertheless, in the opinion of the ET, there is no reason for these problems to persist provided that BOTH the contractor and AID/W make efforts to bridge the location gap. FPMD could and should travel more frequently to Washington to discuss project implementation plans, issues, and problems. The Office of Population needs to assure FPMD that its personnel will be afforded adequate time and entre to exchange views and information, and to resolve problems. Additionally, more time needs to be allocated for *substantive understanding* of FPMD's project activities to occur, perhaps through more frequent and longer visits by USAID project managers to Boston and to FPMD's overseas subproject sites.

3.2.3 Financial Management

Financial management of the FPMD project involves the rational allocation, use, tracking, and reporting of core funds under the "C" contract (totaling \$23 million) plus buy-in funds from USAID missions and regional projects under the "Q" contract. No ceiling or estimate was provided for the latter. To date, there have been 26 buy-ins (delivery orders) ranging in size from \$100 thousand to more than \$4 million.

¹⁴ One exception to this is the resident advisor position in Kenya, where two turnovers have resulted in a noticeable impact on program activities.

¹⁵ A number of CAs are located outside the Washington, D.C. area, including Pathfinder (Boston), MSH (Boston), AVSC (New York), IPPF (New York and London), The Population Council (New York), Alan Guttmacher Institute (New York), INTRAH (NC), University of Michigan (Ann Arbor), Carolina Population Center (NC), Family Health International (NC), East-West Center (HI), JHPIEGO, and PCS/PIP (Baltimore).

Obligations under the "C" contract have totaled \$18.437 million¹⁶; expenditures billed to USAID through 2/28/94 have totaled \$12.8 million or just over 69%.

Obligations under the "Q" contract have totaled \$9.17 million; expenditures billed to USAID through 2/28/94 have totaled \$4.59 million or about 50%. Expenditures under this contract have lagged due to extraordinary contract-related problems (see below).

In general, the rate of expenditures under the core contract has been steady, except for some lag during the first six months of the project due mainly to external factors.

MSH has set up a number of automated and semi-automated systems to manage FPMD finances, including those required to meet USAID's extensive (and ever-changing) reporting requirements. In a very real sense, however, the Project is the victim of a variety of contract-related implementation problems stemming from the USAID procurement system in general and, in particular, from the "C"/"Q" contracting mechanism.

USAID is acutely aware of these difficulties, witness the present elaborate efforts to effect sweeping changes in its procurement practices (the Procurement Reform package). Nevertheless, FPMD project implementation has been and continues to be adversely impacted in a variety of ways by the existing contract arrangements and by numerous reporting and monitoring practices which appear to the ET to be wasteful. These are of sufficient importance as to warrant their discussion/presentation in some detail. Appendix K of this report presents some of the more significant procurement-related problems. Related recommendations for FPMD II are given in Sections 5.6, 5.8, and 5.9.

Overall, the ET had the impression that MSH's financial management of the FPMD project was strong, and was about as good as could be expected under the circumstances. Responses from field interviews supported this view.

3.3 Contract Deliverables and Subproject Activities

3.3.1 Contract Deliverables.

Figure 7 shows FPMD's progress toward meeting its contractual requirements as renegotiated per August 20, 1993.¹⁷ Although these deliverables are an attempt to "quantify" management interventions and are thus not truly reflective of FPMD's scope of activities, the performance to date in terms of "deliverables" is more than adequate.

¹⁶ An additional obligation of approximately \$4.6 million is anticipated in May 1994, bringing total obligations up to the contract ceiling.

¹⁷ This is the date of the letter submitted to the Contract Officer, at the date of this writing (5/94) contractual deliverables are still not finalized.

Achievement of Contractual Requirements Through May 18, 1994

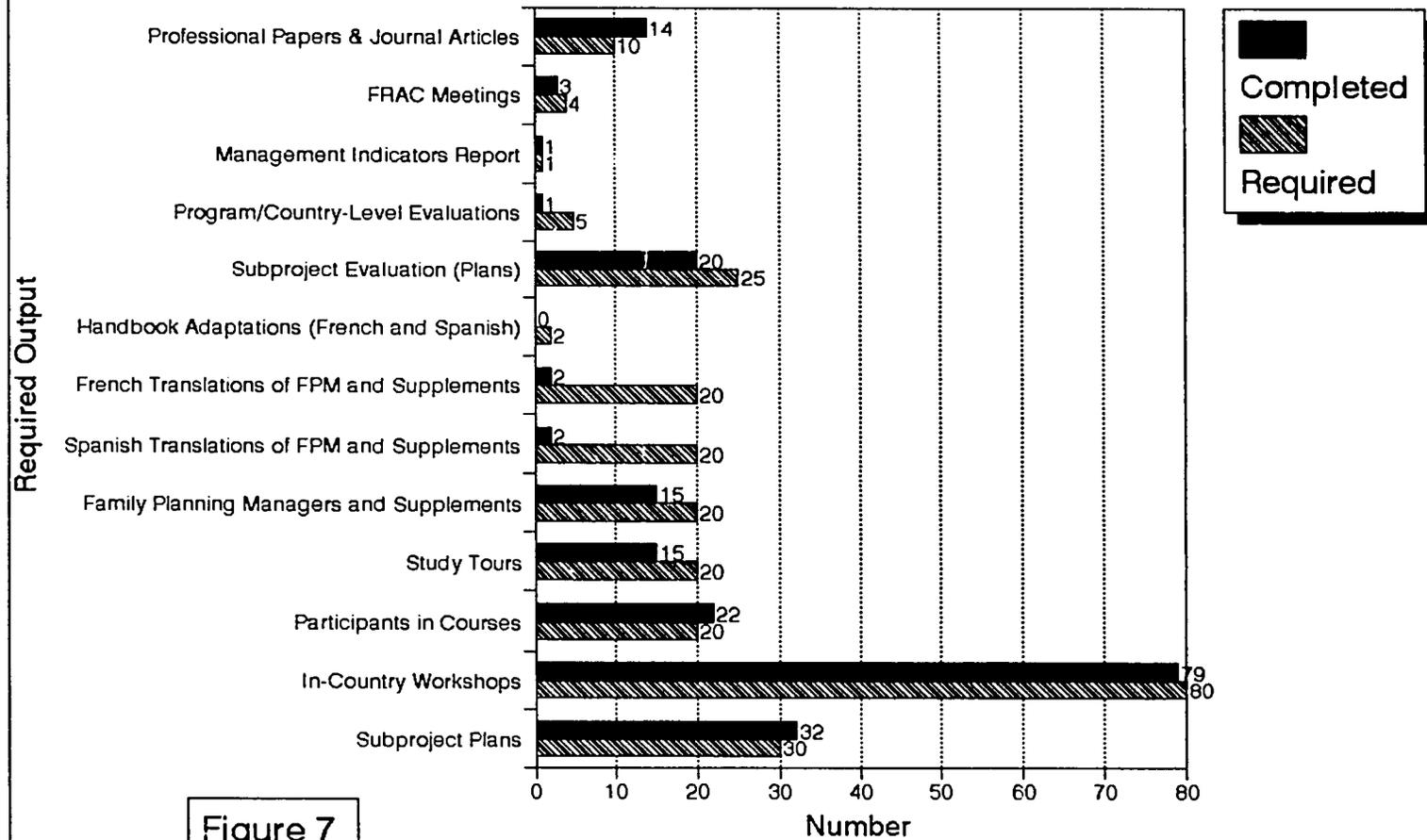


Figure 7

20.

The only area where weaknesses are evident is in publications, where translations of *The Family Planning Manager's Handbook* (published in March 1991) and *The Family Planning Manager and Supplements* have been very slow in coming. As one institution in Mexico said, "nine years is a very long time to deliver something in Spanish." Part of the delay can be attributed to the limited staff and budget allocated to the publications department. The fact that these two publications are greatly used and appreciated in the field, particularly at the management level, makes these delays all the more regrettable. Other deliverables such as in-country workshops, study tours, participants in courses, FRAC meetings, and subproject plans, have all been accomplished as part of FPMD's subproject activities.

3.3.2 Subproject Activities

Summary. Figures 8 and 9 offer an overview of FPMD subproject activities and the specific types of interventions provided. Since 1990, FPMD has worked in a total of 37 countries primarily providing technical assistance and training in areas specifically related to institutional management development. FPMD's portfolio includes 31 active subprojects in 14 countries throughout the world.¹⁸ Six of the 31 subprojects are regional activities (five in Africa, one in Asia). Of the 31 individual country activities the split between private and public sector is equal, although in Africa only three out of ten activities are in the public sector, versus Asia where four out of six are public sector activities. In LAC private and public sector institutions are equally represented. Successful work with private sector institutions, (especially small NGOs of relatively little "strategic importance") has often served as a catalyst to invitations to work in the public sector. Nine of the 25 active institutions worked prior to 1990 with FPMD. In the majority of these institutions the impact of multiple long term FPMD inputs is clearly evident. A number of subproject activities are conducted in cooperation with other USAID/CAs, and FPMD subcontracts with CEDPA to work with one NGO (Maendeleo) in Kenya.

FPMD's management interventions cover a broad range, and vary from institution to institution. MIS, curriculum development/skills training, quality of care, organizational structure, and strategic planning are the most frequent areas of intervention. While MIS is the most frequent area of intervention in all regions, more strategic planning and organizational structure have been done in Africa and LAC than in Asia. In contrast, curriculum development/skill training and quality of care are more common areas of intervention in Asia and LAC than in Africa. Logistics is an area which is rarely covered due to the existence of FPLM/JSI. In general, FPMD subproject activities can be described by the following three characteristics:

- *Aim to cover "depth and breadth" of organizational needs.* Beginning with a "management development assessment or MDA" (a needs assessment), FPMD works to fully comprehend the client institution and its needs. Its greatest success results where multiple interventions are provided at multiple levels over time (e.g., LIP in Bangladesh, FPAK, CIES in Bolivia).
- *FPMD works in close collaboration with their client institutions.* FPMD was consistently described as very responsive to the immediate needs of the institutions, as well as to the needs of other intervening agencies, including USAID missions and other CAs.

¹⁸ The nature of FPMD's activities and contract requirements makes definition of subprojects rather tenuous and results in variations in reporting the number of activities/subprojects.

OVERVIEW OF FPMD ACTIVITIES (ACTIVE AS OF MAY 1994)

Country	Subproject Start Date	Sector	Areas of Intervention (see legend next page)	Strategic Importance	Expenditures Thru 3/31/94
AFRICA					
Burkina Faso	MOH (1987)	Public	CD, OD, Q	65% of mod. method users	\$274,230
Kenya	CHAK (1988)	NGO	MIS, OD, FM, E	Underserved Pop.	\$371,651
Kenya	FPAK (1987)	NGO	FM, OD, SP, MIS, CD, E, Q	10% of mod. method users	\$375,347
Kenya	MSW (1991)	NGO	SP, MIS, FM, OD, Q	Innovative Model	\$41,783
Kenya	MKM (1991)	NGO	OD, MIS, SP	Underserved Pop.	\$208,224
Kenya	MYW (1989)	NGO	OD, FM, MIS	1.5 million served	\$18,008
Kenya	NCPD (1989)	Public	E, MIS, FG	70% of mod. method users	\$384,624
Kenya	NIP (1994)	Public	SP, OP	National Plan	\$0
Kenya	SDA (1991)	NGO	FM, MIS, SP, OD	Underserved Pop./Sust.	\$75,504
Nigeria	PPFN (1992)	NGO	SD, Log, OP, OD, FM, MIS, SP, Q	15% of CYP	\$573,649
ANE					
Bangladesh	LIP (1987)	Public	OP, OD, CD, MIS, E, Q, SD, FG, FM, Log, C	650,000 MRWA	\$3,498,105
Bangladesh	NGO (1992)	NGO	SP, CD, E, MIS, OD, FM, OP, Q, C	25% CPR/Model/Quality/Sust.	\$696,207
Nepal	FPN (1993)	NGO	OP, MIS, CD, E, Q, OD	20% of FP service/ Quality	\$96,801
Philippines	DOH (1991)	Public	CD, OD, E, Q, C	50% of MWRA	\$549,058
Philippines	DOH/LGUs (93)	Public	OD, CD, MIS, FM, E, OP, SD, FG, Q, Log, C	50% of MWRA	
Turkey	MOH (1991)	Public	MIS, Q, C, E	54.8% of mod. method users	\$310,760
Tunisia	ONFP (1990)	Public	FM, MIS, E, Q	39.5% of mod. method users	\$57,762
LAC					
Bolivia	CIES (1988)	NGO	OD, OP, MIS, E, FM, Q	32% CYP, 24% FP visits	\$231,254
Bolivia	CNS (1988)	Public	CD, SP, E, Q, OP	9% CYP, 5% FP visits	\$126,443
Ecuador	CEP (1988)	NGO	FM, MIS	Pop. Research/Training	\$57,503
Honduras	ASH (1993)	NGO	OD, MIS, SP, E, CD	59.5% of CPR/Sust.	\$93,331
Jamaica	NFPB (1992)	Public	MIS	National MIS/Quality	\$172,235
Mexico	FEM (1992)	NGO	FG, M, E	Model/Sustainability	\$104,482
Mexico	MOH (1993)	Public	CD, E, Q	15.5% of CPR	\$16,128
Mexico	MXF (1990)	NGO	FM, FG, Q, E	Model/Sustainability	\$260,929
Peru	MOH (1993)	Public	MIS, CD, OD, Q, E	36% of mod. method users	\$182,485
REGIONAL					
Africa	CAFS (1986)	—	CD, SP, OD		\$394,062
Africa	CLM (1992)	—	MIS, Log		\$66,210
Africa	CRP (1991)	—	OD, SP		\$244,843
Africa	FRAC (1987)	—	Q, OD		\$1,020,907
Africa	IPPF (1994)	—	SP		\$57,116
Asia	TRG (1993)	—	CD		\$1,502

* Expenditure for DOH includes that of DOH (LGUs)

Figure 8

22-

OVERVIEW OF FPMD ACTIVITIES (NOT ACTIVE AS OF MAY 1994)

Country	Subproject Start Date	Sector	Areas of Intervention (see legend below)	Expenditures Thru 3/31/94
AFRICA				
Cote D'Ivoire	(1991)		MIS	\$3,407
Rwanda	ONP (1991)	NGO	FM, MIS	\$5,562
Senegal	NGO (1991)	NGO	SP	\$83,118
Tanzania	UMT (1991)	NGO	C	\$143,541
Togo	FW (1991)	NGO	MIS	\$25,558
Zaire	PSN (1991)	NGO	E, MIS, FG	\$20,523
Zimbabwe	ZNF (1991)	NGO		\$125,122
Uganda	(1993)			\$39,956
ANE				
Cambodia	NGO (1992)	Public	OP, OD, SD, Q	
Egypt	NGO (1991)	NGO	SP	\$18,913
India	(1991)	Public	MIS	\$54,288
Indonesia	BKKBN (1990)	Public	OP, CD, OD, E, SD, Q, C	\$72,157
Morocco	INS (1992)	Public	CD	\$54,417
Sri Lanka	(1991)	NGO	OD	\$184,626
				\$19,249
LAC				
Bolivia	MOH (1993)	Public	OD, OP, MIS, E, FM, Q	
Bolivia	MUL (1993)	Public	CD, SP	\$231,254
Brazil	PAT (1993)	NGO	SP, FM	\$126,443
Ecuador	CEM (1992)	NGO	FM, MIS	\$55,448
Uruguay	AUP (1991)	NGO	OD, MIS, SP, E, CD	\$57,503
				\$93,331

Figure 9

LEGEND FOR TYPE OF INTERVENTION (Figures 2 and 3):

C	= Coordination
CD	= Curriculum Development/Training Skill
E	= Evaluation (subproject/country level)
FG	= Financing
FM	= Financial Management
LOG	= Logistics
M	= Marketing
MIS	= Management Information Systems
OD	= Organizational Structure/Personnel/Supervision
OP	= Operational Planning
Q	= Quality of Care
SD	= Service Delivery/Design
SP	= Strategic Planning

- *Flexibility in all its activities was identified as a major strength of FPMD.* Tailoring its interventions to best suit the social, cultural and economic needs of its clients, FPMD accesses MSH/Boston based, as well as in-country staff and consultants, to provide high quality technical assistance.

Areas of Concern. Given the variety and extensiveness of FPMD's subproject activities at present -- and its potential for the future -- a few areas of concern were identified:

- Difficulties communicating what FPMD really does and with whom it should best do it. The broad and sweeping scope of their activities makes it difficult for FPMD to either "niche" itself in a particular domain, or to efficiently "market" its product.

Recommendation: A clear and logical conceptual framework for operationalizing FPMD's management interventions, including internal examination of these interventions (what do we do?, with whom?, why?, how?), and a more appropriate contractual arrangement would facilitate this process.

- Need to include field perspective, especially at the service delivery level, in their management interventions.

Recommendation: Work closely and collaboratively with service delivery CAs such as Pathfinder in order to strengthen and enhance capacities of the partner CAs as well as the client institution to manage service delivery.

- Need for documentation of all management interventions so client institutions can replicate and share expertise gained from FPMD.

Recommendation: Develop body of "procedural guidelines" (templates) which can be used and adapted to the specific socio-cultural/situational needs and demands of client institutions, with or without outside assistance as the situation requires.

3.4 Evaluation

FPMD has recently developed a cohesive and comprehensive evaluation plan that incorporates the following elements:

- evaluation of FPMD work in five of the major countries where it operates (Bolivia, Mexico, Kenya, Bangladesh and the Philippines), including evaluation of the 17 subprojects in these countries;
- evaluation of two major FPMD programs (FRAC and publications program);
- evaluation of MIS in the eight subprojects that are dedicated exclusively to MIS or that have MIS components;
- evaluation of the seven remaining subprojects that do not include MIS subprojects and that are not included in the country evaluations; and
- final comparative evaluation of major selected management interventions.

By successfully executing this plan, FPMD will achieve the contract requirements of conducting 25 subproject evaluations and five program/country-level evaluations. At the same time, it will have

also evaluated project performance in the countries in which it works most. It will also have evaluated the management intervention that it most supports: MIS.

Evaluation is, however, the one component of the project that has been slowest to initiate activities. The slow start-up has been caused in part by the lack of an overall evaluation plan to guide the project and by the fact that the staff positions in the Evaluation Unit have been vacant during much of the project period to date. The slow start-up is also a consequence of the nature of evaluation activities since time must elapse and activities have to be well along or concluded before evaluation can be conducted.

Of 25 subproject evaluations to be conducted, 20 evaluation plans have been prepared. These plans specify for each subproject the evaluation objectives, methodology(ies) and the process and impact indicators for each subproject. There are five program/country-level evaluations which are in progress (Bolivia, Mexico, Bangladesh, Kenya, and the FRAC).

Several preparatory evaluation activities have taken place which will serve as inputs into the evaluations that have been planned. For example, a quantitative impact of evaluation and a qualitative evaluation of TQM/CQI has been conducted at MEXFAM. The results of these evaluations will be incorporated into the country evaluation in Mexico.

FPMD's current evaluation plan emphasizes a qualitative approach to subproject and country evaluation. This approach should be pursued due to the difficulties in quantifying the impact of management interventions on service access, quality and coverage.

The final comparative evaluation will examine selected major management interventions from across FPMD subprojects. As one of the interventions, the final evaluation should consider examining FPMD's experience with TQM/CQI in terms of its cost-effectiveness. FPMD is committing increasingly more resources to TQM/CQI and needs to evaluate it further, and possibly adapt/simplify it, before replicating it in other settings.

3.5 Coordination With Other USAID Projects

FPMD was designed as a single-focus project: the improvement of FP management systems and practices. As the project does not provide direct assistance in the delivery of family planning services (e.g., contraceptives, medical equipment, financing, technical-medical training, etc.) but works mainly with host organizations which do provide family planning services, it must necessarily interact with other USAID financed CAs working with many of the same host institutions. This was both foreseen and encouraged in the original project design.

The ET found that FPMD in fact does interact extensively and cooperatively with other USAID CAs, though perhaps not as closely as is desirable with respect to the technical aspects of FP service delivery at the lowest levels.¹⁹ Appendix M details the nature of FPMD interactions with other CAs.

An unusual component of the FPMD project is its ability to provide TA and systems support to other A.I.D.-supported CAs and organizations. At first, the ET had some difficulty with this concept and

¹⁹ The need for FPMD to focus at these lower service-providing levels is detailed elsewhere (see esp. pp 29, 33, and Kenya Country Report).

was skeptical of its utility if not propriety. Further examination of this "feature" of FPMD, however, led the team to the strong belief that such interaction is appropriate and can in fact be very effective in moving toward common goals. The CA-NGO subproject in Bangladesh is an example. While CA coordination meetings and donor coordination meetings are ubiquitous in the development world, they are most often sterile and of limited value. In the case of Bangladesh, they are anything but that: CAs (including indigenous organizations and the more traditional USAID CAs such as Pathfinder and AVSC) are interacting on a substantive level to create a common dictionary, common approaches to strategic planning and project management, to training impact evaluation, and common reporting systems which will facilitate overall program coordination by USAID/Dhaka. Recipient host organizations will benefit considerably from this work, particularly those receiving support from multiple CAs.

Numerous requests are being received from other CAs (and USAIDs!) for FPMD assistance in developing stronger management systems and practices. The ET is of the considered belief that FPMD should be encouraged to respond to these requests, and should view them as opportunities to achieve synergistic benefits for all parties.

3.6 Dissemination of Management Intervention Materials

The FPMD Publications and Communications Unit (PCU) has developed an impressive portfolio of management materials which began under FPMT with the development of *The Family Planning Manager's Handbook: Basic Skills and Tools for Managing Family Planning Programs*. The English edition of *The Family Planning Manager's Handbook* has become a standard text for use by family planning managers and is used in management training courses. In response to requests from Francophone and Latin American countries, French and Spanish editions are being developed under FPMD. There are plans to print 5000 copies each of the French and Spanish editions and distribute them during 1994. However, the contractual target to produce these two adaptations of the Handbook has not been achieved (please refer to Figure 7).

Management intervention material developed under FPMD include:

- *The Family Planning Managers and Supplements*
15 of 20 *Family Planning Managers* and Supplements have been published, two of the required translations in both Spanish and French have been completed
- *Family Planning Manager's Pocket Publication*
- Professional Papers/Journal Articles
14 of 10 required professional papers/journal articles have been published
- Field-based publications
- Reports: semi-annual, trip, technical, informational (Fact sheets)

The FPMD materials are highly regarded and reach a large family planning audience:

- Population and Development Professionals
- Policy makers
- Regional coordinators
- Senior program managers and middle program managers
- Clinic Managers
- In-service Trainers

The Family Planning Manager and Supplements

The PCU conducted a survey regarding *The Family Planning Manager* and Supplements to quantitatively and qualitatively assess its dissemination and utilization. The returns of the reader survey indicated that for each person who receives *The Family Planning Manager*, the copy is shared with five other persons. From these data, the PCU estimated that *The Family Planning Manager* is reaching approximately 40,000 family planning and health professionals around the world, in 165 countries, at less than \$.35/copy. The disseminated material is used by the reader audience to increase personal knowledge, for individual staff development, and for group training. *The Family Planning Manager* appears to be an effective vehicle to transfer management technology by providing a forum for sharing management innovations and lessons learned in successful family planning programs.

Field-based Publications

In the area of Field-based Publications, FPMD is providing technical assistance to the Bangladesh Local Initiatives Program (LIP) in the development of a series of training manuals. The ELCO Mapping materials have been translated into Bangla and the ELCO mapping management tool has most recently been introduced in Kenya where an LIP staff member provided technical assistance to the FPAK in its application by CBD agents.

Reports

The PCU has also produced six Fact Sheets which disseminate information about successful management interventions, but even these do not clearly reflect the role of FPMD. FPMD has not communicated in written form exactly what it is that FPMD does. Heavy process orientation versus logical descriptions of activities dominates FPMD communications. To a large extent the constraint comes from the nature of the contract and FPMD's lack of an operational framework.

Characteristics of FPMD Materials

Field visits revealed that FPMD has assembled some excellent management intervention materials. The content and context of these materials have been targeted to organizations through policy boards, senior managers and middle managers with major administrative responsibilities. Other management intervention materials have been focused and applied to supervisors and trainers within those organizations with administrative responsibilities at district levels and FP service delivery responsibilities. However, the content and context become progressively less focused and adapted for the supervisory and trainer staff level and staff below these levels whose responsibilities are primarily FP service delivery.

FPMD develops good management intervention materials, but the materials typically stop at mid-management levels and are difficult to use/translate into action at service delivery levels where practical, user-friendly interventions are necessary. An example is the MIS developed in Kenya with the NCPD to gather service delivery statistics from numerous GOK and NGO service providers: in the opinion of the ET, its content is far too complex to be practical in the field, and if actually used is likely to place an unreasonable administrative burden on fieldworkers and supervisors.

The Family Planning Manager's Handbook and the *Family Planning Manager* Newsletters are notable examples of "TOP-DOWN" level successes (policy, senior and middle management to clinic supervisors) in provision of technical assistance for management assessments, management

development plans, management information systems, training courses and workshops, and publication of management materials. The most striking finding in the "TOP-DOWN" model has been the absence of sufficient documentation to assist middle managers to effectively implement and operationalize the management interventions below the clinic supervisory level.

There are equally notable examples of "BOTTOM-UP" level successes (service provider supervisors, staff service providers, and volunteer FP workers) in technical program collaboration, decentralization of FP systems, and integration of public and NGO activities. The outstanding example is the Bangladesh Local Initiatives Program (LIP). The most striking finding in the "BOTTOM-UP" model has been the creation of excellent, detailed but elementary documentation (e.g., management and workplan manuals, guidelines, checklists, and training manuals for supervision and monitoring) to effectively implement and operationalize local FP service delivery directly to their clients.

There is no question that separately these "TOP-DOWN" and "BOTTOM-UP" technical collaborations, management interventions and management materials are an impressive accomplishment.

FPMD has vigorously pursued the range of methodologies associated with the aforementioned five project outputs and in many respects has been highly successful in establishing distinct operational and structural organizational changes and improvements, reflecting achievement of project purposes, at particular organizational level(s) and for various stages of organizational development.

However, systematized integration of these "TOP-DOWN" and "BOTTOM-UP" accomplishments in a comprehensive framework for all organizational levels of FPMD public and NGO clients would have been more impressive in terms of institutionalizing strengthened FP organizational development.

The lack of systematized integration has resulted in inadequate documentation of FPMD's specific management interventions. For example, no "guidelines" exist on how to do Strategic Planning. Clearly it is desirable to maintain the "flexibility" to approach each institution as a unique entity, but at the same time it is necessary to avoid such problems as:

- (1) Lack of consistency in approach, or of shared philosophy/dictionary among consultants doing, i.e., Strategic Planning. Where is the "added value" of MSH's years of management experience if each consultant has his/her own modus operandi?
- (2) Inability for the average FP organization to replicate the intervention. (Exceptions, of course, are organizations like FPAK with outstanding leadership and a long history of working with FPMT/FPMD.)

3.7 Factors That Have Aided or Impeded Implementation

A number of factors have aided and impeded project implementation, including the following:

Factors which have aided:

- USAID mission support and guidance: USAIDs have generally been very supportive of FPMD;
- Growing recognition of the importance of management interventions among USAIDs, CAs, regional organizations, other donors, and host country institutions;
- FPMD's design which emphasizes holistic assessments of management needs, TA and training interventions (and not other forms of support): FPMD is universally seen as an organization with little to offer other than good advice.....it has no axe to grind, and does not "buy" entry into organizations it assists;
- Wide appreciation of and respect for the quality of FPMD TA;
- FPMD's flexibility in tailoring approaches to situational factors in client institutions, rather than "prescribing" canned solutions; and
- The quality and utility of FPMD publications such as *The Family Planning Manager* and the *Handbook*.

Factors which have impeded:

- The "C"/"Q" contract mechanism and its attendant complications;
- Personnel changes in MSH headquarters and the field and in USAID monitoring personnel in Washington and the field;
- A tendency toward micro-management, both on the part of USAID (largely the result of the contracting mechanism) and MSH (highly centralized decision-structure);
- USAID tendency, on occasion, to use FPMD to "fill gaps" rather than as a strategic tool;
- Some loss of overall direction and focus: the result of the four above-listed factors;
- Limited ability of FPMD to influence the choice of subproject activities; and
- The Gulf War.

All of the above influences are discussed in appropriate sections of this report.

4. PROJECT EFFECTIVENESS AND POTENTIAL FOR IMPACT

4.1. Progress Toward Achievement of Project Purpose

The purpose of FPMD is "to promote institutional development and strengthen the management capabilities of public and private family planning organizations, to enhance the quality and sustainability of their services." Achievement of the project purpose will be determined by the attainment of the following conditions:

- institutions are better able to define objectives and meet targets on schedule while maintaining or improving program quality, coverage and accessibility;
- institutions implement mission statements, structures, strategies and systems which support quality service provision; and
- institutions are increasingly sustainable over time.

A number of institutions that have been assisted by FPMD are better able to define their objectives and meet targets on schedule while maintaining, and frequently improving, program quality, coverage and accessibility. Examples observed during the evaluation include:

- **Define Objectives.** Maseno West, following a single strategic planning exercise was able to restructure their organization and set clearly defined objectives, not just for their health care activities, but for other projects as well.
- **Meet Targets.** The Mkomani Clinic, offering comprehensive health care services to the local population, worked with FPMD to develop their MIS. Despite the lack of a practical field perspective, Mkomani is now able to set clear operational targets for their family planning services. During the last year they have consistently exceeded these targets for "new acceptors."
- **Improve Quality.** In Bangladesh, through ongoing management training and supervision, LIP has facilitated improved service delivery at the field level. Family health workers are better supervised, trained, and equipped to diagnose and treat women's reproductive health issues, and to provide modern contraceptive methods -- largely due to the management systems LIP has helped put in place.
- **Improve Coverage.** LIP continues to expand the number of Thanas in which it is implementing its management interventions. Its demonstrated success in developing systems to improve the delivery of quality health services and family planning in other areas has stimulated interest at both the government and community levels.
- **Improve accessibility.** Accessibility of family planning services has been improved at institutions in Bolivia where the service network has doubled at CIES and service volume has increased more than 120% at CNS.

FPMD-assisted institutions have also implemented mission statements, structures, strategies and systems which support quality service provision. These institutions are also becoming increasingly sustainable, both technically and financially. Examples include:

- **Implement mission statements.** Mission statements have been implemented at institutions such as CIES in Bolivia where the institution's mission was re-defined to specifically focus on family planning service delivery, resulting in expansion of the service network.
- **Implement structures.** In Bolivia, an organizational chart at CNS was developed for the Reproductive Health Program, a matrix program management structure was introduced and staff was assigned, allowing CNS to effectively organize and provide family planning at its nationwide network of hospitals and clinics.
- **Implement systems.** Planning and evaluation workshops are held systematically at CNS in Bolivia in order to set service delivery and IEC goals, evaluate goal achievement, identify service delivery problems and recommend solutions.
- **Increase sustainability.** Institutions are becoming increasingly more sustainable. Information regarding price setting, cost control and new markets provided by FPMD and INOPAL-supported studies will enable FEMAP affiliates in Mexico to make decisions that positively affect their financial self-sufficiency. MEXFAM, also in Mexico, is utilizing US fundraising techniques as one of its cost recovery strategies. Mkomani in Kenya is establishing a laboratory as a means of generating income for family planning service delivery.

To highlight FPMD's progress toward achievement of the project purpose, the following cases are given.

The FPMD Approach to Management Development: Long-term Involvement, Comprehensive Management Interventions. FPMD has made significant progress toward achievement of project purpose in institutions where it has been able to implement the management development approach envisioned in its technical proposal. This approach is characterized by long-term involvement with host institutions and provision of comprehensive management interventions based on an initial management needs assessment. (See Appendix M.)

An example of the effectiveness and potential impact of this approach is Bolivia where project activities began under FPMD. In Bolivia, FPMD conducted a country-wide needs assessment and consequently identified the institutions to which to target its assistance. FPMD then provided assistance to two institutions, CNS and CIES, to define their institutional missions, organize their structures to support service provision and implement management systems. Services at both institutions have expanded and there is evidence that service quality is improving. CIES, which is an NGO, has also greatly enhanced its sustainability.

Non-Government Service Providers

FPMD's work to date has shown the potential impact that management development can have, in a relatively short time, on NGOs. However, since NGOs frequently cover only a small share of the target population, their "strategic importance" is sometimes questioned. The relative size of these groups allows FPMD to provide perhaps only one intervention, such as strategic planning, but whose impact can permeate the entire organization. In Maseno West, in Kenya, for example, this single

exercise enabled the organization to implement structural, personnel, and financial changes which have clearly improved their ability to provide expanded and quality services, both in family planning and in the broader health sector. The ET feels that NGOs are appropriate clients for FPMD, but suggests some consolidation of efforts in working with NGOs like in the CA/NGO project in Bangladesh.

The Bangladesh Model

A unique activity in the FPMD portfolio is the Local Initiative Program (LIP). LIP has operated since 1987 to improve the performance of the Bangladesh Family Planning Program at the grassroots level by strengthening the management capability of government (Thana level) family planning staff and local leaders. LIP does not itself deliver services. Rather, it works closely with existing BDG personnel (MOH and local government) to maximize the use of available resources. Through management training, technical assistance and the provision of small grants, Thana level government employees and institutions (e.g., local health committees) are strengthened. In addition, an active program of monitoring and supervision of project interventions and service providers has resulted in:

- Government employees who are better able to define their job and performance objectives;
- An expanded network of trained service providers (volunteers) who motivate clients (their neighbors) and resupply contraceptives (pills and condoms) at the village level; and
- Service delivery workers (paramedicals) who are providing modern methods (IUDs, Depo-provera) and quality women's health care, as demonstrated by their knowledge, ability and capacity to diagnose and treat reproductive related diseases²⁰.

The potential sustainability and replicability of this model must be exploited by FPMD. Documentation developed during the course of this project demonstrates the impact which management interventions can have when fully implemented in a comprehensive top-to-bottom fashion from upper management down to the service delivery level.

Difficulties in Determining Impact

A number of difficulties arise, however, in assessing the effectiveness of FPMD to achieve its purpose. In many cases, FPMD is not the only agency assisting specific host country institutions, and thus, improvements in service quality, access and coverage are difficult to attribute to the work of one particular CA. Another difficulty is the relatively short amount of time that FPMD has worked with most host institutions. FPMD makes a long-term commitment to institutions. It also makes interventions in succession which take time to complete and require even more time to have impact at the service level. In addition, USAID mission requests for assistance with specific interventions at specific institutions frequently preclude needs assessments which would determine which institutions and interventions to support with management assistance. As a result, in a number of cases FPMD finds itself supporting institutions and/or single interventions that may not be the most effective or have the most potential for impact.

On the other hand, in some instances assistance with single interventions which initially appeared to be of limited potential impact have proved to be important initial steps in collaborating with some

²⁰ An important part of capacity is the availability of medical supplies and pharmaceuticals.

institutions. Provision of management assistance requires trust between FPMD and the host country institution. The opportunity to assist initially with a single intervention has often "set the stage" in developing a mutual trusting relationship which then enables FPMD to provide assistance for multiple interventions.

4.2 Unanticipated Project Effects

Many of the institutions that FPMD assists are not exclusive family planning service providing organizations. Thus, the management assistance FPMD is providing is not only strengthening family planning management capacity but also that of integrated delivery systems.

The demand for FPMD's management expertise is growing among other CAs, USAIDs, other intermediaries, and non-family planning organizations. This demand is somewhat greater than anticipated, and is considered by the ET to be both a reflection of the high esteem other organizations have for FPMD and the increasing awareness of the importance of management improvement. Some of the demand can probably be best met in the future through the sharing and wide distribution of FPMD publications and other management-related materials.

5.0

RECOMMENDATIONS

5.1 Overview

In FPMD II (and III), the overall project goal and purpose should remain the same. However, certain long-term strategies need modification or redirection. The Evaluation Team is NOT recommending five more years of the same approach taken by FPMD I. In its next phases, FPMD needs to move toward a more proactive selection of its client organizations, and toward building and empowering local TA capacity (vs. what has been a heavily centralized operation under FPMT and FPMD). Also needed is a broadening of targeted levels and activities in client organizations, extending to all management and service delivery levels from top to bottom. This reorientation needs to include strategic materials development & dissemination. It will also require a modest but critical change in overall management style from a highly centralized one to an approach more supportive of distributed decisionmaking.

5.2 Long-term Goals and Strategies

Current Situation. FPMD aims at providing a variety of management interventions at different organizational levels in strategically important organizations; these interventions are intended to result in sustainable service delivery improvements and strengthened client organizations.

Problem. The central problem is that the underlying strategy used by MSH at present falls short of that required to maximize the impact of its own management interventions. For example, FPMD is not:

- always working in the right countries or with the right organizations ("right" meaning those which are strategically and operationally most important);
- working effectively at lower organizational levels, due to a preoccupation with middle and upper level management problems, a lack of genuine field perspective, and a paucity of FP service delivery experience among its staff and consultants;
- utilizing local technical assistance capacity to a degree desirable to realize efficiencies of continuous, in-country TA inputs (except in LAC); and
- developing documentation necessary for implementation of management interventions at all levels, especially the service delivery level (exception: LIP/Bangladesh), and which can be used across projects and countries.

Recommendations.

- (1) The Evaluation Team strongly recommends that the FPMD long-term strategy be modified to include actions within a 20-year conceptual framework such as that shown in **Figure 10** in which four five-year FPMD operational phases are identified: emergence, growth, consolidation, and sustainability.

FPMD CONCEPTUAL FRAMEWORK

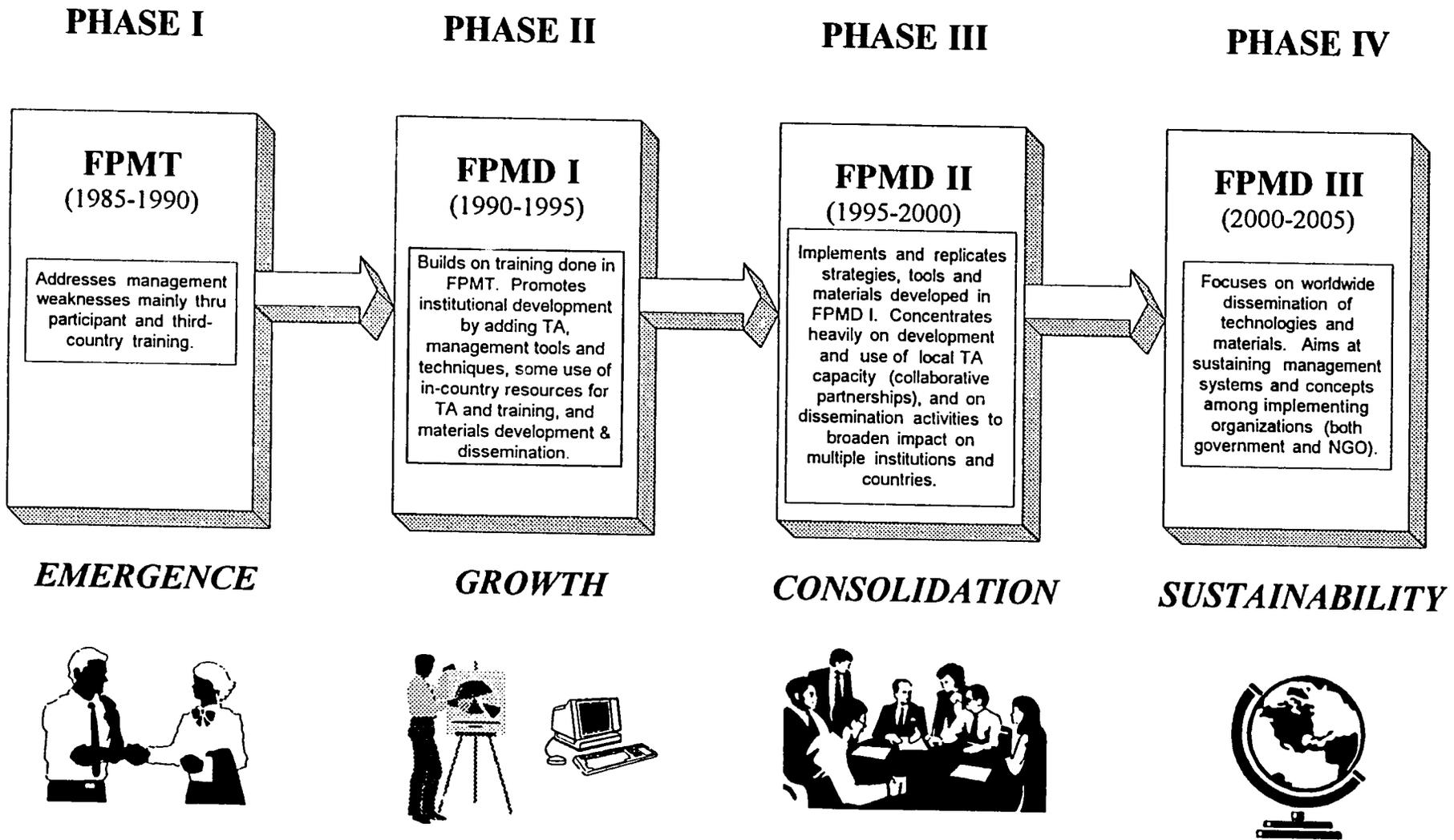


Figure 10

- (2) The end of FPMD I (1995) will signal the half-way point in the 20-year effort, i.e., the end of the "growth" phase (meaning the growth and development of management tools, techniques, strategies). During the next phase, FPMD II, focus should be on the following:
- (a) a more proactive role in targeting and choosing countries and organizations to receive FPMD II assistance;
 - (b) a close, collaborative partnership with service-delivery CAs to complement skills and mandates in order to effectively address management interventions at all appropriate levels from top to bottom in an integrated, coherent fashion;
 - (c) greater emphasis on strengthening of local TA capacity including a shared vision, a shared "dictionary", and shared approaches; and
 - (d) a determined effort to create necessary documentation, both generic and project-specific, in support of (a), (b), and (c) above, and to disseminate such documentation widely.

Each of these four strategic recommendations is further delineated in the four sections below.

5.3 Choice of Countries and Activities

Current Situation. FPMD has graciously accommodated the needs and demands of both USAID and CAs, perhaps to a greater degree than warranted. Choice of country and activities is not always optimized to achieve management impact from interventions.

- Problem.**
- The USAIDs generally make choices with respect to client institutions, and often feel strongly about their prerogative to do so;
 - FPMD has not targeted nor marketed its services and products effectively to appropriate clients; and
 - FPMD often responds to ad hoc requests (including those from organizations making piecemeal requests).

Recommendation.

- (3) The contractor should develop specific strategies to better influence the choice of countries and activities in which it engages. These strategies need to be developed in close collaboration with the Office of Population and the regional bureaus in order to be responsive to Agency strategies and priorities. The strategies should include a clear identification of products and services which FPMD offers, and an effective marketing plan for these products and services.

5.4 Relation to Other USAID Activities (Bilaterals and CAs)

Current Situation. The USAIDs and other CAs (and their CTOs) often aren't entirely aware of what FPMD actually does, or is capable of doing. FPMD isn't always making fully effective use of its relationships with CAs, especially service-providing CAs.

Problem. FPMD is....

- not marketing itself well; and
- not operating under a strategy which allows it to effectively use relationships with other CAs, especially FP service-providing CAs.

Recommendations.

- (4) FPMD should develop a marketing plan and implement it. This plan should explicitly address the potential for FPMD assistance under USAID bilaterals and regional projects (through buy-ins or other arrangements) as well as interfacing with other USAID CAs.
- (5) FPMD should undertake an examination of mutual goals, expectations and responsibilities in each collaborative CA relationship. It should enter into relationships having a maximum potential for use of complementary expertise, i.e., enhanced management geared directly to improved FP service delivery interventions.
- (6) FPMD should exploit the requests it has received (and will likely receive) from other CAs to provide management expertise; it should approach these requests in the context of (5) above.

5.5 Building Local TA Capacity

Current Situation. FPMD has been using local consultants effectively in a number of countries, from TQM/CQI consultants in Mexico and MIS consultants in Kenya to LIP in Bangladesh where a local subcontractor implements a large-scale project to strengthen local-level planning and management skills in support of BDG goals under a USAID/Dhaka buy-in.

Problem. While the use of local consultants has been developed somewhat under FPMD I, their potential has not been fully realized. Further, it is doubtful if FPMD could hope to accomplish its institutional development goals without the more extensive and coordinated use of local TA capacity.

Discussion. To institutionalize improved FP organizational development and improved performance of FP organizations over time, it is necessary to build greater local capacity and empowerment among local colleagues to sustain management interventions from top to bottom levels, particularly at the service provider level.

Enhanced collaborative partnerships would address the need to build greater local capacity and to empower as well as create the opportunity for local experts to integrate management interventions, design appropriate materials and introduce documentation at the FP service provider level.

FPMD need not establish an additional separate capacity to work at the service provider level of FP organizations. An open and equal collaboration and partnership with CA's working with local FP service delivery organizations will provide FPMD the opportunity to integrate management interventions and create materials and documentation in an operational framework appropriate for service providers.

Recommendations.

- (7) It is strongly recommended that FPMD strengthen its technical collaboration with local colleagues and CA partners in order to work effectively at the service provider level of FP organizations through enhanced collaborative partnerships. These partnerships should be developed along lines indicated above.
- (8) In developing local consultant capacity, the focus should be on the creation of in-country networks of consultants (primarily from the private sector or NGOs) having a shared vision, shared "dictionary", shared approaches, and shared systems and materials. Opportunities for "multiplier" subprojects such as the CA/NGO project in Bangladesh should be exploited.

5.6 Use of Management Interventions and Materials

Current Situation. The management interventions and the materials created by FPMD have been well received by their clients. The technical assistance, collaboration, and expertise of FPMD staff and consultants are all held in high esteem. However, FPMD's management interventions and materials focus mainly at the upper and middle management levels. Technical consultations generally do not leave any or sufficient documentation to assist clients to implement the interventions at the next lower level so that there is a "continuous chain of clients served" which extend from the top organizational levels to the bottom where FP service delivery actually takes place.

Problem. The fundamental problem is the absence of an explicit operational and structural framework that communicates and focuses FPMD management interventions and materials, with supporting documentation for implementation at all FP organizational levels, in a clear, uniform, and codified manner. LIP/Bangladesh has the operational potential to apply one such framework. However, FPMD is not making full use of the potential of this subproject for developing, refining, and disseminating management materials and know-how at the peripheral level.

Discussion. The technical content and contextual format of FPMD materials are complex and require high-level reading skills. Enhanced collaborative relationships with local colleagues and CA's would augment FPMD's capability to respond to both upper and lower service provider levels in language syntax, technical content and format that are appropriate, practical and useful for each level, thus creating an explicit, effective and comprehensive operational and structural framework for FPMD II.

Both the LIP activity in Bangladesh and other CA partnerships could provide the experience and opportunity for FPMD to document its management interventions and to operationalize the innovative structures of FPMD management systems with progressively more readable, applicable, adaptive, and practical formats. This would help to transfer the competencies (knowledge, skills and attitudes) to staff who need and could benefit from competency-based materials at the FP service provider level.

Recommendations.

- (9) FPMD should establish a clear conceptual and operational framework for the development, testing, refinement, and dissemination of its management methodologies, systems, and materials. This framework should be linked to cooperative partnerships with other CAs and

to the building and empowerment of local technical assistance capacity, as well as be linked more directly to the provision of quality, sustainable, cost-effective family planning services.

- (10) In addition, FPMD should better exploit its experience with LIP/Bangladesh in regard to the development of management tools: in documenting them, in developing "templates" or "prototypes" specifically intended for adaptation elsewhere, and in disseminating systems, materials and lessons learned.²¹

5.7 Contracting Mechanism

The current contracting arrangement (core and requirements contracts) impose an unnecessary and complex management load on both USAID and the contractor.

Recommendation.

- (11) For FPMD II, USAID should consider the use of a more flexible contracting mechanism which takes into account the institutional development goals of this project and focuses less on relatively meaningless quantitative deliverables. A Cooperative Agreement might be more suitable, particularly in terms of the long-term institution-building activities and subactivities of the project.

5.8 Level of Effort

Keeping in mind the strategic redirections outlined above, and the greatly intensified effort in consolidating, adapting, and disseminating systems and materials developed under FPMT and FPMD I, some readjustment in overall level of effort and in allocation of resources is indicated.

Recommendations.

5.8.1 For Core Staff

- (12) The present level of Boston-based core staff is believed to be adequate for the purpose of both FPMD I and II. Staff is of uniformly high quality. However, additional core financing of field personnel would be desirable, particularly if the ET's recommendations for a greater level of effort in FPMD II are accepted. FPMD also may need to redistribute human resources within the project to fully implement strategic changes recommended, e.g., increased emphasis on dissemination, developing CA partnerships, better marketing of capabilities, stronger service delivery management capacity, etc.
- (13) In addition to Boston-based and field staff, funds should be provided under the core agreement for a limited number of in-country administrative staff to be placed in key countries (one per country).

²¹ A start in this direction has been made with ELCO mapping, adapted from Indonesia, refined in Bangladesh, and exported to Kenya using local staff in an international consulting job.

5.8.2 For U.S. Consultants

- (14) The use of U.S. consultants should be phased down as in-country staff and consultant capacity is augmented. U.S. consultants should continue to be used for the direct provision of TA in some cases, but overall their use should be reoriented toward: (1) building local TA capacity; (2) identifying and bringing U.S. and cross country perspectives and technical expertise; and (3) gaining entry where local consultants can't readily be used (e.g., the CA/NGO subproject in Bangladesh).

(Note that it is unrealistic to expect that host institutions can be fully "weaned" from the need for outside technical assistance. Host institutions, like major U.S. corporations, will likely continue to have some level of need for consultants to address specific management problems. It is the hope of the ET that some or much of this need increasingly can be met through the use of local consultants.)

5.8.3 For In-Country Staff

- (15) In-country staff of FPMD should be mostly local wherever possible. Expatriate staff should be used only exceptionally, where there is good reason to do so (e.g., in a country with a large FPMD portfolio an expat might be required to provide administrative and financial interfacing with USAID and A.I.D./Washington). Where local technical personnel are unavailable to provide management-related services, FPMD should attempt to recruit and develop such in-country expertise.

5.8.4 For Building Local Consultant Capability and Networks

- (16) Except in the case of Latin America and the Local Initiatives Program (LIP) in Bangladesh, FPMD makes heavy use of Boston-based MSH consultants to provide TA. There is a need for MSH to make other regions more like LAC in the use of consultants, taking a more systematic approach to the development and use of in-country consultants in order to maximize their long-term impact. The focus should be on the creation of in-country networks of consultants (primarily from the private sector or NGOs) having a shared vision, shared "dictionary", shared approaches, and shared systems and materials.

5.8.5 For Training (Short & Long Term)

- (17) Long-term training is deemed by FPMD and the ET as not necessary under FPMD II. A greater emphasis should be placed on short-term training, however, conducted more in country and more on a regional basis (e.g., work with selected regional institutions like CAFS to build capacity to conduct management workshops.). Relatively little U.S. based training has been done under FPMD; this pattern should continue, i.e., placing maximum emphasis on short-term, localized, in-country training with judicious use of U.S. based training for special circumstances. Similarly, study tours should be increasingly focused on in-country experiences where possible (as in Bangladesh), with international study tours limited to special cases (mostly, high-level personnel in need of cross-cultural policy and program exposure).

5.8.6 For Materials Development and Dissemination

- (18) The ET recommends that the level of effort for materials development and dissemination be significantly increased in FPMD II, in line with the need to maximize the transfer of management skills across projects and across countries. Without in-depth analysis of the specific elements in an expanded effort, the ET is unable to quantify this recommendation, except to note its strong impression that "much more needs to be done". In considering the question of "how much?", the following general recommendations should be examined.
- (a) The role and objectives of the Publications and Communications Unit (PCU) should be expanded to include functions appropriate to the expanded strategic objectives outlined above. Specifically, these should encompass the design, development, testing, documentation, and broad-based dissemination of the management systems, technologies, and materials developed under FPMT and FPMD I.
 - (b) Greater emphasis should be placed on making these products available in French and Spanish and, where appropriate and possible, in other languages (e.g., Portuguese and Bangla).
 - (c) FPMD should develop an explicit strategy and operational plan for materials development and dissemination under FPMD II, taking into account the extraordinary and growing demand for management related materials. This strategy should include appropriate channels for information dissemination, including through electronic means where feasible and appropriate²².
 - (d) FPMD should investigate the potential utility of Adaptable Template Technology (ATT) as a model for facilitating the transfer of management expertise from one place to another. Templates could be used, with or without FPMD TA as the situation demands, to maximize the transfer of good management ideas and systems from one setting to another within countries, regions, and beyond. In all likelihood, they would result in increasing demands for FPMD-like management assistance -- a desirable result. Further thoughts on the possible use of ATT for FPMD are included in Appendix L.

5.9 Funding

- (19) Core costs must be fully funded, taking into account those resulting from anticipated buy-ins. In general, USAIDs and host countries are unwilling to support core costs through the use of bilateral monies (e.g., buy-ins), resulting in a situation where buy-ins usually result in additional demands on FPMD resources provided within "core costs".

²² FPMD has already begun its thinking along these lines and has developed some preliminary thoughts. These should serve as a point of departure for a more in-depth examination of this very critical FPMD function.

In the opinion of the ET, it would be prudent to envision overall levels for FPMD, including buy-ins, increasing over the next ten years to at least the following magnitudes:

- LAC and Asia/Near East -- increase up to two times FPMD I level
- Africa -- increase up to three times FPMD I level
- NIS & Eastern Europe -- an additional amount as desired by USAID²³

5.10 Reporting, Monitoring, Evaluation (RME)

- (20) Improvements are needed both in terms of USAID requirements for RME and in contractor capacity to provide needed information. FPMD should pursue its present efforts to automate the reporting functions insofar as possible, to be consistent with both USAID and MSH requirements. FPMD should also move quickly to implement its new subproject evaluation plan. USAID should adopt, and stick with, a financial and a management reporting plan commensurate with principles now being laid out in the work of various committees concerned with "reengineering". These plans should minimize the monitoring and reporting burden (on both USAID and the contractor), while providing critical information needed for financial and program management purposes.

Once set up, the plans should be "locked in concrete", at least for a reasonable period (one to two years), to allow the contractor to pursue automated options and to minimize staff time spent on RME activities. Under FPMD I, RME functions have required an inordinate amount of staff time, including that of senior management, drawing time away from critical project implementation functions.

²³ A decision to be made on political and humanitarian grounds rather than for demographic reasons, given the already low fertility levels in the region (due mostly to high rates of abortion rather than effective family planning).

APPENDICES

- Appendix A - Scope of Work
- Appendix B - List of Persons Contacted
- Appendix C - Documents and Publications Reviewed
- Appendix D - Kenya - Observations and Conclusions
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- Appendix H - FPMD Conceptual Framework: Review and Recommendations
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Appendix A - Scope of Work

EVALUATION SCOPE OF WORK

Family Planning Management Development Project (FPMD)

The Office of Population (G/R&D/POP) has a five year (September 1990 - September 1995) \$23,029,000 contract with Management Sciences for Health for the implementation of the Family Planning Management Development (FPMD) Project. The project is now in its fourth year of implementation. The proposed evaluation will examine FPMD's performance and provide guidance for the remaining five years of this ten-year project, to be implemented by a follow-on contract.

I. Basic Project Information

Project Name and Number	Family Planning Management Development (936-3055)
Contracts Numbers:	DPE 3055-C-00-0051; DPE 3055-Q-00-0052
Core Contract Value (C):	\$23,029,471
Obligations (as of 3/1/94):	\$18,437,000
Requirements Contract Value (Q):	\$ 0
Obligations (as of 12/31/93):	\$11,053,041

II. Background

The Family Planning Management Development (FPMD) project is the successor to the Family Planning Management Training (FPMT) project, a highly successful five-year project which ended in 1990. FPMD, a ten-year project, envisions approximately 60 per cent central funds and 40 per cent Mission buy-ins. The project is designed to build on the successes and lessons learned from FPMT which was developed to address serious management weaknesses in family planning organizations in the developing world. Family planning programs in the developing world must be better managed if they are to stem the tide of population growth beyond levels that local governments desire and can support in social and economic terms.

FMPT had as its major focus participant training to address management weaknesses. However, it became clear that a broader approach was needed to address the myriad management and organizational development problems within family planning institutions. FPMD builds on the achievements of FPMT but takes them one step beyond by highlighting quality of care as a major outcome of the management development process. FPMT had not

emphasized client-responsive service provision and had not institutionalized the principles of quality of care. Therefore, the focus of the FPMD project is to institutionalize effective management and quality assurance as guiding principles of the organizational development process. This approach should be integrated into the entire range of management development activities carried out under FPMD.

Project Scope of Work

The purpose of the Family Planning Management Development (FPMD) Project is to promote institutional development and strengthen the management capabilities of public and private family planning organizations and to enhance the quality and sustainability of their services.

Achievement of the project purpose will be determined by the attainment of the conditions shown below:

- o institutions are better able to define objectives and meet targets on schedule while maintaining or improving program quality, coverage, and accessibility;
- o institutions implement mission statements, structures, strategies and systems which support quality service provision;
- o institutions are increasingly sustainable over time.

The Project is expected to incorporate a range of methodologies to achieve its purpose. The expected Project outputs which reflect the range of methodologies to be used, are the following:

1. Diagnostic needs and resource assessments to identify critical management problems;
2. Management development plans to specify programmatic strategies for institutions or organizations;
3. Improved management strategies, structures, and systems in national and local family planning programs, institutions, and organizations. (To be accomplished through technical assistance, training workshops, training of trainers, conferences, and observational study tours.)
4. Management training materials appropriately designed for use in LDC institutions.

5. An active evaluation program and indicators developed for evaluation of process and impact of management interventions for institutions at varying stages of development.
6. Dissemination of project activity results and findings to a wide audience.

III. Evaluation Scope of Work

The evaluation is planned for April 18-May 13, 1994. Its purpose will be to:

- 1) examine project's performance in planning and implementing activities and producing contractual outputs (e.g. management development plans, technical assistance and training activities, training materials, evaluation, and dissemination of results);
- 2) assess the project's effectiveness in achieving its purpose; address the levels of and linkages between project inputs, project outputs, and changes in the management capacity and outputs of family planning organizations which received assistance under the FPMD Project.
- 3) provide guidance for corrections/improvements in the second five-year contract.

The evaluation should address the following questions:

A. Project Implementation, Technical Performance and Impact

1. Are institutions which have received FPMD assistance better able to define objectives and meet targets on schedule while maintaining or improving program quality, coverage, and accessibility?
2. Do institutions have improved structures, systems, and strategies in place which increase management effectiveness, strengthen institutional capacity and support quality service provision;
3. Has there been expanded program output because of FPMD assistance?

4. To what degree have the recipients of FPMD's technical assistance become more sustainable (e.g. decreased financial dependency on external funding sources, ability to adapt to changing environments and client needs, strengthened organizational systems).
5. What factors facilitated and which were constraints in the achievement of progress?
6. Are institutions that received FPMD assistance providing improved quality services?
7. What inputs did FPMD use, e.g., technical assistance, training workshops, training of trainers, conferences and observational study tours? Was the mix of inputs appropriate? How effective were the inputs in achieving the expected project outputs?
8. What FPMD project outputs, e.g., needs assessments, management development plans, training materials, were developed? Were these the appropriate outputs for achieving the project purpose? Could the outputs have been improved? How?
9. Did the inputs or outputs contribute to the institutionalization of skills and technical sustainability?
10. Are the contractual deliverables appropriate for achieving the project purpose, and appropriate to the level of funding?
11. What mechanisms/structures/procedures has FPMD established to evaluate project performance and impact on an ongoing basis? Has the project used feedback to improve performance and/or make corrections?
12. Would higher funding levels have increased the impact of the project? If so, what level might have been more appropriate?

B. Project Organization and Management

1. How effective is the current organizational structure of FPMD?
2. What evidence is there that headquarter and in-country reps/offices are providing efficient and effective project management? Are the number of professional

staff in the project adequate? Do they have the appropriate skills/experience mix?

3. How does the Boston location of the project influence project functioning, impact and communication?
4. What evidence is there of the project's responsiveness to Missions' needs? Is communication between project staff, Missions, USAID/W, in-country representatives, and host countries satisfactory? Does the project receive appropriate guidance from USAID/W?
5. How has FPMD collaborated and coordinated with other cooperating and donor agencies? What has been the impact of such coordination?

C. Financial Management and Contractual Issues

1. Are the financial capabilities of the Project sufficient to ensure compliance with USAID's monitoring and reporting requirements? Are all projects and buy-ins appropriately monitored?
2. Is the current line item distribution of the budget appropriate for the achievement of project objectives? Should any modifications be made?
3. What has been the experience of the FPMD Project with the Requirements (Q) contract, esp. the negotiation/-implementation of Delivery Orders? (FPMD will prepare a response to this question)
4. The project has extended many of their delivery orders. What is the primary reason(s) for needing these extensions.

D. Recommendations for Follow-on Project

1. Which FPMD activities have not contributed to improved management?
2. Which FPMD strategies and activities should continue because they address an important need and are effective?

3. Which activities address a need but require improvement to increase their effectiveness?
4. What activities not currently undertaken by FPMD should be initiated?
5. Should the Office of Population continue to fund this type of management assistance project?
6. If so, what general recommendations of a design, programmatic, technical, financial or logistical nature should the Office of Population consider in the redesigning of the follow-on project?

IV. Methods and Procedures

The evaluation team will review all project documents, including the FPMD Contracts, the 1992 and 1993 Management Reviews, annual and country workplans, semi-annual reports, trip reports, and financial reports. The team will also review the various training materials and manuals, workshop and seminar materials and proceedings, and internal project activity evaluations.

Since this is a worldwide project, which has worked in all regions except the NIS, the team will travel to Kenya, Bolivia, Mexico and Bangladesh. These countries were selected to represent a range of FPMD activities. While in country, the team will meet with USAID Mission staff, local counterparts and others with whom FPMD has worked. The team will look for plausible associations between FPMD activities and changes in the functioning of the recipient family planning institutions.

In addition to travel by the team, a cable will be sent to Missions requesting: a) comments on project performance and impact where the project has provided significant technical assistance, training activities and materials; and b) suggestions for consideration in a follow on project. There may be telephone follow up to the cable if needed.

The team will conduct interviews with FPMD staff in Boston. They will also meet with the G/R&D/POP Communication, Management and Training Division, the Front Office, and selected staff from other Divisions of the Office of Population. These briefings may be augmented by meetings/discussions with Office of Health staff, technical staff of the Regional Bureaus, and cooperating agencies with which the FPMD Project has collaborated.

In order to incorporate the major findings and recommendations of the evaluation into the follow on project, the evaluation should take place as planned (April 18 - May 13, 1994). A detailed outline of key findings and recommendations should be provided to G/R&D/POP and project staff after fieldwork is completed; and a draft report should be available to the CTO no later than May 27, 1994.

It is anticipated that the evaluation can be completed in four weeks: the entire team will spend two days in the Washington D.C. area and three days in Boston, Massachusetts. One consultant will travel to Mexico and Bolivia during weeks 2 and 3 while the remaining three consultants will travel to Kenya and Bangladesh during the same period. The team will reunite in Washington D.C. for the last week for final report writing and debriefing on/about May 13, 1994.

It is anticipated the team will consist of 4 persons, who among them, have the following skills and experience:

- o knowledge of population/family planning program management issues in developing countries;
- o institutional development,
- o organizational development,
- o management information systems,
- o evaluation,
- o materials development and dissemination.
- o proficiency in Spanish (one team member)
- o good writing skills

V. Funding and Logistical Support

All funding and logistical support for the FPMD Project evaluation will be provided through the POPTECH Project. This includes recruitment and payment of the evaluation team, support for all expenses related to the evaluation, logistical support and publication of the draft and final reports.

EVALUATION TEAM

Bill Trayfors, Team Leader
Michele Andina
Karen Lassner
Rodney Powell

FIELDWORK

April 17- May 13, 1994

Appendix B - List of Persons Contacted

U.S.A., Kenya, and Bangladesh

DATE: 06/12/94

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FPMD EVALUATION - LIST OF PERSONS CONTACTED

DATE	NAME	POSITION	ORGAN.	PLACE	TELEPHONE
04/18/94	BILL JOHNSON	CHIEF, RCD DIVISION	G/PHN/POP	ROSSLYN VA	703-875-4775
04/18/94	CHARLOTTE UREKSOY	FPMD PROJECT MANAGER (CTO)	G/PHN/POP	ROSSLYN VA	703-875-4646
04/18/94	JAMES SHELTON, M.D.	ACTG. DEPUTY DIRECTOR	G/PHN/POP	ROSSLYN VA	703-875-4719
04/18/94	JOHN COURY		G/PHN/POP	ROSSLYN VA	703-875-4742
04/18/94	KEYS McMANUS		G/PHN/POP	ROSSLYN VA	703-875
04/18/94	LESLIE CURTIN	DEPUTY CHIEF, FPSD	G/PHN/POP	ROSSLYN VA	703-875-4691
04/18/94	MARIA BUSQUETS-MOURA	FPMD PROJECT MANAGER	G/PHN/POP	ROSSLYN VA	703-875-4768
04/18/94	ROY JACOBSTEIN, M.D.	CHIEF, TRAINING, MANAGEMENT, COMMUN. DIV.	G/PHN/POP	ROSSLYN VA	703-875-4409
04/18/94	WILLA PRESSMAN		G/PHN/POP	ROSSLYN VA	703-875-
04/19/94	JAMES HEIBY, M.D.		G/PHN/H	ROSSLYN VA	703-875-
04/19/94	JOHN TOMARO		G/PHN/H	ROSSLYN VA	703-875-
04/19/94	BARBARA FERINGER	(RESEARCH DIVISION-LA OPS RESEARCH PROJ)	G/PHN/POP	ROSSLYN VA	703-875-
04/19/94	DICK MARTIN	CTO PATHFINDER PROJECT, FPSD	G/PHN/POP	ROSSLYN VA	703-875-
04/19/94	ELIZABETH MAGUIRE	ACTING DIRECTOR	G/PHN/POP	ROSSLYN VA	703-875-4505
04/19/94	JOANN SPICEHANDLER	(RESEARCH DIVISION)	G/PHN/POP	ROSSLYN VA	703-875-
04/19/94	JOHN CROWLEY	CTO FPLM PROJECT, FPSD	G/PHN/POP	ROSSLYN VA	703-875-
04/19/94	JOHN ROSE	CTO AVSC PROJECT, FPSD	G/PHN/POP	ROSSLYN VA	703-875-
04/20/94	ALISON ELLIS	REGIONAL DIRECTOR ASIA/NEAR EAST UNIT	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	CLAIRE BAHAMON	PROGRAM OFFICER, PCU	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	CLAIRE MADDEN	MSH CONSULTANT, BURKINA FASO	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	CYNTHIA VELIKO	PROGRAM ASSISTANT	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	DEBORAH RUHE	SENIOR FAMILY PLANNING ADVISOR, TECH. UNIT	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	EDGAR NECOCHEA	SENIOR PROGRAM OFFICER, LAC UNIT	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	JACKIE FORBES	PRODUCTION/GRAPHICS SPECIALIST, PCU	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	JAMES WOLFF	DIRECTOR, PUBLICATIONS AND COMMUNICATIONS	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	JANICE MILLER	SENIOR PUBLICATIONS MANAGER, PCU	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	JILL SHULMAN	SENIOR PROGRAM ASSISTANT, PCU	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	KATIE SEARS	PROGRAM ASSISTANT	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	LINDA SUTTENFIELD	SENIOR PUBLICATIONS SPECIALIST, PCU	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	MARC MITCHELL	TECHNICAL DIRECTOR, TECHNICAL UNIT	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	MARIBEL DIAZ	SENIOR PROGRAM ASSISTANT, LAC UNIT	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	MARJORIE SMIT	REGIONAL DIRECTOR, AFRICA UNIT	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	MELANIE POWERS	DIRECTOR OF OPERATIONS	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	NANCY MURRAY	REGIONAL DIRECTOR, LATIN AMERICA/CARIBBEAN	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	WENDY WISE	PROGRAM ASSISTANT, LAC UNIT	FPMD/MSH	NEWTON MA	617-527-9202
04/20/94	CATHERINE CRONE COBURN	PROJECT DIRECTOR FPMD	FPMD/MSH	NEWTON MA	617-527-9202
04/21/94	BETSY CHACE	PROGRAM ASSISTANT, TECHNICAL UNIT	FPMD/MSH	NEWTON MA	617-527-9202
04/21/94	BOB BURNS	CONTRACTS/FINANCE DIRECTOR, OPERATIONS U.	FPMD/MSH	NEWTON MA	617-527-9202
04/21/94	CAROL GOMEZ	PROGRAM ASSISTANT	FPMD/MSH	NEWTON MA	617-527-9202
04/21/94	DONNA MONAHAN	SENIOR PROGRAM ASSISTANT, EVAL. UNIT	FPMD/MSH	NEWTON MA	617-527-9202
04/21/94	GAIL PRICE	SENIOR TECHNICAL ASSOCIATE	FPMD/MSH	NEWTON MA	617-527-9202
04/21/94	PAUL FISHSTEIN	SENIOR PROGRAM OFFICER	FPMD/MSH	NEWTON MA	617-527-9202
04/21/94	SALLIE CRAIG HUBER	EVALUATION CONSULTANT, EVALUATION UNIT	FPMD/MSH	NEWTON MA	617-527-9202
04/21/94	WALTER MERTENS	EVALUATION DIRECTOR, EVALUATION UNIT	FPMD/MSH	NEWTON MA	617-527-9202
04/25/94	ANNIE THAIRU	PROGRAM OFFICER	FPMD/NBO	NAIROBI	254-2-442494
04/25/94	BARBARA L. TOBIN	PROJECT ADMINISTRATOR	FPMD/NBO	NAIROBI	254-2-442494
04/25/94	PETER KIBUNGA	MIS SPECIALIST	FPMD/NBO	NAIROBI	254-2-442494
04/25/94	PETER SAVOSNICK	MIS/ORG MGT DIRECTOR	FPMD/NBO	NAIROBI	254-2-442494
04/25/94	CHARLES THUBE	PROJECT OFFICER (POP), HPN DIVISION	USAID/NBO	NAIROBI	254-2-331160
04/25/94	GARY E. LEINEN	DEPUTY CHIEF, POPULATION/HEALTH OFFICE	USAID/NBO	NAIROBI	254-2-331160
04/25/94	GARY NEWTON	CHIEF, POPULATION/HEALTH OFFICE	USAID/NBO	NAIROBI	254-2-331160
04/25/94	ANGELA LORD	CAFS PROGRAM OFFICER	REDSO/ESA	NAIROBI	254-2-331160
04/25/94	RAY KIRKLAND	REGIONAL POPULATION OFFICER	REDSO/ESA	NAIROBI	254-2-331160
04/26/94	DR. ROBERTS	DEPUTY MEDICAL OFFICER	CHAK	CHOGORIA	

U.S.A., Kenya, and Bangladesh

DATE: 06/12/94

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FPMD EVALUATION - LIST OF PERSONS CONTACTED

DATE	NAME	POSITION	ORGAN.	PLACE	TELEPHONE
04/26/94	MR. F. NKONGE	HOSPITAL ADMINISTRATOR	CHAK	CHOGORIA	
04/26/94	DR. LYNN FOGLEMAN	MEDICAL DIRECTOR	CHAK	MAUA	
04/26/94	MRS. LILLIAN KAMATHI	ADMINISTRATIVE ASSISTANT	CHAK	MAUA	
04/26/94	LALIT KRAUSHAAR	REGIONAL ADVISOR (ACCESS, KENYA)	CEDPA	NAIROBI	254-2-740382
04/26/94	CORNELIUS NYAMBOKI	CHIEF ADMINISTRATIVE OFFICER	MYWO	NAIROBI	254-2-222095
04/26/94	DARCAS AMOLO	MIS/RESEARCH OFFICER	MYWO	NAIROBI	254-2-222095
04/26/94	MARGARET WATANI	MIS/RESEARCH OFFICER	MYWO	NAIROBI	254-2-222095
04/26/94	PAUL KIZITO	HEAD, MIS SECTION	NCPD	NAIROBI	254-2-228411
04/26/94	ELIZABETH LULE	REGIONAL VICE-PRESIDENT, SUB-SAHARA AFRICA	PATHFINDER	NAIROBI	224154 OR 331468
04/26/94	NELSON A. KEYONZO	ASSOCIATE REGIONAL REPRESENTATIVE	PATHFINDER	NAIROBI	224154 OR 331468
04/26/94	THOMAS H. FENN	REGIONAL DIRECTOR OF TECHNICAL SERVICES	PATHFINDER	NAIROBI	224154 OR 331468
04/27/94	JOSEPH DWYER	DIRECTOR, AFRICA REGION	AVSC	NAIROBI	254-2-444922
04/27/94	DR OLEMO	MEDICAL COORDINATOR	CHAK	NAIROBI	254-2-49327
04/27/94	ANNABEL S ERULKAR	PROGRAMME OFFICER (RESEARCH & EVALUATION)	FPAK	NAIROBI	254-2-215676..9
04/27/94	BERNADETTE MAINA (MRS)	ASSISTANT PROGRAMME OFFICER	FPAK	NAIROBI	254-2-215676..9
04/27/94	DANIEL G KARAGU	AG. SUPPLIES OFFICER	FPAK	NAIROBI	254-2-215676..9
04/27/94	DR C N KAMAU	PROGRAMME OFFICER (MEDICAL)	FPAK	NAIROBI	254-2-215676..9
04/27/94	GODWIN MZENGE	EXECUTIVE DIRECTOR	FPAK	NAIROBI	254-2-215676..9
04/27/94	GRACE S AMURLE	CHIEF ACCOUNTANT	FPAK	NAIROBI	254-2-215676..9
04/27/94	JAMES M MAINGI	PROGRAMME OFFICER (IRT)	FPAK	NAIROBI	254-2-215676..9
04/27/94	MAUREEN A KUYOH	AG. PROGRAMME MANAGER	FPAK	NAIROBI	254-2-215676..9
04/27/94	NJAGI MUCHIRI	ADMINISTRATOR	FPAK	NAIROBI	254-2-215676..9
04/27/94	RIWELLO N NJENGA	PERSONNEL OFFICER (ADMIN)	FPAK	NAIROBI	254-2-215676..9
04/27/94	SAMSON ARIAGA	FINANCE AND ADMINISTRATIVE MANAGER	FPAK	NAIROBI	254-2-215676..9
04/27/94	ADOLF KAPINGA	ORGANIZATIONAL DEVELOPMENT CONSULTANT	FPMD/NBO	NAIROBI	254-2-442494
04/27/94	JOSEPH L MWANGI	MIS COORDINATOR	FPMD/NBO	NAIROBI	254-2-442494
04/27/94	ABIGAIL DURO (MRS)	HEALTH SUPERVISOR (NURSE)- ST LUKES CLINIC	CCS	SIAYA	0334-21305/21506
04/27/94	ALICE ODIYA (MRS)	ZONAL HEALTH SUPERVISOR - NDORI DISPENSARY	CCS	SIAYA	0334-21305/21506
04/27/94	BEATRICE ODANGO	CBD WORKER - NDORI DISPENSARY	CCS	SIAYA	0334-21305/21506
04/27/94	CHARLES OUKO	WATER TECHNICIAN - BONDO CLINIC	CCS	SIAYA	0334-21305/21506
04/27/94	DORINE OTIGI	CBD WORKER - NDORI DISPENSARY	CCS	SIAYA	0334-21305/21506
04/27/94	HERINE OJUR	HEALTH SUPERVISOR - BONDO CLINIC	CCS	SIAYA	0334-21305/21506
04/27/94	LUCAS WADENYA	DIRECTOR	CCS	SIAYA	0334-21305/21506
04/27/94	PAMELA MAMYALA	CBD WORKER - NDORI DISPENSARY	CCS	SIAYA	0334-21305/21506
04/27/94	PENINA OMONDI (MRS)	HEALTH SUPERVISOR (NURSE)-NG'IIYA HLTH CTR	CCS	SIAYA	0334-21305/21506
04/27/94	PRISCA MOLLO	CBD WORKER - NDORI DISPENSARY	CCS	SIAYA	0334-21305/21506
04/27/94	ROSE MEDAID	VOLUNTEER NURSE (IRELAND)-NG'IIYA HLTH CTR	CCS	SIAYA	0334-21305/21506
04/27/94	ROSE OINDO	ZONAL COORDINATOR - BONDO CLINIC	CCS	SIAYA	0334-21305/21506
04/28/94	CRISPOLLAR CHESOLI	CSW SUPERVISOR - PORT REITZ	MCS	MOMBASA	471592 OR 433152
04/28/94	DR BEN OCHIENG	PROJECT DIRECTOR	MCS	MOMBASA	471592 OR 433152
04/28/94	DR EDWIN MPATE	PROJECT DOCTOR	MCS	MOMBASA	471592 OR 433152
04/28/94	DR JOSIAH ONYANGO	PROJECT DOCTOR	MCS	MOMBASA	471592 OR 433152
04/28/94	DR. AMINA TWAHIR	ACTING DIRECTOR	MCS	MOMBASA	471592 OR 433152
04/28/94	FEISAL SHERMAN	CHAIRMAN	MCS	MOMBASA	471592 OR 433152
04/28/94	JANET AROME	COORDINATOR, CSW PROGRAMME	MCS	MOMBASA	471592 OR 433152
04/28/94	MacDONALD MUOO	CSW WORKER - SHIMANZI ZONE	MCS	MOMBASA	471592 OR 433152
04/28/94	MARGARET ONGULLE	CSW SUPERVISOR - PORT REITZ	MCS	MOMBASA	471592 OR 433152
04/28/94	MWANDA CHENGO	CSW WORKER - SHIMANZI ZONE	MCS	MOMBASA	471592 OR 433152
04/28/94	NURU LWAMBI	CSW WORKER - PORT REITZ	MCS	MOMBASA	471592 OR 433152
04/28/94	OMAR BAASBA	ACCOUNTANT	MCS	MOMBASA	471592 OR 433152
04/28/94	STELLA KILALO	VSC NURSE - PORT REITZ	MCS	MOMBASA	471592 OR 433152
04/28/94	VICTOR WERE	ADMINISTRATOR/MIS	MCS	MOMBASA	471592 OR 433152
04/28/94	P.O. Mokaya, MB.chB., MPH	DIRECTOR	SDA	NAIROBI	254-2-566022
04/29/94	ALPHA M. DIALLO	ACTING DIRECTOR	CAFS	NAIROBI	254-2-448618..20

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FPMD EVALUATION - LIST OF PERSONS CONTACTED

DATE	NAME	POSITION	ORGAN.	PLACE	TELEPHONE
04/29/94	DON ODERA	FINANCE OFFICER	CAFS	NAIROBI	254-2-448618..20
04/29/94	DR. BAKER A.N. MAGGWA	PROGRAMME OFFICER (RESEARCH)	CAFS	NAIROBI	254-2-448618..20
05/01/94	ABU SAYEED	PROGRAM DIRECTOR	FPMD-LIP	DHAKA	880-2-818153
05/02/94	KIRSTEN LUNDEEN	POPULATION PROGRAM MANAGER	TAF	DHAKA	883164/886079
05/02/94	DR. ABU JAMIL FAISEL	COUNTRY REPRESENTATIVE, AVSC	AVSC	DHAKA	325456/317040
05/02/94	AHMEDUL GHANI	SENIOR PROGRAM SPECIALIST	FPMD-LIP	DHAKA	880-2-818153
05/02/94	MUKARRAM H. CHOWDHURY	DEPUTY PROGRAM DIRECTOR	FPMD-LIP	DHAKA	880-2-818153
05/02/94	S.M. KHALEQUZ ZAMAN	SENIOR PROGRAM SPECIALIST	FPMD-LIP	DHAKA	880-2-818153
05/02/94	KHAIRUZZAMAN CHOWDHURY	DIRECTOR GENERAL, DIRECTORATE OF F.P.	GOB-MHFW	DHAKA	862323
05/02/94	A. H. NOWSHER UDDIN		PATHFINDER	DHAKA	880-2-326965
05/02/94	SAIFUL ISLAM	PROGRAM MANAGER	PATHFINDER	DHAKA	326965
05/02/94	DR. M. ALAUDDIN	COUNTRY REPRESENTATIVE, PATHFINDER INTNL.	PATHFINDER	DHAKA	310719/315883
05/02/94	ALAN FOOSE	POPULATION OFFICER	USAID/DHAK	DHAKA	880-2-88470
05/02/94	B. HOSSAIN	PROGRAM SPECIALIST, LOGIS & MGT UNIT	USAID/DHAK	DHAKA	880-2-88470
05/02/94	DAVID PIET	DEPUTY DIRECTOR, HPN	USAID/DHAK	DHAKA	880-2-88470
05/02/94	LOUISA B. GOMES	PROGRAM SPECIALIST (NGOs)	USAID/DHAK	DHAKA	880-2-88470
05/02/94	QUASEM BHUYAN	PROGRAM SPECIALIST (NGOs)	USAID/DHAK	DHAKA	880-2-88470
05/02/94	ROB CUNNANE	IDI (LOGIS. & MGT UNIT)	USAID/DHAK	DHAKA	880-2-88470
05/02/94	ERSHAD UL-HAQ	ASSISTANT DIRECTOR (MIS)	FPAB	DHAKA-1000	416134..6/417552
05/02/94	MIZANUR RAHMAN	DIRECTOR GENERAL (A)	FPAB	DHAKA-1000	416134..6/400028
05/02/94	MILON BIKASH PAUL	DEPUTY CHIEF EXECUTIVE	FPSTC	DHAKA-1217	414735/407943
05/03/94	MS. RENUARA	VOLUNTEER, JOBRA, BANIAJURI UNION	N/A	BANIAJURI UNION	
05/03/94	MS. RUSSIA BEGUM	VOLUNTEER, JOBRA, BANIAJURI UNION	N/A	BANIAJURI UNION	
05/03/94	MS. SHAHINARA	VOLUNTEER, JOBRA, BANIAJURI UNION	N/A	BANIAJURI UNION	
05/03/94	SHABERA KHATOON	FAMILY WELFARE VISITOR, BANIAJURI UNION	N/A	BANIAJURI UNION	
05/03/94	MAHBUB H. SHAHEED	SR. PROGRAM OFFICER (MIS)	TAF	DHAKA	883164/886079
05/03/94	SHAMINA HASAN	DEPUTY PROGRAM MANAGER	TAF	DHAKA	883164/886079
05/03/94	SURESH CHANDRA DATTA	SR. PROGRAM OFFICER (COORD)	TAF	DHAKA	883164/886079
05/03/94	WAHIDUZZAMAN CHOWDHURY	PROGRAM OFFICER	TAF	DHAKA	883164/886079
05/03/94	HILLARD DAVIS	MIS SPECIALIST	FPMD/MSH	DHAKA (TDY)	617-527-9202
05/03/94	MARGARET WATT	MIS SPECIALIST	FPMD/MSH	DHAKA (TDY)	617-527-9202
05/03/94	SAUL HELFENBEIN	DEPUTY DIRECTOR, MSH POPULATION PROGRAM	MSH	DHAKA (TDY)	617-527-9202
05/03/94	STEPHEN SACCA	SR. PROGRAM ASSOCIATE, HLTH FINANCING PROG	MSH	DHAKA (TDY)	617-527-9202
05/03/94	ABDUS SALAM	SENIOR PROGRAMME OFFICER	FPAB	DHAKA-1000	416134..6/417552
05/03/94	KAZI MOHAMMAD ALI JINNAH	ASSISTANT DIRECTOR (USAID-FUNDED PROJECTS)	FPAB	DHAKA-1000	416134..6/417552
05/03/94	ANWAR UL-ISLAM	HEAD, TRAINING UNIT	FPSTC	DHAKA-1217	414735/407943
05/03/94	MD. REZAUL KARIM	ASST. CHIEF EXECUTIVE (FINANCE & ADMIN)	FPSTC	DHAKA-1217	414735/407943
05/03/94	MS. NASRIN HOQUE	PROGRAMME OFFICER	FPSTC	DHAKA-1217	414735/407943
05/03/94	RAFIQUE AHMED	COMPUTER PROGRAMMER (MIS)	FPSTC	DHAKA-1217	414735/407943
05/03/94	ABDUL HOQQUE PATUARY	ASST. THANA FP OFFICER (GHIOR)	N/A	MANIKGANJ	
05/03/94	MD. ANIS UDDIN	ASSISTANT DIRECTOR, FAMILY PLANNING	N/A	MANIKGANJ	
05/03/94	MS. MANISA RANI CHAKMA	ASSISTANT DIRECTOR, CC-FAMILY PLANNING	N/A	MANIKGANJ	
05/03/94	MS. SHAHIN SULTANA	ASSISTANT THANA FAMILY PLANNING OFFICER	N/A	MANIKGANJ	
05/03/94	MUKIESUR RAHMAN	ADDITIONAL DEPUTY COMMISSIONER	N/A	MANIKGANJ	
05/03/94	MURTOAZA MUNSHI	DEPUTY COMMISSIONER	N/A	MANIKGANJ	
05/03/94	REBA RANI SHAHA	SENIOR FAMILY WELFARE VISITOR	N/A	MANIKGANJ	
05/04/94	CHAPAL SAHA	MEDICAL ASSISTANT, MONGALCOAT UNION	N/A	KESHOBPUR-JESSORE	
05/04/94	MRS. MONTAJ BEGUM	FAMILY WELFARE VISITOR, MONGALCOAT UNION	N/A	KESHOBPUR-JESSORE	
05/04/94	FAZIUR RAHMAN KHAN	DEPUTY COMMISSIONER, BAGERHAT	N/A	KHULNA	
05/04/94	MOHAMMED ALAUDDIN	DEPUTY DIRECTOR, BAGERHAT	N/A	KHULNA	
05/04/94	ABDUL MUKTADIR CHOWDHURY	DIVISIONAL COMMISSIONER, KHULNA	N/A	KHULNA	
05/04/94	M. A. RAHMAN	DIRECTOR, KHULNA DIVISION, FP DIRECTORATE	MHFW	KHULNA	
05/04/94	MD. SAIFUL QUADER	CHAIRMAN, UNIT COMMITTEE, JHAIZHARA	N/A	MONIRUMPUR	
05/04/94	MRS. FAZILA KHATUN	VOLUNTEER, JHAIZHARA UNIT	N/A	MONIRUMPUR	

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FPMD EVALUATION - LIST OF PERSONS CONTACTED

DATE	NAME	POSITION	ORGAN.	PLACE	TELEPHONE
05/04/94	MRS. HASINA KHATUN	VOLUNTEER, JHAIZHARA UNIT	N/A	MONIRUMPUR	
05/04/94	MRS. JABURUN NESSA	VOLUNTEER, JHAIZHARA UNIT	N/A	MONIRUMPUR	
05/04/94	MRS. MOMTAZ MIRA	FAMILY WELFARE ASSISTANT, JHAIZHARA UNIT	N/A	MONIRUMPUR	
05/04/94	MRS. NAZMUN NAHAR	VOLUNTEER, JHAIZHARA UNIT	N/A	MONIRUMPUR	
05/04/94	MRS. RANU MOZUMDAR	FAMILY WELFARE VISITOR, JHAIZHARA UNIT	N/A	MONIRUMPUR	
05/04/94	MRS. RIZIA KHATUN	VOLUNTEER, JHAIZHARA UNIT	N/A	MONIRUMPUR	
05/04/94	MRS. SAHANARA KHATUN	VOLUNTEER, JHAIZHARA UNIT	N/A	MONIRUMPUR	
05/04/94	MRS. SHAMSUN-NAHAR	VOLUNTEER, JHAIZHARA UNIT	N/A	MONIRUMPUR	
05/04/94	MRS. SOKINA KHATUN	VOLUNTEER, JHAIZHARA UNIT	N/A	MONIRUMPUR	
05/04/94	MATIUR RAHMAN	FAMILY PLANNING INSPECTOR, MONIRUMPUR	BDG-MHFW	MONIRUMPUR-HAKOBA	
05/04/94	MRS. BINA RANI	VOLUNTEER, MONIRUMPUR UNION	BDG-MHFW	MONIRUMPUR-HAKOBA	
05/04/94	MRS. BINATA RANI	VOLUNTEER, MONIRUMPUR UNION	BDG-MHFW	MONIRUMPUR-HAKOBA	
05/04/94	MRS. HASINA KHATUN	VOLUNTEER, MONIRUMPUR UNION	BDG-MHFW	MONIRUMPUR-HAKOBA	
05/04/94	MRS. JOSHNA RANI	VOLUNTEER, MONIRUMPUR UNION	BDG-MHFW	MONIRUMPUR-HAKOBA	
05/04/94	MRS. SAHIDA KHATUN	FAMILY WELFARE ASSISTANT, MONIRUMPUR	BDG-MHFW	MONIRUMPUR-HAKOBA	
05/04/94	DR. SUBRATA KUMAR ROY	MEDICAL OFFICER (MCH-FP) MONIRUMPUR THANA	BDG-MHFW	MONIRUMPUR-JESSOR	
05/04/94	MD. ABDUL ALIM	THANA FP OFFICER, MONIRUMPUR THANA	BDG-MHFW	MONIRUMPUR-JESSOR	
05/04/94	PRODIP KUMAR BISHWASH	ASST. THANA FP OFFICER, MONIRUMPUR THANA	BDG-MHFW	MONIRUMPUR-JESSOR	
05/05/94	DHIRAJ KUMAR NATH	DEPUTY SECRETARY	MHFW	DHAKA	880-2-241820
05/05/94	M. A. SHAHEED	JOINT SECRETARY	MHFW	DHAKA	880-2-831534
05/05/94	M. ABDULLAH	SENIOR ASSISTANT SECRETARY, PLANNING CELL	MHFW	DHAKA	880-2-
05/05/94	SHAHADET HUSSAIN	ASSISTANT SECRETARY	MHFW	DHAKA	880-2-
05/05/94	WILLIAM GOLDMAN	DIRECTOR, OFFICE OF HEALTH AND POPULATION	USAID/DHAK	DHAKA	880-2-88470
05/10/94	ANNE TERBORGH		DA	ARLINGTON VA	703-276-0677
05/10/94	LORI ASHFORD	CTO OPTIONS PROJECT	G/PHN/POP	ROSSLYN VA	703-875-
05/10/94	KRISTA STEWART	CTO EVALUATION PROJECT & MONITOR NIGERIA	G/PHN/POP	ROSSLYN VA	703-875-4664

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FPMD EVALUATION - LIST OF PERSONS CONTACTED

DATE	NAME	POSITION	ORGAN.	PLACE	TELEPHONE
04/25/94	LOURDES DE LA PEZA	CONSULTANT	MSH	MEXICO	525-684-1661
04/25/94	ESPERANZA DELGADO HERRERA	MEXICO REPRESENTATIVE	PATHFINDER	MEXICO	525-573-6388
04/25/94	DR. CARLOS BRAMBILA PAZ	ASSOCIATE	POPCOUNCIL	MEXICO	525-280-1725/1600
04/25/94	DR. RICARDO VERNON	INOPAL DEPUTY DIRECTOR	POPCOUNCIL	MEXICO	525-280-1785/1475
04/25/94	ART DANART	REPRESENTATIVE	AID/MEXICO	MEXICO	525-211-0042
04/25/94	BONNIE OSEGUEDA	PROGRAM COORDINATOR	AID/MEXICO	MEXICO	525-211-0042
04/26/94	DR ENRIQUE SUAREZ y TORIELLO	EXECUTIVE DIRECTOR	FEMAP	MEXICO	52-16-160833
04/26/94	HUGO DIAZ	EX-DIRECTOR OF SYSTEMS	FEMAP	MEXICO	
04/26/94	LAURA JACQUEZ	SYSTEMS ASSISTANT	FEMAP	MEXICO	
04/26/94	MARIA DE LOS ANGELES VALDEZ	DIRECTOR OF SYSTEMS	FEMAP	MEXICO	
04/27/94	VICTORIA FUENTES	PROJECT OFFICER	IPPF	MEXICO	525-666-7067
04/27/94	(SEVEN PHYSICIANS)	COMMUNITY DOCTORS	MEXFAM	MEXICO	
04/27/94	ALFONSO LOPEZ JUAREZ	EXECUTIVE DIRECTOR	MEXFAM	MEXICO	525-573-7100/7070
04/27/94	DR. ALMA BERMUDEZ	TQM/CQI COORDINATOR	MEXFAM	MEXICO	
04/27/94	DR. GRACIELA VILLANUEVA	TLANEPANTLA COORDINATOR	MEXFAM	MEXICO	
04/27/94	ELOINA RODRIGUEZ	COMMUNITY COORDINATOR	MEXFAM	MEXICO	
04/27/94	MARIA LUISA BANZO	FUNDRAISING COORDINATOR	MEXFAM	MEXICO	
04/27/94	NORMA ZUNIGA TORRES	COMMUNITY COORDINATOR	MEXFAM	MEXICO	
04/27/94	(11 TEAM MEMBERS)	CQI TEAM FOR SIMPLIFICATION OF ADMIN. PROC	SSA/DGPF	MEXICO	
04/27/94	(5 TEAM MEMBERS)	CQI NEWSLETTER TEAM	SSA/DGPF	MEXICO	
04/27/94	DAGOBERTO CONDE JARA	CONSULTANT (CQI ASSISTANT)	SSA/DGPF	MEXICO	
04/27/94	DR. FERNANDO AMADO y LUARCA	DIRECTOR OF SUPERVISION & TRAINING SUPPORT	SSA/DGPF	MEXICO	
04/27/94	MICHAEL HALL	SENIOR PROGRAM OFFICER	MSH	MEXICO (TDY)	
04/28/94	SANTIAGO GONZALES DE COSIO	PERSONAL SECRETARY TO DIRECTOR	SSA/DGPF	MEXICO	525-598-4896
04/28/94	RAFAEL TELLES CARBAJAL	STAFF	MICHEL	MEXICO	
04/28/94	DR. CARLOS ARAMBURU	REGIONAL DIRECTOR FOR LATIN AMERICA	PATHFINDER	MEXICO	525-652-0789
04/28/94	DR. HECTOR HIGAREDA de ORTA	ASST. DIRECTOR OF SUPERVISION & TRAINING	SSA/DGPF	MEXICO	525-598-5498
04/28/94	ELSA SANTOS	DIRECTOR OF PLANNING AND INFO SYSTEMS	SSA/DGPF	MEXICO	
05/03/94	DR.	DIRECTOR, MANCO +APAC CLINIC	CNS	LA PAZ	
05/03/94	DR. ARMANDO MIRANDA PALACIOS	DIRECTOR, 9 DE ABRIL CLINIC	CNS	LA PAZ	
05/03/94	DR. MARIA CRISTINA RENTERIA	REPRODUCTIVE HEALTH PROJECT NAT'L COORD.	CNS	LA PAZ	392713
05/03/94	DR. OSCAR TELLERIA	PHYSICIAN, MANCO KAPAC CLINIC	CNS	LA PAZ	
05/03/94	DR. ROXANA TAPIA	PHYSICIAN, 9 DE ABRIL CLINIC	CNS	LA PAZ	
05/03/94	EDDY VALDA	REPRODUCTIVE HEALTH PROJECT ADMINISTRATOR	CNS	LA PAZ	
05/03/94	SANDRA WILCOX	RESIDENT ADVISOR	MSH	LA PAZ	351938
05/03/94	EARL LAWRENCE	PHN OFFICER	AID/LA PAZ	LA PAZ	786583
05/03/94	SIGRID ANDERSON	DIRECTOR, HEALTH & HUMAN RESOURCES OFFICE	AID/LA PAZ	LA PAZ	
05/04/94	BERTHA POOLEY	PRESIDENT, BOARD OF DIRECTORS	CIES	LA PAZ	390011
05/04/94	CECILIA HUASEBE	CHIEF OF TRAINING	CIES	LA PAZ	
05/04/94	DR. MARCELO FARFAN	MEDICAL SERVICES DIRECTOR	CIES	LA PAZ	
05/04/94	ELIA PEREZ	CHIEF, LOGISTICS AND STATISTICS	CIES	LA PAZ	
05/04/94	IVAN PRUDENCIO POL	EXECUTIVE DIRECTOR	CIES	LA PAZ	390011
05/04/94	PATRICIA SAENZ	ADMINISTRATIVE DIRECTOR	CIES	LA PAZ	
05/04/94	VILMA AVILES	ACCOUNTANT	CIES	LA PAZ	
05/04/94	ELBA MERCADO	REPRODUCTIVE HEALTH PROJECTS OFFICER	AID/LA PAZ	LA PAZ	
05/05/94	JOSE VOLKMAR BARRAGAN BAUER	GENERAL DIRECTOR	FSGABRIEL	LA PAZ	231114
05/05/94	GUY STALLWORTHY	CONSULTANT	MSH	LA PAZ	783365
05/05/94	DR. ALFREDO ARINEZ HERRERA	BOLIVIA PROJECTS COORDINATOR	PATHFINDER	LA PAZ	376331
05/05/94	MARY McINERNEY	ASSOCIATE	POPCOUNCIL	LA PAZ	373947

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Appendix C - Documents and Publications Reviewed

REFERENCE DOCUMENTS

I. FPMD Evaluation Team General Background Materials

Project "C" Contract
Project "Q" Contract
Project Paper
Letter to T. Bordone (08/92) on changes of contract outputs
Interim Workplan April - September 1993
Annual Workplan -- October 1993 - September 1994
Management Review Questions June 1992
Management Review Questions August 1993
Semi-Annual Report -- April - September 1993
Final Evaluation of the FPMD Project (1989)
Evaluation Scope of Work
Subproject Briefing Book
FPMD Midterm Evaluation - April 1994
FPMD Technical Proposal - September 1990
Latin America and the Caribbean Subproject Evaluation Overview
USAID's Program Priorities and Challenges Paper - February 1994
USAID's Strategies for Sustainable Development - January 1994
USAID's User's Guide to the Office of Population - January 1994
FPMD Slide Presentation Text
Handbook of Indicators for Family Planning Program Evaluation

II. Publications and Communications Unit

Summary of Work In Progress - April 1994
The Family Planning Manager's Handbook - 1991
The Family Planning Manager, Vol. III, No. 2, March - April 1994
Future Directions for FPMD Publications
Brag Sheets:
Local Initiatives Project
The Francophone Regional Advisory Committee
The Seventh Day Adventist Rural Health Services Program - Kenya
Making Better Managers Through Publications
The Maseno West Program - Kenya
Improving Family Planning Program Management Around the World

III. Evaluation

Evaluations of FPMD Activities

General Approach and Major Guidelines

IV. Technical Unit

FPMD Strategy & Year 1 Workplan -- October 1990 - September 1991
Role of the Technical Unit - January 1994

V. Operations

Contract No. DPE-3055-Q-00-0052-00 Delivery Order Extensions - April 1994
Recommendations from Population Program Experience for USAID
Reengineering Strategy - April 1994
Approval and Reporting Requirements Under FPMD
Anticipated Quantified Contract Outputs
Experience with the "Q" Contract Mechanism - April 1994
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C. Christian Health Association of Kenya

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E. The Seventh Day Adventist

Management Development Plan and Workplan
September 1991 - September 1993
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F. Family Planning Association of Kenya

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Management Development Plan and Workplan
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Management Development Plan -- October 1993 - September 1995

G. Mkomani Clinic Society

Management Development Plan and Workplan
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A. Mexico

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 - Informe Final Taller Institucional de Planificacion Estrategica de Salud Reproductiva - Enero 1994

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Appendix D - Kenya - Observations and Conclusions

KENYA COUNTRY REPORT

1.0 GENERAL

1.1 INTRODUCTION

Kenya's 1989 growth rate was 3.8%, one of the highest in the world. A substantial unmet demand for FP services is believed to exist. In an attempt to reduce the rate of population growth to 2.8% by the year 2000, efforts are focused on improving FP activities. These specifically include an increase in the number of service delivery points, both for clinical and non-clinical services, and to improve the quality of care delivered at these points.

FPMD Kenya is currently working on nine different activities, including a sub-contract with CEDPA (Maendeleo), and one regional organization based in Nairobi (CAFS). Table 1 (see page 5) provides an overview of the organizations, the nature of FPMD's interventions, and the involvement of other CAs.

1.2 METHODOLOGY

Three members of the FPMD Evaluation Team (ET), visited Nairobi from April 23-30, 1994. Meetings were held with USAID/Nairobi and REDSO. Interviews were conducted with eight of the nine organizations working with FPMD¹ and with three CAs (CEDPA, Pathfinder and AVSC). Field visits to service delivery sites were made to four organizations (CHAK, Mkomani, Maseno West/CCS, FPAK). Detailed reports of the interviews and field visits are appended.

2.0 FPMD ACTIVITIES IN KENYA

2.1 IMPLEMENTATION, TECHNICAL PERFORMANCE, IMPACT

2.1.1 Implementation

FPMD has worked in close cooperation with their clients in conducting management assessments and the subsequent management development plans. All the organizations expressed satisfaction with this process, and the ET feels that, on the whole, the activities conducted were appropriate. Depending on the client's needs and priorities, activities were implemented, in most instances on schedule, although some delays occurred due to the "internal politics" of the organizations or because of contractual delays.

FPMD has implemented *Strategic planning* and the *development of personnel systems* in several organizations, but only a few organizations felt, given the limited time, that they had developed the institutional capacity to replicate this type of activity without FPMD's continued TA (FPAK and Maseno were the exceptions). The implementation of *MIS activities* has been particularly successful and well received by all recipients. FPMD has been strong in this area, although the need for a "field perspective" was observed to be lacking in some of the MIS implemented (Mkomani, Maseno). *Financial systems* have been developed for some clients (CHAK, FPAK, SDA), but more work remains to be done in this area. With two groups (SDA and FPAK), FPMD has assisted in the development of *cost recovery strategies*. Workshops in "Resource Expansion" have also been

¹ The National Implementation Plan, conducted by the Ministry of Health (MOH), is just in its early stages. No meetings were held at the Ministry level.

conducted and a number of organizations are beginning to implement some of the ideas presented (Mkomani, Maseno).

2.1.2 Technical Performance

In Kenya, implementation of FPMD activities has been carried out by a number of different U.S. based consultants, a range of local short term consultants, and a revolving FPMD Nairobi staff. Despite the changing faces, all clients expressed satisfaction with the work conducted. The modalities used have included individual TA, workshops and training sessions - an appropriate mix for the client organizations.

The Family Planning Manager Handbook and the Family Planning Manager publications have been very well received and utilized at the management and supervisory field level. Whether these tools are effective instruments for impacting on the quality and expansion of family planning services is difficult to determine.

2.1.3 Impact

In some instances (Maseno West/CCS, FPAK, Mkomani), client organizations are better able to define their objectives and meet targets as a result of FPMD's interventions. The strengthening of their management capabilities bodes well for the improvement of program quality and coverage, but because few baseline measurements exist, the ET hesitates to state categorically that real improvement of quality or expansion of services has occurred as a direct result of FPMD's interventions. However, virtually all respondents were able to point to service availability or quality improvements which they believed had resulted from FPMD interventions. In terms of sustainability, some organizations have begun to take preliminary steps in this direction (SDA, FPAK, Maseno West/CCS, Mkomani) as a result of FPMD's work.

Except for strategic planning activities (FPAK and Maseno), the institutionalization of many of FPMD's interventions has been uneven. Only minimal documentation for these interventions has been developed (especially for MIS) and most clients continue to be dependent on FPMD for ongoing TA. In addition the ET questions whether the materials developed are always appropriate and applicable down to the service delivery level. Training provided by FPMD (primarily in Boston) has been greatly appreciated, but rarely transferred to other staff of the organization.

Evaluation of FPMD's activities has been conducted in an ad hoc, qualitative fashion. While the qualitative aspect of the evaluation process is appropriate to the interventions, the lack of structural approach is primarily the result of: (1) highly centralized management (Boston) and the lack of autonomy of the Nairobi staff; and (2) the absence of a clear operational and structural framework for FPMD's management interventions.

3.0 ORGANIZATION AND MANAGEMENT

The "organization and management" problems of FPMD Kenya are readily evident. Merely by reading the FPMD Kenya "Semi-Annual Report October 1993-March 1994," one immediately sees the need for a clear conceptual framework for the country activities. The problem is primarily attributable to the highly centralized nature of FPMD in Boston, and to the fluctuating central leadership during the early project years. Recent personnel upheavals in Kenya have also exacerbated an already questionable in-country management structure, heavily dependent on outside consultants rather than working to build in-country, local capacities. FPMD is aware of these problems and is working to overcome them through the putting in place of a new project management structure and other initiatives.

4.0 FINANCIAL MANAGEMENT AND CONTRACTUAL ISSUES

Because of FPMD's highly centralized nature, the particulars of FPMD Kenya's financial situation were not specifically raised during the visit. There was some discussion at USAID/Nairobi about the use of in-country buy-in funds being utilized to support Boston based personnel, but few other financial issues were discussed.

Relationship with USAID/Nairobi and REDSO

The majority of FPMD's interventions have been directed toward organizations identified by USAID or REDSO. Both groups have been very supportive of FPMD's activities and have facilitated their work. At the same time as USAID has facilitated FPMD's work, they have also been quite specific and demanding about their needs and expectations for FPMD. On the whole, USAID and REDSO have been very satisfied with the outcomes, although there have been periodic questions about planning, logistics and communication between FPMD and AID.

Relationships with other CAs

The primary CAs cooperating at various levels with FPMD client organizations are CEDPA, Pathfinder and AVSC. With Pathfinder, FPMD has developed an especially good and collaborative working relationship. The pairing of these two CAs enhances the capacity of each and provides a comprehensive perspective of both the management and the service delivery needs of the client organization. This relationship needs to be further strengthened and focused on management issues, including MIS, at the service delivery level. Work with CEDPA, FPMD's subcontractor (with Maendeleo, a large and powerful woman's organization) needs to be clarified and is presently difficult to assess.

A number of FPMD's client organizations reported a great deal of confusion in dealing with multiple USAID/CAs. While there appears to be little duplication of services, different "messages" are sometimes given. Most organizations requested that the USAID/CAs work together in a collaborative fashion to provide TA that is needed and appropriate for the client organization.

NAME OF ORGANIZATION	TYPE OF ORGANIZATION	BEGAN WORK FPMT/FPMD	FPMD INTERVENTIONS	US\$ BUDGET (LOP)	OTHER CA INVOLVE- MENT
(1) National Council for Population Development (NCPD)	Public/MOH:	1989	Data Entry (100% position), Data Training (50% position), MIS, Computer Hardware, MSH Training, Proposed Restructuring	\$487,181	
(2) The National Implementation Plan (DFH-NIP)	GOK/DFH: assist GOK to develop "blueprint" for future Population program direction and priorities.	1994	Document Review, Situational Analysis, Establish working group for SWOT, Terms of Reference for National Technical Advisory Committee.		
(3)* ² Family Planning Association of Kenya (FPAK)	NGO - service provider	1987	Strategic Planning, MIS, Financial Management, Resource Expansion, Decentralization, Supervision	\$548,987	Pathfinder
(4)* Christian Health Association of Kenya (CHAK)	Umbrella NGO for 230 private church related health facilities	1987	Organizational Development, MIS, Plan and Review, Cost Recovery	\$545,623	AVSC
(5) Maendeleo Ya Wanawake (MYWO)	Women's NGO - Service Provider, CBD only	1989	Develop & Install Financial System, Work with boards and managers	\$30,000	Subcontract CEDPA. Pathfinder
(6)* Mkomani Clinic Society	NGO - Service Provider, comprehensive MCH & FP systems, including curative & urban CBD program	1991	Personnel systems, MIS, board-staff relations, strategic planning, quality of care, organizational development, resource expansion	\$307,163	Pathfinder AVSC
(7)* Maseno West/Christian Community Services (CCS)	NGO - Service Provider, comprehensive MCH & FP, and CBD, rural areas	1991	MIS, Strategic Planning, Financial Management, Regional Maseno/CCS Office	\$138,222	Pathfinder
(8) Seventh Day Adventist (SDA)/Rural Health Services	NGO - Service Provider, focused on rural areas	1991	Strategic Planning, Financial Management, MIS, Supervision	\$168,225	
(9) Center for African Family Studies (CAFS)	Regional Training Institute, (IPPF Affiliated) offices in Nairobi & Lome, Togo	1986	Personnel systems, Computer Training & Mgt., French mid-level managers course, Mgt. Course documentation, Office Equipment, Market Analysis, Strategic Planning, Staff Development, Materials development, Library support	\$688,899	IPPF

² * Indicates field visit to service delivery site.

5.0 RECOMMENDATIONS FOR FOLLOW-ON

In a country like Kenya where multiple activities exist, FPMD2 should:

- (1) Have an "empowered"/decentralized office with regional responsibility³. This office should have minimal expatriate representation and should be staffed primarily with local technical and support personnel.
- (2) Develop a framework for activities appropriate to in-country level needs.
- (3) Be teamed, in a collaborative fashion, with a service provider CA for interventions with those organizations (e.g., small NGOs) working at the service delivery level.
- (4) Focus in on FPMD's specific skills and expertise (i.e., mid-higher level management issues) and work with government (National Implementation Plan), or other appropriate groups needing this level.
- (5) Work together with USAID and other CAs to develop a cohesive approach for organizations receiving USAID TA and funding.
- (6) Improve documentation of activities - both at the level of communicating what it is that they do, and in diffusing "lessons learned" down to the appropriate level of service delivery.

³ There is a limit to the degree of "empowerment" and "decentralization" possible under the existing FPMD contract arrangements. Nevertheless, FPMD should strive to decentralize planning, operations, and accountability as far as possible under existing arrangements, including the possible use of appropriate data communications technologies to facilitate monitoring and approval functions.

KENYA

MAENDELEO YA WANAWAKE ORGANIZATION (MYWO)

Present: (see contacts list)
Place: Maendeleo Building, Nairobi
Date: 04/26/94
Time: 1000 hours

INTRODUCTION:

Maendeleo is the largest women's organization in Kenya with a membership of 1.5 million and branches throughout the country. MYWO plays a key role in mobilizing women to demand family planning services. With support from CEDPA and Pathfinder, MYWO has an "Integrated Maternal Child Health and Family Planning Program," accounting for 60% of their program activities, operating in 10 districts (7 funded by Pathfinder, 3 by CEDPA) with 1028 volunteer community based distributors. The primary role of the CBD is to dispense contraceptives and motivate and refer clients to local clinic facilities. The estimated population served is approximately 30 clients/month/distributor. Catchment area surveys and baseline studies are currently being conducted. Their MIS/Research division exists since 1990.

FPMD:

According to the FPMT evaluation, FPMT worked with MYWO and Pathfinder in financial management, project management and organizational development. CEDPA reports that both financially and structurally, the FPMT interventions have had a positive impact on MYWO. According to Pathfinder sources, FPMT developed the financial management system, and Pathfinder assumed responsibility for its implementation. At the request of USAID/Nairobi, CEDPA has taken the lead in interfacing with this organization. CEDPA currently subcontracts with FPMD for the management interventions, which account for approximately 20% of CEDPA's work with MYWO.

Both CEDPA and MYWO report that the management assessment conducted in 1992, under the leadership of an FPMD/CEDPA appointed consultant, was a very cooperative and positive process. The outcome from this process was a number of recommendations, of which to date, due to numerous reasons (primarily internal politics) only a few have been implemented. The primary output from the assessment were detailed job descriptions and job contracts for the 136 member staff of MYWO. Staff report a high level of satisfaction with these products.

CONCLUSION:

The direct impact of FPMD/CEDPA collaboration on improvement of quality and sustainability of services is difficult to determine. No field visits were conducted, and the collaborative nature of MYWO, CEDPA, FPMD/CEDPA, and Pathfinder makes the causality of the variables difficult to isolate. Given the objectives of MYWO, CEDPA is clearly a very appropriate partner for FPMD. However, efficient and mutually satisfying mechanisms for all partners working together, should be developed for this type of cooperative effort. The ET understands that discussions to develop a sound and effective framework for collaboration are underway both in Kenya and in Washington.

KENYA

NATIONAL COUNCIL ON POPULATION AND DEVELOPMENT (NCPD)

Present: (see contacts list)

Place: NCPD HQ, Nairobi

Date: 04/26/94

Time: 0900 hours

NCPD is the GOK entity responsible for coordinating overall FP programs, including those in the NGOs and private sector. NCPD is now located within the GOK Planning Ministry, and is headed by an officer of Ambassadorial rank. It has approximately 100 staff positions.

FPMD has provided extensive computer and MIS support to NCPD and associated organizations. Over 100 officers have been trained in basic computer skills (word processing, spreadsheets, database basics, and graphics). A number of information system seminars have been held for many of these organizations.

Specific MIS support to the NCPD consists of systems developed for the following functions:

- financial management of the NCPD itself (the Votebook System, modeled after the official GOK accounting system);
- activities monitoring (the Activity Monitoring System or AMS, used to record and report data from NGO work plans and quarterly reports);
- a projects database (the NCPD Projects Database, now integrated into the AMS) which includes data for all NGO projects;
- a financial monitoring system for NGO budgets and expenditures, developed for the NCPD Finance and Administration Division;
- an annotated research bibliography to enable NCPD to record and disseminate results of P/FP research in Kenya; and
- service statistics - development of standardized formats for the reporting of all MOH and NGO family planning service statistics.

Additionally, FPMD has provided NCPD help in processing the DHS survey and other demographic and FP data, and in organizing data on HIV/AIDS.

Comment: While NCPD is not itself a service-providing or grant-giving agency, it is responsible for coordinating such agencies (and for the auditing of NGOs which have received direct grants from the donors). To the extent that FPMD interventions may have facilitated such coordination, and may in the future simplify the reporting burden on the NGOs and the GOK-MOH, it can be assumed that there may be some positive impact on service delivery and QOC. This is, however, impossible to quantify. More significant is the recent invitation to FPMD by the GOK to assist in developing a National Implementation Plan. No doubt, its work with the NCPD was in part responsible for generating this request. It is in pursuit of this Plan, and its sequel, that FPMD may begin to have a real impact on overall service delivery.

KENYA

MASENO WEST/CHRISTIAN COMMUNITY SERVICES

Present: (see contacts list)
Place: Maseno West, Siaya District and field sites
Date: 04/27/94
Time: 0800 - 1700

"Any good changes we've made are a result of FPMD's probing questions." Lukas Wadenya, Director CCS/Maseno West

INTRODUCTION

Within the Diocese of Maseno West, the Christian Community Services (CCS) department was established in 1987. CCS' four major programs are Community-Based Health Care (CBHC), Water Development, Agriculture and Gender Training. CBHC is its largest program, which provides preventive, curative and family planning services to rural populations in the district of Siaya (population 1989 census 728,872, growth 3.1%) through nine clinics and 33 mobile outreach units. Approximately 400 volunteer community health distributors (CBD) conduct health outreach and motivational activities, supported by a staff of 37 people. Maseno West's service delivery component is funded by Pathfinder, who have also provided a portable computer and printer for MIS data. Pathfinder and USAID/Nairobi referred FPMD to Maseno West.

This organization is truly a "star" in the FPMD portfolio. With strong leadership, a committed and supportive board, and offices filled with activities charts, yearly planners and maps, management organization is readily evident. Maseno West also demonstrates FPMD's contention that by addressing the "width and breadth" of an institution's management, positive outcomes can be achieved at the service delivery level. Areas requiring work have been accurately identified in FPMD's technical review especially in financial management and CBD/CHW statistics.⁴

FPMD INTERVENTIONS

In 1992 FPMD began with a Management Assessment, conducted by two consultants (1 Kenyan, 1 expatriate). All levels of Maseno West, from the Bishop down to the CBDs, were involved in this process and report a very rewarding and collaborative experience.

This activity was followed in May 1993, by the collaborative writing of job descriptions, with the same Kenyan consultant who had done the assessment. This process raised awareness of structural weaknesses within the project, e.g., the overloading of the project director, who with some administrative

⁴ Examples observed include: (1) Financial Management - the purchase of adaptor plugs for a recently received portable computer, required an "invoice" for the exact sum of money which the Health Information Officer could not provide, necessitating two trips to Kisumu, a one hour drive (KSh400 for petrol) each way; and (2) CBD/CHW statistics are not at all reflective of the full extent of their activities due to the unique focus on family planning. Because most of the women are also TBAs, activities related to MCH (especially Safe Motherhood and immunization) are not evident.

assistance is now better able to focus his energies on the four different programs he directs under CCS.⁵ On going personnel evaluation and management systems were also developed and have reduced friction between supervisors and their staff.

Development of a strategic plan was facilitated by Peter Savosnick, with all parties, Bishop, to management, to workers, included in the process. Drafts were prepared by the Maseno West staff, and edited with relevant questions included by Peter. The present draft awaits additional input from Maseno West.

FPMD worked again completely collaboratively with Maseno West to develop an activity monitoring system. As designed, these documents are effective tools for tracking new and revisiting acceptors, contraceptive methods used and referrals. Although this was clearly their purpose (as per USAID requirements), due to the lack of a catchment or baseline survey, and follow-up of live births, little information is revealed about the percent of women covered, or the impact of the contraceptive distribution on crude birth rate.⁶

As a result of the FPMD activities Maseno has taken its own initiative in areas such as cost recovery, (a revolving fund for medicines, establishment of a "book shop" selling office supplies to the community and for its own use), and methods for providing statistical feedback to their service delivery sites and CBDs. Maseno West staff feel that they would be able to replicate the development of job descriptions and the strategic planning exercises without any further FPMD inputs. The "Management Assessment" is however, best conducted by impartial outside observers because of the provocative questions which they raised. Maseno West continues to require technical assistance from FPMD or Pathfinder for the computerization of its MIS.

CONCLUSION

The impact of FPMD interventions was clearly visible at the service delivery level where indicators such as adequate staffing, increased numbers of new acceptors and operative MIS exist. Service providers (supervisors, nurses, and CBDs) reported satisfaction and improved understanding of the extent and potential impact of their services. The board and management also express a high level of satisfaction and motivation to further improve the services provided. Work, however remains to be done both in improving the quality of services, e.g., (1) the improvement of infrastructure, i.e., providing electricity to one of the three community health centers which operates 24 hours per day, has a maternity ward, and is expanding to provide surgical sterilization facilities; (2) the provision of medicines for treatment of women's reproductive related ailments (RTI, UTI, vaginitis, etc.); and (3) commodities tracking especially

⁵ Other staffing inadequacies impacting directly on service delivery included: (1) lack of supervision for CBDs became evident, resulting in the development of Senior CBDs (SCBD); and (2) salary considerations revealed that it would cost the organization less, and be more efficient to pay for their own mechanic to service their 12 vehicles than to send them out for maintenance.

⁶ The distribution of contraceptives alone does not guarantee their usage. Other inadequacies also noted in the current MIS was the lack of a tracking system for follow-up of clients receiving contraceptives, especially Depo-Povera which requires a 3 month return.

for contraceptives⁷. Improvement in the financial systems, which are extremely complex due to multiple donor sources and their various accounting requirements, are also needed.

⁷ Note that FPMD's role is one of provision of TA; they have no direct role in providing equipment and supplies, financing, etc., but rather attempt to improve the management of systems which deal with these factors.

11

KENYA

FAMILY PLANNING ASSOCIATION OF KENYA (FPAK)

Present: (see contacts list)
Place: FPAK Urban Clinic (East Leigh)
and FPAK HQ, Nairobi
Date: 04/27/94
Time: 1400-1600 hours

The FPAK is the IPPF affiliate. The East Leigh Clinic serves as an area office for Nairobi (consisting of 4 urban clinics plus 5 satellite [temporary] clinics). FPAK has received a great deal of FPMD assistance (as well as FPMT assistance). Lots of staff have attended training courses in Boston and in Kenya.

Areas of assistance have included: financial management, strategic planning, MIS, personnel management, ELCO mapping, and implementation planning.

In meeting with the senior staff at the HQ office, one gets the impression of an organization with a clear vision, organizational structure, and cooperative workstyle. Each department head was articulate in explaining how FPMD had interacted with their part of the organization, the benefits which resulted, and they types of assistance required in the future. With regard to the latter, one had the impression that this is a mature organization capable of identifying its own problems and TA needs.

Once again, FPAK staff underscored their appreciation of FPMD's collaborative style of TA in all areas. Staff were unanimous in their opinion that FPMD inputs had, in fact, contributed to better family planning services. Staff vs. "volunteer" relations had improved, information flows of all types had improved, there was a better allocation of resources, and a markedly better ability to do strategic and program planning than was the case before FPMD began working with FPAK.

Overall, it is clear that FPAK has made substantial progress in operational and financial management, and in its capacity to develop strategic plans and set budget, program, and management priorities. It continues to work closely with FPMD staff in a collaborative effort to improve the overall program.

One off-key note: there is a need for help in the logistics management area. FPMD stopped short of assisting in this area, probably because of JSI-FPLM's mandate. The FPAK wasn't sure which organization to ask for assistance. The ET suggested they ask USAID/Nairobi.

KENYA

CHRISTIAN HOSPITAL ASSOCIATION OF KENYA (CHAK)

Present: (see contacts list)

Place: CHAK HQ, Nairobi - Field Visits

Date: 04/27/94 - 04/26/94

Time: 0900 hours

CHAK, an umbrella organization for several hospital groups in Kenya, has received FPMT and FPMD assistance since about 1987. Early efforts included a management audit exercise (CORAT Africa) in 1988 and Thunder & Associates assistance in 1990. FPMD has provided assistance in planning, monitoring, reporting, fee recovery, and MIS.

Asked whether CHAK could point to any service improvements (coverage and/or quality) resulting from FPMT/FPMD assistance, Dr. Olembo (Medical Director) said there were several direct results, including:

- improved response time, because better info is available;
- improved staff availability (systems developed with FPMD have resulted in better staff allocation, including TDYs);
- reduced turnover of trained staff;
- improved ability to set realistic fees for services; and
- overall FP and AIDS performance improved "enormously", and cost per CYP has dropped "dramatically".

While the ET didn't have time to verify these "results", Dr. Olembo was quite positive of their reality. Indeed, they seem possible, even probable, from the way he described the intervening processes.

We asked about the degree to which FPMD has completed its work with CHAK along three dimensions: (1) development of tools and systems; (2) institutionalizing same; and (3) self-sustaining same. The answers were:

- development of systems and tools: 90% complete
- institutionalizing same: 50-60% complete
- self-sustaining same: 30-40% complete.

Systems, tools, and procedures are "taking root at the member unit level". There is a need for better documentation of these systems. (Documentation of systems is planned in the MDP for the period May 1994 - September 1995). A restructuring plan has recently been completed for submission to USAID.

KENYA

SEVEN-DAY ADVENTIST RURAL HEALTH SERVICES (SDA)

Present: (see contacts list)

Place: SDA HQ, Nairobi

Date: 04/28/94

Time: 1415 hours

SDA is part of CHAK, but has its own secretariat. It therefore has own authority to hire & fire; purchase own facilities, collect fees, etc. SDA easily reaches over one million total population through its 50 facilities. It uses a PHC model to "reach poor and needy folks" with comprehensive health care (preventive and curative). It is staffed by community nurses (80%) and health assistants, and has a number of CBD workers (about 30 at present).

Most "exciting" effort with FPMD has been the new financial manual which has been in use for over a year and is about to be evaluated. SDA underscored FPMD's collaborative approach which had resulted in several clear gains, including a better relationship with SDA's Board of Directors.

A long discussion was held concerning ways of sustaining outreach services. SDA has achieved a remarkable degree of income from its fee-for-services program, but a current problem is the "degree of erosion of buying power due to exogenous factors". Procedures which used to cost a peasant the equivalent of one banana now cost four or five bananas. This is seen as a real problem for long-term sustainability.

KENYA

MKOMANI CLINIC SOCIETY

Present: (see contacts list)
Place: Mkomani Clinic Society, Mombasa and field sites
Date: 04/28/94
Time: 0900 - 1700 hours

"Our new MIS forms greatly reduce our paper work and allows us to spend more time in the field counseling our clients. "

Margaret Orgulle
CSW/Supervisor, Mkomani Clinic

INTRODUCTION

The Mkomani Clinic Society was founded in 1980, by a coalition of Asian and African community groups, to provide quality integrated family health care to the poor and underserved populations in Mombasa and its environs. Early funding came from community donors and FPIA. Since 1990/91 AVSC and Pathfinder are the primary outside donors. The current staff of 62, including 30 salaried Community Service Workers (CSW)⁸, provide comprehensive preventive, curative and family planning services in two out-patient clinic sites (Mkomani and Bomu), two outreach facilities⁹, and an extensive CBD/CSW program serving urban Mombasa. Dr. Amina Twahir, Acting Director since 1994, has been a doctor with Mkomani since 1987.

Mkomani has been going through significant transitions since beginning their work in 1991 with FPMD. This work has been conducted together with Pathfinder which has occasionally resulted in difficulties for Mkomani to differentiate who has provided which services - FPMD or Pathfinder. Mkomani has stressed the need for collaboration between the multiple donors to avoid confusion among the funding recipients.

FPMD

The first intervention in March 1991, was a "Management Assessment" conducted together with Pathfinder. Initial problems identified by FPMD met with much resistance, and there were questions as to whether FPMD's approach was the most effective. However, over the years, Mkomani has come to realize that the initial assessment was correct and board/staff responsibilities, philosophies and goals need to be addressed if positive changes are to occur. The on-going process of discussions at this level have been very fruitful, with FPMD playing an important facilitative role. A number of different individuals (local and outside consultants, Nairobi and Boston based FPMD employees) were involved in the process which was not found objectionable, because it allowed FPMD to maintain an objective outside perspective. The impact of FPMD interventions has been that Mkomani is presently restructuring their organization and developing a new mission statement.

The MIS development was another major contribution by FPMD. The work of Peter Savosnick has been

⁸ 25 of the CSW are female and 5 are male.

⁹ Offering primarily family planning services including IUD and Norplant insertions and CBDs.

greatly appreciated by all, ranging from the CSW, with whom he collaborated and succeeded in reducing the paperwork, to the management who is better able to utilize service statistics for future planning projections. At present only one person at Mkomani is able to use the computer system (in use since 1/94). FPMD provided him with theoretical training (for Lotus, Word Perfect and D-base, with little actual computer time), at MSH, Boston (7/91), and extensive technical assistance from Peter Savosnick in Nairobi and Mombasa to operationalize the system. He can now work with the system (Quattro Pro) on his own, developing and generating the necessary data out-puts. But, no user handbooks or documentation exists. Financial systems still need to be developed and computerized.

FPMD conducted two "Resource Expansion Workshops." Based on inputs from this workshop, Mkomani is in the process of building their own laboratory for income generation. There was some concern that parts of the workshop may have been of too large a scale for NGOs like Mkomani, but it did provide "food for thought."

The development of a "Personnel Handbook" is still in its early phases and Mkomani feels it will require more work. The Chairman and the Acting Director, are still awaiting the proposed "Study/Exchange Trips" for the board and management. They feel it would be most useful for them to observe positive examples of service delivery in operation in other countries, to then adapt to their own needs.

CONCLUSION

Mkomani is considering many new ideas, including beginning an all male clinic and expanding the number of CSW/CBDs. We would urge consolidation, increased efficiency and organizational systems before any expansion is considered. This will require more inputs from FPMD in collaboration with Pathfinder, who provides the necessary service perspective. To date, the impact of FPMD interventions are primarily visible at the service delivery level in terms of a semi-operative MIS (highly dependent on one technician) and Mkomani's ability to meet operational family planning targets. The impact of FPMD on sustainability is in its very early stages.

KENYA
CENTER FOR AFRICAN FAMILY STUDIES (CAFS)

Present: (see contacts list)
Place: CAFS Regional Office, Nairobi
Date: 04/29/94
Time: 1000 - 1230 hours

INTRODUCTION

CAFS with offices in Nairobi, Kenya and Lome, Togo, was established in 1975 by the African Regional Council of IPPF. It is an autonomous, bilingual, non-profit society, operating under its board of directors. Its objectives are to "inform and educate the people of Sub-Sahara Africa on population and family planning issues. CAFS provides training for family planning staff and managers in the region and provides information and documentation services on family planning in Sub-Sahara Africa."¹⁰ Beginning in 1985 CAFS has received funding from other agencies, including USAID. A research division begun in 1988 has been operational since 1992, and focuses on basic operations research. In recent years IEC has been aimed at the policy level. A total staff of 51 operate out of Lome and Nairobi.¹¹

CAFS most significant direct involvement with FPMD was through a marketing analysis, contracted through REDSO. This was a very useful exercise and has enabled CAFS to better target their potential markets for family planning training services.

Using consultants from Boston, a personnel analysis was conducted, as well as a review of management curriculum and documents. Both activities were viewed as highly beneficial and constructive to CAFS. FPMD has also upgraded some of CAF's support systems, including supplying equipment, especially in the Lome office. A number of staff have benefitted from Boston based training - "Financial Management of Health Programs." FPMD has also conducted a needs assessment of CAFS MIS systems.

Through FRAC and their training, CAFS feels that FPMD has done a great deal with the Francophone countries. The acting director, who attended the FRAC meeting in Tunis felt that this was a good opportunity for exchanging views and experience. The fact that links were maintained during the course of the year also facilitated an ongoing dialogue. He felt that if the resources were made available, CAFS would be an appropriate place to house FRAC activities. He would be most willing to approach other donors (e.g., European agencies) together with MSH about this possible collaboration.

CONCLUSION

Based on our short visit with CAFS, the ET feels that this is an appropriate organization for FPMD activities. Senior staff seem well positioned to work with FPMD to mobilize and improve their current resources, both technical and financial. Collaboration with this type of regional organization could also facilitate the development of local capacities, which enhances the potential for sustainable activities in the African region.

¹⁰ Centre for African Family Studies (CAFS), Programme of Activities 1994, pg. 1

¹¹ Lome has 4 senior and 4 support staff, Nairobi has 18 senior and about 22 support staff (note this only totals 48).

Appendix E - Bangladesh - Observations and Conclusions

BANGLADESH COUNTRY REPORT

1.0 GENERAL

1.1 INTRODUCTION

The 1992 population of Bangladesh is estimated at 112 million with an average increase of 2% per annum. The Bangladesh Government (BDG) fourth *Five Year Plan for Population and Family Planning (1990-1995)*, aims to reduce the population growth rate by sharply increasing the rate of contraceptive users from 39 to 50%. To achieve these ambitious goals, the Government is mobilizing forces in every relevant sector of society to provide improved family planning and health services at the grassroots level.

FPMD/Bangladesh is working on two very different activities:

The Local Initiative Program (LIP) is the largest and longest running FPMT/FPMD activity and is atypical of other FPMD interventions. Funded approximately 95% by a USAID/Dhaka buy-in (LOP = \$7.5 million), it has a local staff of 25 (subcontracted to Technical Assistance Inc, TAI) and currently receives primarily short term and contractual TA from FPMD/Boston. Working simultaneously to strengthen both management and service delivery levels, including the provision of small grants, this comprehensive program seeks to support the BDG's efforts to provide high quality, locally managed and sustainable family planning services.

The CA/NGO activity, was begun in early 1993 as the outgrowth of an ad-hoc assessment by FPMD in 1992 of USAID/Dhaka's NGO portfolio. Funded by a USAID buy-in (LOP = \$999 thousand), this activity provides management TA to five local CA/NGOs - Pathfinder, The Asia Foundation (TAF), AVSC, Family Planning Services and Training Center (FPSTC), Family Planning Association of Bangladesh (FPAB) - who serve as USAID intermediaries to approximately 150 indigenous NGOs. FPMD has provided assistance to the group in three areas: 1) management development assessments (MDA) 2) training impact evaluations (TIE) and 3) MIS as related to QES (quality, expansion, sustainability) of family planning services. TA has been provided in-country by FPMD/MSH Boston based consultants.

1.2 METHODOLOGY

Three members of the FPMD ET visited Dhaka from May 1 - May 6, 1994. Meetings were held with USAID/Dhaka, MOH&FW, Directorate of Family Planning (DFP) and LIP/FPMD. A meeting of the CA/NGO group was attended and separate interviews were conducted with each of the five CA/NGOs. Field visits were made to two LIP area thanas¹, where interviews were held with all levels of management, community and service delivery providers. Observations of health facilities (thana, and union level), a satellite clinic, and a local IEC activity were conducted. (Detailed reports of the interviews and field visits follows this report).

2.0 FPMD ACTIVITIES IN BANGLADESH

Due to the very diverse nature of FPMD's two Bangladesh activities the answers to the SOW questions will be addressed separately as relevant to each activity.

¹ A "thana" is an administrative unit roughly equivalent to a county.

2.1 IMPLEMENTATION, TECHNICAL PERFORMANCE, IMPACT

2.1.1 Implementation

CA/NGO

The FPMD project outputs included Management Development Assessments (MDA), Training Impact Evaluations (TIE), and MIS. All parties voiced satisfaction with FPMD's work, and appreciated their ability to work cooperatively to best meet local needs. Some groups expressed the need for better documentation of the MDA process so that they could apply a similar technique with their NGOs. The only constraint identified was an occasional lack of sufficient briefing for visiting consultants, which meant that initial working time could have been used more constructively.

LIP

Staffed completely with local personnel, FPMD Boston project staff provide short term TA in specified areas, but have little involvement in the day to day operations. Given the nature and history of LIP, the project has continued to implement and expand their program activities since the beginning of FPMD. Most appropriately Overseas Study Tours (OST) to Indonesia have been replaced by In-Country Training Programs (ITP) which demonstrate LIP's success in model thanas in Bangladesh. At the same time, these ITPs further strengthen the capabilities of the model thana by necessitating a formalized process for sharing their experiences. The majority of activities have occurred on schedule and the primary constraint to implementation has been contractual delays and subsequent funding gaps (covered by FPMD core funds).

2.1.2 Technical Performance

CA/NGO

All CAINGOs have stressed the high quality and competence of FPMD's TA. They have greatly appreciated the availability of Boston staff, who they feel bring a needed international perspective to their work. For certain types of TA, FPMD has provided individualized consultants (e.g., MDA) and for areas such as TIE, workshops have been organized.

LIP

The technical aspects of LIP have included the study tours (OST & ITF), training workshops, provision of small grants, technical assistance for providers, management and staff, MIS, personnel, IEC and more. To date this mix of inputs appear to have been most appropriate in achieving the desired output of "supporting the government's effort to provide high-quality, locally-managed, sustainable family planning services to a greater number of couples."²

² Local Initiatives Program, Mid-Term Evaluation Briefing Book, April 1994, pg.11.

2.1.3 Impact

CA/NGO

Because this is a relatively new activity (since early 1993) the impact of FPMD's interventions is difficult to determine. However, the satisfaction of the group and their ability to identify future areas of need in working with NGOs, indicates preliminary impact. The agreement of the group on development of a single monthly report is another example. In order to make this type of determination it will be important to carefully evaluate this activity, especially its eventual impact on the service providing NGOs.

The total costs of this activity appear at first glance to be high (probably due to the expense of transporting and lodging large numbers of Boston based consultants), and one has to wonder if some of the necessary expertise may not exist, or be able to be rapidly built in-country.

LIP

After more than seven years of operation the impact of LIP is clearly visible. In thanas where LIP is active, at the local government level, government employees are well equipped to provide the necessary leadership and supervision for a quality family planning program. At the service delivery level, from Family Health Visitors (FHV - paramedic level) to volunteers, their knowledge, skills and motivation to provide services has been enhanced. Management structures, supervisory systems, logistic supplies, and on going training programs have been institutionalized. As a result, more eligible couples are receiving an expanded and quality contraceptive mix. Some thana areas are slowly reaching a phase of consolidation ready to "graduate" from LIP. It will be imperative for LIP to determine when and how this important transition is made. Evaluative steps are already being made in this direction. (Please see attached report for field observations.)

Of all the activities observed by the ET it was agreed that LIP was an appropriate model for FPMD. LIP truly demonstrates the impact strengthening of management capabilities can have on the expansion and quality of family planning services. LIP's contractual requirements (like those of FPMD) tend to constrain and limit its scope, but LIP has adapted well (as has FPMD) and continues to achieve its goals. The issuance of small start-up grants to local thanas, an important component of LIP's comprehensive "packet of technologies," has raised contractual questions. Because this granting process is critical to successful project implementation, the contract mechanisms must be clarified in future negotiations. If the BDG, USAID, FPMD and LIP agree to continue LIP's expansion of project areas, future funding will need to adequately reflect the expanded work load.

Evaluation is an on-going process within LIP, tracking CAR/CPR, staffing, training and supervisory issues. FPMD/Boston staff have provided technical assistance in conducting micro-surveys and focus group discussions, but local staff appear to be more than capable of handling their internal evaluation needs.

3.0 ORGANIZATION AND MANAGEMENT

CA/NGO

This activity is managed from Boston by the FPMD Regional Director. Some of the CA/NGO members voiced concerns about the difficulties of communicating long distance, and expressed the desire for local presence. The ET would like to see FPMD work to build local capacity by identifying (as they did with TAI/LIP) an appropriate in-country person to fulfill this role.

LIP

Is staffed and run by TAI, the local subcontractors. They report that FPMD Boston has been incredibly supportive and cooperative in all endeavors. Particularly when dealing with AID/Washington contractual issues, their assistance has been invaluable. All day to day management and operations decisions are made by the highly capable director and deputy director. Staffing seems appropriate, although questions were raised about the presence of only one woman at the managerial level. Apparently the difficult nature of the work (traveling frequently to remote rural areas for the ongoing monitoring and supervision of project activities) makes it difficult for women to assume these roles.

4.0 FINANCIAL MANAGEMENT AND CONTRACTUAL ISSUES

4.1 Relations with USAID/Dhaka

Both Bangladesh activities were initiated by USAID/Dhaka and are primarily funded through in country buy-ins. USAID/Dhaka with an extensive population portfolio, a highly competent staff, and a clear vision of their long term objectives, has been instrumental in facilitating FPMD's work in Bangladesh. The issue of buy-in funds being used to support U.S. CAs/intermediaries and/or to support Boston based operations was once again raised as an issue which needs to be addressed at the policy level in Washington. Mechanisms which are satisfactory to all parties (bilateral governments, CAs, local NGOs etc) need to be devised so that important population goals can be achieved in the most culturally appropriate, cost effective and efficient manner.

4.2 Relations with other CAs

The CA/NGO activity is clearly an indication that in Bangladesh, FPMD is working in a highly collaborative and complimentary fashion with local CAs. LIP also has cooperated with CAs (Pathfinder in the past and AVSC activities are planned). While the interactions between American CAs/intermediaries appears to be good, some questions were raised about collaboration with local NGOs. Given the internal politics of Bangladesh NGOs, this concern is understandable, but if the LIP's area of service delivery is to be expanded, it will be most important to cooperate/compliment the NGO's activities with those of LIP, rather than appearing to compete for the same service areas. Given the management skills and level of expertise within LIP this type of collaboration should be possible.

5.0 RECOMMENDATIONS

LIP:

- To continue moving from consolidation phase to sustainability, while continuing expansion in new areas with the tools and expertise developed to date;
- Explore possibility of including more females at the managerial staff level;
- Explore possibility for future working relations with local NGOs.

CA/NGO:

- Identify appropriate local resource to serve as coordinator of FPMD activities
- FPMD to focus on building local, in-country capacities for TA in areas of need

- Develop documentation necessary for CAs/NGOs, to replicate TA activities (e.g., MDA etc.)

USAID/DHAKA:

- Continue to facilitate cooperative efforts between CAs/NGO.
- Continue to serve as a programmatic and financial catalyst to BDG FP Program through support of LIP and other initiatives.

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BANGLADESH

THE CA-NGO PROJECT HEADS

Present: (see contacts list)

Place: USAID PHN Office, Dhaka

Date: 05/02/94

Time: 1515 hours

The directors of the five NGOs collaborating in a USAID-funded project gathered to discuss the overall objectives of this effort, and their experiences with FPMD assistance.

These organizations, called "CAs" in Bangladesh, differ considerably. Three are actually "traditional USAID intermediary organizations" (Pathfinder, AVSC, and The Asia Foundation). In each case, these organizations have **local staffing** (exception: TAB which has one American who is in the process of turning over responsibility to a Bangladeshi).

The FPAB is the IPPF affiliate organization in Bangladesh, really an NGO itself (it does not fund subordinate organizations). The FPSTC is a government-sponsored (but not funded) "special" organization to encourage, finance, train, coordinate, and supply NGO organizations.

This grouping of "CAS" includes the most important FP-related organizations working in the non-governmental sector.

FPMD has provided assistance to the group in three areas:

- (1) how to do management assessments (MDA)³;
- (2) training impact evaluations (TIE); and
- (3) MIS as related to "QES" -- quality, expansion, sustainability (of FP services).

All members of this group expressed satisfaction with the manner in which FPMD provided TA. Their role was to facilitate. A "common dictionary" resulted: all CAs now have a common frame of reference. A quality index was developed for use by all CAs. Training plans were developed for overseas training. Cluster reviews were done. A common reporting system for CAs to use with semi-annual USAID reports was put in place. Some management tools for USAID were developed.

Future assistance required:

- need over next 9 months to make "final products" tools; bring to closure;
- training institutions need time and some TA to internalize/institutionalize changes implied by TIE;
- planning: need MDA participatory workshop in realistic planning;
- with FPAB, need to sort out roles of volunteers vs. staff;
- self-assessment tools for field-level managers need to be developed and put into place;

³ MDAs are intended to strengthen the capability of CAs in identifying technical support they can provide to NGOs they support in promoting managerial, institutional, and financial sustainability.

- sustainability studies and training in sustainability options needs to be done;
- CAS need further training in the use of information for management decisionmaking and for planning;
- need focus on management of CAS as well as management of NGOs;
- need focus on how to collectively (i.e., multiple CAS) do strategic planning for partnerships with BDG program, including how best to transfer NGO skills to government program;
- need to document NGO management systems which have worked well, both for transfer to government program and for other countries; and
- need help in human resources development, personnel management, etc.

BANGLADESH

ASSOCIATION FOR VOLUNTARY STERILIZATION (AVSC)

Present: (see contacts list)

Place: AVSC HQ, Dhaka

Date: 05/04/94

Time: 1000 hours

AVSC/Dhaka is operating under a cooperative agreement (CA) with the USAID Mission in Dhaka (not AID/W). It is staffed entirely by local professionals and supporting personnel.

AVSC concentrates on clinical methods of contraception. Thus, it tends to engage the service delivery system at higher levels than does the FPMD-Local Initiatives Project which works at grass-roots level. These are seen as complementary activities.

AVSC has had little contact with FPMD other than the LIP and a bit thru the CA-NGO project. However, they are looking forward to a greater collaboration in the future in the context of a new program which they have proposed to the government.

Following the recent "Family Planning Fortnight", AVSC submitted a proposal to the BDG for a new project in two districts. The new project would take a "holistic" approach, top to bottom and would cover 100% of each district. It would attempt to put together the experiences and competencies of the many CAs and other FP players in Bangladesh, centering on the client as the organizing force. The new project would activate both civil and technical resources at all levels to provide increased coverage and quality of services.

As there is no wide tradition of "facilitative supervision", i.e., supervision which provides on-site TA and aims at helping the supervisee to do a better job (most supervision being quantitative, or "inspection", or punitively oriented), changing long-established cultural and professional habits will not be easy nor accomplished overnight. This will require continued work over a sustained time period. AVSC believes it is not only possible, however, but imperative if FP services are to truly be "available" and of acceptable quality on a wide scale in Bangladesh. The JHU/PCS IEC model "Jiggasha" (question) will play an important role in the new project, as will the LIP and other initiatives. It is hoped that the BDG (which has approved the plan in principle) will give the go-ahead and name the two districts soon. (NB: the CA-NGO activity should facilitate the harmonizing of CA inputs to the new project).

AVSC is uncertain at this time as to exactly what types of FPMD assistance may be required. They have very good relations with FPMD, however, especially with LIP, and look forward to future collaboration.

BANGLADESH

FAMILY PLANNING ASSOCIATION OF BANGLADESH (FPAB)

Present: (see contacts list)

Place: FPAB HQ, Dhaka

Date: 05/03/94

Time: 1515 hours

FPAB is the IPPF affiliate. It is a large and old organization, with a number of field offices. FPMD has not as yet provided assistance **directly** to FPAB, though FPAB has benefitted from FPMD's overhaul of the semi-annual report to USAID which was done under the CA-NGO project auspices.

However, FPAB would like very much to have FPMD support in the following areas:

- strategic planning - FPAB is operating under a number of budget constraints. The IPF (budgetary planning figure) is fixed for 3 years. FPAB would like to review its organizational structure in detail against its planned targets to see how they can best fit together;
- MIS - FPAB would like FPMD assistance to develop a set of management indicators for FP activities it does other than FP services (FPAB sees its primary role as IEC rather than service delivery);
- volunteer vs staff roles - FPAB is having trouble, as many voluntary organizations do, sorting out appropriate roles for its "volunteers" and its staff. They feel they need a comprehensive review of appropriate roles (a la Kenya FPAK); and
- FPAB feels there is a real need for self-evaluation tools and processes for mid-level managers in the field offices. They believe that the usual management reviews result in "garbage collection" (my term, not theirs), i.e., misleading responses from managers, supervisors, etc. They feel, however, that these workers know their own situations and limitations very well; somehow, they wish to capitalize on this fact to help their managers do self-assessments and corrections.

Some of these points were discussed with Alison Ellis. I promised I'd pass the request along to FPMD and USAID.

BANGLADESH

THE ASIA FOUNDATION (TAF)

Present: (see contacts list)

Place: TAF HQ, Dhaka

Date: 05/03/94

Time: 1015 hours

TAF supports a number of NGO subprojects (n=26) in Bangladesh. They have a population staff of 27 (including drivers and support staff). TAF has begun an experiment in two new areas with LIP. FPMD has provided assistance to TAF in three areas: (1) MIS; (2) TIE; and (3) MDA.

MIS. In the context of the CA-NGO project, FPMD has been working to synthesize/simplify a required semi-annual report to USAID among the five CA participants. This is a hybrid manual-dBase III system at the Asia Foundation. It is nearly complete and there is good satisfaction with the effort so far.

TIE. This activity also involved all CAs. FPMD started with an overall framework, within which protocols and indicators were developed and field tested. This was a "very good organizational learning experience."

MDA. TAF needed a "tool to assess the agencies we support". Steve Sacca, et. al provided necessary TA in a very collaborative way. The result was very positive and will be presented at NCIH meeting in Washington this summer.

Impressions of FPMD:

- They were very impressed with Alison Ellis and her ability to sort out some problems;
- FPMD is very good at using collaborative style;
- They are good at using local field experience (Bangladesh has it); they are mainly facilitators, drawing upon existing expertise;
- In general, consultants are very good and know how to dig out info and use local competencies;
- FPMD reports are "really weak". They are all process oriented. "We don't know what we're accountable for, where we're supposed to go. They just recount processes which we've just gone thru and don't need reminders about." Lack useful detail; too abstract and process oriented.
- Communications problems (again). Need to know context and some details of consultant visits ahead of time in sufficient time to plan own organizational staff resources; this would considerably reduce stress of multiple team visits.
- Coordination at Boston: teams come and ask the same questions; need for better preparation and better info sharing in Boston.
- FPMD needs to be a "more visible partner" in Bangladesh. They need an in-country presence.

The nature of TA differs for MIS, training, management, and service delivery. Much of the need cannot be handled by short-term consultants. There is a felt need (TAF) to move to a stage of critical self-analysis.

BANGLADESH

FAMILY PLANNING SERVICES AND TRAINING CENTER (FPSTC)

Present: (see contacts list)

Place: FPSTC HQ, Dhaka

Date: 05/03/94

Time: 1345 hours

FPSTC is neither an NGO nor a government entity. It was set up pursuant to a directive by the government's National Population Council as a secretariat to the FPCVO (FP Council of Voluntary Organizations). The FPCVO has as its aim the encouragement and coordination of NGO/PVO activities in family planning.

FPSTC has three basic functions:

- (1) to serve as a secretariat for FPCVO;
- (2) to encourage NGOs and to provide TA to them; and
- (3) to coordinate all NGO players.

FPSTC has received USAID assistance since 1983 for the following 6 functions:

- (1) training assistance to NGOs
- (2) TA to NGOs
- (3) funding support for 50 NGOs (some of which are umbrella NGOs)
- (4) publications/communications support to NGOs
- (5) coordination of NGO activities
- (6) provision of contraceptives and other supplies to NGOs.

Under UNFPA funding, FPSTC provides:

- (1) TA to local level NGOs
- (2) seed funds to initiate FP within existing NGOs.

A JHU/PCS project provides funding for FPSTC to do training for BDG personnel in IEC at the local community level.

All FPSTC staff are in the HQ office in Dhaka (consisting of 30 professionals and 29 support staff).

The BDG is experimenting with private sector logistics activities. The FPSTC has a proposal in to the MOH Directorate of FP to do a pilot logistics project in 35 Thanas.

FPMD Support:

FPMD has provided three types of assistance to FPSTC:

(1) MDA (process underway; have learned a lot; may need more TA, especially with respect to taking MDA to the NGO level); too early to evaluate assistance but generally pleased.

(2) TIE Several workshops held. FPSTC was looking for tools and techniques to do TIE. In process. Looks promising.

(3) MIS Revised semi-annual report requirements to USAID. Very useful simplification of procedures (of Asia Foundation).

Observations:

- FPMD works in collaborative way;
- U.S. consultants give international flavor, and help to transport international experiences -- will always need SOME level of their input;
- at some future point, FPSTC can develop local competencies to do this type of assistance with other organizations;
- would be nice if a continuity of personnel could be maintained.

Future requirements:

- (1) training program for program officers - not available anywhere; program officers are "jacks of all trades", and must be able to handle a wide variety of tasks, both technical and administrative; need special training program for them;
- (2) "we gather a lot of information; we need help in assembling and utilizing this information well for management decisionmaking and for planning"

Overall:

Very satisfied with FPMD collaboration thus far.

BANGLADESH

PATHFINDER INTERNATIONAL - DHAKA

Present: (see contacts list)
Place: PATHFINDER HQ, Dhaka
Date: 05/05/94
Time: 0900 hours

FPMD interaction with Pathfinder/Dhaka has been limited but important. In the context of the "CA-NGO" project, FPMD has worked with Pathfinder and other CAs in MDA workshops, TIE, and MIS (the semi-annual USAID report).

MDA assistance was provided via a 2-day workshop at the Sheraton-Dhaka, followed by several one-on-one meetings. Outcome was positive: "pretty good, but not excellent". Overall, it was felt that MDA is a very useful tool. It is particularly useful for "diagnostics", i.e., identifying problem areas. It is short on providing solutions. Pathfinder believes some help in working out solutions would be useful.

The MIS team was OK, but not fully briefed on the programs of the organizations they worked with. Therefore, output from the first visit was not as great as could have been the case had they been better briefed (also, they would have consumed less time of the clients they were to be helping).

TIE was done in conjunction with FPSTC and other CAS Pathfinder sends managers and supervisors to FPSTC for training. Fieldworkers are trained by Concerned Women (Asia Foundation subcontract). TIE was found to be a very useful exercise.

Pathfinder appreciated the very collaborative style of FPMD, rather than a prescriptive approach.

Pathfinder is also engaged in funding NGO outreach activities. Unlike the LIP, these are pretty much independent of the BDG-MOH infrastructure. Volunteers tend to be literate (and keep more elaborate records than those in LIP), and are supervised by NGO supervisors (not MOH personnel). They are assigned to work in areas NOT COVERED BY GOVERNMENT OR LIP EFFORTS. Sometimes, these are the most difficult areas in the country. Clients are referred to MOH facilities for clinical methods. Pathfinder's grantees make some attempts to involve the community and its administrative infrastructure, but these are apparently less elaborate and less intensive than LIP (e.g., no community financing is involved).

These CBD efforts are said to be "data rich", in that they contain very detailed information on each user. (I don't have a good idea of how these data are being exploited, if they are).

BANGLADESH

LOCAL INITIATIVES PROGRAM

Present: (see contacts list)

Place: LIP office Dhaka, Thana field visits

Dates: 05/01-05/94

INTRODUCTION

FPMD's Local Initiative Program (LIP) is its oldest and largest project activity. Atypical of other FPMD activities it is managed and directed by a local subcontractor and today receives primarily contractual and some technical assistance support inputs from FPMD/Boston. LIP's activities involve distribution of small grants, management as well as service delivery interventions, training and study tours, and TA involving over 300 individuals.

HISTORY

LIP is an outgrowth of a 1980-1982 project supported by USAID/Dhaka, under which about 300 Family Planning Officers from the upazilas (local level of government, later renamed thanas) visited Indonesia to observe their successful family planning program. An evaluation of the program suggested that it would be more successful if teams of local government and family planning officials, rather than just one individual, traveled together on observation study tours. In 1987, FPMT under a series of buy-ins from USAID/Dhaka, began to implement this expanded project through a subcontract with Technical Assistance, Inc. (TAI), a local Bangladesh management consulting firm.⁴ The observation study tours (OST) were adapted to conclude with an Action Plan workshop, where the teams planned improvement in their local family planning programs, based on what they had observed. Technical assistance and monitoring of the action plans was provided by FPMT.

PROJECT DESCRIPTION

Funded at a level of \$7.5 million for 1990-1995, LIP has been designed to enable the Government of Bangladesh's (BDG) thana level family planning staff and below to increase their effectiveness in offering high-quality, sustainable family planning services to a greater proportion of eligible couples.⁵ Through an innovative package of carefully tailored training, technical assistance and small grants, LIP has developed high-level support as well as local commitment for management teams, and introduced management skills in planning, implementation and monitoring down to the local levels of service delivery.

To date LIP is operating in 44 of the 64 districts, 79 of the 460 thanas, and 235 of the 4325 unions. A population of 4.5 million people (approximately 4% of the total population), including 728,579 eligible couples are covered with a volunteer field force of 13,586 in addition to government employed health

⁴ Current staff includes a Program Director, Deputy Program Director, 9 program staff, 8 support and administrative staff, and 6 secretarial positions (total 25).

⁵ There are a total of 460 Thanas in Bangladesh. At the Thana level there is usually a referral hospital with in patient facilities, but limited surgical capacity (e.g. no c/sections are performed, but are referred up to one of the 64 district level facilities). The thanas are divided into unions, with each union served by one government employed Family Welfare Visitor (FWV), a paramedic equivalent who has completed 12 grades plus 18 months of training. Unions are further divided into units, with each unit representing a population of approximately 5,000 (i.e. 800 eligible couples). A Family Welfare Assistant (FWA), who has completed 12 grades and 9 months of training, is employed at this level.

workers (FWV and FWA). The current contraceptive acceptance rate (CAR)⁶ in the LIP areas is 59%, versus 55% nationwide.

How LIP works

In recent years the OST has been replaced by in-country training programs (ITPs), visits to successful, well-managed programs in Bangladesh. Six ITPs have been conducted, with teams from four thanas attending each ITP. The teams, consisting of elected officials, thana level family planning staff, and community representatives, observe the details of program management and prepare an action plan for their own thana. Field visits to satellite clinics, volunteers homes and local meetings are an important part of this process.

The action plan is presented to the Ministry of Health and Family Welfare (MOHFW), the Directorate of Family Planning (DFP), FPMD and USAID officials for suggestions and approval. At the end of the ITP each thana team takes with them the approved action plan and the first tranche of a small grant for program implementation (mainly intended to cover volunteer transportation and training costs) in one selected union.⁷ After one year of successful operation in one union, implementation is expanded to other unions. During the entire implementation phase LIP/FPMD provides on-going training, intensive monitoring and technical assistance to all levels of the thana team, from management down to the volunteers.

LIP uses four approaches to providing well-managed, decentralized and community based services:

- (1) Family planning program staff, local leaders and administrators of government health and development programs become partners as part of the thana team.
- (2) Community members are actively involved in managing their FP/MCH program and serve on the family planning management committees that oversee the FP/MCH operations at the village and thana level.
- (3) Local women actively participate in family planning activities by serving as community volunteers who provide family planning information (motivation) and services directly to eligible couples (including resupply of pills and condoms, and working at the satellite clinics).⁸
- (4) The community helps to finance the implementation of the action plans, by matching the LIP grants with at least a 10% cash contribution from local resources.⁹

These above approaches have resulted in an increase in both community participation and in their feeling of responsibility for program performance. Increases in CPR have been demonstrated in all LIP thanas, with significant increases in those thanas where CPR was especially low prior to project implementation. In thanas where CPR was high (50%+) increases have not been as significant, but

⁶ Contraceptive Acceptance Rate (CAR) is the percentage of total eligible couples identified by the program who receive a modern contraceptive method from the program on a regular basis. This term is used by the BDG in its reporting system.

⁷ A very efficient way to shorten a lengthy and complicated BDG approval process.

⁸ Each volunteer serves approximately 50 households, mapping all eligible couples in her area and keeping a register of services provide. She is supervised by a government employed FWA.

⁹ Local Initiative Program, Mid-Term Evaluation Briefing Book, April 1994, pg. 31.

increased community involvement, cooperation and utilization of government services, and improvement of the quality of MCH/FP services (especially availability of curative services and expanded method mix, e.g., injectibles and IUDs) have been the area of focus.

Other LIP/FPMD activities

LIP/FPMD has developed a number of management and training manuals in both English and Bangla for use in this program. These are well developed tools which can be used from the management down to the service delivery level for project implementation. Similar manuals and tools have been developed for internal use. LIP/FPMD has also developed a Personnel MIS system for the DFP enabling them to update and track the transfer of thana level staff on a monthly basis. Another Personnel MIS for FWAs (23,400) has been developed. A number of workshops for thana level management personnel and field level workers (FWV, FWA and FPI) have been conducted. In turn, the local level field workers are responsible for volunteer training.

FIELD OBSERVATIONS OF LIP

During the mid-term evaluation, two days were spent in the field observing the LIP program. Interviews were conducted with all levels of personnel, from thana level officials to the volunteers. Observations were made of a Thana Health Complex (THC) Family Health Center (FHC), Rural Dispensary, and Satellite Clinic.

Interviews revealed a high level of commitment and comprehension of the needs for comprehensive MCH/FP services with active community as well as government participation and cooperation. Words had truly been converted to action in the integration of this volunteer service delivery project, with government provided MCH/FP services. Volunteers stated satisfaction and pride in their work. They also voiced appreciation for the opportunity to be active outside of their homes and for continued training and learning opportunities. FWAs and FWVs, some of them long standing government employees, appreciated the enhanced ability to provide quality and expanded services thanks to the volunteers' assistance. They also stated that improved management practices had greatly improved the available supplies (especially medicines necessary for treatment of reproductive infections, surgical gloves etc.) as well as the support and supervision they received from the supervisory and management levels. Increased workloads were a concern in one area where the utilization of services had increased so significantly that one FWV could barely provide all the care necessary.¹⁰ Community level (Thana, Union and Unit) leaders (primarily men) expressed their satisfaction with LIP and stressed their continued commitment to its goals. Administrative officials from the thana level (doctor, supervisors, family planning officers etc), to the union and unit levels also felt that their awareness of management issues (planning, personnel, MIS, supervision) had been greatly enhanced, but required continuing enhancement and technical assistance for continued program improvement and sustainability. Project implementation in the thanas visited was relatively recent (1991-1992) which explains these comments. LIP is clearly viewed by all as a "long term commitment" to the goal of providing quality MCH/FP services on a sustainable basis.

¹⁰ This was at a satellite clinic where 69 patients were registered in only 4 hours. Ten IUDs were requested, and 7 inserted during this time (3 were rejected and treated for medical reasons).

CONCLUSION

Project accomplishments to date are highly commendable and a model for the integration of "top-down" management interventions at the governmental level, with "bottom-up," community supported development and MCH/FP activities. Credit for the success of this program goes in large part to the long term commitments and support of USAID/Dhaka, the BDG, and FPMD/MSH, Boston. The superb implementation of program activities can be credited to TAI, led by Abu Sayeed, Program Director, whose strong and visionary leadership has allowed this program to develop from infancy to its current "young adult" status. As this program expands to other parts of Bangladesh, and moves toward programmatic sustainability, the continued commitment and support of all parties will be crucial.

Appendix F - Mexico - Observations and Conclusions

MEXICO COUNTRY REPORT

1.0 GENERAL

1.1 INTRODUCTION

Contraceptive use in Mexico has increased from approximately 30% of women in reproductive age in 1976 to 53% in 1987. The increase, however, has not been uniform. In 1987 only 33% of reproductive aged women in rural areas used contraception, compared to 59% in urban areas.

The GOM has increasingly committed itself to an ambitious population program and family planning has consequently become a national priority. In response to this favorable policy environment, a new USAID population assistance strategy was formulated in 1991. The plan's strategic objectives are to increase contraceptive prevalence in rural areas, and increase program sustainability. Implicit in the plan is the phase-out of USAID support within 5-6 years and a reduction in the number of CAs working in Mexico.

Family planning services in Mexico are provided in both the public and private sector. The public sector provides more than 60% of family planning services in Mexico. The primary public sector providers are IMSS (the social security health service) and the SSA (Ministry of Health). The largest institutional providers in the private sector are MEXFAM and FEMAP.

In Mexico, FPMD is working with MEXFAM and FEMAP in the private sector and SSA in the public sector. The SSA is the second largest provider of family planning services in Mexico. It serves approximately 16% of all family planning users. Services are provided in approximately 5,700 hospitals, clinics and rural health posts and by an extensive network of more than 12,000 health auxiliaries who provide services in 13,000 rural Mexican communities. The DGPF, located in Mexico City, is the federal-level body responsible for coordinating the SSA's family planning program which is executed by the states. It's main program responsibilities are planning, information and evaluation, research, training, supervision, and the development of service norms.

MEXFAM is the largest NGO providing family planning in Mexico. As the Mexican IPPF affiliate, MEXFAM provides services in 25 states and in 1993 served over 500,000 clients. To provide services MEXFAM operates a number of programs, including community distribution, community-based physicians, clinic-based services, factory-based services, adolescent sex education and support to other institutions. The programs are coordinated by 36 "logistics centers" located throughout the country. MEXFAM has an operating budget of approximately US \$5 million, of which 80% of funds are provided by external donors, primarily USAID and IPPF.

FEMAP is a federation of 44 private, non-private family planning organizations that provide services in 25 of the 31 states of Mexico. In addition to family planning, FEMAP affiliates provide general health care services. They are also involved in a wide range of social development activities. Since its inception in 1981, FEMAP and its affiliates have relied heavily on USAID support. At its peak, USAID funding represented 65% of FEMAP headquarters annual budget.

1.2 METHODOLOGY FOR ASSESSMENT

Evaluation of FPMD activities in Mexico was conducted during the week of April 25- 29, 1994. Meetings were held with USAID/Mexico and with the in-country representatives of The Population Council, IPPF, and Pathfinder International. A MSH staff member, who was on travel duty in Mexico,

and a FPMD consultant were interviewed. A local research consulting firm contracted by FPMD was also contacted. Visits were made to each of the institutions where FPMD is supporting interventions: SSA, MEXFAM and FEMAP. During these visits, key individuals involved with the interventions supported by FPMD were interviewed. At the DGPF/SSA, where FPMD has just begun to support TQM/CQI interventions, the evaluator attended two QIT meetings. At MEXFAM, where FPMD also supports TQM/CQI interventions, the evaluator conducted a group interview with a group of community doctors who had just completed CQI training, attended a QIT meeting at one of MEXFAM's clinics and observed a CQI training course for community doctors.

2.0 FPMD ACTIVITIES IN MEXICO

2.1 IMPLEMENTATION, TECHNICAL PERFORMANCE, IMPACT

2.1.1 Implementation

FPMD assistance in Mexico has focused primarily on two areas: institutionalization of TQM/CQI and achieving financial self-sufficiency. The bulk of FPMD assistance has also been provided in collaboration with The Population Council OR project, INOPAL.

Institutionalization of TQM/CQI: At MEXFAM, since 1991, FPMD has collaborated with INOPAL by providing training and technical assistance to MEXFAM staff in TQM/CQI. With FPMD support, a series of four manuals have been produced and are used to train MEXFAM staff in TQM/CQI. (Five manuals were to be produced. The fifth manual has not been produced due to changes in leadership in MEXFAM's TQM/CQI activities.) While initially INOPAL covered the honoraria of MEXFAM's TQM/CQI consultants, FPMD has recently assumed this responsibility. Together with IPPF and INOPAL, FPMD also sponsored a regional conference on CQI to disseminate the MEXFAM TQM/CQI model in the LAC region. For this conference, a manual on the quality of family planning was prepared by INOPAL for which FPMD covered the editing and production costs.

In late 1993, the DGPF of the SSA requested FPMD's assistance to implement TQM/CQI. FPMD is providing training and technical assistance to DGPF headquarter staff. In a very short time since sub-project initiation the DGPF has defined its mission and formed seven QITs dealing with improvement of administrative and managerial processes at the central level. Before the end of the first year, TQM/CQI will be introduced on a trial basis in one state and will focus more directly on service delivery processes.

Improving financial self sufficiency: At FEMAP, FPMD and INOPAL have successfully collaborated to assist FEMAP affiliates with achieving financial self-sufficiency. FPMD has provided training and technical assistance to FEMAP headquarters and affiliate staff to conduct client profiles. A Mexican consulting firm has been contracted to conduct market analyses. These activities have been designed to complement INOPAL's support for cost studies. With FPMD assistance, profiles of clinic and CBD clients at 7 affiliates and market analyses at 3 affiliates have been conducted. The information from the cost studies, client profiles and market analyses will be used by affiliates to price services, reduce costs and identify new markets, all of which are expected to contribute to affiliate self-sufficiency.

To assist MEXFAM with attaining financial self-sufficiency, FPMD has been working with MEXFAM since 1993 in the area of fund raising. A fund raising plan based on personal solicitation has been developed and a full-time staff member has been hired to be responsible for fund raising efforts.

Unlike other countries where FPMD works, neither country or institutional assessments have been conducted in Mexico. The decision to work with one or another institution and the interventions to support at each institution has largely been determined by USAID/Mexico and/or FPMD's desire to collaborate with The Population Council. The specific interventions supported at MEXFAM and FEMAP, for example, were selected in cooperation with the local institution and The Population Council.

While the interventions supported at all of the institutions in Mexico meet significant management needs, opportunities for more effective assistance may have been missed. By not conducting needs assessments, the project has been more reactive than proactive in meeting institutional needs for management assistance.

2.1.2 Technical Performance

In Mexico, FPMD has utilized an appropriate combination of technical inputs. For the most part, FPMD has relied on qualified Mexican expertise. In the area of TQM/CQI, for example, FPMD (and INOPAL) have contracted Mexican consultants with TQM experience in the private sector to provide assistance to MEXFAM and DGPF. As mentioned, a Mexican research firm has been contracted to conduct FEMAP's market analyses. FPMD and non-FPMD MSH staff were utilized to provide training and technical assistance to FEMAP in order to conduct its client profile studies. In this case, Mexican expertise -- if available -- might have been more appropriate. A FPMD staff member, who is a former PPFA Director, has been very appropriately used to provide technical assistance to MEXFAM in fund raising based on PPFA techniques used in the U.S.

As a result of FPMD assistance, Mexican institutions supported by FPMD interventions are better able to define their objectives. For example, the DGPF has defined its mission. Both of these accomplishments are direct results of TQM/CQI interventions, supported in part by FPMD at MEXFAM and entirely at DGPF.

Institutions receiving FPMD assistance have/will have improved strategies, structures, and systems in place which will increase their management effectiveness, strengthen institutional capacity and support quality service provision. Owing to the technical assistance provided by FPMD, MEXFAM has re-formulated its Board of Directors in accordance with its fund raising plan and has developed a strategy for fund raising. Also at MEXFAM, the majority of staff have/will have participated in TQM/CQI training and QITs. As a result of the training and technical assistance provided by FPMD and INOPAL in TQM/CQI, new managerial structures, in the form of QITs, have been introduced in the institution. QITs have also been established at the DGPF. Also as a result of combined, FPMD/INOPAL assistance, 8 FEMAP affiliates will have the technical tools to make important decisions regarding costs, prices and new markets in order to improve their financial self-sufficiency.

While the DGPF has just initiated efforts to introduce TQM/CQI within the DGPF, before the end of the first year TQM/CQI will be introduced on a trial basis in one state where its effect on service provision can be measured. The potential impact of this sub-project is significant given that the SSA is the second largest provider of family planning in Mexico.

A number of FPMD outputs contribute to institutionalization. At MEXFAM, for example, the TQM/CQI manuals produced with FPMD assistance have been used for several years. They are now being used at the DGPF for introduction for TQM/CQI. The training and technical assistance provided to FEMAP has strengthened its capacity to conduct client profiles and extend this benefit to other affiliates.

Institutionalization of the methodology and technology transferred to local institutions has encountered problems beyond FPMD's control. A number of Mexican counterparts at the institutions assisted by FPMD have subsequently changed jobs. Such is the case at MEXFAM and FEMAP, where the individuals primarily responsible for the interventions supported by FPMD, and who have received significant training and technical assistance, have left the institutions. Institutionalization has also been made difficult in instances where executive leadership has occasionally failed to promote FPMD-assisted interventions.

2.1.3 Impact

The only sub-project in Mexico that has been evaluated is the TQM/CQI sub-project at MEXFAM. In March 1993, INOPAL and FPMD conducted a joint qualitative process evaluation of the TQM/CQI process introduced at MEXFAM. Using focus groups, INOPAL and FPMD were able to assess the effectiveness of TQM/CQI, as perceived by MEXFAM staff who have participated in the process. That evaluation highlighted the utility of TQM/CQI in clinic rather than administrative settings. Consequently, MEXFAM is now introducing TQM/CQI at more service sites ("logistic centers") than originally planned.

In 1994, FPMD conducted a quantitative impact evaluation of the impact of TQM/CQI on the volume of services provided in "logistics centers" where it had been implemented. Results were mixed and difficult to interpret due to a number of intervening variables beyond FPMD's control (such as the introduction of fees for contraceptives and changes in the types of services offered). In general it appears that there have been isolated improvements in performance, but limited global impact. This may be due to the fact that in many instances TQM/CQI has targeted processes that are indirectly related to or are small components of service provision, such as provider training, client reception, client flow, and clinic facilities. When indeed TQM/CQI was used by community promoters to analyze the process for recruiting new clients, changes in the process resulted in nearly a twenty-fold increase of new users.

A comprehensive evaluation visit is scheduled for the third quarter of 1994 and will examine TQM/CQI more closely. This evaluation is very significant because TQM/CQI is being promoted, and replicated, by both FPMD and INOPAL, without a solid understanding of its effectiveness or cost-effectiveness.

An evaluation of FPMD's interventions at FEMAP is scheduled for 1994.

The TQM/CQI interventions at DGPF and fund raising intervention at MEXFAM are too recent to have undergone evaluation.

3.0 ORGANIZATION AND MANAGEMENT

FPMD sub-projects in Mexico are managed directly from the LAC Unit in Boston. The LAC Unit is currently adequately staffed, although staff shortages early in the project contributed to slow start-up of activities in the region.

USAID/Mexico emphasizes that MSH/FPMD is recognized for the high quality of its staff. The executive management of FPMD sub-projects in Mexico report that FPMD is the best cooperating agency of all with which they work. FPMD is viewed by its sub-projects as a trustworthy, flexible partner in a collaborative endeavor.

4.0 FINANCIAL MANAGEMENT AND CONTRACTUAL ISSUES

USAID/Mexico is very satisfied with FPMD's work in Mexico and describes it as "timely, effective and useful".

FPMD's work in Mexico is characterized almost entirely by collaboration and coordination with other CAs. FPMD has collaborated most with INOPAL (see above for discussion on impact). It coordinates its activities well with the lead CAs, Pathfinder International in the public sector and IPPF in the private sector. This coordination takes the form of reports and visits when FPMD staff is in country.

DIRECCIÓN GENERAL DE PLANIFICACIÓN FAMILIAR (DGPF)

Introduction

The SSA (Ministry of Health) is the second largest provider of family planning services in Mexico. It provides services in approximately 5,700 hospitals, clinics and rural health posts. It also oversees an extensive network of more than 12,000 health auxiliaries who provide services in 13,000 rural Mexican communities. Users of SSA services are generally poor, work outside the formal workforce and live in periurban or rural communities. The *DGPF* is the federal-level body responsible for coordinating the SSA's family planning program which is executed by the states. The *DGPF* is located in Mexico City and has the following program functions: planning, information and evaluation, research, training, supervision and development of service norms.

FPMD

Since late 1993, FPMD has been supporting the introduction of TQM/CQI at the *DGPF/SSA* in Mexico City. The subproject has total support from the *DGPF* Director and is being coordinated by his personal assistant. FPMD has contracted a local consultant who is providing training and technical assistance to introduce TQM/CQI.

To initiate implementation of TQM/CQI at the *DGPF*, FPMD supported a seminar for senior management staff. At this seminar, the *DGPF* mission was defined. The following improvement areas were also identified as the focus for the first year of TQM/CQI activities at the central level: teamwork, improving internal image; simplification of administrative procedures, personnel recognition and merit system, improving internal communication and logistics. Since the seminar, seven QITs (one for each improvement area) have been formed. Following six months of TQM/CQI activities at the central level, TQM/CQI will be implemented in one state and will focus on service delivery issues.

Conclusion

FPMD support for TQM/CQI at the *DGPF* has recently been initiated. It is thus still too early to assess its impact on the quality, access and coverage of family planning services. Senior management, however, reports great satisfaction at the opportunity to address important longstanding problems that affect the effectiveness of the *DGPF* to support service delivery. They look forward to gaining experience with TQM/CQI during the first year of the subproject in order to apply it at the service delivery level.

DGPF/SSA is the second institution in which FPMD is supporting TQM/CQI as a management intervention. The FPMD country evaluation for Mexico should focus heavily on the effectiveness of TQM/CQI as a family planning management intervention and how, or whether, it should be replicated in other settings.

FEMAP

Introduction

FEMAP is a federation of 44 private, non-private family planning organizations that provide services in 25 of the 31 states of Mexico. In addition to family planning, *FEMAP* affiliates provide general health care services, and are also involved in a wide range of social development activities. Since its inception in 1981, *FEMAP* and its affiliates have relied heavily on USAID support. At its peak, USAID funding represented 65% of *FEMAP* headquarters annual budget.

FPMD

In April 1992, AID/Mexico City indicated that FPMD could play an important role in helping to achieve the Mission's goal for improving self-sufficiency in the private sector. The Mission specifically requested that FPMD assistance focus on *FEMAP* since it had already suffered serious reductions in USAID funding and would be more seriously affected by total phase-out of USAID support than MEXFAM, the IPPF affiliate. During this evaluation, the Mission confirmed its interest in the sustainability of *FEMAP* as a federation.

The initial FPMD needs assessment visit to *FEMAP*, also in April 1992, identified that *FEMAP* had already submitted a proposal to The Population Council INOPAL II project to conduct an analysis of service costs at a number of *FEMAP* affiliates. FPMD and The Population Council thus agreed, in November 1992, to collaborate and support complementary activities to assist *FEMAP* affiliates in achieving self-sufficiency. Specifically, INOPAL has supported cost studies at seven *FEMAP* affiliates and production of a manual on cost analysis. At the same seven affiliates, FPMD has supported training and technical assistance for *FEMAP* headquarters staff to conduct client profile studies, emphasizing their ability and willingness to pay for services. FPMD has also supported market analyses for each of the seven affiliates.

All of the cost analyses, client profiles and market analyses have been completed. *FEMAP*, is now preparing reports for each affiliate which combine the results of the cost analysis, client profiles and market analysis. One report has been completed. These reports will provide recommendations regarding price setting, cost control and new markets, enabling the affiliates to make decisions that positively affect their financial self-sufficiency.

FEMAP and INOPAL report that collaboration with FPMD has been excellent. *FEMAP* further reports that one of, if not the most, satisfying CA relationships is with MSH because of FPMD's sincere interest in working with *FEMAP*, and its willingness to work together in partnership in analyzing institutional needs and seeking solutions.

Conclusion

The impact of FPMD assistance on the sustainability of *FEMAP* affiliates can not yet be determined since the reports resulting from project interventions are still undergoing preparation. Given the collaborative nature of the sub-project, future improvement in the sustainability of *FEMAP* affiliates can only be associated with the combined interventions of both INOPAL and FPMD. Future FPMD assistance to *FEMAP* should consider focusing on the sustainability of *FEMAP* as a federation.

MEXFAM

Introduction

MEXFAM is the largest non-governmental organization providing family planning in Mexico. As the Mexican IPPF affiliate, *MEXFAM* provides services in 25 states, and in 1993 served over 500,000 clients. *MEXFAM* operates a number of programs, including community distribution, community-based physicians, clinic-based services, factory-based services, adolescent sex education, and support to other institutions. These programs are coordinated by 36 "logistics centers" located throughout the country. *MEXFAM* has an operating budget of approximately US\$ 5 million; 80% of the funds are provided by external donors, primarily USAID and IPPF.

FPMD

Since 1991, FPMD has collaborated with INOPAL in its effort to introduce TQM/CQI within the institution. Compared to INOPAL, FPMD's support for CQI at *MEXFAM* has been small. FPMD has specifically supported the development of four booklets used by *MEXFAM* to train staff in TQM/CQI. Together with INOPAL, FPMD has also supported training and technical assistance to quality improvement teams that have been formed within *MEXFAM*. These teams have focused on a wide range of administrative and clinical processes, such as expense reporting, evaluation reporting, clinic reception, first time clinic visits, training, community promotion. FPMD also contributed to the production costs of a manual prepared by INOPAL, on the quality of family planning care. A joint INOPAL/FPMD qualitative evaluation of CQI interventions was conducted in 1993. In 1994, FPMD conducted a quantitative evaluation on the impact of CQI on the volume of *MEXFAM*'s new and continuing users.

Since 1993, FPMD has also been providing *MEXFAM* with technical assistance to develop a fund raising program, utilizing PPFA fund raising techniques used in the US, in an effort to assist *MEXFAM* in achieving financial sustainability.

Conclusion

The impact of FPMD support for TQM/CQI on the quality and sustainability of *MEXFAM* services is difficult to ascertain due to the collaborative nature of the work with INOPAL. Impact is also difficult to determine since one of the major problems encountered with implementation of *MEXFAM*'s quality improvement teams is that solutions were implemented without obtaining base-line measurements. Nevertheless, the *MEXFAM* experience with TQM/CQI is important to have received INOPAL/FPMD support; it is the first TQM/CQI initiative to be tried in family planning programs, and will undoubtedly provide important lessons for replication/adaptation in other settings.

It is premature to determine the impact of FPMD support for fund raising on *MEXFAM*'s financial sustainability. This initiative is important because it will also demonstrate the effectiveness of using successful United States fund raising techniques for family planning in a different cultural setting.

Appendix G - Bolivia - Observations and Conclusions

BOLIVIA COUNTRY REPORT

1.0 GENERAL

1.1 INTRODUCTION

Bolivia, a small land-locked country of 6.4 million people, has the highest population growth rate in Latin America (2.7%). Its contraceptive prevalence rate is also one of the lowest in the region. While 30% of reproductive aged women in union use a contraceptive method, only 12% use modern contraceptive methods, primarily the IUD and sterilization.

Family planning has long been a sensitive policy issue in Bolivia. In the late 1980s, however, concern began to grow about the need for family planning services. As a result of a more favorable policy environment, in 1990 USAID signed an agreement with the GOB to implement the National Reproductive Health Services Project.

Both the public and private sectors participate in the Bolivian National Reproductive Health Services project. The two most important public sector institutions providing reproductive health services are the MOH and CNS.

The MOH has the largest infrastructure in Bolivia and provides health care to approximately 34% of the population. However, it provided only 9% of all family planning care (measured in CYPs) in the first semester of 1993 (latest data available), which is less than each of the major NGOs.

CNS is the health services branch of the Bolivian social security institute. It provides health care to formally employed persons and their dependents, who constitute approximately 20-25% of the population. Reproductive health services are currently provided in 7 hospitals and 18 out-patient clinics throughout Bolivia. It also provided 9% of the family planning care (also measured in CYPs) in Bolivia in the first semester of 1993.

CIES is a private, non-profit organization that was founded in 1987. It operates a network of 8 clinics located in La Paz and Bolivia's major cities. It reported 31% of all CYPs in the first semester of 1993, and is thus the largest single provider of family planning services in Bolivia. Family planning services are provided in its clinics as well as through its CBD and Affiliated Doctors Program.

1.2 METHODOLOGY FOR ASSESSMENT

Evaluation of FPMD activities in Bolivia was conducted from May 3-6, 1994. Meetings were held with USAID/Bolivia and with country representatives of Pathfinder International and The Population Council. The FPMD Resident Advisor and a FPMD consultant were interviewed. Visits were made to CNS and CIES where key individuals involved with the interventions supported by FPMD were interviewed individually and in groups. Two CNS clinics and two CIES clinics were also visited. An interview was also conducted with the director of an institution that does not receive FPMD support but who has participated in a management training workshop sponsored by FPMD. Interviews could not be scheduled with the MOH because the program coordinator was on personal leave.

2.0 FPMD ACTIVITIES IN BOLIVIA

2.1 IMPLEMENTATION, TECHNICAL PERFORMANCE, IMPACT

2.1.1 Implementation

In 1991, FPMD conducted a Management Needs Assessment in Bolivia. The plan called for working with the MOH and CNS in the public sector and CIES in the private sector. The assessment further determined the need for a long-term Resident Technical Advisor to provide technical and administrative support to FPMD activities in Bolivia.

FPMD activities at the MOH were canceled since they were to be centrally funded. With the advent of the "Big Country" strategy, FPMD was discouraged from using central funds in Office of Population non-priority countries. FPMD's interventions in Bolivia have thus focused on two institutions initially identified in the needs assessment: CNS and CIES.

2.1.2 Technical Performance

At both CIES and CNS, FPMD has focused its work on the three levels of an organization: 1) mission or strategy, 2) structure and 3) systems.

At the mission or strategy level, FPMD has assisted CIES to re-define its mission and prepare new statutes. Strategic and operational plans based on the institution's new mission have been developed. At CNS, an operational plan for the Reproductive Health Program was developed. Service and IEC objectives have also been established on a regional and clinic basis.

At the structural level, CIES has also been re-structured. Changes were made in the Board of Directors and the roles and responsibilities of the Board, Executive Director and operational levels were re-defined. A new Executive Director was hired. Clinic administration and finances have been decentralized and staffing patterns were reduced and standardized. At CNS an organizational chart was developed for the reproductive health program. A personnel manual was also prepared. With FPMD assistance, a matrix program management structure was introduced, which has given the National Reproductive Health Program Coordinator the authority and responsibility for the program which she previously lacked. FPMD also provided guidance in assuring that the program be adequately staffed at the central level.

At the systems level, steps have been taken at CIES to improve personnel management and logistics and supply systems have been made more efficient. To reduce reliance on external donor funds, income-generating activities have been implemented. CIES' service statistics system is undergoing re-formulation. Progress has been slowest in improving CIES' financial management systems. A computerized finance module, TecApro, has been installed, but none of its modules are yet fully operational. Assistance is currently being provided to improve CIES' manual accounting system in order to make it compatible with the data entry needs for TecApro. Until the system is ready, CIES continues to rely on a cumbersome project-based, rather than institutional, manual bookkeeping system.

At CNS, FPMD has focused its systems interventions on the functions of planning and evaluation. FPMD has sponsored planning and evaluation workshops to set service delivery and IEC goals, evaluate goal achievement and identify service delivery problems and recommend solutions.

In addition to direct assistance to institutions, FPMD has also played an important role in supporting management development at multiple institutions. In a workshop held in 1993 management training was provided for key individuals, primarily Executive Directors, from the private and public sector. A National Reproductive Health Program management sub-committee was formed as a result of this training.

In Bolivia, FPMD has used various types of inputs. A Resident Advisor was placed in the country in 1991 who has provided local coordination for FPMD activities as well as technical assistance. FPMD has also contracted short- and long-term Bolivian and ex-patriate consultants to provide training and technical assistance in program planning and evaluation at CNS and in strategic planning, clinic and financial management and service information systems at CIES. A local accounting firm has also been hired to conduct an institutional audit at CIES. Placement of a long-term internal management consultant at CIES was one FPMD input that was not particularly effective. FPMD has also been providing full-time salary support for the CIES Executive Director. This support will terminate in May 1994 and be picked up by IPPF. While providing salary support for such key staff members in an organization is to be generally avoided, this is an example of where this support was a key to CIES' surviving its management crisis.

2.1.3 Impact

FPMD assistance in Bolivia, together with that of other CAs, has had impact on service output, quality and sustainability. CIES has recently doubled its service network. As a result of technical assistance provided to CNS to structure the reproductive health program, CNS was able to initiate provision of reproductive health services which have increased 400% since FPMD began its support. In a recent survey of CNS users of reproductive health services, 75% classified reproductive health services as "excellent" or "good" compared to 33% for other CNS services. The method mix at both institutions is also improving. Sustainability, in terms of cost recovery, has also improved at CIES. The financial management system is still gearing up to provide cost recovery indicators for the entire institution, Nevertheless, current data indicate that 30% of CIES' budget is covered with income generated locally.

FPMD conducted a Technical Review of its activities in Bolivia in 1993. The review is an excellent and objective appraisal of FPMD's interventions in Bolivia, the findings of which were validated during this evaluation. The results of the Technical Review are being used to correct project performance in Bolivia, as many of the recommendations made in the review had been implemented by the time of this evaluation.

In addition to the Technical Review, FPMD is planning to conduct a country-level impact evaluation. A concern raised by this evaluation team is the risk of over-evaluating FPMD in Bolivia, given the time evaluations take away from local institutions.

3.0 ORGANIZATION AND MANAGEMENT

The FPMD field office in Bolivia is staffed by one technical person, the Resident Advisor. As initially agreed with USAID/Bolivia, although the Resident Advisor is a MSH employee, her time is divided between representing FPMD in Bolivia and coordinating the activities of Development Associates, JHU/PCS (until they opened their own office) and, occasionally, JHPIEGO. Indeed she has spent nearly one-half of her time in this coordinating role.

4.0 FINANCIAL MANAGEMENT AND CONTRACTUAL ISSUES

USAID/Bolivia reports that the FPMD field office in Bolivia has done an excellent job in coordinating the work of FPMD, PCS, DA and JHPIEGO in Bolivia. At USAID/Bolivia's request, however, the field office will be closing in May 1994. USAID/Bolivia points out that funding has been cutback and their strategy has changed. In the future, emphasis will be placed on service delivery, and they will thus be working more closely with service provision CAs, in this case, Pathfinder International. They also believe there is less need for a coordinating role.

USAID/Bolivia perceives that the resources they have invested in management interventions via FPMD may not be totally in accordance with project outputs in Bolivia. This in part may be due to the fact that, although FPMD has covered 100% of the costs of the field office, nearly one-half of the office's efforts have been directed toward representing and coordinating other CAs. The training and IEC outputs from this coordinating role have been significant.

CENTRO DE INVESTIGACION, EDUCACION Y SERVICIOS (CIES)

Introduction

Centro De Investigacion, Educacion y Servicios (CIES) is a private, non-profit organization founded in 1987. Located in La Paz and some of Bolivia's other major cities, *CIES* operates a network of eight clinics that provide health care to women, children and adolescents. It is the largest single provider of family planning services in Bolivia (measured in CYPs). Family planning services are provided in its clinics as well as through its CBD and Affiliated Doctors Program.

FPMD

CIES was founded by women, for the advancement of women. Its initial activities focused on education and research, with a limited health service provision. In 1991, *CIES* was facing a period of institutional crisis. The Executive Director, who also founded the organization, had taken an extended leave of absence and the future leadership of the organization was uncertain. Service provision had decreased, and the organization was seen as faltering. As a result of FPMD assistance, *CIES* overcame its management crisis, regained donor confidence, and expanded services.

The interventions that FPMD has supported at *CIES* are an example of management development assistance provided to an institution to help it organize and consolidate, and prepare for growth and expansion. With FPMD assistance, *CIES* re-defined its mission and prepared new statutes, which now specifically emphasize the institution's commitment to family planning service delivery and the need for financial self-sufficiency. Strategic and operational plans based on the institution's new mission have been developed. The organization has also been re-structured. Changes were made in the Board of Directors; the roles and responsibilities of the Board, Executive Director and operational levels were re-defined. A new Executive Director was hired. Clinic administration and finances have been decentralized, and staffing patterns were reduced and standardized. The service statistics systems is undergoing re-formulation, starting with an assessment of service information needs and followed by the development of instruments and procedures for information flow. Steps have been taken to improve personnel management, by preparation of written hiring policies, job descriptions, and definition of work schedules, benefits and vacation policies. The logistics and supply system have been made more efficient. To reduce reliance on external donor funds, income-generating activities have been implemented. Progress has been slowest in improving *CIES'* financial management systems.

Conclusion

The effect of *CIES'* management crisis, followed by FPMD assistance for management development on a family planning service provision, makes service delivery trends difficult to interpret. From 1991 to 1993, the number of new FP visits and total CYPs steadily increased, as did the proportion of family planning visits compared to other visits. The number of return visits fell considerably from 1991 to 1992 and subsequently increased from 1992 to 1993. The method mix improved. Self-sufficiency has also improved. In approximately two years, *CIES* has increased the amount of locally-generated revenue from less than 10% of total income to more than 30%.

CAJA NACIONAL DE SALUD (CNS)

Introduction

CNS is the health services branch of the Bolivian social security system. It provides health care to formally employed persons and their dependents, constituting approximately 20-25% of the population. *CNS* is one of the major players in the Bolivian National Reproductive Health Program. Initiated in 1991, reproductive health services are currently provided in seven hospitals and 18 out-patient clinics, located primarily in urban areas throughout Bolivia. *CNS* has been a major recipient of USAID assistance via FPMD, Development Associates, JHPIEGO, and Pathfinder International.

FPMD

In 1991, FPMD conducted an Organization Assessment and, based on that assessment, developed a Management Development Plan for *CNS*. The Assessment revealed that the *CNS* reproductive health services program lacked organizational structure and effective work relationships. The plan proposed a series of interventions directed at organizational design and team building. Additional interventions directed at general management development were identified as FPMD work with *CNS* progressed.

With FPMD assistance, an organizational chart was developed for the reproductive health program. A manual detailing personnel functions, supervisory systems and work relationships was also prepared. A matrix program management structure was introduced, giving the National Reproductive Health Program Coordinator the authority and responsibility which she previously lacked. She is now able to make decisions on her own and sign checks. FPMD also provided guidance in assuring that the program be adequately staffed at the central level. A National Program Coordinator was assigned full-time to the program, as was the IEC Coordinator. Other necessary staff members were also added. In order to ameliorate problems with staff relationships, a workshop was held to address interpersonal issues. In terms of general management development, FPMD has focused its interventions on the functions of planning and evaluation. FPMD has sponsored planning and evaluation workshops to set service delivery and IEC goals, evaluate goal achievement, identify service delivery problems and recommend solutions.

Conclusion

The impact of FPMD interventions on *CNS* service volume, quality and sustainability is difficult to assess due to the complementary nature of FPMD's work in conjunction with other CAs. Program coverage is very small, although growing. According to service statistics (which *CNS* recognizes as being deficient), the number of new users grew from 1,922 to 4,366, between 1992 and 1993, an increase of 123%. The method mix is also improving. *CNS* still faces serious delivery problems, but this evaluation revealed that the National Program Coordinator feels better prepared to solve service delivery problems as a result of improved managerial structure at the central level.

Appendix H - FPMD Conceptual Framework: Review and Recommendations

FPMD CONCEPTUAL FRAMEWORK REVIEW AND RECOMMENDATIONS

I INTRODUCTION

A. Overall 20 Year FPMD Program Horizon

To accomplish the most cost-effective return on the substantial USAID investment, the evaluation team recommends that USAID establish an overall 20-year program horizon for this project in four phases, each consisting of five years:

Phase I:	1985-1990	FPMT:	the first five-year project.
Phase II:	1990-1995	FPMD I:	the first five years of the ten-year FPMD project which is the subject of this evaluation.
Phase III	1995-2000	FPMD II:	the second five years of the ten-year FPMD project. One of the findings of this evaluation is to recommend consolidation of the outputs to purpose achievements of FMPT and FPMD I and to provide guidance for corrections and improvements in FPMD II, the follow-on second five-year period of FPMD, especially related to institutionalization, sustainability, and replicability factors.
Phase IV:	2000-2005	FPMD III:	an additional five years to be added to FPMD, recommended by the evaluation team to further enhance durable achievement of the purposes of the FPMD project and to facilitate world-wide dissemination and replication of FPMD management technologies and materials.

Figure 11 is an overview of this 20-year formulation.

FPMD CONCEPTUAL FRAMEWORK

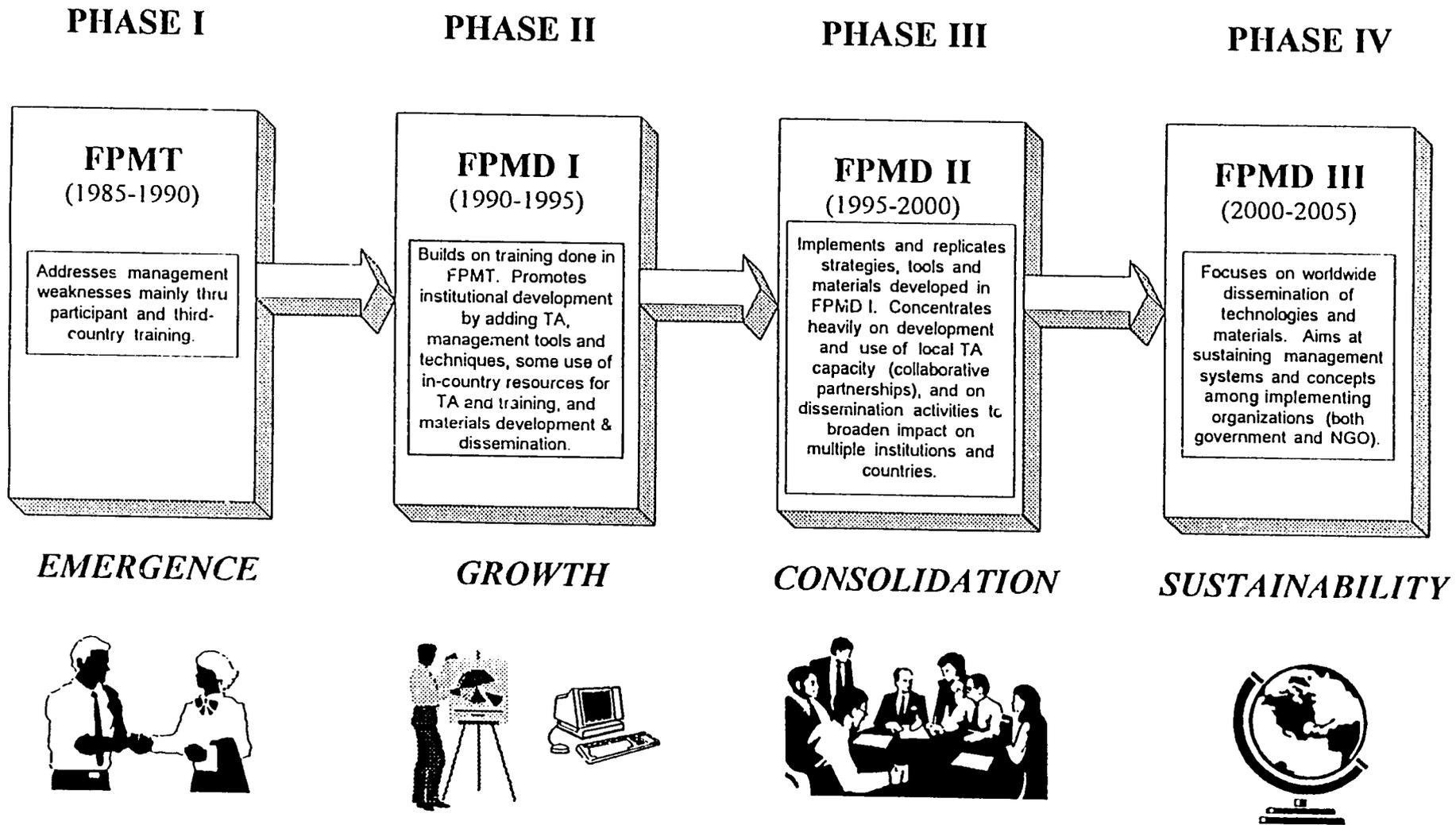


Figure 11

B. FMPT and FPMD I Conceptual Framework Review

FPMT October 1985 - September 1990

FPMT was a highly successful five-year project that initially implemented participant training in management as the major intervention to improve management weaknesses in FP programs. The management weaknesses were viewed as the major obstructions to sustainable delivery and expanded access of cost-effective FP services of acceptable high quality. The project purpose to improve management weaknesses was to be achieved by strengthening the leadership and management of public and private FP organizations through training senior and middle level personnel. FPMT recognized that its focus on participant training, in the absence of concomitant strategies for organizational and management development needs, was not sufficient to result in permanent strengthening of management of FP organizations. The revised FMPT project focus and purpose shifted to institutional development and the provision of technical assistance to FP organizations. The major technical assistance and management interventions identified as sufficient outputs to achieve the revised project purpose were needs assessments, mission definition, strategic planning, management information systems, short-term training, and materials and course development.

FPMD I September 1990 - September 1995

Following the recommendations of the FPMT April 11 - June 30, 1989 external evaluation, the PP framework for the FPMD follow-on project sought to build on the achievements of FPMT. FPMD I augmented the revised FMPT project purpose to include increased attention to client-responsiveness to the provision of reliable, high quality FP services and increased attention to the institutionalization of strengthened management capabilities in FP organizations to assure the quality and sustainability of FP services.

Five major output components, reflecting the range of methodologies to achieve the above envisioned project purpose, were identified for the 10-year FPMD project:

1. Management Development Planning
2. Institutional development through technical assistance and training to help organizations implement management development plans
3. Development, adaptation, use and dissemination of training materials
4. Evaluation of projected-assisted activities and subsequent performance of FP organizations
5. Preparation and dissemination of materials that capture and synthesize the project's experience in supporting organizational and management development of FP programs.

C. FPMD II and FPMD III Conceptual Framework Recommendations

If an overall 20-year program horizon is approved, the FPMD project could benefit from an internal application of the FPMT model for analysis and planning regarding several key program design issues related to mission, strategy, structure, and systems that are relevant to its own four stages in program development.¹

The key program design issues for FPMD II and FPMD III are:

FPMD Mission:	How will FPMD redefine its purpose and values 10 years later?
FPMD Strategy:	How will FPMD establish and structure an operational framework to effectively and comprehensively serve the needs of its diverse FP clients, whose levels of organizational development will continue to span the four stages?
FPMD Structure:	How will FPMD approach its highly centralized operations from Boston vs. decentralization to the field to further enhance local capacity building and empowerment?
FPMD Systems:	How will comprehensive top to bottom management interventions to all levels of FP organizations be systematized, integrated and sustained? How will the management interventions and materials be organized and documentation created to effectively assist all levels of FP clients in an explicit operational and structural framework that communicates and focuses FPMD management interventions and materials in a clear, uniform, and codified manner? How will basic and generic top to bottom management interventions and materials, including lessons learned, be extrapolated, organized, and published that are appropriate for all levels of FP organizations? How will published materials be disseminated, and replicated globally for utilization of the whole package or in part?

Table 1 is an illustrative starting point for application of the management analysis framework to FPMD's stages of Emergence, Growth, Consolidation, and Sustainability. The evaluation team believes that this exercise, if thoughtfully and comprehensively engaged by the FPMD central Boston team, in collaboration with selected local colleagues, will significantly elucidate and expand upon the recommendations of the evaluation team. There are many questions that require more reflective thinking and critical examination than the evaluation team is able to do in the short time frame given

¹ Vriesendorp, sylvia, et al, "A Framework for Management Development of Family Planning Program Managers", Boston, MA, October 1989. The evaluation team is aware that FPMD I has recommended deletion of this theoretical framework from the contract [II Background: pp. 9-12) Part "A" and "B"], but nevertheless believes it will provide a practical and valuable exercise to delineate FPMD past, present and future directions.

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to consider the future direction of FPMD. The nature and characteristics of Collaborative Partnerships to enhance implementation of management interventions at the service provider level and to develop sufficient documentation to institutionalize such management interventions at the service provider delivery level require in-depth exploration.

The contracting mechanisms to do so are burdensome and perplexing for FPMD and USAID. If concurrence can be reached on the future direction of FPMD as a valuable resource in the Office of Population portfolio to establish, institutionalize, and sustain the delivery of expanded, acceptable quality, client-oriented FP services, then it is a given that the Collaborative Partnership paradigm advanced by the evaluation team must include a forum whereby the contracting issues are resolved mutually and before the next phase of FPMD.

The evaluation team believes that it is abundantly clear that it is not feasible or rational to believe that the sustained delivery of expanded, acceptable quality FP services can be institutionalized without improving FP organizational performance at the service provider delivery level.

The FPMT/FPMD project appropriately and successfully addresses the issues of institutionalization and sustainability as they relate to the purposes of the project. It is sophomoric and unnecessary to burden the potential of the FPMD project with an Agency-wide search for the perfect answer as to what constitutes institutionalization and sustainability.

TABLE 1

Management Component	Stage 1 Emergence FPMT	Stage 2 Growth FPMD I	Stage 3 Consolidation FPMD II	Stage 4 Sustainability FPMD III
<p>Mission</p> <p>Purpose: Why FPMD?</p>	<p>Address serious management weaknesses of policy, upper to middle managers in FP organizations</p> <p>Focus evolved to include organizational and management development</p>	<p>FPMT focus augmented to include increased attention to client-responsiveness to the provision of reliable, high quality FP services and increased attention to the institutionalization of strengthened management capabilities in FP organizations to assure the quality and sustainability of FP services</p>	<p>FPMT and FPMD I successful management interventions integrated into top to bottom framework to institutionalize organizational improvements down to FP service provider level where expanded, high quality must be achieved and sustained</p>	<p>Widespread dissemination and utilization of adaptive template materials using local TA capacity and networks developed in FPMD II</p>
<p>Strategies:</p> <p>How will FPMD accomplish its mission purposes?</p>	<p>Planning and assessment to identify specific management training needs</p> <p>Training through short-term in-country, and regional courses, study/observation tours, internships, and long-term training</p> <p>Follow-up technical assistance to help trainees carry out planned management improvements</p> <p>Materials and course development</p>	<p>Management Development Planning</p> <p>Institutional development through TA and training to implement management development plans</p> <p>Development, adaptation, use and dissemination of training materials</p> <p>Evaluation of project-assisted activities and subsequent performance of FP organizations</p> <p>Preparation and dissemination of materials that capture and synthesize the project's experience</p>	<p>Enhanced focus on building in-country TA capacity and networks</p> <p>Explicit operational and structural framework to implement and integrate management interventions from top to bottom service provider level where FP service delivery occurs</p>	<p>Explicit dissemination strategy to target specific public and private FP organizations</p>
<p>Structure:</p> <p>How will FPMD divide, assign, and organize its work to accomplish its purposes?</p>	<p>Central deployment of FPMT core staff and selected MSH staff to country and regional FP organizations</p> <p>TA and cooperation with local counterparts</p>	<p>Continuity of TA from FPMD and MSH staff to implement management strategies</p> <p>Enhanced technical collaboration with local counterparts</p>	<p>Decentralization of TA to field emphasizing empowerment and use of local capacity through Collaborative Partnerships with FP service providers</p> <p>Develop supporting materials documentation to implement and institutionalize management interventions top to bottom to impact FP service deliveries for QES</p>	<p>Implement components of FPMD PCU's Future Directions Strategies that will further enhance and achieve utilization of published management intervention materials</p>
<p>Systems:</p> <p>What are the procedures and mechanisms FPMD will use to plan, implement, evaluate, disseminate, and replicate its purpose achievements?</p>	<p>FPMT utilized local FP staff capability in needs assessments, mission definition, strategic planning and middle management capacity to implement MIS.</p> <p>FP Manager's Handbook developed</p>	<p>FPMD provided and enhanced local FP consultants and FP staff capabilities in:</p> <ul style="list-style-type: none"> Management Assessments Strategic Planning Operational Planning Organizational Structure MIS Financial Planning Human Resource Management Total Quality Management <p>FP Managers and Supplements published</p> <p>Field-based publications</p>	<p>Decentralization of Boston TA to further empower strong development and utilization of in-country local capacity for TA to FP organizations</p> <p>Develop and publish comprehensive management intervention materials using adaptable template technology</p>	<p>Support utilization of local TA capacities and networks developed during FPMD II</p> <p>FPMD central staff support maximal use and continued education of local and regional management capacities for "Continuing Education" and sustainability of improved management capacities of FP organizations</p>

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Appendix I - List of Recommendations (From Section 5.0)

LIST OF RECOMMENDATIONS
(By Order of Appearance in Section 5.0, Recommendations)

- (1) The Evaluation Team strongly recommends that the FPMD long-term strategy be modified to include actions within a 20-year conceptual framework such as that shown in **Figure 11** in which four five-year FPMD operational phases are identified: emergence, growth, consolidation, and sustainability.
- (2) The end of FPMD I (1995) will signal the half-way point in the 20-year effort, i.e., the end of the "growth" phase (meaning the growth and development of management tools, techniques, strategies). During the next phase, FPMD II, focus should be on the following:
 - (a) a more proactive role in targeting and choosing countries and organizations to receive FPMD II assistance;
 - (b) a close, collaborative partnership with service-delivery CAs to complement skills and mandates in order to effectively address management interventions at all appropriate levels from top to bottom in an integrated, coherent fashion;
 - (c) greater emphasis on strengthening of local TA capacity including a shared vision, a shared "dictionary", and shared approaches; and
 - (d) a determined effort to create necessary documentation, both generic and project-specific, in support of (a), (b), and (c) above, and to disseminate such documentation widely.
- (3) The contractor should develop specific strategies to better influence the choice of countries and activities in which it engages. These strategies need to be developed in close collaboration with the Office of Population and the regional bureaus in order to be responsive to Agency strategies and priorities. The strategies should include a clear identification of products and services which FPMD offers, and an effective marketing plan for these products and services.
- (4) FPMD should develop a marketing plan and implement it. This plan should explicitly address the potential for FPMD assistance under USAID bilaterals and regional projects (through buy-ins or other arrangements) as well as interfacing with other USAID CAs.
- (5) FPMD should undertake an examination of mutual goals, expectations and responsibilities in each collaborative CA relationship. It should enter into relationships having a maximum potential for use of complementary expertise, i.e., enhanced management geared directly to improved FP service delivery interventions.
- (6) FPMD should exploit the requests it has received (and will likely receive) from other CAs to provide management expertise; it should approach these requests in the context of (5) above.
- (7) It is strongly recommended that FPMD strengthen its technical collaboration with local colleagues and CA partners in order to work effectively at the service provider level of FP organizations through enhanced collaborative partnerships. These partnerships should be developed along lines indicated above.

- (8) In developing local consultant capacity, the focus should be on the creation of in-country networks of consultants (primarily from the private sector or NGOs) having a shared vision, shared "dictionary", shared approaches, and shared systems and materials. Opportunities for "multiplier" subprojects such as the CA/NGO project in Bangladesh should be exploited.
- (9) FPMD should establish a clear conceptual and operational framework for the development, testing, refinement, and dissemination of its management methodologies, systems, and materials. This framework should be linked to cooperative partnerships with other CAs and to the building and empowerment of local technical assistance capacity, as well as be linked more directly to the provision of quality, sustainable, cost-effective family planning services.
- (10) In addition, FPMD should better exploit its experience with LIP/Bangladesh in regard to the development of management tools: in documenting them, in developing "templates" or "prototypes" specifically intended for adaptation elsewhere, and in disseminating systems, materials and lessons learned.¹
- (11) For FPMD II, USAID should consider the use of a more flexible contracting mechanism which takes into account the institutional development goals of this project and focuses less on relatively meaningless quantitative deliverables. A Cooperative Agreement might be more suitable, particularly in terms of the long-term institution-building activities and subactivities of the project.
- (12) The present level of Boston-based core staff is believed to be adequate for the purpose of both FPMD I and II. Staff is of uniformly high quality. However, additional core financing of field personnel would be desirable, particularly if the ET's recommendations for a greater level of effort in FPMD II are accepted. FPMD also may need to redistribute human resources within the project to fully implement strategic changes recommended, e.g., increased emphasis on dissemination, developing CA partnerships, better marketing of capabilities, stronger service delivery management capacity, etc.
- (13) In addition to Boston-based and field staff, funds should be provided under the core agreement for a limited number of in-country administrative staff to be placed in key countries (one per country).
- (14) The use of U.S. consultants should be phased down as in-country staff and consultant capacity is augmented. U.S. consultants should continue to be used for the direct provision of TA in some cases, but overall their use should be reoriented toward: (1) building local TA capacity; (2) identifying and bringing U.S. and cross country perspectives and technical expertise; and (3) gaining entry where local consultants can't readily be used (e.g., the CA/NGO subproject in Bangladesh).

(Note that it is unrealistic to expect that host institutions can be fully "weaned" from the need for outside technical assistance. Host institutions, like major U.S. corporations, will likely continue to have some level of need for consultants to address specific

¹ A start in this direction has been made with ELCO mapping, adapted from Indonesia, refined in Bangladesh, and exported to Kenya.

management problems. It is the hope of the ET that some or much of this need increasingly can be met through the use of local consultants.)

- (15) In-country staff of FPMD should be mostly local wherever possible. Expatriate staff should be used only exceptionally, where there is good reason to do so (e.g., in a country with a large FPMD portfolio an expat might be required to provide administrative and financial interfacing with USAID and USAID/Washington). Where local technical personnel are unavailable to provide management-related services, FPMD should attempt to recruit and develop such in-country expertise.
- (16) Except in the case of Latin America, FPMD makes heavy use of Boston-based MSH consultants to provide TA. There is a need for MSH to make other regions more like LAC in the use of consultants, taking a more systematic approach to the development and use of in-country consultants in order to maximize their long-term impact. The focus should be on the creation of in-country networks of consultants (primarily from the private sector or NGOs) having a shared vision, shared "dictionary", shared approaches, and shared systems and materials.
- (17) Long-term training is deemed by FPMD and the ET as not necessary under FPMD II. A greater emphasis should be placed on short-term training, however, conducted more in country and more on a regional basis (e.g., work with selected regional institutions like CAFS to build capacity to conduct management workshops.). Relatively little U.S. based training has been done under FPMD; this pattern should continue, i.e., placing maximum emphasis on short-term, localized, in-country training with judicious use of U.S. based training for special circumstances. Similarly, study tours should be increasingly focused on in-country experiences where possible (as in Bangladesh), with international study tours limited to special cases (mostly, high-level personnel in need of cross-cultural policy and program exposure).
- (18) The ET recommends that the level of effort for materials development and dissemination be significantly increased in FPMD II, in line with the need to maximize the transfer of management skills across projects and across countries. Without in-depth analysis of the specific elements in an expanded effort, the ET is unable to quantify this recommendation, except to note its strong impression that "much more needs to be done". In considering the question of "how much?", the following general recommendations should be examined.
 - (a) The role and objectives of the Publications and Communications Unit (PCU) should be expanded to include functions appropriate to the expanded strategic objectives outlined above. Specifically, these should encompass the design, development, testing, documentation, and broad-based dissemination of the management systems, technologies, and materials developed under FPMD I and FPMD II.
 - (b) Greater emphasis should be placed on making these products available in French and Spanish and, where appropriate and possible, in other languages (e.g., Portuguese and Bangla).

- (c) FPMD should develop an explicit strategy and operational plan for materials development and dissemination under FPMD II, taking into account the extraordinary and growing demand for management related materials. This strategy should include appropriate channels for information dissemination, including through electronic means where feasible and appropriate².
- (d) FPMD should investigate the potential utility of Adaptable Template Technology (ATT) as a model for transferring management expertise from one place to another. The ET's thoughts on the possible use of ATT for FPMD are included in Appendix L.

- (19) Core costs must be fully funded, taking into account those resulting from anticipated buy-ins. In general, USAIDs and host countries are unwilling to support core costs through the use of bilateral monies (e.g., buy-ins), resulting in a situation where buy-ins usually result in additional demands on FPMD resources provided within "core costs".

In the opinion of the ET, it would be prudent to envision overall levels for FPMD, including buy-ins, increasing over the next 10 years to at least the following magnitudes:

- LAC and Asia/Near East -- increase up to two times FPMD I level
- Africa -- increase up to three times FPMD I level
- NIS & Eastern Europe -- an additional amount as desired by USAID³

- (20) Improvements are needed both in terms of USAID requirements for RME and in contractor capacity to provide needed information. FPMD should pursue its present efforts to automate the reporting functions insofar as possible, to be consistent with both USAID and MSH requirements. FPMD should also move quickly to implement its new subproject evaluation plan. USAID should adopt, and stick with, a financial and a management reporting plan commensurate with principles now being laid out in the work of various committees concerned with "reengineering". These plans should minimize the monitoring and reporting burden (on both USAID and the contractor), while providing critical information needed for financial and program management purposes.

Once set up, the plans should be "locked in concrete", at least for a reasonable period (one to two years), to allow the contractor to pursue automated options and to minimize staff time spent on RME activities. Under FPMD I, RME functions have required an inordinate amount of staff time, including that of senior management, drawing time away from critical project implementation functions.

² FPMD has already begun its thinking along these lines and has developed some preliminary thoughts. These should serve as a point of departure for a more in-depth examination of this very critical FPMD function.

³ A decision to be made on political and humanitarian grounds rather than for demographic reasons, given the already low fertility levels in the region (due mostly to high rates of abortion rather than effective family planning).

Appendix J - Detailed Project Outputs

Anticipated Quantified Contract Outputs

<u>Type of Activity</u>	<u>Estimated Number</u>	<u>Completed</u>	<u>In Process</u>
Subproject plans	30	33	
<u>Technical Assistance</u>			
Core Staff	1920 PM	1041 PM	
Short-term TA	300 PM	273 PM	
Long-term TA	492 PM	260 PM	
<u>Training</u>			
Workshops	80	79	
Participants to Courses	20	22	
Study Tours	20	15	
<u>Training Materials</u>			
<i>Family Planning Managers</i> and supplements	20	15	3
Spanish translations of the <i>FPM</i>	20	2	11
French translations of the <i>FPM</i>	20	2	11
Handbook adaptations (French and Spanish)	2		2
<u>Internal Evaluations</u>			
Subproject Evaluations	25	20	7
Program/Country-level Evaluations	5	1	5
Management Indicators Report	1	1	
<u>Dissemination</u>			
Meetings of the FRAC	4	3	
Professional Papers/Journal Articles	10	14	

* Numbers in bold are *documented* Contract Outputs as of August 19, 1994

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TRACKING THE DELIVERABLES

As of August 19, 1994

Subproject plans (30 required) and Subproject Evaluation Plans (25 required)

Documented

1. CIES (Bolivia) **(SEP)**
2. ASHONPLAFA (Honduras)
3. NFPB (Jamaica)
4. MEXFAM (Mexico) **(SEP)**
5. FEMAP (Mexico) **(SEP)**
6. DGPF (Mexico MOH)
7. ONFP (Tunisia) **(SEP)**
8. Turkey MOH **(SEP)**
9. Philippines DOH **(SEP)**
10. Philippines DOH/Local Government Units **(SEP)**
11. FPAN (Nepal) **(SEP)**
12. LIP (Bangladesh) **(SEP)**
13. NGO (Bangladesh) **(SEP)**
14. ASCI (India)
15. DFH (Burkina) **(SEP)**
16. NCPD (Kenya)
17. CHAK (Kenya)
18. FPAK (Kenya)
19. Mkomani (Kenya)
20. SDA (Kenya)
21. Maseno West (Kenya)
22. Mandeleo (Kenya)
23. PPFN (Nigeria) **(SEP)**
24. SANFAM (Senegal)
25. CAFS **(SEP)**
26. CERPOD **(SEP)**
27. INAS (Morocco) **(SEP)**
28. Regional Center for Training (Cairo, Egypt)
29. USAID/Colombo (Sri Lanka)
30. USAID/Bangkok Khmer Affairs Office (Cambodia)
31. CNS (Bolivia)
32. Ministry of Health (Peru)

Not counted

Bolivia MOH (2 needs assessments but no activities)

CEFA

CEPAR (Ecuador)

CEMOPLAF (Ecuador)

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In-country Workshops (80 required)

Documentation

Asia/Near East: 29 workshops

1. Bangladesh, LIP, one-day staff development workshop (method mix, indicators, rapid assessment methodology), Huber, 2/94
2. Bangladesh, LIP, program review workshop for Groups 11 and 12, 11/93
3. Bangladesh, NGO project, two-day workshop on training impact evaluation, Vriesendorp and Buxbaum, 11/93
4. Bangladesh, NGO project, one-day strategic planning workshop for 50 participants, Brooks, Helfenbein and Sacca, 10/93
5. Bangladesh, LIP, workshop to enable LIP program managers to share their implementation experiences and formulate policy recommendations, 45 participants, 7/93
6. Bangladesh, NGO project, 2 and a half day workshop, for 60 staff, on management development assessment, Brooks, Helfenbein, Sacca, 6/93-7/93
7. Bangladesh, LIP, workshop on the role of the Union Parishad Chairman, 54 participants, 4/93
8. Bangladesh, LIP, workshop on the role of the Family Welfare Assistant, over 200 family planning personnel, 4/93
9. Bangladesh, LIP Program review workshop, 11/92
10. Bangladesh "action plan" workshop on teamwork, Nieboer 5/92
11. Bangladesh, LIP financial management workshop for program managers, 3/92
12. Bangladesh, LIP workshop for Family Welfare Assistants and FWVs, 10/91
13. Bangladesh, LIP Program review workshop, groups 7, 8, and 9, 9/91
14. Bangladesh, LIP Project review workshop, 9/90
15. India, ASCI Subcontract MIS workshop for 20 state-level health and family welfare administrators, 7/91-8/91
16. Morocco, INAS, Financial management and accounting, Vian and Meunier 5/92-6/92
17. Morocco, INAS, introductory course in health care management, P. Duplessis 2/92-3/92
18. Morocco, INAS, Data Analysis and Report Writing, second workshop on health systems research, Carr-Hill and Thorne, 4/92
19. Morocco, Human Resource Management, Lucien 6/92
20. Philippines, DOH/Office of Special Concerns, workshop introducing the Performance Grant Program to Local Government Units, Fishstein and Hume, 2/94
21. Philippines, Workshop to develop indicators for family planning program managers, Nieboer, 1/93
22. Philippines, Write-shop to develop Filipino Management Course for Mid-Level managers, Nieboer, 10/92
23. Philippines, DHPA Management workshop, Nieboer, 7/92
24. Philippines Supervision of Management workshop, D. Chauls, 2/92-3/92
25. Philippines, management training course for central and regional personnel of the FP Service, D. Chauls, 2/92-3/92
26. Turkey, MCHFP Directorate, workshop with FPLM/CDC on service statistics and contraceptive logistics system, Auxila, 10/93
27. Turkey, MCHFP Directorate, training in a new service statistics MIS and contraceptive logistics, Auxila and CDC, 4/93-5/93
28. Turkey, MIS and Contraceptive Logistics, for 35 people, 7/92
29. Turkey, MOH, assisted local MIS technical team in 3-day workshop, 3/92

Latin America and the Caribbean: 14 workshops

1. Bolivia, MOH, provided strategic planning workshop at USAID's request, Stern, 1/94
2. Bolivia, CNS workshop to provide annual evaluation of activities (1993) and program 1994 activities, Wilcox, 12/93
3. Bolivia, CIES 1993 Operations Planning workshop, Stern, 11/93
4. Bolivia, CNS evaluation workshop, 50 participants, 2/93
5. Bolivia, CIES operational plan workshop for 10 CIES staff, 11/92
6. Bolivia, CIES workshop (3/92)
7. Bolivia, Caja Nacional OD workshop, 10/91-11/91 (MO, SW) (TWO 9 BO 2)
8. Honduras, Organizational development workshop for ASHONPLAFA's senior- and mid-level management, conducted by INCAE, 2/94
9. Jamaica, workshop for senior and mid-level managers of the National Family Planning Board on key MIS concepts and application, Murray, Eckroad, Watt, 11/93
10. Mexico, MOH/DGPF, CQI "sensitization" workshop for senior management, FPMD sponsored, 2/94
11. Mexico, MEXFAM, workshop on basic concepts of CQI for 40 participants from NGOs, CAs, DGPF, AID/W, Murray, Necochea, Keiderling, 10/93
12. Mexico, second in series of QOC workshops, 30 participants (DOH) 5/93
13. Mexico, workshop on QOC for national FP supervisors and training dept. of MOH/DGPF, 4/93
14. Peru, collaboration with Pop Council, MIS workshop for Peru MOH, 11/91

Africa: 34 workshops

1. Burkina Faso, DSF workshop to develop operations guide, 5/93
2. Burkina Faso, Supervision workshop, Ouagadougou, 1/23-2/17/93 Jana, provincial level supervisors
3. Burkina Faso, one week management workshop for ASBEF, 3/91
4. CAFS, workshop to develop curriculum for middle level management course, 4/93
5. CAFS, management of FP/MCH programs, 10/92
6. CERPOD, held internal workshop to discuss reorganization, action plans 2/93-3/93
7. CERPOD Strategic planning workshop, Vriesendorp and Lambiotte, 6/92-7/92
8. CERPOD preparatory strategic planning workshop, 3/92
9. Kenya, Mkomani, sponsored and facilitated "Vision" retreat for Board of Directors and Senior staff, 2/94
10. Kenya, Maseno West/CCS, sponsored and conducted follow-up strategic planning workshop, 11/93
11. Kenya, Maseno West/CCS, sponsored and conducted initial strategic planning workshop, 10/93
12. Kenya, public sector family planning managers and supervisors, master trainer for workshop on COPE instruments and principles of supervision, Vriesendorp, 1/94
13. Kenya, private sector family planning managers and supervisors, master trainer for workshop on COPE instruments and principles of supervision, Vriesendorp, 1/94
14. Kenya, FPAK, Activities monitoring workshop, 8/93, Savosnick and Kibunga
15. Kenya, FPAK, second strategic planning workshop, 7/93, Fenn and Savosnick
16. Kenya quarterly report 4/93: Activities monitoring workshop and Strategic planning seminar with FPAK, 2/93
17. Kenya quarterly report 4/93: Strategic planning with the SDA/RHS, 11/92
18. Kenya quarterly report 4/93: Planning and Review Assessment Seminar with CHAK, 11/92
19. Kenya, FPAK, Activities monitoring workshop, 11/92, Savosnick and Kibunga
20. Kenya, CHAK staff development for senior management, 8/92
21. Kenya, Mkomani Board Staff Relations seminar, 7/92 Shipp, 8/92- 9/92, two-day seminar
22. Kenya, CHAK, semiannual review workshop, 6/92, Krystall
23. Kenya, NCPD MIS seminar, 2/92
24. Kenya, FPAK MIS planning workshop, 11/91

25. Kenya, CHAK quarterly annual review, workshop (AK, JB, CM, CH, SB) 11/91 (TWS 8 KE 1)
26. Kenya, NCPD workshop on NGOs in financing/accounting, 10/91 (TWF 3 KE)
27. Kenya, CHAK, Program planning and review workshop, 6/91, Krystall
28. Kenya, Mkomani, strategic planning workshop with senior staff, 4/91
29. Kenya, NCPD workshop on CBD service statistics for NGOs, 3/91 (TW I KE)
30. Kenya, CHAK planning and quarterly review, March 1991 (TWS 2 KE)
31. Kenya, NCPD and MOH workshop on CBD service statistics for NGOs, 2/91
32. Mali, Strategic planning follow-on workshop, Bamako, 3/93
33. Nigeria, PPFN Planning workshop, Lagos, 3/93
34. Tanzania, UMATI strategic planning exercise, 6/91-7/91 (TWS 4 TA) 24 people

Other workshops: 2

1. Strategic planning workshops for USAID IT division, 1/91-9/91
2. Strategic planning workshops for IPPF/WHO, 1/91-4/91

Total workshops: 79

Participants Sponsored to Courses (20 required)

Documentation

1. Sponsored two Turkish participants to BKKBN course, 12/4-17/91 - Dr. Kazine Aral
2. Dr. Eris Balkan
3. Sponsored four Turkish participants to BKKBN course, 5/7-18/91 - Adriye Tebez Tuquay
4. Dr. Oya Gokmen
5. Seuka Koral
6. Munip Ustenday
7. Sponsored Rose Wasunna/Mkomani Kenya(tuition only), MSH course "Leadership Capabilities", 3/93
8. Sponsored one Kenyan to MT MIS Course, 6/92
9. Sponsored six participants to IPPF/GTZ conference on CBD in Zimbabwe, 9/91 - Mrs. C. Nsekeke, Executive Director/Umati Tanzania
10. Mrs. E. Nyanda, Programme Officer/Umati Tanzania
11. Mr. E. Sekatawa, Executive Director/FPA Uganda
12. Mr. C. Karamagi, Programme Officer/FPA Uganda
13. Dr. Aboubacry Thiam, Senegal
14. Dr. Alpha Dieng, Senegal
15. Sponsored Andrew Murera, Zimbabwe, to "Financing Management for Health Programs", 7/91
16. Sponsored three Kenyan participants, to MSH MIS course, 5/91-7/91 (TSI 1 KE), - Mr. Magiri/FPAK
17. Mr. Peter Kibunga/NCPD
18. Mr. Were
19. Sponsored Mr. Benedict Dlodlo/ZNFPC Zimbabwe, to MSH MIS course, 5/91-7/91 (TSI 2 Z1)
21. Sponsored Charles Onoka of FPAK/Kenya to MSH MIS course, 6/93
22. Sponsored Thomas Chuma of FPAK/Kenya to MSH MT Financing course, 5/93

Study Tours (20 required)

Documentation

1. LIP, 19 Upazila chairmen to Indonesia, 9/90
2. Pakistan study tour to BKKBN, Indonesia 9/90-1/91, 11/90, eight senior officials from Ministry of Population Welfare (first SAR, p. 11) (ST 1 PK)
3. LIP, 24 participants from 4 upazilas to Indonesia, 10/90
4. High level Pakistanis to BKKBN to Indonesia, 11/90
5. Tanzania, UMATI study tour to FPAK, Kenya 7/91 ST 3 TA
6. LIP, 25 participants from 5 upazilas to Indonesia, 7/91
7. LIP, teams from 4 upazilas and 6 high level GOB participants to Indonesia, 11/91
8. LIP, second in-country study tour, 4 upazilas, 29 participants to Bangladesh, 4-5/92
9. LIP, teams from 4 thanas (24 participants) and district-level personnel to Indonesia, 6/92
10. LIP, teams from 4 thanas (25 participants) and district-level personnel to Indonesia, 10/92
11. Bolivia: CIES to Ecuador to visit CEMOPLAF on laboratory income generation, Sept.-10/92
12. LIP, In-Country Study Tour for 4 thana teams in Bangladesh, 11-12/92
13. LIP, IST for 4 new thanas, 7/14-27/93
14. LIP, fifth IST for 4 thana teams, 11/93
15. LIP, orientation and visit of 16 participants of International Workshop on Improving FP Program Effectiveness and QOC through OR, organized by ICDDR,B, to LIP thana to observe activities, TAI, 12/93

Family Planning Managers and supplements (20 required)

1. Reducing Client Waiting Times, March/April 1992
2. Using Service Data: Tools for Taking Action, May/June 1992
3. Supplement to Using Service Data issue: Guide to Graphing Data and Taking Action
4. Charging Fees for Family Planning Services, July/August 1992
5. Improving Contraceptive Supply Management, September/October 1992
6. Using Maps to Improve Services, November/December 1992
7. Using CQI to Strengthen Family Planning Programs, January/February 1993
8. Supplement to Using CQI: Manager's Toolbox for CQI
9. Analyzing Costs for Management Decisions, March/April 1993
10. Reducing Discontinuation in Family Planning Programs, May/June 1993
11. Developing Plans and Proposals for New Initiatives, July/August/September 1993
12. Improving Supervision: A Team Approach, October/November/December 1993
13. Supplement to Improving Supervision issue: Pocket Guide to Service Improvement, October/November/December 1993
14. Learning to Think Strategically, January/February 1994
15. Increasing Community Participation in Family Planning Programs, March/April 1994

Issues in Process:

1. Managing Integration
2. Special Issue for Cairo Conference (Management challenges for the future)
3. Working with Boards of Directors

Spanish translations of the *FPM* (20 required)

For the following issues, the translation and field-based review has been completed and final preparations are in progress; they will be printed in May 1994.

1. Reducing Client Waiting Times, March/April 1992
2. Using Service Data: Tools for Taking Action, May/June 1992
3. Supplement to Using Service Data issue: Guide to Graphing Data and Taking Action
4. Charging Fees for Family Planning Services, July/August 1992
5. Improving Contraceptive Supply Management, September/October 1992
6. Using Maps to Improve Services, November/December 1992
7. Using CQI to Strengthen Family Planning Programs, January/February 1993
8. Supplement to Using CQI: Manager's Toolbox for CQI
9. Learning to Think Strategically, January/February 1994
10. Increasing Community Participation in Family Planning Programs, March/April 1994.

French translations of the *FPM* (20 required)

For the following issues, the translation and field-based review has been completed and final preparations are in progress; they will be printed in May 1994.

1. Reducing Client Waiting Times, March/April 1992
2. Using Service Data: Tools for Taking Action, May/June 1992
3. Supplement to Using Service Data issue: Guide to Graphing Data and Taking Action
4. Charging Fees for Family Planning Services, July/August 1992
5. Using CQI to Strengthen Family Planning Programs, January/February 1993
6. Supplement to Using CQI: Manager's Toolbox for CQI
7. Improving Contraceptive Supply Management, September/October 1992
8. Using Maps to Improve Services, November/December 1992
9. Learning to Think Strategically, January/February 1994.

Subproject Evaluations (25 required)

Subproject evaluation plans have been drawn up for the following subprojects:

1. CIES (Bolivia) (SEP)
2. CNS (Bolivia) (SEP)
3. MEXFAM (Mexico) (SEP)
4. FEMAP (Mexico) (SEP)
5. DGPF (Mexico) (SEP)
6. ASHONPLAFA (Honduras) (SEP)
7. NFPB (Jamaica) (SEP)
8. MOH (peru) (SEP)
9. ONFP (Tunisia) (SEP)
10. Turkey MOH (SEP)
11. Philippines DOH (SEP)
12. Philippines DOH/Local Government Units (SEP)
13. FPAN (Nepal) (SEP)
14. LIP (Bangladesh) (SEP)
15. NGO (Bangladesh) (SEP)
16. DFH (Burkina) (SEP)

17. PPFN (Nigeria) (SEP)
18. CAFS (SEP)
19. CERPOD (SEP)
20. NCPD (Kenya) (SEP)
21. CHAK (Kenya) (SEP)
22. FPAK (Kenya) (SEP)
23. Mkomani (Kenya) (SEP)
24. SDA (Kenya) (SEP)
25. Maseno West (Kenya) (SEP)
26. Mandeleo (Kenya) (SEP)
27. INAS (Morocco) (SEP)

Program/Country-level Evaluations (5 required)

A program-level evaluation has been completed for the FRAC.

Program- and country-level evaluations are underway for:

1. Bangladesh (LIP)
2. Kenya (NCPD, CHAK, FPAK)
3. Philippines (DOH)
4. Bolivia (CIES, CNS)
5. Mexico (DGPF, MEXFAM, FEMAP)
6. *The Family Planning Manager*

Management Indicators Report (1 required)

"Indicators to Measure Service Delivery Operations" developed in conjunction with the Evaluation Project

Meetings of the FRAC (4 required)

1. FRAC IV: Quality of Care in Family Planning Organizations, hosted by FPMD in Boston, August 1991.
2. FRAC V: Decentralizing Family Planning Programs to Serve Hard-to-Reach Populations, hosted by the Rwandan National Population Office, September 27 to October 8, 1992.
3. FRAC VI: Developing supervisory systems for supporting high-quality services and decentralized decisions-making (or, Institutionalizing supervision), hosted by the Tunisian Population Office, November 22-December 2, 1993.

In process: FRAC VII will be hosted by the MOH of Guinea and will be on the theme of Sustainability.

Professional Papers/Journal Articles (10 required)

1. "Evaluation planning and Needs Assessment Guidelines for Family Planning Organizations," paper by Jaime Benavente and Barbara Seligman, 8/1/93
2. "Lessons Learned about Systematic Evaluation in the Organizational Development Process," paper and presentation (NCIH 1992) by Barbara Seligman and Nancy Murray
3. "Building a Sustainable Program: FPMD's Work with the Family Planning Association of Kenya," paper by Deirdre Wulf, 8/92
4. "Training Family Planning Program Managers for the Year 2000," paper and presentation (APHA 1990) by Linda Suttentfield, James Wolff, Susanna Binzen
5. "The Management Implications of Community-Based Participation in Family Planning Service Delivery," paper, presentation (IPPF/GTZ workshop on Community-Based FP Services, Harare, Sept. 1991), and article (IPPF publication), by Leslie Curtin, Sara Seims, Deirdre Wulf
6. "Management Information for Community-Based Services," paper, presentation (IPPF/GTZ workshop on Community-Based FP Services, Harare, Sept. 1991), and article (IPPF publication), by Joellen Lambiotte
7. "Community Participation in the Indonesian Family Planning Program: The Village Perspective and Management Strategies," paper by Donald Chauls and Santoso Hamijoyo, 4/92 (submitted to International FP Perspectives)
8. "Sustainability of Family Planning Programmes in the 1990s," paper, presentation (Seminar on Programme Sustainability Through Cost Recovery, held by IPPF in Kuala Lumpur, Oct. 1991) and article (IPPF publication on sustainability and cost recovery) by Catherine Crone Coburn,
9. "Providing Effective Management Assistance: Six Keys to working with Family Planning Organizations in Developing Countries," paper and presentation (APHA 1991) by Sara Seims, Leslie Curtin, Susanna Binzen
10. "Rapport sur la IVème Réunion du Comité FRAC sur la Qualité des Services," paper and presentation (The Population Council, Journées de Réflexion, Senegal, February 1992) by Sylvia Vriesendorp.
11. "Rapport sur la Vème Réunion du Comité FRAC au Rwanda sur la Décentralisation," (The Population Council, Journées Annuelles de Réflexion, Burkina Faso, May 1993) by Sylvia Vriesendorp.
12. "Norplant Cost Study: Rwanda Final Report," report by Marie Goretti Nyirarukundo, Emmanuel Hakizimana, Taryn Vian, October 1993.
13. "Providing the Foundation for the Development of Self-Sustaining Family Planning Services: FPMD and FEMAP," paper and presentation (APHA, October 1993) by Nancy Murray, Enrique Suarez, and Carlos Brambila.
14. "Institutionalizing Continuous Quality Improvement (CQI): MEXFAM's Experience," Paper and presentation at Operations Research Day organized by the Population Council, October 1993, by Nancy Murray, Ricardo Vernon, Alfonso Lopez Juarez, Ilse Salas, and Jesus Vertiz.

The Subproject Plans: The Actual Documents

1. **CIES (Bolivia) (SEP)**
Memo of Understanding, signed by FPMD October 14, 1992, and subsequent modifications
2. **ASHONPLAFA (Honduras)**
Delivery Order scope of work, signed by USAID April 20, 1993
3. **NFPB (Jamaica)**
Scope of work for Buy-in. There is also a report, Needs Assessment: National MIS for Jamaica, January 24-February 5, 1993, by Murray and Eckroad, with more information
4. **MEXFAM (Mexico) (SEP)**
Memo of understanding to Dr. Juarez, Executive Director of MEXFAM, dated October 1, 1991, with extensions
5. **FEMAP (Mexico) (SEP)**
Memo of understanding to Dr. Suarez, Executive Director of FEMAP, dated November 1 1992 (there is also an extension)
6. **DGPF (Mexico MOH)**
Proposal from the Ministry of Health, faxed August 9, 1993
7. **ONFP (Tunisia) (SEP)**
Report: MIS Needs Assessment, Visit to Tunisia to Identify FPMD Technical Assistance to the Tunisian National Office of Family Planning, May 14-24, 1991 by Helfenbein
8. **Turkey MOH (SEP)**
Report: Needs Assessment and Management Development Plan for the Management Information and Contraceptive Logistics Systems for the Maternal and Child Health and Family Planning General Directorate in Turkey, November 21-December 11, 1991, by Helfenbein and Graves (CDC)
9. **Philippines DOH (SEP)**
Report: Management Skills Needs Assessment of the Philippines Department of Health Family Planning Services Division, August 26-September 6, 1991, by Miller and Nieboer
10. **Philippines DOH/Local Government Units (SEP)**
Report: Management Development Plan, Philippines, May 10-21, 1993, by Mitchell and Eckroad
11. **FPAN (Nepal) (SEP)**
Report: Management Assessment and Management Development Plan, Family Planning Association of Nepal, January 18-29, 1993, by Mitchell and Baker
12. **LIP (Bangladesh) (SEP)**
Report: Visit to Bangladesh, November 9-December 3, 1992, by Helfenbein. Plan was revised by USAID/Dhaka, and the current plan and activities are in the SOW for the new delivery order.

13. NGO (Bangladesh) **(SEP)**
Report: Visit to Bangladesh to Develop a Plan for Technical Assistance to the CA/NGO Project, April 11-26, 1993, by Ellis, Helfenbein, and Sacca. The project and scope of work had actually evolved over several TDYs.
14. ASCI (India)
Report: Visit to India to Prepare Management Development Plan for Third Phase of MIS Program, August 3-17, 1991, by Helfenbein and Savosnick
15. DFH (Burkina) **(SEP)**
Subproject protocol between FPMD and the Ministry of Health, Social Action, and the Family, in French, dated September 30, 1992
16. NCPD (Kenya)
Management Development Plan and MIS workplan for July 1991-September 1993. No date or signature.
17. CHAK (Kenya)
Management Development Plan and Workplan for September 1991-September 1993. Signed by the Executive Director on July 24, 1992
18. FPAK (Kenya)
Management Development Plan and Workplan for September 1991-September 1993. Signed by the Executive Director on July 20, 1992
19. Mkomani (Kenya)
Management Development Plan and Workplan for September 1991-September 1993. Signed by the Chairman on August 19, 1992
20. SDA (Kenya)
Management Development Plan and Workplan for September 1991-September 1993. Signed by the Director of Rural Health Services on July 21, 1992.
21. Maseno West (Kenya)
Management Development Plan Workplan for September 1991-September 1993. Signed by the Director of Christian Community Services on December 1, 1992
22. Mandeleo (Kenya)
Management Development Plan and Workplan for September 1992-March 30, 1993. No signature; dated August 24, 1992
23. PPFN (Nigeria) **(SEP)**
Report: Family Planning Management Development and Planned Parenthood Federation of Nigeria Management Development Plan
24. SANFAM (Senegal)
Report: Rapport du Voyage au Senegal, May 7-22, 1991, by Lambiotte and Seims.
25. CAFS **(SEP)**
Delivery order 8 and report: Needs Assessment of the Centre for African Family Studies (CAFS), May 11-29, 1991 by Vriesendorp and Reimann

26. CERPOD (SEP)
Delivery order scope of work. No date or signature.
27. INAS (Morocco)
Scope of work of Delivery Order 9
28. Regional Center for Training (Cairo, Egypt)
Report: Management Needs Assessment Visit to Regional Center for Training, Cairo, Egypt, July 14-19, 1991, by Mitchell and Nieboer
29. USAID/Colombo (Sri Lanka)
Report: An Analysis of the Potential for Using a Local Apex Organization to Manage USAID/Sri Lanka Family Planning Projects, June 10-18, 1991, by Hall
30. USAID/Bangkok Khmer Affairs Office (Cambodia)
Report: Needs Assessment and Proposal for FPMD Technical Assistance, Integrated Maternal Child Health and Child Spacing Services Cambodia, April/May 1992, by Helfenbein and Seims
31. CNS (Bolivia)
Report: "Caja Nacional de Salud" Reproductive Health Program, Organization Assessment Management Development Plan, November 1991, by Wilcox and Olave
32. Ministry of Health (Peru)
Planning document put out by Development Associates: Peru Family Planning Implementation Plan, 1993 Workplan, June 1993. FPMD's activities on pp. 11 and 16
33. CEPAR (Ecuador)
Report: Assessment of Implementation of the Integrated Financial Management System Installed by FPMT at CEMOPLAF and Assessment of Need for Completion of Technical Assistance at CEPAR, March 19-27, 1991 by Gutierrez

Appendix K - USAID Procurement Related Issues

USAID Procurement-Related Issues

During the entire course of this evaluation, the ET was confronted with FPMD implementation issues and problems related directly or indirectly to the mode of contracting selected for this project. The problems were pervasive, intrusive, and invariably counterproductive to the intended project purpose. They affected both contractor personnel and USAID project managers and procurement officers. They are believed by the ET to be of sufficient importance to require some detailing in this Annex.

The ET is aware of USAID efforts underway to effect Procurement Reform. It is hoped that material included in this Annex will be helpful to USAID in redesigning its procurement policies and procedures, as well as in selecting a procurement mechanism appropriate for FPMD II, whether that be a Cooperative Agreement, a Performance Based Contracting arrangement, or other procurement mechanism.

Included in this Annex are materials prepared by MSH at the request of the ET, and discussed in some detail. They are unedited.

Also included is DHAKA 00726, a USAID cable which outlines specific Mission concerns with the buy-in process as applied to population and health projects. It echoes many of the concerns expressed in the MSH notes.

Finally, MSH notes relating to USAID reporting requirements are included, as well as thoughts on procurement mechanisms for FPMD II.

Appendix K - A.I.D. Procurement Issues

MEMO

TO: Evaluation Team
FROM: Melanie Powers, Director of Operations, FPMD
DATE: April 21, 1994
RE: Experience with the Q Contract Mechanism

As discussed this morning, the first two pages attached present a short overview of the problems we have experienced with the Requirements contract mechanism. The remaining pages in this packet are the materials developed with Leslie Curtin for the Contract Officer's annual planning meeting several years ago. Many of the issues remain unchanged and relevant today.

ISSUES WITH BUY IN DEVELOPMENT
AND ADMINISTRATION UNDER THE
REQUIREMENTS CONTRACT

1. Negotiation and Development

Buy in's are treated as separate competitive procurements making negotiations convoluted and creating numerous organizational conflict of interest and procurement integrity traps.

Buy in's are treated as cost reimbursement (time & materials) contracts rather than established with fixed prices for specific services and goods as prescribed by the FAR.

RFP requirements for buy in's force the development of proposals with too much detail resulting in the need to process time consuming modifications and extensions. (e.g. in-country personnel practices or laws that provide for annual bonuses or specific severance arrangements must be identified, budgeted and documented to the procurement office's satisfaction before a delivery order will be signed.)

Multiplier mechanism and application is mysterious to Missions, USAID/W program offices and clients. Contractors receive conflicting information from the procurement office. (Must it be used on subcontract labor or not? Is this required for only cost-reimbursement subcontracts or fixed-price as well?)

Negotiations take too long (because of all above) resulting in program implementation delays.

Prime contract (C) and Requirements (Q) contract are inconsistent and, in some instances, in conflict. (see letter requesting modification for examples)

Prime calls for 40% of core project salaries to be charged to delivery orders. Missions have universally resisted this for salaries and other costs associated with general project management or buy in administration.

Application of the mythical buy in ceiling of \$250,000 has made negotiations more difficult. Seems to have been a misunderstanding in design.

2. Implementation

Monitoring, reporting, modifying, and tracking requirements are excessive.

Appendix K - A.I.D. Procurement Issues

Approvals under delivery orders for consultants, equipment, subcontracts must come from Washington. USAID/W procurement staff are obviously far removed from the work in-country and often must start from scratch to learn the prevailing rates, common practices, or goods-availability conditions in a given country.

Multiplier is a problem when selecting local subcontractors with different cost structures.

There is no line item flexibility in time/materials contracts so routine changes in buy in's must be processed as formal modifications through USAID/W. (Lack of line item flexibility necessitates formal modifications for changes in implementation strategy e.g. when something is to be done under a subcontract that was originally envisioned as an individual consultancy.) Most changes in implementation strategy are made at the request of the Mission or client organization.

3. General Problems with Requirements Contract for Services

Requirements contract mechanism is not suited to providing responsive technical assistance services.

Wide difference in opinions re: what "companion" contract means when used in connection with the C and Q.

Often procurement office actions relating to buy in's are sent to the "overflow" unit where staff are unfamiliar with the Core contract and the related buy in. (This would work for an agreement to buy batteries but does not with the purchase of technical services.)

The required multiplier mechanism results in an overall reduction in the negotiated fixed fee of the contract and does not accommodate changes in a provisional overhead rate negotiated in the Core.

ISSUES IN DEVELOPING BUY-INS

1. Level of Detail/Timing Required for Buy-in Submissions From Contractor (SOW and Budget)
 - Difficult to estimate LOE and budget for activities to be carried out that are large, complex and cover a multi-year period.
 - Lack of understanding of multiplier rate.
 - Missions cannot estimate what CA inputs are required to manage buy-ins.
 - Conflicting guidance from Contracts Office on what labor categories multipliers should be applied to and whether or not it should be applied to local subcontracts.
 - Mission and contractors find it difficult to estimate each and every labor category required over a period of activity. Contractors must propose individuals (staff, technical and administrative, consultants, and sub-contractors) since multiplier must be applied to an individual's daily rate. Field realities make this extremely difficult to estimate with precision.
 - Budgets must be prepared for both bilaterally funded and centrally funded activities with precision.
 - Missions do not know what CA inputs are required to implement and administer buy-in.
 - Missions precluded from discussions with contractors.
 - CTO becomes go-between between mission and contractor to provide information on CA's multiplier rate, LOE inputs, and calculation of direct costs.
 - Results Missions submitting unrealistic budgets and/or scopes of work forcing, lengthy negotiations, reductions in LOE, delay in field activities, etc.

2. Cost-sharing Between Core and Requirements Contracts

Most buy-ins require large investment of Central funding to administer because:

- Host country governments are unwilling to use bilateral funds to support home office costs and overhead of US-based contractors.
- Bridge funding for continuation of activities until buy-in is executed.
- Funding needed for high level locally-procured TA or expatriate TA in-country.
- Project design flaws over-estimated level of buy-ins which would fund core staff (not one mission willing to fund core staff at even half the level required by core contract).

3. Ceiling on Size of Buy-ins

- For services which cost in excess of \$250,000 missions are urged competitively procure services they seek. However, since CF contract was originally competitively procured, it is difficult to justify this requirement as one that contributes to reinforcing the spirit of open and free competition.
- Missions lack technical, financial and human resources to deal with competitive procurement.
- Mission management might not agree to competitively procure.
- Can't afford nine-month delay and loss of momentum.
- Exceptions require strong justification from missions (difficult in light of declining staff, contractors).

Questions

- Can AID/W Contracts Office delegate authorities to senior mission representative or mission CO to hold discussions with contractors to form better basis for formulating budgets and scopes of work?
- Can Contracts Office provide more detailed guidance to missions and CTOs regarding the level of detail that can be discussed between mission and contractors?
- Can AID/W reduce level of detail required for delivery orders to Q Contracts and treat them like Cooperative Agreements?
- Can Contracts Office clarify what level of detail is now required for amendments to Cooperative Agreements?
- Is there any room for discussion of new Agency design and contracting procedures?
- New design and contracting procedures provide guidance to missions only, not CF Bureaus or projects. Do we define/develop our own guidelines?

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ISSUES IN IMPLEMENTING BUY-INS

1. **Long Lead-time To Negotiate and Execute Buy-ins and Local Subcontracts**
 - Guidance cable (February, 1991) issued to Missions said to allow 60 days from receipt of PIO/T in Contracts Office. Have received conflicting guidance that the 60 days should be counted from receipt of proposal from contractor. Most actions take 90 to 100 days. Consequences:
 - Jeopardize timely implementation of field-based activities.
 - Poses difficulties because implementation schedule is often imposed by Host Country government and activities are sequenced.
 - Budget implications because budgets are prepared using precise beginning and end dates.
 - When buy-in is not executed by start date it sets off a chain reaction to delay implementation of other activities.
 - Overall time frame for activity may need to be reduced.
 - Salaries for project staff (core and subcontract) may be delayed in payment.
 - Lose credibility with Host Country counterparts and risk losing project momentum.
2. **Many Contract Officers Responsible for Executing Amendments Under Q Contract and C Contract**
 - Responsibility for executing delivery orders to Q contracts lies with negotiators from each geographic division in Contracts Office.
 - CTO, mission, contractor are normally not notified which individual has been designated as negotiator.

Appendix K - A.I.D. Procurement Issues

- Complications arise because regional negotiator did not participate in negotiation of core contract and yet, now, must interpret clauses in the Q contract without the benefit of knowing the original intent and history. In most cases regional negotiators have never even read the core C contract.

3. Lengthy Approvals Are Required for Routine Project Implementation Activities

- Contracts are awarded to institutional contractors because of their technical ability and capacity to respond flexibly drawing upon inside resources. And yet, approvals are required for hiring local subcontractors and consultants, project staff (technical and administrative), and short-term consultants.
- Rationale for requiring these approvals for large, world-wide projects is not clear.

Questions

- Will the procedure for negotiating contract amendments under Q contracts continue to be distributed among the geographic divisions of the Contracts Office?
- Can some of these approvals be delegated to the CTO?

ISSUES REGARDING AUDIT/EVALUATION OF BUY-INS

1. **Rigorous Audit Requirements and Competition for Host Country Subcontracts**
 - Becomes difficult to work with local subcontractors even when it is technically appropriate or within the mandate of the project purpose. (Desirable in support of field activities and in the context of institutional development.)
 - Hiring an outside audit firm who can verify that Host Country subcontractor is in compliance with US Government auditing standards is a significant expense, particularly when the subcontract award is only \$25,000 (the level at which audits are required).
 - Regulations require technical services in excess of \$25,000 to be competitively procured. When search for an appropriate subcontractor takes place thousands of miles away from where the prime is managed, this is a lengthy, complicated and expensive process--often more costly than the award itself.
2. **Cost Implications of Using Only One Fixed Multiplier Rate**
 - Where a prime contractor is working with a subcontractor (local or US) which has a lower overhead/fee rate than the prime, the highest overhead rate will prevail because the prime must bill AID at the fixed multiplier rate. The PIO/T budget also must reflect the CAs fixed multiplier rate on all subcontracts.
 - Thus for buy-ins that rely heavily on local subcontracts (as many projects do) true costs may be inflated making the procurement more expensive to the Agency.
 - Savings which could have accrued from using a local subcontract can not be applied to direct costs (e.g., to help finance project costs.) Applying the multiplier to all local subcontracts can mean that the Agency pays twice as much for the same level of effort.

Delivery Order Date Extensions for FPMD

FPMD was awarded a "C/Q" contract from USAID. The "C" or "Core" Contract is a five-year contract for a clearly defined amount of funding. The "Q" Contract is a companion Requirements Contract, which does not have a defined set of deliverables nor a fixed amount of funding. The "Q" contract allows for the flexibility to add specific additional tasks and funding to the project, in the form of delivery orders.

The FPMD "Q" contract has included to date 26 delivery orders. Each delivery order represents a defined set of tasks, such as a workshop, a training course, a strategic planning exercise, a review of MIS or some combination of technical assistance activities. For many reasons which can not be anticipated nor controlled, FPMD is often unable to complete the delivery order scope of work by the designated date. On these occasions, FPMD requests delivery order date extensions.

Specific reasons for date extensions have included: security problems in the countries where the work was to take place; decisions made by the Mission which delayed the work; and activities between the client organization and the cooperating country government which interfered with the scheduling of FPMD activities. Because of these types of issues, it is virtually impossible to predict with precision the implementation schedule of an 8, 12, or 24 month plan of services.

The current processing overload in the USAID contracting office is having serious negative impact on programs. Extensions are frequently not signed before the end date of the original order, forcing work stoppages, breaking of commitments to Missions, cancellation of planned travel and activities, and the loss of personnel when assurances cannot be given regarding future scheduling.

It is of great concern to FPMD that the Procurement office seems to regard the volume of extension requests as evidence of non-performance. Rather, we believe it is more accurately understood as a demonstration of FPMD's ability to be flexible and to meet service delivery obligations in a complicated and fluid environment.

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FM AMEMBASSY DHAKA
TO SECSTATE WASHDC PRIORITY 4744
BT
UNCLAS SECTION 01 OF 02 DHAKA 00726

CLASS: UNCLASSIFIED
CHRG: AID 01/24/94
APPRV: OPH:WRCOLDMAN
DRFTD: OPH:DLPIET:RK2
CLEAR: 1. OPH:ANOR;
T:MRAHMAN; 3.
RYDER;
DISTR: ~~OPS~~ CHARGE
ORGIN: OCR

AIDAC

FOR G/RD/POP, ELIZABETH MACGUIRE; G/RD/POP, MARGARET
NEUSE AND KATHY KOSAR, G/RD/POP/OPS; G/RD/H/RCSS, ROBERT
WRIN; G/RD/H/AP, CARYN MILLER; FA/OP, THOMAS BORDONE

E.O.: 12356: N/A
SUBJECT: POPULATION/HEALTH: MISSION FUNDED BUY-INS TO
POPULATION AND HEALTH PROJECTS

REF: (A) DHAKA 00316, (B) 93 STATE 365834

1. GIVEN THE CURRENT CONFUSION WITHIN THE AGENCY
REGARDING BUY-INS, THIS CABLE SEEKS IMMEDIATE ADVICE
FROM USAID/W ON HOW THE MISSION CAN ACCESS SELECTED
RD/POP AND FD/H CENTRAL PROJECTS. IN THE ABSENCE OF ANY
RECENT OFFICIAL GUIDANCE REGARDING BUY-INS, THE MISSION
IS PLANNING ON SUBMITTING THE FOLLOWING BUY-INS TO RD/POP
AND PL/H OVER THE NEXT SEVERAL MONTHS. PLEASE NOTE
THESE WERE SUBMITTED ON THE SHRET FOR FA/OP ACTION.

A) RD/POP PROJECTS:

- - FAMILY HEALTH INTERNATIONAL (FHI)
(PROJECT NO. 936-3041/AGREEMENT NO. DPE-3041-A-
00-0043-00/PACD 8/95)
- - RAPID IV
(PROJECT NO. 936-3046/AGREEMENT NOS. DPE-3046-C-
00-1047-00 AND DPE-3046-Q-00-1048-00/PACD
9/96)
- - POPULATION COUNCIL PROGRAMMATIC GRANT (FOLLOW-ON
PROJECT PER COMMUNICATIONS WITH RD/POP)
(PROJECT NO. 936-3050/AGREEMENT NO. DPE-3050-A-
00-8059-00/PACD 9/94 OR FOLLOW-ON PROJECT)
- - POPULATION TECHNICAL ASSISTANCE, EVALUATION OF
FAMILY PLANNING PROGRAM IMPACT (OR SIMILAR
PROJECT FOR ASSESSMENTS/EVALUATIONS)
(F.G., PROJECT NO. 936-3060/AGREEMENT NO. DPE-
3060-C-00-1054-00 AND DPE-3060-Q-00-1055-
00/PACD 9/96)

B) RD/HEALTH PROJECTS:

- - BASICS SUPPORT FOR INSTITUTIONALIZING CHILD
SURVIVAL (BASICS)
CONTRACT NO. HRN-6006-C-00-3031-00 AND CONTRACT

ACTION TO:	
REPLY	
DUE	
INFO	
ME	
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PRO	
ONE	
PDS	
OFA	
OPH	
TRG	
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EXO	
CM	
PER	
TRV	
RLA	
CO	
LIB	
GSO	
REPLY/NAN	
Int'l	
Date	
File	

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- COOPERATIVE AGREEMENT FOR CHILD SURVIVAL -- JHU;
OR SIMILAR PROJECT
(SUB-PROJECT NO. 936-5951.01/AGREEMENT NO. DPF-
5951-A-00-5051-00)
- TECHNOLOGIES FOR CHILD HEALTH (HEALTHTECH)
(PROJECT NO. 936-5966/AGREEMENT NO. DPF-5968-A-
00-0025-00)

C) TOTAL ANTICIPATED AMOUNT FOR ALL OF THE ABOVE
COMBINED IS APPROXIMATELY DOLS. 4,000,000.

2. IT IS PARTICULARLY IMPORTANT TO NOTE THAT MOST OF
THESE "BUY-INS" ARE FOR ON-GOING ACTIVITIES OR IN DIRECT
SUPPORT OF ACTIVITIES (I.E., MCH/IP EXTENSION AND URBAN
HEALTH EXTENSION PROJECTS, ICDIP, B; RAPID IV; FFI;
ETC.). ANY DISRUPTION IN FUNDING THROUGH THESE CENTRAL
SUPPORT PROJECTS WOULD CAUSE MASSIVE DISRUPTION IN KEY
PROGRAM ACTIVITIES HERE.

At field level

3. WHILE WE ARE ALL AWARE OF THE TORTUOUS TRAIL,
ESPECIALLY IN RECENT YEARS, OF COMPLETING BUY-INS WHAT
ARE OUR OPTIONS IF BUY-INS ARE DISCONTINUED? WHILE WE
APPLAUD RD/POP, FD/H, AND OTHER OFFICES FOR ATTEMPTING
TO EASE THE TRAIL AND STREAM-LINE THE PROCESS, REF B
WAS THE FIRST OFFICIAL INDICATION WE HAVE HAD OF A
POSSIBLE FUNDAMENTAL CHANGE IN THE WAY USAID/W MAY BE
DOING BUSINESS. IF NOT BUY-INS, THEN WHAT MECHANISM
SHOULD MISSIONS USE? OYR TRANSFERS? INCREMENTAL
FUNDING? OTHER MECHANISM(S)? IF MISSIONS ARE TO USE
ANOTHER MECHANISM, WHEN WILL OFFICIAL DECISION BE MADE;
AND SPECIFIC GUIDELINES IN COMPLETING FUNDING
TRANSACTIONS BE MADE AVAILABLE AND CABLED? FYI, MISSION
HAS THE FOLLOWING CONCERNS REGARDING ANY TRANSFER OF
MISSION FUNDS TO A CENTRAL MECHANISM:

- GENERAL CONCERN: MISSION INTERESTS REGARDING
MANAGEMENT, CONTROL, IMPLEMENTATION, AND MONITORING
(FOR BOTH PROGRAM ACTIVITIES AND EXPENDITURE
TRACKING) OF DELIVERABLES MUST BE SAFEGUARDED.

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*SCOPE of work
Accountability*

1/15/80

AIFAC

Appendix K - A.I.D. ~~Health~~ ~~Program~~ ~~Issue~~ ~~Charge~~ RIDER;
ORIGIN: OCR:

FOR G/RD/POP, ELIZABETH MACGUIRE; G/RD/POP, MARGARET NEUSE AND KATHY FCSAR, G/RD/POP/OPS; G/RD/F/RCSS, ROBERT WRIN; G/RD/H/AP. CARYN MILLER; FA/OP, THOMAS BORDONE

E.O.: 12356: N/A

SUBJECT: POPULATION/HEALTH: MISSION FUNDED BUY-INS TO POPULATION AND HEALTH PROJECTS

- SIMPLY PUT, THE MISSION MUST BE A FULL PARTNER IN
- THE COMMUNICATIONS LOOP AMONG USAID/W (THE
- CONTRACTING AUTHORITY), THE CONTRACTOR, THE
- MISSION, AND THE LOCAL REPRESENTATIVES OF THE
- CONTRACTOR. WITHOUT THESE SAFEGUARDS, PARTICULARLY
- REGARDING IMPLEMENTATION AND MONITORING, IT IS MUCH
- MORE DIFFICULT FOR THE MISSION TO MANAGE CENTRAL
- PROJECT ACTIVITIES.

- - - - SPECIFIC CONCERNS:

(A) IF THE MISSION WOULD DO FUNDING TRANSFER TO A SPECIFIC GRANT, CA OR CONTRACT (E.G., JOHNS HOPKINS UNIVERSITY/CENTER FOR COMMUNICATION PROGRAMS, POPULATION COUNCIL PROGRAMMATIC GRANT, ETC.), WHAT IS THE SAFEGUARD THAT THE BILATERAL FUNDS PROVIDED WILL BE GUARANTEED FOR THE MISSION'S SPECIFIED USE IN BANGLADESH?

(B) FOR REASONS OF ACCOUNTABILITY, MISSION WOULD EXPECT TO SEE QUARTERLY EXPENDITURE REPORTS, BY MAJOR LINE-ITEM. THIS WOULD ALLOW US TO ENSURE THAT FUNDS ARE BEING USED APPROPRIATELY AND IN A TIMELY FASHION FOR BANGLADESH'S DEVELOPMENT. CAN CENTRALLY FUNDED PROJECTS PROVIDE QUARTERLY ACCOUNTING ON A TIMELY BASIS? IF NOT SPECIFIED IN THE AGREEMENTS, CAN A MECHANISM BE AGREED UPON FOR THIS KIND OF REPORTING?

(C) WHAT OTHER SAFEGUARDS FOR MISSION INTERESTS IN FUNDING TRANSFERS DOES USAID/W NOW INCLUDE OR ENVISION IN THE NEAR FUTURE? FOR EXAMPLE, REF B MENTIONS WORKPLANS, SUBAGREEMENTS, SCOPES OF WORK AS BEING THE GUIDING DOCUMENTS. FOR THIS MISSION, THE FIRST SENTENCE OF PAPA 4 IS KEY: "... TO DEVELOP WORKPLANS AND SUBAGREEMENTS IN CLOSE COLLABORATION WITH MISSIONS AND THE HOST COUNTRY." THIS MISSION BELIEVES THAT ONLY THE JOINT DEVELOPMENT OF WORKPLANS OF SUBAGREEMENTS ARE INADEQUATE TO FULLY SAFEGUARD MISSION AND BANGLADESH PROGRAM INTERESTS. THERE MUST ALSO BE OTHER ADMINISTRATIVE, BUDGETARY, IMPLEMENTATION AND CONTROL MECHANISMS IN PLACE FOR FUNDING TRANSFERS TO WORK PROPERLY.

4. AS STATED ABOVE, THE MISSION IS PROCEEDING WITH BUY-INS (MISSION FUNDED PIO/TS) FOR SUBMISSION TO USAID/W OVER THE NEXT SEVERAL MONTHS UNLESS USAID/W PROVIDES SPECIFIC CABLED GUIDANCE VIS-A-VIS OTHER FUNDING MECHANISMS. PIO/TS WILL BE SENT TO USAID/W DURING FEBRUARY - APRIL PERIOD.

UNCLASSIFIED DHAKA 000726/02

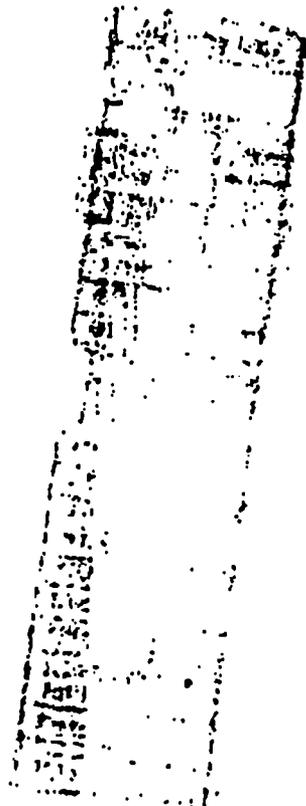
Appendix K - A.I.D. Procurement Issues
5. FYI, THE MISSION HAS REQUESTED (REF A) A SECOND
QUARTER FY 94 ALLOTMENT OF DOLS. 20,993,000 FOR
POPULATION AND HEALTH SECTOR ACTIVITIES. A PORTION OF
THIS ALLOTMENT REQUEST IS FOR BUY-INS; THE REMAINING
AMOUNTS FOR BUY-INS WILL BE REQUESTED IN THE THIRD
QUARTER FY 94.

6. PLEASE ADVISE ASAP. THANKS AND BEST REGARDS.
NACH

BT
#0726

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UNCLASSIFIED DHAKA 000726/02



MEMO

TO: Evaluation Team
FROM: Melanie Powers, Director of Operations, FPMD *Melanie*
DATE: April 22, 1994
RE: Problems with Managing Reporting Requirements

As you requested, I have reviewed the list of contract-required reports for usefulness and/or redundancy. I was surprised to find that I could not really eliminate any as purely replicating information delivered through some other mechanism. The reports are largely for discrete audiences and purposes.

The difficulties in managing the reporting load arise from a combination of (a) changing formats, definitions and requirements and (b) the plethora of ad hoc requests that do, often, replicate information in required reports. The quarterly report (portfolio review/pipeline) format has changed virtually every period of the contract. Terms such as "committed" and "obligated" are defined differently forcing us to attend much more than we would like to the production of the report. For example, we have automated to report expenditures by subproject as defined by our contract. Several of the reports we prepare (both routine and ad hoc) come with different definitions of "subproject" forcing us either to do the report manually or, when possible, redefine the filters in our report writer, in order to respond. This is time consuming and costly.

I noticed that I did not include the annual management review in the required reporting list. Certainly the work for this always replicates our work planning process and because it is needed for a slightly different time frame can double the work load.

At the macro level, it would be much easier for Contractors if contracts were executed in a more standard fashion. (USAID's agenda for procurement reform supports this notion.) MSH does not have two contracts alike, i.e. with the same reporting requirements, definitions, billing arrangements, etc.. This makes it very difficult to design time-saving automated financial information systems as we must always tailor them for "the special provisions" of this or that contract. At the same time, it seems to me that it is incumbent upon Contractors to force the standardization to the extent possible during negotiations by not accepting provisions that require the development of idiosyncratic side systems for reporting.

THOUGHTS ON CONTRACT MECHANISM FOR FOLLOW-ON

Let me preface these comments with my strong belief that this project should have been developed and competed as a cooperative agreement. I think that it is still worth pursuing the strategy of change arguing that the mechanism was a mistake. At the same time, I don't think that it is at all a tragedy if the follow on is awarded as a contract provided that we can improve the "fit" by using a different contract type. The C/Q model has been a constant cause of aggravation for the contractor, the procurement office and all clients from the organizations in the field to the Missions and the Pop office. I think that there would be nearly universal agreement on the notion that the model can and should be improved.

As I indicated, MSH/FPMD would very much like to serve as a pilot for procurement reform, modeling the performance-based contract, and participating in a real-time, development-work test of the Reform Agenda. My conviction has always been that this is the way to benefit soonest from good ideas and what better place to pilot this than in an experienced and conservative management firm and a unique and proven management project.

In addition to applauding and seconding the reform agenda set forth by the USAID procurement office, I would make the following suggestions:

Review available contract types/models and select something similar to the FPMT "Z" type where buy in's are awarded directly to the core contract.

Fully fund the core staff and project management in the core contract. Do not rely on buy in's to off set costs. The current political environments in the countries where we work make it increasingly unlikely that governments will want to support central costs.

Set a realistic and adequate contract ceiling. To do this it is necessary to make a reliable estimate of potential buy in work.

Approve MSH systems, procedures and practices during the proposal and contract negotiations, including personnel, internal audit and procurement. The concept is that with approved systems the contractor can be left to perform without additional individual approvals for salaries, subcontracts, consultant rates and so forth. General parameters such as the FS-1 limitation or a provision that requires contract officer approval of subcontracts over \$250,000, would be fine.

Appendix K - A.I.D. Procurement Issues

Approve as much of the routine work of the project as possible at contract execution. (e.g. international travel (we will still be getting concurrences), technical activity in pursuit of the EOPS indicators, equipment purchases.)

Do not make it a level of effort contract. (The performance-based contracting pilot would solve this.) Level of effort is inconsistently defined and LOE contracts limit the contractor's ability to engage local organizations for subcontracts, for example, as LOE of subcontractors may not count towards LOE deliverables.

Design strong project management structures for countries with intensive programs of technical assistance. Not only is this technically sound in the development/institutionalization of local capacity but it allows a management project to practice what it preaches by supporting responsible administration of public funds.

Effective procurement planning would ensure that incremental funding for the core would be reliable and timely. There have been close calls in this project when expenditures have nearly collided with available funding levels as next tranche funding was delayed. Also, all tranches have been different in amount. Good project financial management would be supported by the up front knowledge of funding.

Alternatively and preferably design letter of credit financing for the core.

**Appendix L - Materials Development and Dissemination
Recommendations**

1/22

Materials Development and Dissemination

Expanded Objectives of PCU

The focus of this annex is to provide analytical comment by the ET and to make recommendations that will strengthen the cause-effect linkages from improved materials development and dissemination that FPMD II and FPMD III can provide to the FP service provider levels.

The intent is to strengthen those outputs of FPMD that require additional attention to transform outputs into purposes that are sufficient to establish institutionalization of management development interventions for expanded, sustained, high quality FP services.

The goals of FPMD II and FPMD III management technologies and materials should be appropriately articulated to:

- Provide a forum for FPMD and MSH Boston staff, local colleagues and staff of other CAs, NGOs and local government to communicate management innovations and experience in applied management techniques appropriate at the FP provider service delivery level.
- Improve collective knowledge of management strategies and share technical information that exists or is developed with and outside the FPMD project that is appropriate and useful at the FP provider service delivery level.
- Provide practical and useful family planning management materials to the population and development community at the FP provider service delivery level.

The following objectives modify and elaborate upon those expressed by FPMD I regarding its "Publications Link to Service Delivery"¹

- Provide family planning managers with materials designed to facilitate adaptation, transfer and documentation (institutionalization) of FPMD management interventions and techniques for improving program management, the efficiency of operations, and the quality of services to the peripheral levels of FP service delivery providers
- Communicate successful experience in solving problems at the service delivery level to a wide audience of family planning professionals in increasingly more simple, more brief, more easily readable format appropriate to each organizational level. Peripheral FP staff and trainers need readily available, easily adaptable materials to assist them in appropriate transfer and development of FPMD management interventions and management systems to service delivery providers.

Simply stated, institutionalizing and sustaining management interventions and systems development is dependent on how effectively and efficiently these interventions and systems are installed and documented throughout FP organizations.

¹ FPMD Publications and Communications, Summary of Work in Progress, prepared for FPMD April 1994 Mid-term Evaluation, p.2.

- Create and provide the above materials to family planning managers at the service delivery level in English, French, and Spanish languages appropriate for each organizational level of FP service delivery.
- Communicate and provide to cooperating agencies, international donor organizations, and other professionals in the population and development community, a comprehensive set of systematic and adaptable materials representing the successful management interventions implemented by FPMD at the service delivery level.

Adaptable Template Technology

The cumulative 10-year experiences of FPMT and FPMD I for field-testing management interventions and systems development have reached the point where attention should be given to rationalizing and consolidating the resultant technologies and lessons learned in a format that permits rapid and widespread adaptation and replication. The recommended format is Adaptable Template Technology:

- The term **technology** is used to indicate the entire body of processes, materials, and methods involved in each of the management interventions used to achieve the sector goal, purposes and outputs of the overall 20 years of FPMD.
- **Template** is used to indicate the original representation, form, or condition that served as a model on which later constructs have been based and/or judged over the 20 years of FPMD.
- **Adaptable** is used to refer to the capacity of such processes, materials, and methods to be easily and systematically modified or changed in response to new or additional FP program implementation sites worldwide, with or without the need for outside help.

FPMD II and FPMD III materials should be designed so that the range of potential FP program users are aware of the total comprehensive package and understand it well enough to know whether the total management development system or parts of it can benefit their FP program's management organizational development.

FPMD II and FPMD III materials development should incorporate design characteristics to facilitate adaptation and utilization with limited assistance and sometimes without assistance:

- the materials should be organized into topic modules, any of which can be used individually or in association with others to serve a specific purpose of organizational development.
- part of a module can be used separately
- the materials should provide structure for curriculum and training development for FP service providers
- the materials should include guidelines and documentation for management interventions and systems installation at peripheral levels as appropriate

The adaptable template technologies are not meant to short-circuit or undercut necessary systems analysis and critical examination of the resources, intra- and inter-agency organizational structures and functions, and other problems inherent to each new FP implementation site.

Adaptable template technologies are designed to provide a departure-point whereby a comprehensive view is presented, complexity is reduced to a manageable level, and practical guidelines are presented in an ordered format to facilitate program expansion and replication.

In FPMD II and FPMD III the adaptable template technologies will serve as an example or guide to be followed in replicating the management improvement interventions for organizational development pioneered and field-tested in FPMT and FPMD I. They are not a prescribed answer or solution to the particular needs of each new public or private FP organization and community site. Individual solutions can be prescribed during the adaptation process.

The availability of documentation in the format of a generic set of processes, materials, and methods (Adaptable Template Technology) to design, implement, operate, and evaluate the basic FPMD top-to-bottom management interventions will greatly facilitate expansion, dissemination and replication of the FPMD project purpose to provide:

- increased attention to client-responsiveness to the provision of reliable, high quality FP services, and
- increased attention to the institutionalization of strengthened management capabilities in FP organizations to assure the quality and sustainability of FP services.

Dissemination Strategy

Ten years is sufficient time for field-testing management interventions and systems development. More emphasis must now be placed on local capacity building for transfer and application through adaptable template materials development that can be shared widely and easily adapted and utilized:

FPMD II:	1995-2000	FPMT and FPMD I materials value (cost-effectiveness) and usefulness (replicability) justify further investment in adaptive template technology development and enhancement of local capacity through Collaborative Partnerships in the development and utilization of such materials development.
FPMD III:	2000-2005	Widespread Dissemination and Utilization of the resultant highly adaptive templates, maximally using management expertise, capacity and empowerment of the Collaborative Partnerships in local, regional, and global applications to: <ul style="list-style-type: none">● deliver quality, integrated FP services to sufficient numbers of women and men who wish to limit the number and spacing of their children;● achieve contraceptive prevalence levels, community-based distribution, method mix, and utilization which will significantly impact population growth rates; and● contribute to the desired objective of reduce dependency on donor funding.

Attention must be paid to "marketing" the FPMD II and FPMD III phases for USAID to realize a significant and fast return on the investment in FPMT and FPMD I and provide for rapid offtake and

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exploitation of the FPMD II and FPMD III successful development of Collaborative Partnerships and Adaptive Template Technology.

FPMD II and FPMD III should develop an explicit 'dissemination strategy' designed to focus on specific FP audiences to identify "opinion leaders", to develop clusters of users within their spheres of influence, and to stimulate further use via the FPMD active user networks by means of the *FP Manager* periodic publications. FPMD has already initiated activities that represent important initiatives to promote secondary diffusion, from one user to another, of the *FP Manager* which the evaluation team applauds.

The comments and judgements of users of similar adaptive template materials in primary health care firmly attest to the validity, practicality, and replicability of such an approach to strengthen health care systems, to provide capacity building and institutionalization of program changes, and to sustain these improvements and changes over long-term perspectives.

The ultimate objective is not dissemination but utilization.

Appendix M - FPMD Collaboration With Other CAs

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7. Please use the format below to summarize your collaboration with other CAs to date:

CA/Project Country Type of Activity

In order to increase the effectiveness of FPMD interventions, we have tried to the fullest extent possible to collaborate with other CA's. Our experience in this regard has been excellent, and we are strongly committed to this effort over the life of the project. Specific examples of such collaboration are summarized below.

CA or project	Country	Type of activity
Asia Institute	Philippines	Provided trainers for the DOH/FPS course.
AVSC	Kenya	Co-financing of Financial advisor at FPAK
AVSC	Nepal	Work with FPAN including the implementation of a "Situation Analysis" and development of a quality of care assessment tool based on the "COPE" methodology.
AVSC	Turkey	Coordination in the implementation of FPMD's MIS project.
AVSC	Kenya	Collaboration in the design and technical oversight of the development of a National Family Planning Implementation Plan.

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CA or project	Country	Type of activity
AVSC, JHPIEGO, PCS, FPLM/JSI, CARE, OPTIONS BUCEN	Philippines	Work with the Office of Special Concerns/DOH. Collaboration in the design of the new project, with plans for continued collaboration. Staff from some of these CAs will serve as resource persons at workshops organized by FPMD/Manila. Also FPMD staff have attended several CAs' meetings in Manila called by AID/Manila.
AVSC Pop Council	Colombia, Rwanda	Norplant Cost Study.
AVSC, Pathfinder, Asia Foundation	Bangladesh	TA in management assessments and strategic planning; training impact evaluation, MIS, human resource management.
AVSC	Latin America	Assistance with planning for phase out of AVSC assistance to organizations.
AVSC	Egypt	Strategic Planning and Workplan development.
AVSC	<i>The Family Planning Manager</i>	Joseph Dwyer-Director, Africa Region, AVSC was guest editor of "Reducing Client Waiting Times."
Bureau of the Census	Philippines	Work with the DOH/Philippines in MIS needs and the development of performance-based monitoring tools and techniques to rapidly assess changes in CPR at the local level.
CDC/FPLM	Jamaica	Coordination in design of MIS training course with CDC logistics module.
CDC/FPLM	Turkey	Joint technical assistance to develop a MIS and Contraceptives Logistics Systems for the MOH.
CEDPA, IPPF/London	Nepal	Coordination to discuss FPMD technical assistance plans to assure no duplication of effort and to assure IPPF's support of FPMD activities.

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CA or project	Country	Type of activity
CEDPA	Turkey	Discussed agenda, topics of working groups, and suggestions for follow-up plans at MOH conference (October 1991).
CEDPA, SEATS	Africa Region	CEDPA provided one of the FRAC facilitators (Ralph Stone). One of the FRAC participants was from SEATS.
CEDPA	Kenya	Intensive collaboration through CEDPAs front-line management of the FPMD subproject with Maendeleo ya Wanawake.
CMT Division CAs	FPMD Publications	Input on future topics to avoid duplication and increase use of publications through meetings of the Training Materials Working Group.
Consortium for International Training	Jamaica	Training in the use of ServStat for Family Planning Service Statistics Analysis with a representative of the Planning Institute of Jamaica.
DA JHPIEGO	Philippines	Conducted seminars on Family Planning technology updates.
DA	Philippines	Future collaboration planned in improving organizational capabilities in management training.
DA, OPTIONS/DGI, Eval. Project	Peru	MOH/MIS system compatibilization and evaluation of activity.
FHI, IPPF	<i>The Family Planning Manager</i>	John Bratt and Barbara Janowitz of FHI, and Lori Ashford-Smith of IPPF reviewed "Analyzing Costs for Management Decisions."
FHI	Honduras	ASHONPLAFA cost recovery/self-sufficiency aspect of management strengthening planned.

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CA or project	Country	Type of activity
FHI PCS IPPF	Nigeria	Needs Assessment: Planned Parenthood Foundation of Nigeria.
Future's Group	Philippines	Identified strategies for providing TA in MIS, IEC, and planning and action plans to test the strategies.
INTRAH	USA	Potential use of a training impact evaluation methodology in FPMD's CA/NGO project in Bangladesh.
INTRAH	Burkina Faso	Development of supervision protocols, training
INTRAH	Burkina Faso	Reviewed and commented on supervision guide and plans for pretest.
INTRAH, Pop Council	Burkina Faso	Future collaboration planned in evaluation and supervision activities for DFH.
INTRAH, Pop Council	Burkina Faso	Operational guidelines and monitoring system for the DFH.
INTRAH, Pop Council	Burkina Faso	Collaboration in development of operations guide.
IPPF/WHR, FHI, Pop Council/ INOPAL II	Mexico	Regional CQI conference.
IPPF/APRO	Africa Region	Plans for collaboration in the provision of strategic planning support to IPPF affiliates in the Africa region; plans for long-term collaboration in the FRAC.
IPPF/WHR	Honduras	Launched a strategic planning initiative.
IPPF/GTZ	Zimbabwe	Jointly sponsored workshop.
IPPF	<i>The Family Planning Manager</i>	Lori Ashford, IPPF (now with AID/Washington) reviewed "Charging Fees for Family Planning Services."

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CA or project	Country	Type of activity
IPPF PROFIT SOMARC Pop Council	Mexico	Team assessment: MEXFAM and FEMAP.
IPPF, Pathfinder, Seventh Day Adventist/Rural Health Services, Kenya, PPFN, Health Department- Turkish State Railways, PROFAMILIA, Belize Family Life Assoc., Philippines DOH/FPS, FPAK, FPAT, NCPD/Kenya, MKOMANI, ZNFPC	<i>The Family Planning Manager</i>	Issues of <i>The Family Planning Manager</i> reviewed by the members of the International Review Board.
IPPF	Latin America	Strategic planning with FPA's.
IPPF	USA	Strategic planning with IPPF/WHR.
IPPF PROFIT SOMARC Pop Council	Mexico	PVO sector coordination. Team assessment of NGOs: FEMAP. Planned coordinated interventions for the first year of implementation strategy.
JHPIEGO PCS, DA, Pathfinder	Bolivia	Coordinate activities through resident advisor.
JHPIEGO	Egypt	Needs assessment: Regional training institute.

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CA or project	Country	Type of activity
JSI/FPLM, CDC	<i>The Family Planning Manager</i>	Rich Owens of JSI/FPLM and Jack Graves of CDC provided technical guidance and review of "Improving Contraceptive Supply Management."
Margaret Sanger Center	Philippines	Resident advisor participated in DOH/FPS course preparation.
Mothercare JHPIEGO	Bolivia	Future plans for technical assistance to FP agencies in Cochabamba.
OPTIONS	CERPOD (Mali)	Strategic planning.
OPTIONS	Peru	Collaboration in designing the PFPAP document.
OPTIONS	USA	Cost sharing in the preparation of French language translations of OPTIONS materials, for use in FPMD supported management training seminars.
Pathfinder	Turkey	Discussions about potential collaboration with Pathfinder-funded NGOs.
Pathfinder	Kenya	Intensive collaboration through the placement of a long term technical advisor in MIS who is shared between FPMD (70%) and Pathfinder(30%).
Pathfinder	Kenya	Collaborative work with several NGO's.
Pathfinder	Tanzania	Funded in-country costs for UMATI workshop participants. Discussed strategic planning exercise.
Pathfinder	USA	Technical review of Evaluation Handbook.
Pathfinder, JHPIEGO	<i>The Family Planning Manager</i>	Review and technical input for "Developing Plans and Proposals."
Pathfinder	<i>The Family Planning Manager's Handbook</i>	Collaboration on development, production and distribution of the French and Spanish editions of <i>The Handbook</i> .

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CA or project	Country	Type of activity
Pathfinder	Kenya	Collaboration in Technical Assistance for Mkomani in development and implementation of MIS.
Pathfinder, Johns Hopkins/PCS	Nigeria	Joint follow-up assessment.
Pathfinder AVSC Asia Foundation	Bangladesh	Assisted USAID/Dhaka and CAs in the preparation of cooperative agreement.
Pathfinder, AVSC	Bangladesh	General coordination on activities in Asia region.
Pathfinder	<i>The Family Planning Manager</i>	Mike Egboh was a guest editor of "Using Service Data."
PCS	Bangladesh	Presentation of a paper on IEC activities in the LIP at a national seminar sponsored by PCS/Bangladesh.
Pop Council	USA	Joint sponsorship of seminar at upcoming Cairo conference.
Pop Council	Africa region	Collaboration in Technical Assistance and strategic planning with CERPOD.
Pop Council	Nepal	Work with FPAN, particularly the design and implementation of a "Situation Analysis."
Pop Council	Mexico	Used Pop Council's training QOC curriculum in training with DGPF.
Pop Council	Burkina Faso	Use of situation analysis for evaluation of FPMD activities.
Pop Council	Burkina Faso	Analysis of data from baseline survey of the supervisory system, and working meetings to design supervision tools for MOH.
Pop Council	Peru	Design and implementation of MIS workshop for MOH/Peru.
Pop Council	Mexico	Development of MEXFAM's TQM model.

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CA or project	Country	Type of activity
Pop Council	Mexico	FEMAP Cost Analysis/Market Studies.
Pop Council	Mexico	Jointly conducted focus groups. Joint preliminary report for Qualitative Interim Evaluation of TQM project.
Pop Council	<i>The Family Planning Manager</i>	John Ross of the Population Council reviewed "Reducing Discontinuation in Family Planning Programs."
Pop Council, FHI	<i>The Family Planning Manager</i>	Ricardo Vernon of the Pop Council and Karen Hardee of FHI were guest editors of "Using CQI to Strengthen Family Planning Programs."
Poptech, Pathfinder, IPPF	Ivory Coast	Design and implementation of FPA executive directors conference.
PROFIT	USA	Review of Users' Manual on Endowments.
POPTECH	Africa Region	Joint funding and technical assistance for finalizing design of the training for IPPF/GTZ CBD workshop.
SEATS	Morocco	Discussions about potential collaboration.
SEATS	Africa Region	SEATS' Regional Medical Counselor participated in the FRAC meetings.
SEATS	Africa Region	Collaboration in support to the Centre for African Family Studies (CAFS) in curriculum development.
SEATS	Burkina Faso	Strengthening management systems and developing training material for ASBF.
SEATS	Tanzania	SEATS representative participated in UMATI planning meetings.
SEATS, PCS, INTRAH, Operations Research	Burkina Faso	Individual interventions in carrying out implementation plan for BFMOH.

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CA or project	Country	Type of activity
TFG/OPTIONS	Jamaica	Collaboration in the coordination of the bilateral project in Jamaica.
TFG-Options	Philippines	Transfer of written material.
UHEP	Bangladesh	Discussions of ELCO mapping techniques and planning for a seminar on ELCO mapping.
UNFPA	Philippines	Joint funding of training workshops for mid-level managers.
WHO	Morocco	Assisted in MT/MSH workshop.
World Bank	Turkey	Collaboration planned for providing MIS assistance to the MCH/FP Directorate.
World Bank	Turkey	Discussions re. Funding of follow-on activities of FPMD in MIS.
World Bank	Zimbabwe	Funding of follow-on activities of FPMD in strategic planning.

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