



A COMPREHENSIVE REVIEW OF THE  
OBJECTIVES, ACTIVITIES, AND PERFORMANCE  
OF THE FAMILY PLANNING PROGRAMS  
OF THE UNITED NATIONS  
FUND FOR POPULATION ACTIVITIES

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## EXECUTIVE SUMMARY

### Overview

The United Nations Fund for Population Activities (UNFPA) is an inter-governmental agency in the United Nations (U.N.) system under the United Nations Development Programme (UNDP). It is devoted exclusively to programs in the field of population. UNFPA is the largest multilateral source of assistance for population and family planning. In 1980, over \$150 million were allocated for a wide range of activities in over 120 countries, and 97 donor countries contributed nearly \$125 million. The United States, which is the largest single donor, contributed \$32 million, or almost 25 percent of the 1980 budget.

More than \$50 million, or nearly one-half of UNFPA's resources, are given in support of family planning services and information, principally at the country level. As a continuing donor, the U.S. Government seeks to determine the effectiveness and the efficiency of UNFPA in meeting its stated objectives. Of particular interest is UNFPA's strategy for support of family planning programs which includes substantial assistance for health-related assistance. The rationale and scope of such assistance need to be clarified in order to ensure consistency with the intent of congressional appropriations from which the UNFPA contribution is derived. This also provides an opportunity to review the consistency of this strategy with the requirements of individual countries and with other development strategies that have been adopted within the U.N. system.

UNFPA's family planning activities are not prescribed under the agency's mandate, but are guided by the World Health Organization's (WHO) definition of family planning. The breadth of this definition raises a major question for policymaking regarding the method of delivering services. There are many reasons for the provision of family planning services, including human rights, demographic and economic objectives, environmental resources, and maternal and child health. The goals of family planning also vary widely among individuals, institutions, and countries, as well as over time. As a part of population strategies, family planning includes linking modern health technologies for birth prevention with people and communities who want such services. Many technologies are nonmedical, but some require clinical support. It is, therefore, understandable and desirable that family planning is often associated with health services; health networks allow for the provision of information and counseling, follow-up and referral, and clinical back-up. Recognizing this, national governments often locate family planning within the health ministry or in a separate but closely linked agency. As an inter-governmental organization, UNFPA may thus be expected to support family planning services through a variety of delivery modes and often in close conjunction with health care. In the past, this has led to some misunderstanding

in the U.S. Government, because the U.S. contribution to UNFPA is made under the appropriation for population assistance, rather than health care or development activities. Therefore, two major issues must be addressed regarding the U.S. contribution to UNFPA.

1. In view of the widespread association of family planning and health care services, what proportion of U.S. support should come from population-designated resources?
2. Does the integration of family planning services into health programs dilute the identity or thrust of fertility reduction concerns? To what extent may this approach be justified within the broad scope of the primary health care strategy?

Answers to these questions must be framed within the larger consideration of how donor assistance can best influence the technical content and effectiveness of national family planning programs. Although a comprehensive assessment of these points is beyond the scope of this review, several generalizations can be made.

- The operative rationales and strategies for family planning programs are specific to the geographic and cultural setting in which services are to be provided. In general, the demographic-economic rationale for family planning is strongest in Asia, while health considerations predominate in Latin America, Africa, and the Middle East.
- The approach taken to family planning also needs to be viewed in terms of the level of socioeconomic development and the strength of service infrastructure in particular settings. Family planning programs are most often organized independently, or vertically, in countries where health networks are minimal or oriented toward urban, hospital-based care. However, investments in health service infrastructure may generate long-term benefits for family planning and other programs. The current trend in most countries is to link family planning and health services.
- The aspect of program design that needs the greatest attention is determination of the relative priority of family planning within primary health care services. With the growth of services, approaches to family

planning support as a part of development assistance has changed. Thus, shifting national and international priorities need to be translated into organizational strategies for making efficient use of support.

- In the context of integrated family planning services, it is difficult and often not meaningful to single out the cost of specific program components. Budgets do not always reflect operational reality, and a high cost burden absorbed by family planning services may reflect a general underinvestment in health care components. In addition, skewed investment patterns may result from imbalances in the relative contributions made by domestic and external resources. These points must be addressed in terms of individual national situations.

The remainder of this summary addresses the following questions set out for this review:

1. What are the documented goals, objectives, and strategies of UNFPA in the family planning area?
2. How are UNFPA resources distributed, according to function, location, means of program execution, and actual use?
3. What has been the operational performance of UNFPA family planning programs, and how is this performance related to agency policy and management processes?
4. What has been the strategy and performance of UNFPA-funded family planning projects executed by WHO?
5. What is the assessment of UNFPA's family planning activities that is made within USAID, and what are the implications of these findings for U.S. Government relationships with UNFPA?

## Summary of Findings

### A. Objectives and Strategies

UNFPA's goals and objectives on population have been evolving since the agency's establishment in 1967. Initially organized as a trust fund, UNFPA has become increasingly operational, taking on the functions of a

specialized agency in the U.N. system. Its broad objectives are to develop knowledge and the capacity to meet population needs, to promote awareness of population problems, and to provide assistance to developing countries by serving as the central U.N. agency in the population field. Major activities include the assessment of basic needs of countries, establishment of priorities between countries, provision of support for intercountry programs, and selective assistance for program budget items.

UNFPA is directed by the UNDP Governing Council and the Economic and Social Council of the United Nations (ECOSOC). It receives contributions annually from governmental donors and disburses funds to recipient countries, often through U.N. and nongovernmental organizations. Thus, UNFPA maintains a complex set of relationships in the international system.

In addition to formal ties with donors and recipients, UNFPA's collegial relationships with other U.N. agencies and the population community are critical for the achievement of objectives. UNFPA policies and actions necessarily reflect the strengths and weaknesses of these institutional arrangements.

Family planning is the largest of UNFPA's eight program areas. Its objective is to support services for birth spacing and the control of family size through a variety of program types in different settings, principally at the national level. The current classification system for program support includes health-related delivery systems (government-operated), community-based systems (operated by other agencies), fertility regulation (contraceptives), and management and evaluation. UNFPA is presently clarifying the scope of its family planning assistance.

The predominant method of delivering family planning services is to integrate it with maternal and child health (MCH) care services. The UNFPA thus supports limited types of MCH care, depending on the strength of the health rationale for family planning and need to operate through country health care networks. At its 1981 meeting, the Governing Council confirmed the priority of family planning within UNFPA activities and emphasized the integration of family planning and health services in the context of primary health care. This answers the concerns of donors and recipients regarding agency strategies and is expected to lead to improvements in the efficiency and effectiveness of UNFPA's allocation of family planning resources.

## B. Distribution of Expenditures

Since its establishment, UNFPA has disbursed some \$726 million in population funds. Expenditures in 1980 exceeded \$150 million, and contributions from 97 donor countries reached nearly \$125 million. Budgetary resources seem to have stabilized, and there will be increasing financial pressure in the 1980s, especially in family planning.

In 1979, the latest year for which complete data are available, UNFPA allocated \$54 million to family planning programs, or 44 percent of its total expenditures of \$124 million. This is slightly less than the 50 percent that was allocated in recent years, but was more than 50 percent greater than expenditures in 1976. Expenditures for nonfamily planning activities doubled over this period. However, the categorization of family planning activities based on the UNFPA work plan is considered restrictive in comparison with the broad WHO definition. By including relevant activities from communication and education, policy implementation, and special programs for women, the family planning allocation exceeds 50 percent of the total budget.

About 90 percent of the 1979 family planning budget went to country and regional activities, with the remainder going to interregional and global projects. Over 50 percent of family planning funds went to Asia and the Pacific; Latin America received 20 percent; North Africa and the Middle East combined received about 10 percent; and Sub-Saharan Africa received about 7 percent. Compared with the 50 percent of all country and regional funds for family planning, the share was 60 percent in Asia, 55 percent in Latin America, over 40 percent in North Africa and the Middle East, and only about 20 percent in Sub-Saharan Africa and for interregional and global activities. These patterns are consistent with perception of the relative priority and strengths of family planning programs across regions and the capacity of countries to absorb family planning assistance. These data show a distribution similar to that of AID funds, but with substantial amounts going to countries not receiving AID population assistance or bilateral support.

Nearly 40 percent of funds in 1979 was administered through direct execution at the country level by government agencies, predominantly in Asia and the Pacific. Over 25 percent was directed through WHO, largely for country activities and country programs in Latin America, through the Pan American Health Organization (PAHO). Some 17 percent of the funds went to the United Nations Children's Fund (UNICEF), primarily for reimbursable procurement of project equipment. Nongovernmental organizations administered about 15 percent of the funds, mainly for intercountry activities and for country programs in Latin America and Africa. The remainder was directed through other U.N. agencies, including the International Labor Organization (ILO), the Food and Agricultural Organization of the United Nations (FAO), and regional committees. This pattern, and its regional variability, seem to be a reasonable distribution. However, they impose constraints on UNFPA's family planning operations which must be considered in assessing program performance.

There is also variation in the allocation of budget items. Equipment accounted for nearly 40 percent of family planning expenditures in the 1978-1979 period, including about 10 percent each for medical supplies, contraceptives, and other equipment, and smaller amounts for vehicles and facilities. Personnel costs were 30 percent of the budget, training was 22 percent, and subcontracted activities were 8 percent. There has been a decrease in the proportion of funds for project personnel, mainly the result of decreased

support for local staff. Correspondingly, the proportion for training has increased. This trend is significant and encouraging, because of the importance of reducing the donors' burden of recurrent costs and expanding development of local resources. However, the distribution of funds varies considerably by region, so there is great latitude for shifting budget item support.

### C. Program Operations and Performance

UNFPA's project development process has improved in recent years and is reasonably effective. The needs assessment helps to determine a country's needs and to identify priorities for population assistance. It has been used successfully in many countries. The current emphasis is on improving communications and promoting the use of the reports. Project-request procedures are straightforward. The major problem of project development is related to UNFPA's annual funding process, which imposes uncertainty on project budgeting and leads to instability in the long-term programs.

Resident UNFPA project advisers and other UNFPA staff are well-qualified and generally effective, but their lack of budgetary authority limits administrative flexibility at the project level. It was impossible to evaluate the implementation of UNFPA projects in detail, but it appears to be satisfactory. There is predictable diversity between countries in project performance and in UNFPA-host government relations. Arrangements with executing agencies generally work well; in particular, WHO ties with national health ministers are important, and UNICEF procurement procedures are quite efficient. Problems that arise are usually related to the project environment and bureaucratic responsiveness.

Project monitoring and review are well designed, but they are not entirely effective. Poor communication between participating agencies and inadequate financial controls have led to budgetary and administrative problems in a number of projects. Progress reports are prepared on a regular basis, but the depth varies substantially among agencies and project settings. The tripartite review, which is conducted by UNFPA, the host government, and the executing agency, has proven to be useful for measuring progress and setting out work plans. Along with the broader annual country review of projects, it should in many cases assess performance more critically.

UNFPA conducts large-scale evaluations of selected programs through an independent branch of the agency. Of the 30 programs evaluated to date, only 4 have been in the family planning area. Evaluations revealed that family planning programs in Egypt, Mauritius, and Colombia were generally effective, but that there were a number of common implementation problems. Because such studies have difficulty measuring the specific effects of UNFPA resources, results are generally inconclusive. Greater flexibility of evaluation procedures and linking of the evaluation to project monitoring and review are

needed in order to conduct more studies in less time. Furthermore, the expansion of UNFPA support for program research and development should be encouraged.

#### D. Execution of Projects by WHO

WHO executes a wide range of UNFPA-supported family planning projects through its regional offices with support from the Division of Family Health in Geneva. WHO supports incorporation of family planning within its primary health care strategy, viewing family planning as a component of community health services. However, this objective is difficult to pursue because the decentralized organization allows the regional office staff responsible for program operations to approach family planning within the tradition of the curative health services. WHO's promotion of family planning may be considered strong, but it is impossible to evaluate the differing claims.

The WHO Family Health Program received \$40 million from UNFPA in 1980 to conduct family planning activities. About 30 percent of this was used for intercountry activities, including technical support for project management and research conducted through the Special Program in Human Reproduction (HRP). The range of administrative and coordination activities performed at the country level varied according to project and region. Resident program coordinators, who generally maintain a close relationship with government health agencies, play a major role.

The performance of family planning programs administered by WHO appears to be good, although a complete review was not made by region. A major problem is the difference in WHO inputs and limited continuity and coordination between them at the central, regional, and country levels. Unevenness in the capacities of the WHO regional offices was also reported. Overall, however, WHO and other U.N. agencies make a positive contribution to UNFPA family planning activities. The influence of WHO on UNFPA is clearly favorable when considering the growing consensus that family planning services should be integrated into primary health care.

#### E. UNFPA's Relationship with USAID

The family planning mandate of USAID, as set out in the U.S. Foreign Assistance Act, which calls for low-cost services coordinated where possible with health, nutrition, and other related programs, is broadly parallel to the mandate of UNFPA. The strategies followed by the two agencies are also similar: responsiveness to individual country needs and the use of a variety of approaches to introduce family planning services. Historically, USAID has promoted vertical programs to a greater extent than UNFPA, but this contrast has become less pronounced in recent years.

The agencies have different advantages as donors, however. UNFPA activities are usually less subject to political resistance, and USAID has greater ability to target support.

The major difference between UNFPA and USAID appears to be in the way the U.S. Government funds UNFPA. Because the U.S. contribution is made through population-designated resources, the USAID staff seems to feel that the use of UNFPA funds to support health services is inappropriate. In view of the formal U.S. support for UNFPA's integrated family planning program strategy, efforts to clarify this will be beneficial.

The assessment of UNFPA family planning programs by USAID headquarters and field offices varies among regions, but is generally favorable. Although there was some disagreement on several issues, such as responsiveness to the unmet demand for family planning services and the need to provide health-related assistance, most USAID staff felt that UNFPA has performed satisfactorily and that the problems it has experienced are common to all development agencies. The principal exception was in Latin America and the Caribbean region where UNFPA programs, particularly those conducted by PAHO, were considered to lack effectiveness. Coordination between the two agencies was generally considered to be adequate.

This review raises a number of issues concerning the design and content of family planning programs that UNFPA, donors, and recipients should clarify, including the definition of basic terms, the identification of various components of family planning services, the respective roles of UNFPA and other donor agencies in providing program inputs, and the effectiveness of program performance. With the prospect of increasing demands, clarification of these and related considerations will help to guide the development and allocation of limited family planning resources.

## ABBREVIATIONS

ACR	Annual Country Review
AID	Agency for International Development
CC	Contraceptives
ECOSOC	Economic and Social Council of the United Nations
FAO	Food and Agricultural Organization of the United Nations
HRP	Human Reproduction
IEC	Information, Education, and Communication
ILO	International Labor Organization
MCH/FP	Maternal and Child Health and Family Planning
NGO	Nongovernmental Organizations
PAHO	Pan American Health Organization
PHC	Primary Health Care
TPR	Tripartite Review
UN	United Nations
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## I. INTRODUCTION

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This report analyzes the objectives, activities, and performance of the family planning program activities of the United Nations Fund for Population Activities (UNFPA). It was prepared as a contribution to the review of the UNFPA that was conducted by the U.S. Government in the spring of 1981. The specific objectives of this portion of the review were to:

- identify the major categories of family planning assistance supported by UNFPA that are significant in terms of the interests of U.S. Government assistance;
- specify regional differences in UNFPA support for family planning programs and the rationale for them;
- describe the extent of and rationale for UNFPA support for health programs that do not include family planning assistance; and
- analyze UNFPA's strategy and practice for contraceptive procurement, especially the adequacy of procedures to forecast program needs.

This review was performed between February and May 1981. Information was obtained from interviews with policy and technical staff of UNFPA, regional and Office of Population personnel of USAID, and staff in the Family Health Division of the World Health Organization (WHO) and its regional office for the Americas, the Pan American Health Organization (PAHO) (see Appendix A). Site visits were made to these agencies in New York, Washington, D.C., and Geneva. A wide range of documents provided by the agencies was reviewed (see Appendix B). Responses to a survey of the views of U.S. Government staff from overseas missions concerning UNFPA country activities were also examined.

The resources available included conversations, agency documents, and visits to headquarters. A comprehensive evaluation was not possible due to time limitation, lack of field visits, and incomplete data. As a result, these findings are only an initial assessment of UNFPA family planning activities.

## II. OBJECTIVES AND STRATEGIES

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### Introduction

The United Nations Fund for Population Activities (UNFPA) was established in 1967 within the U.N. system with the primary responsibility for activities in the field of population. The focus of activities is on countries with the most pressing population problems, primarily in the developing countries. UNFPA still functions under its original mandate, as modified by resolutions of the Economic and Social Council of the United Nations (ECOSOC), the General Assembly, and the United Nations Development Program (UNDP). However, the agency has gained increased autonomy and its responsibilities and priorities have shifted in response to its changing status within the U.N. system.

Family planning (FP) activities are one component of UNFPA's program of population assistance, and a wide range of activities is supported in keeping with the broad scope of its mandate. UNFPA uses the general definition of family planning used by the World Health Organization (WHO),\* which also guides this review:

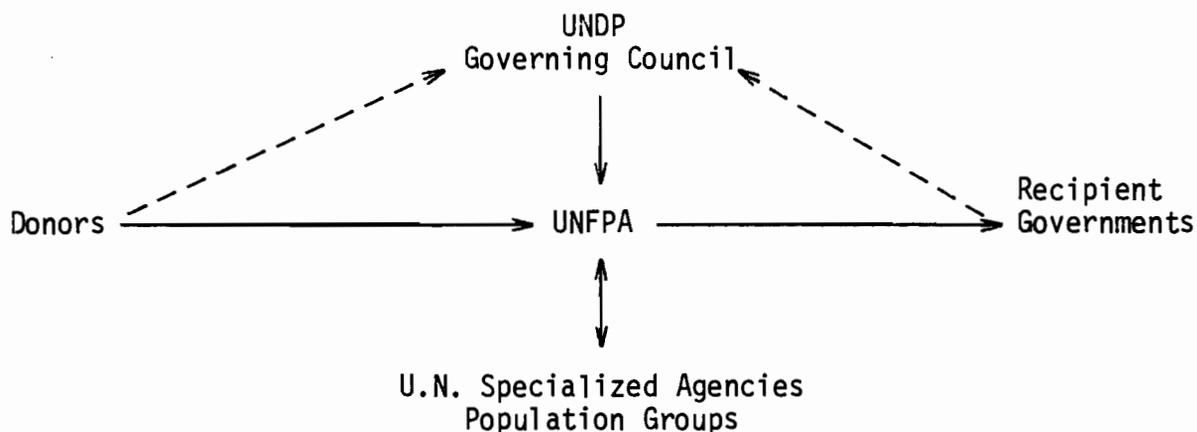
Family planning refers to practices that help individuals or couples to attain certain objectives: to avoid unwanted births; to bring about wanted births; to regulate the intervals between pregnancies; to control the time at which births occur in relation to the ages of the parents; and to determine the number of children in the family. Services that make these practices possible include education and communication on family planning; the provision of contraceptives; the management of infertility; education about sex and parenthood . . . .

However, UNFPA's categorization of family planning programs is somewhat narrower and limits the precision of analysis. This is understandable from an organizational point of view, because UNFPA is an international agency that responds to diverse pressures.

The position of UNFPA within the international system, and its role in providing family planning and population-related assistance, are shown below.

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\* WHO, Technical Report Series, No. 476, 1971, p. 8; cited in WHO, Technical Report Series, No. 569, 1975.



UNFPA was established as a trust fund under the authority of the UNDP Governing Council and the ECOSOC. With the growth of operational responsibilities and technical capabilities, UNFPA has become increasingly autonomous, although it continues to use the administrative and support services of UNDP. UNFPA is presently a subsidiary organ of the General Assembly and participates in the U.N. Administrative Committee on Coordination. ECOSOC is responsible for UNFPA's general and substantive policies. The Governing Council formulates UNFPA's operational policy and approves resource allocations during its annual meetings. UNFPA programs are administered in the field through the local UNDP resident representative.

The UNFPA budget is composed of contributions from donor governments, of which there are currently 97. Several of the major donors, including the United States and Sweden, were among the initial organizers of the agency. Although UNFPA is formally independent of all countries, donors play some role in shaping policies and programs through membership on the UNDP Governing Council. Individual governments, including donors, also participate in technical consultations and meetings with staff.

UNFPA provides financial support for population activities in developing countries upon the request of the governments. Programs are carried out through government agencies, according to the terms of the UNFPA mandate and its position in the U.N. system. UNFPA develops programs jointly with national planning ministries and provides assistance through sectorial ministries, as well as selected international and nongovernmental organizations. It thus has a significant but varying degree of influence over national decisions, although its role is neutral. Conversely, recipient countries may influence UNFPA decisionmaking through requests for assistance and participation in the United Nations.

UNFPA maintains a close relationship with the U.N. specialized agencies and with the organizations that implement its programs. The chief agency in the family planning area is WHO. As a trust fund, UNFPA provided infrastructure support to these agencies for the development of

population capabilities, but, because it has assumed greater operating responsibilities, this support was phased out. However, these U.N. agencies continue to play a role in the strategy and implementation of UNFPA programs. The family planning activities of WHO are described in Chapter 4 of this report.

## UNFPA Objectives and Strategies

### A. Objectives

As established by the Economic and Social Council and elaborated upon in 1976,\* the principal objectives of UNFPA are:

1. To develop, on an international basis, the knowledge and capacity to meet needs in the population and family planning fields at all levels. Emphases are on promoting cooperation, providing technical support to country-level activities, and exploring innovative approaches to population problems.
2. To promote awareness of the socioeconomic and environmental implications of population problems, the human rights aspects of family planning, and the possible approaches to these issues which are consistent with country preferences. Specific target groups, such as women, youth, and local organizations, are to be emphasized. Collaboration with nongovernmental organizations is stressed.
3. To assist developing countries in dealing with their population problems, as requested by recipient countries and suited to their individual needs. This is UNFPA's principal objective. In view of increasing limitation of resources, assistance is generally limited in time and gradually phased out. Given the broadened concept of population activities adopted at the 1974 World Population Conference, UNFPA's priority areas in this field should be clarified.
4. To play a leading role in the U.N. system in the promotion of population programs and to coordinate the projects supported by the United Nations. Effort is made to develop joint funding arrangements with other donor agencies, to explore alternatives for solving population problems, and to promote the integration of population components with social and economic development programs.

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\* UNFPA, Priorities in Future Allocation of UNFPA Resources, New York, 1976.

UNFPA resources serve the following principles, as outlined in the Priorities document:

- (a) To promote population activities proposed in international strategies, particularly the World Population Plan of Action;
- (b) To meet the needs of developing countries which have the most urgent need for assistance in the area of population activities, in view of their population problems;
- (c) To respect the sovereign right of each nation to formulate, promote and implement its own population policies;
- (d) To promote the recipient countries' self-reliance; and
- (e) To give special attention to meeting the needs of disadvantaged population groups.

UNFPA has developed a program of population assistance that has become a major international source of funding. The elements of this program, according to UNFPA's work plan, are:

- basic data collection;
- population dynamics;
- formulation and evaluation of population policies and programs;
- implementation of policies;
- family planning programs
- communication and education;
- special programs; and
- multisector activities.

These areas are reasonably distinct, but there is some overlap. Thus, projects may have elements that fall within the scope of another program area or may provide direct support for projects in other categories. This is especially likely in an area as broad as family planning. For example, in the broad definition of family planning, a number of communication and

education activities and special programs on the status of women may provide direct support to family planning programs. For this review, however, UNFPA's work plan categorization is used.

## B. Program Strategies

UNFPA programs emphasize activities related to and required for population policy formulation and implementation. The strategy for carrying this out has four major elements, which are discussed below.

1. Assessment of national basic needs is conducted because countries vary in population conditions, awareness of population issues, level of development, and attitudes toward population programs. Needs assessment identifies need for assistance in terms of national population goals, policies, and capacities. These provide a framework for coordinated support of national population programs and related activities.
2. Identification of countries most in need of population assistance is based on a combination of economic and demographic criteria rather than on strictly economic criteria or indicative planning principles, such as are used by UNDP. Some 40 countries have been identified using criteria of per capita income, annual rate of population growth, fertility rates, infant mortality rates, and rural population density. Up to two-thirds of UNFPA resources for national programs are allocated to these countries. Goals in providing assistance include responsiveness to national conditions, sensitivity to the local capacity to absorb funds, and promotion of alternative funding arrangements.
3. Intercountry programs at the regional, interregional, and global levels support country projects, including the exchange of information and knowledge regarding policies and programs, experimental projects, development of local expertise and research facilities, and foreign training. The objectives are to: create awareness of population issues; develop an international capacity to support national programs; promote innovative approaches to population issues; and provide technical support for activities at the national level. International organizations are usually used for intercountry activities. Support had been reduced from earlier years, and resources are being concentrated on a relatively small number of interdisciplinary programs.
4. Selective assistance for population programs is provided in the following budget categories: personnel, including

international staff, local salary support, and consultants; subcontracts, including grants to institutions and contracts with NGOs; training, including fellowships and foreign and in-country training; equipment, including facilities and construction costs, vehicles, medical supplies and equipment, and contraceptives; and operations, including administration and maintenance. The mix of costs financed varies widely, according to the type of project and the needs of the country. Personnel and equipment have accounted for the majority of assistance. Governments are encouraged to fund recurrent expenditures themselves. Resources from other donors are also solicited. It is claimed that UNFPA assistance is directed to activities that would not otherwise be funded or that serve as an incentive for support from governments or other donors.

### Family Planning Objectives

Support of family planning programs has always been the largest area of UNFPA assistance. Funding has been provided to all aspects of these programs, including financing of equipment and supplies, institutional development, strengthening of service delivery systems, operational research, improvement of program quality and coverage, and local production of contraceptives.

The two principles of family planning assistance are flexibility and neutrality. Funds are available to countries with varying objectives for family planning services and rationales for birth spacing. Programs based on demographic, human rights, or health issues are compatible with UNFPA, and the adoption of a national policy on fertility control is not a prerequisite.

UNFPA supports family planning services that are offered in various settings, although the emphasis is on incorporation of family planning into health services for mothers and children. Throughout the 1960s single-purpose or vertical programs were promoted by other donor agencies and governments, but this emphasis has shifted as health systems have become better able to absorb family planning services.

UNFPA has increasingly dispersed its support within national programs rather than directing it to individual projects. However, family planning support is only a portion of the total contribution to national family planning activities.

Current support for family planning falls into four major areas, as defined by the UNFPA work plan:

1. Provision of family planning through health-related delivery systems, including maternal and child health (MCH) systems, integrated FP/MCH systems, and independent family planning programs. This category includes all programs negotiated and operated through national governments.
2. Development, strengthening, and maintenance of community-based systems for the delivery of family planning services. These programs are those negotiated through nongovernmental organizations.
3. Research and training in fertility regulation and provision of contraceptives.
4. Management of family planning programs, including planning, administration, and evaluation.

Unfortunately, these areas are not mutually exclusive, nor are their functions or objectives clearly separable. For example, health-related programs include the majority of UNFPA family planning activities and cover all types of programs operated through governments. Community-based programs are distinguished only by nongovernmental operation. It is, therefore, impossible to determine the precise content of UNFPA family planning activities from these categories. Within each area support may cover training, research, support communication, and action programs.

The trend in family planning activities is toward a stronger community orientation and the inclusion of related services, such as the local manufacture of contraceptives. However, there has been no clear delineation of family planning support. To clarify this, UNFPA recently proposed the following basic program of activities for fertility reduction:\*

- Family planning as a single service.
- Integration of family planning into other development efforts, focused on the health sector, specifically MCH services, but including rural development and informal education programs.
- Integration of family planning programs into the organized or public sector.
- Decentralization of family planning services using local

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\* UNFPA, "Major Policy Guidelines," FPA/PSD/52/12 (Draft), September 1980.

infrastructure, community involvement, emphasis on the socio-political aspects of programs, and direct influence on relevant social factors.

- Community-based delivery of family planning to make a full range of fertility-regulating methods available.

Supporting services would include selected information, education, and communication (IEC) activities and training in MCH and family planning. The scope and level of such support would be determined according to maternal and infant mortality levels. For priority countries, assistance may cover the full range of service activities outlined above. Among borderline and other countries, greater assistance would generally be provided to those with higher mortality rates. Countries with low mortality rates would be provided training and advisory services only.

### Family Planning Program Strategies

#### A. Integration with MCH Services

UNFPA support for family planning activities includes a large share of assistance for certain aspects of MCH care, as contrasted with family planning in the narrow sense of contraceptive services. The reasoning for this strategy has three elements which are described below.

1. Interventions in the field of health are needed to improve conditions related to mortality as well as fertility. Both factors are demographic variables which fall under the UNFPA mandate. UNFPA supports the reduction of maternal and child mortality, including promotion of reproductive health through fertility regulation, but not the reduction of mortality in the overall population.
2. Health and family planning are both components of a balanced approach to achieving national population objectives. This is in keeping with the trend toward community-based, multi-sectorial population programs and with the expressed policies and desires of many countries for the inclusion of family planning within national health services. Health networks in many countries are now often based broadly enough to serve as channels for family planning services. Within these networks, programs may be designed to maximize acceptability, effectiveness, and administrative efficiency according to local conditions.

3. Improvements in maternal and child morbidity and mortality are closely associated with long-term changes in fertility. The interrelationships among fertility, mortality, and health and nutrition are widely recognized in developing countries. Although reductions in disease, malnutrition, and mortality may lead to higher fertility, sustained declines are assumed to be possible only under conditions of improved health and nutrition in the family and in the community. Evidence indicates, however, that family planning focused on birth spacing remains essential to fertility reduction.

UNFPA thus provides health-related assistance for some types of MCH care that fulfill these objectives. As outlined in the Policies and Procedures Manual,\* any such support must be used to reduce mortality and morbidity in women of reproductive age, including care during pregnancy, childbirth, and the postnatal period. It may also cover health care for infants after delivery up to one year of age and, to a lesser extent, for preschool children. UNFPA has proposed support for the following components of MCH care:†

- activities related to the care of mothers and newborns, including family planning and birth-spacing information and motivation for the introduction and continuation of contraceptive use;
- health measures in the postnatal period and infancy and the provision of vaccines for immunization;
- advice and care for fertility regulation; and
- nutrition education and the promotion of breastfeeding.

Within MCH-related services there is a clear prohibition against funding general health activities. UNFPA does not support services to improve general health conditions, basic research in MCH, or the development of general health statistical systems. Furthermore, assistance is only given for services that are provided in the course of regular MCH care, rather than for general health services support which is limited to that necessary for the service areas listed above. General gynecological, surgical, and other health equipment is not financed. Similar conditions also apply to costs for personnel, training, facilities, supplies, and management.

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\* UNFPA, Policies and Procedures Manual, 1979.

† UNFPA, "Major Policy Guidelines," op. cit.

All approaches to the delivery of family planning services are supported if they are "feasible, effective, and valuable." Emphasis is placed on services for disadvantaged groups, community-based programs, and activities for special populations. Incentives or disincentives may be employed if they do not violate human rights, are not coercive, and are demonstrably effective.

## B. Current Priorities

At its annual meeting in June 1981, the UNDP Governing Council confirmed family planning support as a priority of UNFPA activities.\* Furthermore, the council strongly emphasized the integration of family planning with maternal and child health services in the context of primary health care. Other aspects of family planning programs that were emphasized include:

- community-level delivery, including improvements in logistical support systems;
- personnel training;
- management strengthening;
- logistical support, including provision of contraceptives where required;
- encouragement of local production of contraceptives, where appropriate; and;
- research and development of traditional and new contraceptive methods.

Preliminary steps were taken to reallocate UNFPA resources to substantially increase support for family planning activities. Under the current proposal, assistance for population education, communication, and information would be increased, while that for data collection and population dynamics would be decreased. Other issues that were decided were limitation of intercountry activities, maintenance of allocations for priority countries, and establishment of guides to the allocation of resources for countries.

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\* UNDP, "Adoption of the Report of the Governing Council to ECOSOC at Its Second Regular Session, 1981" (Annex, UNFPA), DP/L.334/Add.3, June 1981.

These actions respond to many of the concerns voiced by governments, including donors to UNFPA, and by others in the population community regarding a perceived lack of clarity in the UNFPA approach to family planning programs at the national level and the integration of family planning with community-based MCH services. Furthermore, the actions encourage greater rationalization of UNFPA's resource allocation procedures in family planning, as well as in other areas of population assistance.

III. EXPENDITURES FOR FAMILY PLANNING

### III. EXPENDITURES FOR FAMILY PLANNING

#### UNFPA Program Areas

##### A. Family Planning in the Total Budget

During 1980, UNFPA allocated \$150.5 million for population assistance, of which \$62.8 million, or 42 percent, were designated for family planning programs.

By the end of the year, contributions from 97 donor countries reached \$117.6 million, out of \$124.7 million pledged. Primarily due to the limited absorptive capacities of many countries and budget shifts between programs, the amount actually spent in 1980 fell below the total allocated, with expenditure rates varying among program areas.

Expenditures for 1979 are for the latest year for which complete data are available. Population expenditures reached \$123.6 million in 1979 (see Table 1)--an increase of 39 percent over the 1978 level of \$89 million and 78 percent higher than the \$69 million spent in 1976. Of the UNFPA total, \$54.1 million (44 percent) were expended for family planning programs.\* Family planning took more than 50 percent of the UNFPA budget in preceding years; however, because of the overall rise in funding, 1979 expenditures were some 56 percent greater than the 1976 level of \$34.7 million for family planning.

Spending in other UNFPA program areas, which are referred to in this report as non-family planning activities, has grown at a comparatively higher rate, more than doubling between 1976 and 1979. The share of funds for each area has remained relatively constant. Of the \$69.5 million, or 56 percent of the total, for non-family planning activities in 1979, 16 percent was for basic data collection; 11 percent for communication and education; 10 percent each for multisector activities and population dynamics; and under 5 percent each for policy formulation, policy implementation, and special programs.

In relation to the WHO definition of family planning, the UNFPA categorization is restrictive and understates the extent of UNFPA efforts in

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\* Since 1976, UNFPA has also operated a small program of multi-bilateral funding for specific population projects. Within its separate budget of about \$4 million per year, this program has supported a number of activities in the family planning area.

Table 1  
PROGRAM AREA EXPENDITURES, 1976-1980  
(\$000 and Percent of Total)

<u>Program Area</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980 Planned</u>	<u>1976-1979 Increase</u>
Family Planning Programs	\$34,730 (50.1%)	\$33,602 (50.5%)	\$45,738 (51.2%)	\$54,137 (43.8%)	\$62,710 (41.7%)	55.9%
Basic Data Collection	12,016 (17.3%)	9,689 (14.6%)	10,841 (12.1%)	19,686 (15.9%)	28,848 (19.2%)	63.8
Population Dynamics	6,242 (9.0%)	6,004 (9.0%)	7,826 (8.8%)	12,504 (10.1%)	17,154 (11.4%)	100.3
Policy Formulation	2,322 (3.3%)	2,466 (3.7%)	3,727 (4.2%)	5,356 (4.3%)	7,544 (5.0%)	130.7
Policy Implementation	8 (0.0%)	53 (0.1%)	70 (0.1%)	3,559 (2.9%)	1,377 (0.9%)	*
Communication and Education	6,696 (10.5%)	7,024 (10.5%)	9,129 (10.4%)	13,308 (10.8%)	17,633 (11.7%)	98.7
Special Programs	910 (1.3%)	879 (1.3%)	1,502 (1.7%)	2,446 (2.0%)	2,522 (1.7%)	168.8
Multisector Activities	6,444 (9.3%)	6,833 (10.3%)	10,399 (11.5%)	12,628 (10.2%)	12,723 (8.4%)	96.0
Sub-Total, Nonfamily Planning Activities	34,638 (49.9%)	32,948 (49.5%)	43,492 (48.8%)	69,487 (56.2%)	87,761 (58.3%)	100.6
<b>TOTAL</b>	<b>\$69,368</b>	<b>\$66,550</b>	<b>\$89,230</b>	<b>\$123,624</b>	<b>\$150,471</b>	<b>78.2%</b>

\* Increase is not meaningful because of a shift in program categories.

Note: Components may not add to totals because of rounding.

Source: UNFPA Fact Sheet, No. 1.06, July 1981; based on data as of March 31, 1981.

family planning. In particular, elements of communication and education (out-of-school programs and general communication in population), special programs (on the status of women), and policy implementation (implementing MCH/family planning policies) may be considered to fall within the broader scope of family planning programs. It is impossible to determine how valid reclassification would be, since it would rest on judgments concerning individual programs. However, cross-classification of projects within the work plan categories would be helpful in order to identify the content of activities. However, this report covers only those projects in the family planning category of the work plan.

## B. Family Planning Programs

UNFPA has consistently devoted the largest portion of its assistance to family planning activities, regardless of the classification of multiple-area projects. A wide range of programs has been supported within this category.

Eighty percent of family planning funds is expended for health-related programs; 12 percent for fertility regulation techniques (principally contraceptives); and under 5 percent each for program management and evaluation and community-based programs, as shown in Table 2. Although these proportions have stayed roughly the same through 1980, that for health-related programs has declined, while that for fertility regulation techniques has risen.

However, these categories give an incomplete and, to some extent, misleading picture of UNFPA family planning activities. "Health-related programs" refers to all service programs negotiated through national governments and conducted through government health agencies. In view of UNFPA's strategy and trends, nearly all these programs have management and contraceptive components and a community orientation. "Community-based programs" refers only to programs negotiated with nongovernmental organizations (NGOs) and carried out through community-based organizations. The other two categories include activities related to program management or the development and provision of birth control methods. Although work plan subcategories, such as training and research, permit a finer breakdown of program elements, this classification does not yield reliable generalizations about the content of family planning activities. It is recommended that UNFPA develop an alternative framework that provides a more accurate and functional breakdown of family planning support.

Table 2  
 FAMILY PLANNING EXPENDITURES OF UNFPA, BY FUNCTIONAL AREA, 1978-1980  
 (\$000 and Percent of Total)

<u>Functional Area</u>	<u>1978</u>	<u>1979*</u>	<u>1980*</u> <u>Planned</u>
Health-Related FP Programs**	\$39,299 (85.9%)	\$43,874 (81.0%)	\$46,937 (74.8%)
Community-Based FP Programs**	1,164 (2.5%)	1,200 (2.2%)	1,227 (2.0%)
Fertility Regulation Techniques (Contraceptives)	2,856 (6.2%)	6,708 (12.4%)	10,436 (16.6%)
Program Management and Evaluation	2,411 (5.3%)	2,355 (4.4%)	4,110 (6.6%)
Other Programs	8 (0.0%)	-	-
TOTAL	<u>\$45,738</u>	<u>\$54,137</u>	<u>\$62,710</u>

\* Breakdowns for 1979 and 1980 totals are estimated; they are based on preliminary figures.

\*\* In the classification scheme used by the UNFPA, "health-related programs" refers to programs negotiated through governments. "Community-based programs" are those negotiated directly with communities. Thus, "health-related" activities may have a strong community orientation, but available data do not permit a precise breakdown (see text).

Note: Components may not add to 100 percent because of rounding.

Source: UNFPA program data, 1980.

## Location of Activities

### A. Family Planning Programs

In 1979, 80 percent of UNFPA's budget of \$124 million went to country and regional projects, and 20 percent went to interregional and global activities. Table 3 shows the distribution of expenditures in 1978 and 1979, as well as the projection for 1980.

The allocation of funds for country and regional projects varies considerably. Expenditures in 1979 were distributed as follows: Asia and the Pacific, 38 percent, or \$47 million; Latin America, 16 percent; Sub-Saharan Africa, 14 percent. North Africa, the Middle East, and Europe each received part of the remaining 11 percent. This distribution is nearly the same as that for 1978, except for a slight increase for Sub-Saharan Africa and a decrease for Latin America, and it is also projected for 1980.

Table 4 shows that country and regional programs accounted for 90 percent of UNFPA family planning expenditures in 1979, while 10 percent was spent at the interregional and global levels. This reflects the greater proportion of direct services included in the family planning area, in comparison with the 80 percent country and regional share overall and the 71 percent country and regional share for non-family planning programs (see Table 3). These levels have remained in the same range in recent years.

The proportion of UNFPA family planning funds for priority countries is similar to that of non-family planning programs. In 1979, about 59 percent of the \$47.5 million of family planning expenditures was made in priority countries, slightly higher than the approximate priority country shares of 57 percent for all programs and 55 percent for non-family planning programs.

In 1979, 52 percent of the family planning budget for regional funds went to Asia and the Pacific. This is greater than the 38 percent share overall for this region and the 27 percent share for non-family planning activities. Latin America received 20 percent of the family planning assistance, which was also higher than its share of total expenditures and its 13 percent share for non-family planning programs. North Africa and the Middle East together were allocated 11 percent of family planning funds, the same as their overall and non-family planning share, and 7 percent went to Sub-Saharan Africa, or one-half the overall share.

The distribution of family planning funds by regions has remained roughly constant. However, the overall increase in funding for family

Table 3  
 PROGRAM LOCATION EXPENDITURES, 1978-1980,  
 WITH DATA FOR NON-FAMILY PLANNING PROGRAMS IN 1979  
 (\$000 AND PERCENT OF TOTAL)

<u>Program Location</u>	<u>1978</u>	<u>1979</u>	<u>1980 Planned</u>	<u>Non-FP Activities, 1979*</u>
Country and Regional Programs				
Sub-Saharan Africa	\$10,229 (11.5%)	\$17,732 (14.3%)	\$21,335 (14.2%)	\$13,834 (19.9%)
Latin America	17,172 (19.2%)	20,318 (16.4%)	26,783 (17.8%)	9,339 (13.4%)
Asia and the Pacific	32,980 (37.0%)	47,150 (38.1%)	55,831 (37.1%)	18,863 (27.1%)
Europe, North America, and Middle East	10,690 (12.0%)	13,541 (11.0%)	18,099 (12.0%)	7,751 (11.2%)
Total	\$71,071 (79.6%)	\$98,741 (79.9%)	\$122,048 (81.1%)	\$49,787 (71.6%)
Interregional and Global Programs	\$18,159 (20.4%)	\$24,883 (20.1%)	\$28,423 (18.9%)	\$19,700 (28.4%)
TOTAL	<u>\$89,230</u>	<u>\$123,624</u>	<u>\$150,471</u>	<u>\$69,487</u>

\* Percent of total for nonfamily planning programs only.

Note: Components may not add to totals because of rounding.

Source: UNFPA Fact Sheet, No. 1.10, July 1981; based on data as of March 31, 1981.

Table 4  
PROGRAM LOCATION DISTRIBUTION OF FAMILY PLANNING EXPENDITURES, 1978-1980  
(\$000 and Percent of Total)

<u>Program Location</u>	<u>1978</u>	<u>1979</u>	<u>1980 Planned</u>
Country and Regional Programs			
Sub-Saharan Africa	\$ 2,074 (4.5%)	\$ 3,898 (7.2%)	\$ 4,331 (6.9%)
Latin America	11,386 (24.9%)	10,979 (20.3%)	13,058 (20.8%)
Asia and the Pacific	23,641 (51.7%)	28,287 (52.3%)	32,671 (52.1%)
Europe, North Africa, and Middle East	5,048 (11.0%)	5,790 (10.7%)	6,808 (10.9%)
Total	\$42,149 (92.2%)	\$48,954 (90.4%)	\$56,868 (90.7%)
Interregional and Global Programs	3,590 (7.8%)	5,183 (9.6%)	5,842 (9.3%)
TOTAL	<u>\$45,738</u>	<u>\$54,137</u>	<u>\$62,710</u>

Note: Components may not add to totals because of rounding.

Source: UNFPA Fact Sheet, No. 1.08, July 1981; based on data as of March 31, 1981.

planning and other programs has substantially increased absolute levels of funding.

The program location distribution of UNFPA expenditures in 1979 is illustrated in Figure 1, which gives breakdowns for family planning and non-family planning programs. Family planning received 44 percent of all UNFPA funds, while 50 percent of all country and regional funds and only 21 percent of interregional and global funds went to that area. Of UNFPA expenditures, 22 percent went to family planning in Sub-Saharan Africa; 54 percent in Latin America; 60 percent in Asia and the Pacific; and 43 percent in Europe, North Africa, and the Middle East. This distribution is also shown in Figure 1; the share of family planning funds in Asia and the Pacific is especially significant.

This pattern is related to several differences among regions, especially the priority and strength of family planning activities and the capacity of countries to absorb assistance. For example, many countries in Sub-Saharan Africa have an equivocal commitment to formal family planning programs, but existing family planning services, health services, and national infrastructures to channel new program resources are limited. Thus, the distribution of family planning funds appears to be consistent with the needs and opportunities in the various regions of the world.

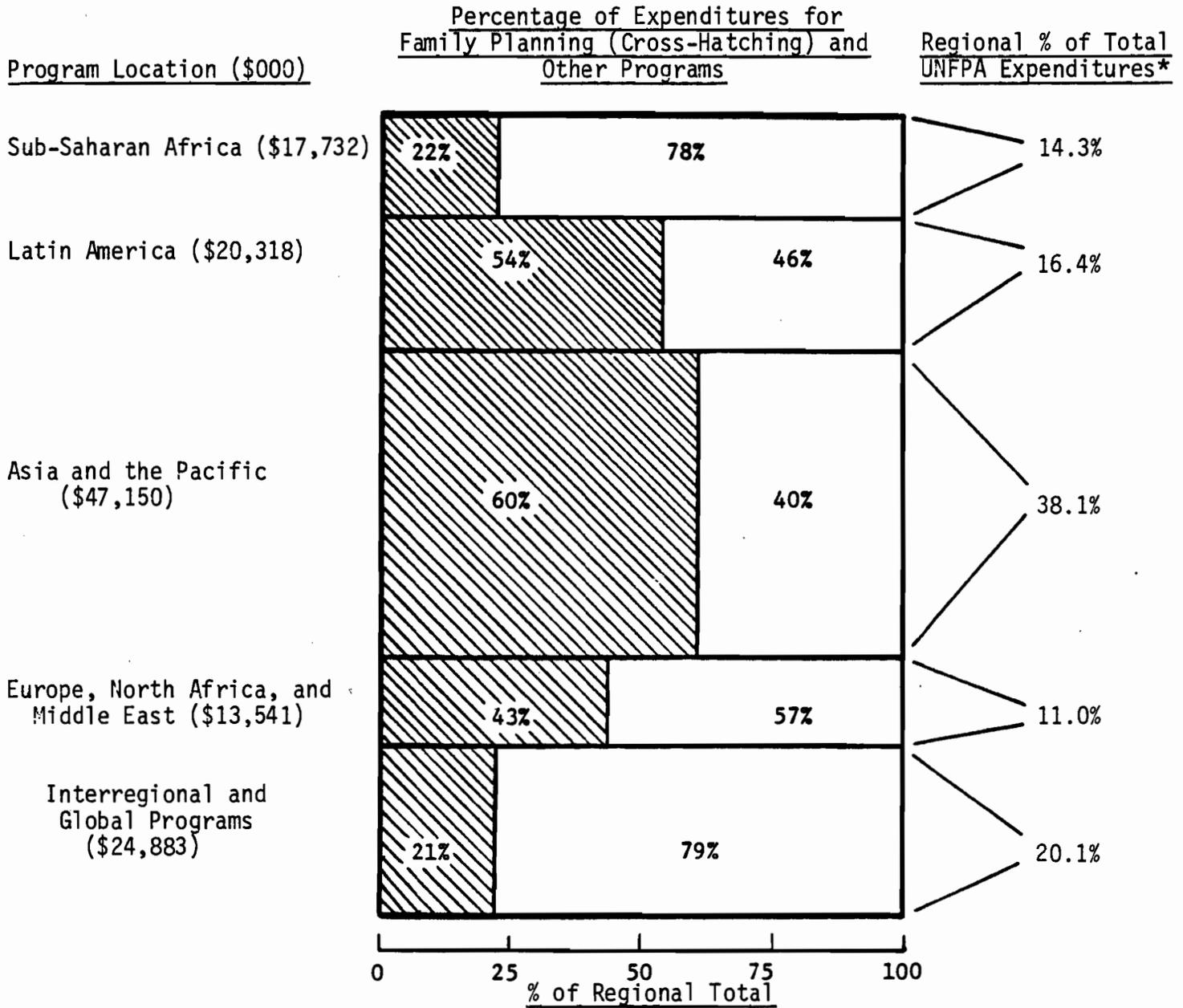
#### B. Allocations by USAID Regions

UNFPA budget allocations for family planning programs, contraceptives, and all programs are arranged by USAID regions and country assistance categories in Table 5. Although the data, which are from a U.S. Government tabulation, are approximate, the breakdown makes it possible to compare the expenditure patterns of the two agencies.

The largest share of 1979 allocations, \$55 million (37 percent), went to the AID Asia Region, and countries in Asia also received the largest allocations for family planning programs and contraceptives. The Africa, Latin America and Caribbean, and Near East regions each received under 20 percent (12-17 percent) of UNFPA allocations. The remaining 19 percent went to UNFPA interregional and global programs. Of countries receiving USAID bilateral assistance, \$52 million (34 percent) went to those with an AID population component, and \$23 million (15 percent) went to others. Of countries not receiving AID assistance, 10 percent of funds went to special interest countries, and 5 percent each went to countries of other U.S. interest and limited U.S. interest. The rest went to UNFPA intercountry programs, which represent additional expenditures in each of these country categories.

Figure 1

UNFPA EXPENDITURES,  
FAMILY PLANNING VERSUS NON-FAMILY PLANNING EXPENDITURES,  
BY PROGRAM LOCATION FOR 1979



Total, UNFPA (\$123,624) ————— 44% Family Planning

Total, Country and Regional Programs (\$98,741) ————— 50% Family Planning

\* Total does not add to 100 percent due to rounding.

Source: Data from Tables 3 and 4.

Table 5

UNFPA ALLOCATIONS FOR FAMILY PLANNING (FP) (Est.),<sup>1</sup> Contraceptives (CC), AND TOTAL PROGRAMS,  
BY USAID REGIONS AND COUNTRY DESIGNATIONS, 1979  
(\$ Millions and Percent of Total)

USAID Country Category  USAID Region	UNFPA Country Programs												UNFPA Regional Programs <sup>2</sup>			Total
	Countries with AID Bilateral Programs						Countries without Direct AID Assistance									
	With Population Component			No Population Component			AID Special Interest			Other U.S. Interest,	Limited U.S. Interest,	FP	CC	Total		
	FP	CC	Total	FP	CC	Total	FP	CC	Total	Total	Total	FP	CC	Total		
Africa	\$ 2.0	\$0.1	\$ 4.8 (3%)	\$4.5	\$0.5	\$12.0 (8%)	\$0.0	\$0.0	\$ 0.5 (0%)	\$0.0	\$1.9 (1%)	\$0.0	\$0.0	\$ 4.5 (3%)	\$ 23.6 (16%)	
Asia	24.6	1.7	33.3 (22%)	1.6	0.0	2.3 (2%)	4.4	1.8	6.6 (4%)	6.2 (4%)	1.0 (1%)	0.7	0.0	5.6 (4%)	55.0 (37%)	
Latin America and Caribbean	5.4	0.4	7.9 (5%)	1.3	0.0	2.6 (2%)	3.6	0.3	4.8 (1%)	1.0 (2%)	2.3 (2%)	1.1	0.0	6.6 (4%)	25.2 (17%)	
Near East	3.5	0.8	5.7 (4%)	2.2	0.3	6.1 (4%)	0.7	0.0	2.8 (2%)	0.0 (0%)	2.0 (1%)	0.6	0.0	1.9 (1%)	18.5 (12%)	
<b>TOTAL</b>	<u>\$35.4</u>	<u>\$3.0</u>	<u>\$51.6</u> (34%)	<u>\$9.5</u>	<u>\$0.9</u>	<u>\$23.1</u> (15%)	<u>\$8.7</u>	<u>\$2.0</u>	<u>\$14.7</u> (10%)	<u>\$7.1</u> (5%)	<u>\$7.5</u> (5%)	<u>\$2.4</u>	<u>\$0.0</u>	<u>\$18.6</u> (12%)	<u>\$122.6</u> (81%)	
UNFPA Interregional and Global Programs												\$5.9	\$0.0	\$27.8 (19%)	\$ 27.8 (19%)	
<b>UNFPA GRAND TOTAL</b>															<u>\$150.4</u> <sup>3</sup> (100%)	

Notes: Components may not add to totals because of rounding.

<sup>1</sup> Includes total procurements, thus exceeds corresponding UNFPA figures.

<sup>2</sup> Based on figures for UNFPA regions.

<sup>3</sup> Total is for 1979 allocation, which exceeds expenditure figures.

Source: USAID and UNFPA data, unpublished, 1980.

Allocations for family planning and contraceptives were concentrated in the Asia Region, especially in countries receiving AID population assistance. AID special-interest countries in Asia also received a large contraceptive allocation. Family planning accounted for the largest share of the UNFPA budget in Asia and Latin America and the Caribbean. Countries with AID programs but no population component received smaller but significant support for family planning. Countries in Africa and the Near East also had relatively large allocations for contraceptives.

Overall, about one-half of UNFPA country allocations in 1979, including substantial amounts for family planning, were made to countries not receiving AID assistance in population. Nearly one-third of the UNFPA country total for all programs, or one-fifth of all UNFPA support, went to countries not receiving AID bilateral assistance. The regional distribution is similar to that for USAID population funds.

#### Use of Executing Agencies

The use of various methods and agencies for implementing projects influences the design and the operation of UNFPA programs. In family planning, UNFPA seeks to maintain a coherent set of activities, while still responding to the objectives and approaches of its executing agencies. UNFPA uses three principal methods to transfer funds and project responsibility: direct transfers to national government agencies, or direct execution; transfers through other agencies in the U.N. system; and transfers to nongovernmental organizations. More than one agency may be employed to carry out a program.

Tables 6, 7, and 8 show how UNFPA family planning expenditures in 1979 were distributed among executing agencies. Of the \$54 million total, 39 percent was administered by direct execution, 27 percent by WHO, 17 percent by UNICEF, 14 percent by NGOs, and 3 percent by other U.N. agencies, including UNESCO, regional commissions, ILO, and FAO.

Family planning programs received 95 percent of the UNFPA funds distributed through UNICEF, 85 percent of those through WHO, 55 percent of those through NGOs, 46 percent of those through direct execution, and smaller or negligible proportions of those distributed through other U.N. agencies. The distribution of the \$69.5 million in non-family planning expenditures is thus different from that for family planning programs, which reflects the emphases of UNFPA and the relative strengths of the other agencies. Of non-family planning expenditures, 36 percent were distributed by direct execution, 4 percent by WHO, 1 percent by UNICEF, and 50 percent by other U.N. agencies.

The level at which family planning activities are conducted (country vs. intercountry) and the regional concentration of country programs

Table 6  
TOTAL FAMILY PLANNING EXPENDITURES, BY EXECUTING AGENCY, 1979  
(\$000)

Region or Program	UNFPA (Direct Execution)	WHO	UNICEF	NGOs	UNESCO	Other U.N. Agencies	ILO, FAO	TOTAL
Country Programs								
Sub-Saharan Africa	\$ 1,664	\$ 568	\$ 1,005	\$ 360	\$ 118	\$ 92	\$ 8	\$ 3,815
Latin America	2,025	5,748	649	1,499	0	0	68	9,989
Asia and Pacific	15,854	3,733	5,319	2,297	184	183	167	27,737
North Africa	1,032	81	1,808	211	0	0	0	3,132
Middle East	309	865	407	53	25	0	0	1,659
Europe	180	301	0	0	0	0	0	481
Total	\$21,064	\$11,296	\$ 9,100	\$ 4,420	\$ 327	\$ 275	\$ 242	\$46,813
Regional Programs	\$ 139	\$ 1,604	\$ 0	\$ 86	\$ 142	\$ 187	\$ 0	\$ 2,158
Interregional and Global Programs	116	1,740	0	3,195	81	51	0	5,183
Total, FP/MCH	\$21,320	\$14,638	\$ 9,188	\$ 7,702	\$ 550	\$ 513	\$ 242	\$54,154
Total Expenditures	<u>\$46,032</u>	<u>\$17,180</u>	<u>\$ 9,653</u>	<u>\$14,094</u>	<u>\$ 4,802</u>	<u>\$22,342</u>	<u>\$ 9,560</u>	<u>\$123,663</u>
Total, Non- Family Planning	\$24,712	\$ 2,542	\$ 465	\$ 6,392	\$ 4,252	\$21,829	\$ 9,318	\$69,509

Note: Components may not add to totals because of rounding.

Source: UNFPA expenditure data, special tabulation, September 1980.

Table 7

PERCENT OF AGENCY FP/MCH TOTALS OF FAMILY PLANNING EXPENDITURES,  
BY EXECUTING AGENCY, 1979

<u>Region or Program</u>	<u>UNFPA (Direct Execution)</u>	<u>WHO</u>	<u>UNICEF</u>	<u>NGOs</u>	<u>UNESCO</u>	<u>Other U.N. Agencies</u>	<u>ILO, FAO</u>	<u>TOTAL</u>
Country Programs								
Sub-Saharan Africa	8.0%	4.0%	11.0%	5.0%	21.0%	18.0%	3.0%	7.0%
Latin America	9.0	39.0	7.0	19.0	0.0	0.0	28.0	18.0
Asia and Pacific	74.0	26.0	58.0	30.0	33.0	36.0	69.0	51.0
North Africa	5.0	1.0	20.0	3.0	0.0	0.0	0.0	6.0
Middle East	1.0	6.0	4.0	1.0	5.0	0.0	0.0	3.0
Europe	1.0	2.0	0.0	0.0	0.0	0.0	0.0	1.0
Total	99.0	77.0	100.0	57.0	59.0	54.0	100.0	86.0
Regional Programs	1.0	11.0	0.0	1.0	26.0	36.0	0.0	4.0
Interregional and Global Programs	1.0	12.0	0.0	41.0	15.0	10.0	0.0	10.0
TOTAL, FP/MCH	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>
FP/MCH as Percent of Total Expenditures, All Areas	46.3	85.2	95.2	54.6	11.5	2.3	2.5	43.8

Note: Components may not add to totals because of rounding.

Source: UNFPA expenditure data, special tabulation, September 1980.

Table 8

PERCENT OF REGIONAL OR PROGRAM TOTALS OF FAMILY PLANNING EXPENDITURES,  
BY EXECUTING AGENCY, 1979

<u>Region or Program</u>	<u>UNFPA (Direct Execution)</u>	<u>WHO</u>	<u>UNICEF</u>	<u>NGOs</u>	<u>UNESCO</u>	<u>Other U.N. Agencies</u>	<u>ILO, FAO</u>	<u>TOTAL</u>
Country Programs								
Sub-Saharan Africa	44%	15%	26%	9%	3%	2%	0%	100%
Latin America	20	58	6	15	0	0	1	100
Asia and Pacific	57	13	19	8	1	1	1	100
North Africa	33	3	58	7	0	0	0	100
Middle East	19	52	25	3	2	0	0	100
Europe	37	63	0	0	0	0	0	100
Total	44	25	19	8	1	2	1	100
Regional Programs	6	74	0	4	7	9	0	100
Interregional and Global Programs	2	34	0	62	2	1	0	100
Total, FP/MCH	39	27	17	14	1	1	0	100
Total Expenditures, All Areas	37	14	8	11	4	18	8	100
Total, Non- Family Planning	36	4	1	9	6	31	13	100

Note: Components may not add to 100 percent because of rounding.

Source: UNFPA expenditure data, special tabulation, September 1980.

vary according to the relative strength of the agencies and the overall distribution of the family planning funds.

- 99 percent of the expenditures for direct execution are made at the country level, especially those in Asia and the Pacific, where government health agencies have a history of involvement in family planning programs.
- About three-fourths of WHO's family planning expenditures are made on country programs. The remainder goes for intercountry activities, including three-fourths of all regional programs and one-third of all interregional and global programs. Over one-half of WHO country funds are spent in Latin America due to PAHO's strength, and most of the rest goes to Asia and the Pacific. (UNFPA funding to WHO is described in greater detail in Chapter 5.)
- All UNICEF expenditures are made at the country level. Funding is used for two forms of assistance. Reimbursable procurement uses UNICEF's role in the U.N. system as a bulk purchaser of equipment. Under this arrangement (described in Chapter 4), UNFPA directly requests UNICEF to purchase items, including medical equipment, vehicles, and contraceptives, for UNFPA-supported family planning programs. This is increasing and amounts to between 5 percent and 10 percent of UNICEF's total procurements. UNICEF also provides project inputs, such as training support, that account for a smaller share of activities, although an exact breakdown is not available. The distribution of UNICEF expenditures follows that for all country family spending, except that it is used to a lesser extent in Latin America, where PAHO does much of its own procurement.
- Only 60 percent of the expenditures by nongovernmental organizations are made for country programs and most of the remaining 40 percent goes for intercountry research and technical support. This includes over 60 percent of all interregional and global programs. NGO country expenditures are slightly higher than average in Latin America and Sub-Saharan Africa, where these agencies have stronger roles and capacities in family planning. However, these figures reflect only the initial allocation of UNFPA resources. Especially in projects executed by governments and by WHO, a significant proportion of resources is channeled to local organizations and international NGOs. Individual project budgets must be examined in order to obtain a more precise breakdown of the final distribution of UNFPA funds, particularly to NGOs.

The percentage of family planning funds distributed in each region according to the type of executing agency may help to clarify these figures (Table 8):

- Sub-Saharan Africa: direct execution, 44 percent; UNICEF, 26 percent; WHO, 15 percent; and NGOs, 9 percent.
- Latin America: WHO, 58 percent; direct execution, 20 percent; and NGOs, 15 percent.
- Asia and the Pacific: direct execution, 57 percent; UNICEF, 19 percent; and WHO, 13 percent.
- North Africa: UNICEF, 58 percent, and direct execution, 33 percent.
- Middle East: WHO, 52 percent; UNICEF, 25 percent; and direct execution, 19 percent.

This clearly reflects, and imposes, varying requirements on UNFPA activities. It may also explain some of the differences in the performance of UNFPA family planning programs. However, these patterns are also the outcome of the agencies' capacities to provide family planning services and the conditions affecting each region and program level. Overall, the trends in the execution of family planning programs are as expected. Further examination of project budgets and the needs and constraints of specific settings will be necessary to assess the relative effectiveness of present arrangements and alternatives.

### Budget Item Expenditures

#### A. Distribution

UNFPA resources for family planning and MCH services are used to support all aspects of program operations, including personnel, training, equipment, miscellaneous costs, and subcontracted activities. The distribution of these expenditures varies widely among project types and regions.

The allocation of funds for budget components has important implications for the efficiency of family planning support, especially the long-term burden of recurrent costs. In particular, high personnel expenditures may reflect an excessive use of international project staff and perhaps an unnecessary subsidy of local personnel. Historically, a high level of

equipment support for local facilities, medical equipment, and vehicles may have encouraged too great a reliance on UNFPA funding. In addition, the use of UNFPA resources to purchase conventional contraceptives from outside sources may discourage the development of local production or alternative methods of acquisition. Although the appropriateness of these expenditures cannot be evaluated, budget data reveal patterns of resource allocation and regional trends.

UNFPA allocates funds according to the following budget categories:

- project personnel, including U.N. and non-U.N. international personnel; administrative support costs, volunteer expenses, and travel costs; and local personnel payments.
- subcontracts to agencies (largely NGOs) and grants to institutions.
- training, including fellowships and other types of training.
- equipment, including expendable equipment (primarily supplies), nonexpendable equipment, such as medical equipment and vehicles, costs of premises, and contraceptives.
- miscellaneous costs, including equipment operation and maintenance, reporting costs, and sundry expenses.

Table 9 shows the distribution of family planning expenditures according to budget categories as averaged for 1978 and 1979. Personnel was 29 percent of all costs; subcontracts, 8 percent, training, 22 percent; equipment, 39 percent; and miscellaneous costs, 3 percent.

There are wide regional variations, which are heavily weighted by the high expenditures in Latin America and Asia and the Pacific. Project personnel expenditures range from 9 percent in North Africa to over 40 percent in Latin America and the Middle East. Local personnel payments fall roughly in the 10 to 20 percent range, with the greatest portion going in Latin America where programs are often conducted through institutional health services. Subcontracts are negligible in Sub-Saharan Africa and the Middle East, but reach nearly 35 percent in Latin America and Asia, where NGOs are more numerous and better organized. Training expenditures reach 30 percent in Asia, where delivery systems are well developed, but are under 5 percent of the total in Sub-Saharan Africa.

Equipment and supplies, including contraceptives, account for about 40 percent, the largest share, of UNFPA family planning expenditures for 1978-1979. Under 5 percent of the budget goes for facilities and rent, 6 percent for vehicles, and about 10 percent each for medical supplies,

Table 9  
 PERCENT DISTRIBUTION OF FAMILY PLANNING COUNTRY PROGRAM EXPENDITURES,  
 BY BUDGET COMPONENT AND REGION, 1978-1979  
 (1975-1977 Figures in Parentheses)

Budget Component	Region										TOTAL	
	Sub-Saharan Africa		Latin America		Asia and The Pacific		North Africa		Middle East			
Project Personnel	29%	(55%)	41%	(46%)	26%	(50%)	9%	(13%)	41%	(37%)	29%	(46%)
International	16	(20)	4	(4)	3	(6)	1	(3)	16	(10)	4	(5)
Local	13	(34)	31	(40)	22	(43)	7	(10)	20	(13)	23	(38)
Other	0	(2)	5	(3)	1	(1)	1	(1)	5	(4)	2	(2)
Subcontracts	1	(0)	8	(4)	9	(12)	6	(2)	2	(1)	8	(8)
Training	4	(4)	10	(7)	30	(8)	16	(7)	8	(6)	22	(7)
Equipment	61	(39)	39	(39)	34	(28)	68	(74)	44	(53)	39	(36)
Premises	4	(8)	2	(0)	2	(2)	0	(2)	5	(28)	2	(3)
Medical	7	(7)	16	(13)	5	(3)	20	(9)	15	(0)	9	(7)
Vehicles	16	(13)	4	(3)	5	(5)	3	(1)	13	(7)	6	(5)
Contraceptives	17	(6)	6	(11)	11	(6)	39	(45)	5	(6)	11	(10)
Other	17	(4)	11	(12)	11	(12)	6	(16)	6	(12)	11	(9)
Miscellaneous	5	(2)	2	(3)	2	(2)	2	(3)	5	(3)	2	(2)
TOTAL	<u>100%</u>	<u>(100%)</u>	<u>100%</u>	<u>(100%)</u>	<u>100%</u>	<u>(100%)</u>	<u>100%</u>	<u>(100%)</u>	<u>100%</u>	<u>(100%)</u>	<u>100%</u>	<u>(100%)</u>
Average Total Annual Budget (\$000)	\$2,803	(\$1,529)	\$10,239	(\$7,833)	\$25,170	(\$14,305)	\$2,191	(\$1,822)	\$1,394	(\$829)	\$41,797	(\$26,318)

Note: Percentages may not add to totals because of rounding.

Source: UNFPA budget data, special tabulation, November 1980.

contraceptives, and other equipment. There is substantial regional variation for some items. For example, vehicle expenditures are highest in Africa and the Middle East, where programs have focused on developing health infrastructures.

Contraceptives are less than 10 percent of expenditures in Latin America and the Middle East, which is related to the absorptive capacities of country projects. This figure is nearly 40 percent in North Africa and only 10 to 15 percent in Sub-Saharan Africa and Asia, although the high level of expenditures in Asia represents a substantial outlay. With no policy shift, this 10 percent level may be expected to continue.

#### B. Trends

Comparison of these expenditures with figures for 1975-1977, which are given in parentheses in Table 9, shows the trends in UNFPA spending. The most noticeable shift is a decrease in project personnel expenditures from 46 to 29 percent and an increase in training expenditures from 7 to 22 percent. The decrease in personnel funds is almost entirely in the area of local staff. The proportion for the other budget categories has remained remarkably stable.

However, there is considerable regional variation among budget categories.

- In Sub-Saharan Africa, personnel costs have fallen considerably, particularly for local staff support, while equipment costs, including contraceptives, have risen.
- In Latin America, support for local personnel as well as for contraceptives has declined slightly, but has risen for subcontracts (NGOs) and training.
- In Asia and the Pacific, personnel costs have fallen by one-half, largely due to a drop in local staff support. The funds for training have risen from 8 to 30 percent, and has also grown for contraceptives.
- In North Africa, training costs have risen while equipment costs have fallen, despite a doubling in the share for medical supplies.
- Finally, in the Middle East local personnel costs have risen, along with support for vehicles and medical supplies, while local premises and other equipment costs have declined.

In general, the rise in training and the drop in local staff assistance reflect an important and encouraging trend, although several qualifications should be noted. First, the family planning budget has increased substantially, so that absolute decreases are less marked and absolute increases are more pronounced than the proportional figures show. Second, these trends mask diverse, and in some cases countervailing, budget shifts within regions. The contribution made by each region to the total varies with the respective share of the budget.

This analysis, therefore, provides only a preliminary view of the pattern and trends of UNFPA resource allocation. It would be worthwhile to examine in greater detail the budget data for individual country and program situations, multiyear program commitments, and projections for 1980-1983. In this way, a clearer picture of the long-term dynamics of UNFPA family planning programs than is presently available may emerge.

#### IV. OPERATIONS AND PERFORMANCE

## IV. OPERATIONS AND PERFORMANCE

### Project Development

#### A. Needs Assessment

An in-depth description of national population issues and potential population projects is developed through the UNFPA needs assessment process. This has three functions:\*

1. To assist the government in developing or strengthening its national population program.
2. To promote national self-reliance in population policy formulation and program implementation.
3. To help the government, UNFPA, and other donors to identify areas for assistance.

The needs assessment includes an analysis of existing population objectives, strategies, and programs and the development of recommendations for a national population program and the need for external assistance. The assessment format deals with each of UNFPA's eight major program areas.

The final report is based on background preparation and the findings of a 10 to 13 day mission to the country. The first part of the report deals with the national setting of population and development and population trends and their implications. The second part makes recommendations in each of the eight UNFPA program areas and describes current and potential sources of financing. Program areas are generally handled separately by different team members. The overall reports may cover either the country's entire population sector or only that part in which UNFPA has been involved. About 60 needs assessments have been completed since 1977. Missions have been scheduled through 1983, including a number for updates.

The UNFPA needs assessment thus provides comprehensive, structured information on national population conditions and the scope for family

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\* UNFPA, Manual for Needs Assessment and Programme Development, March 1980.

planning services. The needs assessment guidelines are clearly written, and it is generally agreed by UNFPA and WHO staff that projects formulated with needs assessments are more clearly presented and are of higher quality than those developed using earlier methods.

The needs assessments are relatively new, however, and few UNFPA projects have been developed using them. Programs in countries where needs assessments have not been made have less formalized decisionmaking processes, and the effectiveness of programming cannot be readily determined because it depends, in large measure, on experience, knowledge, and available time of headquarters and regional staff, and the use of expertise from countries and from other agencies.

While recognizing the general quality of the needs assessments that have been prepared, staff at the agencies contacted noted variability in individual reports. The underlying problems are common to many agencies. For example, the missions themselves are often conducted in a short period of time, and scheduling conflicts may restrict the availability of staff from UNFPA and other agencies. In view of the small size of staff responsible for a given country or program type, personnel limitations may be an important factor. Involvement of staff from national governments and executing agencies, particularly WHO and PAHO, may enhance or bias the needs assessment report. There should also be regular contact between UNFPA headquarters, coordinators, and the mission that writes the document.

To achieve maximum use from needs assessments, channels of communications to all participants need to be clarified, and the use of the reports in program planning and review needs to be promoted. One way to do this would be to hold structured workshops on needs assessment and project formulation in various countries in order to train local personnel.

## B. Requests for Projects

Projects for UNFPA support are identified from the findings of the needs assessment or other missions and previous experience. A draft request for support is prepared by the country's central ministry. Assistance may be provided by an adviser or consultant, who is often obtained through WHO/PAHO. The resident UNFPA coordinator may also participate. Government interest is critical for project initiation, although an outside adviser may play a large role in determining the content of the project requested. However, use of an adviser may lead to a communication gap between the formulators of the program, those responsible for operations, and the funding agency.

The formal request for UNFPA assistance is made by the national government through the local UNDP resident representative, according to a

prescribed format.\* Unfortunately, project documents are often not specific enough for effective monitoring and evaluation. However, revisions instituted in 1978 make a number of substantive and formal changes that specify the format of the document more clearly and emphasize the placement of projects within a national program. New information requirements include implementation plans, the justification of inputs, and clarification of certain budget items.

Appraisal of the request focuses on the scope of assistance and technical aspects of the project, but tends to avoid policy issues such as appropriateness or overall levels of support. Comments are solicited from WHO/PAHO if the project includes a health component. After necessary revisions, the project request is summarized for submission to the Governing Council at its annual meeting.

### C. Funding

The approval of UNFPA project requests follows the procedures set up by the UNDP Governing Council. The staff in all of the agencies contacted for this review commented on the long chain of activities required to obtain approval in the U.N. system. Requests first go through the coordinator's office for initial allocation or approval of any changes. Funding for projects over \$1 million is only approved at the Governing Council's annual meeting, although limited preproject funds are available for interim periods. The average length of time from project identification to approval is now 6 to 12 months. It was felt that the process was faster when UNFPA resources were more abundant. For priority countries and those with special needs, approval may be made relatively quickly. The project approval process necessarily responds to the UNFPA funding system. Because the budget is built around contributions pledged annually by donor countries, projects receive funds only as long as budgeted amounts are available. In selecting each year's programs, priority is given to continuing projects for which support has been committed. New project requests are put in the "pipeline" and approved projects are funded as the budget is increased or as projects close down or are rebudgeted.

Annual budgeting creates some instability, especially since UNFPA programs are usually funded on a four- or five-year cycle. Long-term programs cannot be budgeted with certainty because all programs depend on current funding levels.

UNFPA is experiencing a slowdown in the growth of contributions, but an increase in requests for assistance. This has greatly reduced the agency's rate of response to government requests for new projects, and in

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\* UNFPA, "Instructions for the Preparation of a Project Document," Second Revision (UNFPA, 19/Rev. No. 2), October 1978.

some cases the support for continuing projects. Increasingly, UNFPA is encouraging governments to support a greater share of continuing projects. The number of projects which have been approved but not funded has also risen in recent years.

## Program Operations

### A. Responsibility for Projects

The UNFPA coordinator and the UNDP resident representative are responsible for UNFPA projects in the field. Coordinators supervise all UNFPA projects in their respective countries. They act as a deputy to the UNDP resident representative, who is the official UNFPA representative for cabinet-level contacts. Coordinators thus play a different role than WHO country advisers, who work directly with government health ministries. Although they work with appropriate ministries, they serve primarily within the local U.N. staff. Coordinators generally have considerable latitude for making decisions, but budgetary approvals must go through country and regional desks at UNFPA headquarters.

Overall, the quality of UNFPA field staff is considered to be satisfactory and comparable to that of other donor agencies. Recruitment of UNFPA coordinators is frequently a problem, however, partly because headquarters, field offices, and host country governments each hold veto power over individual appointments. Project administration and monitoring are considered to work well where a UNFPA coordinator is working.

The country project director, who is usually a native of the host country, has direct responsibility for project operations. UNFPA provides administrative support and management, and WHO and other executing agencies usually provide technical staff. Staff at UNFPA headquarters are thus at least two steps away from ground-level operations.

UNFPA contracts with a number of U.N. specialized agencies, principally WHO, to carry out many of its programs. UNFPA is not mandated to work through these agencies, but has done so. Interregional and global resources were originally provided for support of population activities in these specialized agencies, but this is currently being shifted to a 13 percent level of overhead funding.

The UNFPA program activities that are carried out through WHO are operated by several divisions of that organization. Family planning programs are administered chiefly through the Family Health Division. UNFPA also uses a variety of other organizations to carry out its family planning programs. The primary method of operation is "joint execution" between these agencies and host governments. UNICEF conducts a small number

of country projects in addition to its procurement activities. Other U.N. specialized agencies, including UNESCO, ILO, FAO, and the U.N. regional commissions, implement some family planning programs as well.

Nongovernmental organizations received about 15 percent of UNFPA family planning funds in 1979. A wide range of NGOs is employed for this purpose, including semipublic and private agencies. Beyond participation in direct execution, NGOs frequently subcontract to provide services as part of the family planning funds for subcontracts. In addition, NGOs perform many family planning education activities. National institutions are subcontracted chiefly to conduct research activities for programs.

#### B. Coordination and Cooperation

In all development programs, UNFPA project implementation is dependent on the capacity of local agencies, the nature of formal agreements, and financial constraints. Relationships with country bureaucracies are often complex because more than one agency is responsible for family planning operations. Host governments have considerable control over the allocation of resources, and UNFPA usually exercises its influence indirectly through such mechanisms as budgetary signals and meetings.

UNFPA's relationship with governments depends greatly on the individuals involved in country programs. Some UNFPA coordinators have demonstrated a great deal of influence, and WHO country advisers are often able to gain regular representation with their local counterparts. Government response to UNFPA programs in many cases depends on the negotiating and diplomatic skills of donor agency representatives. Poor communication with host governments is consistently observed in projects experiencing implementation problems.

Communication and management problems between operating agencies are also present in many UNFPA projects. There is increasing need for improved coordination, particularly in national family planning programs where agencies combine to support different program elements.

#### C. Logistics and Procurement

Because family planning projects are carried out through national governments, procurement is subject to the conditions of each national setting. General rules for the provision of UNFPA resources are set forth in the Policies and Procedures Manual.<sup>\*</sup> Specific arrangements for the use

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\* UNFPA, 1979.

of resources, including equipment and supplies, are established according to the procedures of the recipient ministry designated as the implementing agency.

UNFPA equipment and supplies are procured through three main channels: direct purchase by UNFPA, reimbursable procurement through UNICEF, and procurement by other executing agencies. In UNFPA projects directly executed by national governments, minor or easily obtainable items are procured through regular means. However, the majority of equipment purchases for projects executed by governments or NGOs is made through UNICEF under reimbursable procurement. Equipment used on projects administered by executing agencies, such as WHO, are procured through the regular channels used by the agency.

Requests for equipment and supplies through UNICEF are initiated at the project site, sent to the UNFPA headquarters, and then forwarded to the New York UNICEF office. UNICEF maintains three supply warehouses to serve the U.N. system: a central facility in Copenhagen and smaller facilities in Geneva and Japan. Many standard equipment items are kept in stock at these sites. Larger items, such as vehicles, are purchased by UNICEF and sent to the appropriate warehouse. The equipment is transferred to the project site, and UNICEF is reimbursed with a 3 percent handling fee. UNICEF also assembles a variety of "set packages" of medical equipment for family planning projects. These packages include instruments and supplies for the operation of an MCH/FP clinic which are grouped for separate shipment to each site in a country project.

Contraceptive supplies are also obtained in these three ways. They are purchased locally or regionally for a number of projects. UNICEF stocks a wide selection of contraceptives at its warehouses in Geneva and Japan. However, UNFPA is increasingly procuring contraceptives directly from manufacturers for shipment to project sites. Contraceptive procurement is straightforward and effective, regardless of the means used.

There are two constraints on procurement in UNFPA programs. The first is related to the project environment: Often it is impossible to carry out certain project activities. For example, obtaining fuel for vehicles has been difficult in some projects, particularly in Africa. The second concerns administrative responsibility: UNFPA project staff and coordinators have little authority to approve reallocations of funds in project budgets. All changes over a certain level have to be made at headquarters, which can lead to delays in purchasing.

Overall, UNFPA's procurement procedures work with reasonable efficiency, particularly when compared with other agencies. Most items ordered are obtained. The UNICEF system provides nearly all items requested, and, in the case of vehicles and medical equipment, these arrangements have proved critical for project performance.

## Project Monitoring and Review

### A. Financial Management

The financial management of UNFPA projects follows guidelines established by UNDP, but in practice it varies considerably among program settings. UNFPA allocates a portion of the project budget to executing agencies and government implementing agencies on a quarterly basis for reimbursement of expenditures presented in financial reports. Problems may arise, particularly in long-term projects with multiple budget categories and several operating agencies. The lack of a resident UNFPA coordinator and inefficient accounting procedures, which are found in many countries, contribute to budgetary difficulties. Financial management problems have adversely affected project performance in a number of UNFPA country family planning programs. Although the extent and severity of these problems cannot be determined easily, it is clear that similar conditions are present in many countries.

Financial reports are frequently incomplete or delayed, and there are cases where the data in progress reports, government figures, and the UNFPA budget vary substantially. This may occur because the initial work plans and budget are often not built around clearly specified project objectives and are not related to original goals. Thus, there may be only a limited connection between the work plan and budgeted activities. The general use of the program budget, rather than the detailed line-item budget, exacerbates this problem. Furthermore, certain resources of governments, such as manpower, are often not accounted for in monetary terms. Finally, budget changes made in the course of a project may not be shown in financial reports. Delays in getting approval for budget shifts that go through UNFPA headquarters may also contribute to problems. It is frequently difficult to determine the current financial status of a project and the rate at which its budget is being expended. Because these problems have implications for all aspects of project operations, they should be given attention by UNFPA.

### B. Monitoring

The history of UNFPA's monitoring process reflects the evolution of UNFPA as an agency. When UNFPA was primarily a banker or conduit for funds, there was only a limited management system. As the agency became more involved in programming, formal management procedures were developed, first within the UNDP system. Development of procedures is a long-term process, and it must be remembered that UNFPA is only 12 years old.

Semiannual progress reports are made to UNFPA by executing agencies and national governments in a prescribed format that covers both budgetary and substantive areas. A brief review of progress reports indicated that they are detailed in many cases but are often brief and of limited usefulness.

The main problem is the location of management responsibility in country projects. When executing agencies are used, UNFPA is primarily concerned with longer-term results, and thus assumes an administrative role, leaving monitoring to the executing agencies. Prior to decentralization, WHO took greater responsibility for the central management of country projects in family planning, and there was closer coordination between WHO and UNFPA headquarters. However, WHO staff presently feel that UNFPA often provides inadequate resources to carry out effective monitoring.

Monitoring cannot be performed consistently from headquarters or regional offices, because of the amount of information maintained at the country and local levels. When a UNFPA coordinator or other project adviser is present in a country, the monitoring is usually considered to be effective. However, one coordinator often serves two or more countries, resulting in fragmented attention, workload pressures, and often decreased site visits. In this situation, or where there is no project adviser, resident agency representatives of UNFPA, UNDP, or other participating agencies are generally unable to perform monitoring functions.

### C. Review

The review of UNFPA country projects is carried out using the tripartite review (TPR), the annual country review (ACR), and the final report.

Tripartite reviews are carried out jointly by the staff of the three principal participants in a program--usually UNFPA, WHO or other executing agencies, and the national government. TPRs are designed for use with large and new projects once or more each year. Comprehensive TPR reports are prepared prior to the country mission and are used to establish work plans for the following year. TPRs are considered a much better monitoring device than semiannual reports. They also vary in quality, and it is felt that they are not always used to their fullest potential.

Several problems arise with TPRs. First, because the coordinator is responsible for all country program activities, it is difficult to do all of the detailed work necessary for an effective TPR, especially if the project has had implementation problems. Second, the final TPR report is prepared by those people who are responsible for implementation and, therefore, is likely to be relatively uncritical. Furthermore, the need

for consensus on the final TPR leads to a somewhat homogeneous product. Overall, TPRs are considered to be reasonably effective, and they should be strengthened.

All UNFPA projects in each country are supposed to be reviewed together once a year in the annual country review, which is usually based on the project TPR reports. ACRs are performed at different rates in different regions, and there are many problems in scheduling reviews. In many countries, ACRs are much less effective than TPRs.

Final reports are required for all completed projects. However, few, if any, final reports have been made for family planning programs because national programs are long-term and commonly rephased or reallocated.

Overall, the UNFPA project review system is comprehensively organized and is felt to be reasonably effective when used. The tripartite review process has a strong qualitative component and can indicate problems in implementation. However, strengthening of the system should be encouraged.

## Program Evaluation and Research

### A. The Evaluation Process

UNFPA projects and programs are evaluated by the agency's Evaluation Branch, which is organized separately from the Policy and Program Divisions. Evaluations are conducted as "objective and in-depth analyses of UNFPA-associated programs, projects, or specific problem areas in them"\* in order to meet requirements of accountability for disbursed funds, and to serve as a basis for decisionmaking. Programs are evaluated if they have long-term significance for UNFPA. Large-scale country programs with limited UNFPA input are generally not evaluated. Evaluations are focused on operational performance and the achievement of immediate project objectives. However, emphasis has often been placed only on performance, since information on the achievement of project objectives is often not available. There is no specific evaluation format; therefore, studies are designed according to context and needs.

Evaluations are conducted by persons who have not been involved in the project, including staff or executing agencies which have participated in a project. Because reports are only prepared for use by UNFPA and

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\* UNFPA, "Evaluation of UNFPA Projects," DP/331, April 1976, and DP/493, April 1980.

submission to the Governing Council, they do not require clearance by governments or executing agencies. Findings are submitted to the Governing Council, and recommendations for action may be made. Because of the detail and time required, the studies take an average of one to two years to complete.

The Evaluation Branch has conducted about 30 evaluations since 1972. Most focused on intercountry projects, since the majority of UNFPA activities fell in these categories. In 1977, the Governing Council recommended greater emphasis on evaluation of country projects and programs, and this is reflected in recent studies. Only a small number of family planning projects have been evaluated, including programs in Egypt, Mauritius, and Colombia and aspects of PAHO regional support activities. These findings are discussed below.

It is significant that UNFPA has evaluated family planning programs only during the past five years. Reasons given for this delay include: the need to develop measurable project objectives, since many earlier projects did not have quantified targets; the need to increase experience with implementation and not to evaluate projects in early phases; and a desire not to interfere in country family planning programs because of their political significance. Furthermore, policymakers may have felt that funds should be devoted to action rather than research, particularly when staff were few and demand for evaluations was minimal.

There is, however, growing support for the inclusion of evaluation methods in projects, although resistance has been experienced in some countries. The needs assessment format now has a section on evaluation, and the revised project document instructions require that quantified objectives be included in project requests. This is expected to permit better performance measurement in project reviews and evaluations. The format revision has been in force for two years, and, with encouragement from UNFPA, current requests are more in accordance with these standards.

These developments indicate a trend toward integration of UNFPA program evaluations with project management and review activities. To date, the Evaluation Branch has functioned with relative autonomy and has produced useful studies for agency policymaking. Nevertheless, more frequent examinations of programs, especially as UNFPA becomes more involved in project operations, are needed as resources become more limited and evaluation skills are developed. If studies of project performance and intermediate results were effectively incorporated into monitoring activities, fewer resources would be needed than for full-scale evaluations. Such a program analysis process requires the development of instruments, procedures, and local capabilities for evaluation. Movement in this direction, whether through the Evaluation Branch or separately, should be strongly promoted.

## B. Results of Evaluations

There are several problems, some generic and some specific to family planning, that have a bearing on the assessment of UNFPA program performance.

1. UNFPA resources are rarely the only ones used in country projects, and they are often not the largest. Frequently, services were underway before UNFPA became involved. Assessment of the effects of UNFPA funds within the national effort and the marginal impact on performance is difficult to make. Generally, it is possible to show only that UNFPA assistance helped the government to achieve the outcomes reached. The relatively long time horizon of family planning interventions contributes to the difficulty of balancing costs and outcomes.
2. Programs may not be strictly comparable, in view of the wide range of activities supported by UNFPA. For example, more vertical programs, such as those typically established in urban areas, are different in environment and operations than the more broadly based programs usually offered in rural areas. Furthermore, since the type of family planning activity is determined to a large degree by a country's policy orientation towards population, differences in program design make the balancing of costs and benefits difficult.
3. Measurement of results requires site visits and considerable extrapolation, in the absence of baseline data and reported information on performance. Even where such information is available, sample selection and data collection are difficult, because information is maintained at the regional or local levels rather than at headquarters.
4. Finally, many diverse and unspecific objectives are often established for family planning programs. Targets are frequently ambitious, somewhat arbitrary, and often adjusted during the course of the program.

Considering these problems, the four evaluations of family planning programs that have been conducted by the UNFPA Evaluation Division were well designed and comprehensive. The results are summarized below.

1. The evaluation of Egypt's national family planning program, conducted in 1976-1978, covered 17 individual projects.\* The conclusion was that UNFPA assistance made a significant but limited contribution to the overall program. Problems relating to management and administration were identified. As a result, substantive changes were made in the program's design and administration. The Government of Egypt declined to clear the report for publication.
2. The evaluation of the national family planning program of Mauritius was conducted in 1978-1979.† The mission found that the program was essentially successful in reducing fertility and in bringing a large proportion of women at risk into the program. However, the rate of decline in fertility rates became so slow that it was doubtful whether the government's targets would be achieved.

Approximately 60 percent of couples at risk were participating in the program or obtaining information in the private sector. However, a large portion of the contraceptives was found to be ineffective, as indicated by the high incidence of illegal abortion. The geographical spread of MCH and FP clinics was good, but the two services were not integrated as planned. Information about FP was widespread, although educational programs on MCH, nutrition, and population were not well developed. The report noted that the government had not adjusted social and economic policies to the two-child family implied in its targets. Mauritius had good data from registration, vital statistics, and clinical sources, but data analysis and evaluation surveys were not undertaken.

Some 70 recommendations were made, primarily to the government, on issues that seemed minor, and all were reportedly accepted. Some were incorporated in the new request for UNFPA support.

3. The most detailed evaluation was the study of Colombia's MCH/FP program.‡ Between 1974 and 1980, UNFPA contributed

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\* Ibid.

† UNFPA, Report of Evaluation of UNFPA Assistance to National Family Planning Programme of Mauritius, March 1979.

‡ UNFPA, Evaluation of UNFPA Assistance to Colombia's MCH and Population Dynamics Programme, 1974-78 (Draft), April 1980.

over \$6.5 million, supplementing the Government of Colombia's contributions of nearly \$10 million, for the integration of family planning into the MCH care service of the National Health System. The purpose of the evaluation was to assist UNFPA's appraisal of Colombia's new project proposal for 1980-1983. PAHO had been the executing agency for the program since 1974, and UNFPA was considering direct execution through the Colombian government.

The National Health System was expanding services to rural areas through the development of local hospitals and shifting funds from centralized programs, such as MCH, into regional block grants. The new proposal emphasized medical equipment and health care facilities; contraceptives accounted for the same 20 percent of the budget as before. Serious problems had been experienced in project budgeting, monitoring, and purchasing through PAHO. The lack of a fully approved budget and frequent budget changes, along with an inefficient management information system, led to continual financial difficulties and a loss of control over program components.

The study found that the substantive aspects of the program, including MCH care, the provision of family planning services, and training and education, were performed reasonably well, although little research or evaluation was conducted. Problems common to MCH and family planning programs--lack of supervision, follow-up, coordination between units, geographical equity, and assessment of program coverage--were observed. Overall, the organized family planning program was considered to have contributed to the observed decline in fertility rates, especially in rural areas. It was impossible to determine the impact on maternal and infant morbidity and mortality.

It was recommended that UNFPA increase support and change to direct execution. Operational improvements, including the placement of a UNFPA coordinator, were also suggested. It is not known if the recommendations were accepted.

4. A major study of the PAHO regional program, which provides technical support and manpower training that in part serves the regions' MCH/FP country programs, is described in Chapter 5.

These reports are a useful resource for any further examination of UNFPA family planning programs.

### C. Program Research

UNFPA has not supported extensive research and development in the family planning area. Intercountry programs in all areas have included research functions, particularly at the global level. However, in family planning the preference has been for action programs. Two exceptions are the program of management assistance and the WHO Special Program for Research, Development, and Research Training in Human Reproduction, which has conducted a wide range of research into contraceptives and other activities (see Chapter 5).

It was, unfortunately, beyond the scope of this review to examine family planning research in detail. However, the UNDP Governing Council has recently given priority to increased UNFPA funding of contraceptive-related research. The need is growing for research into family planning programs, especially the cost-effectiveness of alternative methods of service provision. Significant research capabilities exist in developed and developing countries, and it is recommended that UNFPA explore opportunities to expand the base of knowledge relevant to family planning programs.

V. PROJECT EXECUTION BY WHO

## V. PROJECT EXECUTION BY WHO

### Family Planning Strategy

WHO family planning programs, including those executed under UNFPA funding, are conducted through the Family Health Program. Regional offices are responsible for the execution of UNFPA-funded country programs, and the Division of Family Health in Geneva coordinates WHO activities with UNFPA. The Family Health Division provides technical support for country activities through the Maternal and Child Health Care (MCH) Unit. Family health staff use planning and health service delivery that is consistent with the direction of the primary health care (PHC) movement. However, other parts of WHO have a vertical orientation toward disease-targeted programs and technical support.

The WHO strategy for family planning activities is derived from the objectives of the Family Health Program, which are outlined in WHO documents.\* The objectives are:

- promotion of family health, particularly maternal and child health;
- reduction of the incidence of malnutrition and promotion of better nutrition;
- promotion of health education and information, particularly through community involvement;
- promotion of appropriate technologies for family health; and
- promotion of and collaboration on family health research.

Specific program objectives relevant to family planning are:

- improvement of coverage, efficiency, and effectiveness of integrated family health care, in particular, MCH and family planning;

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\* WHO, "Primary Health Care and Family Planning" (Draft), Technical Report Series, No. 600, 1976, December 1980.

- reduction of maternal, perinatal, infant, and childhood mortality and morbidity, and promotion of reproductive health; and
- development of intervention strategies for social action based on their health implications for women, children, and the family.

Family planning is one of the eight elements of primary health care, which is the central priority of WHO activities and is recognized by all countries as the key to reaching the goal of health for all by the year 2000. Of importance to this review is the recognition of family planning as an integral part of MCH care and PHC overall. The interrelationship between family planning and other PHC components is strongly stated in WHO policy statements and documentation. Furthermore, the integration of family planning with MCH care is reinforced by a common target group, a similar orientation to community-based services, and the use of common resources. UNFPA resources are combined with those from WHO's regular budget and other sources to form a PHC program to which family planning is one entry point. Family planning is also a preventive measure, yielding significant health benefits within PHC. Integration also offers advantages for the delivery of family planning because of the legitimacy of the PHC movement with national governments and the availability of follow-up contact and services to family planning clients.

A major factor affecting the strategies and execution of programs is WHO's administrative decentralization. In contrast to UNFPA, decentralization has brought about country programming and budgeting on the regional level, although the Secretariat in Geneva maintains close contact with regional offices. WHO regions are constitutionally separate from the Secretariat, and regional directors are elected by the countries of each region. The regional office for the Americas, PAHO, is more independent because it was functioning before WHO was established. PAHO is also unique because it has funding other than that provided through WHO.

Like UNFPA, decisions concerning WHO are made by the World Health Assembly, which consists of all WHO member states, and by the smaller Executive Board. These bodies together with the regional offices and the Secretariat make up WHO. Because the World Health Assembly represents national health ministries, WHO policies have often reflected a "medicalized" health focus. However, this orientation has shifted markedly toward primary health care and related priorities in recent years.

Several differences from UNFPA family planning strategies are perceived within WHO.

- WHO maintains that it emphasizes the broader aspects of family care, including lifestyle and continuity of services.
- WHO staff feel that their programs have moved more quickly to train local workers in order to decrease the use of international personnel.
- WHO claims to have focused more directly on women's participation in health and family planning services and women's social status in the design of programs.

These views are similar to those of many UNFPA staff members and follow trends in UNFPA priorities. Similarities in family planning strategy include: increasing emphasis on the use of NGOs and community groups, such as women's unions; expansion of MCH services to include adolescents and problems of adolescent pregnancy; concern with abortion, particularly the high mortality rates associated with illegal abortions; and the development of complementary services integrating family planning with other aspects of MCH care.

Nevertheless, the health care orientation of WHO, particularly regional offices, is often considered by UNFPA and USAID to be conservative in regard to the emphasis on health services, due to the ties between WHO and national ministries of health. More strongly, USAID staff feel that PAHO personnel in the Comprehensive Health Care Division are traditionalists who operate in a medical-oriented environment and continue to see population as a uniformly sensitive issue. Other WHO regional offices, including Africa and Southeast Asia, are also seen as dominated by doctors who have a curative medical orientation and a limited understanding of population policy and the health rationale for family planning. However, PAHO staff feel that their agency has promoted family planning for a long time, with governments setting the pace and PAHO suggesting new strategies. "PAHO is in the business of health," and in this perspective, family planning is viewed as one component of health services whose overall content cannot be centrally decided.

It has been speculated, particularly within USAID, that without UNFPA funds there would be substantially less family planning in WHO-supported primary health care activities. However, the priority of family planning and other PHC components is based on national priorities and technical justifications, rather than on funding sources. The real point of concern is the intensity with which the WHO offices promote family planning. The WHO regions have been criticized on this, although criticisms may be overstated. In general, it is difficult to evaluate these claims.

### Executing Agency Role

The Family Health Program of WHO receives UNFPA allocations for family planning programs at the country, regional, interregional, and global levels. Nearly all of the UNFPA funds for country family planning projects are administered through the Maternal and Child Health Care Unit and are allocated to the regional offices for project activities. Geneva staff serve primarily in a technical capacity.

In 1980-1981, 91 percent of the \$144 million funds for the Family Health Division and 94 percent of the \$78 million funds were from sources other than the regular WHO budget,\* including UNFPA allocations. Total UNFPA funds of some \$51 million for all programs made up 35 percent of the Family Health Program budget. Approximately \$40 million of the UNFPA funds to WHO were allocated to family planning programs in 1980-1981. This represents 53 percent of the total MCH Unit budget and 29 percent of the Family Health Program total. The contribution made by UNFPA to WHO's MCH programs is, thus, substantial.

Table 10 shows the distribution of UNFPA funds to WHO by program type for the years 1974-1980. Total UNFPA expenditures through WHO rose from \$12 million in 1974 to \$17 million in 1979 and \$19.5 million in 1980. The share of funds for country projects has increased from under 50 percent in 1974 to approximately 70 percent, which has been maintained since 1976 with a slight growth to nearly 80 percent in 1979. The share to regional projects has declined slightly, but remains in the 10 to 15 percent range. Interregional and global programs were 40 percent of the total WHO budget in 1974, but have declined to 10 percent in 1980, which partially reflects a redesignation of UNFPA funding to WHO.

WHO received nearly \$24 million from UNFPA in 1980, an amount substantially greater than actual expenditures in this and preceding years. Expenditures have been in the range of 70 to 80 percent of allocated amounts due to several factors, including budget reallocations and the limited absorptive capacities encountered in many country projects.

The principal functions performed by all WHO levels are coordination and technical cooperation. Intercountry activities are examined more fully in other portions of the UNFPA review. Briefly, WHO contributes to UNFPA intercountry family planning activities in several major ways.

First, WHO headquarters and regional staff provide technical support for UNFPA programming and project formulation through participation in needs assessment missions and consultant arrangements for the design of

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\* WHO, Proposed Programme Budget for the Financial Period 1982-83, Geneva, 1980.

Table 10

UNFPA FUNDING TO WHO FAMILY HEALTH PROGRAMS,\*  
1974-1980 (SELECTED YEARS)  
(\$000 and Percent of Total)

<u>UNFPA Funds</u>	<u>1974</u>	<u>1976</u>	<u>1978</u>	<u>1979</u>	<u>1979**</u>	<u>1980</u>
Country Projects	\$ 5,426 (45.7%)	\$ 7,504 (64.9%)	\$ 9,967 (70.0%)	\$11,759 (67.7%)	\$11,296 (77.2%)	\$13,408 (68.9%)
Regional Projects	1,801 (15.2%)	1,779 (15.4%)	1,678 (11.8%)	1,849 (10.6%)	1,604 (11.0%)	2,533 (13.0%)
Interregional and Global Projects	4,652 (36.2%)	2,279 (19.7%)	2,593 (18.2%)	3,756 (21.6%)	1,740 (11.9%)	3,527 (18.1%)
TOTAL	<u>\$11,880</u>	<u>\$11,562</u>	<u>\$14,238</u>	<u>\$17,363</u>	<u>\$14,638</u>	<u>\$19,468</u>
Expenditures as Percentage of Allocations for***						
UNFPA Country Projects			70.0%	78.0%		57.0%
TOTAL, UNFPA			74.0%	81.0%		63.0%

\* Actual expenditures (not including Special Program HRP).

\*\* FP/MCH.

\*\*\* Data not available for 1974, 1976, and 1979 (FP/MCH).

Note: Components may not add to totals because of rounding.

Source: WHO program data, 1981.

Figures may differ from those taken from UNFPA sources.

country programs. WHO staff act in a private capacity, rather than as representatives of WHO.

Second, WHO participates in UNFPA-sponsored training for country personnel in planning and programming at the headquarters, regional, and national levels.

Third, WHO has developed a number of management techniques for country programs, including a risk method for service targeting. This approach uses a set of identified risk factors for mothers and children to screen populations and determine appropriate health care and referral paths. Although it is being tested in a number of countries, it is still highly conceptual, and its effectiveness or applicability to family planning programs cannot be determined yet.

In addition, the WHO Special Program for Research, Development, and Research Training in Human Reproduction (HRP) receives significant support from UNFPA. The Special Program conducts research in areas relevant to family planning, particularly contraceptive development. There is also a small program of service research in family planning, including a study of the management of an integrated health and family planning service in Sri Lanka.

The Sri Lanka study is an evaluation of the impact of two family planning and health care components on the quality and coverage of family planning care. A management component dealing with supervision and evaluation and a curative component are provided individually and in combination in separate areas in the north and south of Sri Lanka. There is a control area in each region. Data are also being collected on the pattern of contraceptive use, MCH service utilization, and contraceptive acceptance and continuity by using surveys, service records, and on-site assessment. Results of the study are not yet available.

For UNFPA country projects, WHO acts as the executing agency through its regional offices upon the request of the government. The relationship between WHO and national governments varies widely, and the role played by the WHO country adviser and other staff members is sometimes quite strong. WHO may be selected as the executing agency on the basis of these ties or on purely technical grounds. No general rule applies because of the diversity of relationships between WHO and health ministries.

When executing country family planning programs for UNFPA, WHO performs most of the following functions:\*

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\* UNFPA, "Background Paper for UNFPA Evaluation of PAHO's Regional Program" (Draft), 1980.

- coordination of technical and financial matters between the host government and UNFPA;
- provision of required reports to UNFPA;
- administration and management of selected project budget items, usually transportation and the purchase of equipment and supplies;
- audit of expenditures of UNFPA funds;
- review of the substantive and financial progress reports submitted by the host government;
- provision of assistance to the government to develop and prepare project proposals; and
- coordination with the government to process requests for technical support.

The scope and depth of these activities vary widely among projects and regions. However, it was not possible to make a more precise evaluation because only one regional office (PAHO) could be visited for this review.

Resident WHO program coordinators are generally not involved in UNFPA program operations, but are available in an administrative and advisory capacity. Frequently, other responsibilities keep coordinators from participating. WHO maintains a small staff attached to its country program or major country projects. In addition, there is a technical support staff for MCH in each of the WHO regional offices and in most country offices.

WHO promotes the evaluation of family planning programs and has developed various techniques in this area. However, no significant evaluations of UNFPA programs have been conducted.

### Performance

Discussion of the execution of UNFPA family planning programs usually focuses on the activities of WHO and its regional offices. WHO's principal objective regarding UNFPA support in many countries is the development of an infrastructure through regional and global projects, and performance in these areas is generally satisfactory. However, because of WHO's decentralization and differences in agency orientation, full coordination or agreement is not always obtained between WHO and UNFPA at the country level. Since WHO coordinates many UNFPA projects with host governments,

this link is critical for UNFPA's knowledge of project operations. A possible lack of responsiveness on the part of executing agency personnel could be a potential bottleneck in project management. Coordination between the technical staffs of the two agencies appears to be good at the central level.

The major problem with WHO that was cited is the varying resources at different levels between center, regions, and countries with limited continuity or coordination between them. Furthermore, the quality of WHO's regional office staff was described as uneven, by sources within as well as outside WHO.

Political considerations are clearly an important aspect of WHO's effectiveness in family planning. Because WHO and PAHO country advisers are close to government health ministries, they may be reluctant to become involved in conflicts about planning and project operations in family planning. Thus, although WHO, and particularly PAHO, exercises little leverage in promoting family planning, from an organizational perspective, there may be valid reasons.

There has been substantial criticism, to some extent surprising, of PAHO's operating methods, technical capacity, and technical support performance. UNFPA is presently evaluating PAHO's regional program, which provides technical support and manpower training in part for the region's UNFPA family planning programs. The evaluation is concerned with the effectiveness of PAHO in its role as an executing agency; the contributions of regional activities to country projects; and policy and program processes and performance in individual areas of family planning. A preliminary report has been prepared and the project is expected to be completed shortly.

In general, the implementation of family planning programs by WHO and other international agencies may be assessed positively. However, there may be valid criticism that the influence of WHO on UNFPA programming has often been excessive, and perhaps constraining, on the promotion of family planning services. However, the movement toward primary health care within WHO and other U.N. agencies indicates a growing consensus about the approach to family planning. A more detailed examination of relationships in the international system will be necessary for a resolution of these issues.

VI. THE UNFPA AND USAID: HOW THE PROGRAMS COMPARE

## VI. THE UNFPA AND USAID: HOW THE PROGRAMS COMPARE

### Family Planning Programs

#### A. Objectives

The basic mandate of USAID family planning activities includes the following points:\*

- Effective family planning depends on economic and social change and on the delivery of services.
- Assistance for voluntary population planning in developing countries includes family planning information and services, demographic research, and activities to encourage small families.
- Motivation for small families is to be supported by all related development programs funded by USAID, including education, nutrition, health care, agricultural and rural development, and assistance to urban areas.
- Population planning programs are to be coordinated with programs to reduce infant mortality rates, improve nutrition for pregnant women and children, and raise the standard of living for the poor.
- Assistance is to emphasize low-cost, integrated delivery systems for health, nutrition, and family planning, utilizing a wide range of methods for delivery and community outreach.
- No assistance funds are to be used to motivate, coerce, or pay for abortions or involuntary sterilization as a means of family planning.

Thus, the family planning objectives of USAID and UNFPA are highly congruent, which may not be widely recognized.

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\* U.S. Congress, Foreign Assistance Act of 1961, as Amended, Section 104.

## B. Strategies

Generally, it is felt in both UNFPA and USAID that governments accept most approaches to family planning and that there is an unmet demand for family planning in many countries. Both agencies also recognized that where a country has few MCH or other health services, it is often necessary to fund the development of those services before initiating family planning activities. Where health services have had a higher priority in national development, legitimacy and institutional capacity has been developed. However, the acceptability of fertility reduction has remained a real issue. Ministries of health and other host government agencies have often resisted the introduction of family planning services for this purpose. Of course, there have been many exceptions, and, therefore, it is not always necessary to wait for the development of health services before family planning is provided.

Differences between UNFPA and AID clearly reflect historical interpretation of these issues, particularly regarding national sensitivities to population issues and the availability of entry points for family planning services. AID has been noted for promoting vertical, contraceptive-based programs, while UNFPA has concentrated on health care programs. Differences have diminished in most regions. However, in Latin America, USAID still supports vertical family planning programs on the premise that this approach is desired and that reduction in fertility can be made and sustained. UNFPA and its executing agency, PAHO, have favored a slower approach and an integrated program design. Underlying this is the perception that health and population activities are linked by the acceptability of family planning and in the overall development process.

Many organizations have studied the relative effectiveness of alternative delivery systems for family planning. In some cases, MCH care has proven to be a worthwhile and even necessary adjunct to population activities, although there is no conclusive evidence. Regional variation is pronounced. There is a pragmatic attitude among many USAID staff that they will "endorse anything that works," which takes issue with ideological proponents of both the MCH and the vertical approach to family planning. It is felt that the MCH approach may be a guide in some cases and an "easy way out" of difficult policy and program decisions in others.

Both agencies recognize that if donors are to get out of the "subsidy business," programs will have to phase out external assistance and become self-sufficient. In USAID it is felt that the large amount of continuing budgetary support provided to ministries of health by UNFPA has hindered or undercut certain AID efforts directed at more intensive family planning services; for example, when large amounts of funds are provided by UNFPA under different objectives. UNFPA notes that determination of the use of funds by national governments is both a constraint and a strength and therefore must be based on rapport with governments. Because of this

orientation, UNFPA may be in a better position to ameliorate political resistance to family planning, but it may also sacrifice institutional initiative and leadership. It was felt within UNFPA and WHO that USAID may be insensitive to national attitudes in areas such as family planning and that the agency does not tend to collaborate but rather to impose excessively on local conditions. Some AID staff, in contrast, view the "suggestion" role positively.

The funding strategies of USAID and UNFPA may be viewed in light of each agency's advantages as a donor. Where the U.S. Government has no bilateral aid relationships, AID cannot contribute to population programs directly but must work through intermediaries or rely on multilateral assistance. In other countries where there is resistance to bilateral funding, a multilateral approach to family planning support is a possible alternative.

In regard to operating strategies, USAID is perhaps freer than UNFPA to use private organizations and agencies as intermediaries. These organizations are especially useful in providing services such as community-based distribution of contraceptives and in promoting private sector approaches to family planning. NGOs have also been useful in places where these agencies already exist. They have allowed the development of experimental and pilot projects for introducing family planning services that might not have been allowed in government agency programs.

Over the past two decades, a number of private programs supported by AID have made significant achievements and have been accepted by some initially resistant governments. It should be mentioned that UNFPA strongly recognizes the importance of working through voluntary agencies and nongovernmental organizations. These projects tend to be less visible than those funded through governments, but UNFPA has supported this mode of operation from the beginning.

Finally, the USAID funding mechanism has a major bearing on the difference between the family planning strategies of the two agencies. This difference is especially perceived by UNFPA. The U.S. contribution to UNFPA is provided through the AID Office of Population and is often considered to be population money. This is in contrast to U.S. assistance for health programs, which is funded under a different line item. This separation has helped create the feeling that UNFPA support of MCH components in family planning programs is an illegitimate leakage of population-mandated monies. In view of the U.S. Government's official support of integrated family planning programs in its bilateral assistance, as well as in UNFPA programs (as reflected in participation in the development of the recent Governing Council priorities), any clarification of this point will be extremely useful.

USAID Staff Assessment of UNFPA Performance

A. Headquarters

A majority of the AID/Washington staff felt that UNFPA's performance is satisfactory. In Asia, regional staff are generally comfortable with UNFPA family planning activities, which are primarily vertical with little assistance to basic health practices. It is felt that USAID aims are well supported by UNFPA, and caution is urged regarding criticism of UNFPA that could impair the credibility of population programs with the U.S. Congress and reduce donor agency influence with host governments. Staff are uncertain about the degree to which donor programs have influenced fertility rates.

AID could not assume all of UNFPA's responsibility in Asia. In Africa, the demand for family planning service was felt to be real, but governments may be hesitant to support programs. It was also felt that UNFPA and USAID did not sufficiently promote family planning. This may partly be due to attitudes in field offices and to the strength of responses to previously aggressive family planning campaigns. Differences between and within countries were said to make generalizations very imprecise.

In the Near East Bureau, there is a greater feeling that UNFPA's support of family planning is too limited and that, with the exception of a few country programs, there is little emphasis on family planning. For example, in Jordan, which is counted as a success story, it is felt that only a small portion of UNFPA assistance actually goes to family planning. Although the number of MCH clinics has exceeded expectations, few have medical staff trained to insert intrauterine devices. UNFPA is the sole donor agency in Turkey and, therefore, might play a stronger role than it has. It was felt that UNFPA programs have achieved substantial legitimacy with governments, but at a high admission price.

Within the Latin America and Caribbean Bureau, there is an attitude that UNFPA programs are misdirected and inappropriate, with little if any impact on achievement of family planning goals. It is felt that UNFPA relies too heavily on PAHO and inefficient government services and does not pursue the use of NGOs and community groups for project execution. In an extreme viewpoint, it was stated that USAID objectives might be furthered if UNFPA assistance were decreased, especially if those funds became available to USAID.

Regarding UNFPA's coordination with USAID, good relations are reported by most AID headquarters staff, but contact is often infrequent at both the headquarters and country level. Similar comments were made by

UNFPA staff as well. In the Near East and Asia regions, a long record of communication and mutual support is noted. In other regions, ground-level communication is said to be more uneven. AID takes a large share of the responsibility for poor communications. The limited number of population officers in AID missions is a major problem. As a result, coordination often occurs only in project development and less frequently during implementation.

Even in project development, limited communication is evident. For example, some AID staff felt that the needs assessment is often inadequate and fails to consider the overall effects of population programs. It seems likely, however, that AID is not fully aware of the scope of the needs assessments. At other points in AID, UNFPA's project development process is considered to be at least as effective as the AID process.

## B. Missions

The U.S. Government survey of the views of overseas missions regarding UNFPA, which was conducted as a separate part of this USAID review, includes detailed assessments of UNFPA family planning program operations and effectiveness at the country level. Regional responses on family planning activities are summarized below.

In the Asia Region, family planning is considered to be central to nearly all national population strategies, with a high priority attached to fertility reduction. Most countries, including those with freestanding programs, favor the integration of family planning into health services. A large portion of UNFPA funds is felt to be used for non-family planning services, although this record varies. UNFPA's provision of contraceptives, with Depo Provera often used, is felt to be effective and important. Moderate but declining shares of UNFPA funds are used for local salaries. Overall, UNFPA programs are considered to be quite effective, particularly in countries where UNFPA is the principal or only donor. Training is also an important element of UNFPA programs. UNFPA and USAID programs are generally interdependent, and USAID projects often rely upon UNFPA contraceptives.

By contrast, in Africa family planning is given a lower priority by governments. There are relatively few family planning services provided, except in certain countries, and UNFPA assistance is not large. All governments require or favor integration of family planning into health ministry operations. Although it is difficult to separate UNFPA expenditures for MCH and family planning, it is estimated that 50 to 90 percent are used for health services not related to family planning. The provision of contraceptives by UNFPA, including Depo Provera, is important in some countries, although distribution procedures and efficiency vary. Support for local salaries is also not large. Training is considered to be of

relatively high importance but of only moderate effectiveness. The connection between USAID and UNFPA programs is limited. U.S. support for family planning is also not strong, but there are some complementarities with some parts of UNFPA programs. Greater attention is being given to family planning by countries in Africa, and services are continuing to be integrated into health services.

The Near East Region reported family planning as a generally low priority, and many countries have no population policy. Most countries require integration of family planning into health services, and the largest share of UNFPA funds in those countries are used to support health care. Exceptions are, for example, Egypt and Turkey, which have strong family planning programs. Contraceptives and local salary support are moderately important parts of UNFPA assistance. Training is felt to be important, but only moderately effective. In some countries there is close coordination between USAID and UNFPA programs, but there are few interagency linkages.

Assessments of the Latin America and Caribbean Region varied widely, including some strongly negative responses to UNFPA programs. Family planning is considered important by many governments, and while a number of countries have no explicit policy, they often support family planning programs. There is some political sensitivity to but often a high demand for family planning services. Most countries favor or require integration of family planning services with health care, but there are also many government-sponsored vertical programs. Health services receive 50 to 80 percent of UNFPA family planning funds. UNFPA's provision of contraceptives is important, particularly the supply of Depo Provera, although there are availability and distribution problems. Support of local salaries is generally not significant and is diminishing. Training is effective where it is adequately funded. In countries where family planning is a central concern, UNFPA is considered to be important but too limited in its support. There is relatively little coordination between UNFPA and USAID, except where USAID programs use contraceptives and other supplies provided by UNFPA. Generally, the performance of UNFPA and PAHO is considered to be ineffective in terms of resources, design, and focus. An exception is Mexico, which has an apparently successful UNFPA-assisted program that functions well. U.S. Government field staff recommended that UNFPA expand and retarget its resources in Latin America and make greater use of NGOs and less use of government services in its family planning programs.

In general, field mission responses parallel the assessments of UNFPA performance made by USAID headquarters staff. However, the survey used for headquarters staff covered a wider range of information and perspectives. The results of the survey should provide a useful base of information for many purposes.

## The Integrated Approach of UNFPA Programs

UNFPA supports an integrated approach to family planning and MCH programs, because it is used by most governments and thus seems to have the greatest likelihood of acceptability, effectiveness, and long-term viability. Despite evidence of change, differences between some USAID and UNFPA staff members concerning the appropriate content (integrated vs. vertical) of family planning may be expected to remain.

Neither UNFPA staff nor WHO staff were prepared to estimate the relative proportions of family planning and MCH activities in their programs. They felt that any attempt to compartmentalize costs would be meaningless, in view of the holistic nature of service delivery and the unreliability of available statistics. However, clarification of the points presented below would be beneficial:

- the specific definitions of MCH and family planning services;
- the distinction between components of family planning programs, including MCH services, and identification of them in UNFPA work plan categories;
- the respective roles of UNFPA funds and other donor inputs in multiple-donor projects for integrated services;
- evidence regarding the marginal contribution to family planning made by comparable inputs in different country settings; and
- examination of qualitative aspects of program performance in terms of institutional and operational dimensions.

UNFPA projects are usually only one part of national family planning efforts. Inputs from other donor agencies, as well as from governments, must be taken into account in assessing the content of UNFPA family planning programs. Furthermore, UNFPA regional and interregional programs often support country projects through training, advisory services, and management assistance.

Finally, the relationship of UNFPA to its host governments and to the U.N. system explains much of the perceived ambiguity in its family planning programs. Governing bodies of UNFPA, UNDP, WHO/PAHO, and recipient countries are all involved in policy decisions concerning family

planning strategies. There is, naturally, more coherence in the design of bilateral programs. In this context, the issue of the UNFPA "effort" in family planning has several sides. It is generally felt that a wider scope for action exists in family planning than is currently realized in the areas of information and policy development, as well as in services. Some non-UNFPA observers feel that UNFPA is too timid, that it does not actively promote family planning services at either the central or field levels, and that a high priority is not given to family planning components of programs. UNFPA readily admits that the organization does not seek to change national policies, but rather takes an incremental approach. On the other hand, this position may be viewed as avoidance when the issue of promotion is raised.

Relationships between family planning and MCH must be developed in light of the conditions and attitudes of individual countries in order for programs to be successful. In Latin America, fertility reduction has not usually been a national priority. The rationale for family planning programs has, thus, centered on health care and integration with MCH services. In Asia, there is currently a movement toward integration of family planning into the existing health infrastructure, which is in part a maturation of some vertical programs. This may lower the visibility of family planning services within MCH, due to the smaller proportion of family planning activities within health services. Countries in the Middle East and North Africa generally only accept family planning on health grounds, and major program emphases tend to be on expanding the coverage and scope of preventive MCH care. In some of these countries, such as Jordan, there has been unexpected growth of the MCH clinic system, as well as evidence of widespread knowledge of the link between family planning and health levels. In Africa, there is a consensus that little family planning is done by any organization, including UNFPA and USAID. Most population assistance continues to be devoted to MCH service development and demographic work.

Nevertheless, a central policy question remains concerning the best path for increasing the scope of family planning services internationally. UNFPA tends to promote a combined approach, on the principle that all investment in programs indirectly supports family planning, through the expansion of health service coverage. Furthermore, intersectorial support of local infrastructure, policy initiatives, education, and research are considered to fall within the UNFPA mandate for family planning. Current trends toward the integration of family planning programs are likely to increase demands made on the resources of UNFPA, as well as those of USAID and other donor agencies. An interagency examination of these trends and their implications for the various organizations in the population community is recommended to facilitate the development and allocation of family planning resources in the 1980s.

## VII. CONCLUSIONS AND RECOMMENDATIONS

## VII. CONCLUSIONS AND RECOMMENDATIONS

This report has identified follow-up actions and areas needing further attention by UNFPA and by other interested parties, including USAID. However, the formulation of detailed recommendations is difficult, because of the complexity of the issues, the breadth of the subject matter, and the limitations of this review. General recommendations are divided into two groups: the first relating to UNFPA as an organization and the second concerning UNFPA's family planning activities.

### Organizational Issues

#### A. Institutional Identity

UNFPA was initiated as a trust fund, but has gradually assumed functions similar to those of a specialized agency in the U.N. system. This evolution should be fostered, since it responds to the needs of both national governments and the international community. In the long run, the impact of UNFPA can and should be more than that of a transferrer of resources. To facilitate this, UNFPA should use more qualified and experienced staff, exert greater leadership in the population field internationally, and develop further cooperative arrangements for the pursuit of UNFPA goals in the U.N. system.

#### B. Financing

Contributions to UNFPA are growing more slowly than in the past and, in view of the economic climate, are not likely to increase substantially over the next decade. The process of annual pledges from donor countries needs to be shifted to a multiyear commitment of funds in order to assure stability and permit effective program planning. At the same time, UNFPA should provide donors and the UNDP Governing Council with concrete plans for ensuring the effective utilization of available population resources.

#### C. Relationship with Donors and Recipients

There are at present few mechanisms to improve communication between agencies, such as UNFPA, and their recipient governments. The need in this area is clear, however, particularly with respect to donor

countries. Activities and perceptions of all countries must be better understood internationally. Problems that arise necessarily impact on UNFPA, because it is a common instrument of donors and recipients and must, therefore, maintain a balance among diverse viewpoints. Formal or informal arrangements, other than the Governing Council, should be considered to perform such a role.

In addition, UNFPA and its governing bodies should develop a process for the long-term evaluation of UNFPA's goals, strategies, and activities, perhaps over a ten-year cycle. Such a review would promote accountability to donor and recipient countries and would provide a basis for self-assessment.

#### D. Organizational Structure

UNFPA's organizational arrangements may not be the most efficient for carrying out its increasingly operational role. Alternative arrangements should be considered, such as decentralization of program responsibilities to the national level, perhaps through a shift to a regional system. This would require strengthening of UNFPA's professional staff both at headquarters and in the field.

### Family Planning Programs

#### A. Integrated Program Strategy

The large number of UNFPA-supported family planning activities in which services are associated with health care programs seems well justified in light of UNFPA's goals and objectives in this area. Integrated program design is consistent with the broad health rationale for family planning and with the approaches desired by most national governments. Although the criticism that health-related assistance is a leakage of population-designated resources also seems to be valid, it should be remembered that neither UNFPA nor many of its recipient governments consider this inappropriate. Attention to integrated programs is likely to increase, and it will be necessary to adopt new criteria for assessing the efficiency and effectiveness of the use of UNFPA funds. The criteria should concern, at minimum, the relative priority of family planning services in the total program and the contribution made by UNFPA resources to family planning outcomes in the context of the individual country. A review of the integrated approach is suggested as a way for UNFPA and its donors and recipients to expand their consensus on this approach and to determine its implications for future assistance.

## B. Executing Arrangements

UNFPA conducts its family planning activities through a wide range of arrangements, including extensive use of WHO and other U.N. specialized agencies. These arrangements necessarily reflect the disciplinary biases and bureaucratic procedures of the agencies employed, which may excessively influence UNFPA's own decisionmaking. However, as the technical capacity and program participation of UNFPA and its host governments grow, these problems will diminish. On the other hand, this approach capitalizes on the strengths of the agencies involved and on the family planning-health care linkage.

As UNFPA has recognized, the use of governmental agencies and non-governmental organizations provide many opportunities for effective program execution, although these arrangements may encounter constraints related to political support and administrative capability. Again, it is necessary to evaluate the advantages and disadvantages of alternative methods of executing programs in particular settings. A systematic review would be an important element in determining long-term strategies for UNFPA's family planning support.

## C. Cost Burden

Because the expansion of family planning programs has placed a large cost burden on governments and donor agencies and because the demand for services will continue to exceed available resources, financing problems will continue to be critical in the foreseeable future. Donor agencies, including UNFPA, are avoiding commitments to large-scale national programs and are reducing recurrent expenses for such items as staff and equipment. UNFPA has played a major role in encouraging governments to assume responsibility for recurrent budgets. Together with donors and recipients, however, UNFPA should consider other ways, including incentives, to transfer the cost burden. Methods must also be developed to ensure that recurring commitments do not exceed the financial capacity of governments and donors.

## D. Contraception

The growth of family planning services has led to the realization that none of the available contraceptive methods optimally meets current needs and that demand will not slacken. UNFPA has supported research and development on contraception, and at the recent Governing Council meetings it was directed to expand this effort. However, UNFPA and other agencies in the family planning field still need to develop a global plan

for the production, distribution, and use of contraceptives, emphasizing the self-reliance of individual countries or regions. This project is beyond the scope of any single agency or country, and leadership would be an appropriate function for UNFPA.

#### E. Program Management

The weakest element of UNFPA's family planning support is the relative lack of continuity and effectiveness of program monitoring, review, and evaluation. This problem, which is common to most development programs and agencies, has been given attention by UNFPA, and improved project guidelines should lead to more effective management. However, the problems that remain will require specific efforts to remedy. Regular project monitoring must be more thorough, and financial management procedures, in particular, need to be strengthened. The recommendations from project reviews need to be better translated into action plans. Finally, consideration should be given to developing more flexible evaluation procedures in order to permit coordination with review activities and to allow a wide range of projects to be evaluated. An independent assessment of UNFPA's management procedures could be helpful in this area. UNFPA's knowledge of its program activities, as well as its management control, would also be improved by the use of a classification system which more accurately identifies program areas and functions, especially in family planning. Such a system could cross-classify projects with objectives that fall into more than one major area and could also offer a more useful categorization of the range of family planning activities.

#### F. Development of Knowledge

Operational research in family planning is not a strong part of program activities. Experience over the past two decades has shown that research, while typically well-organized and reported, is often not relevant to program concerns or applied to specific problems. This has led to the present climate of concern about the support of research, but antagonism toward large-scale research projects. However, large resources are being invested in national programs that are somewhat experimental and risky without any background or record of evaluation to indicate likely returns. The promotion of research internationally through the sharing of knowledge and the formation of expert groups has not been widely effective in generating new knowledge. UNFPA, along with other agencies, should reassess its strategy for policy and operational research in order to identify needs and to develop new methods of obtaining and organizing the knowledge necessary to improve the efficiency of family planning programs.

Overall, this review indicates that UNFPA is meeting its objectives and is carrying out its program activities adequately in all areas, including family planning. UNFPA has completed two phases of its growth: first, establishing its legitimacy in the field of population by collecting voluntary contributions and disbursing them to country and inter-country programs; and second, evolving into an operating organization with specialized functions by building the staff and resources for the technical support and coordination of population activities. Family planning assistance, which has been increasingly integrated with health care services, has emerged as a central element of UNFPA's assistance pattern during this second phase. The direction and implications of this trend must be examined further by UNFPA and its donors, recipients, and executing agencies. The principal needs for the future are to improve the efficiency and effectiveness of resource utilization, to find innovative ways to conduct activities, and to consolidate its position of leadership in the population field.

## APPENDICES

Appendix A  
LIST OF CONTACTS

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Appendix B

LIST OF DOCUMENTS REVIEWED

## Appendix B

### LIST OF DOCUMENTS REVIEWED

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