TRAINING MATERIAL

CASE STUDY 12

POPULATION AND RURAL HEALTH IN AN AFRICAN CONTEXT

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1981
POPULATION AND RURAL HEALTH
IN AN AFRICAN CONTEXT

This project is currently undergoing audit by the Bank, thus every reference to the actual country has been deleted. The main body of the case is very close to the final audit report on the project. It is the first project to attempt to use the conceptual framework for audit purposes. Although not a rural development project per se, it adequately demonstrates the organizational problems encountered in the newer style projects. However, because the project is still under audit, the material from the case cannot be used outside of the seminar context.
POPULATION AND RURAL HEALTH
IN AN AFRICAN CONTEXT

I. PROJECT SUMMARY

From late 1969 to 1973, the Bank helped in negotiations with the government of the country and seven international donors to develop a program for family planning that would be integrated with maternal and child health care. The goals of the program were to reduce the population growth rate from 3.3 to 3% and improve the health of mothers and children. The strategy developed was to reduce what was perceived as the principal constraint, lack of trained paramedical staff. The specific components of the plan called for a) the introduction of full time Maternal Child Health and Family Planning (MCH/FP) services in over 400 government health facilities, b) an extension of those services through the use of 17 mobile teams to some 190 facilities without staff trained in FP, c) the establishment of eight Enrolled Community (ECN) training schools and 30 associated rural health centers, d) training and a new class of supervisors for 600 ECN's, e) introduction and training of a new class of Field workers (FHFES) and their supervisors, f) provision of increased capacity within the Ministry of Health (MOH) to produce education materials, g) the establishment of an organizational unit to plan and support the activities of the MCH/FP program, the National Family Welfare Center (NFWC).

The total cost of the plan was estimated at $38.8m. It was to be financed in part (32%) by the Government and in part by seven donors: IDA, UNFPA, SIDA, USAID, DANIDA, The Federal Republic of Germany, and ODA. The IDA credit of $12m financed mainly the physical infrastructure.

In general, the quantitative targets of the program were achieved. By the end of 1979, 90% of the service delivery points had been established. The mobile teams were

1Adapted from an actual project. Not for use or distribution outside the seminar.
severely delayed in operation and not deployed till 1978. The target for nurse training was increased from 600 to 1,000 and 950 actually received the FP training, but problems of placement where their training could be utilized were experienced.

Major problems were experienced in providing organizational support and integration of family planning activities with MCH activities. The NFWC was never provided with the full complement of staff required to fulfill its function. Though FHPE's were trained in sufficient numbers 750 versus a planned 800, they were inadequately supervised and supported, and their performance was poor relative to the provision of MCH services. A new building provided for Health Education activities was completed by mid-1977 but not occupied till late 1979. The Information and Education activities of the NFWC were not well managed. The planned resources were merged with those of the HEU and diverted to more general purposes. Some progress was made in I & E activities in 1979.

Evaluation and Research provided some useful statistics and reports but failed to provide the monitoring and evaluation function necessary for management and redesign of the program. The establishment of the Population and Research Center at the National University to provide demographic research in support of the program did not achieve its objectives and had little impact on implementation of the project.

The primary objective of the project, was not achieved. The population growth rate rose to a starting 3.9% rather than declining to the 3.0% hoped for. The number of acceptors of family planning services was 310,000 as opposed to the revised goal of 450,000 which had already been reduced from 600,000. The project was not designed in a way that adequate information was available to explain the short falls, thus valuable opportunities for learning were lost. The MCH component performed much more satisfactorily. Between 65-75% of pregnant women were being reached by the program by the end of 1979. The success of the program, however, was inhibited by bottlenecks in training due to: the take over of a nurses dormitory by medical students; limiting the number of training opportunities; the failure of the drug supply system to keep facilities stocked; and the diversion of transportation to more general services. (See Appendix I and II for more details)
II. COMMITMENT TO PROJECT PURPOSES

An evaluation of the successes and failures of the First Population Project requires an interpretation of the relative weight given to its two major components, MCH and FP. From initial conception of the project through preparation, appraisal and implementation, the major stakeholders (the donors, MOF & P, MOH, NGO's, Provincial and District staff, politicians, and the intended beneficiaries) held different levels of commitment to the two parts. A successful process of design required that the differing levels of commitment be understood and accurately perceived by each of the stakeholders and a means found that would satisfy the proposed stake each had in the project outcomes. The problems of design and implementation can be traced to the appropriateness of the fit between project strategy and structure and the relative commitment of the stakeholders to the two major components.

In October 1967, the GO\textsuperscript{2} demonstrated its relative commitment to family planning by disbanding the interministerial Family Planning Council and delegating control of the nation's family planning effort to the MOH. At that time the primary commitment to family planning came from the private sector. The LFPA's commitment was such that the government could not compete in hiring the best qualified Africans to run its programs. The International donors were also strongly committed to FP and provided the country with its major source of expertise. So strong was their commitment that some felt they provided undesirable competition to assist the government.

From the earliest days of project conception in 1969, the local government made it clear that its primary interest was rural health and that it would only consider family planning as part of a maternal and child health program. The Ministry of Finance and Planning took the early lead in negotiating with the Bank and at that time saw more clearly the economic necessity of family planning than did the other Ministries. It was also clear that the local population, especially the 75% living outside of the urban areas, was not in favour of family planning. A 1968 survey covering the six largest tribes revealed a high ideal family size of six children, only slightly less than the 6.8 actually achieved. The survey did, however, also indicate a positive correlation between improvements in education and improved living standards and interest in family planning.

\textsuperscript{2}Government of the country.
During preparation the differences of priority attached to the two components became more evident as specific proposals for project design began to take shape. The World Bank supported the Government’s position giving priority to the MCH component. The UNFPA and USAID objected that the emerging strategy with its massive assistance for construction of rural health facilities and training schools would slow down the implementation of family planning activities and provide only modest returns in terms of reducing the rate of population increase. The difference of viewpoint helped fuel a struggle between the UNFPA and the World Bank for the prime coordinating role relative to the donors. The role was ultimately assigned to the World Bank. The difference however, probably influenced the Bank’s choice of tactics for completing the appraisal report. It declined to mount a joint appraisal by all the donors because:

"Past experience has shown that the technical quality of reports has suffered from having various agencies who tend to press for their agencies' interests rather than the technical quality….. The mission will be comprised of impartial experts and will have a low profile given existing political sensitivities."

The alliance of the World Bank and the Government and their willingness to proceed, if necessary, without the aid of the dissenting donors, was enough to bring about a consensus for an integrated MCH/FP strategy. The consensus was not achieved without cost. Several donors delayed or reduced their financial commitment and one did not participate. The difference of opinion may also have resulted in a relative loss of influence for the dissenting donors which was eventually to have an effect on the performance of the project.
III. THE CHOICE OF STRATEGY AND STRUCTURE

The choice of project strategy was influenced by the process and outcome of the struggle to determine the relative priority of the MCH and FP components. As the struggle continued up to the time of the appraisal mission, a factor of time pressure was added to the negotiations. A five year family planning program provided the trigger for the discussions of strategy. The plan was sponsored by the Ministry of Finance and Planning and the MOH. It was cross sectoral in nature and included an integrated plan for the development of manpower for a range of rural services. The plan had been prepared by expatriate advisors and was not extensively reviewed within the MOH in the context of the overall development of health services in the country.

The World Bank mission reviewed the plan as part of its appraisal mission in December of 1972. The problem the mission faced was to design a strategy that would combine the MCH services and construction of facilities favored by the Ministry with its own mandate as the Population Projects Department, and the family planning mandates of the key contributors. The strategy it chose was to concentrate on removing, what was then perceived as the key constraint to improved MCH FP services, the shortage of trained paramedical staff. It concentrated on the supply of services more than on stimulating demand. Its key elements were: staffing 450 service points, recruiting new acceptors, establishing an organizational center to spearhead a national program and providing it with functional support, increasing information and educational activities and providing research and evaluation.

The GO was disappointed with the proposal because it only provided enough physical facilities to keep pace with the rate of training provided by the program. The WHO criticized the plan for its lack of emphasis on rural services and its exclusive concern with population growth reduction. The UNFPA felt that it did not sufficiently reflect and build on many of the related ongoing health activities already ongoing in the country. The program was excessively expensive and was really a health program masquerading as a population project. The USAID felt that the program lacked an appropriate emphasis on the organizational and management constraints within the MOH that would be likely to hamper the implementation of the project.
Pressed for time the Bank felt that it would be impossible to develop or study radically different approaches. It incorporated what suggestions were feasible and agreed with the GOK to proceed with the modified appraisal report, if necessary, without the support of the dissident donors.

The difficulties experienced in developing a common strategy were equally manifest in the choice of organizational form to implement the project. Up until 1967 family planning activities and rural health services had been conducted under the decentralized control of the County Councils. At the time of project preparation the MOH had still not developed, institutionally, in its ability to handle the large projects that demanded centralized control. The center piece of the organizational strategy was the creation of the NFWC a unit within the MOH that would spear-head the formulation and implementation of the family planning component of the project. It was initially referred to as the National Family Planning Center but under the influence of the integrated strategy became the National Family Welfare Center. It was to be housed in the National Medical Center and would accommodate four functional support units as well as an administrative unit: Clinical Services, Information and Education, Training and Evaluation and Research. Physical facilities would include a dormitory for trainees, a family planning clinic and a Health Education Unit for production of family planning materials. (See Annex IV)

It was hoped that its special status through project funding would enable it to overcome the major barriers facing implementation of such a program within the MOH, shortage of skilled managerial staff and procedural constraints. The Director of Medical Services in the MOH would oversee the program and head an Advisory Working Committee to formulate policy and coordinate with participating agencies. Three advisory committees would provide the working committee with program support in the areas of training, research and information. The NFWC would also closely coordinate its activities with a Project Construction Unit established within the MOH and the new HEU. Details of how this coordination would be ensured were left unspecified. What is clear is that the NFWC's primary role was to support the family planning activities of the integrated MCH/FP strategy. The evaluation and research, information and education were to provide the fundamental intelligence for training and provision of clinical services. The production component would primarily serve the interests of general rural health and MCH.
The organizational linkage between the intelligence and training resources provided by the NFWC and the physical and human nursing resources provided by the MOH was the office of the provincial and district medical staff. (See Chart I) Unfortunately, the staff had not been very much involved in the project design process and by inclination did not tend to give family planning activities a very high priority. The nurses organization was most closely integrated with the projects purpose through the training and supervision of community nurses. The initial plan called for the 46 registered public nurses trained as Provincial and District Nurse Training Supervisors (NT/S) to report to the head of the Clinical Services Division in the NFWC. The Chief Nursing Officer,\(^3\) reflecting the general political mood of the country, was not favorably disposed to give family planning activities a high priority in relation to general nursing duties, nor was she favourably disposed to the degree of power sharing suggested by the organizational arrangements.

A parallel organization was planned to supervise the family planning field workers, a Provincial Family Health Officer as a counterpart to the Provincial Nursing Officer and a District Field Officer equivalent to the District Nurse/Trainer. The compensation for these positions had been based on rates related to those paid by the LPPA. Unfortunately, this created a disparity with nurses salaries and added to the difficulties of the family planning specialists.

The organizational strategy, in summary, relied on strong vertical integration through the provincial and district medical offices and strong lateral coordination with the nursing organization, the HEU and the Production Unit, with interministerial coordination provided by the committees. It failed to supply linkages to external sources of support for family planning activities, e.g., the Ministry of Finance and Planning and NGO's. Its design relied heavily on the Ministry of Health where commitment to family planning was not very strong.

\(^3\)She at one time had been the personal nurse of the country's President and still was perceived as wielding considerable influence.
Administrative Structure at Provincial and District Levels

- Ministry of Health
  - Director of Medical Services
    - Director of the 1st Family Welfare Center

- Provincial Medical Officer
  - Provincial Family Health Field Officer
  - Provincial Nursing Officer
    - Provincial Nurse/Trainee Supervisor
    - Public Health Matron
    - District Medical Officer of Health (Assistant District Medical Officer of Health - to be assigned as doctors become available)

- District Family Health Field Officer
  - District Nurse/Trainee Supervisor
  - Clinical Officer

- Health Center
  - Ungraded Attendant
  - 4 Community Nurses
  - 2 Family Health Field Educators
  - 3 Attendants
  - 1 Cleaner

Source: Ministry of Health.
IV. IMPLEMENTATION

Staffing. The organizational strategy depended on the NFWC to accelerate the activity normal within the MOH in order to move the project forward. The Credit Agreement called for appointment of all key staff within 90 days of project start-up. Six months after start-up none of the four heads of the NFWC had been appointed. During the life of the project the NFWC never had a full time Director nor full time head of the I & E division. No African head was found to run the Research and Evaluation unit which was run by a relatively junior UNFPA advisor. There was considerable delay in appointing a program advisor. The Government preferred a local appointment but none could be found with the necessary experience of running a family planning program. The most serious effect on the project came from the lack of a full time, relatively independent Director. The NFWC never managed to obtain the degree of autonomy or influence necessary to carry out the role envisaged. The principal task of directing NFWC activities fell to the Deputy Directors who were changed three times during the life of the project and themselves received little support. (See Chart II)

Support Functions. The second part of the strategy required the NFWC to develop the intelligence and support systems necessary for the training and service activities of the clinical group. Unlike the provision of physical facilities, which requires a relatively simple implementation strategy, the provision of intelligence and support activities required a relatively sophisticated adaptive strategy. In the case of family planning little was known about fertility determinants in the African context, nor about methods to use in the different provincial contexts to persuade Africans to adopt family planning practices. For planning purposes, assumptions drawn from the Asian context had been employed. Both targets and choice of strategy were based on assumptions that required testing. Major revisions in strategy and tactics should have been expected and planned for. The GO was not in favour of a pilot project approach but little attention was given to develop variety of implementation strategies to feded and accelerate the amount of required learning. For example, the need for fertility determinants was identified and a Population Study and Research Center was established in the National University to carry out relevant studies. Due to internal difficulties within the University, the studies did not materialize during the life of the project. No serious alternatives were developed to obtain this essential information.
ANNEX 10: ORGANIZATIONAL STRUCTURE: NATIONAL FAMILY WELFARE CENTER (NFWC) JANUARY, 1979

*Vacant
**=1 Vacant

NOTE: CAPITALS SHOW POSITIONS OCCUPIED, SMALL LETTERS SHOW VACANT POSITIONS AT PROJECT COMPLETION.
The Evaluation and Research Unit. Operating with a head, managed to produce a number of useful studies and sets of statistics. It did not manage to provide the management information system envisaged in planning. The project was left without the information necessary to test the assumptions on which it was designed, and the insights necessary to revise its strategies, structure and operating systems.

The I & E and HEU. Throughout the life of the project were never able to adequately differentiate their roles. The I & E division thus never developed a strategy backed by an action plan that was implemented. Mid-way through the project the World Bank, in particular, gave very detailed assistance to the I & E division in drawing up a plan of action but it was never followed through. Two of the major successes of I & E were not envisaged in the original design. The unit, with considerable help from the Institute of Adult Education, undertook the training of the family planning field workers, a role originally envisaged for the Training unit. It also mounted a series of seminars to communicate to and motivate the Provincial and District Medical and Clinical Officers. Evidence indicates that these were successful in gaining an acceptance of the concepts of the program but not necessarily in gaining the active support and cooperation of the medical officers. This is probably best evidenced by their lack of support in freeing transportation allocated to the FP program for use by field supervisors. The HEU, sharing the same manager as the I & E, suffered from similar problems. Fifty percent of its resources were meant to be devoted to producing materials for the program. The unit's staff had little experience of FP and general health priorities tended to supercede those of FP.

The Training Division found it impractical to carry out its original mandate to provide all short and long term basic and in-service training. The responsibility had to be shared with several other divisions of NFWC and other organizations. The confusion of priorities attached to the MCH or FP components had its effect also in the training of Field Workers. The trainers were originally unclear about the kind of worker they wanted to produce, how much MCH versus FP. It took till 1977 for the trainers to develop their own clarity based on feedback from early intakes. In spite of the difficulties of role clarity and lack of informational support the results of the training can be seen as one of the highlights of the project. This is particularly true of the training of NT/S whose numbers exceed by a considerable margin those estimated. The success of this training effort has been
hampered by the failure of the Director of the NFWC to negotiate an agreement with the Chief Nursing Officer on deployment of trained nurses. Many are posted to units which do not make use of their training. Similarly, the failure of the NFWC Director or the Ministry of Health to intervene to restore the dormitory facilities to the nursing staff at the NFWC after its takeover by medical students has caused a serious bottleneck in the flow of training recruits. At the end of the project, in service training of clinical officers, essential to the effective supervision of field workers, had not yet begun.

Clinical Services. The strategy of combining MCH/FP at service delivery points has worked well. The quantity of service provided has approximated planned levels but the quality is hampered by lack of supervision, failure of the material supply system, and lack of transport. The CNO never relinquished control of the NT/ES to the Clinical Services Division, nor did the Public Health Nurse transfer to an office in NFWC. In general, the impact on the MCH component at the service delivery points has been greater than that of the FP component. Although 42% of all married women had heard of family planning services less than 6% actually visited one in the surveyed period (12 months), while 65-70% of all pregnant women were being reached by the MCH program.
V. MANAGEMENT INFORMATION

Weaknesses in the Evaluation and Research Division left the project with an inadequate internal system for learning where its strategies and structure and operating systems needed to be revised. The provision of such information was by default, left to an external mechanism, the supervision missions of the donors, and in particular the mid-term review. As no GO or MOH officials were involved directly in either the supervision or mid-term review, the donors were left with the same problem they faced in initiating the original design process - how to translate their learning into actions that had the commitment of the relevant Government officials. The lack of an effective internal learning system caused the donors as a result of the mid-term evaluation to miscalculate the strength of the program. At the time of evaluation the program was going as well as it had ever been. The program advisor was in place and had developed an effective team including an effective Deputy Director and several other key staff in the NFWC. However, the basic problems of commitment had not been solved. The evaluation team foresaw an increase in influence for the NFWC. This failed to materialize. The program advisor left and was not replaced, the deputy Director was transferred along with other key staff. To correct the fundamental problems would have taken strong intervention from outside of the MOH. The Ministry of Finance and Planning had no active role in the project. The international donors if well coordinated, might have been able to trigger such an intervention but had been weakened by the struggle over project priorities. As the second project is being appraised, the same fundamental problems remain: how to design a project that has the genuine commitment and support of the most influential members of the Ministry of Health; how to develop a learning process within the MOH that will enable it to increase its capacity to manage its own staff and resources more effectively.
QUESTIONS FOR CONSIDERATION

1. Review the project and its performance in terms of the conceptual framework

   a) In terms of politics

      • Was there an adequate appreciation of the constraints and opportunities facing the project.

      • Who were the major stakeholders and what was their relative power to influence performance of the project.

      • How adequately was the relative power of the stakeholders recognized by the designers of the project.

      • How large was the gap between project objectives and the purposes of the key stakeholders.

   b) In terms of planning

      • How well did the planning process complement the political situation as you diagnosed it above.

      • Were the key stakeholders involved in the process. Did they suggest alternatives, and were they seriously considered.

      • How well was the planning process linked to the structure of the project.

      • Did the structure facilitate information flow and influence positive perceptions of the project.

   c) In terms of learning

      • Which units were primarily responsible for the learning process. How well was this carried out.

      • What results were obtained and how did these relate the original purpose of the project. Whose purposes were actually served by the project.
2. What design alternatives in terms of politics, planning and learning could have been considered and possibly implemented to improve the probabilities of improved performance.
APPENDIX I

SOCIO-ECONOMIC CONDITION

The 1962 census, the first complete enumeration of country's population, estimated the population to be about 8.6 million. The 1969 census placed the population at about 10.9 million, an increase of about 27% during the intercensal period 1962-1969, and preliminary results of the 1979 census indicate the population to be about 15.3 million. For the period immediately preceding the 1969 census, the crude birth and death rates were estimated to be 50 and 17 per thousand respectively, yielding a natural rate of population increase of 3.3% per annum. There is some evidence that fertility may have been actually increasing during this period. Total fertility rates were estimated to be 6.8 in 1962 and 7.6 in 1969 based upon census data. The total fertility rate and, therefore, the rate of population growth were among the highest in the world. Definitive data on trends in mortality are not available, but the crude death rates may have also been declining during this period. The crude death rate was estimated to be about 20 per thousand in 1962, 15 per thousand in 1969. In 1969, the life expectancy at birth was estimated to be about 47 years in males and 51 years for females and the infant mortality rate was estimated to be about 138 per thousand.

The country is inhabited by various social groups having different traditions and at different stages of socio-economic development. The fertility levels among these groups vary but the differences are generally small. The Africa Fertility Survey Report mentions that the differences in fertility may be due to the modernizing factors of education and urbanity, rather than any cultural diversities in behaviour stemming from social groups affiliation. Polygamous unions and the almost universal practice of long breast-feeding period, to some extent, restrain fertility.

Economic development in the country has been rapid. Per capita income in 1962 was estimated at US $170, which was

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1Extracted from Project Completion Report.
about the median for Africa as a whole. During the first decade after independence, the GNP grew at an average rate of 7% and per capita income at about 3.7% in constant prices. The primary school enrollment rate increased from 47% in 1960 to 64% in 1970, and near universal enrollments now prevail according to most recent estimates.

Despite impressive economic growth during the 1960's, a high rate of population growth continued to influence the socio-economic structure adversely. Although overall population density was low at 19 persons/sq. km. in 1969, nearly 80% of the population lived on 17% of the land (arable land). Therefore, the population density per sq. km. of arable land was estimated to be about 190. Because of population growth, there were two streams of population movement— from the rural countryside to urban centers and from the areas of high agricultural potential to medium potential and land settlement areas. About 7% of the population lived in urban centers of 2000 or more in size in 1962 as compared to 10.2% in 1970. The level of unemployment was high, and continues to remain so, estimated at about 20-24% of the total potential labour force. The dependency burden, defined as the percent of the total population under 15 years of age and 60 or over was 54%, one of the highest in the world. The cost of providing social services was on the rise; in percentage terms, the share of total recurrent expenditures for such services increased from under 24% of the government budget in 1964-1965 to about 43% in 1972/1973. These figures, in addition to improved quality of services, reflected in part a need to provide services to a larger population.

Previous Family Planning and Health Activities

Voluntary FP efforts in the country were begun by autonomous associations in the two major cities as early as 1955. In 1961, the Local Family Planning Association (LFPA) was formed. The Government, based upon the results of the 1962 census, realized that the high population growth rate would impose a major constraint on the country's ability to expand her economy and fully develop her capabilities. Through Ministry of Economic Planning and Development (MOEPD) in 1965, it invited the Population Council to advise on FP activities. In its report, the Population Council suggested that a population program:

- be viewed as an integral part of effort toward social and economic development;
- 3 -

- have an especially close link with the national health program; and

- be wholly voluntary.

It also suggested need for a population policy and outlined program details. In 1966, the government announced the adoption of Family Planning as an integral part of maternal and child health services and formed a FP unit in the Ministry of Health.

By 1968, FP services were being provided through seven mobile teams and 40 static clinics, most of them in MOH facilities and the remaining established by the LFPA. Also in that year the LFPA launched a program for FP educational activities through its field worker program and through mass media and seminars.

Prior to 1970, responsibility for rural health services was decentralized and these services were mainly operated by county councils. However, to establish a more viable framework of expansion of activities and to take over a growing financial burden, rural health services were taken over by MOH in that year. The government health services were organized on a centralized basis and carried out at the central, provincial and district levels through a network of hospitals, health centers and dispensaries to provide both curative and preventive services. In 1970, there were about 600 government rural health facilities consisting of 185 health centers and sub-centers and 414 dispensaries. The rural health delivery system emphasized curative services and, in the absence of an adequate number of trained personnel, was overburdened. These services were organized in the same manner as hospital outpatient departments, offering different services on different days. In 1972, the government formulated with WHO's assistance a ten-year (1974-1984) rural health plan to expand provision of health services by training of paramedical staff, improving the coverage and distribution of rural health facilities, and a systematic attack on those diseases more responsive to the efforts of rural health services.

By 1972, the FP services were offered on a part-time basis in about 300 out of 900 government and non-government health facilities. The number of first visitors and revisitors for FP services grew steadily from 1,500 and 7,900 respectively in 1967 to 45,200 and 172,300 respectively in 1973. Mobile teams visited 72 clinics accounting for a little over one-third of the services in 1972. Some 20% of all FP acceptors were from the Capital, the services being provided by the City Council.
Many foreign agencies had provided assistance in FP activities. In particular, technical assistance was provided by SIDA, USAID, the Population Council and the Government of the Netherlands. The services were supported by IPPF, SIDA and NORAD. Funds for training and fellowships were provided by NORAD and the Ford Foundation. Funds for an information system and for the Program for Better Family Living (which provided family life education) were provided by UNFPA. In addition, support was provided for health education activities by USAID, for equipment by ODM (now ODA), for a contraceptive social marketing project by Population Services, Inc., and for pilot projects for post-partum FP activities by the African Medical and Research Foundation.
APPENDIX II

PROGRAM IMPLEMENTATION

The project was an integral part of the five-year MCH/FP program. Although the program was partitioned into several projects for purposes of financing, the government and the donors viewed the activities under the various projects as an interrelated set, all of which together contributed towards achieving the program objectives.

A. Program Strategy and Components

The program was the first five-year MCH/FP program in the country. It, therefore, was directed towards alleviation of major constraints and was not designed to be an all embracing MCH/FP program. It was designed primarily to strengthen FP activities and only secondarily to strengthen MCH activities.

The major constraint on expansion of the FP program was the acute shortage of trained paramedical manpower at the field level to provide preventive health and FP services. This constraint affected the frequency and quality of MCH/FP services. The program, therefore, focussed on reducing the shortage of those personnel ordinarily involved in dispensing MCH/FP services--the EN/CN--and on FP training of motivational field worker--the Family Health Field Educator (FHFE)--and other paramedical personnel.

More specifically, the program was aimed at: (a) establishing services full-time at 400 service delivery points (SDPs: 65 at hospitals, 185 at RHCs and 50 dispensaries in the first three years) and part-time services by 17 mobile teams; (b) training a new cadre of nursing tutors/supervisors (NT/S) to supervise provision of MCH/FP services and expanding physical facilities for basic training of community nurses; (c) providing

\[1\] Extracted from Project Completion Report.
### COUNTRY POPULATION PROJECT

#### PROJECT COST BY EXPENDITURE CATEGORIES (IN US$'000)

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<th></th>
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<th>As % of Appraisal Estimate</th>
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specialized in-service FP training to 400 EN/CNs, 46 registered Public Health Nurses, 55 nursing tutors, clinical officers and staff of mobile teams; (d) providing training to a new cadre of 800 FHFEs and 46 family health field officers; (e) carrying out I & E activities in MCH/FP and strengthening production capacity of HEU; (f) establishing NFWC to administer the program; (g) strengthening evaluation and research; and (h) providing transportation for MCH/FP activities.

B. Services

Services were to be improved by including the concept of Service Delivery Points (SDP). This involved a change of orientation from "hospital out-patient department" to "supermarket" concept of service. Thus MCH and FP services formerly available only on certain days part-time were to be made available every day full-time. By the end of 1979, about 90% of the target was achieved. Shortage of staff, staff housing and limitation of physical space have resulted in the shortfall.

For sparsely populated districts, 17 mobile teams were planned to be added to district hospitals and were to be staffed by two CN, one nutritionist (if available) and one attendant. These teams were to offer ante-natal, child welfare and FP services.

In addition to constraints imposed by demand for services, the supply of MCH/FP services continues to be limited, both in quantity and quality by a shortage of staff adequately trained in FP. Non-availability of vaccines, at times, also limits immunization services.

C. Training

The program increase in the capacity for basic training of EN/CN. The impact of this increased capacity for training will be felt only gradually as the number of graduates has not yet increased. The course is of 3-1/2 years duration, and of the five CNTSs constructed under IDA project, one admitted students in 1977, one in 1978 and the remaining three only in 1979.

At the time of appraisal, shortage of tutors for basic training of nurses was perceived to be an important constraint. However, this has now been corrected. The
teacher/student ratio averages about 1:25 as compared to appraisal estimate of 1:33.

On an average only one out of about 2.5 EN/CNs trained in FP is posted at an SDP. Therefore, about 1000 EN/CNs need to be trained in FP to staff 400 SDPs. The target for in-service training of EN/CN for FP was originally set at 633 but was later revised to 1000. By 1978, about 850 EN/CNs had received in-service training. The theoretical in-service training is carried out at NFWC and the clinical training in the field. The staff of the training division of NFWC, with some assistance from I & E division, conducted this training. The centralization of training in Nairobi has limited the numbers which could be trained.

By 1978, about 150 NT/Ss and registered nurses, 420 FHFEs, 14 FHFOs, 14 nursing officers and nine matrons were trained in FP. The shortfall in the number of FHFEs trained was due to the delay in receiving approval of the posts from the Department of Personnel. A separate cadre of FHFOs had been established as a part of the program to supervise the new cadre of FHFEs. This separate cadre of FHFOs was discontinued in 1978 and merged with HFOs. Most serious shortcoming, however, is that clinical officers who are in charge of RHCs are not trained in FP. Although plans for training COs were not formulated at appraisal, this need was later identified, both by the government and the Mid-term Review Mission in 1977.

Although substantive progress in developing infrastructure for basic training has been made and a large number of personnel have received in-service FP training, a significant expansion of in-service training activities is necessary if the program is to expand.

D. Information and Education

In stimulating demand for FP, priority emphasis was to be placed on person-to-person education, supported by an enlarged mass communication effort, to introduce a change in attitudes and behaviour so that people can readily accept FP methods. Over the program period, it was stipulated that some 800 FHFEs would be employed to generate community acceptance and support, conduct follow-up and reassurance visits, hold group meetings and liaise with extension workers who have contact with the family unit. The production capacity of HEU was to be strengthened and it was expected to devote about 50% of its capacity for production of pretested FP I & E materials.
Field Workers

By June 1979, about 750 FHFEs were employed, some 150 by LFPA and 600 by MOH. LFPA had employed field workers since 1965 whereas MOH began employing them in 1975. The FHFE is the only outreach worker employed by MOH in addition to a small number of nutrition field workers. In 1979, the number of married women of reproductive age (MWRA) were estimated to be about 2,231,000 in the country. Thus on an average one FHFE needs to cover about 3,000 MWRAs. However, for some FHFEs the coverage may be as high as 9,000 MWRAs. Their job description includes educational activities, client referrals to health facilities, client follow-up, and recording and reporting. Sometimes FHFEs also act as health workers. Their training is for 13 weeks.

In general, three purposes of contact can be distinguished—education/communication, recruitment/motivation, and follow-up. It is estimated that on an average, about 63 persons are reached per week by a field worker through home visits, group talks, clinic contacts and local meetings. Of these about 16% are male and are largely reached by group talks and local meetings. About 11 home contacts are made on an average per week by a field worker. At this rate and at the existing level of personnel, only about 17% of all MWRAs are visited at home in a year.

In 1978, the FHFEs recruited about 18% of all FP clients (about 11,000 new acceptors, about 15 to 18 per year per FHFE) and about 5% of all MCH clients (about 26,000 antenatal and 27,000 child welfare clients, a total of about 70 per year per FHFE). An investigation into causes for drop out among the clients recruited by FHFEs suggests that about 25% had become pregnant, another about 10% wanted an additional child, and an additional 25% cited clinical reasons (such as desired method refused, asked to come during menstruation) for dropping out.

The above data suggests that the efficiency of FHFE is low. The 1979 evaluation of FHFEs, carried out jointly by NFWC and LFPA, suggests that of the 35 hours working time per week about 38% is spent in travelling. Of the 29% of time spent in health facilities, only nine percent is for MCH/FP contacts, the rest being used for other duties. Therefore, only 42% FHFEs' time is spent on outreach and contacts. About half of this time or about nine hours per week is spent on home visits and about 11 home visits are made. It is estimated that on an average three contacts are required to recruit one client. Only 75% of those recruited visited the
clinic and of those who visited the clinic, 22% accepted FP and 74% accepted MCH. Thus the loss in efficiency arises on several counts: high overhead cost of outreach activities due to travelling and other loss of time, non-selectivity of contacts and lower priority give to FP. About 25% had no formal education, 10% had between standard four to seven, and remaining 25% had more than seventh standard education.

Several environmental factors result in poor effectiveness of FHFEs. Services are still not always available and easily accessible. Mass communication activities and development of educational and communication support material did not expand as envisaged and therefore, FHFEs did not receive adequate support from such activities. Finally, spacing and fertility limitation are not widely accepted ideas in the community. Therefore, FP activities receive lower priority than MCH activities. Of the total clients recruited by FHFEs, the percentage of FP clients declined from 33% in 1976 to 29% in 1977 and 22% in 1978.

**Mass Communication Activities**

The production capacity of the then existing HEU in MOH was considered inadequate and had to be strengthened. At the time of program appraisal, USAID had provided two advisors to the government for the Health Education Unit and a master plan for HEU building would be included in the IDA supported project and the equipment would be supplied by USAID. The building for HEU was ready by mid-1977 but was not occupied until October 1979. First, the equipment was not available and the building was being used as a store. After the equipment arrived, it took many months for the furniture stored in the building to be sorted out. The level of sophistication of hardware proposed by the government was questioned by USAID. For a variety of reasons, including frequent changes in USAID population officer resident in Nairobi, it took about three years for resolution of this difficulty. The unit was functional (except for the television studio) by December 1979 but production of material in the new facility has just begun.

Fourteen four-wheel drive vehicles to be used as audio-visual and cinema vans for mass communication activities were available in early 1977. However, the audio-visual equipment has not been procured yet. The approval of National Radio is required before such equipment can be procured and this approval could not be obtained (refer to paragraph 2.23). These vehicles are, therefore, being used for general transport.
Thus the program inputs for expanding health education activities were not effective up to December 1979 and it would be some more time before they could be fully effective.

A separate I & E division of NFWC was planned to focus on FP educational activities. However, MOH saw its role only as a task force and perceived it as a part of the existing HEU. Thus the two groups were headed by one person and often acted as one organization. HEU had broad ministerial responsibilities and, therefore, emergency problems such as epidemics of communicable diseases and milk contamination received more attention than routine MCH/FP activities. The planned professional input for the I & E division was inadequate and the division was only involved in training activities until mid-1979, although such involvement was reduced after the mid-term review of 1977. Finally, authority to incur expenditure on I & E activities for MCH/FP was not delegated to the head of I & E unit leading to procedural delays.

A detailed program of I & E activities was not prepared initially. There was a general health education plan, but no specific yearly operational plans. Following the mid-term review in April 1977, a team consisting of a consultant financed by IDA, one staff member of HEU and one staff member of the I & E division developed a program for the remaining two years of the program. But the program could not be implemented in any substantive manner because of a lack of staff and hardware.

Nevertheless, some I & E activities were carried out. In a typical year, about 30 minutes of radio programs are aired per week, about 20 seminars are held attended by about 900 persons, about ten exhibitions are held, and a large number of I & E materials are prepared. Much needs to be done however to improve the quality of material, particularly to prepare materials which are relevant to local cultural settings.

E. Evaluation and Research

One of the important objectives of the program was to establish an E & R division at NFWC to monitor program progress through the establishment of a management information system and to recommend more effective approaches of service delivery and demand creation. The specific tasks assigned were to collect service statistics, carry out special studies and pretest I & E materials.
The division was established and staffed reasonably well. However, a division head was never appointed and the position of senior research officer was vacant up to 1977. The advisor (funded by UNFPA), therefore also served as head of the division. In spite of these limitations, the division succeeded in developing a service statistics system and conducted several studies. A system for collecting information on FP acceptors has been developed.

E & R division also conducted several studies, including a review of SDPs and an evaluation of FHFEs in collaboration with LFPA. The comprehensive review in 1976 of SDPs consisted of collecting information on staffing, transport, equipment, supplies and record keeping. A comprehensive evaluation of FHFEs was carried out in 1979 to assess the workload, type of support needed, content of communication, desired characteristics of FHFEs and community needs for MCH/FP services.

Also part of the five-year MCH/FP program was the establishment of the Population Studies and Research Center at the National University. This center was intended to provide support to the family planning program by conducting in-depth research into determinants of fertility and other demographic matters, and by assisting the E & R division of NFWC to evaluate the impact and effectiveness of the family planning program. The Center which was also to train researchers in demography and population policy, was established with a delay of about two years. It has been successful in establishing a teaching capability for population matters and its researchers have carried out a number of population studies. However, linkages to the MOH have been strongly established and hence the Center has not been very influential in shaping family planning policies.

F. Program Management

A highly visible and well supported institutional infrastructure for administering an expanded MCH/FP program was to be developed. The NFWC was set up under the program for this purpose. Initially housed in rented premises, it is now located in especially constructed new facilities in the National Hospital complex. The Center is the focal point within MOH for all MCH/FP activities.
The Interministerial Working Committee was established but met only once. In spite of repeated discussions during supervision missions, this committee could not be activated. The reasons are not clear, but several factors may have contributed: the tasks for the committee were only vaguely defined, other ministries did not perceive FP as an important program, and MOH did not pursue the matter energetically. Similarly, the other three advisory committees also met only infrequently and did not contribute significantly to coordination of work. Suitable terms of reference need to be worked out if advisory committees are to function.

A specialized field supervision structure for MCH/FP was also planned but it gradually merged with the routine supervisory structure of rural health services. Thus, the separate cadre of NT/S set up to provide technical assistance and supervise MCH/FP activities was merged with the Public Health Nurse position at district level who is responsible for supervision of all nursing personnel. The position of FHFO set up to provide technical assistance and supervise I & E MCH/FP activities was merged with the position of HEO who is responsible for all health education activities. While the cadres were merged, a corresponding increase in the number of supervisory personnel did not occur.

A considerable amount of work has been done in developing NFWC and it has been instrumental in getting the program started. However, management and supervision of the program have not been able to keep pace with program expansion. In addition to staff shortage and changes in field level supervisory structure, several other factors have hampered the growth of NFWC:

a) Program leadership---the Director of NFWC has other responsibilities such as rural health and nutrition. Therefore, he has not been able to give full-time attention to NFWC. The multiple responsibilities of the director has been mixed blessing. It has provided much needed linkages with other departments of MOH, particularly rural health. But the leadership role of NFWC has suffered. The Deputy Director should be able to provide day-to-day supervision. However, during the five-year program period, three persons held this position. The administration of the Center, therefore, has suffered resulting in the lack of direction and lack of coordination among different divisions of NFWC. The mid-term
review mission strongly stressed, and agreement was reached with the government, that before the end of the program a full-time director of NFWC would be appointed. However, this development has not yet materialized.

b) Relationship with other divisions of MOH—a two-way relationship between other divisions of MOH and NFWC is needed. On the one hand, other divisions of MOH should perceive the synergistic nature of interactions between curative, preventive and promotive health services and give suitable importance to MCH/FP activities. On the other hand, NFWC should receive information on postings, transfers, and resignation of health staff concerned with provision of FP services at the same time as the Chief Nursing Officer, and the deployment of supervisory staff, particularly those concerned with MCH/FP, should be done in consultation with NFWC. These linkages continue to remain weak.

In conclusion, an institutional capability for managing MCH/FP program has been created. The midterm review and supervision missions have identified many strengths and some areas that need further attention. Capability for training and service delivery has expanded greatly. The quality of services is being improved by improved supply of contraceptives and monitoring of the program.
APPENDIX III

BACKGROUND TO BANK AND DONOR AGENCIES RELATIONS

When it first entered the population field, the Bank's leaders believed that it could make a distinctive contribution with little cooperation from other agencies. Yet Bank officials responsible for population projects soon began to recognize that their ability to pursue their objectives would be profoundly affected by the activities of other major donors--chiefly the United Nations Fund for Population Activities (UNFPA), the World Health Organization (WHO), and the United States Agency for International Development (AID). UNFPA, the largest multilateral donor in the population field, was established in 1969 as a voluntary fund administratively located in the UN Development Program. Virtually all of UNFPA's funds come from nine Western governments, and, through the end of calendar year 1979, UNFPA had disbursed over $500 million for various population activities, of which about 60 percent went for family planning and related projects. WHO, the UN agency concerned with health, provides technical assistance for the development of integrated health and family planning services. It has been the primary executing agency for UNFPA, using about $90 million from 1969 through 1979. AID, the largest bilateral agency, spent over $1.3 billion for population activities in the same period, although less than half of this amount was used for bilateral assistance, with most of AID funds being channeled through intermediaries such as UNFPA and private organizations.

In contrast to conventional areas of Bank lending, the money potentially available from these agencies to assist family planning has until recently exceeded the demand from developing nations as well as the capacity of many newly launched programs to make use of the funds for the desired purposes. As a result, the agencies have found themselves competing with one another for opportunities to assist national programs, especially in critical areas of technical

1Extracted from "Organizational Commitment As An International Agency: The World Bank's Population Program."
assistance and institution-building. Other agencies have been willing to leave the construction of physical facilities to the Bank, but the Bank has indicated that it would not be satisfied with such a limited role, declaring that it too expects its principal contribution in the population field to be in the form of technical assistance. At the same time, the Bank holds to its traditional position that it is the "lender of last resort" and ostensiibly encourages borrowers to seek support from other agencies with easier financial terms. This norm has been violated in the population field, however. The Bank has not encouraged borrowers to turn to other agencies; instead, it has tried either to finance technical assistance itself or to have other donors do it under a co-financing arrangement in which the Bank develops and oversees the project.

Tensions among the donor agencies go beyond disagreement over who is going to support which components of a program or project. Other agencies have accused the Bank of failing to inform them and consult with them as it is developing projects. More seriously, the Bank has been charged with trying to dominate other agencies and, in the words of a UNFPA official, to use its projects as a vehicle to "run the program from the sidelines." The Bank has also become involved in major disputes with other donors over how to advise governments on program strategy and organization: In Bangladesh, for example, the Bank, UNFPA, WHO, and AID have had continuing disagreements over the relationship between population and health programs. As a basic norm, international agencies agree that it should be up to the recipient government to take the lead in making program decisions and coordinating the activities of external agencies. But unless national administrators are unusually strong and adept, competition and disagreement are likely to have adverse effects on program development—a situation which is injurious to the population objectives of all the agencies involved, including the Bank.

Conflict with other agencies raises serious issues for the Bank even if it eventually prevails; yet, where conflicts have arisen, the Bank has often been the loser. Assistance from other donors in the population field has generally been more attractive to governments than assistance from the Bank. Whereas the Bank is confined to loans and credits, other agencies—UNFPA, WHO, AID, and most bilateral and private donors—provide assistance to population programs in the form of grants with no repayment obligation. In a sector like population where grant assistance has been relatively easy to obtain, the financial terms of Bank assistance have
put it at a more than usual disadvantage. Although the other agencies follow their own versions of the project approach, with many of the same liabilities as the Bank's, their procedures are in general far more flexible and allow a greater role for national program administrators. Among donor agencies providing population assistance, the Bank stands out as the least willing to provide general budgetary support, including support for local and operating costs. Moreover, because other donors are more administratively decentralized, they have been able to cultivate their own clientele among program administrators with the help of advisers and representatives stationed in the countries. By comparison, the Bank has found it more difficult to gain the acceptance of program administrators whose cooperation is essential for developing and carrying out Bank supported projects. In Malaysia, Egypt, and the Philippines, for example, the Bank has been largely confined to supporting health facilities while other agencies have been able to provide considerable support for technical assistance, program operations, and outreach activities intended to stimulate demand for family planning.

Other donors regard themselves as being in a better position than the Bank to help countries in carrying out population programs; as a consequence, they have been less inclined to accommodate to the Bank in order to work with it cooperatively on terms similar to those accepted by these agencies in other development sectors. In some countries, with the agreement of the ministry of finance and planning, the Bank has attempted to coordinate external population assistance. UNFPA and AID have resisted these efforts of the Bank and, as in Africa, have usually negotiated their assistance independently. While the different organizational interests of each of the population donors contributes to inter-agency competition and conflict, this problem is often intensified when the Bank is involved because of its commitment to a high level of independence and control in its relations with other agencies. An examination of the Bank's relations with each of the major donor agencies in the population field reveals some of the obstacles to improving inter-organizational cooperation.
APPENDIX IV

NATIONAL FAMILY WELFARE CENTER AND
SUPPORTING FACILITIES

National Family Welfare Center (NFWC)

The NFWC will be located on the National Medical Center/Medical Training Center complex in the Capital and will house the following functional divisions: Clinical Services, Information and Education, Training, Evaluation and Research, and provide accommodation for the Office of the Director of the Center. The proposed IDA credit will help finance the construction costs of this headquarters building for FP/MCH activities together with supporting facilities, namely a dormitory for trainee, a family planning clinic to provide clinical experience and a Health Educational Unit for production of family planning and health materials. The Ministry of Health (MOH) has no facilities for accommodating an expanded central body to implement the expanded FP/MCH program.

The NFWC will provide basic and refresher training courses for all personnel involved in dispensing family planning services, for medical and paramedical personnel (medical assistants, registered nurses, etc.) who supervise FP/MCH services, the family planning field workers responsible for increasing the demand for family planning services, senior staff at the NFWC, and orientation training courses for other development workers and opinion leaders. The MOH will carry out some of these training courses in rented premises while awaiting the completion of the NFWC.

In addition to the need for a central training facility, the NFWC will also house the Evaluation and Research Division which will evaluate the impact of the Family Planning Program.

To support the training program, a dormitory accommodating 100 trainees will be constructed nearby.

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1 Extracted from Appraisal Report and Mid-Term Review.
The NFWC works closely with two other units in the MOH: the Project Construction Unit, which is responsible for procurement and construction of the civil works components, and the HED, which is responsible for the production of I & E materials.

The NFWC receives advice on policy from the Interministerial Working Committee, headed by the Permanent Secretary of the MOH and composed of representatives of various ministries and non-governmental organizations. Advisory Working Committees chaired by the Program Director or his Deputy provide technical support and guidance for the Interministerial Working Committee and the NFWC in the areas of information, education, and training; medical matters; and evaluation and research.

Family Planning Clinic

Clinical experience will be provided by the financing of family planning clinic. This clinic will house the following functions: Family Planning, Antenatal and Postnatal Care, Maternal and Child Health, Nutrition and Home Economics. Fourteen clinic sessions per week are anticipated, the largest of which will be the antenatal clinic where 180 patients are expected. To achieve maximum use of space, all consulting/examination rooms will be multipurpose and not designated for particular clinical functions.

Health Education Unit (HEU)

This Unit will provide space for the production of various types of audiovisual materials and printed matter, a small cinema and exhibition hall for demonstration and teaching; offices for the staff and writers and artists who will design material; television and cinema studios, workshop and a printing press for production. The existing facility is inadequate for the expansion of health education services necessary to support the national health program including family planning. The premises have exhausted their useful life and replacement is essential. Fifty percent of the total production capacity of the HEU will be spent on family planning. The new facilities will also provide opportunities for inservice training seminars on health education for a variety of health workers and students at the Medical Training Center.