Overseas Development Administration : health and population overseas aid : report / by the Comptroller and Auditor General.

NATIONAL AUDIT OFFICE

REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL

Overseas Development Administration: Health and Population Overseas Aid

HC 782 Session 1994–95
8 November 1995

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This report has been prepared under Section 6 of the National Audit Act, 1983 for presentation to the House of Commons in accordance with Section 9 of the Act.

John Bourn
Comptroller and Auditor General

National Audit Office
20 September 1995

The Comptroller and Auditor General is the head of the National Audit Office employing some 750 staff. He, and the NAO, are totally independent of Government. He certifies the accounts of all Government departments and a wide range of other public sector bodies; and he has statutory authority to report to Parliament on the economy, efficiency and effectiveness with which departments and other bodies have used their resources.

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Summary and conclusions

1 The world's population is 5.6 billion and is currently growing by at least a billion each decade. Developing countries are facing major challenges in ensuring that their people can access essential health care against a background of financial and economic constraints, population growth and increasing health hazards. Many are struggling to provide accessible health care facilities from a health budget of less than £7 a person a year. Most countries are now committed to taking action that would lead to stabilising population growth through improved reproductive health rather than by imposing population control measures.

2 Since April 1988 the Overseas Development Administration have spent £911 million on health and population assistance, mainly in Asia and Africa, including £393 million on emergency aid. This has represented a growing proportion of the Aid Programme in recent years. The pattern of health aid has changed in the last decade and support for reproductive health services has increased following the Administration's population initiative in 1991, and will increase further following the adoption of the Programme of Action at the International Conference on Population and Development in 1994.

3 The objective of the UK's health and population aid is to enable those most in need to gain access to essential health care, including reproductive health services, in ways which make efficient use of available resources.

4 The National Audit Office sought to assess how the Administration monitored progress on health and population projects against measurable targets and took remedial action where appropriate; and the success achieved in terms of project impact and sustainability.

5 The National Audit Office examined bilateral health and population assistance in four countries, covering 16 projects in India, Pakistan, Kenya and Zimbabwe. They also examined the Administration's contributions to multilateral organisations and research funding. The main findings are set out below:

Management arrangements

a) Good management involves close supervision of project implementation and prompt remedial action where necessary. Over the last four years the Administration have recruited 14 country-level health and population field managers, who have been supported over the last two years by four resource centres providing consultancy advice on all aspects of project design, implementation and impact. The Administration plan to evaluate these arrangements in due course to see whether they have improved aid efficiency and effectiveness.

Progress reporting on objectives and targets

b) The Administration expect project managers to report regularly on the extent to which objectives are being achieved and on areas requiring remedial action. However, they do not generally provide guidance on the format of progress reports required either for contracted out projects or those internally managed. It seemed to the National Audit Office that this led to some reports omitting essential detail, such as summaries of progress, progress against project framework or analysis of expenditure targets.

c) In four projects the Administration had set broad goals (for example improvements in health status) without specifying a sufficiently precise lower-level project purpose to relate directly to project activities. In some other cases, purpose level objectives related to expected outputs - for example, the number of clinics built, rather than measures more closely related to purpose, such as clinic usage and treatment provided. The Administration indicated that the setting of appropriate objectives at these various levels was being given high priority in current project design.

d) The Administration have not always been able to set measurable indicators of progress towards project objectives at the purpose level, particularly before projects started. Difficulties were experienced when a project's emphasis was on institutional development. This problem related mainly to earlier projects and the Administration emphasised that recent projects now had clearer and more quantifiable indicators against which progress could be measured.

e) In nine of the 16 projects examined the Administration had either not set measurable indicators of progress towards objectives of project purpose or not made them explicit. Instead they had selected indicators which were designed to enable impact to be assessed after project completion. Recent projects had more consistently set realistic indicators, with data that were readily available, to permit explicit monitoring of the progress of a project towards achieving its purpose. The Administration have initiated a major programme of training for the regular review of project objectives and for resetting of indicators during implementation.

Financial management

f) The Administration held up-to-date financial records for projects overall but in two cases did not have detailed financial breakdowns of project components. In those cases they therefore lacked the necessary information to make judgements about efficiency and effectiveness.

Contractual arrangements

g) The Administration seek competitive proposals wherever possible. For consultancy services where fees are likely to be £50,000 or less, the cost of competition can be taken into account as one, but not normally the only, factor in a decision to waive competitive tendering. For the procurement of goods over £100,000 the procurement agent would normally be identified by competition. Of the 13 contracts examined, competition was waived for seven. This was, in part, due to the Administration's aim to give the British Council the opportunity of first refusal in certain countries and the Administration's contractual arrangements giving Crown Agents exclusive

rights to Administration-funded procurement for certain countries. In two instances the Administration did not provide tenderers with detailed terms of reference describing the services they required.

Monitoring

h) The National Audit Office found that all the projects had been the subject of routine monitoring. This tended, however, to focus on inputs, due mainly to the need to address problems with their delivery (particularly timeliness and quality), and outputs. It often did not relate progress to objectives and targets - and hence potential impact. The Administration indicated that in larger projects impact was assessed through mid-term reviews but the National Audit Office identified only three such reviews in 13 projects examined.

Remedial action

i) The Administration found it necessary to make some adjustments to the design of each of the 14 projects examined to meet changing circumstances. There were four examples where such remedial action had been successful, resulting in prompt improvements. In seven other cases remedial action was partially successful or was effective after an extended period. In three cases, remedial action was not taken or was taken late. This reflects, in part, the difficulty in implementing prompt remedial action in collaborative partnership projects given the shared responsibility for implementation and monitoring.

j) In the National Audit Office's view, delays in taking remedial action were exacerbated because the Administration did not define appropriate responsibility with project managers and, in some cases, because progress reports had paid insufficient attention to the difficulties encountered or had not attached adequate priority to dealing with problems.

Impact

k) To assess whether a project has been successful in achieving its objectives, it is necessary for clear, appropriate, project-specific objectives to be set at the design stage and for relevant data to be collected during and after the project. In health projects it is difficult and often costly to make a full assessment of project impact on people's health status - particularly in projects involving inputs from other donors, where it is impossible to disaggregate the Administration's contribution from the effects of other factors; and in some projects impact cannot be assessed until some time after all inputs have been completed. In nearly half of the projects examined the Administration had not ensured that they had sufficient information to assess impact or intended impact. They have reviewed the benefits obtained through support to health management projects, grants to multilateral agencies and some reproductive health projects.

l) During project design the Administration undertook economic appraisals but did not always give explicit consideration to whether the delivery mechanisms proposed were the most cost-efficient means of achieving their aims. They now attempt to assess the prospective impact of different interventions through their funded research and plan to provide relevant summary information to those responsible for project design.

Sustainability

m) The Administration have well-established procedures to appraise the economic viability of projects. They recognise that it is never easy to ensure the sustainability of social sector services but consider that this issue often needs to be addressed in a wider context than within individual projects. Hence for most projects examined, sustainability considerations did not feature prominently. The Administration explained that, nonetheless, discussions about sustainability of social sector services always took place internally and with recipient countries. The issue is also often addressed through donor agencies' wider dialogue with national agencies about macro economic and social issues, including poverty. Much of this is not documented in project files.

n) The Administration accept that many developing countries are unlikely to be able to meet the full costs of contraceptives, essential drugs and medical supplies. They therefore plan projects on the assumption that donors will continue to contribute to such supplies for many years.

o) Projects are more likely to be sustainable where recipient countries demonstrate a strong commitment at the early stages of design; where well-established organisations have been able to demonstrate a previous record of maintaining projects; and where beneficiaries have been actively involved throughout.

p) In two of the earlier projects examined, the Administration were unable to secure the full commitment of recipient institutions to project objectives or successfully to enhance the capacity of institutions to enable them to be more effective. The Administration now require an explicit commitment to agreed objectives at an early stage in project design.

q) The Administration attempt to ensure that partner institutions comply with their undertaking to provide funding once the project is complete but in eight of the projects examined national authorities were finding it difficult to meet continuing costs. In half of these cases this was a result of deteriorating fiscal conditions. It seemed to the National Audit Office that most of the project proposals examined did not include sufficiently detailed assessments of the recurrent cost implications likely on project completion.

Multilateral organisations

r) The Administration have established a comprehensive process of review and evaluation and have considered a broad span of evidence in assessing the effectiveness of multilateral agencies in providing health and population aid.

Research expenditure

s) The Administration have taken steps to improve the direction of their funded research. They have formalised research agreements and introduced competition into the selection process.

t) The Administration have introduced a number of remedial measures with the aim of directing research funding to more urgent needs and to improving the prospects of projects achieving their objectives. As a result the

Administration consider that the recently completed research work has had an impact on policy formulation and has enabled research skills to be built up in the essential health and population areas.

General conclusions

6 Of the 14 projects that had started, the National Audit Office found that nine had largely achieved, or were likely to achieve, their objectives, three will partly achieve their objectives, and two were likely to have little impact.

7 In the last four years the Administration have taken various initiatives to learn from past experience and improve the prospects of projects achieving their objectives. Changing policies for UK health and population aid have led to sector-focused action in specific countries to develop approaches to facilitate fundamental health systems development. The Administration have increased their emphasis on long-term partnerships with recipient countries, encouraged closer in-country co-operation with multilateral agencies and given less emphasis to discrete projects that have in the past yielded selected health status gains which may prove hard for the recipient to sustain.

8 There have been a number of problems associated with individual projects - in many respects due to the serious difficulties with implementing effective health services in developing countries. As the Administration are working in independent sovereign states where they do not have direct control, it is almost inevitable that some projects will not be as successful as they would wish. The Administration have made significant progress in recent years in setting more realistic and measurable objectives, and in achieving them.

9 The National Audit Office nevertheless consider that there are ways in which project success could be more strongly secured and recognise that the Administration are seeking to achieve this through:

- devoting more attention, where practical and cost-effective, to ensuring at the outset that baseline data will be available and that targets are realistic, measurable and linked to project objectives;
- focusing specific project objectives on clearly defined outcomes that are achievable and realistic;
- giving more consideration to sustainability issues at the design stage - particularly in reproductive health and institutional strengthening projects;
- improving the service from contracted managers by defining their role more clearly, for example by preparing more detailed project management proposals, either in-house or using consultants, and inviting contractors to quote fees on that basis;
- identifying and contracting procurement agents as early as practicable and ensuring that they are involved in project reviews;

- requiring all managers to submit progress reports which, as a minimum: show past and planned expenditure against budget for each component; identify whether indicators of achievement for each component need updating; indicate progress towards achieving outputs; indicate, with reasons, areas where progress is not going according to plan, including the extent to which project purpose is likely to be achieved; and propose remedial action, if appropriate, with a suggested timetable and clearly defined responsibilities;

- providing more guidance on monitoring and its objectives; and allocating specific monitoring responsibilities to nominated professional staff;

- obtaining more reliable data on progress achieved and assessing more systematically the potential impact of projects to see whether they are achieving their objectives;

- increasing their efforts to secure the commitment, and enhance the capacity, of recipient institutions;

- increasing their active role in seeking the reforms necessary to ensure that greater value for money is obtained from multilateral contributions; and

- enhancing the effect of their funded research - giving greater emphasis to identifying opportunities for introducing cost-effective health care, efficient management and effective delivery, and improving their dissemination of summarised results.

Part 1: Introduction

1.1 The world's population is about 5.6 billion and is currently growing by nearly 2 per cent a year - at least a billion more people every 10 years. The rate of growth in developing countries is generally four times faster than in developed countries and the number of people living below the level of absolute poverty is increasing.

1.2 The people of developing countries are at high risk of disability and death as a result of disease. For example, over three million people have developed AIDS and some 14 million to 18 million adults are thought to be HIV-infected; about 110 million people develop malaria every year; and over eight million new cases of tuberculosis, with three million deaths, occur annually.

1.3 Developing countries' limited budgets, coupled with economic, political and technical constraints, hamper progress in meeting health care needs and in providing family planning services. Many developing countries are currently struggling to finance accessible health care facilities from a budget of less than £7 a person a year. Most countries are now committed to taking action that would lead to stabilising population growth through improved reproductive health rather than by imposing population control measures.

1.4 There have been three United Kingdom ministerial policy initiatives in the health and population sector in recent years. First, in 1987, more support was directed to primary health care and less to hospital building; and in 1991 and 1994, increased support was provided to those who want children by choice. As a result of these policy changes the pattern of health aid has changed in the last decade: from support for hospital services to primary health care in the 1980s, to improvements in the management of health care delivery in the 1990s.

1.5 In September 1994 delegates from 180 countries, including the UK, attended the International Conference on Population and Development. It adopted a strategy to enable all women and men, within the next 20 years, to have the opportunity to choose the number and timing of children and to enjoy better reproductive health - already embodied in the UK's children-by-choice strategy. The approved programme of action envisages the need for educational, health care and poverty-reducing activities as well as the need for more and improved family planning services. The strategy calls for a four-fold increase in the investment in reproductive health and family planning to $21.7 billion a year by 2015. Responsibility for implementing the recommendations rests with the individual countries.

1.6 The Overseas Development Administration estimate that over 300 million people do not have adequate access to satisfactory health services and that over 100 million men and women have no access to family planning services. Health

and population activities are therefore a priority of the aid programme and the Administration liaise with recipient governments to assist in the development of appropriate health policies.

1.7 The Administration's objectives for health and population activities are to enable those most in need to gain access to essential health care, particularly reproductive health care, in ways which make efficient and effective use of available resources. Their priorities, developed over the last four years, are to achieve this by focusing on:

- supporting health sector reform;
- encouraging children by choice by helping to provide access to, and guidance on the use of, better reproductive health services;
- developing the use of cost effective technologies to reduce the numbers suffering from malaria, tuberculosis and HIV; and
- helping with better health care in emergency situations (not covered by this report).

1.8 UK assistance takes the form of bilateral project aid to specific countries - sometimes co-financed with other donors and often partly financed by the recipient government - and contributions to multilateral aid organisations. The Administration also provide support for research and give grants to UK non-governmental organisations funded out of the joint funding scheme.

1.9 The Administration's geographical desks have responsibility for bilateral programmes, supported by professional advisers who may also act as project officers. The Chief Health and Population Adviser is responsible for supervising the quality of the professional input provided to programmes by health and population advisors and other specialists, and for ensuring the adequacy of other systems set up to provide health and population professional inputs to programmes funded by the Administration. His staff administer funds for, and undertake value for money checks on, multilateral agencies and general research projects. Over the last four years the Administration have assigned 14 professional health and population field managers to countries in which priority is given to health and population aid. Support for these managers is being developed through four resource centres which provide consultancy advice on all aspects of project design, implementation and impact.

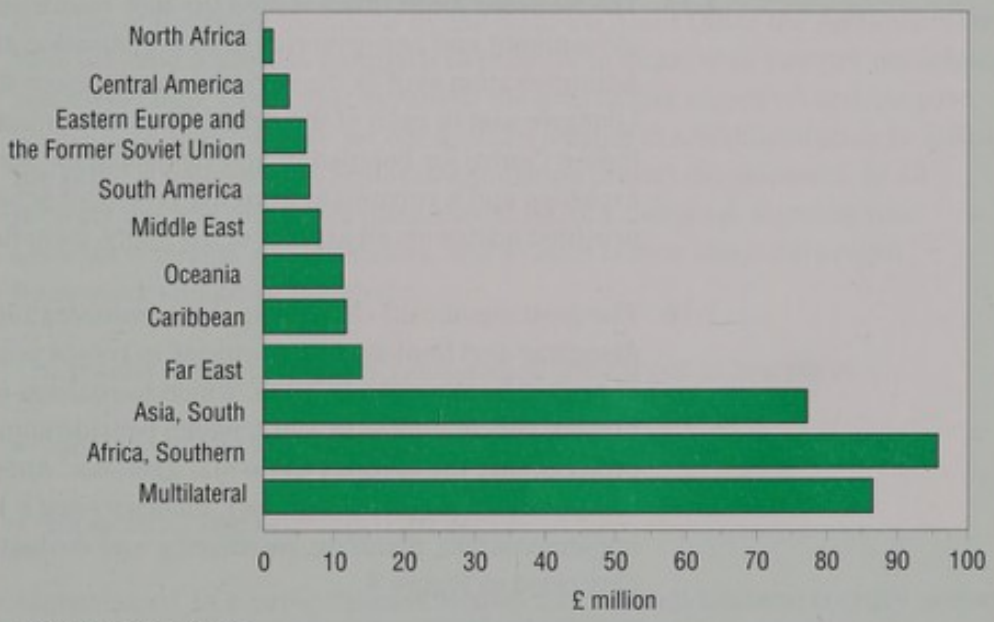
1.10 Over the past six years the Administration have spent £911 million in the sector - including £393 million on emergency aid (Figure 1), allocating a growing proportion of the aid budget to these activities. In 1994-95 the Administration planned to spend about £100 million on health and population assistance, excluding emergency aid.

Figure 1: Health and population expenditure since 1988-89

	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	Total
	£m	£m	£m	£m	£m	£m	£m
Bilateral	30	51	53	58	63	72	327
Multilateral	16	22	28	26	28	39	159
Research	2	3	6	6	7	8	32
Emergency aid	23	31	37	82	96	124	393
TOTAL	71	107	124	172	194	243	911
at 1993-94 prices	100	131	141	185	200	243	

1.11 During those six years the Administration provided bilateral aid in this sector to 70 countries; some 33 per cent went to Africa, 22 per cent to Asia and 34 per cent to multilateral health and population activities (Figure 2). To maximise the effectiveness of resources used, and to ensure that projects are more tightly managed, priority is now given to 20 countries (Figure 3).

Figure 2: Health and population aid 1988-94 - excluding emergency aid



Source: ODA statistics

Over the last six years most health and population aid has been provided to Africa and Asia

Figure 3: The Administration's health and population priority countries

Africa	Ghana, Kenya, Malawi, Nigeria, Namibia, South Africa, Tanzania, The Gambia, Uganda, Zimbabwe, Zambia
Asia	Bangladesh, Cambodia, India, Nepal, Pakistan
Former Soviet Union	Kazakhstan, Kyrgyzstan, Russia
Latin America	Peru

Scope of the National Audit Office examination

1.12 Against this background the National Audit Office sought to examine the:

- Administration's project monitoring; and
- effectiveness of aid, including its impact and sustainability.

1.13 The National Audit Office examined 13 bilateral projects and three joint funding scheme projects in four countries as illustrative examples: seven in Asia (India and Pakistan) and nine in Africa (Kenya and Zimbabwe). These countries received 26 per cent of the Administration's country-specific health and population expenditure between 1987 and 1993. The National Audit Office also examined expenditure on multilateral aid and research activities.

1.14 The 16 projects examined were selected in concert with the Administration to provide an appropriate cross-section. These projects included two approved in 1994 to cover the latest procedural developments.

1.15 The National Audit Office visited the four countries selected, meeting government and non-governmental organisation staff. They interviewed Administration staff in the regional development divisions in Nairobi and Lilongwe and in each of the British High Commissions. A consultant from the Indian Centre for Population and Development Studies provided regional expertise and a consultant from the Liverpool School of Tropical Medicine provided advice on all aspects of the study, including the case-study projects.

1.16 The most significant changes in the Administration's arrangements for designing and implementing projects in recent years have been the introduction of project frameworks in 1986, which formalised objective setting for each project; concept notes in 1992, which provide summary proposals for possible projects; and the "Project Cycle Management" approach in 1993 - a computerised project design tool, incorporating a logical framework to improve implementation, planning, monitoring and evaluation. The three main levels are illustrated in Figure 4.

Figure 4: Responsibilities under the Project Cycle Management approach

Project structure	Responsible professionals	Responsibility
Goal	Chief Adviser	Consistency with the Administration's sector policy
Purpose[a]	Health and Population advisors	To ensure that project purpose is achieved through monitoring of outputs and that outputs lead to achievement of purpose (usually via mid-term review)
Inputs, Activities, Outputs	Field managers and country co-ordinators	To ensure that project outputs are achieved through monitoring of inputs and activities.

[a] Known as immediate objectives under the previous arrangements

This illustrates the three levels in setting objectives, monitoring and impact assessment under the Project Cycle Management approach.

1.17 The Project Cycle Management approach aims to ensure that appropriate objectives and indicators of success are defined; measurable indicators of success defined; key activities identified; critical assumptions underlying the project specified; achievements verified; and required resources adequately defined. Project Cycle Management incorporates a group approach to project development and management and involves greater participation by project beneficiaries and other key stakeholders in needs assessments, planning, implementation and evaluation. Because of the recent introduction of this approach none of the projects examined by the National Audit Office used it though Pakistan Population III applied the Project Cycle Management format for its project framework.

1.18 The Administration make a distinction between project level activities and sector level assistance. The latter can consist of programme aid, aimed at general balance of payments support, or technical co-operation and financial aid directed exclusively at a sector, aimed at achieving policy changes, institutional development, rehabilitation and investment in the sector. This report covers project aid and sector aid directed towards the health and population sector.

1.19 In some of the cases examined by the National Audit Office the Administration have adopted a process approach to projects to improve in-country participation and ownership. Under this approach the goal (wider objective) and purpose (immediate objective) are set out initially, leaving the Administration to define the general indicators of achievement during project development. In all projects the first phase activities should be fully designed, together with associated targets and indicators, and at each review stage the project framework should be updated.

1.20 The results of this case-study examination are set out in two parts:

- monitoring and implementation (Part 2); and
- impact and sustainability (Part 3).

1.21 Appendices 1 to 4 cover the case studies for the main bilateral country projects examined in the four countries visited. Appendix 5 deals with multilateral expenditure and Appendix 6 includes case summaries of research expenditure.

Part 2: Monitoring and implementation

2.1 Health and population activities should have specific measures against which the achievement of immediate and wider objectives can be assessed. As there are many influences on people's health, establishing objectives that a project can realistically achieve and which progress can be monitored against is not always easy, but important. To enable assumptions to be tested before a project is complete, and if necessary re-focus efforts and take remedial action, the Administration also need indicators of progress. All indicators should be practical, independent, targeted and objectively verifiable; and they should specifically define the quantity, quality and timescale for the achievement of the stated objectives.

2.2 In their examination of each of the cases selected for review, the National Audit Office made a judgement of the extent to which the Administration had achieved these goals. The National Audit Office considered that all projects included health and population impact objectives, though in six cases these were either unclear or the objectives were outside the scope of the project - Contraceptive Social Marketing, Cervical cancer, India (Appendix 1A) Population I & II, Reproductive Health Services, ADB III Health, Pakistan (Appendix 2A-C), and Isiolo Hospital, Kenya (Appendix 3A).

2.3 For most of the projects examined contracted managers were given the responsibility for managing projects and tracking progress. The Administration's professional advisers undertake the majority of work relating to project appraisal and design. All projects were monitored by the Administration's geographical desks, closely supported by in-house professional advisers. Frequently the Administration also employed consultants to visit projects on their behalf to undertake monitoring tasks. Financial management was undertaken by the geographical staff.

Project management

2.4 Management arrangements vary between regions and, in the light of past experience, greater capacity is being introduced with the appointment, over the last four years of 14 specialist health and population field managers. In addition increasing use is also being made of contractors to manage individual projects on behalf of the Administration. These arrangements will need to be evaluated in due course to see if they are more efficient and effective.

2.5 In south Asia, the Administration normally employ project managers - in India and Pakistan usually the British Council. In Africa, the Administration tend to manage projects themselves except for procurement, which they contract out. In Kenya and Zimbabwe they relied on staff in their regional offices in Nairobi and Lilongwe to visit projects and monitor progress, although since 1994 they now have field managers in post.

2.6 The Administration cannot identify the comparative costs of their alternative management arrangements as they do not have a system to allocate staff costs to individual projects. An efficiency scrutiny in 1992 recommended that a time recording system be introduced and the Administration are reviewing the outcome of a pilot scheme implemented in other aid sectors in 1993.

Progress reporting

2.7 Progress reporting is assisted by a reporting format which identifies progress towards objectives and highlights key areas for attention. The source of progress reports varies according to the method of project management. Where it is contracted out or undertaken by other agencies, the Administration's staff continue to visit projects regularly for monitoring purposes but rely on reports submitted by managers for detailed information on progress.

2.8 The Administration expect project management contractors to report regularly on the extent to which objectives are being achieved or on areas requiring remedial action. For five of the six contracted out projects examined, the Administration had not agreed a reporting format with the project manager which would provide the necessary information. Managers' reports often included considerable detail but did not provide a ready summary of progress and/or an analysis of expenditure against targets.

2.9 Similarly, where the Administration's field staff managed projects, their progress reports to the geographical desk did not use a common format and, in the National Audit Office's view, did not cover all key areas.

Objective and target setting

2.10 The Administration's framework for project design under their Project Cycle Management approach (paragraph 1.17) requires that objectives be set at three main levels: the wider goal to which the project contributes; the specific purpose which the project is intended to achieve; and the various outputs which contribute to achieving the purpose, and for which the project's inputs and activities are designed.

2.11 The Administration have not always been able to set measurable indicators of progress where the aim has been to improve the general health status of a population, particularly before the projects start. Difficulties are also

experienced when a "process" project's emphasis is, for example, on institutional development. Despite these difficulties the Administration aim to ensure that realistic and measurable targets are set for proposed projects.

2.12 The National Audit Office found that in nine of the 16 projects examined, the Administration had not set measurable indicators of progress towards the project's objectives. In some instances the Administration had set goals to improve health status, which the National Audit Office consider were too broad to demonstrate project impact and too difficult to monitor. Some of the indicators selected were designed to enable impact to be assessed after project completion. In other cases, the indicators measured project achievement at output level - for example the number of clinics built - but not at impact level - such as clinic usage and treatment provided. Such indicators do not enable the Administration to test their assumption that planned outputs will lead to the achievement of project objectives.

2.13 The National Audit Office noted, however, an improvement over time. In particular, in the two recently approved projects (Appendices 2D and 4C) the Administration had designed more realistic and quantifiable indicators with data that are more readily available and useful to monitor progress towards the stated objectives. Whilst the Zimbabwe Sexual Health project (Appendix 4C) set appropriate objectives and useful indicators, some of the targets appear ambitious. They rely on critical assumptions about condom use that were not well documented. The project assumes that the supply and distribution of condoms will result in the usage rate increasing to 25 per cent which in turn will be sufficient to hold HIV infection at its current level. Factors external to the project may result in an increase in HIV infection despite achieving the planned increase in the use of condoms.

2.14 In 1993 the Administration initiated a major programme of training in the procedures for the regular review of project objectives and the resetting of indicators during implementation. These revised procedures are now being introduced by health and population advisers.

Financial management

2.15 Although financial monitoring is the responsibility of the geographical desks, in most instances they did not have a sufficiently detailed knowledge of a project on which to exercise financial control and need to rely on reports submitted by project managers. In most cases financial records were up-to-date but they did not always include details of individual project components. For example, the Administration did not have a breakdown of expenditure by component for Pakistan Population I and II (Appendix 2A) or, until the fourth and final year, for St Stephen's Hospital, India (Appendix 1B).

2.16 In more recent projects, such as health management strengthening and Population III (Appendix 4A and 2D), delays had also been experienced in obtaining expenditure analyses by component. In all these cases the Administration did not have ready access to the necessary information to

exercise judgements about efficiency and effectiveness. For St Stephen's, they had to delay a decision on whether funds should be made available to pay for additional training.

2.17 The introduction of overseas field managers should provide the opportunity to improve the financial control of projects, provided the managers are given clear terms of reference defining their financial responsibilities and access to the Administration's computerised financial information.

Contractual arrangements

2.18 In nine of the 13 projects examined where management, monitoring or procurement tasks had been contracted out, the Administration had not sought competitive tenders. Two of these nine were relatively small - under £50,000 each - a level below which the Administration may waive tender action if the cost of holding a competition is considered significant. The other seven contracts ranged from £100,000 to £1.5 million; competition was waived because the project was an extension of a previous phase, the manager had unique expertise in the area, or because the Administration aimed to give the British Council the opportunity of first refusal or because their contractual arrangements gave the Crown Agents exclusive rights to Administration - funded procurement for certain countries.

2.19 When seeking project management tenders, the Administration ask contractors to submit proposals on the basis of a project outline and brief terms of reference. They then negotiate any adjustments they consider necessary in the fees or services. While this gives contractors who are familiar with the procedures an advantage in submitting proposals, it removes the Administration's need to define in detail the management services they require. The Administration consider that this flexibility can, particularly in process projects, be an advantage.

2.20 Although the Administration had a broad Memorandum of Understanding with the British Council covering project work carried out on the Administration's behalf, in two cases adequate contract arrangements with the Council had not been made. In Orissa Health and Family Welfare (Appendix 1A) the Administration obtained a management proposal from the British Council but the service contract was not signed until two and a half years into the project - by which time the Council had been paid more than £0.7 million. In the Cervical Cancer Research project (Appendix 1C), the Administration employed the British Council as project manager at a cost of £37,000 but no terms of reference were agreed or contract signed.

2.21 Adequate contract arrangements were in place for procurement projects but two had problems:

Emergency Supply of Condoms, Zimbabwe. The Crown Agents were appointed without competition, despite having more limited experience in procuring such contraceptives. Although the first three consignments passed

pre-delivery inspection, the Zimbabwe regional drug control laboratory found the condoms to be defective. The Administration have paid the suppliers, Dongkuk Industries, £0.4 million for two of the consignments. Dongkuk have agreed to replace the defective consignments free of charge over one year ending November 1995 and the contract with Crown Agents for this project has been terminated (Appendix 4B).

Supply of Vehicles to Pakistan (Population I and II). The Administration and the Pakistan Government agreed with a commercial supplier what emerged to be an inadequate specification for 91 vans procured at a cost of £885,000. These vans needed substantial modification, at an additional cost of £22,500. As a direct result of this modification about 75 vans suffered significant damage which cost the Administration a further £16,700 for repairs (Appendix 2A).

2.22 In these cases Administration staff spent considerable amounts of time discussing possible settlements internally and with the procurement agent regarding the negotiation of settlements with suppliers.

Monitoring

2.23 Effective project monitoring aimed at identifying and addressing implementation problems, should be established at the design stage. Monitoring criteria set at this point should include: ensuring sufficient information is provided to track project implementation; setting quantitative and verifiable indicators of project progress and performance; establishing responsibility and providing funding for monitoring; and, where it is essential to identify actual performance, establishing of baseline data.

2.24 The National Audit Office found that satisfactory monitoring criteria had been set for 13 of the 16 projects. Three projects had had formal mid-term reviews, two of which were carried out jointly with the World Bank. The cost of monitoring was not, however, identifiable as the Administration do not record staff time allocations. The Administration have not provided guidance on project monitoring requirements, including how to relate a proposed monitoring strategy to the project's cost and perceived risks. This is being addressed in the Administration's current revision of their Guide to Aid Procedures.

2.25 The National Audit Office considered that project monitoring tended to focus too much on the provision and use of inputs and often did not relate progress to objectives and targets. This was mainly because of the need to address problems with the delivery of the required inputs (mainly timeliness and quality) and monitoring had to concentrate at that level. Where mid-term reviews were undertaken, however as in the case of Orissa (Appendix 1A), there was greater attention to outcomes in relation to the objectives and targets set. The Administration indicated that mid-term reviews were designed to focus particularly on whether project outputs were achieving the purpose as specified

in the project framework, and that routine monitoring missions should be primarily concerned with whether project activities and inputs were achieving the specified outputs.

Remedial action

2.26 When projects are not meeting their planned targets, remedial action needs to be considered. For projects where the management was contracted out, the Administration intervened only at higher levels in recipient institutions, or when delays were particularly serious. However they did not specifically define respective responsibilities for remedial action in their contracts with project managers. In contrast, where the Administration's field staff managed projects, they had responsibility for remedial action and informed the geographical desks of any serious problems.

2.27 The National Audit Office noted:

a) four cases where remedial action had been successful, resulting in prompt improvements in progress:

Family Planning through community institutions, Pakistan, where the Administration noted in 1992 that 97 per cent of sterilisations under the project were for women. They encouraged the Family Planning Association to focus more on men and by September 1993 the proportion of male sterilisations had risen to 40 per cent;

St Stephen's Hospital, India, where persistent pressure by the British Council's building adviser should ensure that the new wing will be completed only eight months late - substantially earlier than had appeared likely (Appendix 1B);

Isiolo Hospital, Kenya, where the additional technical assistance provided after the construction enabled a hospital preventative maintenance system to be introduced and a surgical referral service established (Appendix 3A); and

Kenya Population III (family planning association component), where the provision of an independent architect reduced the construction costs by £65,000 (Appendix 3B).

b) in most other cases the Administration or project managers took remedial action which was partially successful or was eventually effective - for example:

Orissa Health and Family Welfare, India, where, during two years of minimal progress, the Administration and the British Council repeatedly requested the recipient authorities to comply with the project conditions. Faster progress was noticeable after a further 18 months due to a significant

increase in the Administration's monitoring. Despite these delays the Administration nevertheless expected the project to meet its original construction target of March 1995 by June 1995 (Appendix 1A);

Asian Development Bank III, Pakistan, where the British Council have repeatedly pressed a provincial government to authorise staff posts for repair and maintenance workshops to be set up. In May 1994 the Administration formally suspended their inputs under this component and have since received assurances that the posts will be established (Appendix 2C);

Zimbabwe Health Management Strengthening, where there were delays of a year and two and a half years in appointing two technical advisers. In the latter case the delay was in part caused by the Administration's desire not to undermine the project by recruiting an unsuitable person and partly because they had initially set over- ambitious terms of reference for the post. With these problems behind them Administration consider that the project is now performing well and expect it to make a major contribution to health management development in Zimbabwe (Appendix 4A);

Kenya Population III, where the project co-ordinator did not perform satisfactorily. After three years seeking to persuade the World Bank to amend his work objectives so that they provided greater critical dialogue with Kenyan institutions, the Administration withdrew funding for this post. The Administration consider that the co-ordinator's performance neither assisted nor adversely affected the project and that its main components are now providing tangible results which should lead to a marked improvement in reproductive health services (Appendix 3B); and

Emergency Supply of Condoms, Zimbabwe, where the Administration appointed an alternative procurement agent to supply condoms after the first consignments were found to be defective. The replacement condoms began to arrive 18 months after the planned supply date (Appendix 4B).

c) three cases where remedial action was not taken or was taken late because of over-optimistic objectives, professional dispute, and a decision by the Administration to delay action.

Pakistan Population I & II, where a number of the components made limited progress: for example, the innovative and non-governmental components, where only a small percentage of their respective £515,000 and £600,000 allocations were spent. This was partly because of political turmoil in the country, the Administration having no field presence for over three years and no remedial action having been taken to address the delays caused by local bureaucracy and its insufficient implementation capacity (Appendix 2A);

Cervical Cancer Research, India, where the Administration had not formally allocated responsibility for remedial action and disagreements between consultant specialists about the scientific approach hindered progress (Appendix 1C);

St Stephen's Hospital, India, where the Administration took no action on the planned financial consultancy until March 1994, when the project had entered its final year. Steps are now being taken to strengthen the hospital's financial management but the Administration have still not established whether the hospital has the capacity to sustain services to the poor, as expected in a 1990 study (Appendix 1B).

2.28 The delays identified in these cases reflect, in part, the difficulty in implementing prompt remedial action in partnership projects. In these circumstances the Administration have, on occasions, decided to delay remedial action and instead to review the objectives and activities supported.

Contributions to multilateral organisations

2.29 The Administration contribute on a voluntary basis to the health and population activities of three international agencies: the United Nations Population Fund, the International Planned Parenthood Federation and the World Health Organisation. Contributions to the World Health Organisation include funding for health research activities (Part 3).

2.30 Since April 1988 the Administration have contributed some £159 million to these organisations. The National Audit Office examined how the Administration monitor the value for money they obtain from this funding. They concluded that the Administration:

- had established comprehensive review and evaluation procedures, providing management with valuable information on the effectiveness of the funded agencies;

- consider a broad span of evidence, including evaluations performed by other donor countries, in assessing the effectiveness of funded agencies; and

- had been active in seeking the reforms necessary to ensure that their increasing contributions to World Health Organisation's special programmes achieve the optimum value for money.

Part 3: Impact and sustainability

3.1 In assessing projects, the National Audit Office recognised that many operate in difficult conditions often in deprived areas with weak and ineffective management systems - while attempting to tackle major and urgent health and population problems. Projects are also often implemented in difficult political and economic environments. Whilst individuals may benefit when projects improve services, the effects may not always be directly quantifiable through general measures of health status.

Impact

3.2 Project impact arises from the effects - direct and indirect, wanted and unwanted - which result from a project's activities. Comprehensive analysis of the impact, or potential impact, of health and population projects is difficult but evaluation studies can measure the achievement of specific targets, collect qualitative information from implementers and beneficiaries, and draw on national and local surveys producing health and population indicators. Research can contribute to effective monitoring by testing whether indicators are reasonable proxies of impact. Impact becomes complex and costly to assess if attempts are made to disaggregate the Administration's contribution to the overall impact, such as in partnership projects.

3.3 Impact, or potential impact, can be assessed at a number of stages and in a number of ways: at the design stage (paragraph 3.5), in progress reports (paragraphs 3.6 to 3.8), by comparison with objectives (paragraph 3.9), in completion reports (paragraph 3.10), through general research (paragraph 3.11) and in post completion evaluation reports (paragraph 3.12). During implementation many factors can influence project impact (paragraphs 3.13 and 3.14).

3.4 In some of the projects examined the Administration had either delayed carrying out an impact assessment - for example, Isiolo Hospital (Appendix 3A) - or had not carried out any impact assessment during the project's life - such as Kenya Population III (Appendix 3B). The Administration said that the latter project would be included in post-project impact assessment studies currently planned. In seven other cases, such as the non-governmental organisation components of Pakistan Population I and II, the Administration did not ensure that sufficient information was provided to assess impact.

(a) Design stage

3.5 At the design stage the Administration aim to make a general assessment of the likely impact of the proposed projects, where appropriate drawing on the impacts achieved by earlier phases or similar projects. Only two of the projects examined included explicit consideration of whether the interventions proposed were the most cost-efficient. Orissa (Appendix 1A), for example, is based on the Government of India's policy assumption that building static health centres, together with training and other inputs, is the most cost-efficient means of improving health services in rural areas. The Administration did not undertake a rigorous examination of alternatives before commencing Phase II as they perceived that mobile clinics (where an earlier project had failed) were not a viable option to static services and considered that no other choice existed. They also saw the project as an opportunity to bring Orissa up to 50 per cent of the Indian Government's recommended national provision for static services.

(b) Progress reports

3.6 As identified in paragraph 2.25, the Administration's routine monitoring reports focus on the provision of inputs and progress in achieving project outputs. In most cases, they do not include analyses of the impacts - positive and negative - that a project is achieving, or likely to achieve. Such issues should be examined during mid-term reviews. In addition, some separately commissioned evaluation reports on particular on-going projects or project components contained useful analyses of impact: the reports on the vehicles (1988) and contraceptive supply (1990) components of Pakistan Population I and II (Appendix 2A), and the Kenya Family Planning Services project (1992) (Appendix 3C) are examples.

3.7 The Administration have not carried out many impact assessments of the training components of projects. For example, there has been no assessments of the training aspects of Pakistan Reproductive Health Services (Appendix 2B), Kenya Population III (Appendix 3B) or Zimbabwe Health Management Strengthening (Appendix 4A).

3.8 Most of the training provided was UK-based, even though this is more expensive than in-country or regional training. Much of it has been of a high standard but recipients have not always been able to use their new skills to the full. With Orissa (Appendix 1A) and Asian Development Bank III (Appendix 2C), some of the staff who received training in the UK were, soon after their return, transferred to jobs where they were not able to use their new skills.

(c) Achievement of objectives

3.9 The success of a project is generally determined by whether it is achieving, or has achieved, its objectives. To make this assessment it is necessary for clear, appropriate, project-specific objectives be set at the design stage and for data to be collected during and after the project. In the 16 projects examined the National Audit Office found:

- four cases where separate objectives for the scope of the Administration's funded project had not been set. This included two projects (Pakistan Population I and II and the Asian Development Bank III) where the Administration's contributions were linked to multilateral projects, each of which had its own detailed objectives; and

- seven projects lacked the necessary baseline data. For six of the indicators for which targets were set in the Zimbabwe Sexual Health project (Appendix 4C) there were no reliable data on indicator levels at the outset of the project. Studies planned by the Administration to produce baseline data for the Zimbabwe Health Management Strengthening project were delayed by three years.

(d) Completion reports

3.10 The Administration require completion reports on projects costing over £250,000, primarily to identify successful and unsuccessful elements of implementation, assess impacts achieved or expected and to derive lessons. However, reports are often not produced until long after a project has finished, limiting their usefulness. At the time of the National Audit Office examination, of seven completed projects only one report had been produced; three were in draft.

(e) General research

3.11 Various studies have been undertaken on the Administration's behalf to assist in predicting the potential impact of different forms of health and population interventions. Recent work has included assessing the best public/private mix for health care in developing countries, comparing different types of cost recovery systems, and reviews of the effectiveness of health service interventions. The Administration have recently decided to put more effort into summarising the findings of this kind of research so that it can be more easily disseminated.

(f) Evaluation reports

3.12 The Administration's Evaluation Department undertake ex-post reviews of a number of projects each year. In the last five years they have evaluated two small health projects. In one, on water supply and sanitation, it proved impossible to quantify the project's health impacts because of inadequate objectives and a lack of baseline data; in the other, on children's nutrition units, they concluded that the project had had a positive impact on its intended beneficiaries, although they questioned the project's sustainability. The Administration plan to evaluate four population projects over the next two years.

(g) Factors affecting impact

3.13 The benefits derived from a project should be assessed against the cost involved to establish the extent to which value for money has been achieved. The Administration do not charge design and appraisal cost to projects or the time

of their staff. In addition, for four projects, the Administration did not readily know the amount spent on individual components; one of these (Pakistan Population I and II) pre-dated the Administration's management information system.

3.14 A number of factors can affect implementation and project impact: adequate funding arrangements, the timely appointment of technical staff, the timely delivery of project equipment and recipients' commitment to the project. Examples of where problems arose include:

- **poor project design** leading to reduced project impact because the activities lacked coherence, and did not focus on one clear purpose (Pakistan Population I and II, Appendix 2A);

- **lack of commitment** by the implementing agency in Orissa (Appendix 1A) caused delays in the new buildings becoming operational;

- **failure to use inputs effectively** - a minibus in Kenya (Appendix 3B) has remained unused for three years, and a Landrover supplied under the Health Strengthening Project in Zimbabwe (Appendix 4A) remained unused for two years until the technical officer arrived; and

- **procurement problems** led to the failure to deliver 66 million condoms to Zimbabwe (Appendix 4B) and resulted in stocks falling to a critically low level which a follow-on project is beginning to meet.

(h) Findings

3.15 Of the 14 projects that had started, the National Audit Office found that nine had largely achieved, or were likely largely to achieve, their objectives, three will partly achieve their objectives and two were likely to have little impact partly. The Kenya Family Planning project (Appendix 3C), for example, had been a major success in increasing the use of injectable contraceptives; the Kenya Isiolo Hospital (Appendix 3A) had provided a much needed facility; Orissa Phase II (Appendix 1A) has helped to establish the infrastructure for future health services for over 30 million people; St Stephen's Hospital (Appendix 1B) is likely to provide greatly improved services; and the Zimbabwe Supplementary Supply of Condoms (Appendix 4B) is now ensuring access to condoms. On the other hand, the initial Zimbabwe Condom Supply project (Appendix 4B) and Pakistan Population I and II (Appendix 2A) made little progress.

Sustainability

3.16 Sustainability is the capacity to maintain the desired impacts beyond the end of the project. The Administration have well-established procedures to appraise the economic viability of projects but most proposals appeared to pay insufficient attention to how activities could be sustained after UK funding came to an end. The Administration told the National Audit Office that detailed discussions about sustainability always took place internally and with recipient

countries. The issue was also often addressed through donor agencies' wider dialogue with national agencies but much of this is not documented on project files. The Administration are currently preparing a policy statement about health and population sustainability.

3.17 The Administration recognise that projects should always consider sustainability. They however, accept that many developing countries are unlikely to be able to meet the full cost of their contraceptives, essential drugs and medical supplies. They therefore plan this kind of project on the assumption that donors will continue to contribute to such supplies. Where the aim of a project is to achieve a high immediate impact there may be less need to consider sustainability - for example a project addressing the spread of HIV.

3.18 Even where the Administration gave specific project consideration to sustainability, recipient governments were, in many instances, reluctant to commit themselves fully to the continuing cost of providing medical and contraceptive supplies. Given the decreasing levels of funds available for health care in developing countries, the Administration consider that this situation could prevail for several decades.

3.19 Examples where project sustainability was not considered include the Pakistan Reproductive Health Services project (Appendix 2B) and the Population I and II non-governmental schemes (Appendix 2A). In the latter case, 35 of the 171 non-governmental organisation outlets funded closed down after the project finished.

3.20 Three of the six contraceptive supply projects examined provide examples of different levels of sustainability consideration at the outset:

- in **Pakistan Population III** (Appendix 2D) sustainability was considered and action taken. The Government of Pakistan is committed to contributing a specified and increasing proportion of the national population budget over the life of the project. The Administration will not release project funds unless these commitments are honoured;

- in **Zimbabwe Sexual Health** (Appendix 4C) sustainability was considered but the risks remain high. The Government of Zimbabwe has expressed an intention to pay for an increasing percentage of condom procurements but the Administration are not in a position to produce safeguards to ensure such contributions are paid; and

- in **Kenya Family Planning Services** (Appendix 3C) sustainability was not considered. Kenya is largely reliant on donors for contraceptive supplies and the Administration have given thought to ways to reduce this long-term dependence without requiring Kenya to borrow substantial sums, including gradually introducing some user charges and expanding contraception distribution.

3.21 The National Audit Office consider that only three of the 13 projects examined, where activity has started, have good sustainable prospects in the sense that they will lead to continued services and benefits without external financing - Pakistan Family Planning, St Stephen's Hospital (Appendix 1B) and Zimbabwe Health Management Strengthening (Appendix 4A).

3.22 Three main factors can have a significant influence on sustainability:

- the degree of involvement and ownership by the recipient government or institution and beneficiaries (paragraphs 3.23 to 3.25);
- the management capacity of the recipient government or institution (paragraphs 3.26 and 3.27); and
- the availability of recurrent funds (paragraphs 3.28 to 3.32).

(a) Involvement and ownership

3.23 The Pakistan Family Planning project is a good example of how working closely with the beneficiaries from the outset increases the prospects of sustainability. As well as providing land for the new community centres, the local people have accepted responsibility for the buildings' on-going maintenance. Similar commitments have been made in the case of the refurbished clinics being built under Kenya Population III (Appendix 3B).

3.24 In most of the projects examined the National Audit Office found a high level of ownership on the part of recipient institutions. Examples include the commitment by the Zimbabwean Ministry of Health and Child Welfare for the Health Management Strengthening project (Appendix 4A), despite delays in obtaining the planned support from the Administration; and the Family Planning Association of Pakistan's commitment to the community institutions' family planning project.

3.25 There is no evidence that the Administration attempted to secure the commitment of the Ministry of Education to the population studies centres which formed part of Pakistan Population I and II (Appendix 2A). The Ministry have not taken over their funding and one of the two centres closed down in 1993; the future of the other is uncertain. There was also a lack of ownership in Asian Development Bank III (Appendix 2C) by the Government of North West Frontier Province, Pakistan, which suggests that some project activities may not be sustainable.

(b) Management capacity

3.26 Since 1991, improving the management capacity of recipient country health institutions has become a priority area but the Administration's efforts have not always been successful. For example, attempts to strengthen the Kenyan Population Council (Appendix 4A) have achieved little. A more flexible approach to planning - the process approach - is being used to develop management capacity. As this approach becomes better developed it will need evaluating.

3.27 Since the inception of the Administration's project, the effectiveness of the Administration's inputs to Orissa's health sector (Appendix 1A) has been undermined by limitations in local management ability. The Administration were aware of this problem from the earlier phase and the mid-term review of phase II in January 1993 identified a need to strengthen management. The current project now includes pilot work on central and district health management information and training systems, the results of which should inform the design of a successor project.

(c) Recurrent expenditure

3.28 The Administration are reluctant to continue funding recurrent costs because of the long-term commitment which this would involve and their desire to encourage developing countries to help themselves. Equally, recipient governments are often reluctant to commit themselves fully to the continuing costs.

3.29 Most project proposals did not include estimates of the recurrent cost implications and the potential future burden on the recipient's budget. However, five projects specifically considered recurrent costs - for example Zimbabwe Sexual Health (Appendix 4C) where the Administration estimated that an additional £2.8 million a year would be required to sustain activities.

3.30 For seven projects recipients have found it difficult to meet recurrent costs. The initial medical supplies for the Isiolo hospital (Appendix 3A) were therefore funded by the Administration to ensure immediate sustainability following construction. In Orissa (Appendix 1A) the state government is not able to provide adequate funds for the drugs and consumables required by the new centres due to its worsening financial position. Under Asian Development Bank III (Appendix 2C) the Administration and the British Council have lobbied for the project's recurrent costs to be covered by local budgets - but so far with limited success.

3.31 It is likely that most project activities, particularly those targeted at the poor, will not be able to generate enough income to cover all their costs. To be sustainable they are likely to need continued external funds from donors, the government or a non-governmental organisation. In contrast St Stephen's Hospital (Appendix 1B) is likely to be sustainable as it is managed by an organisation which has proved itself to be very successful at securing funds. Similarly, with the backing of the Family Planning Association of Pakistan, the sustainability prospects of the family planning through community institutions project look good.

3.32 Although the Administration have well-established procedures to appraise the sustainability of their projects, it remains hard to predict for projects addressing institutional reforms. The Administration recognise the difficulties, which have recently been re-emphasised following the results of an evaluation of institutional development projects. They plan to provide further guidance in this area.

Impact of health and population research

3.33 The Administration support a wide range of health and population research and development activities through partnerships with academic groups, non-governmental organisations, international bodies and the British Medical Research Council. Since April 1989 they have spent £85 million on health and population research, including £55 million on contributions to seven international bodies and £30 million to UK organisations.

3.34 The main objectives of this research are to provide the information to assist in the establishment of a social and economic climate for people to choose when to have children; and to improve the availability, accessibility and quality of family planning and health care services.

3.35 During their visit to India, the National Audit Office reviewed one country-based research project funded from the bilateral aid programme (Cervical Cancer, Appendix 1C). They concluded that the research project had been poorly designed, had been set an unrealistic objective and had been inadequately implemented. It had not influenced cancer policy or control in India, although it has helped transfer, from the UK, DNA hybridisation techniques in research. The Administration consider that there has nevertheless been excellent value for money from the £300,000 invested as it has improved screening procedures and the viability of the laboratory.

3.36 The National Audit Office also reviewed the general health and population research projects to see what steps the Administration had taken to ensure that they were focused on Departmental priorities, whether they had monitored progress and results, whether completed research had had an impact on policy formulation, and whether the Administration had encouraged follow-up action, including the introduction of cost-effective health measures (Appendix 6).

3.37 The National Audit Office findings were:

- the Administration had taken significant steps to provide greater direction to the research currently undertaken on their behalf. They had formalised the arrangements with the Medical Research Council and had introduced competition into the selection process;

- there had been an impact on policy formulation at country and international level and recently completed research had enabled research skills to be built up in the essential health and population areas;

- the Administration are putting more effort into summarising and disseminating the findings of research studies, assessing the potential impact of different forms of health and population interventions; and

- the Administration are now making arrangements for evaluating most of their research activities.

Appendix 1: India

1 India has a population of over 900 million, growing at a rate of 2 per cent a year. It is expected to rise to over 1 billion by 2000. India also has almost 40 per cent of the world's poor. Despite faster improvements in health than in most south Asian countries, morbidity levels remain high among infants, children and women. Life expectancy is 59 years.

2 India's national health policy aims to provide health for all and to achieve a net reproduction rate of one by 2016. Previous initiatives have emphasised female sterilisation but this has been replaced by a greater focus on spacing methods and increased family planning and reproductive health service provision. The Administration have provided £22 million in bilateral health and population aid since 1988-89. Their current priorities are health sector reform and management strengthening, reproductive health, and efforts to stem tuberculosis, malaria and HIV.

A. Orissa health and family welfare, phase II

Wider Project Objective
- Improve the health and family welfare status of people in Orissa (population 30m), giving particular priority to mothers and children, and tribal groups

Immediate Objectives
- Increase the availability of health and family welfare services in 10 districts, and improve their quality and usage in all 13 districts
- Identify and test new and more cost-effective methods of health care delivery
- Increase community participation in the planning and operation of health services

Project Activities (1990-95)
- 1,484 buildings, including health centres, staff quarters, district training units
- In-service training for health workers
- Promotion of information, education and communication activities
- Developing a health management information and evaluation system
- Repair of buildings erected in Phase I and maintenance of all buildings
- Vehicles for project management, training and health centres
- Research and innovative projects for malaria, safe motherhood, new contraceptives
- Technical co-operation (UK training, consultants, surveys, management and monitoring costs)

Project Cost

Total cost:	£26m (£6m from Indian & Orissan Governments)
ODA Allocation:	£20m (£17.2m local costs, £2.8m technical co-operation)
Expenditure by November 1994:	£7.7m (£5.7m local costs, £2.0m technical co-operation) – the Rupee has consistently depreciated against sterling during the project.

Project Management
Carried out by the British Council
Management charges: £1.5m (8% of allocation, 11% of expected expenditure)

Project history: Phase I, 1980-87
The Administration contributed £13.3m to Phase I. 68% of expenditure was for constructing or upgrading 1,400 health centres and other buildings. These were generally of a low standard and poorly maintained.
The number of nurses increased three-fold; training standards were raised.
A survey in 1989 found some improvement in service delivery since 1981 but people, especially the most disadvantaged, remained unaware of health services or did not feel the need to use them. In 1989 Orissa's infant mortality was 133 per thousand compared with the Indian average of 96.

Targets
Achievement indicators set by the Administration did not enable them to fully monitor progress towards their immediate objectives or to take all necessary remedial action because:
- many could not be quantified until after the end of the project - for example, increase in usage of health services was to be measured over 10 years using baseline and endline surveys;
- some, for example for construction and training, were quantifiable during the project and provided an indication of increased availability of services but did not address quality; and
- the project framework rested on the assumption that the inputs would improve the availability, quality and client usage of the increased services provided.

A. Orissa health and family welfare, phase II

Targets (contd.)

After the mid-term review in January 1993 the Administration concluded that the project required a more precise definition of objectives and related inputs, focusing on health systems development. However because of the project's subsequent slow progress and a change in key personnel, they decided in mid-1993 to pursue only certain aspects of their new strategy and to concentrate their efforts on achieving the original planned outputs. The Administration nevertheless recognised that a clearer set of indicators was still required.

Management and Reporting

- In June 1989, at the Administration's request, the British Council submitted a draft proposal for field management; the Administration did not seek other offers. The Administration began payments from January 1990 but the contract was not signed until October 1992, then covering the period April 1992 to March 1994.
- The contract did not provide a specific reporting format for the Council to follow. Its reports contained considerable detail but did not provide a readily accessible summary of progress, show expenditure against targets for each component, or indicate which key areas required remedial action. After 1991 the Government of Orissa would not provide the British Council with expenditure details for each component. In September 1993 the Administration asked for more information on progress against targets but still provided no specific guidance on format. From January 1994 the Council provided additional monthly update reports.

Monitoring

- The management contract did not provide a clear definition of responsibilities.
- The Administration were concerned from the outset that the Orissan Government might have difficulty in managing such a complex project. They therefore liaised directly with the construction agency. From 1993 they increased the frequency of their monitoring missions from once or twice a year to four visits. This reflected growing problems faced by the project - in particular the building programme had fallen significantly behind schedule because the Orissan Government wanted to use a different building contractor. The project director refused to assign building sites to the authorised contractor until July 1993, as a result of which the building programme was set back a year.
- The Orissan Government was also slow to release funds to the construction agency. Administration pressure was initially unsuccessful and early in 1994 they considered exploring alternative means of funding. However the flow of money improved in mid-1994 and it was expected that the construction target would be met by June 1995.
- Expenditure is expected to be £15.6 million by the end of the project (78% of allocation).

Project progress: construction

- About 70 % (£12.5m) of the project's local cost is intended for construction.
- The Administration did not assess whether this mix of construction and other inputs was the most cost-effective means of delivering primary health care, although construction had also been a major component in Phase I. At the Phase II appraisal stage they considered allocating less to construction but concluded that it was justified by the inadequacy of buildings relative to Indian Government norms. However they recognised the risk that the uptake of health services might remain low, as it had during Phase I. They sought to address this risk by training health workers and through social mobilisation activities but, after the 1993 mid-term review, concluded that uptake of services remained unacceptably low.
- A National Family Health Survey in 1993 demonstrated a low uptake of services in clinics in rural Orissa where 90% of the population lives:
  - only 5% of births were attended by paramedical health staff, many of which were not in a clinic; and
  - 85% of rural deliveries were in homes, attended by relatives or traditional birth attendants.

A. Orissa health and family welfare, phase II

Project progress: construction (contd.)

- Better sub-centre clinics were required in Phase II but the Administration still intended them to be low cost and simple. The buildings are of a higher specification to minimise maintenance requirements but are also 50% larger to allow health workers to live on the premises and to provide greater privacy for the medical staff to work with patients. In November 1993 the British Council buildings adviser proposed a simpler and 30% cheaper design but the Administration did not adopt this alternative, deciding not to delay construction further with changes. They did, however, test the alternative design and the results of this will inform a possible phase III.
- By July 1994 611 of the planned 1,484 buildings had been completed, of which only 279 were in use because the project authority had not released them to the health department. A further 562 are in progress

Project progress: training

- Since 1989 about 60 people have been sent to the UK for training but in 1993 the project authority nominated students for courses without consulting the British Council. As a result, 12 have been rejected by the Indian Government, causing the training opportunities to be lost, and some unsuitable candidates have been sent. In other cases staff have been transferred to non-relevant duties on their return. The situation has improved in 1994 with the British Council becoming more involved although again some unsuitable candidates have been nominated.
- Better progress has been made on the local training component. 13 district training units have been equipped and district training teams have been formed. Substantial progress has been made towards reaching targets for training traditional birth attendants, multi-purpose health workers and other health staff.
- While over 5,000 birth attendants have been trained under this project, the Administration's target of raising the proportion of births attended by trained personnel from 20% to 60% over 10 years seems unachievable.
- The new training system was developed taking account of local needs and training material was locally produced.

Project progress: other components

- Some project components have made little progress:
  - A health management information and evaluation system was planned but the Administration have experienced long delays in agreeing with the Orissan Government the design of a family health card which was to form the basis of the system. An agreed card was finally released in mid-1994.
  - The Administration hoped to identify innovative projects to test new methods of health care in collaboration with non-governmental organisations but to date only one - a study on rice-based oral rehydration - has been completed. A second - impregnated mosquito nets - began in July 1994. Until mid-1994 the project authority did not fund any of the non-governmental organisations, despite pressure from the Administration; 17 organisations have since been provided with 50% of their funds.
  - Implementation of a component to strengthen district level health management, designed progressively from December 1993, started in June 1994 when initial workshops were held.

Impact

- The Administration are concerned that the slow progress will undermine the project's impact. Their and the British Council's efforts have resulted in greater progress during 1994 and a third phase is being considered.

A. Orissa health and family welfare, phase II

Impact (contd.)

- In August 1994 two impact studies were completed:
  - one examined the construction component. It concluded that the sub-centre based approach would have a considerable impact on the delivery of community health care services and found that the new buildings were more spacious and hygienic. The phase II sub-centres have increased the take-up of family planning services and clinic-based deliveries. However the phase II centres are often on the village outskirts, affecting their usage and the security of the health workers;
  - the other reviewed the training component and found the general training of multi-purpose health workers to be too concentrated, affecting both the quality of training and the regular sub-centre work. The intensive training received by 500 female health workers was found to be well conceived and conducted.

Sustainability

- The sustainability of the project is in doubt, because of:
  - weak management in the Orissan health department;
  - the poor record on maintenance of health related buildings. The Administration designated £1.1m to fund repairs but by July 1994 only £0.8m had been spent. The average requirement for maintenance is Rs9 per sq ft but the Government has allocated only Rs0.8 (2 pence);
  - the under-provision for other non-salary recurrent costs, especially drugs and consumables. In 1993 the Administration examined district budgeting for health and family welfare and found that over 80% was allocated to salaries, leaving only Rs3 (6 pence) a head for drugs, maintenance and other costs; and
  - the budget situation in Orissa has worsened considerably over the period of the project.
- The Administration recognise that the absence of drugs and other supplies is one of the factors which contributes to the lack of credibility of the public health system, resulting in low utilisation of clinics. This was among the reasons for their attempt to refocus the project on health management in 1993 and will remain a priority in any future input they make in Orissa.
- Local training through district training units established under the project shows more promising signs of sustainability. The training is relatively low cost and depends primarily on training teams which have developed their own material and are hence strongly committed to its continued use.

3 The main lessons from the Orissa project are:

- realistic targets and an achievable timetable are vital for complex projects with many components - especially when local management is weak;
- health project impacts should be measurable through project specific indicators as well as through wider measures of health status;
- alternative funding channels should be sought if local bureaucracy is likely to cause delays;
- a strong health management capacity in recipient countries is a key requirement for effective aid to improve health care which projects must address appropriately;
- a rigorous appraisal of the cost-effectiveness of project inputs is necessary before extending their use to a second phase; and

- contracted project managers should be required to report showing how activity is linked to progress towards objectives, so that the Administration can easily identify the key areas needing attention.

B. St. Stephen's hospital, Old Delhi

Project Objectives	To reduce death and illness among poor women and newborn infants in the St Stephen's Hospital catchment and outreach areas.	
Project Activities (1991-94)	- Construction of a 340-bed maternal and child health wing with equipment - Development of a community outreach programme in Nand Nagri district - Consultancy to examine financing and charging policies of the hospital - Training and consultancies for medical staff - Establishment of a training resource centre	
Project Cost	Total cost:	£4.91m (100% Administration funded)
	ODA Allocation:	£4.37m building and equipment £0.21m technical co-operation £0.33m additionally approved in June 1994
	Expenditure:	£3.80m by November 1994
Project Management	St Stephen's Hospital is responsible for managing the project. ODA contracted the British Council to co-ordinate project inputs from June 1994 to March 1995 at a cost of £35,000. The Council managed the technical co-operation programme for £39,000 (18% of allocation)	

Targets

- The achievement indicators set by the Administration were sensitive to factors other than project impact - for example, the proportion of low birth-weight babies is affected by factors outside the project's influence.
- Other indicators, such as the maternal mortality rate, are not easy to measure.
- The Administration did not secure St Stephen's agreement to meeting the targets in the project plan.

Management and reporting

- The Administration did not appoint a project co-ordinator until September 1993, two years after the start. St Stephen's appointed an architect and site supervisors. The British Council arranged for consultants to oversee the commissioning of equipment, and set up training visits to and from the UK. The Council's buildings adviser visited the project two days a month.
- St Stephen's submitted monthly reports on progress to the British High Commission in a format specified by the Administration. The High Commission reviewed these reports, attended monthly building committee meetings and reported to the Administration.
- The Administration's health adviser expressed concern in July 1991 and January 1993 that project management was confused. The Administration's September 1993 review mission identified a need for closer co-ordination, asking the High Commission to oversee the management of all project activities in the final year. In June 1994 this work was contracted to the British Council with more detailed terms of reference.

Monitoring

- St Stephen's monthly reports focused mainly on construction progress and activities at the outreach centre; they did not regularly provide updates on progress towards the project objectives. The Administration's health adviser visited the hospital and outreach centre regularly but there was limited evidence that effective remedial action had resulted on key issues such as financial sustainability.

B. St. Stephen's hospital, Old Delhi

Monitoring (contd.)

- Much of the Administration's monitoring focused on the construction programme. Some delays were caused by the frequent changes in plans by the architect which in mid-1993 led to a near breakdown in working relationships with the building contractor. In March 1994 the Administration stipulated that no further plan changes would be accepted. To maintain the pressure for progress, the British Council buildings adviser increased his involvement in the project to up to six days a month.
- The Administration did not have a consolidated record of expenditure by component to enable them to monitor progress against budget until October 1993. This caused uncertainty in financial management: for example, whether funds would be available for additional training of hospital staff.

Impact

- St Stephen's has a clear commitment to serving Old Delhi's poor:
  - 250,000 out-patients a year (40% free of charge);
  - 30,000 in-patients a year (10% free of charge); and
  - the outreach centre in the Nand Nagri slum district provides free treatment for a further 70,000 patients a year and had surveyed the needs of 53,000 (project target: 100,000);
- The new wing is of a high standard and is likely to enhance the quality and quantity of care available in the district. It is not yet in use, so it is not possible at this stage to assess impact in terms of wider project objectives. The Administration have not undertaken a rigorous assessment of whether the hospital is reaching the poor although a 1990 study concluded that the hospital had the capacity to sustain a poverty alleviating policy for poor patients and are at present considering whether and when to evaluate the project's impact.
- St Stephen's staff have benefited from the training programme, which included study visits to British maternity units and in-service training by doctors visiting from Britain. This training has enhanced their motivation and led to numerous improvements in medical procedures.

Sustainability

- The commitment and experience of St Stephen's provide strong assurance that high quality health care for Old Delhi will be sustained. But this is not yet supported by a reliable costing and charging methodology designed to ensure that the provision of subsidised and free health care will be financially sustainable.
- The need to assess the financial sustainability of St Stephen's and to identify a suitable charging policy was recognised at the outset but not pursued by the Administration until the project was nearing its planned completion date. Their project plan had envisaged visits in 1991 and 1993 by a health financing consultant to agree a revised fee structure for introduction after the building was complete. However they did not invite tenders for the consultancy until August 1993 and no appointment was made until December. The consultant visited St Stephen's in February 1994 and reported in April that the hospital "should remain viable". Although the report recommended ways of improving financial accounting and performance and on the apportionment and monitoring of costs, it did not suggest a fee structure to maintain services for poor patients. A follow-up visit is planned.
- Future funding for the Nand Nagri outreach centre is also uncertain. When Administration finance ceased in March 1995, St Stephen's had to cover all recurrent costs from its own income or seek other donors' support. Closer integration between the hospital and the outreach centre is essential to maintain and expand health care to the target 100,000 slum dwellers. The Administration were to address the options as part of a financial consultancy visit undertaken in late 1994.
- Ongoing training for an expanded St Stephen's staff team was also required and a training centre will be established in early 1995.

4 The main lessons from the St Stephen's project are:

- achievement indicators should be closely linked to project activities;
- management and monitoring responsibilities for all project components should be clearly allocated from the outset;
- for large construction projects, special attention should be given to pursuing key non-construction objectives, such as sustaining health care for the poor; and
- the sustainability of health services is more certain when the recipient institution is highly motivated and self-sufficient in covering recurrent costs.

C. Cervical Cancer Research

Project Objectives	**Wider:** to reduce the incidence of cervical cancer through early diagnosis and control **Immediate:** to understand the role of human papilloma virus infection in cervical cancer	
Project Activities (1990-93)	- analysis and follow-up of 12,000 cervical scrapes - training of a local scientist in DNA hybridisation techniques for analysing cervical scrapes - provision of equipment to the Institute of Cytology and Preventative Oncology	
Project Cost	Allocation:	£336,439 (£311,000 plus £26,439 management charge)
	Expenditure:	British Council figure - £281,023
		ODA figure - £289,012
Project Management	Carried out by British Council	
	Management Charges:	British Council figure - £37,863 (15% of expenditure)
		ODA figure - £37,443 (15% of expenditure)

Targets

- No quantified targets were set

Management and monitoring

- Work awarded to the British Council before the Administration had received an estimate of charges.
- Management charges have exceeded the original estimate without the Administration's agreement.
- Some mis-charging of costs was identified by the National Audit Office and a small discrepancy remains.
- Project manager's and consultant's responsibilities were not formally specified and were therefore unclear.
- The Maulana Azad medical college failed to collect sufficient scrapes or to record accurately the supporting demographic data (only 2,063 fully documented scrapes were collected against a target of 12,000). As this was not part of the Administration's project the Institute of Cytology and Preventative Oncology had little leverage. The Administration did not consider bringing this activity within the scope of their project. UK consultants have however accepted that useful results can still be achieved with the greatly reduced sample.
- A deep freezer, supplied by the Administration, was kept in a corridor and subjected to extreme temperatures and had not been operational for several months. The Institute are making plans to relocate the laboratory.

Impact

- To achieve even the immediate objective would require cases to be followed-up long after the project's planned completion date.
- One scientist from the Institute of Cytology and Preventive Oncology was trained in the DNA hybridisation technique at Charing Cross Hospital. Since his return he has passed on his new skils to 35 other scientists.
- The laboratory's diagnostic activities have expanded into other important new areas.

Sustainability

- A high level of commitment and enthusiasm exists amongst the Institute's staff.
- The laboratory's medium-term sustainability has been assured by the commitment of a permanent budget.

5 The main lessons from the Cervical Cancer project are:

- services to be provided by management agents and consultants should be clearly defined;
- project proposals should be reviewed to ensure that there is a clear link between activities and objectives;
- the Administration should exercise more care in charging costs to projects; and
- all possible solutions should be considered when a serious implementation problem arises.

Appendix 2: Pakistan

1 Pakistan has a population of 128 million. It is increasing by 3.1 per cent a year - one of the highest growth rates in Asia - and is expected to reach 155 million by 2000. Pakistan's health indicators are worse than India's, despite a higher per capita income, and only marginally better than those of Bangladesh. Life expectancy is 58 years.

2 The Pakistan Government's policy is to reduce the population growth rate to 2.6 per cent a year by 2000. The Administration have provided £13 million in health and population aid to Pakistan since 1988-89. Their current priorities are health sector reform, and ensuring increased provision and use of reproductive and other health services by women.

A. Population I and II

Project Objectives

No objectives were specifically set for the Administration's project as it was incorporated in the World Bank's programme. The wider objectives of this programme were to provide support to the Government of Pakistan's Population Welfare Plan aimed at slowing the country's rate of population growth.

Project Activities (1983-93)

- Supply of 91 vehicles (mostly as mobile audio visual units to raise contraception awareness)
- Small "innovative" family planning projects (for example, distribution through barbers)
- Various monitoring and evaluation studies
- Establishment of two university-based population studies centres
- Support to 171 non-governmental organisation outlets
- Supply of injectable contraceptives and contraceptive foam

Some of these components are part of a larger, £18m, World Bank project. In 1990 a new component - District Welfare Activities - was developed to use the unspent part of the original grant. This involved general support for family planning activities in five target districts and in particular the establishment of eight mobile service units.

Project Cost

Allocation: £4.8m
Expenditure: £4.45m as at November 1994

Project Management

Carried out by the Administration in-house.
Cost not known.

Targets

- The Administration did not set overall project specific objectives though there was a 1989 framework for the District Welfare Activities component which set objectives and quantified targets.

Management and monitoring

- Because of the fragmentary nature of this project the Administration stipulated that a project management team should be established but none was set up.
- From the start of the project until November 1985, and again from January 1987 until February 1990 the Administration had no field management presence. This seriously hindered project progress.
- The Administration do not have accurate records of the expenditure on each component.
- Under some components (for example, vehicles, innovative projects and non-governmental organisations) the Administration did not obtain sufficient information to enable them to monitor progress.
- As the Administration considered that they did not have the in-house capacity, they contracted the Overseas Development Group to provide monitoring services at a cost of £189,569; competitive tenders were not sought.
- The London School of Hygiene and Tropical Medicine was contracted to provide assistance under the population studies centres component at a cost of £190,632; again no competition was sought. The contracted services were mostly provided despite considerable difficulties posed by local bureaucracy and political turmoil. The Administration did not take action when the School, mainly because of shootings in Karachi, failed to follow all the agreed reporting arrangements.
- Progress reports did not always show progress clearly against the targets.
- The vehicle supplier was chosen despite its limited network in Pakistan. The vehicles were made to specification but on receipt of the first consignment the Government of Pakistan requested window conversions for 75 of them and this was carried out by the supplier at a cost of £22,500. A 1988 assessment found that the structure of the vehicles had suffered major damage as a direct result of the conversions and many were off the road. The supplier provided free repair kits and paid for their shipment to Pakistan. The Administration paid £16,700 for the repairs to be carried out.

A. Population I and II

Impact

- The project's achievements need to be seen in the context of wider political difficulties. During the 1980s, attempts to integrate population activities within the health infrastructure failed and the population programme suffered from over-centralisation. The Administration had to work against substantial political and bureaucratic obstacles.
- The Administration have assessed the impact of some components well while on others, such as innovative projects, there is an absence of material. They did not assess overall impact until 1994 when a draft project completion report was produced; this had yet to be finalised in October 1994.
- Overall the project has had no more than a limited impact. The Administration consider the project has given them field credibility through which they have become an influential voice in national population policy.
- Although there is limited information, there is some evidence that minimal use was made of the vehicles: the average monthly number of audio-visual shows per vehicle was 6.4. One of the problems was that the rationale behind this component was inconsistent with the original proposal - which stated that awareness of contraception was already high and the need was to make services available.
- The Administration supplied £450,000 of contraceptive foam and £500,000 of injectable contraceptives. A 1990 study considered that the Norigest supplies were cost-effective and ethically respectable and that the distribution system was efficient. The injectables were of particular benefit to the poor and to women (who could control their use alone). The study considered the supply of foam to be less effective. Although it made an important contribution towards ensuring that a range of contraceptives were available, it was too expensive for the poor.
- Two centres for conducting demographic research were established and training provided contributed to an increase in demographic expertise in Pakistan. A 1988 consultant's report found that the standard of research was low but also considered that there was no chance that this component could succeed in its two to three year life. The centres were not successful and the Administration ceased funding.
- There is little evidence on which to assess the impact of support for non-governmental organisations. In general the Administration consider they provided a good service although their approaches are now seen as conventional and not necessarily the best way of promoting family planning.
- Apart from eight vehicles (mobile service units) supplied under the District Welfare component, funding did not reach the target districts - though it did provide general budgetary support to the Ministry of Population and Welfare. Mobile service units were the most successful element and are now used more widely across Pakistan. The immediate impact on family planning services was only marginal: the total number of clients in target districts increased by 10% over the component's life.

Sustainability

- There was a lack of local ownership of some project activities.
- The Administration funded the population centres until 1990 when the Ministry of Education undertook to take over recurrent cost responsibility. However this was not made a condition of the grant. The Ministry place little value on the centres and have not taken over their funding. One centre ceased to function entirely in July 1993 and the other is desperate for funds.
- The Government of Pakistan insisted that non-governmental bodies were funded through a central Co-ordinating Council, under their control. A 1994 London School of Hygiene and Tropical Medicine report criticised donors for funding through this body as there had been clear evidence since 1988 that it lacked the capacity to use funds effectively. Funding of these outlets finished, as planned, in June 1993. Since then some 35 of the 171 outlets funded have folded. The Administration did not consider their sustainability at the appraisal stage.

3 The main lessons from Population I and II are:

- the need to establish a stronger field management presence for complex projects;
- project frameworks should be drawn up with a coherent set of inputs contributing to a clear overall purpose;
- the Administration should ensure that they receive adequate information on which to assess project progress;
- project expenditure should be analysed by component to facilitate financial monitoring and enable value for money to be assessed;
- the Administration should be firmer in asserting their rights as purchasers of goods and services;
- early assurances should be obtained that host countries will take over recurrent cost responsibility after project completion; and
- funding mechanisms should ensure that all project money actually goes to the project activities rather than providing general population support.

B. Reproductive Health Services

Project Objectives	- Contribute to the Pakistan Government's objective of reducing the population growth rate from 2.75% (1987) to 1.66% (1991) - Reduce maternal and infant mortality - Ensure adequate availability of reproductive health services throughout the country	
Project Activities (1987-93)	- Renovation/construction of 45 reproductive health service "A" centres - Funding of contraceptive surgery - Supply of medical equipment - Training of doctors and paramedical staff in contraceptive surgery techniques	
Project Cost	Total cost:	$3.46m (also funded by UN Population Fund and Pakistan Government)
	ODA allocation:	£2.5m ($3.12m at 1987 exchange rate)
	ODA expenditure:	£1.77m as at November 1994
Project Management	ODA were supporting a project set up and managed by the UN Population Fund, which charged them a management fee of 5% of their contribution	

Targets

- Achievement indicators set by the Population Fund related to construction and the number of sterilisations.
- Targets for sterilisations were unrealistically high: the Fund now considers that qualitative targets would have been a better management tool and that quantitative targets run the risk of encouraging health workers to coerce women into surgery.
- The Fund did not set indicators to show when "adequate" availability of reproductive health centres had been achieved, or to show progress towards the aim of reducing maternal and infant mortality.

B. Reproductive Health Services

Management and reporting

- The Population Fund managed the project in co-operation with the Pakistan Government and undertook to provide six-monthly progress reports to the Administration.
- Annual reviews took place, in which the Administration were invited to participate. A mid-term review was also planned but not carried out.
- The Fund agreed to prepare a final evaluation report but to date this has not been produced.

Monitoring

- The National Audit Office found three progress reports covering the period 1990-92. The Ministry of Population and Welfare produced a final progress report in December 1993 covering the previous seven years. These reports provided basic statistics on expenditure, centres built, training and contraceptive treatment but included only limited analysis of progress towards project objectives.
- The Administration's health advisers also monitored progress by visits and participation in annual reviews. The British High Commission followed up specific points locally and from February 1990 had professional management oversight of the project.
- By 1992 the cost of building each health centre had doubled to Rs700,000 (£15,900). The Administration did not provide additional funding but asked the Population Fund to set quarterly benchmarks for construction and report on progress. However, the Fund's progress reports contained no information about such benchmarks or of additional monitoring of construction work.

Impact

- The construction target of 45 reproductive health centres was met, bringing the total to 80 country-wide. While total figures for contraceptive services provided are available, the impact of the new centres is not yet known. The centres are attached to larger general hospitals and therefore are conveniently located to serve urban women. However, a significant proportion of contraceptive services are provided at mobile camps held in villages. Rural women find this more convenient and the service could be expanded if more staff were available.
- The project met 48% of the target 917,000 sterilisations between 1987 and 1993. The Population Fund identified the reasons for this under-achievement as low training standards and weak motivation and counselling. The centres were also understaffed during the first three years, when a Government ban on recruitment was in place. The situation has since improved and about 90% of the required staff are now in post.
- The Administration estimate that the sterilisations averted some 590,000 births over the life of the project and consider this to be a cost-effective contribution to containing Pakistan's population growth. Nonetheless the country's annual growth rate is 3.1% - still well above the Government's target of 2.6%.
- The number of doctors and paramedical staff trained in sterilisation techniques exceeded project targets but the Fund considers that the standards of training were not sufficiently high. Impact has not yet been assessed

Sustainability

- The Administration did not address the issue of sustainability when agreeing to contribute to this project. However the Fund remains committed to strengthening reproductive health services and training.
- The Administration consider that the social action plan agreed between the Pakistan Government and the World Bank, and co-funded by the Administration, will provide some guarantee of adequate staffing and recurrent cost provision for these services.

4 The main lessons from the Reproductive Health Services project are:

- realistic targets should be set which are directly related to the project inputs; and
- when an independent implementing agency is used, the Administration should set out a clear reporting format which links activity to progress towards project objectives.

C. Asian Development Bank III

Project Objectives	To improve health care and essential support services in Pakistan and particularly in Balochistan and the North West Frontier Province (NWFP).	
Project Activities (1991-96)	- Establishment of specialist training courses for nurses (Balochistan and NWFP) - Establishment of an unspecified number of repair and maintenance workshops for medical equipment (Balochistan and the North West Frontier Province) - Introduction of strategic planning to federal and all provincial health ministries	
Project Cost	Allocation:	£3.04m (part of a £23m Asian Development Bank project)
	Expenditure:	£1.70m as at November 1994
Project Management	Carried out by the British Council Management charges: £459,050 (15% of allocation)	

Targets

The indicator for monitoring the achievement of the wider objective was too broad to measure impact. No quantified targets have been set to measure the achievement of immediate objectives although some targets have been set for project outputs.

Management and monitoring

- In 1991 the Administration expressed concern at the size of the Council's proposed management charge and stated that the fee should be reviewed after one year. No such review was conducted.
- Between September 1991 and October 1992 the Administration expressed dissatisfaction with the management services but did not consider alternative ways of managing the project and made no changes to the management fee.
- The Administration did not specify a format for progress reports. Before April 1994 these reports focused on inputs and did not relate progress directly to the project objectives.
- Monitoring visits identified a number of implementation problems - for example in North West Frontier Province, the repair and maintenance component has been held back because the provincial government has not sanctioned posts in the central workshop. The Administration have been monitoring the situation regularly and have put pressure on the provincial health ministry to take effective action. In May 1994 their inputs were suspended and they have since received assurances that the posts will be established.

C. Asian Development Bank III

Impact

- The first specialist training courses for nurses began in the North West Frontier Province in March 1993 and the nursing consultant judged the courses successful and pointed to an increase in knowledge base, practical skills and self-confidence among the students.
- There have been difficulties in recruiting nurses for courses because of a reluctance by the authorities to release nurses for training. There is also concern that nurses who complete these courses may not be posted to jobs where their new skills will be used, although so far most have been appropriately posted.
- By May 1994, two nurse tutors had returned to Pakistan following training in the UK. They found their training broadly useful and relevant. English medical books supplied to the nursing colleges in Peshawar and Quetta are proving of limited use to the students, who have only a limited knowledge of English.
- The Administration undertook to supply a minibus to Peshawar nursing college to enable students to attend practical demonstrations. Its purchase has, however, been delayed since 1992.
- The Administration consider the planning component to have been the most successful part of the project and for this reason they extended it to the remaining two provinces. Elements of it have been incorporated in Pakistan's social action programme and three of the four provinces have already made good progress in adopting strategic planning. The federal planning cell, where two officers have so far received UK training, has encountered difficulties in utilising their trainees' new skills. One has been transferred out of the cell.
- The repair and maintenance component has yet to make any headway in North West Frontier Province.

Sustainability

- Sustainability of the nursing component will partly depend on permanent teaching posts being established by the provincial health ministries at nursing colleges.
- There is uncertainty over the commitment of federal and provincial governments to continue supporting the planning cells, some of which do not have regular budgets or permanent posts. The National Audit Office visited the cell in North West Frontier Province and found its accommodation to be unsatisfactory and cramped.

5 The main lessons from the Asian Development Bank III project are:

- targets should be clear, specific and measurable;
- a rigorous assessment should be made of the value for money associated with the different possible management arrangements;
- the Administration should ensure that effective mechanisms are in place to monitor contractor performance;
- the need for early and decisive action where there is a clear lack of commitment to the project from the implementing body; and
- the need to encourage recipient countries to employ trainees in a position to apply their new skills.

D. Population III

Project Objective	To reduce the gap between wanted and actual family size (the total fertility rate) by allowing women and men to exercise increased reproductive choice.	
Project Activities (1994-97)	- Supply of contraceptives - Institutional development of the Ministry of Population and Welfare - Various operational research studies on the family planning programme - A National Fertility and Family Planning Study in 1996-97 - A contraceptive distribution study The project was approved in March 1994 and the Government of Pakistan formally accepted the grant on 31 July 1994.	
Project Cost	Allocation:	£9.045m
	Expenditure:	£1.0m as at November 1994
Project Management	Management and procurement under the contraceptive supply component to be carried out by the UNFPA at a cost of £380,000. Other project management to be carried out in-house by the Administration.	

Plans for implementation

- £7.6m of the grant is intended to provide part of the national requirement for contraceptives but, at present, future requirement figures are not reliable. The Population Fund is addressing this and the Administration will release funds only on receipt of reliable reports on the stock position, the future requirement and the level of expenditure incurred.
- An Administration-funded study began in 1995 to examine improvements to the distribution system being made under the UNFPA project.
- Apart from a research study, planned to start in 1994, other components have been specified only in outline.
- In a number of cases the Administration have not specified their activities in detail because they are co-ordinating their inputs with other donors' activities linked to the World Bank's multi-sector Social Action Programme. The Administration have developed regular contacts with other donors to co-ordinate action.

Targets

- The Administration have set indicators for project outputs which will provide a basis for monitoring project progress; most of these have been quantified. In February 1995 the reporting format was being drawn up.
- The Administration aim to measure the increased use of reproductive choice by monitoring the reduction in the gap between wanted and actual family size; specific targets have not, however, been set.

Management and monitoring

- The Administration have nominated the members of a project management team which will be the key decision-making body and this has started to hold ad hoc meetings.
- The Administration's Health and Population Office in Islamabad is well-placed to carry out field management. The Administration have yet to decide what proportion of their staff time will need to be spent on the project.
- Once activity begins, the Administration intend to carry out financial monitoring by setting up separate expenditure codes for each of the components. So far three codes have been set up for the UK pre-implementation costs, which by June 1994 stood at £111,000. Not all implementation costs have been charged to the project because locally incurred costs have been allocated to a separate cost code.

D. Population III

Impact

- Project activities are more coherent than Population I and II and there is a clearer link with the project objective. If successful, it should contribute to decreasing the population growth rate from 3.1% to 2.6%, although even this lower percentage is behind most other countries in the region.

Sustainability

- As part of the Social Action Programme, the Pakistan Government are committed to increasing their percentage funding of the population programme from 55% in 1993-94 to 66% in 1997-98. Continued donor funding is conditional on this commitment being met and the Administration will be participating in World Bank missions to monitor achievement.

6 The main lessons from the Population III project are:

- the first phase activities should be fully designed, together with associated targets and indicators;
- close monitoring of the country's contraceptive requirements is essential; and
- effective distribution systems need to be established to maximise potential impact.

Appendix 3: Kenya

1 Kenya's population of 26 million is increasing by 3.3 per cent a year and despite its declining population growth rate, is expected to reach 35 million by 2000. There is a serious AIDS epidemic, with HIV prevalence estimated at least at 5.6 per cent, and the number who may be infected with the disease by 2000 is estimated to be 1.6 million. Life expectancy in Kenya is 61 years.

2 Kenya's health policy is to undertake health sector reform designed to improve the management and implementation of health services and to increase staffing efficiency. The Administration have provided £14.2 million in bilateral health and population aid to Kenya since 1988-89. Their current priorities are to support health sector reforms and provide for the immediate needs of Kenya's reproductive health services.

A. Isiolo Hospital and Immediate Support

Project Objectives
- Build and equip a 160 bed hospital and 60 staff housing units at Isiolo by October 1988
- Improve the quality of out-patient health care in the Isiolo district
- Provide improved and sustainable surgical referral services at Isiolo

Project Activities (1986-90 and 1990-94)
- Construction of a 160 bed district hospital in Isiolo
- Construction of 60 associated staff housing units for hospital employees
- Provide a maintenance engineer and a surgeon for three years
- Supply an ambulance
- Isiolo Hospital phase II immediate support for medical supplies (£0.57m)

Project Cost

Total cost:	£3.25m (2.8m construction costs and £385,000 technical co-operation) £569,000 Isiolo hospital phase II immediate support
Expenditure:	£3.8m (£0.52m technical co-operation) - by November 1994

Project Management Carried out by TRIAD (Architects/planners) and Crown Agents (procurement of consumables)
Management charges: £394,000 (14% of allocation)

Project history The contract was awarded to Gina Ratna for Ksh77.6m (£2.53m) after some initial difficulties in the tender selection process. The hospital was formally opened in January 1990, after which the Administration provided drugs and medical supplies.

Targets
- To construct a 160 bed hospital and 60 housing units by October 1988 at a cost of £3.25m.
- No other measurable indicators were set. There was no clear definition of the catchment area or the hospital's relationship to other health facilities attempted. And there was no assessment of its likely impact on recurrent costs to the district, or limits suggested.

Management and monitoring
- Architects were engaged in 1986 to design the hospital and supervise the work.
- Progress reports were provided in a format specified by the Administration's architectural adviser; these focused on construction progress and problems encountered.
- AMREF were appointed to oversee the commission of the hospital equipment and stores and Crown Agents to monitor the storage and distribution of consumables.
- Most of the Kenya Government payments were late; this delayed many of the UK payments.

Implementation
- The Administration approved three time extensions because of problems caused by delays in making payments to the contractor and in obtaining import licences.
- The hospital was completed in December 1988 and patients were first admitted in February 1989.
- The final construction cost of Ksh86.6m was Ksh9m in excess of the Ksh budget but was within original sterling budget, due to favourable changes in the exchange rate.
- The maintenance engineer and surgeon provided expertise to set up a hospital maintenance support unit and establish a surgical referral service.

A. Isiolo Hospital and Immediate Support

Impact

- It is difficult to assess impact because of the Administration's difficulty in setting specific targets at the project design stage.
- No data were produced on quality of service, referral function or target throughput of services to patients.
- The hospital was completed, equipped and brought into use with only minor delay.
- A much needed facility and a wide range of medical services have been provided to the district.
- Hospital workload statistics show an increase in the number of in-patients treated and major surgical cases undertaken. Minor surgical cases have, however, significantly decreased.
- The need for adequate stores accounting systems was recommended but supervision and systems have not improved - a quantity of insulin cannot be accounted for and the police are investigating the discrepancy. The National Audit Office also observed some excess stock of UK funded supplies and a further stock discrepancy.
- The vehicle workshop was initially by-passed and fleet repairs undertaken at a garage in Isiolo.

Sustainability

- The hospital displays a good general appearance, is clean, well equipped and operational. Some structural cracking has occurred and this is being investigated to assess its seriousness.
- Except for the vehicle maintenance workshop, all the facilities appeared to be utilised.
- Maintenance engineer assistance was conditional on a counterpart being employed to study appropriate techniques but he could not undertake his training role for 15 months until counterpart was appointed.
- The surgeon was provided on condition that he would be replaced immediately after his contract was completed; it took a year to appoint a replacement surgeon. Efforts are now being made to find another replacement.
- The maintenance department was functional and preventative maintenance system continues to operate. Except for two items, all the equipment was operational and appeared to be utilised.
- The hospital recurrent budget (excluding staff costs) is to increase by 27% over two years. The Kenyan Government have given assurances that they will make adequate staffing and recurrent cost provisions.
- Staff numbers and costs have increased since the hospital opened. The complement appears high - an analysis of the recommended staffing levels against current levels by the National Audit Office suggested a doubling. The Administration informed the Ministry of Health of the high staffing levels but they had not acted on this advice.
- The old hospital, which Isiolo Hospital was meant to replace, is being refurbished as a 99 bed tuberculosis unit. Its operating cost (Ksh0.5m) will add pressure on the existing hospital recurrent budget.

3 The main lessons from the Isiolo project are:

- the requirement for a hospital facility should be based on an assessment of need, including defining the target population;
- the impact of the hospital on recurrent costs should be assessed at the outset;
- setting up a preventative maintenance system is helpful;
- consideration of immediate support requirements is essential for the effective running of a new facility; and
- the need for effective control over stocks.

B. Population III

Wider Project Objectives	- To reduce the rate of population growth through greater awareness of family planning and better services	
Immediate Project Objectives	- To increase the acceptance of, and demand for, family planning services through an information, education and communication programme - To increase the availability, accessibility and quality of family planning services provided by the Government of Kenya and non-governmental organisations - To strengthen the capacity of the National Council for Population and Development to plan, programme, finance, co-ordinate and monitor programmes	
Project Activities (1988-94)	- Expand family planning services in five non-governmental organisations in Kenya - Support new initiatives by non-governmental organisations - Study long-term alternative non-governmental organisational funding mechanisms - Train National Council for Population and Development staff	
Project Cost	Total cost: UK contribution: UK expenditure:	$28.3m (World Bank $12.2m, Kenya $2.7m, Norway $5.0m) £4.6m ($8.4m) and £0.3m (increased to £495,000) technical co-operation £4.17m (£490,000 technical co-operation) - by November 1994
Project Management	Managed by the Kenya National Council for Population and Development and the Administration's Development Division.Procurement agents were Crown Agents. The Administration also funded a World Bank project manager and co-ordinator.	

Targets

- The project framework set generally measurable targets at the output level, although quantifiable indicators of impact were less clearly established.
- The five indigenous non-governmental organisations funded under the UK component set specific objectives but quantifiable indicators were not set.

Management and reporting

- The National Council for Population and Development have responsibility for co-ordinating the monitoring and implementation of population programmes.
- The Administration funded a population project co-ordinator who was seconded to the local World Bank office to manage and oversee the implementation of Population III and IV.
- The project was extended one year from June 1993 following implementation and disbursement problems, the World Bank components of this project are some three years behind schedule.
- The Administration reimbursed the Council through the Kenyan Treasury for advances made to the five participating non-governmental organisations. The procedures for transferring funds were, however, recognised by the Administration to be inadequate to ensure the timely receipt of funds by implementing agencies and attempts to get the Government of Kenya to change the procedures failed.
- There was little activity in the first year, except continuous revision of the five agency plans.

Monitoring

- Participating agencies were required to produce quarterly progress reports in a format that was changed by the Council on a number of occasions. These gave a clear picture of the various activities being undertaken but did not measure progress against targets set or achievement of project objectives.
- Improved monitoring could have been achieved if the Council had produced summarised progress reports.
- The Administration participated in all eight review missions undertaken by the World Bank during 1989 and 1994.

B. Population III

Monitoring (contd)

- The project co-ordinator did not perform to a satisfactory standard due partly to unclear terms of reference and partly to the difficulties of reporting to both the World Bank and the Administration. This vital co-ordination role was insufficiently supervised in-country by the World Bank and key project activities were not sufficiently progressed. The Administration did not therefore renew the post beyond December 1993.
- The Administration insisted on appointing an architect to review the design for Nyeri and Kisumu clinics; the proposed re-design reduced construction costs by Ksh6m (£65,000).
- The Administration suspended disbursements in 1992 when the Government of Kenya failed to provide audit reports, similar action was not however taken by the World Bank.

Impact

- The impact of the different components of this project have been variable and difficult to measure because of the lack of an effective monitoring system, inadequate/no assessments and the absence of measurable indicators.
- Delays in funding slowed the project and reduced the final impact.
- Assessments have been carried out by only three of the non-governmental agencies, despite the Administration's efforts to encourage the Council to ensure that suitable arrangements were made.
- The assessments found that service delivery had been the most successful element while the information, education and communication components were only partly successful.
- The Administration considered only one assessment to be to a satisfactory standard.
- The Kenyan population programme has made considerable progress over the last few years. The 1993 demographic and health survey indicates increased use of modern contraceptives, reduction in the desired size of families and almost a 100% awareness of modern family planning methods. This project can claim some credit for these improvements but it is difficult to quantify or attribute the individual components' contributions.
- More clients are using family planning services but the unmet demand for these services has not declined. Almost the same number of people in 1989 and 1993 stated that they wanted to use the services but for a variety of reasons, were constrained from doing so.

(a) Family Planning Association of Kenya component

(Allocation £1.533m: Expenditure by November 1994 £1.76m)

- A new clinic at Nyeri, built at a cost of Ksh9.55m (£104,000) and opened in January 1994, has significantly improved facilities but client attendance initially dropped by 7% because of relocation. It has now recovered and is reporting figures above pre-relocation levels.
- A new clinic in Kisumu was completed by the end of 1994 at an estimated cost of Ksh14m (£155,000).
- Both new clinics replaced outdated poorly equipped clinics.
- Service statistics for all the Association's clinics between 1989 and 1993 show a 17% reduction in the static clinics' performance and a reduction of 8% in outreach performance.
- The Association considered that its performance had actually improved and said that, in the above figures, it had double counted client throughput in the years up to 1992.
- Population III has increased the operating costs of the Nyeri clinic but data were not available on the overall level of the increased recurrent costs of the rehabilitated clinics

(b) Christian Health Association of Kenya component

(Allocation £1.221m: Expenditure by November 1994 £1.2m)

- The Administration, in collaboration with a Dutch donor, have assisted the Association in rehabilitating 31 clinics at an average cost of Ksh722,000 (£8,000) - of which the Administration contributed 52%.
- For Administration-funded clinics more clients were assisted for the child welfare, ante-natal, curative and family planning services - an overall increase of 93,400 (22.5%) in clients assisted.

B. Population III

Christian Health Association of Kenya component (contd)

- The nearly completed rehabilitated clinic at Ngecha visited by the National Audit Office will provide substantially more space and facilities than the old, cramped, dispensary.
- Under the youth training element, a total of 3,185 youth educators have been trained, who have in turn provided youth training to up to 230,000 young people each year.
- The impact of this training has not yet been satisfactorily assessed. A consultancy assessment was undertaken but it was not supervised and the output proved unacceptable.

(c) National Council of Churches of Kenya component

(Allocation £0.741m: Expenditure by November 1994 £0.73m)

- The impact of this component is difficult to measure. Some 3,100 volunteers and motivators have been trained under the Council's family life education programme but more than half have since left the project.
- Part way through the project the Council informed the National Council for Population & Development that it had changed its objectives by excluding the community-based distribution of contraceptives but no action was taken.
- An internal assessment was carried out by the Council but it proved entirely inadequate, as the Council did not have the technical expertise to undertake the work.

(d) Kenya National Union of Teachers component

(Allocation £330,000: Expenditure by November 1994 £200,000)

- 38 seminars, involving some 1,700 teachers, were undertaken by the Union between 1988 and 1992 to make teachers aware of the problems involved in family planning and population expansion. No formal impact assessment has been undertaken.
- Both the Union and the Administration felt the programme was extremely weak and ceased funding in 1993.
- A minibus provided to the Union in 1990 to transport seminar participants has not been used. Some attempts have been made to find an alternative use for the vehicle but as at July 1994 it remained unused.
-

(e) Kenya Catholic Secretariat component

(Allocation £180,000: Expenditure by November 1994 £220,000)

- The family life programme encourages the use of natural family planning and has been operational for 12 years but as yet no formal impact assessment has been undertaken.
- Since 1982 over 1,400 teachers have been trained including 250 in the last four years - of which 1,000 and 200 respectively remain active. Some 4,140 clients enrolled for natural family planning training in the four years since April 1988.
- An evaluation is being planned to establish the impact, user satisfaction, cost effectiveness (compared with artificial methods) and the benefits attained.
- The Administration propose to continue to provide modest funding for natural family planning programmes to ensure that a full range of family planning methods remains generally available.

(f) Innovative projects component

(Allocation £271,000: Expenditure by November 1994 £44,000)

- Little activity has been undertaken on innovative projects.
- Problems were encountered in approving projects submitted by the agencies which were acceptable to the Administration and the National Council for Population and Development.
- The Council failed to encourage and develop new non-governmental organisations and private sector providers as only 25% of the funds have been allocated.

B. Population III

(g) Council strengthening component

- The National Council for Population and Development has received considerable technical assistance from donors; the Administration have contributed with 27 training awards. Despite this assistance the Council remains technically and managerially weak and the project objective to strengthen the organisation has not been met.
- The training awards provided by the Administration have not given a sufficient balance of skills because of the Council's desire to concentrate on one year UK demographic courses.

Sustainability

- The Administration included provision to undertake a study of the long-term alternative mechanisms for funding non-governmental organisations. The terms of reference for this study were amended, at the request of the Kenya Government, with the result that the examination of sustainability issues was reduced.
- The report of the long-term sustainability of non-governmental organisations was completed in 1991. The Kenya Government has not so far responded to the report's recommendations.
- The new dispensary at Ngecha had the full support of the local community - they contributed 10% of the Ksh1.6m construction costs and have established an enthusiastic and active management committee committed to ensuring its long-term sustainability.

4 The main lesson from Population III are:

- adequate procedures for disbursing funds should be established at the project outset;
- if the management capacity of the monitoring organisation is not assured, consideration should be given to undertaking additional monitoring reviews;
- management and monitoring responsibility for all project components should be clearly specified at the outset; and
- measurable targets should be set directly related to the project's objectives.

C. Family Planning Services

Wider Project Objectives	- To assist the Government of Kenya to reduce the population growth rate by lowering the total fertility rate.	
Immediate Project Objectives	- To increase the demand for family planning - To increase the number of functional family planning clinics	
Project Activities (1991-94)	- Supply three million doses of Depo-Provera (with disposable syringe and needle) - Supply 40 family planning equipment kits to government/non-governmental organisations - Supply 450 Intra Uterine Contraceptive Device insertion clinic kits	
Project Cost	Total cost:	£1.97m (plus £30,000 technical co-operation funding)
	Expenditure:	£1.96m as at November 1994 (technical co-operation £14,000)
Project Management	Carried out by Development Division. Procurement undertaken by Crown Agents Monitoring cost: £14,000 (0.7% of allocation). Procurement fees: £109,000	

Targets

- In addition to quantities of contraceptives to be delivered the Administration set a number of target indicators.
- The main target was to achieve 750,000 couple-years of family planning protection.
- Specific targets for this project were set before the significant increase in the uptake of family planning services which surpassed the Government of Kenya projections; as a result targets were not sufficiently robust.

Project management

- Project approved in April 1991 and the Development Division in Nairobi was given management responsibility.
- Crown Agents were appointed as procurement agents without competitive tendering.
- Options (formerly Marie Stopes Consultancy) monitored the distribution of supplies.

Monitoring

- The Administration monitored the project by attending monthly contraceptive logistics committee meetings (a multi-donor/Ministry of Health co-ordination group), periodic visits to the family planning logistics management project and the Ministry of Health family planning stores, and reviewing progress on contraceptive deliveries.
- 1.3m doses of Depo-Provera were ordered in September 1991. They arrived in Kenya in November 1991 but took six months to reach the medical stores control unit. 16 clinic kits and 180 intra-uterine device insertion kits were also ordered in September 1991; these arrived in April 1992 and took five months to reach their destination.
- Delays occurred at Embakasi port because handling charges were not paid - the Administration did not fund these charges as it is their policy not to pay for in-country costs that involve inter-departmental charges and taxes. The other two tranches of supplies suffered the same problem and delays occurred in distributing supplies.
- Options carried out a monitoring visit in October 1992 to assess progress towards project objectives. The evaluation confirmed that the contraceptives had been delivered to the central/district stores and were being distributed to service delivery points.
- In some minor instances supplies were not fully delivered or utilised. 90% of service delivery points received their Depo-Provera with needles and syringes.

C. Family Planning Services

Monitoring (contd)

- Options reviewed the clinical standards applied to the use of Depo-Provera and found that adequate medical standards were being maintained. It also found that some non-consumable equipment had never been used. As a result the clinical equipment component was dropped and disposable gloves were provided with the third tranche.
- The final consignment of UK-funded Depo-Provera had been at Embakasi port for five months at the time of the National Audit Office visit in June 1994. Stocks were then very low and unless urgent action was taken there was a high risk that stocks would run out.
- 2.8m doses of Depo-Provera have been delivered since April 1992. The final UK-funded consignment of 446,400 doses represented sufficient supplies for Kenya up to the end of 1994.

Impact

- The project has been a major success in increasing the use of injectable contraceptives in Kenya and has directly increased the number of functional family planning clinics by 23.
- The couple protection years achieved from the UK-funded Depo-Provera is assessed at 725,000 (an average of 260,000 a year). This is a significant increase over the figure for 1990 of 172,000.
- The Administration's consultants considered Depo-Provera to be a vital component in the Kenya family planning programme. It is popular with women in Kenya who are offered a full choice of contraceptive methods.
- The injectable method is generally considered the most effective reversible method of contraception. Consumer demand for Depo-Provera is increasing where high continuation rates (80% over 12 months) have been recorded.
- During the period the Administration have been funding the supply of Depo-Provera, the contraceptive prevalence rate for injectables has also increased from 3.3% to 7.2%.
- The level of contraceptive use has almost doubled in Kenya in the past decade - from 17% of married women in 1984 to 33% in 1993. The use of injectable contraceptives has increased from 3.7% in 1991 to 7% in 1993.

Sustainability

- Less than 5% of the current contraceptive supply in Kenya is funded from local Kenyan sources but limited consideration has been given to reducing the Kenyan Government's reliance on donor support.
- More than 95% of the Depo-Provera being supplied to Kenya is now funded by the Administration, against a planned provision of 60%. Planned UNFPA supplies were changed to latex gloves at the request of the Government of Kenya. Donor meetings are being planned to determine whether alternative supplies can be funded by other donors or by the Kenyan government.
- Despite the significant increase in the supply of Depo-Provera from UK aid to Kenya, the National Audit Office noted that the Family Planning Association of Kenya was obtaining its own supplies. It was also considering setting up a separate contraceptive distribution network because of previous poor performance of the Government network.
- The Association however accepted that Government supplies had significantly improved in recent years and that it would be more effective to use this network to obtain future supplies.

5 The main lessons from the family planning project are:

- injectable contraceptives are now the main method of contraception in Kenya and could prove useful in other developing countries;

- close monitoring of the country's contraceptive requirements is essential;

- effective remedial action can be achieved from well directed mid-term reviews;
- all major constraints to the successful implementation of a project should be highlighted at the project appraisal stage;
- targets should be realistic and measurable during a project's life;
- the problems in quantitatively measuring project impact, or the goals set; and
- opportunities for developing indigenous suppliers should be sought.

Appendix 4: Zimbabwe

1 Zimbabwe's population of 10.9 million is increasing by 2.8 per cent a year and, despite having the highest contraceptive prevalence rate in Africa, is expected to reach 13.2 million by 2000. There is a serious AIDS epidemic, with HIV prevalence estimated at least at nine per cent; the number who may be infected with the disease by 2000 is estimated at two million. Life expectancy is 58 years.

2 Zimbabwe's health policy is to promote health and quality of life by providing appropriate health care in the community and hospital services. The Administration have provided £4.9 million in bilateral health and population aid to Zimbabwe since 1988-89. Their current priorities are health management strengthening, contraceptive supply and research into malaria control.

A. Health Management Strengthening

Wider Project Objectives	- To obtain optimum use of limited health resources and to create sustainable management systems and procedures
Immediate Project Objectives	- To give health sector staff access to relevant information to manage resources more effectively by creating appropriate management systems. - To mobilise increased resources for the sector
Project Activities (1991-95)	- Technical advisers on health management and financial planning - Short-term consultancy (Organisation Development Consultant) - Link with UK Health Authority providing regular short-term assistance (NICARE) - Local consultancy and training - Supply of books, equipment and computers
Project Cost	Total cost: £2.063m parallel financing with the World Bank UK expenditure: £957,104 as at November 1994
Project Management	Carried out by Development Division. Procurement initially carried out by Hundhill and later by Balfour Williamson. Procurement fees: £13,860 (5% of goods)
Project History	The project was drawn up in liaison with the Zimbabwe Ministry of Health and the World Bank in the light of experience with the previous Family Health Project I. Under that project the UK provided support for personnel and general management to eight pilot districts to improve the Government's institutional capacity to plan, manage and evaluate health services.

Targets

- The project was not fully designed when it was approved and the project proposal was too open-ended.
- The project framework did not specify precise indicators for the immediate objectives, leaving them to be defined in baseline studies carried out during the first two months of the project. The baseline studies were not completed until 1993 and measurable indicators have not been incorporated into the project framework.
- Other areas where the project design did not adequately address implementation issues include:
  - no prioritising individual components or inputs
  - failure to establish a robust disbursement mechanism
  - not determining the Ministry of Health and Child Walfare's contributions and obligations
  - not setting targets for budget allocations to shift expenditure towards primary health care
  - failure to determine the requirements for computers, books or local consultancies at an early stage.

Monitoring

- The Administration's health and population adviser in Malawi had managerial and supervisory responsibility.
- Six-monthly meetings were proposed to monitor the progress of the project with annual reviews attended by all project participants. In the event six-monthly reviews were undertaken which were attended by the programme director, all component leaders, technical co-operation officers, the Health Authority consultants (NICARE), British High Commission staff and advisers from the Development Division.
- The level of review appears to be excessive in relation to the spend, although the Administration consider it appropriate at the time to ensure project decisions were taken at the highest level.
- Some duplication of work arose with NICARE, the ODC consultant and the Ministry of Health producing reports.
- The format of consultants' reports differed and was confusing; the Administration could have specified a format designed to draw out progress towards achieving objectives. NICARE proposed revised reporting arrangements in early 1995 which would explicitly show targets, priorities and controls.

A. Health Management Strengthening

Project implementation

- Insufficient attention was given to improving the quality of the early project implementation, which has been particularly slow: there have been long delays in the appointment of the two advisers; nearly two years delay in procuring equipment and supplies, some delays in the NICARE input (after a long delay in issuing NICARE a contract) and difficulties in agreeing with the Zimbabwe Ministry of Health the procedures to be adopted for paying for and controlling local inputs (training, consultancies and top management team support).Increased efforts were made to take remedial action two years after the project started.
- There was a one year delay in employing the financial management adviser and two and a half years in arranging the health management adviser. The procedures for identifying individuals for the posts proved slow, partly because the advertising was poorly targeted and late and partly due to the time taken to obtain the Zimbabwe Government's approval for the proposed consultant and his responsibilities. These delays seriously disrupted the rest of the project.
- Delays in agreeing the mechanics for transferring funds for in-country expenditure resulted in little in-country training, local consultancy or support for the top management team (Allocation £435,000; Expenditure by November 1994 £204,000).
- From 1994-95 the Administration have made quarterly advances against expenditure proposals with the aim of facilitating the disbursement of funds. The funding arrangement has been adopted by other country programmes.
- There has been considerable difficulty with the procurement of equipment. Hundhill was appointed in December 1992, some 15 months after project approval, soon after which they went out of business. New procurement agents were not appointed until September 1993 but there was no contract and fees were paid on the basis of a memorandum of understanding relating to incomplete Hundhill contracts. As a result, the new agents received fees of up to 10% rather than the 5% they had originally bid in competition with Hundhill. The Administration considered their performance poor and some of their work was carried out by the finance adviser or his staff. Balfour Williamson consider that they faced a number of difficulties in this case which hampered progress. Most of the equipment did not arrive until May 1994. (Procurement allocation £231,000; expenditure as at November 1994 £207,000)
- The management adviser should have identified requirements and developed the management tools; instead the finance adviser was employed first and by necessity the finance component drove the project

Training (Allocation £155,000: Expenditure by November 1994 £36,000)

- The Ministry of Health had difficulty in obtaining access to Administration funds and virtually no spending has been incurred by the in-country project activities. The activities of the financial management adviser have, as a consequence, been severely restricted.

Impact

- With the exception of the finance component there had been little early project progress. The short-term consultancy has been undertaken, as has the link with the UK Health Authority but the impact of these is not yet clear.
- Expenditure has been slower than estimated - £957,100 was spent by November 1994 against an expected £2 million.
- The cost recovery target was set at Z$60m a year by 1994-95 - 10% of the Ministry of Health's expenditure. Actual data were not available in a convenient form.

(a) Finance component (Allocation £135,000: Expenditure by November 1994 £133,000)

There has been substantial progress in producing computerised accounting systems necessary for effective management, but more work is needed at the strategic planning and forecasting levels. The computer systems have been implemented at the Ministry of Health's central offices and will gradually be cascaded to the provinces and central hospitals.

A. Health Management Strengthening

(b) General management component (Allocation £135,000: Expenditure by November 1994 £78,000)
There had initially been only limited progress made as the health management adviser was not appointed until February 1994. Work has been undertaken by NICARE on training needs assessments, and pilot training workshops have been held. Further progress has now been achieved with the production of a corporate plan and a paper on a Patients' Charter, which were additional requirements of this component.

(c) Management information systems component
There has been poor progress in agreeing the management information requirement due to differences of approach and a lack of agreement on implementation priorities. Some work is being carried out by another donor to design an information database.

(d) Equipment component
The Ministry of Health and Child Welfare were not satisfied with progress; requirements changed and following high level discussions the component was incorporated into another project.

(e) Supplies component
Existing manual systems have been standardised and rationalised stores management systems have been introduced into two central hospitals which is expected to improve the quality of services provided. Work on computerising systems was not started until July 1994 as priority was given to improving the existing manual system.

(f) Public Health component
An additional component with limited progress and no impact. A draft public health report has been produced and a medical audit framework developed.

(g) Health services planning and management component
By default this has taken a low priority. The identification of skills requirements has been carried out but the department has not yet been strengthened as planned.

(h) Link with UK Health Authority (Allocation £424,000: Expenditure by November 1994 £262,000)
UK experts from various health disciplines have proved most useful. This component is seen locally as an innovative and potentially useful link, although visits were infrequent and too short. It galvanised local action at the time of a visit but the lack of a continued presence has reduced its impact.

Sustainability

- Project ownership is not in question. The Ministry of Health have been very supportive but frustrated by delays in obtaining technical assistance, supplies and equipment, and in agreeing procedures for local expenditure.
- The Ministry of Health have remained committed to decentralising financial authority and planning. They are also committed to producing a more efficient use of resources and providing more effective health services.
- The results of a recent review by consultants from the Institute of Health Sector Development indicate that full use is now being made of technical cooperation input.

3 The main lessons from the management strengthening project are:

- projects should be as fully designed as possible before approval and the project memorandum updated as the project design develops;

- related preceding projects should be properly evaluated to identify relevant lessons;
- appropriate indicators should be established at an early stage and incorporated in the project framework;
- effective procedures for disbursing funds should be agreed at the outset;
- target dates should be established for inputs and achievement closely monitored; and
- essential technical staff should be appointed promptly.

B. Emergency and Supplementary Supply of Condoms

Wider Project Objectives	- To help reduce fertility and HIV transmission rates by supporting the Government of Zimbabwe Family Planning and AIDS Prevention and Control Programmes
Immediate Project Objectives	- To ensure that the supply of condoms to Zimbabwe is sufficient to meet demand - To procure and deliver 66m condoms over an 18 month period - To help the Government of Zimbabwe develop a long-term contraceptive strategy - Under the supplementary emergency supply project to procure and deliver 24.54m condoms by May 1994 (5m by end of March 1994)
Project Activities (1992-94)	- Provision of 66m condoms to Zimbabwe - Technical assistance to developing a long-term strategy for contraceptive supplies - Supplementary provision of 24.54m condoms following rejection of the original supplies
Project Cost	Total cost: £1.08m plus £0.5m supplementary supply UK expenditure: £0.39m plus £0.5m supplementary supply by November 1994
Project Management	Crown Agents were employed to procure the original condoms and the International Planned Parenthood Federation to purchase the supplementary supply. Procurement agents fees: £50,000

Project history

- The requirement for 66m condoms was based on a USAID-funded contraceptive forecast consultancy. This projected a 30% increase in 1992 and 15% in 1993, representing 22m and 44m condoms respectively.
- The Crown Agents ordered 66m condoms in July 1992 from Dongkuk Techo Rubber Industries, to be supplied in 6 consignments between September 1992 and November 1993.
- The first shipment arrived in Harare in December 1992 and the second in February 1993; the third was ready for dispatch in July 1993. All the condoms had passed pre-delivery inspection but failed the post-delivery tests carried out by the Zimbabwe Regional Drug Control Laboratory. They were subjected to extensive further testing which concluded that the manufacture was of poor quality.
- The Administration have paid for the first two consignments but the contracts between the Administration, the Crown Agents, Dongkuk and the Government of Zimbabwe have been terminated.

Supplementary supply of condoms

- Because of the failure to deliver satisfactory supplies, the Administration approved another project to provide 24.54m condoms. The lowest quotation was provided by the UN Population Fund but the International Planned Parenthood Federation was selected because it could provide immediate supplies and was considered to have the required local expertise. In the event the IPPF provided the condoms from international supply sources, delivery of which was initially delayed.

B. Emergency and Supplementary Supply of Condoms

Supplementary supply of condoms (contd)

- Despite early delays in delivering the first few consignments arising from customs clearance and local laboratory testing, 8.05m condoms were despatched by air by July 1994. The remaining 16.49m condoms were shipped in consignments up to the end of August 1994

Targets

- To procure and deliver 66m condoms and to provide consultancy assistance to assist the Government of Zimbabwe with developing a long-term strategy for contraceptive supplies.
- No specific targets were set for the wider objective of reducing fertility and HIV transmission rates.

Monitoring

- Monitoring was carried out mainly by the Crown Agents and IPPF, who provided periodic progress reports.
- The health and population adviser in Malawi also carried out monitoring visits when the condoms failed testing and initiated remedial action in the form of the supplementary supply of condoms project in November 1993.

Impact

- The immediate objectives were not met. Zimbabwe was initially severely short of condoms, putting at risk the objective of fertility and HIV transmission rates being reduced.
- Remedial action was taken to provide supplementary supplies, initially airfreighted.
- The aim of filling the gap in Zimbabwe's condom stockholding has been partially achieved but at a cost.
- Despite the failure to deliver the original supply of condoms, Zimbabwe has not run out of stocks - this is explained in part by a significant drop in demand in 1992, which followed Zimbabwe's decision to introduce charges, and a bureaucratic exemption procedure. IPPF consider that stocks will be sufficient for Zimbabwe's 1995 requirement.
- The potential loss to the Administration was initially put at £300,000 but a negotiated settlement with the manufacturers by the Crown Agents has reduced the loss to £85,000.
- There was a risk that the failed condoms would re-appear elsewhere if Dongkuk took the condoms back - following negotiations with the manufacturer the failed condoms were disposed of locally. The cost to the Administration for storing the faulty condoms in Zimbabwe and in disposing of them safely is estimated at £17,000.
- The failed 24.54m condoms are being replaced by Dongkuk over a twelve month period commencing November 1994. The balance of the 66 million condoms was to be supplied by IPPF by February 1995.

Sustainability

- USAID, then UNFPA and now the Administration have supplied virtually all Zimbabwe's condom requirements.

4 The main lessons from the condom supply projects are:

- pre-shipment testing must be carried out to the appropriate standards;
- only agents with the relevant expertise should be appointed as procurement agents;
- close monitoring of a country's contraceptive requirements is essential; and
- the long-term sustainability of supplying contraceptives should be assessed.

C. Sexual Health project

Wider Project Objectives
- To promote sexual health by reducing the incidence and impact of sexually transmitted infections, including HIV and AIDS

Immediate Project Objectives
- To develop cost effective treatment and prevention policies and protocols, and disseminate them throughout the health system
- To improve the quality of provincial and district treatment and prevention services, with particular emphasis on services for women
- To develop Zimbabwean capacity for procuring condoms and ensure adequate supplies.
- To ensure efficient distribution and improved access to condoms throughout the country

Project Activities (1994-2000)
- Establish a National Sexually Transmitted Infections Programme Office
- Supply 277.5m condoms and improve the distribution system within Zimbabwe
- Establish a capacity within the Zimbabwean National Family Planning Clinic to procure condoms and computerise stock management
- Produce 10 operational and policy research studies
- Train 3,882 health workers in the prevention and care of sexually transmitted infections

The project was approved in April 1994 and the Government of Zimbabwe formally accepted the grant on 15 September 1994.

Project Cost

Total cost:	£57.35m (World Bank £43m, Government of Zimbabwe £5.33m)
UK contribution:	£9.016m (£4.118m capital, £4.898m technical co-operation) by
UK expenditure:	Nil by November 1994 (1994-95 allocation £293,000)

Project Management
Implementation is monitored by a joint Programme Management Committee. The Administration field officer will undertake in-country monitoring. Management and monitoring charges: £270,000

Project History

- This five year project consists of two components: the first to establish a National Sexually Transmitted Infections Programme Office, equip a central training and referral centre, conduct research and policy development, formulate national and provincial action plans, and provide funds for service development equipment, transport and management support; the second to supply 277.5m condoms and improve the arrangements for their quality testing, storage and distribution

Targets

- The project framework included generally quantifiable indicators of impact, although for some specific targets the current level of achievement was not clear. Some of the targets rely on assumptions that are not well documented. For example, to hold HIV infection at its current level assumes that the project will be implemented and effective instantly, preventing any further transmission and that condoms will be used regularly by all groups. Factors external to the project, such as an HIV epidemic already in progress, could significantly impede the achievement of the project's objectives. Funded activities are appropriate to the wider objective.
- Operational research within the project and activities under the management strengthening project may provide some of the baseline data currently lacking in Zimbabwe.
- The project assumes that the condoms supplied will be regularly used by those people at risk but the source and reliability of condom usage rate - one of the main target indicators, is on a small study and uncertain.

C. Sexual Health project

Project management

- The project was approved in April 1994 with the aim of starting in July 1994. The project commenced in September 1994.
- The Administration's health and population field manager will be responsible for ensuring that funds are used.
- Research proposals will be overseen by a research advisory panel of the management committee.
- Effective implementation depends on the timely local recruitment of the key project members. No target date has been set although fund disbursement has been made conditional on the appointment of the programme manager.
- The Administration will monitor the Zimbabwe Ministry of Health contract with the National Family Planning Council to reimburse the cost of condom handling and distribution - it should ensure full cost is recovered.

Monitoring and project progress

- The Administration will fund six consultancies to develop local capacity and employ a consultant to monitor and evaluate the effectiveness of the project.
- In-country monitoring will be undertaken by the Administration's health and population field manager. Joint bi-annual reviews will look at operational matters and consider progress on the achievement of objectives.
- Since the project was formally accepted, staff have been appointed to the posts of project manager, condom manager and administrative officer.

Condom supply

- The project will provide Zimbabwe's main supply of condoms from 1995-96 to 1998-99 - some 277.5m. However the numbers required, based on World Bank projections, need re-assessing.
- The forward projection for condom demand, a 12-fold increase in 11 years, looks high
- A calculation error over-assessed need by some 8.5m condoms. Using the UN Population Fund's base 1993-94 figure the total requirement would be 34.5m less; alternatively, by basing the calculation on issues, requirement would be 74.5m less.

Impact

- The project aims, by 1999, to decrease the number of sexually transmitted infection clients visiting public sector clinics from 900,000 to 600,000 and to reduce the number of couples contracting infections by 800,000. It will provide 2.77m couple years of protection.

Sustainability

- The project provides for the Zimbabwe Government to contribute an increasing percentage of the cost of condoms (from 10% in year 3 to 30% in year 5). There is a risk that this may not be achieved as such a level of contribution has not been attempted in a developing country by any other condom project. Similarly, direct procurement by recipient governments has not been attempted before but the benefits of the Family Planning Council procuring condoms have not been documented. The Council could not demonstrate what immediate benefits they would achieve by purchasing the condoms themselves; they agreed that any savings on procurement agents' fees would not be offset by the higher price which they may, as a small purchaser, have to pay.
- The Government of Zimbabwe is fully committed to the project and the associated national AIDS programme.
- The post-project recurrent costs of £2.8m a year are likely to cause a problem in sustaining the programme but the Administration consider they are affordable within the overall Zimbabwe health resources available.
- The cost of providing procurement training and developing a long-term strategy for condom supplies is £223,000.

5 The main lessons from the Sexual Health project are:

- external factors which impede a project achieving targets should be fully documented;
- target dates should be set for recruiting key personnel; and
- the benefits and cost-savings from developing an indigenous capacity to procure condoms should be highlighted in project proposals.

Appendix 5: Multilateral aid

1 Since April 1989 the Administration have provided £135 million to three multilateral organisations. The United Nations Population Fund, which received £38.5 million, promotes awareness of population issues and facilitates international co-operation in population issues, demography and family planning. Its 1994 budget was £152 million to which the Administration contributed £8.5 million.

2 The International Planned Parenthood Federation is a voluntary family health care organisation working in 130 countries through its associate members. It has received £39 million from the Administration since April 1989. In collaboration with governments and non-governmental and community organisations it provides reproductive health and family planning services. In 1994 it received £7.5 million from the Administration towards its annual budget of £77 million.

3 The World Health Organisation is responsible for international public health matters and is funded by 184 countries. In addition to the UK's regular budget contribution, paid by the Department of Health, the Administration contributed £57.5 million over the last five years (£16.7 million during 1993-94).

4 Contributions to these organisations account for over half of the Administration's expenditure on reproductive health and other population activities. Increasing pressure on the aid budget, caused largely by the growth in non-discretionary contributions to the European Community, has led the Administration to place increased emphasis on value for money and to re-assess and adjust the balance of their multilateral contributions.

5 The National Audit Office examined how the Administration monitor value for money from their contributions to multilateral organisations. The sources used to influence the direction and effectiveness of programmes are shown in Figure 5.

6 The National Audit Office concluded that:

- through their population services agreement, the Administration have established a comprehensive process of review and evaluation, providing management with valuable information on the effectiveness of the funded agencies;
- the Administration consider a broad span of evidence, including evaluations performed by other donor countries, to assess the effectiveness of funded agencies; and
- the Administration have been active in seeking the reforms necessary to ensure that their increasing contributions to World Health Organisation Special Programmes achieve optimum effectiveness and value for money.

Figure 5: Sources used to influence the direction and effectiveness of programmes

Form of monitoring undertaken by ODA	Results or findings
The United Nations Population Fund	
Participation in consultative meetings Chief Health and Population adviser accompanied by UK mission at UN	Raised concerns over the Fund's policies and priorities and encouraged improved monitoring.
Representation on UNDP Governing Council Chief Health and Population adviser	Influence is limited but the Administration used the meetings to play an active and constructively critical role.
Administration's evaluations Options reviewed programmes in Ghana and Pakistan. Tanzania and Nepal programmes also reviewed in 1994	The Administration did not receive good value for money in either country but it was achievable if improvements in local management continued. Activities lacked clear strategic objectives and quantified targets. The Administration are uncertain of the Fund's commitment to the reforms needed to improve effectiveness.
Evaluations by other donors 1993 review of Fund activities carried out jointly by three other donors.	The findings supported the conclusions reached in Administration reviews. They provided additional information on the effectiveness of the Fund.
International Planned Parenthood Federation	
Participation in annual donors meetings Health and Population Division	The Administration played an active and constructively critical role at meetings. The Federation is now providing more evidence to donors on how money is spent and on its impact.
Administration's evaluations Options reviewed programmes in Ghana and Pakistan. Tanzania and Nepal programmes also reviewed in 1994	The Administration obtained good value for money from Federation activities in Pakistan but not in Ghana. Improvements in planning and local management are underway in Ghana to establish greater value for money.
World Health Organisation	
Participation in Assembly meetings Department of Health's Chief Medical Officer plus input from the Administration	Opportunities to discuss and influence the Organisation's policies. The Administration have monthly liaison meetings with the Department of Health to put their views on development issues.
Participation in individual programmes Health and Population Division	Opportunity to examine the programme's strategic options and ensure their relevance to the Administration's objectives.
External reviews of programmes	The Organisation's four largest programmes have been reviewed in recent years. Improvements in co-ordination between UN agencies have been suggested. The Administration have been active in encouraging greater strategic guidance to developing countries.

Appendix 6: Research expenditure on health and population

1 Since 1989-90 the Administration have spent £85 million on health and population research, including £55 million on international research and £30 million through UK organisations. Until 1991 the Administration had no formalised health and population research strategy which led to a lack of clarity of requirements and objectives. The priorities now set for research include communicable diseases, reproductive health problems, non-communicable illnesses and the analysis and development of cost-effective health care. The objectives are to establish a social and economic climate for people to choose when to have children, to improve the availability, accessibility and quality of family planning and health care services, and to control communicable diseases.

2 The Administration support a wide variety of health and population research and development activities through partnerships with academic groups, non-governmental organisations, international bodies and the British Medical Research Council. Their research funding concentrates on support for developing and applying technologies appropriate to developing countries, and research into policies, management procedures and systems for resource allocation. The aim is to produce results which enable decision makers to choose between competing priorities for expenditure and enable them to organise management change.

3 The Administration have funded international research into AIDS, human reproduction, tropical diseases, diarrhoea, respiratory infections and recently tuberculosis. UK-based research comprises work programmes, research under the HP-ACORD and a grant-in-aid to the Medical Research Council.

Work programmes

4 In 1990 the Administration approved support for 14 five-year research programmes at the London School of Hygiene and Tropical Medicine and the Liverpool School of Tropical Medicine, at an estimated cost of £16 million. By June 1993 £8.7 million, including a 40 per cent contribution to overheads, had been spent on these programmes; matching resources were obtained from other funding bodies.

5 From April 1995 these projects were replaced by eight new research programmes. The Administration are defining the topic areas to ensure that the work undertaken is directly linked to their priorities. Three negotiated projects are to be shared by the two schools and will cover malaria, reproductive health and health economics research. The remaining five were subjected to open competition.

HP-ACORD

6 In January 1992 the Administration established a Health and Population Advisory Committee on Research and Development to review applications for research funding for projects costing up to £100,000 over a three year period. By August 1994 32 projects had been approved totalling £5.6 million.

MRC Concordat

7 Since April 1990 the Administration have contributed £8.6 million to the Medical Research Council, representing some 16.5 per cent of its costs of undertaking relevant research over the last three years. Before 1993 the Administration did not specifically focus or direct the Council research they funded. In December 1992, however,the Administration established a concordat with Council which established a framework for the promotion, funding and management of scientific research relevant to the health of developing societies. Some 85 per cent of the Council's 1993-94 £11 million programme is on bacterial infections, parasitic infections, reproductive health and HIV/AIDS.

Monitoring

8 Monitoring of health and population research has varied. Before the concordat with the Medical Research Council monitoring was spasmodic and unstructured. The work programmes undertaken at the schools of medicine were reviewed in 1991 and 1992 and triennial reviews were undertaken in 1993.

9 The August 1993 triennial review of the London School of Hygiene and Tropical Medicine concluded that the nine work programmes were helping to develop the School's institutional and training capacity, fostering institutional links with developing country institutions, and stimulating new research. The review team, however, considered that the value of the individual programmes was not easy to measure in precise terms.

10 The October 1993 triennial review of the Liverpool School of Tropical Medicine's work programmes concluded that it had achieved its broad objective of developing its institutional capacity. The five programmes were on course to strengthen training and institutional links but the review felt that it was too early to conclude whether the programme objectives would be achieved. Two of the programmes had started two years late and "research" became a key objective only later in the programme.

11 The triennial reviews have proved effective in influencing the direction of the individual programmes: many needed to be more tightly focused on specific interventions, cost-effectiveness and affordable health measures. A number of the initial objectives attached to the research programmes did not directly correlate with the Administration's own priorities and they have therefore introduced a number of changes, including the need to improve the assessment of value for money.

12 In May 1994 the Administration appointed a consultant research adviser to assist in monitoring research projects. This work aims to ensure that research efforts better meet the needs of clients in developing countries and thereby add value. Evaluations of the work programme and the initial HP-ACORD projects will form part of the consultant's responsibilities.

Impact

13 It is rather early to comment on the results of much of the research. The core work programme and the first batch of HP-ACORD three-year research projects were completed in March 1995. Of the remaining research projects funded over the last five years, some 19 projects costing £2.35 million have been completed.

14 Six of the London School of Hygiene and Tropical Medicine programmes have had an impact on policy formulation at country or international level and on its implementation. Two programmes (tropical disease control and AIDS) are showing good progress and are likely to achieve their objectives. One programme (tropical health technology) has developed a number of new technologies, several of which have been transferred to developing countries. The October 1993 review found that the Liverpool School's five programmes have had some impact on health policy practices in developing countries; two programmes (reproductive health and primary health care management) have demonstrated significant achievements.

15 The National Audit Office sought to identify the extent to which the results of completed research had been assessed by the Administration but only limited information was available. The results of the two cases examined are set out below.

Controlled trial of vitamin A supplementation on child survival in Northern Ghana

Researchers: London School of Hygiene and Tropical Medicine and Kumasi University, Ghana
Cost: £1.1m
Objective: to test whether illness and death are reduced in children given capsules of vitamin A regularly in an area of known vitamin A deficiency with few health services.
Results: there was a 19% reduction in deaths in children receiving vitamin A, and fewer hospital admissions and clinic attendances. However, the presence of common illnesses, such as chest infections and diarrhoea, were not affected - implying that the vitamin acts by reducing the severity of illnesses in vitamin deficient children.
Action taken: recommendations are that the agricultural and health sector act on these findings in Ghana. These include introducing vitamin A supplementation mechanisms in the district. Vitamin A supplies should be bought nationally and included on the government's essential vitamin list.

Evaluation of the risks to human health from parasitic nematodes in treated wastewater used for irrigation

Researchers: University of Leeds, Department of Civil Engineering
Cost: £115,000
Objective: to evaluate whether the current World Health Organisation guideline of one viable intestinal nematode per litre of treated waste water for irrigation of crops for human consumption is set too low.
Results: confirmed that the guidelines of one egg will lead to plant contamination with namatode eggs; with fresh foodstuffs for human consumption, tolerance of levels higher than the guidelines may risk infecting people.
Action taken: a need for further work on improving the effectiveness of wastewater stablisation ponds and monitoring nematode eggs in wastewater.

16 Various studies have been undertaken on behalf of the Health and Population Division to assist in predicting the potential impact of different forms of health and population interventions. Recent work included assessing the best public/private mix for health care in developing countries, comparing different types of cost recovery systems, the development of new malaria control measures, reviews of the effectiveness of health service interventions, and consideration of possible revisions to existing emergency feeding programmes. The Administration have recently decided to put more effort into summarising the findings of research so that it can be more easily disseminated.

17 The Administration need to consider the extent to which their support for research informs decision making at local, national and international levels and how it leads to better health and access to health care in developing countries. To ensure that research contributes to effective health care the results need to be disseminated and adopted. The Administration need to ensure that researchers specifically consider this aspect in the research design, and they should also consider how they and the researchers should take an active part in disseminating results and encouraging effective policy formulation.

Phase I Sub-centre,
Orissa, India (Appendix 1A)

Isiolo Hospital, Kenya (Appendix 3A)

Phase II Sub-centre,
Orissa, India (Appendix 1A)

Health education street theatre,
Orissa, India (Appendix 1A)

New Ngecha clinic nearing completion - Christian Health Association of Kenya component of Population III project (Appendix 3B)

Ngecha clinic - old (note use of bottles for medicines) (Appendix 3B)

Condom testing, Zimbabwe Regional Drugs Control Laboratory (Appendix 4B)

Overseas Development Administration's Health and Population Projects

Reports by the Comptroller and Auditor General Session 1994-95

The Comptroller and Auditor General has to date, in Session 1994-95, presented to the House of Commons the following reports under Section 9 of the National Audit Act, 1983:

Treasury Management in National Health Service Trusts in England ..... HC 7
The Financial Health of Higher Education Institutions in England ..... HC 13
The Management of Intellectual Property in The Ministry of Agriculture, Fisheries and Food ..... HC 15
General Practitioner Fundholding in England ..... HC 51
Overseas Development Administration: Management of Programme Aid ..... HC 68
Department for Education: Management of Office Space ..... HC 72
Crown Office and the Procurator Fiscal Service: Scottish Courts Administration Resources in Sheriff Courts ..... HC 119
Resource Accounting and Budgeting in Government ..... HC 123
Department of Transport: Sale of DVOIT ..... HC 128
Sale of Forward Catering Services Limited ..... HC 150
Managing to be Independent: Management and Financial Control at Colleges in the Further Education Sector ..... HC 179
Severance Payments to Senior Staff in the Publicly Funded Education Sector ..... HC 202
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Entry into the United Kingdom ..... HC 204
HM Customs and Excise: Writing Off VAT Arrears ..... HC 209
IT Security in Government Departments ..... HC 231
Inland Revenue: Market Testing the Information Technology Office ..... HC 245
Ministry of Defence: The Risk of Fraud in Defence Procurement ..... HC 258
Contracting for Acute Health Care in England ..... HC 261
National Rivers Authority: River Pollution from Farms in England ..... HC 235
Interim Report: PSA Services - The Sale of PSA Projects ..... HC 306
Commission for the New Towns: Disposal of Land and Property Assets ..... HC 308

Sale of County Hall (Riverside Building) to Shirayama Shokusan Company Limited ..... HC 314
Administration of Retirement Pensions ..... HC 360
Department of Employment: Financial Controls in Training and Enterprise Councils in England ..... HC 361
National Health Service Outpatient Services in England and Wales ..... HC 359
Department of Social Security: Purchase of Postal and Courier Services ..... HC 362
Medical Research Council: Sale of the Mount Vernon Site, Hampstead ..... HC 363
Ministry of Defence: Management of the Capital Works Programme ..... HC 417
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