THEMATIC EVALUATION OF POPULATION AND DEVELOPMENT ORIENTED PROGRAMMES IN EC EXTERNAL CO-OPERATION

March 2004

Final Report

Volume 2

For the

Consortium composed by
PARTICIP GmbH
CIDEAL
ECDPM
IDC
SEPIA

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Volume 1 Synthesis Report

Volume 2 Country reports
Annexes

Table of content Volume 2

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The Steering Committee for this evaluation has been a most constructive partner. Without thanking its members by name, we would like to express a particular debt to its Chair, and the EC official mainly responsible for this evaluation – Mr. Pieter Van Steekelenburg of the Evaluation Unit at EuropeAid.

List of abbreviations

ACP	African, Caribbean and Pacific countries
ALA	Asia and Latin America (ALA) countries
BA	Budget Aid
CARDS	Community Assistance for Reconstruction, Development and Stabilisation covering the Western Balkans
CED	Committee for Economic Development
CRIS Database	Common Relex Information System Database
CSE	Country Strategy Evaluation
CSP	Country Strategy Paper
DAC	Development Assistance Committee (OECD)
EC	European Commission
EDF	European Development Fund
EU	European Union
FP	Family Planning
HAP	Health Aid and Population
HIPC	Highly Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
ICPD	International Conference on Population and Development
IDP	Internally displaced person
IMF	International Monetary Fund
MEDA	Measures to accompany the reforms to the economic and social structures in the Mediterranean non-member countries
MS	Member State
NGO	Non-Governmental Organisation
NIDI	Netherlands Interdisciplinary Demographic Institute
NIP	National Indicative Programme
NPC	National Planning Commission
NSA	Non-State Actor
OECD	Organisation for Economic Cooperation and Development
PHARE	Aid for Economic Restructuring
PRSP	Poverty Reduction Strategy Paper
RD	Rural Development
RH	Reproductive Health
RIP	Regional Indicative Programme
SRH	Sexual and Reproductive Health

STIs	Sexually Transmitted Infections
SWAP	Sector Wide Approach Programme
TACIS	Technical Assistance for the Commonwealth of Independent States
TB	Tuberculosis
TOR	Terms of reference
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
US AID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation
WTO	World Trade Organisation

Analytical descriptors in population and development database

ICPD core sectors

FP	Family planning
Pol-Mgmt	Policy and management
RH	Reproductive health
STIs/HIV/AIDS	Sexually transmitted infections / HIV/AIDS

Health

Basic	Basic health care
Infect	Infectious disease control
Infra	Basic health infrastructure
Pol-Mgmt	Policy and management
Sector	Health sector support
Trng	Health personnel development

Displaced persons, refugees, emergency humanitarian assistance, etc.

DispPop	Displaced population
EmRel	Emergency relief
IntDisPop	Internally displaced population
Migr	Migration
PostCon	Post conflict
ReconRel	Reconstruction relief
Rehab	Rehabilitation
Reint	Reintegration
Return	Return

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THEMATIC EVALUATION OF POPULATION AND DEVELOPMENT ORIENTED PROGRAMMES IN EC EXTERNAL CO-OPERATION

COUNTRY REPORT FOR EGYPT

Landis MacKellar and Salah Abdel-Atty

January 2004

For the

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CONTENTS

FIGURES and TABLES

ANNEXES

1. INTRODUCTION

1.1 Background to the mission

On 29 November, 2001 the Board of EuropeAid requested the European Commission's Evaluation Unit to undertake an evaluation of the population theme in EC external assistance over the period 1994-2002 in order to "… verify the logic and consistency of individual actions with the stated objectives and expected impacts."

This evaluation represents the first-ever global assessment of the theme "Population and Development in EC external cooperation programmes." The objective of this evaluation is to provide the Commission with an independent expertise to assess the nature and evolution of its objectives and policies on population and development in external co-operation programmes, the evolution and volume of the programmes concerned, to assess its relevance, effectiveness, efficiency, sustainability and impact, and internal/external coherence.

Population is a multi-dimensional concept at the EC, and this evaluation is similarly intended to take a broad view of population and development. The template adopted is the International Conference on Population and Development (ICPD) Programme of Action, spanning the entire field of demography, from reproductive health (including sexually transmitted infections and HIV/AIDS) and family planning through age- and spatial distribution of populations, urbanisation, international and internal migration (including refugees, internally displaced persons, and asylum seekers), disabled persons, population data collection and analysis, and policy making. Information, education, and communication (IEC) activities and activities aimed at gender equality and equity are an important component.

The EC plays a significant role in international population assistance, providing approximately 5-10% of global support for the ICPD goals focusing on six areas:

- Maintaining and increasing the gains already made in providing access to sexual and reproductive health services,
- Ensuring that women have the opportunity of safe pregnancy and childbirth,
- Promoting the sexual and reproductive health of young people,
- Limiting the spread of HIV/AIDS and caring for those who live with the virus,
- Addressing problems of gender-based violence and sexual abuse, especially of young women and children,
- Building partnerships with civil society.

The EC is also a major source of humanitarian assistance to refugees and displaced persons, a significant amount of which overlaps with population (reproductive health of displaced populations, resettlement and repatriation programmes, etc.).

The legal bases for population assistance for the period covered by this evaluation (1994-2002), which contain the relevant policy objectives are:

- for reproductive health and family planning: the 1992 Council Communication on Family Planning and the 1997 Council Regulation 1484/97 on aid for population policies and programmes in developing countries.
- for sexually transmitted diseases, HIV and AIDS : the 1994 Communication on Health COM(94)78, Council Regulation 550/97 on HIV/AIDS-related operations, the Communication on Accelerated Action Targeted at Major Communicable Diseases Within the Context of Poverty Reduction (COM (2000) 585).
- for distress migration, internally displaced people and refugees : Council Regulation 1257/96 concerning humanitarian aid, Council Regulation 2258/96 covering rehabilitation and reconstruction operations, and Council Regulation 2130(2001) on operations to aid uprooted people in Asia and Latin America. While the Regulation covers only ALA, it can be construed as expressing EC policy broadly speaking in other regions of the world.

Almost all budget lines and the EDF have been found to finance population-related activities. This evaluation is therefore not limited to any particular financial instrument. The overall objective of this evaluation was to achieve improved coherence and application of the Commission's approach to Population and Development in partner countries through improved decision-making and project management. The evaluation was to have been implemented through provision of independent expertise to assess the nature of policies and objectives related to population in external cooperation programmes, the evolution and volume of programmes concerned, and their relevance, effectiveness, efficiency, sustainability, impact, and internal / external coherence. The focus was on a verification/testing of the logic and consistency of EC-funded actions with the stated objectives and expected results.

The evaluation concentrated on the period 1994-2002. It took into consideration, however, issues which were of more recent vintage such as the emerging importance of Sector Wide Approaches (SWAPs). The evaluation covered the Commission's actions in the field of Population and Development in Asia and the Pacific, Latin America, the Caribbean, Africa (including the Mediterranean area), the Balkans, the Commonwealth of Independent States, and the non-accession countries in Central and Eastern Europe.

The **thematic scope** of the evaluation was bound by the following considerations:

- Gender aspects of Population and Development should be discussed with reference to the on-going evaluation of this area. Work in the ongoing Rehabilitation evaluation will also be taken into account.
- Health aspects took into account findings already developed by the evaluation in this area, putting these results / conclusions in perspective and updated as indicated. The evaluation team were complementing, not repeating, work undertaken by the recent HIV/AIDS evaluation.

- The analysis of international migration was limited to migratory movements between countries in the same region and within countries and was to include displaced persons / uprooted people. Migration from partner countries to Europe was not covered in the analysis.
- Only limited attention was be given to population, development and education; however, the work on education and communication of DG EAC was be taken into account.

Co-ordination, coherence, and complementarity with other key international actors in Population and Development were a key subject of the analysis; as were co-ordination, complementarity and coherence with NGOs.

Field visits

A major component of the Completion Phase of the evaluation consisted of five country field visits: Egypt, Georgia, Guatemala, India, and Kenya. The purpose of the country visits was to test and verify the logic and consistency of project and programme actions against stated objectives and anticipated impacts. Through consideration of Evaluative Questions, the evaluation team has assessed the relevance, effectiveness, and coherence of EC Population and Development strategy(ies) and programmes.

Each mission was carried out by a senior international consultant, who collaborated with a national expert recruited in advance of the mission. The duration of each country mission was approximately 10 days plus two days mission preparation and four days report drafting. Approximately five days were be dedicated to meeting different stakeholders, in the EC delegation, in partner organisations (line Ministries, NGOs, bilateral funders, etc.) and national actors involved in population issues. Donors (multilateral and bilateral) as well as major NGOs involved in population were interviewed for bench-marking of EC approach to population. A mixture of participatory techniques, including face-to-face interviews and focus group discussions were used. Approximately five days were dedicated to an assessment of selected programmes or projects. Techniques will include interviews and focus groups with beneficiaries (women and men), local implementers and other key stakeholders.

1.2 Why Egypt?

1.2.1 Introduction

Egypt is a major EU partner country and the main aid recipient in the MEDA region. In line with the Barcelona agreement, one of the priorities of EC assistance is supporting stable and balanced socio-economic development.

EGYPT COUNTRY PROFILE	
LAND AREA	1 million km²
POPULATION	
Total Population (estimate 2003):	67.313
Total Population 2021 (millions):	89.4
Population Growth 1996-2001:	2.1
Urban Population (%):	43
FERTILITY AND CONTRACEPTION	
Crude birth rate (births per 1,000 of a population in a given year):	27.5 *(1998)*
Total Fertility Rate (Sum of the age-specific fertility rates in a given year):	3.5 *(2000)*
Women aged 15-49 using contraception (all methods) (%):	56.1
Women aged 15-49 using contraception (modern methods) (%):	53.9
MORTALITY	
Crude Death Rate (deaths per 1,000 of a population in a given year):	6.5 *(1998)*
Average Life expectancy in years (men):	65.0
Average Life expectancy in years (women):	68.1
Infant Mortality Rate (Number of deaths to infants under one year of age per 1,000 live births in a given year):	43.5
Maternal Mortality Rate (Number of deaths to women due to pregnancy or childbearing complications per 100,000 live births in a given year):	84
HEALTH	
Population with access to :	
Health services %: Urban	100.0
Rural	99.0
Piped water %: Total	91.3
Rural	82.1
Sanitation %: Total	93.6
Rural	78.2

EDUCATION AND EMPLOYMENT	
Literacy Rate (men) (%):	67%
Literacy Rate (women) (%):	44%
Combined basic and secondary enrolment ratio % (2000/2001)	86.0
Unemployment rate %:	
Total	9.0
Female	19.8
Adults 15 – 29	20.4
Urban	8.9
Rural	9.2
Unemployment rate by education 15+ %:	
Below secondary	1.5
Secondary	22.4
University	8.8

ECONOMY:	
Natural resources:	Oil, natural gas, phosphates.
GDP:	- total: € 90.7 billion, (Egy £364.8 billion). - per capita: € 1396 - real growth rate 4.9 % (EIU report 2.5)
GDP growth:	4.6% (average 1997/98-2001/02) 3% (2001/02)
National budget:	(fiscal year 2002-2003): - revenue: £ Egy 111.5 billion. (27.5% of GDP) - balance: £ Egy – 30.2 billion (7.5 % of GDP) - net deficit: - 17.2 (4.3 % of GDP)
Imports from the EU:	€ 4.2 billion (30 % of total imports)
Exports to the EU:	€ 1.5 billion (31.4 % of total exports)
Trade balance:	- € 2.7 billion
Exchange rate:	€ 1 = £ Egy 7 (official rate is £ Egy 1= $6.95)
Inflation :	3% (average, 1998-02) 2.7% (average, 2002)

Sources:

- *The Central Agency for Public Mobilization and Statistics (CAPMAS), 2003*
- *Egypt Human Development Report 2003, UNDP and the Institute for National Planning*
- *Egypt Demographic and Health Survey, 2000.*

Egypt was one of the earliest countries to cite rapid population growth as a barrier to development prospects, and policy statements have placed a strong emphasis on reducing the rate of demographic increase. EU support to social development in Egypt focuses directly on basic education, basic health, and poverty alleviation.

The Health Sector Reform Programme covers the phased rationalisation of Egypt's health care delivery system, prioritizing access, equity, quality and efficiency and provision of a cost effective basic health care package. A large population policy implementation project with a focus on safe motherhood, family planning and reproductive health (the Upper Egypt Population Programme) spanned the years of this evaluation.

1.2.2 Country profile: demographic situation and population policy priorities

Egypt is a lower-middle income country and has the demographic profile typical of a country at this stage of development: rapid population growth, relatively high age-specific fertility rates, relatively high age-specific mortality rates, and a relatively young age structure which guarantees considerable demographic momentum (see the accompanying chart and Table 1 at the end of this report). The latter means that even if age-specific fertility rates decline rapidly, population growth will continue to be rapid as large cohorts move through their childbearing years. Also typically, there is a pronounced urban-rural gap in fertility and mortality, with the countryside characterized by high fertility and high mortality. There is also a regional dimension, Upper Egypt being characterized by much higher fertility and mortality than Lower Egypt. The Egyptian Demographic and Household Survey for 1995 (EHDS95) showed that contraceptive prevalence among women in Upper Egypt was 24 percent, as opposed to 53 percent among women in Lower Egypt and 42 percent among married women in the Frontier Governates.

Egypt has historically been a leader in population policy, not only within the Arab world but globally as well. The formation of a National Committee for Population Affairs dates back to 1953 and, in 1958, the national network of public family planning clinics was put in place. In 1991, the National Population Council issued a policy document detailing priorities for 1992-2007, corresponding to the period covered by this evaluation. Goals and targets included reducing the total fertility rate from 4 children to 3.5 children by 1997 and 2.7 children by 2007. The means specified to achieve this were an increase in contraceptive prevalence from 48 percent in 1991 to 53 percent in 1997 and 63 percent in 2007, as well as an increase in the efficiency of contraceptive methods used. It was estimated that the rate of natural increase of the population would decline from 2.5 percent per year in 1991 to 2 percent in 1997 and 1.8 percent in 2007. In addition to goals in the areas of contraceptive prevalence, the policy outlined approaches involving mother and child health, women's status, youth and development, and education and literacy, rural development ad other areas broadly related to population. The role of these broader aspects was emphasized in a 1995 modification of the national population policy, based on recommendations of the 1994 ICPD. More recent updates of population

policy call for the attainment of replacement level fertility (ca. 2.1 births per woman) by 2017.

Funding for family planning services is provided primarily by the Government of Egypt (GoE) and donor agencies. A study of the cost of family planning during the period 1999-2000 found that, of the total cost of activities conducted by the public (i.e., not-for-profit) sector, GoE provided 58 percent of funding, donor agencies provided 36 percent, while client payments covered 6 percent. Government financed the overwhelming majority of services delivered (LE 159 million pounds out of an estimated total expenditure on family planning of LE 165 million), including not only direct provision but also subsidization of drugs and contraceptive supplies and insurance payments. However, service delivery (as opposed to finance) is primarily private: most women obtain RH/FP services from the private sector and most pregnant women receive ante- and post-natal care privately as well. Part of the explanation for this apparent paradox is that, public salaries for doctors being exceedingly low, Government allows doctors to receive private patients in public clinics outside office hours. There is a strong and accurate perception that the quality of public-sector services is low as compared to the private sector, often meaning that the same doctor will offer higher quality services to a private client than to someone coming during public consultation hours. "Quality" is a multi-dimensional term, but aspects include privacy, pleasant surroundings, sensitive client service, choice of physician and continuity of service (i.e., seeing the same doctor every visit) wide choice of contraceptive method, responsive attitude of staff, etc. It is observed in Egypt (and confirmed by project documentation reviewed below) that *privacy* is an especially important consideration in Egypt. Despite the wide availability of public RH/FP services, most consultations take place in the private sector. To put it simply, a woman with available resources will seek private, not public, service provision. Widely cited as a problem, this cloud may, however, have a silver lining, as it gives evidence of significant willingness to pay, even on the part of poor women. This suggests, in turn, opportunities for cost recovery and enhanced sustainability. The idea that primary health care should require zero out-of-pocket expenditure retains considerable appeal, however, and any discussion of cost recovery in RH/FP is controversial, requiring considerable dialogue among stakeholders before policy decisions can be made.

In 1996, the Government of Egypt underscored the importance it attached to population by creating a population section within the Ministry of Health, which was re-named the Ministry of Health and Population (MoHP). MoHP has the largest role in service delivery through 3,700 service units in both urban and rural areas (hospitals, MCH centers, health center, and health units). In addition to administering these units and training their personnel in family planning delivery, the MoHP is responsible for ensuring availability of contraceptive supplies, not only for MoHP units, but for family planning clinics run by private voluntary organisations and the private market. Thus, the MoHP is responsible for the import and local production of contraceptives and for the distribution of these to approximately 4,000 family planning centers, to over 9,500 pharmacies, to private hospitals and clinics, and to retailers.

The Ministry of Social Affairs (MoSA) is responsible for supervising voluntary organizations in the field of population and family planning. MoSA supervises the activities of the Egyptian Family Planning Association (EFPA), which operates about 450 service delivery units. In addition, MoSA provides training of workers and community leaders in population and family planning. Other government ministries and agencies involved include Ministry of Information, Ministry of Education, Ministry of Local Government, and the Central Agency for Public Mobilization and Statistics (CAPMAS). Organisations active in research and training include Cairo Demographic Center (CDC) and the universities. Religious organizations, both Muslim and Christian, play a role in encouraging provision of family planning services.

Current policy concerns include a slowdown in the increase of contraceptive prevalence, which appears to have reached a plateau in the 1990s. The highly medically-oriented delivery system needs to be supplemented by a strong outreach programme. Another area of concern is high rates of discontinuation among contraceptive users. This pattern of discontinuation necessitates putting more effort into screening and counseling of prospective users on the appropriate method to be used and widening the range of methods offered. Despite the relative availability of trained health personnel and facilities, a significant number of Egyptian mothers do not receive ante-natal care, and relatively few receive the targeted standard of at least four ante-natal consultations. Non-trained health personnel continue to assist in the majority of births.

Egypt is also notable in that it is one of the relatively few developing countries to have an official policy on population distribution. Concentration of the vast majority of Egyptians on a small portion of the territory (the Nile Valley) and urban sprawl in Cairo and Alexandria have long been policy concerns. Government is embarking on three major land reclamation projects in Sinai and Toshka in Upper Egypt, with the goal of providing job opportunities and settlements away from the Nile Valley. Past experience has not, however, provided grounds for optimism: past projects have attracted no more than a single-digit fraction of the targeted population.

1.3 Summary of the mission

The mission was carried out by Mr. Landis MacKellar, international consultant based in Vienna, Austria, and Mr. Salah Abdel-Atty, national consultant based in Cairo. The evaluation was carried out at two levels. At national level, the team worked with staff from the EC Delegation, other international agencies, NGOs, and research organizations. AN examination of the Population-Development Project Database developed as part of the evaluation (see Annex 3) indicated that two projects dominated in monetary terms, so the evaluation focused on these::

the Upper Egypt Population Programme (UEPP), a population budget line project which ran from 1997 through 2003, and the Health Sector Reform Programme (HSRP), financed by MEDA, which began in 1998 and is expected to end in 2005. The team also visited local NGOs which had received support from the MEDA-financed Social Fund for Development (SFD) although it did not attempt to evaluate

this project in detail. The reason for selection of these projects were (i) UEPP was the EC's flagship population project in Egypt and (ii) capacity built and progress made by UEPP will need to be carried forward by the HSRP.

The approach to the evaluation involved review of literature, including financing documents, project monitoring and evaluation reports, project final reports and impact studies, the Egypt Country Strategy Paper and National Indicative Programme, interviews with key informants and stakeholders, and site visits.

A detailed chronology of the mission and list of persons interviewed is given as Annex 1 of this Country Report. A list of documents consulted is given as Annex 2. Annex 3 gives an overview on major ICPD Interventions in Egypt, by thematic cluster.

1.4 Constraints

Time available was, as usual, the principal constraint. The EC Delegation official responsible for the health and population portfolio had taken it over only several weeks prior to arrival of the team. It should also be pointed out that neither member of the team has a medical background and their comments on strictly medical aspects of the projects should be considered in this light. It would be fair to say that the team has learned more in depth about the UEPP than the HSRP: not only was this project focused on population, but it has completed the entire project cycle and a substantial amount of evaluation and impact assessment material is available.

The team considers that, in general, the mission went well and that they were able to fulfill their terms of reference. They would like to thank all the officials, experts, and clinic staff who gave so generously of their time. They are especially indebted to Dr. Hanem Abdel Azeem and Dr. Yahia El Hadidi of MoHP for facilitating sit visits to Upper Egypt and to Mr. Pascal Odul of the EC Delegation for supplying documentation and facilitating the mission.

2. EVALUATIVE QUESTIONS

2.1 Evaluative Question 1

Since 1995, what has the European Commission put in place, in terms of global policies, strategies, and programmes (Cotonou agreement, TACIS, MEDA, ...) to operationalise its engagements with the ICPD Plan of Action and ICPD+5?

To what extent are the EC policies, strategies and programmes coherent with ICPD?

This Evaluative Question is being answered via Brussels-based interviews, document analysis, etc. The Preparatory Phase concluded that the EC's population policy focus has shifted from concern with rapid population growth as a deterrent to economic development to concern with the right to adequate sexual and reproductive health. In addition to its focus on women, the EC has actively targeted adolescents. This evolving population policy has been *externally coherent* with shifts in the stance of other policy institutions. Moreover, the *internal coherence* of EC population policy has improved over time. There is little sign from policy documents, however, that the EC has sought to exploit synergies with other areas of EC assistance (apart from health and support to refugees / internally displaced persons). Nor has there been adequate consideration of strategic linkages between population policy and policies in other areas.

In view of needs in poor countries and the scarcity of resources, the *relevance* of EC population assistance appears to be assured. The Preparatory Phase did not reach a judgment on whether EC assistance has been *effective* in pursuing policy goals. The validity of the *efficiency* criterion is diminishing with the move towards a human-rights based approach, however, as poor reproductive and sexual health particularly affect vulnerable groups, and as the unit costs of most interventions are low, the EC's population activities may be very efficient means of addressing inequities. The Preparatory Phase also did not reach a conclusion regarding *sustainability*; however, it is widely known that available international financing falls far short of needs and governments are reluctant to commit resources.

The evaluation team has found that the Commission's record-keeping and accounting systems for population projects have been over-stretched as a result of the multiplication of sectors, budget lines, and directorates, as well no doubt as by rapid staff turnover. The team noted that steps are underway in Brussels to unify databases.

More generally, the Preparatory Phase of this evaluation found that there are opportunities for the EC to enhance its impact in the population field and, by exploiting synergies with other sectors, to bolster the relevance and effectiveness of its overall development approaches. In order to translate these preliminary indications into practical steps and actions, the Preparatory Phase recommended that the Commission proceed with the Completion Phase of this thematic evaluation on population and development.

2.2 Evaluative Question 2

To what extent did EC third country co-operation strategies (especially CSPs, NIPs, etc.) reflect an overall population and development sector approach, and respond to the needs of the Cairo Action Plan?

At the level of countries: Were country strategies internally coherent from the standpoint of population and were these population components coherent with the global development policy of the EU?

General overview of EC assistance

The Egypt Country Strategy Paper (CSP) 2002-2006 provides a strategy framework for assistance, setting out co-operation objectives, policy responses, and priority fields based on an analysis of the partner country's policy agenda and situation. The National Indicative programme (NIP) 2002-2004 sets forth the programme objectives, expected results, and conditionalities in more detail.

EU co-operation objectives with Egypt are based on the Barcelona Declaration, which identified three main goals: creating an area of peace and stability based on respect for human rights and democracy, creating an area of shared prosperity through sustainable and balanced socio-economic development (and notably through progressive establishment of free trade), and improvement of mutual understanding among peoples of the region and development of an active civil society. Barcelona objectives are pursued through bilateral Association Agreements; negotiations for the EU-Egypt Association Agreement began in 1994 but were only concluded in 1999 and signed in 2001. The MEDA programme provides financial support for the objectives of the Barcelona Declaration.

As of September 2000, the overall policy agenda of GoE included the following elements:

- Continued denationalization of public sector interests
- Expansion and modernization of infrastructure
- Savings and investment promotion
- Fiscal, monetary, and financial sector reform
- Bureaucratic and industrial modernization
- Natural and human resource development
- Social reforms
- Regional resettlement "mega-projects"

There is widespread recognition that social sector has lagged behind the economic reform process, especially that job opportunities created are running far behind population growth. A National Conference on Social Development (2000) moved social development closer to the centre of overall development policy. In its dialogue with donors, the GoE has expressed its wish to involve the international community more closely in social sector development. Key priorities are health sector reform, educations sector reform, and application of the Social Fund for Development (SFF) as a tool for promoting grassroots development and the development of civil society.

Government commitment to the population sector is made clear by section 1.b above. Public pronouncements in the area are often nuanced by the need to avoid conservative social and religious backlash. However, President Mubarek has recently emphasized population in his speeches. The reflection of GoE population policies in EC assistance is discussed below.

From 1977 to 1996, EC-Egypt co-operation was carried out under four succeeding bilateral protocol agreements (under the last of which the UEPP was financed). Since 1996, cooperation has been financed under MEDA. The latter has been devoted to two main goals: support to economic transition and socio-economic balancing. The former has concentrated on the Industrial Modernisation Programme (Euro 250 million) and the latter on three components: the Education Enhancement Programme (Euro 100 million), the HSRP (Euro 110 million) and the SFD (Euro 155 million). The first two are sector-wide multi-donor reform programmes with large technical assistance components; the latter is also multi-donor but is distinguished by the large degree of self-responsibility for planning and execution.

Priority action areas for assistance identified by the CSP and NIP are

- Support to trade enhancement
- Support to comprehensive restructuring
- Supporting the process of economic transition through
    - human resource development,
    - financial and investment sector reform, and
    - adoption of an “innovation culture”; and
- Supporting stability and balanced and sustainable socio-economic development through
    - Decentralized and integrated local development initiatives (particularly addressing development disparities in South Sinai and Upper Egypt),
    - Support to social development and the development of civil society structures, and
    - Support to measures to protect Egypt’s fragile marine and land environment.

The population sector falls under support to social development. To get an

idea of the importance of the social sector in EC cooperation, Annex II of the CSP 2002-2006 lists interventions ca. 1995 – 2006 totaling Euro 845 million. The UEPP, the SFD, the Education Enhancement Programme, and the HSRP thus account together for 44 percent of EC assistance.

Population in EC assistance

The Egypt CSP 2002-2006 contains repeated references to rapid population growth and GoE concerns in the area. These concerns are grounded in the problems of unemployment and limitations on the natural resource base (i.e., concentration of population onto a fraction of the land area). The jobs issue, in particular cuts across all sectors of GoE policy and EC assistance and is repeatedly placed in the context of demographic pressure against the poor job-creation performance of the Egyptian economy.

The GoE is committed to reducing the goal of fertility to replacement level by 2017 in order to slow population growth. While it has not abandoned quantitative targets and a general orientation towards family planning, the GoE has embraced the broad approach of the International Conference on Population and Development (ICPD) Programme of Action, as evidenced by the document "Population and Development Strategies 2002 / 2007" prepared by the Population and Family Planning Sector of MoHP under the aegis of the UNFPA-funded Population and Development Strategies Project. EC policy has been evolving similarly, as discussed at length in the Final Report of the Preparatory Phase of this evaluation. The background paragraphs of Regulation 1484/1997 on aid for population policies and programmes make it clear that reduction of fertility rates and deceleration of population growth were central EC population goals in the late nineties, even 3 years after such quantitative goals had been de-emphasised by ICPD. However, to judge from the new EC council regulation on Sexual and Reproductive Health now (July 2003) under consideration, the EC is increasingly aligning itself with the broad view of population and development implicit in the ICPD Programme of Action.

The population component of EC country strategy in the period 1994-2002 consisted mostly of population budget line (BL 6312) support (Euro 10 million) to the Upper Egypt Population Programme (UEPP). This project, after some startup problems and a slight delay, ran from 1997 to 2003, closing only a few weeks prior to arrival of the evaluation team. The core of the UEPP was reproductive health and family planning (RH/FP), plus an impressive range of "non-classic" key action areas from the ICPD Programme of Action (such as female literacy and income generation components). While the orientation of the project is made clear by its overall objective "to increase contraceptive prevalence in Egypt," it was ahead of its time in representing the first attempt in Egypt to integrate FP into a broader context of RH and mother and child health (MCH). Outreach, awareness creation, and IEC activities were prominent and successful.

Council Regulation 1484/97 on aid for population policies and programmes in the developing countries calls on targeting population assistance towards those countries furthest from ICPD targets and those which have failed to experience the onset of demographic transition. Egypt meets neither of these criteria yet, paradoxically, the population project database constructed during the Preparatory Phase of the evaluation reveals that the UEPP was by far the most significant EC-supported project tightly focused on goals (excluding HIV/AIDS projects, which correspond more closely to Council Regulation 550/97 than to 1482/97). Why would a country that would normally receive low priority in terms of population assistance the recipient of such significant support? The answer is clearly the strong commitment of GoE to population policy. However, this raises the paradox that countries targeted by the relevant regulation, i.e. those most in need of population assistance, may attach low priority to the sector.

The second project implemented over the evaluation period having major ICPD components was the Health Sector Reform Programme (HSRP). As a project aiming to provide universal access to a comprehensive primary health care package called the Basic Benefit Package (BBP), the HSRP is less focused on population concerns than was the UEPP; however, RH/FP and MCH are key components of the BBP. Three governates (just increased to five) were covered by the HSRP during the evaluation period: Alexandria, Menoufia, and Sohag. Note that the latter is in Upper Egypt and was also a focal point of the UEPP. The HSRP began in 1998 (with the Programme Support Stage commencing in 2001) and is expected to end in 2005, with EC support amounting to Euro 100 million.

While the evaluation team has devoted less attention to it, the SFD supported many Community Development Associations (CDAs) in activities related to population. These included renovation of clinics offering RH/FP services, outreach and awareness-creation activities, as well as women's literacy and income generation projects. Somewhat less closely related to population, but connected through the health impact, the SFD has also supported many sanitation projects.

Finally, the EC has funded several environmental actions in South Sinai which have provided clear understanding of the population-development imbalances affecting the region. Through its policy dialogue with GoE, the EC has injected environmental concerns into one component of GoE population policy, namely regional development projects to encourage population to move into now-sparsely inhabited zones.

It must be noted, however, that these activities have not resulted in the EC enjoying a high profile in the area of population and development in Egypt, especially as compared to USAID. Whereas virtually every official and expert interviewed by the evaluation team was aware of USAID's assistance in the area of population, only those with direct experience of EC projects knew about the EC. To get an idea of the relative sizes of programmes, according to Annex III of the CSP 2002-2006, in 1995-2000, USAID financed population / family planning activities to the extent of Euro 55 million and MCH activities to the extent of Euro 36 million; moreover, these activities were the continuation of long-standing support in these areas.

Overall answer to Evaluative Question 2

EC assistance to Egypt incorporated a consistent Population and Development orientation and an overall sector approach. While the emphasis of population assistance was on family planning, broader Cairo themes were also addressed. This broad welfare-based approach was consistent with the EC policy, which moved from concern with family planning indices and demographic targets towards reproductive health and empowerment of women. The EC's good response in Egypt EC to Cairo needs should be understood in the context of the Egyptian Government's long-standing commitment to population as a key policy area.

2.3 Evaluative Question 3

Reproductive health: How far have EC supported actions in this field addressed specific objectives related to Chapter 7 of the ICPD and those of Regulation 1484/97?

Health (including primary health and health sector), morbidity, and mortality incl. HIV/AIDS: To what extent have EC supported actions addressed specific objectives related to Chapter 8 of the ICPD and those of Regulation 550/97?

This question will not repeat the evaluation of "AIDS and population" of 2000, but rather provide an update where relevant.

Reproductive health

Through the UEPP, the HSRP, and the SFD, the EC has supported a broad and comprehensive range of activities related to Chapter 7 of the ICPD and to the relevant Council Regulation 1484/97. Within the constellation of ICPD activities, the emphasis has been on FP within the broader context of RH.

Components of the UEPP include

- Improved access to RH/FP
- Putting-in-place of qualified human resources at rural health units (RHUs), villages, and district capitals (district FP referral centres)
- Increased awareness and demand on RH-related issues among the public
- Increased income and literacy among women
- Increased capacity and integration of NGOs.

In addition to providing RH/FP services, with an emphasis on the latter, the project produced and disseminated IEC materials targeting both women and men, promoted outreach, and empowered women through literacy activities and income generation projects based in rural health units (RHUs).

Within the HSRP, EC support for key ICPD actions consists of support for the BBP, in which RH/FP and MCH are core components. By increasing coverage and equity of the Egyptian health system taken as a whole, the HSRP makes a strong contribution to ICPD goals. While speaking of broad contributions, it is important to remember that the EC also supports education reform in Egypt. While the Brussels desk officer interviewed could not cite any specific ICPD content of educations sector support, experts interviewed in Cairo felt that expansion of girls' education was having very significant spillover effects in the population sector.

To summarise, actions relative to Chapter 7 of the ICPD which have been supported by the EC include family planning counseling, IEC services; education and services for prenatal care, safe delivery and post-natal care and infant and women's health care; prevention and treatment of infertility (provided at District Health Centers supported by the UEPP); abortion as specified in paragraph 8.25 of the ICPD Programme of Action, treatment of reproductive tract infections, sexually transmitted infections (STIs) and other reproductive health conditions; and IEC on human sexuality, reproductive health and responsible parenthood. Specific actions related to family planning supported by the EC include those designed to help couples and individuals meet their reproductive goals; to prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality; to make quality services affordable, acceptable and accessible to all who need and want them; to improve the quality of advice, IEC and services; to increase the participation and sharing of responsibility of men in the actual practice of family planning (through men's groups sponsored by the UEPP). Actions related to prevention and treatment of STIs and HIV/AIDS have been less visible and it is not apparent that the EC has "promoted and distributed high-quality condoms as integral components of all reproductive health-care services" as called for by the ICPD. The EC has not focused on adolescents and youth, however, it has supported non-formal education and community-based efforts designed to reach adults, efforts supporting active and open discussion of the need to protect women from abuse, including actions designed to stop the practice of female genital mutilation and protect women and girls from all similar unnecessary and dangerous practices. As discussed below, the evaluation indicates that actions related to female genital mutilation have not had significant impact.

Referring to Council Regulation 1482/97 on aid for population policies and programmes in the developing countries, EC actions in Egypt have supported the establishment, development, and increased availability of RH services; improved RH services, supported IEC campaigns addressed at promoting better RH, provided FP services, supported (especially through the SFD and the outreach component of the UEPP) development of grassroots structures for the implementation of programmes. It is not clear that the EC has provided help with drafting legislation or with broad population policy development, however, these areas have been effectively supported by USAID and UNFPA. In addition, capacity-building needs in these areas are limited, since Egypt already has substantial expertise in place.

Primary health care, safe motherhood, and child survival

The UEPP and HSRP have both supported a broad and comprehensive range of activities envisaged by Chapter 8 of the ICPD Programme of Action. These include vaccination, ante-natal care, post-abortion counseling and care, etc. More specifically, with reference to the ICPD Chapter 8, the EC has supported actions to increase the accessibility, availability, acceptability and affordability of health-care services and facilities, and to increase the healthy life-span and improve the quality of life of all people, as well as to reduce the disparities in life expectancy between and within countries, to ensure community participation in the planning of health policies,

to ensure access to health-care services for all people and especially for the most underserved and vulnerable groups, and to make basic health-care services more sustainable financially, while ensuring equitable access. The EC has supported actions to extend, within the framework of primary health care, integrated reproductive health-care and child-health services, including safe motherhood, child-survival programmes and family planning services, to all the population and particularly to the most vulnerable and underserved groups, to reduce the major childhood diseases, particularly infectious and parasitic diseases, and to prevent malnutrition among children. In the area of women's health and safe motherhood, the EC has supported actions to expand the provision of maternal-health services in the context of primary health care, to prevent, detect and manage high-risk pregnancies and births, to engage men's support for maternal-health and safe motherhood, to devise strategies to ensure that men share responsibility for sexual and reproductive health, to reduce the number of deaths and morbidity from unsafe abortion, and to improve the health and nutritional status of women, especially pregnant and nursing women.

The EC has undertaken few actions in Egypt in the area of HIV/AIDS. Experts interviewed were of two minds on this. Some felt that Egypt is a genuinely low-prevalence country and likely to remain that way; others pointed to the existence of significant risk groups (homosexuals, prostitutes, drug users) with significant needs. A MoHP survey of STIs apart from HIV/AIDS showed very high rates of prevalence among high-risk groups, a finding that can only cause concern as regards future transmission of the HIV virus. The MoHP is discreetly addressing itself to high-risk groups, through hot lines and other outreach and information efforts, but must step carefully to avoid a religious and social backlash.

Both the UEPP and the HSRP provide adequate documentation of the intervention logic. This logic is summarised in Figures 1 and 2 at the end of this note. Intervention logic is naturally more focused on ICPD concerns in the case of the UEPP, whose overall objective is increased contraceptive prevalence in Egypt, whose project purpose is increased functional and utilised RH/FP services in Sohag and Qena Governates, and whose results leading to achievement of the purpose are the five components listed above. In the case of the HSRP, the overall objective is universal coverage of the Egyptian population by a health insurance system that guarantees delivery, free of charge or in return for a modest co-payment, of the BBP.

It is too early in the history of the HSRP to assess results in the area of RH/FP and MCH. By contrast, the UEPP *Final Report* includes a comprehensive statement of results achieved. The evaluation team has attempted to summarise these in Table 2 at the end of this Country Report. As is evident, improvements have been registered across a wide range of indicators. With very few exceptions, almost all project results were judged by the authors of that report to have been fully or partially realized based on the objectively verifiable indicators identified. In a separate *Impact Assessment* report, qualitative assessment methodologies based on ethnographic approaches documented impressive gains in the level of information and knowledge regarding reproductive health and family planning. Respondents appreciated the upgrading of facilities, although relationships with clinic staff continued to be strained in places.

One area in which survey results indicate that the UEPP achieved little progress was in changing attitudes towards female genital mutilation (FGM). Attitudes continue to be strongly supportive of FGM and ethnographic investigation suggested that there is a significant amount of resentment over what is perceived to be external interference in cultural traditions. This is despite significant change in attitudes regarding other aspects of RH/FP and MCH, some of which can be attributed to the highly successful IEC, outreach, and awareness-raising components of the UEPP.

Are these positive results of the UEPP, and others not evident in the statistics, likely to continue? Are they likely to be replicated in other areas of the country? In answering a later Evaluative Question, we concern ourselves with project sustainability. Here we ask more generally whether contraceptive prevalence is likely to continue to rise, RH to improve, etc.

Our answer is a qualified "yes." First, while the impact of EC-financed activities has been significant, it is important to note that these favourable trends, which are summarized in Table 1 at the end of the Country Report, ante-dated EC support for population in Egypt. They are driven by three factors. One is the strong policy stance of the GoE in all matters related to population, and its capacity to deliver on its commitment. The second is rapid attitudinal change; while much of the Egyptian population is poor, it is not isolated. Satellite dish TVs, mobile telephones, bicycles, etc. are common even in poor communities, in significant degree because of Gulf remittances. Civil society, a key ingredient of information dissemination and attitudinal change, is well developed. Third, some favourable developments in the population field are due to problems in the economic sphere that are unlikely to be solved soon. Age at marriage has risen with breathtaking speed as young couples find it harder to set up a household.

We qualify the answer because, several experts interviewed underscored that diminishing returns are becoming apparent in some areas, particularly those having to do with contraceptive prevalence. The easy gains, according to this view, have already been made, with over half of all Egyptian women already practicing contraception. Further gains will have to be made by concentrating on issues such as quality and the closely related issue of reaching out to women who adopted contraception but later abandoned it because of dissatisfaction with the method.

One area where there are considerable opportunities to be exploited is adolescents, a key concern of the ICPD Programme of Action in which the EC has taken little initiative (somewhat contrary to the guidance given in Council Regulation 1484/97). A widening gap has emerged between age at sexual maturity and age at marriage, and the resulting health and information needs must be met. Despite the controversial nature of anything having to do with adolescent sexuality, all GoE officials interviewed expressed strongly the view that GoE is ready and willing to take on these issues.

A key sustainability issue is the "taking over" of UEPP activities by the HSRP, and these issues are discussed below.

Overall answer to Evaluative Question 3

The EC has supported, in Egypt, a broad and comprehensive range of activities related to Chapters 7 and 8 of the ICPD Programme of Action, generally emphasizing family planning within the broader context of reproductive health. The EC has done little in the area of AIDS. Projects studied adequately established intervention logic and the team expresses cautious optimism that gains made continue. However, in a context of diminishing marginal returns (over half of all Egyptian women already practice modern contraception) sustainability and further progress will depend on improvements in the quality of RH/FP, improvements which will need to be made in the context of the ongoing primary health care reform.

2.4 Evaluative Question 4

Refugees, IDPs, and distress migration: How far How have EC supported actions addressed specific objectives related to the relevant subsections of Chapters 9 and 10 of the ICPD for all countries, and of Regulation 2130/2001 for Asian and Latin American countries?

The answer to the question will take account of the results of the ongoing evaluation on rehabilitation.

Internally displaced persons (IDPS) have not been a problem in Egypt since the displacements associated with the Aswan Dam.

Cairo accommodates a large foreign population consisting mostly of Sudanese, followed by Ethiopians, Eritreans, and refugees from the Great Lakes region. The vast majority of these, although they have left their homes under distressed conditions, do not have legal refugee status as determined by the UN High Commission for Refugees (UNHCR). Thus, whereas estimates of the number of Sudanese in Egypt range from a few hundred thousand to 2-3 million, the total number of legally registered asylum seekers, recognized refugees, and resettled refugees of all nationalities does not exceed 20,000. The EC has not supported significant activities in the area of refugees.

Overall answer to Evaluative Question 4

The EC has not supported projects concerning refugees, IDPs, and distress migration in Egypt. Needs in this area are low.

2.5 Evaluative Question 5

Population composition (incl. age structure, indigenous populations, and people with disabilities) and distribution (incl. internal migration apart from displaced persons, large urban agglomerations, and international migration apart from migration into Member States): To what extent have EC supported actions addressed specific objectives related to the relevant subsections of Chapters 6, 9 and 10 of the ICPD?

The GoE has expressed concern over the over-concentration of population in core areas of the Nile Valley and rapid growth of the Cairo urban agglomeration. It is engaged in two large regional development schemes, one in Upper Egypt (the Toshka project) and one in the Sinai. Each is based on large-scale irrigation and the attempt to attract commercial farmers into the regions. However, GoE intends to pursue broader-based regional development, including putting in place factories for the processing of agricultural products, housing, etc.

This is not a new approach. Egyptian planners have long dreamt of expanding cultivation and settlement beyond the Nile Valley, simultaneously bringing new agricultural land under cultivation, providing employment, and relieving pressure on the major cities of Cairo and Alexandria. De-concentration projects do not, however, have a good track record in Egypt, as despite many years of effort, population and livelihoods continue to be concentrated in traditional areas.

The EC has not been explicitly involved in population re-distribution projects, However, via policy dialogue, the EC has worked to ensure that environmental considerations are integrated into the Sinai development project. The EC does not support the introduction of population on anything approaching the scale envisioned by GoE planners into the affected region of Sinai.

Its reason is that even the existing population is placing a strain upon the resource base. The impact of newcomers on the indigenous Bedouin population also needs to be taken into account. Through the policy dialogue, EC experts are expressing these views. Thus, the EC is attempting to place its imprint on GoE policies corresponding to the following key actions identified in the ICPD: promotion of sustainable development in sending and receiving regions, addressing inequitable access to available land, encouraging the growth of small- and medium-sized urban centers, and seeking to develop rural areas by supporting access to land-ownership and water resources.

Overall assessment of Evaluative Question 5

The Government of Egypt, through regional development projects, is actively seeking to change the spatial distribution of population in Egypt. The role of the EC in this area has been to warn, through policy dialogue, that the environmental impact of the massive population redistribution foreseen will be very serious.

2.6 Evaluative Question 6

To what extent has the design of EC supported actions facilitated (or not) progress towards the achievement of tangible improvements in the lives of target populations? This includes the choice of beneficiaries (including identifying needs for capacity building and gender), the funding instruments, the planning process, …

The UEPP was carefully formulated in order to maximise impacts on target populations. In terms of regional targeting, Upper Egypt is well known to be a demographic "hot spot" characterised by high fertility, low contraceptive prevalence, poor RH, and high prevalence of practices and traditions injurious to women. A community-based needs assessment in 1994 informed the design of project approaches. The foundation for careful monitoring and evaluation was laid in a thorough baseline survey documenting limited autonomy of women in making decisions and substantial unmet need for FP.

Local communities were involved in project evaluation, as evidenced by the *Impact Assessment* document. The success of the IEC component of the project was attributed by senior MoHP advisers as due to involvement of the local population in developing materials.

Community seminars and meetings were an integral part of the UEPP and successes and failures in this regard were analysed in both the *Final Report* and the *Impact Assessment*. All clinic staff interviewed, as well as local MoHP officials, agreed that the main constraints to improved RH and MCH in Qena and Sohag are traditional attitudes, not lack of facilities, human capacity, or drugs and equipment.

It is clear that the UEPP was relevant to target population needs and made a tangible improvement in their lives (this was also a strong conclusion of the mid-term evaluation report prepared in 1999 by EPOS Health Consultants). That the target populations were poor is not in question, mostly because any woman with resources available would go to a private provider, or to a clinic operated by the Egyptian Family Planning Association (EFPA), not to a public clinic. The reasons for this are succinctly given: better surroundings, choice of physician, continuity of care (i.e., seeing the same physician on subsequent visits) and, by far the most important, privacy.

Given choice of project interventions, would women in the target population have chosen an RH/FP project? It is difficult to believe, reading the ethnographic interviews in the *Impact Assessment*, that they would have. But RH/FP and MCH are "merit goods," and both governments and international donors have insisted on concentrating resources on their delivery even in settings where they are not high on beneficiaries' priority list. Part of the reason for this is dynamic: beneficiaries include not only the current generation of women, but the next generation of women (and men) as well, which (i) cannot express its views today and (ii) does not suffer from the sometimes low quality of the services provided. In the ethnographic interviews referred to above, a theme that comes out repeatedly is the hard, short childhoods

experienced by the female respondents, and the lack of education. There is little doubt that they would wish their mothers had had access to a programme like the UEPP.

How could the tangible improvements have been strengthened, and what lessons can be learned for the population components of the HSRP? It is clear from the ethnographic interviews cited above that, for many women, visiting a public RH/FP provider is an unpleasant experience, whether the provider is clinic-based or mobile, whether the physician is male or female, and whether the clinic is EC-supported or not. The women complain of insensitive treatment and a one-size-fits-all approach boiling down to the insertion of IUDs. Clinic doctors, for their part, complained in interviews of the traditional attitudes which lead women to avoid necessary treatment and of the persistence of cultural habits (FGM, home delivery, etc.) damaging their health. This is a classic low-level equilibrium trap – doctors blame women for being backward, women blame doctors for being insensitive—which can only be resolved by sensitising doctors, on the one hand, and accelerating attitudinal change in the target population, on the other.

Moral hazard problems in service delivery are acute and difficult to address effectively. Doctors expressed the view that the only reasons for having a MoHP appointment were (i) to have a steady "basic income," (ii) to qualify for a pension, and (iii) the have the ability to get their private patients into public facilities when a serious procedure was required. During public visiting hours, doctors are fatigued from the hours spent in their private practices (essentially, they are working two jobs) and fully aware of which side the bread is buttered on as regards their income. It is essential that the HSRP break out of vicious circle in which doctors receive little pay for their public-clinic functions and thus provide low-quality service; in which clients pay low fees but receive concomitantly poor service in return.

There is no question that secondary beneficiaries, such as doctors, nurses, and staff, all benefited from working with the UEPP. There has been substantial training and capacity building. A MoHP official expressed his view that training in management information systems, accountancy, and the like has been especially useful and that the benefits will persist long after the project has ended.

The evaluation team has no reason to believe that the HSRP, while by necessity more macro- in conception, has been less sensitive to beneficiaries' needs than the UEPP. The BBP has been designed by a group of consultants in conformity with international protocols and RH/FP concerns are addressed. The MoHP has a strong track record in IEC, outreach, and awareness training, and this will be evident in all HSRP activities.

What will be critical as the HSRP moves forward will be ensuring that clinic staff is sensitive to quality in RH/FP. Incentive payments from the Family Health Fund (FHF) financed by the EC can serve a major role in guaranteeing the responsiveness of staff and ensuring quality more generally (cleanliness, short waiting time, etc.). However, it should not be taken for granted that all clinic staff is sympathetic to ICPD concerns or the GoE's interpretation of them.

Overall answer to Evaluative Question 6

Target populations for EC interventions related to Cairo have been identified carefully and projects have resulted in tangible benefits to target groups. These benefits would have been strengthened, however, if the quality of RH/FP services provided had been higher. The new health sector reform project must ensure that incentives are in place for clinic staff to be sensitive to client needs.

2.7 Evaluative Question 7

To what extent have implementation set-ups (i.e. suitable structures for planning, implementation, monitoring and evaluation), management mechanisms/tools and processes facilitated (or not) the achievement of expected impacts?

All persons interviewed have expressed the view that, while co-ordination is well established at the policy level (mostly through the Health and Population Sub-Committee of the Donors' Assistance Group), co-ordination at the implementation level is poor. One example gives an idea of the situation. In the UEPP, an innovative component carried out women's income generation and literacy activities in the MoHP RH/FP facilities funded by the project. District MoHP officials, including a clinic supervisor, were not aware of these activities. Why? Because they had been implemented by UNICEF, not MoHP. In Qena and Sohag, the team learned, UEPP and a large USAID funded Systems Development Project operated side by side with no attempt at co-ordination. The result seems to have been not so much duplication as the failure to explore possibilities for cooperation and the likely failure to realize synergies. The establishment of the Administration for Technical Support and Projects within the MoHP is an important step in the right direction to address this problem.

The team did not encounter systematic evidence of problems in equipment procurement, drug supply, maintenance, etc. in EC-supported facilities. One doctor dismissed, as follows, a question about procurement: "This is equipment a doctor would dream of working with. So what if it is a few months late?"

Incorporating beneficiary views into project implementation and changing strategies on the basis of that input, was a significant feature of the UEPP. While on first reading it might appear to be a "classic" vertical family planning project, the UEPP was in fact notable for its attempt to incorporate FP into a broader RH and MCH context. The fact that both the UEPP and HSRP have been implemented by the MoHP is a plus factor for sustainability. While some problems were noted in getting technical assistance for the UEPP off the ground (essentially, difficulty in getting appropriate international staff in place), these were fairly quickly resolved. The EC chief technical adviser for the HSRP was aware of RH/FP issues and keenly interested in ensuring that these are taken into account in the HSRP.

Monitoring of both the UEPP and HSRP has been very effective. EPOS Health Consultants GmbH were responsible for monitoring the UEPP and AEDES has been awarded the monitoring contract for the HSRP. Nine UEPP progress reports were filed, in addition to a thorough mid-term review (end-1999). The main

recommendation of the latter, to extend the project in view of its ambitious goals, was implemented. MoHP officials affiliated with the HSRP praised the quality of monitoring missions and expressed their view that the regular meetings with Delegation staff regarding implementation issues were highly effective.

Both the UEPP and the HSRP have been implemented on the basis of annual work plans, with disbursement of next year's allocation dependent on review of progress in the current year. While highly labour intensive, because it involves the Delegation in tracking all expenditures, this approach appears to be best suited for present circumstances. In only one component – the Family Health Fund (FHF) – is the HSRP being implemented on the less hands-on "sector support" basis. Delegation staff report that there are issues to be resolved regarding the use of funds that have been allocated to the FHF. The same staff were of the opinion that the sector support approach, and much less the broad budget support approach (in which funds are disbursed not to MoHP but the Ministry Of Finance) would not work at present in Egypt because accounting systems are still insufficiently developed to be able to adequately track expenditures.

Overall answer to Evaluative Question 7

Co-ordination at the policy level, i.e. consultations between donors, is excellent, but co-ordination at the project implementation level is poor. A new unit at MoH is designed to improve this situation, but the incentives for project staff to concentrate on their own work plan, their own deliverables, etc., are very strong. Project implementation has been smooth, and monitoring and evaluation have been effective. However, it is questionable whether a sector support approach is yet viable in Egypt.

2.8 Evaluative Question 8

How far has necessary capacity (planning, integrating population into development policy and planning, implementation, monitoring, evaluation, etc.) been created (country level, EC delegations; EC headquarter) to support and facilitate preparation and implementation of population and development strategies and action?

At the level of the GoE, capacity-creation needs are limited by the fact that there are few countries in the world, which can match Egypt for the depth and quality of capacity already in place in the area of population and development. This ranges from the statistical agency CAPMAS, which is responsible for the Census, through the National Population Council (research wing of MoHP), through the Cairo Demographic Center (research wing of CAPMAS), through the Institute of National Planning (research wing of the Ministry of Planning), through the National Council on Population and Development (NCPD) supported by USAID and UNFPA. Policy makers are abundantly supplied with timely, high quality demographic analysis and statistics. Egypt is a world leader in the integration of population concerns into development planning.

In the MoHP, the presence of a Technical Assistant for health care reform financed by the EU is increasing capacity.

The range of ICPD concerns is covered through various units in the MoHP, which are represented at the Undersecretary level and staffed with a high level of expertise: there is a family planning unit, an MCH unit, a primary health care unit, etc. Less visible is an HIV/AIDS unit. In the past, the vertical nature of MoHP has been a problem – for example, the MCH unit not communicating with the FP unit and vice versa. This led, inter alia, to considerable waste and duplication at lower levels. Clinic staff would find themselves engaged in multiple reporting systems, staff were pulled out too often for narrow sector-specific training, etc. One of the contributions of the UEPP – which affected only two governates – was to demonstrate that FP could be integrated with RH and MCH concerns, and one of the goals of the HSRP is to integrate the various units through their contribution to the BBP. Thus, reporting will be based on provision of the BBP, training will take the BCB as its unifying theme, etc. If successful, this will be a major step forward.

In general, drugs and commodities appear to be in adequate supply in EC-funded health facilities. This is in contrast to MoHP facilities not receiving support. For example, the team visited a MoHP family planning facility in Aswan that was essentially devoid of supplies.

The availability of health facilities in Egypt is relatively good. In the governates covered by the HSRP, the entire population is within roughly an hour of a district-level health facility, and RHUs are closer still. A key issue now being debated is how rapidly the HSRP will be expanded. Two governates are being added to the original three, but this still leaves a large part of the population outside the umbrella.

Similarly, due to effective outreach and IEC, the general level of awareness of the Egyptian population regarding RH/FP and MCH is good. However, if quality of service in much of the country remains low (as, for example, in the one MoHP clinic visited by the team which received no international support and was, as a result, suffering severe shortages of equipment and supplies), this awareness will not translate into practice or better health outcomes.

At the level of the Delegation, this mission did not perhaps occur at the best time to judge capacity. The health and population sector expert left several weeks before the team arrived and the dossier is being temporarily looked after by a regional development expert (who is responsible for policy dialogue with the GoE regarding the two large regional development projects in Sinai and Toshak). The evaluation team was assured that this "caretaker" situation – which is not sustainable in view of the large size of the EC commitment to HSRP – will not persist, however, concerns were expressed that the putting-in-post of a new expert might take time.

Overall answer to Evaluative Question 8

Egypt already has excellent capacity in place for the incorporation of population concerns into development planning and policy making, so the need for technical assistance in this area is (and has long been) small. Availability of health care facilities and trained personnel is satisfactory in Egypt, however, health facilities not receiving international support are sometimes poorly equipped and undersupplied with drugs. One of the priorities of the health sector reform project, through its introduction of the Basic Benefit Package (which includes RH/FP), is to use existing physical and human capacity more effectively and equitably. The EC Delegation has a health expert post; this post was empty at the time of the mission but is expected to be filled soon. The presence of a Technical Assistant for health care reform in the MoHP is contributing to capacity building in that institution.

2.9 Evaluative Question 9

To what extent have cross cutting themes (gender, environment, population and poverty, human rights, etc.) been taken into account during the implementation process and whether synergies between the different pillars of population and development have been sufficiently exploited?

Gender issues have been a major component of EC-supported activities in the area of population and development. As seen above, the UEPP contained a significant component related to women's empowerment through literacy and income generation. Its outreach and awareness-creation seminars were carried out through Women's Clubs, Men's Clubs, and mass meetings open to both women and men. Increasing the availability of female physicians was a central goal of the project. Also important is that the project led to substantial efforts to collect data on women's well being and health, and on the attitudes of both men and women.

The GoE has taken a strong, although not yet very effective, stand against FGM, and the UEPP included efforts to discourage the practice. However, the self-assessment in the *Final Report*, supported by attitudinal surveys carried out among project beneficiaries, was that these efforts had borne only limited fruit. Researchers in Cairo interviewed by the evaluation team believe they have uncovered evidence of considerable, though still latent, attitudinal change regarding FGM. This suggests an opportunity for the HSRP to make considerable progress in this difficult area.

The team did not notice any striking gender imbalance in staff met, whether at the highest level in the MoHP in Cairo or at the level of clinics.

Regarding the integration of various pillars of population and development in development planning, the situation in Egypt is very good. Employment and labour market analyses are based on high-quality demographic data and analyses. The GoE and experts interviewed are keenly aware of the linkages between education of girls and future fertility; experts interviewed (admittedly none of them GoE officials) are willing to entertain the idea that investing in girls' education may, in the long run prove more effective in reducing fertility than investing directly in the provision of family planning. This indicates that international best-practice understanding of the dynamics of fertility decline has been taken on board. The team did not see any hard evidence that population trends had been taken into account in poverty-reduction strategies, however, this is implicitly the case because the core of the GoE approach to reducing poverty is addressing the long-run issue of jobs creation and the explicit goal of population policy in Egypt is to reduce pressure on the labour market by slowing population growth.

Both at the level of the GoE and, as described above in discussing EC-supported environmental components of the Sinai regional development project, at the level of the Delegation, there is awareness of the relationship between population and the natural resource base. GoE and EC expert views do not necessarily coincide, however.

Overall answer to Evaluative Question 9

The gender theme has been carefully taken into account in EC-supported activities. However, progress on one key gender concern, female genital mutilation (FGM) has not been encouraging despite the strong stand of Government. Population is effectively taken into account as a theme cutting across the entire range of development concerns, including the labour market and livelihoods, education, environment, etc.

2.10 Evaluative Question 10

How sustainable are the effects and impacts of EC-supported policies and programmes in the field of population and development, both at the level of individuals and at institutional and policy level in the partner countries?

Egypt at the moment presents an excellent opportunity to consider this question. As concerns the ability of the GoE to pursue population policy objectives, it is clear from the discussion above that the evaluation team is optimistic.

As concerns the Delegation, it is urgent that a full-time staff member dedicated to health and population issues be put in post. If not, given long lead times in country programming, continued EC support to the HSRP (which has a 15-20 year time horizon) may be compromised. Recall that the current support framework expires in 2005.

As concerns projects and beneficiaries, the picture is mixed. The UEPP, by almost all measures a success, has just ended. The HSRP, which will ensure RH/FP and MCH needs for all Egyptians in the future, is underway in 3 governorates (just raised to 5).

Not surprisingly, UEPP staff in clinics visited expressed concern at the withdrawal of international support. However, the evaluation team took these complaints with a grain of salt. Two aspects were brought out repeatedly. One was that referrals from RHUs to District Family Planning Referral Centers had slowed dramatically because RHU staff is no longer being paid a modest "bounty" for each patient referred. Yet this system is so replete with moral hazard that a significant proportion of the referrals previously made must have been on fairly flimsy grounds. The odds that women with a health-threatening condition will not be referred because there is no longer a financial incentive to do so strikes the team as low. On the other hand, it must be admitted that RHU staff may be no longer bothering to refer women whose health is not endangered, but who have special needs. This again falls under the general issue of quality.

The second theme raised by clinic staff was that, after international support ceased, it was no longer possible to obtain state-of-the-art cytological examination of pap smears. However, in a burdens-of-disease sense, cervical cancer is not a serious problem in Upper Egypt (this reflects not just the evaluation team's speculation but responses of physicians interviewed). In other words, money spent on detecting cervical cancer through the pap smear programme would have saved more lives and avoided more sickness had it been spent on other areas of RH/FP. In one District Referral Center, not a single case had been detected in the entire life of the UEPP. Moreover, as the evaluation team discovered after it had expressed concerns, many similar concerns about the pap smear programme – its relevance, cost-effectiveness, and sustainability --were raised by the EPOS evaluation team in 1999.

The situation with respect to drugs appears to be mixed. All clinic staff (with the exception of the health care worker at the Aswan clinic mentioned above) agree that the basic RH/FP drugs are available through the MoHP. With regard to higher-end

drugs, there was disagreement – in one clinic, the doctor said that drug availability was a problem; in another, the physician said that it was not.

The phase-out of international support for the UEPP has been orderly and carefully planned, and sustainability issues have been taken into account. These were considered carefully in the 1999 mid-term evaluation and receive lengthy treatment in the project *Final Report*. However, the Governorate-level MoHP official interviewed by the team seemed to have a rather confused vision of how sustainability concerns were being met.

A system of co-payments has just been approved for the HSRP and, as usual, views are mixed. Some experts interviewed felt that this would be distributionally vicious and discourage poor people from seeking care, others stressed that without a significant degree of cost-recovery, it would be impossible to achieve sustainability. The team would point out only that the very significant expenditures made by women, including poor ones, in private RH/FP clinics demonstrate that there is substantial willingness to pay. The challenge for public facilities is to raise quality and improve their reputation so that they can compete effectively for the Egyptian health pound.

The key question at present for sustainability is how gains made by the UEPP will be kept alive as RH/FP supply shifts into the HSRP via the BBP. Here the team wishes to express concern. Doctors in Qena and Sohag outside the one HSRP clinic visited were not informed of the HSRP and how it would affect their work. There is urgent need for an information campaign aimed at medical personnel and officials in districts not presently covered by the HSRP. The team's second concern, which was first raised by Delegation staff, has to do with the striking fact that not a single district included in the UEPP was chosen (so far) to be covered by the HSRP. Potential synergies may have been unexploited. More importantly, the opportunity for experimenting with integration of UEPP activities into HSRP clinics while the UEPP was still operational has been missed. In the *Final Report* of the UEPP, it was reported that the possibility was being explored (in fact, it was strongly implied that the matter had been settled) of using a budget line from the HSRP to continue some support to the UEPP. This might provide an avenue for integrating UEPP activities into the HSRP framework with a minimum loss of project accomplishments.

Overall answer to Evaluative Question 10.

EC support to the Upper Egypt Population Programme (UEPP) has been phased out and RH/FP concerns are being "taken over" by the health sector reform project. In general, the gains made by the UEPP appear to be sustainable, although project staff voiced a number of concerns about drugs, the financing of tests, etc. However, there appears to have been no effort made to ensure that gains made and lessons learned in the UEPP are taken over into the health sector reform project. At the policy level, the commitment of Government to ICPD that incorporation of population into development planning is not dependent on international donor support. At the facility level, however, facilities visited that received international support were clearly superior to those dependent on MoH resources.

3. OVERALL ASSESSMENT

3.1 Relevance

Relevance would demand that EC- supported activities in the population sector in Egypt be relevant to the needs of the target population and to GoE development goals as a whole. As demonstrated by clear need for RH/FP interventions identified during the UEPP project-preparation phase and the inclusion of RH/FP in the Basic Benefit Package of the HSRP, EC activities have clearly been relevant to needs. RH/FP is a sector in which poor women have particularly strong needs, as well as a sector with strong potential for the empowerment of disadvantaged groups. The choice of Upper Egypt as the region for the UEPP represented a good example of going where the need was greatest. The HSRP has been less narrowly targeted, either geographically or in terms of addressing the needs of poor women, however, it is intended to serve as a template for the country and the population as a whole.

Both programmes have been relevant to, and consistent with, the development objectives of the GoE as well as consistent with the overall development policies of the EC. This relevance applies not only to the narrow goal of increasing contraceptive prevalence but to the overall policy goal of reducing the rate of population growth and thereby pressure on the labour market. Partly because of the long history of GoE in integrating population into development planning, cross-cutting themes, including gender and the environment, have been taken into account in the EC country programme. A broad and heuristic approach to population is in evidence.

By broadening the context in which FP services are delivered to encompass RH (in the case of the UEPP) and primary health care (in the case of the BPP of the HSRP), EC support has enhanced the relevance of population sector support. Both programmes represent an attempt to move beyond the "classical" vertical design of population projects.

Global assessment of relevance

EC support to ICPD goals in Egypt has been highly relevant to target population needs and has been consistent with Government development goals.

3.2 Effectiveness

Interventions are effective when they achieve expected goals. The objective of the UEPP was to increase contraceptive prevalence in Egypt by supplying RH/FP in a particular region, that of the HSRP is to put in place universal coverage of the population, by an affordable, efficient, sustainable, and satisfactory health system. To judge by the data presented in Table 2 at the end of this Report, the UEPP was effective in increasing contraceptive prevalence in Upper Egypt; however, it is difficult to reach a judgment about its impacts on the country as a whole. It was certainly effective in its subsidiary purpose of achieving better availability and utilisation of RH/FP services in Qena and Sohag, an area of acute need. Final project results indicate that there were notable successes in broader goals such as female literacy, income generation, IEC, awareness creation, and empowerment more generally. The one exception appears to be FGM, where there is little evidence that the programme made an effective contribution to either reducing the prevalence of or changing the attitude towards this practice.

Since the HSRP is still in its relatively early phases, it is too early to judge effectiveness. However, the population component of this programme, namely the inclusion of RH/FP in the Basic Benefit Package, is absolutely necessary to achieving the programme goal of putting in place a satisfactory health service.

One requirement for effectiveness is that the RH/FP services provided be of high quality and that services respond to client needs. There is still an unmet need for quality of service, as characterized by such factors as privacy, continuity of service, wide range of choice, sensitive attitude on the part of providers, etc. Both the UEPP and the HSRP programmes take on board the rhetoric of quality, however, the UEPP does not appear to have fully met goals in this area and the HSRP still must prove itself.

Implementation setups have generally worked well. The exception is the lack of inter-agency coordination at the implementation level, which means that potential complementarities and synergies have not been exploited.

The team has found that policy co-ordination – the exchange of views among donor agencies and GoE related to policy goals and general programme orientations – has been effective while co-ordination at the implementation level has been lacking. This implies that, whatever successes have been attained, effectiveness could have been enhanced had project staff had a better idea of the whole picture.

It also remains to be seen whether EC involvement in regional development projects will be effective in incorporating population concerns into the sustainability debate surrounding these projects.

Has EC support to the population sector effectively contributed to the overall EC co-operation goals of support to economic transition and socio-economic balancing? Contribution to the first, which involves mainly privatization, encouragement of free trade, and modernization of institutions and structures, must be admitted to be tangential. However, population sector support has clearly contributed to the second goal, which is occasioned by the observation that economic reform in Egypt has far

outstripped the evolution of the social sector. That having been said, it must also be pointed out that the social sector in Egypt is already evolving dynamically – rapid fertility decline, rapid increase in age at marriage, etc. all attest to this. A considerable degree of social sector progress, including progress in the population sector narrowly defined, would have occurred in the absence of EC support, simply from the combination of rapid attitudinal change, effective GoE policies and programmes, and economic forces. However, It must be recalled that EC population support focused on Upper Egypt, the lagging region of the country.

Global assessment of effectiveness

EC-supported ICPD projects have achieved their main goals; however, effectiveness would have been enhanced by better co-ordination at the implementation level and by increased attention to the quality of services provided.

3.3 Efficiency

It has been argued in the Final Report of the Preparation Phase that, as the international community has moved towards a human-rights based approach to population issues, the efficiency criterion has become less relevant. We have touched on this issue above in identifying RH/FP (and empowerment of women more generally) as a merit good; one whose supply donors may feel free to support regardless of government and, indeed, target populations' priorities. It would serve little purpose to examine the question of whether overall development goals in Egypt could not have been more efficiently pursued by allocating resources to a sector other than population (indeed, this very question is the subject of a recent major review, not cited here because it is still under academic review). It is likely that other areas of the EC's support to Egypt, in the areas of rationalizing economic structures, supporting free trade, and the like, will be at least as efficient in supporting overall development goals as population, or indeed overall social sector support. However, experiences elsewhere, notably in Southeast Asia, suggest that accelerating the demographic transition is an effective complementary strategy in the pursuit of development.

As support to the social sector moves forward, policy makers and international partners may wish to debate the relative advantages to empowerment of the women, especially poor women, through education sector support as opposed to traditional women's health sector support. As to whether population sector support was efficiently allocated within the sector – i.e., as between training of providers and provision of equipment – the evaluation team has no strong opinion. A more medically oriented team might have more to say. The team did have concern, however, that the great emphasis placed on the pap smear component of the UEPP,

and the ensuing energy expended in dealing with associated problems, was not particularly efficient in a burdens-of-disease sense (i.e., cervical cancer is not one of the most important threats to women's heath in Upper Egypt). Significant sums were expended in an area with relatively low payoff given the health profile of the target population. Similar concerns, as the team learned later, had already been expressed by an earlier monitoring team.

Overall assessment of efficiency

The efficiency criterion is of limited relevance when access to RH/FP has been framed, as in the Cairo Programme of Action, as a human rights issue. However, international evidence indicates that provision of RH/FP is a cost-effective development intervention, as well as one benefiting a traditionally deprived group, namely poor women.

3.4 Sustainability

The mission produced mixed feelings on sustainability. If the goal is increasing contraceptive prevalence and reaching GoE targets for fertility decline (for the research literature indicates clearly that rising contraceptive prevalence is the driving variable in fertility decline), then the focus of donor support will need to move to quality of service. The high rate of contraceptive method abandonment indicates that choice of method is still restricted and the clients' perception of service quality is still low. On the other hand, rapid attitudinal change (even, perhaps, regarding FGM if recent research results are correct) suggests that the potential for continued rapid demographic transition is present.

A number of specific questions regarded to the sustainability of UEPP gains in view of the end of the project have been raised above: for example, too much concern over financing pap smears and referrals; not enough attention to informing project staff about the new HSRP. The evaluation team would suggest that, as a matter of urgency, the question of how UEPP project results will be taken over into the HSRP be discussed by GoE and the EC Delegation. The window of opportunity is open for the moment, but it will not stay open long.

The bright spot in the sustainability landscape is the enormous capacity in place for, and long-term GoE commitment to, incorporation of population into development policy and planning. Offsetting this, however, there are structural problems in the Egyptian health sector, starting with the incentive structure facing individual health care providers. One of the crucial goals of the HSRP, explicitly incorporated into the Family Health Fund (FHF) quality incentive payments system, is to reduce the quality gap between public and private medical services. This is an ambitious goal,

but it must be achieved if quality constraints on improving the health of poor women are to be addressed.

The existence of this quality gap, taken as a natural experiment, has however demonstrated that there is considerable willingness to pay, even among poor women, for high quality health care. This suggests that co-payment and other cost-recovery schemes can be a significant part of future RH/FP schemes so long as the needs of those women who are without resources are met. Moves in this direction will be controversial, however, and it seems to the team, based on the generally scant attention paid to the private sector in either the UEPP or HSRP project documentation, that considerable discussion, perhaps backed up by new research, will be necessary.

Global assessment of sustainability

The high level of commitment of Government to ICPD bodes well for sustainability. However, there has been insufficient attention paid to how gains made by the UEPP will be taken over into the HSRP. Quality concerns need to be met and the role of the private sector has received insufficient attention.

3.5 Impact

The impact of the UEPP has been thoroughly and expertly analysed in the *Final Report* and *Impact Assessment* cited above. These generally favourable conclusions will not be repeated here, however, it is clear that family planning increased and reproductive health improved in the area benefiting from the project. Through the UEPP, and now through the HSRP, the EC has had a positive impact on the achievement of GoE goals in the area of population and, more generally, GoE and EC development goals. These impacts have been achieved in a relatively effective manner.

EC actions have facilitated progress towards tangible improvements in target populations' well being. Quality of service provided would appear to be the main weakness, and this is more related to structural problems within the Egyptian health system itself than to project design flaws. The HSRP is attempting to address this problem through the EC-financed FHF. Especially given diminishing marginal returns in the effort to raise contraceptive prevalence and the increasing importance of quality, it is important, in order to guarantee sustainability of gains, that quality be explicitly targeted in future RH/FP activities and that special aspects of quality in this area – especially privacy – be taken into account.

EC assistance has increased technical capacity at the MoHP and utilization of health facilities and staff is improving as a result of changes being implemented under the HSRP.

Global assessment of impact

EC activities have had a measurable impact on target populations, as judged by statistics such as prevalence of family planning, mother and child health, etc. Capacity in the MoHP and in MoHP facilities has improved.

3.6 Internal / external coherence

The EC programme has been coherent with EC development policy as set forth in relevant regulations and with the ICPD Programme of Action as a whole.

The EC supported a broad (nearly comprehensive) range of ICPD activities related to RH/FP and MCH; it has done little however, related to HIV/AIDS or specifically targeted at adolescents. Both of the latter are emerging areas of concern. Egypt may be a genuinely low-prevalence country with respect to HIV/AIDS; however, due to rising age at marriage and rapid attitudinal change, the needs of adolescents, more attention to this target group would improve coherence with ICPD.

EC support to the population sector has been coherent with GoE population policy goals, which have, in turn, been formulated in a broad development perspective. The CSP does a good job of placing population in the broader context of GoE development goals, especially as these relate to the problem of rapid labour force growth. This is important because it prevents population from becoming a sector unto itself; links with the economic sector are brought out explicitly.

In conclusion, the EC Egypt country programme reflects a population and development sectoral approach that is consistent with the policy orientations of GoE and global EC development policies and the ICPD Programme of Action.

Overall assessment with respect to internal / external coherence

EC assistance has been fully coherent with EC policy and GoE policy regarding population. Links with broader development priorities are well established in setting country.

4. RECOMMENDATIONS

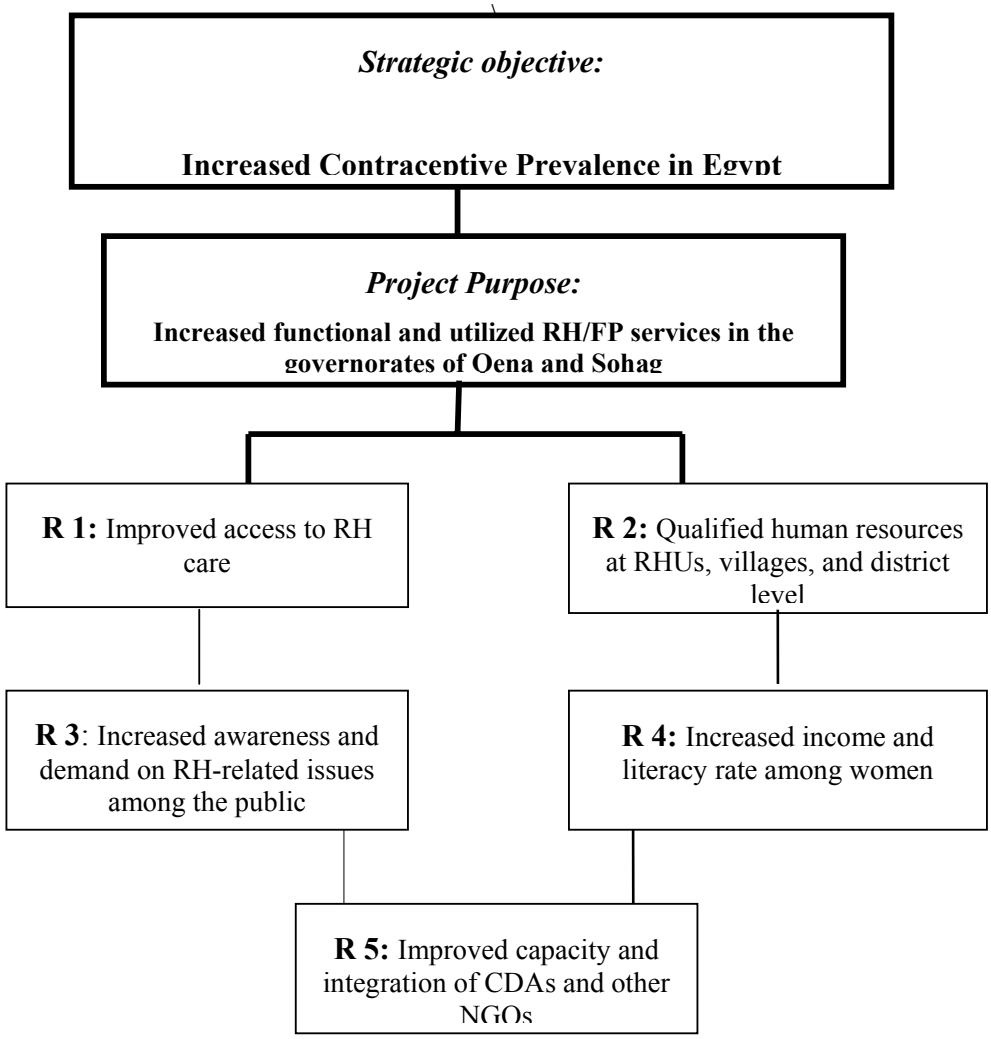
We have given a fundamentally upbeat assessment of EC support for ICPD-related activities in Egypt. At the general level, the EC should concentrate its attention on the role of sexual and reproductive health and family planning within the health sector reform programme, especially the question of how quality of service concerns will be addressed. A number of more concrete suggestions – for example, to examine how the UEPP project achievements will be taken over into health sector reform and ensure adequate technical capacity at the EC Delegation in Cairo – have been given in the body of the text. However, the overall assessment above also leads to a few more specific recommendations for concrete actions:

The Delegation should increase the frequency of contacts with US AID, UNFPA, and other partners to raise the visibility of EC involvement and improve coordination in implementation.

In view of limited progress in the area, and some evidence of incipient demand, the EC should consider increasing attention given to FGM. The needs of adolescents also need to be taken account in view of the rapid attitudinal changes taking place, rising age of marriage, etc.

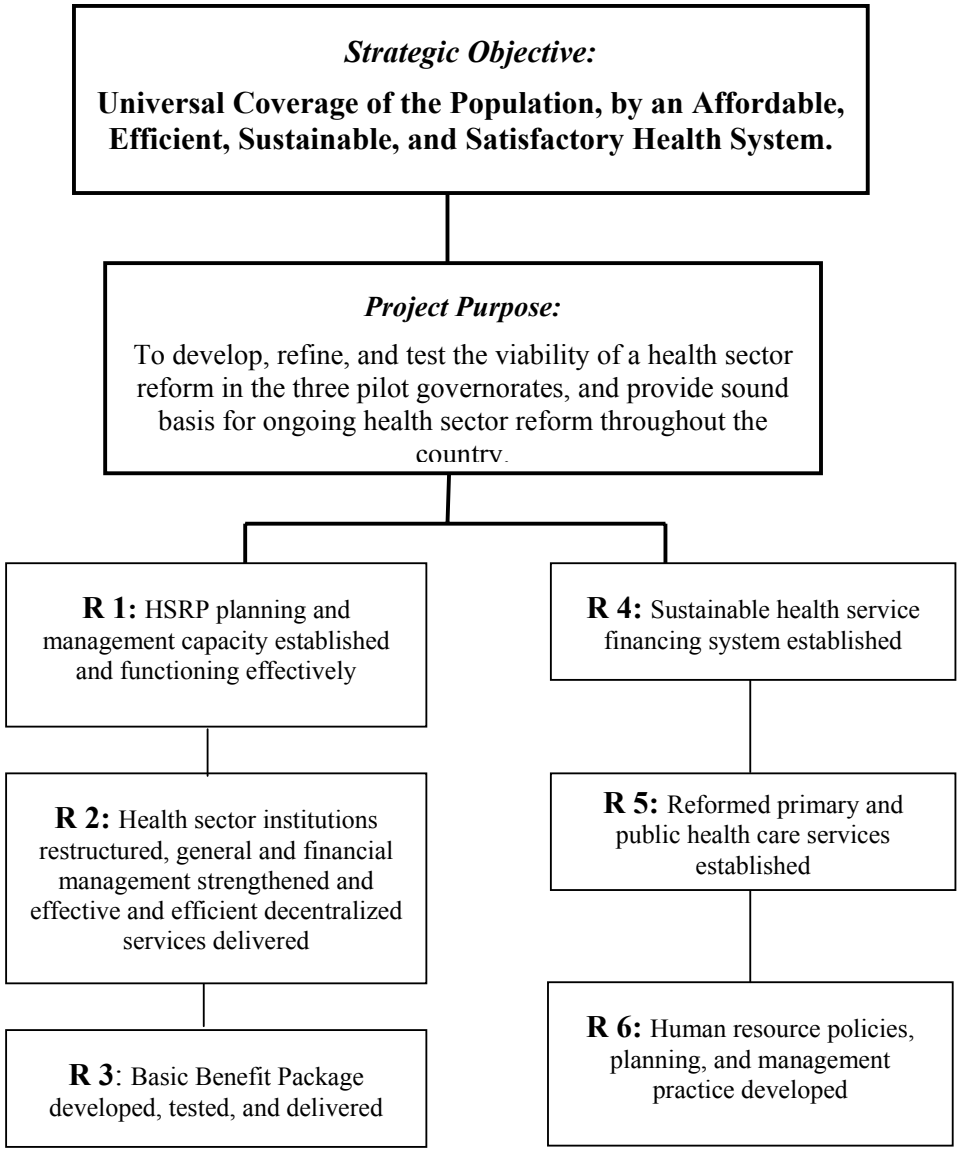
Given the excellent capacity in place, at the Cairo Demographic Center and elsewhere, Egypt could serve as a resource for ICPD-related training and technical assistance activities. In view of the Barcelona Declaration's strong vision of a development path shared by Europe and the MEDA region, a natural focus for such work might be international migration. Alternatively, Egypt's experience in incorporating reproductive health and family planning into national policy making may be of interest to Arab countries which have not yet experienced demographic transition.

Figure (1): Result Framework for the UEPP



Source: UEPP Final Report

Figure (2): Result Framework for the HSRP



Source: HSRP log frame

Table (1): Demographic Indicators *
Egypt 1988-2000

Indicator	1988	1992	1995	2000
Crude Birth Rate	36.6	26.2	27.0 *(1994)*	27.5 *(1998)*
Crude Death Rate	8.1	6.6	6.4 *(1994)*	6.5 *(1998)*
Total Fertility Rate (TFR)	4.4	3.9	3.6	3.5
Contraceptive Prevalence Rate (CPR):				
Any Method	37.8	47.1	47.9	56.1
Any Modern Method	35.4	44.8	45.5	53.9
Infant Mortality Rate ($_1q_0$) "	74.2	NA	66.1	43.5
Under-five Mortality ($_5q_0$) "	102.5	NA	84.2	54.3
ANC	NA	NA	39.1	52.9
RANC	NA	NA	28.3	36.7
Tetanus Toxoid Vaccination	11.4	57.8	69.5	72.4
Medically Assisted Deliveries	34.6	40.7	46.3	60.9
Maternal Mortality Rate ** *(per 100,000 live births)*		174 *(1992/93)*		84

" : *0-4 years preceding the survey*

Sources:

* : Egypt Demographic and Health Surveys: 1988, 1992, 1995, and 2000

** : National Maternal Mortality Surveys, 1992/93, and 2000

Table (2) : Comparative Indicators of the Baseline and End-line Surveys, Upper Egypt Population Programme

Indicator	*Sohag*		*Qena*	
	*1997 **	*2002 ***	*1997 **	*2002 ***
TFR:				
Original Districts	**5.25**	**4.10**	**5.11**	**4.25**
New Districts	**4.33** *(1999/2000)****	**4.11**	**4.50** *(1999/2000)*	**3.91**
% of FP Users Receiving Their Methods from Public Facilities:				
Original Districts	**18.00**	**39.80**	**28.20**	**51.40**
New Districts	**35.33** *(1999/2000)*	**42.33**	**59.70** *(1999/2000)*	**38.65**
% of FP Users Receiving Their Methods from Private Facilities:				
Original Districts	**78.50**	**59.15**	**65..00**	**48.35**
New Districts	**64.66** *(1999/2000)*	**57.43**	**63.45** *(1999/2000)*	**58.23**
CPR	**20.08**	**28.72**	**29.28**	**34.90**
Ante-natal Care *(1-4 visits)*	**31.16**	**60.32**	**21.92**	**70.25**
Regular Ante-natal Care *(4+)*	**16.84**	**27.06**	**14.63**	**38.42**
% ANC Received in Public Facility	**3.92**	**29.98**	**7.08**	**43.50**
% ANC Received in Private Facility	**28.08**	**38.94**	**15.37**	**39.77**
% of Live Births Delivered in a Public Health Facility	**9.38**	**12.78**	**9.68**	**16.13**
% of Live Births Delivered in a Private Health Facility	**9.50**	**21.66**	**7.07**	**18.02**
% of Live Births Delivered at Home	**80.86**	**65.54**	**83.28**	**65.85**

***Source**: Averaged using data of the "Final Report" of the EC Support to Population Programme in Upper Egypt, March 1998 - March 2003, MOHP and European Commission.*

* : Baseline Survey, 1997

** : End-Line Survey, 2002

*** : Quick Count Surveys, 1999/2000

ANNEX 1: CHRONOLOGY AND LIST OF PERSONS INTERVIEWED

The consultants began their round of interviews on 25.06.03 and concentrated during the first few days on obtaining information in the capital. On 27.07 the team travelled to Aswan, where it spent the day meeting representatives of Community Development Associations (CDAs) active in pursuing ICPD goals. In the evening, the team travelled to Luxor, its base for the next three days. It spent 28.07.03 in and around Qena visiting clinics, which had participated in the Upper Egypt Population Programme (UEPP). On 29.07, the team travelled by train to Sohag, where it visited a clinic recently re-organised under the Health Sector Reform Programme (HSRP) as well as clinics that had benefited from the UEPP. 30.07 was spent in document review and return travel to Cairo. The remainder of the mission was spent interviewing Ministry staff, NGO representatives, researchers and other experts, and EC Delegation staff in Cairo, as well as report preparation. A de-briefing was held at the Delegation on 06.07 and the international consultant departed on the morning of 07.07.

Date and approximate time	Persons interviewed
Wednesday, 25.06 (Cairo)	
09:30-12:30	• Dr. Mona Khalifa Assistant UNFPA Representative in Egypt
12:00-13:00	• Mr. Pascal Odul Regional Development Expert EC Delegation, Cairo
14:00-15:00	• Dr. Yahia El-Hadidi Undersecretary of Family Planning and Population Sector, Ministry of Health and Population • Dr. Morsey Mansour Upper Egypt Population Project, Ministry of Health and Population
16:00-17:00	• Professor Hesham Makhlouf Director Cairo Demographic Centre
Thursday, 26.06	
10:00-12:00	• Dr. Hanem Abdel-Azeem Zaher Director Central Department for Technical Support and Projects

	Ministry of Health and Population • Dr. Moshira El-Shafey Senior Health Adviser Ministry of Health and Population • Dr. Rafeek Hosny Senior Health Policy Adviser EC Technical Assistance Team Health Sector Reform Programme, MoHP
Friday, 27.06 (Aswan)	
10:00-15:00	Meeting with 20 members of the Aswan NGOs Federation
Saturday, 28.06 (Qena)	
09:00-10:00	• Dr. Abbas Moustafa Mahmoud Director of Family Planning, Qena Governate Ministry of Health and Population • Dr. Abdel- Rahim Mohammed Clinic Supervisor Family Planning department Ministry of Health and Population, Qena
11:00-12:00 13:00-14:00 16:00-18:00	• Dr. Salah Director FP District Referral Centre Abu Tesht, Qena • Dr Violette Bibawi Abdel-Maseeh Physician responsible for FP Gezirat Al-Dom Rural Health Unit, Qena • Dr. Esmat Donkol Undersecretary of State for Health, Ministry of Health and Population Qena

Sunday, 29.06 (Sohag)	
12:00-16:00	• Dr. Samy Kamel Abdel-Malek Family Planning Clinic Supervisor District Central Hospital Sohag • Dr. Nazik Family Planning Physician • Dr. Abdel- Basset Director of Family Planning Sohag District • Dr. Karam Morgan Director Family Planning District Referral Centre District Central Hospital El Minshah, Sohag • Dr. Abdul-Moaty Head, Rural Health Unit, Awlad El-Sheikh, Sohag
Monday, 30.06	Document review, travel
Tuesday, 01.07 (Cairo)	
10:00-12:00	• Dr. Barbara Ibrahim Regional Director for West Asia and North Africa Population Council • Dr. Abdel-Ghaffar Ahmed Director, MEAwards Population Council • Ms. Rania Roshdy Economist Population Council

15:00-16:00	• Dr. Atef Mohammed El-Shaitany Executive Director Egypt Population Project (World Bank) Ministry of Health and Population • Mr. Fouad Abdel-Hadi MIS Expert EPP Project
16:30-17:30	• Dr Esmat Mansour Undersecretary Primary Health Care Ministry of Health and Population • Dr. Imam Mousa Deputy Chief Central Department for Technical Support and Projects
Wednesday, 02.07	
11:00-12:00	• Dr. Mahmoud Sweed Executive Director Egyptian Family Planning Association • Dr. Ahmed Ahmed Amr Chief, Medical Department Egyptian Family Planning Association
13:00-14:00	• Professor Sayed Abdel-Maksoud Institute of National Planning • Dr. Hegazy El-Gazar Expert of Economics Institute of National Planning
Thursday, 03.07	
10:00-11:00	• Mr. Pascal Odul Expert EC Delegation
14:00-15:00	• Dr. Nasser El-Sayed

	Director, AIDS Programme Ministry of Health and Population
19:00-21:00	• Mr. Ayman G. Zohry, Expert Migration Studies Center American University in Cairo
Friday, 04.07	Report preparation
Saturday, 05.07	Report preparation
Sunday, 06.07	
10:00	• TBI • Ms. Shadia Saad Attia, Program Managemenr Specialist, USAID, Cairo
14:00	• De-briefing, EC Delegation

ANNEX 2: LIST OF DOCUMENTS CONSULTED

A new Egyptian health care model for the 21st century. Cairo: Ministry of Health and Population.

Population and Development Strategies 2002-2017. UNFPA Population and Development Strategies Project. Ministry of Health and Population.

National Population Council 1991. National Population Strategy, 1992-2007.

National Population Council, 1996. National Population Policy 1997-2012.

Financing agreement between the EC and the Egyptian Government, "EC Support to the Health Sector Reform Programme," 1998

Financing agreement between the EC and the Egyptian Government, "Support to Population Programme in Upper Egypt," 1995

Health Sector Reform Programme log framework.

Egyptian Family Planning Association Strategic Plan, 2002-07.

United Nations Population Fund Proposed Projects and Programmes for Egypt, 1997

Egypt Country Strategy Paper 2002-2006 and National Indicative Programme 2002-2004.

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Annex 3: Major (>Euro 100,000) ICPD Interventions in Egypt, by thematic cluster, 1994-2001

Note:

HLTH …. Health

HUMAN … Humanitarian assistance (refugees, IDPs, natural catastrophes, etc.)

ICPD …. ICPD core sectors, including HIV/AIDS

OTHR …. ICPD related sectors (employment, education, indigenous populations, etc.)

Source: Population-Development Database

Cluster	Brief description	Project title	Amount	Budget line	Commitment year	Project number
HLTH	Sector support	EC support to the Health sector reform	282.000.000,00	B7 4100	1998	MEDA/EGY/220/010/A
HLTH	Sector support	EC Support to the Health Sector Reform Programme	110.000.000,00	B7300	1996	EGY/B7-4100/IB/98/1050
HLTH	Infrastructure	RADIOLOGICAL SERVICES UPGRADIN G AND DEVELOPMENT	2.827.276,00	B9650		1995/0146 - 220/02/014
HLTH	Health policy and mgmt	T.A. to the Health Sector Reform - Programme I	736.125,00	B74100	1997	EGY/B7-4100/IB/97/0366
HUMAN	Refugees / IDPS	*** NO PROJECT TITLE ***	500.000,00	B7510		ECHO/EGT/B7-510/94/0100
HUMAN	Humanitarian aid	*** NO PROJECT TITLE ***	130.000,00	B7516		ECHO/EGT/B7-516/94/0200
ICPD	Reproductive health	Support to Population Programme in Upper Egypt	10.000.000,00	B75077	1995	SEM/04/220/020/A
ICPD	Population policy and mgmt	SUPPORT TO NGOS TOWARDS THE IMPLEMENTATION OF THE ICPD PROG-RAMME OF ACTION	395.021,00	B7 4100	1997	CDC/1995/7
OTHR	Women in Development	PROMOTION FEMININE DANS LA REGION DE MINIA, HAUTE EGYPTE	128.648,00	B76000		PVD/1996/390

THEMATIC EVALUATION OF POPULATION AND DEVELOPMENT ORIENTED PROGRAMMES IN EC EXTERNAL CO-OPERATION

COUNTRY REPORT FOR GEORGIA

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January 2004

For the

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CONTENTS

TABLES

ANNEXES

1. INTRODUCTION

1.1 Background to the mission

On 29 November, 2001 the Board of EuropeAid requested the European Commission's Evaluation Unit to undertake an evaluation of the population theme in EC external assistance over the period 1994-2002 in order to "… verify the logic and consistency of individual actions with the stated objectives and expected impacts."

This evaluation represents the first-ever global assessment of the theme "Population and Development in EC external cooperation programmes." The objective of this evaluation is to provide the Commission with an independent expertise to assess the nature and evolution of its objectives and policies on population and development in external cooperation programmes, and the evolution and volume of the programmes concerned; and to assess its relevance, effectiveness, efficiency, sustainability and impact, and internal/external coherence.

Population is a multi-dimensional concept at the EC, and this evaluation is similarly intended to take a broad view of population and development. The template adopted is the International Conference on Population and Development (ICPD) Programme of Action, spanning the entire field of demography, from reproductive health (including sexually transmitted infections and HIV/AIDS) and family planning through age- and spatial distribution of populations, urbanisation, international and internal migration (including refugees, internally displaced persons, and asylum seekers), disabled persons, population data collection and analysis, and policy making. Information, education, and communication (IEC) activities and activities aimed at gender equality and equity are an equally important component.

The EC plays a significant role in international population assistance, providing approximately 5-10% of global support for the **ICPD goals** focusing on six areas:

- Maintaining and increasing the gains already made in providing access to sexual and reproductive health services.
- Ensuring that women have the opportunity of safe pregnancy and childbirth.
- Promoting the sexual and reproductive health of young people.
- Limiting the spread of HIV/AIDS and caring for those who live with the virus.
- Addressing problems of gender-based violence and sexual abuse, especially of young women and children.
- Building partnerships with civil society.

The EC is also a major source of humanitarian assistance to refugees and displaced persons, a significant amount of which overlaps with population (e.g. reproductive health of displaced populations, resettlement and repatriation programmes, etc.).

The **legal bases** for population assistance for the period covered by this evaluation (1994-2002), which contain the relevant policy objectives, are:

- For reproductive health and family planning: the 1992 Council Communication on Family Planning and the 1997 Council Regulation 1484/97 on aid for population policies and programmes in developing countries.
- For sexually transmitted diseases, HIV and AIDS : the 1994 Communication on Health COM(94)78, Council Regulation 550/97 on HIV/AIDS-related operations, the Communication on Accelerated Action Targeted at Major Communicable Diseases Within the Context of Poverty Reduction (COM (2000) 585).
- For distress migration, internally displaced people and refugees : Council Regulation 1257/96 concerning humanitarian aid, Council Regulation 2258/96 covering rehabilitation and reconstruction operations, and Council Regulation 2130(2001) on operations to aid uprooted people in Asia and Latin America. While the Regulation covers only ALA, it can be construed as expressing EC policy broadly speaking in other regions of the world.

Almost all budget lines and the EDF have been found to finance population-related activities. This evaluation is therefore not limited to any particular financial instrument. The overall objective of this evaluation was to achieve improved coherence and application of the Commission's approach to Population and Development in partner countries through improved decision-making and project management. The evaluation was to be implemented through provision of independent expertise to assess the nature of policies and objectives related to population in external cooperation programmes, the evolution and volume of programmes concerned, and their relevance, effectiveness, efficiency, sustainability, impact, and internal / external coherence. The focus was on a verification/testing of the logic and consistency of EC-funded actions with the stated objectives and expected results.

The evaluation concentrated on the period 1994-2002. It took into consideration, however, issues which were of more recent vintage such as the emerging importance of Sector Wide Approaches (SWAPs). The evaluation covered the Commission's actions in the field of Population and Development in Asia and the Pacific, Latin America, the Caribbean, Africa (including the Mediterranean area), the Balkans, the Commonwealth of Independent States, and the non-accession countries in Central and Eastern Europe.

The **thematic scope** of the evaluation was bound by the following considerations:

- Gender aspects of Population and Development should be discussed with reference to the on-going EC evaluation in this area. Work in the ongoing Rehabilitation evaluation was also to be taken into account.
- Health aspects took into account findings already developed by the EC evaluation in this area, putting these results/conclusions in perspective and updating them as indicated. The evaluation team were complementing, not repeating, work undertaken by the recent HIV/AIDS evaluation.

- The analysis of international migration was limited to migratory movements between countries and within countries and was to include displaced persons / uprooted people. Migration from partner countries to Europe was not covered in the analysis.
- Only limited attention was given to population, development and education; however, the work on education and communication of DG EAC was taken into account.

Co-ordination, coherence, and complementarity with other key international actors in Population and Development were a key focus of the analysis, as were co-ordination, complementarity and coherence with NGOs.

Field visits

A major component of the Completion Phase of the evaluation consisted of five country field visits to: **Egypt, Georgia, Guatemala, India and Kenya**. The purpose of the country visits was to test and verify the logic and consistency of project and programme actions against stated objectives and anticipated impacts. Through consideration of Evaluative Questions, the evaluation team has assessed the relevance, effectiveness, and coherence of EC Population and Development strategy(ies) and programmes.

Each mission was carried out by a senior international consultant, who collaborated with a national expert recruited in advance of the mission. The duration of each country mission was approximately 10 days plus two days mission preparation and four days report drafting. Approximately five days were dedicated to meeting different stakeholders, in the EC delegation, in partner organisations (line Ministries, NGOs, bilateral donors, etc.) and national actors involved in population issues. Donors (multilateral and bilateral) as well as major NGOs involved in population were also interviewed for bench-marking of EC approach to population. A mixture of participatory techniques, including face-to-face interviews and focus group discussions were used. Approximately five days were dedicated to an assessment of selected programmes or projects. Techniques included interviews and focus groups with beneficiaries, local implementers and other key stakeholders.

Why Georgia?

Georgia was selected by the evaluation team in consultation with responsible desk officers in DGRelex, who **requested that the Country Report comment on the overall economic, social, and political context in Georgia**; particularly implications for the evolving direction of EC country strategy. **One aspect of this request, seconded by the Delegation, was that the Report comment on the new primary health care (PHC) focus** in the revised EC assistance strategy.

At first glance, Georgia would appear an odd choice for a population and development evaluation. The global project database assembled by the evaluation team did not contain a single project in Georgia, in addition to which, a brief review of country strategy revealed that the EC was little involved in the social sector in

Georgia during the evaluation period. However, Georgia offered three aspects of interest:

- First, as developed in the demographic context section below, Georgia is an excellent example of the overall post-Soviet demographic situation in the Tacis region (declining fertility and increased mortality), in addition to being affected by major internal population displacements and out-migration. The social sector, in particular the health system, has deteriorated and formal social safety nets such as the pension system have all but collapsed.
- Second, Georgia offers a salient example of a country in the grip of socio-economic crisis. Following independence, and due in significant part to civil, ethnic, and political conflicts that are currently stalemated, Georgia suffered one of the most severe economic declines ever recorded. The result has been widespread impoverishment of households. The formal economy has collapsed, resulting in de-monetisation of the economy in the most seriously affected areas and a return to subsistence-level activities. Well over half the population is estimated to live in poverty. Two separatist republics (Abhazia and South Ossetia) have established de facto independence, the security situation in the country is fragile, and the political outlook fraught with uncertainty. Inability to generate economic recovery, widespread corruption, and the perceived non-functioning of democratic institutions has seriously impaired the credibility of the Government of Georgia (GoG) with both its own citizens and the international donor community.
- Third, the adverse situation described above has led to major shifts in EC policy, and especially in the EC's engagement with the social sector and civil society. Georgia is a major EU partner country and has received over Euro 385 million in aid since 1991. The basic goal, as incorporated into the 1999 Partnership and Cooperation Agreement, is to promote democratic principles, the rule of law and human rights, and development of a market economy. However, the history of EU assistance to Georgia has been a difficult one. The latest revised strategy, contained in the draft Country Strategy Paper 2003-2006, acknowledges the need to
    - strengthen conditionality
    - focus exclusively on reform programmes to which GoG appears truly committed, and
    - provide increased support to civil society structures (i.e., NGOs) outside state structures.

In summary, Georgia is (i) post-Soviet, (ii) embroiled in crisis and (iii) assistance is recognised to have not worked well.

1.2 Country profile: demographic and health situation

Demography

Especially considering the crisis conditions that prevail, demographic and health data availability is generally adequate in Georgia:

- A census was taken in 2002 (excluding the two breakaway republics) and, subject to correction for differences in coverage, can be compared to Soviet-era censuses.
- A comprehensive reproductive health survey was performed in 1999/2000 with the technical support by the U.S. Centers for Disease Control (CDC).
- Although there are no national health accounts, EC Tacis funded a medical expenditure and service provision study carried in the first quarter of 2000 by the State Department for Statistics of Georgia (SDSG).
- It is known that many data, both from SDSG and from the Center for Medical Statistics and Information (CMSI, Ministry of Labour, Health and Social Affairs) are incomplete. For example, official abortion statistics reflect only a fraction of actual procedures. However, working both from independent sources and indirect estimation methods, demographers affiliated with the Institute of Demographic and Sociological Research of the Georgian Academy of Sciences have corrected basic population, fertility, mortality, and migration data. These are presented in a user-friendly volume, *Demographic Overview of Georgia*, financed by the United Nations Population Fund (UNFPA).

The bad news on the data front is that utilisation of demographic and health data for effective planning is poor. Due to political mistrust, demographic data is highly politicised, with various factions citing sometimes fanciful statistics to bolster their positions. What data is available does not appear to be effectively utilised in policy making, particularly at the macro-economic level. Government is not the only guilty party here: project preparation material consulted by the evaluation team made little use of demographic and health data. One purpose of technical assistance is to serve as an example-setter, and more could be done to frame donor advice in quantitative terms using available data.

The demographic consequences of economic collapse in Georgia are wide ranging and include:

- Declining population. According to the State Department for Statistics of Georgia (SDSG) estimates, total population declined from 5.4 million in 1990 to 5.1 million in 2000 (see Table 1 overleaf).
- High levels of out-migration and brain drain, resulting in the estimated out-migration of up to 1.5 million (close to a third of the population). Skilled workers, especially prime labour-aged males, comprise the bulk of this outflow.
- High levels of internal displacement, with approximately 300,000 internally displaced persons (IDPs) from the breakaway regions of

Abkhazia and South Ossetia being housed in collective centres, former hotels, etc. Most of these (about 160,000) are in Zugdidi. Perhaps half of IDPs have de facto settled in their zone of displacement.

- Acute fertility decline, with the total fertility rate (TFR) is estimated, depending on the source, to be 1.1 – 1.4. Fertility decline represents reduced marital fertility as a result of economic insecurity as well as decline in the proportion of the population married. As shown in Table 1, between 1990 and 2000 the proportion of women 45 who never married increased from 6% to over 10%.
- Poor basic population health indicators. Life expectancy is estimated to have stagnated during the 1990s at about 71.5 for both sexes combined. Life expectancy at 65, an index of the health of the elderly, declined by over half a year. Both infant mortality and maternal mortality increased.
- Rapid population aging due to fertility decline (and out-migration of the young) coupled with collapse of the social insurance system.

Table 1: Population and reproductive health summary, 1990 and 2000

	ca. 1990	ca. 2000
Population and age structure		
Total population (000)	5413.5	5100.5
% > 65	9.1%	13.3%
% <15	24.7%	20.4%
Mortality		
Life expectancy at birth, both sexes	71.5	71.4
Life expectancy at 65, both sexes	15.1	14.5
Infant mortality rate (per 1000 live births)	20.7	22.1
Fertility		
Total fertility rate	2.2	1.1
Female never-married, age 45-49 (per 1000)	60	105
Abortions per live birth	--	200
Total abortion rate (per woman)	--	3.7
Family planning		
Unmet need for family planning* (% of women 15-44)	--	27.1
Proportion of last pregnancies mistimed	--	10.1
Proportion of last pregnancies unwanted	--	48.9
Women 15-45 who have heard of any method of contraception	--	95.1
Women 15-45 using any method of contraception	--	40.5
of which modern method	--	25.2
Reproductive health		
Proportion of women receiving inadequate pre-natal care	--	47.4
Proportion of deliveries occurring at home	--	7.8
Maternal mortality rate (per 100,000 live births)	41.0	51
Women 15-45 who have had routine gynecological exam within last year	--	29.6
Proportion of women aware of breast self-exam	--	46.9
Incidence of syphilis (per 100,000)	12.5	27.5
HIV-AIDS prevalence rate (per 100,000)	0.1	1.72
Proportion of women 15-45 reporting ever-physical abuse	--	5

* Proportion of women sexually active, fecund, not pregnant/postpartum or seeking to become pregnant, either using no method of contraception (11.8%) or using a traditional method (12.3%).
--: not availble

Sources: Demogaphic Overview of Georgia (1960-2000)
Women's Reproductive Health Survey Georgia, 1999-2000

Reproductive health (RH) care is at a low level:

- Less than half of women received pre-natal care considered adequate by international standards (see Table 1). Not shown in the Table is that less than half received information about signs of complications or the negative effects of smoking and alcohol consumption during pregnancy. A baseline survey done by US AID in the context of the Safe Motherhood Initiative (see below) found that fewer than one-third of clinicians effectively counsel women on risk factors associated with pregnancy;
- A significant number of deliveries occur at home, and among Azeri women, the proportion is on the order of 15%.
- Preventive RH care is inadequate. Fewer than 30% of women of reproductive age have ever had a gynaecological exam (international standards recommend one exam per year) and less than half were aware of breast self-examination (BSE).
- Contraceptive awareness is high but, typical of post-Soviet societies, acceptance and practice of modern family planning (FP) is very low. The situation is especially serious in Georgia: modern contraceptive prevalence (about 25%) is the lowest of any of the 12 post-Soviet republics. Part of the reason is persistence of fear that modern contraception carries serious health risks, a fear which originated during the Soviet era, when high-risk pharmaceuticals not used in the West were unscrupulously marketed in the East. Using the conventional international definition, unmet need for family planning amounts to about 25% of women 15-45. About half these women are practising no contraception at all and another half are employing traditional methods. Physician training in family planning is very low (for physicians who have received no internationally-supported training, it is effectively zero).

The result is a high level of unwanted pregnancy (about half of all last pregnancies, according to survey results in Table 1) and an abortion rate, which, at 200 abortions per live birth or about 3.7 lifetime abortions for an average woman, is among the highest in the world. Abortion is legal and elective during the first twelve weeks of pregnancy and is an important source of physician revenue (costing on average about GEL 20 per procedure).

One bright spot is HIV-AIDS, where incidence continues to be very low ad confined to high-risk populations of injecting drug users and prostitutes. However, experience in other CIS countries, especially Russia and Ukraine, shows that HIV can lurk at very low prevalence levels for years, only to explode later. It is too early to say whether such a situation will prevail in Georgia, however, complacence would be a mistake. As in other CIS countries, there was a sharp rise in syphilis incidence rates during the 1990s (more than doubling in Georgia from 12 to 27 cases per 100,000), and it is well-established that the presence of other STIs promotes HIV infection.

Health

Based on an analysis of the poorest CIS countries, Word Bank researchers (Maria E. Bonilla-Chacin, Edmundo Murrugarra, and Moukim Temourov, "Health Care During Transition and Health Systems Reform: Evidence from the Poorest CIS Countries," paper prepared for the Lucerne Conference of the CIS7 Initiative, January 2003) categorised counter into those with very low (<2%) versus low public health spending as a share of GDP and those that have made significant progress versus little progress in health care reform. Georgia falls into the category of countries with very low public health care spending who have taken significant steps towards reform. For example, the Soviet-era guarantee of free access to health care has been removed from the Constitution and there has been significant downsizing of the hospital sector since independence. The researchers note that the sequencing of reforms, however, has created a "perverse equilibrium" in which lower public spending led to increased out-of-pocket spending, in turn reducing demand for health care and revenues for the health sector as a whole. The result has been skyrocketing health care inequalities, with primary health care for the poor suffering the most.

According to the Medical Service in Georgia study financed by EU Tacis, total health spending during the first quarter of 2000 is estimated to have been GEL 91.8 million of which GEL 52,0 million represented the cost of medical services and GEL 39,8 million represented the cost of medicines (see Table 2). "Total health spending" is here defined to include out of pocket money expenditure (payment of fees to health care providers, mostly polyclinics, according to official fee schedules; purchase of pharmaceuticals; and unofficial payments to physicians), social insurance reimbursements, and the imputed value of free service obtained from friends and in-kind remuneration. Multiplied by 4 and divided by the estimated population of 5.1 million, this suggests that total health care spending in 2000 was GEL 72 per capita. GDP per capita was very roughly GEL 1000 per capita, suggesting that about 7 percent of GDP was expended on health care This accords with the latest estimate of the World Health Organisation (WHO World Health Report 2002). For comparison, the same source estimates that health care spending was 6.5% of GDP in Armenia, 2.1% in Azerbaijan, and 5.3% in the Russian Federation. GEL 57 per capita (a little less than 80%) represented non-emergency formal medical sector care (i.e., inpatient care in a hospital or clinic, outpatient care in a polyclinic or ambulatorium, and chargeable care obtained from a private physician).

All medicines must be paid for out of pocket, and this represents one of the greatest challenges to health care reform in Georgia. Given low incomes, unless government can guarantee access to a basic basket of medicines, patients will continue to avoid medical consultations on the grounds that they will not be able to afford the needed medicine anyway, or consultations will be ineffective because of patient non-compliance with the physician's instructions.

Table 2: Total expenditure on medical services, 2000:I (000 GEL)

		Total		Out-of-pocket (% of total)
Emergency services				
Medical services	2618.3	66.6%		38.1%
Medicines	1313	33.4%		100.0%
Total	3931.3	100.0%	4.3%	58.8%
Outpatient *				
Medical services	10123.8	49.4%		78.4%
Medicines	10387.7	50.6%		100.0%
Total	20511.5	100.0%	22.4%	89.3%
Inpatient *				
Medical services	28716.7	79.8%		83.1%
Medicines	7252.6	20.2%		100.0%
Total	35969.3	100.0%	39.2%	86.5%
Private physician (chargeable) *				
Medical services	7892.1	47.3%		82.4%
Medicines	8790.1	52.7%		100.0%
Total	16682.2	100.0%	18.2%	91.6%
Private physician (free treatment by a friend)				
Medical services	1700	41.0%		0.0%
Medicines	2443	59.0%		100.0%
Total	4143	100.0%	4.5%	59.0%
Home treatment with no medical consultation				
Medical services	459.1	4.9%		0.0%
Medicines	8896.1	95.1%		100.0%
Total	9355.2	100.0%	10.2%	95.1%
Folk medicine				
Medical services	491.4	42.2%		60.3%
Medicines	674.2	57.8%		100.0%
Total	1165.6	100.0%	1.3%	83.1%
* Non-emergency formal sector				
Medical services	46732.6	63.9%		82.0%
Medicines	26430.4	36.1%		100.0%
Total	73163	100.0%	79.7%	88.4%
All sectors				
Medical services	52001.4	56.7%		76.1%
Medicines	39756.7	43.3%		100.0%
Total	91758.1	100.0%	100.0%	86.5%

Source: State Department for Statistics of Georgia, "Medical Service in Georgia," Tbilisi 2000.

* Includes out-of-pocket expenditure, covered expenditure, and imputed value of gifts and free service. Medicines associated with free treatment by a physician friend and home treaement without medical consultation are assumed to be paid for out of pocket.

In addition, about 80% of non-emergency formal medical care must be paid for out of pocket. When discussing health care spending, Georgian policy makers and members of the international community often cite the figure "70 percent out of pocket," but this includes :

- emergency care (in which the law of rescue dictates that care must be given whether the patient is likely to pay or not),
- care obtained free or in exchange for in-kind gifts, and
- Home treatment with no medical consultation.

According to the data presented in Table 2, when the cost of medicines is taken into account, 86% of all health spending is out of pocket. This accords almost exactly with WHO data, which estimates the private sector share (essentially out-of-pocket plus a miniscule private health insurance component) at 89.5%. For comparison the private sector shares in Armenia, Azerbaijan, and Russia respectively are estimated by WHO to be 57.7%, 55.8%, and 27.5%, respectively. Thus, Georgia is an extreme case, for the region, of the role of out-of-pocket spending in health care.

As a general proposition, there is nothing wrong with a high share of private spending in financing the total health care basket (witness the case of the United States, which enjoys a reasonable standard of health care, albeit with pronounced inequalities). The problem is that in Georgia, for all but a small fraction of the population, the high share of out-of-pocket finance is inconsistent with receiving adequate care. Failure to seek and receive even basic health care is widespread due to low household incomes, as a result of which, many patients are seriously ill by the time they enter the medical system. Extreme income inequality means that poor health has become highly correlated with poverty and is in fact an impoverishing agent. Chapter 3 ("Dimensions of Human Development") of the UNDP *Human Development Report*, Georgia, 2001-2002) analyses health care access in detail and concludes that there are "appalling disparities in access to health care by poor and rich Georgians" (page 57).

The burden of out-of-pocket spending is especially serious; in fact, it is a matter of life and death, for the elderly population (see Table 3). Confining ourselves to non-emergency formal medical care, average out-of-pocket expenditure among the pension-age population amounted to GEL 20 per capita in the first quarter of 2000, a total of GEL 80 for the year (note that this figure was GEL 52 for the population as a whole). The standard pension, for comparison, is GEL 14 per month.

According to data in Table 4, total out-of-pocket spending per capita was roughly equal for males (GEL 14.4) and females (GEL 13.5). Not surprisingly, spending on inpatient care was about the same (GEL 6.4 and GEL 6.7), as these treatments typically represent major disease episodes. However, women spent much less out of pocket on outpatient care (GEL 2.4 versus GEL 5.8 per capita) and much more on care received from private physicians (GEL 4.1 versus GEL 2.1). The fact that women are less likely than men to visit polyclinics and more likely to visit private physicians (see Table 5) does not explain all (or even most) of the difference. The out-of-pocket charges incurred per woman in the course of a single outpatient visit to a polyclinic are less than half as great as those incurred by males (GEL 43.4 as opposed to GEL 97.3). The ordering is reversed for visits to private physicians (average out of pocket expenditure of GEL 94.5 per visit for women and GEL 67.2 for males).

Some of these differences are explained by the fact that, whereas men and women are evenly balanced in the non-elderly population, women are over-represented among the elderly – who are more likely to go to a private physician than a polyclinic. Other differences are associated with reproductive health care costs of women. During the first quarter of 2000, women aged 15-49 in the sample spent an average of GEL 8.9 apiece out of pocket on birth-, pregnancy-, and abortion-related care (see Table 5). To give a rough benchmark for comparison, women of all ages spent GEL 13.5 out of pocket on all forms of health care in the formal health care sector during the same quarter (see Table 4). The figures are not directly comparable – one refers to the formal sector and the other to all forms of health care, one refers to women 15-49 and the other to women of all ages – but clearly RH is one of the largest items in women's lifetime health care budget.

The average abortion costs GEL 20 and the full costs associated with a delivery are about GEL 100-200. With a TFR of, say, 1.5 and a total abortion rate of 3.7, one might estimate lifetime birth-, pregnancy-, and abortion-related spending at ca. GEL 300 per woman. This is a very substantial sum in a country as impoverished in Georgia, and it should come as no surprise that the level of reproductive health care, as we saw above, is low.

Table 3: Out-of-pocket spending, by age, non-emergency formal medical sector, 2000:I

	GEL per 1000 inhabitants		
	<15	15-pension age	> pension age
Outpatient services			
Medical examination	915.5	487.1	1228.9
Medical procedures	530.1	354.8	308.3
Consultation, checkup	1056.3	459.5	767.1
Medical services, total	2501.9	1301.4	2304.3
Medicines	2558.3	1245.7	5198.6
Total	5060.2	2547.1	7502.9
Inpatient services			
Medical examination	496.5	661	1201.7
Medical procedures	268.2	491.1	703.3
Consultation, checkup	614.5	758.2	1619.2
Surgery	539.4	3097.3	5345.7
Medical services, total	1918.6	5007.6	8869.9
Medicines	858.5	1171.3	3564.4
Total	2777.1	6178.9	12434.3
Private physician services			
Medical examination	5	19.3	25
Consultation, checkup	12.1	17.6	20.8
Medical services, total	17.1	36.9	45.8
Medicines	20.7	46.9	67.3
Total	37.8	83.8	113.1
Non-emergency formal sector total			
Medical services	4437.6	6345.9	11220
Medicines	3437.5	2463.9	8830.3
Total	7875.1	8809.8	20050.3

Source: State Department for Statistics of Georgia, "Medical Service in Georgia," Tbilisi 2000.

Table 4: Out-of-pocket spending, by sex, non-emergency formal medical sector, 2000:I

	GEL per 1000 inhabitants		GEL per visit	
	Male	Female	Male	Female
Outpatient services				
Medical examination	925	525.5	15.4	9.7
Medical procedures	547.2	235.1	9.1	4.3
Consultation, checkup	936.9	369	15.6	6.8
Medical services, total	2409.1	1129.6	40.1	20.8
Medicines	3444	1227.1	57.2	22.6
Total	5853.1	2356.7	97.3	43.4
Inpatient services				
Medical examination	978.5	524	42.9	25.4
Medical procedures	690.6	318.1	30.3	15.4
Consultation, checkup	947.7	851.4	41.5	41.3
Surgery	2360.5	3631.2	103.5	175.9
Medical services, total	4977.3	5324.7	218.2	258
Medicines	1465.3	1659.1	64.2	80.4
Total	6442.6	6983.8	282.4	338.4
Private physician services				
Medical examination	616.2	796.9	17.6	18.3
Consultation, checkup	514.3	844.3	14.7	19.3
Medical services, total	1130.5	1641.2	32.3	37.6
Medicines	1000.3	2483.7	34.9	56.9
Total	2130.8	4124.9	67.2	94.5
Non-emergency formal sector total				
Medical services	8516.9	8095.5	290.6	316.4
Medicines	5909.6	5369.9	156.3	159.9
Total	14426.5	13465.4	446.9	476.3

Source: State Department for Statistics of Georgia, "Medical Service in Georgia," Tbilisi 2000.

Table 5: Out-of-pocket spending on birth-, pregnancy- and abortion-related care*, 2000:I

	Per 1000 inhabitants (GEL)
Medical examinations	111.4
Emergency room service	12
Maternity hospital care	382.4
Women's consultation	347.4
Individual physician	58.6
Folk physician	24.6
Medicines	266.9
Total	1203.3
	Per 1000 women 15-49* (GEL)
Medical examinations	825.5
Emergency room service	88.9
Maternity hospital care	2833.6
Women's consultation	2574.2
Individual physician	434.2
Folk pysician	182.3
Medicines	1977.7
Total	8916.5

Source: State Department for Statistics of Georgia, "Medical Service in Georgia," Tbilisi 2000.

*Assuming women 15-49 = 13.5% of the sample population

Government policy

The primary goal of this document is to review EC involvement with the ICPD Programme of Action in Georgia, however, one of the key aspects of that involvement is coherence with government policy and success in encouraging government to adopt policies consistent with EC priorities.

Poverty reduction plan. In accordance with the new and unified policy stance of all international donors, poverty reduction is the overall objective of assistance and governments will be judged by their commitment and performance in this area. A Poverty Reduction and Economic Growth Programme for Georgia was developed in the late nineties, circulated to NGOs and stakeholders for comment, and has recently (July 2003) been formalised in the Economic Development and Poverty Reduction Programme of Georgia (EDPRPG). This programme is set forth schematically in Technical Annex III of the UNDP *Human Development Report* Georgia 2001-02 (corresponding to the October 2001 draft of the EDPRPG); information on operational strategies is contained in Annex I (Plan of Activities) of the EDPRPG.

Economic growth is the main concern of the EDPRPG, leading UNDP to comment (page 53) that substantial portions of the draft programme were indistinguishable from a standard structural adjustment programme.

The treatment of population and health (indeed, the social sector generally) in the EDPRPG is not of a high technical standard, indicating a need for capacity building and perhaps technical advice at the policy making level. In describing the socio-economic background (Chapter 1, Section 1), no mention is made of the diminishing population. The health situation is briefly described under "Human Capital" (section 1.1.7), but the problems identified are poor health habits and inefficient functioning of the health system, not the lack of budgetary resources at the Ministry level and purchasing-power at the household level. Chapter 1, Section 2 ("Analysis and Main Problems" again cites poor efficiency of the health system. Under "Gender and age problems" (Section 1.2.15), youth unemployment, juvenile delinquency, and the problems of children without sufficient parental care are mentioned, but here is no allusion to the rapid ageing of the Georgian population, nor is ageing mentioned in the sections dealing with the pensions crisis. Emigration highlighted cited as a problem (Section 1.2.12) but not radically sub-replacement fertility. Proposed strategic actions related to health (Section 3.4.1) are vague. By contrast, strategic actions proposed with respect to pensions (Section 3.3.6.6) are clearly, albeit very briefly, set out.

In general, the draft EDPRPG throughout its first three chapters highlights governance problems, the need for institutional reform, and macroeconomic stability. The reader is surprised to learn in Chapter 4 ("Macroeconomic Forecasting and Cost-Evaluation"), which details operational, as opposed to strategic, priorities, that government proposes to highlight the social sector. During 2003-05, 70% of government own-resources will be devoted to the social sector (education, health, social security and protection), which will allow government to finance all health sector activities and almost all activities related to pensions. Laudable though this may be, it indicates a lack of congruence between strategic priorities (macroeconomic and institutional) and operational priorities (social). How will the pursuit of social goals, placed at the top of the operational priority list, "jump-start" the Georgian economy, which is essentially the strategic goal? This is nowhere made clear. How will economic growth translate into welfare gains for households? After all, the Georgian economy has grown in recent years, but this growth has been concentrated in sectors generating little household income.

Health. The key health policy document is the Georgian National Health Policy (1999), under which current international donor initiatives have been prepared, and the associated Strategic Plan (designed to run 2003-08). From a population point of view, this document is much crisper than the EDPRPG document reviewed above. For example, in identifying mother and child health as its leading priority, the document notes "The acute demographic situation which exists in the country, expressed in the low level of reproduction … and increased emigration, creates the risk of depopulation. Improvement of maternal and child health and reduction of maternal and child mortality are of great importance in the given situation." It identifies three ICPD-related targets (reduce maternal mortality 15%, reduce infant morbidity and mortality 15%, and reduce rate of stillbirths 25%) and identifies the strategies by which these goals can be pursued. A sub-section "Implementation Strategies" identifies clearly the institutions implicated in the strategies and the actions called for, even though the latter are rather broad (e.g., "prioritise maternal and child health … when developing budgets …," etc.). Monitoring indicators and the bodies responsible for collecting relevant data are identified.

Policy directions for pursuing the priority goals are set forth in a separate chapter. The lead section deals, appropriately, with health financing. Goals are to provide accessibility to a basic health package through public finance and to promote higher-level care through establishment and development of private, voluntary, and community health funds. Quantitative targets are proposed (e.g., increase state funding of health care to 6% of GDP by 2010). Under "Development of curative medicine" (Section 4.9), sub-sections on equity, access, and affordability call for establishment of a basic package, development of a sustainable insurance system, putting-in-place of a primary health system to serve as "gatekeeper" for access to more expensive treatments. A goal of special interest is to "recapture" current unofficial out-of pocket payments into the official health system in order to rationalise the system (including, one assumes, physician and health workers' salaries). The importance of this is underscored by the Medical Service in Georgia study described above, which found that the volume of medical services produced was some 6 times greater than the amount of services reported by medical establishments.

The "Georgia Primary Health Care Strategy" makes specific recommendations to pursue PHC reform. One of the most important of these is the definition of a Basic Benefit Package (BBP) with the intention of concentrating health care resources on guaranteeing that all citizens will have access to this bundle of medical treatments. In theory, all citizens have the right to access to the BBP, which is financed on a solidarity basis by payroll taxes split between employers and employees (3% employers and 1% employees, although most economists would argue that the entire incidence of the tax is really on employees). While the goal of universal access to basic services is laudable, the inevitable result has been that the BBP has become a political football, with various actors vying to take credit for expanding the package, which in its most recent form included organ transplantation, paediatric cardio-surgery, and other major interventions that would usually be dealt with outside a basic benefit framework. The process by which the BBP has been decided on is opaque (a large proportion of the population is unaware of its health care rights under the BBP) and rationalising it should be a major priority for health care reformers. If it has been "costed," then the evaluation team did not see the relevant documents.

Analysing and rationalising the BBP is crucial because the financial means to deliver it in its current form will not be available. BBP approaches (which are not uncommon) require, first, that the benefits covered truly be basic. The political discipline for ensuring this has not been present in Georgia, as a result of which, the costs of the BBP have ballooned. Second, BBP approaches win political support by virtue of the fact that they are universal, i.e. that all families have access. Such a universal approach is, however, at variance with the lack of GoG budget resources. To give an idea of the shortfall, in 2002 Central Budget (Ministry of Finance) allocations to the Ministry of Labour, Health, and Social Affairs (MLHSA) and the United Social Security Fund (SISUF) were only 12% of those foreseen in the original budget. Contributions from municipalities (10% of whose budgets must be contributed to support health programmes) were 60% of the planned level.

The dream of health reformers in the post-Soviet setting is invariably "generate resources for health care," a goal which is typically contextualised by reference to the fact that, in the Soviet era, health was considered a low-priority unproductive sector, and thus was relegated to the end of the budget queue. In Georgia, the putting-in-place of a system of social contributions to go directly to SISUF is designed to overcome this scarcity of resources. However, the system as envisaged is a generic

Western-style system oriented towards wage employees in formal enterprises, precisely the sector of the Georgian economy that has collapsed.

Pensions and the social safety net. Anton Dobronogov, "Social Protection in the Poorest CIS Countries," cited in the list of documents consulted, presents data in his Table 1 that put the share of the informal sector at 63%, highest in the region. His Tables 3 and 4 present data indicating that the ratio of contributors to working-age population (40.2%) is the lowest in the region and the system dependency ratio (beneficiaries to contributors), at 123%, is the highest in the region. The implosion of pension payments to GEL 14 per month is in attributable to collapse of the contribution base due to (i) shrinkage of the formal sector, (ii) reductions in wages of those who do work, and (iii) evasion.

In 1997 a "Family Poverty Benefit" was defined as 35% of the Minimum Consumption Basket, but funds to finance the programme were unavailable. In 2000 and 2001, EC Food Security Programme (FSP) financing was used to make this targeted social assistance programme operational. Eligibility is categorical (as opposed to means-tested) and the average benefit is GEL 22 for single-person households and GEL 35 for other households.

Population. Georgia does not have a national population policy and, as argued above, population concerns are poorly incorporated into the EDPRPG. However, ICPD concerns, especially mother and child health, figure prominently among health priorities identified in the National Health Policy. A paragraph-by-paragraph analysis of these documents (Guram Kiknadze, Maya Sulakvelidze, Givi Javashvili, and Akakai Barkalaia, "Reproductive Health and Reproductive Rights in Georgian Legislation," UNFPA, Tbilisi, 1992) reveals

- Close compliance of both the Policy and the Strategic Plan with items of the ICPD dealing with safe delivery and the health of mothers-to-be and infants.
- Commitment at both the policy and planning level to developing RH/FP services.
- Commitment at the policy and strategic level to prevention and treatment of reproductive cancers.
- Commitment to education and monitoring of sexually transmitted infections (STIs) including HIV-AIDS.

In general, priority continues to be given to Mother and Child Health (MCH) and Safe Motherhood. The RH/FP aspect of the ICPD Programme is subsumed under two general strategic goals

- Development of a system of RH/FP services for the years 2000-2009 and
- Promotion and extension of RH/FP consulting offices and centres network (2001-2015).

There is relatively little attention to broad-based health promotion, IEC, or the needs of special groups such as adolescents. It remains to see how effectively ICPD health issues will be incorporated into ongoing PHC reform process. The Georgian health

care system, both in terms of the mentality of health practitioners and administrative structure, is much better attuned to safe delivery and child health than it is to RH/FP. The fact that family planning is not included in the BBP must be seen from the ICPD point of view as a serious omission. Admittedly, in a context of radically sub-replacement fertility and population decline, it is difficult to mobilise policy makers' interest in family planning; however, the health and social consequences of unplanned pregnancies and repeated abortions are agreed upon.

International assistance in pursuit of ICPD goals

United Nations Population Fund. During the period covered by the evaluation, the United Nations Population Fund (UNFPA) rehabilitated so-called Women's Cabinets, provided contraceptive supplies, trained medical personnel, and financed IEC activities. The project "Strengthening of Reproductive Health Services in Georgia" (1996-2000), which aimed to reduce unwanted pregnancies and abortions by 50%, opened 55 regional RH/FP centres, trained over 400 doctors and midwives, provided equipment and medical supplies, and financed IEC activities such as television slots and press coverage of RH/FP issues. A national programme on reproductive health, subsequently incorporated into the National Health Policy, was prepared. Other activities included support to the 2002 census, the reproductive health survey whose data were cited above, and the putting-in-place of mobile RH/FP teams to cover remote areas. Activities related to IEC, social marketing of contraceptives, and medical supplies are continuing.

US Agency for International Development. Working through UNFPA-financed cabinets, US Agency for International Development (US AID) financed training, provided contraceptive supplies, and promoted awareness of RH/FP issues. The project, entitled "Care for Each Other," ran from 1999-2002 and focused on increasing the prevalence of family planning. Components were upgrading of services, media promotion, provision of IEC materials (brochures, etc.) and community outreach. USAID also financed the Safe Motherhood Initiative (SMI) in the East Georgia region of Kakheti, an initiative designed to produce significant improvements in a very short period of time (2 years). The theme unifying project components was information, namely (i) awareness of women about health care, (ii) awareness of practitioners about international standards and counselling, and (iii) awareness of policy makers about prevalence of STIs, anaemia, and maternal / perinatal health indicators. Both of these USAID initiatives have now ended. Their accomplishments are being consolidated, and lessons learned are being applied, in a new USAID project (just put out for tender) entitled "Healthy Women in Georgia" ($3 million over 3 years).

European Union. EC assistance in the ICPD area was limited and scattered over the evaluation period. Three aspects were significant and have been selected for analysis below:

- The European Community Humanitarian Office (ECHO) provided substantial aid for IDPs, including renovating and supporting health facilities providing a significant amount of reproductive health care.

- Tacis-LIEN financed 7-8 small NGO-executed projects, several of which provided RH/FP at renovated clinics.
- Through the Family Assistance Programme component of the EC Food Security Programme, proposed by the GoG in the late 1990s, FSP funds were made available to MoLHSA to provide targeted assistance to elderly households (as well as households with many children and some other categories of households, but the overwhelming share of resources goes to the elderly). This initiative dates from the "National Food Security Policy Framework" elaborated in 1999 and approved in January 2000, in which concern was expressed regarding access to food. As a result, EC FSP funds were attributed during 2000 and 2001 to social protection, particularly in favour of the elderly. Less closely related to ICPD but still of interest, EC FSP funds have also been made available to the Ministry of Education to support a wide range of activities (including food) benefiting institutionalised children, most of them orphans.

As a result of strategic changes in favour of the social sector described below, PHC reform is one of the emerging foci of EC assistance. A World Bank credit (Health Care 1) contributed to rehabilitating health facilities; a second soft loan (Health Care 2) and a EC / DFID / World Bank project is now being prepared. This is an ambitious project from the coordination point of view: DFID is providing technical assistance, the World Bank is financing reconstruction of PHC facilities, and the EC is financing reconstruction of PHC facilities in a pilot region (Kakheti) and providing technical support to the Ministry of Labour, Health, and Social Affairs (MoLHSA) to reform the financing of PHC. EC has, in a sense, taken on the most difficult aspect of the project because, as the discussion above makes clear, success will depend crucially on whether financing problems can be solved.

1.3 Summary of the mission

The mission was carried out by Mr. Landis MacKellar, international consultant based in Vienna, Austria, and Mr. Mamuka Alavidze, national consultant based in Tbilisi. The evaluation was carried out at two levels. At national level, the team worked with staff from the EC Delegation, other international agencies, NGOs, and research organizations. At the project level, the team focused on:

- Reproductive health and family planning projects carried out under the Tacis-LIEN programme
- Rehabilitation of health facilities by ECHO, particularly in the Samagrelo region, with a focus on reproductive health and family planning
- The Family Assistance Programme component of the EC Food Security Programme, which provided targeted social assistance to the elderly, to orphans, and to other vulnerable groups.

The reason for selection of these areas were (i) the immediate relevance of the Tacis-LIEN clinic projects reviewed to ICPD goals, (ii) the importance of ECHO aid given the humanitarian crisis in Georgia, and (iii) the evaluation team's special interest in examining how EC aid had benefited, not women and children (the major target

populations of ICPD) but rather the elderly. This is especially relevant in a rapidly ageing society such as Georgia's.

The approach to the evaluation involved review of literature, including financing documents, project monitoring and evaluation reports, project final reports and impact studies, Georgia Country Strategy Papers and National Indicative Programmes, interviews with key informants and stakeholders, and site visits.

A detailed chronology of the mission and list of persons interviewed is given as Annex 1 of this Country Report and a list of documents consulted is given as Annex 2.

1.4 Constraints

Due to mission and vacation travel, a number of persons were unavailable for interview. These include ECHO programme officers in Moscow (M. Phillippe Rouen) and Brussels (Mme. Lea Drouet). Documents in archive, including those related to ECHO (in Brussels) and Tacis-LIEN (in Tblisi; however, the responsible official was away) have not been examined.

The team considers that, in general, the mission went well and that they were able to fulfil their terms of reference. They would like to thank all the officials, experts, and project staff who gave so generously of their time. They are especially indebted to Mme. Khachidze Manoni of MoHSA and Ms. Maria Menabde, former programme officer of the EC FSP, for facilitating contacts, and to Mme. Adriana Longoni and Mme. Colette Selman of the EC Delegation in Tbilisi for their keen interest in the mission.

2. MAIN FINDINGS

2.1 Evaluative Question 1

Since 1995, what has the European Commission put in place, in terms of global policies, strategies, and programmes (Cotonou agreement, TACIS, MEDA, ...) to operationalise its engagements with the ICPD Plan of Action and ICPD+5?

To what extent are the EC policies, strategies and programmes coherent with ICPD?

This Evaluative Question is being answered via Brussels-based interviews, document analysis, etc. The Preparatory Phase concluded that the EC's population policy focus has shifted from concern with rapid population growth as a deterrent to economic development to concern with the right to adequate sexual and reproductive health. In addition to its focus on women, the EC has actively targeted adolescents. This evolving population policy has been *externally coherent* with shifts in the stance of other policy institutions. Moreover, the *internal coherence* of EC population policy has improved over time. There is little sign from policy documents, however, that the EC has sought to exploit synergies with other areas of EC assistance (apart from health and support to refugees / internally displaced persons). Nor has there been adequate consideration of strategic linkages between population policy and policies in other areas.

In view of needs in poor countries and the scarcity of resources, the *relevance* of EC population assistance appears to be assured. The Preparatory Phase did not reach a judgment on whether EC assistance has been *effective* in pursuing policy goals. The validity of the *efficiency* criterion is diminishing with the move towards a human-rights based approach, however, as poor reproductive and sexual health particularly affect vulnerable groups, and as the unit costs of most interventions are low, the EC's population activities may be very efficient means of addressing inequities. The Preparatory Phase also did not reach a conclusion regarding *sustainability*; however, it is widely known that available international financing falls far short of needs and governments are reluctant to commit resources.

The evaluation team has found that the Commission's record-keeping and accounting systems for population projects have been over-stretched as a result of the multiplication of sectors, budget lines, and directorates, as well no doubt as by rapid staff turnover. The team noted that steps are underway in Brussels to unify databases.

Most generally, the Preparatory Phase of this evaluation found that there are opportunities for the EC to enhance its impact in the population field and, by exploiting synergies with other sectors, to bolster the relevance and effectiveness of its overall development approaches. In order to translate these preliminary indications into practical steps and actions, the Preparatory Phase recommended that the Commission proceed with the Completion Phase of this thematic evaluation on population and development.

2.2 Evaluative question 2

To what extent did EC third country co-operation strategies (especially CSPs, NIPs, etc.) reflect an overall population and development sector approach, and respond to the needs of the Cairo Plan?

At the level of countries: Were country strategies internally coherent from the standpoint of population and were population components coherent with the global development policy of the EU?

General overview of EC assistance

Over the decade 1992-2002, the EC allocated about Euro 340 million to Georgia (see Table 6 at the end of the Report). The EC's strategy in Georgia has evolved significantly in response to the changing economic and political climate. Initially, country strategy concentrated on transition towards democracy and the market economy, stressing technical assistance as the main strategic instrument. The main problems encountered were (i) the difficulty of effectively mobilising, under very difficult political circumstances, the good intentions and accurate understanding of problems expressed by the GoG and (ii) dealing with the adverse on-the-ground situation of conflict, IDPs, poor governance, corruption, and weak civil society institutions. These factors have led to a shift to the overall objective of poverty reduction. Coupled with this is a desire to more effectively implicate NGOs and local communities in implementation of the strategy. The evolution of EC strategy has been gradual, in response to lessons learned in Georgia and elsewhere. At the same time, it has been dramatic, involving a marked shift towards the social sector.

Prior to 2000

Prior to institution of the Country Strategy Paper (CSP) system in 2000, it is possible to judge EC aims from those of the Tacis National Programme 2000-01: (i) support for institutional, legal, and administrative reform, (ii) support to private sector development, and (iii) development of infrastructure networks.

CSP 2002-06

As a result of limited progress, the first Georgia Country Strategy Paper (CSP 2002-06) adopted on 27 December 2001 re-oriented EC strategy towards the following three priority areas: (i) support for institutional, legal, and administrative reform), (ii) support for addressing the social consequences of transition, and (iii) development of infrastructure. Replacement of private sector development with social consequences of transition was a response to the perceived lack of progress towards improving the life of ordinary Georgians.

The CSP 2002-06 identified poverty reduction as the main goal of cooperation. It aligned itself with the interim Poverty Reduction Strategy Programme published by GoG in late 2000, which in turn identified improvement in conditions in the social

sector (health and education) as a key strategic direction. With regard to health, the goal was given as increasing the share of GDP devoted to health care from 0.9% of GDP in 1999 to 7%, with emphasis given to improving health care financing.

The National Indicative Programme (NIP) 2002-03 associated with CSP 2002-06 identified two actions related to health. The first (Euro 1.3 million) addressed Priority (i) above and consisted of technical assistance to the MoLHSA. Extreme inequality in health care availability was noted, reference was made to the 1999 Health Care Policy adopted by GoG, and the need to coordinate with the World Bank's Health Care 1 soft loan was emphasised. Expected results were an improved legislative and regulatory framework for access to PHC by the poorest strata of society, especially outside Tbilisi. Under Priority (ii), the NIP 2002-03 called for expenditure of Euro 7.5 million to rehabilitate PHC delivery points not covered by other programmes (e.g., World Bank), especially in the most impoverished areas.

Revision and draft CSP 2003-06

In response to continued lack of progress and irregularities in the cooperation programme, including grave security problems, a revision of the country strategy was undertaken in 2002, resulting in the revised CSP 2003-06 (still in draft). The new strategic priorities are (i) promoting rule of law, good governance, and respect for human rights and institutions, (ii) reducing poverty, targeting assistance to the most vulnerable groups, especially in rural areas, and (iii) enhancing stability and security through confidence building measures aiming at the prevention and settlement of internal conflicts and actions in favour of affected populations. This striking change of priorities reflects a high-level judgement that previous approaches in Georgia were not working. In effect, the new draft CSP warns that the lack of policy will on the part of GoG is not going unnoticed and that credible reform steps are crucial. Assistance will only be continued, the CSP seems to say between the lines, if it is coherent with the political situation: "There is evidence that influential forces in Georgia, in and outside the Government, do not adequately support reform. The resolution of internal conflicts also appears as a major condition for sustainable economic and social development." (p. 4).

All of the CSPs reviewed make reference to phenomena such as IDPs, emigration, breakdown of social protection, the poor public health situation, etc. They would benefit, however, from consideration of the broad population theme taken as a whole – depopulation, aging exacerbated by emigration of the young, rising mortality, and sub-replacement fertility as a consequence of high risk and low household income -- as a major contextual variable for development strategy.

Activities related to population / ICPD

ICPD Programme of Action-related components of EC country strategy in Georgia over 1994-2002 consisted of

- Small NGO projects implemented under the TACIS-LIEN programme.
- Targeted social assistance, mainly to the elderly and to disadvantaged children, implemented through the Food Security Programme (FSP),

- ECHO humanitarian emergency assistance to internally displaced persons (IDPs), which included a significant component of financing the rehabilitation and operation of health facilities.

All of these activities were coherent with EC development policies and commitments to ICPD goals. They do not, however, add up to a comprehensive effort to take ICPD into account at the country level. This observation must be placed in the context of the shifts in EC strategy described above and limited engagement with the social sector prior to the present. Moreover, GoG policy itself, while consistent with ICPD, continues to be heavily oriented towards a limited basket of ICPD priorities, namely safe motherhood and mother and child health.

The major emerging area of EC support is Tacis support for health sector reform emphasising access to primary health care for the poor.

This activity, as it moves forward, offers a significant opportunity for the EC to increase the ICPD component of country assistance.

Tacis-LIEN. In the mid-to late 1990s, the Tacis-LIEN programme supported 7-8 small (ca. Euro 100,000 – 300,000) NGO-implemented activities in Georgia with an explicit social focus towards disadvantaged groups. The overall objective was strengthening of civil society, with social reintegration of deprived and marginalized groups the project purpose and improved delivery of social services to target groups one of the anticipated results (see Table 7 at end of Report for the logical framework). One of these projects, implemented by Family Planning Association of Georgia in collaboration with International Planned Parenthood Federation (IPPF), rehabilitated, equipped, and supported the operation of RH/FP clinics in Aspindza and Akhaltsekhe (South Georgia) as well as Tbilisi (a clinic targeted at IDPs). The total amount committed was ca. Euro 200,000.

Following a mid-term evaluation in 2000, the Tacis-LIEN programme was phased out, apparently in large part because of the evaluation's finding that management and administration procedures were inefficient. This must be seen as a disappointment at the country level, as project evaluations in Georgia were generally favourable. Coherence of the projects with EC country strategies and global development goals was not questioned. However,

- coherence with other Tacis projects was limited,
- Tacis-LIEN interventions were small, scattered, and unfocused, raising issues of impact and sustainability, and
- LIEN procedures were judged to be too complicated, with the effect of reducing efficiency.

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EC Food Security Programme (FSP). Starting in 2000, the EC FSP financed a programme to provide (through the MoLHSA) social assistance to targeted members of the elderly population; in addition, institutions caring for children without parents were supported, as were families with many children and disabled persons including

the blind. The establishment of a social safety net for the elderly (see logical framework given as Table 8 at the end of the Report) is consistent with ICPD, with EC development objectives, and with country strategy. As shown in Table 9, social protection financed through FSP is in fact much more significant than the traditional food security activities per se that are implemented by the Ministry of Agriculture.

European Community Humanitarian Office (ECHO). In the early and mid-years of the period covered by this evaluation, ECHO was active across a wide range of activities dealing with alleviating the plight of IDPs, including providing health care which, in turn, included a modest amount of RH/FP and a more significant MCH / Safe Motherhood component. These activities were concentrated mostly in Zugdidi, Samagrelo region. Other regions covered included Abkhazia, South Ossetia, Adjara, Imereti, and Tbilisi. International partners included Medecins sans Frontiers, Feed the Children, International Federation of Red Cross Societies, International Committee for the Red Cross, CARE, Oxfam, WomanAid International, and others; in addition, the World Food Programme was involved. In Zugdidi, emergency assistance in the health area was implemented by Technical Assistance to Georgia (TAG), a local NGO, in collaboration with Save the Children. The Republican hospital in Zugdidi, including the maternity department (which also provides limited RH/FP services through a Women's Cabinet) was renovated, and a polyclinic reserved for IDPs was established. 15 village ambulatories were renovated and provided with drugs; in addition, staff was trained. Most clients benefiting from these facilities are IDPs.

Overall answer to Evaluative Question 2

EC assistance in support of ICPD goals was scattered over the evaluation period. RH/FP projects in the context of Tacis-LIEN focused on strengthening civil society and socializing marginalised groups, not on broad ICPD goals. While internally coherent and coherent with EC policy, these projects did not attain the level of a strategic approach to population, nor does population broadly speaking play a large role in CSPs. ECHO humanitarian assistance in rehabilitating health centres offering RH/FP and safe motherhood services was a major ICPD-related intervention, as was EC FSP-financed targeted social assistance for the elderly. However, both are meant to deal with emergency situations, not to provide long-term strategic support for development. Work on primary health care reform begun during the evaluation period and currently being expanded offers the opportunity for a more coherent approach to ICPD issues.

2.3 Evaluative question 3

Reproductive health: How far have EC supported actions in this field addressed specific objectives related to Chapter 7 of the ICPD and those of Regulation 1484/97?

Health (including primary health and health sector), morbidity, and mortality incl. HIV/AIDS: To what extent have EC supported actions addressed specific objectives related to Chapter 8 of the ICPD and those of Regulation 550/97?

What has been done?

Reproductive health.

Within Tacis-LIEN and ECHO humanitarian support, EC support for ICPD Chapter 7 key actions consisted of

- support for RH/FP through clinic renovation,
- staff training,
- provision of medicines
- provision of information, education, and communication to clinic clients

Through PHC ongoing reform, the EC is supporting

- Improved access to RH/FP
- Putting-in-place of qualified human resources at health facilities
- Increased awareness and demand on RH-related issues among the public

The latter activity is, however, in its very early stages. Moreover, as mentioned above, FP is not incorporated into the Basic Benefit Package that is at the heart of the PHC reform. It would appear that the EC should be more active in urging the GoG, especially as the PHC reform project advances, to take a broader view of ICPD concerns.

Primary health care, safe motherhood, and child survival.

All of the Tacis-LIEN and ECHO activities described above supported a broad and comprehensive range of activities envisaged by Chapter 8 of the ICPD regarding PHC, safe motherhood, and child survival. These include antenatal care, safe delivery, vaccinations, and health care of children under the age of 3. Interviews with MoLHSA officials and document review clearly indicate that these are priority areas and expanded EC support will be forthcoming as the PHC project financed by EC / WB / DFID moves forward.

HIV/AIDS.

The EC has done little in the area of HIV/AIDS. However, the GoG application for $12 million from the Global Fund to Combat AIDS, Tuberculosis and Malaria has recently been approved, presaging a major expansion of activities.

The Tacis-LIEN and ECHO interventions represent small "one-off" projects and emergency assistance, not a broad sectoral intervention. While consistent with broad development goals, GoG policies, and interventions in other areas, they cannot be considered to have made a substantial or sustainable contribution towards ICPD goals. Tacis-LIEN was geared primarily towards strengthening civil society and only secondarily towards vulnerable populations; ECHO interventions were by definition emergency activities not designed to be long-term in nature. Aggregate trends in basic indicators such as maternal mortality were adverse throughout the evaluation period, although project personnel reported improvements on a highly localised level (lower incidence of abortion, more pro-active attitudes towards health, etc.). None of these improvements appear to have been sustainable once project interventions ceased. Sustained improvements in health are unlikely without the recovery of household incomes.

Overall assessment of Evaluative Question 3

In terms of the range of activities supported, the EC programme has been satisfactory. Commitment to ICPD goals requires, however, that the EC seek, through policy dialogue and technical assistance, to broaden Government's approach to emphasis RH/FP in addition to safe motherhood and mother and child health. ECHO interventions in the area of RH/FP have served their immediate goal of humanitarian assistance well, but have not contributed much to a long-term resolution of unmet ICPD needs. Trends in health indices over the evaluation period have been adverse.

2.4 Evaluative question 4

Refugees, internally displaced persons, and distress migration: How far have EC supported actions addressed specific objectives related to the relevant subsections of Chapters 9 and 10 of the ICPD for all countries, and of Regulation 2130/2001 for Asian and Latin American countries?

What has been done?

Through ECHO, the EC supported emergency health care activities related to IDPs as described above. The ICPD activities from Chapters 9 and 10 undertaken have consisted of work to provide

- access to adequate accommodation (through rehabilitation activities, including rehabilitation of infrastructure),
- education;
- health services, including family planning; and other necessary social services.

In view of the fluid political situation, there have been no activities undertaken to promote return or resettlement or to search for durable solutions or address root causes of displacement. Absent a political breakthrough, there appears to be little chance that the situation on the ground will change. A large proportion of IDPs in Georgia have essentially settled in the zone of displacement; in the far west of the country, IDP families move fluidly across the border with the breakaway Abkhazia region. There is an urgent need to forge a durable link between IDPs and general development activities.

The acute humanitarian emergency having passed, ECHO's mandate in Georgia has ended. Some activities have been taken over with new financial resources; however, most have not. For example, in one ECHO-financed clinic visited by the team, a community-based health care finance scheme has resulted in a steady supply of basic medicines. In other clinics visited by the team, the shelves are empty. ECHO activities in favour of IDPs in Georgia assuredly pass the standard tests of relevance, effectiveness, efficiency, impact, and "connectedness" employed by ECHO itself in its evaluations. Whether they were linked to longer term development is to be questioned, however, because the humanitarian situation is frozen in a low-level equilibrium trap – not sufficiently acute to warrant continued ECHO involvement, but not resolved either.

Overall assessment of Evaluative Question 4

The EC has engaged in a broad range of activities related to IDPs in Georgia, including provision of health services that are at the core of ICPD. It has done little in the area of return because of the political situation.

2.5 Evaluative question 5

Population composition (incl. age structure, indigenous populations, and people with disabilities) and distribution (incl. internal migration apart from displaced persons, large urban agglomerations, and international migration apart from migration into Member States): To what extent have EC supported actions addresses specific objectives related to the relevant subsections of Chapters 6, 9, and 10 of the ICPD?

What has been done?

The allocation of EC Food Security Programme (FSP) resources to finance targeted social assistance has had a major impact on the poor elderly and disadvantaged children. The first activity (the "Family Allowance Programme") finances what is, in effect, the only operational widespread social protection safety net in Georgia, and benefits received by the elderly are, in many cases, their main source of monetary income. Monitoring results indicate that the great majority of benefits received are spent on food and medicine.

Specifically, EC FSP funds have been used to

- develop formal and informal old-age support systems, to enhance the self-reliance of elderly people, to put in place social safety nets for the elderly
- to prevent malnutrition among children (a Chapter 4 goal)

Indicators identified range from increase in income of the poorest groups, budget execution details on the payment of social welfare benefits, and nutritional status of institutionalised children. A Food Security Observatory was established at the SDSG and given the task of monitoring aggregate result; programme implementation was monitored by local NGOs.

This programme is highly coherent with the EC's goal of mitigating the social consequences of transition, one of which has been the impoverishment of the elderly and other vulnerable groups due to disintegration of the social safety net. It is also coherent with GoG's stated priority on ensuring food access for the poor. However, there has evidently been no effort to coordinate this programme with the broader social sector reform agenda, particularly health care financing reform and pension reform. As these go forward, the important role of the EC FSP needs to be taken into account.

As discussed above, availability of disaggregated demographic data in Georgia is reasonably good, but there is not much evidence that this data is effectively used in planning, particularly at the macroeconomic level. There is, by contrast, an effort at the MoLHSA to use demographic and epidemiological data in planning.

Overall assessment of Evaluative Question 5

Through the EC FSP, the EC has financed a successful targeted social assistance programme for the elderly (which also benefits certain vulnerable groups of children as well). While this is a stopgap measure, it nonetheless represents an innovative approach to an important ICPD area.

2.6 Evaluative question 6

To what extent has the design of EC supported actions facilitated or not) progress towards the achievement of tangible improvements in the lives of target populations? This includes the choice of beneficiaries (including identifying needs for capacity building and gender), the funding process, the planning process, …

The ECHO, EC FSP, and Tacis-LIEN interventions described above have been relevant to target population needs and made a tangible improvement in their lives. That the target populations were in need is not to be questioned and problems in proper identification of beneficiaries have been adequately dealt with in planning and monitoring. This is not to say that there were not occasional problems or that the Georgian system for identifying the poor is ideal, but only that these problems did not appear to be rife.

One problem with Tacis-LIEN interventions (from the ICPD point of view) is that project design concentrated on very general goals – strengthening civil society and integrating deprived and marginalized groups of improving -- instead of focusing on improving the lives of ordinary women. "Improved delivery of social services to target groups" was stated as a project result, well down the page in the hierarchy of the logical framework.

Two cautionary notes with possible relevance for ongoing activities should be sounded.

- Regarding EC FSP support for the Family Assistance Programme, data reveal (see Table 10 at the end of this Report) that single pensioners living alone, who have been identified as the top-priority recipients of Family Assistance Programme target payments, have the *highest* caloric consumption (probably the best proxy variable for poverty). Large households with children have the lowest median caloric intake and are most at risk for extremely low intake (< 1800 kcal per adult equivalent). These data are annual averages from 2000, so the well being of elderly households might have to do with the fact that they were already receiving FSP-financed social assistance. But the data are based on quarterly monitoring, and even in the first quarter of 2000, before FSP funds were attributed to social protection, single pensioners living alone were doing well, in terms of food consumption, relative to the rest of the population. The Family Assistance Programme now also includes families with many children, but the 2000 data suggest that families with even a few children may also be at a disadvantage. The economic hardships of having children are in large part to blame for the precipitous decline in fertility. To conclude, it should be confirmed, based on a new survey if necessary, that Family Assistance Programme priorities are still valid, and these should be adjusted if necessary.

- Regarding IDPs, while most persons interviewed characterised IDPs as socially vulnerable and deprived, a significant number of IDPs are better off than the populations among whom they have settled. According to the reproductive health survey cited above, the RH situation of IDPs in Georgia does not appear to be any worse than that of the general population. This suggests that the distributional impacts of projects disproportionately benefiting IDPs should be carefully assessed. Dobronogov (2003) in the paper referred to previously, cites research indicating that IDPS account for 25% of all social protection spending in Georgia and 6% of total public spending, the latter of which is over three times state expenditure on health. In view of the large sums involved and the desperate shortage of resources throughout the system, the proper targeting of programmes benefiting IDPS needs to be assured.

To the team's knowledge, it is nowhere made explicit how and why the Kakheti region has been chosen for the new PC initiative. Two reasons mentioned by experts interviewed were ease of implementation (close to Tbilisi) and geographical balance of aid (Western Georgia has received the bulk of assistance). These are valid criteria, but they should be made explicit. Two high-level technical assistance activities are underway to improve targeting and ensure effectiveness: a survey of living conditions and economic activities being undertaken by SDSG with the support of an international consultant, and the second a health facilities and services survey / master plan being undertaken by MoLHSA with international consulting support.

Secondary beneficiaries, in the forms of doctors, nurses, and staff, have benefited from working with the projects. There has been substantial training and capacity building. Note that, in ECHO and Tacis-LIEN supported activities, no salaries were paid.

Overall assessment of Evaluative Question 6

EC-funded projects have led to tangible improvements in the lives of primary beneficiaries and also benefited staff via training, the opportunity to work with good equipment, etc. Some concerns were raised about targeting; these amount to suggestions for improvements rather than broad criticisms. The Tacis-LIEN programme's impact on the lives of ordinary women was limited by the fact that its overall objective was to strengthen civil society – a laudable goal, but one only indirectly tied to ICPD.

2.7 Evaluative question 7

To what extent have implementation set-ups (i.e., suitable structures for planning, implementation, monitoring, and evaluation), management mechanisms / tools and processes facilitated (or not) the achievement of expected impacts?

The context for implementation has been very bad. Georgia is in the throes of a serious social, economic, and political crisis. The household economy has imploded, immiserating all but the well to do. Health indicators, and social indicators more generally, have undergone a spectacular deterioration. The GoG is caught in a vicious circle in which its ability to raise revenues through taxation and social contributions is gravely impaired. As a result, it cannot meet its obligations to the Georgian people, which in turn makes it all the more difficult to collect taxes and re-establish basic social services.

International donors, including the EC, have complained of poor implementation, leading to suspensions and reductions of assistance (which in turn make it more difficult for GoG to honour commitments). Among the problems raised in a candid assessment (p. 17 of the latest draft CSP) are:

- weak implementation of law,
- **insufficient engagement with GoG in policy implications of reform** (i.e., what needs to be done at the policy level),
- **limited policy content of projects**,
- **ineffective conditionality** (failure to reach effective agreement with GoG on key steps to be taken, resulting in excessive attention to project activity targets), and
- **focus on GoG interlocutors to the exclusion of the main representatives of civil society**.

All the points in bold refer to problems inherent in implementation set-ups (including project formulation and planning); the first point refers to the bad contextual situation.

There are some bright spots. All persons interviewed expressed the view that coordination is well established at the policy level (in health reform, for example, through the Primary Health Care Committee of the MoLHSA). There is some coordination at the implementation level, for example, through the monthly coordination meetings held at the Zugdidi Regional Health Centre. NGOs interviewed were well informed of the complementary activities of other NGOs.

However, at the national level, the ideal coordinating institution for international ICPD assistance is the UNFPA, which has been given the mandate in this area. Contacts between EC and UNFPA appear to have been very limited, and should be increased.

Moving forward, it needs to be noted that coordination needs at both the policy level and the implementation level will increase markedly. It has already been noted that the PHC reform project involves three international donors, EC, World Bank, and DFID. At the same time, USAID will be financing a major women's health project. The need for coordination between the social protection components of the EC FSP and broader social insurance reform has been noted.

Regarding partners, a note of caution should be sounded regarding the last point made above. In the health area of ICPD, Tacis-LIEN and ECHO have long worked through NGOs in Georgia, with good results in terms of impacts on target populations but very limited results in terms of sustainability. There are many functions related to health that are by their nature public-sector concerns. Over-utilising NGOs will, in the long run, lead to as many problems as under-utilising them.

One of the basic barriers to implementation in Georgia is the lack of GoG budgetary resources. The EC FSP illustrates some of the difficulties of operating under these circumstances. All persons interviewed agreed that FSP activities were adversely affected by delays in tranche payments. Euro 60 million was allocated between 1996 and 1999, however, only Euro 24 million was actually disbursed. Implementation was interrupted from mid-1999 until the end of 2000 due to (i) poor execution and (ii) difficulties between Georgia and the IMF ("Proposal for a Commission decision on a Financial Allocation in Support of a Food Security Programme for Georgia, AIDCO/261/2001, page 6). The 1998 allocation was simply allowed to lapse: whoever was to blame, loss of a year's potential support under the poverty circumstances prevailing in Georgia is not acceptable. Improved GoG performance allowed the 1999 allocation to be implemented in 2000. A 2001 Memorandum of Understanding was signed in July 2002 to carry the programme forward; this permitted the payment of a Euro 2 million advance in June 2003; in effect, this tranche served to finance expenditure that had already been undertaken in 2002. During the summer of 2003 a request for release of the second tranche of Euro 5 million was made to Brussels and this is expected to be received soon.

In addition to problems (i) and (ii) listed above, there have been difficulties in securing necessary technical assistance for the FSP. Technical Assistants responsible for the FSP left in May 2002 and there has been a delay in recruitment of replacements. A consultant has served as a stopgap measure to oversee implementation of the 2001 programme and prepare a new proposal; recruitment of a regular TA is foreseen for the fall of 2003.

Monitoring of EC project implementation presents a paradox, and the team is hard pressed to reach a conclusion. All local project staff, local and international NGO workers, persons working in monitoring NGOs, and Ministry staff express satisfaction with monitoring. Yet based on donor complaints of widespread corruption and poor performance with respect to conditionality, there is clearly something wrong.

Overall assessment of Evaluative Question 7

Implementation has been poor in Georgia, due to (i) the adverse political situation, (ii) the lack of GoG budgetary resources, (iii) poor project formulation (insufficient policy content, insufficient policy dialogue with government), and (iv) inappropriate implementation set-ups. These problems have led to a sweeping revision in EC strategic policy in Georgia.

2.8 Evaluative question 8

How far has necessary capacity (planning, integrating population into development policy and planning, implementation, monitoring, evaluation, etc.) been created (country level, EC delegations, EC headquarters) to support and facilitate preparation and implementation of population and development strategies and action?

At the level of the Delegation, there is no technical expertise regarding health, population, or social protection; however, project management capacity is in place and high-level international expertise has been obtained where needed. The lack of in-house technical expertise puts the Delegation at a disadvantage with respect to other donors in the ICPD field (such as USAID, perhaps also DFID) in policy dialogue. It should be noted that this problem is not unique to the EC Delegation in Georgia. EC personnel policy appears to favour generalists, rather than technicians. The Delegation appears to rely heavily on international expertise for project formulation.

There is a reasonable amount of GoG expertise for the production of demographic statistics, analyses, and integration into the planning process; however, the team saw little evidence that the demographic situation described above is systematically taken into account in planning. This suggests, inter alia, that EC project formulation and implementation processes have not fully taken advantage of capacity that is available. The MoLHSA appears take epidemiological and medical statistics into account when setting priorities and allocating resources; however, use of basic demographic data for medium- and long-term planning appeared to be non-existent.

Implementation of health-related ICPD activities requires that the necessary physical and human capacity, in the form of health care workers, be in place. The main problem of the Georgian health system is not lack of physical and human capacity, it is (i) overcapacity and consequent inability to properly maintain and equip facilities or pay salaries and, a less serious problem (ii) the wrong kind of capacity (too many specialists, not enough family doctors; too many hospitals, not enough PHC clinics; low quality of existing facilities, i.e. lack of heating and water; etc.). Georgia is still reasonably well endowed with medical facilities, even if those facilities not supported by external donors are in disrepair and lack drugs and equipment. EC assistance, by rehabilitating damaged or decrepit facilities has created new, high-quality physical capacity. But this has not been done in the context of shutting down the old, low-quality facilities, often in the same city. Thus, the paradoxical situation that EC assistance has created capacity and over-capacity at the same time.

While they assuredly need training (for example, in RH/FP), medical staff are competent and, most importantly, still dedicated to the goals of their profession. Tacis-LIEN and ECHO-financed ICPD projects provided training which continues to benefit target populations so long as staff remain in post. Training provided was in badly under- represented areas such as RH/FP and family medicine.

The existence of overcapacity is universally agreed upon, both at the level of the Ministry and at the local level, where hospital staff interviewed admit the existence of redundant facilities and staff. As the PHC project goes forward, one option that could be considered is simply the "buying out" of personnel that should be made redundant under a rationalisation scheme. This would eliminate one of the main barriers to rationalisation of the medical system, namely that salary arrears are so high that it would be prohibitively expensive to cut staff.

Substantial capacity for project design and implementation has been created in the local NGOs with which Tacis-LIEN, EC FSP, and ECHO have worked. The problem is that all of these projects have been short-term, meaning that when project support ceases, trained staff is left looking for another project in which to apply their skills. This results in inefficiency and waste of human capital.

Overall assessment of Evaluative Question 8

The EC has not created technical capacity at the level of the Delegation, but has secured international expertise for project formulation. Within Government, there already exists relatively good technical capacity, but it is under-utilised in the current political climate. Tacis-LIEN and ECHO financed the creation of capacity in the form of rehabilitated health facilities, but also needed is a strategy to get rid of unneeded duplicate facilities. In the case of medical staff, significant needed training took place and continues to benefit target populations. Project management and implementation capacity in NGOs, by contrast, has been inefficiently utilised as projects have been short-term in nature.

2.9 Evaluative question 9

To what extent have cross cutting themes (gender, environment, population and poverty, human rights, etc.) been taken into account during the implementation process and have synergies between the different pillars of population and development been sufficiently exploited?

One of the strong points of the Soviet legacy is the presence of well-trained, senior women in management structures, especially in the health sector.

EC-implemented Tacis-LIEN projects were small, and for the most part simply supplied RH/FP services with little attention to cross-cutting themes. EC assistance has not significantly shifted the traditional approach to ICPD issues within MoLHSA, which continues to reflect strongly the Soviet emphasis on safe motherhood and the health of children. Because of the low priority given to RH/FP, much remains to be done to exploit synergies between mother and child health, safe motherhood, and RH/FP. All women giving birth or receiving abortions at the Republican hospital in Zugdidi receive a consultation in RH/FP, however, it is not clear that the results are very significant.

As demonstrated by a community-based health care finance project carried out in villages in Samagrelo by Oxfam, there are strong synergies between community development and health. The integration of clinics rehabilitated by ECHO into a broader network of community financing demonstrates some attention to these synergies. However, links between the supply side of health care and the ability of households to purchase what is available need to be more clearly made.

Attention to cross-cutting themes is difficult because the political context is not favourable to treating population itself as a broad theme. The hortatory tone of the draft poverty reduction programme document (i.e., the EDPRPG) and its generally low technical quality reflect, in part, the fact that the overall context of a declining, ageing population is not taken into account as a factor cutting across all policy sectors. Links between an aging population, a declining workforce, and a pension system in crisis are not drawn. The poverty implications of radically changing household structure, with many women left alone as men have emigrated, the splitting-up of families due to displacement, etc., are not taken into account.

Overall assessment of Evaluative Question 9

Implementation of EC RH/FP projects paid little attention to cross-cutting themes. ECHO-financed clinics in Western Georgia have been incorporated into a community health care financing scheme, which recognises links between health care supply and the demand side. In general, however, EC assistance related to ICPD has met urgent needs rather than played a role in a long-term strategy. Until this situation changes, it will be difficult to address cross-cutting themes or exploit synergies.

2.10 Evaluative question 10

How sustainable are the effects and impacts of EC-supported policies and programmes in the field of population and development, both at the level of individuals and at the institutional and policy level in the partner countries?

Sustainability must be seriously questioned in Georgia.

Based on its review of activities, the team noted a range of discouraging problems:

- Small Tacis-LIEN projects, while some have managed to survive after the termination of EC support, are not operating effectively due to shortages of resources. When Tacis-LIEN assistance to reproductive health centres ceased, the supply of necessary drugs and equipment instantly dried up. Health facilities that benefited from ECHO assistance are now suffering from lack of supplies and medicines. Facilities participating in an innovative community-health care finance scheme are faring better, but several years will be required before the actuarial viability of this scheme can be established.
- Target populations have very limited resources to meet out-of-pocket payments due to the collapse of the economy. Substantial cost-recovery based on co-payments would appear to be a distant dream in the poorest strata of Georgia.
- Health facilities suffer from non-payment of salaries – so far, many clinic staff have remained on the job for reasons ranging from loyalty to the opportunity to generate informal payments, but this situation cannot persist indefinitely.
- Local NGO staff, once their small project ends, are left looking for another internationally-supported position, and taking with them the expertise and local know-how they have developed.

In the case of ECHO and EC FSP, criticism based on non-sustainability is in a sense unfair because these are supposed to finance emergency interventions, not long-term strategic ones. The EC FSP-supported programme of targeted social assistance, by all accounts a very important, well perceived, and well-executed effort, cannot substitute for broad social insurance / assistance reform. ECHO rehabilitations cannot guarantee the long-term flow of budgetary resources necessary to maintain and supply clinics.

It is not clear that lessons learned and gains made in Tacis-LIEN, ECHO, and EC FSP activities is being systematically taken into account in formulating the health care reform project.

No international donor can possibly finance all health care, all pensions, etc. The GoG must have adequate financial resources to meet its commitments. As a result, ICPD-oriented actions in Georgia, as well as broader social sector interventions, cannot succeed until GoG financial constraints have been eased, which requires an improved political and economic climate.

There is no national population policy and policy in the area of health generally pays insufficient attention to RH/FP. Family planning is not included in the Basic Benefit Package. Apart from supplying ammunition to political commentators, demographic data and projections of trends play little role in the national policy dialogue.

Overall assessment of Evaluative Question 10

Virtually none of the EC interventions in ICPD areas in Georgia appear to be sustainable, i.e., the flow of benefits to primary target populations will not long outlast international support. When international support ceases, clinics and their clients no longer have access to drugs and local non-medical project staff no longer have jobs in which to apply skills gained. Government strategy related to ICPD does not extend beyond the narrow health sector, where the emphasis is on safe motherhood and mother and child health, to the detriment of RH/FP. It is not clear that, in formulating the new health care reform project, ICPD concerns have been given much prominence.

3. OVERALL ASSESSMENT

3.1 Relevance

Despite the difficult circumstances, the EC has undertaken significant activities related to the ICPD Programme of Action in Georgia. In fact, considering the range of areas covered – RH/FP, MCH, emergency health aid to IDPs, social assistance to the elderly and children from disintegrated households – Georgia has implemented a wider range of ICPD-related activities than most countries. However, there has been a lack of integration, as evidenced by the fact that the population theme in all its aspects (depopulation, aging, sub-replacement fertility, etc.) plays no significant role in CSPs.

The Tacis-LIEN, ECHO, and EC-FSP interventions reviewed by the team have clearly been relevant to target populations' needs. Among these are a low level of reproductive health, very low acceptance of modern family planning, and over-reliance of abortion to reduce unwanted fertility. The high level of internal displacement requires that projects and programmes make special efforts to reach out to IDPs, and this has occurred, in large part through ECHO. Impoverishment of the elderly calls for programmes to soften the consequences of transition, and the EC FSP has financed such programmes. Identification of target populations appears, in general, to have been adequately carried out.

Relevance would also require that EC interventions be consistent with government development policy. EC interventions have been highly relevant to GoG sectoral goals and strategies as spelled out in the Georgian National Health Policy. The problem is that this policy itself is embedded in a poverty reduction programme, the EDPRPG, which in its latest draft form consists of a set of social sector activities tacked onto, as UNDP correctly characterised it, a generic structural adjustment plan. The link between social sector interventions and the broader economic growth necessary to finance sustainable social sector development needs to be better made. Broad, cross-cutting aspects of the population theme (population decline, ageing, sub-replacement fertility, out-migration, etc.) are poorly integrated into the EDPRPG. The danger, therefore, is that EC assistance in the ICPD field (especially health-related aspects, as pension reform is better dealt with in the EDPRPG) is concentrating on aspects not really closest to Government's heart.

Overall assessment of relevance

Projects have been relevant to target populations' needs and care has been taken to identify target populations properly. EC activities have also been relevant to the National Health Policy. However, there is no national population policy, population having been not very effectively integrated into CSPs, and there is a mis-match between the operational priority given to the social sector and the traditional growth and reform orientation of the poverty reduction programme. The best way to improve this situation would be to support a comprehensive integration of population into macroeconomic planning and policy making.

3.2 Effectiveness

Effectiveness demands that interventions achieve expected goals. The record is mixed. Tacis-LIEN projects improved delivery of social services to target groups, financing clinics have provided significant RH/FP services, thereby improving FP and reducing the number of abortions; however, these local projects were adrift in a larger project vehicle whose broad goal was to strengthen civil society. ECHO projects were effective in providing desperately needed rehabilitation of health facilities in war-torn zones, as well as in a multitude of other activities, such as rehabilitation, provision of temporary housing, etc. However, broad health indices such as those reviewed in the early pages of this report continued to deteriorate over the period covered by the evaluation. Particularly alarming is the deterioration in the maternal mortality rate, reduction of which is both a Millennium Development Goal and a goal figuring prominently in the Georgian National Health Policy. Failure to include family planning in the Basic Benefit Package of the primary health care reform project will severely limit the ability of this reform to advance ICPD goals.

Monitoring indicates that EC FSP-financed socially targeted payments have substantially benefited the elderly as well as institutionalised children.

Project design and implementation set-ups have, unfortunately, not worked well. Donors including the EC have complained of poor project performance and failure to meet conditionality. One sign of donor frustration with is that donors including the EC are moving away from the GoG towards civil society partners. It is always laudable to include NGOs in development work, and in some areas of ICPD concern (such as advocacy and awareness raising) no one does better work than NGOs. But ultimately social services, social protection, and health care in Georgia are the concerns of the GoG. We have seen, in this evaluation, the limited impact and poor sustainability of multiple small, scattered, short-term NGO interventions, even when each intervention taken individually was successful.

Overall assessment of effectiveness

Individual projects were effective, however, interventions as a whole have not managed to stop deterioration in important aggregate indices. Implementation has not worked well. The significant revision of EC country strategy now in course is designed to improve implementation performance. It is not clear that moving from GoG to NGOs as interlocutors is always going to work.

3.3 Efficiency

Efficiency adds to effectiveness the condition that better results could not have been obtained by expending resources otherwise. In weakened form, it demands that project results were attained at reasonable cost. It has been argued in the Final Report of the Preparation Phase that, as the international community has moved towards a human-rights based approach to population issues, the efficiency criterion has become less relevant. RH/FP, safe motherhood, and mother and child health are everywhere

today regarded as merit goods, and as such goods supply donors may feel free to support regardless of government and, indeed, target populations' priorities.

RH/FP health interventions financed by EC have, in all likelihood been extremely efficient by virtue of the highly adverse RH situation prevailing in Georgia. As we saw in the health review section above, the average woman has 3.7 abortions over her lifetime, at an out of pocket cost of something like GEL 80. The out-of-pocket cost alone, let alone the imputed damages to RH (post-abortion infection, secondary sterility, etc.) would be enough to justify large investments in reproductive health and family planning, including IEC.

The team cannot comment on the more technical aspects of efficiency, i.e. the cost of clinic rehabilitations, etc. It notes that donors have in general been concerned that the ratio of outputs to inputs in Georgia has been low.

Overall assessment of efficiency

The RH/FP and health interventions reviewed were undoubtedly cost efficient in a burdens of disease sense (i.e., producing the most health per euro spent), because reproductive health is at an extremely low level in Georgia and safe motherhood / MCH interventions are widely regarded as cost effective. We cannot comment on cost effectiveness aspects such as value-for-money in rehabilitation work etc, although it is again to be remembered that donors have complained of poor implementation. The most promising avenue for increasing burdens-of-disease efficiency is investment in IEC and advocacy activities to address the fatalistic and suspicious attitude of Georgians toward modern family planning.

3.4 Sustainability

Apart from the fact that trained medical staff have remained in post despite receiving no salaries, there is no evidence that any of the EC interventions reviewed here are sustainable, in the sense of likely to continue delivering benefits after international support is withdrawn. Save in cases where an experimental community health care financing scheme is in place (and several years will be required to establish that this is actuarially viable), clinics supported by EC ran out of medicine and supplies as soon as international assistance ceased.

Sustainability in Georgia essentially means finance, which is unlikely to be forthcoming without economic recovery combined with reform of public finances (including pensions, health, and social assistance). Regarding health aspects of ICPD, the most urgent task in Georgia is neither facility reform nor technical assistance at the ministry level, but rather improving access to care for the poor, i.e. reforming the financing of health care with a special eye on equity problems. Given budgetary constraints, it is likely that the system of out-of-pocket payments will continue, even for access to services in theory covered by the Basic Benefit Package, in the foreseeable future. This risks weakening what should be one of the impacts of a BBP programme, namely reduction in health care disparities between the rich and poor. International expertise has been secured to study these problems, but this will need to

continue well beyond the "fact finding" or "situation analysis" stage. There is a need to examine alternative financing approaches and lessons learned elsewhere, including experiences in the application of BBP approaches and experiences elsewhere in Georgia with community health care financing schemes (which could be looked upon simply as a means of "regularising" out-of-pocket payments while simultaneously strengthening civil society). Moreover, the BBP is not really basic, and needs to be rationalised.

Regarding social safety nets, again, sustainability essentially means finance. EC FSP support for social assistance is not designed to be a long-term programme; it can only serve as a stopgap until pensions have been reformed, medical care has been made affordable, and a real social safety net has been put in place.

Sustainability is also closely linked to the relevance of ICPD interventions to GoG's long-term development strategy. We have commented that, while the social sector is given top operational priority in the EDPRPG, the strategic thrust of the plan is towards economic growth, structural adjustment, and institutional reform, not the social sector. There is no national population policy and population is not effectively incorporated, as a broad theme, in EC country strategy.

Overall assessment of sustainability

It is unlikely that any of the interventions reviewed can be sustained by GoG, or by beneficiaries out of their own pockets, following the end of international assistance. Sustainability is not possible until there is economic recovery, including significant increases in household incomes, combined with reform of pensions, health, and social assistance financing. In the meantime, the potential for sustainability will be greatest if projects focus on financing mechanisms (with special attention to equity and access). The Basic Benefit Package as currently defined does not appear to be consistent with sustainability and should be re-examined. More generally, the EDPRPG should not be seen as an end-point of a policy dialogue and technical assistance process: it leaves much to be desired and should continue to evolve. Policy dialogue and, where necessary, technical assistance related to incorporating population planning into economic planning would have large pay offs.

3.5 Impact

The Tacis-LIEN and ECHO-financed ICPD interventions reviewed here had clear impacts on target populations. Local project staff cited improvements in indicators such as prevalence of family planning and number of abortions performed. These projects have assisted the GoG, at the local level, to achieve goals figuring in the National Health Policy (such as improved access to RH/FP). At the local level, and so long as the focus is on strict project goals, these interventions have been effective.

However, from a broad development perspective, the impact of the ICPD health interventions reviewed has been miniscule compared to the scale of the problems being faced and these interventions have not had durable, sustainable positive impacts. Such impacts have been impossible given small project size, short project duration, the lack of budgetary resources on the part of GoG and the seeming inability of policy makers to deliver sustained economic recovery benefiting households and communities. A large part of this problem must be blamed on the political situation. Needs are enormous and cover the entire range – improved housing, rehabilitation of agricultural holdings, and above all, income and employment generation. Addressing ICPD concerns cannot uplift entire communities, which is what is really needed in the current crisis situation.

Some bright spots can be identified, but these are far removed from ICPD. EC FSP financed rural development projects (repair of irrigation schemes, for example) that were not reviewed by the team are anecdotally reported to have had broad community impacts. The same is true for ECHO-financed community development and capacity-building projects (a fish processing plant, bee keeping, etc.) that generated resources subsequently spent by beneficiary communities on, for example, repairing a school and building a water mill for maize milling.

Size and impact are related, as mentioned above. The EC FSP-financed social assistance targeted at the elderly and at orphans had enormous impacts on the lives of these groups, which had been identified by the GoG as among the most vulnerable. Given the size-impact relationship, it is to be hoped that the new PHC reform programme will have a very substantial impact. For this to happen, we have argued, difficult questions regarding the financing of health care and equitable access will need to be addressed.

Overall assessment of impact

Project impacts have been positive for immediate beneficiaries but miniscule compared to the scale of overall national needs. With the exception of the EC FSP-supported social assistance payments to the elderly, the interventions reviewed were too small, scattered, and uncoordinated to lead to substantial development impacts.

3.6 Internal / external coherence

EC-supported ICPD projects in Georgia have been coherent with EC development policy as set forth in relevant regulations and with ICPD as a whole. The EC supported a broad (nearly comprehensive) range of ICPD activities related to RH/FP, MCH, IDPs (with the exception of return), and strengthening of social safety nets for the elderly. However, interventions reviewed were scattered, small in size, planned and executed under crisis situations, implemented under the umbrella of projects whose concerns were far from ICPD (i.e., Tacis-LIEN), etc. A mid-term review noted a lack of coherence between individual projects and the rest of Tacis. Impressive as individual project effectiveness may have been, and impressive as were the impacts designed by EC FSP socially targeted assistance, these do not add up to a comprehensive ICPD programme. As RH/FP, safe motherhood, and other core concerns of the ICPD are taken on board to the primary health care reform project, this will change. The absence of family planning from the Basic Benefit Package is, however, a source of concern.

GoG population policy goals do not extend much beyond basic health goals set forth in the National Health Plan, with which EC support to ICPD activities has been coherent. An interesting situation will arise as pension reform and primary health care reform go forward. How will consistency between the existing social safety net, which operates largely with EC assistance, and these longer-term reforms be ensured? It has already been seen that a substantial proportion of targeted assistance to the elderly, which is designed to serve the goal of ensuring food security, is used to purchase medicine.

The most recent draft CSP for Georgia mentions a number of the important aspects of population, but does not succeed in tying these together as a broad theme that runs through many aspects of development strategy, from the labour market through public health through pensions and social safety nets, etc. Links between population and the economic sector are not brought into clear focus.

A good step in this direction would be to establish closer links with UNFPA in Tbilisi, which already has experience of working with USAID. Coordination needs will be demanding as the new EC /World Bank DFID primary health care reform project goes forward (keeping in mind that USAID is also starting large activities in this field and the EC FSP is heavily involved in financing the social safety net for the elderly).

Overall assessment of coherence

The interventions reviewed have been coherent with EC development policy and with ICPD goals. However, coherence with GoG policy is difficult to achieve because GoG population policy does not extend beyond the narrow health sphere. EC country strategy as set forth in CSPs does not contain an internally or externally coherent population approach incorporating the range of concerns (worsening mortality, sub-replacement fertility, low-level reproductive and maternal health, IDPs, population ageing, etc.).

4. RECOMMENDATIONS

Georgia is an exceptionally difficult country to work in because of the collapse of the economy and political turmoil. However, even under these discouraging circumstances, some practical steps may be taken to improve the integration of population into the EC's programme and, through this integration, to improve the EC's poverty reduction efforts. Our overall assessment gives rise, however, to a number of more general recommendations that deserve to be highlighted.

Country-ownership is vital if the poverty reduction strategy is to work, but so is a long-term holistic vision of the development process, which has been lacking in Georgia. The absence of a broad view on the relationship between population and labour markets and unemployment, between demographic trends and social insurance and safety net needs, and more generally on the importance of demographic indicators for planning, makes it important for donors such as the EC to encourage better integration of population into the national poverty reduction strategy. At a minimum, the incorporation of population projections into resource and budgetary planning could be insisted upon in policy dialogue.

The EC should attempt in its policy dialogue to ensure that the new primary health care orientation delivers a pro-poor impact. One key specific recommendation – that family planning be included in the Basic Benefit Package – has been mentioned several times in the text above. Given the prevalence of mis-information about family planning, the payoff to advocacy measures towards family planning should be high. A good modality for examining these RH issues could be a roundtable convened to examine the deterioration in maternal mortality taking place in Georgia.

The emerging focus on AIDS should be encouraged. Georgia appears to have a chance to avoid an epidemic of the sort that is nascent in Russia; however, the window for interventions to stem the epidemic does not remain open for long and indicators measuring the epidemic remain deceptively reassuring long after it has taken hold.

Ideally, technical resource constraints at the EC Delegation should be solved by putting in place an expert in health and the social sector. Barring this, training for existing staff is an option. Capacity constraints increase the importance of EC coordination with other donors in the population and health areas. A natural partner in population is UNFPA, which has been given the mandate for taking on the lead on international ICPD commitments.

The EC should encourage long-term social insurance reform as a replacement to stopgap measures such as the EC FSP-supported targeted social payments system. This appears to be underway.

Table 6 : Total EU grants to Georgia 1992-2000

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Humanitarian Aid:									
ECHO		11.77	17.81	27.47	10.17	5.80	3.96	3.00	3.25[2]
				41.00'	21.55				
FEOGA		6.00							
Exceptional Humanitarian Aid								4.00	
Aid against effects of Russian Crisis									
Food Security Programme (FSP)					18.00	16.00		12.00	
Tacis National Allocations	9.00	4.00	4.00	6.00	8.00	8.00	8.00	8.00	15.0[3]
Rehabilitation in Conflict Zones						8.50	1.50	2.50	
Exceptional financial assistance[4]							10.00	9.00	
CFSP Assistance to Border Guards									1.00
Total	**9.00**	**21.77**	**21.81**	**74.47**	**57.72**	**38.30**	**23.46**	**38.50**	**10.1**

[2] Including € 1.65 million in 2000-2001 to mitigate the effect of the drought.

[3] Allocation 2000-2001.

[4] Conditional on progress on macro economic reform.

The following allocations should be added:

1. Tacis 2002-2003: € 14 million
2. FSP 2002-2003: € 25 million
3. ECHO 2002: € 0.7 million
4. EIDHR 2002: € 1.9 million

Grand total 1992-2002: € 342.88 million

Source: http://europa.eu.int/comm/external_relations/georgia/intro/#5

Table 7: Logical Framework - Tacis-LIEN

OVERALL OBJECTIVE
Civil society strengthened

PROJECT PURPOSE
- Social integration of deprived and marginalized groups, and disadvantaged women

ANTICIPATED RESULTS
- Strengthened NGO capacity in the social sector - Partner organisations rendered capable of managing their own projects - Improved delivery of social services to target groups - Strengthened social links of NGOs within Tacis countries

Source: Table 2, "Mid-term Evaluation of Tacis-LIEN Programme," ITAD Ltd., May 2000.

Table 8 : Logical Framework - Social protection components, EC Food Security Programme

OVERALL OBJECTIVE
Improve sustainable access to food

SPECIFIC OBJECTIVES
- Enhance transparent financial management at Ministries supported by FSP - Improve monitoring of the food security situation in Georgia - Improve immediate food security situation for the most vulnerable - Establish an effective social welfare system - Payment of selected social welfare benefits with no arrears - Improve acute food security and living conditions of orphans - Improve management capacity of children's institutions both on ministerial and institutional level

ANTICIPATED RESULTS
- Effective line ministries supported by FSP - Efficient line ministries supported by FSP - Increase effective demand for food products in vulnerable households - In crease of daily caloric intake of orphans - Increase of sanitary facilities fore orphans - Increase of heated accommodation for orphans

Source: "Proposal for a Commission Decision for a Financial Allocation in Support of a Food Security Programme for Georgia," D(2001) AIDCO/261/2001.

Table 9: EC Food Security Programme, 2001 targeted EC budget (corresponding to 1999 allocation)

	Planned	Actual 2002*
Ministry of Education	2,249	1,947
Ministry of Agriculture	5,119	1,120
Ministry of Labour, Health, and Social Affairs	4,566	3,763
State Statistics Department	66	60

Source: Progress Report on Implementation of the 2001 Food Security Programme
* At approximate 2002 exchange rate of Euro 1 = GEL 2

Table 10: Caloric intake, by household structure, 2000

	Median caloric intake	< 2100 kcal / day (%)	< 1800 kcal/day (%)
Couple without children	3345	15	8
Couple with children	2366	41	27
Extended household with no children	2607	32	19
Extended household with children	2227	45	32
Single adult or pensioner with children	2603	32	18
Single adult or pensioner with children	3807	15	9
Single pensioner	4015	13	8
Single adult and pensioner	3179	20	14

Source: Food Security Situation Bulletin, April 2001 (publisjhed as Annex 6 of "Proposal for a Commission Decision for a Financial Allocation in Support of a Food Security Programme for Georgia," AIDCO/261/2001.

Annex 1: Chronology and list of Persons Interviewed

The consultants began their round of interviews on Tuesday, 29.07.03 and concentrated during the first few days on obtaining information from Ministry officials, NGO representatives, representatives of other international organizations, locally-based researchers, and EC Delegation staff in Tbilisi. On Monday 04.08 the team travelled to Aspindza in South Georgia, where it paid a site visit to a reproductive health cabinet supported by Tacis-LIEN in collaboration with the Family Planning Association of Georgia. On Wednesday 06.08, the team travelled to Zugdidi, in West Georgia on the border of the breakaway Abkhazia region, where it visited health facilities renovated by Technical Assistance Georgia (TAG) with financial support from the European Community Humanitarian Office. Thursday-Friday 07.08 – 08.08 were divided between further Tbilisi interviews and preparation of an aide-memoire submitted to the Delegation. A de-briefing was held at the Delegation on 08.08 and the international consultant departed on the morning of 09.08.

Date and approximate time	**Persons interviewed**
Friday, 25.07 (Brussels)	
09:30-11:30	M. Pierre-Andre Borgoltz, Principal Administrator Eastern Europe, Caucasus, and Central Asian Republics DG Relex
16:00-17:00	Mme. Ellen Pederson Eastern Europe, Caucasus, and Central Asian Republics Private Sector EuropeAid
17:00-18:00	Mme. Mandeed Bains Desk Officer Food Security Programme
Tuesday, 29.07 (Tbilisi)	
11:00-1:00	Co-ordination meeting, international and national expert.
16:00-16:30	Mme. Adriana Longoni Head, Operations Sector EC Delegation, Tbilisi

17:00-18:00	M. Alain Mouchiroud Country Director UNFPA Mme. Tamar Khomasuridze National Programme Officer UNFPA
Wednesday, 30.07	
10:00-11:00	M. Emmanuel Anquetil Political Officer OSCE (EC Delegation Programme Officer, ECHO, 1993-97)
11:00-12:00	M. Nodar Jibladze Senior Monitor Tacis and Balkans / CARDS Monitoring Programme
14:00-15:00	Mme. Colette Selman Project Manager EC Delegation
17:00-18:00	M. George Tsuladze National Statistical Office (seconded from Georgian Academy of Sciences)
Thursday, 31.07	
10:00-11:00	Mme. Keti Getiashvili Programme Manager Oxfam
11:30-12:30	M. George Tsuladze National Statistical Office (seconded from Georgian Academy of Sciences)
13:00-14:00	Lunch with Oxfam and various representatives of local NGOs in Tbilisi for training
14:00-15:00	M. Luka Heitzman Coordinator International Committee for Red Cross

16:00-16:30	M. Thomas Legge Task Manager European Initiative for Democracy and Human Rights EC Delegation
16:30-17:30	Mme. Mariana Fotaki EC expert for preparation of Khaketi PHC Master Plan Dr. Dineke Venekamp EC expert for preparation of Khaketi PHC Master Plan
Friday, 01.08	
10:00-11:00	Mme. Nona Ivanova Director Technical Assistance for Georgia (TAG) Dr. Irakli Pruidze Health Programmes Manager TAG
11:30-13:00	Mme. Indira Amiranashvili Deputy Chief of Party Save the Children
13:30-14:30	Mme. Manoni Khachidze Deputy Minister (social affairs) Ministry of Health, Labour, and Social Affairs
15:00-17:30	Participation in Primary Health Care project discussion meeting, Ministry of Health
Saturday, 02.08	Document review Mme. Maria Menabde Former EC FSP Officer
11:00-15:30	Document review
16:30-18:30	Mme. Maria Menabde Former EC FSP Officer

Sunday, 03.08	
12:30-14:30	M. Pierre Auffret EC Expert, PHC reform
15:00-18:00	Document review
Monday, 04.08 (Field visit to Aspidza)	
10:00-13:00	Dr. Levan Chalhudze Obstetrician / Gynecologist Reproductive health cabinet financed by Tacis-LIEN Dr. Natali Janashvili Obstetrician / Gynacologist Reproductive health cabinet financed by Tacis-LIEN
Tuesday, 05.08	
10:00-13:00	Mme. Manoni Khachidze Deputy Minister (social affairs) Ministry of Health, Labour, and Social Affairs M. George Chokhonelidze President Institute of Social Justice (local NGO responsible for monitoring Family Assistance Programme of FSP) M. Zaza Sikharulidze President Union of Good Children (local NGO responsible for monitoring Family Assistance Programme of FSP) M. Anzor Totadze Head Demography Department Ministry of Health, Labour, and Social Affairs
13:30-14:30	M. Geno Malazonia Deputy Minister (responsible for orpah support component of FSP) Ministry of Education

	M. Kakha Khaindrava Head Division of Economy, Information and Prognosis Ministry of Education M. Merab Sanikidze Head Department of Education for Pre- and Secondary School Education and Children's Rights Defense Ministry of Education
15:00-16:00	Dr. Niko Nutsubidze Head Policy Making Department (includes MCH) Ministry of Health, Labour, and Social Affairs
Wednesday, 06.08 (field visit to Zugdidi)	
10:00-11:00	Dr. Roland Athalia Head Surgery department (renovated by TAG with ECHO financing) Republican Hospital
11:00-12:00	Dr. Lira Achamia Head, Health Department of Samagrelo region (MoLHSA official responsible for region)
12:00-13:00	Dr. Ala Grasova Head Maternity and Reproductive Health Department (renovated by TAG with ECHO financing) Republican Hospital
13:00-14:00	Head doctor and staff Ingui ambulatory (renovated by TAG with ECHO financing)
14:00-15:00	Mme. Madelena Gozuwa Programme Assistant Grass Roots Supporting Centre (local partner of Oxfam in Community Health Care Finance scheme)

15:00-16:00	Dr. Nana Kikaleishvili Head Doctor Achalisopeli ambulatory (part of Community Health Care Finance scheme)
Thursday, 07.08	
10:00-11:00	M. Zurab Sosselia First Deputy Minister of Finance M. Vasiko Gigolashvili Deputy Minister of Finance M. Ioseb Skhirtladze Head External Public Debt Department Ministry of Finance
12:00-13:30	Dr. Gegi Mataradze Project Management Specialist, Health USAID
Friday, 08.07	
09:30	Representative UNHCR
15:00	De-briefing, EC Delegation

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THEMATIC EVALUATION OF POPULATION AND DEVELOPMENT ORIENTED PROGRAMMES IN EC EXTERNAL CO-OPERATION

COUNTRY REPORT FOR GUATEMALA

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January 2004

For the

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CONTENTS

Tables and figures

ANNEXES

1. INTRODUCTION

1.1 Background to the mission

On 29 November, 2001 the Board of EuropeAid requested the European Commission's Evaluation Unit to undertake an evaluation of the population theme in EC external assistance over the period 1994-2002 in order to "… verify the logic and consistency of individual actions with the stated objectives and expected impacts."

This evaluation represents the first-ever global assessment of the theme "Population and Development in EC external cooperation programmes." The objective of this evaluation is to provide the Commission with an independent expertise to assess the nature and evolution of its objectives and policies on population and development in external cooperation programmes, and the evolution and volume of the programmes concerned; and to assess its relevance, effectiveness, efficiency, sustainability and impact, and internal/external coherence.

Population is a multi-dimensional concept at the EC, and this evaluation is similarly intended to take a broad view of population and development. The template adopted is the International Conference on Population and Development (ICPD) Programme of Action, spanning the entire field of demography, from reproductive health (including sexually transmitted infections and HIV/AIDS) and family planning through age- and spatial distribution of populations, urbanisation, international and internal migration (including refugees, internally displaced persons, and asylum seekers), disabled persons, population data collection and analysis, and policy making. Information, education, and communication (IEC) activities and activities aimed at gender equality and equity are an equally important component.

The EC plays a significant role in international population assistance, providing approximately 5-10% of global support for the **ICPD goals** focusing on six areas:

- Maintaining and increasing the gains already made in providing access to sexual and reproductive health services.
- Ensuring that women have the opportunity of safe pregnancy and childbirth.
- Promoting the sexual and reproductive health of young people.
- Limiting the spread of HIV/AIDS and caring for those who live with the virus.
- Addressing problems of gender-based violence and sexual abuse, especially of young women and children.
- Building partnerships with civil society.

The EC is also a major source of humanitarian assistance to refugees and displaced persons, a significant amount of which overlaps with population (e.g. reproductive health of displaced populations, resettlement and repatriation programmes, etc.).

The **legal bases** for population assistance for the period covered by this evaluation (1994-2002), which contain the relevant policy objectives, are:

- For reproductive health and family planning: the 1992 Council Communication on Family Planning and the 1997 Council Regulation 1484/97 on aid for population policies and programmes in developing countries.
- For sexually transmitted diseases, HIV and AIDS : the 1994 Communication on Health COM(94)78, Council Regulation 550/97 on HIV/AIDS-related operations, the Communication on Accelerated Action Targeted at Major Communicable Diseases Within the Context of Poverty Reduction (COM (2000) 585).
- For distress migration, internally displaced people and refugees : Council Regulation 1257/96 concerning humanitarian aid, Council Regulation 2258/96 covering rehabilitation and reconstruction operations, and Council Regulation 2130(2001) on operations to aid uprooted people in Asia and Latin America. While the Regulation covers only ALA, it can be construed as expressing EC policy broadly speaking in other regions of the world.

Almost all budget lines and the EDF have been found to finance population-related activities. This evaluation is therefore not limited to any particular financial instrument. The overall objective of this evaluation was to achieve improved coherence and application of the Commission's approach to Population and Development in partner countries through improved decision-making and project management. The evaluation was to be implemented through provision of independent expertise to assess the nature of policies and objectives related to population in external cooperation programmes, the evolution and volume of programmes concerned, and their relevance, effectiveness, efficiency, sustainability, impact, and internal / external coherence. The focus was on a verification/testing of the logic and consistency of EC-funded actions with the stated objectives and expected results.

The evaluation concentrated on the period 1994-2002. It took into consideration, however, issues which were of more recent vintage such as the emerging importance of Sector Wide Approaches (SWAPs). The evaluation covered the Commission’s actions in the field of Population and Development in Asia and the Pacific, Latin America, the Caribbean, Africa (including the Mediterranean area), the Balkans, the Commonwealth of Independent States, and the non-accession countries in Central and Eastern Europe.

The **thematic scope** of the evaluation was bound by the following considerations:

- Gender aspects of Population and Development should be discussed with reference to the on-going EC evaluation in this area. Work in the ongoing Rehabilitation evaluation was also to be taken into account.
- Health aspects took into account findings already developed by the EC evaluation in this area, putting these results/conclusions in perspective and updating them as indicated. The evaluation team were complementing, not repeating, work undertaken by the recent HIV/AIDS evaluation.
- The analysis of international migration was limited to migratory movements between countries and within countries and was to include displaced persons / uprooted people. Migration from partner countries to Europe was not covered in the analysis.
- Only limited attention was given to population, development and education; however, the work on education and communication of DG EAC was taken into account.

Co-ordination, coherence, and complementarity with other key international actors in Population and Development were a key focus of the analysis, as were co-ordination, complementarity and coherence with NGOs.

Field visits

A major component of the Completion Phase of the evaluation consisted of five country field visits to: **Egypt, Georgia, Guatemala, India and Kenya**. The purpose of the country visits was to test and verify the logic and consistency of project and programme actions against stated objectives and anticipated impacts. Through consideration of Evaluative Questions, the evaluation team has assessed the relevance, effectiveness, and coherence of EC Population and Development strategy(ies) and programmes.

Each mission was carried out by a senior international consultant, who collaborated with a national expert recruited in advance of the mission. The duration of each country mission was approximately 10 days plus two days mission preparation and four days report drafting. Approximately five days were dedicated to meeting different stakeholders, in the EC delegation, in partner organisations (line Ministries, NGOs, bilateral donors, etc.) and national actors involved in population issues. Donors (multilateral and bilateral) as well as major NGOs involved in population were also interviewed for bench-marking of EC approach to population. A mixture of participatory techniques, including face-to-face interviews and focus group discussions were used. Approximately five days were dedicated to an assessment of selected programmes or projects. Techniques included interviews and focus groups with beneficiaries, local implementers and other key stakeholders.

1.2 Why Guatemala?

1.2.1 Introduction

Guatemala is the largest EU aid recipient in Central America. Much of the social sector assistance provided by the EC has focused on problems of indigenous populations and persons uprooted by the civil war. Half the population at the national level, and up to 80% in some regions, consists of indigenous people, who suffer racial, social, economic, and cultural discrimination. 70% of them live in very poor conditions and indigenous populations consistently score at the bottom on all social measures. Guatemala has received substantial assistance from ECHO to aid victims of the conflict and victims of natural catastrophes such as Hurricane Mitch. Issues of population and the environment and urbanisation are prominent in Guatemala: 60% of the population lives in the rural zone, crowding into ecologically unstable mountainous areas in the centre of the country. Half the urban population lives in the capital city. An interesting aspect of Guatemala is that, like other Central American states, it offers an opportunity to study EU policy dialogue with a country that has traditionally been critical of the international population policy agenda.

1.2.2 Country profile: demographic situation and population policy priorities

With a population of 11.6 million, Guatemala is an independent republic, located at the south border of Mexico, at the most western point of the Central American Isthmus.

TABLE 1: SOCIO-DEMOGRAPHIC PROFILE: GUATEMALA

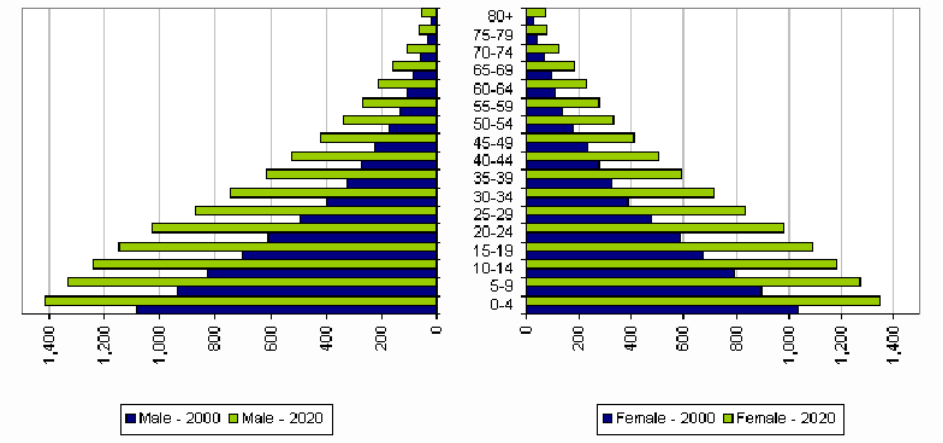
POPULATION	
Mid-year Total Population 1998 (millions):	11.6
Mid-year Total Population 2025 (millions):	19.8
Annual Growth Rate (%):	3.1
Urban Population (%):	38
FERTILITY AND CONTRACEPTION	
Crude birth rate (births per 1,000 of a population in a given year):	38
Total Fertility Rate (Sum of the age-specific fertility rates in a given year):	5.1
Women aged 15-19 giving live births each year (%):	13
Women aged 15-49 using contraception (all methods) (%):	31
Women aged 15-49 using contraception (modern methods) (%):	27

MORTALITY	
Crude Death Rate (deaths per 1,000 of a population in a given year):	7
Average Life expectancy in years (men):	63
Average Life expectancy in years (women):	68
Infant Mortality Rate (Number of deaths to infants under one year of age per 1,000 live births in a given year):	43
Maternal Mortality Rate (Number of deaths to women due to pregnancy or childbearing complications per 100,000 live births in a given year):	200
HEALTH	
Access to Services (%):	36
Access to safe water (%):	77
Population per doctor:	4000
EDUCATION AND EMPLOYMENT	
Rate of Employment (%):	34
Literacy Rate (men) (%):	63
Literacy Rate (women) (%):	49
Workforce (men) (%):	82
Workforce (women) (%):	18

Source: International Planned Parenthood Federation (IPPF)

With a slightly female predominance, and a wide base of the population under the age of five (figure 1), the demographic composition of Guatemala had traditionally exhibited rapid growth and high fertility rates.

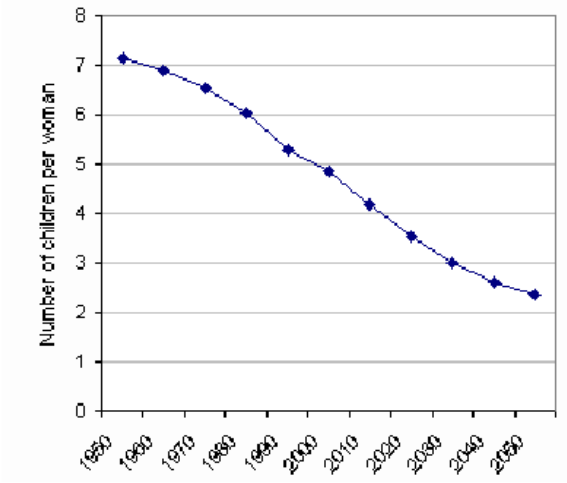
Figure 1: Current and Projected Population by Age and Sex (in thousands)



Source: USAID. *Country Health Statistical Report for Guatemala* (March 2003)

This is now gradually changing, due to a reduction in fertility rates (figure 2) and increases in prevalence of use of contraceptive methods.

Figure 2: Estimated Total Fertility Rate per Woman



Source: USAID. *Country Health Statistical Report for Guatemala* (March 2003)

The projected figures for the year 2020 indicate changes in the shape of the demographic pyramid, with an increase in population in the age to work. In the year 2020, the population between the ages of 10 and 29 will represent 42% of the total population.

The economically active population is about 4.9 million, with a 3:1 gender ratio in favour of men. Most of this population resides in rural areas (60%), and about 44% are self-identified as indigenous.

GDP per capita is US$ PPP 3,770 (World Bank, 2000), which classifies Guatemala as a medium-low income country in the World Bank ranking. But this aggregated figure does not reveal the impact of income inequalities. Living conditions are particularly precarious for the indigenous and rural populations.

The initial Peace Accords, which included the Government's main commitments in the social policy sphere, were to end in 2000. However, having failed to produce all the expected outcomes, the Accords were extended by a few years.

About one million people became internally displaced or fled the country during the military conflicts. In addition to war-induced population displacements, other forms of migratory movements have affected Guatemala during the period of reference for this evaluation. These included:

- Crops driven temporarily migration, from the highlands to the fertile coast.
- Rural-urban permanent migration, formerly directed exclusively at Guatemala City, and now increasingly involving secondary cities too.
- Transit migration, i.e. transit of migrants from Southern continental countries to the USA, involving the temporary stay of migrants in Guatemala's major cities and border cities to work for short periods of time.
- Emigration of nationals to other countries, most notably the USA, across Mexico.

Mobile populations are core groups for HIV/AIDS transmission. Recent studies provided evidence of higher rates of incidence at cities along the route connecting the south and the northern borders. The HIV/AIDS epidemic in Guatemala has been growing rapidly, and forecasts about the future spread of the infection are even more alarming. Whilst according to national averages the epidemic is categorised as being concentrated[1] in certain parts of the country, recent surveys suggest that HIV-positive cases are expanding from higher risk to lower-risk groups, and is thus becoming a generalised epidemic.

The problems related to a fast growing population, high poverty rates, lack of education and a long-term drought process and environmental degradation in rural areas, have been conducive to a major food security problem. In the most vulnerable municipalities, an increasing number of cases of deaths by hunger, involving both children and the elderly, have been evidenced.

Public policy on Population and Development during the second half of the 1990s has emphasised maternal and child health, in particular the delivery of a package of basic services through health coverage extension programmes. This policy was pursued by the new government administration in 2000-2003.

The reproductive rights of the population have not formed part of public health policy, although this area has received significant support from USAID, through public health facilities, NGOs such as APROFAM (Association for Family Well-Being) and the IGSS (the Social Security Institute of Guatemala).

Table 2: Guatemala's Human Development Index

Life expectancy at birth (years), 2001	65.3
Adult literacy rate (% age 15 and above), 2001	69.2
Combined primary, secondary and tertiary gross enrolment ratio (%), 2000/01	57 1
GDP per capita (PPP US$), 2001	4,400
Life expectancy index, 2001	0.67
Education index, 2001	0.65
GDP index, 2001	0.63
Human development index (HDI) value, 2001	0.652
GDP per capita (PPP US$) rank minus HDI rank	-22

Source: UNDP - Human Development Indicators 2003

[1] The epidemic is "concentrated" when sero-prevalence is higher than 5% in high-risk groups and lower than 1% in pregnant women; it is "generalised" when sero-prevalence is higher than 5% in high-risk groups and also higher than 1% in pregnant women.

Throughout the 1990s, the government, under the influence of the Church, had been reluctant to promote a policy of reduction in population growth. This has gradually changed under the new government, which has been in office since 2000. The Law on Social Development (2001), as well as the Policy on Social Development and Population (2002), have provided an exhaustive package of policy priorities and components, and have designated appropriate executing agencies, to promote a range of population and development themes. These changes have owed significantly to the efforts of the members of the health and family matters commission of the National Congress.

As the table below indicates, during the period of reference for this evaluation, the EC has been Guatemala's most important donor in grants.

Table 3: Main sources of development aid to Guatemala in 1996-2001 by donor	**US$ million**
European Commission	28.0
Norway	16.0
United States of America	15.0
Sweden	12.5
Spain	12.0
Netherlands	10.0
Austria	9.3
United Kingdom	9.0
Canada	8.0
Italy	5.1
France	4.0
Switzerland	3.5
Belgium	2.0
TOTAL	140.4

Source: COINDE (Development Institutions Council)

1.3 Summary of the mission

The mission was carried out by Mr. Solon Ardittis, senior international consultant based in Brussels, and Mr. Ricardo Valladares, national consultant based in Guatemala City, between the 19th and 30th of July 2003.

The evaluation was carried out at two levels. At national level, the team worked with staff from the EC Delegation, national government agencies, international organisations and NGOs.

At project level, the team focused on three main projects:

- The APRESAL project ("Proyecto de Apoyo a la Reforma del Sector Salud"), a five-year, 11 Meuro project, which aimed to improve the quality and reach of public health delivery services in the region of Alta Verapaz, as well as to increase the capacity of water and sanitation services in that region.
- The project on "Productive reincorporation of demobilized people of the URNG (Chimaltenango)", which was supported by the EC in 1997-1999, and which aimed to assist returning URNG combatants in their socio-economic reintegration.
- The project on "Prevention of STD/HIV/AIDS for adolescents and woman in precarious areas of Guatemala City", which was managed by Médecins sans Frontières between 1997 and 1999, and which aimed to produce self-learning guides, organise workshops for local medical staff, and run public awareness activities, in two metropolitan townships of Guatemala City, Milagro and El Mezquital, and in the country's second largest city, Quetzaltenango.

The project selection was conducted on the basis of a close review of a range of projects supported by the EC during the second half of the 1990s, As Annex 3 indicates, between 1994 and 2001 some 42 projects were supported by the EC in the population and development sector, for a total financial allocation of almost MEUR 72. Of these projects, 9 were in the health sector, 23 in the humanitarian assistance sector, 4 in the ICPD core areas and 6 in ICPD-related areas.

The approach to the evaluation involved a review of relevant literature (i.e. financing documents and project evaluation reports, where available, and the Guatemala Country Strategy Paper and National Indicative Programme); interviews with AidCo and Relex desk officers; the EC Delegation; key central government agencies (Ministry of Health, National Planning and Programming Secretariat of the Presidency – SEGEPLAN, and the central government agency responsible for the Peace Accords – SEPAZ); international organisations (UNFPA, UNAIDS, PAHO-WHO and IOM); and NGOs (Médecins sans Frontières, Movimondo, CARE and the Fundación Guillermo Toriello).

A detailed chronology of the mission and list of persons interviewed is given as Annex 1 of this Country Report.

1.4 Constraints

The first constraint faced by these evaluators has consisted of the violent street riots, which unfolded in Guatemala City during the mission and which, for two days, paralysed every activity in the city. The riots were aimed at, and were eventually successful in, forcing the constitutional court to overturn a supreme court ban on the presidential candidacy of General Efrain Rios Montt, who ruled Guatemala in the early 1980s following a military coup. For two days during the riots, the EC Delegation as well as all government and private offices were closed, which meant that many of the meetings planned had to be cancelled. It was subsequently agreed, however, that these meetings would be re-scheduled after the original completion

date of the mission but would be attended, only, by the national expert. All the originally planned meetings have thus taken place and have enabled the evaluators to collect all the necessary material for their evaluation.

The second constraint has consisted, occasionally, of some mismatches between project information (including database information) held at the Commission in Brussels and at the EU Delegation respectively, and therefore of some difficulties in identifying the appropriate project implementers or project reference details for EC activities of relevance to this evaluation.

Despite the above limitations, due mention should be made of the outstanding cooperation received from the EC Delegation at every stage of the mission. The evaluators are thus particularly indebted to Mr. Daniel Garcia, and Mr. Philippe Combestot, for their time and support in making this mission possible.

2. EVALUATIVE QUESTIONS

2.1 Evaluative Question 1

Since 1995, what has the European Commission put in place, in terms of global policies, strategies, and programmes (Cotonou agreement, TACIS, MEDA, ...) to operationalise its engagements with the ICPD Plan of Action and ICPD+5?

To what extent are the EC policies, strategies and programmes coherent with ICPD?

This Evaluative Question is being answered via Brussels-based interviews, document analysis, etc. The Preparatory Phase concluded that the EC's population policy focus had shifted from concern with rapid population growth as a deterrent to economic development to concern with the right to adequate sexual and reproductive health. In addition to its focus on women, the EC has actively targeted adolescents. This evolving population policy has been *externally coherent* with shifts in the stance of other policy institutions. Moreover, the *internal coherence* of EC population policy has improved over time. There is little sign from policy documents, however, that the EC has sought to exploit synergies with other areas of EC assistance (apart from health and support to refugees / internally displaced persons). Nor has there been adequate consideration of strategic linkages between population policy and policies in other areas.

In view of needs in poor countries and the scarcity of resources, the *relevance* of EC population assistance appears to be assured. The Preparatory Phase did not reach a judgment on whether EC assistance has been *effective* in pursuing policy goals. The validity of the *efficiency* criterion is diminishing with the move towards a human-rights based approach. However, as poor reproductive and sexual health affect considerably vulnerable groups, and as the unit costs of most interventions are low, the EC's population activities may be very efficient means of addressing inequities. The Preparatory Phase also could not reach a conclusion regarding *sustainability*; however, it is widely known that available international financing falls far short of needs and governments are reluctant to commit resources.

The evaluation team has found that the Commission's record-keeping and accounting systems for population projects have been over-stretched as a result of the multiplication of sectors, budget lines, and directorates, as well no doubt as by rapid staff turnover. The team noted that steps are underway in Brussels to unify databases.

More generally, the Preparatory Phase of this evaluation found that there were opportunities for the EC to enhance its impact in the population field and, by exploiting synergies with other sectors, to bolster the relevance and effectiveness of its overall development approaches.

2.2 Evaluative Question 2

To what extent did EC third country co-operation strategies (especially CSPs, NIPs, etc.) reflect an overall population and development sector approach, and respond to the needs of the Cairo Action Plan?

At the level of countries: Were country strategies internally coherent from the standpoint of population and were these population components coherent with the global development policy of the EU?

With a population of 11.6 million and a GDP per capita of approximately US$ 1,700 in 2001, Guatemala is the largest economy in Central America and accounts for about a third of the regional GDP (21.5 billion US$ in 2001). Poverty affects more than half of the population, almost 25% of which lives in extreme poverty.

Since 1984, Guatemala has formed part of the inter-ministerial San José Dialogue between the Central America countries and the European Union and, with an average of EUR 30 million per annum since 1990, it has been one of the most important beneficiaries of EC aid in Central America. The EC is currently Guatemala's most important multilateral donor in grants.

Originally, most of the EC-supported activities had concentrated on Financial and Technical assistance, uprooted people and food aid and security. At the beginning of the 1990's, priority was shifted towards integrated rural development programmes in the poorest regions of the country with a high concentration of indigenous communities. This was followed by the adoption of a sectoral approach, in favour of such areas as education and health.

The current framework for economic and development co-operation activities is the 1993 Regional Development Co-operation Framework Agreement between the six Central American countries and the Commission. This Agreement only came into effect in 1999, following its ratification by all parties. The agreement covers a broad range of sectors and foresees the establishment of a Joint Committee to oversee its implementation, as well as sub-committees for detailed examination of specific sectors of the Agreement.

Since 1997, co-operation with Guatemala has aimed to provide political and financial support for the implementation of the Peace Accords, particularly as regards: the demobilisation and rehabilitation of former guerrilla and armed forces; the improvement of the citizens' security through the establishment and development of a civil police force; the strengthening of the judicial system; and the provision of legal protection to property ownership through the creation of a national land register.

The national Government's plan for 2000-2004 is also set out in the framework of the Peace Agreements, which have been declared a "state policy" by the current President. The main aims of the national plan are poverty alleviation; the re-activation

of the economy; the improvement of access to basic services; the consolidation of the democratic system; the decentralisation process; and the strengthening of the rule of law.

A Country Strategy Paper for co-operation with Guatemala during 2002-2006 was adopted by the Commission in May 2002. The implementation of the Peace Accords remains the pivotal element and pre-condition for this strategy, which includes the following focal co-operation sectors:

- Good governance, consolidation of the rule of law and protection of human rights.
- Local development based on participation, inclusion and equity.
- Equitable economic growth and job creation.

The Country Strategy Paper for Guatemala also follows the guidelines adopted in the "Joint Declaration of the Council of Ministers and the European Commission on the EU development policy in Guatemala", of November 2000. This Joint Declaration foresaw that EU aid and cooperation should concentrate on measures likely to reduce poverty. Cooperation should aim, in particular, to strengthen the inter-linkages between trade and development; to support regional integration and cooperation; and to support macroeconomic policies and equality of access to social services, transport, food security and rural development, and good governance.

The indicative financial resources for Guatemala under the two main EC budget lines for Latin America (Financial and Technical co-operation; and Economic Co-operation) are €93 million for the period 2000-2006.

The CSP for Guatemala has foreseen the following three main cooperation axes:

1. Consolidation and modernisation of the State, democratisation and human rights.
2. Local development and decentralisation.
3. Equitable and sustainable development of the economy and employment.

These are supplemented by three main "Cross-cutting priorities":

1. Equal opportunities.
2. Environmental protection and management and fight against vulnerability.
3. Regional integration.

Actions of primary relevance to the Evaluation of Population and Development programmes are to be found in the so-called "Complementary actions", which refer, in particular, to:

- Actions related to HIV/AIDS; and
- Actions related to the prevention of conflicts.

The CSP indicates that priorities within each of these complementary actions "will need to be defined on the basis of the strategic directions outlined in the CSP". The coherence between the different actions could also be reinforced through the adoption of a list of "geographic priorities", as defined in the CSP's Cooperation Axis 2 on "Local development and decentralisation".

At the level of Guatemala's own national development strategy, and due to the strong influence that had traditionally been exerted by the Church, the government authorities in office had largely ignored population components during most of the period of reference for this Evaluation. Only under the present government, elected at the end of 1999, was the first ever Law on Social Development drafted and approved, in October 2001. The Law aims to support increased public interventions in the field of: reproductive health and the prevention of HIV/AIDS; education in population and development affairs (including the development of relevant curricula, the establishment of a Master's in Population and Development at the University of San Carlos de Guatemala, and public support for research in relevant P&D subject areas); employment and migration; the prevention of natural disasters; and the implementation of public information campaigns to promote the objectives of the Law on Social Development, with particular emphasis on aspects addressing issues of gender and multiculturalism.

According to the National Planning and Programming Secretariat of the Presidency (SEGEPLAN), the government has not been implementing the Cairo Action Plan in any systematic way. A recent evaluation by UNFPA further indicated that, whilst Guatemala was generating a wealth of statistics of relevance to population and development affairs, there was still limited capacity to process such statistics in a policy formation perspective.

Overall answer to Evaluative Question 2:

During most of the period of reference for this evaluation, the EC's co-operation strategy in Guatemala did not reflect an overall population and development sector approach, nor did it respond to the needs of the Cairo Action in any noteworthy manner. This is due to the mostly emergency and food aid-related nature of EC interventions during the armed conflicts, and to the reluctance of the GoG to engage in P&D activities after the armed conflicts. However, under the current government, which has been in office since 2000, the first ever Law on Social Development has been enacted, which aims to support, inter alia, increased public interventions in the field of reproductive health and the prevention of HIV/AIDS, education in population and development affairs, and employment and migration. Subject to the results of the presidential elections in November 2003, Guatemala's national strategy in the field of P&D appears likely to gain increased coherency with the needs of the Cairo Action Plan and the population components of the EU's global development policy.

2.3 Evaluative Question 3

Reproductive health: How far have EC supported actions in this field addressed specific objectives related to Chapter 7 of the ICPD and those of Regulation 1484/97?

Health (including primary health and health sector), morbidity, and mortality incl. HIV/AIDS: To what extent have EC supported actions addressed specific objectives related to Chapter 8 of the ICPD and those of Regulation 550/97?

As in other Latin American countries, Guatemala's health sector has been undergoing a major reform process as from the mid-1990s. The main aim of this process has consisted of extending the coverage of services to those who had always lacked access to health care, i.e. about 45% of the total population. The last few years have thus been devoted to increasing coverage by an estimated 35% of the total population. The strategy consisted of an alliance between government, through the Ministry of Health and Social Assistance, and NGOs, whereby the Ministry was responsible for the establishment of regulations and the provision of funds, and NGOs were entrusted with the training of personnel and the development of appropriate infrastructure. NGOs were offered to act as services providers (i.e. through direct delivery of health care) or as administrative organisations (i.e. through management of the national government funds for coverage extension).

During the period of reference for this evaluation, there have been three main streams of international donor funds in support of the health reform process in Guatemala. First, a loan of US$38.5 million, from the Inter-American Development Bank, through a programme specifically designed to address the reform agenda. Second, activities conducted by the US Agency for International Development, the most important bilateral donor in Guatemala, who, in coordination with IADB and the Ministry of Health and Social Assistance, integrated its two main programme activities - one on Maternal and Neo-Natal Health, and one on Income and Food Security - into the overall national efforts on health sector reform. And third, the European Commission, who provided extensive funds for a project in support of the health reform process – the so-called APRESAL project ("Apoyo a la Reforma del Sector Salud") which, until 2001, supported a range of integrated activities related to training, the provision of equipment and the development of sanitary infrastructure in less resourced regions of Guatemala.

Despite what has often been described as too vertical, supply-led, a model of health reform, the above process has proved effective in extending the ability of NGOs to deliver health services at community level. Reportedly, the main limitations faced by this process have included the poor information system related to the provision of new health services at community level; the lack of criteria and instruments to monitor and supervise activities implemented by the new services providers; and the

insufficiently stringent criteria for selecting the implementing NGOs, due to the relatively limited number of such organisations in Guatemala.

Despite the above constraints, the European Commission has been effective in the field of health, and particularly on reproductive health, in a number of ways.

Firstly, through the APRESAL project, the EC carried out a considerable number of activities to improve infrastructure (health centres, water and sanitation) as well as a significant number of activities in the area of training. Even though the contribution of the project to the health reform process appears to be questionable, APRESAL contributed actively to increasing the health status of part of the population.

Other smaller EC projects have had a more focused geographic emphasis on areas with high fertility and mortality rates, particularly in Alta and Baja Verapaz. National survey data show that these interventions have had a positive effect on the reduction of fertility, maternal and child mortality rates in these areas.

Together with other donor agencies, such as UNFPA, UNICEF, MINUGUA and CARE, the EC was also instrumental in the generation and publication, in 2003, of the first ever baseline data on maternal mortality in Guatemala. Prior to this exercise, data was being collected in a mostly unreliable manner, and under-registration of maternal mortality had reached about 45% due to poor levels of detail of post-mortem information. Since the baseline data was produced, there have been better incentives to trace and document maternal mortality cases.

In addition, by providing a more reliable instrument to measure and track the evolution of this social indicator, the production of baseline data on maternal mortality has responded directly to the objective included in the Peace Accords of a reduction in maternal mortality. The Peace Accords had set as a target a reduction of 50% in maternal mortality over the five-year duration of the Accords.

Due to the fact that this drastic reduction could not be achieved within the period set by the Accord (i.e. in 1995, the maternal mortality rate was 190/100,000; in 2000, it was estimated to be 153/100,000), emphasis was then placed on the generation of process indicators enabling the measurement of the level of access to, and the quality of interventions. Consequently, through the EC-funded APRESAL project, the European Commission was instrumental in the production of the National Survey of Maternal and Child Mortality in 2002. By including, inter alia, such variables as access to care during pregnancy and during delivery, this Survey contributed significantly to documenting the process through which maternal mortality had been decreasing since the baseline point.

In addition to the APRESAL project, EC support for reproductive health and family planning has been channelled through major NGOs, and through projects at a regional level, such as the “Maternal Health Project” and the “Support for productive health in Alta and Baja Verapaz” projects. Both of these projects were implemented by CARE, an NGO which has been contributing to social development activities in Guatemala for the last forty years and which, through a framework agreement with the Government, has gained an important role in the delivery of services aimed at the strengthening of local capacities in a range of sectors such as health, food, education,

environment, sustainable agriculture, small credits and the reinforcement of a democratic culture. With a staff of over 320 assigned to ten local offices, three regional offices and the national headquarters, CARE Guatemala is supported by a range of financial contributions from GoG, the European Union and official assistance to development (ODA) from the governments of Austria, Japan, the Netherlands, the United Kingdom and USA.

In the field of HIV/AIDS, EC support appears to have been minimal: only one project, in 1997, on "prevention of STD/AIDS for adolescent and women in precarious areas of Guatemala City", was directly supported by the European Commission. The project, which was implemented by Médecins sans Frontières, ran in two metropolitan townships of Guatemala City, Milagro and El Mezquital, and in the country's second largest city, Quetzaltenango. For schools and health care centres in Coatepeque (located in Quetzaltenango) and Guatemala City, the MSF team produced self-learning guides, organised workshops for local medical staff, and run public awareness activities.

The guides were produced with the participation of local NGOs, such as OASIS (Sexuality and AIDS Organization) and AGPCS (Guatemalan Association for AIDS Control and Prevention), which also participated in workshops with teachers and adolescents, and health staff training.

The project's approach was innovative in 1997, introducing peer-to-peer education as a strategy for prevention among adolescents. The self-learning guides helped to develop, within a vulnerable group awakening to reproductive life, capacities to protect themselves and to inform others about risks and safety measures to avoid HIV infection.

The selected sites for project implementation were also noteworthy. Mezquital and Milagro are two shantytowns in Guatemala City, where sentinel studies have reported high prevalence of HIV in commercial sex workers (4.7% in 1998). Coatepeque is a coastal city of the Department of Quetzaltenango, which ranks second in number of reported cases of AIDS.

However, according to staff who participated in the project implementation as members of local NGOs, and who were interviewed in the course of this evaluation, the self-learning guides have not produced the range of expected results. Multiplier effects were poor and the school staff failed to integrate the STD/AIDS information into their programmes after completion of the project. Sustainability has indeed been a major deficiency of the project, not to mention the fact that there was no institutional memory of this project at the MSF headquarters or within any relevant national government agency. Although students obviously form a volatile group, the schools did not succeed in maintaining an appropriate flow of information, education and communication when the project came to an end.

MSF, however, is well positioned in Guatemala as an international NGO with experience in HIV/AIDS prevention and care. At Roosevelt Hospital in Guatemala City, MSF has begun antiretroviral treatment for 70 AIDS patients and currently treats opportunistic infections for about 400 people. In Coatepeque, in the Quetzaltenango area, MSF supports the "Proyecto Vida" treatment centre, running

external consultations and donating drugs to 250 AIDS patients. In Hospicio San Jose, outside Guatemala City, MSF is in charge of treating and caring for AIDS patients. The team offers consultations as well as antiretroviral treatment for children and adults. A similar programme at Hospicio Marco Antonio in Guatemala City ended in late 2000. MSF is also active in basic health, community health staff training, water and sanitation, and daily care centres for marginalised children and adolescents. It has also helped with health responses to emergency situations, caused by both disasters and epidemic outbreaks.

Overall answer to Evaluative Question 3:

Through the APRESAL project, the EC carried out a considerable number of activities to improve infrastructure (health centres, water and sanitation) as well as a significant number of activities in the area of training. Even though the contribution of the project to the health reform process appears to be questionable, APRESAL contributed actively to increasing the health status of part of the population, and therefore addressed specific objectives related to Chapter 7 of the ICPD and those of Regulation 1484/97. Together with other donor agencies, the EC was also instrumental in the production of the first ever baseline data on maternal mortality in Guatemala. In the field of HIV/AIDS, however, EC support appears to have been minimal.

2.4 Evaluative Question 4

Refugees, IDPs, and distress migration: How far have EC supported actions addressed specific objectives related to the relevant subsections of Chapters 9 and 10 of the ICPD for all countries, and of Regulation 2130/2001 for Asian and Latin American countries?

Major population displacements occurred in the early 1980s when indigenous populations in the areas of Petén, Quiché and Huehuetenango were targeted by military operations. Many people were killed and about one million people became internally displaced or fled the country. At least 80,000 were given asylum in Mexico alone.

In 1997, the US Committee for Refugees reported that there were still 250,000 internally displaced people in Guatemala. The Inter-American Commission on Human Rights (IACHR) reported in mid-2002 that thousands of displaced persons still required access to basic services such as education and health care. Often, they were not incorporated into formal resettlement efforts, were marginalised from resident populations and lived under extremely poor conditions.

Of the seven Peace Accords issued between 1994 and 1996, one was concerned exclusively with "the Resettlement of Up-rooted Populations after the Armed Conflict". The text of this Accord foresaw, in particular, that "the resettlement of up-rooted populations should be a dynamic factor in the social, cultural and economic development of the country, and thus an important contributing factor to the long-lasting nature of the peace process". Two institutions were created to implement the Accords: a technical commission to supervise resettlement projects (CTEAR) and a consultative assembly of the displaced people (ACPD).

Many displaced persons living in cities lack adequate housing and are squatting abandoned buildings. The creation of durable housing solutions and a long-term rural development plan, benefiting those people uprooted during the conflict, remain priority challenges for the government.

Another problem which faced the displaced populations was the loss or destruction of personal identification documents during the conflict. In the absence of such documentation, returnees are unable to conduct basic transactions, vote or access social services. In 1997, a special law easing documentation procedures for displaced persons and other vulnerable people was enacted for a three-year period.

The EC supported significantly every stage of the international and internally displaced people resettlement process, through such programme activities as: a) voluntary *repatriation* of Refugees in Mexico (1996); b) *coordination* of activities of refugees (1997-1999); c) personal *documentation* of returned and other uprooted people (1997-1999); d) *development projects* for populations displaced by violence in specific settlements of Quiché and Alta Verapaz (1994, 1996-1999); and e) support to the *reintegration* of refugees, including access to land; education; productive projects;

loans; gender activities; and infrastructure (2000-2003). This last project on reintegration is on-going under the co-direction scheme, with SEPAZ (National Fund for Peace) as the national counterpart.

Another of the Peace Accords, signed at the end of 1996, related to the "Basis for the incorporation of URNG (*Unidad Revolucionaria Nacional Guatemalteca)* combatants into legality". The text of this Accord defined incorporation as "the process through which the members of the URNG will integrate into political, economic, social and cultural life, in a spirit of dignity and safety, through the granting of civil liberties, and through the full exercise of their rights and duties as citizens".

The EC developed a comprehensive mid-term programme to accompany the URNG reintegration process. This included: a) *support for the demobilisation* process (1996), including a major study on the socio-economic profile of the ex-combatants, emergency support for camps, and assistance with personal documentation; b) *support to war invalids* (demobilised members of URNG and Army); c) *productive reinsertion of URNG* members (1997-1999); d) *rehabilitation of war disabled* (1997-1999); and e) support for the *permanent reincorporation* of URNG members (ending on 2003).

One project that was selected for more detailed examination by these evaluators was the "29 de Diciembre" settlement for demobilised URNG ex-combatants[2]. This settlement is located at 13km from Chimaltenango and pertains to the municipality of Zaragoza. One hundred houses were built, with public housing funds. Efforts to resettle these combatants involved various organisations, from public sector and co-operation agencies. The EC project, on "Productive reincorporation of demobilised people of the URNG", was implemented in 1997-99 with a budget of 1.2 Meuro.

As other projects related to the ex-combatants, this EC project was overseen by the "Fundación Guillermo Toriello", which was established as a civil society organisation representing the interests of demobilised people and assisting in their reincorporation process. The Spanish NGO "Solidaridad Internacional" was also an implementing agency of this project.

The EC's support focused on the economically productive components of the re-incorporation process. This included feasibility studies for productive projects, basic supplies and equipment, technical assistance and training. The productive projects were chosen, on an individual basis, by the beneficiaries and approved in compliance with the skills identified in the socio-economic diagnosis, which was conducted by the EC when these groups were still residing in a temporary settlement at Los Aposentos, Chimaltenango.

The productive projects comprised a wide range of economic activities: brick building, carpentry, stores, restaurants, transportation, pharmacies, bakeries, tailor

[2] It is important to note that this evaluation has not covered the regional budget line on "Support to Displaced Persons in Central America", which is managed by the EC Regional Coordination Office in El Salvador.

shops. Most of these projects were run on an individual basis. Only the bricks factory and the carpentry were established as collective projects.

Regrettably, however, these productive projects failed to establish a sustainable source of income for the beneficiary households. Only the stores, the pharmacy and the tailors were still in operation when the settlement was visited by these evaluators, four years after the project's completion.

According to the "29 de Diciembre" committee, who was interviewed in the course of this evaluation, the ex-combatants' lack of experience as producers and traders, as well as the temptation to spend the funds on more basic and immediate needs, considerably eroded the limited capital funds available for each project (i.e. approximately 500 Euro). According to the Director of the Fundación Guillermo Toriello, the failure of many of the productive projects can also be attributed to other factors. The design of the project appears to have been very rigid, with little flexibility to adapt to a range of difficulties arising in the course of its implementation. Furthermore, the EC financial support was suspended after about 1.5 years, thus limiting the necessary follow-up and technical assistance services needed by the newly-established productive projects.

Whilst the current situation of the ex-combatants having benefited from this project remains fragile, at least 70% of the men, and 30% of the women, have found a job in Chimaltenango, El Tejar or Guatemala City. This was facilitated by the settlement being located near the Panamerican Route, thus enabling easy access to various urban work places.

Overall answer to Evaluative Question 4:

The EC has actively addressed specific objectives related to the relevant sub-sections of Chapters 9 and 10 of the ICPD, and of Regulation 2130/2001 for Asian and Latin American countries. It supported every stage of the international and internally displaced people resettlement process through a range of programme activities, including a mid-term programme to accompany the URNG reintegration process. The EC was less successful, on the other hand, in securing sufficient follow-up activities to some of these projects, with the result that many of the returnees' productive activities supported by the EC have ceased to exist at the end of the EC funding.

2.5 Evaluative Question 5

Population composition (incl. age structure, indigenous populations, and people with disabilities) and distribution (incl. internal migration apart from displaced persons, large urban agglomerations, and international migration apart from migration into Member States): To what extent have EC supported actions addressed specific objectives related to the relevant subsections of Chapters 6, 9 and 10 of the ICPD?

Specific ICPD objectives were addressed directly by the EC-funded APRESAL project, which was targeted predominantly at the indigenous populations in Alta Verapaz. The project developed activities to improve mother and child health and it also supported the extension of health services coverage by financing the construction of new health infrastructure (health centres and posts). In addition, in a country that is still heavily affected by water-related communicable diseases, the project supported activities to improve access to safe water and sanitation.

Alta Verapaz is also one of the regions with the highest maternal mortality rate, and the APRESAL project was able to devote resources for the training of indigenous midwives and health volunteers, with a view to improving the early detection of complications during pregnancy and after delivery, and the referral system and quality of training for the deliveries attention.

The Mother and Child health project implemented by Care UK in Alta and Baja Verapaz was also effective in developing activities to improve the mother and child health indicators, in addition to raising awareness and improving performance in the field of reproductive health and family planning. This project aimed to reduce maternal mortality by improving access to, and the quality of, essential maternal health care for poor rural Mayan families in the Departments of Alta and Baja Verapaz.

The project helped communities and health care providers to identify models and strategies that can improve the detection, referral and quality treatment of obstetric complications. Community members and the Ministry of Health then evaluated these approaches in order to share lessons within the project area and at national level. The project worked with all key actors in the area of maternal health, including the ministry, private sector health providers, non-governmental organisations, women's groups and international organisations. The aim was to ensure that the strategies tested by the project were embodied within the policies and practices of these organisations.

Other than the extensive support of the EC for several returnees and reintegration programmes, issues of internal and international migration have not benefited from any EC support. While Guatemala is affected by relatively high levels of illegal immigration and is further confronted with growing human trafficking/smuggling activity, none of the programme activities implemented by the International organization for Migration (IOM) in Guatemala has been supported by the EC.

UN Convention refugees are not an issue, and the UNHCR has had to close its offices in Guatemala when the number of its staff members started to exceed the number of asylum applicants in the country.

Finally, limited efforts are underway overall, and none supported by the EC, to assess the effects of, and to develop productive ways of channelling, the considerable flows of remittances originating from the over 1.3 million Guatemalans living abroad.

Overall answer to Evaluative Question 5:

The EC has supported actions addressing specific objectives related to the relevant subsections of Chapters 6, 9 and 10 of the ICPD, as regards issues of indigenous populations, and people with disabilities. In particular, specific ICPD objectives were addressed directly by the EC-funded APRESAL project, which was targeted predominantly at the indigenous populations in Alta Verapaz, and which also included a component on people with disabilities. On the other hand, other than the extensive support of the EC for several returnees and reintegration programmes, issues of internal and international migration have not benefited from any EC support.

2.6 Evaluative Question 6

To what extent has the design of EC supported actions facilitated (or not) progress towards the achievement of tangible improvements in the lives of target populations? This includes the choice of beneficiaries (including identifying needs for capacity building and gender), the funding instruments and the planning process.

As was already mentioned in the introductory sections of this report, there have been two key phases in EC cooperation activities in Guatemala over the period of reference for this Evaluation. The first one, covering the period of armed conflicts, was defined by the predominantly emergency and food aid-related nature of EC interventions, which were implemented, mostly, by ECHO. The second phase, as from 1997, witnessed the development of a wider EC cooperation agenda in Guatemala, which was closely inspired by the regional security agenda resulting from the San José Dialogue. The main objective of EC interventions in Guatemala during the second half of the 1990s has thus consisted of accompanying the implementation of the Peace Accords and to support the national plan of action designed by the National Planning and Programming Secretariat of the Presidency (SEGEPLAN) and the National System of Public Investment (SNIP).

EC interventions in the field of population and development have adopted, firstly, a strong geographical focus, by targeting the least well resourced areas of the country, such as Alta Verapaz, Chiquimula, Escuintla and Quiche. The second major focus of EC interventions in the field of population has consisted of placing particular emphasis on prominent risk groups such as demobilised soldiers and former guerillas, as well as the indigenous populations.

The process of project design and funding has followed two different formats. This has included, firstly, the design of projects implemented through the national-EU co-directorship principle and responding directly to national, government priorities. The second type of projects, which entailed limited, if any, involvement of the relevant national government institutions, consisted of support for activities implemented directly and exclusively by NGOs, and targeting the end users/beneficiaries.

An example of the first type of projects has been the APRESAL project ("Proyecto de Apoyo a la Reforma del Sector Salud"), which was selected as a case study for this Thematic Evaluation. The main objective of this five-year, 11 Meuro project, was to: improve the quality of the health care services in Alta Verapaz; improve water supply and sanitation in the same area; guarantee access of the population to basic medicines; and increase the professional level of human resources and develop managerial skills. The project was implemented through Guatemala´s national health system, at the central, regional and local levels, involving all relevant institutional actors and ensuring the continuity of activities after project completion. The public facilities built with the APRESAL project's support are still operating, through a dedicated budget and staff able to deliver health services. The APRESAL project did

not deliver any health care services, but fostered the improvement of human, material and infrastructural capacities of the MoH to extend coverage of such services. However, technical assistance to public health providers, which depended on APRESAL and the Decentralised Technical Cooperation of PAHO, have ceased to exist with the ending of funding from these two agencies. At the time this evaluation was conducted, no additional funding sources had been identified, negotiated or committed.

An example of the second type of project, also selected as a case study for this Evaluation, was the project on "Prevention of STD/HIV/AIDS for adolescents and women in precarious areas of Guatemala City", which was implemented by Medecins Sans Frontieres in 1997-1998. The project was implemented with limited, if any, coordination and liaison with the national government health authorities, with the effect that the institutional memory of the MSF project has proved to be very poor. The Ministry of Health, which had not been involved at any stage of its implementation, had very limited knowledge of the project's objectives and outputs and had not received any of the project's documentation or final report. At the MSF office itself, these evaluators have failed to identify a single staff member who had any recollection of this project. The project's sustainability was particularly limited since, in the absence of any institutional involvement in the course of implementing the project, its activities have not been incorporated into any relevant government programme at the end of the EC funding period.

Despite the above limitations, progress towards the achievement of tangible improvements in the lives of target populations have been clearly evidenced within the framework of the sampled projects.

The APRESAL project has led to the construction or rehabilitation of health centres benefiting 40,000 people; it supported the development of sanitary services in 442 schools; the creation of a water treatment system benefiting 60,000 people; and the establishment of 113 small rural shops offering a range of medicines. It also contributed to the drafting of the national plan on popular and traditional medicine.

The project on "Productive reintegration of demobilised people of the URNG-Chimaltenango" benefited one hundred households through support to productive and commercial initiatives. Support included basic supplies and equipment, technical assistance and training, and a small working capital. The project also targeted disabled people by offering them special training as tailors, and for the establishment of stores and pharmacies. Whilst most of these productive projects have now ceased to exist, many of the project beneficiaries have been successful in obtaining salaried jobs in nearby factories, farms, NGOs and government offices.

Overall answer to Evaluative Question 6:

By adopting a strong geographical focus, targeting the least well resourced areas of the country (Alta Verapaz, Chiquimula, Escuintla and Quiche), and by placing particular emphasis on prominent risk groups such as demobilised soldiers and former guerillas, as well as the indigenous populations, the design of EC supported actions has facilitated progress towards the achievement of tangible improvements in the lives of target populations. The experience in Guatemala shows, however, that projects implemented through the national-EU co-directorship principle and responding directly to national, government priorities have been much more effective and sustainable than those implemented directly and exclusively by NGOs, which have entailed limited, if any, involvement of the relevant national government institutions.

2.7 Evaluative Question 7

To what extent have implementation set-ups (i.e. suitable structures for planning, implementation, monitoring and evaluation), management mechanisms/tools and processes facilitated (or not) the achievement of expected impacts?

According to the findings of the "Global Evaluation of EC aid in Guatemala", conducted by Integration Gmbh in 1996 on behalf of the Commission, the initial period of reference for this Evaluation there had been a high dispersion of projects due to multiple budget lines. As a result, many of the EC-funded projects have only had concrete effects for the duration of the project implementation period, but have not been mainstreamed, nor have they generated any significant multiplier effects. Prior to the adoption of the new Country Strategy Paper, there had also been limited planning and strategy in the definition of EC programme activities in Guatemala.

In 2000, a new coordination body, entitled Mesodialogo, was established among the government of Guatemala, the European Commission, representatives of the EU member states and European NGOs. Mesodialogo was established in response to the need expressed by the European Commission to restructure and decentralise its interventions in Guatemala with a view to adopting a more sectoral, and less project-centred, approach to cooperation. The effectiveness of Mesodialogo in establishing greater synergies among European donors and executing agencies was recognised, inter alia, at the "Conference on EU Projects and Counterparts" which was held in April 2002. The Conference concluded that Mesodialogo had proved to be an effective instrument to define and design new EU cooperation programmes and sectoral strategies. The conference also recommended that Mesodialogo be expanded as a more decentralised body to include, in particular, representatives of all the indigenous organisations at a sub-national level. It was also suggested that Mesodialogo could contribute to the design of some of Guatemala´s national public sectoral policies.

Interviews held in Guatemala suggest, however, that the role of the EC within the donor community's interventions on Health Reform and HIV/AIDS has not been a prominent one, and has largely been overshadowed by activities supported through such agencies as IADB, PAHO and USAID. On the other hand, the EC has proved to be a lead donor agency as regards issues of refugees and displaced persons. In contrast with activities supported by other donor agencies, which were more emergency-centred, the EC was successful in adopting a more structured, long-term vision of the full reintegration cycle of returnees.

Due to the fact that Guatemala is under the responsibility of the EU Delegation in Nicaragua and only has an EU Office in Guatemala City, projects have been monitored, mostly, by AidCo in Brussels and by the EU Delegation in Managua. In addition, projects falling under the Programme for Displaced Populations in Central America have been managed by the EU Regional Coordination Office in El Salvador.

The experience of these evaluators is that the institutional memory and tractability of EC-funded population projects in Guatemala during 1994-2002 are largely perfectible. This can be attributed, in part, to a high staff turnover at both AidCo and the Guatemala EU Office. Some inconsistencies between the projects database held by AidCo in Brussels and that held at the EC Office in Guatemala were also evidenced (i.e. the exact list of projects, and at times the actual titles of projects, differed between AidCo and the EC Office in Guatemala).

Perhaps the most integrated and complex implementation set-up observed during the evaluation term (1994-2002) related to the process of resettlement of displaced persons, refugees and demobilised people of the URNG.

The government established the Secretariat for Peace, in order to ensure that the design and execution of the activities and projects of the Executive Organism were coherent with the government's policies related to the Peace Accords. Two commissions were also created: the CTEAR (Technical Commission for the Execution of the Resettlement Accord) and the CSI (Commission for the Follow-up of Reincorporation). The National Fund for Peace (FONAPAZ) was created as the financial institution responsible for the channelling of public and foreign resources related to the implementation of the Peace Accords.

The target populations too were able to develop appropriate coordination mechanisms: the ACPD represented the up-rooted population communities; and the Fundación Guillermo Toriello represented the interests of the demobilised populations and also served as an implementing agency for several projects directed at these populations.

The EC project activities in this subject area, which have benefited from the co-direction principle of execution, especially as regards the PAREC I and II projects on "Support to the Reintegration of Ex-Combatants", appear to have been mainstreamed into the full reintegration/resettlement policy process.

Overall answer to Evaluative Question 7:

Until the establishment, in 2000, of a new coordination body ("Mesodialogo"), bringing together the Government of Guatemala, the European Commission, representatives of the EU member states and European NGOs, suitable structures for planning and implementing EC interventions had been particularly sub-optimal. In addition, due to the fact that Guatemala is under the responsibility of the EU Delegation in Nicaragua and only has an EU Office in Guatemala City, and due to a high staff turnover at both AidCo and the Guatemala EU Office, the monitoring and evaluation functions of EC interventions in Guatemala have not proved satisfactory.

2.8 Evaluative Question 8

How far has necessary capacity (planning, integrating population into development policy and planning, implementation, monitoring, evaluation, etc.) been created (country level, EC delegations; EC headquarter) to support and facilitate preparation and implementation of population and development strategies and action?

Projects related to reproductive health, family planning and HIV/AIDS, executed under co-financing arrangements with NGOs, have usually relied on the NGOs' capacities to implement the full range of project activities. The experience with this type of projects in Guatemala has been that only limited capacities have been created at the level of the country or the EC Delegation. Monitoring of these projects has usually been conducted through AidCo in Brussels, mainly by tracking scheduled progress and financial transparency. Intermediate and final external evaluations have been implemented through consulting firms contracted by the European Commission. During the country mission to Guatemala, these evaluators have encountered several limitations in obtaining appropriate project documentation or detailed project references. The project teams had changed, the records were incomplete and, overall, there was poor institutional memory of this type of projects. Interviews with relevant government agencies have evidenced the fact that, while projects implemented by NGOs have delivered services directly to the end-beneficiaries, these activities have usually not taken any account of the need to establish or strengthen capacity within local or national institutions.

The co-direction scheme, on the other hand, has proved a much more effective capacity-building instrument. EC projects supported under the co-direction scheme have been established on the basis of formal agreements between the government and the EC Delegation, and have been monitored by both AidCo and the EC Delegation. The national government counterparts have also requested periodic reports on project progress and achievements from the implementation units. During the evaluators' meeting with the Projects Unit at the Ministry of Health, detailed documentation was found, for example, of the APRESAL project, both as regards the project's design and its execution. What is more, projects such as APRESAL, executed under the co-direction scheme, have almost systematically included components to strengthen capacities on policy development and managerial skills at national and local levels.

Signs of change have been observed, however, in the more recent projects, such as the Mother and Child Health Care project implemented at the Verapaces. Interviews at the Reproductive Health Unit of the MoH have documented the fact that this project, implemented by CARE UK, has been closely interacting with the MoH authorities at different organisational levels, and has devoted special efforts to raising the quality of public providers. This has included support for the development of Reproductive Health Standards of Care, and baseline assessments of health care quality of performance. Gaps in performance have also been addressed through training activities for public health staff.

Overall answer to Evaluative Question 8:

EC projects supported under the co-direction scheme, which have been established on the basis of formal agreements between the government and the EC Delegation, have almost systematically included components to strengthen capacities on policy development and managerial skills at national and local levels. Projects implemented directly and exclusively by NGOs have usually not taken any account of the need to establish or strengthen capacity within local or national institutions. As a consequence, their contribution to supporting and facilitating preparation and implementation of population and development strategies and action appears to have been sub-optimal.

2.9 Evaluative Question 9

To what extent have cross cutting themes (gender, environment, population and poverty, human rights, etc.) been taken into account during the implementation process and whether synergies between the different pillars of population and development have been sufficiently exploited?

Available evidence does not testify to any conscious, structured efforts to integrate the above cross-cutting themes into the sampled projects, nor to establish links among projects in order to generate synergies. Some of the components of the projects sampled for this evaluation, however, related directly to many of these cross-cutting themes.

The APRESAL project had a component on water and sanitation, which generated a policy debate on the causes of environmental degradation, the loss of water sources and water contamination. An educational programme arose from that discussion, targeting school children, teachers and headmasters.

The projects on resettlement for people up-rooted by the armed conflict, as well the reintegration programme for ex-URNG combatants, included productive projects, loans and training aimed at increasing the capacities of these communities to fight poverty. However, lack of experience as business owners and market-oriented producers has considerably limited the success and impact of these initiatives.

The MSF activities on HIV/AIDS, including the EC-funded activities, have addressed the realities of increased-risk populations in marginal settlements around Guatemala City. Discrimination and stigma, and the loss of self-esteem, contributed to making commercial sex workers in Guatemala particularly vulnerable. Thus the self-education guides and training workshops directed at these groups have intended to strengthen issues of empowerment, self-organisation and awareness of existing rights. These activities, however, have been considerably hindered by the lack of support from the public authorities: prostitutes continue to be chased by the police, and activists in NGOs (including the MSF collaborating organisations) who have been denouncing such abuses from the police have been regularly intimidated through menacing phone calls or illegal detention.

Overall answer to Evaluative Question 9:

While there does not appear to have been any deliberate effort to integrate cross-cutting themes into the sampled EC interventions, some of the components of the projects examined by these evaluators related directly to some of these themes. This included the component of the APRESAL project on water and sanitation, which generated a policy debate on the causes of environmental degradation, the loss of water sources and water contamination. Projects on resettlement and HIV/AIDS, by their very nature, also addressed cross-cutting themes such as poverty and human rights.

2.10 Evaluative Question 10

How sustainable are the effects and impacts of EC-supported policies and programmes in the field of population and development, both at the level of individuals and at institutional and policy level in the partner countries?

At policy and programme levels, during the period of reference for this evaluation, EC co-operation with Guatemala has consisted, first, of providing emergency and food aid, and, as from 1997, of supporting the implementation of the Peace Accords. Whilst in the current CSP for 2002-2006 population and development affairs are only explicitly referred to in the "Complementary actions" of the CSP, discussions with the EC Delegation and relevant central government entities suggest that most policy concerns related to P&D will be addressed under the general cooperation axis related to "Decentralisation". In that respect, future EC interventions in Guatemala will give extensive priority to the implementation of the National Policy on Social Development and Population, which resulted from the 2001 Law on Social Development. According to the National Planning and Programming Secretariat of the Presidency (SEGEPLAN), the lead government agency for the drafting of the National Policy on Social Development and Population, the EC and UNFPA have not only been instrumental in the formation of this policy, they have also expressed increased support and cooperation for its adequate implementation.

The results of the next general elections in November 2003 will also be a major determinant in the nature and extent of future EU, and international, cooperation activity in Guatemala. The violent street riots which unfolded in Guatemala City during this Evaluation mission, which were aimed at, and which succeeded in, forcing the constitutional court to overturn a supreme court ban on the candidacy of General Efrain Rios Montt, who ruled Guatemala in the early 1980s following a military coup, have generated significant concern among foreign donors. Following these events, both the EC Delegation in Guatemala and major non-EU bilateral donor such as the US government, have issued statements indicating that cooperation would be seriously affected in the event of General Rios Montt's election.

At project level, three types of occurrences have been identified with regard to sustainability:

a) *Projects with limited impact and sustainability.* The MSF project on HIV/AIDS, in addition to its short duration and narrow geographical focus, did not establish any links with public institutions, nor did it create new capacities within local institutional agencies. The NGOs collaborating with the project did not pursue their activities after termination of EC funding, nor did the target schools integrate the MSF educational programmes into their regular curricula.

b) *Projects with adequate impact but questionable sustainability.* The project on "Productive Reintegration of Demobilised people of the URNG" provided essential support for the resettlement of this community, and addressed its immediate needs. However, productive projects were not supported by sufficient business training and follow-up commercial counselling activities. Many of the residents in the "29 de Diciembre" community still believe that their productive projects could become effective sources of income if new resources, financial and technical, were to be injected to give such activities a second chance.

c) *Projects with adequate impact and sustainability*. The projects on Health Reform (coverage extension) and Maternal and Child Health were successful in creating new capacities, and sharing responsibilities with local institutions in such a way as to enable project outputs to be pursued and mainstreamed at the end of the EC funding. Two issues limiting the above assertion have included, in the case of the APRESAL project: the loss of continuity in the efforts to link health and environmental problems to respond to health risks in Alta Verapaz; and the lack of follow-up in activities aimed at strengthening the capacities of managerial staff at the MoH's facilities at central and local levels.

Overall, the main lesson drawn by these evaluators with regard to sustainability is that considerable improvements could be generated in P&D programme activities in Guatemala through a proper interaction of the following three processes:

a) The Mesodialogo scheme, which offers an ample and participative forum to coordinate and assign priorities to various cooperation budget lines, should become the only channel through which new EU programmatic decisions are taken. Mesodialogo is now supported through, and is explicitly mentioned in, both the new Law and the new Policy on Social Development and Population.

b) The strengthening of the EC Delegation in Guatemala should be seen as a *sine qua non* to increasing the efficiency and effectiveness of future EC interventions on Population and Development. This includes the capacity of the Delegation to develop effective monitoring and evaluation systems to assess cooperation projects in a multidimensional perspective: as a cooperation agency (i.e. with specific policy commitments to the development of the country); as a technical assistance team (i.e. with staff able to strengthen capacities within local institutional agencies); and as administrative officers (as regards issues of transparency and effectiveness in the use of funds).

c) The decentralisation process, now a key priority in Guatemala's national development policy and in the EC Country Strategy Paper for 2002-2006, implies that an appropriate Population and Development agenda be drawn up and implemented at the level of the local governments and Development Councils. This is a pre-condition for future cooperation initiatives to adapt as closely as possible to the particular local needs of such a diverse and multiethnic country as Guatemala.

Overall answer to Evaluative Question 10:

The answer to this question is not univocal and varies according to the types of EC interventions examined by these evaluators. The MSF project on HIV/AIDS, which did not establish any links with public institutions, and which did not contribute to the creation of new capacities within local institutional agencies, appears to have generated a very limited sustainable impact. The projects on Health Reform (coverage extension) and Maternal and Child Health appear to have been successful in creating new capacities within local institutions in such a way as to enable project outputs to be pursued and mainstreamed at the end of the EC funding. The strengthening of the EC Office in Guatemala, the development of the Mesodialogo forum and the on-going decentralisation process in the planning and execution of EC interventions on P&D are all key determinants in the future improvement of the potential for sustainability of EC-supported policies and programmes in the field of population and development in Guatemala.

3. OVERALL ASSESSMENT

3.1 Relevance

The relevance of EC-supported activities in the field of Population and Development in Guatemala has been evidenced within each and every project examined by these evaluators.

In terms of addressing the relevant priority needs of the relevant target populations, the evaluation has verified, first, that EC interventions had applied a clear bias in favour of some of Guatemala's most prominent risk groups during the period of reference for this evaluation, i.e: demobilised soldiers, former guerrillas, and other internationally/internally displaced people; the indigenous populations; and adolescents in areas of Guatemala City exhibiting the highest rates of HIV prevalence. EC interventions targeted at these groups appear to have addressed some of the most pressing needs of these populations over the period of reference for this evaluation, i.e: the multifarious components of return and reintegration assistance as regards IDPs, refugees and demobilised soldiers; a range of activities, including staff training and the development of infrastructure, to extend coverage of health services in the least resourced areas of Guatemala; and innovative educational and communication material in the field of HIV/AIDS prevention.

In terms of the relevance of EC cooperation vis-à-vis Guatemala's national development goals, the very fact that, since 1997, EC cooperation has aimed to provide political and financial support for the implementation of the Peace Accords, is a valuable indicator of the relevance of EC interventions for priority development goals set by Guatemala, and of the full integration of such interventions into the national programmatic/implementation framework established by the Peace Accords. The uniqueness of the peace process in Guatemala in fact opened new opportunities for accompanying a radical reform agenda that began with the regularisation and reintegration of populations mobilised by, or fleeing, the armed conflict, and which was gradually conducive to the initiation of more integrated population and development initiatives, such as the Law and Policy on Social Development and Population. EC interventions have thus proved relevant along all stages of emergency, resettlement and productive reintegration.

Overall conclusion in relation to Relevance:

EC interventions on Population and Development in Guatemala have exhibited a high degree of relevance by having been directed at prominent risk groups and by having addressed the most pressing needs of these groups. The relevance of EC cooperation vis-à-vis Guatemala's national development goals was also largely evidenced. The fact that EC cooperation has aimed to provide political, financial and programmatic support for the implementation of the Peace Accords has ensured that the EC interventions have been relevant to priority development goals set by GoG.

3.2 Effectiveness

Most projects examined for this evaluation have produced tangible results that were coherent with the projects' design and budget.

The conclusion of these evaluators is that the EC interventions were effective in generating a range of basic outputs, and of intangible results related to policy formation and change whose concrete results will only mature over a longer period of time.

Project interventions being as effective as the local staff committed to implement the resulting changes and reforms, the APRESAL project, in particular, was also effective in investing a considerable range of it activities in staff training, at a local and national level, thus creating and strengthening local capacities to implement further, post-project reforms.

On a more negative front, these evaluators express strong reservations about the MSF project on HIV/AIDS, whose effectiveness is, at best, difficult to establish. Although an assessment of the project's effectiveness would have required measurement of possible changes in knowledge, attitudes and behaviour of the adolescents and women covered by the project, the fact that there does not appear to be any records of the achievements of this project, including in terms of baseline data or a final evaluation report, or in terms of the project's institutional memory within the Ministry of Health, does not generate excessive optimism as to the possible effectiveness, let alone the possible impact and sustainability, of this intervention.

Similarly, the productive components of the EC project on demobilised people do not appear to have been effective in their planning and funding of measures related to the creation of small businesses by the targeted returnees. In addition to the insufficient level of seed capital allocated to each business project, poor managerial training and commercial guidance activities have undoubtedly eroded the overall effectiveness of this project.

Notwithstanding the above assertions, the EC has been effective in integrating its full interventions package into the various Peace Accords established as from the second half of the 1990s. This is despite the fact that, although the EC has been Guatemala's most important donor in grants (cf. Table on major donor contributions in 1996-2001, on page 10 of this report), the experience of these evaluators is that the visibility of the EC's interventions in Guatemala is still considerably overshadowed by interventions supported by other major agencies such as USAID and UNFPA. In addition, a recurrent trend observed in meetings with various government agencies in Guatemala was the natural inclination of interviewees to discuss, when asked about EU interventions on population and development, the role of EU bilateral donor agencies, rather than that of the EC.

The point should also be made that, in contrast with some of the other four countries selected as case studies for this evaluation, which exhibit a better track record and history of public sector interventions in the field of P&D, population and development affairs only started to ascend Guatemala's policy agenda in the late 1990s. Against this background, it can be assumed that effectiveness is more easily achievable when interventions are targeted at filling in a blank page than when they

aim to impulse more refined reform processes. In assessing effectiveness, consideration should also be given to the fact that EC interventions in Guatemala have mostly been directed at providing emergency and food aid-related assistance during the initial period of reference for this evaluation.

Overall conclusion in relation to Effectiveness:

With the exception of the MSF project on HIV/AIDS and the productive components of the EC project on demobilised people, most projects examined for this evaluation have produced tangible results that were coherent with the projects' design and budget and were effective in generating a range of concrete outputs and of intangible results related to policy change. Despite its poor visibility within the foreign donors community, the EC was also effective in integrating its full interventions package into the various Peace Accords established as from the second half of the 1990s.

3.3 Efficiency

Due to multiple budget lines, there has been a high dispersion of projects during the initial period of reference for this evaluation. As a result, many of the EC-funded projects have only had concrete effects for the duration of the project implementation period, but have not been mainstreamed, nor have they generated any noteworthy multiplier effects. Reportedly, prior to the adoption of the new Country Strategy Paper, there had also been limited planning and strategy in the definition of EC programme activities in Guatemala.

At project level, delays in allocating resources for the second phase of the "support to reintegration of ex-combatants project" appear to have caused some irreversible negative consequences for the ability of the project beneficiaries to sustain the small businesses they had established during the first phase of the project. Similarly, the limited capacity of the EC Delegation and government authorities to track and oversee the implementation of projects established under the NGO co-financing principle appears to have reduced considerably the efficiency of some of the EC interventions, most notably the HIV/AIDS prevention project implemented by MSF.

At a wider policy level, the question as to whether development goals could have been more efficiently served by allocating resources to sectors other than population does not really apply to Guatemala during the period of reference for this evaluation. With regard to the first phase of this period, during the armed conflicts, the scope for the EC, or any other donor agency, to make any informed strategic choices based on different development options, or to diversify their sectoral areas of interventions, was particularly limited. Emergency assistance and food aid were among the few windows of opportunity available to any foreign donor agency to intervene in Guatemala in the course of the military conflicts.

During the second phase of the period of reference for this evaluation, as from 1996, the range of priority, development-inducing, intervention areas in post-conflict Guatemala was, again, relatively limited. The emphasis placed by the EC on measures related to the assisted return and reintegration of refugees and IDPs appears, by any account, to have been well-founded. Similarly, the contribution of the EC to the gradual development of a package of interventions in the field of health coverage extension, and to a lesser extent in the field of reproductive health, appears to have been an efficient means of promoting wider development goals and targets in a country where, in the early 1990s, about 45% of the total population lacked any form of access to health care. Account should also be taken of the fact that, until the late 1990s, issues of reproductive health and the prevention of HIV/AIDS had been proscribed by the successive governments in office, acting in close coordination with the Church.

Finally, the new EU donors' coordination body, Mesodialogo, which was established in 2000 among the government of Guatemala, the European Commission, representatives of the EU member states and European NGOs, bodes well for the future efficiency of EC programme interventions in Guatemala. As was already indicated in this report, Mesodialogo was established in response to the need expressed by the European Commission to restructure and decentralise its interventions in Guatemala with a view to adopting a more sectoral, and less project-centred, approach to cooperation. Mesodialogo is already proving an efficient instrument to define and design new EC cooperation programmes and sectoral strategies in coordination with the EU's main institutional and implementing agencies in development cooperation affairs.

On the other hand, the absence of the EC from some thematic working groups, mostly notably those on reproductive health and HIV/AIDS, established within the Grupo de Dialogo, which brings together all the national and international donor agencies active in Guatemala, was signalled on several occasions. The point was made, however, that with the gradually declining role of USAID interventions on Population and Development under the current US administration, there would be significant potential for the EC to gain prominence in these areas in the future.

Overall, it should be stressed again that the fact that Guatemala is currently placed under the responsibility of the EU Delegation in Nicaragua and only has an EU Office in Guatemala City, has not facilitated issues of efficiency. Projects have been monitored, mostly, from AidCo in Brussels and from the EU Delegation in Managua, not to mention the projects funded under the Programme for Displaced Populations in Central America, which have been managed by the EU Regional Coordination Office in El Salvador.

Overall conclusion in relation to Efficiency:

Prior to the adoption of the new Country Strategy Paper (2002-2006), there had been limited planning and strategy in the definition of EC programme activities in Guatemala, and a high dispersion of projects due to multiple budget lines. Despite these limitations, the efficiency of EC interventions in Guatemala appears to have been facilitated by the fact that, during the armed conflicts, the scope for any other donor agency to make any informed strategic intervention choices was particularly limited, with emergency assistance and food aid being among the few windows of opportunity available to any foreign donor. After the armed conflicts, the emphasis placed by the EC on measures related to the assisted return and reintegration of refugees and IDPs, and the development of a package of interventions in the field of health coverage extension, appears to have been an efficient way of promoting wider development goals and targets in a country where, for example, in the early 1990s, about 45% of the total population lacked any form of access to health care.

3.4 Sustainability

As was discussed in earlier parts of this report, sustainability appears to have been weak for most projects examined by these evaluators.

With the exception of the projects on Health Reform (coverage extension) and Maternal and Child Health, which were successful in creating new capacities, particularly at community level, and in mainstreaming some of the project outputs at the end of the EC funding, the rate of survival of projects' results at the end of the EC funding is all but encouraging.

The MSF project on HIV/AIDS, which ceased all its activities at the end of the EC funding, did not succeed in establishing any linkages with public institutions, nor did the target schools integrate the MSF educational programmes at the end of the project. The extent to which the peer-to-peer educational material and the self-learning guides have been conducive to behavioural changes among the beneficiary adolescents, was a variable beyond the reach of these evaluators.

Similarly, a key component of the project on "Productive reincorporation of demobilised people of the URNG", which aimed to support the initiation of productive projects by the targeted returnees, has largely failed to establish a sustainable source of income for the beneficiary households. Only a few of the small businesses established with the EC project's support were still in operation when the settlement was visited by these evaluators, four years after the project's completion.

As was suggested by the EC Office in Guatemala, one potentially worthwhile recommendation to result from this evaluation could be the promotion of post-project

missions to assess the state of infrastructure, capacities, benefits and possible multiplier effects one to three years after project completion. The underlying message to be conveyed by such missions to the recipient authorities and the direct beneficiaries would be: "we have not forgotten you"; these missions would further contribute to raising the profile of the EC within the international donors community in Guatemala and to increasing its status as a key development cooperation agency.

In this respect, mention should be made again of the fact that, of the two formats for project execution adopted by the EC during the 1990s (i.e. the co-direction scheme and the NGO scheme), there is evidence to suggest that NGO-executed projects have generally taken limited account of the need to establish or strengthen capacity within local or national institutions, and therefore to facilitate sustainability of project outputs. The co-direction scheme, on the other hand, has proved a much more effective long term capacity-building instrument, since EC projects supported under this scheme have been established on the basis of formal agreements between the government and the EC Delegation, and have been monitored by both the EC and the national government counterparts.

Notwithstanding the above comments, the outlook for the sustainability of future EC interventions in Guatemala appears to be positive. The Population and Development policy of GoG is still in the making, with the first ever Law on Social Development and Population only having been enacted in 2001 and the first ever National Policy on Social Development and Population having been adopted in 2002. In a country operating traditionally under the strong influence of the Church, the National Policy addresses a relatively comprehensive set of policy objectives and targets in the fields of reproductive health and the prevention of HIV/AIDS; education in population and development affairs (including the development of relevant curricula, the establishment of a Master's in Population and Development at the University of San Carlos de Guatemala, and public support for research in relevant P&D subject areas); employment and migration; and the implementation of public information campaigns to promote the objectives of the Law on Social Development, with particular emphasis on aspects addressing issues of gender and multiculturalism. The EC, together with other international agencies, most notably UNFPA, not only has been instrumental in the formation of this policy, it has also expressed increased support and cooperation for its adequate implementation.

The sustainability of future EC interventions in Guatemala will be likely, therefore, to benefit from the recent adoption of a more integrated, and less project-centred, approach to public sector interventions in the field of P&D. This is reflected, in particular, in the new CSP for 2002-2006, which integrates most P&D activities under the general cooperation axis related to "Decentralisation". This will be likely to imply that an appropriate Population and Development agenda will be drawn up and implemented at the level of the local governments and Development Councils, thus increasing the potential for sustainability of future interventions as from the lowest institutional layer of population programmes' management and execution. Decentralisation is also believed to have the potential to reduce the very high levels of clientelism and corruption, which have affected public expenditure practices at central government level.

Overall conclusion in relation to Sustainability:

With the exception of projects on Health Reform (coverage extension) and Maternal and Child Health, sustainability appears to have been weak for most projects examined by these evaluators. In the experience of these evaluators, the rate of survival, let alone mainstreaming, of projects' results at the end of the EC funding has been extremely poor. Projects executed under the co-direction scheme, which have been established on the basis of formal agreements between the government and the EC Delegation, appear to have generated a more notable long term capacity-building potential.

3.5 Impact

There is little doubt that EC interventions on P&D during the period of reference for this evaluation have contributed to tangible improvements in the well-being of the target populations.

In quantifiable terms, some of the outputs generated by the sampled projects have included: the construction or rehabilitation of health centres benefiting 40,000 people; support to the development of sanitary services in 442 schools; the creation of a water treatment system benefiting 60,000 people; the establishment of 113 small rural shops offering a range of medicines; the production of innovative educational material and self-learning guides on HIV prevention; and direct assistance to one hundred households composed of demobilised people, including special measures for people with disabilities.

Perhaps the most noteworthy impact of EC interventions in Guatemala during the period under review can be related to measures in favour of returnees. As was indicated in previous reports prepared for this Thematic Evaluation, the long-term impact of EC policy in the field of forced population movements should be assessed, primarily, by the extent to which some of the main root causes of such movements, particularly military conflicts, have been eliminated. This is justified, in particular, by Regulation (EC) No 2130/2001 (on "Operations to aid uprooted people in Asian and Latin American developing countries") which aims to support measures to prevent conflict and/or to reconcile parties to a conflict. Assessment of human rights violations and political persecution against particular segments of the national population is an equally important judgement criteria, as is the extent to which repatriated/resettled populations have acquired the means for self-sufficiency. This is again justified by Regulation (EC) No 2130/2001, which foresees that EC action should facilitate the move from emergency stage assistance to long-term socio-economic development.

Against this background, the impact of EC interventions in Guatemala has been fully evidenced by these evaluators. Notwithstanding some of the limitations and constraints which have been observed in relation to the economic reintegration components of some of the EC projects, the EC has actively supported every stage of the international and internally displaced people resettlement process, from voluntary repatriation and issues of personal documentation to reintegration measures, including access to land, education and economic activity. The EC has further developed a comprehensive mid-term programme to accompany the URNG reintegration process, which, according to some of the former combatants interviewed in the course of this evaluation, has been particularly effective and significantly more far-reaching that programmes supported by other foreign donors.

Experience shows that the impact of repatriation and resettlement activities can depend upon a range of factors related to the political, economic and socio-cultural climate in the (re)settlement countries. The time factor (i.e. the time elapsed since the programme was implemented) is therefore an important element in the judgement criteria to be used for this intervention level. With regard to the host communities, measures to foster acceptance of uprooted people often encompass, in addition to strict awareness-raising campaigns, activities related to local employment/business creation, and well-tailored vocational training in line with the nature and needs of the local economic fabric. Again, with the exception of measures related to the funding of productive activities, the EC has been a particularly active player within the donors community in Guatemala in taking on many of these challenges.

Overall conclusion in relation to Impact:

Notwithstanding some of the limitations and constraints which have been observed in relation to the economic reintegration components of the refuges projects, and the HIV/AIDS interventions, EC interventions on P&D sampled for this evaluation have contributed to tangible improvements in the well-being of the target populations. Some key examples of such impacts include: the construction or rehabilitation of health centres benefiting 40,000 people; support to the development of sanitary services in 442 schools; the creation of a water treatment system benefiting 60,000 people; the establishment of 113 small rural shops offering a range of medicines; the production of innovative educational material and self-learning guides on HIV prevention; and direct assistance to one hundred households composed of demobilised people, including special measures for people with disabilities.

3.6 Internal / external coherence

EC interventions in the field of population and development have been extremely coherent with the main EC Council Regulations of relevance to this evaluation. If anything, Guatemala appears to have acted as a "model test ground " for the implementation of Council Regulation 2130/2001 on "Operations to aid uprooted people in Asian and Latin American developing countries". Three major aims of the Regulation which have been fully embodied in EC interventions in Guatemala have included:

- The provision of support to operations aimed at the self-sufficiency and reintegration into the socio-economic fabric of uprooted people and demobilised former soldiers.
- Assistance to those who voluntarily return to and settle in the countries of origin or other countries, if conditions permit.
- Assistance to returnees for the recovery of their belongings or property rights and aid for the settlement of human rights violations against the people in question.

With regard to Council Regulation 550/97 on "HIV/AIDS-related operations in developing countries", the EC interventions in Guatemala only appear to have responded to one of the Regulation's core aims:

- To provide IEC on sexual and reproductive health and rights, with special attention to high-risk and vulnerable groups

EC interventions have also been coherent with one of the aims of the Council Regulation 1484/97 on "Aid for population policies and programmes in the developing countries":

- To give "special assistance" to countries which have not yet experienced fertility decline.

At project level, in the health sector, the Peace Accords had established specific targets for coverage extension of health services. The APRESAL project, and subsequently the Maternal and Child Health project, were particularly relevant to such a key national policy objective in view of :

The projects' geographic targeting: by selecting the Verapaces, the APRESAL and Maternal and Child Health projects focused on the resources of a territory with an enormous social deficit; inaccessible and very poor communities with a high density of indigenous people; the country's worst indicators in maternal and child mortality; health staff reluctant to work with NGOs; and severe deficiencies in health, water and sanitary infrastructure.

The projects' complementarity with other foreign donors' interventions: the IADB loan for Health Reform and USAID's efforts developed in the highlands plateau have run parallel, in a coordinated manner, to the EC interventions. The APRESAL project, in particular, contributed to a comprehensive and synergetic approach to coverage extension, by taking on its own share of activities and allocating specific geographic responsibilities among different donors' interventions. What is more, the decision of the APRESAL project team to relocate its offices in Alta Verapaz gave further impetus to the involvement of civil and health authorities in the project execution, thus facilitating follow-up and mainstreaming activities at the end of the EC funding.

In terms of external coherence, and more perhaps than in many other developing countries where foreign donors may have been inclined to introduce their own development policy agenda, most EC interventions in Guatemala have been part and parcel of the State's national programme of activities, as resulting from the various Peace Accords. The fact that the EC and other foreign institutional parties have been contributing partners in the drafting of the Peace Accords is of course not indifferent to the achievement of such a close coherence of EC interventions with the GoG's own agenda. The point was made, however, that during most of the 1990s, EC cooperation in Guatemala was considerably more supply - than demand-led.

One possible exception to the above assertion may have been in the field of HIV/AIDS, which was not a government priority at the time the MSF project was launched in 1997. The National AIDS Programme at that time was poorly resourced and of marginal concern to the Guatemalan government. The HIV/AIDS Act was only drafted and approved after the MSF project was completed (without the MSF project having had any causal effect on the drafting of the Act) and the government's awareness of the epidemic has only developed gradually during the early 2000s.

In terms of the external coherence of EC interventions in relation to further ICPD objectives, the EC, together with other bilateral and multilateral donor agencies, was instrumental in the production of the first ever baseline data on maternal mortality in Guatemala, and of the first National Survey of Maternal and Child Mortality. This has responded directly to the objective included in the Peace Accords of a reduction in maternal mortality, and evidence suggests that, since the baseline data was produced, there have been better incentives to trace and document maternal mortality cases. Furthermore, as was reported by the National Planning and Programming Secretariat of the Presidency (SEGEPLAN), the programming of future EC interventions in the field of population and development in Guatemala will now be closely bound to the implementation of the 2002 Policy on Social Development and Population, which touches upon many ICPD areas of action (reproductive health and the prevention of HIV/AIDS; education in population and development affairs; and employment and migration).

Two major shortcomings with regard to coherence have related to the difficulty of incorporating cross-cutting issues in P&D activities, although such criticism would no doubt apply to a range of other target countries; and the particularly limited efforts, in the opinion of these evaluators, to establish synergies among the different

projects forming the EC's interventions package on population and development affairs in Guatemala.

As was already mentioned, while the new CSP for 2002-2006 makes little explicit reference to issues of population and development, most P&D activities appear to have been integrated under the general cooperation axis related to "Decentralisation". This is an encouraging sign, which bodes well for the more integrated and synergetic character of future EC interventions on P&D in Guatemala.

Overall conclusion in relation to Internal/External Coherence:

EC interventions in the field of population and development have been extremely coherent with two key EC Council Regulations of relevance to this evaluation (Council Regulation 2130/2001 on "Operations to aid uprooted people in Asian and Latin American developing countries", and Council Regulation 1484/97 on "Aid for population policies and programmes in the developing countries"). In terms of external coherence, most EC interventions in Guatemala have been part and parcel of the State's national programme of activities, as resulting from the various Peace Accords. This has secured a very close coherence of EC interventions with the GoG's own policy and programmatic agenda.

4. RECOMMENDATIONS

In view of this overall assessment, the following key suggestions are being formulated by the team.

Capacity should be increased to enable the GoG to process the wealth of statistics, which it is able to generate in a more policy formation perspective and in more direct response to the requirements of the Cairo Action Plan.

While the EC has been highly effective in supporting refugees, IDPs and ex-combatants at emergency and resettlement stages, activities to develop sustainable reintegration strategies appear to have been somewhat sub-optimal. Increased and well-designed project efforts should be expended to assist the on-going socio-economic reintegration process of returnees and resettlers, particularly in the Quiché and Alta Verapaz regions.

Similarly, in view of the fact that Guatemala is increasingly affected by relatively high levels of illegal immigration and human trafficking/smuggling activity, there would be merit in supporting new programme activities to study and counteract such adverse phenomena, including in conjunction with efforts already deployed by the International organization for Migration (IOM).

If the EC is to continue providing support for activities implemented directly and exclusively by NGOs, alongside the co-direction scheme involving the relevant national government authorities, then increased efforts should be deployed to monitor NGOs' activities more closely and to ensure regular liaison and coordination with relevant government entities and programmes, and with the EC Delegation, at all stages of project implementation.

Similarly, increased staffing and technical capacity should be secured at the EC Office in Guatemala to monitor project activities more closely within the various population thematic areas. This is all the more justified by the fact that, at the time of this evaluation, Guatemala was under the responsibility of the EU Delegation in Nicaragua; many projects were being monitored by AidCo in Brussels and by the EU Delegation in Managua; and projects falling under the Programme for Displaced Populations in Central America were being managed by the EU Regional Coordination Office in El Salvador.

In view of the limited sustainability of many project activities implemented in Guatemala, it is suggested that the Mesodialogo scheme, which offers an ample and participative forum to coordinate and assign priorities to various cooperation budget lines, should become the only channel through which new EU programmatic decisions are taken. It is also suggested that the on-going decentralisation process, a key priority in Guatemala's national development policy and in the EC Country Strategy Paper for 2002-2006, should contribute to the design of an appropriate Population and Development agenda at the level of local governments and Development Councils. This should be seen as a pre-condition for future cooperation initiatives to adapt as closely as possible to the particular local needs of such a diverse and multiethnic country as Guatemala.

ANNEX 1: LIST OF PEOPLE INTERVIEWED

BRUSSELS		
Thursday 3 July 2003		
15:00	Ms. Maria Cruz Razquin	AidCo/E/4
Monday 7 July 2003		
14:30	Ms. Anna Herrero-Romeu	AidCo/E/2
Wednesday 9 July 2003		
11:00	Mr. Federico Zorzan	Relex, ER.G.2
GUATEMALA		
Monday 14 July 2003		
15:00	Mr. Philippe Combestot, EC Resident Representative and Mr. Daniel Garcia, Institutional Modernisation Officer, EC Office in Guatemala	EC Office in Guatemala
Monday 21 July 2003		
9:00	Messrs. Daniel García and Michel Bosco	EC Office in Guatemala
11:00	Fernando Rivera, Director, Social and Economic Policies; Eugenia Rodríguez, Director, International Cooperation; Susana Palma, Analyst, International Cooperation; Vinicio Mora,	SEGEPLAN (National Planning and Programming Secretariat of the Presidency)

	Analyst, Population and Development; María Elena Ortíz, Analyst, Multilateral Cooperation; Mirtala Trabanino, Analyst, Multilateral Cooperation; Ana María Ruiz, Analyst for EC Multilateral Cooperation.	
14:00	Dr. Elena Pagano	Medical Coordinator, Médecins sans Frontières
15:30	Dr. Julio Molina Avilés	Minister of Health
Tuesday 22 July 2003		
9:00	Dr. Mario Aguilar	Programme Officer, UNFPA and UNAIDS
11:00	Mr. Gunter Mussig	Director, International Organization for Migration (IOM)
12.30	Dr. Pedro Luis Castellano	Director, Organizacion Panamericana de la Salud, World Health Organization
14:30	Licda. Dory Lucas	Director, National AIDS Programme, Ministry of Health
Wednesday 23 July 2003		
9:00	Lic. Víctor Castro	Head, External Cooperation Unit, Ministry of Health
11:00	Lic. Enrique Corral Alonso	Director General, Fundación Guillermo Toriello
14:00	Ida Pierotti	Director, Movimondo
15:00	Dr. Roberto Santiso	Head, Reproductive Health Unit, Ministry of Health

Thursday 24 July 2003		
Violent street riots – all meetings cancelled		
Friday 25 July 2003		
Violent street riots – all meetings cancelled		
Sunday 27 July 2003		
9:00	Focus group (project managers and beneficiaries): María Teresa Calderón, President of the Development Council; Angel Montejo, Vice-president of the Neighborhood Association; Virginia Cardona, Fundación Guillermo Toriello, Monitor for the South Coast and Chimaltenango.	Project on "Productive Reintegration of Demobilised People », in Chimaltenango, with the NGO "Solidaridad Internacional"
Monday 28 July 2003		
All day	Writing of the Aide-Mémoire	
Wednesday 6 August (these persons were met by the national consultant to discuss specific issues to be integrated into the final report)		
14:00	Nancy Méndez and Ana Victoria Ramírez	SEPAZ, the National Secretariat in charge of the Peace Accords
17:00	Rubén Mayorga	Director, OASIS (local NGO that participated in the implementation of the MSF project on HIV/AIDS prevention)

ANNEX 2: LIST OF DOCUMENTS CONSULTED

- APRESAL, *Memoria de actividades 1997-2002*.
- CARE. *Maternal Health Project*. Sept. 2002.
- CLAPP & MAYNE / GSD Consultores Asociados. *CARE and the Health Sector Reform*, Guatemala, 2001.
- European Commission. Guatemala, Country Strategy Paper 2002-2006.
- Fundación Guillermo Toriello. *Diagnóstico Socioeconómico del Personal Incorporado de la Unidad Revolucionaria Nacional Guatemalteca*. May 1997.
- Fundación Guillermo Toriello. *Memoria 1998-1999*. Guatemala.
- Fundación Guillermo Toriello. Memoria 2002. Guatemala.
- Guatemala. Acuerdo para el Reasentamiento de las Poblaciones Desarraigadas. July 17th 1994.
- Guatemala. *Acuerdo sobre bases para la Incorporación de la Unidad Revolucionaria -Nacional Guatemalteca a la legalidad.* Dec. 12th, 1996.
- Guatemala. *Encuesta Nacional de Salud Materno Infantil* 1995.
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- MSPAS. *Estudio Multicéntrico Centroamericano de Prevalencia de VIH/ITS y comportamientos de Trabajadoras Sexuales en Guatemala*. May, 2003.
- MSPAS. *Línea Basal de la Mortalidad Materna para el Año 2000*. Guatemala, march 2003.
- OIM. *La OIM y el proceso de retorno/repatriación de refugiados guatemaltecos*. February 2000. Cuadernos de Trabajo sobre Migración No. 2.
- SEGEPLAN. *Política de Desarrollo Social y Población*. April 2002.
- SEPAZ. *Informe de Avance sobre el Cumplimiento de los Acuerdos de Paz 1996-1999.*
- SEPAZ. *Informe de Avance sobre el Cumplimiento de los Acuerdos de Paz 2000-2001.*
- SEPAZ. *Programa de Apoyo al Reasentamiento de Poblaciones Desarraigadas*. http://www.procesodepaz.gob.gt/programas-reasentamiento.htm
- SIGLO XXI. *Donors are changing the assistance modality*. Suplemento Pulso Económico, july 29th, 2003.
- Sistema de Naciones Unidas en Guatemala. *Metas del Milenio: Informe del Avance de Guatemala.* 2003.

- USAID. *Country health statistical report Guatemala, march 2003. Population, Health, Nutrition Information Project*.
- USAID. *Guatemala: HIV/AIDS Country Profile*. Bureau for Global Health, April 2003.
- Worby, Paula. *Lessons learned from the UNHCR's involvement in the refugee repatriation and reintegration programme* (1987-1999)

ANNEX 3: Major (>Euro 100,000) ICPD Interventions in Guatemala, by thematic cluster, 1994-2001

Note:

HLTH …. Health

HUMAN … Humanitarian assistance (refugees, IDPs, natural catastrophes, etc.)

ICPD …. ICPD core sectors, including HIV/AIDS

OTHR …. ICPD related sectors (employment, education, indigenous populations, etc.)

Source: Population-Development Database

Cluster	Brief description	Project title	Amount	Budget line	Commitment year	Project number
HLTH	Sector support	Apoyo a la reforma sector salud - APRESAL	11.300.000,00		1995	95/0086
HLTH	Basic health care	Progr;education à travers la radio faveur populati	2.105.000,00	B7310	1996	1996/0252
HLTH	Basic health care	Integral health progr. for UP in reinstalment and precarious urban areas	1.910.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/97/753
HLTH	Sector support	Reforme sectorielle en matière santé	975.000,00		1996	GTM/B7-3010/95/179
HLTH	Training	ASECSA'S NATIONAL TRAINING AND SUPPORT PROGRAMME FOR COMMU- NITY HEALTH PROMOTERS AND MIDWIVES IN 19 DEPARTMENTS OF GUATEMALA	711.496,00	B76000	1998	PVD/1998/398
HLTH	Basic health care	FORTALECIMIENTO TECNICO Y ORGANIZATIVO DE PROGRAMAS COMUNITARIOS DE SALUD ALTERNATIVA Y PREVENTIVA EN GUATEMALA	702.022,00	B76000	2001	PVD/2001/556
HLTH	Basic health care	FOR THE RIGHT TO COMMUNITY ORAL HEALTH-GUATEMALA	608.134,00	B76000	2001	PVD/2001/293

Cluster	Brief description	Project title	Amount	Budget line	Commitment year	Project number
HLTH	Basic health care	CREATING A COMMUNITY HEALTH CARE SYSTEM WITH RURAL INDIAN COMMUNITIES IN EL QUICHE AND TOTONICAPAN, SOUTH WESTERN GUA-TEMALA	497.914,00	B76000	1999	PVD/1999/836
HLTH	Basic health care	MEJORA DE LAS CONDICIONES DE SANEAMIENTO Y FORTALECIMIENTO ORGANIZATIVO EN 7 COMUNIDADES DEL DEPARTAMENTO DE PETEN - GUATEMALA	313.007,00	B76000	2001	PVD/2001/543
HUMAN	Humanitarian aid	Multiannual regional programme 2001-2004 (share of !!!)	4.250.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	AML/99/307
HUMAN	Rehabilitation	Support for the rehab. and self sufficiency of the municipality of Ixcán	3.500.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/97/603
HUMAN	Refugees / IDPs	Co-ordination of the actions for uprooted people	1.990.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	98/365
HUMAN	Rehabilitation	Econ. reactiv., health+sanitation and munic. developm. (Sololá)	1.500.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GTM//99/92
HUMAN	Reconstruction relief	Proyec.reconstruc.Coop.serv.varios Ixán Grande	1.367.000,00	B7212	1996	ALA/AC/RR/13/94/GUAT
HUMAN	Return / Repatriation / Resettlement / Reintegration	Product. reincorpor. of demob. people of the URNG (Chimaltenango)	1.230.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/98/463
HUMAN	Post-conflict	Prog. apoyo al proceso desmobilización de la URNG	1.200.000,00	B7641	1996	GTM/B7-641/96/378
HUMAN	Return / Repatriation / Resettlement / Reintegration	Personal documentation of returned and other uprooted people	1.100.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/97/773
HUMAN	Rehabilitation	Rehabilitation of war disabled	1.030.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GTM/99/94
HUMAN	Refugees / IDPs	Global education programme for uprooted people	1.000.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GTM/99/334

Cluster	Brief description	Project title	Amount	Budget line	Commitment year	Project number
HUMAN	Return / Repatriation / Resettlement / Reintegration	Voluntary Repatriation of Refugees from Mexico	1.000.000,00	B7212	1996	GUA/B7-212/96/09
HUMAN	Return / Repatriation / Resettlement / Reintegration	Socioeconomic reactivation (Río Chixoy)	880.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/97/460
HUMAN	Return / Repatriation / Resettlement / Reintegration	Reinc. of UP and devel. of their co-operatives (Petén, Costa Sur)	825.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GTM/99/93
HUMAN	Return / Repatriation / Resettlement / Reintegration	Socioeconomic reactivation (Ixil, Quiché, Huehuetenango)	690.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/97/439
HUMAN	Post-conflict	Support to war invalids (demobilised members of URNG + Army)	600.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/97/772
HUMAN	Refugees / IDPs	Support for IDP and resident population (Uspantán, Fr Bartolomé)	600.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/97/588
HUMAN	Return / Repatriation / Resettlement / Reintegration	Mejoram.atenc.educ.asent.retornados ALTA VERAPAZ	500.000,00	B7212	1996	1996/0100
HUMAN	Refugees / IDPs	Apoyo poblac.indigenas desplazadas, región de Ixil	450.000,00	B73020	1994	1994/0391
HUMAN	Refugees / IDPs	Dev.project for population displaced by violence (Ixil, Quiché)	440.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/97/438
HUMAN	Return / Repatriation / Resettlement / Reintegration	Strength. of community organ. and democratis. at local level (Petén)	350.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/97/760
HUMAN	Rehabilitation	Productive reactivat. and consolidat. of smallholders organizations	300.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/97/589
HUMAN	Return / Repatriation / Resettlement / Reintegration	Support for the development of co-operatives (Petén)	210.000,00	B7/212-B7/3020-B7/3120	1997-1998-1999	GUA/97/756

THEMATIC EVALUATION OF POPULATION AND DEVELOPMENT ORIENTED PROGRAMMES IN EC EXTERNAL CO-OPERATION

COUNTRY REPORT FOR INDIA

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January 2004

For the

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CONTENTS

ANNEXES

Annex 1: List of people interviewed

Annex 2: List of documents consulted

Annex 3: Major ICPD interventions by thematic cluster, 1994-2001

ACRONYMS

ANM	Auxiliary nurse midwife
CNAA	Community Needs Assessment approach
CSP	Country Strategy Paper
DA	District agency
DAP	District Action Plan
DFID	Department for International Development (UK)
DHS	District Health Society (a 'District agency' registered as a society)
DOFW	Department of Family Welfare
DFID	Department for International Development
EAG	Empowered Action Group
EC	European Commission
ECHO	The European Commission Humanitarian Organization
ECTA	European Commission Technical Assistance
FA	Financing agreement
GoI	Government of India
H&FW	Health and Family Welfare
JSC	Joint Steering Committee
MOU	Memorandum of Understanding
NACO	National AIDS Council Organisation
NGO	Non-governmental Organisation
NFHS	National Family Health Survey
NIP	National Indicative Programme
PMB	Programme Management Bureau
PPP	Project Preparation Phase
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
SAP	State Action Plan
SIP	Sector Investment Programme (the overall H&FW Sector Investment Programme, except Gujarat's redevelopment)
SRC	State Reform Cell
SRS	Sample Registration Survey
SWAP	Sector-wide Approach
TBAs	Traditional birth attendants

UNFPA	United Nations Fund for Population Activities
WB	World Bank

1. INTRODUCTION

1.1 Background to the mission

On 29 November, 2001 the Board of EuropeAid requested the European Commission's Evaluation Unit to undertake an evaluation of the population theme in EC external assistance over the period 1994-2002 in order to "… verify the logic and consistency of individual actions with the stated objectives and expected impacts."

This evaluation represents the first-ever global assessment of the theme "Population and Development in EC external cooperation programmes." The objective of this evaluation is to provide the Commission with an independent expertise to assess the nature and evolution of its objectives and policies on population and development in external cooperation programmes, and the evolution and volume of the programmes concerned; and to assess its relevance, effectiveness, efficiency, sustainability and impact, and internal/external coherence.

Population is a multi-dimensional concept at the EC, and this evaluation is similarly intended to take a broad view of population and development. The template adopted is the International Conference on Population and Development (ICPD) Programme of Action, spanning the entire field of demography, from reproductive health (including sexually transmitted infections and HIV/AIDS) and family planning through age- and spatial distribution of populations, urbanisation, international and internal migration (including refugees, internally displaced persons, and asylum seekers), disabled persons, population data collection and analysis, and policy making. Information, education, and communication (IEC) activities and activities aimed at gender equality and equity are an equally important component.

The EC plays a significant role in international population assistance, providing approximately 5-10% of global support for the **ICPD goals** focusing on six areas:

- Maintaining and increasing the gains already made in providing access to sexual and reproductive health services.
- Ensuring that women have the opportunity of safe pregnancy and childbirth.
- Promoting the sexual and reproductive health of young people.
- Limiting the spread of HIV/AIDS and caring for those who live with the virus.
- Addressing problems of gender-based violence and sexual abuse, especially of young women and children.
- Building partnerships with civil society.

The EC is also a major source of humanitarian assistance to refugees and displaced persons, a significant amount of which overlaps with population (e.g. reproductive health of displaced populations, resettlement and repatriation programmes, etc.).

The **legal bases** for population assistance for the period covered by this evaluation (1994-2002), which contain the relevant policy objectives, are:

- For reproductive health and family planning: the 1992 Council Communication on Family Planning and the 1997 Council Regulation 1484/97 on aid for population policies and programmes in developing countries.
- For sexually transmitted diseases, HIV and AIDS : the 1994 Communication on Health COM(94)78, Council Regulation 550/97 on HIV/AIDS-related operations, the Communication on Accelerated Action Targeted at Major Communicable Diseases Within the Context of Poverty Reduction (COM (2000) 585).
- For distress migration, internally displaced people and refugees : Council Regulation 1257/96 concerning humanitarian aid, Council Regulation 2258/96 covering rehabilitation and reconstruction operations, and Council Regulation 2130(2001) on operations to aid uprooted people in Asia and Latin America. While the Regulation covers only ALA, it can be construed as expressing EC policy broadly speaking in other regions of the world.

Almost all budget lines and the EDF have been found to finance population-related activities. This evaluation is therefore not limited to any particular financial instrument. The overall objective of this evaluation was to achieve improved coherence and application of the Commission's approach to Population and Development in partner countries through improved decision-making and project management. The evaluation was to be implemented through provision of independent expertise to assess the nature of policies and objectives related to population in external cooperation programmes, the evolution and volume of programmes concerned, and their relevance, effectiveness, efficiency, sustainability, impact, and internal / external coherence. The focus was on a verification/testing of the logic and consistency of EC-funded actions with the stated objectives and expected results.

The evaluation concentrated on the period 1994-2002. It took into consideration, however, issues which were of more recent vintage such as the emerging importance of Sector Wide Approaches (SWAPs). The evaluation covered the Commission’s actions in the field of Population and Development in Asia and the Pacific, Latin America, the Caribbean, Africa (including the Mediterranean area), the Balkans, the Commonwealth of Independent States, and the non-accession countries in Central and Eastern Europe.

The **thematic scope** of the evaluation was bound by the following considerations:

- Gender aspects of Population and Development should be discussed with reference to the on-going EC evaluation in this area. Work in the ongoing Rehabilitation evaluation was also to be taken into account.
- Health aspects took into account findings already developed by the EC evaluation in this area, putting these results/conclusions in perspective and updating them as indicated. The evaluation team were complementing, not repeating, work undertaken by the recent HIV/AIDS evaluation.
- The analysis of international migration was limited to migratory movements between countries and within countries and was to include displaced persons / uprooted people. Migration from partner countries to Europe was not covered in the analysis.
- Only limited attention was given to population, development and education; however, the work on education and communication of DG EAC was taken into account.

Co-ordination, coherence, and complementarity with other key international actors in Population and Development were a key focus of the analysis, as were co-ordination, complementarity and coherence with NGOs.

Field visits

A major component of the Completion Phase of the evaluation consisted of five country field visits to: **Egypt, Georgia, Guatemala, India and Kenya**. The purpose of the country visits was to test and verify the logic and consistency of project and programme actions against stated objectives and anticipated impacts. Through consideration of Evaluative Questions, the evaluation team has assessed the relevance, effectiveness, and coherence of EC Population and Development strategy(ies) and programmes.

Each mission was carried out by a senior international consultant, who collaborated with a national expert recruited in advance of the mission. The duration of each country mission was approximately 10 days plus two days mission preparation and four days report drafting. Approximately five days were dedicated to meeting different stakeholders, in the EC delegation, in partner organisations (line Ministries, NGOs, bilateral donors, etc.) and national actors involved in population issues. Donors (multilateral and bilateral) as well as major NGOs involved in population were also interviewed for bench-marking of EC approach to population. A mixture of participatory techniques, including face-to-face interviews and focus group discussions were used. Approximately five days were dedicated to an assessment of selected programmes or projects. Techniques included interviews and focus groups with beneficiaries, local implementers and other key stakeholders.

1.2 Why India?

India is a major EU partner and ranks fourth worldwide for EC funding in the population sector receiving 320.4 million euros for activities in the population and development sector (Bangladesh is ranked first with 433.63 million euros).

In 1952, India was the first country in the world to launch a national programme emphasising family planning to reduce birth rates to stabilise the population at a level consistent with the requirement of the national economy. In 2000, India's population reached one billion i.e. 16 per cent of the worlds population on 2.4 per cent of the globes's land area. Population continues to be a major concern for the Government of India and receives a high political profile as shown by the Prime Minister who chairs the National Population Commission.

India also receives the largest EC support for a single population programme with the provision of Euros 240 million to the National Family Welfare Programme to provide system support to enhance central, State and district capacities to implement the Family Welfare system policy reform and the target-free approach. This is aimed at increasing the quality and impact of services as well as ensuring cost-effective coverage of the full range of family welfare and reproductive and child health services. This major multi-donor initiative involves among others the World Bank, and the UK Department for International Development (DFID). In addition, the EC has also funded 63 NGOs in 2003.

1.2.1 Country profile: demographic situation and population priorities

India is the second most populous country in the world and passed the one billion mark in May 2000. According to the 2001 Census, India's population is 1,027 million and accounts for more than 16 per cent of the world's population. Over the last 50 years, population size has nearly tripled from 361 million in 1951. Between 1991 and 2001 the population increased by 21.3 per cent which is slightly lower than the increase during the 1981 to 1991 period of 23.9 per cent. In absolute terms, the population of India increased by 181 million. The average annual exponential growth rate also decreased from 2.22 per cent during the 1961-1971 period to 2.14 per cent during the 1981-91 period and an estimated 1.8 per cent during the 1991-2001 period.

Population density (per km^2) increased from 177 in 1975, to 230 in 1981, to 273 in 1991, and finally to 324 in 2001. Almost 60 per cent of the population lives in the rural areas. In 2001, the sex ratio of the population (number of females per 1000 males) was 933, which is slightly higher than the sex ratio in 1991 (927 females per 1000 males). Age composition of the population indicates that 35 per cent of the population are children under the age of 15 years and 5 per cent are elderly (aged 65 years and over). The proportion of the population aged 0-14 years declined from 42 per cent in 1971 to 35 per cent in 2001, indicating a decline in fertility during the period. It is projected that over 85 per cent of total growth of the population during the next two decades (i.e. 2000-2020), estimated to be about 300 million, will be in the working age group 15-64 years. It is also estimated that by 2020, the population in the age group 0-14 years is expected to constitute 25 to 28 per cent of the population, the age group 15-64 years, about 66 to 69 per cent of the population and those aged 65 and over, about 6 per cent of the population. Thus, expected age structural changes imply that demand for reproductive health services will multiply rapidly during the next two decades while the demand for child health services will remain more or less stable.

The religious composition of the population has not changed much between 1971 and 2001, although there has been a slight increase in the proportion of Muslims during recent years. The literacy rate in India has increased both for males and females but is still very low, especially for females. The gap between males and females is still significant.

According to estimates derived from the Sample Registration System (SRS) in 2001, India has a crude birth rate of 25 per 1000 population, a crude death rate of 9 per 1000 population; the total fertility rate is 3.2 births per woman, which is a significant decline from the rate of 4.5 births per woman in 1981. The infant mortality rate (IMR) has also declined from 129 per 1000 live births in 1971 to 67.6 per 1000 in 1998-99. Estimates of life expectancy show that female life expectancy increased by more than 12 years from 49 years in 1951 to 61 years in 2001; the sex differential in life expectancy has reversed; females in India live slightly longer than males, which is the pattern observed in most populations.

There are wide inter-state, male-female and rural-urban disparities in outcomes and impacts. These differences stem largely from poverty, illiteracy, and inadequate access to health and family welfare services, which coexist and reinforce each other. The GoI has set up the Empowered Action Group (EAG) for states where demographic indicators are sub-optimal in order to design programmes in terms of geographical and thematic areas with a focus on capacity building. The five member states are Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh (together with the three new states formed in this region, Jharkhand, Chattisgarh and Uttaranchal). These states had a combined total fertility rate (TFR) of 4.5 around 2000. For the EAG states, it would take nearly 26 years to reach replacement level of fertility under the current rate of decline. On the other hand, the Southern states have already achieved a total fertility rate of less than 2.5.

Similarly, in many states, the widespread health infrastructure is not responsive. Consequently, these states continue to experience a high infant mortality rate, maternal mortality rate, and most importantly the sex ratio (female to male) in 0-6 year age group has been steadily declining. The practice of discrimination against the girl child and female foeticide are still very prevalent. Son preference has been found to be significant. The 2001 Census of India indicates not only worsening sex ratios among children in Gujarat, Goa, Maharashtra, Haryana, Himachal Pradesh and Punjab but also overall sex ratio as well.

Clearly there is a need for strengthening the knowledge and capacity of women and girls. The increase in female literacy is strongly correlated with fulfilling women's aspirations and raising their capabilities. It is also noted that women's empowerment and the meeting of reproductive and sexual rights depends on literacy and higher educational attainment. This means intensification of action plans to empower women through creating an enabling environment is urgently needed to realise the 2001 National Policy for Empowerment of Women.

In India, migration is a dominant social, cultural, and economic phenomenon. Factors influencing the extent and patterns of migration in India include poverty, drought, urbanization, industrialization and socio-cultural traditions. In general, migration occurs within India either within the same state or between states. Often the migration is seasonal, corresponding with drought and the lack of economic opportunities in the place of usual residence. However, much migration occurs in order to seek new and better employment in areas of industrialization or improved agricultural prospects.

Both men and women migrate, sometimes together as part of a nuclear or extended family, but often it is the men who migrate leaving their families behind in their home community. The duration of migration is a variable ranging from short-term (i.e. weeks or months) to extended relocation that spans years.

The data on migration based on the 2001 Census are not yet available. However, the earlier Censuses indicate that the great majority of migrants (60 per cent) in India have made intra-district movements, followed by those who have moved between districts (inter-district) and about 11 per cent migrants have moved between states. Data for 1991 Census of India indicate that intra-district and inter-district migrants correspond to 23.8 per cent of the population compared to 26.9 per cent in 1981. This decline seems to be related to the decline in shorter distance moves. The Census data also imply that short-term migration described as "circulatory" in character, and involves men more than women, has declined in importance due to improved transport networks.

Internal migration also has an implication for urbanization. The volume of net rural to urban migration has been increasing significantly at the national level. According to the 2001 Census, there are a total of 5161 towns, an increase of 472 compared to 1991. The urban population was 17.3 per cent of the total population in 1951 and has increased to 27.8 per cent in 2001. The annual growth rate of the urban population was 2.71 per cent during 1991-2001 compared to 3.79 per cent during 1971-81. Though the pace of urbanization has declined, the country's urban population has increased by nearly 68 million during the 1990s. The urban population is projected to grow fastest in states like Bihar, Uttar Pradesh and Madhya Pradesh which are the states with relatively low levels of urbanization at present.

It is important to mention the largest urban areas. According to the 1951 Census, there were only 5 cities with more than one million people; in 1991, the number of such cities had risen to 23; while the 2001 Census showed that as many as 35 cities fell into this category, constituting 38 per cent of the total urban population. Of these 35 cities, three cities have a population of more than 10 million: Greater Mumbai with 16.4 million, Calcutta with 13.2 million and Delhi with 12.8 million. Furthermore, three cities have a population of over 5 million: Chennai, Bangalore and Hyderabad with 6.4, 5.7 and 5.5 millions, respectively. These six cities contributed 60 million people to the urban population and constituted about 21.1 per cent of the entire urban population in India in 2001.

Regarding mortality and morbidity, reliable data at the national level are lacking. However, WHO studies conducted at different levels, regional or area specific, indicate that reproductive morbidity among women is very high. Moreover, there is a large discrepancy between reported gynaecological problems compared to clinical examinations. For instance, a study conducted in central India showed that while 55 per cent of women reported gynaecological problems whereas clinical examinations revealed 9 per cent had at least one gynaecological disease. However, a study conducted in South India revealed that about one-third of women had experienced at least one symptom of reproductive morbidity. It was clear that women who had undergone tubectomy reported greater reproductive morbidity. The National Family Health Survey (NFHS) conducted in 1998-99 also collected information on some common symptoms of RTIs. Based on this national large sample, NFHS reported that 39 per cent of women reported at least one reproductive health problem.

1.2.2 Population Policies and Perspectives

In 1952, India was the first country in the world to launch a national family planning programme to check population growth. Since then, the family planning programme has undergone various changes. During the time of the National Emergency, 1975-77, the programme experienced its biggest setback. Due to increased coercion, there was a sudden increase in the number of sterilizations carried out from 2.67 million in 1975-76 to 8.26 million in 1976-77. People reacted strongly against it. As a result, there was a change in government in 1977, a new National Population Policy was adopted and the welfare approach to the population issue was re-emphasized. The new government redesigned the family planning programme and called it the Family Welfare Programme, and the Community Health Volunteer (CHV) scheme was introduced.

A new population policy was drafted in 1994. It is quite understandable that the International Conference on Population and development (ICPD) in Cairo must have had some influence. The new programme is oriented towards the holistic approach of the Reproductive and Child Health (RCH) programme. This programme also includes components relating to Sexually Transmitted Diseases (STDs) and Reproductive Tract Infections (RTIs).

The revised National Population Policy approved in February 2000 states that the overriding objective of economic and social development is to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become productive assets in society. The policy gives special attention to the health and education of women and children to achieve population stabilization for the country by 2045. It also sets the goal of attaining replacement level fertility by 2010. In order to achieve this goal, the policy proposes to improve RCH services, including an emphasis on education, women's empowerment, the involvement of men in the programme, compulsory education for all up to the age of 14 years, a reduction in infant mortality rate to less than 30 per 1000 live births, and a reduction in the maternal mortality ratio to less than 100 maternal deaths per 100,000 live births. Furthermore, the policy aims to achieve universal immunization of children, delivery assistance by trained personnel for all births, and 100 per cent registration for births, deaths, marriages, and pregnancies. The new policy also addresses the unmet needs of clients. This is particularly important because both the National Family Health Surveys of 1992-93 and 1998-99 indicate high levels of unmet need for contraception in the Empowered Action Group States. This was confirmed by the Reproductive and Child Health Survey.

The target-free approach as discussed in the National Population Policy, 2000, also emphasizes modifications in the planning and monitoring of health care to make it a demand-driven system. Each year, health workers would assess the needs of the community, based on consultations with families, women’s groups, anganawadis and panchayats. The aim is to improve the health services including quality and accessibility of health services, especially for women and children. Both poor quality of care and women’s lack of autonomy in decision-making or movement are important constraints on the lack of progress in meeting women’s reproductive health needs. There are also social, cultural and economic constraints in accessing services for them. Adolescent girls’ have many unmet needs including health, especially reproductive health, nutritional status, the risks arising from early marriage and child bearing. At the same time, the health information needs of adolescent girls are rarely

addressed and adolescent girls remain particularly ignorant about their bodies and sexual behaviour and pregnancy. Policy actions should attempt to deliver health services in ways, which are sensitive to a cultural mindset, which inhibits adolescent girls and women from expressing reproductive health needs or seeking health services. Greater efforts should be made in empowering women. Low level education, lack of control over material resources, lack of decision-making, freedom of movement and time can restrict visits to the health center for their reproductive health problems.

A major challenge for the government is the prevention and control of HIV/AIDS. This is due to the interrelationships between factors at societal and individual levels that influence both the vulnerability of populations to HIV transmission and the response of the society to mitigate the impact of HIV/AIDS. Currently, the dominant approach for prevention strategies is based on the UNAIDS/WHO formula. Whereas much of the country is considered to have a low level or concentrated epidemic requiring "targeted interventions", there is a general acceptance that in the four southern states of Maharashtra, Andhra Pradesh, Tamil Nadu and Karnataka, the HIV epidemic has become "generalized" with HIV prevalence consistently exceeding 1 per cent among antenatal women. There has been an impetus to redirect prevention programmes accordingly. However, such a re-orientation of prevention programmes to "general populations" is based on unsupported assumptions about the nature of sexual networks and transmission dynamics in India. Developing more effective programmes for HIV/AIDS prevention, care and support has become difficult because India lacks reliable data on the levels and trends in HIV infection resulting in complacency on the part of public health functionaries towards the issue. The estimates of low prevalence of HIV/AIDS produced from NACO seems to be reinforcing the idea that HIV/AIDS is not a major public health issue in India.

However, in many areas, such as northern Karnataka, HIV infection is growing rapidly because of the prevailing poverty and its associated factors such as illiteracy, low status of women, seasonal out-migration, widespread practice of prostitution, and trafficking of women to larger cities, and the prevalence of the traditional Devadasi system. The spread of the disease can also be attributed to changing attitudes regarding sex in a rapidly changing world and an increase in promiscuity indicating a weakening of the traditional as well as societal controls on sexual behaviour.

There are also other problems associated with the pandemic. The number of screening and diagnosis facilities is inadequate for early detection and preventing the further spread of infection. Also, there seems to be general absence of any counselling and rehabilitation facilities either at the level of health care providers or at the community level. People who test HIV positive are simply told their test result, and dismissed often without any counselling to them or their family members as to what does it imply and what precautions need to be taken to protect others from contracting the disease. Those people and their families who are most deeply affected by HIV infection are left to cope up with the situation themselves, often having to face social procrastination, stigmatization and isolation. There has been no societal mechanism to raise awareness in the community and to change attitudes towards HIV-infected people.

Another challenge for the government is the situation of adolescents, in general, and the range of issues included under the rubric of adolescent sexual and reproductive health, in particular. Unfortunately, in India, obstetric, particularly gynaecological,

morbidity is endorsed by women as a fact of life and in which women are shy to reveal these conditions or discuss them with health care providers. The available evidence of adolescent abortion patterns suggests an urgent need for counselling, information and other services. The need for ready access to reliable information, sympathetic counselling and safe abortion services is as urgently required among adolescents as it is among adult women.

1.3 Summary of the mission

The field mission to India took place between 10 July and 24 July 2003. The mission was carried out by one national team member, Prof Shiva Halli, Dept of Community Health Sciences, University of Manitoba and one international team member, Jane Cole, a UK-based consultant.

The evaluation was carried out at two levels. At national level, the team worked with staff from the Delegation, government ministries at the central and state levels, intergovernmental agencies, other donor organisations and NGOs.

At the programme/project level, the team examined three case study programmes/projects supported by the EC:

- Sector Investment Programme (Health and Family Welfare Sector Development) in Haryana

- HIV/AIDS Community-based care and Support in Tamil Nadu - The International HIV/AIDS Alliance in collaboration with Palmyrah Workers Development Society (PWDS)

- HIV/STI Prevention and Care Research Programme - Population Council

The case study projects were selected for several reasons. One was the logistical feasibility of visiting the projects within the short time available. Another reason was that the Health and Family Welfare Sector Development (H&FWSD) Programme is the EC's flagship population project in India (total budget Euro 240 m.). While HIV/AIDS is a major concern in the population sector in the country. Another was the budgetary constraints.

Between 1994 and 2001, the EC allocated Euro 320 m. to 74 programmes/projects in the population and development field. Of this Euro 243 m. (75.9%) was spent on 10 health interventions, including Euro 240 m. on H&FWSD Programme; Euro 52.48 m (16.4%) on humanitarian assistance activities; Euro 19.68 m (6.2 %) on ICPD sector; and Euro 4.94 m. (1.5%) on other ICPD related sectors e.g. education, employment etc. A table with the major ICPD interventions in India by thematic cluster, 1994-2001 is given in Annex 3.

The methodology used in this evaluation has included a review of relevant literature, including reports, evaluations, Country Strategy Paper (CSP), National Indicative Plans (NIPs), and policy documents; interviews with key informants and stakeholders, focus group discussions and site visits.

Annex 1 gives the programme for the assignment and the persons interviewed.

1.4 Main constraints and difficulties encountered

The team arrived at a busy time at the Delegation as the two health staff were working with two other field missions. As a result, the team spent much time arranging all their own appointments, with assistance from the EC for the field trips, and was not able to spend much time with key Delegation staff.

It was unfortunate that Dr Richard Brough, ECTA Team Leader was away during the country mission, although the team enjoyed helpful assistance from the Acting Team Leader, Mr J Misra, in his absence. Rajiv Mehta, responsible for NGO projects was also away.

Documentation was not always available to the team, in particular relating to NGO and ECHO projects which made assessment of these difficult. One of the team members spent one day in Brussels prior to the country mission and held meetings with five EC staff to discuss the assignment. However, only basic information on NGO projects was available from the computerised files, all closed NGO projects were in the archives and difficult to access in the short time available. The delegation did not have access to detailed information on the NGO projects since NGOs report to Brussels. This will change with deconcentration in 2004. Although ECHO staff provided a list of ECHO projects in India, detailed information, including evaluation reports, was not available.

2. MAIN FINDINGS

2.1 Evaluative Question 1

Since 1995, what has the European Commission put in place, in terms of global policies, strategies, and programmes to operationalise its engagements with the ICPD Plan of Action and ICPD+5?

To what extent are the EC policies, strategies and programmes coherent with ICPD?

This Evaluative Question is being answered via Brussels-based interviews, document analysis, etc. The Preparatory Phase concluded that the EC's population policy focus has shifted from concern with rapid population growth as a deterrent to economic development to concern with the right to adequate sexual and reproductive health. In addition to its focus on women, the EC has actively targeted adolescents. This evolving population policy has been *externally coherent* with shifts in the stance of other policy institutions. Moreover, the *internal coherence* of EC population policy has improved over time. There is little sign from policy documents, however, that the EC has sought to exploit synergies with other areas of EC assistance (apart from health and support to refugees / internally displaced persons). Nor has there been adequate consideration of strategic linkages between population policy and policies in other areas.

In view of needs in poor countries and the scarcity of resources, the *relevance* of EC population assistance appears to be assured. The Preparatory Phase did not reach a judgment on whether EC assistance has been *effective* in pursuing policy goals. The validity of the *efficiency* criterion is diminishing with the move towards a human-rights based approach, however, as poor reproductive and sexual health particularly affect vulnerable groups, and as the unit costs of most interventions are low, the EC's population activities may be very efficient means of addressing inequities. The Preparatory Phase also did not reach a conclusion regarding *sustainability*; however, it is widely known that available international financing falls far short of needs and governments are reluctant to commit resources.

The evaluation team has found that the Commission's record-keeping and accounting systems for population projects have been over-stretched as a result of the multiplication of sectors, budget lines, and directorates, as well no doubt as by rapid staff turnover. The team noted that steps are underway in Brussels to unify databases.

Most generally, the Preparatory Phase of this evaluation found that there are opportunities for the EC to enhance its impact in the population field and, by exploiting synergies with other sectors, to bolster the relevance and effectiveness of its overall development approaches. In order to translate these preliminary indications into practical steps and actions, the Preparatory Phase recommended that the Commission proceed with the Completion Phase of this thematic evaluation on population and development.

2.2 Evaluative Question 2

To what extent did EC third country co-operation strategies (especially CSPs, NIPs etc.) reflect an overall population and development sector approach, and respond to the needs of the Cairo Action Plan?

At the level of countries: Were country strategies internally coherent from the standpoint of population and were these population components coherent with the global development policy of the EU?

In 1994, the EC-India Partnership in Development Cooperation Agreement was agreed by the EC and GoI providing a strategy for development cooperation. This strategy focused on supporting poverty reduction projects that promoted a more efficient and sustainable use of resources, and sector programmes aimed at improving basic social services. Although population was not mentioned in this Agreement per se, population issues were addressed (see Article 16) under 'public health, especially in primary health care', in which cooperation aimed to increase the quality of health care in India of the most disadvantaged sections of the population both in urban and rural areas; population issues were also considered under 'rural development', including the promotion of employment in rural towns, and of the role of women in development, with emphasis on education and family welfare.

During the early 1990s, significant change in the development cooperation portfolio occurred with the introduction of sector support programmes. National reform initiatives were supported with guidelines for planning and implementation, such as the selection of backward districts, setting criteria for funding, cost-sharing arrangements, and the definition of individual programme components etc.

Primary education was the first sector to be supported through a sector programme. This was followed by primary health and family welfare, when the GoI designed the Reproductive and Child Health Programme (RCH I) as India's response to the Cairo agenda with assistance from the World Bank. These two sector programmes provided an entry point for the EC's engagement with the country's macro-policy agenda for two major social sectors.

The EC's support to the RCH programme was aimed at helping states to make a paradigm shift away from the target-oriented family planning approach to a more holistic health care system, focusing in particular on women and children. In education, the programme targeted the most deprived districts in the country with particular focus on girls' participation.

Consistent with the idea of donor collaboration in support of the Government's health sector reform programme, the EC agreed to fund 'Support to the Health and Family Welfare Sector Development Programme, 1998-2003' and the Financing Agreement was signed with the GoI in 1997. This comprised a one year preparatory phase, followed by a Sector Investment approach (SIP) over four years for the development of family welfare services. (The SIP was later extended until 2004). The SIP provides support to the H&FW Dept. to enhance capacities and to implement H&FW sector reforms. (It should be noted that the EC provides only 4% of the overall budget of

H&FWP). Since the RCH project had already started, the GoI decided that it should continue and encouraged other agencies to collaborate under the RCH umbrella. At the same time, bilateral and multilateral support continued financing existing and new projects under the Dept. of Family Welfare. Although the EC plays a major role in supporting the GoI to implement health sector reform, the support of other major donors under one strategic framework has not materialised. Only recently in the design phase of RCH II has the potential for a sector wide approach evolved through improved coordination between major donors (WB, UNICEF, UNFPA, DFID, USAID and possibly the EC) in which the reform processes and tools developed during the implementation of the SIP programme will be adopted and/or continued.

Later, the EC-India Country Strategy Paper for the five-year period, 2002-2007, was drawn up by the EU in collaboration with GoI based on the priorities of the GoI including macro-level and sectoral policy documents (e.g. National Population Policy 2000, National Health policy 2001; 10th Five-year Plan, 2002-2007) as well as the European Community's development policy, November 2000. The CSP aims to set out the course for development and economic cooperation between India and the EC. The overall guiding principle governing EC cooperation is the elimination of poverty, with basic health and education as the key factors. As part of the strategy, the EC will assist India to build its 'human capital' by:

- improving health services in favour of hitherto deprived
- population groups;
- making elementary education universal;
- restoring and safeguarding a healthy environment; and
- helping communities at risk to be better prepared for disasters.

The environment will be developed as a cross-cutting intervention by promoting environmental awareness in schools, local authorities and local industry; and widening access to safe water and sanitation. EC will also commit resources to fostering an enabling economic environment under an agenda of improved governance. This is essential in order to orient the EC's sector work towards promoting equitable economic growth and long-term sustainable development.

Basic health delivery is critical to reducing the vulnerability of the poor, and EC efforts will focus on:

- restoring quality health services and targeting financial sustainability
- through community involvement;
- setting up standard facilities and a needs-based referral system; and
- promoting transparent, participatory management.

EC will continue its action in the area of basic health through:

- the large ongoing HFWSD Programme, in collaboration with the central health authorities, which aims at integrating family, maternal and child health care in line with the ICPD Programme of Action.

- Incorporating basic health into a state-focussed package under a 'Partnership for Progress'. Health will link with elementary education, and will extend to include water supply and sanitation to reduce morbidity. Initially partnerships will involve two States committed to reducing poverty through a social and economic reform agenda.

Another area of EU strategic cooperation is the area of natural disasters, for example, during the 1999 cyclone in Orissa and the earthquake in Gujarat in 2001. South Asia, including India, will continue to be amongst the main areas of implementation of ECHO's disaster preparedness programme. In addition, the EC is ready to cooperate on a bilateral disaster preparedness project with the GoI to assist communities at risk to be better prepared for natural and man-made disasters.

The central cross-cutting themes for the ECs co-operation strategy will comprise improved governance, the devolution of decision-making and management and the participation of stakeholders, in particular women and disadvantaged groups.

The CSP elaborates on the key perspective outlined in the Commission's Communication on 'an EU India Enhanced Partnership'. It further addresses the key issues highlighted at the EU India Summits of Lisbon in June 2000 and New Delhi in November 2001, including universalising elementary education, promoting basic health services and seeking a common approach on the environment.

The EC cooperation strategy links the issues of poverty, sustainable economic growth and enhanced trade and is thus in line with the most recent general and specific political guidelines for development cooperation outlined in the Statement by the Commission and the European Council of November 2000.

The CSP further identifies Indian civil society as a motor of social and economic reform and accords it a key role in the design and implementation across the entire range of actions proposed. It is thus coherent with the positive experience of ten years of decentralised cooperation through co-financing the work of Indian and European NGOs.

At the level of the National Population Policy, the immediate population objective is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The medium-term objective is to bring the total fertility rate to replacement levels by 2010, through vigorous implementation of intersectoral operational strategies. The long-term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection. This population policy is broadly in line with the International Conference of Population Development (ICPD) Programme of Action.

Overall answer to Evaluative Question 2

In 1994, the EC-India Partnership in Development Cooperation Agreement was agreed by the EC and GoI providing a strategy focused on supporting poverty reduction projects that promote a more efficient and sustainable use of resources, and sector programmes aimed at improving basic social services, including health and education. Following ICPD, the GoI and the EC agreed upon the formulation of a Sector Investment approach (SIP) consistent with the idea of donor collaboration in support of a Government health sector reform programme. The SIP provides support to the H&FW Department to enhance capacities and to implement H&FW sector reforms. Since the World Bank had already started with the formulation of the RCH project, the GoI decided this should continue and that other agencies should collaborate under the RCH umbrella. At the same time, bilateral and multilateral support continued financing existing and new projects under the Dept. of Family Welfare. Although the EC plays a major role in supporting the GoI to implement sector reform, the support of other major donors under one strategic framework did not materialise. Only recently in the design phase of RCH II has the potential for a sector wide approach evolved through improved coordination between major donors (WB, UNICEF, UNFPA, DFID, USAID and possibly EC) in which the reform processes and tools developed during the implementation of the SIP will be adopted and/or continued.

The EU-GoI CSP (2002-2007) continues to have as its overall guiding principle the elimination of poverty. As part of the strategy, the EC will assist India by improving health services in favour or hitherto deprived population groups; making elementary education universal; restoring and safeguarding a healthy environment; and helping communities at risk to be better prepared for disasters. It was drawn up in coherence with the National Population Policy, 2000, which is broadly in line with the ICPD Programme of Action. It is also coherent with the population components of the EC global development policy.

2.3 Evaluative Question 3

Reproductive Health: How far have EC-supported actions in this field addressed specific objectives related to Chapter 7 of the ICPD and those of Regulation 1484/97?

Health, morbidity and mortality including HIV/AIDS: To what extent have EC-supported actions in this field addressed specific objectives related to Chapter 8 of the ICPD and those of Regulation 550/97?

Reproductive Health

Soon after the ICPD in 1994, there was a definite paradigm shift in the Government of India's approach in addressing the health concerns of vulnerable groups, such as women and children. The Department of Family Welfare changed its thrust from a highly centralized target-based approach to a decentralized and client-driven approach. It recognised that quality of services have to be enhanced to create demand from clients. The service options were broadened and an attempt was made to have an integrated RCH package of services that included family planning and MCH. This paradigm shift called for a massive reform in the way in which the health sector functioned and was organized.

The EC support to the GoI to reform the Indian Family Welfare Sector using the ICPD Programme of Action as an overarching framework for Reproductive Health and Reproductive and Rights could not have come at a better time. In September 1997, the EC signed an agreement with GoI towards financing the project 'Support to Health and Family Welfare Sector Development' with a grant of Euros 200 million over five years, this was later increased to Euros 240 million to include reconstruction following the Gujarat earthquake. (The EC contribution amounts to only 4% of the overall budget of the H&FWSD project.) The agreement supported a one-year Programme Preparation Phase (PPP) followed by a four-year Sector Investment Programme (SIP) phase. The key areas for the reform included:

- Local (or district and lower) level operational reforms
- State level policy and operational reforms
- National level policy and operational reforms
- Pilots and developmental activities, and
- Additional support to the RCH/FW programme

It should be emphasized that the EC programme is results-oriented based on the broad principles of a participative, emergent and iterative process of identifying primary areas of health reform. The SIP has a unique strategic advantage that the funding is untied, as long as the investments are planned. The participating states and districts have the flexibility of designing their own programmes within broad parameters of policy and funding ceilings.

Since the overall objective of the SIP is to improve quality and accessibility of the health services, with a particular focus on women and child health, it must be evaluated using health and demographic indicators including under-5 mortality rate, infant mortality rate, maternal morality rate, couple protection rate, and total fertility rate. It is clear that these indicators show encouraging signs based on the recent findings from NFHS, SRS and RCH Surveys. However, the achievements have not been uniform throughout India, including in some of the participating states and striking regional differences persist. As a result, in 2001, the GoI set up an Empowerment Action Group (EAG) in the Ministry of H&FW to facilitate the preparation of area-specific programmes with special emphasis on the eight states that have been lagging behind in containing population growth to manageable limits. These states are: Bihar, Madhya Pardesh, Orissa, Rajasthan and Uttar Pradesh, Jharkhand, Chattisgarh and Uttranchal.

Constraints, which have impeded progress to meet women's reproductive health needs include the lack of nearby and adequate health care facilities, and women's lack of autonomy in decision-making or movement. There are other social, cultural and economic constraints that prevent women from discussing gynaecological and obstetric conditions and in accessing services for them.

Similarly, the general health and reproductive health needs of adolescent girls are also neglected especially in view of the serious risks associated with early marriage and child bearing. Furthermore, health information needs of adolescent girls are rarely addressed and adolescent girls remain particularly ignorant about their bodies, sexual behaviour and pregnancy.

Unfortunately, the SIP has not attempted to deliver health services in ways, which are sensitive to a cultural mindset, which inhibits adolescent girls and women from expressing their reproductive health needs or seeking health services. Another constraint is the lack of effort to empower women. Low level education, lack of control over material resources, lack of decision-making, freedom of movement and time can restrict visits to health centres to seek medical care for their reproductive health problems

The EC has supported several reproductive health projects through NGO co-financing including: improving access, utilisation and sustainability of RH services, especially for low income families; IEC projects; and RH training.

However, through EC-supported actions, the opportunity could have been used to enhance our understanding of sensitive aspects of sexuality and gender relations by supporting evidence-based interventions within the reproductive rights framework. Some of the questions that have important programmatic implications and need to be answered are: How the resources divided between men and women and how does that division impact on the reproductive and sexual health of women? How does domestic violence impact on the sexual health and reproductive health of women? Where does counselling fit into all this? Who should deliver community-based, culturally-sensitive counselling, and how? Is the government system capable of doing this? If not, then how best to complement the existing system? How should adolescent reproductive health needs be addressed? Opportunities provided through the EC programme could have been used to validate the peer-based and community/family-based programs to reach out more to adolescents.

The EC programme has made some important contributions through the efforts of health sector reform to strengthen capacity for addressing broad reproductive and child health concerns. However, in discussions with many stakeholders, the team were told of other areas that needed attention, including prevention and treatment of infertility, provision of safe abortion services, meeting unmet needs for an expanded choice of contraceptives, and improving the quality of services and care for women, men and adolescents.

The Mid-term Review in April 2003 had found 'no clear indications yet of an improved quality or utilisation of health services', but also commented that 'perhaps it was too early in the programme to see such improvements'. While this lack of progress may be linked to larger issues, the team considered the EC funds could have been more effective to raise the concerns at the appropriate platforms and advocate for greater decentralization of powers and responsibilities. It is noteworthy that reproductive rights were never mentioned to the team during their discussions with various stakeholders at all levels.

As regards ICPD activities in India funded from the NGO Co-financing budget, of the total 35 NGO projects supported during the 1994-2001 period, the vast majority 24 (69%) concerned HIV/AIDS, 5 (14%) were on reproductive health and rights, 3 (7%) involved safe motherhood, 2 (6%) on population and 1 (3%) on basic health. Detailed information on these projects was not available.

HIV/AIDS

Over the last 15 years, the HIV/AIDS epidemic in India has become a serious public health problem. Since the first HIV and AIDS cases were reported in 1986, there has been a rapid increase in HIV prevalence and AIDS cases with over 4 million HIV-infected people in 2000 (about 1 percent of the adult population). India currently has the largest number of PLWHA outside of South Africa.

With reference to the Council Regulation 550/97 on HIV/AIDS, EC has supported projects through a budgetary programme and NGO co-financing. Under the SIP, DAPs and SAPs can include specific activities to fight HIV/AIDS. For example, in Orissa, EC funds are supporting a social marketing programme conducted through PSI aimed at urban slum populations, although action in this area, but action other projects were not evident in other states.

NGO projects funded through co-financing have focused largely on a certain high risk target group - intravenous drug users - including provision of treatment, especially for STDs, and aftercare; and drug abuse demand reduction. Other projects supported include: HIV policy and strategy development; community care and support for PLWHA; prevention in the context of a human rights approach; prevention of mother-to-child transmission of HIV/AIDS; planning for socio-economic impact of HIV/AIDS, and HIV/AIDS prevention.

EC action on HIV/AIDS has been limited in other areas including: training medical and paramedical personnel in HIV clinical care, quality of HIV/STI care at different levels of health care settings, reduction of stigma and discrimination, and improving

knowledge of transmission dynamics. A major challenge in improving the overall quality of HIV/STI care depends on the active involvement of the private sector, especially those who cater to the health needs of the rural population. Another challenge is to rapidly expand coverage of HIV/AIDS programmes to reach young, illiterate populations and rural communities, especially women.

One critical aspect that is missing from the EC programme on STI/HIV/AIDS is the gender dimension of the disease. Action has focused largely upon clinical and epidemiological aspects. The evaluation team considered that a more balanced portfolio of combining the social/ behavioural parameter of STIs/HIV/AIDS along with the clinical parameter would produce a more comprehensive understanding of the epidemic. Moreover, addressing the epidemic within a rights framework would produce more gender-sensitive responses.

The evaluation team visited EC-supported projects conducted by two NGOs - International HIV/AIDS Alliance and the Population Council. The Alliance has pioneered an integrated, multi- sectoral home and community-based care and support programme for PWHA and their families in Tamil Nadu, Andhra Pradesh and Delhi.

The Population Council is conducting an HIV/STI prevention and care research programme, which aims to identify or develop evidence-based, affordable, appropriate, and effective intervention strategies to control the spread of HIV and other STIs in India. Ten research projects are underway aimed at: generating essential epidemiological data, developing intervention studies, developing a model for physician training to improve clinical care; case management of RTIs; feasibility study for access to ARVs; and improving and evaluating care and support services. However the impact of this research has not yet been assessed.

It should be noted that in recent times, the EC together with EU member states are the biggest donor to the Global Fund to fight AIDS, TB and malaria having contributed 55% of the total pledge of the Global Fund of 4.7 billion dollars. India received a grant of US$130 million from the Global Fund earlier this year, the largest single country grant in Asia. The Indian proposal will focus on (1) scaling up PMTCT services (including short-course NVP and VCT) to prevent HIV among, and to provide care to, mothers and their infants and families; and (2) providing antiretroviral treatment to PWHA through public-private partnerships.

Advocacy is another important area in which the EC is involved largely through its collaboration with the GoI on the H&FWSD Programme and its attendance at the monthly donors coordination meetings organised by NACO. It should be noted that through the support of NGO projects on HIV/AIDS, the EC has also contributed to influencing the policy level, since the NGOs are actively involved in policy dialogue at national and state levels.

In conclusion, it is difficult to assess the extent to which have the EC supported actions have achieved the objectives of the Regulation and ICPD, since baseline information has not always been collected and monitoring of programmes based on relevant indicators has not always been carried out.

Overall answer to Evaluative Question 3:

The EC-supported action in reproductive health has addressed all the specific objectives related to chapter 7 of the ICPD and those of the Regulation 1484/97 to varying extents. The largest support has been for the EC-GoI Health and Family Welfare Sector Programme, which also covers Regulation 550/97. However, opportunities could have been used for more action to improve the quality of family planning services, meet unmet needs in family planning, infertility, safe abortion, adolescent reproductive health, sexuality and gender relations. Action through NGO co-financing addressed most of the objectives above, but detailed information was not available on these.

The EC-supported action in Health, including HIV/AIDS, has addressed specific objectives related to chapter 7 of the ICPD and those of Regulation 550/97. As mentioned above, the H&FW Sector Programme has been the main health programme supported. Other projects have been supported through NGO co-financing.

As regards HIV/AIDS, projects supported through the budget line and NGO co-financing have been supported mainly in the areas of drug abuse and HIV/AIDS, policy and planning, and community care for PLWHA. EC-supported action has been limited in such areas as: training medical and paramedical personnel in HIV clinical skills, quality of HIV/STI care at different levels of health care settings, reduction of stigma and discrimination, and improving knowledge of transmission dynamics.

2.4 Evaluative Question 4

Refugees, IDPs and distress migration: How far have the EC supported actions addressed specific objectives related to the relevant subsections of Chapters 9 and 10 of the ICPD for all countries, and of Regulation 2130/2001 for Asian and Latin American countries?

Most of the refugees in India are from Tibet in the North and from Sri Lanka in Tamil Nadu in the South. While, distress migration following natural disasters has caused a lot of movement of populations. As for irregular migrants, large numbers of them cross over the border from Bangladesh and to a lesser extent from Nepal and Tibet, and many have settled permanently in the country. Seasonal migration within the country also results in mass movements of populations from poorer to richer states in search of work. Rural to urban migration continues to increase.

The GoI has not yet ratified the Geneva Convention on Refugees and has developed its own rules in this area. This situation complicates action for international humanitarian agencies, such as UNHCR, and limits the number of actors working in this field. Nor are refugees mentioned in the GoI's National Population Policy, 2000.

EC-supported actions on refugees, IDPs and distress migration have been conducted mainly through ECHO and NGOs and to a lesser extent through the SIP. These actions have covered all the areas given in Council Regulation 2130/2001 and the ICPD Programme of Action. However, ECHO follows the principles of international humanitarian law, rather than the principles of the ICPD or the EC regulations.

In January 2001, the SIP was allocated Euros 40 million for distressed and displaced persons following the devastating earthquake in Gujarat. The main objective was to support the reconstruction of more than 1200 health facilities across earthquake-affected areas. A Memorandum of Understanding signed by GoI, Gujarat Government and the EC in February 2002 underlined the necessary implementation of the redevelopment activities with a focus on reforms and in accordance with SIP system and procedures. NGOs have also actively participated in the redevelopment activities. However, despite comprehensive state planning and all operational structures put in place, progress to implement the reconstruction plan was delayed by one year due to bureaucratic barriers. The procurement process was also delayed due to difficulties experienced by the state authorities with EC procedures. An ECTA team has been set up for the Gujarat project to provide technical support. To date, nearly 100 temporary health facilities have been established. Future activities to assist refugees, IDPs and migrants can be supported under the SIP if these are included in the action plans prepared by states and districts.

ECHO is the largest donor in India in humanitarian assistance for those affected by conflict and disaster. Between 1996 and 2000, ECHO provided 14.48 million Euros to support disaster management activities through partnerships with various NGOs. ECHO's work is classified in three main categories: emergency response, protracted humanitarian crisis, and disaster preparedness.

ECHO has provided much needed assistance to Gujarat earthquake survivors, the victims of the recent drought, cyclone, flood-affected areas in Rajasthan, Orissa, West

Bengal and Eastern India, and to communities affected by the violence in Gujarat in 2002. This assistance has included the rapid distribution of essential relief items, safe drinking water, medical aid and temporary shelter.
In protracted humanitarian crises, ECHO has been assisting the vulnerable victims of conflict in Kashmir. Assistance has also been provided to the Sri Lankan refugees living in camps in Tamil Nadu over the last four years, which will continue until they can return to Sri Lanka (this depends on current peace talks). Support has included food and nutritional aid, health interventions, psychosocial support and education for children.

Every year earthquakes, floods and cyclones cause many deaths in India. About 50-60% of the total area of the country is vulnerable to seismic activity of varying intensities. The Government with the international community, NGOs, panchayats and other civil society groups are focusing efforts to improve disaster preparedness and disaster management. The EC also has a special programme on disaster preparedness in India, interventions include the setting up of early warning systems, training, and improving management to cope with any disaster.

ECHO and the EC Delegation coordinate their work on disaster preparedness through weekly information-sharing meetings. The EC Delegation staff member responsible for disaster preparedness attends many external meetings together with his colleague from ECHO ensuring coherence of action within the EC system.

NGOs are frequently in the forefront of mitigating the worst consequences of natural and man-made disasters. Hence they have become an increasingly important implementing partner for the EC and Government alike. The EC has funded several NGOs, mainly in support of the Tibetan refugees in India. This includes support for an integrated development programme, a health care project, construction of a school and library, and development of a transit school to provide literacy and vocational skills to young adults. Other NGO projects have included rehabilitation for earthquake affected villages in Gujarat and Maharashtra and provision of a hostel for tribal girls in Orissa.

Overall answer to Evaluative Question 4

The EC has addressed specific objectives related to the relevant sub-sections of chapters 9 and 10 of the ICPD, and of Regulation 2130/2001 through activities of the EC-GoI Sector Investment Programme, ECHO and NGOs. Delays have hampered the reconstruction following the earthquake in Gujarat, which has been allocated Euros 40m.

ECHO is guided by the principles of humanitarian law in its work, much of which includes action as laid down in the ICPD programme of action. One problem is the lack of success in handing over longer-term projects to other parts of the EC or other development agencies, exit strategies do not always include an appropriate time frame e.g. project for Tamil Sri Lankans in Tamil Nadu.

2.5 Evaluative Question 5

Population composition (incl. age structure, indigenous population, and people with disabilities) and distribution (incl. Internal migration apart from displaced persons, large urban agglomeration and international migration apart from migration into Member States): To what extent have EC supported action addressed specific objectives related to the relevant subsections of Chapters 6, 9 and 10 of the ICPD?

During discussions with various stakeholders, the team did not find much evidence of EC-supported activities addressing specific demographic issues either through the SIP or through support to NGOs under cofinancing.

It should be mentioned here that although not directly, the EC sector-wide approach has a lot of relevance to the demographics of the country, but in its present form it finds it difficult to address broad developmental and structural issues that would have direct implications for the population composition and distribution. A broad development-based approach would address both the demographic issues as well as the health issues more justifiably.

Under the SIP, EU support is being provided to districts and states and several urban centres to enhance the quality of health care services for the disadvantaged populations, including tribals (indigenous groups), rural populations, and slum dwellers. However perhaps it is still too early in the programme to assess improvements made.

It may be useful to consider briefly how current demographic realities challenge current health sector reform activities by examining the age distribution of the population and internal migration.

India has a young age structure with 35 percent of its population below the age of 15 years. The population in the 15-59 year age group (currently 58 percent) is projected to increase to nearly 64 percent by 2016, and the 60 years and over age group is projected to increase from the current levels of 7 percent to nearly 9 percent by 2016. Substantial differences are evident between states in the achievement of basic demographic goals. Furthermore, there are large male/female and rural/urban disparities between states. These differences stem largely from poverty, illiteracy and inadequate access to health and family welfare services, which co-exist and reinforce each other. In many states, the health infrastructure is not adequate. Consequently, India continues to experience a high infant mortality rate, maternal mortality rate, and most importantly the sex-ratio (female to male) in 0-6 year age group has been steadily declining. The practice of discrimination against the girl child and female foeticide are still prevalent and son preference remains significant. It seems clear that women and girls need increased knowledge and capacity building, attitudinal change requires focusing also on the beliefs and behaviour of boys and men, and on service providers and staff at all levels. All these factors have obvious relevance for the future health care needs.

With respect to the elderly, a survey conducted in 1995-96 estimated that 30 percent of the males and 70 percent of the females were completely dependent on others for economic support. In 1999, the Ministry of Social Justice estimated that about one-third of the population in the 60 years and over age group were living below the poverty line. The GoI needs to develop comprehensive policies and services to protect the health and security of the elderly.

Migration has become an essential characteristic feature of every modern society. The latter half of the twentieth century has witnessed a huge shift of population both voluntary as well as involuntary across national as well as international boundaries mainly due to a paradigm shift in the socio-economic and demographic environment in both the developed and less developed parts of the world. Agricultural development, industrialization and urbanization in India have led to internal migration throughout the country as people take advantage of the work opportunities to better their livelihoods.

However, this large-scale movement of population in India has also had a significant bearing on the spread of diseases, including sexually transmitted diseases (STDs) and HIV/AIDS. Moreover, most of these migrants are poor with low levels of education who seek jobs in the informal sector in big cities usually leaving their wives and families behind. They live and work in conditions characterized by poverty, powerlessness and social instability, which further aggregate their vulnerability to STD/HIV/AIDS. Many men who become infected return home later and transmit the infection to their spouses and others. It is in this sense that migration is seen as a facilitating mechanism for the spread of HIV/AIDS. Thus, the contributing factors to the spread of STIs/HIV/AIDS have more to do with power dynamics between partners and their socio-economic situation.

The above arguments are based on a field visit by the team to an HIV/AIDS care and support project managed by the International HIV/AIDS Alliance in Tamil Nadu where HIV/AIDS prevalence is very high compared to other states. It is unfortunate that none of the EC-funded projects in India on HIV/AIDS have developed strategies to contain HIV infection through migration. Rural women need to be empowered not only socio-economically but also with knowledge to understand the modes of transmission and preventive measures, the available channels of awareness generation and to assess the needs for an organized educational campaign. Any intervention strategy should also take into account the linkages between overall socio-economic development and patterns of migration. Although there are some programmes targeting truck drivers and commercial sex workers funded by DFID and other donors, the team did not come across any programmes targeting migrant workers and their families at their place of origin as well as their place of destination. This should be a priority for the EC to assist in containing the spread of the HIV infection in India.

Internal migration also has an implication for urbanization. The volume of net rural to urban migration has been increasing quite significantly at national level in recent decades and will continue to rise. This will create further problems in health, environment and transportation, especially in cities like greater Mumbai, Calcutta and Delhi which already experience an unhealthy environment due to their enormous population size of 16.4 millions, 13.2 millions and 12.8 millions, respectively (according to 2001 census data). Other large cities include Chennai, Bangalore and

Hyderabad with populations of 6.4, 5.7 and 5.5 millions respectively. Unless proper planning is carried out these cities may suffer disastrous consequences.

In conclusion, the team suggest that future EC-supported programmes should consider these demographic realities so that the health care reform initiatives would be sustained within the demographic context.

Overall answer to Evaluative Question 5:

EC supported actions in population composition and distribution have addressed some specific objectives related to the relevant subsections of chapters 6,9, 10 of the ICPD.

The EC sector-wide approach has a lot of relevance to the demographics of the country but does not address broad developmental and structural issues that would have direct implications for the population composition and distribution. The EC has not supported any NGO action under co-financing in this area.

2.6 Evaluative Question 6

To what extent has the design of EC-supported actions facilitated (or not) progress towards the achievement of tangible improvements in the lives of target populations? This includes the choice of beneficiaries (including identifying needs for capacity building and gender), the funding instruments, the planning process……

The Health and Family Welfare Sector Programme was designed to improve the health of the Indian population, in particular poorer women and children, by improving the quality, efficiency and access of the health services. The approach was designed to be needs-based, client-oriented, and participatory. Initially, in 1999, the Programme was started in 11 states, which expressed their commitment to health sector reform. In 2000-2002, all states were invited to join the Programme, which was extended to some 40 districts in 24 states. In 2003, 12 non-performing states were excluded from the programme with 12 states remaining (the original 11 except Kerala plus West Bengal and Chattisgargh). They include: Andhra Pradesh, Assam, Chattisgargh, Gujarat, Haryana, Himachal Pradesh, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Uttar Pradesh, West Bengal.

One of the main approaches of the programme was to involve communities in district planning through initial consultation workshops. The team found in Yamunagar, Haryana, that during the design phase, several workshops had been held attended by representatives of PRIs, NGOs, and elected public representatives to identify their problems and priorities in order to develop effective district action plans (DAPs). These workshops continue to be held to review the plan and activities. Moreover these same groups are invited to the quarterly meetings of the District Health and Family Welfare Societies.

The Community Needs Assessment Approach (CNAA), developed by the World Bank for RCH I, is used for monitoring the programme. Health indicators are developed at each level and simplified registers are used by health workers at sub-centres to feed back into the planning process. However proper needs assessments based on actual and perceived needs of communities are not carried out and mechanisms need to be developed for this.

Village health committees or PRIs are the two main bodies, which enable the involvement of communities in health services management. Although sensitisation for decentralisation is taking place, it is not yet effective. Certain powers can be handed over to PRIs through the Decentralisation Act. In the health sector, it is generally limited to mobilisation of communities for immunisation. In Haryana, functional control of the health sub-centres in the three pilot districts, Ambala, Y.Nagar and Karnal, have been transferred to the PRIs, a small one-time grant of Rps 2500 is provided, under the SIP. As part of this process, PRI representatives (a total of 443 males and 311 females) have attended a training course, each course has about 25 representatives, on the health system and other health and social issues (gender, foeticide etc.) in support of their new responsibilities. A longer-term strategy will be necessary for capacity building and participation in the strategic planning process.

Approaches for community mobilisation differ between states. In Haryana, the Sanjeevani Programme designed by the Department of Women and Child

Development has been adapted under the SIP in the three pilot districts. This programme aims to bring women at community level on a common platform to achieve the goal of holistic development. Other aims include development of leadership skills, awareness of rights and health issues, and optimising the use of health services. These objectives are to be achieved through Sanjeevani leaders who act as volunteer change agents in their villages. They are selected by the Departmental Committee and PRIs and receive 10 days training covering health issues, social mobilisation and legal issues and accounts and record keeping. The role of the Sanjeevani leader is to mobilise the women as an activist social group for collective action through weekly meetings attended by a minimum of 20 women to share knowledge on various health, social and legal issues. A small incentive payment is provided for each meeting held.

The team observed a Sanjeevani meeting of 30 women in progress in which discussions were interspersed with songs and dance. The leader under her own initiative had written songs with strong health and rights messages, and posters with similar messages were placed in strategic places. Records were kept of each meeting. The team noted the enthusiasm of the potential of such groups for attitude and behaviour change, and real bottom-up planning. Later, the sanjeevani leaders told the team that they had found the training useful and hoped it would be extended to others and that refresher training would be provided. As a result of the efforts by the sanjeevanis, referrals to health services are now increasing. However the generation of demand for services through community participation needs to be accompanied by an improvement in the quality of the health services.

Other activities in the community include health camps, especially for immunisation, which provide free and accessible health services to the community. These are organised with the PRIs and were valued by community members.

NGOs also have a role in extending health services to disadvantaged populations and in mobilising communities towards improving their health. Under the SIP, NGOs have been involved in hospital management, organising immunisation campaigns (Pulse Polio), holding health camps on STDs/AIDS, eye problems etc. and providing management advice and support. Some states are working with NGOs to operationalise different approaches to involve communities. Some districts are contracting out service delivery to NGOs and the private sector, for example in Haryana this includes maintenance of facilities and care of hospital gardens.

The team were unable to assess improvements in the lives of the target populations since baseline surveys had not been carried out. However greater involvement of the target populations in the design of the Programme should help to increase their participation in the implementation and monitoring of the programme and facilitate improvements in their lives. In Haryana, the team found that programme managers were collecting data as part of a self-assessment process. They were informed of improvements in the quality of health services through actions at district level relating to personnel and resource allocation issues, and in the access to services for slum dwellers. At the 50-bed district hospital, a doctor was now on duty during the nights and a medical officer had been provided with transportation to supervise the health sub-centres. Transport was also available for pregnant women to reach hospital for emergency deliveries.

Other beneficiaries of the programme include senior medical officers, nurses, ANWs, TBAs through the training activities. These benefits will last long after the EC support has ended.

As part of an integrated approach to population and development, programmes from other sectors have been funded by the EC. These include the District Primary Education Programme (DPEP) and Education for All (SSA), two sector-wide education programmes which include important women's empowerment components focusing strongly on deprived girl children, as do other EC-funded NGO projects in the education sector. However, time did not permit a closer examination of these.

Overall answer to Evaluative Question 6:

The team were unable to assess the extent to which the design of EC-supported actions under the HFWSD Programme facilitated progress towards the achievement of tangible improvements in the lives of target populations due to the short time that had elapsed since the programme had started. This Programme focuses on improving the health of the Indian population, particularly the poorer women and children, using an approach that is designed to be needs-based, client-oriented and participatory. By greater involvement of the target population in the design of the programme, it is anticipated this will help to increase their participation in the programme and facilitate improvements in their lives. Although many projects have been funded under NGO co-financing, evaluation reports were not available to the team.

2.7 Evaluative Question 7

To what extent have implementation set-ups (i.e. suitable structures for planning, implementation, monitoring and evaluation), management mechanisms/tools and processes facilitated (or not) the achievement of expected impacts?

The response to this question is based mainly on the implementation of the Health and Family Welfare Sector Programme under the responsibility of the Department of Family Welfare, and does not reflect NGO implementation mechanisms or the Education Programme due to time and other constraints. The management structures for programme implementation of the H&FWSP are as follows:

- **Joint Steering Committee (JSC)**

JSC is chaired by the Union Family Welfare Secretary and comprises representatives from the DoFW, DoH, other ministries such as Finance, Human Resource Development, and the Planning Commission as well as donors and Indian institutions; State H&FW departments and NGOs can be invited as observers. The JSC provides overall supervision/guidance. It is regularly informed by the Programme Management Bureau (PMB) on programme implementation and proposed technical measures to address reform issues as an input to steer implementation of the national reform agenda. JSC is also the focal point for donor coordination, programme performance review and programme monitoring and evaluation.

- **Programme Management Bureau (PMB)**

The PMB is responsible within the DoFW for the provision of technical support, management and the monitoring of the entire programme implementation. It reports to the JSC and implements its decisions. PMB Chair is the Secretary for the DoFW and members are selected from the DoFW staff.

- **The Inter-departmental Committee**

In the Financing Agreement, this Committee comprises representatives from different government departments and, in parallel, proposes, analyses and monitors activities in related sectors with the aim of ensuring coordination among sectors and addressing cross-cutting policy issues. However it has not yet been established.

- **EC Technical Assistance Office (ECTA), New Delhi**

ECTA which was set up in November 1999 is headed by a European Programme Manager and supported by European and local technical assistance. ECTA works with DoFW and states/districts. Its activities include monitoring and evaluation, programme supervision, assistance on institution building and capacity building initiatives, collaboration with Ministry of H&FW on progress, and preparation of information on implementation (more than 100 papers have been produced on various aspects of the programme). ECTA reports to the EC on its activities and its reports are shared with the PMB.

In 2001, ECTA appointed 5 state facilitators to advocate the concepts of the programme and support the participating states in implementing them and in using the programme's facilities. The number of states was later reduced to three, due largely to financial reasons.

After the earthquake in Gujarat, an additional Euro 40 million was provided to SIP for redevelopment work, part of which was used to set up an ECTA in Gujarat to provide technical support.

Meetings of the different groups above have been variable. The JSC is meant to meet quarterly, but few meetings have been held to date. The PMB usually meets monthly. The Inter-Departmental Committee has never met. It is unfortunate that the supervision and steer of the reform agenda at high level is not being provided. The JSC, in particular should meet quarterly as planned and follow up on its decisions in order to strengthen overall programme organisation.

At central level, certain officers from the Ministry of Family Welfare are charged as 'Link officers' to oversee the reform programme in specific states, in addition to carrying out their regular work. The Mid-term Review (MTR) did not consider this concept was functioning effectively.

The original ECTA team did not perform well and members left. The current team has a larger proportion of national programme advisors than originally planned and consists of competent persons who are providing the main thrust behind much of the programme output. Their role is valued by partners in the centre, states and districts.

State facilitators are reported to be competent and respected but for budgetary reasons their numbers have been reduced from 5 to 3 (in Assam, MP, Rajasthan). Ideally, there should be one facilitator in each participating state if funds were available.

The technical assistance (TA) programme has two main components:

- Information and Visibility component
    - Awareness and understanding of health sector reform issues among stakeholders, including opinion makers and media
    - Advocacy for reforms
    - Information and exchange of good practices
- Institutional Cooperation component
    - Develop partnerships between Indian and European institutions to provide support for reforms
    - Draw on expertise and experience of appropriate European institutions in assessing the reform process
    - Exchange programme, action learning programme
    - Focus on strengthening public health management skills

The TA component should have been started after the TA team arrived and the programme started in 1999. Delays occurred which apparently were due largely to EC internal procedures and it started three years late. The team found some concern that more TA input is required which should be less disjointed than in the past.

Apart from investing in service provision *per se*, the SIP focuses on building up systems and capacities that would ensure the provision of services over the longer

term. One of the early and important interventions was the constitution of integrated District Health & Family Welfare Agencies in the pilot districts, tactically to replace a plethora of vertical programme related societies and strategically to put into place a corporate body that would be able to handle decentralised responsibilities in future. The initiative arose from Orissa and Rajasthan where such integrated societies predated the SIP. The same concept appears in the National Health Policy (2002). At present, nine states have such integrated societies in all districts. Other structural and system initiatives were the Sector Reform Cells at State level and progressive decentralisation; performance-based funding and Memorandum of Understanding between States and the DoFW, both of which are likely to be used in the RCH II.

While operational structures are in place, management skills are weak at state and district levels. There appears to be a willingness to do health sector reform but there is a lack of decision-making power because of the overall state structure. In many states the operational and policy issues in the Ministries of Health and Family Welfare are separate which has raised many problems, which should have been sorted out at the design stage.

Thus, a package of reform tools and processes has been developed which are expected to improve systems and health management. However the team noted that governance still needs to be strengthened and an empowered structure is needed for the management, including financial management, for the Programme to achieve the expected impacts. A longer period of time is required for these changes to become evident.

Due to the slow implementation of the programme, in May 2003 it was decided to withdraw 12 of the total 24 states where progress was lacking and continue the programme with the remaining 12. Other States are expected to join the programme at a later date.

Workplan for Programme implementation

Although in early 2001 the PMB resolved to develop a workplan for the Health Sector Reform Programme this has still not occurred. The time-frame of 5 years for implementation of the programme was clearly inadequate and several stakeholders have indicated a minimum of 10 years would be more realistic.

Overall answer to Evaluative Question 7:

As regards the H&FWSD programme, operational structures are in place but management skills should be strengthened at all levels. The team noted that governance also needs to be strengthened and an empowered structure is needed for the management, including financial management, for the Programme to achieve the expected impacts. While the HFWSD Programme is addressing all these issues, it is perhaps still too early in the programme to make an assessment. This answer does not reflect on NGO implementation mechanisms or the Education Programme due to time and other constraints.

2.8 Evaluative Question 8

How far has the necessary capacity (planning, integrating population into development policy and planning, implementation, monitoring, evaluation, etc.) been created (country level, EC delegations; EC headquarter) to support and facilitate preparation and implementation of population and development strategies and action?

At country level, India has a strong capacity in the area of population and development. The GoI has set up, supports and monitors a network of 18 population research centres in 12 universities and 6 institutions of national repute scattered over 17 states in India. These centres conduct research on various aspects of population stabilization, conduct demographic and socio-demographic surveys, and study communication of Population and Family Welfare Programme. As a result, policy makers are supplied with high quality demographic analysis and data.

At the level of the EC Delegation, population and development is the responsibility of the local health adviser and a local European health assistant. Other EC staff are responsible for NGO projects and disaster preparedness. ECHO staff deal with humanitarian action and liaise with the delegation on disaster preparedness.

Delegation staff were not aware of the EC population policy and were therefore not familiar with the details of the ECs commitments on population and development. However these commitments are in line with the GoI policies and EC development policy which are all followed by the Delegation. Through its participatory approach, the GoI has involved the EC Delegation as well as other donors in the development of GoI strategies on population, RH and HIV/AIDS. This has helped to ensure coherence between EC and GoI policies and strategies.

An objective of the EC-supported Health Sector Programme is to improve managerial and technical capacity among MoH & FW officials. The SIP Document in 1999 noted the wide agreement that if decentralisation was to be effective there must be a great deal of capacity building at local levels. A capacity assessment was carried out as part of the Preparation Phase of the Programme, and although needs varied from state to state, capacity was assessed as weak overall in financial and general management at all levels. The JSC took the decision to institute a 3-month course in public health management aimed at medical officers at district level on the understanding that it would be evaluated and replicated in regional institutions. As a result NIHFW has developed the course and three pilot courses were held during 2001 and 2002, with 22 trainees attending each course (a total of 58 trainees). The evaluation of the pilot course carried out by the Tata Institute of Social Science was positive. In future, it is planned to train three medical officers in each of the 594 districts in the country i.e. a total of 1800 over the next two years in collaboration with 12 other training institutions. This is being supported under the Institutional Cooperation Component of ECTA whose staff have provided technical and financial assistance and are represented on the task force to oversee the course. NIHFW described collaboration with the EC as ‘ceremonial’ which ECTA saw as a positive sign that the NIHFW had now assumed ownership and control of the course. Other areas in which capacity has been identified as weak includes: management of drug supplies and logistics.

At district level, the team found that in Haryana, the Sanjeevani Programme had enabled 159 sanjeevanis (women leaders) from four community health centres in the pilot districts to attend 10-day Foundation training courses organised by the Department of Women and Child Development. Each course covers a health package, social mobilisation, rights, legal literacy, accounts and record-keeping. The team interviewed several sanjeevanis who were very enthusiastic about the training which they said had raised their knowledge and their confidence. In addition, 243 (160 male, 83 female) members of PRIs have also received training to maintain the health sub-centres. Plans are being drawn up to expand the training to all districts in the state. Other states have similar training for PRIs, community leaders and TBAs.

EC is also supporting capacity building through NGO projects. The team visited the Alliance-PWDS project in Tamil Nadu which has conducted capacity assessments among the network of 20 participating NGOs and based on the outcome has developed training courses for NGO workers in such areas as: HIV/AIDS prevention, care and support, sex and sexuality, counselling skills, confidence building, and monitoring and reporting skills. As mentioned previously, detailed information on NGO projects was not available to the team. The Delegation informed the team that NGOs in India in general have a role of advocates and provide hands-on support to the government. They provide relevant inputs to management and planning at local level and partnership for sustainability.

Overall answer to Evaluative Question 8:

An objective of the H&FWSD Programme is to improve managerial and technical capacity among MOH & FW officials. Following a capacity assessment, NIHFW has organised a training course in Public Health Management aimed at medical officers at district level. 1800 medical officers will be trained over the next two years. This will need to be scaled up later to make an effective impact. EC is also supporting capacity building through NGO projects, however the extent of this was not known.

2.9 Evaluative Question 9

To what extent have cross-cutting themes (gender, environment, population and poverty, human rights etc.) been taken into account during the implementation process and whether synergies between the different pillars of population and development have been sufficiently exploited?

The EC-GoI Country Strategy Paper, 2002-2006, focuses on basic health and elementary education as key components of poverty reduction in India. The environment is being developed as a cross-cutting component thus grounding the sectoral work on sustainable development parameters. A pro-choice, pro-gender and rights approach is being adopted during the implementation of EC supported actions in line with the ICPD Programme of Action and EC Development Policy. In support of this, the Delegation has appointed an environment and a gender coordinator in its Development Section. However, the team were not able to meet these staff.

As regards gender, policies, programmes and systems will be established in India to ensure mainstreaming of women's perspectives in all development processes. The National Policy for the Empowerment of Women, 2001, reiterates the national demographic goals for Infant Mortality Rate, Maternal Mortality Rate set out in the National Population Policy of 2000. The policy recognises the critical need of men and women to have access to safe, effective and affordable methods of family planning of their choice and the need to suitably address the issues of early marriages and spacing of children. Moreover, greater attention will need to be given to women's education, which is strongly associated with lower fertility in India. Gender mainstreaming is an integral part of the Country Strategy Paper, 2002-2006.

While, the SIP does not place any specific emphasis on addressing gender equity and equality, poverty or human rights, these cross-cutting themes may be specifically taken into account in the implementation of the programme.

The EC has supported many NGO projects with a gender focus. These include: a Women's Empowerment Center which provided training on gender and development issues; and a Sustainable Tribal Empowerment Programme in which women's health and education are important components. In Gujarat, the EC supports eleven post-earthquake projects aimed at self-sustainable development of the affected families. Women's empowerment through micro-credit is one of the major components of these projects.

The GoI is taking a strong, although as yet not very effective stand, against sex determination. The sex ratio has been declining, especially in poorer states, such as Rajasthan and Bihar where the ratio of females to males is 600 to 1,000 (the global ratio of females to males is about 1,005 to 1,000). This is largely attributed to the strong son preference and discrimination against the girl child leading to lower female literacy, female foeticide, higher fertility and higher mortality levels for females, in all age groups up to 45 years.

In Haryana, another state with a declining sex-ratio, some doctors are using pre-natal diagnostic techniques to determine the sex of a foetus during the antenatal period and providing abortions, even though it is illegal. Health officials told the team that they

had recently caught a doctor red-handed and that other doctors were awaiting trail. The team were told that State officials give social messages in favour of small family size. However, this could be considered against the spirit of the ICPD programme of action in which governments should support the principle of choice in the number of children people have. Incentives are also provided to women by the State authorities to undergo sterilization, although this is not national government policy. Again, this is contrary to the ICPD principle in which 'population and development objectives should be met through education and voluntary measures rather than schemes involving incentives and disincentives'. For example, a couple who volunteer for the sterilization scheme are expected to have a sterilization within a 5-year period; if they have a sterilization following a girl child they can receive 500 rupees per month over 20 years, the amount for sterilization following a boy child is less, 200 rupees. 2500 couples have already enrolled on the scheme and 169 have had sterilizations (16%). It is anticipated that attitudes towards the girl child will largely change through education, empowerment of women and improved paid work opportunities for women, but behaviour change will take a longer period of time.

As regards reproductive rights, there are no effective programmes to address issues of gender power relations and decision-making that determine a woman's ability to adopt safer sex. This should be a concern of policy makers and health professionals who widely advocate interventions such as condom use. These are likely to have limited effectiveness for STD/HIV prevention because women do not have power to negotiate changes in sexual behaviour that are necessary to ensure condom use by their partners. This is also relevant for other reproductive health problems such as unwanted pregnancy and its consequences.

The team did not have the opportunity to make any observations on gender imbalance among government staff. Interestingly, the ECTA team of five (previously seven) has never had a female staff member. In Haryana state, at community level, 30 per cent of places for PRI board members are reserved for women. However, when the team visited PWDS, an EC-supported NGO in Tamil Nadu, all the board members present were male. The Director said that it had been difficult to appoint women members. He was also aware of the gender imbalance among the staff and had recently offered the post of technical officer to a woman who had turned it down because of the large amount of travel in the field.

As regards the integration of various pillars of population and development in development planning, the situation in India is good. Quality demographic data and analyses are available for planning purposes. Population stabilisation is seen as a multi-sectoral endeavour requiring constant and effective dialogue among a diversity of stakeholders, and coordination at all levels of the government and society. Spread of literacy and education, increasing availability of affordable RCH services, convergence of service delivery at village levels, participation of women in paid work force, together with a steady equitable improvement in family incomes will facilitate early achievement of the socio-demographic goals.

Within the EC Delegation, synergies between the different pillars of population and development do occur and should be strengthened. Gender has already been mentioned above. But education is also an important part of an integrated approach to population and development. The EC is supporting the District Education Programme

and 'Education for All', two sector-wide education programmes which include important components on women's empowerment focussing strongly on deprived girl children, as do other EC-funded NGO projects in the education sector.

Overall answer to Evaluative Question 9:

The EC-GoI CSP focuses on basic health and elementary education as key components of poverty reduction in India. The environment is being developed as cross-cutting component thus grounding the sectoral work on sustainable development parameters. A pro-choice, pro-gender approach is being adopted during the implementation of EC-supported actions in line with the ICPD Programme of Action. In support of this, the Delegation has appointed an environment and a gender coordinator in its Development Section.

However, the SIP does not place any specific emphasis on addressing gender equity and equality, poverty or human rights. Although these cross-cutting themes may be specifically taken into account in the implementation of the programme. A limitation of the SIP is that it has to fit the Government policy framework and structures and as a result issues such as gender may not be adequately addressed. Many NGOs supported through co-financing work on cross-cutting themes, including gender issues.

As regards the integration of various pillars of population and development in development planning, the situation in India is good. Quality demographic data and analyses are available for planning purposes. Population stabilisation is seen as a multi-sectoral endeavour with coordination at all levels of government and society. For its part, the Delegation implements programmes in health, education, and gender as part of an integrated approach to population and development.

2.10 Evaluative Question 10

How sustainable are the effects and impacts of EC-supported policies and programmes in the field of population and development, both at the level of individuals and at institutional and policy level in the partner countries?

The EC support to the GoI's Health and Family Welfare Sector Programme is expected to lead to the envisaged health sector reform system, which should be sustainable almost by definition. However, this is likely to take much longer than the five years planned. The H & FWSD Programme is characterised by structural changes in the health care system, such as decentralisation, community participation and public-private partnership. This approach is based on decentralisation of powers and functions to the states and district levels.
District H & FW Societies are being formed which include representatives of the private sector, NGOs and civil society. These societies are delegated certain powers, for example, in terms of management of personnel and finances, and planning according to priorities and needs. As part of a cost-recovery system, they can retain user charges to meet costs of capacity building and repair and maintenance of equipment and facilities. Those people living below the poverty line are provided services free of charge. Once the societies start functioning, it will enable them to expand their services without budgetary constraints. It will also encourage motivation, efficiency, and accountability. The team found that in Haryana State, H&FW societies had been formed at district level but were not yet empowered to make them effective.

SIP also has the potential to develop a sustainable health system at the village level by involving the panchayat leaders in the preparation of action plans. This is necessary to establish linkages with local health care services for sustained support and to foster attitudinal change for greater acceptance of the reforms. However, proper planning is needed for the transfer of responsibilities to PRIs with the provision of the necessary capacity building.

The slow progress in implementing the programme is a cause for concern. However Haryana, which was visited by the team, is an example of a State where progress seems to have been taking place in recent months. To speed-up programme implementation, stronger political commitment, ownership, effective local and national institutions, and funding will all be important.

Government efforts alone will not be sufficient to achieve the desired objectives of the health sector reform programme. Over 80% of health practitioners work in the private sector and more than three quarters of all curative health services are provided by them. While SIP has recognized the untapped potential of the private sector for improving coverage and quality, the challenge is to find ways and means to optimize their potential involvement. For example, larger industries could provide health care services, including reproductive and child health services to their workers and families and extend these services to other people living in the area. Similarly, smaller industries could form a cooperative group for providing H & FW services, in collaboration with the Government. Managerial, marketing and other skills available in the corporate sector could be made available to improve the quality of health and family planning services and IEC activities provided by the Government.

Community participation and empowerment have an important potential to contribute to health and family welfare and it will be important to identify and promote the development of village level support organizations, such as self-help groups of women. Some progress seems to be taking place involving NGOs in health sector reform. Strong linkages need to be made between these organizations and the community-based organizations. This linking and sustaining process becomes the thrust in the following phase with the planned interventions. NGOs should assist in enabling the community to organize themselves, and in implementing various interventions as a response to the community needs in the area of population and development. More efforts will need to be made to improve networking between the State/Districts administration, Panchayati Raj Institutions and NGOs.

In sum, at national level, trend analysis reveals improvements in social and health indicators and shows that the country is committed to the ICPD and the Millennium Development Goals. However these trends mask disparities across and within states on such population issues as gender inequities, HIV prevalence, and the presence of under-served populations such as tribal groups and urban slum dwellers. Other population issues where action has been limited include ageing, urbanization, migration, adolescent health and gender-based violence.

Overall answer to Evaluative Question 10:

The EC-supported H & FWSD Programme was not intended to be sustainable but to lead to the envisaged health sector reform system, which will be sustainable almost by definition, as it is assumed that decentralisation and community involvement will make health services more effective as well as more efficient. The Programme has recognised that Government efforts alone will not be sufficient to achieve the desired objectives of health sector reform and has recognised the untapped potential of the private sector for improving coverage and quality; a challenge will be to find ways to optimise their potential involvement.

As regards NGO projects, information on sustainability was lacking but discussions with stakeholders indicated that sustainability of interventions by NGOs had generally been weak.

3. OVERALL ASSESSMENT

3.1 Relevance

India has made considerable improvements in the health status of its population over the evaluation period with increases in life expectancy and a decline in infant mortality. However it also faces several challenges - maternal and child health indicators are among the lowest in the world. To a large extent, this can be influenced through quality health services. However in India these are often of poor quality and/or poorly accessible, which affects vulnerable groups, in particular women and children. In this context, one must view the definition of the overall development objective of the EC contribution to 'Support to Health and Family Welfare Sector Development' given in the Financing Agreement which is 'to improve the quality and accessibility of health services with particular focus on women's and child health status'. The relevance of this objective is clear.

Since it is becoming increasingly acknowledged worldwide that poor management is the one major factor underlying poor health services in most countries, the relevance is also apparent of the objective of the EC contribution to the National Family Welfare Programme which is 'system support to enhance central, state and district capacities to implement the Family Welfare system policy reform and target-free approach. This is aimed at increasing the quality and impact of services as well as ensuring cost-effective coverage of the full range of family welfare and reproductive and child health services'.

The HFWSD defines an approach characterized by decentralisation and community participation, which should be relevant to contributing to family health of vulnerable groups in the participating states. However there has been little real participation of the community in many of the states perhaps because insufficient time has elapsed for a change to occur. However in Haryana State, which was visited by the team, sanjeevani leaders have been trained in health, social and legal issues which, makes them a valuable source of information to other women in their communities.

In July 2003, the H & FW Department organized a meeting of major donors including WB, DFID, USAID and EC to join in the design of the Reproductive and Child Health (RCH II) Programme planned for the period 2004 to 2008. (RCH II follows RCH I which was largely concerned with data collection and funded mainly by the World Bank). RCH II provides a broader framework for the implementation of H & FW interventions focusing on reproductive and child health and explicitly also on population stabilization (through family planning). For the first time, there seems to be a chance to improve coordination and collaboration between the major donors. RCH II could be very relevant to the EC and might offer the opportunity to spread the concept of health sector reform nationwide. The risk is that reform might be submerged by other activities. The outcome of the recent mission is not yet known but clearly a cautious approach will be needed.

At project level, NGOs supported under EC co-financing have carried out projects in a range of areas under the ICPD programme of action including: reproductive health, basic health, STDs/HIV/AIDS, empowerment of women, employment, education, distress migration, refugees and research. Other areas where action has been lacking include, reproductive rights, population structure and distribution, ageing, urbanization, migration, gender-based violence and adolescent health. One problem is that the NGO projects are selected from Brussels after a call for proposals and

therefore do not necessarily relate to the priority needs or areas in the country. Moreover, there is a lack of integration with the existing health sector interventions, which also reduces relevance.

3.2 Effectiveness

The effectiveness of the H&FWSD is difficult to determine since the Programme is still at an early stage of implementation. However, there are signs that health sector reform is taking place, although the Programme has been only partially effective. Whereas some 32 per cent of programme funds released by the GoI have been used so far for national activities, the funds held by the GoI for states and districts activities have only been partly released, awaiting preparation of adequate action plans. Although the EC budget may have increased resources to the GoI, the question is: has this led to an improvement in the quality and accessibility of health services? According to the recent Mid-Term Review this has not yet occurred.

The limited progress in health sector reform in a country as vast and complex as India should not be surprising. In a process that is described as bringing about a 'change in attitude', it is to be expected that in the initial stage, progress has been very slow. The work of State Reform Cells in the states has been uneven and some SRCs have met only once or twice since the start of the programme. Momentum is likely to develop, but only gradually. However some 'change in attitude' is becoming evident in places. At the same time, persistent steering in the planned direction is needed. For instance, effectiveness could be improved if the SIP had programme facilitators in all states (only 3 state facilitators exist at present) and if national consultants were used to provide more assistance.

Recently the GoI has required all participating states to sign a Memorandum of Understanding in which they pledge to undertake a clearly defined set of reform measures. This may have a positive effect on health sector reform.

Activities to strengthen capacity to support health sector reform are occurring at district, state and central levels. The NIFHW plans to train 1800 medical officers in 18 training institutions over the next two years. However, this is a small proportion of the medical officers nationwide and the training programme will need to be extended to have an effective impact on health sector reform in the future.

Since the start, ECTA has produced various documents and disseminated them widely including on the internet. This has enabled actions to be designed and planned effectively based on past experience.

Effectiveness of EC actions in other areas of the ICPD is difficult to assess. Many projects have been conducted by NGOs and ECHO but detailed information on them, including objectives, outputs, and evaluations, were not available.
According to the Mid-Term Review, effectiveness of the 'redevelopment work' in Gujarat (i.e. all reconstruction other than the prefab buildings paid from the SIP) has so far been limited.

3.3 Efficiency

EC interventions in health and reproductive health appear to have been an efficient way of promoting wider development goals and targets in India.

As regards the EC-supported Health and Family Welfare Sector Programme, initially, many delays occurred in the implementation of activities in a number of states and districts and in the rate of disbursements. Many observers commented that programme implementation could have been more efficient if GoI had been more consistent in its motivation to reform.

According to the Mid-term Review in March 2003, of the 240m euros allocated for the Programme, only 94 million (41%) had been disbursed to the GoI and of those funds only 63% had been disbursed to national, states and districts activities. This equals 25% of total available EC budget. Perhaps as little as 13% of the available EC budget had actually been spent.

It should be noted that in the first two and a half years of implementation, the planning activities, including development of sector reform mechanisms, establishment of new management bodies and procedures, funding systems etc., have been relatively low-cost activities. The rate of disbursements is expected to accelerate now that Action Plans from several states have been received by the Programme Management Bureau and are awaiting approval. However, unless there is an improvement in the quality of SAPs and the rate of approvals and disbursements, the rate of implementation is unlikely to increase.

The ECTA team has performed a major role in supporting the SIP at all levels. Following a new strategy, it is now focusing and intensifying its support on a smaller number of states, which should enhance efficiency in the future.
Finally the EC is a significant member of an informal donors coordination group on population and reproductive health. Other members include the World Bank, UNFPA, and DFID. The MOH and NACO are also invited to attend. The group meets monthly and discussions currently are focused on the design of the RCH II Programme. Improved coordination among donors should result in a more efficient use of funds.

3.4 Sustainability

The EC-supported H & FWSD Programme was not intended to be sustainable but to lead to the envisaged health sector reform system, which will be sustainable almost by definition, as it is assumed that decentralisation and community involvement will make health services more effective as well as more efficient. Moreover, decentralisation is not expected to increase the costs of services. The initial investment costs such as planning, training programmes, developing M & E capacity, strengthening Management Information Systems etc. are being covered by the EC programme, so long as it is there. In the longer term, it is unlikely that recurrent costs of a decentralised service would be higher than those of the existing system. Moreover experiences elsewhere have shown that the health sector reform programme may result in a considerable decrease in costs. However, great care will need to be taken when funding recurrent government expenditure with EC funds e.g. payment of community workers, ANMs, as these funds are likely to cease at some point and sustainability will be at risk.

The HFWSD Programme is due to end in December 2004 however this is too short a period to ensure sustainability of the interventions for health sector reform. Additional time will be needed as well as more concentrated technical assistance inputs (in the form of state facilitators) in a limited number of states and more capacity building.

As regards organisational or social sustainability, it should be noted that the concept of health sector reform arose from 'A Paradigm Shift' produced by the Department of Family Welfare in 1996. This states that the GoI was prompted into its new approach by the expectation that this would lead to an increased coverage and utilisation of services, because grassroots level planning with a bottom up approach would create a sense of participation and belonging among villagers. The same would apply to H & FW staff at the lower levels. Enabling them to do the planning and manage their work would create a sense of participation and belonging among them, and would have the advantage of using specific local expertise.

The benefits of a people's programme with its total reorientation to the clients needs-based approach, decentralised planning and introduction of the RCH package are expected to be permanent phenomena and offers the opportunity to make the whole system more sustainable.

The current negotiations on the design of the RCH II programme is very relevant for the EC programme and may offer great opportunities to spread the concept of health sector reform nationwide. But it also carries the risk of this concept being submerged by other activities. In July 2003, the EC was invited by the GoI to participate with other major donors including the World Bank, USAID and DFID in the design phase of RCH II. This could be a major step towards better coordination of programmes and projects in H&FW and could be recommended under certain conditions that guarantee the survival of the reform concept as a leading principle.
As regards NGO projects, information on sustainability was lacking but discussions with stakeholders indicated that sustainability of interventions by NGOs appeared to be weak. While some large NGOs, e.g. Population Council, will have no difficulty obtaining funds from other donors after EC funding ceases, the situation for smaller NGOs would be more difficult.

3.5 Impact

The EC-supported H & FW Sector Programme was scheduled to cover the five-year period, 1998-2003. Due to various delays, the First Annual Review Mission did not take place until May 2002. Thus the period the Programme has been operating has been too short for it to have had any measurable effects on health and family welfare indicators. Moreover the output indicators are process indicators and are qualitative rather than quantitative indicators and therefore not measurable.

At central level, there appears to be considerable support for the programme and its objectives. In many states, there is also evidence of support and commitment by health managers and administration officials for the reforms, this includes Haryana state, which was visited by the team. There is also support among other agencies, NGOs and community organisations, which offer a wide choice of family welfare methods in line with the GoI reform policy.

The ECTA team are making efforts to ensure the reform structures are in place and operational, that health mangers have the capacities to draw up realistic and achievable plans and that these plans are endorsed and funded in a timely manner.

To assess impact, an important question to consider is how useful are the four outputs of the programme.

1. Policy and operational framework

As yet there is no consolidated strategic framework highlighting the GoIs policy on reform. Probably because of this, there is also no clear guidance to states and districts on possible options for reform, which they can include in their SAPs and DAPs. As a result the SAPs and DAPs still contain a large variety of activities other than health sector reform interventions.

2. Decentralisation

Decentralisation has involved setting up State Reform Cells (SRCs) and District Health and Family Welfare Agencies (DHFWAs), which are mostly in place although many SRCs do not meet regularly. However, handing over health sub-centres by the state to the village leadership has not yet proven effective. It appears that the PRIs generally lack management skills and are not sufficiently integrated in the planning process.

In April 2003, the Mid-Term Review found that in the six states visited, decentralised planning had failed to take into account the expressed needs of communities and mainly focused on the views of health workers and epidemiological data. Some states are planning to exercise their decentralised powers to impose user fees. But the option of health insurance is still underdeveloped.
The involvement of NGOs in representing the population is essential in the decentralised planning process. Working in partnership with NGOs has a huge potential to increase people's knowledge of available health services, their awareness of health issues and thus their access to health care. The SIP has stimulated the development of policies with regard to the involvement of NGOs and private sector in health care, and has contributed to the design of NGO and Social Marketing guidelines. However the ability of districts to prepare comprehensive plans and define areas of NGO service delivery interventions still needs to be strengthened.

3. Managerial and technical capacity

Deficiencies in financial and general management skills are apparent at all levels in the health system. EC-funded actions aim to improve individual managerial skills as well as to increase the number of people with such managerial skills. Training courses in Public health management, covering health sector reform issues, are being organised by NIHFW in 18 training institutions nationwide. To date 58 medical officers have attended the training courses in the pilot phase. 1800 medical officers will be trained over the next two years. However this is a small proportion of the total number of medical officers in the country, and training will have to be scaled up to have a measurable impact in the longer term.

4. Integrated health service delivery and partnerships

Both at district and state level the Programme is moving towards establishing one overall Society. These integrated societies are envisaged to develop one comprehensive plan for their area, rather than a separate EC plan. This is not easy

since DAs and SRCs are still faced with a series of vertical fund flows each earmarked for a special purpose e.g. malaria, TB etc. Nevertheless at state and district levels, with support from ECTA, there is now a strong tendency towards coordination of programmes to avoid duplication of interventions.

SAPs and DAPs vary greatly as each state and district has its own objectives and priorities. Generally, they only address reform issues to a limited extent and largely contain various other activities, including more of the existing activities, aimed at strengthening health services.
Many NGOs play an important role in supporting the reform process through conducting projects, providing technical support and capacity building. NGOs, civil society and the private sector are involved to a varying extent as members of the SRCs or the DFWAs. Their membership allows them to take part in needs assessment and planning.

3.6 Internal/external coherence

The EC-supported actions in population and development in India have been coherent with the three relevant EC regulations on population and development: Reg. 1484/97 on Aid for Population policies and programmes; Reg. 550/97 on HIV/AIDS-related operations; and Reg. 2130/2001 on Operations to aid uprooted people in ALA-MED.

As regards Regulation 1484/97 on Population, EC interventions have supported all three programme objectives, in particular the third objective 'to help … reform health systems in order to improve the accessibility and quality of reproductive health care for women and men including adolescents….'. The H&FWSD Programme fully embodies the programme objective of the Regulation.

EC interventions have responded to all the areas of activities listed under the Regulation to varying extents. Further action needs to be taken to target adolescents and to eradicate of all forms of sexual violence in order to improve coherence with this regulation.

However, EC assistance has failed to complement and reinforce assistance provided under other instruments of development cooperation with a view to taking population issues fully into account and to integrating them in Community programmes.

With regard to Regulation 550/97 on HIV/AIDS, again EC interventions have responded to all the programme objectives largely through to support to NGOs but also through the H & FWSD programme. The NACO representative advised the team that HIV prevalence had not changed much in India since 1998 and that HIV was stabilizing in the general population; the trend in the state of Tamil Nadu was even declining. However the team noted that although the HIV prevalence in India is generally low, there are wide disparities between different states and HIV/AIDS has become one of the most serious public health problems in the country. Greater support will be needed to combat the epidemic in the future. Activities that need strengthening to improve coherence with the Regulation are in the following areas:

- To improve access to treatment for people infected with HIV;
- To increase women's autonomy and enable them to encourage application of means and methods to avoid transmission; protect health of unborn children; IEC to increase awareness among men, women and adolescents.

Finally, regarding Regulation 2130/2001 on aid to uprooted people, EC interventions have responded to the three main aims through ECHO and support to NGO under co-financing.

As regards external coherence, EC-supported actions in population and development have been coherent with the GoIs National Population Policy, 2001; and its National Health Policy, 2002. The main EC-funded programme, 'Support to Health and Family Welfare Sector Development' actually supports the National Family Welfare Programme.

The H & FWSD Programme was based on the Government's 'Paradigm Shift' that defines an approach characterised mostly by decentralisation and community participation and reflects the current policy environment in India. It contains important innovations in its responsiveness to state and district needs, the strength of the dialogue between GoI and EC on policy issues, and its promotion of outcome funding. If successfully implemented, it will contribute to the Programme objectives enabling centre, states and districts to implement reform.

The EC interventions are also in line with the GoI's National AIDS Prevention and Control Policy. As already mentioned, most of these activities are conducted by NGOs, but some activities to strengthen capacity and promote IEC are also conducted as part of the H & FWSD Programme under SAPs and DAPs.

The new CSP, 2002-2007, does not specifically mention population among EC cooperation objectives unlike the previous 5-year plan, which had a specific objective to reduce population growth. The overall guiding principle governing EC cooperation is the elimination of poverty. The EC cooperation strategy will assist India to build its 'human capital' by dedicating its responses to improving basic health services, providing universal elementary education, and restoring a healthy environment. The EC will 'continue to assist in the area of basic health through the ongoing sector programme in collaboration with the Central authorities that aims at integrating family, maternal and child health care in line with the recommendations of the 1994 UN Conference on Population and Development of Cairo'. Other strategic areas of cooperation linked to population include promoting economic and humanitarian cooperation. The new poverty focus of the CSP should enable a more integrated and synergistic approach for EC interventions on population and development in India in the future.

4. RECOMMENDATIONS

The team noted that the EC provides a significant share of multilateral funding in India in the population and reproductive health field and should have a greater presence in the country in discussions on population and development. The challenge for the EC is to make more effective use of its substantial resources so as to work in a partnership approach to make a difference to India's poor. Coordination between the EC Delegation and Member States could be strengthened as well as with other donors and development agencies to avoid duplication and overlap and enable a more efficient use of donor funds.

While EC programmes/projects are addressing many of the issues under the ICPD umbrella and EC regulations, stronger action is needed in a range of areas including: maternal and child health, adolescent SRH, HIV/AIDS, gender equity and equality and migration. Although India is still in the nascent stage of the HIV/AIDS epidemic this is likely to change and the EC response to HIV/AIDS will need to be further strengthened through support to NGOs and through the health reform process supporting decentralization of HIV/AIDS programmes to states. In the past, EC-supported action on HIV/AIDS through NGO co-financing has focussed mainly on targeting high-risk behaviours, as the stage of the epidemic changes, EC support should back up national efforts in a comprehensive approach which addresses all the dimensions of HIV/AIDS.

EC support for the GoI's Sector Investment Programme is due to end in 2004, but progress has been slow and EC funds are seriously underspent; longer-term EC support, including technical assistance, will be required to ensure sustainability of the interventions for health sector reform. Closer collaboration will be needed with the Ministry of Family Welfare and others, in particular, to build and strengthen local capacity to lead the process.

Within the Delegation, action in support of ICPD objectives should not be limited to the health sector, population issues should be taken into account and integrated into other relevant sectors. Training, awareness-raising and capacity building on population issues, especially in relation to poverty reduction, should be provided to EC staff, as relevant. This will be increasingly important with devolution, as the Delegation will not only be involved in programming but will also manage programmes directly which should result in improvements in the quality and speed of delivery of funding to all population and reproductive health programmes.

As regards monitoring and evaluation of population and reproductive health programmes/projects, output and outcome indicators should be used that are quantitative as well as qualitative so that progress is measurable. While considerable quality information has been provided on the SIP, now available on the internet, this is not yet the case for the EC-supported NGO projects.

Annex 1: List of persons met and institutions visited

Date and approximate time	Persons interviewed
Tuesday, 8th July	
0700	Depart for Brussels
10.00 – 12.30	Ms Barbara Kerstiens, AIDCO, D4
14.00	Mrs Teufel, India Desk for European NGOs
14.45	Marianne Lipponen, Task Manager, HIV/AIDS and RH budget lines
15.30	Mrs R Teerink, Relex/H/3
16.30	Antoine Lemasson, ECHO, Desk Officer for India, Nepal, Sri Lanka, Bhutan
19.15	Depart for London
Friday, 11th July	
9.00	Meet Prof Shiva Halli, National Expert for EC Country Mission
9.30	Dr N J Kurian, Adviser, Planning Commission
11.00	World Population Day - Experience Sharing Workshop on Communication Strategies for Reproductive and Child Health Strategies: Lessons for Programming and Research
13.00-13.30	Dr Saroj Pachauri, Country Coordinator, Population Council
16.30	Mr S S Brar Joint Secretary, Ministry of Health & Family Welfare
Sunday, 13th July	Document review
Monday, 14th July	

9.30	Dr M. Kapilashami, Director, National Institute for Health & Welfare
11.00	Mr Parimal Bardhan, Team Leader, Health Sector, Delegation of the EC
	Mrs Diana Rosenow, Health Sector Adviser, Delegation of the EC
15.00-17.00	Mr Surendra Nath, Member Secretary, Nat'l Commission on Population
Tuesday, 15th July	
8.30	Mr Francois Farah, UNFPA Rep. India and Country Director, Bhutan
10.00	Dr Ranjana Kumar, Health Adviser, DFID
11.30	Dr Sabine Flessenkamper, Head of Programme, Population Council
	Dr Gurumurthy Rangaiyan, Director of Projects Population Council
14.00-18.00	Mr J P Misra, Programme Adviser, ECTA

Wednesday, 16 July	
12.00-14.30	Mr A R Nanda, Executive Director, Population Foundation of India (former Secretary, Ministry of Family Welfare 1999-2001)
16.30-18.30	Mr Christian Mandra, TA-Head of Office, South Asia, ECHO Dr Tapan Mahapatra, Programme Asst.-Disaster Preparedness, India, Nepal, Bangladesh, Sri Lanka, Bhutan
Thursday, 17 July	Preparation of Aide Memoire
16.00-17.00	Dr P L Joshi, Project Director, NACO
Friday, 18 July	Visit PWDS-Int'l HIV/AIDS Alliance HIV/AIDS Community based Care & Support project in Tamil Nadu accompanied by Mr Anandi Yuvaraj, Programme Officer, India HIV/AIDS Alliance Meeting with Mr Arthur Harris, Vice President; Prof Joseph Yesudian, PWDS Secretary; D T Rejichandra, Director, PWDS; Sam L Edwin, Sr. Programme Officer, PWDS-Alliance; Selwyn Rose, Programme Officer, PWDS-Alliance; J D John Jayaraj, Programme Executive, PWDS, C Samuel Kumar, Programme Officer, PWDS Alliance; A J Sunder Singh, Programme Officer, PWDS-Alliance.
Saturday, 19 July	Salvation Army, Catherine Booth Hospital, Nagercoil (Partner PWDS-Alliance) Major P Suthanatha Dhas, Administrator Mr Benjamin, Project Manager, Community Health and Development Mr Suresh Kumar, Project Coordinator, Care and Support, Alliance Programme

	Dr Vasanta Rani, VCT centre Sam L Edwin,Sr Programme Officer, PWDS-Alliance Mr Samuel Kumar, Programme Officer, PWDS-Alliance Visit to Centre for Social Reconstruction, Nagercoil Mr Anil Kumar, Programme Coordinator, Programme Coordinator State AIDS Control Society Project Focus Group discussion with 3 social workers, 6 peer educators and 7 volunteers Visit to Community-based Care and Support project in Kuleasekaram and Arumanai Visit to PWDS office, Martandam

Sunday, 20 July	Preparation of report Return Delhi
Monday, 21 July 11.00	Field Visit to Haryana Civil Surgeon and Nodal Officer, Y Nagar Field visit to review Sanjeevani Programme Lunch Meeting with Dr M L Ranger, Deputy Commissioner and Civil Surgeon, Y-Nagar, Dr M. Saluja, Additional Director, Directorate General of Health Services, Haryana; Nodal Officer Visit to District hospital Y-Nagar Depart for Chandigargh
Tuesday, 22 July 10.00 12.00 14.00 17.00	 Dr M Salujah, Additional Director, Directorate General of Health Services, Haryana Dr G S Narula, Data Management Consultant, SIP Mr Rahul Jain, Systems Analyst Lunch meeting: Dr M L Ranger, Dr V V Parshar, Deputy Director, Surveillance ad blood safety, Haryana AIDS Control Society, Dr H Gupta, Director MCH, G L Singel, Asst Drugs Controller, (PNDT Act) Dr V Gupta, Deputy Director, STD Control, Haryana AIDS Control Society Mr Raj Kumar, Commissioner and Secretary to Government Haryana, Department of Health &

	Medical Education Project, Director SIP, Mr M L Ranga, Mnisty of Health Return to Delhi
Wednesday, 23 July 10.30 15.00	 Dr Preeti Kudesia, Public Health Specialist, World Bank Finalise Aide Memoire Debriefing: Parimal Bardhan, Delegation of EC
Thursday, 24 July	Depart for London

Annex 2: List of documents consulted

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Annex 3: Major (>Euro 100,000) ICPD Interventions in India, by thematic cluster, 1994-2001

Note:

HLTH …. Health

HUMAN … Humanitarian assistance (refugees, IDPs, natural catastrophes, etc.)

ICPD …. ICPD core sectors, including HIV/AIDS

OTHR …. ICPD related sectors (employment, education, indigenous populations, etc.)

Source: Population-Development Database

Cluster	Brief description	Project title	Amount	Budget line	Commitment year	Project number
HLTH	Basic health care	Support to Health and Family Welfare Sector Development	240.000.000,00	B73000B00		1996/0009 - ALA/96/09
HLTH	Health policy and mgmt	Preparation Phase for Health and Family Welfare	716.000,00	B7300		1996/0029 - IND/B7-3000/96/029
HLTH	Basic health care	PROGRAMME TOWARDS SUSTAINABLE HEALTH AND NUTRITION DEVELOP- MENT FOR WOMEN AND Children / Youth IN NEED - INDIA	473.585,00	B76000		PVD/1997/543
HLTH	Basic health care	APPUI AUX COMMUNAUTES DE TROIS ZONES DE BIDONVILLES A BOMBAY INDE	442.832,00	B76000		PVD/1997/625
HLTH	Basic health care	SUPPORT TO INDIGENEOUS NGOS IN THE PROVISION OF WATER,SANI- TATION AND HEALTH EDUCATION IN NORTH EASTERN INDIA	401.432,00	B75010		PVD/1995/88
HLTH	Basic health care	TIBETAN REFUGEE HEALTH CARE PROJECT IN INDIA, PREVENTIVE AND PROMOTIVE PROJECT WITH SPECIAL EMPHASIS ON LEPROSY-/TB-CON- TROL – INDIA	325.387,00	B76000	1999	PVD/1999/1010

HLTH	Infectious disease control	INTEGRATED PROGRAMME OF TB CONTROL, HIV/AIDS AWARENESS AND LEPROSY ELIMINATION IN JEYPORE SUBDIVISION OF KORAPUT DIST- TRICT, ORISSA, INDIA	275.673,00	B76000	1998	PVD/1998/205
HLTH	Basic health care	Establish. of aftercare &rehabilitation centre	124.415,00	B75080	1994	IND/B7-5080/94/114
HLTH	Basic health care	AIDE AU DEVELOPPEMENT ET A L'ACTION SANITAIRE DANS LE VILLAGE DE SELIAMEDU, REGION DE PONDICHERY (ETAT DE PONDICHE RY, SUD-EST DE L'INDE)	117.980,00	B76000		PVD/2001/213
HLTH	Infectious disease control	AUNDIPATTY TUBERCULOSIS PROGRAMME - INDIA	114.362,00	B76000		PVD/1997/307
HUMAN	Rehabilitation	REHABILITATION India 2001 - NGO Post Earthquake Rehab.Programme for the State of Gujarat	15.000.000,00	B73030B		2001/0301
HUMAN	Humanitarian aid	Emergency shelter and health care to the victims of the eartquake in Gujarat	10.000.000,00	B7210		ECHO/IND/210/2001/02000
HUMAN	Humanitarian aid	Aide humanitaire en faveur des populations victimes des inondations provoqués par le cyclon 05B sur la côte E de l'Inde.	5.200.000,00	B7210		ECHO/IND/210/1999/02000
HUMAN	Humanitarian aid	Emergency assistance to victims of floods in Eastern India and drought in the Western States of India.	4.650.000,00	B7210		ECHO/IND/210/2000/01000
HUMAN	Humanitarian aid	Emergency humanitarian aid for the people of Rajasthan affected by the drought	3.000.000,00	B7210		ECHO/IND/210/2002/02000
HUMAN	Humanitarian aid	Emergency aid to the victims of the eartquake in India	3.000.000,00	B7210		ECHO/IND/210/2001/01000
HUMAN	Humanitarian aid	Emergency aid to victims of the floods in Orissa	2.150.000,00	B7210		ECHO/IND/210/2001/03000
HUMAN	Humanitarian aid	Humanitarian aid for the most vulnerable people of India affected by the communal violence in Gujarat, the conflict in Kashmir and for the Tamil refuge	2.000.000,00	B7210		ECHO/IND/210/2002/01000
HUMAN	Humanitarian aid	Aide humanitaire d'urgence en faveur des victimes des inondations en Inde.	2.000.000,00	B7210		ECHO/IND/210/1999/01000

HUMAN	Humanitarian aid	Aide humanitaire en faveur de groupes vulnérables affectés par le cyclone de 1999 et la sécheresse successive à Orissa (Inde).	1.180.000,00	B7210		ECHO/IND/210/2000/02000
HUMAN	Refugees / IDPs	Agricultural Development for the Tibetan community	677.266,00	B76008	1996	IND/B7-6008/96/095
HUMAN	Humanitarian aid	Aide humanitaire en faveur des victimes du cyclone en Andhra Pradesh du 6/11/96	570.000,00	B7210		ECHO/IN-/B7-210/96/0100
HUMAN	Refugees / IDPs	THE DEVELOPMENT OF TIBETAN TRANSIT SCHOOL, INDIA	563.775,00	B76000	2001	PVD/2001/564
HUMAN	Humanitarian aid	Aide humanitaire d'urgence aux victimes des inondations en Inde.	500.000,00	B7210		ECHO/IND/210/1998/01000
HUMAN	Humanitarian aid	Humanitarian aid in favour of the victims of flooding in West Bengal - India	380.000,00	B7210		ECHO/IN-/B7-210/97/0100
HUMAN	Rehabilitation	INTEGRATED DEVELOPMENT AND REHABILITATION PROGRAMME FOR THE PEOPLE FROM THE EARTHQUAKE AFFECTED VILLAGES IN LATUR AND OSMANABAD DISTRICTS WITH SPECIAL	323.145,00	B76000		PVD/1996/140
HUMAN	Refugees / IDPs	THE 1993PROJECTS PORTOFOGLIO INTEGRATED DEVELOPMENT FOR TIBETAN REFUGEE SETTLEMENTS IN INDIA	282.313,00	B75010		PVD/1994/506
HUMAN	Refugees / IDPs	INTEGRATED DEVELOPMENT FOR TIBETAN REFUGEE SETTLEMENTS IN INDIA	268.406,00	B76000	1998	PVD/1998/516
HUMAN	Refugees / IDPs	INTEGRATED DEVELOPMENT FOR TIBETANS REFUGEE SETTLEMENTS IN INDIA (THE 1996 PROJECTS PORTFOLIO)	240.010,00	B76000		PVD/1997/523
HUMAN	Refugees / IDPs	REFUGEE DOCUMENTATION PROJECT	235.633,00			DDH/1997/158
HUMAN	Refugees / IDPs	CENTRE AGRICOLE POUR REFUGIES TIBETAINS - ETAT D'ARUNCHAL PRADESH - INDE	146.842,00	B76000		PVD/1997/621
HUMAN	Refugees / IDPs	Emergency assistance in favour of the Tibetan refugees in the Rabgayling camp.	110.000,00	B7210		ECHO/IN-/B7-210/97/0200
ICPD	STD Control including HIV-AIDS	STI/HIV/AIDS Policy and Strategy Development Fund India	1.990.574,00	B7 6310-6211	99	B7-6211 99/379
ICPD	STD Control including HIV-AIDS	IND/B76211/1999/379 - STI/HIV/AIDS Policy and Strategy Development Fund India	1.990.574,00	B76211	1999	1999/0379
ICPD	STD Control	Mobilising Community Care and Support for People living with HIV/AIDS in	1.950.000,00	B7 6310-	99	B7-6211 99/335

	including HIV-AIDS	India		6211		
ICPD	STD Control including HIV-AIDS	Comprehensive HIV/AIDS and STD Treatment and Care Programme for Intravenous Drug Users and their Sexual Partners in India-SHARAN	1.850.000,00	B7 6310-6211	98	B7-6211 98/533
ICPD	STD Control including HIV-AIDS	IND/B76211/98/533 - HIV/AIDS & STD Treatment and Care for IDUs & their partners in India	1.850.000,00	B76211	1998	1998/0533
ICPD	Reproductive health	Development of Models and approaches for Support& Care of PLWHAs; and Improving Reproductive and sexual health of Vulnerable Communities	1.074.091,00	B7 6310-6211	2000	IND/AIDCO/2000/2311
ICPD	STD Control including HIV-AIDS	Prevention of mother to Child transmission of HIV/AIDS	1.015.650,00	B7 6310-6211	2000	IND/AIDCO/2000/2301
ICPD	Reproductive health	Ensuring Basic Reproductive Rights of Maternal Health Care to Poor Women of the Community	777.586,50	B7 6310-6211	2000	IND/AIDCO/2000/2314
ICPD	Safe motherhood	Family Welfare sector Development Preparation Phas	716.000,00	B73000		1997/0090 - IND/97/0090
ICPD	STD Control including HIV-AIDS	B7-6211/97/023	668.000,00	B76211		1997/2239 - AIDS
ICPD	STD Control including HIV-AIDS	Prevention of HIV/AIDS/STD through Human Rights Action	668.000,00	B7 6310-6211	97	B7-6211 97/23
ICPD	STD Control including HIV-AIDS	PREVENTION OF HIV/AIDS/STD, H.R. ACTION	668.000,00	B76211	1997	SAN/1997/23
ICPD	Population policy and mgmt	Children / Youth'S RIGHT TO PROTECTION AND EDUCATION, THENI DISTRICT, TAMIL NADU - INDIA	600.044,00	B76000		PVD/2001/460
ICPD	Reproductive health	A REPRODUCTIVE HEALTH CARE, TRAINING AND INFORMATION, EDUCA- TION AND COMMUNICATION PROJECT IN THE PERI-URBAN AREAS OF HOWRAH, CALCUTTA, USING EXISTIN	493.199,00	B76000		PVD/1996/132
ICPD	Safe motherhood	PROGRAMMA SOCIO-SANITARIO DI BASE E DI SALUTE MATERNO-INFAN- TILE NELLE PROVINCE DI VIJAYAWADA (NAGAYALANKA E ISOLA DI EDURUMONDI) E NAGPUR (THANA) -	390.420,00	B76000		PVD/1997/986

ICPD	Family planning	AN EDUCATIONAL,MOTIVATION AND SERVICE PROJECT FOR IMPROVING MATERNAL AND CHILD HEALTH AND ENHANCING FAMILY PLANNING SERVICES AMONGST LOW INCOME FAMILI	328.761,00	B75010		PVD/1994/495
ICPD	Reproductive health	IMPROVED ACCESS, UTILISATION AND SUSTAINABILITY OF REPRODU- CTIVE HEALTH SERVICES IN EIGHT CLINICS IN INDIA	320.237,00	B76000	1999	PVD/1999/1005
ICPD	STD Control including HIV-AIDS	Treatment and aftercare of drug-dependent persons	243.792,00	B75080		1995/0123 - IND/B7-5080/95/123
ICPD	STD Control including HIV-AIDS	PREVENTING HIV-AIDS-STDS-AND MINIMISE THE IMPACT OF HIV-AIDS ON THE POPULATION OF GUJARAT-INDIA	233.146,00	B76000	1999	PVD/1999/333
ICPD	STD Control including HIV-AIDS	Drug demand reduction forDelhi slums	219.909,00	B75080	1994	IND/B7-5080/94/117
ICPD	STD Control including HIV-AIDS	Drug Demand reduction Project for Delhi Slums	207.635,00	B76210		1996/0030 - IND/B7-6210/96/030
ICPD	Reproductive health	INTEGRATED WOMEN & CHILD DEVELOPMENT PROJECT IN FIVE DIS-TRICTS OF KARNATAKA - INDIA	186.072,00	B76000		PVD/1997/687
ICPD	STD Control including HIV-AIDS	Drug Demand Reduction Programme in Calcutta	183.960,00	B76210		1996/0086 - IND/B7-6210/96/086
ICPD	Safe motherhood	RAFFORZAMENTO DEL RUOLO DELLA DONNA E MIGLIORAMENTE DELLE CONDIZIONI DI VITA DELL'INFANZIA NEL DISTRETTO DI TIRUVALLUR, TAMIL NADU, INDIA	174.009,00	B76000		PVD/2001/108
ICPD	STD Control including HIV-AIDS	PLANNING FOR THE SOCIAL AND ECONOMIC IMPACT OF HIV/AIDS IN D EVELOPING COUNTRIES	170.000,00			SAN/1997/37
ICPD	STD Control including HIV-AIDS	PLANNING FOR THE SOCIAL AND ECONOMIC IMPACT OF HIV/AIDS IN D EVELOPING COUNTRIES	170.000,00			SAN/1997/40
ICPD	STD Control including HIV-AIDS	Assistance for Community Based Drug Addiction	162.054,00	B76210		1996/0088 - IND/B7-6210/96/088
ICPD	STD Control including HIV-AIDS	B7-6210/1996 - Drug Abuse Demand Reduction	141.521,00	B76210		1996/0042 - DRUGS - IND/B7-6210/96/042

ICPD	Safe motherhood	DALIT WOMEN & CHILD DEVELOPMENT	122.138,00			DDH/1997/222
ICPD	STD Control including HIV-AIDS	De-addiction and rehab. for women chemically dep.	112.583,00	B75080	1994	IND/B7-5080/94/110
OTHR	Women in Development	AWARENESS CREATION CUM SELF SUPPORTING PROGRAMME FOR RURAL WOMEN	997.000,00			DDH/1997/246
OTHR	Women in Development	Training Insitute for the Empowerment of Women.	976.000,00	B7300		1996/0041 - IND/B7-3000/96/041
OTHR	Women in development	WOMEN EMPOWERMENT THROUGH SELF-HELP - INDIA	718.694,00	B76000	1999	PVD/1999/738
OTHR	Employment	SANTE PRIMAIRE, PREVENTION DE L'ECHEC SCOLAIRE ET ACCES A L'EMPLOI SUR 10 QUARTIERS DE PUNE - INDE	450.000,00	B76000		PVD/1997/392
OTHR	Women in development	DEVELOPMENT OF DROUHGT PRONE AREA OF MARUNGAPURI AND THIRUVARANGULAM BLOCKS (TAMIL NADU - INDIA)	438.146,00	B76000	1999	PVD/1999/158
OTHR	Women in development	EMPOWERING WOMEN THROUGH SUSTAINABLE DEVELOPMENT II - INDIA	260.919,00	B76000	1999	PVD/1999/47
OTHR	Women in Development	AUSBILDUNG VON MADCHEN UND FRAUEN FUR DEN GESUNDHEITDIENST IN 22 DORFERNIN KOTAGIRI TALUK, TAMIL NADU, INDIA	241.592,00	B76000		PVD/1997/830
OTHR	Women in Development	WOMEN DEVELOPMENT PROGRAMME -ASSEFA-INDIA	204.392,00	B75010		PVD/1994/560
OTHR	Women in development	DALIT DEVELOPMENT PROGRAMME IN BIHAR - INDIA	185.078,00	B76000	1999	PVD/1999/466
OTHR	Employment	CTUC PROJECT FOR TRADE UNION TRAINING IN INDIA	178.190,00	B75010		PVD/1995/347
OTHR	Women in Development	Gender Sensibilisation and training of trainers	161.159,00	B7611		1996/0014 - IND/B7-6110/96/014
OTHR	Women in Development	SUPPORT TO THE INTEGRATED PROGRAMME FOR THE WOMAN AND CHILD IN NEED, CINI, CALCUTTA, INDIA	131.497,00	B75010		PVD/1994/806

THEMATIC EVALUATION OF POPULATION AND DEVELOPMENT ORIENTED PROGRAMMES IN EC EXTERNAL CO-OPERATION

COUNTRY REPORT FOR KENYA

Jane H. Cole and Boniface K'Oyugi

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For the

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CONTENTS

II

ANNEXES

Annex 1: List of people interviewed

Annex 2: List of documents consulted

Annex 3: Country profile: Demographic situation and population policy priorities

Annex 4: Major ICPD intervention in Kenya, by thematic cluster, 1994-2001

ACRONYMS

CBD	Community-based distribution
CPR	Contraceptive Prevalence Rate
DHS	Demographic Health Survey
DFID	Department for International Development
DMPA	Depo Provera (injectable contraceptive)
DSRS	The Department of Standards and Regulatory Services
FPAK	Family Planning Association of Kenya
GTZ	Gesellschaft für Technische Zusammenarbeit
ICPD	International Conference on Population and Development
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Agency
KFHP	Kenya Family Health Programme
MOH	Ministry of Health
NACC	National AIDS Control Council
NGO	Non-governmental Organisation
NCPD	National Council for Population Development
NHSSP	National Health Sector Strategic Plan
ODA	Overseas Development Administration, UK
PMU	Programme Management Unit
PRSP	Poverty Reduction Strategy Programme
RH	Reproductive Health
SQF	Service Quality Function
STIs	Sexually transmitted diseases
UNFPA	United Nations Population Fund
USAID	United States Aid for International Development
VCT	Voluntary Counselling and Testing

1. INTRODUCTION

1.1 Background to the evaluation

On 29 November, 2001 the Board of EuropeAid requested the European Commission's Evaluation Unit to undertake an evaluation of the population theme in EC external assistance over the period 1994-2002 in order to "… verify the logic and consistency of individual actions with the stated objectives and expected impacts."

This evaluation represents the first-ever global assessment of the theme "Population and Development in EC external cooperation programmes." The objective of this evaluation is to provide the Commission with an independent expertise to assess the nature and evolution of its objectives and policies on population and development in external cooperation programmes, and the evolution and volume of the programmes concerned; and to assess its relevance, effectiveness, efficiency, sustainability and impact, and internal/external coherence.

Population is a multi-dimensional concept at the EC, and this evaluation is similarly intended to take a broad view of population and development. The template adopted is the International Conference on Population and Development (ICPD) Programme of Action, spanning the entire field of demography, from reproductive health (including sexually transmitted infections and HIV/AIDS) and family planning through age- and spatial distribution of populations, urbanisation, international and internal migration (including refugees, internally displaced persons, and asylum seekers), disabled persons, population data collection and analysis, and policy making. Information, education, and communication (IEC) activities and activities aimed at gender equality and equity are an equally important component.

The EC plays a significant role in international population assistance, providing approximately 5-10% of global support for the **ICPD goals** focusing on six areas:

- Maintaining and increasing the gains already made in providing access to sexual and reproductive health services.
- Ensuring that women have the opportunity of safe pregnancy and childbirth.
- Promoting the sexual and reproductive health of young people.
- Limiting the spread of HIV/AIDS and caring for those who live with the virus.
- Addressing problems of gender-based violence and sexual abuse, especially of young women and children.
- Building partnerships with civil society.

The EC is also a major source of humanitarian assistance to refugees and displaced persons, a significant amount of which overlaps with population (e.g. reproductive health of displaced populations, resettlement and repatriation programmes, etc.).

The **legal bases** for population assistance for the period covered by this evaluation (1994-2002), which contain the relevant policy objectives, are:

- For reproductive health and family planning: the 1992 Council Communication on Family Planning and the 1997 Council Regulation 1484/97 on aid for population policies and programmes in developing countries.
- For sexually transmitted diseases, HIV and AIDS : the 1994 Communication on Health COM(94)78, Council Regulation 550/97 on HIV/AIDS-related operations, the Communication on Accelerated Action Targeted at Major Communicable Diseases Within the Context of Poverty Reduction (COM (2000) 585).
- For distress migration, internally displaced people and refugees : Council Regulation 1257/96 concerning humanitarian aid, Council Regulation 2258/96 covering rehabilitation and reconstruction operations, and Council Regulation 2130(2001) on operations to aid uprooted people in Asia and Latin America. While the Regulation covers only ALA, it can be construed as expressing EC policy broadly speaking in other regions of the world.

Almost all budget lines and the EDF have been found to finance population-related activities. This evaluation is therefore not limited to any particular financial instrument. The overall objective of this evaluation was to achieve improved coherence and application of the Commission's approach to Population and Development in partner countries through improved decision-making and project management. The evaluation was to be implemented through provision of independent expertise to assess the nature of policies and objectives related to population in external cooperation programmes, the evolution and volume of programmes concerned, and their relevance, effectiveness, efficiency, sustainability, impact, and internal / external coherence. The focus was on a verification/testing of the logic and consistency of EC-funded actions with the stated objectives and expected results.

The evaluation concentrated on the period 1994-2002. It took into consideration, however, issues which were of more recent vintage such as the emerging importance of Sector Wide Approaches (SWAPs). The evaluation covered the Commission’s actions in the field of Population and Development in Asia and the Pacific, Latin America, the Caribbean, Africa (including the Mediterranean area), the Balkans, the Commonwealth of Independent States, and the non-accession countries in Central and Eastern Europe.

The **thematic scope** of the evaluation was bound by the following considerations:

- Gender aspects of Population and Development should be discussed with reference to the on-going EC evaluation in this area. Work in the ongoing Rehabilitation evaluation was also to be taken into account.
- Health aspects took into account findings already developed by the EC evaluation in this area, putting these results/conclusions in perspective and updating them as indicated. The evaluation team were complementing, not repeating, work undertaken by the recent HIV/AIDS evaluation.

- The analysis of international migration was limited to migratory movements between countries and within countries and was to include displaced persons / uprooted people. Migration from partner countries to Europe was not covered in the analysis.
- Only limited attention was given to population, development and education; however, the work on education and communication of DG EAC was taken into account.

Co-ordination, coherence, and complementarity with other key international actors in Population and Development were a key focus of the analysis, as were co-ordination, complementarity and coherence with NGOs.

Field visits

A major component of the Completion Phase of the evaluation consisted of five country field visits to: **Egypt, Georgia, Guatemala, India and Kenya**. The purpose of the country visits was to test and verify the logic and consistency of project and programme actions against stated objectives and anticipated impacts. Through consideration of Evaluative Questions, the evaluation team has assessed the relevance, effectiveness, and coherence of EC Population and Development strategy(ies) and programmes.

Each mission was carried out by a senior international consultant, who collaborated with a national expert recruited in advance of the mission. The duration of each country mission was approximately 10 days plus two days mission preparation and four days report drafting. Approximately five days were dedicated to meeting different stakeholders, in the EC delegation, in partner organisations (line Ministries, NGOs, bilateral donors, etc.) and national actors involved in population issues. Donors (multilateral and bilateral) as well as major NGOs involved in population were also interviewed for bench-marking of EC approach to population. A mixture of participatory techniques, including face-to-face interviews and focus group discussions were used. Approximately five days were dedicated to an assessment of selected programmes or projects. Techniques included interviews and focus groups with beneficiaries, local implementers and other key stakeholders.

Why Kenya?

The EU is a major actor in development assistance for Kenya, accounting for about half of all aid received. There is a substantial health programme. The main project relevant to population and development is the Kenya Family Health Programme co-funded with DFID from 1997-2002. Over five years, it increased the use of quality family planning services in the country. There have also been over 40 projects funded under the NGO co-financing budget as well as ECHO projects benefiting refugees and displaced persons.

Kenya was the first Sub-Saharan Africa country to have an explicit population policy in 1967. Several population research centres are supported by the government ensuring that quality demographic data and experts are available.

However, in view of the difficult political situation in the country during the evaluation period, the lack of government interest in the project, and the high levels of corruption in the system, the choice of Kenya might seem surprising. Since this situation could arise elsewhere, hopefully lessons might be learned on how to deal with such problems in the future.

1.2 Country profile: Demographic situation and population policy priorities

1.2.1 Demographic situation

Kenya's population has more than tripled since independence in 1963 from 9 million to 31.5 million in the year 2002[1]. This rapid increase was initially propelled by high fertility accompanied by substantial decline in mortality particularly infant and child mortality during the period preceding 1980. Since then there has been significant decline in fertility from 8 children per woman in 1980 to 4.7 children in 1999 (a drop of about 41%) and an increase in infant and child mortality (NCPD 1989 &1998; CBS 1996 & 2002). The increase in child mortality is a reflection of diverse socio-economic and demographic factors, including the increasing poverty levels and the emergence of the HIV/AIDS pandemic.

Population Size, Growth and Structure

Kenya's population was enumerated at 28.7 million in 1999[2] and is projected to reach 36.5 million by the year 2010 taking into consideration the impact of HIV/AIDS. The annual growth rate declined to 2.6 per cent in 1999 from 3.8 and 3.6 per cent in 1979 and 1989 respectively. The 1989-1999 growth rate was highest in North Eastern Province (9.5%) and lowest in Central Province (1.8%). The population is still predominantly youthful with about 42 per cent below 15 years of age. Since a significant increase of young women entering reproduction age is expected, the increase in population will continue even with the decline in fertility rate.

Fertility and mortality

Kenya has experienced a rapid decline in Total Fertility Rate (TFR) in the recent past. The fertility rate has declined from 8 children per woman in 1979 to 6.7 in 1989 to 5.4 and 4.7 in 1993 and 1998 respectively[3]. The decline has been attributed mainly to increase in contraceptive use. Contraceptive Prevalence Rate (CPR) increased from 26.9 per cent in 1989 to 39.0 per cent in 1998[2]. However, the momentum of decline has reduced in the 1993 - 1998 period especially in the urban areas. The 1989 - 1993 momentum of decline needs to be maintained so as to attain the national target of

[1] Government of Kenya 2002: Analytical Report on Population Projections, June 2002

[2] Government of Kenya, Central Bureau of Statistics: Kenya population and Housing Census; Vol. 1, 2001

[3] Macro International and Government of Kenya: Demographic and Health Surveys. 1989,1993 and 1998

[2] As above

achieving a growth rate of 2.0 by 2010. The major challenges include tackling the unmet need for family planning especially for the under-served regions, males, young people and other special groups. The national target for CPR is projected at 62 per cent for the year 2010.

Trends in Knowledge of Family Planning Methods and Sources

Knowledge about family planning methods is high and on the increase. Table 6 shows that the trend has continued going upwards. For instance, from 1984 KCPS to the 1989 KDHS, to the 1998 KDHS, knowledge about any method of family planning has increased from 81.0 to 90.0 to 96.8, respectively; whereas knowledge about any modern method increased from 79.7 to 88.4 to 96.3 respectively. Moreover, knowledge about condom use more than doubled from 40.0 as observed during the 1977/78 KFS to 91.5 during 1998 KDHS. Thus, it is plausible to conclude that knowledge about any family planning method is universal throughout the country.

Mortality trends

Indicators for mortality portray an upsurge in both childhood and adulthood mortality in the recent past. Infant mortality rate has increased from 63 per 1000 live births in 1993 to 71 per 1000 live births in 1998. Similarly, under-five mortality rate has also increased from 93 per 1000 live births in 1993 to 105 per 1000 live births in 1998. At the same time, maternal mortality ratio has increased from an estimated 365 maternal deaths per 100 000 live births in 1995[4] to 590 per 100 000 live births in 1998[5], this is a gross underestimate of the true picture. Regional disparities in the mortality rates have persisted with urban areas recording relatively lower rates when compared to the rural areas. Life expectancy at birth declined in the 1989 - 1999 period from 58 to 54 for males and from 61 to 57 years for females. A number of factors are associated with this decline. These include the increase in child mortality, the rising HIV prevalence, other diseases such as malaria and Tuberculosis and the deepening poverty levels among others.

Based on the 1999 population census data, it is now projected that for the period 2005 - 2010, the under five mortality is expected to be 108/1000 for females and 116/1000 for males, while the life expectancy is expected to be 47 years for males and 53 for females. This takes into account the HIV/AIDS pandemic.

Life expectancy

Life expectancy is a very important indicator for both socio-economic and demographic purposes. It is the only indicator that does clearly show whether there is any improvement is the social welfare of a people or there is a decline. Table 8 shows that at the national level there has been a decline in the life expectancy of Kenyan, for both the female and males. For instance, during the intercensal period 1979-89, the male life expectancy was 57.9 and, thereafter declined to 52.8 during the intercensal

[4] PSRI/UNICEF Kenya Country Office; A study on Maternal Mortality in Kenya 1995

[5] Macro International and Government of Kenya: Kenya Demographic and Health Survey 1998

period 1989-99. Likewise, the female life expectancy in 1979-89 was 65.9 and, thereafter declined to 60.4.

This scenario is similar for all the provinces, except for North Eastern province that did record an increase in her life expectancy for both the sexes. For instance, the male life expectancy in 1979-89 intercensal period was 55.3 and it did increase to 62.2; while that for the females was 54.1 in 1979-89 and increased to 61.5 in 1989-99 period.

Migration and urbanization

The rate of urbanization has increased from 15 per cent in 1979 to 18 and 19 per cent in 1989 and 1999 respectively. The urbanization process in Kenya is largely determined by rural-urban migration due to socio-economic development disparities between rural and urban areas, as well as the government policy to accelerate and create enabling environment for growth of smaller urban centres. Other movements include rural to rural mainly due to demand for arable land, and to a small extent internally displaced persons for various reasons, there has been occasional influx of refugees from neighbouring countries.

1.2.2 Policies, programmes and critical issues

Kenya was the first Sub-Saharan Africa country to have an explicit population policy in 1967. This policy focused on family planning as a means of reducing the rate of population growth. The government had earlier in the Sessional Paper No. 10 of 1965 acknowledged the negative impact of high population growth on socio-economic development.

The implementation of the above policy was not successfully done. The total fertility rate increased from 7.6 children per woman in 1969 to the highest level of 8 in 1979. Data collected in the Kenya Fertility Survey of 1978 indicated that the contraceptive prevalence rate was low (below 10% for all methods. The population growth rate also increased from 3 % in 1969 to 3.8% in 1979. This unexpected trend led to the revision of the 1967 policy in 1984 through Sessional Paper No. 4 on "Population Policy Guidelines."

The 1984 policy was more comprehensive. It incorporated both demographic and socio-economic goals as well as diversification of implementing ministries, non-governmental and religious organizations. The following demographic goals were articulated:

- Reduction of population growth rate from 3.8% in 1984 to 3.3% by years 1988 and to 2.5% by years 2000;
- Reduction of fertility;
- Reduction of mortality particularly infant and child mortality; and
- Reduction of rural-urban and rural-rural migration.

The socio-economic goals focused mainly on the improvement of women's status through access to formal education and employment. Kenya had entered a fertility transition phase by 1994 when ICPD was held. The total fertility rate had substantially declined from 8 in 1979 to 5.4 in 1993. The percent of women who were using modern contraceptive methods had also increased from 9.7 in 1984 to 33% in 1993.

Kenya's response to the ICPD agenda was the development of the National Reproductive Health Strategy in 1996, which covers the period 1997 -2010. To operationalise this, two manuals on implementation and training for reproductive health were developed. These documents have been and continue to be extensively utilized at policy, programme and service levels.

The actions and recommendations agreed upon at ICPD propelled the revision of the 1984 policy in 2000 (Sessional Paper No. 1 of 2000). This policy has adequately incorporated ICPD recommendations particularly the inter-relationships between population dynamics and development processes.

Critical Needs in Population and Development

The goal of the Government is to improve the well-being and quality of life of the individual, the family and the nation as a whole. The population programme is one of the programmes that have been developed and implemented to achieve this goal. The various Sessional and policy framework papers articulate the policies, strategies and programmes dealing with population and health as well as other development issues. The Sessional Paper No 4 of 1984 on Population Policy Guidelines guided the implementation of population programmes from 1984 to the year 2000 when the Sessional Paper No 1 of 2000 on National Population Policy for Sustainable Development was put in place.

The focus of the current population policy and programmes is on the following areas in cognisance of the ICPD Plan of Action:

i. Issues pertaining to population and sustainable development;

ii. Issues on population as related to the environment, children, the youth, the aged, persons with disabilities and HIV/AIDS epidemic; and

iii. Family, gender and reproductive rights.

Population has remained a major concern for the government in terms of its impact on the development process. The overall aim of the current population policy is to attain a balance between Kenya's population growth rate on the one hand and sustained rate of economic growth for sustainable development on the other hand[6]. Other major strategies that have been put in place to respond to the concerns include: district focus for rural development; rural urban balance; structural adjustment programs and poverty reduction strategy. The national population policy for sustainable development underscores the integration of population variables in the development process. These concerns include gender perspectives, the family, the youth,

[6] Republic of Kenya, National Council for Population and Development, Ministry of Finance and Planning: Sessional Paper No. 1 of 2000 on National Population Policy for Sustainable Development. PP 2

environment, urbanization and migration, human rights, reproductive health and education. Enhancement of the integration of population variables in sectoral planning is to be attained through sensitisation of policy makers and opinion leaders, strengthening of district documentation centres and family planning committees.

The main focus of gender perspectives is mainstreaming of gender concerns in development planning. As far as the family is concerned the issue is to promote equal opportunities for family members. The involvement of youth in policy formulation and implementation is underscored. The policy urges for implementation of the 1994 National Environment Action Plan. Promotion of rural development particularly rural industrialization to enhance income levels as well as development of smaller urban centres to curb the influx of people into major urban areas are envisaged to respond to the challenges posed by rapid urbanization and the high rate of migration. Expansion of educational opportunities to sustain high enrolment and completion rates at all levels is the key strategy in the current population policy. The plan of action to implement the population policy has been developed at the national and district levels covering the period 2001-2010.

A review of past development plans and Sessional papers indicate that minimal efforts have been made towards integration of population variables in sectoral planning. However, the 9th development plan covering the period 2002-2008 and the Poverty Reduction Strategy Paper (PRSP) for the period 2001-2004 have taken into account the population variables particularly in identifying target groups. To enhance this process there is need to intensify the appropriate use of population data in planning at all levels.

1.3 Summary of country mission

The country mission to Kenya took place between 23 June and 1 July 2003. The mission was carried out by and one international team member, Jane Cole, a UK-based consultant and one national team member, Dr Boniface K'Oyugi, Senior Lecturer, Population Studies and Research Institute, University of Nairobi.

The evaluation was carried out at two levels. At national level, the team worked with staff from the Delegation, government ministries, intergovernmental agencies, other donor organisations and NGOs.

At the programme/project level, the team visited four case study projects:

- Kenya Family Health Programme, Bomu Clinic, Mkomani, Mombasa
- Strengthening of STD/AIDS control, Coastal Province Hospital, Mombasa
- Prevention of mother to child transmission of HIV – Uzazibora project
- Kenya Family Health Programme, Community Health Department, Chogoria Mission Hospital, Meru, Eastern Province

The case studies were selected for several reasons. One was the logistical feasibility of visiting the projects within the short time available; both of these locations were relatively accessible (unlike for example projects in Western Kenya and the border area with Somalia which had security issues). Another reason was that the Kenya Family Health Programme was the EC's flagship population project between 1994

and 2001. While the projects on the prevention and control of STIs/HIV/AIDS are an area of major concern in the country.

Between 1994 and 2001, the EC provided a total budget of Euro 35.4 million for 32 major ICPD interventions in Kenya. Of these, Euro 13 m. (36.8%) was provided to 14 humanitarian assistance projects; Euro 12.99 m (36.7% of total budget) was allocated to 6 health interventions; Euro 7.8 m. (22.0%) to ICPD core sectors, including HIV/AIDS; and Euro 1.57 m. (4.4%) to 4 other ICPD-related sectors (employment, education etc.). A table of major ICPD interventions in Kenya by thematic cluster, 1994-2001, is given in Annex 4.

The methodology used in this evaluation has included a review of relevant literature, including reports, evaluations, CSPs, NIPs, and policy documents; interviews with key informants and stakeholders, and site visits.

The programme for the country mission and people interviewed is given in Annex 1.

1.4 Main constraints and difficulties encountered

The programme was quickly and efficiently put together, but not until after the arrival of the international consultant.

Time constraints restricted the number of interviews conducted and the choice of case studies to those in reasonably accessible areas. Many interviews were held in quick succession over a short period with little time for analysis, discussion and report writing.

The team were unable to interview some key informants including the desk officers for Kenya at ECHO as they had to leave the country on an emergency mission; the DFID staff member involved with the KFHP who was on leave; and the Reform Secretariat was not able to arrange an appointment. The international consultant held a phone interview with the ECHO Officer for Kenya, but was unable to reach the DFID staff member.

The Kenya Family Health Programme was completed in June 2002 so the team were unable to interview the PMU staff who had all the left the country and some other stakeholders involved with the programme had moved from their posts.

Detailed information on NGO projects, including objectives, implementation, evaluations, could not be obtained either from Delegation as NGO co-financing projects are managed from Brussels, or from EC staff in Brussels.

2. MAIN FINDINGS

2.1 Evaluative Question 1

Since 1995, what has the European Commission put in place, in terms of global policies, strategies, and programmes to operationalise its engagements with the ICPD Plan of Action and ICPD+5?

To what extent are the EC policies, strategies and programmes coherent with ICPD?

This Evaluative Question is being answered via Brussels-based interviews, document analysis, etc. The Preparatory Phase concluded that the EC's population policy focus has shifted from concern with rapid population growth as a deterrent to economic development to concern with the right to adequate sexual and reproductive health. In addition to its focus on women, the EC has actively targeted adolescents. This evolving population policy has been *externally coherent* with shifts in the stance of other policy institutions. Moreover, the *internal coherence* of EC population policy has improved over time. There is little sign from policy documents, however, that the EC has sought to exploit synergies with other areas of EC assistance e.g. rural development, education (apart from health and support to refugees / internally displaced persons). Nor has there been adequate consideration of strategic linkages between population policy and policies in other areas.

In view of needs in poor countries and the scarcity of resources, the *relevance* of EC population assistance appears to be assured. The Preparatory Phase did not reach a judgment on whether EC assistance has been *effective* in pursuing policy goals. The validity of the *efficiency* criterion is diminishing with the move towards a human-rights based approach, however, as poor reproductive and sexual health particularly affect vulnerable groups, and as the unit costs of most interventions are low, the EC's population activities may be very efficient means of addressing inequities. The Preparatory Phase also did not reach a conclusion regarding *sustainability*; however, it is widely known that available international financing falls far short of needs and governments are reluctant to commit resources.

The evaluation team has found that the Commission's record-keeping and accounting systems for population projects have been over-stretched as a result of the multiplication of sectors, budget lines, and directorates, as well no doubt as by rapid staff turnover. The team noted that steps are underway in Brussels to unify databases.

Most generally, the Preparatory Phase of this evaluation found that there are opportunities for the EC to enhance its impact in the population field and, by exploiting synergies with other sectors, to bolster the relevance and effectiveness of its overall development approaches. In order to translate these preliminary indications into practical steps and actions, the Preparatory Phase recommended that the Commission proceed with the Completion Phase of this thematic evaluation on population and development.

2.2 Evaluative Question 2

To what extent did EC third country co-operation strategies (especially CSPs, NIPs etc.) reflect an overall population and development sector approach, and respond to the needs of the Cairo Action Plan?

At the level of countries: Were country strategies internally coherent from the standpoint of population and were these population components coherent with the global development policy of the EU?

EC Delegation staff interviewed during the evaluation were not aware of EC policies on population and were therefore not familiar with the details of the EC's commitments on population. The Economic and Political Counsellor who is responsible for population concerns explained that the Delegation does not explicitly emphasise population issues in its activities, but considers that they are addressed nonetheless since population was seen as a cross-cutting issue integrated in development interventions, especially in the health sector.

The recent Kenya-European Community Country Strategy Paper (CSP) and National Indicative Programme (NIP) for the period 2003-2007 developed by the European Commission and the Kenyan Government were drawn up in accordance with the provisions of the Cotonou Agreement signed in June 2000. The CA includes a section on Social and Human Development which states that cooperation shall aim at: integrating population issues into development strategies in order to improve reproductive health, primary health care, family planning and prevention of female genital mutilation; and promoting the fight against HIV/AIDS. However, the CSP does not give health or population priority, instead it focuses on agricultural and rural development and physical infrastructure. Population is not mentioned in the CSP.

The objective of the CSP is to support the Kenyan Government in its efforts to achieve higher and sustained economic growth and to reduce the high incidence of poverty. The CSP reviews GoK priorities and as well as the basic principles, objectives and sectoral priorities of the Poverty Reduction Strategy Programme (PRSP) which remain the guiding framework of Kenya's development strategy and proposes the specific contribution that the EC can provide.

The PRSP identifies seven priority areas of action:

- Agricultural and rural development
- Physical infrastructure
- Macroeconomic support
- Public administration
- National security
- Trade, tourism and industry
- Human resource development

Of these, EC support is concentrated in two main areas: agriculture and rural development, and physical infrastructure, with a focus on roads. In addition, support will be given in appropriate circumstances to macroeconomic and public sector reforms as well as budget support reflecting other PRSP priorities. Under macroeconomic support, one objective is to support improvements in public service delivery, which would include basic health and reproductive health services. However such support is contingent upon Kenya getting back on track with an IMF macro-economic programme.

Population issues are covered in the PRSP mainly under the area of 'Human Resource Development'. While this is not one of the two priority areas for EC direct support, the EC will support the development of capacity for the delivery of local health services and infrastructure strengthening.

In June 2003, the new NARC Government under President Kibaki, issued its 'Economic Strategy for Wealth and Employment Creation, 2003-2007' which is guided by two main principles: democracy and empowerment. The strategy, which is based on the PRSP, the Government Action Plan, NARC manifesto and post-election Action Plan, is relevant to the CSP. Recognising the deterioration in the general health of Kenyans due to HIV/AIDS, corruption and emigration of health workers, the new strategy aims to take corrective action through rehabilitation of existing health facilities and overhauling the system of procurement and distribution of drugs for public health facilities. HIV/AIDS is also on the agenda spearheaded by the President who will chair a Cabinet sub-committee on HIV/AIDS.

Prior to the current CSP, the 8th National Indicative Programme (NIP) of January 1997, was drawn up in accordance with the provisions of the fourth Lome Convention. The four priorities included:

- development and consolidation of democracy, and the rule of law as well as
- respect for human rights and fundamental freedoms
- poverty reduction
- sustainable economic and social development
- integration into the world economy, in particular through the promotion of the private sector and development of trade.

As part of social sector development, one of the main sectoral strategies was to reduce population growth via continued emphasis on family planning service delivery. As a result, EC action in the population area focused on reproductive and sexual health, including HIV/AIDS.

However, reproductive health remained a low priority for the Government of Kenya and to a large extent continued to be donor led, mainly through the Kenya Family Health Programme, supported by the EC and DFID.

EC Cooperation 1994-2001

In response to the Government's Health Strategic Plan (NHSSP, 1999-2004), the EC, in consultation with other donors, has developed a District Health Services and Systems Development Programme (Euros 120m over 3 years), which follows the earlier EC support for the Kenya Family Health Programme (Euros 14.8m over 5 years). These programmes aim at strengthening the quality of and access to health services delivered by public and non-public providers and respond to community needs. The DHSSD Programme was due to start in 2002 but has been delayed.

As regards research, Kenya is a partner in the EC led North-South research cooperation, which has focused mainly on agricultural research. However, the country is expected to be closely involved with the European Developing Countries Clinical Trials Programme on new interventions, drugs and vaccines against HIV/malaria and TB and specific efforts on trial capacity building in Africa.

Other Support areas include humanitarian aid and the link between relief, rehabilitation and development (LRRD). Often due a lack of disaster preparedness in the country, ECHO has had to intervene to deal with the results of drought and conflict, providing support for refugee assistance and drought relief. Community action in disaster preparedness and LRRD are in line with EC development policy. However ECHO is phasing out its programme in Kenya during 2003.

Consistency and relevance of EC-programmes

The current EC country programme is relevant to Kenya's reform framework and consistent with the main policy objective of poverty reduction of both the Government and the EC. The sectoral breakdown is broadly consistent with the sectoral priorities defined in the PRSP. Recent project evaluations including Family Health and community development programme have confirmed the positive trend in project relevance, implementation and impact.

The major weaknesses of ongoing EC-cooperation as identified in the CSP is that (i) it is spread across too many projects, which are difficult to manage; (ii) implementing agencies have not always performed satisfactorily, and (iii) in the absence of sector-wide policy reforms, the sustainability of some programmes may be difficult to achieve.

Overall answer to Evaluative Question 2

The NIP of January 1997 was drawn up in accordance with the fourth Lome Convention. One of the main sectoral strategies was to reduce population growth via continued emphasis on family planning service delivery. As a result, EC action in the population area focused on reproductive and sexual health. However reproductive health was a low priority under the previous Moi Government.

The recent Country Strategy Paper for the period 2003-2007 does not reflect an overall population and development sector approach. The focus is on agricultural and rural development and physical infrastructure. The CSP reviews GoK priorities as well as the PRSP, which remain the guiding framework of Kenya's development strategy. Under the PRSP, one objective is to support improvements in public services, which include basic health and reproductive health services. The new Kibaki Government in its 'Economic Recovery Strategy (2003-2007), has recognised the deteriorating health situation due to HIV/AIDS, the misuse of health resources due to corruption and emigration of health workers, and aims to take corrective action through rehabilitation of existing health facilities and overhauling the system of procurement and distribution of drugs. HIV/AIDS will be given a higher profile and the President will chair a cabinet sub-committee on HIV/AIDS.

2.3 Evaluative Question 3

Reproductive Health: How far have EC-supported actions in this field addressed specific objectives related to Chapter 7 of the ICPD and those of Regulation 1484/97?

Health, morbidity and mortality including HIV/AIDS: To what extent have EC-supported actions in this field addressed specific objectives related to Chapter 8 of the ICPD and those of Regulation 550/97?

Reproductive health

The EC has supported actions in reproductive health, which have addressed all the objectives in Chapter 7 of ICPD and those of the Regulation 1484/97. The main programme supported in reproductive health has been the Kenya Family Health Programme, 1997-2002 (start delayed by two years), co-funded with DFID. EU support amounted to Euros 28m in total while DFID's contribution was Euros 16.5m. This programme was built on an earlier project supported by DFID.

Other projects which are supported through the NGO co-financing budget include: Expansion of MCH/FP services in three selected provinces, Rift Valley, Eastern and Western; and Provision of psychosocial and health support for women and girls in RH/SH in Mosocho Division.

EC actions, in particular the KFHP, have addressed the following specific operational objectives of the Regulation 1484/97:

- Support establishment, development and increased availability of RH care services
- Help with drafting, application or financing of policies which contribute to the better reproductive health of women and girls
- Improve RH care services
- Support IEC campaigns aimed at promoting better RH
- Family planning policy and services, including information and safe and effective family planning methods
- Develop grassroots structures, the voluntary sector, local NGOs and south-south cooperation

The overall goal of the KFHP was to improve reproductive health status of Kenyans in the reproductive age group. The programme led to increased utilisation of quality family planning services in Kenya through the NGO sector, via establishment/rehabilitation of static and mobile clinics and community-based distribution programmes. Family health providers improved the quality of service by being more responsive to client needs. Cooperation and coordination among the FP providers was also strengthened. Unfortunately due to delays in establishing the Standard Quality Function (SQF) Unit in the Ministry of Health, work on improvement of quality standards only started towards the end of the project.

The KFHP had six components:

- Programme management
- Procurement of FP commodities (injectables and condoms)
- NGO support (NGOs with clinic and community-based FP/RH service delivery)
- Private sector support (FP training of 200 providers and provision of equipment)
- Service quality function (within MoH)
- Operations Research

As a result of activities, KFHP had procured 80 percent of national needs for injectable contraceptives and 20 percent of public condom requirements. Distribution to district level was ensured by a USAID-funded logistics management project.

To increase access, KFPH had provided funds to 14 NGOs for infrastructure development, capacity building, training, subsidised family planning equipment and NGOs' running costs.

Under SQF, standards were defined and tools and systems to monitor and improve quality developed. In addition, a curriculum for health inspectors was developed and 15 health inspectors trained.

The final evaluation report prepared in June 2002 concluded that this programme had largely achieved its purpose. By increasing utilisation of family planning services, the KFHP has made an important contribution to meeting the ICPD goals. However it had not been possible to quantify impact.

As regards action in the area of policy under the Regulation, the EC has been represented on the Reproductive Health Advisory Board, chaired by the PS in the MOH which was set up to formulate RH policies and strategies. These include the reproductive health strategy (1999-2021), adolescent reproductive health strategy (2003, funded by the KFHP), commodity procurement strategy and the condom strategy (in development). Moreover the EC attends the monthly Health Sector Donor Coordination Meeting also chaired by the PS MOH, which focuses on the policy and strategic level.

With reference to Chapter 7 of ICPD on Reproductive Rights and Reproductive Health, EC actions have addressed the specific objectives concerning:

- reproductive rights and health
- family planning
- STDs and HIV prevention
- human sexuality and gender relations
- adolescents

Gender concerns have been an integral part of the programme. The NGOs participating in the programme have gender policies and in view of the nature of reproductive health, women are well represented in the workforce and most of the beneficiaries are women. Some projects have dealt with family life education in schools that focus on behaviour change, which focuses on young girls and boys.

Since HIV/AIDS is included in the ICPD Programme of Action under both the chapters on Reproductive Health and Health they have been dealt with under Health.

Support by the Delegation in the past may have been limited since there are no staff with specific expertise in health or reproductive health. However this will change in the near future when a Social Development Officer will join the Delegation to deal with health, education and other social development issues.

Between 1994 and 2000, an EU technical assistant worked in the Ministry of Health as a link between the Delegation and the Ministry to assist with the formulation and implementation of policies in compliance with EU policy and strategies. Other donors also had representatives in the MoH. By 2000, the previous government ended these arrangements with donors. However with the new government, two EU technical assistants will be recruited shortly to assist the MOH implement the District Health Services and System Development Programme co-funded by the EC as part of the new sector-wide approach, which is replacing the previous vertical programme.

PHC, safe motherhood and child survival

With reference to the objectives in Chapter 8 of the ICPD and Regulation 550/97 on HIV/AIDS-related operations in developing countries, EC actions have addressed most of these mainly through the Kenya Family Health Programme.

Within the framework of primary health care, the KFHP integrated reproductive health care and childcare services to vulnerable groups in the poorer areas of the country.

Such services included family planning, antenatal care, post-abortion counselling and care, prevention and control of STDs/HIV, postnatal care for the mother and infant, and access to essential obstetric care. Use was made of community-based services and cost-recovery schemes with a view to increasing the range and quality of services available.

As regards policy, the EC was a contributing agency in the formulation of the National Health Sector Strategic Plan: 1999-2004.

The health situation in the country is of major concern. The leading causes of mortality are related to maternal and perinatal causes; AIDS and AIDS-related diseases such as pneumonia, TB, cardiovascular, malaria and injury. Diarrhoea, pneumonia, measles, malaria and PCM accounts for more than 70 percent of deaths among the under-fives.

Health indicators such as maternal mortality and infant mortality, which were decreasing are now increasing. Moreover with the large population in the 15-49 year group, increased health services are required to meet needs. The Central Bureau of Statistics carries out routine data collection but more specialised statistics would be useful. NCPD has conducted DHS in 1984, 1989, and 1999. The current DHS in 2003

is being done by CBS. NCPD is currently coordinating an assessment of achievements in reproductive health for UNFPA, which will be available shortly.

HIV/AIDS

Two evaluations have been carried out on EC HIV/AIDS projects in recent years. The first was an Evaluation of the EC AIDS/HIV Programmes in Developing Countries carried out by HERA in 1996 which concluded that 'generally the strategies supported by the EC AIDS/HIV Programme cover most of the needs for AIDS programming and are relevant to the problems of the epidemic. It also suggested that the EC AIDS policy for developing countries provided an appropriate framework for present and future AIDS/HIV programming.' A country mission was conducted in Kenya as part of this evaluation. The second evaluation was on policies and programmes in developing countries, 1997-1999, by AEDES. In addition, an overview of the ECs Health, AIDS and Population Portfolio in Developing countries, 1990-1999, was carried out by IHSD in 2000. As a result, the evaluation team will only comment on actions since those assessments.

The EC is a member of a Consortium Group of donors that meets regularly with the National AIDS Control Council to discuss policy and strategic issues. As a result, the national AIDS policy is coherent with EU development policy.

In 1999, the EC supported the publication of HIV/AIDS curriculum developed by the Ministry of Education Science and Technology in collaboration with the Kenya Institute of Education. The curriculum promotes family education in upper primary and secondary schools focusing on behaviour change as one way of creating a window of opportunity to check the spread of HIV/AIDS. In future, the NACC in collaboration with the Ministry of Higher Education is planning action to target university students.

Most EC action however has been conducted through the centrally-managed budget line used to test innovative approaches over short periods of time. The main project concerns strengthening of STD/AIDS control in Nairobi and Mombassa, which started in 1989 and is still ongoing. The project has received several EC grants for differing periods to achieve different objectives within the overall goal. (The question was raised how this project was still being funded under this budget line, but a satisfactory answer was not provided). This programme aims to strengthen management of STD patients and their partners at first and second level; extend STD care from referral centres to PHC centres; and provide support for health education, including outreach programmes and condom promotion; and to strengthen the referral centres' role in training, quality assurance and operational research.

The project is being conducted by the University of Nairobi, Nairobi City Commission (Casino STD clinic), the Mombassa Municipality (Gajoni STD clinic) and the University of Ghent. The Project Manager is based at Coast Province General Hospital, which is a referral hospital for the project. The 2000 Evaluation Report concluded that 'the goal of decentralised, integrated services has only been partly achieved. To achieve it, the project may have to address quite fundamental issues, including project planning and consultative processes, the balance between preventive, community and curative inputs, the project management and participation structure, the competence and limitations of universities and the design and delivery and responsibilities of technical assistance'. The Project Manager noted that the

Ganjoni STD clinic had voluntary counselling and testing (VCT) before the project started when a large proportion of clients were sex workers and food handlers. One outcome of the outreach work has been the introduction of new clients working outside the sex industry and the destigmatisation of HIV/AIDS. The impact of this programme has not yet been properly assessed. However, the programme is unlikely to be fully sustainable after EC funding eventually ends, although the health staff would continue to function and the research continue, however, the service delivery component is donor dependent and would cease.

Since 2001, a programme to strengthen cervical screening has been set up in the provincial municipal council clinics in Mombassa, which is being replicated in Nairobi. This 3-year project involves the following collaborating agencies: the Ministry of Health, Mombassa; University of Ghent for coordination, training, implementation; an Italian university? provides testing for viral infections, including HIV; University of Nairobi for quality assurance; and the Department of Community Health at Makere University, Uganda for a community outreach project. ARVs are provided to HIV positive women during delivery in line with government policy through the Dare project funded by the World Bank. (HIV prevalence through antenatal screening was found to be 14 percent, while HIV prevalence nationally is 11 percent. An innovative approach involves CBOs in the project, which is expected to improve implementation, also the setting up of a cervical screening taskforce, which includes beneficiaries among its members.

The Uzazibora project concerns the prevention of mother-to-child transmission of HIV in Mombasa (formerly called Maisha project). This 4-year project, which started in June 2002 is being undertaken by the University of Ghent in collaboration with the MoH. A clinic was set up to improve access to facilities and provide basic health services as well as VCT. Activities include antenatal care, care during delivery, postpartum care, basic health services and VCT. The project involves village health committees, which is intended to improve implementation. However capacity will need to be strengthened to ensure sustainability after the project ends.

Between 1995-98, a regional programme was supported which aimed to build STD management capacity in Anglophone Africa. This was also carried out by the University of Ghent with contributions from Kenyan organisations, particularly the University of Nairobi and the Nairobi and Nairobi City Commission. Two regional training courses were held in Nairobi and included fieldwork at the Special Treatment Centre, an STD referral centre in Nairobi reconstructed with EC funds.

In view of the high and increasing prevalence of HIV/AIDS in Kenya, the EC will need to consider scaling up its response against HIV/AIDS to make a greater impact for the prevention and control of the pandemic. Substantial EC funds have already been provided through EDF and NGO budget lines, large EC funds have also been provided to the Global Fund on HIV, TB and malaria of which Kenya is a recent beneficiary. However other support could also be important, for example, to improve project design, implementation, monitoring etc. to ensure any response is effective.

Overall answer to Evaluative Question 3

EC-supported actions in the field of Reproductive Health have addressed all the specific objectives related to Chapter 7 of the ICPD and those of Regulation 1484/97. The main programme supported in the fields of both health and reproductive health has been the Kenya Family Health Programme (1997-2002) co-funded with DFID.

The EC-supported KFHP and other projects funded through NGO co-financing in the field of Health, morbidity and mortality have addressed specific objectives related to Chapter 8 of the ICPD and those of Regulation 550/97. In the field of HIV/AIDS, a major EC contribution has been ongoing support to strengthen STD/AIDS control in Nairobi and Mombassa since 1989 through the University of Ghent in partnership with the Nairobi University, Nairobi City Commission and Mombassa Municipality.

2.4 Evaluative Question 4

Refugees, IDPs and distress migration: How far have EC-supported actions addressed specific objectives related to the relevant sub-sections of Chapters 9 and 10 of the ICPD for all countries, and of Regulation 2130/2001 for Asian and Latin American countries?

ECHO and UNHCR staff interviewed were all unaware of the ICPD or EC Regulation 2130/2001. However ECHO action is supported in line with the 1996 Regulation on Humanitarian Assistance, which is coherent with Regulation 2130/2001. The Cotonou Agreement links with both these.

Over the years, the EC has been one of the largest donors in Kenya (through centrally-controlled funds) supporting work in two refugee camps in Dadaab (Somalia border area) and Kakuma (Sudan border area). At present, the total number of refugees is 230,000, of which 145,000 are in Dadaab and 85,000 in Kakuma. Many of the refugees have been in the camps now for 12 years. At the start of the emergency, ECHO short-term support had been provided mainly in the area of protection, registration, health including reproductive health, education, and repatriation, among others. However in recent years, longer-term support for the semi-permanent community living in the camps has been provided by other donors, including and USAID.

A major concern in both the camps has been the high level of maternal mortality (although within WHO standards) due largely to nutritional deficiencies and deliveries by TBAs. Child mortality rates are high but also within WHO standards. It is interesting that the HIV/AIDS prevalence rate is lower in this region than the national figure of 10%, and lower in the camps than in the surrounding areas, 5-7% in Dadaab and 4-5% in Kakuma, although the accuracy of this data is uncertain. At present, a breakdown in WFP food supplies is raising serious concerns. One problem is that food aid is used by women to barter for other goods. It is often found in the local market, which discourages local food production and reduces self-sufficiency. Water supplies are found to be below the minimum standards and teacher-pupil ratios in the primary schools set up in the camps are 1:85 compared to 1:35 in the national schools. This may be partly attributable to the current financial crisis of UNHCR in Africa. However although the situation in the camps may be poor, it is still better in many respects than in the surrounding areas. This can cause further difficulties with the local population and calls for improved coordination between government authorities, donor agencies and NGOs involved in the camps.

Within government, refugee concerns are the responsibility of the Refugee Unit in the Ministry of Home Affairs, which collaborates with development agencies such as EC and OFDA. The Unit may be upgraded to a Department in the near future. The large refugee population exerts pressure on natural resources as well as on government resources/service delivery and an upsurge in insecurity through proliferation of small arms. With the new government the controversial camp-confinement policy of the former government is likely to be relaxed and refugees may even be allowed to get jobs outside the camps, although the camps themselves are likely to remain a feature of the refugee protection system in Kenya.

During the floods of 1997/98 and droughts of 1996/1997 and again in 1999/2000, there was a certain amount of short-term displacement (particularly during the floods) and ECHO provided funds to various member state NGOs.

Since early 2000, ECHO has focused on mitigating the impact of the 1999/2000 drought as well as building capacities to cope with future natural disasters. For the period 2002-2003, ECHO has supported an integrated package of drought relief projects includes the rehabilitation of over 200 water points and the creation of water management committees, and the training of hundreds of animal health workers in livestock vaccination and treatment. One project designed to establish 'water mapping' system in four districts of northern Kenya will provide pastoralists with practical tools and skills for overcoming future climate-related hazards. Projects have been carried out by NGO partners such as Merlin, OXFAM, COOPI and Intermon. However now that the emergency phase has passed longer-term donors are needed. The World Bank plans to fund a 6-year programme, 2004-2010, in the area of emergency/disaster preparedness aimed at improving Kenyan administrative capacity in disaster management, including drought, in critical areas of the country.

DG Dev has not provided funds through co-financing for refugees, IDPs and distress migration. However during the drought it provided support to the World Food Programme for food relief activities.

Meetings on the Food Security situation in Kenya are being coordinated by the Office of the President, under the Arid Lands Resource Management Project, and attended by representatives of relevant government departments and donors including ECHO and EC.

ECHO also collaborates with UN agencies. Previously, UNHCR used to host donor coordination meetings on an ad hoc basis depending on needs. However over the past two years, under a new initiative, Joint Strategic Planning Workshops have been held annually to which ECHO/EC has been invited. UNHCR has presented a country needs assessment identifying areas for support by donors. This is proving a useful mechanism for coordination, although ECHO has no funds available.

For its part, ECHO is phasing out its funding for Kenya during 2003 since the situation no longer requires short-term emergency assistance. No funds will be provided in 2004 unless a new disaster emerges in the country. New partners are needed from among the development agencies to take over the longer-term action.

Overall answer to Evaluative Question 4

EC-supported actions have addressed specific objectives related to the relevant sub-sections of Chapters 9 and 10 of the ICPD for all countries, and of Regulation 2130. Over many years, ECHO has supported work in two refugee camps on the borders with Sudan and Somalia. ECHO has also focused on mitigating the impact of the 1999/2000 drought as well as building capacities to cope with future natural disasters. However since the emergency phases are now over ECHO is phasing out its programme in Kenya and funds will not be provided in 2004.

2.5 Evaluative Question 5

Population composition and distribution: To what extent have EC supported actions addressed specific objectives related to the relevant subsections of chapter 6, 9, and 10 of the ICPD?

In the 1994-2001 period, the EC programme support to Kenya focused on the RH component of the population sector although a number of EC-supported actions addressed indirectly some of specific objectives related to the relevant subsections of chapters 6, 9 and 10 of the ICPD.

On population growth and structure, chapter 6 of the ICPD contains specific objectives that required actions in four main areas: fertility, mortality and population growth rate; children and youth; elderly people and persons with disabilities. The Kenya Family Health Programme partially addressed some of these ICPD objectives and recommended actions. The supply of injectable contraceptives (80 percent of Kenya's requirement over the 1996-2000 period) and condoms (20 percent of the total distributed in the same period) partially addressed the ICPD objective of facilitating the demographic transition to reduce the imbalance between demographic rates and social economic and environmental goals.

The need to optimise demographic trends with social and economic development is very critical. In this regard, EC supported interventions on poverty reduction among the poor and mitigating the socio-economic impact of HIV/AIDS, especially in the education sector and on economic productivity.

The programme also covered adolescents, youth and rural-urban poor. It therefore contributed towards meeting special needs of adolescents and the youth particularly young women with regards to provision of high quality reproductive health services. Moreover the recent National Adolescent Reproductive Health Policy launched in July 2003 had benefited from inputs form the EC and other donors.

On mortality, the programme may have contributed indirectly, although trends in mortality rates especially infant mortality that had been declining over time started to rise again in the 1993-1998 period. The programme, however, did not address the ICPD objectives on the elderly and persons with disabilities.

Chapter 9 of the ICPD on internal migration contains specific objectives in three main areas: population distribution and sustainable development; population growth in large urban agglomerations and internally displaced persons. Although no specific EC programmes in Kenya addressed these specific objectives, the 8th EDF National Indicative Programme implemented from 1997 had two areas of focus (stipulated in sections 2.1.1 and 2.2.1 of the document) could have contributed indirectly towards addressing the objectives on internal migration. The two areas of focus were the productive sector strengthening and social sector development.

The specific objectives on chapter 10 of the ICPD on international migration are in the areas of: international migration and development; documented and undocumented migrants; refugees; asylum seekers and displaced persons. The EC supported actions that appear to focus on the third listed area although the interventions have been carried out under the centralised controlled budget. Discussions by the team with the staff of ECHO and UNHCR confirmed that EC

contribution is substantial in financing the operations for resettlement and repatriation of the refugees and IDPs.

Kenya's National Population Policy for Sustainable Development came into force in the year 2000. It outlines the population and development goals, objectives and targets to guide its implementation up to the year 2010. The scope of the policy is wide and incorporates aspects of the ICPD Plan of Action that are relevant to Kenya. With specific reference to chapters 6,9 and 10 of the ICPD, the population and development goals, objectives and targets outlined in Kenya's policy document also include full integration of population concerns into development process and in particular the integration of the youth, the elderly and persons with disabilities into the mainstream of national development. The policy also recognises that development catalyses reduction in mortality, fertility and population growth due to improved health care and family planning services. The NCPD, which was established in 1982, is the advisory body of the government for coordination and promotion of all population related issues. It is a department in the Ministry of Planning and National Development. The NCPD has a secretariat with five divisions. District-based officers with support of the secretariat undertake the district level implementation and coordination.

The assessment of the ability of the Government to support the achievement of EC programme objectives sufficiency/consistency of activities carried out and results is based on the results of the discussions with key officers in the line ministries of Health, Finance and Planning. It has also taken into consideration the discussions with selected NGOs that participated in the EC supported Kenya Family Health Programme. The government had in place structures that were appropriate for achieving the EC funded programme during the review period including the NCPD responsible for providing population policy directions and coordinating the implementation of the policy and programmes. In this context, the formulation and implementation of the EC funded Kenya Family Health Programme involved the stakeholders. Measures were put in place to strengthen some of areas perceived to be weak, especially for the NGO component. The individual project sites were spread widely targeting disadvantaged rural areas in Kenya, such as Tharaka District in Eastern Province and urban slum populations in Mukomani in Mombasa.

In conclusion, the focus of the EC support in RH programme during the review period was mainly on family planning and is consistent with the national population policy as stipulated in the National Population Policy for Sustainable Development. Supporting Kenya in its family planning efforts had some contribution in improving access and use of family planning methods. The actual contribution of EC support in slowing down the population growth rate and changing the age structure was not possible to quantify due to inadequacy of information

Overall answer to Evaluative Question 5

EC supported actions have addressed specific objectives related to the relevant subsections of chapters 6, 9, and 10 of the ICPD but mainly indirectly. In particular, the Kenya Family Health Programme addressed the ICPD objective of facilitating the demographic transition to reduce the imbalance between demographic rates and social economic and environmental goals. It also covered adolescents, youth and rural-urban poor. On mortality, trends of mortality rates, especially infant mortality have actually been increasing in the 1993-98 period. EC actions did not address the ICPD objectives on the elderly and persons with disabilities. As regards internal migration, no specific EC programmes addressed these specific objectives. EC has also supported action on refugees and distress migration through ECHO and the NGO co-financing budget.

2.6 Evaluative Question 6

To what extent has the design of EC actions facilitated (or not) progress towards the achievements of tangible improvements in the lives of the target populations? This includes the choice of the beneficiaries (including identifying needs for capacity building and gender), funding instruments, planning process

Discussions by the team with the officials from EC delegation, line ministries, and the stakeholders confirmed that the EC-funded RH programme in the past was formulated based on the priorities of the government as stipulated in the policy documents. It is difficult to quantify and isolate the actual contribution of the EC-funded RH programme in terms of impact. According to the 1998 Kenya Demographic and Health Survey (KDHS) the total fertility rate decreased in the 1993-1998 period with an increase in contraceptive prevalence rate, but since the KFHP had only started in 1997 it cannot have had much effect. The EC Programme assistance focused on increasing access to family planning commodities with a bias on injectables. It facilitated increasing the choice of family planning methods and attainment of family size aspirations of the population served. It would be interesting to see from the results of the 2003 KDHS survey if the 1993-1998 momentum of fertility decline has changed or maintained following the start of the KFHP. It must be stated that the impact of the NGO projects under the EC-funded RH programme was difficult to measure since the NGOs did not do baseline surveys. In addition, not many of them had the capacity to do needs assessments although this may have improved after some of the training. Since the NGO projects were small, the evaluations could only focus on outputs and not outcomes.

Although the design of the KFHP was finalized after the 1994 ICPD, its focus remained in the narrow area of family planning rather than integrated reproductive health. Various attempts were made during the project lifetime to widen the focus by supporting NGO clinics that provided integrated reproductive and general health services. The design was guided by the Health Policy Framework, that stipulated among others, the Ministry of Health intention to create an enabling environment for increased private sector and community involvement in health services provision and finance. The EC support for NGO service delivery of family planning was in line with the policy objectives of the government and DFID. The NGOs were expected to provide a more cost-effective service than the government and hence more responsive to community needs and targeting the underserved groups.

The KFHP design was built on lessons learned from previous NGO support through the MOH/World Bank Integrated Rural Health Services/Family Planning Project and the World Bank/ODA Third Population Project. The funds for the previous NGO support had been channelled through the NCPD. The KFHP was therefore designed as a joint collaborative exercise involving EC and DFID with a parallel financing arrangement whereby EC support was through the government while DFID support was provided directly to NGOs through KFHP. There has been a shift in policy towards a sector-wide framework for the future and in this regard, NGOs will be able to access public funding from government and donors through contract from the District Resource envelope. The design was also consistent with the pro-poor approach as stipulated in the National Poverty Eradication Plan 1999-2015, interim

Poverty Reduction Strategy Paper 2000 and national health plans. In these documents, the government commits itself to enhancing the equity, quality, accessibility and affordability of basic health resources to the poor.

During the KFHP project preparation, the EC and DFID involved the MOH, NCPD, NGOs and other donors. A social development appraisal in the field was carried out during the preparatory phase in an attempt to involve targeted communities in the project design. DFID undertook detailed technical, economic, institutional development and gender appraisals. A taskforce was set up by NCPD and MOH to facilitate the nomination process for the potential participating NGOs. The criteria for selection took into consideration the NGO's proposed activities, institutional capacities, gender and sustainability issues. The beneficiaries were therefore selected after broad consultations involving government and the EC Delegation. In the past, beneficiaries were not very involved in the projects, however, from the lessons learned beneficiaries are increasingly being included in the steering groups and task forces for the NGOs and CBOs.

Although the individual NGOs that participated in KFHP were not fully assisted to develop planning management tools more relevant to their organizations, the project assisted them to acquire new skills to improve the quality of their programming in RH. Their institutional assessment had revealed weaknesses in the following areas: organizational structure and management systems; financial management and accounting; monitoring and evaluation; and, RH/FP programming and technical skills. At the individual project level, the participating organisations were assisted to assess their capacities and initiate measures to address them. However, it was noted that the strengthening of the capacities of the NGO component only took place towards the end of the project. It would have made a big difference if this had been done at the beginning of the project. Discussions with the NGO project staff suggested that they had learnt a lot from the implementation process.

The target population were all men and women of reproductive age regardless of marital status, the vulnerable (widowed, divorced, young girls), and the underserved groups (youth and men). Attempts were made to reach the poor and to target the rural communities. The demand creation aspect of the project was not well designed. The project assumed that improved supply of quality services would lead to increased demand. The question that remains and not well answered is whether the poorest are really being reached. Another question might be are the poorest using the services, and if not, why not?

In sum, the EC-funded KFHP contributed to the vision of the health sector to create an enabling environment for the provision of sustainable quality health care that is acceptable, affordable and accessible to all Kenyans. The EC actions therefore contributed to the two national targets of increasing access to family planning (from 60 to 90 % by 2010) and reducing prevalence of HIV/AIDS (by 15%) and also STDs (by 50%). The actions also supported the strategic national objectives of managing the population growth rate (to stabilise at 2.1% by 2010 as stated in the population policy document) and creating an enabling environment for increased private sector participation in health provision (as stated in the National Health Sector Strategic Plan, 1999-2004). The EC actions through the KFHP provided indirect support to the Reproductive Health Strategy 1997-2021. The RH strategy aims at increasing contraceptive provision to maintain the CPR levels, reducing the large unmet need in some geographical areas and some segments of the population, such as the unmarried

youth, and involving the private sector to reach the low-income populations. The EC actions therefore contributed to Kenya's efforts towards achieving the MDGs and targets, especially in RH.

Overall answer to Evaluative Question 6

The EC-funded KFHP contributed to the vision of the health sector to create an enabling environment for the provision of sustainable quality health care that is acceptable, affordable and accessible to all Kenyans. The project design is consistent with the pro-poor approach in the PRSP and national health plans. The target population of the KGFHP were women and men of reproductive age, particularly the vulnerable (widowed, divorced, young girls) and underserved groups including youth and men, in poor urban and rural communities. A social development appraisal was carried out in the field during the preparatory phase in an attempt to involve targeted communities in the project design. However, the demand creation aspect of the project was not well designed. The project assumed that improved supply of quality services would lead to increased demand. The question remains: whether the poorest are really being reached. If not, why do people lack interest in reproductive health?

2.7 Evaluative Question 7

To what extent have implementation set-ups (i.e. suitable structures for planning, implementation, monitoring and evaluation), management mechanisms/tools and processes facilitated (or not) the achievement of expected impacts?

The response to this question has been based mainly on the implementation of the Kenya Family Health Programme.

The KFHP pre-dated the ICPD (1994) and was designed as a vertical family planning programme now outdated and replaced by a sector-wide approach. The KFHP was built on an earlier FP project funded by DFID. Later, efforts were made to expand the breadth of the project to encompass reproductive health, particularly following the Mid-term Review in 1999.

The programme organisation and management of the KFHP consisted of the Programme Management Unit (PMU), Programme Steering Group (PSG) and EC Technical Assistant to the programme. The PMU was responsible for the technical implementation with the expected close involvement of a MoH counterpart, which was intended to promote ownership by the MoH, but this was not successful as MOH did not provide adequate manpower. Overall direction of the programme was provided by a Programme Steering Group chaired by the PS in the MOH that included representatives from the EC Delegation, NAO and PMU. This group met regularly, initially even monthly, and functioned well. Closely linked but independent to the PMU was the EC Technical Assistant. His role was to ensure co-ordination and communication between all parties and the MoH, which was responsible for the overall implementation. He also had an advisory role on general issues concerning the health sector.

However, the PMU performed a useful role in efficiently managing the project at a time when organisational structural changes were occurring within the MoH. The Final Evaluation Report considered that 'it is unlikely that other arrangement would have succeeded as well in the circumstances'. However even with the PMU, delays were incurred in setting up systems that suited the demands of the two donors and the GoK. EC tendering procedures (banking and procurement procedures) took longer than expected. Further delays were due to the EC requirement for prior approval of costed Annual Work Programmes for each of the EC-funded NGOs as well as for the PMU. NGO reporting systems also took time to develop. The programme, which was due to start in 1995 was eventually implemented in 1997, two years late.

The procurement process for contraceptives was complex and time-consuming. The tendering and financing processes of the two donors involved two sets of rules and procedures. However the PMU did ensure that information for procurement of commodities flowed smoothly through a complex supply chain that included donors, international manufacturers, the Logistics Management Unit, and a multi-tiered in-country pipeline.

Overall the PSG provided effective support for project implementation. Problems did arise initially as the PSG met quarterly and there was no effective mechanism to make more frequent management decisions. As a result, a PSG 'Core Group' was formed which met monthly comprising GTZ, MOH Project Coordinators, and representatives from DFID and EC, which worked well.

The PMU was closed and staff left the country in June 2002. However the NGO projects were not completed until December 2002 and they were assisted by the NCPD in the interim period with funds from the World Bank.

Since completion of the project, issues remain to be resolved regarding the unspent funds (Euros 3m), which were earmarked by the PSG for procurement of injectables since stocks have become low nationally. This is particularly unfortunate since partly as a result of the programme 45 per cent of women currently use injectables as their preferred method of contraception. In the meantime, UNFPA have agreed to provide injectables to avert a stock out situation.

Overall answer to Evaluative Question 7

KFHP predated the ICPD and was built on an earlier DFID-funded project. It was designed as a vertical family planning programme, which is now outdated in favour of the sector-wide approach currently being promoted by the EC. The Programme Management Unit was responsible for the technical implementation with the expected close involvement of the MoH counterpart, but the latter did not occur. Overall direction was provided by a Steering Group chaired by PS, MOH. Even with the efficient PMU, delays occurred for various administrative and organisational reasons and the programme started two years late. The Final Evaluation report stated that it was unlikely that an arrangement other than the PMU would have succeeded as well in the circumstances. Euros 3m remained unspent at the end of the project which had been earmarked for procurement of injectable contraceptives.

2.8 Evaluative Question 8

How far has necessary capacity (planning, integrating population into development policy and planning, implementation, monitoring, evaluation etc.) been created to support and facilitate preparation and implementation of population strategies and action?

The EC support to Kenya in the broader population and development field during the review period as noted earlier focused on the provision of RH services. The results of the analysis of the KFHP budget strongly indicate that the programme target was on contraceptive supplies (allocated 62% of the total budget) and NGO service provision (allocated 27%). That meant that only 11 percent of the programme funds were allocated to the remaining four other programme components as follows: NGO capacity building (5.6%); service quality function (3.3%); private sector training (1.0%); and, operational research (1.1%).

At country level, discussions by the team with government officers suggest that KFHP component of Service Quality Function partly facilitated creating the necessary capacity in the Ministry of Health to develop the Kenyan Quality Model (KQM) for health services and systems monitoring and evaluation. Delays meant that the KQM was not available until the end of the project, thus reducing its effectiveness. The Department of Standards and Regulatory Services (DSRS) is already piloting the use of the master checklist and Kenyan health standard scoring system to test the model in selected health facilities at provincial and district levels. The model can be used to assess the quality of health services being provided in a facility based on a number of variables including: leadership, human resource management and resources. The model is capable of providing the management and policy makers with critical information for improving the process and results of Health Service Delivery System. The improvement of the health service delivery system is a critical factor in provision of quality health services in general and RH services in particular. This by extension has an indirect contribution to improvement of the MOH institutional capacity for planning, policy development, implementation, monitoring and evaluation of national RH programme that is one of the critical components of the ICPD Plan of Action.

The KFHP funding allocated for NGO capacity building, private sector training and operational research created some necessary capacity, especially for the 14 participating NGOs to facilitate planning, implementation, monitoring and evaluation of the RH services in their organizations. The coverage and the vertical nature of the programme limited the overall national impact and sustainability of the created capacities nationally and for the participating institutions.

It must be pointed out that Kenya as a country has developed the necessary capacity to plan and facilitate the implementation of population and development strategies and actions aimed at integrating population into development policy and planning, implementation, monitoring and evaluation. A number of critical national institutions are already in place. These are: the Central Bureau of Statistics responsible for national data collection including population data; Population Studies and Research Institute at the University of Nairobi responsible for population research and training; the National Council for Population and Development responsible population policy

development and implementation; and, other local, regional and international organizations involved with population and related matters. However, a difficulty is to motivate and retain staff.

Since the 1994 ICPD, the government has put in place a National Population Policy for Sustainable Development as a Sessional Paper No. 1 of 2000. It has also put in place a Plan of Action to implement this policy from 2001 to 2010. The sub-regional Plans of Action (for 57 districts) have been completed. Significant actions have been taken on integrating population concerns into development planning, implementation, monitoring and evaluation. However, some critical capacity issues require attention and these include: strengthening the framework for coordinating inter-sectoral integrated population development planning; developing appropriate population-development planning models relevant for Kenya; and, improving the utilization of population and related data for effective planning, implementation, monitoring and evaluation of development programmes at all levels.

At the level of the EC delegation, the assessment by the team is that insufficient capacities exist to facilitate full integration of population into development policy, planning and implementation. This is partly attributed to the priority areas for EC support to Kenya during the review period. Since the EC funds went mainly towards health infrastructure strengthening, perhaps health experts were not considered so necessary as now. The broader area of population and development was partly covered under the social sector development in the health section. The planned increase of programme staff in this sector will enhance the required capacity especially on HIV/AIDS.

In conclusion, the assessment by the team is that appropriate structures exist in the government to support and facilitate preparation and implementation of population strategies and action. However, the structures require further strengthening and financial support to facilitate the implementation of the national and sub-regional population Plans of Action. The relevant EC programme assistance to Kenya focused mainly on RH service delivery and to some limited extent the capacities of the government and NGOs targeted by the programme assistance were created. However, the capacities created for the NGO organizations are not sustainable due to the vertical nature of the programme. The EC programme assistance during the review period therefore, partially facilitated creation of the capacity to support preparation and implementation of population strategies and actions.

Overall answer to Evaluative Question 8

Appropriate structures exist in government to support and facilitate preparation and implementation of population strategies and action. However, the structures require further strengthening and financial support to facilitate the implementation of the national and sub-regional population Plans of Action. The EC programme assistance partially facilitated creation of the capacity to support preparation and implementation of population strategies and actions. However, capacities created for the NGOs are not sustainable due to the vertical nature of the programme.

2.9 Evaluative Question 9

To what extent have cross-cutting themes (gender, environment, population and poverty, human rights, etc) been taken into account during the implementation process and whether synergies between the pillars of population and development have been sufficiently exploited?

During the 1994-2001 period, EC support to Kenya was provided based on the National Indicative Programme (EDF VII and VIII). The GoK/EC cooperation priorities, overall objectives and areas of cooperation as outlined in the document clearly show that at the planning took into account the cross-cutting themes of gender, environment, population and poverty, human rights and other related themes. Out of the four GoK/EC cooperation priorities in the NIP, 1997 (EDF V111), three covered these thematic areas adequately as follows: the development and consolidation of democracy and the rule of law as well as respect for human rights and fundamental freedoms; poverty reduction; and the sustainable economic and social development (particular emphasis is given to the development of infrastructure and human resources, gender issues and environmental protection). The stated overall objective pursued was to assist Kenya in achieving economic recovery and sustainable economic growth, increased employment creation, and poverty reduction. This objective remains unchanged in the 2003-2007 period as contained in the draft GoK/EC Country Strategy Paper (CSP). The objective as stated in the draft CSP document is to support GoK in its efforts to achieve higher and sustained economic growth and reduce the high incidence of poverty.

Besides the two areas of focus in the 1997 GoK/EC cooperation programme, 20 percent of the resources were allocated to a number of selected activities that are covered under the two thematic areas of environment and human rights. To facilitate conservation and sustainable use of country's natural resource base, EC funds were earmarked for the following two activities: the preservation and sustainable management of key endangered eco-systems with particular attention to Kenya's indigenous forests; and, the promotion of community "partnership" in the sustainable use of natural resources. In this regard, the EC facilitated the GoK to implement the National Environmental Action Plan (NEAP) in line with the Policy Paper on Environment. To facilitate promotion of human rights, EC funds were also allocated to initiatives aimed at consolidating the rule of law and democratisation process including civic education. The draft 2003-2007 Country Strategy Paper incorporates these cross-cutting thematic areas of concern in the proposed programmes.

The beneficiaries targeted by the KFHP also demonstrate that gender concerns were adequately taken into account. The programme was designed to reach: all men and women of reproductive age regardless of marital status; the vulnerable identified as widowed, divorced and young girls; and the, underserved groups of men and women.

The general impression is that these concerns have been taken into account as far as the planning process is concerned. Visits by the team to selected projects established that at the implementation level, gender imbalances were noted at the service provider level due to the nature of the RH programme. The team was not able to assess whether environmental concerns were adequately addressed at the implementation level. The main thrust of Kenya's development strategy is linked to poverty reduction

(PRSP) so all the programmes/projects by design had to address poverty and human rights issues.

As regards the integration of various pillars of population and development in development planning, this was considered as weak in the National Plan of Action on Population for Sustainable Development. Family stability and security were rampant. It was also noted that provision of basic needs to children and youth, and provision of socio-economic support and care to the elderly was inadequate. Persons with disabilities have also received inadequate support. Rural-urban migration and migration to the marginal and high potential areas with the subsequent mismanagement of the environment were additional issues that the Plan of Action addressed.

Implementation of the Plan of Action will be through a multi-sectoral and multi-dimensional, integrated approach. This will involve many stakeholders and coordination through relevant government, NGO and private sector organisations. In the Plan, integration of population issues into development has four core components: integration of population into the development process; the family; children and youth; elderly persons with disabilities; population and environment; and population distribution, migration and urbanization. If successful, this Plan of Action will give implementing and donor agencies direction on the broad population and development needs of Kenyans.

Overall answer to Evaluative Question 9

During the 1994-2001 period, EC support to Kenya was provided based on the National Indicative Programmes (EDF VII and VIII). The GoK/EC cooperation priorities, overall objectives and areas of cooperation as outlined in the document show that planning took into account the cross-cutting themes of gender, environment, population and poverty, human rights and other related themes. At the implementation level, gender imbalances were evident due to the nature of reproductive health, environmental concerns were difficult to assess, poverty and human rights issues are addressed.

As regards synergies between the pillars of population and development, this was considered as weak in the National Plan of Action on Population for Sustainable development. Areas in which support has been inadequate include: provision of basic needs to children and youth, socio-economic support to the elderly, rural/urban migration and management of the environment. The Plan of Action will address these through a multi-sectoral and multi-dimensional, integrated approach. If successful, this Plan of Action will give implementing and donor agencies direction on the broad population and development needs of Kenyans.

2.10 Evaluative Question 10

How sustainable are the effects and impacts of EC-supported policies and programmes in the field of population and development, both at the level of individuals and at institutional and policy level in the partner countries?

The Kenya Family Health Programme, which was designed as a vertical project for reproductive health service delivery has not been sustainable. While there was some contribution to, and ownership of, the Service Quality Function by the Ministry of Health, delays meant this did not occur until the end of the project and subsequently. However, there was little ownership of the remaining aspects, in particular the NGO and private sector service delivery component.

When funding for the KFHP ended, the result was a reduction in stocks of injectables in the MoH. The GoK did not fulfil its role in ensuring the provision of FP commodities, and although it has made a commitment to provide local contributions for contraceptive procurement, DFID has estimated that continued high levels of donor inputs will be required until at least the year 2010. The recent National Condom Policy, 2001-2005, has reiterated the intention of the GoK to introduce a budget line for contraceptives by the end of 2002/3. Such a commitment would signal GoK leadership and commitment to the RH programme.

Moreover, the MoH also has no long-term funding plan or firm commitments for four of the seven family planning methods available in the country. A review of the documentation reveals occasional stock-outs, which tend to be averted by 'emergency shipments' in a culture of crisis management. At the present time, Microgynon is not available in the country, as a result many women have stopped taking oral contraceptives altogether even though an alternative oral contraceptive is available; stocks of injectables are very low although UNFPA will augment stocks, and condoms are being supplied by World Bank.

A further threat to sustainability of supply is that family planning commodities are not included in the Essential Drugs List, except for low dose pills (which has occurred after 5 years of donor advocacy). The Treasury gives health a low priority and leaves funding of RH commodities to donors. In future, the team suggest that the EC should encourage the MoH and NCPD to adopt a more pro-active advocacy role by lobbying for a budget line for the procurement of contraceptives. Further advocacy is needed to include all contraceptives in the MoH Essential Drug List.

The distribution of family planning commodities is managed by the Logistics Management Unit run by the USAID-funded DELIVER project, which now has the mandate to distribute a wider range of pharmaceuticals (e.g. vaccines, STI/HIV test kits and drugs). This also raises concerns about sustainability since this vertical system is not compatible with the GoK plans for the parastatal KEMSA established in 2000 to distribute medical commodities and currently under major reorganisation. Moreover, insufficient attention has been paid to building of local capacity in logistics over the last 5 years.

As regards NGO support, sustainability was not considered in the design stage of the project. Later, the PMU tried to promote cost awareness and encourage NGOs to increase cost recovery and develop exit strategies. However charging for services is

difficult among poor people, especially when government services are provided free. Three clinics were constructed and six refurbished which would remain after funding ended, except for one clinic built for FPAK, which had to close for financial reasons. The capacity building programme has improved the chances for NGOs to generate funds from different sources and managing them more efficiently and effectively. Nevertheless, since the project ended, of the 14 NGOs, 4 NGOs have ceased RH programme activities, and ten are continuing programme activities having had to reduce the numbers of CBDs or other staff. NGOs had previously provided honoraria to CBDs as an incentive, which was not possible when funds ended. A few CBDs have continued to work as volunteers, and like volunteer CBDs in the government service they receive a small percentage of the price of the goods they sell. Some NGOs had anticipated that the CBDs from their projects would be absorbed into the government system, but political synergies had not been properly explored at the start, and this did not occur.

It is clear that NGOs providing PHC services to the poor will always need subsidies from government or donors, or, alternatively will also have to target the better off to cross-subsidise services.

Finally, the Service Quality Function after its delayed start has most potential for sustainability given the MOH ownership, funding commitment by DFID and GTZ, and the integrated systems approach adopted. However, funding is required to build up the capacity of the cadre of health inspectors to ensure the Quality Improvement Model will be fully institutionalised as a routine component of health service delivery.

It is envisaged that the change of thrust from a vertical programme towards the sector-wide approach for the follow-up programme 'Strengthening District Health Systems' will help towards sustainability in the future. However the project design must ensure that the funds reach the grassroots.

Overall answer to Evaluative Question 10

The Kenya Family Health Programme which was designed as a vertical project for reproductive health service delivery has not been sustainable. While there was some contribution to, and ownership of, the Service Quality Function by the MoH, delays meant this did not occur until the end of the project. The GoK did not fulfil its role in ensuring the provision of FP commodities, even though it has made a commitment to provide local contributions for contraceptive procurement. As a result, high levels of donor inputs will continue to be required. Regarding NGOs participating in the KFHP that provided PHC/RH services to the poor, these will always need subsidies from government or donors, or else need to target the better off to cross-subsidise services. The NGOs did not link with any local or national government institutions. Most of the NGOs have had to reduce or end their programme activities after EC funding ceased.

3. OVERALL ASSESSMENT

The assessment will focus on the main population programme between 1994 and 2001 which has been support for the Kenya Family Health Programme, other programmes considered include STDs/HIV/AIDS control and refugees/IDPs/distress migration.

3.1 Relevance

The KFPH was a classical vertical programme supporting family planning activities. However its scope broadened to explore the possibilities to expand health services through support to NGOs and to improve health services through other innovative approaches.

The objectives and strategies of the KFHP were highly relevant to the goal of the Kenyan Government in the health sector: 'creating an enabling environment for the provision of sustainable quality health care that is acceptable, affordable, and accessible to all Kenyans'.

The KFHP directly contributed to two of the national targets:

- increasing access to family planning services from 60% of facilities to 90% by the year 2010
- reducing the HIV/AIDS prevalence by 14% to 15%, and prevalence of sexually transmitted diseases by 50%.

It also supported the strategic national objectives of managing population growth (the national population policy aims to stabilise population growth to 2.1% by 2010), enhancing the regulatory role of government in health care provision, and creating an enabling environment for increased private sector and community involvement in provision and finance (National Health Sector Strategic Plan, 1999-2004).

The four expected results of the KFPH were:

- increased availability and access to family planning services,
- improved quality standards of FP services,
- enhanced quality of service, and
- co-operation and coordination among FP providers

These results all contribute to national efforts to address these problems. The relevance of these activities is as follows:

- Increasing the supply of contraceptives has been relevant because of the serious shortfall in still not shown its commitment to RH by including a budget line for procurement of contraceptives and including all contraceptives in the MoH Essential Drugs List. As a result contraceptive supply remains donor-driven.
- The Programme supplied two specific commodities, injectables, which are the most popular and common method of contraception, and condoms, which have the highest public health impact in prevention of HIV/AIDS.

- Support for service quality was important because the MoH had little capacity to establish and maintain minimum standards of service in both the public and private sector.
- The focus on responsiveness to clients' needs is linked to quality of service and these two components will strengthen systems that enhance quality of care and use of services.
- Support to NGOs is in line with government policy to gradually increase the proportion of services provided by NGOs (while decreasing the proportion of government service providers).

As regards the NGO co-financing budget, the main project has been the long-running strengthening of STD/AIDS control in Nairobi and Mombassa. In view of Kenya's large STD burden and growing HIV/AIDS epidemic, the reconstruction of a Special Treatment Centre and introduction of STD services in peripheral centres has been very relevant. The project's geographic focus on Nairobi and Mombassa, the two largest cities with rapidly growing HIV epidemics, is equally relevant. Other NGO projects on prevention of HIV/AIDS are also supported.

Projects funded under the NGO co-financing budget are supported in the area of MCH and basic health care, which mainly target women and children. Since these two groups are affected by most of the disease burden in the country again relevance of action in this area is clear. Unfortunately as already mentioned, detailed information on NGO projects supported by the EC was not available to the team.

3.2 Effectiveness

In general, KHFP was effective in achieving the planned objectives, in particular the supply of injectables and condoms.

The main objective of the KFHP was to increase utilisation of quality family planning services. The data from the Logistics Management Unit showed that the consumption of injectables continued to rise, but not at the expense of other methods. This suggests an increased uptake of contraceptives. Projections using the Future's Group Spectrum software suggest that the percentage of married women using any method (including traditional) had increased from 39% in 1998 to 43.83% in 2002. The total fertility rate is estimated to have fallen from 4.7% to 4.3%. If a rise in CPR is confirmed in the DHS being conducted in 2003, the KFHP will have made a significant contribution.

There is a lot of evidence in the scientific literature that improvements in population indicators can be attributed primarily to increased contraceptive use. Thus it is probable that the almost constant supply of commodities (injectables and condoms) through the KFHP has contributed substantially to any increase in CPR, especially for the injectable, DMPA, which is increasingly the method of choice. In 1998, 23.6% of all women were using a modern method and, of these, 37.2% were using DMPA. Spectrum software predicts that the percentage of married women using DPMA has increased from 11.9% in 1998 to 15.5% in 2002.

Although it is unlikely that use of condoms for family planning has increased, one can assume that the provision of 138 million condoms will have averted some pregnancies and significantly contributed to lower rates of STIs, including HIV.

As regards implementation strategies, after the slow start of the PMU, it performed effectively and efficiently, particularly since mid-1999. Frequent organisational changes, particularly with senior MoH staff, had hampered effectiveness. The Steering Group also appears to have functioned well and efficiently. Its structure is effective in view of its mandate. The EC Technical Assistant was closely linked to the PMU but independent to it. He was responsible for liaising with all stakeholders concerning the programme activities and future planning. Relations between partners were good. Policy and strategy decisions could have been improved if the operational research fund could have been used more effectively, for example, to review the role of NGOs in service provision and the appropriateness, effectiveness and cost-effectiveness of different modes of service delivery. The role of each of the NGOs needs to be examined within the local context. Best practice and project experiences have not been as well documented and disseminated as was originally envisaged.

The KFHP has helped the MOH to lay sound foundations for an integrated, institutionalised system to assure the quality of all services in both public and private sectors. Whether the MoH can maintain the momentum and provide the resources to implement it remains to be seen.

Effectiveness of EC-actions conducted in other areas of population and development including HIV/AIDS, refugees, IDPs and distress migration is difficult to assess due to the lack of detailed information available to the team.

3.3 Efficiency

By the end of the project, the EC still had about Euro 4.13m unspent, which the Government of Kenya had proposed should be used to procure additional injectable contraceptives in view of the expected demand and shortfall of doses available in the coming years. However although a contract was signed with a supplier and an order placed by the Ministry, the tender was later declared non-valid, by which time the financing agreement expired. As a result the unspent funds were not used.

Clearly procurement of contraceptives is an essential, cost-effective input into a family planning programme, particularly in the context of Kenya, which has a relatively high and rising demand, but insufficient government budget for procurement. Sound management of the procurement process has resulted in commodities being procured at competitive prices in line with or better than original budget estimates.

The final Evaluation report was not able to say conclusively in view of the lack of information available whether the increased supplies of contraceptives through quality services could have been achieved through cheaper means. Nor was it possible to say with any degree of certainty that the available funds could have achieved a better result if used differently.

There was no consensus on the appropriateness and cost-effectiveness of the CBD programme. The project should have given more emphasis to undertake feasibility studies, piloting different approaches and monitoring and disseminating lessons learned. Although the PMU did carry out a costing exercise to assess cost-effectiveness of the CBD programme, the figures produced should be treated with extreme caution before any conclusions can be derived about the relative efficiency of public versus NGO CBD programmes. Cost data also needed to take into account the

quality of service, which was not systematically assessed. It needs to link in with qualitative information about the individual project, such as target groups, the age of the programme and the distances. CBDs often provide more than just supplies, some are community pharmacy managers and there is evidence that clients are more likely to discuss sensitive RSH issues with CBD agents than with other less familiar providers. The main conclusion was that the unit cost was influenced more by productivity of the individual CBD agents than, for example, the cost of staff or the size of the programme.

Productivity in some programmes could certainly have been higher with better planning, preparation and marketing of services. The PMU had suggested that productivity could be increased by the payment of a modest monthly salary to the CBD agents. However other studies, including one funded by KFHP concluded that voluntarism and self-improvement are more important factors. One of the projects (Mkomani) paid full-time CBD agents (not out of project funds) and productivity was higher. However data was not available on the cost per CYP. This arrangement was not sustainable and when EC funding stopped, the 20 CBDs could no longer be paid and the four remaining agents now work as volunteers.

The project experience suggests that CBD programmes can be cost-effective, but that the local context must be carefully considered and certain criteria must be met.

3.4 Sustainability

As regards the KFHP, political commitment, ownership, institutional structure and financial support varied for different aspects of the project. There was ownership of the service quality function towards the end of the project, largely due to the facilitator role of the PMU and the leadership in the MoH. However there was little ownership of the other components of the project, in particular the NGO and private sector service delivery. The reasons for this might include the vertical nature of the project, the inadequate manpower of the MoH which resulted in an over reliance on the PMU to drive the implementation process. MoH staff had commented on the lack of clarity of their role and, perhaps more importantly, the expectation of financial incentives as apparently provided by other donors, although DFID did not consider this the underlying issue since it has another project with the MoH with a similar arrangement. However, the EC and DFID considered that they were staff doing their usual duties and should be supported by the MoH not the donors.

NCPD expressed concern to the team that it had not been involved in the project steering group and had not had more of a coordination role in the KFHP. In the DFID project which had preceded the KFHP, NCPD had a coordination role and benefited from the training fellowships, computers etc. However, the team were told by EC staff that since this was mainly a health service delivery project, it only required involvement of the MoH. After the PMU left in June 2002, NCPD assisted NGOs until the end of the project in December 2003 with funding from the World Bank.

It is possible that ownership was compromised at the beginning due to the heavy bureaucracy of the two donors and lack of control given to the government officers who had not always carried out their duties, and also to the high profile and direct influence of DFID and more especially the EC. It should be noted that KFHP was built on an earlier DFID project. The MoH would have preferred the funds to come through them and for the donors to empower MoH staff to use them efficiently.

The procurement of commodities was effective, especially injectables. However injectables are now the most popular and convenient method of contraception but also the most expensive.

One problem was the lack of empowerment of the NGOs. There was no attempt to conduct a SWOT analysis to try to strengthen the NGOs. As a result when the funding stopped, the work effectively carried out by the NGOs was not sustainable.

Most of the STI/HIV/AIDS programmes supported by the EC are carried out by NGOs through co-funding for which detailed information was not available. However it appeared that sustainability is unlikely in most cases. The main programme on strengthening of STD/AIDS control in Nairobi and Mombassa, which has been ongoing over 14 years is unlikely to be fully sustainable after EC funding eventually ends. While the health staff would continue to function and the research continue, the service delivery component is donor dependent and would cease. The programme is also dependent on the EC technical assistant and local capacity has not been strengthened adequately to take over.

3.5 Impact

An assessment of impact of the KFHP has never been conducted because the impact indicators need special longitudinal studies, and because it is almost impossible to single out the impact of one donor intervention in an environment where other inputs (donor and non-donor related) are present.

The team have therefore considered the usefulness of the four outputs of the Programme.

1. Availability of and access to FP services increased

The KFHP has procured sufficient supplies of injectable contraceptives and condoms to satisfy national demand from all registered family planning providers (public and private) throughout the project. As a result of activities, KFHP had procured 80% of national needs for injectable contraceptives. The project was expected to procure 20% of public sector condom requirements the balance being supplied by other sources, in particular the World Bank, which never materialised. Since 1999, the KFHP has procured 100% of public sector condoms for the project. During the course of the programme more than 57% of the total amount of public sector condoms distributed have been procured through KFPH (138 m). The remaining 43% were already available when KFPH procurements arrived or have been provided by other donors. Distribution to district level was effective through a USAID-funded logistics management project.

2. Quality standards of FP services improved and quality assessed

The setting up of the Service Quality Function was adversely affected by the uncertainty of the MoH reform process and staff turnover. In 1999, the National Health Sector Strategic Plan (NHSSP) made a commitment to introduce quality management and a quality assurance group was established. But it was not until early 2001 that the Department of Standards and Regulatory Services was mandated and

resourced, with leadership, staff and budget, when the project had almost ended. Since then progress has been made. Facilitated technically and financially by the PMU, the approach to quality has been conceptualised and operationalised, in line with the NHSSP, into the Kenya Quality Improvement Model. This model integrates evidence-based medicine practised according to agreed public health and clinical standards and guidelines, coupled with total quality management and patient partnerships. Standards are integrated into a Master Checklist for both self-assessment and external assessment by health inspectors using a scoring system. The KFHP has supported advocacy, orientation and training of health managers at all levels. Health laws are being reviewed. Despite the delayed start, the process and systems development approach adopted by the KFHP has been effective, and the MoH is now carrying the process forward.

3. FP providers give an enhanced quality of service, which is more responsive to clients needs

The KFHP did not carry out an objective assessment of the quality of care in clinic and community-based NGO services. Many of the NGOs use quality assurance processes and tools, such as COPE, but there is little objective documentation at PMU level of any quality improvements resulting from these initiatives or from the project inputs.

Although the KFHP has facilitated the development of tools, it has not monitored whether and how effectively they are applied. Some efforts to assure quality and establish linkages with the wider SQF have occurred. A standard client exit interview format was developed and is being used by selected NGOs, and has even been incorporated into MoH Quality Improvement Tools.

The potential of the project to identify and disseminate best practices had not been fully exploited which was a missed opportunity to contribute to the reform process.

4. Coordination and cooperation among FP providers strengthened at all levels

At national level, the KFHP has been actively involved in several coordination forums. The main forum for coordination of the RH activities of the NGOs involved in the project was the NCPD Committee on Reproductive Health, which met quarterly and attended by the Project Coordinator. The meetings were criticised as being poorly structured and for not tackling strategic issues.

The main forum for coordination in the MoH was the Reproductive Health Advisory Board. The Board was not always active due to the lack of a head of the Division of Reproductive Health for a time.

The PMU has also taken part in the logistics working group. Coordination between the PMU, MoH, the Logistics Management Unit, the donors and the procurement agent have all been effective. As a result, stock outs of injectables and condoms have been avoided.

The PMU convened quarterly meetings of the NGOs involved in the project, which proved to be a useful forum for information sharing and dissemination of lessons learned.

At district level, according to the NGO evaluation, improvements in district level coordination have been variable. NGOs have established good relationships at the operational level, especially with individuals. But establishing coordination at a more strategic level has been less successful. Only two NGOs reported regular coordination meetings with the district health management teams. Moreover there is little evidence that NGO activities have involved other service providers. The KFHP does not seem to have examined the impact of increased NGOP service provision on the use of other service delivery points.

While NGOs do try to work closely with district population officers some of these are not very active. Where district population and family planning committees function, NGOs are members but the level of coordination and planning seems more operational. The KFHP has not had a clear systematic strategy to promote better working relationships at district level.

3.6 Internal/external coherence

The EC-supported actions in population and development in Kenya have been coherent with the three relevant EC regulations on population and development: Reg. 1484/97 on Aid for Population policies and programmes; Reg. 550/97 on HIV/AIDS-related operations; and Reg. 2130/2001 on Operations to aid uprooted people in ALA-MED. Although Delegation staff were not familiar with the EC population policy or ICPD programme of action, since these are in line with international development policies (PRSP, Cotonou Agreement) and GoK Population Policy, coherence was assured.

As regards Regulation 1484/97 on Population, EC interventions, in particular the Kenya Family Health Programme, have supported all three programme objectives, in particular the third objective 'to help develop or reform health systems in order to improve the accessibility and quality of reproductive health care for women and men including adolescents….'. One area of activity in which EC action has not been taken is the eradication of all forms of sexual violence.

In the past, however, EC assistance has failed to complement and reinforce assistance provided under other instruments, for instance in the education and health sectors, with a view to taking population issues fully into account and to integrating them in Community programmes.
With regard to Regulation 550/97 on HIV/AIDS, again EC interventions have responded to all the programme objectives through support to NGOs and the KFHP. HIV/AIDS has become one of the most serious public health problems in the country. Greater support will be needed to combat the pandemic in the future. Activities that need strengthening to improve coherence with the regulation are in the area of:

- improving access to treatment for people infected with HIV;
- increasing women's autonomy and enable them to encourage application of means and methods to avoid transmission; protect health of unborn children;
- IEC to increase awareness among the male population.

Finally, regarding Regulation 2130/2001 on aid to uprooted people, EC interventions have responded to the specific objectives through ECHO and support to NGOs. Many long-stay refugees are found at the borders with Sudan and Somalia, a situation that

shows no sign of changing. Moreover, distress migration has occurred as a result of the 1999/2000 drought and earlier floods. ECHO has provided humanitarian assistance for refugees and IDPs in Kenya in the past but since the emergency phases have passed, funds will not be provided in 2004.

As regards external coherence, EC-supported actions in population and development have been coherent with the GoIs National Population Policy, 2000; the National Health Policy, 1999, the National AIDS Policy, 1997 and the National HIV/AIDS Strategic Plan, 2000. Through its involvement in national policy making, the Delegation can try to ensure policies are also coherent with EC development policy.

The main EC-funded programme, the KFHP, was carried out in partnership with the Government of Kenya and DFID. The extensive appraisal work done by the EC and DFID at the preparation stage ensured that the programme components fitted into the future reforms and actively assisted the MoH, in particular the integration of family planning into reproductive health. All the stakeholders, i.e. MoH, national NGOs, international donors, service providers and the private sector considered the programme purpose as very relevant and in line with the national priorities.

The main contribution of the KFHP was ensuring availability of increasing quantities of injectable contraceptives at national level. The project also resulted in an increased supply of FP services through the NGO sector. It had some success in supporting development of a sound foundation for an integrated, systems approach to quality assurance in the whole health sector. However some potential opportunities to contribute to health sector reform were missed. For example, collaboration with existing capacity building initiatives to strengthen strategic planning and coordination at district level, and the use of operational research to inform policy and strategy development.

As regards HIV/AIDS, the National AIDS Control Council has used a participatory approach in the development of the AIDS policy involving a wide range of stakeholders including donors, such as the EC. The NACC ensures coherence between the National AIDS policy and the national development policy. The National AIDS Strategic Plan focuses on reducing HIV prevalence, increasing access to care and support, and strengthening institutional capacity and coordination at all levels, which is coherent with the EC Regulation on HIV/AIDS. EC activities over the evaluation period have focused largely on a programme of institutional strengthening of STD/AIDS clinics in Nairobi and Mombasa, which is coherent with government and EC policy, although an appropriate balance between preventive, community and curative inputs needs to be addressed, as well as project management and participation structures.

On refugees and IDPs, the Ministry of Home Affairs is responsible and is setting up a Refugee Unit to deal with these concerns. To date, the GoK has not provided funds for the refugee camps, which are managed by UNHCR. In future, the new Government is likely to relax the camp-confinement policy and allow refugees with demonstrable skills to work in the country, although with current high unemployment levels, especially around the border areas, jobs may be hard to find.

Representatives of ECHO and the EC Delegation attend UNHCR's regular donor coordination meetings. The team were told that donor funds were urgently required due to chronic shortages of food, water and sanitation, hospitals, schools, roads etc. in

the camps. But the UNHCR budget had been cut for Africa. Moreover ECHO had no funds for Kenya in 2004 and it was not clear if the EC would provide any assistance.
The objective of the new Country Strategy Paper, 2003-2007, is to support the Kenyan Government in its efforts to achieve higher and sustained economic growth and to reduce the high incidence of poverty. It does not specifically mention population unlike the previous NIP, 1997-2002, which had a sectoral strategy 'to reduce population growth rates via continued emphasis on family planning service delivery to achieve higher modern contraceptive use'. The PRSP remains the guiding framework of Kenya's development strategy. The PRSP sectoral priority relevant to population is investment in Human Resource Development. In the health sector, the Government's priority is to enhance equity, quality accessibility and affordability of health care. Health resources will be shifted towards preventive/promotive/rural health services. On HIV/AIDS, Government policy in the area of HIV/AIDS emphasises the promotion of safe sex, prevention of mother-to-child transmission, blood screening and capacity strengthening to respond to the epidemic.

The new poverty focus of the CSP should enable a more integrated and synergistic approach for EC interventions on population and development in Kenya in the future.

4. RECOMMENDATIONS

"The EC should carefully note the GOK's National Plan of Action to implement the Sessional Paper No.1 of 2000 on National Population Policy for Sustainable Development which provides direction for integration of population in the development process.

While the Delegation has lacked capacity in population and reproductive health in the past, the team were advised that a social development officer would join the staff shortly. It is anticipated that he/she will be able to provide good technical follow-up to programmes, increase dialogue with relevant ministries and improve the visibility of the EC in the population and reproductive health field.

The EC have carried out a wide range of population and reproductive health activities in line with the relevant EC policies and ICPD programme of action. However action could be strengthened to combat the HIV/AIDS pandemic, with an appropriate balance between prevention, treatment and care activities. Other areas that require stronger action include women and child health, adolescent reproductive health, elderly people and persons with disabilities, gender concerns, rural/urban migration, as well as improved project design and management.

The EC should make greater use of operational research to inform policy and strategies to address population and development concerns.

While many EC-supported population projects/programmes have been effective, documentation of project activities and dissemination of best practices needs to be improved.

It is envisaged that the change of thrust in the EC from support for a vertical programme such as KFHP towards a sector-wide approach for the follow-up programme 'Strengthening District Health Systems' will help towards sustainability in the future. However, sustainability is difficult to achieve for many of the NGO projects and needs to be considered carefully at the project design stage.

Coordination and cooperation fora for staff in government, international and donor agencies and NGOs working in the population and reproductive health field needs to be well structured and tackle strategic issues at national and district levels.

Annex 1

List of persons contacted and institutions visited

Date	Time	Organisation	Name of Contact
Thurs 196	10.30	European Commission, Brussels	Anna Caudron, Gender Officer, AIDCO
	11.30-16.00		Thierry Barbe, Former Desk Officer, Kenya, AIDCO
	16.00		Dr Charles Todd, Human and Social Development Unit, DG Dev
	16.30		Angelina Eichorst, Social and Development Unit, DG Dev
	17.30		Helen Jenkinson, Former Desk Officer Kenya, AIDCO
Friday 20/6	9.30	European Commission	Thierry Barbe, Former Desk Officer, Kenya, AIDCO
	10.45		Joaquim Salgueiro, DG Dev, Kenya Desk
	12.30		Solon Ardittis, Evaluation Consultant, PARTICIP
	14.00		Pieter Van-Steekelenburg, Evaluation Unit
	15.30		Veronique Dehaudschutter
	19.15		Depart for London
Mon 23/6	9.00 am	Delegation of the European Commission, Nairobi	Andrea Fennesz, Economic and Political Counsellor
			Rhoda Njuguna, Technical Assistant
	14.00	Centre for the Study of Adolesence	Rosemarie Muganda-Onyando, Executive Director

Tue 24/6	8.30 am	UNFPA	Fabian Byomuhangi, Deputy Representative
		UNFPA	Ibrahim Sambuli, Programme Officer
	10.00 am	MoH	Dr. Tom Mboya, Director, Standards Quality Function
	2.00 pm	World Bank	Wachuka Ikua, Operations Officer
	3.30 pm	PMU, former NGO Coordinator	Mary Njenga
Wed 25/6	9.00 am	Family Planning Association of Kenya	Dr. Linus Ettyang, Programme Manager
			Tom Chuma, Finance & Administration Manager
			Charity Mailutha, Programme Officer-Youth
	11.00 am	WHO	Dr Kalu, Ag. WHO Representative
			Mrs Oduri, Reproductive Health
			Dr Dominique Mutie, Disease Prevention and Control
	4.00 pm	Marie Stopes International	Dr. Cyprian Awiti, Programme Manager Martha Warratho, National Clinical Services Manager
Thur 26/6	11.00 am	Bomu Clinic, Mkomani, Mombassa	Mrs. Anjarwala, Executive Director
			Ali Al-Beity, Financial Manager
			Fatima Warshad, Project Coordinator
	2.00 pm	Coast General Hospital, Mombassa	Dr. Madallia
		International Centre for Reproductive Health, Mombasa	Dr Mark Hawken, Project Manager

Fri 27/6	8.00 am	NHIF former Director PHC, MoH	Dr. Hassan
	10.00 am	MOH/GTZ Reproductive Health Project	Mr. Michael K'Ombugoh, Project Administrator, Finance & Logistics
	12.00 pm	Crown Agents, Kenya Ltd	Mr. Alan Pringle, Managing Director
	2.30 pm	Ministry of Finance	Dex Agourides, EU Desk Officer, External Resources
	3.00 pm	National Authorising Office	Mr Kambogo, Asst. Desk Officer
	4.00 p.m.	Ministry of Finance	Kenneth Waithuru, External Resources Dept (EU Desk)
Sat 28/6	10.00 am	Chogoria Hospital	Becky Mugambi Jane Njeru/Joyce Mutua
Mon 30/6		ECHO	Jan Eijkenaar, Southern Sudan Programmme,
		National Council for Population & Development	Mr Chipsoror, Deputy Director Karuga Ngatia, Senior Assistant Director, Head of Programme Coordination
		National AIDS Control Council	Joshua Ng'elu, Public Sector Manager Mr Makumi, Field Coordinator
Tue 1/7	8.00	UNHCR	Arun Sala-Ngarm, Deputy Representative
	15.00	Debriefing, Delegation of EC	Andrea Fennesz, Rhoda Njuguna
		Depart Nairobi	
		ECHO	Gael Griette, Kenya Desk Officer (phone interview)
		DFID	Marilyn McDonagh, Health Adviser (phone interview)

Annex 2

List of documents consulted

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Status of ARH projects within the Kenya Family Health Programme: a report of the process monitoring, Centre for the Study of Adolescence

Improving Adolescent Reproductive Health Programs, Lessons from Kenya. Muganda, R. et al. Centre fort he Study of Adolescence, September 2002

Annex 3

COUNTRY PROFILE: DEMOGRAPHIC SITUATION AND POPULATION POLICY PRIORITIES BY DR B. K'OYUGI, UNIVERSITY OF NAIROBI

1. INTRODUCTION

Kenya's population has more than tripled since independence in 1963 from 9 million to 31.5 million in the year 2002[1]. This rapid increase was initially propelled by high fertility accompanied by substantial decline in mortality particularly infant and child mortality during the period preceding 1980. Since then there has been significant decline in fertility from 8 children per woman in 1980 to 4.7 children in 1999 (a drop of about 41%) and an increase in infant and child mortality (NCPD 1989 &1998; CBS 1996 & 2002). The increase in child mortality is a reflection of diverse socio-economic and demographic factors, including the increasing poverty levels and the emergence of the HIV/AIDS pandemic.

1.1 Population Size, Growth and Structure

Kenya's population was enumerated at 28.7 million in 1999[2] and is projected to reach 36.5 million by the year 2010 taking into consideration the impact of HIV/AIDS. The annual growth rate declined to 2.6 per cent in 1999 from 3.8 and 3.6 per cent in 1979 and 1989 respectively. The 1989-1999 growth rate was highest in North Eastern (9.5%) and lowest in Central (1.8%). The population is still predominantly youthful with about 42 per cent below 15 years of age. Since a significant increase of young women entering reproduction age is expected, the increase in population will continue even with the decline in fertility rate.

Table 1: Population age structure for Kenya, 1992-2003

(Population in `000s)

Population Segment	Base Year: 1989		1992		1997		2003	
	No.	%	No.	%	No.	%	No.	%
Total pop.	23150	100.0	25240	100.0	29011	100.0	33264	100.0
Children 0-4 Years	4190	18.1	4421	17.5	4741	16.3	4907	14.8
Children 0-14 Years	11316	48.9	11999	47.5	12966	44.7	13829	41.6
Children 0-17 Years	12761	55.1	13686	54.2	15096	52.0	16210	48.7
Persons 15-64 years	11315	48.9	12645	50.1	15273	52.6	18418	55.4
Persons 65+ years	519	2.2	596	2.4	772	2.7	1017	3.1

[1] Government of Kenya 2002: Analytical Report on Population Projections, June 2002

[2] Government of Kenya, Central Bureau of Statistics: Kenya population and Housing Census; Vol. 1, 2001

Females 15-49 Years	4999	21.6	5585	22.1	6733	23.2	8075	24.3
Primary Sch. Age 6-13 years	5701	24.6	6077	24.1	6576	22.7	7141	21.5
Sec. Sch. Age 14-17 years	2106	9.1	2442	9.7	2966	10.2	3260	9.8
Dependency ratio	105:1		1.00:1		0.90.1		0.81:1	

Source: Central Bureau of statistics, Ministry of Planning and National Development: Economic Survey 2003, Government Printer, Nairobi & Republic of Kenya (Forthcoming). 1999 Population and Housing Census. Analytical Report Vol. III: Population Dynamics of Kenya.

Table 1 above show the population age structure for Kenya during the period 1992-2003. The percent population of children aged 0-4 years declined from 17.5 in 1992 to 16.3 in 1997 and to 14.8 in the year 2003. Similarly the percent share of the population under 15 also declined from 47.5 in 1992 to 41.6 in the year 2003. However, the critical population that forms the labour force aged 15-64 did increase from 50.1 percent in 1992, to 552.6 in 1997 and, then 55.4 in the year 2003. Most interesting to note is also the aged population, which did increase from 22.4 percent in 1992 to 2.7 in 1997 then, 3.1 percent in 2003.

1.2 Population Distribution

The main regions of population concentration are the Lake Victoria Basin, Central Rift and associated highlands and the coastal belt. As shown in table 2, the overall ranking in population size by province did not change much in the period1989-1999 and is expected not to change in the future. However, the population distribution is influenced by a number of factors including physical, historical, patterns of economic development and policies pertaining to land settlement. The growth rate for Nairobi, Nyanza, Rift Valley and Coast provinces are expected to remain relatively stable.

Table 2: Distribution of Population by province (1969 - 1999)

PROVINCE	**1969**	**1979**	**1989**	**1999**
Nairobi	509,286	827,775	1,324,570	2,143,254
Central	1,675,647	2,345,833	3,111,255	3,724,159
Coast	944,082	1,342,794	1,825,761	2,487,264
Eastern	1,907,301	2,719,851	3,768,689	4,631,779
North Eastern	245,745	373,787	371,391	962,143
Nyanza	2,122,045	2,643,956	3,507,160	4,392,196
Rift Valley	2,210,289	3,240,402	4,917,551	6,987,036
Western	1,328,298	1,832,663	2,662,397	3,358,776
Kenya	**10,942,705**	**15,327,061**	**21,448,774**	**28,686,607**

Source: Central Bureau of Statistics 2001: 199 Population and Housing Census Vol.1, Population Distribution by Administrative Areas and Urban centres (Table 1a, pp xxvii)

2. FERTILITY AND MORTALITY

Kenya has experienced a rapid decline in Total Fertility Rate (TFR) in the recent past. The fertility rate has declined from 8 children per woman in 1979 to 6.7 in 1989 to 5.4 and 4.7 in 1993 and 1998 respectively[3]. The decline has been attributed mainly to increase in contraceptive use. Contraceptive Prevalence Rate (CPR) increased from 26.9 per cent in 1989 to 39.0 per cent in 1998[2]. However, the momentum of decline has reduced in the 1993 - 1998 period especially in the urban areas. The 1989 - 1993 momentum of decline needs to be maintained so as to attain the national target of achieving a growth rate of 2.0 by 2010. The major challenges include tackling the unmet need for family planning especially for the under-served regions, males, young people and other special groups. The national target for CPR is projected at 62 per cent for the year 2010.

2.1 Trends and regional differentials in Fertility

Tables 3 show the emerging changes in fertility at the provincial levels over the periods 1984-88, 1990-93 and 1995-98. It is evident that according to the subsequent surveys, there has been a constant decrease in fertility levels for the respective provinces. A comparative look at the 1989 KDHS through 1993 and 1998 KDHS, the fertility declines were highest during the interval period 1984/88 and 1990/93 than it was between 1990/93 and 1995/98, as is evidenced by the 1989 KDHS, 1993 KDHS and 1998 KDHS.

At the national level, it is noted that there has been a steady decline in TFR, from a high of 6.7 (KDHS 1989) to 5.4 (KDHS 1993) and finally to 4.7 according to KDHS 1998.

Table 3: Total fertility rates by province and percent change 1984-88 and 1990-93

Province/period	1989 KDHS	1993KDHS	Percent Decline	1998 KDHS	Percent Decline
	1984-88	1990-93		1995-98	
Nairobi	4.6	3.4	26.0	2.6	24.0
Central	6.0	3.9	35.0	3.7	5.0
Coast	5.5	5.3	4.0	5.1	4.0
Eastern	7.0	5.9	16.0	4.7	20.0
Nyanza	7.1	5.8	18.0	5.0	14.0
Rift Valley	7.0	5.7	19.0	5.3	7.0
Western	8.1	6.4	21.0	5.6	13.0
Total	6.7	5.4	19.0	4.7	13.0

Source: KDHS 1993; KDHS 1998.

Table 4 shows age-specific and total fertility rates for Kenya during the period 1990-2020. The data shows that there has been a progressive decline in both age-specific and total fertility rates. The decline has been very steady through all the age groups as noted for the years 1990-95 when it was high to lower projected levels of 2005 through 2020.

[3] Macro International and Government of Kenya: Demographic and Health Surveys. 1989,1993 and 1998

[2] As above

Most conspicuous is the TFR that did decline steadily from a high of 5.37 during the 1990-95 to a low 3.18 level of 4.51 in the period 1995-2000. However, the projected figures of TFR do continue giving decreasing levels to a low level of 3.18 in the years 2015-2020.

Table 4: Model Age-specific and Total Fertility rates for Kenya, 1990-2020

Age Group	1990-95	1995-2000	2000-05	2005-10	2010-15	2015-20
10-14	0.0039	0.0030	0.0024	0.0019	0.0016	0.0014
15-19	0.1533	0.1273	0.1113	0.0987	0.0907	0.0856
20-24	0.2659	0.2252	0.2008	0.1816	0.1703	0.1638
25-29	0.2472	0.2094	0.1868	0.1690	0.1585	0.1526
30-34	0.1962	0.1652	0.1465	0.1318	0.1229	0.1176
35-39	0.1375	0.1147	0.1007	0.0897	0.0828	0.0785
40-44	0.0620	0.0509	0.0441	0.386	0.0351	0.0328
45-49	0.0079	0.0064	0.0054	0.0046	0.0041	0.0037
TFR	5.37	4.51	3.99	3.58	3.33	3.18

Source: Republic of Kenya (forthcoming) 1999 Population and housing Census. Analytical Report Vol. III: Population Dynamics of Kenya.

Table 5 shows fertility by background characteristics in the form of: total fertility rate for the three years preceding the survey and mean number of children ever born to women age 40-49, by selected background characteristics, Kenya 1993. Data show that TFR in the rural areas is high than that of the urban area. This is evident from the two surveys, KDHS 1993 and 1998, that total fertility rates were as follows: 3.44 in 1993 and 3.12 in 1998 in the urban, against 5.80 in 1993 and 5.16 in 1998, in the rural areas, respectively. The same follows for the number of children ever born being highest in the rural areas compared to that of the urban areas, as evidenced by the 1993 and 1998 KDHS.

This is more so, at the provincial levels. However, it is worthy noting that there was a decline in the TFR and CEB values recorded during the KDHS 1998, as compared to the higher figures recorded during the 1993 KDHS. This compares favourably well with the TFR and CEB values by education levels; giving a similar trend in the declining flow, as evidenced by the 1993 and 1998 KDHS data.

Table 5: Fertility by Background Characteristics, 1993 and 1998

Background Characteristics	Mean number of Children Ever Born to women age 40-49			
	1993 KDHS	1998 KDHS	1993 KDHS	1998 KDHS
	TFR	TFR	CEB (Mean)	CEB (Mean)
Residence				
Urban	(3.44)	3.12	4.67	4.59
Rural	5.80	5.16	7.62	6.99
Province				
Nairobi	(3.40)	(2.61)	(4.26)	4.14
Central	(3.93)	(3.67)	6.89	5.93
Coast	(5.25)	5.05	6.44	6.28
Eastern	(5.89)	4.68	7.44	6.56
Nyanza	(5.80)	4.98	7.69	7.40
Rift Valley	(5.70)	5.31	7.91	7.03
Western	(6.35)	(5.63)	7.86	6.97
Education				
No Education	(6.03)	(5.80)	7.58	7.11
Primary incomplete	(6.18)	5.24	7.71	7.21
Primary complete	(5.02)	4.79	6.83	6.31
Secondary +	(4.03)	3.53	4.99	4.93
Total	**5.40**	**4.70**	**7.32**	**6.62**

Source: 1993 KDHS; 1998 KDHS.

Note: rates shown in parentheses (for KDHS, 1993) indicate that one or more of the component age-specific rates is based on fewer than 250 woman-years of exposure; while for KDHS, 1998 are based on 400-999 women age 15-49.

2.3 Trends in Knowledge of Family Planning Methods and Sources

Knowledge about family planning methods is high and on the increase. Table 6 shows that the trend has continued going upwards. For instance, from 1984 KCPS to 1989KDHS, through 1998 KDHS, knowledge about any method of family planning has increased from 81.0 to 90.0 through 96.8; whereas knowledge about any modern method increased from 79.7 to 88.4 through 96.3. Most so, knowledge about condom use more than doubled from 40.0 as observed during the 1977/78 KFS to 91.5 during 1998 KDHS. Thus, it is plausible concluding that knowledge about any family planning methods is universal throughout the country.

Table 6:Knowledge of Family Planning Methods and Sources

Method	Know method					Know source	
	1977/78 KFS	1984 KCPS	1989 KDHS	1993 KDHS	1998 KDHS	1989 KDHS	1993 KDHS
Any method	88.0	81.0	90.0	95.6	96.8	88.1	88.2
Any modern method	84.0	79.7	88.4	95.2	96.3	86.5	87.6
Pill	74.0	72.7	84.4	91.9	92.6	81.6	82.7
IUD	49.0	55.2	62.0	73.3	72.0	60.0	67.4
Injection	55.0	58.9	76.3	87.6	89.7	74.2	80.1
Diaphragm/foam/jelly	20.0	26.3	24.4	38.3	33.6	23.2	35.2
Condom	40.0	41.5	53.4	83.4	91.5	49.2	73.3
Female sterilisation	54.0	55.0	68.2	81.1	81.8	65.9	72.7
Male sterilisation	14.0	18.1	19.8	41.3	47.7	19.0	36.9
Any traditional method	U	62.0	54.8	71.9	72.6	44.6	51.0
Rhythm	51.0	46.1	50.7	64.2	68.8	44.6	48.6
Withdrawal	24.0	24.6	16.8	29.5	36.9	NA	NA
Other	U	U	5.1	9.3	8.1	NA	NA
Number of Women	8100	6581	7150	7540	7881	7150	7540

Source: KFS 1978; KCPS 1984; KDHS 1989; KDHS 1993; KDHS 1998. NA – Not applicable; U – No information

Table 7 shows percentage of currently married women age 15-49 who are currently using specific family planning methods, Kenya, 1984, 1989, 1993, 1998 and 2001. Data shows that there has been a remarkable increment in the level of contraception, as witnessed during the 1984 KCPS and 1998 KDHS. A comparative review of usage of any method and any modern method shows an increment from 17.0 to 64.1 and 9.7 to 53.4, respectively.

At the respective surveys level, it is notable that the levels of contraception, for all kinds of contraceptive had remarkably increased through KDHS 1998; almost doubling the contraception levels recorded during the 1993 KDHS. Notably, condom usage had increased at more than 100.0 percent, according to the 1993 KDHS level of 0.8 and that of 1998 KDHS level of 9.7.

Table 7:Trends in Current Use of Family Planning Methods

Contraceptive method	1984 KCPS	1989 KDHS	1993 KDHS	1998 KDHS
Any method	17.0	26.9	32.7	64.1
Any modern method	9.7	17.9	27.3	53.4
Pill	3.1	5.2	9.5	32.7
IUD	3.0	3.7	4.2	8.3
Injection	0.5	3.3	7.2	24.9
Diaphragm/foam/jelly	0.1	0.4	0.1	1.1
Condom	0.3	0.5	0.8	9.7
Female sterilisation	2.6	4.7	5.5	6.2
Male sterilisation	0.0	0.0	0.0	0.8
Any traditional method	7.3	9.0	5.5	21.9
Rhythm	3.8	7.5	4.4	19.3
Withdrawal	0.6	0.2	0.4	4.1
Other	2.9	1.3	0.6	2.3
Number of Women	4627	4765	4629	4834

Source: KCPS 1984; KDHS 1989; KDHS 1993; KDHS 1998.

2.4 Mortality trends

Indicators for mortality portray an upsurge in both childhood and adulthood mortality in the recent past. Infant mortality rate has increased from 63 per 1000 live births in 1993 to 71 per 1000 live births in 1998. Similarly, under-five mortality rate has also increased from 93 per 1000 live births in 1993 to 105 per 1000 live births in 1998. At the same time, maternal mortality ratio has increased from an estimated 365 maternal deaths per 100 000 live births in 1995[4] to 590 per 100 000 live births in 1998[5], this is a gross underestimate of the true picture. Regional disparities in the mortality rates have persisted with urban areas recording relatively lower rates when compared to the rural areas. Life expectancy at birth declined in the 1989 - 1999 period from 58 to 54 for males and from 61 to 57 years for females. A number of factors are associated with this decline. These include the increase in child mortality, the rising HIV prevalence, other diseases such as malaria and Tuberculosis and the deepening poverty levels among others.

Based on the 1999 population census data, it is now projected that for the period 2005 - 2010, the under five mortality is expected to be 108/1000 for females and 116/1000 for males, while the life expectancy is expected to be 47 years for males and 53 for females. This takes into account the HIV/AIDS pandemic.

[4] PSRI/UNICEF Kenya Country Office; A study on Maternal Mortality in Kenya 1995

[5] Macro International and Government of Kenya: Kenya Demographic and Health Survey 1998

2.5 Mortality differentials

Life expectancy is a very important indicator for both socio-economic and demographic purposes. It is the only indicator that does clearly show whether there is any improvement is the social welfare of a people or there is a decline. Table 8 shows that at the national level there has been a decline in the life expectancy of Kenyan, for both the female and males. For instance, during the intercensal period 1979-89, the male life expectancy was 57.9 and, thereafter declined to 52.8 during the intercensal period 1989-99. Likewise, the female life expectancy in 1979-89 was 65.9 and, thereafter declined to 60.4.

This scenario is similar for all the provinces, except for North Eastern province that did record an increase in her life expectancy for both the sexes. For instance, the male life expectancy in 1979-89 intercensal period was 55.3 and it did increase to 62.2; while that for the females was 54.1 in 1979-89 and increased to 61.5 in 1989-99 period.

Table 8: Life Expectancy at Birth by Sex and Province, 1979-89 and 1989-99

Province/District	Life Expectancy at Birth (Years)					
	Males		Females		Both	
	1979-89	1989-99	1979-89	1989-99	1979-89	1989-99
Kenya	57.9	52.8	65.9	60.4	61.9	56.6
Nairobi	65.3	54.1	66.8	59.8	66.1	57
Central	67.7	60.4	69.1	68.0	68.4	64.2
Coast	55.8	52.0	57.2	58.3	56.5	55.1
Eastern	66.7	57.6	67.7	65.5	67.2	61.5
North Eastern	55.3	62.2	54.1	61.5	54.7	61.9
Nyanza	49.5	41.7	53.5	48.0	51.5	44.8
Rift Valley	60.9	59.1	62.8	66.4	61.9	62.7
Western	55.6	49.8	57.7	55.8	556.7	52.8

Source: Central Bureau of Statistics, Ministry of Planning and National Development: Economic Survey 2003, Government Printer, Nairobi.

Table 9 provides infant and child mortality rates by background characteristics. Data comparison shows that There was an increase in both infant and child mortality rates. For instance, 1993 KDHS shows that IMR by urban residence was 45.5 compared to 55.4 recorded during the 1998 KDHS; likewise IMR by rural residence according to 1993 KDHS was 64.9 as compared to 73.8 recorded during the 1998 KDHS.

Table 9: Infant and Child Mortality by Background Characteristics

Background Characteristics	Infant Mortality rate		Under Five Mortality Rate	
	1993	**1998**	**1993**	**1998**
Residence				
Urban	45.5	55.4	75.4	88.3
Rural	64.9	73.8	95.6	108.6
Province				
Nairobi	(44.4)	41.1	(82.1)	66.1
Central	30.9	27.3	41.3	33.5
Coast	68.3	69.8	108.7	95.8
Eastern	47.4	53.1	65.9	77.8
Nyanza	127.9	135.3	186.8	198.8
Rift Valley	44.8	50.3	60.7	67.8
Western	63.5	63.9	109.6	122.5
Education				
No education	66.3	82.2	99.8	122.5
Primary incomplete	80.1	91.4	120.6	138.1
Primary complete	57.4	61.4	78.8	86.9
Secondary +	34.8	40.0	53.7	59.9
Medical maternity care		-		
No antenatal/delivery care	*	-	*	
Either antenatal or delivery	64.0	-	115.0	
Both antenatal & delivery	50.4	-	76.5	
Total	**62.5**	**70.7**	**93.2**	**105.2**

Source: KDHS 1993 and KDHS 1998.

Note: KDHS, 1993: rates in parentheses are based on 250-499 children exposed, whereas asterisk means the rate is based on fewer than 250 children, thus has been suppressed.

However, a comparative review by provinces shows that IMR for all the provinces did increase from the levels recorded during the 1993 KDHS to that recorded during the 1998 KDHS, except Nairobi and central that did recorded reduction in their IMR levels, from 44.4 (KDHS 1993) to 41.1 (1998 KDHS), more so, Central province's levels of 30.9 (KDHS 1993) to 27.3 (KDHS 1998).

There was no decline in IMR and under-five mortality rate education levels as recorded during the two surveys. Conversely, for those with primary school level completed, there was an increase in IMR and under-five mortality rate, from a low of 57.4 to 61.4, as per 1993 KDHS and 1998 KDHS, respectively.

Thus, it is summarily noted that according to the 1998 KDHS, IMR and CMR both increased. According to 1993 KDHS, IMR by background characteristics was 62.5 compared to 70.7 recorded by the 1998 KDHS; whereas under five mortality rate was 93.2 according to 1993 KDHS, compared to 105.2 recorded by the 1998 KDHS.

3. MIGRATION AND URBANIZATION

The rate of urbanization has increased from 15 per cent in 1979 to 18 and 19 per cent in 1989 and 1999 respectively. The urbanization process in Kenya is largely determined by rural-urban migration due to socio-economic development disparities between rural and urban areas, as well as the government policy to accelerate and create enabling environment for growth of smaller urban centres. Other movements include rural to rural mainly due to demand for arable land, and to a small extent internally displaced persons for various reasons, there has been occasional influx of refugees from neighbouring countries.

3.1 Lifetime Net Migration Trends and Patterns by Provinces

Table 10 shows trends and patterns of migration by province. It gives an account of lifetime in-migrants and out-migrants. It is notable from the data that from 1979 through 1999, the provinces have maintained a particular trend and pattern of migration. For instance, the following provinces are in-migration areas: Nairobi, Coast and Rift Valley. Whereas the following are out-migration areas: Nyanza, Western, North Eastern, Central and Eastern.

It should be interesting to note that according to the 1979 Kenya Population and Housing Census, Eastern province was an in-migration area. However, the situation changed as reflected by the 1989 and 1999 Population and Housing Censuses data. Rift Valley province had more people move out than into the area.

Table 10:Lifetime Net Migration Trends and Patterns by Provinces

District	Lifetime In-migrants			Lifetime Out-migrants			Net Migrants		
	1979	1989	1999	1979	1989	1999	1979	1989	1999
Nairobi	615942	930074	1448159	-91570	-157450	-179427	524372	772624	1,265,710
Central	191102	242969	332495	-465253	-639782	-771903	-2274151	-396813	-363,203
Coast	222229	275123	320060	-47983	-79940	-101398	174246	195183	274,485
Eastern	89966	136465	133763	-263957	-400378	-632385	173991	-263913	-446,683
N. Eastern	14998	14176	10509	-30347	-13470	-52867	-15349	-17294	-10,551
Nyanza	109130	160975	190611	-375596	-574401	-743206	-266466	-413426	-55,354
Rift Valley	625594	901347	1055813	-146385	-219507	-335395	479209	681840	-65,152
Western	103181	149289	152491	-390808	-556658	-734185	-287627	-407369	-14,612

Source: UNHCR but computed and modified for the Kenya Population and Housing Census 1999, Analytical Report (Forthcoming).

3.2 Refugee Population in Kenya by Country of Origin

Table 11 shows levels and trends in refugee out flow and influx in Kenya. The level, trend and pattern of refugee movement shows that refugee movement from various countries had shifted from that of more influx to that of more out flow, with the exception of Sudan. In 1999, much of departing refugees was evident among the Somalia, Rwandans, Ugandans and the Congolese. Conversely, more incoming refugees were from Sudan, Ethiopia, Eritrea and Tanzania.

On the whole, there were more departing refugees in 1999, with a net migration of 14491 refugees. In 1998, however, there were more refugees immigrants with a net figure of 3118. There was a shift in migration pattern among the refugee migrants in 1999, with more going out of the country than those coming in. This could have been necessitated by relatively more calm experienced in the countries of origin in 1999 than was the case between 1994 and 1998.

Table 11: Trends of Refugee Population in Kenya by Country of Origin, 1979-99

Origin	**1997**	**1998**	**1999**	**1997-98 % Change**	**1998-99 % Change**
Somalia	176,816	164,657	141,088	-6.88	-14.31
Ethiopia	8,634	8,099	8,191	-6.20	1.14
Sudan	37,351	48,162	64,254	28.94	33.41
Uganda	5,310	6,003	5,947	13.05	-0.93
Congo (DRC)	139	388	251	179.14	-35.31
Burundi	115	556	205	383.48	-63.13
Rwanda	5,762	8,665	2,858	50.38	-67.02
Eritrea	-	-	90	-	-
Liberia	-	-	8	-	-
Tanzania	-	-	295	-	-
Other	-	583	509	-	-
Total	**235,069**	**238,187**	**223,696**	**1.33**	**-6.08**

Source: UNHCR but computed and modified

3.3 Immigrants in Kenya by Age, Sex and Regions of Origin

Table 12 shows immigrant population in Kenya, enumerated, by sex and age in the 1999 Census by sex and region of origin. The data shows that the foreign population had a sizeable percentage share of the total population of those respective age groups. For instance, the age groups 30-34 through 55-59, the foreign population had a share of 2% in those respective age groups. In 1999, about 1.3% of the total Kenya's population were foreigners. The proportions of the total males and females that were foreigners were 1.2 and 1.3 percent, respectively.

Table 12: Immigrants in Kenya by Age, Sex and Regions of Origin

Age	Sex	Africa	Europe	Asia	America	Other Aliens	Total	Total Census Population	Percent Alien Pop.
0-4	Male	5084	650	2667	447	8848	17696	2202293	0.80
	Female	5136	587	2492	409	8624	17248	2167998	0.79
	Total	10220	1237	5159	856	17472	34944	4370291	0.79
5-9	Male	3943	652	2551	440	7586	15172	1994184	0.76
	Female	4091	614	2477	427	7609	15218	1958048	0.77
	Total	8034	1266	5028	867	15195	30390	3952232	0.76
10-14	Male	3843	595	2714	415	7567	15134	2014718	0.75
	Female	4058	624	2375	419	7476	14952	1981344	0.75
	Total	7901	1219	5089	834	15043	30086	3996062	0.75
15-19	Male	5455	407	2170	436	8468	16936	1676197	1.01
	Female	5580	483	2097	396	8556	17112	1722400	0.99
	Total	11035	890	4267	832	17024	34048	3398597	1.00
20-24	Male	6415	391	2348	465	9619	19238	1322815	1.45
	Female	6965	533	2661	403	10562	21124	1516531	1.39
	Total	13380	924	5009	868	20181	40362	2839346	1.42
25-29	Male	6688	546	2886	497	10617	21234	1091439	1.94
	Female	6262	590	2820	332	10004	20008	1176493	1.70
	Total	12950	1136	5706	829	20621	41242	2267932	1.81
30-34	Male	4941	701	2621	375	8638	17276	839221	2.05
	Female	4425	772	2456	333	7986	15972	854887	1.86
	Total	9366	1473	5077	708	16624	33248	1694108	1.96
35-39	Male	3706	783	2302	332	7123	14246	696143	2.04
	Female	3539	806	2091	320	6756	13512	734109	1.84
	Total	7245	1589	4393	652	13879	27758	1430252	1.94
40-44	Male	2595	758	1882	336	5571	11142	517147	2.15
	Female	2323	788	1674	288	5073	10146	524107	1.93
	Total	4918	1546	3556	624	10644	21288	1041254	2.04
45-49	Male	2085	674	1496	274	4529	9058	422123	2.14
	Female	1652	741	1501	196	4090	8180	425979	1.92
	Total	3737	1415	2997	470	8619	17238	848102	2.03

Age	Sex	Africa	Europe	Asia	America	Other Aliens	Total	Total Census Population	Percent Alien Pop.
50-54	Male	1549	762	1307	233	3851	7702	346068	2.22
	Female	1171	883	1208	178	3440	6880	345577	1.99
	Total	2720	1645	2515	411	7291	14582	691645	2.10
55-59	Male	952	626	929	153	2660	5320	225750	2.35
	Female	642	739	801	126	2308	4616	240882	1.91
	Total	1594	1365	1730	279	4968	9936	466632	2.12
60-64	Male	629	533	748	118	2028	4056	195823	2.07
	Female	597	584	663	104	1948	3896	218570	1.78
	Total	1226	1117	1411	222	3976	7952	414393	1.91
65-69	Male	429	349	522	76	1376	2752	142654	1.92
	Female	401	427	465	63	1356	2712	163544	1.65
	Total	830	776	987	139	2732	5464	306198	1.78
70-74	Male	316	204	320	57	897	1794	119798	1.49
	Female	281	296	333	49	959	1918	138162	1.38
	Total	597	500	653	106	1856	3712	257960	1.43
75+	Male	357	264	365	44	1030	2060	176532	1.16
	Female	335	440	441	40	1256	2512	206683	1.21
	Total	692	704	806	84	2286	4572	383215	1.19
NS	Male	2	2		1	5	10	894	1.11
	Female	2	3	2		7	14	868	1.61
	Total	4	5	2	1	12	24	1762	1.36
Total	Male	48989	8897	27828	4699	90413	180826	13983799	1.29
	Female	47460	9910	26557	4083	88010	176020	14376182	1.22
	Total	96449	18807	54385	8782	178423	356846	28359981	1.25

Source: Central Bureau of Statistics, Ministry of Planning and National Development: Kenya Population and Housing Census 1999, Analytical Report (Forthcoming).

3.4 Urban Population Distribution

Table 13 shows provincial urban population distribution and the trends it has taken from 1979 to 1999. Generally, it shows that the urban population has been increasing over the years. Nonetheless, the provinces that have had the largest share of the urban population over the last three decades are Nairobi, Coast and Rift Valley provinces. Their percentage share of the national urban population, as depicted by the 1989 and 1999 Kenya Population and Housing censuses were as follows: 34.1 and 38.9; 15.2 and 16.7 and; 17.3 and 17.5, respectively.

However, that the intercensal urbanisation growth rate declined in Kenya during the period 1989-99, to 3.2 from 5.2 as recorded during the period 1979-89. However, of all the provinces, it is only Coast province that did record increase in her national urbanisation share from 3.7 in 1979-8ç period to 4.2 in 1989-99.

Table 13: Urban Population distribution, 1979-99

Province	**Urban Population**			**Share Percent of National Urban Population**		**Intercensal Growth Rate (%)**	
	1979	1989	1999	1989	1999	1979-89	1989-99
Nairobi	827775	1324570	2087668	34.1	38.9	4.7	4.5
Central	128932	309821	354017	8	6.6	8.8	1.3
Coast	406991	588470	894311	15.2	16.7	3.7	4.2
Eastern	233316	354359	2165280	9.1	5	4.2	2.9
Nyanza	207757	352527	423183	9.1	7.9	5.3	1.8
Rift Valley	341696	672177	940311	17.3	17.5	8.8	3.4
Western	105743	186047	270503	4.8	5.1	5.6	3.7
North Eastern	-	90724	125644	2.3	2.3	3.6	3.3
Total	**2315696**	**3878697**	**5360916**	**100**	**100**	**5.2**	**3.2**

Source: Republic of Kenya, Central Bureau of Statistics, Ministry of Planning and National Development: Analytical Report 1999 (Forthcoming).

Table 14 shows the distribution of urban centres by numbers and population sizes. It is worthy noting that there have been many administrative and municipal boundary changes after 1989. Thus, it has been necessary to internally correct for any unforeseeable errors in the comparisons by distinguishing the two urban components i.e. core urban and local authority.

The pure urban category shows that the urban centres with a population of 2,000-4,999 were the majority, with a share of 41.3%, followed by the centres with a population of 10,000-19,999, having a share of 19%. Those with a population of 5,000-9,999 and 20,000-99,999 tied at 33 each, having a share of 18.4%. The lowest share was that of the centres with a population of 100,000+, having a share of only 2.8% of the total urban centres. Comparatively, the local authority category showed that the urban centres with a population of 20,000-99,999 were the majority, commanding 41.8% of the total; followed by the urban centres with a population of 2,000-4,999 at 25.4%. The centres with a population of 10,000-19,999 were the least in the local authority category.

Table 14: Distribution of Urban Centres by Population Size, 1962-99

Size of Centre	1962		1969		1979		1989		1999			
									Core Urban Boundary		Local Authority Boundary	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
100000+	2	5.9	2	4.3	3	3.3	6	4.3	5	2.8	19	9.6
20000-99999	2	5.9	2	4.3	13	14.3	21	15.1	33	18.4	84	41.8
10000-19999	3	8.8	7	14.9	11	12.1	19	13.7	34	19	17	8.5
5000-9999	11	32.4	11	23.4	22	24.2	32	23	33	18.4	30	14.9
2000-4999	16	47	25	53.1	42	46.1	61	43.9	74	41.3	51	25.4
Total	34	100	47	100	91	100	139	100	179	100	201	100

Source: Republic of Kenya, Central Bureau of Statistics, Ministry of Planning and National Development: Economic Survey 2003, Government Printer, Nairobi

3.5 Trends and Patterns of Urbanization

The national urbanization process shows that the percentage of total urban population has been highest in Nairobi, Coast and Rift Valley provinces, in that descending order. For the periods 1989 to 1999, the trend in urbanization for the provinces fluctuated, with others like Nairobi, Coast, Rift Valley, and Western experiencing an upturn, while the rest had a downturn save for North Eastern province that maintained the same percent share in the national urbanization process of 2.34%. Eastern had the greatest share loss, while Nairobi had the greatest share gain as shown in table 15.

In general, the urbanization process at the provincial level is a true compound reflection of what is also depicted at the district level. It shows that for the period 1989-99 the urbanization growth was highest in Nairobi followed by Coast and Western. Nonetheless it is noticeable that although Western province had the third highest intercensal growth rate during the period 1989-99, it had a downturn trend from that (5.6%) recorded in 1979-89. In conclusion, a comparative analysis of the tempo of urbanization by province shows that Coast province had the highest rate of 4.2 % in 1989-99 up from 3.7% in 1979-89.

Table 15: Trends and Patterns of Urbanization by Province, 1962 – 1999

Size of Centre	1962		1969		1979		1989		1999			
									Core Urban Boundary		Local Authority Boundary	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
100000+	2	5.9	2	4.3	3	3.3	6	4.3	5	2.8	19	9.6
20000-99999	2	5.9	2	4.3	13	14.3	21	15.1	33	18.4	84	41.8
10000-19999	3	8.8	7	14.9	11	12.1	19	13.7	34	19	17	8.5
5000-9999	11	32.4	11	23.4	22	24.2	32	23	33	18.4	30	14.9
2000-4999	16	47	25	53.1	42	46.1	61	43.9	74	41.3	51	25.4
Total	34	100	47	100	91	100	139	100	179	100	201	100

Source: Republic of Kenya, Central Bureau of Statistics, Ministry of Planning and National Development: Economic Survey 2003, Government Printer, Nairobi

4. POLICIES, PROGRAMMES AND CRITICAL ISSUES IN POPULATION AND DEVELOPMENT THEMATIC AREA IN KENYA

Kenya was the first Sub-Saharan Africa country to have an explicit population policy in 1967. This policy focused on family planning as a means of reducing the rate of population growth. The government had earlier in the Sessional Paper No. 10 of 1965 acknowledged the negative impact of high population growth on socio-economic development.

The implementation of the above policy was not successfully done. The total fertility rate increased from 7.6 children per woman in 1969 to the highest level of 8 in 1979. Data collected in the Kenya Fertility Survey of 1978 indicated that the contraceptive prevalence rate was low (below 10% for all methods. The population growth rate also increased from 3 % in 1969 to 3.8% in 1979. This unexpected trend led to the revision of the 1967 policy in 1984 through Sessional Paper No. 4 on "Population Policy Guidelines."

The 1984 policy was more comprehensive. It incorporated both demographic and socio-economic goals as well as diversification of implementing ministries, non-governmental and religious organizations. The following demographic goals were articulated:

- Reduction of population growth rate from 3.8% in 1984 to 3.3% by years 1988 and to 2.5% by years 2000;
- Reduction of fertility;
- Reduction of mortality particularly infant and child mortality; and
- Reduction of rural-urban and rural-rural migration.

The socio-economic goals focused mainly on the improvement of women's status through access to formal education and employment. Kenya had entered a fertility transition phase by 1994 when ICPD was held. The total fertility rate had substantially declined from 8 in 1979 to

5.4 in 1993. The percent of women who were using modern contraceptive methods had also increased from 9.7 in 1984 to 33% in 1993. The actions and recommendations agreed upon at ICPD propelled the revision of the 1984 policy in 2000 (Sessional Paper No. 1 of 2000). This policy has adequately incorporated ICPD recommendations particularly the inter-relationships between population dynamics and development processes.

4.1 Critical Needs in Population and Development Thematic Area

The goal of the Government is to improve the well-being and quality of life of the individual, the family and the nation as a whole. The population programme is one of the programmes that have been developed and implemented to achieve this goal. The various Sessional and policy framework papers articulate the policies, strategies and programmes dealing with population and health as well as other development issues. The Sessional Paper No 4 of 1984 on Population Policy Guidelines guided the implementation of population programmes from 1984 to the year 2000 when the Sessional Paper No 1 of 2000 on National Population Policy for Sustainable Development was put in place.

The focus of the current population policy and programmes is on the following areas in cognisance of the ICPD Plan of Action:

i. Issues pertaining to population and sustainable development;
ii. Issues on population as related to the environment, children, the youth, the aged, persons with disabilities and HIV/AIDS epidemic; and
iii. Family, gender and reproductive rights.

Population has remained a major concern for the government in terms of its impact on the development process. The overall aim of the current population policy is to attain a balance between Kenya's population growth rate on the one hand and sustained rate of economic growth for sustainable development on the other hand[6]. Other major strategies that have been put in place to respond to the concerns include: district focus for rural development; rural urban balance; structural adjustment programs and poverty reduction strategy. The national population policy for sustainable development underscores the integration of population variables in the development process. These concerns include gender perspectives, the family, the youth, environment, urbanization and migration, human rights, reproductive health and education. Enhancement of the integration of population variables in sectoral planning is to be attained through sensitisation of policy makers and opinion leaders, strengthening of district documentation centres and family planning committees.

The main focus of gender perspectives is mainstreaming of gender concerns in development planning. As far as the family is concerned the issue is to promote equal opportunities for family members. The involvement of youth in policy formulation and implementation is underscored. The policy urges for implementation of the 1994 National Environment Action Plan. Promotion of rural development particularly rural industrialization to enhance income levels as well as development of smaller urban centres to curb the influx of people into major urban areas are envisaged to respond to the challenges posed by rapid urbanization and the high rate of migration. Expansion of educational opportunities to sustain high enrolment and completion rates at all levels is the key strategy in the current population policy. The plan of

[6] Republic of Kenya, National Council for Population and Development, Ministry of Finance and Planning: Sessional Paper No. 1 of 2000 on National Population Policy for Sustainable Development. PP 2

action to implement the population policy has been developed at the national and district levels covering the period 2001-2010.

A review of past development plans and Sessional papers indicate that minimal efforts have been made towards integration of population variables in sectoral planning. However, the 9th development plan covering the period 2002-2008 and the Poverty Reduction Strategy Paper (PRSP) for the period 2001-2004 have taken into account the population variables particularly in identifying target groups. To enhance this process there is need to intensify the appropriate use of population data in planning at all levels.

Kenya's response to the ICPD agenda was the development of the National Reproductive Health Strategy in 1996, which covers the period 1997 -2010. To operationalise this, two manuals on implementation and training for reproductive health were developed. These documents have been and continue to be extensively utilized at policy, programme and service levels.

Maternal Mortality Ratio (Deaths per 100 000 live births) rose from 395/100 000 in 1993 to 590/100 000 in 1998. The under 5 Mortality has increased from 93/1000 to 105/1000 in 1998. Access to health care is crucial to influence the trend yet disparities exist in health care provision. Both will be greatly influenced by the rising poverty levels, the HIV/AIDS pandemic and associated infections, and diseases such as malaria and TB. Most pregnancy-related deaths occur around the time of delivery or at postpartum, and present themselves as obstetric emergencies and therefore require emergency care. Obstetric emergencies are basically random events that can occur in any pregnant woman. Every pregnancy faces risks. Some of the conditions that precipitate women's death, however, can be averted. Women with adequate nutritional status, devoid of infectious diseases and who deliver in health facilities or with highly trained health care providers and receive timely emergency care are more likely to survive than those who do not. At antenatal care level some of these begin to be addressed. Although for most births reported during the KDHS both in 1993 and 1998[7], most women (more than 90%) had been seen by a professional provider at least once, there is no concomitant attendance at birth by professional providers or deliveries taking place at a health facility. During the same surveys, the proportion of deliveries with skilled attendance reported were low (38% in 1993 and 39% in 1998), while births that took place in a facility were reported as 33 % in 1993 and 42% in 1998. Despite this slight increase this proportion is still low. Most births in rural areas occur at home, and poor access to care, either because of the long distance, and or due to lack of prompt transportation to referral hospitals contributes to this mortality. Only 15% facilities are able to provide Basic Essential Obstetric Care (BEOC), while for emergencies a mere 9% facilities were equipped to provide Comprehensive Essential Obstetric Care (CEOC) (this includes caesarean sections, and blood transfusion services)[8]. Ante- and post-partum haemorrhages continue to be major causes of maternal mortality, as they require quick response, which is often not readily available.

There is a minimal increase in the use of contraceptives between 1993 and 1998, from 33% to 39% for all methods. There are regional variations with a high of 55% in Central Province and the lowest in Coast at 20%. This proportion is lower than expected because of the expressed unmet need of 24% within the same cohort[9]. Women's low socio-economic status can also expose them to physical and sexual abuse, mental depression. Unequal power relationships expose them to unwanted pregnancies.

[7] Macro International and Government of Kenya: Kenya Demographic Health Surveys 1993 and 1998

[8] Macro International and Government of Kenya: Kenya Service Provision Assessment, 1999

[9] Macro International and Government of Kenya: Kenya Demographic Health Surveys 1993 and 1998

Only one third of sexually active adolescents protect themselves from STIs by use of condoms. High proportions are at risk of pregnancy and or STIs including HIV. There is need to address the low demand for modern contraceptive use among adolescents. Although the TFR has dropped to 4.7, there is selective method use. Use of male sterilization and barrier vaginal methods is rare. There is sharp contrast in use between married men and sexually active single men. Only 8 % married men are using condoms compared to 47 % of unmarried using the same[10]. Low use of the dual method is evident. This has implications in terms of male involvement, and prevention of STIs.

A high proportion of facilities provide FP services (87%). But 13% still refer patients to other sites for family planning for various reasons including stock-outs for contraceptives. Only 28% of the facilities provide special counselling to adolescents for FP[11]. KDHS in 1998 found predominant use of the injectable methods and the pills. Government facilities provide contraceptives to 58% of the users, 33% through private medical sources and only 3% through CBDs. The most frequently used supplier after the government are the private hospitals and clinics (14%)[12].

It is estimated that in 2002 young people aged 10 -24 constitute about 38% of the total population and those aged 10 - 19 form 28%[13]. A large proportion of the morbidity and mortality in this group can be attributed to unsafe abortion, complications associated with early childbirth and HIV/AIDS. Although the ICPD recognized them as a special group the available indicators to monitor progress are inadequate. The social environment heavily influences their sexual behaviour across the board. Age at first sex is decreasing, reported at 16.8 for boys in 1998, and 16.8 in 1993 for girls and 16.7 in 1998. This puts them at increased risk to STIs, HIV/AIDS, pregnancy, and subsequently unsafe abortion. They are also at risk of Human Papilloma Virus (HPV) infection and subsequently cancer of the cervix. Sexual activity is widespread among all adolescents with multiple partners and unprotected most times. More in girls (by age 19, about 56% girls have had sex compared with 46% among boys at the same age). With increasing levels of education fewer begin sex early. A significant proportion (54.2%)is not sexually active. There is limited access to both information and services. There is no national consensus on Family Life Education (FLE). Parents lack capacity to discuss ARH issues with adolescents, and are in favour of FLE for young people. It is estimated that 13.5% of adolescent girls had dropped out of school due to pregnancy in 1995[14]. National guidelines on return to school policy are in place, but not widely disseminated and hence their limited enforcement.

The proportion of adolescents using modern methods of contraception is extremely low (4% for those aged 15 to 19 and 19% for those aged 20 to 24 years) despite early sexual debut. The group also portrays high HIV prevalence. Among the infected population aged 10 to 24 years, 22% are girls aged 10 to 15 years old and 4% boys in the same age group; 37% are girls aged 20 to 24 years old compared to 11% boys in the same age bracket[15]. A substantial proportion engage in high risk unprotected sexual practices with girls more vulnerable. AIDS Education Curriculum in schools has been introduced, but no time allocated in school timetables.

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[10] Macro International and Government of Kenya: Kenya Service Provision Assessment, 1999

[11] Macro International and Government of Kenya: Kenya Service Provision Assessment, 1999

[12] Macro International and Government of Kenya: Kenya Demographic Health Surveys 1998

[13] Republic of Kenya, Central Bureau of Statistics: Population Census Projections 1999

[14] Ferguson Allan: A study among adolescent girls in schools in Kenya 1995

[15] Republic of Kenya: National AIDS Control Programme (NASCOP): Report on AIDS in Kenya, 2001

Self-reporting for STDs is low but the high HIV prevalence in the same group depicts a different scenario. High awareness levels do not spur action towards prevention. Behaviour change is still very low. Adolescents/Youth are utilizing various channels to get information (Friends - over 35%; Schools - over 35%; Radio - over 50%)[16]. Community based institutions and channels play a key role in information dissemination for this group. Girls use print media more than boys. More boys listen to the radio. Peer based programmes are important for the promotion of ARH.

School based ARH programmes can capture sizeable number of youth; Media can greatly enhance ARH programmes. The age group 10-14 so far although at risk is not current targets in ARH programs. Few programmes address the needs of out of school youth. Focus is primarily on awareness creation with no linkage to service delivery. There are inadequate "youth focused services", yet access to ARH services is often limited by cost, physical environment, as well as the choice and skills of service providers. There are small pilot initiatives nation wide and no indications of scaling up. Gender and geographical disparities skewed more towards males and urban areas and there are no National standards and guidelines for youth friendly ARH services.

On drug and substance abuse there is little documented and known nationally. Anecdotal information is used to guide programming. Drug abuse among adolescents and youth of both sexes is widespread. There are clear linkages between drug use and abuse and risky sexual behaviour. Current legal provisions do not protect youth adequately against drug abuse There are few drug rehabilitation programmes available for adolescents and youth in Kenya.

There is inadequate research data, documentation and indicators for ARH information and service initiatives. Regarding information, the community as well as the family are important units in support of ARH services, yet few programmes target them. In addition most of the current IEC materials are tailored towards RH needs of the adults.

The prevalence of HIV in 2001 was estimated at 13.5% nationally with 2.2 million Kenyans reported infected[17]. This is based on sentinel surveillance data. Prevalence displays regional variation as high as 40% in some districts. Gender and age variation is observed with a peak at 24 to 29 years among females, and 35 to 39 years for males. Adolescents and youth, again are the most hard hit, with girls more affected than boys as reflected in the statistics on infection in this group (15 - 19 year old group among those infected girls are 22% compared to 4% boys; and in the group 20 - 24 years old 37% are girls and 11% boys). Most people do not know their HIV status. Voluntary Counselling and Testing (VCT) services are now available, but selectively accessible. Provider skills and competencies are limited, with facility and regional variation.

Death due to AIDS is on the increase and estimated at 700 deaths per day nationally. The number of AIDS orphans is on the rise (about 400,000 in 1997 and just over 700 000 in 1999) with about 78,000 between 0 and 14 years infected with the virus[18]. Home based care for those infected is a newer focus for HIV/AIDS programmes, in addition to prevention. The links with the formal health system are weak. Consistency in data collection methods and techniques is lacking. As a result the appropriate utilization of available information in programming and service delivery is minimal. There have been several programmes on prevention over the years, and only lately has the focus begun to address treatment with Ante Retro Viral (ARV) drugs, however the cost of these drugs is prohibitive. The Kenya AIDS Vaccine Initiative (KAVI) is now focusing on vaccine development.

[16] Macro International and Government of Kenya: Kenya Demographic Health Surveys 1998

[17] Republic of Kenya: National AIDS Control Programme (NASCOP): Report on AIDS in Kenya, 2001

[18] United Nations: Kenya Country Assessment 2001

Cancers of the reproductive tract, though not included in the figure of maternal deaths, are significant contributors to deaths of women in the same age group. To further influence women's reproductive and sexual behaviour, morbidity patterns and fertility regulation this aspect needs to be addressed. Cancer of the cervix is the most common reproductive tract cancer among women in Kenya. Screening services are only available at selected sites, with limited personnel. Current trials with cost effective, but simple methodology are in progress for screening. For breast cancer 80% cases occur in women, but it is more fatal in men. The current screening procedures are expensive. Prostate cancer is a common killer among older men, but often slow in progress and usually detected late. For all these there are no national figures only service statistics, which are often incomplete.

Harmful practices such as female genital cutting (FGC), early marriages, domestic violence, wife inheritance, gender discrimination in access to education, and at times health services need to be included in the RH issues, even if minimally, to eliminate infringement on women's reproductive rights. Most programmes focus on communities rather than individuals, with predominant use of advocacy and lobby groups. Information on FGC has been minimal, with findings from KDHS in 1998 showing the proportion of women among those married and aged 15-49 years who have been circumcised at 36%. Among girls aged 15 - 19 years it was recorded that 26% of respondents at the KDHS in 1998 had undergone some form of FGC. There are emerging issues such as child-to-child marriages, and trafficking in children and women that also need to be tackled. Strong socio-cultural influence is evident here.

Overall education helps girls and women to know their rights and to gain confidence to claim them. Benefits of education are evident in the prevention of the diseases such as HIV and AIDS. Women are five times more vulnerable than men to HIV/AIDS, yet they are not empowered to protect themselves in a variety of ways. These include making decisions regarding prevention abstinence, delaying age of sexual relations, behavioural changes in the sexual relations, and the use of condoms.

ANNEX 4: MAJOR (>EURO 100,000) ICPD INTERVENTIONS IN KENYA, BY THEMATIC CLUSTER, 1994-2001

Note:

HLTH ……. Health

HUMAN … Humanitarian assistance (refugees, IDPs, natural catastrophes, etc.)

ICPD ……. ICPD core sectors, including HIV/AIDS

OTHR …. ICPD-related sectors(employment, education, indigenous populations, etc.)

Source: Population-Development Database

Cluster	Brief description	Project title	Amount	Budget line	Commitment year	Project number
HLTH	Sector support	FAMILY HEALTH PROGRAMME(CF 6 KE 58/59;7 KE 78)	11.450.000,00	FED 07	23.11.2001	7 ACP KE 79
HLTH	Health policy and mgmt	PROMOTION OF COMMUNITY BASED HEALTH INSURANCE IN NYERI AREA,KENYA	375.219,00	B76000	2000	PVD/2000/409
HLTH	Basic health care	CONTINUATION OF A RURAL COMMUNITY HEALTH PROGRAMME IN SIX DISTRICTS OF KENYA	369.940,00	B76000	2001	PVD/2001/284
HLTH	Basic health care	PROGRAMA DE SALUD COMUNITARIA Y DESARROLLO INTEGRAL EN WEMA, DIOCESIS DE GARISSA - KENIA	359.740,00	B76000	1999	PVD/1999/81
HLTH	Basic health care	PROGRAMA INTEGRAL EN KOKUSELEI-LAPUR-TURKANA-KENYA	288.518,00	B76000	1998	PVD/1998/912
HLTH	Sector support	Support to Health Sector	145.000,00	EDF	30.06.1999	8 KE 4
HUMAN	Refugees / IDPs	DISPLACED PERSONS AFFECTED BY DROUGHT AND INTER ETHNIC CONFL	2.568.631,24	FED 07		7 ACP KE 5
HUMAN	Refugees / IDPs	ASSISTANCE TO REFUGEES OF SUDAN, ETHIOPIA AND SOMALIA	2.523.039,21	FED 07		7 ACP KE 11

HUMAN	Humanitarian aid	ECHO/KEN/254/2002/01000 - AIDE HUMANITAIRE - KENYA	2.500.000,00	FED 08	2002	8 ACP KE 32
HUMAN	Humanitarian aid	ECHO/KEN/254/2001/01000 - HUMANITARIAN ASSISTANCE TO THE VIC MS OF DROUGHT	1.600.000,00	FED 08	1996	8 ACP KE 26
HUMAN	Refugees / IDPs	UNFORESEEN INFLUX OF SOMALI REFUGEES	592.376,79	FED 07		7 ACP KE 3
HUMAN	Humanitarian aid	ECHO/KE/ART254/100	549.442,91	FED 07		7 ACP KE 54
HUMAN	Humanitarian aid	ECHO/KEN/254/1999/01000	517.867,89	FED 08	1999	8 ACP KE 5
HUMAN	Refugees / IDPs	ASSISTANCE FOR DISPLACED PEOPLE IN GARISSA	473.389,00	FED 07		7 ACP KE 75
HUMAN	Refugees / IDPs	INFLUX COMALI REFUGEES	427.799,75	FED 06		6 ACP KE 49
HUMAN	Refugees / IDPs	SOMALIAN REFUGEES PROGRAMME IN NORTH-EASTERN KENYA(ART.255)	388.134,00	FED 07		7 ACP KE 66
HUMAN	Humanitarian aid	ECHO/KE-/ART254/94/0300 - AID TO LAND-CLASH VICTIMS	365.107,23	FED 07	1994	7 ACP KE 62
HUMAN	Humanitarian aid	ECHO/KE-/ART254/95/0300 -HUMANITARIAN ASSISTANCE TO SOMALI	314.840,00	FED 07	1995	7 ACP KE 77
HUMAN	Humanitarian aid	ECHO/KE/ART254/94/200.	206.952,75	FED 07	1994	7 ACP KE 55
HUMAN	Food / Nutrition	ECHO/KE-/ART254/95/0100 NUTRITIONAL MEDICAL AND SANITATION	166.768,22	FED 07	1995	7 ACP KE 69
ICPD	Family planning	FAMILY HEALTH PROGRAMME(CF 6 KE 59)	1.693.481,00	FED 06	23.11.2001	6 ACP KE 58
ICPD	Reproductive health	FAMILY HEALTH PROGRAMME	1.666.019,00	FED 06	23.11.2001	6 ACP KE 59
ICPD	STD Control including HIV-AIDS	STRENGTHENING STD & HIV/AIDS PROGRAMME IN NAIROBI & MONBASA.	1.577.500,00	FED 07		7 ACP KE 68
ICPD	STD Control including HIV-AIDS	HIV/AIDS and Population Related Operations in Developing Countries	1.288.514,00	B7 6310-6211	2001	KE/AIDCO/2001/0460

ICPD	Safe motherhood	A PROJECT FOR THE EXPANSION OF MATERNAL AND CHILD HEALTH AND FAMILY PLANNING SERVICES IN THREE PROVINCES IN KENYA: THE RIFT VALLEY, EASTERN AND WESTE	499.351,00	B76000	1998	PVD/1998/482
ICPD	STD Control including HIV-AIDS	AIDS/STD CONTROL IN KENYA	385.000,00	PIN-07-KE		FED/KE/08000/000
ICPD	STD Control including HIV-AIDS	SUPPORT PROGRAMME FOR CARE SERVICES FOR HIV/AIDS PATIENTS IN HOMA BAY DISTRICT, NYANZA PROVINCE, KENYA	354.451,00	B76000	2000	PVD/2000/689
ICPD	STD Control including HIV-AIDS	AIDS/STD CONTROL IN KENYA RENOV. & EXTENS. STD CLIN. NAIROBI	353.862,45	FED 07		7 ACP KE 24
OTHR	Women in development	SUPPORT FOR WOMEN-OWNED ENTERPRISE THROUGH SACCOS(SWOES) KENYA	497.459,00	B76000	2000	PVD/2000/404
OTHR	NGOs	BOMET INTEGRATED RURAL DEVELOMENT INITIATIVE - KENYA	450.000,00	B76000	1998	PVD/1998/648
OTHR	Women in development	PSYCHOSOCIAL, HEALTH-SUPPORTING WORK FOR AND TOGETHER WITH WOMEN AND GIRLS OF MOSOCHO DIVISION - SEXUAL AND REPRODUCTIVE HEALTH - OVERCOMING OF FEMALE	320.473,00	B76000	2001	PVD/2001/691
OTHR	Women in development	REHABILITATION OF STREET GIRLS AND THEIR FAMILIES IN KENYA	303.303,00	B76000	2001	PVD/2001/27

N.B. The health sector support project 'District health Services and Systems Development Programme' – Project No. 8 ACP KE 30 - (follow up to the Kenya Family Health Programme) has a budget of Euro 15 million under budget line FED 08, has been delayed and does not appear in the table.

ANNEX 1

QUESTIONNAIRE FOR DELEGATIONS: MANAGEMENT AND MAIN RESULTS

Thematic Evaluation of Population and Development Oriented Programmes in EC External Co-Operation

1. PART 1. CHOICE OF COUNTRIES

The selection of countries should concentrate on those with significant programmes but, in the spirit of this thematic evaluation, should contain countries with projects across the range of the population and development theme. A set of 20 countries for questionnaire administration has been tentatively selected, as follows.

In Step 1, countries were listed in descending order of size of programme in each of the four areas in the evaluation database: core ICPD activities, health, humanitarian assistance, and other population-related areas (note that, in Steps 3 and 4 below, the order in which these sectors are listed has an impact on the final selection of countries). The top five countries in each category were selected, as follows (in descending order of size of programme).

- Core ICPD: India, Morocco, Malawi, Tanzania, Egypt
- Health: Egypt, Bangladesh, Thailand, Congo, South Africa, Mozambique
- Humanitarian assistance :Angola, Palestine, Congo, Liberia, Burundi
- Other : El Salvador, Guatemala, Venezuela, Peru, Nicaragua

In Step 2, India, Egypt, and Guatemala were removed because they are being covered in field missions. In each sector where they were barred, the next country on the list (i.e., the next largest country programme) was selected:

- Core ICPD: Morocco, Malawi, Tanzania, Mozambique, FYROM
- Health: Bangladesh, Thailand, Congo, South Africa, Mozambique
- Humanitarian assistance: Angola, Palestine, Congo, Liberia, Burundi
- Other: El Salvador, Venezuela, Peru, Nicaragua, Honduras

In Step 3, countries already identified in a previous sector were barred and the country with the next-largest country programme was substituted.

- Core ICPD: Morocco, Malawi, Tanzania, Mozambique, FYROM
- Health: Bangladesh, Thailand, Congo, South Africa, Angola
- Humanitarian assistance: Angola, Palestine, Liberia, Burundi, Rwanda
- Other: El Salvador, Venezuela, Peru, Nicaragua, Honduras

Step 4 removed Angola from the Humanitarian assistance list because it now appears in the Health list:

- Core ICPD: Morocco, Malawi, Tanzania, Mozambique, FYROM
- Health: Bangladesh, Thailand, Congo, South Africa, Angola,
- Humanitarian assistance: Palestine, Liberia, Burundi, Rwanda, Afghanistan
- Other: El Salvador, Venezuela, Peru, Nicaragua, Honduras

The resulting tentative list of countries to receive the questionnaire is as follows:

Africa:	Malawi, Tanzania, Mozambique; Congo, Angola, Liberia, Burundi, Rwanda, South Africa
Asia:	Bangladesh, Thailand, Afghanistan
Latin America:	El Salvador, Venezuela, Nicaragua, Honduras
MEDA:	Morocco, Palestine
CARDS/Tacis:	FYROM

The revised database shows that ACP accounts for 56% of total assistance in the four population-related sector, MEDA for 15%; Asia and Latin America about 13% apiece and CARDS/Balkans/Tacis for 1% (regional and global projects account for the rest). Our procedure has resulted in 9 of 20 countries being located in Africa, 4 in Latin America, 3 in Asia, and one in CARDS. This is geographical spread not completely at variance with the distribution of programme spending.

The country selection procedure is clearly ad hoc, and any suggestions for tinkering will be entertained. For example, a non-African ACP country could be substituted for one of the African countries. Since all Latin American countries have been included because of large "Other" projects, a Latin American country with a large programme in one of the other three sectors could be substituted.

2. PART 2: PRESENTATION OF THE STANDARD FORMULAR SENT TO THE DELEGATIONS

Thematic Evaluation of Population and Development Oriented Programmes in EC External Co-Operation

QUESTIONNAIRE FOR DELEGATIONS

N.B.: An information note AIDCO/H6/JLC/PvS/vm D(2003) 21689 dated 25/06 has been sent out by Email on 26 June 2003 to the 26 delegations covered by this questionnaire

2.1. Explanatory note

This Questionnaire is part of the first-ever evaluation of the theme "Population and Development in EC external cooperation programmes". The objective of this evaluation is to provide the Commission with an independent expertise to assess the nature and evolution of its objectives and policies on population and development in external co-operation programmes, the evolution and volume of the programmes concerned, to assess its relevance, effectiveness, efficiency, sustainability and impact, and internal/external coherence.

The reference adopted is the "International Conference on Population and Development (ICPD)" and its Programme of Action (Cairo, 1994). The EC plays a significant role in international population assistance and provided approximately 5-10% of global support for the ICPD goals from 1994-2001. It focuses on six main areas:

- Maintaining and increasing the gains already made in providing access to sexual and reproductive health services,
- Ensuring that women have the opportunity of safe pregnancy and childbirth,
- Promoting the sexual and reproductive health of young people,
- Limiting the spread of HIV/AIDS and caring for those who live with the virus,
- Addressing problems of gender-based violence and sexual abuse, especially of young women and children,
- Building partnerships with civil society.

The EC is also a major source of humanitarian assistance to refugees and displaced persons, a significant amount of which overlaps with population (reproductive health of displaced populations, resettlement and repatriation programmes, etc.).
The purpose of this Questionnaire is to gain information on how a sample of 26 Delegations have been dealing with the population and development theme, thus broadening the evidence base beyond the limited number of countries scheduled for field missions (Kenya, Egypt, Guatemala, India, Georgia).

It is our hope that the time spent in filling out the Questionnaire will also assist each of the selected delegations to better appreciate the population and development theme and its potential for contributing to sustainable development. It will also assist us to give

recommendations on how better to enable Delegations to implement the population and development theme.

This Questionnaire is intended to supplement, not substitute for, field visits during which Evaluative Questions will be answered in detail.

Chapter 2.3 gives full details of what activities are covered in the relevant chapters of the ICPD Programme of Action, in relation the list of questions on the following pages..

Almost all budget lines and the EDF have been found to have financed population-related activities. This evaluation is therefore not limited to any particular financial instrument.

The preparatory phase to the evaluation has included an analysis of all relevant key documents and previous evaluations, the establishment of a database of relevant actions, and a field visit to Uganda in October/November 2002. The information collected will be complemented by information obtained from the enclosed questionnaire and from field missions to five countries.

We would like to thank you in advance for your cooperation which will help us and the units involved in this evaluation to improve future EC policy and programmes design / implementation.

Please send/fax this completed form before 19 July to:
Cornelia Schmitz; PARTICIP GmbH;
Phone: +49 761 790740; Fax: +49 761 7907490 ; Cornelia.Schmitz@particip.de

NB : Please note that the term 'activities' refers to programmes, projects, and activities at all levels, and 'operators' to the executing agency which is the prime contractor.

2.2. QUESTIONNAIRE FOR EC DELEGATIONS

Thematic Evaluation of Population and Development Oriented Programmes in EC External Co-Operation
Period covered: 1994-2002

Delegation to (name country)			
Name of the person who completed the questionnaire			
E-Mail			
Position in the Delegation			
	Male ☐		Female ☐

Question 1.
Are you aware of the EC policy documents and issues related to the population and development theme? (please tick box)

Yes ☐ No ☐

Question 2.
Is there someone responsible for population issues at the delegation? (please tick box)

Yes ☐ No ☐

If Yes, what is this person's position in the delegation?

Male ☐ Female ☐

Approximately what percent of his / her time is devoted to population issues?

How does he/she perceive the role of the delegation as regards population and development strategies, programmes, projects, or other actions?

Question 3.

What is Government's approach to population and development?

How much priority does Government give to population and development issues?

Item	None	Low	Medium	High
In policy statements				
In negotiations				
In committing to actions				
In (co-)financing actions				
In implementing actions				
Other (please describe)				

General remarks:

Question 4.
During the drafting of the current Country Strategy Paper:

Were assessments of the population and development theme in the country carried out?

Yes ☐ | No ☐

If yes, please describe briefly

Was there dialogue with Ministries related to the population and development theme?

Yes ☐ | No ☐

If yes, please describe briefly.

Was there consultation with other actors working in the population and development area (multilateral and bilateral agencies, NGOs, academic institutions etc.)?

Yes ☐ | No ☐

If yes, please describe briefly.

Question 5.
Is the Delegation involved in any co-ordination fora (committees, working groups, etc.) regarding population and development with other actors active in this field (Government ministries, World Bank, UNFPA, UNAIDS, bilateral donors like DFID, USAID, etc,)?

Yes		No	

If yes, please describe briefly.

Does this include health sector dialogue in the context of SWAp?

Yes		No	

If yes, please describe briefly.

Question 6.
Reproductive Rights and Reproductive Health (apart from sexually transmitted infections and HIV/AIDS):

(i) To what extent have EC-supported actions in this field addressed specific objectives related to Reproductive Rights and Reproductive Health (apart from sexually transmitted infections and HIV/AIDS)? The main areas of action envisaged are reproductive health, family planning, human sexuality and gender relations, and adolescents. For a full list of for a list of key actions of the International Conference on Population and Development (ICPD) related to Reproductive Rights and Reproductive Health, see Annex 1.

(ii) For each activity, please rate whether the results and impacts that have occurred were satisfactory on a scale of –3 (highly negative impact) to +3 (highly positive impact). Where possible, also please give key figures / indicators with respect to results and impacts.

Activity	**Comments**
1.	
2.	
3.	

Question 7.
Health (including primary health care and health-care sector), morbidity, and mortality (apart from sexually transmitted infections and HIV/AIDS):

(i) To what extent have EC-supported actions addressed specific objectives related to Health, Morbidity, and Mortality (apart from sexually transmitted infections and HIV/AIDS)? The main areas of action envisaged in the ICPD are primary health care and the health-care sector, child survival and health, women's health and safe motherhood. For a full list of key actions of the ICPD related to Health, Morbidity, and Mortality, see Annex 1.

(ii) For each activity, please rate whether the results and impacts that have occurred were satisfactory on a scale of –3 (highly negative impact) to +3 (highly positive impact). Where possible, also please give key figures / indicators with respect to results and impacts.

Activity	Comments
1.	
2.	
3.	

Question 8.
Sexually transmitted infections (STIs) and HIV/AIDS:

(i) **To what extent have EC-supported actions addressed specific objectives related to sexually transmitted infections (STIs) and HIV/AIDS?** The main areas of action envisaged in the ICPD are related to sexually transmitted infections (STIs) and HIV/AIDS, see Annex 1.

(ii) **For each activity, please rate whether the results and impacts that have occurred were satisfactory on a scale of –3 (highly negative impact) to +3 (highly positive impact). Where possible, also please give key figures / indicators with respect to results and impacts.**

Activity	**Comments**
1.	
2.	
3.	

Question 9.
Refugees, internally displaced persons (IDPs), and distress migration:

(i) **To what extent have EC-supported actions addressed specific objectives related to refugees, IDPs and distress migration?** The main areas of action envisaged in the ICPD are to offer adequate protection and assistance to displaced persons, to address the root causes of movements of refugees and displaced persons, and to strengthen support for international activities to protect and assist refugees and displaced persons. For a full list of key actions of the ICPD related to refugees, IDPs, and displaced persons, see Annex 1.

(ii) **For each activity, please rate whether the results and impacts that have occurred were satisfactory on a scale of –3 (highly negative impact) to +3 (highly positive impact). Where possible, also please give key figures / indicators with respect to results and impacts.**

Activity	**Comments**
1.	
2.	
3.	

Question 10.
Population composition (including age structure, indigenous populations, and people with disabilities) and distribution (including internal migration apart from displaced persons, large urban agglomerations, and international migration apart from migration into EU-Member States):

(i) To what extent have EC supported actions addressed specific objectives related to Population Growth and Structure, Population Distribution, Internal Migration (apart from IDPs), Urbanisation and International Migration (apart from international migration into EU-Member States)? The main areas of action envisaged in the ICPD are to promote the positive contribution of migration, both internal and international, to sustainable development, to protect the rights of international migrants and fight trafficking, to address problems of rapid urbanisation and population ageing. For a full list of key actions of the ICPD related to Population Growth and Structure, Urbanisation, Internal and International Migration, see Annex 1.

(ii) (For each activity, please rate whether the results and impacts that have occurred were satisfactory on a scale of –3 (highly negative impact) to +3 (highly positive impact). Where possible, also please give key figures / indicators with respect to results and impacts.

Activity	Comments
1.	
2.	
3.	

Question 11.
(i)What have been, if any, the obstacles to increased EC activity in the area of population?

(ii)What measures, in your opinion, could contribute toward improved programmes in the future?

Please add any further comments below:

We are grateful for the time you have generously given us by completing this questionnaire, thus sharing with us your experience and much appreciated views.

2.3. ACTIONS AREAS IDENTIFIED IN THE ICPD PROGRAMME OF ACTION IN RELATION TO THE QUESTIONS ON THE PRECEDING PAGES

Note to Question 6: key ICPD actions related to Reproductive Rights and Reproductive Health (apart from sexually transmitted infections and HIV/AIDS).

The main areas of action envisaged in the ICPD are **reproductive health, family planning, human sexuality and gender relations, and adolescents**. Specific actions related to **reproductive health** include family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and treatment of infertility; abortion as specified in paragraph 8.25 of the ICPD Programme of Action, treatment of reproductive tract infections and other reproductive health conditions; and information, education and counselling on human sexuality, reproductive health and responsible parenthood. Specific actions related to **family planning** include those designed to help couples and individuals meet their reproductive goals; to prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality; to make quality services affordable, acceptable and accessible to all who need and want them; to improve the quality of advice, information, education, communication, counselling and services; to increase the participation and sharing of responsibility of men in the actual practice of family planning; and to promote breast-feeding to enhance birth spacing. Actions related to **sexuality and gender relations** include those giving support to integral sexual education and services for young people that stress male responsibility for their own sexual health and fertility and that help them exercise those responsibilities. non-formal education and community-based efforts designed to reach adults, efforts supporting active and open discussion of the need to protect women, youth and children from abuse, including sexual abuse, exploitation, trafficking and violence, and actions designed to stop the practice of female genital mutilation and protect women and girls from all similar unnecessary and dangerous practices. Actions related to **adolescence** include those that promote responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and provide appropriate services and counselling specifically suitable for that age group.

Note to Question 7: key ICPD actions related to Health, Morbidity, and Mortality (apart from sexually transmitted infections and HIV/AIDS).

The main areas of action envisaged in the ICPD are **primary health care and the health-care sector**, **child survival and health**, **women's health and safe motherhood**. Specific actions related to **primary health care and the health care sector** include actions to increase the accessibility, availability, acceptability and affordability of health-care services and facilities, and to increase the healthy life-span and improve the quality of life of all people, as well as to reduce the disparities in life expectancy between and within countries, to ensure community participation in the planning of health policies, especially with respect to the long-term care of the elderly, those with disabilities and those infected with HIV and other endemic diseases, to ensure access to health-care services for all people and especially for the most underserved and vulnerable groups, and to make basic health-care services more sustainable financially, while ensuring equitable access. Specific actions related to **child survival and health** include those aiming to assess the underlying causes of high child mortality and to extend, within the framework of primary health care,

integrated reproductive health-care and child-health services, including safe motherhood, child-survival programmes and family planning services, to all the population and particularly to the most vulnerable and underserved groups, to reduce the major childhood diseases, particularly infectious and parasitic diseases, and to prevent malnutrition among children, especially the girl child. Specific actions related to **women's health and safe motherhood** include actions to expand the provision of maternal-health services in the context of primary health care, to prevent, detect and manage high-risk pregnancies and births, particularly those of adolescents and late-parity women, to engage men's support for maternal-health and safe motherhood, to seek changes in high-risk sexual behaviour and to devise strategies to ensure that men share responsibility for sexual and reproductive health, to reduce the number of deaths and morbidity from unsafe abortion, and to improve the health and nutritional status of women, especially pregnant and nursing women.

Note to Question 8: key ICPD actions related to sexually transmitted infections (STIs) and HIV/AIDS.

The main areas of action envisaged in the ICPD include those to prevent, detect and treat STIs and other reproductive tract infections; providing specialized training to all health-care providers in the prevention and detection of, and counselling on STIs, especially infections in women and youth; making information, counselling for responsible sexual behaviour and effective prevention of STIs and HIV integral components of all reproductive and sexual health services; and promoting and distributing high-quality condoms as integral components of all reproductive health-care services, reducing the spread of and minimizing the impact of HIV infection, ensuring that HIV-infected individuals have adequate medical care and are not discriminated against, and intensifying research on methods to control the HIV/AIDS pandemic and to find an effective treatment for the disease.

Note to Question 9: key ICPD actions related to refugees, IDPs and distress migration.

The main relevant areas of action envisaged in the ICPD are those related to **internally displaced persons** and **refugees, asylum-seekers, and displaced persons**. Specific actions related to **internally displaced persons** include those to offer adequate protection and assistance to persons displaced within their own countries, particularly women, children and the elderly, and to find solutions to the root causes of their displacement, with a view to preventing it in the future, and to facilitate their return or resettlement; to put an end to all forms of forced migration, including "ethnic cleansing"; to address the causes of internal displacement, including environmental degradation, natural disasters, armed conflict and forced resettlement; to establish the necessary mechanisms to protect and assist displaced persons; to ensure that internally displaced persons receive basic education, employment opportunities, vocational training and basic health-care services; and to find lasting solutions to questions related to internally displaced persons, including their right to voluntary and safe return to the home of origin Specific actions related to **refugees, asylum-seekers, and displaced persons** include those to address the root causes of movements of refugees and displaced persons, to strengthen support for international activities to protect and assist refugees and displaced persons, to meet the basic needs of refugees and to assist in the search for durable solutions, and to provide refugees with access to adequate accommodation; education; health services, including family planning; and other necessary social services.

Note to Evaluative Question 10: key ICPD actions related to population composition (including age structure, indigenous populations, and people with disabilities) and distribution (including internal migration apart from displaced persons, large urban agglomerations, and international migration apart from migration into EU-Member States).

The main areas of actions envisaged in the ICPD are those related to **internal migration** (other than IDPs), **international migration** (other than refugees and subject to the restrictions of the Terms of Reference that international migration into Member countries not be covered by this Evaluation), and **population composition and structure** (including age structure, large urban agglomerations, indigenous populations, and the disabled). Specific actions related to **internal migration** include those to promote sustainable development in both sending and receiving regions, to reduce factors encouraging people to migrate such as inequitable allocation of development resources, the use of inappropriate technologies, and the lack of access to available land, to encourage the growth of small or medium-sized urban centres and seek to develop rural areas by supporting access to landownership and to water resources, especially for family units and by making or encouraging investments for increased rural productivity. Specific actions related to **international migration** include those to address the root causes of migration, to make remaining in one's country a viable option for all people, to foster inflows of remittances by sound economic policies and adequate banking facilities, to consider the use of temporary migration, to promote voluntary return, to exchange information on migration policies and the monitoring of stocks and flows of migrants through adequate data gathering, to ensure that documented migrants who meet appropriate length-of-stay requirements, and members of their families, receive regular treatment equal to that accorded nationals with regard to basic human rights, to protect women and children who migrate as family members from abuse or denial of their human rights, to promote integration of family reunification into national legislation in order to protect the unity of the families of documented migrants in a manner consistent with the universally recognized human rights instruments, to reduce the number of undocumented migrants; to prevent their exploitation and protect their basic human rights; to prevent international trafficking in migrants; and protect them against racism, ethnocentrism and xenophobia, to identify the causes of undocumented migration and its economic, social and demographic impact; to adopt effective sanctions against those who organize, exploit or traffic in undocumented migration; to deter undocumented migration by making potential migrants aware of the legal conditions for entry, stay and employment in host countries; and to try to find solutions to the problems of undocumented migrants through bilateral or multilateral negotiations on, *inter alia*, readmission agreements that protect the basic human rights of persons involved in accordance with relevant international instruments. Specific actions related to **population composition and age structure** include those designed to develop formal and informal old-age support systems, to enhance the self-reliance of elderly people, to put in place social safety nets for the elderly and to eliminate all forms of violence and discrimination against them; to increase the capacity and competence of city and municipal authorities to manage development in larger urban agglomerations and to respond to the needs of all citizens and to give migrants, especially females, greater access to work, credit, basic education, health services, child-care centres and vocational training; .to recognize the specific needs of indigenous people, including primary health care and reproductive health services, to compile demographic data on indigenous populations, to enhance the ability of indigenous people to manage their lands while protecting the natural resources and ecosystems on which they depend; to develop infrastructure to address needs of disabled persons, to recognise their needs including reproductive health care, and to eliminate discrimination faced with regard to reproductive rights, household and family formation, and international migration

3. PART 3: SUMMARY OF THE QUESTIONNAIRES FOR EC DELEGATIONS CONCERNING THE "THEMATIC EVALUATION OF POPULATION AND DEVELOPMENT ORIENTED PROGRAMMES IN EC EXTERNAL CO-OPERATION"

Period covered: 1994-2002

This chapter presents the results of the questionnaires returned by the delegations. 22 delegations did return the questionnaires: These delegations are presented in the table below.

Only four delegations (Mozambique, Tanzania; Peru and Venezuela) couldn't send us the questionnaires.

By the first analysis of the questionnaires, we were very impressed by the quality and the degree of details of the answers so that we decided to report all information in the presentation of the results, instead of making an overall summary, which would have forced us to simplify the information, though loosing a high amount of qualitative data.

The result is a detailed presentation of the answers of all delegation, allowing the reader to make its own judgment on the way things are perceived according to each country or each specific context.

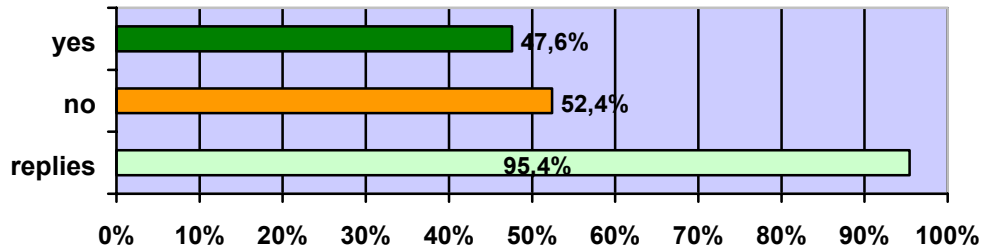
Countries included:

ANG - Angola	CON - Congo	NIC - Nicaragua	RWA - Rwanda	TU - Tunisia
BAN - Bangladesh	SAL – El Salvador	NGA - Nigeria	SOM - Somalia	SIM - Zimbabwe
BRU - Burundi	FY - FYROM	PA - Pakistan	SA – South Africa	
KPU - Cambodia	MAW - Malawi	PAL - Palestine	TSA - Chad	
CHN - China	M - Morocco	PHI - Philippines	THAI - Thailand	

Question 1.

Are you aware of the EC policy documents and issues related to the population and development theme?

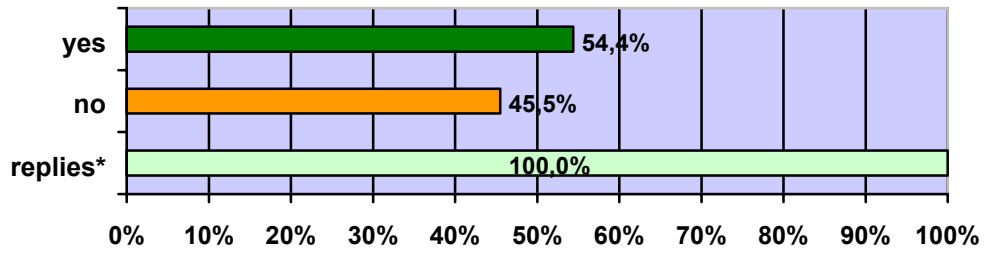
Yes	ANG	BAN	BRU	CHN	M	PA	PHI	RWA	SA	TU	
No	KPU	CON	SAL	FY	MAW	NIC	NGA	SOM	TSA	THAI	SIM



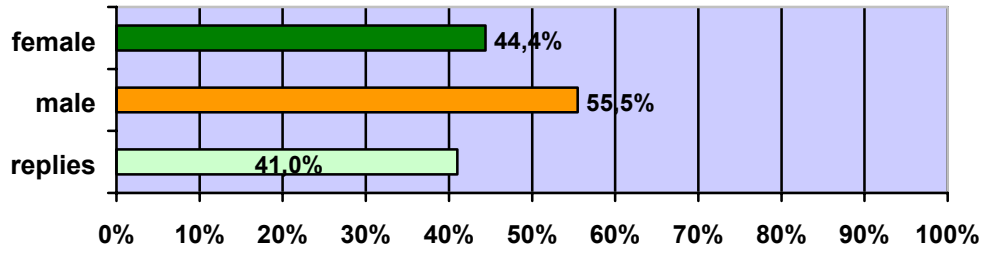
Question 2.

Is there someone responsible for population issues at the delegation?

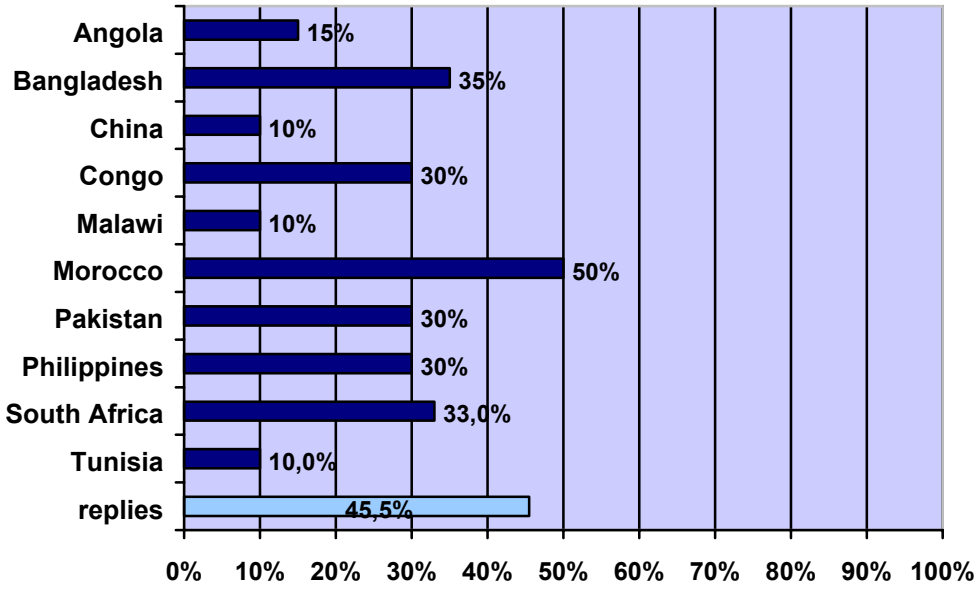
Yes	ANG	BAN	KPU	CON	MAW	M	PA	PHI	RWA	SA	TSA	TU
No	BRU	CHN	SAL	FY	NIC	NGA	PAL	SOM	THAI	SIM		



If Yes, what is this person's position in the delegation?	
Angola	Health Expert, Second secretary
Congo	Resident Advisor, Development
Malawi	Young Expert in Training
Morocco	Conseiller, Secteurs sociaux et Développement rural
Pakistan	Development Adviser
Philippines	Project Officer
South Africa	Most of the "population" issues are covered by the Health Advisor although "population development" is an area of cross-cutting development throughout the EPRD
Tunisia	Responsibility for population issues at the delegation is shared: Expert for Civil Society: Horizontal budget lines which include reproductive health (B7-631), Gender (B7-622), as well as project concerning disabled people under b.l. B7-6000. Expert: Asylum and Migration issues, budget line B7-667, coordination of research on Tunisia in 2010 (which includes demographic trends),
Cambodia	No responsible designated explicitly. Implicitly, the SPO Education, Health, Social Development



Approximately what percent of his / her time is devoted to population issues?



How does he/she perceive the role of the delegation as regards population and development strategies, programmes, projects, or other actions?*	
Angola	some effects over programmes, projects, or other actions related to the health situation of the population, concerning the specific population and development strategies this role is not particularly well structured and it is of little relevance.
Bangladesh	Health is number one priority with the aim to improve the human development indicator National Indicative Plan has proposed highest amount (120 Million Euro) for the Health sector. The EC has gradually increased its involvement in this field and now the largest bilateral donor in the Health and Population Sector Programme
Cambodia	to monitor the various EC-funded projects, having or not a population & development focus, and to follow-up related sectors (e.g. education, health, social development) with rather a sectoral approach.
China	Important but not a main priority as priorities for cooperation in China, as agreed in the CSP and NIP do not include this population issue as a top priority.
Congo	The Delegation focuses mainly on refugees and IDPs and reproductive health. The role is to propose assistance programmes which are most appropriate to cover the essential existing needs in this respect as well as to strengthen authorities' response capacity.
FYROM	small delegation since the European Agency for Reconstruction is in charge of the implementation of the main EC CARDS assistance programmes in the country. The EC Phare assistance provided for the period 1996-1999 and 2000 has been managed in centralised way from Brussels with assistance provided from the Delegation. It is important to notice that ECHO was operating the country during the period from 1992- !996

* replies partly shortened

How does he/she perceive the role of the delegation as regards population and development strategies, programmes, projects, or other actions?*	
Malawi	Health is not a focal sector of the Joint Government-EC Country Strategy Paper. Most of the Delegation's health projects have ended. Due to the fact that the Delegation does neither have its own nor a regional health adviser, the Delegation's role in this sector is limited due to limited human resources. Despite these limitations, the Delegation plays as active a role as possible on the policy level, especially with respect to the ongoing deliberations on the establishment of a Sector Wide Approach (SWAp) to Health, coordinating closely with all development partners involved in the process, in particular in the context of linking the SWAp to the EC's Budget Support activities.
Morocco	La Délégation a un rôle principal dans la gestion des projets qui touchent le domaine de la population et développement financés par l'UE. Elle est l'interlocuteur vis-à-vis des autorités marocaines et d'autres bailleurs de fonds présents au Maroc, participant aux manifestations concernant les diverses questions couvertes par l'ICPD et diffusant la politique communautaire dans le domaine.
Pakistan	Actively involved in implementing family planning, safe motherhood, reproductive health and HIV/AIDS awareness, research and service delivery focused programmes in rural as well as urban areas.
Philippines	o Delegation has to be proactive in putting forward the population and development agenda at the forefront of international organizations' policies/strategies and on the Government policy agenda as well (through policy dialogues with the Government and the donor community as well as the private and non-governmental institutions).
South Africa	South Africa has a unique constitution; a well-developed and rich civil society and a government committed to levelling inequity and the eradication of poverty. Against this background, the Delegation's role is perceived to be one of support to the various government departments and advocacy organisations involved in the development and population development agenda.
Tunisia	Role of the delegation is active for what concerns migration and management of projects financed under horizontal budget lines (including B7-631). Some research concerning demographic trends is ongoing.

Question 3.

What is Government's approach to population and development?*	
Angola	population census wasn't carried out since 1970 in cause of the war National Statistical Office carried out a Multiple Indicator Cluster Surveys (MICS) in 1997 and 2001 official consultation paper on a national population policy prepared in 1997 Government made the preparation of a PRSP its priority and there will be found an outline for a future policy on population Government prepares a PRSP which has variously been announced and postponed
Bangladesh	Since 1998, Bangladesh Government has introduced "Sector Wide Approach" (SWAP) for the Health sector Govt. has submitted a revised alternative action plan in request of the donors community Govt. is keen to provide basic "Essential Service Package (ESP)" which includes immunization, control of diarrhoeal disease, ARI and provide reproductive health care for women.
Cambodia	The Government has a number of sectoral strategic plans, as well as a Socio-Economic Development Plan, a Poverty Reduction Strategy, a MDG action plan, and a EFA action plan. The recently produced National Health Strategic Plan includes maternal health as one of the priorities, and reproductive health as a key issue (including maternal health care, birth spacing and safe abortion). Another priority is the control of communicable diseases, including STI and HIV/AIDS.
China	PRC government very concerned about development issues and population. Clear targets and success in terms of reduction of poverty and improvement of living conditions.
Congo	Given the fact that the country is emerging from several years of civil war and a transition government is being formed so far no clear sectoral policies have been elaborated. Realistically, a more systematic approach may only be expected once the political and security situation remain calm over a longer period of time and the socio-economic situation recovers.
El Salvador:	There is a Population Policy reviewed and approved in 1993. Population and development is not consider within the current public policies, nor is it included as a factor of analysis in the political and governmental agenda. Nevertheless, some actions are undertaken by sectoral ministries such as the Ministry of Public Health, Education, the National Secretariat for the Family in the area of Sexual and Reproductive Health and Rights. Given the political and economic pressures the fundamentalists groups attached to the hierarchy of the catholic church assert upon the government to modify public policies, the government rather consider not to be outspoken on population and development issues, and makes timid advances on reproductive health and rights

* replies partly shortened

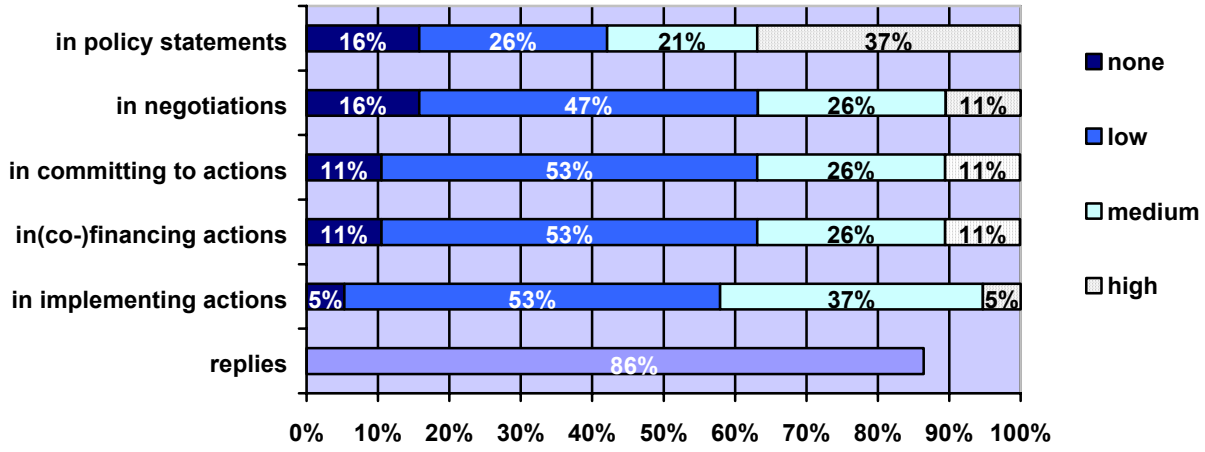
What is Government's approach to population and development?*	
FYROM	Government has no coherent programme or strategy tackling the Population and Development. Mainly the Ministry of Health and Ministry of Labour and Social Policy (MoLSP) covers the related issues. Within the MoLSP there is a Department for Human Population and Child Protection Policy and separate units for family and legal child and family protection and unsocial cases and problems in the family as wall as a unite for promotion of gender equality. current legal framework was introduced in the 90s with the adoption of the Family Protection Law of 1992 and was completed with the Social Welfare Law of 1997 and the Children Protection Law of 2000.
Malawi	Government is currently trying to take a "comprehensive" approach to population and development issues; Government not only tries to coordinate these issues in the health sector, but also with a clear linkage to the Malawi Poverty Reduction Strategy launched in April 2002; no clearly defined Working Group on Population (and Development), it's all subsumed in the *Health and Population Subgroup*, comprising of both Government and Development Partners. As a general principle, Government in its policies (except for the ongoing SWAp process0 doesn't seem to act on the basis of international agreements (apart from the Millennium Development Goals), but often rather on an ad hoc basis. Strategies and resulting policies are often "donor driven", thereby making it difficult to define, what approach Government really takes on these issues.
Morocco	En 2001 le gouvernement du Maroc a adopté son « Plan de Développement Economique et Sociale 2000-20004 ». Les priorités et initiatives principales de la politique sociale du Maroc incluent : • la décentralisation de l'administration et de la prise des décisions • un appui aux initiatives locales pour la promotion de la condition de la femme • l'extension de la protection sociale • l'amélioration de la qualité des services de santé reproductive et la réduction de la mortalité maternelle et néonatale
Nicaragua	There is a Population Policy reviewed and approved in 1993. Nevertheless, there is not a specific unit that follow up the policy after the institutional restructuring of the government, eliminating the Planning Ministry. Neither is there a interest in the application of the policy. The Ministry of Foreign Affairs follows up the international conferences, among them the ICPD, and is member of the Committee on Population and Development at the United Nations. Population and development is not consider within the current public policies, nor is it included as a factor of analysis in the political and governmental agenda. Nevertheless, some actions are undertaken by sectoral ministries such as the Ministry of Public Health, Education, the National Secretariat for the Family in the area of Sexual and Reproductive Health and Rights. Given the political and economic pressures the fundamentalists groups attached to the hierarchy of the catholic church assert upon the government to modify public policies, the government rather consider not to be outspoken on population and development issues, and makes timid advances on reproductive health and rights.

What is Government's approach to population and development?*	
Nigeria	ICPD areas are not a field of activity of the Delegation in Nigeria, therefore information in our possession are limited. In 1991 the Government made a "one woman four children" policy, which was never respected. The Federal Government supports nowadays the Planned Parenthood of Nigeria, a family planning NGO through the Ministry of Health. The FMoH also supports campaign for the eradication of vesico-vaginal fistula (V V F).
Pakistan	Population is recognized as a major cross-cutting issue in all development plans of Pakistan. The current Ninth Five Year Plan (1998-2003) views population issues in broader terms than those relating only to reproductive health and family planning delivery services, and takes into account both the impact of development programmes on population growth and the direct contributions to the population welfare programmes of other sectors, including NGOs and the private sector. Given the urgency and critical situation of the population issues in terms of its high momentum of growth and a fast-growing dependent and youth population, the Five Year Plan involves all sectors in exploring ways in which population problems and their consequences can be comprehensively addressed.
Philippines	The overarching goal of reducing poverty is the government's medium term policy agenda as expressed in its updated Medium-Term Philippine Development Plan for 2001-2004. To pursue this goal, the government set four strategies: a) macroeconomic stability and equitable growth based on free enterprise, b) agriculture and fisheries modernization with social equity, c) comprehensive human development and protecting the vulnerable, and d) good governance and the rule of law. The government recognized that the ability to implement poverty alleviation and broad-based development is constrained by the rapidly growing population. A population management program therefore has been defined, which shall be based on "sound reproductive health for women, men, and adolescents and freedom to choose consistent with project's cultural and religious beliefs from a menu of family planning services is in place. Access to family planning services by the poor is guaranteed." Specifically, the population policy is embodied in the Philippine Population Management Program Directional Plan and has a companion document on the Population Investment Plan.
Rwanda	Recently published "National Population Policy for Sustainable Development of Rwanda" based on consultative process and incorporating ICPD goals and actions. Broad approach to population and development, based on improving quality of life, incorporating health, education, food security, employment etc. Coordination by ONAPO (National Population Office) under MINISANTE (Ministry of Health). National Population Policy proposes creation of National Council for Population and Development to replace ONAPO.

What is Government's approach to population and development?*	
South Africa	"Population and development" is a function of the Chief Directorate Population and Development (CDP&D) of the Department of Social Welfare (DSW). The CDP&D has the following three strategic objectives: • To promote policy development and planning and international liaison • To advocate and strengthen intersectoral collaboration and human resource development • To analyse and interpret population and development interrelationships, monitor national policy implementation, evaluate population strategies and programmes and initiate population research. However, given the crosscutting nature of population development many facets of the population development agenda are also addressed by other government departments, such as health and education.
Chad	Une politique de population promue par l'UNICEF et le PNUD essentiellement a fait l'objet d'une proposition de loi refusée dans un premier par l'Assemblée nationale, car non respectueuse de la sensibilité nationale, vis-à-vis de la contraception, de la liberté de la femme, de la sexualité, etc. Une seconde version a été acceptée. Une division existe au Ministère du Plan (Ordonnateur National) pour suivre cette politique de population.
Thailand	The current national plan of economic and social development (9th 2002-2006) addresses "All Thai citizens, at all ages, will be entitled to enjoy their well being" under the following plans: • Human development and social protection • Rural development and sustainable urbanisation • Management of natural resource and environment • Macro-economic management • International competitiveness • Science and Technology • Development management and good governance. Self-reliance/sufficient economy is emphasized. Thailand has still working in South-South Cooperation of health related areas with neighbouring countries and UN agencies. Regarding bilateral agreement with EC, the Thai/Ministry of Public Health's 30 Baht scheme of universal coverage project is in place as Thais' social safety net under EC finance.
Tunisia	The Government's approach is axed on: • the consolidation of progress made in fecundity management • promotion of Reproductive Health/Family Planning, focusing on determined regions • promotion of Reproductive Health projects targeting young and adolescents Concerning the implementation of the Cairo Action Plan: Tunisia fully adhered to the recommendations of the ICPD, many of which are already a realty (access to health care, maternity and infant death linked to contraception, scholarisation, illiteracy). Despite this progress, some issues still need to be addressed: • Access to Reproductive Health services in the South, Center-West and peri-urban zones is lower than the national average. • Inadequate knowledge of the youth about Reproductive Health • Tunisia is in the last phase of the demographic transition and therefore needs middle and long term planning to address new needs.

What is Government's approach to population and development?*	
Zimbabwe	Government has no clearly defined integrated population and development policy. Policy issues affecting population and development are dealt with on a sectoral basis such as agriculture, mining, industry etc

How much priority does Government give to population and development issues?



General remarks:	
Angola	A Population Studies Unit exists within the Planning Ministry in the Framework of Angolan co-operation with the UNFPA. The National Population Policy draft aims to shift the direction of population growth in order to facilitate the rebuilding of the country and improve standards of living. Specific areas are dealt with in order to achieve this objective, namely sustainable developments, family and demographic transition, health, territorial distribution, education, teenagers, the aged, the handicapped, gender, gathering of statistics and different groups according to ethnicity and language.
Bangladesh	Utilization of public sector health and FP free services is limited (25 to 30%) Immunization and Family Planning have achieved major success other interventions did not reach the result as expected like MMR or IMR socio-economic conditions are also contributing negatively to the overall performance of the health sector NGO sector is also contributing to this sector
Cambodia	Government is taking a sectoral-focused approach and not directly talking about "population and development" as such. • MCH and HIV/AIDS are recognized as top priorities. • In view of the Cambodian population structure (with 60% of the population under the age of 24), the Government is very much aware of the need to address education and employment creation, in particular in rural areas. • Refugees/returnees are not a priority issue anymore.
China	If the question relates to EU only then the replies on committing ,co financing and implementing actions should be rated "low"

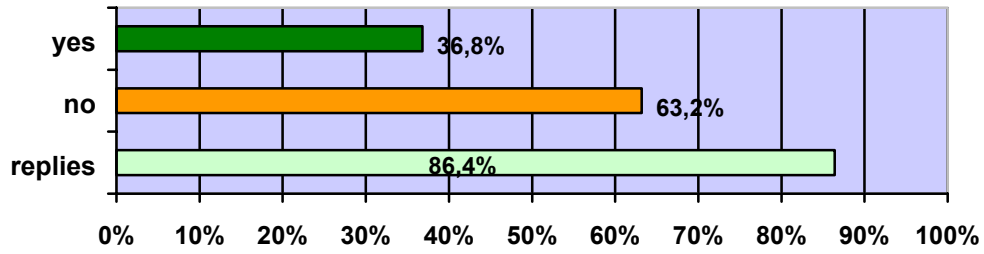
General remarks:	
El Salvador	In January 2003 UNFPA Executive Board approved the V El Salvador Country Programme which includes a subprogramme for P&D. The Ministry of Economics through DIGESTYC is seeking the Parliament approval for the legislation to create the National Institute for Statistics, and at the same time it is advocating to obtain funds to undertake the population census. The last one was in 1992.
FYROM	The Macedonian society has faced tremendous challenges during the last ten years. Its road to the market economy is bumpy with a significant decline of the Gross Domestic Product (GDP) per capita from USD 2,235 in 1990 to USD 1,801 today. Unemployment is at its highest with 371,000 jobless persons according to the State Employment Bureau. Extreme poverty today affects one quarter of the population of the country. At the end of 2000, the average salary is around 10,000 Denars. Welfare benefits amounting from 3,000 to 4,500 Denars are the source of income for 10% of the population i.e. 71,000 households.
Nicaragua	In January 2003 UNFPA Executive Board approved the V El Salvador Country Programme which includes a subprogramme for P&D. The Ministry of Economics through DIGESTYC is seeking the Parliament approval for the legislation to create the National Institute for Statistics, and at the same time is advocating to obtain funds to undertake the population census. The last one was in 1992.
Pakistan	Pakistan's development strategy in the past was growth-oriented, based on the premise that the effects of economic growth filter down to the masses. Therefore, investments in such social sectors that lay the foundations for future growth have remained low and human development has continued to suffer in the process of economic development. Consequently, progress in literacy and education has been much below the desired levels.
Philippines	Population is a sensitive issue in the Philippines attributed to religion (we are predominantly Catholic) and socio-cultural beliefs which has influence the political actions of the Government. As such, Government actions to address the country's increasing population has been very limited. Notwithstanding, it should be recognized that the Government has committed itself to pursue reproductive health and family planning information and services.
South Africa	It is difficult to assess or quantify the levels of priority across the line items owing to the broad development agenda in South Africa.
Zimbabwe	Under the current macroeconomic and political crisis facing Zimbabwe population and development issues are low priority for the government. Government efforts are focused on addressing pressing food and fuel needs of the population

Question 4.

During the drafting of the current Country Strategy Paper:

a) Were assessments of the population and development theme in the country carried out?

yes	BAN	CON	M	PA	PAL	SA	TU					
no	ANG	BRU	KPU	CHN	FY	MAW	NGA	PHI	RWA	TSA	THAI	SIM

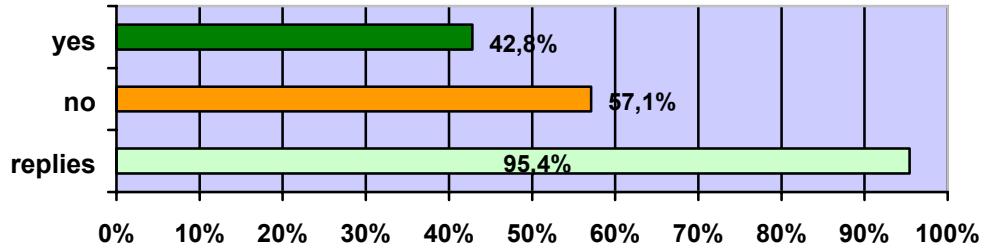


If yes, please describe briefly	
Bangladesh	The Delegation is very much actively involved in this sector and so we are aware of all the research and studies carried out. All relevant documents were consulted for the country strategy paper. Individual discussion with other member state representatives, UN representatives, GoB partners helped to formulate the CSP.
Congo	General evaluation of the situation of refugees and IDPs as well as the problem of HIV/AIDS
Morocco	Le Document de Stratégie aborde les questions clé de population et développement. Il analyse la situation sociale du pays, les objectifs du Gouvernement marocain en ce qui concerne le volet « social et pauvreté », les défis, etc et établi les réponses stratégiques de l'UE, avec ses priorités et les objectifs spécifiques de sa coopération notamment dans le volet social.
Pakistan	The assessment was done during implementation of an EC funded project "Reproductive Health Initiative
Palestine	Assessments carried out by local agencies (the Palestinian Central Bureau for Statistics, the Ministries of Health and Education), the World Bank and some UN agencies such as the UNRWA.
South Africa	The process for the development of the Country Strategy Paper involved bi-lateral negotiations with relevant government departments - including the social cluster (health, education, welfare etc). The product of the bilateral discussions was consolidated into the first draft. Simultaneously a civil society forum was established to input into the various discussions. The draft CSP was then renegotiated with the Civil Society Forum, government departments and EU member states to reach the final product.
Tunisia	The CSP identifies the management of the demographic transition's consequences as one of the main challenges in the medium term for Tunisia. Demographic growth (of 1.3% in the decade 1990-2000) follows a stable trend. Poverty decreased from 40% in 1960 to 7,4 in 1990 (World Bank). Tunisia gives priority to investment in human capital, in particular in health and education. The main challenge in primary education is to increase the completion rate. Tunisia's public health system offers free or highly subsidized health care to 50% of the population, despite only 7,4% lives under the poverty line. However, public care services are inadequately financed, available resources are not used in the most efficient manner and the quality of services does not respond to the population's expectations.
Further comments	
Burundi	Burundi is a country in a post-conflict situation. As a consequence, the staff at the Delegation is very limited and did not have the time to do in-depth assessments or studies for the CSP.
El Salvador/ Nicaragua	The EC should prepare a Country Population Assessment (CPA) in contribution to the government in order to support and strengthen the analysis and the proposed

	outcomes., taking into consideration Poverty Reduction, Maternal Health, women empowerment and gender.
FYROM	In the CARDS CSP 2002-2006 only certain specific issues related to the population and development are covered.
Nigeria	The Appraisal study did not take into account the population and development theme as a whole, anyway some of the principles and the ICPD goals were considered during the analysis of the existing Government/Donors sectoral programmes (health, water, education…).
Rwanda	Not explicitly, but education, health and food security featured.

b) Was there dialogue with Ministries related to the population and development theme?

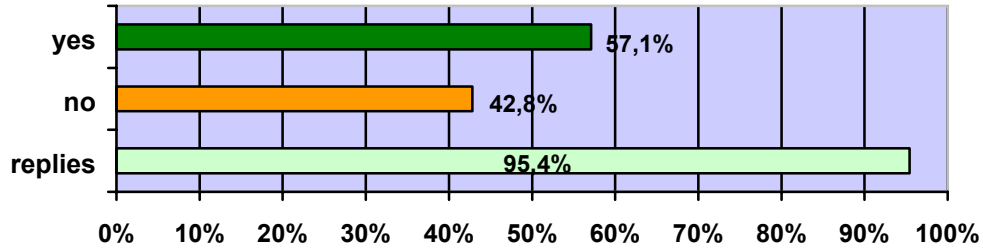
yes	BAN	BRU	CON	SAL	MAW	M	RWA	SA	TU		
no	ANG	KPU	CHN	FY	NIC	NGA	PA	PHI	SOM	TSA	THAI	SIM



If yes, please describe briefly	
Bangladesh	A dialogue was organized by the Economic Resources Division (ERD) of the Finance Ministry with all concerned ministries at our request. The draft CSP was circulated beforehand for their comments. All contributed at that meeting. On the basis of that, the document was finalized.
Burundi	The CSP was entirely drafted and discussed between the Commission, the Delegation, and the NAO.
Congo	With the Ministry of Health regarding HIV/AIDS
El Salvador	In February 2002, the El Salvador Government held a meeting to address the country interest for support on strategic population issues.
Malawi	These consultations took place in the context of the impact of HIV/AIDS on development
Morocco	Ministère de la Santé Publique, Ministère de l'Education Nationale, Ministère du Développement Social.
Rwanda	Ministries of Health and Education were consulted
South Africa	There was full consultation with all government ministries/departments and with Civil Society representatives throughout the CSP Process - see above.
Tunisia	The document was prepared following a process that included a discussion with the government on its development strategy.

c) Was there consultation with other actors working in the population and development area (multilateral and bilateral agencies, NGOs, academic institutions etc.)?

yes	BAN	BRU	CHN	CON	SAL	MAW	M	NIC	SOM	SA	TSA	TU
no	ANG	KPU	FY	NGA	PA	PHI	RWA	THAI	SIM			



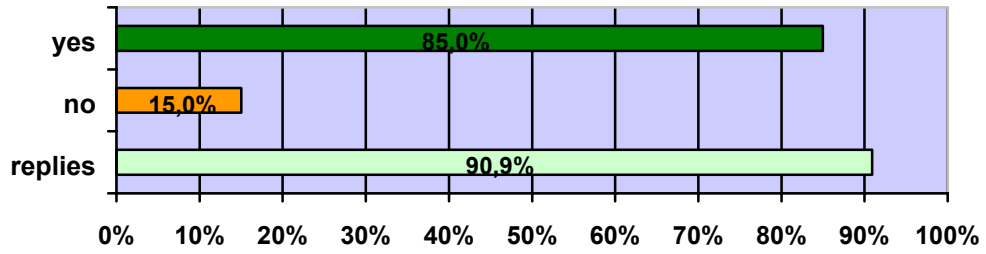
If yes, please describe briefly	
Bangladesh	Yes, another meeting was arranged with member states, Development Partners, NGOs to have their views through dialogue and written comments.
Burundi	The main donor agencies and NGOs active in Burundi were consulted on the main topics considered in the CSP.
Cambodia	Not specifically on population and development issues, but there were of course consultations on the various sectors of priority for the CSP
China	Consultations with MS and other important donors in China including Japan, Canada, Australia and Ford Foundation
Congo	Consultation with UN agencies, Member States and other bilateral donors regarding their assistance to refugees and IDPs and their intervention in the field of HIV/AIDS
El Salvador/ Nicaragua	UNFPA at field level held consultations with other government institutions at sectoral level, national NGOs, other donors such as USAID, CIDA, IDB, and other UN agencies. At headquarters level consultation were held with donors.
Malawi	Consultations took place with other donors and some NGOs. However, as indicated above, these consultations were limited to the context of the impact of HIV/AIDS on development.
Morocco	FNUAP, associations féminines
Somalia	In the absence of a recognized government in Somalia, the Somalia Aid Coordination Body (SACB) was established in 1993, as a coordination mechanism for Donors, UN Agencies, NGOs and Somali representatives to respond to humanitarian and development needs in Somalia. Key members of the current Somali administrations participate intermittently in meetings of the SACB in Nairobi and sectoral coordination meetings in Somalia. WHO Somalia, UNFPA and UNICEF are part of this coordination body.
South Africa	See above plus also especially EU Member states and, where appropriate, multilateral and other agencies e.g. UN + USAID
Chad	La préparation de la Stratégie Nationale de Coopération et du PIN 9e FED a été axée sur la concentration dans deux secteurs : routes et hydraulique, les secteurs hors-concentration se sont limité à la poursuite de certaines actions antérieures

If yes, please describe briefly	
	(PMR, appui ON, etc.) et d'introduire de nouvelles actions en matière d'appui aux Acteurs Non Etatiques, et d'appui à la Bonne Gouvernance. Les institutions telles le PNUD, l'UNICEF, les ONGs ont été associées et informées de l'évolution de la préparation de la S.C.N.
Tunisia	The document was prepared following a process that included a dialogue with the representations of the EU Member States and a co-ordination with the main multilateral donors (IEB, World Bank, IMF, ADB).

Question 5.

Is the Delegation involved in any co-ordination fora (committees, working groups, etc.) regarding population and development with other actors active in this field (Government ministries, World Bank, UNFPA, UNAIDS, bilateral donors like DFID, USAID, etc,)?

yes	ANG	BAN	BRU	KPU	CHN	CON	FY	MAW	M	PA	PHI	RWA	SOM	SA	TSA	THAI	SIM
no	NIC	NGA	TU														



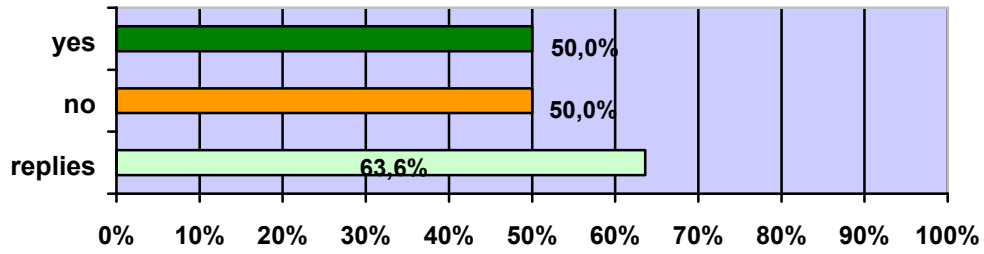
If yes, please describe briefly	
Angola	• participation in the humanitarian coordination group and in a working party • participation in the UN AIDS Groups both at political and technical levels
Bangladesh	• Very much involved both at the Donors' level as well as GoB level. EC Representative was the chair of the Steering Committee (SC) of pool funders for Health and Population Support Office (HPSO) twice. Also active member of the Donor Consortium (DC). Other partners like WB, UNFPA, UNAIDS, DFID, USAID – all are also either member of the SC or DC. • Like other donors, EC also gets involved in different working groups, committees of the GOB specially during Annual Programme Review (APR) which takes place twice a year. • Recently established GOB-donor Coordination Committee members will meet bi-monthly to monitor the progress of the action plan submitted and committed to by the GOB for the extended time up to December 2003. All donors involved in the sector including EC will be members of this committee.
Burundi	Although the Delegation's presence cannot be assured at each coordination meeting, due to a lack of human resources, the Delegation participates to all main meetings and fora. These are related to health, economy, trade, agriculture, rural development, food security, and many topics related to population and development.
Cambodia	• The Delegation is member of the Advisory Board of the EU-UNFPA Reproductive Health for Youth in Asia (RHIYA – second phase). • The Delegation is involved in sectoral donor working groups (e.g. education,

If yes, please describe briefly	
	health, social development) and related sectoral groups Governement/Donor/NGOs.
China	• Informal donors group with all major donors and some MS representatives • Member of the GFATM committee.
Congo	• Thematic group "Health" under the aegis of Germany • Country Coordination Mechanism for the Global Fund TB, AIDS, Malaria • World Bank: consultation on programming for MAP
FYROM	Through exchange of information and participation on the donors coordination meetings. The WB , USAID , WHO and UNDP are the only international organisations involved in this field
Malawi	Coordination takes place in the context of the *Health and Population Subgroup*, and not in a specific forum on population and development. The Delegation plays – compared to its human resources – a relatively active role, providing input in close consultation with Headquarters.
Morocco	Participation aux : • réunions du Groupe Thématique ONUSIDA/Maroc ainsi qu'aux réunions du Comité de Coordination du Maroc du Fonds Mondial de Lutte contre le Sida, la Turberculose et le Paludisme. • réunions du Groupe Thématique Genre organisées par l'UNIFEM.
Pakistan	The Delegation is a part of all donor coordination fora on population issues available in the country
Philippines	The Delegation is an active member of the donors coordination group on Population, Health and Nutrition (PHN) which meets on a monthly basis. The donors group is composed of the World Bank, ADB, USAID, UNFPA, UNAIDS, WHO, Japan Embassy and its international cooperation agency, EC Delegation, Australia, Canada, GTZ, Spanish Technical Cooperation Agency, Packard Bell and Ford Foundation. The coordination group discusses various issues, among others, related to reproductive health, HIV/AIDS, family planning and use of contraceptives, women's health, and the Government's Health Sector Reform Agenda. This is also serves as a venue to discuss future cooperation with the Government of the Philippines in relation to health, population and development under the policy of complementarity of actions among donors.
Rwanda	Not explicitly population and development, but involvement in education, health and agriculture/ rural development sector planning processes.
Somalia	The World Bank, UNFPA and USAID are members of the SACB Health Sector Committee (HSC) of which the EC has held the chairmanship since mid 2001. USAID has however substantially decreased its participation during the past one and half year. The World Bank presented the LICUS project (Low Income Countries Under Stress) to the SACB in 2002. This project is to be implemented in partnership with UNDP Somalia.
South Africa	There are donor coordination fora across a range of priority development areas. The "population" component tends to fall within the context of "health" which has semi-annual "general" donor co-ordination meetings (although not very effective) and bi-monthly HIV/AIDS donor co-ordination. There is a full range of participating partners - although UNFPA is not normally represented nor the World Bank (which is not highly active in this field in South Africa). Currently UNFPA in South Africa is in a state of transition following the departure of many staff and the re-recruitment process underway. For the last three-four years it has not been a significant player in the SA donor community.

If yes, please describe briefly	
Chad	• Comité interagence ONUSIDA • Comité coordination inter-agence PEV (EPI) • Toutes agences NU + bailleurs autres BM, FMI, France, … • Delegation initiated in 2001 an informal forum of Health donors : monthly meetings are organized with nearly all Health donors, including the main national private organizations. The objectives of the group are four: strengthen the coordination by Ministry of Health, improve coordination on capacity building, help the Ministry of Health to produce national detailed Health programme, and improve reactivity of Ministry against outbreaks. • Comité de pilotage/suivi du projet Santé 8e FED • Ministère de la Santé, Plan, Délégation CE, bailleurs de la Santé
Thailand	The Delegation participates: • As member of the Advisory Board of the EU-UNFPA Reproductive Health Initiative in Asia (RHIA-until December 2002) • In meetings with UNFPA in Laos, mainly related to the elaboration of the Reproductive Health Initiative for Youth in Asia • Regional Donor Information Meetings with UNAIDS SEAPICT in Bangkok. The meeting provides an informal forum for the bilateral community supporting HIV/AIDS programs in the sub-region to meet on a quarterly basis. The meetings give opportunities to for all stakeholders to share their programme experience, progress and future directions and key priorities concerning HIV/AIDS work in the sub-region • Member of the UN Task Force on DRUGS convened by UNODC participants members are government ministries (M of Interior and MOPH), International NGOs and UN agencies • Member of UN Task Force for Youth until 2002. • The fifth Asian and Pacific Population Conference organized by ESCAP in Bangkok from 11-17 December 2002.
Zimbabwe	The delegation participates in UN agency led donor coordination committees on health, HIV/AID and humanitarian assistance
Further comments	
Palestine	The Delegation is involved in the Reproductive Health thematic group, chaired by the MOH and with the involvement of the main stakeholders in this area. The Delegation is also involved in the coordination of the Health Sector review, together with the MOH, the major donors and major stakeholders of the health sector. The review represents a process that will lead to mid term strategic planning for the health sector.
Nicaragua	Throughout the Project of Strengthening of the Health System in Nicaragua, we are participating in the incipient project of Sector Support from MINSA, and some other participants of this project are: EEMM (DFID, Netherlands…), WHO/PAHO, BID, World Bank, UNFPA, USAID

Does this include health sector dialogue in the context of SWAp?

yes	BAN	KPU	MAW	PHI	RWA	SOM	SIM
no	ANG	BRU	CHN	FY	M	NIC	PA



If yes, please describe briefly	
Bangladesh	Policy Dialogue is a major component of the Annual Programme Review (APR) under the SWAP mechanism (the Health & Population sector programme). Every year APR and Policy Dialogues are usually followed by a joint field visit by GOB and DP. This dialogue includes all kinds of stakeholders involved in this sector. Other than the GOB organized Policy Dialogue, other organizations like Center for Policy Dialogue, donors also organize Policy Dialogue. EC representatives usually take part. Different partners also share their SWAP experience in other countries through presentation followed by discussion. Documents are also shared by all.
Cambodia	The Cambodian Ministry of Health and the donor community decided that is still too early to apply SWAp in Cambodia because national managerial capacity and financial administrative systems in the health sector need to be developed further. Instead, Cambodia has opted for a precursor to SWAp called Sector-Wide Management (SWiM) which means co-ordination of programme and project funding by the government and the donor community on the basis of the mutually agreed Health Sector Strategic Plan and mutually agreed management arrangements. SWAp will be retained as an objective for the medium-term future.
Philippines	Discussion under the PHN donor coordination group is mostly concerning the Philippine health sector, particularly, the priority programmes of the Department of Health in the areas of Health Sector Reform Agenda, reproductive health and women's health programmes, HIV/AIDS, and family planning. This fora is dealing with the SWAp approach at a minimal level in terms of putting Government up front to promote ownership of actions/programmes/projects and in strengthening donor coordination mechanism.
Rwanda	Rwanda at early stages of developing a health SWAP. EC support through budgetary support d 8th EDF health project focused on planning and institutional development
Zimbabwe	Information sharing in relevant sectors
Further comments	
Nicaragua	The project Strengthening of the Health System in Nicaragua is cooperating with the Health Ministry –MINSA- in the sector support, they participate in the sector table and they have implemented some actions supporting the work of the SILAIS.
Palestine	Since from the beginning, the EC has coordinated the Health Sector review jointly with the MOH and other major donors. The outcome of the health sector review will be the identification of the future strategies for the health sector. Continuing the positive experience started with this process, the EC will coordinate the donor's future support to the health sector, which will eventually lead to the sector wide approach.
South Africa	Not currently, but may be introduced on to the agenda. It should however be retained that a basic principle of SWAp is that the agenda is beneficiary led, and should involve all donors; at the present time the South African

	Government does not lead a full donor coordination or dialogue.
Chad	Il n'y a pas d'approche sectorielle au sens strict : Politique et Plan d'action/CDMT/coordination pilotée par le Gouvernement, mais une situation où les bailleurs du secteur se concertent et en informent le gouvernement, mais chacun restant dans une logique « projet »

Question 6.

Reproductive Rights and Reproductive Health (apart from sexually transmitted infections and HIV/AIDS):

(iii) To what extent have EC-supported actions in this field addressed specific objectives related to Reproductive Rights and Reproductive Health (apart from sexually transmitted infections and HIV/AIDS)?

(iv) For each activity, please rate whether the results and impacts that have occurred were satisfactory on a scale of –3 (highly negative impact) to +3 (highly positive impact). Where possible, also please give key figures / indicators with respect to results and impacts.

Country	Activity	Comments
Bangladesh	**Asia Initiative for Reproductive Health (AIRH)** a regional project. It has addressed both Reproductive Health (RH) and Reproductive Rights (RR). Interventions were aimed to improve quality of reproductive health care for man and women with special focus to adolescents. RR was part of the Gender training as well as integrated in different steps of services like during counselling session. Second phase of this project will focus on adolescent RH and RR. Hopefully second phase will achieve more on the basis of lessons learned during the first phase.	**+ 3** • very successful project, implemented by 4 local NGOs Lessons learned from this project encouraged the GOB to take special programme for adolescents for the next health programme. Gender was another major component of this project. Second phase of this programme has been approved and will start implementing this year within a short time because of its success. RR was a cross cutting issue of this project.
Burundi	none	Considering that this topic was a priority for other donor organisations, the EU decided to concentrate on other topics which were left aside by these donors. However, some actions related to this topic are undertaken within the framework of a health rehabilitation project.
Cambodia	**EC/UNFPA Asia Initiative for Reproductive Health** – ALA/96/07 – 1998-2002 was the response of the EC to the ICPD plan of action. Will be followed by the **EU/UNFPA Reproductive Health Initiative for Youth** in Asia – mid-2003 to end 2005.	**+ 2** • Establishment of youth-friendly SRH services. • Establishment of a network of peer educators. • Three annual youth camps were organized. • Advocacy activities increased support for youth SRH interventions at community and policy level.

Country	Activity	Comments
Congo	**Reproductive health** : prenatal and postnatal care	**+ 2** Activities with the aim of improving the health of mother and child carried out in the strategic framework of the ongoing health care programme
	Sexuality and gender relations	**+ 1** Activities with the aim of sexual education and raising the youth's awareness as to related health risks carried out in the strategic framework of the ongoing health care programme
FYROM	**Project: "The use of the modern contraceptive means, perquisite for prevention of unwilling pregnancy and diseases at Roma population"** Health education for Roma women and men on family planning and contraception. Three seminars in different cities were held and minimum of 50 young Roma trained and educated to extend their knowledge to others in order to prevent the early family forming and early sexual activities. Budget € 7,800	No analysis of the positive and negative affect was carried out.
	Women's health and Social Rights Education in the marginal Regions. Opening a Woman's Health and Right Centre for productive Health education of the ethnic minorities in different municipalities in the country. The project meets the priority needs of the Roma, Macedonian–Muslim and Macedonian Women from the marginalised rural regions. Budget (€ 8.000)	No analysis of the positive and negative affect was carried out.
Malawi	While some EC projects in Malawi (e.g. construction of two district hospitals and the Health Sector Reform and Decentralization Project) have indirectly had linkages to Reproductive Health, there have been no projects specifically dedicated to Reproductive Health in the previous CSP.	
Morocco	**Projet d'appui à la santé maternelle et néonatale**. Financement communautaire : € 9 000 000. Projet clôturé.	Le Projet a pu contribuer à une amélioration de la situation du volet « Maternité sans risque » du programme de la santé de reproduction du Ministère de la Santé par le renforcement du niveau de référence des Soins d'Obstétrique et Néonatalogie d'Urgence (SONU) du secteur public. En outre, on y trouve une augmentation de l'accès des SONU de qualité pour les femmes, aussi pour les femmes moins aisées. De plus, l'accessibilité géographique de ces services a augmenté comme le résultat de l'acquisition des ambulances. Les activités se sont centrées sur : • Des réalisations physiques : mise à niveau des maternités hospitalières (rénovation et

Country	Activity	Comments
		équipements) ; véhicules d'évacuation. • Des actions d'appui concernant : une assistance technique ; la formation continue ; la réorganisation des activités des maternités ; la mise en œuvre de programmes d'IEC en matière de maternité sans risque et PF ; études et recherches opérationnelles.
Nigeria	N.A.	Reproductive health and reproductive rights represent neither a focal sector nor a non-focal sector in the EC development cooperation strategy in Nigeria. Therefore no activities are being supported in these two fields. There is one Budget-line project titled Participatory based approach to reproductive health. The case of Delta State. However budget lines are still managed directly from Brussels.
Pakistan	**Asia Initiative for Reproductive Health** The project was supposed to : • Develop local capacities for the delivery of quality RH services ; • Strengthen community participation ; • Promote gender equity and equality ; • Target the most vulnerable groups.	**+ 2** Implementation was done through partnerships between European private organisations as Executive Agencies (EAs) and local private organisations as Implementing Agencies (IA), under overall leadership of UNFPA at the central and national levels The gender component was not that successful
	Reproductive Health Initiative for Youth in Asia (RHYIA) The overall objective of the RHIYA is to improve the sexual and reproductive health of young people (10-24 years of age) with emphasis on gender equity.	Assessment is not possible as the project has just taken a start The overall purpose is to ensure availability and appropriate use of S7RH services by young people through : Ensuring that young people are factually informed on S&RH issues and lead them to adopt responsible attitude and behaviors ; Increasing access to and utilization of quality RH services, including S&RH information and counseling, that meet the needs of young people ; Building capacity and creating an enabling environment to allow Governments, local NGOs and other community based organizations to design S&RH policies and services.

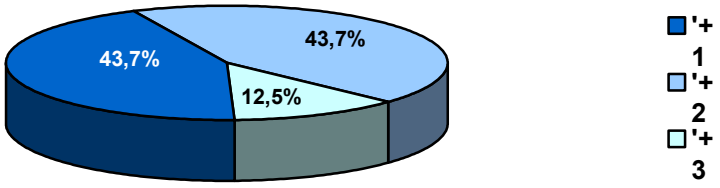
Country	Activity	Comments
	Improving the Reproductive Health and Rights in Extreme Need : Kohat - Pakistan The objective is significant impact upon the reproductive health and rights of the vulnerable and impoverished, underserved and refugee affected District of Kohat.	Assessment is not possible as implementation has not yet started properly
Palestine	The Delegation has supported the **National Programme for Women's Health and Family planning**, including organization of health services, education and promotion in the area of reproductive health and family planning. Main components of the programme were : • Organization of reproductive services and their integration at the Primary health care level clinics: • Family planning, pre and postnatal care, screening for breast and cervical cancer, screening of high-risk pregnancies, organization of the referral services to secondary care clinics.	**+ 1** The activities carried out were in general satisfactory. However, the Intifada has affected greatly the last period of the implementation of the programme. Difficulties in access have affected professionals and patients movement, with great impact on services delivery and training activities. The programme still needs improvement, especially in the area of quality of the services and capacity building in management and financing.
	Education of health professionals: • -Training of health professional in RH/FP • -Specific trainings: PAP smear, STI diagnosis and treatment.	The same as above
	Health promotion: **Awareness activities**: • Women's; Youths; Men.	The same as above
Philippines	**Women's Health and Safe Motherhood Project – Partnerships Component** (Bilateral Programme) The project is implemented in selected poor and remote villages of 5 regions in the Philippines. The following are the major project results/activities : • highly recognized result is the empowerment of the women beneficiaries, who are now organized and are considered active members of the communities (from the traditional role of full-time housewives). These women are now engaged in small livelihood projects, which help augment the family incomes. They became strong advocates for the promotion of good health in their communities and is now able to demand for better health care services from the local leaders. There is now a heightened awareness on reproductive health issues and concerns among the women.	**+ 3** • another successful intervention is the child to child approach, which seeks to engage children's participation and develop their life skills in terms of knowledge, attitudes and capacity to take action for health so that they can lead a healthy and productive life. The children beneficiaries have been equipped with this knowledge and are able to articulate their health needs and rights to their parents and also to the local leaders. • improvement in the delivery of primary health care services through the rehabilitation of village (barangay) clinics, providing basic equipment and medicines, and training of family health workers that could provide assistance to the rural and

Country	Activity	Comments
		barangay health workers. • implementation of health savings scheme that could be used for health emergency needs.
Somalia	The EC in Somalia does not specifically fund programmes related to Reproductive Rights and Reproductive Health. However the EC Somalia Unit (ECSU) supports several PHC components in each of the ECSU funded projects. Antenatal and Post-natal health care, breast-feeding as a best way to strengthen the infants immune system and child-spacing, safe pregnancy and safe deliveries represent some of the activities supported by the EC in the MCHs in Somalia. The SACB/HSC is at the moment looking for validating a statement on ERADICATION of Female Genital Mutilation (FGM) which should be endorsed by all partners soon. FGM practices represent one of the most important causes for premature-death of pregnant women in Somalia as amongst the highest in the world.	ECHO is also funding several projects in more insecure areas where the EC is not yet funding rehabilitation/development projects (i.e. Mogadishu). These projects focus particularly on mother and child health care (MCHs and Maternal/Pediatric hospital). However counseling on human sexuality, responsible parenthood, sharing of responsibilities of men in the actual practice of family planning, sharing male responsibility for their own sexual health and fertility, healthy sexual behaviour, including voluntary abstinence, are activities not specifically funded by the EC in Somalia. It is expected that UNFPA will boost its funding presence in Somalia. However there are significant challenges in a society in which any topic related to sex is extremely sensitive in a Muslin, male dominated society and where, women themselves, including midwives, rarely utilize family planning methods.
South Africa	**Improved access to health services especially by women**	**+ 2** In the context of South Africa it is impossible to disaggregate these issues from HIV/AIDS & Health Service Development interventions
	Improved management of health services	**+ 2** The improved management of health services is a holistic approach which, by its very nature, includes reproductive health.
	Through budget line support (HIV/AIDS and NGOs) - **support to the Reproductive Health Research Unit at Baragwanath Hospital** looking at hostel based (male) peer educators to improve male and female reproductive health.	**+ 1**
Chad	Reproductive rights: nothing is done Reproductive Health: it's a part of objectives of improving quality of care in Health Districts: there is a project 8 ACP CD 014 National Health Policy Support.	
	Appui aux services de santé du premier échelon et aux hôpitaux de référence des districts sanitaires, permettant la tenue des	**+ 1**

Country	Activity	Comments
	consultations prénatales, la prise en charge des accouchements normaux et compliqués, la consultation des nourrissons et une petite activité de planning familial	
	Appui au programme élargi de vaccination au niveau national permet d'assurer les équipements et l'organisation de l'approvisionnement en vaccins pour les VAT des femmes enceintes et les vaccinations du PEV de routine	**+ 1**
	Appui pour une gestion rationnelle de l'approvisionnement en médicaments essentiels et génériques	**+ 1**
Thailand	**RHIA Reproductive Health Initiative in Asia** (Laos & Cambodia components) EC-UNFPA The AIRH programme was the response of the EC to the Plan of Action adopted at the ICPD (Cairo in September 1994) and would: i) develop local capacities for the delivery of quality RH services; ii) strengthen community participation; iii) promote gender equity and equality; iiii) target the most vulnerable groups. The countries selected for participation were: Bangladesh, Cambodia, Lao PDR, Nepal, Pakistan, Sri Lanka and Vietnam.	**+ 1** The Final Evaluation concluded that the project has been highly relevant to each of the countries. In Laos, the relatively broad scale and sufficient depth of impact on target groups are important outputs, like the establishment of the Vientiane Youth Centre, design, production, distribution and use of IEC materials, the training of peer educators in one of the provinces as well as two feasibility studies covering adolescent sexual behaviour and media interventions. No indicators of impact are available because the instruments for baseline surveys and end of project survey were developed by London School of Tropical Medicine and Hygiene too late for their use.
	RHIYA Reproductive Health Initiative for Youth in Asia (RHIYA) (Laos & Cambodia components) EC-UNFPA The overall objective of the RHIYA is to improve the Sexual and Reproductive Health (S&RH) of young people (10 to 24 years of age) in Bangladesh, Cambodia, Lao PDR, Nepal, Pakistan, Sri Lanka and Vietnam, with emphasis on gender equity.	The overall purpose is to ensure availability and appropriate use of S&RH services by young people through: i) ensuring that young people are factually informed on S&RH issues and lead them to adopt responsible attitude and behaviours; ii) increasing access to and utilisation of quality RH services, including S&RH information and counselling, that meet the needs of young people; iii) building capacity and creating an enabling environment to allow Governments, local NGOs and other community based organisations to design S&RH policies and services. RHIYA Strategies. Programme strategies would be in accordance with each country situation and priorities – but defined within the standard range of strategies in the programme, as follows: i) Raising awareness, improving knowledge

Country	Activity	Comments
		and behaviour; ii) Improving access to and utilisation of Adolescent S&RH services; iii) Capacity building and creating an enabling environment
	To address the **Unmet Needs for Reproductive Health** (Burma/ Myanmar) PVD/2001/509	**+ 2** Until 2001 the Delegation had regular contacts with project staff and made two field visits. The project was very successful providing quality and relatively affordable reproductive health services (STD, FP). Since then the project has been followed by the HQ
Tunisia	Under budget line B7-6312, the EC funded 676,672 Euros for project « **Promotion de la Santé Reproductive et du Planning Familial auprès des hommes par l'intermédiaire des instituteurs** », implemented by Office National de la Famille et de la Population. The project ended in April 2003	**+ 2** The project aimed at promoting Reproductive Health by raising awareness among Tunisian men living in remote areas through the use of school teachers. A total of 18 632 men participated to the workshops and seminars organised within the project.
Zimbabwe	**Reproductive Health**	Not directly supporting reproductive health
	Family Planning	Not directly supporting family planning activities
	Human sexuality and gender	Not directly involved

Rating of impact **on a scale of –3 (highly negative impact) to +3 (highly positive impact)**



In question 6: 16 rankings (between + 1 and +3) were identified to relevant projects.

Question 7.

Health (including primary health care and health-care sector), morbidity, and mortality (apart from sexually transmitted infections and HIV/AIDS):

(iii) To what extent have EC-supported actions addressed specific objectives related to Health, Morbidity, and Mortality (apart from sexually transmitted infections and HIV/AIDS)?

(iv) For each activity, please rate whether the results and impacts that have occurred were satisfactory on a scale of –3 (highly negative impact) to +3 (highly positive impact). Where possible, also please give key figures / indicators with respect to results and impacts.

Country	Activity	Comments
Angola	support to primary health care and the health care sector including child and women's health • Institutional support • Training • Support to middle level health services • Support to the physically handicapped:	 **+ 1** **+ 2** **+ 2** **+ 2**
Bangladesh	**Health and Population Sector Programme (HPSP)** This programme has extended up to December 2003 following SWAP. EC is the major bi-lateral donor with other pooled funders. HPSP aimed to provide quality of health services for the poor specially for women and children. This programme addressed to reduce mortality and morbidity specially for mother (by increasing safe motherhood initiative) and children (immunization). Because SWAP was introduced first time in Bangladesh, it created lots of confusion and was not accepted to all concerned in the central and field level.	**+ 2** In spite of all confusion, argument and difficult dialogues with the GOB, the performance of the health sector did not go down but steadily as a plateau. EC also took strong part to negotiate with the GOB along with other Donors to encourage the GOB to keep following SWAP. Because EC is a member of the pool, it is difficult to identify specifically the impact of EC funding.
	Bangladesh Health Action Research Programme (BHARP) : Through this EC supported three studies, implemented by an international centre called ICDDR,B Contraceptive Use Dynamics 2.Male Involvement in Reproductive Health and 3.Essential Obstetric Care.	**+ 1** Study findings indirectly helped to take actions on Family Planning method use specially how to increase the involvement of Man to share responsibility and reduce female focused family planning practice. Also how to reduce mortality and morbidity by utilizing Emergency Obstetric Care (EOC). This project was not as successful as anticipated
	Cox's Bazar Primary Health Care Project, Phase 3 :This project is a very innovative one, community based health care services are being provided. This project has been serving one area in the hill districts where malaria is the major problem. As a consequence of malaria other health problems also prevailing.	**+ 3** This project is helping people of that area with special need and also taking care of other PHC problems.
Burundi	**Rehabilitation of hospitals and health centres**.	**+ 3** This project allowed the rehabilitation of health infrastructures so the population had

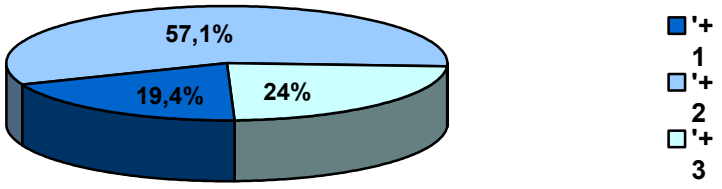
Country	Activity	Comments
		places to go to for medical attention.
	Health rehabilitation	**+ 3** The health project financed by the Commission in Burundi focuses on 5 provinces (out of 16) in which it rehabilitates the health infrastructures and the structures.
Cambodia	The **Malaria Control Project** was part of a regional programme in Cambodia, Laos and Vietnam – ALA/CAM/95/13 – 1997-2002	**+ 2** Overall objectives: • to support the National Malaria Control Programme (NMCP) in decreasing malaria incidence, morbidity and mortality; and, • to reinforce the capability of the health services to implement the NMCP.
	The EC has also funded a number of NGOs to support the development of primary health care services, including child survival and health, women's health and safe motherhood.	
Congo	**Women's health and Safe Motherhood**	**+ 2** Activities carried out in the strategic framework of the ongoing health care programme as well as part of food security programmes (nutritional aspects)
	Child survival and health	**+ 2** Activities carried out in the strategic framework of the ongoing health care programme as well as part of food security programmes (nutritional aspects)
El Salvador	we started some **health projects with NGOs into the PRRAC program** but we don´t know their impact yet	
Malawi	**Safe Motherhood and Child Welfare Initiative** (finalised)	**+ 3** The objective of this project was to contribute to the reduction of the morbidity and mortality levels of women and children in the respective catchment's areas of the hospitals concerned. By improving the facilities for health care provision, the risks of death through infection, overcrowding and malnutrition were to be reduced significantly.
Morocco	Projet MEDA **« Appui à la gestion du secteur de la santé (PAGSS) »** Contribution communautaire : € 20 M (dont environ € 2.1 MAT ; € 8 M équipements ; € 9 M travaux) Programme en cours.	Le projet marque le passage à un type d'intervention plus institutionnelle, venant en appui de la reforme du secteur de la santé en cours au Maroc notamment les aspects suivants : • la décentralisation de la gestion des services publics de santé et la rationalisation de l'offre de soins ; • l'amélioration des procédures d'allocation des ressources budgétaires et le renforcement de la gestion financière du secteur hospitalier ; • le rééquilibrage de l'offre de soins entre réseau primaire et réseau hospitalier intra-régional.

Country	Activity	Comments
		L'objectif spécifique est d'améliorer la performance du système de santé régional, dans l'objectif global d'améliorer l'état sanitaire de la population.
	Programme MEDA **« Appui à la réforme de la Couverture Médicale ».** Contribution communautaire : € 50 M sous forme d'un appui budgétaire. Programme en cours.	L'objectif global est l'amélioration de l'état de santé de la population ; l'objectif spécifique est la généralisation progressive de la couverture universelle du risque maladie qui garantit un accès égal à un panier de soins de base. Le programme porte sur l'appui à l'élaboration et l'application du cadre légal et réglementaire de la réforme du financement du secteur de la santé, ainsi que les mesures permettant l'efficience du système de production de soins.
Nigeria	In the framework of child survival and health activities, the EC-funded **PRIME programme** can be ascribed. PRIME (Partnership to reinforce immunization efficiency) supports the: 1) 2001 Polio National Immunization Days 2) Routine immunization in six selected States	 1) An additional funding has been agreed by the Commission for the 2003 NIDs 2) Regarding Routine Immunization, the programme has just started. The service contract for technical assistance has been signed in March 2003 for a period of 5 years.
Pakistan	**Safe Motherhood Applied Research and Training** The goal of the project is to develop, implement, and evaluate community based intervention strategies to help increase the utilization of existing reproductive health services, with the intent of reducing maternal mortality and morbidity in the project sites	The project is just started
Rwanda	**Health infrastructure** (health centers, hospitals etc.) under 2 Rehabilitation Programmes.	**+ 2** rebuilding infrastructure destroyed in 1994
	Support to health districts (infrastructure, equipment, drugs and medical supplies) under 2nd Rehabilitation Programme.	**+ 2**
	Institutional support to **MINISANTE** (health care department)	**+ 1**

Country	Activity	Comments
Somalia	The EC-SU (Rehabilitation/Development operations) funds a network of 20MCHs/OPDs all over Somalia. Other 10MCHs are funded by the EC - ECHO – together with several SFCs (Supplementary Feeding Centres and TFCs (Therapeutic Feeding Centres. All over the country 150 MCHs are operational and the majority of them are supported by UNICEF and Local authorities. These health facilities focus their activities on the prevention and treatment of health problems affecting women in child bearing age, mothers, infants, and under 5 children.	The services provided in these health facilities are free of charge, being women in child bearing age, mothers and < 5 children, among the most vulnerable groups in Somalia. Therefore all services such as antenatal care, nutrition surveillance, post-natal care, vaccinations, curative health care to mothers and children, deliveries are not charged. To get precise countrywide data on the impact of Morbidity, Mortality of main diseases affecting women in childbearing age and < children a countrywide survey should be conducted by one of the UN agencies having a country mandate such as UNICEF.
South Africa	Since 1994 there have been a number of initiatives targeting this area using a variety of different structures (government + NGOs) and EC modalities (country programme plus special programmes [1994])	**+ 2** Current health programmes total in excess of ε110 million. Between 1994 and 1999 there were approximately ε40 million of health programmes
	The most relevant ICPD intervention is in the area of Primary Health Care and the health care sector	**+ 2**
Thailand	The **Malaria Control Project** was part of a regional programme in Cambodia, Laos and Vietnam – ALA/95/13 – 1997-2002	**+ 3** Overall objectives are: i) to support the National Malaria Control Programme (NMCP) in decreasing malaria incidence, morbidity and mortality; and, ii) to reinforce the capability of the health services to implement the NMCP. In Laos, the project, using a combination of vector control (Impregnated bed nets) and early diagnosis and treatment of suspected cases (EDAT), started in 13 districts in 1999 and expanded district by district each year until 2002, 39 districts with a total population of 824,186 in 2,244 villages were covered by 235,781 insecticide treated nets giving an average of 3.5 persons per net, much excess of the 80% target. The impact has been very positive with reduction by more than 90% of the malaria mortality and morbidity reported in hospitals and outpatients departments.
	HEALTH CARE REFORM Project in Thailand (I) The project aimed to develop a range of approaches to health reform and achieve more equal access to health services, improve the quality of all health services (preventive, curative, palliative and rehabilitative), and improve efficient use of scarce resources in health care delivery, public and private, in four provinces over a period of three years. To achieve the above-mentioned objectives, a	**+ 2** The expected output was a package of policies and plans to guarantee improvements in key aspects of the health care system. Ten strategies were tried and tested in the field, and have been further developed. Implementation models have been developed, especially primary care models, emphasizing Family Practice. The project has provided extensive support to the MOPH reform process with inputs for strategic development; systematic review and research; policy mobilisation; civil society mobilisation;

Country	Activity	Comments
	number of activities started in 1996, including policy research, field model development, training, and the provision of institutional linkages needed for the improvement of equity and social accountability of the health care system.	exposure, education and training of a range of health personnel; field model development; and alliance building.
	HEALTH CARE REFORM Project (II) The overall objective of the Health Care Reform (HCR) is to increase the equity, efficiency, quality and social accountability of health care delivery in Thailand. The purpose is to improve institutional capacities to effectively implement key aspects of the reform policy, especially the policy on universal coverage of health care.	The activities proposed in this project are aimed at supporting the development and implementation of four key areas of health care provision through the improvement and expansion of family medicine, financing, management and advocacy on health care reform. The Financing Agreement has been recently signed and currently the Delegation is in the process of launching tender for technical assistance.
	Attapeu Primary Health Project, Laos. ONG/PVD/1999/146/UK, Health Unlimited.	**+ 1** Developing a Community participation in Health sector in rural areas.
	'Thai Village Health Project Mae Sariang' in implementation by Malteser (The EC is also funding a number of projects implemented by NGOs in Laos, Burma/Myanmar and Thailand to support the development of primary health care services, including child survival and health, women's health and safe motherhood)	The follow up has been so far centralised in Brussels, therefore the Delegation does not have the relevant information to provide an overview regarding its results and impacts.
Zimbabwe	**Primary health care and the health care sector**	the programme supports people's increased access to affordable quality health services through mainly provision of essential drugs and supplies.
	Child survival and health	supports indirectly
	Women's health and safe motherhood	supports indirectly

Rating of impact **on a scale of –3 (highly negative impact) to +3 (highly positive impact)**



In question 7: 16 rankings (between + 1 and +3) were identified to relevant projects.

Question 8.

Sexually transmitted infections (STIs) and HIV/AIDS:

(iii) To what extent have EC-supported actions addressed specific objectives related to sexually transmitted infections (STIs) and HIV/AIDS?

(iv) For each activity, please rate whether the results and impacts that have occurred were satisfactory on a scale of –3 (highly negative impact) to +3 (highly positive impact). Where possible, also please give key figures / indicators with respect to results and impacts.

Country	Activity	Comments
Angola	• **HIV/AIDS awareness raising** • **Training** of NGOs in HIV – AIDS • Ensure **safe blood supply** in health interventions	on going **+ 1**
Bangladesh	**HASAB** HIV/AIDS and STD in Bangladesh HASAB is one of the pioneer project in this field and acted as a networking NGO. It has provided Technical Assistance and Capacity building training for those NGOs who worked in HIV/AIDS area. Alliance International on HIV/AIDS was the European NGO who provided TA through back stopping missions	**+ 2** HASAB has gone through many difficulties for its existence as an individual organisation and management problem was serious at the beginning. Since its actual implementation phase, it has achieved a lot. It had a strong research component along with other interventions. HASAB is well known to all NGOs specially who are working on HIV/AIDS.
Cambodia	**Care and Prevention of STDs** - B7-6211/96/039 – 1997-2001	N/A – followed by the Delegation in Bangkok (EC AIDS/STD & RH SE Asia Coordination Unit)
	Réduction de la transmission des MST/SIDA et prise en charge des patients infectés par le VIH – B7-6211/IB/98/0602 (Médecins du Monde) - 1999 – 2003	N/A – followed by the Delegation in Bangkok (EC AIDS/STD & RH SE Asia Coordination Unit)
	Assistance Technique Médicale au **Programme National de Lutte contre le SIDA** - PVD/1999/829/FR (MSF) – 1997-2002	N/A – followed by the Delegation in Bangkok (EC AIDS/STD & RH SE Asia Coordination Unit)
	Operation Research in STI and Related Services For Women in High Risk Situations in Cambodia and Thailand – ICA4-CT2002-10027 – 2002-2004	N/A – followed by the HQ (DG Research)
China	A **couple of projects** supported under B7-3, B7-6 and Research framework programme Training of specialists	Project just completed, impact difficult to assess at this stage.
Congo	**Prevention, Awareness Raising, Transfusional Security**	**+ 2** Activities carried out in the strategic framework of the ongoing health care programme
	Testing, Counsellling	**+ 2** Activities carried out in the strategic framework of the ongoing health care programme
	Comprehensive activities targeted to specifically vulnerable groups such as	**+ 2** Activities carried out in the strategic

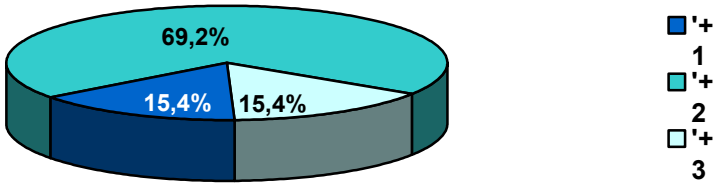
Country	Activity	Comments
	prostitutes	framework of the ongoing health care programme
Malawi	**Malawi Blood Transfusion Project** (ongoing)	**+ 1** The objective of this project is to reduce the incidence of HIV/AIDS and other diseases transmissible by blood in the Malawian population and to ensure the rational use of blood. The specific purpose of the project is to develop a National Blood Transfusion Service in Malawi and to ensure that it is able to provide adequate supplies of safe blood to meet the needs of all hospitals in Malawi. The project is being implemented in a phased manner, starting with the establishment of the MBTS headquarters in Blantyre. Two regional blood banks will subsequently be established in the Central and Northern Region of the Country. (due to limited implementation period – effectively since March 2003, which doesn't allow for a more comprehensive evaluation yet; once satisfactorily implemented, this is supposed to improve over time)
	Prevention of HIV/AIDS among high risk groups Project (finalized)	**+ 2** Objective: To reduce the incidence of the sexual transmission of HIV/AIDS and other STD's. The project was targeting the high risk groups in the Malawi society, to make them firstly aware of the HIV/AIDS pandemic and the modes of transmission of the disease and secondly to make them aware of the prevention of the transmission through education and other campaigns.
Morocco	Projet « **Activités de prévention des MST/SIDA chez les militaires marocains et leurs familles »** Ligne budgétaire B7-6211. Contribution communautaire € 650 000. Projet clôturé.	Le projet a visé à prévenir la transmission par voie sexuelle du VIH parmi les militaires des Forces Armées Royales et leurs familles en promouvant l'information, l'éducation et la communication interpersonnelle par le biais d'éducateurs pairs, d'assistantes sociales des FAR et des volontaires de la Ligue Marocaine de Lutte contre les MST. Les activités principales sont : • recherche socio anthropologique sur les comportements sexuels et attitudes relatives aux MST/Sida auprès de 400 militaires • élaboration d'un guide pour les éducateurs pairs en matière de sexualité responsable • formation de 200 formateurs (médecins et assistantes sociales) et 100 éducateurs pairs • évaluation de l'impact de l'intervention sur les attitudes et

Country	Activity	Comments
		comportements des militaires et leurs famille ainsi que sur l'incidence des MST.
	Projet « **Appui à la prise en charge des maladies sexuellement transmissibles (MST) dans 15 provinces du Royaume du Maroc ».** Ligne budgétaire B7-6211. Contribution communautaire : € 1 135 000. Projet clôturé.	L'objectif général du projet a été de réduire l'incidence des IST par une meilleure prise en charge des cas de IST dans les services de santé. Les objectifs spécifiques ont été d'améliorer les capacités de 810 professionnels de santé publique dans le diagnostic, le traitement précoce des IST et la promotion d'un comportement sexuel à moindre risque ; et d'améliorer les capacités en matière de gestion programmatique des cadres de la santé publique dans les provinces ciblées. Le projet a permis la structuration du programme de contrôle des IST et notamment les aspects relatifs à l'implantation de la prise en charge syndromique de ces infections. le projet à contribué à : • L'élaboration d'outils et de matériels pédagogiques pour l'implantation de l'approche syndromique à l'échelle nationale : le dossier du formateur, le manuel de formation des formateurs et le guide du prestataire pour la prise en charge syndromique des IST ; • La réalisation des quatre cours nationaux de formation des formateurs ; • La mise en place de la surveillance sentinelle des IST par le développement d'un réseau de laboratoire pour la surveillance biologique des IST au niveau de sept provinces et la conduite de deux importantes études épidémiologiques.
Nigeria	N.A. STIs and HIV/AIDS represent neither a focal sector nor a non-focal sector in the EC development cooperation strategy in Nigeria. Therefore no activities are being supported in these two fields.	
Pakistan	**Reach Out II** – a nation-wide integrated health, HIV prevention and drug services programme for street drug users in Pakistan The aim of the project is to establish a nation-wide network of street-based and residential care drug services for street drug users to improve the health, prevent the transmission of HIV and other blood-borne diseases and reduce the harm and demand for drugs.	**+ 2**
Philippines	Accelerating Community Based responses to Reproductive and Sexual Health and HIV/AIDS and STIs concerns of Philippine Youth	**+ 3** For direct beneficiaries, activities include counselling, referrals, clinical services and clinical group discussions on adolescent

Country	Activity	Comments
	(NGO managed project)	reproductive health. For indirect beneficiaries, activities include advocacy, symposium, awareness raising campaigns and networking with the local government. • Establish a center for young people using a clinic-based approach in one of the hospitals in the project area in the Province of Bohol. • Two provinces in Luzon used a community-based/school-based approach to mobilize young people in the implementation of the adolescent RH awareness campaign, including sexual health and HIV/AIDS.
Somalia	The programmes in Somalia are at very early stages of tackling, as separate programmes, both STIs and HIV/AIDS. First of all both STIs and HIV still represent very sensitive, cultural issues which are very difficult to tackle in an open and transparent manner. Secondly the EC did not specifically fund any specific programme to control STIs, except their treatment as part of the curative services provided by the EC supported health facilities (hospitals and MCHs/OPDs) so far.	Concerning the HIV/AIDS, due to the low prevalence in the country to date (<2%), the EC is addressing this emerging health threat as part of the SACB primarily by participation in the drafting of the HIV/AIDS Strategy for Somalia, which has recently been validated also by the existing Somali Health Authorities. The SACB will be probably ready to present a proposal on HIV/AIDS for Somalia to the Global Fund in Geneva by September/ October this year. The EC represents one of the major Donors to the G.F. and therefore, if the proposal is approved by Geneva, the EC will be involved in minimizing the impact of this disease in the Somali populations albeit indirectly.
South Africa	Through **support to programmes implemented by the National Department of Health** (Condoms, life skills development etc.) and through **support to civil society** to mitigate and ameliorate the effects of HIV/AIDS	**+ 3**
Thailand	**EC-HIV/AIDS Programme** BUD/AIDCO/2002/0478	Since January 2003, the EC is supporting four partners (UNICEF, UNODC, PSI and MSF-NL) in the implementation of a programme, which aims to decrease the spread of HIV and to mitigate the impact of HIV/AIDS on individuals, families and communities. The <u>purpose</u> is "People with high risk behaviour have increasingly adopted safe behaviour and enjoy improved access to well managed services for STI, VCCT (Voluntary Confidential Counselling and Testing), PMCT (Prevention of Mother to Child Transmission), reducing the incidence and prevalence of HIV/AIDS, while people living with HIV/AIDS enjoy improved treatment, care and support"
	The EC is funding a number of NGOs in Laos, Burma/Myanmar and Thailand in the sector of HIV/AIDS, such as: <u>Thailand</u>: • 'Improving access to comprehensive care and support for Persons with	**+ 2** Followed by the EC AIDS/STD & RH SE Asia Coordination Unit in Bangkok until the Unit was closed in December 2002. Until that moment, the projects were progressing according to plans, developing very

Country	Activity	Comments
	HIV/AIDS and their families in Thailand' (MSF-B) THA/AIDCO/2000/2302, • Women & children care & support in high HIV/AIDS prevalence areas' (CARE/Raks Thai Foundation) TH/AIDCO/2000/2306	interesting models of Care to PHA and PMCT and Youth Friendly Services.
	MOH/EU STD Project in Lao PDR B7-6211/1996/32	**+ 2** The project aimed to strengthen the capacity of the Ministry of Health in managing a National STD Care and Prevention Programme, strengthening also the public Health Care System capacity to provide access to consistently acceptable, effective and affordable STD services. The objectives had been achieved and currently the MOH has a STD service fully developed and functional at central level, and in a pilot province. With the Global Fund, the MOH has obtained funds to expand STD services to other provinces.
	Asia Pacific Leadership Forum on HIV/AIDS and Development (APLF) B7-6211/AS6/AIDCO/2002/0625	The overall goal is to minimise the impact of HIV/AIDS in the Asia Pacific Region through increased political leadership for effective national and regional action. The project is mainly focussed in advocacy, increase knowledge of and commitment to HIV/AIDS among key decision makers from a range of sectors and Ministries and to develop cooperation and understanding on HIV/AIDS among government and non-government leaders.
Tunisia	The activity presented in question 6 has a component that deals with STIs.	**+ 2** The priority addressed by the project is however family planning.
Zimbabwe	STI	
	HIV/AIDS	supports activities that ensure the continued availability of safe blood

Rating of impact **on a scale of –3 (highly negative impact) to +3 (highly positive impact)**



In question 8: 13 rankings (between + 1 and +3) were identified to relevant projects.

Question 9.

Refugees, internally displaced persons (IDPs), and distress migration:

(iii) To what extent have EC-supported actions addressed specific objectives related to refugees, IDPs and distress migration?

(iv) For each activity, please rate whether the results and impacts that have occurred were satisfactory on a scale of –3 (highly negative impact) to +3 (highly positive impact). Where possible, also please give key figures / indicators with respect to results and impacts.

Country	Activity	Comments
Angola	• Primary Health Care • treatment of severe and acute malnutrition • enhancing the resettlement capacity	**+ 2** **+ 2** **+ 2** By means of supplying emergency food and non-food items, medical assistance and supplies, water and sanitation facilities, and more recently food security measures including farming inputs such as tools and seed.
Bangladesh	**"Programme of Assistance to Myanmar/Burmese Muslim Refugees in Bangladesh"** (EC program) • is the last programme of a series of intervention supported by the EC since the beginning of the crisis in 1992. Under the multi-sector programme, activities cover provision of food, shelter, water, sanitation, health/nutrition, education services as well as operational support to UNHCR to manage the camps and assist it ensuring its protection role towards the refugees. The Government of Bangladesh (Ministry for Disaster and Relief) and an international NGO, CONCERN, are implementing partners of UNHCR.	While 92% of the refugees returned to Myanmar, a case load of about 22.000 people is still pending. Endeavours to secure a self-sufficiency programme for these refugees seems to be in a stalemate as the Government of Bangladesh objects to these arrangements while a rapprochement occurs between Bangladesh and Myanmar since 2002. The camps were visited by members of the Delegation in August 2002 and concern was raised for a series of issues (shelter, sanitation, representation of refugees) to UNHCR. MSF- Holland (not recipient of EC aid under that programme but active in the region) also keeps on alerting the Delegation on poor conditions in the camps. Overall assessment: 0 as, at least for the remaining 22.000 people, there are hardly any hope of improved situation, nor in terms of voluntary repatriation nor in terms of sustainable durable integration in Bangladesh. Only basic needs are addressed under the circumstances. Govt. of Bangladesh recently reports 330 persons returning voluntarily, so a trickle of movement exists.
Burundi	Humanitarian activities (ECHO)	**+ 3** Burundi being in a post-conflict situation, the refugee and IDP population is very important. The EC, through ECHO, is the main donor concerning humanitarian activities in Burundi.
	EDF projects	**+ 2** Although EDF projects do not focus particularly on refugees or IDPs, they have a positive impact by providing part of this population better health care, a salary through

Country	Activity	Comments
		labour intensive projects, or assistance in developing rural communities.
Cambodia	Initiated in 1992, the **European Rehabilitation Programme (ERP)** aimed to bring an immediate improvement in the living conditions of Cambodians, and facilitate the reintegration of former refugees by improving the socio-economic environment of recipient communities. It included work on rural development, basic health infrastructure, education and demining. The ERP has been followed by various long-term projects in the same areas of work.	**+ 1/+ 2**
	Assistance to refugees, returnees and displaced persons has been a substantial part of the EC humanitarian aid in Cambodia. The EC has provided emergency supplies to those affected, such as drinking water, mosquito nets, clothing and food. Support has also been given to refugees and returnees, including repatriation assistance and the establishment of micro-projects to improve living conditions in areas of return.	**+ 1/+ 2**
Congo	Protection and emergency assistance to IDPs and refugees	**+ 2** Short-term projects funded by the Humanitarian Aid Office of the European Commission, ECHO
	Improvement of the living conditions of IDP and refugees by rehabilitating basic social infrastructures and in their current places of settlement (e.g. schools, access to drinking water, sanitation facilities, access to basic health care)	Longer term activities funded by the EDF (article on special assistance to refugees or infrastructures or health care programmes), through food security activities
	Incentive for return of IDPs and refugees by improving basic social infrastructures and communications in their places of origin after the reasons for their displacement have disappeared (typically after stabilization of the security situation); e.g. rehabilitation of roads, schools, health care institutions, water supply and sanitation systems; creation of income-generation opportunities	Longer term activities funded by the EDF (article on special assistance to refugees or infrastructures or health care programmes), through food security activities
FYROM	**Food to IDPs** with host families ECHO with implementing partners has provided monthly family food parcels (1 parcel every 4 persons) to all IDPs with host families after the 2001 crises. Approximately 180,000 displaced people have been assisted with 60,000 food parcels since the beginning of the conflict. ECHO was the only organization assisting the remaining caseload of 6,356 until March 2003.	
	The EC Delegation has provided assistance in the process of reconstruction of the damaged houses during the conflict in 2001 in order to secure the rightful return of the refugees	

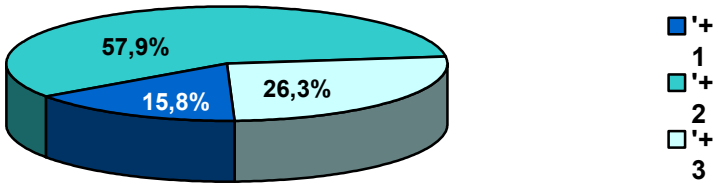
Country	Activity	Comments
	and internally displaced parsons to their homes.	
Philippines	Assistance to Facilitate the Return to Normal Life for the War-affected Families in Maguindanao.	**+ 3** • Agriculture & Livelihood for families • Water supply systems rehabilitation • Community pharmacies • - Schools' rehabilitation
	Support to IDPs and Host Communities in Central Mindanao.	**+ 3** • Livelihood assistance and House • reconstruction • Agricultural rehabilitation • Water & sanitation health improvement • Access to education • - Peace-building initiatives
	Socio-economic integration of the IDP Farmers in Mindanao.	**+ 3** • Distribution of crops and agricultural inputs • Training & Capacity building for farmers • Establishment of Corn Mills • Rehabilitation of Health Centers • Rehabilitation of farm to market roads
	Technical and Organisation Assistance for Civil Society Action of the Displaced and at risk in Mindanao	**+ 3** Results : Capacity building for partners in the fields of management, rural engineering, agricultural production, small enterprise developt., health & education, community mobilisation, and governance and counseling
Somalia	The EC Delegation-Kenya/Somalia is one of the key donors supporting the ongoing IGAD-led Somali National Reconciliation Process. A successful outcome at the current peace talks will be primary in enabling a more permanent solution to the problems of the IDPs and refugees through an enabling environment for reconciliation, peace building and demobilization. That is, through addressing the root causes of their displacement. In addition the EC supports a number of projects directly addressing the needs of IDPs and refugees (see below). In the health sector the EC Delegation-Kenya/Somalia will be supporting an integrated PHC programme in Bosaso, in which four PHC facilities (community based health facilities) will be set up in the three main IDPs camps in Bosaso town starting in August 2003.	1. Support to the IGAD-led Somali National Reconciliation Process; 2. Preparatory activities for support to the outcome of the talks; 3. Rural development sector: rural development and food security projects; 4. Demobilisation projects (Merka, southern Somalia and Somaliland, preparatory activities for large-scale demobilization countrywide); 5. Education projects (ongoing) and vocational training (forthcoming); 6. Physical infrastructure and urban water programmes – ongoing and prospective; 7. Economic recovery projects (ongoing); 8. ECHO: Africa 70: Emergency water project in Hargeisa 2002; 9. ECHO: Africa 70: Emergency Flooding in Bosaso 2002; 10. Africa 70 "Improving living conditions of vulnerable displaced people in Bosaso

Country	Activity	Comments
		– Puntland – Northeast Somalia; 11. Health: Integrated PHC programme in Bosaso (AAH);
South Africa	This has not been a significant focus of the Delegation's work in South Africa but is touched upon (in relations to rights) through two EC supported programmes in South Africa - **Themba Lesizwe** and **Foundation for Human Rights**	These programmes primarily address the issues of internally displaced persons and distress migration - particularly in the context of apartheid - and do not focus on refugees.
Thailand	**Health Project for Displaced People on the Thai-Myanmar border** (MSF-F) THA/B7-302-1B/2000/2002	N/A followed by the HQ
	REH/BUR/2000/2338: Programme Assistance to Uprooted People in Burma/Myanmar (UNHCR)	**+ 2** The programme assisted the smooth return of approximate 230,000 Muslims back to the Northern Rakhine State of Myanmar. They fled to Bangladesh around 1991-2 due to violence, sexual abuse and harsh treatment received from Burmese authorities including compulsory labour, discriminatory taxation, restriction of movement, etc. Following agreements of Bangladesh/Myanmar and UNHCR and upon the refugees' voluntariness, the repatriation started in 1994, also the micro-development projects. The project focussed on strengthening community service, local infrastructure and improving of socio-economic with close coordination with some other UN agencies (WFP, UNOPS, UNICEF, FAO) and other NGOs with different expertise to ensure that the target reintegrate in the country with full respect and self reliance. UNHCR also fulfilled its protection/monitoring mandate. The project has completed at end 2002 and the final report is to be received. The newly proposed programme is under the EC project pipeline for the return of the remaining cases in Bangladesh and strengthening more the reintegration of the returnees.
	THA/B7-3020/1B/99/0134: **Assistance aux Réfugiés Birmans en Thaïlande** (AMI/HI)	**+ 1 / + 2** The project has two parts, one was basic health care and sanitation services and trainings to health workers for the benefit of refugees(mostly are Karen and Karenni) and remote Thai villages surrounding refugee camps; the other was aid to handicapped both inside and outside the camps. The impact was improved physical and knowledge of health ; better access to medical treatment, society and education of people with disability (PDW), positive attitudes toward the both the family members of PDW and communities. The project has just finished in January 2003 and the final result has to concluded.

Country	Activity	Comments
	REH/BUR/2001/0488: **Improving the Livelihood of the Vulnerable Population of Manungdaw and Buthidaung Townships Rakhine State, Union of Myanmar (ACF)**	The project started in mid 2002 and the first report has yet to receive. The project focuses on assistance in community capacity building through water and sanitation, food security and nutritional activities for the vulnerable people in the Rakhine States of Myanmar.
	BUR/AIDCO/2002/0545: **Agriculture and food security in the North Rakhine State of Myanmar(GRET)**	The project has started in September 2002 and the first report has yet to receive. The project aims at facilitating the re-insertion of Muslim returnees by supporting the development of agriculture and improving food security.
	THA/AIDCO/2001/0487: **Food and Cooking Fuel to Burmese Refugees in Kanchanaburi and Ratchaburi Provinces,** Thailand (BBC).	**+ 2** The project provides food items in the main food basket plus cooking fuel aiming at the survival of over 100,000 Burmese refugees residing in the camps along the border of Thailand and Myanmar. Some indicators show the improved percentage of children under 5 with wasting malnutrition and other health relating syndromes. Reduced mortality rates. Improved quality commodities agreed upon, etc. As the situation in Myanmar remains precarious, it is essential that the refugees are assisted in food stuff and essential relief items to sustain their live.
	THA/B7-2120/98/0633: **Women's Capacity Development and Training** on the Thai/Burma Border (WEAVE)	**+ 2** The project addressed some of the most urgent training needs of the refugee population and displaced women (Karen) along the Thai/Burmese border. The results aimed at Karen women being able to be of financial support in the family once they return to their normal life in Myanmar. Trainings of income generation, traditional birth attendant and other capacity building were successfully delivered. Trained women could have the ability to become a trainer in future activities as well as to have knowledge and self- reliance.
	TH/2002/2747 : **Protection and Assistance Programmes for Myanmar Refugees** in Thailand (UNHCR)	The project has been recently starting (2003) The objectives of the programme are to fulfil the refugees' basic needs, paying special attention to the needs of the most vulnerable people; Preserve the external and internal security of the camp; Ensure that the admission and reception of new refugees from Myanmar take place in accordance with international standards and with consideration fro Thailand's legitimate national interests.
	BUR/AIDCO/2002/0694 : **Support for Agriculture and Natural Resource Management in Northern Rakhine State of Myanmar.**	The project has been recently starting (2003) The project aims at strengthening the returnee population to Northern Rakhine State of Myanmar by enhancing food security,

Country	Activity	Comments
		empowering farmer's ability in food production with appropriate crop varieties and multiple cropping system. This project has technical coordination with UN agencies working in Myanmar i.e. UNHCR, UNOPS, WFP including cooperation with international NGOs such as ACF, GRET, etc.
	Some other EC project pipeline of new commitment are aiming more at uprooted people from Myanmar both in Thailand and Myanmar. The activities could be protection and reintegration of refugees, refugees education, vocational training, etc.	

Rating of impact **on a scale of –3 (highly negative impact) to +3 (highly positive impact)**



In question 9: 19 rankings (between + 1 and +3) were identified to relevant projects.

Question 10.

Population composition (including age structure, indigenous populations, and people with disabilities) and distribution (including internal migration apart from displaced persons, large urban agglomerations, and international migration apart from migration into EU-Member States):

(iii) To what extent have EC supported actions addressed specific objectives related to Population Growth and Structure, Population Distribution, Internal Migration (apart from IDPs), Urbanisation and International Migration (apart from international migration into EU-Member States)?

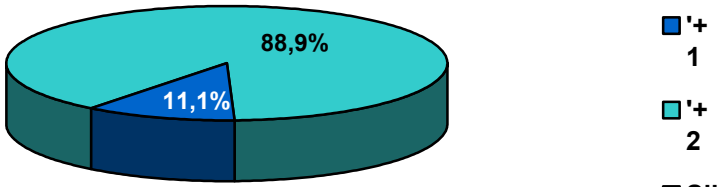
(iv) (For each activity, please rate whether the results and impacts that have occurred were satisfactory on a scale of –3 (highly negative impact) to +3 (highly positive impact). Where possible, also please give key figures / indicators with respect to results and impacts.

Country	Activity	Comments
Angola	project in the area of **institutional support** is about to be financed	
Cambodia	EC activities for **Rural development, food security, education, access to health services, demining, employment creation, environment**, have been and are targeted at isolated and rural areas, which comprise 85% of the population, and as such contributed to reduce internal migration.	**+ 2**
	The EC also support development actions in areas with **ethnic minorities**.	**+1 / +2**
	DIPECHO has assisted with **disaster preparedness**	**+ 2**
	The EC has supported specific activities for the **disabled persons**	**+ 2**
	The EC has a number of projects under the **ASIA-URBS programme**.	**+ 2**
	There are **RHS projects** for young migrants under the EU/UNFPA ARHI/RHIYA	**+ 2**
Congo	**Internal migration** Activities to improve living conditions in the areas registering a rural exodus by improving road communications, access to health care, water supply, relaunching agricultural production	**+ 2** Funded by the EDF through infrastructure, health care and agricultural programmes as well as through food security funds

Country	Activity	Comments
Morocco	Projet MEDA « **Appui institutionnel a la circulation des personnes** » En cours de formulation – Mise en œuvre prévu pour le période 2004-2007. Montant indicatif : € 5 M.	Meilleure structuration de la circulation légale de personnes aux fins de travail (CLPT) entre l'UE et le Maroc par le renforcement institutionnel des structures appropriés Le projet comportera plusieurs volets : Établir un pilotage institutionnel de la CLPT axé sur un partenariat à long terme et porté par une institution structurée à cette fin et dotée de ressources appropriées. Optimiser et adapter les compétences des travailleurs marocains candidats à la migration. Organiser et rendre accessibles les informations sur la CLPT, sur l'accueil et le travail dans les pays de l'UE. Favoriser l'aide et l'orientation en cas de retour et de réinstallation au Maroc.
	B7-667 - **Programme d'appui aux entrepreneurs d'origine marocain aux Pays** Bas pour établir des activités économiques au Maroc Durée du Projet – 2001- 2003 Contribution UE : 448 000 € Contractant : Stichting Intent (NL)	Soutien aux entrepreneurs émigrés pour la création de co-entreprises et de nouvelles entreprises au Maroc. Le projet apporte des informations, le développement de l'esprit d'entreprise, le soutien à la rédaction de propositions commerciales et à l'évaluation des situations, ainsi que des services de conseil après la mise en route.
	B7 – 701 – **Centre pour les Droits des Migrants** Durée du Projet – 2001- 2003 Contribution UE : 395 000 € Contractant : OIM	Le projet vise à : Renforcer les capacités institutionnelles et techniques du gouvernement marocain en matière de formation du personnel national en droits des migrants. Former des experts en matière de défense des droits des migrants Fournir une assistance juridique aux migrants dont les droits ont été violés. Lancer des campagnes d'information et de sensibilisation.
	B7-667 – Le Migrant Marocain comme agent de développement dans sa communauté d'origine Durée du Projet – 2003- 2004 Contribution UE : 890 000 € Contractant : COOPI (IT)	Le projet effectuera des recherches sur les origines et dynamiques migratoires Maroc – Italie dans le nord du Maroc. Il développera des réseaux d'organismes travaillant dans la problématique de la migration dans le nord du Maroc et diverses villes de l'Italie et lancera des actions pilote de développement local à travers la promotion à la création d'entreprises et la formation.
Palestine	Human Rights programmes aimed amongst other things at preventing violence against women and children, early marriage, promote the rights of vulnerable groups such as the disabled and the elderly, support initiatives towards improved legislations as regards the rights of women, children and senior	Some legislations concerning women rights were passed by the Palestinian Legislative Council. It is difficult to assess the exact impact on the Palestinian society but certain taboos regarding the status of women were broken. More awareness pertaining to vulnerable

Country	Activity	Comments
	citizens..	groups rights was created.
	Co-financing programme for development: social and economic development of vulnerable groups in secluded areas.	Significant impact as regards the objectives of the programme by ameliorating the socio-economic status of the target groups. European NGOs expertise in other third countries transferred to the Palestinian society and its development agencies.
Rwanda	EC support (€ 7 m) to 2002 census through **UNFPA** managed basket fund (with DFID, Netherlands)	**+ 2** Consensus produced on rime and high quality
South Africa		Again it is difficult to disaggregate these issues - they are all to a greater or lesser extent integrated into a range of programmes to for example, support to Cato Manor, Local Economic Development Programmes, Health, Education, Justice, Human Rights.
Thailand	B7-701 N/T-2000/032 **"Indigenous Peoples: Training Programme in International Human Rights Standards and the Policy Process"** (Saami Council) • Horizontal project by answering the call for proposals	The project aimed at providing indigenous representatives in Asia and Africa regions to learn about international human rights standards and mechanisms in an easy to understand method. This is to enable them to better protect and promote their rights at the national, regional and international level and to improve their situation in an effective manner. The project included practical training programmes, organized in indigenous areas in The Philippines, Thailand and Africa, in cooperation with local indigenous organizations. The project was managed by the EC/HQ(Human right and Democracy) with only one day participation of the Delegation once the training was held in Thailand.
	B7-60002002/019.958/RAE **Disability Rights, Empowerment, Awareness and Mobility in Indonesia and Thailand** – DREAM IT (VSO) • Horizontal project by answering the call for proposals	The project is under the management of EC HQ and has recently started.

Rating of impact **on a scale of –3 (highly negative impact) to +3 (highly positive impact)**



In question 10: 9 rankings (between + 1 and +3) were identified to relevant projects.

Question 11.

What have been, if any, the obstacles to increased EC activity in the area of population?	
Angola	War after war: no specific policy for this area (problems with good governance and a lack of administrative capacity)
Bangladesh	problems in this sector concern the whole donor community SWAP was not done as a whole, rather as half cooked. That is why it has created lots of confusion, conflict, argument and politics among the concerned ministries and donor community. SWAP had ambitious reform agenda which was centralized and not communicated properly. Interpretation of SWAP was done differently by different people. Capacity to handle SWSWAP at the Ministry level as well as at the field level was not adequate and proper measures were not taken to do that. Very much superficial training was provided. SWAP did not have broad based ownership which could be achieved through Parliament. As a result, the existing Govt. is not respecting the decisions introduced by the previous Govt. Involvement of other actors in decision making was not enough, especially at field level of implementation. On top of that, any change is a risk to people and they resist it. Though SWAP has brought lots of benefit, there is no doubt about it, but it has also taken away power of some individuals which they have been enjoying for a long time. Limited understanding of SWAP was the major problem. The GOB should have taken more careful steps to go ahead with the new approach. Bangladesh health sector has been working through two wings – Health and Family Planning. Under HPSP they were integrated and this has created conflicts between these two wings. Revised job descriptions were not accepted by all. It is more of a power game between the two wings.
Burundi	The main obstacle faced by the Delegation in Burundi is a lack of human resources to provide an in-depth follow-up of the projects.
Cambodia	Despite having no direct knowledge of EC policy in the area of population and development, it appears that most of the ICDP actions have been and are still addressed, but through a more sectoral perspective.
China	Choice made not to be very active in this field considering the level of development of the country, its size, the commitment of the Chinese government and the level of EU resources available in comparison with the needs. AIDS situation and health management system (post SARS situation) may become real issues in the future.
Congo	Lack of sufficient funds given the size of the country (in terms of territory and population), with enormous needs in all sectors given the devastating effect of several years of civil war
FYROM	Since the number of EC activities in this sphere is limited, no particular obstacles can be identified.
Malawi	As mentioned above, there's no clear-cut separation of health and population issues in Malawi. Obstacles to satisfactory EC project implementation and coordination among development partners have often been the low human capacities in the relevant Government departments as well as a lack of clear and prioritized strategies/policies.
Nicaragua	Lack of attention to the issues in the CSP

What have been, if any, the obstacles to increased EC activity in the area of population?	
Palestine	Religious resistance to social changes Natural population growth in Palestine (5.6%) far exceeds economic growth (2.2 before the Intifada and presently at the negative side)
Philippines	None. The Delegation with the assistance of D/4 in Brussels is now at the preparatory stage of its forthcoming EC-Philippines Health Sector Reform Agenda (HSRA) Programme.
Rwanda	Lack of personnel at Delegation 9th EDF focal sectors decision - population not included Absence of National Population Policy prior to 2003 Absence of explicit treatment of population in PRSP.
Somalia	Absence of an internationally recognized government; Continuing instability and insecurity in many parts of the country – a volatile political and security environment.
South Africa	Two possible constraints • Until August 2003 there was a political impasse in relation to many HIV/AIDS issues • The absorption capacity of the SA counterparts
Chad	Le sous-effectif de la délégation (un seul fonctionnaire pour le moment) ne permet pas d'initier de nouvelles actions spécifiques.
Zimbabwe	Lack of clearly defined government policy on population and development and poor coordination.

What measures, in your opinion, could contribute toward improved programmes in the future?	
Angola	women's access to basic health and education (better literacy)
Bangladesh	EC should continue to be one of the active members of the Donor Consortium and support "one voice" of the donors in terms of future actions. EC should advocate for participatory approach for any action from donor side and should try to prevent individual donor's action which is not part of the DC. Rather than putting all our fund into the pool, we could divide it to use through other channel like NGOs. This is very good lesson from DFID. All donors may establish "NGO Pool" to implement gaps in the health sector. EC as well as other donors should consider the outcome of the programme rather than putting too much effort on "Reform Agenda" which will take much longer most likely than expected.
Burundi	Having more human resources within the Delegation will give us the possibility to focus more on specific issues, develop a more strategic vision of its present and future activities and the impact these would have on the country and its population.
Cambodia	If a more population & development focused approach need to be adopted, the first steps would be: • Be informed of EC policies, on a regular basis • If relevant, receive training • Have more staff at the Delegation • Receive a copy of this Evaluation • Have an evaluation in the field, rather than fill a questionnaire

What measures, in your opinion, could contribute toward improved programmes in the future?	
Congo	Stabilization of the political and security situation of the country, allowing better access to affected zones and more efficient implementation of aid programmes Overall improvement of the socio-economic situation permitting a more substantial government contribution to population and development programmes
El Salvador	• To promote among government authorities the consideration of P&D into public policies as means to better address social and economic challenges, • To support efforts toward the consideration of P&D in the formulation of public policies, such as academic research and situational studies on specific themes such as internal migration, territorial carrying capacity, population structure and so forth • To improve coordination among donors for the implementation of activities and generate synergies in accordance to the Government strategic areas of cooperation for P&D. • To celebrate a cooperation agreement with UNFPA to implement P&D activities in accordance to the Government strategic areas of cooperation in P&D
FYROM	Inclusion of the Population Development as a separate sector among the priority areas of EC support to the country.
Malawi	• Increased human capacities on the level of both Government institutions and EC delegations/headquarters • Strengthening of counterparts on implementation level, not only in the respective sectors, but also in the EC's main implementing partner, the National Authorizing Officer's Unit in the Ministry of Finance • Simpler and target group oriented project design, while at the same time increased project implementation periods, which allow for adaptation to the ever-changing working environment in Malawi due to "internal shocks" such as the rampant HIV/Aids pandemic.
Nicaragua	• To promote among government authorities the consideration of P&D into public policies as means to better address social and economic challenges. • To support efforts toward the consideration of P&D in the formulation of public policies, such as academic research and situational studies on specific themes such as internal migration, territorial carrying capacity, population structure and so forth • To improve coordination among donors for the implementation of activities and generate synergies in accordance to the Government strategic areas of cooperation for P&D. • To celebrate a cooperation agreement with UNFPA to implement P&D activities in accordance to the Government strategic areas of cooperation in P&D • Develop non-health-based approaches to HIV/AIDS (eg. Education, community development etc.)
Pakistan	More collaboration with the Government system would mainstream EC funded stand alone activities into the efforts undertaken by the Ministry of Population and ensure sustainability.
Philippines	Commitment of Government to pursue its population policy should be reinforced by direct and resolute actions to address the population issues. Coordination mechanism among international organizations and with the Government should be further strengthened.
Rwanda	The new national policy could pr0vid.c a useful framework. Deconcentration and increased staffing at the Delegation

What measures, in your opinion, could contribute toward improved programmes in the future?	
Somalia	Significant political and economic support to a positive outcome from the current Somali National Reconciliation Process.
South Africa	Significant in roads have been made over the last 1-2 years to improve programmes through increased staffing, increased use of TA and greater ownership of programmes (particularly by the SA Government Departments). EC financial procedures remain an issue owing to their complexity and are often little understood by implementing partners and EU member states. Early indications are that this issue will become more problematic with the new financial regulation and implementing rules.
Chad	Mettre l'accent sur les question reproductives dans le cadre d'un appui intégré aux activités sanitaires, plutôt que de démarrer des programmes spécifiques qui désorganisant le Ministère de la Santé Publique qui est très faible en termes de ressources humaines. Il faut noter que les questions de population constituent une priorité très faible de l'Etat tchadien.
Tunisia	There is no specific request of assistance by the Tunisian government in this area. The enhancement of horizontal budget lines through increased funding could improve programmes in the future.
Zimbabwe	• -formulation of policies and strategies in the population sector. • -improved coordination among government and donor agencies in the population sector. • -formation of government/civil society and NGO partnerships in population and development programmes (dialogue) • -beneficiary participation in policy formulation and implementation. • -mainstreaming population and development issues in development programmes/projects

Further comments	
FYROM	The Health sector in fYROM in general has not been included in the EC Phare/ Obnova/ Cards assistance due to the fact that this sector has been covered by the WB and WHO.
Malawi	Efforts on the international level (such as the ICPD) to improve e.g. the health standard of a given country and coordinate related activities to reach internationally agreed goals and objectives need to be linked more closely to the situation on the ground. Low capacities of the local implementing partners, but also of EC delegations, might otherwise make it difficult to implement such agreements on the ground.
Morocco	L'UE est aussi active dans la promotion de la condition de la femme. Le programme Meda Démocratie a financé plusieurs projets visant à promouvoir les droits de la femme (par exemple, à travers des centres d'information juridique). Actuellement, dans le cadre de l'Initiative Européenne pour les Droits de l'Homme et la Démocratie, l'UE finance le programme « Actions positives pour les droits de citoyenneté des femmes et l'égalité de chances au Maghreb » visant la promotion de ses droits, l'amélioration des conditions de travail et l'orientation sanitaire. Finalement, le projet « Appui au Développement Humain et à l'Intégration Sociale », en cours de démarrage a pour but de renforcer les capacités du Secrétariat d'Etat chargé de la famille, de la solidarité et de l'action sociale.
Nicaragua	• Proyecto de Fortalecimiento del Sistema de Salud en Nicaragua is limited to four departments in Nicaragua: Jinotega, Matagalpa, RAAN and Río San Juan, and its impact is therefore limited to these regions. The Projects objective is to

Further comments	
	fortify the health system and constitutes several components such as infrastructure, equipment and medicines, as well as institutional development. It has not covered the area of Reproductive rights, STD´s or Migration. The Project has undertaken construction of health centres, living quarters for medical staff, and renovated hospitals. In addition to equipping these and health centres it has provided a steady supply of medicines to the areas covered by the project. It is difficult to measure the projects direct impact on the health sector as much of this will be indirect, such as the training of nurses, better equipment, additional ambulances, accessibility to medicines and the training of doctors in the proper prescription of medicines, as well as better medical facilities and equipment like incubators, x-ray machines and sterilizers which all help to save time, money and lives, as well as making medical help more accessible in rural areas. • Project FORSIMA, which strengthens SILAIS Managua, is a project that provides support to the net of primary health care in Managua, through its premises, equipment and the proper professional training for the health staff at all levels.
Rwanda	In the new framework of EC aid, Government's population policy will be supported largely through Budget Support to central Government and increasingly lo decentralized authorities (districts, cellules). Hence, rather than introducing separate programmes or projects lo be funded by the EC, the Delegation will focus on increasing its participation in policy dialogue in this area, especially as regards health aspects.
South Africa	As has been constantly indicated throughout the responses to this questionnaire, development is the foundation of EC support to South Africa. Within "development" the "population development" component is spread across all sectors and the Delegation does not have flagged population programmes per se. The Health, AIDS and Population (HAP) agenda is addressed at different levels and in different ways by a number of EC funded interventions.