ASIAN DEVELOPMENT BANK

PPA: PAK 26373

PROJECT PERFORMANCE AUDIT REPORT

ON THE

POPULATION PROJECT
(Loan 1277-PAK[SF])

IN

PAKISTAN

December 2003

CURRENCY EQUIVALENTS

Currency Unit – Pakistan rupee/s (PRe/PRs)

		At Appraisal (August 1993)	At Project Completion (June 2000)	At Operations Evaluation (October 2003)
PRe1.00	=	$0.0368	$0.0192	$0.0173
$1.00	=	PRs27.20	PRs52.00	PRs57.80

ABBREVIATIONS

ADB	–	Asian Development Bank
CPR	–	contraceptive prevalence rate
DALY	–	disability-adjusted life year
FHW	–	female health worker
GDP	–	gross domestic product
HRD	–	human resource development
IEC	–	information, education, and communication
MCH	–	maternal and child health
MIS	–	management information systems
MOH	–	Ministry of Health
MOPW	–	Ministry of Population Welfare
NGO	–	nongovernment organization
OEM	–	operations evaluation mission
PC-I	–	Population Commission-I
PCR	–	project completion report
PHC	–	primary health care
PIU	–	project implementation unit
PPAR	–	project performance audit report
PWD	–	population welfare department
PWP	–	Population Welfare Program
PWTI	–	population welfare training institute
RHSC	–	reproductive health services center
RTI	–	regional training institute
SAP	–	Social Action Program
SAPP-I	–	Social Action Program Project I
TA	–	technical assistance
TFR	–	total fertility rate
TOR	–	terms of reference
VFPW	–	village family planning worker

NOTES

(i) The fiscal year (FY) of the Government ends on 30 June.
(ii) In this report, "$" refers to US dollars.

Operations Evaluation Department, PE-634

CONTENTS

APPENDIXES

BASIC DATA
Loan 1277-PAK(SF): Population Project

INSTITUTION BUILDING

TA No.	TA Name	Type	Person-Months	Amount[1] ($)	Approval Date
2005	Institutional Development of the Ministry of Population Welfare	ADTA	468	700,000	2 Dec 1993

KEY PROJECT DATA ($ million)	As per ADB Loan Documents	Actual
Total Project Cost	39.0	30.6
Foreign Exchange Cost	12.0	13.4
Local Currency Cost	27.0	17.2
ADB Loan Amount/Utilization	25.0[2]	23.1
ADB Loan Amount/Cancellation	—	1.5

KEY DATES	Expected	Actual
Fact-Finding		28 Jan–18 Feb 1993
Appraisal		16 Jun–11 Jul 1993
Loan Negotiations		24–26 Oct 1993
Board Approval		2 Dec 1993
Loan Agreement		25 May 1994
Loan Effectivity	23 Aug 1994	22 Aug 1994
First Disbursement		6 Oct 1994
Project Completion	31 Mar 1999	31 Dec 1999
Loan Closing	31 Dec 1999	8 Jun 2000
Months (effectiveness to completion)	55	64

BORROWER The Islamic Republic of Pakistan

EXECUTING AGENCY Ministry of Population Welfare

MISSION DATA

Type of Mission	No. of Missions	No. of Person-Days
Fact-Finding	1	110
Appraisal	1	130
Project Administration		
Inception	1	14
Review	11	99
Project Completion	1	76
Operations Evaluation[3]	1	46

— = not applicable, ADB = Asian Development Bank, ADTA = advisory technical assistance, TA = technical assistance.

[1] Represents the approved amount of the technical assistance.

[2] The original loan amount of 17.611 million special drawing rights ($25.0 million) was equivalent to $24.56 million at the time of loan closing.

[3] Comprising K. Hardjanti (evaluation specialist/mission leader) and T. Ahmed (staff consultant).

EXECUTIVE SUMMARY

In November 1992, the Government of Pakistan requested the Asian Development Bank (ADB) to finance part of the foreign assistance requirement of its Population Welfare Program (PWP). The Project was based on this request, and approved on 2 December 1993. Lessons learned from the implementation of a previous project supported by ADB (Health and Population Project, approved 15 December 1981) and Pakistan's previous programs highlighted the importance of grassroots family planning, and this was included in the project design.

The Project was to support PWP in reducing the population growth rate from 3.1% to 2.6% per year by the end of the Eighth Five-Year Plan (FY1993 to FY1998) through an increased contraceptive prevalence rate (CPR) and a reduced total fertility rate. Specifically, the Project aimed to (i) increase accessibility and coverage of family planning services in rural and underserved areas; (ii) improve the quality, supply, and distribution of doctors and paramedical staff in clinical family planning services, and the training of village family planning workers (VFPWs) and government staff; (iii) increase awareness of the benefits of and demand for family planning services; and (iv) strengthen planning, management capacity, and research activities for population welfare services. The Project comprised four main components: (i) service delivery; (ii) human resource development (HRD) and training; (iii) information, education, and communication (IEC); and (iv) planning, management, and research. Attached to the Project was a technical assistance (TA) grant for institutional development at the Ministry of Population Welfare (MOPW).

The project completion report, circulated to the Board on 8 January 2002, rated the Project successful. The project performance audit report (PPAR) presents the findings of the Operations Evaluation Mission (OEM) that visited Pakistan in July and August 2003. Both primary and secondary data were used in preparing the PPAR. The PPAR incorporates information gathered from discussions with officials at the national-level MOPW and the provincial-level population welfare departments (PWDs), the Ministry of Health (MOH), regional training institutes (RTIs), reproductive health services centers (RHSCs), family welfare centers, population welfare training institutions (PWTIs), related aid agencies, and nongovernment organizations (NGOs). A tracer survey of VFPWs and beneficiaries from selected project districts from all provinces was carried out in September 2003. Discussions and interviews were held, and questionnaires were distributed to 115 VFPWs and 118 beneficiaries.

Targets set at appraisal under three components—service delivery, HRD and training, and IEC—were mostly achieved, while the targets envisaged during appraisal for the fourth component on planning, management, and research, was partly achieved. The service delivery component comprises two integrated subcomponents: (i) recruitment, training, and deployment of VFPWs, all of which were women; and (ii) construction and renovation of RHSCs. During the midterm project review, the Government requested that the Project increase its support for 8,000 to 12,000 VFPWs, thus covering the entire Eighth Five-Year Plan target, and 11,570 VFPWs were trained under the Project. All VFPWs were employed by MOPW. They provide services mainly to women in poor and remote areas where unmet need for contraception was high. MOPW's service statistics reveal a rapid increase in the number of clients served by VFPWs. The 2001 national household survey also shows a rise in CPR from 6% in 1990–91 to 22% in 2000–01. The VFPW vicinity survey indicates a CPR level of 51% (2000–01), reflecting much greater impact in the vicinity of workers' rural localities. The recruitment, training, and deployment of 11,570 VFPWs in rural areas have brought additional income to rural households, empowerment of women, and enhancement of women's self-esteem, outcomes that the survey results also demonstrated.

The Project constructed and renovated 184 training centers—against a target of 191—that trained all the VFPWs. The training centers involved 127 trainers and 301 supervisors, compared to the appraisal targets of 191 and 390, respectively. The Project constructed 46 RHSCs, compared to a target of 51 RHSCs. Five RHSCs in Punjab were not built because space was not available in four selected hospitals, and the PWDs and provincial-level departments of health disagreed on the location of the fifth. The OEM observed that the RHSCs constructed under the Project were fully operational and generally well maintained. All of them were provided with small operating theaters, equipment, medicine, furniture, and vehicles. A 2001 survey on RHSCs showed 84% of these centers were easily accessible and 92% of clients were satisfied with services.

The HRD and training component was expected to cover two RTIs and two PWTIs. The OEM observed good quality training in RTIs. The Project also upgraded two reproductive health services master training centers and seven reproductive health services training centers. These centers regularly provide in-service and refresher technical training courses in family planning and reproductive health to staff from MOH, NGOs, and the private sector. The Project played a significant role in improving the skills of VFPWs, doctors, paramedics, and other health providers. It has contributed to building an environment toward comprehensive reproductive health, shifting away from the singular family planning approach. Two PWTIs responsible for imparting nonclinical training to program managers, nontechnical staff, community-based groups, NGOs, and personnel of other line departments—as well as pre-service training for new recruits and counseling skills training for family welfare workers—were to be built under the Project. However, the Government decided to use grant funds from the United Nations Population Fund for this purpose. Loan provisions for international consulting services to upgrade nonclinical training and improve the management capability at PWTIs were reallocated. PWTIs were not constructed because of a government austerity drive and a ban on new construction at the time.

The IEC component supported Pakistan's IEC program by producing radio spots in regional languages and announcements in electronic and print media. These were designed in close collaboration with MOH and the community. This support has played a major role in increasing awareness for family planning, particularly related to the methods and sources of availability. Counseling skills provided to VFPWs have also supported the IEC campaign. The IEC strategy has been decentralized, which has proven to be a good strategy in the IEC campaign. The component on planning, management, and research was intended to improve the strategic management expertise and capacity both at the MOPW and PWDs, thus supporting decentralized management. It helped to build the foundation for decentralization, but implementation only started in 2000. The Project's support for international consultants and construction of the PWTIs was reallocated, and the TA failed to assist institutional development, so the objectives of the planning, management, and research component were only partly achieved.

The TA for institutional development and capacity building at MOPW was unsatisfactory, but the technical support in terms of the VFPW scheme was satisfactory. The consulting firm selected for the TA was better suited to supporting technical expertise related to reproductive health and family planning. The firm had minimal institutional development and capacity-building expertise, and was overloaded by other assignments. The TA design was overly ambitious and only included general terms of references (TORs).

The Project has been highly relevant and consistent with the Government's policy to limit population growth by reducing fertility, enhancing access to reproductive health facilities, and improving coverage of services across Pakistan, especially in underserved and rural areas. It

was also in line with ADB's operational strategy. The Project was efficacious and efficient in achieving its targets as seen in the survey results and the economic assessment. The Government is highly committed to the sector, as shown by its decision to allocate 45% more of its 2003–04 budget to population than it did the previous year. There is a gradual increase in the allocation for 2004 to 2008. The Project's achievements are, therefore, sustainable. Its impact on institutional development was moderate. However, it has had a substantial socioeconomic impact—particularly on rural women, both as VFPWs and beneficiaries—and a significant impact on Pakistan's population and health sector policies. Thus, the Project's impact on institutional development, policies, and socioeconomic conditions was significant. Based on the above, the Project is rated successful.

Key issues facing Pakistan's population sector include (i) provincial governments have to delegate many of their powers and activities to district-level governments as part of a nationwide devolution plan; this includes their jurisdiction over PWP. However, district governments still lack capacity for planning, management, and other necessary aspects of good governance; (ii) the Government's large investment to sustain PWP poses a tremendous challenge to MOPW and PWDs to meet the targets and address emerging needs in reproductive health. With the transfer of the female VFPWs to MOH, MOPW now has fewer human resources. MOPW needs to be proactive and innovative in increasing coverage, access, and quality of services to effectively utilize the allocated funds by working closely with MOH, other relevant institutions, the private sector, and NGOs; (iii) the policy on pricing contraceptives has caused tension between health care providers from the public sector and NGOs, an issue which needs to be resolved; (iv) integrated management information systems (MIS) regarding performance of various components in health and population welfare are needed to alleviate duplication and inaccuracy, which has caused misreporting at lower levels; and (v) the planning approach has remained supply-oriented and needs to be amended.

The OEM recommends follow-up actions on several issues. These include (i) an integrated management information system for the health and population welfare programs to enable accurate reporting by early 2005; and (ii) finalizing the solution on contraceptive pricing by mid-2004 to minimize tensions between family planning workers in the field.

Lessons learned from the Project include (i) the IEC component through customized promotional campaigns by using participatory approach and local languages have brought the desired behavioral changes for small family norms; (ii) no financial and economic analyses were prepared at project appraisal and completion, and no economic baseline data was prepared to support comparative impact analysis. To enable high quality economic analysis, projects should incorporate the necessary baseline data, indicators, and supportive mechanisms at design stage; (iii) the TA did not achieve its objectives because of its overly ambitious design, vague TORs, the wrong experts for implementation, and inadequate review and guidance. To support institutional development, the TA should have focused on institutional capacity building with specific TORs and rigorous review; (iv) for smooth and timely implementation of the Project, related training in ADB procedures and systems is crucial, and should have been provided to all project implementation unit managers at an early stage. Clear information on project objectives, targets, and administrative procedures should have been provided to all staff responsible for monitoring and implementing the Project in provincial and district levels. The project design should have been more program-oriented, thus making it easier to identify and monitor ADB's contribution.


PAKISTAN
POPULATION PROJECT
(as completed)
National Capital
Provincial Capital
City/Town
Reproductive Health Service Center
Regional Training Institute
Population Welfare Training Institute
Project Implementation Unit
Airport
Port
Main Road
Railway
River
District Boundary
Provincial Boundary
International Boundary
Boundaries are not necessarily authoritative.
63°00'E
73°00'E
35°00'N
25°00'N
NORTH-WEST FRONTIER
BALOCHISTAN
SINDH
PUNJAB
Federally Administered Tribal Area
ISLAMABAD
Peshawar
Chitral
Dir
Dasu
Saidu Sharif
Batgram
Malakand
Batkhela
Mansehra
Mardan
Charsadda
Swabi
Abbottabad
Haripur
Attock
Nowshera
Rawalpindi
Hangu
Kohat
Gujar Khan
Karak
Chakwal
Jhelum
Talagang
Bannu
Lakki
Gujrat
Sialkot
Mianwali
Mandi Bahauddin
Khushab
Bhalwal
Narowal
Sargodha
Hafizabad
Gujranwala
Tank
Dera Ismail Khan
Sheikhupura
Bhakkar
Lahore
Zhob
Jhang Sadr
Faisalabad
Shorkot
Leiah
Kasur
M.K. Bazar
Toba Tek Singh
Okara
Chamman
Pishin
Ziarat
Kot Addu
Sahiwal
Khanewal
Quetta
Loralai
Dera Ghazi Khan
Pakpattan
Barkhan
Multan
Kohlu
Muzaffargarh
Vehari
Bahawalnagar
Sibi
Lodhran
Hasilpur
Nushki
Mastung
Dadhar
Rajanpur
Bahawalpur
Kalat
Dera Bugti
Liaqatpur
Jhal Magsi
D.M. Jamali
Kharan
Jafarabad
Jacobabad
Rahimyar Khan
Shikarpur
Khuzdar
Ghotki
Larkana
Sukkur
Khairpur
Panjgur
Dadu
Naushahro
Awaran
Nawabshah
Turbat
Sanghar
Uthal
Mirpur Khas
Gwadar (Makran)
Hyderabad
Umarkot
Karachi
Thatta
Badin
Mithi
Port Qasim
ARABIAN SEA
0 50 100 200
Kilometers
01-2897 HR

I. BACKGROUND

A. Rationale

1. Pakistan formulated its Population Welfare Program (PWP) with the overall objective of reducing the population growth rate from 3.1%—among the highest in South Asia—to 2.6% per year by the end of the Eighth Five-Year Plan (FY1993 to FY1998). This target was set based on the high population growth rate and the understanding that rapid population growth strains public expenditure for social services, depletes natural resources, and undermines economic growth. The long-term goal of PWP is reducing poverty. Not more than 25% of the population had access to family planning services. The coverage in rural areas, where 70% of the population lives, was only around 5%, while coverage in urban areas was 54%. The Government aimed to increase coverage in both rural and urban areas. However, the delivery system was unable to effectively reach those in need, especially poor women in rural areas. For this purpose, the Government planned to recruit, train, and deploy the village family planning workers (VFPWs). Required financing for PWP was estimated at $364 million, with foreign assistance estimated at $257 million.

B. Formulation

2. In November 1992, the Government requested the Asian Development Bank (ADB) to finance part of the foreign assistance requirement of PWP. Based on this request, fact-finding and appraisal missions were fielded in 1993, and the findings of these missions, as well as lessons learned highlighted by the project performance audit report (PPAR) from a previous project,[1] formed the foundation of the final project design.[2] In addition, lessons learned from implementing previous programs in Pakistan—underlining the importance of grassroots family planning services provided by people who live among the target population, a multisector approach, and a shift toward decentralization—were also included in project design. The long-term goal of the Project was to contribute to poverty reduction by addressing and reducing population growth.

C. Purpose and Outputs

3. The Project was to support PWP and the Social Action Program (SAP)[3] in reducing the population growth rate from 3.1% to 2.6% per year by the end of the Eighth Five-Year Plan by increasing the contraceptive prevalence rate (CPR) and reducing the total fertility rate (TFR).[4] Specifically, the Project aimed to (i) increase accessibility and coverage of family planning services in rural and underserved areas; (ii) improve the quality, supply, and distribution of doctors and paramedical staff in clinical family planning services, and train VFPWs[5] and

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[1] ADB. 1981. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Islamic Republic of Pakistan for the Health and Population Project.* Manila.

[2] ADB. 1993. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan and Technical Assistance Grant to the Islamic Republic of Pakistan for the Population Project.* Manila. For SDR17.611 million ($25.0 million), which was equivalent to $24.56 million at loan closing.

[3] SAP is a nationwide, multisector program initiated by the Government in 1992 to enhance human development by improving basic social services in basic education, primary health care, population welfare, rural water supply, and sanitation. The SAP covers 27 subprograms nationwide.

[4] In 1990, the CPR was 14% of married women between 15 and 49 years old, and the total fertility rate was 6.0 births per woman. Contraceptive prevalence was among the lowest in South Asia, and the fertility rate among the highest in that region.

[5] All VFPWs recruited, trained, and deployed under this Project were women.

government staff in nonclinical fields; (iii) increase awareness of the benefits of and demand for family planning services; and (iv) strengthen planning, management capacity, and research activities for population welfare services at different levels.

4. The Project comprised four main components: (i) service delivery, covering 8,000 VFPWs and 51 reproductive health service centers (RHSCs), including the expansion of 9 of these centers into training centers; (ii) human resource development (HRD) and training, covering two regional training institutes (RTIs) and two population welfare training institutes (PWTIs); (iii) information, education, and communication (IEC); and (iv) planning, management, and research.

5. A technical assistance (TA) grant (footnote 2) was attached to the Project. The objectives were to (i) provide advisory services on policy and institutional matters related to PWP; (ii) strengthen the strategic management capability of the Ministry of Population Welfare (MOPW) and the middle-level management expertise and capacity of the population welfare departments (PWDs) at the provincial level; and (iii) strengthen institutional capacity for population welfare services by supporting program planning and management at MOPW and at the provincial PWDs, including monitoring and evaluation functions.

D. Cost, Financing, and Executing Arrangements

6. The total project cost amounted to $30.6 million, compared with $39.0 million estimated at appraisal. Appendix 1 shows appraised and actual project costs. ADB financed $23.07 million of the total project cost. Substantial loan savings were realized from civil works and incremental recurrent costs, as well as the entire provision for consulting services. Reallocations were made to cover additional requirements for equipment and staff training. The balance of $1.49 million was cancelled at loan closing on 8 June 2000.

7. The Executing Agency for the Project was MOPW. Each PWD had responsibility for implementing the components at the provincial level, including coordination with the department of health and the planning and development department. A project implementation unit (PIU), headed by a project director, was established in each province for day-to-day management, coordination, administration, and implementation. At the national level, an interministerial coordinating committee provided guidance and policy direction, while provincial-level project steering committees provided guidance and resolved interdepartmental problems.

E. Completion and Self-Evaluation[6]

8. The Project was completed in December 1999, compared with the expected completion date at appraisal of March 1999. Total project cost amounted to $30.6 million, compared with $39.0 million estimated at appraisal. ADB financed $23.07 million of the Project. The balance of $1.49 million was cancelled on 8 June 2000. The expected closing date was 31 December 1999, but actual closing was completed on 8 June 2000.

9. The project completion report (PCR),[7] which was circulated to the Board on 8 January 2002, rated the Project successful. The PCR cited the Project's realization of its development objectives by contributing to PWP's achievement in reducing population growth from 3.1% to 2.6% per year. The IEC campaign raised awareness of and demand for family planning services, while VFPWs effectively improved access to these services. The Project made a

[6] The opinions given under this section are those reflected by the project completion report, and thereby represent the operational department's point of view in January 2002.

[7] ADB. 2001. *Project Completion Report on the Population Project in Pakistan*. Manila.

positive contribution to empowering women by recruiting and training village women as VFPWs. This has enhanced their status in the community, and demonstrated the advantage of educating girls. Their earnings were used to improve their standard of living and their families'. At the time of the PCR, the Government had adopted the reproductive health program and prepared a basic package of services to be made available throughout the country. To assist the Government in this initiative, ADB provided a loan (Loan 1900-PAK[8]).

10. It was, however, noted in the PCR that performance with respect to institutional strengthening and improved management and planning capacity, including monitoring and evaluation, was less than anticipated and less than satisfactory. MOPW's performance as the executing agency was satisfactory, but coordination with provinces was weak. Financial and economic analyses were not undertaken at project appraisal or completion.

11. The PCR noted that, except for the VFPW scheme, the TA objective to develop the institutional capacity of MOPW was not achieved and there were no improvements in the monitoring or evaluation functions of MOPW or the PWDs. It appears that the consultants were overextended with other assignments. No rating was given for the TA.

F. Operations Evaluation

12. This PPAR assesses the Project's relevance, efficacy, efficiency, sustainability, and institutional development and other impacts. It also identifies lessons and follow-up actions for ADB's ongoing and future operations in the population sector. The PPAR presents the findings of the Operations Evaluation Mission (OEM) that visited Pakistan in July–August 2003 and whose activities included interviews and focus group discussions. The PPAR incorporates information gathered from discussions with officials in central and provincial ministries and departments for population and welfare, health, RTIs, RHSCs, family welfare centers, PWTIs, related aid agencies, and nongovernment organizations (NGOs). A tracer survey of VFPWs and beneficiaries from selected project districts in all provinces was carried out in September 2003. Discussions and interviews were held and questionnaires were distributed to 115 VFPWs and 118 beneficiaries. The report on the survey is provided in Appendix 2. Copies of the draft PPAR were provided to the Government, MOPW, and ADB staff concerned for review and comments, which were taken into account when finalizing the PPAR.

II. PLANNING AND IMPLEMENTATION PERFORMANCE

A. Formulation and Design

13. The Project's goal was to support the Government's PWP and SAP in their efforts to reduce population growth, increase the CPR, and decrease the TFR. To achieve this goal, the Project was designed to improve the accessibility and quality of family planning services, as well as strengthen the institutional capacity of Pakistan's population program. The OEM considers project design and implementation highly relevant to both government and ADB objectives.

B. Achievement of Outputs

14. Achievement of outputs is reported following the Project's four components: (i) service delivery; (ii) HRD and training; (iii) IEC; and (iv) planning, management, and research. Achievement of project targets is shown in Appendix 3.

[8] ADB. 2002. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Islamic Republic of Pakistan for the Reproductive Health Project.* Manila.

1. Service Delivery

15. The service delivery component comprised two integrated subcomponents: (i) recruitment, training, and deployment of VFPWs; and (ii) construction and renovation of RHSCs. These subcomponents were integral parts of the Eighth Five-Year Plan. The Project recruited and trained 11,570 VFPWs against the revised target of 12,000 VFPWs. The original target was for the Project to finance 8,000 VFPWs out of the Eighth Five-Year Plan target of 12,000 VFPWs. During the midterm project review, ADB agreed to accommodate the Government's request for the Project to cover the entire Eighth Five-Year Plan target of 12,000 VFPWs. These VFPWs were employed by MOPW, and their responsibilities were to (i) register all eligible couples in their villages; (ii) provide information on family planning, contraceptive methods and their side effects, family planning, basic medical services, and health education; and (iii) conduct follow-up visits to clients.

16. These services were mainly targeted to women in poor, remote areas where unmet need for contraception was high. The VFPWs' scheme was based on regional experiences, thus it was well accepted by Pakistan's program managers. Pilot testing of the scheme was conducted in selected districts, and the TA attached to the Project supported this subcomponent. MOPW's service statistics reveal a rapid increase in the number of clients served by VFPWs from 118,000 to 265,000 between 1997 and 2000. The 2001 national household survey also shows a rise of CPR from 6% in 1990–91 to 22 % in 2000–01.

17. The Project established 184 training centers compared to a target of 191. The centers were provided with the necessary equipment, and 127 trainers and 301 supervisors were involved, compared to the appraisal targets of 191 and 390, respectively. Among others, these centers trained 11,570 VFPWs. MOPW launched its VFPW scheme in 1992–93 as part of its Accelerated Population Program on a pilot basis to enhance access and coverage of family planning services. Ministry of Health (MOH) also launched its own National Health Workers' Program at the community level as part of the Eighth Five-Year Plan in 1993–94 to improve primary health care (PHC), including family planning, immunization campaigns, maternal care, and tuberculosis prevention. The VFPWs under the MOPW mainly focused on family planning services, while the female health workers (FHWs) under MOH focused on PHC. The number of FHWs placed in communities rose to around 20,000 under the Social Action Program Project I (SAPP-I)[9] in 1995–96 and to 40,000 in 1998–99. Their number was frozen to 43,000 in 1999–2000 to help management consolidate gains and assess past performance and future strategies. The FHW program increased the PHC coverage of the poor population segments in rural areas and urban slums.

18. With the endorsement of the Reproductive Health Package by both MOH and MOPW in 1999, it was necessary to minimize duplication and use available resources more efficiently. This resulted in the transfer of the female VFPWs to MOH, a decision jointly agreed by the two ministries in 2001–02 and completed in July 2002. Male VFPWs remain the responsibility of MOPW. The transfer of female VFPWs has raised the number of workers to around 70,000. VFPWs were screened to ensure that the knowledge and expertise of FHWs in MOH goes beyond family planning. Those that passed screening received additional training in mother and child health, as well as in nutrition.

[9] SAPP-I represents the financing and aid agency assistance to the Government's reform agenda in the sectors covered by SAP. It was the first phase of the Project between 1993 and 1996, funded by a consortium of aid agencies including ADB, the Department for International Development of the United Kingdom (formerly the Overseas Development Administration), World Bank, and Royal Netherlands Government, totaling $589 million.

19. The Project constructed 46 RHSCs, compared to the target of 51 RHSCs. Five RHSCs in Punjab were not built because space was not available in four selected hospitals and the PWDs and provincial-level departments of health disagreed on the location of the fifth within the selected hospital. The OEM observed that RHSCs were fully operational. All of them were provided with small operating theaters, equipment, medicine, furniture, and vehicles. Quality, particularly aseptic conditions in operating theaters, varied between RHSCs and seemed to depend heavily on the knowledge and compliance of staff in charge.

2. Human Resource Development and Training

20. This component was expected to cover two RTIs and two PWTIs. Two RTIs were constructed to train paramedics and doctors on reproductive health and family planning. To meet the rising demand, RTIs also trained additional family welfare workers. Two RTIs (Islamabad and Peshawar) were visited and the OEM observed good-quality training, particularly in Peshawar. The Government also constructed 10 RTIs. All of the RTIs' training coverage extended beyond the public sector to include training to private institutions and NGOs.

21. The Project included two PWTIs for management-related issues. However, the loan provision for international consulting services to upgrade nonclinical training and improve management capability at PWTIs was not used because grant funds were available from United Nations Populations Fund. PWTIs were not built because the Government banned new construction. Savings of $1.652 million were reallocated to support additional requirements for equipment, furniture, vehicles, training, salaries, and expenses for staff development, monitoring, and research. Although the Project's support for PWTIs was reallocated, these institutions were included in the field visits as they are partly responsible for training male motivators to support the future reproductive health[10] and family planning program. The OEM found that PWTIs were not performing well, unlike RTIs.

3. Information, Education, and Communication

22. The Project supported Pakistan's IEC program by producing radio spots in regional languages and announcements in electronic and print media. This support played a major role in increasing awareness for family planning, particularly the methods and sources of availability. The methodology and design of the IEC campaign was implemented in close collaboration with MOH. Counseling skills provided to VFPWs have also supported the IEC campaign. The IEC strategy has been decentralized, and PWDs have been provided with the budget and responsibility to design the plans, activities, and focus of their IEC campaigns. The IEC focus is now shifting to train 10,000 teachers by working closely with the Ministry of Education. Necessary changes are being made in the curriculum of the middle and secondary schools. VFPWs' training in interpersonal communication skills were designed with a built-in mechanism for decentralization, a strategy that appears to have been effective.

4. Planning, Management, and Research

23. One project component was planning, management, and research to improve the strategic management expertise and capacity both at MOPW and PWD, thus supporting decentralized management (Appendix 4 shows the organizational structure of MOPW and PWDs in all provinces). This component helped build the foundation for decentralization, which started in 2000. Because the Project's assistance in building PWTIs and providing international

[10] ADB supports the reproductive health program through Loan 1900-PAK (footnote 8).

consultancy was reallocated (para. 21), the objectives of the planning, management, and research component envisaged during appraisal were only partly achieved.

24. The planning process was reviewed and improved under the SAPP-I process during 1995–1999 through the evolvement of federal- and provincial-level annual operational plans for the population welfare sector. The plans were based on an agreed reform agenda that included decentralization, departmental capacity-building to prepare annual operational plans, monitor progress according to agreed indicators, and institutionalize these mechanisms to build ownership. However, the planning process continues to be supply-oriented, depending on available financial allocations.[11] Monitoring of field and program activities saw significant improvement during 1995–1998, but these efforts were not fully institutionalized. The focus on program monitoring took a downturn in 1998 and was revived in 2002. The Project also supported the decentralization process, but real implementation only started in 2000. Studies related to planning, management, and the VFPW scheme were conducted both by the Project and the TA.

C. Technical Assistance

25. The TA for institutional development and capacity-building at MOPW was unsatisfactory, although the technical support for the VFPWs scheme was satisfactory. The TA's contributions included a baseline survey; operational research on VFPWs in pilot districts by developing curricula, material, and manuals; improving and clarifying responsibilities and duties; helping address policy issues; and forming consensus among MOPW officials on various aspects of the scheme (Appendix 5). However, the TA failed to improve coordination between MOH and MOPW, which could have helped in minimizing the difficulties encountered in developing and placing FHWs. The consulting firm selected for the TA was more suited to providing technical expertise on reproductive health and family planning. It has minimal institutional development or capacity-building expertise and was overloaded with other assignments. The firm did not have the necessary relevant competence to engage comprehensively on the terms of references (TORs). Selection of consultants did not highlight past relevant experience. The TA design was overly ambitious and had vague TORs.

26. The TA aimed to (i) provide advisory services on policy and institutional matters related to PWP, (ii) strengthen the strategic management capability of MOPW and PWDs, and (iii) enhance the institutional capacity for population welfare services by supporting program planning and management. The TA consultants began work in August 1994. As a result of the extensive work on the VFPW scheme, the research base for family planning was expanded. The workshops and the development of curricula, materials, and manuals were effective in clarifying assignments, improving implementation, and addressing policy issues. The target for training activities, including the study tours, was achieved.

27. While the consultants performed well on the VFPW component of the TA, the main requirements related to institutional development were not met. Areas the TA did not address included innovative ways to enhance cooperation between MOPW and MOH; developing the strategic management capability of MOPW and PWDs; improving monitoring and evaluation at MOPW and PWDs; and implementing a management information system, even for the VFPW scheme. The objective to develop the institutional capacity of MOPW was not achieved. Moreover, TA completion was delayed by more than 2 years.

[11] The Government will continue to fund PWP for the next 5 years.

28. The major TA objectives were neglected and the emphasis was placed on the VFPW scheme. Research undertaken was not agreed with MOPW or included within the TA objectives. No significant contribution was made in improving MOPW's management or organizational structure, and there was no interaction during 1995–1997 when MOPW evolved its own rigorous desk monitoring system linking federal, provincial, and district offices. This system is still not operating.

D. Cost and Scheduling

29. The actual project cost amounted to $30.6 million, which was 21.5% lower than the appraisal estimate of $39.0 million. The reduction was attributed to the lower-than-anticipated cost of civil works (including the cancellation of construction of two PWTIs), the unutilized provisions for consulting services, and a weaker rupee against the dollar. By the time of loan closing on 8 June 2000, $23.07 million had been disbursed and the balance of $1.49 million was cancelled. ADB financed $12.9 million of the foreign exchange cost of $13.4 million and $9.6 million of the local currency cost of $17.2 million. There were variations in the allocations during implementation. While savings were realized in several categories, additional requirements were noted in others such as equipment, furniture, vehicles, training, salaries, and staff development. These adjustments in allocation did not pose any significant impact on the achievement of project outcomes.

30. Although delays were encountered in individual components, the Project was completed on schedule. The delays were mainly caused by the fiscal crisis in Pakistan causing delayed release of funds for project implementation. Although completed by the end of December 1999, the loan account remained open until 8 June 2000 to enable processing of withdrawal claims.

E. Procurement and Construction

31. When the loan provision to upgrade nonclinical training and management capability at the PWTIs was reallocated, procurement for consulting services was not carried out. As envisaged during appraisal, civil works were executed by the provincial-level communications and works departments and PWDs through force account or awarded after local competitive bidding. Delays in tendering civil works contracts due to inadequate planning resulted in slower completion of construction and renovation. Land acquisition and site selection also contributed to the delay. Although the facilities constructed were limited in terms of space, the contractors engaged were generally satisfactory and the buildings well maintained. Procurement of equipment and instructional materials were mostly done locally and separately by the PIUs, so international competitive bidding and international shopping procedures were not applied. Contract packaging of similar items was not carried out because there was no procurement plan.

32. At the time of the OEM, construction and renovation works had all been completed except for five RHSCs (para. 19). The OEM inspection showed that construction and renovation of RHSCs and RTIs was satisfactory and well maintained. To accommodate the comprehensive approach to reproductive health, all necessary rooms, including an operating theater, were provided. Due to limited space in district hospitals, these rooms are smaller than planned in many cases. The RTIs were also fully operating and reasonably maintained. The RTI in Islamabad could have been better designed and had larger training capacity if it had more classrooms and an auditorium, rather than its present design, which accommodates big management office, supervisory meeting rooms, and some unnecessary spaces.

F. Organization and Management

33. Covenants to support project outcomes were generally complied with. Compliance was delayed for some covenants, such as maintenance of separate accounts and submission of audited accounts, financial statements, and auditors' reports. Appropriate monitoring indicators, targets, and goals and a mechanism for collecting baseline data were not prepared during appraisal. In addition, no project framework was prepared. Project frameworks became mandatory in 1998.

34. The envisaged organizational project management structure was established, involving MOPW and PWDs. ADB required full-time staff for the Project, but appointments of project directors and PIU staff were made in addition to, or incorporated into, regular assignments. While MOPW's performance was satisfactory, coordination with the provinces was weak. Improved coordination would have made provincial-level staff more aware of the project targets and objectives, as well as ADB's requirements in terms of procurement planning, financial management, and reporting. During the OEM, PIU managers raised the issue of inadequate information and training in ADB administrative procedures, which were eventually remedied midway through implementation.

III. ACHIEVEMENT OF PROJECT PURPOSE

A. Operational Performance

1. Service Delivery

35. The Project's main objective was to improve the accessibility and equity of access to good quality family planning services and information on family planning methods, particularly to women in poor and remote areas where unmet need for contraception was high. The impacts of recruiting and training 11,570 female VFPWs in rural areas included additional income for rural households, empowerment of women, and enhancement of women's self-esteem in a very conservative society. It has also increased the awareness on population, family planning, and health issues in the community, enabled discussion among couples regarding family size and family planning, and improved the right for women to make reproductive health choices. The overall impact surpassed expectations, as these VFPWs conducted house visits, motivated, and won the confidence of illiterate and poor women. These women had wanted to practice family planning but lacked mobility to such facilities and were hindered by cultural barriers and illiteracy.

36. VFPWs provided access and services to around 2.3 million households. The number of direct beneficiaries is estimated to be 2.5 million. They were provided easy access to family planning services, accurate knowledge regarding various contraceptives, and referral to the nearest facility for clinical services. The workers gained a professional status and respect in their neighborhoods through their services and counseling meetings. Their presence in their communities became a source of direct access to services and information. The beneficiaries also benefited in accessing drugs for anemia, minor ailments, and vitamins. Infants and young children (2 to 3 per household) also benefited through prevention and/or cures for malnutrition, anemia, diarrhea, and respiratory infections. By project completion in 1999, almost 10 million married women and children had benefited from various services of VFPWs.

37. The CPR in rural areas increased more than threefold from less than 6% (1990–91) to around 22% (2000–01). Appendix 6, Table A6.1 shows the outcome indicators for CPR, TFR, and the unmet family planning needs of rural and urban areas between 1991 and 2001.

Appendix 6, Table A6.2 indicates the CPR for 2001 and its projection in 2005, while Table A6.3 presents the trend in critical demographic indicators. According to surveys, major beneficiaries have been the young mothers who have stayed away from family planning practices because of traditional travel restrictions. The VFPW vicinity survey revealed a CPR level of 51% (2000–01) reflecting much greater impact in the vicinity of workers' rural localities. Easy access is also translated into continuity in use of contraceptives, which increased acceptability and had a greater effect on fertility. Unlike urban contraception users, users' surveys reveal that the rural users preferred birth spacing to limiting fertility. A rough assessment of number of births averted by PWP reflects that rural users benefited by not bearing almost 1 million births during 1998. Cumulatively, rural women averted more than 3 million pregnancies during 1994–1999, a phenomenon that had direct and indirect effects on mothers, society, and the economy.

38. The OEM observed that RHSCs were reasonably maintained. A survey in 2001 regarding RHSCs[12] showed 84% were easily accessible and 92% of clients were satisfied with their services. MOPW's service statistics show a rapid increase of female sterilization from 85,000 cases to 124,000 cases between 1993–94 and 1999–2000.

39. The comprehensive approach to reproductive health services adopted during the International Conference on Population and Development in 1994 was followed by placing RHSCs adjacent to gynecology, maternity, and pediatric departments, thus providing easy access for staff and clients to interact and share services. On average, these hospitals serve middle and low socioeconomic classes. Some RHSCs are located close to slums, thus serving poor women living in these areas (i.e., Khuda ki Basti in Karachi). Delays in the release of funds to operate these centers have occurred in the past, but this problem has been solved. A number of RHSCs have inadequate PWD staff and are temporarily managed by senior gynecologists already busy with routine hospital duties. This has caused such facilities to perform poorly. Recruitment is currently in process and women medical officers will be placed in the centers within the year after necessary training.

2. Human Resource Development and Training

40. The project components were designed in an integrated manner to achieve long-term objectives and goals. Human development and training focused on improving the quality, supply, and distribution of doctors and paramedical staff in clinical family planning services, and training VFPWs and government staff in nonclinical matters. Pre-service training capacity was enhanced to meet growing staff requirements of the program facilities, while in-service training of doctors, paramedics, and staff of other departments was regularized to meet the demand for contraceptive methods. Revision in the curriculum and changes in scope of services at all levels were made to meet the challenges of the paradigm shift toward reproductive health.

41. The Project upgraded two reproductive health services master training centers and seven reproductive health services training centers. These centers regularly provide in-service and refresher technical training courses for MOPW and MOH staff, NGOs, and the private sector in family planning and reproductive health. With the establishment of these centers, MOPW has been able to produce qualified reproductive health professionals and assist other departments in family planning and reproductive health services. The doctors trained by the reproductive health services training centers enhanced the skills of medical officers of other RHSCs, thus improving the reproductive health service availability across districts in Pakistan.

[12] National Institute of Population Studies. 2001. *Situation Analysis and Users' Survey of RHS Centers*. Islamabad.

42. The construction of two RTIs with training and accommodation facilities has boosted the regular output of trained family welfare workers studying on an 18-month course. Equipment and necessary teaching aids has raised the quality of training. The OEM visited two RTIs (Islamabad and Peshawar) and observed that they were fully operational and well maintained. The RTIs also receive trainees from other line departments, NGOs, and private sector. The in-service training uses active participatory methods and was conducted professionally. The RTIs demonstrated effectiveness in their effort toward HRD.

43. The Project played a significant role in improving the skills of VFPWs, doctors, and paramedics. These skills did not only provide better opportunities to the staff in their working environment, they built confidence in presenting the case for family planning within the broader scope of reproductive health. All of the VFPWs trained were deployed, and all doctors and paramedics trained continue to work in their original institutions. The Project has contributed toward building an environment for comprehensive reproductive health, shifting away from the singular family planning approach.

44. To meet the emerging challenges, MOPW and PWDs will now focus on building the skills of male mobilizers. Because of limited capacity within the Ministry, the training of these mobilizers is being outsourced to reputed agencies in all provincial headquarters. The ADB-funded Reproductive Health Project (footnote 8) will address these matters. Similarly, the training of newly recruited administrative staff by the provincial departments will be outsourced to the National Institute of Public Administration. Doctors and paramedics will continue to receive training in RTIs and RHSCs. During the OEM, staff from MOPW and MOH expressed the urgent need for training in infection prevention, adolescent sexuality, modern contraceptive technologies, counseling on safe motherhood, and complications arising from abortion. With the increase of RTI basic training from 18 to 24 months, the above subjects will be incorporated in the reproductive health curriculum.

3. Information, Education, and Communication

45. One project purpose was to increase awareness of the benefits and demands for family planning services. To achieve this purpose, the Project's interventions focused on generating demand by sharing critical information and messages, and supporting a motivational campaign. It was recognized that there was a gap between knowledge and practice of family planning, which needed immediate attention and a policy shift. Accordingly, programmatic changes were adopted in the late 1990s to focus on reproductive health issues, reaching out to segments of population that were slow to use contraceptives. A gradual transition in key messages from number of children to birth spacing, maternal health, child survival, and greater acceptance of having female children was a major contributing factor to achieving its goals.

46. A recent household survey[13] reveals that there are signs of improvement in the knowledge and use of contraceptives in Pakistan, and that television is the most important medium in urban and rural areas to convey messages on family planning and population issues. Print media did not play a significant role in promoting the objectives because of a high illiteracy rate among women in Pakistan. The project support has been acknowledged as a catalyst in enhancing awareness on family planning and population issues, as well as increasing the demand for family planning services and contraceptives.

[13] National Institute of Population Studies. 2000. *Effectiveness of Media Messages in Promoting Family Planning Program in Pakistan*. Islamabad.

4. Planning, Management, and Research

47. The Project was designed to strengthen MOPW's planning and management capacity and their research activities for population welfare services at different levels. In building the capacity for planning and strategic management both at MOPW and the provincial departments of population welfare, the Project contributed to reviewing and reforming the population policy and decision-making process. Institutional strengthening envisaged support to four major elements: management and planning, operations and system research, monitoring, and evaluation. Central to this component was project assistance to the PWTIs and the attached TA. However, assistance to construct PWTIs and support for an international consultant were reallocated (para. 21).

48. A portion of the assistance for PWTIs was used to support program monitoring of outcomes and impacts through research and evaluation studies. The studies were baseline surveys, situation analysis, progress reports, evaluation of programmatic initiatives, and clinical aspects of various contraceptive methods. No system-related studies were undertaken to provide support to improve existing systems and institutions. The studies contributed to improving program managers' understanding of ground realities but were not adequately translated into remedial measures. There was a lack of linkage between monitoring and management decision-making.

49. Decentralization was included in the Project. However, the Government only paid serious attention to the issue during 2000–2002. The Government, through a consultative process with all provincial governments, decided to transfer PWP to the provinces in 2002. The transfer encompassed transfer of employees (11,864 employees) to respective provincial governments; recruitment, transfers, and promotions of staff; payment of salaries; and planning of program activities. Amendment Ordinance 2001 provided full administrative and financial autonomy to provincial governments to implement PWP field activities. Simultaneously, another exercise undertaken by the Planning Commission focused on downsizing. MOPW voluntarily abolished 173 posts in the Ministry before decentralization.

50. The national governments release of funds to provincial authorities as a single budget line item provides provincial authorities leverage to spend according to their needs, with necessary consultation with the provincial finance department. The provincial departments now produce their own annual plans, including new facilities and staff recruitment.

51. Three national household surveys were undertaken: Pakistan Contraceptive Prevalence Survey 1994, Pakistan Fertility and Family Planning Survey 1996–1997, and Pakistan Reproductive Health and Family Planning Survey in 2000–2001. These provided good trend data on a number of indicators including CPR, TFR, method mix, and source of services. Research studies were integral to allowing MOPW to use field-based findings to shape future reforms. The Project supported research to allow MOPW to utilize field-based findings to improve planning and management.

B. Performance of the Operating Entity

52. In general, the performance of MOPW as the executing agency was satisfactory. Most project targets were met, and staff were provided to implement and reach project objectives. However, coordination with provinces could have been better. This was largely caused by the inadequate information provided to the provincial PIUs on project targets, objectives, and administrative requirements. Management was heavily centralized, and only in a later stage did ADB provide PIUs with adequate information and guidance to minimize delays.

C. Economic Reevaluation

53. Data constraints prevented an economic analysis from being undertaken at appraisal stage or at project completion. During the OEM, efforts were made to conduct an economic assessment with reference to the service and management data of PWP as a whole. Disability-adjusted life years were used for the cost-effectiveness analysis of the Project (Appendix 7).

D. Sustainability

54. The Government is committed to provide family planning services especially in rural areas, through facilities and innovative measures. The average allocation for the population program relative to gross domestic product (GDP) is 0.07% of GDP for 1992–2003.[14] A peak occurred in 1996–97 and a trough in 2001–02. A decline trend was observed during 1996–2002, but given the increased allocation for 2003–2004, the general level of 0.07% is attained. Appendix 8 presents the trend in GDP and percent of expenditure for the population sector, and Appendix 9 shows the allocation, expenditure, and foreign assistance to PWP during 1993–2002.

55. Based on the success in achieving targets in the population welfare sector, the Government continues to address the population issue under its Poverty Reduction Strategy Paper (2003–2008) and its Population Welfare Perspective Plan (2002–2012). Reducing population growth remains the critical focus of the Plan. In order to achieve the replacement fertility level by 2020, the Population Welfare Five-Year Plan within the poverty reduction strategy focuses on curbing population growth from 2.06% in 2003 to 1.72% by 2007–08. The program coverage will be increased from 65% in 2001 to about 85% by 2007–08 and CPR will be increased from 34% (2003) to 45% in 2007–08. The PWP needs to further expand accessibility to good quality reproductive health services by expanding public sector infrastructure (Appendix 10, Table A10.1).

56. The planned infrastructure expansion is ambitious, thus the effort required to meet this target is also expected to be tremendous. To address the ambitious goals and objectives, the Government has allocated much higher investment targets for the population sector. For the current Five-Year Plan (2003–2008), PRs20.978 billion is recommended under the Population Commission-I (PC-I) for the sector. The allocation for the first year (2003–04) is PRs3.19 billion, 45% more than the previous year's allocation. Allocations for 2004–08 increase gradually (Appendix 10, Table A10.2). These allocations, relative to projected GDP, place much more significance than in previous years. Population sector spending rose to 0.07% of projected GDP in 2003–04 and is expected to further rise to 0.09% in 2007–08. Aid assistance to the population sector is given in Appendix 11. The large investment reflects Government's commitment to sustain PWP, and poses a tremendous challenge to MOPW and the departments of population welfare to meet the input targets and address emerging needs in the area of reproductive health. With the transfer of VFPWs to MOH, MOPW now has fewer human resources. MOPW needs to be proactive and innovative in increasing coverage, access, and quality of services to effectively utilize allocated funds by working closely with MOH, other relevant institutions, the private sector, and NGOs. Contracting out service provision to NGOs could be a viable option in light of decentralization.

[14] Data on GDP taken from Economic Advisor's Wing, Economic Affairs Division, Government of Pakistan. *Economic Survey 2002–03.* Islamabad.

IV. ACHIEVEMENT OF OTHER DEVELOPMENT IMPACTS

A. Socioeconomic Impact

57. The Project focused on the poor, particularly rural women, who were experiencing health risks related to frequent and closely-spaced pregnancies. High unmet need for contraception existed because of poor access to services; low awareness of services; and poverty, which impeded them from traveling to urban areas to access these services. The Project recruited and trained 11,570 VFPWs, who were deployed by MOPW, each serving an average of 200 rural households, and 46 RHSCs that provided support to referral cases from rural and urban areas. Thus, the Project developed skills and provided jobs for rural women. A majority of workers are poor, and work as VFPWs to supplement their household incomes. The most encouraging element is the empowerment impact for women deciding how to spend their salary. Appendix 2, Table A2.5 shows a list of preferred items purchased by VFPWs. The survey also noted that women were satisfied with their decisions to become VFPWs. This is a strong indication of social change in a society where family planning messages conveyed by male family planning workers were rebuked in the 1970s and 1980s. VFPWs made house calls and were able to provide services within their cultural norms and won respect without violating traditional customs. The major impact has, therefore, been their role in making family planning accessible to the needy.

58. The benefits to the rural poor of birth spacing and limiting pregnancies include better health status for mothers, bwer infant mortality, and a lower unmet need for contraception, which leads to decreased chances of abortion and more time for mothers to spend on their children, themselves, and other responsibilities. The economic gains can be assessed for pregnancies and births averted by family planning acceptors in the rural areas. Expenses during pregnancy, normal delivery, clothing, and nourishment during the first month, and the remaining period of infancy are around PRs13,000 per household. Savings for rural families living near VFPWs, practicing family planning, and averting births totaled PRs12 billion for 1998–99. Project support contributed in reducing poverty by reducing unwanted pregnancies and births and providing employment to 11,570 VFPWs.

B. Environmental Impact

59. The Project did not pose environmental problems as the construction and renovation of RHSCs was well-planned and executed, involving mainly small-scale physical infrastructure subprojects. The Project had a positive impact to the environment, as it had also included IEC on health, sanitation, and environmental protection.

C. Impact on Institutions and Policy

60. The Project focused on strengthening planning and management capacity at the federal, provincial, and district levels. Before 1993, MOPW had no experience in evolving and establishing grassroots programs such as the VFPW scheme, for which the Project provided critical development and implementation inputs. With project support, MOPW has successfully implemented the scheme, which has had a significant impact on the population program.

61. Decentralization was an essential part of management reforms to improve program efficiency in decision-making. This was an important aspect supported by the Project and Social Action Program Project (SAPP). In this regard, district officers and program staff in charge of RHSCs have been given drawing and disbursing powers along with imprest accounts for operational purposes, which could be replenished when needed. Necessary training of various

staff was also undertaken to enable them to manage the funds/accounts. Due to severe financial crunch during 1995–1998, cash availability to all designated officers was seriously hampered, restricting the reform process. Since 1999, there have been no problems with availability of funds. Decentralization of PWP was further initiated in 2002 as part of long-term management reforms. The provincial departments now have full autonomy to develop their own strategies and initiatives as well as to plan and budget such activities. Provincial governments have also modified administrative structures according to their prevalent system.

62. Institutional strengthening had mixed results during implementation and beyond. The MOPW employed short-term traditional mechanisms to improve program management and did not take any substantive measures to address personnel, governance, or management systems by incorporating a long-term vision. Unfortunately, the TA was weak in assisting MOPW for institutional capacity building. Moreover, project support for PWTIs—including assistance from international consultants for institutional development and capacity building—was reallocated at the Government's request (para. 21). The bulk of the money was reallocated to expand the VFPW scheme from 8,000 to 12,000 people. The focus of MOPW remained on using funds and inputs to the Program, while an organizational structure to sustain immediate gains in outputs and outcomes was not addressed. Providing services to poor communities is an area of the VFPW scheme that received attention under the Project, but with the shift of female VFPWs to MOH, new initiatives are needed in this respect. Institutional strengthening and improvement in management systems received less focus than expected and remains an area that requires attention.

63. In the early 1990s, population policy recognized the issues of coverage, access, and quality of service, as well as inadequate attention to rural areas. Two major initiatives were launched in 1993 to increase accessibility and availability of family planning services in urban and rural areas, including the VFPW scheme, the IEC campaign, and contraceptive social marketing. During this period, health policy acknowledged high population growth as a problem for the first time. The National Health Policy 2001 provides a framework for provinces in evolving their own plans according to their respective priorities and requirements. MOH and provincial-level departments of health recognize that family planning is part of the overall service package at all health outlets, and are making efforts to minimize duplication of services. Other aspects to ensure success of PHC efforts still need to be highlighted in health policy. The two policies reflect commitments on various aspects of the reproductive health components. Integrating VFPWs with FHWs and initiating activities such as focusing on males to streamline family planning, as well as other reproductive health areas, are newer dimensions to be consolidated and pursued in the years ahead.

64. MOH and MOPW population policies reflect the Government's increasing commitment to the population issue and provide guidance to mobilize greater resources. However, coordination between relevant agencies remains weak, specifically in avoiding duplication, providing complementary services, learning from each other's experiences, sharing information, and developing common targets and procedures.

V. OVERALL ASSESSMENT

A. Relevance

65. The Project's goal, purpose, and outputs were highly relevant and consistent with the Government's development policy to reduce population growth by reducing fertility levels, enhancing access to facilities, and increasing coverage of services across Pakistan, especially in underserved and rural areas. The Project envisioned equity of access as critical to achieving

its objectives, in line with ADB's operational strategy for Pakistan at appraisal and at evaluation. Its strategic interventions were relevant as problems caused by rapid population growth were impeding national development. The investment, which focused on rural areas, was also timely because grant assistance for urban-focused marketing of contraceptives had already received significant aid agency support in the 1990s. The emphasis on HRD, training, and institutional strengthening was also relevant. The survey also showed that most VFPWs and beneficiaries considered project initiatives highly relevant, and on average they considered these initiatives relevant (Appendix 2).

B. Efficacy

66. The Project aimed to help the Government reduce population growth from 3.1% in 1993 to 2.6% by 1998, and reduce the TFR to 5.4 from 5.97 births over the same period by increasing the CPR to 24%. Demographic surveys reveal that these targets were surpassed (Appendix 6). The performance of PWP was remarkable during 1990s, but more specifically during the project life from 1993 to 1999, a period that witnessed a rapid rise in contraceptive prevalence, awareness regarding contraceptives and family planning, coverage of family planning facilities, and access to services. The Project's support for IEC raised awareness of population issues and promoted demand for family planning. The Project achieved most of its targets (Appendix 3). Beneficiaries and workers also highly rated the efficacy of project initiatives (Appendix 2). Beneficiaries were mostly very satisfied with the services that VFPWs provided, particularly counseling for family planning and birth spacing and supply of contraceptives and medicines. Beneficiaries said VFPWs performed their duties well and found their services helpful. From the VFPWs' perspective, training was very useful and met the needs of their jobs. The Project was highly efficacious in reaching the targets for three of the four components (service delivery, HRD and training, and IEC). It was less efficacious in achieving the objective of building the capacity of MOPW in planning and strategic management, but it was efficacious in strengthening population welfare research activities (the objectives set for the fourth component for planning, management, and research). Therefore, the OEM concludes that the Project was efficacious.

C. Efficiency

67. The disability-adjusted life year approach has been used to determine the Project's cost-effectiveness (Appendix 7). As the Project supported PWP in its aim to reduce population growth from 3.1% to 2.6% per year by the end of the Eighth Five-Year Plan in FY1998, its achievements and impacts cannot be separated from those of the PWP. Components used for the cost-effectiveness analysis were all related to the family planning/reproductive health program, which were also the focus of the Project through RHSCs, VFPWs, IEC campaign, and training and research components. The survey also showed that VFPWs considered the project inputs highly efficient (Appendix 2). Based on the above, the Project is considered efficient.

D. Sustainability

68. With the transfer of female VFPWs, the capacity of MOH to provide reproductive health services has increased. MOH was in the process of expanding its delivery services in underserved areas. With this transfer, MOH received a trained workforce to supplement its community-based workers, enabling them to expand reproductive health care coverage in underserved areas. Health care field workers became increasingly focused on family planning services, supporting critical reproductive health needs. Other likely impacts of this transfer are the acceleration in the rural CPR and improved referral linkage with RHSCs.

69. The Government, under its Poverty Reduction Strategy Paper, allocates much higher investment targets for the population sector. For the current Five-Year Plan (2003–08) PRs20.978 billion is recommended under PC-I for the sector. The allocation for the first year (2003–04) is PRs3.19 billion, 45% more than the previous year's allocation. Allocations for 2004–08 gradually increase. Allocations relative to projected GDP rise to 0.07% in 2003–04 and 0.09% in 2007–08. In absolute terms, this provides a substantive boost for funding program activities. Project achievements are, therefore, sustainable.

E. Institutional Development and Other Impacts

70. All of the people trained under the Project continued working and spreading their knowledge in Pakistan's health and population sector. The Project's impact in institutional development was moderate (para. 61). However, it has had a substantial socioeconomic impact, particularly on rural women, both as VFPWs and beneficiaries (paras. 57–58, and Appendix 2), and a significant impact to Pakistan's population and health sector policies (paras. 63–64). The Project's impact on institutional development, policies, and socioeconomic conditions was significant.

F. Overall Project Rating

71. Based on the overall assessment of the relevance, efficacy, efficiency, sustainability, and impact on socioeconomic, institutional and policy developments, the Project is rated successful.

G. Assessment of ADB and Borrower Performance

72. ADB performed reasonably well in identifying, preparing, and supervising the Project. Implementation could have been smoother and unnecessary delays prevented if PIU managers, especially those responsible for monitoring and implementation at the provincial and district levels, were trained in ADB administrative procedures at an early stage, not only after experiencing bottlenecks. ADB responded well to the priorities of Pakistan's PWP, especially by expanding the VFPW scheme, the backbone of the program. The Borrower also performed well. Coordination with provinces and districts, which was initially weak, gradually strengthened, and project targets were achieved. Overall, ADB's and the Borrower's performances were satisfactory.

H. Overall Assessment of TA 2005-PAK

73. The TA's assistance to institutional development and capacity building at MOPW was unsatisfactory. It has also failed to assist coordination between MOH and MOPW, which could have helped minimize difficulties in developing and placing FHWs. Technical support to the VFPWs scheme was satisfactory. The consulting firm selected for the TA was better suited to provide technical expertise on reproductive health and family planning than it was to institutional development and capacity building. The TA's design was overly ambitious and the TORs were too general. The TA is, therefore, rated partly successful.

VI. ISSUES, LESSONS, AND FOLLOW-UP ACTIONS

A. Key Issues for the Future

74. The provincial population departments depend on federally supported PWTIs and RTIs for human development and training. There is a serious gap between the needs of the

departments and the capacity of the PWTIs. Systems—such as planning, financial, implementation, supervision, monitoring, information sharing, and coordination—should be reviewed and improved to meet the provinces' increasing demands. As part of the devolution plan, provincial governments have delegated many of their powers and activities to the district, including control over PWP. District-level governments still lack capacity for planning, management, and other necessary aspects of good governance.

75. The two PWTIs are understaffed and seriously lack capacity to meet provincial training needs. The 12 RTIs are well organized, better staffed, and performing much better than the PWTIs. Their pre-service training and in-service training schedules meet the provincial departments' needs and training methodologies are reasonably up to date.

76. The Government's large investment to sustain PWP poses a tremendous challenge to MOPW and PWDs to meet the targets and address emerging reproductive health needs. MOPW has fewer human resources since the transfer of female VFPWs to MOH. MOPW needs to be proactive and innovative in increasing coverage, access, and quality of services to effectively utilize the allocated funds by working closely with MOH and other relevant institutions, the private sector, and NGOs.

77. The policy on pricing contraceptives was a contentious issue between MOPW and MOH during the mid-1990s. MOH and the departments of health recently agreed to ensure availability of family planning services at all health outlets and to provide contraceptives at the lowest possible price. FHWs are allowed to retain the sale proceeds, and this has become an accountability issue for health workers. NGOs working in the same locations have reported that FHWs' sales of condoms to shopkeepers in rural areas were lower priced than announced by PWP. FHWs' dumping condoms has nullified the efforts of NGOs trying to sell condoms at prescribed rates. Pricing for public-sector stakeholders is constantly reviewed by MOPW, and MOH is formulating a uniform pricing policy for all public sector programs. The solution for this policy issue needs to be finalized.

78. There are no integrated management information systems regarding performance of various components in health and population welfare. This has caused continuous misreporting at lower levels and is exacerbated by weak supervision. The matter needs to be addressed to alleviate duplication and inaccuracy in reporting.

79. The planning approach remained supply oriented and did not involve the community. This condition needs to be amended as the supply approach tends to build around the budget and available finances rather than addressing areas of high unmet need.

B. Lessons Identified

80. Lessons derived from the Project include the following:

81. The Project has helped the Government achieve the goals for the IEC component through innovative initiatives such as customized promotional campaigns, participatory approaches, and local languages. This was critical in encouraging people to plan for smaller families.

82. No financial or economic analyses were undertaken at project appraisal or completion, and no baseline data was prepared to support comparative impact analysis. To enable high quality economic analysis, projects should incorporate baseline data, indicators, and supportive mechanisms during design.

83. The TA did not achieve its objectives because of (i) overly ambitious design, which covered factors such as operations, management, and research within a relatively short time period; (ii) vague TORs; (iii) the wrong experts for implementation; and (iv) inadequate review and guidance. To support institutional development, the TA should have focused on institutional capacity-building with specific TORs and rigorous review.

84. For smooth and timely project implementation, training in ADB procedures and systems is crucial and should have been provided to all PIU managers at an early stage. Clear information on project objectives, targets, and administrative procedures should have been provided to all staff responsible for monitoring and implementing the Project at the provincial and district levels. The project design should have been more program-oriented, thus making it easier to identify and monitor ADB's contribution.

C. Follow-Up Actions

85. The Government needs to develop an integrated management information system for its health and population welfare programs to enable accurate reporting by early 2005.

86. The Government needs to finalize a solution by mid-2004 on contraceptive pricing, an issue that has caused tensions among family planning providers in the field.

APPRAISAL AND ACTUAL PROJECT COST
($ million)

	Appraisal			PCR		
Item	**Foreign**	**Local**	**Total**	**Foreign**	**Local**	**Total**
Civil Works	1.089	5.090	6.179	1.105	1.871	2.976
Equipment, Furniture, and Vehicles	2.490	2.300	4.790	2.930	2.656	5.586
Medicines	2.250	0.711	2.961	1.305	0.396	1.701
Consulting Services	0.282	0.146	0.428	—	—	—
Training, Salaries, Staff Development, and Research Studies	3.000	11.690	14.690	4.559	6.223	10.782
Project Implementation	0.336	1.528	1.864	0.058	0.205	0.263
Incremental Recurrent Cost	2.000	5.500	7.500	2.992	5.855	8.847
Service Charge	0.588		0.588	0.474		0.474
Total	**12.035**	**26.965**	**39.000**	**13.423**	**17.206**	**30.629**

— = not available, ADB = Asian Development Bank, PCR = project completion report.

Sources: ADB. 1993. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan and a Technical Assistance Grant to the Islamic Republic of Pakistan for the Population Project.* Manila; and ADB. 2002. *Project Completion Report on the Population Project in Pakistan.* Manila.

TRACER SURVEY OF THE VILLAGE FAMILY PLANNING WORKERS AND BENEFICIARIES

A. Background

1. A tracer survey was designed to assess the impact and contribution of the village family planning workers (VFPWs)[1] to the community. The significance of these workers lies in their doorstep service delivery, counseling for family planning methods, and their referral to the nearest reproductive health service center (RHSC). The RHSCs provide comprehensive reproductive health and family planning services that include all contraceptive methods. The National Institute of Population Studies published a number of surveys in 2000 evaluating various aspects of VFPWs and RHSCs. It did not cover the satisfaction of beneficiaries and service providers on critical service-related aspects or the impact they felt from the program. A survey was designed to obtain information on the VFPWs' performance and the perceived benefits the beneficiaries[2] gained by being part of the community that the workers served. Since the Project supported VFPWs at the national level, the survey was also designed to visit and receive feedback from selected districts[3] in all provinces. The survey was conducted from 8 to 13 September 2003.

B. Methodology

2. The surveys focused on VFPWs and their beneficiaries (Table A2.1). Two types of questionnaires were developed on the relevance of services, task efficacy, efficiency, impact, and benefits of the VFPWs' activities. Responses were also sought from VFPWs on how they used their income and how this benefited them. The questionnaires were simple and coded for data entry. Responses were 3 for highly relevant/highly satisfactory, 2 for relevant/satisfactory, 1 for partly relevant/partly satisfactory, and 0 for not relevant/unsatisfactory.

Table A2.1: Interviews with VFPWs and Beneficiaries

Province	District	Workers	Beneficiaries
Sindh	Sanghar	21	15
	Hyderabad	12	15
Punjab	Rawalpindi	22	14
	Jhelum	19	14
	Faisalabad	21	12
NWFP	Peshawar	6	24
	Haripur	12	12
Balochistan	Quetta	10	12
Total	**8**	**115**	**118**

NWFP = North-West Frontier Province, VFPW = village family planning worker.
Source: Operations Evaluation Mission survey.

[1] The Ministry of Population Welfare employed VFPWs, who have since been redesignated female health workers and fall under the responsibility of the Ministry of Health after being screened and trained on primary health care issues.

[2] Beneficiaries are married women of reproductive age who live in the VFPWs' catchment areas.

[3] The districts were selected from all provinces, considering limited budget and time, population size, availability of VFPWs for interview, and agreement from population welfare departments' executive officers to facilitate interviews.

3. The survey team traced and interviewed 10 to 30 former VFPWs from selected districts in all provinces. Anonymity was maintained to encourage transparency and accuracy.

4. The survey team selected 12 to 15 households in every district for interviews. Households were randomly selected and one married woman of reproductive age (age 20–49) per household was chosen. Client anonymity was maintained. Questionnaires were translated in local languages including Punjabi, Sindhi, Hindko, Pushto, Balochi/Brahvi, and Urdu.

5. Survey questions were concerned with beneficiaries' knowledge about the VFPWs' (i) activities and visits, (ii) performance on specific areas of training, (iii) performance on various services, (iv) continuity of their services, and (v) benefits from the VFPWs' services.

6. The survey questions posed to VFPWs were related to (i) training, (ii) performance of specific tasks, (iii) perception of competence, (iv) utilization of earnings, and (v) the number of clients served and referred to health facilities.

C. Analysis of Responses

7. Questionnaires were distributed to 118 beneficiaries and 115 VFPWs. An analysis of the responses is presented in Tables A2.2–A2.5, followed by discussion and interpretations.

Table A2.2: Responses from 118 Beneficiaries on Relevance, Efficacy, and Sustainability

Summary of Questions		Mode	Mean	Standard Deviation	Mode Label
1.	Relevance of the VFPW services				
	FP	3	2.53	0.78	Highly relevant
	Maternal care	3	2.11	0.99	Highly relevant
	Child care	3	1.95	1.11	Highly relevant
	Treatment of common ailments	3	2.06	0.92	Highly relevant
	Health education	3	1.95	1.15	Highly relevant
2.	Satisfaction regarding number of visits made	3	2.48	1.04	Very satisfied
3.	Satisfaction with VFPW services:				
	Counseling for FP	3	2.49	0.83	Very satisfied
	Counseling on birth spacing	3	2.31	0.90	Very satisfied
	Counseling on maternal health	3	2.19	0.96	Very satisfied
	Supply of medicine and other items	3	2.14	0.97	Very satisfied
	MCH services	3	1.97	0.97	Very satisfied
	Treatment of minor ailments	3	2.03	0.95	Very satisfied
4.	Level of effort the VFPW displayed in serving the community	3	2.47	0.77	Very active
5.	Were services beneficial to you and your community?	3	2.46	0.78	Highly beneficial
6.	Was VFPW adequately trained to serve the community?	3	2.47	0.76	Highly adequate
7.	How often did you seek her services, i.e., went to her home to get health services/ information?	3	2.40	1.05	Once a month
8.	Should her services be continued or stopped?	3	2.48	0.72	Highly supportive
9.	VFPW's work attitudes and behavior				
	Courteous	3	2.45	0.81	Very good
	Appreciative	3	2.28	0.83	Very good
	Responsible	3	2.38	0.89	Very good
	Cooperative	3	2.55	0.70	Very good
	Respectful	3	2.61	0.65	Very good
10.	Satisfaction with VFPW's job performance	3	2.44	0.69	Very satisfied

FP = family planning, MCH = maternal and child health, VFPW = village family planning worker.
Source: Operations Evaluation Mission survey.

Table A2.3: Responses from 118 Beneficiaries on Efficiency

Summary of Question	Response (%)		Total (%)
In what ways were the village family planning workers beneficial to your community?	Positive	Negative	
Helped reduce the number of births	86	14	100
Prevented undesired pregnancies	72	28	100
Improved women's health	83	17	100
Lowered infant and child morbidity	77	23	100
Saved time for women in going to health center	74	26	100
Community accessed health care with least time	86	14	100

Source: Operations Evaluation Mission survey.

Table A2.4: Responses from 115 VFPWs on Relevance, Efficacy, Efficiency, Sustainability, and Other Impacts

Summary of Questions	Mode	Mean	Standard Deviation	Mode Label
Relevance				
1. Was training adequate for performing following tasks:				
Motivating people to use contraception	3	2.71	0.47	Very relevant
Informing about side effects	3	2.65	0.62	Very relevant
Using IEC material for motivation	3	2.22	1.10	Very relevant
Providing information on general health care	3	2.45	0.90	Very relevant
Keeping records	3	2.80	0.48	Very relevant
Making work plans	3	2.76	0.52	Very relevant
Efficacy[a]				
2. Usefulness of training with respect to your job description	3	2.84	0.45	Very useful
3. Performance of trainers	3	2.81	0.51	Very good
Efficiency				
4. Competence and confidence in performing tasks after training	3	2.66	0.49	Very confident
5. Clients were satisfied by services provided	3	2.81	0.44	Very satisfied
Sustainability				
6. Are you satisfied with your decision to become a VFPW?	3	2.77	0.62	Very satisfied
Other Impacts				
7. Worker spent her earnings by her own choice	3	2.61	0.57	Fully by own choice

IEC = information, education, and communication; VFPW = village family planning worker.
[a] Also under efficacy, 59% have received refresher training under the Project.
Source: Operations Evaluation Mission survey.

8. The ways VFPWs spent their salaries are shown below, based on 115 responses:

Table A2.5: Other Impact and Benefits Gained by 115 VFPWs

Impacts and Benefits	Percent
Earnings spent on the following items:	
Kitchen items/food	79
Clothing for children, selves, and husbands	75
Family health-related expenditures	70
Children's education	75
Utility bills	47
Household items	53
Paid fully or partly to acquire following household items from earnings:	
Gas heaters	9
Radio/tape recorders	8
Irons	8
Fans	16
Televisions	24
Room coolers	9
Washing machines	22
Household furniture	15
Bicycles	9

VFPW = village family planning workers
Source: Operations Evaluation Mission survey.

D. Discussion

9. The survey focused on VFPWs and their beneficiaries in various districts in all provinces. Only a fraction of the 11,570 VFPWs were interviewed to assess the relevance, efficacy, efficiency, sustainability, and other project impacts. The beneficiary feedback was an important part of this exercise. Likewise, the survey team interviewed only a fraction of the beneficiaries on the impacts of the VFPWs. The results are conclusive evidence, but they do indicate a societal change toward family planning. The section below presents findings from the VFPWs' and beneficiaries' responses.

10. Survey results show most beneficiaries considered project initiatives highly relevant. On average, the Project's support was rated relevant (2.53 for family planning, 2.11 for maternal care, 1.95 for child care, and 2.06 for treatment for general ailments). Most beneficiaries were very satisfied with the number of visits the VFPWs made. On average, they were satisfied (2.48). The VFPWs responded positively about the Project's contributions, especially motivating contraceptive use, informing women about their side effects, advising on health care, preparing work plans, and maintaining records. All of these areas have an average scale above 2.50. VFPWs said they rarely used information, education, and communication materials, implying that this area needs attention during training.

11. Beneficiaries and VFPWs also highly rated the Project's efficacy. Beneficiaries were highly satisfied with services, especially counseling on family planning, birth spacing, and supply of contraceptives and medicines. Beneficiaries found VFPWs placed less focus on maternal and child health (MCH) services, treatment for minor ailments, and maternal care (average scale 2 or below). Beneficiaries said VFPWs were very active in performing their duties and that their services benefited the communities (average scale 2.5). VFPWs said training was very useful

and met the job requirements (average scale 2.84). The trainers were rated highly efficient (average scale 2.81). They found refresher training less efficacious, and only 59% could recall any such effort. There is a need for refresher training, including more on MCH.

12. Beneficiaries saw a number of benefits from the VFPW scheme. The most prominent was reducing the number of births and improving access to needed services (86%). Fewer unwanted pregnancies, less infant mortality, and less time traveling to facilities were other areas considered important. VFPWs said training had increased their confidence and competence in delivering services (average scale 2.7) and that it had helped their work tremendously.

13. Sustainability of the initiative was also assessed. Beneficiaries found the VFPWs' training highly adequate (average scale 2.47) as reflected by a large proportion of beneficiaries visiting the workers' homes at least once a month. This close interaction is possible only if the community finds the VFPWs courteous (average scale 2.45), respectful (average scale 2.6), and cooperative (average scale 2.55). Most beneficiaries found VFPWs' performance highly satisfactory and strongly supported its role in continuing to provide reproductive health services. On average, they said they were satisfied with VFPWs' performance (average scale 2.48). VFPWs felt very good about their decision to become VFPWs and were very satisfied with their work (average scale 2.77).

14. The VFPWs' main responsibilities were providing basic family planning services and referral for MCH services. On average, the workers referred 66 clients (July 2001–June 2002) for such services to RHSCs, family welfare centers, and other related health centers and units. The VFPWs' interaction with clients was critical in enhancing their role, particularly as counselors.

15. Two-thirds of all VFPWs spent their earnings as they wished (average scale 2.61). Many VFPWs said they spent their earnings on their families' welfare, including food items (79%), school fees and clothing (75% each), and health care of family members (70%). Three household durables were popular expenditures: televisions, washing machines, and fans. These items display social status and acknowledge women's contribution toward family welfare. Employment has helped them make their own decisions and meet household needs. Empowerment of female workers has not only benefited their communities but their families. Contributing to family well-being encourages VFPWs to work harder.

16. Survey results show beneficiaries and workers highly rated project initiatives. Survey findings show the Project can be considered successful.

ACHIEVEMENT OF PROJECT TARGETS

Category	Planned	Actual	% Achieved
A. Training Courses[a]			
1. Training of Village Family Planning Workers	12,000[b]	11,570	96.4
2. Training of Paramedics	12,320	10,609	86.1
3. Training of Doctors	2,845	3,583	125.9
B. Training Centers (Construction and Renovation)[c]	191	184	96.3
C. Reproductive Health Service Centers[c] (Construction and Expansion)	51	46	90.2

[a] Participants were appointed from all provinces in Pakistan (Balochistan, North-West Frontier, Punjab, and Sindh).

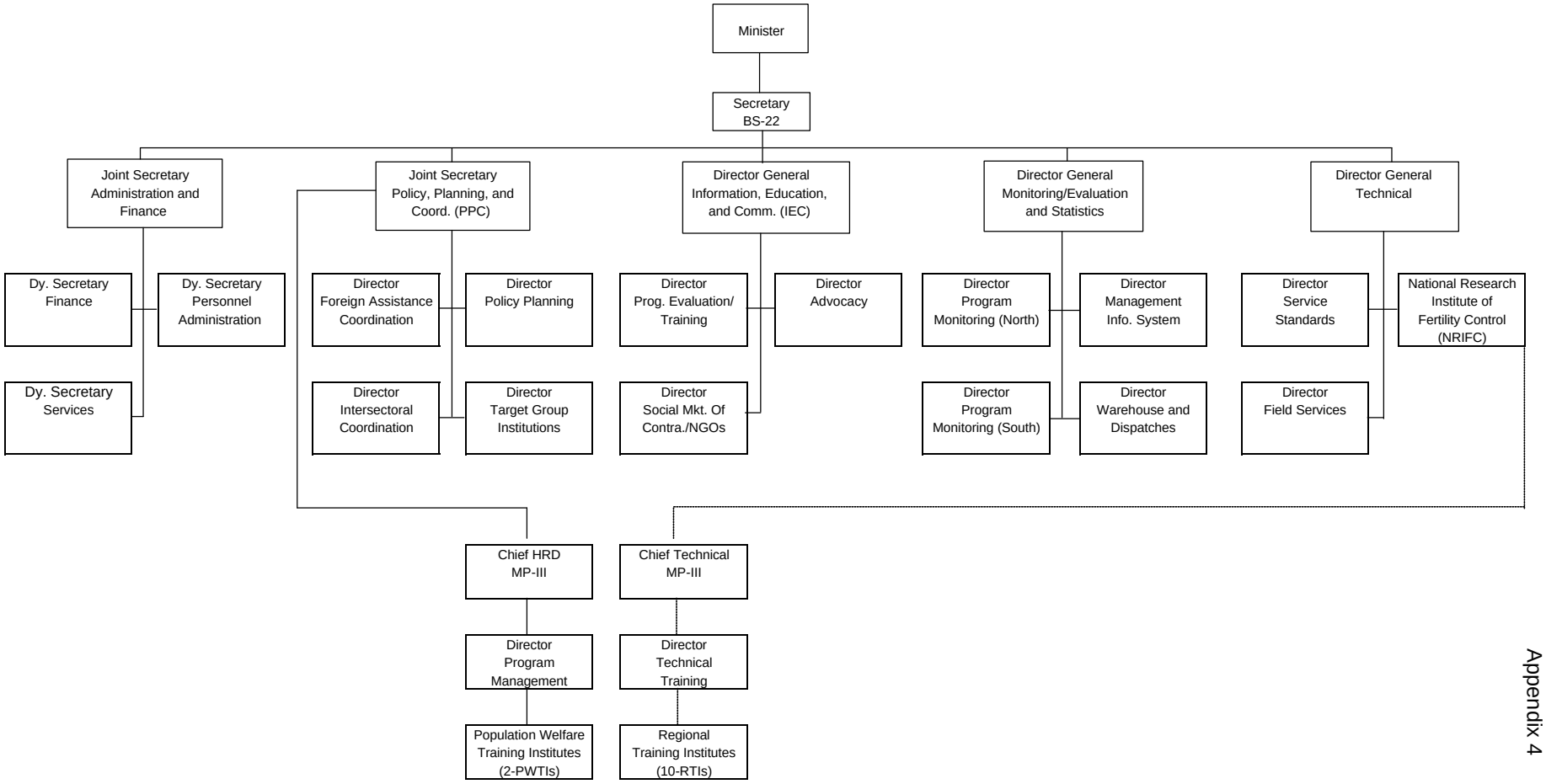
[b] The appraisal target of 8,000 village family planning workers was increased to 12,000 during the midterm review of the Project in 1998, thus covering the entire Eighth Five-Year Plan target.

[c] Training centers and reproductive health service centers were also established in all provinces.

Sources: Asian Development Bank. 1993. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan and a Technical Assistance Grant to the Islamic Republic of Pakistan for the Population Project*. Manila; ADB. 2002. *Project Completion Report on the Population Project in Pakistan.* Manila; Pakistan Resident Mission files.

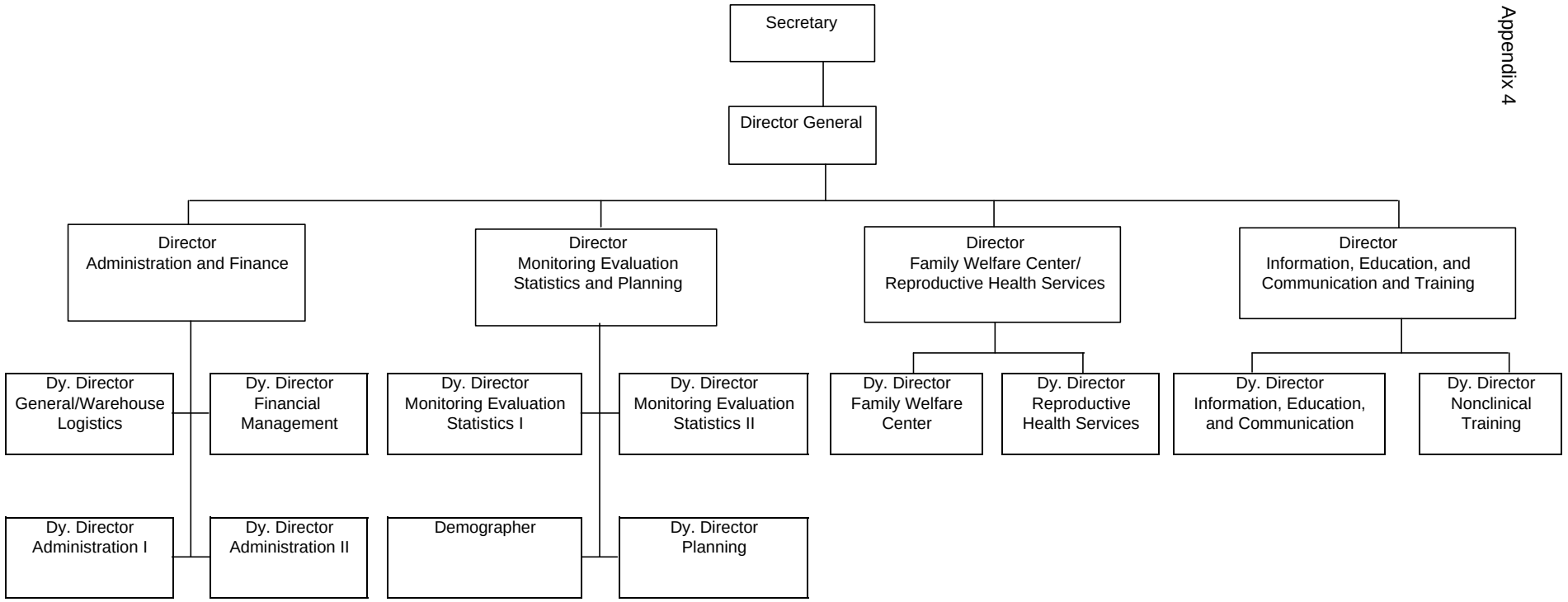
ORGANIZATIONAL DIAGRAM OF THE MINISTRY OF POPULATION WELFARE AND POPULATION WELFARE PROGRAM

Figure A4.1: Ministry of Population Welfare
(Federal level)



Comm. = communication, Contra. = contraceptives, Coord. = coordination, Dy. = Deputy, HRD = human resource development, Info. = information, Mkt. = marketing, NGO = nongovernment organization, Prog. = Program, PWTI = population welfare training institute, RTI = regional training institute.

Figure A4.2: Population Welfare, Punjab



Dy. = deputy

Figure A4.3: Population Welfare, Sindh

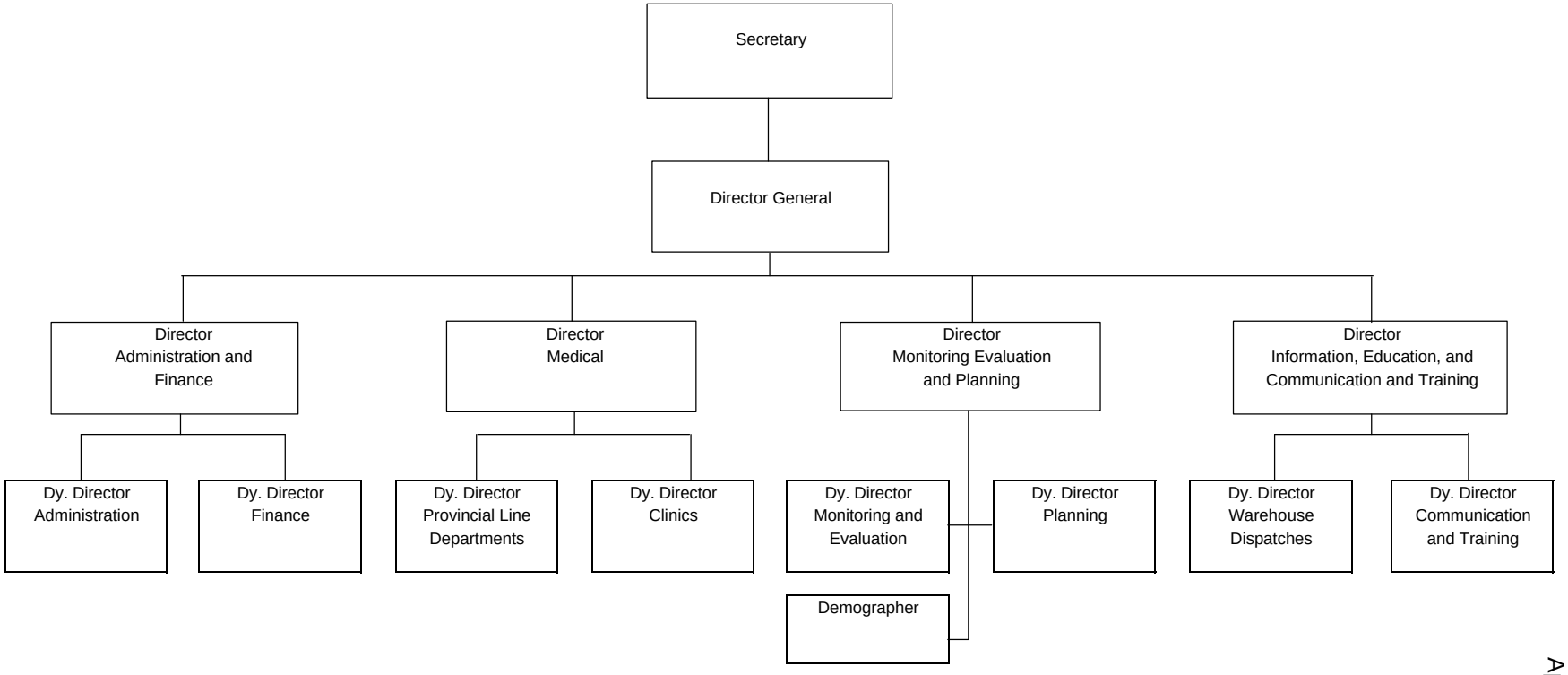
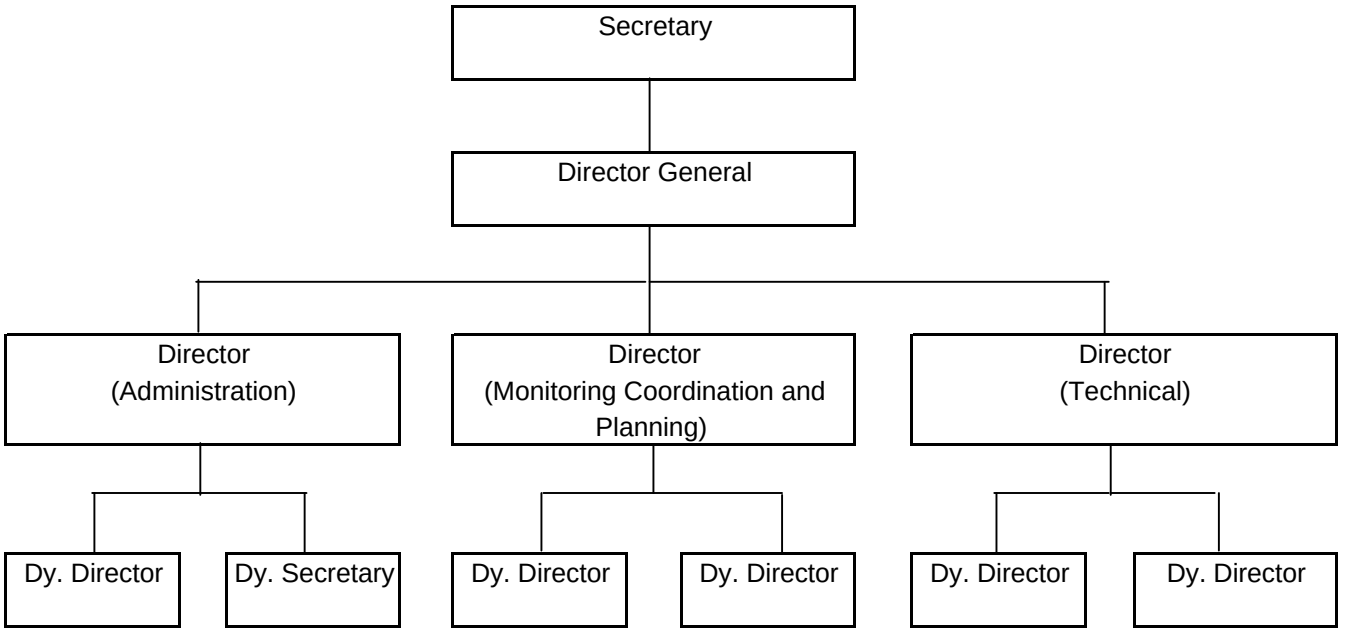
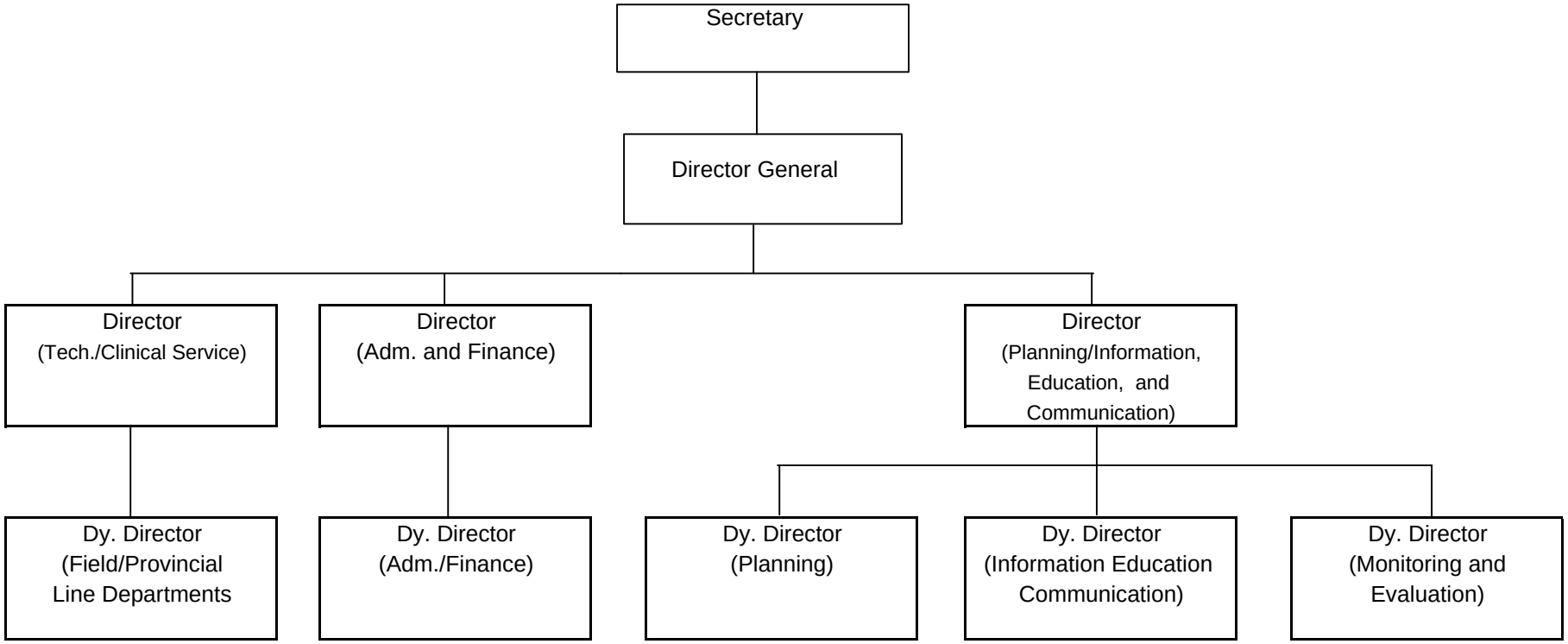


Figure A4.4: Population Welfare, NWFP



Dy. = deputy.

Figure A4.5: Population Welfare, Balochistan



Dy. = deputy.

REPORTS PRODUCED UNDER TA 2005-PAK IN COLLABORATION WITH THE MINISTRY OF POPULATION WELFARE

1. Final Report: Workshop on Village-Based Family Planning Worker Quality Improvement, Murree, 17–19 October 1994. Technical Report No. 9

2. Final Report: Workshop on Village-Based Family Planning Worker Quality Improvement, Quetta, 21–23 November 1994. Technical Report No. 10

3. Final Report: Workshop on Village-Based Family Planning Worker Quality Improvement, Rawalpindi, 19–21 December 1994. Technical Report No. 11

4. Final Report: Workshop on Improvement of Village-Based Family Planning Worker Training Standards, Rawalpindi, 13–15 December 1994. Technical Report No. 12

5. Final Report: Situation Analysis of Village-Based Family Planning Workers in Pakistan. 1995. Islamabad. Research Report No. 3

6. Final Report: Workshops on Improving the Quality of Supervision of Trainer-cum-Supervisors. Pakistan. March–August 1995. Technical Report No. 13

7. Final Report: Strategy Workshop on IEC Material for the Village-Based Family Planning Worker Scheme. Islamabad, Pakistan. 12–14 December 1995. Technical Report No. 14

8. Final Report: Proceedings of the National Seminar on the Village-Based Family Planning Worker Scheme. Islamabad, Pakistan. 4–5 June 1995. Technical Report No. 15

9. Final Report: Proceedings of the Provincial Seminar/Workshops on the Village-Based Family Planning Workers Scheme. Islamabad, 16–18 July 1996 at Karachi, 21–23 July 1996 at Hyderabad. Technical Report No. 16

10. Punjab. Follow-Up of Recommendations of the Workshop on Village-Based Family Planning Worker Quality Improvement. 1. May 1996. Technical Notes

11. NWFP. Follow-Up of Recommendations of the Workshop on Village-Based Family Planning Worker Quality Improvement. 2. May 1996. Technical Notes

12 Sindh. Follow-Up of Recommendations of the Workshop on Village-Based Family Planning Worker Quality Improvement. 3. May 1996. Technical Notes

13. Balochistan. Follow-Up of Recommendations of the Workshop on Village-Based Family Planning Worker Quality Improvement. 4. May 1996. Technical Notes

TRENDS IN RELEVANT DEMOGRAPHIC INDICATORS

Table A6.1: Trends in Total Fertility Rate, Contraceptive Prevalence Rate, and Unmet Need for Contraception, 1990–2001

Year	TFR		CPR		Unmet Need	
	Urban	Rural	Urban	Rural	Urban	Rural
1990/91	4.9	5.6	25.7	5.8	29.3	27.5
1994/95	—	—	32.0	11.0	35.0	37.7
1996/97	4.3	5.9	36.5	18.6	36.0	38.1
2000/01	3.7	5.4	39.6	21.7	30.1	34.4

— = not available, CPR = contraceptive prevalence rate, TFR = total fertility rate.
Source: National Institute of Population Studies (2000–01 Population, Reproductive Health, and Family Planning Survey).

Table A6.2: Contraceptive Prevalence Rates Actual 2000–01 and Projected Rates for 2005

Item	Pakistan	All Methods		Modern Methods	
		Urban	Rural	Urban	Rural
2000–01	28.0	39.7	21.7	30.1	15.3
Mid-2005	41.0	58.0	31.7	48.0	22.4

Source: National Institute of Population Studies (2000–01 Population, Reproductive Health, and Family PlanningSurvey).

Table A6.3: Trends in Critical Demographic Indicators

Year	Crude Birth Rate	Crude Death Rate	Infant Mortality Rate
1990	40.6	10.6	105
1993	39.3	10.1	102
1995	36.6	9.2	95
1997	33.8	8.9	85
1999	30.2	8.3	82
2000	29.1	7.8	80
2001	27.8	7.2	77

Source: Federal Bureau of Statistics, Pakistan demographic surveys.

ECONOMIC ASSESSMENT

1. Pakistan's Eighth Five-Year Plan (FY1993 to FY1998) included a comprehensive Population Welfare Program (PWP) with the objective of reducing the population growth rate from 3.1% to 2.6% per year by the end of the plan. The Government requested the Asian Development Bank (ADB) to finance a part of the PWP to fill the resource gap. The Project[1] supported the Government's Eighth Five-Year Plan's PWP and its implementation was carried out within this framework. The program nature of staffing for project implementation, compounded by an inadequate management information system, caused difficulties in identifying whether the Project had attained specific outputs or results. Separating achievements and impacts was not possible. Economic analysis was undertaken neither at appraisal stage nor discussed in the project completion report due to data constraints.[2] During the Operations Evaluation Mission, effort was made to conduct the economic assessment with reference to the service and management data of the PWP as a whole.

2. Despite the setbacks and weaknesses, the Ministry of Population Welfare (MOPW) performed reasonably well during the Eighth Five-Year Plan, achieving major PWP objectives. This performance is partly a result of the project design, since its components were not only supported during the Eighth Five-Year Plan but also in following years.

3. The cost-effectiveness of a population program can be measured by looking at the cost per client served, assuming that the program has only service delivery as its objective. The variety of objectives addressed by PWP call for other methodology to assess its benefits and cost-effectiveness. One of the methods widely used by health programs in ascertaining cost-effectiveness is determining the disability-adjusted life years (DALY) brought about by the interventions and average cost per annum for every DALY. This Project used the DALY approach to determine cost-effectiveness. The Project supported PWP in its aim to reduce population growth from 3.1% to 2.6% per year by FY1998.

4. Components used for the analysis are all related to the family planning/reproductive health program, which were also the focus of the Project through the reproductive health service centers; village family planning workers (VFPWs); an information, education, and communication campaign; and training and research components. Table A7 provides the details in using DALY and average cost per DALY saved for each year of the program. The data was based on health conditions for which figures were available, i.e., maternal, nutritional, infant-related, childhood cluster, and sexually transmitted infections. The estimates on incidence of disease and DALY were based on the National Health Survey of Pakistan[3] in 1994.

5. Table A7 provides information on three possible impacts of averting the burden of disease, i.e., low case at 10%, most likely case at 15%, and high case at 20%.[4] These bases have been adopted considering the number of average births that the PWP averted each year during the Eighth Five-Year Plan. The births thus averted account for approximately 20% of the average pregnancies per year during that period. Average cost per DALY saved for each of

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[1] ADB. 1993. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan and Technical Assistance Grant to the Islamic Republic of Pakistan for the Population Project*. Manila.

[2] ADB. 2001. *Project Completion Report on the Population Project in Pakistan*. Manila.

[3] The survey was also used in ADB. 2001. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Islamic Republic of Pakistan for the Reproductive Health Project.* Manila; and World Bank. 1998. *Pakistan: Towards a Health Sector Strategy.* Washington DC.

[4] The three percentages denote assumptions under various scenarios, i.e., under the low-case scenario, it is assumed that only 10% of the total burden of certain diseases will be averted by program interventions.

these impacts has been calculated both for the Population Commission-1 (PC-1) cost and the actual cost. Both PC-1 cost calculations and the actual ones have been done for the estimated actual births averted, assuming that PC-1 would result in higher costs because average planned births averted were lower than the actual births averted. Fewer pregnancies improve women's health during their reproductive years and help them avoid many illnesses.

6. The cost per DALY saved amounts to $60.32 for the low-case scenario, $44.18 for the most likely scenario, and $34.85 for the high-case scenario. These compare favorably with the cost data provided in the 1993 World Development Report for the estimated cost per DALY for low-income economies in 1990.[5] According to that report, the combined cost per DALY saved for interventions in family planning, prenatal care, delivery care, and sexually transmitted infections amount to $51 to $83.

7. The Project is institutionally and financially sustainable given that it supported a program and funded its central components. This helped cut population growth; increase accessibility and coverage of reproductive health in rural areas; improve quality and availability of doctors, paramedics, and community-based workers; and raise awareness on the need and benefit of birth spacing. Budgetary allocations have sustained project activities and form part of the PWP for the next 5 years (2003–2008). VFPWs have been merged into a cadre of community workers under the Ministry of Health for integrated, comprehensive health care at people's doorsteps.

[5] The prices in the 1993 World Development Report are in 1990 US$.

Table A7: Cost-Effectiveness of the Population Welfare Program, 1993–1998 (related to the Project)

Disease	Incidence per 100,000	DALYs per Person	Burden of Disease per 100,000	Avg. Burden of Disease Averted by Project per Year						Relevant Population (mn)	DALYs[a] Saved (per year)		
				Low Case per		Most Likely Case per		High Case per			Low Case	Most Likely Case	High Case
				%	100,000	%	100,000	%	100,000				
Maternal[b]													
Hemorrhage (Pregnancy)	200	0.349	69.7	10	6.97	15	10.455	20	13.94	5.645	393.5	590.2	786.9
Sepsis (Pregnancy)	500	0.131	65.5	10	6.55	15	9.825	20	13.1	5.645	369.7	554.6	739.5
Abortion	1,000	0.117	116.5	10	11.65	15	17.475	20	23.3	5.645	657.6	986.5	1,315.3
Pregnancy Complications	561	1.357	761.5	10	76.1501	15	114.2252	20	152.3	5.645	4298.7	6,448.0	8,597.4
Maternal Mortality	638	26.443	16,870.6	15	2,530.6	17.5	2,952.361	20	3,374.13	5.645	142,852.1	166,660.8	190,469.5
Nutritional[c]													
Anemia	4,935	0.141	696.8	10	69.6822	15	104.5233	20	139.364	19.244	13,409.6	20,114.5	26,819.3
Vitamin A Deficiency	154	0.584	90.0	10	8.99976	15	13.49964	20	17.9995	19.244	1,731.9	2,597.9	3,463.8
Infant Related[b]													
Perinatal Causes	192	18.535	3,558.7	10	355.872	15	533.808	20	711.744	5.645	20,089.0	30,133.5	40,177.9
Perinatal Mortality	1,068	27.668	29,549.4	10	2,954.94	15	4,432.414	20	5,909.88	5.645	166,806.5	250,209.7	333,613.0
Childhood Cluster[b]													
Measles	24,000	0.031	744.0	10	74.4	15	111.6	20	148.8	5.645	4,199.9	6,299.8	8,399.8
Pertussis	13,000	0.026	340.6	10	34.06	15	51.09	20	68.12	5.645	1,922.7	2,884.0	3,845.4
Poliomyelitis	44	7.650	336.6	10	33.66	15	50.49	20	67.32	5.645	1,900.1	2,850.2	3,800.2
Diphtheria	500	0.035	17.7	5	0.885	7.5	1.3275	20	3.54	5.645	50.0	74.9	199.8
Tetanus	31.7	32.200	1,020.7	15	153.111	17.5	178.6295	20	204.148	5.645	8,643.1	10,083.6	11,524.2
Sexually Transmitted Infection[c]													
Syphilis	10,000	0.019	186.1	5	9.305	7.5	13.9575	10	18.61	19.244	1,790.7	2,686.0	3,581.3
Gonorrhea	25,000	0.005	133.0	5	6.65	7.5	9.975	10	13.3	19.244	1,279.7	1,919.6	2,559.5
HIV Infection	2	12.650	25.3	5	1.265	7.5	1.8975	10	2.53	19.244	243.4	365.2	486.9
Chlamydia	7,800	0.032	250.1	5	12.5073	7.5	18.76095	10	25.0146	19.244	2,406.9	3,610.4	4,813.8
Pelvic Inflammatory Disease	4,000	0.054	214.0	5	10.7	7.5	16.05	10	21.4	19.244	2,059.1	3,088.7	4,118.2
Total DALY saved per year											**375,104.2**	**512,157.9**	**649,311.6**

Avg. = average, DALY = disability-adjusted life year, HIV = human immunodeficiency virus, mn = million, PC-1 = Planning Commission 1, PRs = Pakistan rupees.

[a] The figures used are historic costs for the periods in which they were actually incurred, and are not discounted to the present.

[b] Maternal, infant related, and childhood cluster are based on estimated pregnant women.

[c] Nutritional and sexually-transmitted infections sections are based on total married women of reproductive age.

Source: National Health Survey of Pakistan, 1994.

Table A7–*Continued*

Disease	Incidence per 100,000	DALYs per Person	Burden of Disease per 100,000	Avg. Burden of Disease Averted by Project per Year						Relevant Population (mn)	DALYs[a] Saved (per year)		
				Low Case per		Most Likely Case per		High Case per			Low Case	Most Likely Case	High Case
				%	100,000	%	100,000	%	100,000				
Avg. cost/year in PC-1 (PRs mn)											1,760.4	1,760.4	1,760.4
Cost per DALY in PC-1 (PRs)											4,693.10	3,437.22	2,711.18
Cost per DALY in PC-1 ($)											**96.96**	**71.02**	**56.02**
Avg. cost/year-Actual (PRs mn)											1,095.18	1,095.18	1,095.18
Cost per DALY-Actual (PRs)											2,919.67	2,138.36	1,686.68
Cost per DALY-Actual ($)											**60.32**	**44.18**	**34.85**

Avg. = average, DALY = disability-adjusted life year, HIV = human immunodeficiency virus, mn = million, PC-1 = Planning Commission 1, PRs = Pakistan rupees.
Source: National Health Survey of Pakistan, 1994.

TREND IN GDP AND PERCENTAGE OF EXPENDITURE ON POPULATION PROGRAMS
(1992–2003)

Year	GDP[a] (PRs)	GNP[a] (PRs)	Expenditure on Population (PRs million)	Total Government Budget for All Population Activities (PRs million)	Allocations on Population as % of GDP	Actual Expenditure on Population as % of GDP	Expenditure on Population by all Public Sector as % of GDP	Population (millions)	Per Capita Income[a] (PRs)
1992–93	1,333,041	1,343,001	762.8			0.0572		115	4,778
1993–94	1,561,104	1,565,092	710.5		0.0705	0.0455		118	4,813
1994–95	1,865,922	1,879,965	1,133.0		0.0643	0.0607		121	4,951
1995–96	2,120,173	2,113,037	1,181.2		0.0676	0.0557		124	5,016
1996–97	2,428,312	2,408,962	1,256.9	3,998.5	0.0824	0.0518	0.16	127	4,927
1997–98	2,677,656	2,653,292	1,194.3	3,887.5	0.0717	0.0446	0.15	130	4,924
1998–99	2,938,379	2,912,832	1,401.6	3,934.0	0.0681	0.0477	0.13	133	4,992
1999–00	3,147,167	3,102,261	2,144.9	4,247.0	0.0699	0.0682	0.13	136	5,073
2000–01	3,423,080	3,372,371	1,617.0		0.0643	0.0472		139	5,089
2001–02	3,628,731	3,660,716	1,454.0		0.0479	0.0401		142	5,214
2002–03	4,018,112	4,198,741	1,797.8		0.0548	0.0447		145	5,558

GDP = gross domestic product, GNP = gross national product.

[a] At market price.

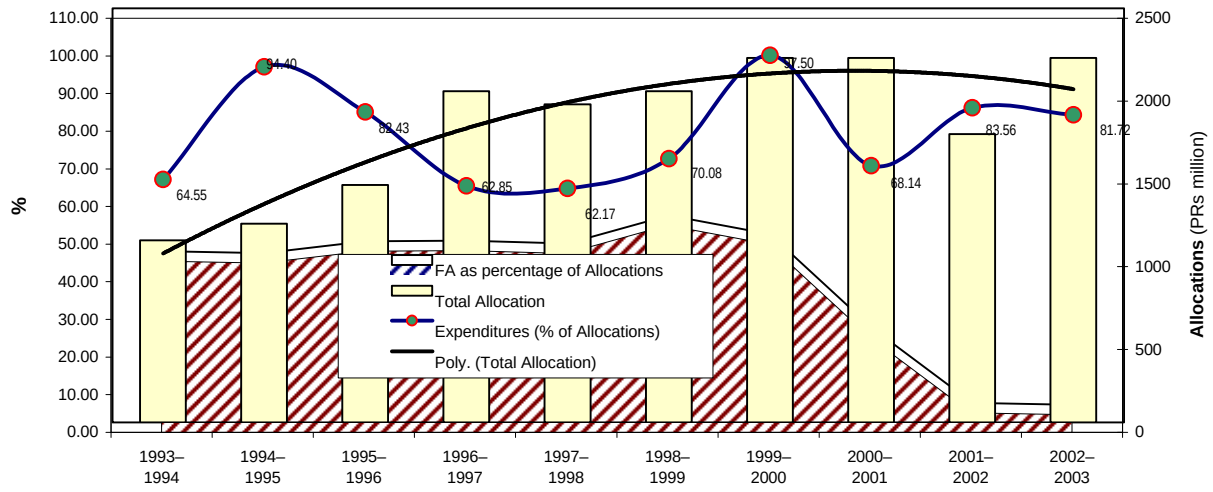
Source: Government of Pakistan. Economic Survey 2002–2003. Finance Division. Economic Advisor's Wing, Islamabad.

ALLOCATIONS, EXPENDITURES, AND FOREIGN ASSISTANCE TO THE POPULATION WELFARE PROGRAM, 1993–2002
(PRs millions)

Allocation/Source/ Expenditure	1993–1994	1994–1995	1995–1996	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001	2001–2002	2002–2003
Government	600.0	660.0	743.3	1,035.0	1,008.9	900.0	1,100.0	1,100.0	1,650.0	1,914.0
Foreign Assistance	500.0	540.2	689.8	965.0	912.0	1,100.0	1,100.0	556.0	90.0	103.3
Total Allocation	1,100.0	1,200.2	1,433.0	2,000.0	1,920.9	2,000.0	2,200.0	2,200.0	1,740.0	2,200.0
Total Expenditure	710.0	1,133.0	1,181.2	1,256.9	1,194.3	1,401.6	2,144.9	1,499.0	1,454.0	1,797.8
% of Allocation:										
Expenditures (% of Allocations)	64.5	94.4	82.4	62.8	62.2	70.1	97.5	68.1	83.6	81.7
Foreign Assistance (% of Allocations)	45.5	45.0	48.1	48.3	47.5	55.0	50.0	25.3	5.2	4.7

Source: Financial Management Wing, Ministry of Population Welfare.

Figure A9: Trend in Allocations to Population Welfare Program, Percent of Expenditure, and Foreign Assistance to Allocations



Source: Financial Management Wing, Ministry of Population Welfare.

PLANNED EXPANSION FOR REPRODUCTIVE HEALTH SERVICES

Table A10.1: Expansion of Infrastructure and Human Resource for Reproductive Health Services

Facilities	2002–03	2007–08	%
Reproductive Health Service Centers	106	189	78
Family Welfare Centers	1,752	3,003	71
Mobile Service Units	131	309	70
Male Family Planning Workers	996	6,895	592

Source: Ministry of Population Welfare.

Table A10.2: Allocations for the Population Welfare Program

(2003–2008) (in PRs million)

Component	2003–04	2004–05	2005–06	2006–07	2007–08
Federal Activities	873	857	984	1,046	1,091
NIPS	40	49	58	68	85
Punjab	1,150	1,424	1,608	1,698	1,776
Sindh	518	655	815	916	991
NWFP	392	466	516	585	678
FATA	25	42	46	63	74
Balochistan	196	251	286	312	344
Total	**3,194**	**3,744**	**4,313**	**4,688**	**5,039**
% rise over previous year allocation	45%	17%	15%	8%	7%
					Total for 5 years (PRs20,978)

FATA = Federally Administered Tribal Areas, NIPS = National Institute of Population Studies, NWFP = North-West Frontier Province.

Source: Planning Commission (PC–I) for the Ministry of Population Welfare, Islamabad.

AID ASSISTANCE TO THE POPULATION WELFARE SECTOR
1993–2003

Donor	Amount (million) Approved	Utilized	Year From	To	Title of Project	Areas of Focus under the Assistance
A. Public Sector Support and to NGOs						
1. ADB	$25.00	$23.07	1994	1999	Population Project (Loan 1277-PAK)	• Provision of vehicles, and support for VFPWs' field work. • Construction of RHSC buildings • Provision of medicine, equipment, vehicles for RHSCs, etc. • Expansion of IEC activities
2. ADB	$22.012	–	2003	2009	Pakistan Reproductive Health Project (Loan 1900-PAK)	• To improve quality and range of RH services. • To promote RH services • To increase awareness about RH among target groups
3. DFID	$13.939 (£9.045)	$13.939 (£9.045)	1194	1998	Population-III	• Procurement of contraceptives • Evaluate VFPWs scheme and institutional strengthening of PWP
4. DFID	$98.656 (£60.000)	–	2003	2007	National Health and Population Welfare Facility	• To achieve national health targets set out in PRSP • To improve health of the poor by increasing the utilization of health and population services
5. DFID	$7.399 (£4.500)	–	2003	2005	Technical Assistance under NHF	• Support development strategy • Strengthen technical capacity, etc
6. DFID	$1.513 £0.920	–			Medium-Term Budgetary Framework	• To improve planning and budget preparation. • Timely flow of funds from Ministry of Finance to Line Ministries (MOPW/MOH)
7. SAPP-I	$11.059 (PRs298.617)	–	1993	1995	SAPP-I Reimbursements	Reimbursement on overall expenditures of Ministry of Population Welfare at 26.4% for the year 1993–94 and 20.1% during the year 1994–95
8. SAPP-II	$21.795 (PRs1,133)	–	1998	2002	SAPP-II Reimbursements	Reimbursement on overall expenditure of Ministry of Population Welfare at 10% for first 2 years and 42.4% during the remaining 2 years
9. UNFPA	$22.749	$13.0 (PRs 512.434)	1995	1999	5th Country Program	• Strengthening of reproductive health and training • Contraceptive procurement • Strengthening IEC capability • Support to demographic research and training

ADB = Asian Development Bank; DFID = Department for International Development; IEC = information education and communication; KfW = Kreditanstalt fur Wiederaufbau; KSM = key social marketing; MOH = Ministry of Health; MOPW = Ministry of Population Welfare; NATPOW = National Trust Population Welfare; NGO = nongovernment organization; NWFP = North-West Frontier Province; PWP = Population Welfare Program; RH = reproductive health; SAPP = Social Action Program Project; tbd = to be determined; UNFPA = United Nations Population Fund; USAID = United States Agency for International Development; VFPW = village family planning worker.

Donor	Amount (million) Approved	Utilized	Year From	To	Title of Project	Areas of Focus under the Assistance
10. UNFPA	$35.00	$13.578	2000	2003	6th Country Program	• Reproductive health • Population and development strategies • Advocacy
11. UNFPA	$34.900	–	2004	2008	7th Country Program	• Reproductive health ($29.750 million) • Population and development strategies ($4.550 million) • Program coordination and assistance ($0.600 million)
12. World Bank	$65.01	$35.329 (PRs1,042)	1994	1999	Loan 2688	• Address areas of resource gaps including various components of PWP • Support and fund NGOs through NATPOW • Supply contraceptives through public sector
B. Social Marketing Initiatives						
13. DFID	£7.040	$10.842	1996	2001	Social Marketing Contraceptives (Hormonal Contraceptives – KSM)	To promote hormonal contraceptives, i.e. oral pills and injectables
14. DFID	£4.060	$6.252	1999	2002	Social Marketing of Contraceptives. SMP-(Green Star)	To provide condoms and operational support to SMP (temporary financing measure)
15. KfW	DM8.000	tbd	2001	2003	Social marketing of Contraceptive	To expand social marketing for and supply of contraceptives
16. DFID UNFPA USAID	$12.332 (£7.500) $8.000 $50.000	–	2003	2007	Social Marketing of Contraceptives	To provide uninterrupted supply of contraceptive through private sector
17. KfW	$6.951 (Euro 6.100)	–	2003	2007	Improvement of Reproductive Health Services in NWFP	• To improve RH of low-income families • To increase utilization of RH services and contraceptives by low-income families.