

## **Mega-planning in Population**

*Sarah C. Clark*

David and Lucile Packard Foundation

*Margo Murray*

MMHA The Managers' Mentors, Inc.

### **ABSTRACT**

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Clark and Murray examine the six Critical Performance Factors for Mega planning in an example drawn from the five-year history of the population program of a major west coast philanthropy. In this article, the authors describe the salience and scope of the population issue as it relates

to other global trends; the steps the foundation took to "scope" the program and establish measurable impacts. It rates performance against the critical factors, then looks at some specific country impacts five years later. This analysis will be incorporated into the plan revision.

### **Introduction**

Widespread poverty, persistently high rates of maternal mortality, and the pandemic of HIV/AIDS are clearly issues that demand Mega-planning if we are to adequately feed people and keep them free of devastating diseases, permanent disabilities and even starvation. For the past six years we have been working on a project to develop leaders to tackle and effectively reduce these problems. We are seeking measured results.

The magnitude of these problems necessitates a significant number of leaders working collaboratively to achieve the desired results. The Packard Foundation, and grantee International Health Programs, invited Murray to join the Policy Action Committee and Resource Team designed to produce the best results possible with the Foundation's investments in future leaders,

internationally. Her specific role is to design and implement facilitated mentoring processes as a vehicle to leverage the investment in leadership development.

In this article Sarah Clark, Program Director Population, David and Lucile Packard Foundation, describes the Mega planning approach used to determine appropriate ways to address the question of rapid population growth. At the end of the article we will add examples of the trends and results being tracked.

### **A Case Study of the Population Program at the David and Lucile Packard Foundation**

In 1996, David Packard co-founder of the Hewlett-Packard Company died and left his estate to the family foundation he and his wife set up in 1964. The Trustees, some of whom are Packard family members, and

the staff of the Foundation then went through many months of planning and identifying ways to apply his wealth to the social problems which had engaged the founders in their lifetime: children, families and communities, conservation particularly marine conservation, science, and rapid population growth. This brief case study will focus on the latter. Because the Board did not undertake to establish at that time a succinct mission statement for the foundation, but rather focused on building out its major programs of work, the programs were not united at a higher level for the organization as a whole, but connected together at the operational level.

The organization was there: the foundation. The Trustees were committed to a problem, rapid population growth, and there were resources, grant dollars, ranging anywhere from \$30 to \$100m annually to address the problem.

But what to do? How to deploy the resources?

The Foundation was undergoing great change as it methodically ramped up its grant making to reflect the new assets from the Packard estate and a boom in the stock market. Major program areas such as that of the population program were vetted by subcommittees of the Board, and the Board itself throughout 1998. However, funding levels were established for all programs at the end of that year. Administrative budgets to support the program were set through a different process. Given the rapidly changing asset base, budget levels were adjusted several times between 1997 and 2002. All of this presented planning challenges.

## Scoping

When the foundation began its strategic planning for its grant programs, it already had a history of grant making in population. How could the organization “forget” its history and take a fresh look at the field? Scoping out the situation, the role of other donors, and the needs of the populations in the field were critical to rethink and strategically reorient the programs in innovative directions. In 1997 and 1998, two steps were undertaken. The first was to borrow part-time a program director from the Rockefeller Foundation to begin the process while a fulltime director was recruited. The second was to commission a series of ten “thought pieces” from the leading thinkers in the field. These two steps let some light shine in on the process.

The mission of the program was established in 1998 as follows:

...to slow the rate of growth of the world's population and to expand reproductive health options among the world's poor. (The David and Lucile Packard Foundation, Population Program Strategy, 1999-2003, p. 3)

Another important scoping step, and an ultimately decisive one, took place in 1998. At that point the team decided to identify which countries were the major contributors to rapid population growth on a global level. In order to do that, all the countries of the world were arrayed from highest to lowest by their annual number of births. In other words, a critical decision was made to address population growth (and the implications of that for survival, health, and well-being), not at the global level, but in countries where it takes place.

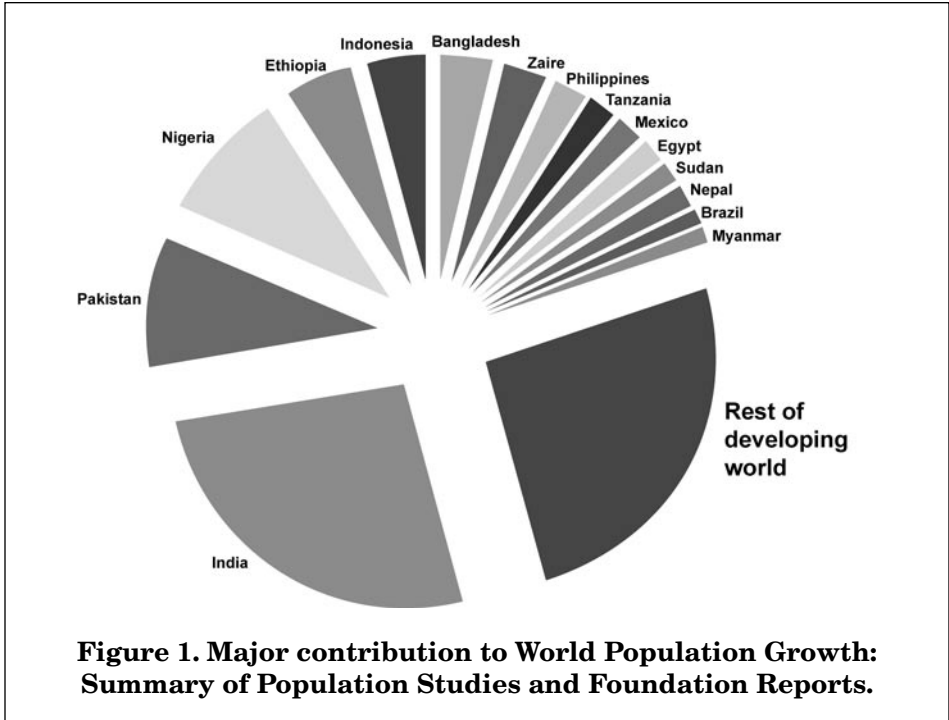
This is a pivotal decision, and one about which there continues to be discussion.

Frequently, international statistics present problems of accuracy, completeness, and comparability of data across countries and time. Inconsistencies are even worse among the countries on the lower echelon of the economic development scale, where population growth is highest. Even under these circumstances, when the results were available, they were very revealing.

For many years, most geographers and advocates have adopted a norm of “zero population growth” where every woman has the number of children (2.1) to replace the parental generation. This is conventional thinking and at the base of our approach. Two factors make a country a major con-

tributor to global population growth: birth rate and population size. In other words, a country can contribute to population growth at the global level by having a lot of women who have an average number of children just slightly above the replacement level. In India for example, the average woman had 3.5 children in 1998. The other alternative—fewer women who have a lot more children! Nigeria, with an estimated fertility of 6.2 is a case in point. Figures 1 and 2 illustrate the impact of these factors with statistics compiled by Packard Foundation from various sources.

This approach is strictly demographic. It does not bring in the humanistic or woman-centered perspective to reflect the *desire* of women to have a specific number of children. A further take on the problem shows



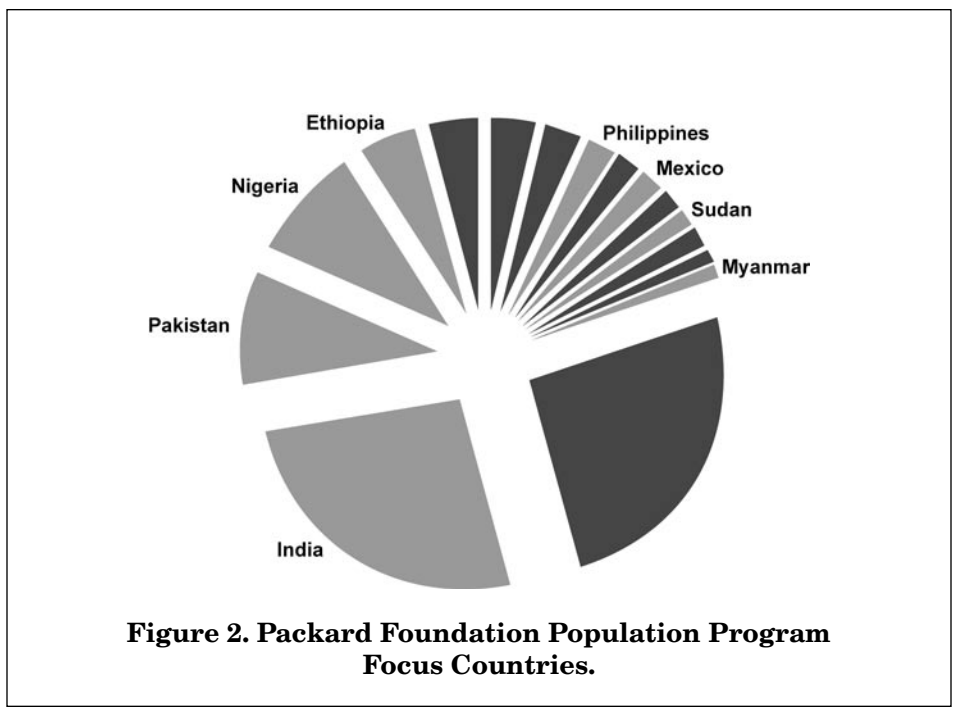
where there were women who wanted to have fewer children than they were actually having. The data for this analysis are even more tenuous, but with some simplifying assumptions, the same countries can also be displayed according to unmet need. This concept of “unmet need”—gaps in actual versus desired birth rates and the consequences of that on the health, safety, and well-being of the populations—tries to capture the number of women who would like to have fewer children than they report having, but do not have the means to do so. In that way, we defined the problem with a solution in mind: how do we meet the unmet need; close the gaps between current birth-rates and the desired rates, and the related health, safety, and well-being?

Even though it is based on conventional thinking and paradigms, the

thinking and clarity of the approach here constitutes legitimate “Mega-planning” (Kaufman et al., 2003) because it relates the desired rates to a general Ideal Vision of the desired conditions of population growth to be reached (i.e., steady state in rate and survival and self-sufficiency consequences).

The next step was to think what resources (staff, grant dollars, brand name) a west coast foundation could bring to address the problem. Taking into consideration where there is value to add and where a non-governmental organization could operate, the array in Figure 2 was presented to the Trustees, and was accepted.

Those countries shifted to the dark gray color did not meet the criteria. Initially, Brazil, the last slice prior to Myanmar, was in light gray. But, we were advised that given the



language, geographic and cultural differences the foundation would have been stretched too thin. So, Brazil had to be dropped.<sup>1</sup>

At this point, the Mega plan was established. It was necessary to go to the next level to accomplish the desired outcome—to slow the rate of population growth and associated deaths, disabilities, and economic privation.

In order to do that, planning was undertaken at the level of each country. The staff identified a short list of the most likely areas of intervention to assist those countries to slow their rate of population growth. This list was comprised of (1) service delivery of family planning and reproductive health, (2) programming to help adolescents, (3) advocacy around programs and policies, (4) mobilization of resources, (5) reproductive rights (and responsibilities?), and (6) leadership development. What criteria were used to guide the selection of interventions? See the following comment, selectively.

Because these elements were selectively adopted and adapted to fit the socio-cultural, institutional and political and economic situation of the country, our Macro planning took place at the country level. Over the next two years, a series of plans was presented to Trustees, Ethiopia, Nigeria, Myanmar and the Philippines in 1999; Mexico, India and Pakistan in 2000; and Sudan in 2001.<sup>2</sup>

## **Building Blocks**

The building blocks of the population program are grants. The program officer for each country mapped out group capabilities and interest; then supported non-governmental organizations with grant funds. Each

grantee in turn reported progress against the overall strategic outputs and outcomes desired. It is assumed that slowing population growth is a long term process that can be measured in decades rather than years. However, a number of intermediate values can be reported, such as the level of use of contraception and the number of youth informed. The individual grantees, with some guidance of the program officer, specified the ways, means, activities and procedures to accomplish their aim with foundation funds. The grantees then report on their accomplishments as they track longer-term results and consequences.

## **Five Years Later**

The population program is now in the process of formal reviews of each of the country subprograms. Reviews for The Philippines, Ethiopia, and Nigeria are complete. India and Pakistan are underway. In 2005, the whole program is up for review.

How did the program measure up on the critical success factors of the Mega-planning process?

## **Critical Success Factor 1**

*Use new and wider boundaries for thinking, planning, doing, and evaluation / continuous improvement.*

Program performance was mixed on this one. The conventional thinking about what constituted “rapid population growth” was adopted and a conventional, but well accepted solution to meet “unmet need” was implicit. Given the nature of the work in population, there was an opportunity to be very specific about the products, outputs, and outcomes agreed to by grantees. Although the Packard Foundation had always

required a proposal from potential grantees that detailed the purpose and goals for grant funds and interim and final reports from grantees about progress and results, moving toward quantifiable “targets” and benchmarking was still being discussed in the philanthropic community. There are many challenges for this and other foundations as they debate how quantitative to be, measure of complex phenomena, against the foundation culture and history of grantor-grantee relationships.

### **Critical Success Factor 2**

*Differentiate between ends and means. Focus on “what” (Mega/outcomes, Macro/outputs, Micro/products) before “how.”*

Looking back, there probably was not a clear differentiation. This will be emphasized in the next round.

### **Critical Success Factor 3**

*Use and align all three levels of planning and results.*

This is probably the clearest win. The program was able to distinguish between grant level, subprogram or country level outcomes, and also keep an eye on the trends and consequences at the Mega level, in this case rates of population growth (and the health, survival, and quality of life consequences of this growth) and rates of change of population growth.

### **Critical Success Factor 4**

*Prepare objectives—including those for the ideal vision and mission objectives—that have indicators of how you will know when you have arrived.*

The record here is mixed. Yes, there were objectives and in some cases, but not all, they were measur-

able and measured. And, they got better over time!

The international part of the population program assumed that it was appropriate to intervene at the country level and that meeting unmet need was the most effective and appropriate means to do so. The weakest link is that there were no established benchmarks for testing these assumptions. An alternate approach to addressing global challenges such as rapid population growth is to adopt global responses. For example, if there is a perceived need—gaps in results—based on the contributions of contraception, then an alternate is to work on delivery systems worldwide, identifying barriers, and addressing policy or logistics obstacles. This is how the Bill and Melinda Gates Foundation approaches global health (e.g., through immunizations), and may be how they approach population growth. Another possibility would have been to address some of the factors that hinder women from having the number of children they want such as lack of education and income.

There was nothing built in at the front end of the planning to provide data on these questions. Therefore, whether the geographic or country focus adopted by the population program is more suited to tackle population growth is up for debate. Similarly, we have no data that address the question of alternate investments in female education versus supplying the means to reduce fertility.

### **Critical Success Factor 5**

*Define “need” as a gap between current and desired results (Not as Insufficient Levels of Resources, Means, or Methods).*

Perhaps because a private philanthropy can bring monetary resources to address a problem, this is the clearest need the population program addresses. Some of the other needs, such as, the consequences—results—of providing useful technical leadership, bringing interested parties together are less well defined, and therefore more often overlooked.

### **Critical Success Factor 6**

*Use an ideal vision as the underlying basis for all planning and doing.*

This brings the discussion full circle. When the program began its planning for the next phase in 1998, discussion moved quickly to the mission. It was not until 2003 that the staff developed and the Trustees embraced its ideal vision:

We are working toward a future where women and couples can fully exercise their reproductive rights; where government provides a supportive climate for reproductive health and family planning services, including a safety net for those who cannot afford to pay; and where a flourishing private and non-governmental sector provides a diverse range of choices for those who can. (Population Program internal document, 2004)<sup>3</sup>

It is now noted that this “ideal vision” was really limited to the Macro level of results and that the Mega level consequences were assumed.

Results being tracked: the extensive evaluations carried out over the past year, and to be continued in 2005, show positive results in some critical areas. An early draft of a report to the David and Lucile Packard Foundation reports the following data gathered from two of the focus countries:

### **Ethiopia**

The National Population Policy was passed in Ethiopia in 1993. Hiruy Mitiku, (Mitiku, 2003) cites the following data:

- Fertility Rate—in 1993 was 7.7; in 2000 it was 5.9
- Maternal Mortality Rate—in 1993 was 871/100,000 live births; that has declined to 560-850/100,000 (the range is cited from UNFPA statistics, and reflects variances in rural and more urban areas)
- Contraceptive Prevalence Rate—overall has gone from 4.8% in 1990 to 8.1% in 2000
- Use of modern contraceptives—increased from 2.9% in 1990 to 6.3% in 2000

### **Nigeria**

The evaluation report for Nigeria shows some results that are disappointing, yet understandable, in light of the length of time programs were operating and the difficult climate. Over 3,000 service points have been established—a huge success! Many youth have been reached with the concept of “youth friendly” services. An unexpected result is the establishment of services to address the health risk of unsafe abortion. Over seven hundred sites have been established, from zero before the project started. Services are provided by all levels of health care and lives are being saved.

- Fertility Rate—in 1990, 6.0 (National Demographic Health Survey); 1991, 5.9 (National Census); 2003, 5.7 (US Bureau of the Census)
- Maternal Mortality Rate—in 1999, 704/100,000 live births (Multiple Cluster Survey, con-

ducted by the Federal Office of Statistics in collaboration with UNICEF); 2003 ranges from 166 to 1,500/100,000 (various reports, 2005 data will be collected)<sup>4</sup>

- Contraceptive prevalence rate—in 1990, 6% for all methods and 4% for modern methods only (NDHS); in 1999, 15.3% for all methods and 8.6% for modern methods only (NDHS); in 2003, 11.6% for all methods and 9.3% for modern methods only, per National HIV/AIDS and Reproductive Health Survey (NARHS)

## Summary and What Next

Indications are that our funding and the work of the grantees are having good impact in the country programs. Systematic, comprehensive reviews involving outside/inside experts, quantitative and qualitative data will be completed in all five country programs by mid-2005. Also in 2005, the Board will work with staff and outside experts to examine the results of grant making and review and discuss our long term, overall approach. Much has changed since 1998. We will review those changes and see if any longer term shifts in funding emphasis will be appropriate. This effort to refresh our strategic thinking will allow us to revise, as appropriate, the stated missions of the population work, its assumptions, and how it fits into the overall work and goals of the Foundation.

## Notes

<sup>1</sup>As it turned out, it was difficult to spread resources and have impact over eight countries. It would have been even harder for a ninth. And, ultimately unsustainable as we had to cut back the program.

<sup>2</sup>As a result of financial difficulties in 2001, the Sudan, Mexico and Myanmar programs were closed.

<sup>3</sup>Perhaps in the future, indicators could be developed which relate to health, safety, survival and well-being as well.

<sup>4</sup>This is the clearest present indicator for Mega planning and consequences.

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**SARAH C. CLARK** is currently the Director, Population Program, at the David and Lucile Packard Foundation. She directs an international grant making program of \$30 million a year to support reproductive rights in the US and women's choices internationally. She joined the Packard Foundation seven years ago after a distinguished foreign service career. She has a PhD in demography and sociology from Brown University.

**MARGO MURRAY**, MBA has earned ISPI's three highest honors—Outstanding Member, Member for Life, and President, and serves as mentor to many of its leaders. The preeminent re-

searcher, designer, and evaluator of facilitated mentoring, she has collaborated with clients on strategic planning and mentoring processes in over 100 organizations in 26 countries. Her best seller book, *Beyond the Myths and Magic of Mentoring: How to Facilitate an Effective Mentoring Process* is considered the seminal work on facilitated mentoring.

Margo has been an invited speaker at many International, Regional, and National events, including the United Nations Secretariat, and is faculty for the ISPI Institutes. *E-mail:* [margo@mentors-mmha.com](mailto:margo@mentors-mmha.com)