PD-AAT-231

Sudan Fertility Control Association

MODEL FAMILY PLANNING PROGRAMMES

Project 650-0063

August 1982

SFCA MODEL FAMILY PLANNING PROGRAMMES
(650-0063)

USAID/SUDAN REVIEW AND RECOMMENDATIONS

I. SUMMARY AND RECOMMENDATIONS

USAID/Sudan has reviewed the Sudan Fertility Control Association (SFCA) proposal for a five-year model family planning project and endorses the approach and program proposed by the Association. The proposal is Sudanese in design and initiative. However, the Mission, with assistance from AID/W and REDSO/EA, has counselled SFCA and assisted in analysis and evaluation of program components. We judge the project to be technically sound, administratively feasible, socially viable and cost effective in its approach. For the Initial Environmental Examination the Director of USAID/Sudan requests categorical exclusion (see attached IEE). The Model Family Planning Programmes proposal is consistent with USAID/S strategy of encouraging private sector distribution of family planning commodities and of promoting family planning as an important contribution to the quality of life and to maternal and child health care. USAID/Sudan is in the process of registering SFCA as a Foreign Private and Voluntary Organization which will make it eligible for an Operational Program Grant (OPG).

The total cost of the project is $4.88 million. Clinic income over the life of the project is expected to be the equivalent of $615,000. The Government of Sudan (GOS) will provide the local currency equivalent of approximately $2.5 million from the Commodity Import Program (CIP) generations to finance the balance of SFCA's local costs. Support for the project in the amount of $822,000 will be requested from AID/W financed contracts for contraceptive supplies and specialized technical assistance. The Mission recommends authorization of an OPG of $920,000 to finance the foreign exchange costs of the project. Five hundred thousand dollars in foreign exchange is required in the first year (FY 82) of the project.

Opportunity Cost

II. MISSION REVIEW AND EVALUATION OF THE SFCA PROPOSAL

A. Consistency with AID Development Assistance Strategy.

There is a growing body of support among Sudanese political and community leadership to provide couples the opportunity to choose family planning (FP) services. Raising awareness among national leaders of the implications of population growth was a key achievement of the Second National Population Conference held in Khartoum in April 1982. The SFCA took the initiative in the development of this proposal to capitalize upon these trends after their research revealed a large pool of unserved women who were requesting FP services. Thus, funding this project offers AID an opportunity to respond to Sudanese initiative by assisting the SFCA intheir efforts to expand family planning in the Sudan.

We consider the present population growth rate to be one of the more serious long-term issues for the Sudan's economy. Unless urban population growth can be curtailed, demand for social and economic services will attenuate the ability of the economy to generate surpluses for investment in new productive enterprises.

Our strategy, as contained in the Country Development Strategy Statement (CDSS) is to work closely with public and private interests to strengthen and expand the availability of family planning services. The private sector will be emphasized because it seems willing and able to address the demands for services more quickly than the public sector. This project will support AID's private enterprise initiatives by contributing significantly to the growth of a private institution. The project furthers AID's Women in Development initiative by including women physicians, social workers and promoters as major participants in project implementation. These professional women will provide positive role models for other women in the Khartoum Metropolitan Area (KMA).

B. Government of Sudan Support for Family Planning and the SFCA Proposal.

The GOS has not formally adopted an official policy nor developed legislation concerning population and child spacing. However, it has indicated its commitment and support through various FP activities in

Sudan which are described in detail in the Background Section of the proposal. The development of this proposal was coordinated with the Minister of Health, senior MOH officers, the Minister of Internal Affairs and the Assistant Undersecretary for Planning at the Ministry of Finance and Economic Planning. These Ministries endorse the project concept and the proposed funding levels. The Minister of Health has stated his support for the Model Family Planning Clinic and when his letter of support is received, the text will be cabled to AID/W.

The GOS has agreed to allocate local currency generated by the Commodity Import Program to the SFCA program. Yearly allocations are as follows:

Year	Amount
1983	$ 382,000
1984	$ 399,000
1985	$ 481,000
1986	$ 597,000
1987	$ 660,000
Total	$2,519,000

This commitment provides concrete evidence of the changing attitude within the Government toward family planning.

C. SFCA Dependence on the GOS

With GOS contributing significant financial support, there is the risk of the project being subject to the whims of politicians. SFCA believes, however, that the project will have a greater impact on the public sector family planning services because of endorsement by the GOS and is therefore willing to take the risk. In fact, one measure of OPG success will be for the GOS to place a higher priority on FP programs and to expand FP services through the primary health care program.

D. Recurrent Costs

The SFCA selected a level of clinic fees, described in the proposal, intended as an incentive for lower income couples to seek FP services. The fees are an incentive because of the pride Sudanese exhibit in not

accepting services in gratis. At the fee scale selected the clinic will be able to finance 70 percent of its recurrent costs by year five of the project. The clinic will collect socio-economic data on its clientele to determine the feasibility of increasing the fees without creating a disincentive to seeking services.

The long-term goal is to achieve a greater degree of self-sufficiency and to decrease the dependency on GOS financing. An avenue of funding to be explored will be voluntary contributions. Additionally, the income from the direct distribution of contraceptives can be increased to make that program self-financing. Evaluation of project success and GOS support for family planning will enable the Mission to determine the advisability and need for additional AID support if more time is required after the initial grant to build a fully self-sufficient program.

E. SFCA Institutional Capability

Of the private and non-governmental organizations available to implement a model clinic and other FP programs, USAID believes that SFCA offers the best chance for success. The Association is enthusiastic about the development of family planning and has taken the initiative to come to USAID with its proposal.

The initiation of the programs proposed by SFCA will greatly expand its level of activity, number of staff and management and administrative requirements to support the five programmatic components: FP clinic; information, education and communication (IE&C); direct distribution program (DDP); training; research and evaluation. Technical assistance, training, and staff positions have been carefully defined and must be provided on a timely basis to ensure the establishment and management of effective programs and the development of realistic plans of operation. The job responsibilities of the proposed staff do not overburden any of the personnel with multiple responsibilities. The objective is to allow the staff of each of the programs to focus on its own activities and objectives. The Board of Directors of SFCA is composed of physicians with considerable cumulative experience in clinic operations. Their

careful selection of the Medical Director and their guidance with that of the Medical Advisory Committee will be key factors in the operation of an effective FP clinic.

The SFCA realizes its limited capacity and thus has phased in the various programs over the first two years of the grant. The proposed implementation schedule for the DDP is particularly cautious because of the serious logistic problems in the Sudan. The Mission believes that this phasing reflects due appreciation of SFCA's institutional limitations and demonstrates the Association's understanding of the need to develop their capacity.

F. OPG Monitoring

USAID project monitoring and program management responsibilities will be vested in the Mission Health/Population Officer and Population Assistant. Special attention will be paid to issues of organization and management during evaluations of the project.

SFCA will be required to submit a series of periodic reports to document implementation performance. Competent financial management will be assured by the receipt, review and approval by the Population Officer of quarterly financial status reports. During the life of the grant, SFCA will be required to have its chartered accountants prepare several audits on accountability and utilization of OPG funds.

USAID will be designated as the allottee of funds, with delegated authority to execute and administer the grant. The source and origin for grant purchased commodities will be the US (code 000), except for some shelf items which will be purchased locally in accord with USAID regulations. For procurement an AID Letter of Commitment may be used.

G. Project Analysis

The economic, technical and social soundness analyses that appear in the OPG proposal were jointly prepared by SFCA and appropriate Mission and REDSO/EA personnel. As such they incorporate the Mission's conclusions on these aspects of the project. However, two concerns are discussed below:

1. The pool of potential acceptors: The SFCA cites results from survey research to bolster its claim that there exists in the KMA a significant demand for FP that is currently unmet. While none of the surveys are comprehensive in scope nor completely free from question about reliability, our information tends to corroborate the estimates made by SFCA. Members of the medical community who have no direct personal interest in FP report that the rate of illegal abortions is rising alarmingly as evidenced by the numbers of women found in their clinics and public hospitals suffering from septic and incomplete abortions. Leaders of the Women's Union of the national political party and others have cited, with increasing frequency over the past three or four years, the lack of FP services as a major concern to Sudanese women. Having thus accepted the SFCA's estimate of the pool of potential clinic users, USAID judges the administrative and technical support staff to be at the minimum "critical mass" needed to run an efficient and effective clinic operation of the size envisioned by the proposal.

2. The SFCA approach to FP, social and cultural soundness: The overwhelming majority of the KMA's population is Islamic. Traditionally, Islamic leaders in Sudan and the general population have applied their religious principles in a moderate, permissive style; a wide range of personal morality and behaviour has been condoned. Most religious leaders view FP as an acceptable means of protecting the health and welfare of women and children; child spacing is part of "responsible parenthood."

There is, however, considerable variation in opinion about sterilization. The predominant view in Sudan is that sterilization is acceptable as long as it is reversible (see Annex 13). All procedures conducted in existing clinics and hospitals are held by the prevailing Islamic opinion to be acceptable.

Yet Sudan is not immune to the forces at play throughout the Islamic world. Recently, conservative Islam has grown more powerful

in Egypt, Saudi Arabia and the Sudan. While it is extremely unlikely that the Sudan will become another Iran, it is reasonable to consider the implications for the present project, should a major national trend towards a more conservative outlook occur.

While a Sudanese variety of conservative Islam would probably continue to tolerate most family planning activities envisaged by SFCA, it is doubtful that voluntary sterilization would be acceptable. Conservative Islamic leaders both in Sudan and abroad often take the position that sterilization is a form of mutilation and therefore forbidden by the Koran. The current small scale, low profile sterilization program offered in the KMA has been ignored. Should the program be rapidly expanded, or should the forces of conservatism grow more powerful, then sterilization could become a focus of controversy and SFCA might have to eliminate voluntary sterilization in order to keep the project viable.

The IE&C component of the project is well designed and targeted. Continuing to increase the awareness of national leaders about demographic issues is of vital concern to the long range development of a realistic national demographic policy. Even now, local media carry informative programs about fertility and family planning. The degree of explicit detail presented might shock the average urban American. There seem to be few socio-cultural barriers to the free and frank discussion of reproductive processes and family planning techniques.

Weighing these factors and those discussed in the proposal, the Mission concludes that the SFCA programs are socially and culturally sound. The best judges of this, however, are the SFCA and Ministry of Health. Their judgment and the project support of participants and leaders within Sudanese society are the strongest endorsements of the proposal's social soundness.

INITIAL ENVIRONMENTAL EXAMINATION

OR

CATEGORICAL EXCLUSION

Project Country: Sudan

Project Title and Number: SFCA Model Family Planning Programmes (650-0063)

Funding: FY 82-86 for $ 920,000

CE Prepared By: John Gaudet - Regional Environmental Officer

Environmental Action Recommended:

Positive Determination: _____

Negative Determination: _____

OR

Categorical Exclusion: xxxx

The project is to establish a model family planning program to include: a family planning clinic, a clinical training center, an information program, a research and evaluation unit, and a distribution program for contraceptives. None of the activities will include construction. Therefore, this project qualifies in accordance with AID Reg. 16 for a categorical exclusion under 216.2 (c) (2) (viii).

Action Requested By: _____ Date: August 17, 1982
(Mission Director)

Concurrence: _____
(Bureau Environmental Officer)

APPROVED _____

DISAPPROVED _____

DATE _____

Clearance: GC/AFR _____ DATE _____

8

P R O P O S A L

MODEL FAMILY PLANNING PROGRAMMES

Presented to

United States Agency for International

Development/Sudan

Submitted by

Sudan Fertility Control
Association

August 1982

تليفون ٧٩٧٤٨ ص ب ٧٠٩٣
الخرطوم - سودان
تلغرافيا : سوفكا
Telephone 79748
P.O. Box 7093
KHARTOUM SUDAN
CABLE : SUFCA
Telex:475 LORTNOC

جمعية تنظيم الخصوبة السودانية

SUDAN FERTILITY CONTROL ASSOCIATION

SFCA

August 12, 1982

Mr. Arthur Mudge
Director,
United States Agency for International Development,
Khartoum,
Sudan.

Dear Mr. Mudge,

The Sudan Fertility Control Association was founded in 1975 by a group of physicians who were concerned about fertility related problems. Since that time, the Association has been actively engaged in biomedical and attitudinal research relative to fertility control and infertility, in teaching medical students and Ministry of Health personnel, and in providing voluntary surgical contraceptive services.

We sense that there is a growing demand for family planning services and information and conclude that it is time for the Association to expand its work to satisfy the need for family planning and therefore request assistance for this purpose from the Agency for International Development. The attached proposal is the result of experience gained during the past eight years and it has been designed and approved by the Association's Board of Directors.

The activities of this Association and those included in the proposal, are complementary to the work and policies of the Government of Sudan. The proposal has been discussed with the Minister of Health. He has verbally endorsed the project. We will forward a copy of his letter when it is received.

The members of the Association's Board of Directors, and I as Chairman, urge you to give favorable consideration to our proposal. The project will be of major benefit to the tens of thousands Sudanese who will receive this important service.

Respectfully,

Dr. El Harith Hamad
Chairman.

SFCA MODEL FAMILY PLANNING PROGRAMMES

(650-0063)

OUTLINE OF PROJECT PAPER

	Page
I. Project Summary and Funding Request	
A. Summary	1
B. Funding	3
II. Background	
A. General	4
B. Demographic Crisis	4
C. Implementation of Family Planning	5
D. Public Acceptance of Family Planning	6
E. Expanding Family Planning Services	8
III. Project Description	
A. Project Goal and Purpose	9
B. Project Activities	9
1. Khartoum Model Clinic	9
2. Information, Education and Communication Programme	12
3. Clinic Training Programme	14
4. Direct Distribution Programme	14
5. Research and Evaluation	16
6. Administration	17
C. Project Budget	17

Page

IV. Project Analysis

A. Economic Analysis

1. General Economic Benefits 20
2. Cost Effectiveness of Programmes 22

A. Financial Viability of the Model Clinic and DDP 23
B. Information, Education and Communication 24
C. Training 24

3. Complementarity with Private Sector 24

B. Technical Analysis

1. Medical Aspects 26
2. Clinic Operation 26
3. Managerial and Administrative Aspects 27
4. Interrelationhip of Programme Components and Coordination 28

C. Social Soundness Analysis

1. The Problem and its Setting 29
2. Conclusions and Recommendations 30

V. Implementation Arrangements

A. Project Implementation Plan 31

B. Procurement and Financing Arrangements 34

C. Project Monitoring 34

D. Evaluation Plan 35

LIST OF TABLES

		Page
1.	Average Target for the Model Clinic	11
2.	Length of Project Summary Budget	18
3.	Yearly Summary Budget by Project and Component	19
4.	Model Family Planning Programmes: Summary of Funding Sources	20
5.	Calculation on Income from Model Clinic	23
6.	Local Recurrent Cost Financing, FP Model Clinic	23

LIST OF ANNEXES

1. Census and Demographic Data in Sudan
2. List of SFCA Publications
3. SFCA Informed Consent Forms
4. Estimated Caseloads for Model Clinic
5. Estimated Contraceptive Requirements
6. Sample Floor Plans for SFCA Programmes
7. SFCA Organization Chart
8. List of SFCA Executive Board Members
9. Proposed Reorganization of SFCA
10. List of Equipment and Personnel
11. Detailed Project Budget
12. Logical Framework
13. Islamic Religion and Family Planning

LIST OF ACRONYMS

AID	-	Agency for International Development
CDC	-	Centers for Disease Control
CDSS	-	Country Development Strategy Statement
CIP	-	Commodity Import Program
DDP	-	Direct Distribution Programme
FP	-	Family Planning
FPIA	-	Family Planning International Assistance
FX	-	Foreign Exchange
GOS	-	Government of Sudan
IE&C	-	Information, Education and Communication
IEE	-	Initial Environmental Examination
IFRP	-	International Fertility Research Programme
IPAVS	-	International Project, Association for Voluntary Sterilization
IUD	-	Intrauterine Device
KMA	-	Khartoum Metropolitan Area
LC	-	Local Currency
LOP	-	Life of Project
MCH	-	Maternal & Child Health
MOFEP	-	Ministry of Finance and Economic Planning
MOH	-	Ministry of Health
MWRA	-	Married Women of Reprodutive Age
O&M	-	Organization and Management
OB/GYN	-	Obstetrics/Gynecology
PT	-	Piasters
PVO	-	Private Voluntary Organization
REDSO/EA	-	Regional Economic Development Services Office/East Africa

R&E		Research and Evaluation
SCOVA	-	Sudanese Council of Voluntary Associations
SFCA	-	Sudan Fertility Control Association
SFPA	-	Sudan Family Planning Association
SSU	-	Sudanese Socialist Union
SWFS	-	Sudan World Fertility Survey
TDY	-	Temporary Duty
TA	-	Technical Assistance
USAID/S	-	United States Agency for International Development/Sudan
VSC	-	Voluntary Surgical Contraception
WFS	-	World Fertility Survey

I. PROJECT SUMMARY AND FUNDING REQUEST

A. Summary

The Sudan Fertility Control Association (SFCA) was founded in 1975 by a group of physicians who were concerned about fertility related problems. Since that time the Association has been actively engaged in biomedical and attitudinal research relating to fertility control and infertility, in teaching medical students and Ministry of Health (MOH) personnel, and in providing voluntary surgical contraceptive services.

The demand for family planning services and information has shown a marked increase in the past few years, particularly in the Khartoum Metropolitan Area (KMA) which will double its population in slightly less than ten years. The family planning services that are available in the KMA are unable to meet the needs of the people.

In response to this situation, the members of the Association, represented by the Board of Directors, consider it imperative to expand the activities of the Association, and we are requesting assistance from the Agency for International Development to support an integrated program of model family planning activities. This five year programme will clearly demonstrate the demand for family planning and offer the MOH an opportunity for expansion of the Government's child spacing programme.

The project will consist of five model activities and the administrative support for these activities.

1. Model Family Planning Clinic

A full time specialized family planning clinic will be established in an easily accessible location within the KMA (Khartoum, North Khartoum, Omdurman). It will provide all family planning services including infertility counselling, natural family planning, and voluntary surgical contraception. The clinic, open six days a week, will be headed by a full-time general practitioner who will oversee all medical activities and treat all cases which need highly skilled physician intervention. Four registered nurses, under the supervision of the clinic director, will be responsible for providing routine family planning consultations. As well as consultation and examination rooms, the clinic will include a small operating room for voluntary surgical contraception. In calculating the potential demand for services, the Association estimates that at least 25,000 women will avail themselves of the clinic services in the first year of operation and that the numbers will climb to 44,000 by year five. Thus, by the last year of the project one eighth of the married women of reproductive age (MWRA) in the KMA will be practicing family planning. Specifically, AID support will include the provision of clinic equipment and furniture, limited technical assistance and training.

2. Information, Education and Communications (IE&C)

Complementing the model clinic will be a programme to promote the concept and practice of family planning. The IE&C programme will encourage the use of the clinic, but more importantly it will educate and inform the public about family planning in general. Special attention will be given to the tenants of Islam and child spacing. Both mass media and person-to-person approaches will be used to promote family planning. AID assistance is requested for short-term advisors, transport and audio-visual equipment.

3. Clinic Training Programme

The clinic, for the first time in Sudan, will support a level of activity sufficient to provide clinical training opportunities in family planning for MOH and other organizations' medical and paramedical personnel. The clinical training programme will provide 20 doctors and 30 nurses/paramedics annually with knowledge and experience relating to client screening, examination procedures, contraceptive method selection, IUD insertion, surgical methods and other clinical practices. Additionally, theoretical classroom presentations will be included in the programme to ensure understanding of the principles supporting the clinical work. AID grant support is requested for a short-term advisor.

4. Direct Distribution Programme (DDP)

The continued availability of contraceptives and their timely distribution has been a serious problem in Sudan, particularly in the MOH clinics. Based on consultation with the Minister of Health, the Association has decided to experiment on a pilot basis with a direct distribution of contraceptives to clinics. The objective of the DDP will be to test the distribution and acceptance of condoms, the pill and spermicides at general health facilities staffed by personnel with basic family planning training. The distribution plan will demonstrate a model distribution program that the MOH can use nationwide. The DDP will not start until approximately one year after the clinic has been in operation and will expand in a phased manner as administrative and operational experience is gained. AID assistance is requested for training, advisory assistance and logistic support.

5. Research and Evaluation

The Association has a strong history in research, perhaps unparallele by any other private family planning organization in Africa. We will continue to pursue important biomedical and attitudinal research on general fertility questions in Sudan, but we plan detailed evaluation and research on the model programme proposed above. Thus, we will need a full-time professional research and evaluation section. Evaluations will be carried out on the efficiency of the model clinic, its acceptability to the population, and the characteristics of its clientele.

Likewise, the IE&C programmes, the Training Programme, and the Direct Distribution Programme will require periodic evaluations. AID assistance is requested for the provision of technical assistance, office furniture and equipment.

6. Administration

AID assistance is requested to permit the Association to provide special training for a full-time professional administrator, who will serve as the SFCA's Executive Director, and be responsible to the Board of Directors for the management of all programmes. We also request assistance for office equipment and supplies, and transport. There is also a contingency of $80,000 which will be used for programme additions or changes resulting from project evaluations.

B. Funding

The Sudan Fertility Control Association is a voluntary, private, non-profit organization which is registered with the Department of Social Welfare of the Ministry of Internal Affairs. All funds requested from AID will go to the support of non-profit activities of the Association.

The Association's request for the five-year project is summarized below:

Life of Project Summary Budget*
($ 000)

Item	Amounts			
	AID-OPG (FX)	GOS (LC)	SFCA (LC)	Total
1. Technical Assistance	189	-	-	189
2. Training	125	14	-	139
3. Commodities**	321	66	45	432
4. Commodity Shipping & Price Contingency	155	-	-	155
5. Personnel	-	1051	570	1621
6. Rent & Utilities	-	773	-	773
7. Media Costs	-	138	-	138
8. DDP Contingency	50	100	-	150
9. Misc. & FX Contingency	80	377	-	457
Totals	$ 920	$2519	$615	$4054

*Inflation is included: 10% compounded annually for foreign exchange
20% compounded annually for local costs

**Contraceptives valued at approximately $762,000 will be provided free of charge to the Association by AID/Washington. Limited technical assistance will be available from other AID/Washington funded contracts.

II. PROJECT BACKGROUND

A. General

Sudan is an immense country the size of Western Europe or the United States between the eastern and western mountains. It contains roughly 18-20 million people, 75 percent of whom are traditional subsistence farmers and herders. The population in the northern two-thirds of the country is largely Arab/Islamic while the southern third is Nilotic and nominally Christian. On almost any index of development, the Sudan ranks as one of the world's least developed countries. Estimates of per capita income place the rural population's at US$ 120-150 per year while the urban figure is $250-300. Average life expectancy is 46.3 years; crude birth rate is 49 per 1000 population; crude death rate is 19 per 1000; infant mortality rate is 140 per 1000 live births (Annex 1). Vast areas of the country are isolated for 4-6 months each year during the wet season because the rail, water and road transport network cannot reach them.

While the Sudan is blessed with vast expanses of fertile soil, is rich in minerals, and seems to contain significant oil reserves, the national economy is beset by a severe crisis - balance of payment deficits have grown larger annually since the mid 1970s when ambitious development projects were initiated. There are no foreign exchange reserves; the country is chronically in arrears on its commercial debt interest payments; agricultural productivity is declining. As a result of this economic deterioration, essential imports have been reduced; there are few funds for expanding social services; external migration, primarily to the Gulf states, creates a "brain drain" for technical skills; investment in the industrial sector is inadequate to create new jobs rapidly enough to meet the demands created by rapid urban growth.

B. Demographic Crisis

Urbanization is the reason for Sudan's demographic problems. While the country has millions of acres of potentially productive agricultural land and many areas experience an acute shortage of agricultural labour, the cities of Sudan, and especially the three towns of Khartoum, North Khartoum and Omdurman which comprise the Khartoum Metropolitan Area (KMA), have experienced massive population increases over the past two decades. The reasons for this growth are many. The drought which affected the northern third of the country during the 1970s pushed many nomads and settled farmers out of their traditional regions and a considerable number turned to towns and cities for survival. The Government of Sudan's (GOS) economic investment programme to create import-substitution and agricultural commodity processing industries focused on the KMA, Port Sudan and Wad Medani where construction and new plants acted as a magnet to attract labourers. Tens of thousands of young male southerners came to the KMA and other urban centers seeking employment to amass the capital needed to buy cattle so that they could return home after two or three years and establish their own herds. Freed from the worst health risks of the rural areas, urban families lost fewer children and thereby contributed to the "natural" higher urban population growth rate. For these and other reasons, the urban centers exploded. The KMA, for instance, grew during the 25 years after independence in 1956 from 500,000 to an estimated four million.

The combination of migration and natural increase in the urban areas has placed a tremendous strain on social services: health care, transportation, education, sanitation and potable water, electricity. The regional transport system is overburdened by the demands for food: meat, sorghum (dura), sugar, vegetables and other staples are periodically unavailable -- especially when fuel is in short supply which is chronically the case. Hundreds of thousands of urban dwellers are periodically unemployed. There are sporadic outbreaks of communicable diseases, especially typhoid, cholera and measles in the KMA and other cities. A variety of gast ointestinal diseases and other health problems stem from inadequate sanitation, overcrowding, lack of potable water, poor diet, etc.

The GOS's response to this urban demographic problem has been shaped by several considerations. Viewed from a nation-wide economic perspective, the country is definitely labour short: many economists and planners argue -- with considerable merit -- that there are vast areas which could become agriculturally productive if there were more people to work them. Heads of parastatal agricultural schemes and owners of large commercial plantations point out that seasonal labour is scarce and that they must pay ever higher wages to attract the hands they require. Yet the pressure on the cities is undeniable and a growing number of persons are becoming concerned about security problems and frustrated over inadequate services. The Government's present demographic policy holds that Sudan is underpopulated (the GOS has provided asylum to half a million refugees since 1978 and sees them as an important economic asset) while tacitly recognizing the need to make family planning information and services available, especially to the urban population. The Government publicly recognizes that uncontrolled fertility is a health risk to women and children; consequently, family planning is an integral component of the national health program.

C. Implementation of Family Planning

Since the inception of the six year National Health Program in 1976, the Ministry of Health (MOH) has included the provision of family planning information and commodities in its Maternal and Child Health (MCH) activity. To this end, the MOH began receiving funds from UNFPA in 1976. In 1982 UNFPA provided $109,094. The UNFPA/WHO/MCH/FP project has allocated $231,593 for 1983. During the period 1981-85, USAID will provide $1.9 million to support family planning through its Rural Health Support Project. Yet this foreign donor support has little impact because most of the funds nominally scheduled for FP are in fact allocated by the MOH to MCH activities not directly associated with the provision of FP services and commodities. Available records indicate that only 600,000 cycles of oral contraceptives have been distributed during the past five years from MOH storage facilities. This volume would support only 9,000 women per year. And although over 2,000 community health workers, medical assistants, health visitors and other health care providers have received some FP instruction, there are no data to indicate that public clinics and health centers are in fact delivering many FP services.

A private voluntary organization (PVO), the Sudan Family Planning Association (SFPA) provides a primary distribution system for contraceptives outside of KMA.

The SFPA provides services through MOH clinics at 12 sites in the KMA and at six branches in other cities. Records show that SFPA supports 10,000 acceptors presently.

Another PVO, the Sudan Fertility Control Association (SFCA), has concentrated its efforts on FP related research. Recently, SFCA has developed several service programs offering FP services and surgical contraception.

The Department of Community Medicine of the University of Khartoum, working in conjunction with Columbia University, is implementing a Community Based Family Health project in 90 villages of Khartoum Province. Village midwives have received training in nutrition, oral rehydration, immunizations and FP. This operational test of the combined MCH/FP approach is currently providing contraceptives to 762 women. However, it is estimated that two to three times this number of women are contracepting, their main source of contraceptives being the private sector.

The bulk of FP activities are carried on by private physicians through their own clinics. They provide FP information and prescribe contraceptives, e.g. condoms and pills. A few physicians provide IUDs. These commodities and services are expensive. For example, a physician may charge the equivalent of US$30.00 for an IUD insertion; one cycle of the pill costs $2.00 and condoms sell for around $.50 per unit of three. While no comprehensive data exist on the total private distribution of contraceptives, approximately 305,000 cycles were imported through private pharmaceutical channels during a recent six-month period. Extrapolating from this figure, we can estimate that around 50,000 women annually could be served through the private market. In effect, Sudan's FP program is being implemented through private channels--physicians' clinics, pharmacies and PVOs.

Nation-wide less than five percent of women of reproductive age are being covered by all sources of contraceptives. This figure is generally in agreement with the World Fertility Survey findings that show 19 percent of women interviewed in the KMA were currently contracepting; outside the KMA, the Survey found that the figure was three percent.

D. Public Acceptance of Family Planning

The limited scope of family planning activities is due to a number of factors including: MOH priorities for other activities; unavailability of foreign exchange to purchase commodities; absence of an effective pro-family planning lobby in Government circles; and very limited donor assistance to family planning. While the low priority, generally timid stance that has characterized FP activities may have rather accurately reflected past official position on Sudan's demographic profile, these attitudes are rapidly changing. Growing numbers of physicians are speaking out about the health risks of too many children too close together. Educators, health planners, economists and other technicians are becoming alarmed about the skyrocketing costs of urban social services. Even military officers, who are normally pro-natalists, are becoming alarmed about the security implications of the burgeoning urban population. Spokeswomen for the Women's Union component of the national political

organization (Sudanese Socialist Union or SSU) are increasingly calling attention through international conferences and domestic workshops to the negative impact of uncontrolled fertility on the health of women and children. And many leaders of Sudan's Islamic communities support family planning as an important aspect of responsible parenthood.

While there is no comprehensive data available on attitudes towards and use of contraceptives, there exists evidence from several pilot studies pointing to a substantial body of opinion in the KMA favorable to family planning. For instance, a 1982 SFCA report presented the results of a survey of maternity patients in four KMA hospitals. The study revealed that while only about 20 percent of the patients had previously contracepted, an average of over 60 percent at each facility desired to use family planning. Another SFCA survey of 2,788 women hospitalized for septic and incomplete abortions revealed that although 10 percent had ever used contraceptives, 46 percent indicated a desire to begin family planning.

A SFCA study in 1982 of male attitudes towards family planning demonstrates what may very well be a widespread view of family planning, that FP can be used to space children rather than limit family size. Among the study's fairly representative cross section of KMA males, 80 percent indicated that they believed in child spacing. More than three quarters of the sample wanted more information on family planning and nearly six in 10 wished to use family planning techniques. Over 90 percent of the sample believed that the KMA's rapid population growth contributed to inadequate social and public services and housing shortages, crime, and rising inflation. Yet only 29 percent favored using family planning to limit family size; in other words, a large majority of the men interviewed wanted more children but through controlled fertility -- that is, child spacing. Those who opposed limiting their families (67%) overwhelmingly cited religious beliefs ("its against Islam" or "Catholicism") as the basis of their attitudes. In this regard, the majority of the men interviewed reflect the position of most Islamic leaders; that it is acceptable to practice family planning to protect the health of mothers and children through spacing births.

If we combine the available survey data with the experiences of physicians and others who provide family planning services, the following picture emerges. The overwhelming majority of women who practice contraception are long-time urban dwellers, at least primary school graduates (and usually secondary school leavers), over 30 years of age, and members of a solidly middle class family. They use family planning to space reproduction -- which, of course, may well have the secondary effect of limiting family size.

Aside from these present acceptors, there appears to be a sizable number of lower middle class and even working class families who are inclined to accept family planning but who are not now contracepting. There are two interrelated factors which impede their use of family planning: cost and availability. Since few if any public providers (hospitals, primary health units, etc.) offer FP services, would-be acceptors must turn to private clinics and individual physicians or to pharmacies. As noted above, services from these providers are relatively expensive. Moreover, few private providers are located in lower middle and working class neighborhoods; consequently,

potential acceptors must bear the added burden of transportation costs to reach providers. If survey data and observations are valid, there are tens of thousands of potential acceptors who would avail themselves of conveniently located, moderately priced services.

E. Expanding Family Planning Services

The Sudan Fertility Control Association believes that the time is ripe for expanding the present family planning program and that the SFCA can play a major role in extending coverage within the KMA. Therefore, we are requesting USAID assistance in this endeavor. The Minister of Health supports our request.

SFCA was established in March 1975 by a group of medical professionals and others who felt there was a need for an organization to conduct fertility research and promote fertility control. The Association is registered with the Department of Social Welfare/Ministry of Internal Affairs and is a member of the Sudanese Council of Voluntary Associations (SCOVA). It is a founding member of the World Federation of Health Agencies for the Advancement of Surgical Contraception, the International Federation for Family Health and the International Association for Maternal and Neonatal Health.

The primary objective of the non-profit Association is to build family planning related research capability in Sudan. The research is of an applied nature in order to be of use in health and population planning in Sudan. But SFCA has not limited its activities to research alone. The Association helps in the training of medical and para-medical personnel in the field of contraceptive practices. An information and education subcommittee within the Association prepares a quarterly FP information newsletter as well as occasional pamphlets and booklets on contraceptive techniques. It organizes FP discussions and films at health centers and clinics in Khartoum. And recently, FP services have been initiated under the auspices of SFCA board members.

SFCA activities are funded primarily through three sources:

1. International Fertility Research Program (IFRP)

Since the establishment of the SFCA in 1975, IFRP has been one of the main funders. Funds have been for research and administrative support. The overall purpose of the IFRP support grants have been to build family planning related research capabilities in Sudan. Three subgrants have been approved from 1979-1982 totalling $300,684. The last subgrant expires September 29, 1982 and totals $72,684. A list of research conducted under these subgrants is listed in Annex 10.

2. International Project, Association for Voluntary Sterilization (IPAVS).

Since 1977, the International Project of the Association for Voluntary Sterilization has been funding SFCA. The objective of its subgrants are (1) to strengthen the administrative capabilities of

the Association, (2) to strengthen the SFCA information and education strategy and (3) to become a resource center for the acquisition and dissemination of information concerning current developments in the field of voluntary sterilization. SFCA also serves as the secretariat for the Regional Arab Federation. IPAVS funding from 1977-1983 totals $194,248. Over the years funding has increased from $25,900 to $54,348 with the last subgrant ending in April, 1983.

In addition to the core subgrant, IPAVS is supporting an "In-service Training Project in Fertility/Infertility at Soba University Hospital." Funding totals $28,925. Also, IPAVS has approved a sum of $54,410 in 1982 for Khartoum North Hospital to establish a female fertility/infertility service programme. Both of these activities are under the auspices of SFCA board members.

3. Family Planning International Assistance (FPIA)

Through SFCA, FPIA funded the establishment of an integrated MCH/FP dispensary in the Hag Yousif area of Khartoum North. Year one of the five-year project began in May 1981 at $31,029.

III. PROJECT DESCRIPTION

A. Project Goal and Purpose

The ultimate goal of SFCA's new direction into delivery of family planning services is to establish a system in Khartoum Province providing family planning information and services. In order to achieve the goal, the Association will develop a family planning clinic in the KMA that can serve as a model and training center for other areas of the country. The Khartoum Family Planning Clinic will have the capacity to serve 44,000 women by the fifth and last year of the project. Other objectives of the project are to create a mass media and person-to-person educational programme to continue to carry out relevant research and evaluation activities and to test, on a pilot basis, a new approach to distributing contraceptive supplies to MOH clinics.

B. Project Activities

1. Khartoum Model Clinic

We propose to establish a full-time specialized family planning clinic in the geographical center of Khartoum. It will serve the greater tri-city area of Khartoum, North Khartoum and Omdurman but also will attract women from the nearby rural areas. Some women are presently traveling three or four hours from other provinces to reach the two Ministry of Health clinics in Khartoum which provide family planning services, but which cannot respond to the increasing demand for services.

The clinic will be open six days each week and nine hours each day. All women who come to the clinic for the first time will be given a physical examination unless they decline. Service will be provided

to every woman on the day she visits the clinic and no woman will be turned away. As a policy, the SFCA will try to ensure that no woman has to spend more than one hour in the clinic, except for out-patient sterilization services.

Women will be registered, thoroughly counselled and examined. Each woman will have a hematrocrit and an urinalysis done, as appropriate. Everyone will be provided with the contraceptive methods of her choice before leaving the clinic. There will be quality control at the last station (an exit interview) to ensure that the woman understands how to use the contraceptive and what to do if complications arise.

A full array of contraceptives will be available including oral contraceptives, barrier methods, and voluntary surgical contraception for both males and females. The mini-lap techniques will be used for tubectomies. Laproscopic procedures will also be available. All services will comply with AID's medical standards for sterilization and informed consent. All women who request surgical contraception and who have the written consent of the spouse, will be served. Abortions will not be performed in the clinic. The backstop facilities for the clinic, should any complications occur, will be the MOH and Soba University Hospitals. A sample consent form is included in Annex 3.

One three-hour session each week will be devoted to counselling on infertility. Cases of infertility will be referred for treatment to the backstop hospitals.

There will be an admission charge of 50 piasters (US$0.50) for each visit to the clinic. In the case of oral contraceptive acceptance, the 50 piasters cover the examination and the provision of four monthly cycles. It is anticipated that each woman will visit the clinic three times each year, irrespective of method chosen. An IUD insertion will cost 2 Sudanese Pounds (LS) (US$2.23). Sterilization (male and female) will cost LS5.00 (US$5.57). All other methods such as condoms, spermicides and diaphragms will be provided free, after the payment of the admission fee. It is estimated that 10 percent of the clientele will be destitute and will receive all services free of charge.

Based on prior experience, the Association believes that 70 percent of the Model Clinic's clientele will choose oral contraceptives. Another 20 percent will choose IUDs, 5 percent sterilization and 5 percent other methods, including natural family planning.

lab facilities?

Women who experience sexually transmitted diseases, vaginitis and urinary tract infections as complications with contraception will be given prescriptions for treatment. For those women who receive services free of charge, there will be a small clinic supply of basic drugs for treatment of these problems. Cases of pelvic inflammatory disease will be referred to the backstop hospitals as appropriate.

In calculating the potential demand for services, we considered three caseload levels (see Annex 4) and chose the more modest estimate, since we believe that there is no question that at least 25,000 married women will avail themselves of the Model Clinic's services by the end of the first year. The following table estimates the projected caseload during the five-year period:

Table 1. COVERAGE TARGET FOR THE MODEL CLINIC - Khartoum Province

	1983	1984	1985	1986	1987
Married Women of Reproductive Age (MWRA) in KMA	250,000	265,000	281,000	298,000	316,000
% of MWRA	10%	11%	12%	13%	14%
Women to be served	25,000	29,000	34,000	39,000	44,000
Total clinic visit	75,000	87,000	102,000	117,000	132,000
Women per day	254	295	346	397	447

? 4 nurses / M.D.

By the time the clinic opens in 1983, there will be an estimated 250,000 MWRA in Khartoum Province. The 10 percent of these women that are expected to use the clinic in 1983 appears attainable based on the latent demand which exists and the limited availability of other FP services in the KMA. Based on experiences in other countries about half of the 10 percent will be current users who will seek a quality service.

The clinic will be staffed by a full-time doctor who will be its Medical Director and who will treat all cases which require highly skilled physician intervention. Four registered nurses who will be trained in the US, and who will work under the supervision of the clinic director, will be responsible for providing the major portion of the clinic's services. They will have appropriate support staff. All clinic personnel will participate in a Training Programme described in part 3 of this section. The sterilization services will be provided by trained OB/GYNs who will be hired by the clinic to work three-hour sessions.

Based on the projected caseload, and taking into consideration the estimated method mix, the model clinic should generate approximately $600,000 during the five-year period. A detailed analysis of the financial viability of the clinic appears in the economic analysis of the project, Section IV.A.

This project does not include funding for contraceptives since it is assumed that they will be provided from central sources in AID Washington. (See Annex 4 for estimates of contraceptive requirements.) In order to ensure that the clinic becomes a truly model clinic in terms of its policies, procedures and efficiency, we will request the technical assistance, at no cost to this project, of the Family Planning Evaluation Division of the Center for Disease Control (CDC) in Atlanta, Georgia. This group will design the clinic flow pattern and the client record system and suggest operational procedures and policy.

How will this be financed?

26

The physical facility will be remodeled to provide adequate examining rooms and clinic facilities. An alternative would be to find a building under construction so that the rental agreement could specify the remodeling requirements. A sample floor plan for the clinic is included in Annex 6.

In summary, the SFCA is convinced that the model clinic and its associated activities will become the fulcrum of quality family planning in the Sudan. It will have an inestimable demonstration impact for the Ministry of Health's future clinical family planning development. Importantly, it will demonstrate, once and for all, the demand for family planning services by most segments of Sudanese society.

2. Information, Education and Communications (IE&C)

Information on family planning in the Sudan is quite limited and its distribution sporadic. Newspapers occasionally carry articles on the results of population research, conferences, and from time to time reports on family planning. Radio and TV also provide limited and infrequent information on this subject. The MOH has produced one pamphlet on family planning, but only a small quantity was printed, and there have been logistical problems in its distribution.

The SFCA, with the support of the IPAVS, has produced a pamphlet on surgical contraception for males and females but quantities are limited. Limited promotions have been done with posters, but nothing with billboards and signs. In the area of person-to-person communications there has been no systematic attempt to educate the population in family planning, although an unknown number of MOH personnel are providing some counselling in its clinics.

With this situation in mind, and taking into consideration the expanded activities contemplated in this proposal, we plan pioneer work in population and family planning communications. We believe that a sustained, persuasive and professional effort is required to:

a. acquaint the population of the services of the new Model Clinic

b. increase the awareness of the Sudanese about population and family planning matters

c. educate the population on the benefits, both health and social, to be derived from the practice of family planning

The SFCA currently has a voluntary committee for IE&C (see Annex 7 for the present organization chart) but with the proposed expansion of the IE&C activity, it will be necessary to recruit professional staff to carry out the programme. The Board of Directors of SFCA (see Annex 8 for list of names) has approved the creation of an IE&C and Training Section as part of the reorganization proposed to facilitate implementation of this project (see Annex 9). A professional Information Officer will be responsible to the SFCA's Executive Director, and will carry out the IE&C strategies which have been approved by the Board of Directors.

One social worker and three promoters (selected from the pool of satisfied users) will be employed to promote family planning throughout the KMA. They will spend five days each week traveling to hold community meetings, visit neighborhoods, and call on households. One day each week will be spent at headquarters preparing reports and teaching in the training courses. Their person-to-person experience will be an important ingredient to FP education. They will also book appointments for surgical contraceptive services and provide a channel for community feedback to the clinic and education programs.

In the area of mass media, all messages and materials will have to be designed, tested and professionally produced. In view of the extensive experience gained in Egypt in population communications by the University of Chicago (U.of C.) the SFCA will request technical assistance in the family planning information programme from U. of C. Final production of materials may be done in Chicago if prices are more economical there and production quality better.

The SFCA plans to disseminate a wide range of family planning messages which are likely to include the following:

- Family Planning Benefits
- The Khartoum Model Clinic
- Contraceptive Methods
- Hazards of Multiparity
- The Islamic View of Family Planning
- The SFCA as a Social Organization at the Service of the People
- Population and Development

Radio and TV will carry family planning spots at various times throughout the week. Pamphlets and booklets will be prepared based on SFCA experience. The material will be distributed in the model clinic, in community meetings, in all MOH clinics in Khartoum Province, and to other MOH clinics that request them. A total of 6,000 posters will be distributed throughout Khartoum Province and to MOH clinics that request them. There will be one advertisement weekly in the leading Khartoum newspaper. Four large billboards will be erected at the main entry points to Khartoum and metal signs will be placed along the streets at strategic points to promote the use of the model clinic and FP in general.

Six one-day leadership seminars will be held at the SFCA's headquarters each year, to discuss population and family planning policies and programmes. Fifteen leaders will be invited to attend each seminar. Speakers will be drawn from the Board of Directors, the SFCA's professional staff, and other respected Sudanese who are conversant with population matters. Another element of the IE&C Section's programme will be the development of innovative IE&C techniques which will be addressed to the husbands who will accompany their wives to the clinic, especially to the evening sessions. A last element of the programme will be IE&C about the medical complications of female circumcision. Religious leaders will be involved in the IE&C activities as much as possible.

3. Clinic Training Programme

Once the clinic has been established and is running smoothly, it will be used as a training center for doctors, nurses and other health personnel. In Sudan at present there is no one clinical training center for all family planning services. The limited instruction that has taken place has been primarily general lectures. Our clinic will offer doctors and nurses the opportunity to learn techniques for IUD insertion, diaphragm fitting and sterilization. Twenty doctors will be trained yearly; five in each of the four two-week courses. Thirty nurses will be trained in three six-week courses. Emphasis will be on clinical training in family planning, but sessions will be given on theoretical aspects as well.

In order to design the two curricula for doctors and nurses, the SFCA will require an Arabic speaking professional nurse-midwife who has experience in family planning curriculum design. The consultant will provide four weeks of service at the beginning of the project, two weeks at month 6, and two weeks at the end of the first year, for a total of two person-months. This will ensure that a high quality and efficient training programme is established.

enough TA?

Funding is also requested for classroom and ancillary equipment and furniture. A detailed list of this equipment appears in Annex 10. The clinic itself will have space for the classroom and necessary offices.

Teaching will primarily be conducted by the staff, but limited funds are requested to pay honoraria for guest lecturers. Per diem and support for the trainees who are government employed doctors and nurses will be paid by the MOH, but the project includes funding for the support of private nurses and doctors working in non-profit hospitals and clinics.

4. Direct Distribution Programme (DDP)

During the past few years, the MOH has experienced difficulty in ensuring a continuous supply of contraceptives to its clinics. Supplies have been warehoused for lengthy periods and no specific distribution plan has been prepared. Usually the only time contraceptive supplies are given out in Khartoum is when the director of a region or of an individual clinic comes to the capital to pick up medical supplies and he specifically asks for contraceptives.

In order to overcome these problems, the MOH and the SFCA have decided to design and test an alternative approach to the supply of contraceptives to MOH facilities, and we are asking for USAID support of this pilot activity. The SFCA will assume responsibility for the importation, warehousing, and distribution of contraceptives to selected MOH hospitals, health centers and other health care delivery points. The objective of this pilot programme will be to test the distribution and acceptance of condoms, the pill and spermicide at general health clinics staffed by personnel with basic family planning training. The medical staff will be given simple directions and guide-

lines for distribution of the commodities and will be visited every 10 weeks for resupply and review of accounting records. Essentially this is a supply side approach to family planning. Once a reliable and affordable source of contraceptives is made available, contraceptive use is expected to increase sharply.*

Since the SFCA will be fully engaged during the first year of the project in establishing the clinic, the DDP will not start until 8-12 months after full clinic operation has begun. The detailed plan of the DDP programme will be established with the assistance of a family planning logistic specialist. To manage the DDP, the SFCA plans to employ a professional pharmaceutical drug salesman who has experience in dealing with medical personnel and logistic systems. The programme will start small, targeting a limited number of hospitals, health centers and dispensaries in the tri-city area. Frequent evaluation will be conducted by the Research and Evaluation Unit within SFCA to determine the pace and type of expansion that makes sense. This unit will also study the extent to which the DDP promotes contraceptive use and family planning. USAID and the MOH with the assistance of an outside family planning consultant will join with the staff of the Evaluation Unit for an interim review of the program at the end of one year of operation. This review will determine the most appropriate use of the remainder of the AID funds provided for developing a contraceptive distribution programme.

The procedures for collection of a contraceptive distribution charge to the client users and the amount to be collected are key issues that must be resolved. SFCA believes that a distribution fee would not discourage use and can be made low enough to be affordable by all. Other FP programmes in the Sudan presently charge a 10-25 pt ($.11-.28) handling fee for each cycle of oral contraceptives. It is possible that the income from the fee would be sufficient to enable DDP to be a self-financing programme and the planning for the DDP should carefully consider options that would lead to financial self-sufficiency.

It should be noted that all contraceptives used in the DDP will be provided from AID/Washington's distribution programme. No request for contraceptives is included in the proposal's budget.

---

*A similar program has proven itself to be successful in Guatemala, where the Family Planning Association assisted the Ministry of Health in logistics for contraceptives. It had taken the Ministry of Health nine years to provide contraceptives in 121 of its 600 clinics. In less than two years, the FPA, with four persons recruited for this activity, achieved full coverage of the MOH's clinics. Moreover, the "scarcity mentality", which usually surrounds the erratic supply of medicines, was removed and clinic personnel began to promote family planning. The women who benefited from this activity would have had to wait many years had it not been for the direct distribution programme.

5. Research and Evaluation

The Association has a strong history in research, perhaps unparalleled by any other private family planning organization in Africa. We will continue to pursue important biomedical and attitudinal research, with assistance from other international donors for specific studies, but with the expansion into new programmes, we will need to have a full-time research and evaluation section. Evaluations will be carried out on the efficiency of the model clinic, its acceptability to the population, and the characteristics of its clientele. Likewise the IE&C programme, the Training programme, and the DDP will require periodic evaluation. Additionally, The Association plans to undertake in the near future operations research and community-based distribution projects. With such a varied Research and Evaluation Programme (R&E), many African countries, particularly the Arabic speaking ones, will be interested in observing and perhaps participating in this important area with us.

To carry out the R&E Programme, the SFCA will create a special section which will be headed by a university-graduated social scientist who will work full-time. This person will receive additional training in the United States at the Family Planning Evaluation Division of the Center for Disease Control in Atlanta, the organization that will provide, at no cost to this project, the technical assistance required by the Research and Evaluation Section. Additional technical assistance for specific studies will be provided by the International Fertility Research Program of Research Triangle, North Carolina. A statistical clerk and a bilingual secretary will also work in the R&E Programme. It is also expected that university students will participate, ad honorum, in the SFCA's programme and thus gain practical experience in research methodologies and the analysis of data which will be used to correct the course of SFCA activities.

The Research and Evaluation section will be responsible for routine monitoring of programme activities. An example is the presentation of a report to the Executive Director and to the Board of Directors every three months. This report will include the number of new acceptors, active users, dropouts* and the number of contraceptives, by type, distributed by the model clinic and the DDP.

Several specific studies have been identified already for the Research Unit. First, since the provision of natural family planning will be an alternative offered at the clinic and very little is known about its use and effectiveness, a detailed study of natural family planning users will be conducted. Data collection will cover the personal and cultural preference for this method, the limitations, if any, on its use and the effectiveness of the method.

---

*"New acceptor" is a woman or man who has never before used a modern contraceptive. An "active user" will be all those persons who continue using contraceptives. They will be dropped from the active users list and become "dropouts" if 3 months elapse after their supplies have run out.

Secondly, tests of various combinations and levels of clinic fees and contraceptive handling fees will be undertaken. There is an obvious trade-off between programme income and thus financial self-sufficiency and the social concerns of providing services to the poor. SFCA and the MOH in general need to know more about these trade-offs.

Related to this second study will be a series of surveys on the cost and provision of private sector family planning service. A special study of contraceptive cost and availability at local pharmacies will be conducted to assist in planning the Direct Distribution Programme.

6. Administration

Currently the Association has only four employees, none of whom are professionals in Family Planning. All of the Association's scientific and technical activities have been carried out on a voluntary and part-time basis by members of the Board of Directors. With the proposed expansion of activities, and considering their scale, it is imperative that we count on a minimum of competent professional and support staff to successfully implement the programme. AID assistance is requested to permit the Association to employ a full-time professional administrator, who will serve as the SFCA's Executive Director, and be responsible to the Board of Directors for management of all programmes. We also request assistance for an accountant, a bookkeeper, an administrative assistant and two secretaries, office equipment and supplies, rent and utilities for headquarters and transport.

C. Project Budget

The SFCA is a voluntary private, non-profit, social service organization which is registered with the Department of Social Welfare of the Ministry of Internal Affairs. It currently has 102 members and a ten-person Board of Directors. Members contribute $5.57 annually. Other income is provided by external donors. The IPAVS and the IFRP presently fund the administrative costs of the SFCA ($37,000 annually) which includes the rental of a two-room headquarters, four employees, and overhead. IPAVS and IFRP also fund research and service activities.

The following summarizes present donor support to the SFCA:

$54,348	International Project, Association for Voluntary Sterilization
72,684	International Fertility Research Program
31,129	Family Planning International Assistance
$158,161	Total in 1982

If AID support is granted for the project proposed in this paper, IPAVS and IFRP will withdraw funding for administrative costs. They will then apply the funds to an expansion of research and service activities. The Association will look forward to continuing consultative services and support from IPAVS and IFRP.

The Association's request for the five year project is summarized in Tables 2 and 3.

Table 2

Life of Project Summary Budget*
($ 000)

Item	Amounts AID-OPG (FX)	GOS (LC)	SFCA (LC)	Total
1. Technical Assistance	189	-	-	189
2. Training	125	14	-	139
3. Commodities**	321	66	45	432
4. Commodity Shipping & Price Contingency	155	-	-	155
5. Personnel	-	1051	570	1621
6. Rent & Utilities	-	773	-	773
7. Media Costs	-	138	-	138
8. DDP Contingency	50	100	-	150
9. Misc. & FX Contingency	80	377	-	457
Totals	$920	$2519	$615	$4054

*Inflation is included: 10% compounded annually for foreign exchange(FX)
20% compounded annually for local costs(LC)

**Contraceptives valued at approximately $762,000 will be provided free of charge to the Association by AID/Washington. Limited technical assistance will be available from other AID/Washington funded contracts.

From Table 2, the Operational Program Grant will fund the foreign exchange cost of $913,000. The local costs for the Model Family Planning Programmes will be provided by the GOS through the provision of CIP generated local currency, $2,519,000 and by the SFCA through the collection of clinic fees, $615,000. These three sources provide for the LOP funding of $4,047,000. Additional contributions to the project are footnoted in Table 3. AID/Washington through a central programme for contraceptive supplies will provide an estimated $762,000 worth of contraceptives to SFCA for distribution as part of the programmes. Other donor or local support for the project will be provided by CDC for technical assistance (4 person months, $60,000) in the design and establishment of the procedures for the model clinic.

In-kind support for the project is varied. The ten member Board of Directors (Annex 8) and other SFCA professionals are expected to volunteer time for SFCA administration, research and teaching. It is difficult to place a value on this combination of volunteer services but the total time is approximately 60 hours a week, most of which is physician time. Additionally the Ministry of

Yearly Summary Budget by Project Component*
($ 000s)

Activity		Year 1	Year 2	Year 3	Year 4	Year 5	Total
1. Khartoum Model Clinic	Foreign Exch.	216	25	25	13	13	292
	Local Costs	175	196	228	275	331	1201
Subtotal		391	217	253	288	344	1493
2. IE&C Programme	Foreign Exch.	103	35	38	11	5	192
	Local Costs	94	75	89	96	115	469
Subtotal		197	110	127	107	120	661
3. Clinic Training Programme	Foreign Exch.	13	13	-	-	-	26
	Local Costs	27	32	39	46	57	201
Subtotal		40	45	39	46	57	227
4. Direct Distribution Programme	Foreign Exch.	-	44	1	63	7	115
	Local Costs	-	9	30	86	97	222
Subtotal		-	53	31	149	104	337
5. Research & Evaluation	Foreign Exch.	-	13	30	-	20	63
	Local Costs	25	30	37	43	52	187
Subtotal		25	43	67	43	72	250
6. Admin. Support	Foreign Exch.	125	6	6	10	5	152
	Local Costs	115	137	165	198	239	854
Subtotal		240	143	171	208	244	1006
Summary	Foreign Exch.	457	136	100	97	50	840
	FX Contingency	80	-	-	-	-	80
	Local Costs	436	475	588	744	891	3134
GRAND TOTAL		973	611	688	841	941	4054

*Inflation Included

Internal Affairs has provided and is expected to continue to provide selected staff on secondment to assist in SFCA research. Hospital and health center facilities for clinical research will be made available by the MOH throughout the life of the project. Additionally the MOH will provide staff and support to the clinics participating in the DDP. In addition, some funds will be generated by the DDP, but the exact amount and their use will not be determined until year 2 or 3 of the project when the detailed planning for the programme is complete.

A detailed yearly budget by component and input appears in Annex 11. Funding contributions to the project, by amount and percentage, are shown in Table 4. By adding the AID/Washington components, the total project cost becomes $4,876,000.

Table 4

Model Family Planning Programmes: Summary of Funding Sources

Funding Source	Amount in $'000s	Percentage of Total Budget
1. GOS-CIP Generated Funds	2519	51.7 %
2. AID-OPG	920	18.9 %
3. SFCA-Clinic Fees	615	12.6 %
4. AID-Contraceptive Supply Programme	762	15.6 %
5. CDC-RSSA	60	1.2 %
Grand Total	4876	100.0 %

The components of the first five programmes in Table 3 were described in Section III B above. Expenses for administration include the central overhead costs for running the five family planning programmatic components. Of the proposal's operational budget for the five FP programmes, that is $2,968,000 which excludes contingency and administrative costs, 50.3 percent supports the clinic. The IE&C programme receives 22.3 percent; DDP, 11.4 percent; Research and Evaluation, 8.4 percent; Training, 7.6 percent. This is a cost effective distribution given the importance of the clinic to the other activities. The clinic is the keystone of SFCA's Model Family Planning Programmes.

IV. PROJECT ANALYSES

A. Economic Analysis

1. General Economic Benefits

The total number of direct beneficiaries of the programme, that is active FP users, will be 44,000/year at the clinic and if the DDP

proves successful and is expanded, approximately 50,000/year additional users will be added. In the last year of the project there will be approximately three million married women of reproductive age (MWRA) in the KMA who could benefit from the project services. Thus the project will be benefiting less than 3.2 percent of the total population of MWRA. Unfortunately this small percentage using project family planning services is not expected to cause a measurable change in the annual birth rate in the KMA. Thus an economic analysis based on a macro change in population growth is not feasible.

Substantial economic benefits, however, will accrue to the women and families who participate in the project and adopt family planning. Provision of family planning services will enable couples to choose the size of family that they want and can afford, thus assuring a higher disposable income per family member. This is especially true for urban families because in the cities children have more difficulty finding work than in the rural areas where child farm labour often is considered essential. Additionally, small families benefit from better nutritional status and increased access to education. The mother's health and that of the infant is enhanced by proper spacing, allowing the baby a better start in life with prolonged lactation. These health benefits have economic impacts on the ability of the mother to work in the care of her family. Spacing of children improves her work productivity and increases the time she is available to work.

Since children are often viewed as a labour asset, especially in the rural areas, and also are expected to provide social security for their parents' old age, motivation to raise small families is often low. However, in the long term lowered child mortality rates due to child spacing, increased access to health services and better nutritional habits should be accompanied by lower birth rates as the children can be expected to survive to adulthood.

In general, the economic benefits that accrue to the family that chooses to plan its children are substantial, but the economic impact of such a choice is difficult to quantify. On the other hand, the effects of present over-population on the environment and quality of life in Sudan are apparent. Sudanese farmers, because of increased population are being forced on to marginal lands which are less productive. The possibilities of erosion and destruction of this type of land are high. The rapid growth in urban and city population means more and more people seek fuel for cooking and other domestic uses from the forests and scrub land around the population centers. The stripping of the land creates a general degradation or even desertificaton.

The urban migration to the KMA, in part caused by rapid population growth in the rural areas, has placed an extreme burden on the education system and supporting services in the city. Power outages are a daily occurance. Water service, although more dependable than electricity, is also frequently out. Housing shortages are severe.

The SFCA family planning programme for Khartoum is relatively small given the enormity of the problem, but even this model program will have substantial impact on the economic well being of the participants. Further, this first step will be important in the development of a national family planning programme that begins to address the enormous population problem that will seriously limit Sudan's economic development in the next 25 years.

2. Cost Effectiveness of the Programmes

The lowest cost solution to the delivery of FP services in Sudan would appear to be through the use of the developing primary health care system of the MOH. Personnel delivering health services, especially MCH services, would be an excellent channel for family planning while at the same time contraceptives could be delivered to MOH dispensaries and centers through its drug distribution channels. To some extent the MOH through the assistance of UNFPA has begun to use MCH programmes for FP. However, the pace has been slow. In SFCA's judgment, family planning has remained undeveloped because the task of providing health care services throughout Sudan is so enormous that the MOH has been fully occupied with it. And still very much remains left to be done. There is a critical need for more trained health personnel at all levels. The health infrastructure especially in rural rareas is weak. The drug distribution system is not adequate and frequently clinics are without even basic drugs. Given these enormous health service problems, it is not surprising that little MOH effort has gone into FP.

The SFCA programme offers an alternative to the MOH family planning approach. It recognizes the constraints that exist at this time in the MOH and will test a model FP clinic and a direct distribution programme of contraceptives. The clinic is essentially a private sector alternative while the DDP programme is an amalgamation of the private and public sector in that it uses MOH centers as distribution points and the SFCA staff and vehicles for logistics. Both programmes as models can be adopted by the MOH at a later date and fitted within the Primary Health Care and MCH programmes. Thus, the proposed SFCA approach, given the present MOH constraints, is the more cost effective. It will provide a model for FP programmes that can be adopted by the MOH when feasible or can continue to run in an independent but complementary way to the MOH system.*

*It should also be noted that in several Latin American countries the independent, direct distribution programme has proven to be the only effective means of contraceptive distribution programme back to the local family planning association after trying and failing in its own MOH distribution programme. This is not to imply the Sudanese MOH is incapable of contraceptive distribution but only demonstrates the cost effectiveness of direct distribution systems.

A. Financial Viability of the Model Clinic and DDP

One measure of the cost effectiveness of a programme is the extent to which it can become financially self-sufficient. SFCA has established a fee schedule for the services it will provide at the clinic. These fees will generate income for the clinic at the levels indicated in Table 5. Fees will be adjusted to reflect inflation and will be applied to the general operating budget of the clinic. Although the clinic is not financially self-sufficient by the end of the project, its self-financing capability increases over time. Table 6 shows that the clinic income as a percentage of recurrent local costs moves from 30.8 percent in the first year of the project to 69.8 percent by year five. Over the life of the project clinic income will pay for 50 percent of the recurrent local costs.

Table 5

Calculation of Income from Model Clinic
($ 000s)

Method	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Orals	25,987	30,145	35,343	40,540	65,340	197,355
IUDs	16,483	19,120	22,417	25,417	29,010	112,744
Sterilizations	10,302	11,950	14,010	16,071	18,132	70,465
Others	1,856	2,153	2,524	2,895	3,267	12,695
Total	54,628	63,368	74,294	85,220	115,749	393,259
Inflation of Fees (20%/yr)	54,628	76,042	106,083	147,260	231,000	615,913

Calculations are based on three clinic visits per year per user. Both admission fee and method fee are included.

Table 6

Local Recurrent Cost Financing, FP Model Clinic
($ 000s)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Local Recurrent Cost	175	196	228	275	331	1201
Clinic Income	54	76	107	147	231	615
Income as % of Recurrent Cost	30.8	38.7	46.9	57.1	69.8	51.2

The Direct Distribution Programme will show a similar recurrent cost trend. However, until a fee schedule and detailed plan are established, it is impossible to quantify the extent to which it will become financially self-sufficient. The detailed plan will include an analysis of financial viability and will identify a fee structure that will insure financial self-sufficiency by year five of the programme operation.

B. Information, Education and Communication

To make the clinic and FP programmes more fully utilized and thus in general more cost effective, the IE&C activity has been added to the programme. Given the Sudan Fertility Survey results which show that 41 percent of rural women are unaware of the possibility of FP, the need for this component is self evident. Even in Khartoum where the knowledge of FP exceeds 80 percent, only 32 percent of ever married women had ever used contraception. The IE&C programme will use mass media, printed matter and posters as well as person-to-person contact to promote family planning use. The use of the community family planning educators and satisfied users as agents for that programme will complement the mass media campaigns. This combination of media and personal contact has been shown to be the most effective means of communication and education in FP activities in other countries. The combination, thus, reflects a cost effective approach.

C. Training

Most of the clinical FP training which will be provided by the project is not now offered on a formal basis anywhere in Sudan. The development of a specialized short course will give doctors and paramedics an opportunity to develop clinical skills in a relatively short period. The double use of the clinic as a model for FP services and a center for training is a cost effective approach. Further it is extremely important at this early stage of family planning in Sudan to develop a clinical programme that trains health personnel in the delivery of FP services.

3. Complementarity with Private Sector

Although it is impossible to quantify the number of women using the private sector for family planning services and contraceptive supply, it is known that private physicians and pharmacies are the largest providers. However, those being supplied are relatively rich members of Sudanese society. The high price in the private sector, that is, $11.10 for a physician's consultation, $2.00 for one cycle of pills, makes it impossible for the majority of the residents of KMA to use private sector family planning services. Additionally, awareness and acceptance of family planning is highest among the more educated women and thus the distribution of women using private sector FP services is skewed further toward the higher income groups.

The target group for SFCA's Model FP clinic is stated as all women of reproductive age in the KMA, but its largest impact will be on the lower income women who have not been able to afford FP services. The women who can afford it will continue to seek FP services in the private sector. The fee structure planned for the clinic will be low enough to ensure that services will be available to all women. Income estimates from clinic fees are based on the assumption that 10 percent of the clinic users will not be able to afford the low fees. Thus, by and large the SFCA clinic with primarily lower income users complements the private clinics and pharmacies which provide services to a higher income clientele.

Because the model family planning clinic will provide top quality services on a par with the private sector, it is anticipated that some women will switch to the SFCA clinic. The experience of programmes in other countries indicates that the total numbers will be small in relation to the overall demand, perhaps 10 percent of those women now receiving private sector services. The SFCA Executive Board members have welcomed this possibility, stating that their own private clinics are too overloaded now.

The supply of services by the private sector has not been sufficient to meet demands. SFCA male attitude and hospital studies, discussed in the Background Section of this paper, show a strong demand for services. Many doctors in KMA have not had the time to focus on family planning because of their heavy medical service burdens and disinterest in FP. Local pharmacies have had difficulties importing contraceptives because of general foreign exchange shortages. SFCA as a private, non-profit organization will provide service to meet the gap. Further, its IE&C programmes will promote family planning in general and thus will encourage family planning among those women who would use private physicians and pharmacies. Finally, some women who live a distance from the clinic may decide to purchase contraceptives at the local pharmacy for convenience in spite of the high cost.

Because so little data is available on the private sector, the Research and Evaluation Unit of SFCA will conduct a series of surveys on the cost and provision of private sector family planning services. A special study of contraceptive cost and availability at local pharmacies will be conducted to assist in planning the Direct Distribution Programme.

In summary, the SFCA family planning clinic will provide services to a different group than the higher income women now served by the private sector. There will be some loss of clients/patients by pharmacies and private doctors in the initial year of operations. This loss, however, will not seriously affect their businesses. Additionally, the SFCA programme will address the unmet demand which neither the private nor public sector is able to supply. A a result of more women receiving services, pharmacies may actually experience an increased demand for contraceptives.

B. Technical Analysis

1. Medical Aspects

SFCA has included the following measures to ensure that the medical aspects of the programme are technically sound:

a. A medical advisory committee will be created to establish general medical policy and clinic protocols as they relate to the safe delivery of family planning services. Committee members will be composed of medical experts on contraceptive technology and will meet quarterly. Since this project and its activities will play an integral and complementary role to the MOH's primary health care programme, a representative from the MOH will be included on the committee. The Medical Director of the clinic will be an ex officio member of the advisory committee and will be responsible for implementing the policies.

b. Standardized medical history forms and screening check lists will be developed and used by all clinic personnel to assure the delivery of high quality family planning services.

c. Couples will be educated on the wide range of available contraceptives including natural methods of family planning. Once a method is chosen, thorough instruction will be given on use of the method, common side effects, warning signals and return visit requirements.

d. The clinic will be staffed by nursing sisters who have received in-depth training in clinical family planning methods at the Margaret Sanger Center, Planned Parenthood or a similar quality training programme. They will be backstopped by the full time medical director and an Ob/Gyn consultant present during clinic hours.

e. Backstop hospitals have been identified for conditions which require more care than that delivered in a routine family planning clinic.

f. Before surgical contraceptive services are provided in the clinic, the theatre must be inspected and certified by the MOH. Once the facility is approved, services will be provided by the consulting Ob/Gyns on an entirely voluntary basis. SFCA's standard informed consent form will be required for voluntary surgical contraceptive services (see Annex 3).

2. Clinic Operation

The technical assistance (TA) requirements for all project components have been carefully determined and discussed in the project description. Some of the TA will be supported by central AID/W population intermediaries. If more assistance is needed, additional support will

be requested from the central resources. The TA provided by CDC/ Family Planning Division is considered an important part of the establishment of efficient patient flow and the health information/ record system which will provide the data required by management for the monitoring of clinic operations.

One innovative aspect of this programme is that nurses and midwives will be providing the majority of the family planning services with adequate medical back-up as described in the medical aspects above. The programme will be able to demonstrate that trained nurses and midwives can provide the bulk of family planning services, releasing medical doctors for the handling of complications and referrals for VSC.

The R&E unit will contribute significantly to clinic operations by the routine monitoring procedure described under III. B. Project Activities. In addition client attitude surveys conducted by the R&E unit will allow the clinic personnel to adjust clinic operations to the needs of the clients.

Many clients must now wait from one to three months for a place on the operating room schedule for VSC. The clinic facility as planned by SFCA is expected to decrease this waiting time by one half.

3. Managerial and Administrative Aspects

Since its founding, SFCA has experienced capable, innovative and continuous leadership under the executive directorship of Dr. Hamid Rushwan. He is held in high regard by his peers as well as politicians and is presently also Chairman of the Department of Ob-Gyn at the University of Khartoum School of Medicine. Despite a busy work schedule his commitment to SFCA and to family planning has increased rather than decreased, and he plans to continue as executive director to provide leadership for this project.

The incentive that the Model Family Planning Programmes provide SFCA is the opportunity to develop a quality family planning service for lower income women which can serve as an example to the professional community and as the focus for teaching clinical family planning. It is believed that the medical community will be the most severe critics of the clinic and, for this reason, the Association intends to run a quality project.

SFCA has shown its ability to carry out research and to meet the objectives of its IFRP and IPAVS grants. The Association, however, has not yet had the opportunity to demonstrate its capability to implement a project of this size. Nevertheless, it has taken a significant step this past year to improve its management capacity.

Funding has come from two major sources since the founding of SFCA: IPAVS and IFRP. Approximately 25 percent of the project budgets has been used for administrative support. In the past, SFCA managed these two projects separately in order to fulfill the different administrative

requirements of each donor agency. However, the SFCA felt that maintaining separate personnel for each project was cumbersome and ineffective. They identified this as a problem area which needed to be improved. After discussing alternatives with USAID/S, SFCA changed its organizational structure and reduced its staff from seven to five. USAID/S feels that this change indicates SFCA's willingness and ability to address administrative problems.

Care will be taken to select a full-time project administrator who has sound management and administrative experience. In fact, a key to the success of this project will be the careful selection of all unit heads for each of the five project components. There are a number of Sudanese trained in population and family planning at various courses in the United States and elsewhere. In recruiting for project staff, efforts will be made to identify these trained people and incorporate their skills into the programme. An early assessment of the management needs of project staff will also be made and an in-service training programme instituted with appropriate TA input. Policies and procedures regarding personnel and personnel actions will be defined early in project implementation. These procedures will be reviewed and approved by USAID/S. Defined personnel procedures will insure objective selection and evaluation of project personnel.

It will be extremely important not to overload project staff by trying to start too many new activities all at once. As mentioned before, while the project has five component parts, each activity will be phased in a logical sequence. The activities of the Research and Evaluation unit will provide timely feedback on the identification of unanticipated technical and administrative problems as well as management data on personnel utilization.

Observation tours for key staff and SFCA board members will include visits to functioning DDPs in Latin America to facilitate the design in the second year of the direct distribution component for the project. CDC technical assistance will contribute heavily to the planning phase. When the pilot direct distribution begins, supervision of field activities will be important. It is realized that for adequate field activities and supervision, vehicles will need to be maintained and operated. In the detailed design of the DDP, the vehicle operation and maintenance problem will be addressed. The options of contract or direct hire mechanics for the programme will be considered as well as a special dealer parts inventory programme.

4. Interrelationship of Programme Components and Coordination

The Model Clinic is the keystone to the project. It is for this reason that the development of the Model Clinic is one of the first activities to take place in this project. Although the Model Clinic will offer comprehensive reproductive health services, the programme will also provide educational, informational, training and outreach services. Each component of thep roject is an integral part of the family planning programme. The training programme depends on a well

functioning clinic operation to serve as the basis for clinical training activities. The Direct Distribution Programme will need to refer couples with problems or those desiring other methods to the Model Clinic for follow-up. The Research and Evaluation Unit will depend upon a sizeable caseload to be able to conduct relevant research on programmatic and biomedical health issues as they relate to FP.

The MOH cooperation at every level and step of project implementation is important. The SFCA will inform the MOH of all project activities and assure their support for child-spacing services to supplement the MOH primary health care programme.

The coordination and interrelationships of MOH staff and SFCA DDP personnel is critical. The MOH will have to assure that the service sites supplied by the DDP will give adequate attention to family planning services. It is also imperative that MOH providers of FP services be trained to screen clients and to distribute contraceptives and know where to refer women with problems. This quality control is essential for the DDP programme and will require careful planning to implement.

The SFCA will be offering clinical training programmes for nurses and physicians, and the MOH will identify potential candidates and give assurance that once trained they will be working in family planning.

A referral mechanism will also be set up whereby MOH clinics not offering comprehensive family planning services can send clients to the SFCA clinic. At the same time those couples coming to the SFCA clinic with health or nutritional problems will be referred to the appropriate MOH clinics.

C. Social Soundness Analysis

1. The Problem and its Setting

The Sudan Fertility Control Association (SFCA) identifies what it characterizes as an "urban demographic crisis" which is especially acute within the KMA. It cites as evidence of this crisis the rapid growth of the area during the past quarter century, a present growth rate estimated at 6.6 percent per year, and the concomitant inability of the economy to generate sufficient employment opportunities, public and social services, housing and so forth to meet the population increase. SFCA argues that while the Government of Sudan (GOS) and many opinion makers and other national leaders generally see Sudan as failing to reach its economic potential because of underpopulation, these same leaders have become increasingly concerned about the social, economic and political implications of urbanization. This concern with urban population increase has led the GOS to tolerate (if not actively encourage) the dissemination of family planning information and services. This urban based FP programme is implemented largely through the private sector, notably private clinics and pharmacies.

The limited scope of the current FP effort is due mainly, according to the SFCA's analysis, to the cost and convenience of available services. The average salary of a clerical or service worker is the equivalent of $100-125 per month; factory workers earn around $2.00 per day. Thus, it follows that the prevailing FP cost structure must surely be a major deterrent to many lower middle and working class couples. The SFCA argues that according to survey results, there exists a substantial pool of potential acceptors who desire FP services and will avail themselves of low-cost, conveniently located providers.

Annex 13, a translation of an article originally in Arabic on Islamic Religion and Family Planning, was written by the present Chairman of the SFCA Board of Directors. This article represents the religious interpretation which guides the family planning services provided by SFCA members.

One of the marked changes in Sudanese society during the 1970s was the increased numbers of young women who completed senior secondary school and received post secondary education. While the urban upper middle class traditionally sent its daughters to secondary school and even colleges in Egypt or Europe, during the '70s members of the middle and lower class began with increasing frequency to be found in post secondary institutions in the Sudan. Many of these women went into professional and semi-professional vocations (medicine, law, agriculture as well as clerical and administrative positions, once the exclusive domain of men) and a goodly number have been able to combine marriage with a career by practicing family planning. These women act as role models for many more couples by demonstrating the economic and health benefits from child spacing and limiting family size.

2. Conclusions and Recommendations

The proposed activity appears to be consonant with prevailing social and cultural institutions and practices. And its activities seem to enjoy the support of key national figures (such as senior Ministry of Health officials) and at least the tacit acceptance of most national political and social leaders. While voluntary sterilization is potentially a controversial issue, it is not so presently and may not become so unless there is a major change in the dominant religious/political alignment within the ruling elite structure. Such a change could take place over the next few years, however, and the project implementors should monitor closely the evolving political climate. Expanded educational efforts directed at senior technicians in the Government and local and national policy makers can reinforce the acceptability of family planning and should be a high priority for the SFCA.

The fee schedule outlined in this proposal was designed to place FP services within reach of the urban lower middle and working class couples. While the majority of the project's clients will likely be from these classes, comprehensive socio-economic survey data should be collected to determine the extent to which the latter groups and members of the middle class are drawn to the programme. This information will provide a sound data base from which fee changes can be determined in relation to the clinic's eventual goal of self-sufficiency. However, it will be equally important to monitor the fee structure so cost does not become a deterrent to seeking FP services.

In order to prepare the way for extending FP services beyond the KMA, studies should be undertaken of the attitudes of rural couples to family planning. Traditional attitudes toward reproduction (e.g., "children are a gift from God") are stronger and information about family planning lower the further one goes out from the urban centers. Hence, a different information/education package may be required to gain the participation of rural couples.

Finally, it should be noted that successful implementation of this relatively ambitious programme (e.g., six days per week, nine hours per day; distribution of commodities; education and information) rests on the administrative capability of a small-scale organization. If the project is to succeed, and if it is to provide a basis for expansion and replication, organization and management (O&M) may well be the key ingredient. Thus, the SFCA and USAID must monitor the operations of the project's management system and establish effective review and feedback mechanisms so that O&M problems can be quickly discovered and remedial action taken. We believe that this proposal reveals an understanding of the factors discussed above. A feasible plan is presented to give the appropriate attention to the socio-cultural aspects presented herein.

V. IMPLEMENTATION ARRANGEMENTS

A. Project Implementation Plan

There are a number of key actions that must take place in the first 9-12 months after OPG approval for SFCA to open the clinic by month 11. Some of the actions, most notably commodity procurement, are not controlled by the Association. Procurement of equipment and vehicles, as well as the provision of operational advances by USAID from a revolving fund, are critical to the establishment of the clinic. Thus, the following Project Implementation Schedule must be followed closely.

PROJECT IMPLEMENTATION SCHEDULE

DATE (by month)	ACTION	RESPONSIBLE AGENT
1	Grant Agreement signed between USAID and SFCA with MOH approval	USAID, SFCA,MOH
1	USAID will send PIO/Cs for commodities and vehicles to AID/W for procurement AFR/DR/POP will urge SER/COM to give expeditious processing	SFCA, USAID, REDSO/EA and AFR/DR/POP
1	SFCA sets up a special non-interest-bearing account for AID project monies, and receives first quarterly advance for operation	SFCA and USAID

DATE (by month)	ACTION	RESPONSIBLE AGENT
1	The SFCA will identify a professional administrator who will be hired as Executive Director of the SFCA as soon as possible	SFCA, USAID
1-12	Recruitment begins for necessary personnel to be hired under the project. In view of expected delays in receiving office and clinic equipment from the United States, most staff should begin working in month 9	SFCA, USAID
1-3	The Executive Director and the Board of Directors seek an appropriate locale for headquarters and the model clinic	SFCA
3	Clinic site is identified, contract signed	
4	SFCA received visit of consultants from the Center for Disease Control. The consultants will assist in designing clinic floor plan, will set up basis for patient flow analysis study and will assist in designing client record systems	SFCA, USAID
5	Six nurses sent to US for FP clinical training	SFCA, USAID
5	SFCA hires consultant to assist in assessing local resources for the IE&C programme. Information officer begins work. Begin design and testing of IE&C materials	SFCA, USAID
4-6	Research and Evaluation Unit Personnel recruited and hired	SFCA, USAID
5	Remodelling of clinic begins, after proper bidding procedures have been followed	SFCA, USAID
6-9	IE&C materials produced are ready for dissemination. Radio, TV and newspapers announce the impending opening of the clinic	SFCA, USAID
7	Director of Research and Evaluation leaves for short course in US	SFCA, USAID
9-10	Model clinic staff receive intensive one-week training course from clinic Director and six US trained nurses	SFCA
10	Office and clinic equipment arrive and are installed	USAID

41

DATE (by month)	ACTION	RESPONSIBLE AGENT
11	Model Clinic opens	SFCA
11	First year research and evaluation plan complete	SFCA
12	SFCA hires nurse/midwife consultant to design curriculum for training courses	SFCA
12	Vehicles arrive for IE&C and administrative motor pool	SFCA
16	First six-week course for 10 nurses begins (repeated regularly every 4 months)	SFCA
18	First two-week course for 5 doctors begins (repeated regularly every 3 months)	SFCA
20	Detailed plan for DDP developed	SFCA
24	Interim Evaluation including Research and Evaluation Section results of model clinic's first year operation	SFCA, USAID, MOH
25	SFCA recruits professional drug salesman to head DDP. Begin six weeks of training in US, Guatemala and Honduras	SFCA, USAID
27	Detail person is recruited for DDP, Ministry of Health provides official letter to target clinics announcing start of pilot DDP	SFCA, USAID, MOH
28-60	All programs operational and outputs achieved. Research and Evaluation Section results of first year's work under DDP. Consultant assistance for Phase II DDP	SFCA, USAID
42	DDP Phase II starts	SFCA
54	Second and final external evaluation of SFCA's programmes	USAID, SFCA
60	End of Project Status achieved	

B. Procurement and Financing Arrangements

The authorized source of procurement per AID regulations is Geographic Code 000 (US only). This purchase will include five U.S. vehicles and spare parts. Because of the limited SFCA capacity to undertake foreign procurement, USAID/S will purchase commodities and vehicles directly. The list of commodities to be purchased appears in Annex 9. All local procurement will be carried out in accordance with AID rules. Hiring procedures for new SFCA staff positions will be in accordance with Sudanese practices and, generally, will seek as much competition as possible.

Since the budget of SFCA is small in comparison to the required expenditures of the new programmes, advances from the grant will be required to begin operations. Advances will be on a quarterly basis and will be from a revolving fund which will be established according to USAID policies and procedures.

C. Project Monitoring

In accordance with AID's own guidelines for programme implementation under an Operational Programme Grant, the Association will monitor its own performance under the grant, ensuring that time schedules are being met and other performance goals are being achieved. This internal project monitoring will be for each SFCA programme component and will be conducted by the Research and Evaluation Unit. The Association will submit a series of three reports to AID on the status of project implementation - a quarterly financial status report, a quarterly performance report and an annual narrative report - as well as interim reports, when appropriate. The financial report will be the document which provides for the liquidation of the previous advance and defines the budget request for the next quarter. The performance report will be based upon the progress toward expected outputs and purposes of the project as described in the logframe (Annex 11). Same report

At AID's request, the Association's chartered accountants, will perform an annual audit to determine the SFCA has expended grant funds in accordance with terms and conditions of the grant. AID funds provided through the grant (included under the Administration component) will be used to cover the additional costs of the audits.

Project monitoring in the USAID Mission will be the responsibility of the Health/Population Office. The Population Assistant, under the auspices of the Health/Population Officer, will maintain regular contact with the Association, making frequent site visits to the headquarters and the clinic. During the site visits, the following activities will be conducted as frequently as necessary and practical:

- review programme accomplishments and management control systems, including review and approval of the financial status reports; and

- provide such technical assistance backstopping as may be required. This may necessitate periodic TDY assistance from the REDSO/EA and EAAC staff in Nairobi (Health Economist, Population Officer, Supply Management Officer, Regional Legal Advisor, Financial Analyst, etc.).

Of prime importance will be establishment of a relationship with the Association to assure coordination with the on-going AID bilateral programme in Sudan, information exchange, guidance in AID reporting requirements and interpretation of AID grant terms and conditions. The Association looks forward to such professional collaboration.

D. Evaluation Plan

The evaluation plan will consist of a series of operational research activities undertaken by the R&E Unit and two special outside evaluations with the participation of AID and the MOH. The R&E Unit will establish a yearly project component evaluation schedule and submit it to USAID/Sudan for review and approval. These evaluations will cover all aspects of the project and will be forwarded to USAID. Funding of $50,000 for outside evaluations is provided within the budget of the R&E Unit. The first interim evaluation is scheduled for one year after the clinic has been in operation. At that time, sufficient information and experience will be available on all components of the project, except DDP. However, the detailed DDP plan will be complete and available for review. The USAID/Sudan Population Assistant with assistance from the USAID/Sudan Evaluation Officer and Health/Population Officer will be in charge. A contract population specialist, REDSO/EA Population Officer and/or AID/W Population Officer will participate as members of the evaluation team. The MOH and MOFNP will be invited to participate in the evaluation to promote understanding of the programme and to consider the project in relation to the GOS FP programme development. The evaluation will assess the following aspects of the Association and the Model Family Planning Programme:

1. Organization and management of SFCA and individual programmes

2. Budget and financial systems

3. Adequacy of records and data collection

4. Validity of the original logical framework and assumptions

5. Extent of success in achieving logical framework output and objectives

Overall, the evaluation will determine the adequacy of the SFCA and AID inputs in quality and quantity to achieve the goal of models providing family planning services. If there have been deficiencies, the evaluation team will in collaboration with the Association recommend immediate action which can be undertaken within the remaining life of the project.

A final evaluation will be conducted in the last six months of the project and will evaluate SFCA success in achieving the logical framework objectives.

CENSUS AND DEMOGRAPHIC DATA IN THE SUDAN

Introduction

Demographic and socioeconomic data for the Sudan are obtained from standard sources such as censuses, household surveys and civil registration. However, data for the latter are not comprehensive nor reliable and household surveys have been taken only on an ad hoc basis. Census problems relative to timing, coordination, equipment, transport and personnel have also affected data quality adversely.

The experience of people working in national development planning in the decade of the 1970s seems to have convinced government officials that an improved statistical base from which to formulate plans and implement programs is essential. Accordingly, it is the mandate of the Department of Statistics, Ministry of Finance and Economic Planning to improve the quality, availability and periodicity of the data. To this end, the Department has scheduled a census enumeration for February 1983. There are also plans to undertake a series of integrated household surveys -- starting in 1983 -- which will gather information on fertility, mortality, migration, employment, income, consumption and social conditions.

Demographic Data

Estimated population; 1982:	20 million
Crude birth rate, 1981:	49 per 1,000 population
Crude death rate, 1981:	19 per 1,000 population
Annual population growth rate:	2.9%
Total fertility rate, 1973:	7.1 (6.0 to 8.9 range for 10 Northern provinces)
Population under 15 years of age, 1981:	47%
Life expectancy, 1981:	46.3 years (N. Sudan 55.1; S.Sudan 37.9)
Mean age at first marriage for females:	27.4 years
Mean age at first marriage for males:	34.4 years
Education, 1973:	0.3 years (women); 2.8 years for Greater Khartoum (women)
Urban population:	18.5% (20.5% in N. Sudan; 10.3% in S.Sudan)
Foreign nationals, 1973:	300,000 (considered an underestimate)
Nomadic population:	11%
Sudanese nationals abroad:	N.A. (estimated by GOS as greater than one half million)

Censuses

1. In order to obtain population data for the various regions within the country, the administration under the central authority of the British Governor conducted a "census" during the period 1898 to 1903. Estimates were obtained from omdas and sheiks but are considered unreliable.

2. The first national census conducted by the Sudanese Government was to extend over a 12-month period starting in July 1955 (actually took 14 months to complete). The long duration of enumeration was justified on the basis of inadequacies in staff and transportation. The census was de jure, since it was felt that double counts would otherwise result over such a long enumeration period if it were de facto. Rural population data were collected on the basis of a 10 percent sample. Data on nomads* were obtained from sheiks. The population in 1955-56 was recorded as being 10.2 million. The count was not considered reliable, for a variety of reasons: there was political unrest at the time in the Southern region; the enumeration was not completed in Eastern Equatoria; not enough qualified enumerators could be found; language problems emerged in areas in which Bari, Dinka and Nuer were spoken; respondent opposition emerged in some areas as a result of poor publicity and prevalent superstitions (such as that of the "Evil Eye"); not all nomadic groups were located.

3. Techniques used in the 1973 census represented an improvement over those of the 1955-56 period, but many of the same problems of transportation, organization, staff, publicity, preparation time (only nine months) and coverage were encountered. Further impeding operations was the delayed installation of the computer system (almost a year after the enumeration).

The population was divided into three categories: urban; rural-settled, including cotton pickers; nomads. Long schedules were used for urban places and for 10 percent of the rural-settled and the nomads. The final count of 12.2 million was quickly challenged and re-enumerations (for cotton pickers and nomads and on a sample basis for the Blue Nile Province) resulted in a revised estimate, including an assumed five percent coverage error, of 14.9 million. To some observers, this still suggested a low and unrealistic growth rate since 1955-56; in any event, the total was substantially less than the previously expected figure of 17.0 million. The census was de facto. An estimate of a seven percent undercount for 1973 is now suggested by the Department of Statistics.

4. It is the objective of the Department of Statistics to provide census data on a decennial basis. Accordingly the next census will be conducted in February 1983.

The following information will be obtained from all respondents: age, sex, household relationship. A longer schedule, as in 1973, will be used for urban places and for 10 percent of the rural-settled and nomads.** The long schedule

---

* Nomads were defined as individuals who had allegiance to a "nomadic sheikh."

**"Pure nomads" are defined as those who tend animals primarily and move as a group; "semi-nomads" are those who generally live in permanent housing and may be agriculturalists. They do not necessarily move as a group, in unison.

will request information on education, employment (occupation, industry and employment status), fertility, mortality, marital status, migration (country of birth, duration of stay, usual residence), nationality, and housing characteristics (building material, type - traditional or modern, number of rooms, electricity, water source). Housing data will be collected only for occupied structures.

It is estimated that 25,000 enumerators and 4,000 supervisors will be needed for the task. Enumeration districts (ED) will average 200 housing units each and approximately five EDs will be assigned to each supervisor. The enumeration period should last about ten days to two weeks. The census will be de facto. Training programs are scheduled to start in August 1982 and precount for the larger agglomerations will be conducted in November 1982.

The UNFPA contribution is estimated as follows, in US$: personnel $53,800; training $63,000; equipment $1,231,350; miscellaneous $440,500; for a total of $1,788,650. The GOS contribution is estimated at LS 5,068,986.

Preliminary results showing province and possibly district totals should become available starting in June 1983; final results will be forthcoming about a year later. A post-enumeration survey taking a one percent sample of EDs is also planned.

Four national committees are involved in the censal operational framework. The National Coordinating Committee and the Central Census Committee deal primarily with policy issues. The Technical Advisory Committee will concern itself with detail aspects of census work. Membership in these groups covers a wide spectrum of government agencies plus some university economists. The National Communications Committee is in charge of the publicity aspects of the forthcoming census. A census coordinator has been appointed within the Statistics Department to oversee operations and training.

The Statistical Department has overall responsibility for statistical activities in the country but has tended to restrict its activities to the 12 provinces of the Northern region. The Statistics Division of the Directorate of Planning of the Regional Ministry of Finance and Economic Planning is in charge of statistical programs in the three provinces of the Southern Region. The Department in Khartoum, however, has laid plans to closely coordinate censal operations for the forthcoming enumeration.

LIST OF SFCA PUBLICATIONS

1. Abdel Aziz, Farouk." Maternity Performance in Relation to Parity in Three Major Sudanese Hospitals, 1975-1976," Unpublished Doctoral Dissertation, University of Khartoum.

2. Abu Bakr, Salah. "Circumcision and Infibulation in the Sudan," Presented at the Seminar on Traditional Practices Affecting the Health of Women, February 10-15, 1979.

3. Adman, Amal M., Abu Bakr, Salah. "Postpartum Lactational Amenorrhoea as a Means of Family Planning in the Sudan: A study of 500 Cases," presented at the Sudanese Ob/Gyn Conference, February, 1982.

4. El Deeb, Tewfik. "Population and Health," presented at the National Population Conference, April 1982.

5. Gerais, Abdel Salam M.A. "A Comparative Study of Two Oestrogen Dosages in Combined Oral Contraceptives Among Sudanese Women," Unpublished Doctoral Dissertation, University of Khartoum, 1980.

6. Gerais, Abdel Salam and Rushwan, Hamid. "Demographic and Clinical Aspects of a Family Planning Clinic in Khartoum Hospital," Sudan Medical Journal, Vol. 15 (1977), No. 2. 37-40.

7. Mustafa, Mutasim Abu Bakr; Mumford, Steven D.; Kelly, S. Elizabeth. "Male Attitudes Toward Family Planning in Sudan," June, 1982.

8. Robinson, Hyacinth E., Sudan Fertility Control Association, Maternity Record Study: Khartoum General Hospital, Omdurman Maternity Hospital, Khartoum North Hospital, Soba University Hospital, March 9, 1982.

9. Rushwan, Hamid E. "Female Circumcision: Present Position and Future Outlook," presented at the 19th Annual Meeting of the Association of Planned Parenthood Physicians, Washington, D.C., October 30, 1981.

10. Rushwan, Hamid E., Ferguson, J.G., Jr., El Nayal, Z.M., El Nahas, E.H.E., and Bernard, R.P. "Three Center Study on Incomplete Abortion in Khartoum, Sudan: A Preliminary Report," presented at the IVth Sudanese Congress of Obstetrics and Gynecology, Khartoum, 1975.

11. Rushwan, Hamid E., Ferguson, J.G., Jr., and Bernard, R.P. "Hospital Counseling in Khartoum: A Study of Factors Affecting Contraceptive Acceptance after Abortion," presented at the VIIIth World Congress of Gynaecology and Obstetrics, Mexico City, 1976.

12. Rushwan, Hamid M.E. "Clinical and Epidemiological Aspects of Incomplete Abortion in Khartoum," Unpublished Doctoral Dissertation, University of Khartoum, 1976.

13. Rushwan, Hamid M.E., Ferguson, James G., El Nayal, Zein M., El Nahas, El Hadi E., Bernard, Roger P. "Incomplete Abortion in Khartoum: A Second Look," 1977.

14. Rushwan, Hamid, Doodoh, A., Nayal, Z., Nahas, H., I - Cheng Chi, Bernard, Roger P. "Contraceptive Practice of Incomplete Abortion Patients in Djakarta and Khartoum. 1978.

UNIVERSITY OF KHARTOUM
SOBA UNIVERSITY HOSPITAL
DEPARTMENT OF OBSTETRICS & GYNAECOLOGY
FERTILITY / INFERTILITY UNIT
STERILIZATION CONSENT FORM

DATE : _____

I (wife's Name) .....
wish to undergo the operation of Tubal Ligation.

Dr. ..... explained to me that there are other temporary methods which I can use for family planning.

I am fully aware that this a surgical procedure that involves some risks which were made clear to me.

My husband ..... and I understand that the operation is irreversible and we can not have any more children after the successful operation.

We reserve the right to change our mind at any time before the operation and that no medical, health or other services or benefits will be withheld from us as the result of that decision.

....
Signature of Patient Signature of Husband

.....
Signature of Physcian

ESTIMATED CASELOADS FOR MODEL CLINIC

	1983	1984	1985	1986	1987
OPTION "A"					
MWRA	250,000	265,000	281,000	298,000	316,000
Goal (% of MWRA)	10%	11%	12%	13%	14%
Women to be served	25,000	29,000	34,000	39,000	44,000
Total clinic visits	75,000	87,000	102,000	117,000	132,000
Visits per day	254	295	346	397	447
OPTION "B"					
MWRA	250,000	265,000	281,000	298,000	316,000
Goal (% of MWRA)	15%	16%	17%	18%	19%
Women to be served	37,000	42,000	48,000	54,000	60,000
Total clinic visits	111,000	126,000	144,000	162,000	180,000
Visits per day	376	427	488	549	610
OPTION "C"					
MWRA	250,000	265,000	281,000	298,000	316,000
Goal (% of MWRA)	20%	21%	22%	23%	24%
Women to be served	50,000	56,000	62,000	69,000	76,000
Total clinic visits	150,000	168,000	186,000	207,000	228,000
Visits per day	508	570	630	701	772

ESTIMATED CONTRACEPTIVE REQUIREMENTS

Khartoum Model Clinic
(US$)

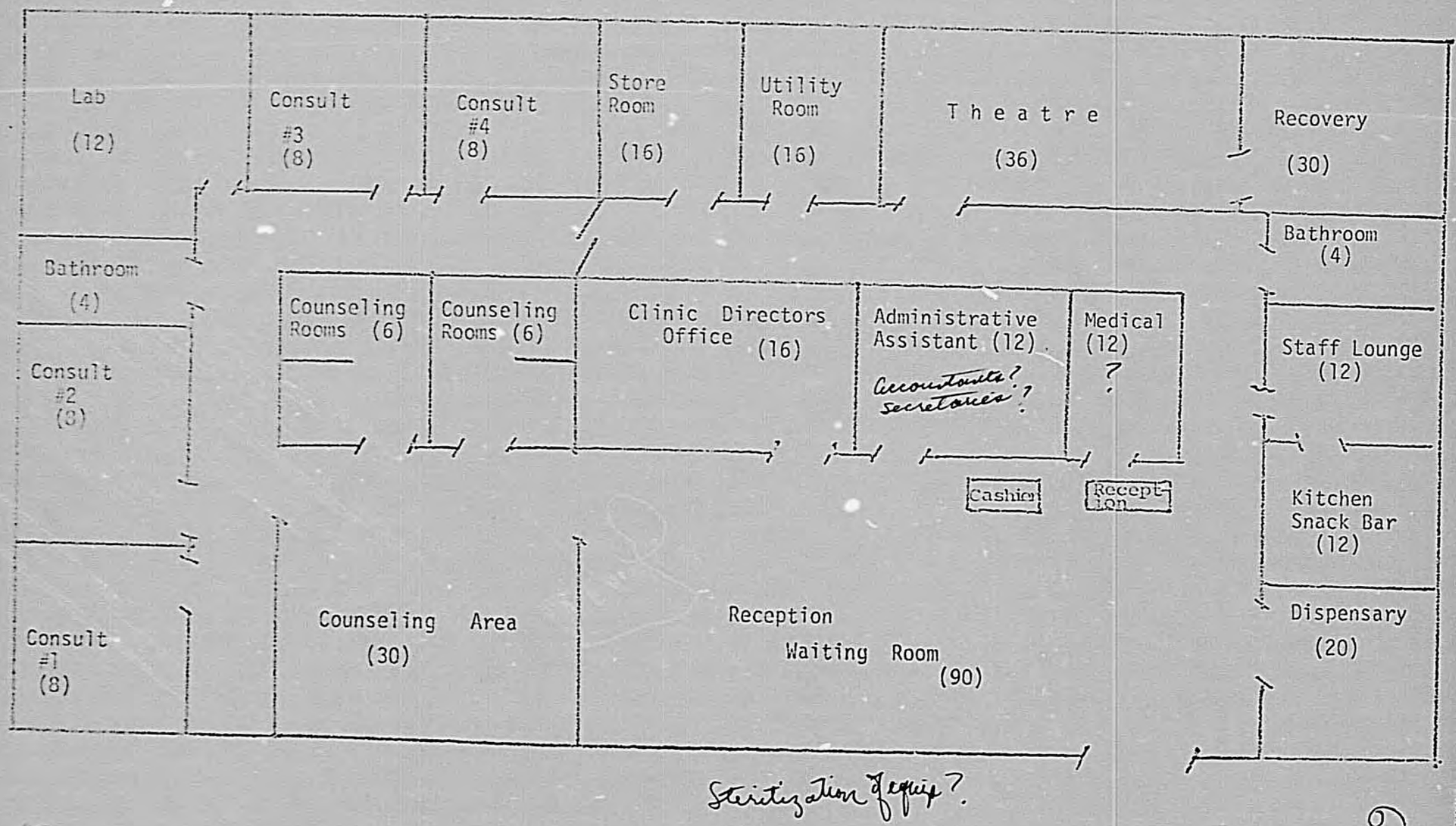
	Year 1		Year 2		Year 3		Year 4		Year 5		Totals	
	Quantity	Cost	Quantity	Cost	Quantity	Cost	Quantity	Cost	Quantity	Cost	Quantity	Cost
Orals	227,000	54,480	263,900	68,614	309,400	86,632	354,900	106,470	400,400	128,128	1,555,600	444,324
Condoms	62,500	3,750	72,500	5,075	85,000	6,800	97,500	8,775	110,000	11,000	427,500	35,400
Foams	62,500	4,375	72,500	5,800	85,000	7,550	97,500	9,750	110,000	12,100	427,500	39,675
IUDs	5,000	2,000	5,800	2,552	6,800	3,264	7,800	4,524	8,800	5,104	34,200	17,444
		64,605		82,041		104,346		129,519		156,332		536,843

ANNEX 5 1

SAMPLE FLOOR PLANS FOR SFCA PROGRAMMES

First Floor Plan

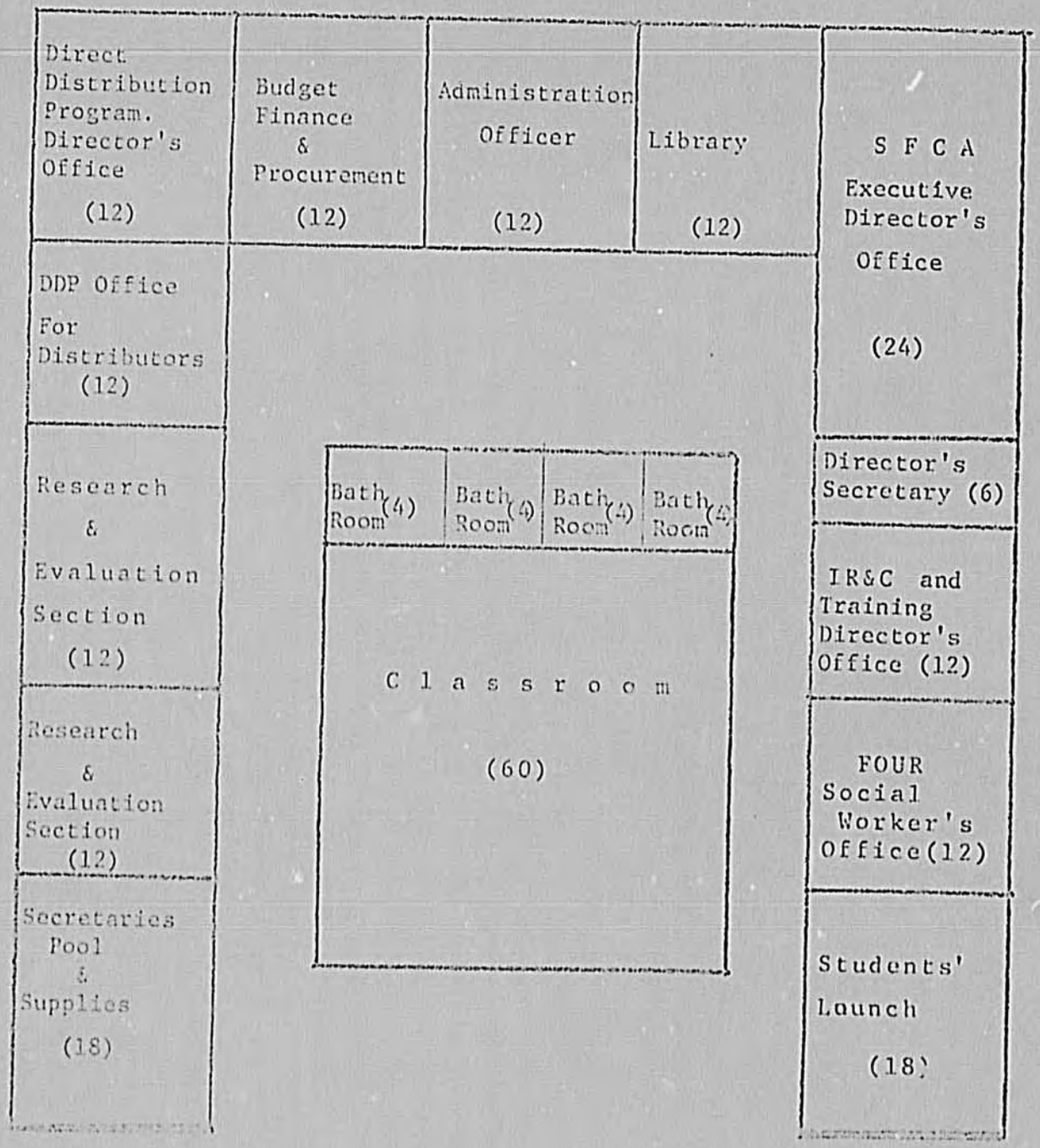
Total Area = 420 Sq.Meters



Sterilization Equip?

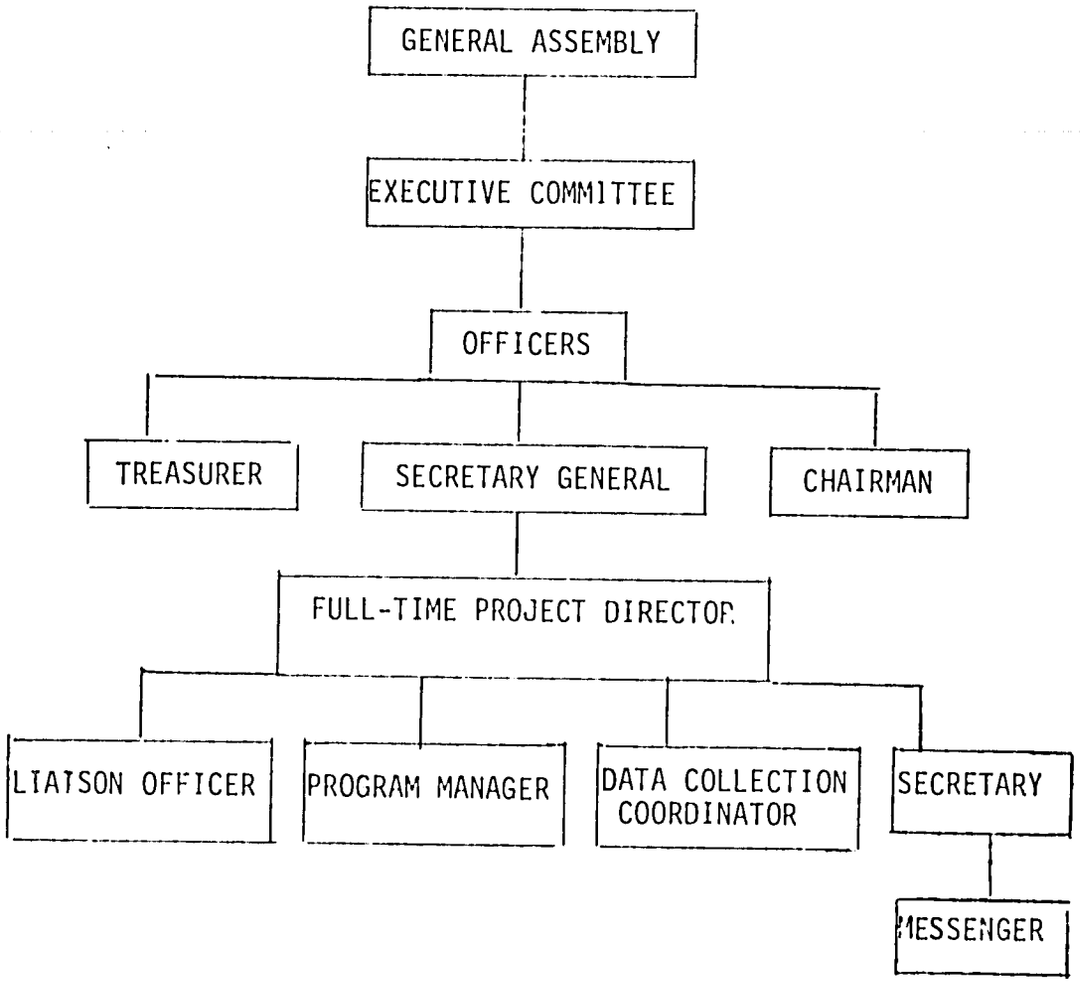
Second Floor Plan

Total Area = 283 Sq.Meters



SUDAN FERTILITY CONTROL ASSOCIATION

ORGANIZATIONAL CHART



February 1982

SFCA EXECUTIVE BOARD*

1. Dr. Harith Hamad Ali
   Chairman and Director of Omdurman Maternity Hospital

2. Dr. Hamid Rushwan
   Secretary-General and Head, Department of Obstetrics and Gynaecology, University of Khartoum

3. Dr. Mutasim Abu Bakr Mustafa
   Treasurer, Director of The Nile Clinic

4. Dr. Fadil Saeed A/Latif
   Member, Consultant at Omdurman Maternity Hospital and Private Practitioner

5. Dr. A/Salam Gerais
   Member and Lecturer, Faculty of Medicine,/University of Khartoum

6. Dr. Farouk A/Aziz
   Member and Lecturer, Faculty of Medicine,. University of Khartoum

7. Dr. Osman Mahmoud Mukhtar
   Member and Senior Obstetrician and Gynaecologist, Ministry of Health

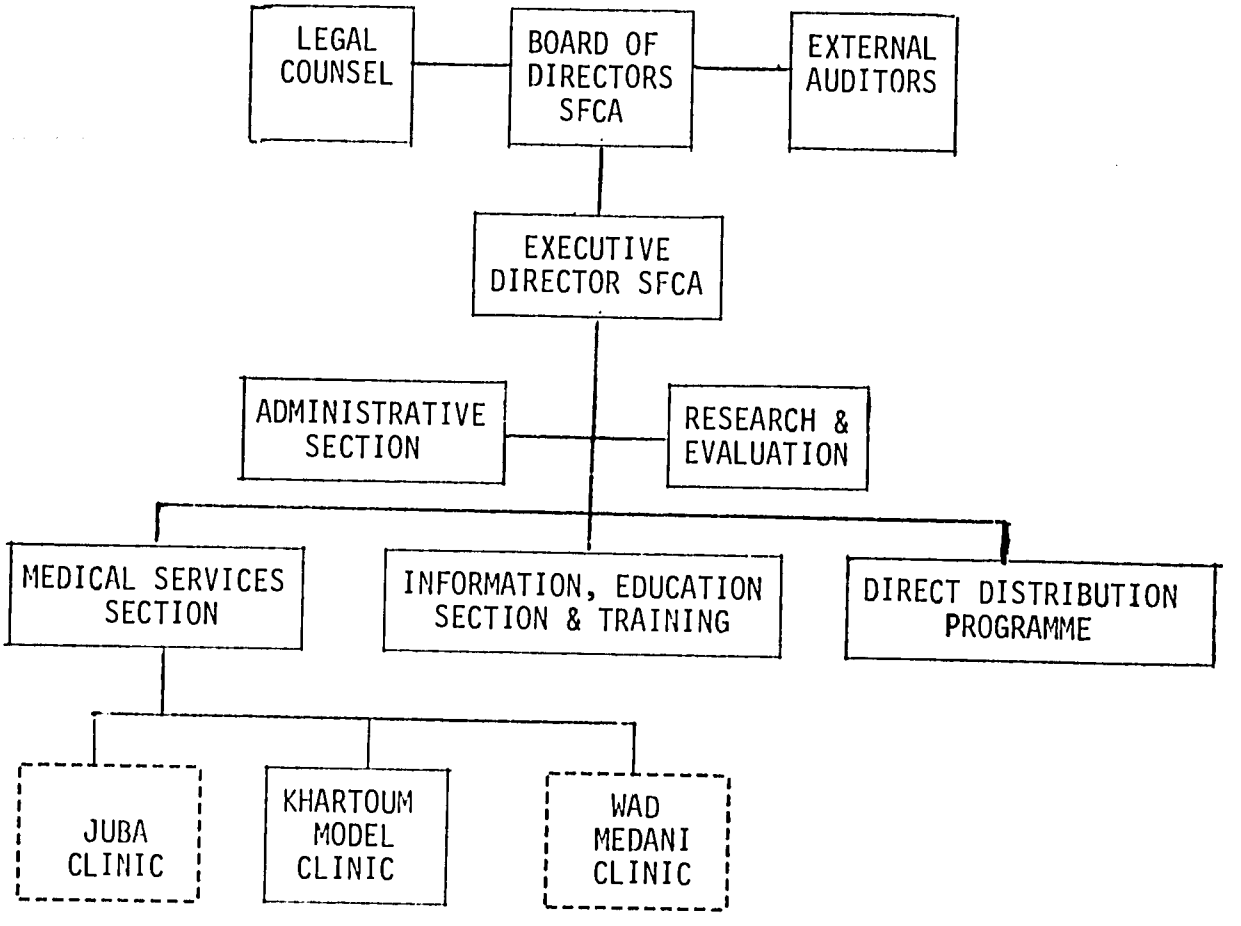
8. Dr. Sadig El Amin
   Member and Senior Obstetrician and Gynaecologist, Ministry of Health

9. Dr. Osman Mahmoud Hassanein
   Member and Senior Obstetrician and Gynaecologist, Ministry of Health

*The Board meets monthly.

PROPOSED REORGANIZATION OF THE

SUDAN FERTILITY CONTROL ASSOCIATION



LIST OF EQUIPMENT AND PERSONNEL

SFCA MODEL FP PROGRAMMES

I. Model Clinic Programme

A. Equipment and Furnishings

4 Examining Tables (4 x $400)	$ 1,600
6 Large Desert Coolers (6 x $1000)	6,000
4 Stethoscopes (4 x $15)	60
4 Sphygmomanometers (4 x $73)	260
1 Microscope	3,600
1 Tabletop Centrifuge with hematocrit Kit	1,500
1 Refrigerator	500
3 Work Tables (3 x $200)	600
4 Supply Cabinets, 24" deep (4 x $250)	1,000
Office furnishings (e.g., desks, chairs, bookcases)	8,790
Waiting Room furnishings (e.g. Blackboard, chairs, small tables, bookcases)	3,470
Medical Records Cabinets (2 x $900)	1,800
Recovery Room furnishings (e.g. beds, sidetables)	1,030
Total	$30,260

Operating Room

1 Operating Table	1,750
1 Operating Light	3,000
Instrument Trolley & Tray	200
1 Stethoscope	15
1 Sphygmomanometer	73

Operating Room (cont'd)

I.V. Stand	$ 75
Sterilizer	916
	6,000
2 Sterilizer Drums (2 x $43)	86
1 Generator	15,000
2 Anesthesia equipment (2 x $300)	600
Nitrous oxide/Oxygen	5,000
Total	$ 32,715*

B. Other Commodities

	Totals for 5 years
1. Disposable lab supplies	
Slides and coverslips $39/100	$ 7,200
Testtubes $51/100	1,500
3 ml Syringes $34/100	1,000
Reuseable needles $79/100	1,500
Lancets, hct tubes, etc.	1,000
Chemicals for lab stains	1,000
Miscellaneous ($3,000/yr) (gloves, speculae, drapes,etc.)	15,000
	$ 28,200
2. Drugs to treat vaginitis, anemia, urinary tract infections, gonorrhea and syphillis for the 10% receiving free services	$ 41,000
Total	$ 69,200

*Instruments for small operating room equipped to perform laparoscopy available locally $5,600 not included above.

C. Clinic Personnel	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1. M.D. Clinic Director (12 mos x $1,670)	20,040	24,048	28,857	34,629	41,554	149,128
2 General Practitioners (12 mos x 2 x $860)	20,660	24,792	29,750	35,700	42,840	153,742
4 Nurses (4 x 12mos x $200)	9,600	11,520	13,824	16,588	19,906	71,438
3 Auxiliary Nurses (3 x 12mos x $150)	5,400	6,480	7,776	9,331	11,197	40,184
4 Counsellors (4 x 12mos x $200)	9,600	11,520	13,824	16,588	19,906	71,438
2 Receptionists (2 x 12mos x $200)	4,800	5,760	6,912	8,294	9,953	35,719
1 Storekeeper (12mos x $350)	4,200	5,040	6,048	7,257	8,709	31,254
2 Drug Dispenser Educators (2 x 12mos x $200)	4,800	5,760	6,912	8,294	9,953	35,719
2 Cleaning Personnel (2 x 12mos x $240)	5,760	6,912	8,294	9,953	11,943	42,862
1 Lab Technician (12 mos x $330)	3,960	4,752	5,700	6,840	8,208	29,460
Sterilization Service						
1 Ob/Gyn Physician (105 3-hr sessions x $55)	5,775	6,930	8,316	9,979	11,975	42,975
1 Nurse (12 mos x $330)	4,560	5,472	6,566	7,880	9,455	33,933
1 Aide (12 mos x $200)	2,400	2,880	3,456	4,147	4,976	17,859
1 Anesthesia Technician (3 hrs x 3/wk x $10/hr x 50 wks)	4,500	5,400	6,480	7,776	9,331	33,487
Total	$ 77,000	92,400	110,877	133,051	159,658	572,986

II. Information, Education and Communication Programme

A. Commodities

Classroom furnishings (chairs, blackboards, tables, bookcases)	$ 13,640
Office furnishings (desks, chairs, typewriter, file cabinets)	5,600
Audio-visual aids (projectors, screens, films, slides)	7,450
3 Small Generators (3 x $500)	1,500
2 Vehicles (2 x $12,000)	24,000
Total	$ 52,190

B. IE&C Personnel

1 Information Officer (12 mos x $780)	$ 9,360
1 Social Worker (12 mos x $390)	4,680
3 Promoters (3 x 12mos x $222)	7,992
1 Bilingual Secretary (12 mos x $500)	6,000
2 Drivers (2 x 12mos x $222)	5,328
Total	$ 33,360

C. Mass Media

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
TV 2-30 sec.spots weekly (2 x $17 x 52 wks)	1,768	2,121	2,545	3,055	3,666	13,155
Radio 2-30-sec. spots daily ($20 x 365 days)	7,300	8,760	10,512	12,614	15,137	54,323
Pamphlets - 250,000 (250,000 x $0.10)	25,000	10,000	10,000	-	-	45,000
Posters - 6,000 (6,000 x $0.75)	4,500	-	-	-	-	4,500
Metal Signs - 100 (100 x $20)	2,000	-	-	-	-	2,000
Billboards - 4 (4 x $950)	3,800	-	-	-	-	3,800
Newspapers ($31 x 52 weeks)	1,612	1,934	2,321	2,785	3,342	11,994
Design	5,000	-	-	-	-	-
Total	$50,980	22,815	25,378	18,454	22,145	139,772

III. Direct Distribution Program (DDP)

Personnel	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Director	-	4,000	10,000	12,000	14,400	40,400
Detail Man	-	-	7,000	8,400	10,080	25,480
Secretary	-	-	4,000	5,000	10,000	15,000
Detail Man	-	-	-	-	6,000	6,000
Total		4,000	21,000	25,400	36,480	87,360

IV. Research and Evaluation

Personnel	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Social Scientist	12,000	14,400	17,280	20,736	24,883	89,299
Statistical Clerk	6,000	7,200	8,640	10,368	12,441	44,649
Secretary	5,400	6,480	7,776	9,331	11,197	40,184
Total	23,400	28,080	33,696	40,435	48,521	187,132

V. General Administration

A. Equipment and Furnishings

Office furnishings for administration, DDP and R&E (desks, chairs, blackboards, filing cabinets, bookcases)	$ 17,400
Office equipment (4 typewriters, 2 copy machines, 3 adding machines, transformers)	16,200
Desert coolers (12 x $900)	10,800
Conference room furnishings (table, chairs, blackboard, rug)	4,900
Staff lounge furnishings (sofas, chairs, tables, rugs, bookcases)	3,000
Staff lounge equipment (refrigerator, vacuum cleaner)	700
Total	$ 53,000

B. Administrative Personnel

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Executive Director (12 mos x $1,500)	18,000	21,600	25,920	31,104	37,324	133,948
Accountant (12 mos x $600)	7,200	8,640	10,368	12,441	14,929	53,578
Bookkeeper (12 mos x $500)	6,000	7,200	8,640	10,368	12,441	44,649
Admin. Assistant (12 mos x $390)	4,680	5,616	6,739	8,087	9,704	34,826
Senior Secretary (12 mos x $450)	5,400	6,480	7,776	9,331	11,197	40,184
Junior Secretary (12 mos x $300)	3,600	4,320	5,184	6,220	7,464	26,788
Janitor/Messenger (12 mos x $250)	3,000	3,600	4,320	5,184	6,220	22,324
Total	$47,800	57,456	68,947	82,735	99,279	356,297

SFCA MODEL FAMILY PLANNING PROGRAMMES

BUDGET ($ 000)

1. Khartoum Clinic*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
I. Foreign Exchange						
A. Technical Assistance (provided by CDC)	-	-	-	-	-	-
B. Training						
1. Nurse training (3 mos x $4000 x 6)	72	-	-	-	-	72
2. Short courses (2)	-	12	12	-	-	24
C. Commodities						
1. Clinic equipment and furniture	63	-	-	-	-	63
2. Lab and other supplies	12	4	4	4	4	28
3. Drugs	21	5	5	5	5	41
4. Commodity shipping & contingency (50%)	48	4	4	4	4	64
FX Subtotal	216	25	25	13	13	292
II. Local Costs**						
A. Personnel	77	92	111	133	160	573
B. Local Supplies	10	12	14	17	21	74
C. Remodel Clinic	15	-	-	-	-	15
D. Rent ($400m^2 x \$10/m^2$ x 12mos)	48	58	69	83	99	357
E. Utilities	10	12	14	17	21	74
F. Misc. & Contingency	15	18	20	25	30	108
LC Subtotal	175	192	228	275	331	1201
Total	391	217	253	288	344	1493

*Inflation is included: 10% compounded annually for foreign exchange.
20% compounded annually for local costs.

**Local costs have been converted to U.S. Dollars at .8973 LS per $1.00.

2. Information, Education and Communication*Programme	Year 1	Year 2	Year 3	Year 4	Year 5	Total
I. Foreign Exchange						
A. Technical Assistance (6 mos short-term)	25	28	30	-	-	83
B. Commodities						
1. Vehicles (2) and parts	24	2	2	3	-	31
2. Other commodities	28	3	3	4	5	43
3. Shipping & contingency (50%)	26	2	3	4	-	35
FX Subtotal	103	35	38	11	5	192
II. Local Costs						
A. Personnel	33	40	48	58	70	249
B. Vehicle Operations	6	8	10	12	14	50
C. Media Costs	50	22	25	19	22	138
D. Other Costs	5	5	6	7	9	32
LC Subtotal	94	75	89	96	115	469
Total	197	110	127	107	120	661

3. Clinic Training Programme*						
I. Foreign Exchange - TA FP Curriculum Designer (2 PM x 2)	13	13	-	-	-	26
II. Local Costs						
A. Doctor/Lecturers	6	7	9	10	13	45
B. Paramedical/Lecturers	19	23	27	33	40	142
C. Leadership seminars	2	2	3	3	4	14
LC Subtotal	27	32	39	46	57	201
Total	40	45	39	46	57	227

*Inflation is included: 10% compounded annually for foreign exchange
20% compounded annually for local costs

4. Direct Distribution Programme*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
I. Foreign Exchange						
A. Technical Assistance (2 PM x 2)	-	14	-	16	-	30
B. Training - Study Tour	-	10	-	-	-	10
C. 1 Vehicle & Parts	-	14	1	2	2	19
D. Shipping for Vehicle	-	6	-	-	-	6
E. Phase II DDP Contingency	-	-	-	45	5	50
FX Subtotal	-	44	1	63	7	115
II. Local Costs						
A. Personnel	-	4	21	25	36	86
B. Vehicle Operation	-	-	4	5	4	13
C. Miscellaneous	-	5	5	6	7	23
D. Phase II DDP Contingency	-	-	-	50	50	100
LC Subtotal	-	9	30	86	97	222
DDP Total	-	53	31	149	104	337
5. Research and Evaluation*						
I. Foreign Exchange						
A. Outside Project Evaluators	-	-	30	-	20	50
B. S.T. Training US (3mo)	-	13	-	-	-	13
Subtotal	-	13	30	-	20	63
II. Local Costs						
Personnel	23	28	34	40	48	173
Publications & Misc.	2	2	3	3	4	14
Subtotal	25	30	37	43	52	187
R&E Total	25	43	67	43	72	250

*Inflation is included: 10% compounded annually for foreign exchange
20% compounded annually for local costs

6. General Administration	Year 1	Year 2	Year 3	Year 4	Year 5	Total
I. Foreign Exchange						
A. Study Tour	6	-	-	-	-	6
B. Commodities						
1. Office, equipment and furniture	53	-	-	-	-	53
2. Two vehicles & parts	24	2	2	3	-	31
3. Misc. supplies	2	2	2	3	3	12
4. Shipping & contingency (50%)	40	2	2	4	2	50
FX Subtotal	125	6	6	10	5	152
II. Local Costs						
A. Personnel	48	57	69	83	99	356
B. Rent ($300m^2$x$10/mo/12mo)	36	43	52	62	75	268
C. Vehicle Operation	6	7	9	10	13	45
D. Utilities	10	12	14	17	21	74
E. Office Supplies	5	6	7	9	10	37
F. Misc. other costs	10	12	14	17	12	74
LC Subtotal	115	137	165	198	239	854
Adm. Total	240	142	171	208	244	1006

SUMMARY

I. All components FX	457	136	100	97	50	840
10% Contingency	80	-	-	-	-	80
II. All components LC	436	475	588	744	891	3134
Total	973	611	688	841	941	4054

OTHER EXPENDITURES

I. AID/Washington Contraceptive Supply Clinic	65	82	104	130	156	537
DDP	-	-	50	75	100	225
Subtotal	65	82	154	205	256	762
II. CDC Technical Assistance	30	30	-	-	-	60
GRAND TOTAL	1068	723	842	1046	1197	4876

SPCA MODEL FAMILY PLANNING PROGRAMMES

Logical Framework

	Objectively Verifiable Indicators:	Means:	Assumptions:
Goal: To establish a family planning system in Khartoum Province to provide contraceptive services to women of reproductive age.	1. Existence of a functional system of family planning clinic in Khartoum Province. 2. Use of contraceptives by 25% of women of reproductive age. 3. Knowledge of nearby family planning clinics and contraceptive methods found in 190% of women of reproductive age.	1. Surveys, census. 2. MOH and other clinic records.	1. The model programme can be replicated on a national basis. 2. The GOS supports a national family planning programme. 3. Funding is available to establish a regional programme.
Purpose: To establish a model family planning programme in the KMA which includes: 1. Family planning clinic. 2. FP clinical training center. 3. Information, education and communication (IE&C) programme. 4. Research and evaluation unit. 5. Pilot direct distribution programme (DDP) of contraceptives.	**End of Project Status:** 1. 165,000 women years of contraceptive protection. 2. Trained personnel are providing FP services at 90% utilization rate. 3. The IE&C programme reaches 90% of women of reproductive age in the Khartoum Province. 4. The Research and Evaluation Unit is capable of evaluating all programme activities and of researching key FP issues in the Sudan. 5. The DDP provides family planning users with contraceptives through MOH hospitals/health Centers and dispensaries in Khartoum Province.	1. Project records. 2. Research and Evaluation Unit reports. 3. IE&C records. 4. Major evaluations. 5. Surveys of Khartoum Province Women. 6. MOH records.	1. Demand for family planning is as great as studies indicate. 2. GOS permits SPCA to distribute contraceptives to MOH clinics. 3. AID provides sufficient and timely funding. 4. MOH actually distributes DDP contraceptives in hospitals, clinics, etc.

ISLAMIC RELIGION AND FAMILY PLANNING

BY

Dr. Harith Hamad Ali,
M.B., B.S., D.G.O., M.G.O.

Note:- This is a summary translation of his article published in the Police Magazine (a quarterly) No.1, Vol.1, Jan. 1974.

The outstanding feature of the Islamic Faith is that it is not confined to a belief and practices of the worshiper towards God; but is in fact a complete pattern of life and a system that organizes the society, morally, socially, politically and economically.

The "Family", the unit of the society has received much attention as testified by many verses of the Koran and quotations from Prophet Mohamed (the two primary sources of Islamic Shareaa i.e. Jurisdiction). Here Family Planning has received less attention but in the other two sources of Islamic Jurisdiction, namely comparison and consensus of its clergy, some litreature is available.

In early times of Islamic faith as can be understood, the look towards family size has been rather two-sided. To encourage marriage, the only legal sextual relation in Islam, and to wide-spread the new Faith, the Prophet has said " Get married, reproduce for by you I am going to boast other nations". However, the desire for few children has been expressed on several occasions. The philosophy of the two-sided view points is probably to allow for latiturde of the Islamic society at different ages and variable socio-economic conditions; the aim is to strike a balance between family needs and that of the Faith (its protection & spread).

1. The Prophet is quoted to have said "The worst of hardships is poverty and too many children".

2. Ibn Abbas, the Prophets direct cousin and very intimate companion has said " Too many children is one of the two states of poverty and few children is one of the two states of welfare".

3. Amr Ibn El Aas, Caliph Omer Ibn El Khattab's appointed ruler of Egypt has warned its people against four things that will lead to destruction, a large family being one of them.

4. The great Islamic thinker, El Imam El Ghazali gave three indications for contraception:-

   i- To attain family welfare i.e. socio-economic aspect of F/P.

   ii- To keep the mothers' fittness and beauty i.e. health aspect of F/P.

   iii- To avoid worries and psychological upsets triggered by responsibilities of large families.

In the early Twentieth Century Imam Abdo EL Sharabasi of Egypt added a fourth indication to avoid herido-familial diseases.

5. Two Islamic practices are known to effect child spacing:-

   i- The official period for breast-feeding is two years as has been stated in verse 233 chapter I (Sourat El Bagarra) - " Mothers shall breast feed for two years if they wish to do so".

   ii- Avoidance of pregnancies during the period of breast-feeding as the mothers milk them (called El Ghila milk) is considered harmful to the nursed child.

<u>The Use of Contraceptives</u>:

The basis for the ruling that the use of contraceptive is permissible in Islam is drawn from the fact that coitus interruptus called El Gazal practiced as a contracptive measure. In pre Islamic Society unlike other practices has not been warned against. In fact some authenticated quotations of the Prophet are well-known e.g.

" In practicing withdrawal the consent of a free wife is mandatory but not that of concubine".

This has established a universal principal of Family Planning, a mutual consent.

Comparing with withdrawal other contraceptives beside abortion &surgical contraception have been legalized.

Unfortunately, this very progressive attitude of Islam (cp. Catholic Christianity) towards family planning has been ignored during the dark ages and is still widely unrecognized.

The first recent Islamic ruling on the use of contraceptives was that made in 1937 by Sheikh Abdel Hageed Salim, the Mofti of Egypt. It says " Contraception by withdrawal, if the wife agrees and by condom, if the husband agrees is permissible and accepted by Islam".

Subsequently many rulings have been made by Islamic resource persons at El Azhar Islamic University (Cairo), Malaysia, Iran, Turkey and Jordan to legalize other preventive contraceptive methods.

Islamic Attitude Towards Abortion

1. There is an Islamic consensus that therapeutic abortion is not only permissible but is mandatory conditioned that the abortion is not more serious than the continuation of the pregnancy. The rationale is illustrated by the analogy that the tree should not be sacrifised for the sake of an off-shoot.

2. In case abortion is induced purely for family planning i.e. socio-economic or personal aspects, Islamic opinion differ depending on the concept when ensolement takes place in foetal development.

Some verses of the Koran e.g. "Verse 12-14 chapter 23 i.e. Sourat El Moaminoon " describes the stages of fetal development in uterus, as the fertilized ovum, the morula, the blastocyst, the formation of bones, then another stage of creation. The last stage is described by some authorities to refer to ensolement and was timed to correspond with Day 120 of the pregnancy. Others believe that the fertilized ovum itself is a life .

The first group legalizedsabortion till Day 120, comprises the Zohaidi Shueites, the Sonni Hanifites and some of the Sonna Shafartes sects.

The second group consider non-therapeutic abortion at any time a grave sin. This group includes all Sonna Malikites and some Shafeites and other smaller sects.

Islamic Attitude Towards Surgical Contraception

The accepted ruling is that in Islam surgical contraception (sterilization is acceptable so long as it is a reversible procedure and as long as the contraceptive is maintaining his faith that God will support any number of children.

A final word to be said " I have described the situation to the best of my knowledge and ultimately we say only God knows."

Outputs:	Levels/Magnitude		
1. Fully equipped SFCA offices functioning adequately in the management of the model FP programmes.	1. a. FP clinic is meeting 70% of local recurrent costs from user fees by 1988. b. SFCA staff trained on the job and retained.	1. Observations. 2. Project records and evaluations. 3. AID records and evaluations. 4. Surveys of Khartoum	1. Trained individuals returned to assigned position. 2. SFCA finds individuals who can manage programme. 3. MOH and other doctors and nurses are available for training. 4. Media accept FP campaigns. 5. Petrol is available.
2. Develop clinic procedures and health information systems.	2. Presence of procedure manuals and record keeping system.		
3. Fully equipped FP clinic providing services.	3. Serving 44,000 active users by year five.		
4. Develop quality FP clinical training center.	4. Curricula developed; 6 nurse trainers instructed as FP practitioners; 80 doctors and 120 nurse paramedics trained by 1988.		
5. Functional IE&C programme producing FP promotional material.	5. Weekly newsletter; 6,000 posters; 250,000 pamphlets; presentations on FP radio 2/day; TV 2/week; 3 motion pictures.		
6. Research reports and evaluations.	6. 2 research projects per year and 2 evaluations over LOP.		
7. Develop functioning DDP logistic and accounting system.	7. 60% MOH clinics in Khartoum Province provided contraceptives on a regular basis by 1988.		

Inputs:	OPG	AID/W Contracts
	($ 000s)	
1. Short-term technical assistance 20 PM.	189	60
2. Training		
Short-term 25 PM	109	
Observational tours 3 PM.	16	
3. Commodities		
5 vehicles	121	
Furniture & Supplies	405	
Contraceptives		762
4. Contingency	80	
Totals	$920	$822

ANNEX 12

27