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FAMILY HEALTH INITIATIVES

Uganda Project Proposal: FY 84-87

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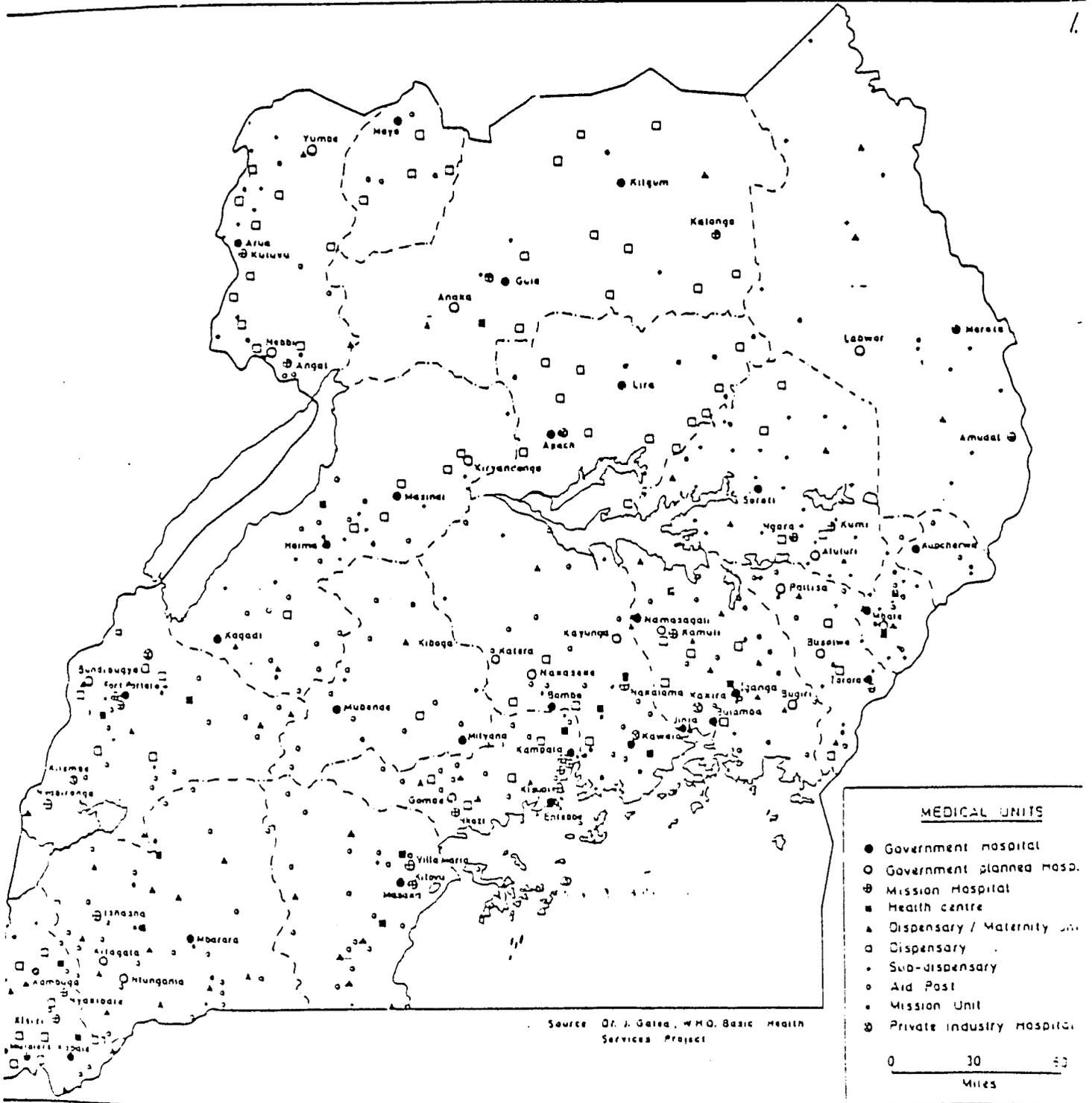
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# MAP OF UGANDA



## GLOSSARY

AID	Agency for International Development
AID/W	Agency for International Development/Washington
CDSS	Country Development Strategy Statement
CPS	Contraceptive Prevalence Survey
CYP	Couple Years of Protection
EIL	Experiment in International Living
ESAMI	Eastern and Southern Africa Management Institute
FHI	Family Health Initiatives
FP	Family Planning
FPIA	Family Planning International Assistance
FPAU	Family Planning Association of Uganda
IEC	Information, Education and Communication
INTRAH	International Training for Health
IP/AVS	International Project/Association for Voluntary Sterilization
IPPF	International Planned Parenthood Association
GOU	Government of Uganda
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MCH	Maternal and Child Health
MOH	Ministry of Health
MWRA	Married Women of Reproductive Age
NFP	Natural Family Planning
NPC	National Population Council
PHC	Primary Health Care

PCS      Population Communications Services  
PSC      Personal Services Contractor  
RAPID    Resources for Awareness of Population Impact on Development  
UNFPA    United Nations Fund for Population Activities  
WWTF    World Wide Training Funds

PROGRAM FACTORS

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## PROGRAM FACTORS

### Consistency with Government of Uganda Strategy

The proposed project is consistent with the development strategies as stated by the Government of Uganda (GOU) in two important documents. The Government's Revised Recovery Program 1982-1984 gives top priority in health strategy to preventive health measures and primary health care, family planning is a significant part of both. The focus includes "family health, education and child spacing". The approach is to be community-based and its specific target groups are mothers, children and the poor. Moreover, the Recovery Program recognized the roles of "substantial donor support, community involvement, self-help effort and the assistance of non-governmental organizations (NGO's). The NGO's have a special role to play ..... and (their) contribution will continue to be welcome. The goal of health for all cuts across many ministries, departments and agencies and close cooperation between all these agents is essential".

Uganda is also one of the few African countries that has a written population policy statement. In summary, the policy states that as population parameters are slow to change, the country will carefully monitor policy goals and strategies over the fifteen year period ending in 1995. The objective of the policy is to attempt to influence mortality and fertility rates with a view to:

- a) Decreasing the population growth rate from three percent to 2.6 per year; and
- b) Increasing the quality of the population in terms of physical, mental and social capacity of the people in their educational status and access to adequate .... social services.

Strategies and measures to meet these objectives include the Government's efforts, within the available budget, to establish family planning services in all hospitals, rural medical units and posts, as well as in missionary and private institutions. Clinic-based and outreach family planning services will cover information, education and communication (IEC) efforts as well as provision of contraceptives.

Given the content of the above documents, it is clear that the proposed Family Health Initiatives project must be considered as consistent with and responsive to GOU strategies and policy.

### Relationship to the CDSS

The Mission Country Development Strategy Statement (CDSS), as updated in February 1984 for FY 86, provides a review of the Ugandan economy, the initial Recovery Program, and the Revised

Recovery Program. Therefore, it is limited in scope and does not adhere to the format prescribed for a full CDSS, which includes an analysis of the population situation and how it impacts on all AID-assisted sectors. A full CDSS for FY 87 will be prepared in February 1985.

This CDSS update does state that "USAID is .... developing a core project called Family Health Initiatives to better coordinate provision of assistance to family planning through training, surveys, contraceptives, etc."

## Program Background

### Economic Overview

Like most sub-Saharan African countries, Uganda's economy is based on agriculture. Coffee, cotton and tea have been the main cash crops and historically contributed a substantial share of the country's foreign exchange earnings. Small holder farmers are an important segment of the economically active population and are engaged both in subsistence farming and in cash crop production.

Marked improvement has characterized the performance of the Ugandan economy over the past three years, reversing a decade of decline. The major factors responsible for this turn-about are the series of policy measures introduced by the Government since 1981 and related external assistance. A Gross Domestic Product that has risen five percent per year since 1981, rising export volumes, a dramatic increase in Government revenues from 0.8% to 6.3%, and a reduction in general inflation are some of the major indicators of the economy's recovery.

Despite this progress, overall levels of economic activity remain substantially below the peak levels achieved in the early 1970's. As a result, the per capita Gross National Product is still only two-thirds of the 1970 level.

The changing health situation over the past three decades in Uganda helps to prove the important role that health and health services play in general socio-economic development. The mutually reinforcing manner in which health improvements interact with the development process underlies the rationale for the increasing emphasis given to "basic human needs," and it recognizes increasing evidence that simultaneous improvements in nutrition and health, declines in fertility, and increases in income are necessary prerequisites (as well as being benefits) or overall socio-economic development.

The Uganda situation provides evidence both of the strength of health and development linkages and the importance of health in a national development strategy. Before 1971, Uganda's health status and health system had reached an impressive level, having been developed in parallel with a national economic development strategy. During the 1970's, however, the political situation led to a serious deterioration of health and social services. By the end of the War of Liberation in 1979, medical personnel of all types had left the country, health facilities' budgets were slashed, drugs and supplies were either depleted or looted, and there was a nearly total breakdown of health services administration. Public health problems which had been under control for most of the country began to reappear as a result of the social and economic decline. An improvement in the pattern and distribution of diseases was reversed.

A 1981 USAID consultant's report<sup>1/</sup> states that "the current delivery capacity of the Uganda health care system is roughly ... equal to what it was in the early 1960's. Just as significant in this reduction of capacity as the shortage of trained manpower, however, is the drastic reduction in the fiscal and physical resources possessed by the system. ....the last decade has seen the real purchasing power of the health budget dwindle to 6 percent of what it was in 1968/69."

Since 1981, the Government has demonstrated its intention to rebuild the system and its intention of providing free health care services to all citizens. An important aspect of the present health issues facing the Government, then, is the budgetary implications of a fully established health care system.

#### Family Planning Overview

As is common in many developing countries, Uganda is faced with high rates of population growth as a result of decreasing mortality rates (13.0 per 1,000) and a continuing high birth rate (49.9 per 1,000). Over the next decade, the population is expected to grow at a rate of three percent per annum. This figure translates into a population that will double in the next 26 years. The dependent population under 15 years of age represents 46 percent of the population. The challenges of development planners

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<sup>1/</sup> Dunlap, David and Scheyer, Stanley "The Role of USAID in Uganda's Health Sector: Recommendations for Program," 1981, p. 30.

in terms of land availability, food needs, social services, employment and economic growth are many.

Uganda's efforts in family planning date from 1957 when the Family Planning Association of Uganda (FPAU) was formed with Pathfinder funds. The first clinic opened in 1963 in Kampala, and in that year FPAU also became an affiliate of the International Planned Parenthood Federation (IPPF).

During the 1970's, FPAU was forced to curtail services because of the political situation. Until that time, however, the largest clinic offering family planning services was situated in the Institute of Public Health, run by Makerere University and Mulago Hospital, and supported by USAID.

FPAU remains the primary mechanism through which contraceptives are distributed and services and information are made available to the public. FPAU's goals also include the motivation of males, family life education and adolescent fertility management, integrating family planning into the Government MCH/FP program, and establishing community-based and mobile clinic programs.

FPAU maintains a total of 60 clinics -- 23 in FPAU's own premises and 37 in Government or mission hospitals. These clinics are manned by Association staff and include some degree of FP outreach activities. Existing clinics are in large towns and cities and serve mostly an urban clientele. Analysis of their service statistics data reveal that about 5 percent of married women of reproductive age (MWRA) in Kampala practice family planning and nationwide two percent of MWRA are protected.

The Ministry of Health (MOH) is not currently providing family planning services but has intentions to integrate family planning into MCH services. Its ability to offer services is limited partly because of lack of resources and partly because of other more pressing priorities.

Analysis of 1983 data shows that oral contraceptives form the most popular method of contraception (70%), followed by Depo-Provera (15%). There are no figures about sterilization available, but it is known that several of the hospitals in Kampala provide this service and have a long waiting list. In an effort to meet this demand and provide a voluntary surgical contraceptive method to more people, the International Project/Association for Voluntary Sterilization will soon be starting a project. (See p.23 for further details.)

Contraceptives are provided free of charge at MOH clinics except for a 10 shilling FPAU annual membership fee per user. At the FPAU clinics, in addition to the yearly membership fee, there is a user charge per contraceptive method which is:

Oral Contraceptives	20 shillings-cycle
Depo-Provera	20 shillings-dose
IUD's	free
Condoms	5 shillings-piece
Neo Sampoons	20 shillings-20 tablets

Pills (Noriday) are sold in pharmacies at 200-300 shillings per cycle, and condoms are available at 100 sh./piece. In 1981, FPAU received \$88,864 in contraceptive sales or 28% of their total yearly budget was covered by user fees. FPAU currently receives total support from the IPPF and their yearly funding level has averaged around \$300,000.

Like many other Family Planning Associations throughout Africa, FPAU has had management problems and has been short-staffed. However, it is IPPF/Nairobi's opinion that FPAU's situation has shown marked improvement since 1979, and this opinion is confirmed by the Africa Branch of IPPF/London. FPAU itself recognizes its weaknesses and one of the goals of the Association is to strengthen its management capabilities. In September 1982, IPPF/Nairobi performed a Management Audit and their report concludes that "in the last two years (FPAU) has made commendable efforts to bring the ship back to an even keel. Today the administration of FPAU is generally sound, and it is hoped that the management audit will have helped in concentrating thoughts on the next stage of Association's rehabilitation, namely, improvements to programme management."

## PROJECT DESCRIPTION

## PROJECT DESCRIPTION

### Perceived Problem

The GOU identified high birth rates and rapid population growth as a serious problem to economic development as early as 1971. It was not until 1981, however, that the country made a significant step forward by developing a written population policy statement as part of a development program prepared for a 1981 UN Conference on Least Developed Countries. The need to translate overall goals and general objectives contained in that statement into achievement strategies, measures and plans of action remains a major challenge to the Government.

Some strategies and measures currently being pursued include plans to integrate population education into all levels of formal and informal education, strengthening the family planning service delivery system to include both clinic and community-based services, integrating family planning with MCH services and focusing on the health and nutrition levels of women and encouraging formal education for all females.

A major constraint to the implementation of these strategies, measures and plans is the lack of resources, both human and financial. This project to a limited extent will assist in providing some of these resources. Very little recent demographic data (including fertility patterns, contraceptive practices, etc.) exist in Uganda. Particularly lacking is manpower trained in the delivery of family planning services. Another obstacle has been the lack of continuous supply of contraceptive commodities and a logistics management system which would allow the MOH to maximize the use of those commodities and equipment. Distribution, storage, record-keeping and inventory control continue to present problems that must be addressed and solved. Technical assistance and support is needed in the areas of IEC. Specifically, assistance is needed in conducting an assessment of the available materials, what activities are taking place, and to develop an IEC plan of action which among other things may include assistance on how to develop simple communication materials and possibly training field educators in motivational techniques in family planning.

Finally, a coordinating mechanism for all population/family planning activities is needed. The purpose would be to coordinate all family planning activities in the country, plan inter-organizational/ministerial activities and develop a population and family planning plan of action.

### Project Goal and Purpose

The overall program goal of the proposed project is to assist in the enhancement of the social and economic development of the population of Uganda through decreased population growth.

The purpose of this project will be to assist the MOH, FPAU and other non-governmental family planning service providers to strengthen and expand the delivery of family planning information and services. In order to achieve this purpose, this project will support a series of mutually supportive and interrelated activities which can be categorized as follows: 1) policy formulation; 2) baseline information/research; 3) contraceptive supply management; 4) training and 5) IEC.

In order to accomplish the project purpose, a series of activities will be undertaken during the course of the project. A RAPID presentation will be conducted for a high ranking and middle level policy and decision makers from a cross-section of ministries and agencies. To coordinate the link the activities and services of the two family planning delivery systems (FPAU and the MCH services of the MOH), a Family Health Advisory Committee will be constituted, composed of representatives from the FPAU, the Ministries of Local Government, Health, Planning and Economic Development and Finance. A joining MOH/FPAU family planning needs assessment exercise will be conducted in MCH facilities to determine requirements in training, personnel, supplies, etc. To obtain necessary baseline information, an early activity of this project will be to conduct a contraceptive prevalence survey (CPS) to gather information on current contraceptive usage and couples' knowledge and attitudes about modern and traditional family planning practices, as well as awareness of the current availability of MCH/family planning services. A national logistics management/reporting system, designed to link the FPAU and MOH supply systems, will be developed. Appropriate personnel will be identified and trained in the use of the system. The MOH will continue to train health personnel for the extension and improvement of family planning services within the MCH service system. Clinical training will be provided for additional registered nurses, nurse midwives, medical assistants and public health nurses. To strengthen the teaching and training capability in professional schools of nurse/midwifery, medical assistants and health visitors, a second set of tutors from these schools will be provided with clinical training. (One set of 22 such tutors are to be trained in April 1984, as part of the INTRAH contract with the MOH.) These tutors will also be trained to integrate family planning skills and knowledge areas into the curricula of their schools. Another project activity will be the development of a multi-focused information and education program to include organizing a mass-media and printed media educational program to reach the population.

#### Expected Achievements and Accomplishments

To accomplish the project purpose, it will be necessary to combine those inputs (described in the next section) to achieve appropriate project outputs. These outputs will be:

- o The political, governmental and medical leadership of country have been made aware of the importance of population concerns and are supportive of family planning activities. (RAPID presentations completed and 12 meetings of the Family Health Advisory Committee held).
- o The family planning needs assessment has been completed and baseline survey undertaken.
- o Family planning services have been expanded, the number of acceptors -- as measured by Couple Years of Protection (CYP)<sup>1</sup> - have increased from 60,000 to 140,000 and the quality of services upgraded. (Clinical training completed for 150 registered nurses, nurse midwives, medical assistants and public health nurses, 22 tutors from professional schools of nurse/midwifery, medical assistants and health visitors have been clinically trained and have integrated family planning skills and knowledge areas into the curricula of the 22 schools they represent; family planning services are fully integrated with MCH services provided at MOH facilities.
- o A logistics management system has been designed and implemented in conjunction with the MOH and FPAU. (A simple record-keeping/reporting format has been instituted, providing the MOH with a viable management tool for national program; 6-8 MOH storekeepers and an additional 50 health workers involved in logistics management have been trained in the system).
- o Part of the at-risk population of Uganda is aware of the importance of family planning, as well as the means of obtaining these services because of radio programs and other mass media techniques, printed materials and health education.

#### Project Inputs and Courses of Action

There are five major components to this project; namely, (1) policy formulation, (2) baseline information and research, (3) contraceptive supply management, (4) training and (5) IEC.

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<sup>1</sup> CYP is a way of measuring contraceptive usage. In this formula, 13 cycles of oral contraceptives distributed and 144 condoms distributed each equal one CYP.

## Policy Formulation

RAPID II Presentations. RAPID II (Resources of Awareness of Population Impact on Development, Phase II) can assist GOU development planners and policy makers to examine the effect of population growth on social and economic development, to analyze country demographic data and to disseminate population information. Although RAPID II services can include a wide array of activities encompassing the entire policy development process, this project will especially encourage RAPID to provide microcomputer-based analyses of population factors and their effect on the attainment of long-range economic and social goals for Uganda. The information will be designed for presentation to senior Government leaders and for influential members of the private sector. It will be done in close collaboration with Ugandan experts including economists, demographers, sociologists, planners, medical personnel, women's groups, lawyers, business leaders, youth groups, media and information specialists and others.

An analysis for Uganda will be prepared in three parts:

- (1) The first part will project and analyze the country's basic demographic factors: fertility and mortality levels, natural increase, age distribution, child dependency, and internal and external migration. Projections will be made of future population growth and change under two or three different assumptions of fertility and mortality levels.
- (2) The second part will project the future effects of continued alternative levels of fertility on social and economic goals for agricultural land per capita on family, food production and other production required for domestic needs, labor force and child dependents, new job requirements, urbanization and growth of cities, housing requirements, primary and secondary school needs, health requirements, exports, imports, balance of payments, international debts and others. A typical country analysis illustrates the effect of population factors on eight or ten such sectors that are particularly important to the country.
- (3) The third part will compare some possible effects of general development and specific population programs in reducing fertility. It also illustrates the effects of a delay in initiating a population program and compares the problems of reducing fertility in a developing country today with those in an industrialized country in the past.

RAPID II will be asked to absorb all the foreign exchange costs of this project. These costs include the provision of a limited number of microcomputers. Local costs are to include presentations using computers with color graphic analyses to high-ranking government policy makers and other decision makers. A small number of workshops or seminars to evaluate and disseminate the results of these presentations will be held. RAPID will also train a limited number of Ugandan government officials in the use of this microcomputer model for policy analyses.

Family Health Advisory Committee is an interim working committee that has been established until such time that the Parliament can create a National Population Council (NPC). When the NPC is formed, the Family Health Advisory Committee will be dissolved. This Committee is one of the recommendations made at the January 1984 seminar for high-ranking officials to discuss FP activities and programs. The committee will meet quarterly; its express purpose is to make recommendations on how the 1981 National Population Policy can best be implemented. It will also coordinate donor inputs in family planning.

A small amount of money has been allotted to facilitate these meetings. The funds will be for petrol (as some ministries are in Entebbe and some are in Kampala) and for incidental expenses such as stationery costs.

#### Baseline Information/Research

GOU and external donors are now operating in a virtual population/family information vacuum. No research in FP has been done since the late 1960's, and the only available 1980 census data is only for three districts and has not yet been analyzed. To help redress this and provide vital baseline information for planning and evaluation purposes for both GOU and external donors, a Contraceptive Prevalence Surevey (CPS) will be conducted. This will yield information not only on current contraceptive usage and knowledge, but on potential interest and demand. Other modules on breastfeeding, traditional FP practices, male attitudes, etc., can be added at the request of the Government.

Some of the specific objectives of the CPS are as follows:

- o To study the characteristics of clients already in the FP program;
- o To investigate the usage of different contraceptive methods;
- o To evaluate the effectiveness of current FP programs;
- o To assess the population's accessibility to FP programs;
- o To assess the methods that have been used to disseminate knowledge on contraceptives;

- o To find out the level of knowledge of contraceptive methods;
- o To examine the extent and causes of drop-outs; and
- o To determine the knowledge and use of traditional methods of FP.

Also under this project, MOH and FPAU will undertake a joint needs assessment by visiting all FPAU/MOH clinics. This was a recommendation included in the REDSO/ESA Population Advisor's December 1982 trip report, and it has not yet been carried out due to lack of financial resources. This will take either two simultaneous teams two weeks to carry out a needs assessment of each clinic's supplies, commodities, training, personnel, needs, etc., or one team one month. Therefore, money has been allotted for petrol and team members' per diems.

#### Contraceptive Supply Management

FPAU reports 48,000 acceptors at the end of 1983. Users obtaining their contraceptive supplies through other sources, i.e., church missions and commercial sales, bring the total number of acceptors to an estimated 60,000 at the end of 1983. This represents approximately 2.0 percent of the eligible population.

With the increased availability of family planning services at MOH facilities, increased training of health workers throughout the delivery system, and a plentiful supply of contraceptives at all levels of the delivery system, a large increase in CYP is expected. In December 1983, the MOH requested FPIA to provide large quantities of contraceptives to the MOH for their future expanded efforts. Action on that request is pending. Availability of these contraceptives, along with those planned for distribution by FPAU, will provide sufficient quantities for Uganda's service delivery program to grow to approximately 140,000 CYP by the end of the 3-year project.

#### Supplies

The latest FPAU figures available indicate the following contraceptive method mix:

Orals	70%
Injectables	15%
Condoms	10%
IUD and Other	5%

Planned provisions by FPAU and FPIA over the life of the project are:

	FPIA/FPAU	PROJECT REQUIREMENTS
	<u>PLANNED</u>	<u>TO MEET CYP</u>
Orals	5.9 million cycles	3.6 million
Condoms	5.6 million pieces	5.6 million

The FPAU 3 year plan calls for IPPF to provide 1,675,000 cycles of oral contraceptives. Although this contributes toward an apparent oversupply of orals, past experience tells us that IPPF ships substantially less than the amount requested.

The difficulty of estimating, with any degree of accuracy, the usage patterns of a population where there has been no program before also suggests we ignore what appears to be an oversupply of orals. Project management will review the overall situation during the second year, after some experience has been obtained through the MOH program.

#### Logistics System Development

This component calls for the development of a logistics management/reporting system to be designed by a consultant sometime during the first year. This system will be recommended to the MOH and will link the new MOH family planning program with existing FPAU activities.

Training of supply personnel and other health workers concerned with logistics management will be essential if the MOH is to link its expanded activities with the FPAU (see Training Section for details).

#### Training

The GOU, through the MOH, seeks to establish family planning services in all hospitals, rural medical units and posts owned by Government, missionary and private institutions. As far as feasible and in accordance with the Government health policy, it is expected that family planning services will be merged fully with nutrition and maternal and child health (MCH) services. It is felt that since these services mutually reinforce one another, the impact on the quality of life of the mother and her child will increase more dramatically when the services are offered as a package, as opposed to when they are offered each in isolation.

Currently, however, the MOH does not have a comprehensive coordinated national plan for the integration of family planning with MCH services. It is clear that MOH employed nurses and midwives constitute the largest proportion of current and potential providers of public sector family planning services.

While the FPAU has 60 clinic sites, all but 23 are located in MOH facilities, staffed by MOH personnel.

Recognizing the need to upgrade the clinical family planning skills and knowledge of its MCH personnel, the MOH recently entered into a contract with INTRAH to provide in-service training opportunities for selected MCH service personnel. To date, 19 of those selected for training have completed the 4 week course and have returned to their posts. Ten of these have been deployed to FPAU clinic sites: the remaining nine have been placed in MOH health facilities that do not yet have the necessary resources required to deliver family planning services. Under the same INTRAH contract, it is expected that an additional 20 health professionals will be trained. In addition, in order to strengthen the teaching and training capability in professional schools of nurse/midwifery, medical assistants and health visitors, 22 tutors from these schools will be provided with clinical training. These tutors will also be trained to integrate family planning skills and knowledge areas into the curricula of their schools.

Training provided through this project will build upon and continue that begun as part of the INTRAH contract. The MOH will select personnel to receive clinical family planning training from its hospitals, rural medical units and posts and other parts of its MCH network, giving special consideration, among other criteria, to the selection of personnel in those facilities which have been targeted for rehabilitation by the UNICEF Health Centers Rehabilitation Program.

Over the 3 year period of this project, it is expected that 150 additional registered nurses, nurse midwives, medical assistants and public health nurses will be provided in-service training. The training will be designed to include information on methods of natural family planning (NFP). To design and implement this aspect of training, technical assistance from one of the international NFP groups such as the International Federation for Family Life Promotion will be sought. It is expected that six 4 week clinical courses (of about 25 participants each) will be conducted through this project. In addition, it is expected that 22 tutors from the 22 professional schools of nurse/midwifery, medical assistants and health visitors will also be trained. They will also attend one of two curriculum development workshops in order to refine and learn to use the curricula developed under the INTRAH contract. As these health personnel are trained and deployed, follow-up supervision site visits will be made by training staff.

Another training intervention will be the development and implementation of Supply Management Workshops. These will be conducted for storekeepers and other health workers involved in the storage, distribution and record-keeping of contraceptives. The Eastern and Southern African Management Institute (ESAMI) in Arusha, Tanzania, has a proposal pending with AID/W and REDSO/ESA to develop and implement a training program in supply management for nine

countries, one of which is Uganda. The ESAMI training will be carried out with technical assistance from CDC logistics experts. This project will provide for the training of an estimated 60 storekeepers and health workers in forecasting needs, inventory control, maximum/minimum stock levels, storage, transport and reporting. These workshops will also deal with supervision/management, using periodic reports as a tool.

In-country costs for these training interventions have been allotted. It is anticipated that a follow-on to the centrally-funded INTRAH contract will allow the new contractor to absorb all the foreign exchange costs to the project.

Information, Education and Communications (IEC) is a necessary component of any beginning family planning project in order to create the awareness and knowledge about FP and where services are available. It has already been proven in other countries that the availability of contraceptive supplies alone does not necessarily or usually translate into demand for family planning services.

AID's Office of Population has a contract with John Hopkins University to provide IEC services in the form of technical assistance for needs assessment and project materials development. This contract, entitled Population Communications Services (PCS), will be requested to come to Uganda to help MOH and FPAU conduct an initial needs assessment. After this assessment, what is needed in the way of mass media materials can be identified and quantified. Mass media could take the form of radio advertisements, posters, pamphlets, etc.

FACTORS BEARING ON PROJECT SELECTION  
AND FURTHER DEVELOPMENT

## FACTORS BEARING ON PROJECT SELECTION AND FURTHER DEVELOPMENT

### Social Soundness Analysis

Uganda's population was estimated at 13,201,000 in 1980. It is situated in East-Central Africa, on the Equator. Land-locked, Uganda is bounded by the Sudan on the north, Kenya and on the East, Tanzania on the south and Zaire on the west. The distance from Uganda's eastern border with Kenya to the Indian Ocean is more than 800 kilometers. Most of Uganda is on a high plateau between 3000 and 6000 feet above sea level. Temperatures vary little throughout the year as they are moderated by the altitude. Uganda has large expanses of savannah and thick tropical forests.

The Ugandan population consists of Africans mostly of Bantu, Nilotic, Nilo-Hamitic and Sudanic origins. The Bantu are the most numerous. The Baganda are the largest single ethnic group, with more than one million members, followed by the Iteso, the Banyankole and the Basoga. There are small numbers of non-African peoples. English is the official language. Approximately three million Ugandans speak Bantu languages; Swahili is in use in trading centers.

Little fertility-related research has been conducted since the late 1960's; therefore, there is little recent information available on socio-cultural factors influencing fertility behaviour. A discussion with a local anthropologist revealed, however, that the same socio-cultural factors that bear on fertility in other East African countries also apply in Uganda. Some of the cultural values and practices that favor high fertility include early marriage, low status of women, high economic value placed on child labor, close knit families and love of children, no social security system and a breakdown of traditionally long periods of abstinence after child birth.

### Beneficiaries

Three categories of beneficiaries will be directly affected: 1) leadership, 2) service personnel, and 3) users. The RAPID presentations will reach a number of highly placed political, governmental and health authorities. Information about population and family planning will permit these leaders to undertake a more active role in supporting family planning initiatives. Service personnel will benefit at several levels. The 150 registered nurses, nurse midwives, medical assistants and public health nurses will receive four weeks of in-service family planning clinical training to upgrade their skills in order to prepare them to more effectively deliver integrated MCH/FP services to meet the anticipated demand. Once re-trained, they will also be supported by a more reliable contraceptive logistics system. Some 50 health workers will be trained in the logistics system, including training in the distribution of contraceptives and the reporting

of usage. Health personnel in the professional school of nurse midwifery/medical assistants and health visitors will benefit from revised curricula that provide family planning knowledge and skills training. The final category of direct beneficiaries will be the users of family planning. It is estimated that at least 140,000 users -- CYP -- will be practicing family planning by the end of the project. New users can be considered to benefit more directly, but at the same time, continuing users will also benefit from better trained service personnel and a more reliable contraceptive and logistics system.

### Participation

Due to the nature of an FHI project which implies a developmental stage of family planning acceptance, it is not possible to provide for actual participation of clients in this particular project design. However, it is fully expected that any follow-up project design would make full use of popular participation in decision-making.

### Socio-Cultural Feasibility

Although large families are traditional and Ugandans place a high value on children, there is sufficient evidence that there exists a demand for family planning services which is not now being met. FPAU, Protestant mission health facilities and, recently, some Government health facilities have begun to provide family planning services. This indicates that family planning is feasible within the socio-cultural context of Uganda. It is believed that this project will serve as an effective mechanism in encouraging an even wider acceptance of family planning in the country.

### Impact

The impact of the project may be viewed in two ways: successful implementation of the project activities could lead to larger bilateral project after this LOP. Equally, successful implementation of the project would help to lead through an intermediate phase of decreased infant and maternal mortality due to child spacing to an ultimate phase of decreased population pressure on available resources. Both potential impacts are desirable.

### Economic Soundness Analysis

#### General Economic Benefits

The total number of direct beneficiaries of the program, that is active family planning users, will be 140,000 per year by

the end of the project. This represents 3.5 percent of the eligible population. This small percentage using project family planning services is not expected to cause a measurable change in the annual birth rate. 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 a family planning method. Provision of family planning services will enable couples to choose the size 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 rural areas where child farm labor 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.

In general, the economic benefits that accrue to the family which 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 the current high rates of population growth are becoming apparent. Because of increased population, farmers are being forced on to marginal, less productive land. The possibilities of erosion and destruction of this type of land are high. The rapid growth in urban population means more and more people seek fuel for cooking and other domestic uses from the forests and scrub land. The stripping of the land creates a general degradation or even desertification. The migration to the urban areas, 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.

#### Cost Effectiveness of the Program

Although it may be possible to approach the goal of decreasing population growth rate in a number of ways, e.g. encouraging entry of women into the labor force, education directed at women, or use of widespread education coupled with economic improvement as in much of the western world, these possible approaches are perceived to be either less practical, less socio-culturally acceptable, or more expensive than the approach selected in this project. In addition, AID has had positive experiences in other countries using the approach described in this project.

Probably, the lowest cost solution to the delivery of family planning services in Uganda is through the use of the primary health care system of the MOH. Personnel delivering health services, especially MCH services, are an obvious channel through which to deliver family planning services. Contraceptives will be delivered through MOH distribution channels. To some extent the MOH has begun to offer family planning in its MCH program. However, family planning has not been a priority because the task of providing basic health care services throughout the country is so enormous that the MOH has been fully occupied with that. The health infrastructure, especially in rural areas, is weak. The drug distribution system is not adequate and frequently clinics are without basic drugs. Given these health service problems, it is not surprising that to date the MOH has placed little emphasis on family planning.

The proposed project, with its largest financial inputs in training and contraceptive commodities, capitalizes on the existing system, despite its deficiencies. As a result, family planning training can be provided for MOH staff without developing a parallel delivery system with all the additional administrative costs such a system would involve. Heavy emphasis on in-country training is thus both less expensive and more appropriate to local conditions than equivalent training overseas.

To assure that family planning becomes more fully utilized and thus in general more cost effective, the IEC activity has been included. It is believed that a large percentage of rural women are unaware of modern methods of family planning. The IEC program will use mass media, printed matter and posters as well as person-to-person contact to promote family planning use. Overall, this project is designed to take advantage of the lower-cost mechanisms for providing the proposed assistance in family planning.

### Administrative Analysis

#### MOH Organization

The Ministry of Health has at the headquarters an administrative set-up consisting of a Minister, a Deputy Minister, a Permanent Secretary and a Director of Medical Services. One of the Assistant Directors of Medical Services is the Chief of the Maternal and Child Health/Family Planning Unit. This Chief will be USAID's main contact and counterpart in the administration of this project. A covenant covering this Unit to insure that it is adequately staffed will be made part of the Project Authorization.

At the regional level, the Senior Medical Officer with a small staff coordinates health activities in the Region and supervises the District Medical Officers and other health personnel.

At the district level, the District Medical Officer is in charge of the district hospital and the rural health services run by the Ministry of Local Government. These facilities in decreasing order of size and population served are termed Health Centers, Maternity Units, Dispensaries, Sub-Dispensaries and Aid Posts.

At the county and sub-county level, MOH is just beginning to implement a Primary Health Care program. When fully implemented, this program will call for a Community Health Worker and Traditional Birth Attendant for each sub-parish. (A sub-parish consists of about 1,000 people.)

The MOH has a network of health facilities. Most are located in urban areas and small towns. In addition, voluntary agencies provide about one-third of all health services in the country. At the current time the Government has the following facilities: 53 hospitals, 86 health centers, 51 dispensaries with maternity units, 5 maternity units, 287 sub-dispensaries and 82 Aid Posts.

It is estimated that these facilities now serve about 30 percent of the population, and that most of this population live in urban areas. However, a detailed National Plan of Action on Primary Health Care was drawn up in 1982, and it is the Government's firm intention to provide greater access to health services through the provision of PHC, as resources permit.

The Government's commitment to improve its public health outlook is also demonstrated by its seeking of foreign credits and assistance to help remedy shortages in personnel, facilities and supplies. MOH has also recently initiated training programs at the Makerere University Faculty of Medicine and at two other institutions. Efforts have also been made to encourage the return of exiled Ugandan medical personnel.

#### USAID Administrative Plans

A Personal Services Contractor will be hired at the beginning of the project and budget allowances have been made so that his/her services will be available during the life of the project. Given the limited in-house capacity and given the approved USAID strategy, it is considered that a PSC is the best solution for day-to-day project management. This PSC will come to AID/W for three weeks orientation at the beginning of the contract. This full-time position will handle both the FHI project and the proposed Oral Rehydration Therapy project with UNICEF.

The services of the REDSO/ESA Population Officer will be available to USAID for general overall guidance and assistance.

#### Project-Related Administrative Plans

Section II described in detail the activities proposed under this project. In summary, this FHI project provides a funding

mechanism for a series of Office of Population intermediaries and a cohesive plan for USAID's population strategy for the next three years. These intermediaries will provide any required technical assistance to see a project through to its completion. Therefore, the PSC serves as a coordinator of USAID inputs and as principal contact between the Mission and MOH rather than as a provider of technical assistance. This administrative arrangement should considerably strengthen chances for a successful project.

In addition, a sound fiscal management system will be instituted through a Kampala-based accounting firm such as Coopers and Lybrand. This firm will handle disbursement and payment of all local costs. A separate line item in the budget has been provided for this firm's services. Therefore, a covenant to the Project Authorization is that an acceptable control system for fiscal management will be in place before initial disbursement. This arrangement will considerably ease project administration.

## Financial Analysis

### Project Financing

Inputs required for this project come from several sources: AID's Family Health Initiative Project, centrally-funded population intermediaries, MOH and FPAU. The budget shown in Table 1 indicates only those inputs being financed from the FHI project totalling \$700,000 in grant funding. It is assumed that if there are any cost overruns, that the relevant Office of Population intermediaries will pick up the additional required amount. The financial design of this project has taken into special consideration guidance provided to all USAID Missions in Africa that to the maximum extent possible, bilateral projects such as this one should absorb in-country costs now being supported by central projects. This is done as this not only builds the Africa Bureau bilateral effort but it also frees up central projects to do more work where bilateral efforts are not yet feasible.

Analysis of the budget shows that 3% of the total project budget is for policy formulation, 22% is for baseline information and research, 42% for training, 14% for IEC, and 18% for other costs.

There will also be complete flexibility within budget lines. GOU's contribution is in kind. The salary time of all the trainees and use of the facilities comes from the GOU. The value of the released time amounts to \$175,000 or 25% of total project costs.

### Recurrent Costs

Given the nature and intent of this project, recurrent costs with the exception of contraceptives do not constitute a problem. The objective of the project is to provide an impetus to

TABLE I

FHI PROJECT COSTS (ALL LOCAL COSTS)

	FY 84	FY 85	FY 86	TOTAL
I. Policy Formulation				
a) RAPID II	15,000	5,000		20,000
b) Family Health Advisory Committee	667	667	666	<u>2,000</u> 22,000
II. Baseline Information/Research				
a) CPS	100,000	50,000		150,000
b) Joint FPAU/MCH Needs Assessment	5,000			<u>5,000</u> 155,000
III. Contraceptive Supplies*				
a) Orals	[200,000]	[150,000]	[200,000]	[550,000]
b) Condoms	[105,000]	[75,000]	[100,000]	[280,000]
	<u>[305,000]</u>	<u>[225,000]</u>	<u>[300,000]</u>	<u>[830,000]</u>
IV. Training				
a) For Paramedical and Auxiliary Health Workers	65,000	65,000	65,000	195,000
b) For Voluntary Surgical Contraception	<u>34,000</u>	<u>33,000</u>	<u>33,000</u>	<u>100,000</u>
c) Training Sub-Total	99,000	98,000	98,000	295,000
V. Information, Education and Communications	34,000	33,000	33,000	100,000
VI. Other Costs				
a) Personal Services Contractor				
1) Salary	25,000	25,000	25,000	75,000
2) AID/W Orientation	3,000			3,000
b) Evaluation				
1) Mid-Term		5,000		5,000
2) Final			5,000	5,000
c) Coopers & Lybrand	<u>13,333</u>	<u>13,333</u>	<u>13,334</u>	<u>40,000</u>
	41,333	43,333	43,334	128,000
GRAND TOTALS	295,000	230,000	175,000	700,000

\*FUNDS FOR CONTRACEPTIVE SUPPLIES ARE NOT INCLUDED IN THE BUDGET TOTALS.

family planning in Uganda by stimulating awareness, providing training and upgrading services. Salaries supplementation and other recurrent costs have been carefully avoided in the project design. The only post-project recurrent cost remaining will be the cost of continuing contraceptives to users who may be attracted by the upgraded services in family planning resulting from project activities.

#### AID-Funded FP Activities to Date/Other Donor Activities

##### AID-Funded Activities

JHPIEGO (John Hopkins Program for International Education in Gynecology and Obstetrics) has trained abroad 18 physicians and 4 nurses in endoscopy and 6 physicians each in infertility and administration/management of family planning programs. In addition, JPHIEGO in cooperation with the Department of Obstetrics/Gynecology of Makerere University Medical School has provided didactic training in reproductive health for 19 physicians and one principal nursing officer in Kampala.

FPIA (Family Planning International Assistance) has made "commodity drops" worth \$24,942.82 up until 1982 to 16 missionary hospitals.

INTRAH (International Training for Health) began in-country training activities in January, 1984 by training 19 nurse-midwives in a one month course on clinical family planning skills. An additional 40 nurse-midwives will be trained in these same skills before August. (The INTRAH contract expires the following month). Also 22 tutors will shortly be trained in how to integrate clinical family planning skills into their particular curricula (public health nursing, nurse-midwifery and medical assistants). INTRAH has also sponsored two Ugandans for U.S. based training and three nurses at a regional workshop.

WWTF (World-Wide Training Funds) have provided U.S.-based training in adolescent fertility management for 2 Ugandans, have trained another 2 Ugandans at Columbia University's course in Program Design, Management and Evaluation, have trained 5 participants at University of Chicago's IEC Program and have trained 4 nurses in a nurse-practitioner program at Margaret Sanger Center.

The Population Council under their Fertility Determinants Research grant is currently assisting the Institute of Statistics and Applied Economics at Makerere University to develop a proposal entitled "The Value of Children as a Major Influence on Fertility in Uganda.: A Case Study of Ankole District". The research framework encompasses the three major groups (pastoralists/farmers, mixed pastoralists and farmers), the economic contributions of sons and daughters to the diverse activities of their mothers and fathers, present and future security roles for

children, the cost of modernization, proximate determinants of the current and last closed birth interval, background household information and background socio-cultural information. Population Council's approval of this proposal is expected in April 1984 with field work scheduled to begin by September 1984. The budget (which will be approved or modified along with approval) is now at \$190,000. The project is scheduled to be completed in two and a half years, and is expected to yield valuable information for policy makers and program managers.

International Project/Association for Voluntary Sterilization (IP/AVS) has a five year program proposal now pending for MOH and USAID review and approval. The project will provide support to the Ministry of Health in order to create fertility management centers in four large hospitals. Its primary goal is to provide laparoscopic and minlaparotomy services to the population of these four regions: Entebbe, Kampala, Jinja and Mbale. In addition, orientation programs will be held for personnel for FP clinics in each area in order to encourage referrals from their facilities to the newly-established centers. Assistance will also be provided to the MOH for the production of IEC materials to be used in the referral centers and for the general public. The budget duration is for 18 months and is at \$157,000.

#### Other Donor Activities

World Bank is planning a health and population project for FY 84. An identification team is scheduled to come sometime later this year to discuss with the Ministries the shape of this project. Therefore, the project amount and components are not known at this time.

UNFPA (United Nations Fund for Population Activities) has recently provided \$500,000 to the Government as preparatory assistance for a larger, more comprehensive project that will follow in three years time. The three components which UNFPA is concentrating on are strengthening the MOH's MCH program, strengthening the demographic training capabilities of Makerere University and providing funds to complete the data analysis of the 1980 census. A Needs Assessment Strategy was initially done in May, 1980 and up-dated in December, 1982.

UNICEF is concentrating their program on growth monitoring, oral rehydration therapy, breastfeeding promotion and immunization. Secondary concentrations as time and money allow will be family planning, food supplementation and female education. They are not currently planning any family planning activities.

UNICEF is rehabilitating and equipping about 100 health centers between 1983-86. To date, 40 have been completed and an additional 20 are in process. UNICEF also provides drugs to these centers. Rehabilitation includes structural repairs (as needed, water sanitation, solar-powered refrigerators, weather-proofing, secure storage for drugs, etc.

The Experiment in International Living (EIL) is helping to carry out a Multi-Sectoral Rural Development Program through the Busoga Diocese and the Anglican Church of Uganda. This community development effort is serving a population of one and a half million people in the three districts of Jinja, Inganga and Kamuli. The health program is run through 30 Aid Posts in the project area. These Posts are currently involved in curative services, but are moving toward preventive services and education through community involvement. It is planned to add family planning services to these Aid Posts.

CARE does not have any current or planned activities in family planning, but the GOU has recently asked them to consider helping the Government in the design of a health curriculum for primary schools.

International Planned Parenthood Association (IPPF) is the major donor to FPAU. FPAU activities have been described under Family Planning Overview (see p.4).

Pathfinder Fund, using non-AID funds, held a seminar in February, 1984 for high GOU officials to address population issues and to determine directions and recommendations. The resulting report is unfortunately not available at the time of this project design. Pathfinder/Nairobi is recommending to Pathfinder/Boston that community based distribution projects and a conference for Parliamentarians be developed and funded.

#### Project Preparation Strategy

Given that the scope of work for the team that prepared this document was to "develop one comprehensive document to include requirements for both PID and PP", the team attempted to collect all necessary information during their field work that would result in a document that could receive AID/W approval. Once the team departs and the AID/W team member finds that any section of sections is not sufficient for project approval in AID/W all attempts will be made to rewrite the document here. This will be done with the knowledge that USAID DH staff is extremely small and there is no one on board now with the relevant technical skills or staff time. The REDSO/ESA Population Advisor may also be called upon to perform a short TDY if necessary to help negotiate GOU approvals and clearances.

The project will be approved and authorized in AID/W, with the target allotment date of July, 1984.

#### Recommended Environmental Threshold

Given the nature of this project as a family planning activity, a Categorical Exclusion is the appropriate determination for the initial Environmental Examination.

#### Issues

Gladys Gilbert will do this in AID/W.

#### Evaluation Plan

Two evaluations have been scheduled for this project. The MOH will be invited to participate actively in both evaluations. The first evaluation is scheduled for December, 1985, approximately at mid-term project implementation. By this time baseline information will be available as the Contraceptive Prevalence Survey initial results will be available. Also by this time all scheduled intermediaries should have completed substantial amounts of work on their respective contracts and progress on their work should be easy to measure and evaluate. If there are deficiencies, the evaluation team will recommend remedial actions which can be undertaken within the remaining life of the project. It is anticipated that the evaluation team will be comprised of the REDSO/ESA Population Advisor, the Personal Services Contractor hired to coordinate and manage this project and MOH counterparts.

The final evaluation will evaluate past performance and also focus on the status of the national family planning program at that time. It is the intention of FHI projects to provide seed monies for FP activities so that after FHI project completion, USAID and the host government will be in a better position to determine if a larger bilateral FP project is in order. Therefore, this determination will be the major focus of the final evaluation. The team members will be the same, with each evaluation taking two weeks to complete.

## Implementation Schedule

The following is the implementation schedule of this project:

<u>CY</u>	<u>Month</u>	<u>Action</u>	<u>Responsibility</u>
1984	March	Draft PP submitted to REDSO/ESA for review	Design Team
1984	May	Draft PP submitted to AFR/RA, AFR/PD and ST/POP for comments and review	AID/W
1984	June	Issues Committee and ECPR review and approval	AID/W
1984	July	Project approved, funds allotted to USAID	AID/W
1984	August	Project Grant Agreement signed	USAID-GOU
1984	August	Personal Services Contractor hired	USAID
1984	September	AID/W Orientation for PSC	AID/W
1984	November	FPAU/MOH Needs Assessment conducted	USAID
1984	December	Family Health Advisory Committee meets (and every quarter for LOP)	GOU
1984	December	Initial visits made by RAPID, PAC contract and CPS (and periodic subsequent visits)	AID/W-USAID
1985	January	Initial shipments of contraceptives arrive	AID/W-USAID
1985	March	PCS makes initial visit (and periodic subsequent visits)	
1985	November	Initial RAPID presentation	GOU-RAPID
1985	December	CPS initial results available	MOH-CPS
1985	December	Interim Evaluation	USAID-REDSO/ESA
1985	February	High level RAPID presentation	GOU-RAPID
1986	June	Final Evaluation	USAID-MOH-REDSO/ESA

ANNEX A

Logical Framework

Project Title & Number: Uganda Family Health Initiatives (617-0108)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To assist in the enhancement of the social and economic development of the population of Uganda through decreased population growth.</p>	<p>Measures of Goal Achievement:</p> <p>To increase country-wide contraceptive prevalence usage to 140,000 Couple Years of Protection (CYP) by EOP.</p>	<p>Contraceptive Prevalence Survey (CPS) will serve as source of baseline information. CYP can be measured by amount of contraceptives distributed to clients as recorded in client record cards.</p>	<p>Assumptions for achieving goal targets:</p> <p>That GOU implements their 1981 National Population Policy and provides tacit and explicit support for increased family planning activities.</p>
<p>Project Purpose:</p> <p>To assist MOH, FPAU and PVO family planning (FP) service providers to strengthen and expand the delivery of FP information and services.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>1. Policy makers will have been made aware of the importance of population concerns. 2. FP Needs Assessment completed. 3. Baseline information available. 4. FP services expanded, number of contraceptors increased, quality of services upgraded. 5. 3 separate kinds of training provided for 7 different personnel categories. 6. A functioning contraceptive logistics system.</p>	<p>1. RAPID analysis and presentation. 2. Needs Assessment report. 3. CPS reports. 4. GBLs for contraceptive supplies received in country. 5. Training reports. 6. CDC trip reports. 7. PCS trip reports.</p>	<p>Assumptions for achieving purpose:</p> <p>1. Centrally-funded intermediaries provide technical assistance, support and contraceptive commodities. 2. GOU will make necessary budgetary allocations to support FP program. 3. Improved delivery of FP services and information will result in increased utilization.</p>
<p>Outputs:</p> <p>RAPID analysis and presentation. FP Needs Assessment. CPS. FP acceptors. Several categories of health personnel trained and providing quality FP services. Contraceptive supply system in place. More Ugandans will know about FP and where services are available.</p>	<p>Magnitude of Outputs: 7. IESC program in process.</p> <p>1. 100 policy makers see RAPID. 2. Needs Assessment report. 3. 3000 HH's surveyed to determine contraceptive prevalence rates. 4. 99,000 pill CYP and 14,000 condom CYP achieved. 5. 172 personnel trained. 6. A functioning contraceptive logistics system. 7. IEC program started.</p>	<p>1. RAPID reports. 2. Needs Assessment report. 3. CPS interim and final reports. 4. Clinic reports and records. 5. PAC Training Contract interim and final reports. 6. CDC trip reports. 7. PCS trip reports.</p>	<p>Assumptions for achieving outputs:</p> <p>1. Intermediary arrangement can be made in timely fashion. 2. MOH, FPAU and PVO's continue to be supportive. 3. MOH can handle logistics supplies effectively. 4. USAID can hire PSC promptly.</p>
<p>Inputs:</p> <p>ST/POP/PPD's RAPID II. Financial inputs for conduct of Needs Assessment. ST/POP/IT's PAC Training Contract. ST/POP/PPSD's FPIA provides contraceptives. ST/POP/IT's PCS Contract. Mission management of project.</p>	<p>Implementation Target (Type and Quantity)</p> <p>1. RAPID II presentation in first year of project (local coast (LC) @ \$20,000) 2. Needs Assessment in first 6 months of project; LC @ \$5,000. 3. In-country training budgeted @ \$295,000; 4. 3.55 M OC cycles valued @ \$550,000 and 5.6 M condom units valued @ \$280,000 provided. 5. IEC activities LC @ \$100,000.</p>	<p>1. RAPID reports. 2. Needs Assessment report. 3. PAC interim and final reports. 4. GBLs for contraceptive supplies received in country. 5. PCS trip reports. 6. Contractor reports.</p>	<p>Assumptions for providing inputs:</p> <p>1. RAPID/Ministry of Planning contract can be finalized. 2. FPAU/MOH Needs Assessment team can be fielded. 3. PAC/MOH contract can be finalized. 4. FPIA will provide required level of contraceptives. 5. PCS/MOH/MOIB contract can be finalized. 6. Appropriate person can be hired locally.</p>

Annex B

Initial Environment Examination

(to be done in AID/Washington by AFR/TR/SHRD)

Annex C

PROJECTED COUPLE YEARS OF PROTECTION (CYP)  
(BY METHOD)

METHOD	Jan '84	Year 1	Year 2	Year 3
ORALS	42,000	51,000	71,000	99,000
CONDOMS	6,000	7,500	10,000	14,000
INJECTABLES	9,000	11,000	15,000	21,000
IUD	1,800	2,000	3,000	4,000
OTHER	1,200	1,500	2,000	3,000
TOTAL	60,000	73,000	101,000	141,000

## ANNEX D

## FAMILY PLANNING ASSOCIATION OF UGANDA

CLINICAL SERVICE STATISTICS

METHOD OF CONTRACEPTION	1979	1980	1981	1982	1983
ORAL	11150	21558	22757	25187	34563
INJECTABLES	3300	6623	5287	5442	6375
CONDOMS	317	874	3321	2682	4658
IUD	577	867	941	1195	1398
STERILIZATION (M)	-	-	-	-	-
STERILIZATION (F)	-	-	-	-	-
OTHER METHODS	395	1008	352	897	1173
TOTAL	15739	30930	32658	36405	48167

Year	Continuing Acceptors	New Acceptors	Total Acceptors	Total Acceptors Visits
1979	9,284	7,254	15,739	26,732
1980	20,962	9,968	30,930	48,338
1981	21,240	11,365	32,658	52,584
1982	23,264	12,141	36,405	88,168
1983	33,451	14,716	48,167	88,168

PROJECTED NUMBER OF POTENTIAL CLIENTS WOMEN AGED 15-49  
(IN THOUSANDS)

Year	<u>1975</u>	<u>1980</u>	<u>1985</u>	<u>1990</u>	<u>1995</u>	<u>2000</u>
No.	2969	3161	3872	4718	5746	6998

ANNEX E

PROJECT AUTHORIZATION

Name of Country: Uganda  
Name of Project: Uganda Family Health Initiatives Project  
Number of Project: 617-0108

1. Pursuant to Part 1, Chapter 1, Section 103 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Uganda Family Health Initiatives Project (the "Project") for the Republic of Uganda (the "Cooperating Country") involving planned obligations of not to exceed Seven Hundred Thousand United States Dollars (\$700,000) in grant funds over a three (3) year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing certain local currency costs for the Project.

2. This Project consists of assistance to the Ministry of Health (MOH), Family Planning Association of Uganda and other non-governmental family planning service providers so that the delivery of family planning information and services can be strengthened.

3. The five principal components of assistance to be provided under the Project include policy formulation, baseline information and research, contraceptive supply management, training, and information, education and communications services.

ANNEX F

WAIVER JUSTIFICATION

SUBJECT: Vehicle Procurement Source/Origin Waiver

I. PROBLEM: Request for Source/Origin Waiver from AID Geographic Code 000 (U.S. only) to Geographic Code 935 (Special Free World).

- A. Cooperating Country : Uganda
- B. Authorizing Document: Project Authorization
- C. Project : Uganda Family Health Initiatives Project (617-0108)
- D. Nature of Funding : Grant
- E. Description of Goods: 4 each Right-Hand Drive 4x4 utility vehicles with seating capacity of 6 persons (and replacement parts)
- F. Approximate Cost : \$67,200
- G. Probable Origin : Japan
- H. Probable Source : Uganda

II. DISCUSSION: The project vehicles will be used by the Ministry of Health's MCH/FP Unit to deliver and transport Family Planning Service providers and officials in their official work. These vehicles are necessary if this project is to achieve the full impact desired by the project. Section 636(i) of the Foreign Assistance Act of 1961, as amended, prohibits AID from purchasing motor vehicles unless such vehicles are manufactured in the United States. However, this section also provides that "..... where special circumstances exist, the President is authorized to waive the provisions for this section to carry out the purposes of this act."

Criteria for such waivers are contained in Handbook 1, Supplement B, Chapter 4C2D(1)(A) and (B). In addition, Handbook 1, Supplement B, Chapter 5 provides that commodities procured under grants must be U.S. Source and Origin, unless a waiver is obtained. The same Handbook provides that a waiver may be granted when it is required in order to carry out the purpose of the FAA and if, inter alia, U.S. manufacturers are unable to provide a particular type of needed vehicle; e.g., right hand drive vehicles; or there is a present or a projected lack of adequate service facilities and supply of spare parts for U.S. vehicles.

III. PRIMARY JUSTIFICATION: There are no right-hand drive utility vehicles manufactured in the U.S. for which there are service facilities and spare parts support in Uganda. Presently in Uganda motor vehicle regulations require vehicles to be driven on the left side of the road. Right-hand drive is imperative for safety reasons in order to facilitate adequate visibility, especially in passing situations.

IV. RECOMMENDATION: On the basis of the above discussion, it is recommended that you (1) determine that special circumstances exist which justify waiving Section 636(i) of the FAA, and (2) certify that exclusion of procurement from Free World countries other than the Cooperating Country and countries included in Code 941 would seriously impede attainment of U.S. foreign policy objectives and objectives of the Foreign Assistance Program.

4. The Cooperating Country shall covenant in substance as follows:

- a. will endeavor to ensure that the Maternal and Child Health/Family Planning Unit of the Ministry of Health is adequately staffed and equipped to implement this project;
- b. an acceptable control system for fiscal management of the project is in place before disbursement.

5. Based upon the justification contained in Annex F of the Project Paper, I hereby approve a source/origin procurement waiver from AID Geographic Code 000 (U.S. only) to Code 935 (Special Free World) to permit procurement of 4 Project vehicles at an approximate cost of \$56,000. Accordingly, I hereby certify that exclusion of procurement from Free World Countries other than the Cooperating Country and countries included in Code 935 would seriously impede attainment of U.S. Foreign Policy objectives and objectives of the Foreign Assistance Program; and certify that special circumstances exist to waive, and do hereby waive, the requirements of Section 636(i) of the Act.

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_