PD-ABE-178
79345

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: ____ — DOCUMENT CODE: 1

COUNTRY/ENTITY: Senegal

3. PROJECT NUMBER: 685-0286

4. BUREAU/OFFICE: AFR — 685

5. PROJECT TITLE (maximum 40 characters): Senegal Child Survival/Family Planning

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 06 DD 30 YY 98

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 92 B. Quarter 3 C. Final FY 97

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	3,900	1,750	5,650	20,450	6,550	27,000
(Grant)	(3,900)	(1,750)	(5,650)	(20,450)	(6,550)	(27,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2. OYB Transfer (Non-Added)	(850)		(850)	(3,500)		(3,500)
Host Country	–	1,200	1,200		5,850	5,850
Other Donor(s)						
TOTALS	3,900	2,950	6,850	20,450	12,400	32,850

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) SS	400	400				27,000	–	27,000	
(2)									
(3)									
(4)									
TOTALS						27,000		27,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 444, 483, 514, 533, 583

11. SECONDARY PURPOSE CODE:

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	TNG	EQTY	PVOU	PVON	BCOW		
B. Amount	1,000	1,000	4,000	1,000	4,000		

13. PROJECT PURPOSE (maximum 480 characters)

To increase the use and knowledge of modern contraceptives.

14. SCHEDULED EVALUATIONS
Interim MM 03 YY 95 | MM YY | Final MM 11 YY 97

15. SOURCE/ORIGIN OF GOODS AND SERVICES
☐ 000 ☐ 941 ☒ Local ☐ Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

Concurrence: Wayne McKeel 6/3/92
Controller, USAID/Senegal

17. APPROVED BY
Signature: Julius E. Coles
Title: Director, USAID/Senegal
Date Signed: MM 06 DD 11 YY 92

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

PD-ABE-178

SENEGAL CHILD SURVIVAL/FAMILY PLANNING (SCS/FP) PROJECT

(685-0286)

PROJECT PAPER

USAID/Senegal

May 20, 1992

ACTION MEMORANDUM FOR THE MISSION DIRECTOR, USAID/SENEGAL

DATE: June 11, 1992

FROM: Lisa Franchett, PDO

SUBJECT: Project Authorization for the Senegal Child Survival/Family Planning Project (685-0286)

I. ACTIONS REQUESTED:

You are requested to approve the Project Paper and authorize a grant of twenty-seven million dollars from DFA funds to Senegal for the Senegal Child Survival/Family Planning Project (685-0286).

II. DISCUSSION

A. Project Background and Description

Since independence, Senegal's rapid population growth and slow economic growth have interacted to limit improvements in the quality of life. Rapid population growth has seriously impacted on the quality of the natural resource base, and Senegal has already surpassed its human carrying capacity in terms of cereals production and sustained forest yields. Senegal's population of approximately 7.8 million is currently growing at a rate of 2.7% annually with an average life expectancy of 48 years at birth. World Bank projections show the population growth rate peaking between 1995 and 2000 at 3.17%. This would put the total population at 10,372,000 in the year 2000.

USAID and other donors have supported family planning activities in order to slow the rapid population growth rate. USAID's proposed Child Survival/Family Planning (SCS/FP) Project will continue this effort through a set of activities aimed at reducing the fertility rate in Senegal.

The fundamental constraints to reducing fertility and increasing the use of contraceptives in Senegal can be grouped into three categories: (1) Limited Demand, (2) Mediocre Quality of MCH/FP clinical Services; and (3) Insufficient Access. The demand for family planning methods in Senegal is limited due to high infant mortality, socio-cultural factors, and a general lack of knowledge about family planning methods. The quality of family planning (FP) and maternal and child health (MCH) services is constrained due to a lack of counseling services, long waiting lines, health care workers who are not sufficiently knowledgeable about family planing methods and treatment of acute childhood diseases, inadequate supervision, and a lack of protocols. Access to family planning services is limited by the part-time basis on which family planning services are provided at clinics and by the unavailability of contraceptives outside of clinics and pharmacies.

B. Project Implementation and Strategy

The goal of the SCS/FP Project is to decrease the total fertility rate in Senegal. The purpose of the Project is to increase the use and knowledge of modern contraceptives. In order to address the major constraints to the achievement of project objectives the project will identify a limited number of existing family planning service sites to serve as high quality, efficient family planning referral centers in the largest urban cities in Senegal where a relatively strong demand for family planning services already exists. In rural areas, the project will increase the demand for family planning services by sensitizing people about the benefits of child spacing. Lastly, since it has been shown that the demand for family planning is related to infant mortality, the project will attempt to reduce the infant mortality rate by controlling diarrheal disease and training health care providers in the treatment of other childhood diseases.

The project will finance local training of health care providers in subjects related to family planning (FP) and maternal and child health (MCH). The project will increase the availability of family planning services in the private sector by providing grants to NGOs and by supporting community based distribution and contraceptive social marketing activities. To improve supervision, and support the Ministry's decentralization plans, the project will finance the MCH/FP components of regional and district health plans, including supervision and annual updating of the plans.

The Project will be implemented by the GOS Office of Family Planning with considerable support from the prime contractor which will provide five long-term technical advisors: an IEC specialist, a logistics specialist, a financial management specialist, a family planning specialist who will serve as Chief of Party, and a health planner. Short-term technical assistance will be provided in the areas of contraceptive technologies, training, clinical quality, management information systems, and municipal activities.

C. WAIVERS

No special waivers are required at present for the SCS/FP Project. However, a waiver may be required from the Mission Director at a later date, to exempt Africare from making a 25% non-federal contribution that is required under operating program grants. This issue will be addressed when the final proposal from Africare has been received and reviewed.

D. CONDITIONS AND COVENANTS

1. Conditions

In addition to the standard clauses, the Grant Agreement will require the Government of Senegal, prior to initial disbursement, to furnish to A.I.D., in form and substance satisfactory to A.I.D. evidence that the Cooperating Country has officially established

the National Office of Family Planning and it is fully staffed with at least eleven (11) professional employees.

2. Covenants

The project grant agreement will also contain the following special covenants:

The Cooperating Country shall covenant that, unless A.I.D. otherwise agrees in writing:

(1) It will make family planning services available full time to regional referral centers;

(2) It will make the following permanent personnel assignments:

(a) two Health Education Service staff to work solely on family planning issues;

(b) one Regional MCH/FP Coordinator to work solely on training and supervision in each region;

(c) a Health Education Service staff member to work full time on family planning in each region;

(d) two GOS professionals to work full time on the Decentralization Committee;

(e) one GOS Chauffeur to work full time for the Decentralization Committee;

(f) one GOS Accountant to work full time in each of the four focus regions;

(g) two GOS Secretaries and two GOS Chauffeurs to work full time at the Office of Family Planning;

(h) for each regional family planning referral center:

(i) at least one midwife per 20 family planning clients per day to staff a family planning consultation room

(ii) at least one aide sociale

(iii) at least one aide infirmiere

(3) It will establish an advance account for the GOS local counterpart contribution and deposit at least $1,350,000 in local currency into the account over the life of Project.

(4) It will analyze the recurrent cost implication of Project activities during the first two years of the project in order to determine how the GOS can begin to assume some of these

C

costs in years 3-5 of the project.

(5) It will obtain from the Ministry of Economy, Finance and Plan an Order that officially registers the Project in Senegal.

III. Financial Summary

Project Budget ($000s)					
Activity	AID		GOS	TOTAL	
	FX	LC	LC	FX	LC
1. Tech. Assist.	10,000			10,000	
2. Procurement	2,000	1,900	661	2,000	2,561
3. Local Account		4,285	689		4,974
4. Buy-Ins	3,300			3,300	
5. Grants	4,600			4,600	
6. Audits/Eval.	300	115		300	115
7. Contingency	250	250		250	250
OYB Transfer (Contraceptives)	(3,500)	-	-	(3,500)	
TOTAL(Cash Cont)	20,450	6,550	1,350	20,450	7,900
GOS In-kind Contribution			4,500		4,500
TOTAL	20,450	6,550	5,850	20,450	12,400

IV. COMMITTEE ACTION AND CONGRESSIONAL NOTIFICATION

The Project Review Committee met on April 28, 1992 to review the Project Paper and to prepare issues for the Mission Executive Committee for Project Review (ECPR) which was held May 22, 1992. The ECPR discussed each of the issues presented by the Project Committee in the Issues Paper and as a result the following revisions were made to the Project Paper:

A. A covenant was added requiring the GOS to analyze the recurrent cost implications of project activities in order to determine how the GOS can begin to assume these costs between years 3-5 of the project. This analysis will also examine how user fees can be utilized more effectively.

B. Annual financial reviews as well as financial audits will

-d

be undertaken during the first two years of the project.

C. Additional short-term technical assistance will be included in the institutional contract to assist in the development, coordination, and monitoring of municipality activities.

D. An operating program grant will be awarded to Africare to work with SANFAM to increase its capacity to support the delivery of family planning services in the private sector.

E. Bi-annual donor coordination meetings related to family planning activities will be held.

The IEE was approved by AID/W on December 2, 1991. The CN was transmitted to Congress on June 2, 1992 and the waiting period will expire on June 16, 1992 after which date you may obligate funds.

V. GRAY AMENDMENT

Two Gray Amendment organizations will be awarded grants under the Project. Approximately $2 million will be awarded to Africare as an operating program grant to strengthen the capabilities of a local NGO which support the delivery of family planning services in the private sector. Morehouse School of Medicine will receive approximately $800,000 to provide training to health professionals in Senegal under a grant to Tulane and Morehouse Universities.

VI. AUTHORITY:

Pursuant to an ad hoc delegation of authority from AA/AFR (see attached Action Memorandum signed 6/8/92), you may approve the Project Paper for the Senegal Child Survival/Family Planning Project and authorize the Project for an amount not to exceed $27 million.

VII. RECOMMENDATION:

That you sign the attached Project Authorization and Project Paper Facesheet.

Approved Julius E. Coles

Disapproved _____

Date 6/11/1992

Clearance:

JWooten, PDO _____ date 6/2/92
LLankenau, HPNO _____ date _____
BGilson, PRM _____ date 5/29/92
SCromer, RCO _____ date 5/29/92
AAdams, RLA _____ date 5/29/92
WMcKeel, OFM _____ date 6/3/92
Jvan der Veen, DDIR(A) _____ date 6/3/92

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C 20523

JUN 4 1992

ACTION MEMORANDUM FOR THE ACTING ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: AFR/SWA, Timothy J. Bork

SUBJECT: Senegal Child Survival/Family Planning Project (685-0286): Ad Hoc Delegation of Authority to Approve and Authorize Project

Problem: You are requested to issue an ad hoc delegation of authority to the USAID/Senegal Mission Director to approve the project paper for and authorize the $27,000,000 Senegal Child Survival/Family Planning Project (685-0286).

Discussion: The purpose of this six-year project is to increase both knowledge and use of modern contraceptives through implementation of three major components: (1) increasing the demand for contraceptives and maternal child health/family planning (MCH/FP) services; (2) increasing access to such services; and (3) improving the quality of MCH/FP services. The project will finance 21 person-years of long-term technical assistance. Short-term technical assistance will be provided in the areas of contraceptive technologies, training, clinical quality and management information systems. Training of health care providers in the areas related to family planning and MCH will be financed. Grants will be given to nongovernmental organizations to increase the availability of family planning service sites in the private sector. To improve supervision and support the Ministry of Public Health and Social Action's decentralization plans, the project will finance the MCH/FP components of regional and district health plans and strengthening of the decentralized health planning systems.

The total cost of the project is now estimated to be $32,850,000. Of this amount, USAID/Senegal will contribute $27,000,000 in grant funds from the Development Fund for Africa appropriation (including $3.5 million through an OYB transfer to finance contraceptives). The Government of Senegal will contribute $5,850,000 in local currency and in-kind costs.

Per referenced cable (attached), the Mission was delegated authority to approve the Project Paper and authorize the project provided that life of project funding did not exceed $20 million. Because life of project funding now exceeds $20 million, a new ad hoc delegation of authority is needed. As the subject project is wholly consistent with Senegal's approved Country Program Strategic Plan and there are no significant policy issues raised under this project, it is the view of USAID/Senegal and AFR/SWA

that there are no programmatic or procedural factors that weigh against the Mission's approving and authorizing the project. The 25 percent host country contribution requirement for this project was waived by the DAA/AFR February 6, 1992.

Recommendation: That you issue an ad hoc delegation of authority to the USAID/Senegal Mission Director to approve and authorize the Senegal Child Survival/Family Planning Project in an amount not to exceed $27 million.

Approved _____

Disapproved _____

Date 6/8/92

Attachment: 91 State 201881

Clearances:
AFR/SWA:JRoyer draft date 6/2/92
AFR/SWA:DDay date 6/2/92
AFR/SWA:JGilmore draft date 6/2/92
GC/AFR:PJohnson date 4 Jun
A-DAA/AFR:MBonner date 6/8

USAID/Senegal:JColes:tv:5/22/92:7-8124:U:\Senegal\0286doa.mmo

PROJECT AUTHORIZATION

Name of Country: Senegal

Name of Project: Senegal Child Survival/ Family Planning (SCS/FP)

Number of Project: 685-0286

1. Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Senegal Child Survival/Family Planning Project (the "Project") for Senegal (the "Cooperating Country"), involving planned obligations not to exceed Twenty Seven Million United States Dollars (US $27,000,000) in grant funds (the "Grant") over a seven-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 foreign exchange and local currency costs for the Project. The planned life of the project is six years and three months from the date of initial obligation. In addition to the $27 milliion Grant, USAID/Senegal will furnish to the Project $3.5 million of contraceptives which will be procured through an OYB transfer to the Central Contraceptives Procurement Project.

2. The Project consists of assistance to increase the use and knowledge of modern contraceptives in Senegal by (i) increasing the demand for contraceptives and maternal child health ("MCH") services; (ii) increasing access to MCH/Family Planning ("FP"); and (iii) improving the quality of MCH/FP services.

3. The Project Grant Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4. a. Source/Origin of Commodities, Nationality of Services

(1) Commodities financed by A.I.D. under the Project shall have their source and origin in countries included in A.I.D. Geographic Code 935, except as A.I.D. may otherwise agree in writing.

(2) The suppliers of commodities and services financed by A.I.D. under the Project shall have as their place of nationality countries included in A.I.D. Geographic Code 935, except as A.I.D. may otherwise agree in writing.

(3) Ocean shipping under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States or of countries included in A.I.D. Geographic Code 935.

b. Conditions Precedent to First Disbursement

Prior to any disbursement, or to the issuance of any commitment documents under the Project Grant Agreement, the Cooperating Country shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(1) An opinion of counsel acceptable to A.I.D. that the Project Grant Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Cooperating Country in accordance with all of its terms;

(2) A statement of the name of the person holding or acting in the office of the Grantee specified in Section 8.2 of the Project Grant Agreement, and of any additional representatives, together with a specimen signature of each person specified in such statement;

(3) Evidence that the Cooperating Country has officially established the National Office of Family Planning and that it is fully staffed with at least eleven (11) professional employees.

c. Covenants

The Cooperating Country shall covenant that, unless A.I.D. otherwise agrees in writing:

(1) It will make family planning services available full time in regional referral centers;

(2) It will make the following permanent personnel assignments:

(a) two Health Education Service staff members to work solely on family planning issues;

(b) one Regional MCH/FP Coordinator to work solely on training and supervision in each region;

(c) a Health Education Service staff member to work full time on MCH/FP related work in each region;

(d) two Government of Senegal (GOS) professionals to work full time on the Decentralization Committee;

(e) one GOS chauffeur to work full time on the Decentralization Committee;

(f) one GOS accountant to work full time in each of the four focus regions of the Project;

(g) two GOS secretaries and two GOS chauffeurs to work full time at the Office of Family Planning;

(f) for each regional family planning referral center:

(i) at least one midwife per twenty family planning clients per day to staff a family planning consultation room;

(ii) at least one aide sociale

(iii) at least one aide infirmiere.

(3) It will establish an advance account for the GOS' local counterpart contribution and deposit at least $1,350,000 in local currency into the account over the life of the Project.

(4) It will analyze the recurrent cost implications of Project activities during the first two years of the Project in order to determine how the GOS can begin to assume some of these costs in years 3-5 of the Project.

(5) It will obtain from the Ministry of Economy, Finance and Plan an Order that officially registers the Project in Senegal.

Julius E. Coles
Director, USAID/Senegal

June 11, 1992
Date

Clearances:

HPNO:	Linda Lankenau	(draft)	Date: 5/29/92
PDO:	John Wooten		Date: 6/2
PDO:	Lisa Franchett	for	Date: 6/2
OFM:	Wayne McKeel		Date: 6/3/92
A/DD:	Jan Vanderveen		Date: 6/3/92
RCO:	Sharon Cromer		6/5/92

Drafted:RLA:DAAdams:5/25/92

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ACRONYMS AND ABBREVIATIONS

ASBEF	Senegal Association for Family Well-Being
ASC	Agent de Santé Communautaire
AVSC	Association for Voluntary Surgical Contraception
CBD	Community Based Distribution
CDD	Control of Diarrheal Disease
CES	Certificate d'Etude Specialize
CESSI	Centre d'Enseignment Superieur en Soins Infirmier
CHU	University Central Hospital
CONAPOP	National Population Commission
COP	Chief of Party
CPR	Contraceptive Prevelance Rate
CPSP	Country Program Strategy Plan
CSM	Contraceptive Social Marketing
CSM	Contraceptive Social Marketing
DAAF	Administrative Affairs and Finance
DFA	Development Fund for Africa
DHS	Demographic and Health Surveys
DRH	Division of Human Resources
EEC	European Economic Community
EPI	Expanded Program of Immunization
EPS	Education pour la Santé
FHI	Family Health International
FHPP	Family Health and Population Project
FP	Family Planning
GOS	Government of Senegal
HES	Health Education Service
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPNO	Health Project and Nutrition Office
HRDP	Human Resources Development Project (World Bank)
IEC	Information Education and Communication
IHD	Institute of Health Development
IRD	Institute for Research Development
ISED	Institue de Sante et Development
JHPIEGO	John Hopkins Program for International Education in Reproductive Health
IUD	Intra Uterine Device
KAP	Knowledge, Attitudes and Practices
LOP	Life of Project
MCH/FP	Maternal and Child Health/Family Planning

MCH	Maternal and Child Health
MEFP	Ministry of Economy, Finance and Plan
MIS	Management Information System
MOPHSA	Ministry of Public Health and Social Action
MWRA	Married Women of Reproductive Age
MWCF	Ministry of Women, Children and Family
NFPP	National Family Planning Program
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
OYB	Operating Year Budget
PACD	Project Assistance Completion Date
PAIP	Priority Action and Investment Program
PDDS	Plan Départemental de Développement Sanitaire (Dept. Health Dev. Health)
PDO	Project Development Office (USAID)
PHC	Primary Health Care
PID	Project Identification Document
PMI	Protection Maternelle et Infantile
PNA	Pharmacie Nationale d'Approvisionnement
PNPF	Programme Nationale de Planification Familiale
POPTECH	Population Technical
PRDSs	Plan Regional de Développement Sanitaire (Reg. Health Development Plan)
PRITECH	Technologies for Primary Health Care
PSC	Private Service Contractor
PVO	Private Voluntary Organization
RTS	Radio Television du Senegal
SANAS	National Service for Feeding and Applied Nutrition
SANFAM	Santé de la Familiale
SCC/MP	Physician Licensing Service
SCS/FP	Senegal Child Survival/Family Planning Project
SIS	Health Information System/Système d'Information
SMI/PF	Santé Maternale Infantile/Planification Familiale
SNH	Hygiène Service
SOP	Community Participation Service
SSB	Dental Health Service
SSE	Statistics Service
SSS	Sugar - Salt - Solution
STD	Sexually Transmitted Communautaire
UNDP	United Nations Development Programs
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Funds
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Since independence, Senegal's rapid population growth and slow economic growth have interacted to limit improvements in the quality of life. Rapid population growth has seriously impacted on the quality of the natural resource base, and Senegal has already surpassed its human carrying capacity in terms of cereals production and sustained forest yields. Senegal's population of approximately 7.8 million is currently growing at a rate of 2.7% annually with an average life expectancy of 48 years at birth. World Bank projections show the population growth rate peaking between 1995 and 2000 at 3.17%. This would put the total population at 10,372,000 in the year 2000.

As domestic agricultural production covered only 59% of food consumption in 1988, Senegal's agricultural resources would be overwhelmed by such an increase in demand and would move the country even further from its target of food self-sufficiency. The health and education sector would also face serious problems should the population increase at the rates currently projected.

USAID and other donors have supported family planning activities in order to slow the rapid population growth rate. USAID's proposed Senegal Child Survival/Family Planning (SCS/FP) Project will continue this effort through a set of activities aimed at reducing the fertility rate in Senegal.

A. Project Goal and Purpose

The goal of the SCS/FP Project is to decrease the total fertility rate in Senegal. The purpose of the Project is to increase the use and knowledge of modern contraceptives.

B. Project Description

The project will achieve its purpose by identifying a limited number of existing family planning service sites to serve as high quality, efficient family planning referral centers in the largest urban cities in Senegal where a relatively strong demand for family planning services already exists. In rural areas, the project will increase the demand for family planning services by sensitizing people about the benefits of child spacing. Lastly, since it has been shown that the demand for family planning is related to infant mortality, the project will attempt to reduce the infant mortality rate by controlling diarrheal disease and training health care providers in the treatment of other childhood diseases.

The project will provide five long-term technical advisors: an information, education and communication specialist, a logistics specialist, a financial management specialist, a family planning specialist who will serve as Chief of Party, and a health planner. Short-term technical assistance will be provided in the areas of contraceptive technologies, training, clinical quality, the design and coordination of municipality activities, and management information systems. The project will finance local training of health care providers in

subjects related to family planning (FP) and maternal and child health (MCH). The project will increase the availability of family planning service sites in the private sector by providing grants to NGOs. To improve supervision, and support the Ministry's decentralization plans, the project will finance the MCH/FP components of regional and district health plans, including supervision and annual updating of the plans.

The SCS/FP Project is a five-year, $27 million project funded from the Development Fund for Africa (DFA). It is expected that $5.65 million will be obligated during FY 1992 and the remainder incrementally over the next five years. In addition, the Government of Senegal will contribute both in-kind and in cash an estimated amount of $5.85 million. Thus, the total project cost will be approximately $32.85 million.

I. BACKGROUND

A. General Background

Since independence, Senegal's rapid population growth and slow economic growth have interacted to limit improvements in the quality of life. Rapid population growth has seriously impacted on the quality of the natural resource base, and Senegal has already surpassed its human carrying capacity in terms of cereals production and sustained forest yields.

Senegal's population of approximately 7.8 million is currently growing at a rate of 2.7% annually with an average life expectancy of 48 years at birth. As health care improves and infant, child and maternal mortality decrease, any decrease in the population growth rate due to declining fertility is far out-paced by increased survival. World Bank projections show the population growth rate peaking between 1995 and 2000 at 3.17%. This would put the total population at 10,372,000 in the year 2000.

As domestic agricultural production covered only 59% of food consumption in 1988, Senegal's agricultural resources would be overwhelmed by such an increase in demand and would move the country even further from its target of food self-sufficiency. The health and education sector would also face serious problems should the population increase at the rates currently projected. In both cases, an increased percentage of the national budget would be required to maintain services, with a large portion of these funds being used for salaries, creating a negative impact on service delivery.

1. Contraceptive Use

Despite extensive contacts with the West, Senegal remains a conservative country, and this has constrained the development of family planning services and the utilization of modern contraceptive methods. In 1989, only 2.4% of Senegalese women were using modern methods of contraception. Nearly all of these users live in urban areas (6.7% of urban women used a modern method while only 0.3% of rural women did in 1986). The urban picture suggests the beginning of the demographic transition - namely because there is a higher population of younger, educated women who use contraceptives more.

2. Desired Family Size/Spacing

The 1986 Demographic and Health Survey (DHS) determined that the total fertility rate in Senegal is 6.6. Though women are having on average 6.4 children, the desired number is 6.8; that is, women desire a slightly larger family than they are actually having. Desired family size is significantly lower in urban areas: 5.5. However, in all areas younger women state a preference for a smaller family size than do older women.

In the 1986 DHS, only 19% of married women in Senegal wanted no more children. However, 61.6% of those women already had 6 or more children and wanted to limit births only because they had achieved their desired family size. There is significant interest in the spacing of children in Senegal. Almost 40% of women in the DHS reported wanting to wait thirty months or more for their next child.

3. Maternal and Child Health

Infant and child mortality rates in Senegal in 1986 were 86 and 113 per thousand respectively. Diarrhea, respiratory disease and malaria were the leading causes of death and illness. The incidence of diarrhea is highest in children between 6-23 months with approximately 10 episodes per child per year. Childhood mortality in Senegal is relatively high and an estimated 27% of all deaths to children under five are associated with diarrhea. Maternal mortality is one of the leading causes of death for women of reproductive age. The high fertility rate is one of the major factors responsible for the high maternal and infant mortality.

B. Macroeconomic Overview

Beginning in 1980, and particularly since 1983, the Government of Senegal has been engaged in economic reform programs. Thanks to generous support from the donor community and the IMF, supplemented by numerous public and private external debt reschedulings, Senegal has been able to undertake macroeconomic reforms as well as reforms in agricultural and industrial pricing and marketing, public sector management, and a major restructuring of the banking sector.

The results of these programs are significant. The trend of economic deterioration, so evident at the beginning of the decade, seems to have been halted, if not reversed:

* The role of the government in the economy, measured by the ratio of public expenditures to GDP, has decreased by about one-third: standing at 32% in FY 1981, this ratio was down to 21% in FY 1990. A number of rural development agencies have been closed and public enterprises are being privatized or liquidated. Subsidies to most of the remaining agencies are being eliminated or severely reduced. The public sector work force is also being reduced.

* The rate of real GDP growth, which continues to be highly dependent on agricultural sector performance (i.e., on rainfall), averaged about 3% per year during the 1980s, slightly above the population growth rate of 2.7%. Earlier trends had resulted in slowly deteriorating per capita income.

* The current account deficit of the balance of payments declined steadily from a peak of 14% of GDP in FY 1984 to an estimated 3.1% of GDP in FY 1990. Concurrently with this improvement, the ratio of savings to GDP, which had fallen

to practically zero in FY 1980, rose to an average of about 7.5% over FY 1987-90 and was estimated at approximately 9% in 1991. The investment ratio has hovered around 12.5% for several years. This is still below the minimum desirable level of 14% required to maintain capital stock, according to the World Bank, but the trend is in the right direction.

* The budget deficit as a proportion of GDP (including grants) declined from a peak of 11.5% in FY 1981 to 1.2% in FY 1988, rebounded to 3.4% by FY 1990, and achieved a position of near balance in FY 1991. Unfortunately, a portion of the improvement is due to the accumulation of arrears. In addition to the government's continuing efforts to expand the tax base and improve revenue collections, it is also crucial to maintain tight expenditure controls. Some of the sources of unexpected budget overruns should be reduced by the phased integration of off-budget accounts into the normal budget process started in July 1991. Nevertheless, corrective actions for the FY 1990 bulge have fallen particularly harshly on recurrent expenditures for materials and supplies: allocations to this category fell by over 25% in FY 1991 and by another 13% in FY 1992.

* Inflation fell from a peak of 11.4% in FY 1985 to about 2.5% in FY 1989 and has remained below 2.5% since.

* Interest rates are highly positive, with a ceiling of 16%, preferential credit allocations have been eliminated in the context of reforms throughout the West African Monetary Union, and more flexible methods of monetary management are being phased in.

In spite of these generally encouraging results, much remains to be done on many fronts -- economic, institutional, social -- to move from stabilization to actual structural change that will permit more dynamic growth and improved standards of living in the future. Years of virtual stagnation followed by resistance to wholesale market liberalization have resulted in severely limiting the economy's capacity to absorb labor, while at the same time population growth puts 100,000 new job seekers on the market each year. No more than 30% of these are currently able to find employment in the urban sector.

Population growth has also outstripped gains in agricultural production, resulting in a 35% decline in per capita agricultural production between 1960 and 1989. Thus, any serious long-term growth strategy must look at the demand as well as the supply side of the equation: policies and programs to slow the rate of population growth must go hand in hand with efforts to create a dynamic environment for production.

C. The Health Delivery System in Senegal

Over the last decade the Government of Senegal has made efforts to streamline and

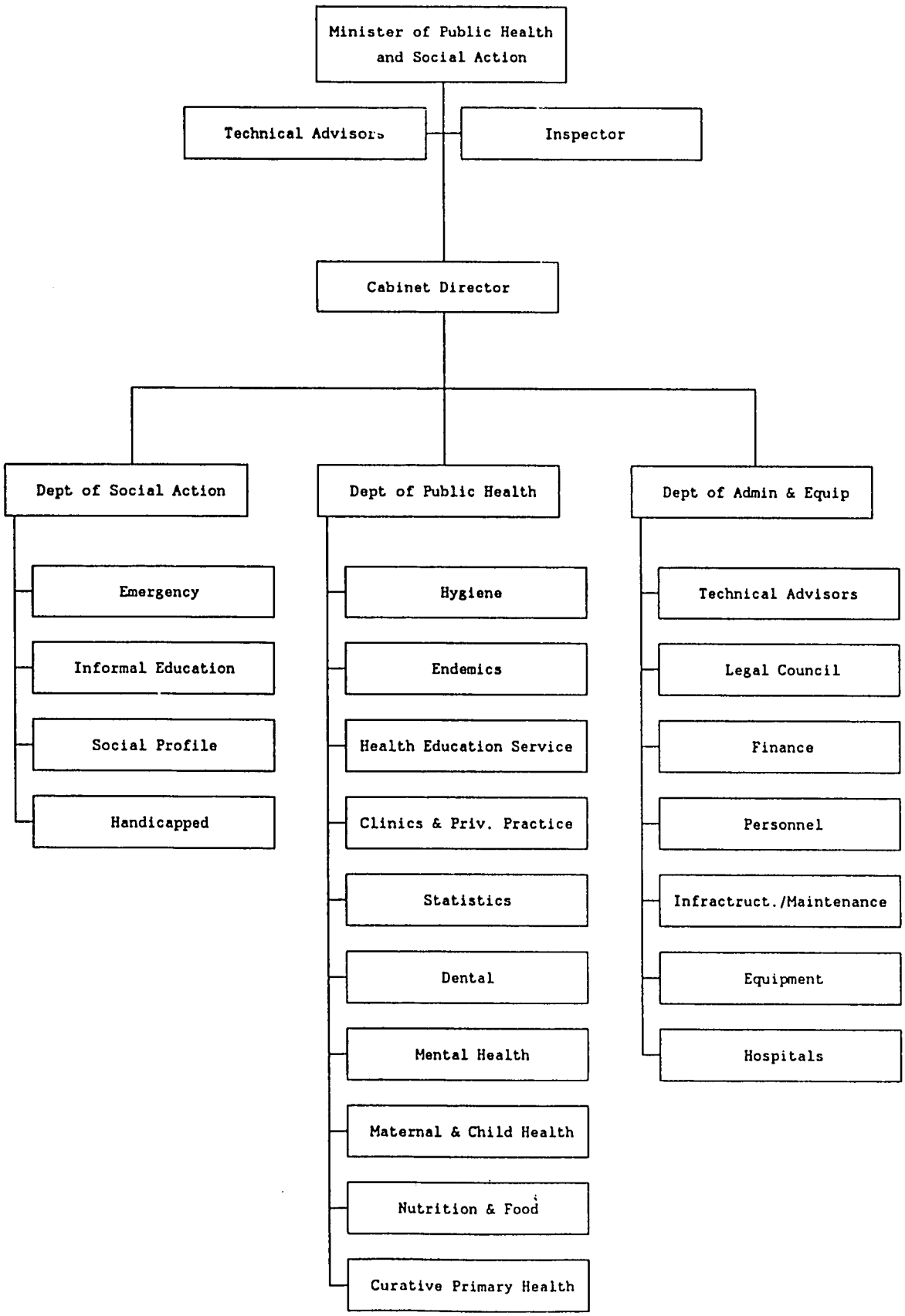
decentralize government activities. As part of this effort, the two previously separate Ministries of Health and Social Development were merged into one Ministry of Public Health and Social Action (MOPHSA) on April 1, 1990, thus effectively bringing together public health and family planning/population activities for the first time. In addition, the number of departments in the new structure has been reduced from six to three, with the former departments becoming offices directly under the supervision and control of the Ministry's cabinet. Decision-making power is now at least theoretically concentrated in the three departments. The intention is for the departments to decentralize their authority and concentrate on being the impetus for regional action. They should focus on coordination, support and evaluation of plans of action, resource use and delivery of services in the ten regions.

Figure 1 represents the current structure of MOPHSA. The Department of Public Health, one of three departments within MOPHSA, is headed by the Director of Public Health. The Department of Public Health consists of the following division and services: Food and Applied Nutrition Service, Statistics Service, Maternal Child Health/Family Planning Service, Health Education Service, Major Endemics Service, Hygiene Service, Dental Health Service, Mental Health Service, Community Participation Service, Physician Licensing Service, and Administrative Affairs and Finance. The Department of Public Health is at the apex of the Senegalese public health system and is directly linked to the programs which are to be planned and implemented by the Medical Regions and Medical Departments. The three services most directly involved in implementation of project activities will be the Maternal Child Health/Family Planning Division, the Health Education Service, and the Food and Applied Nutrition Service.

Health Personnel: In 1988, there were 459 doctors in Senegal (1 per 17,000 population), 2,487 nurses (1 per 3,000 population), and 482 midwives (1 per 14,000). These numbers indicate a shortage of doctors (norm: 1 per 10,000) and of midwives (norm: 1 per 5,000); however, nurses are present in satisfactory numbers (norm: 1 per 5,000). The distribution of health personnel throughout the country is very uneven, with a large percentage located in Dakar. The majority of health personnel are employed in the public sector. At the health post and health center levels, there is a deficit of doctors and administrative personnel, but a large excess of support personnel, both technical (nurse's aides, medical technicians, etc.) and non-technical (janitors, etc.). Paramedicals (nurses, midwives and "agents sanitaires") are also largely in excess at present, but this excess should be absorbed over the coming years if the number of health posts increases, as needed to keep up with population growth.

In the area of health service delivery, the private sector consists of several facets: there are individual private practitioners and their small clinics, providing both modern and traditional health services;and there are institutional, nongovernmental providers of services, including private and voluntary organizations, employers, para-statals, insurance companies and private hospitals. With the exception of the traditional healers and a few of the institutional providers, the private health care sector is neither large nor highly

FIGURE 1


Minister of Public Health and Social Action
Technical Advisors
Inspector
Cabinet Director
Dept of Social Action
Dept of Public Health
Dept of Admin & Equip
Emergency
Informal Education
Social Profile
Handicapped
Hygiene
Endemics
Health Education Service
Clinics & Priv. Practice
Statistics
Dental
Mental Health
Maternal & Child Health
Nutrition & Food
Curative Primary Health
Technical Advisors
Legal Council
Finance
Personnel
Infractruct./Maintenance
Equipment
Hospitals

developed, and access to its services is limited, primarily because of high prices and poor distribution. The vast majority of private clinics, physicians, midwives and pharmacies are in Dakar. Most of the remainder are clustered in a few other large cities. The nonprofit private service providers include the previously mentioned 68 Catholic health posts, 13 Red Cross (Croix Rouge) medico-social centers and 3 Senegal Association for Family Well-being (ASBEF) clinics. Work place provision of health services is not uncommon in Senegal, especially among the larger employers and para-statal companies. Many have on-site clinics or cover services through social insurance programs such as group funds to cover partial costs of members' medical care. Employers of 100 or more personnel are required to establish such funds through payroll deductions and contributions.

The overwhelming majority of Senegalese continue to avail themselves of the services of traditional practitioners in addition to modern medical services through the public health and private health care systems. Traditional medical services are still highly relevant even to urban Senegalese who have modern health services available in reasonable proximity.

Decentralization of the Health Delivery System A National Health Policy (Declaration de Politique Nationale de Sante) was developed in June 1989, with the assistance of the donor agencies including a great deal of input from USAID. The major focus of this policy declaration is on systemic improvements to further the structural reform efforts of the GOS, the decentralization of planning and activity control, as well as implementation of a primary health care perspective in service delivery and professional preparation. The policy calls for the reinforcement of decentralization and a dispersal of management authority governing the use of financial, human and material resources, a reinforcement of the capacity of the chief regional medical officer to assure the coordination, implementation and evaluation of health activities in the region, and elaboration of regional and departmental health plans.

The Decentralization Committee, chaired by the Director of Public Health, is responsible for coordinating the decentralization of health activities to the regions and districts. The Regional Medical Team is a key player in the GOS' decentralization efforts as it is the entity which oversees the regional health program. The Regional Medical Team is responsible for providing technical support and supervision to the district medical teams, and monitor and evaluate regional health activities. In most cases, the team is also very active in regional training.

The major actors on the Regional Medical Team are the Regional Medical Officer, the head of primary health care, the Maternal Child Health/Family Planning (MCH/FP) Coordinator, the head of health education, and the hygiene brigade. In principle, the team should be polyvalent. In other words, each member should be familiar with all of the technical areas. Thus, if the MCH/FP coordinator is unavailable for some reason, another member of the regional team should be able to oversee MCH/FP activities. According to decentralization plans, most training should take place in the regions. Each region has a core of trainers headed by the Regional Medical Officer.

The **Health Education Service (HES)** is charged with bringing health and social issues to the awareness of the population. It is particularly concerned with preventative care and as such often focuses on behavior modification. HES is responsible for the overall development of the Health Education Strategy, the development of prototype materials, research and evaluation.

At the national level, HES consists of 10 professionals with wide ranging expertise including a cinematographer, a social worker, graphic artists and a health education specialist. Although this affords the HES a breadth of expertise, in some cases, it results in lack of depth and a unified approach to health education. Each member of the HES staff is expected to cover several technical areas in health which sometimes weakens specific programs such as Family Planning. These persons are then supported by the technical cadre to work on the design of various media presentation formats. In addition, the HES can call on other design and production units in the private sector by offering contracts for technical work.

The Health Education Service was designated in 1990 to coordinate family planning Information Education and Communication at the regional level. These activities will involve the following key actors: the regional monitors who supervise a group of animation agents that work with women's groups, a regional coordinator for from the Ministry of Youth and Sports who heads a group of animation agents that work with youth groups and clinical and social work personnel from the Ministry of Health and Social Action.

Operational aspects of the National Family Planning Program will be implemented by the **Office of Family Planning** within the **Maternal Child Health/Family Planning Division**. Policy development and negotiation responsibilities requiring interaction with high level decision makers will be handled by the Technical Advisor for Family Planning, a member of the MOPHSA cabinet.

At present, day-to-day operation of family planning activities is managed by three female midwives who have responsibility for the maternal mortality and child survival programs in addition to family planning. Two physicians head the MCH/FP Division and are assisted by logistical and administrative personnel as well as by state certified nurses. The proposed staffing of the newly created Office of Family Planning outlined in the following paragraphs, represents a considerable expansion over current staffing. Nonetheless, it is considered to be the absolute minimum required for an effective National Family Planning Program. It remains to be seen whether MOPHSA will establish all the recommended positions and will be successful in recruiting candidates in a timely manner.

Within the Office of Family Planning, there will be three units: Clinical Services, Information Education and Communications, and Management. The clinical services Unit

will be staffed by a physician and two midwives plus a long-term technical assistant and a Senegalese gynecological specialist funded by the United Nations Fund for Population Activities (UNFPA). The Clinical Services Unit will be responsible for: a) set up of family planning referral centers; b) norms for technical and practical training in referral centers; c) training and supervision at the referral centers; d) supervision and training of Regional MCH/FP Coordinators and midwives who are responsible for management of the referral centers; e) clinical quality assessment; f) private sector quality control; and g) new program development such as community based distribution schemes.

The Information Education and Communications Unit will be responsible for demand creation activities in support of the National Family Planning Program (NFPP). Two MOPHSA staff would comprise the Unit and work in close collaboration with the MOPHSA Health Education Service. The latter will assign two full-time staff and a part-time researcher to focus solely on family planning activities.

The Management Unit will handle finances and commodities for the National Family Planning Program. The handling of donor funds and commodities and preparation of periodic financial and budget reports for USAID, UNFPA, as well as MOPHSA will require at least six staff persons (three accountants, one high level contraceptive logistician, one stock manager at the Pharmacie National d'Approvisionnement (PNA), and a general commodities manager). This Unit will also be responsible for contraceptive logistics, and work in close collaboration with the PNA.

The **Senegal Applied Food and Nutrition Service (SANAS)** is a division of the public health service charged with the development of food and nutrition policy and the implementation of programs in diarrhea, nutrition, and growth monitoring. Its major goal is to coordinate the implementation of these activities through the regional and district health plans.

D. GOS Population and Family Planning Policy/Strategy

Increasingly concerned by Senegal's high rate of population growth and its impact on socio-economic development, the GOS adopted a comprehensive Population Policy Statement in April 1988, calling explicitly for reduced fertility and setting out a multi-sector strategy to attain this objective. While not setting specific demographic targets, the policy statement presented two scenarios for Senegal's demographic transition: a low-growth scenario which called for a contraceptive prevalence rate (CPR) of 29% to reach a rate of natural increase of 2.87% in 2001, and a medium-growth scenario calling for a CPR of 15% for a rate of natural increase of 3.21% in the same year. The conclusion drawn is that a significant decline in fertility is necessary if development efforts are to remain unshackled by excessive population growth.

Since adoption of the national policy, the GOS has defined an $85 million Priority Action

and Investment Program (PAIP) designed to give a major impetus to ongoing population and family planning activities. Among the key elements of the PAIP is the definition of a National Family Planning Program that sets quantitative objectives for the short and medium terms--CPRs of 14% by 1995 and 22% by 2000--and defines a coherent framework for all family planning activities in the country. Not limited to family planning activities, however, the PAIP includes a cross-sectoral range of actions that would help transform the social and economic environment to favor more rapid fertility decline (including improved maternal and child health, promotion of women's status, increasing involvement of youth, improved employment opportunities, and population-related legislation). The multi-sectoral nature of the PAIP signifies an important evolution in official attitudes towards population-related actions, from a narrow concern for the effects of high fertility on the health of mothers and children, to wider concerns for family welfare and national development objectives.

The National Family Planning Program (NFPP) was signed by the President of Senegal on March 15, 1991. GOS population and family planning strategies are embodied in the PAIP and the National Family Planning Program document. The key elements of the strategies include expanding Family Planning (FP) IEC and service delivery, promoting the status of women, involving youth in population and FP efforts, reducing legal and regulatory constraints to fertility decline, strengthening sectoral leadership in population, and involving the private and NGO sector as partners in those endeavors. The objective is to have 80% of the population informed correctly about the benefits of FP and about the existence and correct utilization of modern contraceptive methods by the year 2000.

Efforts to expand the family planning service delivery system are to accompany the IEC efforts. The objective is to capitalize on the interactions between FP and maternal and child health (MCH) by completely integrating these services. According to the World Bank, the GOS has agreed to expand FP services to every level of the public health system, to authorize health post nurses to distribute all types of contraceptives except Intra Uterine Devices (IUDs), authorize village health workers and matrones to distribute condoms and spermicides and to permit matrones, upon completion of appropriate training, to resupply oral contraceptives after initial prescription. The GOS is also encouraging FP service delivery through channels outside of public health facilities including private medical and paramedical practitioners, pharmacists and pharmaceutical depots and private and para-public organizations.

The GOS Population Policy Statement calls for revising or fine-tuning legal and regulatory measures which could have an impact on couples' desired number of children and their access to FP information and services.

The institutional structure responsible for population-related activities is well-defined: the National Population Commission (CONAPOP), serving as advisory body to the Inter-ministerial Council on all population matters; and the Division of Human Resources (DHR) in the Ministry of Economy, Finance and Plan (MEFP), serving as Secretariat to the

CONAPOP. UNICOM (Unite de Communication), a general coordinating and information sharing unit has been established to complement CONAPOP. This structure, which has successfully led the effort to develop a national population policy and to define the PAIP, must now shift efforts towards coordinating the implementation of a large, cross-sectoral action program involving around ten ministries, numerous NGOs and donor organizations. Within this institutional structure, the Ministry of Public Health and Social Action is the nodal GOS body for FP services.

E. AID Experience in Health and Family Planning

USAID's bilateral health and population assistance to Senegal dates from 1977. During the 1980's, USAID was the most significant among donors in terms of the scope and dollar value of its assistance in this sector, providing more than $25 million during the decade. Current USAID priorities in the health sector focus on family planning and child survival through two large projects described below. Both of these projects succeeded in moving Senegal closer to its goals of improving family planning and MCH services. However, AID experience in Thailand and Kenya has shown that at least ten to fifteen years are required to achieve significant and lasting impact in changing peoples' attitudes and improving service delivery. Therefore, the proposed project will build on the gains achieved under the two projects described below.

Family Health and Population (685-0248) is the largest population project in Senegal. The total life of project (LOP) funding under the project (Project Assistance Completion Date, PACD, September 1992) is $22.07 million. The project seeks to enable the public and private sectors to carry out an effective nationwide family planning program and to provide demographic survey and analytical capability to inform policy makers of the impacts of rapid population growth. Although the project enhanced the access of couples to modern family planning methods, an effective nationwide family planning system still does not exist in Senegal. An evaluation of the project in 1991 concluded the following:

* The provision of quality family planning services is a key element in demand generation. Once demand is generated, it is critical to assure the timely delivery of family planning services.

* In order to improve the quality of family planning services, an increased level of individual responsibility and hands-on supervision is needed. To achieve this, family planning must become an integrated part of maternal and child health rather than a separate vertical program with parallel administration, supervision, and service delivery mechanisms.

* The contraceptive logistics system must work more efficiently or the whole family planning program is threatened.

The proposed project addresses each of these recommendations.

Rural Health Delivery Services II/Child Survival (685-0242) was the largest project of its kind in Senegal during the 1980s. The PACD is September 1992, and the LOP is $10.7 million. The project was designed to build on the gains of its predecessor (Rural Health I, 685-0210) to establish a sustainable, community-based primary health care system, and to standardize and improve specific child survival interventions. The project seeks to achieve these objectives by strengthening MOPHSA, encouraging decentralization of primary health programs to the regions and departments, improving child survival interventions, and improving training in public health planning.

A 1991 evaluation concluded that the project successfully introduced child survival interventions in the project area; that it probably contributed to better health of people in the project area; but that it is not clear what the effects of these interventions were. The proposed project will support these decentralization efforts through the financing of MCH components of district health plans. The management information system to be established under the proposed project will enable both MOPHSA and USAID to better assess program impact.

F. Other Donor Activities in the Health and Family Planning Sector

Donors are heavily involved in Senegal's health sector with the majority of funding coming from USAID, UNICEF and Belgium. WHO, France and Italy support most of the research, training and management activities. UNICEF, with its Expanded Program in Immunization, is the primary donor in the area of prevention and control of disease. Development of potable water schemes is an activity of a large magnitude and is funded by Italy, Japan and the African Development Bank.

During the course of the project design, donor coordination meetings with those donors most involved with family planning and child survival activities (see list below) were held. As a result, the complementarity between various donor programs has been maximized. Below the general involvement of each donor in the health sector is described. The division of agreed upon responsibilities for specific family planning/child survival interventions between USAID, UNFPA, and the World Bank will be described later in the paper (Section III.E).

Belgium works primarily in the Pikine district of Dakar providing urban primary health care on a cost-recovery basis. Their inputs include managing the drug supply, logistics, technical assistance, improving facilities and services, and construction. Belgium will also assist one district in Diourbel with the implementation of its district health plan.

Canada has assisted the health sector mainly by supporting the census, and by funding enumerator's salaries, a post-census survey, and publication of the results.

The EEC is not as yet involved in any large-scale health projects but proposed to support the implementation of district health plans in the region of St. Louis.

France in 1990 provided 98 professionals in positions at the major hospitals in Dakar as well as 15 civil hospitals throughout Senegal. France's technical assistance focuses on curative care, technical and management issues, and aid in developing blood analysis for HIV/AIDS and hepatitis. In addition, France will assist in a sanitation program and in the implementation of the regional plan in Tambacounda and Kolda. France will also build an extension to the Hopital de Ziguinchor, and supply vaccines for the expanded program of immunization (EPI).

Italy has provided equipment (hospital vehicles, construction,) funds for UNICEF activities in EPI, and support for several NGOs working in health.

UNDP has supported the study and development of a strategy in reducing maternal mortality, a study of demographic trends and urbanization, and with UNFPA has helped define a medium and long-term population strategy.

The United Nations Population Fund (UNFPA) considers Senegal a priority country and has invested $9.8 million here in population and family planning since 1972. Activities include maternal and child health and family planning, population IEC, and basic data collection and analysis. In 1985 a joint UNFPA/World Bank team conducted a second population sector assessment in Senegal based on which UNFPA developed its current program. This four-year program, begun in 1987, has a budget of $4 million and provides family planning assistance in the four regions of Diourbel, Louga, Tambacounda, and St. Louis. (USAID's Family Health and Population project is active in Senegal's six other regions, though some private sector activities are also supported in Diourbel, Louga and St. Louis.)

UNFPA recently completed the design of a new project whose start up will begin in January 1993. Approximately $2 million will be made available over a period of five years for family planning related activities with an additional $1 million for NGO family planning activities. USAID and UNFPA have closely coordinated their inputs into the health sector.

UNICEF has played an important role in shaping Senegal's health strategy. For the next five years, UNICEF will continue its support of decentralizing health programs and planning in selected districts in five regions where it now has WID projects (St. Louis, Thies, Tambacounda, Kolda, and Ziguinchor) with an emphasis on safe motherhood, nutrition, essential drugs, and control of diarrheal disease.

The World Bank's recently developed Human Resources Development Project (HRDP), Phase I, has as its objectives the reduction of fertility and population growth rates and the improvement of access to basic health services. The proposed $52 million project is to

be funded from a $35 million IDA loan, $2.9 million from the Government of Senegal and the balance from other donors. Because the amount of funding from other donors is as yet unclear, the IDA loan will finance the costs for the first three years of the program.

To achieve the project objectives, the Bank will finance investments in the population sector to:

1. strengthen the National Family Planning Program;
2. promote the status of women;
3. sensitize youth on family welfare issues; and
4. strengthen institutional capacity to promote the national population program.

There is also a policy reform component including the following:

1. liberalization of regulations on contraceptive distribution and use;
2. adoption of organizational norms for the district health system, ensuring increased budget allocations to the health sector; and
3. promotion of essential drugs.

Population activities will receive 28% of the Bank's project funds ($14.6 million), of which one-third supports family planning services and three-fifths is for women and youth activities. Of the $4.8 million dedicated to family planning activities, the major element is IEC comprising nearly 47% of the line-item; 28% is proposed to support private sector activities in family planning. The remaining 25% will support family planning service delivery in Dakar, Diourbel and Thies. The health component will support facility construction and district planning in these same regions.

II. RATIONALE FOR PROJECT

A. Constraints Analysis

The fundamental constraints to reducing fertility and increasing the use of contraceptives in Senegal, as identified in the June 1991 Health and Population Assessment and by project evaluations, can be grouped into three categories: (1) Limited Demand, (2) Mediocre Quality of MCH/FP clinical Services; and (3) Insufficient Access.

Limited Demand. The demand for family planning methods in Senegal is limited due to high infant mortality, socio-cultural factors, and a general lack of knowledge about family planning methods. The rate of infant mortality in Senegal is very high. Almost nine percent of children die before age one due to malaria, respiratory disease, and diarrheal disease. Childhood mortality is also high, estimated at 227 per 1000. Parents compensate for the high rates of infant and child mortality by having a large number of children.

Socio-cultural factors also are a serious constraint to increasing demand for contraceptives in Senegal. Senegalese perceive benefits in having many children, although men and women perceive these benefits differently. Women prefer many children because the children prove a woman's fertility and can work for the household. The average Senegalese woman marries at the age of sixteen and begins having children shortly thereafter.

Men want many children because they are seen as an economic asset. They prove a man's virility, and large families are consistent with teachings of Islam. In addition, families receive a certain amount of financial compensation from the GOS based on the number of children they have. In Senegal, many health care workers require that a woman obtain her husband's consent before they will provide her with a method of contraception. It is not uncommon to find women who would like to use family planning but are prevented from doing so by their husbands. The strong pro-natalist sentiment in Senegal also encourages large families. Men are able to delay retirement if they have children under age five. Families also receive child care payments based on the number of children in the family.

Lastly, the low level of knowledge about family planning methods is a significant constraint to increasing the demand for family planning methods. Both men and women often are unaware of and don't understand the variety of family planning methods available to them. For example, some women believe that taking contraceptive pills will make them sterile forever. The reason for the low level of public awareness of family planning methods is two-fold: 1) there have not been sufficient public awareness campaigns to inform people of the benefits and methods of family planning, and 2) health providers frequently have inadequate knowledge or do not have the interpersonal skills or time to explain family

planning methods.

Mediocre Quality. The quality of family planning (FP) and maternal and child health (MCH) services has considerable impact on whether or not women take advantage of the services. A pre-natal visit to a clinic is often the first point of contact a woman has with health facilities. It is at this point that family planning counseling should begin, followed by further counseling during post-natal consultations. At present very few midwives take advantage of post-partum visits to provide family planning counseling to women. Because of the long waits (often up to 3 or 4 hours) due to poor clinic management, some women choose not to return to the clinics. When women using contraceptives fail to return to clinics there is seldom any follow-up of these drop-outs by the midwives.

According to recent evaluations, the quality of FP/MCH services in Senegal also suffers because health care workers lack sufficient knowledge of family planing methods and treatment of acute childhood diseases. For example, many health care workers are unable to prescribe contraceptives based on a client profile. They are often poorly informed about secondary effects of contraception methods and what to do should they occur.

A third reason for the mediocre quality of MCH/FP services in Senegal is that health care staff are not being properly supervised either because supervisors lack the means to do so, lack adequate management and supervisory skills, or lack protocols which normally provide an approved standard against which to monitor services. Many supervisors view themselves as police rather than instructors. They do not have the interactive skills to use supervisory visits to teach health care staff how to improve their performance.

In addition, many clinic personnel cannot establish realistic goals because they do not understand the linkage among goals -objectives - outputs and inputs. For example, medical personnel can not project the level of effort of activities needed to obtain specific objectives. Their budgeting skills are also very weak.

Limited Access. At present there are just under 200 public and private family planning service sites in Senegal. According to the logistics report undertaken as part of the project design, this number is more than sufficient to cover the contraceptive needs of Senegal provided these clinics are operating efficiently. However, in most instances this is not the case. Very few service sites offer family planning services five days a week, both in the afternoon and in the morning. Thus, a woman may go to a clinic only to be told that she must come back another day when family planning services are provided.

The absence of full-time family planning services and full-time maternal child health services makes it difficult for a mother to make a single clinic visit to obtain family planning services and care for her new born. The frequency with which women utilizing family planning methods need to be seen (often three times a year and for pill users every month) creates a disincentive to contraceptive users and may partially account for drop-

outs.

The "over-medicalization" of family planning services also may serve as a disincentive. For example, most clinic personnel use any point of contact with a client to screen for other health problems. So a woman requesting family planning services may be required to undertake a battery of physical exams (including laboratory exams). This generally entails more time and cost. If she is not in 100% good health she may be denied family planning services even if the problem is not linked to family planning.

In terms of the availability of a variety of contraceptive methods, the frequency of stock-outs has become almost a regular event. It is not unusual to find clinics offering only two types of contraceptive methods instead of the whole spectrum. For women who are currently using a particular method, and for women who are unable to use all methods, stock-outs create a serious disincentive to contraceptive use. In addition, at the community level there is very little outreach. Contraceptives are made available only at clinics and not through community-based distribution networks. Therefore, resupply of pills, spermicides and condoms are generally not available except at clinics where one is usually required to wait and pay consultation fees.

B. Rationale and Strategy

The goal of the Senegal Child Survival/Family Planning Project is to decrease the total fertility rate in Senegal. The purpose of the project is to increase the use and knowledge of modern contraceptives. In order to achieve this, the constraints described above must be overcome. The project strategy, jointly developed with MOPHSA, is consistent with the strategy outlined in the GOS National Family Planning Program (NFPP) developed in December of 1990, and with the strategy presented in the Mission's Country Program Strategy Plan (CPSP). In addition, project activities have been structured to fully support MOPHSA's efforts to decentralize responsibility and authority within the health system.

The project strategy in **urban areas** where the demand for family planning services already exists, will be to **improve the access to, and quality and efficiency of existing family planning service sites.** In order to accomplish this, the project will select 29 clinics (13 regional, and 16 district) from among existing clinics to serve as family planning referral centers in the largest city (the regional capital) in each of the ten regions and in the largest town in each district in the four focus regions (Kaolack, Fatick, Ziguinchor, and Louga). Each of these cities and towns has a population over 10,000. Full-time, high quality services will be made available at these centers. Training will be provided to appropriate health care workers to increase their knowledge of family planning methods and counseling skills. Worn-out medical equipment will be replaced by the project. Innovative, state of the art family planning techniques will first be pilot tested in regional referral centers. IEC activities targeting high priority groups will be undertaken to further increase demand for family planning. Lastly, each of these centers will be closely supervised by regional MCH/family planning coordinators and the National Office of

Family Planning. Supervision is perhaps the single most important element needed to establish and maintain a successful and high quality family planning program.

USAID reviewed various options to address both the access and quality issues of family planning service delivery. In order to increase access, one strategy could have been to continue to expand services from the existing public service delivery points to more health posts and smaller centers. However, given the weaknesses observed in the existing system and the difficulty in providing quality services at over 100 existing sites, this strategy was not selected. Instead, the Project will focus on consolidating and strengthening a limited number of existing urban clinics where client load will be increased and effective use of resources stressed. A study by two contraceptive logistic on consultants that Senegal's family planning service needs can most effectively be met by a limited number of high client load FP service sites in urban selling. Therefore, the project will ensure that **full-time** family planning services and the full spectrum of contraceptives are made available at 13 regional referral centers and 16 district referral centers. The project will also support the provision of family planning services by NGO's and the private sector in urban areas. Ongoing support to 6-7 family planning delivery sites and maternities in towns over 10,000 in the four focus regions will be provided.

In **rural areas as well as in urban areas**, the project strategy will focus on increasing the demand for family planning services. This will be accomplished through IEC activities and an intensive effort to reduce childhood mortality due to diarrheal disease and dehydration. The latter will be accomplished in the four focus regions (Louga, Fatick, Kaolack, and Ziguinchor) by establishing Oral Rehydration Units at health facilities in the four focus regions, providing Oral Rehydration Therapy (ORT) training to health personnel, and supporting supervision of diarrheal control activities. Oral Rehydration Salts (ORS) packets will be supplied and distributed to all ten regions.

Diarrhea is consistently ranked among the most important childhood diseases in all regions of Senegal. Oral rehydration is a proven, cost effective intervention to reduce deaths from diarrhea/dehydration. For over two decades, the medical community has had access to a simple effective means of preventing and tracing the most life-threatening consequence of diarrhea which is dehydration. Oral rehydration can be effectively administered at home as well as in health facilities.

IEC activities will be developed to deliver not only family planning messages, but messages related to control of diarrheal disease (CDD) and other maternal child health issues as well. Activities with religious, traditional, and political leaders will be developed to sensitize these influential groups to the importance of family planning and to elicit their support. In order to increase access to family planning services at the community level, pilot Community Based Distribution and Contraceptive Social Marketing activities will be supported. In order to obtain timely input concerning the impact of the program, the project will support 2 Demographic and Health Surveys (DHSs) and a mid-term Knowledge, Attitudes and Practices Study (KAP) in rural and urban areas.

A strategy which focuses on both the provision of family planning services in the largest urban area in each of the ten regions and on region-wide child survival and family planning activities in four focus regions will ensure that the ten largest urban areas in the country have access to high quality family planning services. At the same time, this strategy will make these services available at the district level in four of the regions in which the World Bank is not operating under its $35 million Human Resources Development Project. Family planning activities in the remaining, primarily rural regions (Kolda, St. Louis, and Tambacounda) will be supported by other donors.

C. Project Beneficiaries

The project addresses rapid population growth, diarrheal disease, other childhood diseases, and factors which contribute to maternal mortality and morbidity. Although each of the project's several components has a differing geographic and beneficiary focus, overall project beneficiaries include almost the entire population of Senegal.

The project's family planning component targets all women and men of reproductive age, particularly those in urban areas (approximately 40% of the population) and those in the low income brackets. Longer birth intervals through more effective child spacing and reduction of high risk pregnancies among adolescents and grand multiparous women will reduce infant, child and maternal morbidity/mortality. If the project is successful in persuading Senegalese to voluntarily limit family size, the financial demands on individual households as well as on the resources of the Government of Senegal will become more manageable.

The project's child survival component will benefit infants and children throughout Senegal but especially in the project's four focus regions. The Control of Diarrheal Disease activities are expected to lead to improved diarrhea case management in health facilities and at home as well as modified behaviors in support of diarrhea prevention. Diarrhea is consistently ranked among the most important childhood diseases in all regions of Senegal, and the incidence is highest in children between 6-23 months of age with approximately 10 episodes per child per year. Although project CDD activities will be concentrated in the four focus regions, the project will supply packets of Oral Rehydration Salts to health facilities throughout Senegal. The project will also explore commercial and community-based distribution of ORS within the pilot Community Based Distribution/Contraceptive Social Marketing activities to be developed with project funding. Training and IEC materials, technical manuals and supervisory protocols developed for project CDD activities will be adapted for use throughout Senegal. The direct beneficiaries of the child survival component are infants, children under five years of age, pregnant women and mothers. Their survival and continued good health is necessary for eventual widespread acceptance of the notion of family size limitation.

Women are primarily responsible for rearing children. Maternal health is a matter of concern for the entire family. The project will attempt to strengthen the public health

system by assisting the Ministry of Public Health and Social Action to decentralize health planning and management to health regions/districts. The upgrading of 29 regional and district family planning service sites to regional and district referral centers under the project will result in improved quality of care and will provide improved prenatal and postpartum care as well as family planning services. Referral center midwives will be trained to recognize signs of high risk pregnancies and to arrange referral to facilities where appropriate obstetrical care can be provided. Since the overwhelming majority of births in rural areas take place without the presence of a trained birth attendant, competent prenatal care to recognize danger signs and refer for appropriate treatment is essential. Project resources will contribute to a lowering of maternal morbidity and mortality. Pregnant women who are healthy and well-nourished are more apt to give birth to infants who are healthy and of normal body weight.

Project beneficiaries will be reached through various institutional arrangements including the public health system, private and para-public companies which offer health and FP services to their employees, NGO health and FP clinics, social marketing activities, community-based activities through NGOs and community organizations and mass media.

D. Relationship of Project to Mission and AID/W Strategy

The proposed project strongly supports the Africa Bureau's Action Plan for the Development Fund for Africa (DFA), as well as the Bureau's Child Survival Action Plan and Population Strategy. The project will contribute to the achievement of one of the four key strategic objectives identified in the DFA Action Plan which focuses on: "improving the management of African economies by redefining and reducing the role of the public sector and increasing its efficiency."

The third target under this objective is "Improved equity and efficiency in providing key public services particularly health, and family planning services." Several of the activities proposed in this Project Paper are focused exclusively on increasing the efficiency of the provision of health and family planning services in Senegal. For example, the proposed management and supervision training is intended to increase the efficiency of resource mobilization and staff deployment at the district level. The benchmarks and targets established during the project paper design will be structured so they will feed directly into DFA benchmarks.

The proposed project will contribute directly to achievement of three out of six goals under the Africa Bureau's Child Survival Action Plan. These include: (1) reducing infant mortality, (2) providing access to appropriate case management of diarrheal disease, and (3) providing access to family planning.

USAID/Senegal's Country Program Strategy Plan (CPSP) was approved by AID/W in April 1991. The CPSP's over-arching goal is to improve the quality of life of the Senegalese

people through a process of long-term development that is equitable, participatory, self-reliant, and environmentally sustainable. In order to achieve this goal, reducing the family size in Senegal was identified as the first strategic objective. This is to be accomplished through a combination of urban and rural strategies.

The Population Sector Assessment undertaken in early 1991 suggested that given the level of existing demand for family planning services in urban areas, the primary strategic approach should be to increase the delivery of high quality services. In rural areas, where there is less demand for family planning services, the assessment recommended that USAID focus on stimulating demand. The Assessment also highlighted the importance of lowering infant mortality to ensure the success of family planning activities since women tend to have more than the desired number of children when they believe a certain number of children will not survive infancy and early childhood. The proposed project will be the Mission's primary vehicle for accomplishing these objectives at the both the rural and urban levels.

III. DETAILED PROJECT DESCRIPTION

A. Project Overview

The Senegal Child Survival/Family Planning (SCS/FP) Project is a five-year project with a Life of Project Budget of $27 million which does not include $3.5 million of contraceptives that will be provided separately through an OYB transfer. The activities to be supported under the project have been grouped into three categories: activities to improve the quality of service, activities to increase access to family planning services, and activities to increase the demand for family planning services. Activities to improve quality will focus on the development of service delivery protocols, the introduction of longer-term contraceptive methods, the establishment of referral centers, the strengthening of management and supervision capacities at all levels, and training. Activities to increase the demand for family planning services include reducing infant and child mortality by preventing deaths due to dehydration and diarrheal disease, and generating demand through IEC activities. Activities to increase access to family planning will include a contraceptive social marketing pilot, community based distribution, the establishment of an effective contraceptive distribution system and the support of PVO activities.

B. Activities to Improve Quality of Services

The quality of family planning services in the majority of clinics in Senegal is much lower than desired. Problems related to quality include lack of space to provide private consultations, poor reception and counseling, insufficient knowledge and application of contraceptive technology by health care workers, limited supervision of health care workers, contraceptive stock-outs and inadequate equipment.

It would be unrealistic for the proposed project to address each of the above problems in all family planning service sites throughout the country. Therefore, the project will focus on thirteen regional referral centers in ten cities in the country and at district referral centers located in the project's four focus regions (Ziguinchor, Louga, Kaolack, and Fatick). Project interventions to improve the quality of services at these sites will include training, equipment, funding for supervision, support to central bureaus such as the Office of Family Planning, the Statistics Division, and the Decentralization Committee.

The institutional framework and guidance for the National Family Planning Program will be provided by the Office of Family Planning. The Office of Family Planning will play several critical roles. These include:

- assisting the regions and districts to plan, implement, monitor and evaluate regional family planning activities;

- coordinating the training of regional trainers in clinical related areas, IEC, and management of family planning activities;

- assuring the quality of service provision;

- prioritizing and coordinating operational research;

- facilitating the introduction of new contraceptive technology;

- monitoring and evaluating the National Family Planning Program and take appropriate actions to rectify weaknesses.

In order to improve the quality of family planning services, the following activities will be supported by the Project:

1. Development of Standards of Care and Supervisory Protocols

At present there are no official standards of care related to the provision of family planning services in Senegal. In order to ensure the provision of high quality clinical services, standards of care must be established and followed. Without these standards it is difficult to develop protocols for supervision and to correct poor clinical practices. A Situation Analysis Study of existing practices at family planning service delivery points will be undertaken during the first year of the project by MOPHSA with technical Assistance from Population Council. The results will be utilized in developing a MOPHSA policy statement of family planning service delivery standards. Treatment and supervisory protocols will developed to describe:

- range of contraceptive methods for each category of service delivery points (SDP)
- treatment protocols for contraceptive methods
- standard equipment lists for each type of SDP
- statement of client rights including guidelines for informal consent
- guidelines for incorporation of STD and infertility services
- guidelines for integration of family planning and MCH services
- procedures for ordering and storing supplies including contraceptives
- reporting requirements and maintenance of service statistics
- guidelines for IEC activities
- guidelines for conducting supervision visits to service delivery points.

Treatment and supervision protocols will be extensively field tested and modified as appropriate. Guidelines for training service delivery personnel in these two areas will be produced as a result of the field testing. The approved treatment and supervision protocols will include a supervision checklist. The checklist will be used for monitoring the standards of care and for performing on-the-job training of service delivery staff to correct noted deficiencies.

2. Contraceptive Technology

Under the Family Health and Population Project, the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), the Association for Voluntary Surgical Contraception (AVSC), and Family Health International (FHI) assisted in the implementation and evaluation of the introduction of new contraceptive technology and surgical contraceptive methods. These long-term or permanent methods currently account for only a very small proportion of clients served. However, as the Family Planning Program becomes more mature, the use of these methods will increase. In order for longer-term methods to be provided in the appropriate environment, a well informed cliental, and a well running follow-up must be assured.

Key long-term methods to be supported under the Project are Norplant, voluntary surgical contraception (mini-lap) and post-partum IUD. USAID will fund the costs necessary for the University Central Hospital (CHU) and MOPHSA to undertake clinical trials to judge their effectiveness and applicability to the Senegalese environment and to diffuse these methods in the health care delivery system.

As in the past with the introduction of Norplant, if new or modified contraceptive technologies become available, MOPHSA and CHU will convoke a coordinating committee. This committee will assure the development of appropriate research methodologies, review and approve ethical research protocols and designate the responsible researcher. The Project will fund short-term technical assistance (STTA) to assist the coordinating committee in developing, analyzing and applying the results of this research. When a method has been adopted, it will first be introduced at the regional referral centers. STTA will assist MOPHSA in the development of delivery systems, training, control and evaluation of the method's expansion.

The Senegal Child Survival/Family Planning (SCS/FP) Project will continue to support work related to the introduction of Norplant, tubal ligations, and post partum IUDs through buy-ins to FHI and JHPIEGO.

- **Norplant.** Under the existing family planning project, a plan for the diffusion of Norplant to 4 urban clinics has been developed. SCS/FP will continue to supply FHI technical follow-up and support to the expansion of Norplant within the health care delivery system. Ongoing research concerning the acceptability of Norplant and the quality of service required to deliver Norplant will be carried out. FHI, in coordination with JHPIEGO, will arrange and facilitate several observation tours and participation in seminars on Norplant. FHI will assist in expanding Norplant to all regional referral centers.

- **Tubal Ligations.** Under the Family Planning and Population Project, a mini-lap center has been established at Le Dantec Hospital and is now being expanded to serve as the national mini-lap training site. USAID/Senegal via grants to PVOs and

NGOs will fund the establishment of up to 5 private/para-statal mini-lap sites. UNFPA will fund the establishment of 10 mini-lap sites in the regional referral centers. In addition, SCS/FP will provide funding for specialized observation tours and training in order to expand surgical contraception.

- **Post Partum IUDs.** The project will fund observation tours, specialized training, and equipment to establish a post partum program. Either AVSC or FHI is likely to facilitate these activities.

In order to ensure that training curricula provide the latest information on contraceptive technology, an updating of curriculum will be financed by the SCS/FP Project. Under the existing project, almost 10 years went by with no update of curriculum, resulting in inaccurate and incomplete information being provided to both service providers and clients. Under the SCS/FP Project, JHPIEGO will provide short-term TA to review, evaluate, modify, and update curriculum in the Medical School (Physician and Midwifery) and at the School of Nursing and CESSI (School of Advanced Training for Nurses) as well as to MOPHSA in-service training.

3. Regional Referral Centers

The project will select one existing family planning service site in each regional capital (four in Dakar) to serve as a regional referral center. The establishment of regional referral centers will be one of the project's top priorities. Both the Office of Family Planning and the contractor will be expected to ensure that high quality services are being provided at regional centers are before selecting existing district family planning service sites to serve as district referral centers. Regional referral centers will offer a full spectrum of family planning services and where difficult cases can be referred. The centers will also serve as point of introduction, diffusion, and training for new contraceptive technologies. The quality of services at these centers must be high enough for these clinics to serve as a model and training site for health care workers. The clinics selected to serve as referral centers (see Table 1) currently provide family planning services, well-baby activities, and pre- and post-natal activities. In order to ensure high quality family planning services, the following conditions will be created in each referral center:

- Personnel - Depending on the client load, an adequate number of midwives will be made available by the Ministry of Health to ensure that the centers are properly staffed (each midwife is expected to see 20 clients/day). At least one GOS aide-social and one GOS aide-infirmiere will work as assistants to the midwives. Midwives and medical officers will utilize proper contraceptive practices. In referral centers where midwives are responsible for supervising district clinics as well as pre- and post-natal activities, a third midwife will be made available to provide full-time attention to the family planning referral center.

- Service Delivery - Full-time family planning services will be made available. Clients

should not wait more than one and a half hours to be seen. Consultations must be provided in privacy (i.e., one client per consultation room), and each center should have a separate waiting room (where IEC activities can be conducted) and a registration room. There should be one consultation room per midwife. Clinic hygiene must be assured, including the availability of clean toilets at each center. In order to maintain high standards of hygiene, each clinic may have to utilize part of its user fees to hire a cleaning person.

Equipment and Contraceptives - A standard list of medical family planning equipment has been developed based on client load. The project will provide this medical equipment, office equipment and expendable supplies to each referral center as required.

Management and Supervision - Currently most gynecologists do not actively participate in the assurance of quality service provision. The regional gynecologist (where one exists) will be responsible for supervising the referral center. Client files will be organized to facilitate quick calculation of the number of active and inactive family planning clients. Regional MCH/family planning coordinators will make at least one supervisory visit per month to the regional referral centers and at least one visit every three months to district referral centers (The regional coordinator should not have any clinic responsibilities. Her role is to supervise). In the first year of the project, each referral center will be visited once every two months by the Clinical Unit of the Office of Family Planning to facilitate the establishment of the centers and to assure that roles and responsibilities are well understood. Beginning in year 2, personnel from this Unit will visit each regional referral center at least once every four months.

Training - Referral center staff will receive training in contraceptive techniques, counseling, supervision, and management of family planning programs.

IEC Activities - Several studies have suggested that couples interested in family planning do not utilize contraceptive methods either because they do not know where to obtain services or they are not satisfied with the quality of services available. Therefore, once the centers are functioning well, IEC activities will be undertaken to publicize the availability of full-time family planning services referral centers in each region.

Table 1 presents a list of the 10 regional referral centers including three additional centers in the Dakar region where demand is the greatest. UNFPA will be financing construction and renovations at one referral center in each region (those marked with an *). The table indicates the number of existing family planning consultation rooms and the number of consultation rooms to be added. USAID will provide family planning equipment to all referral centers.

TABLE 1

REGION	REFERRAL CENTERS	# OF EXISTING FP CONSULT ROOMS	# OF FP CONSULT ROOMS TO ADD	TOTAL FP CONSUL ROOMS	# OF SETS OF NEW FP EQUIP.
Dakar	PMI Medina*	5	1	6	3.5
	CS Roi	1	2	3	
	Baudoin (Pikine)				2.5
	Ab Ndao	1	2	3	2.5
	Hop. Dantec	1	1	2	1.5
Thies	PMI Rendoulene*	1	2	3	2.5
St Louis	PMI Sor*	1	1	2	1.5
Kaolack	PMI Kaolack*	2	2	4	3
Louga	PMI de Louga*	2	0	2	1
Diourbel	PMI Regional*	2	0	2	1
Fatick	PMI Fatick*	1	0	1	.5
Kolda	PMI Kolda*	1	1	2	1.5
Tamb.	PMI Tamb.*	2	1	3	2
Zigchor.	PMI de Ziguinchor (Santiaba)*	2	2	4	3

The SCS/FP Project will support the training of the Office of Family Planning personnel and referral center personnel in clinic techniques, counseling and IEC. In order to ensure that referral centers are properly supervised, the project will provide two vehicles to the Office of Family Planning and sufficient funding to finance at least one visit to each regional referral center every four months by staff from the Office's Clinical Services Unit, IEC Unit, and Management Unit. In addition, the Regional MCH/Family Planning Coordinator should visit the referral center at least once a month. The MOPHSA should ensure that all regional family planning coordinators have received advance training in administration. Short-term technical assistance will be provided periodically to look at quality related issues such as clinic flow and to provide special training in areas such as Norplant.

The SCS/FP Project will include funding for small scale operations research (OR) studies to test alternative approaches to improving the quality of service and the operational effectiveness of the National Family Planning Program. A series of workshops involving national and regional FP managers will be held to identify and prioritize OR study topics. Funding will be made available for the costs of designing, implementing and evaluating up to eight OR studies during the project. Funding will be available for necessary technical assistance and for disseminating the results.

District Referral Centers and FP Service Delivery Points. After regional referral centers are operating smoothly (Year 2 or 3), the Office of Family Planning and the contractor team will begin selecting district family planning service sites to serve as district family planning referral center in each of the districts in the four focus regions. These sixteen district referral centers will serve a similar role and function as that of the regional referral centers described above but on a smaller scale. They will be equipped with a minimum package of medical equipment. Health personnel at these centers will receive training in the same areas as those in the regional referral centers. The Ministry has indicated that other donors will finance similar training in the other six regions. The district referral centers will be supervised by the regional family planning coordinator who will visit each center at least once every month. Outreach IEC activities will be a key activity at family planning service sites. Lastly, there are six existing family planning service sites and seven maternities in the four focus regions which will neither become regional nor district referral centers, but which warrant continued support. The project will make available to them approximately the same package that will be made available to district referral centers.

4. Strengthen Management and Supervision Capacities at Central, Regional and District Levels

Poor management and supervision are two of the reasons that the quality of service at family planning clinics suffers. Supervision has been one of the most intensely studied topics in Senegal. Some of the central problems relating to supervision are (1) high

recurrent costs; (2) lack of supervision protocols and effective training; and (3) role confusion, especially regarding supervision of family planning and MCH activities. While most medical officers who manage clinics have received clinical training, they have not been sufficiently trained in management and supervision.

In order for the decentralization of the health system to move forward, support to the systems of management and supervision must be provided. Specific interventions in family planning and diarrhea case management will be successful only if the whole system is operating smoothly, i.e., from the national program level, to the regional and district level, to the health posts. Therefore, project support will be directed at strengthening the existing supervision and management systems. An important objective will be to enhance a two-way flow of information between all of these levels.

At the central level, the Office of Family Planning, the Decentralization Committee, the Food and Nutrition Service (SANAS) and the Division of Statistics will define technical guidelines (protocols) for management and supervision of health programs, and will identify research needs to clarify policies. They will also play a coordinating role in channeling information and experiences between regions. These central offices will be responsible for helping each region develop clear action plans within the context of the national plan. For example, if regional and district health plans neglect to focus sufficiently on family planning objectives, it is the responsibility of the Office of Family Planning to work with them to address this shortcoming.

The central offices will also be responsible for ensuring that the regional teams are properly supervising referral centers and district medical teams. From time to time, central offices must visit district medical offices and regional referral centers with the regional supervision team. They must also ensure that they are receiving proper reports from the regions on a timely basis.

Specific project inputs to strengthening the supervision and management at the central, regional, and district level are described below:

Office of Family Planning - The organogram for this Office has been developed but has not yet been approved by the Minister of Health. One of the conditions precedent to disbursement under the project is the establishment and staffing of this Office. In order to assist the Ministry in developing and managing its programs more effectively, the project will provide long-term technical assistance and operating support to the Office. Each of the three units of the Office of Family Planning will receive some office equipment based on need and the equipment that the existing FHP Project and the new UNFPA project will provide to each unit. This will include photocopiers, computers, office supplies, flip charts, adding machines, etc. In order to enable this Office to make supervision visits, the project will fund operating expenses under the institutional contract to cover gas, per diem, and maintenance of vehicles. USAID will provide two vehicles for use in making

supervisory visits. In addition, the Management Unit, which will be responsible for establishing a contraceptives logistics system, will receive a large truck for making contraceptive deliveries.

The GOS will be expected to fund at least one chauffeur, two secretaries and possibly a second chauffeur to support the office. A long-term family specialist planning will be provided for five years to assist the Office in developing its strategies and work plans, and monitoring them. Short-term technical assistance will also be made available as need arises. A long-term logistician (3 yrs) will be hired to establish an effective contraceptive distribution system within the Office's Management Unit. Short-term technical assistance will also be utilized, especially for periodic checkup visits after the long-term TA departs.

The Management Unit of the Office of Family Planning will be provided with a long-term financial management specialist for three years. This person will be responsible for establishing a financial accounting system with adequate controls, and will train and supervise the Unit's chief accountant as well as the two assistant accountants. The financial management specialist will also provide the three accountants with the skills to establish financial controls for managing other donor funds. It is expected that at the end of three years, the Management Unit will be capable of assuming financial management responsibility for local project costs.

The services of a long-term IEC specialist (for approximately 5 years) will be procured to assist the IEC Unit of the Office of Family Planning in developing and implementing an IEC strategy. This assistance will be described in more detail in Section III.D1. Lastly, specialized training in family planning management, clinic service delivery, and logistics will be provided to a national FP personnel and key regional persons. The project will also fund limited observation tours and overseas seminars in highly specialized areas.

Decentralization Committee - In order to ensure that decentralization policies are successfully implemented, the Ministry has established a Decentralization Committee. This Committee includes the directors of the central health services of the Ministry, along with the principal donors in the health sector. The Committee meets every three months to: (1) evaluate the progress of implementation of regional health plans and the attainment of objectives; (2) coordinate the activities of various partners involved in the implementation of the plans; and (3) analyze problems encountered and assist in their resolution.

The Decentralization Committee is also responsible for assisting the regions and districts in (1) the revision and updating of their health plans so that all national priorities (including the Control of Diarrheal (CDD) and Family Planning) are incorporated; and (2) the identification of resources necessary to execute the plans. The Committee will be responsible for organizing annual reviews of the

implementation of health plans. The Project will provide the necessary support to the Committee to enable it to make supervision visits to each region every six months. The objective of these visits will be to (a) strengthen the management capabilities of regional teams; (b) promote team efforts; and (c) ensure that activities such as family planning, control of diarrheal disease, and IEC are well developed and well executed.

The precise composition of the Committee and norms and standards for its participation in the regional planning process need to be reviewed as decentralization evolves. The project will provide support to hold a pre-implementation workshop to review the membership and operating procedures of the Committee. Given the important functions assigned to the Committee, it will need to maintain a secretariat of at least two full-time persons who can follow-up on actions needed and address identified problems. Lastly, MOPHSA itself must improve the effectiveness of its management. MOPHSA had indicated its interest in undertaking an organizational and management self-analysis. The self-analysis would look at horizontal, vertical and internal relationships for reporting, supervision, communication and decision making. It would examine roles, responsibilities and management functions within each organizational unit and how these fit together as a whole. The self-assessment would identify bottlenecks and other impediments to management efficiency and effectiveness.

The project will support a five-year technical assistant in health planning to assist the Ministry in its ongoing decentralization process. The long-term health planner will work with the Decentralization Committee. The Health Planner will not only attempt to ensure that the regional planning process does not deteriorate into a theoretical macro-planning exercise of no utility to regional managers, but he/she will also do his utmost to integrate significant family planning concerns into regional plans. In addition to his responsibilities in the decentralization process, the Health Planner will assist the Office of Family Planning to plan the activities of the National Family Planning Program. In order to enable the Committee to fulfill its responsibilities, the project also will provide operational support such as office equipment, a vehicle, office supplies, and operating expenses to cover costs associated with supervision visits.

Statistics Division - To effectively manage health centers and health programs, managers require accurate and timely statistics related to health conditions, client utilization of services, health staffing, supplies and finances. The MOPHSA Statistics Division is responsible for the Health Information System (HIS). Presently, the multitude of reporting systems from the health hut level to the national level generate data that are not generally useful because they are incomplete, of variable quality, non-standardized, and often late. Moreover, at the national level, there is insufficient coordination of the various MOPHSA organizations which collect and analyze data. This has resulted in the lack of a

reasonably functional system for the analysis, interpretation, and dissemination of health data.

In the past, USAID projects have tried to establish vertical information systems to meet data needs because the MOPHSA HIS was not functioning well. However, the establishment of project specific information systems has not met either USAID's or MOPHSA's needs for timely, accurate, and complete data for the planning, implementation, and evaluation of health services delivery.

Over the past year and a half, major changes have taken place. UNICEF and other donors have provided computers and have trained personnel. These persons have been assigned to the Statistics Division. UNICEF assisted the Division in undertaking a major review of the information system. As part of this process, district, central, and regional health personnel were brought together to define the type of information needed, the periodicity, the distribution of information etc. Based on these parameters, data collection forms were reviewed and modified, and a training manual was developed.

Currently a pilot test is underway in one district in each region to evaluate the new HIS/Management Information System (MIS). Data are being consolidated at the district and regional levels before submission to the national level. FP service statistics will be received by the Statistics Division which will forward the raw data to the Office of Family Planning for analysis and utilization. Data related to diarrheal disease and ORT will be similarly forwarded to SANAS. Within a year, the results of the test will be available for use in making any additional modifications to the system. The SCS/FP Project will support the training of personnel in the use of the revised system in the project's four focus regions. Until the HIS/MIS is fully functional, the Office of Family Planning and SANAS will rely on other sources of data. Contraceptive logistics forms should provide data on new FP acceptors and allow calculation of Couple Years of Protection.

SCS/FP will fund short-term TA, most likely via CERPOD (a Regional West African NGO specializing in Population Research and Health Information Systems) to provide periodic assistance to the Statistics Division to evaluate the family planning data being obtained through the system. CERPOD will also work with the Office of Family Planning to develop programmatic information needs. PRITECH (the contractor of an AID centrally-funded CDD Project, Technologies for Primary Health Care II, 936-5969) will work with SANAS to identify the CDD Program's information needs.

Regional and District Level Supervision - It is the regional and district levels that must translate the many national programs into an integrated primary health care program at the service delivery level. They have been trying to accomplish this through the development of regional and district health plans. In the four regions

in which USAID is supporting regional and district level activities, the project will provide support to improve overall management of resources, to improve the logistics system, and to permit regular supervision.

Specifically, each regional team will be provided with a double cabin pick-up truck (with loud speakers for education activities) in which to make supervisory visits and deliveries of supplies such as contraceptives and ORS packets. The project will support expenses associated with supervisory visits both from the region to the district, and from the district to the health post. One important function of these visits will be ensure that trained personnel are applying the material that they've been taught in the various training programs that will funded under the project. A minimum package of office materials will also be provided to each of the four regions.

Management and Supervision Training - In order for health personnel to effectively manage project activities, their management and supervisory skills need to be strengthened. Central, regional and district teams need to be able to develop plans and know how to implement and monitor them. Enhanced management and supervisory skills are also key to the success of decentralization efforts.

Created by Presidential decree in 1987, the Institute of Health and Development (Institut de Sante et Development, ISED) is an independent institute within the University of Cheikh Anta Diop of Dakar. It's mission is to work closely with MOPHSA in training health personnel of all levels in public health and to conduct applied research and evaluation activities in fields applicable to public health. Key to ISED's operations is its training center located near Mbour with access to both rural and urban field training sites. Under the USAID Rural Health Project (685-0242), an inter-university linkage with Morehouse School of Medicine and Tulane School of Public Health and Tropical Medicine was developed. Together they initiated a specialized public health training program (CES) in November 1988. The CES Public Health program is equivalent to a U.S. Master of Public Health degree, but allows District Health Officers (physicians) to continue full-time work while training, and employs training materials and techniques specifically adapted to the needs and existing conditions in Senegal. The first CES class of 7 has graduated, a second class of 14 will graduate in mid-1992 and there are plans to train four additional classes of 14 students each. An evaluation of ISED in 1991 showed very positive results and recommended continuation of the program.

Tulane and Morehouse have presented an unsolicited $2.1 million proposal for funding under the SCS/FP Project containing activities designed to benefit from and build upon the already established linkage between ISED, Tulane and Morehouse. ISED would perform design training programs training, supervise training and develop training materials. In the process, certain training capacities

would be developed within MOPHSA and the institutional capacity of ISED would be further developed by continuing the inter-university linkage with Tulane and Morehouse for five more years. The proposal contains the following specific objectives:

1. Development of complete curricular materials for five training modules including training of trainers, management techniques, supervision, applied epidemiology and operations research;
2. Assistance to MOPHSA in development of other requested training materials;
3. Assistance to MOPHSA in rationalizing and planning for in-service training;
4. Training of up to 65 persons comprising a national team and teams from all 10 health regions in the modules;
5. Supervision of MOPHSA training in the 5 modules at the health district level in the 4 focus regions of Fatick, Louga, Kaolack and Ziguinchor;
6. Short-term U.S. training for up to 10 ISED faculty/staff; and,
7. Master's Level Training for ISED staff member.

The proposed training will take place in 2 phases. The teams will first come to ISED's training center near Mbour for one week of classroom training. Then, they will return to their places of work for a three month practicum during which they will complete a field project related to the material learned in class. After being trained in each of the modules, the 10 regional teams will go on to train health personnel at the district level in the same modules. For the four focus regions of Fatick, Louga, Kaolack and Ziguinchor, ISED faculty will supervise the training by the 4 regional teams of the 5 modules at the health district level.

Tulane and Morehouse will assist with direction of the proposed grant activities, planning, financial management, supervision of technical matters, training of ISED personnel, commodity procurement and provision of technical consultants.

C. Activities to Increase Access

In order to achieve the project goal of reducing the total fertility rate in Senegal, the project must improve and must increase access to family planning services. One way of doing this is through the establishment of referral centers which will make available full-time, high quality family planning services and strengthening the existing family planning delivery points. A second approach to increasing access is to undertake community-based distribution (CBD) and condom social marketing (CSM). A third approach is to work with private sector and non-governmental organizations (NGO) that are active in family planning. At present, no single approach alone is capable of achieving the family planning goals desired in Senegal. For this reason, the project will support all three approaches in order to improve access to family planning. It is important to note as well, that, in order for any of these approaches to work, there must be a stable supply of contraceptives available. The paragraphs below describe how the project will ensure this. Following that are descriptions of CBD/CSM and NGO activities.

1. Establishing an Effective Contraceptive Delivery System

Under the existing project (FHPP), "stock-outs" in contraceptives have been a common occurrence. During the early years of the FHPP project, the contraceptive delivery system functioned fairly well. However, after the sudden unexpected departure of the logistician in charge of contraceptive distribution, the system fell apart. To date there has been a great deal of confusion regarding who is responsible for contraceptive logistics. With the creation of the Management Unit within the Office of Family Planning, this confusion should be dissipated. The Unit will be responsible for:

1) Assuring the delivery of contraceptives to regional warehouses and to the ten regional referral centers on a regular basis.

2) Training personnel involved at the regional level and at referral centers to keep inventories of their stocks and reordering at the appropriate time.

3) Developing a standard contraceptive order form that is easily understood and that provides sufficient information to calculate couple years of protection and new and continuing users.

4) Ensuring that the Management Unit receives all necessary information from the regions at the appropriate time.

5) Liaising with USAID to ensure that the proper quantity of contraceptives are ordered.

6) Managing the central inventory at the PNA.

To assist the Family Planning Bureau in establishing the capability to operate an efficient logistics system, a long-term logistics specialist will be funded for three years under the project. This specialist will work with a contraceptive logistics manager assigned by the GOS to the Office of Family Planning. By the end of the second year, the GOS logistics manager should be managing the system with minimum assistance from the technical assistant. USAID will supply IUD 380-Ts, low-dose pills (Ovrette and LoFeminal), spermicides (Neosperin), Norplant and condoms needed for Senegal in both the public and NGO/para-statal sector. UNFPA will supply all standard dose pills and injectables. The World Bank has reserved funds to cover medicines that are associated with the provision of family planning services and to cover any gaps in contraceptives (such as specialized contraceptives) that may not be met by USAID and UNFPA.

2. Pilot Condom Social Marketing Activity

The Ministry has agreed that the project will finance a pilot test of condom social marketing in Dakar and other major urban areas of Senegal. If successful, this pilot would be expanded to a national program after 2 years. At present, regulations permit only trained medical personnel and pharmacists to dispense contraceptives, including condoms. Condoms are available in commercial pharmacies and in health facilities which offer family planning services. Commercial pharmacies do not promote contraceptives and they sell limited quantities at very high prices. Although public, private and para-public family planning clinics offer condoms at reasonable prices, such facilities are rarely utilized by men. There has been no systematic attempt to date in Senegal to target sexually active males, perform market research, promote the use of condoms and distribute them through convenient outlets at a low price.

Continued use of condoms in Senegal is extremely low. However, survey research based on unrepresentative national samples indicated that approximately one fourth of male respondents admitted use of condoms with girl friends or prostitutes but not with their wives. Condoms are thought to be used in extramarital relationships for prevention of disease or unwanted pregnancies rather than as a method to space or limit children within a marriage.

The objective of the pilot activity is to test the feasibility of culturally-sensitive targeted promotion, widespread availability and readily affordable condom distribution through commercial channels. The primary target consumers will be groups at high risk of acquiring the HIV virus and other STDs. These include prostitutes, truck drivers, mobile traders, transients, soldiers and students. A secondary target group will be sexually active males in general for the avoidance of unwanted pregnancies. Given the extremely conservative nature of Senegalese society and the restrictions surrounding the distribution and promotion of contraceptives, there is the danger that a social marketing activity that appeared to encourage immoral behavior could provoke a backlash on the part of religious leaders. Controversy must be avoided through detailed market research, pre and post tests of promotional materials and cultural sensitivity. In addition, the Office of

Family Planning and the Family Planning Technical advisor will work to alleviate restrictions on the distribution of contraceptives.

USAID has already ordered one million condoms for 1993 delivery which can be used in the pilot test. A brand name, logo and package design will be created locally. If local packaging materials of adequate quality are not available in Senegal, it may be necessary to import packaging from a neighboring country such as Cote d'Ivoire. Focus groups will be used to test acceptability to consumers. The prices of socially marketed products are crucial to eventual financial self-sufficiency. It should be possible to set a price for condoms that is not only affordable to the poor, but will also allow the commercial distributor to purchase replacement stocks on the international market with the sales proceeds. USAID's intention is to initiate a contraceptive social marketing activity which will eventually prove to be self-sustaining. Prices will be tested to ensure that they are affordable to target consumers, that they allow attractive margins to wholesalers and retailers, and that new supplies can be commercially imported using sales proceeds. USAID anticipates that it will be necessary to underwrite the developmental and promotional costs over the long term before the objective of sustainability can be achieved. Although the pilot will be of relatively short duration, there should be a continuity of the social marketing effort over the long term, perhaps broadening the distribution network and introducing other products. A contraceptive social marketing effort in Senegal could require up to a decade of donor support before becoming fully self-sustaining.

A U.S. organization with extensive international experience in designing, implementing and evaluating contraceptive social marketing programs will furnish technical assistance in operational market research, advertising and communications, public relations, financial and information management and in the management of product distribution systems. This organization will sub-contract with private, Dakar-based distributor(s) for distribution. An agreement will be signed specifying performance criteria and evaluation standards and will be initially for a trial period. The agreement will be reviewed and considered for renewal and expansion nationwide thereafter. The U.S. organization will provide technical assistance including comprehensive training to sales agents; evaluating test market launches; expansion to additional retail outlets; and setting up incentive packages for sales people. Distributors, wholesalers and retailers will be trained in the correct handling and storage of condoms.

Advertising and promotion will be focused on high-risk target consumers with the message of condom use as the best protection against AIDS. Since mass media advertising of condoms via radio and television is currently unlawful, alternative strategies for attaining high visibility of the product will be explored. Advertising in pharmacies, hotel receptions, bars, medical centers and other locations will include posters, calendars and decals. U.S. Organization selected will develop the promotion plan in consultation with the Office of Family Planning, the Health Education Service and the National AIDS

Committee. Technical assistance will be provided in the implementation of focus group studies, consumer intercept surveys, retailer audits and in the testing and production of promotional materials.

An evaluation of the effectiveness of the condom social marketing activity will include the following: a) the number and type of retail outlets established; b) the ability of distributors to move stock through the distribution channels; c) the volume of sales and characteristics of individuals purchasing condoms; d) changes in awareness, attitude and use of condoms due to advertising and promotion; and e) the cost of product delivery as compared to other service delivery systems in the same environment.

3. Community Based Distribution (CBD)

The accessibility of family planning services is a major concern to the Ministry of Health. A complementary concern is the unacceptable quality of services at family planning service delivery points. In order to address these concerns, the short-term strategy is to strengthen the existing service delivery points and implement a referral system. The question arises of how the population can be most effectively reached given a limited number of full-service family planning delivery points. One obvious answer is community-based distribution.

Currently, in Senegal, only medical personnel and pharmacists can dispense contraceptives, including condoms. At present probably no more than 20% of rural women have convenient access to modern family planning methods since provision of modern family planning services is largely confined to the formal health sector in urban areas. In addition, the cost of transport and time wasted at clinics to obtain resupply is a constraining influence. Community members, including community health workers and trained traditional midwives, cannot distribute contraceptives. In addition, though included in the essential drug list, contraceptives are not found in the basic drugs delivered to health posts. The Ministry is reviewing these situations in order to modify the existing procedures.

The CBD activities will increase awareness of the benefits of modern methods of family planning, encourage use of modern family planning methods, and make supplies and other services conveniently accessible to couples by drawing upon Senegal's extensive network of community volunteers and organizations in both the private and public sector. There are over 2,400 trained community based health agents (ASC) and matrones working in rural areas and over 1000 community animation agents trained in family planning IEC. Comparable resources exist for the NGO community. Local residents, usually mature adults who are respected in their communities are the key to CBD programs. Limited objectives, stress on basic skills, a supportive supervisory network and a reliable supply system are the essential elements of CBD.

The acceptability of using condoms in rural areas and among married couples is not

clear at this time. Several small ethnographic studies have shown that up to 25% of rural men have used condoms but almost all of those are in situations with casual sex partners, not with their spouse. In addition, female distributors may not be appropriate for the largely male audience. Due to a presumed low demand for condoms in the rural areas, it may not be efficient to design a CBD program only involving condoms - other items may have to be available to allow for the CBD program to have the desired impact in rural areas. Given these uncertainties, the CBD program supported by SCS/FP will proceed in stages.

Under existing donor projects four pilot CBD programs are being tested through operations research activities. The pilot tests are being undertaken under a variety of conditions - in urban and rural areas by NGO and public sector personnel. Condoms are either provided free or a small charge is levied. It is expected that most of these pilots will be completed by the end of 1992. The project will support a national seminar to review these pilot tests and data available from other CBD programs around the world. The Ministry will then prepare a CBD strategy for Senegal. There will likely be a range of programmatic options available, encouraging local initiative but insisting on certain level of quality and standards.

It is anticipated that some type of legal or regulatory changes will be made to allow for CBD by non-medical personnel following the guidelines presented. The Office of Family Planning will host a national information day outlining the elements of CBD and sensitizing both leaders and health personnel. The Office of Family Planning, with short-term technical assistance, will then prepare a technical guide for a basic training program in CBD for the national/regional training teams and supervision guidelines. The expansion of CBD will take place in a phased manner. Resupply of contraceptives to distributors will take place at the local health delivery point or community pharmacy. The first systemic public sector programs will be based at the regional referral center. By year 2 of the project the referral centers will be fully functional. At that time the center staff with TA from the Office of Family Planning will develop a CBD program for the districts in which they operate.

In year 3 of the project, other innovations within the referral center CBD program will be introduced through operations research. This may include the introduction of spermicides, resupply of pills and use of a checklist for initial supply of pills. In addition, the CBD will be expanded to one other district in each region following lessons learned from the first year's activity. The activity will complement any social marketing activity in the urban areas and be expanded to rural areas only following analysis of the viability of such a program. At the end of year 5, recommendations will be made to expand to other districts within the parameters approved by the national CBD steering committee.

By 1997, SCS/FP aims to engage 500 volunteers and 20 supervisors in the provision of non-clinical contraceptives and IEC in 4 regions of Senegal especially to those younger couples and men whom the government clinical systems do not reach easily. By 1997

more than 20,000 coupies could be using contraceptives in these four regions including current FP acceptors.

The CBD programs developed by the NGOs must be approved by the Ministry under letters of agreement. The key family planning NGOs are currently involved in the pilot test activities and their CBD programs will be modified and expanded based on results.

USAID and other donor assistance will be administered under the guidance and approval of the of Office of Family Planning. Standards and quality will continue to be monitored by the regional and district health teams and reviewed by the Department of Public Health. The district supervision teams will need to devote 25% of their time to the establishment of the CBD program including organizing logistics, providing personnel support, arranging training and re-training, reporting performance, liaising with local leaders, and controlling financial resources generated. Approximately 25 volunteers per supervisor will be included in a regional program. Once the program is underway, supervisors will need to devote approximately 10% of their time to CBD.

The proposed USAID CBD activity will provide funding and technical assistance for training, supervision, commodities, equipment, operations research, supplies and other operating costs such as per diem and travel funds. Most of the support for the recurrent costs of the CBD program must come from the GOS regional and district budgeting process. It is anticipated that the introduction of fees for contraceptives will be necessary to provide an incentive for the local CBD agent. In addition payment of fees by the community can begin to defray some planned delivery costs for the essential drug program.

These CBD programs will need strong political and technical/professional support from the GOS leadership, the Ministry and major NGOs. If Senegal's fertility rate is going to begin to decline rapidly, CBD of a full range of contraceptives must play a crucial role in the national program.

4. Private Sector/PVO Activities

The PVO-NGO and private sector have an important role to play in the expansion of the provision of family planning services and primary health care in Senegal. The NGOs marshall private sector resources to extend services to populations that would not be reached otherwise. They have been instrumental in testing new concepts and methods. The National Family Planning Program acknowledges the contributions which PVOs and the private sector can make in the provision of family planning services. At the same time it emphasizes the importance of coordination between private and public sector clinics.

Under the FHP Project, NGOs and the private sector have contributed significantly to many of the project's achievements. The 1991 project evaluation recommended that the participation of PVO and private sector organizations be encouraged to an even greater

degree under the future project. Therefore, SCS/FP will support the expansion of a limited number of larger PVO/NGOs whose activities are critical to the success of the national program.

The Senegalese Family Welfare Association (ASBEF) was established in 1974 to complement efforts of the GOS to improve family well-being in Senegal. It seeks to do this by offering family planning services, educating urban and rural populations about birth planning, and training medical and paramedical personnel. It is affiliated with International Planned Parenthood Federation from whom it receives an annual grant to cover a portion of its operating costs. At present, ASBEF has clinics in Dakar and Louga. In the future, clinics will also be opened in Kaolack, and St. Louis.

ASBEF recently submitted an unsolicited proposal to USAID requesting support for IEC activities focusing on men and to strengthen and expand its existing clinics. ASBEF is the only PVO in Senegal which is currently providing top quality family planning services to a high volume of clients in urban areas. Because most of the proposed activities are fully consistent and supportive of the project's objectives, the SCS/FP Project will provide a grant to ASBEF. Part of the grant will support ASBEF's efforts to increase its client capacity in Dakar and Louga through the provision of equipment and renovations to its clinic in Dakar. The renovations will include converting one consultation room into a training consultation room with three separate cubicles.

At present, ASBEF's Dakar clinic has three full time midwives and two nurses aides. ASBEF would like to hire an additional midwife and nurses aide so that the senior midwife will have sufficient time to focus on supervision and the analysis of client data. A third nurse's aid is required to help improve client flow. In addition a recent evaluation of ASBEF revealed that its nurses aides and midwives could benefit from additional training in IEC and counseling which will be provided under the project. In order to strengthen ASBEF's managerial capacity, technical assistance in financial management may be obtained using grant funds. Lastly, on-going technical assistance in computerized database and financial accounting systems may also be procured.

Over the past five years, ASBEF has developed a dynamic IEC program which has involved mobilizing neighborhood groups and producing spots for television and radio. Part of the grant is intended to allow ASBEF to expand its IEC activities. ASBEF has proposed to undertake an IEC program which will educate groups of men about family planning methods.

Although ASBEF is not currently registered in the U.S., AID regulations allow for a grant to be made to an unregistered local PVO provided it files for registration. The application process is currently underway. Based on the financial and management capabilities of ASBEF, USAID believes that ASBEF's application will be approved.

SANFAM/AFRICARE Sante de la Famille (SANFAM) was registered in Senegal as an official non-governmental organization in 1988. Apart from ASBEF, SANFAM is the only Senegalese NGO to incorporate the provision of safe and effective family planning services as part of its basic mission. SANFAM assists approximately 40 private for profit, private non-profit and para-public organizations to add family planning to the health services these organizations provide to their clients/employees. These activities were begun in 1986 under the Family Health and Population Project to implement the private sector component of the USAID-funded Family Health and Population Project. SANFAM has provided clinical training, IEC training, IEC materials, contraceptives and related medications, equipment, monitoring and supervisory support to the participating organizations.

SANFAM with the assistance of Management Sciences for Health Inc. analyzed its current operations, identified areas of weakness, highlighted needs for outside assistance and established programmatic priorities over the next 3 years. The U.S. PVO Africare has prepared an unsolicited proposal for USAID funding under the SCS/FP Project which builds upon the SANFAM work plan. Africare will provide assistance to SANFAM to enable it to strengthen its capacity to do budgeting, accounting and control, financial reporting, budget monitoring, short and long term financial and programmatic planning and evaluation of its programmatic and management development. Africare will also assist SANFAM in systematically analyzing its needs for management information, and in establishing and maintaining a computerized management information system (MIS). The two organizations will work together to establish personnel procedures, undertake task analyses, revise the staffing pattern, and develop new position descriptions for SANFAM. In order to implement its mission statement, SANFAM will recruit a deputy director for management, a second clinical specialist, a project accountant and a logistician.

SANFAM recognizes that, if it is to become less dependent on donor funding, it must diversify its funding base, pursue local fund raising from individuals and corporations and place increased emphasis on its projects becoming self-sufficient through auto-financing mechanisms. The ability and willingness of private and para-public organizations to pay the recurring costs of offering family planning once SANFAM support is terminated is still uncertain. SANFAM has not yet "graduated" any of the private and para-public organizations. Under the SCS/FP Project, Africare will assist SANFAM in developing cost recovery schemes and plans for phasing out support to those organizations which are able to assume the financial burden. As a NGO, SANFAM will probably always remain dependent to some degree on outside funding of its activities. However, appropriate technical assistance from Africare should equip SANFAM with the management tools that would allow it to attract funding from a variety of outside sources.

D. Activities to Increase Demand for Family Planning

The project will utilize two approaches to increase the demand for family planning. The first is to generate demand through information, education, and communication (IEC).

The second focuses on reducing infant and child mortality by preventing deaths due to dehydration and diarrheal disease.

1. IEC Activities To Increase Demand

Lack of knowledge about family planning methods and where to obtain them has been identified as one of the major constraints limiting demand for family planning methods in Senegal. In addition, there are cultural perceptions about contraceptives which discourage their use; i.e., the idea that condoms are something which one uses only with one's girlfriend, not one's wife. The objective of the IEC component is to overcome these constraints in order to increase usage of modern contraceptives (especially in urban areas) and to increase general awareness and acceptance of family planning especially in rural areas and among Senegalese leadership. The project approach for accomplishing these objectives will be to support a targeted IEC program conceived and led by the Office of Family Planning and implemented by the Health Education Service.

Considerable progress has been made in increasing general population's overall awareness of health and family planning issues under previous AID projects. More than 1,000 social action personnel have been trained to give basic family planning information and motivation. In 1986 only 58% of rural women knew of one modern family planning method but current estimates are over 75%. Almost universal knowledge of at least one method of modern family planning methods now exists among urban women.

Unfortunately, this level of knowledge has not been translated into an increase in utilization of contraceptives. Contraceptive prevalence remains low. A recent evaluation of the FHPP stated that the following efforts are needed to improve the effectiveness of the IEC program: better utilization of well baby and maternity health services as a vehicle for conveying family planning messages, better identification of specific target groups, research focused directly on IEC, a more narrowly targeted materials production and distribution plan, direct involvement of health personnel in education, and a closer coordination between the many government agencies active in IEC. The SCS/FP Project has incorporated these recommendations, including the targeting of urban dwellers into its activities. A special focus will be on leaders - political (at national and local levels) as well as traditional and religious. The project will also focus attention on reaching men who previously had been ignored.

In order to implement the IEC program described below, the project will strengthen the recently created IEC Unit within the Office of Family Planning and provide ongoing support to the Health Education Service. These two units will work as a team in implementing project activities. The Office of Family Planning/IEC Unit will consist of two GOS specialists - one responsible for research and campaign development and the second for training and supervision. The IEC Unit will serve as a focal point for: (1) the conceptualization of the family planning IEC program including innovative approaches to demand generation, (2) the development of IEC protocols, technical guides and an IEC

research strategy, (3) IEC training, and (4) overall monitoring of IEC program impact and evaluation. This Unit will be responsible for defining the parameters of IEC activities not only for the project, but for the entire National Family Planning Program including all other donor financed IEC activities. The project will provide a long-term IEC Specialist (communications planner) for a period of five years who will assist the Unit in developing this important program.

Although the IEC Unit will be responsible for the design and implementation of research and the development of prototype messages, the Health Education Service (HES) will be responsible for health education material and program development. HES's family planning specialists will work hand in hand with the Office of Family Planning's IEC Unit to implement the family planning and maternal and child health program. HES will be charged with developing audience specific materials, pretesting them, monitoring activities, supervising IEC activities on the ground, and providing guidance and support to field personnel. HES's family planning team will consist of a full time coordinator, a full time health education communicator, and a research specialist 50% time. They will be assisted by the technical production staff - artists, designers, etc. - at HES headquarters.

The primary components of the IEC program are described below:

Development of an IEC Strategy - The first step in designing an effective IEC program which avoids the pitfalls encountered under the existing project, is to develop a focused IEC strategy. This requires identifying appropriate interventions. To this end, research will be designed by the IEC Unit of the Office of Family Planning to determine the nature and level of unmet demand for family planning; and to determine in cases where latent demand exists, why family planning has not been adopted. The SCS/FP Project will finance studies and focus groups that will form the basis of the development of the IEC strategy. Key KAP studies to be supported by the project in year 1 are a demand study, a study of men's contraceptive practices, and a study of traditional, religious, and cultural leaders' attitudes. In addition, the project will examine the management of health clinics and client satisfaction in order to better utilize the contact and education time spent with clients.

Once these studies are completed, the IEC Unit will then translate the results of the research into audience specific messages. The HES will adapt the message to individual media, and produce IEC aids such as print and motivational/teaching aids material - posters, brochures, technical manuals, and flip charts. Radio/TV programs and spots will be produced by entities such as private film producers, the national radio and television service (ORTS), and other media specialists. Senegal is well-known for its film industry and rich cultural and artistic heritage. This resource will be tapped by the Project to develop the most effective IEC materials. Traditional folk methods such as theater, storytellers, songs, and other innovative IEC activities such as mobile health education units, will also be

developed in the project's 4 target regions. ORTS will be contracted to do the diffusion of TV and radio programs and spots. The project will support the costs for pre-testing, developing, producing and diffusing the materials, monitoring message impact, and modifying them as appropriate.

Development of Technical Manuals - The project will support the development of an IEC technical manual by the IEC Unit and HES. This manual will be the core document for implementing the strategy identified. It will be comprised of five major components:

(i) a technical section which contains the basic messages and message strategies to be used for the various target groups of the population - i.e. men, women at risk from pregnancy, women who have already reached their desired family size, etc. This section will serve as the technical base on which both mass media and interpersonal educational strategies can be developed;

(ii) individual sections for each category of family planning IEC educators - health workers, social welfare personnel, teachers, and rural development extension agents - explaining the particular educational techniques most appropriate for their work and clientele;

(iii) training sections which detail the training required for each category of personnel;

(iv) work planning sections which detail the number and frequency of interpersonal and group contacts recommended to achieve the change in knowledge, attitudes, and practices desired; and

(v) supervision sections which provide training protocols and methodologies for each category of personnel formally involved in the regional family planning program.

Regional IEC Activities - Once the prototype IEC program has been developed at the national level, it will be implemented at the regional level. A full time MCH/FP IEC coordinator will be named from the Health Education Service cadres in each region. This agent will pull together the various personnel needed to develop the regional IEC plan including facility-based counseling, community outreach, and detailed work plans. Face to face communication will be complemented by the print material and mass media aids produced. Rural matrones, community health workers, rural animators and social aides will be trained in family planning IEC techniques. A system of supervision and follow-up will be instituted to monitor progress, and an award system for performance will be instituted.

Obviously a full expansion of this type of program cannot take place at once. Therefore, in years 1 and 2 of the project, only the districts in which a regional referral center is located will be targeted for intensive intervention. In years 3, 4, and 5, interventions will be expanded by adding one or two districts per year.

Municipal Activities - The municipal governments in Senegal have a distinct comparative advantage in their ability to mobilize local communities and communicate messages to a large population. This is due to the municipal structure which links mayors to neighborhood leaders. Given the urban focus of the project, municipalities can make an important contribution to the project's objective of increasing the population's knowledge of family planning and encouraging the utilization of referral centers.

A fund of approximately $600,000 will be made available under the project to be managed by the prime contractor to finance municipal activities related to family planning. In general, the municipalities will be expected to develop proposals that are consistent with the project strategy and that take advantage of the existing capacities at the municipal level. Below are some basic criteria for participation:

1) The municipality seeking support must allocate at least 8% of its budget to the health sector, or be able to demonstrate that its allocations to the health sector have increased significantly.

2) The municipality must submit a proposal that is well developed and logical. The proposal should include detailed budgets and implementation plans which specify the persons in charge of managing and implementing activities. The implementation plan should also include a well developed time schedule of when each activity is expected to take place.

3) It is preferable that participating municipalities be in large urban areas in the four target regions: Ziguinchor, Louga, Fatick, and Kaolack or in Dakar or Thies. Activities outside of these regions will be financed only if they promote the use of regional referral centers in some way.

4) It is recommended that the municipality sign an agreement with the Ministry of Health and Social Action to ensure that the activities proposed lie within the framework of the regional and district health plans (PRDS and PDDS).

During the second year of the project, a procedures manual which contains directions for developing proposals, will be developed by the contractor. The contractor will be responsible for liaising with municipal governments and informing them about how the municipal component will function. A Technical Review Committee will be formed to review proposals and select those that are appropriate

for financing. The contractor will be responsible for monitoring the implementation of the activities. Short-term technical assistance may be made available by the contractor to assist the project in developing, implementing, and monitoring municipality activities.

Sensitizing Political, Traditional, and Religious Leaders -In 1987, USAID financed the development of RAPID II/Senegal. The presentations of this model played a key role in the elaboration and adoption of the National Population Policy. However, although there exists general political support for family planning and population, these issues have not been brought to the forefront. In order to elicit open public support of family planning from officials, the project will update the RAPID model. The updated RAPID - RAPID III/Senegal - will have as its primary audience the highest level national leaders. In addition, the model will be modified as appropriate to be presented to regional and local leaders. A special child survival/family planning presentation will be developed for health care providers and religious leaders. The development of these models will be funded via a buy-in to the centrally funded project - RAPID IV. The diffusion of this information by national and regional IEC personnel will be financed through a local account managed by the institutional contractor.

Reviews of Legal and Regulatory Constraints to Family Planning Service Provision - At present there are two major types of legal and regulatory constraints to family planning. The first consists of a set of pronatalist policies which provides benefits to individuals based on the number of children they have. For example, a public employee receives an additional payment each month from the government based on the number of children he has. The second type of constraint involves regulations governing the delivery of family planning services. An example of this type of constraint are the restrictions on who is allowed to sell contraceptives. Under the existing family planning project, changes in the latter type of regulations have been recommended. The SCS/FP project will need to assure that these changes have been reviewed at the appropriate levels and implemented. The Director of the Office of Family Planning together with the Cabinet Technical Advisor for Family Planning will be the critical players in moving this activity forward.

Pronatalist policies also will need to be studied and reviewed under the SCS/FP Project. The buy-in to RAPID IV will assess the impact of these policies on fertility behavior. Short-term RAPID technical advisors will work closely with the Department of Human Resources within the Ministry of Economy, Finance and Plan and Plan and the Family Planning Technical Advisor to analyze the results of these assessments. A national committee will be organized to formulate legal and administrative changes needed. A series of seminars, working groups and information booklets may be needed to facilitate the implementation of these changes. The project will directly support the costs of these activities.

IEC Activities related to Child Survival Interventions - The major USAID supported child survival intervention is the control of diarrheal disease (CDD). The overall CDD program and elements are described elsewhere in this paper. The SCS/FP Project will support the development of a CDD program manual which will form the basis for the CDD standards and procedures. In addition, the project will fund a thorough review and evaluation of all existing educational materials to determine to what degree they conform to current norms, standards and program practices in Senegal. The Project will also support the development of a plan which will rationalize the use and distribution plan of IEC materials. Lastly, the production of a limited, well-chosen number of educational materials, and the production of similarly limited and well-chosen radio and TV spots will be financed by the project.

Once these CDD related IEC activities have taken place (Years 1 and 2), work should begin on other important issues, most notably breast feeding, proper hygiene, and the promotion of chloroquine for children as both a prophylaxis during seasons of high risk and as a presumptive treatment. Additional KAP research on current breast feeding and hygiene habits, with particular attention to the social and economic factors which constrain improved practices, will be carried out. Once this research has been completed, technical manuals will be prepared and training programs designed. Educational materials will need to be designed and produced. All CDD, breast feeding, hygiene, and chloroquine promotion work will be done through SANAS. Materials will be produced by the HES.

2. Control of Diarrheal Disease (CDD)

The CDD component of the project has three general objectives which should contribute to reduced childhood morbidity and mortality: (1) improved diarrhea case management in health facilities; (2) improved diarrhea case management at home; and (3) modified behaviors in support of diarrhea prevention.

a. Improved Diarrhea Case Management in Health Facilities

At completion of the project, all health facilities in the four focus regions will have personnel trained in diarrhea case management, including the nutritional management of diarrhea. The materials will be in place to allow for on-site rehydration and observation. This will involve providing a minimum package of equipment to establish OR Units in 16 health centers, 3 pediatric units and approximately 225 health posts. To avoid constantly having to train new nurses, good diarrhea case management and diarrhea prevention will become fully integrated into the professional training programs.

Recent evaluations show that only half the nurses surveyed were able to correctly assess

dehydration and less than half gave adequate and appropriate counseling, especially concerning nutritional management. A review of registers showed that only 57% of diarrhea cases were treated with ORS. Approximately 40% of centers in both evaluations had no ORS in stock at the time of the visit.

These statistics demonstrate that while the early training program clearly had some impact (even 50% correct treatment is not bad for a young program), there is a need for refresher training. Particular attention in refresher training should be given to counseling--both skills and content. Nurses need to understand the importance of their role in convincing the mother of the value of ORT. Certain trained health personnel will also need to be convinced of its value which will require refresher training with a strong hands-on component. The Project will train the medical officers, nurses, diarrheal disease control supervisors, and community health workers in the four focus regions. A three day course will allow each region to deal with counseling, new issues, and region specific problems, and provide each participant with the opportunity to treat cases under close supervision. Assessing the actual practices of trained personnel and identifying gaps for future training will be accomplished by a health facility survey in years 1 and 4 of the project. This type of survey can help to quantify actual diarrhea treatment practices in health facilities. These surveys will be undertaken with short-term technical assistance from PRITECH (Technologies for Primary Health Care II, 936-5969).

The project will finance follow-up supervision of every person trained in the four focus regions, which must be adhered to in order to assure correct application of learned principles and to emphasize the importance of ORT and good counseling. The national program will need to review its policies for good case management and print a clear statement of policy, including policy for treatment of bloody diarrhea at the health post level, referral protocols, and policy on the use of antidiarrheals. The National Program currently has plans to do this using the excellent model in the WHO CDD Program Managers' Course. The Project will work with the Ministry to ensure that such a policy statement is thoroughly explained and posted in every health facility.

b. Improved Diarrhea Case Management at Home

Key to the achievement of this objective will be face to face communications between nurses and mothers coupled with a strong IEC campaign. A diarrhea knowledge, attitudes and practices (KAP) survey in 1989 found that whereas 62% of mothers had heard of ORS and 93% had heard of SSS, only 23% claimed to use one or the other for home treatment of diarrhea. The 1988 health facilities study found that only 5% of mothers had administered ORT before bringing their child to the center. The most serious difficulties, however, are in the areas of feeding during diarrhea (one-fourth of mothers decreased food) and in preparation of the home solution, sugar-salt-solution (SSS), where only 26% could prepare SSS according to the correct recipe and several of the solutions contained a dangerously high salt content.

In order to address these shortcomings, IEC materials which were produced 3-5 years ago will be retested for current understanding and appropriateness of the message content and revised accordingly. As new issues have become more important to the program (exclusive breast feeding and nutritional management of diarrhea), new materials will be developed, tested, and produced. Attention will be given during training and supervision to the correct use of print materials by health personnel in face to face counseling of mothers. This is generally the weakest link in an IEC program. Media (radio/TV) will be used in support of the print materials and counseling given by nurses. Also, the districts will be encouraged to continue their dialogue with community leaders in support of good home management.

c. Modified Behaviors in Support of Diarrhea Prevention.

Preventive measures which will be targeted in Senegal include: exclusive breast feeding until the age of 4-6 months, improved weaning/child nutrition, personal hygiene (hand washing before preparing food and feeding a child and after use of a latrine), and environmental hygiene (latrines, protection of water sources, chlorinization of drinking water).

During the first five years of the CDD program, emphasis was on correct diarrhea treatment with ORT. During this second program phase, the national program will begin to introduce the promotion of simple, relatively low-cost measures to reduce the incidence of diarrhea, while maintaining a strong emphasis on improved case management. Interventions to improve access to clean water (e.g., well digging) are important in Senegal and some actions are currently supported by NGOs such as World Vision in Louga. However, these are too costly for the SCS/FP Project or the National Program to undertake at this time. Priority for resources will therefore be accorded to effective low-cost efforts of good case management and the use of IEC in promotion of the behavioral modifications listed above.

In order to prepare appropriate messages regarding diarrhea prevention, including improved weaning, research will be undertaken to clarify current practices and attitudes in Senegal. This kind of activity is essential to the elaboration of effective messages. To assist in the development of IEC messages and materials, a month of short term technical assistance will be made available in years 2, 3 and 4 of the project. These messages will most likely focus on ORS social marketing, nutrition during and after diarrhea, diarrhea prevention, breast feeding, hygiene, and improving SSS measures.

In order to monitor the impact that the project is having in the area of CDD, a KAP study in years 3 and 5 of the project will be undertaken. A previous KAP study was conducted with PRITECH assistance during the first 5-year phase of the CDD program. Ideally, the results of the year 3 KAP study would be available for use by the mid-term evaluation team, and the year 5 study for the final evaluation.

d. The Role of The National Service for Feeding and Applied Nutrition (SANAS) and PRITECH in the Implementation of CDD Activities

In 1985, the Ministry of Health began a national program for the control of diarrheal diseases under the direction of SANAS. The program has received substantial financial and technical assistance from USAID since its inception through the USAID Rural Health Project and PRITECH. Achievements to date include extensive training activities (1,413 health and auxiliary personnel), the production of 5 IEC materials, an early radio/TV campaign, the development of training materials (including professional school modules), several baseline and monitoring studies, and operations research on issues of interest to the program. Finally, with a view to the second five-year phase of the program, SANAS developed a concrete national five-year program plan. This is intended to provide guidance and policy direction to the regions in the implementation of the new regional health development plans.

As found during program evaluations and reiterated by some of the PRDSs, a great deal has been achieved and the experience of this five year old program is evidenced by the thoughtful presentation of the next five-year national plan. The project should continue and reinforce USAID's support of program initiatives. SANAS will be responsible for coordinating CDD related training, developing protocols, making supervision visits and coordinating research. To strengthen SANAS's ability to serve in this capacity, its staff will be provided training in supervision, management, operational research, and training techniques. In addition, the project will provide SANAS with funding for supervision visits and some operating expenses. The funds for these activities will be managed by PRITECH via a buy-in to the centrally-funded project (Technologies for Primary Health Care II, 936-5969, PACD 8/23/93, PRITECH is the prime contractor).

PRITECH has been assisting SANAS with its child survival activities since 1985. Both the Ministry and USAID have been highly satisfied with the performance of PRITECH. Because of PRITECH's wide experience and expertise in CDD and Nutrition and the role that PRITECH played in the development of the program in Senegal, the Ministry of Health and Social Action has requested that PRITECH continue to support SANAS in its efforts. In addition to managing funds for SANAS activities (supervision and training), PRITECH will take responsibility for the following:

* working with the regional and district health plans to assure that CDD-related activities are clearly planned according to national guidelines and regional health development goals;

* providing organizational support to SANAS to enable the central level to respond in a timely and appropriate manner to the needs of the regional and district levels according to their health plans;

* working with SANAS to strengthen national and regional supervision activities;

* assisting regions with setting up or improving oral rehydration units for training, demonstration, and treatment;

* following-up teaching of CDD in professional schools through the development of proposals for practicums and visits to practicum sites;

* providing short-term technical assistance for CDD-related activities;

* identifying periodic information needs and means of obtaining and utilizing the information collected; and

* identifying overseas training and seminars that are appropriate for Senegalese health personnel.

The centrally-funded Technologies for Primary Health Care II Project is expected to expire in two years. If for some reason there is not follow-on project, or PRITECH is not selected to implement the follow-on project, then an alternative mechanism for providing technical assistance related to CDD activities will be identified.

E. Donor Coordination

USAID/Senegal is by far the most active donor in the area of family planning. The World Bank and UNFPA are also very active in this area. Lengthy discussions with the Bank and UNFPA were held in order to better coordinate donor assistance to family planning while taking into account each organization's particular needs and requirements.

In terms of supporting Regional Referral Centers, UNFPA will fund needed renovations and construction. USAID will provide equipment, operating supplies, and funds for their supervision by the central level. Short-term TA will also be made available for the introduction of longer-term methods.

The World Bank will finance the expansion of FP services to health posts throughout Senegal and will construct additional health posts in under served urban areas. The Bank will finance clinical and management training at the health post level.

All three donors are active in the area of IEC. The World Bank will be supplying equipment to the Health Education Service for production of IEC messages. The Bank will also supply IEC materials to the regions and provide funding for the production of IEC messages. UNFPA will focus its IEC interventions on adolescents and on supporting UNICOM, the national organization responsible for coordinating the GOS's population program across sectors. USAID's involvement in IEC will focus on the development of a Family Planning IEC strategy that will serve as the basis for all IEC activities. To

accomplish this USAID will provide a long-term technical assistant to the IEC Unit of the Office of Family Planning. USAID will also finance the development of materials such as technical guides and protocols that will be used for all IEC training. Lastly, USAID will not only fund the production of mass media materials, but the diffusion of those materials as well.

Both USAID and UNFPA will provide support to the National Family Planning Program including the Office of Family Planning and the Family Planning Technical Advisor. In the area of training, SCS/FP will take the lead in developing materials for training in clinic, IEC, management, supervision, CDD, and training of trainers. The World Bank and other donors will then utilize these materials and provide budget support for training in their specific regions.

The SCS/FP Project will provide long-term technical assistance in IEC, Logistics, Financial Management, Health Planning, and Family Planning Program Management. UNFPA will provide a short-term clinical technical assistance and a national expert clinician. Bi-annual review meetings will be organized and chaired by the Director of the Office of Family Planning to discuss the progress of the National Family Planning Program and the various donor-funded projects that are intended to support it. These meetings will facilitate better coordination and help clarify for both the donors and GOS what the direction and status of each project and the Program as a whole.

IV. SUMMARY OF ANALYSES

A. Economic Analysis

The economic analysis of the project focuses on its family planning component. The purpose of the analysis is to compare the cost of births averted during the life of the project to the savings and other benefits that accrue as a result of a reduction in the rate of population growth. These benefits are numerous and are both quantifiable and non-quantifiable. Because some of these benefits do not come on stream until some years after births begin to decrease, the analysis is carried out over a 20 year period. The principal benefits are identified below.

The basic structure of service delivery relies on existing centers in the principal urban areas. Early on in project development two other options were considered and rejected because they did not appear to be cost effective: one which would have included extensive family planning outreach in rural areas, and one which would have sought to achieve family planning objectives through classic child survival means, such as reducing mortality from infant diseases.

Analysis of the urban-focused option, based on four different scenarios, yields internal rates of return ranging from 27.9% to 37.1%. Compared to the alternative of investing project funds in the banking system for an average return of 15%, these results are quite strong even under pessimistic assumptions regarding the increase and stability in the rate of contraceptive prevalence. However, it must be emphasized that the results are sensitive to additional assumptions on both the cost and benefit sides.

COSTS

The family planning component is estimated to absorb 65% of total project costs. It is assumed that all costs are attributed to the delivery of family planning services and contribute to the increase in contraceptive prevalence, that is to the number of births averted as a result of contraception.

Costs per birth averted are highly dependent on the efficiency of the project in providing services, that is in stimulating an increase in the rate of contraceptive prevalence. Earlier studies (reported in Kramer, 1985) have found that for Senegal, an annual increase in contraceptive prevalence of 3.36% results in an estimated annual decrease 0.1% (one tenth of one percent) in the fertility rate. Thus a 1% increase in prevalence would produce a decrease of 0.03% in the annual fertility rate.

Failure to increase contraceptive prevalence to the assumed levels would have the following consequences:

--slow the rate of population decrease
--reduce the estimated savings and other benefits from population decrease
--increase the cost per birth averted attributable to the project.

Costs are underestimated to the extent they take into consideration only those expenditures currently identified for the project. Other expenditures which may be necessary to achieve the expected increase in contraceptive prevalence, say NGO personnel and other costs, are also relevant. With a lower population impact, the cost per birth averted would increase at the same time as the benefits would decrease. Thus, the net economic return of the project would be smaller. The increase in costs per birth averted due to either cause would also tend to reduce its return.

BENEFITS

The benefits of reduced population growth are numerous. The most obvious quantified benefits to the economy of a family planning program are an increase in per capita GDP and savings from lower public health and education expenditures. Other quantifiable benefits would include savings due to lower expenditures for food and clothing. Private savings on health and education should also be included if information were available. If the cumulated savings were reinvested, given the incremental capital-output ratio of the economy, one could also expect a (lagged) increase in GDP and income per capita as a result of the program.

Non-quantified benefits include:

* decreased morbidity and mortality among women and children, due to fewer births and better spacing of births;
* increased female literacy, as female school drop-out rates due to pregnancy decrease and as the reduced burden of family child care provides more opportunities for female school attendance;
* greater freedom of choice in controlling fertility;
* greater involvement of women in remunerative and development activities;
* increased family welfare as a result of the above;
* improved urban life, as urban population growth slows, reducing stress on urban facilities;
* decreased inequities between urban and rural areas, assuming a redirection of saved public funds to rural infrastructure and other investments.

Only two categories of potential benefits are actually included in the current statistical analysis: those from public expenditure savings on health and education. Average costs of $10.80 per capita for health care and $109 per capita per year for primary school have been identified for Senegal. Education costs are deflated by the primary school enrollment rate of 54.6%, to reflect the fact that not all children whose births are averted would have gone to school. Thus the savings in this respect are about $59.50 per birth

averted. The analysis has not accounted for subsequent drop-outs.

Health savings are treated as accruing once and for all in the year of the averted birth. Education savings begin seven years after project start-up, and accrue each year for a six-year period which represents the span of elementary schooling. The cumulated impact of these savings becomes substantial in the 12th and subsequent years, when age cohorts are fully overlapped.

Additional savings in expenditures for cereal grains alone would eventually amount to over $80.00 per year, assuming adult consumption of 190 kg. at FCFA 130 per kg. (rice), converted at a rate of $1 = FCFA 300.

The benefits estimated for health and education are sensitive to several factors:
First of all, to the extent that per capita costs identified for health and primary education are inaccurate, results would be misleading. Second, to the extent the urban primary school enrollment rate is higher than the national average, the benefits from education are underestimated. Third, no secondary education costs have been incorporated. These costs would translate into additional savings for each birth averted. Fourth, health savings have not been cumulated, but treated as a once-for-all benefit for each birth averted. If these savings were to be cumulated over time, total benefits would be vastly increased.

SCENARIOS

Four scenarios are presented.

Scenario I assumes a one percent increase in contraceptive prevalence for the first two years, rising to 1.5% in each of the following three years, and declining back to zero over the three years following the project. Cumulative contraceptive prevalence increases from the base rate (urban) of 6.7% to 14.7% and stays constant at that level.

Scenario II assumes failure: after similar increases in prevalence during LOP, not only do increases stop abruptly, but the cumulative rate of prevalence reverts to what it was without the project. Previous acceptors stop practicing contraception.

Scenario III repeats the assumptions regarding increase in prevalence during the program period. However it also assumes continuation of program services at a low level of $ 1 million per year to maintain a yearly increase of 1.5% in the rate of prevalence throughout the period of analysis. Cumulative contraceptive prevalence increases from 6.7% to 19.2% in the year 2000 and 34.2% in 2010. Maintaining a steady increase in prevalence at reduced costs implies greatly increased efficiency in service delivery.

Finally, Scenario IV assumes an immediate increase of 3.36% in the rate of contraceptive prevalence, sustained throughout the project, and followed by a rate of increase of 1.5%

sustained throughout the period of analysis. Yearly additional costs of $ 1 million are also assumed.

Because there is a strong presumption that total benefits per birth averted are underestimated, the statistical tables have been constructed as follows:

--the "base" analysis for each scenario includes only the health and educational benefits.

--four alternative benefit levels are included, to approximate percentage increases in the base benefits attributable to savings on food, possible new income, and the "unquantified" benefits.

The results of the analysis are summarized below.

TABLE 2

Scenario	Prevalence			Internal Rate of Return 1992-2010				
	Base	1996	2010	Base	50%	75%	100%	150%
I	6.7	13.2	14.7	30.4	36.6	39.3	41.7	46.1
II	6.7	13.2	6.7	27.9	34.1	36.7	39.1	43.4
III	6.7	13.2	34.2	29.6	36.0	38.7	41.2	45.6
IV	6.7	23.5	44.5	37.1	44.7	48.1	51.2	57.1

Conclusion: These results show that even under the pessimistic assumption (Scenario II) that the project is not sustained, benefits are sufficiently important over the following years to yield an internal rate of return of nearly 28%. Under the modest assumption (Scenario I) that project g ,ins in increased contraceptive prevalence are gradually lost and that overall contraceptive prevalence remains at 14.7%, the base rate of return is over 30%. In spite of substantially better prevalence results in Scenario III, the base rate of return of just under 30% is affected by the assumption that continuing costs are incurred to maintain project gains in increased prevalence. In all cases, the rate of return increases as a function of the proportional increase in estimated benefits over the base benefits assumed.

B. Financial Analysis

Utilization of public health facilities has declined over the past ten years as the quality of care has declined. Between 1978 and 1986, the number of consultations registered in public health facilities decreased by 58.5%, the number of consultants decreased by 35.8%, the number of persons hospitalized decreased by 22.5% and the number of hospital days decreased by 67.3%. During this period the number of health facilities actually increased and Senegal's population increased by 25%. The World Bank's blunt and uncompromising conclusion is that the decline in utilization resulted from a critical degradation in the quality of services at all levels of the health service system as a result of: (i) insufficient recurrent resource allocation to the sector; (ii) inefficient use of available resources; and (iii) a dysfunctional health service system.

Weaknesses in financial management of the public health system are largely responsible for the inefficient use of available resources. There are rigidities in the GOS budget and accounting system which prevent health facilities from exercising effective control over their resources. Control rests with administrative units at the central level and, to some extent, at the regions which are largely unable to cope with the vast planning effort required. The annual budget exercise is a mechanical process without reassessment of current programs. If cuts are necessary, they are usually applied across the board without weighing alternatives. As a result, the budget is an ineffective document to use as a tool for planning, execution or control.

There are serious weaknesses in GOS systems of financial management and control. Accounting for counterpart expenditures under existing health projects has been incomplete and records have never been audited. The DEVRES evaluation team reviewed to the best of its ability the Ministry's financial management of counterpart funds under the Rural Health Delivery Services Project II/ Child Survival. There were shortfalls in the promised Ministry contributions, many documented expenditures were not project-related and some expenditures of funds related to vehicle repair and maintenance, fuel, office supplies and printing appeared irregular. The evaluation team concluded, "Financial management and control procedures are absent, and no cost accounting system exists which would allow expenditures to be attributed to activities or service areas." The team also noted that the Ministry of Economy, Finance, and Plan conducts an annual control visit, but the team was unable to discover any written findings related to these visits.

The final evaluation by DEVRES of the Family Health and Population Project noted that the failure of the GOS to provide its local currency counterpart contribution to purchase gasoline for project vehicles and to pay the operating costs of the headquarters of the national project headquarters crippled implementation of the project. The responsibility of the GOS to assume progressively greater financial responsibility for these costs starting in the fourth year of project implementation was clearly spelled out in two local currency counterpart covenants. The purpose of the covenants was to have the GOS assume greater financial and managerial responsibility so that it would be fully responsible by the PACD. The evaluation report states, "What appears to have happened, however, was that while USAID reduced its support for local expenses according to the Agreement, the GOS

did not meet its increased financial obligation. As a consequence, beginning in the fourth and fifth years, Project activities requiring local costs began to grind down and accomplishments achieved in the first three years were not sustained."

The World Bank has noted that the Ministry's poor financial management is manifest in the lack of oversight of resources pouring into the health sector from international donors and NGOs. The Bank has found that the Ministry makes no systematic effort to monitor external resources: information on the nature, size or geographic distribution of resource flows from individual projects/donors are not centrally maintained, much less information on the aggregate of all contributions. The Bank concluded that there is clearly much potential to channel external resources more productively.

The Bank has also found poor management of funds generated through users fees. In many cases, receipts from service fees collected by community health associations are used to hire support personnel in excessive numbers, channeled to uses not directly related to health service delivery, or hoarded for use as political war chests by local leaders. Not only are insufficient funds collected from users of public health services to meet the chronic budget shortfalls of the facilities, but what little funds are collected are not spent wisely.

USAID's experience in current health projects with the GOS's management of project funds has also not been satisfactory. In the Rural Health project, local accounts at the regional level were closed due to inadequate accounting for funds. A local firm was hired to administer the funds needed at the regional level as an alternative to the previous system. The Ministry was not entirely satisfied with the performance under this contract, and efforts were made to address the Ministry's concerns in a new contract with the same firm. In the Family Planning project, the entire control for local currency costs was moved to the long-term technical assistance contractor after irregularities were found on the part of the GOS. This arrangement also has not been ideal, with the method used by the technical assistance contractor to manage the funds a source of tension and problems impeding project implementation. In both projects, systems maintained entirely by a contractor and not involving GOS personnel have been used, with the result that there are no systems which can be immediately transferred to the new project nor trained GOS personnel.

In order to balance the requirements that AID funds be adequately accounted for and safeguarded against fraud, waste, and abuse with the need for smooth project implementation and GOS participation in the decision-making and implementation process, a different system will be used in this project. Problems in the past have resulted from inadequate financial and internal control systems being designed and installed at the beginning of the projects, insufficient training of accounting staff, inadequate oversight of the accounts, and audits occurring too late after the opening of the accounts or not at all. These problems will be addressed in this project through a Financial Management Advisor who will be part of the technical assistance contractor

team. This Advisor will be responsible for designing and installing systems for accounting, inventory, procurement, reporting, and internal control of local currency funds to be managed at the central level. In the Management Unit of the Office of Family Planning a financial group will be set up which will consist of the Advisor and a GOS staff of three employees--two accountants, a chief accountant, and a procurement advisor. The system will be managed apart from any existing GOS system. The Advisor will train the four GOS staff members and oversee their work. The Advisor will have approval authority over all transactions for procurement, payment, and check signing. This authority will be shared with the GOS Project Director, who will receive training and advice from the Advisor. The Advisor will work with the project for the first three years, with the goal to be able to turn the operation of the financial systems over completely to the GOS at the end of this period. At the end of this period, the Advisor will leave in place four trained GOS staff and accounting, reporting, internal control, accounting, and inventory systems.

USAID will also finance numerous activities at the regional, district, and municipal levels. A study by a C.P.A. firm of the accounting and internal control systems at these levels determined that the systems were not presently adequate to handle USAID project funds. The technical assistance contractor, therefore, will manage these disbursements through control at the central level by the Advisor. For the regions, the Advisor will design and install systems for accounting, inventory, procurement, reporting, and internal control. A qualified GOS accountant will be assigned in each region to manage these funds. The Advisor will train these accountants in the use of the system and will monitor their work as necessary through site visits. Advances will be made from the central account to the regions for 90-day periods based on documented estimated needs approved by the GOS and the Advisor. Monthly financial reports will be submitted from the regional accountants to the Advisor for review and liquidation of the advances each month.

As the work involved to set up and maintain accounts in four regions and at the central level will be considerable, it will not be possible to open additional accounts at the district and municipal levels. Funds for district activities will therefore be disbursed through the regional accounts. Funds for municipality activities will be disbursed directly from the central account through regular procedures for this account. After the departure of the Advisor at the end of year 3, control for regional, district and municipality disbursements will operate in the same manner with control and oversight at the central level (Management Unit of the Office of Family Planning). In order to further safeguard A.I.D. funds, a frequent and rigorous independent audit program will be followed. At the end of each year, a C.P.A. firm will be contracted with to audit the accounts set up for this project at the central and regional levels. A financial review will also be programmed annually for the first two years. The method to be used under this project should address all the requirements of A.I.D. to adequately safeguard U.S. Government funds while allowing the GOS to be involved in the process and in addition to build the institutional capability of the GOS to manage funds.

Conclusion: The proposed project will establish proper systems of financial control as well as address the two major financial problems encountered under the two existing USAID health projects. By requiring that a GOS accountant be assigned at the regional level, a system of checks and balances with a separation of duties will be established. The problem of non-project expenditures of local currency counterpart contributions will be addressed by the inclusion of a covenant in the project identifying agreed upon local currency budget rubrics.

C. Social Soundness Analysis

Senegal's population of approximately 7.8 million is currently growing at a rate of 2.7% annually. Senegal is rapidly urbanizing, and almost 40% of the population now live in urban areas. The Demographic Health Survey of 1986 indicated that only 15% of women and 30% of men were literate. According to the 1988 census, 94.4% of Senegal's population is Muslim, 4.6% is Catholic and 1% is animist or follows traditional religions. All of Senegal's ethnic groups follow traditions of their ancestors upon which have been superimposed Islam and Catholicism. Islam is not only a major determinant of Senegalese social organization and behavior in all ethnic groups; it is also a powerful political force. Throughout Senegal religious leaders (marabouts) have power which extends well beyond religious matters to all the secular concerns of their communities. Practices that are indigenous to local culture are attributed incorrectly to Islam, and practices such as family planning are incorrectly believed to be against Islam.

The status of Senegalese women profoundly influences their attitudes about fertility and desired number of children. Dowry is paid in both Islamic and Christian marriages. Under Islamic inheritance law, the husband is the legal head of the household with authority over the wife, family and choice of domicile. The wife cannot own land or inherit property. The lives of Senegalese women are defined by the patriarchal social structure which places supreme emphasis on a woman marrying and producing a large number of children. Marriage, fertility and childbearing constitute a central element in Senegalese culture. Women are ushered into marriage at a young age: the median age at first marriage for women is 16.1 years according to the 1986 DHS. Polygamy is widely practiced, especially in rural areas. The 1988 census revealed that throughout Senegal more women are in polygamous than monogamous unions.

Although the age at first marriage has increased slightly in recent years, the cultural norm is still early marriage which has been arranged by parents at their daughter's birth or before puberty or at the time of puberty. Many adolescents have their first child when they are so young (12 to 17 years of age) as to be medically high- risk. Recent studies have found that more than one-third of women have their first pregnancy as an adolescent girl at or before the age of 17. Reasons for early marriage are both socio-cultural and economic. Tradition demands, and many Senegalese thus want, a large number of children. The fact that under Islamic law the wife has very limited rights

over the wealth of her deceased husband contributes to the desire of many Senegalese women to have a large number of children as a form of old-age security since the children will be obligated to care for her. Despite a tendency toward monogamy and nuclear family households in the urban environment, the majority of women still live in a polygamous marriage. In a monogamous marriage, fertility may be a weapon with which a young bride consolidates her marriage, avoids divorce and presents the introduction to her household of a co-wife or additional co- wives. In a polygamous household, the woman also seeks, through the number of children, to assure the stability of her marriage and household. When the co-wives are all young, there is rivalry to give birth to male children.

According to the 1986 DHS, women generally favor a large family consisting of 7.2 children, which is even higher than the average of 6.4 births actually produced by women during their reproductive years. Only 19% of women want no more children, and the majority of these women already have 6 or more children. There are a number of practices associated with pregnancy which are harmful and contribute to high rates of maternal, infant and child mortality. Early marriage means that a young girl is likely to become pregnant before her own body has finished its growth and is able to support a healthy pregnancy and safe delivery. Second, the practice of concealing a pregnancy for as long as possible reduces the opportunities for prenatal consultations or immunizations against neonatal tetanus. Third, pregnant women continue heavy physical work throughout pregnancy. Fourth, dietary intake is neither of the quantity or quality necessary for an optimal pregnancy outcome. Most women try to minimize weight gain, based on the belief that weight gain will cause a large baby and thus difficult delivery. Fifth, most deliveries take place at home without the assistance of a trained birth attendant.

Three types of traditional fertility-regulating practices can be identified. First is the deliberate use of plants and other local substances that people believe can prevent conception, reduce fertility or provoke an abortion. Second, women use charms provided by muslim priests and traditional healers to prevent births. Third are behaviors that directly or indirectly extend the interval between births. Prolonged breast feeding is nearly universal among Senegalese women. On average, women breast feed for nearly 19 months. The 1986 DHS indicated that almost 90% of infants 11 months old or younger were being breast fed. Because of the long duration of breastfeeding Senegalese women have an average of 17 months of postpartum infecundity, one of the longest periods observed in Africa. Even though postpartum abstinence is practiced by most women, it prevents few pregnancies because postpartum amenorrhea is almost universal during the period of abstinence.

Senegal is experiencing increased urbanization, migration and disruption of traditional life-styles, all factors that contribute to a reduction in the duration of breastfeeding and postpartum abstinence. If a significant reduction in breastfeeding duration or intensity takes place, the result would be shorter birth intervals and increasing fertility. Recent

studies indicated that two variables, women's place of residence and education, may be more important as determinants of health and fertility behavior than ethnic or religious differences. Urban vs. rural residency is a major determinant of knowledge, attitudes and practices related to health and fertility in Senegal. The majority of rural people do not have reasonable access to public health facilities. Urban residents are less bound by tradition than rural people and more likely to adopt new ways of doing things. Women's education, likewise, is a major determinant of knowledge, attitudes and practices related to health and fertility. Type of women's employment seems to correlate quite closely with women's education as an indicator.

According to the 1986 DHS, 22% of women who have received secondary education use a modern method of contraception, 6% of women with primary education use a modern method of contraception and 1% of women with no formal education use a modern method of contraception. The 1988 census indicated that only 9.2% of girls were enrolled in primary school. The 1986 DHS found only 2.4% of women were currently using a modern method of contraception and 6.3% had ever used a modern method. 6.7% of urban women were using modern methods of contraception, while 0.3% of rural women were users.

Despite the low contraceptive prevalence levels, the 1986 DHS did reveal that there is unmet demand for family planning services. Among currently married, fertile women who were not using contraceptives, 42.5% of urban women either wanted no more children (17.7%) or wanted to space their next child (24.8%); 35% of rural women either wanted no more children (9.5%) or wanted to space their next child (25.5%); overall 37.4% of Senegalese women (married, fertile, not then using contraceptives) want either no more children (12.2%) or want to space their next child (25.3%). The 1986 DHS reveals a clear desire among many Senegalese to space births, but there is apparently little demand to limit the number of births. Traditionally, total family size has been limited only by the end of a woman's reproductive years and the belief that a woman should not continue having children after her eldest daughter begins having children.

While the concept of spacing is entirely consistent with the birth intervals resulting from traditional prolonged and intensive breastfeeding, the concept of family size limitation is an alien concept. Births are already reasonably well-spaced among women who have never used a modern method of contraception. Unless Senegalese women begin to want longer birth intervals that result from prolonged and intensive breastfeeding, child spacing does not seem to be an effective solution to Senegal's population problem. Indeed, evidence suggests that there is little current desire for smaller families, except in urban areas where desired family size is significantly smaller than the national average (5.5 vs. 7.2). Modern contraceptive use is significant only in urban areas where the duration and intensity of breastfeeding is declining. Modern contraceptive methods are used temporarily to space births. Continuation rates for oral contraceptives (10 months) and IUDs (18 months) are low and are consistent with the notion of temporary use for spacing purposes. There appears to be, however, a very small, but growing demand for longer

lasting methods and even permanent methods in urban areas.

Senegal is a conservative country, and three aspects of this conservatism are significant constraints to family planning. The first is socio-cultural. Senegal is a traditional, polygamous, rural, Islamic and tribal society. The influence of marabouts and other traditional leaders is strong, even among urban dwellers. Family ties and values take precedence, and men are the decision makers. The diversity of languages and ethnic cultures in a predominantly illiterate population presents special problems for IEC campaigns. On a more positive note, Islamic teachings do not condemn modern contraceptives and encourage parents not to have more children than they can reasonably care for.

The second aspect of cultural conservatism is extreme medical conservatism. Senegal derives its Western medical tradition from France. Essentially, a medical trade group, the Conseil de l'Ordre de Medecins, exerts tight control over medical decisions and resists participation by para-professionals in areas which it considers its purview. The most obvious examples are the resistance to permitting nurses to provide family planning services and excessive regulation of oral contraceptives and even non-clinical methods (condoms and spermicides). Slow to accept a public health perspective, the medical community favors, by default, curative care for the urban elite. Although Senegal embraced the 1978 Alma Ata Declaration of Health for All by the Year 2000 and legalized contraception in 1980, change is slow and must come from the highest levels of the medical community.

The third aspect is bureaucratic conservatism. In line with French colonial tradition, health systems are centralized and hierarchical, with blockages at any point in the system capable of stopping progress further down the line. Budgetary flows and personnel follow the same pattern.

Conclusion: Although the cultural setting is far from ideal for the establishment of an effective national family planning program, this does not mean to say that the proposed project is not feasible from a social soundness perspective. The project will attempt to improve the quality of services in urban areas where available evidence suggests there is much greater receptivity of modern methods of contraception than in rural areas. While the concept of family size limitation is embraced only by a small minority of the population even in urban areas, there is almost universal support of the concept of child spacing. The emphasis on Information, Education and Communication activities seems appropriate given the limited demand for modern methods of contraception, especially in rural areas. Messages are to be carefully targeted using survey and formative group research to inform and motivate different groupings of Senegalese in appropriate and culturally-sensitive ways. In keeping with the emergent status of Senegal regarding family planning, the project has not adopted overly ambitious targets for family planning acceptance, decline in family size or reductions in the rate of population growth. The proposed project interventions are feasible.

D. Technical Analysis

A Population Sector Assessment was undertaken in 1990 and is part of a larger assessment of the entire health sector conducted by an assessment team in late summer 1990. The assessment included extensive review and study of the several hundred documents that characterize the health and population sector in Senegal. The assessment team attempted through discussions with mission staff, contractors, GOS personnel, other donor agency personnel and private sector representatives, to clarify and evaluate successes and problems and to identify opportunities to build upon USAID's contributions to a strong national MCH/FP program. The Assessment concluded that USAID/Dakar has the most extensive experience and has made the largest investment in the population sector of any of the donors. The assessment proposed the following priority areas of concentration for USAID over the next five years:

Generate demand for methods of child spacing and family size limitation through policy dialogue, IEC, social marketing and the assurance of quality service at existing sites;

Strengthen USAID's infrastructure investments by developing a logistics management system, a management information system and a contraceptive procurement plan;

Promote increased private sector involvement in family planning both in direct service delivery and, especially, in the commercial sale of contraceptives;

Create specialized program support activities to foster the introduction of long-term and permanent methods and to study and develop plans for program expansion;

Integrate family planning and health interventions such as AIDS and other STD prevention, child survival and maternal health; and

Support and coordinate with other donors' efforts in the population sector.

The Assessment concluded that the generation of demand for modern contraceptives by introduction of the concept of family size limitation through policy dialogue, IEC and social marketing is Priority One. There is extremely limited demand for the purposes of either spacing or limiting. In essence, women are already spacing children as much or more than they want through prolonged and intensive breastfeeding. IEC efforts to reduce desired family size should initially target urban audiences who are more accessible to communications efforts and have better access to FP supplies and services. Although the desire for large families is firmly embedded in Senegalese culture, the urban population is at greater risk of short birth intervals and has generated the demand for modern contraceptives that exists by replacing a traditional form of contraception with a

modern one. The assessment recommended that, to generate broader and deeper demand for family planning, USAID should: a) conduct policy dialogue on the need to promote limitation of family size in order to reduce fertility and generate demand for modern contraception; b) introduce the concept of child spacing through combined IEC and social marketing advertising campaigns; c) develop social marketing programs to provide specific product information to encourage women to use contraceptives to limit and space births; and d) develop counseling and one-to-one communication efforts to support the idea of limiting and to encourage the use of modern contraceptives.

Priority Two is the strengthening of infrastructure investments by developing a logistics management system, MIS and a contraceptive procurement system. Although the basic clinical infrastructure with trained personnel and basic equipment is in place, clinic utilization and contraceptive continuation rates are low not only because of lack of demand, but also because of a variety of managerial and logistics problems and lack of staff motivation and skill. The existence of about 200 equipped and staffed clinical service points for FP represents an enormous infrastructure investment on which to build. Low utilization and high drop- out rates are undoubtedly influenced by: poor treatment of clients by providers, poor clinical skills, ignorance of FP service regulations, poor record-keeping and lack of supervision. The assessment recommends that USAID provide TA to: a) improve the MIS for clinic record-keeping and reporting, including design or revision of clinic forms, in-service training in record-keeping and uses of data for clinic and program management and set-up of a regular mechanism for performance feed-back from central levels to clinics; design and implement a contraceptive logistics system; and provide quality assurance, clinical supervision and counseling including development, adoption and dissemination of clinical practice guidelines, counseling manuals, protocols and the use of patient flow analysis to improve clinic performance. The assessment noted with concern Senegal's over-dependence on donor-supplied contraceptives and recommended that USAID conduct policy dialogue with the GOS: a) to reduce duties and other restrictions on commercial contraceptives and contraceptive advertising; b) to develop a long-term procurement plan calling for gradual assumption of contraceptive procurement costs by the GOS, the private sector and other donors; c) to test the idea of user fees, along the lines of the Bamako Initiative; d) to fully integrate contraceptives into essential drug schemes; and e) to continue management by objective target setting and monitoring achievements against expectations.

The assessment's Priority Three is to promote private sector involvement in family planning through commercial sale of contraceptives and direct service delivery by private providers, employers/insurers and NGOs. The limits of the private sector for health and family planning in Senegal must be recognized. The only private sector avenues for serving large, national populations will involve social marketing, CBD and traditional healers. The commercial infrastructure for health and pharmaceutical products is well developed only within urban areas, and the commercial market for contraceptives is weak because of the extremely limited size of the market. Family planning NGOs such as ASBEF and SANFAM may fill the gap for local TA resources, but they themselves must

be strengthened first. To foster an expanded role for the private sector delivery of health and family planning goods and services, USAID should promote commercial delivery of modern contraceptives by developing a social marketing project to expand the present market for contraceptives and ORS; by reinforcing private sources of supply in urban/peri-urban areas and public sources for clinic-based longer term methods and in rural areas where the private sector cannot meet the need; by evaluating and building upon the SANFAM experience in the private sector with a new emphasis on co-financing and sustainability; by expanding contacts within the realm of the for-profit health care marketplace; and by providing TA to existing service delivery NGOs with an emphasis on management, marketing, entrepreneurship, growth, sustainability and quality of care.

Priority Four of the assessment is to promote greater use of long-term or permanent methods of contraception, while concurrently expanding family planning services to rural areas, where purchasing power is limited and CBD systems are essential to achieving full coverage. The assessment recommends that USAID continue to use Cooperating Agency buy- ins to provide specialized technical support. USAID should continue to: develop minilaparotomy service delivery and counseling/referral capabilities at the university teaching hospital and regional levels; support regulatory approval and introduction of Norplant, including training of providers, counseling and promotion; conduct OR in areas related to program effectiveness; and provide technical and financial assistance to DHS and special studies.

Priority Five of the assessment is to integrate family planning with health interventions such as AIDS prevention, maternal health and child survival. USAID should not limit itself to a program which covers only family planning or contraceptive services. Not only does integration increase program acceptability, it also promotes efficient resource utilization and is line with the GOS policy of integrated maternal and child health services.

Evaluations of the Rural Health Project suggested that the control of diarrheal disease was the one area in child survival in which USAID had comparative advantage. The treatment for diarrhea is fairly straightforward, and SANAS (the division of MOPHSA responsible for the control of diarrheal disease) had proven itself to be quite competent in managing this program. It was, therefore, recommended that USAID continue to support this activity as opposed to the treatment of malaria and ARI which were problematic because they either involved vaccinations or were developing resistant strains.

Priority Six is to coordinate with other donors' efforts in the population sector, particularly UNFPA and the World Bank. Senegal's population program is donor dependent and will continue to be in the foreseeable future. USAID has a very clear comparative advantage in certain programmatic and technical areas, notably private sector development, method introduction (VSC and Norplant), logistics and MIS and IEC/mass media campaigns. As multilateral agencies, both UNFPA and the World Bank have comparative advantage in leadership within the donor community. The World Bank is well positioned to fund infrastructure and other large investment costs, while UNFPA should be encouraged to

work with the Ministries of Plan, Education and Youth and Sports. USAID should maintain its longstanding, strong technical assistance role. Donors should develop common policy dialogue agenda. Logistics and commodity procurement should be jointly planned by all parties at yearly workshops. Development of MIS should be a joint effort among donors, the GOS and the private sector.

Conclusion: USAID concludes that the technical strategies presented in the Population Sector Assessment are appropriate and will prove effective for Senegal. The proposed project design has drawn heavily on the technical recommendations presented. The approach is a judicious mix of family planning, maternal health, child survival and AIDS activities carried out by public, NGO and private organizations. It is a pragmatic, politically astute approach utilizing technologies of proven effectiveness in population programs throughout the world.

E. Institutional Analysis

The World Bank in its March 12, 1991 Staff Appraisal Report for the Senegal Human Resources Development Project characterizes the public health system under the direction of the Ministry of Public Health and Social Action as a "dysfunctional health pyramid". The Bank concluded that the Ministry suffered from acute organizational flaws, the most prominent being : (i) absence of realistic and/or clearly defined norms governing the functions assigned to each level of the pyramid, staffing patterns, individual staff assignments, minimum resource needs, geographic coverage, etc.; (ii) undefined norms for administrative, managerial and supervisory roles linking successive levels of the system; (iii) insufficient distinction between first line and referral levels, with most health centers unable to offer basic surgery, laboratory and radiology services needed for effective referral; (iv) unequal distribution of health posts, with a shortage in urban areas, resulting in excessive recourse to hospitals for even minor problems; and (v) excessive reliance on vertical programs.

The shortcomings in the public health sector include: a poor distribution of facilities, staff, programs and supplies; inadequate training curricula, especially in public health management and counseling of patients; job descriptions unsuited for use in a fully integrated primary health care system; incompletely defined program planning needs; support systems unlinked to needs in the field; an inadequate health information system which does not provide the data on health conditions required by planners and managers; a non- functioning pharmaceutical logistics system which results in frequent stockouts of essential drugs and contraceptives; missing or malfunctioning medical equipment; lack of preventive maintenance programs resulting in crumbling health facilities and non-functioning transport; infrequent supervision without supervisory protocols; and a lack of a service orientation on the part of health facility staff towards patients. The GOS itself estimates that the existing system of public health facilities only provides access to 40% of the population. In order to broaden the impact of the

public health system there must be substantial improvements in operational efficiency, quality of care and service promotion.

In addition to the organizational difficulties cited above, the functioning of the public health system is clearly hampered by a severe shortage of funds. The Ministry's share of central recurrent budget allocations has fluctuated from the nearly adequate 9% in the early 1970's to the grossly inadequate 3.8% in the 1986-1988 period. 4.7% of the budget was committed to the Ministry in the revised FY 1990-91 budget, well below the standard of 10% recommended by the World Health Organization. Actual expenditures reveal even a bleaker picture of the failure of the GOS to adequately support the public health system. There is an apparently growing gap between budget commitment and actual spending on public health. In FY 1986-87, for example, 15% of the health budget was not spent. Given Senegal's annual 2.7% rate of population growth, per capita expenditures on public health show a declining trend. The GOS has given assurances to the World Bank that the Ministry's share of the recurrent budget would increase from 4.7% in FY 1990-91 to 7.25% in FY 1996- 97.

The GOS has experimented with the imposition of users' fees in public health facilities over the past decade in order to involve the beneficiaries in the financing of the public health care system. According to the World Bank, the amounts collected have been low, representing less than 5% of total private spending (over the past five years, fees collected averaged only $1 million equivalent per year or about $.15 per capita). The Bank's conclusion is that community health associations formed at the health post, health center and hospital levels have apparently lost momentum, as evidenced by the decrease in amounts of funds mobilized since 1985. If the public health system is to be revitalized, the GOS will have to find new ways to have the public assume a greater share of the costs of delivering public health services. Projected budgetary resources together with the current level of users' fees will not be able to maintain the quality of public health care at even its current unsatisfactory levels.

The donor community does not escape criticism for the Ministry's current organizational difficulties, especially the excessive reliance on vertical non-sustainable programs. During the early 1980s various special programs were established, largely with donor assistance, to promote different elements of primary health care such as MCH, Expanded Program of Immunization, diarrhea management and family planning. According to the Bank's analysis, these PHC programs were mostly established with separate, highly centralized management, supervision and logistical systems, resulting in gross inefficiencies in the use of resources. In the Bank's view, there is a need to integrate these services into the existing system, which itself should develop into an efficient health pyramid able to deliver the minimum health package through multi-purpose health posts in the first instance, and through efficient referral, supervision and support at the higher levels of the system.

Over the last decade the Government of Senegal has made efforts to streamline and

decentralize public sector activities. As part of this effort, the two previously separate Ministries of Health and Social Development have recently been joined into one Ministry of Public Health and Social Action. The number of directorates within the new organization have been reduced from six to three to simplify the decision-making process, reduce the problems of activity coordination and avoid duplication of effort. The Ministry seems to accept the need to move towards a decentralized fully integrated primary health care system as currently advocated by all of Senegal's numerous donors to the health sector. It is less clear that the Ministry fully understands how poorly the public health system has been functioning and how willing senior health managers are to embrace fundamental reform.

Responsibility for family planning had previously been shared by the separate Ministries of Health and Social Development. The responsibility now lies solely with MOPHSA. A new Office of Family Planning is in the process of being established within the Directorate of Public Health. It appears that the Office of Family Planning will be established under the supervision of the Maternal and Child Health Service. Its proposed structure consists of a Clinical Services Unit, an Information Education and Communication Unit and a Financial & Commodity Management Unit. The yet to be appointed Director of the National Family Planning Program and staff will be responsible for program operations. In addition, support to policy level family planning activities is provided by the office of the technical advisor for family planning.

The picture is not as bleak at it might first appear. The apparent decision by the Ministry to create a significant family planning organization is a departure from the usual practice of creating a project organization outside of the formal Ministry structure to administer a donor-assisted activity. The Ministry has not been able to strengthen its own internal structure in part because donor-assisted project management units were viewed as temporary structures which would not be sustained upon completion of the activity. For the first time, sole responsibility for family planning has been given to the Ministry. The Office of Family Planning, though it is not ideally placed within the bureaucratic hierarchy, is to be given substantial manpower and material resources to carry out its functions. Senegalese professionals with expertise in clinical services, training, IEC, logistics and financial management are to be assigned to the office on a permanent basis. Up to six donor-financed long-term technical assistants will work within the office over the next 3-5 years. For the first time, it appears possible to build a sustainable National Family Planning Program that won't whither away when a particular donor's program ends.

The Ministry of Public Health and Social Affairs is a fragile institution which needs strengthening. USAID and the Ministry have attempted to incorporate sufficient assistance within the proposed project to overcome the noted institutional weaknesses. The project emphasis on operational effectiveness, quality of services and service promotion seems highly appropriate. Training will focus on clinical skills, client counseling and public health management. Supervisors will be trained how to

supervise in an educative, supportive manner. Supervisory protocols will be developed to guide supervisors and ensure that supervisory visits do not degenerate into inspection visits. The success of the Ministry's decentralization efforts are crucial to the viability of the National Family Planning Program. The Ministry simply lacks the financial and human resources to attempt to continue rigid central control of the health system from Dakar. The proposed project assistance in health planning will help to ensure that the regional planning process does not deteriorate into a theoretical macro-planning exercise of no utility to regional managers and will also attempt to integrate significant family planning concerns into regional plans.

Recognizing that the Ministry of Public Health and Social Affairs is a fragile institution, that the decentralization process has only just gotten under way, and that the new Office of Family Planning may take some time to become effective, USAID considered other alternatives for the provision of family planning services. The two Senegalese NGOs which are actively providing family planning services through private or para-public clinics simply are too small and have too many organizational/management weaknesses themselves to be a serious alternative to the Ministry. Commercial health facilities and pharmacies exist in only the largest cities. The high costs associated with their services would exclude all but the urban elite.

Conclusion: Despite its weaknesses, the Ministry of Public Health and Social Action offers the best current opportunity to build a family planning program which is national in scope. MOPHSA has already taken steps which indicate it is serious about reforming the health sector and creating a national primary health care referral system. In addition, many of the proposed project activities are intended to strengthen MOPHSA. Therefore, the design team concluded that the institutional weaknesses of MOPHSA will not prevent the project from achieving its objectives.

V. PROJECT IMPLEMENTATION ARRANGEMENTS

A. Implementation Schedule

Annex H presents the detailed implementation schedules for each of the project's major components. Below is a summary of key implementation targets:

6/92	Project Authorization
6/92	RFP for Prime Contractor Issued
9/92	CPs to First Disbursement Met
10/92	Grant to ISED Awarded
10/92	Review of Health Information System Pilot
11/92	Grant to ASBEF Awarded
11/92	Grant to Africare/SANFAM awarded
1/93	Prime Contractor Selected
5/93	Basic Training in Clinical Methods Begins
6/93	Preliminary DHS results available
6/93	Launch of Social Marketing Activities
7/93	Treatment Protocols Developed
7/93	Oral Rehydration Units established.
8/93	Training of Trainers Instruction Begins
8/93	Training of Regional Warehouse Managers and Stock Managers at Regional Referral Centers
8/93	Family Planning IEC Strategy Finalized
9/93	Community Based Distribution (CBD) Technical Guide Developed
1-6/94	Evaluation and Extension of Norplant
2/93	Management Training Course Begins
2/94	Regional Referral Centers Functioning Smoothly
4/94	Contraceptive Logistics System Functioning Effectively
6/94	In-House Evaluation of ISED Modules
7/94	Control of Diarrheal Disease Policy defined and published

8/94 Training of CBD Agents

9/94 Funding of Municipality Activities Begins

3/95 Mid-term Evaluation

5/95 Implementation of Operational Research Module

8/95 District Referral Centers Fully Operational

3/97 Final Evaluation

B. Role of Institutional Contractor

An institutional contractor will be selected after full and open competition. The institutional contractor will have the following areas of responsibility: (a) provision of technical assistance; (b) financial management (including the development and implementation of a financial system for managing local funds); (c) commodity procurement (including local and overseas procurement); (d) participant training and observation tours; (e) computerized project management system and related data bases; (f) project reporting; (g) coordinating and managing municipality activities; and (h) coordination of project inputs.

The institutional contractor will provide 21 person years of long-term technical assistance (Family Planning Management Advisor - 5 yrs, Financial Management Advisor - 3 yrs, IEC Specialist - 5 yrs, Logistics Specialist - 3 yrs , and a Health Planner - 5 yrs) and approximately 20 person months of short-term consultancies. All long-term and short-term personnel must be approved in advance of travel to Senegal by USAID and MOPHSA. Detailed scopes of work for each proposed long-term staff member are included in Annex B. To the extent possible, all long-term TA will be provided office space at the PMI Medina which will house the Office of Family Planning. The Health Planning Advisor will work with both the Decentralization Committee on decentralized health planning and with the Office of Family Planning. The Ministry will provide office space for the health planner that is convenient for both responsibilities. The Family Planning Management Advisor will serve as Chief of Party (COP) and counterpart to the Director of the Office of Family Planning. The Chief of Party will hire three Senegalese administrative assistants for whom MOPHSA will also furnish office space.

The institutional contractor will establish a financial account in Dakar which will be utilized to cover local costs incurred for project activities. The Financial Management Advisor, assisted by three GOS accounting staff, will establish systems of financial management and control. The Financial Management Advisor will also be responsible for tracking and documenting GOS counterpart contributions. At the regional level in the project's four focus regions, local currency accounts will be set up by the Financial Advisor who will train regional accountants assigned by MOPHSA to manage the

regional accounts. The institutional contractor will establish appropriate inventory controls. A GOS commodities manager will be assigned to work with the Financial Management Advisor to undertake local procurement and establish inventory controls for project commodities. A second, relatively senior GOS commodities manager, will be assigned to work with the logistics specialist in establishing and operating a contraceptives logistics system.

The institutional contractor will procure project commodities with the following exceptions: contraceptives, ORS and two vehicles for the technical assistance team which will be arranged by USAID. The contractor will be expected to provide housing, appliances, furniture and all needed office equipment for the long-term staff. The GOS will make available to the technical assistance team, furniture and appliances procured under the existing USAID projects until the arrival of new furniture and appliances. All office equipment under the existing family planning project will be transferred to the Office of Family Planning at PMI Medina and should be made available to the new technical assistance team as needed. Equipment provided under the Rural Health Project II will be transferred to the Decentralization Committee. The institutional contractor will provide a Senegalese administrative assistant to handle all overseas project procurement under the direction of the COP. The contractor will work closely with Ministry counterparts on to identify quantities, desired delivery dates and specifications of the items to be procured. The Financial Advisor will also provide technical advice about the establishment of financial management systems for other related donor funds.

The institutional contractor will be responsible for managing both in-country and overseas participant training and observation tours. The contractor will provide a Senegalese administrative assistant and appropriate home office support who will assist the COP in programming training activities and ensuring that all USAID and GOS procedures related to participant training are followed. These training responsibilities will require frequent consultation with Ministry counterparts and USAID. The administrative assistant will work with the Ministry to coordinate the logistics for in-country training. This assistant will also prepare or obtain all necessary documentation for each overseas training participant. This includes preparing draft cables and PIO/Ps for USAID. The administrative assistant will provide guidance to prospective participants and assist them to complete all pre-departure requirements. The administrative assistant will also make all necessary arrangements for observation tours to neighboring countries for Senegalese counterparts.

The institutional contractor will be responsible for the establishment of a computerized project management system and computerized data bases related to the performance of project components. The Family Planning Management Advisor, assisted whenever appropriate by other technical advisors, will adapt commercial project management software packages to track the implementation of project workplans and progress towards expected end of project status. The contractor will also maintain

computerized data bases reflecting the performance of family planning and diarrheal disease activities in Senegal. The information contained in the data bases is to be utilized in the preparation of project briefing papers and reports.

The institutional contract will contain extensive reporting requirements. The financial management responsibilities contained in the contract are considerable because of the Ministry's demonstrated weaknesses in financial management and control. USAID will require frequent reports on project expenditures by component. In addition, the contractor will be required to prepare annual workplans, analyses and briefing papers. USAID intends to require frequent and comprehensive reporting by the contractor in order to ensure that the project is on track. USAID has proposed a large institutional contract for this project because neither the Ministry nor USAID itself has sufficient resources to manage the project without outside assistance. Stringent reporting requirements will provide both parties the information required for them to discharge their responsibilities while allowing the contractor to assume a large part of the management burden.

In addition to serving as team leader, the Chief of Party (the Family Planning Management Advisor) will work as the principal counterpart of the Director of the National Family Planning Program. This Advisor will assist the Office of Family Planning in the development of implementation plans and indicators of operational effectiveness for the National Family Planning Program. The Chief of Party will be expected to coordinate long-term and short-term technical assistance provided under the contract, subcontracts, buy-ins to AID Cooperating Agencies, and activities involving municipalities. The buy-in process, for example, is particularly burdensome to USAID in terms of developing detailed statements of work, scheduling visits, drafting cables, scheduling meetings with Senegalese counterparts, and disseminating reports or research findings. USAID will develop the original buy-in PIO/Ts in the Fall of 1992. The institutional contractor will take responsibility for all other tasks associated with the buy-ins such as setting up meetings with ministry officials, thus diminishing the administrative burden for USAID. The performance of each long-term technical assistant will be reviewed by MOPHSA and USAID after six months and then on an annual basis. If performance is not satisfactory, the contractor will be requested to replace the non-performing individual.

C. Mission Management

The SCS/FP Project will be managed by the Mission's Health and Population Office with support of a Mission Project Committee. The project will fund a full-time FSN personal services contractor to serve as project officer under the supervision of the Chief Health Officer. During the first two years of the project, HPNO will need to be heavily involved in project implementation to ensure that activities get off the ground, that the technical assistants are operating effectively, etc. Given the importance of the

family planning program within the Mission's Country Program Strategy Plan, the focused efforts of the HPNO staff on the new project is warranted. Although the number of activities to be conducted under the project is quite large, the project contains the minimum number of components required for an effective family planning program.

D. Role of Ministry of Public Health and Social Action

The Ministry of Public Health and Social Action (MOPHSA) will take the lead role in implementing project activities and ensuring that project objectives are achieved. It should be noted that project objectives directly support the National Family Planning Program and National CDD Program, and that the GOS is responsible for the implementation of both of these programs. The Office of Family Planning will be responsible for all family planning related activities including IEC and CBD. This Office will play the lead role in establishing the regional family planning referral centers. This task will involve considerable communication with regional personnel and supervision. Only through close communication will the Office be able to avoid confusion at the regional level about changes in the way family planning services are provided. The institutional contract team will provide technical support to the Office of Family Planning in implementing these activities.

The Office of Family Planning also will have to ensure that the National Family Planning Program becomes a priority in all regions and is fully and actively integrated into regional health plans. As mentioned earlier, the Office of Family Planning will be responsible for establishing an effective contraceptive logistics system, developing an IEC strategy and improving the quality of clinical services. At times, the assistance of the Director of Public Health may be required to resolve issues that can't be resolved at the level of the Office of Family Planning. The Director of Public Health is expected to closely monitor the progress made under the project and intervene when necessary. The Office of Family Planning will be responsible for coordinating with other services such as the Health Education Service and the Division of Statistics to ensure that their needed input is provided in a timely manner. The Office of Family Planning, under the supervision of the Financial Management Advisor, will be responsible for the management of the project's sizable local account. The GOS Technical Advisor for Family Planning will assure that appropriate policy and strategic reviews take place. This Technical Advisor will be the contractor's primary counterpart for elaborating RAPID models, utilizing results of the DHS, and coordinating, reviewing and diffusing the results of CSM activities.

The Decentralization Committee and the Director of Public Health will be responsible for coordinating project activities in support of decentralization. Two full-time Ministry personnel will be assigned to the Decentralization Committee to work with the regions to ensure that their health plans are properly developed and implemented in an effective manner. The Nutrition Service (SANAS) will be responsible for the

implementation of activities related to the control of diarrheal disease and related IEC development.

E. Project Procurement

Procurement needs for this project can be broken down into the following areas: (1) procurement of services of a U.S. contractor to provide technical assistance and commodities; (2) grants to U.S. and local non-profit organizations to perform specific family planning activities; (3) use of AID/W cooperative agreements or contracts to obtain specialized services and to procure oral rehydration salts and contraceptives; (4) procurement by USAID/Senegal/EXO of two vehicles, audits and evaluations, and a project manager; (Oral Rehydration Salts will be procured by AID/W) through an AID/W contract; and (5) local expenses in furtherance of project activities. This section will summarize the areas listed above. Annex J provides a procurement plan which details each of the anticipated procurement.

1. Procurement Summary

Technical Assistance Contractor - Upon signature of the Project Grant Agreement with the GOS and satisfaction of conditions precedent to initial disbursement, USAID will issue a PIO/T requesting the Regional Contracting Officer to issue the Request for Proposals (RFP) for a U.S. technical assistance contractor. Upon receipt of the applications, a review committee composed of representatives from USAID and the GOS will review the applications using the evaluation factors stated in the RFP. Full and open competitive procedures will be followed in accordance with the Federal and A.I.D. Acquisition Regulations. The T.A. contractor will be responsible for procuring in excess of $3.0 million of furniture, gasoline and equipment. This includes office furniture/equipment for the Office of Family Planning, the Decentralization Committee, SANAS, the Statistics Division, the technical advisor for family planning, and the four focus regions. In addition, 11 vehicles will be purchased for use by the GOS in furtherance of project objectives as well as household furnishings and appliances for the T.A. team. The contractor will also purchase equipment and furnishings for the Referral Centers, Health Centers and Health Posts (see Annex J). The contractor will determine exact furniture/equipment requirements once the T.A. team is in place. The contractor will observe A.I.D. source and origin requirements. All procurement will be in conformance with DFA guidelines (discussed below) and a preference for U.S. source and origin will be made wherever practicable.

The T.A. contractor will manage a local account which will make disbursements for various costs including municipality activities, operations research, IEC activities, Office of Family Planning support costs, training, CBD activities, supervision per diem, support to the Division of Statistics and the Decentralization Committee, and expendable supplies. Source of all purchases will be Senegal.

Grants to Non-Profit Organizations and Universities - It is anticipated that three grants or cooperative agreements will be awarded to non-profit organizations for specific family planning activities. One grant will be made to Tulane and Morehouse Universities to work with ISED, a local training organization. A second grant will be made to Africare to assist a local NGO, SANFAM. The third grant will be made directly to ASBEF, a local family planning NGO.

AID/W Cooperative Agreements or Contracts - Buy-Ins with seven centrally-funded AID programs performing family planning activities will be executed. These include: Technologies for Primary Health Care, DHS II, RAPID IV, Training in Reproductive Health (JPHIEGO), Strategies for Improving Service Delivery (Population Council) and Family Health International. USAID will also issue a PIO/C to AID/W requesting that it procure Oral Rehydration Salts for the Mission. All contraceptives will be purchased through an annual OYB transfer to the AID/W Central Contraceptives Procurement Project (936-3057). Source and origin will be U.S.

USAID Procurement - USAID will procure directly two vehicles for the T.A. team from Code 935 origin, and the services of an FSN project manager.

The project will be financed with funds from the Development Fund for Africa (DFA), which provides a special waiver to the Foreign Assistance Act of 1961 pertaining to U.S. source and origin rules for goods and services procurement. The purpose of the waiver is to ease existing procurement procedures, which were seen as impeding project implementation in Africa. Although Geographic Code 935 countries are authorized, the DFA-funded projects still must have a DFA procurement plan which shows an order of preference of U.S. source and origin and then Code 941 source/origin to the fullest extent possible. The special waiver also directs African field posts to formulate comprehensive procurement plans which assure U.S. purchases whenever practicable, consistent with program objectives.

VI. FINANCIAL SUMMARY

A. Cost Summary

The total cost of the project is estimated at $32.85 million. USAID will contribute $27 million under the project and provide $3.5 million of contraceptives through an OYB transfer. The Government of Senegal will contribute approximately $4.5 million in-kind and approximately $1.35 million in local currency.

TABLE 3

Project Budget ($000s)					
Activity	AID		GOS	TOTAL	
	FX	LC	LC	FX	LC
1. Tech. Assist.	10,000			10,000	
2. Procurement	2,000	1,900	661	2,000	2,561
3. Local Account		4,285	689		4,974
4. Buy-Ins	3,300			3,300	
5. Grants	4,600			4,600	
6. Audits/Eval.	300	115		300	115
7. Contingency	250	250		250	250
OYB Transfer (Contraceptives)	(3,500)	-	-	(3,500)	
TOTAL(Cash Cont)	20,450	6,550	1,350	20,450	7,900
GOS In-kind Contribution			4,500		4,500
TOTAL	20,450	6,550	5,850	20,450	12,400

1. U.S. Financed Inputs

The USAID-financed project budget components are summarized below:

1. Institutional Contract ($10 million)

An institutional contractor will provide the following long-term technical assistance:

- Chief of Party, Family Planning Advisor (5 years)
- Health Planner (5 years)
- Logistician (3 years)
- IEC Specialist (5 years)

Financial Management Advisor (3 Years)

The cost of this assistance is approximately $4.3 million. The institutional contractor will also provide approximately 20 months of short-term technical assistance in areas such as IEC, contraceptive logistics, municipality activities and family planning. Approximately $385,000 will be included in the contract for overseas participant training. The remaining funds in the institutional contract will cover home office costs, commodity fees, and a fee for managing the project's local account.

2. Procurement ($3.9 million)

A.I.D.-procurement will include the following items: oral rehydration salts, vehicles for the technical assistance team, and a local PSC project manager. Contractor procured commodities will include both local and off-shore commodities: medical equipment, vehicles for the GOS, gasoline, office furniture and equipment, household furniture and appliances for the long-term technical assistants, and IEC equipment.

3. Local Account ($4.285 million)

The local account will be managed by the institutional contractor and will finance the following activities: operational research, IEC activities, operational support to the Office of Family Planning, the Division of Statistics, the Decentralization Committee, supervision, local training, community based distribution, and municipality activities.

4. Buy-Ins ($3.3 million)

A total of seven buy-ins will be utilized to provide specialized services in clinic quality, management information systems, policy dialogue, commercial social marketing, curriculum strengthening and evaluation of curriculum.

5. Grants ($4.6 million)

Approximately $4.6 million will be provided to four institutions (Tulane University, Morehouse School of Medicine, ASBEF, and Africare to support family planning and training activities under the project. All of the proposals to be financed were received as unsolicited proposals and will be financed either as a grant or cooperative agreement.

6. Audits and Evaluations ($415,000)

A total of five non-federal audits of the local account will be financed under the project. Two evaluations will be financed; one in year 3 of the project and a final evaluation in year 5. In addition, funds will be included in each grant awarded to finance one audit during the life of the grant.

Approximately two percent of the total budget has been allocated to the contingency line item.

8. Contraceptives ($3.5 million)

Approximately $3.5 million of contraceptives will be procured in conjunction with this project through an OYB transfer to a central project (Central Contraceptives Procurement). This amount is not included in the LOP of this project, but should be considered an integral component thereof.

2. GOS Financed Inputs

During the PP design, a waiver to the 25% host country contribution requirement was requested from and granted by AID/W (Annex E). Nonetheless, the GOS contribution to the project is considerable. The in-kind contribution of its health personnel totals $4.5 million (see Annex I). In addition, the GOS will provide local currency equivalent to finance such things as salaries of support staff, vehicle maintenance, operating expenses (electric and telephone bills), educational materials, operating supplies (paper, registration forms, etc), equipment, mobylettes, motocycles, boats, and gasoline. Because of IMF-imposed expenditure ceilings, it is difficult for the GOS to assure that a given level of local currency will be made available in a given year. Nonetheless, over the life of the project, the project should receive a total of approximately $1.35 million in local currency from the GOS.

In addition, during the first two years of the project the GOS will analyse the recurrent costs associated with the Project which the GOS will be expected to begin assuming in years 3-5 of the project. The institutional contractor will make available short-term technical assistance to assist the GOS with this activity.

B. Methods of Implementation and Financing

TABLE 4

Methods of Implementation and Financing			
Element Description	Method of Implementation	Method of Financing	Approximate Amount $000
1. Instit'nal Contractor	AID Direct Contract	Direct Payment or LOC	10,000
2. Procurement - ORS - Vehicles (2) - Project Mger - Local Handling - Contraceptives	AID Direct Contract	Direct Payment	1,200
- Contractor Procured Equipment	Contractor	Direct Payment or LOC	2,700
3. Local Account	Contractor	Direct Payment	4,285
4. Buy-Ins	AID Buy-In Amendment	Direct Payment or LOC	3,300
5. Grants	AID Grant or Coop Agreement	Direct Payment or LOC	4,600
6. Audits and Evaluation	AID Direct Contract	Direct Payment	415
7. Contingency	NA	NA	500
8. Contraceptives (not contained in Authorization)	OYB Transfer to AID Central Project		3,500

All planned methods of implementation and financing are accepted methods and require no justification, with the exception of the Bank Letter of Commitment. This method, however, is justified for commodity procurement when a proliferation of invoices is anticipated and thus can be used in this project. All methods of implementation and financing are consistent with the general assessment performed

for USAID projects in Senegal. Host country contracting will not be used as a method of implementation and thus no assessment of the capabilities of the GOS is contained herein.

Sufficient audit coverage will be provided. As discussed in Section IV.B, funds have been budgeted for an annual audit of the central and regional local accounts. The U.S. technical assistance contract will be subject to audit coverage in the U.S. with no separate audit to be performed or funded in Senegal. For the three anticipated grants (Tulane/Morehouse Universities, Africare, and ASBEF), funds will be provided in the grants to have one audit performed.

Obligation Schedule

The following table shows project obligations by fiscal year for project activities. All project funds will be obligated by the end of fiscal year 1997.

TABLE 5

Obligation Schedule ($ 000's)		
	Project Budget	OYB Transfer (Contraceptives)
FY 1992	5,650	350
FY 1993	5,750	500
FY 1994	5,400	550
FY 1995	5,400	650
FY 1996	4,800	700
FY 1997	-	750
TOTAL	27,000	3,500

VII. EVALUATION AND MONITORING

A. Evaluation

This evaluation plan includes: surveys to estimate current levels of fertility and use of contraception; research on the proximate determinants of fertility; focused operations research; knowledge, attitude and practices studies (KAPs); focus groups, situation

analysis studies; an information system for regular reporting on new and current contraceptive users and flow of contraceptive commodities; and studies on the safety and acceptability of contraception. General progress toward attainment of project purpose will be gauged by the Demographic and Health Surveys (DHS) in 1992/93 and 1997 expected to be conducted by the GOS National Census Bureau (Bureau National de Recensement, BNR). In addition two overall evaluations of the SCS/FP Project will be conducted, one in 1995 and another towards the end of the project, in 1997.

The chief tool for measuring program impact on fertility and contraceptive usage will be the DHS. It must be noted that these surveys generally measure the overall impact of population activities and contraception use. However, with data available from the DHS and trend analyses, the general impact of USAID-finance activities will be analyzed. In particular, the impact of the ten USAID-supported regional referral centers and new approaches to service delivery will be evaluated. The DHS will provide regional level data so that USAID will be able to compare progress in its four target regions compared to the other six where only partial USAID support will be given. The ability to distinguish the impact of AID funded project activities from the impact of other donors will be possible through regular monitoring, site visits and through specially designed sample surveys.

BNR under the guidance of the National Family Planning Program (NFPP) will conduct two demographic and health surveys. The surveys will provide information on contraception knowledge, availability, use and family planning attitudes; fertility and fertility intentions. To ensure continuity and comparable longitudinal data, the upcoming survey will use the same sampling framework, and the same basic questionnaire and general procedures of the 1986 DHS. Refinements will of course be made to include key questions on CDD and knowledge of specific contraceptive methods. The sampling plan will be formulated in such a manner that the surveys will provide estimates of fertility and use of contraception. The Institute for Research Development (IRD) and the Family Health Survey Project (DHS) will provide technical assistance to the BNR for the conduct of the two surveys. Both of these activities will be funded through buy-ins. In addition, in 1995, two USAID supported KAP studies (one urban and one rural) will be conducted to further verify trends.

Two Situation Analysis studies will be initiated during project years 1 and 3. The first Situation Analysis will examine a sample of service delivery points in order to obtain baseline information on the functioning of key family planning subsystems including: logistics, equipment, supplies, facilities, staffing, training, supervision, IEC and record keeping. The Situation Analysis will obtain data on the quality of services provided in terms of: 1) Choice of contraceptive methods; 2) Client information exchange; 3) Competence; 4) Client/provides relations; 5) Mechanisms to encourage continuity of FP practice; 6) Constellation of services.

MOPHSA will be responsible for conducting the Situation Analysis with technical assistance from the Population Council in the areas of sampling, questionnaire design, interviewer training, date collection plan, analysis and reporting. Both Situation Analysis studies will employ the same methodology, management plan and schedule of activities. The results from the two studies will be compared to evaluate progress made and highlight areas for improvement during the remainder of the SCS/FP Project.

Special studies of the acceptability and safety of contraceptive methods will be undertaken by the Department of Obstetrics and Gynecology at Le Dantec Hospital. These will focus on ways to improve the acceptability of methods and help clarify any debates over methods. This work will be conducted in collaboration with the Family Health, International (FHI) and JHPIEGO.

As part of the development of the IEC program, functional research will be ongoing. Thus, the practices of a target group before an intervention will be ascertained and a post-intervention evaluation will take place to measure impact of the IEC intervention. This will be ongoing process in the development of IEC interventions.

The SCS/FP project evaluation schedule includes two in-depth project evaluations, one mid-term evaluation at the end of year three (1995) and a final project evaluation in year five (1997). The purpose of these evaluations will be to review overall progress, to determine the accomplishments or actions taken toward the attainment of project outputs and to identify and make recommendations for elimination of constraints to the achievement of established targets.

The mid-term evaluation will review each major component individually on a staggered basis and will then synthesize these results. The major components include: IEC, CDD, FP service delivery and management/supervision system development. All available survey data, survey reports and community studies will be compiled and analyzed. The interrelationships, constraints and any redundancies among the components will be analyzed. An attempt will be made to document the impact of the project and its various components on fertility, contraceptive use and family planning activities. If a particular component is identified as failing to attain objectives, project funds may be shifted to another component that is achieving better results.

The final evaluation will take place in November 1997. The USAID evaluations will be coordinated by the Population and Evaluation officers, with input from AID/W Population Officers. Outside experts may be hired to assist with the tasks outlined above: a public health physician, an information, education and communication specialist, a health management specialist, and a demographer and social science analyst. AID/W will also conduct routine evaluations of its centrally funded project activities.

B. Monitoring

All project activities, including those funded by AID/W grantees-contractors, will be monitored by USAID staff. Direct monitoring will be the responsibility of USAID HPNO. This office will be supported by the Project Development Office, the Program Office, the Office of Financial Management, the Contracts Office, and the Legal Advisor. The financial specialist provided by the institutional contractor will be responsible for monitoring local counterpart contributions and ensuring that these funds are made available.

Monitoring systems will be established for each project element to identify problems and provide needed information regarding progress toward attainment of project outputs. For example, statistics on the call forward of contraceptives will serve as a proxy for actual consumption. This information may then used to calculate couple year protection (CYP) in order to estimate program impact.

The central collation and computerized reporting of service records for primary health care and family planning is an ongoing activity of the Health Information System (HIS). Currently, data on family planning users from MOPHSA and some of the major NGO programs are collated at the SMI/PF Division. However, reporting is sporadic; no systematic follow-up exists, and data received is not analyzed. Under the proposed SCS/FP project, an improved reporting system for central and local managers should provide continuous up-to-date statistics on family planning users, and current contraceptive use. Program field staff will learn to translate demographic targets and measure program performance in terms of use of contraception among couples of reproductive age.

During the LOP, five non-federal audits of the local account will be made to determine that the GOS management unit, NGOs and other implementing organization are managing funds and activities in an acceptable manner.

VI. SPECIAL CONDITIONS AND COVENANTS

A. Conditions Precedent to Disbursement

Prior to the initial disbursement under the Grant, the Grantee shall, except as USAID may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D.:

evidence that the Cooperating Country has officially established the National Office of Family Planning and it is fully staffed with at least eleven (11) professional employees.

B. Covenants

The project grant agreement will also contain the following special covenants:

The Cooperating Country shall covenant that, unless A.I.D. otherwise agrees in writing:

(1) It will make family planning services available full time to regional referral centers;

(2) It will make the following permanent personnel assignments:

(a) two Health Education Service staff to work solely on family planning issues;

(b) one Regional MCH/FP Coordinator to work solely on training and supervision in each region;

(c) a Health Education Service staff member to work full time on family planning in each region;

(d) two GOS professionals to work full time on the Decentralization Committee;

(e) one GOS Chauffeur to work full time for the Decentralization Committee;

(f) one GOS Accountant to work full time in each of the four focus regions;

(g) two GOS Secretaries and two GOS Chauffeurs to work full time at the Office of Family Planning;

(h) for each regional family planning referral center:

(i) at least one midwife per 20 family planning clients per day to staff a family planning consultation room

(ii) at least one aide sociale

(iii) at least one aide infirmiere

(3) It will establish an advance account for the GOS local counterpart contribution and deposit at least $1,350,000 in local currency into the account over the life of

Project.

(4) It will analyse the recurrent cost implication of Project activities during the first two years of the project in order to determine how the GOS can begin to assume some of these costs in years 3-5 of the project.

(5) Obtain from the Ministry of Economy, Finance and Plan an Order that officially registers the Project in Senegal.

ANNEX A: LOGFRAME

Project name : Senegal Child Survival/FP
Est. Completion : 1992
Date of Revision:
Design Team :

Narrative Summary (NS)	Measureable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
Goal: 1 Reduce total fertility rate.	1.1 National total fertility rate decreased from 6.6 in 1986 to 6.0 in 1997.	1.1 National Census Data DHS	(Goal to Supergoal) 1.1 Use of family planning and ORT will improve child survival and reduce fertility. Increased political support for family planning in public and private sectors. Other donors, namely the World Bank and UNFPA will provide financial support to family planning program.
Purpose: 1 Increase the use and knowledge of modern contraceptives	1.1 Urban contraceptive prevalence (modern methods) increased from 6.7% in 1986 to 18% in 1997. Percentage of women knowledgable about modern contraceptive methods increased from 58.1% in 1986 to 90% in 1997. Percentage of men knowledgable about contraceptives increased from __* in 1993 to __* in 1997.	1.1 DHS KAP Service Statistics	(Purpose to Goal) 1.1 Men and women can be sensitized to perceive greater benefits than disadvantages to child spacing. An unmet demand for modern contraceptives exists. The GOS is willing and capable of developing and implementing policies and action plans.
Outputs: 1 Increased output of existing MCH/FP services.	1.1 Number of clients at Referral Centers (larger volume) increased from__* to ___.* Number of FP Acceptors in 4 focus regions increased from __* to _*.	1.1 GOS Statistics Supervision Reports	(Output to Purpose) 1.1 Women are willing to travel to attend high quality service clinics. 1.2 IEC activities will result in increased demand for FP Services.
2 Improved quality of MCH/FP services.	2.1 Full range of services and contraceptives available at Referal Centers and at health centers in AID-supported districts. 2.2 Increase %* of health providers correctly performing high risk	2.1 DHS KAP Supervision Reports MIS Reports 2.2 Periodic Surveys of Clinics. Supervision Reports	2.1 Health providers apply knowledge aquired through training. Health care supervisors willing to make supervisory visits when provided with the means. National, regional and distric plans implemented, monitored and evaluated.

* Benchmarks to be established after 1993 DHS.

	assessment of pregnancies.		
	2.3 90% of midwives and nurses in referral centers and four focus regions can prescribe contraceptives for a given profile and understand secondary effects.	2.3 Periodic Surveys of Clinics. Supervision Reports	
	2.4 75% of scheduled supervisory visits related to CDD and MCH/FP to regional level, referral centers, districts and health posts accomplished.	2.4 Supervision Reports	
	2.5 65 national and regional health managers trained in management and supervision.	2.5 Project Records.	
	2.6 Pilot Community Based Distribution and Contraceptive Social Marketing tests implemented and supportive policies approved by GOS.	2.6 Project Records.	
	2.7 Model Clinics established by SANFAM and ASBEF and functioning.	2.7 Project Records	
3 Increased knowledge about child spacing.	3.1 Knowledge of 3 benefits of child spacing increased from __ in 1993 to __* in 1997 for both men and women.	3.1 DHS KAP	3.1 IEC messages reach population and are understood.
4 Reduced child mortality due to diarrhea/dehydration.	4.1 Child mortality due to diarrhea/dehydration reduced from __ to __*.	4.1 GOS Statistics* *For a variety of reasons, it is almost impossible to isolate deaths due to dehydration and diarrhea. Therefore, the proxy indicators below will also be utilized.	4.1 ORS packets are available.
	4.2 Proper case management being practiced by 75% of health practitioners and --% of population in 4 target regions (i.e. use of ORS during latest episode of diarrhea, and ability to mix SSS correctly.		
5 Policy and service environment for the promotion and implementation of a national familly planning program created.	5.1 Pronatalist, regulatory, and legal policies re. FP reviewed and efforts undertaken to revise them. Family Planning issues discussed more frequently and effectively by political, trad'l and religious leaders.	5.1 GOS documents and published plans and decrees.	5.1 Significant opposition to family planning initiatives does not arise.

* Benchmarks to be established after 1993 DHS.

	Resources allocated to the FP Bureau are received and utilized by that bureau.		
Activities: 1.1 Establish 13 Family Planning Referal Centers and strengthen district FP services in 4 Regs. 1.2 Support Private Sector Model Clinics and ONG FP Service Delivery.	Inputs/Resources: AID $27 million DFA $3.5 million OYB Transfer: Contraceptives GOS $4.5 Million In-Kind Contribution $1.35 Million Local Counterpart Funds	1.1	(Activity to Output) 1.1 GOS meets AID and IBRD negotiated annual targets for health sector.
2.1 Train health care workers in contraceptive technology, counseling, and management. 2.2 Establish functional contraceptive logistics system. 2.3 Provide supervision to midwives and other clinic staff. 2.4 Provide necessary medical equipment at 13 regional and 16 district referral centers and continuing support to 6 FP clinics and 7 maternities (in four focus regions) 2.5 Establish effective FP/CDD Information System		2.1	2.1 Other donor complementary support to MCH/FP activities materialize as planned.
3.1 Media Campaigns/IEC materials develped 3.2 Study tours for leaders. 3.3 Provide IEC training to relevant health and social outreach personnel.		3.1	3.1
4.1 Establish ORT Units in 4 Regions 4.2 Provide CDD Training and IEC training to health personnel. 4.3 Provision of ORS		4.1	4.1
5.1 RAPID/OPTIONS Activities to sensitize leaders. 5.2 Studies and seminars to discuss and address constraints to FP posed by the policy and regulatory environment. 5.3 IEC activities to sensitize religious leaders.		5.1	5.1

Annex B: Statements of Work for Long-Term Technical Assistants

Family Planning Management Advisor 5 years
Senegal Child Survival/Family Planning Project

Scope of Work

The Family Planning Management Advisor will serve as team leader of a multidisciplinary team of five long-term and numerous short-term technical specialists. His/her duties will include the following:

1. Work as the principal counterpart of the Director of the National Family Planning Program within the Ministry of Public Health and Social Action;

2. Assist the Office of Family Planning in the development of implementation plans and indicators of operational effectiveness for the National Family Planning Program;

3. Coordinate in the inputs necessary for establishment of the Regional Referral Centers and District Referral Centers ensuring that facility renovation, equipment procurement, training and technical manuals production, training, service statistics and logistics systems are scheduled and implemented according to schedule;

4. Assist the Office of Family Planning to develop quality of care standards and supervisory protocols to ensure that full-time family planning services introduced at regional and district referral centers meets those standards;

5. Serve as the representative of the prime technical assistance contractor in Senegal and to be responsible all contract and subcontract inputs to the National Family Planning Program;

6. Coordinate and facilitate long-term and short-term technical Assistance to the National Family Planning Program provided under the contract, subcontracts, buy-ins to AID Cooperating Agencies and grants to non-governmental organizations;

7. Ensure the timely provision of such project inputs to the National Family Planning Program as consultant services, project commodities, operations research, studies, participant training and observation tour;

8. Coordinate the preparation of work plans by the technical advisors and consolidate activities planned across all project components into a single integrated project work plan;

9. Dialogue with the Ministry Technical Advisor for Population regarding policies and plans for social and community-based distribution of contraceptives;

10. Establish a computerized project management system across all project components for tracking the implementation of workplans and progress towards expected end of project status;

11. Maintain a computerized data base including key indicators of family planning and diarrheal disease performance;

12. Prepare all analyses, briefing papers and periodic reports required by the contract for submission to the Ministry of Public Health and Social Action and USAID/Senegal;

13. Monitor the performance of all expatriate personnel financed through the contract mechanism and take appropriate action to address noted shortcomings, after consultation with Ministry authorities, USAID and contractor home office staff;

14. Liaise frequently with USAID, the Ministry Technical Advisor for Population, the Director of the Office of Family Planning, SANAS, the Health Education Service, the Decentralization Committee, the Statistics Service, the GOS census organization, regional/district health authorities, municipalities, ASBEF, SANFAM, other U.S. and Senegalese PVOs, donors involved in Primary Health Care, and commercial firms involved in family planning activities;

15. Analyze the operational effectiveness of project-assisted family planning activities, to identify needs for operations research and to develop or cause to be developed proposals for consideration by USAID and Ministry;

16. Supervise two contract-funded Senegalese administrative assistants who handle general contract administration and manage training;

17. Manage communications with the contractor home office to ensure the timely procurement of project goods and services, placement of participant trainees and the organization of international observation tours; and

Qualifications:

This person will serve as the Chief of Party of a large multidisciplinary team of specialists working in many disparate activities in both the public and private sectors. The person selected must have previous experience as a team leader for a family planning activity and at least 10 years experience in the design, implementation and evaluation of family planning programs. He/she must have demonstrated interpersonal communication skills, keen analytical ability to identify constraints to operational effectiveness and the ability to produce clear written documents.

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It is strongly preferred that the individual selected have previous experience in designing and/or utilizing computerized project management and data base systems. Commercial software packages exist which can be adapted to meet the needs of the project. The person selected will be expected to work closely with USAID and MOPHSA to schedule, facilitate and coordinate all project inputs. Familiarity with both USAID and contractor procedures is required. French language proficiency at the FSI S-3, R-3 level is required. There is considerable flexibility in the academic background requirements. The successful candidate must possess a masters degree from one of a variety of academic backgrounds including graduate training in public health, the social sciences or a management discipline. The person's knowledge of, experience in and commitment to family planning is more important than type of degree.

Statement of Work

Contraceptive Logistics Specialist - 3 years

Background

The contraceptive logistics system in Senegal is very weak. Ruptures in stock at regional and district warehouses and clinics have become a common occurance throughout the country. The Ministry of Public Health and Social Action has requested that the Office of Family Planning take responsibility for establishing an effective contraceptive delivery system until the National Pharmacy (PNA) is able to supply contraceptives on a reliable basis. In order to establish a reliable and efficient system, the Office of Family Planning requires a technical specialist in contraceptive logistics to design a new system and to train personnel to implement it.

Scope of Work

1) Review the existing contraceptive delivery system. Based on this review, the technical expert should either modify the existing system or develop a new system that can ensure that contraceptives are ordered, distributed, stored and inventoried in an effective manner. The resulting system should be computerized so that program managers at the national, regional and district levels receive periodic reports indicating beginning stock levels, consumption during period, ending stock levels and stock on order.

2) Assure the delivery of contraceptives and ORS to regional warehouses and to the thirteen regional referral centers on a regular basis. Assisting SANAS to develop a computerized management system for ORS so that stock levels, consumption, ending stock, and stock on order can be monitored.

3) Train personnel at the national and regional level and at referral centers to keep inventories of their stocks of contraceptives and ORS and to reorder at the appropriate times. Train appropriate district personnel in four target regions.

4) Ensure that the logistics unit and SANAS receives all necessary information from the regions at the appropriate time. The contraceptives reporting form should include information on the number of new acceptors to the program, continuing users, and the type and quantity of contraceptives used. The ORS reporting form should include the number of ORS per diarrhea episode. The logistics specialist should also assess the conformity of contraceptive logistics data with the Health Information System. The logistics expert will also develop a manual on

contraceptive logistics reporting to be used by clinic personnel.

6) Review periodically the status of contraceptives (stocks and expiration date).

7) Issue quarterly status reports.

8) Perform semi-annual book/physical inventory reconciliation.

9) Manage the central inventory of contraceptives at the PNA.

10) Provide on the job training for persons within the Logistics Unit of the Office of Family Planning. Prepare a manual on the computerized logistics system and its operation.

11) Develop a logistics management training plan by identifying training needed either in-country or overseas for logistic personnel.

12) Provide periodic assessments on the progress of PNA in building its capacity to take on the responsibility for contraceptive and ORS logistics.

13) Prepare contraceptive ordering tables to be utilized by USAID for annual contraceptive deliveries.

Qualifications

The logistics technical expert should have at a minimum, five years of overseas experience in developing and implementing logistic/distribution systems associated with health programs. Experience with contraceptive logistics is highly desirable. Practical experience in developing a national logistics system and training staff in how to operate the system is more important than academic qualifications. The proposed candidate should have the requisite experience to establish the computer programs and necessary data forms. A bachelor's degree is required. Military logistics experience may be helpful. French at FSI S-3/R-3 is required, English proficiency at level IV.

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International IEC Advisor - 5 years

Senegal Child Survival and Family Planning Project

Scope of Work

The International IEC Advisor will be placed as a counterpart to the head of the IEC Unit within the Office of Family Planning (1) to advise and provide in-service training to members of the IEC Unit and to the Health Education Service in the following areas:

1. Develop family planning messages about (a) each contraceptive method, its advantages, disadvantages, contra-indications, and instructions for use; (b) information about how family planning can contribute to family health, welfare, and economic improvement; and (c) where individual methods are available. The Health Education Service (EPS), in collaboration with the IEC Unit and the IEC Advisor, will transform these suggested media messages into actual radio and television spots and programs, etc. The technical expert will also be responsible for developing a booklet with recommended mass media interventions for radio, television, and print materials.

2. Develop a research agenda including quantitative and qualitative research. Assist in the idenfication, design and development of KAP research needed. This research will complement those studies already carried out concerning contraceptive preferences, male and female attitudes towards family planning, reasons for non-adoption of planning, etc. The Advisor will also assist SANAS in identifying and developing KAP activities related to CDD. The results of the KAP research will be analyzed and translated into work plans.

3. Develop a Family Planning-IEC Strategy in Collaboration with the Office of Family Planning's IEC Unit including segmentation of target groups, specification of objectives,and identification of messages and research needed.

4. Develop management and supervision models for IEC to be used by individual regions in the planning and execution of their family planning IEC programs. Train regional officials in the application of these management models and undertake supervisory visits to ensure adherence to the norms.

5. Design a model monitoring and evaluation program. The IEC Advisor in collaboration with his/her counterparts will design and implement an evaluation for IEC activities.

6. Assist in the monitoring and supervision of IEC activities at the central and regional levels.

7. Assist in the design, implementation, monitoring and revision of the Office of Family Planning/IEC Unit's annual workplans.

a/6

8. Develop an IEC training plan and design training courses and materials in family planning IEC for relevant personnel. This will include the development of an IEC Program Manual which should be developed in collaboration with the IEC Unit and the Health Education Service.

   This manual should describe: 1) Technical messages; 2) Educational strategies; 3) Techniques of group discussions and interpersonal communication; 4) Work planning and management; 5) Supervision; and 6) Training.

Qualifications

The IEC Expert should be a senior consultant with proven ability in all aspects of IEC. For example, the Expert must understand the relationships among research, message development, creative design, and communications techniques. While the Expert need not have detailed or extensive experience in all aspects of IEC, he/she should be familiar enough with the technical aspects of training, media production, research design, etc. to be able to offer critical advice and review.

His/her professional strength should be in the area of communications planning and strategy development. The Expert should be experienced in program management, i.e. The financial, institutional, and management structures needed to assure program performance.

The Expert should have at least 10 years experience (preferably more) in IEC, with the largest proportion of work done in family planning in francophone West Africa. A Masters in Public Health or related field is required.

The Expert must have experience with public sector programs and have an appreciation for the bureaucratic, administrative, financial, and political constraints which define them. French at FSI S-3/R-3 is required, English proficiency at level IV.

Statement of Work

Health Planner - 5 years

Background The Ministry of Health and Social Action is in the process of decentralizing its health system and establishing a Bureau for Family Planning. To assist the Ministry with both of these activities, the project will provide a health planner for a total of three years.

Scope of Work

1. Provide technical assistance and on-the-job training to the Ministry of Health and Social Action at the central and regional level in the implementation, monitoring, and revisions to the system of decentralized planning;

2. Assist the Comite de Suivi in scheduling training provided by ISED in the areas of management and supervision.

3. Work with relevant MOPHSA offices to develop a manual which describes a model regional health plan and a model MCH/FP health plan. This manual should instruct regional teams on how to adapt the model to their particular regions.

4. Coordinate studies related to health care financing issues.

5. Facilitate the integration of the health information system into the health planning process by coordinating activities between the Division of Statistics and the Comite de Suivi.

6. Develop a general supervision protocol to be utilized by supervisory teams.

7. Provide technical assistance to the Office of Family Planning and the Division of Maternal Child Health/Family Planning (MCH/FP) in the development, implementation, monitoring and revision of annual work plans.

8. Assist the Ministry in defining roles and responsibilities in referral centers and in developing projections of personnel needed to staff them.

QUALIFICATIONS

The long-term technical expert should have an extensive background in the

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organization and management of public and private comprehensive health care delivery systems. In addition, the TA must have had at least five years experience in the planning, implementation and evaluation of MCH/FP programs in a developing country. MPH or Master's degree in health services management and/or health planning is required. Specialized Training in family planning/population desirable. Experience in managing third world health programs, preferably in Africa, is essential, as is familiarity with USAID procedures. The ability to work effectively in a collaborative fashion with MOH staff is essential. French at FSI S-3/R-3 is required, English proficiency at level IV.

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Financial Management Specialist - 3 years

Statement of Work

Background

Local currency funds will be required to be disbursed under the project for central level, regional, district, and municipal activities. At the central level, a Management Unit will be established in the Office of Family Planning. As it is a new entity, there are no financial, internal control, procurement, or inventory systems in place. These systems will need to be designed and installed and GOS personnel trained in the use of the system. To the extent possible, any systems designed should be compatible with the GOS accounting system. For regional activities, past experience under A.I.D. projects has shown that local accounts were not adequately handled and oversight by USAID was too cumbersome and time-consuming.

USAID is unable to give funds directly to the GOS unless their financial management systems are adequate. Therefore during the first three years of the project the financial management specialist will be responsible for financial controls and for developing financial accounting and reporting systems that will be managed by the GOS by the end of the third year of the project.

Scope of Work

The specific responsibilities of the financial management specialist will be to:

1. Design a financial management system for local currency disbursements to be made at the central level. This system will include accounting, internal control, procurement, inventory (for both expendable and non-expendable property) and reporting systems.

2. Install a financial management system within the Office of Family Planning Management Unit.

3. Train GOS accounting personnel in the operation of the financial management system through specific training programs, on-the-job training, and supervision of their daily work.

4. Manage all funds to be disbursed at the central level through oversight and approval authority over all transactions, including ordering, payment approval, and check signing authority.

5. Take appropriate steps to install and implement the system, and train GOS personnel to enable the GOS to take over complete management of the system after three years.

6. Work with the four focus regions to strengthen regional accounting systems. In addition, make advances to regions as appropriate and review and approve justifications of advances submitted from regions and districts.

7. Manage funds for municipal activities using the same procedures, set up in the central level financial management system. In addition, the financial specialist should set up an inventory accounting system in project supported municipalities to account for nonexpendable and expendable property purchased through the USAID account.

8. Coordinate all audits of the USAID financial management systems at the central, regional, and district levels.

9. Provide project financial reports in a timely and accurate manner.

Qualifications

Bachelor's degree in accounting with M.B.A. or C.P.A. preferred. Five years overseas experience in designing and implementing financial management systems. Three years' experience in training in financial management systems. French at FSI S-3/R-3 is required, English proficiency at level IV.

INITIAL ENVIRONMENTAL EXAMINATION
or
CATEGORICAL EXCLUSION

PROJECT COUNTRY: Senegal

PROJECT TITLE AND NO.: Senegal Child Survival/Family Planning (SCS/FP) (685-0284)

FUNDING: FY(s) 1992-97 US$ 28 million

IEE PREPARED BY: Lisa Franchett, Project Development Officer USAID/Senegal; Bill Thomas, AID/AFR/ARTS/FARA

ENVIRONMENTAL ACTION RECOMMENDED:

Positive Determination	
Negative Determination	X
Categorical Exclusion	
Deferral	

SUMMARY OF FINDINGS:
A project involving family planing and population orientated activities are normally eligible for a categorical exclusion under 22 CFR 216.2(C)(2)(viii), which excludes: "programs involving nutrition, health care, or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction, etc...)". Since this project does involve some construction, it is not eligible for this categorical exclusion. However, due to the fact that the construction activities to be undertaken with project funds will be minimal, and that all possible negative effects of the renovation or limited construction work have been studied, and reviews of the subject activity reveal no probable adverse environmental impact, a negative determination is requested. Furthermore, since the project will not have a significant adverse effect on the environment, and the planned construction activities will be minimal, it is eligible and recommended for a negative determination.

CONCURRENCE:
This IEE has been reviewed for clearance by the Regional Legal Advisor (RLA). It has also been cleared by the Mission Environmental Officer (MEO).

INITIAL ENVIRONMENTAL EXAMINATION

I. PROJECT DESCRIPTION

The Senegal Child Survival/Family Planning Project (SCS/FP) (685-0286) is a five year, $28 million project designed to increase the use of contraceptives in Senegal. The project will have three major components: (1) increasing the demand for contraceptives and maternal child health services; (2) increasing access to MCH/Family Planning Services; and (3) improving the quality of MCH/Family Planning Services.

Under the first component, health care workers will be provided training in Family Planning Methods. They also will be trained to control diarrheal disease using ORT. Information, Education and Communication (IEC) activities will be undertaken to educate the public about both the benefits of family planning and ORT.

Under the second component, the project will provide existing clinics with the equipment and commodities to provide family planning services. If renovation of a room is needed, such as adding a wall, painting or putting on a door to provide privacy, project financing will be made available. Although not planned for at present, limited construction on new clinics may be considered during the second half of the project if a need is demonstrated. However, given the small amount of funding available for renovation and construction ($715, 000) and the large number of renovations envisaged, any new construction carried out will be of a limited nature and closely monitored.

Under the third component, the quality of MCH/Family Planning Services will be improved by training health care workers and supervisors in areas such as counseling skills and better intake procedures. Supervisors will receive intensive training in management and supervision.

II. ENVIRONMENTAL IMPACT

The only potential environmental impact that could be generated by this product originates from renovations and the possible construction of Family Planning Service delivery sites. The total surface area likely to be affected at any given renovation site would not exceed two hectares. Since the majority of renovations will consist of adding a wall to create privacy in a large room or constructing a door frame, the environmental impact of such activities would be minimal. If any construction is financed, it is unlikely to occur on more than three sites. The total surface area affected by such construction would not exceed 6 hectares. In summary, any effect the planned renovation or construction activities would have on the environment is negligible.

In fact, achievement of the Project's objectives will have positive impact on the environment due to a reduction in

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population/pressure on Senegal's scarce resources. The proposed clinic renovations will enable clinics to provide family planning services to a larger number of women thereby increasing the use of contraceptives in Senegal. Since the construction activities in this project will be minimal and with negligible environmental impact, this project should qualify for a negative determination.

III. RECOMMENDED ENVIRONMENTAL ACTION

As discussed above, family planing project activities are normally eligible for a categorical exclusion under 22 CFR 216.2(C)(2)(viii), however, because minimal construction activities will be undertaken, a negative determination is requested. The above review of impacts indicates that the activities of this project are eligible and recommended for a negative determination.

Bureau Environmental Officer: for
John J. Gaudet, AFR/TR/ANR

APPROVED: X
DISAPPROVED: _____
DATE: _____

CLEARANCE:

GC/AFR: _____ DATE: 12/2/91

APPR: BS {BS}
DRAFT: WT {WT}
CLEAR: JG {JG}
CLEAR: PJ {PJ}
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UNCLASSIFIED

AID/AFR/ARTS/FARA:WTHOMAS:WT53DAKA
10/31/91 703 235-3837
AID/AFR/ARTS/FARA:BSTONER

AID/ARTS/FARA:JGAUDET
AID/AFR/SWA:JROYER {DRAFT}
AID/GC/AFR:PJOHNSON

ROUTINE DAKAR

ROUTINE ABIDJAN

AIDAC

E.O. 12356: N/A

TAGS:

SUBJECT: IEE FOR SENEGAL CHILD SURVIVAL/FAMILY PLANNING {SCS/FP} {685-0286}

REF: {A} DAKAR 11513, {B} DAKAR 12661

1. PER REF A, BUREAU ENVIRONMENTAL OFFICER CONCURS WITH IEE NEGATIVE DETERMINATION FOR SUBJECT PROJECT. SIGNED IEE WILL BE POUCHED TO MISSION.

2. CORRECT SPELLING OF AFRICA BUREAU ENVIRONMENTAL OFFICER'S NAME IS JOHN J. GAUDET {TELEPHONE 202 647-7016}. HE IS LOCATED IN THE AFR/ARTS/FARA OFFICE. PLEASE PASS THIS INFORMATION TO MISSION ENVIRONMENTAL OFFICER. YY

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SC/ads

ANNEX D - GOS Letter of Request

REPUBLIQUE DU SENEGAL
Un Peuple - Un But - Une Foi

MINISTERE DE L'ECONOMIE
DES FINANCES ET DU PLAN

DIRECTION GENERALE
DU BUDGET ET DE L'ASSISTANCE
AU DEVELOPPEMENT

DIRECTION DE LA COOPERATION
ECONOMIQUE ET TECHNIQUE

N° - - 9 3 6 MEFP/DGBAD/DCET

Dakar, le 10 JUIN 1992

OFFICIAL FILE COPY

Le Ministre,

Date Rec'd 11 JUIN 1992
MIN No 2633
Action Taken To be assigned to
Date 11 Juin 92
Signature Mbengue

OBJET / Requête pour le financement du projet Survie de l'Enfant/Planification Familiale.

Monsieur le Directeur,

07

DUE
ACTION
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EMB
CHRON
RF

Le Gouvernement de la République du Sénégal sollicite, par la présente lettre, du Gouvernement des Etats-Unis d'Amérique, des fonds d'un montant de trente millions cinq cent mille (30.500.000) $ US pour le financement du Projet Survie de l'Enfant / Planification Familiale.

Les activités devant faire l'objet de soutien dans le cadre du projet ont été groupées en trois catégories :

- les activités visant à améliorer la qualité des services ;
- les activités visant à accroître l'accès aux services de planning familial ;
- celles visant à augmenter la demande de services de planning familial.

Le coût total du projet est estimé à 36,2 millions de $ US.

.../...

Monsieur le Directeur
de l'USAID

-=- DAKAR -=-

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L'USAID contribuera pour environ 27 millions de $ US pour le projet plus 3,5 millions de dollars de contraceptifs.

Le Gouvernement Sénégalais contribuera pour environ 4,5 millions de dollars en nature et environ 1,35 million de dollars en monnaie locale.

Les recettes tirées de la vente des préservatifs et des contraceptifs serviront au financement partiel des activités de planification familiale.

Veuillez croire, Monsieur le Directeur, à l'assurance de ma considération distinguée.

Le Ministre
de l'Economie, des Finances
et du Plan

Famara Ibrahima SAGNA

ACTION MEMORANDUM FOR THE DEPUTY ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: AFR/SWA, Timothy Bork

SUBJECT: Senegal Child Survival/Family Planning Project (685-0285) - Waiver

Cooperating Country:	Senegal
Project:	Senegal Population and Child Survival 685-0285
Source of Funding:	DFA
Life of Project:	1992-1996
Total Bilateral Project Funds	$20.0 million
Host Country Contribution:	$ 4.5 million

I. Problem: Your approval is requested to waive the requirement established under Section 110 of the Foreign Assistance Act of 1961, as amended ("FAA"), that the host country provide a minimum of 25 percent of project costs. A.I.D. will provide $20.0 million through the proposed Senegal Population and Child Survival Project. Compliance with Section 110 would require the Government of Senegal (GOS) to provide $6,125,000 of the $24.5 million cost of the bilateral project. (The bilateral project activities will be complemented by a $3.5 million OYB transfer to R&D/POP for central procurement of contraceptives. The Section 110 Host Country Contribution requirement, however, does not apply to such assistance.) Given current budgetary constraints, the GOS is not in a position to make such a commitment. FAA Section 124(d) provides authority to approve a waiver of the host country contribution requirement on a case-by-case basis. The case for such a waiver is outlined below.

II. Background: The Senegal Mission has finalized a Project Identification Document for the Senegal Child Survival/Family Planning Project, a five-year, $24.5 million project that is intended to increase the use of contraceptives in Senegal and

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purpose by increasing the number of maternal and child health/family planning service sites in urban areas (population centers of 10,000 or more). A relatively strong demand for family planning services already exists in these areas. In rural areas, the project will increase the demand for family planning services by sensitizing people to the benefits of child spacing. Lastly, since it has been shown that the demand for family planning is related to infant mortality, the project will attempt to reduce the infant mortality rate by controlling diarrheal diseases and training health care providers in the treatment of other childhood diseases.

The FAA Section 110 requirement that Senegal provide a minimum of 25 percent of total project costs could seriously jeopardize the project's execution. Although the GOS will be making a significant in-kind contribution to the project (approximately $4.5 million), the GOS is not in a position to meet the entire 25% host country contribution requirement. In FY 1990, Senegal's budget deficit was approximately $225 million. A greater deficit was avoided only through drastic cuts in government services. Increased expenditures by the Ministry of Public Health and Social Action are unlikely. Recent expenditure ceilings calculated by the International Monetary Fund call for an 8.5 percent reduction in total government expenditures in 1991 and an additional 3 percent reduction in 1992.

The Mission believes it is appropriate to waive the FAA Section 110 requirement in light of GOS financial constraints. A.I.D. Handbook 3, Chapter 2, Appendix 2G, Section E.2B states that "it seems reasonable to conclude that the granting of a waiver is permissible whenever the initiation and execution of an otherwise desirable project is handicapped primarily by the 25 percent contribution requirement."

Section E.2.B also states that an acceptable starting point for determining whether a country can be considered for a waiver is whether, inter alia, the country appears on the Development Assistance Committee's (DAC) list of "Low Income Countries." Senegal is on the most recently issued DAC list of Low Income Countries.

Another consideration affecting the appropriateness of a waiver is the country's demonstrated commitment to the project. The GOS commitment to establishing a family planning and maternal and child health program is demonstrated by its adoption of the National Family Planning Program which was signed by the

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President on March 15, 1991. Among other goals, the National Family Planning Program seeks to increase the contraceptive coverage rate from an Estimated 10.4 percent in 1991 to 22.2 percent by 2000 and to effect a 50 percent reduction in unwanted pregnancies.

The total GOS in-kind contribution to the project will be approximately $900,000 per year. This consists of salaries for approximately 300 person years per annum of doctors, medical officers, nurse-midwives, nurses, and headquarters staff who will be directly associated with this project. This level of support is expected for each of the five years of the project. The $4.5 million contribution is significant, especially in light of the severe fiscal restraints placed on the GOS, but at 16 percent of the total life-of-project cost it does not meet the FAA Section 110 requirement. However, it does demonstrate GOS interest in and commitment to implementing a family planning program and to this project.

III. Authority: A waiver of the country contribution requirement is permitted under the provisions of FAA Section 124(d). The authority to exercise the waiver has been delegated by the Administrator to, inter alia, the Assistant Administrator for Africa in A.I.D. Delegation of Authority No. 403.

IV. Recommendation: That you waive the FAA Section 110 requirement that the Government of Senegal make a host country contribution of a minimum of 25 percent of the total cost of the Senegal Child Survival/Family Planning Project.

Approve: [signature]

Disapprove: _____

Date: 2/6/92

Clearance:

AFR/SWA:RDay Draft _____ Date: 1/24/92
AFR/SWA:JGilmore [signature] Date: 2/3/92
GC/AFR:PJohnson [signature] Date: 27 Jan 92
DAA/AFR: JHicks [signature] Date: 2/6/92

TOTAL P.04
Credit Union League - Irish League

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ANNEX F

STATUATORY CHECKLIST

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to the eligibility of countries to receive the following categories of assistance: (A) both Development Assistance and Economic Support Funds; (B) Development Assistance funds only; or (C) Economic Support Funds only.

A. COUNTRY ELIGIBILITY CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND ASSISTANCE

1. **Narcotics**

a. **Negative certification** (FY 1991 Appropriations Act Sec. 559(b)): Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? NO

b. **Positive certification** (FAA Sec. 481(h)). (This provision applies to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct N/A

source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

(1) does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement?

(2) has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (b) the vital national interests of the United States require the provision of such assistance?

c. **Government Policy** (1986 Anti-Drug Abuse Act of 1986 Sec. 2013(b)) (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to Congress

N/A

listing such country as one: (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

2. **Indebtedness to U.S. citizens** (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity? NO

3. **Seizure of U.S. Property** (FAA Sec. 620(e)(1)): If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? NO

4. **Communist countries** (FAA Secs. 620(a), 620(f), 620D; FY 1991 Appropriations Act Secs. 512, 545): Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by NO

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the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan? NO

5. **Mob Action** (FAA Sec. 620(j)): Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? NO

6. **OPIC Investment Guaranty** (FAA Sec. 620(l)): Has the country failed to enter into an investment guaranty agreement with OPIC? NO

7. **Seizure of U.S. Fishing Vessels** (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5): (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made? NO

8. **Loan Default** (FAA Sec. 620(q); FY 1991 Appropriations Act Sec. 518 (Brooke Amendment)): (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds?

(a) NO

(b) NO

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9. **Military Equipment** (FAA Sec. 620(s)): If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

The Project does not involve a loan or ESF funds.

10. **Diplomatic Relations with U.S.** (FAA Sec. 620(t)): Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

NO

11. **U.N. Obligations** (FAA Sec. 620(u)): What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

Senegal is not in arrears.

12. **International Terrorism**

a. **Sanctuary and support** (FY 1991 Appropriations Act Sec. 556; FAA Sec. 620A): Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons?

NO

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b. **Airport Security** (ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? NO

13. **Discrimination** (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? NO

14. **Nuclear Technology** (FAA Secs. 669, 670): Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.) NO

15. **Algiers Meeting** (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)

Yes. Senegal "reserved orally". Such has been taken into account in the Administrator's "Taking Into Considerati memorandum.

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16. **Military Coup** (FY 1991 Appropriations Act Sec. 513): Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance? NO

17. **Refugee Cooperation** (FY 1991 Appropriations Act Sec. 539): Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin? NO

18. **Exploitation of Children** (FY 1991 Appropriations Act Sec. 599D, amending FAA Sec. 116): Does the recipient government fail to take appropriate and adequate measures, within its means, to protect children from exploitation, abuse or forced conscription into military or paramilitary services? NO

B. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")

1. **Human Rights Violations** (FAA Sec. 116): Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? NO

2. **Abortions** (FY 1991 Appropriations Act Sec. 535): Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary NO

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sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

C. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO ECONOMIC SUPPORT FUNDS ("ESF")

Human Rights Violations (FAA Sec. 502B): Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest? NO

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. **Host Country Development Efforts** (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

(a) N/A

(b) The Project will encourage private sector to become more involved in the provision of family planning services.

(c) N/A

(d) N/A

(e) N/A

(f) N/A

2. **U.S. Private Trade and Investment** (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

The Project will not foster private trade, but it will foster U.S. participation in foreign assistance programs through a grant to a U.S. PVO and a contract with a U.S. private entity for long/short term technical assistance.

3. **Congressional Notification**

a. **General requirement** (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)?

Yes. A Congressional Notification has been sent to Congress.

b. **Notice of new account obligation** (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. **Cash transfers and nonproject sector assistance** (FY 1991 Appropriations Act Sec. 575(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic poolicy reforms to be promoted?

This is project assistance.

4. **Engineering and Financial Plans** (FAA Sec. 611(a)): Prior to an obligation in excess of $500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) YES

(b) YES

5. **Legislative Action** (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action

NO

will be completed in time to permit orderly accomplishment of the purpose of the assistance?

6. **Water Resources** (FAA Sec. 611(b); FY 1991 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

This is not a water or water-related project.

7. **Cash Transfer and Sector Assistance** (FY 1991 Appropriations Act Sec. 575(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?

N/A

8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

This is not a capital assistance project.

9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

(a) N/A
(b) N/A
(c) N/A
(d) No impact is expected in this area.
(e) N/A
(f) N/A

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10. **U.S. Private Trade** (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

N/A

11. **Local Currencies**

a. **Recipient Contributions** (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

The GOS will contribute $1.35 million in local currency.

b. **U.S.-Owned Currency** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

U.S. does not own excess foreign currency.

c. **Separate Account** (FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

N/A

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(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government? N/A

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes? N/A

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government? N/A

12. **Trade Restrictions**

a. **Surplus Commodities** (FY 1991 Appropriations Act Sec. 521(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A

b. **Textiles (Lautenberg Amendment)** (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of NO

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textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

13. **Tropical Forests** (FY 1991 Appropriations Act Sec. 533(c)(3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

(a) NO

(b) NO

14. **PVO Assistance**

a. **Auditing and registration** (FY 1991 Appropriations Act Sec. 537): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

YES

b. **Funding sources** (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

YES

15. **Project Agreement Documentation** (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

Project agreement will be cabled to State LT and AID Leg.

16. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Yes. As much as is feasible.

17. **Women in Development** (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

Most Project activities are focussed on women.

18. **Regional and Multilateral Assistance** (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

NO

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19. **Abortions** (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? NO

b. Will any funds be used to lobby for abortion? NO

20. **Cooperatives** (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life? NO

21. **U.S.-Owned Foreign Currencies**

a. **Use of currencies** (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. The U.S. does not own any foreign currencies.

b. **Release of currencies** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? NO

22. **Procurement**

a. **Small business** (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Yes. Grants will be given to U.S. PVOs. A large technical assistar contract will be awarded with a U.S. institution.

b. **U.S. procurement** (FAA Sec. 604(a)): Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him? YES

c. **Marine insurance** (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

Senegal does not discriminate against marine insurance companies.

d. **Non-U.S. agricultural procurement** (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

N/A

e. **Construction or engineering services** (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

NO

f. **Cargo preference shipping** (FAA Sec. 603)): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

NO

g. **Technical assistance** (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the

YES

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facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

NO

h. U.S. air carriers (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

YES

i. Termination for convenience of U.S. Government (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

All contracts for procurement will contain a termination for convenience clause.

j. Consulting services (FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

YES

k. Metric conversion (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest

Yes, to the extent practicable.

documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

1. **Competitive Selection Procedures** (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? — YES

23. **Construction**

a. **Capital project** (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? — This is not a capital project.

b. **Construction contract** (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? — No construction is contemplated under the Project.

c. **Large projects, Congressional approval** (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? — N/A

24. **U.S. Audit Rights** (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? — N/A

25. **Communist Assistance** (FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? — YES

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26. **Narcotics**

a. **Cash reimbursements** (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? YES

b. **Assistance to narcotics traffickers** (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? YES

27. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? YES

28. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? YES

29. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? YES

30. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? YES

31. **Military Personnel** (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? YES

32. **Payment of U.N. Assessments** (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? YES

33. **Multilateral Organization Lending** (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? YES

34. **Export of Nuclear Resources** (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? YES

35. **Repression of Population** (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? YES

36. **Publicity or Propoganda** (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? NO

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37. **Marine Insurance** (FY 1991 Appropriations Act Sec. 563): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? YES

38. **Exchange for Prohibited Act** (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? NO

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. **Agricultural Exports (Bumpers Amendment)** (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers? N/A

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2. **Tied Aid Credits** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?	NO
3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	N/A
4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.	Project will strengthen the capacities of the health personnel in-country to plan and deliver family planning services.
5. **Economic Development** (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	Yes. A reduction in the population growth rate will increase the sustaining of economic growth.
6. **Special Development Emphases** (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries	(a) N/A (b) N/A (c) Project will work with PVOs. (d) N/A (e) N/A

and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

7. **Recipient Country Contribution** (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

A waiver of host country contribution has been approved by AA/AFR.

8. **Benefit to Poor Majority** (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Project will support decentralization activities which are intended to provide local populations with a greater role in health programs.

9. **Abortions** (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

NO

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

NO

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

NO

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? YES

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? NO

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? NO

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? NO

10. **Contract Awards** (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? YES

11. **Disadvantaged Enterprises** (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? Approximately 10% will be reserved for contracts or grants with disadvantaged enterprises

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12. **Biological Diversity** (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? N/A

13. **Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)): N/A

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions

which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. **Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded

N/A

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forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry? N/A

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment? N/A

14. **Energy** (FY 1991 Appropriations Act Sec. 533(c)): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases? N/A

15. **Sub-Saharan Africa Assistance** (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)): If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage

(a) N/A

(b) N/A

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private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) to be provided in a manner that takes into account, during the planning process, the local-level perspectives of the rural and urban poor, including women, through close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) to be implemented in a manner that requires local people, including women, to be closely consulted and involved, if the assistance has a local focus; (e) being used primarily to promote reform of critical sectoral economic policies, or to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities; and (f) to be provided in a manner that, if policy reforms are to be effected, contains provisions to protect vulnerable groups and the environment from possible negative consequences of the reforms?

(c) Yes. Project utilizes PVOs in project implementation.

(d) Yes. The Project specifically targets women.

(e) Yes. Voluntary family planning services are key to this Project.

(f) N/A

16. **Debt-for-Nature Exchange** (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

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17. **Deobligation/Reobligation** (FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? N/A

18. **Loans**

a. **Repayment capacity** (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. N/A

b. **Long-range plans** (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities? N/A

c. **Interest rate** (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? N/A

d. **Exports to United States** (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest? N/A

19. **Development Objectives** (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from N/A

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cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

2) N/A

3) Project will work with PVOs including two local PVOs.

4) N/A

5) Project provides funds for regional study tours.

20. **Agriculture, Rural Development and Nutrition,** and **Agricultural Research** (FAA Secs. 103 and 103A):

a. **Rural poor and small farmers:** If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

N/A

b. **Nutrition:** Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

Training in nutrition will be financed under the Project.

c. **Food security:** Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A

21. **Population and Health** (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

Project aims to integrate maternal and child health services with family planning. Project also promotes community-based distribution.

22. **Education and Human Resources Development** (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

23. **Energy, Private Voluntary Organizations, and Selected Development Activities** (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

N/A

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;	N/A
b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;	Project utilizes U.S. and local PVOs in the implementation phase.
c. research into, and evaluation of, economic development processes and techniques;	N/A
d. reconstruction after natural or manmade disaster and programs of disaster preparedness;	N/A
e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;	N/A
f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.	N/A

C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

1. **Economic and Political Stability** (FAA Sec. 531(a)): Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? N/A

2. **Military Purposes** (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes? N/A

3. **Commodity Grants/Separate Accounts** (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? (For FY 1991, this provision is superseded by the separate account requirements of FY 1991 Appropriations Act Sec. 575(a), see Sec. 575(a)(5).) N/A

4. **Generation and Use of Local Currencies** (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? (For FY 1991, this provision is superseded by the separate account requirements of FY 1991 Appropriations Act Sec. 575(a), see Sec. 575(a)(5).) N/A

5. **Cash Transfer Requirements** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 575(b)). If assistance is in the form of a cash transfer: N/A

a. **Separate account:** Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds? N/A

b. **Local currencies:** Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements? N/A

c. **U.S. Government use of local currencies:** Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available? N/A

d. **Congressional notice:** Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance? N/A

DRAFTER:GC/LP:EHonnold:5/17/91:2169J

ANNEX G

Senegal Child Survival/Family Planning Project
(685-0286)

PROJECT BUDGET	YR 1	YR 2	YR 3	YR 4	YR 5	TOTAL
INSTITUTIONAL CONTRACTOR						
Personnel Costs						
COP 5 yrs	360,952	347,190	353,852	379,140	425,742	1,866,875
Fin Mgmt 3 yrs	311,407	286,318	330,729	0	0	928,454
Logistician 3 yrs	281,924	255,360	298,223	0	0	835,508
IEC Specialist 3 yrs	296,666	279,689	319,476	304,342	347,204	1,547,376
Health Planner 3 yrs	344,814	330,245	372,560	359,993	405,637	1,813,249
Total Personnel Costs	1,595,764	1,498,802	1,674,840	1,043,474	1,178,583	6,991,462
Short-Term TA	28,000	29,000	25,000	40,000	40,000	162,000
Home Office Costs	132,354	138,972	145,920	153,216	160,877	731,339
Overseas Training	79,000	115,000	86,000	63,000	40,000	383,000
G&A (10%)	183,512	178,177	193,176	129,969	141,946	826,780
Fixed Fee (7%)	141,304	137,197	148,746	100,076	109,298	636,621
Commodity Fee (6.5%)	89,029	89,029	0	0	0	178,059
Local Acct Fee (3.5%)	23,752	32,558	38,966	0	0	95,275
TOTAL INST CONTRACTOR	2,272,715	2,218,735	2,312,647	1,529,735	1,670,704	10,004,536
GRANTS						
Tulane Morehouse (ISED)	1,000,000	1,000,000				2,000,000
Africare/SANFAM	400,000	400,000	400,000	400,000	400,000	2,000,000
ASBEF	120,000	120,000	120,000	120,000	120,000	600,000
TOTAL NGO SUPPORT	1,520,000	1,520,000	520,000	520,000	520,000	4,600,000
BUY-INS						
Pritech	297,561	308,436	297,561	258,991	230,426	1,392,973
DHS	183,000				192,000	375,000
Rapid IV	0	209,090	53,940	0	0	263,030
JHPIEGO	33,350	39,150	44,950	27,550	30,450	175,450
CERPOD/Pop Council/Others	95,700	63,800	52,200	56,550	56,550	324,800
FHI	49,300	31,900	17,400	31,900	17,400	147,900
PSI/SOMARC	300,000	300,000				600,000
TOTAL BUY-INS	958,911	952,376	466,051	374,991	526,826	3,279,153

ANNEX G

PROJECT BUDGET - p. 2

	YR 1	YR 2	YR 3	YR 4	YR 5	TOTAL
PROCUREMENT						
ORS	50,000	50,000	50,000	50,000	50,000	250,000
Contractor Procured Equip	1,369,683	1,369,683				2,739,366
Vehicles for TA Team (2)	43,585					43,585
Local Handling Contracep	20,000	21,000	22,050	23,153	24,310	110,513
Gasoline	113,115	113,115	113,115	113,115	113,115	565,574
Project Manager	40,975	43,024	45,175	47,434	49,805	226,412
TOTAL PROCUREMENT	1,637,357	1,596,821	230,339	233,701	237,230	3,935,449
LOCAL ACCOUNT	678,616	930,221	1,113,302	905,610	640,054	4,267,803
AUDITS & EVALUATIONS						
Audits	25,000	20,000	20,000	20,000	30,000	115,000
Evaluations			150,000		150,000	300,000
TOTAL AUDITS/EVAL	25,000	20,000	170,000	20,000	180,000	415,000
CONTINGENCY	150,000	150,000	50,000	50,000	98,059	498,059
PROJECT LOP	7,242,598	7,388,153	4,862,339	3,634,036	3,872,873	27,000,000
CONTRACEPTIVES	850,000	550,000	650,000	700,000	750,000	3,500,000
TOTAL AID CONTRIBUTION	8,092,598	7,938,153	5,512,339	4,334,036	4,622,873	30,500,000

Annex H

Detailed Implementation Plan

DATE	ACTIVITIES	RESPONSIBLE
	PRE-IMPLEMENTATION ACTIVITIES (June 1992-March 1993)	
Sept '92	Grant to Tulane/Morehouse Awarded	HPNO, RCO
June '92	PIO/T Drafted for DHS Buy-In	HPNO
Aug '92	PIO/T for USAID Project Manager	HPNO
June '92	RFP Issued	HPNO, RCO
June '92	PIO/T for PRITECH Buy-In	HPNO
July '92	Vehicles for TA Team Ordered	HPNO, EXO
Aug.'92	PIO/T Drafted for RAPID Buy-In	HPNO
Sept '92	PIO/T for JPHIEGO, FHI, Pop Council/CERPOP, SOMARC or PSI	HPNO
Sept '92	Technical RFP Review	GOS,HPNO,PDO,RC
Oct '92	Panel Best and Final, Cont Awarded	GOS,HPNO,PDO,RC
Oct '92	Grant to ASBEF Awarded	HPNO, RCO
Oct '92	Grant to Africare/SANFAM awarded.	HPNO, RCO
Oct '92	ORS Ordered	HPNO, EXO
Mrch '93	Pre-Implementation Workshop	USAID,MOPHSA, UNFPA,WB,Belge
	Evaluations/KAPS	
Oct. '93	- DHS #1	
Nov '95-Mrch 96	- Mini-Evaluations of Project Components (IEC, Clinical etc)	IRD, BNR
Aprl '95	- Second Situational Analysis	USAID, O/FP, Pop Council,
Oct. '95	- Rural and Urban KAPS	HPNO, BNR
Jan-Sep '97	- DHS # 2	MOPHSA,USAID
Nov '97	- Final Evaluation	

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DATES	ACTIVITIES	RESPONSIBLE
	Establishment of Referral Cntrs/FP Service Del	
Oct '92-May 93)	FP Clinical Quality Situational Assessment	COP,CT8,PopC. O/FP,D/CL
Mrch '93	Posting of Staff to Referral Centers	O/FP
Mrch '93	FP Equipment Ordered	Contractor Team, O/FP
Aprl '93	Basic Training in Clinical Methods Begins	O/FP
Aprl '93	Training in Counseling Skills Commences	ditto
May '93	Refresher Training in Clinical Methods	ditto
June '93	Development of Treatment Protocols	COP,CT8 D/FP, D/CL, Pop Council
July '93	Development of Clinical Supervisory Checklist	COP CT8 D/FP, D/CL, Pop Council
Aug. '93	Specialized FP Management Training Begins	OFP
Aug. '93	Review of Medical School FP Curriculum	O/FP, CHU, JHPIEGO
Jan. '94	Review of FP Curriculum at CESSI	O/FP, CESSI, JHPIEGO
Mrch '94	Revision of Medical School FP Curriculum	O/FP, CHU, JHPIEGO
June '94	Revision of FP Curriculum at CESSI	O/FP, CESSI, JHPIEGO
Jan. '94	Eval. of Intro. Expansion of Norplant	CHU, O/FP, FHI, JHPIEGO;
June '94	Norplant Training in Regions	Ditto
1995	Tubal Ligation Training	CHU, O/FP, AVSC
1995	Clinical Trial Norplant - Phase II	CHU, FHI
1996	Revision of midwife and nurse FP Curriculums as necessary	O/FP, CHU JHPI

DATE	ACTIVITIES	RESPONSIBLE
	Management and Supervision Training	
Oct-Jan '93	Finalize FP/CDD Training Plan	O/FP, SANAS, Tul,More,ISED
Jan '93	Develop Management Module	Tul,More, ISED
Feb '93	Implement Mgmt Training Course	Ditto
March '93	Develop Supervision Training Course	Ditto
April '93	Implement Supervision Trning Course	Ditto
May '93	Develop TOT Module	Ditto
June '93	Implement TOT Module	Ditto
July '93	Supervision of Trained Personnel	Ditto
Aug. '93	Training of 3 Modules at Dist. Level	Ditto/Reg'l Team
Oct. '93	Update In-Service FP/CDD Trng Plan	O/FP,SANAS,Tul, More,ISED
June '94	In-House Evaluation of 5 Modules	Ditto
Oct. '94	Update In-Service FP/CDD Trng Plan	Ditto
Jan. '95	Development of Applied Epi. Module	Tul,More,ISED
Feb. '95	Development of OR Module	Ditto
March '95	Implement Applied Epi Module	Ditto
April '95	Implement OR Module	Ditto
June '95	Implement Training in OR, Epi at Dist. Level	Ditto/Reg'l Team
Oct. '95	Update In-service FP/CDD Trng Plan	O/FP, SANAS, Tul, More, ISED

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DATE	ACTIVITIES	RESPONSIBLE
	Strengthening Health Information System	
Oct. '92	Review of HIS Pilot	CERPOD/Div.Stat.
Oct. '92	Implementation of DHS	BNR/IRD/SIS
Jan. '93	Family Planning Program Mangement Information System Established	O/FP,CERPOD, Pop Council
April '93	Quarterly Visits by CERPOD to consult with Div. of Statistics re FP/CDD info	CERPOD
June '93	Preliminary DHS Results Available	BNR/IRN
Jan '94	Publication of Baseline DHS Report	BNR/IRN
June '95	Urban/Rural KAPS	BNR/Contractor
	Support to Decentralization and Implementation of Reg/Dis Health Plans	
Oct. '92	Regional Plans Submitted	Reg'l Teams
Nov. '92	Office of Family Planning/SANAS review Plans and Provide Feedback	O/FP, SANAS
Dec. '92	Regional and District Plans Finalized	Reg'l Teams
June '93	Financing of Regional Activities Begins (training and supervision)	Mgmt Unit, O/FP, Contractor
	The above set of activities will be repeated each year of the project.	

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DATE	ACTIVITIES	RESPONSIBLE
	<u>Contraceptive Logistics</u>	
April '93	Review of Existing Contraceptive Logistics System	Logistics TA, O/FP, DAGE
June '93	Contraceptive Reporting and Ordering Form Revised or Developed	Logistics TA, O/FP, DAGE
August '93	Training of Regional Warehouse Mgers and Ref Centers	Logistics TA, O/F, DAGE
Sept. '93	Refresher Training of Regional FP Coord in use of forms and contraceptiv logistics	Logistics TA, O/FP, DAGE
Nov. '93	Regional Teams begin Logistics Trng	Reg'l Teams
Jan. '94	Inclusion of Contraceptives in Essen Medicines	Log. TA,PNA,O/FP
June '94	Review of Logistics System and Delivery	Log.TA, O/FP
Aug. '94	Review of PNA's Ability to Deliver Contraceptives	O/FP, ST-TA, World Bank, Log.
Jan. 95	Pilot Test of Integration of Contraceptives in one region.	PNA,O/FP, ST-TA

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DATE	ACTIVITIES	RESPONSIBLE
	Contraceptive Social Marketing	O/FP, Cooperating Agency
Jan. '93	Marketing Research, Logo Testing	
June '93	Launch of Social Marketing Activities	
Feb. '94	Mid-Review of Pilot and Design of New Project	CSM
Dec. '94	Pilot Ends/New Project Begins	
	Municipality Activities	
Jan. '94	Admin. Assistant hired to coordinate and manage municipal activities	Contractor
Feb. '94	Criteria for selection and directions for development of proposals drafted	Admin Assistant
March '94	Technical Review Committee Reviews and finalizes criteria and manual	Tech Review Committee
April '94	Meetings to Explain Program to Municipalities	Admin Assitant
July '94	Proposals reviewed by Technical Review Committee	Tech Review Committee
Sept. '94	Funding of Munic. Activities Begins	Admin Assistant and Tech Review Committee
March '95	Progress under Grants Reviewed and Necessary Modifications Made	
June '95	Second set of Proposals Reviewed	

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DATES	ACTIVITIES	RESPONSIBLE
	Community Based Distribution (Condoms Only YR 1, YR 2, pilots with pills, spermicides YR 3)	Core Group: O/FP, CT#8, ST-TA (PopCoun), COP
June '93	Seminar to Review Pilot CBD	Core Group
Sept '93	Strategy for CBD Developed, Apprvd	Core Group
Nov. 93	CBD Guide Technique Developed	Core Group
Nov. '93	Nat'l CBD Information Day	Core Group
Feb '93	TOT CBD National Level	O/FP, ST-TA
June '94	Reg'l CBD Information Day	O/FP
June '94	TOT CBD Regional Level	O/FP
Sept '94	Develop 4 Reg'l CBD Plans	O/FP
Nov '94	Train CBD Agents	Regional Team
June '95	Regional Seminar	Core Group
March '95	TOT CBD District Level	Regional Team
Aug. '95	Dev CBD Plans,Train CBD Agts, Imple	Reg'l Team, O/FP
Nov. 95	Develop Referral Cnter Pilot Tests (Spermicides, Pills etc.)	Core Group
Jan. 96	Train CBD Agents	Reg'l Team
March 96	Regional CBD Seminar	Core Group
Sept 96	Develop Expansion of District Plns	Reg'l Team, O/FP
Jan 98	Nat'l CBD Journee de Reflexion	Core Group

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DATES	ACTIVITIES	RESPONSIBLE
	IEC Implementation Plan	
Sept '92	Review of Existing FP/IEC Materials	O/FP, STTA
Sept '93	Train National Team (2 persons)	USAID, OIT, IEC Unit
March '93	Arrival LT/TA	
March '93	RAPID Presentation	LTTA, O/FP/IEC
March through June '93	Finalization of IEC KAP/OR Research Agenda	
Aug. '93	Family Planning IEC Strategy Complete	LTTA, O/FP/IEC,HES
Oct. '93	Technical Guide Produced	ditto
Dec. '93	Message Development/Evaluation	ditto
June '92	RAPID -CS Hlth Model for Hlth Workers	Futures Group, DRH
Sept. '92	Reg. Polit. Leadrs RAPID Model	ditto
Jan '94	TOT for IEC Reg'l Teams	LTTA,O/FP/IEC,HES
Sept. '93	IEC Regional/Dept. FP Plans Finalized	RegTeams, LTTA,
Feb. '94	IEC Regional Training Schedule Begins	O/FP/IEC
Feb. '94	Media Production	HES
April '94	CS Model for Religious Leaders	Futures Group
June '94	Train National Team (1 person)	Contractor
July '95	Mid-Term Evaluation	Outside Evaluators
Aug. '96	Client Satisfaction OR	O/FP/IEC, STTA

DATES	ACTIVITIES	RESPONSIBLE
	Control of Diarrheal Disease	
Year 1	Equip ORT Units	
	- Inventory Existing Materials	SANAS
	- Develop Equipm Order/Replacement Plan	SANAS/Pritech
	- Order Commodities/Equip	Contractor
	Provision of ORS	
	- Develop Estimatations of Need	SANAS,PRITCH,UNICEUSAID
	- Order ORS	
	- Develop stock mgmt system	Pritech, STTA
	Training Support	
Year 2	- Support regions in development of Reg'l Plans	SANAS, Pritech
Year 2	- Define and Publish CDD Policy	USAID, MOPHSA
Year 1	- ST/TA to develop trng materials	Pritech
Year 2	- Nationwide TOT	Pritech, SANAS
Year 4	- Implementation of Refressher Trn	Pritech, SANAS
Year 1	Develop Supervision Materials	Pritech, SANAS
Year 2 - 4	Monitor of Int'l Courses/Seminars	Pritech, SANAS
Year 1 - 5	Monthly Meetings	SANAS, Reg'l Teams
	Evaluation	USAID, MOPHSA
Year 3	- Mid-Term	
Year 5	- Final	
	Research and Studies	SANAS, Pritech
Year 2	- Identification of Areas	
Year 2	- Development of Protocols	

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DATES	ACTIVITIES - Child Surv. IEC	RESPONSIBLE ORG.
Oct. '92	Review of Existing CDD Material	SANAS, HES, PRIT
Jan. '93	Development of New (or revised) CDD Material	ditto
March '93	Develop Program Manual	SANAS, PRITECH
June '93	Production of New or Revised CDD Material	HES
Oct. '93	Develop Breastfeeding Program Manual	SANAS, PRITECH
March '94	Production of Breastfeeding Materials	HES
May '94	Hygiene Research	SANAS, PRITECH
June '94	Impact Research on CDD/Breastfeeding	SANAS, PRITECH
July '94	Develop Program Manual on Hygiene	SANAS, PRITECH
Aug. '94	Develop Educ. Materials on Hygiene	SANAS, HES, PRITE
Nov. '94	Production of Hygiene Materials	HES
Oct. '95	Impact Evaluation Hygiene	SANAS
Dec. '95	Research ORS Promotional Materials	SANAS, PRITECH
March '96	Develop ORS Promotional Materials	SANAS, PRITECH
June '96	Production of ORS Promotional Mat.	HES

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ANNEX I

GOS Local Currency Contribution

Description	Description	CFA Amount (in Millions)	Dollar Amount (in Thousands)
Salaries	Salaires et Indemnités		
3 Drivers & 2 Secretaries	3 Chauffeurs & 2 Secretaries	19.5	$73.6
Salaries for Project Personnel	Salaires du Personnel du Projet	18.0	$67.9
Secretary, Driver, 2 Directors	Secrétaires, Chauffeurs, 2 Directeurs	16.2	$61.1
Maintenance & Repair	Entretien et Réparations		
- Office Equipment (Computers)	- Matériel de Bureau (ordinateurs)	28.5	$107.5
- Copier, Typewriters	- Photocopie, Machine à écrire	3.0	$11.3
Vehicles			
- Mob.	- Mob.	90.0	$339.6
- Spare Parts.	- Pièces de rechange	10.0	$37.7
- Moto	- Moto	33.6	$126.8
- Boats	- Pirogues	1.9	$7.2
Medecine	Médicaments	40.0	$150.9
Maintenance, repair and handling (For vehicle, equipment, lubricant)	Entretien, Réparation et Maintenance (pour véhicule, équipement, lubrifiant	10.5	$39.6
Petrolium Oil and Lubricants		40.0	$150.9
Construction	Construction	20.0	$75.5
Correspondence	Correspondance	1.5	$5.7
Utilities	Electricité, Eau et Téléphone	20.0	$75.5
Handling	Manutention	5.0	$18.9
		357.7	$1,349.8

GOS In-Kind Contribution

Host Country Contribution Calculation

Health Educators	30 persons X $5000/yr	$150,000
Midwives	400 persons X $3100/yr	$1,240,000
Medical Officers	60 persons X $6000/yr	$360,000
Nurses	300 persons X $2500/yr	$750,000
IEC Workers	100 persons X $2000/yr	$200,000
	TOTAL	$2,700,000/yr

Since the health care professionals listed above will spend approximately 33% of their time focusing on project activities, the total yearly contribution would be one third of the above total or approximately $900,000. Over the five year LOP, the total GOS in-kind contribution would be approximately $4.5 million.

$2,700,000/3 = $900,000/yr x yrs = $4.5 million

ANNEX J

SCS/FP PLANNED PROCUREMENTS

A. TECHNICAL ASSISTANCE TO:

1. MOPHSA, University Central Hospital and the MSPAS Contraceptive Technology Coordinating Committee

Type of TA:	Contraceptive Technology Specialist, Family Planning Curricula Specialists
Type of Instrument:	A.I.D direct contract: Add-ons with JHPIEGO (Agreement No. DPE-3045-A-00-7004-00) and Family Health International (FHI) (Agreement No. DPE-3041-A-00-0043-00)
Means:	Add-on amendments negotiated and awarded by FA/OP
PIO/Ts sent to FA/OP:	August, 1992
Estimated Award Dates:	JHPIEGO November 1, 1992 FHI November 1, 1992
Estimated Costs:	JHPIEGO $174,450 FHI $147,900
Synopsized Statements of Work:	JHPIEGO and FHI will provide short-term TA to: 1) Assist the GOS to implement contraceptive technology research and assist in the institutionalization of this technology; 2) review and update family planning curriculums; and 3) implement quality control mechanisms

2. MOPHSA: Office of Family Planning, Decentralization Committee, Health Education Service

Type of TA:	Chief of Party/Family Planner	60 pm[1]
	Health Planner	60 pm

[1] pm = person months

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IEC Specialist	60 pm
Contraceptive Logistic Specialist	36 pm
Financial Management Specialist	36 pm

Type of Instrument: A.I.D direct contract with a U.S. firm or institution

Means: Full and open competition conducted by the RCO, USAID/Senegal

PIO/T sent to RCO: June 1992

Estimated Award Date: February 1993
Estimated Cost: $17,106,000 (includes commodities and local account project funds $10,000,000 of this represents estimated TA costs)

Sypnopsized Statement of Work: The contractor team will be responsible for assisting the Ministry of Health and Social Action in implementing family planning and decentralization activities. The Contractor will also establish a financial management and contraceptives logistics system.

3. MOPHSA: Statistics Division, Office of Family Planning:

Type of TA: Health Information and Operation Research Specialists

Type of Instrument: A.I.D direct contract: Buy-in with CERPOD/Population Council contract number DPE-3030-Z-00-8065-00
Means: Buy-in amendment negotiated and awarded by FA/OP
PIO/T sent to FA/OP: Sept 15, 1992
Estimated Award Date: December 1, 1992
Estimated Cost: $324,800
Sypnopsized Statement of Work: Population Council and CERPOD will work with the Division of Statistics to ensure that its newly revised health Information System provides needed family planning and CDD data to establish a baseline (using a situational analysis) against which project achievements will be measured; establish research priorities and undertake needed qualitative research to complement quantative research.

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4. MOPHSA and ISED, University of Cheikh Anta Diop

Type of TA:	Specialists in training, supervision, management, and epidemiology.
Type of Instrument:	A.I.D grant or cooperative agreement to Tulane and Morehouse Universities based on a jointly submitted unsolicited proposal.
Means:	Negotiated and awarded by RCO, USAID/Senegal
PIO/T sent to RCO:	June 1992
Estimated Award Date:	August/September 1992
Estimated Cost:	$2,000,000
Synopsis of the Statement of Work:	The recipients will assist ISED in providing training to approximately 65 health professionals in the area of management, supervision, training, epidemiology and operational research.

5. Office of Family Planning, MOPHSA and the Department of Human Resources (DRH), Ministry of Economy, Finance and Plan

Type of TA:	Specialists in demography and population modeling
Type of Instrument:	A.I.D direct contract: Buy-in under the centrally funded RAPID IV project contract number DPE-3046-C-00-1047-00
Means:	Buy-in amendment negotiated and awarded by FA/OP
PIO/T sent to FA/OP:	Oct. 1992
Estimated Award Date:	Dec. 1992
Estimated Cost:	$262,030
Synopsized Statement of Work:	The contractor will assist the DRH and the Office of Family Planning to develop micro-computer based simulation that project population growth, child survival and economic development for National, Regional and Religious leaders and for Health Specialists.

6. MOPHSA:SANAS and HES:

Type of TA:	Specialists in Control of Diarrheal Disease (CDD)
Type of Instrument:	A.I.D direct contract: Buy-in under the centrally funded PRITECH contract number DPE-5969-Z-00-7064-00
Means:	Buy-in amendment for first award (2 year period) negotiated and awarded by FA/OP; second award given to follow-on project as appropriate
PIO/T sent to FA/OP:	Oct. 1, 1992
Estimated Award Date:	Dec. 31, 1992

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Estimated Cost:	$1,392,973 for 5 years
Synopsized Statement of Work:	Assist SANAS in establishing OR Units and in assuring that CDD activities in the districts and regions are properly implemented. Manage funds to cover central level local costs.

7. Office of Family Planning

Type of TA:	Specialist in Contraceptive Social Marketing.
Type of Instrument:	A.I.D direct contract: Buy-in under the centrally-funded Somarc contract number DPE-3051-Z-00-8043-00
Means:	Buy-in amendment negotiated and awarded by FA/OP or cooperative agreement to PSI (an American PVO)
PIO/T sent to FA/OP:	Oct. 1992
Estimated Award Date:	Jan. 1993
Estimated Cost:	$600,000
Synopsized Statement of Work:	The contractor will be responsible for designing and implementing and evaluating a pilot contraceptive marketing activity. The contractor will also develop a proposal for a project follow-on project.

8. Bureau National de Recensement (BNR)

Type of TA:	Specialists in surveys
Type of Instrument	A.I.D. direct contract; Buy-in under the centrally funded DHS II contract number DPE-3023-Z-00-8074-00
Means:	Buy-in amendment negotiated and awarded by FA/OP in amendment negotiated and awarded by FA/OP.
PIO/T sent to FA/OP	June 1992/June 1996
Estimated Award Date:	Oct. 1992/Oct. 1996
Estimated Costs:	$180,000/$195,000 total $375,000
Synopsized Statement of Work:	Assist the BNR in conducting two demographic and health surveys.

B. PVO/NGO SUPPORT

1. ASBEF

Type of Instrument:	A.I.D. grant or cooperative agreement based on an

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	unsolicited proposal
Means:	Negotiated and awarded by RCO, USAID/Senegal
PIO/T sent to RCO:	August 1992
Estimated Award Date:	October/November 1992
Estimated Costs:	$600,000 under the proposed grant
Synopsis of the Statement of Work:	ASBEF will conduct IEC activities focusing on men and strengthen its existing clinics so that they may serve as model clinics. ASBEF may also assist the army in making family planning services available in its clinics.

2. Africare/SANFAM

Type of Instrument:	A.I.D. grant or cooperative agreement based on an unsolicited proposal
Means:	Negotiated and awarded by RCO, USAID/Senegal
PIO/T sent to RCO	September 1992
Estimated Award Date:	December 1992
Estimated Cost:	$2,000,000
Synopsis of the Statement:	Under the proposed grant, SANFAM with technical assistance from Africare will (1) establish 5 model family planning clinics in the private sector, (2) continue support to 40 already established F.P. clinics, and (3) initiate new family planning innovative approaches in the private sector, and (4) provide institutional strengthening TA and support to SANFAM.

C. MISSION MANAGEMENT SUPPORT

1. Cooperating Country National Project Manager

Type of TA:	SCS/FP Project Manager - 60 person months
Type of Instrument:	Cooperating Country National Personal Service Contract
Means:	Limited competition pursuant to AIDAR 706.302-70 executed by EXO, USAID/Senegal
PIO/T sent to EXO:	August 1992
Estimated Award Date:	March 1993
Estimated Costs:	$226,412
Synopsis of the Statement of Work:	Project manager will assist the Mission in implementing the project and provide technical direction.

2. Local Contraceptive Distributor

Type of Support:	Handling and Distribution
Type of Instrument:	Delivery Incentives Contract
Means:	Limited competition pursuant to AIDAR 706.302-70 executed by EXO, USAID/Senegal
PIO/T sent to RCO:	August 1992
Estimated Award Date:	Sept. 1992
Estimated Cost:	$20,000
Synopsis of the Statement of Work:	Contractor will clear contraceptives through customs and deliver them to the Central Warehouse.

3. Evaluation and Audit

Type of Support:	Short-term assistance - 20 person months IQC delivery orders or individual purchase orders.
Means:	If purchase orders are estimated below USD 25,000, limited competition will be employed pursuant to AIDAR 706.302-70 and the contracts will be executed by EXO, USAID/Senegal. IQCs may be accessed through FA/OP or REDSO/WCA/OP.
PIO/T to RCO or FA/OP:	Varied between March 1995 to Jan. 1997
Estimated Award Date:	Varied 2 months following receipt of PIO/Ts
Estimated Cost:	$415,000
Synopsis of the Statement of Work:	Evaluation of individual project components at mid-term, audits of local accounts, final evaluation.

D. COMMODITIES

1. Oral Rehydration Salts (ORS)

Quantity:	2,500,000 sachets of 1 liter
Type of Instruments:	AID Direct contract: Buy-In
PIO/C to FA/OP	Sept. 1, 1992
Estimated Award Date	March 1993
Estimated Costs:	$250,000
Synopsis of the Purpose:	Provide project with needed ORS packets

2. Contraceptives

Quantity:	$3,500,000

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Type of Instrument:	A.I.D. Direct Contract: OYB Transfer
Estimated Award Date:	Annual estimates by cable sent January 1, for following year
Estimated Cost:	$3,500,000
Synopsis of the Purpose:	To provide IUD's, low-dose pills, spermicides, Norplant and condoms needed for Senegal in both the public and NGO/parastatal sector.

3. <u>In-Kind Support provided by USAID to the Contractor and MOPHSA in item A.2. above</u>

Quantity:	2 Project Vehicles
Type of Instrument Means:	AID direct contract
PIO/C to EXO	Sept. 1992 and annually thereafter for gasoline
Estimated Award Date:	Dec. 1992 " "
Estimated Cost:	$635,762
Synopsis of the Purpose:	The vehicles will be procured for use by the contractor team. USAID will procure gasoline for both the Ministry of Health and the contractor.