

PDBBM781

APPENDIX 3A, Attachment 1
Chapter 3, Handbook 3 (TM 3:43)

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE: **A**
A = Add
C = Change
D = Delete

Amendment Number: _____

DOCUMENT CODE: **3**

COUNTRY/ENTITY: **Niger**

3. PROJECT NUMBER: **683-0258**

4. BUREAU/OFFICE: **USAID/Niger**

5. PROJECT TITLE (maximum 40 characters): **Niger Family Health and Demography**

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): **MM DD YY 05 01 93**

7. ESTIMATED DATE OF OBLIGATION (Under 8. show enter 1, 2, 3, or 4)
A. Initial FY **88** B. Quarter **3** C. Final FY **93**

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

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
Grant	2,400		2,400	11,000		11,000
Loan						
Other						
U.S.						
Host Country in-kind		100			698	698
Other Sources						
TOTALS				11,000	698	11,698

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROXIMATE PRIMARY PRIORATION PURPOSE CODE	C. PRIMARY TECH CODE	D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DPA 403	400			2,400		11,000	
(2)							
(3)							
(4)							
TOTALS							

10. SECONDARY TECHNICAL CODES (maximum 5 codes of 3 positions each)
440 450 420

11. SECONDARY PURPOSE CODES

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
A. Code: **BVW/BWW RPOP TNG DEL**
B. Amount: _____

13. PROJECT PURPOSE (maximum 400 characters)
To strengthen the capacity of Nigerien institutions to plan, support and monitor family health services on a national basis, and to produce and use demographic analyses for national planning.

14. SCHEDULED EVALUATIONS

Interim: **MM YY 09 90** Final: **MM YY 12 92**

15. SOURCE/ORIGIN OF GOODS AND SERVICES
 200 941 Local Other (Specify) _____

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

17. APPROVED BY

Signature: **George F. Eaton**

Title: **Director, USAID/Niger**

Date Signed: **JUN 18 1988**

Approved: **Marsha Smith, Controller**

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
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FOR MAURICE MIDDLEBERG

E.O. 12356: N/A
SUBJECT: POPULATION: NIGER FAMILY HEALTH
AND DEMOGRAPHY PROJECT

DUE DATE: 5/2/88

REF: NIAMEY 3147

THIS IS TO PROVIDE RLA CLEARANCE OF ACTION MEMORANDUM
AND PROJECT AUTHORIZATION SUBMITTED IN CONNECTION WITH
SUBJECT PROJECT. KUX

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ACTION RECORD	
NIAMEY	<i>NAN</i>
Date	<i>4/26/88</i>
Initials	<i>WJM</i>

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GLOSSARY OF TERMS

AFW	Niger Women's Association *
A.I.D.	Agency for International Development (Washington)
AIDS	Acquired Immune Deficiency Syndrome
BuCan	Bureau of the Census (U.S.)
CDSS	Country Development Strategy Statement
CM	Medical Center *
CNSF	National Family Health Center *
CP	Condition Precedent
DDS	Departmental Health Directorate *
DES	Directorate for Health Facilities *
DFEPS	Directorate for Training and Health Education *
DHS	Demographic and Health Survey
DPF	Directorate for Family Planning *
DSI	Directorate of Statistics and Computer Services *
DSMI	Directorate for Maternal and Child Health *
ENSP	National Public Health School *
FAC	French development assistance agency
FH	Family Health
FHI	Family Health International
FHI II -	Family Health Initiatives II Project
FP	Family Planning
FPIA	Family Planning International Assistance
GOV	Government of Niger
IEC	Information-Education-Communication
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
KAP	Knowledge, Attitude, Practice
MCH	Maternal and Child health
MCF	Ministry of Plan
MOPH/SA	Ministry of Public Health and Social Affairs
NFHC	National Family Health Center
NFMDP	Niger Family Health and Demography Project
NDHS	Niger Demographic and Health Survey
NHSS	Niger Health Sector Support
ONPPC	National Office for Pharmaceutical and Chemical Products *
OPTIONS	Options for Population Policy
OR	Operations Research
ORTN	Niger Radio and Television Office *
PACD	Project Assistance Completion Date
PCS	Population Communication Services
PMI	Maternal and Child Health *
RAPID	Resources for the Awareness of Population Impacts on Development
RIG/A	Regional Inspector General/Audit (A.I.D.)
SRFMP	Sanel Regional Financial Management Project
STD	Sexually Transmitted Disease
ST/POP	Science and Technology/Population (AID/W office)
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development (Niger)
VHT	Village Health Team

* Acronym represents French language terms

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EXECUTIVE SUMMARY

The Niger Family Health and Demography Project (NFHDP) will be the first phase of a long term program of A.I.D. assistance to the expansion of the Nigerian family health and demographic research programs. This project is for five years, with a budget of \$11,000,000. A second phase bilateral project will be designed in Year Four of NFHDP, and will begin implementation as this project phases out.

The goal of the NFHDP is to assist the Government of Niger in its efforts to achieve a rate of population growth that is consistent with the growth of economic resources and productivity. Towards this end, the project will improve the capacity of the Ministry of Public Health and Social Affairs (MOPH/SA) to deliver family health services and implement an effective national family health program. For the purposes of this project, family health includes family planning, treatment of sexually transmitted diseases and surveillance of high risk pregnancies. The project will also build the capacity of the Ministry of Plan (MOP) to conduct demographic research and analysis and will make a major contribution to the demographic data base for Niger.

The project will consist of two major components - the Family Health Component and the Demographic Research and Analysis Component. The Family Health Component will extend family health services to up to 146 public health facilities and will test private sector and "mixed" approaches to family health service delivery using pharmaceutical outlets and village health teams. Areas of A.I.D. assistance will include constituency development, training, information-education-communication, contraceptive supply and logistics management, management development and operations research. Primary responsibility for implementation of the Family Health Component will rest with the Directorate for Family Planning (DPF), a unit of the MOPH/SA. Prior to creation of the DPF in 1983, the National Family Health Center (NFHC) provided technical direction to the family health program since its inception in late 1984.

The Demographic Research Component will include assistance in the processing and analysis of the 1983 census data, a national demographic and health survey, long and short term training in demography and documentation and dissemination of demographic data. Primary responsibility for management of this component will rest with the Directorate for Statistics and Computer Services (DSI) of the Ministry of Plan. The DSI has strong leadership and its technical skills have increased rapidly in preparation for the 1988 census.

The goal of the NFHDP has the strong support of the Government of Niger. This support has been expressed in public fora on numerous occasions, including the recently released Five-Year Plan. The project has been designed in close collaboration with the MOPH/SA and the MOP. Consultations with other donors in the family health and demographic areas have continued throughout the design phase to assure complementarity of inputs and consistency in aims and objectives. The project will address the disequilibrium between population growth and economic resources which complicates development efforts in a

number of areas, and will contribute to a reduction of infant and maternal mortality. The project is responsive to the A.I.D. strategy for Niger, which calls for support of family health/population programs. In sum, the project meets important development needs and responds to the priorities of both the Government of Niger and A.I.D.

I. PROJECT RATIONALE

In considering the rationale for the Niger Family Health and Demography Project, the Design Team posed three fundamental questions:

1. Does the project respond to critical socio-economic problems and constraints facing Niger?

2. Does the project conform with the A.I.D. development strategy in Niger?

3. Does the project conform with the development strategy and programs of the Government of Niger (GON)?

The Design Team determined that the response to each of these questions is positive. This section reviews the factors that led to this conclusion.

A. Development Settings

1. Physical and Socio-Economic Environment.

Niger is a poor, landlocked Sahelian country with a 1987 population of approximately 6.8 million. The physical environment of Niger is characterized by a severe climate, periodic droughts, widespread soil degradation and desertification. Rainfall is meager and unreliable, and temperatures are usually high with a yearly mean of 29 degrees Centigrade. The droughts of 1973-74 and 1984 had severe consequences on the human population, agricultural production and livestock. Soil fertility is declining in the agricultural zone due to reduction and elimination of fallow periods, farming of poorer soils, use of inappropriate equipment and over-intensive grazing and browsing.

Gross national product per capita is estimated at \$300, which makes Niger one of the world's poorest countries. Economic growth has been highly erratic due to the effects of periodic drought and the instability of uranium prices. As a consequence, per capita GNP has failed to increase; over the period 1965-85 GNP per capita declined at a rate of 2.1 per cent per year.

Most of the population depends directly or indirectly on agriculture and livestock for its livelihood. Agriculture and livestock provide approximately 45% of GDP. Nearly three-quarters of Niger's people are villagers who produce subsistence crops, primarily millet, cowpeas and sorghum, on dry land. Only 12 per cent of the country's vast area is suitable for agriculture or livestock, and only 3 per cent can be used for growing crops. Food production has been erratic and food production per capita has been declining. Crop yields have been decreasing and increased production to meet the needs of the

population has been attained by eliminating fallow periods or by farming the fragile transitional zone just north of the rainfed agricultural area.

Education and literacy levels are low. About 10 per cent of the adult population is literate and 20 per cent of eligible children attend primary school. School enrollment, which rose rapidly during the relatively affluent period of the late 1970's, has stagnated.

2. Population Indicators

The demography of Niger exhibits characteristics which are typical of many sub-Saharan nations. The 1987 population is estimated at 6.3 million, with a rate of natural increase of 3.1 per cent per year. Fertility has remained high and stable over a long period, while mortality, though still elevated, has been declining. Infant and maternal mortality are particularly high. Almost half the population is under the age of fifteen. Nigerian women can expect to marry early (the average age of first marriage is 15.6) and remain in union during most of their lives. Rural to urban migration is significant and the cities are estimated to be growing at 7-3 per cent per year. Virtually no information is available on international migration, but it appears to be largely limited to seasonal movements. Table 1 provides an overview of the principal demographic indicators.

TABLE 1
DEMOGRAPHIC INDICATORS FOR NIGER

TOTAL FERTILITY RATE	7.1
CRUDE BIRTH RATE	51/1000
CRUDE DEATH RATE	20/1000
INFANT MORTALITY RATE	135/1000
MATERNAL MORTALITY RATE	700/100,000
CHILD MORTALITY RATE (AGES 1-4)	28/1000
LIFE EXPECTANCY (BOTH SEXES)	44.5 years
RATE OF NATURAL INCREASE	3.1%/year
PERCENT UNDER AGE 15	47
RATE OF URBAN GROWTH	7-3%/year

Population projections developed by the GON show that the population will continue to grow significantly for the foreseeable future. Table 3 shows the growth of the Nigerian population under the fertility assumptions set forth in Table 2.

The high growth scenario assumes no outside interventions to reduce population growth. The moderate growth scenario involves a moderate mobilization of family health resources. The low growth scenario presumes a serious effort to mobilize family health resources in a policy framework that permits implementation of family health interventions such as those proposed for this project.

All of the scenarios assume a gradual increase in life expectancy, from 44.5 years in 1985-90 to 58.5 years for 2020-25.

TABLE 2
TOTAL FERTILITY RATE: 1985-2025
3 SCENARIOS

	1985-90	1995-00	2005-10	2020-25
HIGH GROWTH	7.1	7.04	6.6	5.08
MODERATE GROWTH	7.1	6.3	5.39	3.55
LOW GROWTH	6.98	6.19	4.34	2.4

Given these fertility rates, Niger's projected population under the three scenarios would be:

TABLE 3
PROJECTED POPULATION OF NIGER: 1985-2025
3 SCENARIOS
(millions)

	1985	1990	2000	2010	2025
HIGH GROWTH	6.4	7.4	10.3	14.4	22.9
MODERATE GROWTH	6.4	7.4	10.2	13.9	19.3
LOW GROWTH	6.4	7.4	9.9	12.6	15.7

As seen in Table 3, the start of a rapid fertility decline has no appreciable impact on population growth in the short term (1985-1990). This is due to the rapidly growing number of women of reproductive age during the same period, as demonstrated by the population pyramid, where one sees that 47 per cent of the population is under 15 years of age. Even if these women have significantly lower fertility than their mothers, the population will continue to grow and the impact of this change will only be felt in the medium term.

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3. Health Indicators

Niger's health indicators have improved markedly in the past 25 years; e.g. life expectancy has increased from 36 to 45 years and the crude death rate has declined from 27 to 20. Nonetheless, the health status of the population is disquieting and parallels that found throughout the Sahelian region. Available morbidity and mortality data must be treated with caution, but for transmissible diseases the following causes of death were most frequently reported: measles, diarrhea with dehydration, meningitis, malaria, pneumonia and tetanus. The most reported categories of illnesses include "presumed" malaria, diarrheal disease, bronchitis, conjunctivitis, rhinopharyngitis and wounds. Malnutrition is widespread. It is estimated that average per capita caloric intake is about 2000 calories per day, well below minimum requirements by international standards.

One of Niger's major health problems is the morbidity and mortality associated with pregnancy. The maternal mortality rate, estimated at 700 per 100,000, is one of the world's highest. Complications of pregnancy such as ruptured uterus and prolonged labor are common. The high fertility of Nigerien women, associated with early childbearing and short birth intervals, contributes to the high levels of maternal morbidity and mortality. These high risk pregnancies add to a high neonatal mortality rate.

Sexually transmitted diseases (STD's) are also a major concern, though reliable data are not available. In 1984, 23,307 cases of gonorrhoea and 10,223 cases of syphilis were reported. AIDS has also become a concern with the discovery of seropositive cases in Niamey.

4. Summary

This brief review of the development setting has shown Niger to be a poor country facing severe economic constraints. While there are many reasons for Niger's slow economic growth, including drought and limited natural resources, rapid population growth has exacerbated the effect of these other factors. Such gains in GNP as Niger has experienced have been vitiated by a high rate of population growth. The effects of rapid population growth complicate development efforts in a number of areas. Most notably, rapid population growth has accentuated the processes of deforestation and desertification, made it more difficult to expand access to schooling and health services and increased the vulnerability of the country to shortfalls in food production.

High fertility contributes to the elevated levels of morbidity and mortality among infants, children and mothers. An increase in the interval between births and a reduction in fertility would have a salutary effect on the levels of infant and maternal mortality. Access to family planning services is very limited, so families have little opportunity to determine the timing, number and spacing of births. Sexually transmitted diseases are an important health problem and have become of increasing concern with the discovery of seropositive cases of AIDS. Additional preventive measures are required to combat the spread of STD's.

3. A.I.D. Strategy for Niger

1. Health and Population Strategy

As set forth in the USAID Country Development Strategy Statement (CDSS), health and population, along with agricultural/rural development, is to be one of the two sectors in which A.I.D. will concentrate its development assistance to Niger. A major objective of A.I.D. assistance to Niger is to improve the health status of the population at large. This means reducing morbidity and mortality, particularly among children, improving nutritional status and expanding access to family planning. The elements of A.I.D.'s health strategy, which are embodied in the Niger Health Sector Support Grant (683-0254), signed on August 23, 1986, include the following:

- Improved resource management, by strengthening the capacity of the GON and the Ministry of Public Health and Social Affairs in information management, planning, policy analysis, project selection and coordination of programs among different executing agencies and donors.

- Expenditure restructuring, to focus expenditures on cost-effective preventive health programs, maintenance and rehabilitation and containment of hospital and medical evacuation expenditures.

- Health financing, through implementation of a cost recovery system.

- Program interventions, aimed at strengthening improved treatment of diarrheal diseases, expanded immunization, nutritional surveillance, malaria control and expanded access to family planning.

The Niger Health Sector Support Grant (NHSS) is a \$15 million sector grant to facilitate the policy and institutional reforms identified above through training and technical assistance and to provide conditional budgetary resources for support of counterpart contributions or local currency requirements of selected health, nutrition, and population programs, with special emphasis on child survival programs. The grant has a series of Conditions Precedent to disbursement of the five increments of U.S. dollars to be transferred to the Government of Niger. The Conditions Precedent are linked to policy reforms, including reforms in the family planning/population area.

Family planning is deemed a key child survival activity that provides health benefits to both mothers and children. The CDSS sets the goal of integrating family planning into the health structure. The CDSS calls for A.I.D. support of the following activities:

- (a) Development and approval of an integrated population strategy.

- (b) Removal of legal barriers to family planning and establishment of legislation allowing health workers to deliver family planning services.

(c) Establishment of an information-education-communication program.

(d) Strengthening of family planning service delivery at all levels through training, community outreach and operations research.

(e) Training health workers to deliver family planning services throughout the health system.

(f) Developing the necessary logistic system for distribution of contraceptives.

(g) Extending family planning services to additional departments.

The Niger Family Health and Demography Project fully conforms as well with A.I.D.'s world-wide population strategy. This strategy calls for building public awareness about the country's demographic situation, support for the development of an effective family planning information and service delivery infrastructure, and testing other potentially effective means to deliver services, such as community health workers. These approaches are all incorporated in this project design.

2. USAID Experience with Population Programs

USAID/Niger has already had significant experience in the implementation of population programs in Niger. The Niger Health Sector Support Grant mandates a number of policy reforms that will facilitate expansion of family planning services under the NFMOP, including legalization of family planning, promulgation of a population policy, development of a plan for extending services, reform of contraceptive pricing and importation regulations and development of a plan for improving the demographic analysis capacity of the Ministry of Plan. USAID has also benefited from the assistance of a number of centrally-funded projects which provide assistance directly from their own funds or through "buy-ins". Under a buy-in arrangement, bilateral or regional resources are added to the cooperating agency's contract to fund a particular scope of work. Centrally funded population projects which have worked in Niger include the following:

- RAPID, which provided microcomputer simulations of the impact of population growth and technical assistance in population policy development.

- Development Law and Population Policy Project, which helped draft the legislation legalizing family planning.

- Operations Research (OR) Project, which has provided a long-term advisor to the Ministry of Public Health and Social Affairs and conducted important OR activities, including a KAP (knowledge, attitude, practice) survey.

- Family Health International (FHI), which has conducted studies of family planning clients, including a longitudinal study of a cohort of oral contraceptive users.

- Program for International Training in Health (INTRAH), which has developed a standard curriculum for in-service training of family planning service providers and will train 50 service providers in the Departments of Zinder and Maradi by April, 1983.

- Population Communication Services (PCS), which has begun implementation of an IEC (information-education-communication) program for Niamey, Zinder and Maradi.

- Bureau of the Census (BuCen), which has provided assistance and training in cartography, census planning, questionnaire design and data processing to the Nigerian Census Bureau.

- Family Planning International Assistance, which has provided contraceptives.

- Training: FHI, Columbia University, Johns Hopkins University (JHPIEGO), and other projects have provided training in-country and abroad that significantly expanded the corps of personnel with relevant skills.

Centrally funded projects will continue to play a role in the development of the Niger population program during the project period. The INTRAH Project will continue training of family planning service providers through June 1983 and the PCS Project will continue its IEC activities in the Departments of Zinder and Maradi through May 1989. These projects have encouraged the expansion of service delivery through training and IEC outside the city of Niamey. They thereby complement the NFHDP and provide a reservoir of experience on which the NFHDP can draw. The Columbia University OR Project will be phased out in December 1983. FHI will complete its cohort study of oral contraceptive users in December 1989. The NFHDP will finance a continuation of BuCen assistance, which will focus on processing and analysis of the census data in the post-enumeration period, and a demographic and health survey with the assistance of the Demographic and Health Surveys Project. The NFHDP will also finance activities by the RAPID III Project in the area of economic-demographic modeling, profiting from the availability of the census data. The IMPACT Project, which has not yet started in Niger, will assist in the dissemination of demographic information to non-technical audiences under financing from the NFHDP. Technical and financial assistance for policy development activities will be provided by the OPTIONS Project, which specializes in population policy development.

3. Summary

The A.I.D. strategy for Niger sets forth a significant and specific role for family planning/population programs. The activities proposed for the NFHDP conform to those proposed in the COSS. The NHSS will encourage the development of a policy framework conducive to the expansion of family planning and related demographic research. In addition, USAID/Niger has had significant experience in the implementation of population programs through the application of centrally and regionally funded projects. Hence, the NFHDP is fully responsive to A.I.D.'s strategy for Niger.

C. Government of Niger Strategy and Programs

The NFHCP responds to the development strategy enunciated by the Government of Niger and its leadership. The GON strategy with respect to population issues has been manifested in at least three ways. First, senior GON officials (including the current and late Heads of State, the Minister of Plan and the former Minister of Public Health and Social Affairs) have made a number of articulate and forceful statements on the potential social and economic consequences of rapid population growth and the importance of providing access to family planning to all desiring such services. On several occasions at the 1987 UN sponsored Roundtable on Niger held in Geneva, the Minister of Plan cited rapid population growth as an important constraint to the development process. The public position taken by the Head of State and key government ministers has been a very important factor in creating an environment conducive to the success of the project.

Second, the GON has, in the recently released Five-Year Plan for 1987-1991, published a comprehensive "Demographic Plan of Action." Inter alia, the Plan of Action calls for integrating demographic factors into national planning, reducing mortality, universal access to family planning services, balanced regional growth, demographic research and training and a public education program on demographic questions. Of particular interest for the purposes of the NFHCP are the sections pertaining to family planning and demographic research and training. The family planning section calls for the following actions:

- Promulgation of legislation authorizing and encouraging family planning services and setting a minimum legal age of marriage.
- Integration of family planning into all maternal and child health programs, as well as other aspects of the health system as appropriate.
- Dissemination of information on family planning on a national basis.
- Distribution of a variety of contraceptive methods to maximize the choices available to individuals.
- Training of health personnel in family planning.
- The treatment of sterility and related problems as part of the family planning program.
- The definition of an appropriate role for non-governmental entities in the delivery of family planning (FP) services.

The section on demographic research and training sets the following objectives:

- Implementation of the 1987 census.
- Implementation of special studies on fertility, mortality, and migration.

- Increased training of government staff in demography.

- Increased capacity to collect and use demographic data for planning and policy-making, particularly in the health sector.

- Implementation of a system for supervising and evaluating population programs.

Third, the GON has concretely manifested its desire to provide family health (FH) services and increase its understanding of Nigerian demography. Beginning with a model clinic opened in late 1984, FH services have been extended to 10 additional facilities in the capital city as well as to several locations in the Department of Dosso. By April, 1988, services should be extended to the Departments of Maradi and Zinder, with technical and financial assistance provided by USAID. Services do not include abortion, which is illegal in Niger. Preparations for the census are well advanced and it is expected that the enumeration will begin in May, 1988. The census data, if properly exploited, should help provide the necessary demographic data base for planning and policy-making.

In sum, the GON has made a clear effort to increase the scope of its population program, with the public and consistent support of its leadership. It nonetheless remains the case that most of the population lacks access to FH services and that the demographic data base is extremely limited. The NFHCP will help the GON to increase access to FH services and to attain its demographic objectives.

II. PROJECT GOAL AND PURPOSES

The Niger Family Health and Demography Project will be a five year, \$11 million project supporting expansion of family health services and development of a demographic data base to be used in planning and policy making. The project will have two distinct but mutually reinforcing components. The Family Health Component will be administered by the Ministry of Public Health and Social Affairs (MOPH/SA). Its objective is to support the development of a national family health program. Activities to be supported under the family health component will include constituency development, training, IEC, contraceptive supply and logistics management, management development, and operations research.

The Demographic Research and Analysis Component will be administered by the Ministry of Plan. Its objectives are to expand the demographic data base and increase the capacity of the GON to undertake demographic research and analysis. Activities to be supported include processing and analysis of the census data, implementation of a national demographic and health survey, training, and documentation and dissemination of demographic data.

A. Project Goal

The project goal is to assist the Government of Niger in its efforts to achieve a rate of population growth that is consistent with the growth of economic resources and productivity.

B. Project Purposes and Expected Accomplishments

The project purposes are to strengthen the capacity of Nigerien institutions to plan, support and monitor family health services on a national basis, and to produce and use demographic analyses for national planning. Each of the two components has distinctive objectives related to the attainment of the project goal and purpose.

1. Family Health Component

Sub-purpose: To improve the capacity of the Ministry of Public Health and Social Affairs to deliver family health services as an integral part of health services.

Planned activities/accomplishments:

(a) Integration of FH into the services offered by all Ministry of Public Health and Social Affairs Medical Centers (39), Maternal and Child Health Centers (29) and Maternities (78).

(b) Training of FH personnel, which will include in-service training of 5 national program managers, 46 regional managers and 344 service providers and integration of FH into the curricula of the health schools.

(c) Implementation of a national IEC campaign, which will include training, audience research, development of IEC messages, development and purchase of IEC materials, an IEC campaign in each department and a mass media campaign.

(d) Organization of constituency development efforts under the auspices of the CPF.

(e) Implementation of a contraceptive supply system.

(f) Development of organizational structures and procedures appropriate to the management of a national FH program.

(g) Completion of two operations research projects to test the feasibility of contraceptive social marketing and community based distribution of non-prescription contraceptives as alternatives to public sector delivery of FH services.

2. Demographic Research and Analysis Component

Subpurpose: To build the capacity of the Ministry of Plan to conduct demographic research and analyses.

Planned activities/accomplishments:

- (a) Processing and analysis of the 1938 census data.
- (b) Implementation of a national demographic and health survey.
- (c) Training of personnel from the Ministry of Plan and other ministries in the collection, analysis and use of demographic data.
- (d) Documentation and dissemination of demographic data.

III. PROJECT DESCRIPTION

A. Family Health Component

1. Overview

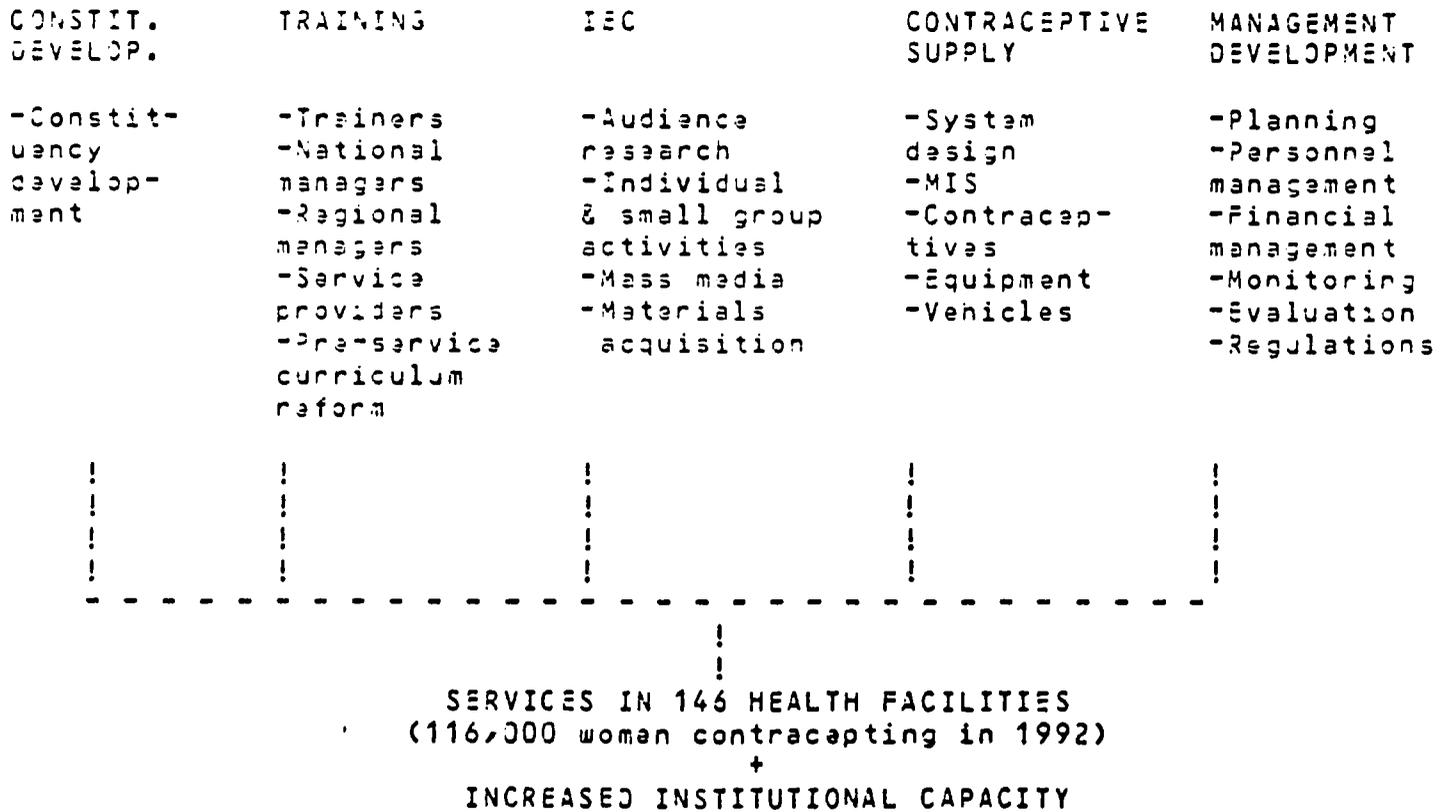
The Family Health (FH) Component is primarily a conventional, clinic-based approach to expanding FH service delivery in public health facilities. This focus on the public sector was selected for two reasons. First, the use of public health facilities capitalizes on an existing infrastructure. Personnel and facilities are already in place, thereby facilitating the expansion of services. The health infrastructure is sufficient to accommodate the number of family health clients to be reached under this project. Public health facilities bear the imprimatur of the Government and the integration of family health services will be a concrete manifestation of the Government's expressed support of family health. This will enhance the acceptability of family planning among local leaders. Given the nascent stage of the family health program it will be important to demonstrate the support of the Government during this first phase of program expansion. Second, the private health care sector is extremely small and could not reach the desired number of clients. The NFHDP will encourage the use of private and "mixed" channels for service delivery, but this must be seen as a longer term complement to the introduction of family health services through the public sector.

Voluntary family planning services offered in Niger encompass the full range of family planning methods and include instruction in natural family planning techniques. FH training for service providers under NFHDP will include natural family planning instruction. Abortion is illegal in Niger.

Family planning services are now offered at the NFHC, the ten maternal and child health centers (PMI) in the city of Niamey, and in selected facilities in the departments of Niamey, Dosso and Zinder. Outside the city of Niamey, however, the level of service delivery tends to be quite low. The NFHDP will

integrate family health services into an additional 112 health facilities outside the city of Niamey. By the end of the project all 39 medical centers (CM), 29 PMI and 78 maternities belonging to the MOPH/SA will be offering FH services. These 146 facilities are often grouped in "installations"; e.g., a PMI and a maternity are often physically adjacent. At the beginning of each of years 1-4 of the project, the national project managers in consultation with MOPH/SA officials will select the departments/arrondissements in which family health services will be integrated, and schedule IEC, training, contraceptive supply, and other activities accordingly. Approximately 15-16 installations will be added as service delivery points in each of these years.

The FH component contains all the basic elements essential to the development of a family health program. These include developing supportive constituencies and health regulations, training health managers and service providers, motivating potential clients through an IEC campaign, supplying contraceptives and developing appropriate management procedures. The component elements are depicted schematically below.



The focus on public sector service delivery is complemented by two operations research projects that will attempt to demonstrate the feasibility of private or "mixed" distribution channels. The first project will focus on commercial distribution of condoms and spermicides through pharmacies. The second

project will test a community-based distribution system using voluntary village health teams (VHT) as IEC agents and distributors of contraceptives.

The FH component will be managed by the Ministry of Public Health and Social Affairs (MOPH/SA) and, more particularly, by the Directorate for Family Planning (DPF). The DPF, which was created in January, 1988, has replaced the National Family Health Center (NFHC) as the MOPH/SA unit responsible for managing the family health/family planning program. From 1985 to 1987 the NFHC had responsibility for providing technical guidance to the family planning program. The DPF is the technical unit within the MOPH/SA charged with expanding access to family health services. The DPF coordinates its activities with the other relevant divisions of the MOPH/SA; of these the Directorate for Maternal and Child Health (DSMI) and Directorate for Training and Health Education (DFEPS) will be the most directly involved. The DPF will house the national family health program managers - the Director, Training Coordinator, IEC Coordinator, Logistics Coordinator and Research Coordinator. Each Coordinator will eventually require an assistant to help in program implementation.

The NFMOP will finance a long-term technical assistance team that will serve as counterparts to the national program managers. The technical assistance team will include a Management Analyst (counterpart: DPF Director), a Training Specialist (counterpart: DPF Training Coordinator) and an IEC Specialist (counterpart: DPF IEC Coordinator). The tenure of the Management Analyst, who will serve as Chief of Party, will be four years and that of the Training and IEC Specialists three years each. Short-term technical assistance totalling 40 person months is also to be provided.

As these staff will greatly increase the space requirements of the DPF, the NFMOP includes funding for the rent of an additional building. An outstanding issue is now to resolve the space needs for the longer term as the MOPH/SA is already affected by its own space constraints. Warehouse space for storage of the contraceptives for the national program is also very limited; USAID has requested the GON to approach other donors to meet this specific need.

The Technical Analysis provides a detailed discussion of the reasons for adopting the strategy and activities described in this section.

2. Institutional Setting

The Family Health Component will be managed by the Ministry of Public Health and Social Affairs (MOPH/SA), and will integrate FH services into existing health facilities and services. Accordingly, this section provides an overview of the public health care system, indicating those points at which the NFMOP will intervene to integrate FH services.

At the top of the health infrastructure pyramid are seven hospitals, one in each department capital. Each department also has a Departmental Health Directorate (DDS) responsible for managing the Ministry's health program at the departmental level.

The next level is at the arrondissement, where there are 39 Medical Centers (CM), run by a physician or graduate nurse. The NFMHP will integrate FH services into all 39 CM's. Reporting to the CM's are 73 maternity units and 29 PMI units nationally. These are usually associated with Medical Centers and are in the more populous areas. The NFMHP will integrate FH services into all maternities and PMI's.

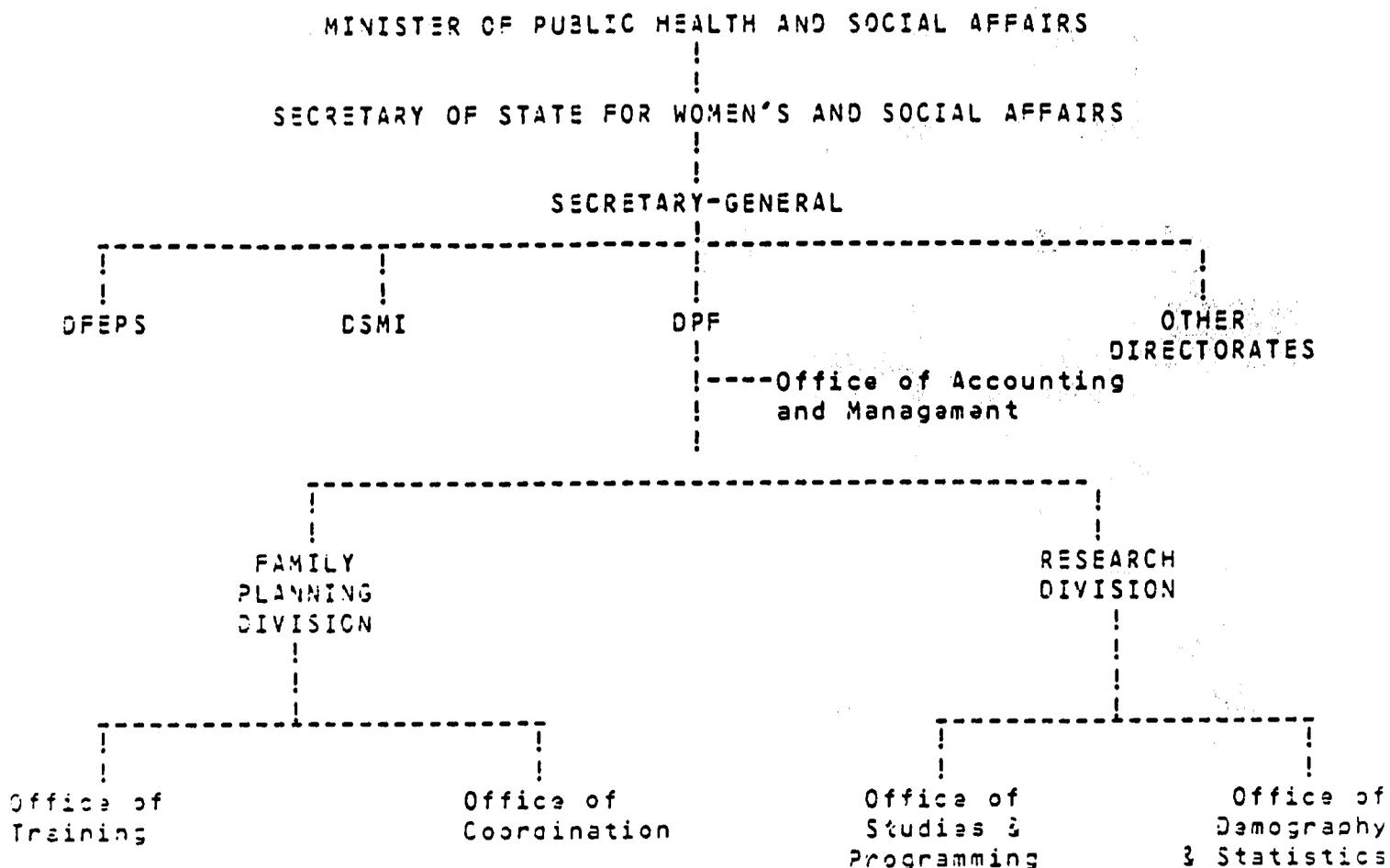
Managers and supervisors at the arrondissement and department levels will integrate family health into their managerial and supervisory duties and site visits and their drug procurement and distribution activities. Each DDS will designate a family health coordinator to oversee family health activities.

At the third level are the 25 Postes Médicales (Medical Posts) and the 215 Dispensaires Ruraux (Rural Dispensaries). These are mostly staffed with one nurse who is also responsible for supervising the local village health teams.

At the base of the pyramid are the village health teams consisting of village health workers and trained birth attendants. There are approximately 5200 health workers and 5400 birth attendants covering approximately 40% of Niger's villages. All village health team members receive an initial two-week training program and are retrained for ten days every three years. The NFMHP will test the feasibility of using village health workers as IEC agents and contraceptive distributors.

The pharmacy system consists of 13 "peoples pharmacies," owned by the parastatal Office National des Produits Pharmaceutiques et Chimiques (ONPPC), and 54 "depots". The latter are small private enterprises that depend on the ONPPC for their supply but provide for a wider distribution of drugs. The NFMHP will test the feasibility of contraceptive distribution through the pharmacies and depots.

Operational responsibility for the Family Health Component of the NFMHP will be assumed by the DPF, which operates under the supervision of the Secretary of State for Women's and Social Affairs. Prior to creation of the DPF, the NFMHC provided technical leadership to the FH program since its inception in 1934. Since the leadership of the NFMHC has now been transferred to the DPF, the new directorate is the locus of Nigerien FH expertise. To assume the task of national program management, the DPF has been organized as shown in the following diagram.



The DPF is responsible for planning, coordinating and evaluating the integration of family planning services into the health services offered by the MOPH/SA. The Director of the DPF is assisted by an Accountant/Manager, who is responsible for financial and personnel management.

Within the DPF, the Family Planning Division focuses on expanding family planning service delivery. The Division's Office of Training is responsible for all family planning training and IEC activities, in collaboration with the other concerned directorates of the MOPH/SA. The Office of Coordination is responsible for managing contraceptive logistics and monitoring service delivery.

The Research Division is responsible for designing, implementing and diffusing studies relevant to the objectives of the DPF. The Office of Studies and Programming will focus primarily on family planning research, while the Office of Demography and Statistics will concentrate on surveys and other demographic research.

Since the DPF is new, staff have not yet been recruited to fill all the

positions. At present, the staff consists of the Director of the DPF, the Chief of the Family Planning Division, an IEC Coordinator working in the Office of Training, a sociologist employed by the Research Division and the Accountant/Manager.

The extant staff is inadequate to the tasks assigned to the DPF. At minimum, the current staff must be complemented by a Training Coordinator (assisted by a team of part-time trainers), a logistics manager, a field supervisor/monitor and an additional researcher. This would bring the professional staff of the DPF to nine and, in the view of the Design Team, is the minimum staff complement needed to carry out the program. A Condition Precedent of the NFHDP will be that the minimum staff required for program operations be assigned to the DPF. The MOPH/SA should eventually consider hiring deputies to the Training, IEC and Logistics Coordinators, as well as additional field monitors.

The NFHDP will finance three long-term technical assistants: a Management Specialist who will serve as counterpart to the DPF Director and Chief of Party, a Training Specialist who will serve as counterpart to the head of the Office of Training, and an IEC Specialist who will serve as counterpart to the DPF IEC Coordinator. The term of the Management Specialist will be four years, while the Training and IEC Specialists will be employed for three years each.

A complete organizational chart for the MOPH/SA is provided in Annex G. For the purposes of the NFHDP, the DSMI and the DFEPS will be particularly important. The DSMI provides overall direction to the maternal and child health program and provides technical direction to all PMI's and maternities.

The DFEPS has oversight responsibility for all training of MOPH/SA personnel. It will have to approve the annual training plan for the NFHDP, identify appropriate candidates and ensure that training facilities are available.

The DFEPS also has responsibility for public health education programs. With assistance from the World Bank, it is strengthening the material and human resources available to carry out such programs. IEC activities carried out under the NFHDP will have to be coordinated with the programs of DFEPS.

The Directorate for Health Facilities (DES) will also play an important role. The DES has management responsibility for all health facilities. It will be expected to encourage and facilitate the integration of FH services into the CM's.

The ONPPC must approve the importation of all pharmaceutical products. One important task in the design of the contraceptive supply system will be to ensure that approval of project financed contraceptives by ONPPC occurs in a routine and expeditious manner.

3. Elements of the FM Component

The elements of the FM component are described in detail in this section. They are comprised of elements common to virtually all family health assistance programs - constituency development, training, information-education-communication, contraceptive supply and logistics management, management development and operations research. The particular mix of activities selected was based on detailed analyses of the needs of the Niger family health program, an assessment of the program's absorptive capacity and the management and budget constraints of USAID/Niger. A detailed discussion of the rationale for the activities selected is given in the Technical Analysis. As experience in implementation is gained and approaches assessed, specific elements or parts may be adjusted.

(a) Constituency Development

The GON has already made significant progress in the area of population policy development. Access to family health services has been promised in the recently adopted National Charter. The Demographic Plan of Action adopted by the Government in the Five Year Plan sets forth a clear agenda of actions to be undertaken in the family planning/population domain. The terms of the NHSS mandate a number of important population policy reforms. Senior government officials, including the Head of State, have been outspoken proponents of family planning, thereby providing the overt political support needed for the program to be implemented. Thus, important strides have been made in establishing the formal framework for population activities.

The NFMCP will focus on constituency development activities that will strengthen and legitimize service delivery. Technical and financial assistance will be provided to the CPF by the centrally funded OPTIONS Project to organize two national conferences for key constituencies in order to elicit their support of population activities. The conferences will focus on the membership of organizations that have conventionally served as mechanisms for mass participation and mobilization - the Islamic Association, the Women's Association, the Samariya and the Association of Traditional Chiefs. These conferences will provide basic information on family planning, focusing on the health benefits for mother and child.

(b) Training

For the training program to be accomplished it will be essential to develop a national training team consisting of 10-12 individuals having expertise in contraceptive technology, STD's, logistics, IEC, management and pedagogy. Not all members of the team will necessarily be expert in all these areas. Rather the team will contain sufficient expertise to meet all training requirements of the program. Individual members of the team will be called upon as needed to conduct courses for particular audiences. The training team will operate under the supervision of the Training Coordinator.

(1) In-Service Training: There are a number of distinct groups within

the MOPH/SA that will require specialized training if they are to fulfill their roles in an FM delivery system. Four distinct categories of potential trainees have been identified: program managers at the central level; regional managers at the departmental and arrondissement level; trainers who will provide training to other members of the FM system; and health service providers who provide services and information directly to the clients. At each level in the administrative hierarchy specialized skills will be required if the FM program is to be successfully implemented. The following discussion reviews the training program for each group; the number, length, and contents may be revised to adjust to needs and evaluation findings.

Program Managers: As discussed above, coordinators will be needed for training, IEC, logistics and research. Each member of this central program management team will require specialized training adapted to their responsibilities. The training proposed for each is as follows:

- Training Coordinator: a training program equivalent to the seven-week course offered by Management Sciences for Health in Boston entitled "Skills for Managing Effective Training Organizations".

- IEC Coordinator: a training program equivalent to the four-week course offered by the University of California at San Francisco entitled "IEC for Health and Family Planning Programs".

- Logistics Coordinator: A three-week course on family planning logistics management will be financed by the NFHDG and held in Niger. Participants will include the Logistics Coordinator, two individuals from the OVPPC and one representative from each DJS. Course content will include procurement, inventory management, transportation, information and record keeping systems, warehousing, logistics system evaluation, supply data analysis and forecasting of contraceptive requirements.

- Research Coordinator: The Coordinator will be sent to the U.S. for a Ph.D. in public health or demography. The training must focus on demography, family planning, research methodology and program evaluation. An example of an appropriate program is the University of Michigan Population Planning Program. The academic training of this individual will be complemented by field experience with an organization such as Family Health International so that he or she develops skills appropriate to research in Niger. The long term training means that this individual will be gone for much of the project period. However, this is the only satisfactory method for developing the research expertise needed over the long term. Moreover, the need for research personnel will be greatest during the last two years of the project, when the operations research activities will be underway. During the absence of the Research Division Chief the remaining researcher employed by the DPF Research Division will assume responsibility for managing DPF research activities.

- Field Supervisor/Monitor: This individual will be responsible for field supervision of program activities, including monitoring and technical assistance to regional managers and service delivery staff. The Field

Supervisor/Monitor will receive short-term family planning management training, such as that offered by the Center for African Family Studies.

As the project expands additional staff may be needed, including deputies for training, IEC, and Logistics, as well as field monitors. Project funds have been set aside for training these individuals.

Regional Managers: This target group will consist of seven DDS representatives (one from each department) and the 39 CM directors. The training will consist of a two week workshop in FH program management and will focus on standards of care, supervision, logistics and record keeping. One workshop for 10-12 people will be offered in each of years 2-5 of the project. Selection of the candidates will follow the expansion of FH service delivery; i.e., the CM directors will be from those arrondissements in which services have been introduced.

The role of the CM directors as managers will be facilitated by the development of procedural manuals under the management development sub-component. The manuals, which will be distributed to the directors of all CM's, PMI's, and maternities, will provide guidance on the basics of FH program management, including supervision, standards of care, logistics and record-keeping.

Trainers: A three-week course will be offered for the training team in each of years 1 and 4 of the project. Members of the training team should be individuals who already have expertise and experience in the delivery of FH services. In selecting the team members the object will be to minimize the amount of additional training required in FH packages (i.e., contraceptive technology, IEC, STD's etc.) and maximize the time that can be devoted to improving pedagogical skills.

In addition to the courses to be offered in years 1 and 4 there will be annual meetings of the training team of 3-4 days duration to review problems and issues in the delivery of training.

Health Service Providers: This target group will consist of the health professionals who will have direct responsibility for delivering services and information to clients. Within this group there are a number of sub-categories, each requiring different training.

- Physicians, Nurses and Midwives: A total of 240 such individuals will be trained to meet the goal of having trained personnel at 146 health facilities by the end of the project. These individuals will each receive three weeks of training in family health using the standard curriculum developed in 1987 by MOPH/SA in collaboration with INTRAH, as revised in light of the INTRAH evaluation. The curriculum includes reproductive physiology, health benefits of family planning, contraceptive technology, sexually transmitted diseases, individual and small group counseling, management of contraceptive stock and record-keeping, but does not include training in IUD insertion. Three courses will be offered in each of years 2-5 of the project with 20 trainees per

course; i.e. 60 service providers are to be trained each year. These trainees are to be drawn from a maximum of 15 "installations" (single facility or group of contiguous facilities) per year.

Of these 240 individuals, 60 physicians and midwives will be chosen for additional training in IUD insertion and follow-up. Fifteen individuals will be trained in each of years 2-5 of the project. Eight of the fifteen will be trained at the NFHC, where there is an adequate client load to support this level of training, and seven will be sent abroad for training (e.g., Morocco). The goal of this training exercise will be to have one person trained in IUD insertion at each of the "installations" identified as locations for service delivery. Training in IUD insertion will not take place unless the MOPH/SA certifies that the health facility employing the nominated trainee has the equipment and facilities needed for IUD insertions.

The project will also finance two physicians from each of the seven hospitals for training in sterilization techniques, if adequate facilities are available for this intervention.

- Pharmacists: one seminar of two weeks for 15 pharmacists will be held in each of years 2 and 5. These seminars will focus on contraceptive technologies and drugs used in the treatment of STD's.

- Social workers: 30 social workers will receive training through 4 two week seminars. The seminars will focus on contraceptive technology and IEC. The goal is to train two social workers in each arrondissement who will serve as local agents for the IEC program.

It is essential that health service providers who satisfactorily complete training be able to exercise their new skills immediately. Otherwise, skills gained in the training will deteriorate and the costly investment will be lost. Therefore, candidates for in-service training will be accepted only upon certification by the MOPH/SA that they will be authorized to provide family health services and will be provided with contraceptives and IEC materials upon completion of the training. Short-term training plans will be reviewed annually, and modifications in training programs will be made as necessary.

Inputs for FH training include three years of long-term technical assistance, 6 months of short-term technical assistance, long-term training, short-term training, procurement of educational materials, and in-country training costs.

(2) Pre-Service Training: A key to integrating FH into the health system is to incorporate FH in the pre-service training of health professionals. Since FH is an essential component of primary health care, it must be treated on a par with other fundamental skills demanded of health professionals. Moreover, training of new personnel coming into the health system is more efficient than attempting to re-educate health professionals who are already in the field. Accordingly, the project will support improvement of FH training at the Ecole Nationale de Santé Publique, which

trains nurse, midwives, social workers and laboratory technicians, and at the Faculté des Sciences de la Santé, which trains physicians and pharmacists. Specifically, the following revisions in the training of health professionals will be accomplished during the project:

- Physicians, nurses and midwives will receive training in FH equivalent to the standard three-week course to be used for in-service training. All midwives and obstetricians/gynecologists will receive additional training in IUD insertion.

- Social workers will receive training in contraceptive technology and IEC for FH similar to the two-week in-service training course.

- Pharmacists will receive two weeks of training in contraceptive technology and drugs used in treating STD's.

The MCHDP will support curriculum reform in three ways. First, training of health school faculty through a curriculum development workshop and a "training of trainers" course for up to fifteen faculty members. Second, through technical assistance to the schools in curriculum and pedagogy for FH training. Third, through purchase of teaching aids and equipment (e.g., pelvic models, IUD kits), as well as books and other publications. Inputs for curriculum reform will include 5 person-months of technical assistance, in-country training, and procurement of educational materials.

(3) Follow-up and Evaluation: The training program must incorporate a system of trainee evaluation and follow-up in order to ensure that high standards of care are maintained. Trainee follow-up and evaluation will include the following elements:

- Competency based testing at the conclusion of the training. All trainees must attain a pre-determined level of competence before being authorized to deliver services.

- Follow-up technical assistance: The Field Supervisor/Monitor, in collaboration with the regional managers, will be responsible for follow-up of trainees in order to provide on-site technical assistance and field reports to program managers.

- Roster of trainees: Since trainees inevitably move from one health facility to another, an up-dated roster of trainees and their location will be maintained by the MCPH/SA.

(c) Information-Education-Communication (IEC)

An effective program for communicating the availability and benefits of family health services will be essential to the success of the project. IEC activities will cover all levels of communication. Individual and small group counseling will be carried out by service providers. Counseling techniques

and methods will be incorporated into the training of doctors, nurses, midwives and social workers. Service providers will be given IEC materials (flipcharts, contraceptive sample cases, brochures) for use in individual and small group counseling. Community level activities, such as community meetings and special events, will be carried out by social workers in collaboration with established organizations for mass mobilization such as the Samariya and the Niger Women's Association (AFN). Regional and national IEC campaigns will be conducted through the mass media.

The IEC element will follow a logical progression - training of the IEC manager, audience research, testing of messages and materials, training of field workers, production and dissemination of materials and messages and evaluation. The IEC element will include the following activities (these may be revised according to needs and experience):

(1) Audience research: Focus group research will be held in four departments: Tahoua, Agadez, Dosso and Ciffa; this will complement similar research conducted with USAID support in the remaining departments prior to project initiation. The research will serve to identify key target groups, develop and pretest messages and materials, and identify media habits and patterns of contact with health and extension services.

(2) Training: As described above, the IEC coordinator will receive specialized training, as will 30 social workers who will serve as field agents for the FM IEC program. In addition, one person from each Departmental Health Directorate will be sent to the Center for African Family Studies or other appropriate institution for short-term IEC training; two seminars on FM programming for radio and television will be held and two study tours for four persons will be conducted to review IEC programs in other African countries.

(3) Mass media: The MOPH/SA will work with the Ministry of Information to coordinate an extensive mass media campaign to publicize the FM program. The mass media campaign will include the following elements:

- Departmental level campaigns - The purpose of these campaigns will be to institutionalize and support community level IEC activities in conjunction with the extension of services. Particular activities to be supported include integration of FM into the health education programs now offered by health facilities, community meetings for women and men to be organized by the trained social workers (at least one per month by each social worker), special events (such as theatre, wrestling matches and debates) designed to promote FM, and dissemination of IEC materials such as banners, cloth and buttons. Community organizations such as the Samariya and the AFN will be involved in the departmental campaigns.

- Radio and television: Television and radio will be used to publicize the FM program at both the national and departmental level. At the national level, Hausa and Djerma speaking theatre troupes will be commissioned to produce a series of plays to be broadcast on radio and television. The plays will have appropriate family health themes aimed at both men and women

such as "sexual responsibility" or "responsible parenting". Programs in each language for each medium, i.e., plays for television and radio, will be financed by the project. In addition, short messages (30-60 seconds) will be produced for broadcast on radio and television.

- National Family Health Week: A national family health week will be held in year 5 of the project to coincide with the extension of services to all arrondissements. Television, radio and press will be used to mark the event; special events will be held and a variety of memorabilia (e.g., cloth, bumper stickers, key chains) will be distributed.

- Newspapers: While the written press has limited outreach, it is an important channel for reaching the literate, francophone members of the society. Family health announcements will be placed each month in the daily newspaper "Le Sahel" and in the weekly "Sahel Dimanche".

- Billboards and signs: Under a centrally funded project 50 billboards and signs will be produced for display at health facilities. The purpose of the signs is to identify locations where FH services are available. Under the NFMDP, additional billboards and signs will be produced to identify FH service locations and promote FH utilization.

(4) Acquisition of IEC materials: A wide variety of IEC materials will be developed and/or purchased over the life of the project. Materials to be procured include contraceptive sample cases and flip charts for use by health workers in individual and small group IEC sessions, brochures, buttons and badges to be worn by family health service providers, banners, commemorative cloth and tee-shirts.

Inputs for the IEC program include 3 person-years of long-term technical assistance, 6 person-months of short-term technical assistance, support for audience research, mass media and acquisition of IEC materials.

(d) Contraceptive Supply and Logistics Management

A critical element in the success of the project will be the ability of the MOPH/SA to ensure a reliable supply of contraceptives to health facilities and providers for distribution to clients. The basic strategy to be adopted by the project is to integrate the contraceptive supply system with the extant system for delivering drugs to health facilities. Drugs are procured by and stored at the ONPPC warehouse in Niamey. MOPH/SA vehicles pick up a supply of drugs from the ONPPC on a regular basis and deliver them to health facilities in the various departments. Contraceptives will be stored at the NFHC and the same vehicles will be required to stop at the NFHC and pick up the supply of contraceptives. If this approach does not work effectively, another plan will have to be adopted. The role of the project will be to ensure that an adequate supply of contraceptives is available and that appropriate stock levels are maintained at each point in the delivery system.

USAID assistance in the development of the contraceptive supply system will focus on four areas:

(1) Purchase of contraceptives: In coordination with other donors (World Bank, UNFPA, IPPF), the NFHDOP will finance the procurement of oral contraceptives, IUD's and condoms in sufficient quantity to meet anticipated demand. It is expected that the number of women contracepting will rise from 15,000 to 116,000 over the course of the project. Based on this projection and certain assumptions with respect to method mix and continuation rates, provision has been made in the budget for purchase of contraceptives over the five-year life of the project. Sufficient quantities will be purchased and distributed to maintain the following stock levels:

NFHC: 9 months of supply for the national program.

DSS: 2 months of supply for all service delivery points in the department.

CM: 4.5 months of supply for all service delivery points in the arrondissement, plus 4.5 months of supply for its own clients.

PMI's and maternities: 4.5 months of supply to meet client needs.

(2) Vehicles and equipment: Although delivery of contraceptives will be integrated into the regular MOPH/SA supply system, a certain degree of redundancy is essential in order to ensure that the project can cope with breakdowns in the regular supply system. Moreover, vehicles will be needed for field visits. For these reasons, the NFHDOP will finance procurement of two long bed, double cabin, 4x4 pick-up trucks. Costs for fuel and maintenance will also be borne by the project.

In addition to the vehicles, a fund will be allocated to each arrondissement for the purchase of equipment and supplies. Each CM director will be expected to identify the equipment and supply needs of facilities within the arrondissement up to the amount allocated. Annex K specifies the items eligible for procurement under this project element.

(3) Design of product flow system: Technical assistance will be needed to establish procedures and manuals for ordering, receiving, stocking and distributing contraceptives at all levels of the supply system. The MOPH/SA will have the responsibility of designating contraceptive supply managers at each point in the distribution chain.

(4) Management information system: Accurate information on past and projected use levels is essential to maintain appropriate stock levels at the various points in the supply system. A simple but accurate management information system can also generate important indicators of program performance, such as couple-years of protection, number of users and number of acceptors. Technical assistance will be needed to define the data requirements of the supply system, the procedures for data collection and the methods for data analysis and reporting. In addition, a microcomputer and

appropriate software will be purchased by the project for installation at the CPF.

Inputs for the logistics system will include 6 person months of technical assistance, procurement of contraceptives and acquisition of vehicles and equipment.

(a) Management Development

Given the complexity of managing a national family health program, particular attention will be devoted to developing management systems and procedures early in the project. Technical assistance will be provided by the NFMDP in the following areas:

(1) Program planning, including the development of measurable objectives and realistic timetables.

(2) Regulations governing service providers - To date the prerogatives of each potential class of service provider (physician, nurse, midwife, social worker, village health worker) with respect to family health remain undefined. Technical assistance will be provided to the MOPH/SA in preparing regulations governing the actions of each class of service provider.

(3) Personnel management, including the areas of performance standards, supervision and personnel evaluation. One critical element will be the development of standards of care for use by service providers in prescribing contraceptives and monitoring clients. In addition, supervisory protocols will be developed for use by mid-level managers.

(4) Logistics and financial management, including instruction in A.I.D. financial management procedures. Assistance in developing the financial management procedures will also be provided by the Sahel Regional Financial Management Project, which is based in Niamey.

(5) Problem-solving approaches: Training and technical assistance will be provided in the application of problem-solving techniques.

(6) Program monitoring: The most important aspect of this effort will be the activities of the Field Supervisor/Monitor, who will visit family health service providers on a regular basis, offering technical assistance and providing program managers with a regular series of reports on field conditions. The work of the Field Supervisor/Monitor will be facilitated by the development of a management information system and procedures for monitoring program implementation and identifying areas that require management intervention.

(7) Program evaluation, including development of indicators and methods for assessing program impact.

Responsibility for technical assistance will fall to the Chief of Party (Management Analyst) of the technical assistance contractor. It will be incumbent upon the Management Analyst to produce procedural manuals for use by managers at the OPF and in the field. Inter alia, the manuals are to set forth guidelines and procedures for program planning, supervision, logistics management, record-keeping, financial management, program monitoring and program evaluation. These manuals are to be developed in cooperation with the OPF leadership and are to be approved by the MOPH/SA.

(f) Operations Research

The NFMDP will focus primarily on the extension of family health services through public sector health facilities. Given the nascent stage of the family health program, the limited private sector and other constraints, USAID believes this is the most appropriate strategy. However, the Design Team is fully cognizant of the potential utility of private sector and "mixed" approaches to family health service delivery and for this reason, the NFMDP will finance two operations research projects to test the feasibility of non-governmental mechanisms. The two projects are described below. The Design Team considers these the most likely candidates, but notes that circumstances may change and require modification.

(1) Operations Research Project -- Village Health Teams: As discussed earlier, the village health teams (VHT) are at the base of the health infrastructure pyramid. Each VHT consists of 1-2 health workers (secouristes) and 1-2 birth attendants (matrones) who have received two weeks of training. The functions of the village health team are to provide primary health care (e.g., administer chloroquine, assist in childbirth) and refer patients requiring more intensive care to health facilities.

The purpose of the operations research project will be to test the feasibility of using VHT's as IEC agents and distributors of non-prescription contraceptives. Twenty-five village health teams will be selected to participate. The VHT project will begin in year 3 of the project and last 30 months.

In phase one of the OR project the VHT's will receive training in family health and IEC. A program of activities will be developed for each VHT (e.g., community meetings, post-natal counseling) and IEC materials will be supplied. Subsequent to implementation of the IEC program the participating villages will be assessed for contraceptive knowledge and use relative to a comparison group of villages.

In phase two of the VHT project, the same VHT's will be supplied with condoms and spermicides for distribution to villagers. The purpose of phase two will be to test the feasibility of a community-based distribution system using VHT's. The Design Team recognizes that it has been very difficult to assure a reliable supply of basic drugs to the VHT's and this same problem is likely to affect contraceptive supply. However, studies are programmed under the NHSS

to identify mechanisms for maintaining drug supply to the VHT's. Assuming that an appropriate drug supply system is designed, condoms and spermicides will be added to the items provided to the participating VHT's. The participating villages will then be monitored over time to identify implementation problems in a community-based distribution system and to test for project impact with respect to contraceptive knowledge and use.

(2) Operations Research Project - Commercial Distribution: As noted in the description of the Nigerien health system there are 18 state-owned pharmacies and 54 privately owned "depots" that sell pharmaceuticals. These pharmaceutical outlets are supplied by the parastatal monopoly ONPPC. A sample of the outlets (5 pharmacies and 15 depots) located outside Niamey will be supplied with project-financed contraceptives through the ONPPC. Only non-prescription contraceptives (condoms and spermicides) will be supplied.

The price at which the ONPPC will sell the contraceptives to the outlets will be negotiated between USAID and the ONPPC, based on an analysis of the project costs to the ONPPC. The ONPPC will be responsible for distributing the contraceptives to the outlets through its regular drug supply system. The outlets will then sell the contraceptives to the general public.

The ONPPC will designate a contraceptive marketing manager who will be responsible for managing contraceptive supply to the outlets and distributing promotional materials. The marketing manager will also collaborate with project-financed technical assistance in training and advising outlet owners and managers.

Project assistance for contraceptive marketing will include short-term technical assistance, cost and market studies, procurement of contraceptives, production of promotional materials and training of pharmaceutical outlet owners and managers.

The contraceptive marketing project will begin in year four of the project and will last 2 years. If the utility of contraceptive marketing is demonstrated, private sector delivery can be expanded during future phases of USAID assistance.

Inputs for the operations research projects will include 20 months of short term technical assistance, in-country short-term training, procurement of IEC and promotional materials and support of local research costs.

3. Demographic Research and Analysis Component

1. Overview

There is a well recognized paucity of Nigerien demographic data, a situation complicated by the limited number of personnel trained to collect, analyze and use demographic data. The only major source of demographic data is the 1977 census, which provides only a limited amount of information and is now

becoming outdated. Other sources of demographic data are scarce and provide information only on sub-regions of the country. The data constraints hamper population program planning and evaluation. A related problem is that demographic factors are not adequately integrated into macroeconomic and sectoral planning. Therefore, trained personnel and institutionalized procedures are needed to develop and exploit demographic data.

The GON has improved its demographic analysis capacity in preparation for the 1983 census. Significant improvement has been made in the material and human resources available for demographic research through technical assistance, training and equipment procurement on the part of the GON and various donors, including A.I.D. Nonetheless, continuing external support will be needed over an extended period in order to build the institutional capacity of the GON to collect and use demographic data.

The Demographic Research and Analysis Component will consist of four major elements - (1) support for processing and analysis of the census data, (2) implementation of a Demographic and Health Survey, (3) short and long term training in demography and demographic applications, and (4) the development of small demographic libraries and a program for disseminating demographic data. Each element is described in detail below.

2. Institutional Settings

The Direction de la Statistique et de l'Informatique (DSI) of the Ministry of Plan has the primary responsibility for demographic research and analysis and will be the focus of project assistance.

In addition to demographic research, the DSI maintains statistics on a wide array of subjects such as climatic factors (rainfall and water levels); status of goods and services (livestock census as well as sales, air passenger flow, vehicle registration, mineral exportation); consumer price indices (African and European markets); monetary concerns (circulation of CFA, balance of payments, external credit, internal loans, currency exchange rates) and concerns of public finance (general budget receipts and expenditures).

Because comprehensive and accurate demographic data are critical to the demographic objectives enumerated in the Five-Year Economic and Social Development Plan (1987-1991), the GON designated the responsibility for demographic data collection and analysis and the integration of demographic data into development planning to the Ministry of Plan. Within the Ministry, DSI has been charged with these important tasks.

The DSI, with over 100 full-time employees, is involved in a broad range of demographic training, research, data collection and documentation activities. Most recently, DSI has been involved in the planning and preparation for the National Census planned for May, 1988.

The DSI is currently undergoing a reorganization. Indications are that the Directorate will be divided into six major functional centers:

- Center for Statistics responsible for the compilation of general statistics for calculations of special indicators such as the consumer price index and gross national product; maintenance of national statistics related to the various development sectors (education, agriculture, industry, health and social services, etc.); compilation of basic demographic data on fertility, mortality and migration; and compilation of all statistics deemed necessary for government planning.
- Center for Studies and Surveys responsible for the conceptualization of studies and surveys conducted by the GON; design of study/survey methodology; design of questionnaires and study/survey manuals; survey sampling; preparation of field work including training of field staff; supervision of field work; general supervision of data collection, analysis and preparation of final reports.
- Center for Training responsible for identifying potential candidates for long and short-term training; tracking students sponsored by internal and external funding sources; conducting technical courses in various aspects of research design, data collection, analysis and dissemination; conducting technical courses for support staff in data entry and processing; and identifying staff development needs and providing necessary on-the-job training.
- Center for Documentation and Dissemination responsible for preparation of statistical documents and reports; reproduction of official statistical reports and documents; dissemination of information as well as reports generated by the DSI; maintenance of a documentation center for background and reference materials, stores of raw data, and collection of audio visual and support materials for functioning of the DSI program.
- Center for Administration and Accounting responsible for personnel management including direct supervision of all support personnel; budgeting for all DSI operations and special projects; fiscal management and accounting of all funds; administration of the DSI properties and equipment; and general management of facilities.
- Center for Computer Services responsible for development of computer programs to meet DSI statistical needs; model simulation; computer presentation of data (tables, graphs, etc.); all data entry and data processing; training of DSI and other government staff in computer sciences; and regulatory services on the importation and licensure of computers in the country.

By using the technical resources above and drawing on a cadre of technical staff (mathematicians, statisticians, sampling specialists, cartographers

etc.), special project units are formed to support a large study or survey which might be conducted by the GON. These units are in existence for the life of the study. Staff are rotated as needs of the special project change.

In addition to the normal DSI structure, the Directorate is responsible for the Central Office of the Census, a semi-autonomous office which has been formed to plan, execute and implement the 1988 National Census.

3. Elements of the Demographic Research and Analysis Component

USAID/Niger has been able to profit from its extensive experience with the GON demographic research program in identifying the elements of the Demographic Research and Analysis Component. This experience was complemented by a detailed analysis of priorities for assistance in this domain prepared as part of the project design effort. The analysis underlying the selection of the activities described below may be found in the Technical Analysis.

(a) Analysis of 1988 Census Data

Project assistance for analysis of the census data will focus on the following areas:

(1) Assistance for data processing and census quality: This element will focus on helping the DSI process the census data in a technically sound and expeditious manner. Project assistance will include technical assistance in data processing, and supplies and software. Assistance for data processing will occur in 1988 and 1989.

(2) Assistance for a series of special analytic reports in preparation for the 1992-1994 Plan: Assistance in this area will focus on exploiting the census data for planning and policy making. The reports will also capitalize on other available sources of demographic data, such as the Demographic and Health Survey. Topics for the reports will include urbanization, migration and spatial distribution, household characteristics, fertility, mortality, schooling and literacy, employment, and health. The analytic reports will be prepared during 1991 and 1992, in conjunction with a series of five Demographic, Policy and Planning Workshops that will increase the capacity of policymakers and planners to exploit demographic data.

Inputs for analysis of the census will be as follows:

- Technical assistance for data processing and census quality
- Technical assistance for analytic reports and financial support for complementary studies
- Microcomputers (4), software and supplies

(b) Niger Demographic and Health Survey

A major part of the Demographic Research and Analysis Component will be support for a nationally representative sample survey (approximately 4,500 women) designed to collect demographic and health information. The Niger Demographic and Health Survey (NDHS) will be implemented by DSI as part of the A.I.D.-financed international Demographic and Health Surveys Program (DHS). The survey will take 24-27 months to complete, with detailed survey design work beginning in 1989 and fieldwork occurring in late 1990.

The NDHS will provide information to Nigerian policy-makers on maternal and child health and family planning. In addition, the survey should serve as a training mechanism for the DSI staff by providing technical assistance in conducting a survey according to accepted international standards. Also, the NDHS will include some secondary data analysis and give attention to presenting survey findings in a form that can be easily understood by non-technical audiences.

The content of the NDHS will fall into three broad groups: demographic, family planning, and maternal and child health. The first group includes questions on fertility, infant and child mortality, nuptiality and breastfeeding, as well as background variables on the woman and her husband. The family planning questions include knowledge and use of contraception, child spacing, fertility preferences and unmet need for family planning. The maternal and child health section includes prenatal care, assistance at delivery, immunization, episodes and treatment of diarrhea, fever and breathing difficulties, ORT and environmental sanitation. Height and weight measures will be taken for children 3-36 months.

Three reports will be produced as part of the NDHS: a short preliminary report 4-5 months after completion of the fieldwork, the principal survey report 12 months after the fieldwork and a summary report for non-technical audiences.

The Ministry of Plan will assign the requisite DSI staff to the unit. At a minimum, this will include 1 demographer, 2 statisticians and 2 computer programmers. As needed, additional DSI staff will be assigned for specialized tasks such as cartography. The Ministry will contribute the use of one vehicle during the pretest of the survey instrument and an additional four vehicles (for a total of five) for five months for use during the listing operation, training and fieldwork.

Project assistance for the DHS will include 12.5 months of technical assistance, local costs for the survey and analysis, part-time local hire researchers and one 4WD vehicle (which will be in addition to the vehicles provided by the MOP).

(c) Training

As in the family health component, training will be a crucial element in the demography activities to be supported. The only long-term solution to

establishing an effective demographic research program is to build a group of technically qualified analysts. Training will fall into three categories:

(1) Long-term training in the U.S.: The project will support one candidate for a Ph.D. in demography and one candidate for a master's degree in demography. It will be essential that the coursework and research undertaken by the candidates prepare them for work in the Nigerian setting. The coursework should also emphasize the application of demography to planning and policy making to avoid too narrow technical training.

(2) Medium and short-term training abroad: The project will support attendance of Nigerian participants at medium and short-term training programs in demography and related areas. These training funds may also be used to support attendance at professional conferences (e.g., IUSSP conferences) germane to the implementation of the Demographic Research and Analysis component. The project will support 16 person-months of medium-term training abroad (2-4 months) and 20 person-months of short-term training abroad (less than 2 months).

(3) Short-term training in Niger: The project will support five 2-week Demography, Policy and Planning workshops to be held in Niger. The workshops will be for individuals from Government ministries with primary responsibility for policy-making and planning. The purpose of the workshops will be to acquaint participants with techniques and methods for integrating demographic variables into planning and policy making. The workshops are to be coordinated with the preparation of the analytic reports to be prepared for the 1992-1996 Five-Year Plan. The workshops are to serve as a means for planning and monitoring the development of the analyses, while simultaneously increasing the skills of the participants.

(c) Documentation and Dissemination

A properly functioning demographic program must receive and disseminate reports, books, summaries of major findings, data tapes and other materials. The program must also have computer software that can facilitate analysis and report production. In order to build the institutions undertaking these functions the project will take the following steps:

(1) Establish demographic documentation and dissemination centers at three institutions: the DSI, the University of Niamey and a third institution to be named by the GON and USAID.

(2) Provide each institution with a budget of \$15,000 to purchase books, materials and subscriptions to demographic journals.

(3) Assist the documentation centers in receiving materials available free of charge from A.I.D. and the United Nations. The documentation centers should be placed on the mailing lists of the appropriate organizations for future publications.

(4) Provide technical and financial assistance in implementing a plan for disseminating demographic information to government agencies, scholars and other potential users.

Assistance for documentation and dissemination will include 4 person-months of short term technical assistance, procurement of books and journals and local cost financing of the dissemination activities.

The institutions which house the documentation and dissemination centers will be responsible for providing library space and staff to manage the library.

IV. COST ESTIMATE AND FINANCIAL PLAN

The major project inputs include long-term advisors, short-term consultants, long and short-term participant training, contraceptives, equipment and vehicles, and support of IEC and research activities. The total cost to AID will be \$11,000,000. The following table provides cost estimates by year and major cost category.

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BUDGET - ESTIMATED ANNUAL DISBURSEMENTS

	YEAR 1 \$	YR 2 \$	YR 3 \$	YR 4 \$	YR 5 \$	TOTAL
ADMINISTRATION	140,208	140,208	140,203	140,208	140,208	701,040
LT TECH. ASSIST.	387,446	492,960	594,243	492,075	161,916	2,128,640
ST TECH ASSIST.	63,552	314,877	410,798	680,369	649,074	2,123,670
LT TRAINING	104,000	79,200	94,344	45,338	52,112	374,994
ST TRAINING (U.S.)	60,000	37,000	38,960	41,057	43,301	220,318
IN-CTRY TRAINING	14,533	132,321	123,350	203,342	160,309	633,904
3RD CTRY TRAINING	15,418	21,343	10,600	11,236	11,910	70,507
IEC	62,792	121,566	114,452	170,133	107,633	576,576
OPER. RESEARCH	0	0	62,500	143,750	137,500	343,750
DEM. RESEARCH	23,750	63,000	51,750	132,250	172,500	443,250
CONTRACEPTIVES	170,923	227,633	290,621	361,301	439,855	1,490,333
HLTH EQUIP.	69,399	69,899	69,399	69,399	69,899	348,495
OTHER EQUIP.	220,359	5,000	5,000	5,000	5,000	240,359
EVALUATION	100,000	0	100,000	0	156,250	356,250
AUDIT	0	50,000	0	50,000	0	100,000
Subtotal	1,443,430	1,755,007	2,106,725	2,545,953	2,307,467	10,158,587
Conting.	105,561	120,317	139,605	228,233	218,338	841,413
TOTAL	1,548,991	1,875,324	2,296,330	2,764,216	2,515,139	11,000,000

Detailed budgets for each cost category may be found as Annex K. Costs are based on prices and exchange rates prevailing at the time the financial analysis was conducted. An inflation factor of 6% was incorporated to account for price and exchange rate fluctuations; however, line items shifts in the budget may be required depending on the scale of such fluctuations.

ILLUSTRATIVE PLAN FOR OBLIGATION OF FUNDS

	EY_88	EY_89	EY_90	EY_91	EY_92	TOTAL
Technical Assistance						
- Long-term	1,000	900	210	19	0	2,129
- Short-term	290	530	450	530	324	2,124
Training	250	350	300	300	100	1,300
Research/IEC	100	150	250	528	341	1,369
Commodities	410	300	350	552	468	2,080
Evaluation	100	0	100	0	156	356
Audit	0	50	0	50	0	100
Administration	125	150	150	175	101	701
Contingency	125	150	190	230	146	841
TOTAL:	2,400	2,530	2,000	2,334	1,636	11,000

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Illustrative Methods of Implementation and Financing

<u>Method of Implementation</u>	<u>Method of Financing</u>	<u>Amount \$000</u>
1. Technical Assistance		
A.I.D. direct contracts	Direct payment	4,953
2. Training		
A.I.D. direct	Direct payment	666
A.I.D. direct contracts	Direct payment	476
Host country financing	Direct payment	158
3. Commodities		
A.I.D. direct	Direct payment	1,870
A.I.D. direct contracts	Direct payment	211
3. Other Costs		
A.I.D. direct contracts	Direct payment	879
Host country financing	Direct payment	490
4. Evaluation		
A.I.D. direct	Direct payment	356
6. Audit		
A.I.D. direct	Direct payment	100
7. Contingency/Inflation		341
Total (Rounded)		11,000

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A. Technical Assistance

Three long-term advisors for 120 person-months, costing approximately \$2,129,000 are required to implement the project. They consist of a management analyst and specialists in training and IEC. The three are expected to arrive in Niger in early 1989. The two specialists will remain for 36 months and the management analyst for 48 months. The cost of the long term advisors includes the cost of USAID/Niger contractor support.

The activities of the long-term advisors will be complemented and supported by approximately 79.5 person-months of short-term consultants. Estimated cost for this activity is \$2,123,670, averaging at \$26,713 per month.

B. Administrative Costs

The project will require a support staff, including an office manager, accountant, 2 secretaries, 2 drivers, a janitor and 2 guards. Additional administrative costs include office rental, utilities, and operating expenses (communications, fuel, maintenance and expendable supplies). Total costs for administrative support amount to \$701,040.

C. Participant Training

Approximately \$375,000 is earmarked for long-term graduate education in the U.S. The cost covers 144 person-months for two Ph.D.'s and two master's degrees. In addition, it is proposed that two candidates for master's degrees in Demography be included under AFRAD support for this project (contingent upon acceptance and tuition waiver by U.S. universities).

Local costs for in-country training are estimated at \$633,905. Short-term training in the U.S. is estimated at 44 person-months with an estimated cost of \$220,000.

Third country training will consist of workshops in countries such as Morocco and Togo, primarily for training in IUD insertion and IEC. Third country training is estimated at \$70,507.

D. Information-Education-Communication

Inputs for the IEC activities include support of audience research, financing of the departmental IEC campaigns and the National Family Health Week, support of community meetings, purchase of contraceptive sample cases and boards, production of billboards and signs, 16 television and radio plays, 96 radio and TV spot announcements, 144 newspaper advertisements, and acquisition of other IEC materials. Total costs to support the IEC campaign, exclusive of technical assistance and training, amount to \$576,576.

E. Operations Research Activities

The costs of the operations research activities include training for the

pharmacists and village health workers, local research costs, promotional and IEC materials and other local costs. Exclusive of technical assistance, costs for the operations research activities are estimated at \$343,750.

F. Demographic Research Activities

Costs for the demographic activities include microcomputers (4), software and supplies for processing and analysis of the census data (\$53,000), studies to complement the census data (\$40,000), local costs for the Niger Demographic and Health Survey (\$260,000) and documentation and dissemination activities (\$45,000 for the purchase of books, journals and documents and \$50,000 for dissemination activities). Total costs for the demographic research and analysis component, exclusive of technical assistance, are estimated at \$443,250.

G. Commodities and Equipment

Contraceptives, vehicles and medical equipment will constitute the bulk of commodity procurements under the NFHDP. Contraceptives are estimated at \$1.4 million, health equipment and supplies for the health installations at \$350,000 and vehicles at \$110,794. The NFHDP will finance procurement of a variety of equipment and supplies ranging from calculators to typewriters to microcomputers. Estimated total commodity costs are \$2,053,000.

H. Audit

Financial management reviews have been scheduled for FY 89 and FY 91 to ensure that appropriate financial management and information systems have been established and are being maintained. If the reviews uncover any weaknesses in the project internal controls, RIG/A/Dakar will be asked to audit the project, USAID/Niger Controller's Office or the contractors.

If required for any reason, a financial audit will be performed on the accounts and records of institutional contractor(s) during the third year of the project or more frequently if necessary. If the project is extended, the audit will be performed before the implementation of any extensions thereof. The audit, which will concentrate principally on financial accountability, may also include some compliance reviews. The audit will cover both the home office and field expenditures.

The contractor will refund to A.I.O. all disallowances found by the audit, if any, and will take prompt action to resolve audit recommendations.

Funds turned over to the Government of Niger for disbursement may be audited twice in conjunction with the financial management reviews. Since these funds are subject to FAA Section 121(d) certification requirements, the audit must be performed under RIG/A/Dakar cognizance.

In accordance with FAA Section 121(d) certification requirements, any agency of the Government of Niger disbursing funds directly must meet the

requirements set forth below and be certified by the USAID/Niger Controller's Office as having an adequate system of accounts. The requirements include having:

1. A separate bank account for A.I.D. funds.
2. An adequately trained accounting staff.
3. An adequate internal control system.
4. Books and records sufficient to account for receipt of funds, disbursement of funds and balances of remaining encumbrances.
5. Management system of approvals and controls adequate to show budgets for future expenditures, actual results compared to actual expenditures and definite plans to meet the quantifiable objectives of the project.
6. Naming a project director.

Definitions

1. An accountant is a person having adequate training and experience in the concepts and applications of accounting principles.

2. Internal control comprises both accounting controls and administrative controls.

A. Accounting control: Plan of organization including procedures and records concerned with (a) safeguarding assets; (b) reliability of financial records; and (c) Assuring that transactions are properly authorized, executed and recorded in conformity with proper accounting principles.

B. Administrative Controls are those plans or organizational procedures concerned with decision making leading to achievement of organizational goals. There must be an internal control system in place for the following: petty cash, gasoline coupons and project property and equipment inventory.

3. A set of books means maintaining on a current basis:

- a. Donor receivable journal for controlling advances.
- b. Cash receipts and disbursements journal
- c. Bank reconciliation worksheet
- d. Disallowance journal
- e. Encumbrance journal

4. Records consist of files, supporting documents and correspondence.

Note: SFRMP II will be involved in establishing the accounting system at the beginning of the project and will perform periodic reviews to ensure that the system is being maintained. PACD for SFRMP II is November 1939. Note: The USAID/Niger Financial Analyst reviews project accounting systems semi-annually to ensure that Section 121 (d) requirements are being maintained. If a problem is discovered and RIG/A is unable to perform an audit in a timely fashion, some of the Contingency amount will be programmed for an audit by CPA firm.

Costs for audits are estimated at \$100,000.

I. Evaluation

A baseline assessment, a mid-point evaluation and a summative evaluation will be scheduled. The baseline assessment is budgeted at \$100,000, the mid-point evaluation at \$100,000 and the final evaluation at \$156,000.

J. In-kind Contribution

The Government of Niger will make in-kind contribution to the project in the form of civil service personnel, infrastructure (use of existing buildings) and equipment (use of existing vehicles and equipment). The monetary value the personnel contribution to the family health component is estimated at \$593,000 over the course of five years.

The contribution of locales and use of equipment has not been estimated monetarily. However, the following contributions are planned:

Use of space for FH services:

- MFHC
- 146 health facilities (by PACD)
- warehouses

Use of space for in-country training

Use of equipment, vehicles belonging to MOPH/SA

Use of equipment, vehicles belonging to MOP.

The value of the personnel contribution by the Ministry of Plan has not been computed, as it will be sporadic and short-term in nature.

V. IMPLEMENTATION PLAN

This section provides an overview of the Implementation Plan. The Implementation Plan is designed to answer the following critical questions for each project subcomponent:

Who is responsible for managing the sub-component?

Who will provide the requisite technical assistance?

Who is responsible for the procurement of goods and services?

What logistical support is needed from the GON counterpart agency?

What is the schedule for project implementation?

See Annex I for detailed schedules and justification for choices of implementation modes.

USAID/Niger oversight of the implementation process will be provided by a contract Population Program Coordinator, working under the supervision of the Health Development Officer, during the first two years of the project. Thereafter, a direct hire Health/Population Officer will be responsible for project oversight. As described below, management of technical assistance for the Family Health Component will be largely the responsibility of the Institutional Contractor, who will be accountable to the USAID Project Officer. Technical assistance for the Demographic Research and Analysis Component, which is all short term, will be managed directly by USAID/HDO.

A. Management Responsibility

The Ministry of Plan will have overall responsibility for the implementation of the NFHDP. This is a role which is within the normal purview of the MCP, which is the official coordinator for all donor projects for the GON. The MCP is also the key agency responsible for NdSS, with the MOPH/SA as the major implementing agency.

Responsibility for implementation of the Family Health Component will fall largely to the Ministry of Public Health and Social Affairs and, more specifically, to the Directorate for Family Planning. The DPF Director will thus have primary day-to-day responsibility for implementation of the FH Component. However, the complexity and magnitude of the project will require delegation of responsibility for specific project elements. Accordingly, implementation responsibility for each project element has been assigned to a specific individual. The following chart shows the allocation of management responsibility for the FH Component elements.

Element	Responsible Unit/Individual
Training	DPF Training Coordinator
IEC	DPF IEC Coordinator
Logistics/supply system	DPF Logistics Coordinator
Management development	DPF Director
Operations Research	
- VHT Project	DPF Office of Studies and Programming and DES
- Commercial distribution project	ONPPC Project Manager and DPF Office of Studies and Programming

Responsibility for management of the Demographic Research and Analysis Component will rest with the MOP and, more particularly, with the Directorate for Statistics and Computer Services (DSI). The planned reorganization of the DSI will create a structure well suited to the implementation of the Demography Component. While the DSI Director will have primary management responsibility for implementation of the Demography Component, delegation of the component elements will occur in accordance with the following schema:

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Element

Responsible Unit/Individual

Census processing
and analysis

Central Office of the Census

Niger Demographic
and Health Survey

DSI/Center for Studies and Surveys

Training

DSI Training Center

Documentation and
dissemination

DSI Documentation and
Dissemination Center

3. Technical Assistance

1. Family Health Component

Technical assistance for the Family Health Component will be provided by an institutional Contractor under a direct A.I.D. contract. The Contractor will provide all long and short-term technical assistance needed to carry out the Family Health Component, with the exception of the constituency development element. Ten person-years of long-term technical assistance and 43 person-months of short-term technical assistance are to be provided in accordance with the schedule set forth in the Project Description. The long term technical assistance team will include a Management Analyst (counterpart: DPP Director), a Training Specialist (counterpart: DPP Training Coordinator) and an IEC Specialist (counterpart: DPP IEC Coordinator). The tenure of the Management Analyst, who will serve as Chief of Party, will be four years and that of the Training and IEC Specialists three years each. In addition, FHI II funds will be used to buy-in to the centrally funded OPTIONS Project to procure 5 person-months of technical assistance to support constituency development.

Because of the high level of management responsibility vested in the Contractor, provision has been made in the budget for a contractor administrative and support staff, which will include a locally recruited accountant/purchasing agent, an office manager and 2 secretaries.

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The specific responsibilities for technical assistance in the FH Component are shown below:

Element	Responsible Party/Duration
Constituency development	OPTIONS: 6 months ST TA
Training	Contractor: Training Specialist (3 yrs.) + 11 months ST TA
IEC	Contractor: IEC Specialist (3 yrs.) + 6 months ST TA
Logistics/supply system	Contractor: 6 mos. ST TA
Management development	Contractor: Management Analyst (4 yrs.)
Operations Research	
- VHT Project	Contractor: 12 mos. ST TA
- Commercial distribution	Contractor: 8 mos. ST TA

2. Demographic Research and Analysis Component

The NFHDP will provide 30.5 person-months of short-term technical assistance for the Demographic Research and Analysis Component. The Demography Component will rely primarily on "buy-ins" to centrally funded population projects to procure the requisite technical assistance. ST/POP finances a variety of projects that provide specialized expertise. Bilateral projects can allocate funds (i.e., "buy-in") to these ST/POP projects to accomplish specific tasks. For example, ST/POP maintains a PASA with the U.S. Bureau of the Census for the purpose of providing technical assistance to developing countries in implementing censuses. USAID/Niger buy-ins to the PASA have been used to procure technical assistance for the 1988 Niger census.

The NFHDP will buy-in to four centrally funded projects:

(a) Bureau of the Census, which provides technical assistance for censuses.

(b) Demographic and Health Surveys Project, which is a world-wide project supporting demographic and health surveys in developing countries.

(c) RAPID III Project, which specializes in economic-demographic modeling.

(d) IMPACT, which specializes in disseminating demographic information to non-technical audiences.

Technical assistance for the Demography Component will be allocated as follows:

Element	Central Project 3 Duration
Census data processing	BuGen: 5.5 person-months
Census quality study	BuGen: 2.5 months
Census analysis reports	RAPID III: 6 months
Niger Demographic and Health Survey	Demographic and Health Survey Project: 12.5 months
Documentation and dissemination	IMPACT: 4 months

C. Procurement of Goods and Services

1. Procuring Technical Assistance

(a) Family Health Component

A direct A.I.D. contract, selected under full and open competition, will be used to hire a Project Contractor for the Family Health Component. The Contractor will be responsible for providing technical assistance, procuring commodities, and supporting participant training. Demonstrated technical competence to meet the project objectives, prior successful experience in managing family health projects (particularly in Africa) and experience in commodity procurement will be given highest priority in the selection of the Project Contractor. Detailed descriptions of the qualifications and responsibilities of the long term advisors to be provided by the Contractor are contained in Annex J.

The decision to undertake full and open competition was made after careful consideration and review of information on Gray Amendment entities and particularly 8(a) institutions provided by AID/Washington. The family health field is not, to this date, a major center of activity by Gray Amendment entities. Therefore, restriction of contracting to 8(a) institutions would not be beneficial to the Agency or to the Government of Niger. However, USAID is hopeful that Gray Amendment entities will be among the competitors for the technical assistance contract, either as prime or as subcontractor bidders.

(b) Demographic Research and Analysis Component

USAID/Niger will prepare the PIO/T's for the buy-ins to the centrally funded projects. The PIO/T's will be issued to AID/ST/POP, which will amend the agreements with the appropriate cooperating agencies in accordance with the PIO/T's.

2. Other Goods and Services

(a) Family Health Component

Procurement of vehicles and most project equipment (office furniture, appliances, microcomputers, etc.) for the Family Health Component will be handled by USAID/Niger. Procurement of contraceptives will be handled through a buy-in to the ST/POP Contraceptive Procurement Project (963-3018); health and medical equipment (such as IUD kits) can be procured most inexpensively and efficiently through the General Services Administration. Contracting for long-term training abroad will be the responsibility of USAID/Niger. Procurement of locally available goods and services needed for the Family Health Component will be handled by the long term contractor; this will include the local costs for in-country training, IEC activities and operations research.

(b) Demographic Research and Analysis Component

Procurement and disbursement of items purchased abroad (foreign exchange costs) for the Demographic Research and Analysis Component will be the responsibility of the Cooperating Agency responsible for the specific project element. USAID/Niger will be responsible for the procurement of books and materials purchased abroad under the Documentation and Dissemination sub-component. Procurement and disbursement for local cost items will be the responsibility of the MCP and, more specifically, the OSI.

(c) Audit and Evaluation

Procurement of audit and evaluation services will be handled by USAID/Niger through buy-ins to existing Indefinite Quantity Contracts.

The following chart shows the distribution of responsibility for procurement and disbursement. The cost categories in the chart are the same as those shown in the detailed budget.

Element	Procurement	Disbursement
Administration	Contractor	Contractor
Equipment (FM Component)	USAID/Niger	USAID/Niger
Equipment (FX - Dem. Component)	Cooperating agency	Cooperating agency
Equipment (Local costs - Dem. Component)	DSI	DSI
Office Rental (FM Component)	Contractor	Contractor
Operating Expenses (FM Component)	Contractor	Contractor
LT Training	USAID/Niger	USAID/Niger
ST Training Abroad	USAID/Niger Contractor	USAID/Niger
IC ST Training (FM Component)	Contractor	Contractor
IC ST Training (Dem. Component)	DSI	DSI
IEC Activities	Contractor	Contractor
Operation Research Activities	Contractor	Contractor
NDMS (local costs)	DSI	DSI
Doc. & Dissam.	USAID/DSI	USAID/DSI
Contraceptives	Contraceptive Procurement Project	AID/W
Audit	USAID/Niger	USAID/Niger
Evaluation	USAID/Niger	USAID/Niger

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D. Logistical Support

For every project element, support from the GON counterpart agency will be required for implementation to succeed. This section provides an overview of the logistical and administrative support required by each element as well the identity of the unit responsible for providing the support. Close collaboration between the GON and USAID in the design of the project has served to clarify the responsibilities of the various parties. The following chart summarizes the logistical support requirements.

Element	Support Needed	Responsible GON Unit
FAMILY HEALTH		
Constituency development	Conference facilities	MOPH/SA
Fm Component Management	Name staff with appropriate qualifications & authority	MOPH/SA
Fm Service Delivery	Authorize and supervise staff	MOPH/SA
Fm ST Training	Nominate participants, training facilities & arrangements	MOPH/SA/DFEPS
Fm LT Training	Nominate participants, assign returned trainees to Fm program	MOPH/SA/DFEPS
IEC	Cooperation of local/regional MOPH/SA staff & mass media	MOPH/SA, ORTN
Contraceptive Supply	Authorize importation, transport contraceptives, maintain records	ONPPC, MOPH/SA
Management Development	Systems maintenance & monitoring	MOPH/SA
Operations Research		
-VHT Project	Identify VHT's, facilitate training, supervise, deliver IEC materials/contraceptives	MOPH/SA
-Commercial distribution	Assign project mgr., identify pharms./depots, supervise, facilitate training, deliver IEC materials/contraceptives	ONPPC

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DEMOGRAPHIC RESEARCH

Census processing and analysis	Provide microcomputers and staff	MOP/DSI
NDHS	Provide vehicles (5), microcomputers & staff, manage survey execution	MOP/DSI
LT Demographic Training	Nominate candidates, assign returned candidates appropriately	MOP
ST Demographic Training	Nominate candidates, training facilities, facilitate training	MOP/DSI
Documentation & Dissemination	Provide library facilities & staff	DSI, Univ. of Niamey

E. Project Implementation Schedule

The Detailed Implementation Plan provides a detailed schedule for the implementation of each project element. However, reasonable flexibility must be maintained by USAID/Niger and the GON to reschedule specific events as the project evolves. Accordingly, USAID and the GON will collaborate in the development of annual work plans to specify the schedule of activities for each year.

This section provides an overview of critical dates, focusing primarily on the schedule for procuring technical assistance and essential A.I.D. management activities.

ITEM	MONTH(S)
FINAL NEGOTIATION	
Grant Agreement Signed	1
PIL No. 1 issued	1
Conditions Precedent Met	4
CONTRACTOR SELECTION (FH Component)	
USAID Issues PIO/T to REDSO	3
AID/W Publishes CBD Notice	4
REDSO Prepares RFP	4
Bidders Submit Proposals	6
Contractor Selected	8
Contract Signed	9
In-Country Logistics	
Support Arranged	10
Contract Team Arrives	12

SHORT TERM ADVISORS (Demography Component)

PIO/T for BuCen Prepared and Forwarded to AID/W	4
BuCen PASA Amended	5
IMPACT PIO/T Prepared and Forwarded to AID/W	8
IMPACT Contract Amended	9
DHS PIO/T Prepared and Forwarded to AID/W	14
DHS Contract Amended	15
RAPID III PIO/T Prepared and Forwarded to AID/W	17
RAPID III Contract Amended	18

CONTRACEPTIVE PROCUREMENT

Prepare PIC/C for 1st Contraceptive Procurement	5
USAID Monitors Contraceptive Procurement	6-10
1st Contraceptive Shipment Arrives and is Cleared	11
Prepare PIC/C's for Additional Contraceptive Procurements	Every 6 mos beginning with month 11

TRAINING

LT Training	
Receive Nominations from GON	4
USAID Prepares PIO/P's Ph.D. & M.S. Candidates	4
Start English Language Training	4
Start LT Training	12
M.S. Candidates Return	36
Ph.D. Candidates Return	57

ST Training Abroad	
Training Course Identified	Ongoing
GON Nominations Received	90 days before training start date for U.S.; 60 days for third country
USAID Prepares PIO/P's	As needed
Logistics Arranged	On-going
Participants Leave	On-going
Participants Return	On-going

IMPLEMENTATION PLANNING

FH Component	
Contractor & DPF Director Prepare Annual Work Plan	13, 25, 37, 49
Work Plan Reviewed by GON & USAID	14, 26, 38, 50

Demography Component

DSI Director & Pop. Officer Prepare Annual Work Plan	12, 24, 36, 48
Work Plan Reviewed by GON & USAID	13, 25, 37, 49

MANAGEMENT AND EVALUATION

Quarterly Reports	Every quarter by contractor
Semi-Annual Review with GON	Every 6 mos. beginning month 6
Baseline Assessment	6
Mid-term Evaluation	28
Second Evaluation	46
AID for Phase II	48
Phase II Project Paper Completed	54
PACD	60

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VI. MONITORING PLAN

This section details the methods by which USAID/Niger will monitor the progress of the NFHCP. The monitoring plan will ensure that USAID/Niger obtains timely, accurate information on the technical, managerial and financial aspects of the project. The monitoring plan will allow USAID to determine the status of inputs and outputs with respect to established benchmarks and schedules, as well as to ensure that project funds are being disbursed legally and for the intended purposes.

Direct responsibility for project monitoring will rest with the USAID/Niger Health Development Office. During the first 24 months of project implementation a contract Population Program Coordinator will be assigned this task under the supervision of the Health Development Officer. Thereafter, a direct hire Health/Population Officer will have full time responsibility for project monitoring and management.

A USAID project committee composed of the project officer and supervisor, as well as representatives from the Management Office, Controller's Office, Program Office and Project Development Office, will assure mission oversight of project implementation. Approval of the committee is required for all substantive implementation decisions (for example, agreement that CPs are met, execution of PIO/PS, PIO/TS and PIO/CS, choice of contractors, waivers). The committee will also meet formally at least twice a year to review project progress toward achievement of project goal and purpose. Meetings may be called on a more frequent basis to deal with particular implementation problems by the membership or on request of Mission management.

Project monitoring will be facilitated by the requirements imposed on the contractors responsible for project implementation. This monitoring plan establishes the mechanisms by which the contractors are to provide timely, accurate information to the Health Development Office. While primary responsibility for project monitoring will rest with USAID/Niger, the reporting requirements will greatly facilitate accomplishment of the task.

A. Sources and Methods for Project Monitoring

1. Project Agreement and PILs - These documents will establish the benchmarks against which progress is to be measured and provide guidance to the implementing agencies as to USAID expectations, policies and procedures. This Project Paper has specified in considerable detail the nature and level of project inputs and outputs, the schedule for implementation of each project sub-component and the contributions expected from each party. The Project Agreement will be equally specific, thereby minimizing the possibilities for misunderstanding as to project elements. Project monitoring will be facilitated by the ability of USAID project managers to refer to specific schedules and objectives provided in the Project Agreement.

2. Annual Work Plans: The Project Agreement will be complemented by

annual work plans to be prepared by the MOPH/SA and the MOP for implementation of their respective project components. The Health Development Office and the contractors will assist the ministries in the preparation of the work plans, which will require the approval of USAID/Niger.

3. Financial Management and Reporting: The long-term contractor will be responsible for establishing work plans for the team and issuing financial reports for the Family Health component which show planned and actual expenditures and explain any variance that may exist. The responsible U.S. Cooperating Agency (DHS, RAPID, IMPACT) will generate financial reports with respect to implementation of the Demographic Research and Analysis component. Financial reports are to be produced quarterly, and will list disbursements and accruals by budget line item for the current quarter, shown comparatively with cumulative disbursements. The USAID Financial Analysts will review the accounting system semi-annually and issue reports on the financial compliance of the project.

4. Technical Reports: Short technical reports will be submitted each quarter by the DPF and the DSI to summarize activities undertaken during the quarter and identify any problems or bottlenecks in project implementation. Both agencies will submit annual reports in conjunction with their annual work plans. The annual reports will provide a detailed review of project progress with specific reference to the targets and schedules established at the beginning of the year. The long-term contractor will assist the DPF in the preparation of all technical reports. Short-term consultants will also be expected to submit concise trip reports.

5. Project Implementation Reports: Semi-annual Project Implementation Reports (PIR) will be prepared by the USAID project officer for review by the mission and submission to AID/Washington. The PIRs will track progress on supply of inputs, achievement of outputs, budget accruals and pipeline status. In addition, the PIRs will be used to review progress towards achievement of project purpose.

6. Consultation with Implementing Agencies: As a matter of practice, the USAID/Niger Health Development Office maintains frequent contact with its counterparts in the MOPH/SA and the MOP. This regular communication will be maintained during the NFHDOP. At a minimum, quarterly meetings will be held with the Directors of the DPF and the DSI to review the quarterly technical reports. An annual project review meeting will be held with senior officials of the MOP and the MOPH/SA to review the annual technical reports and the work plans. As needed, additional consultation with the Directors and other involved GON staff will occur.

7. Site Visits: Site visits will be particularly important for the Family Health Component. As stated earlier, a plan for service delivery expansion that identifies the health facilities in which services are to be introduced is to be provided by the MOPH/SA at the beginning of each year. Site visits will be made to these facilities during the course of each year by DPF staff and the USAID Population Officer. The site visits will be structured to

investigate key issues, including the following:

- Service provider perceptions of the training after they return to their duty posts.
- Levels of service delivery.
- Adequacy of contraceptive supply.
- Availability of IEC materials and level of IEC activity in the surrounding communities.
- Maintenance of record keeping systems.
- Supervision of service providers.
- Problems and bottlenecks perceived by the service providers.

The combination of activities listed above should provide sufficient information for USAID to monitor closely the progress of the NFHDP, identify problems at an early point and develop solutions.

VII. SUMMARIES OF ANALYSES

A. Technical Analysis

The Niger Family Health and Demography Project has the dual aims of implementing a national family health program and establishing an effective demographic research and analysis program. Both of these are relatively new programs to Niger and therefore require substantial inputs in order to develop the institutions which can support and sustain these programs in the long term. Approaches to developing these programs and institutions are just now being tested in Niger, and this project will need to continue these tests in order to determine which approaches and methods are most effective. Given what we presently know about the implementation of these programs in Niger and similar countries in Africa and other countries around the world, the approaches and methods selected for the implementation of both components are practical and appropriate. However, the project design must permit flexibility to adjust approaches if research, monitoring, and/or evaluation findings indicate that some element is not as effective as anticipated.

Each component and its technical appropriateness were examined in detail.

1. Family Health Component

Analysis of alternatives for the nationwide delivery of family health services indicated that the only feasible approach in the near term is to integrate family health services into already existing maternal-child health services/activities. This determination was based on the facts that family

planning services are presently perceived as health services in the context of preventive services for improving maternal/child health and promoting birth spacing, and that the MOPH/SA has the only network of health services delivery institutions in Niger.

The slow and steady approach to decentralization of family health services to the 146 health facilities targeted by this project is justified in the case of Niger; these services are just getting started and there is a lot to learn about how to present and deliver these services and deal with any constraints which may develop.

The elements of the family health component are those which are by now considered standard in the delivery of family health services and which have been derived from long experience around the world and especially in Africa. This experience has shown that to deliver family health services, a program must have: potential clients, that is, people who know that the services exist, where and how to get them, and how they can benefit, information which is provided through the IEC element; people to provide the services, that is, staff who are trained in how to offer these services; the commodities, that is, contraceptive supplies available at all times; and management, which assures that the services are sustained and maintained, and can be extended and expanded. It is also recognized that the introduction and expansion of services are greatly facilitated when key leaders support the services and when legal and other related policies reinforce the delivery of effective services. While operations research is not essential to the development of a national program, the results of the operations research studies will assist in making the determination about future expansion of family health services and the possibilities of using other than the MOPH/SA network in the delivery of the services.

The family planning methods which will be offered through the family health program component are effective modern methods, including natural family planning. The project is endeavoring to offer as wide a choice as possible to all potential users while taking into consideration the levels of training and present policies of the MOPH/SA. The operations research element will explore the possibility of making selected, non-prescription methods (e.g., condoms) available on a wider basis.

(a) IEC

In preparing the plan for IEC, lessons learned from implementation of IEC programs in other countries and Africa were used to identify a series of required activities, i.e. audience research, message testing, media selection, dissemination, and evaluation. Experience to date in Niger was also reviewed to identify specific needs and emphases. Experience from the 21-month project started in December, 1987 will be used to refine the proposed program.

The experience of the NFHC with IEC to date, the roles of other government organizations in the diffusion of information, and experiences with other

campaigns indicate that the mass media are of particular importance in disseminating new information.

At present, research is being done on the effectiveness of community meetings in the promotion of family health services.

Key recommendations include on-going coordination among the donor agencies to assure the most appropriate use of all available resources, identification, assignment and training of staff to carry out IEC activities, monitoring and supervision, careful development of messages for specific audiences, involvement and training of key personnel in those organizations with grassroots outreach and influence, and clear delineation of roles and responsibilities among all the involved entities. To accomplish this, the project has emphasized the provision of technical assistance and training and support for the series of activities which will be needed to implement an effective IEC program.

(c) Training

In order to assure effective delivery of family planning services, all persons responsible for delivery of services, supervision, and management must be able to demonstrate competence in the required skills. Given that this is a new program for which few people have been trained, most staff will require training. To assure quality and quantity, a core team of trainers will be trained in the requisite family health and training skills. Analysis of the training needs for implementation of project activities in the health facilities resulted in the plan presented in the project description. The sequencing and timing of training events were carefully considered to avoid over-burdening staff and to make sure that once people were trained, the supply and supervision systems would be in place to support and reinforce them. Because services will be started in facilities where staff are already placed, in-service training will be needed to meet their training needs. However, over time, in-service training will be reduced to refresher courses as future health care providers will receive training in family health as an integral part of their technical education.

The project has identified the key groups and types of training required for each: managers, supervisors, service providers, and trainers. It also recognizes that training alone is not sufficient to assure effective performance; training must include follow-up, on-going evaluation, and supervision.

The analysis identifies a number of areas which will require special attention throughout project implementation: on-going monitoring of the training itself to insure quality, and follow-up of participants to assist them to translate what they have learned into practice in their work settings. Proposed inputs for the training element are appropriate and sufficient to support the development of an effective training team and program.

(c) Contraceptive Supply and Logistics Management

All aspects of the logistics system and its management were studied in order to develop appropriate recommendations with which to guide the transition from a family health center which essentially manages its own supplies to a national distribution system. These recommendations can be summarized as follows. The program needs to make a decision as to which contraceptives and what brands will be offered. At the present time, there are so many products that management is impossible even within one center. When expansion to other centers takes place, these problems will be compounded. To avoid unnecessary delays in clearing contraceptives from customs, ONPPC procedures should be strictly adhered to. On the other hand, because delays can occur, a preliminary supply of contraceptives should be in place before the project starts. Warehouse space will need to be greatly expanded to accommodate the contraceptives needed for a national program; it is recommended that the NFHC be responsible for storage at the central level and for managing national distribution in coordination with the other major offices of the MOPH/SA.

It is recommended that distribution of contraceptives follow the same procedures as distribution of other donated drugs. When the DDS's place their orders for drugs every trimester, they should also place their orders for contraceptives. Each DDS will send a truck to Niamey to pick up the supplies when they are ready. The truck would stop at the CNSF warehouse to pick up the contraceptive supplies; the DDS's would then follow the normal procedures for distributing the supplies to the health facilities in their departments. For the system to work effectively, all personnel at every level must be trained to manage the supplies; at the same time, to assure against possible breakdowns in the system, there must be safety stocks at each level.

Inputs of training and guidance in how to set up the logistics system, as well as some key inputs for transport, are sufficient to assure effective functioning of the system.

Hand in hand with the logistics system is the information system which permits the system to function; only with adequate information on stocks, out-flow, etc. can the DDS's prepare their orders based on needs rather than guesses. At the same time, developers of the information system must avoid over-burdening health care providers with paper-work.

Special attention will have to be given to the assignment of staff to manage the logistics system, the definition of their roles and responsibilities, and their training, as these will be full-time responsibilities in the national program.

Inputs of technical assistance, training and commodities are appropriate to the identified needs and consistent with experience in many other countries.

(d) Management Development

Effective implementation of the national program will require a variety of

management skills, including budgeting, planning, monitoring and problem-solving. As the specific needs will change over time, on-going assessment will be required to assure that these needs can be met. Short and long-term technical assistance and training are envisaged and are appropriate to the needs. More in-depth analysis of these needs is provided in the Administrative Analysis.

(e) Constituency Development

This element focuses on constituency development activities which will strengthen and assist in the organization of service delivery. Inputs are limited to technical assistance and local cost financing for conferences.

(f) Operations Research

Development of an operations research element and capability was seen to be in the longer-term interests of the project in the ultimate objective of extending family health services to all the people of Niger. Two avenues for developing this capability were explored and then combined in an attempt to take the best of both. These were long-term training of the staff responsible for OR and in-the-field practice in implementing OR studies. An important premise of these approaches and their combination is that a good OR researcher must have both sound academic training and in-the-field experience. While two studies have already been identified, the project should remain flexible to pursue other studies if one or both of these are no longer feasible at the time of implementation. Inputs are in line with the plan for the element: long-term and short-term training, short-term technical assistance and local costs.

2. Demographic Research and Analysis Component

To identify the most appropriate areas for this project to support, experts took the following factors into consideration: needs, that is, demographic data needs for planning and other purposes; inputs and projects of other donors; what is already in place, that is, what there is to build on and work with; and resources available. An institution-building approach was selected which requires steady development of skills and capabilities. As these skills and capabilities require long-term training to develop, the only viable way is to include long-term training of key personnel; this is coupled with short-term training in-country and technical assistance. The DSI of the MOP has the mandate to conduct demographic studies and conduct analyses for planning and has already received substantial assistance in its role in the implementation of the 1988 census. It was deemed highly appropriate to build on this base and to complement what other donors were planning to do. The elements were selected on the basis of the criteria mentioned above. Of special note are two: the Demographic and Health Survey, which will be the only major data collection effort to be implemented by this project and which will provide data complementary to those from the census and of particular utility for health planning; and documentation and dissemination, which are frequently neglected in demographic research.

Inputs are geared to effective implementation of each element and are appropriate and sufficient.

5. Economic Analysis

The economic justification for the NFHD as an appropriate investment of A.I.D. resources is twofold: (1) its social profitability (the value to Niger of expanding FP services nationwide); and, (2) the return on the investment in terms of the gain in GDP per capita derived from slower population growth.

1. Benefit-Cost Analysis

The benefit-cost analysis conducted for the NFHD focuses on the Family Health Component, since a quantitative estimate of the benefits of the Demographic Research and Analysis Component was not possible. It should be recognized, however, that even relatively small improvements in the efficiency of economic planning as a result of better demographic data are likely to surpass the investment of approximately \$2 million in demographic research and training.

A benefit-cost analysis for family planning must take into account the contradictory effects of lowered fertility. That is, lowered fertility is likely to simultaneously raise per capita income (by reducing the number of people who share national output) and lower total income (by reducing the size of the potential labor force). In these circumstances it is not clear a priori whether the economic impact will be positive or negative.

The methodology employed incorporates both the positive and negative effects of slower population growth. In each year of the project analysis, project benefits are defined as the increase in per capita income due to the project, multiplied by the population existing with the project.

Defining project benefits along these lines means projecting over the period of the analysis what population and income would be with the project and without the project. The "slow fertility decline" scenario postulated in the Five-Year Plan is used as the standard of comparison; i.e., GDP per capita without a program that accelerates fertility decline was first calculated. This was then compared with GDP per capita under two different population projections: one that assumes the project yields a moderate decline in fertility and one that assumes the project yields a rapid decline in fertility.

The population projections are the same as those in the Five-Year Plan, which were calculated using a cohort-component methodology. Income was projected by specifying an aggregate production function of the following form:

GDP function of (labor force, capital)

Labor force projections are derived from the population projections and capital stock projections were obtained by assuming a certain ratio between annual net investment and gross domestic product.

A fifteen-year period of analysis was used. This period was chosen for two reasons: first, because the project is likely to have effects beyond the project period, and second, because the differences in the size of the labor force due to a decline in fertility are not likely to emerge until after 15 years.

The results of the analysis are shown in the following table:

	SLOW FERTILITY DECLINE	MODERATE FERTILITY DECLINE	RAPID FERTILITY DECLINE
POP. - 1988	7,019,000	7,019,000	7,019,000
POP. - 2003	11,392,000	11,213,000	10,736,000
GDP/CAP - 1988	\$299.62	\$299.62	\$299.62
GDP/CAP - 2003	\$292.92	\$297.47	\$310.33
% GAIN	-	1.56%	5.96%
DISCOUNTED BENEFITS		\$33,000,000	\$350,000,000
DISCOUNTED COSTS		\$10,606,000	\$10,324,000
BENEFIT/COST	-	7.82	32.27

The results show that under either scenario, the benefit-cost ratio is favorable; under the rapid fertility decline scenario, the ratio is very high. Without the project, per capita GDP declines from approximately \$300 to approximately \$293. Under the moderate fertility decline scenario, GDP per capita is lower than in 1988, but is 1.6% higher in the year 2003 when compared to the slow fertility decline scenario. Under the rapid fertility decline scenario, there is an absolute rise in per capita GDP between 1988 and 2003, and GDP per capita is 6% higher than in the year 2003 when compared with the slow fertility decline scenario.

These projections should not be taken as predictions of the absolute level of income in any one year. Changes in variables such as agricultural production, export commodity prices and so forth will affect GDP per capita. However, changes in these parameters would apply to both the "with" and "without" project scenarios. Hence, the changes would not affect the relative differences between the with and without scenarios.

Another type of benefit-cost analysis which is of some interest is to look at the effect of the project, not on aggregate economic activity, but on the activity in a specific sector such as education or agriculture. While quantitative estimates were not possible, it does appear that the project will yield a number of sector-specific benefits, notably in education, health, urban infrastructure and agriculture. Fewer births will mean a budgetary saving for the educational system, after a lag of 5 or 6 years. The demands

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on health facilities, particularly those associated with maternal and child care, will be reduced. A slowing of the rate of urban population growth means budgetary savings for the government in providing urban services such as sanitation, water supply and transportation.

Of particular interest is the potential impact on the agricultural sector. Between 1961 and 1985 agricultural output grew at an average rate of 1.2%. It seems unlikely that growth was held back to an important extent by agricultural labor shortages, since the population was growing at an average annual rate of 2.6% over the same period. Rather, the reasons for slow agricultural growth seem to be factors like water shortages, lack of funds for investment and various institutional difficulties. In these circumstances, slower population growth is likely to improve the balance between agricultural production and consumption, as a result of reducing consumption needs while having little or no effect on production.

2. Cost-Effectiveness Analysis

One of the more commonly used measures of the effectiveness of family planning projects is "couple-years of protection" (CYP). A couple using a contraceptive method for an entire year is said to receive one CYP. The following table shows the CYP's to be generated each year under the moderate and rapid fertility decline scenarios.

CYP's Under Two Scenarios

	MODERATE FERTILITY DECLINE	RAPID FERTILITY DECLINE
1983	25,700	51,600
1989	30,300	66,200
1990	36,100	81,800
1991	41,700	96,900
1992	47,300	116,000
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TOTAL	182,100	412,500

The cost of the Family Health Component is estimated at \$9,049,000. Under the moderate fertility decline scenario this implies a cost per couple year of protection of \$49.69. Under the rapid fertility decline scenario the cost per CYP declines to \$21.94. Hence, the cost-effectiveness of the project will hinge on the number of family planning users generated by the project. Costs per CYP would be lower if a longer life of project had been selected. Start-up costs (training, equipment) of the program are high (training of FP providers alone costs over \$1 million). Under either scenario, cost per CYP

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is not insignificant. The rapid fertility decline scenario cost (\$22 per CYP) compares favorably with that derived under the equivalent scenario in the 7-year Senegal FP Project, \$29 per CYP.

An alternative approach to the cost-effectiveness question is to measure the recurrent cost per CYP. Recurrent costs are estimated at approximately \$709,334 for the year 1993, the year after the project ends. This implies a marginal cost of \$13.11 per CYP under the moderate fertility decline scenario and a marginal cost of \$5.27 under the rapid fertility decline scenario. These costs will primarily be borne by donors.

3. Recurrent Costs

Main recurrent costs for the FP component consist of contraceptive supplies, depreciation and operation of project vehicles, depreciation of IEC equipment and production of IEC materials for public distribution. Recurrent costs for the Family Health Component are estimated at a maximum of one third the project costs in the last year of the project, plus an increment for a continuing rise in the number of contraceptive users. In 1993, nominal recurrent costs are estimated at approximately \$709,000. Under the rapid fertility decline scenario nominal recurrent costs would rise to approximately \$871,000 by 2003. In both cases recurrent costs are donor-subsidized.

The expenditures for the MOPH/SA for 1987 are estimated at 5.55 billion CFA, or \$18.3 million at the current exchange rate. The future growth of this budget is a speculative matter. If under conditions of continuing austerity, the budget grows at only 1% per year, by 1993, the Ministry's budget would stand at \$19.4 million. The recurrent costs would then represent approximately 3.7% of the annual operating budget.

It should be noted that, for this project, no new civil service employees will be hired by the GON and no new independent service delivery systems will be established. Rather, FP is to be incorporated into the normal service delivery system of the ministry. This will require some readjustments of existing positions, but no growth of the civil service.

The recurrent costs unique to this program will be largely borne by donors over the next five years. The GON will provide personnel, use of existing infrastructure (facilities and equipment), and will incorporate contraceptive delivery into the normal pharmaceutical delivery system of the MOPH/SA. The GON may apply to the NHSS counterpart fund for assistance in recurrent cost support of items which are essential to project success but outside of normal GON budget (certain categories of expenses, such as salaries and perquisites of civil servants, are banned). Selection of activities for counterpart funding is done jointly by the Minister of Plan and the Director of USAID, on advice of a joint GON-USAID management committee. Since replenishment of the counterpart fund is contingent on the GON meeting policy reform conditions and is therefore not guaranteed, this project's budget was designed not to depend on NHSS funding.

It is reasonable to assume that recurrent costs of the program after 1992 will also be largely donor financed. During the life of NFHDP, research will be carried out to identify ways to reduce recurrent costs to the Government. Wider commercial sales of contraceptives would be a way to decrease the Government's costs in a next phase.

4. Cost Recovery

The conditions of budgetary stringency argue for the implementation of a cost recovery system. Moreover, charging a fee tends to increase the aggregate benefits of a service. The service is used only by those who value it highly enough to pay a price, while free distribution tends to leave a significant portion of the benefits to those who place little or no value on the service.

Progress towards implementing such a system is a fundamental component of GON policy and the NHSS. However, such a system will face a number of problems, including developing a collection and accounting system, enforcing the fee schedule and ensuring that revenues are returned to the MOPH/SA to improve services. It should also be recognized, as the benefit-cost analysis demonstrated, that the NFHDP is likely to yield a high economic return. Thus consumption of family planning services should be encouraged by keeping prices low.

Any reasonable level of fees for family planning services will yield only partial cost recovery. For example, the rapid fertility decline scenario projects that 116,000 women will be contracepting in 1992. Assuming three medical consultations per year per woman and a fee of 100 CFA per consultation, cost recovery would yield \$116,000. Thus, only about 17% of recurrent costs would be recovered.

Most importantly, it is not feasible to impose a cost recovery system solely on family planning services. Rather, cost recovery must be integrated into the overall system to be developed by the GON with the assistance of the NHSS. The nature and level of fees for family planning services will be determined at that time.

C. Social Soundness Analysis

1. Social Context and Feasibility

The GON has taken a dynamic role in encouraging family planning and demographic research. The Head of State has taken the lead in mobilizing national resources and institutions towards these ends. His views are reflected as national priorities in the Five-Year Plan and at the MOPH/SA. National, regional and local community-based organizations have also actively supported this program.

MOPH/SA created the NFHC in 1984 to initiate FP services and training in Niamey. Ten MCH/maternity centers in the capital already furnish FP services and health facilities in Maradi and Zinder will initiate such services this

year. The Niamey FP facilities currently serve over 750 clients each month.

The organizations that mobilize community orientations and activities strongly support the FP program. The National Development Council (NDC), which has overarching authority over the Samariya and the Niger Women's Association (AFN), ranks family planning as an important priority. The Samariya and the AFN have organized community meetings in Niamey to facilitate NFHC extension work. The Niger Islamic Association has also voiced support for voluntary family planning within marriage to increase infant and maternal health.

The establishment of FP "installations" in 42 administrative centers dispersed throughout Niger will bring services to rural and urban populations. Approximately 20% of the total population resides within these centers, with another quarter of the population within 25 kilometers. An important proportion of rural and urban women will thus have access to FP services within five years.

The dispersion of the "installations" will cover national ethno-linguistic, social and occupational diversity. Health care use corresponds to family occupation and location rather than ethno-linguistic association. Agriculturalists are 70% of the population. As 15% of the population, pastoralists are the least frequent users of health care services. The other 15% of the population engaged in commerce, services, administration and crafts are wealthier, better educated and concentrated in urban centers. This group is the largest contemporary beneficiary of health care services.

Adapting the FP program to local knowledge, beliefs and attitudes will be critical to extension work. Common attitudes and practices provide a firm basis for presenting FP as birth spacing, as Nigerien women are already familiar with traditional birth spacing practices. Women prefer two to three years between pregnancies and recognize the relationship to improved infant and maternal health. They also state that contemporary family resources are limited due to male absence, low income and low employment. Interviews and surveys indicate that women from all groups are interested in modern FP services in order to space - not limit - births. Many of the new acceptors will thus be previous users of traditional methods.

The NFHDG must also address sociocultural obstacles to contraception. Nigerien women value a high average family size. They generally desire 6 to 7 children, which corresponds to the national average of 7 live births during a woman's reproductive history. Although there are signs that these preferences are changing, at least for urban women, older women will continue to value large families. The IEC campaign must initially focus on the advantages of child spacing to the entire Nigerien family.

Some men currently oppose contraceptive techniques because they fear future female infertility and disease (such as uterine infections). Condoms are currently associated with STD's and the prevention of conception outside marriage. Fathers associate contraception for young women with promiscuity and prostitution. Since women are subject to male authority in their natal

and conjugal households, the IEC campaign must also devote major resources to influencing male attitudes.

2. Beneficiaries

The number of women who receive contraceptive protection will rise from 15,000 to a maximum of 116,000 between 1987 and 1992. These women are likely to live within 5 kilometers of the health facility and to be somewhat better educated than the general population. Users of preventive health services are more likely to come from middle to upper income groups. These women and their children will directly profit from the project through improved health, and the entire family will have more resources available per member.

The participating women will indirectly furnish FP information to their cowives and other female relatives. Given the dispersion of the proposed FP "installations" and the permanent contact of urban women with their rural origins, wide informal discussions of modern contraceptive techniques are likely to result from the project.

Over 400 MOPH/SA employees will receive training during the project. In addition, 25 VHT's will receive IEC agent training during a pilot program. The Nigerian private sector will benefit from a pilot program for distribution of non-prescription contraceptives (i.e., condoms and spermicides) through 10-15 pharmaceutical outlets.

Individuals who receive demographic training and those who use the results of demographic research will also benefit from the project.

3. Participation

The continuing support of the GON and community-based institutions is essential to the success of the NFHD. MOPH/SA commitment to FP at the NFHC and MCM/maternity centers reflects the Government's emphasis on implementing the program. The organization of FP service systems in locations throughout Niger will mobilize personnel and resources. The training of FP personnel will initiate a long-term national commitment.

The NFHD pilot projects for the training of VHT members as IEC agents and the distribution of non-prescription contraceptives through pharmaceutical outlets will set the stage for future extension of FP services.

As in the project design, inputs from users and beneficiaries will be sought through surveys, audience research, and other special studies to monitor and evaluate project progress and effectiveness.

The organizations which direct community activities must deepen their participation in FP campaigns and extension. The National Development Council, the Nigerian Women's Association, the Samariya and the Niger Islamic Association have all voiced support for a FP program. The collaboration of these organizations with the DFF in Niamey must be extended to the national

program.

4. Impact

The NFHDP will have a positive effect on the MOPH/SA capacity to deliver FP services nationally. The women participating in the programs and their children will benefit from better health and decreased mortality.

In the longer term, the households of participating women will have increased per capita resources. Women will be able to devote more effort to generating their own critical contribution to household subsistence.

Demographic research and training will improve the quality and efficacy of economic planning.

The long-term decrease in population growth will reduce pressure on scarce national resources and may yield an increase in per capita income.

5. Issues to be addressed in implementation planning

(a) NFHDP success will depend on continuing GON support for family planning, changing the attitudes of health care personnel as well as their technical skills, active participation of community organizations, use of the national mass media, adaptation of IEC messages to local conditions, and effectively soliciting male support for family planning.

(b) NFHDP must be responsive to the demands and needs of clients, i.e., to the extent possible, offer the kind of contraceptive protection requested by clients; if a client comes from some distance, then the choice may be affected by the frequency with which she must return for care.

(c) NFHDP must effectively educate clients in the use of contraceptives to avoid method failures.

(d) Family planning must be presented as consistent with present cultural practices, i.e., as spacing rather than limiting births.

(e) Because of the dominance of males in family decision making, men must be solicited for their support of family planning.

See Annex F for additional details regarding the social soundness of this project.

D. Administrative Analysis

The MOPH/SA will be charged with planning, implementing and evaluating the family health component of the project with operational responsibility assumed by the DPF. The MOP will be responsible for the demographic research and analysis component of the project with the DSI charged with implementation

responsibility.

1. Directorate for Family Planning (DPF)

(a) Background

In a reorganization of the MOPH/SA in early 1988, a DPF was established and charged with the responsibility of planning, coordinating, and evaluating the integration of family planning services within the Ministry's overall health and social program. To this end, the DPF is responsible for technical leadership in the following areas: oversight for the integration of family planning into the health delivery system; development of IEC programs for family planning; design of training programs in family planning for all levels of personnel; monitoring of the procurement, storage, distribution and resupply of contraceptive commodities and materials for family planning services; technical supervision of family planning activities at all levels in the service delivery system; evaluation of all family planning activities; and, coordination of family planning with other directorates within the MOPH/SA, other ministries, and international donors. Prior to 1988 the functions now assigned to the DPF were assigned to the National Family Health Center (NFHC).

The DPF is also responsible for the National Family Health Center. The NFHC was formed in 1984 under auspices of the UNFPA-funded Family Health Project. As a demonstration effort, the NFHC was mandated to conduct information, training, service, and research activities in order to provide high quality family health and family planning services to high risk mothers and children. The NFHC has ably executed its original charge. It has developed a model service delivery program which provides an extensive range of maternal and child health/family planning (MCH/FP) services to more 7,000 mothers and children a year. In 1986, the NFHC provided more than 14,000 family planning consultations. Under the recent MOPH/SA reorganization, the NFHC will continue to serve as a laboratory for testing service delivery methodologies and as a site for the practical training of personnel.

(b) Administrative Assessment

The following narrative reviews the basic elements of the MOPH/SA/DPF's current administrative structure: organization, management, and staffing.

(1) Organization

Legal Status. The DPF was officially formed during the reorganization of the MOPH/SA in early 1988. Thus, it is a recognized Directorate within the MOPH/SA.

Financial Status. Direct family planning activities are supported mainly through project funding at an annual level of approximately \$1.0 million. Funds come from three primary sources: UNFPA, USAID, and the GON/World Bank. Most project funds to date have been directed to support activities conducted

at and through the NFHC.

Patterns of Organization. Within the MOPH/SA, the DPF reports directly to the Secretary of State for Public Health and Social Affairs. Annual work plans are prepared by the DPF and submitted to appropriate Ministry officials for approval. Within the parameters established by the approved work plans and budgets, the DPF Director has line responsibility for the Directorate and the NFHC staff and is in charge of the national family planning program.

The newly created DPF consists of three principal units: a Family Planning Division, a Research Division and an Office of Accounting and Management.

- The Family Planning Division is responsible for overseeing the integration of family planning services into the services offered by health facilities. The Division includes an Office for Coordination which is responsible for equipment supply and contraceptive logistics, supervision, receiving and synthesizing reports from health facilities and ensuring the integration of family planning services into health facilities. The Division also includes an Office of Training which is responsible for managing all family planning training and IEC activities in collaboration with DFEPS.

- The Research Division includes an Office for Studies and Programming which conducts studies and surveys and an Office for Statistics and Demography which collects data from health facilities and conducts other demographic research.

- The Office of Accounting and Management is responsible for personnel and financial management.

The current DPF staff consists of the DPF Director, the Chief of the Family Planning Division, an IEC coordinator, a researcher, an accountant/manager, a secretary and expatriate technical assistants. As discussed below, additional staff will be needed by the DPF in order to manage a national family planning program.

To implement the national family planning effort, the DPF coordinates with the other directorates under the Secretary of State for Public Health and Social Affairs, namely: the Directorate of Social Affairs, which is responsible for the social service centers throughout the country; and the Directorate of Women's Affairs which is responsible for women's programs such as the foyers feminins, women's associations and related organizations.

In addition, the DPF coordinates with the Directorate of Training and Health Education (DFEPS) and with the other service delivery Directorates under the Secretary General of the MOPH/SA, namely: the Directorate of Health Facilities (DES) which is responsible for hospitals and health centers; the Directorate of Maternal and Child Health (DSMI) which is responsible for the maternities and the maternal and child health centers as well as nutrition education; and the seven Directorates of Departmental Health Services (ODS) which are responsible for all services facilities at the departmental and arrondissement

level. As the family planning program becomes national in scope, coordination at the service delivery level becomes of great importance.

As the DPP is new, the leadership and implementation mechanisms have yet to be tested and refined. As the program expands nationwide, the organizational structure must grow and develop to accommodate greater program responsibilities. The Project will assist in developing the management systems necessary for program planning, implementation and evaluation.

(2) Management

Delegation of authority. Policies and decisions related to the national family health program are made at the ministerial and directorate level.

Experience and Capacity of Managers. The Directorate, combined with the NFHC, offers the country's strongest technical expertise in family planning and reproductive health. The recently appointed Director of the DPP, formerly director of the NFHC, is technically competent.

(3) Staffing and Facilities

Personnel Structure. The new DPP has only a skeleton staff: the Director, the Family Planning Division chief, an IEC coordinator, one researcher and an accountant/manager. All of these positions have been recently created, and the individuals appointed have just begun to work in these designated capacities. The NFHC, on the other hand, has over 40 employees, divided as senior management staff, clinic and service-delivery staff, and support staff. In addition there are national and international specialists who assist with various technical aspects of the program. The present staff is sufficient to continue the current level of the demonstration services conducted at the NFHC. However, additional personnel to serve as technical staff will be required at the DPP to ensure adequate planning, implementation and supervision of an expanded nationwide program.

Facilities. The MOPH/SA houses the DPP. MOPH/SA facilities are now crowded and will not permit expansion of staff within the currently available space. The NFHC is adequate for the current level of services, but not large enough to house administrative and technical staff for a large national effort. The NFHC has a small warehouse for contraceptive supplies, but the storage area is not sufficient for contraceptive commodities needed for the larger national effort.

The project will allot funds for rental of office space. As A.I.D. does not intend to become involved in construction of warehouse space, the MOPH/SA is encouraged to seek additional funds from other donors for warehouse construction or to make other warehousing arrangements utilizing other government properties. This will be considered a GON project contribution.

(4) Program Management Capabilities

Service Delivery. The NFHC has successfully managed a pilot project for comprehensive delivery of services to high risk mothers and children. Services include pre-natal, post-partum, family planning, high risk obstetrics/gynecological and pediatric, sterility and STD consultations. The NFHC has developed basic service delivery protocols and client record systems. The client load has increased dramatically over the past three years. Recent expansion has extended services to MCH clinics in Niamey, Dosso and Zinder Departments. Preparations are underway for expansion of services to Maradi.

Training. The staff have undergone short-term training for skills development. Short courses for various levels of service providers have been conducted in clinical and non-clinical contraceptive methodology, management and supervision, and preparation and usage of visual aids for personnel from Niamey, Dosso, and Zinder Departments. Special discussion sessions have been held in developing curriculum for various training courses.

Information, Education, and Communication. Clinic level IEC and counseling have been initiated. Community education has taken place in selected neighborhoods in Niamey. Educational sessions for influential people have been held. Basic IEC materials have been developed. Plans are underway for IEC campaigns in Zinder, Maradi and Niamey.

Biomedical and Operations Research. The NFHC has conducted several contraceptive method studies to learn about method acceptability and use. In addition, the NFHC has conducted a knowledge, attitudes and practices study in the Niamey area. The NFHC has also conducted internal reviews of service delivery in order to improve program performance.

Contraceptive Commodity Management. The NFHC has managed contraceptives for its program use and has provided contraceptives for other MCH and maternity centers which offer services in family planning. Preliminary record-keeping forms have been developed.

The above illustrates the remarkable program progress which has been made by the NFHC in a very short time period. Although program management has been on a one-clinic basis, there is a strong foundation on which to build an expanded program. However, as the national program grows, current systems will have to be adapted, refined and expanded, and new management systems will have to be put into place for the nationwide effort.

(c) Conclusions and Recommendations

Given the commitment of the family planning leadership, the past level of leadership shown in advancing family planning in the country, and the current level of family planning activities, this analysis indicates that the family planning movement is in a position to grow and expand in Niger. However, it is recommended that organizational/administrative adjustments be made to

ensure successful project implementation and to guarantee the nationwide expansion of family planning program activities. Specifically:

(1) An advisory committee should be created to assist the DPF in planning, monitoring and evaluating the family health program.

The advisory committee would consist of representatives of the concerned directorates of the MOPH/SA, other appropriate ministries, socio-professional organizations and donors. The purposes of the committee would be to (1) facilitate coordination among the involved organizations; and (2) provide technical advice to the DPF in setting program objectives, developing annual workplans, monitoring program activities and evaluating progress towards program objectives.

(2) Adequate numbers of qualified technical and support staff to plan, manage, supervise and evaluate the national family planning effort should be assigned to the program.

National Staff. The MOPH/SA must designate qualified staff to the DPF for the nationwide expansion of the family planning effort. Responsibilities for the management of different functions will have to be delegated. Staff will have to take on responsibilities for implementation and act on their own. To do so, staff must gain the skills and knowledge needed to effectively perform their responsibilities. A comprehensive supervision system to ensure staff development and quality control will be essential. Periodic reporting systems must be initiated and institutionalized so that communications among staff can be maintained.

Only a few positions exist in the current DPF structure. In addition to the extant staff (DPF Director, Family Planning Division Chief, IEC Coordinator, Accountant/Manager and one researcher), the following are the minimum staff needed by DPF to ensure project implementation.

Training Coordinator will be responsible for all aspects of training including planning, coordination, management and evaluation; assessment of training needs; development of training curricula; development and review of training materials; training of trainers; participation as key resource person in training activities; and technical assistance to department level program managers and supervisors.

Training Team (10-12) will be responsible for serving as trainers for the various levels of family health training. Team members will not be full-time training staff but rather will be called upon to participate in training for particular audiences.

Logistics Coordinator will be responsible for the procurement, storage and distribution of contraceptive supplies; analysis of contraceptive flow and forecasting of contraceptive needs; development and execution of a management information system including record keeping and program evaluation; and coordination of logistics with all program management and service provider levels.

Research Coordinator will be responsible for identifying research priorities, research project design and execution, data analysis, and dissemination of research findings to appropriate users. The Research Coordinator will be selected for long-term training.

Field Supervisor/Monitor will be responsible for developing and implementing a program of technical assistance for family health service providers. The Field Supervisor/Monitor will collaborate with departmental and arrondissement level health managers in monitoring the implementation of family health, identifying problems in service delivery and providing technical assistance to service providers.

Departmental Family Health Coordinators (7) will be appointed by each Departmental Directorate for Health Services to serve as the family health liaison officer with responsibility for coordinating all family health activities in the Department. The Coordinator will probably be the person currently responsible for MCH services in the department, but will be assigned additional family health duties.

The above individuals are the minimum technical national staff required for the development and implementation of the project activities. As the program expands, additional staff will be required. It is strongly recommended that the MDPH/SA consider hiring deputy coordinators for training, IEC and logistics, as well as three field supervisors who can provide technical assistance to service providers. Understaffing of the family planning program is a potential serious barrier to program implementation.

Technical Advisory Staff

As family health is relatively new in Niger and experience is limited, successful project implementation will require both long-term and short-term

technical services. Three long-term advisers will be provided, including a management specialist (counterpart to the JPF Director and who will serve as Chief of Party for the Technical Assistance Team), an IEC Specialist (counterpart to the IEC Coordinator) and a Training Specialist (counterpart to the Training Coordinator). The management specialist will be available for four years, and the IEC and Training Specialists will be available for three years. As needed by the program, the long-term technical assistance will be supplemented with short-term technical specialists.

(4) Improved management systems for the planning, implementation and evaluation of project activities should be developed.

The full range of management systems, particularly in program planning and evaluation, personnel management and supervision, and monitoring, documentation and reporting, should be developed to optimally utilize personnel and monetary resources to meet specific goals and objectives. A management information system integrated with the MOPH/SA health management information system is needed, so that program performance can be assessed.

(5) An integrated five-year plan of action with a corresponding budget should be prepared.

As funds for the national family planning effort will come from a variety of sources (e.g., GCN, World Bank, UNFPA/WHO, USAID, etc.), it is recommended that the GCN develop a master program strategy for a comprehensive nationwide program. This action would insure that all program elements are included and funded and that the organizational elements are in place to effectively and efficiently execute the program. This approach would maximize available resources and avoid duplication of effort. Such a strategy would serve as a blueprint for program actions and also serve as a standard by which progress could be measured. Annual work plans with justifiable budgets should also be developed. This program planning process should be initiated in the first program year and integrated into the overall annual review and planning processes. In addition, the donor coordination meetings which were initiated in 1987 should be included in the annual planning process.

2. Direction of Statistics and Computer Services.

(a) Background

The Direction of Statistics and Computer Services (DSI) within the MOP has the primary responsibility for collecting and analyzing information and statistics necessary for Government planning. With over 100 full-time employees, it is involved in a broad range of demographic training, research, data collection and documentation activities. Most recently, DSI has been involved in the planning and preparation for the National Census planned for May, 1988.

(b) Administrative Analysis

The following narrative reviews the basic elements of DSI's current structure: organization, management and staffing.

(1) Organization

Legal Status. The DSI is a recognized Directorate of the Ministry of Plan. The DSI Director works under the direct guidance and supervision of the Minister of Plan and participates in the MOP Cabinet.

Financial Status. As an officially established Directorate, its personnel, operational and program costs are covered by the GON National Budget, at a level of 55 million CFA per annum. An equivalent amount for operational costs is provided by the GON through a World Bank loan. Special research, data collection and analysis and planning activities are conducted with external funding. Major donors to the DSI include the UNFPA/UNDP, World Bank, FAC, German assistance and USAID. The volume of funds currently administered by the Ministry, and specifically by DSI, indicates its ability for financial management. The DSI has a Center for Administration and Accounting which is in charge of budgeting and accounting for both operational and program costs.

Patterns of Organization. Work plans and budgets are prepared by the DSI and submitted to appropriate ministry officials for approval. Within the parameters established by the annual plan and budget, the DSI Director has line authority, is responsible for the entire directorate, and is in charge of the implementation of the DSI work plan.

The DSI is currently undergoing a reorganization. Indications are that the Directorate will be divided into six major functional centers: Statistics, Studies and Surveys, Training, Computer Services, Documentation and Dissemination, and Administration and Accounting.

In addition to the normal DSI structure, the Directorate is responsible for the Central Office of the Census.

(2) Management

Delegation of Authority. Policies and decisions related to the organization and program of the DSI are made at the directorate and ministerial levels. Within parameters approved by the Minister of Plan and appropriate GON officials, the DSI Director has full authority and responsibility for implementation of the annual program and budget. Within the DSI, the Director delegates to his division chiefs or special project directors the responsibilities of their respective program or area of expertise.

Experience and Capacity of the Managers. The DSI offers Niger its best technical expertise in collecting, compiling, analyzing and publishing statistical and demographic data.

Staffing. The DSI senior staff consists of the Director and Deputy Director, a chief of the various centers and project directors. In addition, DSI has over 100 regular employees including program managers, administrative staff, technical specialists and support staff (secretaries, drivers, guards, etc.). In addition to the regular DSI staff, approximately 100 individuals have been assigned to work on the census.

Facilities. The DSI is housed in a separate building in the center of Niamey, close to many of the ministries it serves. In preparation for the census, much equipment is being installed; for example, 25 computers and mapping and cartography equipment. Also, vehicles have been purchased for the census activities. Once most of the census activities have been completed, these facilities will be available for other activities and will strengthen the overall capability of the DSI.

(c) Conclusions and Recommendations

The DSI is the most logical and appropriate service for the demographic research and analysis component of the project. It has the mandate and is the officially recognized government entity to conduct research and to compile demographic data. Although its staff is young and relatively inexperienced, the DSI offers the best statistical and research capability in the country. It has already executed a number of research projects which required sophisticated design and methodological expertise and offers the strong technical resources needed for the project. To ensure the successful implementation of specific program tasks, the following actions are recommended:

(1) Adequate and qualified technical staff should be assigned to work on project activities.

The following DSI staff must be assigned to the project:

Project Coordinator will conduct overall planning and direction of USAID inputs; identify potential policy and demographic research activities; assess progress toward specific policy and research objectives; develop research methodology; coordinate and supervise DSI staff allocated to work on the various demographic research and analysis activities; report and document project activities.

Demographic and Statistical Specialists will be chosen to work on specific policy development or census analysis projects. As the needs will fluctuate depending on specific project activities, individuals will be drawn from the cadre of technical staff available at the DSI.

For the special Demographic and Health (DHS) Survey, DSI staff assigned to the project must include 1 demographer, 2 statisticians, 2 computer programmers and data processors. In addition to the above, the DSI will need to recruit, select and hire field interviewers for the DHS. Special services may be required such as translation of forms into local languages, enumerators to

prepare special survey sites, etc. Appropriate staffing will be a C.P. to implementation of individual studies under this component.

(2) Technical assistance should be provided to the JSI to assist in the execution of selected tasks which require specialized skills.

As demographic policy and research skills could be further developed, short term technical assistance will be required under the auspices of the project. Provision has been made for 30.5 person months of technical assistance for census data processing and analysis, implementation of the NDHS and dissemination activities.

VIII. EVALUATION AND AUDIT PLAN

A. Evaluation Plan

Evaluation of the project will be particularly important, given the nascent stage of the Niger population/family health program. The evaluation will serve to objectively measure progress towards the attainment of project objectives and to identify obstacles to project implementation. All evaluations will be conducted by external evaluators.

Evaluation of the NFHDP will occur in three stages. First, a baseline assessment will be conducted in order to provide an estimate of the key output indicators at the beginning of the project. This will provide a standard of comparison against which the results of later evaluations can be measured. The baseline assessment will be conducted in 1982. The project will finance three person-months of technical assistance to develop baseline indicators.

The second stage will be a mid-point evaluation to be conducted in 1990. This study will serve to measure progress with respect to the output and purpose indicators and to identify the important factors which facilitate or impede project implementation. Three person-months of technical assistance will be provided to conduct the mid-point evaluation.

In 1992 a final evaluation of the project will be conducted to assess whether the project achieved its purposes and outputs as set forth in the project design. The Log Frame contains explicit and quantified measures of project purposes and outputs. The precision of the output measures will simplify the task of the evaluators in determining if the project has met its objectives. The project will support 5 person-months of technical assistance to conduct the final evaluation.

Detailed research designs will be developed prior to each evaluation in collaboration with the evaluation team. As guidance to the evaluation teams and USAID, key questions to be addressed by the evaluation teams are set forth below.

1. Were the inputs delivered in the quantity and manner prescribed by the project design? If not, what changes were made and for what reason?

The project description and the financial plan describe in detail the nature and level of project inputs. Please see logical framework for summary description.

During the course of project implementation, it may prove advisable or necessary to alter the allocation of resources, thereby lowering or raising input levels in any one area. The assessment of inputs should be primarily concerned with determining what inputs were delivered, how these contrast with the original project design and the reasons for re-allocation of resources. The mid-term evaluation may also suggest modifications of inputs (and appropriate design changes required).

2. What are the principal obstacles to implementation?

A key to the evolution of the Niger population program will be the identification of the principal obstacles to program implementation. The history of family planning and population programs in the Sahel and in sub-Saharan Africa generally is fairly short; hence, there is relatively little experience to draw upon in predicting the major barriers to implementation. An implementation analysis will identify the important obstacles to the evolution of population programs in Niger and elsewhere in the region. In priori, it is possible to hypothesize a set of factors that may impede or facilitate implementation - adequacy of the original project design, technical skills of the staff, adequacy of resources, administrative procedures and regulations and attitudes of service providers. Accordingly, the implementation analysis might focus on the following questions.

(a) Was the original design technically sound? The Log Frame contains a number of explicit assumptions upon which the design rests (e.g., continuation of GCM support of family planning), as well as assumed linkages between project elements (e.g., that training will be followed by service delivery). The realism of these assumptions and presumed linkages needs to be tested as the project evolves.

(b) Do the personnel have the skills needed to carry out their roles in the family health and demographic research programs? This is really a two part question. First, did the training yield the predicted changes in knowledge, skills and attitudes? All training sessions will be evaluated for their impact on the trainees. This will be complemented by a compilation of individual evaluations to determine the efficacy of the training program as a whole. Second, did the training neglect important skills or attitudinal barriers that can be shown to be of importance to program implementation? Trainee follow-up can be used to identify domains inadequately treated during the training.

(c) Are the resources provided adequate to achieve the project objectives? While the best possible estimates have been made of the resources

needed to carry out the project, the implementation analysis should benefit from project experience to re-assess the level of resources needed from USAID and the GON to achieve the project objectives. Inaccurate estimates of resource requirements during project design or the inability to deliver resources may prove a major barrier to project implementation.

(d) Are there significant logistical or administrative barriers to project implementation? For example, the contraceptive logistics system may prove difficult to maintain. Alternatively, specific legal or administrative requirements - such as the requirement that women obtain the permission of the husband before obtaining contraceptives - may inhibit project implementation. These and other pertinent administrative issues will have to be identified and their impact assessed during the implementation analysis.

(e) Do service provider perceptions and attitudes serve as a barrier to program implementation? It is as yet unknown if service providers will be supportive of the integration of family health into other health services. The importance they attach to family health and their role in its promotion may be critical to the project's success. Hence, the implementation analysis will need to assess service provider attitudes and perceptions.

The factors suggested here as potentially important for project implementation are neither exhaustive nor will they necessarily prove to be the factors deemed of principal interest at the time of the evaluations. Rather, they are illustrative of the concerns to be addressed by the implementation analysis and as a guide to the factors that are, a priori, of concern to the project designers.

3. Were the project purposes and outputs achieved?

The Project Description and the Log Frame have described in detail the project purposes and the magnitude of the anticipated outputs. The mid-point and final evaluations will determine the extent to which purpose and outputs have been achieved. In particular, the assessments of project purpose will address the following questions:

- (a) Does a national FH program exist with established procedures for management, annual planning and contraceptive supply?
- (b) Are the anticipated number of health facilities (146) offering family health services?
- (c) Is there a system of periodic internal review of the FH program?
- (d) Is there a plan for further extension of FH services?
- (e) Did the project provide the projected level of contraceptive protection?

(f) Do newly educated doctors, nurses and midwives have technical competence in FM?

(g) Is the MOP making use of demographic data in macro-economic planning and allocation of investment budget resources?

The following questions are to be included in assessment of project outputs:

(a) Were the anticipated number of people trained in the prescribed areas?

(b) Were the projected IEC activities realized in kind and number?

(c) Were the management procedures and system described in the project design implemented?

(d) Were the two operations research projects implemented and did they yield usable results?

(e) Were the census data processed and analyzed in accordance with the project design?

(f) Was the Niger Demographic and Health Survey conducted? If so, how have the data been used to improve program management?

(g) Have the demographic libraries been established and was the demographic data dissemination program implemented?

It should be recognized at the outset that attribution of the observed output solely to the project may prove difficult. The contributions of the GON and other donors independent of the NFMOP, as well as secular changes in the socioeconomic environment, may confound efforts to draw direct causal links between project inputs and the status of the population program in 1992. Despite potential difficulties in demonstrating causality, the evaluation of output indicators will provide valuable information on the progress of the population program.

B. Audit Plan

Financial management reviews have been scheduled for FY 89 and FY 91 to ensure that appropriate financial management and information systems have been established and are being maintained. If the reviews uncover any weaknesses in the project internal controls, RIG/A/Dakar will be requested to audit the project, the USAID/Niger Controller's Office or the contractor(s).

If required for any reason, a financial audit will be performed on the accounts and records of institutional contractor(s) during the third year of the project or more frequently if necessary. If the project is extended, the audit will be performed before the implementation of any extensions thereof.

The audit, which will concentrate principally on financial accountability, may also include some compliance reviews. The audit will cover both the home office and field expenditures.

The contractor will refund to A.I.D. all disallowances found by the audit, if any, and will take prompt action to resolve audit recommendations.

Funds turned over to the Government of Niger for disbursement may be audited twice in conjunction with the financial management reviews. Since these funds are subject to FAA Section 121(d) certification requirements, the audit must be performed under RIG/A/Dakar cognizance.

In accordance with FAA Section 121(d) certification requirements, any agency of the Government of Niger disbursing funds directly must meet the requirements set forth below and be certified by the USAID/Niger Controller's Office as having an adequate system of accounts. The requirements include having:

1. A separate bank account for A.I.D. funds.
2. An adequately trained accounting staff.
3. An adequate internal control system.
4. Books and records sufficient to account for receipt of funds, disbursement of funds and balances of remaining encumbrances.
5. Management system of approvals and controls adequate to show budgets for future expenditures, actual results compared to actual expenditures and definite plans to meet the quantifiable objectives of the project.
6. Naming a project director.

Definitions

1. An accountant is a person having adequate training and experience in the concepts and applications of accounting principles.

2. Internal control comprises both accounting controls and administrative controls.

A. Accounting control: Plan of organization including procedures and records concerned with (a) safeguarding assets; (b) reliability of financial records; and (c) Assuring that transactions are properly authorized, executed and recorded in conformity with proper accounting principles.

B. Administrative Controls are those plans or organizational procedures concerned with decision making leading to achievement of organizational goals. There must be an internal control system in place for the following: petty cash, gasoline coupons and project property and equipment

inventory.

3. A set of books means maintaining on a current basis:

- a. Donor receivable journal for controlling advances.
- b. Cash receipts and disbursements journal
- c. Bank reconciliation worksheet
- d. Disallowance journal
- e. Encumbrance journal

4. Records consist of files, supporting documents and correspondence.

SFRMP II will be involved in establishing the accounting system at the beginning of the project and will perform periodic reviews to ensure that the system is being maintained. PACD for SFRMP II is November 1989. The USAID Niger Financial Analyst reviews project accounting systems semi-annually to ensure that Section 121 (d) requirements are being maintained. If a problem is discovered and RIG/A is unable to perform an audit in a timely fashion, some of the contingency amount will be programmed for an audit by a CPA firm.

Costs for audits are estimated at \$100,000.

IX. CONDITIONS PRECEDENT AND COVENANTS

A. Conditions Precedent to First Disbursement

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

1. A statement of the names and titles of the persons who will act as the representatives of the Government of Niger, together with a specimen signature of each person specified in such statement.

2. A document acceptable to A.I.D. that designates by name the full-time personnel at the Directorate for Family Planning (DPF) who fulfill the following roles: DPF Director, Family Planning Division Chief, Research Division Chief, Training Coordinator, Information-Education-Communication Coordinator, Logistics Coordinator, Accountant/Manager and Field Supervisor/Monitor. The MOPH/SA must also designate the individuals who will serve as Departmental Family Health Coordinators.

3. Prior to transfer of funds to any agency of the Government of the Republic of Niger for disbursement in local currency the involved agency will

demonstrate in a manner satisfactory to A.I.D. that adequate accounting and reporting procedures have been established for financial management of local currency disbursements. The standards set forth in FAA Section 121(d) will govern.

3. Covenants

1. None of the funds made available under the Grant may be used to finance any costs relating to (a) performance of abortion or involuntary sterilization as a method of family planning; (b) motivation or coercion of any person to undergo abortion or involuntary sterilization; (c) biomedical research which relates, in whole or part, to methods of, or the performance of, abortion or involuntary sterilization as a method of family planning; (d), active promotion of abortion or involuntary sterilization as a method of family planning.

2. The MOPH/SA will establish minimum criteria for technical competence satisfactory to A.I.D. for any health service provider trained in clinical family health/family planning service delivery using funds provided by the Grant (see section III.A.3.(c) - training of physicians, nurses and midwives). All participants in clinical family health/family planning courses financed in whole or part by the Grant will be tested for technical competence in a manner satisfactory to A.I.D. All participants who demonstrate the required level of competence will be authorized by the MOPH/SA to provide family health/family planning services. No participant who fails to meet the minimum criteria for technical competence will be authorized by the MOPH/SA to provide family health/family planning services using funds provided in whole or part by the Grant.

3. The nomination of any candidate by the MOPH/SA for training in the use of intra-uterine devices (IUD's) financed in whole or part by the Grant will be accompanied by a letter satisfactory to A.I.D. stating that the facility in which the candidate will be conducting IUD insertions is satisfactorily equipped for IUD insertion and that the candidate will be authorized to perform IUD insertion at the facility subsequent to satisfactory completion of the training.

4. The nomination of any candidate by the MOPH/SA for training in sterilization procedures financed in whole or part by the Grant will be accompanied by a letter satisfactory to A.I.D. stating that the facility in which the candidate will be conducting sterilizations is satisfactorily equipped for sterilizations and that the candidate will be authorized to perform sterilizations at the facility subsequent to satisfactory completion of the training.

5. The MOP and the MOPH/SA will provide logistical support for project activities in a manner satisfactory to A.I.D. as specified in Section V.D (Logistical Support) of the Project Paper.

6. Prior to implementation of the Commercial Distribution Operations Research Project (Section III.A.3.f(2)), USAID/Niger and the Office National

des Produits Pharmaceutiques et Chimiques will adopt an agreement governing implementation of the commercial distribution project, including the price at which contraceptives will be sold.