

PD - AAY - 785

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT IDENTIFICATION DOCUMENT
FACESHEET (PID)

1. TRANSACTION CODE
 A = Add
 C = Change
 D = Delete
 Revision No. _____
 DOCUMENT CODE 1

2. COUNTRY/ENTITY
SUDAN

3. PROJECT NUMBER
650-0085 ISN 57513

4. BUREAU/OFFICE
 AFRICA
 A. Symbol AFR
 B. Code 06

5. PROJECT TITLE (maximum 40 characters)
 FAMILY PLANNING DELIVERY AND POLICY

6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION
 A. Initial FY 8 | 9
 B. Final FY 9 | 2
 C. PACD 9 | 5

7. ESTIMATED COSTS (\$000 OR EQUIVALENT, \$1 =)

FUNDING SOURCE		LIFE OF PROJECT
A. AID		17,000
B. Other U.S.	1.	
	2.	
C. Host Country		11,000
D. Other Donor(s)		2,000
TOTAL		30,000

8. PROPOSED BUDGET AID FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. 1ST FY		E. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA	420	400		2,700		17,000	
(2)							
(3)							
(4)							
TOTALS				2,700		17,000	

9. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)
 444 | 484 | 501

10. SECONDARY PURPOSE CODE

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

A. Code	BR						
B. Amount							

12. PROJECT PURPOSE (maximum 480 characters)

1. To expand the availability and use of family planning services and oral rehydration therapy, especially through the private sector.
2. To create a policy environment which promotes the expansion and use of family planning services.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff: CONTRACT: Marketing Management Advisor
 Marketing Research Advisor
 Senior Policy Specialist
 Logistical Specialist
 Sociologist (local hire)
 Engineer (local hire)

DIRECT HIRE: Population Officer, (USAID)
 Chief, HPN, (USAID)
 Economist, (USAID)
 Proj. Development Officer (2) USA
 Program Officer, (USAID)
 Engineer, (USAID)
 Controller, (USAID)
 CMO (USAID) / Contracting (USAID)
 Pop. Officer (AID/W)
 RLA (REDSO/ESA)

Funds: PD&S \$ 50,000
 LS 35,000

14. ORIGINATING OFFICE CLEARANCE

Signature: John W. Koehring
 Title: Mission Director, USAID/Sudan
 Date Signed: JAN 10 1989

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
 MM DD YY
 01 17 89

16. PROJECT DOCUMENT ACTION TAKEN
 S = Suspended
 A = Approved
 D = Disapproved
 CA = Conditionally Approved
 DD = Decision Deferred

17. COMMENTS

18. ACTION APPROVED BY

Signature
 Title

19. ACTION REFERENCE

20. ACTION DATE
 MM DD YY

Sudan Family Planning Delivery and Policy

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I. PROGRAM FACTORS

A. Conformity with Recipient Country Strategy/Program. Since 1986, the Sudanese, both in the private and public sectors, have shown increasing interest in developing the population sector and promulgating a national population program. Impetus for the program has come from population and development interest groups, including the National Population Committee (NPC) - a standing committee of the National Research Council. This interest culminated in the 1987 National Population Conference which enjoyed broad and high level participation by Government of Sudan (GOS) officials. During this Conference and with the support of other key ministers, the Prime Minister announced the GOS intention to formulate and implement a comprehensive national population policy. The GOS later accepted the recommendations of the Conference as guidelines until a final policy document is adopted (Population and Development in the Sudan: Proceedings of the Third National Population Conference, 1987). These guidelines support:

1. "Provision of family planning services and information for all Sudanese couples, [and]
2. Expansion of programs to improve infant and child health, promote child survival, and ensure safe motherhood."

More specifically, the Conference document recommends that Sudan achieve an implied prevalence rate of 30% for modern methods by the year 2000 (up from about 10% in 1988). Further, the document recommends that the role of the private sector in the provision of services be strengthened to meet growing demand for family planning.

GOS concern for promoting child survival interventions has also increased in the past several years. Specific objectives were recently drafted by the Ministry of Health (MOH) in its National Health Plan for Sudan, 1988/89 - 1992/93. MOH goals are to reduce infant mortality from 140/1000 live births in 1988 to 90/1000 by 1993, and to lower child mortality from 20/1000 to 15/1000 during the same period. Since the leading cause of death among infants and children is diarrheal disease, one of the major programmatic thrusts for the MOH is to increase the availability and use of oral rehydration salts (ORS).

B. Relationship to Concept Paper and AID Strategy. USAID/Sudan's Concept Paper, FY 1990 (June, 1988) identifies rapid population growth and high infant and child mortality as major constraints to the achievement of Sudanese development goals. The Concept Paper proposes to address the issue of rapid population growth and infant mortality by initiating a bilateral population project in FY 1989, continue local currency support to the National Office for the Control of Diarrheal Disease (CDD), and by increasing short-term support to UNICEF to expand the use and availability of ORS. The Mission strategy argues for a strong role by the private sector for the expansion of both family planning services and oral rehydration therapy (ORT). (See Mission's sector strategies for child survival [November 1987] and population [February 1988] for further discussion of private sector involvement). An AID-wide review in Washington of the Concept Paper in June 1988 reaffirmed the Mission's strategy to place a high priority on family planning and child survival.

AID is currently supporting a set of population and child survival activities through centrally-funded and local currency financed projects. In population, these include support for policy development, operations research, a demographic and health survey, contraceptives, and several service delivery projects. Except for certain service delivery projects, the major population activities will be concluded by the end of FY 1989. This project will recast and continue successful activities in policy development, operations research, and the provision of contraceptives. Regarding the provision of contraceptives, the project aims at building upon a system that is already working and utilizing infrastructures that, for the most part, already exist. Centrally-funded projects will be employed to complement this bilateral activity only to the extent that they fit into the Sudan's population strategy, and are not inconsistent with the Mission's strategy in support of the Sudanese strategy. Since this project will increase the distribution of ORS through the commercial private sector, it is highly complementary to the Mission's current support to the MOH's CDD and EPI programs.

The role of external donors is critical to population and child survival activities in Sudan. However, donors have directed activities almost entirely on the public sector and PVOs. The UNFPA is sponsoring a pilot MCH/FP project through the MOH, and supports a population education project in the Ministry of Education and a population studies center at the University of Gezira. The IPPF finances the Sudan Family Planning Association (SFPA). In addition, the World Bank is presently developing a multi-million dollar 5-year intervention which is planned to start in mid 1990. The proposed IDA "Population and Health Project" will take into account assistance from other donors and will concentrate efforts on the public sector. The IDA project objectives are:

- a) contribute to the reduction of maternal and child mortality;
- b) promote and develop birth spacing and the practice of family planning;
- c) promote and support key elements of the emerging population program in the public sector; and
- d) strengthen institutional capacity to develop, implement and evaluate health and population programs.

The proposed Family Planning Delivery and Policy Project, with its principle efforts directed primarily at the private sector, will compliment other donor programs.

The proposed project fits well into the Agency's and Bureau's strategies for child survival which includes emphasis on the following elements.

- ORT and immunization as the "twin engines".
- Support for (and coordination with) other important child-survival interventions such as nutrition and birth spacing.
- Support for results-oriented research program related to child survival.
- Special efforts focused on a limited number of "emphasis" countries; and
- Involvement of the private sector.

Sudan is one of eight "emphasis countries" in Africa. The project, with its emphasis on working through the private sector to provide family planning services for child spacing, fits into this overall strategy. In addition the project will attempt to introduce ORT into a social marketing program through the private sector. Finally, the project will fund results orientated policy research directly related to family planning and child survival initiatives in both the private and the public sectors.

II. PROJECT DESCRIPTION

A.1. Perceived Problem: Population. The population sector in Sudan is confronted with numerous constraints. Not the least of these are inadequate public health infrastructure, lack of financing, lack of contraceptive supplies, lack of educational programs, lack of trained personnel, lack of effective Information, Education and Communication programs (IE&C), and the absence of a policy framework to guide the sector. Given the magnitude of the problem, AID's limited resources, and the natural division of labor among available resources, the Mission's strategy is to address two of the most immediate needs as stipulated within Sudan's overall population strategy, where AID has institutional strengths. Therefore, this project will support the delivery of family planning services with emphasis on the private sector, and provide technical support for the implementation of the national population policy. The following problem analysis describes the needs in these two areas.

1. The Consequences of High Fertility. Sudan has one of the highest population growth rates in the world. The GOS recently estimated that Sudan's population is increasing at the rate of 3.1% per year. At this rate, Sudan's population will jump from about 21 million in 1980 to nearly 40 million in the year 2000. Scholars at the 1987 National Population Conference identified a plethora of negative impacts caused by this high rate of growth. Major adverse consequences include severe strain on food availability, the environment, the educational system, and basic health services. Urban centers are experiencing severe pressure from excessive migration as well. High fertility is also seen as an impediment to the improvement of the status of women which has increasingly become a major concern of the GOS. Associated with this is the high rate of female circumcision reported in the Sudan, which can result in serious health problems for women. There are also serious health consequences of high fertility for mothers and children in Sudan. Sudanese researchers estimate that proper birthspacing (24 months or more) could avert about one-fifth of all infant deaths.

2. Unmet Demand for Family Planning. Despite high fertility, there has been a discernible increase in the use and demand for family planning services. Prevalence of contraceptive use was only 5% in 1979. Contraceptive sales records and several demographic surveys indicate that by 1985 this figure had more than doubled to 10% or 11%. Field observations from public health workers, PVOs, and pharmacists suggest that the demand for family planning is rising. A recent Mission report suggests that as many as 200,000 couples wanting to use modern methods have no access to reasonably priced family planning products (Mission Population Sector Strategy, 1988).
3. Lack of Contraceptives. In the face of this demand, the availability of contraceptives has decreased. The majority of contraceptives have been brought into the country through the commercial private sector. Estimates of the private sector share of the contraceptive market several years ago ran as high as 80% to 90%. Then, in 1985 the MOH did not include contraceptives on the "essential drugs" list, which meant that importers were precluded from obtaining foreign exchange to import them. As a result, private supplies dwindled to the point that they were only available sporadically in pharmacies. The black market for contraceptives grew, and the price of contraceptives sky-rocketed, putting them out of reach for thousands of couples. Real prices for a cycle of pills has risen by as much as 150% in the past three years. Private sector shortages placed additional demand on public health outlets, and this new demand accentuated distribution problems in the public sector. This omission has been recently remedied and contraceptives are now on the MOH's "essential drug" list. However, given Sudan's serious foreign exchange crisis this policy change will not guarantee that foreign exchange will be made available to the private sector to import contraceptives. Therefore, there is an immediate need to increase the supply of modern contraceptives in the private sector and to assist the public sector in expanding and improving its system.
4. Lack of Information on Family Planning Services. Surveys indicate that there is inadequate information about contraceptives in Sudan. Even though the private sector is the major source, no advertising is undertaken and pharmacists provide no instructional information to clients. Therefore, there is an immediate need to provide information through the commercial private sector on the proper use of family planning products, especially oral contraceptives.

5. Lack of Policy Framework. Experience in various developing countries with extremely high fertility, has shown that it is extremely difficult to increase the use of family planning without government commitment and active participation in a program. Generally, this process involves developing a broad consensus about a national population policy, formulating and adopting a national policy, setting priorities, and establishing an office to coordinate implementation of the policy, developing specific operational level policies and plans, and evaluating progress. It is operational policies in the form of integrated sectoral plans, regulatory reforms, the removal of legal constraints and human and financial resource allocations that translate national policies into effective programs. The GOS has set into place the mechanism to formulate a national population policy expected to be adopted in 1989. At that time, the GOS will need to formally establish a responsible office, which, in turn, will elaborate, revise, and evaluate operational policies and plans. The effectiveness of this office will be a determinant of the success of the Sudan in reducing high fertility.

A.2. Perceived Problem: Child Health. As noted, Sudan has one of the world's highest rates of infant and child mortality. Nearly 20% of all children do not live to the age of five. One of the principal causes of these deaths is diarrheal disease. A SERISS survey showed that, on any given day, one in five Sudanese children experience a diarrheal episode. The MOH, with support from UNICEF and USAID, has made remarkable progress in the public sector in expanding the practice of ORT and in increasing the general availability of oral rehydration salts. However, ORS is not generally available through the commercial private sector and there is a need to make ORS readily available through commercial channels. First, many Sudanese prefer to obtain health services through private outlets. Therefore, stocking pharmacies and small shops with ORS could greatly increase availability and use. Second, regular distribution and sales of ORS through the commercial sector could institutionalize the demand for the ORS program through commercial channels. Third, the distribution of ORT and family planning services through similar channels is a highly compatible activity and could produce significant synergistic effects.

B. Project Goal and Purpose.

1. The project goal is to reduce high rates of fertility, infant and child mortality, and improve institutional capacity for implementing population programs.
2. The project purposes are: a) to expand the availability and use of family planning services and oral rehydration therapy, especially through the private sector, and b) to create a policy environment supportive of the expansion of family planning services and use.

C. Expected Achievements/Accomplishments.

The project is designed to contribute to achieving the following principal results:

1. A major expansion in available supply and sales of contraceptives and ORS through commercial outlets

By the end of the project, it is expected that the availability of contraceptives will be greatly expanded, particularly in Khartoum and in up to sixteen provincial capitals throughout Sudan. Contraceptives will be made available first in Khartoum and later to the other areas of the country in a phased program. The current security situation precludes working in the South. However, if political stability is achieved, the marketing program can be expanded to the South. The supply of contraceptives to rural areas will be augmented through the Ministry of Health MCH/FP program, through suitable health facilities in the regions covered by AID's Rural Health Support Project, and through PVOs working in rural areas. By the end of the project it is expected that virtually all pharmacies and doctors in urban areas will have continuous and sufficient supplies of reasonably priced contraceptives and ORS. In addition, all existing MCH/FP facilities will be similarly supplied.

2. Strengthened role of the private sector in the provision of contraceptive supplies and information.

By the end of the project it is expected that the major part of contraceptives will be imported to Sudan by private sector entities; probably by the largest pharmaceutical distribution firms in Sudan. Currently, there are approximately five firms existing in Sudan who have the capacity to implement the social marketing program. In addition, ORS will be imported by the private sector and possibly manufactured locally. The project will assist the Government of Sudan, the medical community and the private sector in developing the mechanisms and regulations to assure safety and ethical practices in the supply and use of contraceptives.

3. Removal of Policy Constraints Inhibiting Family Planning Availability and Use

It is not legal in Sudan for other than doctors to prescribe contraceptives. The project will work with the GOS and the Medical Doctors Union to develop ways in which contraceptives can be distributed safely and ethically without a doctor's prescription. Other key policy constraints will be identified and appropriate remedial action taken.

4. Establishment of Operational Level Policies Promoting Family Planning

Family life and health classes will be included in the curriculum at schools and would be a new operational policy for the Ministry of Education. Similarly, programs to raise the consciousness of the population to the problems associated with female circumcision will be promulgated.

5. Improved GOS Capacity to Monitor and Evaluate Population Sector Performances

The GOS will institute a National Population Coordinating Council that will oversee population activities in Sudan to assure that they are consistent with the approved Sudanese strategy and guidelines. The project will provide this body with data on which to carry out this important monitoring and evaluation function.

Through the achievement of the above objectives, it is expected that:

- 1) There will be a significant increase in contraceptive usage in both urban and rural areas. Evaluations during the project will demonstrate decreases in numbers of couples wanting to limit births, but with no access to services.
- 2) Proper birthspacing, fewer births, and appropriate therapy for diarrheal disease will reduce the number of deaths among mothers and children by the end of the project.

D. Project Outline and How it will work.

The overall agreement will be signed with the Ministry of Finance and Economic Planning, which has responsibility for authorizing and overseeing bilateral and local currency projects. The Ministry also has authority for coordinating donor assistance with the private sector. There will be two principal components to this project: 1) delivery of family planning services; and 2) policy development. Each component will have local currency support, external technical assistance, training and commodity support. Technical assistance will be obtained through competitive procurement, either through a contract with a firm or through a joint venture. Contraceptive commodities and ORS will be obtained annually through buy-ins to AID's central procurement project and will be part of the general procurement plan for the project developed to conform with established Development Fund for Africa (DFA) guidelines.

Principle management responsibility will rest with a Project Implementation Committee (PIC). The role of the PIC will be to assure the timely implementation of all aspects of the project, coordinate activities between the two components, and assure timely dissemination of data and studies between components and to interested parties. The PIC will be chaired by a representative from the Ministry of Finance and Economic Planning. Those relevant organizations from the GOS, the donor community and the private sector will be members of the PIC. It is envisioned that membership will surely include representation from the Ministry of Health, National Population Committee, Sudan Family Planning Association, the Ministry of Education, the leading pharmaceutical organizations and firms, the Medical Doctors Union; particularly the pharmaceutical and OBG/YN subgroups; the business community and USAID. The technical assistance contractor will serve as a secretariate for the PIC. Two subgroups, one for delivery of family planning services and one for policy development will form part of the PIC. Each of the subgroups will be comprised of relevant individuals from the PIC. The formation and function of each of the subgroups is described in more detail under each component.

1. Delivery of Family Planning and Health Services

This component is the largest portion of the project, comprising the greatest part of project resources. Besides meeting an acute need for family planning services in major urban areas, this component will supplement the contraceptive and ORS program in rural areas.

A. Social Marketing Program. The exact nature of this activity will be determined at the Project Paper stage. However, its general outlines are clear. The initial objective of this activity is to address the severe shortages of contraceptives that now exist in pharmacies. The longer-term objectives are: 1) to establish a supply system of low-priced, good quality contraceptives through the private commercial sector; 2) to strengthen the position of the private sector in contraceptive distribution by channeling consumer demand through them; 3) to increase the demand for family planning by providing reliable and effective information to consumers; and 4) establish cost-recovery strategies that will allow the commercial sector to substitute AID-donated products for commercially imported ones. The activity will probably be undertaken in coordination with the Ministry of Health and will be overseen by a family planning subgroup under the PIC. The subgroup will be comprised of GOS, private sector and USAID officials. This subgroup will set policy, but will not have direct management responsibility. Marketing, distribution and sales will be carried out ideally by one or two of the leading local pharmaceutical distributors. Promotional and educational materials would be developed by a local advertising agency, and market research would be carried out by a private firm, university researchers, or through the National Research Council (National Population Committee).

Contraceptives (about 70% pills) would be sent from AID/W to a central warehouse. It is not clear at this time whether this central facility will be at MOH Central Stores, or if a separate facility will be found or constructed. This will be determined during Project Paper development. The project will provide technical assistance, and training and is prepared to provide logistical support if need be. However, it is expected that existing logistical and warehousing systems will prove adequate for the social marketing program. This assumption will be confirmed during Project Paper design. The commodities would then be passed to the local commercial firms for handling, marketing and sales. The pharmaceutical distributor would mark-up the contraceptives by an agreed upon percent. The distributor could retain all of the mark-up or a portion of it could be returned to the project to be spent on promotional activities. Some initial market research on the elasticity of demand would assist in setting the prices of the contraceptives. It is expected that AID would supply all contraceptives for the first two years of the project. This will give the project time to establish a viable social marketing program, and begin to demonstrate impact to the Sudanese. It is expected that after this initial period, distributors will begin importing commodities. The project's provision of contraceptives, therefore, should begin to decline as a proportion of total needs. By the end of the project, all contraceptives will be provided by the private sector organizations.

In addition to doctors and pharmacies, for-profit businesses and parastatals offer a unique opportunity to expand family planning availability at low cost. There are several thousand formal employers in Sudan with tens of thousands of employees. The Sudan Businessmen and Employers Association, for example, has over 1,000 member companies. Many of these firms have basic health units and provide certain health benefits to employees. The project, as part of the social marketing program, will direct activities, gaining the commitment of business owners, employers, and unions to offer family planning services as an employee and dependent benefit. The activity will sponsor analyses showing the health and financial returns from offering family planning, and demonstration projects showing the feasibility of the approach. Emphasis will be placed on having the employers assume the costs of service delivery.

Similarly "community pharmacies" are prevalent throughout much of Sudan and their numbers are constantly increasing - especially in the Khartoum area, Central Region, Kordofan and Darfur regions. In the latter two, the Rural Health Support Project is financing and co-managing the activity with the regional health authorities. Community pharmacies obtain their drug supplies from the GOS Central Medical Stores and the private sector at regular prices, and sell at a reasonable price to consumers. The community pharmacies were started in the early 1980s by the MOH as a way to address cost recovery of drugs. All community pharmacies are owned and supervised by the MOH. However, they are completely independent financially and managerially of the public sector and use market rules in their operations. The activity has so far been successful in making drugs available to consumers, is socially and politically acceptable, and is profitable. Profits are being used to expand the service and strengthen its operations. For example, El Obeid Community Pharmacy has paid, within two years, its advance loan of LS 170,000 to the Rural Health Support Project, has loaned six other sister pharmacies in the Kordofan region more than LS 200,000, is currently operating a budget of LS 750,000, and is eligible for a commercial bank loan of LS 1.0 million. However, El Obeid Pharmacy does not stock or sell contraceptive pills (issue currently being negotiated), and the small amounts of condoms they get hold of every now and then are quickly sold out. The Pharmacy also sells ORS. Obviously, community pharmacies offer a working model for the extension of family planning services and a mechanism for cost sharing and recovery in the public sector.

B. Public Sector Delivery Programs. The Ministry of Health currently operates a national MCH/FP project, with UNFPA funding, with WHO being the executing agency. AID has been providing the bulk of contraceptives along with limited technical assistance in logistics. In addition, AID's Rural Health Support Project (RHSP) is assisting in the establishment of a functioning primary health system in Kordofan and Darfur.

The RHSP's general objective is to strengthen the health system's managerial process to deliver primary health care. Project emphasis is directed to serve the rural populations in these two regions, and the strengthening of the MCH/FP component of primary health care services in particular. For each region a Project Implementation Unit (provided by the project contractor) technically supports the regional health authorities. In each region a child survival coordinator and coordinator of MCH/FP sees to the development of the

special emphasis project goals mentioned above. National counterparts work closely with these coordinators. In the Kordofan region there are approximately 900 health facilities - hospitals, health centers, dispensaries, dressing stations, and primary health care units - of which more than 800 are in rural areas. Personnel who will be closely involved in MCH/FP services delivery include 77 medical practitioners, 278 intermediate level health workers (health visitors and medical assistants), and 1,353 peripheral health workers (community health workers, nurses and midwives.) In Darfur there are approximately 670 health facilities, of which 640 are rural. MCH/FP services include 45 medical practitioners, 174 intermediate level workers, and 1,075 midwives, nurses and PHC (community health workers) in the most peripheral units.

During the first two years of the Family Planning Delivery and Policy Project, public sector support to extend MCH/FP services will be established and developed through the RHSP networks in Kordofan and Darfur - which operate throughout the existing health system. Of special note will be project activities to extend MCH/FP services in the rural areas. Eventually, these activities will be introduced to other regions of Sudan. The RHSP already works closely with the National MCH/FP project - this coordination will be strengthened in the future. The RHSP activities in establishing community pharmacies, extending their services in rural areas, and including contraceptive supplies in their stocks, has already been mentioned in the social marketing component.

The National MCH/FP project is operational in three regions. These are: Central (Wad Medani), Eastern (Kassala), and Kordofan (El Obeid). The national MCH/FP is operational in 171 hospitals, where 88 specialists and medical practitioners are working, and in 250 MCH/FP health centres, mostly in urban areas. In rural Sudan, more than 4,000 trained midwives are also providing MCH services. The national program aims at assisting the MOH to expand and improve the development and delivery of MCH/FP services. Through its existing infrastructure, by supplying additional contraceptives and by continuing to improve logistics and training, the project will provide, technical assistance training and essential equipment to strengthen these important activities.

In addition to MOH facilities, PVO's, particularly the Sudan Fertility Control Association and the Sudan Family Planning Association and some U.S. PVOs, could be significant outlets for MCH/FP services. However, to do this PVO's must become more efficient and more cost-effective. This can be accomplished by upgrading management skills, improving operational policies and better targeting clients. The project will provide modest assistance for management training and short-term technical assistance.

C. Oral Rehydration Salts. After establishment of the Social Marketing Program, the project will introduce the implementation of ORS program. Mission views this as a complementing and synergistic activity and feels the marketing of ORS may proceed in much the same fashion as contraceptives. An ORT program already exists in the MOH and the prevalence of ORS use is rising. It is estimated that about 90 percent of the present market for ORS is supplied by free distribution through MOH facilities. The small commercial sector demand is met by imported ORS, sold to middle and upper income purchasers at about LS 2 per packet. Due to an expected rapid

expansion of the total market, one firm in the private sector has already made a limited commitment to local production using ingredients procured under the Commodity Import Program (CIP). The packaged and locally produced product will be sold through pharmaceutical outlets at a more competitive price than the imported ORS.

The estimated annual need for ORS is for 45 million packs (based on 4.5 million children under 5 years, each having 5 episodes of diarrhea and using 2 packs per episode). As awareness and commercial availability increase, the balance will probably shift from the public to the private sector. The AID participation in the private sector could take a variety of forms and involve several arrangements. The current shortage of foreign exchange may make continued importation of raw ingredients an attractive option to consider, at least initially. Since the market can be easily divided into a very price sensitive public sector procurement, and an initially smaller private sector market, various mixes of support to private local producers could be discussed during the PP. The MOH has already a line item in its budget for ORS procurement, though to date, donors (including USAID through UNICEF) have met their needs. The effective demand for ORS is estimated at approximately 7 million packets. Approximately 5 million are annually imported into the Sudan. Also, since ORS has already been put on the "essential drug" list, private sector pharmaceutical companies can import ORS or buy foreign exchange for the ingredients, if available.

The Mission has had one consultancy to look at commercial sector production of ORS. Further assistance will be necessary at the PP stage to refine projections for the market segments (private and public), develop costing figures, consider options for the private sector ingredient procurement, and study the costing and marketing implications of the locally produced ORS versus the international market.

The ORS program will be coordinated through the MOH's National Control of Diarrheal Disease Program (NCDD). The additional quantities of ORS will compliment available supplies from the GOS and the donor community, and are expected to meet the rising demand with the expansion of the national CDD program, especially in rural areas. Project inputs will be directed to strengthen private sector and community pharmacy role in making ORS available at an affordable price.

Implementation of the Family Planning Component. Overall monitoring and implementation of the Family Planning component of the project will rest with the Project Implementation Committee. Specific implementation and planning issues will be monitored by the Family Planning subgroup, which will be headed by the Ministry of Health and consists of the relevant implementing agencies discussed above. The technical assistance contractor will serve as the secretariat for the PIC and will provide technical assistance and training resources for the activities described. Specifically, it is expected that an expatriate advisor will be assigned to the family planning subgroup for the duration of the project. This advisor will be responsible for assisting the subgroup in implementing all aspects of the family planning component. While primarily responsible for the social marketing program, the advisor will assist in the implementation of the public sector program as well. This will require the close coordination of activities with the MOH, pharmaceutical distributors, advertisers and market

researchers to help guide the program. It will also require close coordination with the policy development activities under the project to assure that needed reforms and legislation, as well as acceptable standards for safety and ethical conduct are developed and implemented. It is expected that the adviser will be supported by four local staff, an accountant, logistics officer, administrative assistant and secretary. It is expected that a local project manager will be hired by the local contributors identified to assure that the social marketing is implemented effectively. It is impossible at this time to determine the amount of assistance that will be required in term of logistical support until a decision is made on whether commodities will be stored at GOS Central Stores or a separate warehousing network will be established. This will be undertaken as part of PP design. Nonetheless, it is expected that some technical assistance, training and equipment will be necessary. Mission is making provisional estimates for up to five person years of long-term technical assistance at this time, as well as the provision of equipment and training. The details of the estimates will be determined at the PP stage. While primarily targeted towards the public sector program, it is envisioned that some logistical assistance may be necessary for the social marketing program as well. It is expected that significant short-term technical assistance will be required to support the efforts of the long-term staff. Specific short-term expertise is envisioned for the social marketing program, training programs for the GOS, private sector and PVOs and for logistical support.

2. Policy Development. The purpose of this component is to create a positive policy environment in which the goals and objectives of the national population policy can be achieved. Central thrusts of the expected national policy are the moderation of fertility, a slowing of population growth rate and the adoption of the child spacing and the small family norm. This will be achieved through family planning services provided both by the public, and especially, the private sector. The measure of success that is achieved will be an increase in contraceptive use and prevalence, which can only occur in a favorable social, political, administrative and policy environment. The objectives of this component are: a) developing appropriate operational and programmatic policies to support family planning expansion; b) identifying and removing of policy constraints to program development; c) maintaining a national consensus on population policy; and d) fostering an evaluation and monitoring capacity in the GOS to track sector performance. Achieving these objectives will occur through three sub-components:

A. Policy Analyses and Research. There are a number of policy issues that influence the success of a population policy and program implementation. Some of these are short-term and have direct impact (e.g. operational policies) while others have long term impact through social and behavioral change (e.g. women's status and development and educational policies). This sub-component will support a series of policy analyses and research efforts aimed at identifying the most pressing policy issues, assessing the consequences of alternative policy options, and promoting the policy changes suggested by the analyses. This process will be carried out in collaboration with the appropriate GOS officials having responsibility for the policies under consideration. This approach follows the successful model utilized during the preparation of the policy analyses for the Third National Population Conference.

1. Service Related Studies. This will include developing guidelines for family planning service provision and better definition of the roles and responsibilities of service providers. One of the first areas to be analyzed is the demand for family planning. The Demographic Health Survey (DHS) is expected to provide significant new data on the characteristics of demand for services. This information in turn will be essential in designing programs and targeting contraceptive distribution through the MOH and the social marketing program. This sub-component will also include studies on the use of para-professionals to provide contraception, undertake IUD insertions and the use of non-professionals in the provision of over-the-counter products. Comparative controlled studies of the efficiency and safety of service provision by different providers will be done. Studies on reasons for acceptance and especially discontinuance of family planning and in particular specific methods will be undertaken. This sub-component will also support pilot studies testing potential new avenues or previously unused outlets to promote family planning and/or provide services.

2. Legal and Institution Related Analyses. Studies under this area will include identification of legal constraints to service provision, contraceptive supply and marketing, advertising and distribution of contraceptive products and services. The studies will also examine institutional constraints that prevent expansion of services by bottlenecks in terms of professional rules, procedures and logistic arrangements. Finally, studies will also develop from work by which regulators can establish procedures for safe and ethical prescription and delivery of contraceptives.

3. Special Surveys and Policy Analyses. This activity includes studies and analyses of knowledge, attitude and practice (KAP) of family planning as well as spot surveys. Such surveys will cover identification of current implementation problems; and over time, they will provide a continuing picture of sensitive changes taking place in the program.

4. Studies of Cultural Constraints. Selected studies on socio-cultural factors affecting contraceptive practice and the use of specific methods and procedures will be carried out under this sub-component. These will provide baseline data on socio-cultural factors but more importantly will address specific program issues. These program studies could examine: a) male attitudes in selected areas toward the acceptance of contraception and strategies to overcome them; b) effects of religious values, in particular Islam, on contraceptive practice and their impact on family planning practices; c) specific regional and local community level concerns to family planning provision (e.g. providers, service outlets) and its acceptance, and d) methods of addressing female circumcision in Sudan.

B. Broaden National Consensus on Population. It is expected that the National Population Policy will be adopted by the GOS in 1989. Although this will be a significant achievement, there is a need to achieve universal acceptance of the Policy by broadening and deepening the extent of constituency support both for the policy and for family planning services. This work will direct activities on groups whose influence will have important impacts on program implementation. It will also aim to identify potential obstacles and opposition groups to the expansion of family planning services and seek to gain group leaders public endorsement and support of policy and program goals.

Target groups will include the following: parliamentarians, high public officials, business leaders, professional groups, medical leaders, religious leaders, women's leaders, community leaders, trade union and workers leaders, media personnel and youth leaders. The process of constituency building will involve both raising awareness and providing information on the national policy and program but also on population related issues of special concern to different groups. This will be done by seminars, workshops and by the provision of informational materials and the involvement of leaders in particular program activities.

It is expected that family life and health classes will be included in the curriculum at schools and would be a new operational policy for the Ministry of Education. The WHO has already initiated activities in the area of developing school health curricula. This project, through short-term technical assistance, training and local currency support, will collaborate with WHO and other agencies in this activity.

C. Development of Health Information System. While family planning activities have existed in Sudan for many years, no accurate data collection and evaluation system exists. There is an absence of up-to-date service data and other indicators of contraceptive use. Existing data (the 1979 World Fertility Survey and the 1983 Census which is not yet complete) are of limited use since socioeconomic conditions have changed considerably in the past 5-10 years. No data is collected on such basic indicators as quantities of contraceptives imported and distributed. The current Demographic and Health Survey will provide essential new information, but there is still a critical need to collect and evaluate basic program information. This sub-component is designed to assist in the development of a proper population program monitoring and evaluation system.

The activities that will be supported by this component will include the following studies:

1. Design of a standard service reporting system to be used by the public sector, NGOs and the private sector.
2. Design of national and regional program targets over the next 5 years consistent with the national population policy.
3. Operational research on program issues such as maintenance of an efficient supply system, quality of service providers and their training needs, and service capacity and utilization. Operations research projects could also study new approaches and less costly ways to deliver services, and obtain feedback on client attitudes to different service modes.
4. Measurement of program performance by periodic surveys and analyses of service data, contraceptive sales and use data.
5. Occasional demographic impact studies.

D. National Population Coordinating Council. Along with the passage of the National Population Policy, the Mission feels it will be beneficial to establish an autonomous group that will oversee all population activity in Sudan to assure that it conforms with the stated national policy. This group, the National Population Coordinating Council, will serve as a supra advisory committee and will be charged with the responsibility that all donor and GOS population activities are in concert with national policies and strategies. The composition of the committee will be determined at the PP stage, but will consist of senior level Sudanese who have been involved with population, family planning and health issues.

E. Implementation of the Policy Development Component. As noted earlier, it is anticipated that the GOS will adopt a National Population Policy in 1989, about the time that the proposed project will begin. It is anticipated that this document will either authorize the establishment of an Office of Population, Planning and Coordination (OPPC), or else upgrade the present National Population Committee (NPC) to serve as the management structure for population activities in the Sudan. As with the Family Planning Component, overall monitoring and implementation of the policy component will rest with the Project Implementation Committee. Specific implementation and planning issues will be monitored by the policy subgroup, which will be headed by either the OPPC or the NPC. The subgroup will be headed by a Sudanese official who will serve as policy coordinator and be supported by a full time Sudanese social scientist and operations research specialist. It is anticipated that an expatriate policy coordinator will be assigned to the subgroup for two years to serve as the counterpart of the Sudanese professional and to assist in establishing appropriate procedures and methodologies. Long-term technical assistance may also be needed in the areas of operations research or management information system. The long-term assistance will be supplemented by appropriate short-term consultants. The Project Paper will analyze this need and make appropriate recommendations. The provision of expatriate technical assistance at this level is warranted, because while there are many qualified Sudanese with appropriate skills to fill these positions, experience in the population field is limited. A short apprenticeship with an experienced population professional will contribute significantly to the long-term effectiveness of Sudanese professionals. This core professional staff will be supported by an administrative assistant, an executive secretary and a typist. Funds will be provided for policy analyses, studies, consensus-building and monitoring activities will be carried out directly by office staff or sub-contracted to a variety of local groups capable of undertaking such policy work. Local institutions identified at this stage include University of Khartoum, Faculty of Medicine, especially the Departments of Community Medicine and Obstetrics/Gynecology, Economics, and Social Sciences; the National Research Council's ESRC and NPC; the Population Studies Centre at Gezira; and Government Departments such as Department of Statistics, the Population and Manpower Planning Unit in the Ministry of Finance and Economic Planning, and the relevant divisions in the Ministries of Health and Education.

III. FACTORS AFFECTING PROJECT SELECTION AND FURTHER DEVELOPMENT

A. Social Considerations.

1. Socio-Cultural Context. While fertility is high in Sudan and family planning practice is modest, significant changes are taking place in couples' desired family size. This change is occurring despite the strength of conservative and traditional values in a predominantly rural country. Contraceptive prevalence since the Sudan Fertility Survey (1979) has doubled from 5% to an estimated 11% today. Since reproductive cohorts are growing rapidly, the absolute demand for contraceptives has probably tripled in the same time period. Rapid urbanization and modernization have contributed to this changing behavior and consequent desire for smaller family sizes. Increased educational opportunities and increased female labor force participation are also making a major impact on fertility desires. Further, Islamic leaders are increasingly supporting family planning, stressing the quality of family life and economic opportunities. Perhaps the major impetus for the smaller family norm are the progressively worsening economic conditions and the associated rising costs of health, education and even basic needs. The economic benefits of smaller families is becoming more apparent to Sudanese couples, especially in the cities.

The growing acceptance and demand for family planning is also reflected in the political arena where more and more politicians are speaking out on population issues. The Prime Minister has led this awareness raising effort by mentioning the need for population policy and family planning in a variety of contexts since the 1987 National Population Conference. Family planning, unlike the situation five years ago, is now an acceptable subject for politicians and bureaucrats alike. Despite these advances, population and family planning are still potentially sensitive topics in Sudan and any bilateral assistance project must be designed with these sensitivities in mind.

2. Beneficiaries. The primary potential beneficiaries of this project will be all Sudanese couples in their reproductive years and their children. In particular, the project will most benefit younger couples who are in their more active childbearing years. This is because their lifetime reproductive and health behavior will be more influenced by the project than those who have already had a number of births and/or lost infant children to diarrheal disease. Whereas the project can beneficially affect all Sudanese couples wishing to delay or limit births and avert catastrophic diarrheal episodes, it is more likely to benefit urban dwellers at least in this first phase. This is because the largest part of the project (social marketing) will be implemented through pharmacies and other retailers. Pharmacies in Sudan are mainly found in the cities. In addition, the project is more apt to benefit urban dwellers because they have a much higher demand for family planning than do rural inhabitants.

Secondary beneficiaries obviously include the pharmaceutical retail outlets and members of the product distribution chain which will realize some profit from the sale of family planning and ORT products. The commercial entities involved as partners in social marketing will also benefit from the new business opportunities, new market research, and exposure to potentially new advertising techniques. Other beneficiaries will include public and private sector institutions, policy researchers, policy analysts, and policy makers who will gain much-needed experience in policy work.

3. Participation. Local leaders, government personnel, private sector and other donors have and will be involved in project design, implementation and evaluation. PID preparation involved detailed discussions with the Ministry of Health (MCH/FP Department, Pharmaceutical Department), the Ministry of Finance and Economic Planning (Statistics and External Finance), the Ministry of Youth and Sports, the Ministry of Education, PVOs, and the Sudan Businessmen and Employers Association.

The beneficiary population will participate through market research surveys, through the on-going DHS survey, and possibly focus groups. These consumer surveys will help create promotional and IE&C materials that will improve the quality of product acceptability and use by Sudanese couples. A pharmacy survey has already been undertaken and will be employed at the PP stage.

4. Socio-Cultural Feasibility. On the social marketing side, the PP design team should investigate the relationship between physicians and pharmacists regarding the prescribing of contraceptives. It should be determined that physicians would not object to or block a large program aimed at expanding direct contraceptive sales. Another social marketing feasibility issue regards the ability and proclivity of pharmacists to provide consumer information to clients at the time of purchase. On the policy development side, the major socio-cultural feasibility issue involves the ability of different sectors and groups to work together effectively. Traditionally in Sudan, major program efforts are undertaken "vertically." That is, a self-contained program operates within a given system or ministry with clear lines of authority and a single budget. The population program involves utilizing the existing institutional capacity and infrastructure sectors including the government, the commercial private sector and PVOs. It is an issue whether the GOS can effectively set and implement priorities in population given the disparate nature of the organizations involved.

B. Economic and Financial Considerations.

1. Economic. The main goals of this project are to reduce high fertility and mortality rates. Reductions in these indicators will produce positive economic benefits for the Sudan and individual families. The most immediate economic effects are seen in health care savings as a result of births and maternal/infant illnesses and deaths averted. These savings include public and private expenditures on pre-natal care, deliveries, post-partum care, and any expenditures resulting from complications. In the case of employed mothers, income is potentially foregone during pregnancy and childbirths. Longer-term public and private savings are realized when births averted result in cost savings in educational expenditures and routine health expenditures. These savings can be calculated using cost-benefit analysis which determines benefit-to-cost ratios over time. A preliminary analysis for Sudan shows that if the Total Fertility Rate (TFR) declines from 6.6 in 1985 to 4.4 in 2005, the public health and educational systems would be saving \$63 million annually by the end of the period (assuming constant per capita educational expenditures in these two sectors). This appears to be a realistic objective for the project, based upon the state of family planning services and ORT in Sudan, and similar experiences from other countries. The benefit-to-cost ratio for just these two sectors would be about 4:1 after 20 years.

Besides public and private expenditures averted, lower population growth rates can have a favorable impact on overall economic performance. This impact is most acute in poorer countries according to a 1986 study by the National Academy of Sciences. If the birth rate dropped by 33% (as above) in a 20-year period, GDP per capita could rise significantly. Evidence from other countries suggest that increases in per capita GDP could range from 4% upwards under such fertility decline. This level of increase would produce an overwhelmingly positive benefit-to-cost ratio even at high discount rates.

Finally, the universal use of inexpensive treatments with ORS could reduce infant deaths by 20% to 40%. Such a reduction would reduce short-term health expenditures resulting from prolonged illnesses and deaths. On the other hand, it would produce healthier and stronger children and adults. Higher survival rates might produce increases in short-term health and educational costs, but since it is known that lower infant mortality is a determinant of smaller family size, the long-term savings from fertility decline would offset any increased short-term expenditures.

2. Financial. Both social marketing and policy work are cost-effective approaches to reducing fertility and infant mortality. The cost-effectiveness of social marketing depends upon the degree to which the project relies upon existing commercial channels and distribution systems. The greater the reliance on existing systems, the cheaper the per couple cost per year (CYP).

The Sudan social marketing project will be dependent upon the existing commercial system. Preliminary estimates of a CYP is approximately \$6. Recurrent CYP would be even lower. This compares quite favorable to the \$20 figure that the World Bank considers to be a reasonably cost-effective amount for African countries. Any alternative approach to expanding family planning services in Sudan would be much more costly without any apparent increase in program effectiveness. Alternative approaches would include launching a large program through the Ministry of Health. The costs of these kinds of programs have run as high as \$52 per CYP in Kenya so this would not be a cost-effective alternative for Sudan at this time. Further, the MOH's current budget accounts for only 1% of the GOS expenditures, while family planning makes up only a fraction of this already small amount. The feasibility of expanding the MOH system to meet current demand during the next 5-years is questionable.

The GOS is undergoing a severe shortage of foreign exchange. One of the principle premises of the project is that the private sector will be permitted to utilize foreign exchange to import contraceptives. The Project Paper will carefully analyze the implications of this strategy to the foreign exchange positions of the GOS, and provide appropriate suggestions for achieving objectives.

C. Relevant Experience with Similar Projects. Although this project will be the first AID bilateral in population in Sudan, there is considerable experience within the Mission in the population and health fields. This experience will be called upon during the final design of this project. Centrally-funded population projects have been working in Sudan since the early 1970s. Between 1983 and 1985, the Mission developed a draft PID for a contraceptive social marketing project which was widely discussed among USAID personnel and GOS officials. There was general agreement to proceed with this PID but the activity was cut short by the temporary withdrawal of USAID support in 1985. In public sector contraceptive distribution, the Mission through FPIA, has been supplying the MCH/FP program in the MOH with contraceptives and with limited technical assistance. The success of this activity has been tempered by lack of technical assistance due to travel restrictions, the uncertain future of the AID-FPIA relationship, and limited FPIA funds allocated to Sudan. Centrally-funded operations research projects have been especially successful in Sudan in showing that Sudanese couples will accept well-designed family planning programs and that paramedical personnel can effectively delivery family planning services.

Mission experience in health activities are relevant to this project. The Rural Health Support Project has a small family planning component and a local currency agreement provides substantial support to the MOH Control of Diarrheal Disease program. A recent grant to UNICEF has a large ORS component.

The Mission has a good history in the area of population policy development. Through centrally-funded projects, the Mission has supported the National Population Committee since 1980. This included sponsoring the 1982 National Population Conference which set the stage for Sudan's participation in the 1984 World Population Conference in Mexico City. More recently, local currency agreements have supported the 1987 National Population Conference which has provided impetus for this bilateral, and the current work of the National Population Committee to develop the national population policy. The Mission has considerable technical assistance experience in policy development through the centrally-funded OPTIONS project which has provided all T.A. to the NPC in support of the local currency agreement.

D. AID Support Requirements and Capability. Mission has adequate technical and support staff to monitor the implementation of the project. A full time population officer will be the AID project manager. This person will be backstopped by a project development officer from the Project Operations Office. The project manager will also receive backstopping from a project committee comprised of representatives from the Program, Controllers, Commodity Management, Contracts and Engineering offices, as relevant.

E. Estimated Costs and Methods of Financing. The total cost of the Family Planning Delivery and Policy Project is provisionally estimated at \$30.0 million. It is anticipated that the project will be implemented over a 6 year period. AID will provide all foreign exchange costs amounting to approximately \$17.0 million. The GOS will contribute the local currency equivalent of \$11.0 million. The private sector is expected to contribute the local currency equivalent of \$2.0 million. It is stated that this is a provisional budget. Depending on the analysis of the PP stage, the cost of some components may be altered depending on the findings of the team. For instance, the amount and composition of technical assistance may be altered depending on the recommendations of the logistical analyst. Similarly, costs for equipment, construction and renovation may be altered depending upon the state of warehousing facilities and logistics for the social marketing and public sector programs. The provisional estimates are for the worst case scenario where the project would be forced to fully fund these items to assure the achievement of objectives.

Personnel costs include the foreign exchange and trust fund costs for up to 14 person years of long-term, and approximately 130 person months of short-term technical assistance. Local currency will provide for the services of all local professional and support staff, as well as for the social marketing program.

Equipment costs include vehicles, office equipment, micro-computers, logistical equipment, as well as expendable supplies.

Estimates for contraceptives are calculated at \$4.40 per CYP over five years. ORS calculated at 1 million packets per year at \$.15 per packet.

Training costs include foreign exchange costs for long and short-term participant training, as well as local currency costs for in-country short-term training.

Local currency has been included for any construction and renovation costs for the project. Firm cost estimates will be determined at the PP stage.

Other costs include the provision for operational costs for the two major components of the project, evaluation, contingency and inflation.

Illustrative Project Budget
(\$000's)

	<u>AID</u>	<u>GOS</u>	<u>Private Sector</u>
I. Personnel:			
<u>Expatriate</u>	<u>5,300</u>	<u>700</u>	
a. Family Planning Project Coordinator (5 yrs)	1,200	200	
b. Policy Coordinator (2 yrs)	480	80	
c. Operations Research Specialist (2 yrs)	480	80	
d. Logistical Support Specialist (5 yrs)	1,200	200	
e. Short-Term Technical Assistance	1,940	140	
 <u>Sudanese</u>		<u>5,400</u>	<u>1,400</u>
a. Policy Coordinator (5 years)		400	
b. Social Marketing Coordinator (5 years)			400
c. Operations Research (5 years)		400	
d. Support Staff		2,000	
e. Social Marketing (advertising, research, etc.)		2,000	1,000
 II. Equipment:	<u>2,000</u>		<u>600</u>
 III. Commodities: (Contraceptives & ORS)	<u>8,250</u>		
 IV. Training:	<u>500</u>	<u>2,000</u>	
 V. Construction/Renovation:	-	<u>500</u>	
 VI. Other Costs:	<u>950</u>	<u>2,400</u>	<u> </u>
 TOTAL	<u>17,000</u>	<u>11,000</u>	<u>2,000</u>

F. Design Strategy. The Mission will begin design of the PP o/a May 1, 1989 with a scheduled obligation for the project of July 30, 1989. The May 1 start will allow ample time for AID/W PID review and organization of the design team. In addition, the thirty day period of Ramadan, which will start in late March, would preclude meaningful contact with Sudanese affiliated with the project during the month of April.

The design team will consist of the following expatriate contract personnel:

- Marketing Management Advisor (4 weeks)
- Marketing Research Advisor (3 weeks)
- Senior Policy Specialist (3 weeks)
- Logistical Specialist (4 weeks)

It is anticipated that the following local consultants will be utilized:

- Sociologist (4 weeks)
- Engineer (4 weeks)

USAID staff that will contribute to the design team are as follows:

- Population Officer (4 weeks)
- Chief, HPN (1 week)
- Economist (1 week)
- Project Development Officer (4 weeks)
- Project Development Officer (local hire) (4 weeks)
- Program Officer (1 week)
- Engineer (1 week)
- Controller (1 week)
- Commodity Management Officer (2 days)
- Contract Officer (2 days)

Other direct hire staff involvement will include:

- AID/W Population Officer (4 weeks) (Team Leader)
- Regional Legal Advisor (2 days)

The expatriate advisors will be obtained through buy-ins to centrally funded projects such as SOMARC. If this proves too cumbersome, these advisors will be obtained through IQC mechanisms. A total of \$50,000 in PD&S funds has been reserved for the design effort. The sociologist and engineer will be contracted locally with local currency. The team will work under the technical direction of the AID/W Population Officer and the HPN Division Chief, and under the program leadership of the Supervisory Project Development Officer. Tentative task descriptions for key team members are attached to the appendix of this PID.

G. Recommended Environmental Threshold Decision. As requested in Annex 2, the Initial Environmental Examination, USAID recommends that the project be given a Categorical Exclusion. The exclusion is based on the project not having an effect on the natural or physical environment, and because inputs to the project TA and training do not directly affect the environment.

H. AID Policy Issues.

A. Voluntarism and Abortion. AID policy mandates that family planning programs be absolutely voluntary. All components of this proposed project conform to this mandate. Further, Congress has legislated that no AID monies be used for abortion or abortion-related activities. In Sudan, abortion is illegal. In addition, the methods being proposed in this project are "over-the-counter" products and involve no abortifacients.

B. Sustainability and the Private Sector. AID policy promotes using the private sector for the delivery of social services. One rationale behind this policy is that market-based service delivery in the private sector has a better chance at self-sufficiency than do cost-recovery schemes in the public sector. This project aims to create a solid foundation for the sustainable commercial of contraceptives by increasing the role of the private sector and by promoting policy reforms to enable self-sufficiency.

I. Gray Amendment Consideration.

Every consideration will be given to the availability of minority firms in the development of the RFP. Minority firms will be urged to compete for the contract either by themselves or with joint ventures with other firms.

The Mission maintain a list of Gray Amendment firms who have procurement service agent experience. Equipment for the project should be procured through the use of a PSA contract with a Gray Amendment firm.

LOGICAL FRAMEWORK
FOR
SUMMARIZING PROJECT DESIGN

Est. Project Completion Date FY95

Date of this Summary 12/26/88

Project Title: Sudan Family Planning Delivery and Policy

! NARRATIVE SUMMARY	! OBJECTIVELY VERIFIABLE INDICATORS	! MEANS OF VERIFICATION	! IMPORTANT ASSUMPTIONS
! Program Goal: ! To reduce high rates of fertility, ! Infant and child mortality and ! to Improve Institutional capacity ! for Implement-population programs.	! Measures of Goal Achievement: ! Reduction in population growth rate; ! Reduction in mortality rates.	! - Census and survey data ! - Vital statistics	! For Achieving Goals: ! GOS continues to give high ! priority to population and ! child survival activities.
! Project Purpose: ! Expand availability and use of family ! planning and oral rehydration therapy ! especially through the private sector. ! To create a policy environment supportive ! of the expansion of family planning use.	! End of Project Status: ! - Sales and distribution of contraceptives ! and ORS increase. ! - Strengthened role of for-profit private ! sector in the provision of contraceptive ! supplies and information. ! - Decline in unmet need for contraceptive ! supplies. ! - Decline in infant and maternal deaths. ! - Removal of policy constraints inhibiting ! expansion of FP. ! - Establishment of operational policies ! promoting FP. ! - Improved GOS capacity to monitor and ! evaluate population sector performance.	! - Sales records of ! distributors ! - Ministry of Health ! distribution statistics ! - Contraceptive prevalence ! surveys ! - Project evaluations ! - Site visits. ! - Hospital and clinic ! statistics. ! - Death registration ! statistics ! - Number of analyses and ! projects on sector ! performance ! - GOS policy changes and ! decisions and consequent ! laws, decrees, ! regulations, budgets and ! plans.	! For Achieving Purpose: ! - Contraceptives and ORS can ! be effectively marketed ! without constraints through ! pharmacies. ! - GOS is committed to ! expanding FP through ! private sector. ! - Political and religious ! environment remains ! supportive of national ! population policy. ! - GOS adopts national ! population policy. ! - GOS establishes national ! office for population ! and program coordination ! to oversee implementation ! of national policy. ! - Policymakers willing to ! act on results of policy ! analyses.

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LOGICAL FRAMEWORK (Cont.)

Outputs:	Magnitude of Outputs:		For Achieving Outputs:
<u>Private Sector:</u> Contraceptives and ORS widely marketed through commercial private sector; Increased public knowledge about use and availability of family planning and oral rehydration products.	- 100% of pharmacies with continuous and sufficient supplies of reasonably priced contraceptives and ORS.	- Project statistics	- High demand in private sector for FP + ORS products and services.
	- Increased knowledge of FP + ORT practices.	- Sales data; pharmacy surveys; site visits	- Private sector willing to widely market FP and ORS products.
<u>Public Sector:</u> Increased availability of contraceptives through public outlets.	- 100% of existing public health and MCH/FP facilities with continuous and sufficient supply of contraceptives and ORS.	- MOH distributions records	- Public sector capable of distributing contraceptives.
	- Policy priorities defined; policy bottlenecks identified and analyzed; x numbers of policy analyses and evaluations; x numbers of consensus-building activities (workshops, seminars, promotional activities).	- Demographic and health surveys	- Consumers willing to get knowledge of FP + ORS through commercial outlets.
<u>Policy Development:</u> Policy environment conducive to the rapid expansion of family planning services and use.	- contraceptives on essential drug list.	- GOS annual reports; seminar and study reports; project evaluation reports, operations workplans for key sectors	- Responsible GOS office for population develops institutional and staff capability to manage and coordinate policy work.
Inputs:	Level of Effort/Expenditure:		For Providing Inputs:
AID: Technical Assistance, Equipment Contraceptives, Training Construction/Renovation, other costs.	AID:FX - \$17.0 million		
	GOS: - \$11.0 million		
	Other Donor(s): - \$2.0 million		
GOS: 37% of total budget.	TOTAL: - \$30.0 million		

Annex 2

INITIAL ENVIRONMENTAL EXAMINATION

Project Country : Sudan

Project Title & No. : Family Planning Delivery and Policy
(650-0085)

Funding : DFA/CS U.S.\$ 17,000,000

Life of Project : FY 1989-95

IEE Prepared By : Edward W. Birgeles
Project Development Officer

IEE Reviewed By : Dan Vincent
USAID/Sudan Environmental Officer *NW-*

Environmental Action Recommended : Categorical Exclusion

The major thrust of this Project will be to provide technical assistance, training and commodities in order to 1) expand the availability and use of family planning and oral rehydration therapy, especially in the private sector; and 2) create a policy environment which promotes the expansion and use of family planning services. There may be some minor renovations and constructions utilizing local currency. These will be carefully monitored by AID. Therefore, no negative environmental impacts are anticipated from any of the project's components.

This activity meets the criteria for a Categorical Exclusion in accordance with Section 216.2(c)(1)(i) and 216.2(c)(2)(viii) of International Development Cooperative Agency for International Development 22 CFR Part 216 Environmental Procedures.

Mission Director's Decision

Approved: *D.W. Kuehling*

Disapproved: _____

Date : JAN 10 1989

Bureau Environmental Advisor
AFR/TD/SDP Decision

Approved: _____

Disapproved: _____

Date: _____

Clear: GC/AFR _____ : _____

ANNEX 3

Job Descriptions for Key Project Paper Personnel

Marketing Management Advisor: Senior individual will have overall responsibility for the social marketing sub-component of the PP and preparation of the Scope of Work for the RFP. Because of detailed information required for the social marketing of ORS and family planning supplies, additional expertise may be required to assist.

- (a) Social Marketing of ORS. Ascertain interest of local manufacturers in production, their capacities, and quality control potential. Assess costs and benefits of assisting with hard currency allocation -vs- procurement of new materials -vs- letting manufacturers procure using their own resources on pricing of final product. Assess size of public and private markets at various prices and estimate likelihood of export market development to neighboring countries. Discuss procurement with UNICEF and MOH, given various pricing assumptions. Select strategy and provide rationale.
- (b) Social marketing of FP supplies. Analyze status of consumer information on contraception. Preference for methodology of choice and required information for proper use. Develop guidelines for all aspects of IEC and promotional materials for physicians, pharmacists and consumers. Examine market potential, appropriate channels to be used, pricing of range of products, cost of sales and promotional materials. Determine optimal strategy and estimate resources required.

Market Research Specialist: Assess the skills and capability of market research agencies in Sudan and make recommendations for specific technical assistance they might need. Identify types and costs of market research required to: define consumer segments; ascertain trade specific data; develop concept advertising; evaluate media effectiveness; survey physicians and pharmacies; and evaluate consumer behavior. Examine legal and regulatory determinants of contraceptive and ORS marketing. Assess current and potential impacts of current regulatory environment. Identify regulatory issues to be addressed by policy component of this project. Work with Marketing Management Expert to incorporate findings and implementation plans into PP and RFP.

Senior Policy Specialist: Responsible for overall development of policy component in PP. Examine policy environment for family planning including major constraints both at the national and operational levels. Examine policy making process to understand how decisions policies in population sector are made. In consultation with Sudanese policy makers, program directors, and researchers, determine policy analysis agenda based upon GOS priorities in population sector. Assess needs for consensus building activities and monitoring and evaluation activities. Prepare implementation plans for policy analyses, consensus building, and evaluation to include detailed budgets of each activity. Prepare scope of work for RFP for policy component.

Population Officer (AID/W): Primary responsibility for development of technical sections of Project Paper. Assigns responsibilities for PP preparation. Sets timetables for technical sections. Participates in key meetings with Sudanese counterparts. Develops overall conceptual approach. Assure that components are consistent and integrated. Provides technical advise to consultants working on PP. Writes key sections of PP and RFPs. Presents PP concept and approach to Mission management and GOS officials.

Population Officer (USAID/Sudan): Participates in all aspects of information collection, analysis, design of family planning and policy components, and strategy meetings with GOS and Mission personnel as assigned by team leader. Assesses the role that other donors and USAID projects have in population and health sector. Assures complementarity of project design with on-going and planned activities. Evaluates Mission staff requirements for managing project. Responsible for social impact sections of PP.

Project Development Officer (Local) and Economist: Responsible for financial analysis to include benefit-to-cost study and cost-effectiveness assessment. Works with technical experts on detailed budgets by sub-component. Works with Sudanese counterparts to determine GOS and private sector contribution to project. Works with Marketing Management Expert on demand analysis, pricing, and other issues requiring financial analysis. In addition, working with the Marketing Management Specialist, prepare institutional analysis of private sector for inclusion in PP.

Sociologist. The sociologist will prepare a background study that can be incorporated into the social considerations and institutional analysis sections of the Project Paper. The study will describe social and political constraints to the expansion of family planning services and further policy development work. The study will include an assessment of the acceptability for the proposed project in the Sudanese socio-cultural context, and prospects for the policy changes necessary for implementation.

Project Development Officer: Responsible for overall development of PP. Assure that all components of document are fully addressed. Reviews each section, provides feedback to other team members, makes sure that document meets AID regulations.

Logistical Advisor: Responsible for inspecting and reviewing all logistical aspects of the project for both the social marketing and public sector portions of this project. Specifically, advisor will inspect and review all warehousing, logistical and inventory systems to determine what assistance will be required to achieve project objectives. Advisor will make recommendations, including implementation plan, and cost estimates for improving systems. The work of other donors will be taken into consideration when making decisions. Advisor will be assisted by local engineering firms.

REPORT ON NATIONAL POPULATION COMMITTEE PRIVATE SECTOR WORKSHOP
JULY 17-19, 1988

The Sudan National Population Committee held a workshop on the Role of the Private Sector in Population Programs 17-19 July, 1988. The purpose of the workshop was to inform representatives of the private sector and the government about the potential benefits of private sector involvement in population programs, to assess the interests of the private sector representatives in such programs and to solicit ideas for, and support of them.

The three day workshop was opened by the Minister of Sudanese Workers Abroad, who represented the Prime Minister, who was ill. The workshop was attended by Ministers of Interior, Commerce, Education and Scientific Research, Relief and Rehabilitation, and Social Affairs as well as the Undersecretary of Planning, the President of the National Research Council, the leader of the Womens Association of Umma Party, and many other representatives of the government. Private sector representatives included owners and managers of local industries, members of the Businessmen and Employers Association and the Chamber of Commerce, the Sudanese Bar Association, and numerous owners of pharmacies and import firms as well as private physicians. The Industrial Trade Union was also well represented and the Bank of Sudan participated actively. Representatives of International Organizations (ILO, UNFPA, UNICEF) and USAID attended some sessions, and local NGO's also participated.

The conference included presentations on the following topics:

- (1) International Examples of the Role of the Private Sector in National Population Programs, (Rushwan SFCA; Amin and Hamed, NPC).
- (2) Family Planning Services in the Public Sector (Abu Baker, Bashir, Moshid MOH).
- (3) The need for Family Planning Services and Resources (Farah, NPC).
- (4) Family Planning Services and the Private Sector in Sudan (Sagyroun, NPC; Abdul Habib and Hillal, Private Sector).
- (5) Law and Private Sector Activities (Medawi, Bar Association).

Attendance ranged from 60-80 persons per session with 120 attending the closing session.

This level of attendance was excellent considering that the workshop was held during the mornings when many business people have trouble leaving their work, and that the city was in the midst of a fuel shortage which made transport difficult.

The workshop achieved a number of goals. It was brought out by a number of business owners that the workshop was the first time any government office had come to them to discuss an important social and economic issue, and the union representatives seemed to appreciate this, as well. A clear indication of the appreciation of the effort was the agreement by Industrialists Union to donate LS 100,000 to the NPC for establishment of a documentation center.

The workshop provided a forum for discussion among institutions and individuals which will facilitate development of population policy and programs. For instance, discussions between the Ministry of Health and the Bank of Sudan led to clarification of the process by which medicines and supplies are permitted for import. After the workshop, the Director of MCH and the Medical Supply Department were able to add contraceptives to the Ministry of Health essential drug list which was submitted to the Bank. The result a major accomplishment of the workshop, was the addition of contraceptives to the list of essential commodities allowed for import by the Bank of Sudan. The Ministry of Industry has also begun to accept applications for licensing for importation of contraceptives.

The Department of Maternal and Child Health (MOH) has been renamed the Department of Maternal and Child Health and Family Planning and the Minister of Health has stated that Family Planning programs will be upgraded to the level of the Extended Program of Immunization (EPI) and the Control of Diarrheal Diseases (CDD) programs.

Some of the recommendations of the workshop were:

- 1) the creation of a MCH/FP committee with representatives from relevant ministries, the private sector, universities and the NPC to facilitate coordination of programs;
- 2) the endorsement of factory based contraceptive distribution and the provision of advisors to factory clinics to explain family planning and to provide IEC materials to clinic staff, (Factory owners, in particular were interested in family planning services since, due to heavy outmigration of men, women make up the majority of factory labour at this time. Since an eight week paid pregnancy leave is mandated by law there is a clear economic benefit to factory owners in providing F.P. service);
- 3) the creation of an NPC/private sector working group to continue investigation of social marketing of contraceptives; and
- 4) the conduct of a feasibility study for production, or, at least, repackaging of contraceptives.

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Annex 5

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SUBJECT: SUDAN-NATIONAL POPULATION COMMITTEE-KORDOFAN
 REGIONAL WORKSHOP, SEPT. 19-21, 1988 AND OPTIONS
 PROJECT PARTICIPATION

1. THE KORDOFAN REGIONAL WORKSHOP HELD IN EL OBEID
 SEPT. 19-21 WAS VERY SUCCESSFUL FOR THE DEVELOPMENT OF
 REGIONAL AND LOCAL CONSTITUENCY FOR POPULATION POLICY.
 SUMMARY OF CONFERENCE ACTIVITIES FOLLOWS.

2. SEPTEMBER 19 PM - THE OPENING SESSION WAS ATTENDED
 BY 423 PERSONS REPRESENTING ALL DISTRICTS, IN THE
 REGION, INCLUDING DISTRICT COMMISSIONERS AND SENIOR
 GOVERNMENT OFFICIALS. MOST IMPORTANTLY, COMMUNITY AND
 TRADITIONAL LEADERS FROM THE WHOLE REGION, SOME OF WHOM
 TRAVELLED FULL DAY, ATTENDED THE CONFERENCE.

CONFEREEES WERE WELCOMED BY DR. MIRGHANI, CHAIR OF THE
 LOCAL STEERING COMMITTEE, AND THE GOVERNOR OF KORDOFAN
 WHO CITED ECONOMIC, SOCIAL AND DEMOGRAPHIC PROBLEMS OF
 REGION AND A NEED FOR REGIONAL POPULATION POLICY. DR.
 SAGYOUN, SECRETARY GENERAL OF THE NATIONAL POPULATION
 COMMITTEE, REVIEWED THE POPULATION SITUATION OF THE
 COUNTRY AND OF THE REGION, UTILIZING SELECTED DISPLAYS
 FROM THE SUDAN AND KORDOFAN RAPID MODELS. HE
 INTRODUCED THE NPC AND ITS POLICY DEVELOPMENT GOALS.
 THE PRIME MINISTER, SADIQ EL MAHDI, THEN ADDRESSED THE
 GROUP. HE EMPHASIZED THE NEED FOR A NATIONAL
 POPULATION POLICY AND FOR EFFECTIVE PROGRAMS. HE
 REFUTED TRADITIONAL AND RELIGIOUS ARGUMENTS AGAINST
 POPULATION PLANNING AND SAID CURRENT ECONOMIC AND
 SOCIAL CONDITIONS REQUIRE A RESPONSE.

THE PRIME MINISTER MADE SEVERAL REFERENCES TO KOPANIC
 INSTRUCTIONS REGARDING SOCIAL ISSUES AND REVIEWED THE
 MAJOR POPULATION PROBLEMS IN SUDAN AS BEING: (1) THE
 DETRIMENTAL EFFECTS OF RAPID POPULATION GROWTH ON THE
 QUALITY OF LIFE (HEALTH, EDUCATION ETC) AND (2) THE
 EFFECTS OF EXCESSIVE MIGRATION ON URBAN AND RURAL LIFE,
 INCLUDING THE IMPACT OF LARGE NUMBERS OF REFUGEES ON
 SUDANESE SOCIETY. HE EMPHASIZED THE NEED FOR AN
 INDIGENOUS POPULATION POLICY, ONE BENEFITTING FROM THE
 EXPERIENCE OF OTHER NATIONS BUT NOT GUIDED BY THEIR
 IDEOLOGIES WHICH MAY BE ALIEN TO SUDANESE CULTURE.
 SARAH EL FADIL EL MAHDI ACCOMPANIED THE PRIME MINISTER
 TO THE SESSION. MRS. EL MAHDI IS SUPPORTIVE OF
 POPULATION POLICY AND PARTICIPATED IN THE NPC/OPTIONS

3. OBSERVATIONAL TOUR OF SOMALIA LED BY DELARGY SEPTEMBER 1987. SHE DISCUSSED WITH DELARGY HER INTEREST IN WORKING MORE CLOSELY WITH NPC.

3. SEPT. 26 - SESSIONS ON POPULATION STATISTICS AND EDUCATION, POPULATION AND ENVIRONMENT, AND POPULATION AND HEALTH, WERE EXTREMELY WELL ORGANIZED. PAPERS PRESENTED WERE ALL ORGANIZED AROUND THE FORMAT PREPARED BY NPC. THEY PRESENTED RELEVANT REGIONAL DATA, DISCUSSED ISSUES SUCCINCTLY AND RELATED SPECIFICALLY TO THE RECOMMENDATIONS OF THE THIRD NATIONAL POPULATION CONFERENCE. MODERATORS OF SESSIONS WERE EXCELLENT AT SUMMARIZING DISCUSSION. ENTHUSIASM AND ENERGY WERE CLEARLY HIGH.

4. SPECIFIC PRESENTATIONS ON FAMILY PLANNING SERVICES IN KORDOFAN BY DR. AL HAJ MALIK, TRAINING IN HEALTH SERVICES BY DR. M. ALMAHMOUN, AND THE ROLE OF PEOPLE'S PHARMACIES AND SOCIAL MARKETING OF FAMILY PLANNING BY DR. AZIZA ABDEL AZIZ PROVIDED A DETAILED PICTURE OF FAMILY PLANNING DEMAND IN THE REGION AND PRESENTED NUMEROUS IDEAS FOR IMPLEMENTATION. DURING THE DISCUSSION PERIOD, WHEN ONE LOCAL RELIGIOUS LEADER ARGUED AGAINST FAMILY PLANNING, STATING RELIGIOUS PROSCRIPTIONS AND HEALTH RISKS TO WOMEN, THERE WAS A VOCIFFEROUS RESPONSE FROM PEDIATRICIANS, GYNECOLOGISTS, WOMENS' GROUPS LEADERS, ETC. AFTER LIVELY (AND FRIENDLY) OPEN DISCUSSION, THE STEERING COMMITTEE WISELY DECIDED THAT THE IMAAM (A TRADITIONAL RELIGIOUS LEADER) SHOULD BE GIVEN TIME DURING THE NEXT SESSION TO PRESENT HIS OWN PAPER, IN ORDER TO ENSURE THAT THE CONFERENCE WOULD BE WELL KNOWN TO HAVE BEEN AN OPEN FORUM, TRULY REPRESENTING ALL IMPORTANT POINTS OF VIEW ON THE ISSUES. THIS DECISION WAS MADE BY THE STEERING COMMITTEE INDEPENDENTLY OF THE NATIONAL POPULATION COMMITTEE (NPC), WHO SUPPORTED THE COMMITTEE BY PROVIDING STATEMENTS FROM OTHER RELIGIOUS LEADERS WHO SUPPORT FAMILY PLANNING. THE STEERING COMMITTEE EXPRESSED CONCERN THAT THE OVERALL POPULATION POLICY EFFORT SHOULD NOT BE ENDANGERED BY DIFFERENCES OF OPINION ON ANY ONE ASPECT AND ALL CONFEREES AGREED.

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5. THE PRESENTATION BY MR. AHMED M. KHEIR ON FAMILY PLANNING AND ISLAM, ADDED TO THE SCHEDULE, CITED RELIGIOUS OPPOSITION TO FAMILY PLANNING AS WELL AS HEALTH RISKS OF IUDS AND PILLS. THE STEERING COMMITTEE, ANTICIPATING THESE ARGUMENTS, HAD ARRANGED FOR MR. MUSA, MR. KHEIR'S SUPERIOR IN THE DEPT. OF RELIGIOUS AFFAIRS, TO ATTEND THE SESSION. AFTER POLITE RECEPTION OF THE PRESENTATION BY THE GROUP AND SOME DISAGREEMENT BY WOMEN AND PHYSICIANS REGARDING HEALTH RISKS, MR. MUSA MADE THE STATEMENT THAT MR. KHEIR'S POSITION WAS A PERSONAL ONE AND DID NOT REPRESENT THE GENERAL OPINION OF RELIGIOUS LEADERS ON FAMILY PLANNING. HE STATED THAT FP USED FOR BIRTH SPACING IMPROVED THE HEALTH OF WOMEN AND CHILDREN, THUS STRENGTHENING THE MUSLIM FAMILY. HE ALSO STATED THAT MANY MUSLIM LEADERS IN THE ARAB WORLD SUPPORT FP AS A MEANS OF PROTECTING THE HEALTH OF CHILDREN AND MOTHERS. THE ASSEMBLY APPLAUDED HIS STATEMENT AND ENDED DISCUSSION BY ADOPTING MR. MUSA'S STATEMENT AS THE ISLAMIC IDEA ABOUT FP.

6. SEPT. 21, THE OPENING SESSION INCLUDED PRESENTATIONS ON THE EFFECTS OF POPULATION ON THE REGIONAL ECONOMY, PROBLEMS OF NOMADS, AND THE SITUATION OF RURAL WOMEN. A COMMON RECOMMENDATION OF NEARLY ALL OF THE CONFERENCE PAPERS WAS THE NEED TO IMPROVE INFORMATION FOR USE IN PLANNING - RANGING FROM CREATION OF A VITAL RECORDS SYSTEM TO THE SURVEYING OF ANIMAL RESOURCES. THE DEARTH OF ACCURATE DATA ON POPULATION (OF HUMANS AND ANIMALS) ON HEALTH, EDUCATION, AND NUTRITIONAL STATUS, ON LAND USE AND AGRICULTURAL PRODUCTION, AND IN MANY OTHER AREAS IS A SERIOUS IMPEDIMENT TO REGIONAL PLANNING, INCLUDING THAT OF POPULATION PROGRAMS. THE FINAL CONFERENCE RECOMMENDATIONS WERE PRESENTED FOR DISCUSSION AND ADOPTED. THE WORKSHOP WAS CLOSED BY THE GOVERNOR WHO FORMALLY ESTABLISHED A REGIONAL POPULATION COMMITTEE AND THEN THE CONSOLIDATED RECOMMENDATIONS OF THE PAPERS.

7. THROUGHOUT THE CONFERENCE POLITICAL SUPPORT FOR POPULATION POLICY AND PROGRAMS WAS CLEARLY EVIDENT. THERE WAS MUCH CLOSER CONTACT AMONG OFFICIALS AND EXPERTS FROM DIFFERENT SECTORS THAN OCCURRED IN THE NATIONAL CONFERENCE IN OCTOBER 1987. NPC HAD GOOD RELATIONS WITH LOCAL ORGANIZERS. IT PROVIDED THE INITIAL IMPETUS AND SOME FINANCIAL SUPPORT FOR THE CONFERENCE. ALMOST ALL LOCAL ARRANGEMENTS WERE MADE BY THE STEERING COMMITTEE. PRESS COVERAGE WAS EXCELLENT - POSTERS, RADIO INTERVIEWS - AND LOGISTICS WERE IMPRESSIVE. ALL PAPERS WERE READY IN ADVANCE. THE PROGRAM WAS WELL ORGANIZED. HAND PAINTED CLOTH BADGES WERE PROVIDED FOR PARTICIPANTS USING AN ORIGINAL LOGO BY A LOCAL ARTIST. A LOCAL PRINTING COMPANY DONATED NOTE PADS WITH THE LOGO AND THE PRESIDENT OF THE COMPANY CHAIRED ONE OF THE SESSIONS. FULL BREAKFASTS WERE PREPARED BY NUTRITION TEACHERS AND SERVED EACH DAY.

8. OPTIONS PROJECT ASSISTANCE AT THE CONFERENCE INCLUDED THE COLLECTION OF SECTORAL DATA FOR USE IN PROJECTIONS

HEALTH AND EDUCATION NEEDS, PREPARATION OF DISPLAYS OF REGIONAL AND NATIONAL POPULATION PROJECTIONS FOR USE IN THE OPENING CEREMONY, PREPARATION OF THE FINAL PROGRAM AND OTHER ARABIC PAPER PREPARATIONS. THE OPTIONS TEAM TOOK THE OPPORTUNITY OF GOOD RELATIONSHIPS WITH THE STEERING COMMITTEE TO REFINE THE ARABIC USED IN THE NEWLY ARABICIZED RAPID MODEL AND OBTAIN FEEDBACK ON USEFUL DISPLAYS. OPTIONS WAS ABLE TO REVIEW WITH KPC AND NPC THEIR EXPERIENCES WITH AN EYE TO PLANNING THE REMAINING WORKSHOPS AND SUGGESTED TO NPC THAT IT WOULD BE USEFUL FOR A REPRESENTATIVE OF KPC TO VISIT THE CENTRAL REGION TO SHARE IDEAS WITH THE CENTRAL REGION WORKSHOP STEERING COMMITTEE. OPTIONS, KPS AND NPC ALSO DISCUSSED THE VALUE OF A NEWSLETTER (ALREADY BUDGETED IN NPC) FOR SPREADING INFORMATION ON NPC ACTIVITIES AND FOR SHARING OF EXPERIENCES AMONG REGIONAL COMMITTEES. THE KPC WAS PARTICULARLY ENTHUSIASTIC ABOUT THIS AND SAW IT AS A VEHICLE FOR TRANSMISSION OF INFORMATION OBTAINED BY THE S-C OF NPC AT THE NUMEROUS INTERNATIONAL CONFERENCES HE ATTENDS. OPTIONS ENDORSED THE IDEA WHOLE HEARTEDLY. 9. FYI. ALTHOUGH OPTIONS DID PROVIDE TECHNICAL ASSISTANCE TO NPC AND KPC, THE TEAM FOUND IT IMPORTANT TO MAINTAIN A LOW PROFILE AT THE WORKSHOP DUE TO CLEAR SENSITIVITIES CONCERNING THE ROLE OF DONORS IN POPULATION POLICY DEVELOPMENT, ESPECIALLY IN THE AREA OF FAMILY PLANNING. THE PRIME MINISTER STRESSED THE NEED FOR A SUDANESE POLICY, NOT ONE GUIDED BY FOREIGN IDEAS, AND THIS THEME WAS REPEATED DURING THE WORKSHOP. THE OPTIONS TEAM ATTENDED THE WORKSHOP AS OBSERVERS AND

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TECHNICAL ASSISTANTS TO THE NPC, NOT AS ADVISORS. THIS WAS APPRECIATED BY THE KPC WHO CITED THE IMPORTANCE OF NOT JEOPARDIZING FAMILY PLANNING EFFORTS BY HAVING THEM IDENTIFIED WITH WESTERN AID BY THOSE WHO OPPOSE THEM. THE OPTIONS TEAM FELT THAT KPC HELPED NPC STAFF TO BETTER APPRECIATE THE SENSITIVITIES IN THIS AREA. THE GOVERNOR, IN HIS CLOSING STATEMENT, SAID THAT SOMETIMES DONOR REPRESENTATIVES OR TECHNICAL ADVISORS IMPOSED THEIR OWN IDEAS RATHER THAN BEING RESPONSIVE TO LOCAL NEEDS. HE WAS PARTICULARLY APPRECIATIVE THAT THE OPTIONS TEAM HAD RESPONDED TO THE COMMITTEE'S NEEDS ENTHUSIASTICALLY AND HE EXPRESSED HIS APPRECIATIONS FOR DELARCY AND FREYMANH ATTENDANCE AND ASSISTANCE TO THE CONFERENCE. END FYI.

14. OVERALL, THE WORKSHOP WAS SUCCESSFUL AT MANY LEVELS AND SHOWED THAT SUCH REGIONAL ACTIVITIES CAN BE EXTREMELY PRODUCTIVE IN MOBILIZING BOTH SUPPORT AND RESOURCES FOR POLICY DEVELOPMENT.

PLANNING FOR THE NEXT REGIONAL WORKSHOP TO BE HELD IN LATE OCTOBER IN WAD MEDANI HAS BEGUN. ANDERSON

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