AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: N/A — DOCUMENT CODE: 3

2. COUNTRY/ENTITY: Botswana

3. PROJECT NUMBER: 633-0249

4. BUREAU/OFFICE: Africa Bureau — 06

5. PROJECT TITLE (maximum 40 characters): Population Sector Assistance

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 05 DD 31 YY 93

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

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

A. FUNDING SOURCE	FIRST FY B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(600)	(0)	(600)	(2,000)	(0)	(2,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country		2,317	2,317	0	13,304	13,304
Other Donor(s)						
TOTALS	600	2,317	2,917	2,000	13,304	15,304

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) DEA	400	440		0		600		2,000	
(2)									
(3)									
(4)									
TOTALS									

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 410 | 420 | 440 | 450 | 460 | 490

11. SECONDARY PURPOSE CODE: 420

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

A. Code	BWW					
B. Amount	2,000					

13. PROJECT PURPOSE (maximum 480 characters)

The purpose of the Botswana Population Sector Assistance Program (BOTSPA) is to strengthen Population Programs and services. The Project Data Sheet summarizes financing provided under the Technical and Training Component of BOTSPA. Funds under this component will be used for technical assistance, training, and program management in support of BOTSPA program objectives.

14. SCHEDULED EVALUATIONS
Interim MM YY MM YY Final MM 06 YY 93

15. SOURCE/ORIGIN OF GOODS AND SERVICES
[X] 000 [ ] 941 [ ] Local [ ] Other (Specify)

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

17. APPROVED BY
Signature
Title: Director USAID/Botswana
Date Signed: MM 05 DD 03 YY 88

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM 05 DD 12 YY 88

AID 1330-4 (3-79)

BOTSWANA POPULATION SECTOR PROGRAM ASSISTANCE
(BOTSPA)

(633-0249)

April 1988

Gaborone

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Program Assistance Approval Document

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LIST OF ABBREVIATIONS

AED	Academy for Educational Development
AID	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
ADB	African Development Bank
BFHS	Botswana Family Health Survey
BOTSPA	Botswana Population Sector Program Assistance
BDC	Botswana Democratic Party
CHN	Community Health Nurse
CMS	Central Medical Stores
CPR	Contraceptive Prevalence Rate
CPS	Contraceptive Prevalence Survey
CSO	Central Statistics Office
CTO	Central Transport Organization
CYP	Couple-Year Protection
DFA	Development Fund for Africa
DHS	Demographic and Health Surveys, Westinghouse
DHT	District Health Team
EEC	European Economic Community
EPI	Expanded Program of Immunizations

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FHD	Family Health Division
FNP	Family Nurse Practitioner
FPIA	Family Planning International Assistance
FRG	Federal Republic of Germany
FWE	Family Welfare Educator
FWES	Family Welfare Educator Supervisor
GOB	Government of Botswana
HE	Health Educator
HEU	Health Education Unit
IBRD	International Bank for Reconstruction and Development
IEC	Information, Education, and Communications
IMF	International Monetary Fund
IMPACT	Innovative Materials for Population Action
INTRAH	International Training for Health
IPPF	International Planned Parenthood Federation
IUD	Intra-Uterine Contraceptive Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MCH	Maternal and Child Health
MFDP	Ministry of Finance and Development Planning
MLGL	Ministry of Local Government and Lands
MOA	Ministry of Agriculture
MOE	Ministry of Education
MOH	Ministry of Health
NDP VI	National Development Plan 1985/86-1990/91
NFP	Natural Family Planning
NGO	Non-Governmental Organization
NHI	National Health Institute
NHPU	National Health Planning Unit
NORAD	Norwegian Agency for International Development
NO	Nutrition Officer
NPP	National Population Policy
NU	Nutrition Unit
OB/GYN	Obstetrics and Gynecology
ODA	Overseas Development Administration, United Kingdom
OPTIONS	Options for Population Policy, Futures Group
PCS	Population Communication Services Project, Johns Hopkins University
PCV	Peace Corps Volunteer
PGR	Population Growth Rate
PH	Public Health
PHC	Primary Health Care
PHN	Public Health Nurse
PIACT	Program for the Introduction & Adaptation of Contraceptive Technology
PID	Project Identification Document
PRB	Population Reference Bureau
RAPID	Resources for Awareness of Population Impacts on Development
REDSO/ESA	Regional Economic Development Services Office, East & Southern Africa
RHT	Rural Health Team

RMO	Regional Medical Officer
RN	Registered Nurse
RNM	Registered Nurse Midwife
RSA	Republic of South Africa
SACU	Southern African Customs Union
SAG	Sector Assistance Grant
SIDA	Swedish International Development Authority
STD	Sexually Transmitted Diseases
S&T/POP	Science and Technology, Office of Population, AID/Washington
TBA	Traditional Birth Attendant
UB	University of Botswana
ULGS	Unified Local Government Services
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children Emergency Fund
USAID/B	United States Agency for International Development of Botswana
WFP	World Food Program
WHO	World Health Organization

Exchange Rates: Pula 1 = U.S. $0.06355 and
U.S. $ 1 = Pula 1.57

EXECUTIVE SUMMARY

A. Summary

The Botswana Population Sector Program Assistance (BOTSPA) is designed as a five year, US $5.0 million, sector grant to assist the Government of Botswana (GOB) to improve its population policies and to increase the efficiency of its family planning (FP) programs. A review of Botswana's population sector has revealed that significant progress by the GOB in achieving its goal of reduced population growth rates is unlikely to succeed unless policy, institutional, and structural constraints are removed. In collaboration with the GOB, USAID/Botswana has developed BOTSPA which is based upon achieving seven program objectives which will alleviate some of the most critical of these constraints. BOTSPA objectives are:

1) Support GOB efforts to develop a National Population Policy.
2) Improve coordination among GOB institutions dealing with population programs.
3) Improve the contraceptive logistics system.
4) Expand IEC services.
5) Improve the delivery and management of MCH/FP services.
6) Increase the number of trained staff for population programs and increase GOB financing in the population sector, particularly for contraceptive procurement.
7) Expand participation of NGOs and private sector in population programs.

The sector grant is structured into two components. The sector assistance component will utilize US $3.0 million during the LOP and will consist of five tranches of dollar disbursements. Each dollar disbursement will be conditional upon the GOB's meeting mutually agreed conditions precedents. The technical assistance and training component will provide technical skills required by the GOB to meet program objectives. BOTSPA is based on the principle that family planning must be voluntary; each person must alone decide what is right in his or her own circumstances; but people should also have information available to them on family planning so that they are able to make a rational choice. People should have the right to have as many children as they desire, and that also means fewer children or none, if that is their wish. And this also means that they should have the right to make an informed choice.

B. The Problem

In terms of population size, Botswana has about 1.3 million people. What distinguishes Botswana is the rate of growth of its population which is one of the highest in the world. At an annual growth rate of 3.7%, the population of the country will double in less than twenty years. One of the most critical aspects of this trend is that such rapid growth rates skew the age distribution towards the youngest age groups. Rapid population growth and imbalanced age structure negatively influence prospects for improvements in all social sectors and many economic sectors. Although the GOB has supported population programs since its independence, high population growth rates and its negative

consequences still persist. The birth rate remains just below 50 while the death rate continues to fall. The high number of births per woman, now averaging seven, is one of the highest in the world and will continue to hinder Botswana's development prospects until it begins to decline. The GOB is fully aware of the constraint imposed by high population growth rates and is reexamining its population policies and programs.

C. The Population Sector

The technical components of Botswana's population sector include family planning services, maternal and child health, information and education activities, contraceptive logistics, training, demographic research and analysis, and associated policies. The sector encompasses programs within the Ministries of Health (MOH), Local Government and Lands (MLGL), Education (MOE), and Finance and Development Planning (MFDP), and a limited number of non-governmental organizations (NGOs).

A review of Botswana's population sector has revealed that a strong foundation has been built at both the policy and program levels. In addition, during the past two years there has been a growing public awareness of population issues and the initiation of a national consensus to implement more active population policies. The GOB is committed to reducing the rate of population growth in Botswana. There remain, however, major constraints in the sector which must be overcome before any significant reduction in the rate of population growth can be expected. Furthermore, even after these constraints are alleviated, the GOB recognizes that it will take a period of time before such changes are reflected in the population statistics.

Three general categories of constraints have been identified.

First, there are policy constraints. Most importantly, Botswana lacks a policy framework for expanding population programs. While the operational policies of the GOB for health care including FP services and demographic analyses have been sound, they are not well placed to facilitate commitment to population programs at either the national or district level and are even less effective at providing guidance and/or coordination to the various government and non-government agencies involved in population activities. The GOB has already started internal discussions on the development of a National Population Policy and this effort deserves broad-based and concentrated support.

Second, there are institutional constraints. Many of the key institutions charged with promoting population programs and delivering basic services do not coordinate their activities and programs in population/family planning. There is no current mechanism to facilitate coordination. The overall contraceptive logistic system, which encompasses supply levels and availability at clinics and health units, and contraceptive distribution mechanisms need strengthening. Surveys have indicated that most of the discontinuance in family planning usage is largely attributable to

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contraceptive shortages. The 1984 Botswana Family Health Survey indicated up to 40,000 couples wished to delay or limit births, and were seeking FP services which were often not consistently available. General and specific information and education systems are inadequate, reflecting on the necessity for a stronger IEC effort. Finally, many Batswana, particularly those in rural areas, have no access and to MCH/FP services. Only 60% of current health facilities offer integrated MCH/FP services.

Third, there are structural constraints in the sector. The most critical of these is a need to increase the numbers and trained levels of GOB staff and overall GOB financial resource allocations to the population sector. Initially, the MCH/FP skills of existing health personnel must be qualitatively improved. In addition, the overall numbers of staff within the system must be increased. Likewise, to date, the GOB has depended almost exclusively on donor financing for developing its FP/population programs. Even the recurrent budget for contraceptives has been fully financed from donors. While this strategy offers clear benefits to the GOB from a purely budgetary standpoint, it has been less beneficial from the standpoint of maintaining GOB control over its programs or in increasing the capacity of local institutions to manage and develop population activities. Another structural constraint in the population sector is the limited participation of non-government organizations, including private sector firms, in population programs. There are clear opportunities to use non-government resources to distribute contraceptives, disseminate IEC materials and messages, provide clinical MCH/FP services, and increase overall investment in the sector.

D. USAID Program Assistance Grant To the Population Sector

USAID/Botswana believes that assistance to the GOB population sector is important because of the sector's impact on the overall development environment in Botswana, the success of previous population activities financed by USAID, and, the comparative advantage A.I.D. has through on-going bilateral and centrally-funded population activities in Botswana.

The Botswana Population Sector Program Assistance has been designed as a five-year, $5.0 million dollar effort to assist Botswana to plan and implement improved population policies as well as more efficient and cost-effective maternal/child health and family planning services. The stated purpose of BOTSPA is to strengthen population programs and services in Botswana. The program will provide technical assistance, training and sector dollar disbursements and deposited local currencies to support this purpose.

At the end of the proposed five-year life of the program, it is expected that the GOB will have achieved the following results:

1. Improved population program policy framework (national policy, drafted, promulgated, and under implementation).

2. More effective coordination among GOB institutions and entities dealing with population programs and activities. This will result in an improved contraceptive logistics and delivery system, more effective dissemination of information, services and contraceptives from clinics and health units, expanded IEC activities by Health Education Units at central, regional and district levels, and an improved MCH/FP delivery system.

3. Sufficient number of trained staff and increased GOB resource financing to the sector which will cover all population program needs, particularly in the areas of contraceptive procurement and services delivery, and significantly increased participation of NGOs and private sector entities, including, as applicable, contraceptive social marketing.

The selection of a Program Sector Grant as the assistance modality is based upon: 1) the technical soundness of GOB population programs and the administrative competency of overall GOB implementation; 2) the need to focus attention of the GOB and donors on the impact of their activities on the overall GOB objective for the sector (reducing the population growth rate) and to highlight issues for policy dialogue; 3) the desire to provide the GOB with financing which encourages them to increase the allocation of domestic resources in the sector and which will facilitate improved donor coordination; and, 4) to fully apply the new capabilities provided by the Development Fund for Africa (DFA) appropriation.

The Botswana Population Sector Assistance Program (BOTSPA) is designed to achieve seven program objectives which are central to alleviating the major sectoral constraints identified above.

Program Objective 1 - Support GOB Efforts to Develop a National Population Policy

BOTSPA support for this objective will include activities aimed at awareness-raising among the country's leadership, and building consensus for the national policy. The National Population Policy and associated implementation plans will assist the GOB in defining its commitment to lowering Botswana's high population growth rate as a critical means of improving MCH status and development prospects in general. The national policy will also provide specific guidelines to the public and private sector for achieving the policy goals.

A key target for this objective is the enactment of a National Population Policy, followed by the GOB establishing an institutional focal point with the responsibility for coordinating population policy and programs and the strengthening of the Demographic Unit in the Central Statistics Office. Another target will be to develop implementation plans which elaborate on GOB policy commitments to encourage broadened non-government and private sector participation in population programs.

Program Objective 2 - Improve Coordination Among GOB Institutions Dealing with Population Programs

In addition to various international and bilateral donor agencies and sub-groups involved in varying aspects of Maternal-Child Health/Family Planning/Population Activity Programs, many GOB ministries, agencies, departments, and divisions are involved. From an institutional development perspective, policy coordination will evolve from the drafting, promulgation and implementation of the national policy. The institution to accomplish this, perhaps a National Population Council and Secretariat, will assist in improving overall coordination, implementation of policy and programs and for undertaking expansion efforts.

Program Objective 3 - Improve the Contraceptive Logistics System

The program objective for the contraceptive logistics system is comprised of two elements: 1) a full range of contraceptives, in accordance with GOB approved methods, is available at all health facilities; and, 2) the GOB has undertaken a major, long-term financing role in contraceptive procurement.

The institutional targets for this objective include transferring the responsibility for procuring contraceptives from donors to the GOB's Central Medical Stores and improving the overall contraceptive distribution system, in part through non-government organizations. Additionally there will be an increase of GOB (non-donor) financing for contraceptives. Bottom-line indicators for this objective will be the number of health facilities which have non-interrupted supplies of contraceptives and the levels of GOB contraceptive financing.

Program Objective 4 - Expand IEC Services:

The objective of an expanded and improved IEC program is to increase the quality and quantity of informational and motivational family planning materials and broaden the targets for information and distribution channels used to disseminate the information. The purposes of these activities are to a) increase the awareness of the population on family planning to enable people to make an informed choice; b) motivate greater numbers of Batswana to use family planning methods if and as appropriate to their circumstances; c) increase the demand for family planning services; d) improve the rates for continuation; and e) improve the method mix. The basic aim of this objective is to increase the numbers of new and continuing clients who receive family planning information and services.

The institutional targets for this program objective are to expand the MOH Health Education Unit and strengthen the District Health Education programs so that IEC services can be improved and expanded. This includes the development of assistance mechanisms which will assist non-government organizations to develop and

disseminate IEC materials. The performance of this objective on the sector may be measured, at the health facility level, by the increase in the numbers of couples receiving family planning services for the first time, and those continuing.

Program Objective 5 - Improve the Delivery and Management of MCH/FP Services

The purpose of this institutional objective is to ensure that a full range of quality family planning services is offered by all family planning service providers (both public and private), corresponding to the type and number of staff at each service delivery point.

The targets for this objective are to strengthen the operational policies for staff deployment and delivery resources and to expand integrated MCH/FP services to the 40% of the facilities which do not have them now and to facilitate the implementation of the GOBs policy to decentralize health services. The program will assist the GOB to identify and develop opportunities to deliver MCH/FP services through private sector non-government organizations. The performance of this objective can also be measured by increased couple years of protection provided by MCH/FP services.

Program Objective 6 - Increase the Number of Trained Staff for Population Programs and Increase GOB Financing in the Population Sector, Particularly for Contraceptive Procurement

This objective will play a major role in overcoming the structural constraints, and is closely linked to the institutional objective of improving the delivery and management of MCH/FP services. This objective focuses on the GOB commitment to population programs through the overall number of trained staff assigned to management and implementation, and amount of additional funds allocated to the sector, particularly in FP contraceptive procurement.

Already, the GOB is committed in existing staff and recurrent budget to an ongoing program of some magnitude. Even with the proposed AID contribution of $5 million, GOB contribution to total 5-year program costs equal 71%. But more needs to be done. Key managerial and technical positions need to be created, individuals recruited and trained. To implement the Policy and Institutional objectives already outlined, major financial resources are required as the policy dictates, the population sector and program expand, and as donor financing and technical assistance phase down.

Program Objective 7 - Expand Participation of NGOs and the Private Sector in Population Programs

The final structural objective of BOTSPA is also closely interrelated to the Policy and Institutional objectives. Family Planning and Population Programs are national in scope and require the cooperation, coordination, and, obviously the participation of everyone.

Botswana has several PVO/NGO groups fully involved on the periphery and willing/able to be responsive. Many are already being integrated to MOH training workshops and seminars on various linkages with FP programs. The growing private sector, with its critical human resource needs, also has a major role to play in the structural changes necessary to successfully implement a national policy. One such objective may include Contraceptive Social Marketing of non-medical FP resources within three or four years. These are already available in registered pharmacies, but are yet available in this manner to the vast majority of the population.

E. Structure of the BOTSPA Sector Program Assistance

The Botswana Population Sector Program Assistance grant is structured into two complementary parts: a Sector Assistance Component with a dollar disbursement grant mechanism, and a Technical Assistance and Training Component which is jointly implemented by the GOB and USAID. Both components will be used to achieve common performance objectives for Botswana's population sector described above.

The Sector Assistance Component, estimated at US $3.0 million, will be used for two purposes. First, it will demonstrate to the GOB the effectiveness of increased investment in the population sector with the ultimate aim being a more generous allocation of resources from domestic means. Second, it will encourage and support the GOB's efforts to introduce and implement improved population policies, especially the proposed National Population Policy. The Sector Assistance Component will be disbursed to the GOB in five tranches. Prior to the disbursement of each tranche the GOB must satisfy specified conditions precedent to disbursement. These conditions precedent are intended to encourage the GOB to take action necessary to achieve program objectives.

The $2.0 million TA Component is designed to provide technical expertise and training required by the GOB to achieve the program objectives. The GOB has identified these inputs as critical to the overall success of the program. The TA Component is essential to effective monitoring of this program, to a continuing policy dialogue, and to the establishment of a mechanism for analyses, training and technical expertise which will directly support achievement of the basic objectives in the program grant. This element of interaction between USAID and the GOB is indispensable to the success of the program grant. This component also provides the financing to support the management and monitoring requirements for the program. With respect to levels of effort anticipated under this component, only one long-term USAID-supported TA position is anticipated; an IEC advisor for the Ministry of Health for thirty-six months. Fifty six person months of short-term TA have also been programmed. Five trainees have been identified for degree or diploma courses and funds for observational travel have been budgeted. Peace Corps TA may also be involved.

In the second and subsequent years, annual workplans will be The implementation of Botswana Population Sector Program Assistance will be the responsibility of the Government of Botswana. In actual fact, its timing corresponds directly with the form outlined by the GOB during the Mid-Cycle corrective Review of the Sixth National Development Plan (NDP VI) 1986-91. It also closely follows the recommendations of Two Population and National Development Conferences in September 1986 and June 1987, and the Issuance and Publication of Botswana Family Planning General Policy Guidelines and Service Standards by the Ministry of Health, October 1987. The Ministry of Health and the Ministry of Finance and Development Planning will be the coordinating GOB bodies for BOTSPA. A primary role of USAID/Botswana will be to monitor and evaluate the progress of the GOB in alleviating the identified constraints in the population sector and in achieving the program objectives including the mutually agreed performance targets. The USAID will also have traditional management responsibility for the projectized Technical Assistance and Training Component.

The design of BOTSPA provides for two different types of implementation procedures corresponding to the types of financing provided under the grant. The sector assistance component will be provided to the GOB as a non-project dollar disbursement grants. GOB procurement and contracting procedures will be used for the Sector Assistance Component activities funded with deposited local currency. The TA component will be obligated based upon USAID approval of an annual workplan. For the first year the program document will provide sufficient information to disburse funding required.

Program review meetings will be used to facilitate joint GOB and USAID/Botswana management and monitoring of BOTSPA. For the first year these meetings will be convened quarterly. A major function of these reviews will be to identify and resolve any procedural or implementation issues. Annual sentinel surveys will be carried out to monitor BOTSPA impacts on the sector and to assist the GOB examine other aspects of their population program. A final program evaluation is scheduled for 1993.

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FRAMEWORK FOR BOTSPA IMPLEMENTATION (1)

CONSTRAINTS IDENTIFIED IN THE SECTOR	BOTSPA PROGRAM OBJECTIVES TO ALLEVIATE CONSTRAINTS PROGRAM OBJECTIVES	SCHEDULE OF CP'S LEADING TO IMPLEMENTATION OF THE	INDICATORS TO MEASURE PROGRAM PERFORMANCE	END OF PROGRAM STATUS
A. Policy Constraints	A. Policy Objectives	A. Policy CPs	A. Performance Indicators	A. Policy EOPs
1. Lack of a policy framework for expanding population programs	1. Support GOB efforts to develop a National Population Policy	1. A written plan which sets forth the actions, including technical inputs and public consultations, required to develop a National Population Policy. (Tranche 1) 2. Evidence that the Grantee has prepared a draft National Population Policy and has held consultations with the public and within the Government on such policy. (Tranche 2) 3. Evidence that the Grantee has adopted and publicly described and endorsed its national population policy. (Tranche 3) 4. Evidence that the Grantee has initiated implementation of its national population policy. (Tranche 4)	1. National Population Policy enacted and activities coordinated 2. CSO Demographic Unit more effective 3. GOB commitment to encourage NGO and private sector participation in population sector	1. Improved policy framework for population programs (national policy drafted, promulgated, and under implementation.)

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B. Institutional Constraints	B. Institutional Objectives	B. Institutional CPs	B. Performance Indicators	B. Institutional EOPs
1. Insufficient coordination among GOB institutions which deal directly and indirectly with population program.	1. Improve coordination among GOB institutions dealing with population programs	1. Evidence that GOB has established or designated a governmental office to be responsible for the coordination of population policies and programs.	1.a. Implementation of National Population Policy Coordination Units, possibly by a National Population Council and Secretariat. 1.b. Better coordinated activites from both external donors and internal programs.	1. Efficient and effective national, regional and district level coordination of all MCH/FP/Population
2. Underdeveloped contraceptive logistics system.	2. Improve the contraceptive logistics system.	2.a. A written plan and procedures for the procurement and distribution of contraceptives by the Central Medical Stores. (Tranche 1) 2.b. Evidence that contraceptives are being effectively distributed to and from all clinics and units as planned. (Tranche 2)	2.a. Central Medical Stores responsible for procuring contraceptives 2.b. Improved contraceptive distribution system 2.c. NGO contraceptive distribution channels established. 2.d. Number of health facilities with continuous supplies of contraceptives increased.	2. Overall strengthened support systems for MCH/FP Services at all levels of service (hospitals, clinics and health units).

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B. Institutional Constraints	B. Institutional Objectives	B. Institutional CPs	B. Performance Indicators	B. Institutional EOPs
3. Inadequate IEC Services	3. Expand IEC Services	3.a. Evidence that the Grantee have identified and assigned an appropriate official to function as a counterpart to the project funded IEC advisor (Tranche 1). 3.b. A written plan for the expansion of IEC services provided by the Health & Education Unit district health education teams. (Tranche 2) 3.c. Evidence that the Grantee has inititated its plan for the expansion of IEC services provided by the Health and Education Unit and district health educ. teams. (Tranche 3) 3.d. Evidence of substantial expansion of IEC services provided by the Health and Education Unit and district health education teams. (Tranche 4)	3.a. Improved IEC services from an expanded HEU 3.b. Strengthened IEC in the District Health Education Programs 3.c. NGOs supported to develop and disseminate IEC materials [1] 3.d. Increased first visits for Family Planning Services.	3. Overall strengthened IEC support systems for MHC/FP within both public and private sectors.

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B. Institutional Constraints	B. Institutional Objectives	B. Institutional CPs	B. Performance Indicators	B. Institutional EOPs
4. Limited availability of MCH/FP clinical services	4. Improve the delivery and management of MCH/FP services	4.a. A written plan for improving the quality and effectiveness of existing MCH/FP clinical services and expanding the number of service delivery points. (Trn. 1) 4.b. Evidence that the Grantee has initiated its plan to improve the quality and effectiveness of existing MCH/FP clinical services and to significantly increase the number of service delivery points. (Trn. 2) 4.c. Evidence of improvement in the quality and effectiveness of existing MCH/FP clinical services and a significant increase in the number of service delivery points. (Tranche 3)	4.a. Integrated MCH/FP services extended to all health facilities which significantly expand services 4.b. Strengthen operational policies for staff deployment and staff training 4.c. Expanded use of NGO's and private sector firms to deliver MCH/FP clinical services. [1] 4.d. GOB decentralization of health services smoothly transfers responsibilities from MOH to MLGL 4. d. Increased couple years of protection	4. Overall strengthened support systems for MCH/FP services, significantly expanded to meet 100% of need.

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C. Structural Constraints	C. Structural Objectives	C. Structural CPs	C. Performance Indicators	C. Structural EOPs
1. Inadequate numbers of trained GOB staff and of overall financing for population programs	1. Increase the number of trained staff for population programs and increase GOB financing in the sector particularly for contraceptive procurement.	1.a. Evidence that adequate numbers of staff are assigned to the programs, and that all training opportunities for that staff are effectively utilized. (Throughout LOP). 1.b. Evidence that since the effective date of the subject project agreement the Grantee has procured, with other than donor provided funding, at least Pula 50,000 of contraceptives. (Tranche 2) 1.c. Evidence that since the effective date of the Project Agreement the Grantee has procured, with other than donor provided financing, at least Pula 110,000 of contraceptives. (Tranche 3) 1.d. Evidence that since the effective date of the Project Agreement the Grantee has procured, with other than donor provided financing, at least Pula 380,000 of contraceptives. (Tranche 4)	1. Increased GOB financing for staff and for contraceptives (non-donor)	1. Overall increased GOB financing for population programs

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C. Structural Constraints	C. Performance Objectives	C. Structural CPs	C. Structural Indicators	C. Structural EOPs
		1.e. Evidence which indicates that within five years after the effective date of the Project Agreement the Grantee plans to have procured, with other than donor provided funds, at least Pula 930,000 of contraceptives. (Tranche 5)		
2. Limited participation of NGO's and private sector in population programs	2. Expand participation of NGOs and the private sector in population programs.	2.a. A written plan which describes how the Grantee intends to increase the participation of non-governmental organizations (NGOs), including private sector entities, in population programs. (Tranche 1) 2.b. Evidence that the Grantee has initiated implementation of its plan to increase the participation of NGOs, including private sector entities, in population programs. (Tranche 2)	2.a. Attendance by NGOs and Private Sector in FP/Pop workshops and seminars. 2.b. Possible use of contraceptive social marketing of non-medical FP methods in 3rd to 5th year.	2. Overall expanded and effective participation of NGOs and private sector in population programs.

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C. Structural Constraints	C. Structural Objectives	C. Structural CPs	C. Performance Indicators	C. Structural EOPs
		2.c. Evidence that the Grantee is successfully implementing its plan to increase the participation of NGOs, including private sector entities, in population programs. (Tranche 3) 2.d. Evidence of a significant increase in the participation of NGOs, including private sector entities, in population programs. (Tranche 4)		

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I. BACKGROUND AND RATIONALE FOR PROGRAM SECTOR ASSISTANCE

A. Macroeconomic Setting

1. Overview

Throughout the 1970s and into the 1980s, Botswana's economy achieved impressive rates of growth, large balance of payments surpluses, low levels of debt service, and moderate rates of inflation. In real terms GDP increased at an average rate of more than 11 percent per annum over the period 1977/78-1986/87, fueled by the growth of mineral exports, particularly diamonds. Per capita income is now $940, making Botswana a lower-middle income country. However, income distribution is highly skewed in favor of those in the formal economic sector. The median income of a rural family, 85% of the population, is less than $300 per annum.

The geography of Botswana plays a major role in the country's development. More than twice the size of the United Kingdom, it is landlocked, bounded by South Africa, Namibia, and Zimbabwe. The Kalahari Desert covers 80 percent of its area and drought poses a most serious threat to the country's economic prospects. The present drought, which began in 1981, is the most severe of the century, wiping out one third of the country's national cattle herd and increasing urban migration and unemployment.

Despite increased diamond export revenues and large foreign reserves, the economy remains extremely vulnerable to external factors, notably drought, changes in international exchange rates, trends in the world diamond market, and events in South Africa. About 85% of Botswana's imports come from South Africa, which also provides the vital transport route for the country's exports. Thus, while Botswana enjoys the advantages of strong exports, sustained GDP growth, and prudent economic and financial policies, it nonetheless faces a highly unpredictable future, largely dependent on factors beyond its control.

2. Macroeconomic Performance

The economy remains highly dualistic, with agriculture and mining as the principal activities. Mining now accounts for over half the total GDP, although the sector employs just 6.2% of the population. Botswana is now the largest producer of diamonds in the world and in 1986 diamond exports alone were worth $571 million. Over the next five years, however, Botswana envisages little increase in diamond output, which means that job creation and export revenues are unlikely to rise substantially.

About three-quarters of all rural households, or approximately 62% of the population, depend for their living to a considerable extent on arable farming, principally maize and sorghum. Yields are extremely low and unpredictable because of very weak and unreliable rainfall, poor technology, lack of adequate draft power, and weak producer prices. Botswana will remain dependent on large scale purchases of grain and food aid for the near term, as current grain production provides only 10% of the country's needs. Its rapid population growth seriously exacerbates this problem, as may food import prices over the longer term.

Until the development of the mining sector in the early 1970s, large scale ranching was the country's predominant economic activity. But overgrazing and the drought have killed over 1 million cattle, one third of the national herd. Now, some 5 percent of the 50,000 ranchers own half the cattle, with 45 percent of rural households owning no cattle at all.

Manufacturing capacity in Botswana is small, contributing 3.4 percent of GDP in 1985/86. Manufacturing faces severe constraints: smallness of the domestic market, competition from South Africa and Zimbabwe, expensive utilities, inadequate infrastructure, and lack of skilled manpower. The government has tried to stimulate investment in labor-intensive industries, but job creation remains far below what is needed to address Botswana's 25% unemployment rate and absorb the large yearly increases in the labor force.

The government's financial position has been strong in recent years, reflecting improved diamond sales, higher earnings from the Southern African Customs Union (SACU) pool, and beneficial Pula/Rand/Dollar exchange rate fluctuations. This has stimulated mildly expansionary budgets since 1984/85, but overall government spending policies are quite conservative, allowing Botswana to achieve budgetary surpluses reaching P414 million in 1986/87 (20% of GDP). Grants now account for just 2% of revenues, (compared to 58% of revenues in 1967/68. The increasing value of exports has also allowed the GOB to generate considerable trade surpluses and increase its foreign exchange reserves ($1,442 million in April 1987). But as the 1987 USAID/Botswana Strategy Assessment and Evaluation points out, a high foreign exchange reserves policy is a needed protection against growing risks.

3. Prospects for the Future

Botswana's medium-term prospects continue to look very favorable, assuming appropriate government policies and barring a continuation of severe drought, instability in South Africa, or sudden changes in the world diamond market. Because diamond mining has now reached capacity production, GDP growth should slow to around 8% per annum through 1991. On the other hand, a disaggregation of the economy shows stagnation in economic sectors upon which future employment growth depends.

The present constraints to more rapid development in Botswana are largely non-financial: shortages of skilled manpower and management, shortages of serviceable land, drought, and the GOB's limited implementation capacity. These constraints are interactive and require time to overcome. Furthermore, it should be reemphasized that the surge in foreign exchange reserves is largely due to factors outside of Botswana's control (cross exchange rate movements, world diamond prices) which can change rapidly and unpredictably. These factors have done little to increase the underlying growth rate of the government revenue or the overall economy. Botswana is understandably reluctant to make investments now which would require major increases in recurrent costs and inputs in the future.

B. Botswana Development Strategy

1. Historical Perspective

Since achieving independence in 1966 the GOB has demonstrated a sound, prudent development strategy, following a strong political commitment to pragmatic planning and economic rationality in government decision making. Through the Ministry of Finance and Development Planning Botswana identifies national development objectives, main sectoral issues and the required policy directions. The MFDP also provides macroeconomic "forecasts" and a list of desirable projects. This planning culminates in the National Development Plan, the latest of which, NDP VI, covers the years 1985/86-1990/91.

Over the years, the government's National Development Plans (NDPs) have been remarkable for their thorough resource and sector analyses, realistic economic forecasts, and pragmatic development strategies. The NDPs take stock of the country's strengths and weaknesses, and plan accordingly. For example, NDP IV (1976-1981) correctly planned for and forecast the growth of the mineral sector and related decline of the agricultural sector. NDP V (1979-1985) projected, and designed a strategy for, annual GDP growth of 10.1%, one of the highest growth rates in Africa. The actual growth rate was even higher, 11.2%. Where discrepancies exist between forecasts and actual economic performance, it is usually because the GOB is too conservative in its estimates for growth, or because the economy is affected by events over which the GOB has little control (e.g. drought or rand/dollar exchange rate changes). In short, the GOB's record of development planning and implementation capacity is impressive and worthy of support.

2. NDP VI and Beyond

NDP VI has among its objectives increases in employment, the acceleration of rural development, and the diversification of the country's production and export base. Investments in rural infrastructure, irrigated crop growing, and private sector job creation are emphasized, while education and health services are also to be expanded. Increasing importance is also attached to demographic issues.

Growth targets under NDP VI are relatively modest, reflecting the absence of major planned projects in the mineral sector. Real GDP is envisaged to grow at an average annual rate of 4.8% while inflation is to be maintained at 10% per annum throughout the period. The overall budget balance of the GOB is projected to move from a surplus to a large deficit, as overall government revenue is expected to increase 2% per annum while recurrent spending and development spending are projected to increase by 7% and 2%, respectively.

The NDP VI was prepared during 1984-85 when actual data were available only through 1982/83. Since then there have been rapid and substantial changes in the key factors and assumptions underlying the plan. On the whole, the economic and financial

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performance during the first two years of the plan has been much better than had been envisaged in the NDP VI. All assumptions and projections for the NDP VI are being thoroughly examined and revised as part of the mid-term review of the plan which is nearing completion.

3. GOB Perspective on Population Growth

Since the earliest National Development Plans, the Government of Botswana has recognized the relationship between the population sector and the nation's development. The GOB established implicit policies in its NDPs beginning in 1970. At the same time the Government began to officially support family planning by incorporating family planning services in its health care scheme. Whereas there has been no explicit national population policy, the GOB has increasingly incorporated family planning services as part of the basic health care package for the last ten years. The GOB's population policies are described in detail in Section II.

C. A.I.D. Country Strategy

1. USAID/Botswana Program

U.S.A.I.D.'s strategy is focused on employment generation through the private sector, skills development, and small-holder agriculture production -- directly consistent with Government of priorities. There is a strong emphasis on primary and junior secondary education, on training of Batswana in the United States, in third countries, and locally, and on assignment of key personnel to important development positions under the Workforce and Skills Training projects. A major focus is job creation, investment and strengthening the private sector. Dryland agriculture is being supported to develop effective technologies to help farmers increase production. Small-holder agriculture must be improved not only for consumption needs, but also because agriculture is critical as a residual employer. USAID also finances a Housing Guaranty program to support the construction of 7,000 low-cost houses, sites and services. Two studies carried out in the summer of 1987, a strategy assessment and evaluation and a private sector study have articulated more clearly the direction of USAID's strategy.

2. USAID Population Activities

USAID/Botswana's Country Development Strategy Statement (Revised) of September 1983 listed population under complementary activities (page 61), noting that the GOB had opted for a low-key approach of incorporating voluntary planning services into its maternal and child health care delivery system. At that time USAID's strategy was to encourage policy development on voluntary family planning and continue activities which heightened awareness of the problem. Since that time, the GOB has made significant progress in this area and is in the process of finalizing and promulgating a National Population Policy. During this period, USAID has supported centrally-funded activities which have provided most contraceptives to the GOB's Ministry of Health, a contraceptive prevalence survey and major efforts in family planning training and policy development. It should be noted that it is GOB policy that all family planning initiatives must come under the MOH rubric.

In 1986, the Government of Botswana held a National Conference of Parliamentarians and Chiefs to discuss population and development issues. The recommendations of the conference were that the GOB develop a national population policy to address the many development issues which this sector affects. The GOB is still in this process. In addition, in 1987 a similar conference was held of GOB permanent secretaries and senior civil servants. The GOB is expected to promulgate this policy in the near future.

Based on the changing GOB attitude towards reducing population growth, the mission requested that a Project Identification Document (PID) be prepared. This was completed in March of 1987. In July of 1987 the Mission's Strategy Assessment and Evaluation also indicated that USAID/Botswana should participate in the population sector in stating that "our priorities would include assistance with family planning . . ." Due to strong expressions of interest on the part of the GOB and based on the PID, the Mission requested that a Project Paper be prepared for FY 1988.

D. Justification for Program Sector Assistance

The Program Sector Grant is justified on the basis of three considerations: (1) rapid population growth is a major development problem in Botswana; (2) the GOB is committed to expanding its population programs and USAID/Botswana has interests in supporting the GOB in this area; (3) program assistance as the main element of aid is the most appropriate form of USAID financing.

1. Rapid Population Growth is a Development Problem

Rapid population growth and poor maternal and child health indicators are threatening the development progress Botswana has made since independence. The projected rate of population growth between 1986-1991 is 3.7%, one of the highest in the world. Population doubling time is less than 20 years. The average Motswana woman has 7 live births and nearly one half of the population is under the age of 15. Such a high population growth rate has very serious implications with respect to: (1) the high costs of financing the social services required to house, educate and care for so many new people: (2) the problems of feeding a growing population from the agricultural sector which is already unable to support the present population; (3) the difficulties in creating new employment opportunities for so many new labor entrants; (4) the adverse effects of large families on personal savings; (5) the health of mothers and children; and (6) the strains rapid population growth have on family life and social cohesion.

2. GOB and AID Commitment for Population Programs

While the prominence of family health (including family planning and maternal and child health) as a development issue has risen significantly in the last few years, it has a long history in Botswana. Formal modern family health programs began in 1967, when International Planned Parenthood Federation (IPPF) started providing contraceptives. In 1973 a maternal and child health/family planning unit was established in the Ministry of Health. In 1979 the MCH/FP unit was joined with the nutrition unit and the health education unit to form the family health division. Thus with over 20 years of

family health experience, and mature institutional support mechanisms in place, the GOB family health programs are firmly founded.

But these programs are not, in themselves, sufficient to reduce the rate of population growth and the GOB recognizes this fact. It is raising the public consciousness about population issues within the country and actively seeking donor assistance in this area. The GOB wants to expand its MCH/FP programs and is cognizant of the need to institutionalize a central planning and monitoring point for the development and implementation of a National Population Policy.

USAID/Botswana has a strong interest in supporting these efforts. Including centrally-funded projects, it is presently one of the largest donors in the Population/Family Planning Sector. USAID has been providing most of the contraceptives in Botswana (with the exception of Depo-Provera which is supplied by UNFPA) and assisted in the study of Population Factors and Development carried out by the Ministry of Finance and Development Planning and the Ministry of Health. USAID/Botswana has also contributed to the funding of both Conferences on Population and Development, extremely important events in promoting the development of a National Population Policy in Botswana, and actively participated in the conference proceedings. In short, USAID/Botswana is committed to supporting population programs. The July 1987 USAID/Botswana Strategy Assessment and Evaluation stressed that even stronger emphasis should be given to support for family planning. The program sector grant is the most effective way to accomplish this.

3. Advantages of Program Assistance

The selection of the program sector grant (PSG) approach is based upon several considerations. First, since the GOB POP/FP programs are both technically sound and competently and honestly administered, a PSG is the most efficient mechanism for delivering U.S. financial assistance to reinforce and improve performance of Botswana's population sector. Second, the PSG focuses GOB and donor attention on the impact of their activities on the overall goal of the GOB - reducing the rate of population growth - and highlights issues for policy dialogue. Along these same lines the PSG approach will greatly facilitate integration of the wide variety of elements involved in family planning programs (e.g. training, commodity logistics, IEC, demography research, etc.) as well as in supporting Botswana's emerging national population policy. Third, the PSG approach maintains USAID participation in the sector (particularly with a TA/Training element) while minimizing USAID/Botswana's management requirements. Fourth, the Sector Grant provides a mechanism for monitoring overall resources in the sector and encouraging greater allocations by the GOB. Finally, the PSG through its sector assistance mechanism, provides a means of improving donor coordination by maintaining the largest share of project resources under the control of GOB thereby improving fungibility.

II. ANALYSIS OF BOTSWANA'S POPULATION SECTOR

A. The Role of Population in Botswana's Development

1. Population Growth and Age Structure

In terms of population size, Botswana has about 1.3 million people. What distinguishes Botswana is the rate of growth of its population which is one of the highest in the world. At an annual growth rate of 3.7%, the population of the country will double in less than 20 years. In fact, the total population of Botswana has just about doubled in the short period since 1971. At that time, there were about 600,000 Batswana. An additional 600,000 plus Batswana have been added over the last 17 years. If present population growth rates continue, the Central Statistics Office (CSO) estimates that in the year 2000 Botswana's population will be 2.0 million, in 2015 it will grow to 3.5 million, and by 2035 Botswana will have 7.6 million people. (See Table 1)

One of the most critical aspects of this trend is that such rapid rates of growth skew age distribution toward the youngest age cohorts. Whereas in developed countries a fifth of the total population will be under the age of 15, in Botswana nearly half of the population is under 15. This distribution has enormous consequences for the country's development.

2. Consequences for Development

Rapid population growth and imbalanced age structure negatively influences prospects for improvements in all social sectors and many economic sectors. Some of the principal impacts are felt in social services such as health and education, housing, and in economic sectors such as savings, employment, and natural resources.

Botswana is a country which places great emphasis on universal and equitable access to health care, educational opportunity and adequate housing. The health care system has had to expand very rapidly in order to accommodate increased demand for services caused by increased numbers of clients and improved coverage and quality of health care. Already, the health sector along with education and housing are requiring the greatest annual increases in budget of all GOB sectoral expenditures during NDP VI. If present population trends continue, by 2015 high risk health groups will triple and the need for new hospital beds will increase almost fourfold. The implications of such rapid population growth on sectoral expenditures have been set forth in, "Population Factors and Development: Botswana," prepared in 1987 by the Central Statistics Office of the MFDP and the Primary Health Care Department of the MOH.

More importantly than social expenditures are the adverse health consequences of rapid population growth. The average number of children women are having today in Botswana is about seven. This means that many couples are having more than seven births. For example, 45% of all women just completing their reproductive years (aged 44-49) have had 8 or more births. These high parities are accompanied by high infant and maternal mortality and illness rates. One-in-seven of the births to this group resulted in infant

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deaths. Though the precise relationship between high parity and morbidity is difficult to quantify, it is clear that high population growth rates are one of the major causes of poor maternal and child health status (Botswana Family Health Survey, 1984).

Similarly, in education, the birth rate is the principal determinant of the numbers of students, the numbers of teachers and classrooms needed, and the amounts of investment required to provide sound instruction. Botswana's rapid growth rate is requiring an equally rapid expansion of the educational system. This expansion, in turn, requires enormous resources and places a significant burden on the capacity of the system to meet rising demand. The country is doing an admirable job of meeting demand but the system is still suffering from the effects of rapid population growth. Rapid population growth has the effect of discounting investments in education. The current National Development Plan calls for a 4.8% annual increase in education expenditures. However, since school enrollments are growing at well over 4%, real expenditures on education are increasing only marginally. It is difficult to improve the quality of education without large increases in real expenditures. Yet it will be difficult to provide larger real expenditures given the expanding population. For instance, if the population growth rates are unchanged, the number of children in primary school will grow from 213,000 in 1985 to 695,000 in 2015 requiring an estimated 10,000 new classrooms and 15,000 new teachers. Thus, most new investment in primary education will be consumed in infrastructural development and hiring new teachers.

Besides having one of the highest population growth rates in the world, Botswana also has one of the highest urbanization growth rates in Africa, nearly 13% per annum. This situation is due to both the natural increases in population and rural to urban migration. Utilizing the same population growth rates which were described above, the urban population can be expected to grow from 225,000 in 1985 to 1,472,000 in the year 2015. In order to provide shelter for these people an additional 280,000 housing units would need to be constructed by that time.

In addition to the public expenditure and health consequences, rapid population growth in Botswana has a negative impact on economic growth. This relationship has been acknowledged in every National Development Plan since 1970. Perhaps the best summary of the long-term economic consequences of rapid population growth appears in NDP VI: "...[lower] population growth rates would make the long run tasks of achieving Botswana's development objectives much less difficult (p. 46)." This analysis conforms to a recently completed study by the National Academy of Sciences in the U.S. This exhaustive analysis of the development literature concluded that, "On balance, we reach the qualitative conclusion that slower population growth would be beneficial to economic development for most developing countries (National Academy of Sciences, Population Growth and Economic Development: Policy Questions, Washington, D.C., p. 90)."

Rapid population growth has exerted a major negative effect on the employment of labor in Botswana. In the past 20 years, the economic sectors which generate the most employment have not grown fast enough to absorb growth in the labor force. Underemployment is chronic and prospects are dim that the additions to the labor force in the next 15 years will be absorbed in the formal economy. As the Honorable Minister of Labour and Home Affairs recently remarked, "...even assuming a high rate of employment growth for the rest of the century, it is possible that not more than 25% of the available labour can be expected to be in formal employment in the year 2,000. (Report of the Conference on Population and Development for Members of Parliament and House of Chiefs, p. 211.)." If the rate of population growth began a downturn today, Botswana would begin to feel some easing in demand for formal employment five or ten years after the turn of the century. Therefore, a lowering of the population growth rate will have important and positive long-term effects on employment and per capita labor production.

3. The Case for Reducing Population Growth

Though Botswana has supported the population sector virtually throughout the existence of the Republic, high population growth rate and its negative consequences still persist. The crude birth rate remains at just below 50 while the death rate continues to fall. The resultant high population growth rates, noted several times in this document as one of the highest in the world, will continue to hinder prospects for development in Botswana until it begins to decline. The GOB is fully aware of the constraint imposed by high population growth rates and, in recent years, has reexamined its population policies and programs. A brief overview of these policies and programs is discussed below in the context of Botswana's Population Sector.

B. Description of the Population Sector

1. Overview

Extensive information has been collected and analyzed on the demographic trends and family planning services in Botswana. The description of the population sector provided in this document has utilized such data and analysis wherever possible. In order to determine the GOB's past performance and future objectives in the sector the following documents have been especially important: the current National Development Plan (NDP VI), past National Development Plans (Nos. III, IV, and V), the Botswana Family Health Survey, the Report of the Conference on Population and Development for Members of Parliament and House of Chiefs, the Report of the Conference on Population and Development for Permanent Secretaries and Senior Officers, the MOH Mid-term Review of NDP VI, UNFPA and World Bank documents.

Because population factors affect numerous central aspects of development, the population sector is almost always defined broadly and across other development sectors. The technical components of the Botswana population sector include family planning services, maternal and child care, information and education activities, contraceptive logistics, training, demographic research, and associated operational policies. In addition, a National Population

Policy is presently under discussion by the Parliamentary Council on Population and Development and an interministerial working group for submission to the parliament and the President. This policy is expected to institutionalize GOB commitment to reduced population growth rates and foster integrated implementation plans for increasing use of modern family planning methods. It will probably recommend the establishment of a management office or committee to oversee the implementation of the national policy. The population sector in Botswana, in addition to the services and activities described above, must include current and future policy development activities, the groups now working on the policy, and any coordinating body resulting from the policy.

C. Sectoral Issues and Constraints

This section examines the constraints in Botswana's population sector which limit the progress of the GOB in achieving its goal of reducing population growth rates. For the purposes of this analysis these constraints are divided into three categories - (1) policy constraints, (2) institutional constraints, and (3) structural constraints.

1. Policy Constraints

a. There is a current lack of a policy framework for expanding population activities in Botswana.

What is a policy framework? A general population policy framework is comprised of three principal components:

A National Policy is a comprehensive statement issued by the highest authorities containing general policies and guidelines for the population sector. As recently defined by the Vice President, the National Population Policy should be "inclusive" and incorporate all public or private sector actions that influence any demographic variable regardless of whether that action was intended to produce a demographic effect.

Operational policies are comprised of myriad "intervening" policies at the operational level which translate national policy into actions. Operational policies, therefore, include among others the method of providing family planning services, policies regarding family planning education in the school system, regulations regarding the import and distribution of contraceptives, sector funding levels, sub-sector targets, and in a broader sense, policies which indirectly affect demographic variables. Examples of the the latter would be a policy to lower infant mortality which in turn lowers ideal family size, or a policy to increase employment opportunities for women which would also have the effect of reducing demand for children.

Implementation policies set forth systematic approaches for achieving national and operational policy objectives. They identify particular needs to be addressed, set priorities, specify responsibilities, develop timeframes, and propose sets of actions.

Implementation plans are generally organized collectively under the leadership of the office or offices charged with sector responsibilities.

b. Need for a National Policy on Population

Botswana was one of the first countries in Africa to recognize the potential adverse economic and health effects of rapid population growth. Shortly after Independence, the GOB issued a very strong statement and analysis supporting the need to reduce rapid population growth. In the Third National Development Plan, (NDP III) 1970-1975, presented by Sir Seretse Khama in 1970, clearly set forth the rationale for the nation's approach to population growth:

> "It is better to have fewer children who may be well-fed, well clothed, and properly housed and educated, rather than many children who cannot be adequately cared for, and who will suffer as a result. A strong nation is one where the individual citizen is healthy and educated. Botswana cannot build a strong nation if the developmental effort is continuously undermined by the sheer weight of numbers for whom basic services must be provided (NDP III, p. 15)."

The Third National Development Plan also analyzed the future of Botswana's population growth. The document's high projection for population size as assessed in 1970 was 1,171,000 by the year 1990. Recent GOB analyses show that Botswana will actually have 1,319,000, or 148,000 more than the highest amount thought possible 20 years earlier. By the year 2000, Botswana will have 16% more people than its founders thought desirable in 1970. These figures certainly justify the early planners concerns about high rates of population growth in the 1970s, 1980s and 1990s.

Based on their analysis, the GOB set a target of a 2.5% annual population growth rate for the 1970s. The actual growth rate during the period was 3.6%. By the 1980s, it has risen to 3.7%, or one of the highest rates in the world. During the time that Botswana's growth rate was spiraling upwards, rapid population growth received only passing attention in sub quent national development plans (although various NDPs refer to family planning services in the health sections).

Recognition of the need for a stronger program in the population sector has once again emerged in the 1980s. Calls for a stronger population sector program have also been accompanied by a great deal of discussion about the need to develop and implement a national population policy and effective operational policies. Interest in developing a National Population Policy re-emerged after the 1984 World Population Conference. Shortly thereafter, the Botswana Family Health Survey and the preliminary results of the 1981 census revealed the country's extraordinary population growth rates. In 1986, several important parliamentarians and government officials came together to form an informal Interministerial Working Group on Population and Development. This was followed by two landmark conferences on population and development in Botswana.

The first was for Members of Parliament and the House of Chiefs and occurred in September of 1986 and resulted in the formation of the National Parliamentarians Council on Population and Development. The second took place in June 1987 and included Permanent Secretaries and other Senior Officers of the Government. The recommendations of these conferences were clear in their call for a National Population Policy and supporting policies. Some of the principal recommendations are as follows:

(a) Establish a national population program to carry out the national policy.

(b) Continue to build a consensus about population and development at all levels.

(c) Incorporate population activities into sectoral planning processes.

(d) Develop a "deliberate population and development policy which is clearly defined, comprehensive and well-articulated."

They further strongly recommended that a national office of planning and coordination be established at a high level of government to insure that the national policy is successfully implemented. These conferences and their recommendations have set the stage for the preparation of a National Population Policy.

These discussions are similar to those occurring in a number of other important Sub-Sarahan African countries including Zaire, Nigeria, Zambia, Zimbabwe, Sudan and several Sahelian countries. A principal theme in all of these dialogues is that national population policies and implementation plans are essential components in any effort to lower rapid growth rates.

Indeed, research has shown that a stated commitment at the highest level of government is critical to facilitate policy and programmatic decision making at ministerial and agency levels. Government officials charged with implementing programs are much more likely to undertake positive programmatic decisions if there is stated support and guidance from a higher authority. Similarly, governments with an explicit national policy and goals are more likely to commit the financial resources necessary for program success. Therefore, an explicit National Population Policy which galvanizes commitment and provides overall guidance is undoubtedly necessary for Botswana to achieve the beginnings of meaningful population growth rate decline in this century.

c. Need for Operational Policies and Implementation Plans. Despite the lack of a comprehensive National Population Policy, Botswana has done well in comparison to other African countries in expanding access to family planning services. This is because there have been successful sub-sector operational policies in certain units of the MOH, Central Statistics Office, MFDP and MLGL.

The Ministry of Health has had operational policies to offer family planning services since shortly after the founding of the Republic. Operational policies to provide services and trained personnel have appeared in each National Development Plan since 1970. Family Welfare Educators appeared early in the 1970s and were initially funded by IPPF and UNICEF. Though their job responsibilities have expanded over the years and the GOB has taken over funding, they have always been a focal point for MCH/FP care.

In NDP VI, the Ministry of Health continues to have the primary responsibility for operational policies relating to the population sector. As stated in the document, the Ministry of Health has responsibility for, "...national health policies and strategies." Specific policies in the health sector include: increasing family planning promotion by FWEs; increasing knowledge of family planning; developing an integrated approach to increase utilization of family planning services; targeting high risk mothers; and promoting smaller family sizes for health and socioeconomic reasons (NDP VI, p. 321).

In 1987, the MCH/FP Unit of the Department of Primary Health Care, MOH, developed a comprehensive operational policy document that is undoubtedly one of the best in Africa. This policy document entitled, "Botswana Family Planning General Policy Guidelines and Services Standards," sets forth policy guidelines for the delivery of services. This policy, if it is enforced throughout the system, will have a major impact on expanding the availability of services in a uniform manner. Among other provisions, the policy permits sterilization for women who have achieved desired family size, targets high risk groups (older women and adolescents), and mandates family planning services in all facilities on a daily basis.

Beginning in 1976, the GOB established target rates for the prevalence of modern contraceptive methods. By doing so, Botswana probably was the first country in Sub-Saharan Africa to set any specific targets for contraceptive use. NDPs set contraceptive prevalence targets of 9% for the period 1976-81 and 15% for the period 1979-85. These goals were exceeded according to the latest survey data. This is strong evidence that once the GOB sets an operational policy in the population sector, they have the capability of carrying it out. Current NDP VI quantitative goals to be reached by the year 1991 are: a modern contraceptive prevalence rate of 25%; an infant mortality rate of less than 50; and nearly universal attendance of pregnant women at clinics.

Since the Ministry of Local Governments and Lands has principal responsibility for local health workers (e.g. FWEs, nurses, etc.), this ministry also assumes the MOH operational policy to provide family planning services. Besides the MOH and the MLGL, the Ministry of Finance and Economic Planning has certain operational policies which support the population sector. In concert with the MOH and the MLGL, the MFDP annually appropriates resources to family planning activities through its planning and budgeting exercises.

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Another operational policy related to the population sector in NDP VI is found under the mandate of the Central Statistics Office. The MFDP though the CSO is charged with collecting, processing, interpreting and analyzing a variety of population information. Activities include dicennial population censuses, and demographic and health surveys. Data collection and analysis carried out by the CSO have been an impetus to programmatic decisions and to current efforts to develop a national policy. At present, the CSO has a full schedule of data collection activities underway and they include a 1988 Demographic and Health Survey as a follow-on to the the 1984 Botswana Family Health Survey. Costs for this activity are being borne by Westinghouse (IRD) and through the U.S. Bureau of the Census, a central A.I.D. sponsored project. The dicennial census of 1992 will be the chief focus of activity beginning in 1989.

Whereas the CSO has a full slate of essential activities scheduled for the next five years, manpower constraints may inhibit the complete achievement of CSO goals. These manpower constraints are both quantitative and qualitative. The CSO collects large amounts of data and prepares limited cross-tabs for most. What is lacking is the manpower capability to perform secondary analyses on the data so that it can be better utilized in planning and evaluation. Ameliorating this constraint would require additional manpower at higher skill levels. (The constraint will become more severe in July 1988 when the UNFPA will no longer be funding a senior technical advisor position in the CSO's Demographic Unit.)

As noted in the sector description, population activities cut across many ministries, agencies and private entities. However, operational policies supporting the population sector have not been promoted outside of the GOB ministries. Further, because of certain inconsistencies in operational policies, it has been difficult for the GOB to coordinate all of the various activities of the sub-sectors efficiently and to provide an overall strategy to the different executing agencies. For example, the Ministry of Health has been expanding the number of clinics offering family planning services. Consequently, the supply of services is increasing. At the same time, there has been no concomitant effort to expand information on FP through community based institutions including schools, religious institutions, and the Kgotla.

One of the other main advantages of having a comprehensive national population policy is that it facilitates the preparation of integrated implementation plans which can coordinate and make more efficient the overall effort. These implementation plans have been enormously successful in Nigeria and Zaire.

Such planning in Botswana, which has precedent in previous NDPs, would significantly improve the population program. First, operational policy constraints (e.g. restrictions on health personnel providing family planning services, lack of family life education in schools, etc.) would more likely be identified and revised under such implementation plans. Second, implementation plans establish priorities for line ministries and offices, and donors in the population sector. Since a large share of population

sector resources come from the donor community, implementation plans would be especially helpful in guiding donors since their programs can be ad hoc and sometimes overlapping in approach. Finally, integrated implementation plans can enhance the distribution of resources towards the most effective approaches.

d. Remedies for Alleviating Constraint

Several interrelated factors are involved in establishing a sound policy framework for the population sector in Botswana. The most important of these is the need to develop a supportive political environment for population programs. Another requirement for alleviating the policy constraint is a sound source of data on population trends and programs as well as the technical capacity to analyze such data and to develop practical policy options from this information. Remedies for improving the policy framework for population programs are proposed below.

- Continue National and District Workshops on population issues for the purposes of disseminating information and obtaining consultation feedback from community leaders, politicians, and the public.

- Expand the capability of the GOB Central Statistics Office and Ministry of Health to analyze population data and develop policy options.

- Develop a National Population Policy which provides:

(a) GOB commitment to Batswana couples for providing accurate information on how to space or limit births, access to uninterrupted family planning services; (b) a structure for implementing the policy; and (c) opportunities for non-government organizations and private sector to participate in population programs.

- Improve operational policies in the MOH, MLGL, MOE, and MFDP which improve the quality of existing services, expand the availability of MCH/FP services, and include for the provision of on-going monitoring.

2. Institutional Constraints

Four separate but interrelated institutional constraints have been identified which inhibit the GOB efforts to reduce the rate of population growth. These constraints include:

o Insufficient coordination among GOB institutions which deal directly or indirectly with population programs;

o Underdeveloped contraceptive logistics system;

o Inadequate IEC services;

o Limited availability of MCH/FP clinical services.

a. Overview of the Institutional Structure

In Botswana, the current population sector directly encompasses programs in the Ministries of Health, Local Government and Lands, Education, and Finance and Development Planning.

The MOH and MLGL programs focus on family planning service delivery. Their principal objectives are to improve maternal and child health status and promote reproductive and family health. Activities in these service ministries include educational programs, counseling on family planning methods, the provision of contraceptives, and follow-up care for current users. Services are principally delivered through public sector health facilities. A portion of family planning services is delivered through private sector channels including Mission hospitals, non-governmental organizations and large employers. The MOH also develops basic health strategies, budgets resources, makes human resource allocations, trains personnel, and conducts inservice training for existing staff. All of these affect family planning services.

The MOE is responsible for the bulk of education in Botswana. This ministry presently is providing family life courses in secondary schools. Given the growing interest in expanding the population sector, the MOE will undoubtedly become involved in expanding its population related instruction at the Junior and Senior secondary levels.

The MFDP seeks to promote equitable and sustainable development in its responsibilities for national budgeting and planning. This ministry sets development priorities and allocates financial resources to population activities. As an important part of this process, its Central Statistical Office collects and analyzes data relating to population trends and family planning practices. The ministry utilizes population and health information in its resource allocation decisions and provides data to line ministries for use in programmatic design and evaluation.

As noted, an integral component of the population sector is the emerging National Population Policy which will provide guidelines to implementing agencies for achieving sector objectives. The promulgation and implementation of the national policy is subject to the approval of the executive and legislative branches of the GOB. Since the implementation of policy normally requires a continuing process of revising and evaluating operational policies, and changing regulations and laws, the executive and legislative branches of government are part and parcel of the population sector.

b. Insufficient Coordination among GOB Institutions which deal directly or indirectly with Population Programs

The linchpin of a successful national population policy is a management office that can oversee the implementation of the policy. It is this office that can develop an overall strategy, work with sub-sectors to develop operational policies consistent

with the overall policy, and prepare implementation plans to expand the program. These types of management offices have been established recently by the governments of Nigeria, Zaire, Sudan, and Liberia, and have been essential to policy development in those countries. At present, there is no office in the GOB that has policy responsibilities for the population sector. The current effort to develop a national policy and organize management responsibilities is entirely in the hands of individuals who have full-time jobs in line ministries and work on policy issues in their spare time.

Earlier this year the GOB expanded the terms of reference of its interministerial contraceptive committee to include broader population and family planning issues. However, there still is a need to establish an institutional focal point for population policy with responsibility for conducting analyses of population issues and for serving as the secretariat to the Parliamentary Council on Population. While this is an institutional constraint it is closely related to the policy constraints described in the previous section.

c. Underdeveloped Contraceptive Logistics System

(1) Dimensions of the Problem. There is a need to strengthen the GOB's contraceptive procurement and distribution system to ensure that adequate supplies of contraceptives are available when and where needed. Such an effort should anticipate changes in future demand, both with respect to an overall increase and likely shifts in method mix. Family planning contraceptives are distributed through the MOH Central Medical Stores (CMS) system, along with drugs and medical supplies. However, in contrast to drugs and medical supplies which are largely funded by the GOB, contraceptives are essentially fully funded by donors and procured through donor channels. There have been and continue to be a number of problems resulting from this situation, and these have a negative impact on the ability of the CMS system to meet the overall demand for contraceptives.

Through a Memorandum of Understanding between the GOB and USAID/Botswana, AID has been providing the bulk of Botswana's contraceptive needs since 1983. AID-supplied commodities are principally oral contraceptives and condoms, but also include relatively small quantities of IUDs and contraceptive jelly. Additional commodities, principally Depo-Provera (which AID cannot supply), are provided through UNFPA. The GOB/USAID Memorandum of Understanding was for a five-year period through 1987. The GOB's contraceptive requirements for 1988 will be funded through AID centrally-funded resources. Currently, the GOB contraceptive logistics system is hampered by two problems described below.

o Problems resulting from donor supplies of contraceptives. As indicated in the earlier discussion of FP service delivery, there have been major increases in contraceptive use, especially during the last two years. While these increases underscore the increasing effectiveness of the MCH/FP delivery system, the increases have themselves

created a problem with respect to orders for additional stocks. In the case of both pills and condoms provided by AID, shipments have not arrived in sufficient time and shortages or actual outages have occurred during the last year. Recently there has been a similar experience with a shipment of Depo-Provera through UNFPA. These difficulties were largely beyond the GOB's control, and occurred due to a longer than expected interval between the time of the GOB request to the respective donor and the time the shipment was received incountry.

There have been additional problems in relation to oral contraceptives. One is a result of the proliferation of brands and brand names of pills, many of which are identical in type and chemical composition, but have a different appearance and packaging. With different supplies from different donors (a common occurrence until the last year or two), it was not always possible for CMS to supply the identical pill ordered. In such a case there is a least a client adjustment problem to what looks like a "new pill," and possibly the more serious problem of discontinuation of use -- a major problem in Botswana which probably occurs for other reasons as well. A related problem is that with improved technology and other advances in the field, the oral contraceptive of choice for the average user may change and cause additional adjustment problems. Such has been the case with the progestin-only pill, and more recently the low-dose pill. While on balance there is a net benefit from the introduction of a new product, there may be associated problems. One such problem has resulted from AID's recent decision not to make a standard-dose pill available to national programs unless it is part of a commercial marketing component. As a result, Botswana is currently arranging to purchase the standard-dose pill "Noriday" in order to continue to provide that strength and brand to women who either do not wish to change or who have experienced complications in trying to switch to the low-dose pill. In the meantime, stocks of Noriday were depleted and there has been some resulting discontinuation of use.

o <u>Difficulties within the contraceptive logistics system</u>. As part of the standard CMS drugs and supplies ordering procedure, there is currently a separate family planning commodity order form. Each request for contraceptives is processed as part of the overall requisition from each facility. The present system does not monitor contraceptive inventories at any level except CMS itself, so that there is currently no information on what stock levels exist at the individual health facilities. At times when there are sufficient supplies of all contraceptives in the CMS warehouse the system performs well. However, when central stocks of an item are low or perhaps depleted, the current system is not able to determine where limited available supplies are most needed. As discussed below, some modifications in this system are being considered to overcome this problem.

The contraceptive ordering system also requires strengthening to ensure its effectiveness in supplying orders in a timely fashion. In addition, given the major shipment delays encountered for recent donor shipments, there is a need to modify the ordering system to build in a buffer stock, so that shortages and outages will not continue to compromise MCH/FP program efforts.

(2) Current GOB Strategy and Approach. In order to at least partially overcome many of the difficulties described, the GOB has instituted a number of changes that affect both MCH/FP service delivery and the CMS contraceptive logistics system. As proposed in NDP VI, the CMS storage capacity has now been increased by 50 per cent, and additional office space has been incorporated. Among other things this will allow for additional buffer stocks of contraceptives, which is being implemented both to account for increased contraceptive use and to allow for slowness in receiving donor shipments. CMS is introducing a computerized procurement system for drugs and medical supplies, but since contraceptives are normally donor-supplied the new system will not affect them.

CMS is also planning to implement a program to collect improved contraceptive use statistics, as well as stock levels of contraceptives at all health facilities as part of each new order. This should help overcome the problem of not knowing the magnitude of buffer stock at the facility level, and thus assist in issuing available contraceptives in a rational way. Also, the drug requisition form is being adapted so that contraceptives will be included, and thus integrated into the normal CMS requisition and supply system. The modifications of the form will also reflect the reduced number of contraceptive supply items (especially pills) currently available, thus eliminating the ordering of discontinued items. Furthermore, as of October 1987 contraceptive stocks are being handled and monitored the same as other CMS inventory items; thus the mathematical errors which had occurred occasionally in monitoring contraceptive stock levels should now be eliminated.

An inservice training program has been underway for more than a year to introduce the new oral contraceptives (progestin-only and low-dose). A similar inservice program has been ongoing for more than a year to make a shift from the Lippes Loop to the Copper-T Intra-Uterine Contraceptive Device (IUD). This training requires a clinical component since insertion techniques vary considerably between the two IUDs. These efforts should ease the transition as these new products continue to be introduced, and should minimize client adjustment problems and the potential for discontinued contraceptive use.

In order to continue to offer a standard-dose oral contraceptive, the MOH is in the process of ordering Noriday and financing it from GOB resources. It appears that development funds will be used for the first year, but that after 1988 Noriday estimates will be included in the MOH recurrent expenditure estimates. This is thus the first significant long-term GOB financial commitment to the purchase of contraceptives.

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Based on recently-compiled statistics for 1986 FP visits, it appears that new acceptors have increased significantly but that discontinuation continues to be a major problem, and that the principal reason seems to be that women either fear or experience side effects. The MCH/FP Unit plans to improve family planning counseling, and expects that this effort would minimize discontinuation.

(3) Remedies for Alleviating Constraint. While the GOB has instituted a number of activities and programs to overcome existing constraints in the area of contraceptive supplies, the following remedies are proposed to develop the GOB contraceptive procurement and distribution system:

- o Assign Central Medical Stores the responsibility for procurement of contraceptives.

- o Streamline the current contraceptive ordering/storage/distribution system, based on new mechanisms for monitoring and ordering.

- o Encourage the GOB to absorb a much greater share of the cost of contraceptives into its recurrent budget. GOB funding and control of contraceptive supply will ensure a reliable supply as well as the continuity of products over time.

d. Inadequate IEC Services

(1) Dimensions of the Problem

As reported in the Botswana Family Health Survey, there is a large discrepancy between knowledge and practice of family planning methods. Approximately 80% of women report knowing at least one FP method, and the average woman is familiar with four methods. However, only 19% of women actually use a modern method of FP, according to survey results. In addition, in a study conducted in 1985, just over half (57%) of the men interviewed could name one method of family planning (du Pradal, pg. 37). Some of this gap may be explained by interrupted supplies, less than ideal counselling opportunities, and not enough service delivery points. There is little doubt that a major factor is the public perception about family planning which involves lack of information, incorrect information, and cultural attitudes. There is need to strengthen the GOB's IEC services to ensure that the public has access to information which motivates them to make a rational decision on family planning services. People should have the right to have as many children as they desire, and that also means fewer children or none, if that is their wish. And this also means that they should have the right to make an informed choice.

The GOB has recognized the important contribution of IEC to its family planning efforts. Within the GOB, the primary responsibility for IEC services is with the Health Education Unit (HEU), one section of the Division of Family Health within the MOH. At the District level, the Ministry of Local Government and Lands has recently taken over the administration of the District Health Teams,

on which there is a Health Education/Nutrition Officer post. At the clinic and health post, the health worker has the responsibility for giving health talks and individual counselling. At the community level, the Family Welfare Educators are responsible for the dissemination of information.

At present, the Health Education Unit is composed of thirteen professional staff. The Unit is split into sections comprising training, materials production, research, radio production, graphic arts, community participation, and water/hygiene. The yearly workplan is divided into training, research, seminars, materials development, and special events. Family Planning is one of the many topics covered within the mandate of the Health Education Unit. Much of the work of the Unit is concerned with supporting Primary Health Care activities, as this is a priority of the GOB. The Unit also gives substantial support to the District Health Teams through the lending of equipment, the training of the Health Education/Nutrition Officers, and by participating in seminars and workshops organized at the District level. In conjunction with the Occupational Health Unit, the HEU has begun a Health in the Workplace Program with a family planning component.

Some of the more urgent issues with respect to the GOB IEC efforts are described below.

- o <u>At present, the HEU is not able to meet the demand for IEC services in Population/Family Planning</u>. An ideal Health Education Unit should have research, design, production and evaluation capabilities. At present, most of the staff of the HEU do not have the broad range of skills to carry out some of the more specialized tasks such as research and evaluation, development of curricula for improving health worker communication skills, and materials development. There is no health education curriculum, as such, at either the University of Botswana (UB), nor at the National Health Institute (NHI). As health education efforts are decentralized to the district level, there will be an even greater demand for skilled health education officers at both the central and district levels.

- o <u>Awareness and knowledge about the facts of FP need to be expanded so that people in making voluntary choices base them upon sound information</u>. While the results of the BFHS suggest that most women know something about FP methods, the high rates of discontinuance imply that women are not being given enough information to make informed choices about the method of contraception they select. In addition, the BFHS results demonstrate that women may know more about the benefits of FP than their spouses. HEU staff also recognizes that there is a need for utilization of a greater number of distribution channels, since presently most of the information on family planning has been given out at clinics, where men are less likely to be found. A study which was conducted by nursing students at the National Health Institute found that men are more comfortable receiving advice and contraceptives from

other men. Results of another study suggest that men would like to be approached with information on FP, and that specific materials should be developed for their benefit. Perhaps too much emphasis has been placed on information for the female, without consideration for the fact that the male is often the decision maker for the couple, especially in terms of FP.

o IEC Strategy Needs to Be Guided by Research. Formative research based on behavioral analysis and evaluation of messages and materials is not conducted on a formal basis. Some focus groups and interviews are conducted before materials are produced, but clearly this is insufficient when obstacles to behavior change have been identified, as is the case with the practice of family planning. Further research is needed to understand the issues related to obstacles to continuance; male attitudes to contraception and family planning; how to improve communication between spouses on FP; and the reasons behind the high teenage pregnancy rate. Without this research, messages and materials cannot be properly targeted.

o Printing, distribution and use of materials needs to be evaluated. Materials are usually printed in sufficient quantity to have a wide distribution, but may not be revised and reprinted based on responses from the field. Posters have been used effectively by health workers as visual aides, but alternative teaching aides have not been developed. Most of the materials are printed by the government printer at no direct cost to the HEU. However, the government printer is limited in the types of materials it can print and often takes a long time to produce the work. For example, in order to reproduce flip charts, commercial printers must be contracted. Health workers are not often trained in use of materials, and much of the materials are therefore used improperly. It appears that the HEU does not monitor the distribution and use of materials, and there is a concern that materials sit at the District level instead of being passed down for use to the village and health center/post level. It is necessary to evaluate whether or not the materials have been received and used by the target audience, as well as the effectiveness of these activities. To date, the HEU has not come up with a system which enables them to evaluate either of these areas to their satisfaction.

o Non-governmental channels need to be explored for dissemination of family planning information. As pointed out above, men would like to receive more information on family planning directly, and that they would like to be given that information by men. At present, only two Health Education/Nutrition Officers at the District level and only a small proportion of the FWEs are male. The HEU and NGOs such as the Red Cross work closely together, are involved on intersectoral committees, and share materials. In order to

increase the likelihood that men will be reached, it would be important to find more opportunities to increase the HEU collaboration with NGOs, such as Red Cross and the new IPPF affiliate, as well as industries with primarily male employees, to encourage them to take an active role in the promotion of information on family planning.

(2) Current GOB Strategy and Approach

The goal of the GOB is to increase prevalence of family planning to 25% during the period covered by the NDP VI (e.g. through 1991). The NDP VI recognizes the important contribution of IEC and stated that the Health Education Unit "will give priority to the following areas: inservice training and manpower development, community participation, research, evaluation, and production of radio programmes and visual aides." The plan calls for "increased knowledge and support of MCH/FP in the general population, with special emphasis on the male population and youth."

In order to accomplish these goals, within the area of Family Planning, the HEU has produced several sets of materials for different target groups, including men and teenagers. Some of these materials were produced with assistance from Program for the Introduction and Adaptation of Contraceptive Technology (PIACT - Johns Hopkins University), and are of excellent quality.

Decentralization of health education services through the District Health Education/Nutrition Officers has enabled the HEU to take its proper role as a service unit, providing expertise on health education and health related matters to all central and local government departments, as well as private organizations. As much as possible it aims to decentralize, giving only guidance and support where needed to field workers. The NDP VI states that "the improvement of MCH/FP promotion should be accomplished through follow up and participation at the home level through the strengthening of FWEs and data collection and use." At the village level, Family Welfare Educators use the materials developed by the HEU in their promotion of family planning activities. At the health post/clinic, health workers are supported in their work through materials, such as posters, booklets, and flip charts.

The MCH/FP Division has expressed an interest in pursuing a social marketing strategy through the private sector, and will also be examining its role in supporting the new IPPF affiliate in its informational needs. These strategies will allow further dissemination of family planning messages, materials, and services, and will move family planning away from being a primarily government activity.

(3) Remedies for Alleviating Constraint

The approach of the GOB to IEC has been generally progressive. The impressive increases in knowledge, as suggested in the results of the BFHS, indicate that the HEU has made great strides towards informing the public about family planning methods. However, in order to provide adequate IEC services the following remedies are proposed:

o Increase the number of staff and staff training programs in health and family planning education in Botswana. Skills such as research and evaluation, development of curricula for improving health worker communication skills, materials development, radio production and graphic arts are required in the HEU. Some of these same skills are needed at the district level. Training support both in the form of short courses and longer diploma courses for several staff members is needed to supplement the skill level of HEU staff.

o Expand the HEU's basic items of equipment and supplies. Items such as audio-visual equipment, a video editor, a duplicating machine, and expendable supplies such as paper, and supplies for graphic arts and photography would increase the effectiveness of the HEU. The equipment requirements of the district staff also need to be evaluated.

o Utilize NGO's and private sector organizations to disseminate IEC materials and messages.

o Include other target audiences, such as teenagers and men, requiring the assistance of influential members of their peer groups. There is a need to involve traditional authorities (chiefs, counsellors) in passing along FP information and in encouraging participation in FP, especially among men. Since the workshop on FP involving chiefs and parliamentarians in September 1986, there has been some effort to involve these groups in the promotion of knowledge about FP, but this could be expanded with special workshops, seminars, and conferences.

o Increase funding budgeted for the HEU to undertake Family Planning research and evaluation. Funds should be allocated to undertake necessary research in order to better understand the obstacles to increasing family planning prevalence. Due to the manpower shortage, it may not be optimal to develop extensive research capability within the HEU, but rather to use the funds to contract out to other government supported institutions, such as the University of Botswana, for this work. Perhaps an arrangement whereby students from the sociology department would undertake research projects in coordination with the HEU would assist in lowering the requirement for funds in this area. Seminars for training health workers in the use of materials should be undertaken, and the printing costs for materials not able to be printed at the government printers should be made available. The GOB should consider adding these areas into the budget as a recurrent cost.

o In order to increase its cadre of manpower, the HEU must have a community of trained health educators to draw upon. Within Botswana at present, there is no diploma course,

neither at the University of Botswana nor at the National Health Institute. The GOB should consider re-establishing such a course. This is especially true as the decentralization process continues, requiring more health education officers with family planning training and delivery skills at the District level.

d. Limited Availability of MCH/FP Clinical Services

(1) Dimension of the Problem. The MCH/FP service delivery system needs to expand in order to meet the growing demand for family planning services.

According to the Botswana Family Health Survey of 1984, there were as many as 40,000 couples presently wishing to delay or limit births who desire family planning services now. Several difficulties contribute to the present inadequacy of available services. First, only 60 percent of all health facilities in Botswana currently provide integrated MCH/FP services. Second, the mean period of use for all FP methods is only 13 months, and 40 percent of all current FP users have used contraceptives for less than six months. According to the BFHS, the unavailability of a desired FP method is a major reason for discontinuance.

(2) Current GOB strategy and approach. Throughout the last fifteen years the GOB has implemented a decentralized primary health care (PHC) strategy. Primary health care is defined as essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation, and at a cost the community and the country can afford. The aim is that people will integrate the concept of health into their way of life and not equate it to medical care -- a commodity dispensed by medical personnel and institutions. This framework for PHC has great potential for success, and underlines the importance of individual and community understanding and acceptance of family planning as a critical element of PHC.

Overall responsibility for health service delivery is shared between the Ministry of Health and the Ministry of Local Government and Lands. In the system that has evolved the MOH is responsible for the following functions: 1) National health policies and strategies; 2) Health promotion and preventive services; 3) Curative health care services; 4) Health research, investigative and technical support; 5) Health manpower development and utilization; and 6) Health care administration.

The MLGL, and through it the local authorities and the communities themselves, are responsible for the establishment and day-to-day operation of health posts and clinics. The most peripheral health facility, the health post, is currently staffed by a Family Welfare Educator (FWE). Rural communities with a population of 500-1,000 should have a health post and FWE, although this long-term target will take some time to achieve at the present rate of implementation. The FWE is a health motivator and educator in family and community health, and is the community's first point of

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contact with the PHC system. All health posts are visited regularly by supervisory personnel. The long-term strategy is to have all health posts staffed by enrolled nurses in order to expand the range of services available. The next level of health care is provided at clinics. Clinics are staffed by nurses, and in addition to the health services at health posts they provide a wider range of health education, carry out immunizations, provide up to ten beds for curative and maternity care, and collect statistics.

Although local authorities are responsible for the daily operation of basic health facilities (health posts and clinics), professional supervision is provided by District Health Teams (DHTs). In order to overcome earlier problems arising from this professional supervision being provided by the MOH through Regional Health Teams, the DHTs are now responsible directly to the District Councils. The medical staff of the local and district authorities are employed through the Unified Local Government Service in MLGL. However, because of the joint responsibilities of the MOH and the MLGL for delivering basic health services, a joint Basic Health Coordinating Committee with representatives of MOH and MLGL meets periodically to discuss and resolve policy and administrative matters.

Through its primary health care strategy the GOB has made major strides in maternal and child health and basic family planning service delivery in recent years. However, there is growing evidence that the need for family planning information and delivery services exceeds the quantity and quality of available capacities.

The Sixth National Development Plan states that the first priority for the health sector is primary health care. NDP VI discusses the GOB strategy for the health sector and indicates a number of approaches for overcoming several key service delivery constraints. The NDP VI policy for District and Town Councils is to continue to strengthen local government capacity within the framework of district plans, to operate existing facilities, and to expand services within the limits of available manpower and recurrent resources. This includes more staffing of existing health posts with enrolled nurses (together with housing), within the limits of the recurrent budgets of the local authorities. According to NDP VI, having ensured that existing basic health facilities are effectively run, the next step will be to establish facilities in areas that are underserved; targets are given for modest expansion of facilities in the Plan.

MCH/FP services comprise another important component of PHC. According to NDP VI, major tasks relating to MCH/FP include the following:

- The improvement of MCH/FP promotion, follow-up, and participation at the home level through strengthening of the FWEs in these areas.

- Increased knowledge and support of MCH/FP in the general population, with special emphasis on the male population and youth.

o The development of an integrated approach to MCH/FP care which is effective, efficient, and acceptable at the community level.

o The identification of high-risk groups amongst pregnant women, mothers and children, and appropriate intervention.

o The protection of the health of mothers and infants through planning services, so that each family will be of a reasonable size, corresponding to its socioeconomic and health conditions.

In December 1987 the MOH Planning Unit prepared a Midterm Review of NDP VI which reported progress in meeting NDP VI targets. In the area of MCH/FP services it noted that 60 percent of all health centers and clinics now provide integrated, but limited, MCH/FP services, though further developments are constrained by shortages of nurse-midwives. It was further noted that targets for MCH/FP coverage have been partially achieved, although detailed, up-to-date information is still outstanding. The review also reported that research is being conducted into risk factors associated with place of delivery. Unfortunately, no further details in the MCH/FP area were indicated.

(3) Remedies for Alleviating Constraint. The following remedies offer promise in overcoming the current limitations of the MCH/FP service delivery system:

o Strengthen the overall management of MCH/FP services to ensure that service delivery targets are met.

o Improve the MCH/FP information system to provide service statistics and other information for measuring progress and providing feedback to health workers and facilities.

o Plan and carry out research designed to provide information in at least three key areas: (1) reasons for discontinuity of contraceptive use; (2) how to overcome barriers to FP use (e.g., male resistance); (3) within the limitations of local culture, ways to expand FP method mix to include more permanent FP methods (e.g., implants, surgical contraception); and (4) Based on the research results, design and implement programs to increase continuity of FP use and to overcome identified barriers to further FP use.

o To the extent that new operational policies are introduced, implement these new policies in such areas as an expanded role for the private sector in FP; GOB support to NGOs in providing FP information and services; and promotion of an expanded method mix.

3. Structural Constraints

The structural constraints which must be overcome before significant reductions in the population growth rate include:

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- Insufficient numbers of trained GOB staff and of overall financing for population programs.

- Limited participation of NGOs and private sector in population programs.

a. Insufficient Manpower and Staff and Training for Population Programs

(1) Dimensions of the Problem. The Ministry of Health is currently undertaking a study of all MOH and MLGL health personnel with the assistance of York University. In addition to basic information on the existing numbers of personnel this study includes information on the formal and inservice training of each staff member. The study also tackles the issue of the overall manpower requirements of the health sector. Given the total integration of MCH/FP services with the GOB's health delivery system this study can be expected to provide the details which are necessary to examine the manpower and training requirements of the MCH/FP services - the major manpower area of the population sector. Prior to the release of this study somewhere toward the middle of 1988, some general observations can be made concerning the existing manpower allocations and training programs, as they relate to the population sector. First, it seems clear that there are insufficient numbers of well-trained population and health personnel assigned to deliver family planning information and services. Second, while in some cases additional staff need to be deployed, there are opportunities to better utilize some GOB health cadres and non-government organizations with respect to the delivery of family planning services.

The GOB's nursing and family welfare cadres represent the heart of the MCH/FP delivery system. While the number of nurses has increased dramatically in recent years, they are still insufficient to meet the requirements of the health system, and in particular of the rural health system. There continue to be problems in recruiting nursing staff from this pool to the rural clinics and health posts. Other studies indicate that despite the large number of Family Welfare Educators most of their time is consumed in the health facilities which limits their efforts in providing health education in their communities.

It is difficult to give precise estimates on what manpower is required specifically for family planning services. Such a figure depends not only upon the overall numbers of staff, but also on how much time they can allocate to family planning services. At the lower end, and in consideration of the GOB's target of providing integrated MCH/FP services at all its facilities, there should be sufficient enrolled nurses at least to staff each health facility. With respect to health education, the Family Welfare Educator cadre is extremely important with regards to family planning services, as well as other facets of health care.

In the area of demographic analysis, another important part of the population sector, at present there are only two demographer staff positions and a supernumerary advisor position in the CSO's

Demographic Unit. Only one of the two staff positions has ever been filled. This unit must have enough staff to undertake in depth analysis of survey data as well as to provide the ongoing data dissemination required by the rest of government. Again, as a minimum, the CSO Demographic Unit requires at least three positions, this number would maintain two full time positions and permit scheduled training which will be required by the young Batswana staff which are filling these positions.

There are also a number of personnel management issues which have an important bearing on the recruitment and retention of staff for the population sector. Such things as low salary scales for entry staff, potential remote area postings, lack of promotion opportunities (especially for FWEs) discourage some people from entering or remaining in the government service.

Perhaps the most pressing manpower issue is "Are the present personnel receiving the types of training required to support the population sector?" Given the relative youth of Botswana's workforce, there is a general need for ongoing training throughout the economy. In the population sector, this also appears to be the case and the GOB has several preservice and inservice training programs ongoing, particularly for health staff. Institutionally, the Department of Health Manpower in the Ministry of Health and the Unified Local Government Services (ULGS) Division under MLGL are responsible for MCH/FP manpower planning and development. The National Health Institute is responsible for the content and provision of training for personnel in conjunction with MOH and MLGL. ULGS receives training requests from all District and Town Councils and consolidates them into a master plan. The Ministry of Health is responsible for the basic training of enrolled and registered nurses and allocates a number every year to MLGL. As far as post basic training is concerned, MLGL gets ten training slots per course per year at NHI. Post basic training comprises midwifery, Family Nurse Practitioner, Community Health Nursing, MCH/FP etc.

Preservice training for nurses at the NHI is being upgraded and various schemes are being suggested to ensure that all graduates receive clinical or field experience in family planning, such as an internship period, prior to assuming full duties of their particular category. At present, a graduate of NHI is assigned to either a hospital or health center or to other health delivery points. Those in the former category may not be able to obtain much practical experience in the delivery of FP services. It is possible, therefore, that if such individuals are reposted to MCH/FP positions, many will be in need of refresher training. Currently, clinical experience during preservice training is underemphasized. Clinical experience in IUD insertion, for example, is critical to acquiring the skills to make this method a high-quality service which would result in more acceptance. Each trainee should insert at least 12 to 20 IUDs to qualify as a certified IUD insertion agent. With so few IUD acceptors at a clinic, health center or hospital at present, meeting this goal is problematic. As

acceptance of family planning increases, and the method mix becomes less skewed towards one method, more practical clinical experience will be available to preservice and inservice trainees.

Inservice training in family planning is being conducted by the International Training for Health (INTRAH) project with AID funding. Manuals are being developed for Family Planning General Policy Guidelines and Service Standards and these will be followed by a Manual on Clinical Standards. INTRAH also is working closely with the NHI to improve the Family Planning curricula for preservice training.

Another manpower and training issue, closely related to training, is the need for greater supervision of health care staff. A recent survey carried out by the Botswana Nurses Association found that 73 percent felt that supervision was either inadequate or non-existent. Supervision is one of the keys to the delivery of quality information and services in MCH/FP. There are no supervisory cadres in either the MOH or the MLGL, nor are there clear guidelines on how supervision should be carried out.

Unless FP information and service delivery cadres are thoroughly trained, and regularly supervised, they will not have sufficient confidence to counsel potential acceptors on the whole range of available methods nor deliver quality services. If, for example, an hormonal contraceptive user is not properly screened and counseled on possible side effects, then discontinuation rates will remain high.

Because of the small size of the demographic analysis staff no similar types of inservice training programs have been mounted.

(2) GOB Experience to Date with Human Resource Issues

The GOB's Strategy for providing trained manpower for the population sector is contained in NDP VI. Under the Health Strategy and Programmes for NDP VI, one of the aims is to "develop health service related technical and professional manpower resources to cope with the current requirements and future development needs." (page 319). The first priority in the health sector for the GOB is Primary Health Care. The second priority, in order to carry out the first, is training and manpower development.

The training and manpower objectives of NDP VI are as follows: 1) to develop a sound manpower policy for short and long term use; 2) to identify health manpower needs and develop manpower development plans and programs; 3) to implement manpower development plans and ensure proper distribution and utilization of manpower, and 4) to maintain an up to date inventory of health manpower and carry out research evaluation." The NDP also indicated that PHC curricula were to be incorporated into all training for health cadres, especially at the NHI, and inservice training in PHC was to be scheduled for all serving officers. The Plan specifically called for "strengthening and expanding training in clinical and non-clinical skills in family planning."

According to the recently published MOH Midterm Evaluation of NDP VI, the long-term health manpower development plan is making good progress. Consultants have created a data base of all MOH and MLGL health personnel, which includes names, ages, all training, grade, location and other salient information. Comparisons are being made between workload and staff in order to determine staffing needs in a more systematic manner. The MOH also is reviewing personnel practices and conditions of service with a view to improving efficiency of higher professionals.

The Evaluation also states that 90 percent of local training targets have been met but only 50 percent of overseas training targets. Overall nursing cadre targets were met but those for registered nurses and nurse-midwives were below targets. The reasons for poor performance were listed as space constraints at the NHI and lack of capacity for clinical training. The latter problem will be solved when the New Francistown Hospital opens this year. Lack of suitable teachers was listed as another constraint in training of community health nurses.

(3) Remedies for Alleviating Constraint

While limited manpower has been highlighted as a major constraint in the population sector, it is also recognized as a problem that affects the entire health sector and the country in general. The most effective solutions to overcome this problem are likely to be those that work in the margins such as improved inservice training, better supervision, increased effectiveness of family welfare educators to provide family planning information in the community environment, and, perhaps shifting more responsibilities for family planning information and services to non-government organizations, community groups and the private sector.

b. Inadequate GOB Financing for Population Programs

(1) Overview.

Population sector expenditures are broken down into two components: MCH/FP programs and population analysis activities. The MCH/FP expenditures include those for the Ministry of Health and the Ministry of Local Governments and Lands. Population analysis expenditures are primarily related to the Central Statistics Office, a division of the Ministry of Finance and Development Planning. The Central Transport Organization (CTO) supplies the vehicles for all health services and so a percentage of their costs is included under MCH/FP activities.

At the outset it is important to recognize the difficulty of analyzing population sector expenditures. The major problem is that there is very little data pertaining specifically to allocations for maternal child health/family planning. While the GOB has comprehensive and accurate recordkeeping systems, its accounting process is based on institutional rather than program budgeting. Thus, information regarding Ministry of Health recurrent costs is quite precise, but the distribution of costs by the different health programs is much harder to ascertain. Development budgets are somewhat clearer since they are based on specific projects described in the National Development Plan.

Two conclusions can be drawn from the way in which the GOB examines its financial expenditure. First, there appears to be a need to sharpen the budgeting data in population in developing the population sector. A system for analyzing financial resource allocations to the MCH/FP subsector makes it easier to identify financial constraints to providing MCH/FP services, and to help ensure that the limited resources available are going to the priority MCH/FP activities. Also, program budgeting leads to more precision in the data analysis which follows. MCH/FP recurrent cost calculations have been made by attributing to the MCH/FP subsector certain percentages of more general recurrent health cost figures. The data used is accurate and based on the National Statements of Accounts, but the costs attributable to the MCH/FP subsector could be interpreted in a variety of ways.

The team's interpretation on these budgeting matters was based on discussions with government officials and research of relevant documents.

(2) Allocation of Funds for the Population Sector.

Financial resource allocations to the population sector have increased substantially. Combined recurrent and development expenditures in the population sector for 1987/88 are estimated to be approximately P5.9 million, which translates into 0.33% (less than 1/3 of 1%) of the overall GOB budget. Although this percentage is still lower than most developing countries it is almost three and one half times overall population sector expenditures in 1983/84. Current per capita expenditures in the population sector are estimated to be P5.0 (Appx. US$300) per annum in 1987/88 (including donor contributions). At first glance then, it would appear that overall population sector allocations are quite substantial. However, it is in analyzing these allocations that major gaps in funding appear.

Overall, the majority of expenditures in the sector are for MCH/FP activities (86% in 1986/87 and an estimated 88% in 1987/88). Most of these expenditures are recurrent costs, primarily salaries and staff already on-board. Population analysis activities, which have accounted for an average of only 11% of total population sector allocations over the five year period 1983/84-1987/88, have nonetheless expanded rapidly; they are an increasingly important component to the population sector. Each ministry will now be examined in turn, after which follows a brief analysis of donor contributions to the population sector.

(a) The Ministry of Health. In 1986/87 the MOH provided 64% of all MCH/FP allocations, 82% of which were recurrent costs. Over the last five years MOH funding for MCH/FP programs has increased an average of almost 60% annually, although recurrent spending has lagged somewhat, increasing an average of 54% each year. The 1987/88 estimated expenditures are five times 1983/84 funding levels. Although recurrent costs have consistently been the largest expense (an average of 84% over the last five years), development expenditures have increased at a much faster rate since 1983/84.

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o MOH MCH/FP Programs have expanded considerably, with development expenditures increasing at an average annual rate of 83% between 1983/84 and 1987/88. These development expenditures can be broken down into four major projects: the MCH/FP project (MD 31); the Family Health Project (MD 21); the Health Education Program (MD 32); and the Nutrition Program (MD 09).

(b) Ministry of Local Government and Lands. While the MLGL has not been the primary ministry in the MCH/FP subsector it nonetheless provides essential funds for MCH/FP services. Combined MLGL recurrent and development expenditures in 1986/87 were 27% of total expenditures in the MCH/FP subsector. These expenditures have increased an average of 12% annually over the last five years, with larger increases coming in recurrent costs allocations (annual average increases of 20% between 1983/84-1987/88). In 1986/87 recurrent costs accounted for over 78% of total MLGL contributions to the MCH/FP subsector, and this is expected to increase to 88% in 1987/88. It is in the area of MLGL MCH/FP development expenditures that we see real declines in funding levels. MLGL development spending for MCH/FP programs decreased an average of 10% each year since 1983. There are basically two projects overseen by the MLGL which affect the MCH/FP subsector. They are (1) Development of Basic Health Facilities (LG 20) and (2) District Health Teams (LG 49), both of them largely funded by donors.

(c) Central Statistics Office. The other component to the population sector besides MCH/FP programs is population analysis. In this area all financial allocations go to the CSO, which has expanded rapidly over the last five years. Through its recently established Demographic Unit, the CSO is now responsible for processing and interpreting all information on the demographic characteristics of the population. In 1984/84 population analysis activities constituted just 4.8% of total population sector expenditures; in 1986/87 they accounted for 14% of all sector allocations.

The expansion of the CSO can be seen in the fact that in 1983/84 its development budget was almost seven times greater than its recurrent budget, and in 1984/85 it was three and one half times greater. With the institutionalization of development projects, however, recurrent costs have once again become the principal expense for the CSO, 84% of total expenditures in 1986/87 and 1987/88. It should be noted here that the CSO does much more than demographic analysis. Therefore, just 50% of its recurrent costs have been attributed to the population sector. Total combined expenditures have increased an average of 93% annually since 1983/84. In addition, increased population analysis activities are likely to raise awareness about population issues in general, which should have positive ramifications for future MCH/FP funding levels. The CSO has two development projects in population analysis: the Continuous Household Survey Project (ST 19) and the Population Census (ST 07).

(3) Donor Financing in the Population Sector.

The principal donors in the population sector are USAID, the World Bank, NORAD, UNFPA and UNICEF. Total donor contributions between 1983/84 and 1987/88 were P2,402,736, or $1,526,939. Over the last 5 years donors have financed an average of 69% of all population sector development spending, and if we exclude 1983/84 this figure rises to 77%. More specifically, over the last three years the MCH/FP, Health Education, Nutrition, Basic Health Facilities, and District Health Teams Projects have been entirely financed by donors (except for 1985/86 when the GOB financed 16.5% of the Basic Health Facilities Project). Donor contributions to the population sector are expected to increase over the five-year period, 1985-1990, to $8,185,800. This includes at least 18 different MCH/FP and population analysis activities. Thus, we see not only that donor contributions in the population sector have been the principal means of financing development expenditures, but also that these contributions are increasing significantly.

USAID's population sector activities amount to almost $2 million between 1985-1990 (BOTSPA is proposed through 1993). In addition to providing contraceptives worth approximately $300,000 per year, USAID is funding population policy and analysis activities, as well as family planning training and operations management for primary health care services. UNFPA's programs are also specifically targetted at the population sector, with total assistance of $1.3 million between 1985-1990. Most of UNFPA's funding goes to population analysis activities, with some technical assistance and provision of contraceptives.

Through the Family Health Project (discussed above) the World Bank and NORAD are contributing $2,300,000 and $500,000, respectively, to the population sector. Most of this money has gone for technical assistance, construction and training, although the actual specific expenditures in this area are harder to identify because they are part of a broad project which encompasses more than the population sector. It is important to recognize the fact that other aspects of the Family Health Project (with overall funding of $18 million) contribute to the population sector, as well. By combining health and population activities both sectors benefit, so that final World Bank and NORAD contributions to the population sector are probably greater than $2,800,000.

UNICEF has also committed over $3 million to maternal and child health programs, including $63,800 in support to the CSO's Demographic Unit. This funding will cover the years 1987-91 and will include child survival, basic health and education, rural sanitation, technical support, and social statistics analysis. While these programs are primarily aimed at the health sector, and not at population issues per se, they are nonetheless important components to an overall population program.

(4) Remedies for Alleviating Constraint

While the GOB is allocating considerable recurrent resources of its own to the population sector, development spending is still financed primarily by donors. Moreover, GOB and donor expenditures are not enough, nor are they optimally allocated. A comparison of GOB family planning expenditures to those of other developing countries indicates that the GOB's overall family planning expenditures as a percentage of overall government spending and total health expenditures are less than those of many other developing countries. It also seems clear that the GOB may be allocating insufficient resources to MCH/FP recurrent costs, which jeopardizes past and present development projects in the sector. More specifically, there are a number of areas where increased GOB investment and financing should be undertaken. These include IEC, MCH/FP service delivery, and contraceptives. In order to alleviate the constraint relating to GOB financing for population programs the following areas need to be addressed by the GOB.

(a) Mix of Funding. Current overall GOB funding levels for the population sector are substantial although not fully adequate. This begins to reflect the GOB's increasing emphasis on population issues. However, there are some important gaps in population sector funding, which means that the mix of expenditures is suboptimal and that additional funds are needed. Until now the vast majority of population sector expenditures have been for infrastructure development (construction and furnishing of new facilities, purchases of vehicles) and quantitative increases in MCH/FP and population analysis services. Very little money has been spent on health education, family planning IEC activities, and overall service delivery investments. Expenditures for training programs in IEC and in operations management of the MCH/FP service delivery system have been extremely low. Qualitative improvements in family planning services and the clear need to reach beyond government health facilities require increased spending in these areas.

(b) Source of Funding for the Population Sector. If the GOB is to develop an independent, comprehensive population sector program it must assume more of the responsibility for population sector expenditures. This means two things. First, it should monitor more closely the financial resources going into the sector, especially from donors. Currently there is a great deal of unrecorded technical assistance and training resources, and a limited amount of commodities which are supporting the sector but are not included in MFDP records. Unless there is full awareness of all the resources going into the sector it is difficult to make arrangements to ultimately transfer donor financing to domestic financing. Likewise, there is a real danger that as donor financing phases out, the progress made with these additional resources will be lost as well. This is not to say that there should be a limiting of donor financing to the sector, rather there should be a systematic donor monitoring system by the GOB to

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measure overall resource levels and coordinate the GOB's financing requirements between them. Secondly, as donor funds continue to expand in the area of population programs the GOB should examine its own plans for assuming both the development and recurrent costs.

(c) Recurrent versus Development Expenditures. Although recurrent expenditures in the population sector have risen consistently over the last five years, they have not kept pace with development costs, particularly in the Ministry of Health, the principal ministry concerned with MCH/FP. While MOH MCH/FP development costs have been rising at an average annual rate of 83%, recurrent costs have been increasing at just 54.5% annually. Moreover, for recurrent expenditures to be sufficient they typically must increase even faster than development expenditures.

c. Limited Participation of NGOs and Private Sector in Population Programs

This subject is discussed in greater detail elsewhere in this PAAD. Basically, much greater participation is needed by the private sector and NGOs in carrying out the family planning effort. The Government has stated its desire to have the private sector more involved, and a variety of means outlined in the PAAD aim to help alleviate this constraint.

III. PROGRAM DESCRIPTION

A. Program Goals and Expected Accomplishments

The Government of Botswana's overall goal for the population sector is to reduce the high rate of population growth and to improve overall health status, especially for mothers and children. This goal seeks to achieve a balance between population growth and Botswana's resources.

The Botswana Population Sector Program Assistance has been designed as a five-year, $5.0 million dollar effort to assist Botswana to plan and implement improved population policies as well as more efficient and cost-effective maternal/child health and family planning services. The stated purpose of BOTSPA is to strengthen population programs and services in Botswana. The program will provide technical assistance, training, and sector assistance dollar disbursement and local currency to support this purpose.

At the end of the proposed five-year life of the program we expect to achieve various objectives as discussed starting on page 38. Performance indicators broken down as policy, institutional and structural to demonstrate achievement of the objectives are as follows (please note that these are closely related and that some performance indicators cover more than one area):

1. Policy Performance Indicators: A National Population Policy enacted and activities coordinated.

2. Institutional Performance Indicators:
   a. An operational population coordination office
   b. A more effective CSO Demographic Unit
   c. Contraceptives procured by MOH Central Medical Stores
   d. Improvements to contraceptive distribution systems
   e. Continuity of contraceptive supplies at all health facilities
   f. IEC Services expanded at National Health Education Units and at Districts.
   g. Increased staff development
   h. Integrated and extended MCH/FP/POP services
   i. Increased first FP service visits
   j. Increased "couple - years" of protection.

3. Structural Performance Indicators:
   a. Increased trained GOB manpower in population sector and GOB financing of population programs.
   b. Increased NGO and private sector participation in the population sector.

B. General Strategy

1. Sector Assistance Approach

The sector assistance approach starts from a review of the range of policies, programs, and activities which are now being used by the GOB in its efforts to reduce population growth. Based upon this review, AID has determined that its assistance should be provided to the population sector. For the purposes of this

Program, Botswana's population sector has been defined to include: family planning services as a component of integrated MCH/FP services; information, education and communication services; contraceptive logistics; training; demographic and sociological research and analysis; and associated operational policies. The Botswana Population Sector Assistance Program aims at assisting the GOB to make these areas more effective tools for designing and achieving its population objectives.

From the preceding analysis of Botswana's population sector, contained in Section II, three general categories of constraints have been identified which limit the GOB's ability to reduce Botswana's high population growth rate. These include: policy constraints, institutional constraints and structural constraints which will result in the long run in a reduced population growth rate.

The success of the sector assistance approach does not focus on the outcome of individual activities financed by BOTSPA, but instead on the demonstrable reduction in these sectoral constraints.

2. Focus on GOB Population Programs and Management

The GOB has formulated a clear set of objectives for the population sector (see Section II C). The GOB has also developed an extensive range of institutional resources and basic management systems which are fully capable of implementing expanded population programs if augmented with the requisite technical and financial resources. BOTSPA will provide these resources for existing and planned Botswana population programs in a way that fully utilizes the skills and competence of the GOB for day-to-day management and administration (see Section IV). This approach aims to maximize the developmental impact of the program on GOB institutions and, at the same time, economizes on the management requirements of USAID/Botswana.

3. Structure of the Sector Assistance Grant Program Components

The Sector Assistance Grant is structured into two parts: a Sector Assistance Component (Support Grant); and, a Technical Assistance and Training Component. Both components will be used to achieve common performance objectives for Botswana's population sector described above.

a. Non-Project Assistance Component

The Non-Project Assistance Component will provide the largest share of program resources and is designed to encourage the GOB to maintain momentum in improving its population policies and programs. First, it is intended to demonstrate to the GOB the cost effectiveness of increased investment in the population sector, with the ultimate aim of obtaining more generous allocation policies for the sector from domestic resources. Second, it is expected to encourage and support the GOB's efforts to introduce and implement improved population policies, especially the proposed National Population Policy and improved operational policies that support implementation.

A total of $3 million will be provided to the GOB under the Non-Project Assistance Component. These funds will be disbursed as performance based dollar disbursements in five separate tranches. Prior to disbursement of each tranche, the GOB must satisfy specified conditions precedent to disbursement (see Section V.A.). The conditions precedent are intended to encourage the GOB to take actions necessary to achieve the program objectives and, thereby, alleviate the identified sector constraints. Examples of verifiable indicators upon which USAID may rely in determining whether the GOB satisfies conditions precedent are set forth in Section III of this PAAD and will be included in an Annex to the Grant Agreement or in implementation letters. An illustrative timetable for satisfaction of conditions precedent and disbursement of each tranche of the sector assistance is set forth in Section IV D.

Dollars will be disbursed to Botswana's central bank as conditions precedent are met. Additionally, the GOB is required to open a Special Local Currency Account and deposit therein amounts of local currency equivalent to the amount of the dollar disbursements under this component. The local currency will be used for population sector activities or programs as jointly agreed to by the GOB and the USAID in the annual work plans. They will be used for budgetary support for the following kinds of priority activities: expanded awareness-raising and policy efforts; increased contraceptive procurement; expanded contraceptive distribution programs, including new trial systems; expanded IEC services; expanded MCH/FP delivery systems at the district level; expanded grants to NGOs for population-related services; and demographic research and household surveys.

b. Technical Assistance and Training Component

The Technical Assistance and Training Component will be used to provide the GOB with specialist skills and improve the technical capabilities of local staff in order to achieve the overall program objectives. It is expected that this component will be used by the GOB in a broad number of areas such as: external technical training the development of management systems and training materials, the design of IEC services, and policy analysis. The Technical Assistance and Training Component will be collaboratively programmed and administered by the GOB and USAID for specific technical assistance and training activities. (see Section IV). The TA and Training Component is essential to effective monitoring of this program, to a continuing policy dialogue, and to the establishment of a mechanism for analyses, training, and basic objectives in the program grant. This element of interaction between USAID and the GOB is indispensable to the success of the program grant. The TA and Training Component also provides the financing to support the management and monitoring requirements for the program (see Annex D for the budget).

C. Priority Areas Targeted by BOTSPA - Program Objectives

1. Criteria for Determining Priority

BOTSPA does not, and cannot, address all of the constraints in the population sector. Program objectives are proposed as the means for directing BOTSPA resources at alleviating or eliminating a

specific sectoral constraint. In determining program objectives for BOTSPA, the following criteria were considered: 1) the objective must significantly alleviate or eliminate one or more of the constraints identified by the program; 2) the objective must be broad enough to include significant investment and policy issues and, at the same time, narrow enough to focus program resources in a way that leads to a measurable output during the life of the program; and, 3) the objective must increase the GOB's institutional capacity to manage and administer population programs.

2. Description of Program Objectives

Seven objectives have been selected for the program. These objectives are described below. A section is devoted to each objective and is structured to provide a description of the objective, its relation to the major constraints identified in the population sector, and indicative levels of resources which will be applied to achieve the objective. With respect to the resources which are described it is important to differentiate between the those provided by the Sector Assistance Component and the Technical Assistance and Training Component. The Sector Assistance dollars will be budgeted by the GOB as any other budgetary resource available to it. Illustrative areas have been identified by the GOB for increased investment in the population sector which are required to meet these objectives and these are described in general terms below. The GOB will be responsible for determining the sources of financing for these areas and BOTSPA financing may or may not be used for these investments. By contrast the description of resources from the Technical Assistance and Training represent firm programming of BOTSPA funding to assist the GOB achieve the four selected objectives. The third category of resources described, GOB Contributions, represent the levels of finance the GOB (excluding donor contributions) is currently investing to achieve the program objectives.

a. Support the GOB Efforts to Develop a National Population Policy

(1) Description of Objective

Section II C2 described past and current GOB efforts to develop a national population policy. Included in the development of this policy are plans to continue activities aimed at awareness-raising among the country's leadership, building consensus for the national policy, and establishing a population office responsible for the coordination of operational policies and implementation plans. The objective of this component is to provide technical and financial support to GOB institutions which are developing, and which will carry out the policy.

The national population policy and associated implementation plans will assist the GOB in defining its commitment to lowering Botswana's high population growth rate (as a critical means of improving MCH status and development prospects in general). A National Population Policy which is the ultimate aim of this objective, will also provide specific guidelines to the public and private sectors for achieving the policy goals.

(2) Impact on Alleviating Constraints

The successful implementation which is to support the GOB's efforts to develop a National Population Policy, will relieve several constraints inhibiting the GOB's efforts to reduce the rate of population growth.

(a) This objective directly responds to the lack of a policy framework for expanding population programs in Botswana and is expected to produce two important policy products. First, the development and endorsement of a National Population Policy will provide the main pillars of the policy framework required by the GOB to plan and coordinate all population policies and expand population programs. Second, the NPP and follow-up policy work will provide sectoral guidelines and operation policy analyses for ministries and agencies involved in supporting and expanding MCH/FP services.

(b) The principal institutional impact of implementing Objective 1 will be to help the GOB identify an institutional base responsible for coordinating population policies and programs. Another institutional product of successfully implementing Objective 2 is more effective demographic analyses from the Central Statistics Office. These analyses provide critical information for targetting MCH/FP programs (i.e. IEC, contraceptive distribution, etc.) as well as monitoring and measuring their effectiveness.

(c) The limited participation of NGOs and private sector firms in population programs and inadequate GOB financing for population programs will both be addressed. It is anticipated that during the development of the National Population Policy, a clear role for NGOs, including the private sector, will be developed by the GOB. Likewise, the implementation of the NPP will assist the GOB identify priority areas for increasing its investment in the sector.

(3) Program Resources Required

(a) Sector Assistance

Both the National Parliamentary Council on Population and Development and the Interministerial Working Group have planned a series of activities to carry out the recommendations of the two major population conferences. In order to achieve the BOTSPA program objective related to population policy the GOB has identified the following areas for increased investment, which may be financed from the Sector Assistance Component:

- District Workshops and Awareness-raising Activities: As noted in Section II C2, the Council and Working Group intends to sponsor a series of District-level workshops for local leaders in order to build national consensus for a Botswana population policy. This would involve up to ten regional workshops over several years, and would require a presentation of the Botswana RAPID model at each. These workshops, or similar consultative activities, would also require the time of individuals to give papers and lead discussions. Such an activity would be difficult to undertake without two or more

permanent staff to arrange the details of the workshops. The recent UNFPA agreement contains a small amount of funds for "awareness creation, and policy seminars." In addition, A.I.D.'s OPTIONS Project has several person-months of technical assistance and small amounts of local funds available. Additional technical and financial resources would be necessary to carry out this activity.

(b) Technical Assistance and Training

The GOB and USAID have programmed considerable amounts of short term technical assistance and training to support the GOB's efforts to develop a National Population Policy and establish a coordination mechanism for population policies. Specialist technical skills are critical to carry out tasks of demographic analysis, policy options, etc. At the same time it is important to pass these skills on to the Batswana through training. The following resources will be financed through the Technical Assistance and Training Component:

o Observational Travel: Learning from the experiences of other African leaders who are developing and implementing population policies has proven to be invaluable to a number of sub-Saharan African countries. Observational travel offers the potential of firsthand consultations with other leaders that have gone through the same process, and to learn which approaches are productive and which to avoid. Recent observational travel by Sudanese officials to Nigeria, Kenya, and Tunisia were considered to be the critical input to that country's decision to develop a national policy and establish a coordinating office. Such learning experiences would also benefit Batswana public and private sector leaders. Two or three trips of four people each is recommended. Projected budget: $75,000.

o Technical Assistance for National Policy Development: Technical consultants can play an essential role in the development of both national population policies and operational policies and in preparing implementation plans. The OPTIONS Project has provided some support in this area, and is prepared to provide more. Similarly, the UNFPA HAS additional funds for technical assistance in the policy development area. Support for the first year of the grant would come from these existing sources. For subsequent years the grant would provide technical assistance for additional work on the NPP. Projected budget: $45,000.

o Technical Assistance for Operational Policies: There are also a number of operational policy areas which need further exploration to understand their feasibility. One such area involves the roles of the private sector in family planning. The GOB has had a long-standing operational policy to work closely with the private sector in health care. The delivery of health care in the private sector has included family

planning services, most of which has been subsidized by the GOB. Given potential future resource constraints and demonstrated success in other countries in involving the private sector in support of family planning objectives, feasibility studies along these lines would be useful. In addition, there are operational policies in some of the line ministries which could benefit from short-term technical assistance. For example, operational policies in the MOH are currently overseen by a Family Planning Technical Advisory Committee which coordinates the ministry's activities, sets priorities and establishes service delivery policies. To continue its vital role in developing effective operational policies, the MOH could utilize the services of a short-term technical advisor who would train MOH staff in the analysis of demographic, health, and program data, and work with the Technical Advisory Committee. The improvement of MOH capacity in operational policy analysis would greatly improve the efficiency of the MCH/FP sub-sector and the population sector as a whole. This potential activity would logically follow on the present IBRD/NORAD consultancy to the Health Planning Unit which will end in year 2 of this Program Grant. Projected budget: $135,000.

o Implementation of the National Population Policy: When a national policy is promulgated and the GOB establishes a coordinating office, there will be a need to support its implementation beyond just the MCH/FP sub-sector. This would be a function of the new GOB coordinating office and the relevant ministerial units. Short-term technical advice to any new GOB office responsible for the population sector would be of great assistance in carrying out the national policy and in incorporating consistent operational policies into future National Development Plans. Projected budget for the last three years of the Program grant is $90,000.

o Demographic Analysis: The CSO will carry out activities critical to the population sector during the life of this grant. As noted, CSO financial and human resources will need to be bolstered to achieve CSO data collection and analysis objectives. This component would provide technical assistance in the analysis of demographic and health data beyond the planned DHS work in 1988, further analysis of the 1986-87 Demographic Survey and the 1991 National Population Census. It would also include training for CSO staff in order to raise the general skill level of the Demographic Unit's professionals. There are several centrally-funded projects that could provide excellent technical assistance and training for this component including the OPTIONS Project, Westinghouse, and the U.S. Bureau of the Census. Projected Budget: $300,000.

(c) GOB Contribution for Policy Activities

One of the largest expenses incurred by the GOB in the population sector will be in collecting and analyzing data and information on the population sector. The annual budget of the

Central Statistics Office is fifty percent attributable to the population sector. Likewise, the GOB's share of the upcoming 1991 Census and the Continuous Household Information Project are attributable to the population sector. Together, these contributions represent P4.6 million over the five-year Program grant period.

The GOB contribution also includes the staff time of high level officials including members of parliament and ministers. In addition, a number of other senior officials from the MOH, MLGL, MOE, MFDP will be involved in various policy development activities from time to time. The consultative process to be supported by this grant and any office established by the GOB to oversee the population sector will require the provision of facilities. These contributions have not been included in the calculation of the GOB's financial contribution.

b. Improve Coordination among GOB Institutions Dealing with Population Programs

(1) Description of the Objective

In addition to various international and bilateral donor agencies and sub-groups involved in varying aspects of Maternal-Child Health/Family Planning/Population Activity Programs, many GOB ministries, agencies, departments, and divisions are involved. From an institutional development perspective, policy coordination will evolve from the drafting promulgation and implementation of the national policy. The institution to accomplish this, perhaps a National Population Council and Secretariat, will assist in improving overall coordination, implementation of policy and programs and for undertaking expansion efforts.

o Support for "Office of Population and Development" or Coordinating Group National Population Council/Secretariat: In the event that the GOB promulgates a National Population Policy, it will be necessary to establish a management or coordinating office. This activity may require two or three professional staff, one or two support staff, at least two microcomputers, an office budget, and an activities budget to include local consultants. Even before the promulgation of any national policy, core costs may be incurred. These would include personnel and operating expenses for the Working Group and for the National Council of Parliamentarians. These costs would include the expenses of the Working Group for policy development activities beyond the workshops above, and for any coordinating activities associated with this grant, other donors, or other population sector activities.

(2) Constraint

The present lack of effective coordination among various population efforts must be overcome.

c. Improve the Contraceptive Logistics System

(1) Description of the Objective

From the discussion in Section II C it should be clear that a well-functioning contraceptive logistics system is a fundamental to the GOB's efforts to reduce the rate of population growth. Until a sufficient and continuous supply of contraceptive can be made available to Batswana couples, all of the other interventions (i.e. improved policies and information) cannot be effective. As such it has become the first priority in the proposed program of assistance.

The program objective for the contraceptive logistics system is comprised of three elements:

- A full range of contraceptives, in accordance with GOB approved methods, is available to the public in all health facilities.

- Non government organizations, including the private sector are being used to distribute contraceptives.

- The GOB has undertaken a major, long-term financing role in contraceptive procurement.

The first part of the objective focuses on a smooth-running contraceptive logistics system that ensures a continuous supply of contraceptives at each service delivery point in the MCH/FP service delivery system. As indicated earlier, there is a need over time to shift the mix of family planning methods so that the method used by each contracepting couple is most appropriate to their needs. As the MCH/FP program adapts to make available more permanent methods, the logistics system must be prepared to meet the demand. Similarly, as suggested in the discussion of the constraint, there is a need to streamline the current contraceptive ordering/storage/distribution system, based on a number of mechanisms which are planned and in process for monitoring and ordering contraceptives.

The second part of the objective, highlights the opportunities for community groups, private sector firms, and non-governmental organizations to distribute contraceptives both increase the physical area covered and the range of couples served.

The third part of the objective stresses the importance of GOB control over the contraceptive logistics system in order to ensure continuity of supply. This requires a long-term commitment and assurance of funds for family planning commodities that are critical to a priority GOB development program.

(2) Impact on Alleviating Sectoral Constraints

The successful implementation of this objective will significantly alleviate several constraints (identified in Section II above) which are inhibiting the GOB's efforts to reduce the

population growth rate. In this regard, the improvement of the contraceptive logistics system will have the following specific impacts.

(a) As part of its effort to improve the contraceptive logistics system, the GOB will make significant changes in its operational policies. First, the achievement of this objective strengthens the GOB's operational policy for integrating contraceptives into the overall Central Medical Stores procurement and distribution system. Second, the GOB intends to modify its current operational policies for distributing contraceptives to utilize non-government channels for distributing contraceptive supplies.

(b) The objective to strengthen the contraceptive logistics system is critical to overcoming the institutional constraints of the MCH/FP service delivery system. Adequate and reliable supplies of contraceptives will improve the efficiency and credibility of the staff at clinics and health posts and ultimately increase the numbers of family planning practitioners. Some of the institutional products which are anticipated from the achievement include the following: improved procedures for ordering, storing, and prescribing contraceptives; training materials for staff, and an increased capacity for Central Medical Stores.

(c) The successful implementation will also address some of the structural constraints identified in Section II. Once the operational policies for using NGOs to distribute contraceptives are in place, the GOB will be able to pursue alternative contraceptive distribution channels with community groups, commercial firms with large numbers of employees, and private sector retailers. Also, the design of Objective 1 requires an increasing share of the contraceptive costs to be assumed by the GOB. This represents a major new commitment of resources to the population sector, and should establish an important precedent for further sector support.

(3) Program Resources Required

(a) The GOB has identified three areas, related to the contraceptive logistics system, where additional investment will be required to meet the program objectives of BOTSPA. These include contraceptives, other commodities, and local training costs. Dollar disbursements provided under the Sector Assistance Component may be used to fund some portion of these:

- The purchase of five years supplies of contraceptives. (In addition, funds for contraceptives during the first year of the program will be provided through AID centrally-funded sources at no cost to the Botswana grant.) This includes pills (except the standard-dose pill), IUDs, and condoms.

- In order to expand the channels available for the supply of contraceptives in the private sector, the MOH Occupational Health Unit is planning to implement a trial program using

vending machines in selected industrial establishments. If this trial program is successful the MOH anticipates expanding the number of firms and vending machines. This will require that the GOB purchase additional vending machines.

o As indicated earlier, the CMS ordering, storage, and distribution system will be streamlined, based on revised mechanisms for ordering and monitoring stock levels at the facility level. The GOB will be required to fund the local costs of developing the new forms and procedures, as well as carrying out the training required to initiate the revisions.

(b) Technical Assistance and Training

The GOB and USAID have programmed short-term technical assistance support to improve the contraceptive logistics system. This support will be financed from the Technical Assistance and Training Component and includes the following:

o To support this streamlining of the logistics system, the program will provide $60,000 for short-term technical assistance. In view of the resources available from AID centrally managed projects in this area (for example, the joint effort by the Centers for Disease Control and John Snow Incorporated), they are a likely source for this short-term assistance.

(4) GOB Contributions

In order that increased GOB support for contraceptives can be realistically added to the recurrent budget, it will be phased in during the life of the program. Given projected contraceptive use and cost, and with a GOB share of P50,000 in year 2 and P60,000 in year 3, P270,000 in year 4, and P550,000 in year 5, the total GOB contribution for AID provided contraceptives during the grant period will be approximately $600,000. In addition, with the GOB beginning to purchase a standard-dose pill in 1988, this will add a further GOB contribution during the grant period.

d. Expand IEC Services

(1) Description of Objective

This objective will support the GOB efforts to expand and upgrade IEC services through the MOH, other ministries and the private sector, including NGOs. The purpose of an expanded and improved IEC program is to increase the quality and quantity of informational and motivational FP materials and broaden the targets for information and the distribution channels used to disseminate the information. The results of this effort will be to: a) increase the awareness of the population on family planning; b) motivate greater numbers of Batswana to use FP methods; c) increase the demand for FP services; d) improve the rates of continuation; and e) improve the method mix.

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The upgrading and expansion of IEC materials, targets and distribution channels will help to increase voluntary usage of modern contraception, improve method mix and alleviate high rates of discontinuation. The increased availability of clear and accurate information on each method of modern contraception will make it easier for primary health care personnel to counsel potential and continuing users in their homes and workplaces. At the clinic, improved visual aides will assist health workers to explain the advantages and disadvantages of each method to patients, enabling patients to make more informed decisions about the FP methods they use. Improved communication skills on the part of the health worker will enable improved clinician-patient interaction.

Another important advantage of improved information is that couples can make better informed choices about the best method of contraception to use in their particular circumstances. At a young age and low parity, couples may select a temporary method that allows a rapid return to fecundity when the couple so desires. Couples who have reached higher parity may, other things being equal, select methods which are more reliable such as IUDs, injections and implants when they feel they have reached their desired family size. Those couples that are sure that they have achieved their desired family size should be accurately apprised of the advantages of voluntary surgical contraception.

(2) Impact on Alleviating Constraints

The successful implementation of Objective 3, which is to expand IEC services, directly addresses one of the principal institutional constraints identified in Section II. It also alleviates some of the other constraints.

(a) This objective supports the development of improved operational policies to increase the channels of IEC dissemination through both public and private channels. One important means of reaching the maximum number of couples is through non-governmental organizations such as church groups, athletic associations, womens' groups, and cooperatives.

(b) The principal institutional impact will be to expand and upgrade the capabilities of the Health Education Unit in the Ministry of Health. By achieving this, it will be possible to the quality, quantity, and availability of information to support IEC activities will be improved. Another institutional target is to broaden the audience for IEC programs to include men and teenagers, especially those who are likely to be influential in their peer group. The successful achievement will also improve the district health education programs. These programs directly support the MCH/FP services provided at the village level.

(c) The limited participation of NGOs and private sector firms in population programs will also be addressed. This objective will encourage and support non-governmental organizations and private sector firm. which are interested in providing IEC programs directed at the population sector.

(3) Program Resources Required

(a) Sector Assistance

The GOB has identified three areas where additional investment will be required to achieve the BOTSPA's program objective of expanding IEC services. These include: commodity and equipment procurement, local training costs, and core support for printing, reproduction, researching, and workshops. Resources provided under the Sector Assistance Component may be used to support the following:

o Commodities and Equipment: To improve the capacity of the Ministry's Health Education Unit, there is a need for audio-visual equipment, vehicles for field teams and inservice training, printing equipment, paper, graphic art supplies, general office equipment such as typewriters and duplication machines, as well as for vehicle petrol and repair.

o Local Training Costs: In order to maximize the impact of newly-developed and tested IEC materials on family planning, the Family Health Division will need to conduct training courses for Health Educators, FWE's and primary health care personnel, as well as for personnel from other ministries, NGOs, and the private sector.

o Core Support: The MOH Midterm Evaluation of NDP VI states the need to conduct qualitative research into Batswana attitudes and behavior with respect to family planning, on which to base the development of new IEC materials, both informational and motivational. An increase in the numbers of materials produced will require additional GOB financing for printing costs for pamphlets, posters and manuals. Seminars, workshops and "family planning days" need to be instituted, as well as intersectoral workshops and presentations with NGO's, other ministries, and the private sector. Resources for researching, developing and producing media campaigns, as well as media placement costs, are also required.

(b) Technical Assistance and Training

The GOB and USAID have planned to provide long term technical assistance, short term technical assistance, and external training programs in support of the BOTSPA program objective to expand IEC services. The following resources will be financed through Technical Assistance and Training Component:

o Long-Term Technical Assistance: The services of a long-term IEC Advisor will be financed for the first three years of the grant. The Advisor will provide technical expertise to IEC development and improvement and to provide inservice training to Batswana staff. (See Job Description in Annex C) The individual would be assigned to the Health Education Unit. The estimated cost is $375,000.

o Short term Technical Assistance: For specific technical tasks financing is provided for short term technical assistance.. This could include, for example, conducting formative (qualitative) research, analysis of qualitative data, materials development, or evaluation of IEC activities. Six person months of technical assistance are anticipated over the life of the project, with an estimated cost of $90,000.

o Peace Corps Assistance: Based on discussions with HEU staff, the need for additional assistance in the areas of media production (i.e., radio, video) and graphic arts was identified. Peace Corps has tentatively confirmed their interest in supporting this USAID program, if they receive a formal request from the GOB. This proposed support of two Peace Corps Volunteers (PCV) would fill a critical role identified by the HEU which is not addressed in this PSG.

o Training (External): Third-country training for Batswana staff is planned for up to seven months in the fields of qualitative research design, implementation and analysis; media design and production; and in other IEC-related areas. In addition, one year diploma courses for three IEC staff members could be supported under this budget. The estimated budget for external training is $60,000 for the life of the grant.

(c) GOB Resources Required For Expanding IEC

At present the GOB budgets an estimated P66,290 annually for the professional staff of the Health Education Unit. It is spending an estimated P40,000 annually for the Health Education Unit's recurrent non-salary expenses. Attributing sixty percent of these costs to the MCH/FP work represents a P529,660 contribution over the life of the program. In support of this program sector grant, the GOB will also contribute office space. Assuming the request for the Peace Corps Volunteers goes forward, the GOB support would also include that traditionally given to PCVs.

e. Improve the Delivery and Management of MCH/FP Services

(1) Description of the Objective

The objective of this support is to ensure that a full range of quality FP services is offered by all family planning service providers, corresponding to the type and number of staff at each service delivery point.

(2) Impact on Alleviating Constraints

The successful implementation is to improve the delivery and management of MCH/FP services, responds to the limited availability of MCH/FP clinical services and also strengthen important operational policies related to staff training and deployment.

(a) One of the targets is to develop improved operational policies for staff training, deployment, and supervision. Another operational policy which will be strengthened through implementation will relate to the delivery of MCH/FP clinical services by non-government organizations.

(b) The principal institutional impact will be to expand MCH/FP services. This will be accomplished by upgrading the facilities at the delivery points and improving the capability of the clinical staff by better training, supervision, and support equipment. This objective will support the GOB decentralization of health services which is transferring District Health teams from the MOH to MLGL.

(c) The implementation of Objective 4 will increase the participation of non-government organizations in the sector by providing direct support to non-government organizations and private firms for delivering MCH/FP clinical services.

(3) Program Resources Required

(a) Sector Assistance

The GOB has identified three areas where additional investment will be required to achieve the BOTSPA's program objective of improving the delivery and management of MCH/FP services. These include: support for district MCH/FP services and grants to non-governmental organizations. The resources provided under the Sector Assistance Component may be used to provide the following:

- Support for District MCH/FP Services: One important aspect of improved management and support of MCH/FP services is the to ensure that the transition from Regional Health Teams to District Health Teams proceeds smoothly and effectively. Since most services are delivered and managed through town and district councils, the GOB will be required to provide financing to meet critical needs in support of this transition. For example, rennovation of facilities to accommodate expanded District Health Teams and equipment repair and maintenance are all anticipated. In addition, financing will be required for the purchase, operation, and maintenance of vehicles to support strengthened district-level management and supervision. In order to increase effective MCH/FP services in rural areas, there is also a need for basic rennovation of health posts and/or shelters to accommodate waiting mothers at clinics with maternities.

(b) Technical Assistance and Training

The GOB and USAID have programmed short-term technical assistance and training in support of the BOTSPA program objective to improve the delivery and management of MCH/FP services. The following resources will be financed through Technical Assistance and Training Component:

- Monitoring MCH/FP Programs: Short-term technical assistance ($115,000) will be provided in the management area. This will include assistance to improve the monitoring and evaluation capabilities of the MCH/FP Unit, in order to strengthen the capability to measure progress and provide feedback to health workers and facilities.

o Management Training: Funds for training ($46,000) will include training of the Family Health Division, to institutionalize the expanded program management and monitoring capabilities. External assistance in support of short-term training courses will also be provided in areas of priority need.

(3) GOB Resources Required To Improve MCH/FP Delivery:

GOB requirements to assist in meeting this objective are generally recurrent budget expenditures in support of existing staff and service delivery. Based upon a forty-five percent attribution of the MOH Primary Health Care Budget, the GOB contribution to the Program is approximately P14.1 million over the five year period.

f. Increase the Number of Trained Staff for Population Programs and Increase GOB Financing in the Population Sector, Particularly for Contraceptive Procurement

This objective will play a major role in overcoming various constraints, and is closely linked to the institutional objective of improving the delivery and management of MCH/FP services. This objective focuses on the GOB commitment to population programs through the overall number of trained staff assigned to management and implementation, and amount of additional funds allocated to the sector, particularly in FP contraceptive procurement.

Already, the GOB is committed in existing staff and recurrent budget to an ongoing program of some magnitude. Even with the proposed AID contribution of $5 million, the GOB contribution to total 5 year program costs equals 71%. But more needs to be done. Key managerial and technical positions need to be created, individuals recruited and trained. To implement the policy and Institutional objectives already outlined, major financial resources are required as the policy dictates, the population sector and program expand, and as donor financing and technical assistance phase down.

g. Expand Participation of NGOs and the Private Sector in Population Programs

The final structural objective of BOTSPA is also closely interrelated to the Policy and Institutional objectives (see previous detailed discussions). Family Planning and Population Programs are national in scope and require the cooperation, coordination, and, obviously the participation of everyone.

Botswana has several PVO/NGO groups fully involved on the periphery and willing/able to be responsive. Many are already being integrated to MOH training workshops and seminars on various linkages with FP programs. The growing private sector, with its critical human resource needs, also has a major role to play in the structural changes necessary to successfully implement a national policy. One such objective may include Contraceptive Social Marketing of non-medical FP resources within three or four years. These are already available in registered pharmacies, but are yet available in this manner to the vast majority of the population.

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o Grants to Non-Government Organizations. In order to support the principle of expanding MCH/FP services through alternative delivery channels, the MOH requires financing to strengthen the programs of NGOs in the population sector. For example, both the Botswana Red Cross and the proposed new Botswana Family Welfare Association would seem to offer effective private sector channels. The MOH is examining mechanisms for providing financial support to these organizations so as to increase MCH/FP services that will complement GOB efforts.

D. Performance Targets

1. Purpose

The previous section has identified some of the specific policy modifications, institutional improvements, and structural shifts which are anticipated during the implementation of BOTSPA. These targets will be monitored through the conditions precedent to each disbursement of the Sector Assistance Component.

The more important issue is as to whether taken together they make a significant contribution to the sector. In order to prepare for that question BOTSPA includes specific quantitative indicators, referred to as performance indicators, which measure, either directly or indirectly, the progress of each of BOTSPA's seven program objectives. Performance targets will be used by BOTSPA for two purposes: 1) to establish targets for the program which are jointly agreed by the GOB and A.I.D and can be used to guide the management of the program; and 2) as measurements of performance in the sector.

In selecting the indicators which best measure program performance, several important factors have been considered. First, the indicator involves direct measurement or a proxy therefore. Second, the indicator is as simple as possible. Third, the indicator is measurable by using data that are routinely collected.

2. Selecting End-of-Program Status (EOPS), Program Objectives and Indicators

It is impractical to establish firm performance targets for the entire five-year life of the program. Some of the program objectives require the GOB to develop and implement national policies which will require substantial internal consultations which cannot be tightly scheduled in advance. Flexibility is important to ensure that the consultation and consensus process is satisfactorily concluded, since previous experience in Botswana and elsewhere has demonstrated the importance of building a popular base for policy decisions.

For this reason, firm performance targets will be established for the first year in this document. Targets for subsequent years will be described at the same time; however, these targets will be reviewed on an annual basis and are subject to modification by mutual agreement of the GOB and USAID.

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a. Program Objective No. 1 EOPS and Indicators

-An improved policy framework for population programs (National Policy drafted, promulgated, and under implementation).

o National Population Policy enacted and activities coordinated.

o More effective Central Statistics Office Demographic Unit.

o Commitments to encourage NGO and private sector participation in population sector.

Discussion:

The realm of policy development is not amenable to quantification as are the other objectives of this program. Because policy analysis, policy development, policy evaluation and policy reform are ongoing processes in all development settings, there is rarely an end product in policy work. As envisioned in this program, national and operational policy development will be a continuous process; therefore, the process itself is necessarily the outcome of this objective. Subjective performance indicators will focus on evidence that policy development is occurring, and will include elements of the following:

o Evidence that public consultations and policy analysis are being utilized by the GOB to develop a national population policy; including regular meetings of the National Population Council and the Technical Committee.

o Evidence that population factors are reflected in sectoral planning and in the implementation of GOB development programs; and ultimately

o Evidence that the GOB has determined a national population policy that provides operational guidelines and an institutional base for implementing the strategy.

b. Program Objective No. 2 EOPS and Indicators

-Efficient and effective national, regional and district level coordination of all MCH/FP/Population activities.

o Implementation of a National Population Policy by coordination units, possibly a national population council and secretariat.

o Better coordinated activities both from external donors and for internal programs.

c. Program Objective No. 3 EOPS and Indicators

-Overall strengthened support systems for MCH/FP/POP services at all levels of service (hospitals, clinics, and health units).

o Central Medical Stores procuring adequate contraceptives for population programs and activities.

o Improved contraceptive distribution system.

o NGO contraceptive distribution system.

o Number of health facilities with continuous supplies of contraceptives increased.

Discussion:

This objective is designed to ensure that a full range of contraceptives is available to the public at all health facilities. The indicator chosen to measure this objective is the number of health facilities that do not have outages of any type of contraceptive normally stocked and dispensed, during any month of the program year being reviewed.

This indicator has been chosen because it essentially meets all three criteria indicated -- directness of measurement, simplicity, and availability from routinely collected statistics. However, given identified modifications in logistics system reporting procedures which are to be developed and implemented during 1988, the necessary statistics will not be routinely available from individual facilities until towards the end of 1988. Therefore, measurement of this indicator for 1988 will be on the basis of statistics from Central Medical Stores only; that is, reflecting the national level and not individual health facilities. With the introduction of the new forms and procedures, the needed statistics will be available routinely for year 2 and thereafter.

It is recognized that this indicator does not fully reflect the strategy of the MCH/FP Unit to expand FP service delivery beyond the limited number of static health facilities through alternative FP service delivery points (e.g., private practitioners, the workplace, and the community). Thus in order to encourage efforts to expand the availability of contraceptives, the MOH can include as many alternative FP delivery points as they wish (along with health facilities) in meeting this target in a given year.

The base number of facilities for this indicator is 402 (1986 figures), which includes 15 hospitals, 10 health centers, 150 clinics, and 227 health posts. The year 1 indicator, which will be applied only at the CMS level, is that there will be no outages at CMS (once the Noriday is in stock). The annual performance targets that apply to facilities will begin in year 2, as follows: 165 facilities for year 2, 275 for year 3, 325 for year 4, and 382 for year 5. (Note that 382 equals 95 per cent of all facilities existing in 1986.)

d. Program Objective No. 4 EOPS and Indicators

--Overall strengthened IEC support systems for MCH/FP/Pop within public and private sectors.

- Improved IEC Services from an expanded HEU.
- Strengthened IEC in District Health Education Programs.
- NGOs supported to develop and disseminate IEC materials.
- Increased first visits for FP services.

Discussion:

Measurable indices of successful IEC initiatives should be first and foremost an increase in the numbers of new clients seeking FP information and services. If more clients seek out FP services, one could reasonably conclude that improvement in IEC activities, messages, and materials has motivated this increase. This indicator will be used to measure the performance of the GOB in meeting this objective.

The specific indicator for measuring the effectiveness of IEC initiatives under this program will be the percentage increase in first visits for FP services, as compared with the previous year. This is a direct and simple measurement since "first visits" is a statistic routinely collected on a monthly basis in the MCH/FP program.

It is recognized that this indicator does not reflect all the different impacts of the IEC programs. For example, current IEC emphasis is to improve continuation of FP use. This includes improving counseling so that women choose an appropriate method, understand how it works, and have an idea of possible side effects so that they are more likely to continue to use the method. This emphasis focus on increasing revisits rather than only first visits. Another current IEC focus is to assist with family life education in the schools, which is directed toward future users rather than present ones. The actual targets established for new visits take these other emphases of the GOB's IEC programs into account so that the levels to be achieved are realistic.

Similarly, historical and current data may incorporate a modest overstatement of first visits, since up to the present time a clear definition of "first visit" has not consistently been used. For example, there is evidence that a "first visit" has occasionally been interpreted as the first visit this year, the first visit since the last pregnancy, or the first visit for this method. This inconsistency has been recognized for some time by the MCH/FP Unit, and steps are already being taken to resolve it both through increased emphasis during MCH/FP supervisory visits and through additional follow-up by the Health Statistics Unit.

According to provisional statistics from the MCH/FP Unit, the percentage increase in first visits from 1985 to 1986 was 19 per cent. Since provisional statistics are not yet available for 1987, it is not possible to develop the percentage increase from 1986 to 1987. However, based on available information on the issuance of contraceptives from Central Medical Stores in 1987, it appears that

the percentage increase in FP first visits during 1987 will be at least as high as the previous year. Taking this into account, the performance targets (percentage increase over previous year) for successive years of the program are as follows: 15% in years 1 and 2, and 10% in years 3, 4, and 5.

While these performance targets are lower than the increases experienced in the last two years, they are reasonable given the factors just discussed. Perhaps more important, the performance targets are likely to yield an outcome that falls between two stated targets of the GOB. On the one hand, NDP VI sets a target of 25% prevalence rate for modern contraceptives by 1991. On the other, in view of the apparent progress in increasing contraceptive prevalence since the 1984 Family Health Survey, the operational target of the MCH/FP Unit is to reach 30% modern contraceptive prevalence by 1991. The performance targets for this program objective are likely to achieve a result somewhere between these two.

As indicated above, there is the approximately one-year lag in the availability of provisional statistics from which the indicator is calculated. This means that for year 1 (1988) the base year is 1986 and the comparison year is 1987. Thus the target for year 1 is the percentage increase from 1986 to 1987, and so on for future years.

e. Program Objective No. 5 EOPS and Indicators

--Overall strengthened support systems assisting in delivery and management of MCH/FP/POP services significantly expanded to meet 100% of needs.

o Integrated MCH/FP services at all health facilities.

o Strengthened operational policies for staff deployment and training.

o Expanded use of NGOs and private sector in activities planning and implementation.

o Decentralization of local level health services from MOH to the Ministry of Local Government and Lands.

o Increased "couple-years" protection (CYP).

Discussion:

A strengthened MCH/FP system focuses on improving the management and support of services. The underlying goal is to improve the quality and quantity of MCH/FP services available, and thus to increase the number of couples using family planning. One of the best indicators for measuring increased FP service utilization is the concept of couple-years of protection. This measure uses the quantities of contraceptives dispensed, takes into account the method used, and determines the number of years of contraceptive protection provided to each couple using that method. For example, since women using the pill will need an average of 13 cycles of pills each year, this represents one couple-year of

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protection. A factor must be incorporated to account for contraceptives dispensed and not used, and this will vary by method. Other adjustments may also be required depending on the method; for example, an estimate of the use of condoms solely to prevent transmission of Sexually Transmitted Diseases (STD). Also, a "wastage factor" should be incorporated to account for contraceptives which never reach the client, owing to such things as deterioration or exceeding the expiry date. Once such adjustments have been made based on reasonable assumptions, couple-years of protection is a very effective way of measuring the use of family planning services.

There are two minor problems with using couple-years of protection as a program indicator. The statistics needed to measure CYP will not be routinely collected at the individual facility level until later in 1988. Also, once the new forms are in use there will be a one-year lag in the availability of the provisional statistics from these facilities. Thus it will be necessary to use figures from Central Medical Stores (i.e., quantities dispatched to health facilities) for program years 1 and 2. By year 3 the necessary statistics will be available so that the comparison can be made for contraceptives dispensed at the individual facility level.

The specific indicator will be the percentage increase in CYP as compared with the previous year. According to the unadjusted statistics available from CMS for quantities of contraceptives dispatched in 1986, there were approximately 66,000 CYP provided. Similarly, there were an estimated 85,000 CYP in 1987, or an increase of nearly 29 per cent. This increase is inflated, since it does not include adjustments for wastage at the facility level, the use of condoms for solely STD protection (including AIDS), possible net increases in facility stock levels, etc. Once these and other relevant factors are taken into account, the actual percentage increase would be considerably less. Therefore, the performance targets (percentage increase over previous year) for successive years of the program are as follows: 12% for years 1 and 2, and 10% for years 3, 4, and 5.

As with the use of targets for increases in first FP visits, the targets should be realistic not only in terms of what can reasonably be accomplished but also in relation to the national targets for contraceptive prevalence. Using the more optimistic operational target of the MCH/FP Unit, a contraceptive prevalence rate (CPR) of 30 per cent would be achieved by 1991. Based on the estimate for women of reproductive age in 1991 (324,900), a CPR of 30 per cent for modern methods would correspond to approximately 98,000 women. Once the necessary adjustments are made, the performance targets will reasonably reflect this GOB target.

f. <u>Program Objective No. 6 EOPS and Indicators</u>:

-Overall increased GOB financing of resources for population programs.

o Increased resources for expanding, and training, manpower resources for population program staff requirements.

o Increased financing of contraceptives (non-donor).

Discussion:

The National Population Policy and implementing/coordinating mechanisms (a Population Council on Coordination Board) will determine the magnitude and scope of training needs and manpower staff requirements. At least five long-term degree/diploma training will be offered in addition to short-term observational and invitation travel opportunities. A total of $181,000 from the project component side has been reserved for training. Total numbers of GOB staff to be assigned to population programs and implementing activities will be determined.

Another critical factor for improving the contraceptive logistics system is that the GOB undertakes a major, long-term financing role in contraceptive procurement outside and beyond those financed by bilateral or international donors. The indicator chosen to measure progress in meeting this objective is a targeted amount of financing to be provided by the GOB from non-donor sources for contraceptive procurement during each program year. For this indicator the annual targets are 0 for year 1, P50,000 for year 2, P(0,000 for year 3, P270,000 for year 4, and P550,000 for year 5. These targets will be monitored through the overall contribution of the GOB to the BOTSPA Program.

g. Program Objective No. 7 EOPS and Indicators:

-Overall expanded and effective participation of NGOs and private sector entities in population programs.

o Attendance by NGOs and the private sector in FP/Pop workshops and seminars.

o Possible application of Contraceptive Social Marketing (as applied internationally) relative to non-medical Family Planning methods in third to fifth year of BOTSPA.

Discussion:

Although there are no established quantifiable measurements for this objective, achievement may be measured subjectively and in general implementation activities and involvement by NGO's and the private sector. The GOB, through its policy implementation and FP/POP coordinating mechanisms, will establish in writing, plans to increase NGO participation. It will also implement such a plan in succeeding years of the program to ensure demonstrated and increased participation.

3. Quantifiable Performance Target Summaries

OBJECTIVE	INDICATOR	PROGRAM YEARS 1	2	3	4	5
A. Policy Development and Implementation	Subjective Evaluations (See Texts)	---	---	---	---	---
B. Institutional:						
(1) Improved Logistics System	Total No. of Health Facilities with Continuous Contraceptive Supplies	--	165	275	325	382
(2) Expanded IEC Services	Increased 1st visits for FP Services (% Increase over Previous Years)	15	15	10	10	10
(3) Improved Mgmt/Support of MCH/FP/POP Services	Increased "couple-year" Protection (% Increased over Previous Years)	12	12	10	10	10
C. Structural						
Increased GOB Financing	GOB Funds For Contraceptives Non-Donor (Pula 000's)	--	50	60	270	550

E. BOTSPA Financing Plan

1. Construction of Cost Estimates

The construction of the cost estimates for preparing the budget for BOTSPA differs significantly between the two components of the project. There are no cost estimates for the Sector Assistance Component as it will consist of tranched disbursements to the GOB. The design of BOTSPA has examined the capacity of the GOB to absorb these funds and has determined that the Sector Assistance Component can be fully utilized. The GOB's programming for performance based disbursements will be determined and finalized through the normal GOB planning process. For example, the current NDP VI Mid-term Review and upcoming annual budgeting process will be used by the GOB to establish investment levels and allocate budget resources for the activities which are planned for the next couple of years. Activities planned for the early 1990's will be included in the preparation for NDP VII which starts next year.

The Technical Assistance and Training component budget estimates have been developed with specific quantities of inputs and corresponding costs phased over the five-year life of the Program. Particular levels of effort may vary from year to year but the overall funding level and quantities of inputs are expected to remain firm. These budget estimates are detailed in Annex B.

2. Projected Uses of Funds

The financial plan for the AID financing for the BOTSPA Program is presented on the next page in Annex B Budget Table 1.

3. GOB Contribution to the Program

Section 110(a) of the Foreign Assistance Act of 1961 (FAA), as amended, requires that the GOB provide at least 25 percent of the cost of the entire Program. As the local currency to be deposited in the Special Account, in an amount equivalent to the $3 million of grant disbursements, is host country owned, it may be used to satisfy the host country contribution requirement. The GOB contribution, as summarized in Budget Table 4 clearly exceeds 25 percent of the total program cost. The GOB contribution to the BOTSPA Program have been described in relation to each of the program objectives set forth above. This information is summarized in Annex D which follows.

4. Commitment of BOTSPA Funds by USAID

Sector Assistance Component funds will be released in five separate tranches. The initial tranche of $1.5 million will be provided to the GOB in two separate packages. The funds budgeted for the Technical Assistance and Training Component ($600,000) will be made available after the signing of the Grant Agreement and satisfaction of conditions precedent to initial disbursement. The initial tranche of the Sector Assistance Component ($900,000) will be disbursed upon GOB satisfaction of conditions precedent to disbursement specifically related to that first tranche. Subsequent obligations of funding for the Technical Assistance and Training Component will be used to procure services by USAID using standard A.I.D. procurement practices, and will be used for activities

BUDGET TABLE 1
USAID CONTRIBUTIONS
POPULATION SECTOR GRANT 1988-1992
(U.S.Dollars)

DESCRIPTION	YR 1	YR 2	YR 3	YR 4	YR 5	TOTAL
1. Budget Support	$900,000	$700,000	$600,000	$400,000	$400,000	$3,000,000
2. TA and Training						
- Long Term Technical Assistance						
a. Contraceptive Logistics	$0	$0	$0	$0	$0	$0
b. NFP	$0	$0	$0	$0	$0	$0
c. IEC Services	$125,000	$125,000	$125,000	$0	$0	$375,000
d. MCH-FP Service Delivery	$0	$0	$0	$0	$0	$0
-Short-Term Technical Assistance						
a. Contraceptive Logistics	$30,000	$30,000	$0	$0	$0	$60,000
b. NFP	$150,000	$195,000	$120,000	$75,000	$30,000	$570,000
c. IEC Services	$45,000	$45,000	$0	$0	$0	$90,000
d. MCH-FP Service Delivery	$55,000	$30,000	$30,000	$0	$0	$115,000
- Training						
a. Contraceptive Logistics	$0	$0	$0	$0	$0	$0
b. NFP	$37,500	$37,500	$0	$0	$0	$75,000
c. IEC Services	$20,000	$20,000	$20,000	$0	$0	$60,000
d. MCH-FP Service Delivery	$27,000	$27,000	$0	$0	$0	$54,000
SubTotal	$495,500	$505,500	$295,000	$75,000	$30,000	$1,201,000
3. Administration Management						
- Planning Studies and Evaluations	$30,000	$30,000	$50,000	$20,000	$50,000	$130,000
- Program Management	$30,000	$26,000	$28,000	$28,000	$28,000	$140,000
SubTotal	$60,000	$56,000	$79,000	$59,000	$78,000	$270,000
4. Contingency (10%) *	$54,550	$56,150	$37,300	$13,300	$10,800	$172,100
5. Inflation (5%) *	-	$28,050	$37,200	$19,950	$21,600	$106,800
TOTAL ESTIMATED EXPENDITURES	$1,500,050	$1,345,700	$1,047,500	$566,250	$540,400	$5,000,000
PROPOSED OBLIGATION SCHEDULE	$1,500,000	$1,500,000	$1,000,000	$500,000	$500,000	$5,000,000

*: Applies to TA and Training and Administration/Management

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BUDGET TABLE 4
SDB CONTRIBUTIONS
POPULATION SECTOR GRANT 1988-1992
(Pulas)

DESCRIPTION OF LINE ITEM CONTRIBUTIONS	1988	1989	1990	1991	1992	Total
1. Contraceptives	0	50,000	60,000	270,000	550,000	930,000
2. National Population Policy and Analysis						
a. CSO Recurrent Costs*	521,850	521,850	521,850	521,850	521,850	2,609,250
b. CSO Development Costs SDB Share:						
- Continuous Household Surveys **	200,000	165,000	168,000	168,000	172,000	873,000
- Population Census***	0	185,000	314,000	546,000	150,000	1,195,000
SubTotal	721,850	871,850	1,003,850	1,235,850	843,850	4,677,250
3. Health Education and IEC Services*						
a. Health Education Unit Salaries	66,290	66,290	66,290	66,290	66,290	331,450
b. Non-salary HEU Recurrent Costs	39,642	39,642	39,642	39,642	39,642	198,210
SubTotal	105,932	105,932	105,932	105,932	105,932	529,660
4. MCH/FP Service Delivery						
a. [illegible] MCH/FP Recurrent Costs**	2,818,917	2,818,917	2,818,917	2,818,917	2,818,917	14,094,585
b. MLGL MCH/FP Recurrent Costs**	0	0	0	0	0	-
SubTotal	2,818,917	2,818,917	2,818,917	2,818,917	2,818,917	14,094,585
5. Total SDB Contributions	3,646,699	3,846,699	3,988,699	4,430,699	4,218,699	20,131,435

*: Based on assumption that 50% of CSO's recurrent costs

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BUDGET TABLE 5

FINANCIAL IMPLEMENTATION PLAN

1. Obligation Schedule ($000)

	FY-88	FY-89	FY-90	FY-91	FY-92	TOTAL
Non Project Asst.						
Sector Assistance	900	700	600	400	400	3,000
Proj. Assistance						
TA -- Long-term	125	250	-	-	-	375
TA -- Short-term	280	300	174	41	40	835
Trng. - Short-term	87	74	20	-	-	181
Studies/Evaluation/ Audit	30	30	100	30	-	190
Log. Support	56	24	24	16	-	120
Contingencies/ Inflation	22	122	82	13	60	299
	600	800	400	100	100	2,000
TOTAL	1,500	1,500	1,000	500	500	5,000

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approved in the annual workplans. Funds for the Sector Assistance Component will be released to the GOB based upon program performance in achieving mutually upon agreed performance targets which will be set forth as conditions precedent in the Grant Agreement.

5. Allocation of Funds

BOTSPA has been approved on the basis of $3 million of non-project assistance for the Sector Assistance Component and $2 million of project assistance for the Technical Assistance and Training Component. The $2 million is being authorized at the outset of the project; the $3 million will be authorized incrementally as funds are available ($900,000 of NPA is being authorized in FY88). Subsequent adjustments to these component funding levels, up to the $5 million LOP, may be made as may be agreed upon by the parties. Changes in funding levels should be formally requested by the USAID through the ABS process to allow proper deauthorization of projectized funds and accurate monitoring of the overall percentage of DFA funds being used for non-project assistance.

F. Implementation and Absorptive Capacity of the GOB

1. Implementation Capacity

Over the many years that USAID has supported development programs in Botswana, the GOB has demonstrated its implementation capacity with successful development activities. The Government of Botswana is noted for its sound planning, budgeting, and financial management systems. These systems provice a equate and appropriate controls of donor funds. BOTSPA financing will be provided within the levels anticipated by the GOB National Development Plan VI and will be incorporated into the annual GOB budgets. An important aspect of the Sector Grant approach is that it aims principally at increasing efficiency of existing programs rather than starting new ones. This in itself economizes on the GOB implementation capacity. The technical capabilities of the implementing ministries have also been examined as part of the design of this program and have been found to be generally adequate to implement the program. Fina ing for specialist technicians has been provided in those areas where they may be required.

2. Absorptive Capacity

The combined development and recurrent appropriations for the two Ministries primarily responsible for implementing BOTSPA (Health and Local Government and Lands) was P228,935,770 in 1987/88. The $5.0 million provided under this grant over five years represents less than 4% of one year's expenditure. Although the GOB does not maintain program-focused records of their budgets and expenditures, it is estimated that the grant will at most represent 20% of all expenditures planned in the sector over the next five years.

In addition, the average $1.0 million per year investments planned under BOTSPA for the next five years will not significantly impact on the budget. Costs of centrally funded population activities in Botswana over the past few years have averaged in excess of $500,000 annually.

G. Relationship of BOTSPA to AID Policies

1. AID Policy for Population Activities

The A.I.D. Policy Paper on Population Assistance (September 1982) states that "the major focus of the U.S. (Population) program is voluntary family planning service delivery. The U.S. also supports dissemination of family planning information and education; training for service providers; research on improved delivery systems; and demographic and social science research and analysis designed both to improve voluntary family planning programs and to assist LDCs to develop and improve their development policies and programs." Further, it states that U.S. assistance in the population sector supports the work of these governments, private voluntary and profit-making organizations and universities, as well as multilateral and international population agencies. Thus, the proposed sector grant provides AID assistance within the framework of the Agency's Population Policy. GOB policy is fully consistent with AID policy in that abortion is illegal in Botswana and this legal prohibition is enforced. There are no involuntary sterilization programs in Botswana.

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IV. PROGRAM IMPLEMENTATION

A. Implementation Responsibilities

1. Government of Botswana

The implementation of this sector program grant will be the responsibility of the Government of Botswana. The Ministry of Finance and Development Planning will be responsible for coordinating programs financed by the sector grant and manage the population analysis programs through its Central Statistical Office. The Ministry of Health and the Ministry of Local Government and Lands will be executing agents for the MCH/FP Programs. Specific responsibilities for each ministry are outlined below:

a. Ministry of Finance and Development Planning

- Examining and approval of the AID program grant proposal.

- Negotiating and signing of grant agreement.

- Advising implementing ministries of the terms and conditions of the grant agreement.

- Meeting the conditions precedent to disbursement.

- Evaluation and determination of priority activities to be financed using resources provided through the grant.

- Approving any modifications in activities to be financed or the grant agreement itself.

- Monitoring and reporting to AID on the progress toward attainment of the grants objective.

- Scheduling the Quarterly Review Meetings and ensuring that the recommendations of those meetings are implemented.

- Authorizing implementing ministries to commence incurring expenditures against items covered in Annual Budget.

- Receiving and reviewing monthly returns on the expenditures from the implementing ministries.

- Maintains responsibility for financial accountability to the GOB and AID for expenditures and disbursements.

b. Ministry of Health

- Preparing justification and supporting documentation for activities to be financed under the grant. This will include the preparation of project memorandum for capital expenditure under the Sector Assistance Component and budget requests for recurrent cost items. For the Technical Assistance and Training Component the ministry will be responsible for requesting program financing through the annual workplan.

- Establishing and monitoring the targets for the performance indicators in conjunction with the MLGL.

- Preparing the necessary documentation and justification required by the GOB to procure commodities and services financed by the program.

- Preparing quarterly and annual progress reports for submission to MFDP.

- Participating in the quarterly review meeting.

c. Ministry of Local Government and Lands

- In conjunction with the District and Town Councils preparing justification and supporting documentation for activities to be financed under the grant. This will include the preparation of project memorandum for capital expenditure under the sector assistance component and budget requests for recurrent cost items. For the Technical Assistance and Training Component the ministry will be responsible for requesting program financing through the annual workplan.

- Establishing and monitoring the targets for the performance indicators in conjunction with the MOH.

- Preparing the necessary documentation and justification required by the GOB to procure commodities and services financed by the program.

- Preparing quarterly and annual progress reports for submission to MFDP.

- Participating in the quarterly review meetings.

d. Central Statistics Office

- Preparing justification and supporting documentation for activities to be financed under the grant. This will include the drafting of project memorandum and/or scopes of work for the capital expenditure under the Technical Assistance and Training Component.

- Preparing quarterly and annual progress reports for submission to MFDP.

- Participating in the quarterly review meetings.

2. United States Agency for International Development

A primary role of USAID/Botswana will be to monitor and evaluate the progress of the GOB in achieving BOTSPA's program objectives in the population sector and, in particular, the progress of the GOB in meeting the mutually agreed performance targets. This role will be primarily performed through the quarterly review meetings with the GOB which are described below. USAID staff will also make periodic site visits and hold discussions with individuals directly responsible for the activities supported under the grant.

In order to carry out this role, USAID/Botswana will establish an internal program committee to manage and monitor AID inputs for BOTSPA. The Committee will be chaired by the Deputy Director. Members of the Committee will be the Controller, Regional Population Officer, and Project Manager. Since USAID/Botswana does not have a health officer on its staff, project funds will be used to provide USAID a local hire officer to coordinate its participation in the program. For the Sector Assistance Component, USAID/Botswana will be monitoring program objectives and the progress of the GOB in meeting the performance targets. For the Technical Assistance and Training Component USAID will be implementing jointly with the GOB activities which are tied to achieving the overall objectives of the Grant. Local currencies deposited by the GOB under the Sector Assistance component will be jointly programmed by the GOB and USAID and the USAID will monitor local currency uses for budget support to the GOB budget line item level.

B. Implementation Procedures

The design of BOTSPA provides for two types of financing: the Sector Assistance Component which provides for a support grant to the GOB; and, the Technical Assistance and Training Component for financing specific activities mutually agreed to by both USAID and the GOB. These two components differ in terms of the types of implementation procedures which will be used. The details of each are described below.

1. Procedures for the Sector Assistance Component

The rationale for the Sector Assistance Component has several aspects. First and foremost, the non-project assistance mechanism is meant to encourage the GOB to maintain the momentum it has made in improving its population programs. Secondly, it provides the most effective way of utilizing the implementation capabilities of the GOB for the program. This component explicitly recognizes and is built upon the soundness of the GOB planning, budgeting, procurement, and auditing systems. Using deposited local currencies the GOB will finance commodities and services necessary to achieve the program objectives.

It is anticipated that the majority of the local currency will be used to support four to five existing GOB development programs which are contained within the National Development Plan although the GOB is not in any way confined to these investment areas. These Projects include: Health Education (MD 32); MCH/FP Project (MD 31); District Health Teams (LG 49); Development of Basic Health Facilities (LG 20) and, Continuous Household Surveys (ST 19). Financing which is programmed to support the GOB's development of a National Population Policy may require that a new thumbnail sketch be proposed to the MFDP. Other expenditures, such as contraceptives, may be included as an item in the recurrent budget. GOB planning and budget procedures will be used to specify the precise use of the subject local currency.

The GOB will report on an annual basis on local currency in the special local currency account and will use these funds for activities, as mutually agreed to by USAID, indicated in the annual

workplans. Based on previous USAID experience the GOB has demonstrated the capability to track funds to the project level. USAID/Botswana has the capability and resources to monitor the local currency program. The local currency provided foir budget support will only be tracked by USAID to the program budget line item level not to individual activities.

2. Procedures for the Technical Assistance and Training Component

The purpose of the Technical Assistance and Training Component is to provide technician services and specialist technical training for Batswana staff which is required by the GOB to achieve the objectives established by BOTSPA. This Component will be financed on the basis of annual workplans prepared by the GOB, implemented to achieve specific targets, and monitored with respect to the impact of the financed inputs on the achievement of program objectives.

The technical assistance requirements for the first year have been programmed in this document. The technical assistance requirements for the following years have been estimated but the approval of funds for these years will be based upon the GOB submission of its anticipated requirements in the annual workplan.

3. Procurement Plan

As dollar disbursements are not required to be tracked, AID's procurement rules will not be applied to the dollar disbursement component of the program, or to the host country owned local currency in the special local currency account. However, the technical assistance and training component is subject to AID procurement rules.

All procurement under this component of the Program shall be in accordance with Delegation of Authority 551, Section 5.K., and the AA/AFR approved DFA Procurement Policy Recommendations and Africa bureau Instructions dated April 4, 1988. Accordingly, AID Geographic Code 935 is the authorized code for source and origin of goods, including motor vehicles, and nationality of all services procured under the Component. No procurement waivers are required. In general, all procurement under the subject Program component shall adhere to the following order of preference: (1) Code 000; (2) Host Country; (3) Code 941; and (4) Code 935. The source/origin for procurement of pharmaceuticals and for ocean shipment of supplies shall remain as delineated in AID Handbook 1B, Chapters 4C3 and 10, respectively.

In terms of technician services, AID will contract directly for all long-term and short-term technical assistance positions required under the Program. Competitive procedures will be employed. The long-term IEC Advisor position identified in this document will be filled under a Personal Services Contract for a three year period. It is anticipated that a large share of the short-term technical assistance will be used to purchase services under AID centrally-managed population projects.

The Technical Assistance and Training Component will also finance participant training, both long-term and short-term, in the U.S., in other developing countries, and in a limited number of developed countries. All training requirements will be identified and reviewed in the context of the annual workplan. For external training requests, these will be processed through normal GOB procedures in the Directorate of Public Service Management (DPSM). AID could utilize the existing contract with the Academy For Educational Development (AED) to place and support program financed external training.

No AID-financed commodities are planned under the TA and Training Component.

4. Disbursement Mechanisms

a. Sector Assistance Component

Upon satisfaction of the conditions precedent to disbursement of each tranche of the sector assistance under the sector assistance component, the GOB will submit to USAID/Botswana a written request to release the relevant tranche of funds. Each request shall be accompanied by an SF-1034, Public Voucher. USAID/Botswana will process the SF-1034, submit it to RAMC, Paris and receive a U.S. Dollar check in return. Simultaneous with or immediately after the deposit into the Special Local Currency Account by the GOB of the local currency equivalent to the amount of the U.S. Dollar check, USAID/Botswana will forward this check to the GOB. Dollars will be deposited into Botswana's central bank. Local currency in the Special Local Currency Account shall be used for activities or projects as agreed to by USAID in the annual workplans in support of the Program objectives in the population sector.

b. Technical Assistance and Training Component

Upon satisfaction of the initial condition precedent to disbursements, AID funds to be provided under the technical assistance and training component of the Program may be disbursed. The use of these funds in each year of the program will be determined by USAID and the Grantee on the basis of a workplan to be submitted originally by the GOB which will indicate the level, type, timing and cost of TA and training resources required over the next year to achieve the Program objectives. It is planned that these funds will be disbursed through direct AID contracting and payment procedures for both dollar and foreign exchange costs. No host country contracting is planned with respect to AID funds. The Grantee will, of course, use its own procurement procedures with respect to its own funds contributed to the Program.

5. Payment Verification and Audit

The Mission will implement all categories of the TA and Training Component through direct contracting and direct payment for both dollar and foreign exchange costs. These implementation and payment methods conform to USAID/Botswana's current policies on program financing and implementation as well as AID's preferred

policies. In the event other implementation methods were found to be preferrable during the life of the project, funds have been provided for the necessary reviews/audits to confirm adequacy of the implementing entities capabilities and procedures. The proposed methods for implementing and financing the activities planned under the TA and Training Component are contained in Chart 1 on the following page. All expenditures made by the GOB are included in the Appropriation Account which are audited annually by the GOB Auditor General. This audit is a statutory requirement to ensure financial compliance with applicable laws and regulations. In addition the program budget includes funds for USAID reviews and external audits as may be necessary during the life of the project. Any non-federal audit will be initiated through AID's Regional Inspector General (RIG/A/N) Office in Nairobi.

6. Program Completion Date

The Program Completion Date for the Botswana Population Sector Program Assistance is five years from the effective date of the original Grant Agreement.

CHART 1

METHODS OF IMPLEMENTATION AND FINANCING

CATEGORY	METHOD OF IMPLEMENTATION	METHOD OF DISTRIBUTION	AMOUNT U.S. $ (000)
Non-Project Asst.			
Sector Assistance	Prj. Agreement	Direct	3,000
Project Asst.			
TA - Long-term	Direct AID Contract	Direct Payment or LOC	375
TA - Short-term	Direct AID Contract	Direct Payment or LOC	835
Training - Short-term	Direct AID PIO/P, Contract, TA	Direct Payment or LOC	181
Studies/Evaluation/ Audit	Direct AID Contract	Direct Payment	190
Log Support	Direct AID Contract Purchase Order	Direct Payment	120
Contingencies/ Inflation	As Above	As Above	299
			2,000
Total			5,000

C. Monitoring and Evaluation

The monitoring and evaluation system for BOTSPA is based upon three complementary mechanisms: Program Review Meetings, Sentinel Surveys, and a final Evaluation.

1. Program Review Meetings

Program review meetings will be used to facilitate joint GOB and USAID/Botswana management and monitoring of BOTSPA. During the first year of the program these meetings will be convened quarterly. At the end of this startup period, it may be possible to reduce these meetings to twice a year. The Program Review Meetings will be chaired by the Permanent Secretary, Ministry of Health. Members of this review meeting will include representatives from the Ministry of Health, Ministry of Local Government and Lands, Central Statistics Office, and the Rural Development Unit, MFDP.

Standing agenda items for the review meetings will include: written updates on activities in the sector including any special reference to any field visits made during the preceding period; progress by the GOB on meeting the performance indicators; and, any proposed modifications in activities financed by BOTSPA. A major function of the meeting will be to identify and take steps to resolve any procedural or implementation issues. A report will be prepared by the MOH following each meeting giving the status of progress under the grant and noting any necessary corrective actions to be taken during the next quarter.

One meeting every year will be used by the GOB and USAID to: 1) review evidence that the GOB has achieved the agreed upon performance indicators; 2) make necessary revisions in the performance indicators for the subsequent tranches; 3) review financial position of activities financed during the previous year under the Technical Assistance and Training Component; and, 4) review the workplan for the coming year for the activities to be financed from the Technical Assistance and Training Component.

2. Sentinel Surveys

Short two to three week sentinel surveys will be carried out annually as part of the BOTSPA monitoring process. The purpose of these surveys will be monitor the performance of the sector, both with respect to progress of the program in achieving its program objectives but also assist the GOB to monitor other aspects of its population programs. These surveys are being successfully employed in other countries to monitor and evaluate program changes. Sentinel surveys take place annually in four or six representative locations in the country. The purpose is to obtain immediate feedback on program performance. They are short (10 to 15 questions) and can be carried out and compiled in two weeks. Sample sizes are small amounting to about 2,000 persons (including men and women) in each survey.

3. Evaluation

Since the program will employ annual sentinel surveys, no mid-term evaluation is required. However, a final evaluation is planned for mid-1993 which would measure a number of central

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components to the GOB population programs. This survey would not need to be as large as the planned 1988 demographic and health survey and could involve a smaller sample size or a re-test of 1988 interviewees. In addition this evaluation will examine the program management issues related to the design and implementation of the sector grant approach.

If significant problems develop in achieving the objectives or targets outlined for the program, a special evaluation may be arranged with the joint agreement of the GOB and USAID.

D. Implementation Schedule

The following Implementation Schedule assumes that the Program is authorized by June 1, 1988.

Item	Month	Responsible
- Grant Agreement Signed between AID and GOB	7/88	USAID/MFDP
- Conditions Precedent to Disbursement Met	8/88	MFDP
- Advertisement for Long Term IEC Advisor	7/88	USAID/MOH
- Contracting for Short Term Technical Assistance through Buy Ins	8/88	USAID/MOH/ CSO
- Disbursement of First Tranche to GOB	9/88	USAID/MFDP
- First Quarterly Review Meeting	11/88	USAID/GOB
- Second Quarterly Review Meeting	4/89	USAID/GOB
- Third Quarterly Review Meeting	8/89	USAID/GOB
- First Sentinel Survey	8/89	Contractor
- Evidence Submitted for Meeting Second Year Requirements	10/89	MFDP
- Fourth Quarterly Review Meeting	12/89	USAID/GOB
- Disbursement of Second Tranche to GOB	1/90	USAID/MFDP
- Fifth Review Meeting (Semiannual)	4/90	USAID/GOB
- Second Sentinel Survey	8/90	Contractor
- Evidence Submitted for Meeting Third Year Requirements	10/90	MFDP
- Sixth Review Meeting (Semiannual)	11/90	USAID/GOB
- Disbursement of Third Tranche to GOB	12/90	USAID/MFDP
- Seventh Review Meeting (Semiannual)	4/91	USAID/GOB
- Third Sentinel Survey	8/91	Contractor
- Evidence Submitted for Meeting Fourth Year Requirements	10/91	MFDP
- Eighth Review Meeting (Semiannual)	11/91	USAID/GOB
- Disbursement of Fourth Tranche to GOB	12/91	USAID/MFDP
- Ninth Review Meeting (Semiannual)	4/92	USAID/GOB
- Fourth Sentinel Survey	8/92	Contractor
- Evidence Submitted for Meeting Fifth Year Requirements	10/91	MFDP
- Tenth Review Meeting (Semiannual)	11/92	USAID/GOB
- Disbursement of Fifth Tranche to GOB	12/92	USAID/MFDP
- Eleventh Review Meeting (Semiannual)	4/93	USAID/GOB
- Program Ends	5/93	
- Final Evaluation	6/93	USAID/GOB

V. ESSENTIAL TERMS AND CONDITIONS

In order to facilitate the implementation of the Program, the Grant Agreement will contain, in substance, the following essential terms and conditions:

A. CONDITIONS PRECEDENT TO DISBURSEMENT

1. Conditions Precedent to Initial Disbursement

a. Prior to any disbursement under the Grant, the Grantee shall furnish to USAID, in form and substance satisfactory to USAID:

(1) A statement representing and warranting that the named person(s) have authority to act as the representative(s) of the Grantee with respect to:

(a) Official correspondence regarding the Grant, together with a specimen signature of each person certified as to its authenticity; and

(b) Disbursement of local currency.

2. Additional Conditions Precedent to Initial Disbursement of Resource Transfer

a. Prior to the disbursement of the first tranche of the sector assistance to be provided under the Grant, the Grantee shall provide to USAID, in form and substance satisfactory to USAID:

(1) Evidence that the Grantee has established an interministerial Program Steering Committee responsible for the implementation of this Program;

(2) A written plan which sets forth the actions, including technical inputs and public consultations, required to develop a National Population Policy;

(3) A written plan and procedures for the procurement and distribution of contraceptives by the Central Medical Stores (CMS);

(4) Evidence that the Grantee has identified and assigned an appropriate official to function as a counterpart to the project funded IEC advisor;

(5) A written plan for improving the quality and effectiveness of existing MCH/FP clinical services and expanding the number of service delivery points;

(6) A written plan which describes how the Grantee intends to increase the participation of non-governmental organizations (NGOs), including private sector entities, in population programs; and

(7) Evidence that the Grantee has established in the Central Bank of Botswana a Special Local Currency Account for the deposit of local currency in an amount equivalent to the U.S. dollar disbursements of the sector assistance to be provided under the Grant.

3. Planned Illustrative Conditions Precedent to Subsequent Disbursement of the Sector Assistance

a. Prior to the disbursement of the second tranche of the sector assistance to be provided under the Grant, the Grantee shall provide to USAID, in form and substance satisfactory to AID:

(1) Evidence that the Grantee has prepared a draft National Population Policy and has held consultations with the public and within the Government on such policy;

(2) Evidence that the Grantee has designated a Governmental office to be responsible for the coordination of population policies and programs.

(3) Evidence that CMS has initiated the plan for the procurement and distribution of contraceptives;

(4) A written plan for the expansion of IEC services provided by the Health and Education Unit and district health education teams;

(6) Evidence that the Grantee has initiated its plan to improve the quality and effectiveness of existing MCH/FP clinical services and to significantly increase the number of service delivery points; and

(7) Evidence that the Grantee has initiated implementation of its plan to increase the participation of NGOs, including private sector entities, in population programs.

b. Prior to the disbursement of the third tranche of the sector assistance to be provided under the Grant, the Grantee shall provide to USAID, in form and substance satisfactory to USAID:

(1) Evidence that the Grantee has adopted and publicly described and endorsed its National Population Policy;

(2) Evidence that the Grantee has initiated its plan for the expansion of IEC services provided by the Health and Education Unit and district health education teams;

(3) Evidence of improvement in the quality and effectiveness of existing MCH/FP clinical services and a significant increase in the number of service delivery points;

(4) Evidence that since the effective date of the subject Program Agreement the Grantee has procured, with other than donor provided funding, at least Pula 50,000 of contraceptives; and

(5) Evidence that the Grantee is successfully implementing its plan to increase the participation of NGOs, including private sector entities, in population programs.

c. Prior to the disbursement of the fourth tranche of the sector assistance to be provided under the Grant, the Grantee shall provide to USAID, in form and substance satisfactory to USAID:

(1) Evidence that the Grantee has initiated implementation of its National Population Policy;

(2) Evidence of substantial expansion of IEC services provided by the Health and Education Unit and district health education teams;

(3) Evidence that since the effective date of the Program Agreement the Grantee has procured, with other than donor provided financing, at least Pula 110,000 of contraceptives; and

(4) Evidence of a significant increase in the participation of NGOs, including private sector entities, in population programs.

d. Prior to the disbursement of the fifth tranche of the sector assistance to be provided under the Grant, the Grantee shall provide to USAID, in form and substance satisfactory to USAID:

(1) Evidence that since the effective date of the Program Agreement the Grantee has procured, with other than donor provided financing, at least Pula 380,000 of contraceptives; and

(2) Evidence which indicates that within five years after the effective date of the Program Agreement the Grantee plans to have procured, with other than donor provided funds, at least Pula 930,000 of contraceptives.

B. COVENANTS

1. Special Covenants

In order to ensure that the Program is successful, essential covenants to be included in the Grant Agreement are, in substance, as follows.

a. The Grantee shall not in any way, discontinue, reverse or otherwise impede any action it has taken in satisfaction of any condition precedent to disbursement set forth above, except as mutually agreed to in writing by USAID and the Grantee.

b. The Grantee, through CMS, shall procure and distribute sufficient quantities of contraceptives to satisfy the demand for such contraceptives not met by the private sector.

c. The Grantee agrees to provide to USAID on an annual basis a workplan indicating the level, type, timing and cost of the technical assistance and training resources required over the following year to achieve the objectives of the Program.

d. USAID and the Grantee agree to cooperate on a USAID-financed evaluation program as part of the subject Population Sector Program. The program will include a final evaluation. The program may include, during the implementation of the Program:

(1) Evaluation of progress toward attainment of the objectives of the Program;

(2) Identification and evaluation of problem areas or constraints which may inhibit such attainment;

(3) Assessment of how such information may be used to help overcome such problems; and

(4) Evaluation, to the degree feasible, of the overall development impact of the Program.

e. Pursuant to Section herein, the Grantee will establish in the Central Bank of Botswana a special Local Currency Account and deposit therein currency of the Government of Botswana in a total amount equivalent to the U.S. Dollar disbursements of the sector assistance to be provided to the Grantee under the Grant. These local currency shall be deposited in the Special Local Currency Account prior to or simultaneous with the disbursement of each tranche of dollars under the Sector Assistance Component. The local currency shall be used for general budgetary support for program objectives in the population sector.

f. The Grantee shall maintain and cause recipients of funds from the Special Local Currency Account to maintain, in accordance with generally accepted accounting principles and practices consistently applied, books and records relating to the Special Local Currency Account. The Grantee shall grant or cause such recipients to grant to USAID or any of its authorized representatives the right to inspect such books and records at all times USAID may reasonably require. Such books and records shall be maintained for at least three years after the date of the last disbursement by USAID under the Grant.

g. The Grantee shall refund to the Special Local Currency Account any local currency not used for purposes agreed upon by USAID and the Grantee, except as the Parties may otherwise agree in writing.

h. The local currency in the Special Local Currency Account shall be additional to, and not a substitute for, the Grantees existing budgetary resources for the population sector.

2. General Covenants

The Program Grant Agreement will include the following general covenants:

a. Consultation

USAID and the Grantee will cooperate to assure that the purpose of the Program will be accomplished. To this end, the Parties, at the request of either, will exchange views on the progress of the Program, the performance of obligations under the Program Agreement, the performance of any consultants, contractors or suppliers engaged under the Program, and other matters relating to the Program.

b. Execution of the Program

The Grantee will:

(1) Carry out the Program or cause it to be carried out with due diligence and efficiency, in conformity with sound technical, financial and management practices, and in conformity with those documents, plans, specifications, contracts, schedules or other arrangements, and with modifications therein, approved by USAID pursuant to the Program Agreement; and

(2) Provide qualified and experienced management for, and train such staff as may be appropriate for the maintenance and operation of the Program, and, as applicable for continuing activities, cause the Program to be operated and maintained in such manner as to assure the continuing and successful achievement of the purpose of the Program.

c. Utilization of AID Funds and AID Financed Goods and Services

(1) Any resources financed under the Grant will, unless otherwise agreed in writing by USAID, be devoted to the Program until the completion of the Program, and thereafter will be used so as to further the objectives sought in carrying out the Program.

(2) Goods and services financed under the Grant, except as USAID may otherwise agree in writing, will not be used to promote or assist a foreign aid project or activity associated with or financed by a country not included in Code 935 of the AID Geographic Code Book as in effect at the time of such use.

(3) If any public sector commodity procurement transactions financed under the Grant are not exempt from identifiable taxes, tariffs, duties or other levies imposed under laws in effect in the territory of the Grantee, the Grantee will pay or reimburse the same with funds other than those provided under the Grant.

(4) Funds provided under this Agreement shall not be used for police training or military or paramilitary purposes.

3. Other Standard Provisions

Other standard provisions may be included in the Grant Agreement, as appropriate.

ANNEX

A

REQUEST FOR ASSISTANCE FROM THE GOB

TELEGRAMS: FINANCE
REFERENCE: FDP

REPUBLIC OF BOTSWANA

PRIVATE BAG 005
GABORONE

5th February, 1988.

Mr. John P. Hummon,
Director,
USAID/Botswana,
P.O. BOX 2427,
GABORONE.

Dear Mr. Hummon,

BOTSWANA POPULATION SECTOR PROGRAM ASSISTANCE GRANT
(633-0249)

I refer to recent discussions and meetings between representatives of the Government of Botswana and the USAID staff regarding a proposed Sector Assistance Program in population. The Government of Botswana requests the assistance of the United States Government to fund this US $5.0 million effort to assist Botswana in its population programs and strategies. The Government of Botswana will be contributing substantially towards the population effort, with details to be spelled out in documentation. The actual signing of an agreement on the Sector Assistance Program would be subject to our full review of the program documents.

The Government of Botswana looks forward to cooperating with USAID in this mode of developmental assistance which is new to USAID operations in Botswana..

Yours sincerely,

B. Gaolathe
PERMANENT SECRETARY

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ANNEX

B

STATUTORY CHECKLIST

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1988 Continuing Resolution Sec. 526. Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? No.

2. FAA Sec. 481(h). (This provision applies to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government), has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without N/A.

Congressional enactment, within 30 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, and to prevent and punish drug profit laundering in the country, or that (b) the vital national interests of the United States require the provision of such assistance?

3. Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to Congress listing such country as one (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country? N/A.

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4. FAA Sec. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government? (a) No. (b) No.

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

6. FAA Secs. 620(a), 620(f), 620D; FY 1988 Continuing Resolution Sec. 512. Is recipient country a Communist country? No.
If so, has the President determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism? N/A.
Will assistance be provided directly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, South Yemen, Iran or Syria?
Will assistance be provided to Afghanistan without a certification? No.

7. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? No.

8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC? No.

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

10. FAA Sec. 620(q); FY 1988 Continuing Resolution Sec. 518. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (a) No.
(b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1988 Continuing Resolution appropriates funds? (b) No.

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

12. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption? No.
N/A.

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

Botswana's UN Obligations are fully paid. N/A.

14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism?

No.

15. FY 1988 Continuing Resolution Sec. 576. Has the country been placed on the list provided for in Section 6(j) of the Export Administration Act of 1979 (currently Libya, Iran, South Yemen, Syria, Cuba, or North Korea)?

No.

16. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?

No.

17. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

No.

18. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

No.

No.

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19. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? N/A.

20. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo.) No.

21. FY 1988 Continuing Resolution Sec. 528. Has the recipient country been determined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States? No.

22. FY 1988 Continuing Resolution Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance? No.

N/A.

23. FY 1988 Continuing Resolution Sec. 543. Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin? Yes.

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? — No. N/A.

FY 1988 Continuing Resolution Sec. 538. Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performace of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? — No.

2. Economic Support Fund Country Criteria

FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest? — N/A.

FY 1988 Continuing Resolution Sec. 549. Has this country met its drug eradication targets or otherwise taken significant steps to halt illicit drug production or trafficking? — N/A.

3(A)2 - NONPROJECT ASSISTANCE CHECKLIST

The criteria listed in Part A are applicable generally to FAA funds, and should be used irrespective of the program's funding source. In Part B a distinction is made between the criteria applicable to Economic Support Fund assistance and the criteria applicable to Development Assistance. Selection of the criteria will depend on the funding source for the program.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED?

A. GENERAL CRITERIA FOR NONPROJECT ASSISTANCE

1. FY 1988 Continuing Resolution Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project.

   A CN has been prepared. Obligation will not occur until the expiration of the waiting period without Congressional objection.

2. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

   No further legislative actio is required.

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

   No.

   N/A.

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

The BOTSPA program will encourage private sector family planning services.

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

Under the program technical services, training and commodities will be procured from the U.S. private sector to the extent practicable.

6. FAA Secs. 612(b), 636(h); FY 1988 Continuing Resolution Secs. 507, 509. Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.

The U.S. does not hold exces local currency in Botswana.

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

No.
N/A.

8. FAA Sec. 601(e). Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

9. FAA 121(d). If assistance is being furnished under the Sahel Development Program, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of A.I.D. funds?

N/A.

B. FUNDING CRITERIA FOR NONPROJECT ASSISTANCE

1. Nonproject Criteria for Economic Support Fund

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? N/A.

To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? N/A.

b. FAA Sec. 531(e). Will assistance under this chapter be used for military or paramilitary activities? N/A.

c. FAA Sec. 531(d). Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? N/A.

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? N/A.

e. FY 1988 Continuing Resolution. If assistance is in the form of a cash transfer: (a) are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds? (b) will all local currences that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account to be used in accordance with FAA Section 609 (which requires such local currencies to be made available to the U.S. governnent as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA N/A.

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would themselves be available)? (c) Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

f. FY 1988 Continuing Resolution. Have local currencies generated by the sale of imports or foreign exchange by the government of a country in Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for use, in accordance with an agreement with the United States, for development activities which are consistent with the policy directions of Section 102 of the FAA and for necessary administrative requirements of the U. S. Government?

N/A.

2. Nonproject Criteria for Development Assistance

a. FAA Secs. 102(a), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

The program will assist the GOB to provide population services which will improve the health of women and children, especially in rural areas. Where non-government organizations can provide assistance in these areas, the program will encourage their participation.

b. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Is assistance being made available (include only applicable paragraph which corresponds to source of funds used; if more than one fund source is used for assistance, include relevant paragraph for each fund source):

(1) [103] for agriculture, rural development or nutrition; if so (a) extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, account shall be taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made; (b) extent to which assistance is used in coordination with efforts carried out under Sec. 104 to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people; and (c) extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution. N/A.

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(2) [104] for population planning under Sec. 104(b) or health under Sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outrearch.

The program will be intregrated into the GOBs primary health care services which will operate throughout the country.

(3) [105] for education, public administration, or human resources development; if so, (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A.

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

N/A.

(i)(a) concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and (b) facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

(ii) concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(iii) research into, and evaluation of, economic development processes and techniques;

(iv) reconstruction after natural or manmade disaster and programs of disaster preparedness;

(v) for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

(vi) for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

(5) [120-21] for the Sahelian region; if so, (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multi-donor development plan which calls for equitable burden-sharing with other donors; (b) has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom)? N/A.

c. FAA Sec. 107. Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? N/A.

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d. FAA Sec. 281(b). Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.	The program is managed by GOB institutions and utilizes GOB resources to the maximum extent possible
e. FAA Sec. 101(a). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	The program will provide a major benefit to Botswana's economic growth by maintaining a rate of population growth which can be support by GOB resources.

5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. PROCUREMENT

1. FAA Sec. 602(a). Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?	Yes.
2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him?	Procurement will be under DFA rules as set forth in 88 State 399366.
3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?	Botswana does not so discriminate.
4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)	N/A.
5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those	N/A.

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countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

6. FAA Sec. 603. Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? — No.

7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? — Yes.
Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? — Yes.

8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? — Yes, in accordance with DFA instructions

9. FY 1988 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? — Any such direct AID contract will so provide.

10. FY 1988 Continuing Resolution Sec. 524. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? — Yes.

B. CONSTRUCTION

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A.

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

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? N/A.

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

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

4. Will arrangements preclude use of financing:

a. FAA Sec. 104(f); FY 1987 Continuing Resolution Secs. 525, 538. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion?	(1)Yes. (2)Yes. (3)Yes. (4)Yes.
b. FAA Sec. 483. To make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?	Yes.
c. FAA Sec. 620(g). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President?	Yes.
d. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?	Yes.
e. FAA Sec. 662. For CIA activities?	Yes.
f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?	Yes. DFA authorization provides such a waiver.

g.	FY 1988 Continuing Resolution Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel?	Yes.
h.	FY 1988 Continuing Resolution Sec. 505. To pay U.N. assessments, arrearages or dues?	Yes.
i.	FY 1988 Continuing Resolution Sec. 506. To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)?	Yes.
j.	FY 1988 Continuing Resolution Sec. 510. To finance the export of nuclear equipment, fuel, or technology?	Yes.
k.	FY 1988 Continuing Resolution Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?	Yes.
l.	FY 1988 Continuing Resolution Sec. 516; State Authorization Sec. 109. To be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress?	Yes.

ANNEX

C

ECONOMIC ANALYSIS FOR PROGRAM INVESTMENT

PROJECT

ECONOMIC ANALYSIS

This section is designed to determine if the Botswana Population Sector Assistance Program (BOTSPA) is cost-beneficial to the U.S. and Botswana Governments. Quantifying real costs and long term impacts of social welfare (e.g. health, education, and family planning) activities is problematic, and any attempt to do so requires making a number of somewhat tenuous qualifications. This analysis demonstrates that the BOTSPA Project is economically viable because (1) it will save the GOB and Batswana citizens scarce development resources, (2) it will help reduce the rate of maternal and child mortality and morbidity, (3) the cost per user is consistent with other African family planning programs, and (4) population projects have been judged to be generally efficient by AID standards.

1. Cost-Benefit Analysis. AID Handbook 3, appendix 3E acknowledges the pitfalls of estimating the economic benefits of human resources projects. In recent years, however, cost-benefit methodologies have been developed which have found acceptance among many economists.

These methodologies rely on calculations of the numbers of births averted and the present discounted value of averted births in terms of public sector savings. Such analyses tend to focus on the education and health sectors, where shifts in population growth have the most immediate impacts. The principal problem with these methodologies is that they must make many assumptions, some of them tenuous. In addition, they do not take into account such possibilities as technological breakthroughs that might bear on the nation's capacity to accommodate large additions to the population.

Nevertheless, some of these analyses have been quite accurate in specific, short-term measurements. The validity of these short-term approaches have been confirmed by retrospective studies. In Mexico, the Social Security Institute estimated that family planning investments have saved the system 9 pesos in reduced health care costs for each peso invested over a 15-year period. An analysis of the investments made in Indonesia's National Family Planning Program concluded that reductions in fertility over the period 1971-1984 produced substantial savings in public expenditures in education and health, returning $2 for every $1 invested in family planning. Projecting these savings over a thirty-year period results in a $9 return for every $1 invested.

For the purpose of this PAAD, a brief 2-sector cost-benefit analysis has been conducted. This analysis relies on projections of recurrent program costs and of public savings in the education and health sectors. The analysis is discussed in the following subsections.

Estimating Program Costs: Assuming constant recurrent costs per user, future family planning program expenditures are estimated through a projection relying on Bongaarts proximate determinants of fertility methodology. The results of this projection routine are presented in Table A-1. The projection routine relies on estimates of changes in Botswana's population growth rate and age structure over a thirty-year period (1985-2015). The projection is based on a

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fertility decline scenario (which assumes a TFR of 4.1 is reached by the year 2005) adapted from a demographic analysis prepared under the direction of the Central Statistics Office, Ministry of Finance and Development Planning and the Department of Primary Health Care, Ministry of Health. This scenario assumes a decline in total fertility rate from 6.8 to 2.8 children per woman and an associated increase in women of reproductive age from 256 to 755 thousand by the year 2015.

The second step requires estimating changes in the various proximate determinants of fertility. For this, two changes are introduced. First, it is assumed that the mean age at first marriage will increase over the projection period, resulting in a decrease in the percent of women (of reproductive age) in union from 79 to 74 percent. Second, there is an assumed decline in the average length of post-partum infecundability (PPI) related to reduced length and intensity of breastfeeding known to accompany urbanization and modernization processes. This decline is estimated with international data by regressing levels of PPI on total fertility rates. This results in an estimated decline in PPI from 11.3 to 4.8 months over the projection period.

The projection routine estimates the level of contraceptive prevalence required to attain desired declines in fertility, given the underlying proximate determinant assumptions. These estimates indicate a rise in the contraceptive prevalence (current use of modern methods by currently married women) rate from 18.6 to 73.1 percent over the projection period. This routine also produces estimates of the number of family planning users over the thirty-year period. The number of users rises from 37,600 to 408,300 by the year 2015.

In estimating recurrent costs to the family planning program, two central assumptions are made. It is assumed that the Botswana program provides services for around 90 percent of family planning users, and that this percentage will remain constant to year 2000. It further assumes that the annual recurrent costs for providing services to a single user averages P38, which translates to $20. Recurrent programs costs, then, are estimated to rise from $676,800 to $7,349,400 in constant 1985 dollars over the projection period.

This analysis makes a conservative assumption concerning changes in recurrent per-user costs for providing family planning services. While constant per-user costs are assumed throughout the projection period, per-user costs should decline as the program expands due to increased program efficiencies and economies of scale.

Estimating Program Benefits for Education Sector: In this analysis, benefits associated with a declining rate of population growth are estimated for the education sector in Botswana. The result of this analysis is presented in Table A-2. At the basis of this analysis are the two population growth scenarios previously referred to. The first (projection A) assumes constant fertility and the second (projection C) assumes an expected decline in fertility consistent with Botswana's current socio-economic status. Isolating the relevant population, both projections begin with a 1985 primary school aged population of 212,953. This age group grows to 695,323 under projection A conditions and to 413,835 under projection C conditions over the course of the projection period.

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By comparing the two projection scenarios, a reduction in school enrollments associated with fertility decline is estimated. This reduction estimate assumes constant enrollment rates of 100 percent among primary school-age children, as anticipated by the GOB in NDP VI. The reduction in school-aged children is not realized until year 6 of the projection period, when the 1985 birth cohort reaches school-age. The reduction is 6,045 by the year 1995, and grows to 245,488 by the year 2015.

Public savings in education expenditures associated with enrollment reductions are calculated. The public savings calculation assumes the 1985 annual costs per additional student of 1985 P132 ($U.S. 65.10) for primary school remains constant over the projection period. Annual public savings amount to $393,000 in 1995 and increased to $15,317,000 by 2015 (in constant 1985 dollars).

This analysis assumes no increase in recurrent expenditures per student. Should there be an increase in the quality of schooling provided, education sector savings associated with a fertility decline will be even more dramatic.

Estimating Program Benefits for Health Sector: In this analysis benefits associated with a declining rate of population growth are estimated for the health sector in Botswana. The results of this analysis are presented in Table A-3. This analysis again relies on a comparison of the same two population growth scenarios previously defined. Both projections begin with a 1985 total population of 1,090,504. The total population grows to 3,451,932 under projection A conditions and to 2,439,735 under projection C conditions over the course of the projection period.

Based on a comparison of the two projection scenarios, a reduction in the health client population is estimated. Client reduction reaches 61,969 by the year 1995 and grows to 1,012,197 by the year 2015.

Public health care expenditure savings associated with client reductions are calculated. The calculation assumes constant annual recurrent costs per additional client of P32 as estimated in 1987 by the Central Statistical Office and the Ministry of Health. Annual public savings amount to $465,000 in 1995 and increase to $7,591,000 by the year 2015 (in constant 1985 dollars).

This analysis assumes no variation in individual health care costs across age and sex groups. Yet, in most instances, health care costs are higher for maternal and child population groups than for the population at large. Further, by improving child-spacing practices, family planning itself can reduce complications surrounding the birth and can, thereby, reduce high costs associated with those complications. Additionally, this analysis assumes no improvements in quality of health care provided over the projection period. If quality does improve, health care savings associated with a fertility decline would be even more marked.

Benefit-to-Cost Comparisons: Based on the foregoing analyses, benefits of reduced expenditures in education and health can be compared with costs associated with Botswana's family planning program. This comparison is presented in Table A-4. The first two

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columns of the table list annual and cumulative program costs for each year in the projection period. The second two columns list annual and cumulative savings totaled over public and private education and health sectors for each year. The final two columns present benefit-to-cost ratios calculated for each year and cumulatively over all preceding years.

This table reveals that costs outweigh savings over the first ten years of the projection period -- with the annual ratio drawing closer to unity each year. By year fourteen however, savings exceed costs. The year 1999, then, is the "break-even" point for this analysis. By year 2005 then, is the "pay-back" point for this analysis. By the year 2005, the annual benefit-to-cost ratio is nearly 2-to-1 and by the year 2015 it is over 3-to-1. In terms of cumulative totals, the benefit-to-cost ratio reaches 2-to-1 by the year 2015.

On the basis of this analysis, expected savings in the education and health sectors alone justify the investment in family planning. As noted in the previous subsections, this analysis has made a number of conservative assumptions regarding changes in the quantity and quality of education and health services over the projection period. Had less conservative assumptions been adopted, the break-even and pay-back points would have been achieved earlier in the period. Additionally, this analysis isolated the savings realized in only two development sectors: education and health.

Similar savings will likely be experienced in other development sectors (e.g. agriculture, energy, housing, water and sanitation). Had the analysis been extended to these sectors, the break-even and pay-back points would have been achieved even earlier.

2. Improved Maternal and Child Health. By promoting healthful spacing of children, the BOTSPA project will contribute to the GOB's goal of reducing the infant mortality rate to below 50 per 1,000 (PID, p.5). Child survival is an integral part of the BOTSPA project, where activities in immunization and oral rehydration are emphasized (PID, p.1). Strengthening of the IEC capacity of the GOB, Batswana knowledge of family planning and child survival measures will be greatly expanded. These activities will enhance the Batswana health status and productivity. Additionally, this intervention will contribute to reduced health care costs associated with high-risk births.

3. Program Efficiency. The estimated current recurrent costs for the Botswana family planning program do not exceed $1,000,000 annually. This is translated to approximately $20 per couple now using modern contraceptive methods. Since most of the GOB's costs are fixed (in terms of salaries and facilities) increased contraceptive use by Botswana can be expected to lead to a decrease in the unit cost. The World Bank estimates that the average recurrent cost for all Sub-Saharan African family planning programs is $20 per couple. Thus, the costs of family planning in Botswana are reasonable by present African standards.

4. Efficiency of AID Family Planning Programs. The Program and Policy Coordination Bureau of AID conducts periodic assessments of the efficiency of its development programs. A recent report from

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PPC/CDIE indicates that population projects have been among the most efficient and effective of all AID programs. This project should not deviate from that pattern, and thus represents an efficient use of AID funds.

TABLE A-1

PROJECTED RECURRENT COST OF FAMILY PLANNING PROGRAM
BOTSWANA: 1985-2015*

Year	FEMALE POPULATION AGE 15-49	TOTAL FERTILITY RATE (TFR)	CONTRACEPTIVE PREVALENCE RATE	FAMILY PLANNING USERS (MODERN METHODS)	ANNUAL FAMILY PLANNING COSTS ($U.S.)
1985	256.0	6.78	18.6	37,600	676,800
1990	300.0	6.11	28.7	67,200	1,209,600
1995	357.0	5.45	38.4	105,900	1,906,200
2000	429.0	4.78	47.7	156,400	2,815,200
2005	524.5	4.11	56.6	224,500	4,041,000
2010	620.0	3.45	65.0	301,700	5,430,600
2015	755.0	2.78	73.1	408,300	7,349,400

Sources: for TFR, Central Statistics Office, Ministry of Finance & Development Planning and the Department of Primary Health Care, Ministry of Health. Botswana: Population Factors & Development. Gaborone, Botswana. 1987; for Women aged 15-49, United Nations World Population Prospects, Estimates and Projects as Assessed in (Medium Variant), 1988; for Contraceptive Prevalence, Botswana Family Health Survey, 1984.

- projection assumes decline in fertility where TFR of 4.1 is reached by 2005.
- Contraceptive prevalence rate refers to current use by women in union, aged 15-49 as assessed in the Family Health Survey, 1984.
- Contraceptive prevalence projections based on Bongaarts methodology for estimating family planning program requirements -- assumes changes in post-partum infecundability from an average of 11.0 to 7.2 months and a decline in the proportion of women aged 15-49 in a union from 79 to 74 percent, the percent of women aged 45-49 and childless remains constant at 3 percent and the abortion rate is assumed to be zero;
- Recurrent program costs assumes program serves 90 percent of all users and that annual recurrent costs average P38 per user.
- All costs converted to US dollars (at US$1 = P1.89) and expressed in thousands of constant 1985 dollars.

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TABLE A-2
PROJECTED REDUCTIONS IN EDUCATION EXPENDITURES
BOTSWANA: 1985-2015*

Year	PRIMARY SCHOOL AGE POPULATION Ages (6-12) PROJECTION A:	PROJECTION C:	TOTAL SCHOOL REDUCTION	PRIMARY EXPENDITURES ($ 000's) PROJECTION A	PROJECTION C	TOTAL COST REDUCTION ($ 000's)
1985	212,953	212,953	0	13,857	13,857	0
1990	266,833	266,833	0	17,280	17,363	0
1995	320,777	314,732	6,045	20,873	20,480	393
2000	384,539	349,210	35,329	25,022	22,723	2,299
2005	466,839	378,327	88,512	30,377	24,618	5,759
2010	569,289	401,891	167,398	37,044	26,151	10,893
2015	659,323	413,835	245,488	42,245	26,928	15,317

Source: Central Statistics Office, Ministry of Finance & Development Planning and the Department of Primary Health Care, Ministry of Health. Botswana: Population Factors and Development. Gaborone, Botswana. 198[illegible].

*- Projection A assumes no decline and projection C assumes a decline in fertility where TFR reaches 4.1 in the 2005;
- Total primary school reduction calculation assumes constant enrollment rates of 100 percent;
- All costs converted to US dollars at (1 US$ = 1.69P, and expressed in thousands of constant 1985 dollars;
- Costs assume annual expenditures per primary student of $113.

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TABLE A-3
PROJECTED REDUCTIONS IN HEALTH EXPENDITURES
BOTSWANA: 1985-2015*

Year	TOTAL POPULATION PROJECTION A:	TOTAL POPULATION PROJECTION C:	TOTAL CLIENT REDUCTION	ANNUAL HEALTH SAVINGS ($ 000's)
1985	1,090,504	1,090,504	0	0
1990	1,312,545	1,296,353	16,192	12[illegible]
1995	1,583,726	1,521,757	61,969	465
2000	1,916,803	1,757,935	158,868	1,192
2005	2,328,412	1,999,414	328,998	2,46[illegible]
2010	2,832,875	2,232,176	600,699	4,50[illegible]
2015	3,451,932	2,439,735	1,012,197	7,59[illegible]

Source: Central Statistics Office, Ministry of Finance & Development Planning and the Department of Primary Health Care, Ministry of Health, Botswana: Population Factors and Development. Gaborone, Botswana, 1987.

*- Projection A assumes no decline and projection B assumes a decline in fertility such that TFR reaches 4.1 by the year 2015;
- Health savings calculation assumes constant annual costs per additional person of P32;
- All costs converted to US dollars at (1US$ = 1.89P) and expressed in thousands of constant 1985 dollars.

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TABLE A-4
BENEFIT-TO-COST ESTIMATES
BOTSWANA: 1985-2015

Year	RECURRENT FP PROGRAM COSTS		EDUC & HEALTH SECTOR SAVINGS		BENEFIT-TO-COST RATIO	
	ANNUAL	CUMUL	ANNUAL	CUMUL	ANNUAL	CUMUL
1985	677	677	0	0	0.00	0.00
86	783	1,460	24	24	0.03	0.02
87	890	2,350	48	73	0.05	0.03
88	996	3,347	73	145	0.07	0.04
89	1,103	4,450	97	242	0.09	0.05
1990	1,210	5,659	121	363	0.10	0.06
91	1,349	7,008	268	631	0.20	0.09
92	1,488	8,496	416	1,047	0.28	[illegible]
93	1,628	10,124	563	1,610	0.35	[illegible]
94	1,767	11,891	711	2,321	0.40	[illegible]
1995	1,906	13,797	858	3,179	0.45	[illegible]
96	2,088	15,885	1,385	4,564	0.66	[illegible]
97	2,270	18,155	1,911	6,475	0.84	[illegible]
98	2,451	20,606	2,438	8,913	0.99	[illegible]
99*	2,633	23,240	2,964	11,877	1.13	[illegible]
2000	2,815	26,055	3,491	15,368	1.24	[illegible]
01	3,000	29,115	4,438	19,806	1.48	[illegible]
02	3,306	32,421	5,385	25,191	1.63	[illegible]
03	3,551	35,972	6,332	31,523	1.78	[illegible]
04	3,796	39,767	7,279	38,802	1.92	[illegible]
2005**	4,041	43,808	8,226	47,028	2.04	[illegible]
06	4,319	48,127	9,660	56,688	2.24	[illegible]
07	4,597	52,724	11,095	67,783	2.41	[illegible]
08	4,875	57,599	12,529	80,312	2.57	[illegible]
09	5,153	62,752	13,964	94,276	2.71	[illegible]
2010	5,431	68,182	15,398	109,674	2.84	[illegible]
11	5,814	73,997	16,900	126,574	2.91	[illegible]
12	6,198	80,195	18,402	144,976	2.97	[illegible]
13	6,582	86,777	19,904	164,880	3.02	[illegible]
14	6,966	93,742	21,406	186,286	3.07	[illegible]
2015	7,349	101,092	22,908	209,194	3.12	[illegible]

*Break-even point
**Pay-back point

- Assumes 90 percent of family planning users are supplied by the Botswana National Family Planning Progam.

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ANNEX

D

BUDGET ANALYSIS

BUDGET TABLE 1
USAID CONTRIBUTIONS
FOUNDATION SECTOR GRANT 1988-1992
(U.S.Dollars)

DESCRIPTION	YR 1	YR 2	YR 3	YR 4	YR 5	TOTAL
1. Budget Support	$500,000	$500,000	$500,000	$500,000	$100,000	$2,000,000
2. TA and Training						
- Long Term Technical Assistance						
a. Contraceptive Logistics	$0	$0	$0	$0	$0	$0
b. NFP	$0	$0	$0	$0	$0	$0
c. IEC Services	$125,000	$125,000	$125,000	$0	$0	$375,000
d. MCH/FP Service Delivery	$0	$0	$0	$0	$0	$0
-Short-Term Technical Assistance						
a. Contraceptive Logistics	$30,000	$30,000	$0	$0	$0	$60,000
b. NFP	$150,000	$125,000	$120,000	$75,000	$30,000	$570,000
c. IEC Services	$45,000	$45,000	$0	$0	$0	$90,000
d. MCH/FP Service Delivery	$55,000	$30,000	$30,000	$0	$0	$115,000
- Training						
a. Contraceptive Logistics	$0	$0	$0	$0	$0	$0
b. NFP	$37,500	$37,500	$0	$0	$0	$75,000
c. IEC Services	$20,000	$20,000	$20,000	$0	$0	$60,000
d. MCH/FP Service Delivery	$23,000	$23,000	$0	$0	$0	$46,000
Subtotal	$485,500	$505,500	$275,000	$75,000	$30,000	$1,391,000
3. Administration/Management						
- Planning Studies and Evaluations	$30,000	$30,000	$50,000	$30,000	$50,000	$190,000
- Program Management	$24,000	$24,000	$24,000	$24,000	$24,000	$120,000
Subtotal	$54,000	$54,000	$74,000	$54,000	$74,000	$310,000
4. Contingency (10%) *	$53,250	$55,950	$36,900	$12,900	$10,400	$170,100
5. Inflation (5%) *	-	$27,975	$36,900	$17,350	$20,800	$129,900
TOTAL ESTIMATED EXPENDITURES	$1,493,450	$1,343,425	$1,042,800	$641,250	$535,200	$5,000,000
PROPOSED OBLIGATION SCHEDULE	$1,500,000	$1,500,000	$1,000,000	$500,000	$500,000	$5,000,000

*: Applies to TA and Training and Administration/Management

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BUDGET TABLE 2
TECHNICAL ASSISTANCE PLAN
[illegible] EDISWANO POPULATION SECTOR GRANT

[illegible] Specialization	GOB Department Counterpart	Total Person-Months	Total Cost TA	Total Cost Pula Equiv.	YR 1 mos.	YR 1 $	YR 2 mos.	YR 2 $	Distribution YR 3 mos.	YR 3 $	YR 4 mos.	YR 4 $	YR 5 mos.	YR 5 $
[illegible] Term														
[illegible] Specialist	Health Education Unit	36	$375,000	590,087	12	$125,000	12	$125,000	12	$125,000	0	$0	0	$0
Subtotal - Long Term		36	$375,000	590,087	12	$125,000	12	$125,000	12	$125,000	0	$0	0	$0
Short Term														
Contraceptive Systems	MCH/FP Unit	4	$60,000	94,414	2	$30,000	2	$30,000	0	$0	0	$0	0	$0
[illegible] Development	Ministry of Health	3	$45,000	70,678	0	$0	3	$45,000	0	$0	0	$0	0	$0
[illegible] operational policies	Ministry of Health	9	$135,000	212,431	3	$45,000	4	$60,000	2	$30,000	0	$0	0	$0
[illegible] Implementation	MOH/NFP Coordinating Office	6	$90,000	141,621	0	$0	0	$0	2	$30,000	2	$30,000	2	$30,000
Demographic and Health Data Analysis	Central Statistics Office	20	$300,000	472,069	7	$105,000	6	$90,000	4	$60,000	3	$45,000	0	$0
[illegible] Research, Analysis, Evaluation	Health Education Unit	6	$90,000	141,621	3	$45,000	3	$45,000	0	$0	0	$0	0	$0
[illegible] service delivery	MCH/FP Unit	5	$75,000	118,017	1	$15,000	2	$30,000	2	$30,000	0	$0	0	$0
Technical Support	Ministry of Health	3	$45,000	70,810	3	$45,000	0	$0	0	$0	0	$0	0	$0
Subtotal - Short Term		56	$840,000	1,329,661	19	$285,000	20	$300,000	10	$150,000	5	$75,000	2	$30,000
[illegible] TOTAL		92	$1,215,000	1,919,748	31	$410,000	32	$425,000	22	$275,000	5	$75,000	2	$30,000

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BUDGET TABLE 3

TRAINING PLAN FOR BOTSWANA FOR HUMAN RESOURCE SECTOR GRANT

Type and Cost	Duration mos	Total Cost $	Distribution YR 1 mos.	YR 1 $	YR 2 mos.	YR 2 $	YR 3 mos.	YR 3 $	YR 4 mos.	YR 4 $	YR 5 mos.	YR 5 $
I. Out of-Country Training												
A. Master's Degree												
- Master's of Public Health	24	$46,000	12	$23,000	12	$23,000	0	$0	0	$0	0	$0
Subtotal Master's	24	$46,000	12	$23,000	12	$23,000	0	$0	0	$0	0	$0
B. Non-Degree												
- 3 X 1 year diploma in Health Education	36	$60,000	12	$20,000	12	$20,000	12	$20,000	0	$0	0	$0
- Observational Travel (10 trips at $7,500/trip)	10	$75,000	5	$37,500	5	$37,500	0	$0	0	$0	0	$0
Subtotal - Non-Degree	46	$135,000	17	$57,500	17	$57,500	12	$20,000	0	$0	0	$0
TOTAL	70	$181,000	29	$80,500	29	$80,500	12	$20,000	0	$0	0	$0

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BUDGET TABLE 4

GOB CONTRIBUTIONS

POPULATION SECTOR GRANT 1988 1992

(Dulas)

DESCRIPTION OF LINE ITEM CONTRIBUTIONS	1988	1989	1990	1991	1992	Total
1. Contraceptives	0	50,000	60,000	270,000	550,000	930,000
2. National Population Policy and Analysis						
a. CSO Recurrent Costs*	521,850	521,850	521,850	521,850	521,850	2,609,250
b. CSO Development Costs(GOB Share)						
- Continuous Household Surveys **	200,000	165,000	168,000	168,000	172,000	873,000
- Population Census***	0	185,000	314,000	546,000	150,000	1,195,000
Subtotal	721,850	871,850	1,003,850	1,235,850	843,850	4,677,250
3. Health Education and IEC Services*						
a. Health Education Unit (Salaries)	66,290	66,290	66,290	66,290	66,290	331,450
b. Non-salary HEU Recurrent Costs	39,642	39,642	39,642	39,642	39,642	198,210
Subtotal	105,932	105,932	105,932	105,932	105,932	529,660
4. MCH/FP Service Delivery						
a. MOH MCH/FP Recurrent Costs**	2,818,917	2,818,917	2,818,917	2,818,917	2,818,917	14,094,585
b. MLGL MCH/FP Recurrent Costs**	0	0	0	0	0	0
Subtotal	2,818,917	2,818,917	2,818,917	2,818,917	2,818,917	14,094,585
5. Total GOB Contributions	3,646,699	3,846,699	3,988,699	4,430,699	4,318,699	20,231,495

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BUDGET FOR CONTRACEPTIVES 1988-1992

Description	1988	1989	1990	1991	1992	Total
I. Units Required						
a. Pill	589,000	647,900	712,690	783,959	862,355	3,595,904
b. IUDs	9,410	10,351	11,386	12,525	13,777	57,449
c. Condoms	1,428,800	1,571,680	1,728,848	1,901,733	2,091,906	8,722,967
d.						0
II. Price Assumptions						
a. Pill	$0.30	$0.32	$0.33	$0.35	$0.36	
b. IUDs	$1.15	$1.21	$1.27	$1.33	$1.40	
c. Condoms	$0.06	$0.07	$0.07	$0.08	$0.08	
d.	$0.06	$0.07	$0.07	$0.08	$0.08	
III. Budget						
a. Pill	$176,700	$204,089	$235,722	$272,259	$314,459	$1,203,229
b. IUDs	$10,822	$12,499	$14,436	$16,674	$19,258	$73,688
c. Condoms	$92,729	$107,102	$123,703	$142,877	$165,023	$631,434
d.	$0	$0	$0	$0	$0	$0
Total	$280,251	$323,689	$373,861	$431,810	$498,740	$1,908,352
PAIP Contribution	$280,251	$291,321	$336,475	$387,006	$449,622	$1,316,754
GOK Contribution	$0	$32,369	$37,386	$43,204	$49,118	$591,597

10 Percent Inflation	1	1.05	1.1025	1.15763	1.21550625
10 Percent Demand Growth	1	1.1	1.21	1.331	1.4641

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ANNEX

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TRAINING AND MANPOWER TABLES

TABLE 1

MANPOWER LEVELS FOR DELIVERY OF MCH/FP SERVICES

GRADE	(N2)	(N3)	N4	N5	N6	N7	FWE'S	TOTAL
NURSES MOH	10	42	79	303	162	322	-	938
%	1	4	8	32	19	34	-	-
NURSES ULGS	8	22	52	199	78	357	-	716
%	1	3	7	28	11	50	-	-
FWE'S ULGS	-	-	-	-	-	-	630	630
TOTALS	18	64	131	502	260	679	630	2284

Source: MCH Planning Unit, 1987

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TABLE 2

MIDTERM NDPG TRAINING TARGETS AND ACHIEVEMENTS

TRAINING IN BOTSWANA 1985/86 - 1987/88

PERSONNEL	TARGETS	ACHIEVED	DIFFERENCE	DIFFERENCE
FAMILY HEALTH EDUCATORS	100	101	13	-11
ENROLLED NURSES	231	233	5	2
EH HEALTHS	83	84	1	1
REGISTERED NURSES	0	122	122	
EH HEALTHS	304	170	-126	-41
SPECIALIST NURSES	136	85	-51	-46
HEALTH ADMINISTRATORS	10	1	-9	-90
DENTAL THERAPISTS	15	15	0	0
LAB TECHNICIANS	20	18	-2	-10
PHARM TECHNICIANS	30	34	4	13
HEALTH EDUCATORS	4	0	-4	-100
NUTRITION OFFICERS	16	0	-16	-100
NURSE EDUCATORS	24	22	-2	-8
MEDICAL RECORDS	20	18	-2	-10
TOTAL IN BOTSWANA	1055	1061	114	-10

SOURCES: MOH MANPOWER DEPARTMENT
MOH PLANNING UNIT

NOTES: NURSING GRADES COMPLETED FOR DOUBLE COUNTING

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TABLE 3

MIDTERM HPPG TRAINEE TARGETS AND ACHIEVEMENTS

TRAINEES ABROAD 1985/86 - 1987/88

PERSONNEL	PLANNING TARGETS	EXPECTED ACHIEVEMENT	DIFFERENCE	%DIFFERENCE
HEALTH INSPECTORS	30	13	-17	-57
MEDICAL SPECIALISTS	9	3	-6	-67
MEDICAL OFFICERS	15	4	-11	-73
PARAMEDICAL MEDICAL OFFICERS	5	3	-2	-40
PHARMACISTS	6	0	-6	-100
MEDICAL TECHNICIANS	7	3	-4	-57
DENTISTS	3	1	-2	-67
CONTINUATION TUTORS	6	2	-4	-67
NUTRITIONISTS	3	2	-1	-33
SPECIALIST NURSES	26	9	-17	-65
TOTAL PERIOD	110	40	-70	-64

SOURCES: HPPG HEADQUARTERS DEPARTMENT
HPPG PLANNING UNIT

NOTES: HEADING GROUPS CORRECTED FOR DOUBLE COUNTING

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TABLE 4

TRAINING TARGETS & EXPECTED ACHIEVEMENTS FOR REMAINING PLAN PERIOD

(1988/89 TO 1990/91)

TRAINING IN MALAWI

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	TARGETS	[illegible]	DIFFERENCE	%DIFFERENCE
[illegible]				
[illegible]	110	110	0	0
FORMAL [illegible] EDUCATIONS	100	200	80	42
ENROLLED NURSES	40	81	-41	103
[illegible]	0	125	125	
REGISTERED NURSES	324	223	-101	-31
[illegible]	114	48	-66	-58
SPECIALIST NURSES	15	0	-15	-100
[illegible] ADMINISTRATORS	13	2	-2	-11
DENTAL THERAPISTS	12	17	5	17
[illegible] TECHNICIANS	30	35	4	15
DENTAL TECHNICIANS	3	5	2	67
[illegible] EDUCATORS	16	0	-16	-100
[illegible] OFFICERS	22	12	-10	-45
[illegible] OFFICERS	24	15	-9	-38
NURSE EDUCATORS	18	0	-18	-100
[illegible] RECORDS				
TOTAL [illegible] HOUSEHOLD	1041	1041	20	2

LEGEND:

[illegible] DEPARTMENT
[illegible]

NOTES:

[illegible] COUNTS CORRECTED FOR DOUBLE COUNTING

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TABLE 5

TRAINING TARGETS & EXPECTED ACHIEVEMENTS FOR REMAINING PLAN PERIOD

(1988/89 TO 1990/91)

TRAINEES ABROAD

PROFESSIONAL	PERCEIVED TARGETS	EXPECTED ACHIEVEMENT	DIFFERENCE	%DIFFERENCE
HEALTH INSPECTORS	30	13	-17	-57
MEDICAL SPECIALISTS	9	3	-6	-67
MEDICAL OFFICERS	15	4	-11	-73
SENIORS MEDICAL OFFICERS	5	3	-2	-40
PHARMACISTS	6	0	-6	-100
MEDICAL TECHNICIANS	7	3	-4	-57
DENTISTS	3	1	-2	-67
PARA TECHNICIAN TUTORS	6	2	-4	-67
DIETITIONISTS	3	2	-1	-33
SPECIALIST NURSES	26	9	-17	-65
TOTAL ABROAD	110	40	-70	-64

SOURCE(S): MOH HUMRESOURCE DEPARTMENT
MOH TRAINING UNIT

NOTE(S): NUMBERS ALREADY EXPECTED FOR DOUBLE COUNTING

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TABLE 6

CONTINUING EDUCATION OFFERINGS IN HEALTH - 1987/88

NATIONAL LEVEL

TRAINING ACTIVITY	PARTICIPANTS	TRAINING DATES	VENUE	TRAINERS
1 DHT Management Training	District Health Teams	a 26-30 January b 23-27 February c 23-27 March d 27 April 1 May e 25-29 May f 22-26 June	a Lobatse b Maun c Gantsi d Gaborone e Serowe f Selibe-Phikwe	Primary Health Care Support Unit Team and Central Core Team
MCH/FP PROGRAMME 2 Maternal & Child Health Management & Family Planning Technology	a 20 Registered Nurses and Midwifery, Enrolled Nurses & Midwifery. b 20 Family Nurse Practioners	a 16-20 February b 9-20 March 87	a Lobatse MHI b Lobatse MHI	MHI Staff/Cont. Education Staff " " " "
3 Strengthening FP practice standards	Representatives from: - Health Empower - Primary Health Care - Hospital Services - Nursing Council - Medical & Dental Association Board. - Obs/Gynae specialist - National Drug Committee	6-10 July 1987	Gaborone	1 Intrah trainer 1 MOH trainer
4 Orientation to MOH Family Health Project and FP Training Plan	5 Ia. Principal & Heads of selected MHI programmes. 14 Hospital Matrons 14 HLCS Matrons 1 Representative Nursing Council 1 UB Nursing Dept. Representative 3 FHD Total: 39	29-30 July '87	Gaborone	1 Intrah trainer 4 MOH trainers

SOURCE: CONTINUING EDUCATION UNIT MOH

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5 FP Clinical Procedure Manual Development	6 Core training team members 4 RN incharge of MCH/FP clinics 1 Hospital clinic based 1 Health Centre based 1 Rural clinic 1 Training Clinic 1 MCH/FP/CHN	17-28 July '87	Gaborone	2 Intrah trainers 2 MOH Trainers
6 Draft Manual review and Revision		26-30 November '87		
7 Use of MCH/FP Integration Manual A workshop	35 x 3 tutors	9-13 Nov. 87 16-20 Nov. '87 23-27 Nov. '87		2 INTRAH Trainers 2 MOH trainers (Implementation Task Force)
8 Training of Trainers for Family Planning Integration.	10 Tutors 5 Midwifery/CHN/FNP - NHI 2 EN Tutors 2 Mission Hospital Tutors 4 Allied Health Tutors 1 FWE Tutor 25	18 Jan-13 Feb. '88	Lobatse - NHI	2 INTRAH Trainers 2 MOH Trainers
GENERAL TRAINING SKILLS 9 Training of trainers of Health Personnel	a 18 members of Health Management Teams in Districts & Hospitals b 18 " " " " c 18 " " " " TOTAL: 54	a 16-27 March '87 b 3-14 Aug. '87 c 24 Aug.-4 Sept. 87	Serowe - NHI Lobatse - NHI Francistown	Cont. Education Staff " " " " " "
MANAGEMENT 10 Leadership & Supervision Training	a Matrons & Senior Sisters	a 2-13 March '87 b 16-27 March '87	Francistown Gaborone? Lobatse (YWCA)	MEDEX GROUP MOH Trainers " "
11 FNP/CHN Tutor training	FNP Tutors & CHN Tutors	26 Oct.-6 Nov '87	Lobatse	MEDEX GROUP & IHO Trainers

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12 Management of Nursing Personnel & Implementing clinical standards.	Matrons & Senior Sisters	9-13 Nov '87 16-20 Nov. '87	Lobatse	MEDEX GROUP & MOH Trainers
13 MENTAL HEALTH Diagnosis & Management of Patients with Mental Health Problem – Emphasis: Use of Psychiatric Flow Chart.	a 30 Health Workers who consult in clinics & Health Centres b " " " " " c " " " " "	a 4-18 May 1987 b 8-12 June 1987 c 12-16 Oct. '87	Lobatse – MHI " " "	Mental Health Task Force and Continuing Education Staff
14 RESEARCH Introduction to Research Methodology	Heads of clinics Ward Sisters Some District Health Team Members 30 participants per Workshop	29 June-3 July '87 13-17 July	Lobatse – MHI	Cont. Education Staff & Some Resource people
15 PREVENTION OF BLINDNESS Orientation of General Nurses to common eye problem.		4-6 March	Lobatse – MHI	Opthalmic Care Committee
16 INFECTION CONTROL Orientation to Infection Control	Sisters in charge of wards and Health Centres. (numbers to be determined)	15-19 June	Francistown	Infection Control Officers Mrs Radisa – S/Sister – Jubilee Mrs Mpodi – Sister – MHI C.E Tutors
17 Health Assessment	Health Workers who consult patients at clinics and OPDS	September 1987 October 1987 (Extract data to be determined)	To be determined	Practising Family Nurse Practitioners.
18 Health Administration and Management.	Top level administrators and managers at MOH Headquarters and at Division level	To be determined		Mr Duffy – Health Management Specialist.

MATERNAL AND CHILD HEALTH AND FAMILY PLANNING MANPOWER PLAN
(MOH AND ULGS)

ACTIVITY	DATES	PARTICIPANTS	TRAINERS/CONSULTANTS CO-TRAINERS
*1 FP clinical skills development (in Bulawayo)	Aug 3 - Sept 11 1987 6 weeks	3: 2 NHI tutors 1 Nurse/midwife	ZNFPC
2. Reproductive Health and orientation to FH training plan I	Aug 20-21 1987 2 days	50: MOH/UGLS/NHI MCH/DCHN	2 INTRAH 2 MOH
3. Reproductive Health and orientation to FH training plan II	Aug 24 - 25, 1987 2 days	50: MOH/UGLS/NHI MCH/DCHN	2 INTRAH 2 MOH
4. Formulation of national FP general guidelines	Oct 15 - 16, 1987 2 days	11: policy makers and tech staff	1 INTRAH 2 MOH
5. Formulation of FP practice 'technical' standards	Oct 19-21 1987 3 days	6:	1 INTRAH 2 MOH
*6 FP clinical skills development (in Harare	Oct 19- Nov 27, 1987 6 weeks	3: 1 NHI tutor 1 NHI tutor (basic) 1 Nurse/midwife	ZNFPC
7. Clinical FP Procedures Manual Development 11 MOH/City Council	Jan 11- 29, 1988 15 days	11: 6 CTT 4 RN/M 1 MCH/FP	2 INTRAH 2 MOH
8. Mid-point program review	Feb 5, 1988 1 day	9: 4 Ref GP 2 Task Force 1 Natl FP 1 NHI tutor 1 MCH/FP Dir	1 INTRAH 2 MOH

* INTRAH funded

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ACTIVITY	DATES	PARTICIPANTS	NO	TRAINERS CO-TRAINERS
FP Clinical Skills	Last quarter 88-89	RN, EN lab personnel (MOH, ULGS)	80	MOH
Health Ed inservice training and IEC training	April 1988	RHENO Health Ed St off, FWES (MOH, ULGL)		MOH IBRD
Management, Supervision and Evaluation	1988/89	Senior Nurses SRN FWE Supervisors (MOH, ULGS)	12 40	MOH IBRD
Improvement of Contraceptive Prescribing Techniques	1988/89	Doctors (MOH, ULGS)		MOH IBRD
Overseas Training in MCH (MPH)	1989	Doctors Others (MOH)	2 2	MOH DONOR

ULGS POST BASIC TRAINING

Ongoing Training

Course	Year	No
Community Health Nursing	1986/87	10
Family Nurse Practitioner	1986/87	8
Midwifery	1986/87	16

Planned Training 1988/89

10 per course per year (more for midwifery)

SOURCES: MOH HEALTH MANPOWER DEPARTMENT
MOH UNITED LOCAL GOVERNMENT SERVICE

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REPUBLIC OF BOTSWANA. DIRECTORATE OF PERSONNEL PUBLIC SERVICE SALARY SCALES
(CONDENSED FROM PERSONNEL DIRECTIVE NO.1 OF 1986)

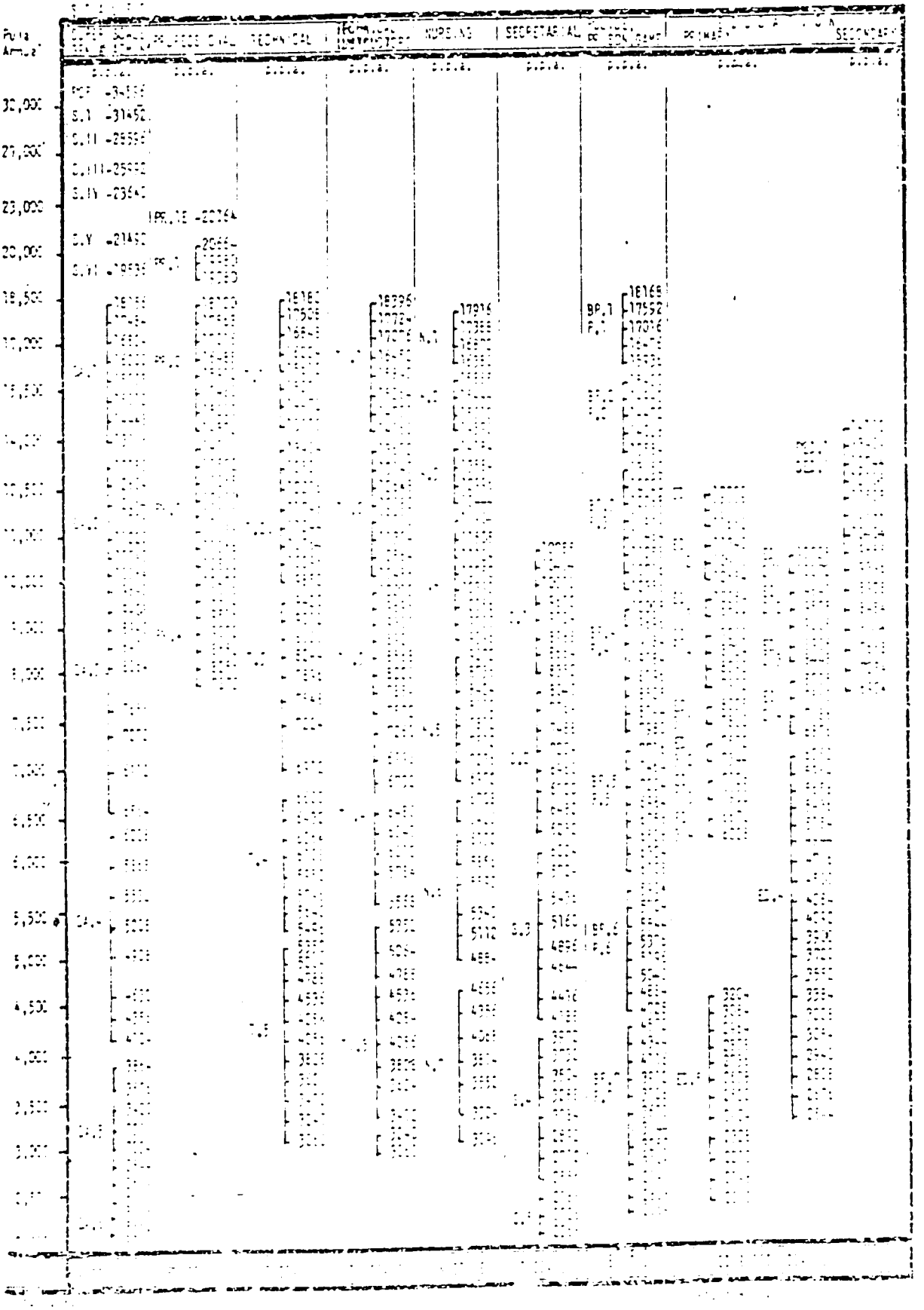

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TABLE 9

NDP6 PROJECTED HEALTH MANPOWER TRAINING REQUIREMENTS

Health Personnel	Training Period	1985/86	1986/87	1987/88	1988/89	1989/90	1990/91	Total
Training in Botswana:								
Family Welfare Educators	10-12 wks	60	60	60	60	60	60	360
Enrolled Nurses	2 years	80	90	65	65	65	65	420
Enrolled Nurses Midwives	16 months	45	—	40	—	40	—	125
Registered Nurse Midwives	4 years	87	109	108	108	108	108	628
Nurse Anaesthetist	1 yr post RN/Mid	0	4	4	4	4	4	[illegible]
Community Health Nurses	1 yr post RN/Mid	18	18	18	18	—	—	[illegible]
Family Nurse Practitioner	1 yr post RN/Mid	18	18	18	18	to be	decided	[illegible]
Community Mental Health Nurse	1 yr post RN/Mid	0	10	10	10	10	10	50
Nurse Administrator	1-2 yrs post RN/Mid	—	8	8	8	8	8	[illegible]
Health Administrators	1 - 2 years	—	5	5	5	5	5	[illegible]
Senior Nurse Administrators	3 years	—	—	4	4	4	4	[illegible]
Dental Therapists	3 years	0	8	7	7	6	6	[illegible]
Laboratory Technicians	3 years	—	10	10	10	10	10	[illegible]
Pharmacy Technicians	3 years	9	11	10	12	9	6	[illegible]
Health Educators	4 years	2	1	1	1	1	1	[illegible]
Nutrition Officers	2 years	—	—	16	—	16	—	[illegible]
Social Welfare Officers*	2 - 3 years	—	—	—	6	6	6	[illegible]
Nurse Educators	Degree	8	8	8	8	8	8	[illegible]
Medical Records	9 months post JC	6	6	6	6	6	6	[illegible]
Subtotal		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Training abroad:								
Health Inspectors	3 years	—	—	10	10	10	10	[illegible]
Medical Specialist	2 yrs post MB ChB	2	3	2	2	2	1	[illegible]
Medical Officers	6 years	2	3	2	2	4	3	24
Pharmacists	4 — 5 years	4	2	4	5	0	0	15
Medical Technicians	2 years	2	2	2	2	2	2	[illegible]
Regional Medical Officers	Degree	1	2	2	1	2	1	[illegible]
Dentists	6 years	1	1	1	1	1	1	6
Health Lab. Tech. Tutors	3 years	—	—	2	1	1	4	
Nutritionists	4 years	3	1	2	1	1	1	9
Specialist Nurses:								
Operating Theatre	1 year	1	2	2	2	2	2	[illegible]
Obstetric	Post	2	1	2	1	2	2	[illegible]
Orthopaedic	Basic	1	2	1	1	2	1	[illegible]
Pediatrics	Nursing	1	2	2	2	2	—	[illegible]
Intensive Care	"	2	2	2	2	2	—	[illegible]
Ear, nose, throat	"	2	2	2	2	—	—	[illegible]
Subtotal		25	26	39	37	33	36	[illegible]
Grand Total		358	392	435	387	399	[illegible]	[illegible]

Source: Ministry of Health, Planning Unit.

Note:
1. Attrition rate of 10% over entire life of each course taken into consideration in final figures.
2. Specialist training targets for Medical and Nursing Personnel difficulty in securing placement abroad.
3. NHI Training facilities can only accommodate 720 students at any given time.
4. Distribution formula for NHI graduates between MOH and ULGS will be reviewed from time to time taking into consideration the overall manpower needs of the country.
5. * Some social welfare officers may be trained abroad.

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ANNEX

F

FINANCIAL ANALYSIS OF GOB EXPENDITURE

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MINISTRY OF HEALTH DEVELOPMENT PROJECTS

Maternal Child Health/Family Planning Project (MD 31).

Total estimated costs for this project are P1,000,000 over six years. As can be seen in Table 7, however, funding for the MCH/FP project has been rather erratic and concentrated in the areas of operations research and infrastructure. Sixty-four percent of the project funds have gone to constructing and equipping the Health Education Units, rather than to actual MCH/FP services. Training and service delivery accounted for just 3.4% of project expenditures between 1983/84-1986/87. Two additional points must be made: (1) fully 100% of this project is funded by donors (see Table Nine); and (2) actual overall project expenditures have been far below what was projected in NDP VI. Expenditures were only 45% of what was expected in 1985/86, and 6% of forecast expenditures in 1986/87. Furthermore, estimated expenditures in 1987/88 are 80% lower than 1986/87 project expenditures. This may be because not all donor contributions to the project were known at the time the estimates were made (although the two major donors, the World Bank and NORAD are accounted for).

Family Health Project (MD 21).

The Family Health Project (MD 21) was begun in 1985/86 with assistance from the World Bank, NORAD, and USAID (provision of contraceptives). This project is the GOB's primary effort in the area of family health, with total funding by the GOB projected to be P6,694,000 over six years. It is really just now coming on stream: actual expenditures were far below projections in 1985/86 and 1986/87, although this year's estimated expenditures are more than three times what was forecast in NDP VI. In the first two years of this project (see Table Nine), the GOB's share of financing dropped from 27% to 11%, and there are no GOB expenditures estimated for 1987/88. Conversely, donor financing has been increasing, with most of the money going to technical assistance and training. Unfortunately, it is difficult to know just how much of this TA and training was for the MCH/FP subsector, as opposed to other health activities. Estimating that 15% of the project's expenditures are for MCH/FP activities, we see in Table 3 that the Family Health Project is the second largest of MCH/FP development funds, although if expenditures proceed as projected for 1987/88 it will become the largest.

Health Education Program (MD 32).

The Health Education Program is designed to complement the MCH/FP project and the Family Health project, conveying basic health information to all Batswana. Total estimated costs are P737,000 between 1985-1991. So far, project funds have been spent mostly on seminars and workshops, water hygiene, and acquisitions of vehicles and equipment. Expenditures for purchases of graphic equipment or other health education materials, however, have been very low. (Some graphic supplies do show up as a recurrent cost line item but they are just few, 9% total for the last five years.) Moreover, total expenditures for the project are quite small: just P[illegible] in 1985 to a P[illegible] in 1986/87 (see Table Eight). Over the last three years donors have financed most of this project. Later,

that 60% of these expenditures are for MCH/FP activities we see that few resources have really gone to improving information, education, and communication (IEC) programs.

Nutrition Program (MD 09).

The fourth project in the MCH/FP subsector is the Nutrition Program, which aims to develop strategies and programs to reduce undernutrition and monitor growth, particularly among infants. As such it is really directed at child health care, with little focus on family planning per se. Although funds have gone primarily to workshops and equipment (important health IEC components), the project remains very small. Total estimated costs are just P123,000 over six years. In 1986/87 expenditures were just P10,171 and in 1987/88 they are estimated to be around P13,000, 100% financed by UNICEF.

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MINISTRY OF LOCAL GOVERNMENT AND LANDS DEVELOPMENT PROJECTS

Development of Basic Health Facilities (LG 20).

Started in 1973, LG 20's objective is to increase the number of rural health posts and clinics. Total estimated costs between 1985-1991 are P5,585,000. Overall, LG 20 has been quite successful. In 1984/85 and 1985/86 most of the project funds went to construction and equipment, with limited funds going to primary health care activities. Yet, understandably, as the GOB approaches its goal of 85% of all rural residents within 15 km of a health facility, this project has been receiving progressively smaller allocations. In 1984/85 expenditures were over P2 million; they are expected to be half of that in 1987/88. Other project components aimed at qualitative improvements (e.g. in-service training and health education) have not received more support as construction has been phased out. In part, this may be because the MLGL has increased the training of its health personnel through LG 55, a ministry-wide manpower training project (which does not have disaggregate figures for health personnel at this time). Because LG 20 was designed to increase overall health service accessibility, only 10% of project funding was attributed to MCH FP activities.

District Health Teams (LG 49).

This project originally began as the Regional Health Team Project (MC 29) under the MOH, but was transferred along with the Regional Health Teams (RHT) to the MLGL in 1986-87. It has consisted mainly of infrastructural support (offices, housing vehicles) for the RHTs, with increasing funding for purchases of equipment. Total estimated costs are P1,250,000 over six years, with 100% of expenditures financed by donors over the last three years. Once again, the focus has been on improving health services quantitatively, rather than on activities such as training and education which might have more impact on the quality of MCH FP services. Because RHT's do much more than provide MCH FP services, only 10% of project expenditures are attributed to MCH FP subsector development.

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CENTRAL STATISTICS OFFICE DEVELOPMENT PROJECTS

Continuous Household Surveys - CHIPS (ST19).

CHIPS was set up under the auspices of the United Nations with the aim of collecting and interpreting a continuous and coordinated flow of demographic information. Total estimated costs for CHIPS are P1,257,000 over the six-year life of the project. Project expenditures have increased steadily at an average annual rate of 40%, with GOB funding averaging 77% over the last 5 years. (see Table Nine) Recent discussions with CSO indicated, however, that UNFPA might be withdrawing its support for the Unit, which would seriously impair the quantity and quality of population analysis produced under CHIPS. Thus, future development budget allocations for this project and the Demography Unit must be watched carefully.

Population Census (ST 07).

This project was designed to implement the 1981 National Population Census, carried out every ten years. It generated the essential information regarding the demographic, social and economic characteristics of the Batswana population, particularly the annual population growth rate. Total estimated costs were P1,228,000 between 1979-1985, with most of the funding in 1980-81 and 1981-82. Expenditures were just P14,000 in 1983-84 and its last year of funding 1984-85, was less than P3,700. Although this population census project no longer contributes to population analysis development expenditures, the 1991 Population Census is expected to be an even larger, more comprehensive project. The decreasing expenditures of this project are therefore misleading: they should not be interpreted as meaning population analysis activities are declining.

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Table One

Summary Table of Population Sector

Expenditures, 1983/84-1987/88

(Pulse)

	1983/84	1984/85	1985/86	1986/87	1987/88 (Est.)
1. MOH/PP Activities					
a. Ministry of Health (MOH) (See Table Three)					
Recurrent Costs	617,141	754,119	859,750	2,162,127	2,818,517
Development Costs	68,891	126,041	171,478	459,325	665,[illegible]
Combined Costs	686,032	880,160	1,031,228	2,621,451	3,484,517
b. Ministry of Local Government and Lands (MLGL) (See Table Four)					
Recurrent Costs	501,981	647,746	761,325	864,568	1,117,451
Development Costs	167,872	216,473	259,188	245,089	151,[illegible]
Combined Costs	669,853	864,224	920,412	1,117,157	1,268,[illegible]
c. Transport Costs (CTO) #	154,721	213,847	627,594	344,765	458,515
2. SubTotal					
Recurrent Costs #	1,719,843	1,615,711	2,147,669	3,371,4[illegible]	4,391,517
Development Costs	221,767	342,513	364,566	711,4[illegible]	816,[illegible]
Combined Costs	1,941,610	1,948,224	2,612,234	4,372,87[illegible]	5,2[illegible]
3. Population Analysis Activities (See Table Five)					
a. Central Statistics Office (CSO)					
Recurrent Costs	5,985	17,771	301,455	503,515	551,85[illegible]
Development Costs	77,494	117,717	194,115	157,751	[illegible]
Combined Costs	83,479	135,474	495,772	661,595	721,85[illegible]
SubTotal	83,479	135,474	495,772	661,595	721,85[illegible]
C. Total Population Sector Expenditures					
Recurrent Costs	1,714,874	1,633,482	2,549,723	3,875,345	4,915,767
Development Costs	414,261	456,222	558,684	859,206	1,018,10[illegible]
Total Combined Costs	1,729,054	2,089,704	3,108,007	4,734,57[illegible]	5,93[illegible]

#: Assume 40% of all Central Transport Organization (CTO) Primary Health Care Care Transport Costs go to MOH-PP

*: Include all CTO MOH-PP Transport costs in this item

**: Assume 50% of CSO recurrent costs go for population analysis

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Table Two

Summary Growth of Population Sector Expenditures, 1983/84-1987/88

	1983/84	1984/85	1985/86	1986/87	1987/88	1988/[illegible]
1. MCH/FP Activities						
a. Ministry of Health						
- Annual % Growth Rate of Recurrent Expenditures	NA	22.20%	14.01%	151.46%	36.38%	
- Annual % Growth Rate of Development Expenditures	NA	82.96%	36.05%	167.86%	44.97%	
- Annual % Growth Rate of Combined Expenditures	NA	26.30%	17.16%	154.21%	32.93%	
- Per Capita Expenditures	0.57	0.73	0.86	2.18	2.5[illegible]	
b. M.O.H.						
- Annual % Growth Rate of Recurrent Expenditures	NA	20.63%	17.38%	10.7[illegible]	28.77%	
- Annual % Growth Rate of Development Expenditures	NA	-19.15%	-1[illegible].8%	28.38%	-27.1[illegible]	
- Annual % Growth Rate of Combined Expenditures	NA	7.38%	1[illegible].22%	16.1[illegible]	1[illegible].33%	
- Per Capita Expenditures	0.07	0.72	0.73	0.92	1.[illegible]	
2. Total MCH-FP Expenditures						
- Annual % Growth Rate of Recurrent Expenditures	NA	22.68%	23.93%	[illegible]	[illegible]	
- Annual % Growth Rate of Development Expenditures	NA	1.71%	0.44%	52.40%	36.04%	
- Annual % Growth Rate of Combined Expenditures	NA	18.39%	34.08%	55.92%	27.9[illegible]	
- Per Capita Expenditures	1.27	1.62	2.18	3.73	4.[illegible]	
- Percentage of Overall GOZ Budget	0.28%	0.27%	0.28%	0.35%	0.3[illegible]%	
3. Population Activities						
- Annual % Growth Rate of Recurrent Expenditures	NA	196.92%	1557.50%	67.05%	3.56%	
- Annual % Growth Rate of Development Expenditures	NA	51.89%	64.92%	-15.71%	26.75%	
- Annual % Growth Rate of Combined Expenditures	NA	62.28%	265.96%	33.47%	9.05%	
- Per Capita Expenditures	0.07	0.11	0.41	0.55	0.6[illegible]	
- Percentage of Overall GOZ Budget	0.01%	0.02%	0.05%	0.14%	0.0[illegible]%	
4. Total Population Sector Expenditures						
- Annual % Growth Rate of Recurrent Expenditures	NA	22.[illegible]%	[illegible]	[illegible]	[illegible]	
- Annual % Growth Rate of Development Expenditures	NA	11.[illegible]%	2[illegible].7%	[illegible].7%	18.4[illegible]	
- Annual % Growth Rate of Combined Expenditures	NA	20.51%	49.1[illegible]	[illegible]	2[illegible].2[illegible]	
- Per Capita Expenditures	1.44	1.7[illegible]	2.5[illegible]	3.5[illegible]	4.9[illegible]	
- Percentage of Overall GOZ Budget	0.3[illegible]%	[illegible]	[illegible]	[illegible]	[illegible]	

Table Three
Recurrent and Development MOH Expenditures for
Primary Health Care and MCH/FP Activities (Pulas)

	1993/94	1994/95	1995/96	1996/97	1997/98 (est.)
1. Total MOH Expenditures					
a. Recurrent Costs	16,285,675	22,334,252	34,998,755	34,166,045	38,941,17[illegible]
b. Development Costs	5,405,907	3,938,348	6,453,417	20,243,123	35,245,[illegible]
c. Combined Expenditures	21,691,582	26,272,604	33,452,172	54,409,121	74,186,17[illegible]
2. Primary Health Care Services Budget #					
a. Recurrent Costs	1,77[illegible],425	1,[illegible]75,919	1,91[illegible],855	4,8[illegible]4,72[illegible]	[illegible]
b. Development Costs	575,[illegible]	828,912	1,558,157	4,17[illegible],[illegible]	15,824,[illegible]
c. Combined Expenditures	2,344,485	2,204,721	3,449,642	8,98[illegible],842	22,[illegible]
3. MCH/FP Activities					
a. Recurrent Costs *	[illegible]	784,119	959,75[illegible]	2,162,127	2,8[illegible],917
b. Development Costs					
- MCH/FP Division (See Table 7)	58,222	107,855	89,85[illegible]	27[illegible],775	5[illegible]
- Facility Health Project **	N/A	N/A	45,000	1,[illegible]	525,[illegible]
- Health Education Program ***	2,481	7,[illegible]	21,85[illegible]	55,755	76,[illegible]
- Nutrition Program ****	2,187	1,255	15,[illegible]	55,[illegible]	[illegible]
Development Subtotal	63,891	126,[illegible]	171,475	489,225	66[illegible]
Annual % Growth Rate	N/A	82,9%	36,05%	187,6%	44,9%
c. Combined Expenditures	65[illegible],132	9[illegible],161	1,131,228	2,651,45[illegible]	3,484,8[illegible]

#: Assume 1993/94 and 1994/95 PHC Recurrent and Development Costs are 7.5% and 19%, respectively, of MCH Recurrent and Development Costs, based on 1995/96 expenditures

*: Assume MCH/FP Recurrent Costs are 45% of PHC Recurrent Costs

**: Assume 15% of BCC contributions to Family Health Project (MCH) go to MCH/FP

***: Assume 6% of Health Education Program (MCH) goes to MCH/FP Activities

****: Assume 8% of Nutrition Program (MCH) goes to MCH/FP Activities

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Estimates of MCH/FP Expenditures
(Pula)

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	1983/84	1984/85	1985/86	1986/87	1987/88
1. Recurrent Expenditures					
a. District Councils					
-Central	1,230,840	1,525,720	1,813,860	1,951,290	2442193
-Ghanzi	215,750	283,690	329,450	416,460	556,590
-Kgalagadi	325,040	339,540	445,690	490,570	652,900
-Kgatleng	317,900	358,260	416,050	455,300	608,480
-Kgatleng	648,660	807,490	992,930	1,124,680	1,415,050
-Kwanengo	279,540	322,550	403,280	524,650	666,000
-North East	461,450	536,300	612,520	707,390	918,080
-North West	214,020	253,480	310,050	351,910	505,450
-South East	745,450	780,270	828,680	931,820	1,109,310
-Southern					
SubTotal	4,438,680	5,207,300	6,155,510	6,954,070	8,874,053
b. Town Councils					
-Francistown	176,360	228,670	278,300	372,750	559,350
-Lobatse	96,950	116,880	115,830	149,920	249,530
-Selebi-Phikwe	207,420	244,040	380,310	[illegible]	439,[illegible]
-Jwaneng	79,140	104,120	95,440	98,020	111,470
-Gaborone	371,230	578,250	578,840	761,120	932,410
SubTotal	931,100	1,270,160	1,447,740	1,885,610	2,291,760
Total Recurrent Health Expenditures	5,369,780	6,477,460	7,603,250	8,849,680	11,174,810
- Total MCH/FP Recurrent Expenditures *	536,981	647,746	761,325	884,968	1,117,481
2. Development Health Expenditures					
a. District Councils					
- Development of Basic Health Facilities (LB 2) **	96,512	215,822	177,340	2[illegible],300	1,2[illegible]
- District Health Teams (LB 49) **	12,464	4,957	11,649	22,762	51,[illegible]
b. Town Councils**	157,500	1,700	4,400	0	0
Total MCH/FP Development Expenditures	267,876	216,478	193,089	242,089	152,2[illegible]
- Total MCH/FP Development Expenditures **	26,788	21,648	19,309	24,209	15,22[illegible]
3. Health Transport Costs for District and Town Council Health Posts and Clinics	1,825,289	2,212,026	2,744,711	3,014,706	3,875,744
- Total MCH/FP Transport Costs ***	730,115	884,810	1,097,724	1,205,894	1,551,898
4. Total District and Town Council Recurrent and Development Expenditures for Health, Including Transport	7,462,974	8,905,964	10,540,649	11,906,505	15,166,754
- Annual % Rate of Growth	NA	19.34%	18.35%	12.96%	27.38%
- Per Capita Expenditures	6.22	7.42	8.78	9.92	12.64
- Percentage of Overall BDF Budget	1.26%	1.07%	1.05%	0.74%	0.87%
5. Total District and Town Council MCH/FP Expenditures	1,2[illegible]	1,554,2[illegible]	1,8[illegible]	[illegible]	2,6[illegible]
- Annual Rate of Growth	NA	2[illegible].12%	21.79%	11.61%	27.55%
- Per Capita Expenditures	1.03	1.29	1.52	[illegible]	2.[illegible]
- Percentage of Overall BDF Budget	(.22%	0.19%	0.19%	0.12%	0.15%
6. Below MCH/FP Recurrent Expenditures as % of Total Recurrent Health Expenditures	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
7. MCH/FP Recurrent Costs as % of MCH/FP Subsector	40%				

Table Five

Recurrent and Development Population Analysis Expenditures

	1983/84	1984/85	1985/86	1986/87	1987/88 (est.)
1. Recurrent Expenditures					
a. Central Statistics Office*	5,955	17,771	301,855	503,905	521,850
2. Development Expenditures					
a. Demographic Household Surveys (DHS) 87/88	82,475	114,227	194,117	157,772	[illegible]
b. Population Census 87/88	14,015	3,455	[illegible]	[illegible]	[illegible]
3. Total Expenditures	87,475	135,472	495,772	661,655	721,85[illegible]

*; Assume 5.5% of CSO's total recurrent costs are attributable to population analysis

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Table Six
Comparative Family Planning Expenditures
as Percentage of Health and Overall GOB Spending

Country	Family Planning Spending as % of Total Government Spending	Family Planning Spending as % of Health Expenditures ¶
Botswana (est.1987/88)*	.000	0.006
Korea (198[illegible])	0.130	4.7
Malaysia (1980)	0.090	2
Fiji (198[illegible])	0.019	0.24
Mauritius (1982)	0.040	5.6
Philippines (1987)	0.450	10.4
Singapore (1987)	0.04[illegible]	1.1
Thailand (1987)	[illegible]	[illegible]

*: Because Family Planning expenditures are [illegible] Total MOH Expenditures

¶ Includes Total MOH Health Budget
and Health Promotion Costs,
and Public Sector and District Council Health Costs

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Table Seven

MCH Development Expenditures for MCH/FP Project (MC [illegible]), 1983/84-1987/88

(Pulse)

	1983/84	1984/85	1985/86	1986/87	1987/88 (est.)
1. Development Expenditures					
- Service Delivery	0	2,54[illegible]	1,2[illegible]	0	NA
- Commodities	0	0	0	0	NA
- Technical Assistance	0	0	0	0	NA
- Transport	(60)	14,85[illegible]	0	0	NA
- Facilities	7,99[illegible]	1,131	55,9[illegible]	280,16[illegible]	NA
TOTAL	7,93[illegible]	18,527	57,21[illegible]	280,16[illegible]	5[illegible]
2. Analysis of Development Expenditures					
- Annual % Rate of Growth	NA	133,46%	208,84%	394,87%	-8[illegible]
- % of Overall PHC Development Budget	NA	NA	[illegible]	[illegible]	[illegible]
- % of Overall MCH Development Budget	0.15%	0.6[illegible]	[illegible]	[illegible]	[illegible]

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Table Eight

Total Expenditures For Development Programs Related
To The Population Sector, 1983/84-1987/88, (Dollars)

Project	1983/84	1984/85	1985/86	1986/87	1987/88 (est.)	Total
1. Maternal Child Health/Family Planning (MC 31)						
a. Donors						
- IBRD/NORAD	0	0	55,966	275,202	53,000	[illegible]
- USAID						
i. PIACT	3,865	1,131	28,095	(2,992)	0	[illegible]
ii. Westinghouse	44,406	86,519	1,271	0	0	[illegible]
- UNICEF	243	0	3,245	7,129	0	[illegible]
- WHO	9,711	5,080	1,252	0	0	[illegible]
- UNFPA	0	14,856	0	0	0	[illegible]
Subtotal	55,223	107,586	89,829	276,339	53,000	[illegible]
b. GOE	0	0	0	0	0	
TOTAL	55,223	107,586	89,829	276,339	53,000	[illegible]
2. Family Health (MC 32)						
a. Donors						
- World Bank/NORAD	0	0	222,194	115,19[illegible]	[illegible]	[illegible]
- World Bank	0		0	559,[illegible]		[illegible]
- USAID	0	0	0	10,[illegible]		[illegible]
Subtotal	0	0	222,194	687,915	[illegible]	[illegible]
b. GOE	0	0	82,247	85,[illegible]		[illegible]
TOTAL	0	0	[illegible]	[illegible]	[illegible]	[illegible]
3. Health Education (MC 33)						
a. Donors						
- [illegible]			[illegible]	[illegible]	[illegible]	[illegible]
- WHO	6,255	8,152	2,726	1,017		[illegible]
- WFP	0	0	[illegible]			[illegible]
- NORAD	27	0	4,795	0	0	4,[illegible]
- [illegible]	0	1,72[illegible]	0	0	0	[illegible]
Subtotal	6,245	[illegible]	34,726	56,325	127,[illegible]	274,[illegible]
b. GOE	2,79[illegible]	2,200	0	0		[illegible]
TOTAL	9,[illegible]	12,872	34,726	56,325	127,[illegible]	274,[illegible]
4. Nutrition Program (MC 49)						
a. Donors						
- UNICEF	5,787	12,059	16,829	36,904	13,000	84,[illegible]
Subtotal	5,787	12,059	16,829	36,904	13,000	84,[illegible]
b. GOE	0	0	0	0	0	
TOTAL	5,787	12,059	16,829	36,904	13,000	84,[illegible]
5. Basic Health Facilities (LE 20)						
a. Donors						
- NORAD	16,295	251,305	388,771	855,105	1,022,000	[illegible]
- Kreditt Anstalt	0	1,669,0[illegible]	1,088,9[illegible]	1,155,162	0	[illegible]
- Netherlands	[illegible],295	0	0	0	0	[illegible]
Subtotal	97,592	1,924,395	1,477,71[illegible]	2,065,267	1,022,000	[illegible]
b. GOE	878,[illegible]	[illegible]	[illegible]			[illegible]
TOTAL	9[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
6. District Health Teams (LE 45)						
a. Donors						
- NORAD	124,[illegible]	47,[illegible]	116,[illegible]	[illegible]	[illegible]	[illegible]
Subtotal	124,[illegible]	47,[illegible]	116,[illegible]	[illegible]		[illegible]
b. GOE	1,[illegible]	[illegible]				
TOTAL	124,[illegible]	49,[illegible]	116,[illegible]	[illegible]	[illegible]	[illegible]

7. Continuous Household Surveys (ST 19)						
a. Donors						
- NORAD	0	81,818	79,567	0	0	161,385
SubTotal	0	81,818	79,567	0	0	161,385
b. GOE	63,479	32,419	114,550	157,793	200,000	568,241
TOTAL	63,479	114,237	194,117	157,793	200,000	729,626
8. Population Census (ST 07)						
a. Donors						
- UNFPA	2,985	2,634	0	0	0	5,619
SubTotal	2,985	2,634	0	0	0	5,619
b. GOE	11,030	834	0	0	0	11,864
TOTAL	14,015	3,468	0	0	0	17,483
9. Total Development Projects Operating						
a. Donors	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
b. GOE	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
TOTAL	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
10. Donor % of Development Operating in Population Sector-Related Projects	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
11. GOE Percentage of Development Operating in Population Sector-Related Projects	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

4 Formerly Population Health Teams (PHT)

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Table Nine

Directly Attributable Expenditures of Development Programs
To The Population Sector, 1983/84-1987/88 (Pulas)

Project	1983/84	1984/85	1985/86	1986/87	1987/88	Total
1. Maternal Child Health/ Family Planning (MC 32) [100% of Project Funds to MCH/FP]						
a. Donor Contributions	58,223	107,586	89,829	276,339	53,000	584,[illegible]
b. GOB Contributions	0	0	0	0	0	0
c. Total	58,223	107,586	89,829	276,339	53,000	584,[illegible]
d. % Donor-Financed	100.00%	100.00%	100.00%	100.00%	100.00%	
e. % GOB-Financed	0.00%	0.00%	0.00%	0.00%	0.00%	
2. Family Health Project (MC 21) [15% of Project Funds to MCH/FP]						
a. Donor Contributions	0	0	33,329	100,187	525,000	[illegible]
b. GOB Contributions	0	0	12,[illegible]	12,751	0	[illegible]
c. Total	0	0	45,66[illegible]	112,[illegible]	525,000	682,[illegible]
d. % Donor-Financed	0.00%	0.00%	72.98%	88.[illegible]%	100.00%	
e. % GOB-Financed	0.00%	0.00%	27.02%	11.02%	0.00%	
3. Health Education Project (MC 33) [60% of Project Funds to MCH/FP]						
a. Donor Contributions	3,8[illegible]	6,28[illegible]	20,83[illegible]	33,795	76,2[illegible]	141,[illegible]
b. GOB Contributions	1,674	7,60[illegible]	20,83[illegible]	33,795	76,20[illegible]	141,10[illegible]
c. Total	5,48[illegible]	7,60[illegible]	20,83[illegible]	33,795	76,20[illegible]	141,91[illegible]
d. % Donor-Financed	69.46%	82.64%	100.00%	100.00%	100.00%	
e. % GOB-Financed	30.54%	100.00%	100.00%	100.00%	100.00%	
4. Nutrition Program (MC 09) [90% of Project Funds to MCH/FP]						
a. Donor Contributions	5,187	10,85[illegible]	15,14[illegible]	33,214	11,70[illegible]	76,1[illegible]
b. GOB Contributions	0	0	0	0	0	0
c. Total	5,187	10,85[illegible]	15,14[illegible]	33,214	11,70[illegible]	76,1[illegible]
d. % Donor-Financed	100.00%	100.00%	100.00%	100.00%	100.00%	
e. % GOB-Financed	0.00%	0.00%	0.00%	0.00%	0.00%	
5. Basic Health Facilities (LB 20) [10% of Project Funds to MCH/FP]						
a. Donor Contributions	9,359	192,039	147,771	209,327	102,200	66[illegible]
b. GOB Contributions	87,553	17,783	29,269	0	0	134,6[illegible]
c. Total	96,912	209,822	177,040	209,327	102,200	79[illegible]
d. % Donor-Financed	9.66%	91.52%	83.47%	100.00%	100.00%	
e. % GOB-Financed	90.34%	8.48%	16.53%	0.00%	0.00%	
6. District Health Teams (LB 45) [10% of Project Funds to MCH/FP]						
a. Donor Contributions	12,4[illegible]	4,70[illegible]	11,64[illegible]	33,7[illegible]	51,00[illegible]	113,[illegible]
b. GOB Contributions	1,05[illegible]	25[illegible]	0	0	0	[illegible]
c. Total	13,46[illegible]	4,95[illegible]	11,64[illegible]	33,7[illegible]	51,00[illegible]	113,[illegible]
d. % Donor-Financed	92.14%	94.94%	100.00%	100.00%	100.00%	
e. % GOB-Financed	7.86%	5.06%	0.00%	0.00%	0.00%	

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7. Continuous Household Surveys (ST 19) [100% of Project Funds to Population Analysis]						
a. Donor Contributions	0	81,818	79,567	0	0	161,385
b. GOE Contributions	63,479	32,419	114,550	157,793	200,000	568,241
c. Total	63,479	114,237	194,117	157,793	200,000	729,626
d. % Donor-Financed	0.00%	71.62%	40.99%	0.00%	0.00%	
e. % GOE-Financed	100.00%	28.38%	59.01%	100.00%	100.00%	
8. Population Census (ST 09) [100% of Project Funds to Population Analysis]						
a. Donor Contributions	2,985	2,634	0	0	0	5,619
b. GOE Contributions	11,030	834	0	0	0	11,864
c. Total	0	0	0	0	0	0
d. % Donor-Financed	ERR	ERR	0.00%	0.00%	0.00%	
e. % GOE-Financed	ERR	ERR	0.00%	0.00%	0.00%	
9. Total Population Sector Projects						
a. Total Donor Contributions	91,967	405,915	396,127	685,824	818,160	2,402,793
b. Total GOE Contributions	164,794	58,895	176,991	204,078	276,200	881,258
c. Total Pop. Sector Contribution	256,761	464,810	573,118	893,002	1,094,360	3,283,988
d. % Donor-Financed	35.82%	87.33%	69.23%	77.11%	74.76%	
e. % GOE-Financed	64.18%	12.67%	30.77%	22.89%	25.24%	
f. Annual % Growth Rate of Donor Contributions	NA	81.03%	23.75%	55.07%	22.54%	
g. Annual % Growth Rate of GOE Contributions	NA	-64.26%	200.55%	15.47%	35.14%	
h. Annual % Growth Rate of Total Contributions	NA	81.03%	23.75%	55.07%	22.54%	

*Formerly Regional Health Teams (MC 29)

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Table 10
Donor Assistance in the Population Sector
(US Dollars)

Source of Funding	Project/ Activity	Duration of Aid	Amount
USAID	INTRAH-Training in Family Planning	1987-88	$100,000
USAID	Westinghouse-Demographic and Health Survey	1988-89	$200,000
USAID	Census Bureau-TA on DHS Survey	1988-89	$75,000
USAID	Options Futures Group-National Parliamentary Council	1987-88	$80,000
USAID	Contraceptive Supplies	1985-89	$900,000
USAID	WHO/SPA-Health Education and Lab. Assistance for AIDS *	1987-88	$50,000
USAID	PIACT-MCH/FP	1985	$15,188
USAID	MEDEX-Operations Management for PHC	1987-90	$589,000
NORAD	Family Health Project (TA, Training) *	1985-89	$500,000
IBRD	Family Health Project (Construction, TA) *	1985-89	$2,300,000
UNFPA	TA for Family Health Division	1985-88	$575,000
UNFPA	Establishment of Demography Unit at CSO	1985-87	$289,200
UNFPA	Intercensal Demographic Survey	1987-90	$342,800
UNFPA	Rapid Analysis Model	1986	$86,040
UNICEF	MCH Activities	1986-90	$3,185,800
Netherlands	Sexually Transmitted Diseases *	1986-88	$22,300
WHO	MCH/FP	1985	$35,000
WHO	Immunizations	1985	$35,000
Total Donor Contributions		1985-90	$8,791,328
- Average Annual Contribution		1985-90	$1,758,265

*: Based on assumption that 20% of AIDS and Sexually Transmitted Diseases Funding applies to Population Sector

#: Based on estimates provided by World Bank officials

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ANNEX

G

BIBLIOGRAPHY OF DOCUMENTS ON BOTSWANA'S POPULATION SECTOR

The first section of this Annex of Botswana Bibliographic Material was compiled by Pia de Pradal, in "Attitudes towards Family Planning and Family Size" July 1982

The second section of the Annex - Botswana Bibliography 1982 - 1987 Special Emphasis on Family Planning Contraception Child Spacing, was compiled by Nomtuse Mbere, January 1988

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BOTSWANA BIBLIOGRAPHY

ALVERSON, H. (BNA & UBS)
Mind in the Heat of Darkness: Value and Self Identity Among the Tswana of Southern Africa. Yale University Press, 1978 and Johannesburg MacMillan Press, 1978.

Gives background data on mortality and fertility rates in Botswana based on the 1971 census figures (p.39). P.67 describes modern family life and points out that 'Children are the only asset whose value and prestige exceed that of the herd in the Tswana conception of wealth. The young infant is truly cherished.'

Weaning at 2-3 years is abrupt and the first real encounter with the system of negative sanctions. Alverson says that there are few inhibitions restricting sex play and 'many households accept the fact that girls will bear children before they are married.' p.68.

In towns, he writes, 'the primary non-economic activity becomes sex. Sex play is an important activity in the rural areas too, but in town the movement from casual union to casual union, to marriage and to divorce, is rapid and often involves only transient commitments to others. Town is not the kind of setting in which weighty moral bonds are established to substitute those of kinship.' p.67.

There is a higher rate of young unmarried mothers in town than in rural areas. 'Lacking access to a supportive circle of kinsfolk, young girls are tied down by children in ways not found in rural areas ... many send babies home.'

He maintains that for the non-educated, the main recreational centre is the shebeen with its drinking, dancing and sex.

Children - a paramount extension of oneself into the future and labour. p.98.

Children "come from the ancestors."

BROWN, BARBARA
Women's Role in Development in Botswana. Gaborone, Ministry of Agriculture, Division of Planning and Statistics, Rural Sociology Unit, 1986. pp.26-29; 41-46.

Briefly discusses aspects of educational, health and development issues as they relate to women. Attributes much of the 'wastage' or the drop-out of girls in secondary school to pregnancy.

75% of secondary school girls see themselves as "mother" in the future, limiting themselves to that role rather than combining it with some job. She shows that the drop-out rate caused by pregnancy has increased during the past 10 years and recommends ways positive and constructive ways of dealing with this. In the survey the students overwhelmingly favoured inclusion of family planning in their education, giving as their reason their desire to avoid pregnancy and the curtailment of education, p.26.

Brown recommends that the Ministry of Education should: (a) allow pregnant girls to remain at school as long as medically possible and return as soon as possible; (b) encourage those in confinement to continue their education by offering special counselling and academic assistance; (c) permit girls to return to previous school; and (d) introduce family planning education in school syllabus. p.47

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In a paper entitled 'Some Aspects of Women and Health', Brown looks at the use of Depo Provera as a means of family planning in Botswana. She expresses concern at its increased use from 3% of women in 1974 to 12% in 1976 since the drug is still under clinical test and has been shown to cause both uterine and breast cancer in rhesus monkeys and beagle dogs. She recommends the withdrawal of Depo Provera as a means of family planning except in exceptional circumstances. Alternatively, that at least there should be improved supervision of its use. pp.41-48

Family size and composition - Brown found in her survey of secondary school pupils that girls wanted an average of 4.1 children, boys 4.8. Gives a table of desired sex composition. p.45.

CENTRAL STATISTICS OFFICE
The National Population Census of 1971. Gaborone. Ministry of Finance and Development Planning, 1971.

This document provides demographic data such as the following:
The crude birth rate - 44.5 per 1,000
The crude death rate - 13.7 per 1,000
Natural Increase - 30.8 per 1,000
Sex ratio - 84 males to 100 females, (caused by migrant labour). On average 6.5 live births to each women who survives the age of 50. Dependency ratio about 115 dependents to 100 supporters. Child mortality rate (0-2 years, - 126 per 1,000. Life expectancy for males 53 years; females 59 years.

CENTRAL STATISTICS OFFICE (NIR, CBS & BNA)
A Social and Economic Survey in Three Peri-Urban Areas in Botswana. 1974. Government Printer, 1974, pp.51-53.

A study on health and fertility showed that the age specific fertility rates in the peri-urban areas are less for each age group, excepting the 45-54 year age group, than those of the country as a whole.

Botswana females as a whole tend to have up to 2.1 more children than those living in the peri-urban areas. The reason for this difference in fertility rate is now known, but it is thought to be associated with (a) education levels of female peri-urban residents; and (b) their greater access to family planning advice and clinics. A fairly high proportion of females over the age of 15 years claimed that they believed in modern methods of family planning.

CENTRAL STATISTICS OFFICE
The Rural Income Distribution Survey in Botswana. Ministry of Finance and Development Planning. Government Printers, Gaborone, 1975/76, p.274.

The data presents socio-economic correlation of fertility behaviour in rural Botswana. In a survey of 1,060 women, questions on the following subjects were asked:

(1) The number of live births for each mother.
(2) The sex distribution of these births.
(3) The residence of children.
(4) The incidence of child mortality.
(5) The desired number of living children by sex.
(6) The fathers aged at the birth of her first and last [illegible]

The attitude towards birth was that children are an asset, the more hands the more farming can be done. It was found that in general:

(1) First child, if a girl, is given to her grandmother to help her in her old age.
(2) To have a few extra children in cases of high infant mortality rate.
(3) Other children may be given to childless relatives.
(4) Boys are needed to herd cattle and girls to carry water and work in fields.

The desired number of children was 6.78, which is higher than the national average.

This information should provide the policy makers with the information on the effect of economic policies on population growth and with inputs for formulating policies to control this growth where it is a policy objective as it is in Botswana.

Some of the findings were that: educated mothers wish to have and actually have fewer children. They seem to give birth to the first child later than the less educated mothers and are subject to lower child mortality rates.

CENTRAL STATISTICS OFFICE
'Country Profile, Botswana'. Gaborone. Ministry of Finance and Development Planning, 1980. p.51.

A general analysis of statistics dealing with the people, the economy, urban profile, rural profile, health, education and children.

They state that family planning services have increased during 1979, having 13,225 new acceptors with 62,285 repeat visits. The users have also shown a marked increase of 48% over the previous year. p.4.

They estimate that there are a 191,000 women of child-bearing age (15-49, with an estimated fertility rate per woman of 6-7 children. P.47 contains a breakdown of the number of women of child bearing age, age by age. It also contains a table of family planning visits according to type and method used in 1979.

CHERNICHOVSKY, D.
Socio-Economic Correlations of Fertility Behaviour in Rural Botswana. Botswana. The World Bank Research Project, May 1979.

Data was obtained from a cross-sectional study of rural women by observing and describing evidence from previous surveys. The study summarises and highlights some of the basic findings relating to fertility behaviour, and considers the utility of "children's services." The purpose is to provide policy makers with information on potential effects of various economic policies on population growth.

Variables associated with fertility behaviour were:
(1) Mother's age at birth of first child.
(2) Presence of (an eligible) husband.
(3) Type of household - extended or nuclear.
(4) Household income.
(5) Mother's education.

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The following include some of the hypotheses based on these variables:

(1) Earlier child bearing leads to more fertility.

(2) Presence of an "eligible" husband brings about fertility.

(3) Mothers of nuclear households have more children than mothers of extended families.

(4) Young educated women use modern family planning practices.

(5) Household income is positively associated with fertility.

The conclusion is that findings presented here are tentative and therefore premature to derive policy implications. They suggest more careful analysis of data. It is hypothesized that income rise and maternal health improvement are likely to induce higher fertility. The trend may be suppressed by a variety of factors: higher levels of education, break-up of traditional extended family, lower child mortality. The data suggests that the migrant labour market may be a "check" on population growth in Botswana. Many tables were used to illustrate the evidence.

Problems met:

(1) Women's age at marriage not available. Instead, age at birth of first child was used.

(2) Little is known from data about women's control of fertility behaviour.

A number of tables were given to analyse the variables.

COLCLOUGH, M., DEC. 1975

<u>Family Planning in Botswana</u>. Report of a Feasibility Study for the Introduction of Community Based Distribution in Family Planning. IPPF Community Based Distribution Department. pp.127 and Appendix

The study was concerned with cultural background to family planning in Botswana and attitudes to specific family planning methods.

44% agree to use condom if not using any other method. 44% did not agree. 79% of women chose modern family planning as it allows a longer period between birth of each child. 20% chose traditional methods. 72% of men chose modern methods for men. Combination of traditional and modern methods 53%. New methods for women 44%, breastfeeding 39%. New methods for both 33%. Abstinence by women 10%. Traditional methods for women 2%. 97% of men agreed that family planning is for the health of child. 100% of women said it was for both.

General recommendations were:

(1) FWE's should be trained to educate people about family planning to reduce drop-out rate.

(2) Male FWE's should be used to motivate other males.

COOK, S.

<u>A Report of an Evaluation of the International Planned Parenthood Federation Programme in Botswana, 1969-1973</u>. Gaborone: Government Printer.

Data in this paper is based on the Rural-Urban Family Planning Programme evaluation study carried out in four places in the country on 359 clients aged 15-44 years, all women.

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Summary and conclusions of the Survey: - out of 359 clients, 129 had not been pregnant, were exposed to risk and were currently contracepting, (120 on same method and 9 on a different method).

28 had not been pregnant, exposed to risk and were not contracepting.

24 had been pregnant.

13 were currently pregnant.

3 were planning pregnancies.

162 were lost-to-follow-up.

Recommendations:

(1) Family Planning record keeping systems be improved, especially with respect to client follow-up.

(2) The programme policy of dispensing one packet of oral contraceptives to new acceptors, and three packets of contraceptive pills to repeat acceptors, be followed more closely.

(3) Greater emphasis be placed on the IUD as a method of contraception.

(4) Greater attention be paid to improving continuation rates of acceptors.

(5) Clinic hours and time-tables be more flexible.

(6) Family Welfare Educators, after careful selection, be trained at rural centres and then complete a probationary post-training period before being registered.

(7) Family Welfare Educators (FWEs) spend more time out of the clinic and, in particular, spend more time on home visits to follow-up family planning clients.

(8) More regular and frequent supervision of the FWE's be given.

(9) Supervisors of FWE's be trained.

(10) The FWE's monthly report forms and quarterly newsletters be continued.

(11) Further evaluation of the programme be conducted.

COOK, S.
Evaluation of Family Planning Programmes: An Example from Botswana. Research for Action: No. 2. International Planned Parenthood Federation, May 1976, p.219.

The findings reported in this paper are a summary of the work conducted by Cook between April 1972 and October 1973 which are fully reported in her 1973 report, "An Evaluation of the IPPF Programme in Botswana 1969-73." The three areas studied were:

(1) The FWE cadre, their workload, problems and training;
(2) The statistics generated by the MOH/FP programme; and
(3) A follow-up survey tracing FP acceptors.

FAKC, T.T.
Some Aspects of Faith and Health Care Behaviour: A Sociological Evaluation of the Role of Independent African Churches in Botswana. Department of Sociology, UCB. Draft Report, June 1980, pp.71-73.

Briefly discusses the attitudes of faith healing churches towards sex, sexually transmitted illness and family planning. M churches feel that modern medicine is better suited for curing

sexually transmitted diseases. Women are seen as main carriers of VD which they 'store' in a 'dirty womb.' States that women tend to have greater responsibility for family planning, contraception and possible abortion, then men. Generally believe, however, that people should 'go and multiply' and therefore against family planning and abortion.

Abstinence is, however, acceptable although not practical. They are flexible with regards to family planning.

FINCH, G.S. and WAY, P.O.
Country Demographic Profiles Botswana, US Department of Commerce, Bureau of Census. ISP-DP-27. June 1981

The profile of the population of Botswana contains tables of selected demographic information, including size of population and estimates of fertility and mortality.

HARPENDING, H. (UBS - BNA)
'Regional Variation in Kung Populations' In Lee, R. and Devore, I. (Eds) Kalahari Hunter-Gatherers. Harvard University Press, 1976, pp.152-165

A study of population processes among the !Kung and changes accompanying sedentism. Interviews conducted with nine groups of !Kung in different parts of the Kalahari - sample 1523. His study contains the total number of live births for women in each area who had completed reproduction by reaching menopause and the number still living. (Definition of live birth - baby living more than three days).

He found a 145 infant mortality rate and 4.65 births for women in !Kangwa and ,Xai,Xai. There was no correlation between size of sibship and mortality in any area.

His most striking demographic impression was one of poor adaptation and high mortality in the North when compared with Southern and Central !Kung groups.

HOWELL, N. (UBS - BNA)
'The Population of the Dobe Area !Kung ' In Lee, R. B. and Devore, I. (Eds) Kalahari Hunter-Gatherers: Studies of the !Kung San and Their Neighbours. Cambridge, Massachusetts: Harvard University Press. 1976. pp.137-151

In this article Howell describes the difficulties encountered in conducting a demographic study of a society in which 'age' and calendar years are unknown. Gives details of methodology used in her study of 840 people, during 1963-9.

Average CBR per 1000 people for the 6 years was 41.
(Same as Southern Africa as a whole)
Average immigration per 1000 people for the 6 years was 22.
Average CDR per 1000 people for the 6 years was 16.
(Botswana is 23) - extremely low mortality rate.
Out migration per 1000 for the 6 years was 8.

The growth rate based simply on births and deaths for the period was 2.5% per year. With migration the population grew at 3.9%.

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Howell investigated the martial and reproductive histories of 165 resident women over 15 years. The mean age of menarche was 16.5. Half the women married before their first menstration with most women marrying between 15-20 years.

First live births tend to occur around the age of 19.5. 20% of infants die during the first year, mostly within the first few days. If the baby dies the mother will conceive again soon afterwards. For the remainder the mother breastfeeds until four to six years old. The timing of the next birth depends to some degree on age - younger women have more closely spaced babies. Few of the intervals are less than three years long, modal length four years. Over the whole reproductive span, ages 15-49, women averaged 4.7 live births for the cohort born 45-49 years ago, and 5.2 for cohorts more than 50. The !Kung level of fertility is considerably lower than any other population practicing natural fertility. (Maximum number of births is 9.)

- Rates of fetal wastage (miscarriage and spontaneous abortion) comparable with other parts of Botswana during study period.

- Knowledge of effective abortion not known.

- Infanticide practiced when considered necessary (6 out of 501 live births), i.e. in all cases of birth defects, one of each pair of twins, sometimes when one birth follows too closely to another, and the baby would drink the milk of his older sibling and when the woman feels too old to produce milk for another baby.

Women do not control their fertility artificially - vague knowledge of herbal tea causing sterility 'but few people say they have used them.' 'Instead women claim that the cause of low fertility is the stinginess of their god, who loves children and tries to keep them all to himself in heaven rather than let them come to earth and bring joy to their mothers and fathers. While in the field she received many requests for medicine to increase fertility and only one request from an overtired mother of four to stop.'

Correlates lower fertility with gonorrhea. Those 35 women who had had it had a fertility rate of 2.4 compared with 5.1.

Life expectation 32.5 years.

KOOIJMAN, K. (UBS)
A Report on the Village of Bokaa. Gaborone, Botswana Extension College, July 1978.

A general analysis of culture contact and social change. Special emphasis placed on village development. During discussion of traditional and modern medicine Kooijman mentions illnesses believed to be caused by transgressions of taboos associated with sexual relationships and childbirth, promiscuity.

In the past secret abortions it was believed directly interfered with the rain and the land and in times of drought all girls would be questioned and examined in order to find such an offender, who would then be treated by the doctor.

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She mentions that the family planning programme has been controversial. 'There is obviously a great need for it because of the many unmarried mothers, but it has aroused great opposition among the men. The young girls and women are highly interested but fear to state this openly in front of their lovers or husbands. They also fear and are suspicious of the contraceptives but have suffered so much hardship in looking after children without fathers that they want to use them.'

'The men, however, are adamant that it is unhealthy, even dangerous, not only to the health of the woman but also to that of the man himself. As traditional medicine emphasises that men and women affect each others blood through the act of sexual intercourse, anything that changes the women's sexual function is believed to have its effect on the man as well. Another major objection is that family planning may encourage women to be promiscuous or to become prostitutes. Married men can also oppose family planning on the grounds that it is a gift of god to have many children and that a large number of children will ensure them security in their old age. This latter reason is in a society in which old age so easily brings poverty and hunger.

Kooijman lists some of the objections voiced by men:

- unnatural to stop women from bearing children - God made them so.

- 'operations of family planning' cause problems like high blood pressure, heart trouble and womb trouble.

- a woman who does not bear children does not have a clear womb. The bearing of children cleans the womb. All the illnesses from the men you sleep with get stuck in your womb. Girls with family planning get their womb filled with illnesses.

- see it as damaging the womb.

- 'I'm afraid to use an FL (condom) because when a young man uses one for a long time he can have damaged his strength of bearing children by the time when he gets married. A man does not know how many children are given to him so it is better to give pregnancy to girls so that he can prove himself a man among men.'

The conflict between men and women on family planning causes women to keep it secret, but if found out could break the relationship.

Recommends that education about family planning should be directed towards men as well as women.

Kooijman discusses 'Women, love and marriage' in Chapter 4 p.94. She includes comments by men and women regarding their relationship and the difficulties faced today. Strong objection by men to their girlfriends, fiances or wives having relations with other men especially when this results in children. Men were anti-family planning because it encouraged their partners to be promiscuous or could result in their passing on VD (p.109).

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Women, on the other hand, were cynical about men, maintaining that as soon as they become pregnant the fathers disappear.

She furthermore discusses the fragileness of marriage. Amongst the Bakaa couples start living together and having families with only 'Peko' being paid, i.e. sheep given to the woman's brother which traditionally allowed him to cohabit with his wife at the lands only. Since today so many unions (38.6%) are based on Peko alone it is much easier for the union to be broken with women keeping the children when Bogadi has been given (45.5% of cases).

KOSSOUDJI, S. and MUELLER, E.
The Economic and Demographic Status of Female Headed Households in Rural Botswana. Research Report, March 1981

The purpose of the survey is to analyse the demographic and economic status of the female headed households in the rural parts of Botswana. Families which were labelled female headed were those whose partners were out of the country, mostly working in South African mines, divorced or separated ones. 1,060 households were selected from 8 largest villages and 12 rural areas, but only 957 households containing 6,475 individuals gave complete information. Data was collected by means of interviews whereby each household was visited 12 times in a period of 12 months to make sure that they belonged to the household. Questions were asked about income distribution, schooling, occupation, industry, fertility, ownership of productive assets.

The purpose of the study was not to analyse the determinants of fertility in Botswana as such. However, the report shows that teenage marriages and teenage childbearing are not frequent. Among women aged 20-24 years, 56% were still single. Among those aged 25-39 years 29% were single. However, the majority of single women aged 20-39 had children. The report shows that there is no statistical significant difference in fertility between women who live with a male partner and those who do not live with a male partner. Migration instead of lowering fertility seemed to maintain it at a higher level and it does so by undermining the economic security of women. Conclusion: The literature suggests that there is a link between the low status of women and high birth rate.

LEE, R.B.
Population Growth and the Beginnings of Sedentary Life among the !Kung bushmen', in Brian Spooner (Ed) Population Growth: Anthropological Implications. Cambridge: MIT Press pp. 328-42.

In this paper Lee is mainly concerned with examining the range of factors effecting optimum birth spacing among the !Kung. He studies tight articulation between women's role in the reproductive system and their role in the economic system. During the year an average women will walk about 2,400 kilometers in search of food, moving camp and visiting. For at least half of this she carries substantial food, water, material goods and all her children under four years. As a result emphasis on child spacing with average being 4 years. Expression: 'A woman who gives birth like an animal to one off-spring after another has a permanent backache.'

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Bushmen woman reach puberty at 15-17 years - first pregnancy further delayed for several years by post menstrual adolescent sterility. First child born at 18-22 years. Discusses economic consequences of child spacing which occurs in the absence of contraceptive measures. The !Kung practice post partum sex taboos for first year 'but the modest amount of excess fertility in relation to resources is readily absorbed by infant mortality, occasional infanticide and by out migration'.

He shows that with reduced mobility a woman may shorten the interval between successive births and continue to give adequate care. He suggests that 'settling down removes the adverse effects of high fertility on individual women.'

He states that women with a three-year birth spacing have such an increased work load that it may endanger their health and the survival chances of their children - long lactation suppresses ovulation - although solid foods introduced at 6 months, they continue breast feeding up until third and fourth year.

Nancy Howell - one of the practical reasons for long lactation is the relative absence of soft, easily digestible foods in the wild diet that are suitable supplements for infants and young children.

MINISTRY OF HEALTH
'Survey of Knowledge, Attitude and Practice on Health and Sexuality among Youth'. Mimeo: Health Education Unit. (undated) (1981, pp.2

A brief proposal for a survey of the knowledge, attitude and current practices of the youth towards such subjects as (a common communicable disease - TB, VD and Bilharzia; (b alcohol and smoking; (c family formation and sexual behaviour; (d pregnancy and family planning; and (e health care facilities.

MINISTRY OF HEALTH
'A Report on Evaluation of School Health Programme'. Mimeo. Maternal Child Health and Family Planning Unit. Undated (1981, pp.5, tables I-IX

79 primary schools throughout Botswana were give health questionnaires dealing with water, refuse disposal, ventilation, playground, nutrition, health instruction and health services.

52 schools felt positively towards family life (sex) education in the school. 35 schools thought that it would help avoid early pregnancies and 18 thought it necessary for responsible parenthood. Other reasons mentioned were to control sexually transmitted diseases, to give knowledge on human reproduction and to correct inadequate and inaccurate information given by parents. 26 schools thought the pupils too immature for family life education.

Of those willing to introduce family life education into the schools, 23 thought that this should be done in Standard V, 18 in Standard VII and 5 in Standard III. See table VI, VII and VIII.

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MINISTRY OF HEALTH
'Report of the Radio Programme Survey' Mimeo, pp.8 Undated.

The results of a survey conducted by FWE's in Mogoditshane, Oodi, Mahalapye, Ghanzi, Tsabong, Francistown and Gaborone. Sample size 155. The survey found that 83.9% listened to programmes on family planning - 42 people enjoyed the programmes on FBP best. However, those that did not like it objected to (a) the use of insulting language, (b) contraceptives have side effects, (c) people are able to keep themselves away from boys, (d) useless because already have children - programme is late, (e) not of help to a creative mind, and (f) useless to old people.

NESSET, T.B.
Primary Health Care and Rural Development: A broad view of health-related problems, practices and services affecting ten small villages in Southern District, Botswana. DERAP Working Papers, A.153. The Chr. Michelsen Institute, Bergen, Norway. For limited circulation. June 1979, pp.58-61

A group of both married and unmarried women of 15-44 years were interviewed. Paper reveals that the average number of children wanted was 5.2 - more by married women and less by unmarried women. After a minimum number of children has been reached it is then that people become motivated to consider family planning to space or reduce pregnancies.

The study also revealed that the general attitude towards family planning was very unfavourable even among the people surrounding the family planning acceptors. 19% said no one knew about their practice. Over a third said partners knew. 42% said their mothers, sisters and aunts knew. Therefore, nationally the rate of family planning acceptance is estimated at 6% for 1976 and target for 1981 being 9%. The study reveals that distance, restricted service hours and migration were major reasons for defaulting.

PIELEMEIER, N.R.
Syncresis: The Dynamics of Health. An Analytic Series on the Inter-Actions of Health and Socioeconomic Development, Main: Botswana, Lesotho and Swaziland. US Department of Health, Education and Welfare, Office of International Health, Division of Programme Analysis.

This study correlates socio-economic factors with health in Botswana, Lesotho and Swaziland. On Botswana, Pielemeier writes: 'Although health problems are not serious, the same factors limiting economic development act as constraints to improved health and to the development of the health sector. Services are unevenly distributed, particularly between the urban areas and the countryside. Limitations in agriculture affect nutrition as well as family income. Rapid population growth places increased demands on health services and high fertility has direct impact on maternal and child health'.

Address Fertility and Family Planning on p.5 and in Chapter 3, pp.25-29.

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POPULATION AND SOCIAL DEVELOPMENT. Communication Newsletter Vol. 3 No. 1. November 1981.

This newsletter focuses on communication training in family planning. Contains a report on overseas workshop activities in which Botswana participated, together with many other countries.

Schapera, I. (BNA - UBS)
'Premarital pregnancy and Native Opinion: A note on Social Change.' Africa, Vol. 6, pp.59-89. 1933

This article describes the strict attitude which prevailed among the Bakgatla in the nineteenth century towards premarital pregnancy and which by the thirties had changed. Such pregnancy was by then both common and generally accepted. It would appear that this change in attitude was caused by the abolition of initiation ceremonies, the discouragement of polygamy and the missionaries objections to the obscene songs which it was customary to sing outside the houses of unmarried, pregnant girls, the increase of migrant labour, spread of education and European culture.

SCHAPERA, I. (BNA - UBS
A Handbook of Tswana Law and Custom, London: Frank Cass. 19[illegible]. First Edition 1938.

This book was written to provide information to Government Officials and administrators on Tswana law and custom, especially Bakgatla. Chapter I deals with family life. Gives details on traditional marriage laws and explains related customs. He discusses the importance of child-bearing and attitudes towards barrenness.

- Seantle Sotorate, (pp. xv and 14)
- Polygamy - pp. 13 and 14
- Initiation, a pre-requisite to marriage - pp.105-107, 11[illegible]
- Procreation - pp.154, 157, 169
- Coitus interruptus - p.154
- 'Seratmane' - a sickly child resulting from its mother becoming pregnant before it is weaned
- Sterility and barrenness - pp.155-156
- Infanticide and induced abortion - pp.261-262
- Unmarried mothers - pp xvii, 262

SIMPSON-HERBERT, M.
Breastfeeding and Body Contact. POPULI Magazine. Vol. 7, No. 2 pp.17-21.

This article discusses why different cultures value breastfeeding and body contact so differently. Analyses different cultures in terms of high or low mother-infant contact using the Kalahari Bushmen as one of her examples of the former.

Referring to M.J. Konner's work she states that during the first [illegible] weeks of life, Bushman babies spend between 74% - [illegible]% of their [illegible] in contact with their mothers, whilst the corresponding figures for western infants is between 20% - 15% (p.2[illegible]).

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She concludes that "there is now some evidence to suggest that frequency of breast stimulation is a determining factor in the suppression of the ovulatory cycle. Those societies with the highest degree of mother-infant body contact also exhibit the longest mean duration of lactational amenorrheah, ranging from 10-16 months postpartum". p.21.

STAUGARD, F.
Traditional Medicine in Rural Botswana. 1981. Unpublished Preliminary Draft for Limited Circulation. (NIR awaiting final draft) (Since compiling this bibiliography NIR has received a copy of his final report).

A study of the consumption of scientific and traditional healthcare in Mahalapye, Shoshong and Mosolotshane. Findings based on two years work as Regional Medical Officer.

Table 6 contains number of family planning cases in 1979: Mahalapye 3,078; Mosolotshane - 35 and Shoshong - 459.

Table 7 - out patient diagnosis for abortion in 1979: Mahalapye - 25; Mosolotshane - 4; Shoshong - 2.

Infertility is classified as a Tswana disease. Thlogwane - Tswana disease - caused by the depression of the anterior fontanelle in an infant. Results in vomiting and diarrhoea. European doctors call it 'gastroenteritis'. Failure to treat what Batswana consider to be the cause of the sunken fontanelle has resulted in lack of treatment and subsequently, a high infant mortality rate.

STEPHENS, B.
Family Planning Follow-Up Study. NIR Discussion Paper, No. 5 Gaborone, July 1977, pp. 61 and Annexes.

This report examines defaulting among family planning acceptors and recommends clinic initiated strategies which should be effective in decreasing the high drop out rate.

Her sample consisted of 200 women attending 7 clinics in rural, semi-rural and urban locations. She found that only 42% of the sample were continual users throughout the ten month survey period. The major cause of defaulting would appear to be distance from the clinic, high rates of mobility and poor communications.

The mean age of acceptors was 25.4; 86% had some formal education. 48.5% were unemployed and not seeking work, and 24% were married. 72% had borne children. 85.5% came from within 5 kilometers, the median distance travelled for the first visit was 2.4 kms, and [illegible] for revisits.

SYSON, L.
'Unmarried Mothers: A Report on clinic and hospital patients in selected centres in Southern Botswana'. Technical Note [illegible] 1 UNDP project BOT/71/014. Gaborone, December 1971

Syson focuses on unmarried mothers in South East Botswana and looks at their financial position. She found that these women are likely to have fewer children than their married counterparts [illegible]

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31-35 looks at their knowledge and use of family planning. She found no evidence to support the view the children of unmarried mothers are less likely to survive than those of married mothers. She found that in urban areas (Lobatse and Gaborone), the unmarried mother was less likely than the married mother to have borne any of her children in hospital, in the villages they had at least an equal chance (p.33). In her study, only 4% said that they had ever used any method of birth control. The highest figure was Gaborone - married women (12%).

WATSON, W.B.
Family Planning in the Developing World. A Review of Programmes. A Population Council fact Book, 1975. New York Population Council.

In Sub-Saharan Africa (Chapter 6, pp. 69-77), Herve Gauthier deals briefly with the Government of Botswana family planning programme, together with other anglophone countries. In 1974 the 55 health centres offered family planning and 4,201 new acceptors were recorded. 1934 accepted the pill, 4% the IUD, 1% DF. The programme was hampered by the paucity of basic health services (especially remote areas) and shortage of trained personnel. New programme designed in 1975, together with UNFPA, aiming at increasing number of health facilities.

Aimed at acceptance of 4.3% of couples by the end of 1977, which would bring down CBR from 42.4 in 1976 to 39.6 per 1,000.

UNITED NATIONS FUND FOR POPULATION ACTIVITIES
Survey of Laws on Fertility Control Country Profiles: UNFPA 1975. pp. 4 and 4[illegible].

Summarises the laws concerning sterilization and abortion.

UNIVERSITY OF BOTSWANA, LESOTHO AND SWAZILAND. (UBS
World Population Year Conference, May 22-26, 1974. Gaborone, Botswana. Department of Statistics. 1974

The conference was held as a contribution to the world population year. The discussions were centered around the problems due to rapid population growth and practical ways in which these problems could be met.

Delegates were divided into eight discussion groups and each group given a topic to discuss. For example:

1. Family size and family planning - pp. 42-43.
2. Tradition, culture and family planning in Botswana - pp.55-61.
3. The use of visual aids and methods of education and communication to adults - pp.61-66.
4. Family planning and its necessity - pp.114-117.

The main conclusions are:

1. The need for providing facilities.
2. The need for education.
3. Good traditional methods of family planning not to be discouraged.

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Gaborone, Botswana National Health Bulletin Vol. 2. No.2

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ANNEX

H

JOB DESCRIPTION OF LONG TERM ADVISOR

JOB DESCRIPTION AND QUALIFICATIONS FOR LONG-TERM IEC ADVISOR

QUALIFICATIONS AND EXPERIENCE OF THE LONG-TERM ADVISOR IN IEC

1. At least a master's degree in health communications; doctorate highly desirable.

2. Demonstrated long-term international (preferably African) experience in implementation and the planning of health education programs.

3. Demonstrated ability to undertake and analyse qualitative and quantitative research (including development of data collection instruments) based on behavioral analysis; and to use the results of that research in developing quality materials and messages.

4. Demonstrated ability to develop materials for literate and non-literate target audiences, working with graphic artists, photographers, printers, script writers, video, radio, and other technicians in creating innovative and effective materials and messages.

5. Demonstrated ability to assist in developing IEC programs to support primary health care initiatives, and in creating materials for use by community health providers.

6. Demonstrated ability in training of health workers and others in communication skills, in planning health education lessons, and in translating technical skills into health education messages.

7. Demonstrated ability to monitor and evaluate health education messages, materials and campaigns.

8. Familiarity with USAID policies and procedures is highly desirable.

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SCOPE OF WORK FOR LONG-TERM ADVISOR IN IEC

As a counterpart to the Chief Health Education Officer (CHEO), of the Ministry of Health, the Long-Term Advisor will:

1. Jointly with the CHEO, prepare a detailed IEC-related work plan for FP for the first year of the assignment, and an outline for each additional year of the program. This workplan should include plans for research, materials development, pretesting, dissemination, monitoring, evaluation, and training, short-term technical assistance, and a budget for all areas. This workplan should be developed and approved by the GOB within the first three months of the assignment. Similarly, prepare (and obtain GOB approval for) detailed workplans for the second and third years of the assignment, prior to the beginning of the corresponding year of assignment.

2. Together with HEU staff, travel to all 16 Districts to discuss needs for training and materials with each Health Education/Nutrition Officer and with a sampling of nurses and Family Welfare Educators.

3. Attend representative seminars conducted by HEU staff, including Responsible Parenthood Seminars for Youth, Community Leader Seminars, and Teacher-Health Worker Seminars; develop suggestions for strengthening these seminars; and assist in implementing improvements.

4. Assist in the design of materials for supervisors and health workers on communication skills, on planning health education sessions, and on specific family planning technical skills needing improvement.

5. Assist in developing and carrying out qualitative research as outlined in the work plan mentioned above.

6. Assist in developing, pretesting and producing innovative and effective FP materials for use at the national, district, and community levels.

7. Help to assess the training needs of Health Education Unit staff, and institute regular training sessions and assignments as required do meet priority needs.

8. Assist in the coordination between GOB and USAID, of short-term technical assistance in support of IEC activities as outlined in the workplan.

9. Participate in the annual program review of IEC achievements and accomplishments.

10. Prepare and submit monthly and annual progress reports on IEC activities.

11. Provide USAID/Botswana with periodic, informal briefings on the status of overall program efforts.

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ANNEX J

PID AND ECPR GUIDANCE CABLES

ANNEX

I

INITIAL ENVIRONMENTAL EXAMINATION

INITIAL ENVIRONMENTAL EXAMINATION

OR

CATEGORICAL EXCLUSION

Project Country:	Botswana
Project Title and Number:	Population Sector Assistance Program 633-0249
Funding:	FY 1988 African Development Funds
IEE/CE Prepared by:	William Jeffers, REDSO/ESA and Donald Keene, RLA

Environmental Action Recommended:

Positive Determination _____

Negative Determination _____

or

Categorical Exclusion X

This Program meets the criteria for Categorical Exclusion in accordance with Regulation 16, Section 216.2 (c) (i), (ii) and (viii). It is excluded from further environmental review because:

1. The program consists primarily of budgetary support to the Government of Botswana (GOB) in the population sector. With respect to the budgetary support component, AID does not have knowledge of or control over, and the objective of AID in furnishing assistance does not require, either prior to approval of financing or prior to implementation of specific activities, knwoledge of or control over, the details of the specific activities that have an effect on the physical or natural environment. Section 216.2 (c) (1) (ii).

2. With respect to the technical assistance and training component of the program, the planned activities (a) do not have an effect on the natural or physical environment, section 216.2 (c) (1) (i) or (b) involve population and family planning services that are not designed to include activities directly affecting the environment, Section 216.2 (c) (1) (viii).

Approved by: Bessie L. Boyd Date: JUN -6 1988
Bureau Environmental Officer
Bessie L. Boyd, AFR/TR/ANR

Concurrence: _____ Date: _____
GC/AFR

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ANNEX J

PID AND ECPR GUIDANCE CABLES

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UNCLASSIFIED

Department of State

OUTGOING TELEGRAM

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ORIGIN AID-03

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AID AFR/TR/HPN:JTHOMAS (DRAFT) AID/AFR/SA:PDMA
AID/GC/AFR:MAKLEINJAN (DRAFT)

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SUBJECT: BOTSWANA FAMILY PLANNING AND HEALTH PID (633-0249) ECPR

1. SUMMARY: SUBJECT ECPR, CHAIRED BY DEPUTY SECRETARY OF MAY 2, 1987, WAS UNABLE TO RESOLVE ISSUES AND DID NOT REACH FIRM DECISION ON HOW TO PROCEED WITH PROJECT. THE PID CONCEPT OF CONVENTIONAL AID SUPPORT TO EXPAND GOB FAMILY PLANNING SERVICES WAS QUESTIONED BY SOME MEMBERS OF THE ECPR BECAUSE OF CONCERNS FOR PUBLIC MANAGEMENT BURDEN, UNCERTAIN GOB POLICY COMMITMENT AND RELATIONSHIPS WITH THE USE OF PUBLIC SECTOR DELIVERY SYSTEMS FOR HEALTH/POPULATION PROGRAMS. ECPR DOES, HOWEVER, WISH TO RESPOND IN A POSITIVE WAY TO OPPORTUNITIES FOR EXPANDING FAMILY PLANNING SERVICES IN BOTSWANA, AND AFR/TR, PD, SA AND STYPOP INTEND TO CONSIDER ALTERNATIVE PROJECT APPROACHES IN CONSULTATION WITH THE MISSION. IN THE MEANTIME, STEPS ARE UNDERWAY TO INSURE THE CONTINUED AVAILABILITY OF A.I.D. CONTRACEPTIVE SUPPLIES. END SUMMARY

2. BASED ON THE HIGH CONTRACEPTIVE PREVALENCE RATE IN BOTSWANA (RELATIVE TO AFRICA), AFR/DAA HAS EXPECTED PD TO PROPOSE FUND TRANSFERS TO GOB MCH WHICH WOULD CONTRIBUTE

TO A SIGNIFICANT EXPANSION OF THE CURRENT FAMILY PLANNING PROGRAM. HOWEVER, PID REFERRED TO AN IMPLIED RATHER THAN OFFICIAL GOB FAMILY PLANNING POLICY, AND DESCRIBED CERTAIN DEFICIENCIES IN THE PUBLIC SECTOR DELIVERY SYSTEM, INCLUDING LOGISTICS, IEC, SKILLS AND PLANNING CONSTRAINTS. THE TECHNICAL ASSISTANCE TRAINING AND COMMODITY PROCUREMENT INTERVENTIONS PROPOSED TO ADDRESS THESE CONSTRAINTS IMPLY A MUCH GREATER MISSION MANAGEMENT BURDEN THAN ORIGINALLY ENVISIONED. GIVEN THESE QUESTIONS AND PREFERENCES FOR MORE UTILIZATION OF THE PRIVATE SECTOR, ECPR WAS RELUCTANT TO COMMIT A.I.D. RESOURCES FOR THE PROJECT APPROACH RECOMMENDED IN THE PID.

3. THE ECPR CONCLUDED FOUR POSSIBLE CHOICES FOR PROCEEDING, AS FOLLOWS.

(A) APPROVING THE PID CONCEPT AS PRESENTED. ECPR HAD RESERVATIONS WITH THIS APPROACH FOR THE REASONS OUTLINED IN PARA 2 ABOVE

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(B) CONDITION NO ASSISTANCE ON POLICY COMMITMENT AND PROGRESS TOWARDS UTILIZATION OF PRIVATE SECTOR DELIVERY SYSTEMS. THIS WAS CONSIDERED INFEASIBLE BECAUSE OF ANTICIPATED GOB RESISTANCE AND THE LOW LEVEL OF DEVELOPMENT OF THE PRIVATE SECTOR IN BOTSWANA.

(C) CONTINUING CONTRACEPTIVE SUPPLY AND SELECTED CENTRALLY FUNDED ACTIVITIES. THIS IS A MINIMUM LEVEL OF ASSISTANCE THAT MAY NOT BE ADEQUATELY RESPONSIVE TO EVOLVING OPPORTUNITIES BUT WILL GO FORWARD WHILE OTHER DESIGN OPTIONS ARE SORTED OUT.

(D) DEVELOPING AN UMBRELLA-TYPE PROJECT PROJECT TO FUND THROUGH BUY-IN ARRANGEMENTS, FAMILY PLANNING COMMODITIES AND LIMITED TRAINING AND SHORT-TERM TA. THIS APPROACH WOULD ALLOW THOROUGH ANALYSIS OF THE HEALTH/FAMILY PLANNING SECTOR, RESERVE SPECIFIC FUNDS FOR ACTIVITIES AND, DEPENDING ON PROGRESS, PROVIDE A BASIS FOR EXPANDED ASSISTANCE IN THE FUTURE. HOWEVER, THERE WAS NO ECPR CONSENSUS ON ITS ADVANTAGES OVER OPTION C OR THE DESIGN STEPS THAT MAY BE REQUIRED (REVISED PID OR DIRECTLY TO PP DESIGN).

4. THERE ARE INSUFFICIENT FUNDS AVAILABLE TO START A NEW FAMILY PLANNING PROJECT IN BOTSWANA IN FY 87. AFR/DP AND TR ARE ARRANGING TO RESERVE LIMITED FUNDING FOR CONTINUING CURRENT CONTRACEPTIVE SUPPLY ARRANGEMENTS. THE ECPR WOULD APPRECIATE MISSION COMMENTS ON THE ISSUES AND ALTERNATIVES RAISED ABOVE. WHITEHEAD

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DRAFTED BY: AID/AFR/PD/SA:VGARY:ELD:4871L
APPROVED BY: AID/DAA/AFR:WBOLLINGER
AID/AFR/PO:CPEASLEY AID/AFR/SA:LPOMPA (DRAFT)
AID/AFR/TR:KSHERPER (DRAFT) AID/AFR/DP:TBETHUNE (DRAFT)
AID/GC/AFR:MAKLEINJAN (DRAFT) AID/AFR/PD/SA:MARIEGELMAN (DRAFT)
AID/AFR/PD/SA:PTHORN (DRAFT) AID/S&T/POP:HCROSS (DRAFT)
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AIDAC NAIROBI FOR REDSO - B. JEFFERS

E.O. 12356: N/A

SUBJECT: BOTSWANA POPULATION SECTOR PROGRAM ASSISTANCE (BOTSPA) 633-0249

REF: STATE 088655

1. SUMMARY. ECPR FOR SUBJECT PAAD WAS HELD ON 3/14/88. ALTHOUGH BUREAU IS SUPPORTIVE OF PROPOSED SECTOR APPROACH, ECPR FELT THE PAAD PROVIDED INSUFFICIENT JUSTIFICATION FOR PROGRAM ASSISTANCE. SUGGESTIONS FOR EITHER REVISIONS TO PAAD (AUTHORIZATION IN AID/W), OR PROJECTIZING ENTIRE ACTIVITY (AUTHORIZATION IN FIELD) ARE PROVIDED. CONCERNS WHICH NEED TO BE CLARIFIED IN THE PAPER, REGARDLESS OF THE APPROACH TAKEN, ARE LISTED. END SUMMARY.

2. THE ECPR, HELD ON 3/14/88, WAS CHAIRED BY C. PEASLEY, DIRECTOR AFR/PD AND ATTENDED BY REPRESENTATIVES OF AFR/SA, PD, DP, TR, GC/AFR AND S&T/POP. H. CROSS S&T/POP AND J. THOMAS AFR/TR/HPN PRESENTED THE PROGRAM ON BEHALF OF USAID/BOTSWANA. DUE TO THE SCRUTINY THAT OFA PROGRAM ASSISTANCE WILL BE GIVEN ON THE HILL AND THE INNOVATION OF A POPULATION SECTOR PROGRAM, THE ECPR PAID

PARTICULAR ATTENTION TO THE RATIONALE AND PERFORMANCE TARGETS PROVIDED FOR THE NON-PROJECT ASSISTANCE (NPA) COMPONENT OF BOTSPA.

IN ORDER TO JUSTIFY NPA THERE NEEDS TO BE MORE EXPLICIT INDICATION OF WHAT THE CONSTRAINTS ARE IN THE POPULATION SECTOR AND WHAT CAN BE EXPECTED FROM THE CASH GRANT IN TERMS OF POLICY, INSTITUTIONAL AND/OR STRUCTURAL REFORM. BOTSPA SPELLS OUT INDICATORS RELATED TO CONTRACEPTIVE PREVALENCE, BUT DOES NOT PROVIDE SUFFICIENTLY DETAILED INFORMATION ON WHAT THE POLICY AND/OR STRUCTURAL CONSTRAINTS ARE OR HOW THEY WILL BE ADDRESSED. THE PAAD NEEDS TO BE REVISED TO INCLUDE A POLICY FRAMEWORK, MUTUALLY AGREED TO BY THE GOB AND USAID, AGAINST WHICH GOB PERFORMANCE CAN BE MONITORED AND DISBURSEMENT DECISIONS MADE.

3. THE REMAINDER OF THIS CABLE PROVIDES SUGGESTIONS FOR EITHER REFINEMENT OF A BOTSPA PROGRAM OR ALTERATION TO A

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PURELY PROJECT ACTIVITY. BUREAU ENCOURAGES MISSION TO CONTINUE WITH PROGRAM APPROACH AND REVISE PAAD AS OUTLINED BELOW FOR AID/W AUTHORIZATION. WE WILL ENSURE EXPEDITED REVIEW OF REVISED PAAD. ALTERNATIVELY, MISSION CAN CONVERT PROPOSAL TO PROJECT ASSISTANCE, CONSISTENT WITH HANDBOOK 3 AND 611(A) REQUIREMENTS. IF THIS LATTER ROUTE IS TAKEN, MISSION CAN APPROVE PROJECT UNDER DOA 551. THE FINAL SECTIONS OF THIS CABLE LIST CONCERNS WHICH NEED TO BE CLARIFIED PRIOR TO EITHER BOTSPA OR PROJECT APPROVAL.

4. REFINEMENT OF BOTSPA PROGRAM: THE BOTSPA PROGRAM IS AN INNOVATIVE APPROACH WHICH THE BUREAU WANTS TO ENCOURAGE. HOWEVER, THE PAAD MUST BE REVISED TO REFLECT A COMMON UNDERSTANDING WITH GOB OF POLICY, STRUCTURAL AND/OR INSTITUTIONAL CONSTRAINTS IN THE POPULATION SECTOR AND A FRAMEWORK WHICH INCLUDES WHAT STEPS NEED TO BE TAKEN IN ORDER TO ALLEVIATE THOSE CONSTRAINTS. SUB-PARAGRAPH 4A PROVIDES SUGGESTIONS REGARDING DEFINITION OF CONSTRAINTS/TARGETS/FRAMEWORK WHICH COULD JUSTIFY APPROVAL OF A PROGRAM APPROACH AND 4B-G LISTS ADDITIONAL ITEMS OF CLARIFICATION NEEDED PRIOR TO A PAAD APPROVAL.

A/ CONSTRAINTS/TARGETS/FRAMEWORK: AS CURRENTLY PRESENTED IN BOTSPA, IT IS DIFFICULT TO ASCERTAIN WHAT ACTUALLY INHIBITS ACHIEVEMENTS OF POPULATION SECTOR TARGETS. IT APPEARS THE GOB COULD ATTAIN THE TARGETS BY SIMPLY EXPANDING SERVICES WITHIN THEIR CURRENT FRAMEWORK. DEFINITION OF CONSTRAINTS SHOULD CLEARLY

SHOW WHAT POLICY/STRUCTURAL OBSTACLES MUST BE OVERCOME TO ACHIEVE THE POPULATION SECTOR TARGETS. THE CONSTRAINTS TO BE OVERCOME AND THE STEPS NECESSARY TO OVERCOME THEM CONSTITUTE A FRAMEWORK.

FOR INSTANCE, BOTSPA IMPLIES THAT THE LACK OF COORDINATION AMONG GOB INSTITUTIONS WHICH DEAL DIRECTLY OR INDIRECTLY WITH POPULATION ACTIVITIES CONSTITUTES AN INSTITUTIONAL IMPEDIMENT IN THE POPULATION SECTOR. SIMILARLY BOTSPA IMPLIES THAT THE LACK OF INVOLVEMENT OF NON GOB ENTITIES IS A STRUCTURAL CONSTRAINT TO EXPANDING FAMILY PLANNING (FP) INFORMATION AND SERVICES. ASSUMING THESE ARE CONSTRAINTS, THEN BY THE END OF THE PROGRAM WE WOULD FORESEE A GOB PLANNING/IMPLEMENTATION STRUCTURE OR UNIT WHICH COORDINATES POPULATION SECTOR ACTIVITIES, AND GOB ACTIONS WHICH ENCOURAGE PRIVATE SECTOR PARTICIPATION. IN THIS ILLUSTRATIVE SCENERIO, STEPS NEEDED TO REALIZE THESE ENDS MIGHT INCLUDE GOB DECISIONS TO CREATE A PLANNING AND COORDINATING OFFICE FOR THE SECTOR, AND TO ALLOW FP INFORMATION AND SUPPLIES TO BE DISSEMINATED VIA NGO'S. THE ECPR FELT THESE SORTS OF STEPS OR PERFORMANCE TARGETS NEED TO BE IDENTIFIED AS GUIDES FOR ASSESSING THE GOB'S ANNUAL WORK PLANS AND FOR DETERMINING DISBURSEMENTS.

CROSS AND THOMAS HAVE DRAFTED MATERIAL WHICH PROVIDES MORE DETAILED IDEAS FOR POSSIBLE CONTENTS OF A FRAMEWORK WHICH THE MISSION COULD USE IN PLANNING FOR ITS DISCUSSIONS WITH THE GOB. THIS MATERIAL WAS DHL'D TO USAID/GABORONE ON 3/28/88. IF THE MISSION DECIDES TO PROCEED WITH THE BOTSPA APPROACH, THE PAAD WILL ALSO NEED TO ADDRESS THE ITEMS IN 4B-G FOR THE NPA COMPONENT.

B/ FACESHEETS: TWO SEPARATE FACESHEETS WILL BE NEEDED FOR THE BOTSPA APPROACH, SINCE THE TA/TRAINING PORTION IS IN FACT PROJECTIZED: 1/ A PROJECT FACESHEET AND AUTHORIZATION SHOULD BE FOR THE LOP OF THE TA AND TRAINING COMPONENT, USING THE PROJECT NUMBER ASSIGNED BY USAID/BOTSWANA. 2/ THE PAAD FACESHEET SHOULD BE THE NPA

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AMOUNT TO BE OBLIGATED IN THIS FY AND SHOULD EXCLUDE ANY REFERENCE TO PROJECT COMPONENT ACTIVITIES SUCH AS PROCUREMENT AND SOURCE/ORIGIN. M/FM WILL ASSIGN THE ACTIVITY NUMBER FOR THE NPA COMPONENT.

C/ AUTHORIZATIONS: A PAAD FACESHEET IS THE AUTHORIZING DOCUMENT FOR NPA. ALTHOUGH THE PAAD TEXT WILL DESCRIBE AND JUSTIFY THE MULTI-YEAR PROGRAM, AUTHORIZATION OF NPA AT ANY GIVEN TIME CANNOT EXCEED THE AMOUNT ACTUALLY AVAILABLE FOR OBLIGATION AT THAT TIME. THUS THE INITIAL PAAD FACESHEET WOULD BE FOR THE NPA FUNDS TO BE OBLIGATED IN FY88. IT WOULD BE AMENDED EVERY YEAR ADDITIONAL NPA FUNDS ARE TO BE OBLIGATED (ASSUMING ONCE YEARLY OBLIGATIONS). EACH PAAD FACESH[illegible] (ORIGINAL AND AMENDMENTS) WOULD INCLUDE THE CP'S FOR [illegible]SEMENT OF ONLY THOSE FUNDS TO OBLIGATED IN THAT FY.

THUS IF THE BOTSPA APPROACH IS TAKEN THE ACTION MEMORANDUM RECOMMENDING APPROVAL WOULD RECOMMEND THE FOLLOWING: 1/ APPROVAL OF A DOLS 5 MI[illegible]ION FIVE YEAR PROGRAM WHICH PROVIDES A FRAMEWORK [illegible]DEFINED IN PARA 4A ABOVE) UPON WHICH FULFILLMENT C[illegible]S WILL BE BASED. 2/ AUTHORIZATION OF THE INITIAL TRA[illegible]E OF DOLS 982,000 IN NPA FUNDS AND DOLS 2,000,000 IN PROJECT FUNDS; AND 3/ DELEGATION OF AUTHORITY TO THE FIELD FOR AMENDMENTS TO THE PAAD EACH OF WHICH SHOULD REFER TO PERFORMANCE TO DATE AND INCLUDE MODIFICATIONS, WITHIN THE CONTEXT OF THE FRAMEWORK LAID OUT IN THE PAAD, AS NEEDED FOR THE NEW YEAR. NOTE: IF THERE IS MORE THAN ONE NPA DISBURSEMENT IN ANY GIVEN YEAR, A CP FOR EACH DISBURSEMENT WILL BE REQUIRED.

D/ CASH DISBURSEMENT MECHANISM: A DESCRIPTION OF HOW THE NPA DISBURSEMENT WILL WORK IS REQUIRED, I.E.: HOW WILL THE FUNDS MOVE AFTER AUTHORIZATION, OBLIGATION, SATISFACTION OF THE CP'S AND BUDGET ALLOWANCE PROCEDURES ARE COMPLETED? WE ASSUME THAT CASH GRANTS WILL BE DISBURSED AS DOLLARS AND THAT LOCAL CURRENCY WILL BE PROGRAMMED AS BUDGET SUPPORT. WHILE USAID/BOTSWANA WILL ADMINISTER THE FUNDS, AID/W IS THE ACCOUNTING OFFICE FOR ALL NPA. THE CASH TRANSFER PROCEDURES, AND PAAD DESCRIPTION, WILL HAVE TO BE SUCH AS TO MAINTAIN THE CASH TRANSFER NATURE OF THE ASSISTANCE (THE RLA SHOULD SPECIFICALLY REVIEW THIS LANGUAGE IN FINAL). BUREAU IS IN THE FINAL STAGE OF PREPARING GUIDANCE FOR DOLLAR TRACKING OF DFA CASH TRANSFERS; WE WILL ADVISE AS SOON AS FINAL DECISIONS MADE.

E/ CONDITIONS PRECEDENT. CP'S SHOULD INDICATE WHAT IS REQUIRED FOR EACH DISBURSEMENT IN TERMS OF THE NEEDED POLICY/STRUCTURAL PROGRAM AS OUTLINED IN THE FRAMEWORK. THE ECPR CONCLUDED THAT THE PAAD COULD MAINTAIN A SYSTEM OF ANNUAL PERFORMANCE REVIEWS PRIOR TO ANNUAL AUTHORIZATION AMENDMENTS AND DOLLAR DISBURSEMENT DECISIONS. THUS THE KEY WILL BE TO ENSURE THAT ANNUAL PERFORMANCE REVIEWS EXAMINE PROGRESS IN IMPLEMENTING POLICY/STRUCTURAL CHANGES IDENTIFIED IN PARA 4A FRAMEWORK IF ANNUAL AUTHORIZATIONS AND DISBURSEMENT DECISIONS ARE TO BE BASED ON THESE REVIEWS. WITH FUNDS AUTHORIZED/OBLIGATED ANNUALLY, THE FORMAL CP'S CAN BE PHRASED IN ANY OF SEVERAL WAYS, INCLUDING: 1) BEING REASONABLY CONCRETE IN EACH CP; OR 2) REQUIRING PROGRESS, IN TERMS OF A BASIC CONSTRAINT AND REMEDY FRAMEWORK LAID OUT IN AN ANNEX TO THE GRANT AGREEMENT. THE PAAD DOCUMENT IS TO INCLUDE THE FRAMEWORK FOR THE LIFE OF PROJECT, WHILE THE PAAD FACESHEET MUST INCLUDE CP'S APPROPRIATE FOR THE FUNDS TO BE OBLIGATED IN THAT YEAR (SEE 4B AND C ABOVE).

F/ COVENANTS: IF THE MISSION BELIEVES A SPECIAL

COVENANT IS NEEDED WHICH CALLS FOR EVIDENCE THAT A.I.D. FUNDS WILL BE ADDITIONAL TO, AND NOT A SUBSTITUTE FOR, GOB'S OWN BUDGETARY RESOURCES FOR THE POPULATION SECTOR, A DEFINITION OF WHAT CONSTITUTES QUOTE EVIDENCE UNQUOTE WILL BE REQUIRED.

G/ CONTRACEPTIVE PROCUREMENT: PAGE 38 OF BOTSPA INDICATES GOB RESOURCES WOULD BE USED FOR AID PROCURED CONTRACEPTIVES. INITIAL INDICATIONS FROM S&T/POP ARE THAT NO RESOURCES CANNOT BE USED TO PROCURE CONTRACEPTIVES VIA THE AID PROCUREMENT MECHANISM. THE MISSION SHOULD ASCERTAIN IF THE GOB PLANS ON USING THE AID MECHANISM. IF AID PROCUREMENT IS REQUESTED, THE MISSION SHOULD EITHER: REQUEST SC/AFR TO FULLY INVESTIGATE THE POSSIBILITY OF WHETHER NO RESOURCES CAN BE USED, OR READJUST THE PROJECT AND NPA FUNDING LEVELS TO INCLUDE CONTRACEPTIVE PROCUREMENT IN THE PROJECT COMPONENT (I.E., FOR A.I.D. FINANCING, AS WELL AS PROCUREMENT). IF THE GOB PLANS TO USE CHANNELS OTHER THAN AID TO PROCURE CONTRACEPTIVES (AS INDICATED IN GABORONE 01282) THE PAAD SHOULD BE REVISED TO CLEARLY REFLECT THIS, INCLUDING A REVIEW OF THE GOB'S ABILITY TO PROCURE THE NEEDED CONTRACEPTIVES. COST ESTIMATES WOULD HAVE TO BE ADJUSTED AS APPROPRIATE FOR PROCUREMENT FROM OTHER SOURCES. WE WOULD ALSO REQUIRE ASSURANCE THAT THE GOB IS BOTH WILLING AND ABLE TO PROCURE THE NECESSARY CONTRACEPTIVES. THIS CAN BE ADDRESSED IN THE GOB'S INITIAL WORKPLAN WHICH SHOULD INCLUDE CONTRACTING AND PROCUREMENT PROCEDURES FOR CONTRACEPTIVES, AND A TIME SCHEDULE INDICATING WHEN THE NECESSARY STEPS WILL BE TAKEN.

5. PROJECT APPROACH: AN ALTERNATIVE APPROACH FOR THE MISSION IS TO PREPARE A PP AND PLAN FOR A STRAIGHT POPULATION PROJECT ACTIVITY. ONE PROJECT SCENARIO, WHICH WOULD BE MOST SIMILAR TO BOTSPA, WOULD BE TO PROJECTIZE THE NPA BY IDENTIFYING SPECIFIC ACTIVITIES FOR WHICH A.I.D. LOCAL COST FINANCING COULD BE DONE. THE PP WOULD HAVE TO INCLUDE COST ESTIMATES TO ENSURE THAT FAA 611(A) WAS MET. NORMAL PROJECT FUNDING WOULD BE USED. ADDITIONALLY IF FULLY PROJECTIZED, CONTRACEPTIVES COULD BE CLEARLY PROCURED THROUGH AID. IF THE MISSION DECIDES TO PROCEED WITH A FULLY-PROJECTIZED APPROACH, THE CLARIFICATIONS NOTED IN THE REMAINING PARAS, WHICH APPLY TO THE PROJECT-LIKE PORTION OF THE CURRENT PAAD, WOULD ALSO APPLY TO THE ENTIRE PROJECT. THE IEE WOULD ALSO NEED TO BE RE-EXAMINED.

6. CLARIFICATIONS NEEDED FOR PROJECT ACTIVITIES:

A/ THE TEXT FOR TA AND TRAINING ACTIVITIES AND CORRESPONDING BUDGET TABLES NEED TO BE RECONCILED.

B/ IF HOST COUNTRY CONTRACTING IS ANTICIPATED A BUDGET FOR EVALUATION OF THE GOB CAPABILITIES WILL BE NEEDED (BUDGET FOR EXTERNAL AUDITING IS ALSO REQUIRED AND IS ALREADY INCLUDED).

C/ IF COMMODITY PURCHASES ARE ANTICIPATED (PG 56) THEY NEED TO BE IDENTIFIED AND A PROCUREMENT PLAN PROVIDED.

D/ REGARDING THE SELECTION PROCESS FOR AN A.I.D. DIRECT CONTRACT (P. 58), WHILE THE GOB CAN BE REPRESENTED ON THE EVALUATION PANEL, A.I.D. SHOULD ENSURE THAT IT HAS A MAJORITY, SINCE A.I.D. HAS THE RESPONSIBILITY FOR ITS DIRECT CONTRACTING PROGRAM.

7. CLARIFICATION - EVALUATION. THE PAAD DESCRIBES A NUMBER OF MONITORING SYSTEMS, INCLUDING ANNUAL REVIEWS,

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WHICH MAKE IT UNLIKELY THAT A MID TERM EVALUATION WILL BE NEEDED. HOWEVER THE ECPR FELT IT WOULD BE USEFUL TO IDENTIFY A SET OF CRITERIA OR CIRCUMSTANCES WHICH MIGHT TRIGGER AN OUTSIDE EVALUATION DURING PROGRAM IMPLEMENTATION. FOR EXAMPLE, INABILITY OF GOB TO MEET PERFORMANCE TARGETS AND LACK OF AGREEMENT AS TO THE CAUSE AND/OR MEANS OF ADDRESSING THE PROBLEM.

8. THE PAAD/PP NEEDS TO SPECIFICALLY ADDRESS PAYMENT VERIFICATION REQUIREMENTS AND THE MISSION NEEDS TO SPECIFICALLY CERTIFY THAT THEY HAVE BEEN MET.

9. PLEASE INDICATE THE GOB'S CONTRIBUTION SO THAT THE FACT THAT IT EXCEEDS 25 PERCENT OF TOTAL PROGRAM COSTS IS READILY APPARENT. THUS FOR BOTSPA INCLUDE A SENTENCE IN THE TEXT WHICH STATES THE DOLLAR EQUIVALENT REPRESENTED IN BUDGET TABLE 4 AND THAT THIS IS X PERCENT OF THE PROGRAM COST AND THIS EXCEEDS THE 25 PERCENT HC CONTRIBUTION REQUIREMENT.

10. IF A FULLY PROJECTIZED APPROACH IS USED, A.I.D.'S STANDARD CLAUSES CONCERNING ABORTION AND VOLUNTARY STERILIZATION SHOULD OF COURSE BE USED, AND THIS SHOULD BE INCLUDED IN THE RP. IF BOTSPA APPROACH IS TAKEN, GC/AFR WILL ADVISE ON THIS ISSUE FOR NPA GRANT.

11. AID/W APPLAUDS MISSION'S EFFORT IN ATTEMPTING AN INNOVATIVE APPROACH TO THE POPULATION SECTOR AND HOPES THE GUIDANCE WILL LEAD TO THE REFINEMENT OF BOTSPA. WE BELIEVE THAT BOTSPA CAN PROVIDE A MODEL OF THE TYPE OF EXCITING APPROACHES WHICH CAN BE DEVELOPED WITH THE DFA. PLEASE ADVISE WHAT OPTION THE MISSION DECIDES TO PURSUE AND IF ANY FURTHER GUIDANCE IS DESIRED. ARMACOST

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