

PD-AAA-173
377-1

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

JUN 15 1988

ACTION MEMORANDUM FOR THE SENIOR ASSISTANT ADMINISTRATOR
FOR SCIENCE AND TECHNOLOGY

FROM: ST/POP, Duff Gillespie *DG*

SUBJECT: Family Planning Service Expansion and Technical
Support Project (936-3048)

Action: Your approval is required to authorize \$75,694,866 for a new project, Family Planning Service Expansion and Technical Support (SEATS), 936-3048.

Discussion: The Office of Population proposes a new ten year project, Family Planning Service Delivery and Technical Support. Authorization for the first five years is requested at an estimated cost of \$75,694,866 (\$50,000,000 from ST/POP and \$25,694,866 from Missions and Regional Bureaus). The purpose of the project is to expand the development of, access to and use of family planning services in currently underserved populations and to help ensure that unmet demand for these services is addressed through the provision of appropriate financial, technical and human resources. The project is also consistent with the Office of Population's strategy to expand services in sub-Saharan Africa especially in countries which have no bilateral population program.

This new project will focus its efforts on developing and strengthening family planning service delivery activities in low contraceptive prevalence countries in sub-Saharan Africa, and selected countries in Asia, the Near East and the Pacific. This will be accomplished by identification and development of 50 subprojects in emphasis countries; establishing regional offices with teams of experts, provision of short term technical assistance in program design, training, information, education and communication, management information and project monitoring and evaluation, fielding long term resident technical advisors in countries with a substantial investment in subprojects and providing long term program/policy advisors to selected countries through a buy-in mechanism. Finally, the project will offer in-country and regional training for subproject staff.

SEATS activities will take place primarily in those underserved countries where other cooperating agencies are not heavily involved. In other countries where bilateral population programs exist or where other cooperating agencies are involved, SEATS will coordinate with them and strive to develop joint projects, to gain economies of shared project development and implementation costs.

The estimated cost for the first five year authorization period is \$75,694,866. This assumes S&T funding of \$50 million and USAID funding of \$25,694 million. Discussions with Africa Bureau staff and responses to a cable describing services available under SEATS indicate that a number of missions are committed to buying in to the project. Therefore, we believe the \$25.7 million estimate is realistic and will be met.

The project will be carried out by a U.S. based contractor selected through the competitive procurement process. The Cooperating Agency will have eleven major responsibilities:

- 1) Establish regional field offices in Francophone and Anglophone Africa, and staff these offices with the teams of experts delineated in their scope of work (approved by A.I.D.). Contractor headquarters for this project, which are to be located in the Metropolitan D.C. area, will maintain a similar, complementary staff of experts who will be responsible for providing technical assistance and project monitoring support to countries located in Asia, the Near East and the Pacific.
- 2) Establish subcontracts with local African based management consulting firms to support the subprojects as required.
- 3) Through country planning visits, initiate contact with local organizations in the countries of emphasis and identify possibilities for subproject development. Once an initial assessment has been conducted, it will be the responsibility of the contractor to develop country strategies and plans for subproject development with staff of the local affiliate, for Mission, Contractor and AID/W approval.
- 4) As part of the planning process, identify needs for technical assistance, financial and program management; training; development of IEC materials; commodity distribution schemes; development of an MIS; and project monitoring and evaluation; and ensure that these needs are responded to in a timely manner for successful execution of the project.

- 5) Organize three regional workshops to discuss project results and lessons learned and to address specific technical types of general interest. Participants would be representatives from projects in the priority countries of the region and A.I.D. officers.
- 6) Develop between five to eight training modules (as appropriate) for use by staff of local organizations on all aspects of family planning program development (needs assessments, IEC, training, MIS, commodity distribution, project monitoring and evaluation). These modules will be used in regional and in-country training programs.
- 7) Conduct regional and in-country training programs for subproject staff on overall family planning program development, as well as in specific technical areas (as previously outlined).
- 8) Establish a mechanism for estimating centrally procured contraceptives, and ensure their timely delivery to individual subprojects. Actual shipping and logistics management will be conducted through the centrally funded Logistics Management Project, in close collaboration with the project's commodities manager.
- 9) Assign resident technical advisors to those countries with large or numerous subproject activities, in order to provide on-site technical assistance and project management and monitoring.
- 10) Assign long term program/policy advisors as requested by missions, provide logistical and technical support to long term advisors placed in countries to assist them in strengthening components of national family planning programs.
- 11) The contractor will develop a data base which shows all subprojects developed, current status of implementation, funding and other information which is compatible with the Office of Population's Project Data Base.

Justification to Congress: An advice of program change has been drafted and is in the clearance process.

Clearances Obtained: The expanded Concept Paper, approved by you on March 17, 1988 was reviewed by the Population Sector Council and there were no major issues raised which warranted exploration through a Project Identification Document. The

Project Paper was prepared in close collaboration with Regional Bureau and REDSO staffs. Comments from the Regional Bureaus, Missions, S&T Bureau, and PPC have been solicited and incorporated in the Project Paper, as appropriate. The Sector Council reviewed the PP on May 2 and recommended approval. The approved Concept Paper and Sector Council minutes are included in Annex A and B, respectively of the Project Paper.

Certification of the Procurement Plan: The certification required in accordance with your memorandum dated November 15, 1985 subject: Increasing the Use of Minority Organizations and HBCUs, appears on page 33 of the Project Paper. The certification recommends full and open competition because of the complexity of the project and the importance of the project to the success of A.I.D.'s population strategy. S&T/POP believes that the interests of the Agency will be best served by full and open competition.

Recommendation: That you approve the attached authorization for the Family Planning Service Expansion and Technical Support project.

Attachments:

1. Authorization
2. Project Paper

Clearances:

| | | |
|-----------------------|-----------|----------------------|
| S&T/POP/FPSD:JRogosch | <u>JR</u> | Date: <u>6/13/88</u> |
| S&T/POP:BKennedy | <u>BK</u> | Date: <u>6/14/88</u> |
| S&T/POP:BCase | <u>BC</u> | Date: <u>6/13/88</u> |
| GC/CP:STisa | <u>ST</u> | Date: _____ |
| S&T/PO:DSheIdon | <u>IS</u> | Date: <u>2/12/88</u> |
| S&T:BLangmaid | <u>BL</u> | Date: _____ |

Drafted by ST/POP/FPSD:BBrown:DLibert: 6/13/88 5098Y

PROJECT AUTHORIZATION

Country: Interregional

Project Title: Family Planning
Service Expansion and Technical
Support

Project Number: 936-3048

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the centrally-funded project, Family Planning Service Expansion and Technical Support (SEATS) project, involving planned obligations not to exceed \$75,700,000 in grant funds over a five-year period from the date of initial obligation, subject to availability of funds in accordance with the A.I.D. OYB/allotment process.

2. The purpose of the project is to expand development of, access to and use of quality family planning services in currently underserved countries; and to help ensure that unmet demand for these services is addressed through the provision of appropriate financial, technical and human resources.

3. The contract which may be executed by the officer to whom such authority is delegated in accordance with A.I.D. Regulations and Delegations of Authority shall be subject to the following terms and conditions together with such other terms and conditions as A.I.D. may deem appropriate.

4. Source and Origin of Commodities, Nationality of Services

a. Commodities financed by A.I.D. under the project shall have their source and origin in the cooperating country* or the United States except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the cooperating country or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing.

*Each country where research, training, technical, or other assistance takes place under the project shall be deemed to be a cooperating country for the purpose of permitting local cost financing of goods and services for the activity being conducted in such country. Such activities may be undertaken in any country included in the A.I.D. geographic code 935.

b. The aggregate cost of all goods and services to be procured under each subagreement in a cooperating country may not exceed \$750,000.

c. Ocean shipping financed by A.I.D. under the project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.



N. C. Brady
Senior Assistant Administrator, S&T

7/19/88
Date

Clearances:

| | | |
|-----------------------------------|-----------|---------------------|
| S&T/POP/FPSD: JRogosch | <u>JR</u> | Date <u>6/13/88</u> |
| up S&T/POP: DGillespie | <u>DG</u> | Date <u>6/15/88</u> |
| GC/CP: STisa | <u>ST</u> | Date <u>6/20/88</u> |
| S&T/PO: DSheldon | <u>DS</u> | Date <u>7/12/88</u> |
| S&T: BLangmaid | <u>BL</u> | Date _____ |

S&T/POP/FPSD: BBrown: BB 6/13/88: 235-2458: 5102Y

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
 C = Change
 D = Delete

Amendment Number

DOCUMENT CODE

3

2. COUNTRY/ENTITY
Interregional

3. PROJECT NUMBER

936-3048

4. BUREAU/OFFICE

S&T/POP

36

5. PROJECT TITLE (maximum 40 characters)

Family Planning Service Expansion and Technical Support

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
12 31 99

7. ESTIMATED DATE OF OBLIGATION
(Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 99

B. Quarter

C. Final FY 97

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

| A. FUNDING SOURCE | FIRST FY | | | LIFE OF PROJECT | | |
|------------------------|----------|--------|----------|-----------------|--------|-----------|
| | B. FX | C. L/C | D. Total | E. FX | F. L/C | G. Total |
| AID Appropriated Total | 3,133 | | 3,133 | 143,874 | | 143,874 |
| (Grant) | () | () | () | (143,874) | () | (143,874) |
| (Loan) | () | () | () | () | () | () |
| Other | | | | | | |
| U.S. | | | | | | 95,916 |
| Host Country | | | | | | 47,958 |
| Other Donor(s) | | | | | | |
| TOTALS | | | | 143,874 | | 143,874 |

9. SCHEDULE OF AID FUNDING (\$000)

| A. APPROPRIATION | B. PRIMARY PURPOSE CODE | C. PRIMARY TECH. CODE | | D. OBLIGATIONS TO DATE | | E. AMOUNT APPROVED THIS ACTION | | F. LIFE OF PROJECT | |
|------------------|-------------------------|-----------------------|---------|------------------------|---------|--------------------------------|---------|--------------------|---------|
| | | 1. Grant | 2. Loan | 1. Grant | 2. Loan | 1. Grant | 2. Loan | 1. Grant | 2. Loan |
| (1) | PN | 440 | | | | 75,694 | | 75,694 | |
| (2) | | | | | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| TOTALS | | | | | | 75,694 | | 75,694 | |

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 1 positions each)

A. Code

B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To expand the development of, access to and use of family planning services in currently underserved populations; and ensure that unmet demand for these services is addressed through the provision of appropriate financial, technical and human resources.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY
0 3 9 1 0 2 9 3

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify) 935

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

Total estimated cost is \$143,873,696 of which S&T contribution is \$95,915,796 and Buy-ins are \$47,957,900. Authorization for the first five years is \$75,694,866 of which S&T contribution is \$50,000,000 and Buy-ins are \$25,694,866.

17. APPROVED BY

Signature

Title Director

Office of Population

Date Signed

MM DD YY
16 15 88

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

MM DD YY

PROJECT PAPER
FAMILY PLANNING SERVICE EXPANSION AND TECHNICAL SUPPORT
(SEATS) PROJECT (936-3048)

TABLE OF CONTENTS

| | Page |
|---|------|
| I. Summary And Recommendations | 1 |
| II. Project Rationale | 3 |
| III. Project Description | 7 |
| A. Goal | 7 |
| B. Purpose | |
| C. Proposed Approach and Areas of Emphasis | 7 |
| D. Beneficiaries | 9 |
| E. Project Outputs | 9 |
| 1. Operational Service Delivery Subprojects | 9 |
| 2. Training | 13 |
| 3. Long Term Program/Policy Advisors | 15 |
| 4. Information Dissemination | 15 |
| F. Cost Sharing | 15 |
| G. Women in Development | 16 |
| H. Emphasis Countries | 17 |
| IV. Project Implementation | 18 |
| A. Primary Cooperating Agency | 18 |
| B. Project Staffing | 20 |
| C. Project Organization | 20 |
| D. Coordination and In-Country Implementation | 23 |
| E. A.I.D. Management | 23 |
| F. Implementation Schedule | 24 |
| V. Budget and Financial Plan | 26 |
| VI. Evaluation | 31 |
| VII. Conditions and Covenants | 32 |
| VIII. Certification of the Procurement Plan | 33 |
| IX. Logframe | 34 |
| Annex A SEATS Concept Paper | |
| Annex B. Minutes of the Population Sector Council Meeting | |
| Annex C. Response to World Wide Cable | |
| Annex D. Technical Analysis | |

FAMILY PLANNING SERVICE EXPANSION AND
TECHNICAL SUPPORT (SEATS) (936-3048)

I. SUMMARY AND RECOMMENDATIONS

A. Face Sheet: Attached

B. Recommendation: That grant funds be provided through a competitively bid contract award to an organization for the purpose of providing family planning services to currently underserved populations in sub-Saharan Africa, and selected countries in Asia, the Near East and the Pacific. A ten year project approval is requested, with an initial authorization period of five years. Funds for the initial five year period will be provided as follows:

(in \$000's)

| Project Year | 1 | 2 | 3 | 4 | 5 |
|--------------|--------|--------|--------|--------|-------|
| Obligation | 12,348 | 18,440 | 21,369 | 13,563 | 9,972 |

Total (5 years): \$75,694,866, including \$50,000,000 in A.I.D. central population funds, and \$25,694,866 in buy-ins from Regional and bilateral funds, will be required to fund this project.

C. Summary Project Description:

1. Program Goal:

To improve maternal and child health in less developed countries, and to enhance the freedom of individuals in these countries to choose voluntarily the number and spacing of their children.

2. Project Purpose:

To expand the development of, access to and use of quality family planning services in currently underserved populations; and ensure that unmet demand for these services is addressed through the provision of appropriate financial, technical and human resources.

3. Principal Activities:

This project will focus its efforts on developing and strengthening family planning service delivery activities in sub-Saharan Africa, and selected countries in Asia, the Near East and the Pacific. This will be accomplished through the following activities:

- 1) Identification and development of 50 subprojects in emphasis countries.

2) Provision of short term technical assistance in program development; training; information, education and communication (IEC); management information systems (MIS); and project monitoring and evaluation; through a team of experts located in regional field offices.

3) Provision of long term resident technical advisors in countries with a substantial investment in subprojects.

4) Establish subcontracts with local management consulting firms or training institutions to provide administrative, financial management and training support for subprojects.

5) Application of results of operations research projects to assist with the development of service delivery projects.

6) Provision of long term program/policy advisors to selected countries through a buy-in mechanism, to assist with family planning program development and related policy issues. These advisors would not necessarily be linked to subproject development, but would serve at a higher, national level.

II. Project Description

A. Project Rationale

1) Demographic Conditions

Over the course of the past two decades A.I.D. has taken the lead among donor agencies in developing and expanding family planning services throughout the developing world. While overall decreases in fertility have been realized in Latin America/Caribbean and some Asia/Near East countries (current growth rates are 2.3 and 2.4 per cent/year, respectively), growth rates in Africa and selected areas of Asia, the Near East and the South Pacific are among the highest in the world, averaging 3.0 per cent/year. If this growth rate is maintained, the population will more than double in the next 25 years. In the case of Africa, this means an increase from 402 to 804 million people in that period of time. For selected countries in Asia, the Near East and the South Pacific, the average doubling time is 27 years, resulting in an increase from 125 million to 250 million by the year 2015.

Population increases of this magnitude have severe implications for the economic development and social well being of these countries. In countries where resources are limited, high growth rates place overwhelming strains on severely burdened economies. This is particularly apparent in terms of the availability of basic necessities such as food and water. For many countries, these resources are limited and in some cases declining. A recently issued FAO report indicates that per capita food production in Africa has fallen 20 percent since 1960. Most striking is the fact that the arable land available per person has fallen from 0.71 hectares in 1960 to 0.57 hectares in 1980. Even to maintain current levels of food production, countries with high growth rates must set extremely high, and often unrealistic targets for agricultural expansion. (From African Agriculture: The next 25 Years; FAO, Rome, 1986). While capacity to expand agricultural production exists, attempts to intensify land use in many countries have led to overcultivation, overgrazing, and deforestation. Consequently, the productivity of this renewable resource has been diminished.

In addition to the already drought stricken countries of the Sahel, other countries such as Yemen and Jordan face the serious problem of water scarcity. In Yemen, only 20% of the rural population has access to potable water. (Yemen, CDSS FY 1987, May 1985) Compounding this, drought and excessive pumping of water for irrigation and household purposes has seriously reduced the availability of water in most areas of the country. (World Bank: "Yemen Arab Republic: Current Position and Prospects" March 17, 1986) For Jordan, rainfall is low and highly variable. Water is scarce, thus limiting agricultural potential and heavy water-consuming industrial development. (Jordan CDSS, May 1986) Needless to say, the prospect of a rapidly increasing population in these areas places an overwhelming demand on these very limited resources.

The effects of rapid population growth can be understood at a family level as well. On average, African women can expect to give birth to 6.5 children, as compared to 4.3 children for women in Latin America & the Caribbean, and 4.9 for women in Asia and the Near East. Fertility rates for selected Asian and Near Eastern countries conform more to African demographic profiles than to Asian. In Yemen, the average woman will give birth to 7.8 children, in Algeria, the rate is 6.4. In Burma and Papua New Guinea, the rates are also rather high, at 4.4 and 5.3 respectively. Large numbers of children not only strain parents' ability to provide them with adequate food, health care, and education, but also increases health risks associated with high fertility.

Many births to African women are high-risk, occurring to women under age 20, following a prior birth by less than two years, or following the fourth child. Births under these conditions increase rates of morbidity and mortality in children and mothers. Jordan has one of the shortest birth intervals observed for a national population -- more than 45% of all births in Jordan occur less than 24 months after an earlier birth, resulting in an infant mortality rate for these children that is twice as high as for children born at longer intervals of 2-3 years. (Jordan: Marketing of Birthspacing PID, 2/9/88) In Yemen, the birth interval average is only 12 months and infant mortality rates are in the 173-190/1000 range -- among the highest in the world. In Burma, pregnancy related ailments (hemorrhage, birth complications), are listed as no. 10 of 60 in a priority listing of health problems.

In order to begin reducing fertility in these regions, and to work to reduce child/maternal mortality rates, adequate family planning service delivery programs must be developed so that those couples who so wish can regulate their fertility.

2) Policy Change

In the past two decades, much change has taken place in Africa with regard to population and family planning. In the late 1960's and early 1970's, many African countries did not perceive development to be hindered by population growth nor family planning as an effective health measure. As demographic information and research on African countries have become more available, government leaders have come to recognize the economic value of efforts aimed at slowing population growth and the health value of offering family planning services. During the past decade, and especially in the past five years, many countries have adopted policies promoting lower rates of population growth and have begun supporting family planning programs as a means of slowing growth rates and improving maternal and child health.

Much the same trend has been seen in Asia, the Near East and the South Pacific. While many countries cannot, for various political reasons, actively support population policies, there is a definite movement in the direction of stronger implicit support for birthspacing and family planning. Jordan, for example has abandoned its traditional neutral policy stance and actively supports a birthspacing strategy.

As of 1983, twelve countries representing nearly 40 percent of all African populations, had formulated explicit policies for lowering population growth rates. Eleven additional countries, while not promulgating explicit policies to lower population growth rates, directly support family planning programs. Together, these twenty-three countries represent over 70 percent of all African populations. Of the seven countries targeted in Asia/Near East and the South Pacific, two (Algeria, Turkey) have explicit population policies. Three others (Jordan, Fiji, Papua New Guinea) do not, but their governments are supportive of direct interventions to reduce growth rates. Of the remaining two, one (Yemen) has a neutral policy stance toward population, but has recognized the Yemeni Family Planning Association; and the other (Burma) is pro-natalist but does support child spacing in an effort to reduce the very high infant mortality rate. Changing policies reflect a growing awareness among African and Asian leaders of demographic conditions, and how population growth rate influences national development and individual well-being.

3) Demand For Services and Available Supply

Heightened awareness among developing country leaders has in turn lead to an increased demand in both the private and public sectors to organize, establish or expand family planning services. Traditional methods of birth spacing are already widely accepted and practiced in a number of different societies in sub-Saharan Africa. A recent A.I.D. funded survey conducted in one region of Zaire showed over 90 percent of the women approving of family planning for spacing or limiting births and over 50 percent currently using a traditional method of contraception (Bertrand, 1985). These methods, however are generally less effective than modern methods and may become abandoned as populations become more modern and no longer subscribe to traditional practices and taboos.

In contrast, use of modern contraceptive methods among women aged 15-49 is very low throughout the region - generally under 10 percent. By way of comparison, over 30 percent of women surveyed in seventeen countries in Latin America and Asia were using contraception.

In the emphasis countries of Asia and the Near East, some of the same characteristics hold true. In Turkey for example, there is a high prevalence of the lesser effective traditional methods, while at the same time a high level of unmet demand for contraceptives. A 1983 survey indicated that 94% of women have knowledge of contraception, and 75% stated they did not want any more children; however, use of modern methods is still only 26%.

Based on current field experience, there is reason to believe that once widely available, family planning services will be heavily demanded in Africa. Areas where family planning information and services have been made readily available have experienced high rates of contraceptive acceptance and use. Zimbabwe is one such example. Results from a 1984 survey showed 39 percent of Zimbabwean women practicing family planning, with 27 percent using modern and 12 percent using traditional contraceptive methods.

Evidence from other sample surveys suggest substantial demand for family planning services. Unmet demand for family planning has been measured from surveys in nine different African countries. Results indicate that between 30 and 64 percent of the women stated a desire to either limit family size or delay their next pregnancy. In Burma, an A.I.D. health sector survey team found that the small family norm has been adopted, however contraceptive supplies were found to be expensive and were often not accompanied by well informed medical advice and service. ("A Review of A.I.D.'s Health Sector Strategy in Burma", David Oot, Alan Fairbank and Timothy Baker, Feb. 1985) In Papua New Guinea, the most recent CDSS reports that demand for contraceptives far exceed supply in rural areas.

In many of these countries, especially in Africa, family planning service facilities and delivery networks--both public and private--are extremely sparse, workers and staff lack clinical and managerial skills, and quality of services is uneven. Thus as demand for services grows, the available service supply, already weak, will be increasingly overtaxed, overburdened and unable to respond adequately.

As interest and commitment--particularly in African nations--grows, future demands for support of both private sector and government efforts to organize, establish or expand family planning services will continue to intensify. Current A.I.D. mechanisms are inadequate to meet the increasing demands. Support for certain aspects of family planning activities has been facilitated by cooperating agencies and other contractors funded by A.I.D, and these organizations have begun to shift emphasis to the African region. However, limited resources and the amount of time needed to program new activities have often prevented these groups from responding to the increased demand for assistance. To address this issue, the S&T Bureau Office of Population is proposing a new Family Planning Service Expansion and Technical Support (SEATS) Project. SEATS will focus on low contraceptive prevalence countries in sub-Saharan Africa, Asia, the Near East and the Pacific with weak infrastructures, which have a substantial unmet need for family planning.

4. Relationship to A.I.D Policy- The SEATS project addresses the two principal objectives of A.I.D.'s Population Sector Strategy which are 1) to increase access to family planning services and education, so that couples can voluntarily choose the number and spacing of their children and 2) to encourage rates of population growth consistent with the growth of economic progress and productivity. By stimulating public and private sector organizations to initiate and support family planning services in their respective countries, the project will work to strengthen and institutionalize service delivery infrastructure. The project is also consistent with the Office of Population's strategy which is to expand services in sub-Saharan Africa especially in countries which have no bilateral population program.

5. Relationship to Other Office of Population Projects: SEATS activities will take place primarily in those underserved countries (see page 17) where other Cooperating Agencies are not heavily involved. In other countries where bilateral population programs exist and/or where other Cooperating Agencies are involved, SEATS will coordinate with them and strive to develop joint projects, where possible, to gain economies of shared project development/implementation costs. In no case will SEATS compete for or duplicate the on-going or planned activities of other Cooperating Agencies. Where feasible, SEATS will draw upon the services of other centrally funded projects such as Family Planning Management Training (936-3039) and Family Planning Training for Paramedical, Auxiliary and Community (PAC) Personnel II (936-3031) when clinical training and family planning management courses appropriate to its needs and schedule are offered. SEATS will also use the services of Contraceptive Procurement (936-3018) and Family Planning Logistics Management (936-3038) to purchase and ship contraceptives for the project. SEATS will provide projections each year concerning the quantity and cost of the contraceptives and their shipment, and funding for these components will be provided for under those projects.

III. Project Description:

A) Goal

The family planning services delivery project will contribute to the achievement of enhanced freedom of individuals in less developed countries to voluntarily choose the number and spacing of their children; and to increase maternal, infant and child survival.

B) Purpose

The purpose of the project is to expand the development of, access to and use of quality family planning services in currently underserved populations; and help ensure that unmet demand for these services is addressed through the provision of appropriate financial, technical and human resources.

C) Proposed Approach and Areas of Emphasis

The project will focus its efforts on developing and strengthening family planning service delivery activities in sub-Saharan, Africa and selected countries in Asia, the Near East and the Pacific. This will be accomplished through the following approaches:

Key Areas of Emphasis

-- Support for Quality Family Planning Services

A key feature of this project will be funding 50 multi-year family planning service delivery subprojects. In all subprojects developed under the SEATS Project emphasis will be on providing quality family planning services to client populations. Quality services means: services provided by well-trained workers in efficiently managed, accessible facilities, in which

informed choice is assured by patient counseling and education on all available contraceptive methods. The contractor will ensure that the staff of local subcontractor agencies are adequately trained in each method of contraception to be offered, and that periodic medical monitoring visits are conducted. Where feasible, an effort will be made to include training in sterilization procedures. It will be the responsibility of the contractor to ensure that protocols and procedures are developed (or adapted) for each method being offered, and that adequate referral facilities are available in the event of an emergency. To the extent possible, the contractor will also coordinate with other centrally funded cooperating agencies (such as AVSC and JHPIEGO) on staff training, and in the case of AVSC referrals for sterilization procedures, if those agencies are working in the same country. All of the above activities will be coordinated with the host country Ministry of Health, family planning association, or other regulatory agency.

--Management and Planning

Experience from previous service delivery programs indicates that one of the major problems has been the lack of proper training of project staff in management and planning. This remains a major impediment to the subproject's allocation of resources and ability to serve a greater client population.

It will be the responsibility of the contractor to ensure that the appropriate staff from each implementing agency receive adequate training in management and program planning. This should include training in developing workplans, establishing agency priorities, and allocation of resources (financial and human) to reflect these priorities. The contractor will maintain records for all participant training financed under the project in a central, computerized tracking system.

--Program Sustainability

The project will place particular emphasis on assisting implementing agencies to achieve sustainability. Previous experience has shown that grantees can often become too dependent on outside funding, and do not seek ways to ensure their survival. Ideally, the project will strive to work with groups which already have ongoing, self-sustaining activities, or alternatively, will assist agencies to develop strategies (marketing plans, fee for service structures, etc.), so they may sustain themselves and continue providing family planning services after A.I.D. project support has been terminated. It is recognized that sustainability of these agencies may not always be achieved during the life of the project, given the amount of time it will take to initiate services and develop a large enough client load. However, a plan will need to be developed for each agency with a scheduled phase out of funding over a period of time which is consistent with the financial and economic conditions of the particular country. The project will assist each agency in identifying ways to market and sell its services (e.g. training, development of IEC materials, provision of services to private firms, etc.), so that a proactive approach will be taken, and A.I.D. funding will decline over time.

D) Beneficiaries

The beneficiaries under the SEATS project will be those couples in the emphasis countries who wish to determine the number and spacing of their children. Using the Target-Setting Model developed by John Bongaarts of the Population Council, a multiplicative model used to quantify the relationship between fertility and its proximate determinants, it is projected that SEATS will serve approximately 1,329,400 women of reproductive age during the period 1988-1993, and 1,941,700 over the life of the project (1988-1998). Based on the method mix for each projection and the discontinuation rate for each method, this would translate into 1,097,000 couple years of protection (CYP) for the period 1988-1993, and 2,369,000 for the period 1988 - 1998. The model and the calculations used to determine the projected number of beneficiaries and CYP is explained in detail in Annex D - Technical Analysis.

E. Project Outputs

Within the scope of the areas of emphasis outlined above, the project will result in four general categories of outputs: 1) operational service delivery subprojects in low prevalence countries; 2) training for subcontractors; 3) placement of Long Term Program/Policy Advisors; and 4) Information Dissemination Activities. A detailed description of each component of the project follows.

1) Operational Service Delivery Subprojects: Two types of activities will be carried out under this component; subproject planning and development and technical assistance and monitoring. All of the technical assistance required to identify, design, initiate, and monitor new subprojects will be the responsibility of the core technical assistance teams which will be based in Africa and in Washington D.C.

The core technical assistance team will establish regional priorities, allocate resources and identify prospective subcontractors. The majority of technical assistance under this project will be carried out by the two regional field offices, one in Francophone West Africa and one in Anglophone East Africa. The Headquarters Office will be responsible for selected countries in Asia/Near East and the Pacific. Each of the regional offices will consist of a team of 10 experts in the areas of program development, training, communications, management information systems, financial management, medicine, and evaluation.

a) Subproject Planning and Development: The majority of assistance under this project, 40-50 percent of the budget, will be directed toward planning and funding 50 new family planning service delivery subprojects in the emphasis countries. Illustrative examples of the types of subprojects which will be funded include approaches such as fixed center clinical family planning service delivery and community based distribution of contraceptives. The

type of service delivery subprojects as well as the extent of support activities such as IEC, training, and materials development will be determined in accordance with the priorities and needs of the organization.

The first activity which the contractor will undertake is to carry out brief planning visits to each of the emphasis countries expressing interest in this project. The choice for these initial visits will be based on requests from host countries, Missions, REDSO and the Regional Bureaus.

The purpose of these initial visits is to create awareness among program leaders and host country officials of the types of service delivery projects working elsewhere and the role that this project can play in helping to design and launch new projects. The visits will also serve to identify potential subcontractors, and to assess the training needs of prospective program managers and staff.

The Contractor may visit 15 to 20 country organizations during the first year, and that out of these visits between 5 to 10 potential subcontractors would be identified. It is anticipated that these on-site visits will result in country assessment reports. These reports are not envisioned as exhaustive studies, but would require between two to three person weeks of effort by two members of the contract team. These reports will draw upon existing information available in the Mission as well as reports prepared by other donors and cooperating agencies.

Once some of the planning visits have been completed the contractor will begin selecting 5 to 10 of the most promising project ideas for subproject development. The core technical assistance teams will move from initial visits to subproject design as the opportunities arise.

Each of the subprojects will be three year projects with budgets ranging between \$300,000- \$450,000 in local costs. The local funding will cover all in-country costs including equipment and all non-contraceptive commodities. The SEATS Project will supplement this local cost funding with technical assistance, and another S&T/POP project will support the subprojects' commodity needs.

The subprojects which are selected should meet the following general criteria:

- 1) be linked to an institution or organization which conducts family planning programs consistent with A.I.D. population assistance policy and will have the means of sustaining the activity once project funds have finished; 2) fit within the Mission and government's overall population strategy; 3) not involve an additional high recurrent cost burden which exceeds the capacity of the organization; 4) in countries where no population program presently exists, the SEATS subproject

should have the potential to demonstrate broader feasibility for implementation in a nationwide family planning program, i.e. demonstrate replicability and 5) in countries where a population program exists, subproject development should complement the ongoing activities . As previously indicated, priority for subproject development will be given to those low contraceptive prevalence countries which do not have bilateral population programs. In low contraceptive prevalence countries which do have bilateral programs who wish to buy-in to SEATS, emphasis will be placed on developing subprojects with private sector organizations to complement the efforts of the governmental bilateral program.

In terms of operational approaches to service delivery, this project will build on the lessons learned through other service delivery projects and operations research studies conducted in Africa and elsewhere that have focussed on training, supervision of family planning workers, cost recovery and integration of family planning services into the existing health infrastructure. The SEATS project will also draw upon relevant market research studies which have been conducted by other cooperating agencies to gain an understanding about the availability and price structure of contraceptives and services through the commercial sector.

Recognizing the problems of coverage, staff turnover and absenteeism, and lack of pharmaceuticals which plague many government services in the illustrative list of countries, this project will strive to develop subprojects with the private sector including NGOs, private associations and church groups. Experience gained to date in sub-Saharan Africa suggests that Anglophone African countries have considerable success on a small scale with a broad range of private sector service delivery projects. Community based distribution projects in Nigeria and Liberia with the Family Planning Associations have demonstrated that this is an effective means of outreach. A market-based project in Nigeria, where trained market vendors sell contraceptives as part of their regular stock has also been well-accepted by consumers. Finally, a distribution system which relies upon private midwives in Ghana has great potential for expanding and complementing the traditional public sector distribution network. In countries where the NGO sector is relatively small or the governments prohibit the distribution of contraceptives by nonmedical personnel, such as many of the Francophone countries, the project will need to adopt approaches which begin by integrating family planning services into the existing health infrastructure.

During the subproject design phase the contractor will send a team from the regional office to develop the detailed subproject document. The subproject document will:

- 1) state the linkage between the subproject and national population priorities;
- 2) examine the subproject catchment area and identify the particular problems which the project will address;
- 3) describe all ongoing family planning programs of the institution proposed to implement the subproject, and the proposed subproject's organization;
- 4) outline measurable objectives, a workplan and a multiyear financial plan.

Ideally, in countries where it is feasible, the financial plan will include the subproject's contribution (at least 25 percent and can include in-kind contributions) and a plan for cost sharing which will show how the grantee plans to assume increasing proportions of the costs of the program during and after the three years funding period. In addition, the financial plan should identify all other donors (both domestic and expatriate) currently supporting the grantee. This plan is not intended to serve as a condition precedent to continued support but to set realistic targets so that recipients begin to assume a manageable share of project costs. Finally, the project design will determine commodity requirements and include a training plan.

The contractor will also establish and maintain a central management information system for all subprojects. The system is expected to provide up-to-date information on subproject financial and programmatic status. Finally, the contractor will establish the capability to estimate contraceptive requirements in its field office headquarters. Actual shipping and logistics for these contraceptives will be handled by the Office of Population's Logistics Management Project.

b) Monitoring and Technical Assistance: Experience shows that most service delivery projects in sub-Saharan Africa and other low prevalence countries require sustained intensive technical assistance to properly initiate and monitor the projects. Recognizing this need, the project will provide frequent and continuous visits by regional staff. It is estimated that each subproject at the outset will require at least one monitoring visit each quarter by the field staff. In order to assure continuity of technical assistance, each staff member will have specific country responsibilities throughout the life of the project. This intensive technical assistance is required to develop programs virtually from the ground up and will provide in-depth systematic experience in planning, problem solving, and management as well as IE&C, and training.

The project will also provide between four to six long term resident technical advisors in those countries which have a major investment in subproject development. It will be the responsibility of these technical advisors to monitor and assist

with the implementation of these subprojects, coordinate technical assistance, identify impediments to project implementation and seek assistance for resolution, and periodically inform the regional offices on the subprojects' progress. In addition to having individual project responsibilities in a given country, the resident technical advisors may provide periodic technical and managerial assistance in neighboring countries.

Finally, short term consultants will also be available in a variety of fields for subprojects which require specialized skills not available through the regional offices' core staff or the resident technical advisors. Consultant visits will, however, be carefully coordinated by the regional offices and whenever possible, the regional staff member assigned to monitor the project will accompany the consultant in order to adequately follow-up on the consultancy.

2) Training- Adequate training and orientation for subproject personnel are essential in the early stages of family planning project implementation; therefore training for subproject managers and staff is a central feature of this project. Another feature of this project is to institutionalize regional training capability by establishing links with African management consulting firms and training institutions.

The SEATS project will address the training requirements of subcontractor staff in a number of ways including a) materials and course development, b) in-service training, c) regional training and d) U.S. or third country training.

a) Materials and Course Development- During the first six months of the project the Contractor will review training materials produced by other cooperating agencies such as INTRAH and the Family Planning Management Training Project prior to designing any new materials for this project. If new materials are required the project will support the design of five to eight specific modules in English on topics which will be covered in most service delivery programs. These modules will be translated into French and Arabic as appropriate. Each module will include a training curriculum, a trainer's guide and participants' materials. The modules will use situational exercises which work on interpersonal skills needed in staff management and quantitative skills which provide hands-on training in computing prevalence rates, estimating commodity requirements, and budgeting. Examples of topics for these modules include conducting a training needs assessment, project administration, financial management, management information systems, commodity management, and basic familiarization with contraceptive technologies.

b) Building Local Management Capability- Given the relatively limited institutionalized management capability of many potential recipients in the emphasis countries, creative approaches are needed to strengthen and link existing regional management capabilities with the service delivery projects. In order to successfully transfer many of the management functions which the prime contractor for this project will oversee, the contractor will identify and establish subcontracts with local private management consulting firms or training institutes in the emphasis countries who will be involved in various aspects of training, materials development, management systems development, logistics and project administration. In countries where this capability does not exist locally, subcontracts could be developed with firms in regional centers to service more than one country. These firms are expected to play a key role in providing direct financial management, logistic support and training to subprojects.

c) In-Country Training- The project will offer up to 50 in-country training courses for subcontractor staff during the five year project in project development and administration and in a variety of technical areas such as program and clinic management, supervision, contraceptive technology, recordkeeping and health care financing.

These courses will be offered by the contract staff based in the regional offices and the management consulting firms. An average of 20-30 participants will attend each course.

d) Regional Training- Up to 10 regional seminars and workshops will be carried out periodically during the five year project and will address topics of general interest to more than one country. Topics such as developing IE&C materials, establishing a management information system and evaluation plan are illustrative of the areas which may be addressed. The courses will be carried out by the regional staff with assistance from the headquarters and consultants if necessary. Between 40-50 participants will attend the regional courses. Where feasible, subcontracts can be developed with regional training institutions to carry out the training programs indicated above.

e) U.S. or Third Country Training - The project will sponsor up to 40 participants to attend technical courses offered by other cooperative agencies either in the United States or in regional locations. Courses such as sterilization techniques, counseling, and I.U.D. insertion are examples of training courses which the SEATS project will support for subproject personnel. The United States and Third Country training component will be managed by the headquarters staff who will be responsible for identifying suitable training courses and making all logistical arrangements for participants.

3) Long Term Program/Policy Advisors -- Based on experience from other regions of the world, the presence of long term resident national population and family planning advisors is often required to stimulate interest and serve as a catalyst for the design of policies, national programs and plans which support family planning objectives. In order to accommodate this need, a third component of SEATS is to provide a flexible technical assistance mechanism to recruit and field long term national family planning program/policy advisors. These policy level advisors would not have any direct subproject management or implementation responsibilities, and might be located in countries where no subprojects operate; they could serve in an operational capacity either within a ministry, family planning organization, or university where they would be responsible for helping shape or guide implementation of the family planning/population agenda in the country. While the contractor would be responsible for recruiting and supporting these advisors in the field, Missions or Regional Bureaus who are interested in arranging for such an advisor would have to fund these services through a buy-in. Under special circumstances, and with explicit approval of the CTO, project monies could be used to fund these advisors. The project would provide up to twelve such advisors during the life of the project for an average three year stay, or a total of thirty-six person years.

4) Information Dissemination - In order to foster positive exchange between country programs, the fourth and final component of SEATS is information dissemination. The project will support a variety of activities aimed at strengthened project management, increasing awareness about program accomplishments and lessons learned. Each year the project will sponsor an annual internal management meeting for the contract and subcontract staff to review their workplans and accomplishments and set future priorities and budget levels. The meeting will be held at the headquarters which will give the field staff an opportunity to meet with the home office team as well as A.I.D./W personnel.

The project will also sponsor three regional workshops over the five year period to discuss subproject design and implementation, project results and lessons learned, and to visit project sites. Workshops will range in length from five to ten days and the number of participants will average 30 people.

F) Cost Sharing

Cost sharing as a means of sustaining service delivery projects is an important element of the Office of Population's strategy in service delivery. In order to incorporate cost sharing in SEATS subprojects, a contribution will be expected from all recipient institutions based on the recipient's financial capability. As indicated previously, a contribution of twenty-five percent of project costs (including in-kind contributions) would be ideal, however, this will not be a condition precedent for development of subprojects. Additionally, each subproject will include a financial plan which sets specific goals for phasing over from A.I.D central funds to other sources of funding. Finally, whenever possible, each subproject design will consider and incorporate cost recovery schemes such as fee-for-service and revolving drug funds as a means of partially recovering costs.

G) Women in Development

The types of public and private organizations targeted for new family planning service subprojects under SEATS will cater to both men and women. Therefore, the project does not include discrete activities targeted to women. Women managers who run family planning associations or NGOs will however, benefit from this project by having access to management training courses which the project will sponsor.

H) Emphasis Countries

Based on discussions with AID/W Regional Bureaus and REDSO/WA and REDSO/ESA, the project will provide technical assistance and finance the design and implementation of 50 new family planning service delivery subprojects in low prevalence countries where there are few existing family planning service projects. The project will not work in countries with bilateral population programs, unless specifically requested by Missions offering buy-ins or with explicit approval of the Cognizant Technical Officer. Possible sites for subproject development follow:

ILLUSTRATIVE LIST OF COUNTRIES TO BE SERVED BY SEATS

| | <u>Africa</u> | <u>Near East</u> | <u>Asia</u> | <u>Pacific</u> |
|---|---------------|------------------|-------------|-------------------|
| * | Burkina Faso | Algeria | Burma | *Fiji |
| * | Cameroon | Jordan | | Papua, New Guinea |
| | Gambia | Turkey | | |
| | Guinea | * Yemen | | |
| | Ivory Coast | | | |
| | Lesotho | | | |
| | Liberia | | | |
| * | Madagascar | | | |
| | Malawi | | | |
| * | Mali | | | |
| | Mauritania | | | |
| | Sierra Leone | | | |
| * | Sudan | | | |
| | Tanzania | | | |
| | Togo | | | |
| * | Uganda | | | |
| * | Zambia | | | |
| | Zimbabwe | | | |

*Potential Buy-ins

IV. Project Implementation

A. Primary Cooperating Agency

This project will be implemented by a U.S. based contractor selected through the competitive procurement process. A cost reimbursable contract with specific deliverables between A.I.D. and a Cooperating Agency (CA) has been chosen to ensure that the Office of Population will be better able to direct activities that are undertaken, and to propose needed changes through contract amendments. Once awarded the contract, it will be the responsibility of the Cooperating Agency to:

- 1) Establish regional field offices in Francophone and Anglophone Africa, and staff these offices with the teams of experts (approved by A.I.D.), indicated in their response to the RFP. Contractor headquarters for this project, which are to be located in the Metropolitan, D.C. area, will maintain a similar, complementary staff of experts who will be responsible for providing technical assistance and project monitoring support to countries located in Asia, the Near East and the Pacific.
- 2) Establish subcontracts with local or regional management or training institutions, or business firms to support subproject financial and logistical management as well as training needs.
- 3) Through country planning visits, initiate contact with local organizations in the countries of emphasis and identify possibilities for subproject development. Once an initial assessment has been conducted, it will be the responsibility of the contractor to develop country strategies and plans for subproject development with staff of the local affiliate, for Mission, Contractor and AID/W approval.
- 4) As part of the planning process, identify needs for technical assistance, financial and program management; training; development of IEC materials; commodity distribution schemes; development of an MIS; and project monitoring and evaluation; and ensure that these needs are responded to in a timely manner for successful execution of the project.
- 5) Organize three regional workshops to discuss project results and lessons learned and to address specific technical types of general interest. Participants would be representatives from projects in the priority countries of the region and A.I.D. officers.
- 6) Develop between five to eight training modules for use by staff of local organizations on all aspects of family planning program development (needs assessments, IEC, training, MIS, commodity distribution, project monitoring and evaluation). These modules will be developed in English, French and as appropriate Arabic or Turkish, be adapted to their local environment, and be used in regional and in-country training programs.

- 7) Conduct regional and in-country training programs for subproject staff on overall family planning program development, as well as in specific technical areas (as previously outlined).
- 8) Establish a mechanism for estimating and tracking centrally procured contraceptives, and ensure their timely delivery to individual subprojects. Actual shipping and logistics management will be conducted through the centrally funded Logistics Management Project, in close collaboration with the project's commodities manager.
- 9) Assign resident technical advisors to those countries with large or numerous subproject activities, in order to provide on-site technical assistance and project management and monitoring.
- 10) Assign long term program/policy advisors as requested by missions, and provide logistical and technical support to these advisors to assist them in strengthening components of national family planning programs.
- 11) Develop a data base which indicates current status of project implementation, funding, commodity procurement/distribution, and other technical information which is compatible with the Office of Population's Project Data Base.

A contractor will be sought that can provide expertise and demonstrated competence in the design, implementation and management of numerous, diverse family planning service delivery projects. The contractor must have demonstrated experience in working in the targeted regions of sub-Saharan Africa, Asia, Near East, and the Pacific identified on page 17 . All staff proposed by the contractor must have the requisite language skills (French) and be able to work in Arabic or Turkish if required. Since a major component of this project will be project development, the provision of technical assistance, training and the preparation of operational guidelines, the contractor must have demonstrated competence in all of these areas. Individual staff members proposed by the contractor will be evaluated on their technical expertise, language capabilities, and previous field experience.

The contractor should also have a demonstrated record of having worked with African based consulting firms, or a clearly conceived plan of action, including suggested potential candidate firms, with whom the contractor might establish such relationships. This plan should indicate the level of effort for this subcontract; how the firm or institution will assist with the implementation of the overall project; and which staff of the institution will be assigned to work on the project and how they will complement the contractor staff. Once a subcontract is established with a management firm, a plan for the training of subproject staff should be developed, which includes training at the institution, as well as in-country. Similarly, if the firm or institution is to assist with the development of operational guidelines, this should be included in an overall plan.

Since the majority of activities in the project will be managed from the field, the contractor should have a demonstrated record of fielding teams, and providing for all office, housing, communications and logistical backstop support that is needed--especially in the Africa region. To the extent possible, a computerized system of recordkeeping and wordprocessing should be developed in each field office, which can interact with the headquarters system so that transfer of information between offices will be managed easily and efficiently.

B) Project Staffing

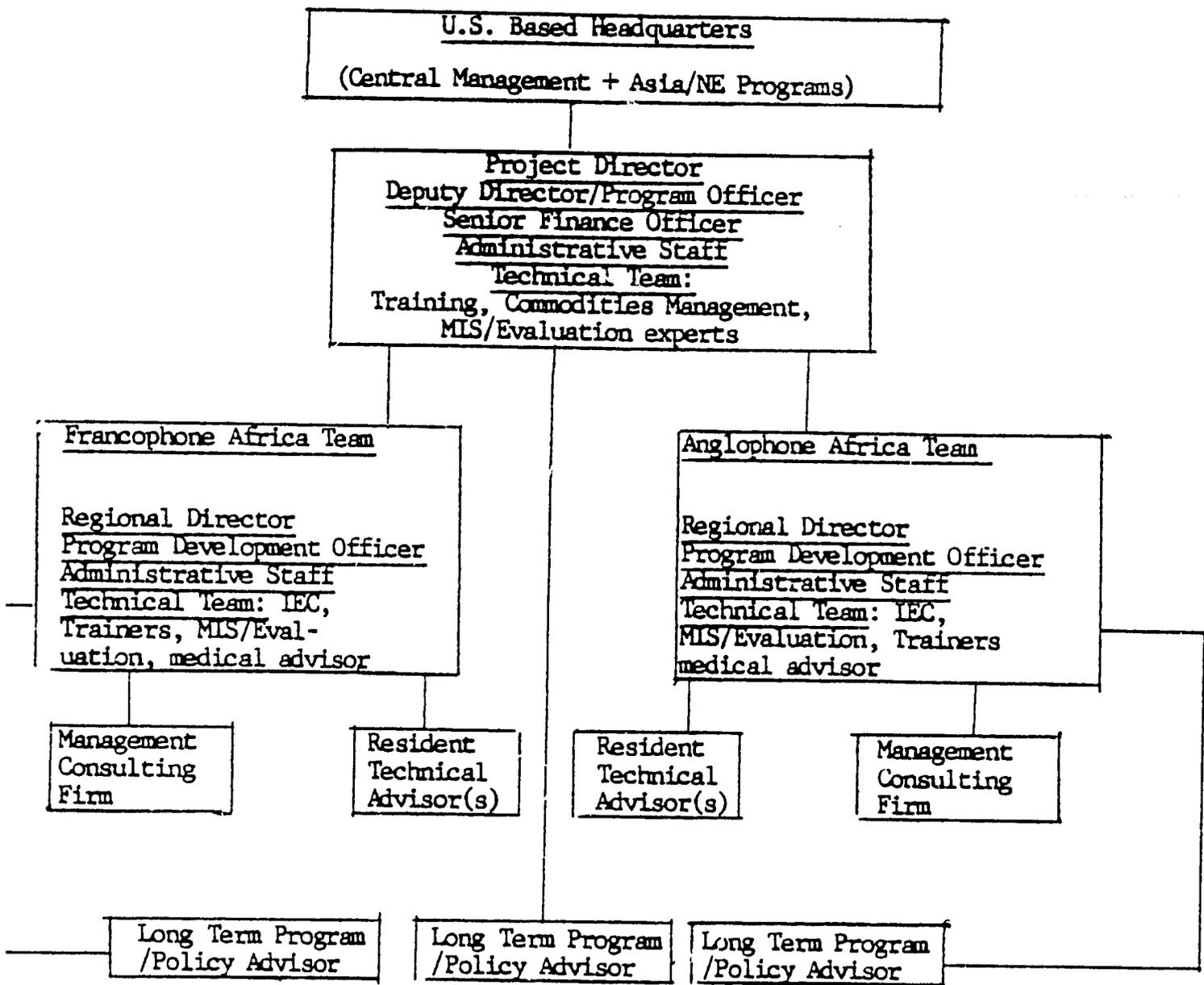
It is anticipated that the project will support a total staff of up to forty-seven: twenty-nine professional and support staff, divided among the headquarters and regional offices and up to six resident technical advisors and up to twelve long term national program/policy advisors. (For a list of the Level of Effort projected for the staff see Table I on the following page 22.) It is anticipated that the entire non professional field support staff, half of the resident advisors, as well as one half to two thirds of the regional technical teams will be composed of residents hired from the region who have demonstrated expertise in the disciplines required for project implementation (program development and management, training, IEC, MIS, evaluation, etc). It will be incumbent upon the contractor to actively seek out experts from their respective regions and ensure such a staffing pattern.

U.S. Based Headquarters: The headquarters staff will be composed of a Project Director; Deputy Director; Senior Finance Officer, three administrative staff (one financial manager, two secretaries); one training technology expert; one commodities logistics management expert; and one MIS/evaluation expert, for a total staff of nine. In addition to coordinating all project activities, the headquarters will also cover Asia/Near East and South Pacific projects.

Regional Field Offices: Each will be composed of a Regional Director; four administrative staff (two financial managers, two secretaries); one program development expert; one IEC expert; two training experts; one MIS/evaluation expert; and one medical expert, for a staff of eleven each, and 20 total for the field.

C) Project Organization

Given the emphasis on regionally based field offices, this project will be organized along decentralized lines of authority, with major responsibility for project implementation delegated to the field. The organization of the project will be as follows:



The Project Director will have overall responsibility for the execution of the contract, and be responsible for assuring project development and provision of technical assistance, training, development of implementation and management guidelines, assuring appropriate, timely deliveries of commodities, and all other tasks related to the achievement of subproject outputs in the emphasis countries of Asia, the Near East and the Pacific. Each of the Regional Directors will have the same set of responsibilities for their respective regions of Francophone and Anglophone Africa and will be responsible for coordinating activities with USAID missions and REDSO. It will also be the responsibility of each Director to assure the supervision of all resident technical advisors and the long term program/policy advisors within their region. Finally, annual coordination meetings of the technical teams will be conducted in the U.S.

Table I

Cooperating Agency Staff

| | <u>Full-Time Equivalents</u> |
|---|------------------------------|
| I. Headquarters | |
| Senior Project Director | 60 pm |
| Deputy Director/Program Officer | 60 pm |
| Training Technology Specialist | 60 pm |
| Management Information/Evaluation Specialist | 60 pm |
| Commodities/Logistics Manager | 60 pm |
| Senior Finance Officer | 60 pm |
| Financial Manager | 60 pm |
| Secretaries (2) | 120 pm |
| | |
| II. West Africa Regional Office | |
| Regional Director | 60 pm |
| Program Development Officer | 60 pm |
| Training Specialists (2) | 120 pm |
| Management Information/Evaluation Specialist | 60 pm |
| Medical Advisor | 60 pm |
| Financial Officers (2) | 120 pm |
| Secretaries (2) | 120 pm |
| Resident Technical Advisors (3 for three years) | 108 pm |
| | |
| III. East Africa Regional Office | |
| Regional Director | 60 pm |
| Program Development Officer | 60 pm |
| Training Specialists (2) | 120 pm |
| Management Information/Evaluation Specialist | 60 pm |
| Medical Advisor | 60 pm |
| Financial Officers (2) | 120 pm |
| Secretaries (2) | 120 pm |
| Resident Technical Advisors (3 for three years) | 108 pm |
| | |
| IV. Long Term Program/Policy Advisors | 432 pm |
| (Up to twelve for three years) | |
| | |
| V. Consultants | 50 pm |

pm = person months

D) Coordination and In-country Implementation

The CA will act as A.I.D.'s principal technical resource for all subprojects. It will be expected to establish good working relationships with all appropriate A.I.D. Regional Bureaus, USAID Missions, and other contractors, or grantees working in similar areas. The CA will also be responsible for coordinating and collaborating with other donors and A.I.D.-funded CAs supporting and implementing family planning programs worldwide to ensure that the SEATS service delivery subprojects are an integral component of family planning programs in a given country.

In terms of the design and implementation of new subprojects, the CA will assure that every effort is made during the feasibility stage to identify all existing sources of data and information relevant to the implementation of this project. The CA will take the lead in developing, managing and implementing subprojects and other activities in the field including assessing current knowledge, attitudes and practices related to contraceptive use, and identifying suitable counterparts and implementing agencies.

E) A.I.D. Management

Primary technical and administrative responsibility for the SEATS project will rest with ST/POP/FPSD. The A.I.D. Cognizant Technical Officer (CTO) will provide the contractor with overall policy and technical guidance and will ensure that project implementation is consistent with A.I.D. population assistance policy and the design set forth in this project paper. In managing the CA, consistent with the degree of operational control involved with contracts, the CTO will exercise a variety of functions including:

- 1) collaborative involvement in the development and approval of an annual workplan and all modifications of the workplan;
- 2) monitoring project implementation; reviewing all regular and special reports; holding project debriefings;
- 3) approval of all activities carried out under this contract including subcontracts, subproject proposals and organizations implementing subprojects, information dissemination, and international travel;
- 4) participation in and periodic management reviews and evaluations to review program progress and future strategy;
- 5) approval of all key personnel and consultants.

The CTO, in conjunction with the Regional Bureaus, USAID Missions and REDSO will define country and specific programmatic priorities during the life of the project. All subproject proposals, contractor travel to a particular country and the assignment of resident advisors will require approval from the appropriate Mission.

All significant findings produced by the contractor and major project accomplishments will be shared with the Regional Bureaus, USAID Missions, REDSO and other family planning donors where appropriate. The CTO will be responsible for organizing periodic special project presentations in AID/W.

Throughout the life of the project, the CTO will assure that coordination with other ST/POP projects is provided. The CTO will also work closely with various technical administrative and Regional Bureau personnel such as M/SEK, PPC, Regional Bureaus, GC and Missions to assure that subprojects and contracts adhere to A.I.D. regulations and are consistent with A.I.D. strategies in a given country.

Finally, the CTO will prepare an initial cable to the field to describe the major components of this project. Missions will be asked to identify future needs and possible buy-ins.

F) Implementation Schedule

The implementation schedule for the major components of the project is presented on the following page. ST/POP, the Population Sector Council, and ST/PO review of the draft project paper should be completed by June 15, 1988 and Project Paper approval is expected to take place by June 30, 1988. Procurement for the contract will begin in the fourth quarter of FY 88.

Once the contract has been awarded subproject planning and design work will get underway with 5 subprojects designed in FY 89, 13 in FY 90; 24 in FY 91; and 8 in FY 92. Project monitoring, technical assistance and subcontracts with local African management firms will take place continuously beginning in the first quarter of FY 90.

In-service and regional training is scheduled continuously beginning in FY 89 and conferences are scheduled for FY 90, FY 91 and FY 92. fiscal year. Two outside evaluations are scheduled; a midterm evaluation in the third quarter of FY 91 and a final evaluation in the second quarter of FY 93. A detailed evaluation plan is specified on page 31. Internal management reviews are scheduled for the conclusion of FY 89, FY 90, and FY 92.

TABLE I

PROJECT IMPLEMENTATION PLAN
BY Quarter (FY 88-93)

| Activity | FY88 | FY89 | FY90 | FY91 | FY92 | FY93 |
|---|----------|---------|---------|----------|----------|---------|
| | 1/2/3/4/ | 1/2/3/4 | 1/2/3/4 | 1/2/3/4/ | 1/2/3/4/ | 1/2/3/4 |
| <u>I. Program Documents</u> | | | | | | |
| PP Approval | X | | | | | |
| Process PIO/T | X | | | | | |
| Process RFP | X | | | | | |
| Select CA | X | | | | | |
| <u>II. Subprojects</u> | | | | | | |
| Design | | 5 | 13 | 24 | 8 | |
| Monitoring | | | XXXX | XXXX | XXXX | XXXX |
| <u>III. Technical Assistance</u> | | | | | | |
| Resident Technical Advisors | | 1 | 2 | 2 | 1 | |
| Long-term Policy Advisors | | 3 | 4 | 5 | | |
| <u>IV. Subcontracts with Management Firms</u> | | | | | | |
| | | | XXXX | XXXX | XXXX | XXXX |
| <u>V. Training</u> | | | | | | |
| | | XXXX | XXXX | XXXX | XXXX | XXXX |
| <u>VI. Conferences/Workshops</u> | | | | | | |
| | | | 1 | 1 | 1 | |
| <u>VII. Internal Management Meetings</u> | | | | | | |
| | | 1 | 1 | 1 | 1 | |
| <u>VIII. External Evaluations</u> | | | | | | |
| | | | | X | | XX |
| <u>IX. Management Reviews</u> | | | | | | |
| | | | X | X | | X |

W 5052Y

V. Budget and Financial Plan

The budget for the five-year period is estimated to be \$75.7 million of which \$50 million would be provided by ST/POP and \$25.6 million through buy-ins. While realization of project outputs is not dependent upon buy-ins, response to a worldwide cable on SEATS indicates that a number of Missions are committed to buying-in to the project and the \$25.7 million estimate will be met. Contraceptive commodities, logistics management and evaluation will be provided under separate projects.

Table I presents the estimated obligations and budget line items by fiscal year. Table II contains an estimated budget for the first year. Future year budgets will be modified based on experience, relative need and evolving priorities.

The budget assumes that 5 subprojects at an estimated \$300,000 per project will be funded the first year, 13 subprojects at \$450,000 the second year, 24 subprojects at \$300,000 the third year and 8 at \$450,000 the fourth year. Although only 25 percent of the budget is allocated for the subprojects' local costs, an estimated 80 percent of the technical assistance is directly related to subproject planning, design and management. Therefore 50 percent of the budget will support subprojects. Cost for travel, consultancies, workshops and training are based on ST/POP/FPSD experience. A six percent annual inflation factor is assumed for all budget components. A ten percent fixed fee on all project costs is estimated.

TABLE I

FAMILY PLANNING SERVICES EXPANSION AND TECHNICAL SUPPORT (SEATS)

| Project Component | YR 1 | YR 2 | YR 3 | YR 4 | YR 5 | TOTAL | YR 6 | YR 7 | YR 8 | YR 9 | YR 10 | TOTAL | Percent |
|-----------------------------|------------|------------|------------|------------|-----------|------------|------------|------------|------------|-----------|-----------|-------------|---------|
| Personnel | 2,888,791 | 3,068,791 | 3,248,791 | 3,428,791 | 3,788,791 | 16,423,955 | 3,788,791 | 3,428,791 | 3,248,791 | 3,068,791 | 2,888,791 | 32,847,910 | 22.8% |
| Indirect Costs | 2,888,791 | 3,068,791 | 3,248,791 | 3,428,791 | 3,788,791 | 16,423,955 | 3,788,791 | 3,428,791 | 3,248,791 | 3,068,791 | 2,888,791 | 32,847,910 | 22.8% |
| Policy Advisors | 1,620,000 | 2,160,000 | 2,700,000 | | | 6,480,000 | 2,700,000 | 2,160,000 | 1,620,000 | | | 12,960,000 | 9.6% |
| Fee (30%) | 486,000 | 648,000 | 810,000 | | | 1,944,000 | 810,000 | 648,000 | 486,000 | | | 3,888,000 | 2.7% |
| Short Term Consultants | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 250,000 | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 500,000 | 0.3% |
| Travel/Per Diem | 216,500 | 250,000 | 250,000 | 275,000 | 275,000 | 1,266,500 | 215,500 | 200,000 | 200,000 | 200,000 | 200,000 | 2,282,000 | 1.6% |
| Materials Development | 250,000 | | | | | 250,000 | 250,000 | | | | | 500,000 | 0.3% |
| In-service Training | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 1,250,000 | 250,000 | 150,000 | 100,000 | 100,000 | 100,000 | 1,950,000 | 1.4% |
| Regional Training | 200,000 | 200,000 | 200,000 | 200,000 | 200,000 | 1,000,000 | 100,000 | 50,000 | 50,000 | 50,000 | 50,000 | 1,300,000 | 0.9% |
| U.S. Third Country Training | 120,000 | 150,000 | 150,000 | 180,000 | | 600,000 | 75,000 | 50,000 | 50,000 | | | 775,000 | 0.5% |
| Coordination Meetings | 20,000 | 20,000 | 20,000 | 20,000 | | 80,000 | 20,000 | | 20,000 | 20,000 | | 140,000 | 0.1% |
| Workshops | | | 100,000 | 100,000 | 100,000 | 300,000 | | | | | | 300,000 | 0.2% |
| Subcontracts | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 500,000 | 350,000 | | | | | 850,000 | 0.6% |
| Subprojects | 1,500,000 | 5,850,000 | 7,200,000 | 3,600,000 | | 18,150,000 | 3,600,000 | 4,500,000 | 6,000,000 | | | 32,250,000 | 22.4% |
| SUBTOTAL | 10,590,082 | 15,815,582 | 18,327,582 | 11,632,582 | 8,552,582 | 64,918,410 | 15,998,082 | 14,665,582 | 15,073,582 | 6,557,582 | 6,177,582 | 123,390,820 | 85.8% |
| Fixed Fee | 1,059,008 | 1,581,558 | 1,832,758 | 1,163,258 | 855,258 | 6,491,841 | 1,599,808 | 1,466,558 | 1,507,358 | 655,758 | 617,758 | 12,339,082 | 8.6% |
| Inflation | 698,945 | 1,043,828 | 1,209,620 | 767,750 | 564,470 | 4,284,615 | 1,055,873 | 967,928 | 994,856 | 432,800 | 407,720 | 8,143,794 | 5.7% |
| TOTAL | 12,348,036 | 18,440,969 | 21,369,961 | 13,563,591 | 9,972,311 | 75,694,866 | 18,653,764 | 17,100,069 | 17,575,797 | 7,646,141 | 7,203,061 | 143,873,696 | 100.0% |

27

TABLE II

Detailed Budget for Year 1

| <u>I. Personnel</u> | <u>Approximate GS Level</u> | <u>Salary \$</u> |
|--|-----------------------------|-------------------------------|
| A. Metropolitan D.C. Headquarters | | |
| Project Director (12 p.m.) | 15-10 | 69,976 |
| Deputy Director (12 p.m.) | 14-10 | 59,488 |
| /Program Director Training & Technology Specialist (12 p.m.) | 13-5 | 43,891 |
| Management Information and Evaluation Specialist (12 p.m.) | 13 | 38,727 |
| Commodities Logistics Management Specialist (12 p.m.) | 14 | 45,763 |
| Senior Finance Officer (12 p.m.) | 14-5 | 51,836 |
| Financial Manager (12 p.m.) | 11 | 27,172 |
| Secretaries (2) (24 p.m.) | 6 (16,521) | 33,042 |
| Subtotal | | 369,895 |
| B. Fringe Benefits (22%) | | 81,376 |
| C. <u>Francophone West Africa Office</u> | | |
| | | Salary Plus Allowances |
| Regional Director | 14-5 (51,836) | 180,000 |
| Program Development Officer | 13-5 (43,891) | 180,000 |
| IE&C Specialist | 13 (38,727) | 180,000 |
| Training Specialist(2) (Locally-Hired) | 13 (38,727) | 77,454 |
| Medical Advisor | 13-5 (43,891) | 180,000 |
| Management Information/ Evaluation Specialist | 13 (38,727) | 150,000 |
| Financial Officers (2) (Locally-Hired) | 11 (27,172) | 54,344 |
| Secretaries (2) (Locally-Hired) | 2 (10,981) | 21,962 |
| Resident Technical Advisor (Assume 2 the first year, 3 the second year and 1 the third year) | 13-5 (43,891) | 360,000 |

28

D. East Africa Office

| | | |
|--|---------------|---------|
| Regional Director | 14-5 (51,836) | 180,000 |
| Program Development Officer | 13-5 (43,891) | 180,000 |
| IE&C Specialist | 13 (38,727) | 180,000 |
| Training Specialist (2) (Locally-Hired) | 13 (38,727) | 77,454 |
| Medical Advisor | 13 (43,891) | 180,000 |
| Management Information/ Evaluation Specialist | 13 | 180,000 |
| Financial Officers (2) | 11 (27,172) | 54,344 |
| Secretaries (2) | 2 (10,981) | 21,962 |

SUBTOTAL PERSONNEL 2,888,791

II. Indirect Costs (100%) 2,888,791

III. Long Term Policy Advisors
(First year assumes 3 for 3 years at \$180,000) 1,620,000

IV. Fee (30%) 486,000

V. Short-term Consultants
\$250 daily rate @ 200 days per year (\$50,000) 50,000

VI. Travel - Per Diem

| | |
|--|--------|
| 18 trips to Africa X \$5,000 | 90,000 |
| 9 trips to ASIA/NE/SP x \$5,000 | 45,000 |
| 27 inter-regional trips x \$1,000 | 27,000 |
| 10 domestic trips x \$350 | 3,500 |
| \$100 per diem for international travel x 200 days | 20,000 |
| \$ 50 per diem for domestic travel x 20 days | 1,000 |
| \$100 per diem for inter-regional trips x 300 | 30,000 |

VII. Training Costs

Materials Development 250,000
(Includes production, testing distribution and translation for first year only)

In-country Training
10 courses per year x \$25,000/course 250,000

Regional Training
2 courses per year x \$100,000/course 200,000

| | |
|--|------------|
| <u>U.S. or Third Country Training</u> | |
| 8 participants per year x \$15,000 per participant | 120,000 |
| VIII. Internal Coordination Meetings \$20,00 per year | 20,000 |
| IX. Regional Workshops (Assume one in years 2 through 4 @ \$100,000/workshop per year) | -0- |
| X. Subcontracts with local African management consulting firms @ \$50,000 per contract Assume 2 subcontracts in year 1 | 100,000 |
| XI. Subprojects Agreements (Assume 5 first year @ \$300,000 per project, 13 second year @ \$450,000 per project 24 third year @ \$300,000 per project and 8 fourth year @ \$450,000 per project) | 1,500,000 |
| SUBTOTAL | 10,590,082 |
| Fixed Fee (10%) | 1,059,008 |
| Inflation (6%) | 698,945 |
| GRAND TOTAL | 12,348,036 |

28

VI. EVALUATION

Overall project evaluations will be conducted by S&T/POP/FPSD and external evaluation teams. The two external evaluations will be funded under the POPTECH Project (936-3024) funded by ST/POP. There are three types of overall evaluation in this project:

1. Continuous monitoring and assessment by S&T/POP/FPSD. The cognizant technical officer (CTO) will closely monitor and evaluate the project on a continuing basis. Annual internal management reviews will be held during the last quarter of each fiscal year to consider issues, project progress and necessary corrective actions.

2. Mid-term project evaluation. This evaluation, scheduled to take place in March 1991, will be conducted by an external evaluation team. A.I.D. staff may or may not participate on the team. The purpose of this evaluation is to examine project effectiveness and continuing needs for project assistance. The evaluation will provide guidance for mid-term correction.

The mid-term evaluation will focus both on the process of project operations, and on the project's success in producing the planned outputs and achieving its purpose. For example, the evaluation team will consider the efficiency with which project actions occur--whether project staff is in place and well qualified; whether the project headquarters operates smoothly; whether planning and implementation of the project's activities take place on schedule, and whether they are responsive to Mission and host country needs and requests; whether consultants and subcontractors are well-qualified for their tasks, and supplied in a timely manner; and whether the overall project implementation plan is realistic. The evaluation team will also examine progress toward achieving project outputs such as initiating subprojects in the eighteen target countries, drafting the training modules, carrying out the training programs and providing follow-up and technical assistance as needed.

3. Final project evaluation: This evaluation, scheduled for January 1993, will also be conducted by an external team, with possible participation by A.I.D. staff. The final evaluation will concentrate on examining indicators that the project has achieved its purpose and to a lesser extent, quality, quantity and timeliness of planned project outputs. The final evaluation will also make recommendations on changes in content, scope, or focus for follow-on projects.

VII. CONDITIONS AND COVENANTS

Source of Origin and Commodities and Nationality of Services Waiver: Each developing country where a subproject is initiated, or other assistance takes place under this project shall be deemed to be a cooperating country for the purpose of permitting local cost financing. The sum of all purchase orders and contracts for goods and services procured under each sub-contract in a cooperating country from A.I.D. Geographic Code 935 countries (Special Free World) may not exceed \$750,000.

Justification: The authority to procure goods and services at this level in A.I.D. Geographic Code 935 countries is essential for the implementation of the project. The essence of the SEATS Project is that host country institutions be supported in establishing sustainable family planning services. Therefore, except for technical assistance provided by a U.S. based contractor and associated U.S. purchased commodities, almost all expenditures in the project will be within the cooperating countries. Since these projects are almost totally dependent on the use of goods and services, it is only through the local procurement of goods and services that the project can encourage the development of improved institutional capacity in service delivery.

Certification: Exclusion of procurement from Special Free World countries other than the cooperating country and countries included in Code 935 would seriously impede attainment of U.S. foreign policy objectives and objectives of the foreign assistance program.

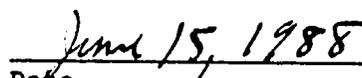
Family Planning Service Expansion and Technical Support
(SEATS) 936-3048

VIII. Certification of the Procurement Plan/Gray Amendment

I certify that the procurement plan for this Project Paper (936-3048) was developed with full consideration of maximum involvement by minority and women-owned firms, historically Black colleges and universities and minority controlled PVOs in the provision of goods and services, and that the Project is not appropriate for minority or Gray amendment contracting. We know of no minority institutions with an on-going program of the type required or the requisite faculty and facilities. However, to ensure consideration of minority organizations as defined in the Gray amendment, we will work with the Office of Acquisition and Assistance Management, and the Office of Small and Disadvantaged Businesses, to include all potential recipients on the bidder's list.



Duff G. Gillespie
Director, Office of Population



Date

Family Planning Service Expansion and Technical Support (SEATS) (936-3048)

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | ASSUMPTIONS |
|---|--|--|--|
| <p>GOAL: To enhance the freedom of individuals in developing countries to choose voluntarily the number and spacing of their children.</p> | <p>MEASURES OF GOAL ACHIEVEMENT: Developing country couples' actual and desired fertility are consistent; safe, affordable methods of family planning are available to all couples desiring them.</p> | <p>Census Data, Vital Statistics, Demographic and Contraceptive Prevalence Surveys.</p> | <p>Assumptions for Achieving Good Targets: 11. Individuals in developing countries have a desire to determine the number and spacing of their children. 12. Accepting couples have access to contraceptives and choose to use them for family planning purposes.</p> |
| <p>PROJECT PURPOSE: To expand development of, access to and use of quality family planning services in currently underserved countries; to ensure that unmet demand for these services is addressed through the provision of appropriate financial, technical, and human resources.</p> | <p>11. Increasing contraceptive prevalence in targeted countries attributable to activities undertaken by this project. 12. Increased capacity for the design, implementation and monitoring of family planning service delivery demonstrated by host country organizations receiving assistance from this project.</p> | <p>Service Statistics, Project Implementation Reports, Surveys, External Evaluations.</p> | <p>Assumptions for Achieving Purpose: 11. Developing country institutions are able to use effectively the resources available under this project. 12. Provision of technical, financial and human resources to develop family planning programs will result in increased utilization of family planning services. 3. 18 target countries support family planning goals.</p> |
| <p>OUTPUTS:</p> | | | |
| <p>11. Family planning service delivery projects established in a minimum of 29 targeted, currently underserved LDCs.</p> | <p>11. Fifty service delivery subprojects developed with private and some public LDC institutions</p> | <p>11.a. Signed agreements with developing country institutions; contractor, mission and CTO site visits; contractor reports. 11.b. Contractor reports; on site discussions with/grantee program managers.</p> | <p>11.a. Host government/USAID Missions will concur with subproject activities.</p> |
| <p>12. Training programs conducted for LDC institutions project managers and staff.</p> | <p>12.a. Between 5 to 8 modules in English, French, Arabic and local languages (as needed) developed in: conducting needs assessments; producing IEC materials; developing training plans; establishing commodity distribution schemes, developing a management information system (MIS); conducting evaluations. 12.b. A minimum of 10 in-service training sessions per year (for a total of 50) conducted for project managers in overall family planning service delivery program management. 12.c. Two regional training sessions each year (for a total of 10) for project staff in development of IEC materials; development of training plans; establishment of commodity distribution plans; development of an MIS; conducting evaluations. 12.d. Up to 40 participants selected from subprojects will attend technical courses offered by other CAs either in the U.S. or third countries.</p> | <p>12.a. Modules printed and distributed in English, French and Arabic. 12.b. Contractor Training Reports; Participants Evaluation Reports.</p> | <p>12.a. Contractor will have adequate expertise to develop guidelines; developing country institutions will utilize guidelines to assist with family planning service delivery. 12.b. Contractor will hire adequate core staff (and outside consultants as needed) with skill mix to provide appropriate technical assistance. 12.c. Contractor will develop pertinent training curricula; developing country institutions will send appropriate participants for training.</p> |

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON DC 20523

MAR 01 1988

ACTION MEMORANDUM FOR THE SENIOR ASSISTANT ADMINISTRATOR
FOR SCIENCE AND TECHNOLOGY

FROM: S&T/POP, Duff G. Gillespie 

SUBJECT: Concept Paper: Family Planning Service Expansion
and Technical Support (SEATS) (936-3048)

Action Required: Your approval is required to design a new ten-year Family Planning Service Expansion and Technical Support Project (SEATS). The purpose of this project is to ensure that the unmet needs for the development and/or expansion of family planning service delivery in currently underserved countries are addressed through the provision of appropriate financial, technical and human resources. The project will focus its efforts on developing and strengthening family planning service activities in Sub-Saharan, particularly Francophone Africa, and selected countries in Asia, the Near East and the Pacific (see Attachment 1 for illustrative list). To strengthen ongoing service programs and to assure that service delivery activities are well designed and implemented, the project will emphasize:

- short term technical assistance in project development, monitoring, training, IEC (Information, Education, Communication), and evaluation, provided by a team of experts located in region 1 field offices;
- provision of a limited number of long-term resident advisors in countries where there is intensive sub-project activity;

Two other unique aspects of this project will be a) the establishment of a formal liaison with an African based management or training institution, and b) the application of results of operations research projects to assist with development of new projects.

The project is not in the FY 1988 CP; it will be added because of the importance of its early implementation.

Relationship to Bureau Strategy: The basic strategy of the population program is the establishment of widespread availability of high quality voluntary family planning services through which couples who wish can regulate their fertility.

The S&T Bureau's Central Program Strategy Statement identified three key strategy areas. SEATS relates directly to two of these areas--expansion of service delivery and emphasis on Africa. The third area - contraceptive development - lies outside of the scope of this project. The emphasis of SEATS will be to develop family planning activities in countries where bilateral population programs currently do not exist, and to complement the efforts of existing projects in other countries. While the project will support activities in selected countries in Asia, the Near East and the Pacific, approximately 80 percent of the project will concentrate on countries in Sub-Saharan Africa.

Budget: Although we are seeking a ten year project approval, the initial authorization period is for five years. The proposed five year budget in S&T Population is \$50 million, and Mission and regional buy-ins \$25 million.

Discussion: Over the course of the past two decades A.I.D. has taken the lead among donor agencies in developing and expanding family planning services throughout the developing world. As pioneer programs in Asia and Latin America have matured and evolved into full scale population programs, A.I.D. has shifted its emphasis and focus on areas of the world with nascent or non-existing programs--namely those in Sub-Saharan Africa and certain countries in the Near East, Asia, and the Pacific. This shift in focus is timely in that major population policy changes have concurrently emerged in a number of countries, particularly in Sub-Saharan Africa, which only recently adopted population policies and established family planning programs. Unfortunately, most African countries have inadequate health infrastructures and often lack the technical expertise to integrate family planning services. Recently there have been increasing demands for A.I.D. to assist in developing family planning services for both private and governmental organizations. Current A.I.D. mechanisms have been inadequate to meet all of these demands.

As interest and commitment particularly in African nations grows, future demands for support of both private sector and government efforts to organize, establish or expand family planning services will continue to intensify. Support for certain aspects of family planning activities has been facilitated by cooperating agencies and other contractors funded by A.I.D.; these organizations have begun to shift emphasis to the African region. However, limited resources and the amount of time and technical assistance needed to program new activities have often prevented these groups from responding to the increased demand for assistance.

SEATS will focus on low contraceptive prevalence countries in Sub-Saharan Africa, Asia, the Near East and the Pacific with weak infrastructures, which have a substantial unmet need for family planning services, and receive limited or no A.I.D. bilateral assistance. The need varies greatly among these countries, ranging from the necessity to provide support for program development including training, development of IEC materials, and logistics distribution for new programs; to providing technical assistance for management, evaluation, and development of information systems for ongoing programs.

To respond effectively to new demands for support of family planning activities, it will be necessary for the new project to identify and address this broad spectrum of need. Consequently, the project contractor must have a wide range of technical capabilities, and ensure a mix of skills to match program needs. Knowledge, links to Sub-Saharan Africa and the other areas to be served, as well as cultural and language skills to work in these areas, will be crucial to the project. Of particular importance will be the ability to work effectively in Francophone Africa.

SEATS will work with PVOs and other organizations in the private sector, and emphasize innovative service delivery mechanisms. Wherever possible, SEATS will apply the results of operations research studies conducted in Africa and elsewhere. Application of "lessons learned" will be an important element of project development, and should help to eliminate some of the start-up and ongoing management problems associated with service delivery. Multifaceted, regionally based technical assistance teams will also serve to address issues as they arise.

SEATS will complement--not duplicate--ongoing efforts, and is designed to respond quickly and effectively to requests for assistance, especially from A.I.D. Missions. As a field-based family planning service delivery project, it will be designed to seek and expand upon opportunities to develop family planning activities in underserved areas, and provide the requisite technical, financial and human resources to support these activities.

Project Mode of Operation:

The project will have the flexibility to provide assistance in the following ways:

44

1. The primary emphasis of SEATS will be to identify project opportunities in the countries of emphasis, and develop and finance pilot, innovative or service expansion/improvement projects with local private sector (and occasionally, government) groups, providing necessary technical assistance and managerial support as needed. It will be the responsibility of the regionally based technical assistance teams to conduct the initial assessments and determine the projects to be funded. Over half of the project's funds will be allocated to specific subprojects, which are in congruence with the host countries' current policy environment, A.I.D. Missions' strategies and other donor activities. Once funded, it will also be the responsibility of the teams to monitor the subprojects and provide any necessary assistance.

2. In addition to developing new family planning service subprojects, SEATS will have the capability to provide an additional mode of support. In countries where large or numerous projects are established, the contractor may assign long-term resident advisors who will provide the projects with ongoing technical and managerial support. These resident advisors may also do project development or provide periodic technical assistance to ongoing projects in one or two neighboring countries. Their efforts would be complemented by short-term technical consultants as needed. It is expected that the contractor would have long-term resident advisors in four or five African locations by the third year of the project. These advisors are intended to assist specifically those countries or Missions with limited technical expertise in family planning service delivery.

The broad technical capabilities of the project's regional office and headquarters staff will provide further technical and managerial assistance to country subprojects, as well as technical and logistical backstopping for the resident advisors. The regional office is still seen as the key technical and managerial coordinating center in the African region. The U.S. headquarters office would serve the same backstopping role for project activities in other regions. It is proposed at the outset that the first regional office be established in a Francophone African country, and that the initial technical assistance team operate from this location.

In order to ensure that the underserved countries indicated will benefit from this project, a contract with specific deliverables has been chosen as the modality for

implementation. In this way, the Office of Population will be better able to direct activities that are undertaken, and propose needed changes through contract amendments. In an effort to institutionalize program planning and management skills, the contractor will be required to establish a subcontract relationship with an appropriate regional institution (most likely in Francophone Africa). The contractor will work closely with REDSO West and East, as well as with A.I.D. Missions. Except in unusual situations, the project will not work in countries with bilateral population programs unless specifically requested by Missions offering buy-ins.

Recommendation: That you authorize S&T/POP to proceed with project development for the new Family Planning Services Expansion and Technical Support (SEATS) project as outlined above.

Approved: J. Bailey

Disapproved:

Date: 3/17/88

with expectation that funding rates be negotiated with Africa Bureau

Clearances:

| | | | |
|-------------------|------------------|------|----------------|
| S&T/POP/R:JBailey | <u>J. Bailey</u> | Date | <u>2-29-88</u> |
| S&T/POP:BKennedy | <u>draft</u> | Date | |
| S&T/POP:BCase | <u>list</u> | Date | <u>3/1/88</u> |
| S&T/POP:JDumm | <u>J. Dumm</u> | Date | <u>3/1/88</u> |
| S&T/PO:KMilow | <u>K. Milow</u> | Date | <u>3/7/88</u> |

S&T/POP/FPSD:DLiberi/JRogosch:2/17/88:4429Y

Attachment 1

ILLUSTRATIVE LIST OF COUNTRIES TO BE SERVED BY SEATS

Africa

Ivory Coast
Cameroon
Togo
Liberia
Lesotho
Zimbabwe
Tanzania
Sudan
Uganda
Zambia
Madagascar
Guinea
Benin

Near East

Turkey
Jordan
Algeria
Yemen

Asia

Burma

Pacific

Fiji
Papua New Guinea

4429Y

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D C. 20523

09 MAY 1988

POPULATION SECTOR COUNCIL
MINUTES

Date and Place: May 2, 1988 10:15 a.m.
Room 6941, Main State

Participants: S&T/POP, Duff Gillespie, Chairman
AFR/TR/HPN, Gary Merritt
ANE/TR/HPN, Charles Johnson
LAC/DR/P, Ruth Frischer
PPC/PDPR, Alene Gelbard
OES/CP, Pamela Bridgewater
S&T/POP, Barbara Kennedy
S&T/POP, Betty Case
S&T/POP, Brenda Colwell
S&T/POP/R, Jim Shelton
S&T/POP/R, Laneta Dorflinger
S&T/POP/FPSD, Dawn Liberi
S&T/POP/FPSD, Betsy Brown
S&T/PO, Leola Thompson
AFR/TR/HPN, Jack Thomas
S&T/POP, Sigrid Anderson, Executive Secretary

Agenda Issues:

1. Review of the Population Council Project Paper

Following a briefing by Laneta Dorflinger, S&T/POP/R, on the new 10-year (FY'88-'99) Population Council Project, the Council reviewed and unanimously recommended approval of the project paper. The overall project purpose is "to improve family planning technology available for use in developing countries and to improve the delivery and use of family planning services in the developing world". The three main areas of emphasis will be: 1) contraceptive development; 2) contraceptive introduction; and 3) family planning program research and technical assistance.

2. Review of the SEATS Project Paper

The Council reviewed and unanimously recommended approval of the project paper following a briefing by Dawn Liberi, S&T/POP/FPSD, on the new 10-year (FY'88-'99) Family Planning Service Expansion and Technical Support (SEATS) Project. The purpose of this project is "to expand the development of, access to and use of quality family planning services in currently underserved populations; and ensure that unmet demand for these services is

addressed through the provision of appropriate financial, technical and human resources". The main project activities will include: 1) operational service delivery subprojects; 2) training; 3) long-term program and policy advisors; and 4) information dissemination.

3. Reprogramming of UNFPA Funds

A draft memo from Duff Gillespie, Chairman, Population Sector Council to Richard Bissell, AA/PPC, on the reprogramming of FY 1988 population funds has been reviewed and cleared by the majority of the Council members. In order to finalize the memo, ANE/TR/HPN and S&T/POP will develop a consensus position on the programming of the \$700,000 for the South Pacific through either or both the SEATS or CEDPA projects. There is a possibility that a decision on reprogramming UNFPA funds would possibly be made by mid-May. (On May 5, 1988 the memo was finalized and sent to R. Bissell).

4. Meeting with Cliff Lewis, DAA/PPC

Duff Gillespie summarized his conversation with Cliff Lewis, DAA/PPC, who has recently been hired and assigned to head a Task Force and draft a document by November 1988 which will outline where A.I.D. should be in the next decade. During this process, the Task Force will reexamine all of A.I.D.'s foreign assistance efforts, and while not exactly clear, will have some relationship to the efforts by Rep. Hamilton's Task Force to review U.S. foreign assistance policy and programs. One way it has already been suggested that we assist the A.I.D. Task Force is to provide some critical inputs, such as demographic projections. A consultant to Lewis' Task Force, who will focus on population issues, Ms. Susan Raymond, will be spending a day in the Office of Population for a briefing on the program. It was requested that she be given the names of all Population Sector Council members so that they can set up meetings with her as well as gather all relevant information on the population program which should be helpful for this exercise.

5. Other Business

Gary Merrit informed the Council members that the Africa Population and Family Planning Strategy Paper should be ready by late May 1988 for Council review.

Barbara Kennedy and Sigrid Anderson were requested by the Chairman to review foreign service backstop-50 recruitment issues.

Next Meeting

The next meeting of the Population Sector Council is scheduled for Wednesday, May 25, 1988 at 10:15 a.m. in room 809B, SA-18. An agenda will be distributed prior to this meeting.

OK

ANNEX C

RESPONSE TO WORLDWIDE CABLE

A worldwide cable describing the SEATS project, and soliciting comments and buy-in requests from Missions was sent out on April 27, 1988.

Of the nineteen responses received by S&T/POP as of May 26, 1988, nine Missions indicated a desire to buy-in to SEATS immediately in FY 89. Several others indicated they would like to buy-in in subsequent fiscal years. All Missions who responded indicated a high level of support for the project, and several of those unable to buy-in nevertheless expressed an interest in receiving assistance from the project.

Based on these responses, S&T/POP does not anticipate any problem in meeting the buy-in level for the project (\$25.7 million) over the five year LOP.

5138Y

TECHNICAL ANALYSIS

I. Introduction

From both a policy and programmatic standpoint, many governments of developing countries consider fertility reduction to be an important component of their overall strategy for improving standards of living. Major fertility declines in developing countries are invariably accompanied by large increases in contraceptive use. (Bongaarts, Stover, 1986) In achieving its objective of expanding the development of, access to and use of quality family planning services, SEATS will increase contraceptive use in the emphasis countries where it works.

In order to make projections on the number of contraceptive users, method mix and Couple Years of Protection (CYP) that could potentially be achieved under SEATS, a mathematical model developed by John Bongaarts of the Population Council has been employed.

II. Description of Methodology

To bring about a decline in fertility, a society has a variety of means at its disposal (Davis and Blake 1956, Davis 1963). A rise in contraceptive prevalence has been the principal cause of fertility decline in most countries, however other factors directly influence fertility. Seven such factors, also called the proximate determinants of fertility, can be identified (Bongaarts and Potter, 1983):

- Marriage pattern
- Contraceptive prevalence and effectiveness
- Induced abortion
- Postpartum infecundability
- Frequency of intercourse
- Spontaneous abortion
- Sterility

Research indicates (Bongaarts 1982) that the first four of these factors are in general the most important determinants of trends in fertility. The model developed by Bongaarts allows one to examine, theoretically, the relative contribution and interplay of the proximate determinants. By making assumptions as to the future trends in the determinants, the contraceptive

prevalence required to reach a desired fertility level in a given year may be estimated. The Bongaarts model expresses TFR (Total Fertility Rate) as the outcome of the fertility reducing effects of the four main proximate determinants on total fertility (TF) - the hypothetical fertility level in the absence of any reduction in fertility by the four determinants. The fertility inhibiting effect of each of the proximate determinants is measured by an index with a value between zero and one. The equation for the model is (Bongaarts and Stover, 1986):

$$TFR = C_m \times C_c \times C_a \times C_i \times TF$$

Where:

- TFR = total fertility rate (births per woman)
- C_m = index of marriage (C_m equals one if all women of reproductive age are in marriage or consensual unions and zero in the absence of such unions)
- C_c = index of contraception (C_c equals one in the absence of contraception and zero if all fecund women in marital unions use 100 percent effective contraception)
- C_a = index of induced abortion (C_a equals one in the absence of induced abortion and zero if all pregnancies are aborted)
- C_i = index of post-partum infecundability (C_i equals one in the absence of lactation and post-partum abstinence and zero if the duration of post-partum infecundability is infinite)
- TF = total fecundity rate (the total fertility rate when $C_m = C_c = C_i = 1.0$ i.e. in the absence of the fertility inhibiting effect of the marriage pattern, contraception, induced abortion, and post-partum infecundability).

For the purpose of the projections under the SEATS project, aggregate data were used as inputs to the model. Four separate projections were made: a) one for sub-Saharan Africa which consisted of data from twelve emphasis countries; b) one for Asia/Near East/Pacific which consisted of data from Algeria and Papua New Guinea; c) a second projection for Asia/Near East/Pacific which consisted of data from Fiji, Turkey and

Burma and d) a third projection for Asia/Near East/Pacific which consisted of data from Jordan. Countries were grouped according to range of current Total Fertility Rates (TFR) and Contraceptive Prevalence Rates (CPR) in order to arrive at averages that would be representative of the subset. For example, the range of TFR for emphasis countries in sub-Saharan Africa is a low of 5.8 for Lesotho and a high of 7.1 for Tanzania, with an average for the thirteen countries of 6.5. Contraceptive Prevalence Rates (CPR) range from a low of 1% in several countries to a high of 20% for Benin, for an average of 5% for the thirteen countries. Data related to proximate determinants and other input values were derived from a variety of sources such as World Fertility Surveys, Contraceptive Prevalence Surveys, field data, United Nations reports, etc.

Projections were made for the period 1987-2000, in order to cover the ten year period of authorization for the project. The analysis relies on medium variant projections of women of reproductive age and total fertility for the years 1985-2010, taken from World Population Prospects, United Nations, 1986, "Annual Mid-Year Population Medium Variant" tables. The projections anticipate future trends in fertility, mortality and international migration for each country, given assumptions of socio-economic development and the absence of famine and epidemics. The medium variant represents the most plausible course for future population trends, and is recommended in the application of the Bongaarts model (Bongaarts and Stover, 1986). Using the Bongaarts methodology, the model projects the contraceptive prevalence, by method, required to reach a given target level of fertility in the future. For the purpose of this analysis, the target level of fertility is the medium variant TFR in the year 2000 for each of the four subsets.

The tables contained in this annex are: Table I - Summary Analysis of the Target Model (for the four projections); and Tables II - V projections for each of the four subsets which contain the Summary of Key Input Assumptions for each projection, and the Output Tables of Contraceptive Prevalence by year and method for each year of the projection.

III. Methodological Constraints

The projections made in this analysis using the Bongaarts model are meant merely to be indicative of the magnitude of potential beneficiaries and possible Couple Years of Protection (CYP) achievable under the SEATS project. However, projections are by definition inexact and highly reliant on the accuracy and validity of the input data. Projections in this analysis are

based on assumptions concerning social, economic and demographic trends, and the dearth of data on Africa and some of the other emphasis countries make any projections of trends in contraceptive prevalence problematic. The projections are compounded by vast socio-economic differences among the populations addressed, as well as variation in the indicators. There is a tremendous lack of data on the proximate determinants, particularly in Africa. Aggregating the data, while useful as an overview, does not allow for differentiation by country and presents an analysis which is not sensitive to such individual variation. With these caveats in mind, we nevertheless feel the exercise is useful and presents a theoretical framework through which certain estimates may be made.

IV. Results of Analysis

Results of these projections indicate that in the aggregate, in order to reach the median variant TFR for each of the subsets in 1993, a total of 13,294,000 people in the emphasis countries would need to be contraceptive users. In 1998 this figure would need to be 19,419,700 contraceptive users. Based on previous experience with other family planning service delivery projects, we have made the assumption that SEATS could serve approximately ten percent of the total number of contraceptive users over the life of the project. This would result in approximately 1,329,400 contraceptive users or beneficiaries over the period 1988-1993, and 1,941,700 for the period 1988-1998. Based on the method mix for each subset this would translate into 1,097,000 CYP (Couple Years of Protection) for the period 1988-1993, and 2,369,000 CYP for the total period 1988-1998. While not all of these Couple Years of Protection will be realized during the life of the project, they can be accrued to the project and attributed to the interventions provided by it. While not to be used as a hard and fast criteria upon which to be evaluated given the constraints of the methodology, this nevertheless indicates the magnitude of protection we hope to achieve with the project, allows us to quantify beneficiary and CYP targets, and provides us with a framework to refine and reevaluate such targets. As more experience is gained over the life of the SEATS project, changes in assumptions regarding certain input data (e.g. method mix), as well as percentage of contraceptive users SEATS is able to serve may be made, which would alter the number of beneficiaries and CYP achieved under the project. The methodology described here can be used as a tool to make annual projections by country and region, and assist in quantifying the impact of the project.

W5139Y

TABLE I

TARGET SETTING MODELSUMMARY ANALYSISI. Total Contraceptive Users Needed To Reach Medium Variant TFR:

| | <u>1993</u> <u>POP (000s)</u> | <u>1998</u> <u>POP (000s)</u> |
|---------------------|----------------------------------|----------------------------------|
| Africa | 3,774.4 | 6,447 |
| ANE P1 | 1,233.9 | 2,036 |
| ANE P2 | 8,038.3 | 10,602.1 |
| ANE P3 | 247.2 | 334.6 |
| | <u>13,293.8</u> | <u>19,419.7</u> |
| 10% Served by SEATS | 1,329,400 | 1,941,700 |

II. Couple Years of Protection by Method:
(000s)

| | | |
|-----------------------------------|-----------------|-----------------|
| 1) <u>Pills</u> | <u>1993</u> | <u>1998</u> |
| Africa | 577.2 | 1,177.3 |
| ANE P1 | 616.9 | 1,018.0 |
| ANE P2 | 869.4 | 1,236.4 |
| ANE P3 | 22.9 | 35.2 |
| | <u>2,086.4</u> | <u>3,466.9</u> |
| 10% Served by SEATS | 209 | 347 |
| 2) <u>IUD *</u> | | |
| AFRICA | 1,260 | 3,381.25 |
| ANE P1 | 224.5 | 526.0 |
| ANE P2 | 2,808.25 | 6,283.5 |
| ANE P3 | 85 | 195.75 |
| | <u>4,377.75</u> | <u>10,386.5</u> |
| 10% Served by SEATS | 438 | 1,039 |
| 3) <u>Female Sterilization **</u> | | |
| Africa | 911 | 2,203.2 |
| ANE P1 | 781.2 | 1,657.2 |
| ANE P2 | 1,926 | 4,508.4 |
| ANE P3 | 74.4 | 162 |
| | <u>3,692.6</u> | <u>8,530.8</u> |
| 10% Served by Seats | 369 | 853 |

| | | |
|-----------------------|--------------|--------------|
| 4) <u>Injectables</u> | <u>1993</u> | <u>1998</u> |
| Africa | 42.3 | 85.3 |
| ANE P1 | 246.8 | 407.2 |
| ANE P2 | - | - |
| ANE P3 | 4.8 | 11.4 |
| | <u>293.9</u> | <u>503.9</u> |
| 10% served by SEATS | 29.3 | 50.4 |

| | | |
|---------------------|--------------|-------------|
| 5) <u>Condoms</u> | <u>1993</u> | <u>1998</u> |
| Africa | 42.3 | 85.3 |
| ANE P1 | - | - |
| ANE P2 | 471.8 | 707.9 |
| ANE P3 | 4.2 | 8.8 |
| | <u>518.3</u> | <u>802</u> |
| 10% Served by SEATS | 52 | 80 |

III. CYP SUMMARY

| | <u>1993</u> (000s) | <u>1998</u> (000s) |
|----------------------|-----------------------|-----------------------|
| Pills | 209 | 347 |
| IUD | 438 | 1039 |
| Female Sterilization | 369 | 853 |
| Injectables | 29 | 50 |
| Condoms | <u>52</u> | <u>80</u> |
| Total | 1,097 | 2,369 |

Notes:

*IUDs provide an average of 2.5 CYP per acceptor. Calculations for total CYP provided by IUDs were derived by multiplying the annual number of acceptors by 2.5 and taking the cumulative total.

** Female Sterilization provides an average of 12 CYP per acceptor. Calculations for total CYP provided by sterilizations were derived by multiplying the annual number of acceptors by 12, and taking the cumulative total.

W5165Y



TABLE II

Projection One: Sub-Saharan Africa

I. Countries in This Projection:

| | |
|-------------|------------|
| Benin | Madagascar |
| Cameroon | Sudan |
| Guinea | Tanzania |
| Ivory Coast | Togo |
| Liberia | Uganda |
| Lesotho | Zambia |

II. Input Data:

- A) TFR: Medium variant projection for the year 2000 taken from World Population Prospects
- B) CPR: Average of data available for 10 of the countries taken from World Fertility Surveys and Contraceptive Surveys
- C) Method Mix: Base year data are taken from the latest Demographic and Health Survey conducted in Senegal in 1986, and are considered reasonable estimates for method mix for the twelve countries used in the projection. Future trends in method mix assume a one percent annual increase in the percent of current users using modern rather than traditional methods (Poole, 1987).
- D) Proximate Determinates:
- 1) Percent of Married Women of Reproductive Age (MWR): Base year estimate taken from 1986 Demographic and Health Survey conducted in Senegal. For the purpose of this projection, no change in the value is assumed over time.
 - 2) Postpartum Infecundability (months): The input value is estimated from a cross-national regression (built into the model) of average post-partum infecundability on TFR. Drawn from World Fertility Data the values for TFR and post-partum infecundability in the regression, range from 8.3 (Kenya) to 3.4 (Trinidad and Tobago) and 13.3 (Cameroon) to 7.1 (Syria) respectively. (Poole, 1987) For the purpose of this projection, no change is assumed over time.
 - 3) Sterility: Childlessness is estimated at around six percent in the base year. The projection assumes that primary sterility will decline by half to three percent in the year 2000, which is the current standard rate for childlessness in less developed countries.

Target Setting Model
03/09/88 02:02:30

SUMMARY OF KEY INPUT ASSUMPTIONS

First year = 1987
Last year = 2000

| | 1987 | 1992 | 1997 | 2000 |
|---------------------------------|---------|---------|---------|---------|
| TFR | 6.50 | 6.19 | 5.88 | 5.70 |
| Women aged 15-49 (Thousands) | 28739.0 | 33813.0 | 38887.0 | 41932.2 |

| Method | Effectiveness | Discontinuation | Consumption |
|----------------------|---------------|-----------------|-------------|
| Pill | | | |
| IUD | 0.90 | 0.46 | 13.0 |
| Female sterilization | 0.95 | 0.17 | |
| Male sterilization | 1.00 | 0.01 | |
| Injectables | 1.00 | 0.02 | |
| Other | 0.98 | 0.40 | 4.0 |
| vaginal methods | 0.70 | 0.00 | 0.0 |
| condoms | 0.00 | 0.00 | 0.0 |

Method Mix

| | 1987 | 1992 | 1997 | 2000 |
|----------------------|-------|-------|-------|-------|
| Pill | 12.00 | 14.85 | 17.69 | 19.40 |
| IUD | 6.80 | 8.45 | 10.11 | 11.10 |
| Female sterilization | 1.70 | 2.12 | 2.55 | 2.80 |
| Male sterilization | 0.00 | 0.04 | 0.08 | 0.10 |
| Injectables | 0.90 | 1.09 | 1.28 | 1.40 |
| Other | 76.80 | 71.26 | 65.72 | 62.40 |
| vaginal methods | 0.90 | 1.09 | 1.28 | 1.40 |
| condoms | 0.90 | 1.09 | 1.28 | 1.40 |

61

Target Setting Model
03/09/88 02:01:31

PROXIMATE DETERMINANTS

| | 1987 | 1992 | 1997 | 2000 |
|---|------|------|------|------|
| Prevalence (%) | 5.0 | | | |
| Percent WRA married | 76.3 | 76.3 | 76.3 | 76.3 |
| Duration of postpartum infecundability (months) | 10.8 | 10.8 | 10.8 | 10.8 |
| Induced abortion rates per 1000 women 15-19 | 0.00 | 0.00 | 0.00 | 0.00 |
| Pathological sterility rates (% childless at age 47) | 5.00 | 4.85 | 3.69 | 3.00 |

Target Setting Model
03/09/88 02:03:00

Africa2

Output Table for All methods from All sources

| Year | Percent MWRA Using | Number Using (Thousands) |
|------|--------------------------|--------------------------------|
| 87 | 5.0 | 1096.4 |
| 88 | 6.6 | 1489.7 |
| 89 | 8.1 | 1902.7 |
| 90 | 9.6 | 2335.0 |
| 91 | 11.1 | 2786.3 |
| 92 | 12.6 | 3256.2 |
| 93 | 14.1 | 3744.4 |
| 94 | 15.5 | 4250.4 |
| 95 | 17.0 | 4774.1 |
| 96 | 18.4 | 5314.9 |
| 97 | 19.8 | 5872.7 |
| 98 | 21.2 | 6447.0 |
| 99 | 22.5 | 7037.6 |
| 00 | 23.9 | 7644.1 |

Target Setting Model
03/09/88 02:03:19

Africa2

Output Table for Fill from All sources

| Year | Percent MwRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Cycles (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 1987 | 0.6 | 131.6 | | |
| 1988 | 0.8 | 187.2 | 147.4 | 2434.1 |
| 1989 | 1.1 | 250.0 | 184.0 | 3249.7 |
| 1990 | 1.3 | 320.1 | 224.4 | 4160.9 |
| 1991 | 1.6 | 397.8 | 268.6 | 5171.4 |
| 1992 | 1.9 | 483.4 | 316.9 | 6284.5 |
| 1993 | 2.2 | 577.2 | 369.2 | 7503.7 |
| 1994 | 2.5 | 679.4 | 425.8 | 8832.4 |
| 1995 | 2.8 | 790.3 | 486.7 | 10273.8 |
| 1996 | 3.1 | 910.1 | 552.0 | 11831.0 |
| 1997 | 3.5 | 1039.0 | 621.8 | 13507.1 |
| 1998 | 3.9 | 1177.3 | 696.3 | 15305.2 |
| 1999 | 4.2 | 1325.2 | 775.5 | 17228.1 |
| 2000 | 4.6 | 1483.0 | | |

Target Setting Model
03/09/88 02:03:43

Africa2

Output Table for IUD from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Insertions (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 1987 | 0.3 | 74.6 | | |
| 1988 | 0.5 | 106.2 | 53.7 | 53.7 |
| 1989 | 0.6 | 142.0 | 64.5 | 64.5 |
| 1990 | 0.8 | 181.9 | 76.3 | 76.3 |
| 1991 | 0.9 | 226.3 | 89.0 | 89.0 |
| 1992 | 1.1 | 275.3 | 102.8 | 102.8 |
| 1993 | 1.2 | 328.9 | 117.7 | 117.7 |
| 1994 | 1.4 | 387.4 | 133.5 | 133.5 |
| 1995 | 1.6 | 451.0 | 150.5 | 150.5 |
| 1996 | 1.8 | 519.6 | 168.6 | 168.6 |
| 1997 | 2.0 | 593.6 | 187.8 | 187.8 |
| 1998 | 2.2 | 673.0 | 208.1 | 208.1 |
| 1999 | 2.4 | 757.9 | 229.6 | 229.6 |
| 2000 | 2.7 | 848.5 | | |

65

Target Setting Model
03/09/88 02:04:06

Africa2

Output Table for Female sterilization from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Procedures (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 1987 | 0.1 | 18.6 | | |
| 1988 | 0.1 | 26.6 | 9.2 | 9.2 |
| 1989 | 0.2 | 35.6 | 10.5 | 10.5 |
| 1990 | 0.2 | 45.6 | 11.8 | 11.8 |
| 1991 | 0.2 | 56.8 | 13.3 | 13.3 |
| 1992 | 0.3 | 69.1 | 14.8 | 14.8 |
| 1993 | 0.3 | 82.7 | 16.3 | 16.3 |
| 1994 | 0.4 | 97.4 | 18.0 | 18.0 |
| 1995 | 0.4 | 113.5 | 19.7 | 19.7 |
| 1996 | 0.5 | 130.8 | 21.5 | 21.5 |
| 1997 | 0.5 | 149.5 | 23.3 | 23.3 |
| 1998 | 0.6 | 169.6 | 25.2 | 25.2 |
| 1999 | 0.6 | 191.1 | 27.2 | 27.2 |
| 2000 | 0.7 | 214.0 | | |

66

Target Setting Model
03/09/88 02:09:18

Africa2

Output table for condoms from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Units (Thousands) |
|------|--------------------------|--------------------------------|---|---|
| 787 | 0.0 | 9.9 | | |
| 788 | 0.1 | 14.0 | 14.2 | 1398.0 |
| 789 | 0.1 | 18.6 | 17.9 | 1858.7 |
| 790 | 0.1 | 23.7 | 22.0 | 2370.9 |
| 791 | 0.1 | 29.4 | 26.5 | 2936.3 |
| 792 | 0.1 | 35.6 | 31.4 | 3556.8 |
| 793 | 0.2 | 42.3 | 36.7 | 4234.0 |
| 794 | 0.2 | 49.7 | 42.5 | 4969.7 |
| 795 | 0.2 | 57.7 | 48.7 | 5765.6 |
| 796 | 0.2 | 66.2 | 55.3 | 6623.2 |
| 797 | 0.3 | 75.4 | 62.4 | 7544.1 |
| 798 | 0.3 | 85.3 | 70.0 | 8529.9 |
| 799 | 0.3 | 95.8 | 78.0 | 9581.9 |
| 000 | 0.3 | 107.0 | | |

Target Setting Model
03/09/88 02:10:11

Africa2

Output table for Injectables from All sources

| | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Injections (Thousands) |
|----|--------------------------|--------------------------------|---|--|
| 87 | 0.0 | 9.9 | | |
| 88 | 0.1 | 14.0 | 10.3 | 55.9 |
| 89 | 0.1 | 18.6 | 12.7 | 74.3 |
| 90 | 0.1 | 23.7 | 15.4 | 94.8 |
| 91 | 0.1 | 29.4 | 18.3 | 117.5 |
| 92 | 0.1 | 35.6 | 21.5 | 142.3 |
| 93 | 0.2 | 42.3 | 24.9 | 169.4 |
| 94 | 0.2 | 49.7 | 28.6 | 198.8 |
| 95 | 0.2 | 57.7 | 32.5 | 230.6 |
| 96 | 0.2 | 66.2 | 36.8 | 264.9 |
| 97 | 0.3 | 75.4 | 41.3 | 301.8 |
| 98 | 0.3 | 85.3 | 46.1 | 341.2 |
| 99 | 0.3 | 95.8 | 51.2 | 383.3 |
| 00 | 0.3 | 107.0 | | |

65

Target Setting Model

03/09/88 02:11:21

Africa2

Output table for Male sterilization from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Procedures (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 1987 | 0.0 | 0.0 | | |
| 1988 | 0.0 | 0.1 | 0.1 | 0.1 |
| 1989 | 0.0 | 0.3 | 0.2 | 0.2 |
| 1990 | 0.0 | 0.5 | 0.3 | 0.3 |
| 1991 | 0.0 | 0.9 | 0.4 | 0.4 |
| 1992 | 0.0 | 1.3 | 0.5 | 0.5 |
| 1993 | 0.0 | 1.7 | 0.6 | 0.6 |
| 1994 | 0.0 | 2.3 | 0.7 | 0.7 |
| 1995 | 0.0 | 2.9 | 0.8 | 0.8 |
| 1996 | 0.0 | 3.7 | 0.9 | 0.9 |
| 1997 | 0.0 | 4.5 | 1.1 | 1.1 |
| 1998 | 0.0 | 5.5 | 1.2 | 1.2 |
| 1999 | 0.0 | 6.5 | 1.4 | 1.4 |
| 2000 | 0.0 | 7.6 | | |

Africa2

Output table for vaginal methods from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Units (Thousands) |
|------|--------------------------|--------------------------------|---|---|
| 1987 | 0.0 | 9.9 | | |
| 1988 | 0.1 | 14.0 | 4.7 | 0.0 |
| 1989 | 0.1 | 18.6 | 5.3 | 0.0 |
| 1990 | 0.1 | 23.7 | 5.9 | 0.0 |
| 1991 | 0.1 | 29.4 | 6.5 | 0.0 |
| 1992 | 0.1 | 35.6 | 7.2 | 0.0 |
| 1993 | 0.2 | 42.3 | 7.9 | 0.0 |
| 1994 | 0.2 | 49.7 | 8.7 | 0.0 |
| 1995 | 0.2 | 57.7 | 9.5 | 0.0 |
| 1996 | 0.2 | 66.2 | 10.3 | 0.0 |
| 1997 | 0.3 | 75.4 | 11.1 | 0.0 |
| 1998 | 0.3 | 85.3 | 12.0 | 0.0 |
| 1999 | 0.3 | 95.8 | 12.8 | 0.0 |
| 2000 | 0.3 | 107.0 | | |

Africa2

Output table for Other from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Units (Thousands) |
|------|--------------------------|--------------------------------|---|---|
| 1987 | 3.8 | 842.0 | | |
| 1988 | 5.0 | 1127.6 | 313.9 | 0.0 |
| 1989 | 6.0 | 1419.1 | 324.8 | 0.0 |
| 1990 | 7.1 | 1715.7 | 335.1 | 0.0 |
| 1991 | 8.1 | 2016.4 | 344.8 | 0.0 |
| 1992 | 9.0 | 2320.4 | 353.8 | 0.0 |
| 1993 | 9.9 | 2626.8 | 362.0 | 0.0 |
| 1994 | 10.7 | 2934.2 | 369.5 | 0.0 |
| 1995 | 11.5 | 3243.4 | 376.1 | 0.0 |
| 1996 | 12.3 | 3552.0 | 382.0 | 0.0 |
| 1997 | 13.0 | 3859.7 | 387.0 | 0.0 |
| 1998 | 13.7 | 4165.7 | 391.3 | 0.0 |
| 1999 | 14.3 | 4469.4 | 394.8 | 0.0 |
| 2000 | 14.9 | 4769.9 | | |

TABLE III

Projection Two: Asia, Near East, Pacific 1

I. Countries used in this projection:

Algeria
Papua, New Guinea

II. Input Data:

- A) TFR: Medium variant projection for the year 2000 taken from World Population Prospects
- B) CPR: Data taken from Population Projections on Papua, New Guinea, The Futures Group, 1987; and Population Reference Bureau.
- C) Method Mix: Base year data are taken from Population Projections on Papua, New Guinea, The Futures Group, 1987. The data used in the projection apply to Papua, New Guinea and it is recognized that these base year data are not entirely applicable to Algeria. However, in the absence of data from Algeria, the values indicated were used for the purpose of this projection. Given the high percentage of use of modern methods, no change in method mix over time was projected.
- D) Proximate Determinants:
- 1) Percent of MWR: General average from Demographic and Health Surveys applied
- 2) Post-partum Infecundability: Cross-national regression from The Target Model applied.
- 3) Sterility: Standard rate for base year and projections in the year 2000 applied.

W5178Y

Target Setting Model
03/17/88 00:28:18

SUMMARY OF KEY INPUT ASSUMPTIONS

Title = anep1

First year = 1987

Last year = 2000

| | 1987 | 1992 | 1997 | 2000 |
|---------------------------------|--------|--------|--------|--------|
| TFR | 5.60 | 5.10 | 4.60 | 4.30 |
| Women aged 15-49 (Thousands) | 6062.0 | 7170.0 | 8278.0 | 8942.4 |

| Method | Effectiveness | Discontinuation | Consumption |
|----------------------|---------------|-----------------|-------------|
| Pill | 0.90 | 0.46 | 13.0 |
| IUD | 0.95 | 0.17 | |
| Female sterilization | 1.00 | 0.01 | |
| Male sterilization | 1.00 | 0.01 | |
| Injectables | 0.98 | 0.40 | 4.0 |
| Other | 0.70 | 0.00 | 0.0 |
| condoms | 0.00 | 0.68 | 100.0 |

Method Mix

| | 1987 | 1992 | 1997 | 2000 |
|----------------------|-------|-------|-------|-------|
| Pill | 50.00 | 50.00 | 50.00 | 50.00 |
| IUD | 5.00 | 5.00 | 5.00 | 5.00 |
| Female sterilization | 7.00 | 7.00 | 7.00 | 7.00 |
| Male sterilization | 0.00 | 0.00 | 0.00 | 0.00 |
| Injectables | 20.00 | 20.00 | 20.00 | 20.00 |
| Other | 18.00 | 18.00 | 18.00 | 18.00 |
| condoms | 0.00 | 0.00 | 0.00 | 0.00 |

Target Setting Model
03/17/88 00:27:41

PROXIMATE DETERMINANTS

| | 1987 | 1992 | 1997 | 2000 |
|---|------|------|------|------|
| Prevalence (%) | 10.0 | | | |
| Percent WRA married | 76.3 | 76.3 | 76.3 | 76.3 |
| Duration of postpartum infecundability (months) | 9.4 | 9.4 | 9.4 | 9.4 |
| Induced abortion rates per 1000 women 15-19 | 0.00 | 0.00 | 0.00 | 0.00 |
| Pathological sterility rates (% childless at age 49) | 6.00 | 4.85 | 3.69 | 3.00 |

Target Setting Model
03/17/88 00:28:48

anep1

Output Table for All methods from All sources

| Year | Percent MWRA Using | Number Using (Thousands) |
|------|--------------------------|--------------------------------|
| 1987 | 10.0 | 462.5 |
| 1988 | 12.0 | 576.1 |
| 1989 | 14.0 | 695.7 |
| 1990 | 16.0 | 821.4 |
| 1991 | 18.0 | 953.0 |
| 1992 | 19.9 | 1090.5 |
| 1993 | 21.9 | 1233.9 |
| 1994 | 23.8 | 1383.0 |
| 1995 | 25.7 | 1537.9 |
| 1996 | 27.6 | 1698.4 |
| 1997 | 29.5 | 1864.4 |
| 1998 | 31.4 | 2036.0 |
| 1999 | 33.3 | 2213.1 |
| 2000 | 35.1 | 2395.5 |

75

Target Setting Model
03/17/88 00:29:07

anep1

Output Table for Fill from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Cycles (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 987 | 5.0 | 231.3 | | |
| 988 | 6.0 | 288.0 | 193.8 | 3744.5 |
| 989 | 7.0 | 347.9 | 224.9 | 4522.1 |
| 990 | 8.0 | 410.7 | 257.4 | 5338.9 |
| 991 | 9.0 | 476.5 | 291.3 | 6194.5 |
| 992 | 10.0 | 545.3 | 326.5 | 7088.4 |
| 993 | 10.9 | 616.9 | 363.1 | 8020.3 |
| 994 | 11.9 | 691.5 | 401.0 | 8989.7 |
| 995 | 12.9 | 768.9 | 440.2 | 9996.2 |
| 996 | 13.8 | 849.2 | 480.7 | 11039.4 |
| 997 | 14.8 | 932.2 | 522.5 | 12118.8 |
| 998 | 15.7 | 1018.0 | 565.5 | 13234.2 |
| 999 | 16.6 | 1106.5 | 609.9 | 14385.1 |
| 000 | 17.6 | 1197.8 | | |

Target Setting Model
03/17/88 00:29:30

anep1

Output Table for IUD from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Insertions (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 1987 | 0.5 | 23.1 | | |
| 1988 | 0.6 | 28.8 | 11.2 | 11.2 |
| 1989 | 0.7 | 34.8 | 12.7 | 12.7 |
| 1990 | 0.8 | 41.1 | 14.1 | 14.1 |
| 1991 | 0.9 | 47.7 | 15.7 | 15.7 |
| 1992 | 1.0 | 54.5 | 17.2 | 17.2 |
| 1993 | 1.1 | 61.7 | 18.9 | 18.9 |
| 1994 | 1.2 | 69.2 | 20.5 | 20.5 |
| 1995 | 1.3 | 76.9 | 22.3 | 22.3 |
| 1996 | 1.4 | 84.9 | 24.1 | 24.1 |
| 1997 | 1.5 | 93.2 | 25.9 | 25.9 |
| 1998 | 1.6 | 101.8 | 27.8 | 27.8 |
| 1999 | 1.7 | 110.7 | 29.7 | 29.7 |
| 2000 | 1.8 | 119.8 | | |

Target Setting Model
03/17/88 00:29:54

anep1

Output Table for Female sterilization from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Procedures (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 1987 | 0.7 | 32.4 | | |
| 1988 | 0.8 | 40.3 | 9.2 | 9.2 |
| 1989 | 1.0 | 48.7 | 9.9 | 9.9 |
| 1990 | 1.1 | 57.5 | 10.5 | 10.5 |
| 1991 | 1.3 | 66.7 | 11.2 | 11.2 |
| 1992 | 1.4 | 76.3 | 11.8 | 11.8 |
| 1993 | 1.5 | 86.4 | 12.5 | 12.5 |
| 1994 | 1.7 | 96.8 | 13.2 | 13.2 |
| 1995 | 1.8 | 107.7 | 13.9 | 13.9 |
| 1996 | 1.9 | 118.9 | 14.6 | 14.6 |
| 1997 | 2.1 | 130.5 | 15.3 | 15.3 |
| 1998 | 2.2 | 142.5 | 16.0 | 16.0 |
| 1999 | 2.3 | 154.9 | 16.7 | 16.7 |
| 2000 | 2.5 | 167.7 | | |

78

Target Setting Model
03/17/88 00:30:17

anep1

Output Table for Injectables from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Injections (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 1987 | 2.0 | 92.5 | | |
| 1988 | 2.4 | 115.2 | 71.8 | 460.9 |
| 1989 | 2.8 | 139.1 | 83.1 | 556.6 |
| 1990 | 3.2 | 164.3 | 94.9 | 657.1 |
| 1991 | 3.6 | 190.6 | 107.1 | 762.4 |
| 1992 | 4.0 | 218.1 | 119.9 | 872.4 |
| 1993 | 4.4 | 246.8 | 133.1 | 987.1 |
| 1994 | 4.8 | 276.6 | 146.8 | 1106.4 |
| 1995 | 5.1 | 307.6 | 160.9 | 1230.3 |
| 1996 | 5.5 | 339.7 | 175.6 | 1358.7 |
| 1997 | 5.9 | 372.9 | 190.6 | 1491.6 |
| 1998 | 6.3 | 407.2 | 206.2 | 1628.8 |
| 1999 | 6.7 | 442.6 | 222.2 | 1770.5 |
| 2000 | 7.0 | 479.1 | | |

71

Target Setting Model
03/17/88 00:30:40

anep1

Output Table for Other from All sources

| | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Units (Thousands) |
|-----|--------------------------|--------------------------------|---|---|
| 987 | 1.8 | 83.3 | | |
| 988 | 2.2 | 103.7 | 23.2 | 0.0 |
| 989 | 2.5 | 125.2 | 24.7 | 0.0 |
| 990 | 2.9 | 147.8 | 26.2 | 0.0 |
| 991 | 3.2 | 171.5 | 27.8 | 0.0 |
| 992 | 3.6 | 196.3 | 29.4 | 0.0 |
| 993 | 3.9 | 222.1 | 30.9 | 0.0 |
| 994 | 4.3 | 248.9 | 32.5 | 0.0 |
| 995 | 4.6 | 276.8 | 34.1 | 0.0 |
| 996 | 5.0 | 305.7 | 35.7 | 0.0 |
| 997 | 5.3 | 335.6 | 37.3 | 0.0 |
| 998 | 5.7 | 366.5 | 39.0 | 0.0 |
| 999 | 6.0 | 398.4 | 40.6 | 0.0 |
| 000 | 6.3 | 431.2 | | |

TABLE IV

Projection Three: Asia, Near East, Pacific 2

I. Countries used in this projection:

Fiji
Turkey
Burma

II. Input Data:

- A) TFR: Medium variant projection for the year 2000 taken from World Population Prospects.
- B) CPR: Data taken from World Fertility and Contraceptive Prevalence Surveys, and the 1983 Turkish Population and Health Survey.
- C) Method Mix: Base year data are taken from the 1983 Turkish Population and Health Survey. Data from Turkey were used for the purpose of this projection, given the size of its population, the lack of available data from Burma and the fact that data from Fiji indicate a high rate of sterilization not considered representative of rates for Burma or Turkey. Future trends in method mix assume an overall increase in the percent of current users using modern rather than traditional methods.

III. Proximate Determinants:

- 1) Percent MWRA: General average from Demographic and Health surveys applied.
- 2) Postpartum Infecundability: Cross-national regression from the target model applied.
- 3) Sterility: Standard rate for base year and projections in the year 2000 applied.

Target Setting Model
03/17/88 01:39:35

SUMMARY OF KEY INPUT ASSUMPTIONS

Title = anep2

First year = 1987
Last year = 2000

| | 1987 | 1992 | 1997 | 2000 |
|---------------------------------|---------|---------|---------|---------|
| TFR | 3.60 | 3.33 | 3.06 | 2.90 |
| Women aged 15-49 (Thousands) | 22362.0 | 24866.0 | 27370.0 | 28873.2 |

| Method | Effectiveness | Discontinuation | Consumption |
|----------------------|---------------|-----------------|-------------|
| Pill | 0.90 | 0.46 | |
| IUD | 0.95 | 0.17 | 13.0 |
| Female sterilization | 1.00 | 0.01 | |
| Male sterilization | 1.00 | 0.01 | |
| Injectables | 0.98 | 0.40 | 4.0 |
| Other | 0.70 | 0.00 | 0.0 |
| condoms | 0.00 | 0.68 | 100.0 |

Method Mix

| | 1987 | 1992 | 1997 | 2000 |
|----------------------|-------|-------|-------|-------|
| Pill | 9.80 | 10.65 | 11.49 | 12.00 |
| IUD | 8.90 | 10.09 | 11.28 | 12.00 |
| Female sterilization | 1.30 | 2.30 | 3.30 | 3.90 |
| Male sterilization | 0.00 | 0.04 | 0.08 | 0.10 |
| Injectables | 0.20 | 0.89 | 1.58 | 2.00 |
| Other | 74.90 | 70.32 | 65.75 | 63.00 |
| condoms | 4.90 | 5.71 | 6.52 | 7.00 |

Target Setting Model
03/17/88 01:39:04

PROXIMATE DETERMINANTS

| | 1987 | 1992 | 1997 | 2000 |
|---|------|------|------|------|
| Prevalence (%) | 31.0 | | | |
| Percent WRA married | 76.3 | 76.3 | 76.3 | 76.3 |
| Duration of postpartum infecundability (months) | 6.2 | 6.2 | 6.2 | 6.2 |
| Induced abortion rates per 1000 women 15-19 | 0.00 | 0.00 | 0.00 | 0.00 |
| Pathological sterility rates (% childless at age 49) | 6.00 | 4.85 | 3.69 | 3.00 |

Target Setting Model
03/17/98 01:40:05

anep2

Output Table for All methods from All sources

| Year | Percent MWRA Using | Number Using (Thousands) |
|------|--------------------------|--------------------------------|
| 1987 | 31.0 | 5289.3 |
| 1988 | 32.8 | 5721.4 |
| 1989 | 34.6 | 6164.2 |
| 1990 | 36.3 | 6617.4 |
| 1991 | 38.1 | 7080.9 |
| 1992 | 39.8 | 7554.6 |
| 1993 | 41.5 | 8038.3 |
| 1994 | 43.2 | 8531.9 |
| 1995 | 44.9 | 9035.2 |
| 1996 | 46.6 | 9548.1 |
| 1997 | 48.2 | 10070.4 |
| 1998 | 49.9 | 10602.1 |
| 1999 | 51.5 | 11142.9 |
| 2000 | 53.1 | 11692.8 |

Target Setting Model
03/17/88 01:40:25

anep2

Output Table for Fill from All sources

| Year | Percent MWRAs Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Cycles (Thousands) |
|------|---------------------------|--------------------------------|---|--|
| 1987 | 3.0 | 518.3 | | |
| 1988 | 3.3 | 570.4 | 321.3 | 7414.9 |
| 1989 | 3.5 | 625.0 | 349.5 | 8124.4 |
| 1990 | 3.7 | 682.1 | 379.0 | 8867.3 |
| 1991 | 4.0 | 741.9 | 409.7 | 9644.2 |
| 1992 | 4.2 | 804.3 | 441.7 | 10455.6 |
| 1993 | 4.5 | 869.4 | 475.0 | 11304.9 |
| 1994 | 4.7 | 937.2 | 509.6 | 12183.6 |
| 1995 | 5.0 | 1007.8 | 545.5 | 13101.1 |
| 1996 | 5.3 | 1081.1 | 582.8 | 14054.8 |
| 1997 | 5.5 | 1157.3 | 621.4 | 15045.2 |
| 1998 | 5.8 | 1236.4 | 661.4 | 16072.8 |
| 1999 | 6.1 | 1318.3 | 702.8 | 17137.8 |
| 2000 | 6.4 | 1403.1 | | |

Target Setting Model
03/17/88 01:40:48

anep2

Output Table for IUD from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Insertions (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 1987 | 2.8 | 470.7 | | |
| 1988 | 3.0 | 522.8 | 151.5 | 151.5 |
| 1989 | 3.2 | 578.0 | 164.9 | 164.9 |
| 1990 | 3.5 | 636.3 | 179.0 | 179.0 |
| 1991 | 3.8 | 697.7 | 193.7 | 193.7 |
| 1992 | 4.0 | 762.4 | 209.1 | 209.1 |
| 1993 | 4.3 | 830.4 | 225.1 | 225.1 |
| 1994 | 4.6 | 901.8 | 241.8 | 241.8 |
| 1995 | 4.9 | 976.5 | 259.3 | 259.3 |
| 1996 | 5.1 | 1054.7 | 277.4 | 277.4 |
| 1997 | 5.4 | 1136.4 | 296.2 | 296.2 |
| 1998 | 5.7 | 1221.7 | 315.8 | 315.8 |
| 1999 | 6.1 | 1310.6 | 336.1 | 336.1 |
| 2000 | 6.4 | 1403.1 | | |

Target Setting Model
03/17/88 01:41:11

anep2

Output Table for Female sterilization from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Procedures (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 987 | 0.4 | 68.8 | | |
| 988 | 0.5 | 85.8 | 20.3 | 20.3 |
| 989 | 0.6 | 104.8 | 22.7 | 22.7 |
| 990 | 0.7 | 125.7 | 25.3 | 25.3 |
| 991 | 0.8 | 148.7 | 27.9 | 27.9 |
| 992 | 0.9 | 173.8 | 30.7 | 30.7 |
| 993 | 1.0 | 201.0 | 33.6 | 33.6 |
| 994 | 1.2 | 230.4 | 36.6 | 36.6 |
| 995 | 1.3 | 262.0 | 39.7 | 39.7 |
| 996 | 1.4 | 296.0 | 42.9 | 42.9 |
| 997 | 1.6 | 332.3 | 46.3 | 46.3 |
| 998 | 1.7 | 371.1 | 49.7 | 49.7 |
| 999 | 1.9 | 412.3 | 53.3 | 53.3 |
| 000 | 2.1 | 456.0 | | |

Target Setting Model
03/17/88 01:44:52

anep2

Output table for condoms from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Units (Thousands) |
|------|--------------------------|--------------------------------|---|---|
| 1987 | 1.5 | 259.2 | | |
| 1988 | 1.7 | 289.6 | 234.3 | 28959.1 |
| 1989 | 1.8 | 322.0 | 259.0 | 32195.8 |
| 1990 | 2.0 | 356.3 | 285.0 | 35632.0 |
| 1991 | 2.1 | 392.7 | 312.6 | 39271.8 |
| 1992 | 2.3 | 431.2 | 341.7 | 43119.4 |
| 1993 | 2.4 | 471.8 | 372.2 | 47178.9 |
| 1994 | 2.6 | 514.5 | 404.4 | 51454.0 |
| 1995 | 2.8 | 559.5 | 438.1 | 55948.8 |
| 1996 | 3.0 | 606.7 | 473.4 | 60667.1 |
| 1997 | 3.1 | 656.1 | 510.4 | 65612.7 |
| 1998 | 3.3 | 707.9 | 549.0 | 70789.3 |
| 1999 | 3.5 | 762.0 | 589.2 | 76200.3 |
| 2000 | 3.7 | 818.5 | | |

TABLE V

Projection Four: Asia, Near East, Pacific 3

I. Countries used in this projection:

Jordan

II. Input Data:

- A) TFR: Medium variant projection for the year 2000 taken from World Population Prospects.
- B) CPR: Data taken from 1983 Contraceptive Prevalence Survey.
- C) Method Mix: Base year data are taken from the 1983 Contraceptive Prevalence Survey. Future trends in method mix assume an overall increase in the percent of current users using modern rather than traditional methods.

III. Proximate Determinants:

- 1) Percent of MWR: General average from Demographic and Health Surveys applied.
- 2) Postpartum Infecundability: Cross-national regression from the target model applied.
- 3) Sterility: Standard rate for base year and projections in the year 2000 applied.

W5183Y

Target Setting Model
03/21/88 00:18:08

SUMMARY OF KEY INPUT ASSUMPTIONS

Title = anep3

First year = 1987

Last year = 2000

| | 1987 | 1992 | 1997 | 2000 |
|---------------------------------|-------|-------|--------|--------|
| TFR | 7.40 | 7.13 | 6.86 | 6.70 |
| Women aged 15-49 (Thousands) | 794.0 | 975.0 | 1155.0 | 1263.3 |

| Method | Effectiveness | Discontinuation | Consumption |
|----------------------|---------------|-----------------|-------------|
| Fill | 0.90 | 0.46 | |
| IUD | 0.95 | 0.17 | 13.0 |
| Female sterilization | 1.00 | 0.01 | |
| Male sterilization | 1.00 | 0.01 | |
| Injectables | 0.98 | 0.40 | |
| Other | 0.70 | 0.00 | 4.0 |
| condoms | 0.00 | 0.68 | 0.0 |
| | | | 100.0 |

Method Mix

| | 1987 | 1992 | 1997 | 2000 |
|----------------------|-------|-------|-------|-------|
| Fill | 7.80 | 9.03 | 10.26 | 11.00 |
| IUD | 8.30 | 9.72 | 11.15 | 12.00 |
| Female sterilization | 3.80 | 4.26 | 4.72 | 5.00 |
| Male sterilization | 0.00 | 0.00 | 0.00 | 0.00 |
| Injectables | 0.20 | 1.66 | 3.12 | 4.00 |
| Other | 79.30 | 73.80 | 68.30 | 65.00 |
| condoms | 0.60 | 1.52 | 2.45 | 3.00 |

Target Setting Model
03/21/88 00:17:38

PROXIMATE DETERMINANTS

| | 1987 | 1992 | 1997 | 2000 |
|---|------|------|------|------|
| Prevalence (%) | 26.0 | | | |
| Percent WRA married | 76.3 | 76.3 | 76.3 | 76.3 |
| Duration of postpartum infecundability (months) | 12.2 | 12.2 | 12.2 | 12.2 |
| Induced abortion rates per 1000 women 15-19 | 0.00 | 0.00 | 0.00 | 0.00 |
| Pathological sterility rates (% childless at age 49) | 6.00 | 4.85 | 3.69 | 3.00 |

Target Setting Model
03/21/88 00:18:38

anep3

Output Table for All methods from All sources

| Year | Percent MWRA Using | Number Using (Thousands) |
|------|--------------------------|--------------------------------|
| 987 | 26.0 | 157.5 |
| 988 | 27.0 | 171.3 |
| 989 | 28.1 | 185.5 |
| 990 | 29.1 | 200.3 |
| 991 | 30.1 | 215.5 |
| 992 | 31.1 | 231.1 |
| 993 | 32.1 | 247.2 |
| 994 | 33.0 | 263.8 |
| 995 | 34.0 | 280.8 |
| 996 | 34.9 | 298.3 |
| 997 | 35.9 | 316.2 |
| 998 | 36.8 | 334.6 |
| 999 | 37.7 | 353.4 |
| 000 | 38.7 | 372.7 |

Target Setting Model
03/21/88 00:18:57

anep3

Output Table for Fill from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Cycles (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 987 | 2.0 | 12.3 | | |
| 988 | 2.2 | 13.8 | 8.0 | 179.2 |
| 989 | 2.3 | 15.4 | 8.9 | 200.0 |
| 990 | 2.5 | 17.1 | 9.8 | 222.3 |
| 991 | 2.6 | 18.9 | 10.8 | 246.0 |
| 992 | 2.8 | 20.7 | 11.8 | 271.3 |
| 993 | 3.0 | 22.9 | 12.9 | 298.2 |
| 994 | 3.1 | 25.1 | 14.1 | 326.6 |
| 995 | 3.3 | 27.4 | 15.3 | 356.7 |
| 996 | 3.5 | 29.9 | 16.5 | 388.4 |
| 997 | 3.7 | 32.5 | 17.9 | 421.9 |
| 998 | 3.9 | 35.2 | 19.3 | 457.1 |
| 999 | 4.1 | 38.0 | 20.8 | 494.1 |
| 000 | 4.3 | 41.0 | | |

Target Setting Model
03/21/88 00:19:21

anep3

Output Table for IUD from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Insertions (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 987 | 2.2 | 13.1 | | |
| 988 | 2.3 | 14.7 | | |
| 989 | 2.5 | 16.5 | 4.4 | 4.4 |
| 990 | 2.7 | 18.3 | 4.9 | 4.9 |
| 991 | 2.8 | 20.3 | 5.4 | 5.4 |
| 992 | 3.0 | 22.5 | 5.9 | 5.9 |
| 993 | 3.2 | 24.7 | 6.4 | 6.4 |
| 994 | 3.4 | 27.2 | 7.0 | 7.0 |
| 995 | 3.6 | 29.7 | 7.6 | 7.6 |
| 996 | 3.8 | 32.4 | 8.2 | 8.2 |
| 997 | 4.0 | 35.2 | 8.8 | 8.8 |
| 998 | 4.2 | 38.2 | 9.5 | 9.5 |
| 999 | 4.4 | 41.4 | 10.2 | 10.2 |
| 000 | 4.6 | 44.7 | 11.0 | 11.0 |

Target Setting Model
03/21/88 00:19:44

anep3

Output Table for Female sterilization from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Procedures (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 1987 | 1.0 | 6.0 | | |
| 1988 | 1.1 | 6.7 | 0.9 | 0.9 |
| 1989 | 1.1 | 7.4 | 0.9 | 0.9 |
| 1990 | 1.2 | 8.2 | 1.0 | 1.0 |
| 1991 | 1.3 | 9.0 | 1.1 | 1.1 |
| 1992 | 1.3 | 9.8 | 1.1 | 1.1 |
| 1993 | 1.4 | 10.8 | 1.2 | 1.2 |
| 1994 | 1.5 | 11.7 | 1.3 | 1.3 |
| 1995 | 1.5 | 12.7 | 1.4 | 1.4 |
| 1996 | 1.6 | 13.8 | 1.5 | 1.5 |
| 1997 | 1.7 | 14.9 | 1.5 | 1.5 |
| 1998 | 1.8 | 16.1 | 1.6 | 1.6 |
| 1999 | 1.9 | 17.3 | 1.7 | 1.7 |
| 2000 | 1.9 | 18.6 | | |

Target Setting Model
03/21/88 00:20:53

anep3

Output Table for condoms from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Units (Thousands) |
|------|--------------------------|--------------------------------|---|---|
| 987 | 0.2 | 0.9 | | |
| 988 | 0.2 | 1.3 | 1.4 | 134.4 |
| 989 | 0.3 | 1.8 | 1.7 | 179.8 |
| 990 | 0.3 | 2.3 | 2.2 | 231.1 |
| 991 | 0.4 | 2.9 | 2.6 | 288.4 |
| 992 | 0.5 | 3.5 | 3.1 | 352.0 |
| 993 | 0.5 | 4.2 | 3.7 | 422.2 |
| 994 | 0.6 | 5.0 | 4.3 | 499.2 |
| 995 | 0.7 | 5.8 | 5.0 | 583.3 |
| 996 | 0.8 | 6.7 | 5.7 | 674.6 |
| 997 | 0.9 | 7.7 | 6.4 | 773.6 |
| 998 | 1.0 | 8.8 | 7.3 | 880.3 |
| 999 | 1.1 | 9.9 | 8.2 | 995.0 |
| 000 | 1.2 | 11.2 | | |

96

Target Setting Model
03/21/88 00:20:07

anep3

Output Table for Injectables from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Injections (Thousands) |
|------|--------------------------|--------------------------------|---|--|
| 1987 | 0.1 | 0.3 | | |
| 1988 | 0.1 | 0.8 | 0.9 | 3.4 |
| 1989 | 0.2 | 1.5 | 1.3 | 5.8 |
| 1990 | 0.3 | 2.2 | 1.7 | 8.6 |
| 1991 | 0.4 | 3.0 | 2.1 | 11.8 |
| 1992 | 0.5 | 3.8 | 2.6 | 15.4 |
| 1993 | 0.6 | 4.8 | 3.1 | 19.3 |
| 1994 | 0.7 | 5.9 | 3.6 | 23.7 |
| 1995 | 0.9 | 7.1 | 4.3 | 28.5 |
| 1996 | 1.0 | 8.4 | 4.9 | 33.8 |
| 1997 | 1.1 | 9.9 | 5.6 | 39.5 |
| 1998 | 1.3 | 11.4 | 6.4 | 45.7 |
| 1999 | 1.4 | 13.1 | 7.3 | 52.4 |
| 2000 | 1.5 | 14.9 | | |

97

Target Setting Model
03/21/88 00:20:30

anep3

Output Table for Other from All sources

| Year | Percent MWRA Using | Number Using (Thousands) | Annual Number of Acceptors (Thousands) | Annual Number of Units (Thousands) |
|------|--------------------------|--------------------------------|---|---|
| 1987 | 20.6 | 124.9 | | |
| 1988 | 21.1 | 133.9 | 11.8 | 0.0 |
| 1989 | 21.6 | 143.0 | 12.1 | 0.0 |
| 1990 | 22.1 | 152.2 | 12.3 | 0.0 |
| 1991 | 22.5 | 161.4 | 12.5 | 0.0 |
| 1992 | 22.9 | 170.6 | 12.7 | 0.0 |
| 1993 | 23.3 | 179.7 | 12.9 | 0.0 |
| 1994 | 23.6 | 188.9 | 13.0 | 0.0 |
| 1995 | 24.0 | 198.0 | 13.2 | 0.0 |
| 1996 | 24.2 | 207.0 | 13.3 | 0.0 |
| 1997 | 24.5 | 216.0 | 13.4 | 0.0 |
| 1998 | 24.7 | 224.9 | 13.5 | 0.0 |
| 1999 | 24.9 | 233.6 | 13.5 | 0.0 |
| 2000 | 25.1 | 242.2 | | |

93