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PROJECT PAPER

SENEGAL FAMILY HEALTH AND POPULATION PROJECT

(685-0248)

Authorized: June 30, 1985
Amount: \$20,000,000

AGENCY FOR INTERNATIONAL DEVELOPMENT

UNCLASSIFIED

1

ACTION MEMO FOR THE DIRECTOR OF USAID/SENEGAL

TO: S. J. Littlefield

FROM: Michael White

SUBJECT: Authorization of the Senegal Family Health and Population Project
(685-0248)

I. PROBLEM

Your approval is requested for a grant of twenty million dollars (\$20,000,000) from Section 121 of the Foreign Assistance Act of 1961, as amended (Sahel Development Program), to the Government of Senegal (GOS) for the Senegal Family Health and Population Project. It is planned that a total of nine million four hundred fifty thousand dollars will be obligated in FY 1985.

II. DISCUSSION

A. Project Description

The Senegal Family Health Project will provide a seven-year nationwide family planning program via public and private sector health providers and will support the improvement of the demographic data base to allow for more effective understanding of the impact of population dynamics on economic development. Major components of the project will include family health/family planning service delivery, training, information, education and communication, data base improvement and population policy development. It is estimated that 15% of Senegal's reproductive age couples will be affected.

Innovative features of this project include a program to assist a variety of organizations in the private and para-public sector to provide family planning/family life information and education as well as family planning service to a segment of the population not being served by the governmental sector. It is hoped that by providing the impetus to private sector institutions family planning will develop its own momentum.

The skills of government health personnel will be greatly upgraded through this project because of extensive training programs, both long and short-term, in-country and abroad. Ministry of Health and Ministry of Social Development personnel will work in concert on this project as providers of clinical expertise to be accompanied by education programs. The mass media will be used in effective ways to inform the public on this subject.

Beneficiaries of this project will include Senegalese public and private institutions, and the general population as consumers in the health sector (especially couples of reproductive age, women and children, and those suffering from sexually transmitted diseases).

B. Summary of Analyses

1. Economic

The economic analysis includes a cost-benefit analysis based on estimates for several kinds of benefits, and discussions of project cost effectiveness, recurrent costs, and user fees. The major macroeconomic benefits are identified alternatively as (a) reduction in food import requirements resulting from a reduction in population growth and (b) reduction in investment required to maintain per capita GNP. If project aims in reducing the population growth rate are achieved, food requirements will be reduced by between 99,000 and 170,000 metric tons; the cost-benefit ratio resulting from reduction in investment requirements is estimated at a maximum of 12 over the period 1986-1992. The proposed project is considered to be cost effective in that it requires no new staff and will rely on existing facilities.

2. Social

There are no significant social constraints to this project, although it is a delicate subject. Scrupulous attention has been given to exploring family planning in the Islamic context to avoid any offensive or controversial ramifications. The present low incidence of family planning interventions in Senegal is due more to a lack of information and means than to any social constraint or taboo. A greater involvement of men in sharing the burden of family planning decisions is another expected result.

3. Administrative

The Ministry of Social Development has overall responsibility for the project and specific responsibility for Information Education and Communication (IEC) outreach activities. The Ministry of Health (MOH) will implement the clinical training programs, establish new service sites while monitoring the present ones, and initiate the Sexually Transmitted Disease (STD) and infertility treatment programs. Both ministries will supply personnel. A Technical Assistance Contractor (TAC) will ensure high standards of IEC and clinical services as well as coordinating the three major project activities: MOH/MSD activities, Bureau National de Recensement (BNR) Census programs, and NGO projects.

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COUNTRY: SENEGAL

PROJECT TITLE: FAMILY HEALTH AND POPULATION

PROJECT NUMBER: 658-0248

1. Pursuant to Section 121 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Family Health and Population Project for Senegal, ("Cooperating Country") involving planned obligations of not to exceed \$20,000,000 in grant funds over a five year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process to help in financing foreign exchange and local currency costs for the project. The planned life of the project is seven years from the date of initial obligation.

2. The Project purposes are the following:

a. To enable the Public and private sectors to carry out an effective nationwide family planning program by 1992.

b. To provide sufficient demographic survey and analytic capability to inform policy makers of the impacts of rapid population growth.

3. The project will consist of three principal groups of activities. These are:

a. Expansion of the current public sector Senegal Family Health project, which is a clinic-based program organized by two GOS ministries, the Ministry of Health and the Ministry of Social Development;

b. Expansion of family planning/family health services into the private non-governmental sector;

c. Assistance to improve Senegal's demographic data base so that more effective development planning can take place and to help increase the awareness of the relationship between rapid population growth and development.

The Project will finance training, technical assistance, advisory services, commodities and other costs to achieve its purposes.

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

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a. Source and Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the project shall have their source and origin in the Cooperating or in 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. Motor vehicles financed under the Project shall have their source and origin in the United States, except as A.I.D. may agree otherwise in writing.

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.

B. Covenants

1. The Government of Senegal agrees to assign the requisite numbers of personnel from the Ministry of Health and Ministry of Social Development to appropriately staff the headquarters of the Senegal Family Health Project.
2. The national headquarters of the Senegal Family Health will be maintained throughout the life of the project or until USAID and the GOS agree that a different management structure would be more effective.
3. Within 90 days of the signing of the Project Agreement, the GOS shall furnish a letter agreeing to the evaluation schedule proposed in the Amplified Project Description section of the Project Agreement and the implied need to redesign or terminate the project should evaluation be unfavorable.
4. Second and subsequent year disbursements will be contingent upon USAID's and the GOS satisfaction with the progress made toward achieving project objectives.
5. The Government of Senegal and USAID will covenant that none of the funds provided by AID will be used to perform abortions or to promote abortion as a means of family planning. The government will further assure that there will be no coercion of any kind and that all use of family planning methods will be voluntary action of the persons involved.

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4. Evaluation

Three evaluations will take place during the LOP, the first at the end of year two (done internally), the second in year four (with a local project team and external assistance), and a final in year six (with more external assistance).

C. Conditions and Covenants

The Project Authorization prescribes a series of Covenants.

The Covenants cover a wide range of GOS undertakings. These include: assignment of headquarters staff and maintenance of a national Project office; satisfactory evaluation for continued disbursement of grant funds; prohibition of use of project funds for abortions; publicity requirements; gradual assumption of gasoline expenses by the GOS; gradual assumption of headquarters operating expenses by the GOS, among other covenants.

D. Waivers

1. A proprietary procurement waiver for micro-computer equipment was approved by the Mission Director on May 3, 1985.
2. A source/origin Waiver for 23 motor vehicles was approved by the Assistant Administrator for Africa on May 29, 1985.

E. Committee Action and Congressional Apprisement

A project review was held on June 10, 1985. The Project Committee recommended that the Director authorize the project.

A CN was submitted to Congress on April 11, 1985. The waiting period expired without objection on June 28, 1985.

F. Senegal is widely recognized as having an excellent human rights record.

G. Environmental concerns

The 611A certification has been approved. Included in this project are plans to renovate 77 MCH centers in the 10 regions of Senegal and the cost estimates are based on renovations carried out in similar facilities of the previous project.

III. RECOMMENDATION

That you sign the Project Authorization and the Project Paper face sheet and thereby authorize the Senegal Family Health and Population Project (685-0248) with a planned FY 1985 obligation of \$9,450,000 and a total LOP of \$20,000,000.

b

6. The GOS agrees to contact its agents posted in areas where the Senegal Family Health Project will be carried out in order to inform them that there will be no supplementary remuneration since family planning activities are an integral part of the professional work of these agents. Any travel required of these agents to carry out family planning activities will be reimbursed according to the USAID policy.
7. The Government of Senegal, through the Ministry of Information and Culture, the Ministry of Health and the Ministry of Social Development will make time available on national and regional radio or TV for government or non-government organizations to provide informational programs on family health and planning.
8. Activities concerning the promotion of family health and planning proposed by organizations in the private and para-statal sector will not be financed until after a review committee has studied and approved them.
9. The Government of Senegal, through the Ministries of Health and the Ministry of Social Development, will name representatives to the private and para statal project review committee of the Family Health and Population project. These representatives will be named before Jan. 30, 1986 or another date agreed to in writing by USAID.
10. The project will pay for all gasoline for project cars for the first three years of activities, after which time the proportion of gasoline expenses supported by the GOS will be as follows:

<u>Year</u>	<u>Total</u>	<u>USAID</u>	<u>GOS</u>
1	\$ 13,000	\$ 13,000 (100%)	\$ 0 (0%)
2	14,300	14,300 (100%)	0 (0%)
3	14,433	14,433 (100%)	0 (0%)
4	15,876	11,113 (70%)	4,763 (30%)
5	17,464	10,478 (60%)	6,986 (40%)
6	19,210	3,842 (20%)	15,368 (80%)
7	21,131	0 (0%)	21,131 (100%)

The Government of Senegal will assure responsibility for supplying the additional gasoline necessary to conduct project activities beginning of Year 4 and onwards. The GOS covenants to allocate line items in the national budget from Fiscal Year 1989 onwards equivalent to the above specified sums for project gasoline purchases. This shall be evidenced by the inclusion of these estimates in the budget provisoire starting in 1987.

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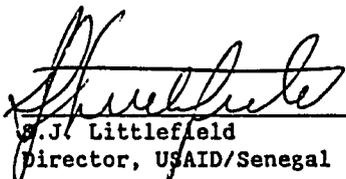
11. The project will pay 100% of the operating costs (utilities, telephone, stationery, etc) of the headquarters for the national project for the first three years of activities, after which time the proportion of these operating expenses supported will be as follows:

<u>Year</u>	<u>Total</u>	<u>USAID</u>	<u>GOS</u>
1	\$ 93,000	\$ 93,000 (100%)	\$ 0 (0%)
2	97,650	97,650 (100%)	0 (0%)
3	102,532	102,532 (100%)	0 (0%)
4	107,659	75,361 (70%)	32,298 (30%)
5	113,041	45,217 (40%)	67,824 (60%)
6	118,693	23,738 (20%)	94,955 (80%)
7	124,627	0 (0%)	124,627 (100%)

The Government of Senegal will assume responsibility for supporting the additional operating expenses of the national headquarters from the beginning Year 4 and onwards. The GOS covenants to allocate line items in the national budget from Fiscal Year 1987 onwards equivalent to the above specified sums for the operating costs of the national headquarters.

13. The Government of Senegal through the Ministry of Economy and Finance will ensure:
- Assignment of appropriate trained personnel to all phases of Census preparation and execution;
 - A minimum of one data entry specialist and two computer systems analysts/programmers to be assigned to the Bureau Informatique for the duration of Census processing.
 - Assured access to the Ministry of Finance computer facilities.
 - Guarantee of the use of a sufficient number of vehicles during the enumeration process and appropriate logistical support for the transfer of Census materials.

Date: _____


 S.J. Littlefield
 Director, USAID/Senegal

Clearances:
 (As shown on action Memorandum)

8

SENEGAL FAMILY HEALTH AND POPULATION (685-0248)

Drafted by:

LA:Dragon

EAD

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PDO:JSchlesinger

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DDIR:CTyson

CT

ENGR:BMosley

BM
1/29/85

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APPENDIX 3A ATTACHMENT

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET		1. TRANSACTION CODE: A A = Add C = Change D = Delete	Amendment Number	DOCUMENT CODE 3
COUNTRY/ENTITY		3. PROJECT NUMBER 085-0248		
4. BUREAU/OFFICE USAID/Senegal		5. PROJECT TITLE (maximum 40 characters) Family Health and Population		
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 06 30 92		7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4) A. Initial FY 85 B. Quarter 4 C. Final FY 89		

A. FUNDING SOURCE	FIRST FY 85			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AIJ Appropriated Total						
(Grant)	(4,053)	(5,358)	(9,450)	(8,335)	(11,074)	(20,000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1.						
2.						
Host Country		1,057	1,057		7,400	7,400
Other Donor(s)						
TOTALS	4,053	6,415	10,507	8,335	18,474	27,400

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) SDP	440B	440			9,450		20,000	
(2)								
(3)								
(4)								
TOTALS					9,450		20,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) 410 460 420 450	11. SECONDARY PURPOSE CODE 410
--	-----------------------------------

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each) A. Code: BWW RPOD TNG	B. Amount
---	-----------

13. PROJECT PURPOSE (maximum 480 characters)

To achieve an effective nationwide family planning program offered through public and private sector institutions and to improve the demographic data base for more effective consideration of population factors on development planning.

14. SCHEDULED EVALUATIONS Interim MM YY MM YY Final MM YY 06 87 01 89 05 91	15. SOURCE/ORIGIN OF GOODS AND SERVICES <input checked="" type="checkbox"/> 000 <input type="checkbox"/> 941 <input checked="" type="checkbox"/> Local <input checked="" type="checkbox"/> Other (Specify) 935
---	--

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

17. APPROVED BY	Signature S. J. Littlefield	18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION MM DD YY
	Title Director, USAID Senegal	

AID 1530-4 (8-79) Clearances: LA:Dragon (in draft)
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 RCON:Jito
 HPNO:MWhite (Draft)
 DDIR:CTyson
 PRM:CSMcclusky

10

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET	1. TRANSACTION CODE: <input type="checkbox"/> A = Add <input checked="" type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	Amendment Number _____	DOCUMENT CODE 3
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COUNTRY/ENTITY	3. PROJECT NUMBER 685-0248	5. PROJECT TITLE (maximum 40 characters)
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BUREAU/OFFICE JSAID/Senegal	6	Family Health and Population
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PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 06 31 92	7. ESTIMATED DATE OF OBLIGATION (Under "D." below, enter 1, 2, 3, or 4) A. Initial FY 85 B. Quarter 4 C. Final FY 89
---	--

A. FUNDING SOURCE	8. COSTS (\$000 OR EQUIVALENT \$1 =)					
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(4,053)	(5,358)	(9,411)	(8,335)	(11,074)	(20,000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1. Host Country		1,057	1,057		7,400	7,400
2. Other Donor(s)						
TOTALS	4,053	6,415	10,468	8,335	18,474	27,400

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
		SDP	440B	440		9,411		20,000	
TOTALS						9,411		20,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) 410 460 420 450	11. SECONDARY PURPOSE CODE 410
--	-----------------------------------

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)					
A. Code	BWW	RPOP	TNG		
B. Amount					

13. PROJECT PURPOSE (maximum 480 characters)

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--	---

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

17. APPROVED BY	Signature S. J. Littlefield	Date Signed MM DD YY 07 30 85	18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION MM DD YY
	Title Director, USAID Senegal		

WD 15504 (8-79)

Clearances: LA: Dragon (in draft)
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7/30/85
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11.11.85

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Matthew Horween	Regional Controller Office
Barnabas Mosley	Engineering Office
Edward Dragon	Legal Advisor
Carrie Sembène	Supply Management Office

II. ACRONYMS

ACNM	American College of Nurses-Midwives
ANSFS	Association Nationale des Sages-Femmes Sénégalaises Senegalese National Association of Midwives
ASBWF	Association Sénégalaise pour le Bien être Familial (IPPF Affil.)
BNR	Bureau National de Recensement
B/G	Borrower/Grantee
CBD	Community Based Distribution
CBR	Crude Birth Rate
CEDPA	The Centre for Development and Population Activities
CESSI	Centre d'Etudes Supérieures en Soins Infirmiers Graduate School of Nursing
CONAPOP	National Population Commission
CRS	Commercial Retail Sales
DRPF	Division de la Recherche, Planification et Formation (Research, Planning and Training Division of the MOH)
DHPS	Direction de l'Hygiène et de la Protection Sanitaire (Division of Hygiene + Health Protection)
ENSFF	Ecole Nationale des Sages-Femmes d'Etat (National School of Nurses)
ENIE	Ecole Nationale des Infirmiers et Infirmières d'Etat
FAFS	Fédération des Associations Féminines du Sénégal (Association of Women's groups in Senegal)
FPIA	Family Planning International Assistance
GOS	Government of Senegal
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IMR	Infant Mortality Rate
ISTI	International Science and Technology Institute
IUD	Intra Uterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MCH	Maternal and Child Health
MOF	Ministry of Finance
MOH	Ministry of Health
MOP	Ministry of Plan
MSD	Ministry of Social Development
MST	Maladies Sexuellement Transmissibles (Sexually Transmitted Diseases)
MWRA	Married Women of Reproductive Age
NFP	Natural Family Planning
NGC	Non Governmental Organization
OR	Operations Research
ORT	Oral Rehydration Therapy
PCS/JHU	Population Communication Services/Johns Hopkins University
PID	Project Identification Document
PIO/C/P/T	Project Implementation Order/Commodities/Participants/ Technical Services

PMI Protection Maternelle et Infantile
 (Maternal/Child Care Center)
PP Project Paper
PSF Project Santé Familiale
 (Family Health Project)
SFHP Senegal Family Health Project
SFS Senegalese Fertility Survey
STD Sexually Transmitted Diseases
TFR Total Fertility Rate
UNFPA United Nations Fund for Population Activities
WHO World Health Organization

Family Health - in this project paper refers to an integrated program of family planning and treatment of STD and infertility.

Senegal Family HealthIII. PROJECT OBJECTIVES, RATIONALE AND DESCRIPTIONA. OBJECTIVES

1. This Project Paper proposes a 7-year, \$27.4 million project of which \$20 million will be provided by USAID and \$7.4 million by the GOS. The project is scheduled to begin mid-1985.
2. The goals of this project are a) to improve the health and wellbeing of Senegalese families by the provision of family planning and family health services, and b) to help provide an accurate and up-to-date demographic data base which will provide the information necessary to examine the relationship between economic development and the rate of population growth.
3. The project will consist of three major groups of activities:
 - a. Expansion of the current Senegal Family Health project, which is a clinic-based program organized by two GOS ministries, the Ministry of Health and the Ministry of Social Development;
 - b. Expansion of family planning/family health services into the non-governmental sector;
 - c. Assistance to improve Senegal's demographic data base so that more effective development planning can take place and to help increase the awareness of the relationship between rapid population growth and development.
4. By the end of the project it is expected that:
 - a. family planning/family health services will be available in all GOS health centers at the regional and departmental level and 25 percent of the dispensaries in the rural communities.
 - b. approximately 15 percent of married women of reproductive age will be using modern methods of contraception. (current contraceptive prevalence is estimated at about 3 percent).
 - c. the role of the private sector in delivering family planning will be greatly expanded such that services will be made more available in regions not covered by the GOS project and in highly populous urban centers;
 - d. the results of the next census will be processed, analyzed and published within three years of taking the census.

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5. It is anticipated that long- and short-term technical assistance for activities 3(a) and 3(b) will be obtained through an 8a firm, and that a PASA with the U.S. Bureau of the Census will help implement the activities covered by 3(c).

B. RELATIONSHIP OF THE PROJECT TO THE CDSS

Reducing the population growth rate is absolutely essential if Senegal is to achieve its goal of food self reliance by the year 2000. This goal is still the long-term goal of the new CDSS, submitted in March 1985. USAID has long recognized the important linkage between rapid population growth and food self-sufficiency. As a result, USAID's current portfolio includes the Family Health project which has greatly expanded the availability of subsidized family planning services in Senegal.

Since 1960, Senegalese cereal production has increased, on the average, by only 1.5% per annum. Additionally, studies financed by the USAID in the former Sine Saloum region, indicate that infant mortality may have decreased considerably since the last nationwide survey was done in 1978. Thus, given the extremely low rate of contraceptive prevalence, USAID is convinced that the crude birth rate has not fallen and that, consequently, the population growth rate is well in excess of 3.0% per annum--twice the rate of increase in food production. At the same time, out-migration to other countries, notably France, is becoming increasingly difficult while growing numbers of migrants are returning from France and other countries. These will place even more demands on the agricultural base in the future as land holdings will need to be divided among ever more family members. The urgent need to harmonize the rate of increase in food production and that of the population is more important than ever.

Based on the mission's analysis of the Senegal situation, it has proposed in the new CDSS a short-term objective of a positive per capita rate of increase in the GDP. This is to be achieved through three parallel, supporting targets: improved economic performance; increased cereals production; and a decrease in the fertility rate, from 48/1000 to 42/1000. The overall objective cannot be achieved without progress in all three of the sub-targets, making the Family Planning program one of the main pillars of any improvement in Senegal's circumstances.

As an indication of its increasing commitment to family health/family planning technical assistance, the GOS has assigned highly qualified representatives from the four major ministries concerned with population, to work with USAID as members of the PID and PP teams. These ministries are the Ministry of Social Development (MSD), the ministry in charge of population activities, Ministry of Health (MOH), Ministry of Plan (MOP), and Ministry of Finance (MOF), the ministry in charge of the census. This commitment has been reiterated as recently as March 28, 1985, when, in an address to the Economic and Social council of the National assembly, President Diouf raised the issue of the relationship between the high rate of population growth in Senegal, the problems confronting this society,

and development. He asserted that this is an issue which must be addressed to assure a certain quality of life for all citizens, now and into the next generations.

In summary, this project is becoming an increasing priority to the GOS and not only falls within the general parameters of the CDSS, but actually plays an essential role in the short-term strategy as well as achievement of the long-term goals set by the GOS and its supporters.

C. PROJECT DESCRIPTION

1. Perceived Problem

At the present time, Senegalese families suffer from distressingly high infant and maternal mortality and morbidity rates. For example, about 15 percent of infants die before the age of one (Infant Mortality Rate - IMR 140). By the age of 5, only about two-thirds of those born will still survive. It is widely recognized that if women could have more effective means at their disposal to better space their births and if related family health services were made available, there would be fewer low birth weight babies born, fewer babies would die and mothers would be stronger and healthier.

By providing couples with access to safe, effective and voluntary contraception, this project will not only improve family health, but also will enable parents to better feed, educate and care for their children.

Senegal's population of 6,500,000 is increasing at about 3 percent annually. If current trends continue, the population size will double every 23 years, each time from an ever increasing base. With a Crude Birth Rate (CBR) of 48 and an estimated Total Fertility Rate (TFR) of 7.1, the age structure of the population is such that larger and larger numbers of women enter the reproductive ages every year. The rapid rate of population increase and the concomitant high dependency ratios make it much more difficult for the GOS to provide basic health and social services for the Senegalese people.

2. Project Goal and Purpose

The goal of this 7 year, \$27.4 million project is to improve the health of Senegalese women and their children and to help achieve population growth rates compatible with Senegal's capacity to provide basic health and social services for its people. The objectives of this project are to:

- a. Improve the capacity of the governmental and non-governmental sector to provide safe and effective contraception to 15 percent of married women of reproductive age (MWRA) - approximately 200,000 couples;
- b. To provide comprehensive support to Maternal and Child Health (MCH) services, for example the detection and treatment of sexually transmitted diseases and infertility; the provision of integrated family planning at the community level.

- c. Improve the demographic data base so that more effective development planning can take place;
- d. Increase the awareness of policy makers, planners and the general community of the impact of rapid population growth on development.

D. MAJOR COMPONENTS OF PROJECT:

1. Overview of project components

This project paper describes in detail how these purposes can be achieved by USAID support to:

- The joint Ministry of Health/Ministry of Social Development Family Health Program
- Appropriate Senegalese non-governmental organizations, and
- The Senegalese Census Bureau and Population Commission.

Expansion of Family Health Services

The current USAID Family Health project is a collaborative effort undertaken by two ministries - the Ministry of Health (MOH) and Ministry of Social Development (MSD). The MSD is the ministry responsible for all family planning activities. It is staff from this ministry who have taken charge of all IEC programs in the current Family Health project. Information, Education and Communication (IEC) services have been made available in several MSD facilities, which have been renovated and equipped by project funds. The staff of the MOH are charged with clinical services. By the end of the project (July 30, 1985) family planning/family health services will be available at 22 centers in six of Senegal's ten regions. This project was evaluated in August 1984 and a copy of the executive summary of the evaluation report can be found in Annex 1.

The new project aims to increase access to safe and effective contraception by building on the momentum generated by the joint MSD/MOH program and in addition will support the development of several other service delivery mechanisms in both the public and non-governmental sectors. By the end of the project, it is expected that contraceptive services will be provided to 15 percent of MWRA (approximately 200,000 users). If such a prevalence level is reached, the Crude Birth Rate (CBR) will have been reduced from 48 to about 42 births per thousand population.

For the first four years of the project, the MSD/MOH joint program will concentrate on the current six regions of activity. During the remaining three years of the project, service delivery will be expanded by the joint program to cover the whole nation.

It is proposed that the joint MOH/MSD program expand service delivery in ten centers/posts annually for the first four years of the project and in twenty-two centers/posts annually for the last three years of the project, leading to a total of 106 service sites by the PACD. At the same time, private health care providers will receive assistance and support to add family planning to the services given to their clients. Extensive IEC efforts organized by public and private sector channels will support these service delivery approaches.

Approximately two thirds of USAID's contribution to this project (about \$14,000,000) will support the GOS family planning efforts.

This support will cover the range of activities necessary to provide dynamic and comprehensive nationwide family planning services. Over \$2,000,000 is destined for incountry and overseas clinical, management and IEC training. About \$1.4 million will provide modern safe and effective contraceptives. Other commodities, such as IEC materials, clinical equipment and medications, totalling to around \$1.7 million will be provided by the project.

In order to reach the target of 200,000 women by the PACD, it will be essential for the GOS to expand beyond their current health center urban based clinic approach and to make services available in secondary urban and rural health posts. In fact, USAID and the GOS estimate that services will have to be introduced to approximately 20% of the the health posts throughout Senegal, if project goals are to be reached. The project will renovate and equip these centers and posts so that it will be feasible to offer expanded family planning services in a safe and pleasant environment.

The project will also support diagnosis of infertility and sexually transmitted diseases - both of which are important social and health problems in Senegal.

The GOS and USAID both support the concept of integrating family planning into other activities designed to improve the quality of life of the women of Senegal. Thus, this project will fund a small number of low cost projects to both provide income generating training to women along with family planning services.

Training

This expanded effort has formed the basis for the training proposed in this project paper. For example, it is essential for Senegal to train all student midwives and as many already qualified midwives as possible. Thus, for the first two years of the project, efforts will be concentrated on providing family planning training to the faculty of the School of Midwives and integrating family planning training in the curriculum of the students. A total of at least 300 midwives will receive family planning training. Since there are insufficient midwives in Senegal to work at the health post level, this project will support the training of nurses in family planning in a manner appropriate for the Senegalese situation. At least one nurse will be trained for each of the health posts where services will be provided. (The nurse is the only state worker at this level). Technical and family planning management training will be also offered to physicians.

Information, Education and Communication (IEC)

In addition to clinical training, IEC materials for a variety of audiences (ranging from poorly educated villagers to technical personnel) will be prepared and distributed. The project will support expanded IEC efforts via local and national radio as well as television. Specially designed family planning IEC training will be integrated into the curriculum of the National Training Center for Extension Agents. These outreach agents report to the MSD -the ministry responsible for family planning. At least 350 MSD outreach personnel will be trained in family planning IEC techniques.

About \$1.5 million of project resources will be allocated for the production of IEC materials, equipment and mass media programming. Approximately \$750,000 will be provided for specialized IEC training for the many different participants in this project. For example, in addition to training the MSD outreach workers on how to educate local women about family planning and where these women may receive services, clinical personnel will also be trained to play an expanded and more helpful role in informing and educating their actual and potential family planning clients.

Senegalese Islamic leaders, many of whom have already publically stated their support of family planning, will be assisted to play a larger role in increasing the population's awareness of the health benefits of birth spacing. Other international Senegalese opinion leaders and decision makers will become involved in the project and encouraged to lend their support to this national family planning effort.

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As far as logistical needs are concerned, under the current Family Health Project, centrally funded experts have worked extensively with the MOH/MSD headquarters and clinic staff to design an efficient system to receive and distribute contraceptives and other commodities. Service statistics collection forms and inventory procedures have already been developed. A computerized management information system has been established and headquarters staff have demonstrated their ability to make sure that there are sufficient commodities at the centers and they have also trained clinical personnel on following service statistics and inventory control procedures. The new project, with its expanded management needs, will basically use the same system but emphasis will be placed on field training and feedback to the centers.

Expanded Private Sector Role

The GOS and USAID have worked very closely together to design a greatly expanded role for the private sector to play in family planning service delivery. Training, contraceptives, equipment and renovations valued at approximately \$1,500,000 will be awarded via small grants to private sector health care providers to improve the availability of family planning to the increasing number of Senegalese couples who wish to more effectively space the births of their children.

USAID feels that it is imperative to take advantage of the dynamism of the private sector if project service goals are to be reached. About half the approximately \$5 million destined for technical assistance will be concentrated on encouraging family planning services in this sector. For example, all businesses employing more than 100 people must provide their own health care services. Some of the largest of these enterprises have been contacted by USAID and all have expressed great enthusiasm towards adding family health planning services. Other organizations, such as the Red Cross, would also like to add childspacing services for their patients.

An interministerial GOS committee and USAID will review on a regular basis proposals developed by the Technical Assistance contractor and private sector organizations. Based on experience elsewhere, USAID expects this to be a most cost effective way to expand family planning services. USAID also expects that after two or three years, the GOS will become more at ease with private sector participation in family planning and will thus be more receptive to a subsidized contraceptive retail sales program.

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Technical Assistance

The technical assistance contractor will open an office in Dakar and recruit a 3 person expatriate staff and a 3 person professional Senegalese staff. The expatriate staff will consist of a Chief of Party who will be expected to provide extensive management guidance to the governmental program and private sector efforts, a midwife who will be charged with working with her Senegalese colleagues to integrate family planning in the school of midwifery, assist the MOH/MSD clinical training needs and develop the training program necessary for private sector providers. The third expatriate position is for liaison officer who will take charge of logistics for procurement, training, travel and all support services.

The Senegalese professionals will include a director in charge of private sector activities, an IEC specialist (who will spend approximately half his/her time providing t/a to the MOH/MSD efforts and half their time with private sector needs. The third Senegalese professional will be an accountant/logistician. This very important position will work with the accountant and logistician in the MOH/MSD program to establish appropriate financial and inventory control procedures.

The contractor will also provide approximately 50 person months of short-term technical assistance which will be supplemented by centrally funded t/a from ST/POP. It is expected that about four person months of centrally funded population t/a will be required annually. The centrally funded projects will concentrate on support to operations and biomedical research, logistical and management training and census related support.

Support to Census, Data Base Improvement and Policy Development

Another highly important component of this project is the census, data base improvement and policy support. About \$2.6 million will be allocated for this program which will provide Senegal with an up-to-date and accurate demographic data base upon which development plans can be formed and which clearly indicates the relationship between rapid population growth and economic development.

The activities proposed in the Project Paper are consistent with and support the Agency's priorities. USAID believes that the improved data base and IEC efforts will sensitize Senegalese leaders to the impact of rapid population growth on development and contribute to meaningful policy reform. Computerized management information systems and the provision of modern contraceptive methods are just two of the examples of technology transfer to be supported by the project. A great deal of project resources are destined to permanently strengthen the capacities of Senegal's medical institutions. Finally, for the first time, the GOS will allocate USAID funding to reinforce private sector health care provision.

The program of support for clinical training, IEC, sexually transmitted diseases/infertility, private sector efforts and census activities are discussed in the following sections and described in detail in the technical annex.

2. TRAINING

a. INTRODUCTION

Much of the success or failure of this project will depend on the quality of the training program, the vigor with which it is carried out, the care in selecting trainees and the degree to which trainees become actively employed in activities associated with project objectives.

There has been considerable training of Senegalese personnel in the past, much in the United States. However, for several reasons there is still a substantial training gap. In many instances, institutional and program development did not proceed fast enough in Senegal to take advantage of skills provided which may no longer be up-to-date. Additionally, there was little success in introducing family planning into the curriculum of pre-service training institutions like the school of nurses and school of midwives. Present graduates are nearly as lacking in family planning training as those of a decade ago. Thus, with a growing program, the training of personnel will continue to be a key requirement.

There are some new skills to be taught as more attention is given to sexually transmitted disease (STD) and sub-fertility. Additionally, it now appears possible to place more emphasis on Senegalese training institution development, providing a higher percentage of the training in Senegal and involving the Senegalese training institutions in both pre-service and in-service training.

Below is the outline of training proposed by the PP. Unless otherwise specified, the training will be managed by the joint MOH/MSD Family Health project.

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b. TYPES OF PERSONS TO BE TRAINED AND GENERAL SUBJECT MATTER**1) Physicians:**

- Those who will be directly involved in planning and providing family planning, STD or sub-fertility services will require specialized training in these skills. Some may require observation training to see how these services are delivered in other countries.
- Those such as regional and health center medecin-chefs (chief doctors) who will be involved in the organization and management of integrated health services (including family health) and will require general training in these subjects, especially in recognizing how they impact on and inter-relate with other health interventions and how to manage an integrated health program providing these varied services.

2) Nurses and midwives:

- Service providers: those who will be providing family health service in the government and non-governmental clinics will require skill training in family health. Nurse-midwives require the full range of skills including IUD insertion. Nurses should be trained to re-supply pills and provide barrier methods.
- Supervisors: those in national or regional supervisory positions in family health, primary health, and maternal-child health will require general knowledge of the impact and inter-relation of family health with other health interventions and skills in planning, managing and supervising integrated health services.
- Faculty members: faculty members, especially from the school of nurse-midwives, but also from the School of Nursing and the Graduate School of Nurses will require advanced post graduate training in family health skills, management of integrated family health programs and in some cases pedagogic methods.

3) Health center/health team:

As family health services are to be provided in an integrated fashion at the health center, all service providers in the center will require general knowledge of these subjects. They will need training in how to integrate family health into other health activities, working as a health team to provide these services. Among other aspects, attention must be given to supply management and reporting, and information and education activities.

4) Logistics and supply and service statistic personnel:

Those involved in the government and non-governmental sector in the handling and storing of materials and commodities, the maintenance of client records and reporting will require initial training in these tasks and continual on-the-job assistance.

5) Information, Education and Communication (IEC) Specialists:

A core group of specialists working in public and non-governmental sectors (media, Project Santé Familial (PSF), MOH, MSD and Ministry of Education) will require training in developing an IEC strategy, developing family life education curricula, mass media and other IEC materials, interpersonal communication techniques, pre-testing and evaluating materials.

6) Pharmacists:

The majority of the oral contraceptives now being provided in Senegal are supplied through commercial imports and are available by medical prescription in the pharmacies. Approximately 190,000 pill cycles were sold in 1983. Additionally some 350,000 condoms and spermicidal tablets were sold through these channels. There is little point-of-purchase informational material (except that which comes in the package) and pharmacists apparently are not involved in client education. Training for pharmacists should include ways to better inform the public and ways to make more efficient or less costly the provision of contraceptive service to the public.

7) Other Health Workers:

At lower levels of the health system workers such as agents sanitaires and traditional birth attendants can be provided simple training in family planning concepts.

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8) Demographers and Development Planners:

Demographers will require retraining in statistical methodology and data processing techniques.

Government planners and researchers will require training in analytical techniques for reviewing the inter-relationship of demographic growth and various development objectives.

Senegalese policy makers and program personnel will require exposure to family health delivery procedures in other countries to provide the basis for more informed judgement about the kinds of approaches that could be used in Senegal.

c. CLINICAL TRAINING PROGRAMS

1) For physicians

Le Dantec:

The SFHP will cooperate with Le Dantec and Johns Hopkins to expand the activities of the JHPIEGO regional training center to provide for a ten day course every 18 months for fifteen to twenty physicians and some nurses in modern techniques in reproductive health. The course will provide technical information on family planning, STD and sub-fertility for the physicians directly involved in the provision of these family health services either in the governmental or non-governmental sector. The methods and procedures will be taught in such a way to assist physicians in reviewing the public health impact of particular approaches and to understand the inter-relationship of these family health services with other health interventions. During the course, arrangements would be made for follow-up practical experience for those physicians requiring this additional training. For the first course Johns Hopkins professors would be expected to take a prominent role. In succeeding courses, Le Dantec faculty would be expected to carry the major responsibility with Johns Hopkins assistance.

Finances of the course would be provided by a tuition grant for each participant to Le Dantec from the project to cover University costs and the travel and per diem of participants (in accordance with USAID/Dakar policy). Johns Hopkins costs would be covered by their grant from AID/W.

The JHPIEGO training for laparoscopy will continue at Le Dantec and other regional centers but will be administered separately from this project.

Seminars on the management and supervision of integrated health, nutrition and population program:

Every two years a seminar would be organized by PSF in cooperation with the MOH/Research, Planning and Training, Division of the MOH, and MSD for physicians (and midwife regional coordinators from MOH and MSD) who are responsible for organizing and supervising the program of family health at the regional and health center level. This two week seminar, for approximately 40 participants, will deal with the issues of integrating family health services into ongoing health and social development activities. Management, supervision and evaluation will be stressed along with emphasis on better understanding of the inter-relationship of family health with various health and social development interventions. An institution with experience in these areas such as Columbia University would provide technical assistance to the seminars. Costs of technical assistance, travel and per diem of participants, facilities and educational materials would be handled by the FHP.

Short-term training at Johns Hopkins:

Three to five physicians will be sent each year to Baltimore or to other Johns Hopkins regional training sites to participate in short courses in the management of sexually transmitted diseases and infertility. Preference will be given to faculty members of the school of medicine but other physicians in lead roles in family health may also be selected. Costs would be handled by the AID/W JHPIEGO grant or the SFHP.

2) Nurses and midwives:

The program of training for nurses and nurse/midwives is described in more detail in Technical Annex I. Basically it will consist of training the Faculty of the School of Midwives and the Saint-Louis School of Health Agents. These instructors would then be able to train their own students in family planning/family health services.

3) Health Center/Health Post and Health Team

A several day visit to health centers by a field training team will be a key element in providing the skills and impetus for a proper integration of family health into the work of the local health team; improving the coordination between PSF, MOH and MSD and laying the groundwork for ongoing supervision and support. This team, composed of members of PSF, MOH and MSD regional offices, and project technical assistants, will visit each health center at least once in the course of the project. The scope of work is discussed in detail in the Technical appendix. This should provide training to approximately 400 members of local health teams (doctors, nurses, nurse-midwives, auxiliaries) in the course of the project. The costs of travel and per diem of the team and the salary of technical consultants to the team would be paid from the SFHP.

4) Logistics, Supply and Service Statistics Personnel

Essential for project operation will be the maintenance of an adequate supply of contraceptives, drugs and IEC materials throughout the system. A main basis for project evaluation and management decision will be the reports of client visits and contraceptive flow. Provision has been made for this as described in Annex 2. Three approaches to this training are described below:

Training at the clinic level by SFHP logistics supervisor at the time of the field team visit described (C) above.

A series of visits, when the SFHP supervisor will work with the center personnel to assure records are maintained correctly and to fill out the monthly reports. These visits will be carried out monthly until the system is firmly established and less often (at the time of contraceptive resupply) thereafter. This system will be decentralized as more centers are included.

Seminars on logistics and record keeping to keep personnel well informed of changes in supply and procedure. This would be once a year for the first two years of the project and less often thereafter.

5) Pharmacists

It is expected that funding to NGO's will aid the Association of Pharmacists, with assistance from appropriate Senegalese institutions, to carry out a series of seminars and training events for its members and their lead employees. Training would be provided on availability and use of contraceptives and MST drugs, and their risks and benefits. There are 100 pharmacies in the country (66 in Dakar). Training two or three persons from each establishment (a total of about 250) would require four or five one-day seminars during the life of the project. More intensive training would be required if it appears the pharmacists can be more actively involved in advertising and selling project products.

6) Other health workers

As the project progresses consideration will be given especially through operations research and actions of the regional health training team to provide training to agent sanitaires and traditional birth attendants. The American College of Nurse Midwives can provide technical assistance, especially for the traditional birth attendants.

Special programs will be required to train personnel in use of the microscope and other basic laboratory techniques required for diagnosis of common STDs.

3. INFORMATION, EDUCATION AND COMMUNICATION (IEC)

This project will build upon and expand the IEC efforts currently undertaken by the MSD/MOH project. It will also emphasize the development and evaluation of new IEC approaches. It is essential that all IEC activities be closely coordinated with family planning services since both efforts are mutually reinforcing.

The new project will concentrate on four areas:

- interpersonal approaches focused on clinics, the general public and special groups
- mass media focusing on radio, but also including TV, newspapers and magazines
- family life education focused on both in-school and out-of-school youth
- IEC Development (training, research, personnel and procurement activities to support the project.

During the last three years of the new project, all IEC efforts will be expanded to serve the remaining four regions of Senegal when family services are in place.

a. Interpersonal Approaches

- The interpersonal approaches will concentrate on the selected audience of mothers waiting in MCH clinics to receive care for their children. These women will be exposed to posters, booklets, videos and slide show demonstrations concerning family planning. Community leaders, women groups, factory workers and others will also receive special IEC programs designed for their particular needs.

- Mass Media

The use of mass media will be one of the most important aspects of the project. Research has shown that in Africa, where the majority of the citizens of many countries cannot read, the radio is the most effective means of communication. Senegal is no exception. Therefore, the greatest emphasis will be placed on production and use of radio on a continuing basis, although other methods will also be tried to promote family planning and to decrease infertility and STD.

- Family Life Education

It is important to educate the next generation about family planning. Programs for students and out-of-school youth will be designed with the help of an advisory committee. This part of the project depends considerably on technical assistance and/or sub-projects implemented by non-governmental groups.

- Project Development Activities: Training, Evaluation, Procurement, Personnel, Other

To support the expansion and development of the project, various activities will be undertaken to make sure that there are enough trained personnel, buildings or forums for discussion, information by which to guide future directions, and equipment as well as other kinds of assistance.

A full program of IEC activities necessary to implement the above will be found in Technical Appendix.

4. SEXUALLY TRANSMITTED DISEASES AND INFERTILITY TREATMENT

a. Sexually Transmitted Diseases

Although data are very incomplete, it would appear that STDs represent an important, and probably growing, public health problem in Senegal. The 1982 document, Programmation Sanitaire du Sénégal, indicated that over 16,000 cases of syphilis and 31,000 cases of gonorrhea were recognized and reported by health care personnel. Given that neither the training of health care personnel nor programmatic interest have particularly emphasized STD management, it is probable that many cases are never reported, and that these reported cases represent the tip of the iceberg.

Senegal currently boasts four centers specializing in the diagnostic, treatment and control of STD. Of these four, two are located in Dakar (the Institut de l'Hygiène Sociale and the Central STD Bureau, both of which share the same facilities), one is in Kaolack and one in Saint-Louis. Among them, these clinics served approximately 3,400 clients in 1984, of which two-thirds were males. Almost half of these clients were diagnosed as actually having an STD; gonorrhea represented a third of diagnosed cases. The GOS recognizes the need to expand its STD services and to provide better community information on the subject. In 1984, for example, it was noted that the number of individuals requesting diagnosis and treatment at the centers rose sharply each time mass media attention was directed at the issue.

STDs are important not only because of the acute morbidity they can cause, but also because of their links to other MCH and family planning issues. In Africa, STDs, in particular gonorrhea, are the major cause of male and female.

infertility. The health of the fetus and/or newborn can be severely affected by syphilis, chlamydia, gonorrhea and other STDs. The selection of family planning methods should, in part, be dictated by the epidemiology of sexually transmitted diseases and the client's own health history in this domain. It is recognized, for example, that barrier methods reduce the risk of STD transmission, and that progesterone-bearing contraceptives such as the combined and mini pills and injectable methods reduce the risk of pelvic inflammatory disease (PID), possibly by their effects on cervical mucus. The IUD may increase the relative risk of PID in women with unrecognized STD or having a high risk of contracting such an infection. The STD component addresses not only maternal-child health concerns, but also those of adult men. Project acceptability as a whole may be enhanced by recognition of this aspect. The need to give the STD problem due recognition, the interest of the GOS in strengthening the STD program, and the clear ways in which such activity dovetails with primary health care and family health concerns, all point to the desirability of including this component in the Family Health Project.

b. Infertility

It is thought that the single most common cause of infertility in Africa is STD, in both males and females. Other causes include poor obstetrical care resulting in pelvic infections, and ovulatory failure brought on by a number of hormonal dysfunctions of which the etiology is frequently unknown. In Senegal, the proportions of cases of infertility due to different causes has not been quantified.. As in the case of STD, the prevalence and geographic and demographic distribution of infertility in Senegal is also unknown. Survey data from Sine Saloum indicate that in that region the extent of the problem was not severe, particularly in the younger age group: over 96% of younger women (15 to 24) reported having been pregnant during the last three years (final report, Sine Saloum Family Health survey, 1982).

It is possible that several distant northeastern regions of the country fall within the belt of low fertility which has been identified in Central Africa (Retel-Laurentin, A., Infécondité en Afrique noire: maladies et conséquences sociales. Paris, Masson, 1974). More importantly perhaps, Senegal is a Moslem country in which childlessness is perceived as a major hardship, particularly for the woman. Given the probability that the incidence of STD is increasing, with concomitant effects on fertility, timely actions may be in order.

A full explanation of USAID's role in assisting the GOS in its efforts to combat STD and infertility can be found in the Technical Appendix.

5. PILOT WID PROJECTS

These projects will be established in areas in which family health activities are already underway. The target groups will be grass roots, self-help women's organizations.

The WID project, not to exceed two-years' duration, should be a means of motivating their beneficiaries to participate more fully in the activities promoted through the SFHP.

a. Targeted Objective:

The objective of these accompanying projects is to help integrate women into the rural development process while being exposed to the beneficial efforts of improved maternal and child health and family planning.

b. Types of project envisioned:

- garden projects/truck gardens
- small livestock (either starting new herds or enlarging old ones)
- community poultry-raising projects
- furnishing materials to lighten women's tasks:
i.e., grain mills, water pumps, husking machines, etc
- small-scale craft activities (cloth dying, sewing, etc.)
- information and educational activities promoting family planning and family well being

c. Locations:

These projects will be initiated in the following regions:

- Ziguinchor	12 women's groups
- Kaolack	12 women's groups
- Thies	12 women's groups
- Fatick	8 women's groups
- Kolda	6 women's groups
- Dakar	12 women's groups

The criteria for selecting the groups will be based on the motivation, dynamism and soundness of the goals of the group and the proportion of financing the group is willing to assume. As much as possible these projects will be initiated in areas where the "cases foyers" (training huts) are already in place.

d. Implementation of the project will be as follows

- Creation of a planning/coordinating body composed of representatives from the Ministries of Social Development and Health, USAID and the SFHP to oversee correct project implementation
- Organization of information meetings on the project objectives/philosophy. This will be the responsibility of the director of SFHP.

- Correct financial management and oversight of the activities of the project will be the responsibility of the MSD.

e. Expected coordination of project's organizers and beneficiaries:

The beneficiaries agree to:

- furnish the manpower for all non-specialized activities of the WID projects;
- help finance the project;
- continue the project even after depleting funds received from SFHP;

The GOS for its part agrees to provide logistics support to the projects.

The SFHP will allocate a maximum of \$7,500 for each project with a total grant of \$375,000. This grant, destined only for materials and equipment purchases, will be managed by the technical assistance contractor.

f. Expected results:

- Improvement of the quality of life of the beneficiaries
- Increased awareness of importance and benefits of family planning for their health and that of their children
- Spillover effect of these benefits/possibilities to other villages and zones outside of project area.

g. Evaluation:

The WID projects will be evaluated along the following lines:

- A system of data gathering will be set up to monitor and manage project activities.
- Reports will be submitted to USAID every trimester.

h. Institutional framework:

The MSD (Office of Women's Concerns) is the coordinating body for the accompanying projects in cooperation with the coordinators of regional and departmental women's projects involved with the SFHP.

6. NON-GOVERNMENTAL SECTOR ACTIVITIES

There is a growing recognition that governmental actions can be usefully supplemented by those of the non-governmental sector in extending health services to the population. Reference is made to a 1985 report by Alpha Dieng the former Deputy Minister of Health, which documents the strength of the private and semi-private sector in providing health care. The non-governmental sector portion of the project (less than 10% of the total) expects to stimulate this activity and channel it into areas in support of the objectives of the Family Health project.

In order to maintain flexibility to respond to changing ideas and institutions, family health projects will be developed with a variety of Senegalese NGOs. A technical review committee will be established, with representatives from the ministries of Health and Social Development, the BNR and USAID. The technical assistance contractor will serve as the executive secretariat of the review committee and work with non-governmental organizations to develop projects for approval. The contractor will assist in implementation. The contractor will hire an accountant to handle the financial management.

The project remains open to any organization in the non-governmental sector (including para-statal), registered with the GOS, that wishes to present a project in support of the objectives of the family health and population project. A list of examples are provided in Annex 2 of the kinds of projects expected in the area of family life education, family planning services, training, or small research activities. Initially, smaller projects would be encouraged but later the size could be expanded. It is expected that about 65 sub-projects totaling \$1.5 million may be approved over the life of the project, according to the following time schedule:

NUMBERS OF NON-GOVERNMENTAL ACTIVITIES PLANNED

Project Year	1	2	3	4	5	6	7	Totals
Training	30	80	100	120	120	100	50	600
IEC materials	30	60	60	60	40	30	20	300
Contraceptives/Medicines/Materials	30	70	90	90	80	70	-	430
Repairs/Renovations	20	20	20	30	40	40	-	170
						Total		1500

	1985	1986	1987	1988	1989	1990	19
NGO Activities	--	7	10	12	12	12	1
COST (\$000)	--	50	100	250	350	350	40

7. TECHNICAL ASSISTANCE ACTIVITIES WITH THE CENSUS BUREAU, GOS

a. Introduction

The goal of the seven-year Family Health and Population Project is to improve the health of Senegalese women and their children through more effective birth spacing and to achieve population growth rates consistent with GOS ability to provide for basic health and social services. One purpose of the project related to this goal is to ensure that sufficient demographic survey and analytical capability exists to inform policy makers of the impacts of rapid population growth.

Thus, the following section describes the technical assistance, training and equipment to support the Direction de la Statistique (DS) in its implementation of the 1987 census of population and housing and a specialized intercensal survey program. In particular, support will be given to two bureaus within the DS: 1) the Bureau National de Recensement (BNR), responsible for census implementation; and 2) the Bureau Informatique (BI), responsible for census processing operations.

This component of the project will cover the following major technical areas:

A PAFSA with the U.S. Bureau of the Census (BuGen) to provide short-term technical assistance for: cartographic activities; census questionnaire design and table specifications; data processing; preparation and implementation of the post-enumeration survey; and post-census analysis activities.

The technical assistance will take the form of in-country workshops, on-the-job training and some training at BuGen's headquarters in Washington.

The project will also provide basic equipment and logistical support necessary to implement a census successfully.

Post-census project activities will emphasize data analysis and making the implications of the census accessible and useful to development planners. A series of national and regional surveys will be designed to help evaluate health and family planning activities and to guide future program development.

The PP also proposes a variety of short and long term training designed to institutionally strengthen the BNR. Full details of this component of the project can be found in the technical appendix.

AID inputs for this project component will be supplementary to the inputs of the Government of Senegal (GOS). In addition, the United Nations Fund for Population Activities (UNFPA) will provide supplementary financial support to the GOS for census operations.

b. Component Description and Background

1) Justification for 1987 General Census of Population and Housing

The GOS had scheduled a Census of Population and Housing for 1986. However, due to the lack of financial resources, particularly directed to cartographic activities, it was postponed until 1987. Such problems have often led national leaders and international donors to relegate the need for a decennial census to a low priority. However, in the case of Senegal, both USAID and UNFPA recognize the census as a fundamental tool for development planning. It serves as the benchmark for comparison with censuses and other surveys; it provides basic demographic data not only for administrative jurisdictions but also for education and electoral districts and health care service areas or any geographically identifiable area. When completed periodically (customarily every ten years), censuses provide information against which change over time can be measured and projections made.

2) Strategy

Attainment of the project purpose requires both available data and its use in planning, operating, and evaluating family health programs. The strategy is two-fold: the first is to provide the Direction de la Statistique (DS) with an increased capacity to meet family health information needs within the limits of modern census and survey practices. This involves more than the collection and processing of data and the publication of results. It means careful attention to questionnaire and survey design, quality control at all steps of the process and the ability to retrieve, statistically analyze, and interpret data for specific purposes.

3) General Schedule of Census Activities

The census activities are divided roughly into four phases: (1) preliminary activities; (2) preparation for the enumeration; (3) the enumeration itself and the post-enumeration survey; and (4) the processing, publication and analysis phase. The four phases are summarized below.

a) Preliminary Activities

These consist of the promulgation of the legislative texts establishing the 1987 census as an official government activity, and the reinforcement of BNR staff for the duration of the census project. This is currently scheduled for July 1985.

b) Preparation for Enumeration

During this phase, scheduled to begin in August 1985, the BNR will maintain contacts with potential users of the data, as well as with regional authorities, and will receive visits from ECA experts in census and data processing operations. The BNR will also begin preparation of the technical documents necessary for a well-conducted census, including the tabulation formats, the questionnaire derived from these tabulations, the specifications for validating (by computer) the data to be collected with the questionnaire, and all internal manuals and training documents. Perhaps the most important operation to be undertaken during this phase will be the cartography, which is scheduled to continue throughout 1986.

However, BNR is planning to give first priority to the mapping of the areas to be used during the Pilot Census, which is currently scheduled for the second half of April 1986. The results of the Pilot Census will be evaluated and will be used to make final modifications to the census questionnaire and enumeration procedures. During this period BNR will also begin the publicity campaign designed to make the populace aware of the importance of the census activity and encourage cooperation.

c) Enumeration Activities

During this phase, scheduled to begin in March 1987, BNR will begin the training of the more than 9000 persons who will be actively involved in the enumeration itself, which is currently scheduled for the second half of April 1987. (This date may be changed if it conflicts with Ramadan).

The post-enumeration survey, which at this point is intended only to measure coverage, is planned for the second half of May 1987.

d) Processing, Publication, and Analysis

Immediately following the enumeration phase, the completed census questionnaires will be returned (via local and regional offices) to the central office, where the Bureau Informatique (BI) of the Direction de la Statistique will assume responsibility for their processing.

This procedure will encompass five distinct phases: 1) check-in of questionnaires; 2) manual editing and coding, and verification of such; 3) data entry and verification of keying; 4) computer editing of keyed data (for valid values and consistency between items); and 5) emission of tabulations.

It is currently estimated that the processing phase will last at least two years, although BNR plans to begin publication of the tabulations, on a regional basis, approximately 15 months after the enumeration date. BNR estimates that the total time required to produce the planned tabulations will be approximately 10 months.

Analysis of the census data is scheduled to begin in July, 1989, when (presumably) all the tabulations will have been published. This activity will require approximately one year, ending the 1987 census operations by mid-1990.

4) Component Activities

a) Management

The implementing institution for the 1987 Census is the Bureau National de Recensement (BNR) of the Direction de la Statistique (DS) of the Ministry of Finance. The BNR has a small staff of approximately 48 persons, among whom are included 13 Statistician-Demographers, 5 Statisticians, and 12 Statistical Agents. In addition, there are 3 cartographers. Data processing of the Census will be accomplished by the staff of the Bureau Informatique (BI) of DS.

Staff of the BNR will be augmented during the Census period by inter-ministerial transfers of skilled personnel. This will be necessary, given the small size of the BNR staff and the fact that few of the staff worked on the previous Census.

The Census requires the support and close collaboration of other GOS institutions. Among the most important are the Ministry of the Interior, which will provide guides to remote rural areas; the Ministry of Defense, which will provide logistical support; and the Ministry of Finance, which will provide computer facilities.

b) Technical Assistance

The technical assistance, to be provided primarily by a PASA with the U.S. Bureau of the Census, will be short-term designed to facilitate BNR Census preparation and implementation activities. The short-term assistance will focus on: 1) cartographic activities; 2) questionnaire design and table specifications; 3) data processing preparation and implementation; 4) the development and execution of a Post-Enumeration Survey; and 5) post-Census analysis activities.

i. Cartographic Activities

Technical assistance in Census cartographic activities will be provided by the U.S. Bureau of the Census. A cartographic workshop tentatively scheduled for September 1985 will be funded by an agreement between the U.S. Bureau of the Census and AID/ST/POP. If approved, it is anticipated that an agreement between the U.S. Bureau of the Census and AID/AFR will provide funding for short-term technical assistance, cartographic equipment and materials, per diem for BNR staff, and salaries for temporary BNR staff carrying out the mapping program.

The Family Health and Population Project will not include funding for cartographic technical assistance. It will fund the following commodities for the field mapping program: four vehicles, gasoline and motor oil, and miscellaneous expenses (e.g. guides, boat rentals, vehicle repairs, etc).

ii. Questionnaire Design and Table Specifications

The BNR has not yet developed a detailed list of questionnaire content. In general, however, BNR has stated its intent to include housing questions in the 1987 Census. The 1976 Census contained only population questions.

A survey statistician from the U.S. Bureau of the Census will assist in the development of a tabulation plan with draft table formats (outlines) that specify the output desired from the Census. From these table formats, the content of the Census questionnaire, in terms of variable and their indicators, will be established. Once established, questions and question sequences will be developed to obtain data on the chosen variables. Finally, the questionnaire itself will be designed to facilitate enumeration and processing.

A data processor will carefully review the draft questionnaire to assure that it can be easily keyed and processed. Working with the questionnaire, the table outlines, and the estimated number of households, the data processor will recommend a software system for processing the Census.

iii. Data Processing Preparation and Implementation

Data processing/systems analysis technical assistance will be provided by the U.S. Bureau of the Census.

CENTS 4 (CENSus Tabulation System, version 4) is a generalized computer software package written in structured COBOL. It produces statistical cross-tabulations of census and survey data in a format which permits publication of tables without further manual preparation. A team of data processors will install the package and teach a three-week course to the available Senegalese programmers. The course will include formal lectures and hands-on application of the package, with specific reference to the tables required for the 1986 Pilot Census.

Training will also be given in CONCOR (CONsistency and CORrection), a generalized computer software package written in structured COBOL which has already been installed on the computer at the Ministry of Finance. CONCOR identifies missing, invalid, or inconsistent data in census and survey files. It can also perform automatic imputation procedures to correct these errors. This assistance will also be given by a team of programmers in a three-week workshop which will emphasize census applications.

Both CENTS 4 and CONCOR will greatly facilitate Census processing by reducing the amount of custom programming necessary. Given that the very limited programming staff available to DS has had no experience in processing a census, these packages will facilitate their work because less experience is required to use them than to write custom COBOL programs.

In addition, BI supervisory personnel will be trained in the use of a data entry software package which will permit the utilization of microcomputers for the data entry process. While training BI personnel in the use of these packages, the Census Bureau advisors will work with them to develop the specific programs to be used during the actual data entry.

After completing the data entry software, the BI analyst responsible for processing the Census will work with the Census Bureau counterpart in developing the overall system for this activity. This will include a general flow chart of the system, specific and detailed charts of the individual elements in the system, and detailed specifications for any custom-coded programs required. During the development, testing and production phases of this system, Census Bureau advisors will monitor activity of BI personnel.

iv. Development of a Post-Enumeration Survey

No matter how careful statistical offices are in carrying out a census program, errors will inevitably result, most typically from failure to follow correct enumeration procedures, omissions, etc.

An assessment of the impact of the errors is required in order to determine the reliability and completeness of the Census data. One way to do this is to compare the results of the Census with the results of a post-enumeration survey conducted soon after the Census itself.

Mathematical statisticians from the U.S. Bureau of the Census will conduct a workshop on census evaluation and post-enumeration surveys. Participants will learn concepts and techniques of post-enumeration surveys, as well as alternative procedures and definitions associated with coverage error. Content of the PES questionnaire will be decided and preliminary matching rules and procedures will be developed.

Additional technical assistance will be given in the areas of preparation of a sample design and statistical plan for the post-enumeration survey, field observation of the PES, and development of estimation methodologies.

v. Policy Development

In order to assure that the results of the Census are made available to GOS planners in a useful and appropriate manner, the BNR will undertake the following activities:

- participate in an in-country training seminar to review the methods by which Census data can be made more useful to development planners (mid-1988);
- hold a workshop for GOS ministries and other interested parties detailing the major findings of the Census, inter-censal trends, and the implications for development planning (mid-1989);
- meet individually with the major groups who must use Census data for their planning and assist these groups by the preparation of special analyses and computer models (mid-1989 to 1991);
- produce a report which analyzes the results of the Census in a way useful to non-statisticians who nevertheless need to be cognizant of demographic trends (late 1989).
- The bilateral project will provide support for the workshop and training costs for the special reports. It is expected that central resources such as INPLAN will provide the necessary technical assistance.

c) GOS Logistical Support

Little logistical support is required for the short-term consultants provided by USAID, except for the following:

- DS/BNR guides for field trips taken to observe the data collection of the post-enumeration survey; and
- Classroom, supplies, and an overhead projector for the CENTS 4, CONCOR, and PES workshops.

d) Technical Analysis

The BNR staff identified three areas for which they considered technical assistance to be appropriate: cartography, data processing and analysis, and design of a master sampling frame. A plan of technical assistance outlined in the following Implementation Plan will correspond with these objectives.

Although the National Census of Population and Housing itself provides data on basic demographic, educational, and employment characteristics of the population, it is preferable to conduct small-scale sample surveys in order to collect detailed information on health, migration, fertility, and mortality. In order to successfully implement such surveys, it is imperative that a statistically sound national sample be identified which can be used in the design of thematic surveys, such as are planned to take place during the 1987-1997 intercensal period.

The remaining area for technical assistance is the preparation, execution, and processing of a post-enumeration survey (PES). A PES was conducted after the 1976 Census of Population, but review of the published methodology and discussions with BNR staff indicate that the survey was in fact not conducted independently of the Census and that its usefulness in determining completeness of coverage was therefore limited.

e) Work Plan

i. U.S. Bureau of the Census Role and Contractual Arrangements

The U.S. Bureau of the Census will provide technical assistance and training in questionnaire design and coding; development of specifications to code, edit, and tabulate the data; overall planning for the data processing; data processing activities and software; sampling, design, and estimation methodology for the post-enumeration survey to evaluate coverage; and preliminary design of a master sampling frame. Assistance would be collaborative in nature and would correspond to actual scheduled Census activities.

The assistance provided by the Census Bureau will be specified in a PASA negotiated between AID and the Census Bureau. The PASA will include a scope of work for technical assistance and will cover personnel costs (including salaries and benefits), travel and per diem costs, training fees and expenses, miscellaneous costs such as translation costs and computer time, and Census Bureau overhead.

The technical appendix contains a preliminary scope of work for the U.S. Bureau of the Census short-term advisors, schedule for Census Bureau technical assistance activities.

ii. Additional Assistance

Additional assistance for Census activities is being provided by the United Nations Fund for Population Activities (UNFPA). More specifically, the UNFPA is supporting the Pilot Census, a publicity campaign, part of the enumeration activities, and printing costs of questionnaires, manuals, summary pamphlets, and eleven reports of raw data (one national report and one for each of the ten administrative regions in Senegal). It is not clear whether technical assistance will be offered during the course of any of these activities; none is specified in the project agreement between UNFPA and the GRS.

Additional short-term technical assistance for data analysis and survey activities will be provided through contractual agreements between AID and private consultants or other non-governmental entities.

IV. COST ESTIMATE AND FINANCIAL PLAN

The Senegal Family Health and Population Project (SFHPP) totals \$27.4 million of which USAID will finance \$20 million and the Government of Senegal \$7.4 million. The USAID contribution will be in the form of grant funds and represents 74% of total project costs. The Senegalese contribution of \$7.4 million represents 26% of project costs and will be provided in local currency equivalent, chiefly the contribution of personnel and facilities for project services.

The table below shows USAID estimated project expenditures for different categories of project costs. Table II details the allocation of the initial \$9.4 million obligation. A more detailed budget is contained in the economic analysis annex. Government of Senegal contributions are found in Tables III and IV. Table V presents the method of implementation and financing.

TABLE I: SUMMARY PROJECT COSTS: USAID CONTRIBUTION

Item	Foreign Exchange (\$000)	Local Currency (\$000)	Total AID Contribution (\$000)	Percent of Total USAID Contribution
Training	634	2,520	3,154	16%
Commodities (excluding contraceptives)	1,407	1,371	2,778	14%
Contraceptives	1,667	0	1,667	8%
Technical Assistance	3,229	1,039	4,268	21%
Renovation	0	750	750	4%
Operations (including salaries)	0	2,855	2,855	14%
Outreach (IEC)	30	716	746	4%
Data Base Improvement	100	500	600	3%
Subtotal	7,067	9,751	16,818	-
Contingency	875	1,118	1,993	10%
Subtotal	7,942	10,869	18,811	-
Inflation 5% compounded	689	500	1,189	6%
Total	8,631	11,369	20,000	-
				100%

Table I shows the provisional estimated breakdown of USAID project expenses in terms of foreign exchange and local currency costs. Of a total USAID expenditure of \$18,811 million before inflation, approximately 42 percent will be in dollars (\$) and approximately 58 percent in local currency (CFA).

A contingency allowance of 10 percent per year has been included on most major line items including a portion of the technical assistance provided by an 8A contractor.

An inflation allowance of 5 percent compounded annually has been included. The choice of an inflation rate is problematic, particularly for a seven year project. While the inflation rate in the U.S. has been somewhat lower than 5 percent in recent years, prospects for the future are uncertain. One mitigating factor is that the price trends for major commodity items such as contraceptives have been decreasing.

Other major local currency items such as vehicles and computers will be purchased early in the project and this will tend to insulate these prices from the impacts of compounding inflation.

Another planning uncertainty is the exchange rate between the dollar and the CFA. In light of recent dramatic fluctuations in the exchange rate, a conservative rate of 400 CFA to the dollar is assumed. At the time of this writing, the rate is actually 470 CFA/\$1, a rate 17.5 percent higher than the one used in the project budget. It is believed that this conservative estimate will provide extra flexibility in the budget to deal with any excess inflation that might occur.

The census sub-project budgeted at \$2.6 million represents 13% of the USAID contribution and 9.5% of the total combined GOS-USAID project budget. The GOS Projet Santé Familiale Budget (\$10.7 million) represents 54 and 39 percent of the USAID and total project budgets, respectively. The non-governmental (NGO) sub-budget (\$1.5 million) represents 7% of the USAID and total project budgets.

The remaining sub-section of the budget is technical assistance (\$4.2 million before inflation). Technical assistance comprises 21% and 15.4% of the USAID and total project budgets.

Table II shows the planned disbursements for the initial allocation of funds.

TABLE II: INITIAL OBLIGATION

<u>Item</u>	<u>YEAR</u>		
	<u>1</u>	<u>2</u>	<u>3</u>
		<u>(\$000)</u>	
Training	236	337	756
Commodities (exclud. contraceptives)	464	466	306
Contraceptives	105	176	286
Technical Assistance (includes Accty)	1,112	964	811
Renovation	199	109	108
Operations (including salaries)	364	418	386
Outreach (IEC)	305	401	118
Contingency/Evaluation	179	179	217
Subtotal	2,964	1,050	2,988
Inflation F. (5%)		.05	1.1
Total	2,964	3,203	3,283
Cumulative Total		6,167	9,450

GOVERNMENT OF SENEGAL CONTRIBUTIONS

The GOS will contribute a range of facilities and personnel to the SFHPP. In terms of the MSD/MOH program (Projet Santé Familiale), it will be asked to designate space and staff to deliver project services in 56 health centers and approximately 70 health posts by the end of project. The implementation plan for expanding services to health centers and posts is shown in Table 4 along with personnel needs. Currently 20 health centers provide family planning services in 6 of 10 regions of Senegal. At the EOP, the GOS will be providing service in 126 facilities in all 10 regions of Senegal. It should be noted that the facilities called for under the project currently exist and are operating. The only construction supported by the project will be very simple huts for the outreach efforts of the MSD. Therefore the project requires only minimal new operating costs. Minor renovations will be required in some of the centers and posts to make them appropriate for extending family planning services. Anticipated renovations in centers and posts are budgeted at \$380,000 over the life of the project with the major share of renovation expenses falling in the first three years of the project. By the EOP, renovations in clinics and posts providing family planning services in every region will be completed.

The GOS will contribute facilities in Le Dantec hospital, the IHS lab. and other hospitals and centers for use in the Infertility and Sexually Transmitted Disease project component. The project will pay approximately \$200,000 for equipping these hospitals to serve as regional centers for infertility and sexually transmissible disease diagnosis and treatment.

The major GOS contribution to the SFHP is personnel. Required personnel include midwives, midwife assistants, guardians, and supervisory and headquarters staff.

Project headquarters staff to be made available by the GOS include a project director, a director and deputy director of IEC, and a director of clinical services.

The project will pay salaries and benefits for current headquarters staff budgeted at approximately \$57,000 per year for a period of four years. Beginning in project year 5, the GOS is scheduled to assume the salaries of government employees working at the project headquarters .

In addition, the GOS has agreed to progressively take over the expenses for gasoline and the operating costs of the national headquarters so that by the end of the project 100 percent of these costs will be absorbed by the GOS. GOS-absorbed costs are equivalent to about \$370,000.

The value of salaries and facilities contributed by the GOS to the project are estimated in Table 3 and 4. Table 3 shows the GOS personnel and facilities required, while Table 4 shows the imputed value of these contributions.

TABLE III

GOS PERSONNEL AND FACILITIES REQUIRED BY
YEAR OF PROJECT

	1	2	3	4	5	6	7
ISD/MOH Program							
no. of facilities	32	42	52	62	74	86	98
midwives/nurses*	48	63	78	93	111	129	147
outreach workers*	64	84	104	124	148	172	196
midwife assistants*	64	84	104	124	148	172	196
guardians*	16	21	26	31	37	43	49
headquarters staff*	-	-	-	-	3	3	3
full-time equivalent							

This project does not propose that the GOS hire any new staff. Rather, it is proposed that the midwives, nurses, outreach workers, assistants, guardians, etc., currently employed by the GOS be assigned to this project. There are about 400 midwives working currently for the GOS. The School of Midwifery graduates about 40 new midwives a year. During the life of this project, the number of graduates will be reduced to about 20 per year. Therefore, it will be particularly important for the GOS to assure the availability of the midwives in the long-term. It is not proposed that the GOS construct new facilities - the buildings for the services currently exist. The project will provide limited construction and renovations.

In order to have some estimate of the dollar value of these host country contributions, the following assumptions have been made:

TABLE IV

Salaries of midwives/nurses at \$2,500 per year increasing 10% annually	\$2,012,000
Salaries of outreach workers at \$1,500 per year increasing 10% annually	1,934,000
Salaries of midwife assistants at \$1,500 per year increasing 10% annually	1,934,000
Salaries of guardians at \$1,50 per year increasing 10% annually	483,000
Gasoline and operating expenses at headquarters	368,000
Salaries of GOS headquarters staff	50,000
Provision of facilities (including operating expenses and some equipment) estimated at \$1,000 annually per center increasing 10% annually	639,000
	<u>\$ 7,420,000</u>

METHOD OF IMPLEMENTATION AND FINANCING

Table V outlines the planned method of Implementation and Financing. The project will use either direct payment or Federal Reserve Letter of Credit as methods of financing unless a decision is made to use a local bank account as discussed below.

In the event that a local project bank account is opened, the disbursements would total approximately \$300,000 per year, mostly for salaries, incountry travel costs, per diems, vehicle repairs, operating costs of project headquarters and local purchases (such as IEC materials).

If a GOS local bank is used, the project will use a USAID-designed accounting system which will provide a cash receipts/disbursements journal identifying each payment by project budget line item. AID funds will be segregated. A local CPA firm will be hired to set up an inventory control system and to perform an annual audit of the account. If the account is to be managed by the technical assistance contractor, it will be audited by the Defense Contract Audit Agency or RIG according to their normal procedures for auditing contractors.

The USAID/Senegal Regional Controllers Office has reviewed the MDS's local account of the Current SFHP and is satisfied with its management. A 121(d) certification has been issued certifying to the MSD's ability to manage this account. (See Annex A.5.)

TABLE V

<u>MODE OF ASSISTANCE</u>	<u>CONTRACTING MODE</u>	<u>METHOD OF PAYMENT</u>	<u>AMOUNT \$000</u>
I. <u>Technical Assistance</u>			
A. GOS census Bureau	PASA with U.S. Bureau of Census	Direct payment/ RCOM	554
B. MOH/MSD program plus private sector efforts	AID Direct Contract with 8a. firm	FRLC	3,714

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II. Training

A. GOS census Bureau	PIO/P	Direct payment AID/W	
(i) long-term			300
(ii) short-term (overseas)	PIO/P	Direct payment/ RCON	100
(iii) in-country	AID Direct Contract	RCON	47
B. MOH/MSD + Private sector	AID Direct Contract	FRLC	500
(i) long-term			
(ii) short-term (overseas)	AID Direct Contract	FRLC	1,406
(iii) in-country	AID Direct Contract	FRLC	800
III. <u>Construction/ Renovation</u>	USAID Direc Contract	Direct Reimbursement	750

<u>MODE OF ASSISTANCE</u>	<u>CONTRACTING MODE</u>	<u>METHOD OF PAYMENT</u>	<u>AMOUNT \$000</u>
IV. <u>Commodities</u>			
A. Contraceptives	PIO/C	Direct payment AID/W (ST/POP)	1,667
B. Vehicles/ computers	Direct procure- ment/USAID-S/O	Direct payment/ RCON	466
C. Other	AID Direct Contract	FRLC	2,623
V. <u>Applied Research/ Data base Improvement</u>	AID Direct Contract	FRLC	658
VI. <u>Operations</u> (inc. salaries)	AID Direct Contract	FRLC	,858
VII. <u>Evaluation</u>	USAID Direct Contract	Direct payment/ RCON	150
		TOTAL PROJECT	16,593
		Inflation	1,780
		Contingency	1,627
		GRAND TOTAL	20,000

USAID and the GOS have discussed in great detail the long term financial viability of the project. As a result, the project financial plan is structured to gradually increase the GOS contribution to selected recurring costs. By the end of the project, the GOS will assume 100 percent of the operating costs of the national headquarters and all gasoline costs. This GOS contribution will total approximately \$370,000. GOS responsibility for these costs will be covenants in the ProAg along with agreement to allocate funds for these expenses in their national budget in advance. By this procedure, USAID will be alerted if the GOS will have difficulty in meeting these obligations.

The recurring costs of the projects are expected to be relatively low. Family planning services will be offered in already existing health structures. The GOS will not be expected to hire additional personnel since the project will emphasize technical and management training of personnel currently hired.

Further details of recurring costs and related issues are given in the Economic Analysis of the PP.

V. IMPLEMENTATION PLAN

A. Responsibility for Implementation

The MSD will be responsible for the overall implementation of Family Health Project activities. It will be the responsibility of the MSD to establish working procedures with the MOH to ensure that Family Health activities are integrated into the existing health structures and take place under the direction of the appropriate medical personnel.

A representative from the Ministry of Social Development will be assigned as the overall director of the Family Health Project. The MSD will also assign two national coordinators for IEC work and a coordinator for every region for FH/IEC activities. The MOH will assign a national coordinator for clinical services and a coordinator for these services in every region. The MOF will be responsible for the census and demographic data collection and analysis activities supported by this project. The MOF will assign the overall responsibility for these activities to the Director of the BNR .

The technical assistance contractor will provide resident and short-term technical advisors and will also be responsible for the financial management of the NGO projects and assisting with the financial management of the MOH/MSD program, coordination of training outside of Senegal and commodity procurement. The US Bureau of the Census will provide short-term technical assistance to the BNR. An independent financial organization will be responsible for the financial management of the census-related activities.

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The USAID population officer will be responsible for assisting the technical assistance contractor to become functional in Senegal and overseeing the adherence of project activities to the project objectives and goals.

A detailed account of the responsibilities of the technical assistance contractor can be found in Annex 3.

B. Work Plan

The timetable for major project implementation activities is as follows:

<u>Activity</u>	<u>Date</u>
1. Project Paper Approved by Director	August 1985
2. ProAg signed by GOS and USAID	August 1985
3. Technical Assistance contract signed	September 1985
4. Local technical assistance team hired	October/Nov. 1985
5. Technical Assistance team in country	November/Dec. 1985
6. Interministerial GOS and USAID review committee formed to evaluate private sector family planning proposals.	January 1986
7. Detailed workplan established for t/a census cartographic and data collection activities.	January 1986
8. First project evaluation	August 1987

In order to achieve the goals of the project, it is absolutely essential that a sufficient number of skilled and motivated personnel from the MOH, MSD and MOF be assigned to project activities. Logistical support in terms of use of GOS facilities and vehicles will also be required.

In order to achieve the target of 200,000 active contraceptive users by the end of the project, a total of 106 health facilities will be renovated consisting of 36 health centers and 70 health posts

This expansion of service delivery, as explained elsewhere in this PP, implies greatly increased training, logistical support, IEC programs and strong management structures.

Detailed year-by-year charts showing the breakdown of activities covering IEC programs, training (in-country and overseas) and clinical services follows. A detailed explanation of these activities can be found in Section III and in the appropriate technical appendix.

Procurement Plan

This project will procure technical services and commodities. Procurement waivers for vehicles and computers can be found in Annex 4. Tables 1-12 in Annex 5 provide a detailed schedule of all procurements, including contraceptives, over the life of the project. The technical assistance contractor will take responsibility for all procurements, except for contraceptives, which will be procured by AID/Washington, and vehicles and computers.

D. Contracting for Technical and Training Service

Technical Assistance

The technical assistance will be provided by the International Science and Technology Institute (ISTI) and will be designed primarily to aid the joint MOH/MSD, Senegal Family Health and the project activities of the non-governmental sector. ISTI will open an office in Dakar which will serve as a meeting and training locale for NGO activities. The office will provide logistics support to all other contractors/grantees associated with the population program in Senegal.

IEC IMPLEMENTATION PLAN

ACTIVITIES	YEAR						
	1	2	3	4	5	6	7
<u>Presentations and Causeries</u> - <u>Nos of presentations</u>							
- at clinics							
- at villages and urban areas	50	100	200	300	500	500	500
- to groups	10	15	15	15	20	25	30
- special events	1	3	2	3	2	3	2
<u>Training</u> - <u>Persons trained</u>							
<u>Out-of-Country/Staff</u>	6	6	6	6	6	6	6
- Regional social agents	50	50	50	70	70	70	70
- Health educators	25	25	25	25	25	25	25
- Leadership training	20	-	20	-	20	-	20
- Audiovisual training	20	20	20	20	20	20	20
<u>Out-of-Country Study Tours</u>							
- Religious/Political Leaders	5	5	5	5	5	5	5
<u>Materials</u>							
a) <u>Materials produced</u>							
<u>Posters</u> (types)							
- Clinical	3	3	2	2	1	1	1
- Promotional	3	3	2	2	2	2	2
- Educational (School programs)	-	-	2	2	3	1	1
<u>Booklets</u>	2	2	1	1	1	1	1
<u>Pamphlets</u>	1	2	-	-	-	-	-
<u>Calendars</u> (types)	3	3	3	3	3	3	3
<u>Flip Charts</u> (types)	1	1	1	-	-	-	-
<u>Training Manual</u>	1	-	-	1	-	-	-
<u>Promotional Items</u> (types, eg key chains, plastic bags, etc.)	5	8	8	8	8	8	8
<u>Comic Books</u>	-	1	-	-	-	-	-

MAJOR IEC ACCOMPLISHMENTS

ACTIVITIES	PROJECT YEAR						
	1	2	3	4	5	6	7
1. Presentations							
- at clinics	bimonthly	bimonthly	weekly	weekly	weekly	weekly	weekly
- at villages/urban areas	twice weekly per region						
- to groups (women, youth, etc)	10	15	15	15	20	25	30
- special events (une quinzaine de la Femme, etc..)							
2. Training							
Nos. of project staff/leaders of special groups	50	100	100	100	150	150	150
3. Materials produced (posters, pamphlets, promotional items, etc.)							
4. Audiovisual programs produced							
	11	18	17	17	19	19	15
5. Mobile AV. Vans Equipped							
	-	1	2	3	2	1	1
6. Radio Broadcasts							
	5	36	60	60	60	60	60
7. TV Broadcasts							
	1	12	12	12	12	12	12
8. School-based Programs							
	-	-	1	1	1	1	1
9. Out-of School Youth Programs							
	-	-	1	2	1	1	2
10. Study Tours: Religious/Political Leaders							

PROJECT TRAINING NEEDS

Type of Personnel	Type of training	Year 1 N° Stu. pers Students Mo.	Year 2 N° Stu. pers Students Mo.	Year 3 N° Person Students Mo.	Year 4 N° Person Stud. Mo.	Year 5 N° Person Stud. Mo.	Year 6 N° Person Stud. Mo.	Year 7 N° Person Stud. Mo.
1) Physicians & some nurses & midwives, service providers	Modern techniques of reproductive health (10 days)		20 6.6			20 6.6	20 6.6	
2) Physicians & some nurses, midwives, planners - MOH Regional supervisors	Management & supervision integrated health nutrition & family planning (15 days)		40 20		40 20			40 20
3) Medical faculty & lead service physicians	MST & Infertility		5* 3.3*	5* 3.3*	5* 3.3*	5* 3.3*	5* 3.3*	5* 3.3*
4) Nurse midwife & nursing faculty, CESSI & schools of health technicians & allied health field. Some MOH regional supervision & Association of Midwives	Advanced training in family health and/or integration of family health in related health fields. (3 months)		9* 27	9* 27*	8* 24*	5* 15*	4* 12*	
5) Nurse-nurse-midwife, faculty-MOH, nurse midwife supervisor	MPH in Public Health, emphasis MCH/FP - 30 mos			1* 30*	2* 60*			
6) Pre-service training for nurse midwives (possibility of School of Nursing) Nurse & CESSI not included	Integrated Family Planning			20 35 (20 graduates)	60 30 (20 graduates)	60 30 (20 graduates)	60 30 (20 graduates)	60 30 (20 graduate)

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* Overseas Training

PROJECT TRAINING NEEDS *

Type of Personnel	Type of training	Year 1		Year 2		Year 3		Year 4		Year 5		Year 6		Year 7	
		N° Stu- dents	Person Months	N° Stu- dents	Person Months	N° Stu- dents	Person Months	N° Stu- dent	Person Months	N° Stu- dent	Person Month	N° Stu- dent	Person Months	N° Stu- dent	Person Months
7) In-service training nurse & nurse-midwives who are service providers	Delivery of integrated family health service (FP/MST/Infertility) (4 to 8 weeks)	20	40	20	30	20	30	20	20	20	30	20	30	20	30
	Integrated family health (2 weeks)	4	4	4	4	6	6	8	8	8	8	8	8	8	8
8) Other categories of health workers, volunteers, women, youth groups	Family life education (2-day seminar)			100	6.6	200	13.3	300	19.9	400	26.6	400	26.6	400	26.6
	Concepts of family planning for Agents Sani-taires & TBA (1 week)														
9) Health Center Health Team:	Field Training team seminar (2 weeks)	30	15			30	15								
	Clinic-by-clinic training at local level (4 days)	20	3	100	13.3	200	26.6	200	26.6	200	26.6				
10) Logistics, supply and service statistics personnel	Field training team			20	6	40	1.2	40	1.2	40	1.2	40	1.2	40	1.2
	Visit by logistics supervisors (average 2 persons/center)	80	3	160	6	160	6	180	7	180	7	180	7	200	7

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PROJECT TRAINING NEEDS *

Type of personnel	Type of	Year 1		Year 2		Year 3		Year 4		Year 5		Year 6		Year 7	
		N°Stu- dents	Person Months	N°Stu- dents	Person Months	N° Stu- dents	Person Months	N° Stu- dents	Person Months	N°Stu- dents	Person Months	N°Stu- dents	Person Months	N° Stu- dents	Person Months
11) Pharma- cists and employees	Seminar on contracep- tives and MST drugs			30	1	60	2			60	2			80	5
12) Demographic Planners and Eco- nomists — Statisti- cians	Short term	1	12	5*	5	5*	5*	5*	5	10*	10	10*	10	0*	10
	Long term					5*	60								
13) Policy Community leaders + high level family planning personnel	Short term			1	12	5*	24	5*	24	10*		10*		10*	
	Long term					2		2*							
	Group obser- vation, travel	6*	6*	6*	6*	6*	6*	6*	6*	6*	6*	6*	6*	6*	6*
	Individual observation or interna- tional mee- tings	2*	1*	4*	2*	4	2*	4*	2*	4*	2*	4*	2*	4*	2*

+ IEC Training on chart

* Overseas Training

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PRE-SERVICE.

Provide equipment to ENSFE

Provide texts, documents, teaching and curriculum materials to ESFE

Send 6-8 faculty from ENSFE for overseas family planning training (e.g., to Santa Cruz)

- a) Preparation seminar Fall 85 →
- b) First faculty return: brief seminar on new curriculum →

Begin teaching FP to 3rd year students then 2nd year

Teach FP in all 3 years begins →

Teaching of entire new curriculum (integrated) completed once →

Review curriculum & training progress

Begin in-country training - faculty ANSFS, regional SFS

Curriculum review & integration into all 3 years. (Summary)

Final evaluation new curriculum July-Sept 1990

In-Service

Committee on continuing education formed - Holds planning workshop →

Begin in-service education program →

Evaluate in-service education program →

MAJOR TASKS/ACTIVITY AREAS	QUANTITATIVE GOAL
1. <u>Refurbishing & equipment</u>	
. IHS refurbish, provide 1 car, provide materials for info system (fiches, files)	IHS equipped with improved laboratory facilities waiting room,
. Equip Hôpital A. 1e Dantec for infertility activities.	Specified equipment related to infertility diagnosis installed.
. Refurbish & equip 2 existing regional STD centers.	Kaolack & St-Louis, STD centers refurbished
. Microscopes for 40 health centers (30 old & 10 new)	40 microscopes installed
2. <u>Training</u>	
. JHPIEGO training in US in STD x 2 persons	2 PM of STD training in Baltimore
. JHPIEGO training in US in infertility x 1 person	1 PM of infertility training in Baltimore
. Developing of STD/Infertility module in curriculum of Ecole Nationale des Sages-Femmes.	STD/infertility module prepared
. Training of 30 health Center personnel in use of microscopes for basic STD diagnosis.	30 health personnel (1 per Health Center) trained.
. Retraining of 2 lab. technicians from 2 Regional STD centers.	2 lab tech. (1 in Kaolack, 1 in St-Louis) trained.
. Regional training activities in FH project for selected personnel for 30 centers.	Health personnel from 30 centers contacted for regional training STD & infertility modules included.
3. <u>Patients seen for MST</u>	
19,400 (14,000 health post (& health center (1,200 Reg. STD cen. (4,200 IHS	19,400 patients seen for STD & records available re: dx, rx or referral.
4. <u>Research Evaluation/Activ. + Information System</u>	
To design a record keeping & data analysis system for STD(IHS & Reg. STD centers), and infertility (1e Dantec)	Information system designed.
5. <u>TA</u>	
- 1 PM for STD information sys. (see 4 above) (FHI)	System involved in FH Project activities
- 1 PM to develop algorithms & treatment protocols for STD for all levels health (CDC)	
- PM for infer. info. System (FHI)	

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WORKPLAN YEAR 2

<u>MAJOR TASKS/ACTIVITY AREAS</u>	<u>QUANTITATIVE GOALS</u>
<p>1. <u>Refurbishing & Equipping</u> 2 additional STD regional centers integrated into existing regional hospitals and/or polyclinics.</p> <p>Microscopes for 5 new health centers added to project.</p>	<p>2 STD referral centers existing in Pikine, Thiès (4 total)</p> <p>10 microscopes in place</p>
<p>2. <u>Training</u></p> <p>JHPIEGO training in STD (US based) for 1 health professional.</p> <p>Basic STD microscopes for selected personnel 10 health Centers.</p> <p>Retraining in basic STD lab techniques for 2 technicians from Regional STD centers.</p> <p>Assist in FH Project Regional training activities for health personnel from 10 new centers. Oversee implementation of STD/infertility module.</p>	<p>1 PM of US based STD training</p> <p>10 Health Center personnel trained</p> <p>2 lab technicians from STD Regional Centers trained</p> <p>STD/infertility module included in FHP regional training activities</p>
<p>3. <u>Patients seen for MST</u></p> <p>27,300 (20,000 health post (& center (2,500 Reg. MST (centers (4,800 IHS</p>	<p>27,300 patients seen for STD & records available re: dx, rx for referral</p>
<p>4. <u>Research/Eval. Acti.</u></p> <p>Screening of selected IHS clientel for PPNG begins.</p> <p>- Operations research to test uses of STD algorithms in the field</p>	
<p>5. <u>TA</u></p> <p>0.75 PM for information system for STD & infertility: to check on utilization of record keeping forms at IHS, le Dantec and STD center level, and to develop for Health Center and Post level. (FHI).</p> <p>0.25 PM of research TA (CDC) for use of algorithms and treatment protocols in the field. (CDC)</p> <p>0.5 PM for PPNG study (CDC or FHI)</p>	<p>1 PM TA in information system</p>

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WORKPLAN YEAR 3

MAJOR TASKS, ACTIVITY AREAS	QUANTITATIVE GOALS
1. <u>Refurbishing & equipping</u> 2 additional STD regional centers integrated into existing regional health facilities	2 additional regional STD (6 total)
2. <u>Training:</u> JHPIEGO training in STD x1 person	1 PM of JHPIEGO STD training in Baltimore
<ul style="list-style-type: none"> . Retraining in basic STD lab techniques for 2 technicians from regional STD center level. 	2 regional STD center laboratory technicians trained.
<ul style="list-style-type: none"> . Training STD microscopes for health personnel from 5 health centers 	
<ul style="list-style-type: none"> . Assist in FH Project regional training activities for health personnel from 10 new FH health posts (can consist of giving advice re: curriculum) 	
<ul style="list-style-type: none"> . STD seminar for 20 Senegalese health professionals in Kaolack 	
3. Patients seen for MST 32,350 (22,400 at health cen: (& health post level (3950 at regional STD center level 6000 at IHS)	32,350 patients seen, and treated for STD
4. IE&C activities; materials produced in conjunction with FH project IE&C Consultant (STD+infertility)	
5. Research Evaluation Activities FPNG study continues <ul style="list-style-type: none"> . STD surveillance study based on record system . Followup of patients treated for infertility (study begins) 	
6. TA 0.5 PM for assistance with STD "surveillance" based on information system (FHI) .5 PM TA for assis. with infertility study (FHI) 1.0 PM to assist in STD seminar (FHI, JHPIEGO or CDC)	

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WORKPLAN YEAR 4

<u>MAJOR TASKS/ACTIVITY AREAS</u>	<u>QUANTITATIVE GOALS</u>
1. <u>Refurbishing & Equipping</u>	
2 additional STD centers in regions	2 additional region STD centers (8 total)
Equipping of IHS for chlamydia culture activities	IHS laboratory upgraded to permit chlamydia culture
2. <u>Training</u>	
JHPIEGO training 1 month for health profes. in STD	1 PM of STD training at JHPIEGO, USA
Retraining in basic lab techniques for 2 technicians in regional STD Cen.	2 lab techn. from Regional STD centers retrained in STD lab. techn.
Assist in FH Project training activities for health post (can consist of giving advice, re: curriculum).	
Infertility seminars for 20 health professionals in Kaolack x 5 days	
3. <u>Patients seen for STD</u>	
38,350 (25,600 at health center and health post level (5550 at MST regional Centers (7200 at IHS	38,350 patients seen, diagnosed and treated
4. <u>Research evaluation activity</u>	
Analysis of infertility service statistics at Hôpital A. le Dantec to acquire greater knowledge of demographic and health characteristics of clients	To obtain information on demographic, social & health characteristics of 500 patients seen for infertility
-followup study of patients treated for infertility continues.	
5. <u>TA</u>	
0.5 PM of TA to assist IHS to plan chlamydia laboratory (FHI)	
0.25 PM for followup of STD info. system (FHI)	
0.50 PM for followup of algorithms (CDC)	
1.00 PM to plan infertility workshop (FHI or JHPIEGO)	

WORKPLAN YEAR 6

<u>MAJOR TASKS, ACTIVITY AREAS</u>	<u>QUANTITATIVE GOALS</u>
1. Equipping 7 additional departmental health centers with microscopes	7 centers equipped with microscopes
2. <u>Training</u> 7 health personnel for departmental health center in microscope use	7 center level health personnel trained in use of microscopes for basic STD diagnosis
3. <u>Patients seen for STD</u> 59,068 (42,000 at health center & post level (6,700 at regional STD centers 10,368 at IHS	59,068 patients seen diagnosed and treated for STD
4. <u>Research activities</u> Chlamydia study ends (year 2)	500 selected patients screened for chlamydia
5. <u>TA</u> 1 PM for chlamydia study (FHI or CDC)	

WORKPLAN YEAR 5

MAJOR TASKS/ACTIVITY AREAS	QUANTITATIVE GOALS
1. Equipping of 7 additional health center with microscopes for STD diagnosis	7 departmental health centers equipped with microscopes
<p>2. <u>Training</u></p> <p>STD seminar at Kaolack training center for 20 health professionals from FH Project areas & associated activities</p> <p>JHPIEGO training in STD x1 health profes. x1 mo., U.S</p> <p>JHPIEGO training in infertility x1 health professional</p> <p>Training for 7 health center personnel in STD microscopys</p>	<p>1 health professional trained in STD at JHPIEGO</p> <p>1 health professional trained in infertility at JHPIEGO, 7 departmental health center personnel trained in STD microscopy</p>
<p>3. <u>Patients seen for STD</u></p> <p>48,740 (34,000 at hlt center (and post levels (6100 at health centers (8640 at IHS</p>	<p>48,740 patients seen, diagnosed and treated for STD</p>
<p>4. <u>Research and evaluation activities</u></p> <p>Chlamydia study begins (year 1)</p>	<p>To screen 500 selected patients for chlamydia</p>
<p>5. TA: 0.5 PM for recheck info system for STD & infert. ty (FHI)</p> <p>1.0 to assist in chlamydia research (FHI or CDC)</p> <p>1.0 PM for STD workshops (FHI, CDC or JHPIEGO)</p>	

WORKPLAN YEAR 7

MAJOR TASKS, ACTIVITY AREAS	QUANTITATIVE GOALS
1. <u>Equipping 7 additional</u> health centers with micros- copes for STD diagnosis	7 centers equipped with microscopes in year 7 (56 total)
2. <u>Training for departmental</u> health center staff in microscope diagnosis of STD	7 center level health personnel trained in use of microscope for simple STD diagnosis
3. Patients seen 71,770 (52,000 health center (& post level (7370 at STD regional (center level) (12,400 at IHS	71,770 patients seen, diagnosed and treated for STD

During the course of the project some 200 person months of technical assistance will be provided by long and short term expatriate residents in management, clinical and organizational skills and IEC. Senegalese professionals will provide approximately 200 additional months of assistance, largely to the non-governmental sector, in organization and training. The technical assistance contractor is expected to enter into a sub-contract with the American College of Nurse-Midwives to provide the long-term technical advisor for clinical services and to help develop training programs for Senegalese medical professionals.

The contractor is expected to be relatively self-sufficient in operating, handling all the arrangements for its own office and staff housing. Also, through its liaison officer, the contractor will facilitate USAID's role in project management, minimizing the administrative tasks of commodity procurement, participant training, arranging for specific technical assistance, progress reporting etc. Particularly in the area of stimulating and assisting projects in the non-governmental sector area, the contractor will be expected to take an active role in sub-project development. In all the assistance provided for management in the public sector, training in the pre-service curriculum development, in-service continuing education, or work in the non-governmental sector, the contractor is expected to become a partner with the Senegalese institutions in planning and implementing these activities in an expeditious fashion. In the non-governmental sector the contractor will take a leading role in developing the structure for project review and approval and in developing the individual sub-projects. The specific requirements of the contractor are spelled-out through the detailed job descriptions of the team members. These are provided in Annex 3.

The cost of providing this technical assistance and maintaining the office in Dakar is estimated at approximately \$6 million for seven years.

The technical assistance contractor will also be responsible for purchasing all equipment, materials and commodities (except contraceptives, vehicles and computers). The contractor will charge an additional fee based on the total dollar value of the purchases for this service.

A PASA with U.S. BUCEN will be the main technical assistance mechanism for census-related activities.

Short-term technical assistance will also be requested from centrally funded ST/POP contractors. It is estimated that approximately four person months of centrally funded technical assistance will be required annually.

VI. MONITORING PLAN

The ultimate responsibility for the performance of this project lies with the MSD. A representative of this ministry will be assigned as the Director of the project. The MOH, as the technical ministry, will assign a clinical specialist to oversee the delivery of health services.

As mentioned earlier, for each region where the SFHP is active, a coordinator from each of the two interested ministries will monitor project performance in their respective regions.

The regional coordinator for clinical activities will be directly supervised by the regional chief physician. It will be the responsibility of the regional team to inform the national level staff of the equipment, commodities and personnel needs necessary to ensure the smooth running of the family health centers. It will be the responsibility of the national level staff to work with the regional team to ensure that all reasonable needs are met.

The Director of the SFHP will contact the appropriate departments in the MOH and MSD to select trainees, design appropriate training programs and assign personnel. For the MOH, the contact department is Direction de l'Hygiène et de la Protection Sanitaire. In the MSD, the contact department is Bien-Etre Familiale.

It will be the responsibility of the Director of the SFHP to ensure that each service center is visited at least once a month by a representative of the national headquarters staff. When the number of service sites has increased to such an extent that these monthly visits are no longer practical, the regional coordinators must take on that function. A monthly report should be written concerning the status of activities in each center.

Once every two months, the SFHP will bring all the regional coordinators together for a two-day meeting. Each region shall take turns in hosting these meetings, the goal of which will be to share experience regarding project management and compare progress in achieving project objectives.

In order to manage this complex and expanded Family Health Project effectively, it will be necessary to ensure that the responsibilities of major staff members be well defined and frequently assessed, and concrete and practical work plans be developed. In this regard, it will be the responsibility of the Director of the SFHP to:

- prepare and submit to USAID within the first three months of the project detailed job descriptions for all the personnel at the project headquarters and for the regional coordinators,
- hold bi-annual planning meetings for national and regional staff to discuss training needs, select trainees, evaluate usefulness of project-funded training to date, assess materials and equipment needs for six months, and to set service delivery goals for the upcoming six-month period.

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The technical assistance contractor will provide the short and long term consultancies necessary to help the GOS ensure high standards of service provision, effective IEC programs and adherence to sound financial and management principles.

The technical assistance contractor will recruit the following professionals to help them execute their responsibilities:

- 1) Chief Management Consultant (4 years)
- 2) Clinical Specialist (midwife + hired through a sub-contract with the American College of Nurse-Midwives - 4 years)
- 3) Liaison Officer (7 years)
- 4) Director, NGO activities (Senegalese - 7 years)
- 5) IEC Specialist (Senegalese - 7 years)
- 6) Accountant (Senegalese - 7 years)

Please see Annex 3 for a full description of their duties.

A very effective and continual monitoring tool is the service statistics which must be obtained on a monthly basis from each center. These data will show, among other things, how many new and continuing contraceptive users are enrolled in each center, the methods being used and trends in usage. It will be the responsibility of the national headquarters staff to analyze these data quickly and inform centers of their progress, identify possible problems and to ensure adequate stock levels.

Financial Monitoring

Immediately upon approval of the ProAg, an independent financial accounting firm will work with the MSD/MOH project accountant and the technical assistance contractor to finalize accounting and inventory control procedures.

The technical assistance contractor will hire an accountant to work with the MSD/MOH project accountant to maintain these procedures.

The project accountants will prepare monthly financial statements, and annual inventories of fixed assets and supplies. The independent financial accounting firm will perform a comprehensive audit each year for the first 3 years of the project. A staff member in the Office of the President of the GOS will audit the project in conjunction with an outside CPA firm after year 3.

The accountant hired by the technical assistance contractor will, whenever necessary, work with NGO's participating in the project, to establish appropriate financial and inventory control procedures.

The independent financial accounting firm will have responsibility for all financial disbursements and inventory provided to the BNR.

Monitoring of NGO Activities

Monitoring of projects with NGOs is discussed in detail in Annex 2. Basically, the technical assistance contractor with input from a committee composed of representatives from the MOH, MSD, SFHP, BNR, USAID and the private sector, will develop, monitor and evaluate this component of the project. The Technical assistance contractor will be responsible for the financial management and supplies provided to the NGOs.

Monitoring of Census-related Activities

The MOF through its BNR will have responsibility for the census and demographic data components of the project. It will be the responsibility of the MOF to provide an adequate, sealed, air-conditioned room for the micro-computers, to make available clean and possibly air-conditioned storage space for the cartographic materials and supplies; to assure sufficient vehicles for the fielding of the census, and to ensure the availability of all necessary personnel.

VII. SUMMARY OF ANALYSES

A. Summary of Technical Analysis

The delivery of family planning services and the improvement of the demographic data base (the two principal objectives of this project) depend heavily of the technical and management capabilities of Senegalese institutions and individuals.

The MSD will assign an overall director to the project who will be a highly trained manager with many years of experience in the administration of family planning programs in Senegal and familiar with model family planning programs overseas. The director will supervise a national headquarters staff consisting of two MSD IEC experts, a MOH midwife in charge of clinical services, a logistician and a project accountant. The Director will be responsible for working through the appropriate channels of the MOH to establish the locale of the new service sites, selecting candidates for incountry and overseas clinical training and in ensuring that family health activities are conducted in a manner consistent with MOH policies.

All headquarters staff will be qualified to provide high level technical management and logistical support to their counterparts at the regional and local level. Emphasis will be placed on MOH/MSD collaboration at all levels and a group approach to the supervision of the services will be stressed. All national headquarters staff will have been trained not only in the technical aspects of their work, but also the management and supervisory requirements of an expanded nationwide family health program.

The Director of the SFHP will also work with the TAC, USAID and the GOS to help expand family planning programs in the private sector.

As far as the delivery of family health services is concerned, the project plans to work with the National School of Midwives, staff of GOS health facilities, the outreach IEC fieldworkers of the MSD, and interested NGOs concerned with improving family planning availability. In order to ensure that the MOH is technically capable of implementing this expanded family planning program, the project will place highest priority on training the faculty of the School of Midwives subsequently introducing family planning into the curricula of the student midwives. Senegal's midwives and nurses are among the best trained in Africa. This project will complete their expertise by introducing comprehensive family planning training and ensuring practical follow-up service delivery activities. The technical annex reviews the resources and capabilities of these institutions and the training program necessary to allow the project goals to be achieved.

Similarly, the project plans to provide long- and short-term training opportunities to the staff of the BNR in order to assist with the successful implementation of census activities. Special in-country workshops and seminars are also planned. As a result of project support to the BNR, census results should be available by the end of the decade and the ongoing survey support program should ensure a high quality and up-to-date data base upon which development plans can be designed and evaluated and leaders sensitized to population issues.

B. Summary of Administrative Analysis

There are five major participants in this project, viz, the Ministry of Social Development, Ministry of Health, the BNR, the technical assistance contractor (TAC) and USAID.

The MSD, as Ministry of "tutelle" will have overall responsibility for the project and specific responsibility for IEC outreach activities. The MSD will work through the MOH to implement the clinical training program, establish new service sites and initiate the STD and infertility treatment programs. The two ministries will supply personnel to the project headquarters. The TAC will not only assist with ensuring high standards of IEC and clinical services but will also be charged with coordinating the three major groups of activities (i.e. MOH/MSD activities, BNR census programs and NGO projects). This coordination will take place by development of workplans, regularly scheduled meetings to monitor the implementation of the work plans, establishment of schedules of supervisory field visits and regular presentations to USAID of the status of the three major areas.

The Director of SFHP will, within three months of the signing of Program, prepare detailed job descriptions for all headquarters staff and all categories of regional and local level personnel. These job descriptions will be reviewed and approved by the MOH, MSD and USAID.

The logistician and accountant will have been fully trained in supply management and methods of collecting and analyzing service statistics. They, with assistance from consultants, will continue to train service delivery personnel in patient record keeping and inventory control procedures. A computerized management information system will be established.

The TAC will hire an accountant who will work with the MOH/MSD project accountant to assure appropriate financial management and inventory control procedures. At the beginning of the project, an independent financial accounting firm will work with the SFHP and the TAC to set up the financial and inventory systems.

In a radical departure from previous USAID practice, logistical support, usually provided by mission staff, will be turned over to the TAC. For example, procurement, travel and training logistics will now be the responsibility of the TAC. These activities have been a tremendous drain on USAID's resources and transferring these responsibilities to the contractor will enable USAID to concentrate more on the technical guidance and the overall effectiveness of the project.

The USAID Population Officer will be responsible for making sure the various coordination activities take place and that specific workplans developed as a result of these meetings are subsequently implemented. The USAID Population Officer will work with the GOS and the TAC to establish the priorities for the workplans. These priorities and their implementation will be frequently reviewed by the Population Officer during field visits. Two representatives of USAID (the Population Officer and one other) will be voting members on the selection committee for NGO activities.

The USAID Population Officer, in collaboration with the GOS and TAC, will develop the scope of work for project evaluations and oversee amendments to the project that may result from these evaluations.

C. Summary of Economic Analysis

The economic analysis of the project includes a benefit assessment of project activities, a comparison of project costs and benefits, a discussion of the cost efficiency of the project along with recurrent costs and project feasibility. Finally, the possibility of offsetting a portion of project costs with user fees is discussed.

The benefits from a successful family health and population program in Senegal over the next several years will be found in numerous areas; some of these can be estimated quantitatively; others are qualitative and quantification is not necessary nor yet possible.

The analysis discusses:

- Benefits of a macroeconomic or demographic nature. These include a probable improvement in the rate of food self-sufficiency over what would otherwise exist, public cost savings in sectors such as education, and aggregate benefits in terms of increased per capita GNP. These are explored below. Additional benefits to the environment and the income distribution are discussed in the technical annex.
- Benefits associated with improved health status and reduced mortality. Access to contraception and family health counselling permits more effective birth spacing, in turn linked to improved health status of mothers, infants and siblings. Problem pregnancies can be more effectively prevented without sacrificing conjugal relations. In weighing relative health risks and benefits of increased contraceptive use, it is relevant to compare the risks to maternal health of both normal and problem pregnancies vis-a-vis the risks of contraceptive use. Rosenfield placed the average maternal mortality rate from uncontracepted pregnancy in developing country situations at 2,000 out of 1 million women's pregnancies (Rosenfield, cited in Bair, 1978). By contrast, rates of maternal mortality for women using IUDs and oral contraceptives was, respectively, 120 and 160 per 1 million contracepting women. The mortality rate of these last is associated primarily with the failure of the method, resulting in exposure to risks of pregnancy, and much less frequently with risks of the method alone.
- Benefits associated with increased freedom of choice to control fertility. Overlapping with the previous, these also include benefits from improved capacity to plan, to coordinate family size with economic ability to provide for children, to permit mothers to finish school before starting a family, etc.

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- Benefits of both a health and a freedom of choice nature associated with the project's Infertility and Sexually Transmissible Disease components. In Senegal, traditionally pro-natalist, infertility can be an onerous burden for a couple to bear. Accordingly, public policy makers value provision of infertility services despite relatively low levels of infertility.
- Distributional benefits by extending family planning and health service delivery to lower income groups and to geographical areas currently unserved by either the fledgling private sector or the public clinic system.

If the project succeeds in reducing population growth rates it will also exert an indirectly beneficial effect on the poor. Rapid increases in population growth in developing countries are frequently associated with broadening disparities in the income distribution. The poor with the most limited access to social services and, by definition, the most limited personal resources, also frequently have high fertility and the least organized political power. The logical implication of all these factors is a population growing faster than the economic pie with the poor forced to divide an already meager share between increasing numbers.

- Benefits of training and education improving the human capital stock of project service providers in both the public and non-governmental sectors. Economic and educational literature has frequently documented the links between appropriate education and productivity, that is, the ability to perform tasks more efficiently. The SFHPP will spend approximately \$3 million or 15% of USAID-contributed project funds on various training activities relating to family health, population policy, infertility and sexually transmissible disease treatment and management and service provision skills. In addition to favorable impacts on the performance of specified tasks training is also likely to have positive spillover effects in the performance of other related tasks.

1. Project Benefits Related to Food Self-Sufficiency

Senegal's food gap, the difference between estimated food needs and domestic food production, is now sizeable, has increased over the past decade, and will certainly increase further in the foreseeable future under most recently analyzed scenarios. Table I shows an extrapolation of estimated cereals needs through the year 2000 based on a cereals requirement of 210 kg. per capita and alternative population growth rates of 2.6, 2.8 and 3 percent per year. If past agricultural production trends are extrapolated as well, the cereals deficit by the year 2000 would be on the order of 1.2 million metric tons (Table II). If the population program succeeds in reducing the population growth rate by .2 or .4 percentage points, the reduction in food needs by the year 2000 would be up to 99,000 to 170,000 metric tons, respectively, depending on how rapidly rates decrease. (If a lower cereals standard than 210 kilograms per capita is used, the deficits are reduced but the substance of the argument remains. For more explanation, consult the technical annex).

2. Estimation of Investment Savings to Maintain GNP

One approach to estimating benefits from a reduction in population growth rates begins from the premise that improvements in per capita well-being from a marginal reduction in the population growth rate are roughly comparable to an equal percentage point increase in the GNP growth rate. (See CRED, University of Michigan, n.d.). Accordingly, the benefits from a decrease of, for example, 0.1 of a percentage point in the population growth rate would be equal to the increase in investment resources that would have been necessary to increase the GNP growth rate by .1 of a percentage point to keep pace with the growing population. By reducing population growth over what it would have been, these saved investment resources can be used to increase per capita GNP.

Senegal is estimated by the Ministry of Plan to have an incremental capital/output ratio of 6.7 (Ministry of Plan estimate of average incremental capital/output ratio for years 1977-1984). Thus, to increase Senegal's annual GNP growth rate by 0.1 of a percentage point, additional yearly investments of 0.67% of Senegal's GNP (GNP estimated at approximately \$2.54 billion in 1984) would be required, an annual amount of approximately \$17 million additional capital expenditures.

To accomplish a 0.1 percentage point reduction in the annual population growth rate, a correspondingly larger reduction in the birth rate is necessary due to the favorable impact of a reduction in the birth rate on the death rate. Demographers in Senegal estimate that perhaps a 0.14 percentage point reduction in the birth rate would be required to bring about a 0.1 percentage point decrease in the population growth rate. (Seims, personal communication).

A demographic rule of thumb based on international evidence is that an approximately 2.4 percentage point increase in the contraceptive prevalence rate (population using contraception) is necessary to obtain a .1 percentage point reduction in the birth rate.

Linking these relationships then, to accomplish a 0.1 percentage point decrease in the annual population growth rate requires a $(2.4) \times (.14)/(.1) = 3.36$ annual percentage point increase in the contraceptive prevalence rate.

It is estimated that Senegal now has 1.05 million fertile couples. An increase of 3.36 percentage points in contraceptive prevalence would be equal to approximately 35,000 new contracepting couples.

If an additional 35,000 contracepting couples are required to decrease the population growth rate by 0.1 percentage point and one can accept the premise that the benefits of a reduction in the population growth rate are roughly comparable to the increases in investment necessary to raise the GNP growth rate by an equivalent amount (\$17 million), then benefits per additional couple year of protection (one couple using contraception for one year) are on the order of \$486. Because the IUD has a multiple-year effect (lasting between two and three years) IUD benefits are higher. The conservative estimate of two years (discounted at 15%) leads to a benefit per couple accepting an IUD of \$909. Table III shows the annual benefits that could be generated if the project reaches target levels of contraceptive use with the contraceptive blends shown in Table IV. Discounted at 15%, aggregate benefits over the 7-year life of the project total \$185 million.

Projected public investment costs of the USAID and the GOS, when discounted at 15 percent, total \$15 million, leading to a benefit-cost ratio of 12. It should be noted that this ratio is obviously sensitive to the capital/output ratio used in the calculations. Senegal has a high capital/output ratio (6.7), implying that relatively high capital investment expenditures were required over the past several years to increase GNP growth. Factors influencing this ratio include the type of capital investment as well as the level and the quantity and quality of the other factors of production influencing GNP (including the labor force). If a lower capital/output ratio were chosen (let us say 4) and all else remained equal, the annual required incremental investment would fall from \$17 million to \$10 million and the benefit per couple year of protection would fall from \$486 to \$290, a reduction of 40 percent. Reducing the benefit cost ratio by 40% yields a ratio of 7.2.

Another factor to which the results are sensitive is the discount rate. Fifteen percent is a fairly high rate and use of any lower factor would increase the benefit/cost ratio. If costs were doubled for some reason, the benefit/cost ratio would be halved, falling to 6. It should be noted that the cost figures included in the analysis are public costs only. In addition, contraceptives and other items are priced at USAID purchase prices. If they were shadow priced at world market rates including transportation charges, they would be somewhat higher.

If the project fails to reach its targets in terms of users, the benefit stream would be reduced and the benefit cost ratio would fall.

With all these considerations, however, a benefit/cost ratio of 12 is sufficiently robust to suggest considerable value to Senegal from a population program meeting the contraceptive target levels defined here.

TABLE III.

Annual Stream of Benefits and Costs from the Senegal Family Health Project

	Y E A R S						
	1	2	3	4	5	6	7
	(\$000)						
Benefits							
Pills	1,944	3,694	6,610	13,608	21,773	30,132	38,880
IUDs	3,636	6,908	12,362	25,452	40,723	56,358	72,720
Condoms/Foam	<u>972</u>	<u>1,847</u>	<u>3,305</u>	<u>6,804</u>	<u>10,886</u>	<u>15,066</u>	<u>19,440</u>
Total Benefits	6,552	12,449	22,277	45,864	73,382	101,556	131,040
15% D. Factor	<u>.87</u>	<u>.76</u>	<u>.66</u>	<u>.57</u>	<u>.49</u>	<u>.43</u>	<u>.38</u>
Disc. Benefits	5,700	9,461	14,703	26,142	35,957	43,669	49,795
Costs	3,228	3,582	3,609	4,371	3,848	3,601	3,228
15% D. Factor	<u>.87</u>	<u>.76</u>	<u>.66</u>	<u>.57</u>	<u>.49</u>	<u>.43</u>	<u>.38</u>
Dis. Costs	2,808	2,722	2,382	2,491	1,885	1,548	1,227
Total Benefits/Total Costs	185,427/15,063						
Benefit-Cost Ratio	- 12 (Maximum)						

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User Targets and average program Costs

If the SFHP reaches its goals, the contraceptive prevalence rate will increase from approximately 5% of the MFWRA in project year 1 to 15% in project year 7.

TABLE IV

Yearly Estimated Numbers of Users According to Assumed Method Mix

Method	YEAR (000)							Total
	1	2	3	4	5	6	7	
Pills (40%)	4.0	7.6	13.6	28.0	44.8	62.0	80.0	240
IUD (40%)	4.0	7.6	13.6	28.0	44.8	62.0	80.0	240
Condom (10%)	1.0	1.9	3.4	7.0	11.2	15.5	20.0	60
Foaming Tablets (10%)	1.0	1.9	3.4	7.0	11.2	15.5	20.0	60
Yearly Totals	10	19	34	70	112	155	200	600

Thus, 10,000 users by the end of year 1 will expand to 200,000 by end of year 7. In total, an estimated 600,000 couple years of protection will have been provided by the end of the project.

If one assumes that every two years of contraceptive use results in one birth averted, then by the end of the project 300,000 births will have been averted during the life of the project. (If one assumes 3 CYP for each birth averted, 200,000 births will be averted.) The total cost of the project, excluding the census volet, is \$17.3 million in US contribution, and \$6.2-7.4 million in GOS contribution of local currency equivalent. These figures yield the following average costs:

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Cost for CYP 600,000 Est. Couple Years of Protection	Cost per Birth Averted 2 CYP=1 BA so 300,000BA	Cost per Birth Averted 3 CYP=1BA so 200,000BA
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In relation to:			
USAID Contribution (16.3 million)	\$27.16	\$54.33	\$81.48
GOS Contribution (7 million)	\$11.66	\$23.33	\$34.98
Total Project (24.3	\$38.83	\$77.66	\$114.99 million)

3. Cost-Effectiveness

The predominantly clinic-based SFHP has the following cost-efficiency features:

- a. the clinics and hospitals already exist and no major construction is required by the project or the GOS. The GOS has extremely limited capacity to construct anything.
- b. the clinic-based approach will utilize existing personnel and will provide services by increasing personnel capacity through training, and by providing medical supplies and equipment. Again, the GOS budget is severely constrained with regard to the capacity to hire any new personnel.
- c. literature reports the conclusion that success of family planning programs in generating sustainable demand for contraceptive services, especially in the medium and longer term, is linked to integration of family planning service and comprehensive maternal and child health services.
- d. the administration of project activities will be gradually taken over and integrated into the existing Ministry of Social Development and Ministry of Health supervisory structure at the end of the project.
- e. recurrent costs of the project are expected to be relatively low. Clinics and health posts are already operating and operating costs are already covered by the MOH budget. Salaries are already covered with the exception of the headquarters staff (discussed below).

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- f. the project financial plan is structured to gradually increase the GOS contribution to the project during the life of the project. In this manner, there should be relatively few new major responsibilities for the GOS at the EOP to maintain service levels. The exceptions to this statement are: commodities, particularly contraceptives; vehicle replacement; a contraceptive distribution system.
- g. USAID contraceptive procurements are phased so as to provide a one year supply of contraceptives at the EOP.
- h. the project will allocate 7.5 cent of resources to non-governmental activities to identify, support and evaluate alternative delivery systems which will extend service delivery and test cost-efficiency.

4. Fees for Service

User payment for health services is becoming established in Senegal. Payments of 100 CFA (and in some locations 200 CFA) per visit to a health center are common. If 100 CFA per visit were charged, local health centers and posts would generate \$420,000 over the LOP. Doubling the charge would of course double the total to \$840,000 as well. The revenues raised in this manner, through relatively small, can be used to defray some of the clinic and private sector recurrent costs. (See technical annex).

D. Summary of Social Soundness Analysis

Senegal is and has been a pro-natalist Country although attitudes are beginning to moderate slowly. Couples have and want large families to such an extent that infertility, while no greater proportionally here than in other countries, is perceived as a major medical problem. Many cultural factors including a high prevalence of polygamous marriages favor the continuation of the large family tradition.

Knowledge and practice of modern forms of contraception are low. The 1978 Senegalese Fertility Survey showed that only about 20 percent of MWRA had ever heard of modern forms of contraception. Only one percent of MWRA had ever used a modern method of birth control. Over half the women interviewed felt that a family with excess of nine children was ideal. A few years later in 1982, a survey in Sine Saloum showed a subtle but significant change in contraceptive behavior. Knowledge of modern methods of contraceptives was up sharply from fewer than 14 percent being cognizant of modern methods to almost 60 percent. In addition, whereas large families were still desired, more than half the women wanted at least three years to pass by until their next pregnancy. These are the women who would be the most likely project beneficiaries.

Family planning in Senegal is approached primarily in the context of facilitating birth spacing and not in terms of birth limitation. Although births are currently fairly well spaced due to the almost universal prevalence of breast feeding and its effects on post partum ammenorhea, if these practices break down in the context of increased urbanization and disruption of traditional life styles, birth rates could quickly increase. Fertility is high in Senegal due to the young age at which women marry thus effectively lengthening the average period of child bearing years.

Social Factors to be addressed in this Project

1. Almost 85 percent of the population of Senegal is Muslim and it undoubtedly has an influence on all facets of life here. It has been important to consider this influence when planning this kind of project and to work within its context. Traditionally, Islam allows spacing of births but not limitation. A national Commission for Population held a Conference in 1982 to discuss "Islam and Family Planning" and to study its broader ramifications. One Muslim scholar carried the traditional practice of voluntary withdrawal one step further by equating it with modern contraceptives. He believes that this practice justifies the contemporary use of contraceptives, unknown at the time of Mohammed, for birth spacing.

Also in the Islamic context, various family planning programs in other Muslim Countries have been and will continue to be studied. Some Islamic scholars have already travelled to Morocco and Egypt to study successful programs there and future trips are planned for project personnel and influential Senegalese working at the policy level of GOS health and social issues.

2. Increasing the involvement of men in the Project. The patriarchal traditions of Senegalese society must be utilized to promote family planning. The major decision makers are male and if they are not convinced of the need for birth spacing there will be little hope of achieving the project potential. A study will be undertaken to better understand male attitudes towards contraception. This will enable a fuller program of activities and educational and informational materials to be developed for men. Specific approaches are already envisioned:

-IEC radio programs for men, following the example of programs underway in Egypt.

-Informal talks at the village level for men only, conducted by medical personnel.

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-Seminars organized by the Census Bureau of Senegal for GOS officials and private citizens studying the economic effects of the population growth using 1987 census data.

-Trips to Islamic countries by national and regional level decision makers to study family planning programs.

3. Cultural acceptability of Family Planning advertising and IEC using Mass Media. It is necessary to recall that more than 75 percent of the Senegalese population is illiterate, therefore support for any kind of advertising has to be adapted to that situation. The message delivered must be tactful, with an emphasis on the medical aspects of the subject.

People should perceive the use of contraceptive methods as being compatible with their beliefs and their own values. Advice for family planning and birth spacing should not be perceived as foreign-inspired or imposed but as coming from their own society. Advertising and messages through Mass Media must be delivered in national languages and adapted to rural and urban settings. Confusing and complicated messages should be avoided.

4. Family Life Education Program for Adolescents. The prevalence of unmarried adolescent pregnancies is high. At present there is no focus of educational programs on this area, even though the need is great. Together with IEC and Mass Media Campaigns special programs will be developed for adolescents to enable them to be better informed and thus more aware of the consequences of their behavior. A Family Life Education program developed in concert with religious leaders, education specialists and health professionals, will be introduced at the last year of elementary School and at the secondary level. A program for out-of-school youth will also be established to reach all levels of this age group.

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CONDITIONS AND COVENANTS

A. Conditions Precedent

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, the Government of Senegal shall:

1. Furnish AID an opinion of counsel acceptable to AID that this Agreement has been duly authorized and/or ratified by, and expected on behalf of, the GOS, and that it constitutes a valid and legally binding obligation of the GOS in accordance with all its terms.
2. Provide a statement of the name of the person holding or acting in the office of the Government of Senegal and of any additional representatives, together with a specimen signature of each person specified in such a statement.

B. Covenants

1. The Government of Senegal agrees to assign the requisite numbers of personnel from the Ministry of Health and Ministr, of Social Development to appropriately staff the headquarters of the Senegal Family Health Project.
2. The national headquarters of the Senegal Family Health will be maintained throughout the life of the project or until USAID and the GOS agree that a different management structure would be more effective.
3. Within 90 days of the signing of the Project Agreement, the GOS shall furnish a letter agreeing to the evaluation schedule proposed in the Amplified Project Description section of the Project Agreement and the implied need to redesign or terminate the project should evaluation be unfavorable.
4. Second and subsequent year disbursements will be contingent upon USAID's and the GOS satisfaction with the progress made toward achieving project objectives.
5. The Government of Senegal and USAID will covenant that none of the funds provided by AID will be used to perform abortions or to promote abortion as a means of family planning. The government will further assure that there will be no coercion of any kind and that all use of family planning methods will be voluntary action of the persons involved.

6. The GOS agrees to contact its agents posted in areas where the Senegal Family Health Project will be carried out in order to inform them that there will be no supplementary remuneration since family planning activities are an integral part of the professional work of these agents. Any travel required of these agents to carry out family planning activities will be reimbursed according to the USAID policy.
7. The Government of Senegal, through the Ministry of Information and Culture, the Ministry of Health and the Ministry of Social Development will make time available on national and regional radio or TV for government or non-government organizations to provide informational programs on family health and planning.
8. Activities concerning the promotion of family health and planning proposed by organizations in the private and para-statal sector, will not be financed until after a review committee has studied and approved them.
9. The Government of Senegal, through the Ministries of Health and the Ministry of Social Development, will name representatives to the private and para-statal project review committee of the Family Health and Population project. These representatives will be named before Jan. 30, 1986 or another date agreed to in writing by USAID.
10. The project will pay for all gasoline for project cars for the first three years of activities, after which time the proportion of gasoline expenses supported by the GOS will be as follows:

<u>Year</u>	<u>Total</u>	<u>USAID</u>	<u>GOS</u>
1	\$ 13,000	\$ 13,000 (100%)	\$ 0 (0%)
2	14,300	14,300 (100%)	0 (0%)
3	14,433	14,433 (100%)	0 (0%)
4	15,876	11,113 (70%)	4,763 (30%)
5	17,464	10,478 (60%)	6,986 (40%)
6	19,210	3,842 (20%)	15,368 (80%)
7	21,131	0 (0%)	21,131 (100%)

The Government of Senegal will assure responsibility for supplying the additional gasoline necessary to conduct project activities beginning Year 4 and onwards. The GOS covenants to allocate line items in the national budget from Fiscal Year 1989 onwards equivalent to the above specified sums for project gasoline purchases. This shall be evidenced by the inclusion of these estimates in the budget provisoire starting in 1987.

11. The project will pay 100% of the operating costs (utilities, telephone, stationery, etc) of the headquarters for the national project for the first three years of activities, after which time the proportion of these operating expenses supported will be as follows:

<u>Year</u>	<u>Total</u>	<u>USAID</u>	<u>GOS</u>
1	\$ 93,000	\$ 93,000 (100%)	\$ 0 (0%)
2	97,650	97,650 (100%)	0 (0%)
3	102,532	102,532 (100%)	0 (0%)
4	107,659	75,361 (70%)	32,298 (30%)
5	113,041	45,217 (40%)	67,824 (60%)
6	118,693	23,738 (20%)	94,955 (80%)
7	124,627	0 (0%)	124,627 (100%)

The Government of Senegal will assume responsibility for supporting the additional operating expenses of the national headquarters from the beginning Year 4 and onwards. The GOS covenants to allocate line items in the national budget from Fiscal Year 1987 onwards equivalent to the above specified sums for the operating costs of the national headquarters.

13. The Government of Senegal through the Ministry of Economy and Finance will ensure:
- a. Assignment of appropriate trained personnel to all phases of Census preparation and execution;
 - b. A minimum of one data entry specialist and two computer systems analysts/programmers to be assigned to the Bureau Informatique for the duration of Census processing.
 - c. Assured access to the Ministry of Finance computer facilities.
 - d. Guarantee of the use of a sufficient number of vehicles during the enumeration process and appropriate logistical support for the transfer of Census materials.

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IX. EVALUATION ARRANGEMENTS

The plan calls for three evaluations during the life of the project. The first evaluation at the end of year two will be done internally by PSF, MOH, MSD and USAID personnel. This evaluation will review whether all procedures and institutional arrangements are in place for the proper administration and implementation of the project, for example: have arrangements been secured for technical assistance, commodity procurement and financial management; is there coordination between PSF, MOH, MSD and regional health officers; what health center renovation is completed or planned; has there been on-going evaluation in the various sub-sections of the project, etc. Some performance evaluation can also be included, since some service delivery, training, IEC, and demographic data collection will have been initiated.

The second evaluation, will be carried out in year 4 with a local project team and external assistance. The evaluation will continue to review management and administration but will focus more on performance in the areas of service delivery, IEC, training, policy development and demographic data collection. At this time some of the broad issues of program management policy and strategy can also be addressed.

The final evaluation in year 6 will be carried out with more external assistance. It will address performance issues as well as make some initial review of project impact in birth spacing and reducing the percentage of high-risk mothers exposed to undesired or high risk-pregnancy. It will address broad issues of the degree of institutionalization achieved, project sustainability and needs for future assistance.

The evaluations will be based on an initial and fifth year contraceptive prevalence/reproductive health survey, the 1987 census, service statistics of client use and contraceptive flow, quarterly progress reports on government and non-government actions, interviews with government personnel, community leaders and trainees, operations and bi-medical research reports, internal evaluation reports of sub-sector activities, and visits to clinic and project sites. A nationwide demographic and health survey is planned for early 1986 which will provide baseline family planning and family health data against which to evaluate this project. The 1987 census and subsequent annual regional surveys will allow frequent objective evaluations. The detailed evaluation plan can be found in Annex 6.