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AGENCY FOR INTERNATIONAL DEVELOPMENT  
**PROJECT PAPER FACESHEET**

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 A  C  D

3. COUNTRY/ENTITY  
 Arab Republic of Egypt

4. DOCUMENT REVISION NUMBER

5. PROJECT NUMBER (7 digits)

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8. ESTIMATED FY OF PROJECT COMPLETION  
 FY

9. ESTIMATED DATE OF OBLIGATION  
 A. INITIAL FY:    
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 C. FINAL FY:   (Enter 1, 2, 3, or 4)

10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$) -

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL	2,410	1,590	4,000	10,027	6,973	17,000
(GRANT)	2,410	1,590	4,000	10,027	6,973	17,000
(LOAN)						
OTHER U.S.						
1.						
2.						
HOST COUNTRY	1,000	5,143	6,143	3,000	15,430	18,430
OTHER DONOR(S)	1,447		1,447	4,343		4,343
TOTALS	4,857	6,733	11,590	17,370	22,403	39,773

11. PROPOSED BUDGET APPROPRIATED FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY		H. 2ND FY		K. 3RD FY	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) SA	489	490		4,000		6,488		6,512	
(2)									
(3)									
(4)									
TOTALS				4,000		6,488		6,512	

A. APPROPRIATION	N. 4TH FY		O. 5TH FY		LIFE OF PROJECT		12. IN-DEPTH EVAL. SCHEDULE
	Q. GRANT	P. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	
(1)					17,000		MM YY 7   8
(2)							
(3)							
(4)							
TOTALS						17,000	

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

1 = NO  
 2 = YES

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE:

TITLE: Donald S. Brown, Director, USAID/Egypt

DATE SIGNED: MM DD YY | 8 | 1 | 5 | 7 | 7

15. DATE DOCUMENT RECEIVED IN AID/W. OR FOR AID/W DOCUMENTS. DATE OF DISTRIBUTION: MM DD YY

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I. Project Recommendations and Summary

A. Recommendations

- |                                                       |              |
|-------------------------------------------------------|--------------|
| 1. Approval of Grant from Supporting Assistance Funds | \$17,000,000 |
| FY 1977                                               | \$4,000,000  |
| FY 1978                                               | \$6,488,000  |
| FY 1979                                               | \$6,512,000  |

2. Based on a Mission request (Annex E) it is recommended that it be determined that U.S. dollars may be used to purchase local currency notwithstanding the fact that Egypt is an excess currency country.

B. Summary

This three-year Project, USAID's first in Population and Family Planning, assists the GOE to respond to immediately identified needs necessary to achieve the objectives of its national population policy. The areas of assistance have been coordinated with other donors and are complementary to their inputs and those of the GOE. The Project is consistent with the Congressional Mandate of the FAA to undertake activities to improve the quality of life of the deprived majority. We will continually analyze experience gained with this Project and will seek a participatory sector strategy to better focus future assistance to the areas of most critical needs. The Project is economically and administratively feasible, and technically and culturally acceptable.

## II. Project Description

### A. Background/Goal/Purpose

The population of Egypt (November, 1976,) totals an estimated 38.2 million. The crude birth rate in 1975 officially was reported to be 37.7 per 1,000 population; the crude death rate, 12.2 per 1,000; the annual rate of natural increase, approximately 2.5 per cent. An estimated 96 per cent of this growing population currently is crowded into only 4 per cent of the land which reasonably will sustain habitation; the population density within that area is more than double the population density of the Netherlands, the most densely settled country in Europe.

At 1975 rates of population growth, Egypt's population would double soon after the year 2,000. The Population and Family Planning Board (PFPB) completed a projection showing that even with gradual achievement of replacement levels of fertility, by the year 2,000, the population in that year would approximate 56 million.

The Government of Egypt (GOE) officially has determined that the continuation of these rates will make difficult, if not impossible, the attainment of its general social, economic, and political development goals. As a result, the GOE articulated in 1973 a population policy of reducing its annual population growth rate to 11 per 1,000 by 1982 (1.1 per cent) by reducing its crude birth rate from 34 to 24 per 1,000 population. The following is extracted from the Policy:

"The Policy Guidelines to the Plan:

"1. The GOE population problem is of a socio-economic and political nature which is affected by social values, and is related to the present and future development of the country.

"2. The Population and Family Planning Plan is to be an integral part of the National Socio-Economic Plan, and seeks to induce a drop in the population growth rate, both as an objective and a result of the over-all Socio-Economic Development Plan. This target should be an integral part of the policies, objectives and activities of all institutions. The Plan should aim at coordinating all efforts of the concerned governmental and non-governmental institutions.

"3. The legislation guaranteeing the implementation of this policy, and the activities scheduled in the Plan, seek the reinforcement and welfare of the family since it is the basic unit of a society, founded on religious and moral values."

Through this bilateral Supporting Assistance Project, USAID/Egypt will work collaboratively with the Egyptian Government and other external donor agencies to help to meet this goal: to reduce the rate of population growth in accord with the GOE Population and Family Planning Policy.

A number of current bilateral AID-assisted activities in Egypt directly and indirectly affect the Egyptian Government efforts to meet inter alia, its population goal. Examples include activities in the fields of health, nutrition, water supply, manpower resource

development, education, employment generation, and the like. Currently, AID/Washington world-wide grants to and contracts with American private and voluntary organizations have assisted the Egyptian Government in a more direct way to help attain its family planning and population objectives. Grantees and contractors include the Pathfinder Fund, the International Association for Voluntary Sterilization, the University of Chicago, the University of North Carolina, the American Public Health Association and others.

Important as these activities are, however, their flows of resources are not sufficient, adequately to express the U.S. Government's interest in helping the Egyptian Government address the population component of its socio-economic development objectives. This project will focus on population-related assistance and complement other US socio-economic assistance efforts.

One of the essential steps that the Egyptian Government has taken to help attain its goal of reducing its annual rate of population growth has been to establish a number of systems for providing family planning information and service in order to reach roughly 6 million married couples of reproductive age (MCRA; 15-44 years). These systems comprise government health centers, private associations, pharmacies, and commercial outlets. A July, 1977, proposal to the World Bank by a Project Preparation Committee chaired by the Egyptian Minister of Health stated that between 15 per cent to 20 per cent of the MCRA currently are limiting their births by using modern contraceptive methods. This participation rate is a commendable start. This rate, however, would have at least to double and be maintained in order for the Egyptian

Government effectively to attain its population objectives. (A recently analyzed National Fertility Survey (for 74-75) shows higher contraceptive participation rates - 26.6 per cent using all methods, with about 85 per cent of these using modern methods).

The purpose of the Project is to strengthen further the currently functioning nationwide family planning systems in order to deliver such services effectively to increasing numbers of Egyptian couples.

Family planning is defined for purposes of this Project to include service delivery systems, training programs, measurement and analysis activities, and efforts to make people at all levels of society aware, informed, and motivated to reduce family size. There are no pat answers to the question: What is the best method of providing effective family planning services to married couples of reproductive age? Many different family planning systems may be developed and tried out. As the systems gain experience, program managers modify the systems and identify gaps that they then attempt to fill. Through this project AID will work collaboratively with the Egyptian Government to assist in the identification of needs for family planning assistance and in responding to these needs.

Each element of AID assistance will be assigned to help attain the Project purpose cited above. Five areas of assistance currently have been identified jointly by the Egyptian and US Governments:

- contraceptive availability;
- administrative improvement;
- integrated social services delivery systems;
- training and;
- innovation and technology transfer.

The joint activities described below will help meet immediately identifiable needs in Egyptian Government family planning systems. At the same time, USAID/Egypt will continue to engage in an ongoing dialogue with host country officials in order to modify these activities, as necessary, to meet changing needs, and jointly to design new activities to meet additional identified assistance requirements and to respond to targets of opportunity.

The Project activities described below have resulted from discussions with Egyptian family planning leaders and have been discussed and endorsed by other donors. Additional analysis will be not only desirable but also necessary to guide future activities. The needs described below are of sufficient magnitude that they must be addressed now without awaiting the outcome of more sophisticated and detailed analysis. As a result of experience with these activities and with the preparation of a multi-year population strategy paper in late CY 1977 or early CY 1978, USAID/Egypt stands ready to revise this Project Paper, when necessary to respond more broadly to Egyptian family planning needs.

B. Assistance Area No. 1: Contraceptive Availability

1. Need

In Egypt, contraceptives currently are distributed primarily by the Ministry of Health (MOH) through 200 MCH centers, 280 health bureaus, 585 rural health centers, 1,520 rural units, and 258 hospitals. Contraceptives also are distributed through a system of 439 Ministry of Social Affairs clinics, in conjunction with the Egyptian Family Planning Association (an IPPF affiliate), and 184 other facilities. Contraceptive services also may be obtained from private physicians.

In addition to these "clinic-based" facilities, contraceptives are sold in about 2,000 pharmacies, numerous commercial retail shops, and, for condoms, by street vendors.

Contraceptives are also distributed through a household and community-based pilot project in 36 villages in the Menoufia Governorate. This project, supported by the Social Research Center of the American University of Cairo with a central AID/W grant, will be extended by this Project to all 302 villages in that governorate.

For a detailed description of the contraceptive logistic system see The Import Manufacture and Distribution of Contraceptives in Egypt by Joseph Loudis and Roger Rochat, May, 1977.

The Egyptian Government has made impressive strides in developing production capabilities for orals and IUD's; however, raw materials for production of orals and IUD's, along with conventional contraceptives and auxiliary fertility-related supplies, are imported and are dependent upon foreign currency. Other donors are assisting in this area; yet supply channels are at times erratic. The Government has requested USAID assistance in the areas outlined below.

a. Condoms

All condoms currently are imported to Egypt by the government-owned Gomhoriya Company, acting on behalf of the Supreme Council for Population and Family Planning.

After clearing customs, condoms are distributed generally through three separate channels: 1. Some condoms are distributed without charge by Gomhoriya to the Egyptian Trading Company (ETC), for redistribution without charge to twenty-five Ministry of Health (MOH)

depots to MOH service outlets. (In these transactions, Gomhoriya and the Egyptian Trading Corporation recover their costs of procurement/distribution from the PFPB.) MOH service outlets request resupply every three months from the MOH depots; MOH depots request resupply every six months from the central ETC warehouse. Receipts from sales at government units are returned to the PFPB for redistribution through a provider incentive scheme. 2. Gomhoriya distributes other condoms without charge to the ETC central warehouse. These are redistributed without charge to forty-eight regional ETC warehouses. Regional ETC warehouses distribute them without profit to pharmacies and private associations. Receipts from sales in private associations revert to the PFPB as above. Pharmacies are allowed a small profit. 3. Remaining condoms are held by Gomhoriya for distribution without profit to commercial outlets, such as cigarette shops, tea stalls, shoe-shine boys, and the like, either directly or through commercial wholesalers.

Current official condom price is one-half piaster per condom (seven-tenths of a US cent), but the Population and Family Planning Board currently is raising this official price to one piaster per condom (one and four-tenths US cents). None of these funds revert as profit to Gomhoriya, ETC, or the Population and Family Planning Board, but serve instead as additional incentive to commercial outlets.

At the start of CY 1977, there were virtually no reserve supplies of condoms on hand in Egypt. From January 1 to July 30, 1977, the PFPB received 18,044,928 condoms (125,312 gross) from Pathfinder Fund for distribution to MOH outlets, pharmacies, and private associations. An additional 21,600,000 condoms (150,000 gross) were requested of

Pathfinder, half for delivery in October/November 1977 and the remainder for delivery in early CY 1978. Most of these condoms will be distributed by Gomhoriya to commercial outlets. Although Gomhoriya distributed condoms to commercial outlets in prior years, it has not had sufficient supplies to distribute to commercial outlets in CY 77. Total supply delivered or ordered in CY 77 totaled 39,644,928 condoms (275,312 gross).

Married couples of reproductive age (MCRA) in Egypt are expected to reach 6 million couples in CY 1978. If only 5 per cent, or 300,000 couples, were to utilize condoms, 30 million condoms would be required in CY 1978, leaving on hand at the end of CY 1978 a reserve supply of only 9,644,928 condoms, minus condoms delivered and used in CY 1977. A moderate increase in numbers of couples who were to request condoms either commercially or through the public sector (e.g. Menoufia Governorate expansion) would deplete condom stocks on hand, with no reserve stocks available for CY 1979. Assistance is required to establish sufficient stocks and pipeline to insure continuing availability.

b. IUD's

Lippes loop intrauterine contraceptive devices (IUD's) are manufactured in Egypt. Although stocks at hand may be sufficient over the immediate future, Lippes loop IUD molds are wearing out and will need replacement prior to further IUD production. Lippes loop IUD inserters are not manufactured in Egypt and must be imported; stocks are exhausted.

c. Oral Contraceptives

The Egyptian Government is committed to the in-country production of oral contraceptives. Three Egyptian Government pharmaceutical

corporations manufacture oral contraceptives, under license with Schering, Searle, and Wyeth, respectively. Raw materials for the manufacture of oral contraceptives are imported. These materials for the public sector are imported by the Gomhoriya Company on behalf of the PFPB of the Supreme Council for Population and Family Planning.

The Gomhoriya Company is recompensed by the PFPB for the costs of procurement and distribution of raw materials to the manufacturers. The costs to the manufacturers of producing the finished product and distributing to the Egyptian Trading Company are paid by the PFPB. The ETC distributes the orals through the same logistics system described for condoms without charge to the recipient. Receipts from sales from MOH units and private associations revert to the PFPB for redistribution in the provider incentive scheme.

Population Family Planning Board (PFPB) officials estimated that 1976 government costs for raw pharmaceutical materials, plus aluminum, plastic, and paper packaging materials come to about 11.5 cents for each finished cycle. One manufacturer estimates its manufacturing costs at 2.3 piasters (about 3.2 cents) per cycle. Thus, the cost for procuring materials and producing each finished cycle approximates 14.7 cents.

From 1971 to 1976, the UN Fund for Population Activities (UNFPA) had provided funds to cover approximately 75 per cent of the foreign exchange requirements for the importation of these raw materials. For both 1976 and 1977, UNFPA approved \$900,000 for the purchase of raw materials. Despite an anticipated annual increase in contraceptive usage of at least 10 per cent per year from a base of about 10 million

cycles, and despite a 10 per cent anticipated increase in unit costs, the UNFPA's annual average level of support for the importation of raw materials to Egypt is projected to decline to \$800,000 for 1978, \$650,000 for 1979 and \$550,000 for 1980. This Project will help assure availability of sufficient orals for program needs.

d. Surgical and Related Clinic Supplies

The Egyptian Government plans to assist 6 university medical centers to train doctors in surgical procedures related to fertility and infertility. Once doctors receive training in these procedures, the Supreme Council for Population and Family Planning hopes to provide basic surgical equipment to each trained physician. The Government has requested fertility related surgical devices from AID.

e. Other

There appears to be a fair amount of interest among program officials in foams and foaming tablets growing out of acceptor distrust or dislike of pills, condoms, and IUD's. While accepting as fact the lower efficiency of foams, there quite possibly is a place for the foams or foaming tablet to gain initial client interest in family planning and to fill the gap left when acceptors and potential acceptors turn away from orals, condoms, or IUD's.

Data presently are unavailable on usage rates or needs for these and other contraceptives, such as diaphragms and spermicidal creams, primarily because sufficient amounts of these commodities have not been available.

2. Outputs

The needs jointly identified above by the Egyptian Government and USAID/Egypt will be met by the following outputs to be generated with

FY 1977 funds. Outputs to be generated with funds in FY 78 and FY 79 are illustrative, for planning purposes.

a. Condoms

Condoms procured with FY 77 funds will be distributed throughout Egypt for use by up to 5 per cent of the married couples of reproductive age (MCRA) (288,000 person/years of protection). Funds are proposed for FY 78 and FY 79 to cover condom procurement for 10 per cent and 15 per cent of the MCRA, respectively.

b. Lippes Loops

Lippes loop IUD's will be manufactured in Egypt in sufficient quantity to meet foreseeable future needs and IUD's will be utilized by an additional 2 per cent of the MCRA (120,000 IUD insertions).

c. Orals

With FY 77 funds made available to the Egyptian Government, the GOE will procure from the United States raw materials for manufacture in Egypt of 900,000 monthly cycles of oral contraceptives, which will be distributed for use by 1 per cent of the MCRA (70,000 women/years of protection) in FY 79. At the same time, a system will be established for future year provision of additional AID foreign exchange for Egyptian Government oral raw material procurement. Funds illustratively programmed for FY 78 and FY 79 will cover the importation by the Egyptian Government of US-source oral contraceptive raw materials to cover manufacture and distribution of orals to 5 per cent and 10 per cent of the MCRA in FY 80 and FY 81, respectively.

d. Surgical Supplies

300 doctors each year who have received training will receive supplies necessary to provide fertility related surgical services.

a. Other

The Egyptian Government will be able to respond to identified needs for other clinical and non-clinical materials and supplies as agreed upon during ongoing GOE/USAID consultations.

3. Inputs

The following are AID inputs proposed to generate the outputs described above:

a. In FY 77 \$730,000 for procurement of 28.8 million condoms (200,000 gross) colored size 52 condoms. (\$1,460,006 in FY 78; \$2,190,000 in FY 79.)

b. In FY 77 \$5,000 for procurement of 2 Lippes loop IUD molds 1 size-C and 1 size-D and 12,000 Lippes loop IUD inserter packs.

c. In FY 77 \$120,000 in foreign exchange for procurement from the United States of raw materials for 900,000 monthly cycles of oral contraceptives (\$514,000 in FY 78; \$1,028,000 in FY 79.)

d. In FY 77 \$38,000 for procurement of 300 minilap kits. (\$40,000 for FY 78; \$42,000 for FY 79.)

e. In FY 77 \$100,000 for procurement of other clinical and non-clinical equipment and supplies. (\$105,000 in FY 78; \$110,000 in FY 79.)

C. Assistance Area No. 2: Administrative Improvement

1. Need

The Supreme Council for Population and Family Planning in Egypt is charged with the general responsibility for coordinating all efforts designed to reduce annual rates of population growth. Under the Council's general coordination, most family planning services are being delivered

by approximately 2,900 urban and rural service units of the Ministry of Health (MOH).

The MOH has established a Department of Family Planning to plan, to coordinate, and to supervise the carrying out of MOH-sponsored family planning services, family planning training, and family planning research.

The staff of the Department totals 2 professionals and one administrative/clerical personnel; while there are other civil service slots allocated to the Department, existing Ministry of Health professionals are not attracted to the Department because of requirements to travel, few opportunities for auxiliary income (i.e. no research funds, private practice), and little professional status associated with this relatively new department. Our assistance has been requested to provide a mechanism for temporary (3 years) professional staff participation until a full-time staff can be developed from newly recruited civil servants. This staff participation would demonstrate to the MOH/GOE the desirability of an expanded role for the MOH Department of Family Planning.

## 2. Outputs

By September 30, 1980, the Egyptian Government will establish 8 additional professional positions and 6 additional administrative/clerical positions in the Ministry of Health's Department of Family Planning and will have recruited, trained, and assigned full-time professional and administrative/clerical personnel to each of these positions. (An appropriate covenant will be included in the Project Grant Agreement.)

## 3. Inputs

For FY 77, \$41,000 will be associated with the local currency financing of up to 8 person/years annually for the services of recent

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graduates of Egyptian universities with the requisite academic training for staff participation. These graduates would be hired through a series of short-time (3-6 month) contracts as full-time "consultants" to the Department of Family Planning. Additionally, funds will be provided to make available up to 100 person hours a month of Egyptian professor-level consultants to the Department for special purposes. Funds also would be associated with the employment of up to 6 administrative/ clerical personnel, and modest amounts of office equipment, supplies, and supporting costs attendant to these temporary employees. For FY 78 and 79 \$45,000 and \$50,000 respectively will be programmed.

D. Assistance Area No. 3: Integrated Social Services Delivery System

1. Need

Although family planning services nominally are available throughout Egypt, estimates of current nationwide contraceptive participation rates vary from a low of 15 per cent to approximately 27 per cent of married couples of reproductive age (MCRA). In rural Egypt, where 56 per cent of the Egyptian families live, contraceptive participation rates are less than half that of the urban areas. A recently analyzed National Fertility Survey for 1974-5 shows participation rates of 16 per cent for rural areas, 41 per cent for urban, with 26.6 per cent overall. This includes modern and traditional methods.

In 1974, the Social Research Center of the American University of Cairo, with central AID/W support, initiated a pilot activity which included household contraceptive distribution in one of the villages (Shanawan) in Menoufia Governorate. Among other achievements, this project led to a 68 per cent increase in contraceptive

participation rates in the space of one year. This pilot activity subsequently was expanded to a total of 36 villages in the Menoufia Governorate. Initial informal findings of this expanded activity have indicated that the modified activity is leading to significantly expanded contraceptive participation rates. (Funding for this continuing activity will be assumed by USAID in this Project.)

Worldwide, small-scale pilot activities in the family planning and other social change areas frequently have not been replicated effectively on a large scale. To address this need, the Social Research Center of the American University of Cairo has worked collaboratively with the Governor of Menoufia and governorate-level family planning, health, and social welfare officials to design an integrated proposal that will provide household and community distribution of contraceptives, basic health services, and social welfare services in the 302 rural villages of the Menoufia Governorate, comprising a rural population of 1.4 million people.

A synopsis of the project proposal accompanied the Project Identification Document. The full proposal with a revised budget are attached as Annex F.

## 2. Outputs

A comprehensive description of the outputs to this sub-activity are delineated in the proposal. In summary:

- a. Baseline and follow-up surveys will take place.
- b. Staff personnel in the fields of family planning, health, and social welfare will be retrained, as will canvassers, community development workers, field supervisors, and community leaders.
- c. Contraceptive, basic health, and social welfare information and services will be delivered at the household and community level in

302 rural villages.

d. New and/or expanded community activities will take place.

e. Cost/effectiveness of a large-scale integrated rural system comprising family planning, health, and social welfare will be documented for possible replication in other governorates.

f. Activities begun under the centrally funded 36 village expanded household distribution project (AID Grant PHA-G-1139) will be completed.

### 3. Inputs

\$1,131,000 in FY 77 -- this amount covers the first year of a three-year project currently totaling \$3,993,000.

Of the \$1,131,000 proposed for obligation in FY 77, only about 10 per cent will cover direct foreign exchange costs. The rest will be dollars associated with local cost financing. USAID is considering the possibility of designing jointly with the American University of Cairo (AUC), a fixed amount reimbursement (FAR) schedule for dollars to be associated with local cost financing. This reimbursement schedule would be based upon output indicators rather than upon input indicators, such as salaries, vehicle maintenance, and the like. Any reductions in budget totals for the first year of this three-year activity will be carried over to the first few months of the second year.

The summary budget of the proposed project is presented below. The three-year total for the project is \$3,993,000.

Budget Summary

Budget Categories	1st year		2nd year		3rd year		Totals	
	(\$000)	(%)	(\$000)	(%)	(\$000)	(%)	(\$000)	(%)
Salaries	462	41	507	35	556	40	1,525	38
Menoufia Activities	612	54	887	61	788	56	2,287	57
Other Costs	57	5	61	4	63	4	181	5
Totals	1,131	100	1,455	100	1,407	100	3,993	100

To our knowledge, an integrated social services delivery project of this nature (including household distribution) has not been attempted elsewhere. Household contraceptive distribution has been done; household distribution with some health services or some social services has been attempted; but no fully integrated delivery approach using household contraceptive distribution has been tried.

This sub-activity recognizes the interdependent and mutually reinforcing relationships existing between delivery of social services, health, and family planning. These relationships are clearly recognized by the GOE at the national and governorate levels, where health and social affairs ministers and governorate general-directors are key

members of family planning policy units. The majority of governmental family planning services are delivered through facilities under the jurisdiction of either the Ministry of Health or the Ministry of Social Affairs. Inputs attributed to either family planning, health or social welfare have effects desirably synergistic to activities in each of the other two functional categories. While we may attribute inputs equally to each sub-sector (1/3 to family planning, 1/3 to health, 1/3 to social affairs), such attributions are arbitrary at best, given the interdependence described above.

A significant portion of the project budget will be allocated to the Social Research Center (SRC) for salaries for design, monitor, research, and evaluation components. The SRC has the expertise to conduct the activity, as a catalytic change agent. These costs are typical of initiating a large innovative social change activity, but to a large extent would not be required for further replication.

E. Assistance Area No. 4: Training

1. Need

Appropriate family planning training is an integral part of successful family planning programs. Many physicians, nurses, midwives, medical social workers and others have not received adequate training in the concepts and techniques of family planning. The majority of newly trained physicians have not been trained for leadership roles in family planning and other preventive health strategies before their assignment initially to rural settings.

Nurses and trained midwives who work as assistants to physicians have learned little about contraceptive methods, performing pelvic examinations and vaginal smears, screening of pill patients, handling

of record cards, counseling first-time visitors, and providing follow-up care to family planning acceptors.

Medical social workers have limited awareness of the role of family planning in comprehensive social service to families and communities and of the counseling interventions that they can make to families to help them accept and continually utilize family planning services.

Postgraduate physicians, nurses, and other professionals who play supervisory roles in the health field, including family planning, have had little supervised field experience in the planning and managing of these services.

Several factors, discussed in the sections below, have inhibited the family planning training of these medical, paramedical and other personnel.

This project will help to address some of these inhibiting factors by:

-- developing and carrying out short, intensive, in-service courses in general family planning for recent medical school graduates before they are assigned to rural health posts.

-- providing clinical family planning experience at the MOH Al Galaa Maternity Hospital, Cairo, to 4 different categories of workers who will receive family health training designed by the International Islamic Centre for Population Studies and Research at Al Azhar University, one of the most prestigious Islamic universities in the world;

-- developing a field training site as an essential element of the University of Alexandria's High Institute of Public Health; and

-- providing long-term and short-term training in the US and third countries for selected Egyptians.

a. Short Courses for Recent Medical School Graduates

Because of the existence of an extensive health delivery infrastructure and annual production of 3,000 physicians, all health and family planning delivery services in Egypt are physician-dependent to a degree rarely, if ever, seen in developing countries outside of Egypt. While trained well to provide general medical care, the majority of these newly trained physicians have not been sufficiently trained for the leadership roles in family planning and health that are expected of them in the rural health setting where they are assigned initially for 1 to 2 years following medical school graduation. Several factors have inhibited their training. The increased volume of medical students admitted for training has severely taxed the training capacity of the available institutions. These facilities have not been enlarged to keep pace with the growing enrollment. In the case of at least 1 institution, enrollment has increased 10 times within the past decade with no commensurate increase in clinical and laboratory training facilities. While numbers of physicians graduated have increased, quality of education in some selective areas has not kept pace.

Of particular relevance to this activity is the need for general family planning training for recent medical school graduates. To meet this particular need, USAID plans to make funds available for up to 4 short-term consultants per year for approximately 3 months each to work with appropriate Egyptian institutions to design short, intensive general family planning training courses for recent medical school

graduates before they are assigned to rural health posts.

Physicians trained in the field of general family planning are key to the successful expansion of family planning services. Once trained in family planning, they will be able not only to provide family planning services themselves, but also to train and supervise paramedical and other family planning workers.

b. Clinical Family Planning Experience at Al Galaa Maternity Hospital, Cairo

A July 5, 1977, letter to USAID from the Director of the International Islamic Centre for Population Studies and Research at Al Azhar University was attached to a comprehensive plan for converting a solidly constructed but run-down Ministry of Health Maternity Hospital into a functioning training center for maternal/child health and family planning and model services delivery. The proposal described the collaborative role between the Ministry of Health and the Al Azhar University Department of Ob/Gyn afforded by a newly created GOE Central Organization for Medical Education. The letter requests AID assistance in renovating the Al Galaa Maternity Hospital. The hospital currently is unable effectively to provide truly modern maternal and child health and family planning services let alone to provide clinical family planning experience to Ob/Gyn's, general medical practitioners, paramedical workers, and medical social workers. A synopsis of the proposal follows:

"On repeated requests from the Supreme Council for Population and Family Planning and from the Ministry of Health, the International Islamic Centre for Population Studies and Research at Al Azhar University, one of the most prestigious

Islamic universities in the world, has developed a training program in family health for 4 different categories of health personnel: Ob-Gyn's, general medical practitioners, paramedical workers (nurses and trained midwives), and medical social workers. Separate courses of instruction for each category of personnel will be given twice each year.

"The first course, primarily for obstetricians and gynaecologists, will demonstrate innovative surgical procedures such as laparoscopy and culdoscopy, will present national and international experience in the use of different steroidal combinations, including injectables, and will describe the newest methods of fertility regulation.

"The second course, for general practitioners, will focus on the health risks and social consequences of unplanned pregnancies, describe and demonstrate the full range of contraceptive techniques and evaluate them in terms of their effectiveness, acceptability, and useful, harmful, or merely annoying side effects.

"The course for nurses and trained midwives who work as assistants to family planning doctors will provide basic facts about contraceptive methods through a programmed instructional series of modules. Supervised practical experience will include the performing of pelvic examinations and vaginal smears; sterilizing instruments; using checklists

for screening of pill patients, preparing, indexing, and summarizing individual case records; and the like. Through role-playing, participants will learn how to provide follow-up care to acceptors.

"The fourth course, training of medical social workers, will give participants an insight into the nature of interpersonal communications that may be used to influence decisions to accept and continue family planning. Role-playing, studying tape recorded interviews with patients, and supervising home visits will teach them how better to strengthen their communications with potential family planning acceptors.

"The unit of Human Reproduction of Al Azhar University's International Islamic Centre for Population Studies and Research will provide direction and control of each training program and will provide lecturers and demonstrators from the medical and social science department of Al Azhar University. It will also arrange for the use of two urban and three rural family planning clinics and will provide field trips to villages where the Centre is conducting family planning research projects.

"What is lacking are requisite clinics, operation theaters, laboratories, and other facilities at the Al Galaa Maternity Hospital in Cairo, a Ministry of Health hospital affiliated with Al Azhar University."

Because of this hospital's direct relationship to Al Azhar University's International Islamic Centre for Population Studies and Research, its use, once renovated for comprehensive clinical training and service in the family planning field, will facilitate the carrying-out of similar training and service programs in other hospitals in Egypt and in other Islamic countries.

Under contract AID/NE-C-1353, a consultation team visited Egypt in Spring 1977 to do a health facilities survey of the Cairo area. The team thoroughly examined Al Galaa Maternity Hospital and determined that renovation could take place during a time frame of 18 months to 2 years at a cost of \$1,000,000.

c. Field Training Site at High Institute of Public Health

The High Institute of Public Health, part of the University of Alexandria, is the only specialized postgraduate preventive health training institute in Egypt. Over 80 per cent of the students are employees of the Ministry of Health and attend the Institute on governmental fellowships. Upon completion of their training, they are obligated to continue working for the Ministry of Health for two years for each year of training.

The Institute's advanced degrees are required for promotions into supervisory positions within the Ministry, particularly in rural health administration.

Relatively new to the Institute is a Department of Family Health headed by Dr. Ahmed F. El Sherbini. With experience in the family planning field both in Egypt and, as a WHO Advisor, in other countries,

he believes that a field training site is an essential element of comprehensive training. USAID assistance has been requested to establish the field training. The main thrust of this field training would be in supervised practical experience in the planning and managing of outreach support in the areas of integrated maternal and child health, family planning, and other areas of primary health care.

We estimate approximately 25 per cent of the inputs of this sub-activity will be directly related to family planning; the remaining 75 per cent will be addressed to teaching and demonstrating the principles of primary health care which relate to fertility reduction less directly in immediacy, but <sup>which</sup> may be equally important in the long run.

The proposed field training site initially would be for students in the Institute's Family Health Department. As the site is developed and utilized effectively, other departments will be encouraged to participate.

#### d. Training in the US and Third Countries

Lacking in Egypt are advanced training opportunities in many disciplines relevant to family planning. Disciplines include, but are not limited to, mass communications, the marketing of social products, family planning administration, and the like. Also useful are experiences in the delivery of family planning services in America and third countries in both urban and rural settings. Finally, specific long-term and short-term US training will be needed in many of the other assistance areas outlined above.

### 2. Outputs

a. By the end of FY 80, systems will be developed, tested and appropriately modified in the 25 governorates to provide short-term general family planning training to recent medical school graduates before their assignment to rural posts.

b. Up to 1,000 physicians will receive this short-term training by the end of FY 78; and up to 2,000 will receive this training each year beginning in FY 79.

c. By mid-to late-FY 80, Al Galaa Maternity Hospital will be renovated in order to provide supervised clinical experience to 4 separate categories of personnel who will be trained under programs that have been designed by Al Azhar University's International Islamic Centre for Population Studies and Research.

d. Once Al Galaa Maternity Hospital is renovated, 40 Ob/Gyn's, 80 general medical practitioners, 80 paramedical personnel, and 80 medical social workers will receive family planning training each year, in course work summarized in section II-E-1-b above.

e. By the end of FY 80, a rural field training site near Alexandria will be developed and integrated into the High Institute of Public Health.

f. Field-based teaching and research programs will be developed.

g. Students at the Institute will receive supervised practical experience in the planning and managing of rural health outreach support for integrated MCH, FP, and other basic health services.

h. 15 selected Egyptians per year in FY 77, FY 78, and FY 79, respectively will receive long-term participant training in specific fields to be determined.

i. 30 selected Egyptians per year will receive short-term participant training in fields yet to be determined.

### 3. Inputs

a. Up to \$104,000 of FY 77 funds will be programmed to cover the direct foreign exchange costs for 4 consultants for 3 months each during FY 78 to assist appropriate Egyptian institutions in designing

and carrying out short, intensive general family planning training programs for recent medical school graduates before they are assigned to rural posts. An additional \$100,000 of FY 77 funds will be associated with the local cost financing for 13 such courses in FY 78. Total for FY 77 funding: \$204,000. For FY 78 and FY 79, \$334,000 and \$358,000, respectively, will be programmed.

b. \$200,000 of FY 77 funds will be programmed to cover the direct foreign exchange costs for A & E services required to help design and supervise the renovation of Al Galaa Maternity Hospital. An additional \$1 million of FY 78 funds would be associated with the local cost financing for this renovation. USAID will not obligate these funds for renovation until preliminary plans and cost estimates are prepared by the A & E study and are reviewed by the Mission. While we expect no significant environmental impact because of renovations of existing structures, the impact will be assessed during the A & E study.

c. \$314,000 of FY 77 funds will be programmed to cover the direct foreign exchange costs for the first 18 months of an institutional contract that will make available for a long-term resident expert (\$171,000), 2 short-term consultants for up to 4 person/months each year (\$68,000), and educational equipment and supplies (\$75,000) in order to assist the High Institute of Public Health to develop its field training site. An additional \$80,000 of FY 77 funds will be associated with the local cost financing of educational seminars and workshops, locally procured equipment, teaching materials, supplies, and miscellaneous costs. Total for FY 77 funding: \$394,000. For FY 78 an additional \$383,000 will be programmed to cover direct foreign

exchange and local cost financing for the remaining 18 months of this 3-year sub-activity.

d. \$436,000 of FY 77 fund will be programmed to cover 15 long-term participants (5 of which will be academic) and 30 short-term participants in FY 78. For FY 78 and FY 79, \$458,000 and \$481,000, respectively, will be programmed for participant training.

F. Assistance Area No. 5: Innovation and Technology Transfer

1. Needs:

During the start-up of bilateral support activities, a variety of opportunities have been identified which will require modest support of local cost financing for immediate family planning impact or will lay the groundwork for subsequent larger investments. Examples which the Mission has discussed with various Egyptian entities include small-scale evaluation of innovative interventions; communications efforts, workshops or conferences with family planning impact; support for innovative services delivery systems in MOH clinics or family planning associations; the introduction and expansion of demographic components into other disciplines such as agriculture, education, rural development; and the like.

In addition to low cost innovative activities which will require local cost financing, moderate amounts of foreign exchange for direct technology transfer will be necessary to bring short-term consultants to Egypt to assist various ministries and other Egyptian entities in the transfer of modern technology in the population field and to provide minimal amounts of equipment and supplies as needs are identified.

A number of areas for greater future assistance have not been addressed specifically in this project. An example is population information, education communications ( I. E. & C.). To the extent possible, I. E. & C. components will be incorporated into each sub-activity; however, procurement, production and distribution of needed teaching materials and population education material would be possible and should be emphasized under this Assistance Area.

G. New Thrusts

This Project Paper describes the general thrust of a 3-year AID bilateral SA-funded project in the family planning field in Egypt. The paper also outlines in somewhat greater detail activities for which funds will be obligated in FY 77. Illustrative figures for FY 78 and FY 79 are cited.

USAID/Egypt will add to its staff a full-time professional in the population field near the end of August, 1977, a Population Advisor. As the USAID staff interacts on a full-time basis with Egyptian ministries and other organizational entities, the Mission may propose modification of certain activities described above and/or generation of new activities.

H. FINANCIAL SUMMARY - AID INPUTS

Family Planning Assistance Areas	FY 77		FY 78		FY 79		LOP	
	(\$000)	(%)	(\$000)	(%)	(\$000)	(%)	(\$000)	(%)
1. Contraceptive Availability	993	25	2,119	32	3,370	52	6,482	38
2. Administrative Improvement	41	1	45	1	50	1	136	1
3. Integrated Social Service Delivery System	1,131	28	1,455	22	1,407	22	3,993	24
4. Training	1,234	31	2,175	33	849	13	4,258	25
5. Low-Cost Innovation and Population Technology Transfer	550	14	595	9	640	9	1,785	10
CONTINGENCY	51	1	199	3	196	3	346	2
TOTALS	4,000	100	6,488	100	6,512	100	17,000	100

H. FINANCIAL PLAN - AID INPUTS  
(\$ 000's)

Family Planning Project Activity	FY 77			FY 78			FY 79			LOP		
	Direct \$ Costs	\$(LC)*	Totals	Direct \$ Costs	\$(LC)*	Totals	Direct \$ Costs	\$(LC)*	Totals	Direct \$ Costs	\$(LC)*	Totals
1. Contraceptive supplies												
a. Condoms	730	---	730	1,460	---	1,460	2,190	---	2,190	4,380	---	4,380
b. Lippes Loop Molds & Inseters	5	---	5	-----	---	-----	-----	---	-----	5	---	5
c. Oral raw material	120	---	120	514	---	514	1,028	---	1,028	1,662	---	1,662
d. Minilap kits	38	---	38	40	---	40	42	---	42	120	---	120
e. Others	100	---	100	105	---	105	110	---	110	315	---	315
2. Assistance MOH Family Planning Dep.	---	41	41	-----	45	45	-----	50	50	-----	136	136
3. Integrated social service deliv. sys.	113	1,018	1,131	54	1,401	1,455	56	1,351	1,407	223	3,770	3,993
4. Training												
a. Short-term training physicians	104	100	204	114	220	334	125	243	368	343	563	906
b. Clinical training	200	---	200	-----	**1,000*	**1,000*	-----	---	-----	200	1,000	1,200
c. Field training	314	80	394	295	88	383	-----	---	-----	609	168	777
d. Participant training	436	---	436	458	---	458	481	---	481	1,375	-----	1,375
5. Low cost innovative activities and pop. tech. transfer	250	300	550	265	330	595	280	360	640	795	990	1,785
Contingency		51			199			196			346	346
Total	2,410	1,590	4,000	3,305	3,183	6,488	4,312	2,200	6,512	10,027	6,973	17,000

\* Dollars associated with local currency financing

\*\* Mission will not obligate until A and E study approved

GOE Contribution

Expenditures of GOE resources attributed to family planning or activities related to this Project can only be very roughly approximated because of the inclusion of most population and family planning related costs into ongoing expenses of several ministries. An illustrative example of the problem in estimating expenditures is the case of the Ministry of Health (MOH), through which a majority of family planning services are delivered. Family planning services are part of the comprehensive, integrated services technically supervised by the central ministry, but delivered through 25 separate governorate administrative structures by the MOH; it is difficult to ascribe to family planning precise percentages of the MOH and governorate health budgets, capital support, operational and other costs. These governorate health expenditures are not disaggregated for family planning services. Similar problems exist for Ministry of Social Affairs activities.

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GOE Contributions

1. Contraceptive Supply

Estimated GOE expenditures for raw materials  
and fertility related commodities

LE 1,000,000 per year x 3 years = LE 3,000,000

2. MOH Department of Family Planning

Staff, office space and operating expenses

LE 18,000 per year x 3 years = LE 54,000

3. Menoufia

These figures were extrapolated from illustrative figures provided for a health district in another governorate in lower Egypt:

A. Health

Governorate and district health offices (8)

LE 3,850,000 per year x 3 years = LE11,550,000

Rural Health Units (134)

134 x LE 18,000 x 3 years = LE 7,236,000  
(A) LE18,786,000

B. Social Affairs

Project-related activities of Governorate  
Department of Social Affairs

25 per cent of (A) = (B) LE 4,696,500

C. Department of Local Government

5 per cent of (A) = (C) LE 939,300

Total (A), (B), (C) = LE24,421,800

1/3 of total of (A), (B), (C)  
considered project related = LE 8,140,600

4. Training

A. Physician Training

LE 10 per physician x 2,500 physicians  
x 3 years = LE 75,000

B. Clinical Training

Operating expenses of Al Galaa  
350 beds x LE 200\*per year x 3 years = LE 210,000

Salaries = LE 840,000

OPD 100,000 visits per year x LE  
0.100 x 3 years = LE 30,000

Land, depreciation of existing  
buildings = ---  
LE 1,080,000

C. Field Training

Use of district facilities +  
staff. LE 50,000 per year x  
3 years = LE 150,000

HIPH field support and staff  
LE 50,000 per year x 3 years = LE 150,000  
LE 300,000

D. Participant Training

Maintenance of salaries/  
allowances = LE 202,500

Total training = LE 1,657,500

5. Innovative Activities

25 per cent of USAID contribution  
(in LE) = LE 312,300

TOTAL of 1, 2, 3, 4, 5 = LE13,164,400

DOLLAR EQUIVALENT AT \$1=0.70LE = \$18,430,160

\* Ministry of Health Report to the  
Peoples' Assembly, 1977

Other Donors

The two major other donors are the UNFPA and the IBDR.

The UNFPA has agreed in principle to a \$10,000,000 activity 1976-1980. The support includes activities implemented through the PFPB and through the Central Agency for Public Mobilization and Statistics (CAPMAS). UNDP documents 76-22914 describes this project activity; a budget sheet for the project follows this analysis.

For purposes of this discussion, only those amounts budgeted for contraceptive supplies and training for 1977-1979 are reflected as closely related to assistance areas of the USAID project:

Contraceptive Supplies	\$3,250,000
Training	<u>\$ 693,000</u>
TOTAL	<u>\$3,943,000</u>

During the life of this Project, the World Bank will be completing a \$5,000,000 project begun in 1973. The Bank has received and is considering a proposal from the Ministry of Health for a 6-year project with a combined MOH and IBRD total of approximately \$42,500,000. The project considers providing about 27% of this amount in the form of home visiting programs, innovative activities and community incentives related to fertility-related achievement. The project is proposed for 5 governorates and 2 districts in Cairo. Other major inputs of the project will be in the area of civil works, furniture and equipment, vehicles, information-education-communications, research and evaluation, fellowships abroad and local training, consultants, incremental salaries, and spin-off projects (23% of total project budget). The latter category of funds would permit replication elsewhere in Egypt of program components found to be

desirable and feasible after mid-project evaluation.

We have included inputs from this project of \$400,000 (2 years of fellowships abroad and local training) as being closely related to project activities of the USAID Project.

Other donors are providing significant monetary and technical contributions which are extremely important in terms of program content; their contributions are not costed in this analysis for purposes of simplicity. High among these are UNICEF, WHO, the International Planned Parenthood Federation, Pathfinder, etc. In recent months the Governments of Great Britain and the Federal Republic of Germany have consulted with the GOE about possible family planning assistance. These potential contributions are not costed. Considerably understated, then, other donor-attributed contributions are: \$4,343,000.

IV. Financial data

42. Estimated UNFPA assistance from 1976 to 1980 by project will be:

	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>Preliminary estimates</u> <u>1979-1980</u>	<u>Total</u>
	\$	\$	\$	\$	\$
<u>Projects implemented through PFPB</u>					
Management, planning and evaluation	232 000	835 000	1 123 000	603 000	2 793 000
Socio-economic, biomedical and action research	250 000	287 000	316 000	475 000	1 328 000
Family planning services	910 000	900 000	800 000	1 200 000	3 810 000
Communication, education and training	205 000	261 500	236 500	500 000	1 203 000
<u>Projects implemented through CAPMAS</u>					
Population and housing census	357 000	-	-	-	357 000
Pregnancy wastage and infant mortality and migration surveys	-	159 500	89 500	173 000	422 000
Population communication unit in the Land Resettlement Scheme	3 000	44 000	40 000	-	87 000
	<u>1 957 000</u>	<u>2 487 000</u>	<u>2 605 000</u>	<u>2 951 000</u>	<u>10 000 000</u>

43. By component the breakdown for the years 1976-1978 will be as follows:

<u>Component</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>Total</u>
	\$	\$	\$	\$
International project personnel	28 000	76 000	58 000	162 000
National personnel	146 500	421 000	419 000	986 500
Subcontracts	159 000	259 000	489 000	907 000
Equipment and contraceptive supplies	1 417 000	1 343 000	1 252 000	4 012 000
Training	110 000	166 500	166 500	443 000
Miscellaneous	96 500	221 500	220 500	538 500
	<u>1 957 000</u>	<u>2 487 000</u>	<u>2 605 000</u>	<u>7 049 000</u>

### III. Project Specific Analyses

#### A. The Problem

The Egyptian Government in 1952 gave considerable attention to economic development as a tool to accomplish political and sociological objectives. The National Economic and Social Development Plan included agrarian reform, land reclamation with agricultural expansion, the High Dam in Aswan, mineral development, accelerated industrialization, and the upward mobility of the Egyptian society through better health care and education. All of these programs were launched between 1952 and 1960.

These rather ambitious objectives were inhibited by at least 3 constraints: (1) an exploding population growth rate of over 2.5 per cent annually, which could result in a surplus of unskilled laborers (in both the agriculture and industry sectors) of over 31 per cent by 1985; (2) a loss of severely limited arable land to housing and industrialization; and (3) the constant subdivision of the independent farmer's land into ever smaller and less efficient units to satisfy Muslim inheritance law. Significant reductions in population growth rates, increased productivity of workers, and curtailment of unemployment could help address these constraints.

However, it was only in the mid-sixties, after several years of experience with economic development, that the Egyptian Government came to recognize the importance of curtailing its population growth through family planning. In 1966, President Nasser enunciated a National Population Policy which has since been supported by President Sadat. In 1973, the Government articulated the goal to reduce the annual growth rate to 11 per thousand by 1982, by reducing the birth rate

from 34 per 1,000 in 1973 to 24 per 1,000 by 1982, at a rate of .1. per 1,000 annually. The target birth rate, coupled with a death rate of around 13 per 1,000, would lead to an annual growth rate of about 11 per 1,000. The pattern of target birth and expected death rates in the decade (1973-1982) would lead to a population of approximately 41 million inhabitants by 1982. However, as will be shown below, the birth rate has not dropped significantly as of 1976 when the population reached 38 million.

#### B. Demographic and Social Characteristics

The population of Egypt entered into its exponential growth phase during the late 1940's. Whereas the population grew from about 2.5 million to about 10 million during the 19th century, it grew to 19 million in less than 50 years (1947) and doubled to 38 million in the following 29 years (1976). Crude birth rates have fluctuated around 40 per 1,000 since 1920, assuming a slight downward trend during the 1960's. Crude death rates, on the other hand, fell precipitously during the middle and late 1940's from about 27 to about 15 in 1970. This disparity between crude birth and death rates, typical of all developing countries, accounts for Egypt's exploding population.

According to the preliminary results of the National Census, completed in November, 1976, the total resident population of Egypt is 38 million people, of which some 4 per cent are abroad for work in Arab, African, or other countries. The annual rate of population increase compounded over the past decade has been 2.3 per cent. Egypt has become more urbanized in the past 16 years as urban population increased from 37 per cent of total population in 1960 to 44 per cent in

1976. This increase is attributed mainly to internal migration from rural areas. Lower Egypt encompasses 43 per cent of the population; Upper Egypt, 35 per cent and Cairo 22 per cent of the population. The population density of Cairo, with more than 8 million persons, increased over a 10-year period by 21 per cent to 23,737 persons per square km; and in two Cairo districts, population density now is over 100,000 persons per square km.

Islam is the religion of the overwhelming majority of the population; the percentage of Christians amounts to 6.3 per cent.

According to the preliminary analysis of the 1976 Census,

"The sex ratio of 104 males to 100 females is determined by three demographic factors: migration, sex ratio of births, and sex ratio of deaths. During the period 1960 - 1976, the sex ratio of births has increased (as a result of the decrease in pregnancy wastage and increase in lower order births which occurs with a reduction of fertility among women over age 35), and the sex ratio of deaths has decreased. Both trends contribute to an increase in the overall sex ratio."

The age pyramid has a broad base. Some 32 per cent of the population is children under the age of 12 years; 65.5 per cent in the productive ages (12-65); less than 3 per cent, 65 and older.

The economically active population of Egypt is based on a denominator of individuals aged 6 years and over. Only 31.5 per cent of the total population over age 6 is economically active, i.e.

53 per cent of males and 9 per cent of females. A decline of 3 percentage points in male economic activity since 1960 may be due to a decrease in the number of children engaged in economic activity as a result of the expansion of education or to a proportion of the male labor force outside of the country. The proportion of females engaged in economic activity has almost doubled since 1960.

The educational status of the population has improved considerably since 1960. Illiteracy (not defined) has decreased from 70.5 per cent to 56.5 per cent among individuals aged 10 years and above. The percentage of those able to read and write increased from 22.5 per cent to about 25 per cent. The percentage of those with primary and intermediate qualifications (i.e., less than university degree) is 16.2 per cent in 1976 compared to 6.2 per cent in 1960. The proportion of males with intermediate qualification is almost twice that of females (20.4 per cent, compared to 11.6 per cent), while the rate of improvement for females is twice that of males.

The distribution of population by marital status (females 16 years and older, males 18 years and older) shows a significant trend toward an increase in the proportion never married and a decrease in the proportion married. Extended and expanded education and economic factors contribute to raising the age of marriage, especially in the urban areas which encompass about 44 per cent of the population of Egypt.

The average household size is about 5.2 persons. The household includes those related or unrelated persons who provide food or other living essentials for themselves. The average number of rooms per household is 2.8, and the degree of crowding is 1.8 persons per room.

These figures reflect an acute housing shortage in Egypt which is aggravated in urban areas. 45.7 per cent of households are served by electricity, (82 per cent in Cairo, 38 per cent in Lower Egypt, 29 per cent in Upper Egypt.) 30.2 per cent of households are provided with purified drinking water within the dwelling. Another 44.6 per cent have access to pure water; 25.5 do not have any source to purified drinking water. 1975 was the last year for which annual growth rates have been analyzed. If the 1975 rate of annual population increase (2.5 per cent) were to continue, the population would double in about 28 years.

In brief, the late 1976 population is over 38 million. About 44 per cent of the population is urban; some 56 per cent illiterate; 31.5 per cent economically active (about 53 per cent of the males). The overwhelming majority is Muslim. Less than half the households are provided with electricity while a quarter of the households are devoid of a source of purified water.

C. Egyptian Program

Egypt has an extensive health infrastructure through which family planning services are provided to rural and urban population. Policy and broad elements of the program are decided by the Supreme Council for Population and Family Planning, which is chaired by the Prime Minister. The Council includes in its membership the Ministers of Health, Education, Planning, Social Affairs, and Religious Affairs, the Chairman of the Central Agency for Public Mobilization and Statistics, the Executive Director of the Population and Family Planning Board, and 4 appointed private individuals. The Population and Family Planning Board of the Supreme Council provides for the overview and coordination of population/ family planning programs carried out by various ministerial entities and

other bodies, reviews the family planning budget in the MOH, and oversees the importation and distribution of commodities throughout the network of supply depots to the clinic, other service outlets, and commercial outlets.

Within the Ministry of Health is a Department of Family Planning with major responsibilities in the area of monitoring the national population policy and achieving population growth targets. Up to the present, the Department has been provided with a staff far too small properly to carry out its responsibilities.

The primary family planning service delivery element is the responsibility of the Ministry of Health, working largely through the clinics and related health installations under the technical jurisdiction of the Ministry. These service installations and clinics are operated by the Health Departments of the 25 governorates. Governorate and county levels of health administration personnel provide overall administrative and direct supervision of facilities and services.

At the community level is the health unit, headed by a recently graduated physician assigned to serve the health unit for one to two years in recompense for his or her state-supported medical education. The health unit is staffed by the doctor, nurses, midwives, a laboratory assistant, and a health practitioner. Although this staff is charged with the delivery of family planning, its members have been inadequately trained in family planning techniques and concepts. This problem seems to extend all the way from the physicians in charge of clinics to the social workers assigned to the outreach function. It has been observed, for example, that clinic personnel, both "professional" and "para-professional," lack knowledge and experience in such basic skills as IUD

insertion, and have little or no information on the value of and limitations involved in the use of oral contraceptives.

Available to deliver family planning services and to motivate couples to accept family planning concepts throughout Egypt are some 18,000 physicians, 5,600 midwives, 1,800 social workers. They work in some 3,000 health service centers, such as hospitals, MCH Centers, Rural Health Centers, and various other units. The regular staff of the clinics and centers work for about two hours, three afternoons a week, on family planning service, motivation, and delivery. For such work, the service staff receive an incentive payment of up to 30 per cent of their salaries in addition to their basic pay. The funds for such incentives are generated from the sale of contraceptives. Non-clinical personnel (supply clerks, administrative, and the like) similarly receive a topping-off payment amounting to 30 per cent of their base pay, for their "work" on family planning.

Despite this imposing catalog of available facilities, the Egyptian family planning program must be strengthened further in order to meet its goal. While various constraints might inhibit the attainment of its population goal (among them demobilization and worsening economic conditions), one of the basic constraints is the less than fully adequate service delivery at the field level. Other program constraints that may be alleviated include less than fully adequate program planning and management at the central level and inadequate responsiveness in timing and amounts of funding available for the overall program.

Other constraints that may be alleviated include:

-- Occasional irregular supplies and periodic shortages of contraceptives;

-- Shortage of communications personnel and of well-tested communications messages; and

-- Not fully utilized service statistics for reporting and monitoring service delivery and commodity flow systems.

The family planning delivery system in Egypt is physician-based. Egypt is unusual for a developing country to have such a large cadre of trained physicians, most of whom are recent graduates. Egypt is currently graduating approximately in excess of 3,000 physicians per year. However, in the past two decades, medical school admissions have increased by four times while the training facilities have remained constant. Enormous classes are instructed primarily in the lecture format. Clinical and laboratory experience is seriously limited. Curriculum is in need of updating. Some graduates have never had a lecture in family planning or done a pelvic examination. Large medical school classes also strain the training capacity of hospitals. It is not unusual for 70 interns from one class to be assigned to a single hospital unit. The dilution of clinical training is further affected by the deteriorated condition of the hospital, the shortage of equipment, and the shortage of fully qualified supervising physicians to oversee the training.

Recently (October 1976), a new government entity was created, the Organization of Medical Education; its objective is to upgrade medical education. One of the steps taken by the Organization is to affiliate selected MOH hospitals with medical schools under the Ministry of Education. Renovation of facilities, improvement of medical school curriculum, and upgrading of hospital staff will have a positive impact

not only on medical education but also on the quality of patient care.

This brief overview of family planning policy, service delivery, and training identifies several areas of obvious need for improvement; namely, a family planning staff at the central level for program planning and management, improvements in the family planning service delivery system, a dependable supply of contraceptives, physician training, and improvement of training facilities.

As of this time, no DAP or sector analysis has been carried out for Egypt; but it is apparent that any such analysis would clearly identify these obvious problem areas as ones needing immediate attention. USAID/Egypt is proposing to initiate program assistance in these identified areas. Based on the experience gained, USAID will modify or focus its assistance as appropriate and will identify additional areas for assistance.

#### D. Environmental Factors

The successful implementation of this project of assistance to Egyptian family planning program efforts, working collaboratively with all other donor activities in family planning, will have a positive effect in moderating environmental problems. The most serious direct and indirect threat to the preservation of the natural environment is the burgeoning population. This leads to the internal shifts into urban areas of already high density; the attendant environmental problems of urbanization; and the taking of agricultural land for industry, commercial, and residential purposes. These problems interact to compromise the quality of human life by inhibiting social-economic development and by hampering progress in the areas of employment, education, housing, food, and health. Rapid population growth also is a substantial factor in the following additional environmental problems:

water pollution, derived primarily from human waste, air pollution from vehicle exhaust emissions, and noise pollution.

This program addresses the problem of a rapidly growing population which at current rates of growth will double in little more than a generation. The population already strains the capacity of the very restricted inhabitable and arable land areas. To the extent that this program succeeds in reducing population growth rates, the impact of the program on the environment can only be favorable.

While construction is not a major component of project activity, renovation of Al Galaa Hospital is proposed for 1978. We do not expect that renovation (vs. new construction) will have a significant effect on the physical environment different from that resulting from the existing hospital, but the possible impact will be assessed during the A & E study funded in FY 1977 and considered in the final design. USAID will not obligate FY 1978 funds for the renovation until it has reviewed and approved the results of the study.

#### IV. Economic, Technical and Administrative Feasibility

##### A. Economic

In this start-up activity, no attempt has been made to do or cost effective traditional cost benefit/analysis. We do not have available disaggregated GOE budgetary figures attributable to project-specific activities, nor do we have sufficient macro-economic data to permit timely development of such an analysis. With experience gained during the project, we expect to develop the data base which will permit more precise economic and other analyses. Mission determination that the project is economically feasible is predicated upon observations from which were developed/comments concerning the the following inputs to each assistance area of the project paper :

##### 1. Assistance Area 1: Contraceptive Availability

Contraceptive availability is widely considered to be the first essential requirement for family planning programs in societies such as Egypt which severely limit legal abortion (vs. Japan) and/or which do not openly promote voluntary sterilization (vs. Bangladesh). The contraceptives provided by this project include the most effective approved products of current technology: IUD's, orals, and condoms. Procurement of condoms through access to AID/W worldwide procurement channels permits economy of scale purchase. Local production of IUD's and orals decreases acquisition and transportation costs. Assuming distribution through already established GOE logistic channels and through another innovative channel (household distribution: see below), we know no more economically feasible way to achieve availability.

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2. Assistance Area 2: Administrative Improvement

Inputs in this area are intended to demonstrate to the GOE the desirability of an expanded role of the Department of Family Planning in planning, monitoring and operations. Because the GOE currently has not had demonstrated the potential worth of an expanded department, it has not been willing to divert from other areas of known need the required risk capital. In view of USAID's view of the potential benefits to the MOH and the family planning program in terms of management, administration, monitoring capability and policy development, we consider these relatively modest investments justifiable. An additional benefit of the approach described in the Project description is the opportunity for on the job-training of civil servants by project-funded Egyptian temporary staff.

3. Assistance Area 3: Integrated Social Services Delivery System

A major concern of this sub-activity is to test whether this innovative approach to the delivery of health, family planning and other social services is cost effective. The approach includes household contraceptive distribution on a wider scale than ever done in Egypt. Experience by the grantee and the GOE on a smaller scale in the same governorate gives promise that the approach is feasible economically on a much larger scale. We, and the GOE, will watch alternative approaches (UNFPA and IBRD funded) which include similar family planning objectives (increase of contraceptive prevalence and a decline in fertility) and will compare the results of the USAID-supported approach with these and existing approaches. If this social action research is successful, not only will improved family planning

services be delivered by the governorate at costs affordable to it, but health and other social services will also be improved at acceptable, sustainable costs. A major portion of the initial USAID costs are intended for comparatively costly startup, training, monitoring and evaluation activities, and largely will not be required to replicate desirable features.

#### 4. Assistance Area 4: Training of Family Planning and Service Providers

Because of the relatively well developed physical infrastructure and wealth of basically trained professional and paraprofessional workers, Egypt's family planning delivery system is clinic-based and physician-dependent to a degree rarely encountered elsewhere. Family planning training of providers, however, has not kept apace.

Because of the role of the physician in provision of services, and his/her key role in the supervision of the services provided by others, we have identified physician training as the most critical training need and the category in which our training inputs should be concentrated. Inputs into training of non-physicians would not be cost efficient if the supervising physician were not adequately trained and motivated. Once trained, the physician's supervisory role will permit him to be a trainer of those he supervises.

Because of the existent physical infrastructure available for training and services delivery, large USAID investments for facility construction are not required. About 7 per cent of project costs are allocated to renovations of physical facilities (a maternity hospital cum training center). When we include the potential benefits which might accrue to the national family planning program because of the relationships of this hospital/training center to a prestigious Islamic

university, we consider these investments justifiable.

#### 5. Assistance Area 5: Innovative Activities and Technology Transfer

A portion of these costs will be used to stimulate small scale innovative Egyptian approaches in the family planning area, and to identify and determine the feasibility of additional areas of USAID assistance in the family planning area. To a large extent the funds thus made available may be considered as investment costs for future potential USAID assistance activities. Other funds will provide the GOE and the Mission with supplemental technical assistance to assure availability of the benefits of worldwide research in information, education and communications, contraceptive technology, management, statistics, demography etc. We consider these expenditures are justifiable project support costs.

#### B. Technical

The major functional areas of immediate AID assistance outlined in the Project paper are in contraceptive availability, administration, management, expanded services delivery, and training.

#### 1. Contraceptive Availability

Worldwide experience with successful family planning programs (US, Japan, Korea, Indonesia, Thailand, Sri Lanka, etc.) have repeatedly shown that while availability is far from the only requirement, it is an essential one. Egypt possesses an oral contraceptive/ IUD production capability and logistics distribution system which can easily absorb the modest additive resources provided by this activity. The commodities provided are all currently in use in Egypt, and all are approved for use in both the United States and Egypt.

## 2. Administrative/Management

Resources supplied by the Project, while modest, are targeted for the area of greatest current need. The technical capabilities to be added to the Department of Family Planning have been identified by Department, Mission and PHA/POP representatives.

## 3. Expanded Services Delivery

Expanded services delivery through an integrated health delivery system, with additive household distribution and emphasis on supporting social services, is an expansion in scale of pioneering efforts carried out by the Menoufia Governorate with support from the American University of Cairo. The mix of health, family planning and social services to be delivered may differ from earlier experience, but the basic approach has been demonstrated to be technically feasible. Earlier work in Comilla (Bangladesh), Narangual (India), Lampang (Thailand), Companaganj (Bangladesh), which integrated delivery systems, and in Egypt, Tunisia, Korea and Indonesia with household contraceptive distribution pilot activities, have successfully demonstrated the technical feasibility of this approach.

## 4. Training

Because of their key role in family planning delivery and the availability of physicians in Egypt, this Project is more attentive initially than most AID projects to physician training than to other professional and paraprofessional categories. This is because the need is greatest in this category. While relatively excellent in-country training staff exist, they will benefit from the technology exchanges in fertility management, administrative and educational technology afforded by consultant visits and by off-shore training.

In summary, the components of AID assistance technically are compatible with the Egyptian Population and Family Planning Policy, have demonstrated effectiveness in Egypt and elsewhere, are appropriate to identified needs in Egypt, and are well within the technical capabilities of the responsible Egyptian professional and paraprofessional.

### C. Administrative

Although the Project will involve a number of Egyptian organizations, the Mission will sign a grant agreement with a single Egyptian government agency which will constitute a bilateral agreement on programatic direction and magnitude. USAID will in turn negotiate implementing documents with each Egyptian entity responsible for implementing sub-activities.

The Mission will sign the overall agreement with the Ministry of Economy and Economic Cooperation. This is consistent with earlier discussions between the Ministry and the Mission, in which the general amounts of USAID funds were agreed to for each functional area of USAID involvement, including Population and Family Planning. Signing the agreement with the Ministry of Economy and Economic Cooperation provides the appropriate GOE agency with a clear picture of financial flows, and precludes the requirement for individual ministries, universities, and other entities to make individual internal GOE justifications for claims to access to foreign currency provided by this Project. The Ministry has experience with receiving, utilizing and auditing external donor funds.

USAID will sign individual agreements including letter agreements and grants with and contracts for the benefit of Egyptian organizations responsible for sub-activities. The following summarizes, by sub-activities, the probable organization with whom agreements for sub-activities will be

negotiated; each listed organization also has had successful experience in receiving, utilizing and auditing external donor funds:

<u>Sub-Activity</u>	<u>Organization</u>
1. Contraceptive Supplies	1. Population and Family Planning Board
2. MOH Family Planning Department	2. Ministry of Health
3. Integrated Social Services	3. American University of Cairo/ Menoufia Governorate
4. Training	4.
a. Short-term	a. Population and Family Planning Board or Ministry of Health
b. Clinical training at Al Galaa	b. Islamic Centre for Population Studies and Ministry of Health*
c. Field training	c. Department of Family Health at the High Institute of Public Health
d. Participant training	d. To be processed by USAID
5. Innovative Activities and Population Technology Transfer	5. As appropriate

Proposals for innovative activities and technology transfer will be reviewed by USAID; approval for expenditure of Project funds for these activities will be granted by the Ministry of Economy and Economic Cooperation using administrative procedures similar to those existing in the Mission's Project 263-0026, Manpower Development and Technology Transfer III.

\* The Minister of Health may prefer that the agreement be signed by the Central Organization for Medical Education which he directs.

To the extent possible, funded PIO/C's will be used for procurement of population commodities through established AID/W central procurement mechanisms to take advantage of economy of scale purchase. A similar mechanism will be pursued for procurement of technical assistance for sub-activities 4 and 5 above.



V. Implementation Plan

STEPS	TASKS	AGENT
1. A-B	Sign with PFPB funded PIO/C worksheets for condoms	GOE/USAID
2. A-C	Sign Project Agreement	GOE/USAID
3. B-D	Procurement - Condoms	AID/W
4. C-E	Sign agreement with PFPB and prepare PIO/C for I.U.D. molds, inserters, minilap kits; release funds for raw materials for orals.	GOE/USAID
5. C-F	Sign agreement with MOH for staffing supplementation	GOE/USAID
6. C-G	Sign agreement with AUC for Integrated Social Services Delivery	AUC/USAID/ Menoufia Governorate
7. C-H	Sign agreement with PFPB for short-term physician training	GOE/USAID
8. C-I	Sign PIOT with MOH for A&E, Al Galaa	GOE/USAID
9. C-J	Sign PIOT with HIPH for Institutional contract - field training	GOE/USAID
10. C-K	Sign PIOP's for participant training. Obligate funds FY 1978 funds	GOE/USAID
11. C-L	Sign agreements for innovative activities. Obligate FY 78 funds	GOE/USAID
12. C-M	Prepare PIO/T's, PIO/C's and purchase orders for technology transfer. Obligate FY 78 funds.	GOE/USAID
13. D-N	Condoms begin to arrive	AID/W
14. E-O	Other commodities arrive	AID/W
15. F-P	Egyptian consultants to MOH performing assigned duties. Obligate FY 1978 funds.	GOE/USAID

STEPS	TASKS	AGENT
16. G-Q	Quarterly release of funds based on scheduled outputs. Obligate FY 1978 funds	AUC/USAID Menoufia
17. H-R	Training plans developed. Agreement for release of training funds	GOE/Contractor
18. I-S	A&E firm selected. Design completed. Obligate FY 78 funds	AID/W/USAID GOE/Contractor
19. J-T	RFP for HIPH. Contractor selected & contract signed	USAID/Contractor/ GOE
20. N-U	Sign with PFPB funded PIO's worksheets for condoms. FY 78 funds	GOE/USAID
21. O-V	Sign with PFPB PIOC's for other commodities, FY 78 funds	GOE/USAID
22. R-W	1,000 physicians trained	GOE/Contractor
23. T-X	HIPH Action Plan completed. Pro Ag. signed	GOE/USAID/ Contractor/AID
24. -Y-	First Annual Review	GOE/USAID/AID
25. U-Z	Condoms arrive. FY 79 funds obligated by PIOC's	GOE/USAID
26. V-A <sup>1</sup>	Obligate FY 79 funds for other commodities	GOE/USAID
27. P-B <sup>1</sup>	Obligate FY 79 funds for Egyptian consultants to MOH	GOE/USAID
28. Q-C <sup>1</sup>	Obligate FY 79 funds for Menoufia activity	AUC/Menoufia/ USAID
29. W-D <sup>1</sup>	2000 additional physicians trained. Obligate FY 79 funds	GOE/Contractor
30. K-E <sup>1</sup>	Sign PIOC's for participant training. Obligate FY 1979 funds	GOE/USAID
31. L-F <sup>1</sup>	Obligate FY 1979 funds for innovative activities.	GOE/USAID
32. M-G <sup>1</sup>	Obligate FY 1979 funds for Technology Transfer	GOE/USAID
33. H <sup>1</sup>	Second joint annual review	GOE/USAID/AID
34. S-I <sup>1</sup>	Al Galaa training fully operational renovation completed	GOE

STEPS	TASKS	AGENT
35. Z-J <sup>1</sup>	Condoms arrived; distributed	GOE
36. A-K <sup>1</sup>	Other commodities delivered, distributed	GOE
37. B-L <sup>1</sup>	MOH Department of Family Planning full staff trained and in place	GOE
38. C-M <sup>1</sup>	Integrated Social Services delivery system in place. Replicable feat- ures identified	GOE
39. D-N <sup>1</sup>	2000 additional physicians trained Contractor assistance no longer required.	GOE
40. X-O <sup>1</sup>	Field Training site fully operative	GOE
41. E-P <sup>1</sup>	All participants in training or re- turned	GOE
42. F-Q <sup>1</sup>	Innovative activities underway or completed	GOE
43. G-R <sup>1</sup>	Technology Transfer activities completed	GOE

## VI. Evaluation Plan

Evaluation activities described in this paper are limited in scope, and principally look at the outputs which will result from the FY 1977 inputs financed under the Project for the family planning system in Egypt. Each of the five areas of assistance will be evaluated at a level commensurate with its importance to the overall effort and to the level of funding provided. To the extent possible, sub-activities will be designed in a fixed amount reimbursable (FAR) mode, so that funds are released against attainment of agreed-upon intermediate outputs. Rate of progress in reaching these intermediate goals will serve as an evaluation of progress. Evaluation activities will be scheduled at appropriate times in order to make needed information available for redesign purposes and to assess the actual accomplishment of the output.

### Assistance Area No. 1: Contraceptive Availability

There is an assumption, based on a non-statistical analysis of the family planning system in Egypt, that the real demand for contraceptives in Egypt exceeds the supply. The size or depth of the demand in the aggregate, or for any individual type of contraception, is not available. AID will furnish under the Project; (1) enough condoms to allow the GOE to maintain a supply adequate to provide an approximate 5 per cent of the MCRA with this form of contraception; (2) IUD molds and inserters to augment the supplies in country for approximately 100,000 MCRA and; (3) raw materials for oral contraceptives.

The Project will monitor the distribution of these supplies, and provide advice to the GOE in their most efficient methods of distribution.

Beginning the third quarter of FY 1978, the Mission will fund under Assistance Area No. 5 of the Project a demand study for contraceptives in Egypt and design an analysis of the extent of the projected impact of the first year inputs of this Project. It will recommend a course of action for a FY 78 and 79 contraception program in Egypt. AID/Washington assistance will be requested to assist the technical portion of this analysis.

Assistance Area No. 2: Administrative Improvement

This assistance is based on the assumption that, as with all effective government bureaucratic units in Egypt, to get and keep good staff, the staff must be thoroughly trained and motivated.

The financing provided in this section temporarily will allow the Department of Family Planning to increase its staff with motivate and consultants to carry out programs and train newly hired staff. After three years it is expected that a fully trained regular staff will have been recruited and trained, and that the Department of Family Planning would budget its regular resources to supporting the staff. Other than monitoring the consultant and training program during the three-year period of the Project, the only major evaluation exercise would be, after the third year, to analyze the Department of Family Planning to assess its increased capability to implement family planning programs in Egypt. We expect that this would be carried out by an independent consultant.

Assistance Area No. 3: Integrated Social Services Delivery System

See Annex F, page 50 for full description of the evaluation activity in this area.

#### Assistance Area No. 4: Training

Evaluation of the training portion of this Project is broken into four separate activities. For the extensive short-term training program and the field training at the High Institute of Public Health, the contract technical assistance teams will be required to design an evaluation component of each of these training programs. This will be part of the training implementation plans which they will submit. It will be reviewed and approved by the relevant GOE operational unit and the Mission. The technical assistance team for the intensive short-term training program will also design and provide advice to the El Galaa training program. As part of this duty, they will be asked to prepare an evaluation plan for the unit when in operation. We expect this evaluation would take place in the third year of the Project.

The family planning related participant training will be evaluated in conjunction with the overall Mission participant training program.

#### Assistance Area No. 5: Innovation/Technology Transfer

The evaluation of each activity financed under this section will be designed and carried out as the activities are identified. An evaluation statement will be part of each activity report and will be summarized by cable annually and forwarded to Washington. We expect the evaluation will be jointly undertaken by Mission and GOE personnel.

Six months after signing of the Project Agreement, USAID/AID/W and the GOE will develop guidelines for an annual review of Project activities which will provide an overall assessment of project progress and permit design changes as required to respond to the findings of the annual review. The first review will be held about one year from Project

Agreement signing; the second review will occur 12 months later. The participants of the review will include representatives from the Ministry of Economy and Economic Cooperation, the Population and Family Planning Board, the Ministry of Health, USAID and AID/W. Representatives from additional organizations may be added if agreed upon in advance by USAID and the Ministry of Economy and Economic Cooperation.

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

INSTRUCTION: THIS IS AN OPTIONAL FORM WHICH CAN BE USED AS AN AID TO ORGANIZING DATA FOR THE PAA REPORT. IT NEED NOT BE RETAINED OR SUBMITTED.

Life of Project:  
From FY 77 to FY 80  
Total U.S. Funding: 17,000,000  
Data Reported: 77  
PAGE 1

Project Title & Number: Family Planning 263-0029

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes: (A-1)</p> <p>To reduce annual population growth rate in accordance with GOE population policy.</p>	<p>Measures of Goal Achievement: (A-2)</p> <ol style="list-style-type: none"> <li>1. Decline in crude birth rate from 34 to 24/1000 by 1982*</li> <li>2. Decline in annual growth rate to 1.1 percent by 1982.*</li> </ol>	<p>(A-3)</p> <ol style="list-style-type: none"> <li>1. National census</li> <li>2. Sample surveys</li> <li>3. Fertility surveys by PFPB and CAPMAS</li> <li>4. GOE vital statistics</li> </ol>	<p>Assumptions for achieving goal targets: (A-4)</p> <ol style="list-style-type: none"> <li>1. Increased support for population by all concerned GOE agencies.</li> <li>2. Acceptance of GOE plans and implementation strategy by non-government commercial sector.</li> <li>3. Political &amp; economic stability permits GOE investment in the social sectors.</li> </ol>
<p>Project Purpose: (B-1)</p> <p>Assist the GOE to strengthen further the currently functioning nationwide family planning systems in order to deliver such services effectively to increasing numbers of Egyptian couples.</p>	<p>Conditions that will indicate purpose has been achieved. End of project status. (B-2)</p> <p>A national family planning system capability for providing multi-sector guidance training support and services for integrated health/family planning/services to 40% MCRA.</p>	<ol style="list-style-type: none"> <li>1. Program reports &amp; documents</li> <li>2. Contraceptive prevalence surveys</li> <li>3. Service statistics</li> <li>4. Project review &amp; evaluation</li> </ol>	<p>Assumptions for achieving purpose: (B-4)</p> <ol style="list-style-type: none"> <li>1. Administrative arrangements can be developed to permit GOE implementation.</li> <li>2. Planned framework &amp; implementation strategies accepted by GOE Agencies and private commercial sector.</li> <li>3. MCRA are motivated to accept and continue contraceptive use.</li> </ol>

\* Official GOE Population Policy, 1973

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Annex A

Life of Project:  
From FY 77 to FY 80  
Total U.S. Funding: 17,000,000  
Date Reported: 8-77

(INSTRUCTION: THIS IS AN OPTIONAL FORM WHICH CAN BE USED AS AN AID TO ORGANIZING DATA FOR THE PAA REPORT. IT NEED NOT BE RETAINED OR SUBMITTED.)

Project Title & Number: Family Planning 263-0029

PAGE 1

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<p>Project Purpose: (B-1)</p> <p>Assist the GOE to strengthen further the currently functioning nationwide family planning systems in order to deliver such services effectively to increasing numbers of Egyptian couples.</p>	<p>Conditions that will indicate purpose has been achieved. End of project status: (B-2)</p> <p>A national family planning system capability for providing multi-sector guidance training support and services for integrated health/family planning/services to 40% MCRA.</p>	<ol style="list-style-type: none"> <li>Program reports &amp; documents</li> <li>Contraceptive prevalence surveys</li> <li>Service statistics</li> <li>Project review &amp; evaluation</li> </ol>	<p>Assumptions for achieving purpose: (B-4)</p> <ol style="list-style-type: none"> <li>Administrative arrangements can be developed to permit GOE implementation.</li> <li>Planned framework &amp; implementation strategies accepted by GOE Agencies and private commercial sector.</li> <li>MCRA are motivated to accept and continue contraceptive use.</li> </ol>

\* Official GOE Population Policy, 1973

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Annex A

Life of Project: \_\_\_\_\_  
From FY 77 to FY 80  
Total U.S. Funding 17,009,000  
Date Prepared: 8-77

PAGE 2

Project Title & Number: Family Planning 263-0029

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Outputs: (C-1)</p> <p>1. Adequate supply of contraceptive materials available, distributed and accessible to meet program needs.</p>	<p>Magnitude of Outputs: (C-2)</p> <p>1.(a) In country supply plus one year pipeline of condoms &amp; IUD's; procurement of OC raw materials and other clinical and non-clinical equipment &amp; supplies to meet current &amp; projected needs.</p> <p>(b) Distribution of commodities to clinics (&amp; commercial sector)</p>	<p>(C-3)</p> <p>1. Project reports &amp; documents.</p> <p>2. Manufacturing production report.</p> <p>3. Inventory of commodities &amp; supplies received &amp; distributed from depots, centers &amp; clinics.</p> <p>4. Service/use statistics</p> <p>5. Field visits</p>	<p>Assumptions for achieving output: (C-4)</p> <p>1. GOE and donors provide resources as projected.</p> <p>2. Local manufacture of OC &amp; I.U.D. maintained at projected levels.</p> <p>3. Commodities continue to be made available through commercial sector.</p>
<p>Project Inputs: (D-1)</p> <p>1. Commodities</p> <p>a. AID</p> <p>(1) Condoms</p> <p>(2) IUD's</p> <p>(3) OC raw materials</p> <p>(4) Minilap kits</p> <p>(5) Other clinical &amp; non clinical supplies &amp; equipment.</p>	<p>Implementation Target (Type and Quantity)(D-2)</p> <p>1. a. AID (see Dollar Budget)</p> <p>(1) FY 77 (28 Mil.) FY 78 (57.6 Mil.) FY 79 (86.4 Mil.)</p> <p>(2) FY 77 (2.Molds, 12000 insertars)</p> <p>(3) FY 77 (900,000 Monthly cycles) FY 78 (3.9 Mil. Monthly cycles) FY 79 (7.9 Mil. Monthly cycles)</p> <p>(4) FY 77 (300 kits) FY 78 (300 kits) FY 79 (300 kits)</p> <p>(5) to be identified</p>	<p>(D-3)</p> <p>a.(1) Bills of lading</p> <p>(2) GOE budget for commodities</p> <p>(3) Program documents</p> <p>(4) Projected production figures for local manufacturing of contraceptives</p> <p>(5) Inventory levels</p>	<p>Assumptions for providing inputs: (D-4)</p> <p>1. GOE, U.S. other donors make adequate funds available.</p> <p>2. Continued interest in local production by GOE</p> <p>3. Adequate private sector incentives for mfg, distribution and sale of contraceptives.</p>

AID 1979-28 (1-73)  
SUPPLEMENT 1PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORKProject Title & Number: Family Planning 263-0029Life of Project:  
From FY 77 to FY 80  
Total U.S. Funding 17,000,000  
Date Prepared: 8-77

PAGE 3

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2)	(D-3)	Assumptions for providing inputs: (D-4)
<p><b>continued commodities</b></p> <p><b>b- GOE</b></p> <p>(1) Funds for raw materials</p> <p>(2) Manufacturing orals, IUD's</p> <p>(3) Internal distribution</p> <p><b>c- Other donors.</b></p> <p>(1) Contraceptive material</p>	<p>b- (1) 200,000 dollars annually budgeted</p> <p>(2) 10,000,000 cycles 77; 10% annual increase 78-79.</p> <p>(3) 3 month supply in sub-deports</p> <p>c- (1) UNFPA, Pathfinder IPPF supply as agreed</p>	<p>b- (1) Annual budgets</p> <p>(2) Production records</p> <p>(3) Logistic records</p> <p>c- Project documents</p>	

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORKAID 402-20 (1-77)  
SUPPLEMENT 1Life of Project:  
From FY 77 to FY 80  
Total U.S. Funding 17,000,000  
Date Prepared: 8-77 PAGE 4Project Title & Number: Family Planning 263-0029

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Outputs: (C-1)</p> <p>2. Improve planning, management evaluation, operational and support capabilities of the Ministry of Health (MOH) Family Planning Department.</p>	<p>Magnitude of Outputs: (C-2)</p> <p>1. Department of Family Planning fully staffed and operational by FY 80.</p>	<p>(C-3)</p> <p>1. MOH reports of program objectives, staffing pattern job description &amp; activities. 2. Site visits, meetings</p>	<p>Assumptions for achieving outputs: (C-4)</p> <p>1. Expanded role for FP Dept. desired by GOE/MOH. 2. MOH/FP Dept. able to attract and retain qualified and motivated for career assignments.</p>
<p>Project Inputs: (D-1)</p> <p>2- a. AID</p> <p>(1) Funds for local consultants and administrative/clerical personnel. (2) Technical Assistance</p>	<p>Implementation Target (Type and Quantity (D-2)</p> <p>(1) Up to 8 person/years for short consultants and 6 Admin/clerical personnel annually. (2) 100 person hours/month.</p>	<p>(D-3)</p> <p>(1) Project documents (2) MOH expenditure reports &amp; records (3) Consultant reports</p>	<p>Assumptions for providing input: (D-4)</p> <p>(1) Qualified personnel are available. (2) On job training will provide desired results.</p>

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of Project: From FY 77 to FY 80  
 Total U.S. Funding: \$ 17,000,000.  
 Date Prepared: 8/77

NO 1010-10 (1-74)  
 IMPLEMENT 1

Project Title & Number: Family Planning 263-0029

PAGE 5

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Outputs: (C-1)</p> <p>3. Governorate-wide (Menoufia) demonstration of village based integrated social service delivery emphasizing contraceptives suitable for possible replication</p>	<p>Magnitudes of Outputs: (C-2)</p> <p>1. Research/Evaluation methods tested/working</p> <p>2. 90% of eligible population exposed to F.P. information: contraceptive prevalence doubles.</p> <p>3. Elements adaptable for implementation in other village/community outreach programs</p>	<p>(C-3)</p> <p>1. Field visits- project reports</p> <p>2. Prevalence surveys &amp; follow-up of surveys</p> <p>3. GOE selects elements for replication based on project evaluation</p>	<p>Assumptions for achieving outputs: (C-4)</p> <p>1. Governorate support at all levels including village leadership involvement &amp; promotion</p> <p>2. GOE accepts and considers results of sub-activity in planning process.</p> <p>3. By the end of the project techniques introduced by grantee can be adopted and implemented by existing governmental and social units within resources available to them on a continuing basis</p>
<p>Project Inputs: (D-1)</p> <p>3- a. AID</p> <p>(1) Funds for</p> <p>(a) Technical assistance</p> <p>(b) Commodities</p> <p>(c) Training of personnel</p> <p>(d) Village social action activities</p>	<p>Implementation Target (Type and Quantity)(D-2)</p> <p>(1) Grant funds of \$ 40 million over life of project</p>	<p>(D-3)</p> <p>(1) Program documents &amp; consultant reports</p>	<p>Assumptions for providing input: (D-4)</p> <p>1. Sufficient grant funds will be made available</p>

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Annex A

Life of Project:  
From FY 77 to FY 80  
Total U.S. Funding 17,000,000  
Date Prepared: 8-17-77

Project Title & Number: Family Planning 263-0029

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Outputs: (C-1)</p> <p>4. Trained family planning service providers.</p> <p>(a) Intensive short-term training programs established for recent medical graduates.</p> <p>(b) El-Galaa service &amp; training facilities renovated and 4 separate categories of personnel trained.</p> <p>(c) Field training established by High Institute of Public Health (Alex)</p> <p>(d) Short &amp; long training in U.S. &amp; third countries</p>	<p>Magnitude of Outputs: (C-2)</p> <p>(a) Training programs established in 25 governorates by FY 80. 1000 medical school graduates trained in FP by FY 78 and up to 2000 annually thereafter.</p> <p>(b) Training and service facilities in place. ObGyn, 80 GMP, 80 paramedical workers, 80 social workers trained in family planning annually.</p> <p>(c) East Alex. District developed as field training site. Curriculum tested &amp; revised; personnel exposed &amp; trained in integrated health &amp; F.P. services.</p> <p>(d) 45 persons participated in long-training and 30 in short term training in health F.P., social service fields.</p>	<p>(C-3)</p> <p>(a &amp; b)</p> <p>(1) Project and consultant reports</p> <p>(2) Review of curriculum training research &amp; operational manuals</p> <p>(3) Field visits</p> <p>(4) Project evaluation</p> <p>(c) Field visits; project reports curriculum evaluation; annual evaluation.</p> <p>(d) Training reports and post-training assessment.</p>	<p>Assumptions for achieving outputs: (C-4)</p> <p>(a) Administrative arrangements can be made permitting Medical Syndicate, University, PFPB, MOH and others to provide required cooperation &amp; support.</p> <p>(b) Replication is technically and economically feasible.</p> <p>(c) Mutually, agreeable administrative arrangements can be made between the HIPH, Alexandria University, MOH and Alexandria governorate.</p> <p>(d) Appropriate candidates are available for training, GOE and US grant appropriate visas. Returned participants will utilize training for intended purposes.</p>

AID 1020-20 (1-73)  
SUPPLEMENT 1

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of Project:  
From FY 77 to FY 80  
Total U. S. Funding 17,000,000  
Date Prepared: 8/77

Project Title & Number: Family Planning 263-0029

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Inputs: (D-1)</p> <p><b>4- a. AID</b></p> <p>(1) Technical assistance, local cost financing for training courses</p> <p>(2) Contract for A &amp; E design services and funds for renovation.</p> <p>(3) Funds for technical assistance educational equipment &amp; supplies, local cost financing</p> <p>(4) Funds for participant training</p>	<p>Implementation Target (Type and Quantity) (D-2)</p> <p>(1) Annually, up to 12 pm of consultants services in design &amp; implementation of training programs. FY 77 (13 courses) FY 78 (25 courses) FY 79 (25 courses)</p> <p>(2) A &amp; E study CY 1978; renovation completed by Mid FY 80.</p> <p>(3) \$ FY 77 \$ 394,000 FY 78 \$ 383,000</p> <p>(4) FY 79 \$ 436,000 FY 78 \$ 458,000 FY 79 \$ 481,000</p>	<p>(D-3)</p> <p>(1) Program documents, consultant reports, field visits Seminars, workshop reports.</p> <p>(2) Design report, site visits, MOH reports</p> <p>(3) Contractor and project reports</p> <p>(4) Program budgets and fiscal documents.</p>	<p>Assumptions for providing inputs: (D-4)</p> <p>USAID approval of results of environmental assessment performed during FY 77-funded A and E study will permit FY 78 obligations for renovation of El Galaa hospital.</p>

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Annex A

Life of Project:  
From FY 77 to FY 80  
Total U. S. Funding 17,000,000  
Date Prepared: 8-77 PAGE 8

Project Title & Number: Family Planning 263-0029

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Outputs: (C-1)</p> <p>5. Small activities for applied research, general services support, I.E.C., and population technology transfer</p>	<p>Magnitude of Outputs: (C-2)</p> <p>(a) At least 6 activities to be identified and funded annually.</p> <p>(b) Areas of population technology transfer activities to be identified</p>	<p>(C-3)</p> <p>Sub-activity reports field visits</p>	<p>Assumptions for achieving output: (C-4)</p> <p>Mutually agreeable projects can be identified</p> <p>GOE desires available U.S. technology.</p>
<p>Project Inputs: (D-1)</p> <p>5. a- AID</p> <p>Funds for identified small activities, minimal commodities, consultants and travel.</p>	<p>Implementation Target (Type and Quantity)(D-2)</p> <p>FY 77 \$ 550,000 78 \$ 595,000 79 \$ 640,000</p>	<p>(D-3)</p> <p>GOE and AID fiscal date</p>	

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6C(2) -- PROJECT CHECKLIST

Listed below are, first, statutory criteria applicable generally to projects with FAA funds, and then project criteria applicable to individual fund sources: Development Assistance (with a sub-category for criteria applicable only to loans), and Security-Supporting Assistance funds.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? IDENTIFY. HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT.

1. App. Unnumbered; FAA Sec. 653(b).
  - (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project.
  - (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure plus 10%)?
    1. (a) Advice of program change will be submitted to Congress at least 15 days prior to execution of the Project Grant Agreement.
    - (b) The amount to be obligated in FY 1977 is within the level of funds appropriated by Congress for Egypt for FY 77.
2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?
 

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

No further legislative action is required other than action notifying the signed grant agreement.
4. FAA Sec. 611(b); App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per Memorandum of the President dated Sept. 5, 1973 (replaces Memorandum of May 15, 1962; see Fed. Register, Vol 38, No. 174, Part III, Sept. 10, 1973)?
 

N.A.
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?
 

N.A.

A.

6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multi-lateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multi-lateral organizations or plans to the maximum extent appropriate?
7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).
9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

No. Egypt is not a newly independent country.

This project, which is designed to develop the capability of the GOE to control the growth of its population, does not directly affect any of the ones described in this question.

U.S. private enterprise will be a source of procurement of goods and technical services required for this project.

The grant agreement will so provide. Also see Annex E for a request for a determination under Section 612 (b) that U.S. dollars may be used to procure local currency for this project notwithstanding the availability of excess local currency.

Yes. Release by the GOE is not a problem at present.

N.A.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria
  - a. FAA Sec. 102(c); Sec. 111; Sec. 291a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

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b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available:

[Include only applicable paragraph -- e.g., a, b, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.]

- (1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;
- (2) [104] for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;
- (3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;
- (4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:
  - (a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;
  - (b) to help alleviate energy problem;
  - (c) research into, and evaluation of, economic development processes and techniques;
  - (d) reconstruction after natural or manmade disaster;
  - (e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;
  - (f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

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(5) [107] by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.

c. FAA Sec. 110(a); Sec. 208(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing?

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on; (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained worker-power in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

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g. FAA Sec. 201(b)(2)-(4) and -(8); Sec. 201(e); Sec. 211(a)(1)-(3) and -(8). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

2. Development Assistance Project Criteria (Loans only)

N/A.

a. FAA Sec. 201(b)(1). Information and conclusion on availability of financing from other free-world sources, including private sources within U.S.

b. FAA Sec. 201(b)(2); 201(d). Information and conclusion on (1) capacity of the country to repay the loan, including reasonableness of repayment prospects, and (2) reasonableness and legality (under laws of country and U.S.) of lending and relending terms of the loan.

c. FAA Sec. 201(e). If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds \$100,000, has country submitted to AID an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner?

d. FAA Sec. 201(f). Does project paper describe how project will promote the country's economic development taking into account the country's human and material resources requirements and relationship between ultimate objectives of the project and overall economic development?

e. FAA Sec. 202(a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources?

f. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

3. Project Criteria Solely for Security Supporting Assistance

FAA Sec. 531. How will this assistance support promote economic or political stability?

4. Additional Criteria for Alliance for Progress

[Note: Alliance for Progress projects should add the following two items to a project checklist.]

a. FAA Sec. 251(b)(1), -(8). Does assistance take into account principles of the Act of Bogota and the Charter of Punta del Este; and to what extent will the activity contribute to the economic or political integration of Latin America?

b. FAA Sec. 251(b)(8); 251(h). For loans, has there been taken into account the effort made by recipient nation to repatriate capital invested in other countries by their own citizens? Is loan consistent with the findings and recommendations of the Inter-American Committee for the Alliance for Progress (now "CEPCIES," the Permanent Executive Committee of the OAS) in its annual review of national development activities?

This assistance will promote economic stability in Egypt by assisting in limiting the growth of the population of Egypt to numbers that can be adequately sustained by the economy of Egypt.

N.A.

6C(3) - STANDARD ITEM CHECKLIST

Listed below are statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by exclusion (as where certain uses of funds are permitted, but other uses not).

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

A. Procurement

- |                                                                                                                                                                                                                                                                                                                                                                  |                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| 1. <u>FAA Sec. 602</u> . Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed?                                                                                                                                                                                                         | Yes. Standard A.I.D. procedures will be applicable to this project.               |
| 2. <u>FAA Sec. 604(a)</u> . Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him?                                                                                                                                                                                               | Yes.                                                                              |
| 3. <u>FAA Sec. 604(d)</u> . If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the U.S. on commodities financed?                                                                                                                                                        | The Grant Agreement will contain an appropriate provision.                        |
| 4. <u>FAA Sec. 604(e)</u> . If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity?                                                                                                                                           | N.A.                                                                              |
| 5. <u>FAA Sec. 608(a)</u> . Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items?                                                                                                                                                                                                              | Yes.                                                                              |
| 6. <u>MMA Sec. 901(b)</u> . (a) Compliance with requirement that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates. | The Grant Agreement will contain an appropriate provision.                        |
| 7. <u>FAA Sec. 621</u> . If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the facilities of other Federal agencies will be utilized,                                                                        | Technical assistance will be procured from private U.S. sources for this project. |

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are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

8. International Air Transport. Fair Competitive Practices Act, 1974

If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?

Yes. The Grant Agreement will contain an appropriate provision.

8. Construction

1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?

N.A.

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

Yes.

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million?

N.A.

C. Other Restrictions

1. FAA Sec. 201(d). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?

N.A.

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

N.A.

3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-Bloc countries, contrary to the best interests of the U.S.?

The Grant Agreement will contain an appropriate provision.

4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the U.S. or guaranty of such transaction?

Yes.

5. Will arrangements preclude use of financing:
- a. FAA Sec. 114. to pay for performance of abortions or to motivate or coerce persons to practice abortions? Yes.
  - b. FAA Sec. 620(a). to compensate owners for expropriated nationalized property? Yes.
  - c. FAA Sec. 660. to finance police training or other law enforcement assistance, except for narcotics programs? Yes.
  - d. FAA Sec. 662. for CIA activities? Yes.
  - e. App. Sec. 103. to pay pensions, etc., for military personnel? Yes.
  - f. App. Sec. 106. to pay U.N. assessments? Yes.
  - g. App. Sec. 107. to carry out provisions of FAA Sections 209(d) and 251(h)? (transfer to multilateral organization for lending). Yes.
  - h. App. Sec. 501. to be used for publicity or propaganda purposes within U.S. not authorized by Congress? Yes.

Request for Assistance

On August 11, 1977 the Undersecretary for Economic Cooperation of the Ministry of Economy and Economic Cooperation verbally requested USAID project assistance and indicated he was forwarding the following letter to USAID.

(See the next page)

DRAFT

Mr. Donald S. Brown, Director  
Agency for International Development  
American Embassy  
Cairo, Egypt

Dear Mr. Brown:

The Government of the Arab Republic of Egypt is desirous of carrying forward a program to strengthen further the currently functioning nation-wide family planning system in order to deliver such services effectively to increasing numbers of Egyptian married couples. This undertaking will extend over several years. The first phase will be directed to areas of immediate need, including:

- A. Increasing contraceptive availability
- B. Improving administration and management
- C. Demonstrating a governorate-wide integrated health, family planning and social services delivery system.
- D. Support for training of family planning service providers
- E. Innovative activities in areas of social action, research, information, education, and communications, and technology transfer..

The Government of the Arab Republic of Egypt therefore requests that AID provide up to \$17.0 million to support the first phase of this program.

Yours faithfully,

Gamal El Nszer  
Undersecretary fo State for  
Economic Cooperation

Draft

Project Authorization and Request for Allotment of Funds

PART II

Name of Country: Arab Republic of Egypt      Name of Project: Population and Family Planning

Project No: 263-0029

Pursuant to Part 2, Chapter 2, Section 532 of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Grant to the Arab Republic of Egypt ("Cooperating Country") of not to exceed Four Million United States Dollars (\$4,000,000) to assist in financing the foreign exchange and local currency costs of goods and services required for project as described in the following paragraph:

The project consists of assisting the Cooperating Country to strengthen its family planning delivery system in order to deliver services effectively to increasing numbers of Egyptians by financing technical assistance, training, engineering and construction services, commodities and operational support (a) to increase the supply of contraceptives available in Egypt, (b) to improve the capability of physicians in surgical procedures relating to fertility and infertility, (c) to support the Department of Family Planning of the Ministry of Health, (d) to extend the integrated social services delivery system, which is presently operating in 36 villages in the Menoufia Governorate, to all of the villages in that governorate, (e) to improve the family planning training of medical school graduates, paramedical personnel, nurses and social workers by developing and implementing short-term training courses, renovating the Al Galaa Maternity Hospital, developing a rural field training site near Alexandria integrated with the High Institute of Public Health and long- and short-term participant training, and (f) to develop and

implement small-scale innovative activities involving transfers of family planning technology (hereinafter referred to as the "Project").

I hereby approve the total level of A.I.D. appropriated funding planned for this Project of not to exceed Seventeen Million United States Dollars (\$17,000,000), of which \$4,000,000 is authorized above and the remainder will be available for additional increments in FY 1978 and FY 1979 subject to availability of funds and in accordance with A.I.D. allotment procedures.

Based upon the justification set forth in Annex   E   of the Project Paper, I hereby approve, in accordance with the last sentence of Section 612 (b) of the Act, the expenditure of United States Dollars for the procurement of goods and services in Egypt, notwithstanding the availability of United States-owned Egyptian Pounds, and direct the administrative officer certifying the vouchers involved with such expenditure to make the certification required under Section 612(b) on the basis of this approval of the justification set forth in Annex   E   of the Project Paper.

I hereby authorize the initiation of negotiation and execution of the Project Agreement by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority subject to the following terms, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Goods and Services. Except for ocean shipping, goods and services financed under the Grant shall have their source and origin in the United States or the cooperating country, except as A.I.D. may otherwise agree in writing. Ocean shipping shall be procured in any eligible source country except the Cooperating Country.

b. Covenant.

The Grant Agreement shall contain a covenant providing in substance that the Cooperating Country, by September 30, 1980, shall establish, and assign personnel to, an appropriate number of additional professional and administrative/clerical positions required by the Department of Family Planning of the Ministry of Health in order to achieve the objectives of the Project.

\_\_\_\_\_  
Administrator

\_\_\_\_\_  
Date

Recommendations to Purchase Egyptian Pounds with U.S. Dollars

Over the life of the Project \$6,627,000 will be used to support local currency expenditures that the Egyptian Government will make for specific items in support of this project. Dollar funds will be used in association with GOE disbursement of Egyptian pounds for the costs of the travel, per-diem, and shipment of household effects of project consultants; related project support costs such as the travel of Egyptian participants, rental of office space, and procurement of secretarial and interpreting services; the cost of the Ministry of Health Family Planning Department temporary supplementary staff; local costs to Menoufia Governorate for an innovative integrated social service delivery system, special costs associated with training, facilities renovation and related miscellaneous costs. The Mission will purchase Egyptian pounds with U.S. dollars provided by the Project. The Egyptian pounds will in turn be made available to the various appropriate Egyptian entity(s) responsible for project implementation for disbursement in accordance with the agreements reached between USAID and the GOE in the Project Agreement.

One reason for using dollar funds in conjunction with Egyptian pound costs is that this represents an additional real resource to the Egyptian economy and provides an incentive for the Egyptian Government to implement new initiatives that otherwise it might not be able to undertake. The Mission considered the use of granting excess U.S.-owned local currency for these Egyptian pound costs; however, the use of existing U.S.-owned local currency would add no additional real resources to the

## Annex E

economy. Given the G.O.E.'s need to restrict the growth in the money supply to correspond to the growth in real resources in the economy, the inflationary impact of using U.S.-owned local currency would have to be offset by reduced GOE disbursements on other programs. Maintaining this fiscal balance is also required under the terms of the current IMF Standby Agreement with Egypt - which the U.S. and other donors have strongly supported.

Consequently, if U.S.-owned local currency were used, it is doubtful that the various Egyptian entities could enter into agreements since they would have to sustain budgetary cutbacks in other areas. Even if the various Egyptian entities were to obtain budgetary funds to provide its full portion of project costs, it is doubtful that it could commit them to this project of particular AID concern unless the added fillip of dollar funding for local currency costs were assured. Given the above considerations and the fact that the Family Planning Project is fully consistent with the Congressional Mandate of the Foreign Assistance Act to undertake activities designed to improve the economic position and quality of life of the poor majority, we have concluded Project costs should be dollar funded.

Based on the foregoing, USAID requests that it be determined that U.S. dollars may be used to purchase local currency in accordance with Section 612 (b) of the Foreign Assistance Act.

Annex F

THE AMERICAN UNIVERSITY IN CAIRO

REVISED INTEGRATED SOCIAL SERVICES  
DELIVERY SYSTEM

Revised By USAID From A Proposal Submitted  
By The American University Of Cairo In June  
1977. A Revised Budget Appears Beginning  
On Page 63

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\* Revised by USAID

## I. INTRODUCTION

The proposed action-research program for promoting family planning, health, and social welfare is designed to test an integrated developmental approach for a population of 1.4 million in Menoufia Governorate. Three types of services will be provided under this project: family planning, health, and social welfare. The project has evolved from earlier AID/W sponsored efforts (AID Grant No. NESA-547 and AID Grant No. PHA-G-1139) of the Social Research Center (SRC), American University in Cairo (AUC) to test, among other things, an innovative family planning delivery system-namely the household distribution of contraceptives. The following project design builds directly on this experience.

The proposed project will be a joint effort of AUC, Menoufia Governorate, the Ministry of Health, and the Ministry of Social Affairs. The duration of the project is three years at a funding level of \$3,993,000. The first year budget is \$1,131,000\*all of which is being drawn from SA funds earmarked for population activities. Years two and three of the project will utilize USAID/CAIRO SA funds programmed for population, health, and social affairs in a proportionately appropriate manner. There is an optional fourth year.

\*USAID Revision

## II. BACKGROUND

Beginning in November 1974, AUC initiated a household contraceptive distribution project in the village of Shanawan (pop. 14,000), Menoufia. Basically, the household contraceptive delivery system entailed the following elements:

- gaining the support and cooperation of local community leaders;
- gaining the support and cooperation of local health and social welfare personnel;
- recruiting and training local women to become household canvassers;
- mapping the households for canvassing;
- canvassing all households;
- offering contraceptives and other family planning information and services to eligible women;
- establishing a resupply mechanism; and
- evaluating the various aspects and final outcome of the household distribution system.

While the above is an oversimplification, it does contain the crucial elements of the delivery system. As a result of the AUC effort, the prevalence of contraceptive use among married women aged 15-44 years increased from 18.4 percent in November 1974, to 30.9 percent in November 1975, an increase of 67.9 percent. It is estimated that contraceptives are now being used by approximately 35 percent of the married women aged 15-44 years.

These remarkable results\* are all the more impressive when one considers them in light of two major weaknesses inherent in many household distribution systems. First, since it would not be feasible to have a family planning program based on the continuous distribution of contraceptives through a household delivery system, household distribution is, for all practical purposes, a one-time affair. This leads to several problems. It is often forgotten that at any point in time, many women are not at risk of pregnancy because they are currently pregnant, breast-feeding, not sexually active, and/or not married. The aggregate of these categories of women can reach about 70 percent of all women in the reproductive ages of 15-44. (In Shanawan it was approximately 60 percent.) It is important to note that the vast majority of them will become at risk of pregnancy in the relatively near future. It is difficult to adequately serve these women through a household distribution system.

Second, the household distribution system does not offer a reinforcement of contraceptive behavior anywhere near the intensity of the initial household distribution which stimulated the contraceptive behavior. Therefore, women who accept contraceptives do

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\* More results from the Shanawan experience can be found in the attached paper by Saad Gadalla, "Household Contraceptive Distribution in Menoufia Governorate, Egypt," March 1977, pp. 22-25.

not have their behavior reinforced in a systematic, intensive manner that assures the continuation of contraception use.

It must be noted here that the above-mentioned weaknesses of the household contraceptive distribution system are relatively minor compared to those of the traditional clinic-based delivery system. Nevertheless these weaknesses still prevent the optimal utilization of fertility regulation methods.

The household contraceptive distribution system implemented in Shanawan is the oldest of the dozen or so which are operating throughout the world. Other household distribution systems, after dramatic increases in users, have experienced a decline in contraceptive prevalence or a levelling off of contraceptive use. (The increase in contraceptive use is still impressive after these declines, however.) It is felt that the two weaknesses described above are the primary reasons for these declines. However, we have seen that contraceptive prevalence is still gradually increasing in Shanawan three and one half years after the initial distribution. While the reasons for this continuing rise in contraceptive use cannot be stated in a definitive, causal way, it is strongly believed that, based on the available data, other developmental activities undertaken by AUC have reinforced the family planning activities.

While working in Menoufia, AUC research staff soon found the villagers expressing individual and community needs. The advice and assistance of AUC was frequently sought. The research staff realized that there existed an infrastructure in rural Menoufia that was designed to respond to the community needs, but for a variety of reasons was unable to effectively address the problems of the community. Later in the project description, the non-family planning activities of AUC will be discussed at length. Here, it will be noted that AUC assisted the villagers in an ad hoc manner, primarily in the broad range of activities that fall under "social affairs." After a while, the research staff perceived a change in the villagers' attitudes toward the staff and themselves. While this is an admittedly subjective assessment, it was also supported by numerous identifiable changes in the community behavior. These changes have led to concrete improvements in the community and also a much less easily described community spirit which is, nevertheless, very real. These non-family planning activities did, in fact, often entail direct or indirect family planning activities and constituted a supportive element to the AUC family planning effort.

AUC has now expanded the Shanawan project to 38 villages in Menoufia, a total population of approximately 200,000. The expanded project has not been in operation long enough to make a rigorous assessment but the initial results suggest that it is on a par with

the Shanawan experience at a comparable stage of development. There are, however, no data on contraceptive use since the household distribution has just been completed. While AUC has attempted to introduce in the expanded project the non-family planning development program begun in Shanawan, a systematic effort has not been possible because of the lack of financial resources specifically designated for such activities.

The proposed project intends to allow AUC to serve as a catalyst for Menoufia Governorate. The Governorate, as stated earlier, has an infrastructure designed to serve the community's needs. The AUC activities will complement the existing Governorate programs in family planning, health, and social welfare. While separately these three types of activities have value, it is also felt that if they are conceptualized and implemented in an integrated fashion, they will reinforce each other in a synergistical manner. In other words, integrated they will have a greater aggregate effect than if they were implemented in isolation from one another.

Specifically, this project will address the following problems in relation to three interrelated levels.

1. Problems Inherent in the Delivery System:
  - ✓ a. Shortage of basic facilities and supplies in health, social welfare, and family planning centers;

- b. complicated operational procedures for delivery of services;
- c. poor quality of services rendered;
- d. difficult access to services and unavailability of services to most of the potential users;
- e. fragmentation of service delivery system;
- f. confusion of organizational relationships and supervision roles;
- g. dysfunctional incentive system for service and supervisory personnel;
- h. lack of firsthand information to guide and evaluate service delivery in the community.

2. Problems Related to Service Personnel:

- a. Lack of awareness of community needs and development goals;
- b. unfavorable attitudes toward serving in rural areas;
- c. insufficient commitment and motivation to work;
- d. inadequate job definitions, functions, and roles;
- e. lack of personnel awareness about community outreach programs and service delivery beyond the premises of the units;
- f. inadequate personnel training to perform specific jobs;
- g. rapid turnover and lack of continuity in service personnel, especially among physicians.

3. Problems Inherent in the Community:

- a. Insufficient awareness and knowledge among villagers about their needs, especially in the areas of hygiene nutrition, preventive medicine, child and maternal care, and family planning;

- b. dissatisfaction with existing delivery systems and service personnel;
- c. negative attitudes toward health, social welfare, and family planning issues;
- d. internal social and cultural barriers against seeking and using the services;
- e. stagnation of local leadership;
- f. lack of knowledge, and inability to introduce social change or to initiate community development efforts.

Because of these problems, neither the rural communities nor the delivery systems for family planning, health, and social welfare, are sufficiently active in themselves or interactive with each other. At present, both tend to wait for crises or catastrophies to occur in order to communicate, and neither reaches out to create a better general environment for family planning, health, and social welfare.

### III. PROJECT SITE

Menoufia Governorate is located in the southern part of the Nile Delta between the two main branches of the Nile (Damietta and Rosetta). The Governorate is divided into eight counties which include eight urban towns and 302 rural villages. According to the 1976 preliminary census results, the population of Menoufia is 1.7 million people representing 4.7 percent of Egypt's total population.

The population served by this project, however, will be 1.4 million. There are eight urban towns in Menoufia having a combined

total population of approximately 300,000. This project is designed primarily for serving the rural population and, as a result, will not cover the urban population of Menoufia. It is well known that, relative to the rural areas, the urban areas have superior and different services. Although these services will be utilized by the project for referral purposes, the project does not intend to address the needs of the urban populations who are using these services.

The main features of the Governorate may be summarized as follows:

1. Menoufia is the most rural, and the least urban, governorate in Egypt. In 1976, the overwhelming majority of its population (80.3 percent) lived in rural villages; the proportion of its urban population (19.7 percent) was the lowest in the country.
2. Menoufia is one of the most densely populated rural governorates in Egypt. In 1976, its 1.7 million people were crowded into an area of 1,500 square kilometers; a population density of 1140 persons per square kilometer.
3. Menoufia is predominantly agricultural. In spite of highly productive and intensive farming, the overwhelming majority of the rural population suffers from low income. This is attributable to the very low land/man ratio and the

very small, fragmented landholdings which individual families cultivate. In 1976, the per capita share of agriculture land was less than 0.2 feddan.\* Thus, each feddan of arable land supports 5.2 persons of the total population and provides means of livelihood for 4.2 persons of the rural population. Some 160,000 families cultivate 330,000 feddans (an average of two feddans per family) and the majority (60 percent) cultivate farms under two feddans.

4. Menoufia is characterized by a high emigration rate. Most of the migrants move from rural villages and settle in Cairo and other urban areas. The high emigration rate is one of the major consequences of the great population pressure on the small cultivated area and the lack of sufficient employment opportunities alternative to agriculture.
5. Menoufia, as throughout Egypt, has high birth rates and moderate death rates. Annual birth rates in the Governorate during the past forty years (1955-1975) have fluctuated between 48 and 38 per thousand population. Death rates, however, have shown a distinct decline from 30 to 15 per thousand population.

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\*One feddan equals 1.038 acres.

Based on preliminary results from the 1976 census, a demographic, economic, and social profile of Menoufia is presented below.

1. Demographic Indicators

- Total population: 1.7 million
- Menoufia's population as percent of Egypt's population: 4.7%
- Rank of Menoufia with respect to population size in relation to other governorates: 10th out of 25 governorates
- Population density in Menoufia: 1140 per km.<sup>2</sup>
- Sex ratio: 104 males per 100 females
- Urban population: 19.7%
- Rural population: 80.3%
- Average household size: 5.5 persons
- Average No. of rooms per household: 3.2 rooms
- Average No. of persons per room: 1.7 persons
- Age composition of population:
  - Percent under 12 years old 31.6%
  - Percent 12-64 years old 64.2%
  - Percent 65 years old and over: 4.2%
- Population size in different census years:

<u>Census Year</u>	<u>Population</u>
1907	970,581
1917	1,072,616
1927	1,105,191
1937	1,159,701
1947	1,165,015
1960	1,347,953
1966	1,458,048
1976	1,710,892

## 2. Economic Indicators

- Ratio of agricultural land to total population:  
1 feddan per 5.2 persons
- Ratio of agricultural land to rural population:  
1 feddan per 4.2 persons
- Percentage of economically active population (6 years old and over)
  - Among males: 50.9%
  - Among females: 9.7%
  - Among total population: 30.7%
- Percentage of homes with electricity:
  - In rural areas: 32.4%
  - In urban areas: 64.5%
  - In governorate: 39.0%
- Percentage of homes with piped (running) water:
  - In rural areas: 2.4%
  - In urban areas: 38.6%
  - In governorate: 9.8%

## 3. Social Indicators

- Educational Status (10 years old and over)
  - Illiterates: 57.0%
  - University educated: 1.3%
- Marital Status of Males (18 years old and over)
  - Single: 28.0%
  - Married: 68.3%
  - Divorced and widowers: 3.7%
- Marital Status of Females (16 years old and over)
  - Single: 17.3%
  - Married: 65.3%
  - Divorced and widows: 17.4%

#### 4. Service Delivery Systems

Number of Health Units:	134
Number of Social Units:	87
Number of Community Development Societies:	123
Number of Welfare Societies:	124
Number of Nurseries:	81

#### 5. Administrative Units

Number of villages:	302
Number of towns:	8

### IV. PROJECT ACTION PLAN

An operations research (OR) approach was used in planning this project. OR methodologies will also be utilized in implementing and evaluating the project. The basic model for the Project is shown in Figure I.

Figure I is the classic OR input/output model with the addition of "goal." The four broad elements of the project (see Figure I) are defined in general terms below. Later, detailed descriptions will be given for the family planning, health, and social welfare components of the project.

Inputs (A): Typically, "inputs" are easily documented and can be quantified. Inputs are simply the resources that are put into the project, e.g. funds, personnel, commodities, and expertise.

Process (B): Basically, "process" is the use the inputs are put to; or, what happens to the inputs. If, for example, an input is training elements, the process would be the actual training. Like inputs, process variables are fairly easy to define and identify. Usually, process variables will be identified in a "yes/no" fashion, the training program did or did not take place.

Outputs (C): In this project, a departure is made from the traditional OR model which usually has "outputs" as the terminal point in the analysis. Here, it was felt that "outputs" should be viewed as an intermediate variable or goal. As will be explained later, "goals" are viewed as the end point of this project and represent the reason for the program, i.e. the inputs, process, outputs. Outputs are the direct product of the process. Thus, the output of a training program is trained personnel. Trained personnel are not, however, the goal of the training program. The goal of a training program is that the personnel perform a particular action which will have certain desired results. A degree of subjective judgement has been required to classify elements or variables as "outputs" or "goals." In general we define outputs as those things which are the immediate product of the process. Because of this definition, most of the outputs of this project will be measurable.

Goals (D): This element includes the ultimate reason for the program. Goals are the reasons why resources have been brought together, processed, and transformed into intermediate objectives. For example, the goal of an immunization program is the eradication or control of a particular disease. An accurate measure of such a program, then, would be the prevalence of the disease before and after the immunization campaign. For a variety of reasons, it is not always possible to measure morbidity. Therefore, the success of the immunization program is measured in terms of the percent of the population covered through the immunization program. In this example, the success of the immunization program can be fairly accurately measured by determining the percent of the population protected, since past experience shows that such coverage can lead to the eradication or control of the particular disease. Primarily for methodological reasons, this project would (in this example) have as one of its goals the reduction of morbidity, but would operationalize it in terms of the percent of the population protected through immunization.

In general, we have tried to conceptualize goals in terms of concepts that lend themselves to measurement. This has not been easy, but a vigorous effort has been made to avoid such terms as "community development," "community well-being," and

"a healthier community." While constructs can be made (and have been made) to measure these vague concepts, such undertakings are very expensive and involve assumptions on the part of the researchers which are frequently open to debate.

As the discussion of the project's goals develop, several problems will occur. First, the goals of the three components are, to a large extent, overlapping. As noted earlier, one of the goals of the health component is the lowering of morbidity. And, it will be seen, one of the goals of the family planning component is longer birth intervals. The latter goal can be viewed as an intermediate goal to lowering morbidity and, for that matter, mortality. Second, in this project, we have tried not to include all the potential goals that can fall under a particular component since this would result in an unmanageable listing and would frequently point out relationships which are quite obvious. Third, we have tried to confine our goals to those that can, at least in a correlational sense, be directly traced to the component activities. It is fully realized that the goals and activities designed to achieve these goals are highly interrelated. For analytical and practical reasons we have chosen to separate them.

The general model employed in this project and, more specifically, the classification of inputs, process, outputs, and goals, can be

questioned. Many of the decisions leading to the conceptualization of this project are based on the following premise: It is strongly held that the research elements of this project should serve the service elements of the project. Frequently, action-research projects place the service elements in a secondary role. The service is designed to provide a platform on which certain hypotheses can be tested. The research component of this project is kept to the necessary minimum required to evaluate the project in such a way that policy makers can make programmatic decisions based on the project's findings.

Before discussing the three components of the services provided under this project, it should be re-emphasized that the three components can only be separated in an analytical manner. They will constitute an integrated effort in which the activities will be intertwined in the field.

A. Family Planning Component

Figure II graphically shows the key elements of the family planning component. Each of these elements is described in some detail below.

Inputs (A): The inputs for this component are more substantial than is the case for health and social welfare, at least in terms of immediate, short term infusion of resources. The main feature of this component is the household distribution of contraceptives

patterned after the successful project conducted by AUC in Menoufia. It should be noted, however, that the infusion of resources is to a large extent temporary.

Household distribution is an episodic intervention which requires intensive activity for a relatively short period of time. After a community has been fully canvassed, the degree of input drops dramatically since the household canvass is a one-time event.

Training Element (A<sub>1</sub>). As with all of the training elements in this project, AUC will play a leading role in planning, coordinating and evaluating the training activities. However, much of the actual training will be done by persons not on the AUC staff. The training inputs of the family planning component consist of the following:

- training of clinic personnel on IUD insertions, contraceptives and their side effects, referral procedures, record-keeping, and, in general, family planning and population;
- training canvassers on canvassing procedures, contraceptives, family planning, referral procedures, and record-keeping;
- training community development workers as "canvassers" with special emphasis on referral services, contraceptive side effects, as well as follow-up procedures;
- training field supervisors on family planning, canvassing procedures, supervisory procedures, record-keeping;

- training community leaders on ways in which they can work with the above personnel to elicit community support for continued contraception use.

Commodities (A<sub>2</sub>). This category includes the purchase of commodities, the existence of commodities in the program, and the provision of the commodities in the proper facilities. In other words, this category encompasses logistical issues. The types of commodities to be supplied are:

- oral contraceptives,
- condoms,
- Neo-Sampoons,
- IUD's and inserters,
- miscellaneous OB-GYN instruments,
- service statistics forms.

Household Distribution (A<sub>3</sub>). A detailed description of the AUC household distribution effort is found in the attached paper by Dr. Saad Gadalla, "Household Contraceptive Distribution in Menoufia Governorate." The design of the household distribution system planned for this project will remain essentially as described except for several important changes in its implementation procedures. In the existing project, AUC takes an active role in all aspects of the delivery system except the actual canvassing and delivery of other services. AUC, for example, recruits and trains the canvassers. Obviously for any large effort AUC should

not contemplate such a role. Under this project the responsibility of recruiting, training and supervising the canvassers would be the responsibility of the physicians, social workers, and county supervisors for the relevant population. AUC's role will be one of training these personnel and offering technical assistance when appropriate.

Contraceptive Re-supply (A<sub>4</sub>). Since there is a need for a continuous supply of contraceptives and since the household distribution system distributes only a four-month supply of contraceptives, it is crucial that a re-supply system is established that will provide easily accessible contraceptives. In the 134 villages that have health units, the re-supply point will be the health unit. In the 168 villages where there are no health units, the re-supply function will be the responsibility of the community development worker (CDW). The community development worker will be recruited from the pool of canvassers and will receive special training. It will be noted later that these community development workers will have functions other than the re-supply of contraceptives.

Follow-up System (A<sub>5</sub>). The follow-up that will be introduced in this system is a traditional one. Namely, when an individual misses a date on which she/he is due for a re-supply, she will be visited by the CDW or, in villages where there are health units, a nurse from the clinic. The purpose of the follow-up

visit is to determine if the client has dropped out and the reasons why. If appropriate, an attempt will be made to get such individuals to resume contracepting. If the individual experienced side-effects, alternative forms of contraceptive methods will be offered and, if called for, a referral to the physician will be made.

Referral System (A<sub>6</sub>). The referral system for the family planning component is mainly for treatment of side-effects from fertility regulation methods. These referrals will usually be the result of follow-up visits or clients presenting themselves to CDW for assistance. However, the referral system could also include a referral from the village clinic to the district hospital for serious complications.

Process (B): Thus far, only what goes into the system has been described. What happens to these inputs will be determined by analyzing the "process" of each input. Of course, the question of the existence or non-existence of inputs in the system is the first thing to be determined. For example, are contraceptives actually available in the rural health units? Do canvassers have contraceptives to distribute? There will also be assessments made of the quality of these processes in terms of managerial or administrative criteria and, when appropriate, corrective actions will be taken.

Training Programs (B<sub>1</sub>). There will be training programs for clinic personnel, canvassers, community development workers, field supervisors, and local leaders. This listing is more or less in the order of the training required for each category of person from the highest training requirement to the lowest. While canvassers and community development workers will receive intensive training, it will not be of the same sophistication as that required for the clinic personnel.

Commodities in the Community (B<sub>2</sub>). This is a very important process and one that will require a great deal of attention. Almost all health units experience chronic shortages of crucial commodities. In some cases, especially with equipment, this is due to an absolute shortage of the items in question. Often, however, it is a logistical problem. The items are available, but it is difficult to get them to the service point. Therefore, it is not enough to allocate commodities for an activity and assume that these commodities will be actually available to support the activity.

Household Visits Made (B<sub>3</sub>); Re-supply Depots Established (B<sub>4</sub>),  
Follow-up Visits (B<sub>5</sub>); and

Patients Treated (B<sub>6</sub>). These processes are described in the attached paper by Gadalla, op. cit., and elsewhere in the

project description. Here it is enough to state that these processes will be followed very carefully by the AUC staff.

Outputs (C). Usually, from careful examination of the program processes, one can predict how well a program is working. However, the first real indication of how well a program is working comes from an examination of its outputs.

Trained Personnel ( $C_1$ ). Initially, this output will be examined in terms of the number of persons who were trained that were supposed to be trained. A more in-depth assessment will be made in terms of the skills that should have been acquired. In some cases this will be done by direct observation, i.e., can the physician insert an IUD in a professional manner. In other cases it will be done by observing and qualifying products of the trained personnel, i.e., is the nurse or CDW making follow-up visits.

Commodities Utilized ( $C_2$ ). Here, the utilization of the commodity inputs will be determined. Is the OB-GYN equipment being used? If not, why is it not being used? Are the contraceptives being distributed? And so on ...

Direct Availability of Contraceptives ( $C_3$ ). This output refers to the degree to which the community was covered by the household canvass. Of the total households, how many

were actually visited by canvassers? Here again, if the percent of the households visited is too low, the reasons for the poor performance will be determined and corrective action taken.

Continued Contraceptive Availability (C<sub>4</sub>). This output does not refer to the existence of re-supply points, but to their utilization in terms of their potential utilization. While the establishment of local re-supply points adequately addresses the distance barrier to continued contraceptive use, there are many other barriers that clients confront. Some of these are easy to identify, e.g., the hours during which re-supplies are actually offered. Others are much more subtle and can require a great deal of innovativeness to isolate and correct.

Minimizing Dropouts (C<sub>5</sub>). The immediate purpose of follow-up visits is to minimize dropouts. An examination of service statistics can give a fairly accurate picture of how effective the follow-up system is functioning.

Minimizing Side Effects (C<sub>6</sub>). Although side effects are often associated with dropout rates, they are not related on a one to one basis. Many persons drop out of programs without experiencing side effects and many persons continue to use contraceptives even though they experience side effects.

Therefore, it is important to assess how well the program is doing in terms of the prevalence of side effects. Of course, there will always be side effects from all contraceptive methods, with the possible exception of condoms. One way to determine how the program is dealing with these side effects is by analyzing their extent and nature. This type of analysis, however, needs to be supplemented by one which determines what the program does with persons who experience side effects or, in other words, how well the referral system is working.

Goals (D). Goals are the most difficult part of the program to assess. Because family planning addresses a behavior that results or does not result in a specific by-product, i.e., a baby, and because it has a well-developed evaluation methodology, this project can easily ascertain the degree to which the project has attained its family planning goals. Other measures of goals will be used, but those described below are the most important and useful.

Increased Contraceptive Prevalence ( $D_1$ ). As with all of the goals, the reference point for "increase" or "decrease" is the period before the inputs. Of the indices used to measure the program's goals, contraceptive use prevalence will be one of the first and most accurate of those utilized since longer birth intervals, lower pregnancy rates, lower birth rates and smaller family size require a longer period

of observation than is possible under this project. This project will not use continuation rates or acceptance rates as a measurement of goal attainment even though they are often used in evaluating family planning efforts. These measurements do not tell much about the success of a program. Obviously, if a program has a low continuation and/or acceptance rate, it is unlikely to have a high prevalence rate. On the other hand, a program can have high acceptance and continuation rates and still have a very low prevalence rate. (The opposite is not true. For example, if a modest increase in contraceptive prevalence is found, then one can safely infer that there is unlikely to be a significant decrease in, for example, birth rates. Or, if such decrease did occur, it is not the result of the program.) Prevalence measures the extent the program is penetrating the eligible population. This is very important. It is often forgotten that, roughly speaking, a population that is sexually active must have a prevalence rate somewhere in the neighborhood of 65 to 70 percent to bring its fertility rate to replacement level.

Lower Age/Parity Users (D<sub>2</sub>). A good measure of a program's success is the extent to which it recruits "hard-to-reach" individuals. In family planning, these hard-to-reach individuals are typically young with few or no children. In order for a

family planning effort to be successful, these persons must be reached while they are young and still in an early stage of family formation.

Longer Birth Intervals ( $D_3$ ); Lower Pregnancy Rates ( $D_4$ ); Lower Birth Rates ( $D_5$ ); and Smaller Family Size ( $D_6$ ). As mentioned earlier, these goals are the most appropriate to measure the success of the program since they represent the ultimate objectives of the program. However, the ability to accurately measure how well the program achieves these goals is limited by the length of the project. The impact of program cannot be adequately measured until a sufficient length of time elapses for births to begin to drop. One example will highlight this methodological problem. Even in a fertile, sexually active population, closed birth-intervals are seldom shorter than two years without any contraceptive protection. Since this project is designed to be only three years long, one can see that it will be difficult to measure impact in terms of these goals. This is one of the reasons it is felt that there should be an option for a fourth year. If the program seems to be highly successful, then USAID may wish to document it in a more definitive manner than is possible in a three year project. Even if the project is not four years long, however, there are analytical and statistical procedures that can be employed to estimate the impact of the program in terms of these goals.

B. Health Component

Relative to other developing countries, Egypt has an extensive health infrastructure. In Menoufia, the rural population is served by 134 health units.

A typical health unit usually serves a large village in which the unit is located and one or more smaller villages about three kilometers away. The health unit is headed by a physician assisted by a staff usually consisting of three nurse-midwives (graduates of intermediate midwifery institutes), two assistant midwives, a laboratory assistant, and a health practitioner (graduates of intermediate public health institutes). The health unit usually includes a health bureau for registration of births and deaths, a dispensary for MCH services, an outpatient clinic for medical treatment of minor illnesses and injuries, and a family planning clinic for distribution of contraceptives.

Despite the fact that there is one clinic per 10,000 people and because of the settlement patterns found in the Delta, these clinics are spatially accessible to the population. The quality and utilization of services, however, is not commensurate with the potential of the health system. Firstly, this project is designed to serve as a catalyst for the existing health organization so that the potential of the health system can come closer to realization. Secondly, the project will emphasize public health activities. Like most countries,

Egypt does not emphasize preventive medicine in its health system. Even if this project were to bring the functioning of the health system to its optimal level of productivity, there would be a gap in the type of services offered since the health system emphasizes curative medicine.

The most important causes of morbidity and mortality in rural Egypt are endemic disease caused by the environment and the interaction of the people with their environment. It is fully appreciated that this area is one of the most difficult to address in the whole spectrum of developmental actions. To deal with, for example, gastrointestinal diseases in an effective manner, would require major changes in the people's behavioral patterns and environment. Changing life-styles centuries old is a very difficult proposition indeed. Nevertheless, it is ethically and programmatically unwise to ignore a problem because it is difficult. It is hoped that the approach adopted here will be more effective than earlier efforts in public health in attacking such problems.

Unlike the family planning and, for that matter, the social welfare component, AUC staff do not have strong experience in health programs. AUC does have experience in the analysis of health systems in an organizational sense and, of course, has extensive experience in studying the life-styles of rural Egypt. Still, there will be a substantial input from outside consultants at the outset of this

project to develop the details of the health component. These consultants will work closely with Governorate health officials. It is believed that the general strategy outlined in Figure III will be adequate for the purpose of the project. What will be required is the development of tactics to implement this strategy.

\* Inputs (A): The health component will emphasize the infusion of new techniques of treating and preventing disease rather than resources such as personnel and commodities. This approach has been taken because it is believed that the most important reasons for service delivery inadequacies are not attributed to lack of major material, physical or human resources.

Training Elements (A<sub>1</sub>). Unlike the situation in family planning, health personnel do receive training in all relevant aspects of health. They have a basic knowledge of health, but, as noted earlier, their training emphasizes the curative approach to health. The proposed training program will emphasize preventive medicine and modifications in the present health delivery system which will be instituted to improve the health services. Perhaps most importantly, the training program will include socio-economic information relevant to public health. This is a crucial element because health personnel are frequently

isolated from the community. Physicians are especially isolated. Physicians are typically recent graduates who not only have little medical experience, but little knowledge about rural life. In addition, they have no knowledge of their patient population. Lastly, very often physicians and other staff do not clearly understand the operation of the existing health system. For instance, AUC has found physicians who do not know how to order certain kinds of supplies. These seemingly mundane problems can have a very important and positive effect on the functioning of the health unit if they are resolved.

The training inputs will concentrate on the clinic staff but will also include the social welfare staff, the community development workers (CDW's), county health supervisors, and selected community leaders. This training will concentrate on the operation of the health system and elementary health education. Like all training, the interrelationships between family planning, health, and social welfare will be discussed in detail.

Commodities (A<sub>2</sub>). The commodity input will be kept to a minimum and, wherever possible, commodities will be drawn from existing government stocks. This input will concentrate mainly on the logistical problems known to exist in rural Egypt. There is frequently no absolute shortage of critical material, but

instead a maldistribution of material or non-distribution of material, i.e., the supplies remain in the Governorate warehouses. A major input item designed to alleviate the commodity problem will be three vans which will be utilized to improve the flow of commodities.

Funds should be made available to purchase commodities that are considered essential to the stated purposes of the health unit. For example, if immunization programs are not being implemented because of a lack of material (not just at the health clinic, but an absolute lack of material), then these materials should be obtained. Other types of commodity requirement might be the purchase of inexpensive items that have potential for a major and immediate payoff, i.e., items that are very cost-effective. One such purchase might be Oralyte. This rehydration salt, or comparable mixtures, has proved effective in reducing deaths from diarrheal diseases in a variety of settings. Illiterate villagers can be taught to use the salts in an effective manner. This possibility will be explored early in the project.

Activate Personnel (A<sub>3</sub>). Health personnel now typically play a reactive role. They wait in the clinic for problems to come to them. In order for the health system to become more effective, the health personnel must adopt a more aggressive

role in addressing the health problems of the community. It is believed that the major reason this reactive stance has become so common is that the staff do not know how to take an active role. This input will be achieved through meetings and discussions with persons from all sectors of the community.

Establish Outreach System (A<sub>4</sub>). A specific modification of existing practices that will enable the health personnel to become more aggressive in dealing with health problems will be the establishment of an outreach system. The nurses will be taught how to go into the community and identify problems that can be solved or referred to other facilities. The other function of the outreach effort is simply to increase the interaction between the staff and the community. The dominant view held among rural Egyptians toward health facilities is that it is a service of the last resort. Often, villagers seek assistance from clinic personnel only after their conditions have reached a crisis status. The only way this type of situation can be resolved is to break through the barriers to the clinic. It is felt some of these barriers are social and psychological and that they can be alleviated if there is greater interaction between the staff and the community.

Establish Referral System (A<sub>3</sub>). This input will be primarily for the CDW's who will act as a referral agent for the health units. There will also be an effort to make the existing referral system between health units and the health centers and district hospitals more effective and efficient.

Process (B): The processes of the health component are more multifaceted and complex than those found in the family planning component. As a result, the monitoring of these processes will require more energy than is the case for family planning. However, the general way the processes will be dealt with will be the same as described for the family planning component. Therefore, it is not felt to be necessary to describe the individual process elements in Figure III: training programs, commodities in clinics, personnel meetings, diffusion of services and utilization of health network.

Output (C): The outputs of the health component will be fairly easy to determine and evaluate. This will be done through field observation and an analysis of service statistics. The monitoring of the outputs will be more or less continuous so that changes in the processes or different inputs can be made. Figure III geographically shows the outputs anticipated in this project.

Trained Personnel (C<sub>1</sub>) and Commodities Utilized (C<sub>2</sub>): These two outputs will be treated in the same way as was described for their family planning counterparts.

Personnel Productivity Increased (C<sub>3</sub>). If the project is successful, one should anticipate an increase in staff productivity in terms of patient load and related activities, e.g., number of outreach visits.

Increased Utilization of Services (C<sub>4</sub>). The utilization of service is related to increased personnel productivity although there are a number of differences. First, if the outreach effort is successful, there should be an increase in the use of services by persons not using them before because of barriers preventing easy access to services. For example, villages outside the village containing the health unit should have a higher incidence of services delivered than prior to the initiation of the outreach effort. The second major element of this output is the type of services delivered. This too should be altered as a result of the project's intervention.

Maximizing Use of Health Facilities (C<sub>5</sub>). Although one picture people have of health facilities in the developing world is of over-crowded clinics and over-worked staff, there is another picture that is not uncommon in rural Egypt. This is a picture of empty clinics and bored staff. The project should result in a higher percent of the staff's working day being spent on the actual delivery of services and a greater use of the physical plant.

Goals (D): The goals of the health component are the lowering of morbidity and mortality rates. It was mentioned earlier that the measurement of the program's success in this area will be difficult and that indirect measurements requiring some degree of inference will be employed, especially for morbidity. There will be very little emphasis based on changes in non-behavioral health variables (i.e., knowledge and attitudes).

Lower Morbidity Rates (D<sub>1</sub>). One of the results of this project is that there will seem to be an increase in the incidence of certain diseases. This increase will be artificial. Since the productivity of the health system will be increased, service statistics should show an increase in the morbidity of the population. Therefore, service statistics will have limited value in measuring the project's impact on morbidity. Morbidity will be measured through before/after surveys which are described in the "Evaluation Plan" section.

Because of problems associated with the interviewee's recall, subjectivism, and poor definitional knowledge, health surveys typically have difficulty in measuring diseases. In order to be meaningful, health surveys require a tremendous investment. This project will not have what is usually termed a health survey. Instead, the surveys will focus on a few items that are easier to determine (but not simple to determine) and concentrate on getting accurate information

on those selected variables. The survey results will be cross-checked with the appropriate service statistics and field observations. Examples of the types of indices that will measure goal achievement would be the percent of the population drinking potable water, and the use of health services.

Lower Mortality Rates (D<sub>2</sub>). Before/after comparisons will be made from existing death registration data. However, these will not be relied upon to make any definitive assessment since these data are of questionable accuracy. The surveys will have questions concerning mortality, but sample variability and the shortness of the project will mean that these data will have limited value. The one area that will be focused on is infant mortality which is much more sensitive to intervention than other forms of mortality.

C. Social Welfare Component

As with the health infrastructure, the social welfare organization is quite well developed in rural Egypt relative to other developing countries. There is approximately one welfare unit per 16,000 persons in Menoufia.

A typical social unit serves a large village in which the unit is located and three or four nearby villages. The social unit is headed by a social worker (university graduate majoring in sociology or in

social work). The social welfare staff usually consists of five or six persons, each in charge of one of the services or programs. The most emphasized service is the provision of financial aid and material assistance to socially disadvantaged individuals. Other services include handicraft and cottage industry projects for increasing the earning and productive power of poor families, home-economic clubs for women, literacy classes for adults, vocational training for school dropouts, nurseries for pre-school children, agricultural extension programs for farmers, and educational public health, family planning, and hygiene programs for the community.

Figure IV illustrates the project's social welfare component in terms of inputs, process, outputs, and goals.

Inputs (A). In terms of cost, the inputs for the social welfare component will be relatively modest. Most of the inputs will be in terms of technical assistance. AUC has considerable experience in social action programs and has a well thought through strategy for developing social action programs utilizing existing resources.

Training Elements (A<sub>1</sub>). The training elements for the social welfare component will be similar to the health component in terms of design. As with health, the staff of the social units have basic knowledge of their respective fields. The training of the social welfare personnel will

focus on ways to better serve the community and will also concentrate on family planning and health.

Selected local leaders, the CDW's, and county supervisors will also receive training in the above areas. Their training will also include ways in which they can better interact with the social unit.

Commodities (A<sub>2</sub>). There will be very little in the way of commodity inputs. The projected inputs for this component will consist mainly of educational and training material. There will also be provisions made for small community grants to respond to urgent community needs and to serve as an immediate reinforcement for the community responsiveness to the welfare efforts. These small grants will be catalytic. It is anticipated that major community projects will be financed through grants obtained from the appropriate governorate departments.

Activate Personnel (A<sub>3</sub>) and Activate Community Leaders (A<sub>4</sub>). These inputs will be comparable to their health component counterparts and, therefore, do not require discussion.

\*Establish Communication Network (A<sub>5</sub>). This is a crucial input. It refers not only to the particular community, but also to relevant governorate departments. There is typically very poor

communication between social welfare units and governorate offices. This frequently results in an under-utilization of services available at the governorate level.

Community Resources (A<sub>6</sub>). While at first glance, this does not seem to be an input since community resources are already present, such resources are frequently not utilized or are under-utilized. For example, physical plants are often not used because they require renovation or no one has ever thought to use the plant for a community activity. Moreover, there are often villagers who have special skills that could be put to use in special projects. In other words, the resources are present but are not being fully exploited. These resources are inputs in the sense that they will be activated.

Process (B), Outputs (C) and Goals (D). Social Welfare can be a vague concept. Such categories as "increased community participation," "increased community self-reliance" and "increased community wealth" sound good and appropriate, but are they real? Or, are they simply constructs of policy makers or researchers? Compared with family planning and health, the processes, outputs, and goals of the social welfare component do seem somewhat nebulous. Nevertheless, they are very real and, to a surprising degree, can be observed and measured. To highlight these aspects on the welfare input/output model, a departure is made from the format used to discuss family planning and

health. Instead of discussing each element of the model in a more or less abstract manner, a specific case will be described in detail.

This specific case is drawn from the AUC experience in Shanawan and other Egyptian villages. While working in the villages, AUC staff have formed a picture of the social, economic and political organization of the communities. They have found that there are several institutions and organizations in Egyptian villages providing various services and performing a variety of functions. In addition to health units, social welfare units, and family planning clinics, there are primary and preparatory schools, agricultural cooperative societies, village councils, mosques, youth clubs, women's clubs, literacy classes, vocational training centers, and so on. There are also several formal and informal leaders whose opinions families and individuals seek in matters related to various spheres of life.

In performing their functions, however, most village organizations and opinion leaders have been confined to their traditionally prescribed roles without recognizing or considering surrounding changes in needs and situations. As a result, some organizations and leaders have become inactive or isolated from the community they serve. Others have continued to struggle with activities and programs that fail to stimulate the participation and support of the people they are supposed to reach.

Under this situation of organizational and leadership stagnation in the villages, it is extremely difficult to proceed with innovative approaches to development. Serious attempts should be made to integrate these activities into community development projects that are sensitive to the changing needs of the people. Existing village organizations should be activated and local leaders should be encouraged to undertake the responsibility of initiating, implementing, and promoting these projects through sustained community effort and support.

As a result of this experience, AUC was keenly aware that the intensive undertaking of household contraceptive distribution in Shanawan cannot be done in isolation. The household distribution must have the community's cooperation and understanding. There are very few social actions that entail the systematic visiting of every household in the community and unlike, for example, malaria campaigns, results in interaction with villagers on topics that traditionally have been viewed as very personal. In other words, although the household distribution system is concerned with family planning, the events preceding the distribution and during the distribution bring to light many other community needs. Like all individuals, villagers do not compartmentalize their lives. They do not view family planning in isolation and find it difficult to understand why or how others can, as suggested by the compartmentalization that is reflected by action programs.

For these reasons, AUC decided to supplement the contraceptive distribution system in Shanawan with a community action project aiming at activating the social welfare services in the village. The underlying assumption of this project is that if the already existing organizations and opinion leaders in the rural communities are helped and stimulated to perform their roles effectively, they will be capable of introducing social changes conducive to community development and improvement of living conditions. Such social changes can be directed toward the attainment of specific community goals, such as promoting family planning practices or any other desirable goal in the community.

In developing the Shanawan project, it was decided that:

- (1) the project should be cost-efficient, replicable in any rural community, and simple in its implementation procedures and evaluating techniques;
- (2) the personnel of the various organizations should be directly involved in the process of activating their organizational functions;
- (3) the activated functions should aim at stimulating greater participation of men and women in their community affairs, improving and intensifying available services, and providing adequate information about areas of knowledge related to important aspects of life such as health care, childrearing, home economics, nutrition, family planning, vocational training, functional literacy, modern agricultural practices, handicrafts, and cottage industries. With these principles in view, the

Shanawan community development project was initiated with a small budget of LE.2,000. An Executive Committee consisting of governorate officials, AUC personnel, and prominent opinion leaders in the village was formed to guide implementation of the project.

The project's activities are graphically shown in Figure V. This figure has been labelled the "Development Reinforcement Cycle" in order to emphasize the interaction which took place throughout the project among family planning, social welfare, and health activities. The reader can refer back to Figure IV to see how the Input/Output model relates to the action illustrated in Figure V.

As can be seen in Figure V the first activity (A) consisted of the contraceptive household distribution program. As a result of this effort, a number of community meetings (B) were held. The meetings included the Executive Committee, the personnel of the Rural Social Unit, and the members of the Unit's Board. During these meetings the obstacles that hindered the efficient operation of the Unit were discussed. In these meetings, the social worker played a key role so her participation is highlighted (B<sub>1</sub>). Over the years, the Unit's building, erected in 1948, had deteriorated considerably and no attempt had been made to repair or remodel it. The Executive Committee found an opportunity in this problem to involve the people in the community in the Unit's affairs. The

Committee suggested that the Unit use funds from its general budget to buy the materials required for repairing and remodeling the building and to recruit volunteer laborers from the community to undertake the job. The Board agreed to this suggestion and the building was repaired, remodeled, and painted in two months for a total cost of LE.240.

Since the Social Unit and the Health Unit are housed in the same building, this renovation also elicited the cooperation of the health personnel and the entire building was renovated. This process is shown in Figure V as C-C<sub>2</sub>. However, the renovation of this building directly led to another improvement activity concerning the nursery (C-D), which is part of the same building complex as the Health and Social Unit.

One of the functions of the Social Unit is to operate a nursery for children aged three to five years. At the initiation of the project only 16 children were enrolled. Although the Unit employed a supervisor and a nanny for the nursery, there were no furniture, toys, or educational aids for the children. As a result, the enrolled children seldom came to the nursery and the few who attended (not more than five daily) had nothing to do except play in the dust in the Unit's backyard.

As a result of a series of community and Executive Committee meetings, it was decided to provide the Unit with an amount of

LE.800 from the project budget to activate the nursery and to improve its facilities. The Unit's old hall was converted into a nursery, needed furniture and educational aids were purchased and the improvement of the nursery's facilities was announced in the community. As a result, enrollment was increased to 52 children and later to 92 children. This large enrollment encouraged formation of a "council" (C - E) consisting of all the mothers of the enrolled children to assist in planning the nursery's program and in implementing needed improvements.

The mothers' council became very active. A series of meetings (F) with the Council and the Social Unit staff led to the decision to form a women's club (G) that would become a center for more active participation of women in community affairs and a nucleus for receiving and diffusing the knowledge related to proper ways and means of family planning, childrearing, health care, nutrition, and home economics. Since its establishment in 1948, the Unit has failed to maintain an active women's club. The Executive Committee decided to allocate to the Unit's Board LE.300 from the project budget to be spent on forming a women's club and on implementing a program for its activities. The Board decided to form the women's club on the basis of establishing small interest-groups so that each group can plan and organize its own activities. A television set was purchased for the club, using part of the LE.300. The female social worker of the Unit contacted

the women in the community and asked them if they would like to come to the Unit in the evenings (after they finished their housework) to do whatever interested them. The women were also told that they could come and watch T.V. or talk with other women. The social worker succeeded in attracting 56 women to join the club and to form several interest-groups.

One such interest group led to the development of a program to encourage school dropouts to attend vocational training classes (H). The women's club employed a variety of techniques to get teenagers, often their own children, to obtain training that would increase their earning potential. This activity, however, was just one of many that the club initiated.

One of the important activities was the establishment of functional literacy classes (I). Working with the Social Unit staff, the women's club collaborated with the village schools to form evening literacy classes for adult men and women. This program was announced to the village and a systematic attempt to recruit people was made. As a result, five classes containing 120 men and four classes for 100 women have been formed and are continuing. The material used in these classes concentrate on family planning, maternal and child health, and nutrition ( $I_1 - I_3$ ).

Another club activity was the formation of discussion groups, led by the Health Unit physician (J). These discussions concentrate on

family planning, child care, nutrition, and hygiene ( $J_1 - J_5$ ). These meetings have greatly increased the interaction of the Health Unit's staff and the community. It is worth noting that this physician has renewed her term of service in Shanawan, a very rare event in rural Egypt.

A popular activity of the club is the home economics class. With the Social Welfare Unit staff, the club has sewing classes and cooking classes which emphasize nutrition. One of the class's specific outputs is uniforms and lunches for the nursery children ( $K_1 - K_3$ ).

The club initiated an active recruitment program to supplement the efforts of the Social Unit's staff. This recruitment drive (L), resulted in spreading the word concerning all of the club's activities ( $L_1$ ). Initially, at least, this drive proved too successful. The club's membership increased to 150. This number is too large to be accommodated in the existing community center which also serves as the nursery.

Because of the growing popularity of the club's activities, meetings were held to determine the best way to respond to this community-wide interest (M). A grant was sought from the governorate which responded with LE.1,650. The grant stipulated that the funds only be used to buy materials and that all of the labor be provided by community volunteers. The building is now almost completed.

In summary, this effort has resulted in a number of significant changes in the community. While AUC has not formally evaluated this effort, a number of important changes are documented below.

	<u>BEFORE</u>	<u>AFTER</u>
NURSERY	16 children	92 children
MOTHERS' CLUB	NO	YES
WOMEN'S CLUB	NO	YES, 150 members
PROGRAM FOR DROPOUTS	NO	YES
FUNCTIONAL LITERACY CLASSES	NO	YES, 220 students
HOME ECONOMICS CLASSES	NO	YES
COMMUNITY CENTER	Old and small	New and large
COMMUNITY MEETINGS	Few	Many

While this is a very good success story, it is realized that such a high degree of success may not be feasible for a governorate-wide program for a number of reasons. First, this program was not competing for governorate funds with other villages. That is not to say that other villages were not trying to get funds, but that they were not as well organized as Shanawan. With a governorate-wide program, the funds will have to be spread more thinly. Second, the success of such efforts cannot be guaranteed by simply instituting a community action program. These programs require competent people to lead them. While there is little doubt that every village

has such leadership, every village will not have a physician and/or social worker, or a cooperative physician and/or social worker. In other words, it is fully expected that some villages will do very well under the program, while others will not. Thirdly, AUC has been active in Shanawan for a number of years, and this has probably facilitated the villagers' ability to initiate activities. Nevertheless, it is believed that there can be an overall and significant improvement in the development of the governorate through this type of project, and that such an improvement can be documented in such a way that policy makers can base decisions on these results.

#### V. PROJECT EVALUATION PLAN AND TIME SCHEDULE

Obviously, the evaluation plan of the project will depend on the implementation procedures of the action plan. Since it would be impossible to cover the entire governorate in one single effort, the project will have three major phases. The first phase will initiate the project in three counties; the second in three additional counties, and the third in the remaining two counties. These counties are shown on the attached map and their infrastructures are illustrated in Figure VI. As indicated in the figure; the organizational structure of health and social welfare services in Menoufia consists of three inter-related levels.

At the governorate level, the General Department for Health is in charge of the overall administration and supervision of the health

facilities in the governorate. The General Department for Social Affairs is responsible for the overall administration and supervision of social welfare services.

At the county level, each of these two general departments has an administrative department for the supervision of the respective services in the county. At present, there are eight county administrative departments for health and eight county administrative departments for social welfare.

At the local community level, health and family planning services are provided by 134 health units and social welfare services by 87 social units, 123 community development societies, and 124 welfare societies.

This elaborate infrastructure and the rural communities it serves constitute the universe for the project's evaluation plan. The components of this plan and the time schedule of its major activities are illustrated in Figure VII.

A. Sample Selection

The evaluation of the project cannot be done for the entire governorate due to financial and time considerations. Therefore, a two-step sampling procedure will be followed. The first step will be drawing a stratified sample of villages. This stratified sample will use the following sampling criteria. In terms of existing

infrastructure, villages can be categorized in the following manner: Health and Social Welfare Units, Health Unit Only, Social Welfare Unit Only, and No Health or Social Welfare Unit. Villages will be randomly selected from each of these categories in the following manner:

Counties	Health and Social Units	Health Only	Social Only	None
1-3	3	3	3	3
4-6	3	3	3	3
7-8	none	none	none	none

The reason for this sampling procedure is based on the following considerations.

1. It is anticipated that the project will have differential impact in communities due to the extent of the existing infrastructure. Thus, communities with Health and Social Units are anticipated to have greater success than those with no such units.
2. Counties 7 and 8 are not included since a five year project would be required to measure the impact of the entire project. As shown in Figure VII, the program will not be operational in these counties until year three of the project. An additional two years would be required to measure the effects of the program in a professional manner. However, it is still important to include these counties

since one of the important elements in evaluating the success of the project is the ability of the government to undertake a governorate-wide effort. Also, it would be difficult to exclude two counties simply for evaluation or methodological considerations.

3. Counties 4-6 will have the complete evaluation plan; this is being done in anticipation that a fourth project year is possible. Since this decision may not be made for some time, it is necessary to collect the appropriate baseline data to insure that evaluation can be carried out if the project is extended for a fourth year.

B. Baseline Data

The primary comparisons that will be made in this project are before/after differences within and between the four types of communities. To measure the before/after differences the following type of data will be collected in the 24 sample villages.

1. Socio-demographic Survey

- a. Fertility behavior
- b. Contraceptive behavior
- c. Social activities
  - i. community meetings
  - ii. community projects
  - iii. membership in community organizations
- d. Health status
  - i. immunization
  - ii. drinking practices
  - iii. cooking practices
  - iv. waste disposal practices

- e. Mortality
  - 1. period prevalence rates
- 2. Organizational Analysis
  - a. Unit activities, service statistics
  - b. Patient and client loads
  - c. Equipment inventory
  - d. Type of services offered
- 3. Community/Leaders Survey
  - a. Community activities
  - b. Physical community facilities
  - c. Interaction with governorate officials
- 4. Health and Social Units' Staff Survey
  - a. Personnel meetings
  - b. Interaction with governorate officials
  - c. Unit activities

The socio-demographic survey will consist of a 20 percent sample of households. Information will be collected from head of the household and married women 15-45 years of age.

The organizational analysis will be composed of an analysis of the units' records and through field observations. This analysis will also draw upon data collected through the staff interviews.

The sample size of the community/leaders survey cannot be determined until the villages are selected for the evaluation. The size of the villages and the number of leaders will vary greatly. However, it is anticipated that all community organizations will be represented in this sample.

The staff survey will include all of the professional and para-professional staff.

The baseline data, as indicated in the time frame shown with Figure VII, will take place in month four of the project. This is a rigorous time requirement but must be adhered to if the project is to be successfully evaluated within its projected life.

One of the most difficult aspects of this evaluation plan is that it will require a great deal of data processing and relatively sophisticated programming. SRC's experience under its two other grants strongly suggests that data collected under this study will have to be processed outside Egypt if a reasonable turnaround time is desired. This recommendation is not made lightly; the experiences of trying to find adequate programming and computer facilities for this type of work in Egypt has been such that no alternative to processing the data outside of Egypt seems feasible at present. SRC now has an arrangement with Ohio State University for the processing of the Menoufia data from the existing project. This relationship has worked well and it is recommended that Ohio State also process data from this project.

The time frame does not show  $B_2$ , or any of the other intermediate stages of the evaluation components (e.g.,  $C_1$  and  $C_2$ ). It was felt that the most important information to present was the beginning and end points of each major evaluation activity.

The analysis of the baseline data is not completed until the tenth month of the project, after the analysis of the input data. This is due to the time required to process and analyze survey data and to the vast quantity of data that will be collected.

C. Input Analysis

The input analysis will be of the following types:

1. Cost data, excluding research costs
2. Person-hours
3. Material
  - a. Described
  - b. Assigned a monetary value
4. Vehicles, depreciated over life of project
5. Commodities
  - a. Described
  - b. Assigned a monetary value
6. Descriptive narrative of inputs.

The last item, the descriptive narrative, is important since there will be some inputs that cannot be quantified. Also, this information will constitute a how-to-do-it manual, describing how the inputs were

injected into the infrastructure and community, problems faced, and how these were resolved or alleviated. The purpose of collecting the input data is to enable the determination of cost-effectiveness ratios for both outputs and goals.

D. Process Analysis

The process analysis will depend heavily on field observations that will determine the existence or non-existence of processes. In some cases, as noted in the discussions of Figures II-IV, processes can be quantified. However, the bulk of the evaluation of the process will be in narrative form and will concentrate on problems in the processes and steps taken to correct these problems.

E. Output Analysis

The output analysis will be based on service statistics and field observation. In almost all cases, the outputs described in Figures II-IV can be quantified. The only exception to this statement is found in the social welfare component, specifically C<sub>5</sub> (Increased Community Awareness). Examples of how the other output will be operationalized are given below.

1. Family planning:

- a. Trained personnel: percent of eligible personnel trained;
- b. commodities utilized: contraceptives accepted as percent of eligible women; contraceptives distributed as percent of unit's stock;

- c. direct availability: percent of households canvassed;
- d. continued contraceptive availability: contraceptives in resupply points, contraceptives resupplied as percent of acceptors;
- e. minimizing dropouts; before/after continuation rates based on service statistics;
- f. minimizing side effects: (detailed analysis of this output cannot be made until the "After" survey) number of referrals as percent of active users by type of referral.

2. Health:

- a. Personnel productivity increased: before/after patient load by staff member and type of patient (clinic versus home visit);
- b. increased utilization of services; before/after patient load by type of service;
- c. maximizing use of health facilities: referrals completed as percent of referrals made by type of health facility, patient load of health facilities.

3. Social Welfare:

- a. Program functioning: before/after increase in number of programs as percent of number of programs attempted;
- b. increased community participation: membership in local organizations;
- c. maximization of community resources; before/after increase in use of physical plants.

There will be many other output variables constructed in the course of the project. The above examples indicate that these variables can be operationalized in a manner that lends itself to quantification and, thus, sophisticated computer analysis.

Outputs will be analyzed in terms of the cost required to achieve these outputs. Ratios will be made not only for monetary cost, but also by person-months per output. There will also be an attempt to measure the relative contribution of the various inputs, but this will be difficult. The very fact that this is an integrated project means that separating the inputs into their component parts will be difficult.

#### F. Goal Analysis

With the exception of the Social Welfare goals, all goals for this project are stated in their operationalized form, e.g., mortality rates. Here again, the analysis will concentrate on before/after comparisons. The primary sources of data for this phase of the project's evaluation will be from the "before" surveys, input data, and the "after" surveys.

The "after" surveys will be basically the same as the "before" surveys. However, there will be no attempt to interview the same individuals on the socio-demographic survey. For the community leaders and staff surveys, the same individuals will be interviewed.

It is anticipated that there will be some staff turnover among the units' personnel. In these cases, their replacements will be interviewed. The same procedure will be followed for community leaders, although turnover and other reasons for loss-to-follow-up will not be as serious with this group as for the health and social welfare staff.

The Social Welfare goals will be operationalized in the following ways. The examples are not all-inclusive. Others will be developed based on the analysis of the baseline information collected and subsequent analyses of the project.

1. Community supported activities: before/after increase in community supported activities (organizations, self-help projects, classes, etc.);
2. increased community wealth: before/ after increase in community facilities (buildings, piped water, etc.), before/ after increase in number of community economic activities;
3. increased community skills: before/after increase in the number of trained personnel with specific job skills;
4. increased community self-reliance: before/after increase in number of self-help activities;
5. meeting community needs: before/after increase in the number of needs expressed per specific activities addressing these needs.

There will be a cost-analysis made for the goals, which will be similar to that described for outputs. There will also be an analysis of the replicability cost and the projected goals for a national expansion of the Menoufia experience.

VI. AUC ROLE AND STAFFING PATTERN

This project will, among other things, promote and integrate the family planning, health, and social welfare activities in Menoufia Governorate. AUC's role in this effort will be to:

1. Provide technical assistance to government officials involved in the program;
2. Train personnel involved in the program;
3. Design, plan, and evaluate the action;
4. Provide guidelines for coordinating the family planning, health, and social welfare components of the program.

The degree of AUC's commitment to this project is substantial, as shown by the following staffing pattern:

Principal Investigator	Full-time
Senior Researcher (Demography)	)
Senior Researcher (Medical Anth.)	)
Senior Researcher (Psychology)	)
Senior Researcher (Sociology)	)
Senior Researcher (Health Education)	) 1/3 time
Senior Researcher (Management)	)
Senior Researcher (Economics)	)
Senior Researcher (Mass-Communication)	)
Senior Researcher (Political Science)	)

Statistical Consultant	)	
Medical Consultant (Public Health)	)	
Medical Consultant (Obst. Gyn.)	)	1/2 time
Medical Consultant (Pediat.)	)	
6 Senior Research Assistants	)	
25 Research Assistants	)	
6 Secretarial, clerical, and support staff	)	Full-time
3 Administrative Assistants	)	
1 Technical Editor	)	

One of the most important elements in AUC's ongoing Menoufia project is the Executive Committee. The membership of this Committee will be enlarged to reflect the proposed project. We suggest that the Committee consist of fifteen members representing the Governorate, the Ministry of Health, the Ministry of Social Affairs, and AUC as follows:

Governorate Level

Governor of Menoufia  
Chairman of Governorate Local Council  
General Director of Health in Menoufia  
General Director of Social Affairs in Menoufia  
Deputy Director of Health in Menoufia  
Deputy Director of Social Affairs in Menoufia  
Director of Public Activities in Menoufia

Ministry Level

Under-Secretary, Ministry of Health  
Under-Secretary, Ministry of Social Affairs  
Director of Family Planning Department, Ministry of Health  
Director of Family Planning Department, Ministry of Social Affairs

AUC Level

Principal Investigator of the Project  
3 Senior Researchers

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The Executive Committee will meet monthly to review the progress of the project and to facilitate difficulties that may be encountered in the implementation of the action and evaluation plans.

#### VII. BUDGET NARRATIVE

This budget replaces that submitted by AUC in its June 1977 proposal "Proposed Action-Research Program for Promoting Family Planning, Health, and Social Welfare in Menoufia Governorate." The budget reflects a careful review of AUC inputs and the decision of USAID to fund Menoufia activities including the previously funded AID Grant No. PHA-G-1139. This AID/W grant will be terminated as soon as USAID SA funds are received by AUC.

#### THE SUMMARY BUDGET

The summary budget of the proposed project is presented below. The three year total for the project is \$3,993,000. This is a reduction of \$567,000 from the sum of the budget presented in the original AUC proposal and the existing Grant No. PHA-G-1139.

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BUDGET SUMMARY

Budget Categories	1st year		2nd year		3rd year		Totals	
	(\$000)	(%)	(\$000)	(%)	(\$000)	(%)	(\$000)	(%)
Salaries	462	41	507	35	556	40	1,525	38
Menoufia Activities	612	54	887	61	788	56	2,287	57
Other Costs	57	5	61	4	63	4	181	5
<b>Totals</b>	<b>1,131</b>	<b>100</b>	<b>1,455</b>	<b>100</b>	<b>1,407</b>	<b>100</b>	<b>3,993</b>	<b>100</b>

AUC Salaries

Salary levels are determined by AUC. Below are descriptions of the staff functions for professional staff.

Principal Investigator: Dr. Saad Gadalla will be the Principal Investigator. Dr. Gadalla received a Ph.D. in Rural Sociology/Demography from the University of Missouri. He has published extensively in the field of population, family planning, and--in general-- socio-economic development. He has held appointments at the University of Missouri, the University of Michigan, and the University of North Carolina. Currently, he is a Research Professor at AUC and the Director of Social Research Center, AUC.

Gadalla will have the overall responsibility of the project.

Associate Principal Investigator: Dr. N. Nasseir will be the Associate Principal Investigator. She received a Ph.d. from Princeton University in Social Demography and has extensive research experience in rural Egypt. Dr. Nasseir will assist Dr. Gadalla in the overall direction of the project. In conjunction with Dr. Gadalla, she will be primarily responsible for the analysis of the project's data.

Senior Researchers: Reflecting the multi-faceted character of this project, there will be senior faculty members working four-person months each from the following disciplines: Demography, Medical Anthropology, Psychology, Sociology, Health Education, Management, Economics, Mass-Communication, and Political Science.

The role of these Research Associates will not entail special studies in their areas of expertise. In keeping with the research philosophy outlined in the proposal, the degree of research encompassed in this project will be kept to the minimum required to make programmatic and policy decisions concerning this form of integrated delivery system. Instead, the Research Associates will work under the direction of the Principal Investigator and provide the following services.

- 1) Technical advice on the system inputs.
- 2) On-site assessment of system's "Process".
- 3) Technical assistance concerning the operationalization of "Outputs" and "Goals".
- 4) Advice on the appropriate analytical plans for evaluation.

This staffing pattern is necessary if the evaluation schedule is to be adhered to.

Senior Research Assistants: All of the Senior Research Assistants have M.A. degrees in Sociology-Anthropology and extensive field experience in rural Egypt. They are the immediate supervisors of the Research Assistants and will spend most of their time in the field. They will be actively involved in the training of fieldworkers, especially the Community Development Workers. The most critical role they will play is insuring quality control over the various field activities, including training, canvasser supervision, CDW supervision, service statistics, and interviewers.

Research Assistants: All of the research assistants have B.A. degrees in Sociology-Anthropology and extensive experience in various methods of data collection and techniques of social investigation. Many of them have attended the Chicago Summer Workshop on Family Planning Education, Communication, and Evaluation. The research assistants will be responsible mainly for the collection of data pertinent to the evaluation of the project and checking of coded data.

Medical Consultants: These consultants will supplement the one area that AUC does not have expertise-medicine. They will assist in determining the appropriate health inputs required to upgrade health services and will train health personnel in family planning and preventive medicine.

Statistical Consultants: These consultants will assist in the analysis of survey data and service statistics.

#### Menoufia Activities:

1) Training Fieldworkers: The following computation was used to determine this cost:

Basis of Calculating  
Training Budget

150 Physicians	\$100 each	\$15,000
150 Nurses	100 each	15,000
100 Social Workers	100 each	10,000
220 Community Development Workers	100 each	22,000
600 Local Leaders	50 each	30,000
		<hr/>
		\$92,000

Local leader will assist  
CDW or Social Worker

Canvassing Costs: This includes the salary of canvassers (\$1.00 per day) mapping costs, etc.

Steering Committee Meetings: This Committee (termed "Executive Committee") is described on page 62 of the proposal. The Committee meets monthly and is critical for a successful project.

Field Headquarters: The headquarters serve as living quarters for research staff, staging points for training and logistical activities (i.e., receiving and temporary points for canvassing forms, etc.). AUC has adopted the strategy of doing most of its quality control and initial "hand-count" analysis in the field. This allows for corrective action to be implemented at the earliest date.

Field Per Diem: AUC gives its staff a per diem for living in the field. The Senior Research Assistants and Research Assistants spend week-long or longer periods in the field.

Support Field Activities: These funds are used for a variety of purposes i.e., maintenance of headquarters, unanticipated expenses, etc.

Village Community Action Program: Based on experience in Menoufia, AUC estimates that it will require \$4,000 per village the first year of the integrated delivery system and \$2,000 the second year, or \$4,000 +\$2,000 X302 = \$1,812,000.

The specific types of activities and items the action program budget will pay for cannot be determined because this will vary from community to community. However, examples are described in the body of proposal. It should be noted that the community will usually identify its needs.

Other Costs

Data Processing and Analysis: Almost all of these funds will be used by Ohio State University where the programming, processing, and analysis of the project data will take place. Therefore, these funds should be in U.S. dollars.

International Travel: This will allow approximately four Egypt-U.S. round trips. These trips will enable AUC to work on the data during the

summer. Also, this will allow key AUC staff to visit Washington for consultation and to present project findings at key meetings.

REVISED  
MENOUFIA/AUC BUDGET (\$'s)

<u>Salaries</u>	Person month <u>per year</u>	1st <u>year</u>	2nd <sup>b</sup> <u>year</u>	3rd <sup>t</sup> <u>year</u>
Principal Investigator (fulltime) <sup>a</sup>	12	30,535	33,325	36,147
Associate Principal Investigator (fulltime) <sup>a</sup>	12	16,965	18,225	19,837
Senior Researchers (9, 1/3 time)	36	60,000	66,000	72,600
Senior Research Assistants (7, fulltime)	84	58,800	64,680	71,148
Research Assistants (29, fulltime)	350	87,500	96,250	105,875
Secretaries and clerks (8, fulltime)	96	28,800	31,680	34,848
Administrative Assistants (4, fulltime)	48	18,000	19,800	21,780
Technical Editors (2, fulltime)	24	14,400	15,840	17,424
Medical Consultants (3, 1/2 time; 1, 1/6 time)	20	20,000	22,000	24,200
Statistical Consultants (1, 1/2 time; 1, 1/6 time)	8	8,000	8,800	9,680
Coders, Key punchers	80	<u>12,000</u>	<u>13,200</u>	<u>14,520</u>
Sub-total		355,000	389,800	428,059
AUC Overhead - 30% of Salaries		<u>106,500</u>	<u>116,940</u>	<u>128,418</u>
Total Salaries		<u>461,500</u>	<u>506,740</u>	<u>556,477</u>

Menoufia Activities

	1st <u>Year</u>	2nd <u>Year</u>	3rd <u>Year</u>
Training of Fieldworkers	30,000	40,000	22,000
Canvassing Costs	21,000	25,000	12,000
Steering Committee Meetings	8,000	3,000	8,000
Field Headquarters	10,000	10,000	10,000
Field per diem	25,000	25,000	25,000
Support Field Activities	8,000	8,000	8,000
Vehicles (8:5 for field staff, 3 for transporting of medical supplies including contraceptives)	67,000	---	----
Vehicle fuel, maintenance, etc	35,000	35,000	35,000
Village Community Action program (302 villages @ \$6,000)	408,000	736,000	668,000
Total: Menoufia Activities	<u>612,000</u>	<u>887,000</u>	<u>788,000</u>

<sup>a</sup>Including summer remuneration primarily for analysis of results at Ohio State University.

<sup>b</sup>Allowances for cost of living increase.

Other Costs

Data processing and analysis <sup>c</sup>	20,000	24,000	26,000
Reproduction and printing	10,000	10,000	10,000
International Travel	6,000	6,000	6,000
Per diem for international travel <sup>c</sup>	6,000	6,000	6,000
Office supplies and equipment <sup>c</sup>	15,000	15,000.	15,000
	<hr/>	<hr/>	<hr/>
Total: Other costs	57,000	61,000	63,000
Grand Total	1,130,500	1,454,740	1,407,477

<sup>c</sup>U.S. dollar costs; most remaining budget items are U.S. dollars to be associated with local currency financing of project costs.

## Details of Village Community Action Program Budget

County	R. Pop	No. of Villages	1st year \$	2nd year \$	3rd year \$	4th year*
1. Shebin	197,663	36	144,000	72,000	—	—
2. Tala	155,758	41	164,000	82,000	—	—
3. Shohada	112,967	25	100,000	50,000	—	—
Sub-Total	466,388	102	408,000	204,000	—	—
4. Bagour	162,499	47	—	188,000	94,000	—
5. Menouf	200,402	32	—	128,000	64,000	—
6. Ashmoun	253,337	54	—	216,000	108,000	—
Sub-Total	615,238	133	—	532,000	266,000	—
7. Sabaa	114,077	22	—	—	88,000	44,000
8. Quesna	177,588	45	—	—	180,000	90,000
Sub-Total	291,665	67	—	—	268,000	134,000
Total	1,374,291	302	408,000	736,000	534,000	134,000

\*To be added to 3rd Year budget.

Details of Training Budget

	<u>1st year</u>		<u>2nd year</u>		<u>3rd year</u>	
	No.	Cost \$	No.	Cost \$	No.	Cost \$
Personnel to be trained						
Physicians	50	5,000	60	6,000	40	4,000
Nurses	50	5,000	60	6,000	40	4,000
Social Workers	30	3,000	50	5,000	20	2,000
Community Development Workers	70	7,000	100	10,000	50	5,000
Local Leaders	200	10,000	260	13,000	140	7,000
		<hr/>		<hr/>		<hr/>
Total		30,000		40,000		22,000

Current Budget\* of  
AID/PHA-G-1139 Grant

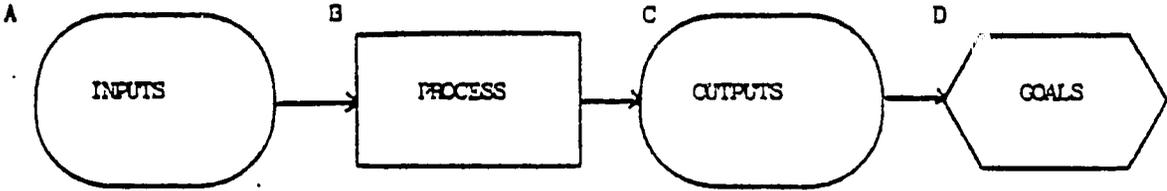
	<u>7-1-76</u> <u>8-31-76</u>	<u>9-1-77</u> <u>8-31-78</u>	<u>9-1-78</u> <u>8-31-79</u>
	\$	\$	\$
I. Salaries	132,800	146,000	160,600
II. Research and Canvassing Cost	93,000	61,200	55,600
III. Other Costs	39,000	39,000	39,000
	<hr/>	<hr/>	<hr/>
Total	264,800	246,200	255,200
University Overhead (20% of Total)	52,960	49,240	51,040
	<hr/>	<hr/>	<hr/>
Total Budget	317,760 =====	295,440 =====	306,240 =====

\*  
All but \$75,000 is in excess Egyptian pounds obtained from the Office of Management and Budget

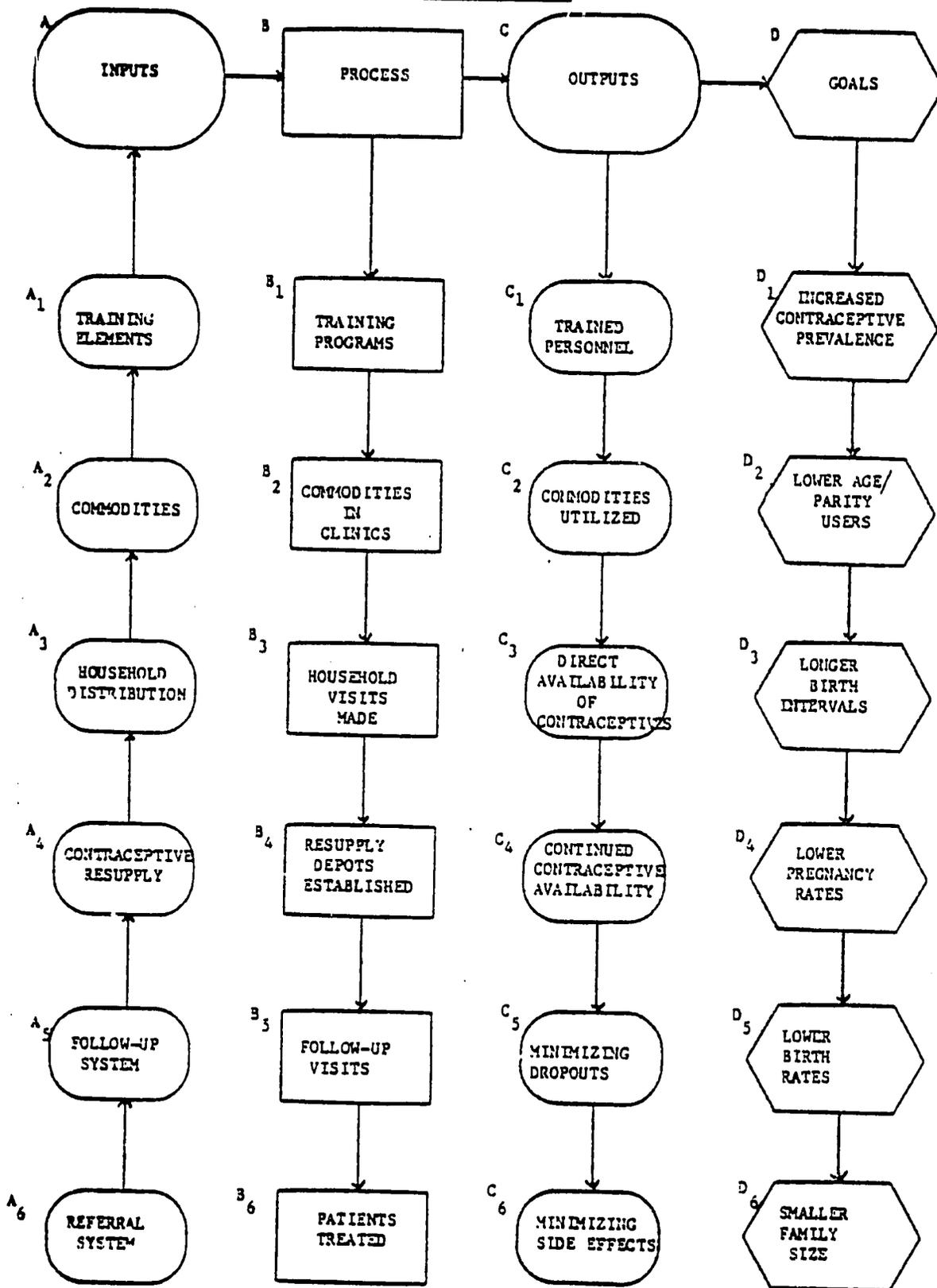
APPENDIX (MAP AND FIGURES)



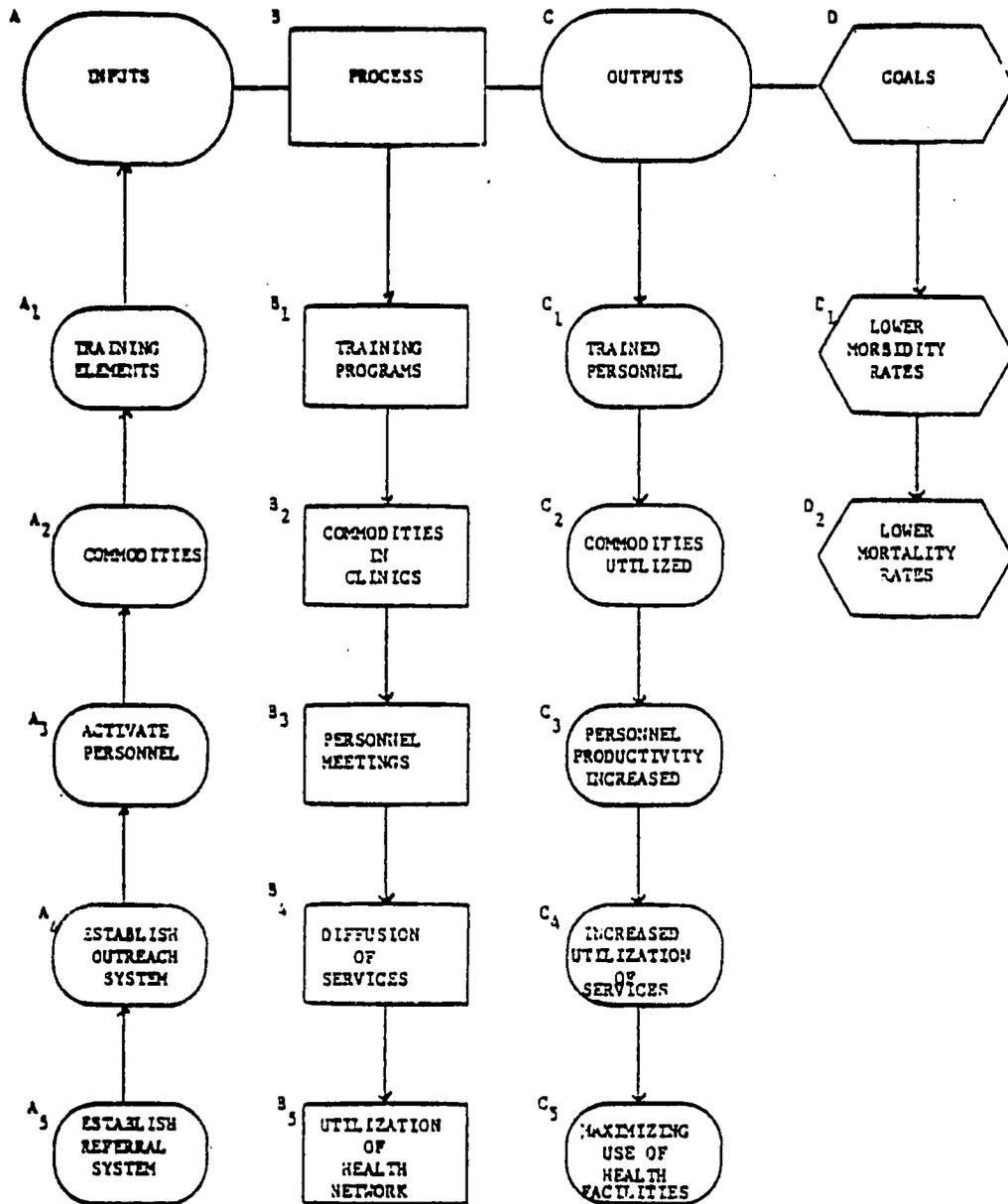
FIGURE 1  
INPUT/OUTPUT MODEL



**FIGURE II**  
**INPUT/OUTPUT MODEL**  
**FAMILY PLANNING**



**FIGURE III**  
**INPUT/OUTPUT MODEL**  
**HEALTH**



**FIGURE IV**  
**INPUT/OUTPUT MODEL**  
**SOCIAL WELFARE**

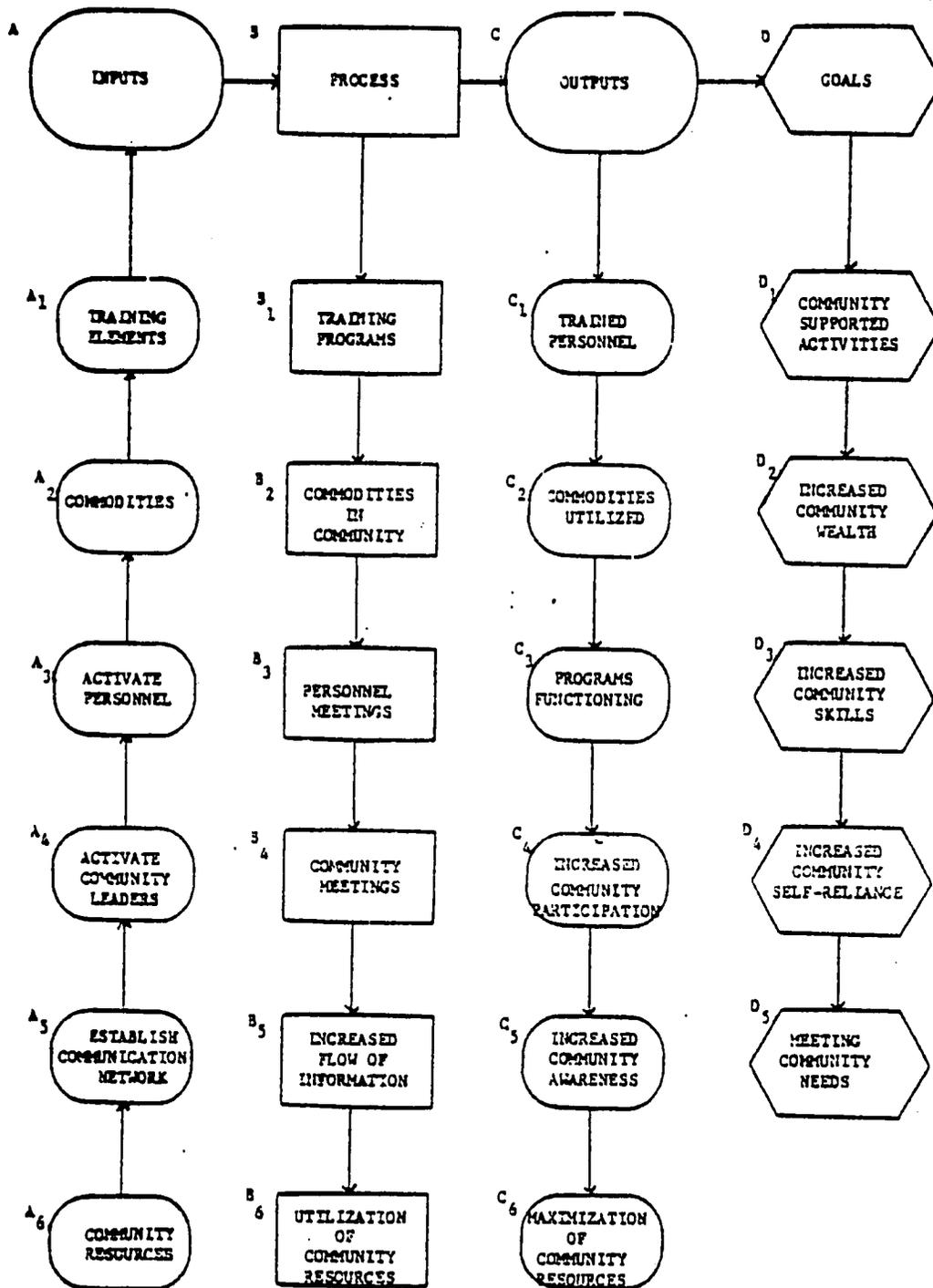


FIGURE V  
DEVELOPMENT REINFORCEMENT CYCLE

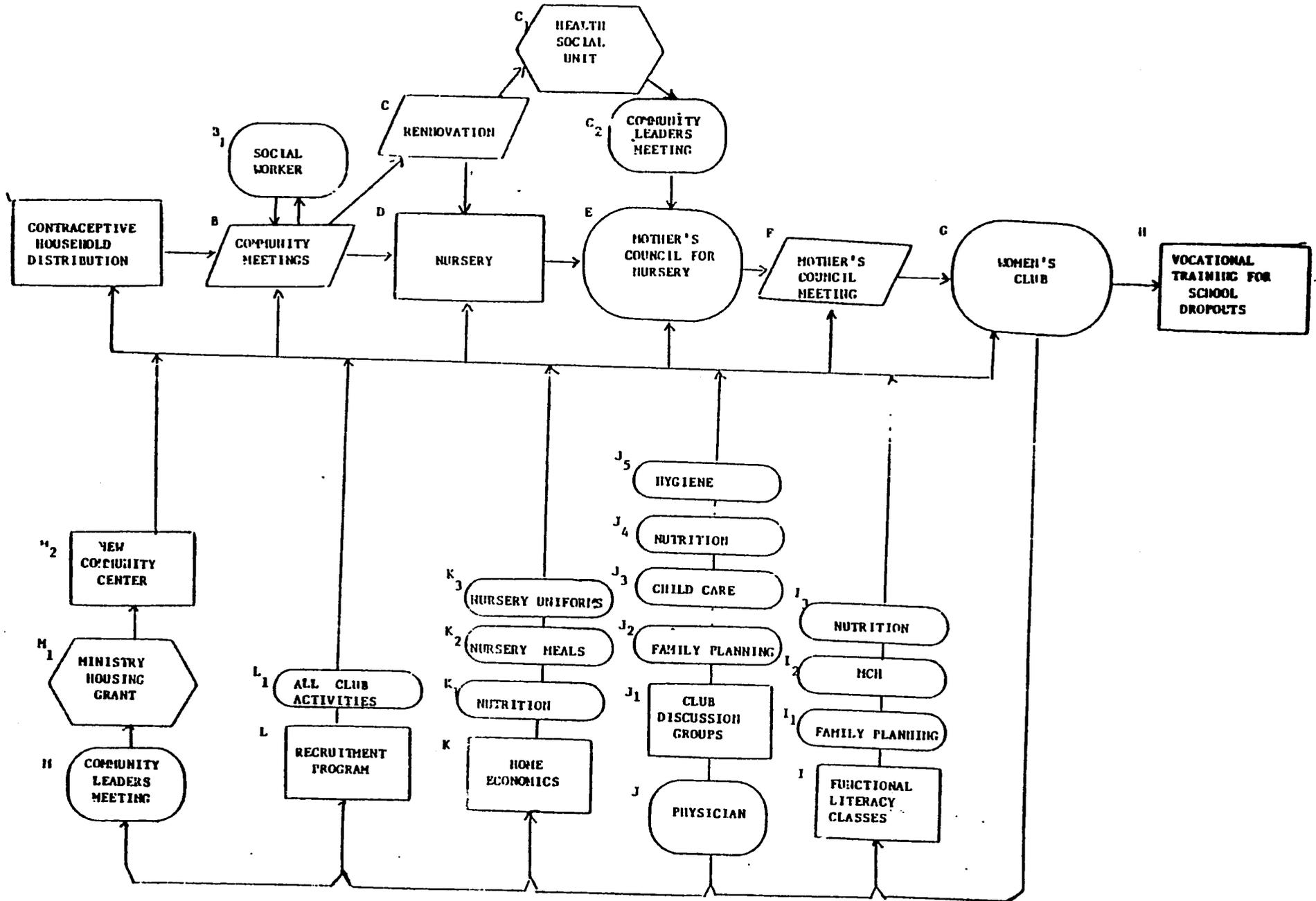
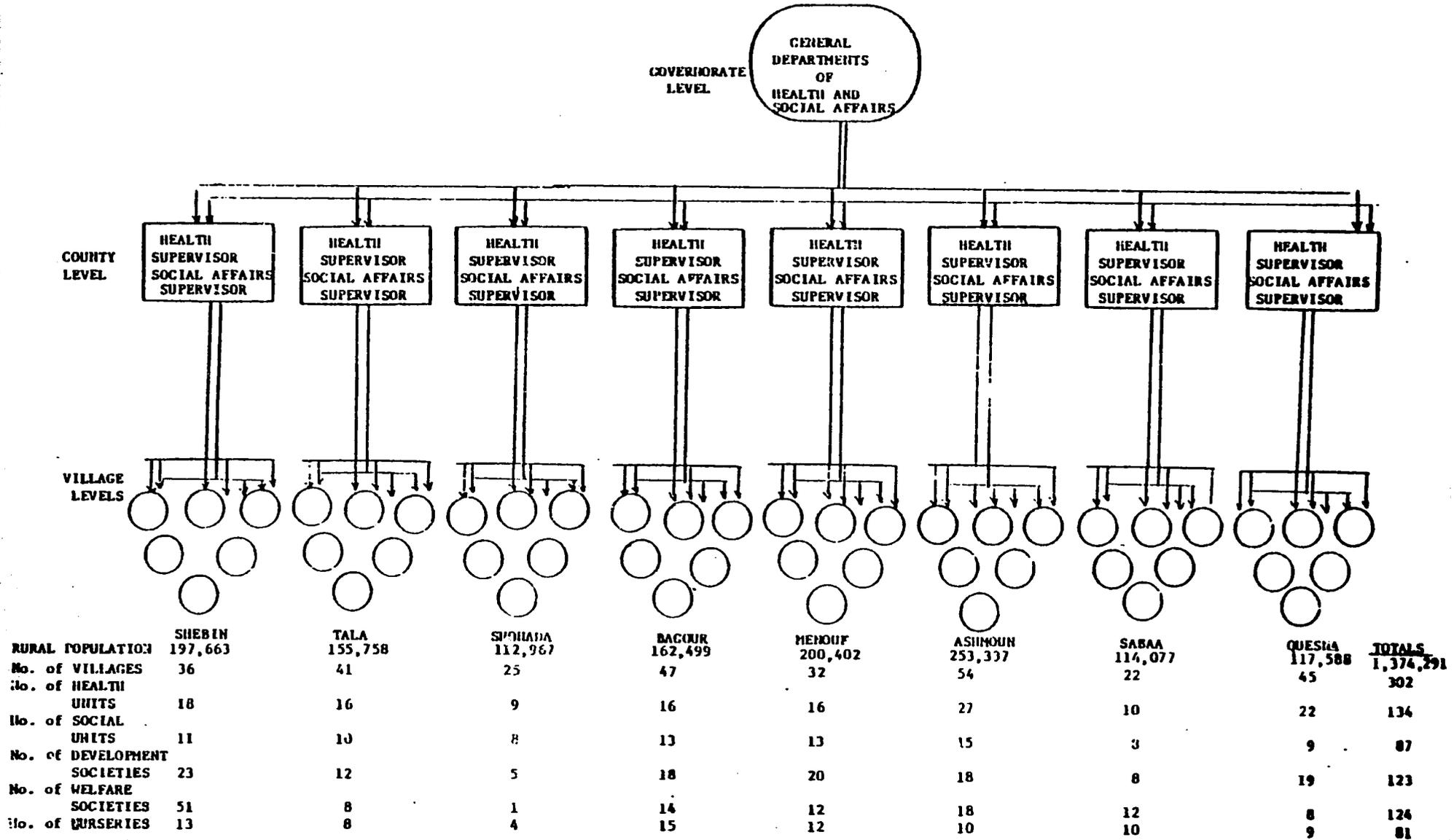
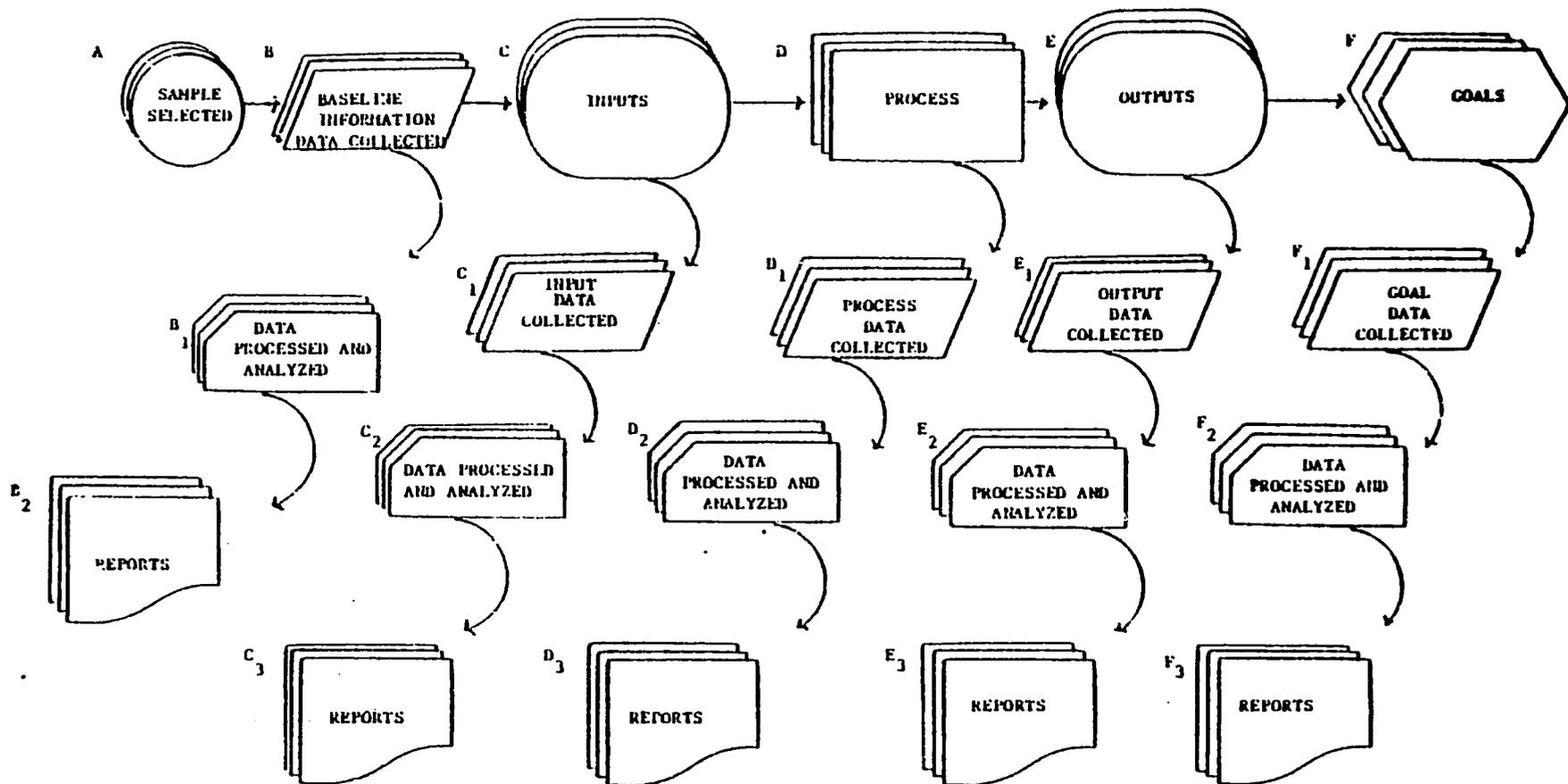


FIGURE VI

ORGANIZATION OF GOVERNORATE SERVICES AND EXISTING SERVICES BY COUNTY



**FIGURE VII**  
**EVALUATION PLAN FOR HONDURAS**



COUNTIES	1-3	4-6	7-8
1-3	A	B C	D C <sub>3</sub> E B <sub>2</sub> D <sub>3</sub>
4-6		A	B C D C <sub>3</sub> E B <sub>2</sub> D <sub>3</sub>
7-8			A BC D C <sub>3</sub> D <sub>3</sub>

PROJECT MONTHS: 3, 6, 9, 12, 15, 18, 21, 24, 27, 30, 33, 36