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WASHINGTON, D C 20523

PROJECT PAPER

EGYPT

POPULATION/FAMILY PLANNING III

(263-0227)

Sources
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A

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1 TRANSACTION CODE

A = Add
C = Change
D = Delete

Amendment Number

DOCUMENT CODE

3

COUNTRY/ENTITY EGYPT

3 PROJECT NUMBER

263-0227

4 BUREAU/OFFICE

Near East

5 PROJECT TITLE (maximum 40 characters)

Population/Family Planning III

6 PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
07 31 91

7 ESTIMATED DATE OF OBLIGATION

(Under B below enter 1 2 3 or 4)

A Initial FY 92 B Quarter 3 C Final FY 96

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

A. FUNDING SOURCE	IRST FY 92			LIFE OF PROJECT		
	B FY	C L/C	D Total	E FY	F L/C	G Total
AID Appropriated Total	10,000	-0-	10,000	37,341	24,659	62,000
(Grant)	(10,000)	(-0-)	(10,000)	(37,341)	(24,659)	(62,000)
(Loan)	(-0-)	(-0-)	(-0-)	(-0-)	(-0-)	(-0-)
Other						
U.S.						
Host Country	-0-	-0-	-0-	-0-	19,500	19,500
Other Donor(s)	-0-	-0-	-0-	-0-	-0-	-0-
TOTALS	10,000	-0-	10,000	37,341	44,159	81,500

9 SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1 Grant	2 Loan	1 Grant	2 Loan	1 Grant	2 Loan	1 Grant	2 Loan
(1) ESF	400	400	-	-0-	-0-	62,000	-0-	62,000	-0-
(2)									
(3)									
(4)									
TOTALS				-0-	-0-	62,000	-0-	62,000	-0-

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

440 450 460 410 420

11 SECONDARY PURPOSE CODE

440

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

A. Code BRW BUW TNG
B. Amount

13 PROJECT PURPOSE (maximum 480 characters)

To increase the level and effectiveness of contraceptive use among married couples

14 SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY
0 5 95 0 7 97

15 SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify)

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

Mission Controller has reviewed and concurs with the methods of implementation and financing included herein.

Douglas L Franklin
Douglas Franklin, Mission Controller

17 APPROVED BY

Signature

Title

Henry Bassford
Mission Director

Date Signed

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

MM DD YY

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ACRONYMS AND ABBREVIATIONS

AED	Academy for Educational Development
CAPMAS	Central Agency for Public Mobilization and Statistics
CBD	Community Based Distribution
CDA	Community Development Association
CDSS	Country Development Strategy Statement
CEOSS	Coptic Evangelical Organization for Social Services
CHO	Cairo Health Organization
CID	Chemical Industrial Development
CIIS	Contraceptive Inventory Information System
CPR	Contraceptive Prevalence Rate
CSI	Clinical Services Improvement Project
CSM	Contraceptive Social Marketing
CYP	Couple Years of Protection
DHS	Demographic and Health Survey
EFPA	Egyptian Family Planning Association
EJMDA	Egyptian Junior Medical Doctors Association
EOP	End of Project
EPTC	Egyptian Pharmaceutical Trading Company
FOF	Family of the Future
FP	Family Planning
FPSD	Family Planning Services Delivery
FPLM	AID/W Family Planning Logistics Management Project
FSN	Foreign Service National
FY	Fiscal Year
GNP	Gross National Product
GOE	Government Of Egypt
HIO	Health Insurance Organization
IEC	Information, Education, and Communication
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
JHU/PCS	Johns Hopkins University/Population Community Services
LE	Egyptian Pound (Currency)
LOP	Life of Project
MCH	Maternal and Child Health
MIS	Management Information System
MOH	Ministry of Health
MOI	Ministry of Information
MOSA	Ministry Of Social Affairs
MWRA	Married Women of Reproductive Age
NGO	Non Government Organization
NPC	National Population Council
OB/GYN	Obstetrics/Gynecology
OC	Oral Contraceptive
OR	Operations Research
ORS	Oral Rehydration Salts
PIL	Project Implementation Letter
PIO/C	Project Implementation Order/Commodities
PIO/T	Project Implementation Order/Technical

POP/FP Population/Family Planning
PVO Private Voluntary Organization
RCT Regional Center for Training
RMU Research Management Unit
SDP Systems Development Project
SIS State Information Service
STC Satellite Training Center
TA Technical Assistance
THO Teaching Hospital Organization
TFR Total Fertility Rate
TS Technical Secretariat
UNFPA United Nations Fund for Population Activities
USAID United States Agency for International Development
VSC Voluntary Surgical Contraception

EXECUTIVE SUMMARY AND RECOMMENDATIONS

A. INTRODUCTION

The strongest rationale for continued investment in family planning activities in Egypt is the negative economic and social consequences of increasing population pressure. Despite encouraging signs that the pace of growth of the Egyptian population is slowing, the level is still high, and, if the rate does not decrease further, Egypt's current population of 54 million will grow to 108 million over the next 30 years. Population growth remains one of the central constraints to the country's economic growth with the negative effects of high fertility evident in many aspects of Egyptian life: population distribution, food supply, education, employment, and health.

Although since the 1960s the Government of Egypt (GOE) has formally identified rapid population growth as a key constraint to development, it was not until the 1980s that strong and consistent leadership at all political levels began to address the population problem and a comprehensive public sector program for delivering family planning services emerged. However, while there is acute awareness of the impact of rapid population growth at the highest levels within the GOE, a critical gap exists between high level policy statements and allocations of government budgetary and operational support. While current reforms are addressing some of the central policy constraints hampering economic growth, it is unlikely that the GOE will be in a position to support its national family program at the necessary level during the coming five years. Substantial donor contributions are warranted and needed during this time, as they have been in the past.

Although family planning activities in Egypt have attained substantial success in recent years, challenges remain. Service volume must be increased, first merely to maintain contraceptive prevalence at current levels, let alone to reach those women who are not currently using contraception but who want to; service quality and user knowledge must be improved to increase contraceptive effectiveness, and improved information must be available to policy makers in order to take advantage of the comparative advantages of the Egyptian sector mix and to reduce the large differentials that still exist in contraceptive use and fertility rates between urban and rural areas and between Upper and Lower Egypt.

Egypt, like other countries at its stage of population program development, must take an increasingly strategic approach. Such

an approach would pay more attention to assuring quality care, making the best use of existing resources, and improving provider effectiveness. It would include measures to facilitate commercial support of family planning by directing more attention to market segmentation and the respective roles of the public, private voluntary, and commercial sectors.

The current Country Development Strategy Statement (CDSS) for Egypt supports expansion of family planning service delivery programs through both the private and public sectors, with an increased emphasis on fees for services and sustainability. To promote this objective, the document also indicates support for public information programs and assistance to the National Population Council to carry out its role for population planning, policy development and program coordination.

Since 1975, USAID has been the principal donor assisting the Government of Egypt in population and family planning, primarily through the two predecessor projects, Population/Family Planning (POP/FP) I Project and the current POP/FP II Project. UNFPA is the most important provider of grant assistance after AID, with the Dutch, Germans, and European Community also providing limited assistance.

The configuration of POP/FP II with 23 subprojects, as well as the importance and high visibility of population activities, and USAID's major direct technical assistance and management role have created a workload which is beyond staff allocations. POP/FP III is based on a consolidated portfolio and streamlined project management.

B. PROJECT DESCRIPTION

The Project's goal is to assist the GOE to achieve its fertility reduction goals. The GOE has set a long-range goal of reducing the population growth rate to 1.8 percent and the total fertility rate (TFR) to 2.7 by the year 2007 and an intermediate goal of reducing the population growth rate to 2.0 percent and TFR to 3.5 by 1997.

The Project's purpose is to increase the level and effectiveness of contraceptive use among married couples. This would be indicated through an increase in contraceptive prevalence from an estimated 48.5 percent in 1992 to 53 percent in 1997 and a decrease in the extended-use failure rate, measured at 13% in 1988, to 5% in 1997. Achieving this purpose requires that couples have access to information and services that will enable them to select an appropriate, effective method, use that method correctly, and continue use.

The Project is composed of eight subprojects, implemented by four GOE implementing agencies and the private sector.

POP/FP III will continue the most successful activities and discontinue those that do not directly or effectively contribute to achieving the sector goal of reduced fertility.

1. Ministry of Health (MOH)

The public sector's role in the national family planning program is to provide services to those least able to pay for them. These target population groups are a major focus of POP/FP III and this strategy dictates continued investment in the MOH. The Project will support three subprojects in the MOH.

The Systems Development Subproject (SDP) is aimed at improving the MOH management system and FP service delivery and is crucial to the Project's effort to improve the management of family planning services. USAID investments in the SDP begun under POP/FP II will be continued under POP/FP III. This investment is intended to enhance the long-term technical sustainability of the MOH family planning program. Systems management will be integrated into MOH family planning and related units through systems analysis and through training courses and workshops using the systems approach. Operational procedures will be refined and disseminated. Records and data banks will be oriented towards information retrieval by system.

The SDP will also support improvements in the quality of family planning services provided through MOH units and hospitals, through continued training in contraceptive technology and counseling, the development of training in new areas, improved training curriculum and methodology, the strengthening of Information, Education, and Communication (IEC) activities, and a modest amount of continued clinic renovation and equipping.

The Contraceptive Commodity Subproject will provide IUDs and a limited supply of condoms and NORPLANT (if approved and registered in Egypt) for distribution to the public sector and non-profit NGOs providing family planning services under the POP/FP III Project. If USAID-donated contraceptives are sold by direct recipient agencies, revenue agreements will need to be instituted to jointly program proceeds from the sales. Support will also be needed to further institutionalize MOH contraceptive commodity procurement, inventory, monitoring, and disposal procedures.

The Teaching Hospital Organization Subproject (THO), initiated under POP/FP II, was designed to improve the quality of family planning services through training and service delivery interventions. Under POP/FP III, THO will continue to provide clinical family planning service delivery through its family

planning units which serve as models for hospital-based clinical family planning service delivery THO training centers will be able to provide practical experience in injectables, NORPLANT, and medically-indicated surgical contraception, in addition to the more usual contraceptive technology experience with pills and IUDs. THO will also develop and implement an outreach program specific to a hospital setting with maternity, outpatient, and surgical facilities

2. National Population Council (NPC)

The NPC is the central government institution responsible for formulating and promulgating population policy and coordinating the population and family planning efforts of all public and private sector organizations. It serves as a coordination body for governorate and national level planning, training, research, and IEC activities The Project will support two subprojects with the NPC

The **Institutional Development Subproject (IDP)** will continue institutional strengthening activities to further develop the capability of the central Technical Secretariat, as well as governorate level NPC offices, to plan, coordinate, and report on family planning activities at the national and the local level Each of the 21 governorates will be provided with a development fund which will be used for activities aimed at broadening the base of community support for family planning and at strengthening governorate staff capabilities in management, planning, and evaluation Through the Research Management Unit (RMU) developed under POP/FP II, the ability of the Technical Secretariat to plan, solicit, and fund needed applied biomedical, policy and programmatic studies will be enhanced, as well as its ability to disseminate the results of that research to program implementers and policy makers. Finally, the NPC's role in policy outreach will continue to be strengthened under this subproject with regard to such issues as medical restrictions, private sector constraints, and ministry level obstacles to cost recovery

The **Regional Center for Training (RCT) Subproject of Ain Shams University with the NPC** will continue to support the RCT in providing high quality clinical family planning training to physicians, nurses, and a reduced number of trainers RCT activities will focus on training and support, especially for private physicians; information development and dissemination; and technical assistance to medical and pharmacy schools to develop and/or refine family planning curricula.

3. Ministry of Information

USAID has enjoyed a long, productive collaboration with the Ministry of Information through the State Information Service

The success of previous IEC efforts and the potential returns to future investment justify greater emphasis on IEC activities in POP/FP III.

The Family Planning Information, Education, and Communication Subproject (IEC) with the State Information Service (SIS) will continue support for mass media demand creation and information messages, as well as interpersonal IEC approaches with local opinion leaders and religious leaders. It will also pay increased attention to coordinating IEC efforts among the various Project implementing agencies.

4. Ministry of Social Affairs (MOSA)

The Ministry of Social Affairs, through its network of registered private voluntary associations, has been the major provider of family planning services in the non-government not-for-profit sector. Although the community based efforts of the private voluntary associations play an important role in legitimating family planning in the eyes of the communities, their contribution to contraceptive prevalence in Egypt is quite low. Therefore, this Project plans to limit its support to the large Clinical Services Improvement (CSI) Project of the Egyptian Family Planning Association (EFPA).

The Clinical Services Improvement Subproject (CSI) of the Egyptian Family Planning Association (EFPA) was initiated under POP/FP II to develop a network of EFPA family planning services centers throughout Egypt, introduce quality assurance management systems and procedures, and establish systems to finance continuation of the centers after the cessation of donor support. The existence of CSI has reportedly placed "upward pressure" on the MOH, motivating interest in improving other publicly-funded family planning services. In several Upper Egypt governorates with the hardest-to-reach populations, CSI contributes a sizeable share of the CYP attributed to all public and PVO clinics. Although financial progress has not been as rapid or uniform as originally anticipated, various design changes currently underway are expected to assist CSI to achieve its objective of increasing cost recovery. One of the Project's most important contributions will be in assisting CSI to increase cost recovery. Therefore, in addition to funds for personnel, operating costs, and other related expenses (on a diminishing basis), the POP/FP III Project will also assist CSI in assessing the feasibility of its self-financing strategy, as well as in defining sub-groups in the general population which are especially important to the USAID and/or national population/family planning strategy and the "quality threshold" at which family planning and cost-efficiency impact are maximized simultaneously.

5. Special Initiatives for the Private Commercial Sector

The private commercial sector delivered approximately 70 percent of all family planning services in Egypt, according to the 1988 DHS. A service delivery participant of this magnitude cannot be ignored under POP/FP III. This sector sustains its own activities through consumer payments for goods and services. Therefore, direct Project support will be limited to relatively small amounts, primarily for training, marketing, and TA in strategically important areas, such as IEC.

Private sector activities will be aimed at enhancing the quality and acceptability of family planning care. Training of private physicians will continue in order to ensure that adequate numbers of private physicians in all geographic areas of the country are competent in family planning clinical and counseling skills. In addition, pharmacists will be trained in contraceptive methods (especially oral contraceptives) and their correct use. Other activities include support for studies to assist USAID to better target its assistance and support for marketing activities, such as mass media messages to promote the use of private sector channels for service delivery.

C. IMPLEMENTATION

The activities planned for POP/FP III build on the foundation put in place under the two previous projects. The Project has the full support of the GOE, and counterparts are in place to work with technical assistance personnel assigned to the subprojects. The NPC's mandate calls for it to serve as the principal policy, planning, and coordination body for the GOE's population program. For the purposes of this Project, the NPC will take a leadership role in ensuring that the various subprojects coordinate activities and share information through the establishment of a Project Coordinating Committee.

Carrying out a more coordinated and targeted family planning program necessitates the elimination of certain POP/FP II activities which are management intensive and have low payoff; the consolidation of ministry support and small grant and research activities, and the procurement of management, technical, and planning expertise under a single contract. This single TA/Management contractor will serve as the central employer/contractor of resident advisors and short-term consultants to assist the GOE implementing agencies to meet their project responsibilities in accord with USAID regulations. The contractor will provide day to day technical advice, routine troubleshooting, and assistance in reporting to meet AID requirements. Although the bulk of the technical assistance/management requirements will be obtained through a single USAID-awarded "Implementation/Goods and Services" contract.

(I/GS), specialized technical assistance requirements which go beyond the scope of this contract will be available through buy-ins to AID/W contracts and cooperative agreements

In contrast to POP/FP II, in which the Mission entered into separate implementation arrangements for each subproject, this Project will have a single annual Project Implementation Letter (PIL) with each implementing ministry (MOH, MOI, MOSA) and with the NPC. Activities with the private sector will be funded through subcontracting under the prime I/GS contract, which will also coordinate and implement non-contraceptive commodity procurement and participant training for the implementing agencies

D. COST ESTIMATES AND FINANCIAL PLAN

The total A.I D cost of the Project is estimated to be \$62 million The first year obligation is expected to be \$10 million

SUMMARY COST ESTIMATES (THOUSANDS OF \$)

ELEMENTS	TOTAL	PERCENT
CONTRACEPTIVE COMMODITIES	\$7,484	12%
IMPLEMENTATION/GOODS&SERVICES	\$27 903	45%
EVAL/AUDITS,BUY INS PROJ SUPP	\$2 655	4%
LOCAL COSTS OF IMP.AGENCIES (NPC MOH,MOI,MOSA)	\$23 958	39%
TOTAL	\$62,000	100%

The GOE contribution of LE 64 3 million will be both cash and in-kind, and includes salaries, normal GOE premium pay, incentives, host-country costs for participant training, radio and television air time, etc Using an exchange rate of \$1 = 3 3, it represents approximately 24 percent of the total Project cost

E. PROJECT NEGOTIATION STATUS

The principle aspects of the Project, i.e. project activities, required resources and implementation arrangements, including project specific conditions and covenants, have been discussed with and agreed to by the MOH, NPC, MOI, and MOSA Collaboration with the GOE during Project development consisted of meetings by

the Project Office with all counterpart implementing units Differences of opinion consist of (1) MOH's views regarding subsidization of contraceptive commodities for the private sector; (2) MOH and MOSA's concerns for USAID supply of contraceptive commodities for subprojects formally supported under POP/FP II but not under POP/FP III (including HIO, CHO, CEOS, CASC, BPSS, Al Azhar); (3) MOSA's views regarding the reduction in the number of participating PVO implementing agencies and its desire to have USAID support for institutional strengthening of MOSA to manage its associations; and (4) Project funded premium pay ("AGR-ADAFI" in Arabic) for GOE employees The GOE's formal submission of request for assistance is included as Annex 4

F. RECOMMENDATION

The Project Committee recommends that you authorize the Population/Family Planning III Project for \$62,000,000 and sign the Gray Amendment Certification.

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I. PROJECT RATIONALE AND DESCRIPTION

A. Rationale

1. Perceived Problem

The negative economic and social consequences of population pressure in Egypt provide a strong rationale that both the GOE and USAID/Egypt should continue substantial investments in family planning activities. Egypt's annual population growth rate, currently reported by CAPMAS to be 2.54 percent, remains one of the central constraints to the country's economic growth. Currently Egypt's population is estimated at 54 million. Despite encouraging signs that the pace of growth of the Egyptian population is slowing, the level is still high, and, if the rate does not decrease further, Egypt's population will double again to 108 million over the next 30 years

While it is impossible to disentangle the web of relationships between economic development and population growth, the negative effects of high fertility are evident in many aspects of Egyptian life population distribution, food supply, education, employment, and health. In the short term, increases in contraceptive use contribute to improvements in the health of women and children, as well as a lessening of the pressure currently experienced by the country's educational and health systems In the long term, increases in contraceptive use contribute to slowing the rate of population growth which allows the economy to expand in real terms, thereby improving the population's welfare In the Egyptian setting, family planning is a sound and necessary investment

Family planning activities in Egypt have attained substantial success in recent years The total fertility rate fell from 5.2 births per woman in 1980 to an average of 4.4 births per woman in 1988 The contraceptive prevalence rate (CPR) increased from 24 to 38 percent between 1980 and 1988 Despite this progress, challenges remain Greater service coverage will be required merely to maintain contraceptive prevalence at current levels in the face of the growing number of married women of reproductive age (MWRA) Population activities must be strengthened to reach those women who are not currently using contraception but who want to limit or space the next birth The program must promote effective use of contraceptive methods and must reduce the large differentials that still exist in contraceptive use and fertility rates between urban and rural areas and between Upper and Lower Egypt.

2. GOE Commitment to Family Planning

Since the early 1960s, the Government of Egypt (GOE) has formally identified rapid population growth as a key constraint to development. It was not until the 1980s, however, that strong and consistent leadership at all political levels began to address the population problem and a comprehensive public sector program for delivering family planning services emerged.

As part of Egypt's Five Year Development Plan for 1992-1997, the National Population Council (NPC) drafted a National Population Policy in 1990. The policy declares, "The population problem is considered the first problem that hinders the development efforts in Egypt with its present population of 54 million and increasing by more than a million every eight months. This population increase will affect the population density, will encroach on the present agricultural land and burden the State efforts for the provision of subsistence, housing, education, services, employment opportunities and decent life for citizens."

The draft Population Policy recommends that the GOE address the problem of national population growth through a multi-pronged strategy that calls for increased contraceptive use and improvements in maternal and child health, the status of women, literacy, and population distribution. President Mubarak and influential religious leaders such as the Grand Mufti and the Pope of the Coptic Church frequently call attention to the importance of family planning.

While there is acute awareness of the impact of rapid population growth at the highest levels within the GOE, a critical gap exists between high level policy statements and allocations of government budgetary and operational support. A number of factors constrain the ability of the GOE to support the national family planning program. The Egyptian economy is suffering severely and experiencing tremendous strains on both private and public resources. While current reforms are addressing some of the central policy constraints hampering economic growth, it is unlikely that the GOE will be in a position to support its national family program at the necessary level during the coming five years. Substantial donor contributions are warranted and needed during this time, as they have been in the past.

3. Conformity with AID's Development Strategy

The Country Development Strategy Statement (CDSS) for Egypt for FY 89-93, updated July 4, 1989, identifies a specific strategy for the population program based on the optimism generated from increasing contraceptive use and declining fertility rates.

"USAID will support expansion of service delivery programs through both the private and public sectors, increasing our

emphasis on fees for services and sustainability. We will use broad-based analysis of fertility determinants to guide Project design. We will support public information programs to increase knowledge of and motivation to accept family planning. And we will assist the National Population Council to carry out its role for population planning, policy development and program coordination "

4. Relationship to Current AID and Other Donor Activities in Health and Population

Since 1975, USAID has been the principal donor assisting the Government of Egypt in population and family planning.

a. Population Assistance

Section I 5, "Relevant Experience with Similar Projects Lessons Learned", briefly describes the USAID Population/Family Planning (POP/FP) I Project and reviews population and family planning activities under the current POP/FP II Project.

b. Child Survival Project

USAID/Egypt's Child Survival Project, valued at \$67.9 million for the period 1985-93, devotes approximately 13 percent of its resources to promoting child-spacing. In coordination with UNICEF, the Child Survival Project is training dayas (midwives) in safe motherhood techniques, including birthing procedures, as well as referral for immunizations, prenatal care, childspacing and family planning, and for high risk births.

c. Health Cost-Recovery/Financing Project

There is potential for future collaboration between the USAID/Egypt Health and Population Offices in the "Cost Recovery for Health Project ". The project's conversion of MOH hospitals to a cost recovery system could be linked with some POP/FP III activities. For example, the results of a cost-recovery study examining the demand for health care services and the ability of potential clients to pay fees will be shared with the Population Office, and some doctors and nurses assigned to participating MOH hospitals could be included in contraceptive technology training courses funded under POP/FP III. Coordination efforts will continue.

d. Local Development Support

USAID/Egypt's Local Development II Project has funded unsolicited proposals from qualified Community Development Associations (CDAs) to support development activities in all sectors. A number of CDAs are providing family planning services. Training and technical assistance in setting up family planning services

has been provided through the Egyptian Family Planning Association (EFPA). This mechanism seems to have worked well

e. Other Donor Activities

Other donors include the United Nations Fund for Population Activities (UNFPA), the European Community, the Dutch, and the Germans.

UNFPA is the most important provider of grant assistance after AID. During the next five years, UNFPA is expected to provide assistance to the National Population Council at both the national and governorate levels to strengthen NPC technical capabilities. In view of USAID's decision to consolidate activities under POP/FP III and curtail provision of contraceptive commodities to the private sector, UNFPA will assume support for smaller population projects, PVOs, and NGOs, and will assist Egypt in developing the capacity to manufacture contraceptives locally. In addition, UNFPA will provide support for improving CAPMAS's vital statistics data collection and analysis activities. UNFPA's diverse portfolio also includes IEC activities, population education programs, and income generation and literacy programs aimed at improving the status of women.

The Dutch Cooperation Agency has focused its limited population assistance in the governorate of Fayoum, while the European Community is supporting the development of 20 clinics in the governorate of Qena. The Germans have provided most of their assistance in the form of soft loans to Schering AG for purchase of raw materials. Schering's oral contraceptives are then manufactured locally by the parastatal CID.

5. Relevant Experience with Similar Projects: Lessons Learned

The USAID Population/Family Planning (POP/FP) I Project provided \$67.6 million in population assistance from 1977 to 1987 to help the GOE establish an institutional framework for family planning and finance targets of opportunity in family planning service delivery. The current ten year, \$117.6 million, POP/FP II Project will end on May 31, 1993. Its seven components are: Contraceptives; Private Commercial FP Programs; National Population Council, Ministry of Health/Public Sector FP Programs; Information, Education and Communication; Population Statistics and Policy, and Population Technical Assistance.

Since the POP/FP II Project Paper was amended in 1987, the project has focused on expanding service delivery and FP IEC activities; on upgrading the quality of service delivery; and on assisting the NPC in policy formulation, program planning and coordination, and research.

The project's emphasis on improved service quality was given further credence by the 1988 DHS findings and the 1989 Population Sector Assessment recommendations. While the DHS showed important gains in contraceptive knowledge, attitudes, and use, it also provided evidence of considerable unmet demand, important regional and residential differences in prevalence, and high rates of contraceptive failure, misinformation, misuse, and discontinuation

The 1989 sector assessment identified major program gains: a rapid increase in CPR (from 30% in 1984 to 38% in 1988); a positive change in political commitment, the establishment of the National Population Council; and improved IEC, delivery systems, and targeting. Pointing out the need for significant increases in numbers of users just to maintain the CPR and for even greater increases to meet GOE goals, the assessment recommended special efforts to promote family planning in Upper Egypt, more emphasis on outreach in family planning service delivery, expanded method mix, research on male attitudes and practice of family planning, and more emphasis on national management and coordination activities. While activities were initiated to address each of the recommendations, further work remains. For example, there have been gains by the NPC at the governorate level in the planning and coordination of family planning, but the NPC has been unable to fulfill its mandate for coordination of the national program. Much data are collected on family planning service, but the quality, analysis and availability to decision makers of these data are limited

Egypt, like other countries at its stage of population program development, must take an increasingly strategic approach. Such an approach would pay more attention to assuring quality care, making the best use of existing resources, and improving provider effectiveness. It would include measures to facilitate commercial support of family planning (FP) by directing more attention to market segmentation and the respective roles of the public, private voluntary, and commercial sectors. Egypt should initiate studies of effectiveness and efficiency and should increase access for poor and uneducated clients to FP services. A I D project assistance needs to support this more strategic approach

The configuration of POP/FP II with 23 subprojects, as well as the importance and high visibility of population activities, and USAID's major direct technical assistance (TA) and management role have created a workload which is beyond staff allocations. POP/FP III is based on a consolidated portfolio and streamlined project management.

B. Goal, Purpose, and End of Project Status Conditions

The Project's goal is to assist the GOE to achieve its fertility reduction goals. The GOE has set a long-range goal of reducing the population growth rate to 1.8 percent and total fertility rate (TFR) to 2.7 by the year 2007 and an intermediate goal of reducing the population growth rate to 2.0 percent and TFR to 3.5 by 1997.

The Project's purpose is to increase the level and effectiveness of contraceptive use among married couples. This would be indicated through an increase in contraceptive prevalence from an estimated 48.5 percent in 1992 to 53 percent in 1997 and a decrease in the extended-use failure rate, measured at 13% in 1988, to 5% in 1997. Achieving this purpose requires that couples have access to information and services that will enable them to select an appropriate, effective method, use that method correctly, and continue use.

USAID estimates that by improving the effectiveness of contraceptive use, the GOE could reach its total fertility target with a lower contraceptive prevalence rate. If both use-effectiveness and prevalence targets are achieved, fertility could be reduced even more. In line with this, the Project looks to a reduction in TFR from an estimated 4.1 in 1992 to 3.5 by the PACD in 1997. (By mid 1993, when the results of the 1992 Egyptian Demographic and Health Survey are available, the 1992 baseline CPR and TFR figures and 1997 target figures will be adjusted accordingly.)

C. Outputs and Indicators

1. Major Outputs

The major outputs of the Project will be

a. Increased service volume and improved service quality as evidenced by contraceptive commodities having been distributed, an effective IEC program in place, training capability having been increased and service providers trained, a curriculum component in population science and/or family planning having been developed for use in medical and pharmacy schools, updated, sector-specific family planning protocols having been disseminated, MOH operations research agenda having been developed and implemented, CSI functioning with increased cost recovery, and conferences and workshops training to enhance the role of the private sector having been planned and implemented.

b. Improved information for policy makers as evidenced by the NPC Research Management Unit (RMU) having been strengthened, a functional, well organized resource center for FP and population

research having been established; availability of research results to program implementers and policy makers having increased; secondary analyses of 1992 DHS and other comparative analyses having been undertaken; and the governorate level NPC having been strengthened.

c. Improved management capacity in implementing agencies as evidenced by the SDP operations manual having been produced, distributed and implemented; utilization of the MOH contraceptive commodities tracking system having improved, MIS collection systems and information flow having been refined, and their management relevance increased; implementing agencies producing comprehensive, timely annual plans; and the NPC having produced and distributed a Strategic Plan for population and FP in Egypt based on service data, research, and national policy

The Project goal, purpose, outputs, inputs, objectively verifiable indicators, means of verification, and underlying assumptions are presented in the logical framework, Annex 2.

2. Impact

The most immediate beneficiaries will be the current and new family planning acceptors who will receive more accessible and higher-quality care. Correctly using the appropriate method to meet their needs, they will experience health and many other benefits associated with fertility regulation. Secondary beneficiaries include those family planning managers and workers whose employment options and practices are increased. Ultimately, the Egyptian population will benefit from a rate of population growth more commensurate with national development goals.

3. Major Inputs

The major inputs under the Project will be contraceptive commodities, an Implementation/Goods and Services Team (which will provide management, TA, non-contraceptive commodities, special assessments, short-term participant training, and subcontracting for private sector initiatives), and the local costs incurred by the implementing agencies for in-country training and conferences, operational support, research and studies, special activities, IEC, audits and financial assessments, etc. The Project will also finance USAID evaluations and audits, and project support.

D. Project Activities

To produce these Project outputs, POP/FP III will continue the most successful activities and discontinue those that do not

directly or effectively contribute to achieving the sector goal of reduced fertility.

The first set of selection criteria were based on the strategic technical considerations of sector mix, identified constraints, and donor advantage. Egypt has an active, multi-sectoral service delivery system: the commercial sector, through pharmacies and private physicians, accounted for approximately 70 percent of all family planning services provided in Egypt in 1988, while the public sector provided 26 percent, and the PVO sector provided the remainder of the services. AID's investment strategy to assist the GOE in achieving its fertility objectives calls for assisting the largest sectors in the program with strategic resources, since those entities can deliver services on a scale large enough to achieve the greatest impact in fertility reduction. However, depending on the sector, the actual amount of resources required may be small or large depending on need. Given the nature of the three sectors, Project assistance to the private/commercial sector may be indirect and structurally more difficult. Moreover, the Project can have more control and assurance of its ability to bring about results in the public-supported sectors than the private/commercial sector. However, the size of the private/commercial sector's participation in family planning service delivery makes the effort mandatory. On the other hand, the amount of resources required from donors to assist the private/commercial sector, even on a priority basis, is small. With respect to PVOs, even though their contribution to contraceptive prevalence in Egypt is quite low, PVO service providers' inherent access to low income, geographically remote, or culturally isolated sub-groups makes them especially attractive.

Assessments of family planning activities have identified several areas of constraints which impact on the availability and quality of family planning services: service delivery which needs to be expanded and improved; commodity provision which must be refocused to increase the strategic value of USAID's resources and to increase prevalence among groups who might otherwise not have access to contraceptives; management capacity of the implementing organizations which needs to be strengthened in order to ensure the institutional sustainability of organizations involved in providing family planning support and services; research which needs to have increased emphasis placed on disseminating research results to policy-makers and program managers.

The major donors in Egypt with respect to population and family planning are USAID and UNFPA. At present, USAID is the principal donor of contraceptive commodities to Egypt, and has a comparative advantage in supporting the MOH, due to past successful initiatives, and USAID's strategic orientation to invest its resources where large scale gains can be made. UNFPA,

while judging population the top priority in Egypt, plans to fund little in family planning service delivery, in view of USAID's plan to continue as a major donor.

Subproject selection criteria also addressed financial consolidation and management consolidation. In population and family planning activities, the financial challenge in Egypt now is to consolidate and increase efforts to achieve sustainability. This is manifested in a number of ways, the most obvious being the smaller number of subprojects. In addition, nearly all the implementing agencies will be receiving a slightly smaller average annual allocation than under the previous project. Because POP/FP II presented a serious management burden to the USAID technical office, the design of POP/FP III reduces the number of subprojects and includes the procurement of TA/management services, which will provide resident advisors and short-term consultants to assist the GOE implementing agencies to meet their project responsibilities in accord with USAID regulations. The contractor will provide day to day technical advice, routine troubleshooting, and assistance in reporting to meet AID requirements.

Each of the subprojects is described fully in this section. The following matrix lays out the relationship between the identified activities and their contribution to the expected outputs.

	Increased service volume and improved service quality	Improved information for policy makers	Improved management capacity in implementing agencies
1 SDP/MOH	X		X
2 Contraceptive Commodity /MOH	X		
3 THO/MOH	X		X
4 IDP/NPC	X	X	X
5 RCT/Am Shams University/NPC	X		X
6 IEC/SIS/MOI	X		X
7 CSI/EFPA/MOSA	X		X
8 Private Sector	X		

1. Ministry of Health (MOH)

The public sector's role in the national family planning program is to provide services to those least able to pay for them (According to World Bank data, 24.2 percent of the rural population and 22.5 percent of the urban population are defined

as poor ¹) This population group is a major focus of POP/FP III and this strategy dictates continued investment in the MOH. During POP/FP II, the capacity of the public sector to serve its target population grew significantly and its absorptive capacity increased. The MOH has a network of over 3,500 units at clinics and 204 hospitals which deliver family planning services and accounted for 23 percent of the total modern method prevalence in 1988. POP/FP III will build upon these positive changes by supporting three subprojects in the MOH. The development and refinement of the management system within the family planning program of the MOH is an important area that warrants continued USAID support. This investment is intended to enhance the long-term technical sustainability of the MOH family planning program. POP/FP III will also support complementary initiatives, such as clinical training in the Teaching Hospital Organization (THO), designed to increase both MOH service quality and, in turn, increase service volume in selected areas.

a. Systems Development Subproject (SDP)

Crucial to the Project's effort to improve the management of family planning services, the Systems Development Subproject (SDP) is aimed at improving the MOH management system and FP service delivery. The MOH/SDP provides services in twenty-one governorates and is a major provider to low income women, with an estimated 509,217 new users in 1990. The MOH is particularly effective in removal of constraints to demand in terms of increasing accessibility, as well as acceptability. USAID investments in the SDP begun under POP/FP II will be continued under POP/FP III.

Systems Management - Additional support is needed to fully consolidate the management and technical systems developed under SDP during POP/FP II to support MOH service delivery. Therefore, the systems development activity begun under POP/FP II will be continued with some change in emphasis. Systems management will be integrated into MOH family planning and related units through systems analysis and through training courses and workshops using the systems approach. Records and data banks will be oriented towards information retrieval by system. To consolidate and emphasize the systematic approach, the Project will

- Continue comprehensive human resource development. The management and supervisory skills of both central and governorate staff require further strengthening in order to consolidate and institutionalize the advances made in systems development under POP/FP II.

¹ World Bank Country Study: Poverty Alleviation and Adjustment in Egypt 1991-92

- Refine and disseminate operational procedures. During POP/FP II, policy and procedures manuals relating to each of the ten management systems identified in the SDP were developed and translated into Arabic. Unfortunately, this excellent library of manuals may not be easily accessible to most managers, especially at the district level and below. An Operations Reference Manual based on these manuals will be developed and disseminated under POP/FP III
- Improve utilization and information flow of the MIS designed and developed under POP/FP II. Decentralized data entry, analysis, and summarization at the governorate level will be tested and refined in six selected governorates (two of which will be in Upper Egypt) before extension to all 21 governorates where the MOH provides family planning services, and will require coordination of computer procurement, training, and systems development
- Assist the MOH to use a systems approach in producing its annual plan. Central analysis of governorate information obtained quarterly will focus on interpretation of system-wide trends and identification of constraints. Quarterly Progress Reports, an essential management tool at all levels of the service system, will be continued and refined. Such information can then be presented in graphic and multi-media formats to appropriate GOE authorities and for use in formulating national family planning strategies and resource allocation

Improvements in Quality of Care - To support improvements in the quality of family planning services provided through MOH units and hospitals, the Project will

- Improve teaching/learning effectiveness by upgrading both the content and methodology of training, by refining current curriculum to be more focused, and by upgrading training staff with annual refresher courses conducted by both US and domestic trainers
- Continue to train service providers in MOH governorate training facilities (either former satellites under POP/FP II or other MOH facilities): 1,000 physicians per year in contraceptive technology, counseling, and management, 1,000 nurses each year at the governorate level in a two week training course in contraceptive technology, counseling, supervision, and outreach; and adequate refresher training for at least 150 staff per governorate originally trained under POP/FP II. Develop and conduct special training courses for service providers and their supervisors, such as an infection control workshop or continuous quality of care monitoring.

- Assist MOH to institutionalize its counseling course and to improve implementation of counseling training to increase user satisfaction and effectiveness.
- Strengthen IEC activities. This would include the development and implementation of an MOH institutional communications/outreach strategy encompassing positioning, client recruitment, user education, and counseling. In addition, IEC efforts will be expanded to include the development of acceptor level print materials and counseling aids for service providers.
- Support the expansion of advanced or surgical contraceptive methods like post-partum IUD and NORPLANT through training and equipment; and encourage a policy/regulatory change which would permit provision of the injectable method by trained non-OB/GYN physicians and nurses
- Develop a specific MOH operations research agenda to carry out selected studies in order to improve efficiency and effectiveness in delivery of quality family planning services. This will be done in technical collaboration with the NPC/RMU, through commissioned research, or with TA Illustrative areas of research include management systems, implementation of infection control procedures, client profile, and client satisfaction.
- Design, implement, and evaluate a special emphasis program intended to increase the scale of MOH family planning operations as well as improve the quality of these operations in targeted MOH clinics, i e most likely the high impact MCH clinics and hospital clinics. This program will include special IEC activities, such as a mass media advertising campaign, and a modest amount of continued clinic renovation and equipping.

INPUTS: The I/GS contractor will provide a full time management advisor and short-term technical assistance Short-term participant training in general family planning management, in management of training, in commodities management, and in systems design and analysis will be provided Additional short term participant training is also proposed to expand knowledge and skills and professional development of trainers and training managers in curriculum design, adult education methods, training, management and logistics, the development of audio-visuals for training, and in the use of training in institutional development A full time local training consultant will be hired to work at the governorate levels. Computer, other office equipment, and vehicles will be provided, as well as local costs related to training, operations, IEC, medical supplies, and

renovations Funds will also be available for special assessments and operations research.

b. Contraceptive Commodity Subproject

USAID will donate IUDs and a limited supply of condoms and NORPLANT (if approved and registered in Egypt) for distribution to the public sector and non-profit NGOs providing family planning services under the POP/FP III Project. If USAID-donated contraceptives are sold by the direct recipient agencies (MOH, THO, and CSI), revenue agreements will be instituted to program proceeds from the sales. Under the Project, the MOH may continue to supply contraceptives to a number of the family planning service delivery organizations that are currently supplied under POP/FP II, but which will not be implementing agencies under POP/FP III. In these instances, the MOH could either (a) sell the contraceptive commodities (at either full or reduced MOH-set prices) to GOE parastatals or PVOs, which would in turn sell them to end users to cover operating costs; or (b) give the contraceptive commodities free to PVOs, which in turn would give them free to end users while charging only for services to cover operating costs.

Under POP/FP II, USAID stopped the EPTC sales of USAID-donated contraceptives to pharmacies and canceled the MOH/EPTC/USAID revenue agreement. A second new agreement covering the "Procurement, Receipt, Storage, Distribution, Monitoring and Disposal of USAID-Donated Commodities" was developed. This provides for monitoring mechanisms to track the USAID-donated commodities in the public sector.

Under POP/FP III, the two alternatives for the distribution mechanism are

- (1) Continue to use the Egyptian Pharmaceutical Trading Company (EPTC) as a distributor for the donated contraceptives, provided the cost is borne by the GOE, or
- (2) Contract the service to a private sector distributor if mutually satisfactory arrangements cannot be made with EPTC. Private/commercial pharmaceutical firms have distribution systems to the governorate level (and beyond) qualifying them to carry out this work.

Support will also be needed to further institutionalize MOH contraceptive commodity procurement, inventory, monitoring, and disposal procedures. The Contraceptive Inventory Information System (CIIS) will need to be maintained, improved, and better utilized as an information tool. The operation of the System will be funded as a GOE contribution to the Project.

INPUTS: The Project will provide contraceptive commodities for the public sector and USAID-supported subprojects, including IUDs and a limited supply of condoms and NORPLANT. Short-term TA will be provided to improve the CIIS and to transfer logistics management technology. A CPA firm will be subcontracted under the prime I/GS contract to make periodic assessments of revenue agreements and contraceptive commodity reporting.

c. Teaching Hospital Organization Subproject (THO)

There are eight Teaching Hospitals in Egypt, four of which are located in Cairo. The THO subproject, initiated under POP/FP II, was designed to improve the quality of family planning services through training and service delivery interventions. Under POP/FP III, THO will continue to provide clinical family planning service delivery through its family planning units. These units will continue to play an important dual role: (1) they will serve as models for hospital-based clinical family planning service delivery; and (2) they will serve MOH family planning training requirements, especially for hospital-based services. Although THO's role in removing constraints to demand depends on its ability to reach and serve new acceptors, its primary strategic function under the Project will be its contribution to improvements in quality and support provided to the medical community in the area of family planning.

THO training centers will be able to provide practical experience in injectables, NORPLANT, and medically-indicated surgical contraception, in addition to the more usual contraceptive technology experience with pills and IUDs. The in-patient OB/GYN departments of the Teaching Hospitals which handle many deliveries each day and the extensive outpatient system in OB/GYN and pediatrics provide excellent training and service opportunities for family planning outreach. The Project will assist THO to:

- Provide at least two weeks of training in clinical family planning service delivery, including quality assurance and infection control procedures, to 200 selected medical and nursing staff from MOH general and district hospitals each year. Minor renovations of THO's existing service delivery sites may be undertaken to increase the training capacity of the THO.
- Provide practical experience for physicians and nurses in the training program of RCT and assure improved coordination and scheduling of RCT internships.
- Continue to demonstrate quality of care in the services provided through THO's eight family planning clinics through implementation of national guidelines and

improvement of existing facilities through minor renovations.

- Develop and implement an outreach program specific to a hospital setting with maternity, outpatient, and surgical facilities.

INPUTS: Yearly short term TA and training materials, furnished through the I/GS contractor, will focus on maintaining and improving the standards of excellence in family planning training through curriculum refinement and participant follow-up. Opportunities for three short-term overseas participant training in family planning are included for teaching hospital staff members. These should be taken in the Project's first, second, and third year to provide greatest benefit in the training process during POP/FP III. Local costs for training, local training materials, office supplies, IEC, and some renovations will also be provided.

2. National Population Council (NPC)

The NPC is the central government institution responsible for formulating and promulgating population policy and coordinating the population and family planning efforts of all public and private sector organizations. It serves as a coordination body for governorate and national level planning, training, research, and IEC activities.

a. Institutional Development Subproject (IDP)

NPC's strategic importance lies with its potential to provide coordination at both the national and governorate levels. More importantly, it is well situated to promote acceptability and to greatly increase local support, as well as play an important role in local resource allocations. POP/FP III will continue institutional strengthening activities to further develop the capability of the central Technical Secretariat (TS), as well as governorate level NPC offices, to plan, coordinate, and report on family planning activities at the national and local level. Through the Research Management Unit (RMU) developed under POP/FP II, the ability of the TS to plan, solicit, and fund needed applied biomedical, policy and programmatic studies will be enhanced. These studies will provide a scientific basis for the expansion of service delivery under the Project, as well as build a base for policy dialogue leading to longer term sectoral development. Finally, the NPC's role in "policy outreach" will continue to be strengthened under this subproject.

The NPC will also conduct the 1996 DHS, either by itself (as in 1988 and 1992) or through a host-country agreement with the Cairo Demographic Center. The 1996 DHS will be the principal evaluation tool for measuring achievement of Project purpose.

(1) Strengthening the NPC Governorate Offices

The NPC governorate initiative will contribute to improved planning, management and evaluation systems. The NPC governorate offices are the decentralized wing of the NPC. Their mandate is to (1) broaden the base of political commitment to family planning at all levels in the governorate and (2) monitor and coordinate family planning activities in the governorate through close collaboration with family planning services providers and through review and analysis of family planning services statistics. The Project will:

- Continue human resource development of the staff of all 21 NPC governorate offices through training in management, planning, computer use, and analysis of family planning data of 120 to 150 participants per year
- Improve communication and collaboration between NPC governorate staff, family planning service providers, and community and political leaders. The Project will support annually an estimated fifteen governorate level (or lower) collaborative workshops, seminars, etc. to identify constraints facing family planning programs in each of the governorates, and to identify possible solutions
- Strengthen governorate staff capabilities in management, planning, and evaluation. Each of the 21 governorates will be provided with a development fund which will be used for activities aimed at broadening the base of community support for family planning. This decentralized planning and decision making process will provide the opportunity to strengthen governorate staff capabilities in management, planning, and evaluation as they undertake the management and planning required to identify projects and utilize funds. These activities also have an important WID aspect, as they provide opportunities for fuller participation of women in these processes

INPUTS: The I/GS contractor will provide a full time management and planning advisor to support the NPC governorate initiative. Training and local costs, including those of the Special Activities, will also be provided

(2) Strengthening the NPC Research Management Unit (RMU)

As the primary agency responsible for disseminating research results and recommendations, the recently reorganized RMU of the NPC/TS is tasked with coordination and dissemination of family planning related research in Egypt. Assistance to the RMU will enhance the planning and management capacity of that unit and generate improved information in the various aspects of Egypt's

family planning program for program managers and policy makers. The Project will:

- Assist the RMU in establishing an organizational structure and in developing a mechanism to identify research priorities and protocols to guide research contracting. TA will be provided in the areas of applied biomedical research, programmatic research, and management.
- Fund applied biomedical and programmatic research projects identified by the RMU
- Fund comparative analyses of the 1990 PAPCHILD and the 1988 and 1992 DHS to evaluate Project progress; fund secondary analysis studies of the 1992 DHS to examine key variables related to service expansion and quality
- Increase utilization of research results by program implementers and policy makers. The Project will support conferences, seminars, research briefs, and a biannual newsletter on current family planning research.
- Assist the RMU to establish a functional, well-organized resource center for family planning and population research.

INPUTS: The I/GS contractor will provide a full-time research advisor to support the NPC/RMU. Computer equipment, training for the resource center manager, funds for purchasing resource materials, and funds for the local costs of research projects will also be provided. In addition, short-term participant training will be provided in the areas such as strategic planning, management, policy development, and research process.

(3) Strengthening Policy Outreach at the National and Governorate Levels

The subproject will further build the NPC's capacity to carry out outreach to policy makers at the national and governorate levels. This has been described by the UNFPA as the "authority of ideas" role. In addition to influencing policy makers about the importance of population and family planning programs to the economic development of Egypt, the NPC should address, in collaboration with other authoritative organizations, policy issues that affect the family planning program in Egypt, such as medical restrictions, private sector constraints, and ministry level obstacles to cost recovery.

INPUTS: Local costs for consultants to research policy issues, and seminars, conferences, and meetings to discuss and define policy issues will be provided. TA from selected buy-ins, such

as the RAPID IV and/or OPTIONS project, will also be provided to supplement the locally funded research

b. Regional Center for Training (RCT) Subproject of Ain Shams University with the NPC

The RCT program aims at the removal of two important supply constraints. provider knowledge and service quality. It provides a direct contribution to improvements in service quality through training and the development of national service delivery guidelines. POP/FP III will continue support for the RCT through a letter of agreement between the NPC and Ain Shams University. The RCT will continue to provide high quality clinical family planning training to physicians, nurses, and a reduced number of trainers. RCT activities will focus on training and support, information development and dissemination, and technical assistance to medical and pharmacy schools to develop and/or refine family planning curricula. The Project will assist RCT to:

- Train 30 trainers (physicians and nurses) per year for the MOH, including the Teaching Hospital Organization (THO)
- Train 300 service providers per year (at least 150 public sector physicians and nurses, with the balance composed of private sector physicians)
- Provide practical clinical experience for their training courses by arranging to use facilities such as those of the THO
- Conduct quarterly meetings with the MOH, medical association representatives, and other groups who receive graduates from the RCT, to discuss curriculum content, criteria and numbers for admission, and to define training needs over the future 12 months.
- Assess the value of the current curricula during the first year of POP/FP III by surveying alumni so that findings can be incorporated into the second year curricula
- Review the content and methodology of training and the general approaches adopted by the RCT for quality assurance in contraceptive technology and counseling, including assessment of the standards of graduates
- Develop and broadly disseminate a "Physicians' Desk/Pocket Reference" which includes quality procedures, infection control, and counseling steps in family planning, using the RCT publication, "National Family Planning Service Delivery Guidelines for Egypt," as a foundation

- Provide TA (1) to medical schools to develop a population science and family planning unit as an important component of the medical curriculum, and (2) to pharmacy schools to develop a unit on contraceptive use and client information for the pharmacy curriculum.
- Explore the time frame and conditions required for RCT to become a formal part of the Ain Shams University structure by EOP and the feasibility of future cost-recovery mechanisms for private physician training.

INPUTS: A long term Training Management Advisor, supplemented by short-term TA, will be furnished through the I/GS contractor to provide technical guidance to the RCT. This TA will also monitor RCT's training approach, discuss technical contraceptive issues with faculty, conduct technical seminars, and monitor overall training conducted under the Project. USAID funds will support RCT trainee tuition costs and training materials as well as in-country travel and per diem Administration, offices supplies, IEC, and office equipment will also be covered In addition, the Project will provide short term participant training opportunities which will focus on adult education methodology, curriculum design, and contraceptive counseling

3. Ministry of Information: Family Planning Information, Education, and Communication Subproject (IEC) with the State Information Service (SIS)

The SIS has a strategic role to play in generating demand for family planning services and for disseminating information on effective contraceptive use and safety. Television, the most powerful medium for reaching the illiterate and poorly educated, is pervasive and inexpensive Effective use of mass media, reinforced by interpersonal communication, can achieve progress toward fertility reduction goals by attracting new acceptors and by contributing to improved contraceptive use

Increased attention will be paid to coordinating IEC efforts. Over time, contact between agencies through the National IEC Strategy committee will create needed message uniformity. For example, a common methods brochure (with space left for each organization to stamp its logo, address, and position statement) can save everyone time and money. Although implementing agencies will be encouraged to take advantage of cooperative efforts coordinated by the SIS/IEC Center, the Project also recognizes that situations may arise where it is preferable for an implementing agency to proceed with its own IEC effort

POP/FP III will continue support for mass media demand creation and information messages, as well as interpersonal IEC approaches

with local opinion leaders and religious leaders. The Project will:

- Develop a National Communication Strategy. The SIS/IEC Center, in collaboration with NPC, will hold a National Communication Strategy Workshop in Year 1 of the Project, and follow-up workshops annually. Directors of all agencies concerned with family planning communication will open and close the workshop; IEC specialists from these agencies will develop specific proposals and work plans with TA during the working sessions between the Directors' participation days. In quarterly meetings, IEC specialists will monitor implementation of the national strategy, review SIS/IEC Center television advertisements and print materials, and share ideas, experience, and resources
- Promote private commercial sector participation in the development of the national communication strategy. Stimulation of use of the private sector services will be done in collaboration with pharmacies
- Intensify SIS family planning television campaigns, strengthen SIS governorate offices, and re-energize SIS IEC coordination activities.
- Develop and implement IEC/outreach programs in implementing agencies, e.g , MOH and NPC

INPUTS: A resident IEC Advisor supplemented by short term TA, as well as IEC training, mass media innovations, audio/visual equipment, vehicles, and impact studies will be funded through the I/GS contractor. In addition, short term participant training will be provided in impact evaluation, market research, state of the art technology. Operational support, information production, and mass media costs for the SIS/IEC Center will be provided, as well as operational support for IEC/outreach in each implementing organization

4. Ministry of Social Affairs (MOSA): Clinical Services Improvement Subproject (CSI) of the Egyptian Family Planning Association (EFPA)

The Ministry of Social Affairs, through its network of registered private voluntary associations, has been the major coordinator of family planning services in the non-government not-for-profit sector. Although the community based efforts of the private voluntary associations play an important role in legitimating family planning in the eyes of the communities, their contribution to contraceptive prevalence in Egypt is quite low. Therefore, under the strategic approach adopted by POP/FP III, support will only be continued to the large Clinical Services

Improvement (CSI) Project of the Egyptian Family Planning Association (EFPA). Other donor funds will be sought to continue support to other associations, and opportunities for funding under the USAID PVO Project will be examined.

The CSI subproject was initiated under POP/FP II to develop a network of EFPA family planning service centers throughout Egypt, introduce quality assurance management systems and procedures, and establish systems to finance continuation of the centers after the cessation of donor support. With services targeted at women a notch above MOH clients, i.e., those who can afford to pay a little, CSI is providing high quality services and reaching an increasing number of women, as evidenced by an increasing level of CYP from 64,905 CYP in 1989/90 to 170,662 CYP in 1990/91. Through a host country agreement between MOSA and the EFPA, USAID will continue to support, on a phase-down basis, CSI's capital and operational costs until 1997. Other donors will be encouraged to support the subproject, particularly the capital costs, as the CSI graduates from USAID support. One of USAID's most important contributions will be in assisting CSI to increase cost recovery. Therefore, in addition to funds for personnel, operating costs, and other related expenses, the Project will

- During POP/FP III's pre-implementation phase, assess the feasibility of CSI's self-financing strategy, with special attention to price schedules and prospects for alternative donor support;
- During POP/FP III's pre-implementation phase, assess and/or carry out operations research studies to ascertain whether sub-groups in the general population which are especially important to USAID's population/family planning strategy and to the national family planning program can be effectively reached and served through the CSI system, and at what cost
- Develop socio-economic and family planning profiles of CSI clients (including an assessment of CSI clients' need for subsidy and their use of the unsubsidized private sector for non-family planning medical care, as well as prices paid for such services)
- Assess and/or carry out market tests to ascertain the "quality threshold" at which family planning and cost-efficiency impact are maximized simultaneously and the role of various components of CSI's quality of care package in user acceptance of family planning
- Assess lessons learned from the CSI experience for family planning service delivery and the potential for the beneficial transfer of those lessons learned to other

service delivery agencies, disseminate lessons learned to relevant institutions and service agencies.

INPUTS: Local costs will be provided on a phased out basis. Under the I/GS contract, the Project will also provide short-term technical assistance and financial support to carry out studies to assist with cost recovery and self-financing. In addition, short term participant training will be provided in business management and private sector family planning service delivery

5. Special Initiatives for the Private Commercial Sector

The private commercial sector delivered approximately 70 percent of all family planning services in Egypt, according to the 1988 DHS. A service delivery participant of this magnitude cannot be ignored under POP/FP III. This sector sustains its own activities through consumer payments for goods and services. Therefore, direct Project support will be limited to relatively small amounts, primarily for training, marketing and TA in strategically important areas, such as IEC

Private sector activities will be aimed at enhancing the quality and acceptability of family planning care. Training of private physicians will continue in order to ensure that adequate numbers of private physicians in all geographic areas of the country are competent in family planning clinical and counseling skills. In addition, pharmacists (who provided 38 percent of all contraceptives used in 1988) will be trained in contraceptive methods (especially oral contraceptives) and their correct use. Other activities include support for studies to assist USAID to better target its assistance, and mass media messages to promote the use of private sector channels for service delivery. This media support to market private sector providers will be carefully coordinated with the activities described below in Activities 5.a and 5 b

Private commercial sector activities will be managed by the I/GS contractor through cooperative agreements or subcontracts with appropriately selected local organizations.

a. Strengthening Private Physicians as Family Planning Service Providers

POP/FP III will assess the effect of physician training and develop and implement such training. The Project will.

- Conduct two studies during the pre-implementation phase to (1) assess the effect of POP/FP II training on private physicians' skills and earning-power, and (2) identify those private physicians for whom family planning training is appropriate by locale.
- Train at least 150 private practice physicians each year through the RCT subproject. Special emphasis will be placed on the training of female practitioners, especially those working in Upper Egypt
- Develop a consumer profile of private physician family planning clients, including a survey of prices paid by clients
- Develop (if required), adopt, and disseminate a "standards of good family planning practice" through an appropriate medical professional association for private physicians, TA will also be provided to establish within the implementing medical professional association a means of promoting and monitoring good practice among its members.

b. Strengthening Pharmacists as Family Planning Service Providers

POP/FP III will develop and implement a basic training course for pharmacists in contraceptive methods and their correct use. Special attention will be paid to including female pharmacists and to the geographic representation of pharmacists selected for this training effort. Follow-up training and refresher courses will be scheduled during the later years of the Project. The Project will, through subcontracts with appropriately selected local organizations.

- Develop the curriculum and reference manual, promote the opportunity for family planning training among pharmacists, identify participants, and implement the training at appropriate sites throughout Egypt. At least 1,000 pharmacists will receive a minimum six-hour training course each year. A simple contraceptive reference manual will be given to each pharmacist who completes the training.
- Determine the feasibility and usefulness of developing and producing store signs, window stickers, business cards, or some similar device for identifying trained pharmacists' shops as special sources of family planning information/referral

- Develop simple print materials -- aimed at pharmacy contraceptive clients and appropriate for non-literate populations -- which support correct and informed use of contraceptive methods for distribution by trained pharmacists to their contraceptive clients

INPUTS: Under the I/GS contract, a Private Sector Advisor will be provided Short term technical assistance will be provided for specific activities, e.g., in the development of printed materials The Project will also cover special activities, such as the local costs of print materials, promotional activities, conferences, workshops and in-country training, as well as mass media support of private sector channels for service delivery

II. COST ESTIMATES AND FINANCIAL PLAN

The total A.I.D. cost of the Project is estimated to be \$62.0 million. The first year obligation is expected to be \$10.0 million.

The GOE contribution of LE 64.3 million will be both cash and in-kind, and includes salaries, normal GOE premium pay, incentives, host-country costs for participant training, radio and television air time, etc. Using an exchange rate of \$1 = 3.3, it represents approximately 24 percent of the total Project cost. The method of verifying the GOE in-kind contribution will be by observation, i.e., if services are being provided, it will be assumed that recurrent costs are being paid. The GOE cash contribution will be monitored through review of GOE budgetary documentation, when applicable.

A. Project Costs by Element

Table 1, below, presents estimated costs by Project element. In this Project, approximately 40 percent of the USAID contribution will be passed through the I/GS contractor. This contractor will be responsible for providing all of the long-term and short-term expatriate technical assistance (except for selected buy-ins); arranging for participant training, assisting implementing agencies in complying with USAID requirements, carrying out special assessments, subcontracting for the private sector initiative activities; and procurement of non-contraceptive commodities from the United States (e.g., vehicles, equipment, etc.). Because of this arrangement, the costs falling under the I/GS contractor schedule are, in fact, associated with specific implementing agencies. The Financial Analysis (Annex B) presents the illustrative line-item budgets for each implementing agency (Subproject Worksheets 1-7), and additional cost detail (Tables B-1, B-2, B-3).

B. Project Costs by Output/Input

The Project costs by output/input are shown in Table 2, below.

C. Project Costs by Project Year

The estimated allocation of Project costs over the life of the Project is shown in Table 3, below. Additional detail on the distribution of costs by implementing agency over each year of

Source Selection Information -- See FAR 3.104

the Project is presented in the Financial Analysis (Annex B), Tables B-2 and B-3, and the Subproject Worksheets

TABLE 1
COST ESTIMATE AND FINANCIAL PLAN (THOUSANDS OF \$)

ELEMENTS	FX	LC	TOTAL
CONTRACEPTIVE COMMODITIES	\$7,484	\$0	\$7,484
IMPLEMENTATION/GOODS&SERVICES	\$27,903	\$0	\$27,903
EVAL/AUDITS,BUY-INS,PROJ SUPP	\$1,378	\$1,277	\$2,655
LOCAL COSTS OF IMP AGENCIES (NPC,MOH,MOI,MOSA)	\$0	\$23,958	\$23,958
TOTAL	\$36,766	\$25,234	\$62,000

HOST COUNTRY Contribution	(LE 000)
Cash	22,587
In-Kind	41 714
TOTAL	64 301

NOTES

- 1 Contraceptive commodities includes the value of commodities provided by USAID to the implementing agencies
- 2 Implementation/Goods & Services includes contractor costs associated with short and long term expatriate TA to implementing agencies, selected local TA, contractor offices and support, activities to be implemented by the contractor, such as the private sector initiative and special assessments assigned to the contractor; non-contraceptive commodities that will be procured by the contractor and used within implementing agencies, and short-term participant training (minus airfare)
- 3 Local Costs include local TA, non GOE project personnel in-country training and conferences operational support, research and studies special activities, IEC locally procured commodities used by the implementing agencies, and so forth
- 4 Contingency is estimated at 10 percent Average annual inflation, included in all figures, is estimated at 5 percent
- 5 Exchange rate is \$1 = LE 3 34 Host Country Contribution is described in detail in the Financial Analysis, Table B-4

Source Selection Information -- See FAR 3.104

TABLE 2
ESTIMATED COST OF PROJECT OUTPUTS/INPUTS (THOUSANDS OF \$)

OUTPUTS	INPUTS						TOTAL
	CONTR. COMMOD	TA/M	EVAL	LC/ USAID	USAID SUBTOT	LC/ GOE	
Increased service volume and improved service quality	\$7,484	\$12,812	\$179	\$20,238	\$40,714	\$17,698	\$58,411
Improved information for policy makers	\$0	\$2,334	\$1,009	\$3,720	\$7,062	\$1,157	\$8,219
Improved management capacity in implementing agencies	\$0	\$13,559	\$665	\$0	\$14,224	\$631	\$14,855
TOTAL	\$7,484	\$28,705	\$1,853	\$23,958	\$62,000	\$19,485	\$81,485

TABLE 3
PROJECTION OF ESTIMATED EXPENDITURES BY PROJECT YEAR (THOUSANDS OF \$)

ELEMENTS	PREIMP 5 MO	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	POSTIMP 1 MO	TOTAL
CONTRACEPTIVE COMMODITIES	\$0	\$1,736	\$1,823	\$1,914	\$2,010	\$0	\$7,484
IMPLEMENTATION/GOODS&SERVICES	\$1,414	\$6,948	\$6,087	\$6,359	\$6,710	\$385	\$27,903
EVAL/AUDITS,BUY-INS,PROJ SUPP	\$112	\$339	\$619	\$898	\$671	\$16	\$2,655
LOCAL COSTS OF IMP AGENCIES (NPC,MOH MOI MOSA)	\$0	\$5,748	\$5,843	\$6,443	\$5,922	\$0	\$23,958
TOTAL	\$1,526	\$14,772	\$14,372	\$15,615	\$15,314	\$401	\$62,000

Source Selection Information -- See FAR 3.104

D. Methods of Implementation and Financing

Table 4, below, illustrates the methods of implementation and financing of Project elements. The methods of implementation and financing are all in accordance with the Agency's payment and verification guidelines. The implementation methods proposed for this Project are PIO/C, direct contract, PIO/T, and PILs. Each is standard, and has been used successfully in the Egyptian context in the current POP/FP II Project.

Of special note is the I/GS contract, which will include the bulk of Project expatriate labor, all participant training, and a large share of non-contraceptive commodity costs. This contract will be competitively bid, with the RFP to be issued in 1992. Review of proposals will include input from various offices within USAID/Egypt and counterparts in implementing agencies.

TABLE 4
METHODS OF IMPLEMENTATION AND FINANCING (THOUSANDS OF \$)

ELEMENTS	METHOD OF IMPLEMENTATION	METHOD OF FINANCING	APPROX COST
CONTRACEPTIVE COMMODITIES	PIO/C (AID/W)	Funds Transfer	\$7,484
IMPLEMENTATION/GOODS&SERVICES	Direct Contract / Cooperative Agreement	Direct Payment	\$27,903
EVAL/AUDITS BUY INS PROJ SUPP	PIO/T (for AID/W Contracts & Coop.Ag) and Direct Contracts	Funds Transfer and Direct Payment	\$2,655
LOCAL COSTS OF IMP AGENCIES	PILs	Reimbursement	\$23,958
TOTAL			\$62,000

Source Selection Information -- See FAR 3.104

III. IMPLEMENTATION PLAN

The activities planned for POP/FP III build on the foundation put in place under the two previous projects. The Project has the full support of the GOE and counterparts are in place to work with technical assistance personnel assigned to the subprojects.

A. Role and Responsibilities of GOE Agencies

Obligation of funds will be through a Grant Agreement signed jointly by USAID, the Ministry of International Cooperation, the implementing ministries, and the NPC. The Secretary General of the NPC will sign on behalf of the GOE to indicate concurrence with the I/GS PIO/T. In contrast to POP/FP II, in which the Mission entered into separate implementation arrangements for each subproject, this Project will have a single annual Project Implementation Letter (PIL) with each implementing ministry (MOH, MOI, MOSA) and with the NPC. The Annual PILs will outline an annual plan for the relevant subprojects for each implementing agency and will provide a vehicle for concurrence on detailed activities and financing. RCT will be funded through a subsidiary Letter of Agreement between the NPC and Ain Shams University. The 1996 DHS will either be conducted by the NPC (as in 1988 and 1992) or will be funded by a Letter of Agreement between the Cairo Demographic Center and the NPC. The CSI Subproject will be funded through a Letter of Agreement between MOSA and EFPA. These Letters of Agreement will follow host country procedures and will be approved in draft and in final by USAID. Activities with the private sector will be funded through subcontracting under the Prime I/GS contract.

National Population Council (NPC) - NPC serves as a coordinating body for Governorate and national level planning, training, research, and IEC activities. It will be directly responsible for the Institutional Development Subproject and the Regional Center for Training (RCT) Subproject of Ain Shams University.

The Ministry of Health (MOH) - The Ministry of Health will coordinate implementation of all MOH units involved in the Project, including the Systems Development Subproject (SDP), the Teaching Hospital Organization Subproject (THO), and the Contraceptive Commodity Subproject.

The Ministry of Social Affairs (MOSA) - The Ministry of Social Affairs will play a coordinating role with respect to implementation of the Clinical Services Improvement Subproject (CSI) of the Egyptian Family Planning Association (EFPA).

The Ministry of Information (MOI) - The Ministry of Information (MOI) will coordinate the mass media activities of the State Information Service, including the Family Planning Information, Education, and Communication Subproject (IEC) with the State Information Service (SIS)

B. Management and Administrative Arrangements

1. Project Coordination

The NPC's mandate calls for it to serve as the principal policy, planning, and coordination body for the GOE's population program. Although the Interministerial Board of the NPC has not yet proven to be effective in these areas, for the purposes of this Project, the NPC will take a leadership role in ensuring that the various subprojects coordinate activities and share information through the establishment of a Project Coordinating Committee. The Committee will be composed of the directors of each of the implementing agencies receiving USAID assistance, USAID representatives (ex officio), and will be chaired by the Secretary General of the NPC or his designee. The Committee will meet at least semiannually to (a) review Project progress in relation to overall objectives and output targets, (b) discuss and find solutions for major problems and bottlenecks encountered during the preceding period, (c) coordinate broad activity plans for the next quarter, and (d) focus on specific implementation activities.

2. Project Management

Helping the GOE to carry out a more coordinated and targeted family planning program will require that USAID technical staff have the time for strategic planning, broad oversight, and dialogue with the government and other concerned Egyptian and donor agencies. This necessitates the elimination of certain POP/FP II activities which are management intensive and have low payoff, the consolidation of ministry support and small grant and research activities, and the procurement of management, technical, and planning expertise under a single contract for "Implementation/Goods and Services". This single I/GS contractor will serve as the central employer/contractor of resident advisors and short-term consultants to assist the GOE implementing agencies to meet their project responsibilities in accord with USAID regulations. The contractor will provide day to day technical advice, routine troubleshooting, and assistance in reporting to meet AID requirements.

C. Technical Assistance Procurement Plan

Under POP/FP II, Technical Assistance was obtained through numerous buy-ins to AID/W projects. Under POP/FP III, the bulk of the technical assistance requirements will be obtained through a single USAID-awarded contract. Specialized technical assistance requirements which go beyond the scope of this contract will be available through buy-ins to AID/W contracts and cooperative agreements.

The following outlines the Technical Assistance needs identified for the Project at this time. The requirements should be viewed as illustrative only, and will be refined further prior to preparation of Scopes of Work and Requests for Proposals. This Technical Assistance Procurement Plan supports AID's "Buy America" policy, as all technical assistance contracts and cooperative agreements for expatriate TA will be with US firms or universities.

1. Prime Contract: Implementation/Goods and Services Team

The Mission plans to fund a competitively awarded contract which will bear first line responsibility for Project management and technical assistance, as well as procurement of non-contraceptive commodities, private sector initiatives subcontracts, and short-term participant training. It appears that certain of these tasks may be appropriately subcontracted to an 8(a) or Gray Amendment firm, e.g. a PSA for procurement of non-contraceptive commodities. Resident advisors, who will include subcontract management among their responsibilities, will be placed in selected implementing entities. In addition, contractor management responsibilities will include assisting the implementing agencies in the development of the initial overall Four-Year Implementation Plan and the subsequent detailed annual implementation plans and in overseeing the timely submission of quarterly reports, end use reports, and vouchers, as well as other special reports as may be required time to time by USAID. This approach, plus the reduced number of subproject implementing agencies, should significantly reduce the USAID direct management burden compared to the current project. This, in addition to its contribution to project coordination and cohesiveness, makes this contracting approach the preferred method for Project implementation. It is anticipated that 385 PM (32 Person Years) of long term expatriate TA and 153 PM of short term expatriate TA will be required, as well as local TA and support. Support staff will include two assistants, two secretaries, and two clerks. The contract will also provide funds for office supplies, office rent, vehicle procurement and maintenance, etc., and an accounting subcontract.

POSITION			PM
LONG TERM TA			
Chief of Party/Private Sector Advisor		Expatriate	55
Finance/Administration		Expatriate	55
MOH	Management Advisor	Expatriate	55
RCT	Training Advisor	Expatriate	55
NPC	Management Advisor	Expatriate	55
	Research Advisor	Expatriate	55
MOI	IEC Advisor	Expatriate	55
SHORT-TERM TA			
MOH	Management, Training, Quality Assurance, Logistics Management	Expatriate	49
	Management, Training, Quality Assurance, Logistics Management	Local	49
SIS	Mass Media Innovation Impact studies	Expatriate	32
CSI	Self Financing studies	Expatriate	16
RCT	Curriculum, Training Methodology Contraceptive Technology Training Management	Expatriate	8
THO	Curriculum Training Management	Expatriate	24
Private Sector	IEC, Marketing, Pricing, Training	Expatriate	24
SUPPORT STAFF			
Administrative Assistants		Local	110
Secretaries		Local	110
Clerks		Local	110

In addition, this Prime Contract will include funding so that the I/GS contractor can undertake responsibility for participant training and consultation/invitational travel, private sector initiatives, and the procurement of the equipment and vehicles required under the Project (see below). In line with the standard procedures of the Mission's Office of Contract Services, a detailed cost budget analysis will be undertaken of the selected firm's proposal. Negotiations during contract finalization will ensure that these items will not be included inappropriately as the basis for excessive overhead or fees.

2. Buy-ins

Buy-ins to AID/W Research and Development/Office of Population (R&D/POP) projects will be used primarily to obtain specialized technical assistance requirements which go beyond the scope of the I/GS contract. If a determination is made that the required expertise is not available through a buy-in, competitive selection will be used to enter into either a Cooperative

Agreement or Contract, as appropriate. In addition to specific policy and research needs, these will include external consultants to provide both mid-term and final evaluations

3. Studies

Under the PILs to implementing agencies, local costs will include local studies and TA procured through host country mechanisms. These will consist of (1) small value (less than \$250,000) host country contracts for consulting services and (2) Letters of Agreement between a Project implementing agency and other local organizations, e.g., between the NPC and the Cairo Demographic Center to undertake the 1996 DHS, if the NPC^a does not implement the 1996 DHS directly.

4. Project Support

A Project funded Personal Services Contractor (PSC) will be identified through competitive procedures to help USAID fulfill its responsibilities in terms of implementing and monitoring Project implementation. The PSC will be housed in HRDC/P and serve as a liaison between the I/GS and HRDC/P

D. Commodities Procurement Plan

Commodity procurement under the Project can be categorized as either (1) non-contraceptive commodities in support of the activities being undertaken by the implementing agencies or (2) contraceptive commodities

1. Non-Contraceptive Commodities

The following list shows illustrative quantities of commodities by type of commodity. It is important to note that these inputs are illustrative and were defined as a result of an analysis of past implementation experience as well as meetings with the implementing agencies. One of the first tasks of the I/GS Team will be to review this list with the relevant implementing agencies in order to develop the necessary specifications and details, within the general framework established by the Project design team.

Item	I/GS Team	NPC	NPC Res Center	MOH	SIS Cent	SIS Gov	RCT	TOTAL
Micro Computer monitor/keyboard/diskdrive micro computer printer micro computer software computer site preparation	8	4	2	45	--	--	16	75
Utility Vehicle (Jeep type) 5 passenger utility vehicle 2 wheel drive 4 cylinder gasoline engine spare parts (up to 15% of vehicle value)	2	--	--	80	3	--	--	85
Office Equipment photocopier (minimum 10 copies/minute)	3	4	2	25	--	--	--	34
Audio/Visual Equipment Items for Governorates • Video Camera & Monitor • Sound Equipment • Video Editing Equipment • Overhead Projector Items for Central Offices • Video Camera & Monitor • Sound Equipment • Video Editing Equipment • Overhead Projector • Dark Room Equipment • Camera Equipment • Artist Tools for Graphics • Trimming & Binding Equipment • Computer Assisted Graphic Design Equipment	--	--	--	--	--	3	--	3
	--	--	--	--	--	1	--	1

Equipment - As part of their contract during the pre-implementation phase, the I/GS Team will assist each implementing agency to develop an equipment procurement plan and develop the necessary specifications. This plan will be finalized and incorporated into the overall Four Year Implementation Plan of each implementing agency, prior to the signing of the first Annual PIL. No commodities will be procured under a subproject until USAID approves its commodity procurement plan, unless USAID agrees otherwise in writing. As computer procurement is expected to exceed \$100,000, the necessary clearance will be obtained from AID/IRM in Washington. Following USAID review and approval of the specifications, the I/GS contractor (or subcontracted PSA) will be responsible for undertaking the actual procurement as part of its contract, and will apply AID's "Buy America" policy, as appropriate. No waivers are anticipated at this time. The implementing agencies will be responsible for obtaining the

necessary customs releases and distributing the equipment to the relevant locations

Vehicles - The I/GS contractor will compile a vehicle procurement plan, based on input from the relevant implementing agencies and in accordance with Mission Order 1-7. Following USAID review and approval, the I/GS contractor will procure the vehicles from the US in compliance with the requirements of the FAA. The implementing agencies will be responsible for obtaining the necessary customs releases. Detailed instructions on this, as well as vehicle maintenance responsibilities and use requirements, will be provided to the implementing agencies via PILs.

2. Contraceptive Commodities

USAID Office of Population staff will work closely with MOH and EPTC personnel to finalize contraceptive requirements for IUDs, NORPLANT, and Condoms. The supply of contraceptives will be closely monitored in order to identify any changes over time in the composition of demand. Stocks and flows will be monitored regularly to insure that they are in balance with consumer preference. Analyses will be undertaken on an annual basis, and will be used to compile annual PIO/Cs which will be sent to AID/W for contraceptive delivery and consumption in the following year.

E. Training Plan

The following outlines anticipated training needs under the Project. Prior to any disbursement for training for a given implementing agency under the Project, the implementing agencies, with assistance from the I/GS Team, will each develop participant and in-country training plans for their subproject (in accordance with Mission Order 10-1) as part of the overall Four Year Implementation Plan. No training will be carried out under a subproject until USAID approves the agency's training plan, unless USAID agrees otherwise in writing. On an annual basis, the plans for each agency will be updated for the following year and incorporated in their Annual PIL prior to any disbursement to a particular implementing agency for each subsequent year. Assistance will be provided to implementing agencies as part of the Technical Assistance contracts, in order to develop the necessary Training Plans.

In-country Training - Plans for in-country training will indicate adequate commitment of the implementing agency, in terms of staff and funding, to complement the USAID contribution to the effort. These USAID funds for operational training costs will be made available through the implementing agencies' annual PILs. The funds do not require a justification under AID's "Buy America"

policy in that they will be used to fund commodities and services which are available only locally, e.g., per diem, transportation, conference space, honoraria, utilities, communications, vehicle O&M, etc. Actual implementation of the In-Country Training Plans will be the responsibility of the respective implementing agency. The RCT will contribute to the improved quality of MOH training by training MOH trainers.

The following provides an illustrative indication of the types of local training courses and workshops visualized under the Project. This will be further defined and finalized on an annual basis as part of each implementing agencies' detailed Annual Implementation Plan and approved in the Annual PIL.

IMPLEMENTING AGENCY	TYPE OF LOCAL TRAINING	NUMBER OF TRAINEES
NPC	Governorate Training Courses	540
	Library Training	1
MOH/SDP	Physician/Nurse Training Courses	8 100
	Refresher Training Courses	3,200
	Computer Training Courses	1,600
	Annual Training Workshops	1,600
CSI	Physician/Nurse/Counselor Basic Training	480
	Physician/Nurse/Counselor Refresher Training	480
RCT	Training of Trainers Courses	120
	Physician/Nurse Training Courses	600
	NORPLANT Training Courses	80
	Family Planning Diploma	16
THO	Specialist Training Courses	800
Private Sector	Physician Training Workshops	600
	Pharmacist Training Workshops	4 000

Participant Training and Consultation/Invitational Travel - The following outlines the Participant Training needs identified for each subproject at this time. This should be viewed as illustrative only, and will be refined further during actual development of the Training Plans by each implementing agency, as part of the overall Four Year Implementation Plan. Final detail will be provided on an annual basis in the detailed Annual Implementation Plan and approved in the Annual PIL. Training is expected to be short-term and non-degree only. Participants will be selected by the respective implementing agency, but it will be the responsibility of the I/GS contractor to subcontract for actual implementation of the training and to monitor and follow up on the participants.

IMPLEMENTING AGENCY	NO OF PARTICIPANTS		TYPE OF PARTICIPANT TRAINING
	Per Year	Total	
MOH/SDP	10	40	General Family Planning Management, Management of Training, Commodities Management, Systems Design and Analysis, Curriculum Design, Adult Education Methods, Training Management and Logistics, Development of Audio-visuals for Training, Use of Training in Institutional Development
THO	1	4	Family Planning
NPC	1	4	Strategic Planning, Management, Policy Development, Research Process
RCT	1	4	Adult Education Methodology, Curriculum Design, Contraceptive Counseling
CSI	1	4	Business Management and Private Sector Family Planning Service Delivery
SIS	1	4	Impact Evaluation, Market Research, State of the Art Technology
TOTAL	15	60	

The I/GS contractor will also arrange and manage invitational travel opportunities for selected project officials and senior policy makers to undertake consultations and to share the Egyptian experience in international fora

F. Implementing Agency Local Costs

Local Costs are expected to be comprised of administrative costs (e.g., non-GOE project personnel, transportation, office supplies); training costs (e.g., honoraria, travel, per diem, training materials); IEC (e.g., brochures, promotional displays, media presentations); rent; renovations; research studies and Special Activities Fund. The funds do not require a justification under AID's "Buy America" policy in that the individual transactions are expected to fall under one of several of the exceptions according to Handbook 1B Chapter 18, most notably, commodities and services which are available only locally; professional services contracts estimated not to exceed \$250,000; and commodity transactions estimated not to exceed \$5,000.

	NPC	MOH	SIS	CSI	RCT	THO
Administrative	X	X	X	X	X	X
Training/Conferences	X	X	X	X	X	X
IEC	X	X	X	X	X	X
Rent				X		
Renovations		X				X
Research Studies	X	X	X	X		X
Special Activities Fund	X					

G. "Buy America" Considerations

Under AID's new "Buy America" policy, local source procurement for new projects generally must fall within one of several categories of local source procurement which are excluded from the "Buy America" requirement, or else must meet one or more of the waiver criteria in Section 5B4a of Handbook 1B. Where an exception to the policy exists, the procurement may be authorized without justification; however, a local source procurement that requires a waiver must be justified by reference to the waiver criteria.

"Buy America" considerations have been discussed in each of the preceding sections of the Implementation Plan, with reference to the relevant exceptions as appropriate. In addition, it is estimated that approximately 16 percent of the costs for long term TA and 22 percent of the costs for short term TA under the I/GS contract will be expended locally on commodities and services that are available only locally, i.e., utilities, communications, rental costs, vehicle O&M, etc. These constitute

an exception under Section 18A1c(6) of Handbook 1B. The following table provides a summary of the local procurement expected during Project implementation.

Elements	Amount (\$000)	Remarks/HB 1B Cite
In-Country Trng/Conf	9,404	Exception/18A1c(6)(f)
Operational Support	8,634	Exception/18A1c(6)(f)
Studies	1,358	Exception/18A1c(4)
Audit/Assessment	475	Exception/18A1c(4)
Spec Activities/IEC/etc	7,151	Exception/18A1c(6)(f)
Local Costs of LT & ST TA	6,281	Exception/18A1c(6)(f)
TOTAL	\$33,304	

The I/GS contractor will undertake limited non-contraceptive commodity procurement (\$3,093,000) for the Project implementing agencies and will be instructed to adhere to AID's source/origin requirements. It will be determined during Project implementation whether local procurement of any of these items is justified, a waiver will be undertaken at that time, if necessary.

H. Implementation Schedule

The Implementation Schedule, which follows, has been developed as an illustrative guide to the sequencing of activities with an understanding that, while the Project purpose must be clearly stated and adhered to, there needs to be sufficient flexibility to allow the Project to adapt to changing needs and capacities of the implementing agencies

For purposes of this Project, the Implementation Phase is defined as the 49 month period during which the implementing agencies undertake their prescribed activities, i e from June 1, 1993 through June 31, 1997. The Pre-Implementation Phase is therefore defined as the intervening period between signing of the Project Agreement and the beginning of the Implementation Phase The Post-Implementation Phase consists of one month of wrap up for the I/GS contractor following completion of the implementing agencies activities.

SUBACTIVITY	WHO	FY					
		92	93	94	95	96	97
		----- Q U A R T E R -----					
		1234	1234	1234	1234	1234	1234
General							
PROAG Signed	USAID/MIC						
Personal Services Contract							
♦ SOW	USAID/NPC						
♦ PIO/T	USAID/NPC						
♦ Advertise	USAID						
♦ Evaluate	USAID/GOE Counterpart						
♦ Execute contract	USAID/Contractor						
I/GS Contract							
♦ SOW	USAID/NPC						
♦ PIO/T	USAID/NPC						
♦ RFP & advertise	USAID						
♦ Technical evaluation results	USAID/GOE Counterpart						
♦ Evaluate cost proposal	USAID						
♦ Negotiate and execute contract	USAID/Contractor						
Pre Implementation Assessments/Studies							
♦ SOWs	USAID						
♦ Buy-in Requests	USAID						
♦ Buy-ins	AID/W						
♦ Assessments/studies completed	Contractor						
Interim Project Evaluation							
♦ SOW	USAID						
♦ Buy in Request	USAID						
♦ Buy-in	AID/W						
♦ Evaluation completed	Contractor						
Final Project Evaluation							
♦ SOW	USAID						
♦ Buy-in Request	USAID						
♦ Buy-in	AID/W						
♦ Evaluation completed	Contractor						
Project Audits							
♦ SOW	USAID						
♦ Request for Proposals	USAID						
♦ Selection, negotiation, & award of contract	USAID						
♦ Contract Signature	USAID						
♦ Audits Completed	CPA						
PACD	USAID/MIC						

FY 92 93 94 95 96 97
 ---- Q U A R T E R ----
 1234 1234 1234 1234 1234 1234

SUBACTIVITY

WHO

Implementation/Goods & Services

Pre Implementation Activities	I/GS	■				
◆ Project MIS established	I/GS	■				
◆ Four Year Implementation Plans	I/A & I/GS	■				
◆ Annual Implementation Plans	I/A & I/GS	■	■	■	■	
◆ Studies	I/GS	■				
◆ Subcontract with CPA firm	I/GS & CPA	■				
Implementation Activities	I/GS	■	■	■	■	■
◆ Subsequent Annual Implementation Plans	I/A & I/GS		■	■	■	
◆ Assistance to Implementing Agencies (See below)	I/GS	■	■	■	■	■
◆ Studies	I/GS	■	■	■	■	■
◆ Reporting to USAID	I/GS	■	■	■	■	■
Post Implementation Activities	I/GS					■
◆ Studies	I/GS					■
◆ Reporting to USAID	I/GS					■

(1) MOH/SDP

Satisfaction of CPs	MOH/SDP	■				
Four Year Implementation Plan	MOH/SDP & I/GS	■				
Annual Implementation Plan	MOH/SDP & I/GS	■	■	■	■	
Annual PIL	USAID & Project Mgr	■	■	■	■	
Refine "Operational Procedures"	MOH/SDP	■	■			
Disseminate "Operational Procedures"	MOH/SDP	■	■			
Decentralized MIS pilot (6 governorates)	MOH/SDP	■	■			
Decentralized MIS in all 21 governorates	MOH/SDP	■	■	■	■	■
Physician/Nurse Training	MOH/SDP	■	■	■	■	■
Refresher Training	MOH/SDP	■	■	■	■	■
Computer Training	MOH/SDP	■	■	■	■	■
Short-Term Participant Training	MOH/SDP	■	■	■	■	■
Annual Workshop	MOH/SDP		■	■	■	■
Evaluation Studies	MOH/SDP	■	■	■	■	■
IE&C Activities	MOH/SDP	■	■	■	■	■
Financial Assessment/Review	AID & MOH	■	■			
Reporting to USAID	MOH/SDP	■	■	■	■	■
Audit	CPA		■		■	

SUBACTIVITY	WHO	FY	92	93	94	95	96	97
		----- Q U A R T E R -----						
		1234	1234	1234	1234	1234	1234	1234

(2) Contraceptive Commodities

Satisfaction of CPs	MOH							
Annual Analysis	MOH & I/GS	■						
PIO/C	USAID							
Procurement	AID/W	■						
Distribution/Consumption	MOH/EPTC		■	■	■	■	■	■
Reporting to USAID	MOH		■	■	■	■	■	■
Audit	CPA		■	■	■	■	■	■

(3) THO

Satisfaction of CPs	THO							
Four Year Implementation Plan	THO & I/GS	■						
Annual Implementation Plan	THO & I/GS							
Annual PIL	USAID & Technical Director	■						
Specialist Training	THO		■	■	■	■	■	■
Short Term Participant Training	THO		■	■	■	■	■	■
Financial Assessment/Review	AID & THO		■	■	■	■	■	■
Reporting to USAID	THO		■	■	■	■	■	■
Audit	CPA		■	■	■	■	■	■

FY 92 93 94 95 96 97
 ----- Q U A R T E R -----
 1234 1234 1234 1234 1234 1234

SUBACTIVITY

WHO

(6) SIS

Satisfaction of CPs	SIS						
Four Year Implementation Plan	SIS & I/GS						
Training Plan	SIS & I/GS						
Annual Implementation Plan	SIS & I/GS						
Annual PIL	USAID & Chairman						
Studies	SIS						
Information Production	SIS						
Annual National Communication Strategy Workshop	SIS						
IE&C Activities	SIS						
Financial Assessment/Review	AID & SIS						
Reporting to USAID	SIS						
Audit	CPA						

(7) CSI

Satisfaction of CPs	CSI						
Four Year Implementation Plan	CSI & I/GS						
Annual Implementation Plan	CSI & I/GS						
Annual PIL	USAID & Director						
Training	CSI						
Studies	CSI						
Financial Assessment/Review	AID & CSI						
Reporting to USAID	CSI						
Audit	CPA						

(8) Private Sector

Consumer Profile	I/GS						
Develop "Standards of Good FP Practice"	I/GS						
Disseminate "Standards of Good FP Practice"	I/GS						
Physician Training	TBD						
Pharmacist Training	TBD						
Special Activities	PS Groups						

TBD = To Be Determined

IV. MONITORING AND EVALUATION PLAN

Within USAID, responsibility for the Project falls to the Office of Population in the Human Resources and Development Cooperation Directorate. Assuming requested staffing reclassifications and allocations are implemented, the Office will be staffed with a direct hire Office Director, two direct hire Project Officers, two FSN Project Management Assistants, one AID Development Clerk, four FSN Program Management Specialists, and one US PSC. The POP/FP III Project Committee established to provide support to the previous Project will continue to also monitor the implementation of this new Project. In addition to members of HRDC/P staff, the Committee is composed of representatives from the Program Office, the Office of Project Support, the Legal Office, the Financial Management Office, the Contracts Office, the Commodities Management Office, and the Economic Affairs Staff. Further involvement of USAID senior officers will be required to place population issues more prominently on the "development agenda."

An important function of the I/GS contractor under the Project will be to design and develop a Management Information System to track activities by the Project's different implementing agencies. The I/GS Team will implement their systems in order to gather, analyze, and evaluate data regarding the activities and impact of the program, as well as ensure the timely submission and analysis of necessary reports (e.g., revenue reports, quarterly service performance statistics; vehicle and commodity reports, participant training follow-up). Information generated by this system will be readily available to USAID.

The POP/FP III Project, as a multi-component project, requires careful monitoring and evaluation to ensure effective Project management. The size and nature of the diverse components call for multiple approaches to Project evaluation. Project monitoring will provide basic indicators to Project implementation and become the basis for in-depth evaluation. Summative evaluations will assess Project impact. Formative evaluations will provide guidance for modifications and amendments to Project structure, staffing, and financing. Individualized studies from various components will be tailored to address specific management concerns or research issues.

A. Monitoring

The I/GS contractor will develop a monitoring system to track the multiple indicators in the logical framework. Computer hardware and software development for this system should employ existing institutional computer capabilities and constraints. The monitoring system will provide systematic information for Project

management as well as important references for the Project's interim and final evaluation.

B. Impact Evaluations

The Demographic and Health Surveys (DHS), scheduled for 1992 and 1996, will substantiate Project impact. These extensive surveys will provide baseline and final impact information which follows the same exacting methodology as the previous DHS of 1980, 1984 and 1988. The DHS provides the most salient and valid mechanism to measure achievement of the Project's goal and purposes

C. Interim and Final Evaluation

A formative interim evaluation will be conducted between 18 and 24 months into the Project. It will be used as the basis for modifying and amending the Project's design and individual component funding. The interim evaluation will focus on the critical points of relevance, efficiency, service delivery, IEC, institutionalization, and sustainability. These concerns include, but are not limited to

- **Service Delivery** The interim evaluation will examine quality of care in service delivery, measured in part by continuation rates, client/provider knowledge and interaction, and cost effectiveness. It will examine the service delivery system for advances in multi-method promotion, consistent supply, and increased access to target groups.
- **Efficiency:** A major thrust of the interim evaluation is to survey and analyze market segmentation to ensure that public and private resources are being used most effectively in pursuit of the Project's goal.
- **Sustainability:** Progress toward sustainability of the national family planning program will be one of the interim evaluation's primary concerns. It will analyze service costs, local support, effect of the Project on long-term sustainability of the Project's differing components, and CSI's implementation of its cost recovery strategy.
- **Institutionalization:** Institutional assessments will be conducted by the interim evaluation on the MOH/SDP, NPC, RCT, CSI, THO and MOI/SIS.
- **IEC:** The evaluation will study IEC's approach to target clients, its refinement of mass media messages, soundness of overall approach, and impact on family planning behavior.

- **Relevance** The evaluation will examine the continuing relevance of individual Project components to POP/FP III's emphasis on consolidation and the avoidance of redundancy, particularly with regard to sector mix. The role of the private sector will be examined, and its success in overcoming identified constraints will be evaluated. Continuing major constraints and recommended actions will be identified.

The final evaluation will have many of the same emphases. It will focus on documenting lessons learned over the life of Project and establish priorities for any follow-on program for funding by the GOE or other donors. To do so adequately may involve a retrospective review of the POP/FP I and POP/FP II Projects.

D. Specific Assessments and Evaluations

Individualized assessments and evaluations are required for differing elements of the individual components. These will be carried out as required by the individual components and will be designed to address specific issues and concerns. Such studies include among others, market research surveys in the evaluation of the private sector involvement, the special research activities of the NPC, and operations research in the MOH including annual cost effectiveness assessments of its family planning program.

E. Audits

All of the implementing agencies will undergo either a financial review/assessment or an audit every year. Each implementing agency will have its initial financial review/assessment during the pre-implementation phase just prior to the first year of subproject implementation and its subsequent reviews/assessments will occur in the third year of the Project. In addition, each implementing agency involved in the Project will be audited during the second and fourth years of subproject implementation.

V. SUMMARIES OF ANALYSES

A. Summary of Technical Analysis

To produce the Project outputs, POP/FP III builds on the successes of POP/FP II but utilizes a more focused and consolidated approach, emphasizing decentralization, and the reduction of redundancy. POP/FP III will continue the most successful activities and discontinue those that do not directly or effectively contribute to achieving the sector goal of reduced fertility. Selection was based on a review of factors that can be classified as technical, financial and management

1. Technical Consolidation

Based on the lessons learned which are outlined in Section I.A.5, on the technical level the POP/FP III Project concentrates on a much smaller set of subprojects, providing the type of national-level support for which USAID is best situated. The selection was based on the strategic considerations of sector mix, identified constraints, and donor advantage.

a. Sector Mix

Egypt has an active, multi-sectoral service delivery system. Two major sectors, the public and the private/commercial sectors, are active and growing in their contribution. First, the commercial sector, through pharmacies and private physicians, accounted for approximately 70 percent of all family planning services provided in Egypt in 1988. The largest part of this was supply methods (oral contraceptives), with the sector providing almost 90 percent of supply methods and serving more than half of IUD users. Second, the public sector is providing another significant portion of services (26 percent in 1988) with a reasonably effective method mix. In 1988, 74 percent of those served by the public sector reported using an IUD. The PVO sector provides the remainder of the services.

In terms of prevalence, in 1988 the private commercial sector, for all methods, contributed 25 percent toward the total prevalence of 37.8 percent, the public sector added another 9 percent, and PVO service providers and other channels added the remainder. Giving another indication of sector mix, during the year July 89 through June 90, PVOs provided 10 percent of the total couple years of protection provided during that period, compared with 65 percent provided by the Private/commercial sector and 25 percent provided by the public sector, using CYPs adjusted for use effectiveness and prevalence/distribution data

The investment strategy for A I D donor resources to assist the GOE in achieving its fertility objectives calls for assisting the largest sectors in the program with strategic resources, since those entities can deliver services on a scale large enough to achieve the greatest impact in fertility reduction. Depending on the sector, the actual amount of resources required may be small or large based on need determination.

However, planning for the Project has been greatly concerned with the need to refine market segmentation by identifying the groups of consumers which each sector intends to serve and the methods which the sectors can appropriately supply to their target client groups.

Private Sector - The private/commercial sector in Egypt is the largest provider of family planning services, and as such should take priority. But, by its very nature as a non-public mechanism, the private/commercial sector is not amenable to the same controls and accountability as are publicly-supported sectors. There is no direct control mechanism to ensure that service volume is maintained or that service quality is high. Likewise, channels through which to feed key inputs such as training are indirect, through professional associations, etc. This is in contrast to the public and PVO service provider sectors, where inputs can be channeled through staff development. The result of this is that the Project can have more control and assurance of its ability to bring about results in the public-supported sectors which account for less than one third of all services provided, than the private/commercial sector which contributes more than two thirds.

While Project assistance to the private/commercial sector may be indirect and structurally more difficult, the size of the sector's participation in family planning service delivery makes the effort mandatory. On the other hand, the amount of resources required from donors to assist the private, commercial sector, even on a priority basis, is small. Because the private/commercial sector sustains its own activities through consumer payments for goods and services received, Project funding assistance to the sector can be limited to relatively small amounts, primarily for training and technical assistance in strategically important areas. However, attention should also be directed at the policy level in order to ensure that the sector has unconstrained access to affordable contraceptives -- especially IUDs.

Under no circumstances, however, should activities under the Project increase or cause to increase the presence of public sector control and/or management of private/commercial sector activities. Such public constraints on private operations have already been identified as the major obstacle to increased effective involvement of the private sector in family planning

service delivery in Egypt. Nor should any activities increase subsidization of this sector, which in turn constrains Egypt's long term prospects for sustainability.

Public Sector - Public sector, i.e., MOH, service expansion will come through more intensive utilization of existing clinics, i.e. facilities in place. The MOH clinics reportedly operate at an estimated 65 percent capacity. Field observations indicate that utilization may in fact be much lower, even in the more active sites. With no further investment in buildings, personnel, equipment or other costly inputs, it is reasonable to assume that increased prevalence can be achieved by motivating women to utilize the existing clinics. Use of the private pharmacies and private physicians can also be further stimulated by IEC.

The MOH system of clinics and hospitals will be the primary focus for Project assistance to the MOH. The smaller THO network will also be included.

PVOs - It is generally assumed that PVOs which provide family planning services, serve low income and underserved segments of the general population. PVO service providers' inherent access to low income, geographically remote, or culturally isolated sub-groups makes them especially attractive to family planning strategists who seek established networks for delivering services to these potential clients. Although the community based efforts of the PVOs play an important role in legitimating family planning in the eyes of the communities, their contribution to contraceptive prevalence in Egypt is quite low. However, in several Upper Egypt governorates with the hardest-to-reach populations, the Clinical Services Improvement (CSI) Project of the Egyptian Family Planning Association (EFPA) contributes a sizeable share of the CYP attributed to all public and PVO clinics. Therefore, under the strategic approach adopted by POP/FP III, support will only be continued to CSI.

The very existence of CSI has reportedly placed "upward pressure" on the MOH, motivating interest in improving publicly-funded family planning services. In the case of CSI, the quality of care provided to its clients is quite high and appears to be proportional to the dollar amount of donor funding which it receives. Although the amount of donor funding for TA and core support required to attain this level of service prevents the CSI system from being used as a direct model for the MOH or private practice physicians, the presence of CSI in the marketplace has provided some upward pressure on other service providers such as the MOH to improve the level of quality of their services insofar as is possible.

b. Constraints

Assessments of family planning activities have identified several areas of activity for dealing with constraints to the expansion of availability and quality of family planning services.

Service Delivery - Three tasks need to be accomplished in order for the Project to achieve its purpose of increasing the level and effectiveness of contraceptive use. (1) Greater service coverage is required because of the growing number of MWRA. (2) The effectiveness of contraceptive use requires improvements in service quality and family planning knowledge, especially with respect to the counseling provided to women who select the oral contraceptive and the training of physicians in IUD insertion. Current trends in the method mix are expected to continue leading to increased dependence on the IUD; these trends will contribute positively to increasing average use-effectiveness. (3) The Project will need to reach underserved groups.

To accomplish these three tasks, POP/FP III will undertake activities in those areas where it has a comparative advantage, notably implementation of service standards and quality assurance procedures, introduction of new contraceptives, operations research, mass media and local IE&C.

Commodity Provision - A different strategy for contraceptive commodity provision under POP/FP III is proposed to increase the level and effectiveness of contraceptive use. Under the Project, a number of changes will be made in both the contraceptive methods supplied by USAID and in the distribution mechanisms used. These changes are being instituted to increase the strategic value of USAID's resources, to increase prevalence among groups who might otherwise not have access to contraceptives, and to increase the effectiveness of methods offered. In POP/FP III, USAID plans to provide IUDs, condoms, and NORPLANT contraceptive supplies to the public sector and to PVOs supported by the Project. There will be increased targeting in providing these subsidized supplies to lower income women and those in hard to reach groups. POP/FP III will also work toward removing GOE policy and regulatory constraints which are impeding more active for-profit, private sector involvement in family planning service delivery. It is the current belief that USAID's withdrawal from providing subsidized contraceptive commodities to the for-profit private sector will not significantly decrease availability of these commodities. In fact, it will most probably positively affect the expansion of supply channels for these commodities, thereby ensuring greater sustainability.

Management - POP/FP III will assist the GOE in strengthening the institutional sustainability of organizations involved in providing family planning support and services. Strengthened management capacity is key to achieving and sustaining quality

standards in the provision of care. Under POP/FP II, management systems are being established in the MOH, THO, CSI, NPC and in the Ain Shams University training facility and its affiliated satellite training centers. These systems will need continued assistance. Information management will be key to the support of an increasingly sustainable and cost-effective family planning program.

Collaboration among organizations providing family planning services has been and continues to be a problematic area for Egypt's national family planning program. Competition is more the norm. While some competition can increase productivity, excessive competition leads to counterproductive activities. Project activities are intended to enhance collaboration. Focussing and consolidating USAID support will strengthen the national program by eliminating duplication of effort and resources, for example, in provider training.

Research - POP/FP III will build on the research institutions and grant mechanisms put in place under previous POP/FP projects. Increased emphasis should be placed on disseminating research results (in Arabic where possible and feasible) to policy-makers and program managers. Support for research proposals from Egyptian researchers should be a priority.

Policy Dialogue - The long term impact of the GOE's current regulatory environment on family planning is not well understood among key policy-makers. Without awareness of the negative consequences of regulatory constraints, there is no constituency of supporting reform. To achieve maximum impact over the longer term on effective contraceptive use, policy and regulatory constraints to the expanded supply of and demand for family planning services must be eliminated. Major areas of concern identified are sustainability, subsidization, and availability of contraceptives. Eventually, policy reform will be required. Although the Project does not directly incorporate a policy dialogue component, it will provide greater support to the Mission's policy dialogue objectives and give priority to analysis and special studies that will provide Egyptian decision makers with better information on key current constraints for Egypt.

c. Donor Advantage

One of the challenges for family planning programs in Egypt at this time is to identify multiple sources for contraceptives as well as to leverage donor and private resources through currency conversion and corporate donations. Comparative strengths of donor organizations to support the various sectors must be identified, as the sectors may have greater or lesser need for technical assistance and budget support from donor agencies, and the donor agencies may be more or less well situated to support

the various needs. The major donors in Egypt with respect to population and family planning are USAID and UNFPA.

At present, USAID is the principal donor of contraceptive commodities to Egypt. It supplies primarily IUDs and condoms to both the public and private sectors. Also, a limited amount of oral contraceptives is provided to the private sector under USAID auspices. The UNFPA is providing injectable contraceptives (which USAID is unable to supply due to US restrictions), Lippes Loop IUDs, and Neosampon vaginal foaming tablets

USAID has a comparative advantage in supporting the MOH, due to past successful initiatives, and USAID's strategic orientation to invest its resources where large scale gains can be made. UNFPA, while judging population the top priority in Egypt, plans to fund little in family planning service delivery, in view of USAID's plan to continue as a major donor.

The International Planned Parenthood Federation (IPPF) has considerable expertise and resources available for support and enhancement of family planning service delivery through its member organizations. It should certainly be expected to be the primary support for its Egyptian affiliate, the EFPA. The Project will therefore limit its support to the EFPA/CSI Project begun under POP/FP II

2. Financial Consolidation

In population and family planning activities, the financial challenge in Egypt now is to consolidate and increase efforts to achieve sustainability. Total service costs, including the cost to the donor, need to be reduced through better management and program efficiency. Further, local support for service should increase

The total system costs in a consolidation stage program are large and will grow rapidly as both the population and contraceptive prevalence increase. Thus it is imperative that public sector resources (both donor and host country) are invested where they will have the most impact and that other sectors function at optimal levels in terms of maximum prevalence and user effectiveness in their target markets

This financial consolidation is manifested in a number of ways, the most obvious being the fewer number of subprojects. In addition, nearly all the implementing agencies will be receiving a slightly smaller average annual allocation than under the previous project. It should be noted that this financial consolidation does not necessarily reflect a decrease in resources, but rather a shift in resource responsibility from USAID project support to other sources (e.g., the GOE or commercial suppliers and distributors). There is also a

substantial reduction and redirection of the distribution of contraceptive commodities

PVOs rely on government and donor allocations while the private/commercial sector relies on client payments to meet service delivery costs. No direct allocation of public resources is needed for the private/commercial sector. There is need to encourage and possibly expand the private/commercial sector through favorable regulations, education opportunities and an assured supply of contraceptives.

3. Management Consolidation

With the proliferation of subprojects, and the current technical and financial monitoring requirements, POP/FP II grew to be a serious management burden to the USAID technical office. Taking this into consideration, the design of POP/FP III reduces the number of subprojects from 23 to eight, and includes the procurement of TA/management services, which will provide resident advisors and short-term consultants to assist the GOE implementing agencies to meet their project responsibilities in accord with USAID regulations. The contractor will provide day to day technical advice, routine troubleshooting, and assistance in reporting to meet AID requirements.

B. Summary of Financial Analysis

The analysis of financial considerations for the POP/FP III Project focuses on detailed cost estimates, based on standard input costs, and estimates of the host-country contribution. In addition, the financial analysis provides an overview of concerns related to CSI's prospects for cost recovery.

From a financial perspective, the POP/FP III Project is substantially more consolidated than was the POP/FP II Project. This consolidation is manifested in several ways: (1) USAID is working with fewer subprojects; (2) There is a general reduction in programmed support; (3) There is a substantial reduction and redirection of the distribution of contraceptive commodities; (4) There is a consolidation in the provision of technical assistance, with all resident expatriate TA being channeled through the I/GS contract to be awarded before Project implementation. Overall, through the strategic approach chosen for Project design and the management option selected, the POP/FP III Project is likely to be far more efficient than earlier projects in the conversion of inputs to Project outputs over its lifetime.

C. Summary of Economic Analysis

The negative economic and social consequences of population pressure in Egypt provide strong indications that both the GOE and USAID/Egypt should continue substantial investments in family planning activities. Evidence on the gap between job creation and the number of labor force entrants, and growing food imports, suggests that rapid population growth is a key constraint on economic expansion. Given current economic difficulties, including reductions in real output and rapid inflation, it is extremely improbable that the GOE will be in a position to support its national family planning program at the necessary level during the coming five years. Substantial donor contributions are warranted and needed during this time, as they have been in the past

Currently, the family planning program is heavily dependent on donor support, particularly from USAID. Design of the POP/FP III Project, while focusing on demographic impact, has taken sustainability (and, in the longer term, self-sufficiency) considerations into account. This includes the following resource projections as part of TA to the NPC, development of institutional capabilities; opportunities for evaluation of cost-effectiveness of different service approaches, focus on increasing the role of the private commercial sector; reduced and targeted provision of contraceptive commodities; and limited, cost-recovery experimentation

It is recommended that two general types of data be collected within the context of the POP/FP III Project. The first is information on the cost and cost-effectiveness of providing services, needed to help the government and donors better allocate their resources. The second is information on consumer characteristics and behavior. Such information is critical to developing cost recovery initiatives, assessing the potential for expansion of the private sector, and determining the effect of release of price controls on contraceptive products

D. Summary of Social Soundness and Women in Development Analysis

This analysis reviews barriers to family planning and fertility reduction in Egypt, including early age of marriage and first birth; high rates of illiteracy, especially among women, disapproval of family planning in conservative and rural areas; high value placed on children; and low status of women, with prestige largely derived from childbearing

The many socio-cultural factors which support family planning and fertility reduction in Egypt are also examined. These include vigorous support for family planning among political, religious and community leaders, an accessible population with a common

language and history; an extensive public and private health care infrastructure; and an effective IEC campaign aired frequently on prime time national television. These factors have contributed to a change in childbearing attitudes among Egyptian women. The 1988 DHS results indicated that the mean ideal family size among women had fallen to 2.9 children, and that over one-third of women expressed a preference for a two-child family.

Family planning services in Egypt are widely available from both public and private sector providers. POP/FP III will continue to support family planning activities utilizing the health delivery system of the MOH. This will have the greatest impact in rural areas, especially Upper Egypt, and among the urban poor. In addition, Project activities will further strengthen the private commercial sector's contribution to the overall Egyptian national family program. POP/FP III provides opportunities for increased participation by women. Public and private sector service providers will be trained in family planning clinical and counseling skills and pharmacists will receive training to strengthen their performance as family planning service providers. Special efforts will be made to ensure that female practitioners and pharmacists from various geographic areas are included in these activities.

The Project's most immediate beneficiaries will be the current and new family planning acceptors (primarily women) who will receive more accessible and higher-quality care. Secondary beneficiaries include family planning managers and service providers whose employment options and practices will increase.

E. Summary of Institutional and Administrative Analysis

The institutional and administrative analyses are combined to review briefly the characteristics and administrative capacity of the implementing agencies to be funded by the POP/FP III Project. The consolidation of the POP/FP III Project reduces the number of implementing agencies receiving USAID support for population and family planning purposes to four. They are: the National Population Council (NPC), Ministry of Health (MOH), Ministry of Information (MOI), and Ministry of Social Affairs (MOSA).

The NPC was designated in 1985 by Presidential decree as the special purpose body responsible for coordination and policy definition in population and family planning. It continues to develop into its major role in policy analysis and coordination. Two long-term resident advisors (one in management and one in research) appear appropriate if the current administrative issues are to be resolved by the end of POP/FP III.

Since 1988 the MOH has been developing a more comprehensive uniform approach to family planning service delivery. Although

it has made important gains, more time and TA are needed to realize fully these gains. The MOI has demonstrated sound administrative capacity during POP/FP II and a similar level of function is anticipated during POP/FP III. The MOSA has been less satisfactory administratively than other implementing agencies, due in part to the administrative relationship between MOSA and the PVOs and NGOs it funds. POP/FP III support will be directed to only one organization, the Clinical Services Improvement Project (CSI) of the EFPA. CSI has demonstrated strong administrative capabilities during POP/FP II.

The activities under POP/FP II have provided focus and administrative strength to the Egyptian institutions so as to enhance their capacity to handle the management burden for family planning services. The POP/FP III Project builds directly on POP/FP II, therefore, implementing agencies will be using similar approaches and skills. During POP/FP III, USAID must safeguard against Project assistance intended to improve or upgrade an existing organization taking on a life of its own, independent of the organization it was designed to strengthen

VI. CONDITIONS PRECEDENT

A. Contraceptive Commodities

Prior to any disbursement of Project funds for the procurement of Contraceptive Commodities, USAID and the GOE will agree to the mechanism for distribution of the commodities, i.e., either to continue to use the EPTC as a distributor for the donated contraceptives, provided the cost is borne by the GOE, or to contract the service to a private sector distributor.

B. Overall Four-Year Implementation Plans

Prior to disbursement of Project funds for the implementation of a particular subproject under an implementing agreement (PIA) with an implementing agency, each implementing agency, with assistance provided by the I/GS contractor, must develop an overall Four-Year Implementation Plan for the entire grant period, with a Detailed Implementation Plan for the first year. This Four-Year Implementation Plan will include a detailed equipment procurement plan supported by the necessary specifications. NO commodities will be procured under a subproject until USAID approves its commodity procurement plan, unless USAID agreed otherwise in writing. The Four-Year Implementation Plan will also include participant and in-country training plans for the relevant subproject in accordance with Mission Order 10-1. No training will be carried out under a subproject until USAID approves its training plan, unless USAID agrees otherwise in writing.

C. Subsequent Detailed Implementation Plans

Prior to each subsequent year's disbursement of Project funds, the implementing agency, with assistance from the I/GS contractor, will develop a Detailed Annual Implementation Plan for that year's activities, for AID's approval.

D. GOE Premium Pay

Prior to each year's disbursement of Project funds, the implementing agency will present evidence, satisfactory to USAID, that the GOE has made available, through its resources, funds to cover normal GOE premium pay (AGR-IDAFI) for the relevant implementing agency management and technical staff (central, governorate, and district level as appropriate) in order to provide for smooth implementation of the family planning subprojects.

VII. ANNEXES

ACTION MEMORANDUM TO THE DIRECTOR

FROM: Robert Jordan, OD/PDS/PS
THRU Christopher Crowley, AD/PDS
SUBJECT Approval of Population and Family Planning III PID
DATE September 15 , 1991

PROBLEM:

Your signature is required approving the Project Identification Document for the Population and Family Planning III Project (263-0227) for \$62 million.

DISCUSSION:

An Executive Committee Review of the Population and Family Planning III PID was held on August 26, 1991. The Executive Committee recommendation was to accept the Project design as presented in the PID in principle, but requested some modification to the document itself. There are no outstanding issues and the changes have been incorporated into the PID document.

Policy and/or Regulatory Reform - The Executive Committee confirmed the Project Committee's decision to exclude a policy based performance disbursement component at this time, and pointed to the possibility of using the Project as leverage on policy issues. However, the Executive Committee directed the Project Committee to narrow the scope of the policy component to issues that are critical, and pointed to cost recovery, subsidization, and a private sector emphasis. Section III D.5 has been rewritten to focus on cost recovery, availability of adequate contraceptive supplies, and subsidization, while highlighting the impact of these issues on the private sector. The rest of the PID has been reviewed with an eye to shifting the document's emphasis from policy reform to a balanced consideration of the Project's other equally important components.

Subprojects - The Executive Committee was concerned by the apparent lack of specificity regarding which of the current twenty-three subprojects would be continued under the new project. Section III.E 2 has been expanded substantially to include a short description of each of the subprojects to be considered during the PP design.

Level of Contraceptive Support - The Executive Committee endorsed

the need to target contraceptive support to the poor; however, it requested that the main points of the Committee discussion (i.e., targeting the poor, insignificant use of condoms, GOE reaction, possible siphoning off of supplies) be clarified in the document, and that necessary controls be incorporated into the distribution system. Section III D 2 has been completely reworked to reflect these changes.

Salary Supplements - The Executive Committee determined that this issue is larger than the project under discussion. The Deputy Director was instructed to chair a committee comprised of representatives of PDS, FM, LEG in order to explore the issue in more depth and define a Mission position.

National Population Council - Although it was accepted that the Secretariat's position with the GOE contributed to its weak performance as policy coordinator, the Executive Committee concluded that it was not advantageous for USAID to push for a change in NPC's status.

Source of Funds - The Executive Committee agreed to include all of the USAID Project costs in the authorization level for appropriated funds, with the understanding that this Project would be subject to subsequent review in this matter if the need were to arise. The Project Committee was further instructed to take a close look at the funding levels proposed for each line item, and to tighten up the budget if possible, while still maintaining the level of activity proposed in the Project. The PID budget has now been revised to reflect this change to a LOP level of \$62 million.

Second Generational Problems - The Executive Committee suggested that the PID should include a more detailed discussion of second generational problems, and thereby provide a better justification for the continuing level of TA under the Project. This discussion has been incorporated into Section III.A.3.

PVO Family Planning Activities - The references to the PVO project in the PID have been rewritten to reflect its use as a management model, and all references to transferring family planning activities to that project have been deleted.

Rationale - A statement concerning sustainable economic growth has been included in Section I B.

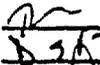
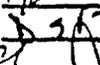
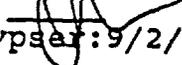
JUSTIFICATION:

The PID has now been reviewed by the Project and Executive Committees, and all necessary clearances have been obtained. STATE 257554 date 6 AUG 91 redelegates PID approval authority for the Mission for the Population and Family Planning III Project.

RECOMMENDATION:

That you sign the face sheet of the attached Population and Family Planning III PID to indicate your approval of the document.

Clearance:

OD/HRDC/P, CCarpenter-Yaman 
AD/HRDC, DMiller 
AD/FM, DFranklin 
LEG, TCarter 
DDIR, GWachtenheim 
(Drafted:PDS/PS:BCypser:9/2/91:P\POPISS)

2 COUNTRY/ENTITY
 Egypt

3 PROJECT NUMBER
 263-0227

4 BUREAU/OFFICE
 Near East A Symbol NE B Code 03

5 PROJECT TITLE (maximum 40 characters)
 Population/Family Planning III

6 ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION

A. Initial FY 92
 B. Final FY 97
 C. PACD 97

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

FUNDING SOURCE		LIFE OF PROJECT
A. AID		62,000
B. Other U.S.	1	
	2	
C. Host Country		940
D. Other Donor(s)		
TOTAL		62,940

8 PROPOSED BUDGET AID FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. 1ST FY		E. LIFE OF PROJECT	
		1 Grant	2 Loan	1 Grant	2 Loan	1 Grant	2 Loan
(1) ESF	489	490		10,000		62,000	
(2)							
(3)							
(4)							
TOTALS				10,000		62,000	

9 SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)
 440 444

10 SECONDARY PURPOSE CODE

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

A. Code BRW BIW
 B. Amount

12 PROJECT PURPOSE (maximum 480 characters)

To increase the level and effectiveness of contraceptive use among married couples of reproductive age

13 RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff
 1 USDH (approx 6 weeks)
 1 FSN (approx 6 weeks)

Funds
 \$170,000 to finance approximately 34 person weeks of TA for PP design, and 6 person weeks for pre-PP studies

14 ORIGINATING OFFICE CLEARANCE
 Signature Henry H Bassford
 Title Mission Director, USAID
 Date Signed MM DD YY

15 DATE DOCUMENT RECEIVED OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
 MM DD YY

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

17 COMMENTS

18 ACTION APPROVED BY
 Signature Henry H Bassford
 Title Mission Director USAID

19 ACTION REFERENCE

20 ACTION DATE
 MM DD YY
 01/15/91

2. Logical Framework

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p><u>GOAL</u></p> <p>To assist the Government of Egypt in achieving the goal of lower fertility</p>	<p>Reduction in TFR from 4.1 in 1992 to 3.5 in 1997</p>	<p>Demographic and Health Survey</p>	<p>1 Confirmation of TFR of 4.1 by 1992 DHS</p> <p>2 Age at first marriage remains constant or rises due to greater adherence to law</p> <p>3 Breast feeding practice (extent, duration, and prevalence) remains constant</p> <p>4 Socio-political and economic conditions continue to favor lower fertility</p>
<p><u>PURPOSE</u></p> <p>To increase the level and effectiveness of contraceptive use among married couples</p>	<p>1 Increase in contraceptive prevalence from 48.5% in 1992 to 53% in 1997</p> <p>2 Decrease in extended use failure rate from 13% in 1988 to 5% in 1997</p>	<p>Demographic and Health Survey</p> <p>FP Service statistics</p> <p>Special studies</p>	<p>1 1992 DHS confirms contraceptive prevalence rate of 48.5%</p> <p>2 Population and family planning remain a high priority for GOE</p> <p>3 Family Planning services continue to improve in quality and to gain acceptance among Egyptians</p>

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p><u>OUTPUTS</u></p> <p>1 Increased service volume and improved service quality</p>	<p>1 Contraceptive Commodities (IUDs NORPLANT Condoms) distributed Estimated CYP increased from 4.1 million in 1992 to 5.18 million in 1997</p> <p>2 Effective IEC program in place TA spots brochures promotional displays other media presentations undertaken National Communication Strategy developed and implemented Agency communications/outreach strategy developed and implemented in implementing agencies IEC staff in implementing agencies upgraded through training</p> <p>3 Training capability increased and service providers trained a 120 training staff upgraded b Service providers trained in improved service delivery and counseling with preference given to women and private physicians</p> <p>Basic training given to 8 700 MOH physicians/nurses 600 private sector physicians 4 000 private sector pharmacists 880 specialists 1 600 governorate staff and 480 CSI physicians/nurses/staff</p> <p>Refresher training given to 3 200 MOH physicians/nurses and 480 CSI physicians/nurses/staff</p> <p>Family Planning Diploma received by 16 physicians</p> <p>--Participant training undertaken by 60 participants</p> <p>4 Curriculum component in population science and/or family planning developed for use in medical and pharmacy schools</p> <p>5 Updated sector specific family planning protocols disseminated</p> <p>6 MOH operations research agenda developed and implemented</p> <p>7 CSI functioning on a sustainable basis</p>	<p>1 CIIS Report, implementing agency service statistics cost/CYP studies</p> <p>2 Quarterly progress reports and impact studies</p> <p>3 Training records with names gender and locations</p> <p>4 Curriculum unit developed</p> <p>5 Existence and dissemination of protocol site visits</p> <p>6 Evaluation Studies completed</p> <p>7 Quarterly Progress Reports financial and revenue reports</p>	<p>1 Cost/CYP study confirms 4.2 level in 1991 in the meantime, in setting this target, it is assumed that estimated contraceptive users derived from contraceptive prevalence rates can be used as a proxy for CYP</p> <p>2 Population Strategy Targets based on PAPCHILD results will be confirmed by the 1992 DHS</p> <p>3 Trained providers will work in FP follow guidelines, and offer improved and more acceptable service</p> <p>4 Television air time continues to be free and GOE continues its liberal approach to message content</p> <p>5 Improved quality of care has an immediate and direct positive impact on continuation rates and use effectiveness</p> <p>6 MOH incentive system remains in place and the GOE will fund normal GOE premium pay for GOE implementing agencies</p>

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
	<p>8 Private Sector Special Activities, such as conferences and workshops, planned and implemented "Physicians Desk/Pocket Reference" developed and broadly disseminated</p>	<p>8 Site visits and reports</p>	
<p>2 Improved information for policy makers</p>	<p>1 NPC Research Management Unit (RMU) strengthened</p> <ul style="list-style-type: none"> a RMU organizational structure established b Research priorities and protocols established c 12 Biomedical Research studies and 12 Programmatic Research studies undertaken <p>2 Functional, well organized resource center for FP and population research established</p> <ul style="list-style-type: none"> a Library Resource Manager trained and library services upgraded b Improved NPC data bank and library, as well as increased access <p>3 Increased availability of research results to program implementers and policy makers At least four national forum (one per year) held by NPC to discuss national policies and regulations related to population growth and family planning service delivery</p> <p>4 Four secondary analyses of 1992 DHS and other comparative analyses undertaken</p> <p>5 Governorate level NPC strengthened</p> <ul style="list-style-type: none"> a 540 governorate level staff trained in management, planning, computer use and analysis of FP data b Governorate staff capabilities strengthened through planning, implementing and evaluating Governorate Special Activities including local conferences planning meetings or other activities at governorate level NPCs c 21 governorate level conferences held to facilitate family planning dialogue 	<p>1 Committee records, documentation of procedures, research funded</p> <p>2 Site visits and reports</p> <p>3 Conference proceedings</p> <p>4 Reports/ Studies</p> <p>5 Training records, Quarterly Progress Reports, conference proceedings</p>	<p>1 Sufficient research capability exists in Egypt to complete required studies</p> <p>2 Appropriate policy level individuals will participate in conferences</p> <p>3 Studies will be conducted on priority regulatory and policy constraints to family planning</p>

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p>3 Improved management capacity in implementing agencies</p>	<p>1 SDP operations manual produced, distributed and implemented</p> <p>2 Improved utilization of the MOH contraceptive commodities tracking system</p> <p>3 Refined MIS collection systems information flow and their management relevance</p> <p>4 Implementing agencies produce comprehensive timely annual plans (including governorate levels and below as appropriate)</p> <p>5 NPC produces and distributes a Strategic Plan for population and IP in Egypt based on service data research, and national policy</p>	<p>1 Manual distributed</p> <p>2 Procurement and distribution records</p> <p>3 Timely availability of interpreted data</p> <p>4 Annual plans produced and distributed</p> <p>5 Strategic Plan disseminated</p>	<p>1 The GOE remains committed to decentralization</p> <p>2 Technical capacity for immediate supervisory functions exists at governorate level</p> <p>3 MOH guidelines on policy and procedures completed in POP/FP II for all ten SDP systems</p> <p>4 MOH managers use operations reference manual</p>
<p>INPUTS</p> <p>Contraceptives</p> <p>I/GS contract (includes long and short-term TA, participant training, invitational travel, special assessments, private sector initiatives, and non contraceptive commodity procurement)</p> <p>Local Costs of Implementing Agencies (MOH NPC MOI, MOSA)</p> <p>Evaluation, audits and specialized buy ins</p> <p>TOTAL</p>	<p>(\$000)</p> <p>7,484</p> <p>27,903</p> <p>23,958</p> <p><u>2,655</u></p> <p>\$62,000</p>	<p>Project records and reports</p>	<p>1 GOE is willing to accept TA inputs</p> <p>2 Availability of contraceptives in the private sector will continue and expand without USAID support</p>

3. Statutory Assistance Checklist

Listed below are statutory criteria applicable to the assistance resources themselves, rather than the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCES	IS COUNTRY CHECKLIST UP TO DATE?	Yes
A CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS		
1	Host Country Development Efforts (FAA Sec 601(a)) Information and conclusions on whether assistance will encourage efforts of the country to	
	a) increase the flow of international trade,	No
	b) foster private initiative and competition,	Project will promote private organizations's participation in family planning activities primarily through training and will encourage policy reform to remove constraints to an expanded private sector
	c) encourage development and use of cooperatives credit unions, and savings and loan associations	No
	d) discourage monopolistic practices	No
	e) improve technical efficiency of industry agriculture and commerce, and	No
	f) strengthen free labor unions	No
2	U S Private Trade and Investment (FAA Sec 601(b)) Information and conclusions on how assistance will encourage U S private trade and investment abroad and encourage private U S participation in foreign assistance programs (including use of private trade channels and the services of U S private enterprise)	U S private enterprise will be a source of procurement of goods and services required for this project
3	Congressional Notification	
	a General requirement (FY 1991 Appropriations Act Secs 523 and 591 FAA Sec 634A) If money is to be obligated for an activity not previously justified to Congress or for an amount in excess of amount previously justified to Congress has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)?	Standard Congressional Notification procedures will be satisfied prior to obligation of funds

ANNEX 3
STATUTORY CHECKLIST

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| b | Notice of new account Obligation (FY 1991 Appropriations Act Sec 514) If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures? | N/A |
| c | Cash transfers and nonproject sector assistance (FY 1991 Appropriations Act Sec 575(b)(3)) If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used with a discussion of U S interests to be served and a description of any economic policy reforms to be promoted? | N/A |
| 4 | Engineering and Financial Plans (FAA Sec 611(a)) Prior to an obligation in excess of \$500,000 will there be (a) engineering financial or 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 |
| 5 | Legislative Action (FAA Sec 611(a)(2)) If legislative action is required within recipient country, with respect to an obligation in excess of \$500,000 what is the basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? | No such action is required |
| 6 | Water Resources (FAA Sec 611(b) FY 1991 Appropriations Act Sec 501) If project is for water or water related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U S C 1962 <u>et seq</u>)? (See AID Handbook 3 for guidelines) | N/A |
| 7 | Cash Transfer and Sector Assistance (FY 1991 Appropriations Act Sec 575(b)) Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)? | N/A |
| 8 | Capital Assistance (FAA Sec 611(e)) If project is capital assistance (e.g., construction), and total U S assistance for it will exceed \$1 million has the Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? | Not such a project |
| 9 | Multiple Country Objectives (FAA Sec 601(a)) Information and conclusions on whether projects will encourage efforts of the country to (a) increase the flow of international trade (b) foster private initiative and competitions (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 | Project will promote private organizations's participation in family planning activities primarily through training and will encourage policy reform to remove constraints to an expanded private sector role |

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| 10 | U S Private Trade (FAA Sec 601(b)) Information and conclusions 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) | U S private enterprise will be a source of procurement of goods and services required for this project |
| 11 Local Currencies | | |
| a | Recipient Contributions (FAA Secs 612(b), 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 in lieu of dollars | The GOE contribution is LE 22 6 million in cash and LE 41 7 million in-kind, and should cover salaries, normal GOE premium pay, incentives, host country costs for participant training, radio and television air time, contraceptives and operation and maintenance costs |
| b | U S -owned Currency (FAA Sec 612(d)) Does the U S own excess foreign currency of the country and if so, what arrangements have been made for its release? | No |
| c | Separate Account (FY 1991 Appropriations Act Sec 575) If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies | |
| | (1) Has AID (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of AID and that government to monitor and account for deposits into and disbursements from the separate account? | Yes Such arrangements have been made under POP/FP II for revenues generated through sales of contraceptives USAID will renew the necessary agreements under this project |
| | (2) Will such local currencies or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government? | Yes |
| | (3) Has AID taken all appropriate steps to ensure that the equivalent of local currencies disabused from the separate account are used for the agreed purposes? | Yes |
| | (4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government? | Yes |
| 12 Trade Restrictions | | |
| a | Surplus Commodities (FY 1991 Appropriations Act Sec 521(a)) If assistance is for the production of any commodity for export is the commodity likely to be in surplus on world markets at the time the resulting | N/A |

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productive capacity becomes operative and is such assistance likely to cause substantial injury to U S producers of the same, similar or competing commodity?

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| b | Textiles (Lautenberg Amendment (FY 1991 Appropriations Act Sec 521(c)) Will the assistance (except for programs in Caribbean Basin Initiative countries under U S Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U S-made components) be used directly to procure feasibility studies, pre-feasibility studies or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U S exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person) work gloves or leather wearing apparel? | No |
| 13 | Tropical Forests (FY 1991 Appropriations Act Sec 533(c)(3)) Will funds be used for any program project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas? | No |
| 14 | PVO Assistance | |
| a | Auditing and registration (FY 1991 Appropriations Act Sec 537) If assistance is being made available to a PVO has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A I D , and is the PVO registered with A I D ? | Yes Indigenous PVO through Host Country arrangement |
| b | Funding sources (FY 1991 Appropriations Act Title II, under heading Private and Voluntary Organizations") If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? | Funding is not to US PVOs |
| 15 | Project Agreement Documentation (State Authorization Sec 139 (as interpreted by conference report)) Has confirmation of the date of signing of the project agreement including the amount involved been cabled to State L/T and A I D LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3 Appendix 6G for agreements covered by this provision) | Case Zablocki Act reporting procedures will be followed with respect to this project |
| 16 | Metric System (Omnibus Trade and Competitiveness Act of 1988 Sec 5164, as interpreted by conference report amending Metric Conversion Act of 1975 Sec 2, and as implemented through AID policy) Does the assistance activity use the metric system of measurement in its procurements, grants and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in | Yes |

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metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will AID specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

- | | | |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 17 | Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development") Will assistance be designed so that the percentage of women participants will be demonstrably increased? | The Project will encourage more active participation by women
Desegregated data on participation of women in Project activities will be collected |
| 18 | Regional and Multilateral Assistance (FAA Sec 209) Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs | No Population sector assistance is multifaceted and is not susceptible to execution as a functional regional or multilateral project Impact will be country specific |
| 19 | Abortions (FY 1991 Appropriations Act, Title II under heading "Population, DA," and Sec 525) | |
| a | Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? | No |
| b | Will any funds be used to lobby for abortion? | No |
| 20 | Cooperatives (FAA Sec 111) Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life? | N/A |
| 21 | U S -Owned Foreign Currencies | |
| a | Use of Currencies (FAA Secs 612(b), 636(h), FY 1991 Appropriations Act Secs 507, 509) Describe steps taken to assure that, to the maximum extent possible foreign currency owned by the U S are utilized in lieu of dollars to meet the cost of contractual and other services | N/A US-owned Egyptian currency is not available for this Project |
| b | Release of Currencies (FAA Sec 612(d)) Does the U S own excess foreign currency of the country and, if so what arrangements have been made for its release? | No |
| 22 | Procurement | |
| a | Small business (FAA Sec 602(a)) Are there arrangements to permit U S small business to participate equitably in the furnishing of commodities and services financed? | Yes |
| b | U S procurement (FAA Sec 604(a)) Will all procurement be from the U S except as otherwise | Yes |

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- determined by the President or determined under delegation from him?
- c **Marine insurance (FAA Sec 604(d))** If the cooperating country discriminates against marine insurance companies authorized to do business in the U S , will commodities be insured in the United States against marine risk with such a company? Egypt does not so discriminate
- d **Non U S agricultural procurement (FAA Sec 604(e))** If non-U S procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U S) N/A
- e **Construction or engineering services (FAA Sec 604(g))** Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries) N/A
- f **Cargo preference shipping (FAA Sec 603)** Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers dry cargo liners, and tankers) financed shall be transported on privately owned U S flag commercial vessels to the extent such vessels are available at fair and reasonable rates? 50/50 shipping rules will apply to this project
- g **Technical assistance (FAA Sec 621(a))** If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes
- h **U S air carriers (International Air Transportation Fair Competitive Practices Act 1974)** if air transportation of persons or property is financed on grant basis will U S carriers be used to the extent such services is available? Yes
- i **Termination for convenience of U S Government (FY 1991 Appropriations Act Sec 504)** If the U S Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? Yes

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| j | Consulting services (FY 1991 Appropriations Act Sec 524) If assistance is for consulting service through procurement contract pursuant to 5 USC 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? | Yes |
| k | Metric conversion (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec 2, and as implemented through AID policy) Does the assistance program use the metric system of measurement in its procurements grants and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will AID specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage? | Yes |
| i | Competitive Selection Procedures (FAA Sec 601(e)) Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? | Yes |
| 23 | Construction | |
| a | Capital project (FAA Sec 601(d)) If capital (e.g., construction) project will US engineering and professional services be used? | N/A |
| b | Construction contract (FAA Sec 611(c)) If contracts for construction are to be financed will they be let on a competitive basis to maximum extent practicable? | N/A |
| c | Large projects, Congressional approval (FAA Sec 620(K)) If for construction of productive enterprise, will aggregate value of assistance to be furnished by the US not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? | N/A |
| 24 | US Audit Rights (FAA Sec 301(d)) If fund is established solely by US contributions and administered by an international organization, does Comptroller General have audit rights? | N/A |
| 25 | Communist Assistance (FAA Sec 620(h)) Do arrangements exist to insure that United States foreign aid is not used in a manner which contrary to the best interests of the United States promotes or assists the foreign aid projects or activities of the Communist-bloc countries? | Yes |

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| 26 | Narcotics | |
| a | Cash reimbursements (FAA Sec 483) Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? | Yes |
| b | Assistance to narcotics traffickers (FAA Sec 487) Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances), or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, and such controlled substance? | Yes |
| 27 | Expropriation and Land Reform (FAA Sec 620(g)) Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? | Yes |
| 28 | Police and Prisons (FAA Sec 660) Will assistance preclude use of financing to provide training advice or any financial support for police, prisons, or other law enforcement forces except for narcotics programs? | Yes |
| 29 | CIA Activities (FAA Sec 662) Will assistance preclude use of financing for CIA activities? | Yes |
| 30 | Motor Vehicles (FAA Sec 636(i)) Will assistance preclude use of financing for purchase sale, long-term lease exchange or guaranty of the sale of motor vehicles manufactured outside U S unless a waiver is obtained? | Yes |
| 31 | Military Personnel (FY 1991 Appropriations Act Sec 503) Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? | Yes |
| 32 | Payment of U N Assessments (FY 1991 Appropriations Act Sec 505) Will assistance preclude use of financing to pay U N assessments, arrearages or dues? | Yes |
| 33 | Multilateral Organization Lending (FY 1991 Appropriations Act Sec 506) Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? | Yes |
| 34 | Export of Nuclear Resources (FY 1991 Appropriations Act Sec.510) Will assistance preclude use of financing to finance the export of nuclear equipment, fuel or technology? | Yes |
| 35 | Repression of Population (FY 1991 Appropriations Act Sec 511) Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the | Yes |

**ANNEX 3
STATUTORY CHECKLIST**

legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?

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| 36 | Publicity or Propaganda (FY 1991 Appropriations Act Sec 516) Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? | No |
| 37 | Marine Insurance (FY 1991 Appropriations Act Sec 563) Will any A.I.D contract and solicitation, and subcontract entered into under such contract include a clause requiring that U S marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? | Yes |
| 38 | Exchange for Prohibited Act (FY 1991 Appropriations Act Sec 569) Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employees expressly prohibited by a provision of United States law? | No |

C CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

- | | | |
|---|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | Economic and Political Stability (FAA Sec 531(a)) Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? | Yes A substantial reduction in fertility will significantly help to improve Egypt's prospects and increase the country's abilities to attain its development goals, thus promoting political stability |
| 2 | Military Purposes (FAA Sec 531(e)) Will this assistance be used for military or paramilitary purposes? | No |
| 3 | Commodity Grants/Separate Accounts (FAA Sec 609) If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? (For FY 1991, this provision is superseded by the separate account requirements of FY 1991 Appropriations Act Sec 575(a) see Sec 575(a)(5)) | Yes Revenue from sale of commodities will be set aside in a separate account |
| 4 | Generation and Use of Local Currencies (FAA Sec 531(d)) Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? (For FY 1991 this provision is superseded by the separate account requirements of FY 1991 Appropriations Act Sec 575(a) see Sec 575(a)(5)) | N/A |
| 5 | Cash Transfer Requirements (FY 1991 Appropriations Act Title II, under heading Economic Support Fund and Sec 575(b)) If assistance is in the form of a cash transfer | |
| a | Separate account Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds? | N/A |

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| b | Local currencies. will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has AID entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of AID and that government to monitor and account for deposits and disbursements? | N/A |
| c | US Government use of local currencies. Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the US government as the US determines necessary for the requirements of the US Government, and which requires the remainder to be used for programs agreed to by the US Government to carry out the purposes for which new funds authorized by the FAA would themselves be available? | N/A |
| d | Congressional notice Has Congress received prior notification providing in detail how the funds will be used, including the US interests that will be served by the assistance, and, as appropriate the economic policy reforms that will be promoted by the cash transfer assistance? | N/A |

THE NATIONAL POPULATION COUNCIL

Secretary General
Prof Dr MAHER MAHRAN

F R C S, PH D (EDIN) F R C O G (LOND)

00292



Careful

Mr. Henry Bassford
Director
USAID/EGYPT
Cairo, Egypt

ACTION	HRDC	SIR
ASST. DIR.		1/2/2
DATE		

Cairo, 9 4 1992
No 27 A

Dear Mr Bassford,

As you are aware, the current USAID support to the Egyptian National Population and Family Planning Program is scheduled to end with the completion of the Population/Family Planning II Project in May, 1993. Many positive advances have been made under the Population/Family Planning II Project. However, as vividly presented in the recent RAPID presentation to the Prime Minister and other cabinet officials, much remains to be done if Egypt is to have a population growth rate consistent with and supportive of its economic development.

This is to formally request on behalf of the Government of Egypt that USAID continue to provide support for Egypt's family planning and population activities after the closing date of the Population/Family Planning II Project, i.e. from 1993 to 1997. I believe the recently published National Population Strategy (1992-2007) outlines the areas of concern to Egypt in the coming years. Of particular interest for USAID funding under the Office of Population are the sections on family planning and population information and communication. Specifically, we request continued USAID assistance for family planning service delivery, mass media and interpersonal communication programs, management systems, research, policy formulation and outreach, as well as improved program coordination.

I appreciate your consideration of continued support for the activities of the Egyptian National Family Planning Program

With my best wishes,

Sincerely yours

Prof Dr Maher Mahran
Secretary General

National Population Council

C&R USAID/CAIRO
1993 APR 13 A 8-55

5. Satisfaction of FAA Section 611(a)

Population/Family Planning III Project

To meet the requirements of 611(a), this Project Paper must demonstrate that, to the extent that technical, financial and engineering plans are needed to carry out the Project, such plans have been made. The Project Paper must also demonstrate that there exists a reasonably firm estimate of the cost of providing the assistance. Input levels were based on the expertise of the Project Design Team's technical specialists, together with the experiences of the POP/FP II Project in carrying out similar activities. As detailed in the Financial Analysis, costs for each project element were obtained by applying standard unit costs to inputs. Estimates of standard unit costs were derived from the following sources:

- Labor and direct costs associated with long-term and short-term technical assistance - basic information from USAID/Egypt FM/FA Office.
- Costs of office supplies, office equipment, medical equipment - information from POP/FP II Project budgets for NPC, MOH/SDP and CSI subprojects, and a cost study prepared by Heilman et al, 1991.
- Costs of vehicle procurement and maintenance - basic information from USAID/Egypt FM/FA Office
- In-country training - information derived from technical specialist estimates, training expenditures and budget data from THO, and a study of costs in the RCT prepared by Martinkosky, 1990.
- Participant training - basic information from USAID/Egypt FM/FA Office
- Host country contribution - information derived from Heilman et al, 1991, and interviews with GOE counterparts.
- US Dollar inflation was calculated at 5%. Local costs are converted into US Dollars at the exchange rate available at the time of drafting the PP with the expectation that local inflation will be more or less compensated for through devaluation

Therefore, costs estimates used in developing the Project are reasonably firm and may be expected to hold for the life of the project, taking into account the contingency factor.

6. Gray Amendment Certification

Population/Family Planning III Project

As Director and Principal Officer of the Agency for International Development in Egypt, I certify that full consideration has been given to the potential involvement of small and/or economically and socially disadvantaged enterprises, historically black colleges and universities and minority controlled private and voluntary organizations covered by the Gray Amendment.

The attached Project Paper discusses the efforts that will be undertaken in connection with the procurement plan to maximize the participation of minority-owned and small and disadvantaged organizations. At the time of each procurement action, every effort will be made to encourage the participation of these organizations and draw upon their knowledge and expertise.

Henry H. Bassford
Director

Date

7. Project Analyses

A. Technical Analysis

1. Introduction

To produce the Project outputs, the Population/Family Planning III Project (POP/FP III) builds on the success of the Population/Family Planning II Project (POP/FP II) but utilizes a more focused and consolidated approach, emphasizing decentralization and the reduction of redundancy. POP/FP III will continue the most successful activities and discontinue those that do not directly or effectively contribute to achieving the sector goal of reduced fertility. Selection was based on a review of factors that can be classified as technical, financial and management.

Family Planning: Preparing for the 21st Century² provided the framework for analysis. The typologies and "Principles for the Nineties" outlined in that document are good yardsticks of current technical thinking by which to assess design issues of the POP/FP III Project in order to increase the availability of safe, effective family planning services.

The framework presented in Family Planning: Preparing for the 21st Century groups countries into five categories based on level of contraceptive prevalence of modern family planning methods. These levels are

- **Emergent**, with 0 to 7 percent prevalence among married women of reproductive age,
- **Launch**, with prevalence between 8 and 15 percent;
- **Growth**, with prevalence between 16 and 34 percent,
- **Consolidation**, with prevalence between 35 and 49 percent;
- **Mature**, with prevalence of 50 percent or higher.

Egypt is considered a **Consolidation** country, with the prevalence of modern contraceptive methods in the range of 35 to 49 percent.

According to the typology outlined for family planning countries at the Consolidation level, Egypt faces multiple challenges. However, the primary challenge at this level is to increase segmentation of

² Liber, Dawn Harnett Destler Janet Smith and John Stover Family Planning: Preparing for the Twenty first Century Office of Population, Family Planning Services Division Washington 1990

the market to ensure that public and private resources are used most effectively. Program activities that should have priority at this level include:

- **Service Delivery** Developing services that are responsive to a diverse and changing population and increasing access for the poor and uneducated clients.
- **IEC.** Development of information systems that are responsive to a more diverse and heterogenous clientele.
- **Institutional Base** Transfer of clients from the government to the private sector and development of collaborative approaches among public and private agencies.
- **Financial Base** Increased efforts to achieve cost recovery and self-sustainability
- **Donor Support** Identification of multiple sources for contraceptives Leveraging of donor and private resources through currency conversion and corporate donations

Proposed POP/FP III activities will be analyzed in relation to these priorities in this technical analysis

The issues facing the Egyptian program seem consistent with those to be expected at the Consolidation level

2. Service Delivery: Constraints and Response

Based on the lessons learned which are outlined in Section I A 5 of the Project Paper, on the technical level the POP/FP III Project concentrates on a much smaller set of subprojects, providing the type of national -level support for which USAID is best situated. The selection was based on the strategic considerations of sector mix, identified constraints, and donor advantage

Egypt needs to move to still higher levels of prevalence; but the sheer size of the program at the consolidation stage requires that public sector (including donor) resources be invested prudently to achieve the greatest return. The fertility objectives of consolidation programs call for programming in three areas of service delivery 1) increasing prevalence, 2) increasing use

ANNEX A
TECHNICAL ANALYSIS

effectiveness, and 3) beginning to reach family planning resistant or hard-to-reach groups.

In order to provide a clearer understanding of how the various service providers interface, the methods they support, and how they will, taken together, meet the family planning needs of all Egyptian families, this section on service delivery examines the estimates of contraceptive prevalence, projections and target setting. It then analyzes sectoral participation, market segmentation, and comparative advantage of each sector.

a. Contraceptive Prevalence

The preliminary (but widely publicized) results of the 1991 PAPCHILD survey indicate that the national contraceptive prevalence rate (CPR) for Egypt in 1990 was 47.6 percent. This rate includes a noteworthy increase of eight percentage points in IUD use from the 1988 Demographic and Health Survey (DHS). A preliminary review of methodology, sampling and questionnaire design does not reveal any reason to think that results would be biased upward.

However, these results must be viewed with some caution. The most obvious reason is that they are preliminary. Although they are being widely discussed, they are still being reviewed by CAPMAS. Further, this CPR of 47.6 is being reviewed by the GOE in terms of resetting its contraceptive prevalence goals for the National Population Policy. These reset goals and targets are not yet decided.

The ultimate objective of increased prevalence is reduced fertility; there are no official estimates of fertility based on the PAPCHILD survey. The issue here is whether the dramatic increase in prevalence is matched by the expected amount of fertility decline.

Thus, USAID should continue to use the DHS figures in programming future project inputs and evaluating their impact. USAID has used the DHS, which has worldwide scientific recognition, over the past ten years in Egypt as the yardstick by which to measure project implementation progress. The following are some reasons that it **may not** be wise to use the PAPCHILD 1990 CPR of 47.6 and then project forward increases in prevalence over the next five years at the same rate prevalence grew between 1988 and 1990.

³ In terms of hard-to-reach groups, community based distribution (CBD) programs are commonly thought of as a way to reach these groups. With its reliance on the IUD, Egypt has a rather effective method mix. Clinic-based service delivery is important in delivering this method. Still, improved outreach is essential in Egypt to bring acceptors into clinics. This issue is discussed further under Section III, Information, Education and Communication, B. Interpersonal Communication.

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- (1) In the context of the Family Planning: Preparing for the 21st Century typology, the prevalence level in Egypt may be approaching that of a mature program, but the service delivery infrastructure, the planning and management process, and the national policy setting and coordination process are not as developed as one would expect, given the level of prevalence. Prevalence has somehow lurched ahead of infrastructure, probably because of accumulated unmet demand. If this analysis is correct, it raises serious questions as to whether a weak public sector infrastructure can continue to support a similar rate of growth in CPR over the next five years as was seen in the two year period between 1988 and 1990.
- (2) Two years is a relatively short segment of demographic history. Egypt has a history of vacillation in prevalence and fertility indicators. Thus, the late 1990 measure may be a high blip, that is, prevalence is obviously rising, but it may not, in the longer run, be rising as rapidly as one might infer by looking only at the rise between 1988 and 1990.
- (3) There may have been special factors which led to the dramatic increase in prevalence during the 1988 - 1990 period which may not continue to show a comparable sustained impact on prevalence over the next five year period. For example, as a result of physician training, IEC, and a major inflow of supplies the IUD was essentially a new, highly available method in 1988. A rapid jump in prevalence under such circumstances is not surprising. However, during the POP/FP III project period it will no longer be a new method with dramatically increased availability.
- (4) Finally, the national prevalence rate is comprised of regional rates, in which there are major differentials. There exist substantial areas of Egypt where prevalence remains very low. These areas will continue to grow rapidly and will continue to exert an upward pressure on the national Total Fertility Rate (TFR) unless an intensive effort is made to provide family planning services to them.

In the absence of data on market segmentation for Egypt, data from several sources were examined in order to describe the Egyptian family planning service delivery system. These sources are: the 1988 DHS, the 1991 Heilman Report on Couple Year Protection (CYP) in Public or PVO Programs, and new acceptor service statistics, -- i.e., the USAID Monitoring System.

The 1988 DHS was conducted prior to a number of significant changes in service delivery. However, DHS data are useful in showing both

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which methods are important in Egypt and which channels (i.e., public, PVO, private, commercial) of delivery are supplying them, and, to some extent, patterns of demand. The data also show the importance of the various channel/method combinations. Table A-1 contains the 1988 DHS source and method data. For planning purposes these data can provide the basis for evaluating the comparative advantage of different sectors in reaching consumers.

For all methods in 1988, the private/commercial sector contributed 25 percent toward the total prevalence for modern contraceptives of 35 percent, the public sector added another 9 percent, and PVO service providers and other channels added the remainder. The individual cell values in Table A-1 identify the contribution of specific channel/method combinations to the prevalence rate of 35 percent for modern contraceptive methods. There are three very important channel/method combinations: first, the pill through pharmacies (13 percent), second, IUDs through private physicians (8.6 percent); and third, IUDs through the public sector (6.7 percent). These three channel/method combinations alone provide nearly 29 percent of the total prevalence rate for modern contraceptive methods of 35 percent. The remaining 6 percent of prevalence comes from pharmacy/condoms, and public sector pills and voluntary surgical contraception (VSC) subject to medical indications. At the time of the 1988 DHS, before the establishment of the PVO Clinical Services Improvement (CSI) Project, the PVO sector accounted for less than 1 percent of prevalence in all methods.

Because so much has happened in the service delivery system since the 1988 DHS, it is important to look also at more recent data on sectoral participation. In 1990, USAID commissioned the Heilman study^{4,5} of output and costs of services and distribution systems supported with public sector funds. The study covered the period July 1, 1988 to June 30, 1989 and July 1, 1989 to June 30, 1990. The data reflect both the continuing major role of the private/commercial sector and the relative shares of the public and PVO sectors. In the year ending June 30, 1990, after adjusting for use-effectiveness of the pill and prevalence/distribution data of

⁴ Heilman, Elizabeth, Margaret Martinkosky and Mohamed El Essely. Report on the Costs of family Planning Activities which received Funding from the Public Sector (July, 1988-June 1989). E. Petrich and Associates, Arroyo Grande, Ca, 1991.

⁵ Heilman, Elizabeth, Margaret Martinkosky and Mohamed El Essely. Report on the Costs of family Planning Activities which received Funding from the Public Sector (July, 1989-June 1990). E. Petrich and Associates, Arroyo Grande, Ca, 1991.

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TABLE A-1

PERCENT DISTRIBUTION OF CURRENT USERS OF MODERN METHODS BY SERVICE PROVIDER ACCORDING TO METHOD, EGYPT DHS, 1988

Service Provider	Pill	IUD Obtained	IUD Inserted	Condom	Female Sterilization	All Modern Methods ^{1/}
Government FP Clinic	3.0	13.0	13.7	0.7	1.3	7.2
Government MCH Center	2.2	7.1	7.9	0.0	0.0	4.1
Government Hospital	3.0	16.6	21.0	0.6	71.5	11.8
Home Delivery Agent	1.3	0.0	0.0	0.0	0.0	0.6
Private FP Clinic	0.3	1.0	1.3	0.0	0.0	0.5
Private Doctor	0.3	43.2	54.3	0.3	25.4	20.3
Pharmacy	87.1	17.4	NA	97.8	1.8	53.4
Other/Not Sure	2.7	1.7	1.7	0.6	0.0	2.0
TOTAL PERCENT	100.0	100.0	100.0	100.0	100.0	100.0
Number of Users	1,258	1,295	1,295	198	122	2,914

^{1/} Includes current users of vaginal methods, injection and male sterilization (N=41) in addition to users of the pill, IUD, condom and female sterilization

NA = Not applicable

condoms,⁶ the private/commercial sector distributed 2,119,955 couple years of protection (CYP), compared to 1,140,841 CYP provided by the public and PVO provider sectors. Based on these distribution data, the private/commercial sector accounted for 65 percent of CYP stemming from USAID-supplied commodities.

With respect to the other sectors, using the indicator CYP adjusted for use effectiveness of the pill and prevalence/distribution data

⁶ This indicator uses an adjusted pill coefficient of 15.854, based on the study's assumption that the 1988 EDHS suggested that 82% of Egyptian pill users are protected while using the method. CYPs from condom distribution data are adjusted based on 1988 condom prevalence figures.

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for condoms, the MOH provided 769,066 CYP, or 67 percent of service delivery supported with public sector funds [This MOH rate does not include the Teaching Hospital Organization (THO), Cairo Health Organization (CHO), nor the Health Insurance Organization (HIO)]. The second largest provider was the Egyptian Family Planning Association (EFPA), which provided 228,031 adjusted CYP (20 percent), through a loose network of 450 local PVO service clinics. CSI was the third largest provider, providing 64,289 adjusted CYP (6 percent). The remaining 7 percent of services supported with public sector funds were provided by a number of smaller public sector affiliates (THO, CHO, and HIO) and PVOs

These data highlight the relative importance of public sector service providers in serving Egyptian families. The data point to the predominance of the MOH in subsidized service provision. These particular data do not, however, take into account the number of outlets that each provider network has. The MOH, with over 3500 centers, is vast compared to CSI, and CSI's client load per clinic is without a doubt higher than the MOH's. That MOH clinics function well below maximum capacity is an acknowledged problem in Egypt.

The two sources cited thus far may still not provide an adequate, up-to-date picture of CSI's contribution to the PVO sector, since CSI is a relatively new program which is just getting up to speed. For this reason, new acceptor data maintained by USAID for calendar year 1990 were examined to see if these data show any trends significantly different from the other sources. In calendar year 1990, the MOH served 509,217 new acceptors (not including THO, CHO or HIO), and CSI served 65,932 new acceptors. While CSI's contribution to the PVO sector and to total service provision continues to be limited, it is expanding and improving its method mix

The new acceptor service statistics may also be used to provide a more up-to-date view of method mix in selected programs. If the last quarter of CY 1990 is characteristic of present service patterns, the following would be the method mixes for the MOH and CSI. For the MOH, 75 percent of new acceptors received the IUD, 22 percent received oral contraceptives, and 2 percent used condoms. The method mix for CSI included 63 percent IUD acceptors, 13 percent OC acceptors and 15 percent condom acceptors.

Although the data may be imprecise, they suggest some broad conclusions about the participation of various sectors in the service delivery system. First, the commercial sector, through pharmacies and private physicians, accounts for approximately 70 percent of all family planning services provided in Egypt. In 1988, the largest part of this was supply methods (oral

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contraceptives) The private, commercial sector provides almost 90 percent of supply methods and serves more than half of IUD users. Second, the public sector is providing another significant portion of services (26 percent in 1988) with a reasonably effective method mix. In 1988, 74 percent of those served by the public sector reported using an IUD. Third, the PVO sector is also contributing to service provision but to a much lesser degree.

Based on this analysis of sector mix, the POP/FP III Project should continue to support selected service delivery activities in the public sector, the CSI PVO service delivery activity (CSI), and a private commercial sector initiative. Studies on market segmentation are also needed to avoid redundancy and to target needed subsidization. The service delivery activities recommended for support are needed to continue to encourage the participation of all sectors in order to continue to increase contraceptive prevalence.

b. Quality Assurance

Quality assurance is a major issue in the delivery of family planning services. Training and supervision can support efforts toward assuring improved quality. Under POP/FP II three channels of training were established, these channels should be maintained with some modifications under POP/FP III. The three channels are the Regional Center for Training (RCT) in the Ain Shams University, the training and service Centers in each of the eight Teaching Hospitals and the MOH training centers in each of 21 governorates.

Within the POP/FP II Project the **Regional Center for Training (RCT) Ain Shams School of Medicine** was funded through a Letter of Agreement with the National Population Council to provide training in Contraceptive Technology for physicians and nurses, including the Training of Trainers. The Ain Shams School of Medicine is well placed to provide medical-technical leadership to Egyptian physicians in the field of contraception. It is also the only Egyptian medical school offering a post graduate Diploma in Family Planning.

Under the POP/FP II Project the RCT increased its training capacity by establishing Satellite Training Centers (establishment of up to 15 such centers was approved). This was based on the expectation that there would be a high demand for trainers and that most service providers would be trained through RCT/STC mechanism. The training outputs of the RCT/STC network are presented in Table A-2.

⁷ But an effective method mix can still be associated with ineffective use if acceptors are not adequately counselled on what to expect and given information to combat rumors.

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In the two years since beginning operation, the RCT and its affiliated Satellite Training Centers have trained more than 1,000 physicians and over 600 nurses. It is apparent from the information in Table A-2 that more than 50 percent of physicians trained were from the private sector (EJMDA). While the MOH prefers to train its own staff in management and supervision, it relies directly on the RCT for training its trainers in contraceptive technology and counseling.

TABLE A-2

RCT/STC TRAINING OF ALL PHYSICIANS AND NURSE IN CONTRACEPTIVE TECHNOLOGY OVER THE TWO YEAR PERIOD ENDING 9/26/91

Year	Physician					Nurse		
	CSI	HIO	EJMD	MOH	Tot	HIO	MOH	Tot.
1990	31	28	277	10	346	26	36	62
1991	21	54	281	311	667	10	560	570
Total	52	82	558	321	1013	36	596	632

A case can be made for the majority of the physicians trained by RCT in the service provider courses to be drawn from the private sector with due attention to selection criteria, either directly, or through the professional associations. Because the private sector provides a major share of the contraceptive prevalence in Egypt, the quality assurance in family planning service provision can be facilitated through the training of private physicians at the RCT. As the economic burden to the public sector is reduced with the increased involvement of the private, commercial sector, every encouragement should be offered for private physicians to take the two week service provider course at RCT. The RCT could most likely train an estimated 300 physicians a year.

In the POP/FP II Project, considerable effort was expended in providing in-service training. Although this work needs to continue in POP/FP III, the environment seems conducive to promoting consideration of a population/family planning unit in the formal medical curricula of all medical schools and pharmacy schools in Egypt. It is in the national interest that graduates have a clear understanding of population issues and of family planning technology which they can use in their practices. The RCT, under the auspices of the NPC, could play a pivotal role in such an activity. It has available the expertise and reputation of the Ain Shams University Medical School to offer extensive technical assistance in curriculum development and training.

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methodology for such academic units. A similar catalytic organization should be identified for the work with Schools of Pharmacy.

The **Teaching Hospitals Organization** of the MOH can influence the public sector health care delivery system in that its hospitals provide internships for physicians entering the MOH system. The THO of the MOH reports directly to the Minister and thus enjoys an independence similar to that of the universities. There are eight Teaching Hospitals in Egypt, four of which are located in Cairo. With the support of the POP/FP II Project, all have developed strong family planning clinics which offer a full range of contraceptive methods. The family planning medical staff are OB/GYN specialists who are enthusiastic and well trained. The clinics have been upgraded to acceptable (well above average for Egypt) standards and are popular, attracting about 50-60 clients daily. Some of the Teaching Hospitals are also Satellite Training Centers (STC) for the Regional Center for Training (RCT).

The teaching orientation and status of the THO lends itself to a specific mandate. That is, the training centers of the THO can provide family planning training appropriate to the needs of the specialists and staff of the more than 200 MOH general hospitals. These training centers at the THO can provide not only improved knowledge and skills in contraceptive technology and counseling procedures, but also expanded professional practice in areas of quality services, clinic organization and patient flow, infection control procedures, the role of nurses, and administrative steps. Based in hospitals, these family planning training centers are appropriate sites for training (practicum, internships) and service delivery in long-term contraceptive methods.

The **Ministry of Health** offers training courses for family planning service providers and staff in all 21 governorates supported through the POP/FP II Systems Development Project. The family planning physician and nurse trainers are graduates of the RCT Training of Trainers course, with sound teaching skills in contraceptive technology and counseling. In addition to clinical training, training in management and supervision based on the requirements of the MOH is provided. Each governorate trains at least 100 staff per year for an average of more than 2,000 and this target could be expanded with no difficulty.

c. Contraceptive Commodities

At present, USAID is the principal donor of contraceptive commodities to Egypt, providing both IUDs and condoms to the public and private sectors. Also, a limited amount of oral contraceptives is provided to the private sector under USAID.

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auspices. UNFPA provides injectable contraceptives, which USAID is unable to supply due to US regulatory restrictions

In POP/FP III, USAID plans to provide IUDs, condoms and some NORPLANT sets (upon the approval of NORPLANT in Egypt) to the public sector and PVOs participating in the Project. This represents a strategic change from the past program in a number of ways

First, USAID will no longer supply the Family of the Future (FOF) with contraceptives after 1993. FOF's commodities (particularly in supply methods which are less cost- and family planning-efficient than clinical methods) accounted for the largest part of USAID's total commodities budget (78 percent in 1990). Continued subsidy of this social marketing program does not seem warranted as it does not appear to be serving a unique segment of the population, unserved by other delivery mechanisms. USAID funds can be invested more appropriately in other parts of the national program

Second, in the public sector IUDs will continue to be supplied and projections will include a generous factor for increased use as well as early discontinuation. The situation in Egypt is dynamic, many new interventions like physician training are being implemented. Given the high effectiveness of the IUD in protecting women who use it correctly from unwanted pregnancy, the Project should support this method generously

Third, the elimination of USAID-supplied contraceptives in the private/commercial sector is expected to cause minimal disruption. In fact, it will most probably positively affect the expansion of supply channels for these commodities, thereby ensuring greater sustainability. Ravenholt's "Preliminary Assessment of the Potential for Increased Involvement of the Private Sector" concluded

- There is a widespread network of diverse mechanisms for delivery of services within the private sector.
- It appears that the ability and willingness of many Egyptians to pay for family planning services in the private sector have been underestimated. (Consumers are already accustomed to paying some price for contraceptives and family planning services)
- Current government regulations do not permit the private sector to contribute fully to family planning services.

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The change in USAID's strategy should have minimal impact on supply and thereby minimal negative impact on fertility. A variety of contraceptive methods have at least some representation in the private market: oral contraceptives, IUDs, condoms and vaginal foaming tablets. All but one oral contraceptive currently on the market are manufactured locally under license from two international laboratories, Schering AG and Wyeth. Of the IUDs, the Nova T is imported commercially by the local representative of Schering AG, and the Multiload is imported from Organon and distributed privately. Some private distribution firms suggest that the abundance of USAID-donated condoms in the market crowds out the possibility of any widespread sale of commercially-supplied brands. In any event, condoms (as well as vaginal foaming tablets) make only a small contribution to national prevalence.

The IUD poses a problem in that it is now the backbone of the national family planning program and those available in the market are substantially more expensive than those supplied by USAID. Under the current POP/FP II Project, TA will be provided to develop alternative sources of affordable, private/commercial sector IUDs. The alternative sources could be either local manufacture or entry into the market of an affordable IUD by a commercial manufacturer. It is vital that the alternative source be in place by 1993, when FOF's USAID-supplied stocks are exhausted. Once the transition from USAID-supplied to commercially-supplied IUDs is completed, a major element of the national program, IUDs inserted by private physicians, will be on a financially-sustainable footing.

The limited NORPLANT provision projected by USAID (if this is all the stock that comes in) would argue for a very gradual introduction in Egypt. Outright resource limitations and a general necessity to be strategic with limited funds constrain USAID's ability to support a widespread adoption of NORPLANT. At \$23 a set, each set is the equivalent of 23 IUDs. Normally, it would be desirable to introduce a new method broadly both in view of patterns of demand (where one satisfied user brings in another) and in view of the importance of not constraining method delivery by numerous practice restrictions. However, the cost of NORPLANT as a method prohibits USAID from supporting mass use.

NORPLANT may be an area of comparative advantage of UNFPA; UNFPA sees the development of widespread demand as the only way to bring the supplier-price of NORPLANT down. If UNFPA wants Egypt to be a part of this volume market, UNFPA may want to supply NORPLANT in large quantities. The Egyptian medical community is very excited about the method, and sees potential demand for it coming both from middle-class and public-sector consumers. The

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UNFPA team currently preparing an assessment of the population/family planning environment in Egypt is aware that entry of a small supply of NORPLANT may provoke a large demand and will highlight this possibility and potential need to the UNFPA donor community.

Prior to the introduction of USAID-supplied NORPLANT, the pricing structure for the method will have to be resolved. To foster the conditions for correct use, a rational price for the product should be determined in relation to other methods. The method is too expensive for it to be used casually (for example inserted for a short period of time). It will be vital for the GOE to adopt a price for the method which signals the need for its serious application.

d. Contraceptive Distribution Mechanism

USAID-supplied contraceptives are currently distributed through two systems -- the Egyptian Pharmaceutical Trading Company (EPTC) and the contraceptive social marketing (CSM) project of the Family of the Future (FOF) Association.

The EPTC supplies the MOH and USAID-supported family planning projects with USAID donated contraceptives. When the EPTC was founded in 1965, it was the only channel by which imported pharmaceuticals could be distributed in Egypt. Now, with the new openness, private sector distribution firms are becoming established and participating in the distribution network. The distribution systems of parastatal pharmaceutical manufacturers also compete with EPTC distribution. For Schering, for example, EPTC accounts for distribution of 20 percent of its oral contraceptives sold, while the parastatal manufacturer CID accounts for 80 percent.

For the public sector, EPTC warehouses and distributes commodities to MOH stores at the governorate level, charging a fee of approximately 10 percent of the value of the goods being distributed. EPTC commissions appear to be in line with prevailing local rates. The MOH reports no particular problems with EPTC's service. There are no major problems and minor problems are quickly resolved through an open line of communication.

With respect to the private commercial sector, EPTC's comparative advantage is judged to be its extended network of supply depots even in remote areas. It is not aggressive in dealing with the private sector, but in view of potential changes in the commodity activity under POP/FP III (to focus on public and PVO sector needs), this may not be an important consideration. Further, as

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with other distribution channels, where EPTC detailing may not be aggressive, stockists need only call to have product delivered in one day

In 1991, USAID stopped the EPTC sales of USAID-donated contraceptives to pharmacies and has suspended the current MOH/EPTC/USAID revenue agreement due to irregularities in condom distribution noted previously. USAID plans to continue the prohibition, to terminate the revenue agreement, and to develop a new agreement covering the "Procurement, Receipt, Storage, Distribution, Monitoring and Disposal of USAID-Donated Commodities."

On a technical level, EPTC's service to the MOH is satisfactory, and if payment issues can be resolved, there would be no need to arbitrarily change a functioning system between POP/FP II and III. As part of its contribution to the POP/FP III, the MOH has agreed to fund through Government of Egypt (GOE) resources the EPTC management and distribution fees to the public sector, as well as the EPTC Commodity Inventory and Information System (CIIS). These costs were previously covered through revenues generated through sales to pharmacies.

While EPTC's extensive supply network gave it a comparative advantage in POP/FP II when it was necessary to supply far-flung pharmacies, the scope of work is changing in POP/FP III. In the new Project, only MOH stores at the governorate level are being supplied. Should EPTC's performance not remain satisfactory under the new mandate, it may be necessary to contract the service to a private sector distributor. In all likelihood, private/commercial pharmaceutical firms have distribution systems to this level (and beyond), qualifying them to carry out this work.

EPTC is apparently under pressure to adopt a more private sector orientation with profitability governing the operation. Although this is described as a move to privatize, it may not be a sufficient step to qualify EPTC to bid on the distribution work to be procured from the private commercial sector.

In the transition to a new supply management system, increased attention should be paid to developing monitoring mechanisms to track the USAID-donated commodities in the public sector. That is, their timely arrival and use in the public sector program needs to be monitored.

FOF is the distribution agent for Contraceptive Social Marketing (CSM) commodities and uses detailing to reach a larger network of pharmacists than offered by the agents representing the

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international manufacturing laboratories. In 1990, FOF sold 2,082,434 cycles of Norminest, which gave Norminest an 8 percent share of the Egyptian commercial market for oral contraceptives. Golden TOPS brand condoms are distributed by FOF, and almost 20,000,000 were sold by FOF in 1990. The FOF Marketing Plan for 1991 indicates that urban middle class males are the primary purchasers of TOPS--not the less educated, less urban male who is the targeted consumer. Condom use accounts for 6 percent of national contraceptive prevalence, according to the 1988 DHS. FOF also distributes USAID-supplied Cu-T 380s, in 1990, FOF is reported to have distributed 400,000 of these IUDs.

CSM programs are generally established in markets where there is an important segment of the population for whom currently available contraceptives are not price accessible or in markets where contraceptives are not available at any price. With current GOE subsidies and price controls which cut across both the public and the private/commercial sectors, it is not clear that FOF CSM activities serve a unique segment of the population, which would be unserved by other delivery mechanisms. These facts are supportive of USAID's decision not to continue CSM activities under POP/FP III.

Institutionally, FOF is restructuring from its period of considerable disarray in mid-1991. This will provide it with a solid foundation from which to undertake its transition to a private distribution firm. For example, revenues from product sales should cover FOF's overall budget in 1992, excluding the cost of AID contraceptive products. FOF has, further, built up a sizeable revenue fund from past sales of contraceptives. With the current heavy TA inputs, it is developing a solid management plan for 1992 and beyond.

As programs develop toward maturity, one of their most critical needs is to be able to operate their own contraceptive commodity procurement, distribution and management systems. That is, the program should be able to handle, by itself, everything required to run the contraceptive logistics system, including projecting requirements, developing international tenders, storing commodities, using products on a timely basis, and efficiently reordering and resupplying at the most local level.

e. Information, Education and Communication (IEC)

The development of information systems that are responsive to a more diverse and heterogeneous clientele is the IEC challenge for Consolidation level countries. IEC activities in Egypt are particularly important because of the need for dissemination of persuasive information on health-related issues of contraceptive

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practice, the liberal climate which exists for family planning messages, and the almost universal access to mass media.

For example, during 1988-90, two highly successful mass media (television) campaigns were broadcast: the "Ana Zanana" and the "Dr. Karima." These were scientifically designed campaigns that were repeated four or five times daily, including prime viewing hours, for over a year. A survey showed that 99 percent of respondents had seen the spots, 98 percent could recall accurately the general content, and 74 percent could recall accurately one or more specific message. While the direct linkage between the campaigns and behavior change has not been specifically studied, significant evidence suggests that the mass media intervention is at least partially responsible for the rapid progress made in increased prevalence. The increase in prevalence simultaneous with the mass media campaigns is consistent with experience in other countries.

It is important to acknowledge this contribution of IEC and to exploit it to achieve further gains. The MOH clinics reportedly operate at an estimated 65 percent capacity. (Field observations indicate that utilization may in fact be much lower, even in the more active sites.) With no further investment in buildings, personnel, equipment or other costly inputs, huge reductions in fertility can be achieved by motivating women to utilize the existing clinics. Use of the private commercial sector and private physicians can also be further stimulated by IEC as has been demonstrated with the use of T V in promoting CSI and EJMDA clinics.

Family Planning in the 21st Century recommends use of mass media for countries in the consolidation stage. The 1989 Population Sector Assessment evaluated the State Information Service (SIS) project positively and included improving outreach as one of its basic recommendations. As prevalence goes up, particularly as it reaches the 50 percent level, greater efforts are needed to motivate users and to connect with hard to reach, underserved populations.

Counseling is integrally connected with improving quality of care (discussed in section 2 b). Counseling, resisted only a few years ago by physicians, has become an integral part of training programs. IEC activities can contribute toward improving the quality of care by educating consumers, modeling behavior for providers, and supporting counseling.

Contraceptive continuation remains a problem in Egypt. Side effects are given as the main or a major reason for the alarming discontinuation rates of 65 percent of ever users of the pill, 37

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percent for the IUD, 72 percent for condoms, and 96 percent for foam tablets. This creates an atmosphere ripe for rumors, myths, and health fears. Only a small percentage of the full potential of IEC to counter rumors is being used.

DHS data demonstrate that most Egyptians associate family planning with limiting rather than spacing births. Specific health benefits of spacing need to be emphasized in mass media campaigns. In rural Upper Egypt, only 43 percent of females are aware of the adverse health effects of early childbearing. Sixty percent of females are aware of the health dangers of late pregnancies but only 35 percent of their husbands share their knowledge. All of these knowledge gaps are susceptible to change through mass media.

IEC can make an essential contribution in improving method mix. Knowledge of methods other than the pill and IUD is low. As new methods are introduced, IEC can rapidly diffuse knowledge and encourage use.

As efforts are made to segment the market, the institution-specific role of IEC activities at the agency level becomes even more important. Each agency requires a market position and a means of reaching specific audiences. A beginning has been made with several key institutions, but more work needs to be done.

Mass Media Television is the most important medium for mass communication in Egypt. A 1988 analysis of the SIS/IEC program found that 95 percent of Egyptians have access to T.V. with 90 percent ownership. Even in the rural areas of Upper and Lower Egypt, only 8 percent are without access to a T.V. Of those with access, eighty-three percent watch T.V. daily with females watching slightly more than males. In Upper Egypt, 80 percent of females with televisions watch it daily.

Eighty-seven percent have watched family planning spots or programs. In rural Upper Egypt, 77 percent of females and 75 percent of males have watched family planning messages. Approximately 60 percent of viewers see family planning messages at least once a day, and over 85 percent are exposed at least once a week.

Other mass communication channels are less important. Radio reached 59 percent of males and 57 percent of females. For rural Upper Egypt the percentage drops to 49 percent and 33 percent. Press reached 41 percent of males but only 24 percent of females. Billboards reached 73 percent and 48 percent of males and females with family planning messages, but in rural Upper Egypt only one quarter of females were reached. Only 6 percent have been

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exposed to family planning messages through printed materials. Interpersonal communication includes home visits and public meetings. Only 5 percent reported being visited at home. Around 15 percent of males and 10 percent of females were exposed to public meetings that discuss family planning. This drops to 6 percent of females in rural Upper Egypt.

The media scene in Egypt, coupled with the fact that 60 percent of females are illiterate (86 percent in some rural areas of Upper Egypt), dictates that careful analysis should be done regarding the contribution that television can make. Experience with the ORS campaign in Egypt offers powerful evidence that mass media (reinforced through other channels) can change behavior. This is corroborated with the family planning campaigns and experience with the commercial sector.

Interpersonal Communication The present family planning situation in Egypt may be described as one in which the "people have gotten out in front of the program." That is, while there are many new acceptors, the failure rates of users (i.e. pregnancies occurring while using a method) are relatively high. Moreover, further inroads need to be made in groups in which the custom of using family planning is less established. An IEC program which contains an appropriate mix of mass and interpersonal, tailored communication can be a powerful force in increasing prevalence and improving user effectiveness. Thus, in addition to the heavy emphasis on mass media envisioned for POP/FP III, selected interpersonal interventions are planned in the form of outreach and counseling.

Outreach is directed at acceptor awareness and knowledge with the goal of getting potential clients into the clinic. Because of the highly effective, clinic-based method mix in the Egyptian program, the outreach strategy should be one which brings together the acceptor and the appropriate clinic service. Although CBD programs are commonly thought of as a way to reach into communities, CBD workers can only provide supply methods, which are much less effective than clinical methods. Therefore, CBD is not a priority consideration for the Egyptian program. Successful outreach efforts begun under POP/FP II need to be analyzed and the successful elements adapted for use by implementing agencies, as appropriate and feasible, to broaden and deepen the acceptance of family planning practice and methods. For example, CSI, has developed a sophisticated outreach program based on catchment targets and field visits. Another example is the National Population Council (NPC), working at the governorate and district levels, has supported activities to increase the awareness and commitment of political and community leaders to family planning. Further, in one MOH district, female

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OB/GYNs are being deployed on a circuit-rider basis to increase the number of clinics where female physicians can serve acceptors who, culturally, prefer to see a woman

Through operations research (OR), mechanisms appropriate for use throughout the MOH system may be identified, tested, and implemented. Lastly, more data on service quality--from the viewpoint of service providers, service consumers and non-users would also facilitate the design of outreach efforts tailored to community-level needs.

While outreach attracts acceptors to services, counseling guides them to select an appropriate method which they can use effectively. Here interpersonal communication is essential because there is, beyond factual knowledge, a nexus of social and familial influences, impressions, and concerns which must be dealt with for a user to adopt a method and use it well. The counseling interaction provides the counselor with the opportunity to use personal selling with the potential acceptor, to meet him or her on the level of personal concerns. A counselor, equipped with correct information and the skills to reach out to where the acceptor is in the decision-making process, is a key element in effective use

POP/FP II has been concerned with counseling, and POP/FP III should continue this emphasis. Currently, contraceptive technology courses contain a counseling module. These need to be reviewed with an eye to tailoring it to specific field conditions

Counseling is a difficult area in which to work in Egypt, because it is not always perceived as a high status occupation. But effective counseling is needed to improve continuation and use effectiveness of methods. In a recent study of management aspects of service delivery which compared "successful" MOH clinics to "unsuccessful" ones, counseling was one factor which distinguished the two.⁸ Further, according to a recent multi-sectoral study of clinic quality, only 50 percent of MOH clinics offered some counseling service. Counseling should remain a priority area of focus for POP/FP III in the MOH as it is not yet institutionalized nor is the system to develop the counseling skills of service providers fully functioning.

⁸ El Nahal, Naglaa. Management Aspects of Family Planning Service Delivery. Egyptian fertility Care Society. Cairo, July 1990

⁹ Nawar, Laila. Selected Aspects of Quality Family Planning Service Delivery in Egypt. CAPMAS. Cairo 1991 (draft)

The CSI project of the EFPA has a well conceived and executed counseling program. In fact, effective counseling is a key element in the top quality service CSI provides.

f. National Communication Strategy

The SIS/IEC Center is the central government agency responsible for family planning IEC. To achieve the goal of developing a national communication strategy, however, it will be necessary to coordinate with many agencies and organizations. USAID-financed organizations will receive priority attention. Other key organizations, particularly from the commercial sector, will be included in IEC strategy and coordination meetings, workshops, and opportunities for sharing IEC materials and for participating in IEC training.

The NPC should be given major responsibility for building and maintaining the positive support of policy makers. The organization's secondary research and analysis unit (the Research Management Unit) should be strengthened and given specific output mandates. The way in which the results are packaged will depend on the dissemination mechanism. Dissemination, with an impact study should be part of each output.

A first priority goal of the IEC component of the Population/Family Planning III project will be to ensure commercial representation on the bodies which formulate the national communication strategy and which review IEC products. In the meantime, IEC work with pharmacists and private physicians could pay major dividends in increasing their clients' correct use of contraceptives and in maintaining targeted levels of use of the private/commercial sector for family planning services.

3. Institutional Base: Sector Mix

The Institutional Base challenge identified for Consolidation level countries in Family Planning: Preparing for the 21st Century is twofold: 1) to transfer clients from the government to the private sector and 2) to develop collaborative approaches among public and private agencies.

a. Transfer from the Government to the Private Sector

As a national country program grows, the costs of serving the increasing number of acceptors, often providing contraceptives obtained with foreign exchange, escalate dramatically. As Egypt moves toward its goal of increasing contraceptive prevalence levels, costs and levels of funding will concurrently become larger. For example, the total local costs of family planning

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activities funded in whole or in part by GOE/donor agency sources rose from LE 44.71 million in 1988/89 to LE 60.40 million in 1989/90 to LE 71.93 million¹⁰ in 1990/91. (These costs exclude foreign technical assistance and overseas training.) During this same time, all individual components of sources of funding (i.e., client payments, sponsoring agency payments, GOE funding and donor funding) and categories of expenditure (i.e., distribution agencies, support agencies, service providers) increased

Escalating costs require that public sector (and donor) resources be invested rationally to get the most return and that all sectors play their optimal roles, functioning where they have a comparative advantage in terms of client groups, geography, and methods supported. In the consolidation stage, latent demand is being actively translated into real demand to achieve 35-49 percent prevalence for modern contraceptive methods. Expanded services are required to meet existing and new demand. The scale at which country programs must function (to serve one-third to nearly half the population) is sufficiently large that all sectors -- public, Private Voluntary Organization (PVO), and commercial sectors -- are important. To optimize resources available for family planning, the service system as a whole must be oriented to market segmentation so that each sector serves its target market effectively, so that subsidies are targeted to those who need them, and so that sectors do not duplicate efforts in attempting to serve the same clientele

Egypt is currently in the enviable position of having most family planning clients obtaining both contraceptive commodities and family planning services from the private/commercial sector. Figure A-1 graphically depicts this favorable mix. The activities under POP/FP III will need to facilitate and strengthen this positive picture. That is, as the real number of family planning users increases, the percentage served by the private, commercial sector should be maintained and, if possible, increased slightly

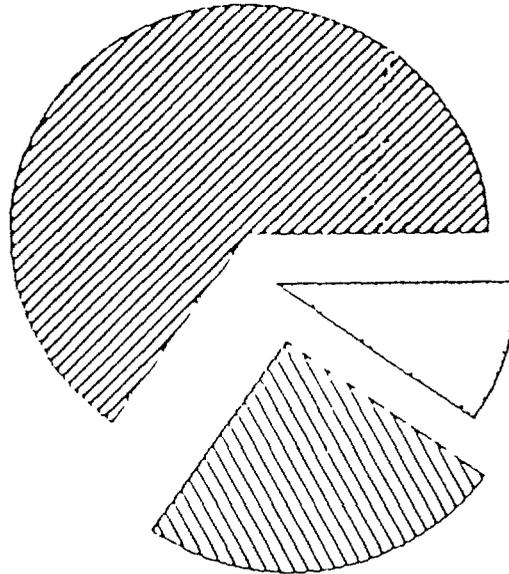
This positive picture with respect to supply and service sources is overshadowed by the fact that the contraceptive supplies themselves are contributed by donors, heavily subsidized, and subject to ceiling price controls determined by the government. Thus, the GOE is subsidizing the private sector, allowing practitioners to purchase contraceptives cheaply and then obtain either a low or high mark-up depending on his/her clientele. For Egypt to really implement an increasingly successful service program heavily dependent on the private sector, it needs to

¹⁰ Estimate further data are being collected

FIGURE A-1
**Relative Burden of FP Services:
Public, PVO, & Private Sector
in CYP (000s)**

Adjusted fo Use-Effectiveness & Prevalence Distribution Data
GOE 89-90

PRIVATE SECTOR (65%)
2120



PVO (10%)
324

PUBLIC SECTOR (25%)
816

PRIVATE SECTOR	EPTC and FOF distribution to private pharmacies and private doctors
PUBLIC SECTOR.	MOH, CHO, THO, HIO, Al Axhar
PRIVATE VOLUNTARY	EFPA, EFPA/CSI, CEOSS, BPSS

mobilize all efforts toward moving contraceptive supply channels to the private sector

b. Collaborative Approaches among Public and Private Agencies

Collaboration among organizations providing family planning services has been and continues to be a problematic area for Egypt's national family planning program. Competition is more the norm. While some competition can increase productivity, excessive competition leads to counterproductive activities. POP/FP III activities are intended to enhance collaboration. Based on the analysis of the sector mix and the contribution of each to contraceptive prevalence, activities for each sector were selected to focus on the strengths of that sector as well as reducing redundancy

c. Impact of Resource Allocation

The investment strategy for A I D donor resources to assist the GOE in achieving its fertility objectives calls for assisting the largest sectors in the program with strategic resources, since those entities can deliver services on a scale large enough to achieve the greatest impact in fertility reduction. Depending on the sector, the actual amount of resources required may be small or large based on need determination

Private/Commercial Sector The private/commercial sector in Egypt is the largest provider of services, and as such should take priority. From a structural viewpoint, this characteristic implies a special challenge in planning assistance to the sector. The national program depends heavily on the private sector to be a partner in service delivery. But, by its very nature as a non-public mechanism, the private/commercial sector is not amenable to the same controls and accountability as are publicly-supported sectors. There is no direct control mechanism to ensure that service volume is maintained or that service quality is high. Likewise, channels through which to feed key inputs such as training are indirect, through professional associations, etc., in contrast to the public and PVO service provider sectors, where inputs can be channeled through staff development mechanisms

This complicates designing assistance to the sector since the direct channels of control and support systems which back up public and PVO service provider programs cannot be employed. As a result, the Project can have more control and assurance of its ability to bring about results in the publicly-supported sectors, which account for less than one third of all services provided, than in the private/commercial sector which contributes more than two-thirds

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However, under no circumstances should activities under the POP/FP III Project increase or cause to increase the presence of public sector control and/or management of private/commercial sector activities. Such public constraints on private operations have already been identified as a major obstacle to increased effective involvement of the private sector in family planning service delivery in Egypt. While POP/FP III assistance to the private/commercial sector needs to be indirect and, therefore, structurally more difficult, the size of the sector's participation in family planning service delivery makes such effort mandatory

On the other hand, the amount of resources required from donors to assist the private, commercial sector, even on a priority basis, is small. Because the private/commercial sector sustains its own activities through consumer payments for goods and services received, Project funding assistance to the sector can be limited to relatively small amounts primarily for training and technical assistance in strategically important areas.

Project assistance should be targeted toward producing improved technical competence among private sector providers (physicians and pharmacists) of family planning services, increasing the number of private sector outlets where quality family planning services are available, increasing easy access to the widest possible range of effective contraceptive methods at consumer-affordable yet provider-attractive prices, and increasing consumer demand for private sector-provided family planning services.

However, attention should also be directed at the policy level in order to ensure that the sector has unconstrained access to affordable contraceptives -- especially IUDs. USAID has provided an indirect subsidy to the commercial sector by making subsidized contraceptives (IUDs, condoms, and oral contraceptives) available. This subsidy will end by December 1993 when supplies made available to the Family of the Future (FOF) are expected to be depleted.

Although small in direct monetary amount, POP/FP III assistance to the private/commercial sector will have significant impact on the achievement of the Project's purpose because of the sector's nationwide scope and fundamental capabilities. In other words, strategic investments in the private/commercial sector are highly leveraged, catalytic inputs returning much more in impact than the size of the investment would normally indicate.

Ministry of Health The second largest sector is the public sector. It is a high priority sector. Its funding needs are

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large and absorptive capacity is improving. The MOH system can do specific things to help increase contraceptive prevalence and improve use effectiveness. Further support to the Family Planning Systems Development Project (SDP) which commenced under POP/FP II is indicated in order to institutionalize the systems developed under the current Project. In addition, the initiatives begun under the Teaching Hospital Organization (THO) need additional time and inputs to develop and to serve the MOH system more fully. For example, the training program is important to the MOH system. Further, THO hospitals can provide demonstration sites for delivery of advanced clinical methods and for more complete use of the MOH hospital setting for delivery of family planning services. USAID has a comparative advantage in supporting the MOH, due to past successful initiatives, and USAID's strategic orientation to invest its resources where large scale gains can be made. UNFPA, while judging population the top priority in Egypt, plans to fund little in family planning service delivery, in view of USAID's plan to continue as a major donor.

Private Voluntary Organizations (PVOs) All private voluntary organizations in Egypt are registered under the Ministry of Social Affairs (MOSA), which has financial and administrative oversight responsibility for their operation. PVOs currently involved in any aspect of the Egyptian national family planning program can generally be divided into two main categories: PVOs which are the representative bodies of large groups of private professionals (such as the Egyptian Junior Medical Doctors Association and the Egyptian Medical Association) and PVOs which are themselves providers of family planning services to end-users (such as community development associations, religious foundations, or other non-profit groups whose clinics, staff, and/or volunteers provide family planning services).

PVOs which exist as the representative or governing bodies of professional groups do not themselves need the financial support of donors in order to exist. Their support is provided by membership fees and fees for services provided to their members. These groups may be, however, appropriate and effective mechanisms for reaching their members with information, training, or other professional opportunities related to improving family planning service delivery.

PVOs which provide family planning services in Egypt have usually been, by definition of the GOE, members of the Egyptian Family Planning Federation. This loose federation of PVO clinics provided less than 1 percent of national contraceptive prevalence according to the 1988 DHS. It is generally assumed that PVOs which provide family planning services to end-users serve low

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income and underserved segments of the general population. Because PVO clients are by this very definition unable to pay the full cost of the services which they receive, service providing PVOs must seek other sources of funds to subsidize their costs of service delivery. In Egypt, such PVO service providers are supported by -- in addition to small scale cost recovery from user fees -- donations from the institutions which run them, fund raising from the population at large, the MOSA, and foreign donors.

PVO service providers' inherent access to low income, geographically remote, or culturally isolated sub-groups makes them especially attractive to family planning strategists who seek established networks for delivering services to these potential clients. Providing assistance to such PVOs can be difficult and managerially intensive, however, since most PVO service providers are independent clinics accountable to community level organizations or are associated with only a small number of other provider PVOs under a religious or other umbrella organization. Even the Egyptian Family Planning Association's (EFPA) large federation of clinics providing family planning services is a loosely knit conglomerate of clinics which are, for the most part, directly responsible not to the EFPA central management system but to the local community development associations which sponsor them.

The PVO service delivery sector requires management and assistance input at the community level to a multiplicity of independent outlets, while it provides service to a significantly limited number of family planning clients. This combination of input and output does not play to the comparative strengths of USAID as a donor/assistance agency. In principle, USAID is not best situated to provide direct family planning funding support to PVOs in Egypt, with the possible exception of the Clinical Services Improvement Project (CSI) initiated under POP/FP II with the EFPA.

The quality of care provided by CSI to its clients is quite high. While the amount of donor funding for TA and core support required to attain this level of service prevents the CSI system from being used as a direct model for the MOH or private practice physicians, the presence of CSI in the marketplace has provided upward pressure on other services providers such as the MOH to improve the level of quality of their services in so far as is possible. This is evidenced by the interest in operations research to improve service delivery, initiation of quality assurance programs throughout the Egyptian national program.

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CSI has also hired, trained, and monitored outreach staff who work in the communities surrounding CSI clinics to promote family planning and CSI services. This promotional work for family planning can benefit other sectors. CSI is relatively new and has the potential to impact on the EFPA, the largest PVO involved in family planning. Thus, while more information is needed on the market segment served by CSI, further support is warranted as it increases its cost recovery and proceeds to a more self-financed basis.

d. Analysis of POP/FP II Implementing Agencies

An analysis was undertaken during the PID stage of Project design to analyze each POP/FP II subproject in terms of its contribution to CYP and its cost effectiveness. This analysis is presented below in Table A-3, and was used as a tool in POP/FP III subproject selection.

**TABLE A-3
POP/FP II IMPLEMENTING AGENCIES: CONTRIBUTION AND COST EFFECTIVENESS**

Subproject by Element	Time Period & Planned Funding as of 4/91	Contribution to Effective Prevalence	Removal of Constraints to Demand	Cost-effectiveness	Reach Target Populations
I CONTRACEPTIVES					
1 Contraceptives & Related Supplies	1983-1993 (5/31/93) \$29,486,000 (total project)	IUDs definitely; OCs, not conclusive, condoms & VFT marginal at best	May enable GOE to maintain price controls (a disincentive to private sector activity), GOE subsidization may limit supply as well as contraceptive choices	Probably Yes for IUDs No for VFTs & condoms -- little impact on CPR relative to large \$ investment Additional information on delivery systems desirable	Contraceptives delivered through various delivery channels have reached MWRA, efficiency of various delivery approaches should be examined

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Subproject by Element	Time Period & Planned Funding as of 4/91	Contribution to Effective Prevalence	Removal of Constraints to Demand	Cost-effectiveness	Reach Target Populations
II PRIVATE/COMMERCIAL FP PROGRAMS					
2 Family of the Future (FOF) Supplies	7/1/88-5/31/93 \$15,000,000 (includes TA excludes contraceptives)	Significant from IUDs to private doctors and pharmacies, Has small share of OC market May contribute indirectly to ineffective use of OCs which is due partly to provision by pharmacies w/o sufficient guidance on use, although condom distribution is effective prevalence is low	OC failure and discontinuation because of lack of information and counseling may limit demand for OCs Distribution of low cost contraceptives may be inhibiting the commercial sector	With respect to condoms and OCs, little impact on CPR relative to large \$ investment – OC distribution is duplicative of that of Schering & Wyeth Need to examine current clinical and community outreach programs	Don't know market share in target areas like Upper Egypt Need SES information for Norminest users
3 Clinical Service Improvement Project (CSI)	7/1/87 - 5/31/93 \$14,866,500 (includes TA & Vehicles)	High quality services reaching significant numbers particularly with the IUD – 70% of acceptors not current users when they came to CSI	Services targeted at areas with high potential number of users who can pay CSI charges – strong outreach program – attention to quality and client needs may produce satisfied users who contribute to increased demand	Initial costs appear high CSI may be providing subsidized services to clients who would otherwise use the low and of the private sector and otherwise competing for clients with delivery systems that are less subsidized CSI is currently donor dependent Reasonable options for substantial cost recovery exist	Services targeted at women a notch above MOH clients i.e., those who can afford to pay a little
4 Private Practitioners Family Planning Project (PPFPP)	10/1/89 5/31/93 \$2,889,320	Difficult to assess – service delivery commenced 7/90 – need to determine if project attracts new acceptors or shifts users	Possibly will further medicalize FP	Need more info could leverage increased interest in FP in private sector if MDs profitable practice – important not to subsidize or "deprivatize" the private sector	Yes if it increases supply of trained female MDs (current priority) from conservative and underserved areas – need info on distribution of trained MDs

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Subproject by Element	Time Period & Planned Funding as of 4/91	Contribution to Effective Prevalence	Removal of Constraints to Demand	Cost-effectiveness	Reach Target Populations
5 Comprehensive Family Care Project (CASC)	11/1/90 - 10/31/92 (planned subagreement pending) LE 1,898,738 and \$160,085 excludes contraceptives) Received earlier support as FPIA subproject	May contribute to increased prevalence in underserved areas -- data not available from period with FPIA support	Uses community leaders & increases FP acceptability as well as generates demand through emphasis on outreach	Data not available	Directed at underserved populations and seeks to increase access through community sanctioned delivery systems
6 Rural Community Based Family Planning Project (CEOSS)	11/1/90 - 5/31/93 (CA pending) LE 1,041,163 \$124,362 (excludes contraceptives) received earlier support as FPIA subproject	Promotes effective use -- need info on relative contribution (i.e. new acceptors and population served) Ltd data from period under FPIA	May increase acceptability through use of community volunteers with access to local leaders	Potentially -- if sustainable -- donor support modest	Directed at rural populations in Upper Egypt
7 Governors' Councils for Women for Development & FP Training Project (ITRFP)	1/1/91 - 5/31/93 \$242,501	Indirect, not service delivery	Could increase demand through training of local woman leaders as FP advocates Broadens FP constituency Could be influential with NPC/local FP decision making	Too early to assess	Directed at Upper Egypt
8 CEDPA Projects in Egypt -- a ITRFP Clinic FPSD b BPESS Upper Egypt	a completed (9/1/86 - 1/1/90) \$53,800 b 3/1/90 - 2/28/93 \$256,257	Can't assess to date, #s for clients only first two quarters Ultimate contribution probably small	b promotes FP acceptability & access in rural areas through quality service delivery and linkages with literacy and income generation	Too early to assess integrated into community organizations so potential for sustainability	Directed at important target population of Upper Egypt and Rural women
9 Training Professionals in Family Life Education and Counseling	Completed (12/10/87 - 2/25/90) LE 352,899 and \$21,210				
10 FPIA Projects in Egypt See # 4, 5 & 14	Terminated 10/31/90 (1987-1990) \$727,744				

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Subproject by Element	Time Period & Planned Funding as of 4/91	Contribution to Effective Prevalence	Removal of Constraints to Demand	Cost-effectiveness	Reach Target Populations
III NATIONAL POPULATION COUNCIL					
11 Institutional Development	9/87 - 5/93 \$4,355,688	Not applicable	Promotes local support and planning. Has the potential to increase acceptability and local resource allocations	Can not assess	N/A
12 Core Support for Egyptian Fertility Care Society	Completed (1/88 - 12/89) \$156,000				
13 NORPLANT Project	4/87 - 5/31/93 IL 1 938 013 \$14 543	If approved and made available	Demonstrated safety and acceptability of NORPLANT which could be important addition to effective method mix	Can not assess	Could be an excellent method for populations with ltd access to FP
14 Regional Center for Training (RC1) in FP	11/1/88 - 5/31/93 IL 4 761 338 \$2 007 000	Direct contributions to service quality through training and development of national service delivery guidelines	Aimed at two important supply constraints -- provider knowledge and service quality need to ensure that it does not further medicalize FP	Require follow up data on trainees and use of guidelines to assess Good potential for some cost recovery but likely to require assistance LOP	If it is training providers who will deliver services to target populations
15 Family Planning Services Project of Al-Azhar University	11/1/90 - 5/1/93 IL 724 891 \$12 000 center support GPA #9		Contributes to acceptability -- very well respected Islamic center of learning	Can not assess	Need information on clinic locations and client populations and extent of activity rural areas
16 Egypt 21 (RAPID)	Completed 4/87 - 12/90 \$22 299 IL 260 500				
IV MINISTRY OF HEALTH IN THE PUBLIC SECTOR FP PROGRAMS					
17 Family Planning Systems Development Project (SDP)	7/1/87 - 12/31/92 \$7 020 220 IL 22 288 250	Supports increased and improved MOH service delivery which is a major provider to low income women (estimated 509,217 new users in 1990) Emphasis on IUD contributes to limited method mix but high CYP	Affects accessibility and acceptability -- need more information on subsequent contraceptive practice by MOH acceptors	Largely if indirectly supported by GOE builds upon GOE existing investments	Provides services in 21 governorates directed at those who can not pay for services

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Subproject by Element	Time Period & Planned Funding as of 4/91	Contribution to Effective Prevalence	Removal of Constraints to Demand	Cost-effectiveness	Reach Target Populations
18 Comprehensive Urban Family Planning Services in Greater Cairo (CHO)	11/1/89 10/31/92 LE 313,000	Ltd impact (3 year target 10,400 acceptors)	Cost reimbursable scheme may be model for social insurance	Probably not -- depends on levels of continued service once USAID support is reduced just to contraceptives	Is not targeted at reaching underserved populations
19 Health Insurance Organization FP Service Project (HIO)	4/88-12/31/92 LE 3,469,846 \$567,571 for TA	122,074 acceptors	Unlikely -- may just substitute for other private services	Probably not	Ltd opportunity to reach new acceptors - serves a population with access to other services
20 Teaching Hospital Organization (THO)	8/1/89 5/31/93 LE 1,991,730	Aimed at improving quality -- too early to assess impact on prevalence	Depends on ability to reach and serve new acceptors Contributes to quality and FP support in medical community, given prominence of teaching hospitals and El Galaa in particular	Can not assess at this time	Need more experience and info on coverage and client population
V INFORMATION EDUCATION AND COMMUNICATION (IEC)					
21 State Information Service	6/83 12/92 (to be extended 5/93) \$9 386,000	N/A	Important for demand generation and info on safety acceptors and use	High air time free	High coverage 79% watch TV daily
VI POPULATION STATISTICS & POLICY					
22 Central Agency for Public Mobilization & Statistics (CAPMAS)	10/85-6/30/91 obligated \$3,564,000 as of 12/89, also \$6,380 700 CIP funds	N/A	Standard data important, potential to identify target beneficiaries of public programs obtain data on SES and define poverty line"	N/A	N/A
23 Cairo Demographic Center	7/1/87 12/31/92 \$529 000	N/A	Could provide important information on constraints and have indirect effects on supply/demand & improve program management and planning	N/A	N/A

4. Financial Base

The financial challenge at the consolidation level is to increase efforts to achieve sustainability. The POP/FP III Project must work towards increasing services and improving service quality on a cost effective basis. Service costs need to be reduced through better management and program efficiency. Further, local support for services should increase.

a. Service Costs Reduced Through Better Management and Program Efficiency

Management has to do with the organization and direction of limited resources to achieve desired ends (goals, objectives, targets) and the assessment of progress or achievement towards those ends. Planning is a process of allocation of limited resources for desired or preferred objectives, and the defining (and redefining) of feasible targets given resource limitation. Supervision is the immediate oversight in the use of resources, particularly the costly and highly variable human resources. These three activities, planning, management and supervision, are often combined under the general rubric of management. The need for management increases directly with the scarcity of resources.

As pointed out previously, as Egypt moves toward its goal of increasing contraceptive prevalence, the costs of the program necessarily increase. However, these costs can be minimized when resources are used effectively and efficiently. Thus, sound management is necessary to support these goals, not to mention the goal of decentralization.

There are a number of management and supervisory strengths that have been developed under POP/FP II. They are.

- Leaders of the family planning implementing agencies are experienced and charismatic, with a strong commitment to policy development, institutional development and targeted achievements.
- Resident consultants are well accepted and are actively working with their counterparts to develop the institutions and their information systems.
- Through exceptional effort, national family planning guidelines, as well as management manuals essential to implementing a management system, have been developed and are in various stages of implementation.

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- A national information system for Family Planning has been developed and could be expanded to become a functional MIS for the FP service program with the inclusion of some management detail
- Computer hardware and software for data entry and analysis exist Although primarily located at the central levels, the potential is good to decentralize

On the other hand there are weaknesses which require attention. They are

- Lack of a strong, widely understood national strategy in FP
- Lack of adequate analysis of service reports and rapid feedback for management purposes
- Lack of sufficient practical training in management practices, especially personnel and decision making practices
- Very limited, if any, delegation of authority and responsibility by central levels
- Physicians as head of units are trained clinically, and may have less interest in the science or application of management Physicians in FP service units are usually temporary and are often absent from the service unit on training or other developmental activities They show no long term commitment to staff or to community.
- Supportive supervision, and its relationship to training and human resource development, is not well understood Supervision is usually confined to checklists and often punitive in nature
- Basic management and supervisory tools for personnel management, such as job descriptions, staff meetings and individual workplans for the coming week/month, are often missing (Job descriptions exist for all categories of manpower, as well as functional statements for Units at all levels, but these are not available to the individuals or their supervisors)
- Salaries are very low, and directly related to the sense of commitment Supplementary incentives are difficult to organize

Structural issues in management within the NPC and MOH need attention Within the Ministry of Health there is the need to

examine the costs and benefits of integrating the SDP into the general structure of the Ministry. Family planning will continue as a Ministry responsibility over many decades. A plan is desirable, within the MOH, for the future integration of the FP service into the Ministry. Continuing support for management and supervision development must come from local and/or foreign technical assistance.

Human resource development is essential to develop service capacity. Leadership must be supported for study and travel internationally to develop the breadth of viewpoint and vision necessary to sound planning and administration. Staff require technical skills in systems analysis, in management, in cost accounting, in commodity and inventory control, and especially in information analysis for planning and evaluation.

b. Local Support for Services

The total system costs in a consolidation-stage program are large and will grow rapidly as both the population and contraceptive prevalence increase. Thus, it is imperative that public sector resources (both donor and host government) are invested where they will have the most impact, and that other sectors function at optimal levels in terms of maximum prevalence and user effectiveness in their target markets. Two sources shed some light on costs of various delivery channels and their sources of financial support, but again the data are not sufficiently strong and complete to be more than indicative.

Acceptor Payment for Services-1988 DHS: In the absence of consumption data which would help to profile the socioeconomic situation of Egyptian families, payment patterns for family planning services may help to clarify willingness and ability to pay. The 1988 DHS asked women about the cost of obtaining IUDs and then having them inserted. Private physicians accounted for 54 percent of IUD insertions; for these IUDs, 58 percent of women paid more than LE 15 for the IUD and insertion.¹¹ Breakdowns on amounts paid by socioeconomic groups are equally revealing. In the urban governorates, 65 percent of women who used private physicians paid more than LE 15. In Lower Egypt, 47 percent paid

¹¹ Note that the MOH has a price list for its contraceptives--the IUD costs 2 LE. According to the EDHS, the majority of users of public sector clinics and MCH centers paid 2 LE or less, while more than 40% of acceptors in public sector hospitals paid in this range.

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more than LE 15, and in Upper Egypt, 69 percent paid in this range.¹²

When level of education is examined, a pattern of increasing use of private physicians--and increased level of payment--is observed as education increases. Within the group with no education, still nearly half (47 percent) used private physicians and 42 percent of these paid more than LE 15 in 1988. Usage and payment increase as education rises, until for those who have completed secondary or high school, 78 percent of women are seeing a private physician and 74 percent of these are paying more than LE 15.

These data, while not conclusive, indicate an underlying willingness and ability to pay on the part of many acceptors. A great many acceptors (even among those with no education) were in 1988 paying more than LE 15 for an IUD insertion. Motivated users were spending relatively large sums to receive family planning services from private physicians, even if it meant they had to stretch to do so. This has two implications. First, many acceptors, even uneducated ones, turn to private physicians as a resource for family planning for which they pay. There is anecdotal evidence to suggest that Egyptian consumers prefer to use private physicians for health care whenever cost considerations permit. This is important in planning the evolution of MOH services. Modest improvements in quality are under consideration in the design of POP/FP III, and in light of this fact, questions always arise about whether these improvements will attract consumers who can afford to pay from other sectors. The availability of profiles of users of various sectors would help greatly to answer the question whether (and under what conditions) Egyptian consumers prefer private providers and whether modest changes in MOH quality would move consumers who can afford to pay to change their source of service to the subsidized public sector.

Second, the underlying willingness and ability to pay has implications for CSI's pricing structure. CSI's price for IUD insertion is LE 12 (which can be offered because of the large subsidy borne by USAID). This price may be too low and thus invite consumers who are willing and able to pay a private physician to switch to the subsidized service. While it is argued that CSI is bringing in acceptors who have not previously used family planning, this begs the question if these users are

¹² The magnitude of the latter figure may be due to the fact that contraceptive usage was comparatively lower in Upper Egypt, therefore the initial acceptors tended to be from the better-off, more motivated stratum.

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from the private physicians' market. This group can afford to pay, and precious public sector/donor resources need not subsidize them.

Public and voluntary agencies rely on government and donor allocations while the for-profit sector relies on client payments to meet service delivery costs. No direct allocation of public resources is needed for the for-profit sector. There is need to encourage and possibly expand the for-profit sector through favorable regulations, education opportunities and an assured supply of contraceptives.

Cost per CYP-the Heilman Study For service providers receiving public sector funds, the Heilman study also looked at cost per CYP (adjusted for use effectiveness of the pill). It must be remembered, however, that cost per CYP comparisons do not necessarily reflect differences in the difficulty of reaching the populations served.

The findings of the Heilman study for the year 1989-90 will be highlighted below, but it is important to keep in mind, as a reference, that the cost to the public sector per CYP delivered by the private/commercial sector is \$0, except for public sector subsidies of contraceptive commodity costs. The Heilman study found that when total cost was considered, MOH cost/adjusted CYP was LE 17.70. By comparison, the second largest service provider, EFPA, was estimated to be LE 13.26 (note that because of managerial problems at the central EFPA offices and because of the loose federation of service providers, there are concerns about the quality of EFPA services and data provided). CSI, the third largest provider, was LE 66.22. CSI costs per CYP will presumably continue to drop as volume increases, but the unusually high standard of quality of care, which competes with good quality programs in the developed world, will always make this an expensive service.¹³ It should be noted that internationally the costs associated with one CYP range from US\$8-20. Cost is influenced by method, transport, contraceptive supply channel, etc.

5. Donor Support

One of the challenges for family planning programs at the Consolidation level is to identify multiple sources for contraceptives as well as to leverage donor and private resources through currency conversion and corporate donations. The supply

¹³ Preliminary data from 1990-91 study indicated CSI cost/CYP fell to LE 45.71, compared to LE 13.64 for the MOH and LE 18.37 for the EFPA.

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and distribution of contraceptive commodities has been discussed under Service Delivery. The impact of donor subsidization is now discussed

Under POP/FP III, a number of changes will be made in both the contraceptive methods supplied by USAID and in the distribution mechanisms used. These changes are being instituted to increase the strategic value of USAID's resources, to increase prevalence among groups who might otherwise not have access to contraceptives, and to increase the effectiveness of methods offered.

One of the significant challenges in the POP/FP III design process is planning how best to support Egypt's active, multi-sectoral service delivery system with technical assistance and operational support so that all Egyptian families have available and accessible services. Therefore, refined information on market segmentation (i.e., identifying the groups of consumers which each sector intends to serve and the methods which the sectors can appropriately supply to those client groups) is essential to this planning. The strategic planning process is also concerned with the comparative strengths of donor organizations to support the sectors. Specific sectors have greater or lesser need for technical assistance and budget support from donor agencies. Also donor agencies may be more or less well situated to support a specific sector in accomplishing their objectives.

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B. Financial Analysis

The analysis of financial considerations for the POP/FP III Project focuses on detailed cost estimates, based on standard input costs, and estimates of the host-country contribution. The following items are included in this financial analysis of the POP/FP III Project

- discussion of financial consolidation within POP/FP III,
- construction of standard unit costs,
- detailed cost estimates, by subproject and project year, including illustrative budgets,
- host-country contributions, by implementing agency and type of contribution (cash vs in-kind);
- recommended mechanism for GOE premium pay (AGR-IDAFI); and
- cost recovery and self-sufficiency considerations for the CSI subproject

1. Financial Consolidation Within POP/FP III

From a financial perspective, the POP/FP III Project is substantially more consolidated than was the POP/FP II Project. This consolidation is manifested in several ways:

- First, USAID is working with fewer subprojects. The approximately \$62 million over nearly five years will be expended within only eight subprojects,¹⁴ rather than the 23 subprojects involved in the previous project. As demonstrated in the Technical Analysis, the subprojects selected are those that have the potential for the greatest contribution to demographic change
- Second, there is a general reduction in programmed support. Nearly all the implementing agencies will be receiving a

¹⁴ These eight subprojects are MOH (SDP), Contraceptive Commodities THO NPC, RCT SIS CSI and Private Sector Initiatives

Source Selection Information -- See FAR 3.104

slightly smaller average annual allocation than under POP/FP II

- Third, there is a substantial reduction and redirection of the distribution of contraceptive commodities. They will no longer be provided to the private commercial sector, but only to the public-sector, and through it, to a limited number of PVOs.
- Fourth, there is a consolidation in the provision of technical assistance, with all expatriate TA being channeled through the I/GS contract to be awarded before project implementation. This leads to greater efficiency in organizing TA inputs.

Overall, through the strategic approach chosen for project design and the management option selected, the POP/FP III Project is likely to be far more efficient than earlier projects in the conversion of inputs to project outputs over its lifetime

2. Standard Unit Costs and Detailed Cost Estimates

a. Methods Used in Estimating Costs

Costs for each project element were obtained by applying standard unit costs to inputs. Input levels were based on the expertise of the technical specialists, together with the experiences of the POP/FP II Project in carrying out similar activities. From this, an illustrative budget was prepared for each subproject, with projected expenditures broken into line items by project year. (These illustrative budgets are included in the Subproject Worksheets which follow.) Then, line items were aggregated into standard categories shown in Tables B-1, B-2, and B-3, and then summarized in Tables 1-4 for the main body of the Project Paper. Standard unit costs were derived from the following sources:

- **labor and direct costs associated with long-term and short-term technical assistance:** basic information from USAID/Egypt FM/FA Office. Detail presented in Input Worksheets 1 A through 1 D and LOE Worksheet 1 A
- **office supplies, office equipment, medical equipment:** information from POP/FP II Project budgets for NPC, MOH/SDP and CSI subprojects, and cost study prepared by Heilman et al, 1991. Detail presented in Input Worksheets 3.A through 3 C and the Subproject Worksheets. An illustrative list of non-

Source Selection Information -- See FAR 3.104

contraceptive commodities to be procured through TA/management contractor is presented in Input Worksheet 3.A

- **vehicle procurement and maintenance:** basic information from USAID/Egypt FM/FA Office. Detail presented in the Subproject Worksheets and Input Worksheet 3 A through 3.C.
- **in-country training:** information derived from technical specialist estimates; training expenditures and budget data from THO, and a study of costs in the RCT prepared by Martinkosky, 1990. Detail presented in the Subproject Worksheets.
- **participant training and consultation:** basic information from USAID/Egypt FM/FA Office. Detail presented in Input Worksheet 2 A through 2 B.
- **host country contribution:** information derived from Heilman et al, 1991, and interviews with GOE counterparts, includes salaries, normal GOE premium pay, incentives, host-country costs for participant training, radio and television air time, etc. Detail presented in Table B-4, including breakdown of cash and in-kind contributions

b. Standard Labor and Related Costs

A large share of the total cost of this project is allocated to expatriate short-term and long-term technical assistance and related costs. For budgeting purposes, standard costs were developed for a person-month of resident TA labor, and a person-month of short-term TA labor. These standard costs are presented in Input Worksheet 1 A through 1 D, below

Source Selection Information -- See FAR 3.104

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INPUT WORKSHEET 1.A
STANDARD COSTS FOR TECHNICAL ASSISTANCE: LONG-TERM U.S

LONG-TERM (4 6-YEAR) CONTRACT WITH U.S. CITIZEN FOR PERSONAL SERVICES WORKING UNDER LONG-TERM CONTRACTOR¹

INPUT	TOTAL
Salary (4 6 years @ \$70,000 per year)	\$322,000
Post Differential (15 salary)	48,300
FICA (0765 on \$51,300 per annum max)	18,052
International Travel (w/22 lbs excess baggage and per diem - employee & 3 dependents)	20,000
Household, Vehicle Shipment and Storage	20,000
Unaccompanied Baggage (600 lbs @ \$3 65)	2,190
Emergency Medical Travel (5 @ \$1,300)	6,500
R&R (2 @ \$8,000)	16,000
Home Leave (1 @ \$20,000)	20,000
In-country Travel (\$120 p/d&transportation x 40 trips/yr x 4 6 yrs)	22,080
Residential Rent (\$14,800/year for 4 6 years)	68,080
Utilities (\$1,800/year for 4 6 years)	8,280
Furnishings/Appliances	4,500
Temporary Lodging Allowance (2 @ \$1 065)	2,130
Education Allowance	87,600
Health and Life Insurance (max)	5,000
Physical	3,000
Misc/Contingency	5,000
SUBTOTAL	678,713
MULTIPLIER (1 7) ²	475,099
TOTAL	\$1,153 811
 COST PER ANNUM	 \$250,829

In full budget, estimate at \$20 902 per month

NOTES

- 1 Assumes 3 dependents (spouse and two school-aged children)
- 2 The multiplier represents the typical amount charged by contractors for overhead fixed fee, etc

Source Selection Information -- See FAR 3.104

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INPUT WORKSHEET 1 B
STANDARD COSTS FOR TECHNICAL ASSISTANCE SHORT-TERM U S.

SHORT TERM (1-MONTH) CONTRACT WITH U S CITIZEN FOR PERSONAL SERVICE WORKING UNDER LONG-TERM CONTRACTOR

INPUT	TOTAL
Salary (\$70,000/year or \$269/day for 25 days)	\$6,725
FICA (0765 on \$51,300 per annum max)	442
International Travel (w/22 lbs excess baggage and per diem)	5,000
Per Diem (\$150/day for 31 days)	4,650
In-country Travel (\$120 p/d&transportation x 3 trips/mo)	360
Misc/Contingency	600
 SUBTOTAL	 \$17,777
MULTIPLIER (1.7) ¹	12,444
TOTAL	\$30,221

In full budget, estimate at \$30,221 per month

NOTES

1 The multiplier represents the typical amount charged by a contractor for overhead fixed fee, etc

INPUT WORKSHEET 1 C
STANDARD COSTS FOR TECHNICAL ASSISTANCE SHORT-TERM EGYPTIAN

SHORT-TERM (1-MONTH) CONTRACT WITH EGYPTIAN CITIZEN FOR PERSONAL SERVICES, WORKING INDEPENDENTLY

INPUT	TOTAL
Salary (\$25,000/year or \$96/day for 25 days)	\$2,400
In-country Travel (\$120 per trip x 3 trips/mo)	360
Misc/Contingency	600
 TOTAL	 \$2,760

In full budget, estimate at \$2,760 per month

Source Selection Information -- See FAR 3.104

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FINANCIAL ANALYSIS

INPUT WORKSHEET 1 D
STANDARD COSTS FOR TECHNICAL ASSISTANCE PSC

LONG-TERM (4 75 YEAR) CONTRACT WITH US CITIZEN FOR PERSONAL SERVICES WORKING IN HRDC/P¹

INPUT	TOTAL
Salary (4 75 years @ \$60,000 per year)	\$285,000
Post Differential (15 salary)	42,750
FICA (0765 on \$51,300 per annum max)	18,641
International Travel (w/22 lbs excess baggage and per diem - employee & 3 dependents)	20,000
Household, Vehicle Shipment and Storage	20,000
Unaccompanied Baggage (600 lbs @ \$3 65)	2,190
Emergency Medical Travel (5 @ \$1,300)	6,500
R&R (2 @ \$8,000)	16,000
Home Leave (1 @ \$20,000)	20,000
In-country Travel (\$120 p/d&transportation x 40 trips/yr x 4 75 yrs)	22,800
Residential Rent (\$14,800/year for 4 75 years)	70 300
Utilities (\$1,800/year for 4 75 years)	8,550
Furnishings/Appliances	4,500
Temporary Lodging Allowance (2 @ \$1,065)	2,130
Education Allowance	90,261
Health and Life Insurance (max)	5,000
Physical	3,000
Misc/Contingency	5,000
TOTAL	642,622
 COST PER ANNUM	 \$135,289
 In full budget, estimate at \$11,274 per month	

NOTES

1 Assumes 3 dependents (spouse and two school-aged children)

c. Level of Effort and Associated Costs

Given standard person-month costs for long- and short-term technical assistance, costs associated with level of effort were estimated. These are shown in the LOE Worksheet, below. As shown, a total of 587 person-months of technical assistance (both US and Egyptian) are budgeted, including the management personnel under the TA/management contract. This LOE translates into approximately \$18.96 million over LOP.

Source Selection Information -- See FAR 3.104

ANNEX B
FINANCIAL ANALYSIS

LOE WORKSHEET 1.A
ESTIMATED LEVELS OF EFFORT (Person-Months)

TYPE	PREIMP	YR 1	YR 2	YR 3	YR 4	POSTIMP	TOTAL
EXPATRIATE							
Chief-of-Party	5	7	6	6	6	1	31
Fin/Admin	5	13	12	12	12	1	55
NPC Adv (Management)	5	13	12	12	12	1	55
NPC Adv (Research)	5	13	12	12	12	1	55
MOH Adv (Management)	5	13	12	12	12	1	55
MOH Adv (Training)	5	13	12	12	12	1	55
IEC Adv	5	13	12	12	12	1	55
Private Sector Adv	0	6	6	6	6	0	24
MOH S-T	0	13	12	12	12	0	49
SIS S-T	0	8	8	8	8	0	32
CSI S-T	0	4	4	4	4	0	16
RCT S-T	0	2	2	2	2	0	8
THO S-T	0	6	6	6	6	0	24
Private Sector S-T	0	6	6	6	6	0	24
EGYPTIAN							
MOH S-T	0	13	12	12	12	0	49
SUPPORT							
Assistants	10	26	24	24	24	2	110
Secretaries/Clerks	4	52	48	48	48	4	220

LOE WORKSHEET 1.B
ESTIMATED COSTS ASSOCIATED WITH LEVEL OF EFFORT

TYPE	PREIMP	YR 1	YR 2	YR 3	YR 4	POSTIMP
US LT TA / Year	\$263	\$277	\$290	\$305	\$320	\$336
US ST TA / Month	\$32	\$33	\$35	\$37	\$39	\$40
Egyptian ST TA / Month	\$3	\$3	\$3	\$3	\$4	\$4
Assistant / Year	\$9	\$9	\$10	\$10	\$11	\$11
Secretary / Year	\$5	\$5	\$5	\$5	\$5	\$6

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**d. Standard Costs for Participant Training and
Consultation/Invitational Travel**

Using information provided by USAID/Egypt FM/FA Office, standard costs for participant training and consultation/invitational travel were developed. These are shown in Input Worksheet 2.A and 2.B respectively, below

**INPUT WORKSHEET 2 A
PARTICIPANT TRAINING**

ESTIMATED BUDGET FOR ONE PARTICIPANT SHORT TERM TECHNICAL, 5 MONTHS, NO DEGREE

INPUT	COST
Education/Training Costs	\$7,500
Maintenance Advance (for 15 days)	975
Living/Maintenance (for 4.5 months @\$800)	3,600
Books & Equipment	300
Book Shipment	60
Local Travel	600
Insurance (HAC for US @ \$34 per month)	170
SUBTOTAL	\$13,205
Administrative Costs	2,078
TOTAL	\$15,283

**INPUT WORKSHEET 2 B
CONSULTATION/INVITATIONAL TRAVEL**

ESTIMATED BUDGET FOR ONE CONSULTATION 10 DAYS

INPUT	COST
Airfare	\$5,000
Per Diem (10 days @ \$135)	1,350
Conference Fee	200
Local Travel	450
TOTAL	\$7,000

Taking into consideration inflation and contingency, the total of sixty 5-month participant training activities twenty-four

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consultations/invitational travel within POP/FP III are estimated to cost a total of \$1.4 million. This does not include the airfare for participant training, which is a host-country contribution.

e. Standard Costs for Non-Contraceptive Commodities

The c.i.f. costs for non-contraceptive commodities were derived from the experience of subprojects supported under POP/FP II and from the USAID/Egypt FM/FA Office. They are shown in Input Worksheet 3.A below, in 1991 dollars

INPUT WORKSHEET 3 A				
C I F COSTS OF NON-CONTRACEPTIVE COMMODITIES				
Item	(\$000)	Cost (\$000)	20% Trans & Cont	CIF (\$000)
Micro Computer		70	14	84
monitor/keyboard/diskdrive	30			
micro computer printer	1.5			
micro computer software	1.5			
computer site preparation	10			
Utility Vehicle (Jeep type)		208	42	250
5 passenger utility vehicle				
2 wheel drive				
4 cylinder				
gasoline engine				
spare parts (up to 15% of vehicle value)				
Office Equipment		40	08	48
photocopier (minimum 10 copies/minute)				
Audio/Visual Equipment		140	28	168
Items for Governorates				
• Video Camera & Monitor	3			
• Sound Equipment	5			
• Video Editing Equipment	5			
• Overhead Projector	1			
Items for Central Offices		350	70	420
• Video Camera & Monitor	3			
• Sound Equipment	5			
• Video Editing Equipment	5			
• Overhead Projector	1			
• Dark Room Equipment	10			
• Camera Equipment	1			
• Artist Tools for Graphics	1			
• Trimming & Binding Equipment	5			
• Computer Assisted Graphic	4			
Design Equipment				

Source Selection Information -- See FAR 3.104

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Given these input costs, the non-contraceptive commodities and associated costs estimated under the POP/FP III Project are shown in Input Worksheet 3 B, below. The total cost of non-contraceptive commodities (including contingency), to be procured by the I/GS contractor, is estimated to be approximately \$3.8 million over LOP. It is important to note that these inputs were chosen as illustrative and were defined as a result of an analysis of past implementation experience as well as meetings with the implementing agencies. Specifically, the number of vehicles was defined in light of replacement needs of the current fleet. The implementing agencies, with assistance from the I/GS contractor, will draw up exact specifications and details as part of the Four-Year Implementation Plan process, in order to verify the findings of the Project Design Team.

**INPUT WORKSHEET 3.A
NON-CONTRACEPTIVE COMMODITIES**

TYPE	PREIMP	YR 1	YR 2	YR 3	YR 4	TOTAL
Vehicle	2	21	21	20	21	85
Computer	8	67				75
Off Equip	3	31				34
A V Equip		Yes				
Training Materials		Yes				

**INPUT WORKSHEET 3 B
ESTIMATED COST OF NON-CONTRACEPTIVE COMMODITIES**

TYPE	PREIMP	YR 1	YR 2	YR 3	YR 4	TOTAL
Vehicle	\$50	\$551	\$579	\$579	\$638	\$2,397
Computer	\$67	\$591	\$0	\$0	\$0	\$658
Off Equip	\$14	\$156	\$0	\$0	\$0	\$170
A V Equip	\$0	\$97	\$0	\$0	\$0	\$97
Training	\$0	\$33	\$35	\$36	\$38	\$143
TOTAL	\$132	\$1,429	\$614	\$615	\$676	\$3,465

f. Subproject Estimates

The following Subproject Worksheets lay out the preliminary costs estimates assumed for each subproject to be financed under the Project. The final worksheets identify the budget for the remaining costs under the I/GS contract, as well as the Project evaluations. The accompanying notes identify the input assumptions on which the estimates are based, using 1991 costs.

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with inflation estimated at 5 percent per annum, compounded. Contingency is estimated at 10 percent per annum. It should be noted that these worksheets have been developed as illustrative guides for undertaking the planned activities, with an understanding that, while the Project purpose must be clearly stated and adhered to, there needs to be sufficient flexibility in actual implementation of the Project to adapt to changing circumstances.

SUB-PROJECT WORKSHEET 1.A					
SUB-PROJECT SDP (MOH) (THOUSANDS OF \$)					
INPUT	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	TOTAL
I/GS Contract					
TA/M					
Management Advisor (1)	\$300	\$290	\$305	\$320	\$1,215
ST TA US (2)	\$433	\$420	\$440	\$463	\$1,755
ST TA E (3)	\$40	\$39	\$41	\$43	\$163
Special Assessments (4)	\$165	\$174	\$182	\$191	\$713
Participant Trng / Consultation (5)	\$177	\$186	\$195	\$205	\$763
Non Contraceptive Commod					
Computers (6)	\$397	\$0	\$0	\$0	\$397
Copiers (6)	\$126	\$0	\$0	\$0	\$126
Vehicles (7)	\$525	\$551	\$579	\$608	\$2,263
Audits					
Financial Assessment (8)	\$11	\$0	\$12	\$0	\$23
Audit (9)	\$0	\$23	\$0	\$26	\$49
Local Costs					
Local Training (10)	\$485	\$509	\$535	\$562	\$2,091
Workshops (11)	\$22	\$23	\$24	\$26	\$95
Administrative Costs (12)	\$551	\$579	\$608	\$638	\$2,376
Renovations (13)	\$441	\$463	\$486	\$511	\$1,901
Medical Supplies (14)	\$11	\$12	\$12	\$13	\$48
IE & C (15)	\$33	\$35	\$36	\$38	\$143
Subtotal	\$3,717	\$3,303	\$3,456	\$3,642	\$14,119
Contingency	\$377	\$335	\$350	\$369	\$1,432
MOH/SDP TOTAL	\$4,094	\$3,638	\$3,807	\$4,011	\$15,550

NOTES

- 1 Management Advisor Under TA contract
- 2 Short-Term TA (US) Average 1 month long TDY per month over LOP

Source Selection Information -- See FAR 3.104

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- 3 Short-term TA (Egypt) Average 1 month-long TDY per month over LOP
- 4 Evaluation Studies 3 studies per year @ \$50,000 per study
- 5 Training (other) 10 participant training per year (5 month non-degree, @ \$15,283 per course) plus one consultation/invitational travel per year (@ \$7,000 per consultation)
- 6 Office Equipment Estimate 20 computers @ \$7,000 and 10 photocopiers @ \$4,000 required per year
- 7 Vehicles 20 vehicles per year @ \$18,000 per vehicle
- 8 Financial Assessment Estimate from USAID FM/FA
- 9 Audit Estimate from USAID FM/FA
- 10 Training (local) 135 physician/nurse training courses per year @ \$2,400 40 refresher courses per year @ \$2,400, 20 computer training per year @ \$1,000
- 11 Workshops 20 governorate level workshops per year @ \$20,000
- 12 Administrative Costs Average @ \$500,000 per year (based on an estimated average of \$20,000/governorate office and \$80,000 per central office) to cover project related costs such as expendable supplies per diem, travel, honoraria, and maintenance
- 13 Renovations Estimate based on Heilman et al, 1991, Attachment 1, increased to correspond to new initiatives
- 14 Medical Supplies Estimate based on Heilman et al, 1991 Attachment 1 and estimate of technical specialist
- 15 IE&C Estimate from technical specialist

SUB-PROJECT WORKSHEET 1 B

SUB PROJECT CONTRACEPTIVE COMMODITIES (THOUSANDS OF \$)

INPUT	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	TOTAL
Contraceptive Commodity					
IUDs (1)	\$1,103	\$1,158	\$1,216	\$1,276	\$4,752
NORPLANT (2)	\$254	\$266	\$280	\$294	\$1,093
Condoms (3)	\$221	\$232	\$243	\$255	\$950
Subtotal	\$1,577	\$1,655	\$1,738	\$1,825	\$6,795
Contingency	\$160	\$168	\$176	\$185	\$689
Contraceptive Commodities TOTAL	\$1,736	\$1,823	\$1,914	\$2,010	\$7,484

NOTES

- 1 IUDs Estimated by FPLM projection 1991
- 2 NORPLANT Estimated based on projected need

Source Selection Information -- See FAR 3.104

**ANNEX B
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3 Condoms Estimated based on projected need

**SUB-PROJECT WORKSHEET 1 C
SUB-PROJECT THO (THOUSANDS OF \$)**

INPUT	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	TOTAL
I/GS Contract					
TA/M					
ST TA US (1)	\$200	\$210	\$220	\$231	\$861
Participant Trng / Consultation (2)	\$24	\$26	\$27	\$28	\$105
Non Contraceptive Commod					
Training Materials (3)	\$6	\$6	\$6	\$6	\$24
Audits					
Financial Assessment (4)	\$11	\$0	\$12	\$0	\$23
Audit (5)	\$0	\$23	\$0	\$26	\$49
Local Costs					
Local Training (6)	\$55	\$58	\$61	\$64	\$238
Specialized Local Training (7)	\$221	\$232	\$243	\$255	\$950
Training Materials (8)	\$6	\$6	\$6	\$6	\$24
Office Supplies (9)	\$26	\$28	\$29	\$31	\$114
IEC (10)	\$17	\$17	\$18	\$19	\$71
Renovations (11)	\$35	\$37	\$39	\$41	\$152
Subtotal	\$600	\$642	\$662	\$707	\$2,611
Contingency	\$61	\$65	\$67	\$72	\$265
THO TOTAL	\$661	\$707	\$729	\$779	\$2,875

NOTES

- 1 Short Term TA (US) 6 1-month TDYs
- 2 Training (other) 1 participant training per year (5-month non-degree @ \$15 283) plus one consultation/invitational travel per year (@ \$7,000 per consultation)
- 3 Training Materials Estimated from Heilman et al 1991 Attachment 3, and technical specialist
- 4 Financial Assessment Estimate from USAID FM/FA
- 5 Audit Estimate from USAID FM/FA
- 6 Practical experience and internships for physicians and nurses in RCT training program based on \$2750 per course
- 7 Training (local) 200 specialists @ \$1 000 per specialist
- 8 Training Materials Estimated from Heilman et al 1991, Attachment 3 and technical specialist
- 9 Office Supplies \$3 000 per year per teaching hospital

Source Selection Information -- See FAR 3.104

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- 10 IE&C Estimate by technical specialist
- 11 Renovations \$20,000 for each teaching hospital over LOP

**SUB-PROJECT WORKSHEET 2.A
SUB-PROJECT NPC (THOUSANDS OF \$)**

INPUT	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	TOTAL
I/GS Contract					
TA/M					
Management Advisor (1)	\$300	\$290	\$305	\$320	\$1,215
Research Advisor (2)	\$300	\$290	\$305	\$320	\$1,215
Participant Trng / Consultation (3)	\$24	\$26	\$27	\$28	\$105
Non Contraceptive Commod					
Office Equipment (4)	\$55	\$0	\$0	\$0	\$55
Library Equipment (5)	\$28	\$0	\$0	\$0	\$28
Audits					
Financial Assessment (6)	\$11	\$0	\$12	\$0	\$23
Audit (7)	\$0	\$23	\$0	\$26	\$49
Specialized Buyns					
DHS 1996 (8)	\$0	\$0	\$486	\$0	\$486
Research and Policy	\$100	\$100	\$100	\$100	\$400
Local Costs					
Governorate Training (9)	\$66	\$69	\$73	\$77	\$285
Library Training (10)	\$2	\$1	\$1	\$1	\$6
Office Supplies (11)	\$33	\$35	\$36	\$38	\$143
Biomedical Research (12)	\$66	\$69	\$73	\$77	\$285
Program Research (13)	\$66	\$69	\$73	\$77	\$285
Conferences (14)	\$138	\$145	\$152	\$160	\$594
Governorate Special Activities (15)	\$116	\$122	\$128	\$134	\$499
Admin (TS) (16)	\$110	\$116	\$122	\$128	\$475
IEC (17)	\$33	\$35	\$36	\$38	\$143
DHS 1992 St (18)	\$0	\$116	\$122	\$0	\$237
DHS 1996 (19)	\$0	\$0	\$425	\$0	\$425
Subtotal	\$1,448	\$1,506	\$2,476	\$1,523	\$6,953
Contingency	\$147	\$153	\$251	\$154	\$705
NPC TOTAL	\$1,595	\$1,659	\$2,727	\$1,677	\$7,658

NOTES

- 1 Management Advisor Under TA contract
- 2 Research Advisor Under TA contract
- 3 Training (other) 1 participant training per year (5 month non-degree @ \$15,283 per course) plus one consultation/invitational travel per year (@ \$7,000 per consultation)

Source Selection Information -- See FAR 3.104

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- 4 Office Equipment Assumes 1 computer (@ \$7,000) and 1 photocopier (@ \$4,000) provided per year, on average
- 5 Library Equipment Assumes 1 computer (@ \$7,000) for Year 1 and Year 2 one photocopier or similar (@ \$4,000) for Years 3, and 4
- 6 Financial Assessment Estimate from USAID FM/FA
- 7 Audit Estimate from USAID FM/FA
- 8 DHS 1996 Buy-in for 1996 Demographic and Health Survey to Institute for Resource Development/DHS, with quality module [Source IRD/DHS]
- 9 Governorate Training 6 courses per year @ \$10,000 per 1 week course for 20-25 participants [Source NPC IDP budget, August 1, 1990, fourth version]
- 10 Library Training Technical specialist estimate
- 11 Office Supplies Estimated at \$1,000 per governorate per year, plus \$4,000 for Research Management Unit and IDP per year
- 12 Biomedical Research 3 studies per year @ \$20,000 per study
- 13 Programmatic Research 3 studies per year @ \$20,000 per study
- 14 Conferences Annual conferences for approximately 150 participants @ \$100 average per diem and travel, \$2,000 for materials, \$1,500 for facilities, and \$6,500 for coordination and contingencies
- 15 Governorate Special Activities Local conferences, planning meetings or other activities at governorate NPCs, averaging \$5 000 per year per governorate (discretionary funds)
- 16 Administration (TS) Administrative expenditures at Technical Secretariat, averaging \$100,000 per year, to carry out project-related activities
- 17 IE&C Brochures promotional displays media presentations [Source Technical specialist estimate and other organizations budgets]
- 18 DHS 1992 Secondary Analyses 4 secondary analyses @ \$50 000
- 19 DHS 1996 Local costs for sub-contract with demographic researchers in Egypt

Source Selection Information -- See FAR 3.104

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**SUB-PROJECT WORKSHEET 2 B
SUB-PROJECT RCT (THOUSANDS OF \$)**

INPUT	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	TOTAL
I/GS Contract					
TA/M					
Training Advisor (1)	\$300	\$290	\$305	\$320	\$1,215
ST TA US (2)	\$67	\$70	\$73	\$77	\$287
Participant Trng / Consultation (3)	\$24	\$26	\$27	\$28	\$105
Non Contraceptive Commod					
Training Materials (4)	\$28	\$29	\$30	\$32	\$119
Computers (5)	\$141	\$0	\$0	\$0	\$141
Audits					
Financial Assessment (6)	\$11	\$0	\$12	\$0	\$23
Audit (7)	\$0	\$23	\$0	\$26	\$49
Local Costs					
Project Personnel (8)	\$221	\$232	\$243	\$255	\$950
Local Training (9)	\$657	\$690	\$724	\$761	\$2,832
Training Materials (10)	\$28	\$29	\$30	\$32	\$119
Conference (11)	\$83	\$87	\$91	\$96	\$356
Administration (12)	\$44	\$46	\$49	\$51	\$190
Office Supplies (13)	\$7	\$7	\$7	\$8	\$29
IEC (14)	\$33	\$35	\$36	\$38	\$143
Transport (15)	\$4	\$5	\$5	\$5	\$19
Subtotal	\$1,646	\$1,568	\$1,634	\$1,728	\$6,576
Contingency	\$167	\$159	\$166	\$175	\$667
RCT TOTAL	\$1 813	\$1 727	\$1,800	\$1,904	\$7,243

NOTES

- 1 Training Advisor Under TA contract
- 2 Short Term TA (US) 2 1 month TDYs
- 3 Training (other) 1 participant training per year (5-month non-degree, @ \$15 283) plus one consultation/invitational travel per year (@ \$7,000 per consultation)
- 4 Training Materials Estimate by technical specialist
- 5 Office Equipment Estimated 4 computers per year @ \$7 000
- 6 Financial Assessment Estimate from USAID FM/FA
- 7 Audit Estimate from USAID FM/FA
- 8 Non-GOE Project Personnel Managerial administrative and technical [Source Martinkosky, 1990]

Source Selection Information -- See FAR 3.104

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- 9 Training (local) 60 person-months per year of training of trainers @ \$2 000 per person-month, 20 physician/nurse training courses per year @ \$20,000 per course, NORPLANT training for 20 specialists @ \$56,000 per year; training of 4 specialists per year @ \$5,000 per year (family planning diploma)
- 10 Training Materials Estimate by technical specialist
- 11 Conference Annual conference @ \$75,000
- 12 Administration Estimate based on Martinkosky, 1990
- 13 Office Supplies Estimate by technical specialist
- 14 IE&C Estimate by technical specialist
- 15 Transport Estimate by technical specialist

SUB-PROJECT WORKSHEET 3
SUB-PROJECT SIS (THOUSANDS OF \$)

INPUT	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	TOTAL
I/GS Contract					
TA/M					
IE & C Advisor (1)	\$300	\$290	\$305	\$320	\$1,215
ST TA US (2)	\$266	\$280	\$294	\$308	\$1,148
Special Assessments (3)	\$110	\$116	\$122	\$128	\$475
Participant Trng / Consultation (4)	\$24	\$26	\$27	\$28	\$105
Non Contraceptive Commod					
A/V (5)	\$97	\$0	\$0	\$0	\$97
Vehicles (6)	\$26	\$28	\$0	\$30	\$84
Audits					
Financial Assessment (7)	\$11	\$0	\$12	\$0	\$23
Audit (8)	\$0	\$23	\$0	\$26	\$49
Local Costs					
Information Production (9)	\$138	\$145	\$152	\$160	\$594
Admin (10)	\$110	\$116	\$122	\$128	\$475
Local Training (11)	\$110	\$116	\$122	\$128	\$475
Mass Media (12)	\$226	\$237	\$249	\$262	\$974
Subtotal	\$1,419	\$1,376	\$1 403	\$1,517	\$5,715
Contingency	\$144	\$139	\$142	\$154	\$579
SIS TOTAL	\$1,563	\$1,515	\$1,546	\$1,670	\$6,294

NOTES

- 1 IE&C Advisor Under TA contract
- 2 Short Term TA (US) 8 1-month TDYs per year

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- 3 Studies 2 per year @ \$50,000 for market research, etc
- 4 Training (other) 1 participant training per year (5 month, non-degree, @ \$15,283 per course) plus one consultation/invitational travel per year (@ \$7,000 per consultation)
- 5 Office Equipment Estimated at an average of 2 audiovisual equipment @ \$10,000
- 6 Vehicles 3 vehicles @ \$18,000 per vehicle
- 7 Financial Assessment Estimate from USAID FM/FA
- 8 Audit Estimate from USAID FM/FA
- 9 Information Production estimated from Heilman et al, 1991, Attachment 8
- 10 Administration Estimated from Heilman et al, 1991, Attachment 8
- 11 Training (local) Estimated at 5 workshops per year @ \$20,000 per course
- 12 Mass Media estimated from Heilman et al, 1991, Attachment 8

SUB-PROJECT WORKSHEET 4
SUB-PROJECT CSI (THOUSANDS OF \$)

INPUT	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	TOTAL
I/GS Contract					
TA/M					
ST TA US (1)	\$133	\$140	\$147	\$154	\$574
Special Assessments (2)	\$44	\$46	\$49	\$51	\$190
Participant Trng / Consultation (3)	\$24	\$26	\$27	\$28	\$105
Audits					
Financial Assessment (4)	\$11	\$0	\$12	\$0	\$23
Audit (5)	\$0	\$23	\$0	\$26	\$49
Local Costs					
Project Personnel (6)	\$662	\$463	\$365	\$255	\$1,744
Local Training (7)	\$110	\$104	\$109	\$102	\$426
Rent (8)	\$77	\$69	\$61	\$51	\$258
IEC (9)	\$99	\$93	\$85	\$77	\$353
Transport (10)	\$77	\$58	\$61	\$38	\$234
Subtotal	\$1,238	\$1,022	\$915	\$782	\$3,957
Contingency	\$126	\$104	\$93	\$79	\$401
CSI TOTAL	\$1 363	\$1 126	\$1 008	\$861	\$4 358

NOTES

- 1 Short Term TA (US) 4 1 month TDYs

Source Selection Information -- See FAR 3.104

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- 2 Studies 2 assessments per year @ \$20,000 per study
- 3 Financial Assessment Estimate from USAID FM/FA
- 4 Training (other) 1 participant training per year (5-month, non-degree, @ \$15,283 per course) plus one consultation/invitational travel per year (@ \$7,000 per consultation)
- 5 Audit Estimate from USAID FM/FA
- 6 Project Personnel Managerial, administrative and technical [Source Heilman et al, 1991, Attachment 6]
- 7 Training (local) 12 person-months per year @ \$5,000 per person month
- 8 Rent Estimate based on Heilman et al, 1991, Attachment 6
- 9 IE&C Estimate by technical specialist
- 10 Transport Estimate by technical specialist

SUB-PROJECT WORKSHEET 5
SUB-PROJECT PRIVATE SECTOR INITIATIVES (THOUSANDS OF \$)

INPUT	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	TOTAL
I/GS Contract					
TA/M					
Private Sector Advisor (1)	\$138	\$145	\$152	\$160	\$596
ST TA US (2)	\$200	\$210	\$220	\$231	\$861
Local IEC (3)	\$77	\$81	\$85	\$89	\$333
Local Training (4)	\$11	\$12	\$12	\$13	\$48
Local Special Activities (5)	\$276	\$289	\$304	\$319	\$1,188
Subtotal	\$702	\$737	\$774	\$812	\$3,025
Contingency	\$71	\$75	\$78	\$82	\$307
Private Sector TOTAL	\$773	\$812	\$852	\$895	\$3,332

NOTES

- 1 Private Sector Advisor Under TA contract (half time)
- 2 Short Term TA (US) 6 1-month TDYs
- 3 IE&C Estimate by technical specialist
- 4 Training-local Training for 1 000 pharmacists per year @ \$10 per pharmacist curriculum development will be carried out under the I/GS contract
- 5 Special Activities discretionary funds for conferences workshops special training, etc

Source Selection Information -- See FAR 3.104

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WORKSHEET 6

TA CONTRACT (THOUSANDS OF \$)

INPUT	PREIMP 5 MO	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	POSTIMP 1 MO	TOTAL
TA/M							
COP (1)	\$110	\$161	\$145	\$152	\$160	\$28	\$757
PreImp Advisors (2)	\$549	\$0	\$0	\$0	\$0	\$140	\$689
Fin/Admin (3)	\$110	\$300	\$290	\$305	\$320	\$28	\$1,353
Management Support							
Assistant (4)	\$7	\$20	\$20	\$21	\$22	\$2	\$92
Sec/Clerk (5)	\$7	\$20	\$20	\$21	\$22	\$2	\$92
Accounting Subcontract (6)	\$53	\$55	\$58	\$61	\$64	\$34	\$324
Vehicle Maintenance (7)	\$2	\$2	\$2	\$2	\$3	\$3	\$14
Office Supplies (8)	\$74	\$77	\$81	\$85	\$89	\$40	\$446
Office Rent (9)	\$32	\$66	\$69	\$73	\$77	\$7	\$323
Special Assessments (10)	\$210	\$221	\$232	\$243	\$255	\$57	\$1,227
Non-Contraceptive Commod							
Computers (11)	\$67	\$0	\$0	\$0	\$0	\$0	\$67
Copiers (11)	\$14	\$0	\$0	\$0	\$0	\$0	\$14
Vehicles (12)	\$50	\$0	\$0	\$0	\$0	\$0	\$50
Subtotal	\$1,284	\$923	\$917	\$963	\$1,011	\$350	\$5,448
Contingency	\$130	\$94	\$93	\$98	\$103	\$35	\$552
TA/M TOTAL	\$1 414	\$1 016	\$1 010	\$1,061	\$1 114	\$385	\$6,001

NOTES

- 1 Chief-of Party half-time (shared with private sector initiative)
- 2 Resident Advisors Start up for 5 resident advisors who work within implementing agencies, after pre implementation phase, costs are attributed to implementing agency/sub project
- 3 Finance/Administrative full time
- 4 Assistant High-level assistant @ \$5 000 plus multiplier of 1.7
- 5 Secretaries/Clerks 2 secretaries and 2 clerks @ \$ 2,500 plus multiplier of 1.7
- 6 Accounting Contract sub-contract with local firm estimated @ \$50,000 per year
- 7 Vehicle Maintenance Estimated at \$1,000 per year per vehicle
- 8 Office Supplies Estimated based on other organizations' experience
- 9 Office Rent Estimated for multi room office for management staff
- 10 Studies 4 special assessments per year @ \$50 000 per study
- 11 Office Equipment 8 computers @ \$7 000 and 3 photocopiers @ \$4 000 for the start-up

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12 Vehicles 2 vehicles @ \$18,000 over LOP

WORKSHEET 7							
PROJECT SUPPORT AND OTHER BUY-INS (THOUSANDS OF \$)							
INPUT	PREIMP 5 MO	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	POSTIMP 1 MO	TOTAL
Evaluation (1)	\$0	\$0	\$174	\$0	\$191		\$365
Project Support (2)	\$101	\$142	\$149	\$157	\$164	\$14	\$728
Subtotal	\$101	\$142	\$323	\$157	\$356	\$14	\$1,093
Contingency	\$10	\$14	\$33	\$16	\$36	\$1	\$111
Other Buy ins TOTAL	\$112	\$156	\$356	\$172	\$392	\$16	\$1,204

NOTES

- 1 Evaluation Midterm and EOP evaluations @ \$150,000
- 2 Personal Services Contractor @ \$135,289

3. Budget Detail

Tables B-1, B-2 and B-3, below, present foreign exchange and local costs, and by-year budget figures, desegregated into somewhat greater detail than in the summary cost estimate tables presented in the body of the Project Paper. In particular, Table B-3 shows the distribution of estimated project expenditures among the subprojects, including all of the short- and long-term expatriate technical assistance. These estimates are based on illustrative line-item budgets by subproject, presented in the Subproject Worksheets. Throughout, we have assumed a dollar inflation rate of 5 percent; contingency of 10 percent; and a 1991 exchange rate of LE 3.34 to the dollar.

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**TABLE B-1
COST ESTIMATE AND FINANCIAL PLAN (THOUSANDS OF \$)**

ELEMENTS	FX	LC	TOTAL
CONTRACEPTIVE COMMODITIES	\$6,795		\$6,795
IMPLEMENTATION/GOODS&SERVICES	\$25,334		\$25,334
- TA/Management	\$8,873		\$8,873
- Mgt Support/Special Assessment	\$8,685		\$8,685
- Private Sector Initiative	\$3,025		\$3,025
- Part Trng / Consultation	\$1,286		\$1,286
- Non Contraceptive Commodities	\$3,465		\$3,465
EVAL/AUDITS,BUY INS PROJ SUPP	\$1,251	\$1,159	\$2,411
LOCAL COSTS OF IMP AGENCIES		\$21,752	\$21,752
- NPC		\$3,377	\$3,377
- RCT		\$4,638	\$4,638
- SDP (MOH)		\$6,653	\$6,653
- THO (MOH)		\$1,549	\$1,549
- SIS (MOI)		\$2,519	\$2,519
- CSI (MOSA)		\$3,016	\$3,016
Subtotal	\$33,381	\$22,911	\$56,292
Contingency	\$3,385	\$2,323	\$5,708
TOTAL	\$36,766	\$25,234	\$62,000

NOTES

- 1 Contraceptive commodities includes only the value of commodities provided by USAID to implementing agencies under POP/FP III
- 2 Technical Assistance and Management includes both short and long-term expatriate TA to implementing agencies and professional labor associated with contractor's management functions see Input Worksheet 1 and LOE Worksheet
- 3 Management Support and Special Assessments includes all non-expatriate labor costs associated with the TA/management contractor offices, management duties etc , and all costs associated with the completion of a set of assessments assigned to the TA/management contractor
- 4 Private Sector Initiative includes local costs associated with the activities to be implemented by the TA/management contractor (no implementing agency) labor costs are included under the I/GS contract
- 5 Participant Training includes all training costs other than airfare associated with participant training activities see Input Worksheet 2.A Consultation includes the costs associated with invitational travel see Input Worksheet 2 B
- 6 Non-Contraceptive Commodities includes the costs of non-contraceptive commodities that will be procured by the TA/management contractor and used within implementing agencies, see Input Worksheet 3

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- 7 Local Costs associated with each implementing agency includes all local TA, non-GOE project personnel and locally procured commodities used by the implementing agencies

**TABLE B-2
PROJECTION OF EXPENDITURES BY PROJECT YEAR (THOUSANDS OF \$)**

ELEMENTS	PREIMP 5 MO	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	POSTIMP 1 MO	TOTAL
CONTRACEPTIVE COMMODITIES	\$0	\$1,577	\$1,655	\$1,738	\$1,825	\$0	\$6,795
IMPLEMENTATION/GOODS&SERVICES	\$1,284	\$6,308	\$5,526	\$5,774	\$6,093	\$350	\$25,334
- TA/Management	\$768	\$1,959	\$1,887	\$1,982	\$2,081	\$196	\$8,873
- Mgt Support/Spcl Assessment	\$384	\$1,920	\$1,975	\$2,074	\$2,177	\$154	\$8,685
- Private Sector Initiative	\$0	\$702	\$737	\$774	\$812	\$0	\$3,025
- Part Trng / Consultation	\$0	\$298	\$313	\$329	\$345	\$0	\$1,286
- Non-Contraceptive Comm	\$132	\$1,429	\$614	\$615	\$676	\$0	\$3,465
EVAL/AUDITS BUY-INS PROJ SUPP	\$101	\$308	\$562	\$816	\$609	\$14	\$2,411
LOCAL COSTS	\$0	\$5,219	\$5,305	\$5,850	\$5,377	\$0	\$21,752
- NPC	\$0	\$631	\$777	\$1,241	\$729	\$0	\$3,377
- RCT	\$0	\$1,076	\$1,130	\$1,186	\$1,246	\$0	\$4,638
- SDP (MOH)	\$0	\$1,544	\$1,621	\$1,702	\$1,787	\$0	\$6,653
- THO (MOH)	\$0	\$359	\$377	\$396	\$416	\$0	\$1,549
- SIS (MOI)	\$0	\$584	\$614	\$644	\$676	\$0	\$2,519
CSI (MOSA)	\$0	\$1,025	\$787	\$681	\$523	\$0	\$3,016
Subtotal	\$1,386	\$13,412	\$13,049	\$14,178	\$13,904	\$364	\$56,292
Contingency	\$141	\$1,360	\$1,323	\$1,438	\$1,410	\$37	\$5,708
TOTAL	\$1,526	\$14,772	\$14,372	\$15,615	\$15,314	\$401	\$62,000

Source Selection Information -- See FAR 3.104

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**TABLE B-3
ESTIMATED PROJECT EXPENDITURES BY SUB-PROJECT AND PROJECT YEAR (THOUSANDS OF \$)**

SUB-PROJECT	PREIMP 5 MO	YEAR 1 13 MO	YEAR 2 12 MO	YEAR 3 12 MO	YEAR 4 12 MO	POSTIMP 1 MO	TOTAL
NPC	\$0	\$1,448	\$1,506	\$2,476	\$1,523	\$0	\$6,953
RCT	\$0	\$1,646	\$1,568	\$1,634	\$1,728	\$0	\$6,576
SDP (MOH)	\$0	\$3,717	\$3,303	\$3,456	\$3,642	\$0	\$14,119
THO (MOH)	\$0	\$600	\$642	\$662	\$707	\$0	\$2,611
SIS (MOI)	\$0	\$1,419	\$1,376	\$1,403	\$1,517	\$0	\$5,715
CSI (MOSA)	\$0	\$1,238	\$1,022	\$915	\$782	\$0	\$3,957
CONTRACEPTIVES	\$0	\$1,577	\$1,655	\$1,738	\$1,825	\$0	\$6,795
PRIVATE SECTOR INITIATIVES	\$0	\$702	\$737	\$774	\$812	\$0	\$3,025
TA CONTRACT (MGT & SUPPORT)	\$1,386	\$1,065	\$1,240	\$1,120	\$1,367	\$364	\$6,541
Subtotal	\$1,386	\$13,412	\$13,049	\$14,178	\$13,904	\$364	\$56,292
Contingency	\$141	\$1,360	\$1,323	\$1,438	\$1,410	\$37	\$5,708
TOTAL	\$1,526	\$14,772	\$14,372	\$15,615	\$15,314	\$401	\$62,000

NOTE

Included in each subproject are the costs associated with short and long term technical assistance, procurement of non-contraceptive commodities, participant training etc , that will be processed through the I/GS contractor. The "Management" line refers only to the labor and other costs associated with project management and management support.

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4. Host-Country Contributions

Table B-4, below, presents the estimated host-country contributions over the life of the POP/FP III Project, by implementing agency. As shown, the contribution is estimated at LE 22.6 million in cash and LE 41.7 million in kind over five years. This total contribution of LE 64.3 million (approximately \$19.5 million) constitutes approximately 24 percent of the total value of the POP/FP III Project of \$81.5 million.

a. Estimates of Host-Country Contributions

The estimate of host-country contributions is conservative in three ways:

- First, inflation factors were excluded, with the exception of salaries, which were increased at an average annual rate of 4 percent
- Second, a large share of actual contributions were excluded from the calculations because of difficulties in monitoring and auditing. For example, depreciation of government buildings and other capital goods is excluded from this estimate, although it clearly is a contribution of the GOE to the national family planning program. In addition, maintenance and operation of the MOH facilities were also excluded, since it is difficult to estimate the proportion of such costs that should be attributed to the family planning program versus other health-related activities carried out by the MOH.
- Third, the costs of commodities distribution by the EPTC, to be borne by the GOE, have been excluded because of the possibility that the POP/FP III Project will have to take up responsibilities for such costs in the event that the EPTC mechanism proves unsatisfactory.

Therefore, the estimates presented below should be considered a minimum. Notes accompanying the table entries provide information on the means of measuring host-country contribution.

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**TABLE B-4
HOST COUNTRY CONTRIBUTIONS (THOUSANDS OF 1991 LE)**

ELEMENTS	CASH	IN-KIND	TOTAL
Ministry of Health			
MOH/SDP Salaries (1)	0	3,830	3,830
MOH/SDP and THO Premium Pay (2)	2,015	0	2,015
Contraceptive Raw Materials (3)	2,240	0	2,240
Contraceptive Production (4)	1,040	0	1,040
Incentives from Contraceptive Sales (5)	269	0	269
Participant Training (MOH & THO) (6)	726	0	726
Vehicle O&M	0	855	855
Subtotal MOH	6,290	4,685	10,975
National Population Council			
Salaries (7)	0	2,548	2,548
Operating and Maintenance Costs (8)	0	1,216	1,216
Premium Pay (9)	54	0	54
Participant Training (RCT & NPC) (10)	132	0	132
Subtotal NPC	186	3,764	3,950
Ministry of Information			
Salaries (11)	0	1,698	1,698
Operating and Maintenance Costs (12)	0	640	640
Radio and TV Time (13)	0	30,927	30,927
Premium Pay (14)	507	0	507
Participant Training (SIS) (15)	66	0	66
Subtotal MOI	573	33,265	33,838
Ministry of Social Affairs			
MOSA Contribution (16)	2,112	0	2,112
CSI Cost Recovery (17)	13,360	0	13,360
Participant Training (CSI) (18)	66	0	66
Subtotal MOSA	15,538	0	15,538
Grand Total	22,587	41,714	64,301

NOTES

- 1 MOH/SDP salaries for that portion of MOH employees' time devoted to family planning services Bab 1 expenses (salaries), with increases estimated at 4 percent per year
- 2 MOH/SDP Premium Pay for approximately 1,094 mid level MOH employees, THO Premium Pay for approximately 84 employees
- 3 Contraceptive Raw Materials for local production of oral contraceptives used in MOH family planning services
- 4 Contraceptive Production for local manufacture of oral contraceptives used in MOH family planning services
- 5 Incentives from the Sales of Contraceptives both contraceptive donated by USAID and those that are locally manufactured
- 6 Participant Training for MOH and THO Personnel allotting \$5 000 for airfare per trainee
- 7 NPC Salaries for employees within the central and governorate-level NPC offices, BAB 1 expenses (salaries), with increases estimated at 4 percent per year

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- 8 NPC Operating and Maintenance Costs for operation of central and governorate level NPC offices, BAB 2 expenses
- 9 NPC Premium Pay for approximately 62 employees under the Institutional Development Project
- 10 Participant Training for NPC and RCT Personnel, allotting \$5,000 for airfare per training
- 11 MOI Salaries for employees of central IE&C Center and local State Information Service offices, BAB 1 expenses (salaries), with increases estimated at 4 percent per year
- 12 MOI Operating and Maintenance Costs for operation of IE&C Center and local State Information Service offices, including Project vehicle O&M, BAB 2 expenses
- 13 MOI Radio and TV Time, calculated as the number of minutes of air time multiplied by the rates for government advertisement (i.e., lowest rate)
- 14 Participant Training for MOI Personnel allotting \$5 000 for airfare per trainee
- 15 MOI Premium Pay for 214 employees of the State Information Service IE&C Center
- 16 MOSA Contribution for operation of CSI
- 17 CSI Self Financing represents the operating and other costs that will be covered as CSI phases into self financing; exact amount can be better estimated during preparation of annual implementation plan
- 18 Participant Training for CSI Personnel allotting \$5 000 for airfare per trainee

b. In-kind Contributions

GOE in-kind contributions, as identified in Table B-4, consist mainly of salaries and operations and maintenance costs. The AID funded activities under agreement with these counterparts are just a few of the various activities being implemented by these ministries.

Several hundreds of regular GOE employees (full time and part-time) are employed by the Ministries of Health, Information, Social Affairs and other entities. The number of employees assigned by each of these ministries to the AID activities, both at the central and the governorate levels, cannot be easily identified or documented either through the GOE annual budget document or the payroll records which are not established in a manner that readily identifies the benefiting activities within each ministry.

The same situation applies to operations and maintenance costs (Chapter 2 of the GOE annual budget document). Annual allocations for O&M benefit both the central and the governorate levels (26 governorates with an average of 10 markaz in each governorate and more than one clinic in each markaz).

This situation creates a major difficulty in accounting, reporting and verification of these inputs. It also affects the

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degree of confidence in any data submitted by the GOE in compliance with AID Host Country Contribution requirements. The verification of the accuracy of such data by AID will almost be impossible.

To overcome this situation, this paper proposes the use of consulting services in order to conduct a study covering a representative sample of main and sub-offices/clinics directly involved in the implementation of this project. The study should provide AID with an acceptable basis for use in estimating in-kind Host Country inputs to this project. The basic information developed by the consultant will include estimates of average annual salary of professional personnel, administrative personnel, nurses and part-time help. The study will also provide estimates of staffing by each category of personnel for a standard FP clinic, Governorate office and Central office. The number of offices and clinics included in implementation of this project will be counted. Estimates of recurrent costs other than salaries, i.e. utilities, maintenance, operations, etc. will also be developed by the consultant.

USAID, with assistance from the consultant, will develop an annual estimate of GOE annual inputs to the project as a one time exercise during the first year of implementation. These estimates will remain valid through LOP and may only be adjusted if major assumptions of cost factors change during the implementation of the project.

c. Cash Contributions

The GOE cash contribution consists of incentives and premium pay, travel for participant training, and contraceptive purchases. The GOE contribution for air line tickets will be verified by reviewing both USAID and GOE records pertaining to the number of trainees actually sent and applying a standard cost for a round trip ticket Cairo/Washington/Cairo. If incentives and premium pay appear as a separate line item in GOE budgetary documents, review of this line item to ensure that funds have been allocated will suffice, if it is not identifiable as a separate line item, USAID will rely on reports from the GOE, which will be verified as needed. Contraceptive purchases will be verified through review of MOH and parastatal pharmaceutical manufacturer records. In all of the above cases, the implementing agencies will be required to provide AID with reports on its cash contributions, for each item of contribution as detailed above.

5. GOE Premium Pay

Premium pay (*AGR-IDAFI*), which is in line with normal GOE procedures and which supplements government employees' low wages, has been a small but critical part of the expenditures under a few POP/FP II Project subprojects for several years. *AGR-IDAFI* has been provided to personnel working on USAID-funded projects to motivate and reward the additional efforts required of government employees to foster project success. In the strongly voiced opinions of government officials in the implementing agencies, technical specialists working on project design, and USAID personnel in the technical office overseeing the POP/FP II Project, the *AGR-IDAFI* has been essential to the cooperation and dedication of government employees involved in the family planning program

The POP/FP II Project was authorized to provide such premium pay through USAID grant funds to GOE employees in the form of salary supplements, however, POP/FP III will not have a waiver for similar purposes. Therefore, in accordance with Mission Order 3-32, salary supplements can no longer be provided through USAID grant funds. Given the importance of premium pay to Project implementation, it is recommended that the *AGR-IDAFI* premium pay be provided by the GOE, in line with its normal procedures, to POP/FP III implementing agencies (MOH, SIS, and NPC).

6. Cost Recovery Prospects for CSI Subproject

While sustainability of the family planning program is not considered a primary objective of the POP/FP III Project, one component -- the Clinical Services Improvement Subproject -- has the potential to demonstrate sound cost recovery practices¹⁵ within the context of quality service delivery. In this section of the financial analysis, we briefly review the experiences of CSI during the POP/FP II Project; potential for success in cost recovery effort during the POP/FP III Project; and recommended modifications in CSI's financing strategy

a. Experiences of CSI during the POP/FP II Project

CSI was designed in 1987-88 to assist the Egyptian Family Planning Association (EFPA) "to realize its potential as the preeminent source of organized clinical family planning services

¹⁵ CSI uses the term Self financing and defines it to mean the ability to cover operating costs through client revenues or other sources of funding, including support from donors other than USAID

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in the private sector¹⁶" (CSI Project Modification, July 1990: 3). The subproject's purpose was to establish 158 new EFPA family planning service centers throughout Egypt; introduce quality assurance management systems and procedures, and establish systems to finance the continuation of the new centers after the cessation of donor support. This section analyzes the latter aspect of the purpose

With respect to financing, the design of CSI involved the use of USAID and GOE support for all start-up capital costs and the majority of operating costs for the early years of the subproject. By the subproject's original end date, 1993, fee-for-service and contraceptive sales income was intended to cover operating costs, exclusive of the cost of contraceptives

The financing plan for CSI was ambitious from the start, and based on optimistic projections of both costs and revenues. Under the design, as shown in Table B-5, below, during Stage I USAID was to provide nearly all of the financing (91 percent), with MOSA contributions, user fees and other donors accounting for a small amount of funding. Starting in January 1992, the USAID contribution was scheduled to decrease to cover about half of the subproject's expenses, correspondingly, service fee and contraceptive sales revenues were to increase dramatically. By the beginning of Stage III, CSI was supposed to obtain 60 percent of its support from user financing, and shift a considerable proportion (22 percent) from USAID to other donors

¹⁶ The private sector includes both private voluntary organizations, such as EFPA, and private/commercial enterprises, including private, fee-for service physicians

TABLE B-5 ORIGINAL FINANCING PLAN FOR CSI			
SOURCE	STAGE 1 (1/1/88- 12/31/91)	STAGE 2 (1/1/92- 5/31/93)	STAGE 3 (6/1/93- 12/31/95)
USAID	91%	51%	11%
MOSA	3%	6%	7%
Fee-for-Service & Contraceptive Sales	5%	40%	60%
Other CA Agencies	1%	3%	22%
TOTAL	100% (LE 24,817,688)	100% (LE 15,141,664)	100% (LE 28,833,268)

The increase in user financing was to happen in two basic ways -- increases in client volume, and increases in service and contraceptive prices

During Stage I of the subproject, CSI has succeeded in many aspects of its efforts. For instance, by all accounts the CSI clinics provide family planning clients with impressively high-quality care at a low or moderate cost (to the user). It is reported that the very existence of CSI has placed "upward pressure" on the MOH, motivating interest in improving other publicly-funded family planning services. In several Upper Egypt governorates with the hardest-to-reach populations, CSI contributes a sizeable share of the CYP attributed to all public and PVO clinics.¹⁷ And several of the primary and secondary centers met or exceeded their revenue targets in the most recent fiscal year.

On the revenue side, financial progress was not as rapid or uniform as originally anticipated. Overall, CSI achieved approximately 90 percent of its revenue target for 1990. Nearly all of the difference between projected and actual revenues is due to the volume component, since there were very few scheduled price increases during the first few years of operation. The causes of high or low performance remain an open question -- one that is being pursued actively by CSI management.

¹⁷ This excludes the private/commercial sector, which provides the vast majority of CYP throughout Egypt, particularly in the form of oral contraceptive sales by pharmacies.

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On the cost side, initial start-up activities have entailed a large proportion of donor support being devoted to capital goods, which is a relatively expensive proposition. During FY 89-90, capital goods accounted for nearly half of the total USAID contribution of about LE 6 6 million (\$2 5 million)¹⁸

b. Potential For CSI's Success in Cost Recovery Effort during the POP/FP III Project

As the CSI Subproject will be implemented by a Private Voluntary Organization (PVO), USAID will expect primary attention to be directed toward quality service provision. However, USAID will also expect the PVO to continue to be attentive to cost recovery issues. USAID understands that PVOs, by their very nature, require outside donor support for such things as special campaigns and capital equipment. However, it is expected that PVOs will increasingly cover a larger percentage of their routine operating costs. Although there are concerns as to whether CSI's current plans for self-financing are feasible and realistic within the time allotted, it is noted that its costs have come down while maintaining quality service delivery. CSI will need to develop a strategy based on realistic assumptions of: growth in client population; its ability to increase fees and client responses to these increases, its ability to contain costs, and prospects to attract varied donor support. The cost recovery challenge that CSI will face during POP/FP III is how to attain increasing cost recovery under existing circumstances.

c. Recommended Modifications in CSI's Financing (Cost Recovery) Strategy

The CSI management has shown its ability to provide first-rate family planning services under POP/FP II. With a more feasible and realistic strategy, CSI may well be able to make great progress toward increased cost recovery in POP/FP III. For example, pricing should correspond to demand. Price increases should correspond to price elasticities of demand. To achieve a more favorable financial condition, CSI should analyze and consider revision of its price schedule. Through focused market research and a few market tests, CSI should be able to determine, even roughly, how prices should vary from place to place, service to service. Further, while the overall ability to reach target revenues appears to be relatively good, it is not apparent how or whether the high-performing clinics will subsidize the low-performing clinics. In the absence of such subsidization, overall average performance statistics are not particularly

¹⁸ Excludes expatriate technical assistance, which has included a full-time resident advisor since the project's inception

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meaningful indicators of fiscal health or progress. Political and programmatic constraints, particularly due to the relationship of CSI to MOSA, may interfere substantially with CSI's ability to close low-performing centers. This has the potential to be an extremely serious barrier to CSI's ability to cover its operating expenses

C. Economic Analysis

The economic analysis for the POP/FP III Project addresses the following issues relevant to the overall economic soundness of the technical approach:

- economic environment for family planning in Egypt;
- progress toward sustainability of the Egyptian family planning program;
- economic policy constraints to family planning in Egypt, and
- economic data required for decision making within the POP/FP III Project

1. The Economic Environment for Family Planning in Egypt

This section addresses three questions. First, is rapid population growth hampering expansion of the Egyptian economy? Second, does the GOE have the resources required to support the national family planning program during the 1990s? And, third, what is known about the effective demand for family planning services in Egypt?

a. The Egyptian Economy and the Need for a National Family Planning Program

The negative economic and social consequences of population pressure in Egypt provide strong indications that both the GOE and USAID/Egypt should continue substantial investments in family planning activities. In the short term, increases in contraceptive use contribute to improvements in the health of women and children, as well as a lessening of the pressure currently experienced by the country's educational and health systems. In the long term, slowing of the rate of population growth allows the economy to expand in real terms, improving the population's welfare. In the Egyptian setting, family planning is a sound and necessary economic investment.

Looking at employment, the number of new entrants into the labor force overwhelm the economy's absorptive capacity. In 1983-84,

the employment gap¹⁹ was 5 million jobs; by 1988-89, that gap had grown to nearly 3.4 million (CDSS Update, 1989-1993). The formal sectors of the economy, including government and public sector enterprises, the formal private sector and agriculture, were unable to absorb half of the net annual increase in the number of job-seekers. While many factors contributed to this gap, the burgeoning labor force -- 289,000 net entrants to the labor force in 1983-84 and at least 322,000 in 1988-89 -- has aggravated the problem of unemployment in Egypt. According to an official survey, the average level of unemployment in 1989 was estimated at about 8.1 percent total, with 10.4 percent unemployment in urban areas.

Rapid population growth also has contributed to growing levels of importation of food commodities, and the government currently must use a large portion of its scarce foreign exchange to meet basic food requirements. For example, in 1989 Egypt imported more than \$1 billion of agricultural products from the U.S., including wheat, corn, tallow, cotton, soybean meal, liver and frozen poultry. Food imports are now at \$2.1 billion per year. In interpreting the increases in food imports, it is important to recognize that the relationship between a growing population and the increasing need for imported food is not as direct as it appears on the surface. Just as unemployment is driven both by population growth and the sectoral distribution of capital, factors other than population size influence the ability of a country to feed itself, such as a transition in the agricultural sector away from cultivation of staple foods and toward non-staple, high-value cash crops for export or a transformation in the diet from primarily cereal-based to increasingly meat-based consumption. However, in the case of Egypt, staple food production (wheat, rice, and beans) has increased on a total metric tonnage basis from 4.039 million metric tons in 1980 to 7.054 million metric tons in 1990, while food consumption has not significantly shifted. Per capita consumption examples, comparing 1980 consumption in kg per year to 1990 consumption, are wheat, 146 kg to 183 kg; rice, 34 kg to 37.5 kg, broad beans, 5 kg to 5 kg, and red meat, 9.4 kg to 13.2 kg. The major factor contributing to increasing food imports is that food production increases lag population growth.

The apparent negative economic and social consequences of population pressure in Egypt provide strong indications that the GOE and USAID/Egypt should consider substantial further investments in family planning activities, designed to lower the

¹⁹ The employment gap is the difference between the total jobs required by the population and the actual jobs created (or gross fixed investment/investment to create one job). It is an indicator of the economy's ability to absorb net entrants into the labor force.

fertility rate (and, indirectly, the rate of growth of the population).

b. The Ability of the GOE to Support the National Family Planning Program

Given the economic (and social) justification for public support for a national family planning program in Egypt, the question is whether the GOE currently is in a position to provide such financial support. That is, to what extent does the GOE require assistance from USAID or other donors to meet its needs for family planning service development?

A look at a couple of key macroeconomic indicators paints a picture of an economy that is suffering severely, and experiencing tremendous strains on both private and public resources

Output.²⁰ Average annual growth in gross domestic product between 1984-88²⁰ was about 5 percent in nominal terms, combined with rates of inflation estimated at more than 20 percent per year, this implies a substantial reduction in real output in recent years.

Inflation A very large government budget deficit and excessive monetary expansion during the 1980s has been identified as the primary cause for inflation rates that reached up to more than 20 percent annually. In addition, recent reductions in government subsidies of consumer goods -- steps that were necessary to reduce the budget deficit -- have accelerated the pace of inflation. According to official estimates, consumer prices in urban areas in January 1990 were 26.5 percent higher than those of a year before.

The implications of these economic indicators are quite clear. The government is facing a situation in which expenditures for the most basic services far outstrip the revenues generated from taxes and other sources. In part, this is attributed to the historical policies of general consumer subsidies, excessive public employment, and large investments in inefficient parastatal manufacturing enterprises. In addition, as stated above, rapid population growth has at least exacerbated the country's economic problems.

Current policy reforms, particularly those put forth by the World Bank/International Monetary Fund and USAID, are addressing some of the central policy constraints hampering economic growth.

²⁰ No data are available for a more recent period.

However, it is extremely improbable that the GOE will be in a position to support its national family planning program at the necessary level during the coming five years. Substantial donor contributions are warranted and needed during this time, as they have been in the past.

From a longer-term perspective, any donor contributions should be geared toward advancing the sustainability of Egypt's national family planning program. This issue is discussed in Section 2, below.

c. Knowledge of Demand for Family Planning Services

Design of the POP/FP III Project has been driven by an assessment of key constraints on the supply of, and demand for, family planning services in Egypt. On the supply side, factors considered have included the availability, acceptability and quality of family planning services. [These issues are reviewed in the technical analysis of service delivery.] On the demand side, information on the determinants of the demand for children (from which the demand for family planning services is derived), unmet demand for family planning, and willingness and ability to pay for family planning services were reviewed. These issues are summarized below.

Demand for Children In strictly economic terms, the demand for family planning services among fertile married (or sexually active) women or couples is considered to be a function of the demand for additional children, constrained by the household budget. Demand for children, in turn, is influenced by the costs incurred in the bearing and raising of children balanced against the economic (and non-economic) benefits they bring to the household. For example, costs may include health care, educational and food expenses, while benefits may include the children's productive activities in the home and support of parents during their old age.

Such a framework can be useful to explain observed differentials in contraceptive prevalence and fertility, and to identify the policy, service delivery or other types of initiatives that may be implemented to increase demand for family planning services. For example, rural-urban differentials in fertility often have been explained by saying that the costs of bearing and raising children in an agricultural setting may be lower than in an urban area, given the availability of food and low school enrollment. At the same time, the value of children as agricultural workers and as old-age security is greater in rural areas than in urban ones.

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Does such an explanation carry weight in Egypt? The answer appears to be a cautious and qualified "yes". In Egypt, differentials in contraceptive prevalence and fertility by residence and other characteristics are well documented. Shown in Table C-1, below, are data from the 1988 DHS, but similar patterns are found in nearly all other demographic surveys. With respect to fertility and contraceptive use, rural fertility is consistently higher; contraceptive use is consistently lower. This appears to correspond well with the notion that children are more "valuable" in agricultural settings. On the other hand, it is the regional differences that are the most striking, with Upper and Lower Egypt clearly distinguished.

TABLE C-1 DIFFERENTIALS IN FERTILITY, CONTRACEPTIVE PREVALENCE AND PAYMENT FOR FAMILY PLANNING SERVICES IN EGYPT, 1988 DHS		
Background Characteristic	TFR ('86-88)	Currently Uses FP Method (%)
Urban Governorates	3 01	56.0
Lower Egypt - Urban	3.80	54.5
Lower Egypt - Rural	4 73	35.6
Upper Egypt - Urban	4 17	41.5
Upper Egypt - Rural	6 15	11.5

It turns out that poverty levels appear to be as important predictors of fertility and contraceptive use levels as is urban/rural residence. The levels of fertility and contraceptive use in Egypt correspond very closely to what is known about the distribution of household resources, at least on a regional level. While data on the level of poverty in Egypt are extremely scarce, the World Bank estimates that in the governorates of the Fayoum, Beni Suef, Minya, Assiut and Sohag, more than half of the rural population is estimated to be in poverty. In Suez, Dakahliya, Sharkiya, Galiobiya, Beni Suef, the Fayoum, Sohag and Matruh more than half of the urban population is poor (World Bank, Annex B, p 3). These same governorates have the lowest contraceptive prevalence rates.

Unmet Demand for Family Planning With such a close correlation between contraceptive use and poverty, it is reasonable to wonder whether women who wish to have no more children are simply unable

to afford family planning services. In fact, a strikingly large proportion of Egyptian women do appear to have unmet demand for family planning. According to 1988 DHS, 47 percent of currently married women who said they either wished to have no more children or wished to delay the next birth were not using contraception. The gap between reproductive wishes and contraceptive behavior was greatest in rural areas: among rural women, 58 percent of women who wished to space or limit their births were not contracepting, in urban areas, 35.5 percent of women in need were not using contraceptives. As with other indicators, the most significant problem was in rural Upper Egypt, where more than 64 percent of women in need were not contracepting.

Does this indicate that women cannot afford the services they need? That is, are they unable to make their demand effective? While it is difficult to obtain information on this issue directly, data from the DHS again is helpful, and indicate that cost is not a primary deterrent to contraceptive use. When women who did not wish to have additional children (at the time of the survey) were asked why they did not use contraceptives, only 0.4 percent stated as a reason that the services available to them were unaffordable. (The principal reasons for non-use were breastfeeding, side effects for women, etc.)

Willingness to Pay for Family Planning Services. Answers to survey questions about affordability is one means of assessing whether economic barriers are preventing women from obtaining needed family planning services. Another is to examine the prices paid.

Due to price controls on contraceptive commodities, women in all regions and at all income levels can purchase oral contraceptives and IUDs at very low cost. For example, nearly 90 percent of oral contraceptive users reported that they paid LE 0.35 or less for one cycle of pills. Therefore, little information can be derived from commodity sales data about "willingness to pay." However, price differentials are found in family planning services, ranging from nearly free services at Ministry of Health facilities, to low-cost services in the private voluntary and private commercial sector, to medium- to high-cost services in the private commercial sector.

Data on the prices paid by women in various regions of the country for IUD insertion, shown in Table C-2, below, indicate that the majority of women obtain services priced at LE 10 or less. Interestingly, the urban-rural differentials in prices paid are not as large as would be expected from the differences in levels of poverty. In urban areas, about 50 percent of women

obtaining IUD insertions pay LE 2-10; in rural areas, this percentage rises to 60 percent. In both urban and rural areas, about 20 percent of women pay the moderate price of LE 11-20 for IUD insertion.

With respect to differences between Upper and Lower Egypt, the central finding is that there is almost no distinction between the distribution of prices paid in urban and rural Upper Egypt. In Lower Egypt, on the other hand, larger proportions of urban women pay relatively high prices.

PRICE RANGE	URBAN (%)	RURAL (%)	LOWER EGYPT		UPPER EGYPT	
			URBAN (%)	RURAL (%)	URBAN (%)	RURAL (%)
LE 2-10	49.8	59.8	43.3	61.9	48.9	47.3
LE 11-20	19.3	21.0	23.2	21.5	18.6	18.0
LE 21-50	20.7	14.6	20.9	12.0	23.7	30.9
LE 51 or more	10.0	4.6	4.8	1.9	7.0	2.2

A tentative interpretation of these data is that, while low-priced services are widely available and used in Egypt, sizable market segments are willing and able to pay moderately high prices for family planning services, in both rural and urban areas. However, far more investigation of this matter is required before one would be able to draw conclusions about the Egyptian woman's willingness and ability to pay for contraceptive commodities or services.

2. Sustainability and Self-Sufficiency of the FP Program

In financial terms, sustainability of any organization or program implies that all costs are covered by a secure source of revenue, including both capital and recurrent costs. For a family planning service provider, this is likely to include at a minimum the cost of renting, equipping and maintaining clinics, training and providing wages and benefits to workers, and supplies. On the other hand, self-sufficiency refers to an organization's ability to attract revenues to cover only operating costs (primarily salaries and benefits, equipment maintenance, and

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supplies). The self-sufficient organization may still require outside support for capital costs, technical assistance, etc. In general, self-sufficiency is considered to be a more realistic objective than is sustainability for the near term for health and family planning services in developing countries.

There is a potential, and in some instances realized, tension between the financing objectives (sustainability or self-sufficiency) and demographic goals (fertility reduction) in the Egyptian context. Currently, donors provide approximately half of the support for the public family planning program; of all donor assistance, USAID provides approximately 75 percent. This heavy dependence on USAID implies that the family planning program currently is not sustainable, and very large decreases in donor support would lead to a dramatic slowing of progress in family planning. As emphasized earlier, the overall economic situation of Egypt prevents the government from allocating additional large amounts of resources to the family planning program, and would therefore either reduce the services available or turn to service users for financing, if USAID were to withdraw support. While we have no direct evidence about the effect of a change in prices on consumer behavior (i.e., elasticities), it is possible that a dependence on user-financing would lead to a reduction in use of family planning services, at least among some segments of the population -- likely to be those with highest fertility.

Recognizing this, the (former) USAID/Cairo Mission Director explicitly noted that "the priority [in USAID-supported family planning projects] should be to get results in fertility reduction . . . obtaining results in fertility reduction was more important than achieving sustainability in the various family planning organizations" (Carpenter-Yaman, April 15, 1991, "Minutes of Meeting with Mission Director Marshall Brown ")

Despite this potential conflict between sustainability and fertility reduction objectives, design of the POP/FP III Project has taken sustainability (and, in a shorter term, self-sufficiency) considerations into account. This includes the following:

Resource Projections Part of the technical assistance to be provided to the National Population Council and other implementing agencies will be used to estimate the current and future demand for family planning services, the cost of those services (under various method- and source-mix scenarios), and the potential revenues. This exercise, which will be an enhancement of activities that currently take place on both national and governorate levels, will assist the government in

seeing the magnitude of the resources required in the near future. It is expected that this analysis will motivate a more serious effort to seek alternate means of financing, including broadening the role of the private commercial sector

Institutional Capabilities: The several management activities within the project include activities that strengthen the most important administrative and supervisory functions within the Egyptian family planning program. This will lead to better strategic decision making, based at least in part on cost, cost-effectiveness and demand information

Evaluation of Cost-Effectiveness of Different Service Approaches: Over the long term, the GOE will have vital decisions to make about investments in family planning. Is it better to reach target populations with stationary or mobile services? Should the government continue to provide services directly or should there be consideration of contracting out to private providers? Do private voluntary organizations require smaller subsidies than government facilities? Under POP/FP III, there will be opportunities to evaluate the cost-effectiveness of various service delivery approaches. This evaluation will inform future decisions about how to most wisely use government (and USAID) resources

Increasing the Role of the Private Commercial Sector Several activities of the project will emphasize the role of the private commercial sector, already the leading provider of family planning services in Egypt. Long-term sustainability in Egypt's family planning program will be realized only if the government's role is transformed into one of facilitating a diversity in service provision to meet the needs of a very diverse population. Neither the government nor donors can or should provide low-cost services and contraceptive commodities to all. Such untargeted subsidies imply intolerably large direct costs, and immense opportunity costs. Appropriately, the commercial private sector should be allowed to take a larger role in service and commodity provision. This does not imply providing subsidies to the private commercial sector, thereby turning them quasi-public. Rather, it means loosening current constraints to private commercial sector operation

Reduced and Targeted Provision of Contraceptive Commodities: Currently, USAID provides oral contraceptives, condoms, vaginal foaming tablets, and nearly all IUDs. It is incumbent upon USAID to ask whether its activities help or hinder the long-term sustainability of Egypt's family planning program. To what extent do USAID-provided contraceptives "subsidize the subsidies," making release of price controls appear to be less

vital to the GOE? In this way, does USAID contribute to the constraints on private commercial sector participation in provision of commodities? These questions were considered at length during the design of the POP/FP III Project, with the result of a new, more strategic approach to commodity provision. Under this project, USAID will provide IUDs and a very limited supply of NORPLANT and condoms only to POP/FP III subprojects. Given the stage in development of the Egyptian family planning program, this is an appropriate use of USAID funds. It is a shift that will provide incentives for the government to move toward a more sustainable supply of contraceptives -- either local manufacture, or direct importation from commercial sources

Limited Cost-Recovery Opportunities Review of the experiences to date in the POP/FP II Project, information from other settings, and general principles of cost recovery imply that there is some potential for recovery of a small to moderate proportion of operating costs in family planning clinics and related training programs.

In the recent USAID-support study of costs in government- and donor-supported family planning activities, Heilman (1991) found that, on average, about 7 percent of total costs of service delivery were covered by user payments, with the remainder evenly divided between government and donor support. While it is premature to expect current POP/FP II activities to be self-sufficient, it is not too early to ask what their prospects of cost recovery are. Fairly good guesses can be made for a couple of key activities, though it is worth noting that they are being made in the absence of sufficient data.

For most of the MOH units, the prospects are weak. In general, it is safe to assume that a large share of MOH clients could not afford to pay much for family planning services, and that the quality of services probably is not high enough to attract a large share of clients who can pay (and by doing so subsidize needy clients). In fact, it may be that effective self-targeting currently characterizes utilization of MOH facilities. If the MOH is expected to maintain or increase and improve its services, cost recovery should be planned only for the quite distant future.

For THO and CSI clinics, in which quality of services apparently is considerably higher than in most of the MOH, considerable gains can be made in cost recovery and, at the same time, lessons can be learned about the tradeoffs between quality and prices. CSI is implementing step-wise increases in the prices of some services, adding revenue-generating services, and currently anticipates achieving self-sufficiency (defined as recovery of

100 percent of operating costs, which do not include contraceptive commodities supplied by USAID) by 1995-97. [A further discussion of CSI efforts at cost recovery is presented in the financial analysis.] At present, THO has no plans to increase clinic prices, but could be a useful setting for price experimentation, given the relatively good quality services offered, and the recognized leadership of the THO in health care.

On the other hand, however, a tension exists between the demographic goals of the family planning program -- to reduce fertility through expanded and improved contraceptive use -- and the drive toward self-sufficiency, at least in the short term. In terms of a concrete example, there is a risk that an organization such as CSI, under increasing pressure to achieve self-sufficiency, will turn its emphasis toward revenue-generating activities, such as provision of ultrasound, Pap tests, other laboratory tests, etc. As in the U.S. health care system, economic imperatives in private or semi-private institutions can lead to over-utilization and other inefficiencies in service delivery. It is also possible that the move toward increasing prices will push CSI into even greater competition for the segment of the population currently served by low- to middle-priced private providers. This would be a counterproductive result.

Turning away from service delivery, considerable opportunities exist for cost recovery in training. According to a recent USAID study, tuition per person that would have to be charged by the Ain Shams Regional Center for Training to cover 100 percent of variable costs would range from LE 363 for a 1-week NORPLANT training course, to LE 1,451 for a 6-week course for physician trainers. Tuition for a 2-week advanced physician training would be LE 725 (Martinkosky, 1990). Given little or no information on willingness of participants to pay, it is impossible to make inferences about the prices that should be charged. However, this appears to be a promising avenue, particularly for training of private physicians, who benefit financially from the training. As the project progresses, opportunities will arise for both obtaining information on willingness of trainees to pay for training, and to try specific market tests.

3. Economic Policy Constraints to Family Planning

As described in the issues paper on the private sector (Ravenholt, 1991), opportunities for private commercial sector participation in provision of pharmaceuticals is severely constrained by tight controls on prices, and corresponding direct and implicit government subsidies. In addition, current pricing

policies have potential negative equity effects on consumers, and considerably limit the family planning program's ability to achieve sustainability

Consumer subsidies, part of a secondary income flow, can be seen as a means of redistribution of resources, albeit inefficient. Earners pay taxes, which are then used by the government to support purchase of consumer goods, which are then available at low cost to the entire population. In general terms, free (or below-cost) public health services available to all operate in a similar fashion. The World Bank (1990:2) has stated that "the government makes large income transfers through an extensive subsidy and price control system from which the vast majority of the population benefits in an indiscriminate manner." A 1987 USAID study estimated that the secondary income flow in Egypt was equal to 5 percent of the GDP in the form of education and health benefits, and another 5 percent in other in-kind consumer subsidies, including low-cost pharmaceuticals (Lampman, 1987).

The effect of subsidies on consumer behavior and welfare in Egypt is not known because there have been few market tests. However, it is apparent that the provision of subsidies is contributing to the economic deterioration in Egypt. The government is increasingly unable to support the level of subsidization traditionally provided.

From the perspective of the GOE, the provision of universal subsidies, a category that includes price-controlled contraceptives and other pharmaceuticals, and public health and family planning services, is placing intolerable pressure on resources. In the case of contraceptives, this pressure will mount if and when USAID discontinues its provision of free commodities. The need to reduce the level of subsidization is clear. Again, as the World Bank states, "The pressure to reduce public expenditures makes it imperative to consider ways of containing the overall cost of the various social services and transfer programs while ensuring that the neediest people are not adversely affected" (World Bank, 1990:3).

This change is slow in coming, largely for fear of taking the political risk of limiting subsidies, precipitating sharp price inflation and further jeopardizing the poor during a period of economic constriction. The risks are thought to be particularly great in the case of price controls on contraceptives, given the high visibility of the problem of rapid population growth. The government is unlikely to release price controls if there is fear that contraceptive prevalence will fall (or fail to rise at an adequate pace).

While accepting the existence of rigid price controls as a given, the design of the POP/FP III Project does indirectly address the issue in two ways. First, reduction in the level USAID-subsidized contraceptive commodities will place a small to moderate amount of pressure on the system to release the price control constraint. At the least, it will remove an artificial and ultimately unproductive support of the price control system. Second, the project has sufficient means within the private sector initiative component in the event that social marketing activities become an appropriate avenue for the Egyptian family planning program to follow. Funding would be available for social marketing if and when price controls are released to the extent that additional pharmaceutical manufacturers enter the market, and a market segment is identified that would benefit from a special, low-cost (subsidized), and commercially-available product.

4. Economic Data Required for Decision Making

Two general types of data should be collected within the context of the POP/FP III Project. The first is information on the cost and cost-effectiveness of providing services, needed to help the government and donors better allocate their resources. The second is information on consumer characteristics and behavior. Such information is critical to developing cost recovery initiatives, assessing the potential for expansion of the private sector, and determining the effect of release of price controls on contraceptive products.

Cost and Cost-Effectiveness. Subprojects should include a means of on-going collection of the type of information required for cost-effectiveness analysis, including standard measurements of time (salary) inputs, other recurrent costs, and capital costs and depreciation. Specific standard efficiency indicators can then be calculated and compared across different service delivery units and system. At the least, the cost study currently available (carried out by Heilman et al since 1989) should be updated annually, and the skills to collect and interpret cost information should be institutionalized through one-on-one training and transfer of technical knowledge.

Consumer Characteristics and Behavior. Lack of information about the market for family planning services severely hampers the GOE's ability to estimate the effect of cost-recovery efforts or release of price controls. In addition, the private sector would greatly benefit from data on characteristics of various market segments.

D. Social Soundness and Women in Development Analysis

1. Introduction

The goal of the Population/Family Planning III (POP/FP III) Project is to assist the Government of Egypt (GOE) in achieving the goal of lower fertility. Its purpose is to increase the level and effectiveness of contraceptive use among married couples. Achieving this purpose requires that couples have access to information and services that will enable them to select an appropriate, modern contraceptive method, to use that method effectively, and to continue use. Thus, the Project will support activities designed to:

- increase service volume and improve service quality,
- improve information for policy makers, and
- improve management capacity in implementing agencies.

Project activities will be carried out by four public sector implementing agencies. The Project will also support a private sector initiative intended to promote increased and improved private commercial sector involvement in family planning service provision to complement activities in the public sector.

This analysis discusses the social soundness of the proposed POP/FP III activities, as well as their conformity with AID's women in development policies.

2. Socio-Cultural Feasibility

Important barriers to family planning and fertility reduction in Egypt include early age of marriage and first birth, high rates of illiteracy, especially among women, disapproval of family planning in conservative and rural areas; high value placed on children; and low status for women, with prestige largely derived from childbearing. This section describes these constraints, many of which are also discussed in the context of Women in Development, Section 5.

On the other hand, there are many socio-cultural factors which support family planning and fertility reduction in Egypt. These include support for family planning by senior political and religious leaders, an accessible population with a common language and history, and an extensive public and private health

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infrastructure These factors are analyzed in this section The difficult economic conditions which cause families to rethink the costs of children are presented in the Economic Analysis, Annex C.

a. Political and Religious Leader Support

The 1980s were years of increasing political and religious support for family planning in Egypt. President Mubarak took the lead, warning that unchecked population growth would "devour" Egypt's resources and doom to failure all efforts to accelerate development and improve the quality of life Increased national level attention to family planning was reinforced by the participation of prominent Muslim and Coptic religious leaders In 1988, a Fatwa was issued by the Grand Mufti stating unequivocally that family planning is not forbidden by the Quran In March 1991, the Pope of the Coptic Church and the Grand Mufti appeared together on television to support family planning and reaffirm its religious acceptability. Continued support from religious leaders is vital to the success of Egypt's family planning efforts because religion has been particularly significant in shaping the character of Egyptian social life and has provided the moral authority that helps shape and sustain patterns of behavior Governorate officials spoke out on the need for strong family planning programs, and began developing governorate population plans in collaboration with local policy makers, leaders, community organizations, and private groups Such broad support has had a significant impact on the availability and acceptability of family planning services.

In this positive climate, substantial progress was made in increasing contraceptive use and reducing fertility The total fertility rate (TFR) fell from 5.2 births per woman in 1980 to a TFR of 4.4 births per woman in 1988 The contraceptive prevalence rate (CPR) increased from 24 to 38 percent during the same period Nonetheless, large differentials in family planning practice remain in 1988, the CPR among urban women was double that of rural women Similarly, women with at least a primary-school education were twice as likely to use family planning as women with no education

b. Accessible Population

Egypt's population is densely settled in the Nile delta (Lower Egypt) and in the narrow Nile valley to the south (Upper Egypt). In 1986, there were almost 1,200 persons occupying each square kilometer of inhabited area Although the majority (56 percent) live in rural areas, Egypt is becoming progressively more urbanized Almost 12 million people live in Greater Cairo alone

Clustered along the Nile, almost all the population is readily accessible by road, rail, and telecommunications. The last is particularly important since slightly less than half the population is literate, according to the 1986 census. Egypt may be almost unique in its ability to reach so many through its national television network. Television is a highly effective medium for communicating family planning messages to Egyptian women. Three-quarters of the married women interviewed during the 1988 Demographic and Health Survey (DHS) said they watched television daily and 69 percent had seen a family planning message in the month before the survey.

In addition to being accessible, Egypt's population is also relatively homogeneous. Egyptians, who are 94 percent Muslim and 6 percent Christian, according to official estimates, share a common language and history. Information, Education, and Communication (IEC) efforts under POP/FP III will continue to capitalize on this combination of accessibility and homogeneity in the design, production, and dissemination of effective family planning messages.

c. Extensive Public and Private Health Infrastructure

Family planning services in Egypt are widely available from both public and private sector providers. Unlike many countries where the public sector is the predominant service provider, the private commercial sector serves the majority of women who adopt family planning in Egypt. According to the 1988 DHS, 98 percent of married women knew of at least one modern contraceptive method and almost all women could name a provider. Moreover, most said they would go to a pharmacy or private doctor for contraceptives.

In the face of the growing number of married women of reproductive age, greater service coverage will be required merely to maintain contraceptive prevalence at current levels. As Egypt's population program expands, maintaining the current public-private service mix will be critical to meeting Egypt's family planning needs effectively in the future. The commercial private sector, through pharmacies and private physicians, provided approximately 70 percent of all family planning services in 1988, the public sector 26 percent. During POP/FP II, the potential of the public sector to serve its target population has grown significantly and its absorptive capacity has increased. The public sector provides services to those least able to pay; those Egyptians who can find a way to afford it seek private care. Many doctors in MOH hospitals and clinics also practice privately in the evenings. Women who are willing to pay fees to the more qualified medical practitioners for personalized and timely care utilize these services even though, with a long wait,

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they could probably obtain medical attention free, perhaps from the same doctor, in a government facility. There is, however, a significant group, particularly in villages and rural areas, who cannot afford to pay. Any expansion of private family planning care will diminish the burden on the MOH system without additional government capital investment or operating budgets.

In addition to maintaining the public-private service mix, significant attention to the preparation of service providers is needed in order to capitalize fully on this extensive network to increase the effective use of family planning methods to achieve fertility reduction targets. Most women surveyed in the 1988 DHS said they were satisfied with the clinical services they received, but 24 percent of pill users felt they did not receive enough information, and 31 percent of IUD users said the method cost too much. Women who stopped using a method of family planning in the five years prior to the 1988 DHS gave a variety of reasons for discontinuation. Among both pill and IUD users, the most common reason was side effects. The DHS and other studies have also documented the fact that many pill users do not take the pill correctly. Noncompliance can lead to unwanted pregnancy. Almost one in six women who discontinued using either the pill or the IUD did so because she became pregnant while using the method.

The POP/FP III Project will continue the efforts begun under POP/FP II to support the GOE in its efforts to assure quality care, make the best use of existing resources, and improve provider effectiveness. Private sector activities will be aimed at enhancing the quality, availability, and acceptability of family planning care. Improved information for policy makers will lead to more effective population and family planning policies, and improved management capacity. Better management and improved quality of family planning services is expected to reduce failure rates and misuse of contraceptives. Increasing the effective use of family planning methods will also contribute to achieving fertility reduction targets.

d. Fertility Determinants

In addition to the vigorous support for family planning from political, religious, and community leaders and the increased contraceptive use among married women noted previously, declining fertility in Egypt can be attributed to several factors. Among them are increases in female education rates, a rise in the average age at first marriage, and maintenance of the traditional practice of prolonged breastfeeding.

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Age at Marriage and First Birth: The age at which a woman first marries often determines the length of her active reproductive life. One can assume that women who marry earlier tend to have more children than those who marry later. There is evidence that laws governing the legal age at which women may marry in Egypt (i.e., 16 years of age) are being more strictly and uniformly enforced. For example, in the 1988 DHS the average age at first marriage was 17 among women aged 45-49 but had increased to 21 among women aged 20-24.

Age of marriage is also influenced by educational achievement and place of residence. Urban and educated Egyptian women tend to marry later. Urban women age 25-49 in 1988 married at age 20 on average, while rural women married at 17. Women with at least a secondary school education delayed marriage until 25, while half of those with no education were married by 17.

The very early childbearing associated with early marriage can pose serious health risks for women and their children. The 1988 DHS, which reports that 8 percent of Egyptian women gave birth before age 16, and one in five women before age 18, indicates a decline in early childbearing. Nearly 30 percent of women in their late 30s and 40s had their first birth before age 18; however, only 15 percent of women in their 20s experienced their first birth before age 18.

Breastfeeding/Postpartum Abstinence Following the birth of a child, a woman is not in immediate risk of another pregnancy. The length of this protected period is determined both by the practice of sexual abstinence and by how long a woman breastfeeds her child. Breastfeeding can delay the return of the menstrual cycle and ovulation. In Egypt, children born in the three years prior to the 1988 DHS were breastfed for an average of 17 months. However, women practiced abstinence for an average of only three months following a birth and the average protected period following a birth lasted nine months.

e. Attitudes Toward Family Size and Contraception

The 1988 DHS results indicated that childbearing attitudes among Egyptian women are supportive of further fertility reduction. The mean ideal family size is 2.9 children, and over one-third of women express a preference for a two-child family. Among women not using contraception when they were interviewed in 1988, over half indicated that they would accept a contraceptive method in the future. In addition to the 38 percent of married women who were using family planning in 1988, an additional 33 percent said they wanted no more children, and 27 percent said they wanted to delay their next birth for at least two years. While rural women

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are more conservative than urban women, there is considerable potential demand for family planning services in rural areas. Nearly 60 percent of rural women wanted no more children or wanted to space their next birth although they were not using contraception

While the general attitudes toward family planning are encouraging, the picture in Upper Egypt is somewhat different. The 1988 DHS reported that of the women who know a contraceptive method in this region, one in five disapproved of a couple using family planning. Further, one in four women in rural Upper Egypt believed that her husband disapproved

The geographic differences observed in attitude towards family planning are also evident in actual fertility rates. The 1988 DHS reported that the fertility rate was 3.3 children per woman in Urban Governorates, 4.8 in Lower Egypt, and 5.6 in Upper Egypt. Rural women in Upper Egypt have the most children, an average of 6.4 each. Overall, the declines in fertility of the past decades have been occurring at a faster pace among urban women than among rural women. Recently, however, the decline has been greater among rural women. This trend, if continued, will lead to a narrowing of the difference between urban and rural fertility levels

f. Conclusions

Based on the analysis of Egypt's current social situation and that in which POP/FP II was developed and implemented, it seems reasonable to conclude that the activities planned for POP/FP III are socially sound. The nationwide service delivery interventions, especially in the public sector, should continue to address the needs of the large urban poor populations while continuing to increase access in Upper Egypt

3. Impact and Spread Effect of Project Activities

The POP/FP III Project is a sector-wide umbrella Project. Its activities will be implemented by three Ministries (i.e., Ministry of Health, Ministry of Information, and Ministry of Social Affairs) and the National Population Council. Several subprojects (activities) will be carried out nationwide; that is, in the 21 most populated and, therefore, most demographically significant governorates

Although the Project is more consolidated than the previous one, its more strategic approach to resource allocation should have an even greater impact than before. For example, POP/FP III will

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continue to support family planning activities utilizing the vast (more than 3500 units) health delivery system of the Ministry of Health. This will have the greatest impact in rural areas, especially Upper Egypt, and among the urban poor. In addition, with only limited inputs to the private commercial sector, the Project will further strengthen that sector's contribution to the overall Egyptian national family planning program. In sum, expansion of service accessibility will be ensured throughout the country.

The knowledge and skills gained by the service providers and managers in the implementation of the Project are more generalizable to their wider work responsibilities and functions. This is especially true in the Ministry of Health where the skills gained from this sector-specific project can form the stimulus for greater Ministry-wide improvements in management and decentralization.

The studies proposed in order to provide information to policy makers are intended to have a nationwide impact. This is especially true if the findings and recommendations from these studies are translated into national policies and regulations which support improved access and quality of services.

Of special importance are the activities designed to strengthen the private commercial sector, both service providers and contraceptive distributors. If these efforts are successful, the broad government subsidy in family planning traditionally enjoyed by high and middle income households should be reduced. If these income levels are no longer subsidized by the public program, there should be increased resources available to improve services and outreach to the poor.

Because of unusually high rates of access to television, viewing habits, and low literacy rates, Egyptians are particularly well suited to televised messages. Egypt has capitalized on these social factors and the popularity of television to broadcast prime time messages about the benefits of family planning, the availability of services, and the proper use of contraceptives. Family planning constraints can be eased and contraceptive use significantly increased if accurate information concerning contraceptive use and side effects is effectively communicated to potential and current users. Through this Project, Egypt has the potential of developing one of the best national IEC programs in the world.

4. Social Consequences and Beneficiaries

The negative economic and social consequences of population pressure in Egypt provide strong indications that both the GOE and USAID/Egypt should continue substantial investments in family planning activities. In the short term, increases in contraceptive use contribute to improvements in the health of women and children, as well as a lessening of the pressure currently experienced by the country's education and health systems. In the long term, increases in contraceptive use contribute to slowing the rate of population growth which allows the economy to expand in real terms, thereby improving the population's welfare.

The Project's most immediate beneficiaries will be the current and new family planning acceptors (primarily women) who will receive more accessible and higher-quality care. By correctly using the appropriate method to meet their needs, they will experience improved health as well as many of the benefits associated with fertility regulation.

For example, early and late childbearing, high parity, and closely spaced births increase mortality and morbidity risks for both mothers and children. Accurate maternal mortality rates are difficult to obtain and can be expected to vary from one area to another. However, a recent hospital-based study in Giza found a maternal mortality rate of 140 maternal deaths per 100,000 live births. A high percentage of the deaths in Giza occurred to high risk mothers. Two-thirds of the women who died had never used contraception. Almost half the deaths occurred to women having their fourth or subsequent pregnancy. More than one third of the deaths were to women over age 35. Recent data from the vital registration system suggest that infant mortality in Egypt has decreased from a level of nearly 200 deaths per thousand births in the early 1950s to around 50 per thousand in the mid-1980s. However, according to 1988 DHS results, infant mortality varied substantially with the length of the birth interval from more than 150 per thousand when the interval between births was less than two years to around 40 per thousand when the interval between births was four years or more. Thus, better spacing will reduce the number of births which occur close together and thereby contribute to decreasing the mortality levels of Egyptian infants and children as well as the mortality levels of mothers.

Secondary beneficiaries include family planning managers and service providers whose employment options and practices will increase. Ultimately, the Egyptian population will benefit from a rate of population growth more commensurate with development goals.

5. Women in Development

a. Opportunities for Women's Participation

POP/FP III provides several areas for increasing women's participation in the Project as well as in the overall national family planning program. In-country training is the largest opportunity, and it will be discussed separately in Section 5.d Through training efforts for non-physician categories, a number of women involved in family planning services will be provided supervisory and management skills which may be extended to their general work requirements

In addition, among the studies to be conducted for policy makers will be those which argue for increased service delivery responsibility for trained nurses

b. Constraints to Women's Participation

Women's access to education, paid employment, and health and family planning care are constrained by the dominant role of males, traditional restrictions on women's activities, strong social pressures to produce many children, and conventional expectations that women will be subordinate to men. According to the Women in Development Action Agenda published by USAID, Cairo, in September 1989, the traditional role of women in Arab cultures is to enhance the dominant role of males. Males are considered the protectors of females and the basic bread winners. Middle and lower class women tend to adhere to patterns of modesty, submissiveness, and conservative behavior despite the progress women have made in Egypt relative to other Arab countries (Women in Development Action Agenda, USAID, Cairo, September 1989)

The family in Egypt is still the most valued social institution. The rigidity of sex roles within the family has often been underemphasized by writers focusing on the increasing number of Egyptian women receiving advanced education or engaged in full time employment outside the home. In fact, the deeply-rooted traditional expectation within families that women will be subordinate to men frequently limits women's access to education, paid employment, and health and family planning care. One result is that approximately 62 percent of women are illiterate, contrasted with 39 percent of men.

A woman's status in Egypt has traditionally been associated with the number of children she produces. Thus, as fertility increases, her status within the family and society increases. Societal values encourage the strongly held belief that it is children which give permanence to the marriage relationship and

that a couple only becomes a family after they have had children. Having at least one male child affects not only reproductive behavior, but also the stability and continuation of marriage. Particularly in rural areas, children are also seen as low cost contributors to family income or subsistence and as old-age security. This perception appears to influence the larger family sizes still common in rural areas, especially in Upper Egypt.

While Egypt is often seen as having one of the most liberal approaches in the Middle East to female employment, most women, upon marriage, are likely to discontinue working for pay.

Access to family planning services may be restricted by the belief that women should only receive care from women. Although Egypt has a relatively large population of women physicians (an estimated 40 percent of annual medical graduates are women), the same societal norms that encourage women to seek female doctors in conservative areas may limit the likelihood of women physicians seeking employment or being able to practice medicine. Women doctors are also subject to constraints on their mobility and experience conflicts between their roles as physicians and as wives and mothers. They are less likely than male doctors to continue their medical education and specialize.

c. Overcoming Constraints to Participation

An indication that the gender disparity described in the previous section may be narrowing comes from the Ministry of Education's Office of Statistics. In 1986, 88 percent of eligible males and 74 percent of eligible females were enrolled in primary schools. Despite traditional beliefs about women's roles, growing economic pressures and rising educational attainments of women are contributing to an increase in the employment of women. Smaller family size has particular impact on the opportunities for girls and women since, when families have to choose between children, sons still receive preference. Access to family planning can have other impacts on woman's status -- decreasing the time devoted to childbearing and rearing and improving health provide more time for education and advancement. The Project's IEC messages and outreach activities will be directed at both women and their husbands, and are expected to increase awareness of the benefits associated with family planning and demand for services. The expansion of family planning services can also have a very direct impact on women's employment. For example, women make up 76 percent of the staff of the Clinical Services Improvement Project which will be supported under POP/FP III.

d. Efforts to Increase Women's Inclusion in Training

The majority of training activities under POP/FP III will be in-country. Public and private sector service providers will be trained in family planning clinical and counseling skills to upgrade service quality and increase availability of services. Special emphasis will be placed on training female practitioners, especially those working in Upper Egypt. Training will also be conducted for nurses, social workers, and community outreach workers, the majority of whom are women. In addition to basic contraceptive technology courses, training directed at these cadres will include supervisory and management components.

POP/FP III will also include training activities aimed at strengthening the pharmacist's role as a family planning service provider. Special efforts will be made to include female pharmacists representative of various geographic areas in Egypt in these activities.

Design and scheduling of these courses will seek to increase the numbers of women participating by taking into account their dual responsibilities in both the home and the work place. Thus, most sessions will not require lengthy periods away from home.

Finally, efforts will be made to increase female participation in the limited number of short-term participant training opportunities available through the Project. However, it is recognized that limited English language skills as well as other social constraints outlined in the Section 5 b of this analysis may prevent their participation in training activities outside of Egypt.

E. Institutional and Administrative Analysis

The institutional and administrative analyses are combined to review briefly the characteristics and administrative capacity of the implementing agencies to be funded by the POP/FP III Project. The consolidation of the POP/FP III Project reduces the number of implementing agencies receiving USAID support for population and family planning purposes to four. They are: the National Population Council (NPC), Ministry of Health (MOH), Ministry of Information (MOI), and Ministry of Social Affairs (MOSA)

1. Overview of the Implementing Agencies

The NPC was designated in 1985 by Presidential decree as the special-purpose body responsible for coordination and policy definition in population and family planning. While the structure is in place, its role and function are still emerging. The coordination function, as it rests more on the "authority of ideas" than on fiscal or statutory authority, will take time to be accepted.

The MOH has an extensive and well-established network of clinical facilities intended to provide care to the poor. These same facilities have been upgraded under POP/FP II to provide family planning services. In 1989, an Undersecretary for Family Planning position was established providing distinct visibility as well as greater coordination of all family planning activities within the Ministry of Health.

The MOI, under which the State Information Service (SIS) operates, has provided the population and family planning program with generous amounts of television and radio time for IEC messages. The IEC Unit of the SIS has direct responsibility for family planning-related media activities.

The MOSA is responsible for registering and, in broad terms, overseeing the activities of private voluntary organizations (PVOs) and other non-governmental organizations (NGOs) throughout the country. The Egyptian Family Planning Association (EFPA) is the principal MOSA registered, PVO provider of family planning services.

2. Administrative Characteristics and Constraints of the Implementing Agencies

a. The National Population Council

In 1985 President Mubarak replaced the Supreme Council for Family Planning and Population, and the Population and Family Planning Board, with a new National Population Council (NPC) by issuing a decree (No. 19) that emphasized the importance of solving Egypt's population growth problem as an integral part of the nation's overall development strategy. The NPC was initially headed by the President himself, as Council Chairman, and was composed of: the Prime Minister, Ministers of Health, Social Affairs, Planning and International Cooperation, Information, Education and Local Government, plus four other representatives to be selected by the Chairman; and a Council Secretary General. In 1988 the President delegated responsibility for chairing the NPC to the Prime Minister

The mandate of the NPC is to

- (1) Formulate population policies which realize the highest possible rates of economic and social development,
- (2) Approve annual programs for population projects and programs;
- (3) Evaluate the annual achievements of the above and other projects, and issue directives for the elimination of any obstacles in their course,
- (4) Decide on the annual budgets of the above and other projects,
- (5) Determine and coordinate the roles of public and private organizations; and
- (6) Conduct negotiations with foreign donor organizations on population and family planning, and supervise implementation of assistance

The Prime Minister was assigned responsibility to represent the NPC in its relations with other entities and the Secretary General was assigned responsibility to manage the technical secretariat, which was assigned the following responsibilities:

- (1) Prepare draft national population plans;

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- (2) Disseminate decisions of the NPC and follow-up on their implementation;
- (3) Communicate with foreign and international organizations to exchange information and experience in the fields of population; and
- (4) Follow-up on population plans, programs and activities approved by the National Population Council and submit regular reports thereon.

Since its inception, the NPC has formulated and issued a national policy on population and family planning and has produced, in collaboration with implementing agencies, a more comprehensive five year plan with quantifiable targets against which to measure progress. In 1989 the current five-year plan was up-dated. As a result of these NPC activities, the GOE now has a policy framework that clearly recognizes Egypt's multi-faceted population problem.

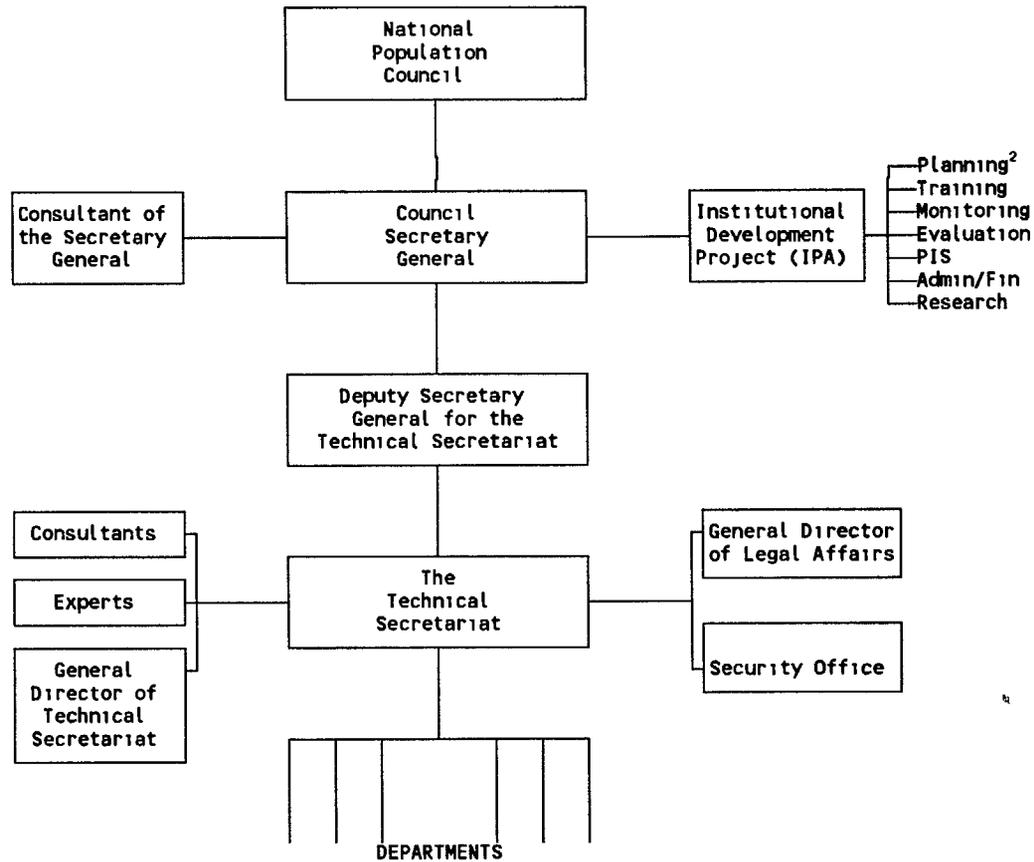
The UNFPA and USAID have supported the NPC since it was first constituted in 1985. UNFPA and USAID support for institutional strengthening of NPC requires continuing close coordination between NPC, UNFPA and USAID officials.

As is the case with other GOE organizations and ministries, inadequate salary and allowance levels of the NPC result in the employment of under-qualified personnel and high turnover among the limited number of higher quality personnel attracted to NPC service. This is a problem that is only solvable by the GOE. USAID, together with the UNFPA, will continue to encourage reform in this major problem area.

The Institutional Development Subproject (IDP) under the Population/Family Planning II Project was designed to strengthen the capacity of NPC to formulate and promote policies on population and family planning, develop comprehensive multi-year and annual plans at the national and governorate level, monitor, coordinate and evaluate the work of family planning implementing agencies; and plan and manage research (including demographic and health surveys), information, training and other support services necessary to develop and sustain the above functions. The organization chart in Figure E-1 shows the placement of the IDP subproject within the overall NPC.

Also under the POP/FP II Project the NPC has had experience with implementing host country Letters of Agreement with Ain Shams University for the Regional Center for Training in Family

Figure E-1
ORGANIZATION CHART: EGYPTIAN NATIONAL POPULATION COUNCIL



² These departments have staff members seconded to IDP to provide both expertise and direct communications with IDP activities.

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Planning (RCT) and with the International Islamic Center of Al Azhar University for the "Family Planning Services Subproject."

Although it has developed under the POP/FP II Project, especially at the governorate level, the NPC will continue to require assistance under POP/FP III in developing into its major role in policy analysis and coordination. Under POP/FP III, the management capacity of the NPC will continue to be supported by a resident advisor, as additional management support is needed to ensure effective development of the 250 employees, as well as to oversee fiscal affairs, host-country agreements, and general functions at the governorate levels. The technical responsibilities of the NPC/TS relate to information collection and distribution. A full-time resident advisor in research is needed to guide this process as it relates to family planning research over the LOP. With the daily inputs of long-term advisors, the current administrative issues of delegation, experience-building, and appropriate staffing should be resolved by the end of POP/FP III.

Under a host-country agreement, the NPC will delegate major responsibility for training in contraceptive technology and counseling to the Ain Shams University Regional Center for Training (RCT). The RCT has shown itself to be capable of providing a high-quality educational service; its responsibilities will be expanded in POP/FP III. Internal management of the RCT was determined to be a weak aspect of the RCT under POP/FP II. A full time training management advisor is suggested for the RCT. This strategic location of the advisor will have influence beyond the RCT.

b. Ministry of Health

The MOH is the principal public institution for delivering family planning services and has been doing so for over 20 years. Despite the increasing need for FP and a growing awareness about the health justifications for FP, the MOH FP program had very limited success prior to 1987. Systemic characteristics of the MOH have served to inhibit desired development. For example, its vast physical and human resources are underutilized for preventive health services of all kinds including FP, and the challenge to mobilize more effectively these resources continues to be a vexing problem. Despite the above systemic characteristics, the MOH remains the principal health care organization in Egypt and is the most appropriate institutional resource for delivering urgently needed FP services.

The MOH has over 3500 physical facilities including many out-patient clinics and hospitals that could offer complete FP

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services It is estimated that there is a facility within 3 kilometers of every village with a population over 3000 and that there is an average of one facility for every 9200 rural people There are a variety of MOH facilities in every urban area of every governorate with close proximity and ease of access to target populations.

Further, the MOH has over 19,000 physicians with a growing number of these physicians working in primary health care jobs that should include family planning The MOH has over 36,000 nurses and many other health personnel in daily contact with clients/patients, and who are fully capable, if properly trained, of educating and counseling clients/patients about modern birth control methods

In 1987, the Systems Development Project (SDP) was designed to respond to the GOE policy commitment to FP which reached the point of a clear mandate to up-grade the entire national MOH FP program The MOH recruited FP doctors and nurses for full-time posting in FP service units, and mobilized its vast physical and personnel resources in support of improved and expanded FP services.

The SDP has supported comprehensive "up-grading" of the MOH FP service system in 21 governorates of Egypt to support increased contraceptive prevalence and effectiveness of contraceptive use The SDP is managed by a central MOH Project Office This office has primary responsibility for overall implementation including preparation of implementation plans for centrally implemented activities and review and approval of governorate implementation plans The planning and management of project implementation activities at governorate level and below are decentralized to governorate FP Management Units staffed by full-time physician and senior nurse managers and support staff.

This FP Department of the MOH has primary responsibility for nationwide planning, supervision and evaluation of the MOH FP program and, therefore, has a role to play in the formulation of SDP implementation plans at central and decentralized levels At central level, staff of this office will collaborate closely with SDP staff in the formulation of plans for centrally implemented activities including plans to up-grade the FP Department itself At the governorate level, staff of this office will collaborate closely with the central Project Office in offering technical assistance to governorates in the preparation of their annual implementation plans, in central MOH review of governorate plans, in the continuing oversight and monitoring of FP service delivery and supervision at governorate and other levels.

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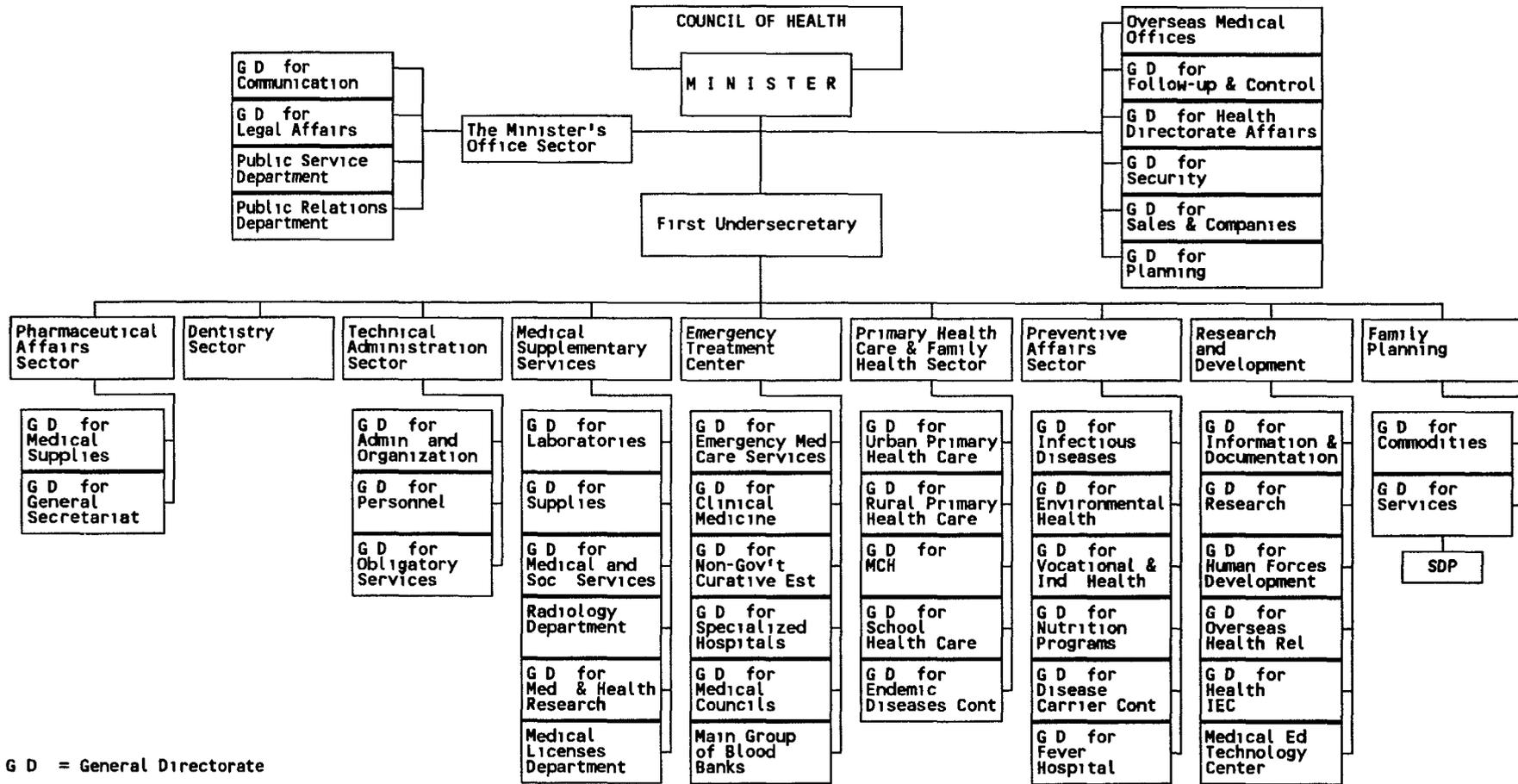
The MOH has proven it is capable of implementing large scale USAID projects. In addition to the SDP, the MOH has demonstrated its ability to fully implement the four year \$26 million ORT project. The MOH also successfully implemented the Population/Family Planning I Project (263-0029) at a \$20 million level.

With the beginning of the Systems Development Subproject (SDP) in 1987, a more comprehensive, uniform approach to family planning service delivery started. Staff and line functions are clear, but the administration focuses more on form than function, with emphasis on reports rather than change in client status. See the attached organization chart in Figure E-2. Current administrative leadership is dynamic and forward thinking. The SDP has stimulated new thinking in management systems and in data collection and analysis for MIS, but time is needed for institutionalization of this knowledge and related skills.

Despite significant positive strides in developing management and administrative capacity at the central level, especially in financial management and reporting, continued long-term TA is needed to solidify the gains made. This advisor will need to be skilled in applied management and possibly MIS. Further, management, supervision and training at district levels have yet to move from form to effective function. Local MIS and management inputs will be needed. The administrative complexity of contraceptive commodity procurement will also require assistance during POP/FP III, especially those aspects related to monitoring and reporting on distribution. The MOH is expected to achieve administrative independence in its family planning program by the end of POP/FP III.

The MOH maintains eight teaching hospitals under the administrative direction of the Minister of Health. Under the grant funds available to the MOH, USAID will continue to support family planning activities of the Teaching Hospital Organization (THO). The THO hospitals will also be used as demonstration and training sites for medical staff from the district hospitals. With the increased responsibility for training the THO's administrative burden will increase slightly under POP/FP III. However, THO has gained administrative experience through POP/FP II and no major problems are anticipated. TA will be available through the Implementation/Goods and Services Contractor (I/GS) for monitoring of all medical and administrative responsibilities.

Figure E-2
ORGANIZATION CHART: MINISTRY OF HEALTH



G D = General Directorate

c. The Ministry of Information

The FP IE&C unit was initiated as a separate unit of the SIS in 1980. The unit has produced a wide variety of informational materials and mass media programs that have significantly increased public awareness of population and family planning issues. USAID support has consisted of local costs (for materials and program production and dissemination, rent, training, and salary supplements for key staff) and expatriate TA and vehicles to support local village-level activities in the governorates.

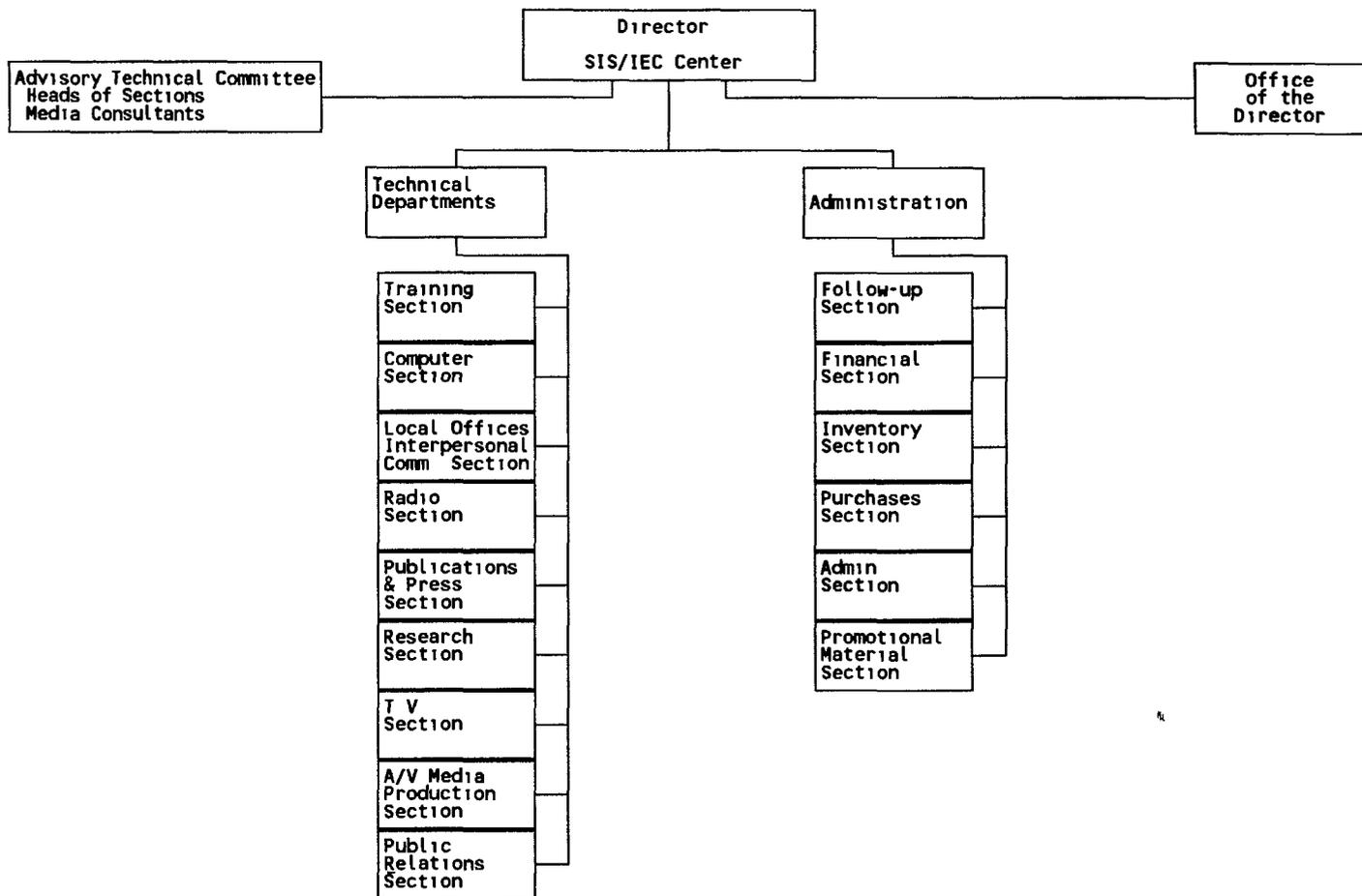
The 1986 AID Population Assessment Report pointed to other problems with the SIS program including internal organizational difficulties and lack of interagency coordination as well as an overemphasis on "population" vs. "family planning and health" related messages. However, the Assessment also acknowledged important changes that occurred in 1986 which showed promise for overcoming SIS's difficulties, including the appointment of a capable new Project Director and the development of a detailed "workplan" for future project activities. The organization chart is attached as Figure E-3.

The SIS was acknowledged to have an important role to play in informing and motivating the public and opinion leaders of the benefits of family planning and the dangers of over-population. The Information, Education and Communication Center of SIS has demonstrated sound technical capacity during POP/FP II and a similar level is anticipated during POP/FP III. The administrative capacity has improved steadily with heavy technical assistance inputs from AED and JHU/PCS. However, additional inputs are required to institutionalize this capacity. Thus, although primary responsibilities of the planned resident advisor are technical, the position will incorporate monitoring of financial, reporting and assessment procedures required by USAID.

d. The Ministry of Social Affairs

The MOSA has been less satisfactory administratively than other implementing agencies, due in part to the administrative relationship between MOSA and the PVOs and NGOs it funds. In all countries, PVOs traditionally have weak administration as they are often staffed by volunteers whose interest is in service delivery and not administration. Under POP/FP III, USAID support through MOSA will be directed to one organization, the Egyptian Family Planning Association (EFPA), to assist it in implementing the Clinical Services Improvement (CSI) project. The EFPA is the largest "semi-private" family planning organization under the

**Figure E-3
ORGANIZATION CHART: SIS/IEC CENTER**



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jurisdiction of the Ministry of Social Affairs. With over 450 FP clinics located throughout Egypt EFPA has the potential to make a significant impact on contraceptive prevalence. However, for a variety of reasons performance of EFPA clinics are far below standard.

The CSI subproject has focused strongly on internal management during POP/FP II and is regarded as highly capable of financial and service reporting. No administrative difficulties are anticipated in this subproject provided that the system established under POP/FP II are retained and refined in POP/FP III.

e. Special Institutional and Administrative Concerns in POP/FP III

The activities under POP/FP II have provided focus and administrative strength to Egyptian institutions, so as to enhance their capacity to handle the management burden for family planning services. The POP/FP III Project builds directly on POP/FP II; therefore, implementing agencies will be using similar approaches and skills. However, there is a need for some relocation of USAID development initiatives during the project implementation to achieve maximum, sustainable management capacity. For example, the USAID-funded Institutional Development Project (IDP) under POP/FP II is separate from the general structure and functions of the NPC. Integration is required under POP/FP III. Upgrading and improving is a technical and administrative process, and should not be tied so tightly to producing output that the institutional strengthening becomes blurred. USAID must safeguard against project assistance intended to improve or upgrade an existing organization taking on a life of its own, independent of the organization it was designed to strengthen.



UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

CAIRO, EGYPT

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ANNEX F
INITIAL ENVIRONMENTAL EXAMINATION

ACTION MEMORANDUM FOR THE BUREAU ENVIRONMENTAL OFFICER

August 1, 1991

Ken LuePhang, Mission Environmental Officer (MEO), USAID/Cairo

Population/family planning III, Project No. 262-0227
Concurrence in Initial Environmental Examination (IEE)

ISSUE:

Your concurrence is requested for a "Categorical Exclusion" IEE for the above subject project.

BACKGROUND:

The Population/Family Planning III project (POP/FP III) will assist the Government of Egypt (GOE) in its efforts to reduce the Egyptian fertility rate. POP/FP III will increase the level and effectiveness of contraceptive use among married couples by expanding the availability, quality, sustainability and use of family planning services in Egypt, building upon progress made in the Population/Family II project. POP/FP I and POP/FP II were granted Categorical Exclusions previously.

Project implementation will begin in FY 1992 and will continue for five years. It will be funded at approximately US \$80 million, with USAID'S contribution totaling US \$70 million.

DISCUSSION:

The project will include improved quality of family planning services, improved information for decision-makers on regulatory and policy constraints, and improved planning, management and evaluation systems in the implementing agencies.

The project will have no significant environmental effects. The contraceptive commodities, technical assistance, training activities, IEC research and service provision will not have a direct effect on the physical environment. The assistance to be provided to the host country will be used primarily for contraceptive supply, operational costs of service delivery, and management services. Grant funds will be used for contraceptive commodities, technical assistance, short-term participant training, non-contraceptive commodities, in-country training, IEC, research and service provision activities. The project is for population and family planning services. No construction is included in this project.

AUTHORITY:

Under USAID Environmental Procedures, 22 CFR part 216.3(a)(2)(i), you may signify your concurrence with the determination by the officer in the originating office.

RECOMMENDATION:

That you concur with the IEE "Categorical Exclusion" by signing below and on the attached face sheet, which will be used as an Annex to the Project Paper. Please return the original copies of the signed documents for our files.

CONCUR: 
For Ronald Greenberg, NE/DR/AE/ENR

NOTCONCUR: _____

date: August 20, 1991

INITIAL ENVIRONMENTAL EXAMINATION

Project Location : Egypt
Project Title and Number : Population/Family Planning III
No 263-0227
Funding : A.I.D. : FY 1992 US \$10.0 million
LOP US \$70.0 million
GOE : FY 1992 US \$ 2.0 million
LOP US \$ 10.0 million

Life of Project : 5 years, FY 1992-1997
IEE Prepared : Signature Marilyn A. Schmidt
Marilyn Schmidt, HRDC/P
USAID Project Officer
Date August 1, 1991

Environmental Action Recommended : Categorical Exclusion
Mission Environmental Officer's concurrence : Signature Kenneth P. LuePhang
Kenneth P. LuePhang
Date Aug 1 1991

Associate Mission Director's Concurrence : Joe Signature Paul Thorn
Paul Thorn, AD/DR
Date August 1, 1991

Decision of Environmental Officer, Bureau for Europe and the Near East : Concur Ronald Greenberg
for Ronald Greenberg, ENE/DR/AE/ENR
Not Concur _____
Date August 20, 1991



UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

PROJECT AUTHORIZATION

CAIRO EGYPT

Name of Country: Arab Republic of Egypt
Name of Project Population/Family Planning III
Number of Project: 263-0227

1 Pursuant to Section 531 of the Foreign Assistance Act of 1961, as amended (the "Act"), I hereby authorize the Population/Family Planning III Project (the "Project") for the Arab Republic of Egypt ("Cooperating Country") involving planned obligations not to exceed sixty-two million United States Dollars (\$62,000,000) in grant funds from the date of authorization until July 31, 1997, subject to the availability of funds in accordance with the A I D. operating year budget/allotment process, to help in financing the foreign-exchange and local-currency costs of goods and services required for the Project. The estimated life of the Project is five years and three months from the date of initial obligation

2. The Project will assist the Government of Egypt ("GOE") to achieve its fertility reduction goals by increasing the level and effectiveness of family planning use among married couples. The Project will do this by furnishing technical assistance, training, commodities, and related local costs

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

a. Source and Origin of Goods and Services

Goods and services financed by A I D under the Project, except for ocean shipping, shall have their source and origin in the United States, or in Egypt as authorized pursuant to the requirements of State 410442 and A I.D Regulations stated in the A.I.D. Handbooks, except as the USAID/Egypt Mission Director, or his/her designee, may otherwise agree in writing. Ocean shipping financed by A I.D under the Project shall, except as A.I.D. may otherwise agree in writing, be financed on flag vessels of the United States

4. Based upon the justification set forth in the Project Paper, I hereby determine, in accordance with Section 612(b) of the Act, that the expenditure of United States Dollars for the procurement

of goods and services in Egypt is required to fulfill the purposes of this Project, the purposes of this Project cannot be met effectively through the expenditure of U S -owned local currencies for such procurement, and the administrative official approving local cost vouchers may use this determination as the basis for the certification required by Section 612(b) of the Act.


Henry H. Bassford
Director

6/19/92
Date

Clearances

- OD/HRDC/POP C Carpenter-Yaman CCY
- AD/HRDC.D Miller JM
- PDS/PS B Cypser BC
- Environmental Officer G Rutanen-Whaley GRW
- PDS/P R.Handler RH
- AD/PDS:C Crowley PC
- LEG.V Moore VM
- for AD/LEG.T Carter TC
- FM/FA M Mounir MM
- AD/FM D Franklin DF
- AD/EAS S.Skogstad SS
- D/DIR G Wachtenheim GW