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POPULATION POLICY IN EGYPT

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EXECUTIVE SUMMARY

The mission had two purposes. The first was to help prepare for a conference in Alexandria on the general subject of integrating population concerns into the activities of the sectoral ministries of the Government of Egypt. The second was to discuss the proposal for a Population Policy Program with the relevant authorities in the Government of Egypt and in USAID, Cairo, and to undertake the first steps towards preparing the documentation for this program.

There was too little time for a thorough preparation of papers for the conference. Despite the rush, the conference was very effective in assembling key government staff and involving them in a very detailed discussion of the relationship of population growth to the activities of their ministries.

A number of important steps were undertaken to advance the work on the Population Policy Program. Attached documents present a draft of the agreement between the PFPB and USAID Cairo, and work on the next stage should follow directly.

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ABBREVIATIONS

AUC - American University, Cairo

CAPMAS - Central Agency for Public Mobilization and Statistics

CDC - Cairo Demographic Center

PEPB - Population and Family Planning Board

RTI - Research Triangle Institute

UNFPA - United Nations Fund for Population Activity

USAID - United States Agency for International Development

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INTRODUCTION

This assignment was one of a continuing set of activities sponsored by international agencies to help the Government of Egypt with the establishment of an effective population policy and program. There were two purposes to the consultant's visit. The first was to help with a conference arranged by the PFPB, with technical assistance from the International Population and Development Program of Research Triangle Institute. The conference is an outgrowth of the long-run concern of the Planning Division of the PFPB with the coordination of the population-related activities of the various sectoral ministries. The consultant's role was to help the Egyptian coordinator of the conference with the preparation of papers for two of the sessions and to assist with the general design of the conference where appropriate.

The second purpose of the assignment was to follow up on a series of visits to Egypt made by the consultant on the behalf of UNFPA and USAID to help develop a Population Policy Program. The POP is a coordinated effort to improve the data base and the planning capability of the various ministries working in the area of population in the hope that, by strengthening this part of the population effort, the more direct interventions to reduce fertility or to influence the distribution of population might be more successful.

II. OBSERVATIONS AND FINDINGS

OBSERVATIONS AND FINDINGS

The visit to Egypt had two main purposes. The first was to assist Dr. Hussein Abdel Aziz Sayed in the preparation of the Conference on Population and Planning scheduled for May 25 and 26 in Alexandria. The second was to discuss with Dr. Sayed of the Population and Family Planning Board and with Tim Seims of USAID, Cairo the next steps in implementing the Population Policy Program, which has been under discussion for some time. Activities directed towards achieving these two objectives are detailed below.

The Alexandria Conference

The meeting in Alexandria was designed to assemble leaders from a number of different ministries in Egypt for the purpose of discussing methods of integrating population concerns into the planning process and of coordinating the activities of the many ministries working in the population area. The agenda of the meeting was intended to underscore the importance of population growth in Egypt, to familiarize participants with some of the previous work done in the area of population and family planning and with appropriate planning methodologies, and to give the participants a chance to suggest how the question of population should be handled in the future.

There were six formal meetings:

- May 25: 1. Introduction by Dr. Bindary
2. Discussion of previous research in population and family planning - Drs. Sayed and Khorazaty
3. Discussion of population and family planning activities in the Ministries of Health, Manpower, Education and Agriculture
- May 26: 4. Formal paper on the integration of planning and population with special reference to the sectoral ministries - Dr. Sayed
5. Discussions of computer models for education and health
6. Closing session: discussion and recommendations

All of the sessions required extensive preparation, and most of the consultant's time during the first week in Cairo was devoted to this task. In particular, the papers for sessions 5 and 6 needed revision and the consultant worked intensively with Dr. Sayed on the required changes. Just 4 days before the conference, Dr. Hakim, the President of the Shura Council (roughly the equivalent of the Senate in the United States), was cancelled as the keynote speaker. He had been asked by President Mobarak to participate in the Nile Valley Parliamentary Meeting. This unanticipated event required us to rewrite the speech that had been prepared with an elaborate support of slides and that had, with Dr. Hakim's agreement, a very strong endorsement of the need to

take a more active stance to reduce the rate of growth of Egypt's population. Several more weeks of preparation time would have helped, but the final funding decisions for the conference had come too late to allow for more time.

The consultant's role in the conference was to prepare an English language draft of a paper describing a computer-based model of the population and health system and to assist Dr. Sayed in the adaptation of the background paper prepared for session 4. (The consultant's U.S.-based participation in the preparation of the health sector paper was funded through a consultancy with RTI.) The health sector paper is attached (Appendix A), but no English version of the session 4 paper was available.

The conference went very well. Participants were very involved in discussion, listened attentively to formal presentations, and made insightful comments on the needs for coordination among ministries and future work in their own ministries. There were also intensive exchanges between ministerial groups concerning questions of importance. For example, the representatives of the Ministry of Health asked their counterparts in the Ministry of Planning to explain why their capital budget had been reduced when it was intended to deal with a critical issue such as population and when most of it came from foreign sources. Other ministries also raised questions concerning the coordination of activities in population and family planning. It is the consultant's impression that such exchanges seldom take place in the normal course of events in Cairo.

The papers and the models presented were all well received. The computer-based education model prepared by Jim Knowles was especially appreciated by the participants, and the paper given in session 4 sparked a great deal of interest during the discussion on the agenda for future work.

The Population Policy Program

The week before leaving for Cairo, discussions were held with Sarah Clark, Lenni Kangas, Tim Seims, and Judith Seltzer in Washington concerning the PPP. The consensus in that meeting seemed to be that the program was a good idea and that the consultant should devote as much time in Cairo as possible to bringing the proposal to the next stage.

On the basis of the Washington briefing and initial discussions in Cairo, the major tasks to be undertaken were as follows:

1. In consultation with the PFPB and USAID, Cairo office prepare a draft project implementation letter and a budget for the first year of activity.

2. Arrive at some general understanding concerning the intermediary organization, its role, and budget.

3. Discuss the proposed activity with the UNFPA representative in Cairo and establish tentative plans for UNFPA participation in the project.

4. Work with the PFPB and others to establish a plan of action for the first year.

1. The PIL for the PFPB has been drafted and left with USAID in Cairo. The letter was written after detailed discussions with staff members of the PFPB, but most contacts in the last stages were with Dr. Sayed. Other staff members in the Board still need to comment and approve. The details of the budget similarly need further negotiation (Appendix B).

2. A draft letter of understanding concerning the role of the technical assistance contractor (intermediary organization) has been drafted and is attached (Appendix C). It was not possible to proceed any further with the development of a budget or a specific set of activities, since the mechanism for funding had not been established as of the time of departure. If it had become necessary to use a competitive bidding mechanism to select the contractor, this consultant would have been precluded from bidding because of these budget discussions. However, the contract can be handled as an amendment to the Rapid II agreement, with which the consultant is affiliated. He is currently working on a budget proposal.

3. The UNFPA initiated the proposal for the PPP when they sent the consultant to Egypt for the purpose of recommending mechanisms for strengthening the coordinating function in the Egyptian population program. At a meeting in September 1982, they decided that they were not in a position to fund the activity at that point, although they maintained a continuing interest in the subject. During the interim period between September 1982 and the visit to Cairo in May 1983, the UNFPA sent a tripartite review team to Cairo to review UNFPA funded programs. They recommended that a means be found to strengthen programs or activities in the area of population analysis and coordination.

Thus when the consultant visited Hamid Fahmy, the UNFPA Deputy Representative in Cairo, he was quite interested in ways of cooperating with the project. The difficulty with UNFPA involvement is that their project review procedures are quite involved and there is a strong likelihood of delay if the project is to wait for a full UNFPA review. After discussions with UNFPA, the PFPB, and USAID, the tentative decision was made to go ahead with the USAID funded component of the project and to build in the UNFPA on specific activities during the next 6 to 8 months. The most likely activity for the UNFPA would be to fund a population analysis activity in one of the central ministries; planning or manpower seem attractive possibilities. The details of such involvement remain to be worked out.

The consultant stopped in New York on his return to discuss the possibility for UNFPA participation with Mr. Abu Nuwar, the UNFPA desk officer in charge of Egypt. One possible administrative step to involve the UNFPA may be to have the consultant complete the frame document based on his earlier reports concerning policy analysis in Egypt. On the basis of that framework he could visit Cairo during the fall to draft a specific proposal for the UNFPA activity.

4. The plan of action for the first year remains to be established. The consultant has held discussions with Dr. Sayed, but the details will have to be worked out in another visit. In the meantime, some tentative notes will be prepared and attached to the final draft of the APHA report.

Next Steps

Two steps seem clear. First, the consultant will complete the preparation of a draft plan of action for the coming year, a budget and draft proposal for the T/A contractor, and the overall activity framework as required by UNFPA. These materials will be sent to the relevant parties as soon as possible for review and discussion. Second, the consultant will stop in Cairo on his way to Bangladesh in July and attempt to have a round of discussions with the relevant parties. After that visit, it should be possible for USAID to go ahead with funding its component of the project.

A Central Issue

The most important issue that needs to be resolved if the project is to be successful is to find a mechanism to increase the incomes of the senior staff involved in the project. Without salaries higher than the government permits, it will be difficult to recruit and retain the quality of staff who will make the difference in the success of the project. The tentative proposal is to give key technical staff consultant contracts through the U.S. technical assistance contractor. If this mechanism does not work, other devices may need to be examined.

Other Comments

In addition to the two activities listed above, the consultant also had discussions with CAPMAS concerning their need for training in the area of statistical analysis. The consultant has been discussing the possibilities with colleagues at the University of Michigan and hopes to be able to make a proposal to CAPMAS by the time of the July visit. He arranged for a visit by Jim Knowles to the Cairo Demographic Center to discuss possible USAID assistance to a CDC training program and also

consulted with staff of the American University in Cairo concerning the need for a systems approach to the study of family planning service delivery.

III. RECOMMENDATIONS

RECOMMENDATIONS

There have been recent recommendations to greatly increase the amount of international resources spent on population and family planning activities in Egypt. The Egyptian Government has also undertaken various steps to increase the level and effectiveness of population-related activities. For such activities to have their desired effect, it will be necessary for the Government of Egypt to monitor developments in various aspects of population and related programs and to coordinate the activities of different ministries. Activities such as the Alexandria conference are one mechanism for assuring coordination. The Population Policy Program would also do much to institutionalize the capacity to monitor and coordinate. Thus, the clearest recommendation that comes out of the present mission is that there is a need to continue and strengthen such activities.

Appendix A

Demographic Factors and the Health Sector: Initial Steps Towards a Planning Model

In the previous session we discussed some of the possible relationships between demographic characteristics and demographic change and the health sector. In this presentation we want to go a step further and illustrate the nature of some of the relationships within the framework of a model of the health sector. To illustrate the working of the model we make use of some empirical data collected from the rural areas of Lower Egypt. The model in its present form is still quite elementary, and the data used in this model may be out of date and inappropriate in some instances. Nonetheless, the model illustrates both the strong impact of demographic factors on the health sector and the potential utility of health planning models of this variety.

The model can be thought to have two essential components. First, there is the core model of the health sector. The health sector model determines the number of persons who experience different illnesses during a given time period, the number of days of disability associated with each episode of illness, the number of persons who seek medical treatment, and the number of deaths associated with each illness. The relationships in the health model are illustrated in figure 1. The inputs to the model are the age and sex structure of the population and the assumptions made about the various parameters in the system. In the figure the assumed parameters are indicated by the enclosing circles. The numbers calculated by the model are enclosed in rectangles.

In the simple model of the health sector, the demographic features of the system are determined outside of the model and are in fact assumed to be constant. The primary use of the model in this form is to permit an exploration of the consequences of changing some of the other parameters in the system. Thus the analyst may want to examine the implications of the introduction of rehydration salts on the mortality associated with diarrhea. Presumably the introduction of a new kind of intervention will affect the case fatality rate for individuals who have experienced diarrhea. Thus an examination of the literature would be made or appropriate clinicians would be consulted to decide on an alternative set of rates. Those new rates would then be inserted into the model, and a new set of outcomes would be calculated for comparison with the first.

The second step in the model as used for the presentation today is the introduction of demographic change. In this

version this has been accomplished by projecting the population forward from the base year of 1980 to the years 1990 and 2000. The health model has then been run with all of the other assumptions intact. The full model is shown in figure 2.

To illustrate the possible effects of changes in fertility on the health status of the population and on the utilization and costs of health services, we applied alternative fertility assumptions from 1980 to 2000 to a health sector model which estimates age specific death and days of disability.

The health sector relationships in the model were developed by two physicians, Dr. Fatma El-Hady and Dr. Osama Saleh of the Ministry of Health in a research seminar at the University of Michigan. The data were developed for a rural region of a governorate of Lower Egypt. The numbers we use in the illustrations have been expanded to reflect the total rural population of Lower Egypt. It should be understood that considerable variation in disease patterns exists among regions, but lacking specific data we made the simplifying assumption for illustrative purposes that the region studied is representative of rural Lower Egypt.

As noted in the attached flow chart, the initial input is a description of the population by age and sex at the first time period--1980. The age and sex-specific disease incidence rates for the first year are then applied to estimate the numbers ill by disease and age. Of these a proportion seek and receive care at health centers or health units. The remainder, frequently a substantial proportion, do not receive medical treatment. For each of these groups a case fatality rate and a disability day rate was estimated, making it possible to calculate deaths and disability days for the total population or any subset. Over time (and we show computed results for the years 1980, 1990, and 2000), the mortality and fertility effects influence the size and age composition of the population. Depending upon the assumed fertility rates, there will be considerable differences in future years in numbers of deaths, numbers of disability days, and on the utilization levels and costs of curative medical services. These variations of health status and service requirements are substantial even without taking into account other benefits of lower fertility rates, such as increased time between births, smaller families, and higher per capita incomes or other social changes.

Table 1, Disease Parameters for Measles, illustrates the nature of the health inputs used for each disease in the health effects computation. The numbers in the population of each age group are the additional critical input.

These population inputs change over time as births and deaths take place. Our calculations are designed to demonstrate

the effects of differing gross reproduction rate movements over time.

Starting with the assumption of a gross reproduction rate of 2.88 in 1980-85, we examined changes in the health of a population in succeeding years, projecting, as shown in table 2. These reproduction rates vary from an unchanging 2.88 to a very low variant in which it is projected that the reproduction rate drops to half that level 1.44, in 1995-2000. No other causes of changes in health status were assumed. Thus the age specific mortality rates were held constant.

Given the structure of the model, the health effects of the changes in fertility work mainly through the total numbers in the population and the age structure of the population. The number of children, a group with high mortality and morbidity, varies considerably depending on the assumptions that are made about the pattern of fertility. The amount of variation for the year 2000 as expressed both in percentages and in absolute numbers is shown in table 3.

Tables 4 through 8 show the effects of different fertility assumptions on specific diseases. Shown are the numbers of cases, the numbers of visits to health facilities, the number of days of disability and the number of deaths for each of the five fertility assumptions and for 1990 and 2000. Moving down any one of the column of numbers gives an indication of the important influences of fertility trends on the pattern of health in the country.

Table 9 summarizes the results for all diseases. In that table it can be seen that the number of deaths in the year 2000 is more than 50 percent higher with the high fertility than with the very low variant. Thus it is to be expected that a reduction in fertility will have a major impact on the health of the population.

In sum, these various tables show that the effects of population growth (or fertility) on health outcomes are quite dramatic. By virtually all of the measures reported there -- costs of care, disability days, or deaths -- the effects of fertility reduction are to dramatically reduce the burden on the health system. Such outcomes as shown in this model are undoubtedly understated given the rigid nature of the assumptions used.

The above presentation, while excessively simple, illustrates some important tasks for planners who wish to integrate population concerns into their work. In using this model the planner would want to undertake as careful efforts as possible to estimate the fixed parameters in the system accurately. Thus the coefficients which represent the incidence rates for various

diseases greatly influence the outcomes of the model. The user will want to be sure that the rates assumed in the base period are as accurate as possible. This by itself may involve a very considerable research effort. It is also important to make careful estimates of the way the coefficients change under different assumptions about preventive health and other changes in the environment which determine the incidence of disease. Once the various parameters in the model are adequately estimated, the planner will want to examine alternative interventions to see which changes will lead to targeted changes in the various model outcomes or to see how changes in the parameters can be made that will minimize an outcome such as mortality. Thus when the model is properly estimated, it should be possible to adjust the assumptions to explore the consequences of various changes in policy.

The beginning point in an analysis of the kind implicit in the model is the set of policy objectives which have been assigned to a given ministry. Planners in the ministry need to explore alternative mechanisms for accomplishing these objectives. To do this they must have a thorough understanding of the causal mechanisms which influence the extent to which they are able to achieve their sectoral goals. In the case of health, the determinants of health and disease and the factors which influence fertility need to be understood. In the case of other ministries, a similar understanding will be required, but obviously the exact subject matter will be somewhat different. Planners also require specific data to explore alternatives. They need data concerning the resources which are available to help them in their work, concerning the target variable (e.g., health status or the pattern of illnesses) and the way that this changes over time, and concerning other factors which are likely to influence their work.

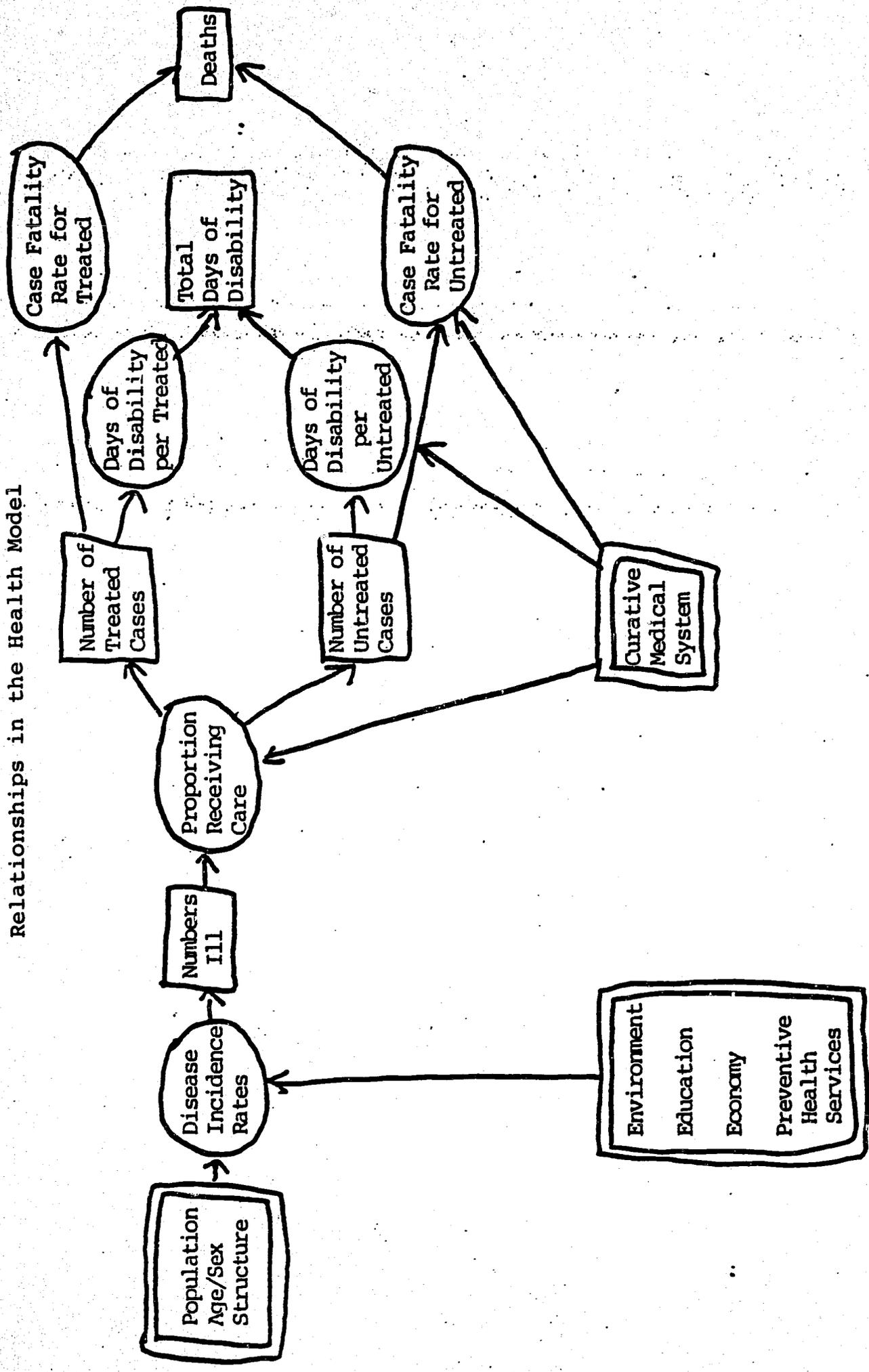
It may be noted that the model illustrates the simple feedback mechanism that connects population with nearly all development programs. Assumptions about the size and structure of the population are the beginning point of the model. But as these demographic characteristics work their way through the system they in turn create a new set of demographic variables which influence the next time period.

The primary concerns of the health sector are to use the resources at their disposal to decrease mortality and morbidity to the lowest level possible and to use resources to bring the level of fertility into line with national objectives. The model as described above illustrates some of the concerns that we have as sectoral planners. First we want to be sure that the underlying model of the world with which we are working is as accurate as possible. That implies that careful efforts should be made to model the relationships described in the model

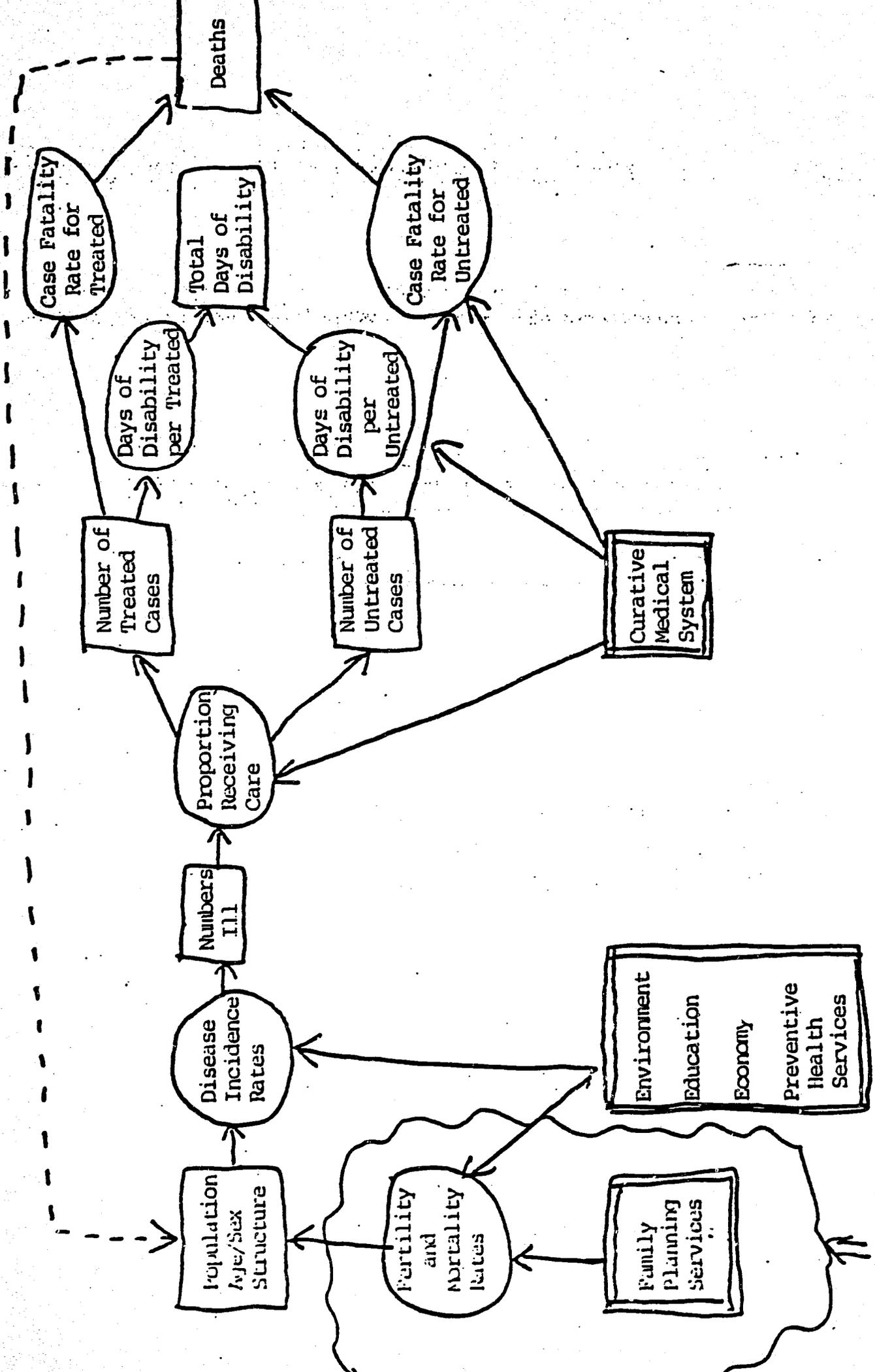
and that the parameters should be estimated as accurately as possible. Second, the model should be adjusted so that the decisions that the decision-maker has to work with are accurately built into the model. That is, if the basic choice for the health planner is between allocating resources to curative programs and to preventive programs, then these alternatives should be mirrored in the basic model.

Figure 1

Relationships in the Health Model



Health Model 2



Demographic component of Health Model

TABLE 1
DISEASE PARAMETERS
FOR MEASLES

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AGE GROUP	INCIDENCE RATE	% SEEKING CARE	VISITS PER CASE	DAYS LOST TREATED	DAYS LOST UNTREATED	FATALITY RATE TREATED	FATALITY RATE UNTREATED
فئات السن أقل من سنة 0-1 YEAR	0.1500	0.20	2.00	5	15	1.00	8.00
1-4 YEAR	0.1500	0.10	2.00	5	15	1.00	6.00
5-14 YEARS	0.0	0.0	0.00	0	0	0.0	0.0
15-49 YEARS MALES	0.0	0.0	0.00	0	0	0.0	0.0
15-49 YEARS FEMALES	0.0	0.0	0.00	0	0	0.0	0.0
50 + YEARS	0.0	0.0	0.00	0	0	0.0	0.0

مدى الامتداد
الاجمالي

TABLE 2
GROSS REPRODUCTION RATES
ASSUMED IN PROJECTION VARIANTS

Projection Name التنبؤ الكائن	GRR Assumption for Period: مدى الامتداد الاجمالي			
	1980-1985	1985-1990	1990-1995	1995-2000
مستوى ثابتة Constant Fertility	2.88	2.88	2.88	2.88
مستوى مرتفعة High Variant	2.88	2.83	2.70	2.58
مستوى متوسطة Medium Variant	2.88	2.66	2.48	2.34
مستوى منخفضة Low Variant	2.88	2.49	2.28	2.12
مستوى اقل انخفاضها Very Low Variant	2.88	2.40	1.92	1.44

Table 3
 The Population Aged 0-4
 السكان من ٠ إلى ٤ سنوات

التنبؤ	Projection	Number in Millions	Percentage of Total
سنة الإحصاء ١٩٨٠	Base 1980	1.8	14.5
عام ٢٠٠٠: خصوبة عالية	Year 2000, Constant Fertility	3.9	17.4
عام ٢٠٠٠: خصوبة مرتفعة	Year 2000, High Fertility	3.5	16.0
عام ٢٠٠٠: خصوبة متوسطة	Year 2000, Medium Fertility	3.2	15.0
عام ٢٠٠٠: خصوبة منخفضة	Year 2000, Low Fertility	2.9	14.1
عام ٢٠٠٠: خصوبة أقل انخفاض	Year 2000, Very Low Fertility	2.0	10.9

TABLE 4
MEASLES SUMMARY STATISTICS
BY YEAR AND PROJECTION VARIANT

الحصبة

PROJECTION NAME	YEAR 1990					YEAR 2000						
	CASES	VISITS	DAYS LOST	DEATHS	CASES	VISITS	DAYS LOST	DEATHS	CASES	VISITS	DAYS LOST	DEATHS
التنبؤ الكامن Constant Fertility	467520.	112180.	6451900.	26740.	590130.	141620.	8143850.	33760.	590130.	141620.	8143850.	33760.
عالية الخصوبة High Variant	459410.	110240.	6339950.	26280.	528660.	126860.	7295600.	30240.	528660.	126860.	7295600.	30240.
متوسطة الخصوبة Medium Variant	431810.	103620.	5959050.	24700.	479480.	115040.	6617000.	27430.	479480.	115040.	6617000.	27430.
منخفضة الخصوبة Low Variant	404210.	96980.	5578250.	23120.	434410.	104240.	5994950.	24850.	434410.	104240.	5994950.	24850.
أدنى الخصوبة Very Low Variant	389600.	93480.	5370600.	22290.	295060.	70800.	4071900.	16880.	295060.	70800.	4071900.	16880.

NOTE: Baseline 1980 Summary Statistics
TOTAL CASES 276310. TOTAL VISITS 66300.
TOTAL DAYS LOST 3813150. TOTAL DEATH 15810.

TABLE 5
MILD DIARRHEA SUMMARY STATISTICS
BY YEAR AND PROJECTION VARIANT

PROJECTION NAME	YEAR 1990			YEAR 2000		
	CASES	VISITS	DAYS LOST	CASES	VISITS	DAYS LOST
التنبؤات الحاسنة Constant Fertility	12085340.	2243720.	24012800.	15262070.	2833140.	30324290.
عسيرة مرتفعة High Variant	11879760.	2205850.	23610300.	13701010.	2545510.	27259350.
عسيرة متوسطة Medium Variant	11180560.	2077050.	22241340.	12448550.	2314710.	24793160.
عسيرة منخفضة Low Variant	10481360.	1948250.	20872380.	11300750.	2103160.	22532240.
عسيرة منخفضة جداً Very Low Variant	10061750.	1865220.	19925030.	7705910.	1434230.	15331790.

NOTE: Baseline 1980 Summary Statistics
TOTAL CASES 7188170. TOTAL VISITS 1338160.
TOTAL DAYS LOST 14345090.

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TABLE 6
TETANUS SUMMARY STATISTICS
BY YEAR AND PROJECTION VARIANT

PROJECTION NAME	YEAR 1990				YEAR 2000			
	CASES	VISITS	DAYS LOST	DEATHS	CASES	VISITS	DAYS LOST	DEATHS
Constant Fertility	65850.	16560.	531110.	23240.	84360.	21230.	681920.	29780.
High Variant	65020.	16370.	524830.	22950.	77810.	19780.	631690.	27510.
Medium Variant	62180.	15750.	503200.	21970.	72330.	18600.	599270.	25610.
Low Variant	59350.	15100.	481730.	21000.	67310.	17530.	550350.	23870.
Very Low Variant	56860.	14370.	460830.	20030.	51360.	13810.	425910.	18230.

NOTE: Baseline 1980 Summary Statistics
TOTAL CASES 42240. TOTAL VISITS 10920.
TOTAL DAYS LOST 344890. TOTAL DEATH 14990.

TABLE 7
 SEVERE DIARRHEA SUMMARY STATISTICS
 BY YEAR AND PROJECTION VARIANT

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PROJECTION NAME	YEAR 1990				YEAR 2000			
	CASES	VISITS	DAYS LOST	DEATHS	CASES	VISITS	DAYS LOST	DEATHS
Constant Fertility	1151580.	374570.	5084100.	64960.	1464400.	473520.	6525690.	82420.
High Variant	1138060.	369710.	5019200.	64100.	1351760.	434590.	5978890.	75450.
Medium Variant	1092060.	353150.	4798400.	61150.	1252890.	401710.	5494170.	69530.
Low Variant	1046060.	336590.	4577600.	58210.	1161760.	371470.	5047140.	64080.
Very Low Variant	922730.	298120.	4262770.	52590.	795230.	249560.	3595870.	43730.

NOTE: Baseline 1980 Summary Statistics
 TOTAL CASES 745510. TOTAL VISITS 238770.
 TOTAL DAYS LOST 3205340. TOTAL DEATH 41030.

TABLE 8
L.R.T.I. SUMMARY STATISTICS
BY YEAR AND PROJECTION VARIANT

إحصاءات التكاثر

PROJECTION NAME	YEAR 1990					YEAR 2000				
	CASES	VISITS	DAYS LOST	DEATHS	CASES	VISITS	DAYS LOST	DEATHS		
Constant Fertility	591730.	129150.	8114310.	47810.	755320.	165500.	10363460.	60840.		
High Variant	583080.	127430.	7996660.	47080.	687700.	151980.	9442000.	55190.		
Medium Variant	553640.	121530.	7596300.	44590.	631870.	140800.	8679720.	50570.		
Low Variant	524200.	115630.	7195940.	42100.	580590.	130560.	7979380.	46320.		
Very Low Variant	506630.	112110.	6957030.	40660.	425670.	99570.	5868850.	33390.		

NOTE: Baseline 1980 Summary Statistics
TOTAL CASES 365850. TOTAL VISITS 81720.
TOTAL DAYS LOST 5026130. TOTAL DEATH 29260.

TABLE 9
ALL DISEASES SUMMARY STATISTICS
BY YEAR AND PROJECTION VARIANT

المجموع

PROJECTION NAME	YEAR 1990					YEAR 2000						
	CASES	VISITS	DAYS LOST	DEATHS	CASES	VISITS	DAYS LOST	DEATHS	CASES	VISITS	DAYS LOST	DEATHS
Constant Fertility	30906150.	8123670.	205508160.	272800.	40377030.	10694020.	272915680.	350860.				
High Variant	30630360.	8069170.	204502880.	270040.	37863750.	10134450.	261169280.	328120.				
Medium Variant	29692110.	7883770.	201080320.	260500.	35489220.	9560900.	248231840.	308440.				
Low Variant	28753860.	7698230.	197658240.	251170.	33292070.	9028150.	236169600.	290110.				
Very Low Variant	27522750.	7272730.	189129760.	234240.	26876330.	7426620.	203048960.	225500.				

NOTE: Baseline 1980 Summary Statistics
TOTAL CASES 20742370. TOTAL VISITS 5615330.
TOTAL DAYS LOST 145835760. TOTAL DEATH 182330.

Appendix B

Dr. Aziz Bindary
Chairman
Population and Family Planning Board
Dar El Salam, Maadi
Cairo, Egypt

Subject: AID Project Grant Agreement
No. _____ for Population
Policy Program

Dear Dr. Bindary,

Pursuant to the Foreign Assistance Act of 1961 as amended, (and the Subject Grant Agreement, as amended) the Agency for International Development (A.I.D.) hereby makes available to the Population and Family Planning Board (PFPB) an amount not to exceed the Egyptian Pound equivalent of \$ _____ to finance the Population Policy Program (PPP) for 12 months as more fully described in the PFPB Budget Proposal for this period submitted to AID under cover of the letter signed by Dr. Hussein Abdel Aziz Sayed (?), Deputy Project Director on May ____, 1983.

This Grant is effective as of the date of this letter and shall be available for expenditures by the PFPB under the subject agreement during the period from _____ to September 30, 1984.

This Grant is made available to the PFPB on the condition that the PFPB administer the Grant in accordance with the budget in Attachment A; with the general proposal in Attachment B; with "Payment Provisions", Attachment C; with the Memorandum of Understanding concerning the T/A contractor, Attachment D; and with the Subject Grant Agreement, as amended.

The requested AID funds may be used to support a Population Policy Program oriented towards the identification and implementation of actionable research and analysis projects designed to help well identified decision makers or groups develop information concerning the impacts of population growth and distribution on Egyptian life and institutions so that they can make better decisions about the programs and policies that can be implemented to change demographic variables. This project will have as one of its long run objectives the establishment of an institutional capacity to undertake population planning activities on a continuing basis. Training programs of both short and long duration should be a part of this process.

Funding for the PPP is divided in two parts. First, funds are provided for a small secretariat activity to be run through the Board. The staff and funding to be associated with this part of the activity are specified in the attached budget documents. Second, the bulk of the PPP funding will be devoted to policy oriented sub-projects which are described in more detail below. These sub-projects are the heart of the PPP and it is their planning and implementation that will be PFPB's priority activity. The process of developing and implementing a sub-project would have the following elements:

1. Project Definition:
 - a) select relevant population related policy issues including input from decision makers.
 - b) identify key decision makers that the sub-project is intended to assist. Where appropriate this should be done by name.

2. Project Implementation:
 - a) identify the key decision variables and the appropriate analysis framework.
 - b) identify the data needs associated with the decision variables.
 - c) confirm data and analysis needs by feedback from decision makers.
 - d) collect and analyze data.
3. Diffusion of Results: develop and implement a program possibly including publications, workshops, and formal and informal meetings to bring the results of the analytic activity to the attention of the decision makers.

The PPP would be implemented under the following guidelines:

First, the PFPB must demonstrate to USAID that adequate and appropriate staff have been assigned to the Project in order to ensure funding subsequent to the initial advance. USAID must be informed in writing of any changes in previously identified key personnel.

Second, the PFPB will sign and administer all subcontract or subgrant activities. USAID's approval will be necessary for all such subgrants or subcontracts of more than \$20,000 in value.

Third, requests for advances of funds against the grant will take place quarterly or more often if necessary. USAID's technical and controllers's office approval will be necessary for these advances. USAID will grant funds to PFPB for research and communication activities which are the raison d'etre for the project.

Fourth, as a part of the quarterly request for an advance of funds the PFPB should report its quarterly accomplishments and short-term plans for the next quarter. In this report it should discuss sub-project proposals under development.

Fifth, the project will be defined for one year, but it is recognized that the activity is likely to continue on a longer term basis, and a continuation grant will be considered annually on the basis of a proposal for extension with a new work plan.

The work of the PPP is the responsibility of the PFPB and its sub-contractors. However, a technical assistance (T/A) contractor will be appointed by USAID through its Washington office, with approval of the PFPB, in order to assist the PFPB and its subcontractors carry out the specified work plan. USAID, Cairo will regularly confer with the T/A contractor before making decisions regarding the approval for USAID funding of activities and sub-contracts of the PPP. To achieve the objectives of this project USAID expects a relationship of close consultation between the PFPB and the T/A contractor. Consultants engaged on the project by the T/A contractor will be approved by the PFPB. Approval is not required for technical assistance such as typing, programming or research assistance.

It is recognized that the UNFPA has expressed an interest in funding part of the PPP activity. Both the PFPB and USAID agree in principle to UNFPA participation in this project. The specific nature of that involvement can be considered in due course. Appropriate changes, if necessary, will be made at that time.

If you agree with the terms of this project implementation letter, please sign the original and four copies of it to acknowledge your acceptance. Please return the original and two copies to this office.

Sincerely yours,

Howard Lusk
Associate Director

Elements of a Three Year Budget

Egyptian Budget

	Year 1	Year 2	Year 3
I Expenditures through Population and Family Planning Board			
A. Committee and Secretariat			
1. Staff - Director	6,000	6,500	7,000
2. Junior Professionals	4,000	4,200	4,500
2 Clerical Positions	4,000	4,000	4,000
1 Accountant	5,000	5,000	5,000
1 Driver	1,000	1,000	1,000
2. Space, Supplies, Computer, etc.	10,000	10,000	10,000
3. Honoraria to Committee Members	6,000	6,000	6,000
4. Miscellaneous	<u>5,000</u>	<u>5,000</u>	<u>5,000</u>
Sub-total	41,000	41,700	42,500
B. Project Expenses	150,000	250,000	250,000
Number of Projects	(4)	(5)	(6)
C. International Travel			
4 trips @ \$5,000	20,000	20,000	20,000
D. Training - Short Term in Sgypt (15)	7,500	7,500	7,500
Short Term in USA (4)	60,000	60,000	60,000
Ph.D. Level (2 per year)	<u>30,000</u>	<u>30,000</u>	<u>30,000</u>
Sub-total	97,000	139,500	139,500
E. Dissemination			
Seminars, Printing, etc.	<u>30,000</u>	<u>50,000</u>	<u>60,000</u>
Sub-total I	<u>338,500</u>	<u>501,200</u>	<u>512,000</u>
II Expenditures through T/A Contractor			
A. Egyptian visitor to T/A contractor and overhead (?)	22,000	24,000	26,000
B. Egyptian consultants			
1) 3 for secretariat @ 12,000/year			
2) 4 for sub-project @ 35,000/year	<u>56,000</u>	<u>60,000</u>	<u>65,000</u>
Sub-total II	<u>78,000</u>	<u>84,000</u>	<u>91,000</u>
TOTAL	416,500	585,200	603,000

Appendix C

Draft Memorandum of Understanding

Subject: Role of Intermediary Organization, Technical Assistance Contractor for Population Policy Project

The PPP is a complex project designed to improve the population policy process in Egypt. The general role of the T/A contractor will be to assist the PFPB in the conduct of the project and to advise both the PFPB and the USAID in such a way as to facilitate the operation of the project with a minimum of administrative burden to the existing AID staff. The details of the PPP are spelled out in the PIL _____ and supporting documents. The purpose of this memorandum is to spell out the role of the T/A contractor in more detail. The T/A contractor has two major responsibilities:

1. The T/A contractor will assist the PFPB to establish an overall strategy and operating plan, help identify policy opportunities for the PPP, help develop sub-project proposals, assist in the conduct of the sub-projects through technical assistance and assist with the dissemination of results to the appropriate bodies.
2. The T/A contractor will confer regularly with USAID, Cairo regarding USAID approval for funding for project activities and sub-projects as provided in the PIL.

— To carry out the above two functions the T/A contractor will have part-time representatives in Egypt to deal with the PFPB and the sub-contractors. These representatives will also have a variety of skills as appropriate for the various activities funded under the PPP. The T/A contractor will also maintain a capacity to undertake research and analysis related to Egypt in its U.S. office. Provision will be made in the budget for the provision of consultation from Egyptian and American consultants who may not have regular appointments in the organization of the T/A contractor.

The activities of the T/A contractor will be governed by the understandings specified in the PIL document.

Appendix D

Itinerary

- May 10 Briefing with Mr. Lenni Kangas, Drs. Sarah Clark and Judith Selzer, and Mr. Tim Seims of USAID.
- 13 Depart Ann Arbor for Cairo.
- 16 Arrive in Cairo -- -- meet Tom Croley.
- 17 USAID, PFPB for meeting with Drs. Hussein Abdel Aziz Sayed, and Nabil Khorazaty -- discuss conference plans. Tim Seims.
- 18 Meetings at PFPB, American University of Cairo and Ministry of Health.
- 19 PFPB work on papers for conference, USAID.
- 20 Meeting with Seetharam of ILO, Ministry of Manpower, dinner with Drs. Gadalla and Beramawy, typing at USAID.
- 21 Appointment with S. Gadalla, AUC; Institute of Statistics, Univ. of Cairo.
- 22 AID, meeting with Hamid Fahmy at UNFPA, meeting with Khorazaty and Kelly on paper for Dr. Bindary.
- 23 AID for typing, PFPB, Paul Richardson at AUC.
- 24 To Alexandria -- final arrangements for conference, AID.
- 25, 26 Conference
- 27 Conference ends -- return to Cairo; discussions with Dr. H. Beramawy, Ministry of Health.
- 28 Meet with J. Knowles and Dr. El Badrey of CDC, with Allen Kelly and then dinner with Ataf Khalifa, Kelly, S. Cochran, and El Badrey.
- 29 Long meeting with HAAS, meeting with Saad Zaghoul, Nizzamuddin and other staff at CAPMAS.
- 30 Meet with T. Seims, L. Slobey, USAID, meeting with T. Seims and Dr. Sayed and then longer meeting with 2 above and Dr. Hamid Fahmy to discuss coordination between USAID and UNFPA on PPP, see Aziza Rashad of AUC, then T. Seims, then Seetharam of ILO.
- 31 Departure for Geneva, where I was able to discuss the ILO Egyptian Manpower report with Dr. Samir Radwan and the women and development project with Dr. Richard Anker.
- June 2 Arrive in New York - Visit Mr. Abu Nuwar of UNFPA concerning the Population Policy Programme for Egypt.
- 5 Arrive in Ann Arbor.