

(18)

**Report to Population Office, USAID/Cairo
NGO Programming in Family Planning
Linda Oldham
May 1997**

Introduction

This report is a summary of findings of a POPTECH consultancy to the Population Office of USAID/Cairo. The purpose of the consultancy was to undertake a review of NGO programming in Egypt, in terms of factors of relevance to the possible establishment of a funding mechanism for supporting NGO activities in family planning and reproductive health. A list of these factors is attached here as Annex A.

The consultancy was undertaken between 21 March and 18 April 1997. Activities of the review included meetings with NGOs and donors active in maternal health and family planning, site visits to NGOs and field programs in Aswan and Cairo, and meetings with USAID personnel currently working on the development of a general umbrella fund for NGOs in Egypt. A list of people seen is attached here as Annex B.

The main conclusions of the report are as follows:

1. Increasing the options of women with unmet need for family planning, via measures such as the strengthening of NGOs which provide health care services, to also render quality family planning services is a necessary but not sufficient condition to increase contraceptive prevalence, particularly in Upper Egypt.
2. Improvements in availability of diverse, appropriate family planning services needs to be matched with improvements in community-level outreach to women with unmet need.
3. The current climate, including levels and objectives of donor funding to NGOs in Egypt, is particularly conducive to strengthening both family planning service providers and community-oriented NGOs which can provide community outreach services.

The main recommendations of the consultancy are as follows:

1. The Population Office of USAID should consider supporting not only NGOs which currently provide health care services to develop quality family planning services, but also community-focused NGOs which can support women to choose to use these services.
2. The most parsimonious and most effective way to support increased use of contraception via support to NGOs working in family planning is to buy in to the Democratization umbrella fund now being designed.
3. The Population Office should consider ways in which the relationships among the community,

the family planning service providers, and community-oriented NGOs can be strengthened via the umbrella funding mechanism, through encouraging joint proposals, targeting specific areas, or some other mechanism.

The Planned Umbrella Funding

The umbrella funding now under consideration is a component of the Population/Family Planning IV Results Package, entitled "Subresult 4.2.2.8: NGOs." This component of the institutional strengthening of family planning services provision is designed to establish new institutional capability to provide family planning services on a permanent, sustainable basis in 15 existing local NGOs and five national NGOs. The component is designed to work with NGOs which provide health services, supporting them to develop high quality family planning services as part of their overall health care programs.

It is planned that these NGOs will be upgraded and provided with technical assistance as needed in the following fields: medical services; promotion and marketing; human resources; financing management and accounting; strategic planning; management information systems; monitoring, evaluation, supervision and quality assurance; and income generation. The participating NGOs are to be given three-year grants for operating costs, with financial support constituting a declining portion of total operating costs, and the programs are to be financially independent and sustainable at the end of the grant period. A copy of the outline of Subresult 4.2.2.8 is attached as Annex C.

The Impetus for the Review: Findings and Implications of the 1995 DHS

The 1995 DHS survey showed that contraceptive use doubled in Egypt between 1980 and 1991, from 24 to 48 percent, but that there had been almost no change at all in the rate of use between 1991 and 1995. It also showed the rate in urban Lower Egypt to be more than double the rate in rural lower Egypt. The survey pointed to the ongoing problem of discontinuation of use of contraception: 30 percent of Egyptian women discontinue using contraception within the first year.

The study concluded that there is considerable scope for increased use of contraception. "Unmet need" is defined by the DHS as characterizing women who are not currently using contraception but who wish to wait two or more years for the next birth or to have no more children. More than one in six women were found to have unmet need for family planning. Two thirds of these women were found to live in rural areas, and more than half had never been to school.

This unmet demand cannot be attributed to lack of availability of family planning services: virtually all ever-married women know of at least one modern method of contraception, and more than 90 percent know at least one source of contraceptives. Ninety percent of evermarried women stated approval of family planning, and 83 percent reported that their husbands also approved.

Although the DHS showed little change in aggregate levels of contraceptive use, changes occurred in the patterns of use, including a major switch from oral contraceptives to IUDs. The finding of primary

relevance to this review is that the percentage of women obtaining contraceptives from NGOs rose from 2 percent in 1992 to over 9 percent in 1995, despite the fact that USAID funding to NGO family planning activities was at a very low level during this period. Practically all of the contraceptives obtained from NGOs were from two NGOs: The Egyptian Family Planning Association (6 percent) and the Clinical Services Improvement Project (2.5 percent).

This finding gave rise to the question of whether NGO family planning/reproductive health services might be an avenue to improving overall rates of contraceptive use. The Population Office rationale for thinking that strengthened NGO programming in family planning services may help to increase the overall use rates for contraceptives are listed and discussed below.

Rationale 1: *NGOs are somehow more appropriate service providers for some part of the client population because they often have religious affiliations, and they may be seen as trustworthy because they are local* It appears that the reason that some clients prefer to use religious institutions for obtaining health care/family planning services is not so much that they are religious, but that they are affordable and relatively well run, and have succeeded in attracting senior physicians to their staffs. That is, it is often the religious motives of the provider, and not necessarily of the client, which makes these clinics attractive.¹ In the case of the larger religious institutions, including hospitals as well as clinics, donations from abroad have often made it possible to acquire better equipment than is present in competing institutions, without any need to amortize the costs via patient fees, which are typically low.

Rationale 2: *Adding NGO providers to the available sources of family planning may serve to intensify competition, leading to better quality and lower costs of family planning.* Whether adding NGO providers to a local environment has the effect of bringing down costs of private clinic family planning services or not is a proposition which can be tested in communities where the Clinical Services Improvement Project is working.² CSI staff in Aswan report that both public and private sector providers have adopted some of the approach of CSI, by, for instance, beginning to maintain permanent records for patients, providing more respectful service and conducting a range of laboratory tests before providing contraceptives.

Rationale 3. *Strengthened NGOs will become stronger advocates of family planning.* As discussed in more detail below, the group of NGOs which now provide health and/or family planning services are distinct from the NGOs which do or readily could advocate family planning. The former have neither the inclination nor the management skills to carry out advocacy activities, while this is a central focus of the

¹Most, and quite possibly all, of the Islamic hospitals which are chartered as NGOs attract both Moslem and Christian patients. The same is true for Christian hospitals.

²This is not, however, a straightforward procedure, as there are differences not only in costs but also in the package of services offered. CSI requires a medical history and laboratory tests prior to insertion of an IUD, while other clinics may not.

latter. Strengthening of family planning services provision NGOs is therefore unlikely to increase advocacy, though strengthening of NGOs concentrating on overall community development can do so.

Rationale 4. *Supporting NGOs to provide quality family planning services will give the NGO community a stake in family planning.* Again as discussed below, the NGOs in Egypt are not a single community. The health care services established as NGOs are many and varied, ranging from large modern hospitals to moribund family planning units, and these institutions do not feel a sense of community even among themselves, much less with the community-focused NGOs. Supporting individual NGOs to provide quality family planning services will give those NGOs a stake in family planning, but it is not to be expected that the broader NGO community will feel that it therefore has a stake in family planning..

Rationale 5. *Coverage and access to services will increase because NGOs are often located in towns or neighborhoods where services from other providers are either inaccessible or unaffordable.* Like the private clinics, NGO family planning services are very much concentrated in urban areas. In LaTowsky et al.'s 1994 survey of NGO expenditures and revenues for the Governorate of Sohag, for instance, 51 NGOs were found to operate health services, of which seven were family planning clinics. Only 11 of these NGO health units were located in rural communities, and three of the 11 were moribund family planning clinics.³ Mosque clinics and Islamic hospitals are also concentrated primarily in urban areas.⁴

The Potential Role of NGOs in Increasing Contraceptive Prevalence

The preceding discussion of rationales and counter arguments is not an argument against supporting NGOs with established health programs to build strong family planning service units. Establishment of more, better, and more accessible family planning services is a necessary condition for increasing contraceptive use. It is also a sufficient condition for some current users, in that quality family planning services can be expected to decrease discontinuation rates and may also act to further raise the percentage of users who choose the IUD over the oral contraceptive.

However, the highest level of unmet need is in the rural areas, and most particularly in rural Upper

³The same study reports that 20 NGOs in Sharqiya Governorate were providing family planning services outside the context of general health services, and one additional NGO was providing family planning services as part of a polyclinic. Fourteen of these NGOs were community development associations, and six were non-religious social welfare associations. No religious organizations were engaged in offering family planning services. Two of these NGOs reported total annual user fees of LE 250-300 each in 1992, but the others all had revenues of less than LE 100. LaTowsky et al. estimate the total number of clients seen by all NGO family planning services at a maximum of 1500 women.]

⁴The DHS 1995 figures reflect the urban character of mosque and church clinics; more than three times as many urban women as rural obtained contraceptives from mosque/church clinics

Egypt. The women of rural Upper Egypt are poorer, less educated, and more secluded than women elsewhere in the country. They know the least about modern methods of family planning, use less contraception, begin childbearing earliest, suffer the greatest child loss, and have the highest fertility. At the same time, the women of rural Upper Egypt have the highest level of any region of unmet need for family planning; fully one quarter of ever-married women 15-45 met the DHS definitions for unmet need.⁵

It is simply not credible that this unmet need remains unmet solely because of the distribution of providers. There are rural health units with capability to provide family planning services throughout the country (at least one unit in every main village). In much of Upper Egypt, the Nile Valley is very narrow and transportation plentiful and inexpensive, so that women who have decided to contracept have access to urban providers, including NGOs which provide family planning services at quite low prices.⁶

If women have knowledge of family planning, their husbands mostly approve of its use, sources of contraceptives are known, and there is reasonably good access to service providers, then it is difficult to explain unmet demand as a whole except by factors such as:

1. problems in the relationship between providers and potential clients,
2. costs, in the case of the poor, and/or
3. a higher degree of ambivalence toward family planning than is reflected in the survey data.

These are factors which ~~must~~ be dealt with at the community level. That work within the community can increase translation of unmet demand into practice of family planning is clearly demonstrated by the Family Development Project of the Social Fund for Development, among others. This project has been able to ameliorate some of the relevant constraints on women with unmet need by identifying and developing relationships with women who are potential users, supporting them to make the decision to access family planning services, accompanying groups of women to pre-arranged sessions for inserting IUDs, explaining the procedure in advance and providing instructions on how to deal with possible infection or bleeding. The fact that program staff accompany women to the clinic visits, and that the women go in groups, appears to be a major factor in the rate of acceptance.

⁵Use for spacing is defined as women who are using some method of family planning and say they want to have another child or are undecided whether to have another. Use for limiting is defined as women who are using and who want no more children.

⁶Although DHS also found that a large portion of the women using contraception knew of only one source, and that rural residents are generally much farther from the nearest known source than urban residents.

Integrating Community-Focused NGOs into the Family Planning Initiative

The potential for meaningful integration of community-focused NGOs into a program to increase levels of contraception in Egypt is high. The sector is now growing rapidly, with new NGOs, new support institutions, and new funding to support further NGO development. There also appears to be a lessening of government attempts to micromanage the sector. This growth and development has been spurred by the work in Egypt on the International Conference on Population and Development (ICPD), and subsequently on the Women's Conference in Beijing. There is widespread commitment to enhancing the status of women, including, inter alia, reproductive health and family planning. The section which follows provides background on the status of NGOs in general, and then examines these new trends.

Background on NGOs in Egypt

There is a substantial literature on NGOs in Egypt, growing with the international donor community's increasing emphasis on working through NGOs. Much is made in this literature of the controlling role of the Ministry of Social Affairs and Law 32/1964, which is the enormously detailed enabling legislation for the establishment and operation of most kinds of NGOs in Egypt.⁷ A central element of this legislation is the Ministry's responsibility for prevention of abuse of the population via bureaucratic requirements prior to action. A central utilization is the devolving of Ministerial tasks by establishment of purpose-established national-level NGOs, not to distance them from government but so that government can benefit from the less stringent employment regulations affecting NGOs.

One of the most constraining features of this legislation is the provision that NGOs cannot raise money for community projects without explicit advance permission from the Ministry for both the fundraising initiative itself and the purpose of the funding, a permission that can be quite difficult to get.⁸ The

⁷Other Ministries, including Education and Youth and Sports also have the right to register and oversee NGOs in their own realms of action.

⁸See, for instance, Robert LaTowsky, 1986, *Rebuilding the Community Development Association as a Base for Community Action: The Financing of CDAs*, unpublished report to The Integrated Social Services Center, Tanta, Egypt. Similar findings are reported by Denis J. Sullivan, 1994, in *Private Voluntary Organizations in Egypt*, Gainesville: University Press of Florida, and in Ibn Khaldun Center, 1993, *An Assessment of Grassroots Participation in Egypt's Development*, report to UNICEF. LaTowsky, however, has revised his 1986 assessment on the basis of his three-governorate study, and no longer sees the central problem of Egyptian NGOs as one of resource mobilization. Further analysis of these data is likely to show that specific types of NGOs are finding their way with fundraising, and these are mostly NGOs which from their founding have very strong technical capabilities and, often, connections abroad (see Sullivan 1994, 85 *et passim*) but that other categories of NGOs are having great problems in accessing financial resources. The former category contains the quite impressive hospitals which have been established under Law 32, and the latter, sadly, the NGOs most concerned with supporting development in the resource-poor communities of the

picture of NGOs which emerges from this literature, and from experience in the field, is one of mostly languishing organizations which provide a narrow package of services defined by the Ministry of Social Affairs, but which are for the most part unable to finance or manage the projects most needed by their communities.⁹

While this picture does not characterize all of the NGOs of Egypt, it does apply to the majority. LaTowsky *et al.* analyzed the financial accounts for the NGOs of three governorates of Egypt, Giza, Sharqiya and Sohag, for 1992.¹⁰ The status of the 14,500 NGOs of Egypt as a whole was estimated based on the analysis of NGO revenues for the three governorates. Of the total, 35 percent were found to be inactive in community programs. This group includes moribund and very new NGOs, neither of which had revenues, along with NGOs established to serve only their own memberships. The remaining 65 percent were classified as follows:

Classification	Activity Level	Revenue Range/US\$		NGOs	
		Minimum	Maximum	Number	%
Very weak	low level of activities, often part-time	> 0	1,000	2,400	25
Limited	1-2 small but regular services + 1-2 minor periodic activities	1,001	5,000	2,600	27
Modest	2-3 established service programs	10,000	5,001	1,700	18
Intermediate	1-3 intermediate-sized programs	10,001	25,000	1,300	15
Pre-professional	1-2 large service programs, full-time program and administrative staff	25,001	50,000	1,000	10
Professional	1-4 major service programs, full-time program staff, administrative support staff	50,000+		500	5

LaTowsky et al. describes the "professional" category as consisting of two distinct types of NGOs:

...one half (250) are social service associations with close historical ties to government (usually the Ministry of Social Affairs) and directed by former (retired) senior ministry officials with government-seconded staff. Many of these associations provide welfare services

villages and peripheral urban settlements.

⁹Discussions of NGO activity in Egypt often seem to be based on an assumption that this is a uniform group of organizations. In fact, NGO is by definition a residual category worldwide, and certainly in Egypt aggregate data on NGOs gives little understanding of the variety of institutional purposes, groups served, relevance to economic development, potential for growth and development, necessary and sufficient conditions for effective programs, and other dimensions of NGOs..

¹⁰Robert J. LaTowsky, Tarek Abdel Ghany and Hussein Tamaa, *Financial Profile of Egypt's PVO Sector*, report to The World Bank, 1994.

to special categories of needy and disabled, or administer general public services (e.g., Productive Families, Red Crescent). The remainder of this largest 5% - approximately 250 PVOs in Egypt -- are large, independent associations established and directed by private citizens (p. 33).

International agencies supporting projects through NGOs have therefore had to provide intensive training and ongoing handholding, as well as finance, to the NGOs in order that programs be implemented. The structure of the relationship between donors and implementation agencies has been such that automatically the training and technical support has been in the service of the specific project at hand, rather than of the NGOs themselves. These projects have in many cases produced quality results, but even in excellent projects, sustainability has been weak and generalization of the project into an organizational program has been essentially nil.

Trends in NGO Development

This is a gloomy picture, but one which is now changing. Growing international conviction that civil society can only be strengthened if NGOs play an important role in national development and national life laid the groundwork for this shift, and in Egypt the International Conference on Population and Development, and next the Women's Conference in Beijing, concentrated interest in the private voluntary sector.

In the course of the preparations for the ICPD, a number of new and interesting developments occurred. First, Cairo-based NGOs, mostly with a feminist orientation, began to take a new interest in working with NGOs in the countryside. Second, interest in ways and means of speeding change in the status of women was generated through a broad spectrum of the NGO community. Third, a vigorous network of urban NGOs developed strong cooperative working relationships. Fourth, demand for greater autonomy of the NGO sector became much more insistent. And fifth, these changes were from the outset characterized by an insistence that enhancement of the status of women requires a much greater control by women over their own bodies and their own lives, implying, *inter alia*, that population/family planning programs needed to be defined very broadly.

1. Second Level Institutions

One of the most important developments in the NGO sector is that new institutions and programs are taking up the education and training of communities in general NGO programming, and in building and developing networks of NGOs which can jointly access critical resources. The most significant of these new institutions is the National Committee on Population and Development, which was established in 1994 to lead the implementation of the resolutions of the ICPD. NCPD is working intensively at the grass roots level to develop a national network of NGOs, which can support projects originated at the grass roots with technical assistance, building of local coalitions which carry out projects on a wider basis than the individual community, develop linkages between rural and urban groups, channel funds and information into the sector.

There are also a number of foreign organizations in Egypt working on networking among national

NGOs, technical assistance, and management training. Those which are working with a broad range of NGOs, rather than only those which participate in specific projects of the foreign organizations, include the Center for Development Studies, Support Centers International, and UNICEF.

As these secondary institutions progress in accomplishing their mission of strengthening the NGO sector in general, there will ultimately be less need for donors to be directly involved in training NGOs in the skills needed for project management, and a larger group of NGOs will be capable of making good use of donors funds than is now the case.

2. *Modification in Institutional Oversight*

Preparations for the ICPD and subsequently the Women's Conference in Beijing drew together a diverse group of NGOs working on the issues of these conferences in a task force format. The Minister of Population was an active sponsor of this work. During this period, the government transferred administrative responsibility for NGOs working on population issues to the Ministry of Population. When the Ministry of Health became the Ministry of Health and Population, supervision of these NGOs was transferred to this Ministry, which established an NGO department to work with these NGOs. No further NGOs are being transferred to the MOHP for the time being.

The implications of the transfer are unclear; MOHP is very new to the NGO business and only beginning to establish its modus operandi vis-a-vis NGOs. It appears, however, that the MOHP, like MOSA, regards the NGOs under its supervision as something of an extension of the Ministry itself, and does not at this point regard the NGO sector as a pluralistic proposition.¹¹ At present, the Ministry view is that donor funding to NGOs should be given to the MOHP, which will allocate funds and carry out program supervision itself.

3. *The "New" NGOs*

The development of mosque clinics and Islamic hospitals antedates the florescence of NGOs in general as a result of ICPD. There are two main streams of development of Islamic associations which provide health services. The older associations include: the Association of the Followers of Mohammed's Path, whose main activities are building mosques and production and distribution of Moslem religious materials; the Association for the Quran, which built and operated Quranic schools from the 1920s until the 1970s, when the Azhari school system was established; and the Legal Association, whose main activity is supporting orphans. These associations have been in operation for decades, and are present in most of the governorates of Egypt. Many of the local chapters of all of these associations have established small health clinics in the countryside.

In the 1970s, Egyptians returning from periods of work in the Arabian Gulf States began to invest substantial capital in charitable activities. They initially invested in building mosques, and then

¹¹However, MOHP has appointed a senior consultant on NGOs who retired from the Ministry of Social Affairs after a career of overseeing NGO activities.

established NGOs affiliated with these mosques to provide community services, particularly in health care. These same investors in many cases had developed strong connections with people in Saudi Arabia and Kuwait, both Egyptians living permanently there and nationals of these countries, who were prepared to invest in charitable concerns in Egypt. Some of the very large Islamic hospitals were founded as a result. Information is generally unavailable on sources and amounts of initial investment, but it is well known that a number of these hospitals, such as the Mustafa Mahmoud Hospital in Mohandisiin, have ongoing access to funds from the Gulf for investment in equipment.¹²

These hospitals were registered as NGOs because that was the simple way of registration; they were not built by pre-existing NGOs which already had a range of activities. LaTowsky's category of "professional" NGOs includes a number of such hospitals. These hospitals are typically well managed and particularly well equipped, which makes it possible for them to attract senior physicians. Cost of care is typically lower than in the private sector hospitals, and the hospitals typically have provision for free treatment for the poor, at least in their outpatient clinics.

The mosque clinics and Islamic hospitals have proven to be difficult to study.¹³ They are known to be heavily concentrated in the urban centers of the Delta, although there are such clinics and hospitals throughout the country. There is probably considerably more variability in quality and range of services, and in the availability of basic medical equipment, in the mosque clinics than in the hospitals.

Some of the Islamic health care facilities provide family planning services as part of their obstetrics/gynecology departments. Others, however, specifically reject family planning.

NGO FP/RH Service Delivery

Family planning activities take place in a spectrum of types of programs. Some NGOs, such as the Clinical Services Improvement Project (CSI) and the Egyptian Family Planning Association (EFPA), operate family planning clinics. Others, such as the Coptic Evangelical Organization for Social Services (CEOSS), are strong advocates of family planning in the community, but do not operate clinics. Still others, such as mosque and church clinics and hospitals, provide family planning services in the context of broader medical services programs, via health clinics and hospitals..

The MOHP position vis-a-vis NGOs is that the appropriate role for NGOs in family planning is the operation of intense advocacy and educational campaigns, and that in the future NGOs should not be allowed to undertake the provision of family planning services per se. MOHP further argues that the

¹²Reported by Sullivan (1994) and by key informants in Cairo.

¹³See Priti Dave Sen (1994) and Sullivan (1994). Sullivan reports that a study of the mosque clinics, including their numbers and distribution, was being undertaken by Egyptian social scientists as of 1994, but without citation, and Sullivan's book was unfortunately available to this consultant only after the consultancy.

rural communities which have poor access to family planning services will be adequately served as the Ministry begins to operate mobile family planning clinics which visit such communities on a regular basis.

In general, programs have succeeded in providing family planning services per se on any scale only when the NGOs are either national level NGOs specialized in family planning, such as the parastatal NGO, EFPA, or to a lesser extent when family planning services are part of a broader medical program which is the central activity of the organization. CSI has worked splendidly not because it is an NGO but because it has been well planned and well managed from the outset, and because USAID funding and technical/managerial support have been provided over a sufficiently long duration that the organization has been able to develop institutional strength.

Family planning clinics located in smaller or weaker organizations have performed indifferently and some which are reported as active have actually ceased to function.¹⁴ In general, these clinics are located in urban areas, and are heavily dependent on subsidies to bridge the gap between costs and revenues; if subsidies stop, so do programs. The LaTowsky et al. data on NGO expenditures and revenues reinforces the field observations here.¹⁵ Data for Sohag show that the total of 51 NGO health services in the governorate have median total annual revenues LE 1,850 for 1992, only about half of which was in user fees; the revenues of the 7 family planning clinics included in this total. Only 11 of the 51 health services are located in rural communities, and 3 of these are moribund family planning clinics.

Indicators of NGO Performance

Assessment of the performance of NGOs in Family Planning/Reproductive Health requires the use of standardized indicators of the results of programs. Such indicators are not available for reproductive health programs, defined in a narrow medical sense, which cover a broad range of activities and are generally imbedded in hospital and clinic facilities. The assessment problem is also complex for NGO family planning programs.

Family planning service providers are required to report their levels of distribution of various types of contraceptives to the National Population Council on a monthly basis. However, only those NGOs which work exclusively or predominantly in family planning via specialized clinics are able to produce copies of monthly or quarterly records, and it is only in the case of CSI that the costs of service

¹⁴There is a continual and confusing overlap in definitions of whose program a given family planning service is part of. For instance, the field visits for this consultancy included the Al Atwani village community development association in Edfu District, Aswan Governorate. This clinic is located within the premises of the CDA, and is described by the board of directors as belonging to the CDA. The board of directors reports that the clinic has been closed for many months due to lack of a physician and to alternative sources of services nearby. It is also, however, listed on the books of the EFPA chapter in Aswan Governorate as an EFPA program, and as a functional clinic, albeit in need of development.

¹⁵Personal communication, Robert LaTowsky.

provision are clearly defined with relation to services provided. There are also many clinics and hospitals operating under Law 32/1964 which provide family planning services as part of their overall obstetrics/gynecology clinics, but do not actually dispense the methods, and it appears that data on these facilities are not routinely reported to NPC.

Furthermore, much of the work of NGOs in the area of family planning cannot be translated into CYPs at all, because it consists of advocacy of child spacing and limitation of fertility. For the Family Development Project of the Social Fund for Development in Aswan Governorate, records of the monthly numbers of IUDs inserted are available, but only for those IUDs inserted in EFPA clinics, and it is impossible to disaggregate the costs of family planning services from the other elements of the program.¹⁶

A number of NGOs operate, or have operated, primary health care projects which include a strong emphasis on child spacing and fertility control as part of broad programs of community development. These include the Coptic Evangelical Organization for Social Services, the Institute for Cultural Affairs, Save the Children, and perhaps others. None of these NGOs operates clinics or distributes contraceptives.

Results: Evaluating the Results of Family Planning Advocacy Programs

The NGOs now working in reproductive health/family planning, along with the Family Development Program¹⁷ are generally weak on documentation and evaluation, even where they are strong on practice. It makes sense that such support programs can be effective in translating unmet need into met need, but actual impact is difficult to document. Certainly the DHS format has not, and probably cannot, provide indicators of the impact of NGO support programs.¹⁸ There are no readily documented indicators such as CYPs of success in this area. Even if usage rates increase as a result of NGO activity, DHS credits these to the organization or location where contraceptives were obtained, not the organization which fostered their being obtained. More than this, the woman who has an IUD inserted can only do this in one place at a specific point in time, while she may be influenced by a number of sources of information and encouragement/discouragement to insert that IUD; even if all of these sources could in principle be known, it remains impossible to say what exactly made the difference in her changed behavior vis-a-vis family planning.

¹⁶The formula for deriving CYP consists of multiplying the number of each kind of contraceptive dispensed by a program by a constant specific to that contraceptive, and the constant is assumed to be standard across programs, which is actually an empirical question which has not been researched as part of program evaluation in Egypt.

¹⁷Which is not an NGO but is working in the style of a community-focused NGO.

¹⁸The 1995 DHS only asks nonusers whether they have discussed family planning with a range of possible people, including home visits from family planning outreach workers.

Community-focused NGO working in reproductive health/family planning take the position that without a much broader range of activities supporting the status of women, bridging the gap between unmet need and accessing of family planning services is unlikely to occur. This is a convincing argument. However, even if the appropriate documentation of increase in utilization of contraception in NGO programs were available, which it generally is not, calculation of cost-effectiveness of community-focused NGO family planning activities would be difficult.¹⁹

This is not to say that nothing can be learned from the experiences of NGOs working at the grass roots level in encouraging and facilitating the use of family planning. Rather, it is to say that a different kind of monitoring and evaluation of impact is called for when the soft side of family planning programming is under consideration. NGOs working in family planning are themselves the best source of ideas on how this work can be evaluated in a systematic way; ideally, they should be supported to establish a task force to work on this problem together. Whether a methodology can be developed which meets the stringent criteria of the Results Package approach is unclear, and certainly there is a substantial tradeoff here between immediate, easily measured results and long-term effects on prevalence of contraception.

Synergy among NGO Community Programs

If the Population Office of USAID opts to establish an umbrella fund mechanism, independently or through a buy-in with the USAID Democratization umbrella fund, now in the planning stages, for NGO family planning/reproductive health activities, and to invite NGOs working in both health service provision and community-focused development, considerable synergy would be possible.

At the level of the umbrella mechanism, community-focused organizations could notify community residents of the new or improved family planning services available at grantee medical NGOs. At the level of USAID, synergy could be created among programs in health and population, as well as between USAID programs and the programs of other donors. The Healthy Mother/Healthy Child project now in preparation will work with physicians in both the public and private sectors on issues of antenatal and perinatal health, and will advocate institution of a visit to a physician 40 days after the birth of a child, at which time family planning is to be discussed. This project has a very substantial NGO umbrella fund for HM/HC activities, and will carry out a solid program of community education as well. The Small Schools Project, also in preparation by USAID, will work to enhance not only prevalence but relevance of education for girls, and includes a component of education in girls' and women's health. The European Union's program on family planning in Upper Egypt, now in preparation, will include a program of financial and technical support to NGOs in Qena and Sohag.²⁰

¹⁹CEOSS has experience in disaggregating expenditures on family planning advocacy from other activities with women in their communities.

²⁰CEDPA's program in Minya, which was not visited during this consultancy, is also working with girls and women on gender issues and on increasing autonomy and self-actualization of girls and women.

All of these programs are planning substantial investments in education, training and technical support in the fields of family planning, reproductive health, and the status of women. As donor funding now in the preparation stages begins to impact on the sector, it is to be expected that more NGOs will focus on FP/RH, particularly in Upper Egypt. Funding levels are relatively high

Still more agencies are working with NGOs to develop their institutional capabilities. CARE, for instance, is working in dozens of villages of Upper Egypt to increase the capabilities of community development associations to develop and manage programs in areas ranging from rural sanitation to small business development. and UNICEF are working intensively with groups of NGOs to facilitate development of institutional capabilities and program development, as well as to establish ongoing networks of NGOs with common interests. There are also a number of Cairo-based consulting firms which have experience in management and financial training for NGOs.

Status of Possible Umbrella Organizations (CSI, NCPD, USAID/IDP)

CSI is occupied with ensuring the financial and managerial integrity of its system, and is in any event very focused on the provision of family planning/reproductive health services through its clinics system; it has little if any experience to date with working with other NGOs, and no expertise in community-focused institution-building and overseeing a diverse range of programs.²¹ CSI's role in a possible umbrella mechanism would more appropriately be defined as provision of training for other NGO health service providers in management of family planning services.

NCPD is the one organization seen which has defined its role as supporting both provision of family planning services and in working in communities. NCPD is still a young organization, and is now working at the grass roots level to carry out broadbased needs assessments in cooperation with local NGOs which can serve as the basis for support to the sector. Clearly the organization has a vision which is conducive to strengthening the NGO sector as a whole, and has quality management and staff. NCPD will likely remain a major player in the NGO development process, and should certainly be engaged in the umbrella organization from the outset, as a participant in policy making and as a grantee with capability of managing relations with other, smaller NGOs. Should USAID opt to establish an umbrella organization for NGOs in reproductive health/family planning separate from that of the IDP, NCPD could also serve as a partner in that organization.

A buy-in to the IDP umbrella fund is the strategy of choice, for a number of reasons.

²¹The support which has been given to CSI to develop self-supporting, quality service to the community has been an obvious success. At the same time, however, this orientation toward cost recovery means for the organization that outreach to the community has been limited to developing a base of consumers, not to encouraging women who do not use contraception to begin to do so. In Aswan, at least, outreach work was carried on when the clinics were new, but was stopped as soon as a client base had been established. This does not detract from the accomplishments of CSI, but does indicate that its role in the umbrella mechanism projects should be defined to capitalize on its strength, which is economical, quality family planning and reproductive health services provided on a cost recovery basis.

1. USAID already has substantial experience in design and management of umbrella funding for NGOs in Egypt.
2. There is a strong case for integrating reproductive health/family planning concerns into a broader development context; this is readily done if the umbrella fund is attending to a range of NGO concerns (and also facilitates collaboration with other USAID projects working with NGOs in relevant areas).
3. Ongoing institutional development and intense networking among NGOs are being carefully planned for the IDP umbrella fund. These are critical to the success of the family planning initiative as well.
4. Until the smoke settles in the discussions of control of NGOs in Egypt, and particularly those working in reproductive health/family planning, independence of the fund can best be assured through USAID management.

ANNEX A
FACTORS TO BE EXAMINED IN CONSULTANCY

NGO Issues:

1. Extent of NGO FP/RH service delivery and trends.
2. Status of established NGOs (CEOSS, CSI, EFPA, etc.)
 - staff
 - finances
 - donor support
 - facilities
 - systems (MIS, FM, personnel, strategic planning, supervision, etc.)
 - coverage
 - "vision"--objectives, strategy
 - relationship to GOE (NPC, MOHP, MOSA)
 - geographical coverage
 - rural/urban focus
3. Status of possible umbrella organizations
 - CSI
 - NCPD
 - USAID/IDP
4. Assessment of new NGOs, especially mosque clinics
 - services
 - distribution
 - organization
 - constraints, limitations
 - potential
 - relationships with established NGOs, GOE
5. Other donor activities and plans for NGO programming in FP/RH
6. USAID options, with advantages and disadvantages of each
 - scale
 - programmatic focus (service delivery, demand generation, advocacy, etc.)
 - implementation mechanisms

ANNEX B
People Seen

Aswan Family Planning Association

Executive Director

Zeinab Mohammed Kamel El Sherbini, Director of Aswan Family Development Project

Aswan Directorate of Social Affairs

Fathi El Gabalawi, former director of PVO Department

Cairo Family Planning Association

Aziza Hussein

Dr. Samir Aleesh

Clinical Services Improvement Project

Dr. Mohammed Edris, Executive Director

Dr. Talat Fathi, Aswan City CSI Center

Coptic Evangelical Organization for Social Services

Wafaa William, Sector Director for Specialized Programs (Director)

Egyptian Family Planning Association

Dr. Aziz El Bindary, Board of Directors

Dr. Abdel-Salem Hassan, Executive Director

Ministry of Health

Dr. Moushira El Shafa'i, Undersecretary for Family Planning

Dr. Maha Hamida, NGO Coordinator

Dr. Moetez Mohamed, Consultant to the Minister

Dr. Ashraf Ismail, Consultant to the Minister

MotherCare Project of USAID

Dr. Reginald Gipson, Chief of Party

National Committee for Population and Development

Dr. Mahassin Mostafa, Executive Director

Social Fund for Development

Dr. Aziz El Bindary

Eheb Zaghloul

UMI

Marian Kenali, Deputy Director

UNICEF

Dr. Fatma Khafagy

UNFPA

Dr. Kanchi V.R. Moorthy

USAID

Dick Martin

Angela Franklin Lord

Aimee Martin

Amani Selim

ANNEX C
POPULATION/FAMILY PLANNING IV RESULTS PACKAGE
INTERMEDIATE RESULT 4.2.2: INSTITUTIONAL STRENGTHENING
SUBRESULT 4.2..2.8: NGOs

1. Results

- a. 15 local NGOs with new institutional capability to provide family planning services on a permanent, sustainable basis.
- b. 5 national NGOs with new institutional capability to provide family planning services on a permanent, sustainable basis.

2. Activities

The objective of this component is to strengthen the institutional capability of NGOs to provide family planning and associated reproductive health services on a permanent, sustainable basis. The component will provide selective, individualized support to approximately 15 small, local, community-based NGOs and also to approximately 5 large, national NGOs.

The approach of the component will be to identify existing NGOs that are already established as providers of health services, but which provide minimal family planning services. The component will then provide individualized assistance and financial support to each selected NGO to create the capability to provide high quality family planning services.

The component will provide assistance in strengthening as many of the following capabilities as may be required to enable each NGO to offer good services:

1. Medical services
2. Promotion, marketing
3. Human resources: staff development, support and management
4. Financial management and accounting
5. Strategic planning
6. Management information systems
7. Monitoring, evaluation, supervision, quality assurance
8. Income generation

The methodology to be used will be the following. First, USAID will establish an NGO "umbrella" program through an institution with a strong critical mass of experience and resources to strengthen and support NGOs. The SO4 results package -- Population/Family Planning IV -- will then provide \$3.7 million to the USAID NGO umbrella institution to support the development of family planning services in approximately 20 NGOs. With technical guidance from the SO4 Results Package team, the umbrella institution will provide individualized support to the 20 NGOs. In most cases, the following sequence of activities will take place:

1. The umbrella institution will create an in-house unit to manage the SO4 activity. This capability will consist of an international advisor assigned to the activity for four years, and an Egyptian advisor assigned to the activity for eight years, and clerical support.
2. The umbrella institution will develop a list of qualifying criteria for candidate NGOs. It will orient the NGO community on the program and invite NGOs to apply. It will then screen applicant NGOs and select the most appropriate NGOs to actually participate in the program.
3. The umbrella institution will then provide inputs -- training, technical assistance, upgrading of facilities, counseling materials, and medical equipment -- to each selected organization as needed. This upgrading may take from six months to one year.
4. Each participating NGO will then be rated according to qualifying criteria that will be developed by the umbrella organization.
5. Once an NGO has been upgraded and rated as qualified, it will receive a three-year grant to support operating costs of family planning services. The operating grant will be performance-based; grant funds will be provided in proportion to production of CYPs by the NGO. The operating grant will be based on a diminishing proportion of unit costs in order to initially provide an incentive to build a large clientele and subsequently to recover costs and achieve sustainability. For example, the operating grant might cover 150% of direct CYP costs during the first year, 100% during the second year, and 50% during the third and final year of the grant.

3. Rationale

Developing the institutional capacity of NGOs to provide family planning services helps meet a number of objectives, all leading to accomplishment of USAID's Strategic Objective 4, "Reduced Fertility." Specifically, strengthening NGO institutional capability has the following objectives:

1. It broadens the institutional base of family planning service provision in Egypt. NGOs represent a different kind of institution for family planning services, different from the government sector and the commercial private sector. NGOs may be more culturally suitable for some women because of a religious affiliation or their trustworthy, familiar, local nature. For clients, choice of services is expanded.
2. Having another institutional category of providers -- in addition to government providers and private commercial providers -- may intensify competition among providers, resulting in more services, better quality, and lower costs.
3. NGOs will assume a stronger advocacy role in favor of family planning. Strengthening NGOs to provide family planning/reproductive health services gives the NGO community a stake in family planning.
4. Coverage and access to services will be enlarged. NGOs often work in towns or neighborhoods where, because of poverty or remoteness, services from other providers are not available.

ANNEX D
Other Donor Activities and Plans for NGO Programming in FP/RH

A large volume of resources is about to be provided to the NGO sector for activities in FP/RH. These include the following:

- Support to Population Programme in Upper Egypt, European Community, ECU 10 million for family planning/reproductive health, an as-yet undefined part of total budget for NGO activities, now in planning stages, expected start-up late 1997. Special focus on Sohag and Qena.
- The Population Activities Program, World Bank, \$10 million for family planning and reproductive health, working entirely through NGOs in Upper Egypt. In advanced stages of preparation. Implementation via Social Fund for Development.
- Family Development Project, Social Fund for Development, family planning/reproductive health, working on awareness and adoption of family planning, Aswan, Qena, Sohag, modus operandi yet to include planned emphasis on local NGOs. Scheduled to conclude in November, 1997, but most likely to be extended for several years.
- UNFPA Support to National Commission on NGOs in Population and Development, CEOSS and other NGO activities. Currently preparing country plan, budget not yet available.
- USAID's Healthy Mother/Healthy Child Project, scheduled to begin in January 1998, with two separate budgets for NGO activities, one totaling \$20,000 for small grants to NGOs, and another much larger fund.

ANNEX E

Status of Established NGOs (CEOSS, CSI, EFPA)

EFPA was established as an extension of government activities in the area of family planning, and remains parastatal. Its registration is with the Ministry of Health and Family Planning. Its institutional structure is parallel to that of the Federations of NGOs in Egypt, whereby governorate-level organizations implement programs under the supervision of the central organization. In practice, the EFPA is not in a position to carry out much oversight, due to budgetary and institutional limitations. Governorate-level organizations are also languishing since the IPPF decided to stop its funding of the system. Those government associations which have succeeded in acquiring their own funding, mainly the Cairo and Alexandria Family Planning Associations, are working quite independently of the EFPA, and are registered with the Ministry of Social Affairs.

EFPA has a network of clinics in the governorates which provide family planning services. It is difficult to tell without a complete review of the activities of these clinics how many are actually active, but it appears that family planning services in these clinics are subsidized and have therefore shrunk with decreases in organizational funding. Some clinics are on the books but are not functioning at all.

Probably the major program of EFPA today is the Family Development Project being funded by the Social Fund for Development. This program, which is under way in Sohag, Qena and Assiut Governorates, is in actuality not only financed but managed by the Social Fund itself, with EFPA serving chiefly as a pass-through for funds.

CEOSS has been working in the field of family planning for many years. Family planning activities are integrated into overall community development programs. Funding for family planning is primarily from UNFPA. CEOSS promotes family planning through awareness and outreach programs, but the actual service provision is from the formal medical sector. Focus is on poor communities. Greatest geographical emphasis is on rural Upper Egypt, primarily Minia and Assiut, but urban programs are increasing. CEOSS is registered with the Ministry of Social Affairs.

The Clinical Services Improvement system of clinics is providing quality reproductive health/family planning services through 90 clinics around the country, with support from USAID. Sustainability has been built into the program in terms of cost recovery and management systems; the system is progressing well in the direction of potential independence from external funding. High quality management information systems are in place, and supervision from the central level is good. These clinics are located in population centers, predominantly district capitals, but draw in rural residents. Earlier in the system's development, outreach workers were employed by the program to bring women to the clinics, but this function has been abandoned now that the program is well established. According to the director of the Aswan clinic, the purpose of the outreach activities was to develop a clientele for the clinic, not to advocate family planning. While the services are provided at lower cost than those in the private sector, they are substantially higher than those being provided by community development programs and other NGO programs with a poverty-orientation. CSI's attention at present is to achieving full sustainability.

REFERENCES

- Kandil, Amani, 1995. *Field Description of Projects of PVOSs in Egypt and Their Needs After the Population Conference*, unpublished report.
- Khalifa, Mona, 1997. *System Research Consultation Report*, prepared for the Social Fund for Development [evaluation of the Family Development Project of the SDF].
- LaTowsky, Robert J., Abdel Ghany, Tarek, and Hussein Tamaa, 1994. *Egypt PVO Sector Study: Report No. 1: Financial Profile of Egypt's PVO Sector*, draft working paper prepared for The World Bank, Washington, D.C.
- Sen, Priti Dave, 1994. *Case Studies of Mosque and Church Clinics in Cairo, Egypt*. Report to Data for Decision Making Project and USAID, Cairo.
- Sullivan, Denis J. *Private Voluntary Organizations in Egypt: Islamic Development, Private Initiative, and State Control*, 1994. Gainesville: University Press of Florida.