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**FINAL EVALUATION OF THREE
FAMILY PLANNING SUBPROJECTS
UNDER THE EGYPT POPULATION/
FAMILY PLANNING II PROJECT
(263-0144)**

The Comprehensive Family Care Subproject of the
Coptic Association for Social Care (C/ASC)

The Upper Egypt Family Planning and Community
Development Subproject of the Bishopric for Public,
Ecumenical, and Social Services (BPESS)

The Rural Community-Based Family Planning
Subproject of the Coptic Evangelical Organization for
Social Services (CEOSS)

by

Joel Montague
Mary Wright
Nabil Younis

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Population Technical Assistance Project
DUAL Incorporated and International Science
and Technology Institute, Inc.
1601 North Kent Street, Suite 1014
Arlington, Virginia 22209
Phone: (703) 243-8666
Telex: 271837 ISTI UR
FAX: (703) 358-9271

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Glossary

A.I.D.	United States Agency for International Development (Washington)
AO	authorized official
BPESS	Bishopric of Public, Ecumenical, and Social Services
CASC	Coptic Association for Social Care
CBD	community-based distribution
CEDPA	Centre for Development and Population Activities
CEOSS	Coptic Evangelical Organization for Social Services
CYP	couple year of protection
EPTC	Egyptian Pharmaceutical Trading Company, Ltd.
FLE	family life education
FPIA	Family Planning International Assistance
FOF	Family of the Future
IEC	information, education, and communication
IUD	intrauterine device
LE	Egyptian pound
MOSA	Ministry of Social Affairs
NFP	natural family planning
PVO	private voluntary organization.
UNFPA	United Nations Population Fund
UNESCO	United Nations Educational, Scientific, and Cultural Organization
USAID	United States Agency for International Development (mission)

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Executive Summary

Introduction

The three subprojects funded by USAID/Cairo under the Population/Family Planning II project (263-0144) examined in this final evaluation include the Comprehensive Family Care subproject of the Coptic Association for Social Care (CASC); the Upper Egypt Family Planning and Community Development subproject of the Bishopric for Public, Ecumenical, and Social Services (BPSS) and the Rural Community-Based Family Planning subproject of the Coptic Evangelical Organization for Social Services (CEOSS). Each project has implemented a different approach to providing family planning services. The CASC approach features family life education; the BPSS approach links women's development, literacy, and income generation with family planning; and the CEOSS subproject provides family planning within a comprehensive community development framework.

The Centre for Development and Population Activities (CEDPA) has been the contractor for the BPSS project and has provided technical assistance to all three projects, initially by its Washington office and, more recently, by its regional advisor based in Cairo.

The purpose of the evaluation was to

- determine the progress of each organization toward meeting the subproject goals;
- document the lessons learned from the approaches of each subproject; and
- review progress towards sustainability.

Constraints to Project Implementation

All three projects have been hampered in the achievement of their objectives and completion of deliverables by serious bureaucratic and financial delays. In the case of CASC, which was to start November 1, 1990, there was an 11-month delay in obtaining approval by the Ministry of Social Affairs (MOA) which delayed signing the contract and caused resubmission of implementation plans. The project received its first funding in May 1992. In the case of BPSS, which was to begin March 1, 1990, initial funding was received from CEDPA on time; however, CEDPA was unable to advance any funds between January and July 1992 because it was in the midst of negotiations with A.I.D. Funding has only been resumed in the last two months. CEOSS, which was set to begin on October 1, 1991, experienced a 10-month delay at the start of the project and only received its first reimbursement check on August 16, 1992. In some instances, the delays in reimbursement were due to delayed or inaccurate reporting by the implementing voluntary agencies.

Project Impact

Despite numerous impediments, the three subprojects are well under way and have met some of their objectives. In the case of CASC, whose objectives are to improve quality and to increase the number of contraceptive clients, new acceptor statistics indicate that 52 percent of the target has been reached with one month remaining in the funding cycle. In the case of CEOSS, against a revised target of 12,314 new acceptors, 66 percent have been reached with nine months remaining in the funding cycle. In the case of BPSS, a total of 19,156 home visits have been made and the project has reached 5,283 new acceptors or 58 percent of the 9,000 originally targeted. Systems have

improved in CASC, and the CEOSS subproject has done excellent work in training, informational meetings, and outreach and follow-up. The BPESS project's work in literacy training appears to be statistically associated with the number of new family planning acceptors.

Although revenue generation and sustainability activities were major components in each project, little progress can be reported in these areas.

Recommendations

1. Funding should be continued for CASC and BPESS until the end of May 1993, when the Population/Family Planning II Project comes to an end.
 - a) USAID should provide no-cost extensions to CASC and BPESS to enable them to accomplish specific outputs agreed upon by the project and USAID. Particular attention should be given to management development and implementation of training and supervision plans. CEDPA should coordinate and provide technical assistance.
 - b) CASC and BPESS should demonstrate their commitment to the projects and enhance the likelihood of self-sustainability by making a significant contribution of personnel and funding in order to facilitate approval of the no-cost extensions.
2. To the extent possible, CASC, BPESS, and CEOSS, with CEDPA's assistance, should design reporting requirements to re-focus analysis of effectiveness on couple years of protection rather than the number of new and continuing acceptors in each program.
3. CASC, BPESS, and CEOSS, with the assistance of CEDPA, should each examine and analyze the internal resources it can bring to support family planning. Concurrently, each agency should develop a plan to approach the international donor community, particularly UNFPA and The Population Council.
4. With the implementation of the Population/Family Planning III project, USAID and the Ministry of Health should develop a revenue agreement that would allow the Ministry of Health to continue providing A.I.D.-donated commodities to the organizations at no cost, and the organizations should continue to retain revenues from sales of the commodities. The Ministry of Health would be responsible for monitoring compliance with the revenue agreement.
5. CASC, BPESS, and CEOSS, with CEDPA's assistance, should place more emphasis on improving the quality of medical services they provide, including documentation of client history, physical examinations, and adherence to the National Family Planning Guidelines for Egypt.
6. BPESS, with CEDPA's assistance, should implement income generation activities immediately in order to generate income to support the women participating and the program's clinical operations.

1. Introduction

1.1 Background

The three subprojects funded by USAID/Cairo under the Population/Family Planning II project (263-0144) examined in this final evaluation include the Comprehensive Family Care subproject of the Coptic Association for Social Care (CASC); the Upper Egypt Family Planning and Community Development subproject of the Bishopric for Public, Ecumenical, and Social Services (BPSS) and the Rural Community-Based Family Planning subproject of the Coptic Evangelical Organization for Social Services (CEOSS). Each subproject has implemented a different approach to providing family planning services. The CASC approach features family life education; the BPSS approach links women's development, literacy, and income generation with family planning; and the CEOSS subproject provides family planning within a comprehensive community development framework.

At the time that Family Planning International Assistance (FPIA) ended its cooperative agreement with A.I.D. in October 1990, the Centre for Development and Population Activities (CEDPA) was asked to take on the role of providing and coordinating technical assistance for CEOSS and CASC. CEDPA was already involved in funding local costs and providing monitoring and technical assistance for BPSS. These activities were initially carried out from CEDPA's Washington office with quarterly visits to the project in Egypt by a Washington-based member of the CEDPA staff. The number of subprojects in which CEDPA became involved increased sufficiently so that in March 1992 a regionally based advisor was appointed to provide a major emphasis on the Egypt projects.

Funding for the three programs is different and bears description because the flow of funds to each has been disrupted, for different reasons. CASC is funded through a host-country agreement with the Ministry of Social Affairs (MOSA). Funds go directly to CASC, but responsibility for the project lies with the MOSA. BPSS is funded through a buy-in to A.I.D./Washington's cooperative agreement with CEDPA. CEOSS has a cooperative agreement with USAID/Cairo.

A.I.D. funds allocated to each project and the life of each project are as follows:

Table 1
A.I.D. Funding of Subprojects

Name of Organization	Starting Date	Estimated Date of Completion	Planned (LE)	Obligated (LE)
CASC	11.01.90	10.31.92	564,606	287,648
BPSS	03.01.90	03.31.93	727,744	727,744
CEOSS	10.01.91	05.31.93	1,041,163	1,041,163

1.2 Evaluation Purpose

The evaluation of the three subprojects was conducted between August 15 and September 17, 1992, with the exact dates of each member's participation varying somewhat. The three-member team included Joel Montague (team leader) and Mary Wright from the United States and Dr. Nabil Younis from Egypt.

The purpose of the evaluation was to

- 1) Determine the progress of each organization towards meeting stated subproject goals/objectives;
- 2) Document the lessons learned from the approaches of each subproject; and
- 3) Review progress towards sustainability after USAID funding ends.

See Appendix A for the complete evaluation scope of work.

1.3 Evaluation Methodology

The evaluation consisted of a number of key activities: briefings by USAID; review of documentation; consultation with senior staff of the agencies to be evaluated; and field visits to project and service delivery sites, primarily in Upper Egypt. (See Appendix B for a list of persons contacted.)

The clinics visited were selected by program administrators based on geographical ease of access and availability of staff. Sites visited included 5 of CASC's 23 or 27 (it was not possible to ascertain exactly how many clinics are operating) clinical facilities; all 6 BPSS centers; and 4 of CEOSS's 7 clinical facilities, as well as a graduate partnership village. The team interviewed clinic staff members representative of all roles — physicians, fieldworkers, educators, and clinic directors; a few clients when available; and literacy and income generation teachers. In addition, some clinic activities were observed.

In order to generate comparable data from subproject service delivery sites, the team modified a series of non-copyrighted functional analysis service delivery evaluation questionnaires field tested by The Population Council: "Observation Guide for Interaction between Consenting Family Planning Clients and Service Providers"; "Community-Based Distribution (Fieldworker) Interview Schedule"; "Interview Schedule for Staff Problems Providing Family Planning at the Service Delivery Point"; "Program Manager Questionnaire (Self-Administered)"; "Inventory for Facilities Available at the Service Delivery Point and Summary of Service Statistics".

In addition, the evaluation team developed questionnaires for BPSS income generation projects and for CEOSS family planning clients, and adapted a UNESCO literacy questionnaire for local use by personnel at the BPSS literacy sites. The team also developed a rating scale to facilitate the analysis and reporting of its findings (see Appendix C).

**2. The Comprehensive Family Care Subproject of the
Coptic Association for Social Care (CASC)**

2. The Comprehensive Family Care Subproject of the Coptic Association for Social Care (CASC)

2.1 Background and Organizational Development

The CASC project is an activity undertaken by the Coptic Orthodox Church of Egypt. The church itself consists of some 33 dioceses headed by a patriarch, the Pope of Alexandria. Church membership numbers approximately 9 million out of a total country population of 55 million; thus, the church's social welfare programs are of great importance. Since 1973, the church has implemented a family health program that has included some element of family planning organized by and through the Bishopric for Public, Ecumenical, and Social Services (BPESS), a department of the church.

The CASC project operates as part of the BPESS and uses BPESS's administrative systems to carry out some of the project's work. The project activity had been implemented by BPESS and funded by Family Planning International Assistance (FPIA) until October 30, 1990. At that time, CASC, though legally constituted at an earlier stage, became functional as an MOSA-registered voluntary agency (within the Coptic Church) eligible to receive A.I.D. funds.

2.2 Project Purpose and Design

The project was designed to extend family planning activities to 11 governorates through a consolidated network of comprehensive family care clinics, mobile teams, and fieldworkers. The project was to serve 58,688 new and continuing clients from November 1, 1990 through October 31, 1992. CASC was to open two new clinics and one mobile unit to serve low-prevalence villages and towns in Upper Egypt. CASC was to strengthen its institutional capability through the implementation of a strong training program designed to improve staff skills at all levels. Finally, a new training program in family life education was to be implemented in order to educate women and youth leaders about the importance of small families for good family relations, with the expectation that this information would contribute to an increase in demand for family planning services.

2.3 Key Project Developments to Date

2.3.1 Finances

The project has suffered serious delays as a result of bureaucratic and financial problems. Although the agreement between CASC and USAID was agreed upon in principle in November 1990, the MOSA, which regulates all private voluntary organization (PVO) activities, did not approve the project until September 24, 1991.

The project's budget covering the period November 1990 to October 1991 was LE 965,633. Actual expenses incurred during this period were LE 418,962, representing approximately 43 percent of the total agreed upon budget. The entire amount was financed by the BPESS, which took out bank loans to support project costs. CASC received its first reimbursement check from USAID on May 7, 1992. It should be noted that there is a joint responsibility for acquisition of funds from USAID: the

recipient agency must submit accurate, complete vouchers for expenses incurred using the prescribed forms before USAID can process the vouchers and generate a check to reimburse them for the expenses. Breakdowns in this system accounted for some of the delay.

2.3.2 Service Delivery

At the beginning of the USAID funding period, the project had 47 clinics, with a plan to reduce the number to 28 by closing the least cost-effective centers. This activity was completed by the end of April 1991, and by the end of August 1991, the number of clinics had been further reduced to 27. Currently, either 23 or 27 clinics are in operation (see Section 1.3).

CASC also operates three mobile teams: in Beni Suef, Magaga, and Tahta. The teams visit villages three times a week and consist of a physician, nurse, and fieldworker (female). Of the three teams, only one is attached to a fixed service center.

2.3.3 Family Life Education (FLE)

The evaluation scope of work notes that what makes the CASC subproject different from the other subprojects is that it "has promoted family life education (FLE) as one mechanism to create demand for family planning services." To achieve this FLE objective, CASC developed a series of discussion issues on the following FLE topics:

- marital harmony,
- understanding one's mate,
- attitudes towards the opposite sex, and
- attitudes towards one's body.

Each month, a 20-page pamphlet and cassette were sent to CASC centers along with information on how to teach the topic. This series lasted for nine months, during which feedback from the centers was highly positive. At that point, the project's authorized official (see Section 2.4.2) decided to change the format of FLE from oral presentation to that of a magazine, which was widely distributed. No copies of this magazine were seen, but apparently it has no family planning content.

Since the pamphlet-cassette program, there has been no structured program on FLE, although in some parishes, individual center directors (local priests), who serve as the FLE leaders, provide FLE programs through their churches. From November 1990 through June 1991, FLE leaders conducted group meetings that reached a total of 12,150 people compared to the project logframe target number of 7,560. Although this target number was exceeded, the FLE group meetings were not conducted by trained FLE leaders as planned in the Project Paper. Plans were made to draft a curriculum to train 72 FLE trainers, but the activity was dropped due to lack of funds.

Although these efforts in FLE may have been useful, the discussion series that was developed only mentioned family planning as an aside, and there was little evidence of association between this component of the program and numbers of new contraceptive acceptors at the CASC centers visited.

2.4 Organizational Structure and Activities

2.4.1 Organizational Autonomy

At the moment, CASC's family planning activities are largely dependent on USAID. Its autonomy is severely constrained by the financial support, program directives, and procedural regulations of the United States government in addition to those Egyptian government regulations (including detailed reporting on family planning programs) which circumscribe all social welfare activities undertaken by non-profit agencies in Egypt.

2.4.2 Leadership

CASC has three levels of leadership:

Policy and program leadership is provided primarily by the authorized official, a bishop of the Coptic Church who devotes varying amounts of time to the project.

Managerial and administrative leadership of the project is provided by the executive director (whose time is split between CASC and BPESS), the medical field managers, and the financial manager for the Bishopric.

Technical and regional leadership is provided by unit heads, consultants, regional supervisors, and medical field managers.

2.4.3 Management and Administration

Planning. Some preliminary work has been undertaken in the area of long-range planning by the project's authorized official. There was little evidence of written plans, however, outside of those that are specifically related to the CASC project itself, such as workplans. Implementation plans are prepared annually and reports sent to USAID quarterly, as are service statistics.

One of the project outputs noted in the logframe was "clinic improvement, expansion, and reduction according to an established timeline". The clinics were phased out according to the planned timeline, but no new clinics were added.

Another project output was the development of a fieldworker monitoring plan. There was no evidence of such a plan. At present, fieldworkers are supervised by the center educator, with weekly meetings of the whole staff at each center.

Coordination. Communication between the executive director and the financial manager appears to be weak, and they are not working as collaboratively as a project of this nature requires, particularly given the problems with funding. The project operates as one piece of an integrated series of polyclinics, each of which has its own director, policies, procedures, structures, and objectives. The executive director's authority and responsibility is thus limited, and the subproject's plans are implemented only if he is successful in influencing the local priest who is the center director. This method of family planning management constitutes a real limitation to the executive director's authority and limits senior management's ability to enforce uniform systems and apply normal management standards.

Commodities and Equipment. There was no evidence of any problems in the area of contraceptive commodities, other than those problems posed by the large number and changing varieties of oral contraceptives.

The logistics system for CASC is substantially the same as that of BPSS. The central warehouse is maintained by the Nasr City office of the Bishopric. The storekeeper orders supplies from the Egyptian Pharmaceutical Trading Company, Ltd. (EPTC) (previously supplies were also obtained from the Family of the Future [FOF], a contraceptive social marketing program which was sponsored by USAID). When he purchases them, he retains a copy of the voucher (purchase order) and gives the finance office another for repayment. Once items have been accepted by the storekeeper into the storeroom, he signs the voucher, then registers the commodities by type in a general ledger. The ledger includes both family planning and non-family planning commodities. In Cairo, the general ledger is also used to register both receipts and disbursements of the individual commodities, with a separate page being kept for each item. At the center or clinic level, the educator or nurse keeps commodities records in an inventory book, recording the dates and numbers of disbursements and receipts of commodities. A separate page is kept for each item. With this information, the center is responsible for tracking commodities, forecasting need, and ordering supplies. The field supervisor, who visits Cairo monthly, files a written request for commodities with the medical field manager to obtain authorization to receive supplies. He then completes, with the storekeeper, the requisition form. The centers currently obtain commodities from the project on an as-needed basis. To improve the efficiency of the system, however, the supervisor has been advised to project and order supplies for a three-month period.

In summary, the system in place for distribution of commodities to the clinics is efficient and effective. A.I.D.-donated commodities are supplied at no cost to the program through EPTC. In the follow-on Population/Family Planning III project, it will be possible to continue the provision of commodities at no cost if the proper revenue agreements can be negotiated with the Ministry of Health.

It was intended that the project would purchase new equipment and renovate existing clinics and furnish three new clinics. Both the opening of new clinics and the purchase of equipment have been delayed due to a reported lack of funds.

Organizational Change. Over time, organizational structures change or are modified as the needs of their clients change, new funding sources are discovered, or the vision of the leadership changes. In the case of CASC, however, family planning clinical services do not appear to have grown to be a high priority at the service delivery level, leading to the conclusion that such clinical activities are considered to divert attention away from some of the major social welfare and religious interests of the Church. This conclusion was to some extent reinforced by conversations with church bishops in both Cairo and Aswan.

Training. One of the logframe objectives of the project was the development of resources (for training) for manuals for infection control. CEDPA provided a consultant who undertook a survey of infection control procedures in a sample of clinics and then provided program staff with guidelines and training in infection control. Another logframe objective was that comprehensive, skills-based training would be conducted for all staff. All levels of central staff, except for senior managers, were provided with initial training in 1992 even though USAID funds were not available. Four training sessions, totalling 31 days, were completed for fieldworkers, nurse educators, and physicians. The original training plan was also intended to provide training for center supervisors and refresher training for all staff categories. This training should have been completed within the first year of the

project; however, CASC reported that there were no available funds until early 1992, at which time training activities were resumed.

Evaluation and Monitoring Systems. The centers provide monthly reports on clinic services to the central CASC office. These reports include information on numbers of general physical examinations; numbers of new and continuing acceptors broken down by method; other medical services provided; numbers of contraceptive user dropouts and reasons; family life education activities by type, subject, and number of participants; health awareness activities by type, subject, and number of participants; visitors to centers; problems; and recommendations for improvement.

The center also provides a monthly financial report which details basic salaries for staff; numbers of clients for general physical examinations and family planning examinations by physicians; numbers of new and continuing clients seen by fieldworkers; clinic revenue; and clinic expenses.

The CASC subproject is handicapped by a lack of written guidelines with clear definitions for the management information system. These need to be available at each clinic. One of the logframe objectives of the project calls for improved planning, evaluation, and monitoring systems. This has happened to some extent, but further progress needs to be made specifically in the area of the utilization of data now being collected. With the help of CEDPA, project staff have begun to assess project activities compared with objectives.

Supervision. From the central level, the project director visits each center once a year for overall supervisory purposes. Three medical field managers cover the clinics; each is to visit assigned centers three times a year to review medical systems and procedures (see Section 2.5.4). The regional supervisor, who is responsible for seven to eight clinics, visits each center twice a month. He has overall supervisory responsibility for the clinic staff.

One of the objectives of this project is an improved community-based distribution (CBD) program. Each clinic has two or three fieldworkers who report to an educator, who plans and supervises their work.

One of the project indicators of improved systems was the development of a supervisor's handbook. There was no evidence of such a handbook, nor were there any guidelines or checklists to systematize the planning, supervision, or evaluation of program activities.

2.5 Family Planning Activities

2.5.1 Background and Logical Framework Objectives

The first output for the project is to "provide quality family planning services at 28 centers." In order to assess the quality of clinic management and services, site visits were made to 5 of the 23 or 27 operating family planning clinics, 2 in Cairo, 1 in Suez, 2 in Upper Egypt (Qena and Edfu). In addition, documents relating to the planning, development and implementation of the project were reviewed in conjunction with the project's executive director, one of the medical field managers, and the regional director for Upper Egypt.

2.5.2 Overview of Activities

Each clinic is open three days a week for about three hours per session. Generally, the sessions are held in the late afternoon or evening, although the centers within which the clinics operate are open during more hours and for more days. Each clinic is staffed by a physician, an educator, and two or three fieldworkers. Staffing is generally consistent with the plans set forth in the Project Paper.

The fieldworkers visit women in their assigned areas to discuss family planning with them, to provide non-clinical contraceptive commodities, to resupply continuing acceptors with oral contraceptives, and to refer new acceptors to the clinic for medical assessment and choice of contraceptive method. It was reported that up to 70 percent of oral contraceptives are distributed by these fieldworkers. Although the elements of this improvement were not precisely defined, the outreach and very basic CBD activities carried out by the fieldworkers is a major strength of this program. All of the clinics operate in areas with multiple sources of family planning services, but most of the competing services passively receive clients rather than recruit them.

It was also reported by the medical field managers that the turnover rate of fieldworkers has been very high in this program, a program in which they are the foundation of the motivation and recruitment process. Low salaries and part-time work hours account for much of the turnover, and clearly this has an impact on their morale, their willingness to go out on their own to make visits, and ultimately on their productivity.

The educator receives women at the clinic, registers them, and describes the different methods in detail to prepare the women for their consultation with the physician. The physician performs a general and a pelvic examination for each woman, and counsels her about the most appropriate method for her. If an IUD is selected, the physician inserts it at that time and schedules a return visit one week later.

The clinics provide minor medical services in addition to family planning services.

2.5.3 Staff Training, Experience, and Client Assessment Skills

The training of educators is quite variable, with two of four interviewed having excellent training experiences, one fair, and one in need of improvement. The educators had been in their jobs for more than a year on average, giving them the advantage of experience in family planning, even in the absence of lengthy training. Client assessment skills were also variable, with one educator rated in each of the evaluation team's four evaluation categories (see Appendix C). Educators demonstrated fair knowledge about the different methods, the indications and contra-indications for each, and the appropriateness of method in different situations. One notable exception was an educator who had developed her own information, education, and communication (IEC) materials and had managed to become very sophisticated in her assessment of women's needs.

The physicians' training, experience, and client assessment skills were found to be good. Although there were no gynecologists in the group, most physicians had received family planning clinical and didactic training from the program, if not previously.

The fieldworkers' training, experience, and client assessment skills were found to be generally fair. As noted above, there has been a good deal of turnover in this role, and given the scaled-down

training and supervision activities caused by funding delays, newer staff have not been thoroughly trained and are not well supervised by the clinic physicians.

2.5.4 Supervision

Administrative supervision is meant to be provided at all clinics on a bi-weekly basis, during which commodities are delivered, reports reviewed and collected for the central office, and any administrative concerns raised by the center director are addressed. At three of the centers, this supervision was carried out reasonably well (rated good), and at two centers it was rated excellent.

Clinical supervision is meant to be carried out on a twice monthly basis by the medical field managers; however, funding delays have constrained the travel budget of the medical supervisors, and these visits have not been conducted in Upper Egypt. Three of the clinics that are more easily accessible to Cairo have good clinical supervision, while the two in Qena and Edfu were not visited as frequently as planned.

2.5.5 IEC Materials

In all but one center, no printed IEC materials were to be seen, and only the fieldworkers reported that providing information outside of the clinic itself is part of their role. As discussed in Section 2.3.3, an extensive family life education program has been developed, but it does not address family planning to any great extent.

2.5.6 Logistics, Supplies, and Medical Equipment

Commodity distribution systems were good in all clinics, with no stock-outs reported, good storage in enclosed cabinets (except for one clinic in Upper Egypt where the temperature exceeded 40 degrees centigrade, and injectables were exposed to excessive heat), and inventory systems were appropriate to the volume of the clinic. Inventory is checked by the center director and the regional supervisor in conjunction with the fieldworkers, and resupply is carried out by the regional supervisor. There were no outdated commodities noted. Medical equipment was checked for quantity and quality, and physicians participated in the evaluation of the equipment. In two clinics, the equipment was ranked as good, in one it was fair, and in two clinics replacement of some instruments was indicated.

2.5.7 Clinic Facilities

Clinic facilities varied in their quality with regard to the evaluation team's indicators, with one clinic rated as having excellent facilities, one good facilities, and two fair facilities. Although efforts are clearly made to provide good lighting and ventilation, power outages affected both lighting and ventilation at one clinic, and lighting and ventilation needed improvement at the others. Water was available at all clinics.

2.5.8 Record Keeping and Service Statistics

Records are kept of home visits made by fieldworkers and of commodities distributed by them. These are of variable quality in different clinics. Client records are initiated by the educator, and medical information is recorded by the physician on each visit. This information is amalgamated monthly.

The records were good in all clinics visited, with some differences in the recording systems noted, but with no apparent effect on the quality of reporting. Reports are collected by the regional supervisor and carried to the central office monthly. It should be noted that the definition of a "new acceptor" leads to redundancy because one woman may be a new acceptor in each of four to five local programs.

2.5.9 Client Satisfaction Assessment

An assessment of client satisfaction was not possible during the evaluation, as all the clinics were open during hours when the team was not able to travel.

2.5.10 Quality of Services

Choice of Contraceptive Methods. Each clinic has the full range of methods that are approved for use in Egypt and available through the suppliers indicated in the Project Paper.

Provider-Client Information Exchange. Fieldworkers and educators are selected from the communities served by the clinics and are generally representative of the more educated and higher socioeconomic level. Even so, they presented themselves as able to understand clients' concerns and questions, as well as to provide information at a level appropriate to the woman being addressed. Although some programs believe that in order to carry out the education and motivation functions a fieldworker should be married, the senior staff of the project did not find that this was necessary, and some of the fieldworkers are indeed unmarried. There was no indication that this poses a problem. Physicians have varying amounts of training and experience in counseling women about contraceptive choice, and this often determines the degree of collaboration about choice of method versus prescription based on the physician's opinion.

Provider Competence. As noted above, client assessment skills vary among the educators, fieldworkers, and physicians. Competence is based on training and experience, and these have been compromised for fieldworkers due to rapid turnover of staff, drastically scaled-down training activities, and little on-the-job training and supervision. Educators have been more stable in their positions, but also vary in the amount of training and experience they bring to the role. Physicians vary in their competence based also on training and experience.

Although baseline qualifications are described for each job category, availability of qualified personnel is often based on location of clinic, salary of job, and number of hours of work offered. This has led to a reduction in requirements in some job categories, which would probably not pose a problem if the training and supervision were carried out as planned. The project prefers to hire female physicians, but this has not been possible in some clinics, and male physicians are providing family planning services without any apparent negative impact.

Technical competence is difficult to assess without observing the actual procedures being carried out, but inferences can be drawn from the descriptions of these procedures by staff. Infection control practices were described according to the guidelines developed recently with the CEDPA medical consultant. Physicians have learned how to insert IUDs either in their specialty programs or in training sessions provided by the program. They appeared to have a firm foundation of knowledge about the procedure and reported a high level of technical competence and a low infection rate.

Mechanisms to Encourage Continuity of Use. Fieldworkers reported a major emphasis on delivering new acceptors to the program. This *may* be done at the expense of following up on continuing acceptors. It was unclear whether this reported emphasis is supported by the program's objectives or by management's view of the funder's objectives. Fieldworkers and administrators gave conflicting reports about whether fieldworkers who wish to travel to more remote parts of their service areas can be reimbursed for the cost of transportation.

2.6 Project Impact

2.6.1 Population Targets

The purpose of the project related to service delivery, as described in the Project Paper of December 1990, is to increase contraceptive clients and improve the quality of family planning services. The targeted numbers are 20,330 new acceptors and 38,358 continuing acceptors by 1992.

New acceptor statistics are available through March 1992, and indicate that 10,570 new acceptors have entered the project. This constitutes 52 percent of the target, with one month left to the end of project. It should be noted that performance dropped off substantially from January to December 1991. Although the decline may have been seriously aggravated by the failure to receive USAID funds in 1991, it is also true that the high point in acceptor recruitment was in 1985 and that such a high number of acceptors has not been achieved since then.

Continuing user statistics are available through June 1992 and indicate that 88,517 "visits"¹ were made. It is not clear, based on the available information, whether the large number of continuing acceptors is related to the length of the project, to an emphasis on serving continuing acceptors, or to a combination of the two factors.

The number of new acceptors who have become continuing acceptors since November 1990 is not available, as the project has been accumulating and shedding continuing acceptors for 15 years, and it is not clear who of those continuing acceptors entered the system and at what date.

2.6.2 Method Mix

Statistics on the method mix show the following:

Table 2
Method Mix
CASC Project

	Pills	IUD	Condom	Foamtab.	Diaph.	NFP	Inj.
New Acc.	6,334	2,371	1,280	187	210	204	17
% of total	59.8%	22.4%	12.2%	1.7%	1.9%	1.9%	.1%

¹These visits can have any number of objectives, some of which may be related to family planning and some of which may not.

It is clear from the table above that the preferred method by the women in this program is the pill. Given the importance of the fieldworkers in providing new acceptors with information about contraceptive methods, it may be inferred either that the project's emphasis is on the use of pills for pregnancy prevention, or that the effect of negative rumors about the IUD may be sufficiently strong to counteract the promotion of IUDs by the project staff.

In comparing method mix targets with actual utilization rates between the first year of operation and the first six months of the second year, it was found that the expected increase in use of IUDs from 22 percent to 30 percent did not occur. On the contrary, IUD use decreased from 23 percent in the first year to 20.5 percent in the first six months of the second year.

The targeted use of injectables was 4 percent in the first year, 7 percent in the second year. Service statistics indicate that injectables were not used at all in the first year (perhaps because they were not available), and their use accounted for only 0.5 percent in the first six months of the second year.

**3. Upper Egypt Family Planning and Community
Development Subproject of the Bishopric for
Public, Ecumenical, and Social Services (BPESS)**

3. Upper Egypt Family Planning and Community Development Subproject of the Bishopric for Public, Ecumenical, and Social Services (BPSS)

3.1 Background and Organizational Development

The Upper Egypt Family Planning and Community Development subproject is implemented by the Bishopric for Public, Ecumenical, and Social Services (BPSS), the same unit of the Coptic Orthodox Church that supports the CASC project. Senior BPSS staff are virtually the same for both CASC and BPSS, and many of the systems in place for the CASC project are similar to, but perhaps less effective than, those of the smaller BPSS activity.

3.2 Project Purpose and Design

The purpose of this project related to service delivery (as described in the Project Paper) is to establish and maintain quality family planning services at each of the project's six centers. At the design stage, it was estimated that 9,030 new family planning acceptors would have been served with an estimated 60 percent continuation rate by the end of the subproject. Similar achievements were anticipated in female literacy and income generation. Approximately 405 women were expected to participate in literacy training.

The BPSS subproject differs from the CASC project in four major ways:

- 1) It geographically targets Upper Egypt where contraceptive prevalence rates are far lower than Egypt as a whole, and where the issue of contraception is far more sensitive. It is headquartered in Aswan, with three subproject centers in the Aswan governorate and three other subproject centers in the Qena governorate.
- 2) It addresses obstacles to family planning practice through an innovative approach to family planning service delivery within a "women's community development framework." The subproject was designed to integrate four components: clinical family planning services, literacy training, income generation/practical skills, and outreach/health education.
- 3) The BPSS subproject is funded through a buy-in to the CEDPA centrally funded cooperative agreement. The subproject was established and is managed independently of other BPSS programs.
- 4) A key feature of the subproject is the long-term goal of financial self-sufficiency. According to initial plans, revenues collected from services and a small agreed upon percentage of income from the income generating activities are to be placed in a special revenue fund. Plans and projections are to be prepared for eventual financial sustainability to support subproject activities after the termination of USAID support.

3.3 Key Project Developments to Date

3.3.1 Finances

As has been the case with the CASC project, the BPSS subproject has had bureaucratic and financial problems that have prevented the implementation of many planned activities.

BPSS began receiving direct funds from CEDPA in February 1990. At that point, project staff and CEDPA began preparations for setting up the program in Aswan. Clinical systems, including fieldworker activities, were established by the end of 1990. At this time, the project office was located in Kom Ombo near Aswan.

Unlike the CASC project, from February 1990 through the end of 1991, there were no problems with funding for project activities. From January through July 1992, however, CEDPA was unable to advance funds to BPSS while its new cooperative agreement with A.I.D./Washington was being negotiated and finalized.

One of the outputs of the project was to be an overall plan to sustain quality family planning services in the absence of external funds following the three-year USAID funding period. This expectation was found to be unrealistic, given the delayed start-up of the income generation activities. These activities have not yet begun due to difficulties in advancing funds. This lack of funds has held up the procurement of equipment and implementation of income-generation plans which were finalized in late March 1992.

3.3.2 Service Delivery

Because the project was conceptualized as a "women in development project," CEDPA was given the responsibility for funding local activities and coordinating and providing technical assistance to the subproject. There was a good deal of pressure to appoint a woman to direct the project, which in retrospect was probably not advisable given the status of women in Upper Egypt. Any woman in this leadership position would have had a very difficult time as a project director, and the appointed director was not able to overcome the substantial obstacles to her success. In 1991, the program experienced a series of problems and it was decided to move the project office to Aswan, to terminate Kom Ombo staff, and hire new staff in Aswan. This administrative restructuring, which took place in June and July 1991, slowed down project activities at that time.

Although start-up problems were significant, with CEDPA's help, clinical activities and fieldworker (female) home visits began in Kom Ombo and Daraw, in August 1990; by October 1990, all six clinics and fieldworker systems had begun operating. Clinic sites had been selected based on a set of criteria which included availability of space; good potential for service delivery activities; the absence of many other providers nearby; accessibility to adjacent areas; and the potential for expansion of the coverage area.

3.3.3 Income Generation

One of the most important elements of the BPSS subproject is a survey of income generation potential for women and the creation of income generation activities for 360 women who are to participate in local income generation activities.

Income generation staff interviewed were found to be competent and enthusiastic, but only one had received long-term academic training in a commercial field.

Although 394 women have participated in informal programs — primarily in sewing as part of the program — the major investments needed to provide new sources of funds for women and help achieve social change have yet to be made.

Several factors have led to delays in the project. During the project start-up phase, after the establishment of program centers, the economic development consultant and the income generation trainers conducted a number of focus group discussions in their areas to probe household opinions on possible income generation activities. These meetings indicated that sewing activities were preferred by local women. Both USAID and CEDPA felt that the marketing potential was too low for this type of activity, however. On the recommendation of USAID, BPSS consulted a marketing firm (February 1991) to conduct a feasibility study on the issue. The study proposed a number of different items that could be easily marketed, such as statuettes to be sold to tourists. Center staff and potential income generation participants rejected the idea on the grounds that the statuettes were too unusual, not traditional enough, and because they had no experience in working in this area.

In the summer of 1991, a second income generation consultant was hired through CEDPA to conduct another feasibility study, taking into consideration the possibility of offering an individual small loan program at each center. This idea was also rejected by center staff and participants.

It was finally decided to allow each center to develop its own proposal and plan rather than to impose something on it from outside. The funds would be provided to each center in stages, and indicators were set so that projects could be evaluated at each stage to determine their suitability for continued funding. Guidelines were given to the centers for the development of these plans. Plans were submitted in early 1992, and approved by CEDPA in March. However, funds were not available from CEDPA at that time. These funds are now available in the Aswan suboffice. To date, no income generation activities have been established at any of the centers.

3.3.4 Literacy

One of the major components of the BPSS project is the development of a literacy curriculum and the initiation of literacy training programs at each of the six centers. A review of the literacy programs at three of the six centers and an interview with the Bishopric's literacy consultant indicated that the literacy training was being offered, that women were participating in it, and that the training contributed to the women's self-esteem. In addition, the literacy program is making a long-term contribution to the achievement of family planning objectives by addressing the subject within the curriculum and by providing group settings in which women are able to discuss family planning.

Although it was originally projected that 70 percent of the (405) literacy trainees who completed the two-year literacy course would go on to pass the third primary examination, none of these women has as yet taken this examination. Moreover, the indicator implies that the BPSS will schedule and support women's entry into this examination, but such a system has not been set up. It is understood by program staff, however, that upon completion of the two-year curriculum, participants should be capable of passing this examination were they to take it; that is, they have been brought to an educational level equivalent to those who have passed the third primary examination.

Since August 1990, a total of 337 women have participated in the literacy training programs, meeting approximately 83 percent of the three-year participation target of 405 women. Of this number, a total of 219 women have completed the two-year curriculum.

Women who are not family planning acceptors pay a small fee to participate in the literacy classes. So far as could be determined, literacy courses are taught in appropriate, reasonably well-lighted, well-equipped facilities, and both teachers and students are provided adequate educational materials.

The curriculum and materials used in the classes were developed by the Bishopric and are used in its other programs. After the six centers had been established, the Bishopric's literacy consultant used the Bishopric's two-day teacher training curriculum to train the literacy teachers in the use of the new literacy curriculum and to provide them with practice in using up-to-date methods of adult education. The teacher training curriculum focuses on the processes of class communication and behavioral change. Under the BPESS, individual teachers then integrate health and family planning messages into their lessons. All literacy teachers interviewed were college graduates and appeared to be enthusiastic and well trained.

In the last week of February 1992, a three-day training program was conducted for all literacy teachers. The training program focused on improving the registration system, planning for the next semester, and arranging for the May 1992 examination.

Participants in literacy training are enrolled according to criteria established during the project planning phase and incorporated in program documentation. In general, they are young married women, at the beginning of their reproductive cycles with a low parity. The average age of current literacy participants is 27, with an average parity of 2.

The program has made a considerable effort to ensure that a strong association is made between literacy and family planning, and figures support this: of the 219 participants who have completed the course, 16 were acceptors on entry into the course; by the time they completed the course, 44 were acceptors. Given the very low socioeconomic status of the women, it can be presumed that only a small number of these women would have become acceptors without the catalytic effect of the literacy program.

3.4 Organizational Structure and Activities

3.4.1 Organizational Autonomy

Although this project labors under the same funding constraints as does the CASC project (problems largely associated with having a single source of funding), its ability to function effectively is significantly enhanced by its association with CEDPA, particularly now that CEDPA has a regional staff member based in Egypt. This enables the project to draw upon a wide variety of technical and other support on a continuous basis, thereby increasing its flexibility and its ability to meet donor requirements and improving the quality of its outputs.

3.4.2 Leadership

The project is carried out under the overall responsibility of the BPESS, with the Bishop designated as the authorized official. No formally constituted policy-decision board exists, although one was

called for in the project design. The senior staffing configuration of this project is the same as that of CASC. Unlike the CASC activity, however, the project director has direct authority over the project coordinator, located in Aswan. The project coordinator, in turn, is responsible for the six center directors, to whom report the literacy, income generation, clinical, and other staff.

3.4.3 Management and Administration

Supervision. Since the BPESS project is complex and innovative, effective supervision is especially important. In theory, the supervision system works as follows:

- At the central level, both the project director and the medical field manager should visit all six centers every four months. Of his four visits, the project director makes one supervisory visit per year; the other visits are made in collaboration with visitors, donors, and consultants.
- From Aswan, the project coordinator must either travel to centers or bring center directors to a general meeting on a monthly basis in order to get monthly reports and to cover other administrative issues. He must visit all six centers every two months.
- The literacy consultant visits each center on a quarterly basis to review technical aspects of the literacy activity, conduct on-the-job training, and assess training needs for the next formal training program, which he personally implements.
- The income generation activity is monitored by the project coordinator, who, prior to his appointment to this role, was the income generation consultant for 16 months.

Although administrative supervision appeared to be relatively good, medical supervision from Cairo was limited. This is attributed to the funding delays which have constrained travel to Upper Egypt.

A supervision and monitoring system has been conceptualized, but not yet committed to writing in one coherent document. No written guidelines for field visits currently exist in either the medical or administrative area.

Although the project has a supervision and evaluation plan to improve project effectiveness, the development of quality of care guidelines and the establishment of evaluation systems for women's development activities (both called for in the logframe outputs) have yet to be realized.

Two objectively verifiable indicators of the project were an outreach manual to be developed, printed, and distributed to fieldworkers, and written administrative guidelines. There was no evidence that such materials existed or were used.

Training. One of the logframe objectives of the project is the establishment of "comprehensive and precisely focused" training programs for all project participants. The training program has focused on the development and upgrading of staff knowledge and skills. All training is based on a regular process of needs assessment and is therefore carefully focused. The training officer makes field visits twice a year to assess staff needs.

A brief synopsis of the training programs shows that short courses were held from November 1990 through April 1992 in various sites on subjects such as infection control; contraceptive technology; communication, counseling, home visiting; planning; and laboratory training and laboratory refresher.

In the workplan covering the period January 1992 through March 1993, emphasis was also placed on the training of center directors. It was felt that the regular meetings held by the project coordinator with center directors could be used as a venue for this training. In March 1992, the training officer visited Aswan to participate in a center directors' meeting and to conduct a training needs assessment. Topics seen as future needs were the management of small groups, planning and periodic plan updating, improvement of communication skills, and staff motivation. It was planned to conduct the first center directors' training in these areas in April 1992, but the activity was delayed due to lack of funds.

In early 1992, the project adopted the Egyptian National Family Planning Guidelines made available through the Ministry of Health. Two of the project physicians attended a training program on the guidelines conducted in conjunction with CASC in Cairo in March 1992. Copies of the written guidelines were not evident in the clinics visited.

In summary, although the training schedule was seriously compromised by the lack of funds, some training activities were conducted. Senior staff report a strong commitment to the didactic and practical training described in the Project Paper, and they are eager to resume training activities when funding makes this feasible.

Management Information. Some management information is available, but the computerization of management information is expected to increase the value of the information by accelerating analysis of data and its feedback to the program managers.

One of the major outputs of this project is the establishment of an outreach program to make home visits in an effort to recruit and educate acceptors, to provide non-clinical contraceptive supplies, and to make clinic referrals. This system is in place and the data from the system are reported on a monthly basis to the regional office in Aswan and then to Cairo.

Commodities. BPSS reports quarterly to CEDPA on amounts of commodities dispersed and numbers of clients referred during the reporting period. It also reports quarterly on revenue earned on the sale of commodities and services performed during that period. The central records for BPSS commodities are maintained in the Aswan suboffice by the project accountant. He is also responsible for projecting needs for program supplies. The project is decentralized in this respect, and the record keeping for commodities and services is superior to that of CASC. It should be noted that the main portion of the clinic register found in every clinic includes among other information the literacy status of the client.

3.5 Family Planning Activities

3.5.1 Background and Logical Framework Objectives

The first output for the project is to establish and maintain quality family planning services at each of the six centers. In order to assess the quality of clinic management and services, site visits were made to five of the six clinics at Aswan, Daraw, Qus, Komombo, and Naqada. In addition, documents

related to the planning, development, and implementation of the project were reviewed in conjunction with the executive director, one of the medical field managers, and the project coordinator in Aswan.

3.5.2 Overview of Activities

Each of the six clinics provides services five days a week, four hours per day. Clinic sessions are generally held during the late afternoon or evening. Each clinic is staffed by a physician, a nurse, two or three fieldworkers, an income generation coordinator, and a literacy teacher. Staffing was consistent with the plans set forth in the Project Paper.

The fieldworkers visit women in their assigned areas to discuss family planning with them, to provide non-clinical contraceptive commodities, to resupply continuing acceptors with oral contraceptives, and to refer new acceptors to the clinic for medical assessment and choice of contraceptive method. The local literacy teacher and/or income generation coordinator often accompany the fieldworkers on initial home visits in order to invite the women to participate in the other programs offered.

Fieldworkers have had a difficult time in this project, with several reports of fieldworkers feeling unsafe when making home visits on their own. The solution to this problem has been for the fieldworkers to pair up for home visits from some clinics, which necessarily reduces their productivity. The fear of working on their own and the part-time work hours contribute to less than optimum morale. This is problematic in a program in which the fieldworkers are the foundation of the motivation and recruitment process.

The nurse generally receives the women when they enter the clinic, registers them, and provides some information about contraceptive methods prior to consultation with the physician. Her major role is in infection control, and making sure the clinic is kept clean. The physician performs a general and a pelvic examination for each woman, and counsels her about the most appropriate method for her. If an IUD is selected, the physician inserts it at that time and schedules a return visit one week later.

3.5.3 Staff Training, Experience, and Client Assessment Skills

Three physicians were interviewed to assess their training, experience in family planning, and client assessment skills. One is a resident in gynecology and one is a gynecologist; both have had attended multiple training courses and rated excellent on training, experience in family planning, and client assessment skills. The third physician was rated as having good training and experience and good client assessment skills.

Of the eight fieldworkers interviewed, three need improvement in their training, three had good training, and two had fair training. With regard to experience in family planning, two had excellent experience, four had good experience, and two were newly hired and had little experience. Client assessment skills were equally variable, with two needing improvement, two excellent, and four good. Again, this job is the foundation of the recruitment effort for family planning, and the relatively low level of training and experience does not afford these fieldworkers the opportunity to do their jobs as well as they might. Most expressed strong interest in obtaining additional training, and most reported using their meetings with the physician to improve their level of knowledge. One of the fieldworkers is based in a village two and one half hours from the Daraw clinic, and carries out her work independently except for her weekly visit to the clinic for staff meetings. She is functioning in

a more traditional CBD role, prescribing oral contraceptives and administering injectables, but without the level of training that is needed to prepare her for these responsibilities.

Only two of the clinics had a nurse on staff, one of whom had excellent training and experience in family planning, and good client assessment skills; the other had good experience and training and fair client assessment skills. Both were very conversant with infection control measures and carry them out without problems.

3.5.4 Supervision

Administrative supervision is meant to be provided at all clinics on a monthly basis, during which commodities are delivered, reports reviewed and collected for the central office, and any administrative concerns raised by the center director or staff are addressed. One of the centers had excellent supervision, three had good supervision, and one had fair supervision.

Clinical supervision is meant to be carried out every two to three months by the medical field manager who is shared with CASC; however, funding delays have constrained the travel budget, and these visits have not been conducted in Upper Egypt. This has left all clinics needing improvement in clinical supervision, which has only been available when the medical field manager accompanies consultants to the field. Visits by the CEDPA medical consultant have focused on infection control procedures, which now appear to be firmly in place.

3.5.5 IEC Materials

IEC materials for distribution and use in presentations by the staff need improvement in all centers. Although it was reported that fieldworkers use an educational flipchart, none was seen at any of the centers. It was also reported that outreach manuals are at each clinic, but none was seen. No printed materials were seen, and only the fieldworkers report that providing information outside of the clinic itself is part of their role. Other staff are informally involved in educating friends, families, and colleagues about family planning. At least one family planning poster was displayed in each clinic.

3.5.6 Logistics, Supplies, and Medical Equipment

Commodity systems were good in all clinics (with no stock-outs reported), good storage, and workable inventory systems, but there were no "bin cards." No outdated commodities were noted.

Medical equipment was checked for quantity and quality, and physicians participated in the evaluation of the equipment at hand. In all five clinics visited, the equipment was rated as good.

3.5.7 Clinic Facilities

Clinic facilities were good in all five centers visited according to the indicators used by the evaluation team.

3.5.8 Record Keeping and Service Statistics

Fieldworkers keep records of their visits and the commodities they distribute, and transfer the information to client records when they return to the clinic. Physicians keep records of medical

findings for each client, but the actual transcribing of information is not always done by the physician. Client record keeping was good in four of the clinics visited and fair in one, with some variability in the systems used to maintain records. Records were easily available for review, and kept in an orderly manner; the extent of information contained in them was variable.

Reports are submitted to the project coordinator based on client service statistics that are gathered from client records. The project coordinator reviews the reports and submits them to the central office.

3.5.9 Client Satisfaction Assessment

An assessment of client satisfaction was limited to one interview, and the client rated the services and attention she received as excellent.

3.5.10 Quality of Services

Choice of contraceptive methods. Each clinic has the full range of methods that are approved for use in Egypt and available through the suppliers indicated in the Project Paper.

Provider-Client Information Exchange. As in the CASC program, fieldworkers are selected from the communities served by the clinics, and while they are generally representative of the more educated and higher socioeconomic level, they present themselves as able to understand clients' concerns and questions, as well as to provide information at a level appropriate to the woman being addressed. Physicians have varying amounts of training in counseling women about contraceptive choice, and this often determines the degree of collaboration about choice of method versus prescription based on the physician's opinion.

Provider Competence. As noted in Section 3.5.3, client assessment skills vary among the nurses, fieldworkers, and physicians. Competence is based on training and experience, and these have been compromised for fieldworkers due to drastically scaled-down training activities, and little on-the-job training and supervision. Physicians vary in their competence based also on training and experience. Nurses have primary responsibility for infection control and cleaning, with less direct service provision. Their counseling and education skills are limited by their lack of training in these areas, although they are well able to carry out the infection control, record keeping, and supervision of cleaning required.

Although baseline qualifications are described for each job category, as in the CASC project, availability of qualified personnel is often based on location of clinic, salary of job, and number of hours of work offered. This has led to a reduction of requirements in some job categories, which might not be a problem if supervision and training were happening as planned. Again, it has not been possible to hire female physicians in all clinics, but this does not seem to have had a negative impact on the project.

Technical competence is difficult to assess without observing the actual procedures being carried out, but inferences can be drawn from the descriptions of these procedures. Infection control practices were described by both physicians and nurses according to the guidelines developed recently with the CEDPA medical consultant. Physicians have learned how to insert IUDs either in their specialty programs or in training sessions provided by the program, and they appear to have a firm foundation of knowledge about the procedure and report a high level of technical competence and a low infection rate.

Mechanisms to Encourage Continuity of Use. Fieldworkers in this program also report a major emphasis on delivering new acceptors to the program, and often at the expense of following up on continuing acceptors. It is unclear whether this emphasis is supported by the program's objectives or by the program's view of the funder's objectives. The message, however, seems to be consistent, and when time is a constraint, continuing users are less actively followed up with home visits.

3.6 Project Impact

3.6.1 Population Targets

The purpose of this project related to service delivery (as described in the Project Paper) is to establish and maintain quality family planning services at each of the six centers. The project targets are 9,030 new acceptors over the life of the project, with a 60 percent continuation rate of contraceptive use.

Although it is not noted in the logframe, home visit targets for fieldworkers were set at 80 per month. A total of 19,156 home visits have been made since August 1990. About half of these visits can be termed productive in that they resulted in either a new acceptor or the provision of supplies to a continuing acceptor.

For the period August 1991 through July 1992, of 11,350 home visits, 23 percent resulted in a new acceptor, and 30 percent were follow-up visits for resupply. This rate of productivity (52 percent) might be improved if fieldworkers received the quantity and quality of training planned by the project, and if they felt able to conduct home visits singly rather than in pairs, and perhaps if they had more IEC materials.

New acceptor statistics are available through July 1992, and indicate that 5,283 new acceptors have entered the project (71 percent of whom were recruited through fieldworker home visits). This constitutes 58 percent of the program's target, with six months of funding remaining.

Revisits through June 1992 indicate that 5,256 visits were conducted with continuing acceptors. This probably indicates that continuing acceptors had more than one visit each. It is not possible to calculate the continuation rate using the number of visits; what is needed is the number of clients.

3.6.2 Method Mix

The method mix is approximately as follows: 74 percent of the acceptors are users of oral contraceptives; 11 percent are users of the IUD; 3 percent are users of injectables; and 12 percent are users of condoms, foams, and gels.

**4. Rural Community-Based Family Planning Subproject of the
Coptic Evangelical Organization for Social Services
(CEOSS)**

4. Rural Community-Based Family Planning Subproject of the Coptic Evangelical Organization for Social Services (CEOSS)

4.1 Background and Organizational Development

CEOSS is a private non-profit organization licensed by the MOSA, and the only one of the three subprojects fully registered with USAID. CEOSS began in December 1952 as an adult literacy project. In 1960, it was transformed into a comprehensive community social development organization. With headquarters in Cairo, it concentrated its services at first in Middle Egypt, then extended to the Cairo, Giza, and Qualubia governorates with 154 full-time staff. Services presently include adult literacy, Bible study for Christians, family life education, community health and family planning, agriculture, and income generation through economic development. Over the years, CEOSS has worked in more than 100 communities. Currently, 94 communities are being served, and the staff has expanded to nearly 400.

FPIA supported the family planning activities of CEOSS for over 15 years, until October 31, 1990. Since it began in 1975, the CEOSS family planning project has expanded from 1 village to 45 villages located in the Upper Egypt governorates of Minya and Assiut, and more recently a few villages in peri-urban areas near Cairo.

4.2 Project Purpose and Design

The purpose of the Rural Community-Based Family Planning subproject is to increase the quantity and quality of contraceptive use, while also increasing cost recovery to sustain CEOSS family planning services on a long-term institutionalized basis. It was believed that through the improvement of existing and the development of new cost-recovery measures and explorations with other funding sources, the CEOSS family planning subproject would be more capable of attaining financial self-sufficiency than the other two subprojects.

4.3 Key Project Developments to Date

4.3.1 Finances

As was the case with the CASC and BPSS subprojects, the implementation of this project suffered serious delays, primarily for bureaucratic reasons. The MOSA delayed the approval of the subproject until September 24, 1991 (almost nine months after FPIA funding ended). Because of the delay, the implementation plan and supporting budget required revision, and additional documentation had to be submitted. The cooperative agreement between USAID and CEOSS to implement the subproject was finally signed on April 16, 1992. Most activities and all scheduled technical assistance proceeded during the delays. Those that required cash outlay were either canceled or postponed.

The first reimbursement USAID check was received in August 1992, after USAID and CEOSS reconciled the amount previously provided to CEOSS by FPIA. The funds were for salaries,

training, IEC meetings, administrative expenses, and other direct expenses. A total of LE 212,387 has been borrowed by CEOSS so the program could remain active. The funds to renovate clinics and purchase a computer were delayed, and payment was made for only the most essential items such as salaries (primarily for doctors) and training.

4.3.2 Activities Provided under the Project

In terms of the objectives of the logframe, the project has done remarkably well considering that it operated cautiously with borrowed money:

- Five villages were added to the 28 existing villages which receive CEOSS family planning services.
- In terms of meetings conducted, the total targets were nearly accomplished; these included town meetings and meetings with mothers and grandmothers. The target for meetings with husbands was exceeded.
- Various training activities were completed (see Section 4.4.3 for a discussion of these activities).
- A variety of inter-agency agreements were established with the assistance of USAID.

As previously noted, the clinic facilities could not be renovated nor equipment purchased. Also, although it was hoped that there would be monthly computer generated service statistics, these were delayed because of the lack of funds to purchase the computer.

4.4 Organizational Structure and Activities

4.4.1 Organizational Autonomy

The CEOSS is remarkable in that although it operates entirely within the rules and regulations which govern all non-profit agencies licensed by the MOSA, its programs are so good and reputation so strong that it manages to operate with a high degree of independence and autonomy.

4.4.2 Leadership

CEOSS has a participatory management style with counsels, boards, and advisory groups at all levels taking part in decision making. This has led to the development of good leadership from the village on up. It should be noted that the founder of CEOSS continues to provide dynamic leadership as director of the organization. This continuity in leadership by a dedicated and charismatic leader has done much to establish the organization's excellent reputation.

4.4.3 Management and Administration

Planning. Planning is taken seriously at CEOSS. At the top level, a Three Year Plan has been produced for the community development sector covering the period 1993-1995, laying out the goals and objectives of the organization and specifying department directions. Planning takes place at all

other levels and includes workplans and supervision plans. The statement of work for the original project included a project training plan, a commodity procurement plan, a technical assistance plan, a project management plan, and a financial plan.

Personnel and Job Descriptions. CEOSS has a detailed and complete set of personnel policies and guidelines, and written job descriptions are available at all levels. The present head of the family planning program has strong support from senior management and appears to have a thorough knowledge of the family planning project and the village environment in which it takes place.

Organizational Change. CEOSS has learned from mistakes and has shed those activities that are redundant or no longer appropriate (such as an income generation project which had outlived its usefulness). It has also recognized the growing importance of environmental and ecological programs, and in the future will place increasing emphasis on new directions related to water, sanitation, air pollution, and reforestation. CEOSS is the only one of the three organizations with a department devoted to special studies and research. Such activities have the potential to assist the program in terms of efficiency and effectiveness.

Training. A major objective of the project is "improved capability to train village leaders, midwives, and CEOSS field staff." This been accomplished. The training program for family planning includes at least 20 separate training sessions for various CEOSS staff on a yearly basis. In addition, there are three training conferences for volunteer leaders at their staff center in Miniya; 150 training sessions for village leaders; and training sessions for influential men, midwives, and grandmothers, youth leaders, midwives and couples. The training covers the health and medical aspects of family planning, religion and family planning, the population problem in Egypt, communication, and how to deal with rumors about contraceptive methods.

Training objectives include the following:

- 110 village leaders — four training sessions were held for 132, and one session for 23 new leaders;
- 98 midwives — 40 were trained and provided with equipment;
- 98 influential men — 65 were trained; and
- 110 CEOSS staff — three weeks of concentrated training were provided for 120 staff, and 10 sessions were provided for female staff who are working primarily with family planning clinics.

IEC. Of the three subprojects, the IEC program of CEOSS is by far the most highly developed. Targeted for special efforts are women in their reproductive age groups, youth, grandmothers, midwives, husbands, and pregnant women. An annual IEC plan and monthly and weekly workplans are produced. All targets related to providing information in public meetings were met or exceeded, as this activity is considered essential to the community development educational effort.

4.5 Family Planning Activities

4.5.1 Logical Framework Objectives

The objective of this project is to provide improved quality of clinic facilities and services. In order to assess the quality of clinic management and services, site visits were made to four partnership communities (el Nasseria in Minia; el Motamedia and Hekr I and II in Cairo) and one follow-up community (Samalot East). In addition, meetings were held with the general director, the family planning project head, and the community development program director. Visits to more rural villages with functioning clinical facilities could not be made due to the timing of the evaluation in relation to the holiday time of community development staff who reside in the villages, and to the consequent scaling down of activities during the month of August.

4.5.2 Overview of Activities

CEOSS operates its program as a series of comprehensive community development projects. Villages apply to become partners in their community's development; if their needs are such that the project is able to work with them, a partnership is formed. This entails moving a cadre of 8 to 12 young, enthusiastic, university graduates into the village with one supervisor and supporting their efforts to become a part of village life in leadership roles. They survey each family in order to understand its needs, strengths, and problems, as well as the ways in which the family can contribute to the community and the ways in which new ideas can be brought to the family.

As village committees are formed to identify problems and solutions, different methods of solving problems are developed. For example, a family planning clinic requires a place for women to gather, an examining room for the physician, and storage space for equipment and supplies. This need is usually met by a family contributing the space in their home.

Clinics are held with varying frequency, depending on the needs of a community. In the rural village visited, the clinic was held once every two weeks for as long as it took to see the women attending. If a woman is in need of services between clinic sessions, she visits a gynecologist in a private clinic, often transported by CEOSS staff.² In Cairo, where the program also functions, the clinics are held weekly for at least three hours per session. One staff member, specifically trained in family planning, is the coordinator of the family planning activity in each community.

Unlike the CASC and BPESS subprojects, CEOSS assigns both male and female workers to villages. Female fieldworkers work closely with village women, and male fieldworkers focus on improving awareness and attitudes regarding family planning among men. The fieldworkers become intimately involved with families in the villages where they work, and they provide them with information and education about family planning, as appropriate in their relationships with the women. It is through these relationships that women become family planning acceptors. When the women first visit the clinic, records are established relating the family planning history and care, and general medical and pelvic examinations are performed by the physician. The physician, often in conjunction with a

²Contracts are developed with local physicians who provide family planning services to village women in their private clinics at CEOSS rates with vouchers from the village leaders and commodities that continue to be supplied by CEOSS. No contract physician was visited.

fieldworker, counsels the woman about the most appropriate contraceptive method for her. If an IUD is selected, the physician inserts it, and a follow-up appointment is made with the fieldworker and later with the physician.

This supportive environment is continued into the follow-up phase, when CEOSS is no longer resident in the village, but serves a monitoring function only. In this phase, women leaders who have been identified and trained during the partnership phase become responsible for visiting their neighbors and providing them with non-clinical methods, as well as information and education about family planning.

4.5.3 Staff Training, Experience, and Client Assessment Skills

Staffing is consistent with descriptions in the Project Paper. Staff are selected from among thousands of applicants on the basis of their commitment to community development, their leadership potential, and baseline qualifications as university graduates. A week-long orientation further refines the selection, and those candidates who are not appropriate do not continue. Physicians are selected from a nearby community, and whenever possible they are gynecologists.

Two CEOSS staff fieldworkers were interviewed. Both had good training and client assessment skills, one had excellent experience, and one had good experience.

Two physicians, one of whom works in two clinics, were interviewed. One of them had attended several training courses and was rated excellent on training, experience in family planning, and client assessment skills. The other physician has many years of experience in family planning, but has not taken any continuing education courses for many years, and her client assessment skills are limited.

4.5.4 Supervision

Administrative supervision is carried out weekly by a field assistant in family planning during which commodities are delivered, reports reviewed and collected for the central office, and any problems encountered by the staff in delivering family planning services are addressed. The head of the family planning effort visits monthly.

Medical supervision has not been a part of this program. Although clinical practices have not been identified as problematic, it was recently suggested by the CEDPA medical consultant that a part-time medical consultant be engaged to provide clinical review for the physicians. The project director is currently negotiating with an appropriate consultant, and expects to have one on board within two months.

4.5.5 IEC Materials

The IEC materials observed were of very high quality. Printed materials with writing and with pictures are plentiful, as they are produced by the CEOSS publishing house, and are freely available in the villages. All of the staff provide information and education outside of the clinic itself as part of their roles. Several monthly family planning informational meetings are held for men, women, youth, grandmothers, midwives, and couples. Educational materials include films (video and cinema), magnetic boards, flip charts, pamphlets, and brochures.

4.5.6 Logistics, Supplies, and Medical Equipment

Storage and commodity inventory systems were good in three of the clinics, fair in one. No stock-outs were reported or outdated commodities noted. Commodities are delivered on an as-needed basis by the field assistant who visits the clinic weekly for administrative supervision.

Medical equipment was checked for quantity and quality, and physicians participated in the evaluation of the equipment at hand. Two clinics had good equipment, one had fair, and equipment replacement was indicated at one.

4.5.7 Clinic Facilities

As noted in Section 4.5.2, clinic facilities are donated by village residents as part of their contribution to the community development effort, and are generally located in someone's home. Given the poverty criterion for CEOSS's entry into a community, it is impressive that three of the four clinics were rated good, and one was rated fair.

4.5.8 Record Keeping and Service Statistics

Extensive records are kept on each member of each family. The family planning clinic record is kept in the clinic and is used by fieldworkers when they make home visits to resupply clients or to visit for other reasons. It is also used by the physician to document her findings when she examines a client. Individual reports are folded into statistical reports on a weekly basis and given to the field assistant, who then prepares monthly and other reports for the project director. Physicians reported that the forms they had to use were not appropriate for good medical practices as too few and inappropriate questions were included.

4.5.9 Client Satisfaction

A client satisfaction assessment was done on the basis of three interviews in which two clients reported excellent experience with the services and attention received, and one reported good experience.

4.5.10 Quality of Services

Choice of Contraceptives. Each clinic has the full range of methods that are approved for use in Egypt and available through the suppliers indicated in the Project Paper. Fieldworkers and village leaders, as they become more experienced, work in conjunction with the client and the physician to help determine the most appropriate method for a particular woman.

Provider-Client Information Exchange. The fieldworkers in this social work centered project have a much broader job description than those in the other projects, as they are participating in a comprehensive community development effort, of which family planning is one aspect. The clinics visited were crowded with women, and fieldworkers circulated freely in the waiting areas, greeting and talking with the women. Relationships were clearly positive, with lots of good will and smiles. Services are provided to Muslim and Christian clients, both of which groups are represented at all levels of planning and program implementation.

Provider Competence. Competence is based on training and experience, and these have been provided in conjunction with close supervision for the fieldworkers in this project. They have not been provided so thoroughly for the physicians, and this is being addressed currently by the attempt to hire a medical consultant.

Fieldworkers are carefully selected from among a large number of applicants. A university degree is required, as well as assessed leadership potential. As noted above, a week-long orientation provides the candidates with an opportunity to assess themselves and to be assessed by others with regard to their appropriateness for this role.

Although it is required that a physician be a gynecologist in order to work in this project, it has not always been possible to meet the criterion. Villages are often isolated, offering few other opportunities to practice, and very few hours are required for the family planning clinic. This limits the number of qualified gynecologists who might work with the project.

Technical competence is difficult to assess without observing the actual procedures being carried out, but inferences can be drawn from the descriptions of these procedures. Infection control practices were said to be followed according to the guidelines developed recently with the CEDPA medical consultant. Physicians have learned how to insert IUDs either in their specialty programs or in training sessions provided by the program. They generally appeared to have a firm foundation of knowledge about the procedure and reported a high level of technical competence and a low infection rate.

Mechanisms to Encourage Continuity of Use. Fieldworkers in this project make several visits to women in the course of a week, talking with them about all the projects they are working on collaboratively. The fieldworkers are, therefore, always available to the women, and questions or problems related to family planning are a part of their everyday experience. That this constant contact is good for promoting continuation of use is reflected in the 95 percent continuation rate reported below.

4.6 Project Impact

4.6.1 Population Targets

The Project Paper of December 1990 calls for 19,050 new acceptors by the end of the project; the project director stated that this goal was renegotiated to 12,314 new acceptors to reflect the actual 20-month implementation period remaining. Against this target, the 8,203 new acceptors recruited constitutes a 66 percent achievement with nine months left in the funding cycle. Given the funding constraints, these achievements are acceptable.

The target for continuation of use was 80 percent, and it is reported that 95 percent of new acceptors have continued use beyond one year. The overall continuation rate for the long-term program is reported to be 80 percent.

4.6.2 Method Mix

Table 3
Method Mix
CEOSS Project

	Pills	IUD	Condom	Other
Acceptors	22,102	18,905	2,069	1,467
% of total	49.6%	42.4%	4.6%	3.4%

It appears from these findings that the program is encouraging the use of some more effective methods (IUD and pills), which would lead to fewer unplanned pregnancies. The inclusion of injectables in the program would add to the list of more effective methods and would presumably support the reduction of unplanned pregnancies.

5. Comparison of CEOSS, CASC, and BPSS Programs

5. Comparison of CEOSS, CASC, and BPSS Programs

The strengths and weaknesses of the service delivery approaches used by each of the subprojects were assessed on the basis of the following criteria:

Effectiveness. Is the subproject achieving satisfactory progress toward its stated objectives?

Efficiency. How do the costs of the program compare to the costs of other program options?

Impact. What are the positive and negative effects of the subproject?

Sustainability. Are the effects of the subproject likely to become sustainable development impacts; that is, will they continue after A.I.D. funding has stopped?

5.1 The CASC Approach

All three subprojects aim to provide comprehensive family care through family care clinics and fieldworkers. What makes the CASC approach different from the other two project approaches is that family life education is a major component of the CASC project.

5.1.1 Effectiveness

The subproject is not achieving satisfactory progress towards achieving the agreed upon logframe objectives. The organization's strengths remain its integrated medical facilities and follow-up and recruitment by fieldworkers. The system's weaknesses are in its supervisory and management systems, its slow implementation of training plans, and lack of cohesion and emphasis on family planning.

This project's special component, family life education, was substantially altered and changed during the life of the project. Had it been carried out as planned, however, there is no reason to believe that it would have produced significantly more family planning acceptors than the BPSS and CEOSS approaches due to the absence of specific family planning content in the family life education curriculum. Although family life education is a highly appropriate (church) activity, a project with this as a major component in the Egyptian context may not be cost effective unless the family life education includes major components of family planning motivational materials.

5.1.2 Efficiency

According to a recent study of the project's cost-effectiveness,³ the program was seen to have inordinately high costs per couple year of protection (CYP) as opposed to government clinic-based programs and social marketing approaches such as Family of the Future. For fiscal years 1988/89 and 1990/91, the church's total costs per CYP and subsidy per CYP were the highest of all service providers. In 1989/90, which is felt to be a more representative year as all data components were available, the total costs per CYP and subsidy per CYP were still in the high range of cost compared

³Report for the Bishopric of Public and Social Services (FPLA): Trends in the Costs of Its Family Planning Activities (July 1988-June 30, 1991). Martinkosky et al., August 1992.

to the other service providers. Although the CASC approach is based upon *both* fieldworkers *and* clinics it may be an expensive approach towards the achievement of purely family planning objectives. It should be noted, however, that all family planning is delivered in a poly-clinical setting so the other services may legitimize family planning.

5.1.3 Impact

The positive impact has been that the CASC system received some much needed outside assistance which was used to deliver additional services, train staff, and improve systems. A weakness has been that the erratic nature of funding and the pending termination of A.I.D. funding has led to a decline in subproject staff morale.

5.1.4 Sustainability

The CASC system has no major sustainability component. However, a strength of the system is the decentralization and quasi self-sufficiency of some of its medical facilities. These facilities open and survive, to some extent, based on their ability to generate income from a variety of local resources including patient fees. In addition, contraceptive commodities are provided at a cost which varies from clinic to clinic, depending on the socioeconomic status of the community being served. A revenue fund agreement with USAID allows the project to retain its funds in order to subsidize project operations. Also, unlike the BPESS project, in which the clinical family planning facilities are entirely dependent on USAID funding, at least some of the local CASC centers may survive and continue to provide family planning services from their own resources after USAID funding stops.

CEDPA plans to begin discussions about sustainability shortly. Discussions will consist of further visits to potential donors to gain a sense of who is out there and what they would be willing to fund; a workshop will be held to plan the new programs; concept papers will be drafted and taken to donors for feedback; and finally, detailed project proposals will be developed and submitted to donors. This process is expected to be completed by the end of 1992 or early 1993, in the hopes that some means can be found to continue activities in the interim period between October 31, 1992 and the next donor.

Even though CASC has no written plans related to sustainability, and appears to be totally dependent on donor funds, the church has a number of revenue-generating activities (e.g., clinical medical and other facilities) with which it could support these programs, if it had a strong commitment to family planning.

5.2 The BPESS Approach

Although this subproject styles itself as having a family planning and community development approach, it is perhaps a misnomer to think of it as a community development project in the classic sense. What makes the BPESS approach different and innovative is not "community development," but the combination of women's development, family planning service delivery, literacy, *and* income generation activities provided by the same center. The literacy program has shown its utility in promoting family planning. It would be premature to judge income generation activity as no significant work in this area has taken place.

5.2.1 Effectiveness

Much work needs to be done in income generation, but clinic activities are well under way; home visits are institutionalized as a means of motivating new acceptors and resupplying continuing users; literacy activities are of high quality and offered at six sites; and administrative systems as well as local supervision and monitoring systems appear to be working.

5.2.2 Efficiency

The fundamental assumption underlying this project is that *both* increased education and increased income may affect the desired family size of rural women and presumably their spouses. Certainly a wife's earning capacity may have a somewhat ambiguous role in a short-term project such as this, but the hypothesis is that cash income may be positively related to contraceptive acceptance in the long term. It is assumed also that the empowerment of women through education — even in as simple a fashion as literacy courses — will be associated with contraceptive acceptance. Worldwide, women with primary education are much more likely to use family planning than women with no education. Women who can read and write may be more likely to use family planning services than those who cannot, particularly if such services are readily available. One of the most attractive aspects of the BPSS subproject is that literacy and family planning services are available at the same location, and in the future those same centers will house income generation projects.

Although it is conceivable that this approach (a truly integrated one) may be expensive in terms of the number family planning acceptors it achieves, the alternatives need to be looked at. In communities which are essentially pro-natalist, where child marriage is common, and where contraceptive prevalence is low, it seems unlikely that a standard vertical clinical approach (such as has been tried elsewhere) will work even with a strong IEC program.

5.2.3 Impact

The positive impact of this project is that six entirely new and useful development and family planning activities have been established in areas characterized by low contraceptive prevalence, low literacy rates, and little opportunity for women to earn any income. So far as can be determined, this project has had no negative effects, although the income generation staff and the community are discouraged by the delays in the initiation of income generation activities.

5.2.4 Sustainability

This project is unlikely to survive the cessation of A.I.D. funding. The centers established in Upper Egypt are entirely USAID funded, and they will not generate enough revenue to survive should further donor assistance not be forthcoming. Nonetheless, some income will be available, when and if the income generation activities come into being and a cross-subsidy becomes available for the clinical services. It is unlikely, however, that profits from the income generation activities will ever form a major part of the clinic budgets of BPSS. As is the case with the CASC project, CEDPA plans to begin discussions about sustainability in the near future.

USAID might wish to consider providing additional funds to CEDPA to continue to support and possibly expand this project after the project completion date. An internal end-of-project evaluation by CEDPA might usefully precede such an activity.

5.3 The CEOSS Approach

All three subprojects have elements of community-based distribution. What makes the CEOSS subproject most interesting is that it is a true community development project in which the initiation of family planning activities is the result of the felt needs of villagers themselves. It is this basic "bottom-up" approach that makes it different from the other two subprojects.

5.3.1 Effectiveness

The project is achieving satisfactory progress towards its stated objectives particularly with regard to new acceptors, continuing acceptors, informational meetings, training of staff and village leaders, and new and improved approaches to income generation. Weaknesses are shown in the purchase of equipment, renovations, and the computer purchase, all due to funding delays.

5.3.2 Efficiency

It is impossible to determine whether the CEOSS approach is cost efficient, particularly when compared to the two other subprojects. Funds have not become available for any of the subprojects until recently. More importantly, in the case of CEOSS, family planning services are only one component of a total village development activity in which each element reinforces the other. It should be noted that a study by E. Petrich and Associates⁴ on the costs of family planning for CEOSS indicates that the CYP costs estimated within the CEOSS project were probably relatively low. Indeed, CEOSS's cost per CYP appears to be at the low end relative to the highest and lowest costs per CYP of all the service providers working in the non-profit sector. CEOSS's total cost per CYP was LE 17.65 in 1988/89 as compared to a low of LE 8.36 and a high of LE 92.95 by other agencies. These estimated costs, which seem accurate as the *actual* family planning expenditures, have probably been disaggregated by CEOSS.

The CEOSS approach (and USAID does not pay for the total CEOSS approach) within which the family planning program operates, and on which it is totally dependent, is not inexpensive as it involves a variety of non-family planning program interventions of great importance to the success of the family planning effort. In the case of the BPESS project, for example, USAID is paying for the costs of the entire integrated approach — literacy, income generation, and family planning. In the case of CEOSS, other donors are paying for the many other interventions (such as literacy training and income generation which are also part of the CEOSS project) which make the overall approach such a success.

Literacy may quite independently have a population impact. One study,⁵ covering 24 Asian countries, compared the effects of increasing family planning program effort with the effects of changing specific socioeconomic indicators. The researchers calculated that, if family planning staff were doubled, a program would gain 18 additional acceptors per 1,000 eligible couples each year. If the literacy rate doubled, the program would gain 16 additional acceptors per 1,000 eligible couples.

⁴Report for the Coptic Evangelical Association for Social Services (CEOSS): *Trends in the Costs of Its Family Planning Activities*. Martinkosky et al., August 1992.

⁵G.D. Ness, I. Johnson, and S. J. Bernstein. *Program Performance: The Assessment of Asian Family Planning Programs*. Ann Arbor, Michigan. Center for Population Planning. October 1983.

The researchers did not calculate the costs of doubling family planning staff or doubling the literacy rate, but they assumed that doubling literacy would be more difficult and more expensive than undertaking efforts in family planning.

5.3.3 Impact

The results of A.I.D.'s intervention are entirely positive. It seems likely that A.I.D.'s promotion and support of an integrated project which satisfies, to some extent, the felt needs of rural women in three basic and important areas of their lives will do much to promote family planning in Upper Egypt.

5.3.4 Sustainability

Although it has no formal sustainability plans,⁶ CEOSS has significant potential with regard to sustainability primarily because family planning is a high priority within the organization, and because the CEOSS approach has attracted the attention of a large number of international donors. The organization's records show that approximately LE 25,000 has been generated over the past six months through the sale of medical, contraceptive, and related services. Some of these funds will be allocated to support family planning activities. A number of international donors have already received draft proposals from CEOSS for continued support of its maternal and child health/family planning activities. With CEDPA's continued support, additional donor funds will probably be located to cover the project once A.I.D. funding ceases.

Not only will CEOSS find the wherewithal from its own or other donor resources to support family planning services, but those who have started contracepting will in all likelihood continue to do so (in the graduate villages) whether or not CEOSS services are available.

5.4 Lessons Learned

Although a number of lessons learned are generic to all three subprojects, it should be noted that the lessons and the experience from these projects cannot easily be reduced to simple universal rules because good management in Egypt is more of an art than a science. Ultimately, good management and good clinical services are what works. In the case of these three subprojects, funding and other constraints were so great that it is difficult to make generalizations about what has worked and why.

5.4.1 Project Design

Local, social, cultural and religious environments create special parameters which donors must understand during the design of complex comprehensive family planning subprojects in Egypt. Projects require a longer duration to achieve their objectives, greater flexibility to change direction as changes and impediments occur, and a far more secure commitment of financial resources over a longer period of time than has been given in the past. Project designs should include the quantification of local inputs whether in cash or kind.

⁶At the team's first meeting with the general director of the project, he stated that he was unaware the project was coming to an end in May 1993. It is, therefore, understandable that there are no formal sustainability plans.

5.4.2 Management Factors

Subprojects that are located in remote or isolated areas require a certain degree of autonomy and independence over their own resources to respond effectively to local needs and demands. At the same time, they also require adequate financial, technical, and logistical support if they are to meet their objectives.

In addition, from the very start of donor-funded family planning activities donors should attempt to instill a greater sense of project ownership on the part of PVOs. This ownership is not facilitated if the donors attempt to intervene too directly in ongoing operations, or if they impose excessive and/or changing bureaucratic requirements on the agencies.

5.4.3 Administration

Excellent monitoring and feedback are, of course, essential to the successful implementation of projects especially if a "learning approach" is utilized — as in the case of CEOSS. Both CASC and to a lesser extent BPESS have relatively simple, informal, indigenous management systems at the service delivery level (most of which is not in written form) which may in some instances be more appropriate and effective than more formal systems.

5.4.4 Sustainability

Although the three subprojects evaluated are relatively new, the organizations which run the projects have been receiving funds for some aspects of their family planning work for over 10 years. This being the case, the organizations need to increase their efforts to find ways to increase the mobilization of public and private resources and to improve allocation of existing resources to family planning throughout the lives of their projects. There must be a continuous and active involvement by PVOs with efforts toward sustainability. Certainly, additional emphasis needs to be given at all stages of subproject design and implementation to the issue of recurrent costs. Appropriate procedures for accessing and dealing with non-donor costs of the project need to be an integral part of each subproject's management system. Although A.I.D. has made sustainability a major focus of both the BPESS and the CEOSS subprojects, it is obvious that the donor's concern was not fully appreciated by the two agencies. In the future, greater care must be taken to assure that A.I.D.'s priorities are well understood before project agreements are signed. This priority needs to be reiterated throughout the life of each project.

6. Conclusions and Recommendations

6. Conclusions and Recommendations

6.1 Conclusions

Sustainability/Finance

1. The designs of the three projects were unrealistic in their expectations for income generation activity and self-sustainability.
2. Delays in funding will result in unexpended funds and uncompleted outputs for CASC and BPESS at the end of the projects, which appears to warrant no-cost extensions for them.
3. The agencies have become very dependent on donors in part due to the failure of the donors to create partnerships in terms of personnel and funding contributions by the agencies.
4. To date, CASC and BPESS have given limited attention to sustaining their operations beyond the A.I.D. funding period. CEOSS is actively involved in seeking other donors to support its family planning activities.

Program Approach

5. The priorities of CASC for its comprehensive family care program do not seem to include family planning as a major component. Future plans to promote family planning service delivery should be viewed with caution.
6. CEOSS and BPESS have the potential to affect the lives of numerous Egyptian families in a permanent way through the promotion of social change from the bottom up. Although their contribution to the solution of Egypt's population problems may be limited, the projects represent the best that the private non-profit sector has to offer.
7. The BPESS project represents an interesting innovation in Upper Egypt, combining literacy and income generation activities, both of which may be tied to contraceptive acceptance and to empowering and improving the status of women.
8. All of the projects were notable for their commitment to outreach and follow-up, and for their efforts to ensure client satisfaction through good services.
9. Family planning activities promoted by religious institutions appear to have a great deal of credibility and acceptance by Egyptian women and men.

Management and Information Management

10. The absence of continuous management development assistance in the early days of CASC and BPESS has handicapped both projects in relation to program

implementation and planning. The recent addition of a resident regional advisor from CEDPA, though perhaps costly in the short term, may help to prepare the projects to carry on beyond this funding cycle.

11. Many issues could be profitably studied through operations research activities, the results of which might contribute to the improvement of services. Examples include identification of hours for high-volume attendance at clinics, impact of marital status on effectiveness of outreach workers, and cost-effectiveness of mobile units.
12. CASC and BPSS appear to lack important information and are unable to analyze the information they do have about their programs in order to use it in operating, planning, and monitoring their activities. CEOSS, on the other hand, demonstrates that it evaluates the effectiveness of its programs and makes decisions about continuation of programs based on their effectiveness.

Quality of Care

13. Although the evaluation team was informed that guidelines and protocols for medical practice were in use at the clinics, there was no evidence of their presence.
14. Medical information about clients is not adequately recorded, which compromises the physician's ability to provide high-quality services. At CEOSS, the forms did not ask for the appropriate information; at BPSS, the forms were not completed by the physician.

Evaluation Constraints

15. It was difficult to conduct a rigorous assessment of program performance and impact because the current definitions of new and continuing acceptors allow women to be counted more than once in different programs serving the same geographic area.
16. The bureaucratic and financial delays in the CASC, BPSS, and CEOSS projects were so significant that many of the activities that were meant to be evaluated had not yet been undertaken, and thus could not be evaluated.
 - a) Training was a major component of the three project designs, and plans were made to collaborate with various training centers, but the lack of funding prevented implementation of most training activities for CASC and BPSS.
 - b) CASC and BPSS were meant to develop and implement supervision and evaluation *systems*. Although supervisory activities are occurring, they are not being done systematically, resulting in little follow-through in problem areas.

Recommendations

Recommendations are presented in priority order, as follows:

1. Funding should be continued for CASC and BPESS until the end of May 1993, when the Population/Family Planning II Project comes to an end.
 - a) USAID should provide no-cost extensions to CASC and BPESS to enable them to accomplish specific outputs agreed upon by the project and USAID. Particular attention should be given to management development, implementation of training and supervision plans. CEDPA should coordinate and provide technical assistance.
 - b) CASC and BPESS should demonstrate their commitment to the projects and enhance the likelihood of self-sustainability by making a significant contribution of personnel and funding in order to facilitate approval of the no-cost extensions.
2. To the extent possible, CASC, BPESS, and CEOSS, with CEDPA's assistance, should design reporting requirements to re-focus analysis of effectiveness on couple years protection rather than the number of new and continuing acceptors in each program.
3. CASC, BPESS, and CEOSS, with the assistance of CEDPA, should each examine and analyze the internal resources it can bring to support family planning. Concurrently, each agency should develop a plan to approach the international donor community, particularly UNFPA and The Population Council (see Appendix H for a discussion of alternative sources of donor funding).
4. With the implementation of the Population/Family Planning III Project, USAID and the Ministry of Health should develop a revenue agreement that will allow the provision of A.I.D.-donated commodities to continue to the agencies at no cost, and the agencies should continue to retain revenues from the sale of the commodities. The Ministry of Health would be responsible for monitoring compliance with the revenue agreement.
5. CASC, BPESS, and CEOSS, with CEDPA's assistance, should place more emphasis on improving the quality of medical services they provide, including documentation of history, physical examinations, and adherence to the National Family Planning Guidelines for Egypt.
6. BPESS, with CEDPA's assistance, should implement income generation activities immediately in order to generate income to support the women participating and the program's clinical operations.

Appendices

Appendix A

Evaluation Scope of Work

Appendix A

Evaluation Scope of Work

A. ACTIVITY TO BE EVALUATED

Project: Population/Family Planning II (263-0144)

Subprojects to be evaluated:

1. Comprehensive Family Care Subproject of the Coptic Association for Social Care (CASC);
2. Upper Egypt Family Planning and Community Development Subproject of the Bishopric for Public, Ecumenical and Social Services (BPSS);
3. Rural Community-Based Family Planning Subproject of the Coptic Evangelical Organization For Social Services (CEOSS)

PACD:

1. CASC: 10/31/92
2. BPSS: 3/31/93
3. CEOSS: 5/31/93

TA Contractor: Centre for Development and Population Activities (CEDPA)

Period to be Evaluated:

1. CASC: 11/1/90 - present
2. BPSS: 3/1/90 - present
3. CEOSS: 10/1/91 - present

Period of Evaluation: Four weeks late July - September

Project Purpose:

1. CASC: To increase contraceptive use by serving 20,330 new and 38,358 continuing acceptors through static clinics, mobile teams and community-based fieldworkers.
2. BPSS: To increase contraceptive use, to improve the level of female literacy and to improve the income generation potential of women located in the target areas of Qena and Aswan.
3. CEOSS: To increase the quantity and quality of contraceptive use, while increasing income generation to sustain CEOSS FP services on a long-term institutionalized basis.

Copies of the Logical Frameworks for each subproject are attached to this Scope of Work (SOW).

B. PURPOSE OF THE EVALUATION

The purpose of the evaluation is to 1.) determine the progress of each organization toward meeting the stated sub-

project goals and objectives; 2.) document the lessons learned from the approaches of each subproject; and 3.) review progress toward sustainability after USAID funding ends.

C. BACKGROUND

Egypt's annual population growth rate, currently reported by CAPMAS to be 2.54 percent, remains one of the central constraints to the country's economic growth. Family planning activities have attained substantial success in recent years. The total fertility rate (TFR) fell from 5.2 in 1980 to 4.4 in 1988. The contraceptive prevalence rate (CPR) increased from 24 to 38 percent between 1980 and 1988. The Ministry of Social Affairs, through its network of registered Private Voluntary Organizations (PVOs), has been the major sponsor of family planning services in the non-government, not-for-profit sector.

Although the community-based efforts of the PVOs play an important role in legitimating family planning in the eyes of the communities, their contribution to contraceptive prevalence in Egypt is low. Therefore, under the strategic approach adopted by the follow-on Population/Family Planning III Project, the subprojects scheduled for this evaluation will be not be continued. Rather other donor funds will be sought to continue support to these associations, and opportunities for funding under the USAID PVO Project will be examined. The information gained in this evaluation will assist, among other things, in guiding the continued contribution of these organizations to family planning in Egypt after the end of the specific USAID-supported subprojects. The following paragraphs provide specific background information on each of the three subprojects to be evaluated.

The Comprehensive Family Care Subproject (CFC) of the Coptic Association for Social Care (CASC) is a subproject the activities of which were previously funded through Family Planning International Assistance (FPIA) to the Bishopric for Public, Ecumenical and Social Services (BPSS) until October 30, 1990. CASC has a close relationship with the BPSS which enables CASC to use BPSS facilities to implement the clinical work of the subproject. The planned level of funding for local costs is LE 1,898,738. The subproject was designed to extend family planning services to eleven governorates in Egypt. Through a consolidated network of 25 family care clinics, 3 mobile teams and 130 fieldworkers the

CFC subproject was to serve 58,688 new and continuing clients from November 1, 1990 through October 31, 1992. CASC was to open two new clinics and one mobile unit to serve low prevalence villages and towns in Upper Egypt. CASC was to strengthen its institutional capability through the implementation of a strong training program designed to improve staff skills at all levels. Finally a new training program in Family life Education was to be implemented in order to educate women and youth leaders about the importance of good family relations and planning their families which can contribute to creating demand for family planning services in the future.

Since 1973 the Coptic Orthodox Church has implemented a family health program serving approximately 7,000 - 9,000 new contraceptive clients per year. The emphasis of the current subproject is to improve services to clients, develop quality of care and monitoring systems, improve cost-effectiveness and implement cost recovery plans. Fees are charged for services at all centers. Revenue from the centers is placed in special revenue funds and these funds are to be used to support equipment needs and other administrative costs as specified in the Revenue Agreement. By investing in the capital needs of the subproject, the development of human resources, and the improvement of management systems, CASC is planning for the short term impact in terms of cost effectiveness and quality of services, and a long term contribution to the sustainability of the program.

This is the first time that CASC is receiving funds directly from USAID. A pre-award financial assessment was conducted by Shawki and Co. which determined that financial systems were satisfactory to handle USAID funds.

Project Implementation Letter (PIL) No. 32 which approved the subproject and committed funds for the first year of the subproject (November 1, 1990 - October 31, 1991) was delayed in the Ministry of Social Affairs and finally signed by the Minister on September 23, 1991. This has caused delay in some subproject activities. A Revenue Agreement is in place between CASC and USAID to cover the disposition of revenues from the sales of USAID-donated contraceptive commodities.

The Upper Egypt Family Planning and Community Development subproject is implemented by the BPSS through a buy-in to the CEDPA centrally-funded Cooperative Agreement. At the design stage it was estimated that 9,030 new family planning

acceptors would have been served with an estimated 60% continuation rate by the end of the subproject. Similar achievements were anticipated in female literacy and income generation. Approximately 405 women were expected to participate in literacy training.

In Upper Egypt, the contraceptive prevalence rate (CPR) has consistently lagged behind the rate for Egypt as a whole. According to the 1988 Demographic and Health Survey (DHS) the CPR for Aswan was estimated at 18.8% and for Qena it was estimated at 12.2%. The status and role of women are believed to contribute directly to the low CPR. Since Upper Egyptian women marry at an average age of 15 years and 10 months, they receive little formal education. They have lower rates of literacy. They have fewer skills and are unable to contribute to the economic well being of the family.

The Upper Egypt Family Planning and Community Development Subproject was designed to address these obstacles to family planning practice through a BPSS innovative approach to family planning service delivery within a community development framework. The subproject was designed as a community-based program which integrates four components: clinical family planning services, literacy training, income-generation/practical skills and outreach/health education. The subproject headquarters are located in Komombo, Aswan Governorate. Three subproject centers are located in Aswan governorate and three subproject centers are located in Qena governorate. Each subproject center provides family planning services (both through clinics and through field workers) and literacy training. Income generation activities have recently begun and are being implemented according to a modified plan. Family planning acceptors are to be given priority for both literacy training and income generation training.

A key feature of the subproject was to be the long term goal of financial self-sufficiency. Toward this end fees are charged for services. Revenues collected from services and a small agreed upon percentage of income from the income generating activities are to be placed in a special revenue fund. Plans and projections are to be prepared for eventual financial sustainability to carry on subproject activities after the termination of USAID support. This subproject is part of the BPSS' comprehensive strategy to improve the quality of life for the very poor in remote areas of Upper Egypt. This subproject was established and managed independently from other BPSS programs.

There has been progress in meeting most of the subproject outputs with the help of technical specialists provided through CEDPA. Quality family planning services have been established and maintained at six centers in Aswan and Qena. A literacy program for women has been established and is ongoing at each of the six centers. An outreach program was established and is ongoing at each center for home visits to educate and recruit acceptors, to provide non-clinical contraceptive supplies and to make clinic referrals. A supervision and evaluation system has been designed and is being implemented to assure subproject effectiveness, quality of care and constructive women's development activities. Comprehensive and precisely focused training programs have been developed. A Revenue Agreement is in place between BPESS and USAID to cover the disposition of revenues from the sales of USAID-donated contraceptive commodities.

The activities of the Rural-Based Family Planning Subproject of the Coptic Evangelical Organization for Social Services (CEOSS) were previously supported for over fifteen years by Family Planning International Assistance (FPIA) until October 31, 1990. Since it began in 1975, the CEOSS family planning project has expanded from one village to 45 villages located in the Upper Egypt governorates of Minya and Assiut, and more recently a few villages in peri-urban areas near Cairo. The Project has been, singularly, the most successful family planning community-based distribution (CBD) program in Egypt. Its approach to mobilizing, developing and then graduating villages to self-sufficiency has enabled it to expand family planning services coverage without equivalent increases in donor financial support despite serving relatively poor and disadvantaged communities.

The purpose of the Rural-Based Family Planning Subproject is to increase the quantity and quality of contraceptive use, while also increasing income generation to sustain CEOSS family planning services on a long-term institutionalized basis. By the end of the subproject it is estimated that 12,314 new acceptors will have been recruited and served. Eighty percent of new acceptors will continue contraceptive use beyond one year. Through the improvement of existing and the development of new cost-recovery measures, the CEOSS family planning subproject will be more capable of financially sustaining itself after the subproject period ends and future USAID support may not be available.

MOSA delayed in approving this subproject until September 24, 1991 (almost nine months). Because of the delay the implementation plan and supporting budget needed revision

and additional documentation had to be submitted. Thus, the Cooperative Agreement between USAID and CEOSS to implement the subproject was finally signed on April 16, 1992. Certain activities and all scheduled technical assistance had proceeded during the delays. However, some activities have been either canceled or postponed. A Revenue Agreement is in place between CEOSS and USAID to cover the disposition of revenues from the sales of USAID-donated contraceptive commodities.

D. STATEMENT OF WORK

TASK ONE- Review the Comprehensive Family Care Subproject of the Coptic Association for Social Care (CASC) and determine the progress it is making toward meeting its subproject goals and objectives.

TASK TWO- Review the Upper Egypt Family Planning and Community Development Subproject of the Bishopric for Public, Ecumenical and Social Services (BPSS) and determine the progress it is making toward meeting its subproject goals and objectives.

TASK THREE-Rural Community-Based Family Planning Subproject of the Coptic Evangelical Organization For Social Services (CEOSS) and determine the progress it is making toward meeting its subproject goals and objectives.

TASK FOUR-Each of the subprojects has a sustainability objective. Is this objective feasible?. Review the progress which each organization has made toward sustaining family planning services after funding through the USAID Office of Population ends. Assess the feasibility of each organization's plan. Make realistic recommendations to improve the plans to ensure continuation of family planning services after the subprojects end.

TASK FIVE- Each of the three subprojects has implemented a different approach in providing family planning services. The CASC has featured Family life Education as one mechanism to create demand for family planning services in addition to providing services through family care clinics, mobile teams and fieldworkers. The BPSS has implemented an approach to family planning service delivery within a community development framework (literacy training and income generation). The CEOSS sub

project has implemented probably the only family planning community-based distribution (CBD) program in Egypt. In addition it employs a development approach which mobilizes, develops and then graduates villages to self-sufficiency. The evaluators should assess the strengths and weaknesses of each approach in terms of family planning service delivery. The approaches should be analyzed and compared (to the extent possible) to identify lessons learned in terms of effectiveness, efficiency, replicability, cost.

E. TEAM COMPOSITION

The evaluation will require a three person team composed of two expatriate consultants and one Egyptian consultant. Among these persons should be a physician or medically oriented evaluator with management expertise, a family planning/ development specialist and an evaluator experienced with the issues of sustainability in the Private Voluntary Organization (PVO) sector, especially as they relate to the provision of family planning services.

F. METHODS AND PROCEDURES

1. The team shall base their findings, conclusions, and recommendations on data, documents, and other information provided by the TA contractor, USAID project officer, USAID Population Office, and the three PVO implementing agencies as well as site visits and interviews. Documents to be consulted should include, but not be limited to, the subproject papers, Project Implementation Letters (CASC), Cooperative Agreement (CEOSS), buy-in to the CEDPA Cooperative Agreement (BPESS), previous evaluations, the subprojects' annual workplans and quarterly reports, implementing agency records, planning documents, balance sheets and financial statements, and other documentation as requested and as deemed relevant.
2. The evaluation team shall review subproject documentation which will serve as reference points and baseline data for assessing implementation progress. The team shall also consolidate, summarize and analyze data collected by the each of the subproject's ongoing monitoring systems.

3. The evaluation team shall interview appropriate USAID, CASC, BPSS, CEOS and CEDPA staff. It shall also interview selected subproject beneficiaries and shall employ surveys and questionnaires in the study when appropriate.
4. The evaluation team shall interview other donors and the PVO office in USAID's Office of Education and Training in order to recommend realistic funding possibilities for the PVOs in family planning.
5. The team shall conduct relevant subproject site visits.
6. The team shall prepare an evaluation report providing findings, conclusions and recommendations responsible to the questions in the Statement of Work above based on the analysis of information obtained through tasks 1 through 5 above.

G. REPORTING REQUIREMENTS

All reports shall be submitted to the USAID project officer and the evaluation officer.

1. The contractor shall hold regular meetings, the frequency of which will be determined by the evaluation officer, to brief USAID staff on evaluation progress. Final debriefing(s) shall be held for USAID and officials of the implementing agencies after acceptance of the first draft.
2. On or before the fifth working day, the contractor shall submit a workplan which describes roles and responsibilities of each team member and includes a detailed outline and suggested table of contents for the evaluation report.
3. The contractor shall submit a draft report by the end of the third working week. The draft findings shall be reviewed and discussed with key USAID staff and comments provided to the contractor within 2 working days. The final draft report, due before the team's departure from country, shall include changes or revisions requested by USAID staff. Executive summaries in English and Arabic for both the draft and the final draft reports shall be provided. Within a month after departure, the contractor shall provide 20 copies of the final report to the USAID/Egypt Mission for distribution.

4. The format for the report should be as follows:

Executive Summary:

Not to exceed three single-spaced pages. This shall be provided in English and Arabic.

Listing of the Major conclusions and Recommendations:

This section shall briefly summarize the most important conclusions and recommendations in the evaluation. The recommendations shall be listed in priority order with responsible parties assigned to implement each recommendation. The report shall provide only principal recommendations which are viable in view of the constraints facing each responsible party. (Other suggestions, ideas, or improvements for project implementation should be provided in a separate annex.)

Main Report:

The report shall respond directly to the key questions in the Statement of Work and should not exceed 30 double spaced typed pages.

Appendix B

List of Persons Contacted

Appendix B

List of Persons Contacted

USAID

Dr. Tawhida Kahlil, Project Management Specialist
Marilynn Schmidt, Population Development Officer
Carol Carpenter Yaman, Director, Office of Population
Arthur Braunstein, Population Development Officer
Randall Parks, Evaluation Officer
Sarah Harbison, Temporary Duty from Office of Population, A.I.D./Washington
Duncan Miller, Associate Director, Office of Human Resources and Development Cooperation
Rochelle Thompson, Office of Population, A.I.D./Washington

CASC and BPESS

Bishop Serapion, Authorized Official
Dr. Hany Samir, Executive Director
Dr. Emad Mansour, Medical Field Manager
Adel Gaid, Financial Manager
Magala Habib, Project Coordinator

Staff of the following clinics

CASC: Suez Center
El Nahda Center
El Karma Center, el Tera El Boulakia
Edfu Center
Qena Center
BPESS: Aswan Center
Daraw Center
Komombo Center
Naqada Center
Qus Center

CEOSS

Rev. Dr. Samuel Habib, Director General
Nabil Samuel Abadeerm , Director of Comprehensive Development Program
Wafaa William Khalil, Head of Family Planning; Head of Health Unit
Ibrahim Maharan Ghattas, Field Director of CDP in Minia and Upper Egypt

Staff of the following clinics

El Motamedia
El Hekr I
El Hekr II
El Nasseria

Others

Leslie Perry, Regional Advisor, CEDPA
Sjaak Bavelaar, Country Director, UNFPA
William Darity, The Population Council
Jim Coberley, Country Director, Care Inc.
Dr. Addison E. Richmond, Executive Director, UMI. Egypt

Appendix C

Site Visit and Interview Rating Scale

Appendix C

Site Visit and Interview Rating Scale

Scoring of the interviews is based on the following indicators using a four-point scale of "Excellent," "Good," "Fair," and "Needs Improvement":

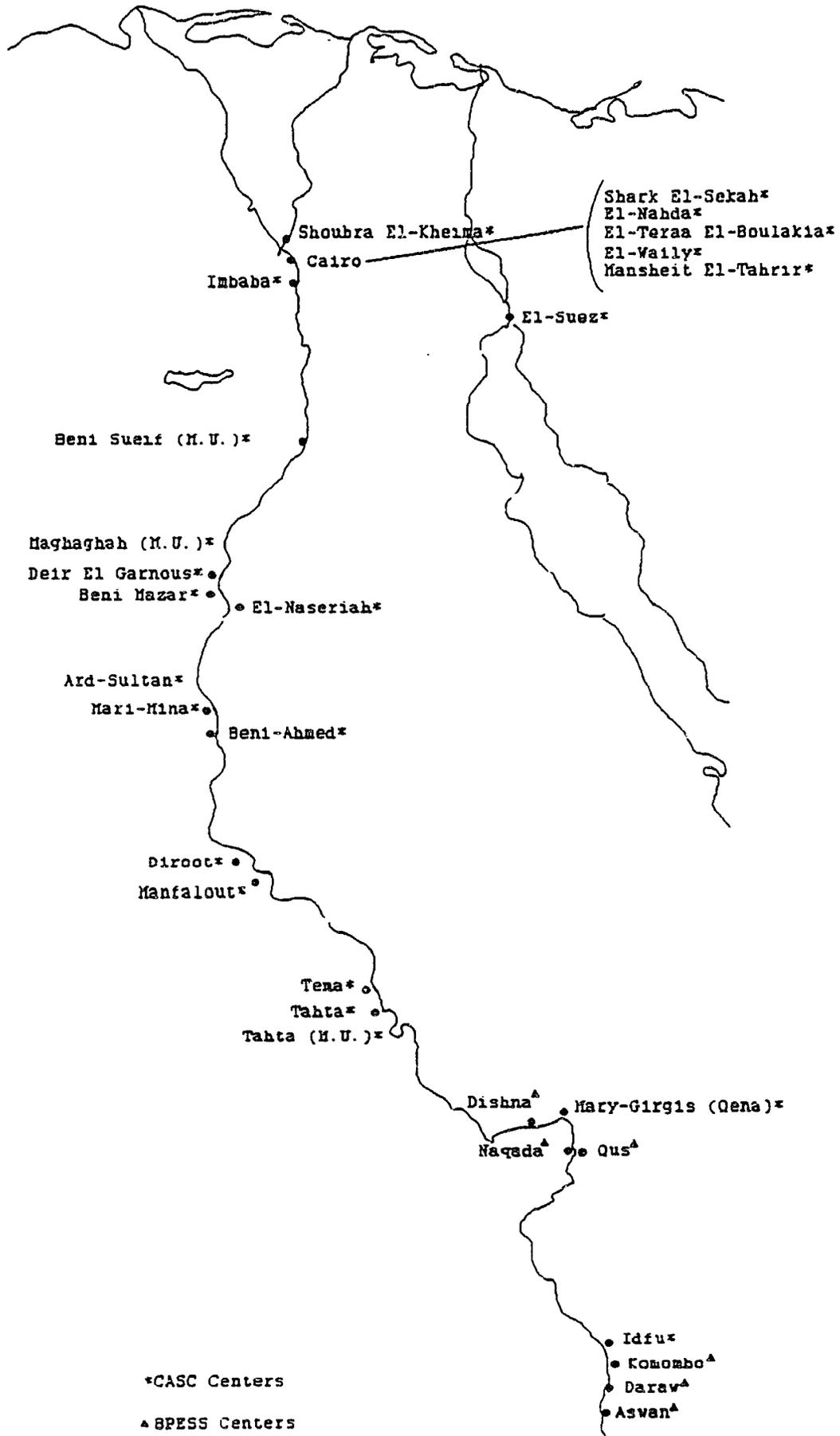
Training:	based on the number of training programs attended by each staff member, the length of the training, and ability to recollect the content of the programs
Experience:	based on the number of years working in the current program, as well as on family planning experience in other agencies, either concurrently or prior to current position
Client Assessment Skills:	based on questions relating to interactions with potential and actual clients about methods recommended under various circumstances, and measures taken to address problems
Administrative Supervision of Clinic:	based on number and content of clinical supervisory visits
Clinical Record Keeping:	based on presence, organization, and completeness of client records
Reporting Systems:	based on presence, frequency, and content of reports about clinic activities
Commodity Supplies:	based on number and quantity of methods available, storage, and inventory systems
Medical Equipment:	based on quantity and quality, observed and reported, of basic medical equipment used in family planning
Clinic Facilities:	based on amount of appropriately furnished space, cleanliness, ventilation, privacy, light available in the clinic, and running water
Adequacy of Staffing:	based on number of staff as described in the Project Paper
IEC Materials:	presence of printed and audio-visual IEC materials appropriate to the population served
Client Satisfaction:	based on reports of family planning acceptors

Appendix D

Map Showing BPESS and CASC Facilities

Appendix D

Map Showing BPESS and CASC Facilities

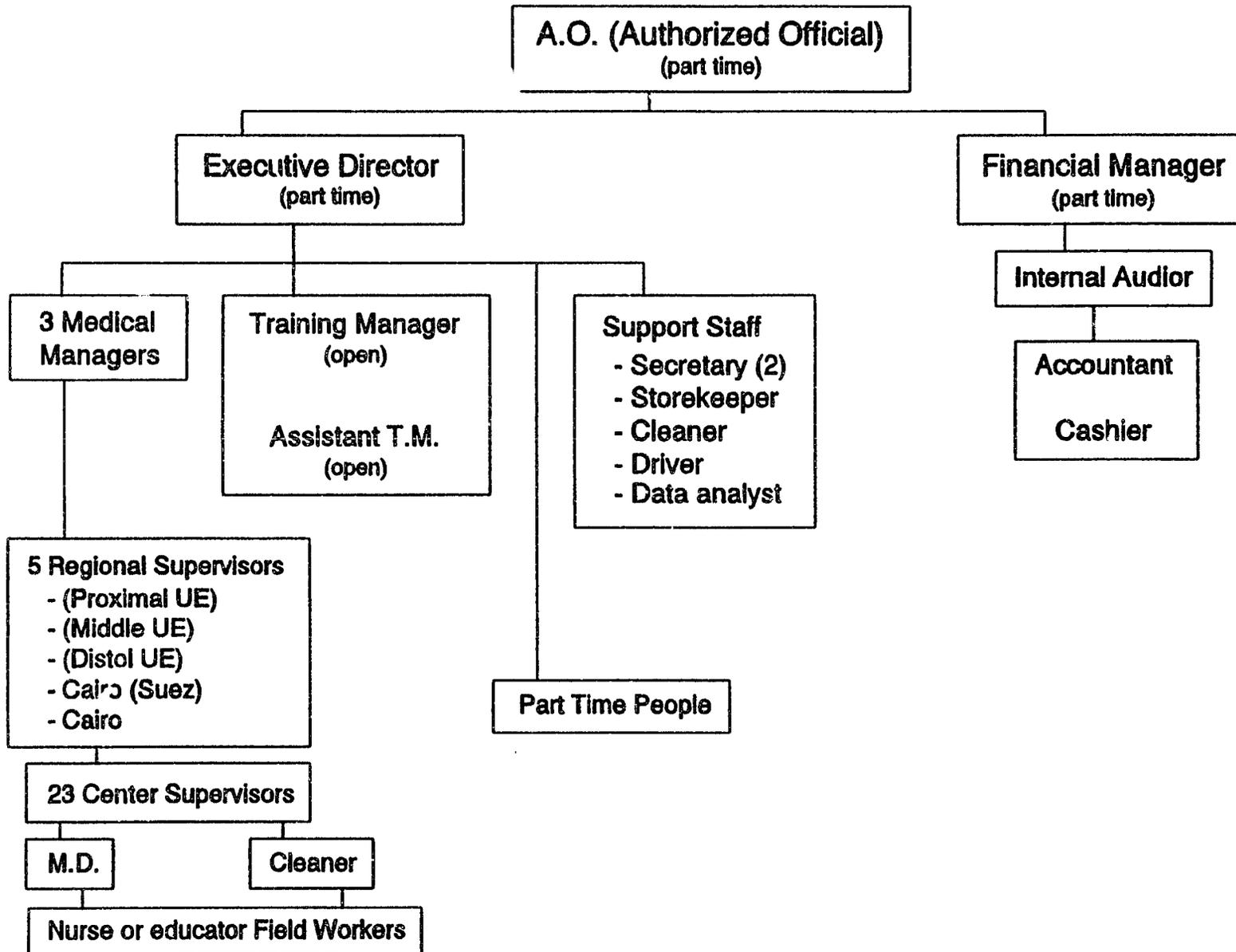


Appendix E

Organization Charts CASC, BPESS, and CEOSS Family Planning Subprojects

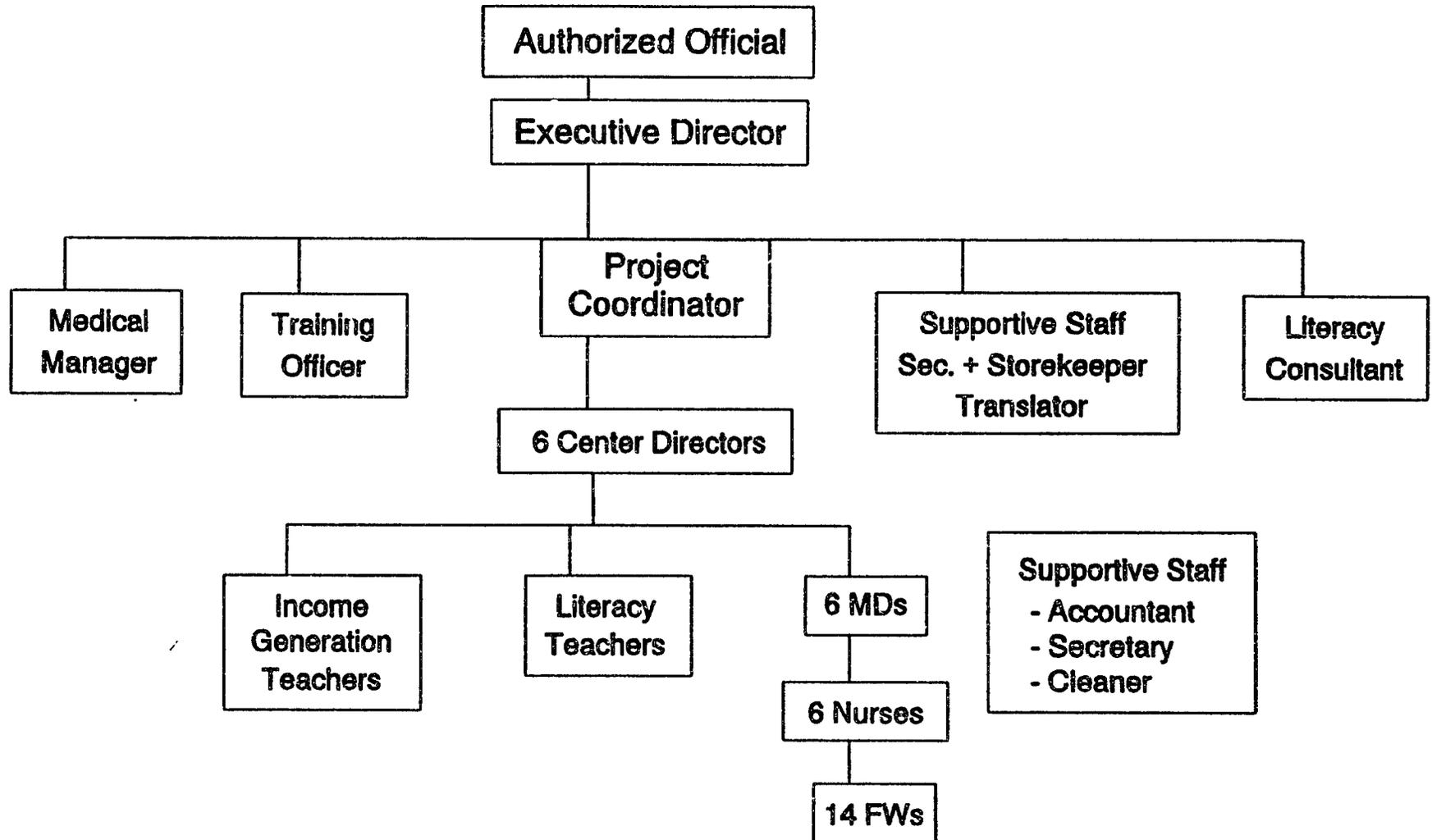
CASC

No Real Committees

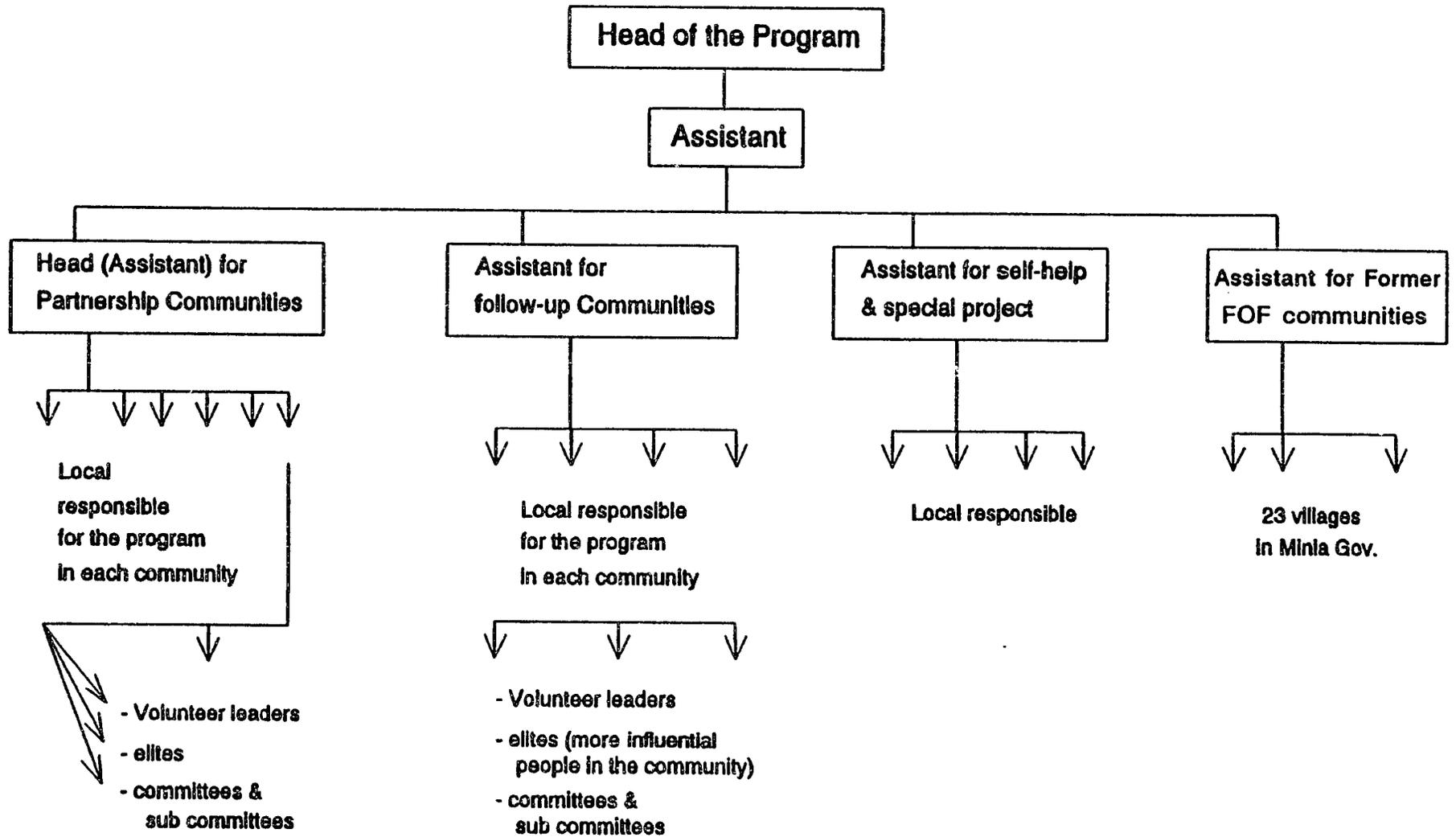


Organization Charts
CASC, BPRESS, and CEOSS Family Planning Subprojects

BPESS



CEOSS



E-3

Appendix F
Potential Operations Research Projects

Appendix F

Potential Operations Research Projects

Direct Population Council Assistance and/or Operations Research Options - at the request of CASC/BPESS/CEOSS
Tuesday, Sept. 8/1992.2

The (US) Population Council considers Upper Egypt as an important priority, and moreover, agreed that NGOs such as those just evaluated by the PopTech team were the kinds of institutions that could best reach rural underserved areas. The Population Council would encourage any interest on the part of the projects to propose OR activities in Upper Egypt for Population Council support. The importance of the recipient institution having in-house research capability, was pointed out but the Population Council would provide as much ongoing TA as needed throughout an activity within reason.

The procedure for organizations seeking funding for Operations Research through the Population Council was discussed and a sample of a "Pre-Concept Paper" to be submitted to guide initial discussions was received. A concept paper is the next step.

It was noted that OR activities could be funded through the (Egyptian) National Population Council's RMU Division through 5/93, and that potential OR activities should also be discussed with them.

The following ideas, some of which were tabled at the PopTech's Team's mini-workshops on sustainability and income generation for the three PVO's were suggested as potential OR activities:

- Cost efficiency/effectiveness of mobile units, field workers and Static Clinics in service delivery.
- CBD/Outreach FWs - Impact of age of worker, marital status, parity, appearance, and other indicators on their effectiveness in a traditional, rural setting.
- Depot holders effect on continuation of use of non-medical methods.
- Service statistics: enhancement of MIS through OR intervention using control & experimental clinics.
- Literacy Training, Income Generation - their individual and combined effect on contraceptive uptake.

Appendix G

Rationale for Extensions of BPESS and CASC Projects

Appendix G

Rationale for Extensions of BPESS and CASC Projects

BPESS

o Under a CEDPA buy in covering the period January 1, 1992 through March 31, 1993, the total BPESS budget is LE 863,883.

o To date, average monthly expenditures are about LE 24,000 per month. At this rate, expected expenditures by the end of September 1992 are about LE 216,000. Add to this fairly immediate expenditures of about LE 120,000 to implement the Income Generation Plans (including hiring TA). Then increase average expenditures to LE 35,000 a month to support increased training and other activities over the next six (final) months, at LE 210,000:

LE 216,000
LE 120,000
LE 210,000

LE 546,000

This is the total expected spent by March 31, 1993

Balance by 3/31/93 would therefore be approximately LE 317,883.

RECOMMENDATION: Provide two-month extension, through May 31, 1993, to provide additional time to complete planned activities.

Justification for Extension - BPESS

Activities:

1. By March, 1993, the Income Generation activity would have started up, and consultants in small business and marketing and would have been brought in to develop center-specific training plans. The centers would, however, probably not have completed all three phases of their Income Generation plans by May 1993. It is crucial that they be given additional time not only to fully complete their plans, but that after completion of these plans, they are able to benefit from additional central and technical support to fine tune IG activities.

2. Service statistics and the MIS could be greatly enhanced during an extension period. Over the next six months, some work will be done on improving data collection for the system as it now exists. However, there is a lot of information (such as age and educational level of woman, parity) that is collected at the center level and sent to Aswan, but not currently made use of. An additional period of time would enable more input into the improvement of this system.

3. During the next six months, the FW curricula on IEC and motivation will be finalized; however, there will be insufficient time to do appropriate training and followup. Further, the plan for training Center Directors in a variety of management areas was delayed for lack of funds; this training will begin within the next six months, but would be more valuable if there were additional time to follow it up and link it with supervision.

4. Supervision, both technical and managerial, needs improvement. To ensure standard quality of care, monitoring tools will be developed over the next six months for use by Medical Field Managers. The Project Coordinator will also collaborate in the development of supervisory tools for program management purposes. However, six months is insufficient if one intends to institutionalize supervisory systems and clearly link them with feedback systems for regular training of staff.

5. IEC needs strengthening, both at the macro and micro levels. Center-specific IEC plans, to attract more clients and to target new communities, will be developed over the next six months; however, the implementation of these plans requires close support and followup, which is only possible if there is an extension.

6. The development of proposals for post-AID funding will take some months, and carryover funding may not be available by 5/93. Additional time is needed to secure funds for project continuation.

CASC

o The total budget covering the period November 1, 1990, through October 31, 1992, is LE 1,898,738.

o The Year One Commitment, covering the period November 1, 1990 through October 31, 1991, was LE 965,633. This first year of the subproject was given a no-cost extension until March 31, 1992.

o A Workplan was submitted for the Second Year, requesting a total budget of LE 881,015. If this amount is approved, this would make the total amount committed LE 1,846,648.

o Average expenditures have been about LE 35,000 a month. Through March 31, 1992, about LE 632,000 had been spent. By the end of October, an estimated additional LE 245,000 will be spent, making the total spent by October 31, 1992 - LE 877,000.

o Assuming the workplan is approved and funds are obligated, the project will have more than sufficient funds (@ LE 970,000) to cover a seven-month extension period to purchase equipment and supplies for clinics, to complete planned activities in training, and to enhance project management systems.

RECOMMENDATION: Extend project an additional seven months, through May 31, 1993, to allow additional time for completion of activities.

Appendix H
Alternative Sources of Donor Funding

Appendix H

Alternative Sources of Donor Funding

Background

Since it is planned that by the end of May 1993 USAID will cease funding the three subprojects, all of the organizations involved have started to contemplate other possible donor assistance. Further international support is critical as income generation activities are quite modest and unlikely to sustain any one of the three projects for any significant period of time after USAID ceases funding.

Of the two major organizations (the Evangelicals and the Coptic Church) CEOSS is by far the most attractive to international (governmental and private) donors, both in terms of its family planning philosophy and in terms of its ecumenical and community development approach. BPSS, with its concentration on Upper Egypt where government services are weak, prevalence rates are low, and women are in need of empowerment, has a potentially very attractive activity for all the major donors. The Bishopric (as opposed to CEOSS) has relatively little experience with donor management, marketing, and project proposal preparation. As much as any other management and administrative area, entrepreneurial approaches to donors by all the organizations will require outside assistance from CEDPA.

Options for USAID Funding

Although USAID has made it clear that under the upcoming Population/Family Planning III Project no funds will be made directly available for the three Egyptian NGOs working in population, under Population/Family Planning III Project, there may be alternate channels for supporting these agencies. These include

- The USAID-funded program under the USAID NGO office entitled National Council of Negro Women's Umbrella Management Institution (UMI). UMI will provide technical assistance, training, and grant funding to assist between 10 and 20 experienced NGOs to become registered with A.I.D. and to design, implement, monitor, and evaluate development activities. In theory, each of the Egyptian NGO subprojects could be eligible for these funds. They are among the best non-governmental organizations in Egypt and already represent a major U.S. government investment. This newly established agency will receive incremental funding of six million dollars to fund activity grants for A.I.D.-registered U.S./Egyptian NGOs. The project focuses on developing and testing a model to reduce constraints to NGO access to financial resources and technical assistance.
- USAID may continue to provide USAID donated contraceptives to the NGO's with the development of an appropriate revenue agreement with the Ministry of Health.
- Association with a U.S. NGO. Although there is no intention of routing population funds to a U.S. NGO already working in Egypt, in a theoretical sense funds could be made available from A.I.D. via one of the existing agencies now in Egypt (such as CARE, Save the Children) which could manage numerous grants and cooperative agreements for Egyptian agencies working in the non-profit population area.
- The Egyptian National Population Council. Under the Population/Family III project, funds will be provided to the Egyptian government and to its National Population Council for Governorate Development Support Grants. It is conceivable, should USAID and the Egyptian government be interested, that USAID funds could be made available through this mechanism to private non-profit groups such as the Coptic Church and CEOSS, particularly in areas of the country where government services are weak and prevalence rates are low.

Options for Funding from United Nations Agencies

- The United Nations Population Fund represents by far the most attractive opportunity in the U.N. for non-profit agencies working in the area of family planning. During the next five years, approximately \$20 million (of which \$10 million could be programmed from the United Nations Population Fund resources) is committed to Egypt. These funds are available via the National Population Council.

The coordinator of the United Nations Population Fund in Egypt is interested in submitting concept papers from the three subprojects to the consortium of international donors which meets periodically in Egypt. He is interested in projects (such as BPESS) which work in Upper Egypt where contraceptive prevalence rates are low and government medical facilities are sparse. The UNFPA is interested in women, population, and development and gearing up for work in the private sector. Specifically mentioned as a potential source of support (in association with the U.N.) was the German Ministry of Economic Cooperation and the German Agency for Technical Cooperation which has earmarked substantial funds for work in Egypt. There are concerns, however, with regard to obtaining MOSA approval for NGO family planning projects.

- World Bank. A credit amount equivalent to \$140 million is potentially available to the Arab Republic of Egypt Social Fund Project as part of a continuing effort to ensure a social safety net associated with the development and economic progress in Egypt. The proposed investments would focus on income and employment generation activities and the provision of public and other services. One of the major specifically proposed projects (one of the six core programs) will be in the area of community development. Funds in excess of \$40 million might become available for improvements in primary care, maternal and child health/family planning, and related activities. Although there is considerable interest in the Social Fund, it appears that there are some impediments and hindrances to private voluntary agencies accessing funds for a variety of reasons and one cannot be optimistic that any of the three agencies will meet immediate success in obtaining funds through this route.

It should be noted that all the possible options indicated above would require MOSA to sign off.

Options for Other Donors

- The Population Council. Population Council officials have expressed great interest in the potential of a collaborative effort with BPESS or CEOSS in the area of operations research and/or activities in Upper Egypt and plan to discuss these possibilities fully with the three agencies concerned.