

**MIDTERM EVALUATION OF THE
EGYPT POPULATION/FAMILY
PLANNING III PROJECT
(263-0227)**

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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ABBREVIATIONS

ANE/ORTA	Asia Near East/Operations Research and Technical Assistance Project
AVSC	Association for Voluntary Surgical Contraception
CA	cooperating agency
CIIS	Contraceptive Inventory and Information System
CPA	certified public accountant
CPR	contraceptive prevalence rate
CPT	Contraceptive Procurement Tables
CSI	Clinical Services Improvement Project
CSMP	Contraceptive Social Marketing Project
CT	contraceptive technology
CYP	couple years of protection
DANIDA	Danish International Development Agency
DHS	Demographic and Health Survey
EDHS	Egyptian Demographic and Health Survey
EFPA	Egyptian Family Planning Association
EJMDA	Egyptian Junior Medical Doctors Association
EPI	Expanded Program of Immunization
EPTC	Egyptian Pharmaceutical Trading Company
FHI	Family Health International
FOF	Family of the Future Project
FP	family planning
FPLM	Family Planning Logistics Management Project
FPU	family planning unit
Futures	The Futures Group
GOE	Government of Egypt
GTI	genital tract infection
HM/HC	Healthy Mother/Healthy Child Project
HRDC/POP	Human Resources Development Cooperation/Population
ICPD	International Conference on Population and Development
IEC	information, education, and communication
I/G&S	Implementation/Goods and Services
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IRM/W	Information Resources Management/Washington
IUD	intrauterine device
LE	Egyptian pounds
LIC	Local Information Center
LMIS	Logistics Management Information System
LMO	local management office
LOA	letter of agreement
LTA	long-term technical assistance
MCH	maternal and child health
MIS	management information system

MOE	Ministry of Education
MOH	Ministry of Health
MOI/SIS	Ministry of Information/State Information Service
MOPFP	Ministry of Population and Family Planning
MPS/NPC	Management and Planning Specialist/National Population Council
MWRA	married women of reproductive age
NGO	nongovernmental organization
NPC	National Population Council
NPC/TS	National Population Council/Technical Secretariat
NPIC	National Population Information Center
Ob/Gyn	obstetrician/gynecologist
OC	oral contraceptive
OR	operations research
PDP	Population and Development Project
PDS	Population Data System
PFPB	Population and Family Planning Board
PID	Participant in Development
PIL	Project Implementation Letter
PIS	Population Information System
POP/FP III	Population/Family Planning III Project
PPC	Population Project Consortium
PSI	Private Sector Initiative
PY1/PY2	Project Year 1/Project Year 2
QIP	Quality Improvement Program
RAPID	Resources for the Awareness of Population Impact on Development Project
RCT	Regional Center for Training in Family Planning and Reproductive Health
RFP	request for proposal
RHU	rural health unit
RS/RMU	resident specialist/Research Management Unit
RTI	reproductive tract infection
RTS	resident technical specialist
SDP	Systems Development Project
SIS	State Information Service
SOMARC	Social Marketing for Change Project
STA	short-term technical assistance
STD	sexually transmitted disease
TFR	total fertility rate
THO/FPS	Teaching Hospitals Organization/Family Planning Subproject
TMS	training management specialist
TOT	training of trainers
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

1. Background

The United States Agency for International Development (USAID) has been the largest foreign donor to Egypt's national family planning program since the 1970s and has reaffirmed its commitment under the Population/Family Planning III Project (1994-1997). The goal of the USAID Population/Family Planning Project III (POP/FP III) is to assist the Government of Egypt (GOE) to reach its short- and long-term demographic targets: to reduce the population growth rate from 2.2% (1992) to 2.0% (1997) and to reduce total fertility rate (TFR) from 3.9 (1992) to 3.5 (1997).

The project purpose is to increase the contraceptive prevalence rate (CPR) from 47% to 53% between the years 1992 and 1997 and to decrease the extended contraceptive use failure rate from 10% to 7%.

POP/FP III is an umbrella project consisting of eight subprojects implemented through three GOE agencies and the private sector as follows:

Ministry of Health

1. Systems Development Project (SDP II)
2. Contraceptive Commodity Project
3. Teaching Hospital Organization Project (THO)

National Population Council

4. Institutional Development Project (IDP II)
5. Regional Center for Training Project (RCT)
6. Clinical Services Improvement Project (CSI)

Ministry of Information

7. State Information Service/Family Planning Information, Education, and Communication Project (SIS/IEC)

Private Sector

8. Private Sector Initiatives Subproject (PSI)

Activities under this project are managed by an Implementation/Goods & Services (I/G&S) contractor, The Population Project Consortium (PPC). The consortium is led by Pathfinder

International and includes Johns Hopkins University (JHU), Family Health International (FHI), The Futures Group (Futures), and Ernie Petrich & Associates.

2. Subprojects

Service Delivery and Training

Systems Development Project (SDP). SDP, whose mission is to improve the management, service delivery, and sustainability of the MOH family planning program, had laudable success in POP/FP II and has continued that development in POP/FP III. The MOH is providing increasing higher quality services through a vast network which includes 3,706 service delivery points. The key SDP strategy is the Quality Improvement Program through which SDP has established QIP standards, protocols, systems, and manuals for effective management and quality service delivery. SDP is implementing these improvements through training at the central, district, and unit level, and through careful supervision and monitoring, together with targeted renovation of clinical sites. QIP, now in the second of three phases of implementation throughout the country, has been successful: QIP clinics are attractive, well utilized, appropriately equipped and supplied, and well staffed. SDP anticipates that by the end of the project, 2,500-3,000 of the existing units will have been brought up to QIP standards.

SDP has exceeded its CYP targets throughout the country; service volume, which soared in POP/FP II, has continued to steadily increase. Average utilization of MOH facilities, however, is low for a variety of factors. These include the fact that many facilities are tiny rural units in small villages where it has been difficult to secure/maintain physicians and female providers. Further, the MOH IEC effort relies on governorate-level MOH/IEC supervisors and district-level MOH/IEC officers for whom family planning is only one of several duties. Coordination between the MOH/IEC supervisors and SDP managers has been insufficient: the first run of IEC materials has been insufficient to stock MOH facilities, and IEC materials are only just beginning to arrive at MOH clinics.

MOH efforts to address the preference for female providers look promising. District nursing schools are being opened in Upper Egypt. Mobile teams, staffed by female physicians, appear to be successful in increasing utilization, particularly for IUD insertion.

SDP is fulfilling its mission of providing increasingly high-quality family planning services: in light of that success and Egyptian demographic data on maternal morbidity and mortality, it is time to consider expanding the SDP mission to include broader reproductive health components.

Clinical Services Improvement Project (CSI). CSI's purpose is to become an increasingly self-financing organization that continues to augment the number of high-quality family planning and related reproductive health services it provides, and it has performed very well during POP/FP III. Although CSI has had severe financial difficulties due to delays in the release of USAID funds, it

is meeting its CYP targets; has developed strong management systems; and increased its level of self-financing through a combination of cost recovery, cost control, and income generation. CSI has converted to a performance-based payment system: USAID pays CSI per CYP on a sliding scale that favors governorates with lower prevalence rates and Upper Egypt.

Although CSI has closed down some of its low-performing clinics, utilization is still low relative to capacity. Nonetheless, utilization of CSI clinics is significantly higher than utilization of MOH clinics, particularly in districts in which QIP has not yet been introduced. Clients travel farther, bypassing MOH clinics, to attend CSI clinics which charge higher user fees but are perceived to have better quality services. CSI should, however, continue to monitor clinics on the basis of utilization and level of self-financing and close those that are low performers and a financial drain.

CSI management is strong: responsibility for clinic management has been decentralized and a sophisticated MIS introduced. However, CSI needs additional technical assistance to help with strategic planning, financial management, definition of its market niche, and marketing. CSI's funding problems necessitated a severe cutback in the level of training and IEC—activities which are now a high priority if CSI is to maintain the level of quality for which it is known.

Technically, CSI is a project of the Egyptian Family Planning Association (EFPA) which in turn reports to the National Population Council (NPC), a public sector entity. CSI's status as a "project" has some advantages; but that status also hinders CSI's efforts to become a self-sufficient, competitive organization. CSI should seek to become a legally recognized, independent nongovernmental organization (NGO). USAID should help CSI become part of the worldwide group of flourishing family planning organizations by giving the management of CSI the opportunity to get to know some of the more successful organizations, particularly in Latin America.

Teaching Hospital Organization Subproject (THO). THO provides models for hospital-based family planning services and an entry point for introducing postpartum IUD services and NORPLANT® in the public sector. Because THO has only eight clinics, the subproject is not intended to contribute a significant number of CYPs to the national program. However, each clinic must generate a sufficient number of clients to be a model of hospital-based services and to enable it to be a training site for hospital-based methods. It is expected that THO will convert to performance-based payments in July 1996.

THO training for THO permanent and house staff and other MOH physicians and nurses has helped to expand the knowledge of family planning service delivery, particularly clinical methods, throughout the public health system. THO activities, including hospital-specific brochures and an IEC plan to counsel hospital inpatients and outpatients, are a model for hospital-based services.

Under dynamic new leadership, a new and streamlined headquarters staff has developed and implemented systems for service quality monitoring, clinic management, and supervision. However, management systems are not yet adequate for conversion to the output-based payment

system. To successfully address these needs, THO requires a new type of long-term technical assistance in the areas of financial management and strategic planning.

Regional Center for Training (RCT). The purpose of RCT is to train physicians, nurses, pharmacists, and family planning service providers. The long-term goal of the institution is to be a self-financing, regional family planning training center. USAID converted RCT to a performance-based payment system two years earlier than originally planned in order to support RCT's progression toward becoming a self-sufficient, sustainable institution.

RCT currently has an agreement with SDP to provide all of the latter's training of trainers (TOT) courses for physician and nurse trainers. There have been a number of problems and misunderstandings in the past between SDP and RCT. However, the new leadership in RCT recognizes the need to improve the quality of RCT training and to be more responsive to client requirements. The training skills of physician trainers need to be upgraded and non-physician trainers need to be recruited to provide specialized non-clinical training. Some short-term technical assistance (STA) will be required.

RCT will have to cut costs and market its services. USAID should shift the focus of their long-term technical assistance to strategic planning, financial management, and marketing to assist RCT to become a more business-oriented organization.

Information, Education, and Communication (IEC)

State Information Service Family Planning IEC Subproject (SIS/IEC). The SIS/IEC subproject supports efforts to increase demand for and the correct use of contraceptives, through mass media and interpersonal activities, and to improve SIS management capacity. SIS/IEC has met all of its numerical targets in producing IEC materials, developing mass media messages, and holding meetings, and it has developed some extremely effective materials and approaches. However, there needs to be more direct emphasis on male responsibility and method-specific use and guidelines developed for presenters at village meetings.

Useful IEC materials produced by SIS/IEC include flip charts, method brochures, and method spot videos. A coordinated effort needs to be mounted to determine the needs of all of the subprojects for these materials and arrangements made to produce and distribute materials as needed.

NPC should make a more concerted effort to coordinate a national IEC strategy bringing all relevant agencies together to identify and allocate training and materials production tasks and to share resources and finished materials based on each agency's comparative advantages in these areas.

Policy

Institutional Development Project. The primary objectives of the Institutional Development Project (IDP) are to strengthen the capacity of the National Population Council/Technical Secretariat (NPC/TS) to engage in policy analysis and formulation, coordinate policy-based research, and strengthen the capacity of the NPC/Governorate (NPC/G) offices in strategic planning and coordination of population and family planning activities.

The ability of the IDP to strengthen the management and planning capacity of the NPC/TS is limited. The staff capacity is weak; the NPC leadership does not provide direction on policy and planning issues; and no staff members are charged with policy dialogue or coordination. The Research Management Unit (RMU) technical staff appear to be motivated and interested in research directed to policy and planning guidance but they are isolated from policy and planning discussion.

While it is recommended to continue to limit the scope of IDP activities at NPC/TS level with primary concentration on the RMU, one new initiative in the NPC/TS is recommended. Technical assistance should be provided to the Statistical Unit in the areas of 1) annual governorate-level family planning target setting, coupled with demographic analysis to assess the achievement of targets, and 2) the development of a national management information system (MIS).

There is evident improvement in the ability of governorate-level NPC personnel to plan and coordinate activities, related in large part to IDP efforts, and these efforts should be continued. However, with the disjuncture between the targets established for the governorates by the NPC/TS and the reality at governorate level, true coordination and strategic planning remain elusive. Upgrading the computers and follow-up of the ongoing strategic planning training for NPC/G personnel would strengthen NPC/G ability to analyze data and coordinate family planning activities at governorate level.

The leadership of the population sector should be encouraged to provide the RMU with guidance and support in the stimulation of policy-related research and to support research and policy development in the areas of commodity pricing, family planning service subsidies, and efforts to enhance the private sector (e.g., removing economic barriers to contraceptive manufacture and retail sales), in order to ensure long-term family planning program sustainability.

Private Commercial Sector

The private sector has played an important role in family planning in Egypt, contributing about 70% of overall prevalence in 1988 and 63% in 1992. Implementation of the Private Sector Initiatives (PSI) subproject is just getting under way. It is a large-scale effort in selected governorates in Lower Egypt to train 4,000 pharmacists and 600 physicians and establish a complementary referral service between them.

As relatively little is known about what works in terms of training and promoting private sector providers, each of the components needs to be carefully evaluated individually and an assessment

made as to whether there is a positive cumulative effect of the combination of interventions. Future activities to support the private sector should be tested on a smaller scale to determine effectiveness.

The distribution of subsidized contraceptives to the private sector by the centrally funded Social Marketing for Change Project (SOMARC) is ending. The SOMARC objective has been to support the transition to commercial sales and to help strengthen the private sector and attract commodities to the Egyptian market at competitive prices. There have already been some positive consequences with an increase in the availability of imported contraceptives commercially. The phasing out of subsidized contraceptives provides a good opportunity to assess price elasticity and client behavior.

Since the midterm evaluation was conducted, the Ministry of Population and Family Planning (MOPFP) has been dissolved by Presidential Decree, and the Ministry of Health has been expanded to become the Ministry of Health and Population. Recommendations for MOPFP should be considered in light of these changes.

3. Achievement of Project Outputs

Service Volume, Quality, and IEC

POP/FP III is making good progress toward achieving the projected outputs of service volume, quality, and IEC. The MOH infrastructure alone includes a vast network of 3,706 units: no one is further than five kilometers from a source of health care. The focus of POP/FP III has been to improve the quality of services and to institutionalize high-quality care and the systems that are necessary to support quality services. Training provided to SDP staff through the QIP program and other similar project support provided to CSI and THO have strengthened the capacity of these institutions to offer quality services. The project has supported an effective program of mass communication, local IEC activities, and interpersonal communication through SIS and the MOH.

Full and informed choice is an important dimension of quality. In the long term, it is an indispensable element of sustainability. One concern is the heavy reliance on the IUD, although a recent dramatic increase in the use of the injectable is encouraging.

Improved Management Capacity

A great deal of progress has been made in developing the mission, strategy, structure, staff, and systems in the POP/FP III subprojects. However, the developments are scattered throughout the subprojects, and most of the subprojects are in need of additional technical assistance—some short term and some long term—to reach more comprehensive institutionalization for sustainable operations.

Improved Information for Policy-makers

Although Egypt faces some difficult policy issues at this time, there exists no body for which such dialogue and policy formulation represents a priority. Without such ground setting, there is a risk that Egypt's family planning efforts will be unprepared for the inevitable financial and sectoral changes to come (i.e., eventual removal of free contraceptives given by foreign donors and changes in national price control strategies in all sectors).

Given their central role in the population sector, it is crucial that the new Ministry of Population and Family Planning (MOPFP) and/or the NPC retain a strong orientation toward policy, planning, and research issues as these issues are of immense importance and uniquely within their scope. The new Ministry is in a unique position to support the service and IEC activities of other ministries and agencies, to ensure that there is no duplication of efforts, and to assist implementing agencies to emphasize quality of service. Support for new service delivery activities is not recommended since coverage is adequate. The pressing issues are service quality, efficiency, and cost effectiveness. The new Ministry, along with a restructured NPC, would be in an ideal position to coordinate these directions and thus to add substantially to family planning utilization.

4. Project Management

POP/FP III represented a radical change in project management. The overall program management and coordination was put under a single contract with eight subprojects, unlike POP/FP II, which had 24 individual subprojects with technical support provided through a series of cooperative agreements. The umbrella mechanism used in POP/FP III has distinct advantages. Bringing together the elements of this project under one management structure facilitates coordinated planning and implementation which is critical to ensure complementarity and mutual reinforcement and to avoid overlap. It also decreases the USAID management burden.

While we recommend an umbrella mechanism for a follow-on project, USAID should consider a more flexible contracting mode. The necessity for rigid adherence to a contract forces a focus on deliverables rather than on qualitative outputs and puts a heavy burden on all sides for detailed documentation. Either a cooperative agreement or performance-based contract would provide considerably more flexibility for collaboration between USAID, the technical assistance team, and the implementing agencies in design and implementation, and would permit everyone to spend more time and resources on the program instead of on the process.

An important lesson learned from POP/FP III is that the time frame is too short. The project, initially conceived as a five-year effort, has been compressed into less than four years. This short period has forced an orientation toward detail—achieving deliverables—and diverted attention from the big picture. Five years is the absolute minimum for a program that has long-term goals

and vision; and ten years would be better. The existing project should be extended and the follow-on project should be designed with an overall implementation period of ten years.

1. INTRODUCTION

1.1 History

The United States Agency for International Development (USAID) has been the largest foreign donor to Egypt's national family planning program since the 1970s and has reaffirmed its commitment under the Population/Family Planning III Project (POP/FP III) for the period 1994 to 1997. POP/FP I (1977-1987, US\$67.6 million) established an institutional framework for family planning in Egypt and supported services and innovative delivery systems in selected governorates. POP/FP II (1987-1994, US\$117.6 million) expanded these activities nationwide through 24 subprojects which were implemented by a range of Government of Egypt (GOE) agencies and nongovernmental organizations (NGOs) through cooperative agreements with various USAID-funded agencies. The success of POP/FP II is evident from the rise in the contraceptive prevalence rate (CPR) over those years: 30% in 1984, 38% in 1988, and 47% in 1992.

It was recognized, however, that continued efforts were needed, particularly, in the areas of USAID program coordination, service and information quality, GOE and nongovernmental organizations (NGO) institution building, regional disparities in services and contraceptive use, and inadequate GOE policy development and planning. POP/FP III (US\$62 million) was designed to address these issues. The overall program management and coordination was put under a single Implementation/Goods and Services (I/G&S) contract; the number of subprojects was reduced (from 24 to 8) in order to focus on service quality and institution building; and a major focus was put on disseminating information to GOE policy-makers to support the GOE policy-making process.

The goal of POP/FP III is to assist the GOE to reach its short- and long-term demographic targets: to reduce the population growth rate from 2.2% (1992) to 2.0% (1997); and to reduce total fertility rate (TFR) from 3.9 (1992) to 3.5 (1997).

The purpose of this project is to increase the CPR from 47% to 53% between the years 1992-1997 and to decrease the extended contraceptive use failure rate from 10% to 7% in the same years.

POP/FP III is an umbrella project consisting of eight subprojects under three GOE agencies and the private sector. The participating institutions and eight subprojects are as follows:

Ministry of Health

1. Systems Development Project (SDP II)
2. Contraceptive Commodity Project
3. Teaching Hospital Organization Project (THO)

National Population Council

4. Institutional Development Project (IDP II)
5. Regional Center for Training Project (RCT)
6. Clinical Services Improvement Project (CSI)

Ministry of Information

7. State Information Service/Family Planning Information, Education, and Communication Project (SIS/IEC)

Private Sector

8. Private Sector Initiatives Subproject (PSI)

Activities under the POP/FP III project are managed and coordinated by an I/G&S contractor—the Population Project Consortium (PPC)—led by Pathfinder International and including Johns Hopkins University (JHU), Family Health International (FHI), The Futures Group (Futures), and Ernie Petrich & Associates.

This midterm evaluation of the POP/FP III project assesses progress to date of the eight subprojects and provides recommendations concerning modification and amendment of overall project design and its individual components. The team based its findings on document reviews, interviews, and observations during a field visit in October-November 1995. Since the evaluation was conducted, the Ministry of Population and Family Planning (MOPFP) has been dissolved by Presidential Decree, and the Ministry of Health has been expanded to become the Ministry of Health and Population. Recommendations for MOPFP should be considered in light of these changes.

1.2 Policy and Institutional Context

Egypt has had a long history of efforts to develop policies and plans in the population and family planning sector. The National Commission for Population Matters was created in 1953, and the 1962 National Charter emphasized the seriousness of population issues. By 1965, the inter-ministerial Supreme Council for Family Planning, chaired by the prime minister, was established to plan and coordinate policy and services with its operating agency, the Executive Family Planning Board. A lack of clarity regarding the roles of the Family Planning Board and the Ministry of Health (MOH) led to confusion with respect to responsibilities. An effort to integrate family planning quickly and at low cost into existing MOH services resulted in the rapid creation of over 2,000 potential outlets for family planning services. However, insufficient attention was paid to the family planning role of health care providers and the program did not achieve hoped-for gains in family planning use (Robinson and El-Zanaty, 1995).

The focus on improving family planning services, *per se*, was further reduced during the period of the Population and Development Project (PDP) which began in 1975. The policy shifted to an emphasis on the importance of socio-demographic development as a key factor in reducing fertility. PDP activities were placed under a new Population and Family Planning Board (PFPB), which had as a key activity improving the standing of rural women in order to stimulate the demand for family planning. This period saw the introduction of the *raidat rifiyya*, a full-time, multipurpose female village extension worker. The new approach effectively fragmented the overall family planning effort, with clinical services provided by the Ministry of Health, but outreach, IEC, and training all placed under the PFPB. Activities such as policy formulation, coordination of activities, and ensuring constant contraceptive supplies did not receive the necessary support. The efforts of the *raidat rifiyyat* appear to have been poorly coordinated, inadequately supported and overly ambitious in scope. By the mid-1980s, a number of evaluations and national surveys demonstrated that contraceptive use had not increased in PDP areas compared to the rest of the country (Moreland, 1995; Robinson and El-Zanaty, 1995).

Since the early 1980s, a number of distinct improvements have occurred in the policy and political context of the population sector in Egypt. President Mubarak and other key leaders speak often of the importance of family planning; indeed, President Mubarak was recently awarded the United Nations Population Prize for this advocacy role. Presidential Decree 18 of 1985 established the National Population Council (NPC), which took over from the Supreme Council, with much the same membership. The secretary general of the NPC has provided visible and vigorous leadership for population and family planning activities in Egypt. In conjunction with donor support, the GOE has undertaken major and comprehensive service expansion, training, commodities support, and IEC programs in support of family planning within the public, NGO, and private sectors. The executive arms of the NPC, the National Population Council Technical Secretariat (NPC/TS) and NPC Governorate (NPC/G) offices are coordinating a more decentralized approach to family planning which emphasizes governorate level initiatives (Moreland, 1995).

In 1993, the visibility of population and family planning was further enhanced when the secretary general of the NPC was also named Minister of State for Population and Family Welfare. The 1994 International Conference on Population and Development (ICPD) in Cairo further emphasized the importance of population issues and brought them high visibility within Egypt. A number of substantial problems remain to be addressed, however. First among the policy concerns is the lack of clarity regarding the role of the Ministry of Population and Family Planning (MOPFP), which is being organized under the Minister of State for Population and Family Planning. The relationship of MOPFP to the National Population Council (which is nominally a policy and planning body), and to the Ministries of Health, Information, and Social Affairs (primarily implementing bodies) is unclear and could potentially lead to duplication of effort. At the same time, it is uncertain whether much needed policy dialogue and formulation will be highlighted within the new MOPFP.

Carefully conceived policies are critical to the long-term sustainability and development of family planning in Egypt. Moreland (1995) noted two areas which will have an impact on long-term

success: the current over-reliance on only two contraceptive methods (the IUD in particular), and the balance between private and public sector delivery of family planning services. The latter area includes such thorny issues as contraceptive price controls and subsidies, both of which lower the cost to the consumer but hinder private sector involvement and may consequently reduce contraceptive availability.

The lack of policy dialogue and coordination results in anomalous situations such as government entities at the central and governorate levels calling for (and indeed, implementing) additional subsidies for nominally needy public sector family planning users while USAID is advocating reductions in subsidies and price controls (and indeed, has stopped the provision of contraceptives to the private sector). The lack of reliable and coordinated data to inform such decisions further leads to policy disjunctures and program inefficiencies.

To put the discussion of achievements, problems and challenges into perspective, it should be noted that contraceptive prevalence in Egypt has been increasing since the 1960s. Even before the improvements of the last decade in the policy and service milieu, contraceptive prevalence had risen from approximately 5% in 1960 to almost 30% in 1985, an increase of a percentage point per year. (The rate of increase in the last decade approaches 2% per year.) Overall, family planning in Egypt must be considered a success story. The evaluation which follows is meant to provide guidance for what is hoped will be further improvements. As a cautionary note, however, issues of inter-ministerial and interagency roles in family planning service delivery, information, population advocacy, and policy dialogue urgently need to be resolved to avoid the fragmentation and loss of momentum which emerged during earlier phases of Egypt's population program.

2. PROJECT INPUTS

2.1 Contraceptives

Under POP/FP III it is projected that USAID will donate approximately US\$7.5 million of commodities including IUDs, Depo-Provera, NORPLANT®, condoms, and related equipment, such as IUD kits and NORPLANT® insertion kits. USAID provides contraceptives to the public and NGO sectors through the Egyptian Pharmaceutical Trading Company (EPTC). USAID is the sole provider of IUDs and condoms to the public sector. The United Nations Population Fund (UNFPA) is currently the sole provider of Depo-Provera. USAID will become the provider of injectables to the public sector after UNFPA stocks are depleted around mid-1996. Small quantities of NORPLANT® are currently available for phased introduction; larger quantities will be provided in mid-1996. USAID-donated contraceptives are provided free to the public sector, and the revenue is generated and distributed according to guidelines jointly agreed upon by implementing agencies.

Under POP/FP II, USAID provided IUDs, pills, and condoms to the private sector through the SOMARC-implemented Contraceptive Social Marketing Project (CSMP). Although the provision of contraceptives to the private sector was completed as planned, SOMARC, through a subcontract with the Middle East Chemical/MedTech Pharmaceutical Company, has continued to distribute contraceptives that were in the pipeline. These stocks will be completely exhausted by May-June 1996.

2.2 Buy-ins

2.2.1 Demographic and Health Surveys

The 1996 Egyptian Demographic and Health Survey (EDHS) conducted its field work in November 1995 and will offer preliminary results early in 1996.

2.2.2 RAPID IV

Under POP/FP III, the Resources for the Awareness of Population Impact on Development Project (RAPID) has: 1) conducted a 4,000-sample household survey of expenditure on children, 2) in collaboration with NPC/IDP, offered strategic planning and target setting exercises for NPC/Governorate officials in Port Said, Damietta, and Sharqiyya, and 3) consolidated materials from the Egyptian Family Planning Program Cost-Benefit Study (Moreland 1995) and the ICPD RAPID presentation for governorate-level presentations. The linkages with POP/FP III have been facilitated by the fact that The Futures Group is both the contractor for RAPID IV and a member of the PPC consortium.

2.2.3 *OPTIONS II*

During POP/FP III, the Options for Population Policy Project (OPTIONS II) has organized a major policy conference (May 1995) and conducted policy-relevant studies on market segmentation from secondary analysis of the 1992 DHS, free market IUD pricing, private sector clinic service pricing, and regulatory barriers. OPTIONS II consultants wrote a history of the Egyptian family planning program (Robinson & Zanaty, 1995) and helped NPC prepare for the ICPD. The Futures Group is also the contractor for OPTIONS II.

2.2.4 *AVSC*

The AVSC buy-in provides support to three university-based hospitals to test and demonstrate the demand for postpartum IUD insertion and tubal ligation for medically indicated reasons and to develop these services. A team from AVSC will visit in January 1996 to discuss additional assistance to extend postpartum IUD services through the MOH system.

Working in conjunction with the obstetrics and gynecology (Ob/Gyn) departments at Alexandria, Mansoura, and Ain Shams Medical Schools, AVSC has coordinated the development of an in-hospital referral system, standards of practice, and training components. Equipment has been received and renovations completed at Alexandria and Ain Shams Medical Schools. Training in counseling was conducted at these two sites. Equipment, renovations, and counseling training are scheduled for the Mansoura Medical School.

This is a demonstration project to lay the groundwork for more widespread introduction of long-term contraception in Egypt. Methodologies for introduction (interviews, focus groups, and follow-up with providers and clients) are carefully planned and studied so that expansion of the programs can be based on tested means of gaining acceptance for new family planning methods. A steering committee and annual update conferences have been planned to ensure the dissemination of lessons learned.

2.3 Local Funds and Government of Egypt Contributions

Under the POP/FP III Project Agreement with the GOE, USAID provides funds to implementing agencies under a series of Project Implementation Letters (PIL) to cover the local costs of project activities. The GOE has also agreed to provide funds to support project activities and cover salary supplements, and to make in-kind contributions such as personnel, facilities, TV and radio air time, and press space.

The release of USAID funds is contingent upon approval by USAID of detailed implementation plans and the fulfilling of specific conditions and covenants specified in the Project Agreement.

GOE delays in releasing salary supplements for NPC/IDP personnel, a Condition Precedent of the Project Agreement, delayed the release of the initial tranche of funds for the NPC/IDP subproject. This also delayed the release of funds to the Clinical Services Improvement (CSI) and Regional Center for Training in Family Planning and Reproductive Health (RCT) subprojects which are under the IDP umbrella.

The payment mechanism for two of the subprojects, CSI and RCT, is based on performance-based outputs rather than activities.

2.4 Implementation\Goods & Services Contractor

2.4.1 The Consortium¹

Pathfinder assembled a consortium of agencies to implement POP/FP III—the Population Project Consortium (PPC). The primary strength of the consortium was the participating agencies' experience and credibility in Egypt. Each of the institutional members had a significant and specialized technical role in POP/FP II and a history of well-established relationships and effective collaboration with implementing organizations. The majority of individuals employed by each agency as long- and short-term advisors had substantial involvement in that collaboration and had provided beneficial technical support. This continuity has contributed significantly to the performance of the POP/FP III project.

A major challenge faced by the consortium and USAID was the need to adjust to a radical change in contractual relationships: POP/FP II was implemented through Cooperative Agreements; POP/FP III is a contract. Cooperative Agreements allow a much more flexible and collaborative relationship between the Cooperating Agency (CA) and USAID. Moreover, the CAs that were working under POP/FP II utilized core funding; so while the CAs were generally responsive to USAID/Egypt, they were ultimately accountable to USAID/Washington. Cooperative Agreements require detailed work plans that must be agreed upon by both sides, but they can be altered relatively easily to accommodate changing circumstances, unforeseen constraints, or new opportunities. A contractor, on the other hand, is bound to produce precisely specified deliverables, and USAID is bound to monitor conformance with the contract and, therefore, has rigorous accountability requirements.

2.4.2 Technical Assistance

Long-term Technical Assistance (LTA). Pathfinder fielded the long-term advisors relatively quickly after the contract was awarded in October 1993. With the exception of the research advisor, all of the resident advisors were on the job within approximately three months. Several

¹ Note: This is not a legally constituted consortium.

of the advisors had already been in Egypt working under the predecessor project and were simultaneously involved in winding up POP/FP II activities and beginning POP/FP III. While this overlap put an extra burden on both the advisors and implementing agencies, it facilitated a smoother transition. Although consultants were brought in to assist with the close-out, it was nonetheless time consuming for everyone and did inhibit the start-up of POP/FP III. In the future, some allowance must be made for time lost during project transitions.

Although there has been some turnover of resident technical specialists (RTS), for the most part, the changes were shifts in responsibility by individuals who had been involved in various ways with both POP/FP II and POP/FP III. The first chief of party left in December 1994 and the current chief of party, who had been the management and planning specialist/National Population Council (MPS/NPC), was officially designated in June 1995. The financial and administrative specialist acted as liaison with Pathfinder during the interim period. The new MPS/NPC officially began work in September 1995. The research specialist/Research Management Unit (RS/RMU) position was supported by a combination of short-term and resident technical assistance from January 1994 to June 1995. A new RS/RMU, who had been working in Egypt as a long-term technical consultant on related activities, began work in June 1995.

The transition to POP/FP III required the creation of a coordinated team, complex management systems, and a new relationship with USAID. Although, the start-up phase was troublesome, some of the subprojects began relatively smoothly. The Systems Development Project (SDP) and IDP, for example, had continuity of technical support from POP/FP II. After some personnel changes were made, there was a marked improvement in teamwork within PPC and in overall project management.

The first chief of party, who had been the CSI advisor under POP/FP II, had the challenging role of setting up and managing the new umbrella project. According to the project design, she also had responsibility for providing technical assistance (TA) to CSI and the management of the Private Sector Initiatives Project (PSI), a new activity for which PPC was the implementing agency. Given the enormous management burden on the chief of party, especially during the project start-up, and her continued focus on CSI, PSI was not given much attention during the first year of implementation.

The development of the PSI project activity is a good example of the advantages of providing technical assistance through the umbrella mechanism and an example of productive PPC teamwork. Under the guidance of the financial and administrative specialist, the resident technical specialists combined forces, each providing assistance in his or her area of expertise, to plan and launch this subproject which had been neglected during POP/FP III's first project year. The research specialist/RMU and the financial and administrative specialist took the lead, and the other resident technical specialists provided support in management, contracting, IEC, and training, and organized specialized short-term technical assistance (STA) from three members of the consortium.

The role that the IEC/SIS advisor has played in coordinating IEC activities is another good example of the value of the umbrella arrangement. Although his primary responsibility is to provide technical assistance to the SIS subproject, he has supported SDP activities both within the context of the contract between SDP and SIS and in collaboration with the MS/SDP advisor. He also provided technical assistance to PSI and has been an important link between the Johns Hopkins University/Population Communication Services and PPC in planning IEC short-term technical assistance.

A key part of the consortium RS/RMU advisor's role—that is, ensuring that USAID-funded research is planned to respond to the most pressing research needs—could be strengthened. While he is responsible for coordinating the PPC special studies, those studies were largely planned in advance so there is limited flexibility to modify studies to respond to the current policy and program priorities. He does not play a formal role in providing guidance to USAID-funded, project-related research outside the PPC mandate. As a Futures Group staff member, he is able to coordinate closely with the RAPID and OPTIONS projects; but he has no coordinating role in other USAID/Washington-funded research activities, such as the Population Council and Women's Status project studies.

The Teaching Hospitals Organization (THO), CSI, and RCT subprojects require a different type of long-term technical assistance than has been available to them. (See sections 3.3, 3.5, and 3.6.) As these subprojects move toward self-sufficiency, they will require specialized assistance in the areas of strategic planning, financial management, and marketing. One resident advisor could provide support to the three subprojects.

Short-term Technical Assistance. The initial contract agreement budgeted 148-person months of STA, which represented a dramatic decrease from the level of STA provided under POP/FP II. The project design team evidently believed that the long-term advisors would be able to provide technical support sufficient to warrant a reduction in short-term assistance. However, given the additional management burden of the new contract, the long-term advisors have not been able to devote as much time to technical assistance as had been anticipated. Early on it was recognized that more STA was required and, because of a savings in LTA, about 34-person months of LTA were converted to STA. PPC has thus been able to program much needed specialized technical support in areas that were not originally planned, such as STA in financial management for SDP. More STA is urgently needed and should be programmed if, there is a project extension, in areas such as IEC, statistics and information systems, and management.

In general, STA has been timely and effective. Much of the STA is a continuation of support provided under POP/FP II. The advantages of the umbrella project are evident in the flexibility to use STA across subprojects. There are important cost efficiencies in being able to program a single STA trip for several purposes, and there are technical advantages in coordinating TA needs among the subprojects. The same STA/MIS advisors have worked with PPC, SDP, RCT, and THO in the design and implementation of computerized information systems. Short-term IEC and research advisors have worked with SIS, SDP, and PSI.

2.4.3 Planning and Reporting

As noted, the change from a cooperative agreement to a contract also necessitated a shift by USAID and the I\G&S to more specificity in work plans and to stricter accountability for implementation of those plans. This affected the relationship between USAID and the contractor, both of whom had been accustomed to more flexibility in project planning and implementation.

The initial PPC activity was the development of detailed Life of Project and Year 1 implementation plans in English. For subprojects such as SDP, in which there was continuity of LTA, STA, and the activities, the process was relatively smooth and rapid. The process for others, such as RCT and THO, was slower. The advisors were supposed to help improve their counterparts' capability to develop work plans; but the advisors' approach to this task has varied. Under SDP, for example, the Life of Project plan was developed collaboratively, involving SDP personnel at all levels, and was written largely by the technical advisor. SDP staff have gradually taken over more responsibility for the annual plans, with support from PPC and some English language training. The RCT and THO Life of Project plans were developed initially by the subproject staffs with less guidance from PPC and required a fair amount of refinement before being approved by USAID.

Quarterly reports that reflect achievements in relation to implementation plans are mandated for each subproject and for PPC. The first two quarterly reports produced by PPC reported, in tabular form, every activity performed. The presentation was confusing and repetitive, there was more detail than USAID needed, little narrative, and no analysis. USAID asked PPC simply to report achievements by core tasks (of which there are seven) and technical strategies (there are seven). The current reports are still long and repetitive: the same activity may be reported under three rubrics.

Under the contract, the subprojects must submit quarterly reports within 45 days after the end of the reporting period. PPC has 60 days after the reporting period to submit quarterly reports because of the need to incorporate the subproject reports. Given the requirement to include the subproject reports into the PPC quarterly PPC report, this long period is necessary. However, the lag time reduces their usefulness for project management.

2.4.4 Participant-in-Development Training and Invitational Travel

PPC has direct responsibility for Participant-in-Development Training (PID) and invitational travel. The original contract estimated 60 PID and 24 invitational travel participants. In response to a PPC request for an increase in PID participants to satisfy the needs of all of the subprojects, the contract was amended and the number of authorized PID participants increased to 94. The Life of Project implementation plan was finally approved in October 1995 although PID training

began in October 1994. Development of the plan has been a complex process involving coordination with each of the subprojects.

PPC has organized a strong PID program. The training management specialist (TMS) identified appropriate training opportunities in the U.S. and third countries. Some of the courses are in Arabic for participants unable to function adequately in English. The TMS designed a workshop for returning participants to ensure the maximum benefit to their sponsoring agency: each participant prepares an action plan specifying how he or she will apply the training.

There is preliminary evidence of the usefulness of the training. For example, after the SDP director and a senior Egyptian Pharmaceutical Trading Company staff member attended training in logistics management they helped to develop a RCT training program in contraceptive logistics management. SIS and THO participants in IEC courses have developed strategies and materials after their return; a member of the THO staff is working with the THO IUD insertion curriculum as part of his program.

2.4.5 Management Information System

PPC established a management information system (MIS) that tracks the activities and outputs of each of the subprojects and consolidates the information for the quarterly PPC report. Although all the subprojects are generating the necessary data, they are at varying stages in the development and computerization of their information systems. By the end of POP/FP II most of the subprojects had reasonably good systems which needed relatively minor readjustments, reformatting, and computerization. SDP presented a greater challenge because of its magnitude and complexity and the need to collect information from each of its delivery units. The quality and timeliness of all subproject reporting has improved substantially in POP/FP III. The recent USAID performance audit found that reliability of subproject reporting was good.

PPC had a more difficult time setting up the consolidated report. Initially, the consolidated report was coincident with the overly detailed, complicated quarterly report. PPC, with some assistance from USAID, developed the streamlined MIS and reporting format that has been used since the latter part of 1994. It is an annex to the quarterly report. The PPC Consolidated Subproject Output data report is organized by output specified in the POP/FP III logframe. It presents quarterly and cumulative individual subproject outputs under each of the specific output indicators, as relevant. It is clear, easy to read, and useful for program monitoring.

2.4.6 Financial Monitoring

PPC was mandated to hire a certified public accounting (CPA) firm for financial monitoring of the subprojects. The contract with a CPA firm was not signed until May 1995. Delays occurred for a number of reasons, including discussions between USAID and PPC on the Scope of Work, time

for the financial and administrative specialist to assist in developing the sample size required for monitoring, and time required by the Pathfinder and USAID contracts offices for review of the request for proposal (RFP).

The CPA firm monitors all monthly expenditure reports by implementing agencies to ensure that they are within budget, the costs are allowable and reasonable, and that transactions conform to USAID regulations. In the case of the performance-based subprojects, they are responsible for verifying outputs. The role of the CPA firm is to identify problems in accountability and reporting so they can be corrected—a process which should help to forestall some of the kinds of audit problems that occurred at the end of POP/FP II. Although it is too soon to assess the performance of the CPA contractor, the first set of reports have been produced for all the subprojects. To date no major problems have been found. A few errors in the accounting systems of implementing agencies have been identified and PPC is assisting the implementing agencies to correct them.

2.4.7 Procurement

Pathfinder had approximately US\$3.8 million in the contract to procure non-contraceptive commodities and vehicles for the project. Before any procurement could begin, PPC had to develop an overall project procurement plan linked to each of the subproject implementation plans. PPC did not submit a plan to USAID until September 1994. Some adjustments were made and the plan was approved by USAID in late 1994, excluding procurement of computers. The necessary waivers for vehicles and other commodities were not obtained until early 1995. The computer procurement was held up by the Information Resource Management office at USAID/Washington (IRM/W), which questioned the diverse software requested for each of the agencies. The issues were finally resolved by May 1995, with assistance from an IRM/W official who fortuitously made a trip to Egypt, and an short-term MIS advisor. Pathfinder began the bidding process in September 1995 and the computers are expected in Egypt in December 1995.

There have been multiple problems with the non-computer procurement, ranging from a lack of clarity in the specifications of some items submitted by implementing agencies, to procurement snags and delays from Pathfinder/Boston; to problems in moving commodities through port formalities; and difficulties in arranging receipt by the implementing agencies. However, the vehicles and most of the commodities have been delivered. PPC worked closely with USAID to respond to some requirements that had not been anticipated, such as the need to provide repair tools in order to set up a vehicle maintenance system for SDP.

Delays in procurement have affected project implementation. For example, vehicles were not in-country in time to launch the SDP mobile clinics according to the implementation schedule. Delays in computer procurement have hampered the introduction of data processing and management systems at all levels.

2.5 USAID Administration and Support

POP/FP III is managed by the Office of Population of USAID. Most of the same staff also managed POP/FP II and were responsible for the close-out of that project and transition to POP/FP III. The change to a contractual relationship required a significant adjustment in USAID management style. Moreover, USAID/Egypt staff are under unusual pressure, having been subjected for the last several years to intense scrutiny by financial and programmatic auditors.

The difficulties associated with the transition to POP/FP III created some tensions between USAID and PPC. USAID had to ensure that adequate systems were established for programmatic and financial planning, tracking, and reporting. While PPC required a fair amount of direction and assistance from USAID in setting up these systems and in developing implementation plans, there has been, at times, the perception within PPC that HRDC/POP staff were overly attentive to details. Relationships between HRDC/POP and PPC improved once the Life of Project implementation plans were completed and acceptable reporting formats were set up. Communication has further improved in recent months.

The HRDC/POP staff are dedicated to utilizing USAID resources most effectively to help Egypt to reach its population goals. They provide constructive oversight and significant support to PPC and the implementing agencies, assisting them to realize the maximum benefit of USAID support. There has been sufficient continuity within the office to afford a critical historic perspective and a good programmatic understanding of subproject strengths and weaknesses. Project officers monitor the subprojects conscientiously and have a good substantive knowledge of their status based on frequent meetings with the RTS, subproject directors and staff, periodic field trips, and review of reports.

Project officers hold quarterly review meetings with subproject executive directors and staff to review progress, address issues of concern, and agree on actions. Decisions taken at the review meetings are summarized in a letter to the director and followed up. Twice a year HRDC/POP prepares a status report for USAID on each subproject.

The umbrella contract has relieved USAID of some management burden. The major responsibility for coordination of project activities has been transferred to PPC. However, HRDC/POP staff still have an important management and coordination role. They circulate all major planning and reporting documents for review and comment so that each project officer can ensure that the activities of the projects he or she manages are in harmony with the others. Although this may be necessary for internal coordination, it is time-consuming for the project officers and delays feedback. PPC administration of procurement and participant training reduces HRDC/POP's direct management responsibilities although there are still a lot of bureaucratic tasks that USAID must do.

A major constraint for HRDC/POP, PPC, and the implementing agencies has been the volume of documentation and approvals required by USAID. HRDC/POP is attempting to reduce paper

work by negotiating within USAID and holding discussions with PPC. HRDC/POP has been able to reduce reporting requirements for CSI and THO, both of which have shifted to performance-based payments. SDP, like the other service delivery subprojects, has an extra burden of reporting to USAID on revenue generated by USAID-provided contraceptives. It would be more efficient for SDP if the revenue report could be integrated with routine reports required by the MOH.

2.6 Conclusions and Recommendations

The PPC consortium is composed of a group of agencies and individuals with much experience in population and family planning in Egypt and which have established relationships with POP/FP III implementing agencies. This knowledge and experience greatly facilitated the transition from POP/FP II to POP/FP III. However, the new contracting mode changed the way both PPC and USAID operated. The increased documentation required for planning, reporting, and monitoring were burdensome and diverted both PPC and USAID staff from broader management and programmatic issues. It also forced a change to more formal and less collaborative relationships between the two organizations. Although the start-up period was difficult, the PPC consortium is now functioning well.

The umbrella contract has distinct advantages for the implementation of POP/FP III, which incorporates a number of disparate activities that are all focused on the same goal. Bringing together the elements of this project under one management structure facilitates coordinated planning and implementation and is critical to ensure complementarity and mutual reinforcement and to avoid overlap. Some of the activities are linked through formal agreements such as the contract between SDP and SIS for IEC; others are linked informally such as the involvement of the SIS/IEC specialist in planning the promotional activities of PSI. While some of the inter-institutional relationships could exist in the absence of the umbrella, the PPC structure enhances and intensifies these associations and provides the nucleus of advisors associated with PPC who can coordinate project resources to optimize their impact.

An umbrella mechanism also has the benefit of decreasing the USAID management burden by transferring major responsibility for overall coordination and for special functions including participant training and non-contraceptive commodity procurement. However, in order to maximize this advantage, USAID has to be able to limit some of its oversight responsibilities, which are partly the consequence of internal USAID accountability requirements.

An important lesson learned from POP/FP III is that the time frame is too short. The project, initially conceived as a five-year effort, has been compressed into less than four years. This short period has forced an orientation toward detail—achieving deliverables—and diverted attention from the big picture. Five years is the absolute minimum for a program that has long-term goals and vision; and ten years would be better.

Recommendations:

1. **The existing project should be extended to ten years and a follow-on project should be designed with an overall implementation period of ten years.**
2. **While there should be an umbrella mechanism in a follow-on project, USAID should consider a more flexible contracting mode.** The necessity for rigid adherence to a contract forces USAID and the contractor to focus on quantitative deliverables rather than qualitative outputs. A cooperative agreement or performance-based contract would provide considerably more flexibility to design and implement a program that is developed collaboratively with USAID and the local implementing agencies. It would also provide the flexibility to amend the strategy as the situation evolves during implementation. It would lessen the burden on all sides for the detailed documentation mandated by a traditional contract and allow everyone to focus more time and resources on the program instead of the process.
3. **HRDC/POP should continue to work with PPC on minimizing paperwork and to explore within USAID ways in which PPC and implementing agencies can reduce their reporting. PPC and USAID should agree on a streamlined format for quarterly reports that provides the essential but minimum information needed for project management and monitoring by both PPC and USAID.** Perhaps the full individual subproject reports could be submitted separately so that the overall PPC report could be submitted more quickly. Quarterly reports should be a useful management tool for both USAID and PPC to monitor project implementation; they should not be an onerous task that diverts PPC from programmatic work.
4. **It would facilitate procurement for a project of this size and complexity if the procurement plan could be disaggregated and procurement could begin as the needs are specified for individual entities.**
5. **Project staffs should learn to develop implementation plans. However, they should be permitted to write them in Arabic, if necessary, and the project should provide resources for translation.** While it is important for managers to learn effective project planning, requiring them to prepare documents in English is very time consuming, may result in more involvement of expatriate advisors in the interest of efficiency, and can limit the pool of potential project managers.
6. **The research specialist/RMU should be given a mandate to advise HRDC/POP on planning USAID-funded research to ensure that it is designed to respond to the most critical research needs as defined by RMU.**
7. **A new long-term advisor should be recruited to provide technical assistance in strategic planning, financial management, and marketing to THO, CSI, and RCT.**

8. **The necessary contractual adjustments should be made to permit programming additional short-term technical assistance, especially in the areas of IEC, statistics and information systems, and management.** Additional STA needs are specified under the individual subproject sections.

3. PLANNING AND IMPLEMENTATION: THE SUBPROJECTS

3.1 Ministry of Health/Systems Development Project

The Systems Development Project in the Ministry of Health was initiated under the POP/FP II project. The goals are to improve the MOH family planning management and service delivery systems and enhance the long-term technical sustainability of the MOH family planning program. Projected outputs are

1. Strengthened management infrastructure through an improved program management supervision system; integrated MIS; improved management capacity in the areas of finance, non-contraceptive commodities, facilities and maintenance, personnel, training, IEC, operations research (OR), and planning/evaluation.
2. Improved quality of services through improved clinic facilities and equipment; counseling and service provision; supervision, management, and support systems.
3. Increased family planning service volume through greater method choice; improved rural access through mobile teams and more female nurses; better counseling and referral by maternal and child health (MCH) nurses, nurse midwives, and *dayas*; improved perception of service quality; more and better IEC; and OR studies.

3.1.1 Management

USAID has assisted the MOH to define its family planning mission; develop and implement strategies to achieve that mission; establish a structure congruent with those strategies; develop human resources through technical assistance, training, and invitational travel; and develop, implement, and refine systems in planning, finance, operations, management information, logistics, and monitoring/evaluation. Increasingly, these six elements form an interdependent whole.

Mission. The mission of SDP is to improve family planning services, and the SDP has been, as the final evaluation of POP/FP II stated, very successful in achieving that mission. The evaluation team believes it is time to consider a carefully phased expansion of the SDP mission to a broader reproductive health program. Recent international findings indicate that family planning is most effective when offered in the context of a full reproductive health service.² Priority program

² See 1) Aitken, I. and L. Reichenbach, Reproductive and Sexual Health Services: Expanding Access and Enhancing Quality. Sen, G., A. Germain, and L. Chen (eds.) *Population Policies Reconsidered: Health, Empowerment and Rights*, Harvard School of Public Health, Boston, MA, and 2) Bongaarts, J., and J. Bruce. 1995. The Causes of Unmet Need for Contraception and the Social Content of Services, *Studies in Family Planning* 19, 2, 57-75; and 3) Implementing Reproductive Health Programmes, Report of a Donor Workshop, USAID and ODA, June 1995.

components would include, in addition to family planning, safe pregnancy and the prevention and management of reproductive tract infections. A reproductive health approach within the MOH would provide the continuity of care associated with continued contraceptive use and significantly improved maternal and child health. The same MOH resources now being channeled specifically to family planning would, with a marginal additional effort, provide a more effective comprehensive reproductive health service.

Such an expanded mission for the SDP seems particularly important in light of the 1992-1993 Maternal Mortality Survey which revealed the inadequate referral of women who are experiencing a high-risk pregnancy, and delays on the part of women in seeking care and delayed referral for women in the throes of an obstetric emergency. Almost 20% of the maternal deaths in the survey had occurred among women with reported contraceptive failure or undergoing an otherwise unwanted pregnancy. The expansion of the SDP mission to include safe pregnancy seems highly warranted—as does the inclusion of sexually transmitted disease (STD) treatment and STD and HIV prevention, the third component of a reproductive health program. There are obvious interfaces between family planning and STD/HIV programs: family planning providers need to be aware of the STD risk profile of a client when helping the client to select a contraceptive method; moreover, providers are in an ideal position to identify and treat STDs. The provision of reproductive health services, offered in close collaboration with those of the upcoming USAID-funded Healthy Mother/Healthy Child Project, is a natural evolution for the SDP.

Strategies. The central strategy of the SDP in POP/FP III is to improve quality through the Quality Improvement Program (QIP). The strategy involves the development of a human resource structure in which training is passed on from the central office down to the local clinic. In QIP central office staff are trained; they in turn train, supervise, and motivate governorate teams who train, supervise, and motivate district teams who train, supervise, and motivate service providers. The program is supported by systems for planning, financial management, supervision and training, logistics, and reporting. QIP is an ambitious strategy, vital to national success. It is a strategy designed for five years while the duration of the POP/FP III project is, for implementing agencies, only 3.2 years. Three years is not sufficient time to achieve such an ambitious goal.

Structure. The MOH family planning infrastructure includes a vast network of service delivery points with no person being more than five kilometers from a source of health care. SDP anticipates being able to bring approximately 2,500-3,000 of the total 3,706 sites up to QIP standards for clinical family service provision within the next several years. SDP anticipates developing the remaining units as non-clinical sites providing IEC, counseling, pills, condoms and referrals, with mobile teams visiting as needed.

The first phase of clinic renovations is complete: the renovated clinics are much improved. As a result of QIP, MOH family planning personnel have been trained and systems introduced at the central, governorate, and district level to plan, supervise, and report on MOH family planning service delivery.

Positioning the SDP within the MOH is sound. SDP should remain within the MOH to augment the effects of the investment that USAID and the GOE have made over the last six years in implementing the Quality Improvement Program and strengthening the staff and systems that support family planning services.

Systems. The SDP has focused significant effort on upgrading the systems that support service delivery. One of the most critical systems—supervision—involves a systematic step-down of management systems from the central office to the governorate, district, and unit levels. Pilot tested during POP/FP II, the supervision system is currently in the second phase of implementation. The Standards of Practice and Standards of Service form the foundation of the system which addresses all aspects of service delivery including cleanliness of the clinic, interactions with clients, stock of commodities, supplies of basic equipment and medical instruments, and technical service. The systems will be supported by a series of procedure manuals being developed by the Systems Development Unit, with project-funded, short-term technical assistance. Training, financial, and MIS management manuals are complete; a first draft of the commodities manual is complete; and a first draft of the first part of the IEC manual is finished. More time is needed to refine systems currently in the process of development.

Human Resources. The SDP benefited from excellent succession planning by the POP/FP II MOH SDP executive director and has sustained a continuity of leadership with the promotion of the previous deputy director to the executive director role. There are many new individuals in other key roles, however, who will need training and other support to bring them up to the standards required by the project. The hiring of specialists with the appropriate expertise, such as the MIS specialist, has been a successful strategy.

There is a vast supply of physicians in the country, including 5,000 new graduates each year who are required to perform one year of government service. Nonetheless, there are many rural areas with no physicians and urban areas with a surplus. This maldistribution and the failure to retain physicians where they are most needed is a serious problem.

3.1.2 Training

The purpose of POP/FP III training is to standardize and institutionalize the quality of care in the service delivery system. To this end, a series of courses was designed to create a decentralized training system based on a cascade approach to orientation and training from the central office to the clinic. In POP/FP II, central office staff training included orientation to SDP and family planning program management, supervision and technical assistance, MIS analysis and design. In POP/FP III, SDP is providing courses in orientation to QIP, training methodologies and management of training, clinic management, and service delivery. To date in POP/FP III, the SDP has provided a total of 274 courses for physicians, nurses, and management staff at the central, governorate, district, and unit level. There have been 6,558 participants, 63% of them female, in the courses. (See details in Annex 1.)

Although the late start-up of the project delayed the implementation of the training program and Project Year 1 (PY1) targets have not been met, there has been an impressive amount of activity, and results are visible in many aspects of many clinics. Some courses were postponed for strategic reasons (e.g., MIS and computer courses). Given delays in delivery of computers, it made more sense to conduct courses in manual record-keeping so that staff could learn the principles of record-keeping first and then learn how to computerize the record-keeping when the computers arrive. Training for MCH nurses in counseling and referral has not yet begun due to the delay in mounting the operations research study related to referral issues. The clinic staff who have received QIP training are proud of their ability to apply what they have learned and to implement changes.

The Training Management Unit is very well organized. A monitoring system is in place to track the courses delivered and the personnel trained in order to ensure that those who need training receive it and that those who have already received it do not unnecessarily repeat a course. Course curricula are organized in a library and are easily accessible for quick reference.

While POP/FP III offers extensive opportunities for short-term training, it has not offered sufficient long-term (master's degree) training. One of the measures of success of the USAID-funded population projects is the outstanding contributions of Egyptian staff working in leadership positions in subprojects in the PPC and at USAID/Egypt. Most of them were recipients of long-term training in POP/FP I or POP/FP II and are applying their training effectively with visible results in POP/FP III. Continued development of that resource and leadership base is advisable, with the most qualified employees from the central, governorate, or district level being selected for training.

Collaboration with RCT. The Regional Center for Training (RCT) has responsibility for providing all training of trainers (TOT) for SDP physician and nurse trainers and for SDP Ob/Gyn specialist courses. Lengthy and complex negotiations between the SDP and RCT resulted in several courses that are tailored to meet the needs of the SDP. However, the service delivery course for Ob/Gyns, commissioned over a year ago, has not yet been up-dated to meet the specifications of the MOH Standards of Practice. The old course is still being delivered. All courses, except the technical course for physicians, are conducted in Arabic, which is an improvement from POP/FP II when training materials were produced in English.

While the RCT/SDP Letter of Agreement indicates that RCT has funding for specified SDP courses and that SDP will obtain specified training from RCT, this letter is not a contract, and RCT is therefore not held to contractual standards to deliver what SDP requires. SDP thus has had the illusion of being able to get what it needs from RCT but there has been no way to enforce the delivery of their agreed-upon products. An example of the problems resulting from this situation is the TOT for nurses which was to be delivered three times. The primary purpose of the course was to introduce the new counseling flip chart. The curriculum was developed by SDP and RCT agreed to present it. After the second course, SDP discovered that RCT had not used the new curriculum. The nurses had to be reconvened to receive the appropriate training at SDP's

expense because there was no mechanism to hold RCT accountable. Currently, change is under way in RCT which is expected to result in greater client responsiveness (see Section 3.5).

3.1.3 *Quality of Care*

The Quality Improvement Program delineates about 100 indicators of quality grouped in three categories:

1. Clinical services management—client registration, history, family planning information, physical examinations, method-specific counseling, method provision, infection prevention, client satisfaction, contraceptive commodities;
2. Support services management—IEC activity, records and reports, clinic management; and
3. Facilities and equipment management—clinic equipment, furnishings, and supplies.

Each service delivery point is rated against all the indicators and a score is assigned. All clinics are expected to score 100%; those that do will be identified as gold star clinics and staff, contingent upon maintaining their scores.

The Quality Improvement Program, which entails training, monitoring, and evaluation, is being implemented in three phases: the first phase was completed in selected districts in all governorates; the second phase is in progress; and the third phase will complete the introduction of the program in all districts. Monthly monitoring visits are conducted by the central office to each governorate; governorate staff visit each district monthly; and district supervisory teams visit each clinic quarterly unless deficiencies require more frequent visits.

A work productivity payment plan is a key component of the SDP quality program and, the team believes, is critical to its success. All family planning staff in service delivery sites, from the physician to the support staff, share on a set basis (40%-5%) revenues earned from sale of USAID-donated contraceptives. A small percentage (3%) of the revenues is paid to selected district level staff. Clinic staff, when asked about the importance of these payments, replied that they were very important in motivating staff to perform well.

Method Mix. The five contraceptive methods available at all MOH family planning service delivery points are the Copper T 380A IUD, oral contraceptives (OC), injectables, condoms, and foaming tablets. Each service delivery point visited had in stock, and within the expiration dates on the package, three months of supplies of all methods. No stock-outs were reported. Pills are only available in 21-day pill strips, however, making the utilization of pills more complicated for women, particularly in the absence of consistent information from service providers.

Interviews and observations of nurses, social workers, and counselors indicate that all methods are reviewed with clients, although the information provided is not always entirely correct. There

are new flip charts designed to standardize the information given to clients throughout the system. They are to be set up with the counselor and client across the table from each other. As the counselor reads from the back of the flip chart the client sees a graphic representation of the information provided. These flip charts were present in most clinics but were not consistently being used or used as intended. Information is, therefore, not standardized, and in most cases the directions for OC use and IUD longevity were not consistent with the QIP guidelines. In some cases, it was observed that misinformation was given to clients by physicians and nurses. The QIP monitoring check-list does address the issue of pre- and post-provision counseling by nurses and physicians but it does not require that the monitor assess the accuracy and completeness of the information offered.

Method-specific brochures printed by the SIS had not yet been distributed to the clinics visited in Aswan and Beheira Governorates; they were newly available in some Alexandria clinics.

The following table shows the percentage of couple years of protection (CYP) that was contributed by each method during PY1. The team's review of MOH service statistics, however, indicates dramatic increases in injectable users from June-July 1995 onward following the promotion of injectables by the Minister of Population and Family Planning and a concerted IEC effort in support of the method. MOH service providers in Upper and Lower Egypt indicated that the monthly number of injectable users has doubled, with the total including many new users as well as switchers from the IUD.

QIP Facilities. In most of the clinics in which QIP had been introduced, there were new boilers, and the steps for infection prevention were written out in Arabic and hung on the

Table 1

MOH Percentage Distribution of FP Methods to CYP - 1994/1995

	Total Egypt	Frontier Governorates	Upper Egypt	Lower Egypt	Urban Governorates
IUD	90%	75%	84%	90%	90%
Pills	4%	15%	8%	5%	3%
Injectables	4%	6%	6%	4%	4%
Others	2%	4%	2%	1%	3%

Source: SDP data.

wall for easy reference. Standards of Service notebooks, distributed at QIP training sessions, were available in all clinics and prominently displayed in most. Where renovations had been completed, there was a separate area, or separation within an area, for infection control, counseling, examination, and registration. Expendable supplies, however, are still reportedly unavailable through MOH supply lines. This lack of supplies is handled differently by individual clinics: some ask clients to pool their resources and go to the pharmacy to buy their own; some

get petty cash from a health center or hospital director; some clinic staff buy the supplies themselves; some use the clinic revenue fund.

The linkage between MCH and the family planning units is an indicator of quality for the project. As a planned operations research study of the linkages has been delayed, MCH providers have not yet been trained. Linkages between the services, therefore, are based on the training and good will of individual physicians and nurses. In some units the team visited, there was ample evidence of strong collaboration; in others, there was none.

3.1.4 Access

The evaluation team believes that the barriers to access are related to quality and that neither distance nor cost is a significant barrier. There are 3,706 service delivery sites which adequately cover the country; fees for services are low. Data show that in Upper Egypt many of those units are by-passed by clients who seek the higher quality services provided by CSI clinics³. In Sohag, Qena, and Aswan, three Upper Egypt governorates with low CPR, the MOH averaged 98 CYP per unit in 1994/1995, while in the same period in the same region, CSI averaged 2,124 CYP per unit, although CSI service fees are about five times that of MOH.^{4,5}

Many underutilized MOH clinics are in locations where it is very difficult to retain physicians: small villages, where access to the nearest bus stop entails walking five kilometers in hot weather, and the run-down physician quarters attached to the rural health center have neither running water nor electricity. For example, in Fayoum, a governorate one hour south of Cairo, 25% of the clinics, all of them in rural areas, lack physicians. The percentage of rural clinics without a physician is probably higher in areas more distant from major population centers.⁶

³ In Upper Egypt the QIP is in its infancy. In contrast, in Lower Egypt there are high-quality MOH facilities crowded with clients.

⁴ CSI has been strongly encouraged to focus efforts on Upper Egypt through the USAID CYP output-payment mechanism which pays CSI for CYPs in Upper Egypt at three to four times the rate for Lower Egypt.

⁵ Although the CSI units were much better utilized than those of the MOH, the CSI units were themselves underutilized: staffed and open six hours a day, six days a week, they averaged only 2-4 new family planning clients a day and a total number of daily client visits (including the new family planning clients) of 10-16.

⁶ In each governorate the MOH attempts to deal with its own physician problem. While the problem in Upper Egypt is scarcity and retention, in Alexandria, it is a problem of surplus. The team visited one family planning clinic staffed by 5 full-time female physicians although it averaged 15 clients a day. To deal with such a surplus, the MOH undersecretary recently issued a decree establishing two shifts for family planning workers in Alexandria. Although there was some opposition to it, as of November 1, 1995, there are two shifts in Health Bureaus, MCH Centers, and Urban Health Centers. It remains to be seen how many physicians and clients will show up in the afternoon. Additionally, in Alexandria, the SDP Governorate Director is assigning female physicians from overstuffed units to rural units.

There is an additional access barrier: psychosocial attitudes. Many women, particularly in Upper Egypt, prefer a female provider. To address this preference and compensate for the lack of physicians in rural areas, particularly in Upper Egypt, the SDP has undertaken two initiatives: district nursing schools and mobile clinical teams. In addition, access is expanding with the availability of injectables that are provided by nurses (with a physician's authorization).

District Nursing Schools. The 13 district nursing schools in Upper Egypt allow village girls to remain at home while attending a combination of nursing and high school. Extensive negotiations between the MOH and the Ministry of Education (MOE) were required to establish the academic curriculum⁷, as well as many visits to the five governorates to locate suitable sites. These factors, in addition to the difficulties in negotiating the joint bureaucratic obstacles of USAID and Egyptian procurement regulations, resulted in a one-year delay of the opening of the schools. Eight schools have opened in Aswan (2), Minya (2), Beni Suef (1) and Sohag (3), with a total of 228 15-year-old girls in attendance. The opening of the five schools in Qena, with an enrollment of 94 students, continues to be delayed due to difficulties in procuring furnishings and equipment.

The team visited the two schools in Aswan. The classes were well-attended. The students were enthusiastic and very pleased that the school was close to their homes. Some reported that they would not have been able to become nurses without a local school that enabled them to live at home; others reported that although they had been accepted in the nursing school in Aswan city, they preferred to study closer to home.

Mobile Teams. Mobile teams are not new to the MOH family planning program; but they have been specifically initiated in Upper Egypt in this project to address the difficulty in getting services to women by women. While the data for the new program have not yet been disaggregated, evidence from reviewing registries during site visits in Fayoum and Beheira (which are not part of the new program), clearly indicates that on the days that mobile teams with female doctors visit, a higher number of women come for IUDs.

The SDP supports mobile teams in 45 districts in six governorates; by the end of PY2, the program will expand to four more governorates. These governorates that are involved are supplied with additional vehicles, fuel, and funding to cover per diems for the physicians. In those governorates where teams are already working with governorate funds, the project is only providing supervision and receiving reports; it is not duplicating the funding.

The criteria for selecting sites to receive mobile teams are: lack of a physician, lack of a physician who is trained in family planning, or lack of a female family planning physician. The teams go out twice weekly in each district. Supervision of mobile team sites is part of the overall district and governorate level supervisory plan for family planning units.

⁷ Graduates receive a nursing diploma and a high school certificate after their three-year program.

3.1.5 Image

The IEC effort relies on governorate-level MOH/IEC supervisors and district-level MOH/IEC officers, who have non-family planning duties. The IEC officers' chief SDP task is to ensure the availability of print materials in clinics and to conduct audiovisual meetings. The flip chart and brochure distribution chain has many links, but no specific person is held responsible for end point delivery and resupply at the local level. Governorate- and district-level distribution tracking forms have been developed but are not used consistently. Under POP/FP II, old MOH brochures and posters were often absent from clinics while stocked in warehouses. A distribution system without a pull mechanism similar to that of EPTC's for contraceptives will result in the same situation.

Flip charts are not yet available in some clinics. Brochures have not yet arrived in some Local Information Centers (LIC) for pickup by SDP and distribution to SDP clinics. The first print run of brochures was insufficient to stock MOH units adequately. Average distribution in Alexandria Governorate was: 1,100 IUD brochures/unit; 88 OC brochures/unit; 71 injectable brochures/unit. In Aswan Governorate the distribution was: 44 IUD brochures/unit; 50 OC brochures/unit; 13 injectable brochures/unit; 3 local methods brochures/unit. The print run was based on the available budget and the per unit distribution formula was appropriately based on historical contraceptive use rates by method by governorate.

Twelve new audiovisual vans have been in Cairo for two months waiting for equipment fitting. In PY2, two MOH Information Center audiovisual meetings are planned for every month for every district. The audiovisual meetings offer an opportunity to show the one-hour QIP documentary, "Visit Us," and old MOH spots in clinics.

Governorate-level MOH IEC officers have attended two day SIS/SDP workshops with joint planning and information sharing exercises between LIC and MOH IEC staff. This was an overdue introduction to each other's work. Step-down training to district level MOH IEC staff is not apparent, and regular meetings between LICs and MOH IEC local staff are not budgeted. Although MOH IEC district staff have many non-family planning duties, training and support can motivate in family planning.

The community-based workers of the MOPFP (e.g., *raidat rifiyyat, muthaqqifa sukaniyya*) are important resources of IEC for the national program and for the MOH by providing IEC and referrals to MOH and NGO service delivery points. Throughout the country, the evaluation team heard of both their supporting and overlapping activities.

3.1.6 Service Utilization

The MOH is exceeding its CYP targets. Nationwide, in PY1, the MOH achieved 116% of those targets: in Upper Egypt 112%, in Lower Egypt 134%, in Urban Governorates 108%, and in

Frontier Governorates 142%. The SDP director recognizes that POP/FP III targets, set during project design, are low. They were not based on final CYP data from POP/FP II because the information was not available at the time the new project was designed. In fact, the 1994/1995 target is only 91% of the 1993/1994 CYP. Although the MOH exceeded PY1 targets by 13%, total CYP in PY1 of POP/FP III exceeded the previous year by only 6%. See table 2, which compares CYP data by governorate for the first four official quarters of 1994/1995 with the preceding four quarters of 1993/1994.⁸

3.1.7 Conclusions and Recommendations

Mission. The SDP is fulfilling its mission of providing high-quality family planning services to an increasing number of Egyptian women. In light of recent international trends incorporating family planning into a broader reproductive health context and Egyptian health and demographic data, it would be wise for the SDP to consider expanding to a more inclusive reproductive health role. The SDP belongs in the MOH for two critical reasons: 1) the SDP management strategy, structure, human resources and systems form an interdependent whole and SDP success to date arises from the skilful congruence of those components; and 2) location of the SDP within the MOH allows the MOH, if it should so desire, to build upon and expand family planning into reproductive health, thus serving broader Egyptian health needs.

Management. The SDP has made good progress in improving management of the MOH family planning program: it has implemented and refined the QIP strategy, developed and improved both the physical infrastructure and the human resource structure, and made considerable progress in systems development and refinement. There is still a lot of work to be done, however, in training:

- A number of personnel in the second layer of the central office management team need extensive training; in some cases it would be wise to hire specialists rather than train physicians in the specialized areas.
- Long-term training (master's degree level) for well-qualified SDP staff would be valuable.

While training is vital to success, so too are supervision, monitoring, and incentives. QIP training imparts a good deal of new information: consistent and thorough monitoring and supervision are essential to institutionalize the newly learned information and behaviors. The work productivity payment plan continues to motivate family planning service delivery staff.

Access. The MOH has a superabundance of service delivery points. The issue is access with quality. The MOH provides intense geographic coverage yet average utilization is low for a

⁸ USAID and SDP consider the last quarter of 1993/1994 to be a pre-implementation quarter of POP/FP III; therefore, CYP achieved in this quarter is presented as POP/FP III achievements. However, for purposes of actual chronological achievements, they are presented in this table as CYP per fiscal year.

variety of reasons. The reasons include poor quality and psychosocial barriers, such as clients' preference for a female provider, particularly in Upper Egypt. The team believes that with the continued expansion and strengthening of QIP, utilization in the estimated 2,500 QIP clinics will be far higher by the end of the project than it is now.

MOH strategies to address the psychosocial barriers—more nursing schools and mobile teams—look promising. However, the continued success of the district nursing schools will depend on the availability of qualified, experienced nursing instructors, of whom there is a shortage in Upper Egypt. While the SDP has expanded the use of mobile teams, there remain many so-called rural areas within an hour of significant population centers. These rural areas meet the criteria for mobile teams and could easily be reached by mobile teams of female physicians from areas where there is a surplus of physicians. The effectiveness of the mobile teams in increasing access in Upper Egypt cannot be documented until the SDP disaggregates the data.

Quality. Quality of services is improving. QIP clinics are attractive and the staff apparently motivated. Adequate supplies of all contraceptives are available and all methods are reviewed

Table 2 Insert

with clients. Wider distribution of SIS-printed method-specific brochures is necessary as are improvements in counseling, even in QIP clinics. The non-QIP clinics visited by the team were very weak and provide at least a partial explanation of the low average utilization of MOH facilities.

The recent promotion of injectables was highly effective. Continued mass media campaigns with method-specific messages will have a salutary effect on the method mix, which is currently heavily biased toward the IUD.

Image. The SDP, in collaboration with other MOH staff and units, must devote more attention to IEC: to strategies, training, monitoring and supervision of staff, ensuring that clinics are stocked with supplies and equipment as planned, and that IEC activities are implemented and evaluated.

Utilization. POP/FP III targets are too low, compared to the CYP achieved in the last year of POP/FP II. To the extent that SDP and USAID have viewed those targets as minimum rather than maximum figures, there has been no real problem. However, CYP achievements must be assessed by comparing annual CYP performance historically as well as against targets.

Recommendations:

General

- 9. USAID should extend POP/FP III to enable continued development and refinement of strategies and systems currently in process.**

Mission and Management

- 10. USAID should continue to fund the SDP as an integral part of the MOH. There has been real success to date.**
- 11. USAID/Egypt should urge MOH to expand SDP in a carefully phased manner, into a reproductive health program with family planning as a key component. Such a program should closely integrate activities with the Healthy Mother/Healthy Child Project. This program could be piloted in several SDP clinics during the remainder of POP/FP III and, based on the results, expanded nationwide during the follow-on project.**
- 12. The SDP should strengthen the leadership in the central office. SDP should have professional staff to carry out specialized functions instead of asking physicians who are not trained in these specialties to perform them. Project-funded vacancies in controller and accountant positions should be filled immediately.**

13. **Revenues from the sale of USAID-donated contraceptives should continue to be used to reward those who directly provide services; the work productivity plan should continue as currently structured.**

Training

14. **USAID should fund long-term training for individuals who demonstrate a capacity/willingness to learn and an ability to serve the SDP in leadership and technical roles. USAID should stipulate selection criteria.** Long-term training must be followed up by effective support in-country to assist returned trainees to apply skills and knowledge gained during training.⁹
15. **SDP should provide timely, frequent feedback to RCT regarding the quality of all courses RCT provides, including very explicit guidance on courses that do not meet SDP's standards. SDP should refuse to send trainees to the programs until RCT meets the requirements.**

Access

16. **SDP should disaggregate service statistics for clinics using mobile teams to document the effectiveness of sending female providers to rural and underserved areas.**
17. **SDP should conduct operations research to measure the success of the district nursing programs, which will graduate their first classes in June 1998.**
18. **The USAID Offices of Population and Education should collaborate to support a joint effort of the Ministries of Education and Health to develop a high institute of nursing in Aswan. This will address the shortage of well-educated nurses who could become nurse educators in Upper Egypt.** This would probably involve forming an alliance with the university in Assiut and using its branch nearest Aswan as a satellite base for higher education.
19. **In those areas where there is a surplus of female physicians who are underutilized in family planning, SDP should transport them to underserved areas.** Compensation might be provided by assigning them to work on mobile teams while continuing their full-time salaries.

⁹ Here we address the SDP need for staff with the benefit of long-term training; however, USAID should consider long-term training for all subprojects.

Quality

20. **USAID should continue its current support to SDP's Quality Improvement Program which carefully targets the critical issues of quality and underutilization of existing resources.**
21. **USAID should continue to support free and informed choice of all contraceptive methods.**
22. **District supervisors should assess the knowledge of physicians and nurses by observation and interview in order to ensure that they provide standardized information to clients.**
23. **Funding for expendable clinic supplies should be standardized at the MOH central office level to ensure that all clinics have sufficient supplies available. This could be accomplished by making expendable supplies a GOE/central office budget line item or by issuing a directive that clinic revenues be used for this purpose.**

Image

24. **Governorate- and district-level MOH IEC officers must be given intensive training in IEC and regularly informed about SDP and LIC activities in their area.**
25. **A MIS must be established to 1) incorporate a push/pull system to ensure that flip charts and brochures are delivered to clinics and resupplied as needed; 2) track MOH IEC meetings to verify that they occur as planned and are reported by location, subject discussed, and audience type; and 3) document that MOH audiovisual vans are used as intended. Flip charts and brochures should be reprinted to ensure adequate supply at SDP district offices, SDP units, and LICs.**
26. **New audiovisual vans should be dispatched as soon as possible to governorates so that IEC meetings at clinics can proceed. SIS method-specific spots and docudramas on video should be provided to all vans. Meetings should take place only at high-volume catchment sites with high-risk populations such as postpartum mothers at MCH clinics and rural health units (RHU) on vaccination days.**
27. **SDP should work with the MOPFP to develop a pilot training program in counseling and referral for MOPFP community-based workers and their supervisors. MOPFP community-based workers should somehow be linked to LICs, such as by attending educational workshops/community meetings held by the LIC at the local level. (Training could be contracted to the Coptic Evangelical Organization for Social Services, which has considerable experience and success in training, utilizing, and supporting community workers.)**

Targets and Utilization

28. **SDP management should continue to encourage MOH family planning providers to excel and expand CYP beyond the minimum CYP targets set in the Implementation Plan. USAID and SDP, at all levels, should monitor and assess the CYP achievements of this project in terms of historic CYP achievement as well as against current targets.**

3.2 Contraceptive Commodity Subproject

3.2.1 Introduction

Background. Since 1983, USAID has been the principal donor of contraceptives in Egypt. USAID has assisted the MOH, the EPTC, and the CSMP to establish and improve the contraceptive commodities supply and distribution system. The public sector contraceptive logistics system is large and complex, providing the full range of methods to service providers for distribution in over 3,000 service sites. Contraceptives are stored and issued from the central EPTC warehouse through EPTC governorate warehouses to MOH governorate warehouses on a "pull" system. From the MOH governorate warehouses, contraceptives are distributed on a pull system either to MOH directorate stores or directly to service units.

Technical assistance to the Contraceptive Commodity Project is provided through a buy-in to the Family Planning Logistics Management Project (FPLM), which has provided support for improving the contraceptive logistics management system and, in particular, refinement of the EPTC Contraceptive Inventory and Information System (CIIS). In collaboration with FPLM, the PPC MOH management specialist provides technical assistance to transfer logistics management technology to the government counterparts. In addition, through the PID program, two senior officials, one from SDP and one from EPTC, attended the FPLM senior logistics management training course in Washington.

Projected Outputs. The purpose of the Contraceptive Commodity Project is to ensure a reliable supply of high-quality IUDs, condoms, NORPLANT® and Depo-Provera. Project outputs are expected to be 1) increased service volume through a regular supply of contraceptive commodities; and 2) improved institutional capacity in contraceptive commodities management.

3.2.2 Achievements

Supply. The supply of contraceptives at the service level is generally appropriate as a consequence of a well-functioning information system and the implementation of an effective pull system. The EPTC and MOH developed guidelines on inventory control to ensure a sufficient

supply of contraceptives at all times and to avoid overstocking. There has been extensive training for staff at all levels on implementation of these guidelines under SDP.

The logistics management information system is excellent and the reliability of its information extremely high. The system tracks stock inventories and movement at all levels. The EPTC CIIS tracks the warehousing and distribution of contraceptives from their receipt in-country to their distribution from EPTC governorate warehouses. The MOH has developed a recording and reporting system that tracks the contraceptives from MOH warehouses to the client. The system collects information from nearly 100% of service units and reports with a high level of accuracy stock levels, quantities dispensed, and receipts.

The NPC has developed a database that collects information from the MOH, EPTC, NGOs, and the private sector. The goal of the NPC LMIS development is to establish a database that is compatible with EPTC's and that will be used collaboratively by the EPTC, MOH, and other agencies at governorate and central levels for logistics system management, reporting, and forecasting. However, the coordination of the NPC and EPTC systems has not been realized. Technical assistance from FPLM is programmed to help EPTC/MOH to implement the coordinated system. Technical assistance to NPC/TS to help institutionalize the system is recommended. (See section 3.4.5.)

Institutionalization. Contraceptive logistics management has been institutionalized at the highest levels of EPTC and the MOH as demonstrated by the fact that the LMIS functions smoothly with minimal support from FPLM periodic STA. Additional in-country training is still needed to institutionalize that capability at intermediate levels. Warehouse, inventory control, and reporting appears to be institutionalized at all levels. Stocks are available in the appropriate quantities at service delivery points and intermediate warehouses and are stored and distributed according to acceptable practices.

Contraceptive procurement tables are still prepared by FPLM STA. This function also needs to be transferred. Although the SDP and EPTC officials trained by FPLM have the capability to do the contraceptive procurement tables, the function needs to be institutionalized at governorate and national levels. In the past, forecasting was more problematic and was based primarily on the volume of stocks issued by EPTC. With the upgraded LMIS, which provides reliable and timely information on contraceptives actually dispensed to the user, forecasting can be more accurate. As the facility with the LMIS increases and, most importantly, once the NPC and the EPTC/MOH systems are compatible and functioning in a coordinated manner at governorate and national levels, the capacity to do contraceptive procurement tables at all levels will exist and a minimum amount of training will be required.

3.2.3 *Conclusions and Recommendations*

The contraceptive logistics management system functions smoothly: statistics are reliable and stocks are available in the right quantities in the service delivery units. The LMIS is excellent; however, the EPTC/MOH and NPC information systems are not compatible. The capability to manage the system has been institutionalized at the top but more effort is needed to develop the capability to manage the system at intermediate levels and to develop contraceptive procurement tables.

Although achieving self-sufficiency and sustainability in the family planning program are laudable goals, the primary and overwhelming priority within the Egyptian population sector is that of assisting implementing agencies to further increase contraceptive prevalence. Until replacement fertility is achieved (commensurate with a national contraceptive prevalence rate estimated at 74%), any activities which lead to a slowing in family planning acceptance or reduce continuation will have serious economic and development repercussions. Thus, carefully designed studies are needed to guide any reductions in the supply of public sector contraceptives to determine the potential rate of price increase that can be absorbed by the market in different socioeconomic strata and regions of the country, and to assist in developing a rational timetable for reductions in free commodities and subsidies.

Current GOE efforts, particularly at the governorate level, to ensure a safety net for indigent clients are laudable. However, a careful analysis of patterns of free service provision, client characteristics (including previous contraceptive use) and screening techniques used to decide eligibility are all needed to inform the GOE whether the program is reaching the target population (persons who would otherwise face a barrier to contraceptive initiation or continuation).

Recommendations:

- 29. Continue USAID support to assist the MOH/EPTC to develop compatibility between the NPC LMIS and the MOH/EPTC systems and the coordinated utilization of that system.**
- 30. Continue efforts to institutionalize the capacity to manage the contraceptive logistics system at all levels. The capability to prepare contraceptive procurement tables should be transferred to the MOH/EPTC.**
- 31. The GOE should not consider reducing contraceptive subsidies to the public and NGO sectors until information is available regarding the effects of ending the private sector social marketing program and until there are data from carefully conducted household expenditure and price elasticity studies carried out in a number of geographic locations of the country.**

32. **USAID should assist the GOE to conduct an analysis of the program currently occurring in a number of governorates, which provides free contraceptives and related services to clients who cannot afford to pay.**
33. **USAID and the GOE should begin to plan for a phase-out of the supply of USAID-donated commodities.** Such a plan may include increased subsidization by the GOE and a replacement of USAID support by other donors.

3.3 Teaching Hospitals Organization/Family Planning Subproject

3.3.1 Management

THO II is intended to provide models for hospital-based family planning services and clinics in which postpartum-IUD services and NORPLANT® can be introduced in the public sector. Discussions are in process about expanding postpartum-IUD services through the buy-in with AVSC. In addition, as the introduction of NORPLANT® is expanded, THO will receive the necessary training to begin the service in the public sector through THO hospitals. This is projected to happen in mid-1996.

Given the small number of clinics, the project is not intended to contribute a significant number of CYP to the national program. However, there must be a large enough client base to 1) provide a demonstration of effective hospital-based clinic operations and 2) enable clinical training in hospital-based methods to take place to ensure that physicians working in public sector hospitals will be well trained.

One of the goals of the project is to integrate the family planning clinics into hospital operations and the management into the THO management structure, leaving only a technical secretariat at the project level. Under the leadership of a dynamic new executive manager who joined THO in April 1994, a new and streamlined headquarters staff has developed and implemented systems for service quality monitoring, clinic management, and supervision. It has also developed planning and review processes involving the directors of THO hospitals and the heads of Ob/Gyn departments in each hospital.

It is expected that THO will convert to performance-based payments in July 1996, with the costs of training built into the payment per CYP achieved. Short-term technical assistance is being provided to adapt and integrate CSI's precedent-setting, performance-based payment mechanism to the different needs of THO.

3.3.2 Quality

The team visited only one of the eight THO clinics; therefore, our observations are limited. The contraceptive methods available are the Copper T 380A IUD, oral contraceptives, injectables, condoms, and foaming tablets. There were adequate supplies of all methods and they were within the expiration dates on the package. No stock-outs were reported. Only 21-day pill strips were available.

Interviews with and observation of the social worker indicate that all methods are reviewed with clients, and that information is accurate. The permanent, full-time Ob/Gyn specialist has worked at the clinic for several years. He is committed to the improvement of quality and expansion of services. The head of the Ob/Gyn Department of the hospital is supportive and involved in planning.

A review of infection-prevention practices in six of the hospitals, conducted in September 1995, revealed that most of the clinics were doing quite well with only minor deviations from expected standards.

3.3.3 Achievements

Service Utilization.

Table 3

Percentage of Service Utilization Achieved (PY1)

	Target PY1	Achieved PY1	Percent Achieved
Clients	62,526	44,105	70.4%
CYPs	35,640	24,762	70%

Quality. The Quality Assurance Monitoring System has been somewhat revised. Two sites are visited per quarter to assess service provision, appropriateness and acceptability of services, management, supervision, monitoring, and the MIS. Recommendations are made to address deficiencies although there is no indication of follow-up from previous reports.

A major revision of the quality assurance program is scheduled for PY2. It will incorporate the SDP Standards of Practice and will be integrated into the in-service training of all staff, both on the job and in special workshops.

Training. A master plan for pre- and in-service training of THO-related staff lists 54 courses to be offered in the three active training sites from July 1995 to June 1996. Courses include family planning service delivery; contraceptive technology (CT) update; family planning orientation for Ob/Gyn specialists, residents, and nurses; and orientation for house officers and paramedicals. Training activities for PY1 were as follows:

Table 4

THO Trainees

	Target	Achieved
THO Nurses	60	49
THO Physicians	105	94

Table 5

Trainees From Other MOH Facilities

	El Galaa Hospital	Shebeen El Kom Hospital	Damanhour Hospital
MOH Nurses	32	0	66
MOH Physicians	15	12	45

In PY2, a new, one-week course ("Family Planning Screening, Counseling, and Service-Delivery Orientation") will be conducted for THO house officers rotating through the THO hospital system. This will result in an increase in the number of providers trained in family planning as these house officers move out into the public sector.

IEC/Outreach. An IEC/outreach plan has been completed which includes the role of the social workers in an in-reach program to the inpatient and outpatient areas of the hospitals. Hospital-specific brochures with the appropriate names and phone numbers have been printed and are available in the clinics. Method-specific brochures with good instructions for contraceptive use and explanations of side effects are also available. Video tapes with family planning information were recorded and are available to be played on video cassette recorders in the clinics.

No community outreach plan was in evidence yet, although it is in the plan for PY2. A short in-service course about outreach will be developed for social workers.

Renovations. Minor renovations have been completed in all clinics.

Improved MIS. An MIS workshop was held for all management-related staff. New computers are available in the clinics. Reporting is still done manually, with reports being compiled at the central office for the whole subproject.

Central Office Staff. A full-time executive manager is in place, as well as finance and training managers. An IEC specialist is to be recruited in PY2 from within the THO system to assist with the development of the hospital in-reach and community outreach systems. A full time senior accountant will be added to the staff on the recommendation of the auditors. During PY2 the management, administrative, and financial policies and procedures that were developed in PY1 will be implemented.

Job Descriptions. Job descriptions are available for all positions.

Written Sustainability and Financial Plan. These are being developed in PY2 as the conversion to performance-based payments is planned. As of January 1995, the only family planning unit (FPU) salaries paid by USAID are for the secretary and the cleaner. All other salaries are paid from GOE funds and the THO revenue account.

3.3.4 Conclusions and Recommendations

THO has spent PY1 developing the management and administrative systems and mechanisms that will carry the project toward full integration within the Teaching Hospitals Organization. While many of these systems are in place or about to be in place, the major outstanding concerns are financial management, strategic planning, and marketing. Management and financial systems are not yet adequate for the conversion to output-based payment. Although some support is provided in these areas by short-term technical assistance, the change in payment mechanism is a major change for THO. Therefore, long-term technical assistance is required to help develop THO's strategic planning, financial management, and marketing strengths.

Recommendations:

- 34. A different kind of long-term technical assistance is required from what is currently programmed. THO should have a resident technical specialist with strong skills in finance, strategic planning, and marketing who can dedicate approximately 20-30% of his or her time to working with THO.**

- 35. Funding to THO should be continued, based on its performance, to the end-date of the POP/FP III project, and further, if it is desirable to keep it active as a complement to RCT for MOH and CSI training.**

3.4 National Population Council/Institutional Development Project

The name National Population Council officially refers to the senior body chaired by the prime minister. NPC is charged with policy formulation and planning in support of population/family planning activities in Egypt. Given that this body has not met since 1987, the name now commonly refers to the executive branches of the NPC, namely, the NPC Technical Secretariat (NPC/TS) and the NPC Governorate (NPC/G) offices.

The NPC/TS has a number of core directorates, including Planning, Training, and Evaluation; Monitoring; Governorate Affairs; Statistics; and two units (Research Management Unit and National Population Information Center). There are 26 NPC Governorate offices, one in each governorate.

The Institutional Development Project (IDP), which originated under POP/FP II and continues under POP/FP III, has as its mission the institutional strengthening of NPC/TS and NPC Governorate functions, including assistance and training in management, strategic planning, and policy dialogue. The expected outputs are

- the reorganization of the NPC/TS structure to promote decentralized management;
- strengthened NPC/TS capacity to develop population policies, perform quality program monitoring, coordination and evaluation, fund, monitor and evaluate research studies, and engage in proactive policy formulation;
- strengthened capacity of the NPC Governorate offices to produce quality population plans, perform quality program monitoring, coordinate and evaluate, as well as collect, process, and validate service statistics reports utilizing the TA8 form; field the EDHS in 1995 and produce a final report by November 1996.

At the time this report is being prepared, the future role and structure of the NPC/TS must be considered in the context of the envisaged creation of the MOPFP. As currently conceived, most of the NPC/TS divisions (Planning, Training, and Evaluation; Monitoring; Governorate Affairs; and in all probability, Statistics and Research), are to be moved to MOPFP and the future role of NPC/TS is not yet known.

It is also unclear whether the NPC Governorate offices will be retained. Their potential roles and the mechanism for contact with the Ministry and the central NPC will also need clarification. (It is possible that plans may call for the NPC/Cairo office to retain some direct control over the NPC

Governorate offices, if the latter continue to have a presence distinct from that of the MOPFP functions in the governorates. The dual contact with the governorate—via the NPC and via the MOPFP—would then afford the population sector greater presence than is the case for other sectors.)

Background. IDP I, initiated in 1987, encountered substantial challenges in trying to fulfill the NPC institutional development role. Principally, a dearth of permanent, qualified, full-time staff at the NPC/TS led to an overdependence on *ad hoc* task forces and consultants, and weakened IDP efforts to institutionalize the critical and complex functions under its charge. Given these constraints, the IDP was redirected to expend principal resources at the local NPC offices in the governorates (NPC/G).

IDP I activities at the NPC/TS level were ultimately limited to

1. the creation and maintenance of a National Population Information Center (NPIC) which enabled the center to function effectively in preparation for and during the International Conference on Population and Development (ICPD) in Cairo in 1994;
2. assistance to the NPC/TS Research Management Unit (RMU) to coordinate and direct population and family planning research directed at policy issues and program planning. Due to a lack of qualified personnel and follow through at the RMU, the latter activities met with only limited success, although a number of studies were solicited and monitored by the unit;
3. assistance to the NPC/TS "Division of Governorates" and a program of small Governorate Support Grants to initiate innovative outreach and advocacy activities which resulted in substantial strengthening of NPC Governorate teams; and
4. technical assistance at the NPC/TS and NPC Governorate levels with the goal of strengthening NPC statistical functions (including the NPC/TS Statistical Unit).

Institutional Context. IDP II was originally scheduled to begin on July 1, 1994. However, disbursements for the project did not begin until Dec 1994 due to GOE delays in releasing salary supplements for NPC staff seconded to the IDP and to accounting difficulties the NPC/TS encountered in closing out the IDP I accounts. By ministerial decree, the IDP received a GOE bridging loan that covered a number of projected activities. IDP was thus able to provide substantial assistance to the NPC in preparing for the ICPD in September 1994.

IDP staff have acted quickly to make up for the time lost to the funding delay and a large number of activities have been carried out, including planning exercises in all governorates, a national policy conference, and numerous workshops and conferences relating to research activities. The rapid progress is largely due to a high degree of commitment and cooperation between experienced PPC advisors and dedicated Egyptian IDP staff. The IDP II director, seconded to

the IDP from the NPC, has achieved a degree of job security and independence in the director's role which did not exist in IDP I.

Most IDP II Egyptian staff are NPC/TS employees, and their IDP responsibilities are complementary to their official positions in the NPC/TS. As employees seconded to a project, they receive a regular government salary and are meant to have an IDP salary supplement provided by the GOE. The disbursement of the previous year was apparently shared with all NPC staff, whether attached to the IDP or not. This factor is resulting in some concern among IDP staff.

3.4.1 IDP II Activities within the NPC Technical Secretariat

Management. NPC/TS division directors and staff (including many of those who are not seconded to the IDP) have routinely attended IDP training workshops on planning, team building, training of trainers, and basic statistical/demographic skills. Unfortunately, the potential to apply lessons learned has not been exploited by the NPC/TS. Communication on technical matters between NPC/TS divisions appears to be weak and there are no organized efforts to coordinate strategic planning.

Overall NPC/TS management weaknesses are due primarily to low levels of skills, interest, and commitment on the part of NPC/TS senior staff, and to a lack of direction provided in key planning and policy issues by NPC leadership. At present, the energies of the NPC/TS are also being directed toward the design of the new MOPFP, which is expected to subsume most NPC/TS units. IDP abilities to improve management at the NPC/TS thus remain very constrained.

It should be noted that some improvements were apparent in the functioning of a number of the NPC/TS units—principally, the Statistical Unit and the Research Management Unit as a result of IDP I and IDP II inputs.

Substantially more rapid entry of service statistics data at the NPC Governorate level (made possible through computerization and training provided by the IDP), has enabled the NPC/TS Statistical Unit to prepare monthly governorate- and national-level statistics on CYP within one to two months after data collection (rather than after five or more months, as was previously the case). In addition, the IDP has assisted in a substantial revision of the TA8, the basic data collection form used at the clinic level in all public and NGO units. The new form represents a marked improvement over the older version: it is more streamlined, collects additional program data on available manpower and training, tallies IUD insertions and removals, and collects lost-to-follow-up information for other methods.

When the new form is implemented, data flow and comprehensiveness, and thus the usefulness of reports produced by the Statistical Unit, should be further enhanced. Implementation of the new

TA8 form at the governorate level awaits a final decision by the NPC and MOH, along with the necessary software and training in its use. SDP, which is to be one of the prime users of the form, will receive computers from PPC in order to initiate training for MOH staff in TA8 data entry. Implementation of the TA8 by NPC at the central and governorate levels represents a high priority; the NPC will need IDP support in coordinating all concerned sectors in TA8 use and in training at all levels.

In spite of the noted improvements, the NPC/TS Statistical Unit still demonstrates substantial limitations in its role of setting annual numeric targets for the governorates. In this capacity, the unit acts in complete isolation from other NPC units and the governorate NPC offices. (Indeed, the unit is overseen by an external consultant to the NPC, rather than by NPC staff.) As a result, national demographic and family planning target setting remains weak and mechanistic, based on manipulations of demographic formulas and having as its benchmark demographic targets for the years 2007 and 2012. Programmatic capability is not considered in the target setting exercise. The mechanistic target setting results in unrealistic goals for many governorates and opens them to criticism for not having met the nationally set targets. For all practical purposes, the governorates set their own work plans on the basis of their decentralized planning, further reducing the value of centrally developed targets.

It is possible to conceive of a system wherein the governorates set their own annual demographic and family planning targets on the basis of local capability and accomplishments to date. The function of the central Statistics Unit could be amended to that of collating CYP data from the governorates (monthly and annually) to assess whether the trends in estimated current population coverage are roughly consistent with the long-term population CPR and TFR targets. If the governorate efforts fall below what is needed to progress toward the long-term national goal (especially if this falloff were confirmed by periodic DHS surveys), the central level could signal this finding to the leadership of the population sector. It would then be the task of the leadership to work with the governorates in order to improve the programs.

Policy/Policy Outreach. Within the NPC/TS, there are no staff charged with policy dialogue or coordination. The NPC-sponsored national conference, "Further Strengthening the Policy Environment for Family Planning" (May, 1995), organized in large part by IDP II and the Futures Group under the OPTIONS project, established four policy working groups. Priority topics selected for the groups included contraceptive pricing, medical training/curricula, the regulatory environment, and the expansion of contraceptive methods. These groups have never been reconvened. NPC/TS divisions which could theoretically have substantial involvement in providing data and guidance for policy issues (e.g., Planning, Statistics, Research Management Unit) have not been encouraged by higher GOE levels and they shy away from discussions of potentially controversial issues. (As discussed below, some progress is being made by the RMU, with IDP assistance.)

At the time of this report, much NPC/TS time and energy is being expended on the shift of departments from the NPC to the MOPFP. On the basis of the draft ministerial organization

chart, it would appear that current plans call for the new Ministry to have substantial involvement in implementation issues, specifically family planning service delivery and IEC. However, it would be desirable that policy, planning and coordination represent the primary activities of both the MOPFP and the NPC/TS (although the latter may be reconfigured with the emergence of the MOPFP). For example, one of the urgent issues is coordination at national level of IEC activities. It is critical that NPC/TS coordinate a national IEC strategy that is aimed at dividing tasks and sharing resources based on the comparative advantages of each of the implementing agencies involved.

The UNFPA Management Project is working with the NPC/TS and the new Ministry in the design of ministerial structures and functions, including financial systems and accounting, human resource management, and training of trainers. The Project does not address policy, planning, or technical issues such as target setting or the design of programs.

3.4.2 Research Management Unit

The goals of the RMU are to develop and manage a program of applied research that is responsive to the issues of concern to other implementing agencies (SDP/MOH, SIS/MOI, THO, RCT, CSI, and the private sector), and to take primary responsibility for policy research design, implementation, and analysis. In order to fulfill these goals, the RMU has a full agenda which includes coordinating family planning research activities, developing a research agenda (in the programmatic, biomedical, and demographic spheres), conducting training courses, stimulating and managing a program of contracted research, assisting other implementing agencies in the design and analysis of specific studies, carrying out policy analyses, ensuring results are disseminated and included in the development of policies and programs, and producing a Research Information Base of population-related studies carried out in Egypt. The IDP project provides long- and short-term technical assistance to the unit to support these activities.

It should be noted that the RMU does not have a mandate to build local research capacity. RMU's role is to identify existing experienced researchers, award grants to the most qualified bidders, and monitor the ensuing studies. This approach is reasonable as the unit's agenda is very broad.

Overall, the RMU has made substantial progress since IDP I. The current mid-level unit staff are involved on a full-time basis in the RMU and appear energetic and enthusiastic. With the assistance of the IDP technical specialists, there has been substantial effort to develop a focused research agenda on the basis of policy and planning priorities. The RMU has developed procedures, conducted seminars and training activities, and is currently reviewing proposals and developing additional RFPs for solicited research.

Following a meeting of experts and the Seminar on the Setting of Biomedical, Demographic, and Programmatic Research Priorities (conducted in October 1994), a list of more than 40 potential

research questions was developed, 22 of them in the programmatic area. Recently, in order to focus on a smaller number of more urgent topics, the programmatic list was refined by the RMU to encompass five areas: 1) the role of NGOs in family planning, 2) the role of *raidat rifiyyat*, family planning educators, traditional birth attendants, and other community workers in family planning, 3) cost-effectiveness analysis for different family planning service delivery units (e.g., MOH facilities, CSI), 4) training of medical residents and interns in family planning, and 5) client perspectives toward family planning, including facilities, methods, providers and prices. This programmatic research agenda appears reasonable, particularly two of the areas mentioned above: the role of *raidat rifiyyat*, family planning educators, traditional birth attendants, and other family planning community workers and client perspectives toward family planning. However, it would be desirable to include issues of price elasticity and service quality among research priorities. The value of the research would be substantially greater if the studies focus primarily on rigorous comparisons of the effectiveness of different service delivery, IEC, or training strategies, rather than descriptive analyses of process.

The list of demographic research topics developed at the October 1994 meetings contains suggestions for secondary analyses of the 1992 and 1995 EDHS. The list needs to be refined because not all of the proposed issues are covered by the DHS. The biomedical research list contains ten items, of which a number appear to duplicate topics that have been extensively researched elsewhere or are very diffuse (e.g., the use of low-dose pills in women over age 35 and comparisons of different pill brands). In general, such medical studies and clinical trials do not represent a good use of resources. (In contrast, clinical trials specifically designed to facilitate the registration and adoption of a new contraceptive in Egypt—such as the NORPLANT® studies—have been very successful in broadening the range of methods available in the country.) The biomedical list does contain an important priority area, that is, the assessment of genital tract infection rates and the management of such infections in family planning clinics.

Substantial challenges remain for the RMU and for IDP assistance to the Unit. The goals and tasks outlined for the RMU in the IDP Implementation Plan are very broad, and it is unlikely that any body could accomplish the described tasks unless it had very experienced researchers and policy-makers with substantial authority. Although the RMU staff includes a number of individuals with strong quantitative skills (engineering, statistics), none are trained researchers and none have carried out operations research activities. These limitations are particularly problematic in the case of the director of the RMU unit, who has over 20 years field experience as a social worker but no formal quantitative or qualitative research training or experience (and appears to have some difficulty in articulating the unit's role).

The RMU technical staff remain isolated from discussions of policy (in part because the NPC/TS as a whole represents something of a vacuum in this area). Under the circumstances, it is rather commendable that the RMU's ability to discern priority research areas is as good as it is. The placement and role of the RMU within the NPC/TS needs to be clarified. At this time, the director of the RMU reports directly to the Minister of Population and Family Planning but has little contact with NPC/TS units. There is also some concern that the RMU may be diverted from

the research priorities they have identified. For example, the unit has recently been asked to conduct a situational analysis regarding the "cost effectiveness" of proposed units of the new ministry (e.g., family planning services, family planning information, governorate affairs). Not only is the request somewhat difficult to interpret, but it would draw staff away from their current activity of soliciting research in the identified priority areas. Moreover, staff are not yet trained in cost-effectiveness studies and soliciting outside proposals in that area would require substantial time and technical assistance.

In order for the RMU to meet its potential, greater attention should be given by the leadership of the NPC/TS to include RMU members in policy and planning discussion. It is also important to staff the RMU, especially the RMU directorship, with personnel experienced in research management. IDP technical assistance to the RMU is unlikely to have long-lasting results in the absence of such support from the NPC/TS. In addition, where local expertise is lacking, a mechanism is needed to enable the RMU to bring in highly qualified external TA to work with Egyptian researchers to design and monitor specialized research projects.

3.4.3 Population Information System: The National Population Information Center and The Population Data System

The development of the Population Information System (PIS) appears to be proceeding smoothly. With the assistance of a full-time IDP consultant, and impetus provided by the 1994 ICPD, the National Population Information Center (NPIC) is functional and is developing an adequate library of books, documents, audiovisual materials, and press clippings. The NPIC has Popline and is now on the Internet, which will allow access to Medline. Although NPIC is still not officially open, the Center received approximately 170 visitors, including researchers and groups of secondary school students, during a four-month period in 1995. The NPIC will need to formulate a long-term plan of proactive outreach to researchers and policy-makers in order to fully utilize the resources it is accruing.

The Population Data System (PDS) is compiling reports, and where possible, accessing data files from demographic/family planning research and surveys carried out in Egypt, including the census and DHS. This aspect of the PIS remains somewhat laborious, partly because of the difficulty in tracking down relevant Egyptian research activities.

3.4.4 NPC Governorate Offices

There has been a decided improvement in overall NPC/Governorate (NPC/G) office management and planning ability since the initiation of IDP I, and during IDP II. In the stronger NPC/G offices, the NPC/G director now has the ability to deal in more sophisticated ways with service statistics data available from the governorate, and to adjust local plans accordingly. Computerization of NPC/G offices, and the provision of facsimile and photocopy equipment,

enables faster transfer of data from the NPC/G to the NPC/TS, and greatly facilitates communication.

Problems remain, however. Staff turnover at the NPC/G offices, particularly in key positions such as that of the director or statistician, can seriously affect the office's ability to collate and interpret service data and to conduct planning and coordination. The computers available to the offices are old and slow (80286s), and they are primarily tied up in TA8 data entry, limiting the ability of the governorate offices themselves to conduct basic data analysis. In addition, the lack of programs for and training in data processing, results in the more capable governorates attempting to conduct their own analyses through hand tabulations, and the less advanced governorates being limited solely to what the NPC/TS produces, which results in a one- to two-month lagtime.

Although there has been much improvement in the ability and confidence of NPC/G offices to coordinate the activities of local implementing agencies, true strategic planning and the ability to develop innovative approaches to problem areas still remain somewhat elusive. NPC/G target setting and planning abilities are hampered by the disjuncture between local programs and achievements, and the mechanistically derived annual CYP/CPR targets produced by the NPC/TS, described above. The central targets, rather than being perceived as a useful planning tool, are distrusted and intensely disliked.

The IDP has well-conceived plans to further improve planning and monitoring activities in the governorates. The strategic planning curriculum, developed by the RAPID IV project, is being piloted in three governorates (Port Said, Sharkia, Damietta). The training, aimed at the senior governorate staff of the NPC, SDP, and SIS/IEC/LIC, incorporates modules on computerized data processing and long-term program development, and is designed to provide theoretical knowledge and hands-on experience. The introductory seminar and theoretical background workshop have been completed; training in the use of computer tools is scheduled for November 1995; workshops for the preparation of strategic plans will be held in 1996. Plans call for all governorates to have received the training by the end of IDP II. Ideally, the IDP should follow up with short-term technical assistance (2-3 days) within a few months of the training to ensure that participants apply the new techniques appropriately and that they do not return to business-as-usual after the training. Not unexpectedly, strong NPC/G offices tend to absorb and apply the training, whereas weak offices need further assistance.

IDP II is also reintroducing the program of Governorate Development Grants (previously named Governorate Support Grants), initiated under IDP I. The grants, representing a monetary value of up to LE 100,000 under IDP II, are open to competitive proposals by the governorates. The goals are to stimulate innovative advocacy activities, improve quality of service and, potentially, test cost-recovery programs. Grants may be used to develop local Population Information Centers (and as such may be applied toward upgrading NPC/G computers). The grants are not designed to cover family planning clinical service activities. Grant announcements have been sent to the governorates but none have yet been awarded.

A well implemented governorate grant program has the potential to provide NPC/G offices with additional planning and monitoring experience. IDP may be advised to provide technical assistance to governorates in the conceptualization of the proposals. (Based on governorate visits conducted during the evaluation, it appears a number of NPC/G offices still plan to submit proposals for service provision—including, in one case, community-based distribution of free contraceptives by *raidat rifiyyat*. Such service delivery is not a priority area for this small grants program.) Technical assistance in the conduct of the grants should also be provided, to ensure that the necessary steps in program development are clearly understood and can be applied in the future.

Potentially, the greatest uncertainty the NPC/G offices face is their role vis-a-vis the MOPFP. If the NPC/G offices were to be subsumed under the MOPFP, the restructured NPC/G functions would be under the direct authority of the governor, with salaries paid through the governorate office and the role restricted to a technical advisory function, as is the case for other ministries. It is hoped that, were this restructuring to occur, the planning and coordination roles of the NPC/G offices would not be lost.

IDP II activities will need to be tailored to circumstances as they arise. Given the emphasis in IDP on policy, planning, management and coordination within the population sector (rather than on service delivery per se), the design of any IDP follow-on project will have to take into consideration the appropriateness of activities in the restructured population sector, particularly in the restructured NPC.

3.4.5 Conclusions and Recommendations

There is evident improvement in the ability of governorate-level NPC personnel to plan and coordinate activities, related in large part to IDP efforts. The efforts to enhance the strategic planning ability of the NPC/G offices, which are being continued with the Strategic Planning initiative, are well conceived and should be strongly encouraged. However, the NPC/TS develops annual service delivery targets for the governorates without taking into account governorate strategic planning or previous accomplishments: this results in targets that are not particularly meaningful in guiding governorate activities.

The ability of the IDP to strengthen the management and planning capacity of the NPC Technical Secretariat is very limited at best, due in large part to the structural and personnel context of the NPC/TS. At this time, it is also unclear which functions will remain in the NPC/TS and which will be moved to the new MOPFP. While there are major policy questions facing the Egyptian population and family planning sector (including pricing and free market issues, and the role of the new MOPFP) the NPC/TS and the MOPFP have not demonstrated a coherent commitment to policy dialogue.

Although RMU technical staff themselves appear to be motivated and interested in research directed to policy and planning guidance, they are isolated from policy and planning discussions, and thus have difficulty in discerning priority areas. If the RMU is not permitted to mature in this role, its capacity may diminish over time to that of a research information clearinghouse. A major potential national-level policy and planning tool will be lost. Donors may be placed in the position of moving the coordination and research stimulation function to another public, quasi-governmental or private organization, or having to coordinate their own research. Were this to become necessary, it would be unfortunate, as it would further weaken GOE efforts to guide policy-related research.

Recommendations:

- 36. USAID is urged to continue its dialogue with the NPC and the Ministry of Population and Family Planning and to support the Ministry and NPC efforts in policy dialogue and formulation, policy related research, the development of a comprehensive management information system for the sector, and population sector coordination. USAID funding of new service delivery is not recommended.**
- 37. IDP efforts should continue to focus primarily on the governorate level, especially in the areas of strategic planning and coordination of family planning activities. Hands-on technical assistance should be provided following training courses in order to enhance the effects of strategic planning training.**
- 38. Rapid, on-the-job training in basic demographics, service statistics, and computer utilization should be provided for new key NPC/G staff as the need arises. One possibility may be to designate a few of the better functioning governorates as "on-the-job training sites." Newly appointed individuals from weaker governorates could visit a designated training site for a limited time period (up to a week) and be exposed to the skills expected in their new job. The training sites could be enhanced by the development of procedures and simple manuals to guide the practical training.**
- 39. The scope of IDP activities at the NPC Technical Secretariat level should continue to focus primarily on the Research Management Unit, with some assistance to the Statistical Unit. A new initiative in the NPC/TS is recommended: offer technical assistance to the Statistical Unit in 1) annual governorate-level family planning target setting, coupled with demographic analysis to assess the achievement of targets, and 2) institutionalization of the TA8 form and the development of a national management information system which includes all agencies within the population sector. Permanent, full-time, dedicated staff must be identified in the Statistical Unit to manage the national management information system.**

40. **Continuing efforts to promote rapid introduction of the revised TA8 form at the governorate level in the NPC and all relevant population sector implementing agencies should be supported. New computers and concomitant training should be provided to all NPC/G offices.**
41. **In the absence of a clear commitment by the NPC and its leadership to engage in meaningful policy dialogue, IDP should not expend untoward efforts to organize policy conferences.** Small scale but intense efforts, which may include the involvement of international policy experts, to convince the leadership of the need for policy research and formulation may be more fruitful in the short term in setting the stage for future policy development. The planning stages of the new Policy Project provide an ideal opportunity for dialogue with the NPC, MOPFP, and IDP in order to develop strong linkages and formulate a plan of action for the Policy Project in Egypt.
42. **Governorate Development Grants should support activities that emphasize quality of services, population/family planning advocacy (including the creation of small governorate Population Information Units), and innovative cost recovery. Technical assistance should be provided to develop grant proposals and to support their implementation.**
43. **USAID is urged to continue pressing the NPC to develop an actionable FP/IEC national strategy by bringing all agencies with an IEC function to the table to divide training and materials production tasks and to share resources and finished materials based on each agency's comparative advantages in these areas.**

Research Management Unit, NPC/TS

44. **The leadership of the population sector should be encouraged to provide the RMU with guidance and support in the stimulation of policy-related research; select the RMU director from among individuals with strong applied research training and experience and high stature in the research and policy arenas; and to involve RMU technical staff in planning and policy.** Any future funding to the RMU should be contingent on a clear and active commitment by the Minister of Population and Family Planning and of the NPC/TS to involve the RMU in policy dialogue and to inform it of major policy and planning issues. The same conditions should apply if the RMU is moved to the MOPFP.
45. **Every effort should be made to ensure that the RMU remains a research management unit, rather than a research implementation unit.**
46. **The research expertise of the RMU technical staff should be enhanced by adding highly trained and experienced researchers, and by providing existing staff with short-term training in research design and techniques in specialized research areas**

such as economic and cost-effectiveness studies. Given budgetary and time limitations, long-term overseas research training for existing staff would not be appropriate at this time. Short-term, focused workshops conducted by U.S. and Egyptian programmatic, biomedical, and demographic research experts should be considered.

- 47. The RMU research management agenda should be reassessed periodically to ensure that key policy and programmatic issues are being addressed.**

3.5 National Population Council/Regional Center for Training

3.5.1 Introduction

The purpose of RCT in POP/FP III is to increase the number of physicians, nurses, pharmacists, and family planning service providers trained at RCT from 581 in the period 1988-1993 to 1,800 by July 1997. The subproject was created to achieve five outputs:

- improved management systems relating to institutional strategies, structure, staffing and systems;
- enhanced utilization of RCT professional education capability as evidenced by materials, publications, guidelines, and videos;
- expanded and enriched family planning training program;
- expanded technical assistance provided to other institutions;
- achievement of institutional status.

3.5.2 Improved Management and Increased Institutionalization

POP/FP III anticipated extensive management changes at RCT. These have occurred. The organization is restructured with a Board of Directors, a new Executive Director, and a simpler organization chart with all four units reporting directly to the Executive Director. A recent addition to the structure was a Deputy Director for the National Network of Family Planning Centers, a unit suggested by the Minister of Population and Family Planning. RCT has reduced the number of staff from 34 to 28. Currently, they are trying to recruit a professional financial manager, a position necessitated by the POP/FP III project's emphasis on more efficient management and payment for outputs. New manuals and job descriptions reflect these changes.

The institutionalization of strategic planning is one of the indicators of improved management. RCT made a start on strategic planning between April-June 1995; however, a good deal more needs to be done. The new executive director indicated that the draft strategic plan was in the hands of consultants and she was not sure when it would be ready for review. A self-financing plan is also being developed by consultants.

RCT has developed marketing objectives, activities, and a list of contacts in neighboring Arab countries. It is a good start from which to develop a real marketing plan with detailed activities, a time frame, assignment of responsibilities and a budget. One tool in this plan will be the *RCT Catalog, July 1995-June 1996* which describes the RCT capability and program. The evaluation team reviewed the English version, which is intended to promote RCT's capability to train in English. It contains numerous English and other errors and should be carefully reviewed by a native English speaker before further marketing dissemination.

Considerable progress has been made on systems development. A new MIS has been implemented which includes a cost accounting module that was finished in March 1995.

When POP/FP III was developed, USAID and RCT envisioned that increased institutionalization would be achieved by the Ain Shams University assuming greater responsibility and integrating RCT into the university fiscal and management structure. Since that time, however, the NPC has taken steps to be more responsible for the RCT. The recent agreement between the NPC and RCT reads "The NPC will provide the RCT with full political and programmatic support and will encourage private and public sector family planning service delivery projects to utilize RCT training resources. NPC audiovisual and information, education and communication (IEC) equipment will be made available to the RCT as necessary. RCT staff may also be invited to attend courses and presentations organized by the NPC to improve their technical and training skills."

RCT's management believes that the organization now has a permanent home and that institutionalization has been achieved. However, the executive director recognizes that continued effort is needed to secure RCT's market niche as a high-quality regional training institute. Because RCT is one of the few clinical family planning training institutes in the Middle East and could potentially serve the region, the executive director recognizes the need to develop RCT's training skills to a high level before a large expansion is undertaken. RCT has approval to train non-USAID sponsored trainees and the executive director has had contact with WHO, IPPF, UNFPA and the European Community. RCT has not been approved as a provider for USAID-sponsored third country training.

3.5.3 Relationships with Clients

RCT's long-term goal is to be a self-financed regional and international family planning training center. In the short term, its primary client is the SDP. There is a Letter of Agreement that assigns all of SDP's TOT courses for physician and nurse trainers, and Ob/Gyn specialist courses to the RCT. The SDP then provides training to its service providers.

Interviews with RCT's major client reveal that SDP and RCT have successfully negotiated several agreements: all curricula except the technical ones for physicians will be prepared and delivered in Arabic; the director of SDP has sign-off authority on courses being delivered to his staff; and SDP

staff can freely visit the RCT courses to monitor their quality. Nonetheless, a number of concerns were cited:

- The Ob/Gyn specialist's clinical supervision course that was supposed to have been updated over a year ago to incorporate the QIP standards of practice had not been received by SDP for approval, although RCT believes that active negotiations are in process;
- Items in the Letter of Agreement that reportedly have not been forthcoming include brochures for trainees, evaluation of trainees' skills performance with reports to SDP, end of course evaluations by trainees copied to SDP, site visits to trainees by RCT staff for on-the-job training, and follow-up with trainees to assist in determining remedial training needs;
- MOH nurses who attended a TOT course were reportedly dissatisfied with the quality of the training;
- The Letter of Agreement calls for quarterly meetings between RCT and SDP representatives to facilitate the agreement. Only two or three meetings have reportedly been held and those were related to specific issues. Apparently, SDP considers that convening these meetings is not under their control, although the RCT director believes that either side can take the initiative.

Discussions with RCT indicate that they are eager to do all they can to address SDP's concerns, and that they were unaware of many of the issues.

3.5.4 Output-based Payments

On October 1, 1995, after extensive negotiations with NPC and RCT, USAID converted RCT to a performance-based output payment system, two years earlier than originally planned. This change is intended to support RCT's progression toward becoming a self-sufficient, sustainable institution. In the six months preceding October 1, USAID worked with RCT and the NPC to define and determine outputs and to establish prices following cost analyses. The agreement is that USAID will pay for training and workshops, while leaving open the possibility that USAID will pay for other outputs as needed and appropriate.

It is too early to judge the success of the new system. RCT has some concern that prices may not cover costs, although a good deal of effort was made by USAID, RCT, and NPC to make those prices appropriate. If RCT conducts as much training for USAID as planned, USAID revenues will cover about 75% of RCT's current costs. RCT will have to cut costs and market its services to make up the difference—a process similar to that which CSI has gone through in the last year and a half. The strong advantage to instituting the performance-based output payment system

now, in the middle of POP/FP III, is that RCT will have a year and a half to strengthen its financial, administrative, and program capacity before it must function independently in the competitive training market.

3.5.5 Training

From August 1, 1994, through the end of September 1995, RCT held 36 training courses attended by 401 participants, of whom 178 were female and 223 were male: 72% of courses were for the MOH, 14% of courses were for the EPTC, 8% were for CSI, and two courses (6%) were for the MOPFP. Forty-three of the female participants were in the all female TOT for nurses. See the Training Report in Annex 1.

Curricula were reviewed and updated for the courses for physician service providers, physician trainers in family planning, and NORPLANT® training for physician service providers. These courses were approved by the SDP for delivery to MOH staff.

A new curriculum was developed and approved by the MOH for the orientation to family planning of THO house officers. Course materials include trainer and participant manuals that are well-designed and very thorough.

3.5.6 Conclusions and Recommendations

RCT is in need of strong leadership, and there is a great deal of information that the new director must learn, assimilate, and use to guide her in leading an organization that has a long history and a mixed reputation. It will be important for her to be able to make the personnel changes necessary to create an organization with appropriately trained professionals in its leadership positions. It is essential that the director take charge of the strategic planning and marketing efforts currently under the responsibility of outside consultants hired by PPC.

USAID will need to monitor the effectiveness of using the financing mechanism as a tool to reform the RCT system. It may be necessary to make adjustments to that system over time if the quality of courses and client responsiveness do not improve.

Recommendations:

- 48. RCT's consultants should work with RCT management to finalize the strategic plan and self-financing plan as soon as possible. PPC should provide the technical assistance necessary to ensure that RCT fully "buys into" these plans, understands the plans, and implements them step by step.**

49. **PPC and USAID should work closely with the new director of RCT to help her "engage" with the clients and address the deficiencies in RCT's performance.**
50. **RCT should hire other appropriately trained and qualified professionals (in addition to a financial manager) to carry out specialized functions for which its physicians are not trained.**
51. **RCT should develop a pool of professional trainers for the non-clinical parts of courses.** This would provide role models for physician trainers as well as improve the quality of the courses.
52. **The short-term technical assistance for TOT and TOTOT should be increased to improve the training skills of physician trainers.** It should be intensive, focused, and participatory training.
53. **The long-term technical assistance should be changed: a long-term advisor with skills in finance, strategic planning, and marketing should be made available to RCT approximately 20%-40% of the time.** In light of RCT's transition to performance-based payments and its anticipated development as a business-oriented institution, it requires this kind of focused technical assistance.

3.6 National Population Council/Clinical Services Improvement Project

3.6.1 Introduction

CSI was developed in POP/FP II as an integral part of the Egyptian Family Planning Association (EFPA) with the purpose of improving EFPA and serving as a model of self-financing. Increasingly CSI became an institution in its own right. It had notable successes, offering high-quality services in 103 centers throughout the country. CSI also had major problems: poor management, high costs, and underutilization. The final evaluation of CSI recommended specific studies and improvements, and concluded that USAID should phase out all funding for CSI over the following two years unless research indicated that there was a clear market niche for CSI and a possibility of its becoming self-financing. POP/FP III funding for CSI was targeted to address weaknesses and strengths noted in the evaluation.

CSI's purpose in this project is to increase service volume, as demonstrated by CYPs which are expected to increase from 199,729 in PY1 to 222,298 in PY3 for a three year CYP total of 633,739. Projected outputs are

1. Increased cost recovery for the provision of family planning and other reproductive health services by restructuring and decentralizing the organization, reducing operating

expenditures, and undertaking special studies to define a more effective approach to program self-sufficiency.

2. Increased family planning and other related reproductive health services with centers showing increasing examination room utilization and quality services accessible at client-friendly times and places in urban and rural areas. The following logframe targets for utilization per examination room were reduced during PY1.

Table 6

Targets for Utilization per Exam Room (PY1)

Type of Service	Lower Egypt		Upper Egypt	
	Original Logframe Targets	Current Targets Established in PY1	Original Logframe Targets	Current Targets Established in PY1
New Family Planning Acceptor	6	2.9	3	3.2
New Other Services Acceptor	6	2.7	3	2.9
Revisitor	10	5.8	14	6.7
Total	22	11.4	20	12.8

3. Improved quality of FP and other reproductive health services with indicators to measure improved quality, including a Quality Assurance Management Model.
4. An improved service marketing strategy that defines and focuses on increasing demand within a specific market segment. CSI was to undertake a special study to develop a profile of CSI potential clients and to develop a marketing strategy and materials to reach those clients.

3.6.2 Management

CSI faced tremendous challenges. After a good deal of work in attempting to develop a sound output payment mechanism, CSI and PPC presented the first Life of Project Implementation Plan in July/August 1994. The USAID Project Committee did not approve that design which included

payments to CSI for management improvements as well as for CYP outputs.¹⁰ The Life of Project design was not finalized until October 1994; a month later the NPC submitted the CSI Life of Project plan and signed a Letter of Agreement (which was not officially received by USAID until mid-January 1995). In January, as soon as USAID received the first year annual plan, a Condition Precedent for disbursements, USAID issued a PIL which approved use of revenue funds as a temporary host country contribution. USAID then authorized payments for CYP performance outputs through December 1994; CSI submitted vouchers in January 1995 and received payment in March for the period July through December 1994.

Over this entire period CSI—with reminders from USAID—attempted to deal with the issue of the 1993/1994 host country contribution, which had fallen through the cracks when CSI was transferred from the Ministry of Social Affairs to the Ministry of Population and Family Planning. In May 1995 USAID wrote to CSI advising that due to the overdue host country contribution, USAID was suspending payment of the January and February vouchers. In July, HRDC/POP staff met with the Mission's Financial Management/Legal Offices to develop a solution to the impasse. A decision was consequently made that the NPC would request Ministry of International Cooperation Special Account funds, and USAID approved payment of the vouchers. By mid-November, CSI had received USAID funds for services delivered through July 1995. The GOE informed USAID and CSI that LE 1,108,000 would be released to CSI in November, including the stipulated 1993/1994 contribution plus an additional contribution equaling nearly 50% of the stipulated amount. The GOE letter further indicates that LE 904,000 will be allocated for 1994/1995 and 1995/1996.

Fortunately, over the extremely difficult first fifteen months of the project, CSI has been led by two excellent entrepreneurial executive directors and had skillful assistance from the first PPC chief of party who played a key role in the design and start-up of the newly converted subproject. The first POP/FP III executive director led CSI through an arduous process of self-assessment and reorganization and, with the PPC chief of party's support, helped CSI to rebuild its institutional culture, including:

- Decentralization of responsibility for clinic management to local management units;
- Development of sophisticated, but essential, financial management and management information systems that would be the envy of long-established USAID-funded family planning NGOs in other parts of the world; and
- Initiation of the new USAID modality of payment for CYP achieved (including differential payments by governorate).

¹⁰ Although the Project Paper identified a “Mobilization Advance” loan of LE 450,000 at project start-up, USAID could not give such an advance when the project began due to a number of POP/FP II outstanding audit issues totalling over LE 3 million.

The recently appointed executive director is a physician with extensive management and cost-recovery experience. He has the skills and background to build upon the progress achieved and to lead CSI into becoming a first-class, increasingly self-sufficient family planning organization. He welcomes good technical assistance which CSI needs. Although the first chief of party devoted significant time to the project, it was a mistake to assume that the chief of party would be able to provide continuing long-term support. Since her departure, CSI has received little technical assistance.

CSI Local Management Office (LMO) staff state that despite the worries at the central level, morale has been high at the LMO and clinic levels. Salaries and incentive payments were paid regularly and on time, and LMOs were accorded more authority and responsibility.

3.6.3 *Self-financing*

CSI began POP/FP III activities by utilizing a POP/FP II carry-over of LE 1.2 million, and continued to spend-down those carry-over funds for more than eight months, almost to the point of bankruptcy, before the USAID payments were received in March and August 1995. In the process, CSI developed and implemented successful strategies and systems for increasing its level of self-financing through cost recovery, cost control, and income generation.

USAID pays for CYPs delivered on the basis of a fee scale biased toward governorates with lower prevalence rates and Upper Egypt. For example, USAID pays LE 12.21 per CYP in Alexandria (1992 CPR of 57%); LE 16.72 per CYP in Giza (1992 CPR of 48%); LE 30.86 per CYP in Sohag (1992 CPR of 17.2%); and LE 40.70 per CYP in Qena (1992 CPR of 23.1%). LMOs establish fees (cost recovery) for family planning services appropriate to the local market, with a range established by headquarters. In PY1, CSI recovered 35% of the total costs of delivering family planning services (including costs of LMOs and headquarters but excluding fixed assets and the value of USAID-donated commodities).

CSI achieved this by applying strict cost-control measures and reflecting good management in the face of threatening bankruptcy. Because CSI was desperately short of funds, they spent only 69% of their planned PY1 budget of LE 6.6 million. CSI underspent all budget line items except salaries, incentives, and rent. CSI spent only 28% and 17% of funds budgeted for IEC and training respectively. Due to the lack of funds, none of the special studies was undertaken. PY1 expenditures were 76% of the previous year's spending level.

CSI worked hard to generate income from other reproductive health services (in addition to family planning). The market segmentation study, however, which would have helped CSI identify and target appropriate markets, has not been undertaken. CSI presented a revised Scope of Work for the study in March 1995. When USAID advised that the study should be coordinated with the larger PPC study of all service providers, CSI decided to postpone it. This larger study is under consideration by USAID.

CSI reports that total revenues from family planning and other services were LE 2.3 million in PY1, compared to total revenues of LE 9.3 million over the previous six years. (See table 7.) PY1 revenues were 4% higher than the previous year. At the end of PY1, CSI reported that service fee revenues covered 51% of their total direct costs.

CSI is a relatively new member of the group of USAID-sponsored private sector family planning organizations striving for increased financial self-sufficiency and sustainability. Many of the most successful such organizations are the International Planned Parenthood Federation/Western Hemisphere (IPPF/WHR) affiliates in Latin America, where USAID has been supporting private sector family planning for 25 years. PROFAMILIA of Colombia is the most successful of the group and an excellent model for CSI. In 1994, locally generated income covered 65% of total PROFAMILIA expenses (including fixed assets and the value of USAID-donated contraceptives).

Table 7

CSI Total Revenues by Service 1994/1995

Service	Revenues in LE
Family Planning	1,433,304
Lab	334,747
Sonar	13,116
Immunization	29,039
Sale of non-USAID contraceptives	433,863
Pharmacy	67,515
Pediatrics	1,899
Total	2,292,253

Source: CSI data

A recent USAID evaluation of the centrally funded IPPF/WHR Transition (to Sustainability) Project concluded that the following are critical factors in achieving sustainability: ¹¹

- Institutional commitment to the concept of sustainability;
- Effective and flexible management infrastructure, systems, and qualified staff;
- Identification of market niches and relevant strategies;
- Well thought out pricing strategies;
- Provision of high-quality service in an efficient manner; and,

¹¹ See Wickham, Robert, Roy Brooks, Laurel Cobb, and Cynthia Steele Verme. "Midterm Evaluation of the International Planned Parenthood/Western Hemisphere Region (IPPF/WHR) Transition Project," POPTECH Report No. 95-039-020. June 1995.

- Diversification of activities to include services that generate a surplus.

There are many important differences between CSI and PROFAMILIA, perhaps the most fundamental being the state of the family planning market in which they operate and their institutional affiliation. PROFAMILIA entered family planning 25 years ago when there was very little competition, no public sector family planning, and a free market. CSI entered a market with very heavy competition, a subsidized public sector, and market controls. PROFAMILIA has always been an independent NGO, affiliated with IPPF/WHO, but run by a Colombian Board of Directors free to make decisions. Technically, CSI is only a project of the Egyptian Family Planning Association, which in turn reports to a public sector entity, the National Population Council.

Despite these important differences, CSI could learn from PROFAMILIA, particularly in the area of diversification to include services that generate a surplus while maintaining high levels of quality in all services.¹² PROFAMILIA revenues cover 65% of total costs because, although its mission is family planning, it offers a wide variety of other services which cross-subsidize family planning and low-income clients. As indicated in table 8, those eighteen CSI centers generating revenues sufficient to cover their own direct costs have a slightly higher proportion of new other service clients.

Table 8

Balance between Family Planning and Other Services

	Average # of new FP clients per exam room per workday	Average # of new Other Service clients per exam room per workday
CSI centers generating less than 100% of their expenditures	2.65	2.16
Centers with revenues 100% or more of direct center expenditures	3.73	3.88

Source: CSI data

3.6.4 Service Outputs

Access. In 1994 CSI closed down 20 of its low-performing clinics and put 10 more on

¹² If CSI management is able to visit Latin America, they should visit PROSALUD of Bolivia. PROSALUD was developed by USAID in the 1980s to be a self-financing primary health care provider. Although family planning is only a small part of their total services, PROSALUD is a major service provider in urban areas and is approximately 90% self-financed (total costs).

probation. A major criterion for determining which clinics to close was accessibility. Clinics that were far from public transportation, located in sparsely populated areas, and had low performance were judged to be drains on the system and were closed.¹³ Those that remain in operation were, except for the 10 on probation, believed by the management to be accessible to a significant population. The fact that CYP has increased in spite of the reduced number of service units substantiates their judgment.

Some local directors have taken the initiative to increase accessibility by sending mobile teams to provide services in underserved rural areas within their governorates. In the absence of an appropriate facility, they rent vans and transport clients to the nearest CSI clinic. This activity is dependent on the entrepreneurial spirit of the local director and the availability of a stand-by physician to go out to the rural areas.

Quality. As only 17% of the PY1 training budget was spent, newly hired staff have not received the quality of orientation or training for which CSI was well-known under the POP/FP II Project. Those who recently joined the staff have been oriented by existing staff who may or may not be skilled at their own jobs or able to train someone new. As a result, interviews and observation reveal that many staff are functioning at an adequate level but do not have the self-confidence and competence that were so clearly conveyed to clients in the past. The reinstatement of training will no doubt contribute to the revival of these skills.

CSI expects to receive its clinical training from RCT, with which an agreement has not yet been negotiated. Careful attention should be paid to the terms of that agreement to ensure that CSI has control over execution of the agreement.

CSI staff follow infection-prevention routines, but the staff in some clinics could not locate the relevant procedure manual. In other clinics, only the physician's manual was present, in English, and therefore not useful to any of the other staff, nor to some of the physicians.

Information given to clients about how to take the 21-day pill cycles was inconsistent from clinic to clinic. Physicians had different reasons for suggesting one IUD over another from the choice of three they offer. The longevity of an IUD was incorrectly stated as 3-8 years, with most physicians recommending routine replacement in 3-5 years. A recent Population Council study indicated that the average CSI IUD user kept her IUD for 4.2 years—longer than the Egyptian average of 2.5 years (and the 3.8 years which is the official USAID standard for conversion to CYP).

¹³ Assessment of the 30 low-performing clinics was carried out by five teams of local project directors and physicians, each assisted by a consultant. The teams developed an assessment tool rating the clinics on criteria such as accessibility, location, evidence of supervisory attention, presence and training of staff, and number of clients. The entire group then reconvened to compare the findings and recommended 20 closures and 10 probationary clinics.

Image. IEC is an important determinant of image, but the severe cash flow crisis has prevented CSI from engaging in IEC efforts. The director has identified this as an area requiring attention and training, and he plans to seek sources of training for PY2.

3.6.5 *Center Capacity and Service Utilization*

The methodology for establishing utilization targets in CSI's implementation plans, as in POP/FP II, confuses capacity with utilization. Project documents identify utilization data as the basis for determining exam room capacity, whereas from a management perspective, capacity is determined not by use but by inputs of space, staff, equipment, and supplies. The new executive director agreed that adjustments are needed.

CSI centers are open six hours a day, six days a week. Each exam room is fully equipped and staffed with a physician (all but one of whom are female) and a multi-purpose worker. CSI's management estimates that if five of the six working hours are devoted to service delivery (and one hour a day to administration), and if a physician sees, on average, 3-4 clients per hour (new and revisitors, both family planning and other), then a fully staffed and equipped exam room would have the capacity to service, on average, 15-20 clients a day (or an average of 17.5 clients per day).

Whether one uses the original CSI methodology or the methodology described above for estimating capacity, one must conclude that CSI examination rooms are very underutilized. Sixty percent of exam rooms have fewer than three new family planning clients a day.

Three LMO supervised centers (Domiati, Kafr El Sheikh, and Minya) averaged a total of only 5-8 clients a day. Another nine LMOs supervised centers with a total of 9-13 clients a day. Only three LMOs (Alexandria, Giza, and Qena) supervised centers approaching full utilization, with a total of 14-16 clients per day. Assuming an average daily capacity of 17.5 clients per exam room per day, the average CSI exam room was utilized at 65% of capacity. That figure rises to 85% for the urban governorate of Alexandria. Average governorate utilization was 58% in Upper Egypt and 59% in Lower Egypt. See Annex 1, table 3, which breaks out these data by service (new family planning, new other services, and revisitors) and by governorate.

Despite the underutilization, or perhaps because the targets were realistic, CSI is achieving its CYP targets. In PY1 1994-1995, CYP increased by 7% over the year before. Significantly, 1994/1995 CYP in Upper Egypt is 113% of the previous year. In Lower Egypt it is 103%, while in Alexandria it is 123%. (See table 9.)

3.6.6 *CSI's Role in Upper Egypt*

In PY1 CYP increased by 13% in Upper Egypt and, despite the fact that CSI clinics are underutilized, those clinics contribute CYPs disproportionately to their number, relative to the

MOH.

Table 9: CSI's CYP Achieved by Governorate

Table 10**CSI Relative Contribution to Governorate Level CYP**

Governorate (1992 CPR)	CSI		MOH		MOH/CSI	
	# of units	1994/1995 CYP	# of units	1994/1995 CYP	CYP ratio	unit ratio
Aswan (29%)	3	6,792	115	8,515	1.3 to 1	38 to 1
Qena (and Luxor) (23%)	6	12,331	220	21,332	1.7 to 1	37 to 1
Sohag (17%)	9	19,115	226	25,357	1.3 to 1	25 to 1
Total	18	38,238	561	55,204	1.4 to 1	31 to 1

3.6.7 Conclusions and Recommendations

Overall, CSI has performed very well during POP/FP III. Considering the financial odds CSI has faced, merely surviving is a worthy feat. But not only has CSI survived, it has reorganized, developed good management systems, maintained morale, and exceeded CYP outputs. However, the costs have been high: there has been little training or IEC—a situation which CSI greatly regrets and intends to remedy as soon as funds are available.

CSI examination room capacity is underutilized, with great variation between governorates. The rather convoluted methodology used to establish utilization targets has not helped CSI to make a realistic assessment of utilization.

CSI needs long-term technical assistance from an advisor who has both dedicated time and first-class credentials in strategic planning, financial management, and marketing.

CSI's status as a project, rather than an institution, may have some advantages, but there are real disadvantages to being a project while striving to be a self-sufficient, competitive organization. From a morale and identity perspective, projects are temporary, with time-limited career possibilities; organizations are more permanent, strive to endure and offer career tracks. Donors are more likely to fund organizations directly. CSI is at a disadvantage in its efforts to obtain European and Japanese donor support because it is a USAID-funded project of a local institution.

Recommendations:

- 54. It is time to invest in the long-term sustainability of CSI. CSI should use the GOE contribution to fund overdue training and IEC activities. CSI should designate a staff member to advise and monitor IEC activities.**

55. **CSI should continue the process of monitoring centers on the basis of two criteria (CYP and level of self-financing) and close centers that do not perform and those that are a drain (Fayoum, for example).** Utilization, a critical issue for organizations seeking self-financing, should be monitored carefully by CSI. CSI should distinguish between utilization targets and exam room capacity.
56. **USAID should provide top-notch technical assistance in strategic planning, marketing, and IEC to CSI to support its continued development as an increasingly self-sufficient institution. A PPC resident technical advisor in planning, finance, and marketing should be available to CSI for 40% of his/her time. USAID should also ensure that CSI receives good short-term technical assistance in IEC as soon as possible to help CSI regain the momentum it has lost over the last year and a half.**
57. **USAID should facilitate the efforts of CSI management to gain exposure to and become a part of the international group of family planning organizations that are making real progress toward financial and institutional sustainability. USAID should sponsor a visit of key CSI personnel to PROFAMILIA in Brazil and PROSALUD in Bolivia.**
58. **Inasmuch as the Population Council's study of CSI IUD-use rates indicates an average rate of 4.2 years, USAID should pay CSI for CYPs converted at 4.2 rather than 2.5 years.**
59. **CSI should establish itself as an NGO in its own right, independent from the EFPA.**

3.7 Ministry of Information/SIS Family Planning IEC Subproject (SIS/IEC)

3.7.1 Introduction

The SIS/IEC Center under the Ministry of Information's State Information Service was established with USAID support in 1979 to serve as the GOE's primary FP/IEC unit. SIS's historical experience in producing public information campaigns involved using mass media and local outreach, that is using MOI's Radio and Television Union and 60 Local Information Centers (LIC). This moved FP/IEC beyond the clinical setting, where the MOH's cadre of IEC officers promote family planning via audiovisual presentations.

SIS/IEC Center messages have narrowed in focus over the years from general promotion of smaller families to more specific reasons for having fewer children, and from general promotion of contraception to more specific information about each method. This narrowing of focus follows the success of the more generalized campaigns of the past. National awareness, knowledge, and positive attitudes toward the concept of family planning is the norm.

The need now is to confront the high rates of misuse, misinformation, dissatisfaction, and discontinuation of the most commonly used methods—IUDs, and especially oral contraceptives—which the public sees as having distinct problems.

Also needed is a shift from an exclusive focus on women toward a male involvement campaign which would help overcome the barriers of disapproval and non-support of using contraceptives that some wives face from their husbands.

Project outputs for the SIS/IEC Center under POP/FP III are to

1. Improve strategic communication to increase effective use of modern methods.
2. Increase demand for and correct use of contraceptives through mass media and interpersonal activities.
3. Improve SIS management capacity through institutional development and training.

As SIS has come to realize in recent years, strategic communication requires a research-based cycle of message design, placement, and impact analysis. Increasing demand for and correct and effective use of contraceptives requires direct confrontation of the known reasons for nonuse and misuse of, and dissatisfaction with specific methods. Improving SIS management capacity requires the following: development of an effective MIS, development of staff capacity, and training staff to demand high standards from their subcontractors in the areas of research, training, and materials production.

3.7.2 Demand Generation Campaigns

Verifiable indicators for the SIS/IEC subproject performance under POP/FP III for the year 1997 as shown in table 11.

Achieving these numerical goals requires separate campaigns in different media with varying kinds of interagency cooperation both at the central and local levels.

Husband-Wife Communication. According to the 1992 DHS (1992 DHS tables 13.16/17) for the rural areas of Upper Egypt, 33% of men and 38% of women (13% and 18% respectively nationwide) were either unsure or wrong about their spouse's actual attitude toward

Table 11

Indicators for the SIS/IEC Subproject Performance

Verifiable Indicator	1997	1992
CPR	53%	47%
Extended use failure rate	7%	10%
Husband-wife communication (on desired family size)		
Men	46%	39%
Women	46%	44%
Reasons for nonuse and discontinuation due to:		
Side effects	8%	11%
Health concerns	36%	41%
Knowledge of injectables	91%	81%

contraceptive use. This perceptual gap can only be overcome by making contraception acceptable conversation topic between spouses.

Five spots centered on "male responsibility" have been produced and aired and a film entitled *Not Impossible Dreams* has been produced. All have been script- and production-supervised and pretested by SIS/IEC Center staff. One spot won an Egyptian film award. Five new spots centered on "husband-wife dialogue" are now in the storyboard stage of production and should be pretested before a working copy is produced.

The spots already aired seem overly generalized. For example, on the theme of male involvement in household affairs, the campaign tag line is "The Man... not by his word alone, The Man... by caring for his house and family," and no specific mention is made of family planning. Moreover, the film is abstract and does not address husband-wife communication about FP.

A key barrier to FP services is a husband's disapproval of his wife seeing a male doctor. According to the 1992 DHS, husband disapproval is 31% nationwide, 36% in rural Upper Egypt, and 23% in urban Lower Egypt. These issues need to be addressed through a male responsibility campaign.

Another barrier, especially in the rural areas of Upper Egypt, has been the male perception of Islam's position toward family planning. In the 1992 DHS, only 58% of rural Upper Egypt men (and 69% of rural Upper Egypt women) believed Islam permitted family planning. Given the LIC effort in recent years to involve pro-family planning sheikhs in public discussions of the topic,

these percentages are likely to rise in the next survey. This barrier and the strategy to overcome it are cited here as a success story of a campaign aimed largely at men.

Effective Use of Promotion for Injectables and OCs. Four new "Dr. Karima" method spots have been produced: Two will introduce the injectable as a newly available method; one will introduce the IUD as a 10-year method; and one will review the method mix available. To reinforce this strategy, spots should address correct use and risk for discontinuation. For the injectable, spots should stress compliance with the need for quarterly reinjection and possible but temporary/nonthreatening side effects; for the IUD, they should note the need for same day removal/reinsertion and/or alternative protection before insertion and after removal. These new spots do provide information of this type. It is important to distinguish for the public that FP injectables differ from other commonly used ones such as vitamin injections.

Given the high rates of misinformation about OC use among both providers and users, the need for correct daily compliance should be a priority area for the use effectiveness campaign. According to the 1992 DHS, 25% of current OC users had taken a pill out of sequence that month, 20% did not know what to do in the event of missing one day, and 14% reported having stopped temporarily for what might have been tolerable side-effects (e.g., spotting, fatigue) had adequate counseling been offered.

Early Dr. Karima OC spots continue to run. However, the only OC-specific media planned to date under POP/FP III is the new SDP OC method brochure, of which 400,000 were printed (compared to 850,000 for IUDs). Even though IUD users far outnumber OC users at MOH clinics, an OC user is counseled to refer to the brochure for at-home instruction, and it is likely she will need more than one brochure over the period of her OC use. The average MOH per unit distribution is nonetheless low, as indicated by the low number of OC brochures distributed per unit: 88 OC brochures/unit in Alexandria, and 50 OC brochures/unit in Aswan.

The SIS/IEC Center does not have full discretion regarding the language and pictorial content of its FP messages. Mass media messages must be approved by the RTU censorship board and SIS itself before they are aired. Negotiations about the use of even the phrase "family planning" can be delicate. These constraints must be acknowledged in any discussion regarding the lack of message specificity.

Replication of the Minya Initiative. The 1992-1993 Minya Initiative was an intensive governorate-wide SIS campaign managed locally by the LIC and aimed at coordinating interagency resources, training local opinion leaders, and using local media. CPR rose some eight percentage points at the end of the specially funded activities. The security situation in Minya in recent years has forced a cut-back in routine governorate-wide activities. Whether CPR remains high will be seen in the 1996 DHS, although CYP in Minya has increased 189% from 1989-1994, while in Beni Suef and Assiut (surrounding governorates) CYP increased only 73% and 69% in the same years (1994 NPC Statistical Report, table 3.1.4).

The Select Village project forces each LIC to think for itself, especially as LIC staff draw their own lessons from Minya. These include the advantages of local interagency planning and activity implementation, assuming local authority to make decisions and schedule activities, and motivating staff with special campaigns and individual reward for performance. Minya was also a research-intensive effort, however, and Select Village projects need not rely on or generate the same level of burdensome and time-consuming baseline information in order to plan and implement activities. Select Villages should try to quickly graduate from the pilot phase and move into a routine LIC activity.

SDP is now providing important planning input—by helping to choose new Select Villages only where QIP clinics are operating and by sharing resources once the project is under way. This kind of early interagency coordination should reduce the research and start-up time that was required in the Select Village's first two years when LICs alone initiated projects.

Special Populations - Rural Upper Egypt. Many LIC meetings in rural Upper Egypt are planned to engage opinion leaders at village council headquarters. These leaders tend to be repeat participants, are more accessible, and are free to leave their home. A focus on nonuser and hard-to-reach groups requires extra effort—door-to-door recruitment by *raidat rifiiyyat* (in coordination with NPC); smaller meetings in homes or courtyards; simple, method-specific information; and female lecturers—in order to reach those with the least access to other FP message sources such as TV and clinic counselors.

The 1992 DHS findings (1992 DHS table 4.7) show that most FP meeting attendees are not those who are most in need of information, that is the rural and uneducated nonusers. In Upper Egypt and nationally, 9% and 4% of ever married women from urban and rural areas, respectively, attended FP meetings (most presumably SIS-sponsored). National figures by education, contraceptive use, and cash income status show similar disparities—17% and 3% respectively for ever married women with completed secondary and no education; 8% and 4% for current users and never users; and 17% and 4% for cash and noncash income earners.

Region-specific programming on local TV (Alexandria, Delta, Canal, Minya, and Aswan) to date deals with generic demographic and socioeconomic problems of overpopulation. There is no region-specific and method-specific mass media campaign planned for Upper Egypt TV and radio. In the absence of this, LIC meetings and Select Village projects are the only means available for raising public information and awareness of FP in Upper Egypt.

Population density rather than low CPR seems to be the criterion for choosing the site of Select Village projects—thus there are more Select Villages in Lower Egypt than Upper Egypt. Of the new group of 24 Select Villages chosen for a six-month intensive campaign in 1995, seven are in Upper Egypt and 17 are in Lower Egypt and urban governorates. Of the 1994 group of 16 Select Villages chosen for three-month follow-up campaigns in 1995, five are in Upper Egypt and 11 are in Lower Egypt and urban governorates. Of the 1993 group of 16 Select Villages now

"graduated" out of special activities, five were in Upper Egypt and 11 in Lower Egypt and urban governorates.

Interpersonal Activities. The Implementation plan suggests a target number of interpersonal activities by type per LIC per year (e.g., eight public meetings, 15 audiovisual meetings, 10 interagency meetings, seven meetings of local influentials, and one poetry evening). This target has been surpassed by 100%—from April-June 1995 each LIC averaged 5.7 public meetings, 8.7 audiovisual meetings, 5.8 interagency meetings, 5.2 meetings of local influentials, 0.7 poetry evenings—or one meeting every three days.

Seven LIC meetings were observed—three in Aswan (al-Shatba, al-Ga'afra, and Dindin villages), one in Tanta (MOH mouldid tent), one in Kalyubia (al-Munira village), one in Beheira (Basantway village), one in Alexandria (Abees village). Some messages delivered by lecturers—LIC staff, non-SDP physicians, social workers, and sheikhs—were indirect, obsolete, generalized, or incorrectly interpreted by listeners.

Some lecturers cited nationwide demographic, economic, and environmental statistics, such as the percentage of arable land, dependency ratios, and urbanization rates, in order to promote a couple's adoption and use of contraception. These are not useful persuasion tactics to promote a personal decision about private behavior. The Quranic verse frequently cited by sheikhs about breastfeeding for "two full years" was often mistakenly interpreted by listeners to mean that two years is the Quranic ideal for a birth interval. Some lecturers concentrated on the nutritional benefits of breastfeeding without drawing the analogy that breastfeeding is an imperfect contraceptive that must be supplemented with modern methods.

LIC meeting presentations would improve if there were written message-specific outlines on such subjects as birth spacing for no less than three years, a husband's involvement in his wife's decision to use contraceptives, common misuses of and/or misinformation about contraceptives, the need to use modern methods while nursing, and an additional child's actual monetary costs to a household. The existing SDP flip charts could be reprinted in larger format to help FP lecturers at meetings, especially non-SDP physicians and LIC officers, to thoroughly cover subjects such as correct method use for injectables and OCs.

The PPC Technical Approach proposed holding SIS-sponsored creativity workshops for regional artists to develop inter-educate shows, poetry, theater, and artwork. There is warm public response which was evident in local meetings with *zagal* poets and at the play, "Valley of the Ants," during the Minya initiative.

The activities MIS and a new meeting report form will be designed to verify activities. LIC meetings are presently recorded by the LIC officer by name of village, type of meeting, names of lecturers, number of attendees, and include space for brief comments. The two LIC officers specifically asked about reporting requirements for meetings did not mention minutes. Taking of minutes is overly burdensome to LIC staff and not useful as a quality measure of documentation.

SIS has discussed designing an LIC meetings evaluation instrument using exit interviews with attendees to measure message comprehension and perceived relevance. This would be feasible only if used periodically and conducted by independent researchers as a spot check. LIC staff do not have the time or means to do this after every meeting.

Egyptian consultants trained in case study research might visit LICs to write a narrative report on how a meeting was planned, lecturers and attendees recruited, lectures delivered, discussions conducted, and messages comprehended. This would be a valuable written feedback mechanism to LIC staff, SIS/IEC Center staff, and USAID. The quarterly report gives little sense of the quality of LIC meetings.

3.7.3 Institutional Development

SIS/IEC Center Institutionalization. Because the SIS/IEC Center is firmly established as an institution, there was little managerial disruption when a new executive director took over at the end of last year. Decision-making is freely delegated by the executive director to staff who thereby assume ownership of a task. Senior staff continuity—and institutional memory—is the norm, yet younger staff are also being trained in market research, computers and MIS, strategic media planning, and their role as clients for subcontracted work. It is important to keep the junior staff, once trained in high-demand private sector skills, from leaving.

Training and technical assistance in strategic communications helps the SIS/IEC Center to function as an advertising agency capable of designing different campaigns simultaneously (e.g. SIS/SDP, Male Responsibility, and Correct Method Use), while subcontracting actual production execution of ads to the private sector. This approach is not less staff intensive but will result in higher quality products and faster turn-around times.

The SIS/IEC Center's in-house research function is being appropriately scaled back to limited qualitative testing of spots and Select Village pre-implementation situation analyses. Meanwhile, the Center is slowly learning to supervise the subcontracting of more demanding research (eg., psychographic profile, media habits survey, SDP baseline study) to external consultants.

Once new computers arrive and are networked for each department, a budget-coded computerized MIS (a paper version now exists) for task tracking and status reporting will provide department heads and executive staff with instant access to all SIS/IEC Center activities. This is important as more subcontracted work is done out-of-house and some tasks along a critical path might be overlooked. A financial MIS is now in place. External and SIS computer consultants are charged with training SIS staff and designing the MIS, and will oversee installation early next year.

Under POP/FP III, SIS/IEC Center staff are or soon will be learning new skills, especially in the areas of computer use and MIS, the subcontracting process for research and media production,

and interagency cooperation (especially, SIS/SDP). Given the Center's ambitious output targets (e.g., numbers of LIC meetings, numbers of spots produced) this learning burden will strain staff capacity if other campaigns are assigned. SIS/IEC Center staff and especially LIC staff will be overworked and lose their primary FP focus if the Healthy Mother/Healthy Child Initiative, and other possible GOE campaigns (e.g., anti-smoking and anti-littering), are channelled their way. Even as additional staff are recruited to help on new initiatives, existing staff who were trained and acquired experience under POP/FP II and III should not be "lent" to these new campaigns. The SIS institutional memory in the area of family planning should be protected.

PID and in-country training for LIC staff strengthens the staff members' links to the SIS/IEC Center and focuses LIC staff efforts on family planning. For this reason, the publication "Panorama" should be revived as an internal newsletter to reinforce communications between the SIS/IEC Center and LICs and among LICs themselves.

Decentralization. The 60 LICs are the backbone of SIS's local outreach effort. In the past, their work has been overly controlled by Cairo, which assigned uniform performance indicators—meetings by type, such as youth, local influential, public, artistic, interagency, and audiovisual—to all LICs and set each LIC's numerical target without input from the LIC. Being responsible for a Select Village is the best way for LIC staff to learn the skills and procedures of self-initiative, local problem solving, and decentralization. Each Select Village offers unique problems that all acknowledge cannot be solved in Cairo. SIS/IEC Center staff, meanwhile, learn to support local decision-making without second guessing. The governorate-level interagency and local leader cooperation and joint training model which first proved successful in Minya is maintained.

Coordination with MOH/SDP. A letter of agreement was signed at the start of POP/FP III between the SIS/IEC Center and MOH/SDP which specified planning, production, evaluation, and training procedures for the SIS/IEC Center and MOH IEC staff. This was the first time such specified interagency activities, obligations, and resources were defined and carried out in detail. This letter of agreement might serve as a model for other interagency cooperation.

The SIS/SDP collaboration established eight interagency working committees: Steering, Management/Finance/Contract Review, Logistics, Client/Provider IEC Materials, Multimedia Marketing, Local Activities/Distribution, Coordination/Training, and Research. This alignment may have unnecessarily delayed the design, production, and the completion of distribution of brochures and flip charts (scheduled for April 1995 in the PY1 SIS Implementation Plan) and should be reviewed.

An introductory wave of QIP TV and radio spots have been produced and will be aired shortly. Because the media launch date is tied to SDP's still incomplete QIP-clinic designations, any delay in media production has not affected the overall program. A second wave of spots showing the gold star as a clinic marker will run early next year, depending on QIP scores, when about 1,000 clinics should be so marked.

Eight two-day workshops were held for LIC directors and governorate-level MOH FP and IEC directors to explain the local IEC needs of the QIP program and to plan joint local activities. LIC directors will seek SDP physicians to lecture at meetings, although many physicians are likely to have schedule conflicts because most LIC meetings take place during morning clinic hours or at night. The most fruitful local planning will be around Select Village projects—to be sited only near QIP clinics—as LIC outreach will be able to refer to a guaranteed high-quality provider and counselor.

National IEC Strategy. The NPC claims responsibility for coordinating a national IEC strategy with assistance from SIS. Several standing interagency committees meet monthly or quarterly at non-technical levels of representation, but it is still unclear if their purpose is to develop a coherent strategy with follow-through or rather for each agency simply to brief others about ongoing work.

Following the ICPD, the NPC promoted such non-FP issues as urbanization and national economic growth, which have taken up much SIS/IEC Center staff training and media time. Further off target, some agencies think that a national communications strategy means promoting their agency via desk calendars, TV coverage of high-level meetings, and the like to the public and other GOE bodies. This occurred before and after the ICPD and delays activities aimed solely at reducing fertility.

More problematically, NPC is working with UNFPA support to train local leaders and produce its own media messages. NPC governorate-level training of opinion leaders (sheikhs, youth, village notables, and poets/actors) does not appear to have been communicated to or coordinated with LICs. The UNFPA project document reportedly did not mention SIS. This is not a helpful start if a national strategy means the assignment of separate tasks of communication—mass media, training village influentials, informing national opinion makers—to those agencies with special expertise in their respective areas. Duplication of trainers' effort and message diffusion to those trained may result.

LIC staff hope that the new NPC-trained and salaried cadre of *muthaqqifaat sukaniyya* (population educators) will work with them. Egypt has not had a well paid and educated group of community workers before. If the *muthaqqifaat* are well salaried and trained in sufficient numbers for the long term, SIS must be involved in decisions regarding how and where they are used.

Many LIC staff consider *raidat rifiyyat*, who were established under the Ministry of Social Affairs and now also work under NPC, to be too poorly educated, underpaid, and inadequately supervised to work dependably with them. A 1995 Population Council report on *raidat* found them to be personally motivated and idealistic but often ineffective because few *raidat* had links to service providers or male village leaders nor did they have adequate training in family planning communication and method use. The report concluded that "Coordination among all the organizations involved with the *raidat* system is essential."

Recommendations:

60. **SIS and NPC should jointly define a national family planning IEC strategy aimed at increasing CPR and take immediate steps to bring all relevant IEC agencies in agreement on who should do what, based on each agency's unique resources and talents.**
61. **The SIS/IEC Center should determine IEC needs (flip charts, method brochures, and method spot videos) of clients of all subprojects and Egyptian family planning NGOs. The Center then needs to develop a plan, write a budget, and deliver a proposal to USAID for funds to reprint/recopy and distribute materials to these agencies.** Brochures and flip charts could be used in all clinic and clinic outreach settings. Videos should be used in THO waiting rooms and MOH audiovisual vans.
62. **More method brochures should be printed immediately as MOH clinic supplies are very limited.**
63. **Messages aimed at men through mass media and LIC activities should be tied more closely to increasing husband-wife dialogue specifically about contraceptive use and reducing male resistance to male FP providers.**
64. **Method-specific spots should be explicitly tied to correct and continued use of contraceptive methods. This requires that misuse, noncompliance, side effects, and negative rumors be anticipated and clearly addressed in the messages.**
65. **The Select Village Project should be continued with a slowly phased scale-up with simplified pre-implementation planning and baseline research inputs.** To demonstrate the project model's success to date, for each SIS quarterly report, one LIC director could write a narrative of one of his Select Village's progress during the reporting period.
66. **New Select Villages must be chosen with an emphasis on Upper Egypt** and special technical and financial support should be given to Upper Egypt LICs in recognition of the longer travel times, less adequate interagency resources, and greater cultural barriers to FP communication and acceptance in that region.
67. **More LIC meetings in rural Upper Egypt should be planned specifically for uneducated and nonuser populations.** To track LIC activities in Upper Egypt, the quarterly report should break out the numbers of meetings in Upper Egypt. Head counts of attendees should be dropped altogether, and the currently reported six meeting categories should be collapsed to two or three in order to simplify the matrix.

68. **LIC and SIS/IEC Center staff should develop together performance indicators and guidelines for ensuring the high quality of lectures and message-specific outlines rather than simply setting goals and reporting outcomes by numbers of meetings held.** The number of general LIC meetings should be reduced in order to concentrate efforts on Select Village activities.
69. **Outlines of talking points for LIC meetings should be developed and tested at the central level and delivered to LICs for both LIC staff and invited lecturers, especially non-SDP physicians and social workers.** Invited lecturers should review these before speaking. The flip chart should be reprinted in large format and distributed to each LIC.
70. **Workshops with MOH input aimed at writing method-specific poetry and plays should be explored.** *Zagal* contests could be recorded and aired for local broadcast and winners could be paid to tour villages within a governorate.
71. **SIS/IEC Center staff trained under POP/FP II and POP/FP III must not be assigned to upcoming non-FP IEC campaigns.**
72. **SIS should explore the feasibility of a formal letter of agreement with NPC for SIS to train local opinion leaders and to use NPC-salaried community workers** (especially, *muthaqqifaat sukaniyya*) in LIC meetings and Select Villages. This will require a degree of joint planning, information exchange, and sharing of staff and project tasks that does not exist today.

3.8 Private Commercial Sector

3.8.1 Private Sector Initiatives

Private Sector Initiatives (PSI) is the only subproject for which PPC is the implementing agency. The PPC chief of party was designated as the person responsible for coordination of PSI. Given that the chief of party position requires a person with a broad background in family planning policy and programming, it is not likely that a person with those qualifications will have the requisite private sector experience to provide innovative guidance and leadership for implementing a private sector program.

The start-up of PSI was delayed for about a year due primarily to a lack of management focus by PPC because the chief of party was burdened with too many other responsibilities. Leadership was ultimately provided by the RS/RMU and the financial and administrative specialist. The original three-year Life of Project implementation plan was compressed into a two-year plan. RFPs were developed to implement the three components of the subproject: continuing education, advertising/marketing, and research/monitoring/evaluation. These RFPs were designed as fixed

price contracts with all deliverables specified in order to ensure that technical responsibility would be taken by the contractors and the PPC management burden minimized.

The letting of the subcontracts was completed in August 1995 following standard procedures. PPC resident technical specialists, with short-term technical assistance, managed the bidding, review, and award process. A PSI coordinator, deputy coordinator, and finance specialist were recruited to manage the subcontracts.

PSI will work in selected governorates in Lower Egypt. Its primary focus is to improve the quality of care that pharmacists and private physicians provide. It plans to train 4,000 pharmacists, or approximately 80% of pharmacists in the catchment area. There is also a plan to train pharmacist assistants if warranted. In addition, the subproject will train 600 physicians in the same area and attempt to establish a complementary referral service between physicians and pharmacists. The subproject will promote pharmacists and physicians who have participated in the training by advertising their services as high quality.

The research contractor will do a baseline, mid-point and final assessment to measure the quality of provider services and related patterns of client use. The baseline survey is in progress. Training activities have not yet begun. It is therefore premature to assess the effectiveness of the approach or the implementation.

A logo-based, mass media campaign is planned to promote private providers to the public. This campaign will receive a 50% discount from the RTU for airtime and might be launched during or soon after the SDP gold star TV campaign promoting MOH providers. The RTS/IEC will supervise the private ad agency assigned to the PSI campaign.

In the past, there have been examples of unintended message conflicts between public and private sector campaigns. For instance, CSI messages suggested that MOH services were faulty, and the Egyptian Junior Medical Doctors Association physician spots ran counter to SIS's *Ana Zanaana* peasant-as-correct informer spots. SIS/SDP research found that some tested logos would create a negative inference for those clinics without logos. A campaign with paid airtime might also erode SIS's access to free airtime and choice time slots.

The effectiveness of each component of the PSI approach needs to be monitored carefully and it will be important to determine if the combination of interventions has a positive synergistic effect. Although a fair amount is known with respect to deficiencies in pharmacist knowledge, there has been little experimentation with approaches to pharmacist training with the exception of CSMP detail men providing information on product use. Physician training by PSI is somewhat problematic: there is likely to be overlap, as most private physicians also work for the MOH and most MOH physicians are being trained in family planning under SDP. The PSI approach to promotion of providers is new, as is the attempt to foster the pharmacist/physician linkage.

3.8.2 *Contraceptive Social Marketing Program*

The Contraceptive Social Marketing Program (CSMP) is implemented by the centrally-funded SOMARC project with core funding which will end in June 1996. SOMARC has been distributing the subsidized contraceptives that remained after USAID withdrew support from the Family of the Future project. The stocks of IUDs were sold out by October 1995; oral contraceptives and condoms will be sold out by April or May 1996. The SOMARC project's objective has been to bring about a transition to the private sector and commercial sales. The discontinuation of subsidized contraceptives and the shift to a free market will strengthen the private sector and attract commodities to the Egyptian market at competitive prices.

SOMARC has taken the lead in bringing together major international contraceptive manufacturers with private sector interests in Egypt. A new commercially marketed IUD, aimed at the niche filled by the socially marketed IUD which had sold for LE 3, will be available from U.S. manufacturers for approximately LE 10-LE 12. An Indian IUD will sell for LE 7.5. Prices of more expensive IUDs currently available will drop from approximately LE 30 and LE 35 to LE 16 and LE 18. The socially marketed oral contraceptive, Norminest, currently selling for 50 piasters, will be sold for roughly LE 2.5. Egyptian produced OCs are available for 95 piasters, although the manufacturers have begun negotiations for increases to about LE 1.5 to cover actual costs.

SOMARC is exploring sources of low-cost, high-quality condoms. SOMARC has negotiated with a Depo-Provera supplier to sell each dose packaged with a syringe at a relatively low price. Under the agreement, SOMARC will promote Depo-Provera and supply an appointment card to be inserted in each packet.

In 1994 the SOMARC market share of contraceptives was approximately 22% of IUDs, 24% of OCs and 71% of condoms. The transition to significantly higher commercial prices will certainly have consequences. A modelling exercise based on the 1992 DHS of projected effects on the IUD market predicted little change in contraceptive prevalence with some shifting to the public and NGO sectors. The evaluation team found that pharmacy stocks of subsidized IUDs are exhausted, and the new lower priced commercial IUDs are not yet available. This hiatus could cause a disruption in the IUD market. It will be important to assess the effects of the substantial price increase on switching to other IUD providers, method changes, overall CYPs and, possibly, leakage from the public sector.

There has been prior experience with effects of availability and price increases on the OC market. Between December 1994 and August 1995, Norminest was not available due to registration problems, and there was a temporary dip in CYP. This was seen particularly in some governorates. With heavy advertising, Norminest regained its market share within a month of being available. The increase in price after more than six years, from 35 piasters to 50 piasters per cycle, had no effect on sales.

SOMARC is gradually increasing the price of the Golden Tops condoms so that by the time the stocks are exhausted they will be selling at a commercial price. Moderate price increases in the past have not affected sales.

Using returned-to-project funds, SOMARC is planning to train approximately 1,800 pharmacists in Upper Egypt. A primary focus of the training will be on the injectable, but it will cover all methods sold by SOMARC. Accrued funds continue to be used for advertising, especially the promotion of Depo-Provera.

Discussions are under way between USAID/Egypt and SOMARC regarding a continuing SOMARC role for an additional year, with funding from the Mission. Various activities are under consideration, including a proposal to help organize the pharmaceutical companies to be more involved in social responsibility activities.

3.8.3 Conclusions and Recommendations

The private sector has played an important role in the Egypt family planning program. The 1988 DHS found that approximately 70% of prevalence was attributed to the private sector, dropping to about 63% in the 1992 DHS. The private sector was the source for over 86% of pill users, almost 53% of IUD users, and 83% of condom users.

A strong private sector is critical because it serves clients who otherwise would not utilize public family planning services. With the ending of a highly successful social marketing effort, it is important to assess continually the state of private sector market share and to test interventions that are effective in supporting the private sector without disrupting the open market.

Pharmacists are the critical group on which to focus, as pharmacy sales represent almost 84% of the pill market, 82% of the condom market, and 28% of the entire market, according to the DHS. As market share of IUD diminishes, and particularly with the growing popularity of the injectable pharmacies will have an even greater market niche.

Recommendations:

- 73. Having work experience in the private sector should be a prerequisite for filling positions for planning and implementing private sector activities.** Managing a private sector program requires extensive experience in working in the private sector and familiarity with the types of commercial private sector networks involved in family planning-related activities.
- 74. The PSI research needs to be carefully analyzed to evaluate the effectiveness of each of the PSI interventions and to determine whether there is a positive cumulative effect of the combination of interventions.** Some additional research may be warranted to ascertain the effects on client attitudes and behavior if the PSI research is not adequately designed to pick up the nuances.

75. **A series of relatively small operations research studies should be planned to test the effectiveness of various approaches to supporting the private sector, particularly pharmacists.** It may be useful to perform some smaller scale pilot studies to test the effectiveness of a variety of approaches to working with private providers before scaling up to the level of the PSI effort.
76. **USAID should continue to support, through SOMARC and PSI, a variety of promotional activities in the private sector that not only captivate the consumer but that help to make the client a more informed consumer.** The family planning client who is an informed decision-maker will be a more satisfied and compliant user.
77. **USAID should continue to promote the elimination of all price restrictions on contraceptives, including those manufactured in Egypt.** In order to ensure the health of the private sector and the availability of a range of contraceptives, manufacturers and distributors must be able to operate in a free competitive market.
78. **The repackaging of oral contraceptives produced in Egypt should be encouraged to include seven placebo or iron pills (i.e., a 28-day strip) and to mark off days of the week.** Incorrect use of oral contraceptives by clients remains a programmatic concern. The effectiveness of a full 28-day cycle and of markings denoting every seventh day should be considered as a means of enhancing correct use. The price increases needed to permit such repackaging need to be discussed with manufacturers and price regulatory bodies within the GOE.
79. **Support should be provided to assess the Egyptian mechanism for ensuring that quality control of imported contraceptive products for efficacy and technical capability, including the IUD, condoms, and oral pills is acceptable.**

4. ACHIEVEMENT OF PROJECT OUTPUTS

4.1 Increased Service Volume, Quality, and IEC

4.1.1 Utilization

Access. Newly opened district nursing schools and mobile clinics were two of the strategies implemented by SDP to increase access to family planning services for women in Upper Egypt. Eight of the thirteen nursing schools were opened in September 1995 and five more are expected to open soon. Although it is too early to measure the impact, there are strong indications that these schools will increase the number of women who are trained and willing to work in Upper Egypt.

Mobile teams have been used in several governorates over the years with funding at the local level. The SDP mobile team initiative is primarily directed to increasing access in Upper Egypt. While it has not been formally documented, it appears that the mobile teams with a trained female doctor are successful in increasing the use of IUDs by rural women.

Utilization. In the first official twelve months of the project, July 1994 to June 1995, the three service providers reported a total of 1.9 million CYPs—the annual number projected in the Logframe to be accomplished in 1996-1997. The MOH achieved 116% of its targets, CSI, 94% and THO, 69%. (See table 12, Project Year 1 CYP Achieved by Service Provider by Governorate.) Although the success in increasing CYP has been significant, project targets were too low.

Success of the Upper Egypt Strategy to Date. Although the PPC Technical Approach did not explicitly define an “Upper Egypt Strategy,” USAID, PPC, SDP, and CSI have obviously had such a strategy. Components include

- CYP performance-based payments biased in favor of Upper Egypt for CSI;
- The MOH development of nursing schools in Upper Egypt, where there had been none;
- The MOH use of mobile teams to reach centers that did not have female physicians nor IEC promotion;¹⁴

¹⁴ Wisely, all service providers involved here share in the incentives from increased family planning service delivery: the male physician staffing the clinic shares in the incentives and the female provider is paid a bonus for being on the mobile team.

- Seeking female physicians (with competition among providers for such physicians) to staff clinics in the belief that women in Upper Egypt prefer a female physician, particularly for IUD insertion; and
- Introduction and promotion of injectables, including giving authority to nurses to provide the injectable upon a physician's approval and supervision (throughout Egypt but with beneficial consequences expected particularly in Upper Egypt).

The results of that strategy to date are that, in PY2, the MOH surpassed its Upper Egypt CYP targets by 12%, and CSI achieved 100% of its total Upper Egypt targets, despite its financial difficulties.

Overall CSI, which runs fewer than 3% of the total service delivery points, provided more than 15% of the CYP: CSI has 38 units and 74,935 CYP; MOH has 1,475 units and 416,126 CYP. One might conclude that:

- Access, in terms of number and location of service delivery points, is not the principal reason for low CPR.
- Quality, not surprisingly, matters a great deal in Upper Egypt.¹⁵
- As the MOH QIP program succeeds in Upper Egypt, utilization of MOH clinics will increase and the comparative figures presented above (MOH and CSI) will change.

4.1.2 *Improved Quality (SDP, CSI, THO)*

Overall, the quality of care is better now than it was in 1993; moreover, structures and systems in the process of implementation will continue improving the quality of care both in the short run and in the long term.

Choice of Method. Service units in SDP, CSI, and THO all offer IUDs, injectables, pills, foaming tablets, and condoms. CSI offers three different IUDs and two brands of pills. Inventories of all methods were good, and there were no stock-outs reported.

NORPLANT® is being offered in the five university hospitals where clinical trials were held and plans are under way to begin a larger training effort when a sufficient volume of clients has developed. The introduction of postpartum IUD is in the planning stage, and will be phased in

¹⁵ Indeed, the evaluators interviewed a number of clients in CSI clinics in Upper Egypt and asked them why they sought service at CSI. The reason given was the high quality. A group of five women at the Edfu clinic said they came from a village five kilometers away; together they had rented a taxi to come in, bypassing a MOH unit (not yet within the QIP program) on the way.

gradually throughout Egypt. The introduction of these methods represents excellent progress since the end of POP/FP II when clinical trials were still under way and no plans had been made for the introduction of NORPLANT® or postpartum IUD, and only Ob/Gyn specialists could give injectables.

Counseling. Counseling is a major focus of training for nurses and social workers in all three subprojects, and for curriculum development in RCT and THO. Additional training and follow-up of counseling is needed. An excellent flip chart was produced for the SDP project, and should be used in all the projects to support standardization of method-specific information. CSI's training in counseling produced some of the best counseling in POP/FP II; a reduction in availability of training funds, and telescoping of the counselor role with the clerk's role, has had a slight, but visible, negative impact on the quality of counseling in POP/FP III.

Service Provision. While the team did not observe IUD insertions, discussions with physicians were considered sufficient to determine that the proper techniques are being used; and training manuals indicate that this area is covered in ample detail. In addition, the QIP training includes a "refresher" demonstration by physicians of their IUD insertion skills, which will constitute another level of training.

Method Mix. The IUD is clearly the predominant family planning method used in Egypt. Ninety percent of reported MOH CYP in 1994/1995 is IUD-based; the comparable figure for CSI is 93% (see table 13). Three things are noteworthy about these statistics: 1) the IUD is the best and only long-term method widely available in Egypt; 2) the data are for 1994/1995, prior to a widespread, and apparently successful, campaign for injectables; and 3) method mix among CSI clients has shifted toward the IUD since the final evaluation of CSI in POP/FP II.

Methods as percentage of CYP is different from method mix among users. It is nonetheless apparent (tables 13 and 14) that while use of methods among MOH and CSI in 1994/1995 seems quite similar (a 90% and 93% IUD-based CYP respectively), the pattern of use had been quite different in 1992. At that time there was a marked difference: 89% of all MOH clients were IUD users and only 50% of CSI clients were IUD users. The reason for the CSI shift toward the IUD is unknown. One might question, however, if the CYP output-based payment mechanism is not biasing providers in the direction of the IUD.

4.1.3. Image

IEC linkages between subprojects (and other non-USAID supported family planning NGOs) are not yet as tight as they should be. Materials produced or training conducted under one subproject do not find their way into other agency activities. For example, the SIS method TV spots are not copied for MOH audiovisual vans or THO waiting rooms; THO or SDP method brochures are not offered in CSI, EFPA, or the Coptic Evangelical Organization for Social Services clinics; SDP flip charts are not offered to NPC community workers; NPC-

Table 12

Table 13**1994/1995 Method Mix in the MOH and CSI: CYP**

Institution	Methods as Percentage of CYP			
	IUDs	Pills	Injectable	Other
MOH	90%	5%	4%	1%
CSI	93%	1%	5%	1%

Source: MOH and CSI reports

Table 14**1992 Method Mix in the MOH and CSI: Users**

Institution	Method Mix: Percentage of Users		
	IUDs	Pills	Other
MOH	89%	9%	2%
Upper Egypt	66-90%	8-27%	1-6%
Lower Egypt	81-95%	3-14%	1-3%
CSI			
Upper Egypt	50%	28%	22%
Lower Egypt	70%	11%	19%

Source: L. Cobb et al. "Final Evaluation of the Clinical Services Improvement Subproject of the Egyptian Family Planning Association under the Population/Family Planning II Project." POPTECH, 1993.

trained community workers are not formally integrated into QIP or LIC activities; NPC does not train local leaders in coordination with the SIS/IEC Center.

This lack of integration stems from the absence of a national family planning IEC strategy aimed specifically at planning, sharing, and pooling resources, materials, and activities. The present national strategy-making process, limited to quarterly meetings attended by high-level representatives, is not sufficient nor is it oriented to the operational IEC level.

SIS/IEC subproject outputs, expenditures, and STA are now on schedule despite past delays due to preparations and follow-up for the ICPD, a change in SIS/IEC Center executive directors, lapses in GOE contributions, computer procurement for MIS, and subcontracting of SIS/SDP client IEC materials production.

Eight SIS staff (five from LICs and three from the SIS/IEC Center) have attended JHU workshops in Morocco and Tunisia. One SIS/IEC Center staff member and one THO staff member attended a JHU workshop in Baltimore. Training in MIS for SIS/IEC Center staff is under way. Eight regional workshops were held for LIC and MOH IEC officers and joint SIS/SDP planning of field activities is evident. Ten workshops were held for LIC directors. Training of local leaders and sheikhs is proceeding as planned.

Strategic planning for mass and print media production and placement is taking place. Results from outsourced research—e.g., secondary analysis of the 1992 DHS and the psychographic survey—will focus attention on priority groups, including high propensity-to-use nonusers and drop-outs, low-parity women, and men opposed to family planning.

Production briefs have been written for media campaigns and research is scheduled and budgeted for the materials production cycle. All spots are regionally pretested at the working copy stage. The feasibility of storyboard (animatics) pretesting is under consideration. Writing RFPs for subcontracted research and negotiating with outside agencies is now becoming familiar to SIS/IEC Center staff.

LIC activities concentrate increasingly on Select Villages with pre-launch situation analysis and joint SIS/SDP planning and follow-through. LIC meetings are running 100% above the number programmed. Medical lecturers at LIC meetings will now be drawn from QIP-trained SDP staff whenever possible, although they will be frequently unavailable due to conflicts with clinic hours.

Subproject quarterly reports are prepared by SIS/IEC Center staff and Implementation Plans are jointly written with the resident technical specialist. A computerized financial MIS is well properly and the computerized activities MIS will be introduced early next year.

SDP client IEC materials have been printed and are in distribution. Through SIS/SDP workshops, governorate MOH IEC supervisors have been introduced to their LIC counterparts and must next coordinate with district IEC officers. All MOH IEC staff require further training in FP communications.

The CSI client segmentation study has not been conducted, so no marketing plan has been based on these results. The PSI marketing subcontract has only recently been signed. SOMARC brand-specific pan-Arab TV spots for OCs and injectables will be aimed at a high-income user segment. THO method-specific and hospital-specific brochures have been printed. The NPIC is open to serve researchers, high-level opinion leaders, and school groups, although the number of visitors is still low (averaging 42 per month in mid-1995).

4.1.4 *Conclusions and Recommendations*

The project is making good progress toward achieving project outputs of service volume, quality and IEC. Access to improved quality of services is expanding. The QIP, new nursing schools and mobile teams all provide ways to offer better access. The team expects that the fruits of these efforts will be visible in the final evaluation. Service volume has increased and targets were exceeded, although the MOH targets were too low.

Full and informed choice is an important dimension of quality. In the long term it is an indispensable element of sustainability. CSI's shift toward the IUD is a potential source of concern. Counseling skills, although adequate, need strengthening.

Recommendation:

- 80. CSI and the MOH should ensure that all clients are fully informed and freely choose a contraceptive method. Public sector programs and training courses in the public and private sectors should promote individual methods in a balanced manner.**

4.2 Improved Management Capacity

4.2.1 Institutional Strengthening

Institutions are built and strengthened through interventions in five areas: mission, strategy, structure, staff, and systems.

Mission. The first step an agency must take toward accomplishing its plans is to determine what the agency is and what the agency wants to accomplish—that is, its mission. The decision of USAID to fund CSI and RCT with output-based payments created the need for these agencies to define exactly what they would do in return for payment. In effect, they defined and refined their missions in relation to USAID. SDP identified its mission some time ago and has been in the process of developing its high-quality services for those most in need of service. THO's mission as a model for hospital-based family planning services will be strengthened after the output-based mechanism is introduced.

Strategy. Strategies to achieve mission level goals and objectives are an important part of POP/FP III. Successful strategies have been developed by CSI (to expand other services in addition to family planning); by SDP (implementation of the QIP). RCT and THO need to develop their strategies further.

Structure. An impressive amount of structural development has been carried out to accomplish the strategies of SDP, CSI, RCT, and THO. Management teams have been restructured, job descriptions written, reporting lines clarified and largely respected.

Despite training and technical assistance efforts by IDP, management and planning capacity at NPC/TS is still very limited. In part, this is due to structural problems and the lack of support from NPC leadership and, in part, to deficiencies in the staff. With effective decentralization, the NPC governorate level offices have made substantial progress in their ability to plan and coordinate activities. The strengthening of NPC/G continues with a major strategic planning exercise which is currently in process.

Staff. Short-term training and invitational travel are two mechanisms being used under POP/FP III to augment the skills, vision, and frame of reference of selected participants across institutions. While these are undeniably useful and enriching experiences for the individuals involved, it is difficult to demonstrate many lasting programmatic benefits.

Many of the individuals in leadership positions in subprojects in the PPC and at USAID were recipients of long-term training under POP/FP I or POP/FP II. While the cost of long-term training is high, in the long run it may be more cost-effective than short-term training.

Invitational travel is very valuable when used selectively, as it serves to broaden the perspective of people in leadership roles. For example, the relationship developed over several years between CSI and Planned Parenthood of the Rockies has been very helpful to CSI in many ways, although systems and practices are not necessarily directly transferrable from one organization to the other.

Systems. Management systems are being introduced into SDP, RCT, THO, and SIS; they are already in place, for the most part, and working well at CSI. Whether those systems will be institutionalized remains to be seen. Manuals are being written by intermittent short-term foreign consultants for most of the management systems. Some of these consultants gather information, then return home to write the manuals, then revisit the projects to review and adapt the manuals; others do all the work in-country on a continuously interactive basis.

Training curricula and courses were developed for each of the SDP systems. The evaluators are not aware of any linkages among the management systems of the subprojects. The opportunity exists for linkages and some standardization because there is continuity and consistency of MIS consultants among some of the projects.

The financial management systems at RCT, which has just converted to output-based payments, and at THO, which is preparing to do so in July 1996, are not fully developed.

Strategic planning has not been integrated into the work of any of the service delivery or training organizations except CSI, which is desperately in need of TA to be able to strengthen its internal capability and commitment to conduct this kind of exercise.

4.2.2 Increased Financial Self-sufficiency of FP Program

Increased financial self-sufficiency of family planning systems is one of USAID's objectives in their recently reworked strategic framework. The Mission's population framework identifies three activities to that end: growing independence from external subsidies and increased targeting of internal subsidies; improved cost effectiveness; and increased cost recovery.

A free-market private sector is, by definition, self-financing. Termination of the CSMP-subsidized contraceptives in the private sector has increased the commercial viability of contraceptive products in Egypt. The newly competitive market has become more attractive to contraceptive manufacturers and distributors, although there are still legal and regulatory barriers to be addressed to further facilitate this process. Imported IUDs, orals, injectables, and condoms are becoming available commercially at lower prices and the variety of brands is increasing.

The MOH, by its very nature as a public sector institution, will never be self-financing. However, through the minimal price most clients pay for USAID-provided commodities, two things are accomplished: 1) clients learn to pay for services, and thus services may have a higher perceived value than free services; and 2) revenues are generated to provide performance payments to the service providers. Both contribute to the sustainability of the MOH program.

CSI is the subproject which best illustrates the prospects for self-financing when all institutional efforts are brought to bear toward that end. From 1993/1994 to 1994/1995, CSI increased revenues by 4%, decreased expenditures by 14% and increased CYP by 7%. When faced with USAID/project funding suspension, CSI reduced costs dramatically. In so doing, CSI developed excellent financial management tools which will enable it to plan and manage for increased self-sufficiency over the long term.

It is too early to judge the effect of USAID's emphasis on self-financing on RCT. Moving to an output-based payment system, RCT, with newly developed financial management systems, will be invested in cost control and income generation. Another year will tell the extent to which the RCT-USAID negotiated prices will recover appropriate RCT costs. As with CSI, however, at the end of this year RCT will have the systems and the experience to plan and manage for increased self-sufficiency over the long term.

The THO and USAID can learn from the CSI and RCT experience. One question raised with CSI is whether a tremendous push to generate income, combined with a CYP-output payment mechanism, biases method mix. A question raised with RCT is how to ensure training quality with a trainee-output payment mechanism. Both questions, once raised however, can be dealt with. The trend is clear: THO, CSI, and RCT are moving toward increased local (Egyptian) financial self-sufficiency.

4.2.3 *Conclusions and Recommendations*

A great deal of progress has been made in developing mission, strategy, structure, staff, and systems in the POP/FP III subprojects. The developments are scattered throughout the subprojects. However, most of them are in need of additional TA, some short term and some long term, to reach a more comprehensive institutionalization of sustainable operations.

Recommendation:

- 81. Additional technical assistance should be provided in conjunction with an extension of the project.** USAID and PPC should work together with the subproject directors to ensure a fair allocation of long-term and short-term technical assistance where it is needed.

4.3 Improved Information for Policy-makers

4.3.1 Policy

Policy Environment.

(1) Medical Regulatory Environment

Many regulatory constraints to contraceptive availability have been removed in the past few years. Injectables are now available from general practitioners in the public and private sectors, and NORPLANT® is in the process of being introduced throughout the country through Ob/Gyns. The regulatory changes occurred as a result of donor urging and on the basis of Egyptian clinical trials (supported in large part by USAID), which helped to convince the medical establishment of the appropriateness of these methods in the Egyptian context. Progesterone-only minipills are in the process of being legally registered, and the use of voluntary permanent clinical contraception for medical indications is being assessed. Although many improvements are not a direct output of POP/FP III, these changes represent the positive effects of long-term investment in policy and regulatory adjustment.

As indicated in a recent review of the regulatory environment in Egypt (Ravenholt and Russell, 1993), the overall medical regulatory climate for family planning in Egypt is generally favorable. At this time, striving for additional medical regulatory changes (such as the provision of voluntary permanent clinical contraception for anything other than maternal health, or broadening the role of nurses in providing clinical contraceptive services) would probably be counterproductive.

(2) Contraceptive Commodity and Service Pricing and Subsidization

Ravenholt and Russell's review identified commodity pricing as the single major constraint to long-term contraceptive availability in Egypt. Recently, some progress has been made. As noted above, the competitive environment is improving with the ending of the subsidized contraceptives in the private sector. Two imported IUDs will soon be available at less than a third the price of the commercially marketed IUDs currently available in pharmacies. The price of those IUDs will also drop dramatically.

The price that may be charged for locally-produced OCs is under negotiation although there is some question as to whether there will be sufficient incentive to local manufacturers in the longer term. Moreover, with the restraints imposed by price controls, local manufacturers produce the minimum acceptable product (e.g. the 21-day pill cycles rather than 28-day cycles).

(3) Private/Public Sector Balance

The public sector CYP doubled in the last five years and the percentage of public sector-supplied users increased from 23% to 35% between 1988-1992 (DHS). Some of this shift has been due to very positive steps, such as substantially improved family planning availability and quality through the MOH; however, some have resulted from circumstances which may have weakened the private sector, such as disruptions in the availability of key contraceptive products. In conjunction with policy discussion of contraceptive pricing, dialogue is also urgently needed on the private sector's role and how to enable it to best fill that role.

In addition to the pricing issues noted above, the expansion of free contraceptive services, provided by governorate Social Welfare funds with the encouragement of senior leadership in the population sector, may in some cases undermine future program self-sustainability and private sector supply. Although the provision of reduced cost or free contraceptives to some market segments will always be necessary, movement toward greater self-sustainability must also be planned in a rational manner. Policy dialogue and research are urgently required at this time to guide contraceptive pricing and subsidization, including the speed and degree of subsidy reductions.

(4) Organization and Roles Within the Population Sector

An overriding policy issue concerns the role of the Ministry of Population and Family Planning, and its interface with the NPC/TS and NPC/G, and with existing implementing agencies. The emphasis that will be placed on policy issues in the reorganized population sector is unclear. The NPC/TS has been asked to establish eight working groups to assist in planning the functions of the new Ministry (Office of the Minister, Family Planning Services, NGOs, Information, Planning and Evaluation, Administration and Finance,

Governorate Affairs and Foreign Agreements). This suggests that the new ministry may be inclined towards consideration of implementation issues, including family planning and IEC. Were the Ministry to become involved in service provision and IEC, the population sector would run a strong risk of duplication of activities, fragmentation of scarce resources, and competition for clients (without the necessary coordination to ensure that new activities target unserved clients). The scope for the private sector to develop in a climate of public and NGO/PVO competition for clients may also be affected.

There is a risk that some of the unfortunate experiences in the history of Egypt's population program may be repeated. These have included a) the lack of a clear focus on family planning and on quality of services issues, and a consequent weakening of family planning activities within implementing agencies such as the Ministry of Health, and b) the proliferation of poorly trained cadres without a clear family planning orientation. With the establishment of good cooperation and clear, defined, non-duplicative roles for the various players in the population sector, such problems can be avoided.

(5) Contraceptive Method Mix

As indicated above, recent developments are increasing the contraceptive mix available in the public and private sectors. There remains some concern, however, that in the quest to reach high CYP targets, programs may be placing over-reliance on the IUD.

Policy Outreach. Overall there has been little focus on national FP policy development under POP/FP III. Unfortunately, the Minister of Population and Family Planning was unable to attend much of the conference organized in May 1995 to discuss strengthening the policy environment, and a number of key NPC/TS staffers were also called away from the conference. Since then, there has been no follow up. The RS/RMU has worked to help formulate a policy-driven research agenda, which could in part serve as a basis for follow-on policy outreach. This activity is being carried out without substantial inputs from the NPC/TS.

There has been little attempt to develop a national family planning IEC strategy that defines priority public messages aimed specifically at the actionable determinants of fertility—CPR, use effectiveness, and discontinuation rates. The quarterly "strategy coordination" meetings which now take place are not sufficient.

4.3.2 *Research*

A substantial number of studies and secondary analyses have been produced recently or are planned for the near future, including those supported by the RMU, PPC and USAID/Egypt and USAID/W. The USAID-funded research activities with some relevance to POP/FP III are summarized in Annex 2. Since there was no preexisting comprehensive listing of such research, the list was compiled by the evaluation team.

Timeliness of Research.

(1) Research Management Unit

The RMU experienced substantial delays in initiating its research activities because of funding delays. However, the unit has made good progress in establishing operating procedures and in bringing together experts to try to define research priorities. It is unlikely that the RMU will meet its target of six proposals funded in its first year of operations. To date, the RMU has funded two major studies (Linkages between FP/MCH Services and A Study of Injectables) and the probability of achieving the target in its second full year is high.

(2) Special Studies

PPC has proposed undertaking four special studies conducted directly by consortium members.

- a) Quality of Care in Service Delivery, Family Health International. To be conducted within implementing agencies such as the CSI and SDP. Proposed methodologies will include client interviews and focus groups regarding perceptions of service quality, as well as structured observations of providers. Status: A proposal has been prepared and is under review.
- b) Market Segmentation, The Futures Group. To be conducted within the RCT and the THO. Proposed methodologies include secondary analysis of the 1992 EDHS and client surveys. Status: A proposal has been prepared and is under review.
- c) User, Nonuser, Drop-out Segmentation, Johns Hopkins University. This study is being conducted within SIS. Activities include secondary analysis of 1992 EDHS, qualitative studies, and surveys. Status: Under way.
- d) Cost studies, E. Petrich and Associates. Activities include data collection and analysis of private sector family planning costs in Egypt. Status: Under way.

Appropriateness of Research Agenda. The current and planned research agenda discussed below addresses many of the major crosscutting issues which need to be addressed to enhance the family planning program and its sustainability but also contains some gaps.

Pricing and Subsidies. Completed and planned research includes market segmentation studies (in large part based on secondary data analysis of the 1992 EDHS), cost-effectiveness of different family planning points of services, assessment of private provider prices, and a study of household expenditures on care of children. Not included are programmatic/operations research on price elasticity, monitoring of market reaction to the end of the USAID-sponsored social marketing

program with its concomitant increases in contraceptive prices, and assessment of household financial decision making related to contraception. Secondary analysis of the EDHS, which is an excellent demographic tool but is not designed as an economic survey, is not sufficient to answer many pricing questions. The effects of expanding subsidized family planning services (occurring in a substantial number of governorates) should be assessed for appropriateness of client selection and for its effects on the public, NGO, and private sectors.

Private/Public Balance. The new EDHS will provide data on the current proportion of public sector/private sector clients. If the private sector market share is found to be falling, research will be needed to determine reasons (improved public services? overly pronounced competition from subsidized services? rising prices?) and to assess further whether some correction to current policies and programs is needed to keep the private sector adequately involved. Some background data on market niches were provided by a recent study of private providers in Egypt. The latter study did not focus on trends in service delivery.

Cost and Cost-effectiveness of Services. Given that Egypt has a sufficient number of service delivery sites, it is important to determine which service modalities offer the most cost-effective services, and can thus contribute to long-term program sustainability. The RMU is preparing an RFP to assess cost effectiveness in a broad range of public sector service delivery agencies. This research can provide valuable data, although it may be advisable to concentrate on a smaller number of key agencies which can be assessed in greater depth. Additional research on private sector costs per client in different market segments may also be warranted. (Such costs would include IEC and continuing medical education costs, plus client expenditures.) Technical assistance from an experienced economic researcher would be valuable in guiding oversight of the RFP process and of the research.

Coordination of Services. The issue of coordination has become particularly acute given the current efforts of the Ministry of Population and Family Planning to define its role. Among the pressing issues is that of avoiding duplication of efforts. It would be appropriate to assess the degree to which intensive promotion of specific family planning service delivery sites (particularly in areas where alternate service sites already exist and are utilized) results in new acceptors or simply in switching, which is not a cost-effective, long-term strategy.

Quality of Care. A number of studies concentrate on quality of care. FHI is undertaking projects on quality of care and infection control and on client perceptions of quality in the SDP, CSI, and other implementing agencies; IUD use dynamics in Egypt and contraceptive continuation in CSI have recently been assessed.

Improved Method Mix. A study on expanding the availability of injectables is being implemented by the RMU. Under the ANE/OR TA project, The Population Council is proposing to conduct research on the NORPLANT® introduction program. Data on public and private provider attitudes and counseling are needed, because of the over-reliance on the IUD in a number of

service delivery sites. If warranted on the basis of the data, training for service providers and IEC for consumers could be designed to further address the issue.

Population Coverage. The new EDHS will shortly provide an accurate and comprehensive database to assess this issue at the national level. Depending on findings, additional focused surveys and research may be warranted in selected population groups.

Reproductive Health. The 1992-1993 study on Maternal Mortality identified a substantial proportion of deaths occurring in women who had experienced a contraceptive failure or who were otherwise experiencing an undesired pregnancy. An ongoing study of linkages between family planning and maternal and child health services should shed light on improved mechanisms of referral for high-risk women to family planning services. Research has been conducted by the Population Council on medical care and family planning referral of postabortion patients, and follow-on studies are proposed on this topic. There are few systematic data on sexually transmitted diseases and genital tract infection rates in Egyptian populations. The RMU is currently preparing an RFP to assess STD rates; populations to be sampled have not yet been determined. Adequate technical assistance should be assured for the latter study to ensure that new, appropriate STD diagnostic methodologies are incorporated into the study.

4.3.3 Conclusions and Recommendations

Although Egypt faces some difficult policy issues at this time, there exists no body for which such dialogue and policy formulation represents a priority. Without such ground setting, there is a risk that Egypt's family planning efforts will be unprepared for the inevitable financial and sectoral changes to come (eventual removal of free contraceptives donated by foreign donors, changes in national price control strategies in all sectors). Although IDP II has attempted to initiate policy dialogue, without strong backing from the senior leadership of the population sector, it is unlikely that the efforts of a foreign technical assistance project will have substantial effects. It is clear that a policy body is urgently needed.

In their central role in the population sector, it is crucial that the new Ministry of Population and Family Planning and/or the NPC retain a strong orientation toward policy, planning, and research issues, as these are of immense importance and uniquely within their scope. The new Ministry is in a unique position to support the service and IEC activities of other ministries and agencies, to ensure that it does not duplicate their efforts, and to assist implementing agencies to emphasize quality of service. USAID is urged to support these unique functions. Support for new service delivery activities is not recommended, since population coverage and availability of service sites are far less pressing issues than are service quality, efficiency, and cost effectiveness. It is also important that the Ministry emphasize quality, rather than quantity of services in the population sector.

The investment by USAID in population research in Egypt has resulted in some positive accomplishments. The periodic DHS provide invaluable data to assess progress and plan programs to fill existing gaps. Previous clinical trials have resulted in the registration of NORPLANT® and other contraceptives. Current work on postabortion contraception and voluntary permanent clinical contraception for medical indications may well yield similar dividends. Cost and economic studies have provided some guidelines regarding market activities, although as indicated above, more concrete data are now needed. Research on service delivery at SDP and CSI has identified areas of progress and points requiring improvement.

Some research areas, however, appear somewhat less useful or need to be approached with caution. Economic secondary analysis and modelling based on the 1992 EDHS has some inherent limitations; although the results may be informative, care must be taken not to over interpret the findings. Studies which only ask how a program functions (such as some of the studies of *raidat rifiyyat*), cannot answer the fundamental question of the effectiveness of a program compared to that of other activities. Clinical trials of various OC combinations available in Egypt, or trials that ask questions for which there exists a large body of knowledge internationally, do not represent an ideal use of resources.

In summary, the research agenda funded by USAID in Egypt is generally appropriate, but at times misses key issues. The special studies under PPC, the general content of which was determined long before project implementation, are nested in priority areas but do not necessarily address the most critical points within those areas. Allowing for greater flexibility in future research design may thus be called for. The RMU is making a concerted attempt to identify and address key research areas but will require substantial short-term technical assistance in the design and monitoring of specialized research projects.

Recommendations:

- 82. USAID is urged to continue dialogue with the MOPFP and the NPC regarding research and policy development in the areas of commodity pricing, family planning service subsidy, and efforts to enhance the private sector (e.g., removing economic barriers to contraceptive manufacture and retail sales), in order to ensure long-term family planning program sustainability.**
- 83. Specific research is needed to study the effects on client behavior of the phasing out of subsidized contraceptives. This research should look particularly at price elasticity within the private sector and the extent to which utilization is disrupted, discontinued and/or transferred to the public/NGO sectors.** It is clear that clients are willing to pay for the convenience and perceived quality of private sector family planning services. What is not known is how much clients are willing to pay. The phasing out of subsidized contraceptives provides a good opportunity to assess price elasticity and client

behavior. There are implications for cost-recovery strategies in the public/NGO sectors and for targeting drop-outs.

84. **Methods to enhance the capacity of the GOE and of USAID-funded agencies to rapidly identify, coordinate, and implement research in emerging priority areas need to be developed.** Current mechanisms, such as the PPC special studies, are not sufficiently flexible to address new issues as they arise. To give but one example, the recent ending of subsidized SOMARC contraceptives provided an ideal opportunity to observe the effects of subsidy discontinuation on service utilization; unfortunately, no research group was positioned to conduct the small-scale surveys to assess any trends while they developed.