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Population, Family Planning, and Reproductive Health

(POP IV)

Results Package No. 263-0267

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TABLE OF CONTENTS

TABLE OF CONTENTS	i
ACRONYMS	iv
Executive Summary	viii
I. OVERVIEW	1
A. Statement of the Problem	2
• Supply of Family Planning Services	4
• Demand for Family Planning Services	5
• Financial Self-Sufficiency	5
• Institutional Capacity	6
• Legal, Budgetary, and Public Awareness Barriers	7
B. Customers and Partners	7
1. Customers	7
2. Partners	8
a. The Government of Egypt (GOE)	8
b. NGOs and PVOs	9
c. The Commercial Private Sector	10
d. Other Donors	10
e. Other SO/RP Teams	11
C. Previous USAID Involvement in Family Planning	12
D. Total Approved Funding Level and Life Of Results Package (LORP) Period	13
II. ACTIVITY DESCRIPTIONS	14
A. POP IV - The Sustainability Phase	14
B. POP IV Activities	15
1. Enhanced Supply (IR 4.1.1.)	15
a. Increased Coverage of Family Planning/Reproductive Health (FP/RH) Services (IR 4.1.1.1.)	15
(1) New Contraceptive Technologies More Widely Utilized in Public, NGO and Private Sectors (Including CSI) (IR 4.1.1.1.1)	15
(2) Increased Service Volume Among Targeted Market and Provider Niches (IR 4.1.1.1.2.) ...	16
(3) Start-up or Expanded FP Services	

	Implemented in NGO Sector (IR 4.1.1.1.3.)	18
(4)	Allocation and Productivity of Community-Based Workers Enhanced (IR 4.1.1.1.4.)	19
(5)	Availability of female service providers in Upper Egypt enhanced (IR 4.1.1.1.5.)	19
b.	Improved Quality of FP Services (IR 4.1.1.2.)	20
(1)	Human Resource Capacity for Service Delivery Improved (IR 4.1.1.2.1.)	20
(2)	Service Delivery Environment Improved in the NGO and Public Sector (IR 4.1.1.2.2.)	21
(3)	Quality Improvement Systems Developed and Enhanced (IR 4.1.1.2.3.)	21
2.	Increased Demand (IR 4.1.2.)	22
a.	Public Better Informed About FP/RH (IR 4.1.2.1.)	22
b.	Couples More Highly Motivated to Use FP/RH Services (IR 4.1.2.2.)	23
c.	Providers More Highly Motivated and Demand Oriented (IR 4.1.2.3.)	25
3.	Increased Financial Self-Sufficiency of FP Systems (IR 4.2.1.)	25
a.	Growing Independence from External Subsidies and Increased Targeting of Internal Subsidies (IR 4.2.1.1.)	25
b.	Improved Cost Effectiveness (IR 4.2.1.2.)	27
c.	Increased Cost Recovery (IR 4.2.1.3.)	27
4.	Strengthened Institutional Capacity (IR 4.2.2.)	28
a.	Strengthened Human Resource Base (IR 4.2.2.1.)	28
b.	Improved Management Systems (IR 4.2.2.2.)	30
c.	Increased Strategic Planning Capacity (IR 4.2.2.3.)	31
5.	Improved Policy Environment (IR 4.2.3.)	32
a.	Strong Political Commitment that Supports, Strengthens and Sustains the Population, Family Planning, and Reproductive Health Program in Egypt (IR 4.2.3.1.)	32
b.	Population/Family Planning Information Utilized to Create Awareness and Support for Policy Change Among Policy Makers (IR 4.2.3.2.)	34
III.	IMPLEMENTATION PLAN	36
A.	Implementation Mechanisms	36
1.	Institutional Contract	36

2.	Task Orders/Delivery Orders	37
3.	Activity Implementation Letters (A/ILs) to GOE Agencies . .	39
4.	US PSC	39
5.	Endowments or Other Sustainability Mechanisms	39
B.	Management Plan	40
1.	Membership, Roles and Responsibilities of the RP Team . . .	40
a.	USAID/Egypt Team Members	40
b.	USAID/Washington Members	40
2.	Management Burden	40
3.	Budget Constraints Due to "Metering"	41
C.	Performance Monitoring Plan	41
IV.	ANNEXES	42
A.	SO Framework	A1
B.	Technical Analysis	B1
C.	Economic Analysis	C1
D.	Institutional Analysis	D1
E.	Initial Environmental Evaluation	E1
F.	Congressional Notification	F1
G.	Statutory Checklist	G1
H.	Bibliography of Studies and Analytical Sources	H1

ACRONYMS

A/ILs	Activity Implementation Letters
ANE	Asia and Near East
BAFO	Best and Final Offer
BSE	Breast Self-Examination
CAs	Cooperating Agencies
CIDA	Canadian International Development Association
CN	Congressional Notification
CPA	Certified Public Accountant
CPR	Contraceptive Prevalence Rate
CPS	Commercial Private Sector
CSI	Clinical Services Improvement
CSMP	Contraceptive Social Marketing Program
CYP	Couple Years of Protection
DTII	Development Training II
EDHS	Egypt Demographic and Health Survey
EFPA	Egyptian Family Planning Association
ENGO	Egyptian Non Governmental Organization
EPTC	Egyptian Pharmaceutical Trading Company
EU	European Union

FP	Family Planning
FP/RH	Family Planning/Reproductive Health
FSN	Foreign Service National
FY	Fiscal Year
GFR	General Fertility Rate
GOE	Government of Egypt
HIO	Health Insurance Organization
HM/HC	Healthy Mother/Healthy Child
I/G&S	Institutional/Goods & Services
ICPD	International Conference on Population and Development
IDI	International Development Intern
IDS	Institutional Development Support
IE&C	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
IR	Intermediate Results
IUD	Intra Uterine Device
JICA	Japan International Cooperation Agency
LAM	Lactational Amenorrhea Method
LIC	Local Information Centers
LORP	Life of Results Package
MCH	Maternal and Child Health

MCH/FP	Maternal and Child Health/Family Planning
MIS	Management Information System
MOHP	Ministry of Health and Population
MOI	Ministry of Information
MOI/IEC/SIS	Ministry of Information/Information Education & Communication/State Information Service
MOSA	Ministry of Social Affairs
MWRA	Married Women of Reproductive Age
NCPD	National Committee for Population and Development
NGOs	Non-Governmental Organizations
NPC	National Population Council
OB/GYN	Obstetrics and Gynecology
PES	Policy Environment Score
POP IV RP	Population IV Results Package
POP/FP & RH IV	Population, Family Planning, and Reproductive Health IV
PPIUDs	Post-Partum Intra Uterine Devices
PSC	Personal Service Contractor
PVOs	Private Voluntary Organizations
RCT	Regional Center for Training
RF	Reduced Fertility
RH	Reproductive Health

RP	Results Package
RR	Ra'aidat Rifiyat
SDP	Systems Development Project
SOW	Scope of Work
TA	Technical Assistance
TFR	Total Fertility Rate
THO	Teaching Hospitals Organization
SIS	State Information Service
SO	Strategic Objective
TL	Tubal Ligation
UNFPA	United Nations Fund for Population Activities
US	United States
USAID	United States Agency for International Development

Executive Summary

The Population/Family Planning/Reproductive Health IV (POP IV) Results Package (RP) sets up a process to continue USAID's assistance to the Egyptian national family planning/reproductive health (FP/RH) sector for up to ten years. Begun in 1975, USAID assistance to date has totaled about \$190 million. Phase 1 of POP IV will provide an additional \$90 million over the five-year period 1997-2001. Phase 2 is illustrative, laying out the continuing need for support to achieve sustainability.

POP IV is USAID's only planned results package under Strategic Objective 4 (SO4), "Reduced Fertility." Two overarching intermediate results (IR) -- increased use of family planning services and increased sustainability of family planning systems -- will be accomplished by POP IV in order to achieve SO4 (Annex A).

POP IV is designed around five specific intermediate results that address five significant problem areas. The five specific intermediate results represent key strategic interventions for which USAID has important resources to offer and has a comparative advantage over other national or international institutions. These IRs are ambitious but achievable and manageable by USAID and its partners. They are coordinated with other USAID, donor, and Egyptian programs and resources. The five POP IV intermediate results are expected to be necessary and sufficient to lead to the full accomplishment of SO4, Reduced Fertility.

In brief, the five problem areas and corresponding intermediate results are the following:

1. Supply of Family Planning Services

While the physical availability of family planning/reproductive health (FP/RH) services in Egypt is adequate, the quality of services offered by many providers needs further improvement. Inconsistent or deficient quality of care contributes to low utilization of services; high discontinuation; a poor image of family planning; incorrect use of methods causing method failure and medical complications; unwanted pregnancies; and widespread misinformation, fear, and dissatisfaction among users. Through POP IV, USAID will enhance the supply of services by helping to improve the following: (1) the contraceptive method mix, (2) client volume in existing underutilized facilities, (3) family planning-health linkages and referrals, (4) commercial private sector service quality, (5) non-governmental organization (NGO) services, (6) community outreach activities, (7) facilities, (8) standards of practice, (9) the technical skills and motivation of medical staff, and (10) information given to clients.

2. Demand for Family Planning Services

In spite of widespread knowledge about family planning and favorable attitudes toward it on the part of Egyptian women, active demand for family planning services appears to have leveled off or even declined in Egypt during the 1990s. As a consequence, growth in the contraceptive prevalence rate (CPR) has also leveled off. This fact was discovered through the 1995 Egyptian Demographic and Health Survey (EDHS) findings that revealed the CPR had "plateaued" at 48%, reflecting, in part, the fact that information, education and communication (IEC) activities are failing to attract new clients. POP IV will help increase demand through: (1) more energetic and modern public information, education, and communication (IEC) activities, especially television, (2) a major new high profile marketing effort using modern, scientific, private sector marketing techniques, (3) expanded interpersonal outreach activities by the government, NGO, and commercial sectors, and (4) making services more client-friendly to attract and retain users.

3. Financial Self-sufficiency

Many services are heavily subsidized and regulated in Egypt, creating distortions of different kinds in supply and demand. Dependence on internal and external donor subsidies constrains long-term sustainability prospects. POP IV will support the national family planning system as it evolves toward a more market-driven, financially self-sufficient future by: (1) helping wean the system from USAID-donated contraceptives, (2) establishing a safety-net provision for truly indigent clients, (3) strengthening financial management and planning capabilities of providers, (4) helping providers cut costs and improve efficiency, and (5) working to establish endowments for qualified NGO providers.

4. Institutional and Human Resource Capacity

Over twenty years of USAID assistance, family planning providers have made considerable progress in areas such as management information, training, commodity management, and strategic planning. However, some of these capabilities still require further strengthening, capacity build up, and consolidation. Other management systems such as financial management, personnel management, and human resources (especially in management-related skills) are needed to be modernized if the national program is going to meet the challenges of the future. To help create the conditions for strong, permanent, autonomous institutional support for family planning and reproductive health, POP IV will: (1) strengthen the human resource base through FP clinical and managerial training programs, (2) support strengthening of management systems in NGOs and Government of Egypt (GOE) providers, (3) support

management decentralization, (4) enhance strategic planning and business development capabilities, and (5) selectively upgrade providers' facilities and equipment.

5. Policy Environment

While the policy environment for FP/RH is generally favorable in Egypt, there are operational and budgetary policies that constrain the delivery of services and distort market forces to the detriment of long-term sustainability. To analyze policy constraints and create the most favorable policy and regulatory climate possible, POP IV will support: (1) policy research and (2) advocacy activities with national and local political leadership, the mass media, and the general public.

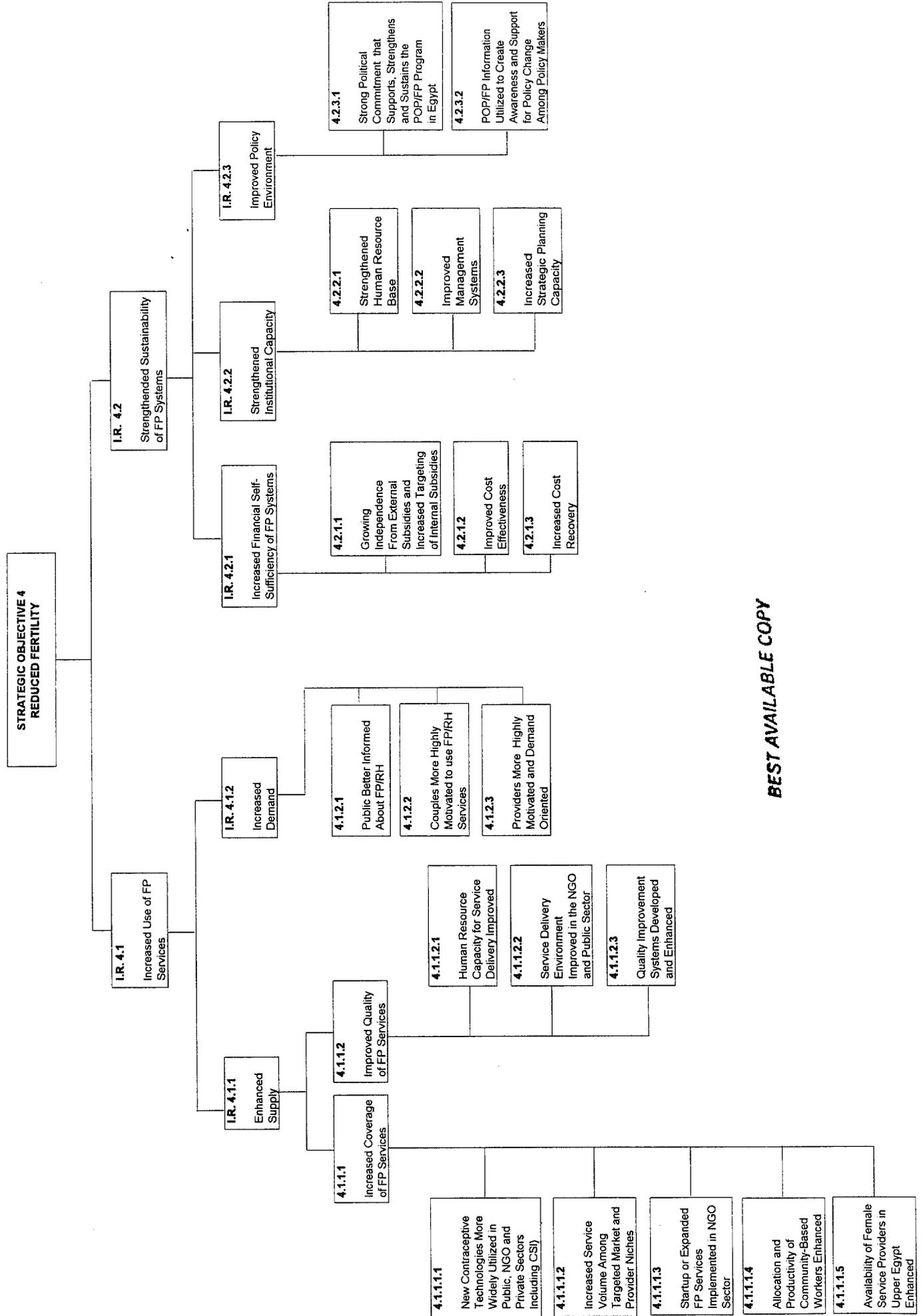
POP IV will be managed by the USAID/Egypt SO4 team. Major Egyptian partners include: (1) the Ministry of Health and Population (MOHP), which will implement the largest component of the RP and assume an overall coordination/advisory function on behalf of the GOE, (2) the Ministry of Information's State Information Service IEC Center (MOI/SIS), (3) the National Population Council (NPC), (4) the Regional Center for Training (RCT) at Ain Shams University, (5) the Egyptian Pharmaceutical Trading Company (EPTC), and (6) the Clinical Services Improvement (CSI) Subproject. An institutional contractor will provide technical assistance and some commodities, and will directly manage certain components such as support for the commercial private sector. Participant training and some local training support will be provided by USAID/Egypt's "Development Training II" RP. Some NGO support will be channeled through a planned USAID/Egypt "NGO Service Center" RP, thereby minimizing management burden and promoting cost-efficiency on the SO4 team.

POP IV is designed to significantly strengthen administrative and programmatic linkages between USAID's health and population sector programs. Major population policy issues will be addressed by the Health Policy Support Program (HPSP). Mass media activities will be implemented jointly by the Healthy Mother/Healthy Child RP and the POP IV RP. A number of service delivery support components from the two portfolios will be coordinated. Important research and data-gathering activities, including the DHS, will be implemented jointly.

Strategically, it is planned that Phase 1 of the RP -- the first five years -- will support rapid expansion of coverage, improvement of service quality, strengthening of institutions, and lifting key policy constraints. These activities will consolidate past progress and create a sound institutional base for sustainability. During the second five years -- Phase 2 -- the emphasis of USAID assistance will shift to enabling implementing agencies to attain financial and institutional autonomy. This phase will

be formally designed and approved after the strategy period for SO4 is extended and available resources increased. By the planned end of Phase 2, at the end of FY 2006, it is anticipated that thirty years of USAID assistance will have helped create a robust, well-diversified national family planning program. At that point, USAID/Egypt anticipates that Egypt should be able to finish the important job of reaching replacement level fertility largely on its own, with little or no additional USAID support in the future.

S.O. # 4: REDUCED FERTILITY



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I. OVERVIEW

The Population, Family Planning, and Reproductive Health IV (POP IV) Results Package (RP) is the only RP planned under Strategic Objective 4, Reduced Fertility. The life of the RP spans two five-year phases. Phase 1, FY 1997 through FY 2001, encompasses the time frame of the current Egypt Strategic Plan (FY 1996 - FY 2001) and the resource level approved for SO 4 in the USAID/Egypt/ANE Management Contract for that strategy period. Phase 2, FY 2002 - FY 2006, is a "vision" phase that will be developed and receive funding when the strategy period is extended and SO 4 resources increased. Both Phase 1 and 2 are included in this RP to highlight the fact that USAID's continued support will be required for the Government of Egypt (GOE) to reach its long-term goal of a contraceptive prevalence rate of around 74%, at which point fertility is expected to reach the "replacement" level of 2.1 children per family.

In terms of results and activities, Phase 1 is designed to stimulate greater utilization of family planning/reproductive health services by Egyptian families, to expand method and provider options for clients, to improve the quality of services and information that are provided to users, to improve the policy environment, and to strengthen the institutions that provide services. Phase 1 will enable the national program to deliver more and better services, setting the stage for a permanent high level of program performance to meet Egypt's FP/RH service needs into the future. Phase 2 will shift the emphasis of USAID assistance to creation of the conditions for permanent sustainability of the national program. By the end of Phase 2, it is planned that the national program will be capable of sustaining and expanding high quality services on its own. The end of Phase 2 in FY 2006 will mark the completion of thirty years of USAID assistance in the FP/RH sector. At that point, successful accomplishment of Phase 1 and Phase 2 results, as described in this RP, should make it possible for a strong Egyptian national program to serve its clients and support its activities on its own.

In this RP document, the two highest level intermediate results (increased use of FP services and strengthened sustainability of FP systems), and the five specific mid-level intermediate results (supply, demand, financial self-sufficiency, institutional capacity, and policy environment) all represent planned long-term, ten-year, results. The lower level results, indicators, and activities of Phase 1 five year plans are described in detail in Chapter II of this RP paper. Relationships between this SO4 RP and other Agency and Mission strategic objectives, the causal logic underlying the SO4 strategy, and critical assumptions for achieving the results are all explained in a prior document (USAID/Egypt Strategic Plan 1996 - 2001, September 1996). In

addition, detailed financial, technical, economic and institutional analyses that support this core RP document can be found in Annexes B - E.

To make it easier to understand the structure of the program and to follow the logic of this paper, it is suggested that readers study the strategic framework (Annex A) and the Table of Contents prior to reading subsequent sections of the RP paper.

A. Statement of the Problem

USAID/Egypt's Strategic Plan Goal (FYs 1996-2001) is broad-based sustainable development with increased employment and quality of life. Investments in economic development and their quality of life benefits would be largely undermined by growing population pressures had USAID's support for expanded family planning information and services not occurred. With that assistance, the total fertility rate declined between 1980 and 1995 from an average number of 5.2 live births per woman to 3.63, thereby averting 7 million unplanned births.

Even if the GOE's "replacement" level goal is achieved by the year 2015, Egypt's population will not stabilize until the year 2069, and then the population will be 108 million, compared to 61 million in 1996. If the total fertility rate had remained unchecked at the 1980 rate, in 2069 Egypt would find itself with a staggering 658 million inhabitants.

There are significant demographic and institutional challenges to the continued success of the national family planning program. Because of population momentum, a huge and rapidly expanding number of young Egyptians is entering its reproductive years. Furthermore, the rapid growth of contraceptive prevalence and of couple-years-of-protection (CYP) achieved during the 1980s appears to have slowed after 1991. The rate of decline in Egypt's fertility also shows signs of slowing, and the growth of demand for family planning services is leveling off.

The population/family planning community in Egypt was surprised by the news from the 1995 Egypt Demographic and Health Survey (EDHS) that the national program has leveled off -- "**plateaued**" -- at a contraceptive prevalence rate (CPR) of about 48%. CPR has not moved up since 1991, women's "demand" for spacing and limiting of births has declined, the use of commercial private sector services has declined, and urban CPR has declined.

Factors that contributed to this slowing include: (1) population momentum -- rapid growth of the number of women of reproductive age, requiring great increases

in the number of women served just to "stay in place" in terms of the contraceptive prevalence rate; (2) the growing challenge of serving ever more difficult-to-reach clients (poor, rural, illiterate) after the initial easier-to-reach clients (middle class, urban, educated); (3) USAID's termination of donated contraceptives to the commercial private sector, causing availability to diminish and prices to increase; (4) lack of a strategic approach to promoting private sector services; and (5) diminishing impact of the program's information, education, and communication (IEC) activities.

Political leadership and policy support for family planning is in transition (see Annex D, Economic Analysis). A period of national leadership favoring vertical family planning services ended in 1996 and was replaced by different leadership favoring integrated health/population services.

Discovery of the CPR plateau has led Egyptian partners and donors alike to resolve to get the national program moving upward again. "Our policy now," said a key advisor to the new Minister of Health and Population (MOHP), "is to blow the plateau." To do this, the GOE is developing a new 15 year national strategy. Among other things, the strategy includes a new approach emphasizing integrated women's health, as opposed to vertical family planning services which the MOHP believes will attract new clients. The GOE abolished the controversial Ministry of Population and moved family planning into a combined Ministry of Health and Population, creating an expanded "Population and Family Planning Sector" unit to manage it. The MOHP will create new women's clinics throughout the country and plans to field hundreds of new mobile clinics to remote communities. With USAID assistance, the MOHP has begun to re-mobilize an abandoned corps of thousands of rural community outreach workers (Ra'aidat Rifiyats) to serve new clients.

The national family planning program is at an important juncture in its evolution. As Egypt's major donor, USAID is being looked to for strong support, resources, and flexibility to help Egypt revitalize this essential program. This Results Package responds to the challenge of the plateau with a series of new initiatives and shifts in emphasis. These include: (1) a major new emphasis on using commercial marketing and advertising to attract new clients, (2) massive support for the mobilization of the thousands of MOHP community outreach workers, (3) re-initiation of USAID support for family planning NGOs, an untapped resource under FP/POP III, (4) expansion of the successful Clinical Services Improvement (CSI) organization into new urban markets, including Cairo, (5) expansion of the "Gold Star" quality improvement program to more MOHP clinics to attract new clients and recover discontinued users, (6) expansion of FP services to include post-partum contraception, tubal ligation for medically indicated reasons, and selected reproductive health services, (7) upgrading the medical school curriculum in family planning/reproductive

health so that doctors will give more and better services, and (8) supporting private physicians, pharmacists, and pharmaceutical companies to improve the availability of quality services and contraceptives in commercial channels.

The design of this RP is structured around five intermediate results which, in turn, address five major problem areas that have been identified based on studies and analyses, some of which are listed in Annex I. The five major problem areas are as follows:

- Supply of Family Planning Services

Physical coverage of family planning/reproductive health services is technically adequate, although some regional deficiencies exist. The Ministry of Health and Population network of over 3,700 government clinics and hospitals means that almost all Egyptian women are within 30 minutes of a facility offering services. The government system is complemented by thousands of private physicians with their private clinics and hospitals, by pharmacies, and by non-governmental organizations (NGOs) that offer services. Some remote communities still lack physicians in existing clinics, leading the MOHP to deploy mobile teams and clinics to reach them.

The most serious supply issue is not access to physical facilities, but the quality of family planning services offered in the existing facilities. Poor quality of care is common across all sectors, contributing to low utilization of available services; high discontinuation; a poor image of family planning; incorrect use of methods and medical complications; unwanted pregnancies and abortions; and widespread misinformation, fear, and dissatisfaction among users.

The 1995 EDHS indicates that about 16% of married women of reproductive age who would like to delay their next birth or not have any more children are not using contraception ("unmet need"). Egypt's national long-term contraceptive prevalence rate objective can be met by simply improving and expanding services to satisfy this existing unmet need. Improving the supply of services to attract and retain clients requires: (1) diversifying the kinds of family planning service providers to give women more choices, (2) diversifying the method mix of contraceptives so that women have greater options, (3) improving the service environment, eg., clinic appearance, cleanliness, privacy, hours of service, availability of women physicians, etc. so that women feel comfortable and safe during counseling and service provision, and (4) improving the information given by counselors so that method characteristics and side-effects are adequately understood by clients.

- Demand for Family Planning Services

While rudimentary technical knowledge about family planning methods and services is high among women in Egypt, active demand for services trails behind. The concept of "demand" captures the attitudinal dimension of clients' family planning behaviors, and strong demand is a prerequisite for strong performance in a voluntary program.

According to 1992 to 1995 EDHS trends using several different measures, "demand" is level or even declining in some parts of Egypt. It appears that the traditional information, education, and communication (IEC) methodology used by the national program and supported by USAID in recent years has succeeded in informing the population about family planning, but it may have reached its limit in terms of producing positive perceptions and active demand for family planning methods and services. The current IEC methodology has made heavy use of television programming and local information centers operated by the Government of Egypt's State Information Service (SIS). The work of SIS was judged technically adequate by the USAID Population III project's mid-term evaluation, but the current plateau shows that something additional is needed to stimulate new demand. New modern commercial marketing strategies, available in Egypt's dynamic private sector, may offer part of the solution.

An additional component of deficient demand, not readily amenable to marketing techniques, is negative perceptions of services and methods based on rumors and bad experiences. The EDHS and focus group studies are showing that interpersonal networks in Egypt are increasingly conveying incorrect information about dangerous and unhealthy consequences associated with modern contraceptive methods. Some of this demand-inhibiting interaction is attributable to providers who give incorrect information or no information at all to family planning clients. Clients discontinue when faced with unexpected or misunderstood side-effects, and their accounts of the unhealthy consequences of contraceptives may quickly become exaggerated and gain wide currency.

- Financial Self-Sufficiency

Family planning in Egypt has historically been heavily subsidized. Due to subsidies and price controls of various kinds, supply and demand are distorted. Market forces do not operate normally to assure the wide availability of good quality services at the right price. Egypt is presently undergoing a shift from a centrally-controlled economy to a free market economy; however the health sector, along with other social sectors, is not moving quickly or easily in this direction. In general, the government and the public still regard free or subsidized health care as a birthright of Egyptian citizens.

USAID has been in dialogue with the GOE on the issue of cost recovery for public health services for years. In the family planning sector, USAID has supported the MOHP in establishing the practice of charging a modest, symbolic fee to the client for her contraceptive, although there is no fee for professional services. This concession by the GOE has been possible because the contraceptives provided by the MOHP are donated by USAID, but the principle of user fees has not really been internalized. USAID agrees with the MOHP that services and commodities should be provided free-of-charge to the indigent who can not afford even a symbolic payment. A "safety net" of free services for the indigent and subsidized services for the poor is needed, but EDHS and other research evidence shows that most clients -- estimated at about 70% -- are financially willing to pay for their services from NGO and private providers. Women can pay for the services they receive and even prefer to pay when alternatives to subsidized services offer higher quality.

USAID stopped providing donated contraceptives to the commercial private sector several years ago. Private suppliers have not moved in to fill the vacuum with competing commercial products because of contraceptive pricing issues (see Annex C, Technical Analysis). As a consequence, commercial contraceptives are in short supply in private outlets. This situation has constrained the expansion of private sector services.

- Institutional Capacity

Although considerable progress has been made in creating and strengthening institutional capacity in family planning service delivery, the institutional base is not yet sufficiently robust or efficient, with adequate technical resources, to function effectively on its own. Development and installation of modern management and administrative systems and practices has begun, and Egyptian institutions and their staff enthusiastically accept and use them. However, a number of important management systems are still weak, constraining the expansion and efficiency of services.

In the public sector, the MOHP and the National Population Council (NPC) have received USAID institutional strengthening support for many years. Considerable progress has been made in the areas of management information, training, commodity management, and strategic planning. However, these areas still need improvement, and other areas such as financial management, personnel management, and human resources development (especially in management-related skills) are urgently needed.

For the private/NGO sector, CSI has become a showcase for modern management systems and institutional resources and practices. CSI represents a breakthrough in

Egyptian family planning service delivery because it has fully institutionalized not only modern management systems but a competitive, customer-oriented, cost-conscious, private sector corporate culture as well. A major challenge is to transfer the technologies, systems, and approach of CSI to other NGOs and even to public sector organizations.

- Legal, Budgetary, and Public Awareness Barriers

While the policy, legal, and regulatory environment is favorable for FP/RH programs in Egypt, certain legal and regulatory constraints exist in Egypt that, according to analysts, may inhibit optimal service delivery and stifle the operation of market forces. These include, among other things, pricing and importation policies affecting contraceptives and restrictions on services that can be offered by non-physicians. Other operational practices such as the limited availability of minipills and surgical contraception further restrict services.

On the budget level, lack of permanently-institutionalized funding for recurrent operational costs in the MOHP may negatively affect the quality of services in the future. Major over-arching health sector issues such as the relatively high portion of the health budget that is reserved for public sector curative facilities and services also directly affect the availability and quality of family planning services.

Finally, awareness of Egypt's urgent demographic circumstances and commitment to national family planning objectives must be revitalized at the level of national political and economic leadership. Public awareness is also at stake, with the decline of positive media coverage, leaving open the platform to unfavorable press reports. Media support must be reactivated. Attention in the Cabinet and in the Parliament about the population phenomena could usefully be strengthened.

B. Customers and Partners

1. Customers

The principal customers or beneficiaries of POP IV are Egyptian married women of reproductive age between 15 and 49 years old. Men, adolescents and even non-users of family planning services are considered "customers" because the program gives them the choice of whether or not to plan their families. Mothers-in-law and grandmothers are also considered customers because of their influential role.

The RP is national in coverage for most services, including IEC programming, quality improvement activities such as Gold Star Clinics, institutional strengthening, and sustainability interventions. However in some cases it may concentrate resources on specific geographic or demographic groups with special needs. One emphasis area will be major urban centers, where populations are huge and growing extremely fast and where contraceptive prevalence, while high relative to rural rates, declined between 1992 and 1995. Special emphasis will be given to young, low parity women because of their low use of contraceptives.

The strategy for Strategic Objective 4 is based in part on a concept of complementary customer "niches." The niche or clientele for government-provided services is approximately the poorest 30% of the population, families that require extremely low-cost or free services. Since most of the "unmet need" that remains is found among poor, rural families who can be best reached by low-cost, widely-accessible government services, USAID will continue to provide considerable assistance to government services during the life of the RP. However, it is important to stress that this support does not reflect a desire to see government services grow at the expense of private sector providers. Government services should normally serve as the family planning "safety net" for families who can not afford private fee-for-service providers.

2. Partners

a. The Government of Egypt (GOE):

The role of the GOE is crucial in achieving the strategic objective. It controls and regulates the work of all health care organizations and service providers, and is itself the country's single largest health provider. It is also responsible for regulating the production, importation, and pricing of all contraceptives. It is responsible for health and population policy formulation. It controls and operates most of the country's mass media. Among the different GOE partners, USAID's strategy will be to directly support the work of the following entities:

The MOHP: Foremost among the GOE partners is the Ministry of Health and Population, the largest supplier of health services to Egyptians. The MOHP's large network of clinics and hospitals located throughout Egypt offers services at little or no cost to clients. Supervision of clinical services occurs through full-time MOHP family planning management teams at the central, governorate and district levels. USAID's main counterpart for population, family planning, and reproductive health activities in the MOHP is the Population and Family Planning Sector unit headed by the First Undersecretary for Population and Family Planning.

The MOI: Another GOE partner is the Ministry of Information (MOI). The Ministry of Information supports the national family planning program through the Information, Education, and Communication center in its State Information Service (SIS). MOI/IEC/SIS supports family planning through television programming and its nationwide network of local information centers (LIC).

The NPC: Other GOE partner organizations include the National Population Council (NPC), a semi-autonomous GOE unit headed by the Prime Minister which was created to conduct research and coordinates the activities of different family planning organizations; the Regional Center for Training (RCT) at the Ain Shams University Medical School, which trains family planning clinicians for all sectors; and the Egyptian Pharmaceutical Trading Company (EPTC), a parastatal which is responsible for the management and distribution of USAID-supplied contraceptives.

b. NGOs and PVOs:

Nationally, NGOs and PVOs are not major providers of family planning services and they make only a small contribution to the strategic objective of fertility reduction. However, the need to accelerate the expansion of family planning services coverage in Egypt requires a new look at NGO providers.

Clinical Services Improvement, the USAID-supported FP-service "model" for NGOs, has successfully developed and showcased state-of-the-art approaches to quality of care, management systems, and cost recovery. Egyptian family planning NGOs have received new attention as a consequence of the 1994 Cairo "International Conference on Population and Development" (ICPD) and are now viewed by the GOE as partners. A likely partner in any effort to channel resources to Egyptian NGOs in the population area is the National Committee for Population and Development (NCPD), an umbrella NGO launched after the ICPD that currently receives support from the UNFPA and other donors.

NGOs offer the ability to deal with politically and culturally sensitive issues (such as female circumcision and age of mother at first birth), and to advocate needed policy reforms. They can also perform effective community-level outreach activities, demand generation, and service delivery. An interesting new development on the Egyptian scene is mosque clinics. A recent study by USAID's Data for Decision-Making project found a number of informally-managed mosque clinics to be offering high quality, low-cost services to their communities and to have high credibility with clients.

c. The Commercial Private Sector:

The commercial private sector includes private physicians, private pharmacists, and pharmaceutical companies. Traditionally, it has been difficult for USAID to support this sector because it is fragmented and dispersed, lacking an institutional base. Also, commercial private services are already self-sustaining, and any donor support runs the risk of creating new and undesirable dependencies. Its role in increasing the coverage of family planning services, increasing the range of contraceptives available to Egyptians, improving the quality of service, and securing an adequate supply of contraceptives is therefore critical to the national program.

Under POP IV, USAID will explore new means to expand work with the commercial private sector through pharmaceutical companies, professional medical associations, and the mass media. During the RP period, USAID assistance is expected to shift gradually from public sector support to private sector support. The MOHP agrees that most expansion in the clientele for family planning services should take place in the private sector.

d. Other Donors:

USAID is the lead donor in family planning in Egypt. Among other donors, UNFPA has also been a long term important supporter of the Egyptian program, followed by the World Bank, European Union, the Dutch, International Planned Parenthood Federation and CIDA. An active family planning/population donor committee meets quarterly to coordinate activities. Specific donors supporting the family planning sector include:

UNFPA: UNFPA is beginning a new five-year period of assistance which provides about \$20 million for innovative family planning and reproductive health services in selected governorates, capacity building within the central population sector unit, plus IEC/advocacy. UNFPA from 1992-1996 committed about US \$15 million for family planning/reproductive health; population and development; and IEC/advocacy, with \$5 million allocated for each component.

World Bank: In July 1996 the World Bank and GOE entered into a Credit Agreement of US \$20.7 million in support of a five-year population project, anticipated to begin in 1997. The project contains two components: 1) capacity building (US \$2.6 million) which assists the MOHP's central Family Planning/Population sector unit with policy and program development and 2) population activities (US \$18.1 million) which supports demand creation activities smaller

families and family planning where fertility remains high and contraceptive demand is low, such as in rural Upper Egypt. Project funds for this component will be provided to NGOs and local community organizations, and implemented through the Social Fund for Development.

European Union (EU): For the period 1994-1997, the European Union financially supported (US \$2.4 million) the upgrading of 400 family planning clinics operated by the EFPA mainly in the Delta governorates. A continuing program of assistance (US \$13.0 million) supports family planning and population activities in Qena and Sohag governorates from 1995-1999.

The Royal Government of the Netherlands: In 1996, the Dutch committed financial resources of approximately US \$8.3 million for Phase II of the Fayoum Rural Health and Family Planning Project for the period 1996-2000. The Project uses an integrated multisectoral approach that includes health, education, credit, WID, etc. Activities rely heavily on local outreach workers in collaboration with the Fayoum Governorate Directorate of Health.

International Planned Parenthood Federation (IPPF): IPPF provides technical and financial resources to the IPPF NGO affiliate: Egyptian Family Planning Association which has approximately 450 clinics throughout Egypt.

Canadian International Development Association (CIDA): CIDA provides US \$527,000 for applied research to foster conditions and social behavior conducive to later marriages and reduced programs. This project is being executed by the Population Council.

Japan International Cooperation Agency (JICA): In 1994 JICA concluded a reproductive health service delivery Project in Qena Governorate. While over the last several years, the Japanese have had several exploratory meetings with the GOE about possible FP/POP Projects, no further projects have been developed.

e. Other SO/RP Teams:

The RP is linked in two different ways to other USAID Strategic Objectives. First, it is linked functionally with several other SOs to increase impact: Accelerated Private Sector-Led, Export-Oriented Economic Growth (SO 1); Increased Participation of Girls in Quality Basic Education in Targeted Areas (SO 2); Sustainable Improvements in the Health of Women and Children (SO 5); Increased Access to Sustainable Water and Wastewater Services (SO 6); and Reduced Generation of Air Pollution (SO 7).

The second kind of linkage between the POP IV RP and other USAID SOs is administrative. Several activities will be implemented in conjunction with other SO teams and contractors, reducing management burden while enhancing synergies. The following administrative linkages are planned:

Offshore training, some in-country training, and some overall training support (needs assessment, follow-up with trainees) will be implemented by the institutional contractor under the Development Training II (DTII) RP, funded under Special Objective E, Improved Human Capacity Development System Linked to Strategic Priority Areas. Results will be tracked and reported on by SO4.

PVO support -- both institutional strengthening activities and operational grants -- will be implemented by a cross-sectoral NGO umbrella mechanism that is being designed under Strategic Objective 3, Increased Citizen Participation in Public Decision Making, and funded under POP IV.

A number of activities will be jointly implemented with Strategic Objective 5, Sustainable Improvements in the Health of Women and Children. These include: (1) selected IEC activities for both the Healthy Mother/Healthy Child and POP IV RPs will be implemented by the MOI/IEC/SIS unit, (2) curriculum reform in medical schools, (3) policy analyses and initiatives, (4) selected reproductive health activities, and (5) related results monitoring and evaluation.

C. Previous USAID Involvement in Family Planning

USAID has provided continuous assistance to the Egyptian family planning program since 1975. Institutional capacity has been strengthened through the training of thousands of provider staff, the upgrading of facilities, improvements in the quality of care, and improvement of management systems. Sustainability prospects have been enhanced with the implementation of cost-recovery mechanisms and support for commercial private sector services.

USAID's family planning strategy has predominantly supported public sector services, with significant but smaller amounts of assistance for NGO and private sector activities. Public sector providers historically have been favored because they have the greatest need for assistance and serve the poorest sectors of Egypt's population.

After many years of experience and considerable assistance, from USAID and other donors, the national program has momentum, resources, and many of the elements required for success. For example:

- knowledge of family planning is virtually universal (99.4 percent);
- thousands of clinics are spread throughout the country, offering broad access to services;
- supplies and services are available from public and private sources at prices within the means of users; and
- There is strong commitment at the highest levels of government to the program.
- A great deal has already been accomplished:

Contraceptive prevalence (the percentage of married women of reproductive age currently using contraception) reached 47.9% in 1995 in Egypt, up from 5% in 1960 and almost double the rate in 1980. The total fertility rate (a measure of average number of live births per woman) fell from 6.7 in 1960, to 5.2 in 1980, to 3.9 in 1992, to 3.63 in 1995.

D. Total Approved Funding Level and Life Of Results Package (LORP) Period

The ANE Bureau - USAID/Egypt Management Contract (Secstate 118845 dated June 8, 1996), approved Strategic Objective 4, Reduced Fertility, with resources estimated at \$87 million for the strategy period 1996-2001. Early planning levels were based on rough estimates of program needs. Based on subsequent detailed analysis and budgeting that took place during the design of the RP, a total requirement for POP IV has been set at \$90 million to achieve planned Phase 1 results (see Annex B).

II. ACTIVITY DESCRIPTIONS

A. POP IV - The Sustainability Phase

Modern family planning services provide the only effective means of regulating fertility. Family planning services enable couples to voluntarily take control of the spacing and number of their pregnancies. Nationally, as more couples make use of family planning services, the fertility rate will decline. However, to help achieve a permanent, sustainable fertility reduction, full accomplishment of SO4 requires that two intermediate results be achieved: (1) increased use of family planning services, and (2) strengthened sustainability of family planning systems.

Increased use of family planning services (IR 4.1) requires that there be a supply of services that is adequate in coverage and of good quality. While an adequate supply of services is a pre-requisite for utilization of services by clients, supply alone does not assure utilization; increased demand is also necessary. Fertility reduction occurs over a long period of time as families choose to space and limit pregnancies throughout their reproductive years. To permanently affect fertility, changes in reproductive behaviors must be permanent. Therefore, the systems that support these new behaviors must be fully institutionalized and financially self-sufficient (IR 4.2).

USAID has been the principal donor supporting the Egyptian national family planning program since 1975. During the early years of USAID assistance, emphasis was placed on expanding the coverage of family planning. Subsequently, focus shifted to strengthening the national institutions that provide family planning services. Now, in the period marked by the beginning of this Results Package, emphasis will shift again toward creating the conditions for permanent financial and institutional sustainability and the eventual phase-out of USAID assistance. An optimistic, but not impossible, expectation is that the following conditions favorable to overall sustainability will exist by the end of the POP IV planning period: (1) contraceptive prevalence will be rising steadily, (2) permanent GOE budgetary support for family planning services will be adequate, (3) self-financing NGO services will catch on and grow, and (4) the overall "share" of clients going to sustainable commercial private sector providers will increase substantially. If these conditions prevail, full sustainability can be reached in ten years.

This ten-year RP period is therefore considered the "sustainability phase" of USAID's assistance to family planning in Egypt. It involves: (1) the eventual phase out of USAID donated contraceptives, (2) the creation of endowments for certain key

partners, (3) policy reforms leading to the GOE assuming greater financial responsibility for the national program, and (4) an emphasis on further promoting sustainable commercial private services.

B. POP IV Activities

Activities are organized around the five intermediate results (IR): Enhanced Supply (4.1.1.), Increased Demand (4.1.2.), Increased Financial Self-Sufficiency of FP Systems (4.2.1.), Strengthened Institutional Capacity (4.2.2.), and Improved Policy Environment (4.2.3). It should be noted that many of the activities share cross-cutting links, e.g., assistance that impacts on both supply and demand, policy reforms that affect institutional capacity, etc.

1. Enhanced Supply (IR 4.1.1.)

a. Increased Coverage of Family Planning/Reproductive Health (FP/RH) Services (IR 4.1.1.1.)

(1) New Contraceptive Technologies More Widely Utilized in Public, NGO and Private Sectors (Including CSI) (IR 4.1.1.1.1):

Indicators:

- a. Post-partum contraceptive services operational at governorate and district hospitals and selected university hospitals;
- b. Tubal ligation for medically indicated reasons introduced into public sector governorate and district hospitals, selected university hospitals, and other providers;
- c. NORPLANT services expanded to all university and public sector hospitals and CSI clinics;
- d. Introduction and expansion of other under-utilized or unavailable contraceptive methods (e.g., Progesterone only Pills) supported.

Activities:

- **Expand contraceptive technologies**

Assistance aimed at expanding the availability of contraceptive technologies such as PPIUDs, NORPLANT, and Depo Provera injectables will cut across the public,

private commercial, and NGO sectors. Unavailable or underutilized methods such as progesterone-only pills will be introduced and/or expanded. The use of tubal ligation will be supported for medically indicated reasons. Contraceptive commodities will continue to be provided as donations to public and NGO sector providers for the next several years, while concurrently supporting the development of a GOE contraceptive commodities and logistics management sustainability plan that will shift procurement to the GOE budget over time (see IR 4.2.1., below).

For the private sector, which will not receive contraceptive donations, complementary activities will support policy initiatives and marketing activities to increase the availability of contraceptives through private sector channels (IRs 4.1.2 and 4.2.3). Technical assistance and training will be provided to institutions in the public, private commercial, and NGO sectors. This includes MOHP and university medical schools, the Teaching Hospitals Organization (THO), the Health Insurance Organization (HIO), and CSI.

- **Expand post-partum contraceptive services**

In addition to continued support for clinic-based FP/RH services in the public and NGO sectors, inpatient post-partum contraceptive services at public sector and university medical school hospitals will be encouraged. Normally these services are only available on an outpatient basis. Inpatient post-partum IUD, post-abortion, post-caesarian family planning, and tubal ligation for medically indicated reasons, will give inpatient clients valuable additional methods of choice. Hospital and clinic-based FP/RH services will form the centerpiece of a unified public sector family planning/reproductive health service delivery system within the MOHP, that will be promoted through the Gold Star Quality Improvement Program.

(2) Increased Service Volume Among Targeted Market and Provider Niches (IR 4.1.1.1.2.):

Indicators:

- a. Increased contraceptive prevalence in rural Upper Egypt and selected urban governorates;
- b. Increased contraceptive prevalence among young and low parity women;
- c. Increased contraceptive prevalence among women with no or some basic education;
- d. Increased utilization of private sector providers.

Activities:

- **Expand service volume**

The service delivery infrastructure of the MOHP FP/RH system (hospitals, urban health centers, MCH centers, and rural health units) is extensive and does not need to be expanded. However, many of the existing facilities are underutilized, in part because they sometimes offer inadequate services or are poorly maintained.

Improving the facilities themselves and the quality of services they offer appears to be the best strategy for increasing service volume.

In selected areas of low prevalence and high discontinuation, innovative FP/RH service delivery approaches will be designed, tested and replicated to reach young, low parity women, women in low prevalence regions of Upper Egypt and low income peri-urban areas, and women with no education or some basic education. In addition, to maximize impact within selected governorates of high need, an intensive approach that coordinates and links FP/RH services among the public, private, and NGO sectors will be undertaken.

CSI's "Capacity Enhancement Initiative" will continue to provide a model for the NGO community. This initiative increases client volume through diverse activities including community education, community-based marketing activities, and a series of outreach teams that link the community with CSI laboratory and follow-up services. Operational grants under the new (SO 3) NGO Service Center will be tapped for innovative service delivery approaches to help expand family planning services further. In addition, the development of an FP/RH NGO service delivery referral system to coordinate linkages to MCH/FP services among NGOs is planned.

- **Enhance MCH/FP linkages**

MCH/FP linkages will be strengthened by institutionalizing cross-referral of MCH outpatient clients and post-partum clients to FP/RH care, including contraceptive services. The health card developed and used by MCH clinics will be expanded to include family planning/reproductive health services so that women using health centers can be ensured continuity of care as they move through their reproductive years. It will contain such items as individual reproductive health history, family planning usage, infant vaccination and growth records, and other relevant socio/health information.

Collaboration between the population and health sectors in the MOHP will also be strengthened with the addition of selected reproductive health interventions, such as breast self-examination, diagnosis and treatment of reproductive tract infections, and the prevention of female genital mutilation, to family planning services.

Special emphasis will be given to the development and initiation of a 40th day post-partum follow-up care program for mother and child. This approach will be used particularly in expanding delivery of services to young, low parity women. The program will be undertaken in close collaboration with the Healthy Mother/Healthy Child Results Package under SO 5 and will build on the success of Egypt's child immunization program by making family planning services available to those women bringing their infants in for initial immunizations (approximately 40 days after birth).

- **Expand private sector service delivery**

The RP will support expansion of the role of the private commercial sector, specifically pharmacists and private physicians, in service provision through training, marketing, research and technical assistance. Particular emphasis will be given to promoting the use of private commercial sector service providers among clients that can afford to pay. The follow-on methodology will continue the training, IEC and research activities initiated during POP/FP III, but with more concentrated emphasis on commercial marketing and advocacy of private sector services.

Selected marketing support will also be given to the Egyptian pharmaceutical sector that imports, supplies, and distributes contraceptive commodities to ensure availability of contraceptive products in the private sector. National pharmacy retail audits will also be performed to monitor the availability of contraceptives in the private sector. Activities will be closely linked with those under Improved Policy Environment (IR 4.2.3), to encourage the removal of restrictive regulations on importation, pricing, and distribution of contraceptives.

(3) Start-up or Expanded FP Services Implemented in NGO Sector (IR 4.1.1.1.3.):

Indicators:

- a. FP service programs implemented through five national level NGOs;
- b. FP services offered through 15 local community NGOs.

Activity:

- **Provide operational grants to NGOs for FP/RH service delivery**

In collaboration with the NGO Service Center, approximately 20 grants will be awarded to NGOs to encourage them to initiate or expand their family planning/reproductive health services. Grant support will be provided in two phases: Initial support will be for institutional strengthening (IR 4.2.2); following a period of institution-building, each qualifying NGO will receive an operational grant which will partially fund expansion or improvement of its family planning support activities.

(4) Allocation and Productivity of Community-Based Workers Enhanced (IR 4.1.1.1.4.):

Indicators:

- a. Increased numbers of FP referrals;
- b. CBD activities piloted in selected areas.

Activity:

- **Expand community-based FP worker activities**

In the public sector, training for FP/RH outreach workers, known as Ra'aidat Rifiyat, will continue. These workers will be linked to targeted FP/RH units in all governorates. Efforts will be made to expand the utilization of male Ra'aidat Rifiyat in FP/RH service referral where feasible. In areas of low contraceptive use where physicians or female health service providers are deficient, community-based activities will use improved mobile teams including female nurses to expand service availability and acceptability.

(5) Availability of female service providers in Upper Egypt enhanced (IR 4.1.1.1.5.):

Indicator:

Increased numbers of female nurses trained in district nursing schools.

Activity:

- **Support district nursing schools in Upper Egypt**

To increase the availability of female nurses in underserved areas, several years of continued financial and technical assistance will be provided to enable high school women in Upper Egypt to attend non-residential district nursing schools.

Under the MOHP/Systems Development Project (SDP), POP/FP III supported the establishment of 14 district nursing schools in Upper Egypt. Student nurses at these school receive both general nursing and FP/RH training. These nurses are likely to live and work in or around their village, thus addressing a staffing shortage of female providers. The first class of nursing students graduate in 1998. USAID will continue support for this activity during Phase 1 of POP IV after which the GOE will assume this responsibility.

b. Improved Quality of FP Services (IR 4.1.1.2.)

(1) Human Resource Capacity for Service Delivery Improved (IR 4.1.1.2.1.):

Indicators:

- a. Enhanced counselling;
- b. Strengthened service provision;
- c. Improved infection control.

Activities:

- **Strengthen provider clinical skills in FP/RH service delivery**

Human capacity development in FP service delivery will be guided by the FP/RH Standards of Practice developed by the MOHP. Related clinical training activities with service providers and supervisory staff will further strengthen and assure the quality of FP/RH counselling, infection control, and service provision. Special attention will be given to enhance the management of side effects and to address rumors.

Within the public sector's family planning Gold Star quality improvement program, support will continue for central and decentralized training activities that improve quality in both inpatient and outpatient services, building on the MOHP's extensive training capacity at the governorate level. Special focus will be given to expanding

the Gold Star initiative to include such activities as post-partum contraception.

Support for private sector training activities will continue to focus on disseminating contraceptive technology information and counselling techniques to address reasons for non-use among clients of private sector physicians and pharmacists.

Activities to Strengthened Institutional Capacity (IR 4.2.2) will complement these efforts by improving program management systems that support FP service delivery.

(2) Service Delivery Environment Improved in the NGO and Public Sector (IR 4.1.1.2.2.):

Indicator:

Improved selected public sector service facilities.

Activity:

- **Improve facilities supporting service delivery**

Assistance for minor renovation and equipment at selected public sector service facilities will be provided to establish post-partum IUD and tubal ligation (TL) rooms in OB/GYN departments within MOHP, THO, HIO, and university hospitals.

Minor renovation and equipment for district level MOHP FP/RH offices, Management Information Services (MIS) offices, and training centers will also be supported to enhance decentralization of FP/RH management systems.

(3) Quality Improvement Systems Developed and Enhanced (IR 4.1.1.2.3.):

Indicators:

- a. Standards of practice updated and disseminated;
- b. Supervisory systems to ensure quality in place.

Activity:

- **Enhance quality improvement/assurance systems**

Continued support will be provided for MOHP systems development to improve

quality inpatient and outpatient FP/RH services. Systems development for the NGO sector will also be provided to ensure consistent high quality service delivery. Systems to be enhanced include clinical examinations, client counselling, infection control, and supervision of clinical services.

Assistance will be provided to the MOHP to regularly update its FP/RH Standards of Practice. As a regulatory agency for quality services, the MOHP will disseminate these standards to providers in the public, private and NGO sectors. Reproductive health services such as diagnosis and treatment of reproductive tract infections (RTIs) will be added to the FP service delivery menu, and the MIS will be expanded to allow tracking of data on FP/RH activities. The Gold Star Quality Improvement Program will continue to be marketed under Increased Demand (IR 4.1.2), to increase public awareness of improved MOHP FP/RH services.

2. Increased Demand (IR 4.1.2.)

a. Public Better Informed About FP/RH (IR 4.1.2.1.)

Indicators:

Knowledge of FP methods, services and providers improved, resulting in:

- Awareness of enhanced quality services, improved service provision, and more expanded method choices in public, private commercial, and NGO (including CSI) sectors increased;
- Public awareness of availability of needs-based safety net system;
- Knowledge of all FP services including post-partum contraception and methods such as PPIUD, NORPLANT, injectables, TL for medically indicated reasons, and lactational amenorrhea method (LAM) improved;
- Knowledge of health and socioeconomic benefits of FP increased;

Population more accurately informed about specific contraceptive methods and side effects.

Activities:

- **Strengthen MOI media campaigns**

The MOI/IEC/SIS working with private commercial firms will create strategically planned media campaigns to inform the population about family planning. The GOE

is expected to continue to provide air time on television and radio, as well as space in printed publications. Messages will be about specific contraceptive methods with special emphasis on under-utilized ones such as Depo Provera and PPIUD.

- **Enhance information about family planning**

Dispelling rumors and information about side effects will be a focal point of the campaigns. The clients will be reassured about the safety of contraception and the professionalism of the providers.

- **Create messages about fee waiver**

Messages will include information about a fee waiver system for indigent clients.

- **Target niche groups**

Specialized information activities will be designed for strategic niche groups such as grandmothers, husbands, illiterate, rural, and Upper Egyptian women. Working collaboratively, the MOHP, the MOI, NGOs and the private sector will produce creative ways to better inform the population, e.g., Help Lines and Peer to Peer education. Also, signs on buses, billboards, and other innovative media will be employed.

- b. **Couples More Highly Motivated to Use FP/RH Services (IR 4.1.2.2.):**

Indicators:

- a. Fertility-related attitudes such as ideal family size, age of marriage, son preference, delayed first birth and birth spacing, more positively in favor of family planning.
- b. Images of family planning methods and services improved.
- c. Underserved groups or hard-to-reach communities better motivated to use family planning.

Activities:

- **Implement commercial marketing campaign**

In order to energize the demand creation efforts to motivate clients to use services, a private commercial firm will introduce innovative techniques of capturing audiences' attention, educating consumers, and encouraging clients to seek and maintain family

planning. A focused, research based, and dynamic new approach to marketing family planning will be deployed using the techniques of the private sector. Innovative marketing techniques will include celebrity spokespeople, dynamic television shows, etc. The commercial sector will also be used to further enhance and expand the image of CSI. This activity will be designed and implemented by Egyptian commercial marketing enterprises, and will use powerful, modern, research-based techniques for informing and mobilizing new clients. Grounded in modern quantitative and qualitative behavioral research, activities will use a comprehensive approach to marketing that fully considers packaging, placement, and pricing, along with critical cultural and motivational components of prospective clients' perceptions and decisions.

- **Enhance group meetings and other outreach techniques**

Group meetings will be used, along with other channels, to motivate potential clients about the ease, safety, and accessibility of family planning. These meetings will focus on certain groups such as young, illiterate, or rural women, and influential persons such as religious or community leaders. These meetings will be conducted by the LIC workers of the SIS and by MOHP IEC workers.

- **Promote Gold Star**

Gold Star will continue to be promoted as a primary activity through various media channels. More local advertising such as bill boards will be used to direct clients to the clinics.

- **Institute linkages with MCH**

Systems will be established to insure cross referral. The 40th day postpartum concept will encourage women to seek care for themselves, practice family planning and to receive care for their children during the 40th day immunization visit.

- **Strengthen training of outreach workers**

The Ra'aidat Rifiyat and other outreach workers of the MOHP will be trained to inform and motivate clients as well as distribute selected contraceptives. The SIS local information centers will continue to disseminate family planning messages through their extensive local networks.

- **Improve use of research**

Research will be undertaken to find out what is missing in people's knowledge,

attitudes, and practices, and to assess the impact of various demand creation activities. Research will be used to refine messages, define niche audiences, to develop campaigns, etc. Market research will drive the demand creation activities.

- **Expand availability of FP IEC materials**

The RP will support creation of a FP IEC Resource Center at the SIS for family planning/reproductive health IEC materials for client counseling. Assistance will be provided to reprint IEC materials such as flip charts, method-specific brochures, clinic and videos, and make them available to public, NGO and private providers at no or a modest cost.

- c. **Providers More Highly Motivated and Demand Oriented (IR 4.1.2.3.)**

Indicator: Provider staff proactively responsive to clients' information and service needs.

Activity:

- **Conduct motivational activities**

Various activities, including training, newsletters, use of electronic media, will be used to motivate service providers, including physicians, nurses, and Ra'aidat Rifiyat to provide quality family planning information and services. Market research will be used to motivate and make providers client oriented. This activity also contributes to Enhanced Supply.

3. Increased Financial Self-Sufficiency of FP Systems (IR 4.2.1.)

- a. **Growing Independence from External Subsidies and Increased Targeting of Internal Subsidies (IR 4.2.1.1.)**

Indicators:

- a. Public sector contraceptives and support system fully financed by GOE:
 - One or more USAID-donated method self-financed by GOE.
- b. Needs-based safety net developed and established:

- System introduced and tested by end of Phase 1;
 - System fully operational by end of Phase 2.
- c. CSI and RCT achieve financial sustainability.

Activities:

- **Assist the GOE in assuming the responsibility of contraceptive commodities management and financing**

The GOE will receive technical assistance to establish a phase-out plan of donor contraceptive commodities and a GOE phase-in plan and schedule; conduct a needs assessment to identify resource requirements and to build up the capability of the MOHP's financial management; and develop a rational contraceptive pricing scheme and refine a revenue distribution plan to MOHP/FP service providers. Part of that scheme will be to encourage policy changes (IR 4.2.3.) that increase the price of contraceptives according to clear market segmentation and clients' ability to pay. The MOHP performance based payment plan which distributes revenue generated from the sales of USAID contraceptives will be continued.

- **Encourage the GOE to permanently and adequately finance the operating costs of FP national program**

The RP will support analysis, studies and policy dialog to help the MOHP to institutionalize adequate budget support for FP services in governorates and districts. Special attention will go to recurrent expenses such as infection control supplies, salary supplements to FP supervisors, fuel and maintenance of USAID-provided vehicles, and maintenance for USAID-provided computers and other office equipment. This activity will contribute to the accomplishment of I.R. 4.2.1.1. and I.R. 4.2.3.

- **Establish a fee-waiver system for indigent MOHP/FP clients**

The RP will assist the MOHP in establishing criteria and threshold levels for a needs-based safety net, analyze and project the proportion of married women of reproductive age who will fall within safety net, assess the implications for resources required, and develop alternative mechanisms for the MOHP to identify the most appropriate approach to implement.

- **Strengthen the financial management and other systems for MOHP, CSI, NGO's, and the RCT**

The different management and strategic planning systems in MOHP, CSI, NGO's, and RCT will be strengthened to improve efficiency and high accountability. This will include the financial management and accounting, human resources, MIS, income generation and diversification, and institutionalization. These activities will be among the prerequisites for possible endowments and/or NGO operating grants to be provided in Phase 2 by this RP.

- **Plan a financial endowment for CSI and RCT for Phase 2**

The establishment of endowments for CSI and RCT is envisioned for Phase 2. To prepare for those endowments, a phased implementation strategy will be developed. Technical assistance will be used to systematically determine the optimal organizational structure, feasibility and timing, legal requirements, other necessary steps and lessons learned/experiences from other organizations.

- b. **Improved Cost Effectiveness (IR 4.2.1.2.)**

Indicators:

- a. Efficiency of MOHP FP units improved.
- b. CSI and RCT efficiency improved:
 - Increased volume of activities;
 - Decreased operating costs.

Activity:

- **Improve operating efficiency**

The MOHP, CSI, and NGOs will develop strategies to increase service volume to reduce the fixed costs per client and increase CYP contribution. Clinic operations will be analyzed and new approaches pursued such as flexible clinic operating hours, staff time utilization, and closing of inefficient clinics to improve the operating efficiency. A MIS will be developed for the MOHP and NGO's, and CSI's MIS strengthened to track cost effectiveness improvements.

- c. **Increased Cost Recovery (IR 4.2.1.3.)**

Indicators:

- a. MOHP cost recovery levels maintained or increased.

- b. CSI operating costs fully recovered through service diversification.

Activities:

- **Test and replicate cost recovery mechanisms**

Support for performance in cost recovery and operational efficiencies among MOHP, CSI and RCT will be emphasized. Different cost-recovery mechanisms may be tested and replicated within the MOHP and NGOs. Among the approaches is a flexible user-fee range based on geographic and demographic criteria.

- **Develop cost containment strategies and additional reproductive health and MCH services to cross-subsidize FP services**

The MOHP, CSI, and NGOs will receive assistance to analyze and pilot test cost containment schemes, and will develop strategies for containing costs at the unit level in order to reduce the variable costs per client. The potential for additional clinical services in reproductive health and maternal and child health will be analyzed to determine the means to diversify and cross-subsidize the range of income-generating services. New clinical services will be tested and implemented at clinics to strengthen their financial base and strengthen linkages to RH and MCH services.

4. Strengthened Institutional Capacity (IR 4.2.2.)

- a. **Strengthened Human Resource Base (IR 4.2.2.1.)**

Indicators:

- a. Entry-level and middle-level managers and technical staff trained and functioning.
- b. Graduating physicians skilled in family planning and reproductive health services.
- c. In-service family planning staff skilled in family planning and reproductive health services and management.
- d. Family planning and reproductive health training systems and programs for medical and managerial staff institutionalized in key organizations.

Activities:

- **Strengthen partners' staff capabilities**

The human resource base of family planning providers will be built up, developing a new generation of technical and managerial leadership. A variety of long-term and short-term training will be provided for this purpose, both in-service and pre-service. Simultaneously, permanent in-house training systems will be created and strengthened. Physicians, pharmacists, pharmacist assistants, nurses, community outreach workers, managers, administrators, "multi-purpose" workers, counselors, and lab technicians are some of the professional staff categories that will be trained.

- **Expand national leadership**

A "Leadership Training" program will be implemented, providing U.S. Masters degree programs for up to 100 Egyptians to work across the national FP/RH program in areas such as management/administration, policy analysis, etc. Much of the training and training support under this activity will be provided by the Development Training II institutional contract, under SpO E, with oversight and participation by the POP IV RP management team and partners.

- **Strengthen Egyptian FP/RH NGOs**

The institutional strengthening of 15 small, local NGOs and 5 larger national NGOs is planned. Assessments of participating NGOs will be done, following which the NGOs will be provided with the following kinds of upgrading, as needed: (1) medical; (2) marketing and promotion; (3) human resource management; (4) financial management and accounting; (5) strategic planning; (6) management information systems; (7) monitoring, evaluation, supervision, quality assurance; and (8) income generation. Networking arrangements among NGOs will be established. The RCT will be utilized as a source of NGO training and CSI will be an important source of technical assistance.

- **Support new FP/RH pre-service curriculum in medical schools**

Improved medical training in the areas of family planning and reproductive health will be introduced by upgrading facilities in university medical schools, by developing and providing modern instructional materials, and by offering training and observation opportunities to faculty and administrators. Close collaboration between POP IV and Healthy Mother/Healthy Child (RP under SO 5), which is introducing other complementary curriculum reforms, will be ensured.

b. Improved Management Systems (IR 4.2.2.2.)

Indicators:

- a. Management Information Systems (MISs) improved:
 - Management information systems (MISs) functioning in family planning partner agencies.
 - Management information systems linked and decentralized.
- b. Marketing and business development techniques integrated into the activities of family planning partner agencies.
- c. Supervision of family planning services strengthened.
- d. Monitoring and evaluation functions improved.
- e. National population research capability strengthened.
- f. Contraceptive commodities logistics systems institutionalized and sustainable.

Activities:

- **Establish permanent organizational structures**

The most advantageous long-term institutional structures (e.g., NGO, civil company) will be identified for RCT and CSI. Once identified, these entities will be formally reorganized in the best institutional arrangement for each. The institutional bases established for these organizations will enable them to market their services as broadly as possible and with as much independence and autonomy as possible. The institutional framework(s) selected should facilitate USAID-funded endowments during Phase 2 of POP IV. Phase 1 will be focused on technical and legal assistance.

- **Strengthen and decentralize management functions**

Management systems and practices in the different Egyptian partner organizations will be improved, tailored to the particular needs of the different organizations. Partners in this activity will include the MOHP, CSI, SIS, RCT, NGOs, and possibly NPC. Management functions receiving support include: (1) planning and budgeting, (2) supervision, (3) contraceptive logistic management, (4) management of facilities and equipment, (5) training, (6) service statistics and other management information, and (7) IEC. The MOHP will receive support to further decentralization its management functions to the governorate and district levels.

- **Improve the capacity of partners' management information systems**

Support will be provided to upgrade management information systems (MIS) in the MOHP FP/RH Undersecretariat and other participating Egyptian institutions. Service statistic reporting arrangements (presently under development as the GOE's "TA8" data collection form) will be finalized and institutionalized, with users and analysts trained. Linkages will be established between the MOHP FP/RH MIS, other MOHP MISs, MOI/SIS/IEC and other GOE MISs, and private MISs. Technical assistance, training, software, and hardware, and will contribute to accomplishment of this activity.

- **Establish sustainable business development capabilities**

The following business development capabilities in CSI, RCT, and participating NGOs will be enhanced: (1) a marketing/public relations capability, (2) a strategic planning capability, and (3) a staff training capability. RCT will receive assistance to assess the feasibility of expanding its client base through development of new courses to be marketed regionally and nationally. Assistance to CSI will help it strategically expanding its coverage and services, setting the stage for eventual institutional autonomy on a large scale.

- c. **Increased Strategic Planning Capacity (IR 4.2.2.3.)**

Indicator:

Strategic planning techniques utilized in national family planning partner agencies.

Activities:

- **Install and consolidate strategic planning**

A good strategic planning methodology has been developed at the NPC under POP/FP III. This capability will expand to function at the district, governorate, and national levels. With the coordination of the MOHP, it will involve all Egyptian FP/RH providers. Continued support will be provided under POP IV.

- **Support coordination of the national program**

Coordination of activities among partners and donors will be enhanced by annual FP/RH coordination meetings organized by the institutional contractor. These

meetings will focus on the coordination of institutional resources, strategic planning processes, management and program information, and service delivery activities. The meetings will be chaired by the MOHP, and will involve broad participation by the NGO and university community as well as the major RP "partners."

5. Improved Policy Environment (IR 4.2.3.)

a. Strong Political Commitment that Supports, Strengthens and Sustains the Population, Family Planning, and Reproductive Health Program in Egypt (IR 4.2.3.1.)

Indicators:

Improved policies that affect Supply:

- a. Improved policy environment and less restrictive regulations that affect the public and private sectors:
 - Provision of family planning services by nurses and para-medical providers;
 - Removing restrictive regulations on importation and pricing of contraceptives;
 - Removing restrictive regulations on media advertising for contraceptives.
- b. A policy environment that supports and enhances the expansion of NGO involvement in family planning advocacy and service delivery.
- c. Policies that provide a safety net for those who can not afford the cost of family planning services and/or contraceptives.

Improved policies that affect self-sufficiency:

- a. Commitment and allocation of adequate resources:
 - Budget line items for the procurement of contraceptives(especially long term, more effective methods);
 - Permanent budgeted amounts for recurrent costs especially medical supplies, gasoline, etc.;
 - Allocation of resources for the optimum placement, training and compensation of family planning service providers;
 - GOE budget allocation for Family Planning media support institutionalized.
- b. Policy actions that support cost recovery in family planning service delivery

Activities:

- **Clarify roles and responsibilities**

The MOHP, the NPC and other implementing agencies (including the NGO's and the private sector) will be assisted to define their roles at the national and regional levels. A technical working group of counterparts will hold meetings and develop a clear policy program document that clearly defines each agency's role.

- **Articulate strategic vision**

Implementing agencies that are participating in the population/family planning/reproductive health program will receive training in the form of a series of workshops to enable them to identify the strategic vision for the country as a whole and the strategy for each of the agencies and its role to reach common goals. Strategic planning training for the implementing agencies will be updated and supported.

- **Conduct studies and research**

In addition to the Demographic and Health Survey, a limited number of studies will be implemented to inform the development of policies that would enhance the family planning program. Another purpose for the studies is to serve as inputs to the strategic planning process. Evaluations, assessments and situational analysis studies in addition to operations research will be implemented. Study results will be widely disseminated to policy makers, parliamentarians and the news media in various forms such as briefings, news worthy material, presentations and written materials.

- **Raise policy issues**

Multi-sectoral technical working groups will be organized to craft strategies and policy reform measures using the background studies results as a springboard for discussions. The working groups will handle issues such as the expansion of the role of the private sector in the family planning program and will support the financial self-sufficiency of the program.

- **Conduct policy events**

Policy analysis workshops will be held for implementing agencies staff. Policy analysis units may be established to assist in converting research results into policy recommendations.

- **Update and issue population policy**

A revised Population Policy document will be drafted and reviewed by the policy working group members to be presented to the People's Assembly. Policy issues that are hindering the progress in implementation of the family planning program should be confronted and addressed.

- b. **Population/Family Planning Information Utilized to Create Awareness and Support for Policy Change Among Policy Makers (IR 4.2.3.2.)**

Indicators:

Improved Policies that affect demand:

- a. Maintain current discount on family planning advertising;
- b. Free air time for GOE family planning media campaigns
- c. Discount on private commercial sector and NGO advertising

Activities:

- **Strengthen the capabilities of mass media**

Mass media (electronic and print) staff will receive information to improve their appreciation of the family planning program and of Egypt's national program. Training will enable media managers and reporters to become accurate interpreters of demographic phenomena. Study/observation tours to appropriate countries will be designed and implemented for selected members of the news and electronic media.

- **Develop a systematic, proactive, sustainable advocacy program**

The program will support specific policy reforms and will work to build support for the population program among the public and within the country's political leadership. GOE agencies, NGO's and the private sector will receive training on advocacy and will participate in developing a national advocacy plan. Private public relations companies will be contracted with to design awareness raising activities. Local level advocacy workshops will be held at the sub-national level to create and support advocates for the program.

- **Conduct observational study tours**

Study tours will be organized for GOE officials, NGO's and the news media to appropriate countries with strong family planning programs.

III. IMPLEMENTATION PLAN

A. Implementation Mechanisms

This RP involves five standard types of USAID implementation tools -- an institutional contract, task orders, delivery orders, activity implementation letters with GOE agencies, and a U.S. personal service contract -- plus planning for endowments to promote long-term sustainability of select service providers in Phase 2 that are expected to be fully privatized during the course of Phase 1. These are described in greater detail below. The cross-collaboration that exists among the five intermediate results will be reflected in all scopes of work under this RP to establish channels for formal linkages.

1. Institutional Contract

Core activities for the five areas of intermediate results under SO 4, POP IV, will be carried out under a competitively awarded, performance-based umbrella institutional contract. The prime contractor will provide both management and technical assistance to strengthen participating institutions and build up their technical and managerial capacity. Its tasks include the following:

- o Support for in-country training and, in collaboration with the institutional contractor under the Mission's Special Objective E, Improved Human Capacity Development System Linked to Strategic Priority Areas, Development Training II, support for off-shore participant training and observational study tours.
- o Collaboration with the institutional contractor responsible for a Non-Governmental Organization Service Center under Strategic Objective 3, Increased Citizen Participation in Public Decision Making, to extend support to NGOs engaged in family planning/reproductive health services.
- o Management of (1) non-contraceptive commodities procurement, (2) subcontracts for innovative commercial marketing including advertising campaigns for private sector initiatives, (3) grants for innovative approaches to service delivery, and (4) a CPA firm conducting financial oversight of the RP's activities.

Under this umbrella approach, most long-term technical specialists will function across IR activities to ensure consistency of approach and of systems throughout, rather than be assigned to specific institutions. Expatriate advisors will in all cases have Egyptian specialists as partners in order to transfer skills. Each activity

will be supported in country by a locally hired, full-time activity coordinator who will be responsible for organizing technical assistance and providing day-to-day management support.

There will be substantial representation by Egyptians as technical advisors. The following types of U.S. resident advisors and/or partner Egyptian advisors are envisioned.

- Strategic Planning Specialist
- Evaluation Specialist
- Management Specialist
- Management Information Specialist
- FP/RH/QA Specialist (OB/GYN)
- Training/Curriculum Development Specialist
- IEC/Demand Creation Specialist
- Commercial Marketing Specialist
- Business Development Specialist

The following is the tentative schedule for procurement of the institutional contract:

Completion of draft SOW and budget	August 1997
Finalization of SOW and clearance	September 1997
Submission of PIO/T to D/PROC	September 1997
Solicitation issued	December 1997
Proposals received	February 1998
Technical evaluation completed	March 1998
BAFO, selection, negotiations completed	April 1998
Contact awarded	April 1998
Contractor start-up	May 1998

The institutional contract under POP/FP III has been extended to July 31, 1998, to provide a transitional period of two months overlap between the closure of the existing I/G&S (Institution/Goods & Services) contractor and the arrival of the second.

2. Task Orders/Delivery Orders

Specialized technical assistance requirements which go beyond the scope of the I/G&S contract will be secured through task orders/delivery orders under contracts managed by the USAID/Washington Global Bureau's Family Planning Services and Research Divisions, Center for Population, Health and Nutrition. A number of task orders/delivery orders are currently in place and effective through July

31, 1998, providing assistance in the following areas:

- Technical assistance to conduct policy analysis, including marketing studies and research to produce policy-related data. Technical support will also be provided for the development and implementation of a Policy Environment Score (PES), a modified Lapham Mauldin scale which will be administered annually to assess the policy environment surrounding the Egyptian national family planning program. It will also quantify improvements in Population Policy Reform, the annual indicator under I.R. 4.2.3, Improved Policy Environment. A resident policy advisor will be provided to oversee all policy-related activities. (The POLICY Project, 936-3078)
- Technical support is provided for the planning and delivery of the 1995 EDHS includes annual monitoring of selected EDHS indicators. (Egypt Demographic and Health Surveys, 936-3023 until August 1998, to be replaced by MEASURE Project).
- Technical assistance is being provided to expand and strengthen the integration of post-partum and surgical contraception for medically indicated reasons in the national family planning program. (Program for Voluntary and Safe Contraception, 936-3068).
- Support is provided for the evaluation of Population Family Planning III and other related activities. (Population Technical Assistance, 936-3024).
- Ongoing technical assistance is provided to further enhance MOHP capacity to project program contraceptive commodity needs, to procure required commodities, and to effectively manage storage and distribution of commodities. (Family Planning Logistics Management/Centers for Disease Control, 936-3038).
- Support in operations research design and implementation continues to identify innovative solutions to FP/RH service delivery issues and provide critical direction to national program strategies and approaches. (Strategy for Improving Service Delivery/Operations Research, 936-3030 until January 23, 1998, to be replaced by Frontiers Project).
- Selected contraceptive commodities are procured and shipped through this central procurement mechanism to provide continuing support to national family planning program needs. (Central Contraceptive Procurement, 936-3057).

Contracting for deliver orders under POP IV would begin around April 1998.

3. Activity Implementation Letters (A/ILs) to GOE Agencies:

A/ILs will be used to finance local costs for several implementing agencies, including the MOHP, SIS, NPC, CSI, and RCT. These include administrative costs (e.g., non-GOE activity personnel, transportation, office supplies); training costs (e.g., honoraria, travel, per diem, training materials); IEC (e.g., materials, promotional displays, media presentations); rent and renovations. A justification to use these funds under USAID's "Buy America" policy is not expected in that the individual transactions should fall under one of several exceptions in A/ILS 311, Local Procurement, most notably: commodities and services which are available only locally; professional services contracts estimated not to exceed \$250,000; and commodity transactions estimated not to exceed \$5,000. A/ILs for local activities will be developed during the first quarter of RP implementation.

4. US PSC:

A U.S. Personal Services Contractor will be competitively selected to assist in management, implementation and monitoring responsibilities under this RP. The US PSC will serve as a liaison between the institutional contractor and the RP Team, with an office in the Population Division of the Office of Human Development and Democracy. The individual will establish coordination mechanisms and collaborate closely with activity managers under other SOs that support activities contributing to POP IV to ensure that linkages are maximized where feasible. Examples include the Health Policy Reform Results Package under SO 5, Sustainable Improvements in the Health of Women and Children, which will be used to leverage policy reforms supporting the family planning program; the NGO Service Center under SO 3, which will contribute to institutional and service delivery strengthening under grants to family planning-related NGOs; and Development Training II under SpO E, which will support SO 4 participant training and observational tour needs. Contracting for this position will begin about January 1998.

5. Endowments or Other Sustainability Mechanisms

The Clinical Services Improvement Project and Regional Center for Training are, respectively, service and training providers developed with USAID support in collaboration with the GOE. They increasingly operate in a private sector context. Over the course of Phase 1 of POP IV, as these institutions grow stronger, USAID will encourage the GOE to change the status of these entities to allow them to

operate legally as private not-for-profit firms. If successful, and the firms maintain strong track records for a reasonable period, to be determined by objective studies, endowments would be considered during Phase 2 to reinforce their sustainability and allow them to expand their services more easily to meet growing future demand promoted under the RP.

B. Management Plan

1. Membership, Roles and Responsibilities of the RP Team: In keeping with the cross-cutting design of this RP, the responsibilities of the team members noted below apply to all five intermediate result areas.

a. USAID/Egypt Team Members:

Core Team: This RP will take 100% of the time of three USDH population officers, one US PSC for technical/management support, one FSN medical advisor, one FSN technical/financial analyst, one FSN advertising/marketing specialist, one FSN social scientist/economist, and three FSN administrative support staff. About 25% of the USDH program development officer, 20% of the USDH procurement officer, 10% of the USDH legal advisor, and 20% of the FSN financial analyst will also be required.

Expanded Core: 25% FTE of USAID/Egypt Office of Health staff, 5% of the FSN economic analyst, 5% of the FSN Data Management Specialist and 2% of the USDH private sector officer.

b. USAID/Washington Members: Extended Team: 10% of a population officer from the Global Bureau's Center for Population, Health and Nutrition.

2. Management Burden:

A process to reduce the management burden of the Mission's family planning portfolio began several years ago under POP III when 24 activities were consolidated into 8. POP IV furthers that process by clustering activities under five categories of intermediate results, all of which will be managed by one umbrella institutional contract.

Implementation under SO 4 will be limited to one results package, POP IV, and obligated under a single Strategic Objective Agreement. To the extent

possible, obligating agreements and contracts will be set up to be easily extended to accommodate the anticipated extension into the five-year second phase.

A US PSC who assists the Mission in management, monitoring and contract support continues under POP IV. The levels of effort for all SO/RP team members listed under paragraph B.1.a., above, are reasonable and sufficient for SO/RP management. No reduction is envisioned over the near term.

As a result of the Mission's long involvement in this sector, and the skills that have been built up in partner organizations, more work is being turned over to partners and to Egyptian specialists involved in contract support.

3. Budget Constraints Due to "Metering"

For the last two years, USAID population activities have been hampered by U.S. Congressional restrictions on funding obligations. The effect of the required cuts and slow parceling out of funds in many small increments ("metering") has been to make population assistance more management intensive and to reduce the scale of activities. If the metering requirements continue into the future, they will negatively affect the POP IV RP to an extent that cannot be determined and factored in at this time. The impact of metering, should it continue, will be assessed and adjustments made, as necessary, during the course of implementation.

C. **Performance Monitoring Plan**

The results, indicators and monitoring for this RP are those indicated in the Results Framework for SO 4, Reduced Fertility, Annex A. Annual surveys will be conducted to provide early measurement of indicators and to provide more useful backup for the four year Egypt Demographic and Health Survey, as proposed in the March 1997 Results Review and Resource Request Report. The annual surveys, carried out in collaboration with the SO 5 Team which is also dependent on the EDHS, will collect basic data on fertility, family planning, and maternal and child health to monitor progress and improve assessments of future impact based on more current data.

Annual work plans will also be developed for each activity to measure other dimensions of progress in greater detail for lower level intermediate results and for management purposes.

IV. ANNEXES

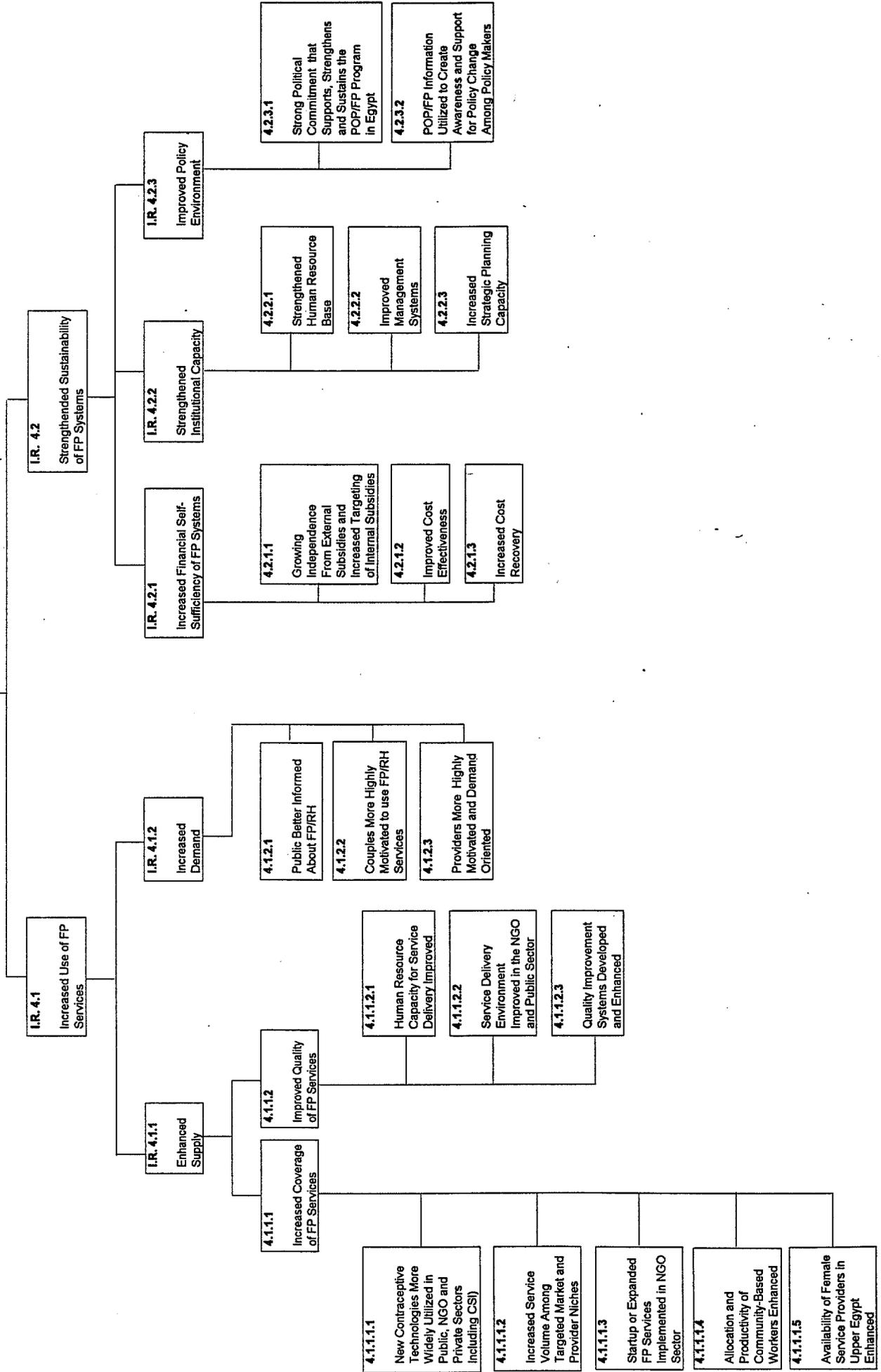
- A. SO Framework
- B. Technical Analysis
- C. Economic Analysis
- D. Institutional Analysis
- E. Initial Environmental Evaluation
- F. Congressional Notification
- G. Statutory Checklist
- H. Bibliography of Studies and Analytical Sources

ANNEX A

SO Framework

S.O. # 4: REDUCED FERTILITY

STRATEGIC OBJECTIVE 4
REDUCED FERTILITY



ANNEX B

Technical Analysis

TECHNICAL ANALYSIS

Introduction

This annex provides the technical basis and rationale for the approach proposed in this results package. The analysis is organized by the five intermediate results, which, according to the SO4 Strategic Framework, are judged to be necessary and sufficient to accomplish SO4, Reduced Fertility. The FP/RH Results Package is specifically designed to build upon USAID experiences worldwide and the recent experiences, particularly the successes, of the previous POP/FP III project, but with a more concentrated, and ambitious approach. Like its predecessor, POP/FP III, the new RP will continue with the most effective activities such as the MOHP SDP clinics, CSI, and RCT, while adding new interventions, such as medical school curriculum, operational grants to NGO's and long-term training to young leaders, to achieve even greater impact. The overall objective of the activities is to make a substantial contribution, materially and technically, to achievement of the SO goal of Reduced Fertility.

The Technical Analysis of the previous POP/FP III project provided a comprehensive assessment of the stage of growth, challenges, partners, and opportunities for the national family planning program in Egypt for the period 1995-1997. Many of the findings, conclusions, and recommendations remain applicable to the issues under consideration in the current results package design. Therefore, this technical analysis will begin by re-examining and updating the program status, analyze new challenges, and examine briefly how they will be addressed in the RP. The analysis is based upon new information from the Egyptian DHS-95, the midterm evaluation of the POP/FP III project, and other recently conducted studies.

Background

According to the framework presented in Family Planning: Preparing for the 21st Century, Egypt can still be regarded as a **Consolidation** Country, which means that the prevalence of modern contraceptive method use is in the range of 35 to 49 percent (48%, EDHS-95). While the country is considered to be in a consolidation phase of growth, USAID assistance to the Egyptian national family planning program is in a **Sustainability** phase, i.e., assistance that emphasizes the conditions for permanent financial and institutional sustainability and the eventual phase-down of USAID support.

Currently, Egypt faces a number of challenges, including the 1995 EDHS data revealing that the national program has leveled off at a CPR of 48%; overall demand for FP has declined; and a decline in commercial private sector services. In addition, Egypt faces the primary challenge of a consolidation country, which is to increase segmentation of market niches so that all resources - public and private - can be used most effectively. This is a critical period in the Egyptian national family program with growing concern at finding strategies to "blow the population plateau", while at the same time decrease reliance on donor assistance and increase financial autonomy either through cost recovery or internal GOE subsidies.

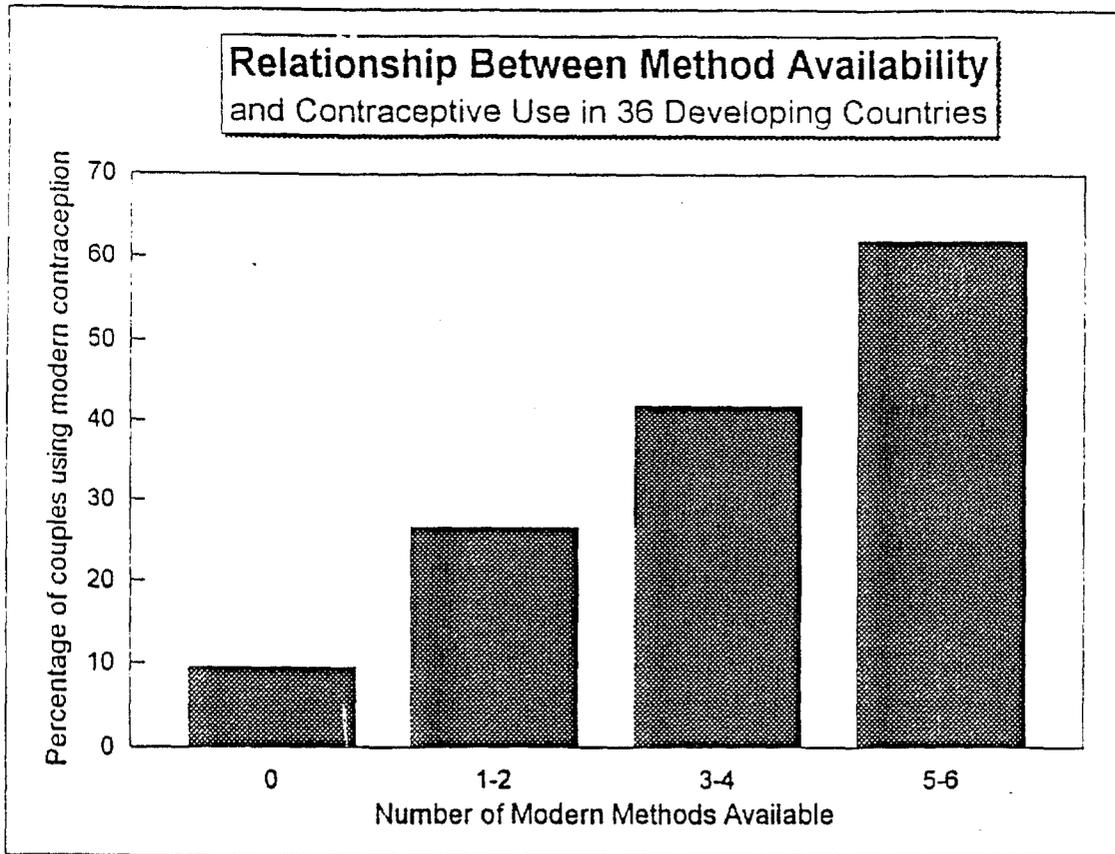
With these factors as background, the proposed activities in the results package will be analyzed in relation to the expected achievement of their corresponding intermediate result.

Constraints to Enhancing Supply

o *Quality of Services Supplied.* Despite much progress, the principal barriers to access remain those related to quality of services rather than cost or distance. Data from Upper Egypt show that clients generally by-pass MOHP FP units to seek higher quality services at NGO clinics, where service fees are about five times that of the MOHP (USAID Midterm Evaluation, 1995). An important quality issue involves provider bias toward IUDs: Egypt remains a two method country, with IUDs and pills the primary methods (63% and 22%, respectively, EDHS-95). Twelve percent of all Egyptian users stopped use because of side effects or health concerns. This suggests the need to make additional methods (injectables, progesterone-only pills, and NORPLANT) more widely available to clients throughout all sectors -- public, private commercial and NGO. Cross-country studies (Figure 1) indicate that widespread availability of even one additional contraceptive method is associated with an increase in national contraceptive prevalence of up to 12 percentage points (Ross, JA, 1989).

Clearly, improving the method mix and method availability has the potential for substantial impact on contraceptive prevalence. Expanding the method mix and other service quality issues, such as counseling and infection control, are being addressed through the Quality Improvement Program (QIP) under POP III. The POP IV RP proposes to increase beyond the current POP/FP III project to expand the availability of such contraceptive technologies as PPIUDs, NORPLANT, Depo Provera injectables, tubal ligation for medically indicated reasons, and progesterone-only pills across all sectors.

Figure 1



From: Ross JA et al. Management Strategies for Family Planning Programs. New York, Center for Population and Family Health, 1989.

The RP design also features new initiatives intended to improve the quality of FP/RH services provided and broaden the reach of family planning. Among the activities are: expansion of FP/RH services as part of normal hospital post-partum care, including initiation of a 40th day post-partum follow-up care program, and enhanced cross-referrals of MCH outpatient clients to strengthen the MCH/FP linkages. Lessons learned in Egypt and elsewhere strongly suggest that appropriate linkages of FP/RH and MCH services will lead to greater impact on the lives of women and children.

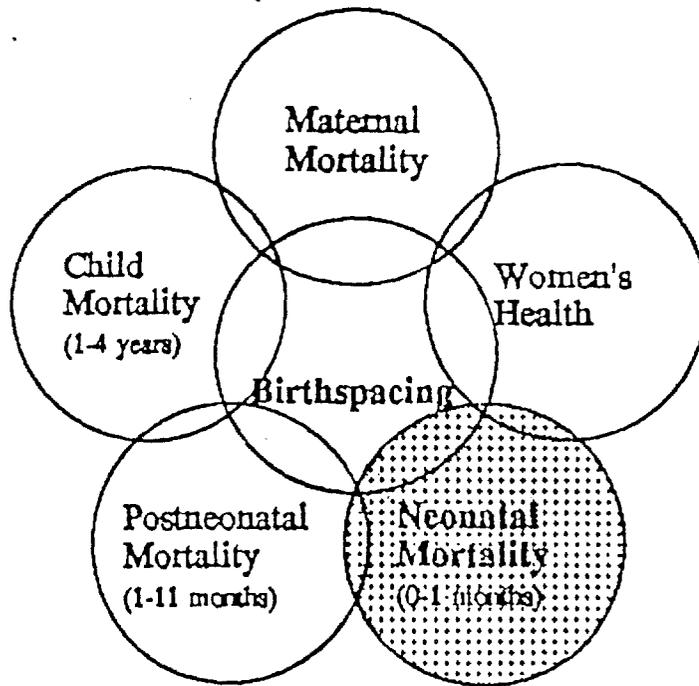
o *Limited Service Outreach to Young Women of Low-Parity in Need of Birthspacing.* To date, services designed to reach young, low-parity women in need of birth spacing services have been limited. The potential health impact of birthspacing is considerable. In Egypt, where 26% of non-first births occur after an interval of less than 24 months of the previous birth, infant mortality could be reduced 37% if all births were spaced 24 months or more (EDHS-95). Birthspacing's greatest impact is on neonatal mortality (Macro, 1996) (Figure 2). In Egypt, neonatal mortality constitutes slightly more than half (51%) of infant mortality (EDHS-95).

Improved birthspacing through effective use of modern contraception will also contribute to lowering Egypt's relatively high maternal mortality ratio (estimated at 174 per 100,000 live births, with the ratio for metropolitan Egypt even higher at 233) due in part to unwanted pregnancies. Twenty percent of maternal deaths occurred among women with unwanted pregnancies or reported contraceptive failure (National Maternal Mortality Study, 1994). Nineteen percent of hospital OB/GYN clients are admitted for treatment of abortion complications (POP Council, 1995).

Activities identified under the new RP seek opportunities for reaching young, low parity women, especially through linkages with MCH programs and use of the Ra'aidat Rifiyat, community family planning health workers. Egypt's MCH infrastructure for immunization, high child immunization rates and percentage of births occurring in public hospitals (35%) suggest opportunities for reaching women in need of birth spacing. One-third of Egyptian unmet need (of total unmet need at 16%) represents women in need of spacing services. Under the POP IV RP, USAID should continue support for expansion of post-partum and post-abortion pilot programs, plus the Ra'aidat Rifiyat and their community-based outreach activities, initiated under POP III, and establishment of MCH/FP referral services.

o *Limited Utilization of Supply Channels/Outreach to Disadvantaged and Hard-to-Reach Groups.* USAID experience worldwide indicates that the greater the number of service delivery channels, approaches, service delivery points, and types of providers used in a program, the greater the likelihood of increased contraceptive use (USAID Synthesis Report, 1997). To date, family planning services have been less used

Figure 8 - Health Impact of Birthspacing: Greatest Impact on Infants 0 - 1 Month in Age (Neonatal Mortality)



Birthspacing has an impact on:

- Neonatal mortality - excess mortality risk associated with birth interval < 24 months is 116%
- Postneonatal mortality - excess mortality risk associated with birth interval < 24 months is 67%
- Child mortality - excess mortality risk associated with birth interval < 24 months is 32%
- Maternal mortality - due to reduction of unwanted pregnancies/abortion and high parity births
- Women's health - due to reduction of maternal depletion resulting from too closely spaced births*

* *DHS Comparative Studies: Infant and Child Mortality*, Macro International, August 1996.

Prepared by: USAID Office of Population, Family Planning Services Division

among disadvantaged and hard-to-reach groups. In rural Egypt and rural Upper Egypt, 59% and 76%, respectively, of currently married women are not current family planning users. These percentages reflect the supply as well as the demand for services. Egypt is beginning to expand the kinds of outreach programs that have contributed to high contraceptive prevalence rates elsewhere (e.g., in the successful Tunisia and Thailand programs, mobile units and teams were key contributors to program achievements; and community-based outreach and distribution programs were critical for achieving relatively high contraceptive prevalence rates in many countries).

It is important for USAID support for community-outreach and mobile teams, initiated under POP/FP III, to expand under the new RP. Also, training support for female and male Ra'aidat Rifiyat to function as FP/RH outreach workers linked to service delivery centers should also be continued. The new RP support for the training of high school women at district nursing schools in underserved areas with the goal of increasing the availability of nurses in underserved areas is likely to have high impact on the quality of FP services. It should be noted that these activities are designed with a built-in phased sustainability plan whereby the GOE is expected to assume the responsibility during the RP life.

Other channels, such as operational grants to NGOs to initiate or expand their family planning/reproductive health services, also appear to provide a flexible resource to reach the underserved.

o *Limited Services To Address Medical Indications for Permanent Contraception.* To date, services to address medical indications for permanent contraception have been limited. Voluntary surgical contraception (VSC) for medically indicated reasons has not been widely available in either the public or the private sector. In fact, use of VSC among all users declined between 1988 and 1995, from 4 to 2.3%, respectively. Yet two-thirds of unmet need for family planning in Egypt represents need for limiting services. Sixty-five percent of births to women age 40 and older are unwanted (EDHS-95). Global experience indicates that many countries move to high levels of contraceptive prevalence only after voluntary sterilization has become widely available (e.g., Mexico, Tunisia) (Ravenholt and Russell, 1993). Under the POP IV RP, USAID support for the expansion of a pilot program (initiated under POP/FP III) to increase the availability of tubal ligation for medical indications will have a greater effect, particularly as the pilot program extends across all sectors (i.e., public, NGO, and private).

o *Availability/ Quality of Services Supplied through Private Commercial Sector.* In Egypt, the private commercial sector is the most important source for contraceptive supplies. Sixty-three (63%) of users obtain contraceptives through the private sector

(EDHS-95). However, private providers and pharmacists lack accurate and up-to-date knowledge of modern contraceptive methods and their health benefits. In addition, GOE price controls inhibit imports and sales and contribute to the disappearance from the marketplace of contraceptive products already approved. Pharmaceutical companies have declined to introduce new technologies in Egypt and parastatals have refused to supply retailers with low-dose oral contraceptives due to financial losses. Yet research indicates that IUD users would be willing to pay "considerably more" and injectable users would be willing to pay "more" for contraceptive commodities (EDHS-95). Other studies have also documented a willingness to pay more for IUDs (Sine and Winfrey, 1995). Such restrictions on the private sector mean that the public sector will bear an increasingly large share of the cost of service delivery to rapidly increasing numbers of women of reproductive age. Under the POP IV RP, USAID's continued support to the private commercial sector of physicians and pharmacists is appropriate. The addition of a new partner, the Egyptian pharmaceutical sector that imports, supplies, and distributes contraceptive commodities should complement efforts in this area. USAID support that is closely linked with policy dialogue will further encourage the removal of restrictive regulations on importation, pricing, and distribution of contraceptives.

o *Limited Services provided through NGO Sector.* At present, only 9% of current users obtain FP services from NGOs (EDHS-95). However, NGO performance to date -- in terms of leadership, financial management, cost recovery and new acceptor rates -- suggests a greater NGO role in service delivery is warranted. For example, the USAID-supported NGO, the Clinical Services Initiative (CSI) sub-project is: contributing more CYPs per clinic than the MOHP; recovering 48% of direct costs and has a longer IUD continuation rate of 4.2 years (USAID Midterm Evaluation, 1995). The lessons learned from POP/FP II in working with large numbers of NGO's (POP/FP II) and later reducing the number of NGO's to one (CSI) under POP/FP III are important. USAID's strategic decision to continue to support to CSI in the new RP is important. The new initiative that provides support for 20 other family planning/reproductive health NGOs appears needed at this time. The phased-in grant support to NGOs that will facilitate institutional strengthening and performance-based payment for service delivery are particularly noteworthy, and should foster greater sustainability. In addition, the implementation arrangement of collaborating with a USAID-funded NGO Umbrella Project for the administrative management of the 20 NGOs coupled with the use of CSI as a technical resource/advisor should minimize the management burden on USAID while encouraging additional linkages among the NGO community.

Constraints to Increasing Demand

o *Contraceptive Prevalence/Infant Mortality Plateau -- Leveling Off of Demand for Family Planning.* Between 1980 and 1995, contraceptive use in Egypt doubled from 24 to 48 percent. During the 1980s, the pace of change was rapid, yet it slowed significantly in the 1990s, with virtually no change occurring in the use rate during the period 1991-95 (EDHS-95). Reduced demand for family planning may be having important health consequences. Since birthspacing is the most important demographic variable related to child survival, the leveling off of demand for family planning may be contributing to the recent plateauing of infant and neonatal mortality rates. For the period 1991-95, the infant mortality rate is estimated at 63/1000 live births compared with 62 for the period 1988-92 (EDHS-95). Under the POP IV RP, a wide range of strategies will be employed to address the leveling off of demand, especially by increasing focus on hard-to-reach and underserved areas as noted above under Enhanced Supply. The RP design features include substantial strengthening of the MOHP IEC effort through IEC officer training and greater strengthening and involvement of MOI local information centers; the training and deployment of 5,000 community outreach workers (Ra'aidat Rifiyats) and the greater use of mobile teams. Strengthened counseling on the advantages of birthspacing for both mother and child, along with MCH and FP/RH linkages should increase demand for both family planning and MCH services.

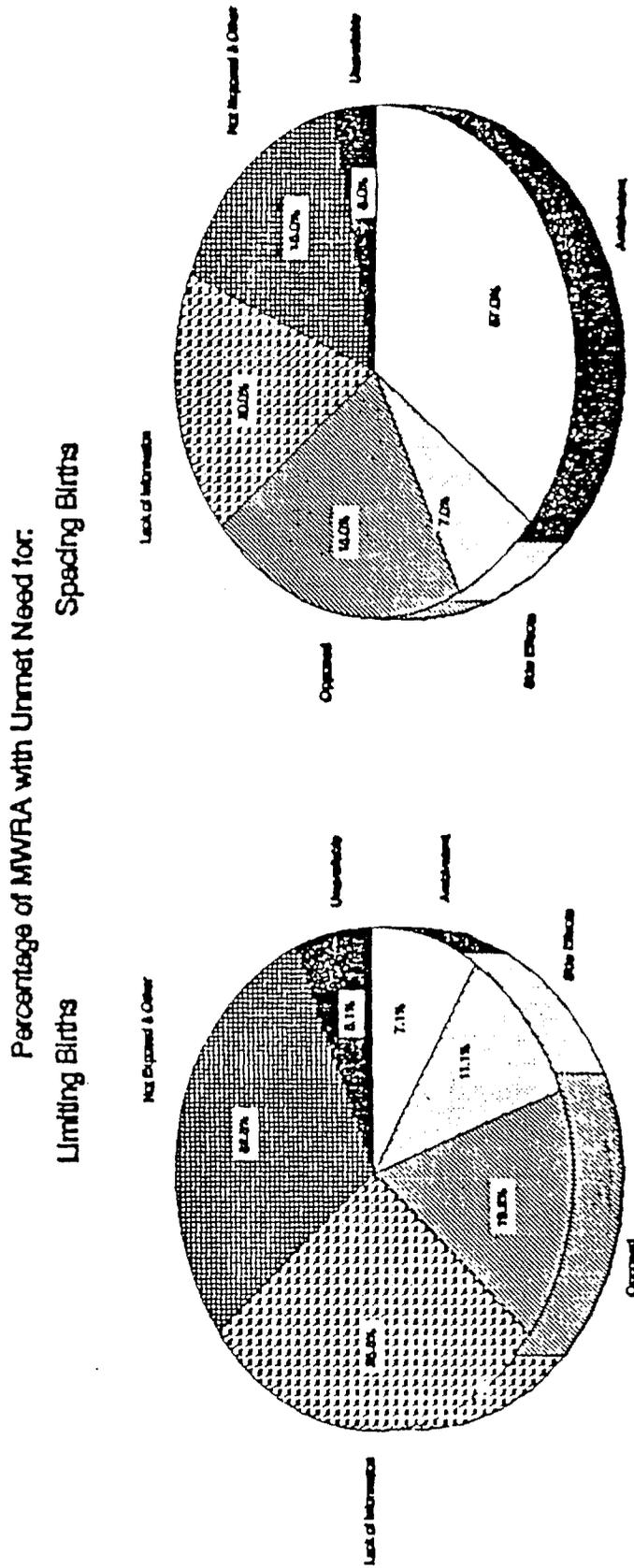
o *Variation in Demand by Residence.* In the 1990s, the upward trend in use rates slowed significantly in both urban and rural areas. Between 1992 and 1995, virtually no change occurred in current use rates in urban areas, and use rates increased by only 2 percentage points during the period in rural areas. With respect to trends in use by governorate between 1992-95, substantial increases in use occurred in only 2 governorates, and less significant increases (2-5%) occurred in five governorates. Use rates remained virtually unchanged or decreased slightly in most of the other governorates, with the exception of Assiut, where there was a significant decline from 28 to 22% (EDHS-95). The lessons learned from the current POP/FP III project strongly suggest continued focus on motivating couples in areas of underserved or hard-to-reach communities, and certain demographic groups such as young women of low parity. The focus of the new RP design on addressing the needs in these areas through a multi-faceted approach of: enhanced quality services, linkage with MCH services; strengthened training of outreach workers; increased public information about FP/RH; and emphasis on niche groups of influentials (such as husbands, illiterates, grandmothers and service providers) appears technically sound and strategically responsive to increase demand.

o *Lack of Knowledge about Family Planning's Contribution to Infant and Maternal Health.* Contributing to low demand for family planning and reproductive health services is a pervasive lack of understanding of family planning as a health intervention to reduce neonatal, infant and maternal mortality. It is doubtful that policymakers and the general public fully understand the concept of high risk fertility behavior. In Egypt, between 1990-95, 55% of births were in one risk category and 18% of births were in two risk categories. Short birth interval and high birth order were the most important risk categories, increasing the risk of child death 2.4 times (EDHS-95). Understanding of these important concepts may motivate couples to use family planning, and encourage policymakers and opinion leaders to increasingly support it. As discussed above in the previous section (Enhanced Supply), infant mortality in Egypt could be reduced 37 percent if all births were spaced two years or more.

Focus group research in Egypt indicated that both male and female participants used family planning only to stop childbearing, and not as a method to plan the family and space their children. In-depth interviews with uneducated women indicated that they "never considered the use of contraceptives for spacing their children". Yet the same women seemed to recognize the relationship between many pregnancies and health. The majority of female focus group participants included deterioration in health as the primary motive that influenced their desire for no more children (Macro Qualitative Study, 1996). This research suggests the importance of seeking opportunities to educate both men and women about use of family planning for health purposes. The importance of a strong education and information program is demonstrated by a recent analysis of EDHS data in 36 countries. This analysis (Figure 3) showed that "lack of information" rather than "lack of access" is the *principal reason* that women with unmet need for family planning remain non-users. Under POP IV, IEC activities appropriately focus on increasing opinion leaders, policymakers, service providers, clients' and non-clients' understanding of family planning as a health intervention that saves women's and infants' lives, and providing accurate information about family planning and reproductive health. Developing a public-private partnership for preparing and implementing a national IEC strategy, and undertaking private sector market research to identify the particular concerns and interests of special population groups (males, adolescents, young low-parity women, other) should also be activities pursued under the POP IV RP.

o *Inaccurate Knowledge and Myths and Rumors about Family Planning /Lack of Information for Side Effect Management.* Many physicians and pharmacists have minimal, outdated and/or incorrect knowledge about family planning. A 1996 study of injectable use showed that over half of the physicians, nurses and midwives believe that the injectable should be used by women who want to limit childbearing since it

Figure 3. Distribution of Main Reasons for Not Intending to Use Contraception Among Subgroups of Women with Unmet Need in 24 Countries Surveyed by the DHS



Note: Unweighted averages for 24 countries, 1990-94
 MWRA = married women of reproductive age
 Source: Westoff & Bankole 1995 (234)

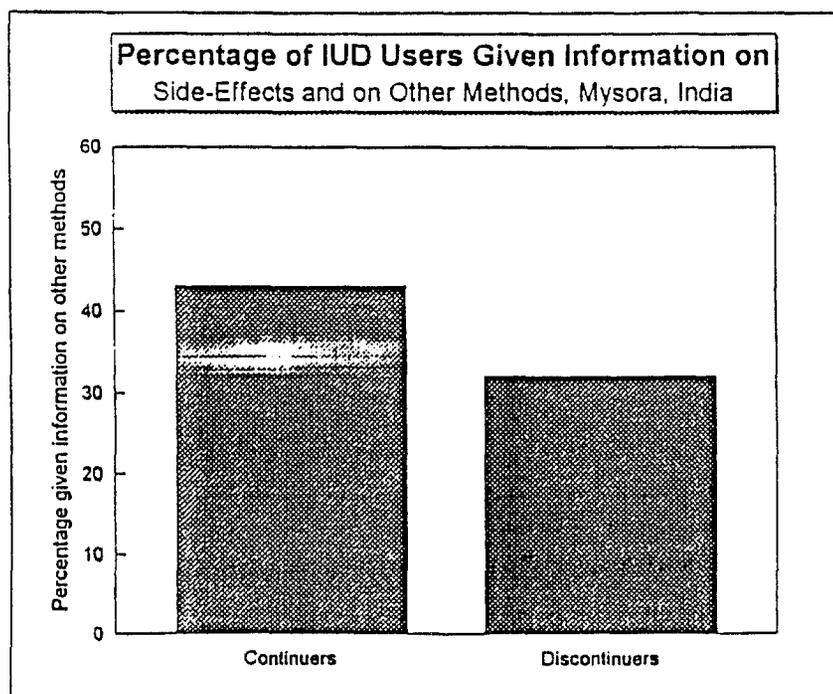
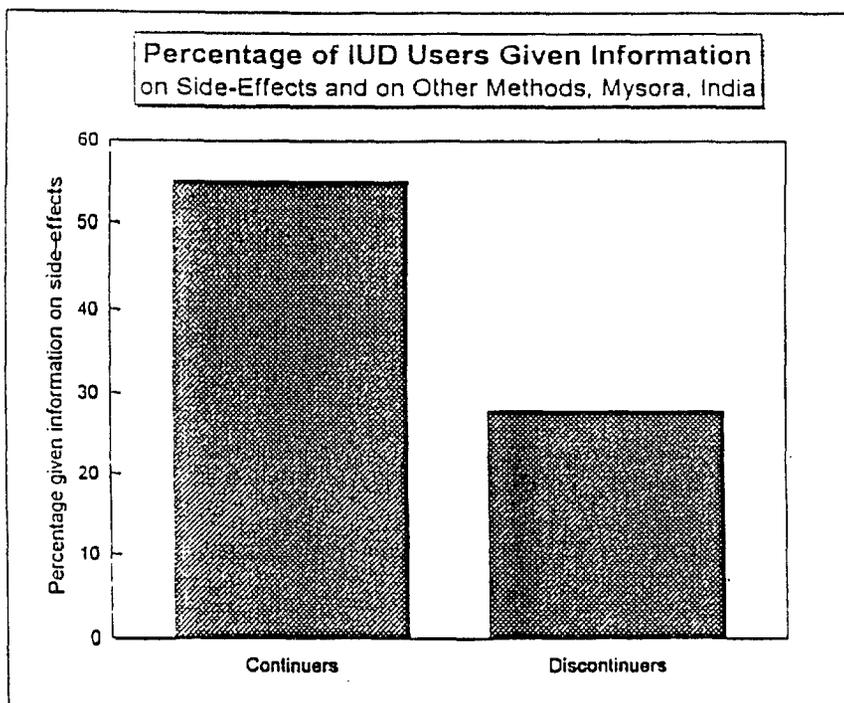
Adapted from *Population Reports*
 Series J, Number 43, September 1996

55

causes infertility. A 1992 survey of pharmacists found that many believed oral contraceptives cause cancer. Rumors about Norplant include that the method causes cancer, diabetes, infertility, paralysis and heart problems and that it moves around inside the body. Such rumors are heard not only by clients, but also from physicians (Ravenholt and Russell, 1993). The same survey found that only half of the physicians in the survey discuss side effects with their clients. Yet research indicates that contraceptive use can increase from 30% to 55% when clients are given information about side effects and other methods (Ross et al, 1989). Figure 4 illustrates the potential for impact on contraceptive prevalence of including information to clients about side effect management. Under POP IV, considerable strengthening of messages and education is planned in order to provide accurate information about family planning and reproductive health, to combat myths, rumors and misinformation, and to ensure improved counseling by public and private providers. The design strategy of using a commercial mass media advertising and marketing firm to augment the MOHP and MOI public media efforts will be costly and is not sustainable. However, given the plateau and need to rejuvenate the national FP program effort, a large scale, private sector media campaign is worthwhile and should, in fact, revitalize and "sell" family planning to a sluggish market.

o *Men's/Women's Attitudes, Woman's Status and Cultural Values.* Cultural values in Egypt tend not to favor use of family planning, as much value is attached to a woman's continued childbearing until the family has at least one son. The culture also attaches much value to female privacy; 31% of males nationwide disapprove of their wife seeing a male doctor. This percentage increases to 36% in rural upper Egypt. With respect to woman's status, an Egyptian woman's autonomous decision-making authority is severely circumscribed, a fact which influences her acceptance or non-acceptance of family planning. Three-quarters of Egyptian woman have not selected their own spouse and, in keeping with the patriarchal tradition, more than half of all ever-married women move in with their husband's family immediately after their first marriage. Woman's freedom of movement is restricted in many ways. Only two-thirds of women are permitted to go alone to the local health center; most of the remainder have to be escorted there by another adult. Visits to friends or relatives are possible for 37% of women only if they go with another adult. Over one-third of women are not permitted to go out all for recreation in the neighborhood. In rural upper Egypt, almost 40% of women need to be accompanied by another adult or cannot go at all to the local health center or doctor (EDHS-95). Global experience indicates that community based outreach, education and distribution, are critical in situations in which woman lack autonomy and in which traditional cultural values support high fertility. Under POP IV, a variety of new community outreach programs are considered, including the community FP outreach workers, mobile teams, IEC officers at Local Information Centers, and increased support to the NGO community

Fig. 4



From: JA et al. Management Strategies for Family Planning Programs. New York, Center for Population and Family Health, 1989

57

to work especial in rural and peri-urban areas where public sector services are less available. Also, USAID's continued support to CSI, in which 99% of the physician staff is female is important. A large percentage of MOHP mobile teams, also to be supported by USAID, is staffed by female physicians.

o *The Minya IEC Initiative.* The Minya IEC Initiative was an intensive governorate-wide public and NGO sector campaign managed by the MOI Local Information Center and the National Population Council. It aimed at coordinating interagency resources, training local opinion leaders, and using local media. Contraceptive prevalence rose eight percentage points at the end of the specially funded activities (USAID Midterm Evaluation, 1995). The 1992-93 Minya Initiative demonstrates the potential positive impact of a well-organized IE&C effort in an environment in which demand is low, and suggests that continued USAID investment in demand creation activities merits considerable support. It is also a lesson learned about the importance of activities that are, by design, sustainable. Given the status of the national FP program, the population plateau, and history of USAID assistance in the sector, the POP IV RP appears to correctly balance the need for an appropriate response to the population challenges with activities that reflect USAID's interest in strengthening the sustainability of Egyptian partners.

Constraints to Increasing Financial Self-Sufficiency of FP System

To achieve the intermediate result of increased financial self-sufficiency of FP systems, it will be necessary for the MOHP and NGOs to move away from dependence on external (donor) sources of financial assistance and towards greater financial autonomy. This means that family planning institutions will have to maximize efficiency, reduce operating costs, and increase cost recovery and revenue generation, and particularly for the public sector, shift financial responsibility to the GOE. This result will contribute to a more efficiently segmented market that will meet the demands of those who can pay and provide an adequate supply of appropriately targeted subsidized services through the public sector for those who cannot pay. Specific issues include the following:

o *GOE Financial Support for Family Planning.* Increased GOE financial support for family planning, both to the public and NGO sectors, will be an important element of any effort aimed at increasing MOHP and NGO financial self-sufficiency and reducing donor dependency. Current information gaps, however, constitute an important constraint to monitoring GOE support for FP/RH, and assisting the GOE in reaching judgements about the adequacy of such support. Generally, the MOHP has lacked accurate information on the proportion of government expenditures on various

kinds of health facilities and types of health care (DDM, 1996). A recent analysis of 1992-3 data from three governorates suggests that the level of MOH financial support for family planning during those years was low. Expenditures for family planning in Alexandria, Beni Suef and Suez were 1.20%, 1.92% and 1.17%, respectively, while expenditures for curative care in these same governorates were 51.33%, 37.69% and 39.58% (Cressman/DDM, 1996). More recently, the MOHP has pledged a 10% increase per year in support through the Health Policy Support Program, but the level of increased support for family remains unclear.

- o *External and Internal Subsidies.* Given the sustainability phase of USAID assistance, it is reasonable to work towards the phase out of USAID-donated contraceptives. The RP includes a phase-out plan for donated contraceptives, with one USAID-donated method self-financed by the GOE by the end of the 5 year RP, and five methods self-financed by the end of 10 years. This schedule appears reasonable because it allows sufficient time for contraceptive pricing policies to be addressed, GOE budget mechanisms developed, and other administrative, managerial, and logistical arrangements to be institutionalized. There are early indications that the MOHP would like to accelerate this schedule. To the extent that a more aggressive and realistic phase-out/phase-in schedule can be developed and implemented, it should be. However, it is essential that the supply of contraceptive commodities is not adversely affected during the transition.

With respect to internal subsidies, given low service utilization in Upper Egypt, and in rural areas in Egypt generally, public sector expenditures appear poorly targeted to those regions with the highest fertility and infant mortality rates, and the lowest incomes. This means that the public sector is subsidizing those groups that are able to pay for services and failing to reach the most underserved and disadvantaged. USAID should work with the MOHP to target subsidies appropriately so that subsidies support only populations such as the very poor or high-risk groups such as adolescents, for whom reductions in fertility rates have significant social payoff but who would not seek unsubsidized services. The new RP design features establishment of criteria and threshold levels for a needs-based safety net, or fee-waiver system for the poor. This system represents an important step towards appropriate alignment of the market so that public and private resources can be used most effectively. In developing a safety net, it is imperative to thoroughly analyze and project numbers of women who will fall into this category so that adequate GOE resources can be budgeted and allocated.

- o *Cost Effectiveness of Public and Private Non-Profit Sector Services.* Low service utilization rates in both the public and private sectors suggest that cost-effectiveness of family planning service provision is low. Yet family planning has been identified as one of the most cost-effective reproductive health interventions

(World Bank, 1993) and has been included as an essential element in recently developed essential packages of health services in a number of developing countries (DDM, 1996). While the NGO sector has a somewhat higher level of service volume than the public sector, suggesting marginally greater cost-effectiveness, NGO service volume, and hence cost-effectiveness, can also be improved considerably (NGO exam room utilization rates are used at 65% of capacity). More broadly, a recent study of the Egyptian health sector found that significant health resources are currently devoted to very cost-ineffective services (DDM, 1995). Activities under the Intermediate Results Enhanced Supply (4.1.1.) and Increased Demand (4.1.2) are designed to increase service volume, which in itself, will be a step toward greater cost-effectiveness. At the same time, activities under IR 4.2.1, Increased Financial Self-Sufficiency, will work to raise awareness of policymakers and opinion leaders of the cost-effectiveness of family planning as a health intervention. It will be important to develop, monitor and assess strategies for improving cost-effectiveness and operational efficiencies, in both the public and private non-profit sectors.

o *Cost-Recovery in the Public Sector.* While the MOHP, as a public sector entity, will never be fully self-financing, there is ample room for improved cost-recovery and revenue generation, which in turn will permit improved service quality and service volume, greater coverage of underserved and hard-to-reach groups, and lessen dependency on donor financing. Currently, the MOHP charges clients a minimal price for USAID-donated and other commodities. Revenues earned are used to provide performance payments to service providers, contributing to both quality and sustainability. Cost recovery efforts are important and should continue to be pursued under the new RP. However, the public sector has responsibility for serving the needs of women who cannot afford even the most modest price for services and contraceptives. It is important to recognize the role of the public sector in providing a "safety net" for poor clients. The RP proposes to introduce and pilot test a needs-based safety net. As noted above, a waiver system for indigent clients should enable the public sector to continue with cost recovery for the rest of its clients who can afford to pay modest fees for services and better segment the market accordingly.

o *Cost-Recovery in the Private Non-Profit Sector.* The success of CSI unquestionably demonstrates the potential for improved cost recovery in the NGO sector. Between 1994-95, through skilled management and the use of a range of financial management tools, CSI increased revenues by 4%, decreased expenditures by 14% and increased CYP by 7% (USAID Midterm Evaluation, 1995). CSI is using a multi-faceted strategy to increase self-financing through pricing strategies, revenue generating activities, cost-containment and other donor funding. By 1996, CSI had: increased utilization of CSI centers by 104% from the previous year; achieved 109% of actual compared to planned targets; and increased revenue through client fees by

111%, recovering 75% of centers' operating costs and 53% and 48% after including the 14 local management offices' (LMO) and headquarters' costs respectively (CSI Progress Report, Oct-Dec 1996). As with the public sector, CSI should continue to pursue cost recovery under the new RP. However, unlike the public sector, CSI has added organizational flexibility to aggressively test and pursue a variety of cost recovery strategies and cross-subsidy options.

o *Analytical capacity in the MOHP to undertake strategic planning, monitoring and evaluation of options for and progress toward financial self-sufficiency.*

Currently, the institutional locus within the MOHP for strategic planning, and monitoring and evaluation of financial self-sufficiency remains unclear. Considerable data gaps and limited technical expertise currently inhibit MOHP FP/RH financial planning and programming. Achieving the institutional capacity needed for ongoing financial analysis and strategic planning will need to become an integral element of broader institutional strengthening. Among the needed technical skills are in areas such as economic analysis, financing, accounting, strategic planning, management, marketing and sustainability, and health planning. Currently, however, the MOHP is staffed principally by physicians who lack training and experience in these areas. These gaps appear to be adequately addressed in the "Leadership Training" program and through training activities under Institutional Strengthening (IR 4.2.4). The benefit from these activities should have the carryover effect of strengthening the MOHP's capacity to critically analyze and strategically move towards greater financial sufficiency.

o *Increased FP/RH Service Provision Through the Private Commercial Sector and the Private Non-Profit Sector.* A free-market private sector is, by definition, self-financing. As part of USAID's sustainability phase, the RP should contribute to the extent that USAID can contribute to (a) an increasingly competitive market that is more attractive to contraceptive manufacturers, suppliers and distributors, through policy dialogue leading to removal or reduction of price controls, and (b) increased demand for and supply of quality FP/RH services through the private commercial and NGO sectors. USAID will contribute to the financial self-sufficiency of both the public and NGO sectors, and improve the targeting of public sector services to those most in need. Currently, approximately 50% of family planning users in Egypt are reliant on the public sector as a source for services *principally because they know of no other source of supply* (EDHS-95). Clearly, this finding indicates the need for strengthened IEC programs about private commercial and NGO sources of supply for FP/RH services. The new RP design provides proportionally more assistance to the private commercial and NGO sectors than the POP/FP III project. This shift in assistance is strategic and should contribute to additional clients using FP/RH services in these sectors.

Constraints to Strengthening Institutional Capacity

Since its inception in the 1970s, USAID population sector assistance in Egypt has worked to strengthen the national institutions that deliver or support family planning services. USAID's institutional support is broad. Currently, the following institutions are recipients of institutional-strengthening support from USAID's POP/FP III Project:

1. The Ministry of Health and Population (MOHP)
2. The National Population Council (NPC)
3. The Regional Center for Training (RCT) at Ain Shams University
4. The Teaching Hospital Organization (THO)
5. The Egyptian Pharmaceutical Trading Company (EPTC)
6. Clinical Services Improvement (CSI)
7. The Family Planning Information, Education, and Communication (IEC) Unit of the State Information Service (SIS) in the Ministry of Information.

The kind of institutional support USAID provides varies among the different organizations. Program-wide, USAID's support for institutional-strengthening has included the following inputs:

1. Training to upgrade institutions' human resources
2. Technical assistance to improve institutions' management systems, with most emphasis on improving the following managerial capabilities:
 - a. management information systems (MIS)
 - b. strategic planning
 - c. monitoring, evaluation, and research
 - d. supervision and promotion
3. Upgrading facilities
4. Commodities, including vehicles, computers, and furniture

At one time, USAID provided institutional-strengthening support to a number of family planning NGOs, but this activity proved to be excessively management-intensive and was dropped. Currently only a single NGO -- CSI -- is receiving USAID institutional support.

The Midterm Evaluation of the Population/Family Planning III Project (March, 1996) reviewed USAID's institutional strengthening activities in some detail. Some key

findings and recommendations of the midterm evaluation of the Population III project, with their implications for the Population IV Results Package, are the following:

- o Under the Systems Development Project (SDP) with the **Ministry of Health and Population (MOHP)**, USAID has upgraded a number of critical MOHP capabilities, including the Ministry's supervision, training, financial, and information systems. The midterm evaluation observes that the Population/Family Planning project has not offered sufficient long-term (master's degree) training, noting that many of the current sector leaders were recipients of U.S. long term training under previous projects. The midterm evaluation also recommends further decentralization of important MOHP administrative functions from the governorate to the district level.
- o The institutional capabilities created with USAID assistance in the **Egyptian Pharmaceutical Trading Company (EPTC)** are very efficient and fully institutionalized. The planning, importation, warehousing, distribution, and tracking of contraceptive commodities is exemplary.
- o The Institutional Development Project (IDP) at the **National Population Council (NPC)** is producing mixed results because of political conflict and uncertainties about the future of the NPC. Some NPC functions, including research and governorate-level strategic planning, are performing well but are very dependent on USAID support. Other functions, including the TA8 data entry mechanism and public information about population, are not getting good results. The midterm evaluation noted "management weaknesses due primarily to low levels of skills, interest and commitment on the part of NPC senior staff."
- o "CSI" -- the family planning NGO model established with USAID support -- was successfully increasing its clientele while recovering a growing portion of its costs.
- o The **State Information Service's information, education, and communication (SIS/IEC)** program is successfully reaching almost all of the population of Egypt. The evaluation recommended a number of technical improvements -- especially increasing interpersonal communication activities in Upper Egypt -- to increase the impact of SIS/IEC.

The **1995 Egypt Demographic and Health Survey (EDHS)** also had important implications for the design of the Population IV Results Package. A few representative implications for institutional strengthening activities are:

- o Existing institutional arrangements are not responding well to the needs of urban clients. Urban use of family planning has stagnated, while the urban population of Egypt is growing rapidly.
- o The share of services provided by commercial private sector providers has declined, while the share of services provided by the government appears to have increased.
- o Deficient counseling services offered by providers are leading to harmful rumors and discontinuation.
- o Users are willing and able to pay providers for services.

Response

Under the Population IV Results Package, USAID will continue to work to strengthen Egypt's key family planning institutions. Much of the kind of work that has been undertaken by previous projects will be continued, but with shifts in emphasis. Overall, the following will be emphasized under the Results Package's activities:

1. Decentralization: Institutions will be encouraged to decentralize planning, management, and administrative functions to governorate, district, and local levels within their hierarchies.
2. Sustainability: Assistance will concentrate on reducing the role of outside expatriate technical assistance advisors in national family planning institutions and increasing the role of indigenous Egyptian technical assistance.
3. Middle level management: Assistance will focus on deepening the managerial capability of family planning institutions, with emphasis on helping create and establish young managers skilled in modern management techniques to prepare for future leadership.

Major progress has been made in creating institutional capacity in family planning service delivery through the SDP Project. The task ahead is to sustain the gains achieved and further expand and improve services. Such progress has been achieved through development and use of management systems. These systems include supervision, contraceptive logistic management, facility and equipment management, training, MIS, and IEC. These systems will require strengthening for a number of reasons: (1) addition/expansion of services such as a national post-partum IUD

program, post-abortion care, and MCH/FP referral system; (2) addition of community-based health workers linked to the health unit level, and (3) decentralization of systems from the governorate to the district level. Strengthened institutional capacity in these areas will contribute to the sustainability of quality public sector family planning services.

The MOHP's FP/Reproductive Health Sector has the overall responsibility for planning, coordinating and ensuring the quality of family planning services for the public, NGO, and private sectors. Such planning and coordination normally occurs at the Central Level with involvement of the various partners. The Governorate Family Planning Director is responsible for planning and coordinating family planning service delivery activities within the governorates. Given the new responsibilities and structure, further strengthening of capacity is both desirable and possible.

The MOHP also has the responsibility for ensuring the availability of contraceptive supplies nationwide in the public sector. Since 1983, USAID has been the principal donor of contraceptives commodities to Egypt. Additionally, technical assistance has been provided for the contraceptive planning and management resulting in a well-developed MIS for contraceptive logistics. Building upon this base, MOHP should move closer to contraceptive self-reliance during the RP period. USAID will phase out one USAID-donated method by the end of project year 5 through a jointly agreed upon plan. Concurrently, technical assistance will be provided to institutionalize the MOHP's capacity to phase in, manage and procure contraceptives. The contraceptive MIS would be a part of overall POP/FP Sector's MIS.

Despite substantial progress in many areas, however, sector systems for planning and coordination and technical skills are not fully developed. To accomplish this, the sector will require a comprehensive yet simple, timely and accurate management information system for service delivery. Through the MIS and strategic planning training/workshops, both the Governorates and Central Office would develop the capacity for region and national specific plans. Such plans should allow for maximizing resources and flexibility to response to opportunities and needs.

Constraints to Improved Policy Environment

Traditionally, the GOE had charged two organizations with responsibilities for population and family planning/reproductive health (FP/RH) policy. These have been the National Population Council (NPC) and the Ministry of Health (MOH). In the continuum of population and FP/RH policy, the NPC had traditionally worked in the areas of gaining high-level support, intersectoral collaboration and advocacy, and

coordination and strategic direction. The MOH has traditionally implemented mandated health policies (i.e., policies about pharmaceuticals, prescription requirements, credentials, licensing, regulation of the private sector, and more) and set policy for the programs and services which it delivers.

In early 1996, these traditional alignments changed. The Ministry of Health took on certain responsibilities for population and has become the Ministry of Health and Population (MOHP). While the responsibility for service delivery is clear and consolidated in the MOHP, other roles, responsibilities and coordination mechanisms remain unclear between the two organizations. The MOHP is also in the process of establishing the strategic directions for the newly-configured sector.

The policy challenge becomes one of creating an effective policy apparatus in the aftermath of the change, with well-defined responsibilities, well-configured staffs, and staff members functioning at policy formulation and implementation. There are numerous policy issues which this apparatus will have to address, including the plateauing of program growth, new strategies to serve the urban areas and Upper Egypt, demand, service integration, the role of private sector and NGO service providers, contraceptive sustainability, and contraceptive pricing and cost recovery.

Key Policy Issues

There are two types of key policy issues. First are policy capacities, that is, the organizations responsible for policy and their capability to formulate policy and advocate reform regardless of the specific policy issue. Second are the thematic policy issues themselves. In this section the policy capacities and issues are briefly described. In the following section the links between these issues and USAID/Cairo's strategic results framework are reviewed.

Policy Capacities

o *Clarifying roles and responsibilities.* There is a need to clarify the roles and responsibilities of the organizations involved in population and FP/RH policy. What part of the policy canvas the MOHP really wants to work in needs to be determined. The corresponding part of which the NPC could work will then be clearer. It is important to identify the types of ongoing coordination these two organizations will need to maximize their efforts in population and FP/RH policy and to achieve the greatest advocacy from combining their efforts.

o *Developing a strategic vision.* Once the roles and responsibilities are clarified, it will be important for the MOHP and the NPC to develop their strategic visions. This means that the MOHP and the NPC must identify their organizational missions and direct activities towards accomplishing their vision. This could go as far as developing strategic plans for the sector and for the organizations, since both are major players in the sector. The results of the strategic planning process may be strengthened by using a participatory approach which includes a range of stakeholders and draws on data to shed light on needs.

Participation is important in strategic planning for two reasons. First, the outcome is more honed and tailored -- and is likely to be more feasible -- by getting a broader range of input into the process. Second, inclusion of stakeholders, in a process in which they have genuine input, often creates ownership of the process. Participants then advocate for the plan after it is created.

Efforts to develop a strategic vision at the central level would, of course, be dovetailed with on-going initiatives in strategic planning at the governorate level.

o *Capacity building for responsible agencies.* With a clear articulation of roles and responsibilities and a strategic vision, policy organizations should clearly be able to determine what types of capacities are needed. Policy champions, those staff who will be responsible for formulating policy and advocating reform, need skills in the following four areas:

- Analysis of implications (i.e., resource requirements, program effort required, cost/benefit analysis) of policy change;
- Advocacy: to make an effective argument in a format tailored to the target audience which clearly identifies the action needed;
- Coordination: the ability to convene mixed groups of stakeholders and facilitate their working together on common interests, setting aside more narrow organizational interests during the collaborative process; and
- Ability to manage the process of change. Policy champions must understand the legal process of policy change, but more importantly, the informal factors that influence change (who is in power, how change will affect stakeholders, how to negotiate and emerge with the most favorable policy alternative given that compromise will be essential)

Policy Issues

o *Program development and growth of service utilization.* A number of program initiatives have achieved nationwide status. Among the most noteworthy is the Quality Improvement Program (QIP) in the MOHP/Systems Development Program. QIP is now in all governorates accompanied by a strong promotional component which emphasizes improved clinical services. This program uses standards, procedure manuals, training curriculum for doctors and nurses as quality indicators. A clinic receives a Gold Star if it meets 100% of the pre-determined quality standard checklist for two consecutive quarters. To date, approximately 33% of the public sector's family planning clinics have achieved a score between 90-100%. The quality emphasis is supported by means of a detailed supervisory feedback system and an extensive MIS.

At the same time, family planning service utilization has plateaued between the last two measurements, 1992 and 1995. What is worrisome about the plateau is that it is an unexpected departure from a decade of strong, sharp growth. The urban governorates are hovering around 58% CPR, and usage in the rural areas has only grown by 2% in the period, to the present level of 40.5%. Marked differences in the level of family planning use are found among regions. Use among rural women in lower Egypt (54%) is more than twice the level among rural women in Upper Egypt (24%). These findings indicate a need to develop new, innovative strategies which can be tailored to the demand and supply situation in particular areas, i.e., urban areas or Upper Egypt; whether different types of programs and services are needed; and whether pilot efforts to decentralize strategic planning should be extended and intensified. Concerns arise about the method mix, availability of women physicians, needs for community-based services, and about expanding the role of nurses (i.e., licensing them to give injectables). Manpower may be a more important issue than assumed; concerns are raised about absenteeism, which may cripple clinic functioning, and turnover of male physicians who may not see their involvement as long term.

Policy makers at the MOHP have critical decisions to make about these new approaches. These programmatic directions will help to flesh out the definition of the strategic vision described above.

Linkages

There is much interest in Egypt in better integration of family health services, be they women's reproductive health or child survival services. The MOHP/SDP is gradually moving toward a broader reproductive health framework by conceptualizing the links to THO, MCH, treatment of STDs and other related services within the MOHP's

domain. In the case of MCH/FP, recent research¹ documents the potential that linked referral systems would have in increasing use of family planning and vaccination and/or antenatal care. Developing these links would increase demand for services. However, adoption of programs to make these links operational will require policy decisions to make the approach a program priority, and resolve thorny operational issues like whether and how to pay performance incentives to referring providers.

Linkages between the Population and Health programs should be strong in the policy area. The Health Policy reform initiatives should take population policy in consideration as a major area of reform.

Demand. The stall in growth of program usage has renewed interest in new approaches to creating demand. The challenge of the more traditional areas of Egypt, Upper Egypt, may warrant policy outreach links to initiatives to increase girls' school enrollment, expand adolescent reproductive health education, etc. Further, a policy has been recommended to implement a national IEC strategy which brings together all relevant IEC agencies in agreement about who should do what, based on each agency's unique resources and talents. Lastly, policy decisions may be important as the sector moves towards increased reliance on mobile teams, outreach workers and other community based activities.

Contraceptive expansion. Another new approach, about which policy decisions will be needed, is contraceptive expansion, i.e., expanding the techniques by which methods are provided. A case in point is post-partum and post-abortion insertion of the IUD. In pilot areas where this technique has been introduced, it has been successful and appears promising. Adopting this approach into the program at the national level would entail a number of policy and planning decisions about phasing, resources, and more.

Contraceptive sustainability. USAID is still providing the vast majority of contraceptives used in the public sector and NGO components of the program. USAID has just completed the process of phasing-out subsidized contraceptives for the private sector through the social marketing program. Strategic Objective 4 addresses the system's reliance on external subsidies and therefore its vulnerability to shifts in donor policy. The recent midterm evaluation of Population and Family Planning III recommended that USAID and the GOE begin to plan for a phase-out of USAID-donated contraceptives, by which subsidization from the GOE would increase, possibly augmented by support from another donor. The indicator for Intermediate

¹Khalifa, Mona A. and A-G Mohamed Abdel Ghani, 1995.

Result Strengthened Sustainability of FP Systems (4.2) calls for GOE support to the program to grow from 39.72% in 1992 to 48% by 2000. Phasing-out of USAID support to contraceptives, with corresponding increases in GOE support, would contribute to this.

The private commercial sector. The active participation of the private commercial sector is a critical asset to the Egyptian national program as it seeks to meet ambitious goals of high service usage and increased financial sustainability. Experience has shown internationally that the policy climate can have the inadvertent effect of limiting that participation. This happens in two principal ways: (1) unintentional but direct competition for consumers who can afford to pay and (2) policies that unduly constrain the private sector. This section will discuss unintentional competition and a later section will address policies such as price controls which constrain the private sector.

Policy analysis of the 1992 EDHS² and a small survey of private sector providers in 1994³ suggested that, at that time, Egypt had a fairly well-segmented market for family planning services. The various service providers were generally serving different segments of the consumer market according to the missions of their organizations. There were even possibilities for expansion. The study of private providers found that there exists an important group of physicians (many of whom are women and many of whom are located in Upper Egypt) who serve the social marketing consumer who has some, limited ability to pay.⁴ Unexpectedly, within this group of physicians is a sizeable group which is not yet actively providing FP. This group might be a resource for future expansion.

Also, at the time, the public sector was charging a small fee for USAID contraceptives as an incentive to the providers and the clinic. International experience suggests that this type of charge promotes market segmentation (even when it is set at a very low level), as it signals consumers to think about all the alternative sources which may be available to them.

The existence of a well-segmented market allows the public sector to focus its subsidies on those who cannot afford to pay. The public sector, as the safety net provider, needs to extend its distribution network into the hardest-to-reach areas,

²Berg, R. J. Sine and W. Winfrey. 1995.

³Foreit, K. and J. Sine. 1995.

⁴Foreit, K. and J. Sine. 1995.

where the private sector would not be commercially viable. There have been notable success in this regard. The same policy analyses of the pill market showed that 35% of users of the low-priced public sector pill lived in rural Upper Egypt (by comparison only 18% of the low-priced private sector segment lived in rural Upper Egypt).⁵ Since these analyses were completed, the situation has evolved further. It will be important to assess the impact of changes to determine whether the well-segmented market has been preserved or whether more unintentional competition is occurring now between the public and private sector. Issues to consider include:

- a) Donated contraceptives are no longer available to the private commercial sector. Have private sector consumers been able to afford the move to fully commercial products?
- b) Have performance payments for the MOHP/SDP (undifferentiated CYP targets) created conditions of increased competition for consumers who can afford to pay?
- c) How is the composition of the user market changing (eg., demand among poorer families). Change could affect the size of the public and private shares without being indicative of flagging effort on the private sector side nor of increased unintended competition on the public sector side.

The NGO sector. Historically, NGO providers have played a small role in service provision in Egypt. However, with the need for new approaches indicated by the plateau of program growth, it is be important to reconsider the role of NGOs. They have a unique niche in their ability to test new service models (services to adolescents), tackle controversial issues (female genital mutilation), and advocate for policy support and policy reform. The recent plateauing may be an impetus for decentralized approaches, that is, giving fuller recognition to the unique character of the governorates of Egypt and the need for local solutions. Many NGOs have a local character and grass-roots base and therefore can be important partners in decentralized initiatives. This could range from their inclusion as stakeholders in planning to financial support for their programs.

Contraceptive pricing and other policy constraints on the private sector. Policy constraints to the private sector can curb its participation beyond the constraint described above of unintended competition. Several regulatory issues have been

⁵Berg, R. J. Sine and W. Winfrey. 1995.

identified as constraints. Price restrictions on contraceptives limit the operation of a free market and make it difficult for manufacturers and distributors to sustain their products in the market. Import tariffs imposed on contraceptive products limit profits among suppliers and distributors, raise their cost to the consumer, and reduce the size of the market which might otherwise seek private sector services in the absence of tariffs.

There is a new climate of interest in dialogue with the private sector. USAID/Egypt is beginning the process of strengthening the private sector's ability to analyze policy constraints and advocate for change in a coherent way. If this is coupled with investments in policy analysis, formulation and advocacy with the public sector, it will interject more dynamic elements into the policy environment in which the private sector operates.

Public sector cost recovery. The market segmentation studies of the 1992 EDHS suggested that most consumers, whether public or private⁶ sector, were willing to pay more for their method. This suggests that (at the time) the MOHP could have considered modest price increases, if deemed appropriate, to increase system sustainability, improve provider incentives or to increase clinic revenues available for quality improvements. These types of analyses will be repeated on data from the 1995 EDHS through a Special Study of the POP/FP III Project currently underway. Since the earlier analyses were performed, the situation has evolved. It will be important to consider a number of issues such as:

- o Whether the expansion of free contraceptive services, provided by governorate Social Welfare funds, has had an effect on service utilization;
- o Has service utilization increased because more poor clients have new access?
- o Has service utilization decreased because providers are less motivated?
- o Has the expansion provided free services to those who can afford to pay the MOHP's low fee?
- o Has the expansion attracted private sector clients to use free services?

⁶Berg, R. J. Sine and W. Winfrey. 1995. The only group not willing to pay more was users of high-end IUDs in the private commercial sector.

The last of these questions signals the important link between service policies in the public sector and participation of the private sector in the contraceptive market.

Links of Policy Issues to Strategic Results Framework

Table 1 shows the links between these policy issues and USAID/Egypt's strategic results framework. Development of improved policy capacities will contribute to both Intermediate Result Strengthened Institutional Capacity (4.2.2) and Intermediate Result Improved Policy Environment (4.2.3).

Success in program development and increased service utilization will contribute to Intermediate Result Increased Use of Family Planning (4.1) by Enhancing Supply (4.1.1.) and Increasing Demand (4.1.2).

Improvements in integration of services and making linkages between MCH/FP and other reproductive health services, and successful expansion of contraceptive techniques would contribute to Increased Demand (IR 4.1). If policy interventions cause increased focus on efforts to directly influence demand (IEC efforts) or establish links into areas indirectly stimulating demand (girls' education, adolescent curricula), this will also contribute to achievement of Increased Demand.

Phasing-out of USAID support to contraceptives, with corresponding increases in GOE support, will contribute to achievement of Increased Sustainability of FP Systems (IR 4.2).

Success in maintaining the active involvement of the private commercial sector (by maintaining a segmented market and removing policy constraints) contributes to Intermediate Result Increased Financial Self-Sufficiency (4.2.1) in that the private commercial sector is by definition self-sustaining. Increasing the involvement of NGOs also contributes to this, since NGOs increasingly have cost recovery mechanisms intended to cover portions of their costs. This success will also contribute to enhancing supply (IR 4.1.1), if in a well-segmented market more private physicians and pharmacists offer family planning services, and if the network of NGO service providers widens thereby offering more choice and more channels for innovative approaches.

Similarly, public sector cost recovery contributes to Increased Financial Self-Sufficiency (Intermediate Result 4.2.1). Cost recovery can also play a role in enhancing supply (IR 4.1.1.) if, as some evidence suggests, providers are motivated by the payments and consumers are not deterred by them.

ANNUAL POLICY BUDGET
LINKS BETWEEN POLICY AND RESULTS

POLICY AREA	4.1.1 ENHANCED SUPPLY	4.1.2 INCREASED DEMAND	4.2 STRENGTHENED SUSTAINABILITY	4.2.1 INCREASED FINANCIAL SELF-SUFFICIENCY	4.2.2 STRENGTHENED INST. CAPACITY	4.2.3 IMPROVED POLICY ENVIRONMENT
POLICY CAPACITY	- CLARIFY ROLES AND RESPONSIBILITIES				X	X
	- STRATEGIC VISION				X	X
	- POLICY SKILLS				X	X
POLICY ISSUES	- PROGRAM DEVELOPMENT SERVICE UTILIZATION	X				X
	- CONTRACEPTIVE EXPANSION AND SUSTAINABILITY		X			X
	- PRIVATE SECTOR/ NGO	X				X
	- COST RECOVERY	X				X
- POLICY BARRIERS TO PRIVATE SECTOR	X					X

Success in reforms related to the specific policy areas described here all contribute to Improved Policy Environment (IR 4.2.3).

ANNEX C

Economic Analysis And Sustainability

Introduction

This annex provides the economic framework and justification for the strategy developed in the RP focussed on achieving SO4, the reduction of fertility in Egypt. Specifically, the annex: (1) demonstrates a large economic payoff to the proposed program at both the macro and micro level and shows that it is complementary to and consistent with other economic and social objectives; (2) establishes that the proposed program is firmly based on a strong, client demand and that a substantial unmet need exists for services; (3) shows that prospects are good for sustainability, if not total self-sufficiency, for substantial sectors of the overall program; (4) outlines the privatization and deregulatory steps which will be required of GOE to insure success of the RP; (5) finds that the cost-effectiveness (cost per unit of services) of the proposed program is good compared to other similar national programs and that it has improved over time; (6) presents a financial picture of the present program and shows how under the RP USAID involvement will gradually diminish; (7) proposes a series of improvements in the program statistics and monitoring system needed to keep track of progress under the RP.

(1) Economic Environment for Family Planning in Egypt

(a) The present macroeconomic situation and future prospects

The Egyptian economy in recent years has shown a mixed but cautiously positive trend. The average annual growth rate has been consistently 2.0 percent and over for the last decade and in 1995-96 rose to 4.2 percent. Modest though these rates may appear, they constitute significant improvement over earlier decades in which growth rates were lower still and in some years even negative. The rate of inflation has moderated and the last decade has seen major efforts at restructuring the economy, most particularly deregulating industry, privatizing previously government-owned facilities and dismantling price and other controls in agriculture. The private sector now accounts for over 60 percent of total output and total factor productivity is increasing at 3 percent a year. These policy measures have now begun to yield positive results in the form of increased output, particularly in agriculture, and future growth rates should be higher still. The official GOE target for the next five years is an annual growth rate of 8.0 percent.

Egypt's external economic balance of payments has also improved and now shows an overall surplus. Oil and gas revenues remain good and new export products

are emerging. Most importantly, tourism earnings have recovered and promise to surpass previous records. The burden of foreign debt fell in 1995-96 and debt service charges now amount to only 10 percent of current foreign exchange receipts. Foreign exchange reserves have risen. Foreign investment has been flowing into Egypt at record rates, much of it stimulated by recent Egyptian-US commercial agreements (USAID/Cairo, 1997; World Bank, 1997).

These improved economic prospects will take time, however, to reverse the unfortunate legacy of past state-controlled inward-looking economic policies. Official GOE figures put unemployment at about 10 percent of the labor force but unofficial estimates are as high as 15 percent. At least one third of the households and families of Egypt live below the poverty line. Many villages in the rural areas still lack such basic amenities as electricity, pure water and access to a paved road. Rapid growth in the urban centers due to in-migration from the rural areas has resulted in the creation of over-crowded slum areas on the fringes of many of the cities. These areas, like the remote rural ones, typically lack modern amenities and are poor, unhealthy breeding grounds of social and political discontent. They also typically have higher mortality and fertility than the surrounding areas. An important goal of government policy remains poverty-reduction and strengthening the social "safety-net" of public services to such low-income groups.

The appropriate measure of real changes in economic activity is per capita output; that is, total measured output divided by population. Rapid population growth can effectively offset aggregate economic growth and Egypt prospects for dealing with poverty and raising the average standard of living thus depend on the future course of fertility as well as economic growth as such. Rapid economic growth, such as the GOE is aiming at, will in turn make it easier for the government to pay for continued family planning programs as well as making it more likely that contraceptive demand will be strong enough to encourage the private sector to play an increasing role. Reducing population growth is thus an important part of the GOE and USAID economic and social policy strategy for the next five to ten years.

(b) Economic and Social Payoffs to Reduced Fertility

Egypt has pursued a government-sponsored family planning program for some time and this program has already been successful in reducing average completed family size (the total fertility rate or TFR) from over 6.0 to under 4.0 and the overall rate of natural increase from 2.8 to 2.0. During the decades of Egypt economic stagnation, the decreases which had already occurred in population growth enabled Egypt to hold its own economically in per capita terms. That is, per capita income did not rise in the 1960s and 1970s, but more importantly it did not fall

precipitously. Egypt was spared the economic crisis and social and political deterioration which took place in many countries of Africa and the Middle East. Striking gains actually took place in school enrollment, health standards and infrastructure development. These gains would have been even more difficult had population growth been even more rapid than was already the case.

USAID has sponsored a detailed cost-benefit study of the economic and social impact of reductions in fertility, past and future (Moreland, 1996). Future benefits are projected to the year 2015 which is the year the GOE aims at reaching replacement level fertility (TFR = 2.1). Some of the key findings of this study are as follows:

- The local consumption requirements of key agricultural goods (wheat, cotton) will be reduced and the gap between domestic production and consumption will be 20 percent lower.
- Egypt presently subsidizes the price of such staple foods as rice, bread and sugar costing the GOE roughly 600 million LE a year. Reaching the GOEs fertility target by 2015 will reduce the annual cost of such subsidies by almost 200 million LE. Cumulatively, from 1993 to 2015 it would save the GOE over 1,300 million LE.
- The lower fertility will mean 4 million fewer pre-university students by 2015 and that 8,000 less new primary and secondary schools will be required. Overall, the governments expenditures on education can be 6,000 million LE lower than would otherwise be the case, even allowing for further efforts to increase quality.
- GOE presently spends large sums building new housing and cities. The reduced fertility will result in a cumulative saving of over 4,000 million LE due to reduced housing needs.
- Health programs (both curative and preventive of which family planning is one) cost the GOE some 800 million LE in 1993. The increase in this annual figure by 2015 will be nearly 200 million LE less with the planned reductions in fertility and the cumulative savings between 1993 and 2015 over 1,000 million LE.
- Water and sewage facilities also require large GOE expenditures and both are directly linked to population. Reaching the lowered fertility level will save the GOE water supply program 3,700 million LE and the sewage treatment operation 2,800 million LE cumulatively between the present and the year 2015.

- Employment problems will also be eased with lowered fertility. By about 2015, 1.5 million fewer new jobs will be required and this will mean that 85 million LE in investment can be shifted to making existing jobs more productive rather than simply providing jobs for new workers.

At the overall macroeconomic level, reduced fertility will make possible a higher level of aggregate savings and investment raising total national produce by some 5 percent by the target year. Since there will be somewhat fewer new households, average household income will be 6 percent higher due to reduced fertility.

The cumulative savings from GOE expenditures not required for all such programs due to lowered fertility is estimated at 19,000 million LE from now to 2015. This may be compared to the GOE estimates that reaching their fertility reduction target by 2015 will cost just over 600 million LE. Thus the benefit to cost ratio is highly favorable, being on the order of 30 to 1. There will be additional gains in the form of increased quality of services, reduced environmental pressures, improving level of living and other amenities. These are hard to quantify but real nonetheless.

(c) Population programs in relation to other economic and social goals and plans

GOE planning documents and pronouncements have always correctly placed family planning (efforts to reduce fertility) in the larger context of overall economic and social development. Thus, Egyptian population policy consists of: reducing fertility through family planning; reducing the density of existing areas with new agricultural reclamation schemes and newly created urban-industrial centers; increasing the quality of the population and labor force through education, health and other measures (GOE, MOHP, 1996).

This continues to be the overall policy and the very ambitious recently-announced "New Valley" project represents a new venture of the second type of policy. Details of this project are not yet known but it would appear that the plan calls for irrigating large new areas in the southwestern desert so as to create a "new Nile Delta and Valley" between Aswan and Kharga thus creating new arable land. Numerous new cities would then be built to provide services and support for this new rural settlement area. The plan is ambitious but not unprecedented. Egypt has already added some 25 percent to its arable land base through irrigation projects since 1960 and many new urban-industrial complexes have been built in the Delta, and along the Suez Canal.

There is occasional misunderstanding in the popular press and elsewhere about the role of the "New Nile Valley" project compared to the continuing efforts at fertility reduction. The two are not competitive but rather complementary. The point is perhaps obvious but is worth repeating. No resettlement scheme can "solve" the problem of excess population or over-crowding so long as fertility remains high and the population is growing rapidly. A simple example can put these relationships in perspective.

There are presently some 6 million feddan under cultivation in Egypt comprising some 4 million farm units. Suppose in the next five years one million additional feddan are brought under cultivation (a very ambitious goal in view of the fact that only 2.5 million feddan were added in the entire period 1952-1993). Then assuming the farm size to remain constant at about 1.5 feddan, some 700,000 new farm units could be created and if each farm household consists of 4.5 persons then 3.0 million persons could be settled on the new land. Now suppose further that ten new cities were created to service this new rural population, each of 100,000 population, making a total of one million persons so settled. The total population of this very ambitious scheme would be 4.0 million persons resettled in five years. (We must be clear that these numbers are hypothetical and do not purport to be based on the actual "New Valley" Project.)

Now at the present rate of growth some 1.6 million persons are being added to the population each year and if we assume this rate continues in future then in the next five years some 8.0 million persons will be added to the population. In other words, the very ambitious resettlement scheme outlined above would effectively deal with just over half of the new natural increase and would make no inroads on existing over-crowding or structural employment difficulties in old urban and rural areas.

Thus the goal of a "better distribution" of population can not logically be seen as an alternative to fertility control. Properly seen, it is a complement or corollary to family planning. Reaching the goal of still lower fertility by 2015 will then mean that resettlement schemes will begin to make headway against existing problems of crowding and density, thus raising the quality of life for the old areas as well as the new ones.

The third aspect of the overall "population policy", improving quality of the population, can be seen in the same light. It does not compete with fertility reduction but rather builds on it. Increasing the quality of the human capital base and the quality of life of the population are crucially related to the society getting control over its numbers which is the goal of the family planning program. In the final

analysis, controlling fertility is the necessary condition for the other population-related policies and programs to succeed in raising standards of living.

(d) General Social and Public Environment for Family Planning

Egypt has had a clear policy favoring family planning since 1954 and a program aimed at providing services and information since 1960. Support has been unwavering if somewhat sporadic in budgetary terms. Some particular methods of fertility control remain controversial and there are still some groups in the population who are opposed to the program as such. But, there would appear to be no significant political, social or cultural barriers to the programs planned expansion or attaining its goals. The program seems to have established a constituency and created a demand for its services (we will discuss this point when "sustainability" is discussed below.).

(2) **The Sources of Demand for Family Planning**

(a) Behavioral Basis for Family Planning Programs

The RP is organized around a conceptual scheme which sees the problem of reducing fertility as involving efforts to increase the demand for contraceptive services and simultaneous efforts to increase their supply, while also dealing with financial, human resource and policy constraints affecting both efforts. This demand-supply framework is essentially an economic paradigm and it may be helpful to spell out the assumptions of this framework since they will underlie the logic of the program and policy measures which the RP proposes.

The notion of a demand for family planning stems from the intuitive assumption that children are, for most couples in most cultures, viewed as desirable and valuable. Children constitute one of the main purposes of forming family units through marriage. They bring psychic and also material benefits to their parents and the demand for them is nearly universal. There exists therefore a rational demand for children and since contraception represents an effort to avoid having children it must be based on what can be called a negative demand for children. Having children usually requires no special effort but couples may not (almost never do) want all the children which nature will send them if they marry early and both stay in good health (which turns out to be 12 to 15 live births per couple). Anthropologists have found that even primitive societies frequently develop effective means of controlling fertility. This desire to control fertility becomes a demand for family planning services - information and supplies of contraceptives - and it can be to permanently avoid more children ("stopping") or to affect the timing of births, even when more births are

desired ("spacing"). At any given moment of time, the demand for family planning services rests on a combination of these two types of demand for control over fertility. Typically it is couples of higher income and educational status who are the first to be motivated to control their fertility in this fashion. But, there is also a growing body of evidence internationally that with economic and social development both these motivations for increased control over fertility increase among couples of all socio-economic status. (This is the essence of the well-known theoretical paradigm, the "demographic transition".)

The important point arising from these theoretical notions is that both the desire to have children and the desire to avoid having children represent rational choice by couples. A public sector family planning program must take these as "given". Measures to increase the supply of services are an effort at assisting couples to reach the family size goals they have decided upon. But, this supply includes new, relatively sophisticated methods unfamiliar to even educated women and men in traditional societies. So programs frequently must undertake informational campaigns, advertising and door-to-door field worker activity aimed at educating prospective clients and reducing their natural concerns and anxieties. These measures can be seen as mobilizing the latent demand for family planning which already exists. The existence of such latent demand is clearly indicated in numerous surveys which show an "unmet need" - many couples who indicate a desire for no more children or a desire to space their next child but who are not currently contracepting. Program efforts can help these couples achieve their family goals also with appropriate measures.

The underlying logic is thus that couples decide their own best family size and that programs simply help them reach those goals. Efforts to affect behavior are really efforts to widen choice and open new options for people. All effective programs are and should be totally voluntary and that is true in Egypt. The aim is to provide information and services making it possible for people to more effectively pursue and attain their own welfare as they perceive it. This is the underlying logic of the RP.

(b) The strength of demand for family planning in Egypt

The demand for family planning services in Egypt can be tracked quite precisely over the last two decades, thanks to a series of very solid national surveys undertaken largely with USAID funding. These occurred in 1980, 1984, 1988, 1992 and 1995 (El-Zanaty and others, 1996; and earlier reports cited therein). These measure not only current actual use of family planning by all methods but also shed light on underlying attitudes and preferences about family planning and family size.

The following table presents the key findings:

Year of Survey	Total Fertility Rate	Contraceptive Prevalence Rate	Ideal Family Size
1980	5.28	24.0	4.1
1984	4.85	30.0	3.6
1988	4.41	38.0	2.9
1992	3.93	47.0	2.9
1995	3.59	48.0	2.8

The actual demand for and use of contraception has doubled in 15 years, resulting in a fall of nearly 2 births per women in completed fertility. These changes have been distributed broadly across Egyptian society and have affected rural as well as urban couples, and more traditional Upper Egypt as well as more modern Lower Egypt, although in differing degrees. Egypt very clearly has experienced a profound attitudinal change about the benefits of large families.

This conclusion is borne out by the changes in ideal family size, which can be interpreted as the target fertility towards which couples are finding their way. Since 1980 this has been consistently lower than actual fertility and this is still the case. Even given the rapid increase in actual use, there appears to be still a latent demand not yet acted upon by couples or satisfied by existing supply.

Another recent, USAID-sponsored study (Moreland, 1997) found that households on the average spend about 13 percent of their income on caring for their children. The cumulative cost per child, from birth to young adulthood, is 40,000 LE for households in Cairo and 26,000 LE for families in Upper Egypt. Even without having made the precise calculation these numbers seem intuitively clear to most couples in Egypt today. The desire to avoid large numbers of children has a solid economic foundation.

(c) Measuring "Unmet Need" for family planning

There is considerable technical literature on the definition of latent demand, or "unmet need" (Harbison, 1995). The most commonly accepted definition

84

has unmet need being equal to the percentage of women at risk (currently married and fecund) who state their desire not to have another birth or to postpone their next pregnancy plus those women who are either pregnant or have just given birth who state that the pregnancy or birth was not wanted or was mistimed. The following table (based on the same survey data) indicates the changes since 1988 in these percentages:

Year of Survey	Need to Limit (%)	Need to Space (%)	Total Unmet Need (%)
1988	18.1	11.1	29.2
1992	13.3	6.8	20.1
1995	10.7	5.3	16.0

Total demand is this latent demand (unmet need) added to active demand (or current prevalence) and comparing these two tables we see that in the period being reviewed about 65 percent of the women at risk have "demanded" or indicated that they perceived themselves as being in need of family planning services. These figures also indicate the programs growing success over time in creating a supply which allows couples to activate their latent demand since unmet need has been falling as a percentage of total demand. However, in 1995 unmet need still comprised about 25 percent of total demand. One of every four women wanting to use family planning services was not doing so. This is a clear indicator that the program still has work to do.

(d) Measuring Perceived Client Benefits from the Services

The logic of the demand-supply framework sketched out above would suggest that people using family planning services are, in their own judgement, benefiting from such services. This implies that they should also be willing to pay for such services, subject only to the caveat that very low income groups might lack the necessary resources to do so.

The present total supply is a mix of public and private sector with respect to the source. But, regardless of the source, most Egyptian contraceptive users do pay something for the services and commodities they consume. The two main methods in use presently are the IUD and the oral pill. The 1995 Survey found

85

that 80 percent of the pill users paid 50 piasters or more for a cycle and 20 percent paid one pound or more, with the median price being 66 piasters. Some 55 percent of the IUD users paid ten pounds or less to receive the device and 2 percent received it free, with the median price paid being about 8 pounds. Most pill users (86 percent) go to private pharmacies and a majority of IUD acceptors (55 percent) receive the device from a private physician.

A third method is also beginning to come on line in the program and this is the injectable, which now accounts for five percent of total prevalence. About one third of these users paid less than 5 pounds, while one half paid between five and ten pounds. The median price paid was 5.1 pounds.

Fees charged at all government installations are nominal and the commodity prices in the private sector have been subsidized and controlled deliberately to keep them low. Thus, these prices do not reflect either the cost of the service or commodity or the willingness of the client to pay.

The 1995 Survey also found that most clients expressed a willing to pay higher prices. than they were currently paying, particularly for longer-term methods, such as the IUD and the injectable. For the IUD, 47 percent of the respondents said they would be willing to pay 25 pounds, compared to a present mean price of 16 pounds, and 22 percent would pay as much as 50 pounds. For the injectable, 36 percent expressed a willingness to pay 15 pounds and 24 percent would pay as much as 20 pounds, compared to a present mean price paid of about 9 pounds. Other market studies undertaken earlier bear out these findings (Sine, 1995).

These findings imply that for many, if not all, clients contraceptive services are a "bargain" at the present fee schedule. Presumably, this group is made up of the mostly-urban middle-income users who are already obtaining their services from the private sector and are presently benefiting from the subsidy-fixed-price program strategy pursued in the past by the GOE. The low-income and rural segments of the population, at whom the present low-price strategy is aimed, presumably are represented by the respondents who expressed no such willingness to pay higher prices. Not surprisingly, the client "market" seems to divide itself into segments with different price elasticities of demand for contraception based on residence, education and income. This has important implications for program strategy, which the RP takes into account.

(3) **Prospects for Program Sustainability**

(a) Sustainability as a Strategic Objective of the RP

Sustainability of a national family planning effort means that all present and prospective future clients can be assured that the aggregate supply of services and commodities will be adequate with respect to total quantity, method mix and other qualitative aspects, to enable them to attain their desired family size. In other words, that supply will be available to meet their demand (Perla and Nassar, 1995; Levine and Bennett, 1995).

Where supply flows mostly from the private sector, sustainability is presumably assured so long as the service remains valuable enough to the clients so that they will pay the real scarcity price of the resources required to produce the services involved. The sustainability of supply flowing from the public sector raises different issues, particularly when substantial commodity and other inputs have historically come from external donors. Public sector sustainability is sometimes seen as resting ultimately on top political and administrative leadership support for the program. It also requires the continued existence of a viable administrative and technical capacity to operate the program without excessive technical assistance from abroad. Finally the program must be financially sustaining in the sense that it is self-financing through cost-recovery fees and charges or that it commands a regular line item in the government budget which is viewed as "permanent" by the Ministry of Finance and other government agencies. This full sustainability is almost always viewed as a goal towards which programs strive and there have been several in Asia and Latin America which can be said to have achieved this goal after years of heavy dependence on external assistance.

The RP assumes that Egypt must approach full sustainability over the next ten years and outlines a strategy for doing so. This strategy aims at the following intermediate results (IRs): (1) growing independence of the program of external (donor) subsidies; (2) more precise targeting of the internal GOE subsidies; (3) improved cost-effectiveness; (4) increased program cost-recovery.

This strategy builds on the three-way segmentation of the market which seems to have emerged with program experience. The RP outlines a sustainability plan for each of the three present program components pursuing separate but inter-related strategies and activities.

(b) Sustainability of the Private Commercial Sector

There is a vigorous demand for contraceptive supplies and services in Egypt. A majority of clients are already serviced by private physicians, clinics and pharmacies and some 60 percent of all spending on health and family planning takes place in the private sector (Perla, 1995). The typical urban consumer spends between 5 and 10 percent of their income on health-seeking activities (Moreland, (1997) which includes contraception. Many family planning clients have indicated that they would be willing to pay higher prices than those presently prevailing (as was noted earlier). The demand seems clearly present.

All domestic production of oral contraceptives comes from GOE-owned production facilities and is sold at fixed prices which have nothing to do with the cost of producing the commodities. These flow through the Egyptian Pharmaceutical Trading Corporation, a quasi-public entity. The private sector is regulated with respect to the prices which can be charged for these commodities when they are sold to the final users. Those contraceptives which are not produced by the GOE facility - low-dose oral pills, injectables and IUDs - must be imported but there exist a daunting array of controls and regulations facing private would-be suppliers who attempt such importation (Ravenholt, 1993). Under earlier USAID population projects, there existed a "Contraceptive Social Marketing" Project (CSMP) under which private suppliers - pharmacists and physicians - were subsidized for supplying contraceptives. Training for the providers was also part of CSMP and IEC campaigns were undertaken as well. This project ended in 1995 and the expectation was that private suppliers, previously a part of the CSMP system, would continue contraceptive marketing on their own. The controls on prices and other regulatory barriers seem to have prevented this from occurring. Private sector contraceptive supply probably decreased in the last two years.

All these elements make the existing market picture highly artificial and difficult to analyze fully. Presumably private providers are finding some profit margin in the present situation or they would not be generating services at all. Presumably also, were they freed of controls over their inputs and also over the prices they can charge, they could find their way to larger and more profitable scale of operations. More contraceptive suppliers might well be attracted into the market, limiting any sharp increase in prices, particularly if imported commodities were more freely available. Going a step further there seems no reason that production and wholesale distribution of contraceptives should remain a public sector monopoly. The public interest with respect to quality and safety can be adequately insured without full public ownership. Allowing competition in production as well as distribution and sale would be the best guarantee to the client of both a fair price and good quality.

Thus, for the private commercial sector sustainability is most likely to be insured by prompt measures to decontrol local prices, remove import restrictions, and privatize local production of contraceptives.

(c) Sustainability of the NGO-PVO Sector

The Non-governmental Organizations and Private Voluntary Organizations have played a pioneering role in making family planning services available in Egypt. The Egyptian Family Planning Association (EFPA) and related groups continue to be important in the overall supply picture and USAID has supported these organizations over time. Such organization typically operate on very limited budgets and are aware of the need to cost-recover and to attract donations from inside and outside Egypt. The Clinical Services Improvement Project (CSI) an offshoot of EFPA, has received USAID support in the past and has been an outstanding success story. It has achieved a near 70 percent cost-recovery rate on its operations and become a demonstration project for how to achieve high-quality clinical services. The RP plans to extend this CSI experience to some 20 other NGOs (5 national and 15 local), using performance-based grants with reimbursements gradually declining over time to encourage cost-recovery by the NGOs. These grants will be channeled through a Mission-wide NGO initiative which, in turn, will work closely with a newly-created umbrella NGO group (the National Center for Development Planning, NCPD), which has UNFPA funding, and the World Bank Social Fund. Specific goals in terms of acceptors and CYPs will be established for the NGOs and their performance will be monitored. CSI itself is to be provided by the end of the RP with an endowment to insure its future self-sustainability and its continued presence as a model for other NGOs.

The biggest stumbling block facing the NGO-PVO Sector is the fact that they are not really "non-governmental"; the Ministry of Social Affairs not only registers them, but insists on burdensome accounting and regulatory reports. It also effectively prevents them from changing the scope or direction of their activities and discourages innovation. These controls all are a part of "Law 32" which USAID and other donors have urged GOE to eliminate or drastically amend.

The NGO-PVOs presently account for about ten percent of total supply and are not likely to ever become the major source of supply. But, left to their own devices, they will almost certainly do what NGOs are good at doing in other countries - filling in the gaps which exist in particular areas and for particular client groups supplementing the official GOE program and serving groups not able to supply themselves adequately in the commercial market. Their motivation for internal efficiency and to become self-sustaining is inherent in their situation. Limited

subsidies from outside and occasional project-specific support from donors or GOE will go hand-in-hand with a fee-for-service philosophy of operations. Once they are allowed to operate free of governmental restrictions, there seems no reason to doubt the NGOs sustainability.

(d) Sustainability of the GOE/MOHP Program

The GOE is legitimately and appropriately concerned with insuring that all those in need of family planning services obtain them, whether they can pay the full cost of such services or not. The "social safety net" should include contraceptive services as well as maternal and child health services and general primary health care. Given that such a program philosophy automatically targets low income groups, the issue of cost-recovery and sustainability is more complex. Several points need to be made.

Firstly, there is considerable literature which shows that even very poor clients tend to value a service more when they do make some payment, even if it only a token compared to the actual cost. Putting it in another way, clients distrust things which are free and disvalue them. Most GOE facilities already charge a modest fee so the system clearly understands this principle. A modest degree of cost recovery already occurs, perhaps 5 to 10 percent of total GOE costs. Presently, this is used as work performance payments to the providers. This should continue and be expanded.

Secondly, other programs have found it possible to employ some type of "means test" to clients, frequently a self-enforcing one with clients asked to pay what they feel they can afford for services. Experiments on such an approach would seem to be warranted. If a given potential client is unwilling to pay even a modest fee then this must call into question whether the client really values the services.

Thirdly, the GOE operations should over time be concentrated on those segments of the population which are likely to fall below a market cutoff of income and affordability. Such groups will likely include the urban poor and the remote rural areas but they should be more closely identified using appropriate program-related operations research and monitored over time. Low cost operation in such areas can be subsidized by insuring that fees are charged to other client groups which can afford them. And, over time the GOE should aim at allowing the private commercial sector to services those groups able and ready to pay for services, thus shifting its own focus to those still in need of free or subsidized services.

Long run sustainability of services from the GOEs regular revenue budget should be possible for the restricted and, hopefully, diminishing segment of the

population in the poverty group. It would presumably be part of a comprehensive minimum health care package which would be guaranteed to all families. But this would not mean that contraceptive services or general health care would be free for everyone. That has not proven sustainable even in high income developed nations.

(4) Policy Issues Arising from Long-run Sustainability Goals

(a) Enhancing The Supply of Contraceptives

(1) In the short run, all controls should be removed on the prices of contraceptives supplied in the private commercial and NGO sector. Prices at these non-governmental suppliers will rise but there are numerous studies indicating consumer willingness to pay higher prices and this will provide a much-needed profit incentive for the commercial suppliers and a greater opportunity for cost-recovery by NGOs. (Note that this does not imply decontrolling all drug prices; it implies only that contraceptives be removed from the list of "essential" and hence controlled prices.)

(2) Presently all domestic production of contraceptives (oral pills, chiefly) comes from government-owned factories. There is no particular logic to this and they should be privatized as soon as possible. A market for these products clearly exists in Egypt so there should be no shortage of prospective buyers in the private sector. The GOE could write into such a sale an agreement that MOHP would be guaranteed a concessionary price for ten years with any increase in this price to be negotiated. (In this case also, we are referring only to contraceptives, not all drugs or pharmaceuticals.)

(3) All restrictions should be removed on the importation of contraceptive commodities and supplies. Import duties as such are already low but there are a variety of restrictions which make it cumbersome and difficult for a local firm or service provider to import the new contraceptives not produced locally. These include the IUD, the progesterone-only pill, the injectable and the Norplant implant, which have in the past usually been supplied on concessionary terms by foreign donors through the MOHP. There is a clear demand for these methods and as soon as the private sector can easily obtain them they will become more widely used.

(4) The process by which new contraceptive methods are approved for use must be made more transparent and predictable. Prospective clients must be fully protected but the process by which this is accomplished must not be allowed to become an excuse for inaction or for opposition to all changes.

(b) Increasing the Demand for Family Planning Services

(1) The recent State Information Service media campaigns on behalf of family planning have been much more sporadic and muted than the earlier efforts which were notably successful. A new State Information Service (SIS) led campaign must be launched featuring, on the one hand, strong endorsements of the renewed family planning effort by the top leaders and public figures of the country; and on the other hand, highly-specific "ask the doctor" type discussion of the various family planning methods aimed at dealing with client uncertainties and fears about side-effects.

(2) GOE must make it clear in public pronouncements that it continues to support family planning and does not support the view that new economic initiatives, such as the "New Nile Valley Project", are alternatives to continued efforts to reduce population growth. An impression to this effect is frequently conveyed in press accounts of the new project. Even with all the success one could imagine such new economic ventures, they will be totally swamped by population growth unless fertility continues to decline.

(c) Moves to Increase Prospects for Sustainability

(1) The GOE should develop an explicit long-range strategy which recognizes the important present role of the private sector (commercial and NGOs supply over 60 percent of clients) and assigns it a growing role over time. Long-run sustainability will mean most contraceptive services being supplied on a full cost-recovery basis by the private sector, with the MOHP supplying family planning to the hard-core poverty groups as a part of a general health and social welfare package. A social "safety net" can be provided but it must be targeted precisely at the truly needy groups and not provide an unneeded subsidy for middle-class urban groups.

(2) MOHP should explicitly adopt a two-sector two-price strategy for supply family planning services. The MOHP will continue to provide services at very low cost for a large segment of the population, particularly the rural and urban poor. The private commercial sector should be encouraged to supply services to the middle and upper income clients both rural and urban, charging whatever price the market establishes. NGOs should be free to charge whatever price they deem appropriate for the particular group they serve. Our expectation is that many of these groups will serve the poor and charge modest fees, thanks to subsidies by foreign donor groups. Others, however, will serve middle-income clients and can aim at cost-recovery. NGOs should be, in reality "non-governmental", and freed of all restraints except normal legal and financial accountability.

(d) Strengthening the Institutional Setting

(1) Clarifying and eliminating the existing confusion among the several institutions involved in family planning policy-making, research and service provision is important. MOHP is clearly the lead ministry but the National Population Council (NPC) continues as a separate agency and the Ministry of Social Affairs (MOSA) still has control over the NGOs. There is no particular logic to this structure. NGOs doing mostly family planning should coordinate with MOHP (as they do in fact now) and removed totally from the need to report to MOSA. The useful secretariat functions of NPC - policy-program research, governorate-level planning, and the management information system -should be shifted to MOHP in a new secretariat or support center attached to the under secretary. This institutional clarification will simply be a formal recognition of what is already a reality but it will eliminate much duplication and confusion.

(2) The MOHP policy of incorporating family planning as part of a comprehensive reproductive and women's health package will no doubt entail greater integration of facilities and services at the hospital-clinic-field worker level. The goal is to enhance the flow and to increase the quality of such services. However, efforts to increase quality must not be allowed to result in decreasing of the volume of services. Integration must not result in the cessation of any useful services presently being provided at any MOHP facility.

(3) As the program moves forward and attempts to deal with hard-to-reach low-use high-fertility groups, policies must become more flexible and adaptable to local needs and situations. This means giving local (governorate, district) program managers more decision-making authority and fiscal autonomy within the broad framework established by the national plan. Steps in this direction have already been taken under NPC and these should be continued under MOHP.

(5) **Cost-Effectiveness of the Program Components**

(a) Analyzing the Costs of the Egyptian Program

Both the microeconomic and macroeconomic benefits of the Egyptian family planning program far exceed estimated program costs and that the program is a sound investment. The other point of economic or financial interest is whether the Egyptian program is internally efficient. That is, accepting that the program is a good idea, is it being pursued in an efficient, cost-effective manner?

There are several dimension to this question; (1) how do the costs within the overall program vary by subcomponent agencies, regions, mode of delivery and contraceptive method; (2) how have the program costs per unit changed over time; (3) how do the program costs here compare to other national family planning efforts.

Answers to these questions can be provided. The financial inputs to the program come from several sources, external as well as domestic and these can be tracked reasonably well since they involve the expenditures of money, commodities or other resources. Measuring the outputs of the program involves more difficulties, however. The final goal of the program is reduced fertility (and this is the "final result" to be achieved by this Results Package) but the intermediate result is the enhancement of the supply of contraceptive services and an increase in demand (or prevalence) for their use. This enhanced supply requires an increase in a wide range of specific outputs from the many public and private groups concerned. Conceptualizing and measuring all these in terms of a single common unit of services (or "output") has lead to the use of an analytical model based on the notion of "couple year of protection" or CYP.

This approach (developed by Wishik in connection with the Pakistan family planning program some 30 years ago) focusses on the actual distribution of contraceptives and through a series of assumptions and calculations converts all the various methods used - the IUD, oral pill cycles, condoms, injectable, surgical methods, and so on - into a single common unit, the CYP. The CYP represents the provision of "protection" from the risk of pregnancy provided to a couple for 12 months, by any method whatsoever. Thus, one CYP is produced by 13 cycles of oral pills, by four injections of Depo-provera, or by 120 condoms (when coital frequency is assumed to be 2 incidents per week), and so on. The factors involved in converting the specific methods into CYPs may vary from country to country and vary still more because no method is 100 percent effective in practice and hence a use efficiency attrition factor must be added to the calculation. (A detailed discussion of this methodology is found in: Geary and Abdelakhar, 1996). But, with such adjustments in the end we can produce an estimate of CYPs for the program as a whole and for the major subcomponents thereof. CYP becomes the standard unit of output and with this estimate of output, costs can then be expressed on a per unit basis and comparisons among components, over time and cross-nationally can be made.

(b) Costs Per unit for the Major Subcomponents

USAID has for nearly the last ten years funded an annual review of the costs of the overall family planning effort in relation to its outputs (Geary and

Abdelakhar, 1996; and the earlier studies cited therein). The table below presents a summary of the overall total costs and CYP outputs.

Year	Total CYPs (in Millions)	Total Costs (in thousands of LE)	Cost per CYP (in current LE)
1988-89	2.62	44,711	17.07
1989-90	3.73	60,400	16.19
1990-91	4.17	72,305	17.30
1991-92	3.73	79,305	21.26
1992-93	2.97	72,234	24.32
1993-94	3.56	66,565	18.69
1994-95	3.81	95,611	25.09

It should be noted that these cost data are in current LEs. The rate of increase in the general level of prices in Egypt for the last decade has been of the order of 5 to 10 percent per year. Thus, in real terms the cost per CYP has been constant as the following data show:

Cost per CYP
(1988-89 LE)

1988-89	34.96
1989-90	32.53
1990-91	25.72
1991-92	25.41
1992-93	21.26
1993-94	24.80
1994-95	33.92

These cost studies also show a breakdown of the total in terms of the not-for-profit sector (the GOE and NGOs which received some funding from GOE) compared to the -for-profit sector. This last description is misleading since the numbers consist actually of the agencies supplying commodities to the private sector suppliers, such as the Contraceptive Social Market Company, and the Egyptian Pharmaceutical Trading Corporation. No truly private sector firms costs are included. These are at best the subsidized commodity costs. The following table shows this breakdown of costs per CYP for the most recent year available (1994-95).

Not-For-Profit	34.46 LE
For Profit	6.58 LE

(A list of the groups included in these two categories is shown in: Geary and Abdelakhar, 1996)

Finally, it is also possible to compare the several approaches to the provision of services which the program presently employs. These costs per CYP are shown below for 1994-95.

Clinic-Based GOE	13.44 LE
Clinic-Based Non-GOE	30.43
Community-Based Distribution	49.69
Social Marketing	6.38

One must be careful not to draw too many conclusions from these comparative data. They suggest that the public sector cost per unit is much lower than the for-profit private sector figure, but many of the support services for the MOHP operation are joint with other MOHP programs and are not charged to the family planning effort as such and this make the GOE costs artificially low. In fact, the largest component of the GOE input to the program is the cost of the media time (TV and radio) provided by the State Information Service to MOHP. Almost no provision is made for the facilities or personnel engaged in providing services.

On the other hand, the for-profit figure really is simply a reporting of the cost per CYP's worth of contraceptives distributed to private supplies and even these costs are misleading since the commodity prices are subsidized. These commodity costs are, moreover, only a fraction of the actual fees charged by private, for-profit services providers; according to one USAID-funded study commodities are perhaps as

little as ten percent of the final fee charged by private physicians (Since, 1995). Similarly the NGO sector does charge fees and cost-recovery but is also acutely aware of its need to serve special groups. This sector also receives subsidized commodities from GOE and donors and external assistance. Hence, its apparent cost per CYP is by means a true cost-of-production.

These cost data are useful for many purposes and will be increasing useful as the program moves forward into a more explicitly cost-effective cost-recovery mode but they must be supplemented with new studies and new data sources in the period covered by the RP to become useful tools for financial management. It would be dangerous to attempt using them for program planning purposes at the present time.

(c) Unit Costs Compared to Other National Programs

All the costs discussed above are expressed in terms of Egyptian Pounds (or LE) but it is possible to compare these costs per unit with other national programs by converting all such data into a common currency the dollar. There are serious methodological difficulties with such a conversion but this is frequently done in other analyses and we can at least get an order of magnitude comparison from such an exercise. The following table presents Egypt cost per CYP compared to a range of other country-program figures.

<u>Cost Per CYP</u>	
(in current US Dollars)	
Egypt	
Not-for-Profit	5.00
For-Profit	1.94
Bangladesh	
Social Marketing	7.40
Surgical Method	11.40
Morocco	
Community-Based	7.70
Surgical Method	22.50
Indonesia	
Social Marketing	1.10
Thailand	
Clinics	17.20
Community-Based	4.20

97

This makes it clear that the Egyptian program is highly cost-effective when compared to other comparable programs (Moreland, 1996).

(6) Past and Future Financing of the Program

(a) Sources of Financing of the Program

The same USAID-funded cost studies discussed above also provide a good picture of the sources of funding for the two main sector of the overall program- the "not-for-profit" and the "for-profit" groups of agencies. The following table presents a breakdown for these two over time.

Year	Not For Profit Sector				For Profit Sector			
	GOE	Donor	Client	Other	GOE	Donor	Client	Other
1988-89	62.8	34.1	2.3	1.0	3.6	72.3	24.1	0.0
1989-90	51.0	44.3	4.1	1.0	4.1	68.8	26.0	1.1
1990-91	44.6	49.4	3.9	2.2	5.2	67.6	25.4	1.8
1991-92	45.4	46.0	7.0	1.5	7.0	61.9	28.6	2.5
1992-93	39.7	47.4	10.5	2.2	9.7	56.2	29.0	5.1
1993-94	49.5	36.3	11.3	2.9	1.0	75.4	24.6	0.0
1994-95	58.4	33.9	6.2	1.5	26.5	56.3	19.9	0.0

In 1994-95, a total of LE 95,610,984 was spent in both sectors with funds from all sources, with the for-profit sector accounting for LE 9,991,837 and the not-for-profit accounting for LE 85, 619, 147. Combining the two sectors, in 1994-95 GOE was the source of about 55 percent of the funding, donors about 36 percent and client payments about 8 percent, and other sponsoring agencies about 1 percent. These data exclude some donor inputs such as foreign-based technical assistance and training. The apparently anomalous movements in the "for-profit" sectors distribution of funding by source in 1993-94 stems from a change in the treatment of the sales

funds stemming from the CSMP. Prior to 1993-94 these revenues were used to fund the implementing GOE agencies and hence considered a GOE input, whereas in 1993-94 CSMP was "privatized" and the sales revenues were not included in the funds covered by the study. In 1994-95 the system reverted to the earlier procedure and counted these revenues.

There is no clear trend over time with respect to the goal of financial self-sustainability. The donors share of the total has been roughly constant as has clients inputs. The apparent rise of GOEs share in 1994-95 is spurious, in a sense, since it arises because of a sharp increase in the value accorded the State Information Service's contribution of TV and radio time. Large infusions of GOE funds were also required as CPs for several new UNFPA and USAID project agreements which were signed in this period. As was noted above, the figures shown here as the "clients share" represents in reality only a small fraction of the actual spending by clients obtaining family planning services in the private sector. Clients are already paying for a substantial share of the services and commodities they receive and the RP aims at a better tracking of this total picture. (This is discussed below.)

(b) The Financial Sustainability Issue

The data presented above are encouraging on the sustainability issue. The GOE is already making a major financial input to the program including a substantial subsidy to the for-profit sector. Revenue generated by client fees is substantial, particularly in the for-profit sector, in spite of the fact noted above that the prices and fees charged have been artificial low. Clients would pay more and substantial cost-recovery, if not full sustainability, of the for-profit sector within five years is a reasonable goal. In the short-run a renewal of the social marketing of contraceptives may be required but this would be only a stop-gap measure. Once the private sector is free to make its own arrangements about supply, the relative importance of the for-profit service providers and the NGO-PVOs should increase, and the need for USAID direct support to MOHP program should fall over time. The MOHP program should also move carefully but deliberately over time towards greater reliance on cost-recovery financing, accepting that full self-sustainability will not be possible so long as serious poverty groups persist in the country. To repeat, sustainability will be pursued by moving more and more of the services now provided on a subsidized basis into a full or partial cost-recovery mode.

(c) Cost-recovery versus other Program Objectives

The goal of longer-run program self-sustainability is obviously tied to pricing and cost-recovery issues. A review of the market studies done in Egypt and

the strength of the underlying demand for family planning services makes one optimistic that the for-profit private sector and the NGOs can play a growing role in the overall provision of services and sustainability will thus take care of itself. But, this will not happen over-night. Moving too quickly to dismantle public sector services or to end subsidized supply can be damaging to attaining the overall program target of replacement fertility early in the next century. Cessation of the Contraceptive Social Marketing Project two years ago may well have been part of the reason that prevalence levelled off between 1992 and 1995.

Putting the matter another way, there is always a tension between achieving program goals as quickly as possible and doing it as cheaply as possible and this tension will continue to exist in the future of the GOE-USAID cooperative effort in Egypt. But, the very legitimate and inescapable goal of sustainability should not obscure the fact that Egypt must reach replacement fertility as soon as this is programmatically possible. Reaching replacement level fertility early in the next century means an Egypt which will experience an ultimate population stabilization at around 120 million people (roughly double today's figure). If this is postponed even 20 years, the eventual total would be 180 million or half again as high. Egyptians want to control their fertility and it is in the best national interest that it be sooner not later. Nothing must disrupt the flow of services or the efforts to improve quality by broadening and deepening client information and choice.

(d) Alternative Scenarios for Program Effort

Much of the analysis in this Annex is independent of the precise level of financial effort which USAID Cairo is able to put into the implementation of the new RP. The long-run strategic objective (SO 4) will remain unchanged by such considerations, as will the several intermediate results (IRs) outlined in the RP. But, if the scope and pace of the specific activities outlined is seriously affected by the level of program effort possible under the RP, then the attainment of the IRs and SO would be delayed beyond the five year target set in the RP. The consequences of such delays will be considerable. Each years delay in reaching the goal of replacement fertility adds over a million people to Egypt's ultimate population total thus putting at further risk the chance for long-run economic and social stability.

(7) **Future Data Needs for Monitoring and Assessment**

(a) Monitoring Final Program Impact

SO 4 is fertility reduction and past USAID Cairo projects have created a good data base and procedures for measuring the impact of the RP on fertility

through contraceptive prevalence as well as infant and child mortality through the series of national Demographic and Health Surveys (DHS). These will continue under the new RP and additional smaller-scale follow-up surveys will also be undertaken to provide in-depth analysis of particular target groups (non-acceptors, remote rural households) and to relate program efforts to socio-economic policies and programs also underway. Since these surveys are of all households, no change in the sample design or methodology will be required as the emphasis of the overall effort shifts from public sector (GOE) to the private commercial and NGO sector. The indicators to be used are familiar - the total fertility rate (TFR), and the contraceptive prevalence rate (CPR).

(b) Measuring Intermediate Results

These same surveys will yield continuing estimates of total demand (latent plus actual) by measuring the extent of unmet need (as this concept was discussed and explained earlier in this Annex). Demand creation as an intermediate result will be monitored by tracking increases in overall demand and also movement of clients from latent to actual use.

The measure used of total supply will continue to be the couple-year-of-protection (CYP), which was also discussed and explained earlier in this Annex. This measure, as will be recalled, requires data on the actual number of contraceptive devices and commodities distributed in any given time period. At present all commodities flow through the Egyptian Pharmaceuticals Trading Company (EPTC). As privatization proceeds, commodities will originate and flow through the private sector, and a new effort will be required to track these commodity flows. This will mean adapting the tracking system now used by EPTC for use by whatever private sector firms come into the picture. The mission has adequate technical resources (in house or from contractors) to deal with this need.

The CYP as a measure of service output gives heavier weight to the IUD and other relatively-long term methods, as compared to the oral pill or the condom which are relatively short-term use methods. There is concern that this has lead to NGO service providers favoring the IUD over other methods when they are aware that their performance is being evaluated and reimbursements based on CYPs. For this and other reasons an additional monitoring need is to establish a uniform system of recording and tracking clients - new acceptors and continuing users - as such to complement the CYP which, in effect, tracks the commodities.

An earlier USAID project, the Institutional Development Project (IDP) assisted in improving within NPC a computer-based system for compiling and

reporting the total number of clients - new acceptors, revisits, by method - for all the clinics and other public sector service points. This system does work at present but the data are far from timely or reliable. A renewed effort will be made to create a meaningful Management Information System (MIS) housed within the new MOHP. This will build on the existing TA-8 system but be more closed integrated with the control over service delivery. The system must record and track all clients, wherever they are receiving their services or supplies. Such data will also be another useful measure (in addition to CYPs) of the changing balance from public to private sector within the overall flow of the program.

The intermediate results pertaining to increasing cost-recovery and self-sustainability will require a new effort in the area of program cost and financing. The present series (Geary and Abdelakhar) which was drawn upon earlier in this Annex, has focussed on reported GOE inputs to its own program as well as to NGOs and organizations servicing the "for profit" sector. This series must be continued and the GOE expenditure and other input data examined and recorded even more carefully. As, the focus of program effort shifts from NPC to MOHP, structures must be put in place to allow routine monitoring of the financial and cost side of MOHP's family planning activities.

The "for-profit" or commercial sector was recorded as spending only the cost-value of the commodities transferred to private service suppliers by EPTC and this is no real measure of the scale or scope of commercial operations. Other donor groups recently sponsored one household expenditure surveys to collect data on consumer spending on health and contraceptive services. Such survey efforts should be continued and expanded to give estimates of the consumer spending on contraceptive commodities and services and the number of consumers using the private market. This will permit a tracking of the shift in consumer focus towards the private sector as this occurs over time.

A new research effort will also be required to develop a methodology by which the total private sector financial effort can be measured. This will involve a monitoring system of a selected sample of private suppliers to obtain data on costs, sales, and pricing behavior. The experience and the expertise of the USAID Cairo contractors and US-based CAs already familiar with the data base can be employed. These expenditure data will permit a calculation of the total financial picture of the whole family planning service effort and thus enable USAID to track the shift in emphasis toward the private sector.

Another important IR is improved quality of services and the measures necessary to monitor these activities are spelled out in the RP. They do not affect the

overall demand, supply or financial and sustainability aspects of the RP however and are not treated in this Annex.

The other major intermediate result called for in the RP is a series of policy reforms required to energize the private sector and allow the price mechanism to do its work. These include deregulating contraceptive prices in the retail market, removing barriers to contraceptive commodity imports, and moving contraceptive commodity production from the public to the private sector. These are essentially "yes-or-no" activities and no long-term monitoring processes or new data sets are required. But, total management in the USAID Mission must monitor these activities and be in constant dialogue with GOE.

Similarly, another important intermediate result of the RP (and one on which many of the other IRs depend) is the strengthening of the existing MOHP managerial capacity and clarification of the institutional structure with respect to NPC, and SIS. GOE needs a new vision statement, and a detailed plan for reaching its goal of replacement level fertility, taking into account the latest data on the CPR and the TFR and the recent reshuffling of authority. The RP plans training for MOHP staff at several levels and offers TA when needed. But the achievement of these objectives depend on initiatives largely within the domain of the GOE. Constant dialogue must be maintained on these issues also.

(c) Summary on Data for Monitoring and Assessing

The periodic demographic surveys and annual cost studies will be continued and new data collection and analysis efforts will be launched to deal with the shift of the program towards more private sector involvement. A new effort will be made to obtain direct measures of clients to supplement the measure of CYPs. Additional surveys will be needed of private commercial suppliers, with respect their sales and costs. The mission already has the expertise, in-house and through contractors, to deal with these continuing and new tasks.

**Percentage Distribution of Total MOHP CYPs
By Region and Method, 1994-95**

	All Egypt	Frontier Governors	Upper Egypt	Lower Egypt	Urban Governor
IUD	90.	75.	84.	90.	90.
Pills	4.	15.	8.	5.	3.
Injectables	4.	6.	6.	4.	4.
Others	2.	4.	4.	1.	3.

ANNEX D

Institutional Analysis

This institutional analysis reviews briefly the characteristics and capacity of implementing agencies to be funded under the Population/Family Planning (POP/FP) IV Results Package. The consolidation of activities between POP/FP II and POP/FP III had reduced the number of implementing agencies supported by USAID in an effort to focus on strengthening and expanding the role of key players in the sector. Under POP/FP IV, however, given recent demographic and institutional changes, USAID sees the need for renewed emphasis on family planning supply and demand issues, and will thus broaden its assistance to enable an enhanced private commercial and NGO sector to participate more effectively in the national family planning program and to offer women a wider range of choice of quality providers. Moreover, USAID's focus will strengthen and expand support to program technical and management development, including the improvement of medical school curricula, to address issues of long-term program sustainability and self-sufficiency.

I. Overview of the Egyptian Family Planning Program Implementing Agencies

Established by Presidential Decree in 1985, the **National Population Council (NPC)** was originally designated as the special-purpose body responsible for coordination and policy definition in population and family planning. Until 1996, it functioned as an interministerial body mandated to plan, coordinate and evaluate family planning activities throughout the country, but recent GOE shifts have reduced its role to one of population policy analysis and coordination.

The **Ministry of Health and Population (MOHP)** is the principal government agency responsible for delivering family planning services in Egypt. Through its extensive and well-established network of clinical facilities, it has been providing services to low income clients since the 1960s. In 1973, the MOHP was delegated full responsibility for planning, budgeting and administering Family Planning services both within and outside of the MOHP, but until recent realignment of program responsibilities, effectively did not function in this capacity. The MOHP is also now named as the agency responsible for overseeing the activities of private voluntary organizations (PVOs) and other non-governmental organizations (NGOs) throughout the country.

The **Ministry of Information** is the umbrella under which the State Information Service/Information, Education and Communication Center (SIS/IEC) operates. SIS/IEC is the lead government agency responsible for family planning communication in Egypt. Since its establishment in 1979 with the technical and financial assistance of

USAID, the SIS/IEC Center has carried out its public education activities at the national level through the mass media and at the governorate level through interpersonal communication activities conducted by Local Information Centers (LICs). The Ministry of Information, for its part, has provided the national population and family planning program with generous amounts of television and radio time for IEC messages.

The **Private Commercial Sector** includes a network of approximately 60,000 physicians with private practices, an estimated 12,000 privately owned pharmacies, and contraceptive commodities marketing and distribution companies. Physicians participate in family planning service delivery in Egypt as sources of client information and supply. Pharmacies participate in family planning service delivery in Egypt as retail outlets for sales of contraceptives to end-users. Commercial marketing and distribution companies participate in family planning services delivery through the provision of contraceptive commodities.

II. Recent Changes Affecting the Institutional Development of the Program

In a major shift in 1996, the GOE realigned the responsibilities of the agencies responsible for population and family planning and reproductive health policy and service delivery. The MOH traditionally implemented health policies (i.e., policies about pharmaceuticals, prescription requirements, credentials, licensing, regulation of the private sector, etc.) and set policy for the programs and services which it delivers, while the National Population Council focused on the areas of gaining high-level support, facilitating intersectoral collaboration and advocacy, and providing coordination and strategic direction. In January 1996, however, these alignments were changed, and the Ministry of Health took on broadened responsibilities for population programming and was renamed the Ministry of Health and Population (MOHP). The shift was aimed at rationalizing the use of limited resources, increasing coverage, and ensuring effective integration of reproductive health, particularly family planning, at all service delivery levels.

However, while it is clear that service delivery will be consolidated under the MOHP, implications for other planning and policy functions are less clear. The two organizations, MOHP and NPC, have not yet fully clarified their roles and responsibilities within the national FP program, nor has the MOHP established clear strategic direction for the newly-configured Ministry.

III. Implementing Agencies and Activities: Institutional Characteristics, Constraints and Opportunities

A. National Population Council

The NPC, until recently, was the central government institution responsible for formulating and promulgating population policy and coordinating the population and family planning efforts of all public and private sector organizations. The original mandate of the NPC was to: formulate population policies realizing the highest possible rates of economic and social development; approve annual programs for population projects and activities; evaluate annual achievements, and issue directives for the elimination of any constraints to program success; decide on annual budgets; determine and coordinate the roles of public and private organizations; and approve and supervise implementation of foreign donor support to population and family planning activities. The Prime Minister represented the NPC in its relations with other entities and the Secretary General was assigned responsibility to manage the NPC Technical Secretariat, which was responsible for preparing draft national population plans; disseminating decisions of the NPC and following up on their implementation; communicating with foreign and international organizations to exchange information and experience in the field of population; and following-up and reporting on population plans, programs and activities approved by the National Population Council.

The UNFPA and USAID have supported the NPC since it was first constituted in 1985. USAID has supported two important activities under the NPC that have contributed to improved capabilities in the areas of family planning service statistics, information management and dissemination, and policy outreach. These have included institutional strengthening activities to further develop the capability of the Technical Secretariat (TS) and governorate level offices, to plan, coordinate, and report on family planning activities at the national and local level; support to the Research Management Unit (RMU) to strengthen the ability of the TS to plan, solicit, and fund needed applied biomedical, policy, and programmatic studies; and support for the NPC's role in policy dialogue and outreach.

Two key subprojects have been supported by USAID to date and will continue to receive funding under POP/FP IV:

- o The **Institutional Development Subproject (IDP)** under the Population/Family Planning II and III Projects focused on strengthening the capacity of the NPC to formulate and promote policies on population and family planning; developing comprehensive multi-year and annual plans at the national and governorate

level; monitoring, coordinating, and evaluating the work of family planning implementing agencies; and planning and managing research (including demographic and health surveys), information, training, and other support services necessary to develop and sustain the above functions.

Although it has matured under the past two population projects, especially at the governorate level, the NPC will continue to require assistance in strengthening its major and continuing role in policy analysis, research, and coordination to provide improved information for policy makers. For the short-term, USAID support will aim to develop and implement a strategic approach to improving the policy environment. Activities will focus on increasing political commitment to policy reform which strengthens and sustains the population/family planning program. Given the shift in national FP program management and implementation responsibility, however, much of the assistance previously provided to the NPC in strategic planning and information management will shift to the Ministry of Health to support its newly acquired functions.

o **The Regional Center for Training (RCT) in Family Planning and Reproductive Health** is affiliated with the Department of Obstetrics and Gynecology, Faculty of Medicine, Ain Shams University. It was established in November, 1988 to address constraints in the national family planning program. These constraints included insufficient numbers of well-qualified family planning trainers and family planning service providers as well as an insufficient number of family planning training programs with standardized curricula, quality training materials, and clinical training sites. The RCT was originally funded as a subproject for a three year period (November 1988 - October 1991) through the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO). In June 1990, USAID/Egypt began to fund the RCT directly under a host-country letter of agreement mechanism, and assistance has aimed at supporting the RCT to conduct clinical training for family planning trainers and service providers. In the second year of implementation under POP/FP II, RCT support shifted from an input-based funding approach to a performance-based output payment system which pays the RCT for numbers of trainees trained.

The RCT has shown itself to be capable of providing high-quality training services. However, as the RCT seeks to achieve increased self-sufficiency and strives to function as a more independent regional training center with an expanded client base, it will need assistance in defining and establishing itself as a permanent and more autonomous organizational structure. The RCT also requires further support in strengthening its technical, management, and business development capacities and in improving its cost effectiveness and efficiency in order to improve

operational performance and enhance its ability to sustain itself in the long term.

B. Ministry of Health and Population

The MOHP is the principal public institution for delivering family planning services and has been doing so for over 20 years. USAID support to the MOHP began in 1977, but prior to 1987, the FP program had limited success, and it was not until 1988 that the MOHP FP program began to rapidly develop under the USAID-supported Systems Development Project (SDP), which focused on improving FP service delivery and management systems toward enhanced long-term sustainability. In 1989, an Undersecretary for Family Planning position was established in the MOHP, providing distinct visibility as well as potential for greater coordination of all family planning activities within the Ministry of Health and Population.

Although important improvements have been made in the quality of services delivered through the MOHP, systemic characteristics of the MOHP continue to inhibit desired development. For example, the challenge to effectively and efficiently utilize and mobilize the Ministry's vast physical and human resources continues to be a vexing problem. Nonetheless, the MOHP remains the principal health care organization in Egypt and is the most appropriate institutional resource for delivering urgently needed FP services.

Shifting greater responsibility for FP services to the MOHP should reduce duplication of efforts, strengthen linkages between FP and MCH services, and enhance the prospects of financial and institutional sustainability. However, it will require even greater levels of USAID support to enhance its institutional and managerial capabilities to carry out newly acquired functions at both central and governorate levels while sustaining the gains already achieved. Given the complexity of the revised structure and increased responsibilities of the MOHP, USAID assistance will focus on enabling the MOHP to face a host of critical new challenges, including building national capacity to carry out population policy objectives, formulating implementation guidelines to operationalize its programs, and providing direction and support to a large number of local and international partners.

Two subprojects under the MOHP have been supported by USAID to date and will continue to receive assistance under POP/FP IV:

- o The **Systems Development Subproject (SDP)** will receive ongoing assistance to improve its provision, management and promotion of high quality family planning services. Continued support for the Gold Star Quality Improvement Program

(QIP) will incorporate the expansion of available services to include post-partum care and tubal ligations for medically indicated reasons, reproductive tract infections, and other selected reproductive health interventions. Management systems will be further strengthened, with special emphasis on the decentralization of systems to the district level under the supervision of the governorates. Efforts will also aim to enhance MOHP capacity to independently manage contraceptive commodities logistics systems, including projecting needs and procurement of contraceptives.

While most Results Package assistance will focus on improving program service provision and management capacities, RP assistance will also be expanded to include support for capacity building for the recently appointed population sector within the MOHP. Support will emphasize the development of a sector-wide MIS for service delivery in family planning and reproductive health services, policy analysis and development, and strategic planning.

o **The Clinical Services Improvement (CSI) Subproject** was developed under the POP/FP II Project as a special activity intended to serve as a model for family planning service delivery. An official decree of the Minister of Social Affairs seconded the subproject to the Egyptian Family Planning Association (EFPA), an affiliate of the International Planned Parenthood Federation (IPPF) which is the foremost national organization providing organized clinical family planning services in Egypt. By upgrading clinical family planning service provision and management in selected EFPA clinics, the CSI Subproject aimed to enable the EFPA to realize its potential to provide high quality clinical family planning services to increased numbers of acceptors nationwide and in so doing, to make a significant contribution to increased contraceptive prevalence.

Since its start-up under POP/FP II, the CSI Subproject has been governed under the authority of a special Project Committee, appointed by and responsible to the Minister of Social Affairs. The Project Committee, composed of members of the EFPA Board of Directors, including the EFPA Executive Director, provides technical and financial oversight to the subproject; in addition, the EFPA Executive Director provides guidance to CSI on administrative matters to ensure coordination and consistency with EFPA policies and activities.

Although it had problems early on in its development, by POP/FP III it had achieved major successes, offering high quality family planning services in centers nationwide. CSI's achievements in self-financing under POP/FP III have been strengthened through a performance-based output payment system established by USAID to improve CSI's financial self-sufficiency and enable it to identify alternative funding sources and approaches. USAID support under POP/FP IV will focus on

supporting CSI's continuing development as an increasingly self-sufficient institution and further strengthening its strategic planning, marketing, and business development capacities.

C. Ministry of Information

The FP information, education, and communication unit of the State Information Service under the Ministry of Information 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 using mass media through the MOI's Radio and Television Union and local outreach using SIS's 60 Local Information Centers (LICs) has moved FP IEC beyond the clinical setting and into the consciousness of the Egyptian public, significantly increasing public awareness of population and family planning issues.

USAID support to the SIS has greatly improved IEC center technical and administrative assistance. However, given the need to reinvigorate public support for the program and demand for family planning, SIS requires strengthened capacity to inform and motivate public and opinion leaders to be advocates for family planning, to implement targeted and carefully focused activities that directly support the family planning service delivery activities of major implementing agencies and sectors, and to plan, coordinate and mobilize program partners in the implementation of a national IEC strategy.

USAID assistance to the MOI under POP/FP IV will continue for one subproject currently funded under POP/FP III:

o **The State Information Service/Information, Education and Communication (SIS/IEC) Center** will receive ongoing support to strengthen its planning and delivery of communications activities, both mass media and interpersonal. Emphasis will be placed on the use of research to guide message development, the targeting of messages to segmented audiences, and on correcting misinformation about contraceptives. Focus will also be given to further enhancing SIS management structure and systems so that SIS can effectively support family planning IEC activities at both the central and LIC level and coordinate the national IEC program.

D. Private Commercial Sector

USAID assistance to the private commercial sector was energized with the development of the Private Sector Initiatives activity implemented under POP/FP III. The focus of this initiative has been on improving both the quality of care provided by both private physicians and pharmacists and the demand for private sector services through a combination of targeted training, marketing and promotional, and referral activities. Under POP IV, USAID intends to broaden and expand its support to private sector activities to enhance private sector participation in the national program. Efforts will also focus on increasing the role and contribution of contraceptive commodity marketing and distribution groups to long-term program sustainability.

USAID support to the private sector under POP IV will continue for one subproject currently funded under POP/FP III:

- o The **Private Sector Initiatives (PSI) Subproject** will be renamed the Private Commercial Sector Subproject to reflect an expanded, national level approach to training of private sector physicians and pharmacists, marketing and promotion of private sector services, and strengthening of linkages between these two provider groups. Expanded mass media and marketing support will aim to increase the availability of contraceptive commodities in the private sector and to improve effective contraceptive use. Emphasis will be placed on coordinating subproject activities with the broader POP/FP IV policy agenda to facilitate legal and regulatory changes to enable the expansion of private sector services and availability of contraceptive commodities.

E. Medical Schools

Medical education in Egypt consists of seven years of study. The first four years are spent studying basic sciences, after which students spend two years completing clinical education requirements, during which 60 hours of obstetrics and 30 hours of gynecology are taught to students. Four to six of the final GYN hours are devoted to family planning. Clinical education is followed by one year of compulsory internship, which is known as house officer training and serves as the seventh year of medical training. During this year, students rotate in two-month segments through five departments to learn four core subjects: medicine, surgery, OB/GYN, and pediatrics.

Thirteen Egyptian medical schools graduate over 3,000 physicians annually. These schools vary greatly in their structure, student body, and teaching

methodologies. Government policy to completely subsidize medical education results in enormous enrollments with classes of several hundred students each. Access to meaningful laboratory and clinical experiences is extremely limited. Overall, the curriculum is curative in orientation, hospital-based, and technology centered. Except for reproductive physiology, little time is devoted to FP. All of this implies that graduates of medical schools enter the market with a wide range of knowledge and skills about family planning, and that overall, medical education in Egypt does not prepare the graduate to function effectively as a family planning service provider in either a public or private setting.

USAID efforts under POP IV will support a comprehensive approach to strengthen undergraduate, or pre-service, medical education, including standardizing and strengthening the content of the 4-6 hour didactic module on family planning; improving faculty members' curriculum development and teaching methodology, including clinical teaching methods; strengthening house officers' curricula, including the clinical skills of students during their year of internship; providing medical schools with basic equipment and materials to support the provision of quality family planning and selected reproductive health services to clients; and providing students with opportunities for guided practice in family planning service delivery in this setting.

IV. USAID's Strategic Approach to Institution Building under POP IV

The March, 1996 Midterm Evaluation of the POP/FP III Project reviewed USAID's institutional strengthening activities, both cross-programmatic and institution-specific, in some detail. Key findings and recommendations of this evaluation have important implications for the POP/FP IV Results Package. In general, it recognized that a great deal of progress had been made in developing mission, strategy, structure, staff, and systems in the POP/FP III Subprojects. For example, it noted that institutional capabilities created within The Egyptian Pharmaceutical Trading Company (EPTC) were quite efficient and fully institutionalized. It recognized that critical MOHP capabilities, including systems in supervision, training, financial management, and management information, had been successfully upgraded, and that SIS IEC programs were effectively reaching the majority of the population.

The evaluation emphasized, however, that most institutions were still in need of additional support, including technical assistance, in order to attain a more comprehensive, sustainable institutionalization of systems. For example, it pointed out that service delivery, demand creation, and training institutions require additional focus on integrating strategic planning approaches into their organizations. The evaluation team felt that even the CSI Subproject, which had some experience in

strategic planning, required additional support to be able to strengthen its internal capability and commitment to conduct strategic planning as a regular part of program planning exercises.

The strengthening of institutional capacity to effectively plan, deliver, and manage the national family planning program is increasingly important as the program expands in scope. Since USAID began providing assistance to the national program, USAID support has had a consistent focus on institutional capacity building. As noted in the evaluation, activities to date have provided focus and technical and administrative strength to Egyptian institutions. However, although major progress has been made in creating institutional capacity in FP service delivery, institutional strengthening is still required throughout the national system.

The national population program, as it moves forward, requires enhanced coordination between partners with clear definition of roles; participatory planning so that ownership and management of planning and implementation is fully decentralized; and continuing focus on quality management to enable improved identification of goals, improved utilization of information to support decision-making, and more rational utilization of resources, all of which will further enable institutions to manage and support the national family planning program.

Strengthened institutional capacity to manage FP programs, which includes well-developed and sustainable infrastructure and systems, will contribute to strengthened sustainability of family planning systems. Operational capacity - that is, skilled human resources, particularly middle level managers, effective management systems, strategic planning capacity, and effective communication/coordination networks are required if services are to respond to the pressures of a rapidly growing number of clients on a permanent basis. At the same time, program resources should be invested rationally to get the most return, meaning that all sectors play optimal roles, functioning where they have a comparative advantage in terms of client groups, geography and methods.

As such, USAID support to family planning program institutions under POP IV will build on previous activities and focus on three primary results. First, it will provide comprehensive, sector-wide strategic assistance that both creates and supports skilled and knowledgeable service providers to strengthen the human resource base for the national program. Second, it will focus continued efforts on expanding and improving program management systems. Third, it will enhance program strategic planning capacity both at the national and institutional level to maximize resources within the sector and enhance program impact.

Given recent demographic and institutional changes, there is now an opportunity to revitalize the national FP program. A number of activities will be undertaken that will contribute significantly to program expansion and enrichment. USAID's strategic approach to institution building under POP IV will address continuing program needs, or gaps, in a variety of areas, including:

Management/Operational Systems Gap: To further build a cadre of skilled human resources for the national program, USAID support will provide continuing focus on enhancing and decentralizing management systems throughout institutions. A systems approach will continue to emphasize the institutionalization of management systems and operational procedures to enhance long-term sustainability of the national program.

Information Gap: The national service statistics reporting system management function will ultimately move to the MOHP Population Sector, which will take on the function of overall program coordination. Currently, however, the MOHP does not have the institutional capacity to manage this function effectively. USAID assistance will support upgrading of MOHP management information systems to better manage the national program, and of partner institution systems to participate more actively and effectively in the program.

Strategic Planning Gap: The IDP has made tremendous strides in institutionalizing a strategic planning function within NPC governorate offices. MOHP and SIS personnel actively participate in all governorate level strategic planning sessions. However, with recent shifts in program responsibilities, USAID will place emphasis on facilitating the transfer of the strategic planning function to the MOHP and building capacity within the MOHP to manage this function effectively.

At the same time, the realignment of government responsibilities, simultaneous with new information on demographic conditions in Egypt, provides an important opportunity to meet new challenges facing the health sector. The need to clarify goals and strategies in the newly configured agencies and to adopt new service delivery strategies suggests the need to identify strategic direction, to mobilize program resources, and to develop plans that will get programs up and running to accomplish program goals. The MOHP has begun to develop its mission, objectives, and broad strategies in a process including its partner organizations. USAID will provide continuing assistance so that the MOHP can better clarify its roles and responsibilities for the new population sector and develop and document strategic plans for accomplishing its goals.

Sustainability Gap: USAID will continue to expand capacities in cost recovery and funding diversification among partner agencies, particularly RCT, CSI, and selected non-governmental agencies participating in the national family planning program. Efforts will also focus on shaping an expanded and more permanent role of the NGO sector in family planning supply and demand activities.

Educational Gap: The development of an indigenous and sustainable capacity to meet an ongoing need for trained providers of family planning services has to start with the formation of strong medical school family planning curricula. In a comprehensive sense, this includes not only the ability of individuals to function as proficient faculty, but also the capacities to plan, implement, manage, and evaluate the country's family planning program. Medical schools are the training grounds for thousands of graduating physicians annually. Under POP/FP IV, USAID support will aim to improve the quality of pre-service medical education, an investment which will ultimately ensure the improvement of family planning/reproductive health service quality delivered to clients.

Coordination Gap: Currently, the national family planning program suffers from insufficient coordination and lack of "mission" at all levels among groups charged with FP service delivery and demand creation, not only within organizations at the national level, but between national and local level members of the same organization and among different organizations. Given the incomplete definition of the roles of implementing organizations and their interrelationship in a uniform and integrated strategy for the national family planning program, there is clear need for strategic management which includes participatory planning and the definition of each group's role to ensure supervision and accountability under a decentralized system as well as to maximize available resources. To address this opportunity to achieve a higher level of coordination between the Ministry and other FP programs, USAID POP IV assistance will provide intensive support to strengthen the MOHP in its role as overall coordinator of the national family planning program.

Leadership Gap: USAID support will aim to build the family planning program human resource base by identifying the next generation of young, upcoming population professionals and provide them with long-term, masters' level training and leadership development in specialized management areas.

V. Institutional Strengthening under SO 4, Reduced Fertility

Developing the institutional capacity of agencies in the national family planning program, making developing institutions more solid and mature through a strengthened

human resource base, improved program management systems, and enhanced strategic planning capacity, will contribute to the achievement of I.R. 4.2.2., strengthened institutional capacity, which, along with increased financial self-sufficiency of family planning systems (I.R. 4.2.1) and an improved policy environment (I.R. 4.2.3), will lead to strengthened sustainability of family planning systems, I.R. 4.2. Sustained reductions in fertility require permanent changes in reproductive behaviors supported by systems that are permanent, fully institutionalized, and financially sustainable. Strengthened sustainability of family planning systems, along with increased use of family planning services, are the results that, together, will contribute to the accomplishment of Strategic Objective 4, Reduced Fertility.

ANNEX E

Initial Environmental Evaluation



CAIRO, EGYPT

UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

THRESHOLD DECISION
BASED ON
INITIAL ENVIRONMENTAL EXAMINATION

Results Package Location: Egypt
Results Package Title/ID: Population, Family Planning, and Reproductive Health (263-0267)
Fiscal Year and Amount: FY 97 - FY 01, \$90 million

Prepared By:

Date:

Signature of Seifalla Hassanein
Seifalla Hassanein
Environmental Specialist

6.12.97

Strategic Objective Team Leader's Concurrence:

Date:

Signature of Richard Martin
Richard Martin
OD/HRDC/POP

6-16-97

Decision of Environmental Coordinator,
Bureau for Asia & Near East:

Approve: _____

Disapprove: _____

Date: _____

Clearances:

APatterson, MEO, DR/ENV
DBarth, LEG

Signature of APatterson date June 12, 1997
Signature of DBarth date 6/14/97



CAIRO, EGYPT

UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

**THRESHOLD DECISION
BASED ON
INITIAL ENVIRONMENTAL EXAMINATION**

Results Package Location: Egypt
Results Package Title/ID: Population, Family Planning, and Reproductive Health (263-0267)
Fiscal Year and Amount: FY 97 - FY 01, \$90 million

Prepared By:

Date:

Seifalla Hassanain
Seifalla Hassanain
Environmental Specialist

6.12.97

Strategic Objective Team Leader's Concurrence:

Date:

Richard Martin
Richard Martin
OD/HRDC/POP

1. 16. 97

**Decision of Environmental Coordinator,
Bureau for Asia & Near East:**

Approve:

Joy R. [Signature]

Disapprove:

Date:

30 June 1997

Cleanances:

APatterson, MEO, DR/ENV
DBarth, LEG

Asst
Dgo

date
date

June 12, 1997
6/14/97

Discussion
of
Major Environmental Relationships
and
Environmental Action Recommended

BACKGROUND & DISCUSSION:

The Population/Family Planning/Reproductive Health IV ("POP IV") Results Package (RP) will continue USAID's assistance to the Egyptian national family planning/ reproductive health (FP/RH) sector for up to ten years. Begun in 1975, USAID assistance to date has totaled about \$206 million. Phase 1 of POP IV will provide an additional \$90 million over the five year period 1997-2001.

This RP is considered the "sustainability phase" of USAID's assistance to family planning in Egypt. It involves: (1) the eventual phase-out of USAID donated contraceptives; (2) the creation of endowments for certain key partners; (3) policy reforms leading to the GOE assuming greater financial responsibility for the national program; and (4) an emphasis on promoting sustainable commercial private services. Activities are organized around five Intermediate Results (IR): (1) Enhanced Supply; (2) Increased Demand; (3) Increased Financial Self-Sufficiency of FP Systems; (4) Strengthened Institutional Capacity; and (5) Improved Policy Environment. To achieve these results the RP will provide contraceptive commodities, technical assistance and training, awareness campaigns, grants to local NGOs and support to a number of participating organizations in the form of technical assistance, training, office equipment, training equipment, vehicles, and other support equipment.

Discussion of Environmental Impacts & Recommendations:

The training and institutional development components of this Results Package have no impact on the natural or physical environment and thereby qualify for a categorical exclusion pursuant to 22 CFR, Part 216.2 (c)(2)(i): "Education, technical assistance or training programs except to the extent such programs include activities directly affecting the environment".

The procurement of commodities in support of the institutional development activities (office equipment, training equipment, vehicles, etc.) component under this RP have no significant environmental impact on the physical and natural environment and therefore, pursuant to 22 CFR 216.3(a)(2)(iii), the Mission recommends a negative determination of significant environmental effect for these inputs of the RP.

The procurement of contraceptive component of this RP qualifies for a categorical exclusion pursuant to 22 CFR, Part 216.2 (c)(2)(viii): "Programs involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.).

Grants provided to local NGOs under this RP will finance office and clinical equipment and procurement of contraceptives, therefore, they fall into the two categories of activities discussed above (procurement of commodities and procurement of contraceptives). It should be noted that no construction is included in this project.

As with all USAID-funded projects, and pursuant to 22 CFR 216.3(a)(9), if new information becomes available which indicates that any of the proposed actions to be funded by these subgrants might be "major" and their effects "significant," the threshold decisions for those actions listed above will be reviewed and revised by the BEO and an environmental assessment prepared by the Mission, as appropriate.

ANNEX F

Congressional Notification

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
ADVICE OF PROGRAM CHANGE

PROGRAM: EGYPT
PROJECT TITLE: POPULATION, FAMILY PLANNING, and
REPRODUCTIVE HEALTH IV
PROJECT NUMBER: 263-0267
FY 1996 CP REFERENCE: NONE
APPROPRIATION CATEGORY: ECONOMIC SUPPORT
LIFE-OF-PROJECT FUNDING: \$90,000,000 (ESF)
INTENDED FY 1997 OBLIGATION: \$10,000,000 (ESF)

This is to advise that in FY 1997 USAID intends to obligate \$10,000,000 in Economic Support funds for the Population, Family Planning and Reproductive Health IV Project. This is a new project, managed by USAID/Egypt, with a life-of-project funding level of \$90,000,000.

The purpose of this project is to improve the quality and coverage of family planning and reproductive health services on a sustainable basis in Egypt.

Attachment: Activity Data Sheet

**UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
ACTIVITY DATA SHEET**

CP 81-05 (4-85)

PROGRAM: EGYPT		PROPOSED OBLIGATION (In thousands of dollars)	
TITLE POPULATION, FAMILY PLANNING, AND REPRODUCTIVE HEALTH IV		FY 1997 \$10,000 ESF	LIFE OF PROJECT (Auth.) \$90,000 ESF
NUMBER 263-0267	GRANT <input checked="" type="checkbox"/> LOAN <input type="checkbox"/>	INITIAL OBLIGATION FY 1997	ESTIMATED FINAL OBLIGATION FY 2000
NEW <input checked="" type="checkbox"/> CONTINUING <input type="checkbox"/>	PRIOR REFERENCE NONE	ESTIMATED COMPLETION DATE OF PROJECT FY 2001	

Purpose: To improve the quality and coverage of family planning and reproductive health services on a sustainable basis in Egypt.

Background: The Government of Egypt's (GOE) national family planning program, which began in 1975 with USAID support, has resulted in major accomplishments: the contraceptive prevalence rate has reached 48%, almost double the rate of 1980; the total fertility rate has fallen from over five children per married woman in 1980 to 3.6 in 1995; knowledge of family planning is nearly universal among Egypt's adult population; and family planning enjoys broad support. Egypt has 3,700 government clinics that provide family planning services nationwide. Services are also available through thousands of private medical providers. Nevertheless, major obstacles remain to be overcome.

The 1995 Egypt Demographic and Health Survey showed that the program had reached a "plateau," with growth in coverage leveling off. Factors that contributed to this slowing included population momentum -- rapid growth of the number of women of reproductive age, requiring great increases in the number of women served just to "stay in place" in terms of the contraceptive prevalence rate -- and the growing challenge of serving ever more difficult-to-reach clients (poor, rural, illiterate) after the initial easier-to-reach clients (middle class, urban, educated) had come into the program. It is also apparent that many users are discontinuing family planning due to incorrect information about health dangers associated with contraceptives. The GOE has begun to take steps it believes will attract new clients. The government abolished the Ministry of Population and moved family planning into a combined Ministry of Health and Population (MOHP), creating a greatly expanded new unit to manage family planning/reproductive health (FP/RH) services. Both public and private FP/RH services need to be revitalized.

Project Description: Population, Family Planning and Reproductive Health IV responds to the challenge of the plateau with a series of new initiatives and shifts in emphasis. This includes: (1) a major new emphasis on using commercial marketing and advertising to attract new clients; (2) massive support for the mobilization of thousands of MOHP community outreach workers; (3) initiation of support for

family planning non-governmental organizations (NGO), a previously untapped resource; (4) expansion of the successful Clinical Services Improvement organization into new urban markets, including Cairo; (5) expansion of the "gold star" quality improvement program to more MOHP clinics to attract new clients and recover clients who discontinued the use of contraceptives; (6) the expansion of FP services to include post-partum contraception and selected reproductive health services; (7) upgrading medical school curriculum in family planning/reproductive health; and (8) working with private physicians, pharmacists and pharmaceutical companies to increase the availability of FP/RH services and contraceptives through commercial channels.

Beneficiaries: The principal beneficiaries, or customers, are Egyptian married women of reproductive age between 15 and 49 years of age and their husbands. Men as well as women, and non-users as well as users, are considered customers because the availability of family planning services opens up choices.

Other Donors: USAID has been the lead donor in the Egyptian family planning program since its inception in 1975. Among other donors, UNFPA has provided important support encouraging capacity building and advocacy (\$15 million - 1992-1996; \$20 million - 1997-01). The European Union (\$2.4 million - 1994-97) is working with an NGO, the Egyptian Family Planning Association (EPPA) in Delta Governorates and in two Upper Egypt governorates, Qena and Sohag (\$13 million - 1995-99). The Dutch program (\$8.3 million - 1996-00) is working in the Fayoum. The International Planned Parenthood Federation is also working with the EPPA and a recently approved World Bank IDA loan (\$20.7 million - 1996) for capacity building and demand creation also includes NGOs as partners.

Results: This project is designed to reduce fertility. Key targets include a reduction in the Total Fertility Rate (the average number of children a woman would have by the end of her childbearing years) from 3.63 in 1995 to 3.59 in 1999 and 3.55 in 2001 and an increase in the Contraceptive Prevalence Rate (the percentage of married women of childbearing age currently using contraceptives) from 47.9 in 1995 to 48.7 in 1999 and 51.6 in 2001.

U.S. FINANCING (In thousands of dollars)			PRINCIPAL CONTRACTORS OR AGENCIES Principal Contractors or Agencies:
Obligations	Expenditures	Unliquidated	
Through September 30, 1995	0	0	Ministry of Health and Population National Population Council Ministry of Information (State Information System) Clinical Services Improvement (CSI) U.S. contractor(s) TBD
Estimated Fiscal Year 1996	0	0	
Estimated Through September 30, 1996	0	0	
Future Year Obligations		Estimated Total Cost	
Proposed Fiscal Year 1997	10,000	80,000	90,000

126

ANNEX G

Statutory Checklist

STATUTORY CHECKLIST

I. COUNTRY CHECKLIST FOR EGYPT

The Country Checklist for Egypt for FY 1997 is attached to the Results Package for the Partnership in Economic Reform, Results Package No. 263-0269

II. ASSISTANCE CHECKLIST

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

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE? YES

A. DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND

1. Congressional Notification

a. **General Requirement** (FY 1997 Appropriations Act Sec. 515; FAA Sec. 634A): If the obligation has not previously justified to Congress, or is for an amount in excess of the amount previously justified to Congress, has a Congressional Notification been made?

Congressional committees will be notified in accordance with regular Agency procedures. The Congressional notice will include all information required.

b. **Special Notification Requirement** (FY 1997 Appropriations Act, "Burma" and "NIS" Title II headings and Sec. 520): For obligations for NIS countries, Burma, Colombia, Guatemala (except development assistance), Dominican Republic, Haiti, Liberia, has a Congressional Notification been submitted, regardless of any justification in the Congressional Presentation?
N/A

c. **Notice of Account Transfer** (FY 1997 Appropriations Act Sec. 509): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees?
N/A

d. **Cash Transfers and Nonproject Sector Assistance** (FY 1997 Appropriations Act Sec. 531(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted? N/A

2. **Engineering and Financial Plans** (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? Yes

3. **Legislative Action** (FAA Sec. 611(a)(2)): If the obligation is in excess of \$500,000 and requires legislative action within the recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

All international agreements must be ratified by the People's Assembly. In the past, the Assembly has ratified all grant agreements in a timely manner.

4. **Water Resources** (FAA Sec. 611(b)): If the assistance is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? N/A

5. **Cash Transfer/Nonproject Sector Assistance Requirements** (FY 1997 Appropriations Act Sec. 531). If assistance is in the form of a cash transfer or nonproject sector assistance:

a. **Separate Account:** Are all such cash payments to be maintained by the country in a separate account and not commingled with any other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)? N/A

b. **Local Currencies:** If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be

generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account? N/A

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government? N/A

(3) Has A.I.D. taken all necessary steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes? N/A

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government? N/A

6. **Capital Assistance** (FAA Sec. 611(e)): If capital assistance is proposed (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the assistance effectively? N/A

7. **Local Currencies**

a. **Recipient Contributions** (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

The Government of Egypt is expected to contribute to the Results Package a cash amount in Egyptian pounds of approximately the U.S. dollar equivalent of \$16.819 million.

b. **US-Owned Foreign Currencies**

(1) **Use of Currencies** (FAA Secs. 612(b), 636(h)): Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. N/A

(2) **Release of Currencies** (FAA Sec. 612(d)): Does the U.S. own non-PL 480 excess foreign currency of the country and, if so, has the agency endeavored to obtain agreement for its release in an amount equivalent to the dollar amount of the assistance? N/A

8. **Trade Restrictions - Surplus Commodities** (FY 1997 Appropriations Act Sec. 513(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A

9. **Environmental Considerations** (FAA Sec. 117; USAID Regulation 16, 22 CFR Part 216): Have the environmental procedures of USAID Regulation 16 been met? Yes

10. **PVO Assistance**

a. **Auditing** (FY 1997 Appropriations Act Sec. 550): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of USAID? Yes

b. **Funding Sources** (FY 1997 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? If not, has the requirement been waived? N/A

11. **Agreement Documentation** (Case-Zablocki Act, 1 U.S.C. Sec. 112b, 22 C.F.R. Part 181): For any bilateral agreement over \$25 million, has the date of signing and the amount involved been cabled to State L/T immediately upon signing and has the full text of the agreement been pouched to State/L within 20 days of signing?

Case-Zablocki Act reporting procedures will be followed with respect to this Results Package.

12. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements,

grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage? **Yes, to both questions.**

13. **Abortions** (FAA Sec. 104(f); FY 1997 Appropriations Act, Title II, under heading " Development Assistance" and Sec. 518):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? (Note that the term "motivate" does not include the provision, consistent with local law, of information or counseling about all pregnancy options.) **No.**

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? **No.**

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? **No.**

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? (As a legal matter, DA only.) **N/A.**

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? (As a legal matter, DA only.) **N/A.**

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? **No.**

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? **No.**

14. Procurement

a. **Source, Origin and Nationality** (FAA Sec. 604(a): Will all procurement be from the U.S., the recipient country, or developing countries except as otherwise determined in accordance with the criteria of this section?
Yes

b. **Marine Insurance** (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

Egypt does not so discriminate.

c. **Insurance** (FY 1997 Appropriations Act Sec. 528A): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. insurance companies have a fair opportunity to bid for insurance when such insurance is necessary or appropriate? **Yes**

d. **Non-U.S. Agricultural Procurement** (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) **N/A**

e. **Construction or Engineering Services** (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)
N/A

f. **Cargo Preference Shipping** (FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the

gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

All applicable shipping rules and procedures will be followed.

g. **Technical Assistance** (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? **Yes**

h. **U.S. Air Carriers** (Fly America Act, 49 U.S.C. Sec. 1517): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

All applicable air carrier rules and procedures will be followed.

i. **Consulting Services** (FY 1997 Appropriations Act Sec. 549): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? **N/A**

j. **Notice Requirement** (FY 1997 Appropriations Act Sec. 561): Will agreements or contracts contain notice consistent with FAA section 604(a) and with the sense of Congress that to the greatest extent practicable equipment and products purchased with appropriated funds should be American-made? **Yes**

15. Construction

a. **Capital Assistance** (FAA Sec. 601(d)): If capital (e.g., construction) assistance, will U.S. engineering and professional services be used? **No, construction is limited to modest-value renovation activities.**

b. **Large Projects - Congressional Approval** (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? **N/A**

16. **U.S. Audit Rights** (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A

17. **Communist Assistance** (FAA Sec. 620(h)). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes

18. **Narcotics**

a. **Cash Reimbursements** (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes

b. **Assistance to Narcotics Traffickers** (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? Yes

19. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes

20. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes

21. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? Yes

22. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes

23. **Export of Nuclear Resources** (FY 1995 Appropriations Act Sec. 506): Will assistance preclude use of financing to finance, except for purposes of nuclear safety, the export of nuclear equipment, fuel, or technology? Yes

24. **Publicity, Propaganda and Lobbying** (FY 1997 Appropriations Act Sec. 546; Anti-Lobbying Act, 18 U.S.C. § 1913; Sec. 109(1) of the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989, P.L. 100-204): Will assistance be used to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? **No**

25. **Commitment of Funds** (FAA Sec. 635(h)): Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement? **No**

26. **Impact on U.S. Jobs** (FY 1997 Appropriations Act, Sec. 538):

a. Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business? **No**

b. Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U.S.? **No**

c. Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country, or will assistance be for the informal sector, micro or small-scale enterprise, or smallholder agriculture? **No**

B. DEVELOPMENT ASSISTANCE ONLY

N/A. PART B OF THE ASSISTANCE CHECKLIST, WHICH IS APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY, HAS BEEN OMITTED BECAUSE IT IS INAPPLICABLE TO THIS ESF FUNDED RESULTS PACKAGE.

C. ECONOMIC SUPPORT FUND ONLY

1. **Economic and Political Stability** (FAA Sec. 531(a)): Does the design

and planning documentation demonstrate that the assistance will promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? **Yes**

2. **Military Purposes** (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes? **No**

3. **Commodity Grants/Separate Accounts** (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? (For FY 1997, this provision is superseded by the separate account requirements of FY 1997 Appropriations Act Sec. 532(a), see Sec. 532(a)(5).) **N/A**

4. **Generation and Use of Local Currencies** (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? (For FY 1997, this provision is superseded by the separate account requirements of FY 1997 Appropriations Act Sec. 532(a), see Sec. 532(a)(5).) **N/A**

5. **Capital Activities** (Sec. 306, Jobs Through Exports Act of 1992, P.L. 102-549, 22 U.S.C. 2241a): If assistance is being provided for a capital project, will the project be developmentally-sound and sustainable, i.e., one that is (a) environmentally sustainable, (b) within the financial capacity of the government or recipient to maintain from its own resources, and (c) responsive to a significant development priority initiated by the country to which assistance is being provided. **N/A.**

ANNEX H

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