

COMPARATIVE STUDY OF INTEGRATED FAMILY PLANNING  
PROGRAMS IN EGYPT

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I. INTRODUCTION

The purpose of this paper is to examine the importance of the organizational dimension on the effective delivery of family planning information and services to rural areas in Egypt. In particular, our interest is upon the integration of family planning programs with other health and socioeconomic components. The first section develops a typology of three levels of integrated family planning programs.

The second part of the study provides a background of integrated family planning programs in Egypt. These programs have gone beyond the singular function of providing contraceptive services by placing family planning within a more broadly conceived developmental approach. Organizationally, family planning projects of this type have become part of programs addressing other socioeconomic development issues. In some cases, this has implied the integration or collaboration of different public agencies in a joint effort. Two integrated programs are examined in terms of their impact on family planning, and community development, as well as some of the constraints and shortcomings of each.

In the last section, the process of integrating various public agencies within an ongoing family planning program is examined. The objective is to analyze the process of integration at

the upper administrative and the lower service delivery levels in order to uncover the organizational processes associated with the operationalization of project goals. Obviously, these two levels are related since organization effectiveness at the upper level is carried over to the local delivery level.

There has been little analysis of the actual processes involved in the administration and implementation of family planning programs in LDC's, as well as in Egypt. The experience of upper level public officials and the relationship between that experience and actual program functioning at lower levels have remained largely unexamined. This analysis constitutes an effort to illustrate organizational realities surrounding family planning implementation in rural Egypt. The Egyptian experience in family planning implementation is determined by the organizational and institutional structure in which it is imbedded, in particular a limited capacity to implement. The question is whether the organizational requirements of integrated family planning programs are commensurate with existing public bureaucratic capacities in Egypt.

## II. TYPOLOGY OF INTEGRATED FAMILY PLANNING PROGRAMS

The degree of integration between family planning and other health and socioeconomic activities can be typified as varying from low to high. The following three types of family planning programs which vary in terms of their integration should be distinguished from clinic-based programs.

### Type I: Family Planning and IEC

Family planning programs in their least integrated form consist of vertically structured organizations providing family planning services through health units, neighborhood depots and outreach workers. An effort is also made to inform, educate and communicate (IEC) with communities regarding the program and the utility of family planning. The best example of Type I is community-based family planning programs with IEC components that aim to stimulate demand, as well as increase acceptance in the community for the family planning effort. IEC efforts involve such things as community meetings and discussions with local leaders (formal and informal) regarding the need for family planning and the health benefits to mothers and children. Integration in this type of family planning program consists basically of an effort to collaborate with community members and gain their support.

## Type II: Family Planning, IEC and Health

Similar to Type I family planning programs, community preparation and other IEC efforts are implemented to gain community acceptance and stimulate demand. Proponents of this approach argue that the linking of family planning to the upgrading of health facilities and the provision of health services, especially maternal child health (MCH) care, provides greater credibility and community support for the family planning component than a Type I program. This is due to the fact that community members are more supportive of tangible improvements in health. The argument follows that rural villagers do not feel that family planning services alone bring salient benefits which affect the welfare of their families. Therefore, it is necessary to integrate family planning with other health services having more "tangible" benefits which can be recognized by rural villagers.

## Type III: Family Planning, IEC, Health and Development Activities

In the third level of integration, family planning is integrated into a more broadly conceived program effort which encompasses both health and socioeconomic activities. In Egypt, programs providing family planning services are also responsible for a wide range of developmental activities such as income generating projects, transportation facilities, nurseries, women's clubs, etc. In some cases, Type III projects are not only charged with administering family planning services but also a wide variety of health and developmental concerns requiring the interaction and collaboration of public agencies and their personnel.

Among proponents of integrating family planning with other socioeconomic concerns, the following arguments are commonly espoused:

1. Rural villagers will not be motivated to limit family size in lieu of a considerable improvement in the socioeconomic wellbeing. Current norms regarding family size leave little room for family planning interventions. Massive social and economic transformation and related structural changes are necessary for fertility decline, without this change family planning will have little impact.

The basic policy assumption is that an integrated rural development approach will initiate a major social change, decreasing the benefits of children to parents while

increasing their costs, thereby enabling an increase in the proportion of families who want less children.

2. The cooptation of formal and informal community leaders through funding and implementing socioeconomic activities is necessary to provide support and credibility for the family planning component; IEC efforts alone are not sufficient. Without the cooptation of community leaders, the impact of family planning programs will be limited, and in some cases, the program will be rejected or reputed through rumors and other forms of disruptive behavior.

Type I constitutes the first step from clinic-based family planning delivery and includes outreach services such as neighborhood depots and/or direct home distribution. Type II incorporates features of Type I but also includes the health services such as MCH within the same organizational framework. Type III programs seek to integrate family planning services with other socioeconomic activities and, in some cases, health services are also provided. Usually the major focus of Type III programs is upon socioeconomic developmental efforts. In conclusion, the shift from Type I to Type III raises a host of organizational and management issues which family planning projects and related public agencies in LDC's are typically ill prepared to meet.

Before examining the impact of several integrated programs in Egypt, it is first worthwhile to question the empirical and historical validity of the arguments for including broad based socioeconomic concerns within the administrative framework of family planning programs. Although the argument that family planning programs can not "succeed" in the absence of considerable social change of a modernizing character and are unnecessary in its presence is frequently used as a basis for integrating family planning within the framework of a broader developmental program, the empirical evidence is lacking. Studies by Ansley Coale (1973), Tietelbaum (1975), Freedman and Berelson (1976), and others have not shown a consistent relationship between fertility decline and socioeconomic development. This holds true for both the decline of fertility in Europe and currently developing areas. The findings of the European Fertility Study suggest that barriers to diffusion across cultural lines and channels for diffusion within cultural groupings had a major impact on adopting birth control measures (Freedman and Berelson, 1976). In widely different cultural and economic settings characterized by vigorous family planning programs, considerable increases in contraceptive prevalence have

occurred, e.g., Taiwan, Korea, Bali, East Java, Bangladesh, Colombia, Costa Rica, and Mexico. Furthermore, it is clear that countries with the largest declines in fertility also have the stronger family planning programs.

### III. IMPACT OF TYPE III INTEGRATED FAMILY PLANNING PROGRAMS

This section examines the impact of two integrated family planning programs in Egypt: the Population and Development Project (PDP) and the Menoufia Project.

#### Population and Development Project

In 1972-73, the Population and Family Planning Board (PFPB) formulated the policy that family planning programs must deal with the concerns of entire communities and that reception of family planning would be better conceived if introduced within the context of a total development package. Accordingly, the PDP started in 1977 in 20 Village Councils and expanded to 12 governorates by 1980 (the present number). Presently, PDP covers about 70% of the Egyptian population. Two components of the PDP are:

1. To provide improved family planning delivery systems,
2. To stimulate socioeconomic development.

Family planning is promoted through female extension workers (Raidat Rifiat) in local communities; they numbered 3064 at the end of 1982. The second component entails the funding of small-scale projects in villages. Support for the PDP is provided by the UNFPA, USAID and the Egyptian Government.

What has been the impact of the PDP on the delivery of family planning through its extension workers? A comparison of PDP and non-PDP villages are drawn from the First and Second Rural Fertility Surveys. Results for ever married women from the Second Rural Fertility Survey (RFS) are presented separately for Lower and Upper rural Egypt. In Lower Egypt characterized by relatively higher levels of contraception, levels of contraceptive prevalence in PDP and non-PDP villages are similar, 23.1% and 23.8% respectively. In Upper Egypt, modern contraceptive usage was not substantively different between PDP and non-PDP areas, 5.8% and 4.5% respectively.

By comparing the First and Second RFS's, it is also possible to measure increases in contraceptive prevalence between PDP and

non-PDP areas. The only significant changes were 1) an increase in contraceptive prevalence for non-PDP areas in Lower Egypt (19.3% to 23.8%), and 2) a decline in prevalence in PDP areas in Upper Egypt (9.7% to 5.8%). To compare PDP and non-PDP differentials in rural Egypt as a whole, prevalence rates must first be standardized according to the Lower-Upper distribution in the First RFS. Once rates are standardized for the Lower-Upper composition, a decline in contraceptive prevalence in PDP areas from 16.8% to 15.4% (-1.4 percentage points) and an increase in non-PDP areas from 12.4% to 14.3% (+1.9 percentage points) are found.

The effect of the PDP upon knowledge and proper use of the pill--the principal contraceptive method distributed by the PDP extension workers--is equally negligible. Although knowledge of oral contraceptives is higher in PDP areas, proper use (i.e. daily) is higher in non-PDP areas. While knowledge and ever use may be slightly higher in PDP areas, current use effectiveness and continuation which are more salient for fertility levels do not vary significantly.

What are the reasons for the lack of success of the PDP's outreach program in altering fertility behavior. The Second RFS shows that extension workers are not providing family planning information and services on a regular basis. Only 8.6% of rural women (11.3% Lower and 4.2% Upper Egypt) have been visited by someone for family planning. When women who were visited were further asked if they had been visited by a PDP extension worker, only 27.1% responded affirmatively. Hence only 2.3% of the respondents recall a visit by the PDP workers. Finally, when women are asked if they are visited regularly (i.e. once per month), the percentage drops to less than 1%. When the Beni-Suef Project requested the names of PDP extension workers in order to incorporate them into the household distribution of contraceptives, some of the PDP workers could not be located. They had moved, retired or simply could not be found. The data from the Second RFS clearly demonstrate the inability of the PDP through its extension workers to meet the needs of rural women for family planning service and stimulate demand.

The impact of the PDP upon community development is not much better. Approximately 75% of the funding for developmental concerns for the PDP has gone for 1) transportation facilities (i.e. small vans or buses) and 2) sewing machines. The projects that are funded frequently do not reflect the input and desires of community members since the majority of the projects are decided upon by the head of the Local Unit and the PDP coordinator at the

local level. Because there is a need on the part of the PDP to show that something has been accomplished, the PDP pushes Local Units to utilize available funds. Finally, funding for PDP projects is not linked to family planning concerns at the community level. Villagers do not even realize that funding for socioeconomic projects and the activities of extension workers are part of the same integrated program, as is the case in the Menoufia Project.

Since applicants for projects must provide a guarantee for receiving PDP funds, villagers with good relationships with members of the Local Unit become the primary recipients, in particular their kin. This is to be expected since Local Unit members will only guarantee those people who they know personally and have strong ties. In a sample of PDP villages, 90% of the recipients receiving project funds for sewing machines and milk separators had strong links with members of the Local Units. Although the purpose of PDP funding is to promote income generating activities, 60% of the sewing machines recipients used them in their own homes and did not produce marketable items. Moreover the PDP did not 1) train women to use the machines, 2) provide for inputs of material, 3) help to see that the machines are maintained, nor 4) develop marketing outlets for products.

#### Integrated Menoufia Project

The Menoufia Project evolved through two phases. In the first phase, the project was only concerned with family planning and related health services in 38 villages (in the counties of Tala and Shebin El Kom). Family planning services were offered in upgraded health units and through one round of home visits. During the home visits, family planning information and supplies were distributed. After only nine months of the program, contraceptive prevalence, as indicated by pre- and post-intervention surveys, increased from 19.1% to 27.7% for a substantial rise of 45%. In areas with the lowest contraceptive prevalence, the increase in contraception was the greatest. Moreover, relatively salient increases occurred among women with low parities: women with 2 living children increased from 13.1% to 21.0% and with 3 children from 21.0% to 30.4% (Gadalla, Nosseir, and Gillespie 1980).

The next phase of the Menoufia Project sought to expand the experience of the 38 villages throughout the governorate. The family planning component consisting of a single round of household canvassing was retained, but other integrated components

where included within the framework of the project, referred to as the Integrated Social Services Delivery Systems Project (ISSDSP). Oral rehydrants, for example, were distributed to mothers with children under 5 years of age through a separate distribution effort. A major component was the funding of a broad range of developmental projects such as nurseries, boy's and girl's workshops, women's clubs, Mother's Councils, productive family projects and literacy classes.

The results of pre- and post-intervention surveys on a selected number of villages show that unlike the 38 villages, contraception only increased from 19.3% to 21.7%. In recent preliminary findings from the entire rural area of Menoufia, contraceptive prevalence does not vary significantly from other rural areas of Lower Egypt, even though the funding for family planning has been greater.

What are the reasons for the substantial increase in the 38 villages and only a minor increase in the fully integrated project? Some have argued that the 38 villages were not typical of the remainder of the governorate; yet the increase is so substantial that it is doubtful if the 45% increase can be relegated to being atypical. Another reason that is given for the minor increase is the reliance on a single round of household canvassing. Nevertheless, the 38 villages only received one round of visits with less qualified canvassers.

The reasons for the sizeable increase in the 38 villages and the negligible impact on the remainder of the governorate appear to be related to differences in scale and organization, and the priority of family planning in the project. The move from the 38 villages to the entire rural area of the governorate involved a larger program effort and manpower outlay. The experience of family planning programs in LDC's is that they tend to be relatively successful on a limited or experimental scale where tight control over the program can be maintained, and the amount of manpower to be trained, supervised and utilized is rather small. When the program effort is expanded or replicated on a larger scale, project control becomes more diffuse and the technical administrative capacity becomes taxed. In the ISSDSP, not only did the coverage of the program increase but also the number of project activities expanded into new areas requiring divergent technical, administrative and training skills. For example, the training and problems related with oral rehydration are different from family planning delivery. Moreover, the linking of family planning and oral rehydration proved to have some deleterious

side effects on the family planning component. The funding and implementation of social activities in rural communities requires yet another set of advisory and supervisory skills. Furthermore, the incorporation of oral rehydration and social activity components into the ISSDSP meant that funding and personnel which could have been utilized in family planning efforts were involved in other areas.

While villagers in Menoufia realized that funds for social activities were provided by the same project carrying out the family planning component, no direct integration was made between family planning and social activities. For example, the project could have used social activities that were upgraded and established as a basis for family planning IEC efforts. Also the allocation of funds for social services were not contingent upon meeting family planning goals. Finally, the project was not flexible and responsive to community needs in implementing social activities. Each community was required by the project to implement five or six different activities. Since many communities did not have the infrastructure (i.e. personnel and facilities) to implement some activities, approximately 35% of the allocated funds were not spend by the end of the project; communities were not permitted to redirect these funds into other activities they desired.

#### IV. PROCESS OF TYPE III INTEGRATION: BENI-SUEF PROJECT

This section examines the process of interorganizational integration in the Beni-Suef Project between participating public service agencies. The official goals of the integrated Beni-Suef Project, as stated in the project proposal, are to provide family planning, health and social services to the rural population of Beni-Suef Governorate over a three year period.

The Beni-Suef Project is a a joint effort of the Local Administration of the governorate and the Departments of Health and Social Affairs. Technical assistance and research is provided by Ain Shams University and the Social Research Center, American University in Cairo. The role of the Technical Assistance Team (TAT) is to assist governorate officials in designing, implementing, and evaluating the training, and action programs such as the household distribution of contraceptives and oral rehydration salts.

According to the original project design, it was envisaged that manpower and funding would be supplied by the various

integrated agencies of Health, Social Affairs, PDP and the TAT. Political and executive support would be provided to the project by the Governor's office and through funding from AID to the governorate. The primary officiating body, chaired by the Governor, is the High Committee which determines the policy and implementation procedures of the project.

Family planning information and services are provided through a two tiered delivery system involving local health units and extension workers. Contraceptives are offered in health units in which the medical staff has been trained by the project. To increase accessibility to family planning, direct home visits are made on a periodic basis by extension workers: 1) health unit nurses, 2) PDP Raidat, and 3) Social Affairs Raidat. While the latter two types of family planning personnel work under the organizational auspices and supervision of their own agencies, they also report to health unit physicians who serve as local supervisors of the contraceptive distribution effort.

The following discussion attempts to demonstrate that the organization of the Beni-Suef Project is a product of 1) an evolving collective compromise and consensus, 2) an instrument for the interests of stakeholders, and 3) a structure for the fulfillment of these interests. The Beni-Suef Project may strive towards integration, but integration of whom and for what purpose is the basic question, as the organization consists of divergent and conflicting interests.

#### Official Versus Operative Goals

Although the "official" goals of the Beni-Suef Project were described in the proposal for funding, it is necessary to analyze the process determining "operative" goals. Stated official goals serve a necessary function, especially for new organizations in providing 1) a focus or orientation for the activities pursued within the organization, and 2) the legitimation and mandate that a new organization may require. In contrast, operative goals and organization are what stakeholders with different interests and resources make of formal organization goals.

Conflict and divergent interests in organizations and between them, as in the rest of society, cause organization members and groups to compete with one another. This competition often takes the form of striving to achieve operative goals. The justification may even be through the official organization goals. For example, organizations often replace their initial goals with new

goals through a process involving a bid for power by one or more stakeholders in the organization. While competition and conflict over operative goals is normal, it may assume such a magnitude that official goals become radically inoperative as stakeholders seek to assert and operationalize goals which meet their own particular interests.

Operancy makes the difference between stated or official goals and real goals. Although stated and operative goals may be the same, there is frequently a difference between imposed official goals, and emergent and changing operative goals. Because official goals are frequently not the basis for organizational action, the determination of an organizational goal(s) becomes an empirical matter and not one based upon a priori assumptions. This is only acquired through the analysis of organization actions and the meaning attached to them. Following this perspective, both operative goals and structure are viewed as responses to functional needs within the organization and the external environment, and therefore are dependent variables (Abramsson 1977:122-23). Since organizational goals change over time and are redefined, they tend to be difficult to uncover and specify. Furthermore, it becomes unrealistic to consider the finality of goal achievement, as internal and external factors continue to impinge upon organizational groups reshaping organizational action.

While the proposal for the Beni-Suef Project outlined project components and various integrated agencies that would participate, the precise operationality of the project goals remained largely ambiguous and undefined. The different participating agencies were obviously aware that the Beni-Suef Project would imply inter-agency integration and collaboration; nevertheless, they did not have a clear idea of what their specific inputs and roles in the project would entail. That is, how they would work together to meet the formal or official goals of the project. Additionally, the concept of integration is not a common experience among public bureaucracies in Egypt since they tend to function separately in terms of budget and administrative structure. Factors which facilitate interorganizational integration are: 1) past experience in successful integration, 2) receptivity to change, 3) willingness to make concessions, 4) ability to arrive at a mutual concensus and reach shared objectives, and 5) interdependency. At the beginning of the Beni-Suef Project, none of these facilitating factors were present. During the last eighteen months of the project, these factors have been slow to develop. If the project improves its performance in the next two

counties where the project will be implemented then there is a chance that some of these facilitating factors will emerge.

Once the Beni-Suef Project was funded and initiated, the participating agencies began to define and assert their own interests through the operationalization of the project's structure and implementation procedures. Each party provided different interpretations of the form the project should take. Hence a long period of negotiation coincided with the project's training and implementation phases. This process consisted of strategies for control of the operating goals and key resources of the Beni-Suef Project.

### Rules and Policies

Rules, laws and policy procedures were drawn upon by the participating agencies to legitimate certain actions favorable to them and thus operationalize goals in their interest. Laws, rules and professional procedures are effective when used by one group(s) to gain organizational control and implement operative goals in their interest. They tend to be effective because other groups accept them for the time being since they feel that 1) they can do nothing to alter them, 2) they may promote stable group relations, or 3) they are couched in professional language leaving their interpretation only to those desiring their implementation. If subordinate groups feel that they can do nothing to alter rules outside of their purview, they will usually acquiesce, for some time, but they will often seek to counter, circumvent or change the rules. Sometimes this involves a reinterpretation of rules and procedures.

The action of the MOH in Beni-Suef demonstrates the use of rules to define and implement operative goals which they desired. The designers of the Beni-Suef Project sought to overcome the limited one round distribution of contraceptives, which characterized the Menoufia Project, by carrying out periodic household visits to married women of reproductive age (MWRAs). The plan was to directly supply women with contraceptives in the home. When members of the TAT sought to implement this part of the project, they were blocked by the MOH. The MOH representative maintained that according to MOH policy oral contraceptives could not be distributed without women first being examined by a health unit physician, due to the contra-indications for prescribing steroidal hormones. This, in turn, enhanced the role of the MOH in the project.

By causing women to go to a health unit before receiving pills, the implementation of the project was delayed. The impact of the contraceptive distribution effort was reduced, at least in the first phase, since nurses were also not permitted by the MOH to directly supply oral contraceptives in the home to current users, as well as new acceptors. Later contraceptives became available for women already contracepting who had been previously examined by a physician.

Another use of rules to control operative goals is illustrated in the way contraceptives are distributed to health units. The project obtained approximately 10,000 cycles of pills from the PDP. As the project started, it became apparent that oral contraceptives were not available in all health units. Members of the TAT then wanted to distribute the project's pills to health units, but this was also blocked. The MOH maintained that all oral contraceptives used in health units must be distributed through their regular distribution channels for which the MOH would receive program credit. Again departmental rules and policies became the means of operationalizing a particular group's interest.

The ability to determine operative goals in the interest of one group may simply involve an interpretation of rules by professionals. For example, some of the members of the High Committee are not physicians nor have a background in public health and its terminology. Hence the MOH representatives can interpret rules and procedures related to the delivery of health services while those members without a medical background do not have the capacity to question and counter with their own interpretation. Because the procedural interpretation is couched in medical terminology, they do not question the authority or validity of the procedures desired by the MOH. Consequently, the MOH is able to shape project procedures and implementation by alluding to governmental rules and policies, and using medical nomenclature.

### Project Funds

Instead of having one consolidated budget, the funding agency (USAID) provided project support through the governorate, the MOH, and the Social Research Center (TAT), each with its own budget. The budgets of the TAT and the Governorate were known to all participating public agencies, but the amount of funding from the MOH and the activities to be supported remained unknown to outside agencies. Since the High Committee did not demand a

clarification of the amount and use of funds provided by USAID, policy decisions were made by the High and Executive Committees without a full accounting of available funds. Therefore, project funds were not pooled into a unified budget and administered under one authority in accordance with the integrated needs of all participating agencies.

The budget of the governorate and the MOH both had funds for transportation; each budget had funds to purchase four cars. The Governor and Secretary General of Beni-Suef however did not know exactly how much funding was included in the MOH budget for cars, maintenance, and gasoline. When the MOH offered to provide cars for the project, the Governor thought that they would be directly available to the project and under his authority. After a year and a half, the cars began arriving; but the MOH asserted that the cars were only to be driven and maintained by MOH personnel in the governorate who would be paid from MOH funds. This situation was unagreeable to the Governor who wanted to use the cars for any project-related activity that he wanted. Consequently, the Governor began to realize that he must spend the L.E. 74,000 in the governorate budget for vehicles. This problem has resulted because there was not a clarification between the governorate and the MOH regarding the collaborative use of funds and vehicles. The Governor mistakenly thought that he would have authority over the four vehicles supplied by the MOH budget; this was not the case. As a result, the project is currently in need of more cars as the project is being expanded into two additional counties.

#### Organizational Change among Participating Agencies

Integration and interorganizational collaboration, as envisaged in the official project proposal, necessarily meant a change in the rules of the game. The reaction of various group members was to contend the formulation of new rules in order to define them in accordance with their own interests, particularly when rules affected the control of key resources and credit for program efforts.

Integration also requires a situation of mutual interdependency between participating agencies. When traditionally rigid and indulgent organizations are pushed toward interdependency, this tends to create uncertainty which is perceived as threatening to different group interests. In Beni-Suef, dominant stakeholders used various strategies to minimize group dependency--and therefore integration--in order to increase their power within a set of "rules of the game".

In order to achieve an integration of the Beni-Suef Project among the participating governmental agencies and the TAT, changes in each of these agencies are necessary. Each agency must make alterations or modifications in the organizational tasks, technology and structures related to the project, owing to the overlapping integrated design of the official integrated project. Changes in tasks undertaken by the project require alterations in organizational structure including changes in the patterns of authority and communication, as well as the roles of members. Moreover, the agencies must perceive change to be in their own interests. This, in turn, demands adaptability and receptivity to change as agreed upon by all parties in the integrated project organization. If change is believed to be risky, threatening or unnecessary, integration becomes difficult to achieve. Organizational change is complicated by the fact that elements, both internal and external to Egyptian public bureaucracies, create not only pressures for change but also pressures for intransigence and stability.

When group members perceive the organization as highly inflexible and view the probabilities for change as slim, they may not even bother to identify problems and suggest change. Hence it is important that group members at various levels of the organization believe that the project directors do, in fact, desire change and are willing to resolve problems. For this reason, it is easier to initiate change in organizations that have loosely defined roles, horizontal communication structures, and relatively decentralized authority structures. Moreover, it is easier to implement change in completely new organizations than in organizations which have become fossilized and inert (Cooke 1979:168).

For the Beni-Suef Project to become integrated as envisaged by the official proposal, changes in the tasks, structure and roles of members working in the various participating agencies are required. Nonetheless, each of the agencies sought to maintain their own bureaucratic structure intact and, in some cases, reinforce it. In the household distribution of contraceptives, the Departments of Health, Social Affairs, Local Administration and PDP participate. Technical support is provided by the TAT. The project enlisted extension workers from the PDP and the Dept. of Social Affairs, and Health Unit nurses; additional extension workers were recruited and placed under the administration of the PDP. The foregoing female extension workers (Raidat and nurses) were given the task of carrying out household visits in order to inform MWRA regarding family planning services and supply contra-

ceptives. In order to monitor their activities and gauge the impact of the project, project forms are filled out by each extension worker. These are then turned over to health unit physicians who compile a summary of each extension worker's efforts. Next, a general summary of the health unit's activities is compiled and turned over to county level health officials. Finally, these records are sent to officials at the governorate level. This record keeping system serves as the basis for evaluating and paying personnel at all levels of the project (i.e. extension worker, health unit clerk and physician, and directors of health in each county). For all of these project-related personnel, these new tasks and recording keeping system constituted a change or modification.

What was the reaction of the various agencies to the new system of records? While personnel linked to different agencies were allowed to fill out the new forms, the previous record keeping system was maintained leading to an increase in the paperwork of personnel. For example, the PDP permitted the integration of extension workers with health unit personnel, but in order to be paid by the PDP, extension workers were still required to fill out the forms which are used nationally. The PDP was hesitant to make concessions or changes which would vary from the record system used in the other eleven governorates where they are operating, even though the information supplied by the project forms could have served this purpose. Because the PDP has insisted that extension workers continue to fill out the standard forms use in other governorates, a double set of forms are maintained. The reason given by the PDP is that the project forms would make it impossible for the PDP to coordinate the activities in Beni-Suef with other areas and compare PDP efforts. Moreover, the Regional Coordinator of the PDP did not receive written permission from higher level PDP officials to modify the program in Beni-Suef in order that PDP procedures would be more consistent with the overlapping and integrated nature of the project.

Because the integrated project sought to place new demands upon subordinate members of the participating public agencies and develop ties between these agencies, this was viewed as a lose of control over personnel. The response of the agencies was to try and maintain their separate agencies intact. As noted, extension workers of the PDP were incorporated in the program to carry out home visits and distribute family planning information and supplies. The project provided them with training, charged them with new tasks, taught them to fill out daily records of their

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visits, and placed them under the supervision of local health unit physicians. All of this was added to the previous job description of the PDP. Nevertheless, the PDP did not modify the administrative or supervisory systems which are utilized elsewhere. The job description, for example, of the extension workers was not decreased, only amplified, even though the present job description far exceeds their capabilities.

Under the Beni-Suef Project, extension workers must report to local health unit physicians and are supervised by county health unit officials. At the same time, they remained under the jurisdiction of their original public agencies. Hence extension workers must also report to local Social Affairs officials, Heads of Local Units, and PDP Coordinators in the village. Moreover, members of the TAT visit health unit workers and provide technical assistance which is viewed as another form of supervision. The result of this rather complex organizational structure and the divergent interests served by it is that that authority, accountability and responsibility are diffused. While the county level supervisor makes visits to health units and is a part of the project, nobody is directly responsible for meeting with all of the extension workers, helping them overcome problems, and providing them with encouragement.

## V. CONCLUSION

The integrated family planning programs discussed in this paper demonstrate a shift from clinic-based and Type I family planning delivery programs to more broadly conceived socioeconomic developmental programs. In the case of the PDP, this is based upon the assumption that overall social development together with the provision of family planning services will lead to a reduction in population growth. In the PDP, the Menoufia Project and the Beni-Suef Project, integration has meant the provision of family planning and community development efforts within the same organizational structure, requiring coordination between program components and different public agencies.

The impact of integrated (Type III) programs upon increased contraceptive prevalence and stimulating demand has been limited. The levels of prevalence which have been achieved have fallen below the levels desired by program implementors, population planners and funding agencies. The reason for implementing integrated programs was to end the either/or situation of economic growth versus family planning by providing for both simultaneously. While nobody suggests that socioeconomic development is not

required in Egypt nor will have an impact upon birth control, the central issue is whether public and private population and health organizations can effectively carry out all of these activities under the same organizational framework. In relation to the PDP, it appears that family planning is a less important policy issue than community development and the funding of small scale economic projects. In the Menoufia Project, a substantial increase in prevalence was obtained in 38 villages, in only nine months, without integrating socioeconomic activities. When community development activities and oral rehydration were added to the expanded project covering the entire governorate, the impact upon family planning was reduced. Family planning became only one activity among a variety of other project components requiring divergent technical skills and organizational capabilities.

The process of integration in the Beni-Suef Project underscores the many problems which occur when public bureaucracies try to function effectively in an integrated fashion. Any attempt at interorganizational integration and collaboration must first consider the lack of experience in working in an interdependent manner and second the different interests and power of stakeholders which militate the development of a shared policy and administrative framework. Many of the factors which could facilitate integration and change are absent. Without a strong organizational development component, the potential for their emergence is limited. For these reasons, we suggest that dedicated family planning programs such as community-based distribution with IEC efforts (Type I) are a more viable alternative to the pressing problem of population growth in Egypt.

Given a particular situation in which credibility for the family planning program is lacking, Type II programs with limited MCH may be incorporated into the program effort. Care should be taken to not include MCH and other primary health care services where they are unnecessary, at least, in the initial phase of the program when the administrative framework is already being taxed. When a comprehensive delivery system is in place and the work load decreases, then health related concerns can prove to be a valuable adjunct to the program. Even at this point, caution should be maintained in order that family planning is not relegated to only a trivial part of the overall program effort.

In conclusion, we emphasize the gap between plan and implementation. Successful family planning programs are less distinguished by their content than by systematic and thorough implementation. For the most part, family planning programs and strategies have not failed, rather, they have not been adequately tried nor implemented.

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