

A.I.D EVALUATION SUMMARY PART I

(BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS)

A. Reporting A.I.D. UNIT (MISSION OR AID/W OFFICE)  
USAID/EGYPT  
(ES : 86-5 )

B. WAS EVALUATION SCHEDULED IN CURRENT FY ANNUAL EVALUATION PLAN?  
yes  slipped \_\_\_ ad hoc \_\_\_

C. EVALUATION TIMING  
interim \_\_\_ final \_\_\_  
ex post \_\_\_ other

D. ACTIVITY OR ACTIVITIES EVALUATED (List the following for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report)

Project :	Project/Program Title (or title & date of evaluation report)	First or PROAG equivalent (FY)	Most recent PACD (mo/yr)	Planned LOP Cost ('000)	Amount Obligated to Date ('000)
263-0029 & 263-0144	Population/Family Planning I & II	77 83	9/86 5/88	67.4M 102.6M	67.4M 26 M

E. ACTION DECISIONS APPROVED BY  
MISSION OR AID/W OFFICE DIRECTOR  
Action(s) Required

Name of officer  
responsible for  
action      Date action  
to be  
completed

- Increase and broaden policy dialogue with selected target groups, e.g., decision and opinion makers, planners and health care providers, utilizing local technical assistance resources to the maximum extent feasible. T. Tiffany,  
HRDC/P      Through  
life of  
Project  
263-0144
- Increase emphasis on family planning services in the project, and incorporate improved systems for monitoring outputs in service delivery subactivities. T. Tiffany,  
HRDC/P      1/87
- Further expand Family of the Future (FOF) retail marketing and distribution activities. New clinical and community outreach initiatives should be encouraged, provided they are supportive of CRS activities and do not detract from FOF's continuing programs in this area. T. Tiffany,  
HRDC/P      On-going
- Initiate a subproject with the Egyptian Family Planning Association which will improve its capacity to manage and upgrade the quality of its clinic services. T. Tiffany,  
HRDC/P      1/87

(Attachments, if necessary)

Action Decisions (Continued)

	<u>Officer Responsible</u>	<u>Completion Date</u>
5. Incorporate improved management systems for monitoring sub-activity performance and program expenditures.	USAID HRDC/P & FM/FA staff.	3/87
6. Examine alternatives for project implementation mechanisms which are less staff intensive.	T. Tiffany HRDC/P	6/87

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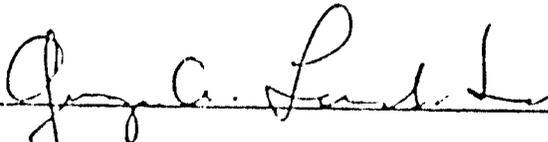
F. DATE OF MISSION OR AID/W OFFICE REVIEW OF EVALUATION:

G. APPROVALS OF EVALUATION SUMMARY AND ACTION DECISIONS:

T. Tiffany, HRDC/P  
B. Wilder, AD/HRD

~~S. Conly, DPPE/PE~~ *AM for Oct 23. '86*  
V. Molldrem, ~~DPPE/PE~~ PPP/PL, Oct 23. '86  
G. Laudato, AD/DPPE *Nov. 2*

Approved:

  
Frank W. Kimball, Director, USAID/Egypt

Nov. 2 1986

Date

ATTACHMENTS (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier)

USAID'S POPULATION PROGRAM IN EGYPT; ASSESSMENT AND RECOMMENDATIONS

MAIN REPORT

SPECIAL REPORT: USAID MANAGEMENT CONSIDERATIONS

ATTACHMENTS

COMMENTS BY MISSION, AID/4 OFFICE AND BORGHERN/GRANTEE

The Assessment Report is useful in placing past experience in perspective and in identifying broad directions for future assistance. Its usefulness is constrained, however, by its lack of specificity in several important areas. We recognize that the team had only limited time available for a very comprehensive review. However, the team did not completely fulfill its explicit charge to assist the Mission in identifying more effective, implementation modes and mechanisms; in particular, the lack of specific guidance as to how technical assistance (TA) should be handled, leaves this issue open.

1. Institutional Development and Technical Assistance: USAID agrees that the impact of past population assistance has been somewhat diffuse, and that current efforts to narrow program focus and improve its overall effectiveness should continue. Philosophically, however, the Mission differs with the Assessment Team's recommendation that institutional development and service delivery should be the dual themes of future assistance. In USAID's view, institutional development is a means to an end, rather than an end in itself. The primary focus of future assistance should be on family planning services, i.e., expanding both the availability of and the demand for these services. Institution-building efforts should support this overall objective.

The discussion in the report regarding institutional development and technical assistance does not adequately reflect the realities of the current situation. The major, continuing constraint to institutional development is the lack of a single, effective GOE agency responsible for program implementation. The report implies that TA is a solution to current implementation problems, but TA can only have a limited impact on institutional development in the current context. Realistically, TA cannot assume the burden of developing institutions where effective organizations do not exist.

USAID is ready to provide assistance to strengthen the National Population Council (NPC) and the Ministry of Health (MOH), if the GOE provides the inputs that are essential to effective utilization of this assistance, i.e. clear organizational roles, leadership, staff and budgets. USAID has provided initial funding to the NPC, and should not provide major additional assistance until the GOE has demonstrated, even in a limited manner, its own commitment to establishing an effective organizational structure. USAID will, however, continue to respond flexibly to requests for assistance in future program development and administrative reorganization.

MISSION COMMENTS ON FULL REPORT

Finally, the recommendation to increase TA would have been more useful if it included specific guidance regarding the locus and type of this assistance, given the lack of effective, existing organizations. Moreover, the report does not discuss the potential for using local consulting resources. From the GOE's perspective, these are likely to be a more acceptable source of TA than expatriate contractors, but USAID should recognize that these local resources are limited.

2. Private Sector Strategy: USAID accepts the recommendation that the Mission review its private sector strategy, but we believe that the assessment team did not carefully think through the private sector interventions proposed in the report. The Mission plans to obtain assistance from the central Enterprise Project or other appropriate source, to explore opportunities in both the for-profit and non-profit private sector and to identify specific, feasible new activities. It will not be easy, however, to design appropriate activities to assist the "real" private sector - pharmacies and private physicians - as proposed by the team.

3. Data Analysis: The breakdown of expenditures on p. 10 of the report is misleading. According to this table, only 5 per cent of USAID expenditures have supported family planning services. The definition of "services" is very narrow; for example, contraceptives, a major USAID input essential to service delivery, are not considered to be a part of "services" in this table. We believe a more thoughtful analysis would indicate a significantly higher percentage of USAID assistance in direct support of family planning services.

However, we accept that information has not been readily available to facilitate this kind of analysis by program category. One failing of the assessment report was the absence of specific recommendations for improved project monitoring systems. USAID staff are currently working to improve USAID financial reporting systems. USAID will also improve data on the effectiveness of service delivery activities.

4. Child Spacing vs. Family Planning: USAID strongly endorses the team's recommendation that the new Child Survival Project communicate a message distinct from family limitation and contraceptive advice, emphasizing health benefits to mothers and children in order to increase demand for family planning services. Media and training activities for the child spacing and family planning programs will need to be closely coordinated. Moreover, we need to recognize that the same health care personnel will provide "child spacing" and "family planning" services, and the MOH may have difficulty in absorbing and differentiating the two programs in the rural health clinic system.

5. State Information Service: USAID agrees with the team's assessment of past experience with the SIS. However, the team's recommendations vis-a-vis the SIS had already been anticipated by Project Implementation Letter # 54, issued on January 17, 1986, which seeks to increase the effectiveness of SIS programs.

6. Policy dialogue: USAID agrees that it is now appropriate to expand policy dialogue to a broader spectrum of governorate and central-level government officials, and other specific target audiences. High U.S. visibility in such efforts would, however, be counterproductive, and policy development efforts must be consistent with the low profile USAID has chosen to maintain in the sector. If exploratory discussions are promising, implementation of an expanded policy development program should maximize use of local consulting resources to the extent feasible.

7. Rural vs. Urban Programs: The Assessment Report concludes that USAID assistance, particularly to the private sector, has been primarily urban-based and has not made much headway in increasing prevalence rates in rural areas. While USAID agrees with the essence of this analysis, we point out that a substantial portion of USAID assistance - contraceptives, training, research, etc. - do not specifically target either rural or urban programs, and support activities in both rural and urban areas. The report would have been more useful, moreover, if it provided specific suggestions to USAID and the GOE to increase program effectiveness in rural areas.

8. USAID Staffing Considerations: USAID has agreed to take several actions to increase management efficiencies:

- 1-Focusing project activities on delivery of family planning services;
- 2-Incorporating improved management systems for monitoring sub-activity performance and program expenditures; and
- 3-Examining alternative project implementation mechanisms which are less staff intensive.

These actions should result in a more effective use of USAID's limited staff resources, and they should be given high priority.

We agree with the Assessment team, however, that even with improved management, if the GOE program gains momentum, USAID staff limitations may hinder project implementation. The options proposed by the team--a JCC appointment or periodic TDYS from AID/W staff--are not adequate solutions.

If the program needs dictate, we will take whatever actions are necessary to provide adequate staffing.

USAID's population/family planning program in Egypt aims to assist the Government of Egypt (GOE) to increase contraceptive prevalence. This assessment of USAID population assistance was conducted in February 1986, to review the effectiveness of the current USAID program and to provide guidance for future USAID support to the GOE. The assessment team reviewed available documents, including a background paper on USAID-assisted activities, and interviewed over eighty GOE and Egyptian private sector personnel, as well as USAID staff. The major findings and conclusions are:

- o USAID population assistance has been characterized by plurality. The diversity of activities supported has contributed to a diffusion of effort. Service delivery activities have not been adequately emphasized.
- o Policy dialogue has been limited to a few top-level GOE leaders. Strategies to develop awareness of population issues among decision makers, opinion leaders and health care providers are inadequate, and need redirection to provide broader-based support.
- o USAID has increased the proportion of assistance for private sector activities since 1980; these activities have been very successful. However, the emphasis has primarily been on the non-profit sector, and these activities have had limited, primarily urban, coverage.
- o USAID has supported very different approaches in urban and rural areas. Rural programs have been less effective than urban programs; services are still not fully available in rural areas.

The assessment team recommended that future USAID assistance should:

- o adopt a more focused approach, emphasizing service delivery and institutional development activities.
- o provide for an expanded role for the private sector, encompassing both traditional non-profit and market-oriented elements.
- o incorporate support for an augmented, Egyptian-designed and implemented policy development program. This program should be carefully-targeted to broaden support in policy-making circles.

The major lesson learned from the Egyptian experience is that a "targets of opportunity" approach, adopted in the absence of a strong host-country political commitment and institutional framework, is likely to result in diffusion of effort and program impact. Moreover, in the overall political and institutional context, assistance to the private sector has proven relatively more effective than efforts to energize the government family planning program.

## I. EVALUATION COSTS

### 1. Evaluation Team

<u>Name</u>	<u>Affiliation</u>	<u>Contract Number OR TDY Person Days</u>	<u>Contract Cost OR TDY Cost (US\$)</u>	<u>Source of Funds</u>
John Dumm	AID/S&T/POP	34 days	\$ 4,900	OE
Connie Carrino	AID/S&T/POP	30 days	\$ 3,200	OE
Antony Schwarzwalder	Management Sciences for Health	21 days	(	Central Project
John Tomaro	Program for Applied Technology in Health	25 days	(	Funds
Karima Lotayif	Ind. Consultant	263-0144-0-00-602	\$ 4,350	(PRITECH) Project

### 2. Mission Professional Staff Person Days

### 3. Borrower/Grantee Professional

# A.I.D. EVALUATION SUMMARY PART II

## B. SUMMARY OF EVALUATION FINDINGS, CONCLUSIONS AND RECOMMENDATIONS (Try not to exceed the 3 pages provided) Address the following items:

- o Name of mission or office
- o Purpose of activity (ies) evaluated
- o Purpose of the Evaluation and Methodology Used
- o Findings and Conclusions
- o Recommendations
- o Lessons learned

USAID/EGYPT  
POPULATION ASSISTANCE ASSESSMENT  
FEBRUARY 1986

### Evaluation Purpose and Methodology:

Over the past decade, USAID has provided substantial assistance to Egyptian efforts to increase family planning practice among Egyptian couples of reproductive age through the Population/Family Planning I Project and its successor, Population/Family Planning II. This assessment was scheduled prior to the preparation of a major Project Amendment for the Population/Family Planning II Project. The purpose was to review the institutional context and effectiveness of the current USAID population assistance program in Egypt and to provide guidance to USAID in identifying priority areas for future support, maximizing program impact and improving program management.

The assessment was conducted by a four person team - two AID/W personnel and two external consultants - in February 1986. The assessment report is based on interviews with over eighty Egyptian Government, USAID, private sector and technical assistance personnel; a review of published materials, project files and financial data; and selected site visits. The report also draws on a background paper prepared prior to the team's arrival, which compiles available information on USAID-assisted subproject activities.

### Findings:

Since 1977, USAID has contributed more than US\$ 63 million to the Government of Egypt (GOE) program, or about 47 percent of total foreign assistance for population activities. USAID initially funded a range of initiatives, including clinical and management training, biomedical and social science research, construction activities, family planning service delivery, contraceptive commodities, and logistical and administrative improvements. The program supported activities in both the urban and rural areas of Egypt, and gave some emphasis to policy dialogue with national leaders and to the involvement of the private sector.

The 1984 Contraceptive Prevalence Survey indicated a prevalence of contraceptive use of 30 percent of married women of reproductive age, an increase in prevalence from less than five percent in 1960, but only about five percentage points higher than the 1974-75 level. Prevalence data and contraceptive distribution statistics indicate that about three-quarters of Egyptians receive contraceptives or family planning services from the private sector. The successful family planning service initiatives of such private sector organizations as the Family of the Future (FOF) and the Alexandria Family Planning Association (AFPA) indicate the existence of a significant but primarily urban-based demand for family planning services.

Date this summary prepared: April 16, 1986

VII

Within the last two years, the GOE has begun to bring more focus to its population program, beginning with the establishment of the National Population Council (NPC), charged with planning, monitoring, and evaluating all population and family planning activities in Egypt. More recently, the Minister of Health has stated plans to create a unit to coordinate the implementation of all family planning activities in the country. However, government policies and programs to implement a coordinated and comprehensive family planning program are still inadequate. The recent decisions and actions of the GOE, and the limited effectiveness of current program activities, suggest that population and family planning activities in Egypt have reached a turning point.

### Conclusions:

The assessment team concludes that the following have been the major features of USAID population assistance:

- o USAID assistance has been characterized by plurality. The diversity of activities supported has contributed to a diffusion of effort. Service delivery activities have not received sufficient emphasis. Several early initiatives have, however, recently terminated, while core service delivery, training and research activities continue to be supported.
- o Policy dialogue has been limited to a few top-level GOE leaders. Strategies to support policy development and awareness of population issues are inadequate, and project activities in IEC and policy development need redirection to provide more focused support for the GOE's evolving needs.
- o USAID support for private sector activities has increased over time, and these activities have generally been highly successful. However, USAID assistance has emphasized the non-profit sector and has had limited coverage, focusing primarily on urban areas. Family planning services are still not fully available in rural areas, which have been perceived in the past as the responsibility of the MOH health care delivery system.

### Recommendations:

The GOE's current interest in addressing its population problem requires a measured, patient, and deliberate response from USAID. USAID should support Egyptian initiatives by working closely and collaboratively with Egyptians in both the public and private sector. This support should be characterized by: (a) a more focused approach; (b) an expanded role for the private sector; and (c) increased policy development activities.

(a) Program Focus: Through close, candid, and continuous cooperation with the GOE, USAID should frame its program to achieve two objectives:

- o develop institutional capacity to design, implement, monitor and evaluate family planning programs
- o increase the availability and acceptance of safe, efficacious family planning commodities and services through both the public and private sectors.

In keeping with the team's understanding of GOE delegations of authority for the population program, assistance to the National Population Council should center on policy development, family planning operations research and clinical trials. The team was given to understand that most Council activities will be undertaken in cooperation with other GOE and Egyptian institutions. Assistance to the Ministry of Health and to PVOs should be directed primarily to improvements in family planning service delivery in both the public and private voluntary sectors. Current support to the MOH clinical training programs should continue. At the same time, the child spacing component of USAID's Child Survival Project provides a unique opportunity for the MOH and USAID to emphasize the maternal and child health benefits of child spacing.

(b) Expanded Private Sector Role: Given the acceptability of the private sector and USAID's success with the social marketing of contraceptives through the FOF project, USAID is in a position to capitalize on its private sector advantage. The report recommends that USAID develop a comprehensive private sector strategy for family planning service delivery. This strategy should include the traditional PVO sector, represented in the present program by FOF and the Egyptian Family Planning Association, and the more market-based sector, represented by pharmaceutical firms and private physicians. This strategy should include, but not be limited to, analysis for supporting three types of activities: factory-based programs; increased pharmaceutical production; and technical and financial assistance to private Egyptian physicians.

(c) Increased Policy Development Activities: Given the apparent difficulties the GOE has experienced in implementing its family planning program and some observed misconceptions and lack of information in policy-making circles, USAID should place a priority on providing coordinated and quality assistance to the government in the area of policy development. The character of this policy development must be carefully targeted to different audiences, predominantly Egyptian in content and presentation, and well-coordinated and monitored. Such a program would provide support to the twin objectives of developing institutional capacity to design and manage family planning programs and expanding the availability of safe and effective family planning services.

#### Management Considerations:

The assessment team felt that implementation of the initiatives outlined above would require increased levels of long-term technical assistance, which is likely to be sensitive to the GOE. Moreover, in the event that proposed initiatives are successfully realized, the program may also require increases in USAID staffing levels. Finally, the team recommended that USAID develop more comprehensive, "management-useful" systems to track inputs and outputs for subproject activities, as well as indicators to measure institutional change.

#### Lessons Learned:

Without a strong host-country political commitment and institutional framework, USAID efforts to energize the GOE family planning program have had limited success. The "targets of opportunity" approach, adopted in the absence of a strong host-country program, has resulted in a diffusion of effort and program impact. In this context, assistance to the private sector has proven relatively more effective.

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USAID'S POPULATION PROGRAM IN EGYPT:  
ASSESSMENT AND RECOMMENDATIONS  
MAIN REPORT

Prepared by:  
John Dunn, Team Leader  
Constance Carrino  
Anthony Schwarzwald  
John Tomoro

February, 1986

## ERRATA

1. The Table of Contents lists the Background Paper on USAID-supported projects as Appendix E. This is not included with the main report. It is separately bound and available on request from the USAID/Egypt Population Office.

Also in the Table of Contents, Appendix E should read "Population/Family Planning Projects in Egypt by Donor", and Appendix F should read "The Need for a Factory Centered Family Planning Program for all Egypt: Misr Spinning and Weaving Company, Mehaila-Kubra".

2. The Executive Summary omits the name of one team member, Dr. John Tomaro, Executive Director of the Program for Applied Technology in Health.

USAID'S POPULATION PROGRAM IN EGYPT:  
ASSESSMENT AND RECOMMENDATIONS  
MAIN REPORT

Prepared by:  
John Dunn, Team Leader  
Constance Carrino  
Anthony Schwarzwalder  
John Tenoro

February, 1986

## Executive Summary

From January 26 to February 26, 1986 a four person team, consisting of John Dunn, Associate Director of the Office of Population in the Science and Technology Bureau, AID (Team Leader), Constance Carrino, economist in AID's Office of Population, Anthony Schwarzvalder, Director of Program Development for Management Sciences for Health, visited Egypt to review USAID's assistance to the Government of Egypt's population program. An earlier population sector assessment had been conducted in March-April, 1982.

The purpose of this 1986 assessment was to review the institutional context and the effectiveness of the current program in order to provide guidance to USAID in identifying priority areas for future support, maximizing program impact and improving program management.

To complete this assessment, the team interviewed over 80 people in the Government of Egypt, and the private sector, in USAID, and in organizations providing technical assistance to the Egyptian program. The team read numerous published materials on population characteristics, policy, and projects, and reviewed the USAID project files and financial data. Site visits were made to selected clinics, hospitals, offices, pharmacies, and factories in Alexandria, the Delta of Egypt, Greater Cairo, and Beni Suef.

### Findings

Since 1977, USAID has contributed more than US\$ 63 million to the Government of Egypt program. This represents about 47 percent of the total foreign assistance for population in Egypt since 1974. At first, USAID funded a range of initiatives, e.g., clinical and management training, biomedical and social science research, construction activities, family planning service delivery, contraceptive commodities, logistical and administrative improvements. The program supported activities in both the urban and rural areas of Egypt, and gave some emphasis to policy dialogue with national leaders and the involvement of the private sector.

The 1984 Contraceptive Prevalence Survey indicated a prevalence of contraceptive use of 30 percent of married women of reproductive age, an increase in prevalence from less than five percent in 1960, but only about five percentage points higher than the 1974-75 level. The successful family planning service initiatives of such private sector organizations as the Family of the Future (FOF) and the Alexandria Family Planning Association (AFPA) indicate the existence of a significant but primarily urban-based demand for family planning services.

The team found that USAID's assistance to the Egyptian program has been characterized by:

- limited policy dialogue
- plurality of project activities
- limited private sector
- urban/rural based strategies

Many diverse project activities, begun in the earlier years of USAID's assistance, have been brought to a close. Core service delivery, training, and research activities have continued to be supported. Some project activities in IEC and policy development should be redirected in order to address current needs and provide more focused and coordinated support for the Government's evolving plans. Strategies to support policy development and awareness of population issues are inadequate. Private sector initiatives have been successful, but limited in coverage. Family planning services are not fully available in the rural areas.

Within the last two years, the Government of Egypt has begun to bring more focus to its population program. In January 1985, a presidential decree established and charged the National Population Council with planning, monitoring, and evaluating all activities in population and family planning in Egypt. Concurrently, a new director of the Information, Education and Communication Center of the State Information Services was appointed, and more recently the Minister of Health has stated plans to create a unit to coordinate the implementation of all family planning activities in the country. However, government policies and programs to implement a coordinated and comprehensive family planning program still need to be improved. The recent decisions and actions of the Government of Egypt, and the limited effectiveness of current program activities, suggest that population and family planning activities in Egypt have reached a turning point.

#### Recommendations

The Government of Egypt's current interest in addressing its population problem requires a measured, steadfast, and deliberate response from USAID. USAID should support Egyptian initiatives by working closely and collaboratively with Egyptians in both the public and private sector. This support should be characterized by: a) an increase in policy development, b) a more focused approach, and c) an increased role for the private sector.

The government of Egypt has expressed an increased willingness to improve the service delivery capacity of public and private sector institutions, to provide the information required to create "awareness" of the value of family planning, to emphasize the health benefits of child spacing, and to make services more widely available. USAID has an opportunity to structure support in a manner that strengthens the planning, management and implementing capacity of key government institutions, fosters the service delivery capacity of private sector organizations and increases the availability and acceptance of family planning. Through a close, candid, and continuous cooperation with the Government of Egypt, USAID should frame its program to achieve two objectives: 1) assist in developing the institutional

capacity to design, implement, monitor and evaluate family planning programs, and 2) to support programs in both the public and private sector which demonstrate the potential to increase the availability of safe, efficacious family planning commodities and services.

In keeping with our present understanding of Government of Egypt delegations of authority for the population program, assistance to the National Population Council should center on policy development, family planning operations research and clinic trials. We understand that most Council activities will be completed in cooperation with other Government of Egypt and Egyptian institutions. Assistance to the Ministry of Health and Ministry of Social Affairs should be directed primarily to improvements in family planning service delivery in both the public and private voluntary sectors. Current support to the Ministry of Health's clinical training programs should continue. At the same time, the child spacing component of USAID's Child Survival Project provides a unique opportunity for the Ministry of Health and USAID to emphasize the maternal and child health benefits of child spacing.

Prevalence data and contraceptive distribution statistics indicate that about three-quarters of Egyptians receive contraceptives or family planning services from the private sector. Given the acceptability of the private sector and success of the social marketing of contraceptives through the FOF project, USAID should capitalize on the success in the private sector. We recommend that USAID develop a comprehensive private sector strategy for family planning service delivery. This strategy should include the traditional PVO sector, represented in the present program by FOF and the Egyptian Family Planning Association, and the more market-based sector, represented by pharmaceutical firms and private physicians. This strategy should include, but not be limited to, analysis for supporting three types of activities: 1) factory based programs, 2) increase of pharmaceutical production, and 3) technical and financial assistance to private Egyptian physicians.

Given the apparent difficulties the Government has experienced in implementing its family planning program and some observed misconceptions and lack of information in policy-making circles, we recommend that USAID place a priority on providing coordinated and quality assistance to the Government in the area of policy development. The character of this policy development must be: 1) carefully targeted to different audiences, 2) predominantly Egyptian in content and presentation, and 3) well coordinated and monitored. Such a program would be a major increase in USAID's assistance to policy activities, and also provide fundamental support to the twin objectives of developing institutional capacity to design and manage family planning programs and to expand the availability of safe and effective family planning services.

We have addressed USAID's management requirements for its population assistance program in a separate report.

## Outline

### USAID's Population Program in Egypt: Assessment and Recommendations

Executive Summary

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## I. THE EGYPTIAN SETTING

### 1. Demographic Trends\*

The population of Egypt more than doubled in the last 30 years and is now close to 50 million. Ninety percent of the population live in approximately four percent of the land, and close to 44 percent of the population live in urban areas. Life expectancy at ten years of age is estimated to be approximately 55 years for males and 60 years for females.

Population growth: Growth rates have been cyclical in the last 30 years. Annual growth ranged from 2.6 to 2.8 in the late 1950s, declined to approximately 2.0 in the early 1970s, rose to a high of 3.0 in 1980, and is presently hovering around 2.7. These movements in rates are generally attributed to a rapid and more or less consistent decline in the crude death rate and to cyclical movements in the crude birth rate. Net emigration has had no significant effect on population growth rates.

Fertility: The crude birth rate declined from approximately 45 per thousand in 1952 to 34 per thousand in 1972. It then rose as high as 40 per thousand by 1980 and is now estimated to be approximately 37.7 per thousand. Egypt's total fertility rate decreased from 6.7 in 1960 to 5.7 in 1976 and is estimated to be approximately 5.3 in 1985. Completed family size in 1985 was estimated to be close to 7 children. Fertility decline is attributed 1) to a reduction in the proportion of married women, 2) to a small reduction in marital fertility, and 3) to an increase in contraceptive prevalence from less than five percent in 1960 to approximately 30 percent in 1984. Contraceptive

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\*Data for this section were provided by CAPMAS.

prevalence surveys, summarized below, indicate that urban prevalence in the last ten years has kept pace with the number of women in their childbearing years. Rural prevalence has been maintained and has shown a slight increase. The number of women between the ages 15 and 49 increased by approximately 1.3 million between 1980 and 1985 and now number 7.4 million.

Estimated Contraceptive Prevalence Rates  
by Urban and Rural Residence, 1974-1984

<u>Survey</u>	<u>Total</u>	<u>Urban</u>	<u>Rural</u>
NFS 1974-75	26.5	45.4	12.9
RFS, 1979			15.5
EFS, 1980	23.8	39.8	11.7
Egypt Rural CPS, 1980			17.1
RFS, 1982			17.7
SIS/CAPMAS Survey, 1982	33.5		
Egypt CPS, 1984	30.3	45.1	19.2

Sources: CAPMAS, 1978; Khalifa et. al., 1979 Hallouda et. al., 1983; Khalifa et. al., 1982, and SIS, 1982; CAPMAS 1985.

Mortality: The crude death rate declined by approximately 43 percent between 1952 and 1980 and is now stabilized around 10 per thousand. The decline represents mortality reductions in all age groups and for both sexes yet some differences in magnitudes can be identified. Higher mortality is found in rural areas and Upper Egypt and generally attributed to lower access to markets and health care services, and lower literacy rates, especially among women. A potential for further reductions in mortality exists as regional and sex differentials are erased.

Focused attention on alleviating infant mortality, presently estimated to range between 102 and 124, is also crucial to further reductions in death rates. Some specific child survival interventions such as ORT and immunization appear promising.

As health interventions begin to take effect, reductions in natural mortality will begin to focus more on the effects of closely spaced births and large family size on infant and maternal mortality. Virtually no data are available on these types of morbidity and mortality at the present time.

Projections: CAPMAS estimates that by 2001 Egypt's population will total 69 million, which assumes that the birth rate will decline from 37 to about 30 per thousand and the death rate will decline to 9 per thousand with the infant mortality rate declining by 38 percent over the next 15 years.

Official targets: Targets for population growth decline were announced first in 1973 when the objective was to reduce the birth rate by one point per year from 33.6 in 1973 to 23.6 in 1982. As Egyptian birth rates began to increase, a new target was set in 1980 to reduce the crude birth rate from about 40 in 1980 to 20 in 2000. Little relation exists between these birth rate targets and feasible patterns for demographic change. Only if Egypt's birth rate had begun a steady decline in 1980, commensurate with declines experienced by countries such as Singapore, Korea and Colombia, could the 20 per 1000 rate be met in 2000 (World Bank, 1984).

## 2. Population Policy

Egypt's national population policy was formulated in 1965 with the creation of the Supreme Council for Family Planning headed by the Prime Minister and its Secretariat, the Family Planning Board. The Family Planning Board was charged with coordinating the activities of government and private voluntary institutions involved in the delivery of population services.

By the early 1970s the institutional capacity to implement a national family planning policy appeared to exist. The Ministry of Health had three

units for family planning, the Ministry of Social Affairs was providing family planning services through the Egyptian Family Planning Association (EFPA); and the Ministry of Information began raising national awareness about population issues through the State Information Services.

In 1973 the names of both the Supreme Council and its Secretariat were changed to reinforce what had become a broad GOE population and development policy which stressed an integrated community development approach to solving Egypt's population problems. The basic philosophy assumed that development would solve the population problem, without considering that population growth will in itself retard development. The new coordinating bodies were called the Supreme Council for Population and Family Planning, and the Population and Family Planning Board (PFPB). Program responsibility was transferred to the respective Ministries and the PFPB kept its planning, research, follow-up, and evaluation functions. In 1977, USAID/Cairo and the UNFPA began supporting the Board's work through the Population and Development Project aimed at transforming social and economic conditions in rural areas. By this stage it became clearer that program decentralization at the national level were hindering GOE progress.

Expression of support by national leaders for a strong national population program has evolved over time. President Nasser stressed development as the best solution to population pressures. President Sadat's administration included population and family planning on Mrs. Sadat's priority list for social development initiatives. President Mubarak has made more forceful statements on family planning than either of his predecessors. He supported his statements in January 1985 with the announcement through a Presidential

Decree to establish a National Population Council under the direction of a predominantly interministerial committee chaired by the President to coordinate all population activities in the country.

### 3. GOE Institutions involved in Population/Family Planning Programs

Since 1977 USAID and other international donors, namely The United Nations Fund for Population Activities (UNFPA), The World Bank and the Government of the Federal Republic of West Germany have been supporting population and family planning activities in Egypt. Total commitments in excess of US\$ 130 million have enabled the GOE to initiate significant activities in policy formulation, clinical research, and family planning service delivery (See Graph 1: International Donor Assistance to Population/Family Planning in Egypt 1974 to 1985).

In spite of significant donor commitments to the GOE's population/family planning programs, current indications are that efforts to reduce rapid population growth have achieved only a modest rate of contraceptive prevalence (30% in 1984). Analysis of the program suggests that the outcomes are in large part attributable to the mixed performance of the Egyptian institutions responsible for carrying out population and family planning programs.

While a number of factors constrain effective program planning and implementation (See for example Section I.4: Societal Perceptions), the administrative limitations of the GOE organizations responsible are key constraints. The public sector institutions involved in creating awareness of the need for family planning and delivering services, namely the State Information Services (SIS) of the Ministry of Information, the Ministry of Health (MOH), and the Ministry of Social Affairs (MOA), do not make family

planning their top priority. In addition, the mandate to plan, monitor and evaluate the components of a national program, has been recently placed in the newly created National Population Council (NPC).

Analysis of program performance suggests that:

1. Egyptian public sector institutions have inherent structural constraints which inhibit effective planning and implementation and,
2. population and family planning activities are not afforded high priority within the appropriate GOE institutions.

The policies and practices in effect in the GOE institutions responsible for population and family planning activities mitigate against effective program planning and implementation. However, these policies and practices are not unique to the organizations involved in population and family planning.

A large number of Egyptian and expatriate management consultants have assessed GOE institutions in the last decade; all have arrived at similar conclusions. In general, most public sector institutions, especially those in the social service sector, are characterized by: (1) non-responsive, non-directive management systems, (2) an inadequate supply of trained and dedicated managers and technical staff, and (3) an oversupply of unmotivated, poorly paid and poorly trained employees. Numerous studies have analyzed the causes of these conditions; all have suggested that structural reforms would be difficult to implement.

In addition to organizational weaknesses, population and family planning programs historically have suffered from lack of priority attention from many senior GOE officials. On the other hand, President Mubarak's recent statements and his support for the NPC are encouraging in this regard and there are indications that the GOE intends to invest significant resources

(financial and human) and establish the effective leadership and coordination needed to address population-related matters.

Population and family planning programs are not the central focus of any GOE ministry or institution. There is now no line item in the GOE budget, or the budgets of any ministry, for population and family planning activities. Budgets are arranged according to the institutions earmarked for support, and not by programs or functional categories. The NPC, although mandated to play a leading role, came into being without a programmatic budget contribution from the GOE.

With few exceptions, the management and staff of the Ministry of Health and the Ministry of Social Affairs consider family planning programs one among a range of important activities; all are "priorities" and worthy of equal support and attention. It would be wrong however to conclude that donor resources in population and family planning are not highly valued. Indeed, these resources are a source of competition among GOE institutions. The struggle is not for hegemony in the sector, however, but for additional influence within the hierarchy of GOE institutions.

Population and family planning programs confront significant obstacles. To be effective, these programs have to overcome the limitations of public sector institutions and the absence of policies and practices that indicate that population and family planning are a high priority.

#### 4. Societal Perceptions of Population and Family Planning

Contraceptive prevalence in Egypt has barely increased by five percent in the last ten years. The inability of public sector institutions to deliver

enough quality services partially explains the fact that use of modern contraceptives is not more widespread. At the same time, the strength of resistance to family planning programs or to accepting family planning for religious, cultural, patriotic and individual reasons cannot be underestimated.

Resistance to using modern methods of family planning is in large measure based on operative perceptions. These all suggest that family planning is not in the best interest of the nation and the individual. It is difficult to quantify the relative importance of any given perception. It is, however, apparent from a cursory review of popular publications in Egypt, and from discussions with informed and educated Egyptians, that all the perceptions summarized below have an effect on the willingness of the population to accept and use modern family planning methods.

These perceptions are essentially four:

- a. Egypt does not have a population problem. The country needs more people to: (1) settle the desert, (2) serve in the military, and (3) provide technical assistance to the other nations of the region and generate remittances to Egypt.
- b. Family planning is anti-Islam. The birth of a child is a happy event and an indication of Allah's favor. Many children are a blessing. To attempt to frustrate the will of Allah is a grievous offense.
- c. The GOE employs family planning to curtail individual liberty. Family planning is seen by some as a government program designed to control and prevent the population from fully participating in Egyptian society and freely expressing its collective will.
- d. Family Planning means to stop having children. Family planning or birth control is viewed as antithetical to basic Egyptian societal values which stress the value of children. Thus, to date there is only limited appreciation of the health and financial benefits of child spacing.

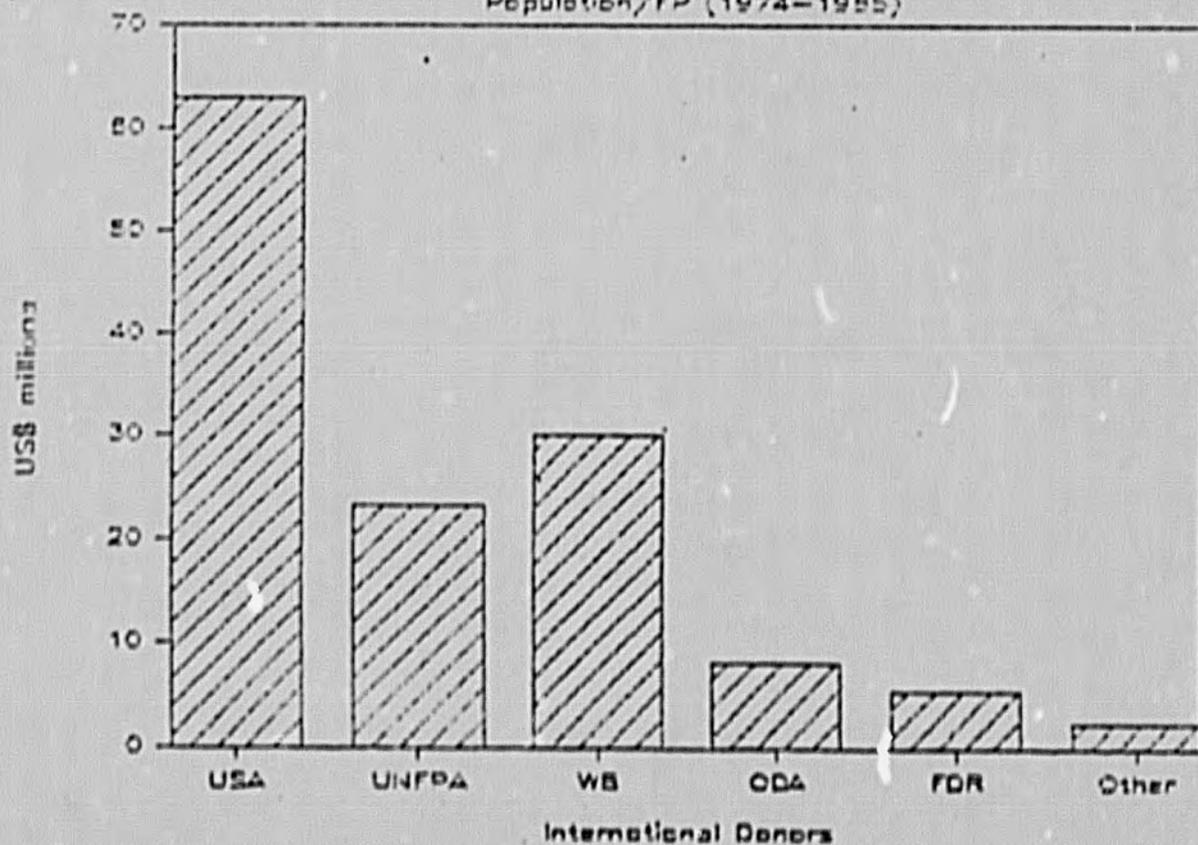
Some elements of the Egyptian society undoubtedly mouth slogans that incorporate these perceptions to curry political support. In large measure, however, these perceptions appear to be genuine convictions. They are espoused by a broad spectrum of the Egyptian population.

5. Donor Assistance to GOE for Population and Family Planning: 1974-1985

Appendix F, entitled "Population/Family Planning Projects in Egypt by Donor," lists the GOE organizations that have received donor contributions, the projects supported, and their present status, and the amount budgeted. The graph below records donor contributions.

Graph 1

International Donor Assistance to GOE  
Population/FP (1974-1985)



The United States' contribution has been approximately 47 percent of the more than US\$ 132 million made available to the GOE. World Bank IDA loans constitute 23 percent, and UNEPA donations represent 18 percent of the total amount. The remaining 12 percent has been donated by the British ODA, IDRC of Canada, the World Health Organization, the International Planned Parenthood Federation and several private American foundations, principally the Rockefeller and Ford Foundations.

The amounts indicated do not necessarily reflect actual disbursements. While the US Government had disbursed slightly more than US\$ 63 million through December 1985, some resources that were made available by the British ODA and The Federal Republic of West Germany and not used by the GOE have been withdrawn. Also, approximately US\$ 5 million of the World Bank's second loan remains unspent.

US assistance has supported a wide range of activities -- research, training, services, commodities, logistics, construction, and administration (See Section II). The US has made resources available to a number of different organizations, agencies and institutions involved in population and family planning. The support provided by the other major donors (UNFPA, WB, ODA, FRG) has largely been made available to the Ministry of Health. This assistance has been designed to upgrade the ministry's infrastructure, train government personnel and improve organizational operations. The remaining donations, given by IPPF, IDRC, the Rockefeller Foundation and others, have been used to support biomedical and social science research as well as family planning services.

II. REVIEW OF USAID'S SUPPORT OF POPULATION AND FAMILY PLANNING PROGRAMS IN EGYPT: 1977-1985

Since 1977 USAID has disbursed slightly more than US\$ 65 million in support of population and family planning activities (See Appendix E: USAID-Supported Projects - 1986 USAID Population/Family Planning Program Assessment). (These figures were extremely difficult to compile. While we believe they reflect the broad magnitude of resource allocation for USAID's assistance, additional work would be required to verify their accuracy). This figure includes USAID "buy-ins" to centrally-funded programs for technical assistance, but not for other central project costs. The major categories of expenditure have been in contraceptives, IEC, and research. Together, these activities account for 68 percent of the total. Analysis of the expenditure data (US\$ millions) through December 31, 1985 suggests the following breakdown by program category:

		<u>Percentage</u>
Training	3.2	6%
Research	8.9	15%
IEC	15.2	26%
Services	2.8	5%
Administration	5.4	9%
Logistics	0.7	1%
Contraceptives	15.7	27%
Technical Assistance	<u>5.7</u>	<u>10%</u>
Total US\$	57.6 million	100%

An additional amount (approximately US\$ 7.5 million) was spent to renovate the El Galaa Maternity Hospital, the largest facility of its type in the country.

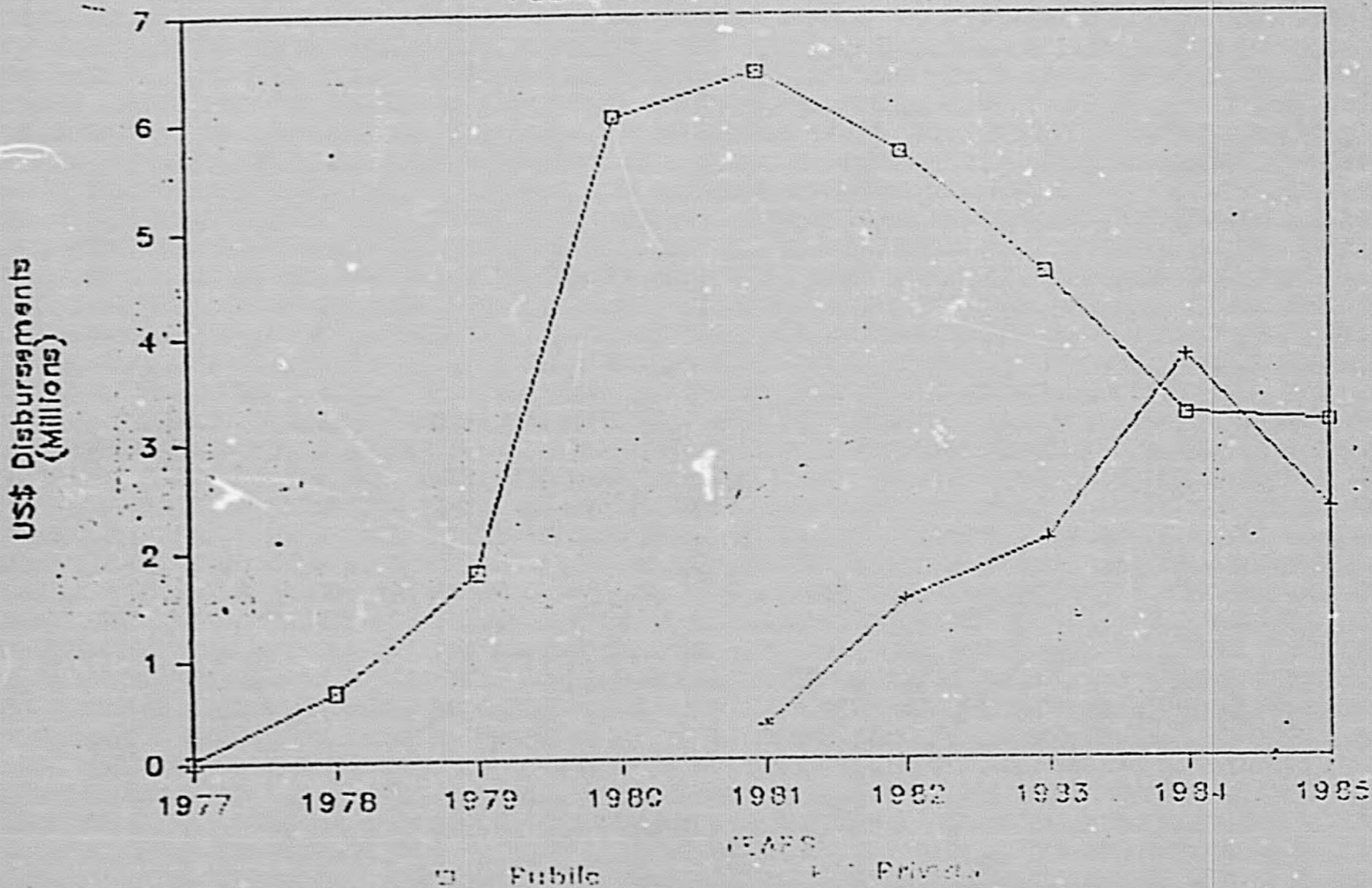
It was not possible to obtain actual expenditures by year for each category of program activity. The estimated average annual expenditures in US\$ (millions) through December 31, 1985 are summarized below:

1977	1.32
1978	1.96
1979	3.09
1980	7.43
1981	8.08
1982	8.51
1983	8.01
1984	8.30
1985	<u>13.08</u>
Total US\$	59.78 million

These figures, which do not include the additional US\$ 7.5 million for El Galaa Maternity Hospital, document the programmatic build-up in population and family planning in the three-years previous to significant program launch in 1980. The expenditure level achieved in 1980 was maintained through 1985. Graph 2: "USAID Assistance to the GOE by Public/Private Sector: 1977-1985" reveals (1) a clear down-turn in Mission support for public sector programs and (2) the increasing investment in private sector activities, especially the program of the Family of the Future (FOF).

# USAID Assistance to GOE

Public/Private Sector: '77-'85



Graph 2

2. Table 1.

SUMMARY OF USAID  
POPULATION ASSISTANCE TO EGYPT  
1977 - 1985  
MISSION FUNDED

ORGANIZATION	EXPENDITURE THROUGH 12/31/85 LIFE OF PROJECT			AVERAGE EXPENDITURE PER YEAR
<u>MOH</u>				
El-Galaa Construction and Training	7,508,080	78-85	=	938,510
ICD Training	739,705	80-85	=	147,941
Refresher Training	608,497	84-85	=	304,249
House Officer Training	656,031	82-85	=	164,008
Family Planning Service, Beni Suef	1,609,607	82-85	=	402,402
ISSD, Research	4,333,219	79-82	=	1,033,305
Administration Improvement	208,979	77-85	=	23,220
<u>FOF</u>				
IEC	7,625,000	80-85	=	1,270,833
Research	902,000	80-85	=	150,333
Administration	1,006,000	80-85	=	167,667
Services	501,000	80-85	=	33,500
<u>PDP</u>				
Training	719,000	80-84	=	143,800
IEC	359,000	80-84	=	71,800
Research	718,000	80-84	=	143,600
Logistics	120,000	80-84	=	24,000
Administration	4,189,000	80-84	=	837,800
<u>HIPH</u> , In-Service Training	239,052	79-84	=	39,842
<u>Al-Azhar</u> , SHIP, Training	230,146	81-84	=	57,537
<u>CHO</u> , Family Planning Services	662,989	83-85	=	220,996
<u>CDC</u> , Research	262,329	83-85	=	87,443
<u>CAPMAS</u> , Research	2,661,504	81-88	=	332,688
<u>EPIC</u> , Logistics	550,982	82-85	=	137,746
<u>SIS</u> , IEC	7,223,189	80-85	=	1,203,865
<u>MOE</u> , Training	40,561	77-83	=	5,794
Contraceptives	15,678,490	77-85	=	1,742,054
Technical Assistance from Office of Population Projects	<u>5,664,291</u>	77-85	=	<u>629,366</u>
TOTAL		<u>*65,016,651</u>		TOTAL <u>10,364,299</u>

\* Expenditures for Buy ins from the Office of Population not included.

## 2. Findings

i. Policy Dialogue Efforts at policy dialogue have been targeted almost exclusively at the senior-most public sector leaders. During his visits to Egypt, USAID's Administrator always includes population on his agenda and the Mission Director frequently raises the issue with the Council of Ministers. The presentation of RAPID to President and Mrs. Sadat and President and Mrs. Mubarak clearly made a lasting impression on Mrs. Sadat and President Mubarak. Recently, policy dialogue concentrated on the establishment of the National Population Council. RAPID-type presentations have not been made for over two years nor has a strategy been developed for a series of messages and issues tailored for different constituencies.

ii. Plurality Statements clarifying the teachings of the Koran vis-a-vis the acceptability of practicing of family planning were first made in the 1930s. However, the first attempts to encourage family planning only began in 1962, when the societal perceptions discussed in Section I were considerably stronger than they are today. For the most part, explicit GOE encouragement of family planning has been restrained. For example, the government's main planning documents, a succession of Five Year Plans, have contained neither population targets nor a separate family planning budget. In this ambivalent environment, USAID opted to fund a strategy which emphasized plurality. Essentially this meant supporting a wide variety of organizations (mostly public) to see which ones flourished. Thus, since the inception of the program, USAID has funded dozens of organizations and sent over 100 people to the U.S. and third countries for individual training and invitational travel. Projects funded cover virtually every type of activity ranging from service delivery to hospital construction.

iii. Private Sector Use of the market-based private sector channels to deliver family-planning services in Egypt is constrained by various characteristics of the country's economic policy and structure. Most notably are constraints resulting from (1) nationalization of businesses, (2) subsidization, and (3) the individual nature of economic activity.

The non-profit PVO sector suffers from many of the operating constraints described above in the discussion of the public sector. All family planning PVOs in Egypt are registered with the Ministry of Social Affairs (MOSA), and, with a few exceptions after the first announcement of Decree 19 establishing the NPC in January 1985, rely on MOSA approval for the receipt of all foreign and GOE donated funds. Few raise funds from Egyptian sources.

USAID support to the Egyptian population program has incorporated some of the strengths of the private sector (e.g. advertising, commercial distribution) through the Family of the Future project. Nevertheless, USAID has no private sector strategy, neither has it supported formal discussions, conferences, or projects in the USAID portfolio aimed at encouraging the GOE to change its policies of pricing, subsidies, or institutional development as they relate to the delivery of family planning commodities or services.

iv. Urban/Rural Strategy In approaching service delivery, a distinction was made between the urban and rural areas in Egypt. In general, public sector (especially the MOH) was seen as working in the rural areas while the FOF played the key role in the urban areas. This urban/rural distinction has become progressively blurred especially in the Delta (Lower Egypt) although there are undeniable differences regarding contraceptive prevalence. For example, the 1984 Contraceptive Prevalence Survey showing

30 percent of married couples practicing contraception, with 45 percent of practising in urban areas and 19 percent in rural areas.

#### 4. Assessment of Portfolio

The purpose of USAID's population program in Egypt is to assist the GOE to improve family planning and contraceptive supply services nationwide. The program objective is to increase the number of couples actively practicing family planning. Sufficient data were not available to enable the team to make judgments on the impact of all USAID supported activities on achieving this purpose. Project documentation, field trips, and discussions with Egyptian and USAID officials did provide sufficient evidence for the team to recommend continuation of some activities and a redirection of others. Project performance, to the degree we were able to measure it, and the potential for institution building and expanding service delivery were the principal indicators we used to arrive at our conclusions. USAID has already terminated, or plans to terminate a number of activities supported under Project 0029. The team has no disagreement with our understanding of USAID's planned termination of project activities. Our review covered only currently active project activities.

##### i. Project Activities to be Continued

###### Service Delivery

- Family of the Future
- Egyptian Pharmaceutical Trading Company
- Cairo Health Organization
- Egyptian Family Planning Association (Proposed)

###### Training

- MOH House Officers Training
- MOH IUD Insertion Training
- MOH Clinic Refresher Training

### Demographic Data Collection and Research

-CAPMAS:

Demographic Data Development Support for the 1986  
Census

-NPC:

NORPLANT Field Trials

The service delivery activities of FOF, and the Cairo Health Organization, and the proposed project with EFPA, and the provision of contraceptives, principally through the Egyptian Pharmaceutical Trading Company, provide direct support for Egypt's family planning program and should be continued. (A full discussion of these projects is provided in Section III, Future Considerations/Recommendations).

Support for three training programs of the Ministry of Health seems to have resulted in an expansion of clinical services within the MOH delivery system and has probably also increased the availability of IUD services in the private sector since many MOH trained physicians work in the private sector after their service to the government in the mornings.

While it seems almost self evident that these training programs have enhanced the MOH's clinical family planning services, it was not possible in the short time available to us to determine how many trained physicians were providing family planning services, especially IUD insertions, their geographical distribution, and the need for additional training. These questions need to be answered to enable the MOH and USAID to determine more precisely the type and level of training needed for the MOH for the future.

### Demographic Data Collection and Research

The Mission has provided over \$10 million to CAPMAS for demographic data development and the 1986 census. These activities are essential in developing

an accurate data base which the Government can use to formulate population related policies. While a review of USAID's support for the 1986 census is not included in our scope of work, we think that support for both the census and the demographic data development activity form the basis for an expanded policy dialogue program which is particularly important at this time in the development of Egypt's program.

A three-year NORPLANT contraceptive field trial has just begun in Egypt. Experience to date in over 20 countries has demonstrated that NORPLANT is a safe, effective, and acceptable contraceptive. Results of the clinical trial here in Egypt will be very important since voluntary sterilization services are limited and couples use the IUD and other temporary methods for terminating their fertility. This is an important activity with a high potential for having a significant impact on the Egyptian program.

ii. Project Activities to be Redirected

IEC

-State Information Services

Service Delivery

-Beni Suef

Program Coordination and Management

-National Population Council  
-MOH Administrative Improvement

Policy

-RAPID

The IEC activities of the State Information Services and the service delivery activities of the Beni Suef Project are fully discussed in Section

III, Future Considerations/Recommendations). Valuable lessons have been learned from these two major components of USAID's population assistance program. These lessons should be used to redirect the mission's strategy in communications and services.

USAID has provided funding to NPC and the MOH for administrative support for their population/family planning activities. Because of changes now underway in both organizations relating to their roles in the national program, USAID should be prepared to reassess how these resources can be best put to use to assist these key ministries in developing their administrative capacities. The RAPID activity in the National Population Council seems to be dormant at this time. Continued use of RAPID needs to be considered in the context of comprehensive policy development strategy. (See III. 4).

### III. FUTURE CONSIDERATIONS/RECOMMENDATIONS

#### 1. Focus of USAID Projects

i. Identify Objectives. The discussion above has highlighted the diversity of population activities funded by USAID during the past eight years. Some have established excellent records and should form the base for future efforts. Unfortunately, others have not worked out as planned and should be phased out according to project implementation status. Much of this trimming away has already occurred. The current USAID staff which works with the projects daily can continue this process. A framework should be adopted which can provide a basis for reviewing current and new proposals. Utilizing this suggested framework would permit greater programmatic cohesion in the portfolio than currently exists, and permit a mutual understanding to develop

between USAID and the GOE regarding the types of activities which could be considered for future support. Two themes are recommended in this suggested framework:

--Institutional Development

--Family Planning Service Delivery

In a transition period through perhaps the end of FY 89, activities not directly or indirectly supporting these two objectives would be phased out. Some might stop altogether while others might continue with funding with alternative sources. By FY 90 only activities directly contributing to these two objectives would be funded resulting in a smaller, more focussed and easily managed portfolio.

The approach suggested is shown in the following Conceptual Framework.

CONCEPTUAL FRAMEWORK - PROGRAM FOCUS

<u>Current (From FY 86)</u>	<u>Transition (FY 87-90)</u>	<u>New (FY 90 &amp; beyond)</u>
<u>Institutional Building</u>	<u>Institutional Building</u>	<u>Institutional Building</u>
<u>Direct</u>	<u>Direct</u>	<u>Direct</u>
---	---	---
---	---	---
<u>Indirect</u>	<u>Indirect</u>	---
---	---	
---	---	
<u>Service Delivery</u>	<u>Service Delivery</u>	<u>Service Delivery</u>
<u>Direct</u>	<u>Direct</u>	<u>Direct</u>
---	---	---
---	---	---
<u>Indirect</u>	<u>Indirect</u>	<u>Other</u>
---	---	---
---	---	---
<u>Awareness/IEC</u>	<u>Other</u>	
---	---	
---	---	
<u>Community Dev.</u>		
---		
---		
<u>Policy Not Related To</u>		
<u>Institution Building</u>		
<u>Or Service Delivery</u>		
---		
---		
<u>Other</u>		
---		
---		
---		

ii. Characteristics of Population/Family Planning Projects

a. Increase Policy Dialogue

As stated in Section II, USAID efforts at population policy development have been concentrated at the senior levels of the Egyptian Government. These efforts have been partially successful in creating awareness and concern for the development implications of rapid population growth. The establishment of the National Population Council with the President as Chairman is a tangible manifestation of these efforts.

As successful as these activities have been, however, in order to energize the bureaucracy to increase support for family planning, policy dialogue cannot be limited to the senior-most government leaders. It is clear to the team that at all levels more support needs to be given to improve the understanding of the relationships between population and development issues and particularly the health benefits of using family planning for spacing births. A comprehensive and sustained strategy at policy development aimed at a cross-section of public and private sector officials would support USAID's efforts to assist the GOE to improve the delivery of family planning services through strengthened institutions. Specific suggestions on the content and the targeted audiences are provided later in this report.

b. Frame Projects in Light of Objectives

Since the beginning of its assistance to Egypt's population program, USAID has had to operate in a highly ambivalent environment in respect to the priority the GOE assigned to family planning. This led USAID, appropriately so, to finance a wide variety of activities among many organizations with the expectation that some would take root. While this "plurality" approach has

worked to a limited extent, in that there are now a number of fairly well established family planning services activities, it has also led to a diffusion of effort and a reactive approach to potential projects and strategies rather than a systematic and orderly formulation of USAID program activities in the context of specific objectives.

The evaluation team suggests that USAID begin the process of designing new project activities that directly support the twin objectives of institutional development and service delivery. The discipline that this process will bring to the development of USAID population strategy may in turn focus the GOE's attention and time to fundamental family planning issues.

c. Increase Role of Private Sector

The distribution of contraceptives through commercial channels has been successful and data on the distribution of contraceptives through the private sector suggest that pharmacies, and to some extent private physicians, are appropriate distribution points for USAID supported family planning service delivery projects.

To begin to ride the private sector wave, while avoiding the funding of projects in a reactive manner, USAID is urged to develop a strong rationale and plan for supporting private sector activities which focus on the potential of a project to simultaneously increase coverage and decrease long-term USAID support for project activities. Encouraging an increase in the retail price of contraceptives is essential. Given the size of USAID's population budget and the historical success of the FOF private sector initiative, the objective of increased coverage, however, should remain paramount.

Support should also be given to policy development and research activities in coordination with, but not exclusively implemented by, USAID supported private sector projects. The public nature of enterprise in Egypt makes communication of the role of private sector initiatives, especially to health care providers, important. Likewise, the lack of information on topics such as the effectiveness of service delivery as compared with contraceptive distribution, or the substitution efforts of USAID funded programs with the existing private sector, are crucial for evaluating USAID's strategy.

2. The Strategy for Public Sector Programs

i. The National Population Council

Overview and History. The National Population Council was established by Presidential Decree No. 19 in January 1985, and was the direct result of the agreement reached at the 1984 National Conference on Population that activities in population and family planning should be expanded and given higher priority in Egypt. The NPC replaced the Supreme Council on Population and Family Planning, chaired by the Prime Minister, and at this writing has the following members:

the President

the Prime Minister

the Ministers of Health, Social Affairs, Plan and

International Cooperation, Information, and Education

four public figures in the field of population, and

a Rapporteur/Secretary General.

The National Population Council is obligated by the enabling decree to develop a "National Population Plan" and to plan, coordinate and monitor the

activities of the other ministries, agencies and institutions involved in the sector. Until the first two Council meetings in January 1986, both of which were chaired by President Mubarak, some within the GOE and the international donor community thought that the NPC would have a role in the implementation of family planning services.

Some significant differences exist between the NPC and the former council. Over time, and with a significant amount of political will, financial resources, and technical assistance, these new elements could produce dramatic effects on the program.

First, the President of Egypt is Head of the NPC. He has given his attention and credibility to population and family planning activities. Since the President is not formally associated with any other institutions in Egypt, his presence at meetings of the Council indicates that population issues have a high priority in the government.

Second, the NPC, meeting as a Council, reviews and approves all national and international contributions for population and family planning activities. The Secretary General of the NPC is responsible for preparing and submitting the national plan to the Council for comment and action. In effect, the Secretary General has the capacity to influence programmatic priorities and to seek the endorsement of the Council. His role is potentially very powerful but requires considerable diplomatic skill. Through proper preparation, good staff work, and persuasion he is capable of focusing all population and family planning activities in Egypt.

Third, the Secretary General and staff of the NPC are responsible for planning, coordinating, monitoring, and evaluating all programs in population and family planning. Since the NPC is required to prepare the national plan and to recommend the course of action to be taken, it must have access to the information needed to formulate policy and define programs. As such, the NPC has the authority to review and assess the programs implemented by other ministries, agencies and institutions working in Egypt.

The NPC is potentially a very significant force in the field of population and family planning in Egypt. However, some serious barriers to the Council's viability are already apparent. The Council's decisions to withhold implementing authority from the NPC and to insist that the salaries of the staff of the NPC comply with the official GOE structure are regarded as disappointing positions by those who viewed the NPC as an organization similar to several special quasi-governmental authorities in Egypt, e.g. the Suez Canal Authority (SCA). The SCA and some other GOE parastatals are organized functionally and are exempt from many regulations, including salary structure, that constrain other ministries, agencies and institutions. On the other hand, the Suez Canal Authority provides the GOE with half as much foreign currency revenue as international aid agreements.

The recent decision of the Council suggests to many that the NPC will not be able to recruit and retain the most qualified staff. Without professionals of the highest quality, and without implementing authority, the NPC could become little more than the former Supreme Council on Population and Family Planning. As a result, there is concern that little new emphasis and impetus will be given to population and family planning activities.

To improve program results in the population and family planning sector, an enduring, consistent, and comprehensive effort should be made to develop the capacity of the National Population Council (NPC). While the NPC is admittedly in its infancy. Nevertheless, it is beginning to experience the problems that debilitate many other GOE public sector institutions, it is the one institution that is new to the population/family planning scene in Egypt and has a presidential mandate to make a programmatic difference.

The Proposed Role and Structure of the National Population Council. As currently defined the NPC is a policy-making body responsible for:

- a. planning, monitoring, coordinating and evaluating population and family planning activities in Egypt, and
- b. coordinating the allocation of GOE and international donor resources to programs and projects that reflect national priorities and/or facilitating the process of formulating national policies and programs.
- c. shaping a policy-oriented research agenda concentrating on issues of greatest concern to the President.

The Council is responsible for developing a program that (1) defines and expresses the national development objectives pertaining to population -- reportedly to be set forth in the next five-year development plan, (2) assures that the activities of the ministries, agencies and institutions involved in population are coordinated, monitored, and evaluated, and (3) formulates the policies relating to population that should be put into effect.

The last responsibility mentioned above is in many respects the most important. With a proven capacity to define the appropriate policies for the GOE, the NPC would be able to execute the other responsibilities assigned. It is imperative, therefore, for the Council to develop the capacity to frame and conduct the following types of research:

- a. policy analysis (e.g., pricing of contraceptives, cost-benefit of family planning programs),
- b. operational research (e.g., the role of dayas and nurse/midwives in family planning service delivery),
- c. clinical trials (e.g., effectiveness and acceptability of long-acting steriodal contraceptives).

The NPC is not yet an effective institution and because it does not have adequate staff it does not have the capacity to fulfill its mandate. To have impact within the constellation of Egyptian institutions the NPC must become an institution staffed with personnel capable of carrying out a defined but evolving program that contributes to reaching the goals of Egyptian society, and have enough resources (GOE and donor) to ensure a sustained effect. To become effective some key inputs and considerable time is required. At the same time, the NPC must carry out its mandate. In short, while maturing as an institution, the NPC must function as one. Given resources and time, the NPC could have a dramatic effect on population and family planning activities in Egypt.

Three key inputs are minimally required to develop the capacity of the NPC. Three are local and one is external. The local components are:

- leadership
- adequate manpower and finance
- trained technical staff

The local components are essential but need strengthening.

Leadership, in the person of the President and several key cabinet ministers, is present but unable to focus full-time attention on population and family planning activities. The incumbent Secretary General is committed to a program

of family planning service delivery but only available part-time. In addition, the Council does not have any religious leaders from either the Muslim or Christian communities. Still, the current membership of such high level government officials and committed individuals suggests that population is a significant development concern and more than a "health" matter. External technical and financial assistance is required for program management, management information systems, and the design and execution of research and institutional development activities.

The resources currently available to the NPC are wholly inadequate, and a complement of trained technicians is unavailable. There are few technicians on hand; and those who are, are part-time. No program or project managers are available and no new ones have been assigned to the NPC. In addition, no significant GOE funds have been committed to operations of the council.

As it develops, NPC will be faced with a need to influence and contend with a wide variety of ideas, issues, policies, institutions and individuals. To do this effectively it will have to remain flexible without compromising its central function, or "core" technology. NPC's "core" technology is policy-making.

An organization should be structured to allow the core to operate effectively and to achieve the organizational goal. In the case of the NPC, this is ultimately the formulation of policies pertaining to population and family planning activities in Egypt. To complete this task the team recommends support for NPC's Research Unit to conduct operational research in family planning, service delivery, policy analysis, and clinical trials. These three program areas offer the most potential for improving the delivery

of services carried out by the implementing agencies and for development relevant policy guidelines for the program as a whole.

NPC offers great potential to both guide and facilitate the work of the key GOE operating agencies. USAID should join the GOE and other donors in supporting this new initiative. We believe that USAID's assistance can be most effective if it is programmatically focussed and operationally carried out within the context of GOE policies and practices. This suggests that efforts should be made to:

- a. develop the proposed Research Unit of the NPC through the recruitment and training of qualified staff willing to work within GOE salary and consultant agreement constraints.
- b. enhance the Unit's ability to address policy, service delivery and clinical trial issues, and
- c. develop middle managers who can define, plan and monitor and research activities and build a constituency for the importance of the NPC among the other ministries, institutions and agencies in Egypt.

The existing organizational chart(s) of the NPC (Appendix D), developed before the January 1986 meetings, feature a significant implementation division. Since the NPC no longer has implementation authority, the chart will have to be redrafted to emphasize its policy-making role.

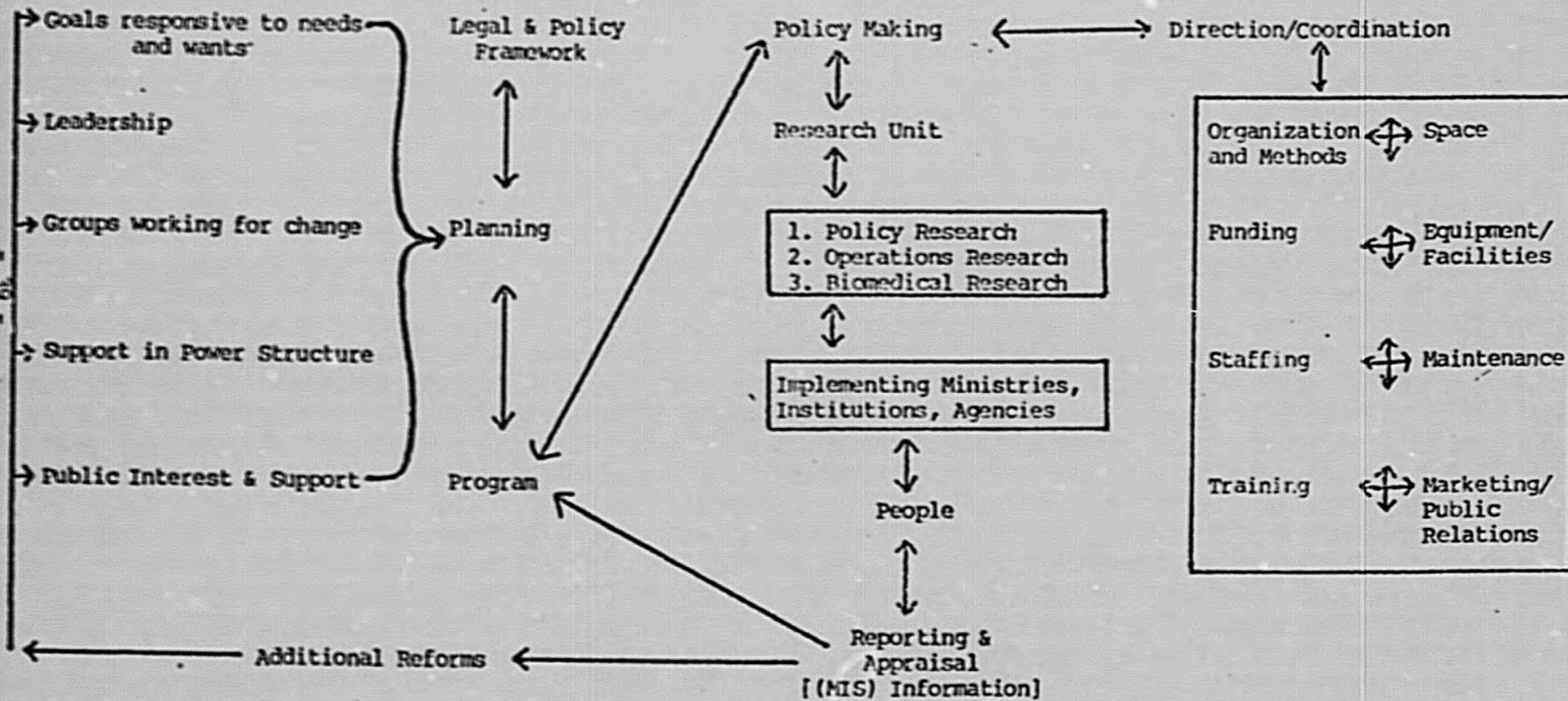
INSTITUTIONAL DEVELOPMENT PROCESS: NATIONAL POPULATION COUNCIL (NPC)

1. Public-Political Support

2. Program Development

3. "CORE" Technology

4. Administration



The Role of USAID. Given the current incomplete staff of the NPC it is not unwarranted to question whether USAID should invest resources in the institution. When considering this question, two key points should be kept in mind. First, the NPC is a significant, new initiative that has the blessing and attention of the President. Second, USAID and other donors gave strong encouragement to the creation of the NPC. Backing away now could undermine GOE credibility in US support for population and family planning.

USAID should support the Council, but in a limited, focused sense, and within the context of existing GOE policies and practices. Conditions precedent for USAID support should include GOE and USAID developed criteria which would measure progress in the NPC's development toward a fully viable institution. Significant progress should be expected in 3-5 years. Support in the form of expatriate (management, research administration and management information systems) and Egyptian technical assistance, training and other key inputs need to be made available.

While the NPC would play a key role in defining the research issues, monitoring the research and using the findings to draft the national plans for population and family planning activities, other institutions or groups of experts from a variety of institutions would actually conduct the research and present the results to the NPC. The issues selected would be those of interest to the members of the Council. From the perspective of USAID, the issues of principal interest would be those that address concerns related to increasing the availability and utilization of services.

In the context of supporting the institutional development of the NPC USAID should carefully define process rather than output indicators that

assess NPC's organizational capacity. The following could be among the indicators chosen:

- a. quality of administrative policy and practice.
- b. development of the intra-institutional environment, i.e., manner in which top staff are selected and compensated, discrete research projects completed, quality of technical staff recruited and trained, an increasing amount and kind of resources made available, the availability and effectiveness of outside (expatriate and Egyptian) technical assistance and the NPC's ability to absorb such assistance.
- c. coordination within the inter-institutional environment, i.e., the building of a network of supportive institutions within the technical field (researchers), across technical lines (doctors, planners, educators), and among supportive and controlling institutions (ministries).

For the NPC to play a role in population and family planning activities in Egypt it must first earn a place among the established ministries, agencies and institutions. The GOE line ministries responsible for implementing the program must view the NPC as a resource to them. The GOE itself, USAID, and other donors, should contribute to the development of the NPC as a lean and highly focused organization that defines, monitors, and evaluates experience and research pertaining primarily to increasing the availability and utilization of family planning services. USAID should facilitate the training of key staff who can manage the research program. USAID investment should be

cast within a framework of clear and realistic rubrics of institutional development.

ii. The Ministry of Health

The Ministry of Health (MOH) has been the principal public sector agency responsible for delivering family planning services in Egypt. In addition to providing services through its more than 3500 university and public hospitals, urban clinics and rural health units, the MOH has supervisory authority over a number of semi-autonomous groups, e.g., The Cairo Health Organization (CHO), that are involved in the delivery of health care services. The recent decisions of the Council indicate that the implementation of family planning programs in the public sector will remain under the control of the Ministry of Health.

The MOH and agencies operating under its aegis consider family planning to be part of an integrated maternal and child health program. Family planning is a "priority" program for the ministry, but it is one of several priority programs; others, for example, are growth monitoring, the control of diarrheal diseases and immunization and vaccination.

By virtue of the way in which family planning activities have been, and continue to be, organized within the ministry, it is difficult to conclude that delivering family planning services and estimating their impact is a high priority of the GOE. At present, the family planning program of the Ministry of Health is decentralized in two ways. First, there is no central coordinating unit for family planning. While a Directorate for Family Planning has been established, the staff is limited to two professionals, budgetary resources are very scarce, and there is no project to implement.

Largely responsible for documenting program activities, the director-general has to depend on reports submitted by those charged with implementing the different donor-supported projects (USAID, World Bank, Federal Republic of West Germany, and British ODA). Each family planning activity is organized as a separate project; each has its own staff and budget; and each has a distinctive manner of reporting program results. While there are reports that the MOH originally intended to establish and convene a standing committee to plan, coordinate and assess the activities of the different donor-assisted projects in family planning, only one meeting has been held in the last five years. The planning, coordination and evaluation functions required to define and implement a national family planning program are not centralized at the national level.

Second, implementation authority is decentralized to the governorate and district levels. Health officers at both levels are required to report program activities to the responsible authorities at the national level. However, because the budget allocation provided by the Ministry of Finance does not allow the officers to carry out all facets of the preventive health care program, in many respects they are free to determine their workplans, to allocate the limited resources available to respond to their local priorities, and to decide on the type and timeliness of the reports to be submitted to the MOH. The health officers are in effect allowed to interpret and implement the directives of the MOH. There is no centrally-organized, funded and directed structure in place to implement and support a comprehensive family planning service delivery program.

USAID began to work with the Ministry of Health to support family planning activities in 1977. Over the years USAID has:

- a. provided some salary support (in the form of incentive payments), contraceptive supplies and a great deal of clinical training (physicians, nurses and nurse-midwives - dayas) and some management training,
- b. refurbished the El Galaa Maternity Hospital, and
- c. developed a contraceptive inventory and supply system.

The thrust of USAID's program has been to improve the quality of clinical services and increase acceptance of family planning. In general, the strategy has proven to be effective. There appears to be some correlation between the provision of clinical training, especially training in IUD insertion, and the perceptible increase in contraceptive acceptance from 1980 to 1985. This is not to suggest that it is possible to determine the level of services provided through the clinic network of the Ministry of Health. It is suggested, however, that MOH clinical personnel trained with USAID assistance are providing an increasing amount of service through either the MOH network or their private clinics.

In 1984 USAID began examine other service delivery opportunities that offered the promise of rapid improvements in the availability of family planning services and the levels of contraceptive acceptance. Increased support was given to private sector activities in family planning, chiefly through the Family of the Future, and to the expected development and implementation of a new "Family Planning Project" under the authority of the National Population Council.

The January 1986, decisions of the NPC indicate that the MOH will continue to have primary authority for implementing family planning programs in the

public sector. Discussions with the Minister of Health, the Director for Family Planning and the Director of Planning suggest that the Ministry is about to create a central directorate, perhaps an undersecretariate, that would be responsible for coordinating all activities in family planning and would report directly to the Minister of Health. The proposed unit, which was recommended by the USAID assessment team in 1982 and again by the UNFPA Needs Assessment in 1985, would meet regularly to coordinate, monitor and evaluate all donor-assisted activities in family planning. In addition, some members of the ministry have suggested that this unit would be responsible for convening meetings of donors interested in supporting family planning activities in Egypt.

The Role of USAID. After USAID's and other donors' direct and indirect efforts to urge the MOH to emphasize family planning service delivery, an organizational reform that could produce improved program performance appears to be imminent. USAID should continue to encourage the development of the proposed unit, and offer the assistance that may be requested and needed to strengthen the planning, coordination, management and evaluation capacities of the unit. It might be worthwhile to review the efforts made by USAID to support the development and introduction of management information systems at the MOH. Perhaps among the different MIS projects that USAID has supported at the MOH there is one model that could be adapted for use by the unit and capable of providing information on program performance.

In addition to encouraging the establishment of the new family planning unit at the MOH, USAID should continue to support the clinical and management training activities. The House Officer Training Program, the Clinical

Refresher Program and the IUD Training programs appear to be well accepted and, over time, likely to generate increasing levels of family planning service. USAID should also continue to ensure that sufficient supply and selection of contraceptive commodities are available to the public sector programs of the GOE. Contraceptives could be provided from USAID central procurement program and/or produced locally.

USAID should also give additional consideration to increasing support of the family planning service delivery programs of the Cairo Health Organization and other organizations like it. At the moment, services available to family planning acceptors through CHO are subsidized by USAID, although the other services are paid for by the clients. While continuing to support the family planning program of CHO, USAID should encourage the organization to ask clients to pay something for family planning services.

The Office of Health of USAID is in the process of developing and launching a major Child Survival Project (263-0203) in collaboration with the Ministry of Health. The proposed project will have four principal programmatic activities: (a) immunization, (b) acute respiratory infection, (c) child nutrition and (d) child spacing. All are designed to reduce rates of infant and child mortality and morbidity in Egypt. While some thought has been given to placing the child spacing component of the new project among the family planning projects directed by the MOH, USAID should keep the two initiatives separate for the foreseeable future. Adding the child spacing component to the family planning structure could delay and perhaps impede the implementation of both programs. Combining the two programs at a time when the family planning and the child survival units are being organized might present the MOH with a very difficult management burden.

Given the importance of the child spacing component of the Child Survival Project as a new initiative in the MOH and the continued ambivalence there toward establishing family planning as a priority activity, USAID should seriously consider establishing in the project's implementation plan a system by which the child spacing component of the project receives as much attention as the other three interventions. Indeed, it would be a tragically lost opportunity if child spacing, potentially the most important intervention, was not implemented with as much vigor as the other components.

Fertility studies have shown that family planning in Egypt is perceived as fertility termination. According to those involved in delivering family planning services, Egyptian women more readily accept contraceptive methods after they have achieved the desired family size. The child spacing component of the child survival project is designed to encourage a younger cohort of women to accept contraceptives as a means to prolong the interval between births. While the women wishing to space births and those desiring to avoid all future pregnancies are likely to seek services at the same health units, each group has a different profile and will be responding to a different message. While it may eventually be desirable to link the two programs more closely, in the immediate future, because of the management burden and the fact that two different audiences are potential acceptors of contraceptive service, it is important to keep the national level programs separate and distinct.

USAID support for the Beni Suef project began in September 1982 under an agreement with the Ministry of Health. The objectives of the project were to increase local awareness of population issues, encourage local officials to

participate in social service decision making, train social service personnel, introduce household distribution of contraceptives and oral rehydration salts and to evaluate project results. Besides this extensive list of objectives, the project was incorporated into the Population and Development Project (PDP) administered by the Population and Family Planning Board. Participating institutions include the Beni-Suef governorate, the MOH, the PFPB and the Social Research Center (SRC) of AUC.

USAID is faced with two questions concerning this project. First, whether to fund a comprehensive evaluation of the Beni-Suef project, and second, whether to continue funding the project.

In keeping with USAID's family planning objectives, the team supports an evaluation of the family planning outreach component of the Beni-Suef project, not the comprehensive evaluation proposed by AUC. The outreach component originally involved representatives from MOSA, MOH and the PDP program visiting households to provide information, education and referral on family planning and other social services. MOSA social workers and MOH nurses worked overtime to participate in the project. Today, however, project salaries have been reduced for MOSA, MOH, and PDP staff. Thus, the family planning component of the Beni Suef project is operating somewhat at half mast.

MOH outreach and some PDP outreach still exists. In clinics where MOH nurses are supported by physicians who have received population training, the numbers of contraceptives distributed as a result of referrals is considerably higher than in clinics with no special population program. Research of this component could compare the Beni-Suef outreach, which at present is directed only to family planning, with the existing MOH rural program outreach

program. Possible synergistic effects between physicians' population training and the outreach workers working out of clinics with physicians trained through other USAID supported projects could also be evaluated. Some attention might also be given to the potential for direct distribution of contraceptives by outreach workers.

In sum, the team suggests that USAID evaluate and take programmatic advantage of the fact that a family planning thread has naturally separated itself from the activities of an integrated project, and that that thread could be an effective way to increase family planning coverage. The team suggests no further funding of the Beni-Suef project as it now stands and encourages USAID to assist the MOH to incorporate any "lessons learned" into the Ministry's rural outreach program.

In summary, USAID should:

- a. support the development and effective operation of the proposed family planning unit of the MOH,
- b. continue to support clinical and management training of MOH personnel,
- c. ensure the availability of adequate supplies and range of contraceptive methods
- d. support the family planning program of CHO, and other MOH-associated organizations like it, and
- e. encourage the effective implementation of the child spacing component of the new Child Survival Project but keep this activity separate from the other family planning service programs of the MOH.
- f. assist the MOH to incorporate lessons learned from the Beni Suf project into its future plans.

iii. The State Information Service (SIS)

The Information, Education and Communication Center (IEC) of the State Information Service of the Ministry of Information is responsible for creating

an "awareness" among the people of Egypt of the role that family planning plays in ensuring the health of women and children and contributing to the national development of the country. Since 1980 USAID has provided funds to: (a) develop and publicize a national population/family planning campaign, (b) buy time on television and radio, (c) train more than 20 staff in population communication skills, and (d) supplement the salaries of key staff. In addition, USAID has financed long term expatriate technical assistance to SIS.

A recent assessment of program activities suggests that the investments have produced mixed results. The key findings are summarized below.

a. The SIS campaign to create "awareness" appears to have been minimally effective. According to the 1984 Contraceptive Prevalence Survey (CPS), there has been a decline in the level of awareness of family planning methods in parts of Egypt since the previous 1980 Egyptian Fertility Survey was conducted. The IEC director of the SIS attributes this decline in awareness to funding constraints which caused a decrease in the number of mass media spots in the last two years. This interpretation indicates that SIS is rather confident about the relationship between their messages and awareness building.

b. The messages broadcast by the SIS, emphasizing the two-child family and promoting a strong family planning theme, were inappropriate for Egypt. These messages have reportedly been developed without identifying the specific audience to be reached, without requesting advice and assistance from the other agencies involved in population and family planning programs, and without using a plan that focuses the program or employs a methodology that matches the message with the appropriate audience.

c. The two staff trained in population communication techniques are serving in another department of SIS and not available to the IEC Center. The resident expatriate technical assistance provided by USAID was unable to establish a collaborative and effective relationship with the management and staff of the IEC Center.

As a result of the recent assessment, significant changes have occurred.

Dr. Galal el-Rashidi, an experienced program manager with expertise in

communication, has been appointed Director of the Center, and the technical assistance contract with the Academy for Educational Development has been restructured to emphasize short-term rather than resident assistance. In addition, the "lessons learned" over the last five years have been kept in mind when framing the plan for current and future activities.

With assistance from AED, the IEC Center has produced a 1986 Workplan that calls for:

- a. hiring and training four new staff (over 70 applications have been received),
- b. developing and pre-testing different messages designed to reach specific audiences at different levels of Egyptian society and in different regions of the country
- c. increasing the number of radio and tv spots, and broadcasting each continuously for an extended period of time, and
- d. working with private firms, experienced in public relations and advertising (e.g., Moheeb Productions and Team Misr), to develop appropriate messages.

The preparation of a workplan is an important development. Still, the value of the SIS mass media approach, which incorporates population and development messages as well as the "family planning ensures better maternal and child health" message, is unproven in Egypt. The program of SIS remains largely uncoordinated with, and unrelated to, the activities of the other agencies involved in population and family planning activities, e.g, FOF, MOH, NPC. In addition, since SIS does not prepare and broadcast product-specific or service-specific messages, it is difficult to assess the extent to which the work of SIS -- creating "awareness" -- contributes to the acceptance and utilization of family planning services.

The Role of USAID. The recent promising developments at SIS suggest that USAID should continue to support the work of the IEC Center. However, assistance should be framed in a limited and focused fashion to ensure that "awareness" of the importance of spacing children is equated with trends in service statistics. The current program of activities should be encouraged. Specifically, USAID should foster:

- a. the continued development and use of a methodology that frames the messages in terms of the concerns of the different audiences by socio-economic level and region of the country
- b. the establishment of a formal linkage between the public awareness campaign of SIS and the programmatic objectives of the National Population Council, the Ministry of Health, the Egyptian Family Planning Association and others, and
- c. an increasing reliance by the IEC Center of SIS on Egyptian private sector firms experienced in advertising and public relations.

Utilizing this strategy should enable USAID to ensure (a) that the resources allocated to SIS contribute to achieving specific service objectives, and (b) that the program is better coordinated with other population and family planning activities, somewhat less identifiable as "government" propaganda, and more cost effective.

### 3. Recommendations for Private Sector Initiatives

In recent years contraceptive distribution statistics and contraceptive prevalence surveys indicate that most Egyptians, in fact about three-quarters, receive contraceptives or family planning services from the private sector. Pharmacies are the most popular point of distribution. Given the acceptability of private sector distribution, and the success of the "social marketing" of contraceptives through the FOF project, USAID should capitalize on the success in the private sector. The team's recommendation is for USAID

to develop a comprehensive private sector strategy for family planning service delivery. This strategy would provide the rationale and define activities to be implemented by the traditional PVO sector, represented in the present program by FOF and EFPA, and the more market-based sector (e.g. pharmaceutical firms and private physicians). A plan for overall private sector program management would also be included.

i. Rationale. Having a rationale for USAID private sector activities seems particularly important at this time. Private sector activities already initiated or in the planning stages appear to have resulted from the "let-many-flowers-bloom" era of the program. If not defined in terms of their potential for increasing both family planning coverage and non-AID support to the family planning program in Egypt, existing projects in this category (e.g. FOF) could lose focus, while outstanding proposals may never receive funding (e.g. pharmaceutical production assistance, factory family planning programs).

ii. Recommended activities. The team suggests that a private sector strategy include, but not be limited to, some analysis for supporting the following three types of activities: (1) factory based programs, (2) the increase of pharmaceutical production, and (3) the provision of technical and financial assistance to private Egyptian physicians who provide family planning services.

Factory based programs appear to be a natural for a country where most industries are required to provide health care services for their employees free of charge. Factory programs can potentially increase family planning coverage while working within an existing health care structure (the company

health service) and can almost immediately call on the factory to assume the costs of family planning service delivery (e.g. through use of facilities, personnel, existing reporting systems). Two factory-based initiatives are already underway in Egypt. The first, the Mehalla-Kubra project, began operating in 1962 in the Misr Spinning and Weaving Company, (see Appendix G for the company's project description). More recently FOF began adding family planning clinics to factory health programs. FOF factory programs are now operating in 12 locations.

At present, FOF plans to expand its activities through its USAID grant and the directors of the Mehalla-Kubra project have submitted a \$1.5 million proposal to the National Population Council to expand factory-based family planning services. Some coordination of these two initiatives is necessary, along with a clearer plan for factories to begin assuming the costs for delivery and some simple evaluation guidelines to determine whether these factory initiatives do in fact reach acceptors who are not already paying for their own family planning services.

In a similar vein, employer-paid insurance groups may also be willing to include family planning among their services. In these cases USAID's strategy may be to work with the insurer to identify the potential cost savings in pre- and post-natal care for mothers and children if the insured families were to accept family planning services.

Increasing pharmaceutical production. In 1982 USAID received a proposal from two local pharmaceutical firms, CID and El Nil, to purchase equipment to increase their production of oral contraceptives. CID's estimate at the time was that it could increase its monthly production of orals from 750,000 to

1,200,000 cycles with the necessary equipment and that existing demand could absorb the increase in production. If the rationale for such an investment by USAID is clear and if the implementation plan takes into account the sensitivity of the USAID's population program, such a strategy could assist Egypt to increase contraceptive coverage through the already popular private sector.

In terms of rationale, it should be clear that the objective in providing equipment to an Egyptian pharmaceutical firm is not to help the firm develop as a firm. Rather the objective would be to increase the availability of safe and effective contraceptives while encouraging non-USAID funding of the Egyptian population program. The project would provide the firm with financial and technical incentives to increase production of one commodity (the pill) over others. Without such assistance those "other" choices may be made because they require lower start-up or expansion costs, or show potential for attracting more revenue.

Likewise it is important to note that buying equipment for an Egyptian firm does not provide lower cost contraceptives. USAID's worldwide economy of scale in contraceptive procurement is almost certainly less costly than the production costs of Egyptian pharmaceutical firms. The costs saving to USAID of providing equipment and installation would derive from not having to pay for the contraceptives for Egyptian citizens after the initial investment is made. Thus in CID's case, local pill production would soon be increased and funded through the Egyptian economy possibly with continued assistance from the German government which is providing the raw materials for the pills through a low interest loan.

Some care must be given to this approach. Providing risk capital, or in this case equipment, is not a usual activity for USAID's population program. Despite the financial viability and internationally accepted safety standards of the Egyptian companies involved, the activity should include a technical and informational follow-up activity not included in the original request for equipment. Technically, USAID must be assured that the equipment is being used correctly. Some follow-up reporting or analysis on increases in production, sales, and revenues is necessary for USAID to assess the project and contemplate further work in this area of the private sector.

Assistance to private physicians. Approximately ten percent of contraceptives in Egypt are distributed through private physicians all of whom began their careers in the public sector or are presently practicing in the mornings in government facilities and in the afternoons or evenings on their own. FOP's contraceptive distribution program provides contraceptives (mostly IUDs) and some training to private physicians. Many physicians receive training in IUD insertion and other contraceptive technology through donor funded training programs with the MOH and universities. A possible private sector initiative to further encourage the delivery of family planning services by private physicians would be to establish a project providing risk capital and technical assistance for the private physician wishing to create or augment a practice which focuses on the delivery of family planning services.

At best, improving the ability of the private sector to provide family planning services will allow private physicians to absorb a segment of the of the public sector demand which includes people who are willing and able to pay

for services. Public programs can then focus better on the clients less able to pay.

iii. Existing Private Voluntary Organization (PVO) Activities. FOF and Egyptian Family Planning Association (EFPA) are the two significant family planning PVO's at this time. FOF has been USAID funded since 1979 and considerable institutional support for EFPA is contemplated to begin very soon. FOF is clearly a star project and deserves continued GOE and USAID support. Such support should be focused so as to benefit from the marketing and private sector distribution of products. Present plans for factory programs, and experimenting with price differentiation should be stressed over branching further into clinic operations or rural CBD. FOF may be able to absorb a larger scale factory distribution program and a program for private physicians. In terms of evaluation, the cost of delivery by FOF should not be compared with CSM projects in countries with stronger public and PVO programs. FOF is a major provider of contraceptives in Egypt, especially as compared to the public program. While this comparison says nothing about the effectiveness of FOF's IEC and service delivery when compared to other institutions, it does highlight the need to view FOF, at least for the time being, as a project where increasing coverage may be more important than decreasing the cost of that coverage.

EFPA's proposal to establish and manage 250 of its 500 centers as full time family planning clinics has been under development and consideration for the past two years. The proposal calls for a total budget commitment of about \$16 million, including expatriate technical assistance over five years. This proposal was in the final stages of USAID's approval process at the time of the team visit.

The team believes that this proposal is overly ambitious. While the existing proposal plans to phase in the 250 clinics over the five year period, the overall magnitude of the project may exceed the management capabilities of the Family Planning Association even with technical assistance. We suggest that USAID initially limit its support for two years and focus technical assistance on financial planning and resources generation. This proposal would be an ideal setting to experiment with some of USAID's ideas to increase family planning availability through changes in the pricing of contraceptives.

The EFPA project could also test the feasibility of a family planning FVO to fund raise locally. If after the first two years of support, this approach to establishing full time family planning clinics is successful, both in terms of expanding high quality services and in strengthening EFPA's management capabilities, USAID can continue support and even expand the project to reach the initial 250 clinics. The point here is not to raise expectations at this time before the basic idea can be tested.

It is also recommended that USAID discuss its plans for the EFPA with IPPF London, especially as the proposed funding will overshadow IPPF's support for the affiliate. Finally, cost-sharing formulas should be negotiated with the MOSA, especially now as the new Five-Year plan is being formulated. Substantially increased GOE contributions should be forthcoming in at least the second year.

iv. Implementing private sector projects. To implement a multifaceted private sector program, the mission may want to consider buying-in to the centrally funded Enterprise Program (John Snow, Inc.) or

calling on that program to develop an RFP for U.S. based assistance. FOF, EFPA and the pharmaceutical firms would be the Egyptian implementing agencies. The FOF and EFPA activities would of course, be closely coordinated with the MOSA. Existing technical assistance which the mission has found useful, especially that provided by Triton Corporation and Needam, Porter and Novelli, could be incorporated into the program.

4. Opportunities for Policy Development

i. Present activities

As mentioned above, USAID's policy analysis and policy dialogue activities have primarily focused on discussing the relationships among population and development variables with high level government leaders and, in the last two years, on encouraging the creation of the National Population Council.

Computer assisted presentations on the consequences of rapid population growth on Egypt's socioeconomic development and natural resource base were prepared and presented to President and Mrs. Sadat, and subsequently to President and Mrs. Mubarak by The Futures Group. Reactions of both heads-of-state were extremely positive and generally believed to have reinforced these leaders' expressed commitment to a strong population program. Similar presentations to larger Egyptian technical audiences were arranged by CAPMAS in 1981. For the three years since these presentations were made, USAID's formal policy dialogue on population issues has centered on the inclusion of population issues in talking points for high level discussions between USAID and the GOE. (e.g. meetings between the USAID Administrator and President Mubarak.) There was also considerable informal dialogue by the USAID Population Office and representatives of USAID

cooperating agencies regarding the establishment of the National Population Council.

While a minimal amount of RAPID training and presentation activity is the only entry listed under "policy activities" in the Mission's portfolio, other ongoing policy development activities initiated or supported by USAID include: (1) assistance to the State Information Service which allows its IEC program to participate in awareness building lectures to groups of national and regional opinion leaders or potential opinion leaders (e.g. police academy graduates, governorate level leaders), and (2) Support to a CAPMAS project which coordinates CAPMAS's demographic and MPIC's planning activities at the regional level in preparation for the regional-level five year plans.

ii. Comprehensive approach

Given the apparent difficulties the GOE has experienced in implementing an effective population/family planning program despite over twenty years of expressed political commitment, and given some of the observed misconceptions and lack of information in policy-making and policy-influencing circles, it is strongly recommended that USAID's population program put a priority on providing quality assistance to the GOE in the area of policy development. The character of this policy development must be (1) carefully targeted to different audiences (decision-makers, opinion leaders, government planners, and health care providers); (2) adequately differentiated to allow for different absorptive capacities and requirements of the audiences; (3) predominantly Egyptian in content and presentation; and (4) well coordinated and monitored. Such a policy program would be a major increase in USAID's assistance to policy activities but would provide fundamental support

to the twin goals of increasing institutional support for expanding family planning services.

iii. Channels and messages

Table 2 provides an example of the types of audiences, activities and institutional responsibilities which may be appropriate for a comprehensive policy dialogue program. Many groups within Egyptian society must be brought into policy dialogue with the GOE and its population community, some at a very general level and others in a manner leading to the incorporation of population information and plans into other macroeconomic or social service planning.

Table 2:

POLICY DIALOGUE: AUDIENCES, ACTIVITIES, AND RESPONSIBILITIES

<u>Audiences</u>	<u>Activities and Institutional Responsibilities</u>
<u>Decision-makers:</u> ministers; party leaders; governorate leaders.	National and governate level RAPID presentations as appropriate. RAPIDs to include both an analysis of the macroeconomic consequences of population growth and the health benefits of family planning in Egypt. For Ministries of Health and Social Affairs, analysis may include how to meet family planning targets.  RAPIDs to be prepared in close collaboration with Egyptian institutions, especially the NPC, CAPMAS, MOH and SIS. NPC to coordinate presentations and follow-on policy dialogue activities. Some Mission and Embassy involvement will be necessary for informal policy dialogue. Outside TA from the Futures Group.
<u>Opinion leaders:</u> military; police; businessmen; medical community; academia; religious leaders; media.	Same as above with additional attention to contraceptive technology, discussions of the regulations affecting service and commodity delivery, meetings on religious and ethical issues surrounding family planning.  NPC to take coordinating lead in cooperation with specific groups of opinion leaders and appropriate ministries. Outside TA from Futures Group, Population Council, FHI, AED, and Population Reference Bureau.
<u>Government planners:</u> MPIC; National Planning Institute; CAPMAS; Office of the President; requiring national Authorities.	Projects aimed at incorporating demographic information and objectives into national and regional planning, e.g. modelling exercises, long-term advisors. Emphasis on project  NPC to establish long-term relationships with national and regional planning institutions, but some non-NPC projects can be useful (e.g. CAPMAS and MPIC coordination.)  NPC and CAPMAS to take the lead in coordination. Outside TA from RTI and PSCs.
<u>Health care providers:</u> factory managers; private physicians; pharmaceu- tical firms; health care PVOs, insurers.	Prepare and disseminate business analyses on the health effects of family planning and, for some providers, the cost savings of incorporating family planning into health care programs.  NPC and private organizations to take lead. Outside TA from Population Reference Bureau and John Short & Assoc.

Discussions with Egyptian policymakers and opinion leaders, and other observers, suggest that at least three kinds of messages must be communicated by the Egyptian population community:

- a. Despite the fact that increasing or stable population growth rates can quickly result in a doubling of population size, declines in growth rates do not lead to a decline in the size of the population, even within the next century.
- b. Socioeconomic and natural consequences of rapid population growth exist both at the national and governorate level.
- c. Birth-spacing can help improve the health of mothers and infants, and can reduce unacceptably high maternal and infant mortality rates.

The first message is simple but is a significant part of the answer to those who still believe Egypt needs more people to assure its strength. The second message has proven useful to national level decision-makers. More detailed analysis of population and development relationships however for national and regional planners, and more regionally discrete analyses for governorate level officials, remains to be done. The third message is becoming increasingly accepted on a theoretical level by family planning program managers and population researchers but country level data supporting the message is lacking. (GOE and USAID should note that the policy analysis results for either the macroeconomic or health messages can be useful for a more understanding population policy dialogue.)

iv. Available technical assistance

Technical assistance in policy analysis and message presentation is readily available from outside of Egypt. Various AID/Washington policy development cooperative agreements and contracts are eligible for USAID buy-ins, thus simplifying USAID management of a comprehensive policy initiative. These agreements and the prime executing institutions include the following:

- RAPID II/The Futures Group (University of Michigan is a sub)
- INPLAN/Research Triangle Institute
- IMPACT/Population Reference Bureau
- TIPPS/John Short and Associates

The Office of Population's Users Guide (November 1985) provides more detail on the various activities and services available under these contracts. The Futures Group and RAPID have enjoyed good relationships in Egypt in the past and have developed new analyses on the health benefits of family planning and contraceptive requirements. INPLAN, a program directed at assisting national planners to incorporate population variables into national and program level planning, is presently discussing possible collaboration with planners and mid-level managers at the National Population Council and the National Planning Institute.

Other technical assistance could easily be obtained from the Academy for Educational Development in communications, and Family Health International in contraceptive technology as part of their existing TA agreements in Egypt. Also, while the Population Council has no direct agreement with the Mission, it has a strong regional presence and expertise in both contraceptive technology and targeting models for proximate determinants of fertility and contraceptive requirements. Finally, many countries (e.g. Pakistan, India) have benefited from long-term technical assistance in policy development, generally through a Personal Services Contractor (PSC) placed in an appropriate government planning agency.

The key to using this assistance effectively is to coordinate the activities of both the Egyptian and TA institutions involved in policy analysis and dialogue. The NPC is the logical coordinating unit on the GOE

side at this time, especially if USAID support for the NPC follows the plan outlined in Section III, 2. Some responsibility for coordinating, monitoring and reporting on policy activities should be entrusted to one of the individuals or institutions involved with providing technical assistance.

SCOPE OF WORK

POPULATION PROGRAM ASSESSMENT

A. PROGRAM DESCRIPTION

USAID has assisted Egyptian efforts to reduce population growth since 1977. The Population/Family Planning I Project has provided \$67.6 million since 1977 in support of family planning activities. The final obligation under the project was made in 1982 and the project completion date is September 30, 1986. The successor project, Population/Family Planning II, was authorized in mid-1983. It provides for further assistance of \$102.6 million over a four year period to continue support for programs to increase family planning practice among Egyptian couples of reproductive age. \$26 million has been obligated under the project to date. The project is currently scheduled for completion in 1988.

B. PURPOSE OF THE ASSESSMENT

The Project Paper for POP/FP II planned a mid-term evaluation of project progress in 1984. This evaluation was rescheduled for FY 86 owing to GOE organizational changes in late 1984 and early 1985.

USAID anticipates that obligation of additional funds under POP/FP II will be necessary in FY 86 to continue support for successful elements of the ongoing program and to initiate new activities. A Project Paper Amendment will be prepared prior to the obligation of funds to define a strategy for future USAID assistance. There have also been major recent institutional

changes within the GOE; in January 1985, a new entity, the National Population Council (NPC), was created and given a central management role in the sector. In this context, USAID considers a broader program assessment more useful than the originally planned mid-term evaluation of project progress.

The purpose of the assessment is to review the institutional context and the effectiveness of the current program in order to provide guidance to USAID in identifying priority areas for future support, maximizing program impact and improving program management. The assessment should assist USAID and the GOE in developing a more focused and effective and better managed program of USAID assistance.

#### C. BACKGROUND

Egypt's population of 49 million is growing rapidly, at 2.7 percent annually. Extreme urban overcrowding, high rural density and heavy dependence on food imports are major development problems. The crude birth rate is 37/1000, and contraceptive prevalence is estimated at approximately 28%. The GOE has been unable to implement an effective family planning program of the magnitude and vigor required for a rapid reduction in fertility.

At the time U.S. bilateral assistance in the population sector was initiated in 1977, GOE priorities in the sector were not well defined. The POP/FP I project reflected this lack of focus and adopted a flexible approach, responding to available targets of opportunity. In 1980 the GOE articulated a national strategy for the sector, and the project agreement was amended in response to this strategy to support certain new activities. It was subsequently amended to maintain their momentum.

In 1982, prior to the development of a follow-on project, USAID supported a Population Sector Assessment to provide

recommendations for future assistance. The Assessment stressed the importance of political commitment to the program. It also made specific recommendations for support of family planning services and "beyond family planning" activities. The POP/PP II Project Paper was prepared in 1983 and included support for seven major components:

- (i) continued provision of contraceptive commodities: \$24 million
- (ii) private and commercial sector initiatives; the major activity contemplated was continued assistance to the ongoing social marketing program, Family of the Future (FOF): \$13.5 million
- (iii) programs emphasizing community participation in population activities. The major planned activity was the GOE integrated rural Population and Development Project (PDP): \$18.7 million
- (iv) a new, intensive MOH rural family planning campaign: \$21.2 million
- (v) continued support for IEC activities, primarily the State Information System media campaign: \$11.2 million
- (vi) statistical and policy-oriented activities, including demographic research by CAPMAS: \$8.1 million
- (vii) bilateral assistance to population intermediaries, e.g., Pathfinder, FPIA: \$9.9 million

Some progress has been made in implementation of certain project components. FOF in particular has developed into a dynamic, expanding (although primarily urban) social marketing and retail sales program. Contraceptive commodity assistance, CAPMAS demographic research and analysis, MOH physician training and the SIS media campaign are all underway, but their impact has not yet been established.

Less progress has been made in the area of family planning service delivery. Support for the integrated PDP was discontinued after it was perceived to be ineffective at increasing family planning acceptance. Doubts have also been raised regarding the effectiveness of the ongoing Beni Suf Integrated Services Project. The major MOH rural campaign envisioned in the Project Paper has not been developed by the MOH, apparently owing to lack of capacity within the MOH to develop and to implement a large-scale program, or given capacity, a lack of interest. USAID is, however, currently considering support for several new initiatives, including upgrading Egyptian Family Planning Association clinics and a community-based contraceptive distribution program.

Current service statistics indicate that the vast majority of couples using contraception are served by pharmacies (65% of CYP\*) with a significantly smaller percentage (15% CYP) relying on MOH clinics. Private physician services and PVOs account for a relatively smaller share of total services (11% and 8% respectively of CYP).

An analysis by distribution system indicates that the Egyptian Pharmaceutical Trading Company (EPTC), the network charged by the GOE with supplying pharmacies and MOH clinics, is the primary distributor of contraceptive supplies. Supplies

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\*CYP: Couple Years of Protection

distributed by EPTC include contraceptives provided by USAID that are packaged differently and priced lower than those marketed by FOF. (Contraceptives distributed by EPTC account for 52% of total CYP.) FOF also accounts for a major share of supplies distributed (34% of CYP).\*

Hopes for a dramatic improvement in USAID efforts in the sector have been centered on the NPC. Since its establishment in January 1985 the NPC has been seeking to gain effective managerial control over all population and family planning activities. USAID vigorously supported the creation of the NPC and wishes to assist it to rapidly establish itself as a dynamic and directive force. It is not yet clear how the NPC is likely to affect future programming efforts in the sector.

D. STATEMENT OF WORK

The assessment will review the implementation status of the major components identified in the POP/FP II Project Paper, and of currently active subprojects funded under both POP/FP I and POP/FP II, except for Bureau of the Census assistance to CAPMAS for the 1986 census. The team will also review proposals for new project activities currently under consideration by the USAID Population Office for future funding. The team will examine the mandate, organizational structure, and current and planned activities of the NPC. It will also assess the organizational capacity of the MOH to provide additional family planning services to those currently provided through the MOH clinical network and to new child spacing initiatives planned under the Child Survival Project.

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\*Contraceptive Inventory and Information System, Monthly Summary Report, July, 1985, prepared by Price Waterhouse Khattab.

The key question to be addressed by the assessment is:

What can we learn from past activities and an examination of present structures to help USAID to better integrate, focus and manage its population assistance program in order to increase its impact on fertility reduction within GOE political and institutional constraints?

The report should respond to the following, more specific questions related to the central management question posed above:

- (i) What has been the impact of the current program of USAID population assistance? The current USAID population assistance program includes support for a wide variety of approaches to encouraging family planning acceptance. For example, some subprojects support integrated rural development activities that include family planning education and services among other components. At the other end of the spectrum are vertical programs such as the FOF contraceptive social marketing effort.

Which individual elements of the program have demonstrated a significant contribution to increased contraceptive prevalence and fertility reduction? Which activities do not appear to have had any significant demographic impact? Which activities are priorities for continued assistance? How can promising activities be further strengthened? Which activities should be discontinued owing to their limited effectiveness and impact on fertility?

- (ii) What are the implications of recent GOE institutional changes for future USAID assistance? What is the current status of the NPC? Has it made progress towards establishing itself as an effective organization? What appears to be a likely time-frame within which the NPC will be in a position to assume managerial control of the national family planning program? What is needed to establish the NPC as an effective locus of program development and implementation? Are there constructive inputs USAID can make into its institutional development? In the immediate term - i.e., the next two years - to what extent should USAID rely on the NPC for new program initiatives and directions, as opposed to continuing to support a mosaic of activities proposed by various elements of the family planning establishment?
- (iii) How can USAID management of the population/family planning assistance program be strengthened? Given limited staff resources, the diffuse and fragmented nature of the current USAID population assistance program has made the task of effectively managing this complex program more difficult. What are the major problems within USAID constraining implementation of the present program or any new program? How can USAID manage the program more effectively? Should USAID consider alternative modes for assistance and for project implementation?
- (iv) What is an appropriate strategy for USAID assistance? What priorities should USAID establish for supporting the GOE strategy? What criteria or guidelines should the GOE establish to ensure that individual elements of the program are integrated

into the overall strategy and focus on the goal of increasing contraceptive prevalence and hence reduce birth rates?

Do current USAID project development efforts meet these criteria? If not, on what program areas should USAID focus project development efforts in order to better ensure consistency with strategic objectives? What important program needs are not currently addressed by current or proposed activities? How can USAID best address these needs?

E. METHODS AND PROCEDURES

The assessment will be conducted in two phases. During the first phase, two background/working papers will be prepared and made available to the assessment team on their arrival in-country in order to facilitate the second phase of the assessment.

A researcher/program analyst will be hired by USAID for eight weeks prior to the team's arrival in-country to prepare a working paper describing ongoing subproject activities and their achievements to-date. This paper will include a review of progress and evaluation reports and compare planned versus actual progress for individual subprojects. The paper will also include an institutional profile of organizations working in the population sector in Egypt. \*

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\*A separate, detailed Statement of Work will be prepared for this Phase I paper.

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Also during the first phase, a second background paper will be prepared by CAPMAS which will synthesize the major findings and trends in demographic research and surveys and in family planning service statistics. This will include an analysis of demographic and service statistics and related socio-economic and program factors by governorate.

The second phase of the assessment will be conducted over a five-week period in December/January 1985. The entire team will remain in-country for a four-week period. The team leader will stay on for a fifth week to finalize the report. The team will be authorized a six-day work week in-country.

The methodology will primarily involve:

- (i) a review of relevant documents, including statistical and financial information
- (ii) interviews with key GOE and USAID officials
- (iii) field trips.

The team should, at a minimum, review: Project Papers, Amendments, and Grant Agreements for POP/FP I AND II; the most recent GOE and USAID sector strategy and planning documents; the 1982 USAID Population Sector Assessment; Annex E, "Population, Health and Nutrition Sector Strategy" of the FY 1986 CDSS; and the working papers prepared during the first phase of the assessment. The team should also review the NPC Action Plan.

The team will conduct interviews with MPIC, MOB and NPC officials, staff of ongoing USAID subprojects, and officials of other major family planning organizations in Egypt. The team will also make selected field trips to familiarize itself with USAID subprojects and with alternative family planning service delivery approaches in Egypt.

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The first phase of the assessment will be contracted through a USAID direct contract/purchase order. For the second phase of the evaluation, the external consultant(s) will be contracted by an AID/W through an IQC, and the counterpart identified by the NPC will be contracted directly by USAID/Cairo.

F. TEAM COMPOSITION

Phase I

- (i) A researcher with strong analytical and writing skills and preferably with previous experience in the population field, to prepare a background paper prior to the team's arrival to facilitate the work of the team.

Phase II

USAID views this team as an expert advisory panel. The team should include:

- (i) A senior AID/W or USAID Population Officer/Advisor with extensive field experience in management of USAID population assistance programs, and familiarity with alternative service delivery systems, to examine the effectiveness of the current program and to recommend an appropriate future strategy and future activities. This individual will also be team leader, and have responsibility for assignments to individual team members and for preparation of the final report;

- (ii) A senior AID/W or USAID Project Development Officer or former Mission Director, with extensive project design and field implementation experience, to advise USAID on strategies for improving the effectiveness and efficiency of program implementation.
  
- (iii) A management/organizational behavior specialist to examine institutional capabilities and practices of the implementing agencies and the NPC, and to recommend strategies for strengthening institutional capacity.
  
- (iv) An Egyptian family planning specialist, to be nominated by NPC, to examine the acceptability of various programming options in the Egyptian context; to advise the team on political and institutional constraints; and to receive in turn a better understanding of the USAID program and implementation process.

The team will, of course, work closely with the USAID Population Office staff, the Associate Director for Human Resources and Development Cooperation, and the USAID Evaluation Officer.

#### G. FUNDING

External consultants participating in the assessment will be funded from project (263-0144) funds. Participation of AID/Washington personnel will be funded from USAID/Cairo's operating expense account. An estimated budget is provided in Attachment I to this Scope of Work.

#### H. REPORTING REQUIREMENTS

Upon the team's arrival in-country, the USAID Population Office staff and Evaluation Officer will brief the team on specific reporting requirements and the format for the report. Prior to their departure, the entire team will hold debriefings for GOE and USAID staff. The team will present their major findings and recommendations for future USAID assistance in the sector. The team should clearly identify, early in the presentation, which elements of the current program it recommends for continued support, and which elements require reconsideration. A matrix summarizing findings, conclusions and recommendations will be distributed prior to these debriefings.

The team will provide a draft report to USAID and the GOE for comment prior to their departure. The team leader will remain in-country to finalize the draft report and incorporate USAID and GOE clarifications and comments as appropriate.

The final report will be submitted by the team leader prior to his departure. The report should include a three-page, single spaced summary (see outline provided in Attachment II). The summary matrix of findings, conclusions and recommendations, keyed to the questions in the Statement of Work, above, should also be incorporated in the report. The body of the report should provide the evidence and analysis on which conclusions and recommendations are based and respond directly to the Statement of Work. The report should also include a ranked listing of priority areas for future USAID assistance. The body of the report should not exceed 50 double spaced pages.

Appendices should include, at a minimum, the Scope of Work for the Assessment, the Project Logical Framework, a summary of the status/attainment of original and modified inputs and outputs (unless this is included in the body of the report), a

description of the methodology, a bibliography of documents consulted, and a list of persons interviewed.

The team must advise the Mission at least two weeks in advance of arrival at post if they plan to bring in computers or related equipment, as advance approval must be obtained from the GOE for import of these items.

Detailed reporting requirements for the first phase of the evaluation will be specified in a separate Statement of Work.

Drafted: S. Conly/11; Disc 0013A; Doc 2083P; 10/17/85

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Appendix C

Organizations Visited and Persons Interviewed

USAID/Cairo

Mr. Frank Kimball, Director, USAID Mission  
Mr. Arthur Handley, Deputy Director  
Mr. Lenni Kangas, Office Director, Office of Population  
Mr. Timothy Seims, Office of Population  
Ms. Charlotte Cromer, Office of Population  
Ms. Laila Stino, Office of Population  
Mr. Turhan Noury, Office of Population  
Dr. William Oldham, Office Director, Office of Health  
Ms. Constance Collins, Office of Health  
Dr. Bernard Wilder, Associate Director, Human Resources Development  
Cooperation  
Mr. George Laudato, Associate Director, Development Policy Planning and  
Evaluation  
Mr. Terrence McMahon, Associate Director, Financial Management  
Ms. Vivikka Mølldren, Office Director, Office of Planning and Evaluation  
Mr. Donald Pressley, Associate Director, Industry and Support  
Mr. Douglas Tinsler, Office Director, Local Administration and Development

US Embassy

Ms. Frances Cook, Counsel General, Alexandria  
Mr. Joe Dijani, AID Representative, Alexandria  
Mr. Hatem El Dali, Senior Commercial Specialist, Cairo

UNFPA

Mr. G.K.C. Kopal, UNFPA Coordinator  
Mr. Gupta, Logistics Consultant to MOH

Ministry of Health (MOH)

Mr. Helmy El Hadidy, Minister  
Dr. Mohamed Said Tawfik, Undersecretary, Alexandria  
Dr. Helmy M. El Bernawy, General Director for Planning, Cairo and  
Executive Director AID/Family Planning Project  
Dr. Woushira El Shafie, Deputy Director, AID/Family Planning Project  
Dr. Ahmed Sany, Egyptian Pharmaceutical Trading Company  
Dr. Fathia Marsafawi, General Director, Family Planning Directorate  
Dr. Aleya Ayoub, Project Director, Child Survival Project

National Control of Diarrheal Diseases Project

Dr. Reginald F. Gipson, M.D., M.P.H.  
Dr. Norbert Hirschhorn  
Mr. Jerry Sullivan

Ministry of Social Affairs (MOISA)

Mrs. Amal Osman, Minister

Ministry of Labor (MOL)

Mr. Hassan Kato, General Director, Alexandria  
Ms. Suzanne Abu Zeid Ahmed, Family Planning Services in Factories,  
Alexandria

Ministry of Planning and International Cooperation

Mr. Ahmed Abd El Salam Zaki, Managerial Accountant

Ministry of Agriculture (MOA)

Mr. Youssef Walli, Minister, Deputy Prime Minister and Secretary General  
of the National Democratic Party

National Population Council (NPC)

Professor Maher Mahran, Secretary General  
Dr. Abdel Salam Hassan, Technical Services

Family of the Future

Mr. Effat Ramadan, Executive Director, Cairo  
Ms. Elham Fattem, Director of Research, Cairo  
Ms. Sawsan el Sheikh, Social Services, Alexandria  
Dr. Nadia Abdel Fattah, Contraceptive Promotion, Cairo  
Ms. Magy Stino, Public Relations and Conference Coordinator, Cairo

State Information Service

Mr. Galal el-Rashidi, Director, SIS/FP/IEC Division

Egyptian Family Planning Association, Cairo

Dr. Badrawy M. Fahmy, Executive Director

Alexandria Family Planning Association

Mrs. Zahia Marzouk, Chairperson  
Dr. Hafez Youssef, Director of the Model Clinic

Institute for Training and Research in Family Planning, Alexandria

Mrs. Salha Awad, Director

El Tawfekia, Beheira Governorate

Dr. Nabil Shaltoot

High Institute of Nursing, Alexandria

Dr. Omama Handy, Director of Training

High Institute of Public Health, Alexandria

Dr. Fouad El Sherbini

Dr. Sawsan Fahmy

Dr. Imad Ied

Beni Suef Governorate

Dr. Fawzia Fahim Gadalla, Project Director

Dr. Mahmoud Abdel Fattah, Director of Rural Health Services

Dr. Atef Ramzy, Tansa Polyclinic  
Dr. Ahmed El Ziecry, Tasmania Health Center  
Dr. Iman Mehamed Mahmoud, El Sherif Pasha Rural Clinic  
Dr. Salah El Barawy, Director of Polyclinic, Lecturer IUD/MOH Training

Center for Development Communication

Mr. Farag El Kamel, Director

Cairo Health Organization for Medical Care

Dr. Mohamed Dewidar, Chairman

Chemical Industries Development (CID)

Dr. Ahmed Hamed, President  
Dr. Farouk Siam, Director of Production Sector  
Eng. Badia Bishara, General Manager and Maintenance

CAPMAS

General Halouda, Director  
Dr. Laila Nawar, Population and Studies Center  
Mr. Moustafa Gaafar, Head, Central Administration Follow-up Statistics  
Eng. Ebdul Hamid Shalaby, Director General, Technical Affairs  
Mr. Mostafa Kamal Eisa, Chief of the Statistical Administration  
Mr. Ahmed El-Baz, Director of the Population Center  
Dr. M. Nizam El Din, UNFPA/Demographer  
Mr. Abd El Salam Sultan, Head of Statistical Sector

Others

Mr. Aly Moheeb, President, Moneeb Productions  
Dr. Mandouh Gabr, Egyptian Medical Syndicate  
Brig. General Dr. Sabry M. Awady, Egyptian Medical Corps, Maadi Hospital  
Mr. Mohamed El Hayawan, Assistant Chief Editor, El Gomhouria Newspaper  
Dr. Sarah Loza, Social Planning, Analysis and Administration Consultants

USAID Consultants

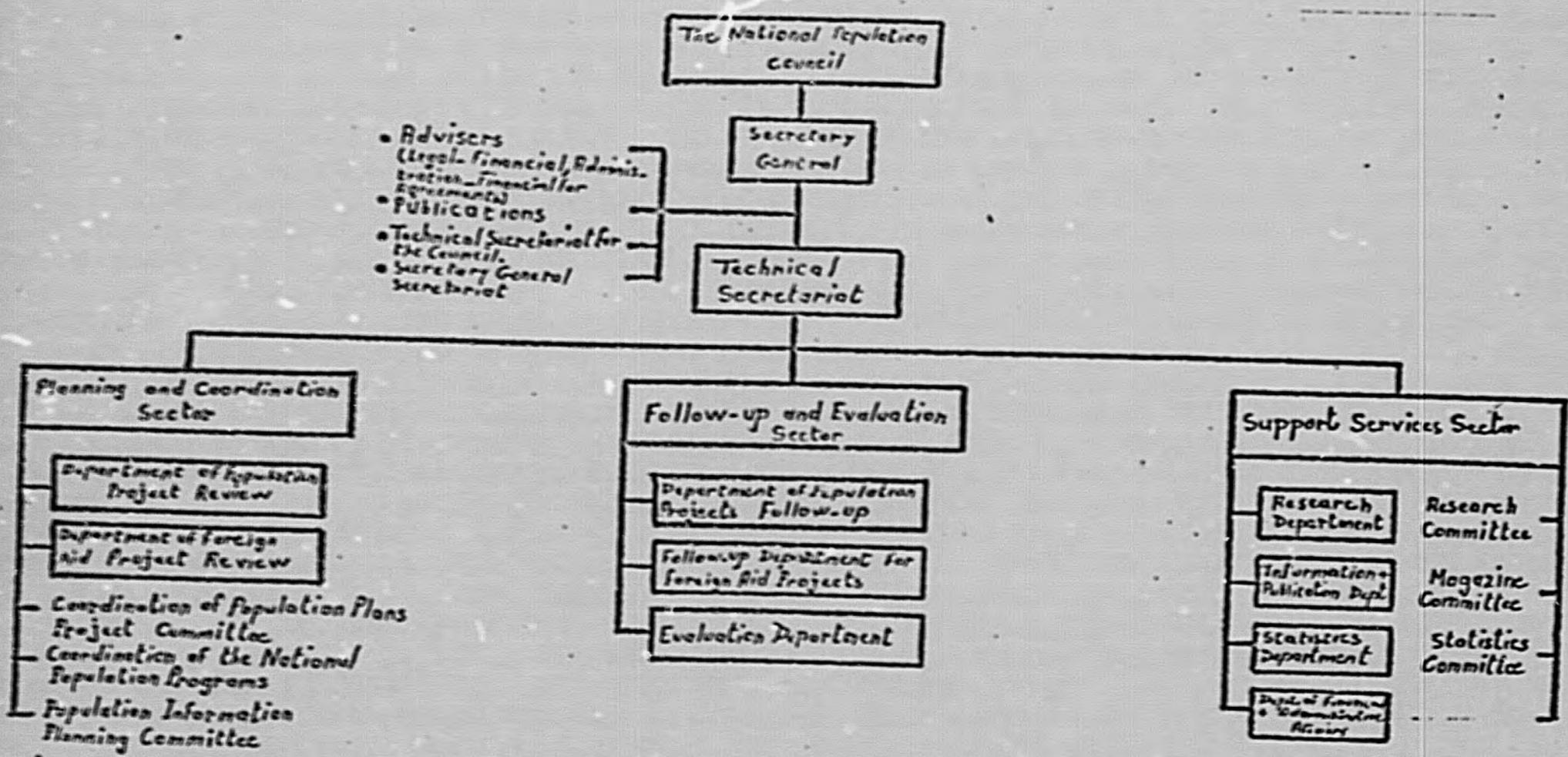
Dr. Patrick Friel, Triton Corporation  
Ms. Michele Lioy, Academy for Educational Development  
Dr. James Kocher, Director, INPLAN Project, Research Triangle Institute  
Dr. Dennis Chao, INPLAN Project, Research Triangle Institute  
Mr. Abdulrazak Thraya, Ronco Corporation  
Ms. Anne Roberts, Ronco Corporation

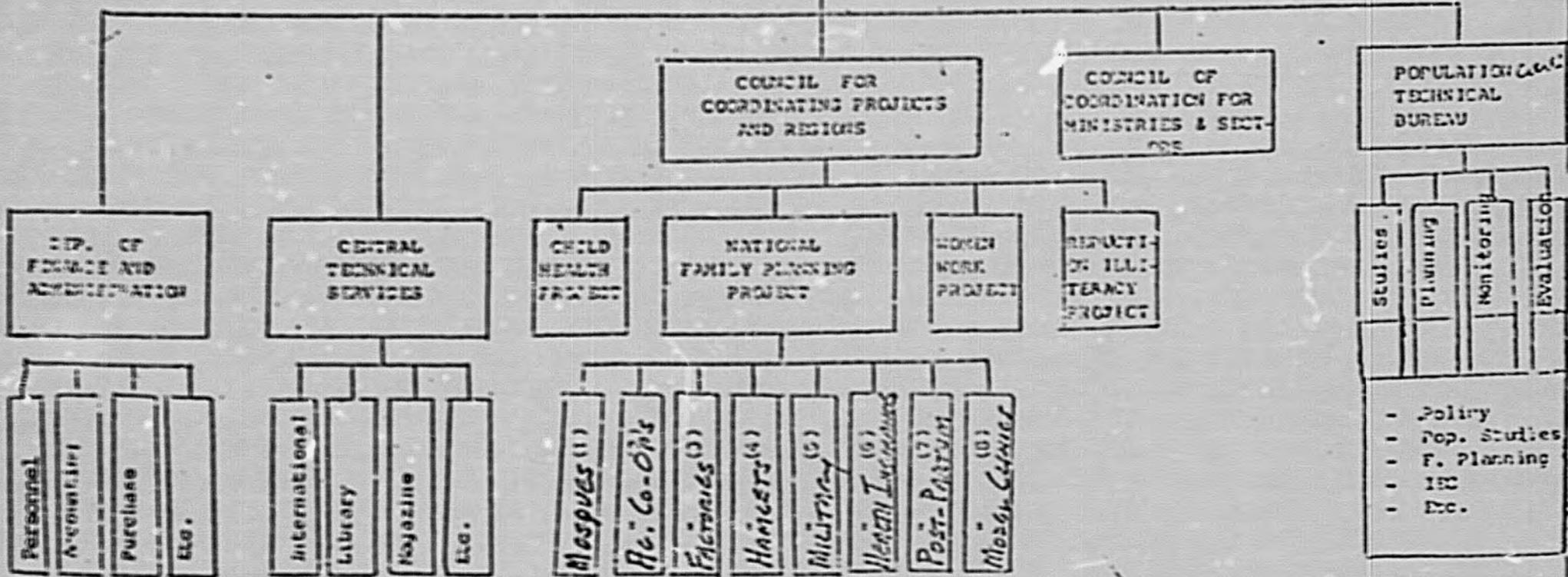
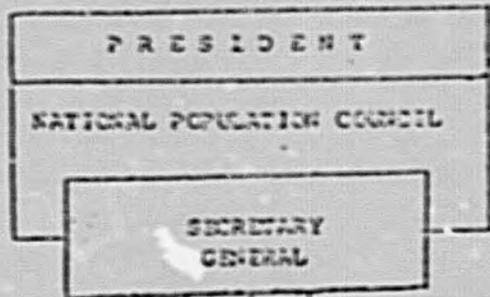
AID/Washington

Ms. Barbara Turner, AIE  
Mr. John Paul James, ST/POP  
Mr. Gary Cook, AIE/TR/HPN  
Ms. Katherine Piepmeir, PPC  
Mr. Tom Reese  
Dr. Malcolm Potts, Family Health International  
Mr. Jack Ganley, Family Health International  
Ms. Carol Bradford, Population Reference Bureau  
Ms. Elaine Murphy, Population Reference Bureau  
Mr. Roberto Cuca, World Bank

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Proposed Organization Chart of the National Population Council (NPC)





DEPT. OF FINANCE AND ADMINISTRATION

- Personnel
- Accounting
- Purchase
- Etc.

CENTRAL TECHNICAL SERVICES

- International
- Library
- Magazine
- Etc.

CHILD HEALTH PROJECT

- Mosques (1)
- Re. Co-ops
- Factories (3)
- Homes (4)
- Military (5)
- Health Institutes (6)
- Post-Partum (7)
- Mosque Campaign (8)

COUNCIL FOR COORDINATING PROJECTS AND REGIONS

NATIONAL FAMILY PLANNING PROJECT

WOMEN WORK PROJECT

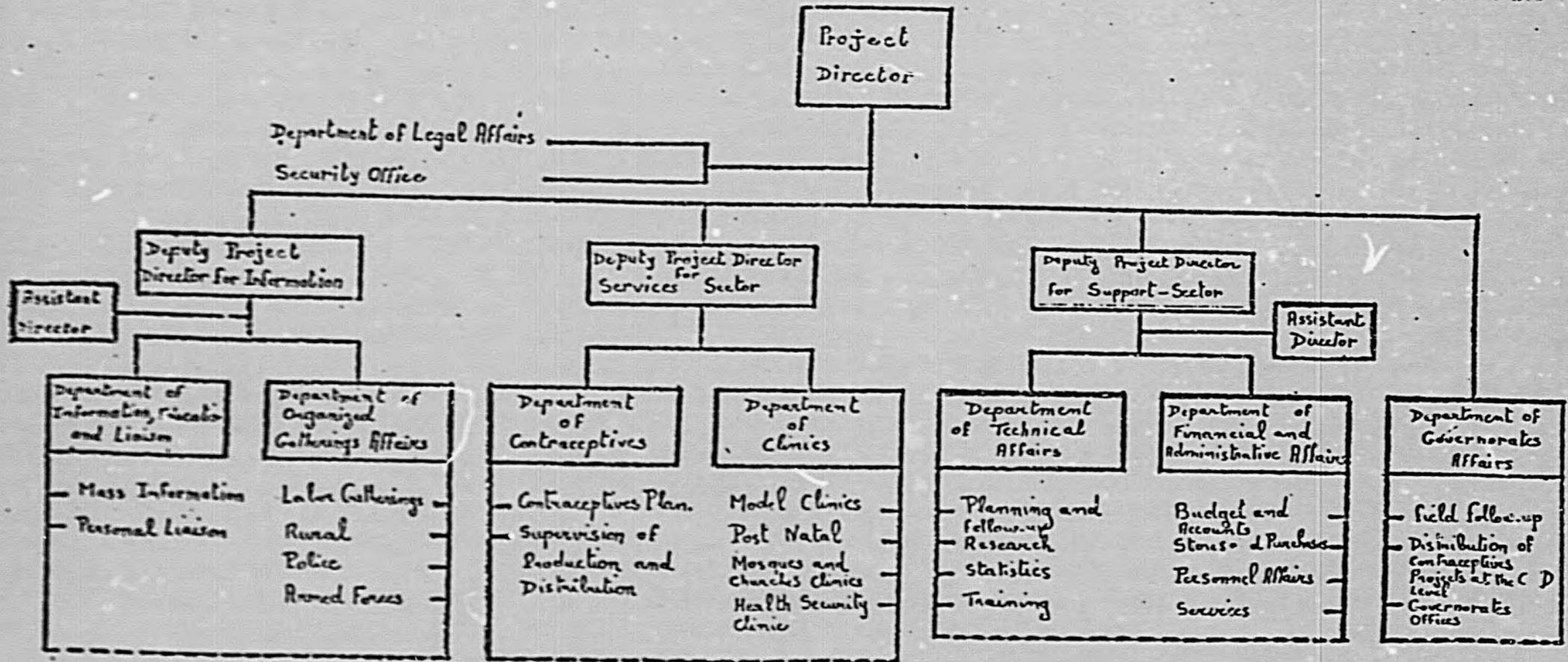
IMPACT OF ILLITERACY PROJECT

COUNCIL OF COORDINATION FOR MINISTRIES & SECTIONS

POPULATION TECHNICAL BUREAU

- Studies
- PLANNING
- Monitoring
- Evaluation
- Policy
- Pop. Studies
- F. Planning
- IIR
- Etc.

Proposed Organization Chart of the National Family Planning Project



POPULATION/FAMILY PLANNING PROJECTS IN EGYPT BY DONOR

DONOR	RECIPIENT ORGANIZATION	PROJECT PURPOSE	BUDGET *	STATUS
USAID 1974-	FPIA	Family planning training and services through the Al-Azhar University, the CEOS, the CABU and Tanta University.	1975-1987 5,135,510	ongoing
	INTRAH/HIN	Training nurses, administrators, supervisors, teaching staff at central and governorate level, in MCH/FP	249,774	T
	RONCO/INTREPA	Training trainers of trainers at the governorate level	LE 27,426	ongoing
	FHI	Norplant	730,000	ongoing
MISSION 1977-	MCH	Physician training in family planning, renovation of clinics, hospitals, administrative support	10,868,151	ongoing
	PPFB	Population and Development project, research, RAPID	6,112,639	T
	NPC	Transition from the PFPB to NPC	520,750	ongoing
	CAPMAS	Upgrading CAPMAS capabilities to collect data, analyze and disseminate demographic information; prepare and implement 1986 Census; research activities	2,238,115	ongoing
	CDC	Demographic analysis and research activities	262,329	ongoing
	SIS	Establish a special IE&C unit to develop family planning messages and materials	7,698,066	ongoing

\* All figures in dollars (\$) unless otherwise indicated.

DONOR	RECIPIENT ORGANIZATION	PROJECT PURPOSE	BUDGET *	STATUS
MISSION 1977-	HIPH	Develop a field training center; train physicians in 10 governorates	402,000	T
	MOE	Workshops for primary and secondary school teachers so that they may introduce family planning concepts into the school curriculum	21,092	T
	Al-Azhar University	Training and family planning services in the governorate of Sharkia	230,146	T
	FOF	Technical assistance, research, contraceptives	10,022,616	ongoing
	CHO	Contraceptive supplies, IEC program, outreach program, data collection, post-partum program	662,989	ongoing
	EPTC	Develop a nationwide contraceptive information and inventory system	550,982	T
	FOF, NPC/ PFPB, EPTC	Contraceptive supplies	11,660,546	ongoing
UNFPA 1971-86	PFPB Government CAPMAS	Contraceptive supplies, provision of new family planning units, upgrading existing units, research, training in management, planning and family planning, mortality and fertility surveys, travel to international conferences, study tours, evaluation, demographic data collection, analysis and publication, population education, support census 1986 activities, technical assistance	23,346,054	ongoing

\* All figures in dollars (\$) unless otherwise indicated.

DONOR	RECIPIENT ORGANIZATION	PROJECT PURPOSE	BUDGET *	STATUS
World Bank 1974-	MOH	1974: First Population Project - construction of 7 multi-purpose integrated health services and training centers in 7 governorates	5,000,000 IDA Credit	T
		1979: Second Population Project - IEC and home visiting activities, training, provision of clinics, equipment, research and evaluation activities, technical assistance	25,000,000 IDA Credit	
WHO 1972	University of Alexandria; Institute of Research for Topical Medicine; Drug Research & Control Center; Assiut University	Research, training, institution-strengthening	2,150,000	ongoing
HHS ** 1981-84		Strengthening health services statistical systems in Egypt	143,571	T

\* All figures in dollars (\$) unless otherwise indicated.

\*\*U.S. Department of Health and Human Services, Public Health Service,  
Office of Assistant Secretary for Health, National Center for Health Statistics.

DONOR	RECIPIENT ORGANIZATION	PROJECT PURPOSE	BUDGET *	STATUS
ODA 1979-	MOH	Second Population Project - IEC and home visiting activities, training, provision of clinics, equipment, evaluation and research	8,000,000	
FDR 1977-85	MOH	Technical assistance, training, commodities, equipment	DM 16,000,000	T
AVS 1982-	EFCS	1982-83: Provision of equipment for trainers, maintenance and repair of equipment, training	532,336	
	Dept./Urology Alexandria University	1984-85: Evaluation Programme in male voluntary surgical contraception	11,717	
	Dr. Atef Khalil Maternity Hospital	1984: Service and education program in female voluntary surgical contraception	7,269	T
	11 University and other hospitals	Reproductive health and management training programs	632,395	
Church World Service, Family Life & Popula- tion Program	CEOSS	Family planning services, operation of clinics	25,000	
	Middle East Council of Churches	Incorporation of family planning into family life education programs	15,000	

\* All figures in dollars (\$) unless otherwise indicated.

DONOR	RECIPIENT ORGANIZATION	PROJECT PURPOSE	BUDGET *	STATUS
Cornell Univ., 1PP 1982-85	PFPB	Evaluation of the inter-relationship between development and family planning	91,000	
FHI	EFCS	Develop, publish and distribute training materials, clinical trials of contraceptives, pilot program of introduction of ultra-sound technology into family planning clinics; data collection, institution building		
FPIA ** 1975-86	Bishopric of Public Ecumenical and Social Services	Family planning IEC and services	414,674	
	CEOSS	Family planning IEC and services	575,834	
	Faculty of Medicine, Tanta Univ.	Theoretical and practical training	403,070	
	Internat'l Islamic Center for Population Studies, Al-Azhar	Family planning IEC and services	723,535	

\* All figures in dollars (\$) unless otherwise indicated.

\*\*As of June 30, 1984, FPIA has provided a cumulative total of \$1,731,332 in family planning commodities to 26 institutions in Egypt.

DONOR	RECIPIENT ORGANIZATION	PROJECT PURPOSE	BUDGET *	STATUS
FPIA ** 1975-86	Faculty of Medicine for Girls, Al-Azhar	Training	135,148	.
IDRC	HIPH	A lactation/amenorrhoea project	CD\$ 212,840	
		1979-84: High risk pregnancy	CD\$ 140,950	
	Azhar Univ.	1976: Post Partum Contraception	CD\$ 87,970	
	Inst. of Stat. Studies & Research	1981: Correlates of Child Mortality & Mortality Fertility Relationships	CD\$ 28,000	
	Supreme Council of Family Planning	1971-73: Epidemiological Study of Induced Abortion	CD\$ 18,316	
Copper T Trial		CD\$ 22,157		
IPPF 1963-	EFPA	Family planning IEC, services, training	1983 226,500	ongoing ✓
Johns Hopkins Dept. of Popula- tion Dynamics 1982-85	NOH	Technical assistance in evaluation of the Beni Suef project	343,325	

\* All figures in dollars (\$) unless otherwise indicated.

\*\*As of June 30, 1984, FPIA has provided a cumulative total of \$1,731,332 in family planning commodities to 26 institutions in Egypt.

DONOR	RECIPIENT ORGANIZATION	PROJECT PURPOSE	BUDGET *	STATUS
Path-Finder Fund 1980-	Alexandria Family Planning Association	1981: Model family planning clinic in Alexandria	150,000	
	Society of Vocational & Productive Families (VIPF)	1980-83: Family planning activities integrated into vocational training	35,329	
	Government	1983-84: Family planning and MCH clinic in a factory area	49,658	
	Government	1981-85: Training in family planning education for leaders and government representatives	125,000	
	HIPH	1983-84: Seminar on family planning population curriculum for primary and secondary schools in Alexandria	6,095	
The Population Council 1982-	Ain Shams University	1982-84: Study of comparative use-effectiveness and safety of Levonorgestrel and TCu 380 Ag IUDs	53,476	
	Government	Institutionalization of policy research		proposal
	Environmental Quality Internat'l	1983-85: Study on child health and mortality in Cairo	approx. 65,354	

\* All figures in dollars (\$) unless otherwise indicated.

DONOR	RECIPIENT ORGANIZATION	PROJECT PURPOSE	BUDGET *	STATUS
Program Introduction and Adaptation of Contraceptive Technology 1982-84	EFCS	Studies on introduction of contraceptives	19,950	
Rockefeller Foundation 1982-85	Assiut University	1984-85: Update International Federation of Gynaecology and Obstetrics manual	25,000	
	The Population Council	1982-83: Study of determinants of socio-economic fertility differentials in Egypt	1,140	
Margaret Sanger, Planned Parenthood of N.Y.C. 1984-	FOF CFPA	Family planning delivery services, evaluation, training		ongoing
Univ. of Northern Carolina, Carolina Population Ctr. 1980-	Government	1980-83: Study of relationship between education, age at marriage and contraceptive behavior and employment		
		1984-85: Analysis of 1982 Egypt Follow-up Survey on Family Life and Family Planning	100,324	

\* All figures in dollars (\$) unless otherwise indicated.

FAMILY PLANNING RESEARCH CENTER  
MISR SPINNING & WEAVING COMPANY  
MEHALLA-KUBRA, A.R.E.  
\*\*\*\*\*

THE NEED FOR A FACTORY CENTERED  
FAMILY PLANNING PROGRAM FOR ALL EGYPT  
\*\*\*\*\*

A MODEL FOR THE SUCCESS OF F.P. PROGRAM  
IN A WORKER'S COMMUNITY TO ACHIEVE A  
DRAMATIC DECREASE IN BIRTH RATE AND  
POPULATION INCREASE  
\*\*\*\*\*

By:  
Dr. SAYED ETWAN  
Chief Gynecologist &  
Head of Family Planning Research Center  
MISR Company's Hospital  
Mehalla-Kubra Egypt.

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FAMILY PLANNING COUNCIL  
MISR SPINNING & WEAVING CO.  
MEHALLA KUERA                      A.R.E.

It is a great honour for me to have the opportunity of showing a picture of Family Planning as I experienced in a community of workers for 17 years.

The invitation for Family Planning among workers of Misr Spinning & Weaving Company at Mehalla-Kubra began by the end of September 1962. Two centers were prepared to fulfill this purpose. The first in the Company's Hospital which serves all the workers totalling 35,000 and their families forming a community of about 175,000 persons. This center operates three days a week. The second center was devoted to serve a small village specially built to accommodate 690 workers and their families forming a community of about 5,000 persons and to whom Family Planning services, antenatal and postnatal care were given for three hours once per week.

I started working in these two centers, truly convinced that the radical solution to many of our national problems, while struggling to build-up our country, lies in two important things:

- FAMILY PLANNING, and
- INCREASED PRODUCTION.

Without them, both together, it is impossible to achieve real progress in the life of the entire population. Therefore, I persuaded all multiparous women to visit both clinics and use contraceptive pills for birth control.

A few months later, some of the employees interested in social work formed a council for family planning and invited all workers to rally to the scheme. Within a short period they realised that the task being primarily a medico-social competence, it could best be carried out by a gynecologist dedicated to the project and so I was asked to preside over the council and shoulder the responsibilities of all the two-fold activities: Medical and Social. So I started with the Council inviting all workers and their wives to visit the centers, believe in family planning and use oral gestogens without fear. Thousands of circulars were periodically issued to answer every question.

Conferences were held nearly every two months with the workers in their sections, with the workers and their wives in open meetings and all the aspects of the subject were covered through lectures made by Doctors, Preachers, Sociologists and Politicians.

Family Planning initiations were added to the courses given to workers by the Labourers Cultural Organisation.

Assisted by the headmasters of Girls' Schools, conferences were held for mothers, girls and teachers and direct talks with them were very useful. All Girls' Schools were visited by the Council and Family Planning Films projected.

Visits made to villages near Mehalla-Kubra, where large groups of workers live, aroused many discussions around the subject and resulted in convincing a vast majority in the usefulness of family planning.

In this manner, we continued throughout 5 years, campaigning for family planning by all possible methods and administering medical service to the best of our ability with constant assurance about the safety of the methods. At the same time, a complete medical follow-up was afforded to women who regularly visited the centers. Drop-outs were also followed-up. Home visits were effected by nurses.

It was necessary, after this sufficient period to assess the harvest we reaped from the whole work. As proof for failure or success of this pilot endeavour, the following evaluation was made :-

- 1) Percentage of fertile women using contraceptive methods after these five years.
- 2) Impact on birth rate.
- 3) Population increase that occurred from the beginning of the scheme till this year.

I have chosen the workers' village to investigate these results as a sample to what happened to all other families for many reasons:

- 1) Labourers and their wives in this village are 99% illiterate and of rural origin.
- 2) Their strong religious beliefs and reluctance to accept birth-control were serious handicaps at the start.
- 3) Their income is relatively higher than that of people of the same class e.g. labourers in other factories in Mehalla-Kubra or farmers in the neighbouring villages and this may make them in less urgent need of contraceptive from the economic viewpoint.
- 4) All workers can easily find a job for their boys and girls at the age of 12 in the carpet factory, especially built for them, thus becoming economically useful.

After 5 years of continuous work including good service, education and information, follow-up of drop-outs by nurses visiting labourers' houses, 51.5% of fertile women planned their families, by one of the available methods, there was a marked drop in birth rate and population increase as shown in the following table.

T A B L E I.  
 =====

Year	Population	Births	B.R.‰	Deaths	D.R.‰	% increased population
1962-63	4751	128	27	28	5.9	2.1
63-64	4825	108		19		
64-65	4966	83		13		
65-66	4977	82	16.44	21	4.2	1.2
66-67	5005	48	6.6	14	2.8	0.68

This means that in 5 years B.R. dropped to 6.6‰ and population increase diminished to 0.68%.

After 10 years, that is (1972) 81.5% of fertile women plan their families resulting in the following:

T A B L E II  
 =====

Year	Population	Births	B.R.‰	Deaths	D.R.‰	% population increase
1972	5113	11	2.1	17	3.3	--

-4-

T A B L E    I I I  
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CHANGES IN AGE SPECIFIC FERTILITY RATE  
 IN 1st. WORKERS VILLAGE  
 -----

<u>Year</u>	<u>Age groups &amp; Fertility rates</u>						
	<u>Up to 19</u>	<u>20-24</u>	<u>25-29</u>	<u>30-34</u>	<u>35-39</u>	<u>40-44</u>	<u>45-49</u>
<u>1962</u>							
No. of women	11	30	93	145	150	120	40
Births	2	10	30	50	32	15	4
%	--	333.3	322	344.8	213.3	125	100
<hr/>							
<u>1967</u>							
No. of women	--	10	27	53	152	142	207
Births	--	2	7	9	12	5	--
%	--	200	259.2	169.9	78.8	35	--
<hr/>							
<u>1972</u>							
No. of women	--	8	26	44	95	197	246
Births	--	6	7	6	5	2	1
%	--	750	269.2	136.3	53.5	10	4

This shows that there is a great drop in the age specific fertility rate, especially in age groups above 30. The drop is very sharp in the 1st. 5 years and gradual in the next 5 years.

T A B L E IV  
\*\*\*\*\*

COMPARISON OF AGE SPECIFIC FERTILITY RATES  
FOR 1st. WORKERS VILLAGE AND ALL BIRTH.  
\*\*\*\*\*

Year	Age groups & Fertility rates						
	Up to 19	20-24	25-29	30-34	35-39	40-44	45-49
1967							
1st. workers village:	--	200	259	269	70.8	35	--
All Births	39.09	232.51	262.19	271.42	205.19	112.69	56.43
1972 :							
1st. workers village :	--	750	289	136	53.5	10	43
All Births	32.64	210.16	236.72	234.13	169.24	95.17	41.72

It is clear that there is a marked drop in age specific fertility rate among workers compared to the whole population, in age groups above 30, less marked below 30, and even higher among younger women below 30 in the year 1972. This shows that, in spite of the high fertility and strong desire to have children in the early period of life, by providing information, good advice, knowledge to men and women and follow-up, it was possible to lower the fertility rate which was high when compared among the whole population, especially if we notice that the age specific fertility rate for workers women (group 30-34) was 300.8 in 1967.

It may still be argued that this is a model of a well controlled community, easy to reach for information, education and follow-up of drop outs. It may be difficult to attain similar success in big labour masses and labour communities living in a fairly big number of villages around their factories, amidst their relatives and neighbours living on agriculture, who have different beliefs in that field based on social, economical and religious factors. To some extent, this is true, but not a sufficient reason to accept failure in this vital field.

The labourers' community of Misr Spinning & Weaving Company in Mehalla Kubra consists of more than 175,000 persons, living in about 100 villages spread around Mehalla Kubra in Gharbia and Dakahlia governorates and in spite of this fact, the following success was achieved.

T A B L E      V  
\*\*\*\*\*

COMPARISON OF ACCEPTABILITY AMONG  
WHOLE WORKERS & 1st. WORKERS VILLAGE

YEAR	ALL WORKERS' COMMUNITY		1st. WORKERS VILLAGE	
	NO. OF SURVEYED FAMILIES	% OF ACCEPTANCE AMONG FERTILE WOMEN.	NO. OF SURVEYED FAMILIES	% OF ACCEPTANCE AMONG FERTILE WOMEN
1968	2304	31.6	649	58.3
1973	1526	46.5	696	86.5
1978	1860	69.2	707	87

It is clear, the acceptability is markedly less among all workers' community than in the 1st. workers' village. However it is a remarkable and effective success reaching 31% after the first 6 years then 46% after 5 more years then soaring to 69.2% in 1978, that invites all responsible bodies and workers to initiate a factory centered family planning program all over Egypt. The high acceptance reaching 69% in 1978 is nearly 5 times the acceptance of 14% now attained for the entire population of Egypt. I think this is a strong stimulus for us to start such program.

There are 116 factories with their communities spread all over Egypt from Alexandria to Aswan. The methodology applied among labourers of Mehalla factory could be taken as a model. Each factory should have one or more Family Planning Centers easy to reach by workers' families.

A follow-up system for drop-outs by nurses and social workers, also trained committees of labour leaders guided by a responsible doctor for continuous education and information through all possible means. These family planning committees work in different sections of the factory and in villages where large groups of workers' families live.

REASONS FOR REFUSING FAMILY PLANNING:

It is useful to those who work in that field to have an actual, non-theoretical idea about the reasons why some people refuse family planning.

It was always thought that religious factors and economical value of children were the most important obstacles.

Our studies among workers and farmers revealed this is untrue.

On the industrial side the picture in 1969 & 1979 was as follows:

T A B L E VI

\*\*\*\*\*

COMPARISON OF REASONS FOR NOT PLANNING AMONG WORKERS' FAMILIES IN 1969 & 1979.

<u>REASON</u>	<u>1 9 6 9</u>	<u>1 9 7 9</u>
Desire to conceive	40.97 (3 children average)	37.92 52% no children 3% more than 3.
Pregnant (3)	17.47	57.41
Lactation	16.92	--
Fear of contraception	7.58	0.61
Ignoring methods	7.00	2.45
Customs & traditions (desiring a boy or big family)	4.72	--
Religious cause	3.89	0.61
Economic reason	1.45	--

The following facts emerge :

- 1) Only 5.4% refused for religious and economic reasons in 1969. This figure dropped to 0.6% in 1979.
- 2) 14.58% feared methods or completely ignored, in 1969. The percentage dropped to 3.6% in 1979.
- 3) 16.9% refused because they lactate and were afraid of harming the children by contraception in 1969. Such reasons did not prevail in 1979.

It is evident that economy or religion are not the main obstacles. Ignorance and fear of methods are the main reasons and have been successfully overcome in 10 (ten) years time.

Consequently, to those who have some hope to succeed in this field and others who have no hope and argue that our women and men are of different social pattern, I present this case to assure them that nearly all our women living in the first workers' village are of rural origin and behaviour with strong attachment to religion, and the conviction that children are the source of strength and wealth and reflect beauty and harmony of human life. In spite of all that, 87% of them are now using contraception. An illustrative case is a woman living in the first workers' village. She married at the age of 12, one year before menarche. She and her husband are from a village in Bahahria governorate, with rural beliefs and behaviour. She had 6 children in 9 years, till 1962, the year we started our program among workers. In spite of being burdened with 6 children, it took us 4 years to convince her and her husband of the benefits of family planning on account of her health. She got 2 more children in these 4 years. Thereafter, in 1966 she used loop and pills for a period of 1 year. 3 years and got a child by mistake, then used pills for 6 years and got a child by mistake, then used pills for 5 years and got a child by mistake. In these 14 years she got 3 more children by mistake. She stopped the method for some side effects. To put an end to this drama, Genila attended the hospital one month after her last delivery this year and requested sterilisation. She was sterilized and discharged the same day. She is now happy and can sleep without fear of another baby by mistake. She is 39 years, illiterate. Her husband can just write his name.

- 12% on the rural side.
- 29.5% on the rural side.

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In conclusion this is an invitation to those who are concerned to start a factory centered family planning programme all over Egypt, applying the 3 main items tested in Mehalla. There is a great chance for success. It only needs a highly authorised leadership, deeply feeling responsible and having strong belief that success can be attained.

Dr.SAYED ETMAN