

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

WASHINGTON, D.C. 20523

PROJECT PAPER  
AMENDMENT #1

ARAB REPUBLIC OF EGYPT: Population Project  
(263-0144)

June 20, 1987

UNCLASSIFIED



UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

CAIRO, EGYPT

July 15, 1987

T. Liercke  
F ANE/Egypt  
Room No. 6723 NS

Attached are copies of Population/Family Planning II Project Amendment and the companion Supplement and the Decision Memorandum for your information. The March 25 Issues Agenda and the March 30 Decision Memo are attached to my memo dated April 14, 1987.

Please pass them to other people who may be interested. Thank you very much.

*D Du Lavey*  
D. Du Lavey  
PPP/R

ANE/PO  
FY I



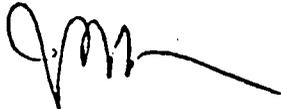
UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

CAIRO, EGYPT

June 16, 1987

MEMORANDUM

TO: DISTRIBUTION

FROM: Vivikka Molldrem, PPP/P 

SUBJECT: Decision Memorandum: Executive Committee Review  
Population/Family Planning II Project Amendment

A. At subject meeting held on June 8, 1987, the Executive Committee approved the Project Paper Amendment as originally proposed.

1. This approval was with the understanding that six months after start-up of activities, the Mission will carefully review the seven first phase governorate implementation plans to ensure the maximum application of performance based project management measures. This review will be in two stages: In the first stage, a collaborative USAID/MOH administrative assessment will be carried out to determine the extent to which governorates are following the guidelines and making good progress toward putting together comprehensive plans with detailed targets. In the second stage, a USAID committee, including HRDC, FM, LAD, IS, and PPP will advise the Mission Director whether methods of implementation and disbursement of funds uses performance based concepts to the optimum extent practical and advisable. If there are good alternatives, the Mission will negotiate with the MOH.

2. Notification of the requirement for this collaborative administrative assessment will be included in Annex II to the Grant Agreement Amendment to the MOH.

B. The following guidance was offered for incorporation into the PPA:

1. Salary Incentive Guidelines: The new salary incentive guidelines just in from AID/W should be reviewed to ensure compatibility with the financial plan outlined on page 34.

2. Incentive Payments: (a) To ensure that incentive payments will go to people who deserve them, spot checking will be carried out through local-hire auditors. The \$50,000 under the project element "Population Intermediaries and Technical Transfer" will cover the cost of non-federal audits. (b) HRDC/P should confer with K. O'Donnell regarding the wording of paragraph two on page 43 regarding performance based incentives.

3. Line Item Flexibility: The PPA recommendation that AID have authority to reallocate budget line items up to 25% of the budgeted amount is a good idea.

Clearance: JConly, (A)AD/PPP (draft)  
BWilder, AD/HRDC (draft)

D = Delete 3

2. COUNTRY/ENTITY: ARAB REPUBLIC OF EGYPT

3. PROJECT NUMBER: 263-0144

4. BUREAU/OFFICE: ASIA/NEAR EAST 03

5. PROJECT TITLE (maximum 40 characters): POPULATION PROJECT

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM DD YY: 01 5 31 93

7. ESTIMATED DATE OF OBLIGATION (Under "B" below, en. - 1, 2, 3, or 4):  
 A. Initial FY: 83 B. Quarter:  C. Final FY: 90

8. COSTS (\$000 OR EQUIVALENT \$1 = )

A. FUNDING SOURCE	FIRST FY 83			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	( 11,000 )	( 9,000 )	( 20,000 )	( 46,230 )	( 56,370 )	( 102,600 )
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S.	1.					
	2.					
Host Country	-0-	18,000	18,000	-0-	63,500	63,500
Other Donor(s)						
<b>TOTALS</b>	<b>11,000</b>	<b>27,000</b>	<b>38,000</b>	<b>46,230</b>	<b>119,870</b>	<b>166,100</b>

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) SA	430	400		44,000				102,600	
(2)									
(3)									
(4)									
<b>TOTALS</b>				<b>44,000</b>				<b>102,600</b>	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 440, 444, 420

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each):  
 A. Code: BRW, BUW, DEI, PART, PVON  
 B. Amount

13. PROJECT PURPOSE (maximum 480 characters):  
 To provide support to the GOE in order to strengthen and expand Egypt's population/family planning activities so as to increase family planning practice among married couples of reproductive age.

14. SCHEDULE EVALUATIONS: Interim MM YY: 01 19 93 Final MM YY: 01 19 92

15. SOURCE/ORIGIN OF GOODS AND SERVICES:  000  941  Local  Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a \_\_\_\_\_ page PP Amendment.)  
 Purpose of PP amendment is to shift the strategic approach of the USAID/Cairo family planning program in Egypt and to extend the PACD for five years to 1993.  
 Methods of implementation and financing are included in this amendment. William Miller AD/FM

17. APPROVED BY: Signature: [Signature] Title: Director, USAID/Cairo Date Signed: 12 20 1993

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

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POPULATION PROJECT  
PROJECT PAPER NO. 263-0144  
PROJECT PAPER AMENDMENT NO. 1  
FEB. 18, 1987

I. SUMMARY AND RECOMMENDATIONS

A. Grantee:

The Government of the Arab Republic of Egypt (GOE). Separate grant application requests from the Minister of Health and the Minister of Social Affairs are attached to sub-project grant proposals Annex A and C respectively.

B. Grant Amount:

No additional funds above the authorized amount of \$102M are requested in this PP Amendment.

C. Project Assistance Completion Date:

An extension of the PACD from 5/31/88 to 5/31/93 is recommended.

D. Project Paper Amendment Purpose:

To revise the content and scope of the Population Project given significant changes in the Project's operating environment and strategic direction since its inception in 1983. To extend the PACD to accommodate important new multi-year project initiatives which show promise of having significant impact on fertility reduction in Egypt.

E. Project Paper Amendment Description:

Inclusion of two major sub-projects for clinical FP service delivery through the MOH and MOSA (EFPA) designed to attract up to 3.7 million new acceptors of contraceptive methods over a five year period. Total cost of these projects is approximately \$35 M (including contraceptives). The revised project description and financial plan reflect a significant increase in funding for private and public sector FP service delivery programs and a corresponding reduction in "supportive" activities such as IE&C, population statistics and population intermediaries. Certain non-productive planned activities are dropped altogether (e.g. population education in the school system) while others, such as the successful Family of the Future sub-project, will continue to receive strong support through the planned extension period.

F. Analyses and Feasibility Statements:

Economic, technical, administrative, and social soundness analyses have been reviewed and updated as appropriate from the original PP. On the whole, there has been little significant change in the overall project environment since 1983 which effects any of these analyses.

G. Environmental Considerations

No change from original environmental impact statement in the PP. Reduction in population growth is by far the most beneficial long term environmental intervention conceivable in any national development program.

H. Statutory Requirements:

All statutory criteria have been satisfied. See Annex E.

I. Project Committee Recommendation:

The Project Review Committee has reviewed all aspects of the proposed Amendment 1 to the Population Project and finds that it is financially, economically, technically, and socially sound, and consistent with both the development objectives of the GOE and those of USAID/Cairo as set forth in USAID/Cairo's FY 1989 CDSS. The Project Review Committee has further determined that the MOH and EFPA are institutionally capable of administering the F.P. Systems Development and Clinical Services Improvement sub-projects respectively. The Committee recommends approval of Amendment No. 1 to the Population project.

J. Project Committee:

Chairman: Terrence Tiffany

Committee Members: Karen Turner, LEG

Youssef Abdel Khalik, FM

Elaine Kelly, IS/CMT

William Duncan, DR/PS

Sidney Anderson, PPP/P

Shanti Conly, PPP/PL

Connie Collins, HRDC/H

## II. INTRODUCTION

The purpose of this PP amendment is to revise the Population Project Paper in the light of several important changes in the Project's operating environment and strategic direction since its inception in June 1983. In addition to these changes, the project has encountered significant implementation delays which will result in an estimated expenditure of only about a third of the authorized \$102 M for project activities by the current PACD of May 31, 1988. Although most of the serious implementation problems have now been overcome, major new project initiatives recently undertaken will have barely begun by 1988. Therefore, this amendment also assumes an extension of the PACD for five years to May 31, 1993 and describes the plan for project activities over that time period.

The following consists of seven major sections and several annexes. The background section describes progress to date in the USAID population sector, continuing constraints to fertility reduction in Egypt, the shift in strategic approach proposed and the rationale for that shift. This is followed by a detailed revised description of all major elements in the PP, a section addressing economic, technical, administrative, and social soundness analyses, a financial plan, and an implementation plan. Annexes are included which consist of proposals for carrying out the two major FP clinical service delivery components of the project: the Family Planning Systems Development Project of the Ministry of the Health (MOH) and the Clinical Services Improvement Project of the Egyptian Family Planning Association (EFPA). Both are voluminous documents recently developed collaboratively among MOH, EFPA and USAID staff and outside consultants. In depth of technical analysis and description, each represents a mini-PP in itself. Another annex consists of an outline of a proposed sub-project with the National Population Council (NPC) consolidating current and suggested new project activities falling under

the NPC umbrella. Discussion of major issues which have arisen in the course of the development of the PP amendment such as phasing new project activities, recurrent costs, etc. have been included throughout the paper as appropriate. In addition, since many of these issues concern the proposed new MOH sub-project, a separate "issues" section is included in that proposal (Annex A).

Although this PP amendment is a major effort, no attempt is made to rewrite or revise the entire PP. This is because the PP remains, on the whole, a good analysis of Egypt's population situation and guide for future programs and activities. For example, in only one of the seven major components described in the original PP has there been a major change in direction (the "Community Population Programs" component) and even in this component the implementing agency (NPC) remains the same. The problem to date has not been so much that the PP was inappropriately designed or directed, but rather that, for a variety of reasons, the activities it proposed were by and large not implemented as planned. These implementation delays and steps planned and recently undertaken to overcome them are discussed below.

### III. BACKGROUND

#### A. Overall Progress to Date

USAID bilateral support for Egyptian population activities began in 1977 with an initial three year obligation of \$17 M under project No. 263-0029. Subsequent amendments increased this total to \$67 M and extended the PACD to 9/87. The basic objectives of the project were to (a) establish an institutional framework (e.g. trained personnel, contraceptive pipeline, upgraded service facilities) for FP service delivery and to (b) finance

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"targets of opportunity" for service delivery resulting in a focus on an integrated services (medical and social) model of projects carried out in selected governorates.

The current Population Project is a continuation and expansion of project 0029. A major Population Sector Assessment was carried out in 1982 to determine "lessons learned" and to lay out a blueprint for activities to be carried out over the next five years under a new project. Project No. 263-0144 was the result. This project consists of seven separate but interlinked components: (1) Contraceptive Supplies, (2) Private/Commercial Sector Initiatives, (3) Community Population Programs, (4) MOH-Rural Family Planning Campaign, (5) Information, Education and Communication (IE&C), (6) Population Statistics and Population Policy, (7) Population Intermediaries and Technology Transfer. The expectation was and is that these activities will assist the GOE in overcoming constraints to greater contraceptive use while at the same time mitigating the factors associated with the demand for large families.

However, since its inception in mid-1983, the project has encountered significant implementation delays primarily due to : (a) inability of the MOH to meet C.P.s to the disbursement of funds for a large (\$21 M) rural family planning (FP) component, (b) creation of the National Population Council (NPC) and prolonged indecision over its role as implementing vs. coordinating agency, (c) a conscious decision by USAID to hold up project activities pending completion of a time-consuming project audit, (d) excessive bureaucratic delays in initiating and carrying out routine project implementation actions. In addition, Population Project No. 263-0029 was and still is (until 9/87) available to fund some activities originally envisioned under Project No. 263-0144 (e.g. State Information State information/education programs, contraceptives, FOF activities, MOH staff training etc.) As a

result, it is estimated that only about \$34 M out of the authorized level of \$102 M for the project will be expended by the current PACD of 5/31/88.

Overall progress to date in USAID's bilateral population efforts is hardly encouraging. Millions of dollars have been spent to establish a national population planning and coordinating body; to train thousands of family planning personnel throughout the country and to support interventions designed to increase awareness, knowledge and use of contraception. Yet with a few notable exceptions such as the private sector Family of the Future program these interventions have had little impact. Taken as a whole, they have not resulted in a decline in Egypt's population growth rate. Since 1980, the annual population growth rate has remained relatively stable at between 2.7 and 2.8 percent.

Despite the foregoing there is good reason to believe the project is now on track to fulfilling its overall purpose of increasing contraceptive practice among married Egyptian couples of reproductive age. Efforts to date have been successful in establishing (1) a high level of public and official awareness of the population problem and knowledge of family planning, (2) a large cadre of health and related agency personnel with training in FP service delivery and (3) an institutional framework (e.g. contraceptive commodity distribution system) which is essential to effective FP service delivery programs.

Moreover, the AID audit is behind us and HRDC is operating as efficiently as current staffing levels permit. On the Egyptian side, NPC's role has been resolved and a capable and energetic new Minister of Health is instituting needed changes (e.g. Full-time project management staff in Cairo under a full-time undersecretary for Family Planning, full time governorate and district level MOH FP program supervisors, full time FP physicians -

initially 100 - in clinics and health centers, etc.). This will allow this important project component to move quickly forward. Another large new (\$6 M) multi-year FP services project component has been developed with the Egyptian Family Planning Association (EFPA) and other long-term FP services activities are in the design stage (Cairo Health Organization, Health Insurance Organization, expansion of Family of the Future activities etc.) Given the increasingly pervasive Egyptian resolve to move vigorously forward in the population sector, there is a sound basis for optimism that the second five years of the project will be characterized by productivity and achievement in at least the same measure that the opposite was true of the first five years.

To be sure, obstacles remain and will continue to hinder the program. Some, like proscriptions against the use of voluntary sterilization, we can do very little, if anything, about. However, other important barriers to project performance are now either removed or not considered as much of a problem as they may have been in the past. Specifically, USAID itself was a major problem. Largely because of the aforementioned audit, for almost two years USAID placed a virtual hold on population project initiatives. That is no longer the case. Moreover, as discussed above, family planning staffing problems at the MOH are in the process of being resolved. Of course we will continue to face delays and various other implementation problems at the MOH as we go along, but that is usual in most Egyptian industries. The NPC is still in need of institutional strengthening. But since it does not hinder actual implementation of FP service delivery activities NPC is not a constraint. In the meantime, we are investing a relatively modest amount of funds to help NPC realize its legal mandate to plan and coordinate FP projects in Egypt. The State Information Service also has been heavily criticized in the past for organizational inefficiency and ineffective performance. However, in recent months organizational efficiency has improved (e.g. the

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"sleeping partners" on the project staff were mandatorily retired) and the quality of mass media programming improved. In any case, The SIS direct contribution to fertility reduction is probably not all that significant, which is why USAID support will be phased down significantly in the future. In sum, programmatic obstacles do and will continue to confront the population program, but none are now of such a nature that they present unscalable barriers to project achievement. Unfortunately, broader more fundamental constraints will continue to hinder the pace of fertility decline in Egypt. This issue of "continuing constraints" is discussed further in the following section.

#### B. Continuing Constraints to Fertility Decline in Egypt

Several important factors combine to constrain fertility reduction in Egypt, foremost among which is limited and ineffective use of contraception. According to the most reliable data source (Fertility and Family Planning in Egypt 1984 CPS) only about 30% of Egyptian couples were currently practicing contraception in 1984. Sharp urban/rural differences in contraceptive practice of 45% and 19% respectively were also revealed. Although the overall use rate may have increased to 35% or so by 1987, this rate is still far too low to have a significant impact on lowering fertility.

Complicating low contraceptive usage rates is the fact that use is very often sporadic and ineffective. The Egyptian population program is limited to oral contraceptives and intra-uterine devices (IUDs), both of which have numerous side effects which often lead to discontinuation after short periods of use. Other long-acting or permanent methods such as injectable contraceptives and voluntary sterilization, which account for much of the fertility decline in other countries, are largely absent in Egypt.

Further complicating this issue is the fact that family planning is not the only factor which determines fertility. Other very important factors inhibiting fertility decline in Egypt include: (a) A widespread, systematic pattern of early marriages. (About 60% of Egyptian women marry at or before age 18 and fully a third at or before age 16); (b) A general preference for early births and no or infrequent use of contraception until after the second or third birth. When these factors are combined with the low and ineffective use of contraception and a rapidly declining infant mortality rate, the inevitable result is high population growth. Although the impact of cultural and religious factors is debatable (only 1% of respondents in the 1984 CPS cited religion as a barrier to contraceptive use) it is generally agreed that these factors impose a depressing effect on the climate of contraceptive use and in some particulars (e.g. proscription against voluntary sterilization) have a direct and negative impact.

Given this background, it would take a highly organized national family planning program with vigorous and gifted leadership to make a real impact on fertility decline. Unfortunately, such has not been the case. With few exceptions, Egypt's national family planning program has suffered from poor structural supports, a poorly developed and managed approach to service delivery, lack of effective coordination among major service providers and poor linkages with community leaders. As a result, with few exceptions, nothing works very well. In addition, for some years, beginning in the early 1980's many in the Egyptian population establishment were taken in by the false promise of automatic fertility decline through the "natural process" of economic and social development. As a result, direct support for free standing family planning services was neglected in favor of "integrated" models where F.P. was only one of many inputs. Fortunately, although the "development is the best contraceptive" idea still has some adherents, the Egyptian leadership has largely repudiated this approach for the failure it has shown itself to be.

C. Shift in Emphasis of USAID's Strategic Approach

In order to overcome these continuing and formidable obstacles to fertility reduction in Egypt, USAID will shift its strategic approach to support as strongly as possible the organization and delivery of family planning services and the removal of policy and program constraints to fertility decline. Specifically, USAID will :

- o expand support for successful private sector family planning programs such as the commercial marketing project of the Family of the Future.
- o support the design and implementation of effective family planning service delivery programs through the extensive network of hospitals, clinics and health centers of the Ministry of Health and the Egyptian Family Planning Association.
- o place more emphasis on a broad based analysis of fertility determinants to guide the design of programs.
- o accelerate discussions with key Egyptian policy makers at the National Population Council (NPC), the Ministries of Health and Social Affairs and other agencies to remove structural and operational obstacles to success. These include weak family planning delivery systems and salary disincentives to program performance.
- o support redirection of public information efforts to encourage not only knowledge and awareness of population issues, but motivation to increase contraceptive usage.

- o assist the NPC to develop the capacity to carry out its responsibility for national population planning, policy making and program coordination.

#### D. Rationale for Shift in Strategic Approach

Dealing with the population problem in Egypt is somewhat analagous to how we deal with the weather: everyone talks about it but no one actually does much about it! However, unlike the weather, something can be done about Egypt's population problem given the right approach to increasing contraceptive use, together with continuing strong political and bureaucratic support at senior levels in the GOE.

The available evidence supports the fact that there exists a large pool of married women of reproductive age (MWRA) who desire smaller families than they are actually having. According to the 1984 CPS over 1/2 MWRA want to cease child bearing. Although the ideal family size was said to be three children, about 1/3 of the women already had more children than they consider ideal and the figure reaches nearly 60% among women over 40 years of age. The CPS also showed that fully one quarter of all currently married women in Egypt "are in immediate need of family planning to avoid an unplanned or unwanted birth." Of the women practicing contraception the median duration of use of the pill was about 2 years and the IUD 4 years. Well over half of the women discontinuing a method did so because of unplanned pregnancy (25%) or adverse side effects (35.3%).

In sum, there is a large unmet demand for contraceptive services that is not being adequately met by the major organized providers of FP services, primarily the MOH in the public sector and the EFPA and other doctors and clinics in the private sector. The task is not primarily one of demand

creation. The demand already largely exists as does the service delivery framework". The MOH has nearly 3500 hospitals and health centers throughout the country within easy reach of virtually everyone. (Unfortunately, MOH facilities are often poorly managed, staffed with poorly motivated and ill-trained personnel and offer inferior quality services.) Likewise, pharmacies and private clinics are ubiquitous. The task is to mobilize the FP service delivery system in such a way as to overcome current barriers to acceptance and to translate latent demand to active use of contraception. Improved quality of services by both MOH and EFPA clinics will attract new clients. And by providing better counseling of possible side effects and by following up drop outs through an extensive outreach program, continuation of women in the family planning program will be greater. By shifting the focus of USAID support as described in detail below, the project will make a major contribution to fertility reduction in Egypt.

### III. REVISED PROJECT DESCRIPTION

Most of the activities described in the original seven components of the PP remain valid today. The major change is one of emphasis away from activities more removed from direct FP service delivery to those which have a direct and measurable impact on increased contraceptive prevalence.

The stated project goal and purpose contained in the original project paper remains unchanged. The project goal is to reduce the rate of population growth in accordance with the GOE national five year plan and strategy. The purpose is to increase contraceptive practice and to strengthen and expand Egypt's population/family planning activities. However, the specific target achievements ("objectively verifiable indicators" in the PP Logical Framework) have been modified to reflect much more modest accomplishments than originally

anticipated. The original PP projected a decline in the population growth rate from approximately 2.7% in 1981 to 2.2% in 1986, a reduction in the crude birth rate of one per thousand per year from 38/1000 in 1983 to 35/1000 in 1986 and an increase in contraceptive prevalence from an estimated 30% in 1982 to 42% in 1986. In fact, the population growth rate in 1986 remained above 2.7%, the birth rate was about 38/1000 and contraceptive prevalence was only about 35%. The revised measures of goal and purpose achievement in this PP amendment reflect the more realistic target of reduction in the birth rate to at least 35/1000 and an increase in contraceptive prevalence to 44% by 1993. See Annexes A and C for a detailed description including logical frameworks for each sub-project.

The project will concentrate support in the key areas essential to fertility reduction as described in the following table:

<u>Activity</u>	<u>Key Implementing Agencies</u>	<u>Project Component</u>
1. National Population/family planning <u>policy</u> development, program planning and demonstration and interagency coordination.	National Population Council (NPC)	- NPC - Intermediaries/ Technical Transfer
2. Delivery of family planning clinical <u>services</u> and distribution of contraceptives through commercial channels and community - based programs	Public Sector: - MOH Private Sector: - FOF - EFPA - Cairo Health Organization (CHO) - CEOS and other PVOs	- Contraceptives - Private/Commercial Sector - MOH - Intermediaries/ Technical Transfer
3. <u>Information</u> , education and communication to inform and motivate people to use contraception.	State Information Service (SIS) Major sub-projects with IE&C components (e.g. MOH, EFPA, CHO, FOF).	- Information/Education Communication - Intermediaries/ Technical Transfer
4. Biomedical, demographic and social science <u>research</u> essential to identify new or support existing policies and programs. (Norplant contraceptive clinical trials, contraceptive prevalence studies, pill compliance study etc.)	CAPMAS NPC Egyptian Fertility Care Society (EFCS) Cairo Demographic Center (CDC)	- NPC - Population Statistics - Intermediaries/ Technical Transfer

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These "four pillars" of USAID's population program in Egypt - policy, information, services and research - are the primary focus of HRDC/P efforts with particular emphasis on expanding clinical services. Current emphasis on "supportive" population activities will either be phased out (CAPMAS census activities) or substantially reduced (SIS) in the future in favor of integrated family planning services delivery programs.

The revised seven components of Project 263-0144 which correspond to these "four pillars" of USAID's population strategy are described in detail below.

A. Contraceptive Supplies

The purpose of this component remains to continue to ensure an adequate supply of contraceptives for the Egyptian family planning program.

a. Progress to Date

The following represent planned and actual contraceptive supply orders which have been placed to date. Expenditures to 12/31/86 were significantly under budget because of (a) an overly optimistic projection in the P.P. of the increase in contraceptive use (30% in 1982 to 42% by the end of 1985. Actual prevalence in 1987 is estimated at not more than 35%), (b) use of over \$2 M out of Project 263-0029 to fund contraceptives originally planned to come out of Project 263-0144, (c) procurement delays - since resolved - arising out of disputes between FOF and EPTC.

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Contraceptive Requirements

1983 - 1985

<u>Contraceptives</u>	<u>Planned in PP</u>	<u>Actual Order</u>
Orals	68,250,000	6,000,000
IUDs	2,880,000	910,000
Condoms	77,500,000	11,413,950
Spermicides	27,000,000	4,310,000

b. Future Directions

Revised Contraceptive Supply Requirements for the total LOP to 5/93 are as follows:

Contraceptive Requirements

1983 - 1993

<u>Contraceptives</u>	<u>Total Required</u>	<u>Ave. Unit Cost \$</u>	<u>Total Cost (\$000)</u>
Orals	13,750,000 cycles	.20	2,750,000
IUDs	6,140,000 pieces	1.00	6,140,000
Condoms	1,625,433 gross	7.00	11,378,000
Norplant	450,000 sets	10.00	4,500,000
Other Methods	12,000,000 pieces	.10	1,200,000
<b>Total USAID Estimated Cost</b>			<b>\$25,968,000</b>

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The revised contraceptive supply requirements to 1993 represent a radical shift away from oral contraceptives and a corresponding significant increase in IUD. Egypt produces most of its own oral contraceptives. Thus there is little need for additional AID-supplied OC's outside of private sector programs such as FOF. IUD's are becoming increasingly popular compared with OC's (particularly the new long-acting CU T 380). It is expected that the new long-acting NORPLANT contraceptive will be approved for general use by 1990.

B. Private/Commercial Sector F.P.

1. Family of the Future (FOF)

a. Progress to Date

FOF is the single most successful activity supported by Project 263-0144. Begun in 1979 as a special project of EFPA, FOF now operates as an independent private association under its own volunteer board of directors. Originally a Cairo-centered urban program, FOF now operates throughout the country covering virtually all of Egypt's 6000 pharmacies and most private physicians. The success of FOF's aggressive marketing program is measured by the fact that it accounts for over 1/3 of all estimated couple years of contraceptive protection in Egypt. In addition to its basic commercial retail sales efforts, FOF has initiated and is expanding a clinical services program with 18 centers serving about 27,600 clients annually. Another eight clinics will be added in the near future.

b. Future Directions

USAID will continue to support FOF's commercial retail sales and clinical services program. FOF's current cooperative agreement with USAID

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expires in 1988 at which time a new multi-year agreement will be developed which builds upon and expands FOF's role as the preeminent private/commercial sector family planning organization in Egypt today and which will lead towards eventual financial self-sufficiency.

## 2. Egyptian Family Planning Association

### a. Progress to Date

The Egyptian Family Planning Association (EFPA) is the largest "semi-private" family planning organization under the jurisdiction of the Ministry of Social Affairs. With over 500 FP clinics located throughout Egypt EFPA has the potential to make a significant impact on contraceptive prevalence. However, for a variety of reasons performance of EFPA clinics are far below standard. As many as 100 EFPA clinics are currently non-operational and many others operates on a very limited part-time basis with volunteer or very poorly paid staff from MOSA or the MOH. Up to \$1.5 M was reserved in the original PP for possible funding of a "Model Comprehensive FP Clinics" project in 5 governorates. However, this project was never designed or implemented.

### b. Future Directions

USAID will support a 5 1/2 year \$6 M project designed to recruit 1.7 Million new FP acceptors through a revitalized EFPA clinical service delivery system. This project is a greatly expanded outgrowth of the original aforementioned "Model Clinics" proposal. It is described in detail in Annex C to this PP amendment.

### 3. Other Private Sector Initiatives

USAID is currently supporting other Egyptian private sector family planning associations such as CEOSS through "buy ins" to AID/W projects such as Family Planning International Assistance (FPIA). Direct bilateral support for additional private sector FP activities will be provided as appropriate depending upon the results of an assessment of additional private sector initiatives (e.g. factory-based FP programs) planned for the summer of 1987. In general, because of the already extensive support for and coverage provided by FOF and EFPA, additional private sector initiatives will not receive major bilateral project support.

#### C. National Population Council (NPC)

##### a. Progress to Date

This component is titled "Community Population Programs" in the PP. Originally, the project envisioned a continuation and expansion of the old Population and Development Project (PDP) begun under project No. 263-0029 which was administered through NPC's predecessor organization the Population and Family Planning Board. The PDP project aimed at enhancing community participation and involvement in family planning through an integrated approach stressing reduction of infant and child mortality, slowing urban migration, and improving population characteristics especially in health, education and women's status. However, the PDD project, budgetted at \$18.7 million, was not continued as originally planned under Project Paper 0263-0144 because PDP evaluation findings showed that the integrated approach was not successful in increasing contraceptive prevalence. Support for the PDP under Project No. 0029 was also discontinued in 1986.

b. Future Directions

Under the revised NPC component, most of the originally planned \$18.7 M will be shifted from PDP to support direct clinical FP services in other components, primarily EFPA. Instead of PDP, in this component USAID will support a new and much more limited Policy, Planning and Program Development Project (PPDP) with NPC. The NPC, created by presidential decree in 1985, is charged with establishing overall policy, program direction and coordination of the national family planning program. USAID project support will help the NPC develop the institutional capability to carry out this vital role at both the central level and through NPC governorate branch offices. See Annex B for a more complete description of the proposed "framework" for the new NPC component.

Another major project activity not foreseen in the original PP which falls under the research element of the NPC is entitled "Long Acting Contraceptive Steroids in Egypt". Approximately \$1.0 M has been earmarked for a three year clinical trial of the new Norplant contraceptive. The research will be carried out in 10 university hospitals under the direction of the Egyptian Fertility Care Society (EFCS) with the close collaboration of the MOH. This project is very important to the future of the Egyptian national family planning program since except for the IUD, which has for some women unacceptable side effects, no other long-term method is currently available through the program for women who do not want any more children. We expect the project to demonstrate the safety and effectiveness of this important new contraceptive and lead to its incorporation into the national program by 1990.

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D. Ministry of Health F.P. Services

a. Progress to Date

This component originally titled the "MOH Family Planning Campaign" represents another planned clinical service delivery activity that did not get off the ground as originally planned. A number of reasons account for this delay, chief among which is the fact that the MOH was not able to satisfy the project C.P.s which stipulate that before project funds may be spent for the MOH rural FP campaign must provide to USAID (1) An administrative and implementation plan to permit rapid implementation of each governorate FP campaign, (2) Evidence that adequate staff are available to administer the expanded family planning program. However, as stated above, the MOH over the last several months has initiated organizational changes to strengthen its ability to manage a national program, including the hiring of dedicated FP supervisory staff. In addition a detailed "administrative and implementation plan" in the form of the new FP Clinical Services Project has been developed in collaboration with USAID. Taken together, these encouraging developments are more than adequate to meet the project conditions precedent.

b. Future Directions

The revised "MOH Family Planning Campaign" (now retitled "FP Systems Development") in its intent and proposed funding level of \$16 M remains essentially as proposed in the original PP. However, the plan of the initial MOH project was intended to cover only the original 12 PDP project governorates, while the current design will expand coverage to 21 governorates on a phased basis over the next 5 years. In addition, the current design is much broader in scope, covering large, urban hospital FP services as well as rural health centers. The total new FP acceptors to be reached under the new

project is 2 million MWRA, which if achieved will have a major impact on fertility reduction in Egypt. For a comprehensive detailed description of the proposed new project, currently planned to begin in April 1987, see Annex A.

Other MOH-related projects which will receive project support during the extended 1987-1993 period include the Cairo Health Organization (CHO) and the Health Insurance Organization (HIO). Both are quasi-governmental organizations with heads appointed by and responsible to the Minister of Health, but with operations largely independent of MOH control. The CHO will receive project support to continue and expand F.P. services through 9 of its hospitals in Cairo while the HIO, which covers factory workers and government employees under a pre-paid coinsurance scheme will incorporate FP services in its ongoing clinical services program. The total USAID project contribution for both projects will be approximately \$2 M.

#### E. Information/Education/Communication

##### 1. Progress to Date

This component has two primary elements: mass media information on population and FP through the State Information Service (SIS) and population education through the Ministry of Education.

The population education element with the MOE was never initiated and will be dropped from the project. It is not considered a high priority activity in terms of its contribution to fertility reduction. Moreover, population education programs in the public schools already exist and receive the support of the United Nations Fund for Population Activities (UNFPA). The planned \$2.9 M in project funds for this activity will be reprogrammed for other project activities.

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Likewise, the nationwide IE&C program under SIS envisioned in the original PP, though initiated, has not progressed as well as originally planned. Initiated as a separate FP IE&C unit of the SIS in 1980, the unit has produced a wide variety of informational materials and mass media programs that have significantly increased public awareness of population and family planning issues. USAID support has consisted of local costs for materials and program production and dissemination, technical assistance, training and salary supplements for key staff. Unfortunately, the increased awareness of family planning does not seem to have led to increased contraceptive use and, in fact, according to the 1984 CPS, even the level of awareness seems to have declined in recent years. The 1986 AID Population Assessment Report pointed to other problems with the SIS program including internal organizational difficulties and lack of interagency coordination as well as an overemphasis on "population" vs. "family planning and health" related messages. However, the Assessment also acknowledged important changes that occurred in 1986 which showed promise for overcoming SIS's difficulties, including the appointment of a capable new Project Director and the development of a detailed "workplan" for future project activities.

b. Future Directions

SIS still has an important role to play in informing and motivating the public and opinion leaders of the benefits of family planning and the dangers of over-population. Under this revision of the PP support for SIS will continue as planned with close USAID monitoring of implementation plans through the initial PACD of May 1988 and continue on a reduced basis to 1992. Given the extensive awareness of population and FP issues in Egypt, there is little need to continue the expensive broad-based approach now employed by SIS. The project will continue to support well-focused informational/motivational activities

such as the "social drama" now being developed by SIS which show promise of motivating large numbers of TV viewers to adopt FP and/or small family size preferences. Other project IE&C activities will be directly supported through FP service delivery activities of major implementing agencies (MOH, EFPA) and specifically focused on achieving F.P. acceptor targets objectives of those activities. This Amendment will also support other currently unspecified population/family planning IEC activities developed by private sector organizations.

#### F. Population Statistics

##### a. Progress to Date

This component was designed to continue and expand previous USAID project support to CAPMAS to improve its capability for data processing, analysis, and compilation/dissemination. In general, activities have been carried out smoothly and without undue delay, including the 1986 decennial census which also receives major project support under this component. A PASA for technical support with the U.S. Bureau of the Census (BUCEN) was initiated in 1984. A new long-term BUCEN advisor to CAPMAS arrived in Cairo in January 1987 to continue work done by his predecessor who left after a 2 year assignment in 1986.

##### b. Future Directions

This component will remain as described in the original project report under "Population Statistics and Population Policy". However, the "population policy" activities, (part B of the original component) which have not yet to be implemented, will be shifted to the NPC component and incorporated under the aforementioned PPPD project. Small scale population studies and statistical analyses of census data will continue to be supported through CAPMAS for approximately 4 additional years beyond the current PACD of

5/31/88, after which project support for CAPMAS will be phased out. In addition a continuing modest level of core support for demographic training and research begun under Project No. 263-0029 for the Cairo Demographic Center (CDC) will be continued under this project. CDC falls under the organizational mandate of CAPMAS and carries out policy relevant demographic research in close collaboration with NPC.

G. Intermediaries and Technical Transfer

a. Progress to Date

Population intermediaries such as Family Planning International Assistance (FPIA), Family Health International (FHI), ISTI, RONCO, The Futures Group and several others which play a vital role in Egypt's national family planning program. FPIA for instance, provides technical and financial support to a number of Egyptian voluntary private and church FP projects. FHI supports biomedical research, including the vital NORPLANT clinical trials now underway in 10 University Hospitals. RONCO assists in the development of FP training activities; ISTI provides expert TA on very short notice and the Futures Group is the source of valuable contraceptive marketing expertise for the FOF and other local organizations. Some population intermediaries such as RONCO and the Futures Group are entirely supported through grants from AID/W. Others such as FHI are partially supported by USAID while still others such as ISTI are entirely supported through Project funds to carry out technical support activities made at the request of USAID and our Egyptian counterpart agencies.

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b. Future Directions

AID population intermediaries fill an important position in the development and implementation of Egypt's population program and will continue to receive project support as appropriate through 1993. However, given the new emphasis in this PP amendment on direct FP service activities as well as the need for sharper focus on fewer interventions, intermediaries will receive less than half the originally planned amount under this component. Major new sub-projects such as the MOH and EFPA proposals attached, have identified intermediaries to meet their TA requirements, thus obviating the need to go through the painstaking, time consuming process of contracting for these services on the open market. Moreover, in order to insure that all intermediary activities fit within the USAID and GOE strategic plan, USAID and NPC have instituted prior review and clearance procedures on all proposed intermediary visits and new activities.

Other FP activities of local organizations such as the EFPA, the Cairo Health Organization (CHO) and the Institute for Research and Training in Family Planning will continue to receive project support as described in the original PP but have been shifted to different components (MOH and Private Sector respectively) where they more appropriately belong.

IV. ECONOMIC, TECHNICAL AND SOCIAL SOUNDNESS ANALYSES

A. Economic

A cost-benefit analysis is not relevant to a population project. Consideration of "least cost", however, is pertinent to this project. The mix of project interventions described herein does represent the most efficient use of project resources to achieve the primary objective of increasing the

number of users of contraceptive services. This is especially true with the new emphasis in this amendment on support for direct family service delivery activities, primarily through the MOH and EFPA. This new emphasis translates into an overall shift of about \$28 M or 27% of planned expenditures in the original PP budget from "supportive activities" such as population planning, informational, statistical and general technical support into sharply focused organized contraceptive services. Also reflected in this shift in emphasis is the elimination of plans in the PP to support highly questionable activities such as population education programs in the school system which have little or no family planning content and which have little or no direct impact on fertility reduction. The primary implementing agencies selected in this amendment (MOH, EFPA and FOF) are the three leading FP service delivery institutions in the country, each with high visibility and a large human and physical infrastructure. The mix of USAID inputs (technical assistance, commodities, training, etc.) is designed in the most cost efficient manner possible to achieve the project purpose of raising contraceptive prevalence (see Annex A and C for more detailed discussion of project inputs).

The crucial importance of raising contraceptive prevalence relates to the impacts on Egypt's current rapid population growth rate and the associated damage being done to Egypt's social and economic development. Egypt's current population growth rate is about 2.7% and is linked to an average number of children per family of 5 1/2 and an average contraceptive prevalence rate of under 35%. To achieve a population growth rate of under 2% by 2005 would require a decline in average family size to 3 children and this result would in turn require that the current contraceptive prevalence rates be more than doubled.

The associated damage being done to Egypt's social and economic development by high population growth rates takes the form of losses in agricultural land and the high costs of extra infrastructure and social

services. Agricultural land is presently being lost at a rate of about 35,000 feddans per year; this loss is equivalent to an additional food import bill increasing by LE 90 million each year. Providing schools, health clinics, transportation facilities and other infrastructure and social services for the additional children born in recent years has caused the GOE's investment and recurrent budgets to rise by many hundreds of million LE each year. A significant reduction in the population growth rate would lower the required food import bill and the costs of the needed social facilities over a long time span. Due to the built-in momentum of population growth, the process of reducing the growth rate of the population is a lengthy one. Each major delay in implementing an effective policy will add additional millions of Egyptians to the population of Egypt and raise the associated long-term costs of importing food and providing social facilities by billions of LE. Hence, the need for this project's interventions in early vigorous efforts to raise contraceptive prevalence rates is urgent.

#### B. Technical

The revised project paper will focus inputs on assisting major Egyptian population and family planning policy making (NPC) and service delivery (MOH, EFPA, FOF) agencies develop the permanent institutional capabilities required to carry out their functions. In the case of FOF, a well trained and highly motivated staff operating under efficient management direction and control is already in place. NPC has articulated the broad population policy and strategy to be carried out in implementing the national population program, but requires technical support and training in key areas before it can function effectively in promoting and communicating policy and in coordinating FP service programs. EFPA has a very weak internal management infrastructure and a highly decentralized clinical services delivery system, which is why the new sub-project is being developed as a relatively autonomous activity extending directly from the Board of Directors to the consumer. The MOH is in

the process of making major improvements in its FP management capabilities' with the creation of a separate Undersecretariat for FP and full-time FP supervisory personnel at governorate and district level.

A key question for consideration in the technical analysis is whether all possible options have been considered in the revised strategy. Why not, for example, put all USAID support behind the FOF and forget the MOH? Why support the NPC at all?

In fact, various options have been considered and the proposed mix of activities is considered to be the best approach. With some modification, our approach basically follows that recommended in the Population Sector Assessment of 1982 and confirmed in a second, AID/W, Population Sector Assessment which was conducted in February 1986. The team reached the following conclusions:

- o USAID's "targets of opportunity" approach resulted in a large number of diverse activities, and diffusion of program impact.
- o USAID's private sector activities were very successful, but had limited, primarily urban coverage. Services were still not fully available in rural areas.
- o The team felt that USAID achieved some success in the area of policy dialogue, but that efforts in this area had been too narrowly focussed on top-level leadership.

The team recommended that USAID adopt a more focused approach, emphasizing service delivery and institutional development. Moreover, USAID should expand successful private sector programs. Finally, USAID should assist the GOE in an expanded policy development effort, to broaden support

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for family planning among decision makers, opinion leaders and health care providers. This amendment directly responds to these three major recommendations made by the assessment team.

Moreover, a very substantial increase in project emphasis in the private sector is proposed (from an authorized level of \$13.5 M to \$32.4 M) for FOF and EFPA which is by far the largest amount for any project component and which is probably at the limit of the absorptive capacity for those organizations.

Equally important is the fact that the MOH also simply must be included for the national family planning program to succeed. There is no alternative to the MOH. Many Egyptians get their health services from the MOH including the highest priority population (i.e. the rural and urban poor with the highest fertility rates). The MOH has thousands of hospitals and health centers within easy reach of almost everyone throughout the country. Moreover, though marginal, USAID has made an investment in the MOH which can be exploited and the timing for a major project initiative is ideal, given a strongly committed new Minister and capable senior MOH USAID project staff. (See Annex A for a more detailed discussion of issues peculiar to the proposed new MOH project.)

As discussed in Section III of this amendment there are a number of complex and interrelated factors which contribute to population growth. This fact of necessity requires the technical design of an interrelated set of policy, informational/motivational and FP service delivery components represented in the seven elements of this project. The basis for this amendment is the readiness of key implementing organizations to proceed with well conceived long range population/FP plans of action.

Given the half-hearted attempts at FP implementation in the past, the question arises as to why USAID should commit itself to the long-range,

multi-year plan for project activities. Why not, for instance, keep our options open by, for instance, approving only a short-term MOH project covering one or two governorates and if that succeeds, expanding the effort to the rest of the country? There are several responses to this suggestion:

- 1) We know from the outset that if we are going to succeed in fertility reduction in Egypt it will have to be a truly national effort involving virtually the whole country. Since we're going to get there anyway, why not plan for the entire program from the onset? Moreover, we know from many years of pilot projects what should work and what won't. We don't need more pilot projects. There is nothing very exotic in either of the large MOH or EFPA projects. Experience in Egypt and other countries with similar approaches indicate our planned approach should work. Modifications can be made as necessary as we go along.
- 2) Large scale multi-year projects contain important economies of scale. For instance, consolidated procurement is more cost effective as are training activities (e.g. It's just as costly to design management training curricula for two governorate level project managers as it is ten or twelve. Design of new IE&C materials, a new client record keeping and reporting system, etc. is as easily done for 18 governorates as it is for one). Moreover, this kind of long-range planning increases efficiency and avoids unnecessary bureaucratic delays (e.g. cuts down on the number of PILs, contracts, PIOs etc. that have to be done).
- 3) Starting out on a large scale does not mean irrevocable commitments are made by USAID. Nobody gets a blank check. For example, both MOH and EFPA sub-projects are designed to phase in governorates over several years. Management controls are built into each project to ensure activities are on track before funds are committed. Each governorate must prepare a project implementation plan and receive USAID approval

before proceeding. Quarterly project implementation meetings will be held between USAID and project counterparts to review past and consider future quarter planned activities. In other words, a planned multi-year expenditure level is conditional upon performance and USAID has the right to change the mix of activities if some are not performing as planned or other higher priority ones emerge. Moreover, we suggest that USAID grant itself unilateral authority to shift funds among project elements up to 25% of the total amount obligated for that element in the next amendment to the project agreement.

- 4) The MOH has proven it is capable of implementing large scale USAID projects; witness its ability to fully implement the four year \$26 M ORT project. Moreover, the MOH has spent approximately \$20 M for population activities under Project No. 263-0029.
  
- 5) Neither the MOH or EFPA sub-projects are totally new. Both were described in the PP, albeit in somewhat more limited form. The \$10 M for the EFPA sub-project is substantially in excess of the \$1.5 contained in the PP for this sub-project whereas the total of \$21.9 M for the MOH is almost the same as the \$21.2M provided in the PP for this sub-project. For almost three years, USAID and EFPA staff have been discussing a large project, which in an earlier rough draft totalled \$13 M. With regard to the MOH, the Ministry's expectation has always been that once they "qualified" (i.e. CPS removed) and came up with an acceptable proposal, USAID would commit the \$21 M earmarked in the PP for this purpose. It would be considered a serious breach of faith on USAID's part for us to now back off from our consistent understanding with both the EFPA and the MOH regarding the extent of our commitment to their sub-projects.

### C. Social Soundness

An extensive and thorough social soundness analysis was done in the original PP. The observations and conclusions of that analysis remain valid today and need no extensive repetition in this PP amendment. Basically, the analysis confirms the desire of large numbers of Egyptian married women of reproductive age to limit their families through culturally appropriate means of fertility control. The ECPS carried out in 1984 has confirmed this basic assumption and shed additional light on knowledge attitude and desires of MWRA for family planning. Key socially relevant findings of the survey for purposes of project design indicate a very large pool of "unmet need" of up to 25% of MWRA and strong desires for smaller size families than are being actually produced. These findings indicate that "motivational" factors are less important than meeting existing demand through quality service delivery programs. At the same time survey results confirm the fact that there are few religious or cultural barriers to contraceptive acceptance (less than 1% of respondents cite religious proscriptions).

### VI. FINANCIAL PLAN

The following is the revised summary project financial plan. As described in previous sections, the revised project budget, including the extension period to 1993, reflects a shift away from support for more peripheral FP activities such as IE&C and Population statistics towards more direct FP service delivery activities in the public and private sectors.

In addition to the following tabular summary of planned project expenditures see also detailed financial plans for MOH and EFPA sub-projects contained in Annexes A and C.

The financial plan assumes a doubling of project expenditure rate during the proposed extension period to 5/31/93. This should be feasible given removal of the most serious past obstacles to project implementation. Moreover, the termination of project No. 263-0029 in FY 87 will result in more expenditures for GOE population activities under Project No. 263-0144.

An important feature of this project is its treatment of recurrent costs required to maintain FP services at the conclusion of the project. In fact, the EFPA project is highly unusual among USAID projects in that it is designed to be fully self-supporting from revenue from contraceptive sales by the end of the project. FOF is also gaining in self-sufficiency from contraceptive sales and will be close to full self-sufficiency by the PACD. New sub-projects with the semi private CHO and the HIO also have built in revenue generations from sales of contraceptives.

Even with the large MOH sub-project most, if not all, recurrent costs will be met through contraceptive sales or absorbed into the regular budget. The largest recurrent cost items - community outreach workers fees and work productivity incentives can be met with revenue from contraceptive sales. The MOH has already budgeted for other future recurrent costs such as the costs of the new FP client registration and reporting system. (See Annex A)

Another major financial issue concerns payments for incentives, salary supplements and honoraria to GOE employees which are an integral part of this project and appear in various forms in most sub-projects. These payments meet Age 3 criteria for payment of salary supplements (honoraria, incentives, fees, bonuses) to host country employees (State 173326, June 7, 1987) for the following reasons:

- 1) Under current GOE laws, GOE employees are allowed to receive salary supplements up to 140% of their base salary. While 140% may seem high,

the base pay for doctors starting out at the MOH is approximately LE 80 a month, less than \$40. The Mission Director has from time to time approved the payment incentives payments for specific activities under this project (and its predecessor project No. 263-1129) and incentive payments in the population sector have been the practice for several years.

- 2) The GOE currently does not have the resources to pay adequate salaries to their employees, much less, salary supplements. Even if the funds were available, the delay in receiving such funds of at least a year or more because of the slow GOE budget process would be unacceptable. For most of the sub-projects the income derived from fees for service and the sale of contraceptives will be used to pay recurrent costs, including incentives. For a detailed description of incentives plans and budgets see pages 30-33 and 79-81 and 88 of the SDP project and pages 40-43 and 46 of the CSI project.
- 3) Adequate administrative procedures at both the governorate and central level have been established in each sub-project to ensure that GOE employees do not receive duplicate payments for the same activity. (See pages 30-33 of the SDP project and pages 40 and 46 of the CSI project.)
- 4) The amount of salary supplements have been established, after discussions with GOE officials, at levels sufficiently adequate to provide reasonable supplementary reward for services rendered, and to attract qualified family planning staff yet not so high as to be prohibitively expensive for the project or for the government when it begins to pay the supplements out of its budget or from sub-project generated revenues.

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- 5) The GOE employees who receive the salary supplements will be engaged in direct managerial, administrative or technical support to the sub-project. (See pages 30-33 of the SDP and pages 40 and 46 of the CIP project for a detailed description of GOE employees at the central and the governorate level that will receive salary supplements).
- 6) Each sub-project has established rules and procedures for periodic monitoring, evaluations and special audits to prevent the potential for abuse. (See pages 30-33 of the SDP project and pages 40 and 46 of the CIP project).

The GOE recognizes the value of incentives and itself routinely provides incentives for high priority project activities out of its limited regular budget. Properly used, incentives, as our experience with FOF has proven, can be a powerful tool for achieving project objectives. The key to success is to make incentives performance based. That is the way the incentive program is designed in the proposed new population project activities. (See pages 30-33 of the SDP project and pages 40 and 46 of the CSI for a more complete description.) Given the extremely low GOE salaries and lack of perceived priority of FP among many service delivery personnel such as MOH staff, not to mention the fact that denial of incentives would be a reversal of current practice, there would likely be no project at all if USAID decided not to allow incentive payments.

Audit coverage: The amendment includes a budgeted amount of \$50,000 under the project element "Population Intermediaries and Technical Transfer" to cover the cost of non federal audits when it is warranted as, for example, in the case of Host Country Contracts.

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GOE Contribution includes salaries, office space, family planning clinics, furniture, equipment, TV and radio time, and contraceptives. Salaries can be either cash or in kind. For example, MOH, NPC etc. pay employees directly from their budgets; however, MOSA sometimes provides employees to the sub-activities without charge to the population project. Office space, family planning clinics, equipment, and furniture are in kind except for furniture and equipment which will be provided during the life of the project. TV and radio time is mainly provided free by the Ministry of Information. For special media campaigns, SIS often purchases, at a reduced rate, TV and radio primetime. Contraceptives are also provided on an in kind basis.

A. SUMMARY FINANCIAL PLAN  
(000)

PROJECT ELEMENT	AID CURRENT BUDGET TO PACD 5/31/88 (\$)		REVISED BUDGET TO PACD 5/31/93 (\$)		GOE CONTRIBUTION (LE)	
	TOTAL	LC	PC	TOTAL	Cash	In kind
1. Contraceptives and Related Supplies	20,000	-	25,968	25,968	500	1,500
2. Private/Commercial Sector FP Services	13,500	24,620	4,134	28,754	1,162	280
3. National Population Council	18,700	4,770	3,313	8,083	11,000	7,370
4. MOH FP Services	21,200	15,540	4,392	19,932	3,500	12,000
5. Information, Education Communication	11,200	7,545	2,651	10,196	1,500	3,500
6. Population Statistics	8,100	3,895	855	4,750	3,000	7,500
7. Population Intermediaries and Technical Transfer	9,900	0	4,917	4,917	-	
<b>TOTAL</b>	<b>102,600</b>	<b>56,370</b>	<b>46,230</b>	<b>102,600</b>	<b>20,662</b>	<b>32,150</b>

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**B. DETAILED PROJECT 263-0144 FINANCIAL PLAN  
CURRENT AND PROJECTED (IN \$000)**

<u>Project Element</u>	<u>Planned Expenditures To PACD (5/31/88)</u>	<u>Obligations to Date</u>	<u>Expenditures to 9/30/86</u>	<u>Cumulative Estimated Expenditures By PACD (5/31/88)</u>	<u>Estimated Unexpended Balance at PACD (5/31/88)</u> (1-4)	<u>Estimated Additional Funds Required for Extension to 5/31/93</u>	<u>Estimated Net Funds Required to 5/31/93</u> (6-5)	<u>Planned Total Expenditures to Revised PACD of (5/31/93)</u> (4-6)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1. Contraceptives and related Supplies	20,000	7,900	2,707	6,578	13,422	19,390	5,968	25,968
2. Private/Commercial Sector FP Services	13,500	13,038	5,514	12,336	1,164	16,418	15,254	28,754
3. National Population Council	18,700	3,393	273	1,471	17,229	6,612	(10,617)	8,083
4. MOH Family Planning Services	21,200	7,278	17	5,337	15,863	14,595	(1,268)	19,932
5. Information, Education/Communication	11,200	5,050	1,789	3,752	7,448	6,444	(1,004)	10,196
6. Population Statistics	8,100	4,153	1,798	3,323	4,777	1,427	(3,350)	4,750
7. Population Intermediaries and Technical Transfer	9,900	3,188	778	2,103	7,797	2,814	(4,983)	4,917
<b>TOTAL</b>	<b>102,600</b>	<b>44,000</b>	<b>12,876</b>	<b>34,900</b>	<b>67,700</b>	<b>67,700</b>	<b>-0-</b>	<b>102,600</b>

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C. PLANNED EXPENDITURES AND REQUIRED OBLIGATIONS BY FISCAL YEAR

PROJECT ELEMENT	ACTUAL As of 9/30/86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	TOTAL
1. Contraceptives	2,707	2,250	2,714	2,826	3,700	4,050	3,800	3,921	25,968
2. Private/Commercial Sector	5,514	2,845	3,900	4,200	4,000	3,200	3,000	2,095	28,754
3. National Population Council	273	750	1,774	1,604	1,300	1,100	792	500	8,083
4. Ministry of Health	17	1,959	3,800	4,100	3,800	3,100	2,100	1,056	19,932
5. IE&C	1,789	1,680	2,100	1,800	1,627	1,200	0	0	10,196
6. Pop. Statistics and Policy	1,798	562	750	680	340	340	140	140	4,750
7. Pop. Intern. and Tech. Trans.	778	530	1,100	890	721	490	247	161	4,917
TOTAL	12,876	10,576	16,138	16,100	15,488	13,480	10,069	7,873	102,600
Required Obligation by Fiscal Year	<u>44,000</u>	<u>15,000</u>	<u>25,000</u>	<u>12,300</u>	<u>6,300</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>102,600</u>

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D. ASSUMPTIONS\* FOR PROJECT EXPENDITURES  
FROM FY 87 TO NEW LOP 5/31/93  
((\$000))

1. Contraceptives

<u>\$ 2,707</u>	- <u>Prior expenditures through FY 86</u>
<u>\$18,761</u>	- IUDs, Pills, Condoms and VFT MOH \$2,377; FOF \$8,952; EPTC \$6,389; EFPA \$1,043
\$ 4,500	- Norplant - New contraceptive MOH \$2,000; FOF \$1,500; EFPA \$1,000
<u>\$25,968</u>	

2. Private and Commercial Sector

<u>\$ 5,514</u>	- <u>Prior expenditures through FY 86</u>
<u>\$10,500</u>	- FOF (\$1,400 average x 7) Based on Previous years funding (Includes TA of \$100 x 7)
\$ 5,740	- EFPA (5 year project, excludes contraceptives)
\$ 4,000	- FPIA (New Grant with USAID/Cairo and current projects (FY 87-FY 91) (\$800x5)
\$ 3,000	- New Private Sector Initiatives (e.g. factory workers (\$500 x 6)
<u>\$28,754</u>	

3. NPC

<u>\$ 273</u>	- <u>Prior expenditures through FY 86</u>
<u>\$ 5,005</u>	- NPC - Core support for NPC central and governorate level offices, training institutional support for research office (and mini-projects (Approx. \$720 x 7)
\$ 1,909	- EFCS Norplant project (\$953) (3 years, April 1987 - March 1990), FHI TA (\$531) and Probable 1 year Norplant study extension-1991 (\$425)
\$ 595	- CPS - \$277 for 1988 CPS and \$318 for 1992 CPS.
\$ 301	- RAPID II 3 year project (buy-in plus local costs)
<u>\$ 8,083</u>	

\* These assumptions are based upon detailed activity and financial plans for MOH and EFPA sub-projects contained in Annexes A and C. For contraceptives supplies, FOF, SIS, CAPMAS, CHO and other currently active sub-projects, financial projections are based upon detailed analysis of prior experience and estimates of future activities. For completely new initiatives to be undertaken (e.g. new private sector initiatives) which comprise only about 7% of the overall budget, estimates are based upon our best current guess of the probable magnitude of project activities and will have to be refined and revised at a later project design stage.

4. MOH

\$ 17  
\$15,731  
\$ 2,000  
  
\$ 384  
\$ 1,800  
  
\$19,932

- Prior expenditures through FY 86  
- MOH - SDP 5 years project  
- MOH - possible one year extension of SDP  
Until new PP is developed, if necessary  
- CHO (\$128 x 3) FY 87 - 89 (PIL No. 14)  
- Health Insurance Organization  
(450 x 4) FY 1987 - 1990

5. IEC

\$ 1,789  
\$ 7,407  
  
\$ 1,000  
  
\$10,196

- Prior expenditures through FY 86  
SIS - \$2,767 for CY 1987 and CY 1988 and \$3,200  
for CY 89-91; AED - TA \$840 (FY 87 - FY 88);  
TA \$600 (FY 89 - FY 91)  
Private Sector IEC

6. Population Statistics and Policy

\$ 1,798  
\$ 980  
  
\$ 1,972  
  
\$ 4,750

- Prior expenditures through FY 86  
- CDC - Core support and small research project (Core  
average \$71 x 7 and Research \$80 x 6)  
- CAPMAS - Strengthening CAPMAS capabilities and small-  
scale population studies/analyses continue until 1992  
Bureau of Census long term and short term TA \$772 (FY  
87-FY 89)

7. Intermediaries and Technical Transfer

\$ 778  
\$ 2,000  
  
\$ 1,889  
\$ 250  
  
\$ 4,917

- Prior expenditures through FY 86  
- Short term TA (ISTI, PSCs and centrally funded  
intermediaries)  
- Other initiatives  
- Evaluation 1989 and 1992 and audit 1990.

E. METHODS OF IMPLEMENTATION  
AND FINANCING

PROJECT ELEMENTS	METHOD OF IMPLEMENTATION	METHOD OF FINANCING*	ESTIMATED COSTS
1. <u>Contraceptives</u>	PIO/C	DP	<u>23,261</u>
2. <u>Private/Commercial</u> <u>Sector F.P. Services</u>			<u>23,240</u>
A. FOF	PIO/T Grant	DP	10,500
B. EFPA	PIL	DR	3,426
	PIO/C	DP	1,000
	PIO/T Contract	DP	1,314
	Buy-in or PSC		
C. FPIA	PIO/T Contract	DP	4,000
D. New Private Sector Initiatives	PIO/T Grants	DP	3,000
3. <u>NPC</u>			<u>7,810</u>
A. NPC Core Support	PIL	DR	5,005
B. EFCS	PIO/T Grant	DP	953
C. FHI	PIO/T Contract	DP	956
D. CPS	PIO/T Contract	DP	595
	Buy in		
E. RAPID II	PIL	D/L COM	201
	PIO/T	DP	100
4. <u>MOH</u>			<u>19,915</u>
A. MOH/SDP	PIL	DR	10,560
	PIO/T	DP	1,145
	PIO/C	DP	3,266
	PIO/Ps	DP	760
B. MOH Extension	PIL	DR	2,000
C. CHO	PIL	DR	384
D. HIO	PIL	DR	1,800

\* DR: Direct Reimbursement - Periodic Advances  
DP: Direct Payment  
D/L COM: Direct Letter of Commitment

PROJECT ELEMENTS	METHOD OF IMPLEMENTATION	METHOD OF FINANCING	ESTIMATED COSTS
5. <u>IE&amp;C</u>			<u>\$8,407</u>
A. SIS	PIL	DR	7,407
B. T/A	PIO/T Contract	DP	1,000
6. <u>Pop. Statistics and Policy</u>			<u>\$2,952</u>
A. T/A BUCEN	PIO/T PASA	DP	772
B. Strength. CAPMAS	PIL	DR	1,200
C. CDC	PIO/T Grant	DP	980
7. <u>Intermediaries &amp; T.T.</u>			<u>\$4,139</u>
A. Short Term TA's	PIO/T Buy in or PSC's	DP	2,000
B. Other Initiatives	PIO/T Buy in	DP	1,889
C. Evaluation	PIO/T Buy in	DP	250

\* DR: Direct Reimbursement - Periodic Advance  
 DP: Direct Payment

Justification for Periodic Advances:

Since the GOE does not have adequate local currency because of budgetary deficits, periodic advances to the implementing agencies are justified.

## VII. PROJECT EVALUATION

The same evaluation plan and procedures will be followed as described in the original PP. In addition major new activities (i.e. MOH and EFPA) contain internal evaluation plans for those components which are described in Annexes A and C. The most important tool for project planning and evaluation is the Egyptian Contraceptive Prevalence Survey (ECPS). Two additional rounds of the Egyptian CPS will be carried out in 1988 and 1992. An interim overall project evaluation will also be carried out in 1989 to assess progress in meeting revised FP project service delivery objectives. This interim evaluation will be carried out by a joint team of Egyptian and foreign FP evaluation consultants with the close collaboration of GOE and USAID project staff. \$150,000 in project funds are reserved for evaluation and audit activities under project element number 7 (Section IV G).

## VIII. IMPLEMENTATION PLAN

Each major element of the project contains a detailed implementation plan for that element. The new MOH and EFPA sub-projects are basically self-contained elements with their own detailed activity, training and procurement plans and schedules (See Annexes A and C). Likewise, the ongoing FOF and SIS sub-projects contain detailed implementation plans and schedules which will not change appreciably through the current PACD of 5/31/88. However, before the expiration of these major sub-projects, work will begin on the design of continuation sub-projects which will, of course, contain revised implementation plans and schedules to carry out mutually agreed upon activities. The same may be said of other key sub-projects such as the forthcoming NPC integrated PPPD sub-project, continuing NORPLANT clinical trials and CDC grant for policy related demographic research.

SV

The important new factor in implementation planning for this PP amendment is the emphasis on the production of annual implementation plans as a requirement for continued funding for major sub-projects and the use of regularly scheduled joint GOE/USAID quarterly implementation reviews, where progress is measured against planned and actual targets contained in the annual implementation plans. This process is an excellent means of monitoring project performance, identifying problems and taking corrective actions.

Assessment of the Project's Implementing Agencies Contracting and Accounting Capabilities:

Except for the MOH, all other agencies except EFPA have been implementing different aspects of the currently operating Project. Even though formal assessments of their contracting and implementing capabilities has not been done in the past, USAID is reasonably satisfied with their familiarity with USAID procurement regulations and their satisfactory implementation of the project. Even the MOH has previous experience of satisfactory implementing Project No. 263-0029. Based on this past experience USAID concurs in continuation of their role as implementing agencies of the project. Also USAID plans to perform detailed assessments of their capabilities in the near future.

The following is a summary implementation plan of key events by component from 1987 to the new PACD of 5/31/93.

PROJECT 0144 SUMMARY IMPLEMENTATION PLAN  
1987-1993

GENERAL	KEY EVENT	'87				'88				'89				'90				'91				'92				'93			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1. Project Management	a) Approval of																												
	- PP Amendment		X																										
	- PACD Extension		X																										
	- Restoration of USDH position in HRDC/P		X																										
	b) New USDH arrives post						X																						
	c) Project Evaluation																												
	- CPS						X				X																		
	- Overall project evaluation										X																		
	d) Obligations																												
	- FY 87 traunch (\$25M)				X																								
	- FY 89 " (\$15M)										X																		
	- FY 91 " (\$12.3M)																	X											
<u>Component</u>																													
1. Contraceptive Supplies	1. Continuous stock review and supply orders as necessary																												
2. Private/Commercial Sector	2. a) FOF																												
	- Approve 1987-88 work-plan				X																								
	- Draft new multi-year project agreement							X																					
	b) EFPA																												
	- Approve new multi-year sub-project				X																								
	c) Other																												
	- Private FP Sector Assessment					X																							
	- New Private Sector FP Project initiatives								X						X														

2

GENERAL	KEY EVENT	'87				'88				'89				'90				'91				'92				'93			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
3. National Population Council	3. New consolidated - Policy Planning Project (PPPD) approved - Cooperative Agreement with EPCS of Norplant study signed - Norplant approval for general use in Egypt/USAID procurement begins		X																										
4. Ministry of Health	4. a) New initiative from President approved and implementation begins b) Project coverage extended to all 21 governorates c) Detailed implementation plans for 1st seven target governorates approved and FP services initiated d) PIL for CIO project continuation signed e) New HIO project developed and approved				X																								
5. IE&C (SIS)	5. - FP Social Drama begins - SIS grant ends - New 2 yr. grant approved for small scale mass media IE&C activities				X			X																					
6. Population Statistics	6. - Preliminary results of 1986 census published - Agreement with CAPMAS for further census analyses and small scale statistical studies - CAPMAS support ends - Pop. Research agreement with CDC approved				X			X																					

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IX. CONDITIONS PRECEDENT AND COVENANTS

A. Source and Origin of Goods and Services

Goods and Services, except for ocean shipping, financed by A.I.D. under the Project shall have their source and origin in the Cooperating Country or in the United States, except as A.I.D. may otherwise agree in writing be financed on flag vessels of the United States.

B. Covenants

(1) The Cooperating Country agrees that the National Population Council (NPC) shall be responsible for the overall coordination and implementation of the Project and will cooperate with other ministries, agencies and institutions involved in family planning;

(2) The Cooperating Country agrees that the MOH shall continue to upgrade urban and rural family planning services, and shall include hospital postpartum services as a component of comprehensive family planning;

(3) The Cooperating Country agrees that no A.I.D. funds made available under this Project will be used to pay for (a) performance of abortions as a method of family planning or to motivate or coerce any person to practice abortion or, (b) the performance of involuntary sterilizations as a method of family planning or to observe or provide any financial incentive to any person to practice sterilizations.

(5) The cooperating country agrees that all project-procured vehicles will be operated and maintained in good order and that adequate GOE funds will be budgeted to ensure continued utilization of project vehicles upon termination of project support.

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FIRST AMENDMENT  
TO  
PROJECT AUTHORIZATION

Name of Country: Arab Republic  
of Egypt

Name of Project: Population Project

Project No. : 263-0144

1. Pursuant to Section 532 of the Foreign Assistance Act of 1961, as amended, the Population Project was authorized on June 6, 1983. Such authorization is hereby amended as follows:

a. The first paragraph is amended as follows:

(1) The words "four year period" in line 5 are deleted and the words "ten-year period" are substituted therefor.

(2) The last line is revised to read as follows:

"The planned life of the Project is ten years from the date of initial obligation".

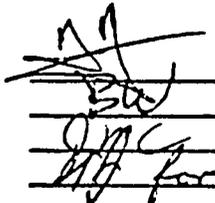
b. A new paragraph "4" is added to read as follows:

"4. The payment of salary supplements, such as incentives, honoraria, per diem, bonuses and other similar payments, to employees of the Cooperating Country, in accordance with AID/W and Mission policy guidance is hereby approved. The required justification and implementation plan for any salary supplement arrangement in any subproject shall be set forth in detail in the document pursuant to which such subproject is approved by the Mission. The implementation plan agreed to by the Mission shall be set forth in a Project Implementation Letter".

2. Except as noted above, the authorization dated June 6, 1983 remains in full force and effect.

Clearances:

OD/HRDC/P, T. Tiffany  
AD/JRDC, B. Wilder  
AD/PPP, J. Conly  
FM, D. Shannon



  
Arthur M. Handly  
Acting Director

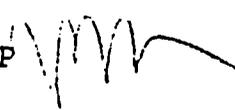
20 JUN 1987  
Date

May 31, 1987

MEMORANDUM

TO : Distribution

FROM : Theresa Ware, PPP/P

THRU : Vivikka Holldrom, PPP/P 

SUBJECT : Executive Committee Review:  
Population/Family Planning II Project Amendment

1. Subject review is scheduled for Monday, June 8, 1987 at 10:00 AM in the ninth floor conference room.
2. Attached are the Project Amendment and the companion Supplement. The PA contains a new budget, revised to reflect recent changes in the exchange rate. The Supplement addresses the questions and concerns raised during the Executive Committee Review of March 26, 1987. Also attached is an HRDC/P cover memo containing further guidance from Acting Director Handly.
3. A copy of the March 25 Issues Agenda and the March 30 Decision Memo are also attached to refresh your memory for the June 8 review.

DISTRIBUTION

A HANDLY, (A) DIR  
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APRIL 1987

PP Amd  
#1

SUPPLEMENT TO  
POPULATION/FAMILY PLANNING II  
PROJECT NO. 263-0144  
PROJECT PAPER  
AMENDMENT NO. I

USAID'S POPULATION PROGRAM IN EGYPT:  
IS THE REMEDY APPROPRIATE FOR THE ILLNESS?

INTRODUCTION

Egypt's population problem is serious and getting worse. Despite the contribution of millions of dollars in AID assistance since 1977, there has been little discernable impact on fertility reduction. Moreover, the strong population control rhetoric of top Egyptian leaders has not yet been translated into effective action programs. Given this background, it is appropriate to raise the fundamental question of whether the current and proposed USAID population program is appropriately designed to overcome the basic problem of high fertility. What, in fact, are the real obstacles to fertility control? How can they be defined operationally and disaggregated so that they can be dealt with effectively? Are there, for example, different attitudinal or behavioral characteristics of different age groups that require new approaches not yet envisioned? Which key constraints to fertility reduction are actionable and by whom?

Having keyed in on the real problem, the next step is to look at what USAID is doing and proposes to do to resolve it. Are we on target or are there gaps in our strategic approach? Are there linkages clearly established between project intervention and problem solution? Is the management of the

population program adequate or are there ways to improve its efficiency and effectiveness? Can we, for example, consolidate some actions or adopt simpler implementation mechanisms to reduce the management burden?

These are the questions which this paper seeks to answer. They correspond to the issues raised in the PPP memorandum of 3/30/1987 continuing the results of the Executive Committee Review of the proposed Population/Family Planning II Project Paper Amendment No. 2. The extent to which these issues are adequately addressed in this supplement will determine the next step required in the approval of the PP Amendment.

### THE PROBLEM

In this section the paper attempts to clearly identify the problem, focusing on its essential dimensions: the demographic setting, the target population, characteristics of the target population, and constraints to fertility control.

#### a) Demographic Setting

The fundamental overall problem that there are large number of births every year (approx. 1.8 million) and fairly small numbers of deaths (approx. .5 million) resulting in a large annual population increase. Currently, the population growth rate is estimated to be close to 3%, which translates into a population doubling time of 23 years. Clearly, a society which has trouble meeting the needs of its 50 million citizens in 1987 will have a major, if not impossible, task of providing for 100 million in the year 2010.

The following table illustrates recent trends in rates of births, deaths and natural increase:

Year	Population Estimate (000's)	Births		Deaths		Natural Increase	
		No.	Rate	No.	Rate	No.	Rate
1980	42126	1580	37.5	423	10.0	1157	27.5
1981	43314	1604	37.0	434	10.0	1170	27.0
1982	44525	1612	36.2	444	10.0	1168	26.2
1983	45755	1723	37.7	457	10.0	1266	27.7
1984	47191	1820	38.6	444	9.4	1376	29.2
1985	47503	1817	38.3	442	9.3	1375	28.9
1986*	50000		38.0		8.5		29.5

\* Provisional Estimates

This table is interesting from several standpoints. First of all it shows the relentless climb in total population from 42 million on 1980 to an estimated 50 million in 1986. The birth rate shows a definite, though modest, decline since 1984 of about .3/1000 per year. However, this decline is more than offset by a rapidly falling death rate, with the result that the rate of natural increase, after dropping slightly in 1985 has risen to a new high of 29.5/1000 (2.95% rate of population growth) in 1986.

This recent sharp decline in the death rate merits special attention because of its impact on the population growth rate. Leading Egyptian demographers expect mortality rates to continue to decline significantly, perhaps going as

low as 5 or 6 within 3 or 4 years. This is because of the age structure of the population and the continuing rapid decline of the infant mortality rate (IMR). Infant mortality accounts for about 1/3 of the total death rate. Thus major improvements in infant and child survival have an important impact on the population growth rate. No doubt, USAID can take credit for much of the improvement in this area through interventions such as the Diarrheal Disease Control Project. However, this otherwise happy result produces unhappy consequences for population growth. If downward trends in mortality continue, the birth rate will have to decrease almost a full point just to stay even. The following is illustrative:

---

	<u>Birth Rate</u>	<u>Death Rate</u>	<u>Rate of</u> <u>Natural Increase</u>	
1985	38.3	9.3	28.9	
1986	38.0	8.5	29.5	
1987	37.2	7.7	29.5	) Hypothetical
1988	35.6	6.1	29.5	) Projection
1989	34.9	5.4	29.5	)

---

The above illustrates that Egypt could achieve a quite respectable decline in the birth rate from 38 in 1986 to only 34.9 in 1989 and, assuming the experts are right that mortality will continue to decline over the next few years until it stabilizes at between 5 and 6, the fall in the birth rate will still not be adequate to drop the population growth rate below its current 2.95%.

Needless to say, it is highly unlikely that the birth rate will fall by more than a point or so per year, even with a much more aggressive national family planning program.

The conclusion from this analysis is that the population growth rate is likely to remain at its current high level or even increase over the next 3 or 4 years, no matter what the GOE and USAID do. However, it is quite likely that fertility will continue to decline over that period as well, and the extent to which that occurs will be the measure of the success of Egypt's population/family planning program, not the population growth rate. Of course, as fertility continues to decline and the mortality rate levels off, the population growth rate will also come down, but that is not likely to happen for at least several years.

From the above we see that given current and past trends in fertility and mortality, it is highly unlikely that population growth will decline over the next several years; though fertility will probably continue to decrease. The basic task for the GOE and USAID is to accelerate that decrease to the maximum extent possible. Assuming for the moment that family planning is the only feasible tool to accomplish this end (see section III for a discussion of other "beyond family planning" measures in Egypt), the next step is to identify the target population\*.

\* Methods also exist to calculate overall contraceptive prevalence targets required to reach desired reductions in Total Fertility Rates (and also to calculate fertility rate reductions from proportional declines in the Crude Birth Rate). Such calculations are beyond the scope of this paper. However, they will be introduced in the near future under the RAPID project with NPC for use in establishing and adjusting contraceptive prevalence targets.

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b. Target Population

Current estimates from the Cairo Demographic Center (CDC) show a total of roughly 11.5 million Egyptian women in their fertile years of 15 to 49. Using data from the 1984 Egyptian Contraceptive Prevalence Survey (ECPS), we can get a reasonable idea of the composition of the target population out of this total. If we assume that the percentage of "unmet need" (women not wanting children but exposed to the risk of pregnancy) is still about 25%, there would be a current target population of approximately 3 million women currently in need of family planning services. Others married women are either using family planning, not exposed to the risk of pregnancy or wanting to get pregnant. It is instructive to look at the ECPS data further to identify the characteristics of the women in the unmet need category:

- the proportion of "limiters" (i.e. want no more children) is 5 times the proportion of "spacers" (i.e. want to delay next pregnancy).
- rural women are more likely to be in need of FP than urban women (28% vs 21%).
- the highest proportion in need is found among rural women in Lower Egypt (29%) and lowest among urban women from Lower Egypt (20%) as compared with 24% in urban Upper Egypt and 27% in rural Upper Egypt.
- the percent in need ranges from 27% among women with no education to only 18% among women with at least a preparatory education.
- the percent in need varies directly with age, from a high of 28% among women age 25-39 years to a low of 21% among women under age 25, with the percentage of spacers considerably higher in the younger age groups.

Data from the ECPS and CAPMAS also strongly indicate that young married women under the age of 20 are not the group creating the biggest population problem. It is true that Egyptian women tend to marry young (the majority

under the age of 18) and most prefer to have at least two children before contracepting. And, other things being equal, women who marry younger tend to have more children over their reproductive life span. However, this is not the same as saying that the major problem of excess fertility is with young married women. In fact, the opposite is the case for the following reasons:

a) Married women under the age of 20 comprise only about 7% of all married couples.

b) On the average only about 2.5% of total births currently are to women under the age of 20.

Recently married women under the age of 20 are very hard to motivate to use family planning. Only about 15% of currently married non users intending to use family planning in the future said in the ECPS that they would do so before the birth of their third child. There are very strong cultural preferences promoting early child bearing and, particularly in rural areas, strong preferences for male children. The percentage of woman in the 15-20 year age group using family planning increased from 1.3% to 5.6% between the 1980 and 1984 ECPS. While this is progress, the numbers of women affected are still quite low. On the other hand, in the 35-39 age groups there was an increase from 20.9% to 43.2% and in the 45-49 age groups contraceptive use nearly tripled from 7% to 21%. This indicates a much stronger receptivity to family planning in these older age groups, even in the absence of a strong national family planning program offering quality services.

In addition, the program costs of recruitment and retention of recently married young women as family planning acceptors is much higher than with more receptive older age groups. This is both because a higher investment must be made in "demand creation" activities (e.g. special IE&C efforts), and because

the younger women are overwhelmingly spacers who will use less effective temporary methods of family planning which require more counselling, follow up and other case management interventions.

Given this background it is clear that, while they cannot be ignored, younger married women with less than two children should not comprise the highest priority for the National Family Planning Program - they account for only a small percentage of total births and they tend to be much more resistant to family planning than older, higher parity married women. The important message to convey to these younger cohorts is the value of FP for child spacing, to which they will tend to be more responsive because of its health rationale and its emphasis on spacing rather than limitation. Moreover, there is no evidence to indicate that married women in the 15-20 age cohort have significantly different attitudinal or behavioral characteristics than older married women (other than a preference for early childbearing) that might require a fundamentally different approach.

Thus we see from this analysis of the ECPS data that the priority target population for family planning services is quite large (about 25% of currently married women or about 3 million women who want no more children and are receptive to family planning). They are spread throughout the country with significantly higher percentages in rural areas in both lower and Upper Egypt and concentrated among women over 25 years of age with at least three children.

A secondary priority should be to convert those women using "traditional" methods (about 5% of current users) to more effective modern methods of contraception. And a third priority should be to reach that large percentage (21%) of currently married women who "need" FP i.e. "say they want no more children" but also do not want to use FP out of ignorance, fear, religious opposition or just plain inertia.

e) Constraints to Fertility Control

This topic is discussed on pages 9 & 10 of the PPA. To summarize, the key constraints to fertility control in Egypt are:-

- 1) Policy (legal and socio-economic support for large families).
- 2) Human (cultural, religious, illiteracy, lack of education).
- 3) Institutional (poor family planning delivery systems, weak program management and leadership).
- 4) Technical (almost sole reliance on the IUD and oral contraceptive)

It is important to try to determine the relative importance of these constraints and to operationalize them as much as possible in order to develop effective action programs to overcome them.

1) Policy

Unfortunately, not much can be done through the USAID Population Project to affect certain key "policy", constraints promoting large families, such as the structure of government subsidies which increases the economic attractiveness of child-bearing in rural areas. Egypt has a law that would promote smaller families (e.g. prohibition of marriage under the age of 16) but it is largely ignored or not enforced. The overall negative impact on population growth of "policy" constraints is probably substantial, though impossible to measure.

It is doubtful however that such constraints, in themselves, constitute overwhelming barriers to fertility control. For example, the FOF program is an example of a successful FP effort that has attracted large numbers of new acceptors, even in rural areas where the effect of policy constraints are assumed to be the strongest.

2) Human

The negative effect of "Human" constraints are also significant. Although the ECPS data reports the effect of religion on non-adoption of contraception is minimal (less than 1% of respondents cite it as a barrier) it probably has a depressing effect in the overall climate of contraceptive use. Regarding the decision to use FP, the evidence indicates that this is overwhelmingly a shared decision and only rarely a decision of the husband alone. 55% of ECPS respondents felt that the final decision should be made by both parties with 17% saying this should be a decision of the husband alone and 18% responding that this should be the wife's sole decision. Fully 64% said that the decision to have another child should be made by both husband and wife. Respondents conceding the decision to the husband were disproportionately concentrated in rural Upper Egypt. Education also plays a very strong role in the adoption of family planning. According to the ECPS, literate women were twice as likely to be using FP than non-literate women. In addition, employment status has a strong effect with the ECPS showing almost 50% use among working women as compared with about 30% among non-working women.

Non-working wives of agricultural workers were much less likely to be using family planning than those with husbands in white collar occupations. Again, it is difficult to measure the precise overall impact of "human" constraints, though it is clear that some, particularly education and employment, are very significant.

3) Institutional

Institutional constraints are addressed in great detail in the PPA and in the accompanying MOH and MOSA/EFPA component documents and are not repeated herein. Suffice it to say that constraints of this nature (e.g. poor

MOH FP service delivery systems) are universally recognized as serious barriers to contraceptive acceptance. This assertion is also borne out by the ECPS: over 20% total non-users of FP cited health problems, fear of side effects, lack of knowledge of methods etc. as reasons for non-use. The other significant point to be made about institutional constraints, unlike many others is that they are clearly actionable. Examples of successful FOF and selected "model clinics" programs demonstrate that high quality FP service programs can attract and retain large numbers of FP acceptors even where policy, human and other constraints are present.

#### 4) Technical

Technical constraints severely limit Egypt's population program, because while most women adopt FP to limit children (84%) rather than space (16%) the IUD is the only long-acting contraceptive available and because of side effects and method of application it is not favored by large numbers of women. Actual use effectiveness of the oral contraceptive is far below its high theoretical effectiveness. Also poor counselling and side effects cause many women to avoid the pill or discontinue use shortly after starting it. Use effectiveness of condoms is also low. The injectable contraceptives Depo-Provera and Noristerat are highly effective, but they have been the subject of public controversy, causing their use to be limited to University Hospitals only. Abortion and sterilization would have a tremendous impact on lowering fertility, but both are explicitly excluded from the program. Eventually the new long-acting Norplant contraceptive will play a major role in fertility reduction in Egypt, but Norplant introduction is still at least 2-3 years away.

In sum, there are significant human, policy, technical and institutional constraints to population control in Egypt. Some we can affect directly while many we can do nothing about. The following section describes in more detail

the specific current and proposed USAID-supported activities required to overcome these constraints and increase contraceptive acceptance.

### III. THE REMEDY

Having clarified the problem, identified the target population and discussed the primary constraints to fertility control in Egypt, the next step is to explore what possible viable options exist to overcoming Egypt's population problem. These options generally fall within two major categories: family planning interventions to directly increase contraceptive prevalence and reduce the birth rate and "beyond family planning" interventions which usually consist of legal and social measures to reduce fertility.

#### a. Beyond Family Planning

"Beyond FP" measures have their strongest effect on the policy and human constraints described above. The country which has had the most notable success in lowering it's fertility rate using beyond FP measures is China. In China the "one child" norm is pushed strongly through the vast apparatus of the state, so strongly in fact that AID in 1985 cut off funding for the United Nations Fund for Population Activities (UNFPA) because of it's support for what AID considered to be a coercive FP program, which was alleged to include forced abortion.

Other countries have tried different forms of this kind of social engineering with varying degrees of success. Various forms of incentive programs (usually positive rather than negative) have been used, for example, such as direct payments to clients to adopt FP methods, or more indirect incentives such as use of interest free development loans or the loan of farm animals on condition the borrower is using FP or has only so many children. It is difficult to measure the impact of such schemes. Often, as in Thailand,

they appear to have been very successful, but their impact independent of strong accompanying FP service programs which are also present is uncertain.

Egypt, as is the case with most Arab countries, has largely avoided the use of beyond family planning measures. While recognizing the theoretical effectiveness of such interventions, the NPC in its policy pronouncements strongly emphasizes the absolute voluntary nature of the national family planning program which its states must be implemented in the context of Muslim tradition and culture. The policy statements also state explicitly that the national FP program does not include abortion or sterilization - two factors which have accounted for the majority of fertility decline in many countries.

Given the absence of the requisite political will to employ them, it is doubtful that "beyond family planning measures" will play a major role in fertility reduction in Egypt. Nonetheless, USAID does support large-scale mass media programs to try to promote small family norms and also supports population policy research and development which could eventually lead to non-family planning fertility control measures. For example, The NPC, with USAID support, is currently finalizing its "Work Plan for the Population Strategy for the Arab Republic of Egypt to the year 2000". This plan calls for a number of non-FP interventions, (e.g. improvement of women's status, increasing literacy, and population redistribution) some of which would contribute to fertility reduction. However, support for implementation of such measures is beyond the scope of the USAID population program, though they could receive support through other USAID projects active in other sectors.

#### b. Family Planning

The limitations of the use of "beyond FP" measures in Egypt highlights the importance of the development of effective FP service delivery programs to reduce fertility. Egypt's national family planning program, long an rhetoric

and short on performance, is not currently dealing effectively with the population growth crisis. At the policy level, as we have discussed, tough decisions which could have significant effect on reducing population growth are avoided (e.g. limitation of government subsidies to families with more than 3 or 4 children, relaxation of proscriptions on voluntary sterilization, etc.) At the family planning service delivery level, a large but very ineffective nationwide system of health clinics exists in both the public (MOH) and semi-private (MOSA/EFPA) sectors. These clinics are generally poorly managed, staffed by poorly trained personnel, lack adequate equipment and supplies, offer sub standard services, do very little community outreach and - as a result - service only a small percentage of women in need of FP services. There do not seem to be any insurmountable structural problems with this FP service delivery system. It is mostly all there; it just doesn't work very well.

There seems to be little doubt that the only workable solution to Egypt's population problem is the development and implementation of a comprehensive national FP program designed to reach the population in need throughout the country. This conclusion has been consistently reaffirmed by Egyptian authorities through the National Population Council (NPC). It was a primary conclusion reached in the UN Report of Second Mission on Needs Assessment for Population Assistance of 1985. Earlier, (1982) it was strongly put forward in the USAID Egypt Population Sector Assessment which called for a "vastly reinvigorated and restructured family planning service delivery system". This conclusion was again reconfirmed and reinforced in the more recent 1986 AID/Washington evaluation of the USAID population program (USAID's Population Program in Egypt: Assessment and Recommendations) and accepted by the Mission in its response to this evaluation. It has subsequently been reconfirmed by the Mission in the CDSS and Action Plan for 1987/88.

Having arrived at the conclusion that USAID support for development of an effective family planning service delivery system is the only feasible means of promoting lower fertility, the next question becomes, how can that be done in a manner which recognizes and overcomes the major constraints to fertility reduction in Egypt?

The PPA, together with its MOH and MOSA/EFPA component documents, goes into great detail articulating the strategy to be used in reaching a target of approximately 3.6 million new FP acceptors over the next five years. What is perhaps not quite as clear as it should be from this extensive documentation are the specific linkages between project interventions and the target population. The next section of this paper attempts to illustrate those linkages more clearly. The following table, reproduced from the PPA shows the major elements of USAID population project and planned expenditures for each element to the year 1993. It should be remembered in reviewing this table, that the USAID population "project" is, in reality, a sector program with major elements (e.g. MOH, FOF) the equivalent of the normal USAID project.

**B. DETAILED PROJECT 263-0144 FINANCIAL PLAN  
CURRENT AND PROJECTED (IN \$000)**

<u>Project Element</u>	<u>Planned Expenditures To PACD (5/31/88)</u>	<u>Obligations to Date</u>	<u>Expenditures to 9/30/86</u>	<u>Cumulative Estimated Expenditures By PACD (5/31/88)</u>	<u>Estimated Unexpended Balance at PACD (5/31/88) (1-4)</u>	<u>Estimated Additional Funds Required for Extension to 5/31/93</u>	<u>Estimated Net Funds Required to 5/31/93 (6-5)</u>	<u>Planned Total Expenditures to Revised PACD of (5/31/93) (4-6)</u>
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1. Contraceptives and related Supplies	20,000	7,900	2,707	6,578	13,422	17,140	3,718	23,718
2. Private/Commercial Sector FP Services	13,500	13,038	5,514	12,336	1,164	20,020	18,856	32,356
3. National Population Council	18,700	3,393	273	1,471	17,229	5,059	(12,170)	6,530
4. MOH Family Planning Services	21,200	7,278	17	5,337	15,863	19,260	3,397	24,597
5. Information, Education/Communication	11,200	5,050	1,789	3,752	7,448	3,244	(4,204)	6,996
6. Population Statistics	8,100	4,153	1,798	3,323	4,777	1,354	(3,423)	4,677
7. Population Intermediaries and Technical Transfer	9,900	3,188	778	2,103	7,797	1,623	(6,174)	3,726
<b>TOTAL</b>	<b>102,600</b>	<b>44,000</b>	<b>12,876</b>	<b>34,900</b>	<b>67,700</b>	<b>67,700</b>	<b>-0-</b>	<b>102,600</b>

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The following table links the major project elements with the target populations described in Section II:

Linkages Between Project Interventions  
and Population Problems

<u>Est Current No. in Target Population</u>	<u>Problem</u>	<u>Project Intervention</u>
<p>2.8 million</p> <p>.2 million</p> <p>2.4 million</p> <p>(included in other estimates)</p> <p>.8 million</p>	<p>1. <u>High Fertility among priority target groups: (in order of priority)</u></p> <p>a. Women in need of FP wanting contraception.</p> <p>b. Women using ineffective traditional methods.</p> <p>c. Women in need of FP but not wanting FP.</p> <p>d. High parity women (over 4 children)</p> <p>e. Young married women up low parity (about 800,000)</p>	<p>1. <u>Contraceptives</u></p> <p>a. Supplies</p> <p>b. Logistics management.</p> <p>2. <u>Private/Commercial Sector FP</u></p> <p>a. FOF - commercial distribution thru pharmacies, private MDs; community outreach; clinical services; public advocacy; mass media promotion.</p> <p>b. EFPA (MOSA) - clinical services/outreach.</p> <p>c. FPIA - FP services thru local PVOs.</p> <p>d. Other private sector (e.g. factory-based clinics).</p>
<p><u>% Age of Pop in:</u></p> <p>Upper Egypt - 30%</p> <p>Lower Egypt - 45%</p> <p>Cairo metro - 25%</p> <p>Urban - 55%</p> <p>Rural - 45%</p>	<p>2. <u>Location of target groups: (in order of priority)</u></p> <p>a. Rural upper Egypt</p> <p>b. Rural lower Egypt</p> <p>c. Urban upper Egypt</p> <p>d. Urban lower Egypt</p> <p>e. Cairo Metropolis</p>	<p>3. <u>NPC</u></p> <p>a. Contraceptive research thru EFCS.</p> <p>b. Policy/program research.</p> <p>c. Policy planning/implementing agency coordination.</p> <p>d. Institutional support/gov. level program coordination.</p>
	<p>3. <u>Other:</u></p> <p>a. Illiterate clients</p> <p>b. Religious opposition</p>	<p>4. <u>MOH</u></p> <p>a. Cairo Health Organization - clinical services in 9 hospitals.</p>

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<u>Est Current No. in Target Population</u>	<u>Problem</u>	<u>Project Intervention</u>
	<ul style="list-style-type: none"><li>c. Pronatalist social policy</li><li>d. Weak FP leadership</li><li>e. Poor management/supervision</li><li>f. Poor quality clinical service</li><li>g. Poor public FP image</li><li>h. Unmotivated staff</li><li>i. Lack of community outreach</li><li>j. Ineffective contraceptive logistics system.</li><li>k. Poorly trained health worker and supervisor staff.</li><li>l. Poorly-equipped medical facilities.</li><li>m. Inadequate contraceptive technology.</li><li>n. Absence of policy/program research.</li><li>o. Absence of operations research.</li><li>p. Weak policy planning/interagency coordination.</li><li>q. Lack of population data base.</li><li>r. Indifferent public attitude towards FP.</li><li>s. Little appreciation of value of child spacing.</li><li>t. Absence of FP in large MCH and hospital programs.</li><li>u. Absence of good quality client-oriented IE&amp;C programs</li><li>v. Organizational rivalry Fragmentation.</li></ul>	<ul style="list-style-type: none"><li>b. Health Insurance Organization - FP in 30 HIO polyclinics.</li><li>c. MOH - Expanding, strengthening FP through nationwide programs with emphasis on rural hospitals and health centers - community outreach, training, performance-based incentives, management systems improvement, clinic upgrading, technical transfer, local IE&amp;C programs.</li></ul> <p>5. <u>IE&amp;C</u> SIS - mass media promotion of FP, institutional development of SIS central and local offices, training local leaders, local FP information seminars &amp; workshops.</p> <p>6. <u>Population Statistics</u> a. CAPMAS - pop. census and small scale population research and analysis. b. Cairo Demographic Center (CDC) - training and research in policy and program - related demographic research.</p> <p>7. <u>Intermediaries/Technology Transfer:</u> a. Project evaluation. b. Buy ins to AID/W centrally funded projects for technical support for training, project design and evaluation, commercial marketing of contraceptives, management development, implementation of PVO FP services, etc.</p>

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While the emphasis of USAID's population program is on overcoming institutional constraints to contraceptive acceptance, the program at the same time contains interventions in the human, policy and technological constraint areas as well. One can readily observe the linkages between the problems, target groups and interventions identified. For instance, virtually all project elements impact directly or indirectly on reaching various target groups of women in need of FP services with different approaches. For example, clinical services delivery programs (MOH, FOF, MOSA/EFPA, etc.) currently or when implemented gear their outreach approach to stress the importance of child spacing to younger married women while promoting child limitation among older age cohorts. Since the target groups are located virtually everywhere, the program is also country wide with the objective of making quality FP services available at every feasible opportunity, from urban hospitals to rural health centers. First priority is, however, given to upgrading FP services in rural areas. Staff training and management systems development is also emphasized to overcome these recognized problems. Contraceptive research is carried out to meet the "technology constraint" discussed earlier, as is policy and program research to meet constraints in this area. The scope of the current and proposed population assistance program is of necessity comprehensive, but at the same time, well focused on overcoming those problems which have been repeatedly identified as being the major constraints to fertility control in Egypt.

Of course, one can conclude that the strategy of developing good quality FP services is the only viable option to fertility reduction in Egypt and still not agree with the specific approach described in the PPA to carry out that strategy. All that can be said in defense of the PPA is that the major new interventions proposed (SP service delivery projects with the MOH and MOSA/EFPA) were developed over several months in full collaboration with Egyptian counterparts at various policy making levels and with the assistance

of some of the best available population planning design consultants. If there is a better approach it has yet to be identified.

#### IV. PROJECT MANAGEMENT

The final question to be addressed in this paper could be phrased as follows: "Is the USAID management of the population program operating as efficiently as possible?" The underlying assumption behind this question is that current project management may be "unfocused", "scattered", and operating at a "micro-management" level requiring many discrete actions which place an unnecessarily large management burden on the Mission.

In considering this question, it is first of all important to recognize the fact that we are in fact addressing a sector program, which is administered under an umbrella project (Population/Family Planning II). Thus, it is unfair to compare the Pop./FP II project with, for example, the Urban Health Project, when, in fact, the population project should be compared with the entire Office of Health sector portfolio. Major population project components are equivalent to most Mission projects in their size, complexity and comprehensiveness. To continue the comparison with Office of Health, that Office currently has 4 active projects: Urban Health Delivery Systems, Suez Community Health Personnel Training, Diarrheal Disease Control and Child Survival. All but Child Survival are scheduled to end in 1987 or 88, though Diarrheal Disease may be extended for 2 more years. There are also plans to develop a new Cost Recovery for Health project. This contrasts with 4 major ongoing "projects" in the Office of Population (FOF, SIS, CAPMAS, MOH) with 3 additional large multi-year projects (MOH Systems Development, MOSA/EFPA Clinical Services Improvement, and NPC Population Policy Planning Program Development) due to begin in FY 87. In addition, the Office of Population has other smaller "projects" with the Cairo Health Organization and the Cairo Demographic Center and is currently developing a new project with the Health

Insurance Organization. Yet as the following table demonstrates, despite a larger project portfolio, the Office of Population has fewer active implementation actions than the Office of Health. This is probably true when comparing the Office of Population with other Mission Offices as well.

ACTIVE 1986  
NUMBER OF MAJOR IMPLEMENTATION ACTIONS  
USAID OFFICE

	<u>Population</u>	<u>Health</u>
PILs	5	37
Grants/Contracts	8	9
PIO/C's / PO's	10	5
PIO/P's	17	3
HCC	<u>2</u>	<u>2</u>
Total	42	56

It should also be noted when discussing management efficiency that the Office of Population manages its portfolio with only 1/2 the number of USDH staff than does the Office of Health (2 vs 4).

Another important point to keep in mind in this discussion is that the nature of the population problem is unique in the sense that it requires official interaction and collaboration with a variety of Egyptian policy making and service delivery organizations in both the public and private sectors. Thus, to accomplish our objectives in the public sector we have grant agreements to NPC (policy formation), the MOH (Clinical services), CAPMAS (population information and research) and so on. In the private sector

we employ similar agreements with key agencies to accomplish our objectives (e.g. FOF, EFPA, CEOS). This, of course, is in stark contrast to Mission offices such as Health and Agriculture who have the comparative luxury of having to deal with almost entirely with only one GOE ministry.

A major reason for the persistence of the myth of "micro-management" of the Population Office is probably historical. Because of strong initial resistance to FP on the part of the GOE in 1977, USAID pursued a policy of "let a thousand flowers bloom". The idea was to fund almost any activity no matter how remote from actual contraceptive services, to get a foothold and establish a presence for population in Egypt's development scheme. This strategy gradually shifted by the early 1980s as the commitment to FP strengthened and it became clear which interventions were working and which were not. Over time ineffective project activities were dropped and others consolidated. The process of consolidation is still continuing. In 1980 the Office had 19 active PILs, in 1985 12 active PILs and today 5 active PILs.

The chart on pp. 41 and 42 of the PPA listing methods of implementation and financing perhaps conveys the misleading impression that the Population Project is needlessly complex in its current and proposed methods of implementation. First of all, note that the chart describes the complete sector program - all of the population "projects", (FOF, MOH, CAPMAS etc.), not just one project. Note also that most of the implementing/financing actions listed are already in place. Major new actions needed in the future will be a single PIL encompassing all MOH direct service delivery activities under the new Systems Development Project, one for MOSA/EFPA (Clinical Services Project), and one for NPC Policy, Planning, and Program Development Project (PPDP). In addition, a new cooperative agreement is planned with FOF beginning in 1988. The following illustrates the method of implementation of key activities through 1993 and indicates whether they are on-going or new.

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(Some activities are ongoing, but will need new PILs or grants after 1987 e.g. FOF and NPC):

Project Element	Method of Implementation	Ongoing	New
1) Contraceptives	PIO/Cs	X	
2) Private Commercial Sector			
FP Services			
a) FOF Project	Grant (Extension needed for ongoing project)	X	X
b) MOSA/EFPA Project	PIL		X
3) NPC			
a) EFCS (Contraceptive Research)	Grant		X
b) PPPDP Project	PIL		X
4) MOH			
a) FP Systems Development Project	PIL		X
b) CHO	PIL	X	
c) HIO	PIL		X
5) E&C			
SIS	PIL	X	
6) Pop. Statistics			
a) CAPMAS	PIL	X	

Project Element	Method of Implementation	Ongoing	New
b) BUCEN	PASA	X	
c) Cairo Demographic Center	PIL (On going activity needing new PIL)	X	X
7) Population Intermediaries			
Buy-Ins to AID/W			
Projects for technical			
Support			
FHI		X	
FPIA		X	
SOMARC		X	
RONCO			X
AED		X	

The approximately 8 new implementation actions shown above is by no means an unreasonable administrative burden for a sector program with the equivalent of 6 major projects projected to 1993: FOF, MOH, MOSA/EPPA, NPC, CAPMAS and SIS. Also included in the portfolio are 5 other activities requiring separate grants, PILs, etc. (EFCS, CHO, HIO, CDC, BUCEN, PASA) as well as several "buy-ins" that require very little USAID administrative action. Over the next 6 year period only 5 new PILs and two cooperative agreements will be needed and some of these are not actually new but are extensions of ongoing programs.

Thus, we see that despite the complex nature of the program, the Office of Population is continuing to achieve efficiencies by consolidating and streamlining actions wherever possible. However, this is not to say that the

USAID population program is any less labor intensive. In fact, if anything, it is becoming more labor intensive as we attempt to improve project monitoring and control through the establishment of a formal system of quarterly project implementation progress reviews for all major project activities. The Population Office continues to be short-staffed, a situation which will get worse as planned new projects come on stream in the near future.

There are, in fact, serious project management problems that hinder USAID implementation. But these are large Mission-wide and not peculiar to HRDC/P. For example, it normally takes weeks and often months with a very heavy investment of HRDC/P staff time to get even the simplest procurement action through the Mission. The Mission, including the Population Office, would benefit greatly from the services of a top flight management consultant to help us streamline current Mission-wide project management operations.

8.