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EGYPT HEALTH AND POPULATION LEGACY REVIEW VOLUME II: ANNEXES

MARCH 2010

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DISCLAIMER

The views of the authors expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ANNEX I: SCOPE OF WORK

USAID/EGYPT HEALTH AND POPULATION LEGACY REVIEW 2009-2010

Phase II: Fieldwork (Final/Revised: 08-24-09)

I. PURPOSE OF THE USAID HPN LEGACY REVIEW

The overall goal of the USAID Health and Population (HPN) Legacy Review is to analyze changes that occurred during USAID's long collaboration with Egypt in health and population programs and determine what conclusions can be drawn linking USAID's technical and financial investments to the documented program outcomes and impacts on the health of the Egyptian people. This twelve to eighteen month comprehensive review will provide USAID with a rich description of the health legacy—the lasting outcomes and impacts that USAID investments have achieved over more than thirty years of assistance.

II. BACKGROUND

Egypt's partnership with USAID over thirty years led to one of the world's most successful and renowned health and family planning programs, with dramatic, well-documented impacts on the health of the Egyptian people, and on the health care systems that serve them. As part of the mutually-planned phase-down of USAID support by 2011, Fiscal Year 2009 is currently slated to be the last year of funding for health and population assistance. The results of the investment and technical collaboration in Egypt are impressive. USAID has been the predominant donor, providing more than \$1 billion for Egypt's population and health sector over a thirty-year period. During the three decades of technical and financial assistance, these USAID contributions helped the Government of Egypt (GOE) and collaborating partners to reduce maternal mortality by more than 50% and infant mortality by more than 70%. The use of contraceptives has more than doubled, and the average Egyptian family size is now three children.

USAID has provided funding and technical assistance for the population-based Egyptian Demographic and Health Survey (EDHS) since 1988. DHS collects, analyzes, and presents high quality, nationally representative and internationally comparable data for use in program planning, monitoring, and evaluation and policymaking in the health sector. In addition to being the biggest DHS customer in the world, Egypt has led innovation in the collection of new data types, such as the 2008 inclusion of an avian influenza (AI) Module and a Hepatitis C biomarker. The 2008 DHS is the ninth Egyptian survey; the final DHS is planned for 2010.

As USAID phases down its support for health and population programs in Egypt, the question naturally arises: What is USAID's legacy—what lasting outcomes and impacts have USAID investments achieved? The rich DHS data sets and other data sources that document major trends over time provide an important base for USAID/Egypt to determine what relationships can be drawn between USAID-supported programs and changes in health outcomes.

III. PHASES OF THE USAID/EGYPT HEALTH AND POPULATION LEGACY REVIEW

This comprehensive review of USAID's Health and Population activities in Egypt over the last three decades is broken down into several phases. Phase I and I.5 will produce a preliminary analysis of health trends in Egypt coinciding with USAID investments in the health sector based

on DHS data (see respective Scopes of Work for illustrative questions), as well as a Framework document outlining the subsequent phases (II and III) and next steps leading towards completion of a final Egypt Legacy report for publication and distribution to diverse stakeholder audiences:

The first phase of the Legacy Review has already been completed in Washington, DC:

Phase I: Planning and Preparing the Framework. Documentation and research including identification of initial key informants and background documents, archival materials and other relevant sources, as required, extensive focused interviews with USAID/W and other US/DC-based key informants and stakeholders, and preparation of a legacy review framework for the comprehensive exercise.

An intermediate phase is currently underway in Washington, DC:

Phase I.5: Further Investigation and Analysis. Further investigational efforts to better relate Egypt's demographic, family planning and reproductive health, and maternal and child health outcomes to USAID program strategies and investments that began with the Pop/FP I project in 1977, drawing on more extensive use and review of demographic and health survey data, other quantitative data sources, and relevant program evaluations and research studies undertaken by USAID's Cooperating Agencies (CAs) active in Egypt.

Future phases of the review include the following:

Phase II: Field Work/Reporting. In country work including Cairo-based Team Planning Meeting, key informant interviews, site visits (if any), and continued information/data collection to enrich the areas of focus identified in the framework. This phase will collect information from expert informants in Egypt, and will produce a final Legacy draft report. It includes draft report discussions/analysis and writing; debriefings with USAID and stakeholders, and draft report revision and submission, final report revisions and final writing; editing/formatting and final submission, and release of final report(s).

Phase III: This dissemination phase will draw on the key findings of the Legacy Review Report in order to prepare and disseminate information and lessons learned from Phases I and 2 with a specific focus on audiences in Egypt, the US and the global health community.

IV. PHASE I – ACHIEVEMENTS AND RECOMMENDATIONS

Identify, collect, organize, and manage archival materials from a range of sources to describe the investments USAID has made in Egypt, as well as the outcomes they achieved.

The Phase I team reviewed hundreds of documents and collected almost 300 relevant documents (past strategies, program descriptions and budgets, implementing documents and agreements, program and strategy evaluations) to serve as reference and source material for the Legacy Framework and for subsequent phases of the Legacy review. GH Tech has cataloged these documents in EndNote bibliographic software, stored them electronically, and made them available on the Egypt Legacy projectspaces.com website. The background materials have been cataloged in the following selected categories:

- Communications
- Data for Decision Making
- Family Planning and Reproductive Health
- Health Systems Development

- Infectious Disease
- Maternal and Child Health
- Population and Development
- Water, Sanitation and Environment

The Phase I team also produced a color-coded timeline detailing the various USAID programs, and surveys taking place over the last three decades in Egypt.

Preliminary Lessons Learned from Phase I

The following are topics emerging from the Phase I interviews and the document review that suggest some preliminary “lessons learned”, worth keeping in mind for Phase 2 of the Legacy Review.

1. **Building evidence-based programs:** The Egypt PHN program is a useful reminder of the value of developing and shaping programs based on reliable data. Because of the resources available to USAID/Egypt, population based surveys such as the DHSs, and Maternal Mortality Surveys, as well as the Health Facility Surveys and National Health Accounts were conducted frequently enough to guide policies and programs. In some cases, unanticipated and completely new problems emerged as a result of these surveys, such as discovering from the 1995 DHS the almost universal prevalence of FGM. Data from the National Health Accounts helped build convincing evidence for health sector reform by demonstrating that the poorest Egyptians were spending a much greater proportion of their income on health than the rich, and that too small a proportion of the government’s budget was devoted to primary and preventive services. The maternal mortality surveys demonstrated the importance of improving the quality of emergency obstetrical care as a high proportion of women were still dying even under the care of obstetricians. Data from DHSs have helped establish trends in contraceptive discontinuation rates and birth intervals that have helped direct resources to problem areas. Without a doubt, building the evidence base has provided a successful foundation for strategic program management, enhanced outcomes and policy change, as well as for documenting progress.
2. **Focus on Quality:** Several decades of focus on quality of care in family planning and health services increased utilization of government primary care services and built the groundwork for a program of health services accreditation underway today. Although developing an independent network of family planning clinics in the PVO/NGO sector may have been expensive at the time, its contribution was invaluable in that these clinics had the unanticipated benefit of pushing the public sector to improve performance and quality of services. While not every element of quality improvement efforts with the MOHP (such as the “Gold Star” program) survived beyond the period of USAID support, the principal components such as the standards of clinical practice and checklists for clinics, modified over time, have provided the basis for the current system of supervision and accreditation.
3. **Policy Environment:** Lessons in public policy are both positive and negative. Strong policy level support from the President’s office for population programs has been, and continues to be, an enormously important asset. This kind of broad political-level support facilitated involving both political and religious leaders in the national population program in a way that has been greatly facilitated reaching every segment of society in Egypt. On the other hand, at a more programmatic level, specific policy or regulatory barriers may constrain achieving some program results and inhibit institutionalizing new initiatives. The fact that there has not been much progress in incorporating private providers into the health policy reform

program, or changing government pricing strategies for contraceptives in order to improve the commercial availability, are examples.

4. **Behavior change and communication:** Developing and institutionalizing IEC and BCC for public health outcomes in the State Information Service, rather than in the IEC Unit of the Ministry of Health, was a very important programmatic decision. It makes more sense to build capacity in an entity that has expertise in this area, rather than in a Ministry that should be focusing on service provision. The program today, however, must go beyond government institutions and take advantage of commercial channels as well as civil society organizations and professional associations, as the medium for reaching people is growing increasingly more pluralistic and sophisticated. Establishing positive health norms is a dynamic process that includes life style choices such as smoking cessation, diet and exercise, a desire for smaller families, breastfeeding, as well as appropriate use of health services.
5. **Flexible modes of programming:** The USAID PHN program in Egypt has benefited from the variety of mechanisms available to channel funds and technical assistance. Funds provided directly to the MOHP through Project Implementation Letters (PILs) and Implementation Letters (ILs) ensured that budgets were available for program recurrent costs (e.g. supervision and training) and built strong ownership and involvement of the MOHP units implementing USAID supported programs. Financial management capacity was also built. The variety of other mechanisms such as the CIP commodity import program, the funds generated from PL480 proceeds, and the policy reform cash transfers also facilitated and helped support the technical assistance activities within contracts and cooperative agreements. The challenge, as the USAID program in Egypt shrinks, is to ensure that the funds for the recurrent costs of key programs are adequately planned for in the regular GOE budget in future years.
6. **Graduation terminology:** In the process of conducting the interviews for developing the Legacy Framework, the question about the “graduation” of the Egypt PHN program generally drew a negative response. Interviewees acknowledged that while Egypt has become a middle-income country with strong health and population indicators, and the nature of the partnership between Egypt and US may need to change, most felt that the term ‘graduation’ was patronizing and inappropriate. A number of areas of program vulnerability were also mentioned in which continued collaboration could help ensure further improvements and a sustained high level of performance in the sector. Interviewees also felt that a continuing relationship in PHN was beneficial to both Egypt and the US, and that it should evolve toward a program based on technical and strategic information exchange and learning.

V. PHASE II—OBJECTIVES, ILLUSTRATIVE QUESTIONS (AND ISSUES TO BE ADDRESSED)

This section describes the second phase of this legacy review process, the fieldwork and reporting phase, of a multi-phase effort to determine what relationships can be drawn between USAID-supported programs and changes in health outcomes, and then, to describe the health legacy outcomes and impacts that USAID investments have achieved.

Illustrative Questions:

The key informant interview guide that was prepared and used in Phase I is attached for reference (Annex I). The Phase II team may adapt this for their in country work. Additional illustrative questions are outlined below:

Resources

- Characterizing the magnitude of USAID financial resources obligated to PHN programs over the past 30 years is an important task for Phase II. Roughly what were the annual obligations for projects during this period? Of these obligations, what proportion was committed to technical assistance contracts or cooperative agreements, how much was obligated through PILs and ILs, how much was obligated through cash transfer or other non-project mechanisms?

Family Planning and Reproductive Health

- What factors may account for the apparent slow-down in Egypt's FP performance since 2000? Have budget allocations and shifting program priorities played a role? Might the push toward greater program integration over the past decade reduced emphasis on family planning services? With the new Family Health Model, is there evidence that family planning or other key services are given less emphasis with the integrated service delivery model? What are the specific issues or areas of concern? Are any steps being taken to address these concerns?
- In Egypt, the public sector plays an increasingly important role in providing FP and other RH services. What accounts for the dominance of the public sector? This trend runs counter to many other countries where the private sector (doctors, nurses, clinics, hospitals, and pharmacies) play an ever greater role.

Maternal and Child Health

- What interventions account for the dramatic fall in Egypt's maternal mortality rates and ratios in recent years? Where have these declines been most pronounced, have they taken place in areas with higher FP use (resulting in fewer high risk pregnancies)? To what extent might USAID's funding and technical support contributed to these declines?
- Do the nurse/midwives trained in recent decades provide mothers with significantly improved delivery outcomes? What trends can be identified in providing more Egyptian women with access to emergency obstetric care? To what extent might the new Maternal Mortality Surveillance System be utilized to assess some of these delivery outcomes during the Legacy Team's proposed visit to Egypt?
- What is the current status of diarrheal disease and ARI efforts that were previously supported by USAID? In theory, they have been incorporated into the new IMCI program, but how widespread is IMCI and how well is it functioning?

Behavior Change and Communication

- What is the current status of behavior change and communications work at CHL and SIS? Have earlier investments in these organizations (by CCP and others) proved sustainable? What elements are still functioning well and what innovations from the past might have diminished staying power?
- In addition to the DHS data which shows trends of increasing awareness of family planning and MCH issues, are there other studies or data that link USAID's program for AI

prevention or HCV with improved knowledge and practice about those diseases? Are there other areas of improved knowledge and practice of health that can be attributed to efforts supported by USAID?

Health Sector Reform/Health Systems Development

- In what ways did the USAID support for various elements of health sector reform contribute to the MOH's current health reform program? This includes National Health Accounts, DDM's early analytic work on PHC sector reform, PHR and PHR+ work on cost analysis, basic benefit packages, accreditation, equity studies, Health Sector Reform pilot projects, etc. How are the current projects like HS 20/20, Takamol and CHL contributing?
- How much of USAID's support for Health Management Information Systems has become institutionalized in the MOHP primary care programs, HIO, CCO and hospital sectors? How reliable is the current HMIS in the MOH?
- What has been the contribution of the two large Health Policy Reform Cash Transfer programs to health sector reform and health systems development? Were there any drawbacks or lessons learned?
- What can be concluded about the USAID-funded program with the US Department of Health and Human Services (DHHS) which has also spanned a 30 year period and covered a wide variety of health topics outside of USAID main areas of focus. (Please clarify what is the HHS program?? MOH in efforts to address the growing importance of chronic disease prevention, control, and treatment as part of the Healthy Egyptian initiative and earlier programs? Were there any lasting health system changes (e.g., in terms of training, disease monitoring and surveillance, and clinical practice) that resulted from this effort?
- Institutional and human capacity development has been strong themes and an overall aim of USAID's program in Egypt. To what extent have these objectives been achieved and in what areas? Large numbers of people were provided leadership and technical skills development through the participant training programs and through short-term training activities in most technical assistance contracts and cooperative agreements. Large numbers of mid-level managers were trained to develop skills in planning, health management information systems, administration, workforce development, logistics management, and financial analysis and management. How did those training investments benefit the program and to what extent has the capacity developed been institutionalized and sustained?
- Ultimately, has enough been achieved and made sustainable to talk meaningfully about USAID leaving Egypt (graduating the country) or is enough undone (or faltering) to justify a major renewed programmatic commitment? And should new forms of partnership be developed for priority needs in population and health that will continue USAID's presence in Egypt, but with new modes of technical collaboration, project strategies, project operations, and budgetary mechanisms?
- From USAID's long experience in Egypt, do there appear to be any specific factors that contribute to or are closely linked with achieving program or system sustainability? Have programs supported previously by USAID continued, and if so with GOE funding or simply by shifting to other donors? Has the GOE made sustainability more likely by tying performance to incentives in some way? What progress, if any, has been made to maintain health infrastructure such that continuous rebuilding is not necessary (which has been the pattern in Egypt)?

The Phase 2 team will also help develop recommendations for the work for Phase 3. This will include consulting with USAID/Egypt about the potential audiences for the Legacy dissemination

in Egypt, as well as with the Near East Bureau in USAID/Washington, and making recommendations about the type of skills needed to develop the dissemination strategy and products during Phase 3.

VI. PHASE II—METHODOLOGY

The Phase II: Fieldwork team should consider a range of possible methods and approaches for collecting and analyzing the information which is required to prepare comprehensive Legacy Report. Data collection methodologies will be discussed with, and approved by, USAID at the start of phase II. Upon initiation of this phase, the team will develop a work plan including timelines for document review, meetings, interviews, and deliverables as detailed below:

Document Review

The Phase II team will review the Phase I Legacy Framework document, as well as the library of background materials compiled by GH Tech. The Research Assistant will continue to manage incoming documents, update the EndNote library, bibliography, and projectspaces.com site. He/she will provide support, as requested by the Team Leader, to retrieve additional resources.

Team Planning Meeting

- A preliminary one day planning meeting will be held with US-based team members in Washington, DC to begin preparing the work plan and the methodology plan. Once the team has arrived in Egypt, a comprehensive two day team planning meeting will be held in Cairo with all team members to finalize the work plan and the methodology plan. This will be shared with USAID/Egypt prior to actual implementation. The team planning meeting agenda may include the following items:
 - Clarify team members' roles and responsibilities,
 - Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion,
 - Review and develop final evaluation questions
 - Review and finalize the assignment timeline and share with USAID,
 - Develop data collection methods, instruments, tools and guidelines,
 - Review and clarify any logistical and administrative procedures for the assignment,
 - Develop a preliminary draft outline of the team's report, and
 - Assign drafting responsibilities for the final report.
 - Interview list for Cairo?

Key Informant Interviews:

- The Phase II team will conduct selected in-depth key informant interviews with former USAID HPN staff, partners, other interested Egyptophiles, and other stakeholders in the Washington area and in Egypt in order to engage in critical discussions, to add detail to the findings of Phase I investigations, and to draw more in-depth conclusions about USAID's activities in Egypt, forming a foundation for the final Legacy report.

Site Visits

The Phase II team will coordinate with USAID/Egypt to prepare for and conduct site visits while in-country, and to interview key informants at these sites and in Cairo. While in-country, the Phase II team will also work with a financial analyst (preferably a local consultant) who will work with USAID/Egypt to reconstruct as much as feasible of USAID health program obligations in the earlier years, and a health sector reform analyst (also preferably a local consultant) who will focus on analyzing and documenting the contributions USAID made to Egyptian health sector reform efforts.

Secondary Data Analysis

At the discretion of the Team leader and USAID/Egypt, the Senior Demographer will continue to conduct analysis of secondary data (Egypt Demographic and Health Surveys, 1975 World Fertility Survey, 1983-84 Contraceptive Prevalence Survey, and other source materials as needed to support and enrich the team's findings. The team will look into developing a "Rapid" type presentation that helps non-health audiences understand the impact of Egypt's demographic and health accomplishments. The Scott Moreland paper will be a starting point for this work.

Wrap-up and Debriefing

At the conclusion of Phase II in country work, there will be debrief meetings with both USAID/Egypt and other interested parties to share findings and get final inputs before preparing the Legacy report.

Advisory Committee

The Phase II team will present its findings and seek feedback from subject experts on the Advisory Committee before completion of the final Legacy report.

VII. DELIVERABLES

The team will produce the following deliverables:

1. **Work Plan:** During the Cairo-based Team Planning Meeting, the Phase II team will prepare a detailed work plan which will include the methodologies to be used in this phase of the work. The work plan will be submitted to the Office Director at USAID/Egypt for discussion and approval.
2. **Methodology Plan:** A written methodology plan (preliminary site visit and interview schedule/operational work plan) will be prepared during the Cairo-based Team Planning Meeting and submitted to the Office Director at USAID/Egypt for review and approval. Any outstanding issues will be discussed with USAID prior to implementation.
3. **Debriefing with USAID/Egypt:** The Team will present the major findings of the Phase II fieldwork through a PowerPoint presentation. The debriefing will include a discussion of the findings, conclusions, recommendations for next steps and outline of the report. The team will consider USAID comments and incorporate those comments and changes into the draft report, if appropriate, prior to submission to USAID.
4. **Draft Legacy Report:** A draft report of the findings and recommendations should be submitted to the USAID Office Director after the team's departure from Cairo. The written report should clearly describe findings, conclusions and recommendations including next steps. USAID will provide comments on the draft report.
5. **Final Legacy Report:** The team will submit a final report that incorporates the team responses to Mission comments and suggestions no later than ten days after USAID/Egypt

provides written comments on the team's draft framework report (see above) and the Advisory Committee has provided feedback. This report should not exceed 40 pages in length (not including appendices, lists of contacts, bibliography, etc.). The format will include an executive summary, table of contents, methodology, findings, and recommendations. The report will be submitted in English, electronically. The Legacy Report will be a polished document whose primary purpose is dissemination to a variety of USAID-selected audiences (TBD).

The final report will be edited/formatted by GH Tech and submitted to USAID/Egypt approximately one month after the Mission has reviewed the content and approved the final revised version of the report. This final revised version of the report can be used as a working document while final report editing/formatting is in process by GH Tech.

The team will also provide a presentation on the Legacy report to be arranged through the Near East Bureau in collaboration with the Bureau of Global Health.

VIII. PROPOSED TEAM COMPOSITION

The GH Tech team will provide the following team members (illustrative designations):

Core Team Members

1. Team Leader/Health Program Specialist- Planning Coordinator
2. Senior Demographer/Data Analyst
3. Population/FP Specialist
4. Public Health Specialist
5. Organization/Institutional/Human Resources/Capacity Building Specialist

Short Term Analysts_(local consultants preferred)

1. Financial Analyst
2. Health Sector Reform Analyst
3. In-country Admin Assistant for scheduling and admin support

Support Team Members:

1. Research Assistant

Advisory Committee Members

While not formal team members, Advisory Committee members will continue to provide advice and feedback to the team throughout the assignment. The Phase I Advisory Committee consisted of Bob Emrey (USAID), Dr. Sameh El Saharty (World Bank), Dr. Ann Way (Macro International), Dr. Marge Koblinsky (JSI) and Elizabeth Schoenecker, (USAID). It is anticipated that the composition of the Advisory Committee will remain unchanged for subsequent phases of the Legacy Review.

Time Line and Level of Effort

USAID/Egypt anticipates that the period of performance of this Phase II: Fieldwork to be approximately September 2009 – January 2010.

The Team Leader will be responsible for the overall planning and implementation of the first task and work coordination among team members; submission of a satisfactory Legacy Report to USAID within the agreed timelines; and overall report writing coordination and the organization of the debriefing presentations.

Illustrative LOE and timeline: Core Team Members only

Task/Deliverable	Duration/LOE	
	Team Leader/Health Specialist*	Core Team Members (4)
Phase II: Fieldwork		
Prepare for fieldwork		
<ul style="list-style-type: none"> DC-based preliminary Team Planning Meeting 	1 day	1 day
<ul style="list-style-type: none"> Review Legacy Framework; detailed document review and discussion 	8 days	7 days
<ul style="list-style-type: none"> Adapt questionnaires for key informants & stakeholders 	1 day	1 day
<ul style="list-style-type: none"> Interviews w/ USAID/W & DC-based key informants 	5 days	5 days
<ul style="list-style-type: none"> Schedule in-country interviews and site visits 	3 days	3 days
Fieldwork – In country		
<ul style="list-style-type: none"> Travel to Egypt 	2 days	2 days
<ul style="list-style-type: none"> Cairo-based Team Planning Meeting 	2 days	2 days
<ul style="list-style-type: none"> In-country briefing with USAID/Egypt 	1 day	1 day
<ul style="list-style-type: none"> Conduct informant interviews and site visits 	11 days	11 days
<ul style="list-style-type: none"> Discussion, analysis and draft report writing in-country 	3 days	3 days
<ul style="list-style-type: none"> Debriefing with USAID/Egypt 	1 day	1 day
Return to Washington, DC	2 days	2 days
<ul style="list-style-type: none"> Complete analysis of all information collected to date, continue draft report writing 	10 days	10 days
<ul style="list-style-type: none"> Prepare presentation; debrief Advisory Committee 	2 days	2 days
<ul style="list-style-type: none"> Complete and submit draft report to USAID for comments and feedback 	3 days	3 days
USAID completes final review (10 working days)		
<ul style="list-style-type: none"> Incorporate Mission comments on draft report and finalize complete Legacy Report 	5 days	3 days
GH Tech edits/formats report (30 days)		
Total Estimated LOE (Core Team Members)	60 days	57 days each

*A six-day workweek is approved while in country.

In addition to the core team members, LOE will be budgeted for supplemental team members who will provide critical inputs throughout Phase II of the Review, at the discretion of USAID/Egypt and the Team Leader, as follows:

Illustrative LOE: Supplemental Team Members

Phase II: Planning the Framework	Duration/LOE
Financial Analyst (local consultant)	15 days
Health Sector Reform Analyst (local consultant)	15 days
GH Tech Research Assistant(s)	20 days
Total Estimated LOE (Supplemental Team Members)	50 days

IX. REVIEW LOGISTICS

USAID/Egypt will provide overall direction to the Phase II team, identify key documents, key informants, site visit locations, and assist in facilitating a work plan. USAID/Egypt personnel will be available to the Team for consultations regarding sources and technical issues, before and during the Legacy Review process.

GH Tech will provide support for the Phase II team when they are working in Washington, DC including work space, projectspaces.com access, set up interviews and meetings, host the Team Planning Meeting, etc. GH Tech will also prepare logistics arrangements for the team's fieldwork portion of the assignment. The GH Tech team will be responsible for all in country logistics, team meeting space and other related support services.

X. KEY DOCUMENTS

- Egypt Legacy Review Framework
- List of Key Informants from Phase I Egypt Legacy Review
- A bibliography and library of relevant program assessments and evaluations, strategic plans, studies, and other background materials has been assembled and cataloged by GH Tech as a product of document reviews in Phase I. This will serve as the Legacy Review team's primary source for reference documents.
- USAID/Egypt will provide additional key background documents to the team in advance of the assignment. As the team receives additional background documents and source material from USAID/Egypt and key informants, GH Tech will continue to collect and catalog these resources.

XI. KEY MISSION CONTACTS

- Holly Fluty Dempsey, Director, Office of Health and, Population
- Vicki Stein, Deputy OD
- Lisa Childs, Population/FP/MCH Program Manager
- Shadia Attia, M&E Specialist
- Other Health Office Members as appropriate

ANNEX I: QUESTIONS FOR PHASE I INTERVIEWEES

Review Legacy—Phase I objectives

Prep Questions:

- What years and in what capacity did you work in Egypt?
- What were the major HPN program areas during your tenure?
- What technical-program area did you have the greatest involvement and knowledge?

Strategic and Programmatic Questions:

- During your tenure, what were some of the key strategic themes that were of greatest importance to the program achievements? (sustainability, integration, capacity development, graduation, etc)
- Can you remember and describe any specific policy or program areas during your involvement in Egypt when USAID made a specific substantive contribution to addressing the strategic themes of greatest importance?
- Name three specific areas do you feel that USAID has made the biggest contribution in terms of achieving PHN outcomes and impact? Why would you choose those areas?
- Do you believe that there is sufficient data or qualitative information to develop a credible association between USAID's investment in those three areas and the outcomes in Egypt? What concrete evidence would you cite?
- Do you know whether the achievements we are talking about have been sustained and continued by the Egyptian government?
- Were there substantive inputs, or collaboration with USAID, from other donor organizations that contributed to achieving the outcomes we have been discussing?
- Do you have, or can you recommend any specific materials (reports, evaluations, surveys) you can share that would help the Legacy team document USAID's contribution to impact in those areas?
- In any of those specific areas, what decisions were made or action taken by the Egyptian government that helped ensure achievement of outcomes?
- Are there specific areas where you think additional secondary analysis of DHS data would help substantiate the impact of USAID's PHN assistance program in Egypt, specifically in the three areas cited earlier?
- In Egypt, USAID used many programming mechanisms such as TA contracts, direct financing through Implementation Letters, budget support tied to policy reform, the Commodity Import Program, etc. From a local ownership, capacity development, effectiveness and sustainability point of view, which mechanisms were most important, and what do you feel were the advantages and disadvantages of these mechanisms? Was the mode of assistance important to achieving program outcomes?
- Were there any decisions or programmatic actions taken by USAID that you would, in hindsight, feel were mistaken or misguided? Why?

Optional Questions (if time permits)

- What do you think about USAID's current plan to graduate out of PHN sector work in Egypt by September 2011? Why?

Any advice for the team? Any documents or data to share? Any other people we should contact? Are there other questions we should be asking?

ANNEX 2: REFERENCE LIST

COMMUNICATIONS

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ANNEX 3: KEY INFORMANTS

KEY INFORMANTS FOR PHASE I

Interviewees

Name	Egypt Knowledge –Time Period	PHN Program Elements
Mickey Aramati	1980–87, 1990–2002	FP/RH
John Borrazzo	2000–2009	Water-sanitation
Carol Carpenter-Yaman	1990–1995	FP/RH
Dennis Carrol	2006–2009	AI, pandemic flu
Andrew Clements	2006–2009	AI, pandemic flu
Connie Collins	1980–1985	CS
Coleen Conroy	1996–present	Maternal health
Gary Cook	2000–2009	All program elements
Brenda Doe	2000–2005	FP/RH
Bob Emrey	1979–2009	All program elements
Reg Gipson	1985–2005	MCH
Sarah Harbison	1993–1995	FP/RH
Ron Hess	1990–2009	All program elements
Marge Koblinsky	1996–1998	Maternal health
George Laudato	1976–1980, 1984–88	All program elements
Dick Martin	1995–1999	FP/RH
Nahed Matta	1980–2009	MCH
Peter Miller	1980–1990	FP
Vikka Molldren	1985–1990	All elements
Maureen Norton	1995–2009	FP/RH
Kathy Panther	2000–2006	FP/RH
Leslie Perry	1995–2000	FP/RH
Billy Pick	2000–2009	HIV/AIDS
Carl Rahman	1994–1998	MCH, HHS, ID
Warren Robinson	1993–1995	FP/RH
Margaret Rowan	1990–2004	FP/RH
Sameh El Saharty	1990–2007	HSS
Liz Schoenecker	1996–2005	FP/RH
Mellen Tanamly	1990–1997	MCH, ID
Ann Way	1988–onward	All program elements

KEY INFORMANTS FOR PHASE II

IN THE UNITED STATES

U.S. Agency for International Development

Anne Aarnes, Deputy Assistant Administrator, Bureau for Near East

Richard Ainsworth, retired (USAID Egypt 1993–2005)

Connie Collins, retired (USAID Egypt 1980–1985)

Bob C. Emrey, Chief, Health Systems Division, Office of Health, Infectious Diseases and Nutrition (HIDN) also Legacy Review Advisory Board

Elizabeth Fox, Deputy Director, Office of Health

Linda Lou Kelley, (USAID Egypt 1995–1999)

George Laudato, Assistant Administrator Bureau for Near East

Richard Martin, retired (USAID Egypt 1995–1999)

Nahed Matta, Maternal and Newborn Health Advisor, Office of Health, Infectious Diseases and Nutrition (HIDN) and former FSN, USAID/Egypt PHN Office

Peter McPherson, retired USAID Administrator

Jane Nandy, Middle East Bureau

Gary Newton, retired (USAID Egypt 1995–2000)

Carl Abdou Rahmaan, Afghanistan Pakistan Task Force (USAID/Egypt 1993–1998)

Bill Reilly, Egypt Desk Officer

Elizabeth Schoenecker, Chief, Policy, Evaluation and Communications Division, Office of Population, and Legacy Review Advisory Board

Barbara Turner, retired Deputy Assistant Administrator and current President –University Research Co.

Francisco Zamora, AFSA (former USAID/Egypt)

U.S. Department of Health and Human Services

Jane Coury, Office of the Secretary for International Health

Doug Hatch, US Centers for Disease Control

Frank Mahoney, US Centers for Disease Control

OTHER ORGANIZATIONS

Abt Associates, Inc.

Ayman Abdelmohsen, MD, MSc, Principal Associate, International Health

Catherine Connor, Deputy Director, Health Systems 20/20

Brandeis University

Nanda Kumar, School of Public Health

John Snow, Inc.

Reginald Gipson

Diaa Hammamy, formerly Rural Health Project and also National Diarrheal Disease Control program

Marge Koblinsky, also Legacy Review Advisory Board

MACRO Systems

Ann Way, also Legacy Review Advisory Board

Population Council

Peter Miller

UNICEF

Ian Pett, Health Reform Specialist

World Bank

Peter Berman

Sameh El-Saharty, Legacy Review Advisory Board

Individuals

Nihal Afez Afifi, former Cost Recovery for Health and health sector reform consultant

Carol Branich, former QA Adviser for Pop III and later JHU/CCP

Samer El-Kamary, Assistant Professor, Division of international Health, Department of Epidemiology, University of Maryland, formerly worked on Hepatitis C Program in Egypt

Alan Fenwick, formerly MSCI Chief of Party under the Schistosomiasis Research Project

Sabry Hamza, OB/GYN former medical school professor. Healthy Mother/ Healthy Child project

Neeraj Kak, formerly with the Futures Group in Egypt

Scott Moreland, RTI and author of “Egypt’s Population Program: Assessing 25 Years of Family Planning”

Betty Ravenholt, former Executive Director SOMARC project

Warren Robinson, author, [The Demographic Revolution in Modern Egypt](#)

G. Thomas Strickland, retired Professor of Epidemiology and Preventive Medicine, University of Maryland

Michael Thompson, formerly with The Futures Group in Egypt

IN EGYPT

U.S. Agency for International Development–USAID/Egypt

Manal Alfred, Development Outreach and Communications Officer

Hilda Arellano, Mission Director

Shadia Attia, Research Advisor

Lucie Cantsilieris, Project Management Assistant

Lisa Childs, Health Officer, Office of Health and Population

Thomas Delaney, Deputy Mission Director
Holly Fluty Dempsey, Director, Office of Health and Population
Akmal Elerian, Manager IDSR Project
Thomas Easley, AI Program Officer
Christine Ezzat, Project Management Advisor
Mahinaz El-Helw, Senior Health Specialist, Health Sector Reform and Communication Programs,
Office of Health and Population
George Sanad, Project Management Specialist, Office of Health and Population
Amani Selim, Program Evaluation Officer, Program Office
Vikki Stein, Population and Health Officer, Office of Health and Population
Fawzia Tadros, retired USAID/Egypt

Office of the President of Egypt

Dr. Magued Osman, Director, Information and Decision Support Office

Ministry of Health, Egypt

Dr. Sohair Wilson Amin, Primary Health Care
Dr. Mohsen Mohamed Fathy, Executive Director Reproductive Health Project
Dr. Hassan El Gabaly, Retired Director of Family Planning Services
Dr. Ali Gadalla, Director General Quality Department
Dr. Abdel Halim, Population and Family Planning
Dr. Nagwa El-Hosseney, Quality Control Advisor and Accreditation
Dr. Amr Kandil, Undersecretary for Infectious Diseases
Dr. Hassan El Khalla, formerly Cost Recovery for Health Project
Dr. Taha A/G El-Khoby, retired Undersecretary, Schistosomiasis
Dr. Esmat Mansour, retired Undersecretary for Maternal and Child Health
Dr. Lamia Mohsen, Advisor to Minister for Neonatology
Dr. Mohamed Mostafa, Director General Schistosomiasis and Endemic Disease Control
Dr. Khaled Ahmed Nasr, Undersecretary of Integrated Health Care
Dr. Mona Rakha, Director General of Childhood Illness
Dr. Samir Abdel Aziz Refaey, Executive Director Epidemiology and Disease Surveillance Unit
Dr. Nasr El-Sayed, Undersecretary for PHC Preventive Medicine and Family Planning
Dr. Moushira El Shafei, retired Undersecretary
Dr. Mehi El Tehewr, Quality Specialist
Dr. Hoda Zaky, Special Advisor to the Minister of Health for Nursing Services

Ministry of State for Family and Population/National Council for Childhood and Motherhood (NCCM) and National Population Council NPC)

Mona Amin, Combatting Female Genital Mutilation Program, NCCM
Dr. Safa E Baz, Former Secretary General, NPC
Aziza M. Helmy, Senior Advisor and Media Supervisor, NCCM

Moshira Khattab, Minister of State for Family and Population
Sherine Mourad, M&E Expert, NPC
Delhia Tawah, Program on Family Justice, NCCM

State Information Service

Mohsen Mohamed Fathy, Director Information, Education and Communication Center
John Hill, IT Consultant, Communication for Health Living, SIS IEC Center
Ismail Khairat, Chairman, State Information Service
Dr. Abdul Kareem Thabet Rashwean, Deputy Chairman, State Information Service

OTHER ORGANIZATIONS

Abt Associates, Inc.

Dr. Samir Mansour, Technical Coordinator, Health Systems 20/20
Dr. Nadwa Rafeh, Chief of Party, Health Systems 20/20

Ain Shams University

Dr. Safa El Baz, Director, Regional Center for Training in Family Planning and Reproductive Health, Faculty of Medicine

Al Galaa Teaching Hospital

Dr. A.K. Shoubary, General Director

American University of Cairo

Dr. Ray Langsten, Professor

Cairo University

Dr. Hussein Abdel Azziz, Professor

Cairo Demographic Center

Dr. Magdi Abdel Kadr, Cairo Demographic Center
Dr. Fadia Adbel Salam, Director Cairo Demographic Center

Clinical Services Improvement Association

Dr. Mohamed Sweed, Executive Director
Dr. Magdy Zein, Medical Quality Management Director

Credit Guarantee Corporation

Nagla Bahr, Executive Director, CGC Consult
Hussein Bakry, HCP Program Manager
Emad El Sabagh, Operation Specialist
Hamdy Said, Financial Analyst

Egypt Finance Executives Foundation

Sherif Fathy, Chairman

Egyptian Medical Syndicate

Dr. Gamal Esmat

Dr. Hamdy El-Sayed, President

El-Zanaty Associates

Dr. Fatma el-Zanaty, President

European Union

Millie Howard, EU consultant

Health Care International

Dr. Samy Gadalla, Chairman and Managing Director

Dr. Hassan ElGebaly, Board Member

Health Insurance Organization

Dr. Abou Bakr

Dr. Mosen

Johns Hopkins University, Center for Communication Programs

Dr. Samir Al-Alfy, Deputy Chief of Party, Technical Senior Communication Advisor, Communication for Healthy Living

Dr. Hassan ElGebaly, Communication Advisor, Communication for Healthy Living

Ron Hess, County Director, Chief of Party, Communication for Healthy Living

Dr. Tawhida H. Khalil, Senior NGO Comm. Advisor, Communication for Health Living

Dr. Hassan El-Shiekh, Private Sector Network and Training Sr Advisor, Communication for Healthy Living

Abdel Bary B. Taher, Senior Comm. Advisor, Communication for Healthy Living

Pathfinder International

Dr. Said El-Dib, Hospital Services Team Leader, Takamol Integrated Reproductive Health Services Project

Manal Eid, BCC Team leader, Takamol

Dr. Shahira Hussein, Assistant Deputy COP, Takamol

Dr. Gamal El-Khatib, Takamol

Hossam Morassa, Takamol

Dr. Rannia Moustafa, Deputy Chief of Party, Takamol

Eng. Mohamed Abou Nar, Chief of Party, Takamol

Dr. Nader Nassif, Private Sector Team Leader, Takamol

Dr. Nagwa Samir, PHC Services Team Leader, Takamol

Maged Youssef, Field Operations Team Leader, Takamol

Population Council

Dr. Nahla Abdel-Tawab, Director, Reproductive Health Research

Tropical Medicine Institute

Dr. Mohamed Abdel Hamid, Director of Virology Lab

UNFPA

Dr. Magdy Khaled, Assistant Representative

World Health Organization

Dr. Zuhair Hallaj, WHO Egypt country Representative

Dr. Ramez Mahaini, Women's Reproductive Health Advisor, WHO

Alexandria Governorate

Mrs. Aziza, Nurse Trainer, Abdel Nasr Hospital

Dr. Asmat, OB/GYN, Clinical Services Improvement Association

Dr. Mohammed Farag, Health Systems 2020, Medical Workshop Trainer

Dr. Farouq, Clinic Director, Clinical Services Improvement Association

Dr. Ali Hegazi, Director, Abdel Nasr Hospital (HIO)

Dr. Nagwa, Accreditation and Quality Assurance Auditor Trainer, Abdel Nasr Hospital

Dr. Rafaat Ibrahim Refaat, Deputy General Manager, International Medical Technology, Ltd.

Dr. Tom Schwark, Abt Associates consultant, Abdel Nasr Hospital

Fayoum Governorate

Dr. Hussein Raafat Ahmed, Avian Flu Officer, Save the Children

Dr. Ari Famy, Treasurer, Community Development Association

Dr. Ahmed Al Masseri, Director General Family Planning, Fayoum Governorate

Dr. Sanaa A. Haroon, Consultant for Childhood and Motherhood Program and Professor at Fayoum University

Dr. Hussein, Undersecretary for Health Services for Fayoum Governorate

Mona Abdel Mogheeth, Communication for Healthy Living Officer

Nakalifa Primary Health Unit

Galal Mostafa Said, Governor, Fayoum Governorate

Abu Bakr El Sedik, Community Development Association

Gharbia Governorate

Dr. Sohir Ashwar, MCH Administration, Gharbia Governorate

Dr. Daha, Taskforce Coordinator for Human Resources, Gharbia Governorate

Dr. Sherif Hammoda, Undersecretary for Health Services, Gharbia Governorate

Dr. Ibou, Technical Inspection Administration, Quality Control

Dr. Sayed Shashar, Director, Hospital El Menshawi

Dr. Rufaida Sultan, Director of Health Information Center, Gharbia Governorate

Ismailia Governorate

Dr. Mohammed Abuzeid, Director, Ismailia General Hospital

Dr. Mohammed Al Sharkawy, Undersecretary for Health Services, Ismailia Governorate

Ms. Dina Babawi, Community Services Director, Takamol Project, Ismailia
Dr. Mohammed Elawadi, OB/GYN, Takamol consultant at Ismailia General Hospital
Dr. Ibrahim El Desouki, District Health Officer, Ismailia Governorate
Dr. Sayeda, Clinic Director, Sabaa Abar (Seven Wells) Primary Health Unit

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Dr. Hussein Abbass, Director of Neonatal Unit, Al Byadya District Hospital
Dr. Samir Farag, Governor of Luxor
Dr. Kamal Fawzi, Director of Obstetrics and Gynecology Al Byadya District Hospital
Dr. Gamal, Al Byadya District Hospital
Dr. Habil, Al Byadya District Hospital
Dr. Osama Kiriti, Field Office Coordinator for Luxor and Qena, Takamol
Dr. Mervat, Head of Family Planning Unit, Al Byadya District Hospital
Dr. Jusef AbdelWafaa Mohamed, Director of Al Hevail Primary Health Unit
Dr. Nabila, Al Byadya District Hospital
Nagwa El Nahas, Assistant Field Office Coordinator for Qena and Luxor, Takamol
Dr. Mohamed Nematallah, Under Secretary of Health
Dr. Ahm El Nouby
Dr. Hossam Rasekh, Sustainability Committee
Dr. Obour Sallam, District Health Officer, Luxor
Nagwa Samir, PHC Services Team Leader, Takamol
Dr. Jihan Shafik, Takamol
Director, Al Byadya District Hospital

Minia Governorate

Mr. Ahmed Anwar, Director of CHL Project, Arab Women's Alliance
Staff of Saft El Kamar Primary Health Unit
Mrs. Intisar, Volunteer, Saft El Kamar Village Positive Deviance/Hearth
Mme. Intisar Mohamed, Head of Board of Directors, Arab Women's Alliance
Dr. Ayman Ragab, UnderSecretary of Health
Boy's Preparatory School, Saft El Kamar Village

Qena Governorate

Dr. Mohamed Fareed, CHL
Mohamed Kamal, CHL
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Dr. Janette, Family Planning Officer, Armant District
Dr. Ayman Abdel Moniem, Under Secretary of Health
Dr. Rafaat Mohamed Abd Al Rehim, District Health Officer
Dr. Sharif, District Health Officer, Armant District
Dr. Suad, Accreditation On the Job Trainer for Isna District

Dr. Tawhida Khalil, CHL

Dr. Siham Yasin, Save the Children

Mohamed Nagy, Supervisor of Capacity Building in Fayoum, Minia and Qena for Save the Children

Members of Women's CDA in El Gabal Village

Members of Dawar in El Gayara Village

Sharkia Governorate

Dr. Aida, MCH Directorate

Mohammed Alshami, Undersecretary for Education, Sharkia Governorate

Hamdi Bakr, Secretary General Sustainability Committee, Sharkia Governorate

Heny Fathye, Undersecretary Finance

Dr. Sayed Abou Al Khier, Undersecretary for Health Services, Sharkia Governorate

Yhaia Abdel Maguied, Governor, Sharkia Governorate

Abdel Raaouf, District Health Manager of Minia Al Kamaha District

Abdel Badyaa Al Sady, Undersecretary Social Solidarity

Sayed Mansour, Undersecretary for Youth and Sports, Sharkia Governorate

ANNEX 4A: USAID/EGYPT OBLIGATIONS FOR HEALTH & POPULATION SECTORS FROM FY 1976–FY 2009 (\$ 000)

FY 1976–FY 1984

Agreement Number	Agreement Title	Start Date (Agreement)	End Date (PACD)	FY 1976	FY 1977	FY 1978	FY 1979	FY 1980	FY 1981	FY 1982	FY 1983	FY 1984
Cash Transfer												
263K638.00G	HEALTH POLICY SUPPORT	9/28/1997	9/30/2003									
263K650.00G	HUMAN RESOURCES & ECONOMIC SECTOR DEVELOPMENT	9/30/2007	9/30/2010									
	Total Cash Transfer											
Commodity Import (CIP)												
	PUBLIC SECTOR CIP											
	PRIVATE SECTOR CIP											
	Total CIP											
Health and Nutrition												
2630015.00G	STRENGTHENING RURAL HEALTH DELIVERY	9/30/1976	3/30/1987	1,700		1,900	4,200				4,500	2,600
2630065.00G	URBAN HEALTH DELIVERY SYSTEMS	11/19/1978	11/18/1988				4,953	20,300	12,000			
2630136.00G	SUEZ CANAL AREA MEDICAL EDUCATION	3/2/1980	7/31/1987				2,700		5,400		2,700	5,100
2630137.00G	CONTROL OF DIARRHEAL DISEASES	9/27/1981	9/30/1991						26,000			
2630140.02G	SCHISTOSOMIASIS RESEARCH	9/27/1988	9/30/1998									
2630170.00G	COST RECOVERY FOR HEALTH	9/30/1988	9/30/1998									
2630203.00G	CHILD SURVIVAL	8/15/1985	8/15/1996									
2630242.00G	HEALTHY MOTHER/HEALTHY CHILD	9/30/1995	9/30/2005									
2630254.00G	TECHNICAL SUPPORT FOR HEALTH POLICY	9/30/1996	9/30/2004									
2630265.00G	COMBATting ENDEMIC AND EMERGING DISEASES	9/30/1996	9/30/2003									
2630287.00G	HEALTHIER, PLANNED FAMILIES	9/30/2002	9/30/2011									
2630287.01G	HEALTHY MOTHER HEALTHY CHILD	9/30/2002	9/30/2011									
2630287.03G	INFECTIOUS DISEASE SURVE & RESPONSE	9/30/2002	9/30/2011									

Agreement Number	Agreement Title	Start Date (Agreement)	End Date (PACD)	FY 1976	FY 1977	FY 1978	FY 1979	FY 1980	FY 1981	FY 1982	FY 1983	FY 1984
2630287.04G	FOCUS ON FAMILY HEALTH	9/30/2002	9/30/2005									
2630287.05G	COMMUNICATIONS FOR HEALTHY LIVING	9/30/2002	9/30/2011									
2630287.06G	HEALTH WORKFORCE DEVELOPMENT	9/30/2002	9/30/2008									
2630287.07G	INTEGRATED FP/HMHC	9/29/2005	9/30/2011									
2630287.08G	HIV/AIDS	9/30/2007	9/30/2011									
2630287.09G	AVIAN INFLUENZA	9/30/2007	9/30/2011									
2630287.10G	OTHER PUBLIC HEALTH THREATS	9/30/2007	9/30/2011									
2630287.11G	MATERNAL AND CHILD HEALTH	9/30/2007	9/30/2011									
2630287.13G	PROGRAM DESIGN & ADMINISTRATION	9/30/2009	9/30/2011									
	Total Health and Nutrition			1,700	0	1,900	11,853	20,300	43,400	0	7,200	7,700
	Population											
2630029.00G	FAMILY PLANNING	9/30/1977	9/30/1987		4,000	6,000	6,500	10,000	18,500	22,400		
2630144.00G	POPULATION /FAMILY PLANNING II	6/30/1983	6/30/1994								20,000	
2630227.00G	POPULATION/FAMILY PLANNING III	9/23/1992	7/31/1999									
2630267.00G	POPULATION/FAMILY PLANNING IV	9/29/1997	12/31/2003									
2630287.02G	TAHSEEN	9/30/2002	9/30/2011									
2630287.12G	FAMILY PLANNING AND REPRODUCTIVE HEALTH	9/30/2007	9/30/2011									
	Total Population			0	4,000	6,000	6,500	10,000	18,500	22,400	20,000	0
	Total Obligations for the Health and Population Sector			1,700	4,000	7,900	18,353	30,300	61,900	22,400	27,200	7,700

* Approximately \$21 million were de-obligated from the Health & Population programs from FY 1976–2009. These funds were returned to the Egypt ESF Program but to other projects in other sectors.

FY 1985–FY 1993

Agreement Number	Agreement Title	Start Date (Agreement)	End Date (PACD)	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993
Cash Transfer												
263K638.00G	HEALTH POLICY SUPPORT	9/28/1997	9/30/2003									
263K650.00G	HUMAN RESOURCES & ECONOMIC SECTOR DEVELOPMENT	9/30/2007	9/30/2010									
	Total Cash Transfer											
Commodity Import (CIP)												
	PUBLIC SECTOR CIP											
	PRIVATE SECTOR CIP											
	Total CIP											
Health and Nutrition												
2630015.00G	STRENGTHENING RURAL HEALTH DELIVERY	9/30/1976	3/30/1987			-1,204	-390	0	0	0	0	0
2630065.00G	URBAN HEALTH DELIVERY SYSTEMS	11/19/1978	11/18/1988	8,300				-2,493	5	0	0	0
2630136.00G	SUEZ CANAL AREA MEDICAL EDUCATION	3/2/1980	7/31/1987									
2630137.00G	CONTROL OF DIARRHEAL DISEASES	9/27/1981	9/30/1991			10,000		0	0	0	-2,140	-52
2630140.02G	SCHISTOSOMIASIS RESEARCH	9/27/1988	9/30/1998				10,000	8,000	0	0	5,000	5,000
2630170.00G	COST RECOVERY FOR HEALTH	9/30/1988	9/30/1998				10,000	10,000	0	0	10,000	12,000
2630203.00G	CHILD SURVIVAL	8/15/1985	8/15/1996	3,000	15,000	8,000	0	0	0	8,000	15,000	12,000
2630242.00G	HEALTHY MOTHER/HEALTHY CHILD	9/30/1995	9/30/2005									
2630254.00G	TECHNICAL SUPPORT FOR HEALTH POLICY	9/30/1996	9/30/2004									
2630265.00G	COMBATting ENDEMIC AND EMERGING DISEASES	9/30/1996	9/30/2003									
2630287.00G	HEALTHIER, PLANNED FAMILIES	9/30/2002	9/30/2011									
2630287.01G	HEALTHY MOTHER HEALTHY CHILD	9/30/2002	9/30/2011									
2630287.03G	INFECTIOUS DISEASE SURVE & RESPONSE	9/30/2002	9/30/2011									
2630287.04G	FOCUS ON FAMILY HEALTH	9/30/2002	9/30/2005									
2630287.05G	COMMUNICATIONS FOR HEALTHY LIVING	9/30/2002	9/30/2011									

Agreement Number	Agreement Title	Start Date (Agreement)	End Date (PACD)	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993
2630287.06G	HEALTH WORKFORCE DEVELOPMENT	9/30/2002	9/30/2008									
2630287.07G	INTEGRATED FP/HMHC	9/29/2005	9/30/2011									
2630287.08G	HIV/AIDS	9/30/2007	9/30/2011									
2630287.09G	AVIAN INFLUENZA	9/30/2007	9/30/2011									
2630287.10G	OTHER PUBLIC HEALTH THREATS	9/30/2007	9/30/2011									
2630287.11G	MATERNAL AND CHILD HEALTH	9/30/2007	9/30/2011									
2630287.13G	PROGRAM DESIGN & ADMINISTRATION	9/30/2009	9/30/2011									
	Total Health and Nutrition			11,300	15,000	16,796	19,610	15,507	5	8,000	27,860	28,948
	Population											
2630029.00G	FAMILY PLANNING	9/30/1977	9/30/1987				-1,881	-416	-44	0	-37	0
2630144.00G	POPULATION /FAMILY PLANNING II	6/30/1983	6/30/1994	6,000	18,000	15,000	15,000	10,000	12,000	21,495	0	0
2630227.00G	POPULATION/FAMILY PLANNING III	9/23/1992	7/31/1999								10,000	10,000
2630267.00G	POPULATION/FAMILY PLANNING IV	9/29/1997	12/31/2003									
2630287.02G	TAHSEEN	9/30/2002	9/30/2011									
2630287.12G	FAMILY PLANNING AND REPRODUCTIVE HEALTH	9/30/2007	9/30/2011									
	Total Population			6,000	18,000	15,000	13,119	9,584	11,956	21,495	9,963	10,000
	Total Obligations for the Health and Population Sector			17,300	33,000	31,796	32,729	25,091	11,961	29,495	37,823	38,948

*Approximately \$21 million were de-obligated from the Health & Population programs from FY 1976–2009. These funds were returned to the Egypt ESF Program but to other projects in other sectors.

FY 1994–FY 2002

Agreement Number	Agreement Title	Start Date (Agreement)	End Date (PACD)	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
Cash Transfer												
263K638.00G	HEALTH POLICY SUPPORT	9/28/1997	9/30/2003				15,000	0	15,000	15,000	10,000	2,340
263K650.00G	HUMAN RESOURCES & ECONOMIC SECTOR DEVELOPMENT	9/30/2007	9/30/2010									
	Total Cash Transfer						15,000		15,000	15,000	10,000	2,340
Commodity Import (CIP)												
	PUBLIC SECTOR CIP											
	PRIVATE SECTOR CIP											
	Total CIP											
Health and Nutrition												
2630015.00G	STRENGTHENING RURAL HEALTH DELIVERY	9/30/1976	3/30/1987	0	0	0	0	0	0	0	0	0
2630065.00G	URBAN HEALTH DELIVERY SYSTEMS	11/19/1978	11/18/1988	0	0	0	0	0	0	0	0	0
2630136.00G	SUEZ CANAL AREA MEDICAL EDUCATION	3/2/1980	7/31/1987									
2630137.00G	CONTROL OF DIARRHEAL DISEASES	9/27/1981	9/30/1991	0	0	74	0	0	0	0	0	0
2630140.02G	SCHISTOSOMIASIS RESEARCH	9/27/1988	9/30/1998	6,000	5,650	0	0	0	0	-200	0	-172
2630170.00G	COST RECOVERY FOR HEALTH	9/30/1988	9/30/1998	18,000	18,500	0	0	0	0	-753	-9	-100
2630203.00G	CHILD SURVIVAL	8/15/1985	8/15/1996	6,941	0	-346	-1,158	0	-1	0	0	0
2630242.00G	HEALTHY MOTHER/HEALTHY CHILD	9/30/1995	9/30/2005		20,000	15,000	0	10,000	14,500	9,000	17,000	0
2630254.00G	TECHNICAL SUPPORT FOR HEALTH POLICY	9/30/1996	9/30/2004			5,000	8,000	7,000	4,000	0	5,500	0
2630265.00G	COMBATting ENDEMIC AND EMERGING DISEASES	9/30/1996	9/30/2003			4,000	2,000	2,000	6,800	2,000	2,800	0
2630287.00G	HEALTHIER, PLANNED FAMILIES	9/30/2002	9/30/2011									40,850
2630287.01G	HEALTHY MOTHER HEALTHY CHILD	9/30/2002	9/30/2011									
2630287.03G	INFECTIOUS DISEASE SURVE & RESPONSE	9/30/2002	9/30/2011									
2630287.04G	FOCUS ON FAMILY HEALTH	9/30/2002	9/30/2005									
2630287.05G	COMMUNICATIONS FOR HEALTHY LIVING	9/30/2002	9/30/2011									

Agreement Number	Agreement Title	Start Date (Agreement)	End Date (PACD)	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
2630287.06G	HEALTH WORKFORCE DEVELOPMENT	9/30/2002	9/30/2008									
2630287.07G	INTEGRATED FP/HMHC	9/29/2005	9/30/2011									
2630287.08G	HIV/AIDS	9/30/2007	9/30/2011									
2630287.09G	AVIAN INFLUENZA	9/30/2007	9/30/2011									
2630287.10G	OTHER PUBLIC HEALTH THREATS	9/30/2007	9/30/2011									
2630287.11G	MATERNAL AND CHILD HEALTH	9/30/2007	9/30/2011									
2630287.13G	PROGRAM DESIGN & ADMINISTRATION	9/30/2009	9/30/2011					0				
	Total Health and Nutrition			30,941	44,150	23,728	8,842	19,000	25,299	10,047	25,291	40,578
Population												
2630029.00G	FAMILY PLANNING	9/30/1977	9/30/1987	0	0	0	0	0	0	0	0	0
2630144.00G	POPULATION /FAMILY PLANNING II	6/30/1983	6/30/1994	-4,532	-1,130	-846	-193	-116	46	0	0	0
2630227.00G	POPULATION/FAMILY PLANNING III	9/23/1992	7/31/1999	10,000	15,000	15,643	7,000	0	0	-704	-1	-39
2630267.00G	POPULATION/FAMILY PLANNING IV	9/29/1997	12/31/2003				2,000	19,067	17,200	23,000	21,000	0
2630287.02G	TAHSEEN	9/30/2002	9/30/2011									
2630287.12G	FAMILY PLANNING AND REPRODUCTIVE HEALTH	9/30/2007	9/30/2011									
	Total Population			5,468	13,870	14,797	8,807	18,951	17,246	22,296	20,999	-39
	Total Obligations for the Health and Population Sector			36,409	58,020	38,525	32,649	37,951	57,545	47,343	56,290	42,879
*Approximately \$21 million were de-obligated from the Health & Population programs from FY 1976–2009. These funds were returned to the Egypt ESF Program but to other projects in other sectors.												

FY 2003–FY 2009

Agreement Number	Agreement Title	Start Date (Agreement)	End Date (PACD)	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	Total Obligated
Cash Transfer											
263K638.00G	HEALTH POLICY SUPPORT	9/28/1997	9/30/2003	0	-177	0	0	0	0	0	57,163
263K650.00G	HUMAN RESOURCES & ECONOMIC SECTOR DEVELOPMENT	9/30/2007	9/30/2010					15,700			15,700
	Total Cash Transfer			0	-177	0	0	0	0	0	72,863
Commodity Import (CIP)											
	PUBLIC SECTOR CIP										234,000
	PRIVATE SECTOR CIP										148,000
	Total CIP										382,000
Health and Nutrition											
2630015.00G	STRENGTHENING RURAL HEALTH DELIVERY	9/30/1976	3/30/1987	0	0	0	0	0	0	0	13,306
2630065.00G	URBAN HEALTH DELIVERY SYSTEMS	11/19/1978	11/18/1988	0	0	0	0	0	0	0	43,065
2630136.00G	SUEZ CANAL AREA MEDICAL EDUCATION	3/2/1980	7/31/1987								15,900
2630137.00G	CONTROL OF DIARRHEAL DISEASES	9/27/1981	9/30/1991	0	0	0	0	0	0	0	33,882
2630140.02G	SCHISTOSOMIASIS RESEARCH	9/27/1988	9/30/1998	0	0	0	0	0	0	0	39,278
2630170.00G	COST RECOVERY FOR HEALTH	9/30/1988	9/30/1998	-114	0	-34	0	0	0	0	77,490
2630203.00G	CHILD SURVIVAL	8/15/1985	8/15/1996	0	0	0	0	0	0	0	66,436
2630242.00G	HEALTHY MOTHER/HEALTHY CHILD	9/30/1995	9/30/2005	0	0	0	-89	0	-33	0	85,378
2630254.00G	TECHNICAL SUPPORT FOR HEALTH POLICY	9/30/1996	9/30/2004	0	0	-162	0	-592	-328	0	28,418
2630265.00G	COMBATting ENDEMIC AND EMERGING DISEASES	9/30/1996	9/30/2003	0	-223	0	0	0	0	0	19,377
2630287.00G	HEALTHIER, PLANNED FAMILIES	9/30/2002	9/30/2011	-38,028	-1,897	2,518	703	0	0	0	4,146
2630287.01G	HEALTHY MOTHER HEALTHY CHILD	9/30/2002	9/30/2011	13,888	6,457	-53	-4,000	0	0	0	16,292
2630287.03G	INFECTIOUS DISEASE SURVE & RESPONSE	9/30/2002	9/30/2011	7,098	3,302	3,166	10,580	-2,000	0	0	22,146
2630287.04G	FOCUS ON FAMILY HEALTH	9/30/2002	9/30/2005	9,531	-893	-100	-1,605	0	0	0	6,933
2630287.05G	COMMUNICATIONS FOR HEALTHY LIVING	9/30/2002	9/30/2011	6,617	5,680	2,836	4,955	2,000	0	0	22,088

Agreement Number	Agreement Title	Start Date (Agreement)	End Date (PACD)	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	Total Obligated
2630287.06G	HEALTH WORKFORCE DEVELOPMENT	9/30/2002	9/30/2008	5,990	4,091	2,556	-7,000	0	0	0	5,637
2630287.07G	INTEGRATED FP/HMHC	9/29/2005	9/30/2011			15,234	24,101	0	0	0	39,335
2630287.08G	HIV/AIDS	9/30/2007	9/30/2011					1,488	0	0	1,488
2630287.09G	AVIAN INFLUENZA	9/30/2007	9/30/2011					5,200	5,329	3,300	13,829
2630287.10G	OTHER PUBLIC HEALTH THREATS	9/30/2007	9/30/2011					11,529	2,130	2,910	16,569
2630287.11G	MATERNAL AND CHILD HEALTH	9/30/2007	9/30/2011					13,144	3,156	4,900	21,200
2630287.13G	PROGRAM DESIGN & ADMINISTRATION	9/30/2009	9/30/2011							3,700	3,700
	Total Health and Nutrition			4,982	16,517	25,961	27,645	30,769	10,254	14,810	595,893
	Population										
2630029.00G	FAMILY PLANNING	9/30/1977	9/30/1987	0	0	0	0	0	0	0	65,022
2630144.00G	POPULATION /FAMILY PLANNING II	6/30/1983	6/30/1994	0	0	0	0	0	0	0	110,724
2630227.00G	POPULATION/FAMILY PLANNING III	9/23/1992	7/31/1999	-226	0	0	0	0	0	0	66,673
2630267.00G	POPULATION/FAMILY PLANNING IV	9/29/1997	12/31/2003	0	0	-6	-11	0	0	0	82,250
2630287.02G	TAHSEEN	9/30/2002	9/30/2011	36,934	13,009	-156	-3,000	0	0	0	46,787
2630287.12G	FAMILY PLANNING AND REPRODUCTIVE HEALTH	9/30/2007	9/30/2011					13,017	12,032	8,900	33,949
	Total Population			36,708	13,009	-162	-3,011	13,017	12,032	8,900	405,405
	Total Obligations for the Health and Population Sector			41,690	29,349	25,799	24,634	43,786	22,286	23,710	1,456,161

*Approximately \$21 million were de-obligated from the Health & Population programs from FY 1976–2009. These funds were returned to the Egypt ESF Program but to other projects in other sectors.

**ANNEX 4B: USAID/EGYPT OBLIGATIONS FOR HEALTH & POPULATION SECTORS
FROM FY 1976–FY 2009 (\$ 000)**

Fiscal Year	Agreement Title	Amount Obligated Per Fiscal Year	Start Date (Agreement)	End Date (PACD)
1976	STRENGTHENING RURAL HEALTH DELIVERY	1,700	9/30/1976	3/30/1987
1977	FAMILY PLANNING I	4,000	9/30/1977	9/30/1987
1978	STRENGTHENING RURAL HEALTH DELIVERY	1,900	9/30/1976	3/30/1987
	FAMILY PLANNING I	6,000	9/30/1977	9/30/1987
1979	STRENGTHENING RURAL HEALTH DELIVERY	4,200	9/30/1976	3/30/1987
	URBAN HEALTH DELIVERY SYSTEMS	4,953	11/19/1978	11/18/1988
	SUEZ CANAL AREA MEDICAL EDUCATION	2,700	3/2/1980	7/31/1987
	FAMILY PLANNING I	6,500	9/30/1977	9/30/1987
1980	URBAN HEALTH DELIVERY SYSTEMS	20,300	11/19/1978	11/18/1988
	FAMILY PLANNING I	10,000	9/30/1977	9/30/1987
1981	URBAN HEALTH DELIVERY SYSTEMS	12,000	11/19/1978	11/18/1988
	SUEZ CANAL AREA MEDICAL EDUCATION	5,400	3/2/1980	7/31/1987
	CONTROL OF DIARRHEAL DISEASES	26,000	9/27/1981	9/30/1991
	FAMILY PLANNING I	18,500	9/30/1977	9/30/1987
1982	FAMILY PLANNING I	22,400	9/30/1977	9/30/1987
1983	STRENGTHENING RURAL HEALTH DELIVERY	4,500	9/30/1976	3/30/1987
	SUEZ CANAL AREA MEDICAL EDUCATION	2,700	3/2/1980	7/31/1987
	POPULATION PROJ/FAMILY PLAN II	20,000	6/30/1983	6/30/1994

Fiscal Year	Agreement Title	Amount Obligated Per Fiscal Year	Start Date (Agreement)	End Date (PACD)
1984	STRENGTHENING RURAL HEALTH DELIVERY	2,600	9/30/1976	3/30/1987
	SUEZ CANAL AREA MEDICAL EDUCATION	5,100	3/2/1980	7/31/1987
1985	URBAN HEALTH DELIVERY SYSTEMS	8,300	11/19/1978	11/18/1988
	CHILD SURVIVAL	3,000	8/15/1985	8/15/1996
	POPULATION PROJ/FAMILY PLAN II	6,000	6/30/1983	6/30/1994
1986	CHILD SURVIVAL	15,000	8/15/1985	8/15/1996
	POPULATION PROJ/FAMILY PLAN II	18,000	6/30/1983	6/30/1994
1987	CONTROL OF DIARRHEAL DISEASES	10,000	9/27/1981	9/30/1991
	CHILD SURVIVAL	8,000	8/15/1985	8/15/1996
	POPULATION PROJ/FAMILY PLAN II	15,000	6/30/1983	6/30/1994
1988	SCHISTOSOMIASIS RESEARCH	10,000	9/27/1988	9/30/1998
	COST RECOVERY FOR HEALTH	10,000	9/30/1988	9/30/1998
	POPULATION PROJ/FAMILY PLAN II	15,000	6/30/1983	6/30/1994
1989	SCHISTOSOMIASIS RESEARCH	8,000	9/27/1988	9/30/1998
	COST RECOVERY FOR HEALTH	10,000	9/30/1988	9/30/1998
	POPULATION PROJ/FAMILY PLAN II	10,000	6/30/1983	6/30/1994
1990	POPULATION PROJ/FAMILY PLAN II	12,000	6/30/1983	6/30/1994
1991	CHILD SURVIVAL	8,000	8/15/1985	8/15/1996
	POPULATION PROJ/FAMILY PLAN II	21,495	6/30/1983	6/30/1994
1992	SCHISTOSOMIASIS RESEARCH	5,000	9/27/1988	9/30/1998

Fiscal Year	Agreement Title	Amount Obligated Per Fiscal Year	Start Date (Agreement)	End Date (PACD)
	COST RECOVERY FOR HEALTH	10,000	9/30/1988	9/30/1998
	CHILD SURVIVAL	15,000	8/15/1985	8/15/1996
	POPULATION PROJ/FAMILY PLAN III	10,000	6/30/1983	6/30/1994
1993	SCHISTOSOMIASIS RESEARCH	5,000	9/27/1988	9/30/1998
	COST RECOVERY FOR HEALTH	12,000	9/30/1988	9/30/1998
	CHILD SURVIVAL	12,000	8/15/1985	8/15/1996
	POPULATION PROJ/FAMILY PLAN III	10,000	6/30/1983	6/30/1994
1994	SCHISTOSOMIASIS RESEARCH	6,000	9/27/1988	9/30/1998
	COST RECOVERY FOR HEALTH	18,000	9/30/1988	9/30/1998
	CHILD SURVIVAL	6,941	8/15/1985	8/15/1996
	POPULATION PROJ/FAMILY PLAN III	10,000	6/30/1983	6/30/1994
1995	SCHISTOSOMIASIS RESEARCH	5,650	9/27/1988	9/30/1998
	COST RECOVERY FOR HEALTH	18,500	9/30/1988	9/30/1998
	HEALTHY MOTHER/HEALTHY CHILD	20,000	9/30/1995	9/30/2005
	POPULATION PROJ/FAMILY PLAN III	15,000	6/30/1983	6/30/1994
1996	HEALTHY MOTHER/HEALTHY CHILD	15,000	9/30/1995	9/30/2005
	TECHNICAL SUPPORT FOR HEALTH POLICY	5,000	9/30/1996	9/30/2004
	COMBATting ENDEMIC AND EMERGING DISEASES	4,000	9/30/1996	9/30/2003
	POPULATION PROJ/FAMILY PLAN III	15,643	6/30/1983	6/30/1994
1997	HEALTH POLICY SUPPORT (Cash Transfer Program)	15,000	9/28/1997	9/30/2003

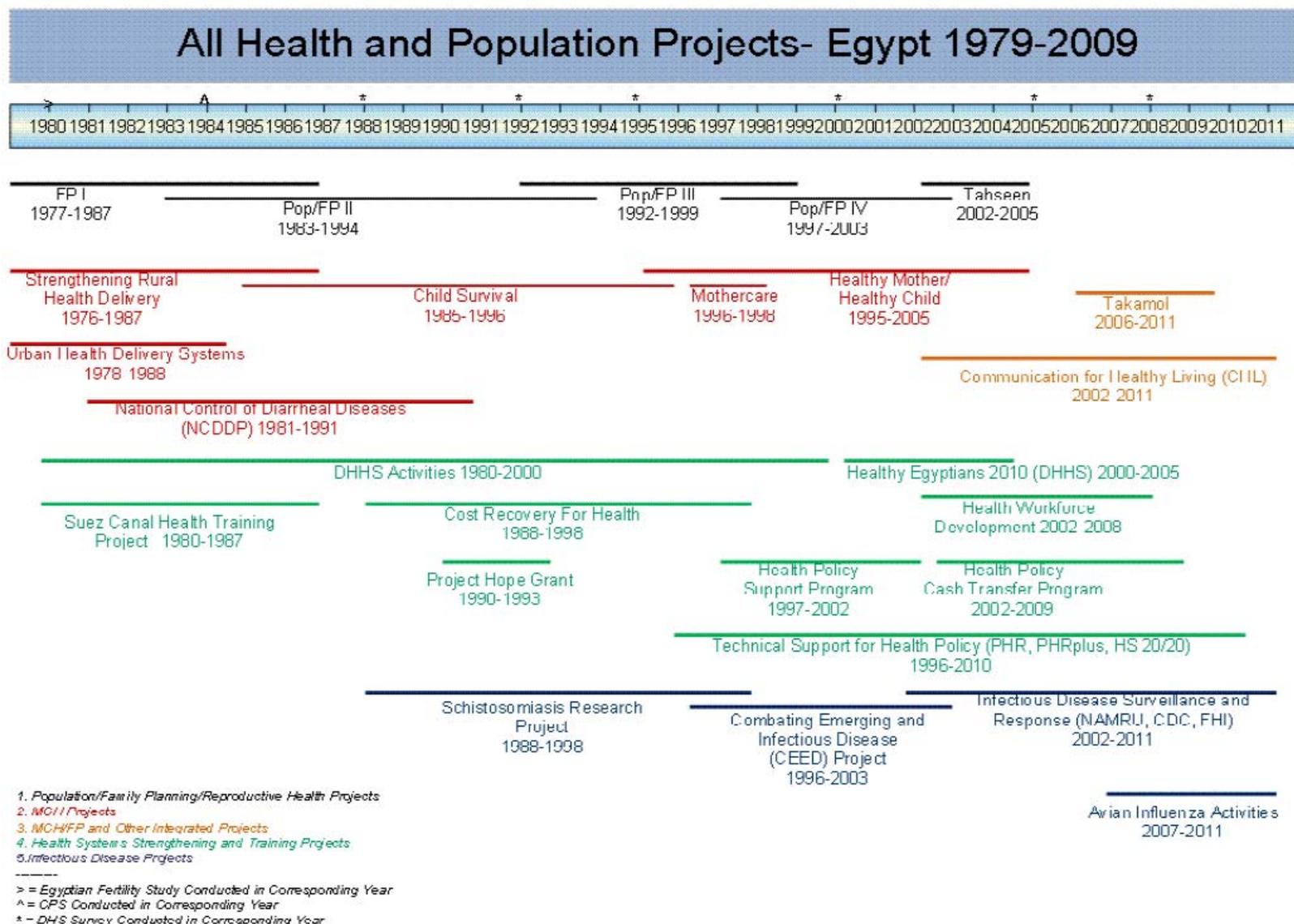
Fiscal Year	Agreement Title	Amount Obligated Per Fiscal Year	Start Date (Agreement)	End Date (PACD)
	TECHNICAL SUPPORT FOR HEALTH POLICY	8,000	9/30/1996	9/30/2004
	COMBATTING ENDEMIC AND EMERGING DISEASES	2,000	9/30/1996	9/30/2003
	POPULATION PROJ/FAMILY PLAN III	7,000	6/30/1983	6/30/1994
	POPULATION/FAMILY PLANNING IV	2,000	9/29/1997	12/31/2003
1998	HEALTHY MOTHER/HEALTHY CHILD	10,000	9/30/1995	9/30/2005
	TECHNICAL SUPPORT FOR HEALTH POLICY	7,000	9/30/1996	9/30/2004
	COMBATTING ENDEMIC AND EMERGING DISEASES	2,000	9/30/1996	9/30/2003
	POPULATION/FAMILY PLANNING IV	19,067	9/29/1997	12/31/2003
1999	HEALTH POLICY SUPPORT (Cash Transfer Program)	15,000	9/28/1997	9/30/2003
	HEALTHY MOTHER/HEALTHY CHILD	14,500	9/30/1995	9/30/2005
	TECHNICAL SUPPORT FOR HEALTH POLICY	4,000	9/30/1996	9/30/2004
	COMBATTING ENDEMIC AND EMERGING DISEASES	6,800	9/30/1996	9/30/2003
	POPULATION/FAMILY PLANNING IV	17,200	9/29/1997	12/31/2003
2000	HEALTH POLICY SUPPORT (Cash Transfer Program)	15,000	9/28/1997	9/30/2003
	HEALTHY MOTHER/HEALTHY CHILD	9,000	9/30/1995	9/30/2005
	COMBATTING ENDEMIC AND EMERGING DISEASES	2,000	9/30/1996	9/30/2003
	POPULATION/FAMILY PLANNING IV	23,000	9/29/1997	12/31/2003
2001	HEALTH POLICY SUPPORT (Cash Transfer Program)	10,000	9/28/1997	9/30/2003
	HEALTHY MOTHER/HEALTHY CHILD	17,000	9/30/1995	9/30/2005
	TECHNICAL SUPPORT FOR HEALTH POLICY	5,500	9/30/1996	9/30/2004

Fiscal Year	Agreement Title	Amount Obligated Per Fiscal Year	Start Date (Agreement)	End Date (PACD)
	COMBATTING ENDEMIC AND EMERGING DISEASES	2,800	9/30/1996	9/30/2003
	POPULATION/FAMILY PLANNING IV	21,000	9/29/1997	12/31/2003
2002	HEALTH POLICY SUPPORT (Cash Transfer Program)	2,340	9/28/1997	9/30/2003
	HEALTHIER, PLANNED FAMILIES	40,850	9/30/2002	9/30/2011
2003	HEALTHIER, PLANNED FAMILIES	-38,028	9/30/2002	9/30/2011
	HEALTHY MOTHER HEALTHY CHILD	13,888	9/30/2002	9/30/2011
	INFECTIOUS DISEASE SURVEY & RESPONSE	7,098	9/30/2002	9/30/2011
	FOCUS ON FAMILY HEALTH	9,531	9/30/2002	9/30/2005
	COMMUNICATIONS FOR HEALTHY LIVING	6,617	9/30/2002	9/30/2011
	HEALTH WORKFORCE DEVELOPMENT	5,990	9/30/2002	9/30/2008
	TAHSEEN (Family Planning & Population)	36,934	9/30/2002	9/30/2011
2004	HEALTHIER, PLANNED FAMILIES	-1,897	9/30/2002	9/30/2011
	HEALTHY MOTHER HEALTHY CHILD	6,457	9/30/2002	9/30/2011
	INFECTIOUS DISEASE SURVE & RESPONSE	3,302	9/30/2002	9/30/2011
	FOCUS ON FAMILY HEALTH	-892	9/30/2002	9/30/2005
	COMMUNICATIONS FOR HEALTHY LIVING	5,680	9/30/2002	9/30/2011
	HEALTH WORKFORCE DEVELOPMENT	4,091	9/30/2002	9/30/2008
	TAHSEEN (Family Planning & Population)	13,009	9/30/2002	9/30/2011
2005	HEALTHIER, PLANNED FAMILIES	2,518	9/30/2002	9/30/2011
	HEALTHY MOTHER HEALTHY CHILD	-54	9/30/2002	9/30/2011

Fiscal Year	Agreement Title	Amount Obligated Per Fiscal Year	Start Date (Agreement)	End Date (PACD)
	INFECTIOUS DISEASE SURVEY & RESPONSE	3,166	9/30/2002	9/30/2011
	FOCUS ON FAMILY HEALTH	-100	9/30/2002	9/30/2005
	COMMUNICATIONS FOR HEALTHY LIVING	2,836	9/30/2002	9/30/2011
	HEALTH WORKFORCE DEVELOPMENT	2,556	9/30/2002	9/30/2008
	TAHSEEN (Family Planning & Population)	-156	9/30/2002	9/30/2011
	INTEGRATED FP/HMHC	15,234	9/29/2005	9/30/2011
2006	HEALTHIER, PLANNED FAMILIES	703	9/30/2002	9/30/2011
	HEALTHY MOTHER HEALTHY CHILD	-4,000	9/30/2002	9/30/2011
	INFECTIOUS DISEASE SURVEY & RESPONSE	10,580	9/30/2002	9/30/2011
	FOCUS ON FAMILY HEALTH	-1,605	9/30/2002	9/30/2005
	COMMUNICATIONS FOR HEALTHY LIVING	4,955	9/30/2002	9/30/2011
	HEALTH WORKFORCE DEVELOPMENT	-7,000	9/30/2002	9/30/2008
	TAHSEEN (Family Planning & Population)	-3,000	9/30/2002	9/30/2011
	INTEGRATED FP/HMHC	24,101	9/29/2005	9/30/2011
2007	INFECTIOUS DISEASE SURVEY & RESPONSE	-2,000	9/30/2002	9/30/2011
	COMMUNICATIONS FOR HEALTHY LIVING	2,000	9/30/2002	9/30/2011
	HIV/AIDS	1,488	9/30/2007	9/30/2011
	AVIAN INFLUENZA	5,200	9/30/2007	9/30/2011
	OTHER PUBLIC HEALTH THREATS	11,529	9/30/2007	9/30/2011
	MATERNAL AND CHILD HEALTH	13,144	9/30/2007	9/30/2011

Fiscal Year	Agreement Title	Amount Obligated Per Fiscal Year	Start Date (Agreement)	End Date (PACD)
	FAMILY PLANNING AND REPRODUCTIVE HEALTH	13,017	9/30/2007	9/30/2011
2008	AVIAN INFLUENZA	5,329	9/30/2007	9/30/2011
	OTHER PUBLIC HEALTH THREATS	2,130	9/30/2007	9/30/2011
	MATERNAL AND CHILD HEALTH	3,156	9/30/2007	9/30/2011
	FAMILY PLANNING AND REPRODUCTIVE HEALTH	12,032	9/30/2007	9/30/2011
2009	AVIAN INFLUENZA	3,300	9/30/2007	9/30/2011
	OTHER PUBLIC HEALTH THREATS	2,910	9/30/2007	9/30/2011
	MATERNAL AND CHILD HEALTH	4,900	9/30/2007	9/30/2011
	PROGRAM DESIGN AND ADMINISTRATION	3,700	9/30/2007	9/30/2011
	FAMILY PLANNING AND REPRODUCTIVE HEALTH	8,900	9/30/2007	9/30/2011
<p>*Approximately \$21 million were de-obligated from the Health & Population programs from FY 1976–2009. These funds were returned to the Egypt ESF Program but to other projects in other sectors.</p>				

ANNEX 5: PROJECT TIMELINE



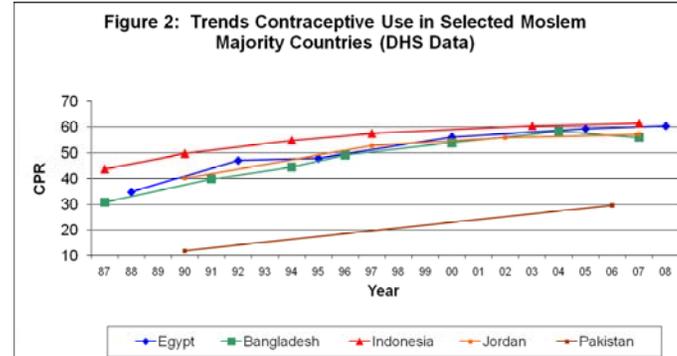
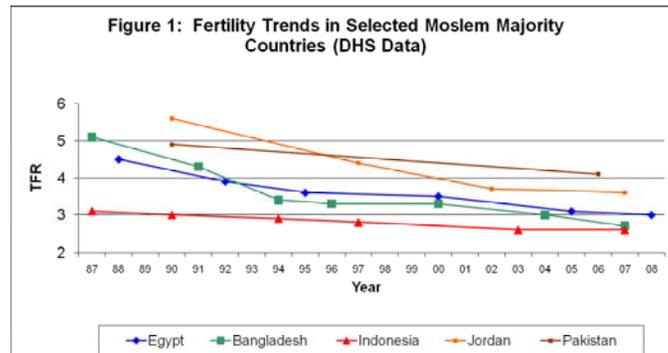
ANNEX 6: POWERPOINT PRESENTATION OF DATA CHARTS

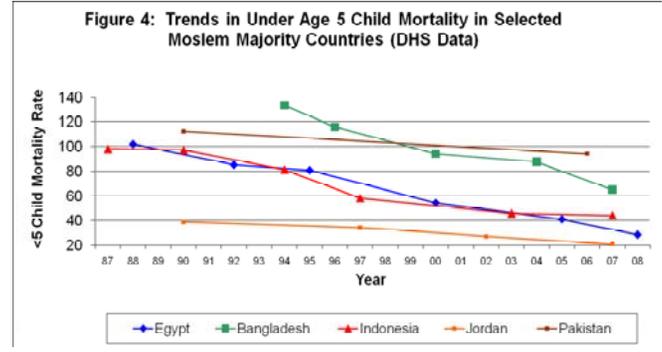
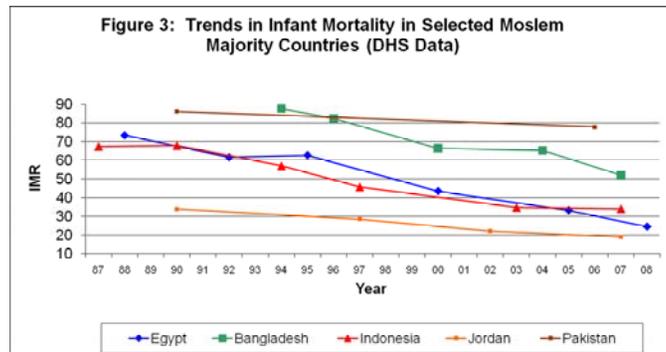
Egypt Population and Health Legacy Review

Data Charts

Cross-Country Comparisons

Demographic Trends in Egypt Compared to Other Moslem Majority Countries





Egypt
Demographic and
Health Outcomes
1976-2008

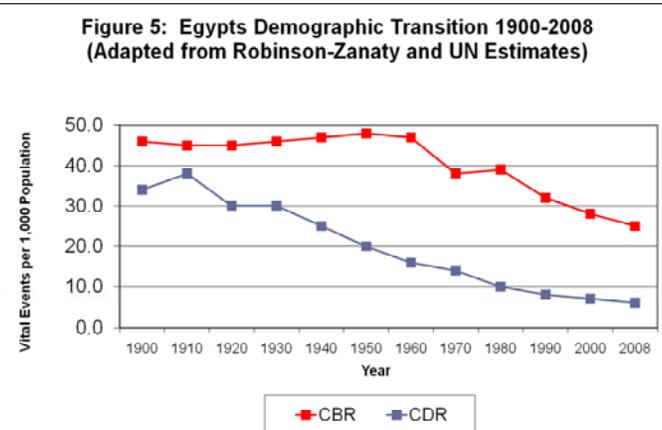
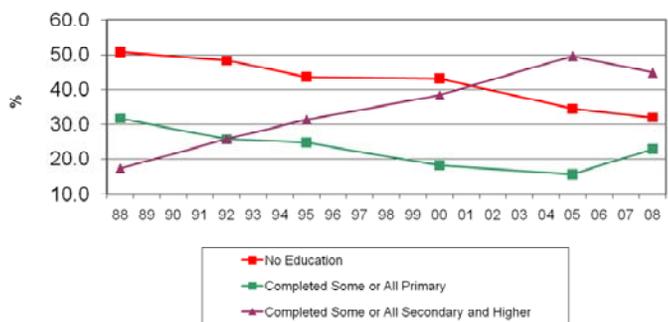


Figure 6: Educational Characteristics of EDHS Ever-Married Women Respondents, 1988-2008



Fertility Levels and Trends in Egypt

Figure 7: Egypt Total Fertility Rate, 1976-2008

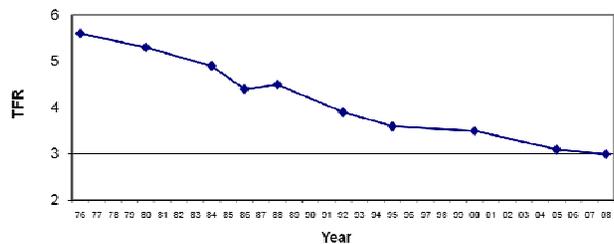


Figure 8: Egypt Total Fertility Rate by Urban and Rural Areas, 1988-2008

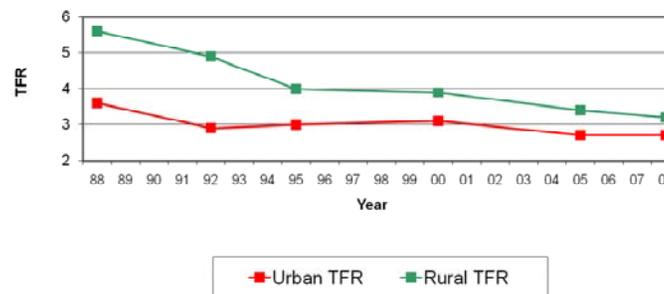


Chart 9: Egypt Total Fertility Rate by Region, 1988-2008

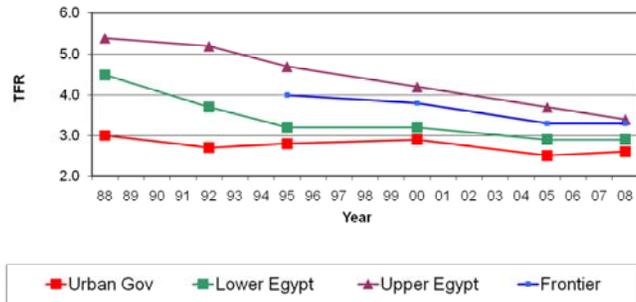


Figure 10: Percentage Distribution of Births and Deaths in the 2008 EDHS Birth History

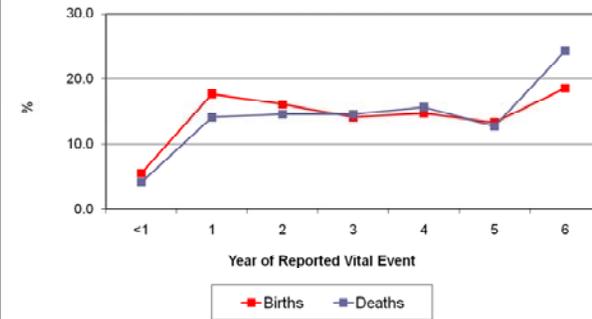


Figure 11: Median Age at Marriage and First Birth, 1988-2008

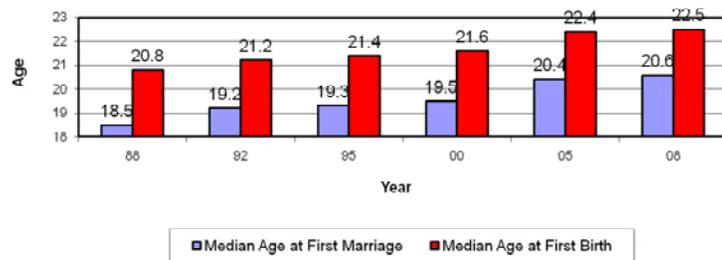


Figure 12: Median Age at First Marriage by Region, 1988-2008

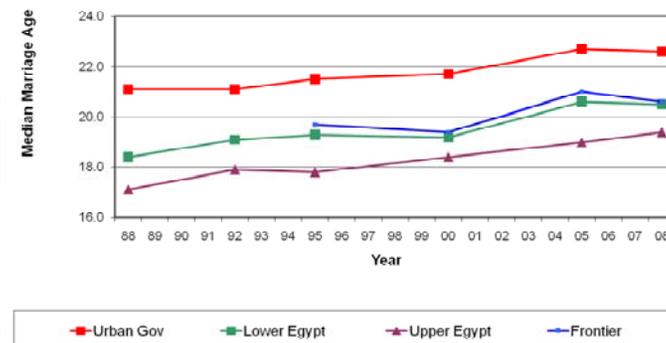


Figure 13: Percentage of Women Aged 15-19 Who Have Started Childbearing, 1992-2008

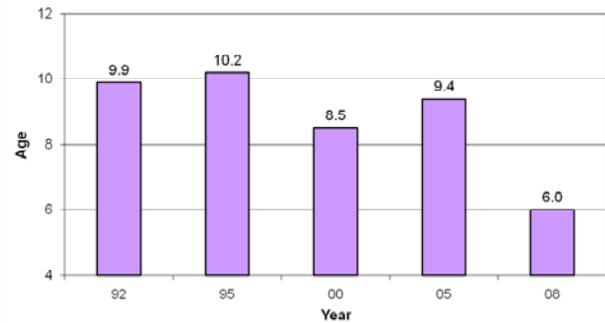


Figure 14: Median Duration of Postpartum Amenorrhea and Postpartum Abstinence (Months), 1988-08

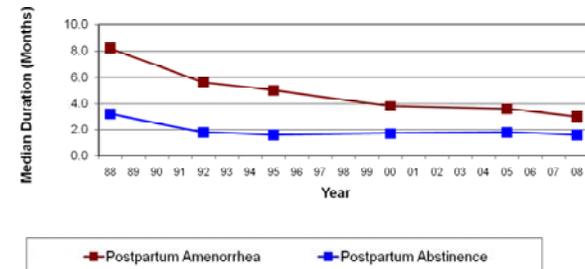


Figure 15: Egypt Total Fertility Rate (TFR), Wanted Fertility, and Ideal Number of Children, 1988-2008

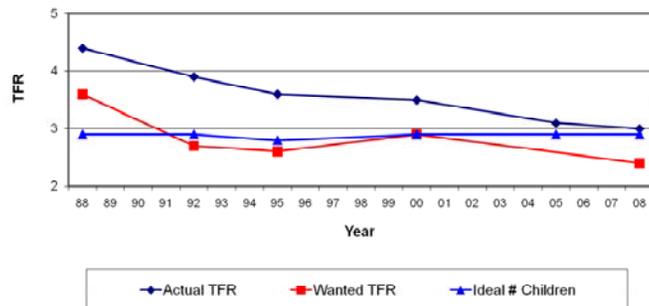
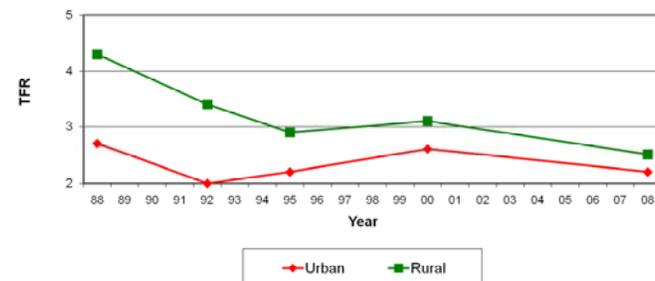


Figure 16: Wanted Total Fertility Rate by Urban and Rural Residence, 1988-2008



Contraceptive Use Levels and Trends in Egypt

Figure 17: Egypt Wanted Total Fertility Rate by Region, 1988-2008

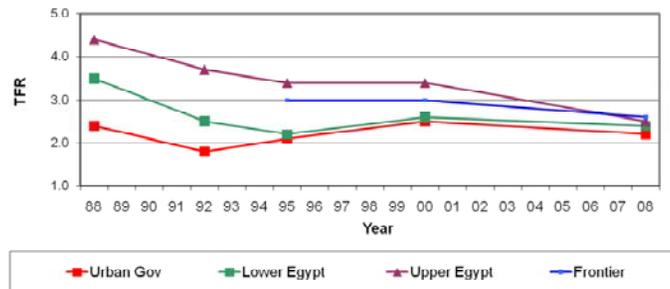


Figure 18: Egypt Contraceptive Prevalence Rate (CPR), 1976-2008

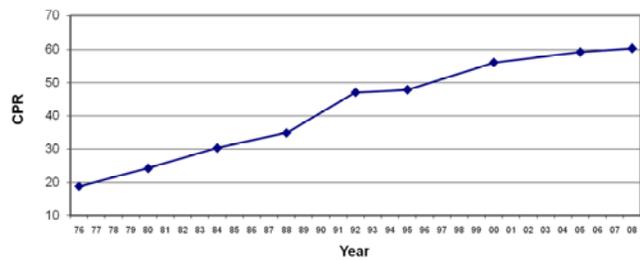
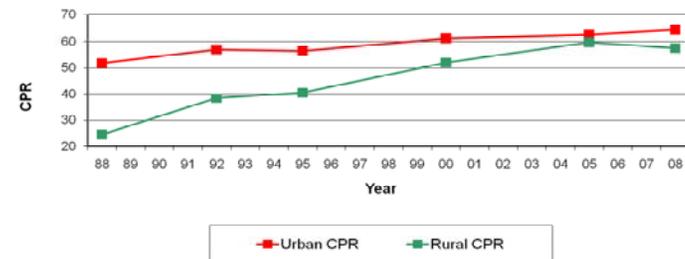
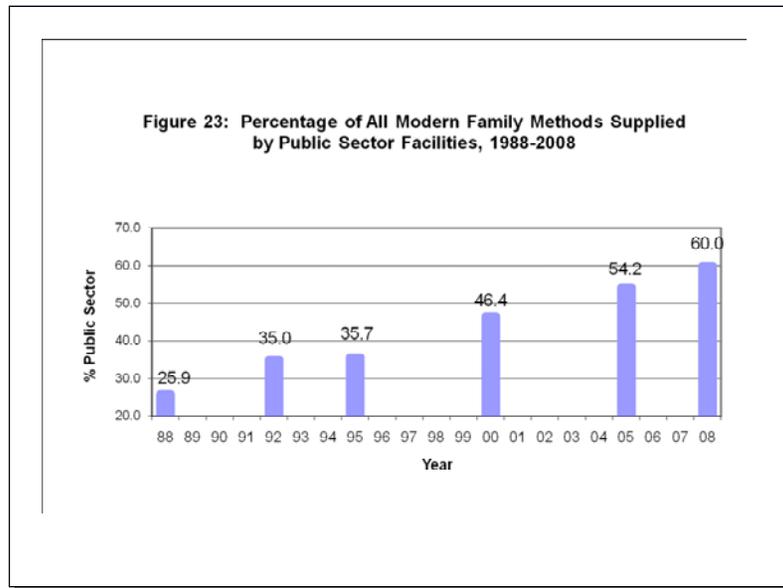
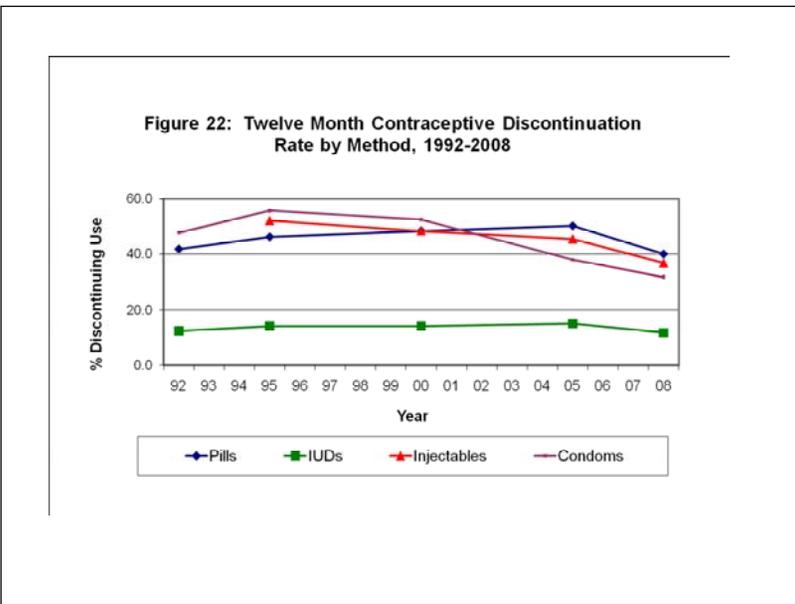
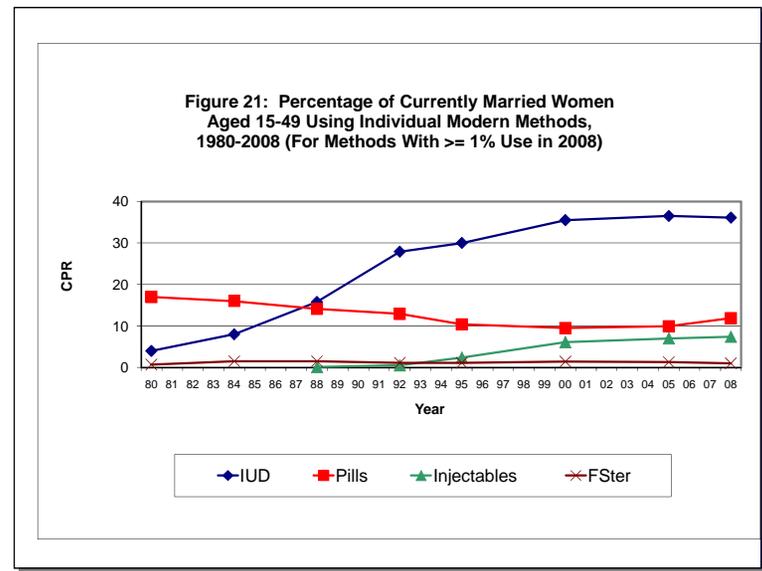
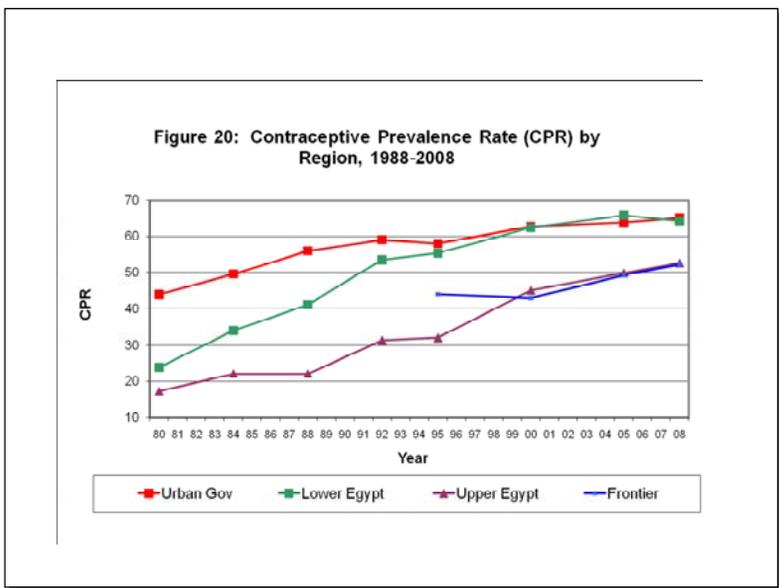


Figure 19: Egypt Contraceptive Prevalence Rate (CPR) by Urban and Rural Areas, 1988-2008





Behavior Change and Communication

Figure 24: Percentage of Methods Supplied by Public Sector Facilities, 1988-2008

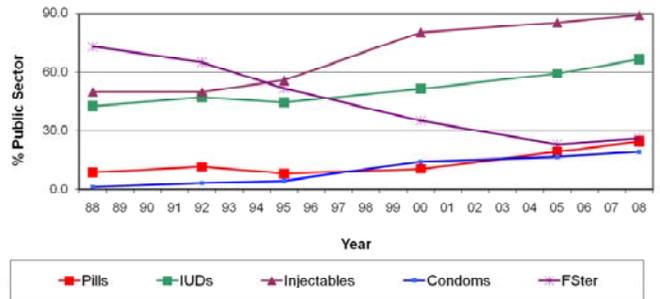


Figure 25: Percentage of Ever-Married Women with Knowledge of Family Planning Methods, 1988-2008

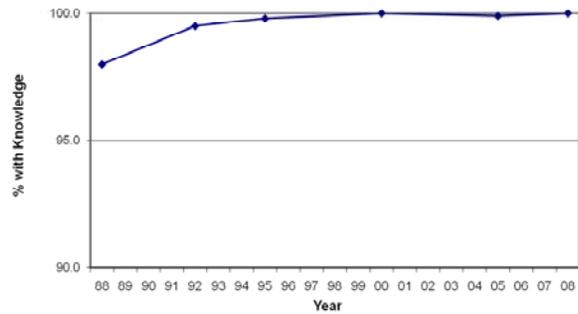


Figure 26: Percentage of Currently Married Women with No Media Exposure to Family Planning Information and Messages, 1992-2008

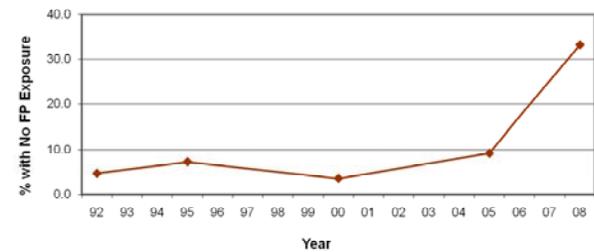


Figure 27: Percentage of Currently Married Women with No Exposure to Family Planning Information and Messages via Radio, TV and Newspapers, 2005-2008

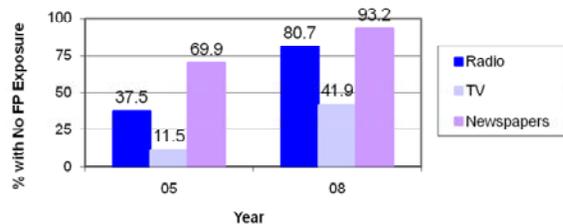


Figure 28: Percentage of Currently Married Women Who Approve of FP Use Before and After Marriage, 2000-2008

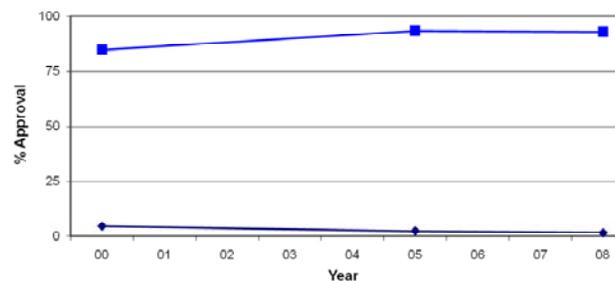


Figure 29: Percentage of Non-Users Who Intend to Use Family Planning, 1988-2008

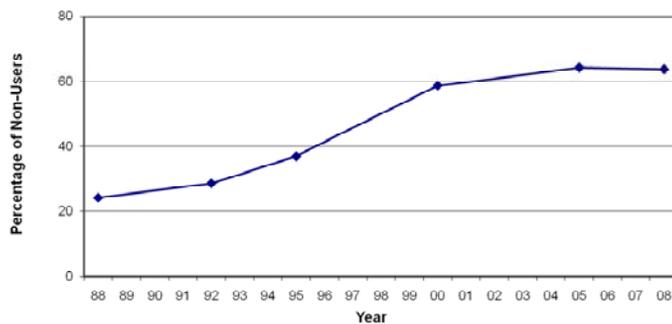
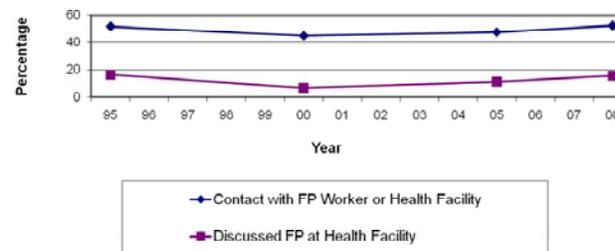


Figure 30: Percentage of Non-Users with Service Provider Contact and FP Discussions at Public and Private Health Facilities in Previous Six Months, 1995-2008



Unmet Need for Family Planning in Egypt

Figure 31: Percentage of Currently Married Women in Egypt with Unmet Need for Family Planning, 1992-2008

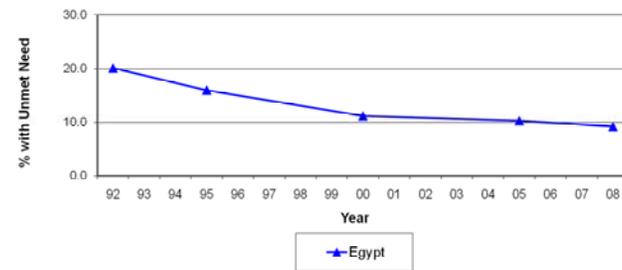


Figure 32: Unmet Need for Family Planning by Urban and Rural Residence, 1992-2008

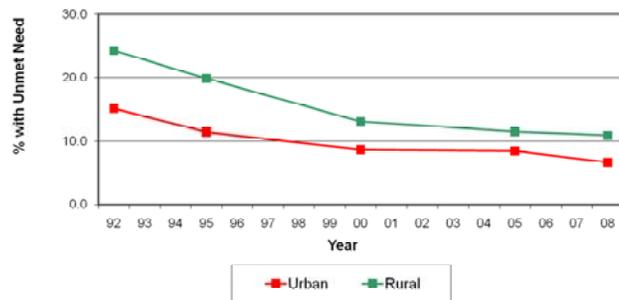


Figure 33: Unmet Need for Spacing and Limiting Methods, 1992-2008

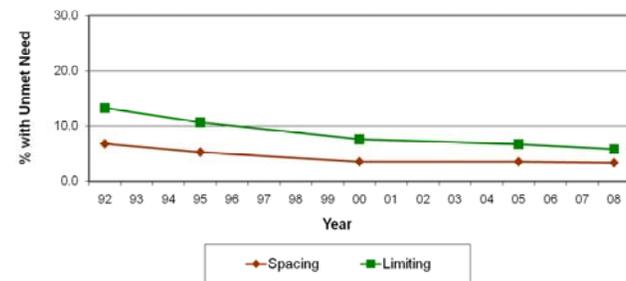


Figure 34: Spacing and Limiting Need by Age, 2008

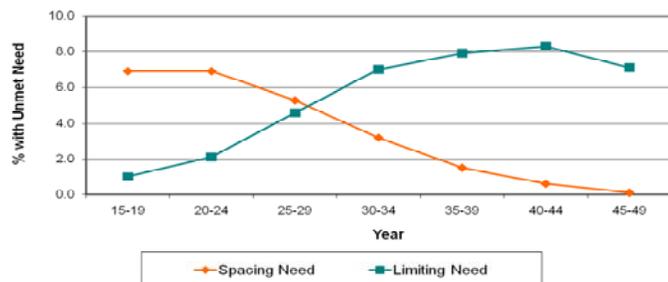
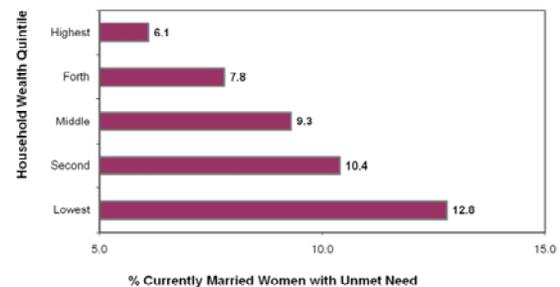


Figure 35: Unmet Need for Family Planning among Currently Married Women Aged 15-49 by Wealth Quintile, 2008



Maternal Mortality in Egypt

Figure 36: Maternal Mortality Ratio (Maternal Deaths per 100,000 Live Births) in Egypt, 1992-2008

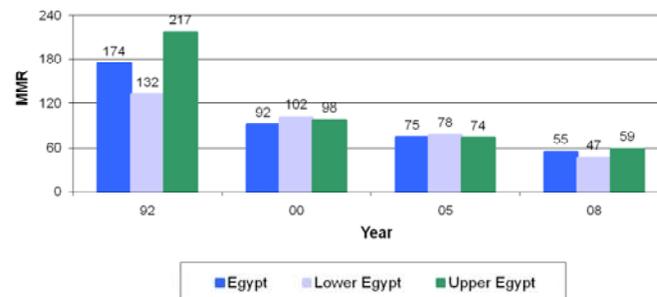


Figure 37: Percentage of Births 5 Years Prior to Survey with Any and Regular Antenatal Care (4 or More Visits), 1995-2008

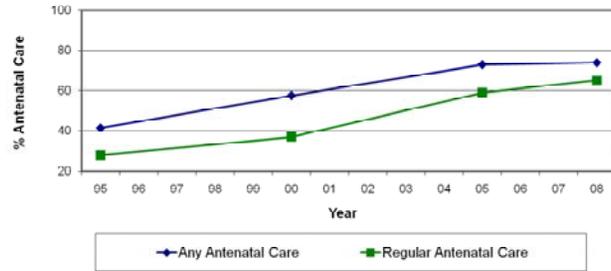


Figure 38: Percentage of Births Five Years Prior to Survey when Mother Received Antenatal Care by Region, 1988-2008

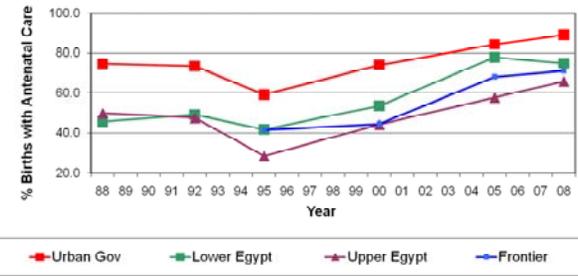


Figure 39: Percentage of Births 5 Years Prior to Survey With At Least One Antenatal Visit at Public and Private Medical Facilities, 1995-2008

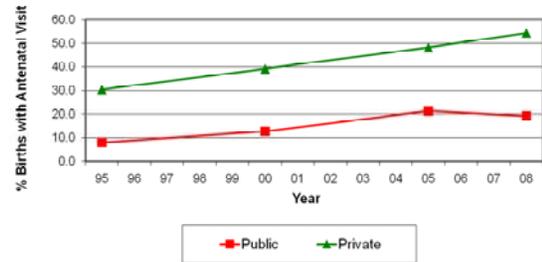


Figure 40: Percentage of Births 3 Years Prior to Survey with Mother Receiving Tetanus Toxoid

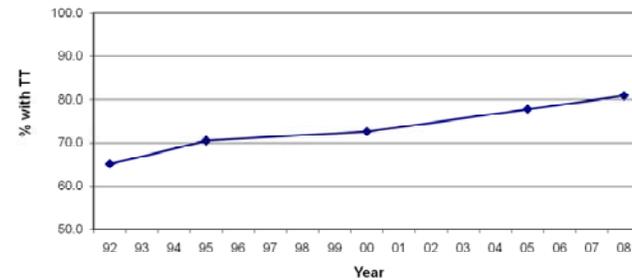


Figure 41: Percentage of Births 5 Years Prior to Survey Medically Delivered by Doctor or Trained Nurse/Midwife, 1988-2008

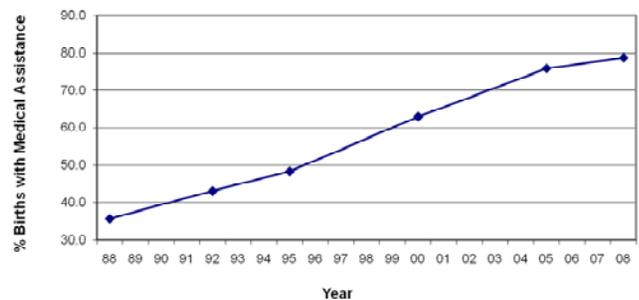


Figure 42: Percentage of Births Five Years Prior to Survey that were Medically Assisted by Doctor or Trained Nurse/Midwife, 1988-2008

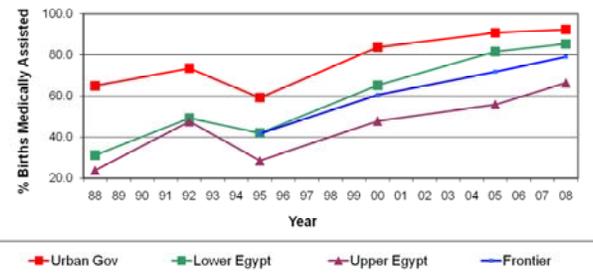


Figure 43: Percentage of Births 5 Years Prior to Survey Delivered at Public and Private Medical Facilities, 1988-2008

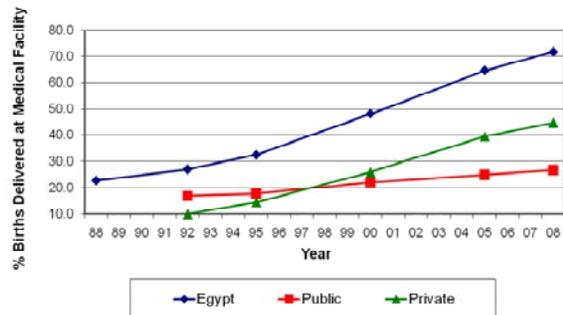


Figure 44: Percentage of Births Medically Assisted by Wealth Quintile, 2008

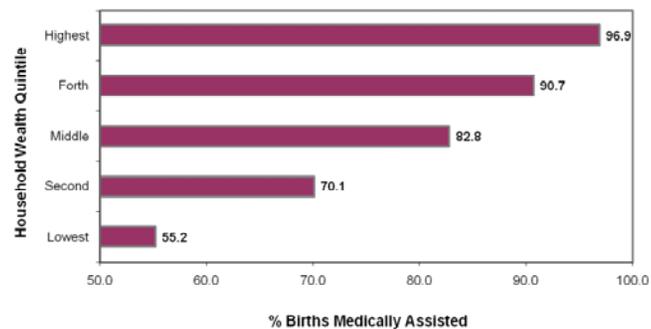


Figure 45: Percentage of Births 5 Years Prior to Survey with Delivery by Caesarean, 1992-2008

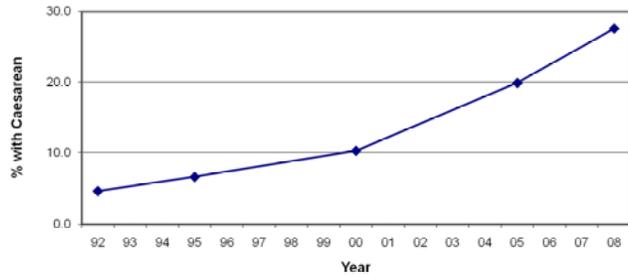


Figure 46: Percentage of Births Five Years Prior to Survey Delivered by Caesarean, 1995-2008

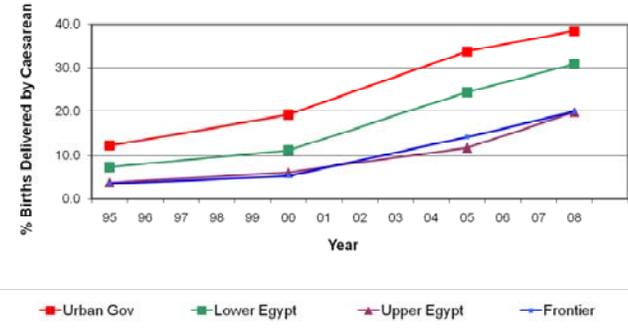


Figure 47: Percentage of Births Five Years Prior to Survey Delivered by Caesarean in Public and Private Health Facilities, 2005-2008

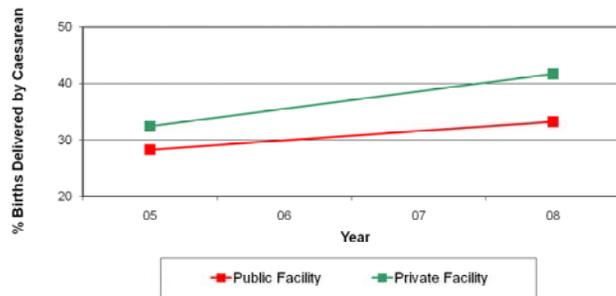


Figure 48: Percentage of Births 5 Years Prior to Survey with Mothers and Children Obtaining Postnatal Checkup, 1995-2008

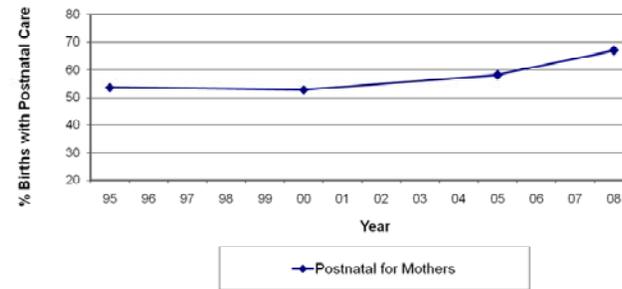


Figure 49: Percentage of Births 5 Years Prior to Survey With At Least One Postnatal Visit at Public and Private Medical Facilities, 2005-2008

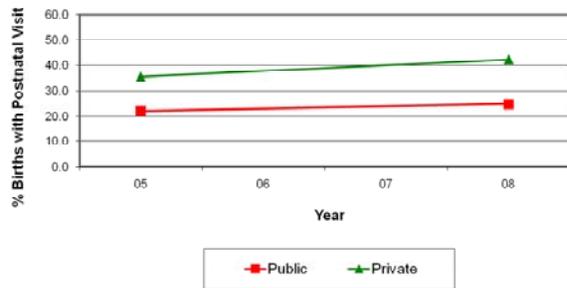


Figure 50: Percent of Ever-Married Women 15-49 Aware of Pregnancy Danger Signs, 2003-2008

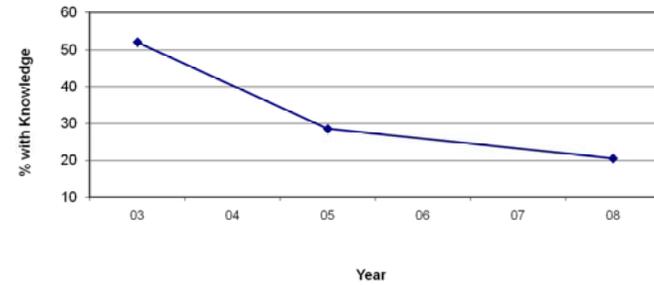


Figure 51: Percent of Ever-Married Women 15-49 Aware of Pregnancy Danger Signs, Urban and Rural, 2003-2008

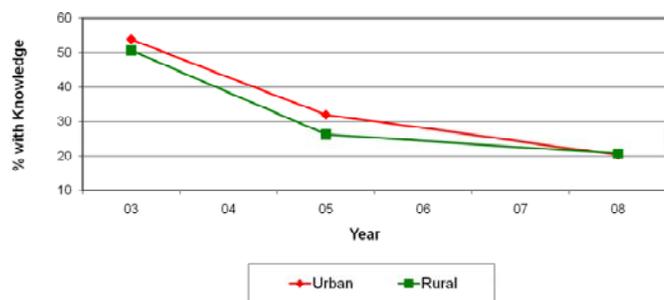
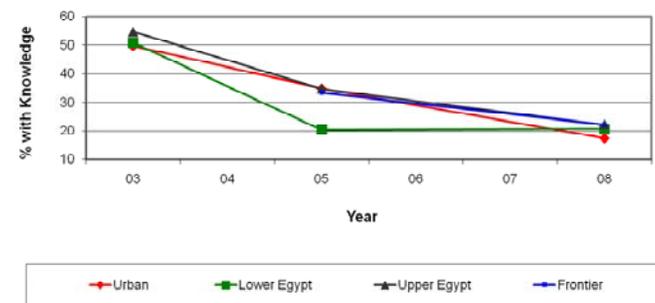


Figure 52: Percent of Ever-Married Women 15-49 Aware of Pregnancy Danger Signs, Region, 2003-2008



Infant and Child Mortality in Egypt

Figure 53: Egypt Infant Mortality Rate (IMR), 1976-2008

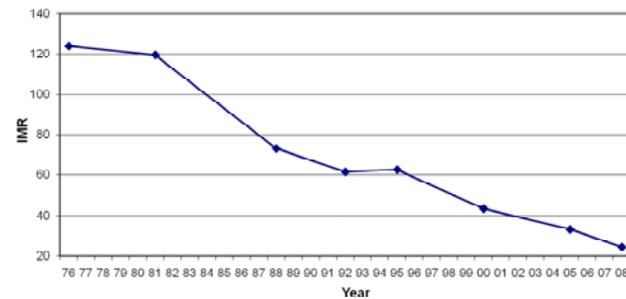


Figure 54: Egypt Infant Mortality Rates by Urban/Rural Status, 1988-2008

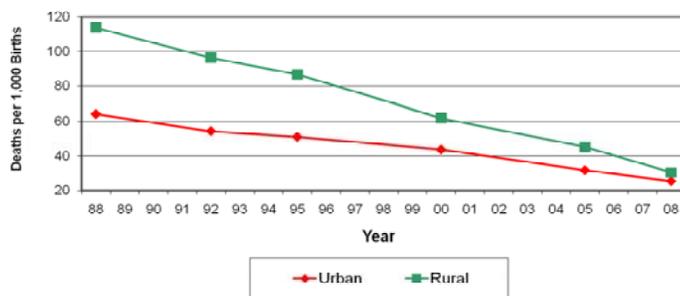
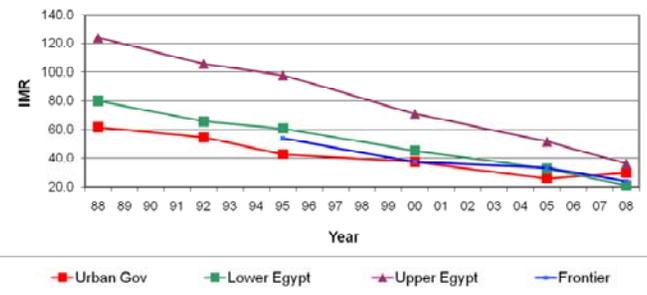


Figure 55: Infant Mortality Rate by Region, 1988-2008



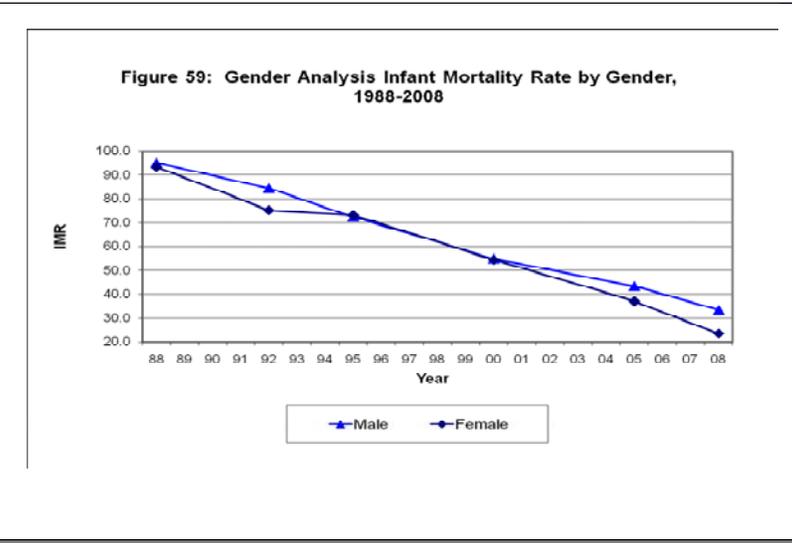
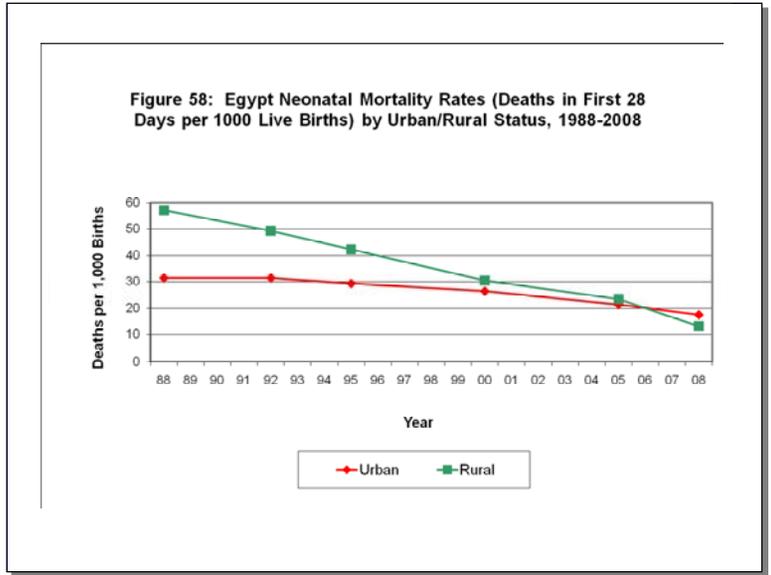
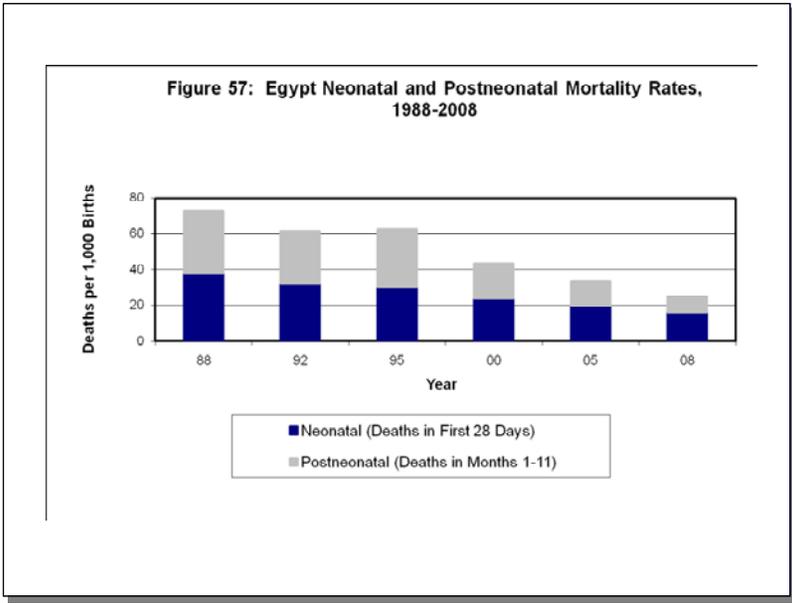
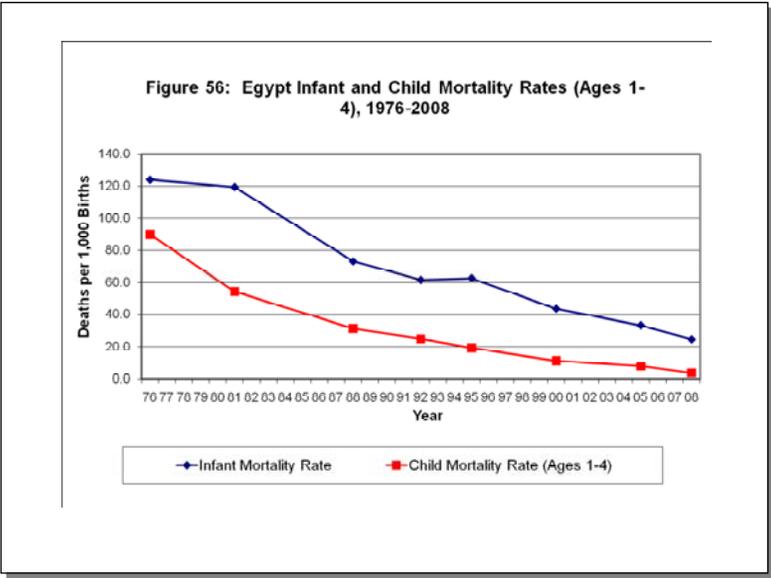


Figure 60: Gender Analysis Child Mortality Rate (Ages 1-4) by Gender, 1988-2008

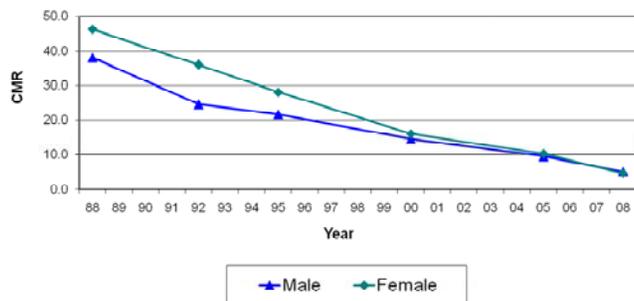


Figure 61: Gender Analysis Neonatal Mortality Rate (0-28 Days) by Gender, 1988-2008

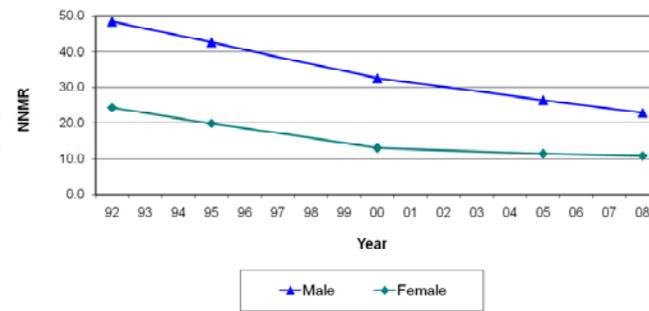


Figure 62: Gender Analysis Postneonatal Mortality Rate (Months 1-11) by Gender, 1988-2008

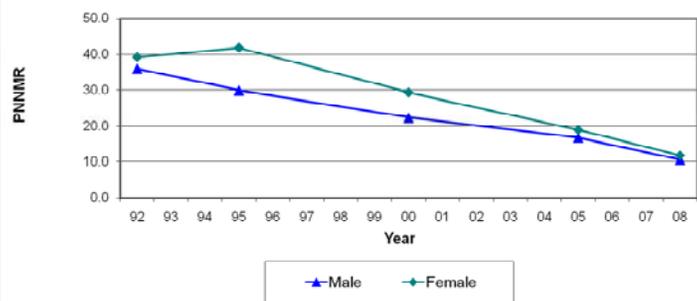


Figure 63: Percentage of Children Aged 12-23 Months Fully Immunized, 1988-2008

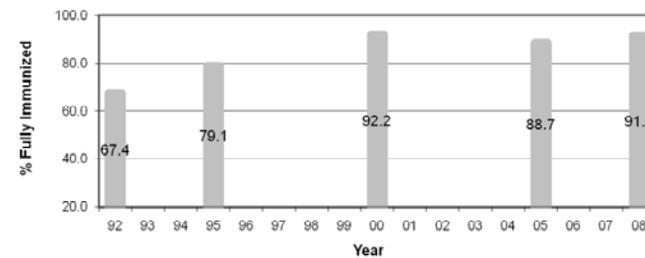


Figure 64: Gender Analysis Percent of Children 12-23 Months of Age Fully Immunized by Gender, 1988-2008

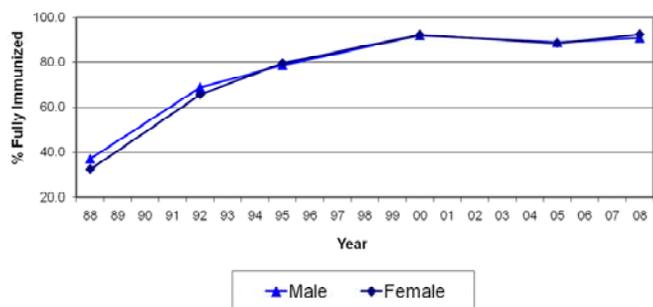


Figure 65: Percentage of Children <5 Years of Age Ever Breastfed and <3 Years of Age Exclusively Breastfed for Six Months, 1992-2008

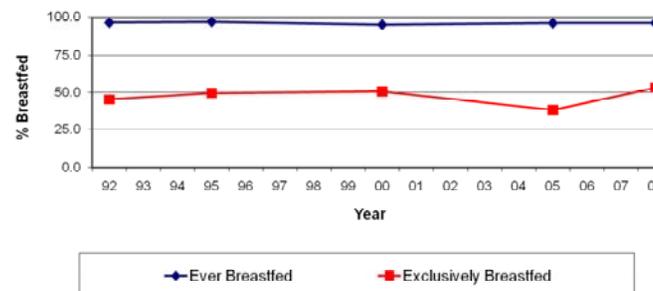


Figure 66: Median Duration of Breastfeeding for Children <5 and Exclusive Breastfeeding among Children <3 Years of Age, 1992-2008

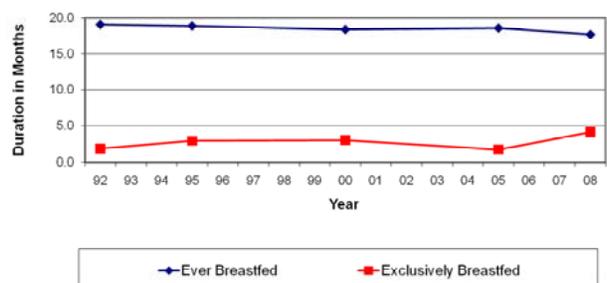


Figure 67: Percentage of Infants Under 6 Months Living with their Mothers Exclusively Breastfed for Three Months, 1988-2008

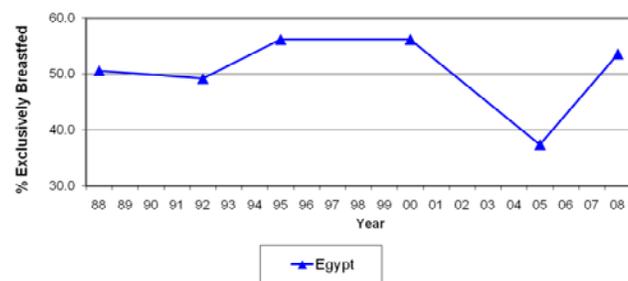


Figure 68: Gender Analysis Percentage of Infants Under 6 Months Living with their Mothers Exclusively Breastfed for 3 Months by Gender, 1988-2008

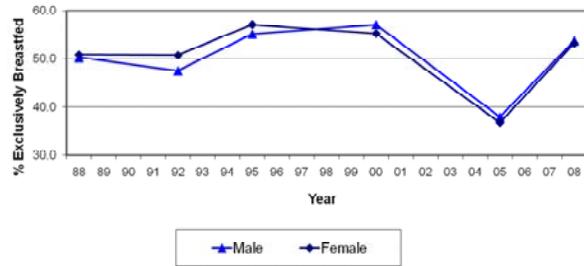


Figure 69: Gender Analysis Duration of Breastfeeding, 1992-2008

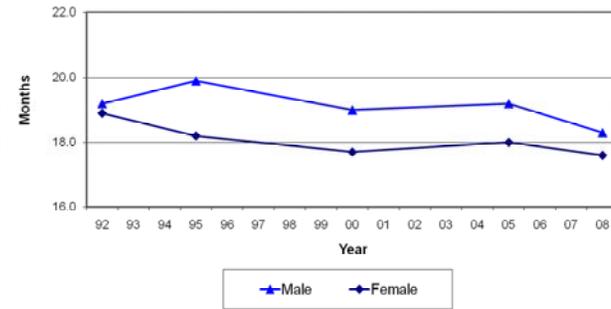


Figure 70: Gender Analysis Duration of Exclusive Breastfeeding, 1992-2008

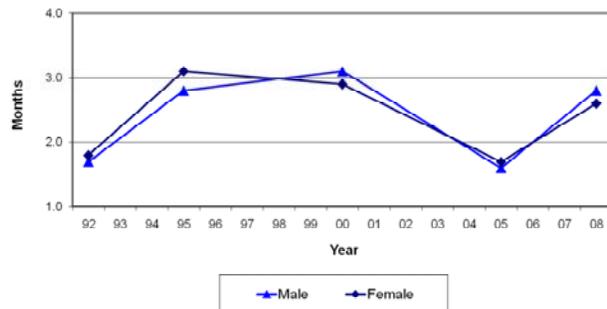


Figure 71: Percentage of All Births Classified as High Risk, 1988-2008

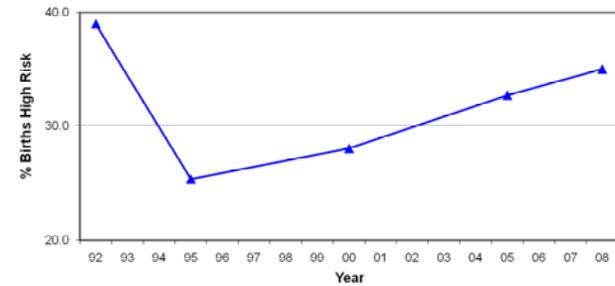


Table 1: Trends in Largest High Birth Risk Categories, 1992 and 2008

1995
 Birth Order > 3 – 21.1%
 First Birth Order – 20.2%
 Birth Interval <24 Months – 12.1%

2008
 First Order Births – 30.0%
 Birth Order >3 – 12.1%
 Birth Interval <24 Months – 9.0%

Figure 72: Mean Birth Intervals for Births <5 Years Prior to Interview and Ideal Birth Interval, 1992-2008

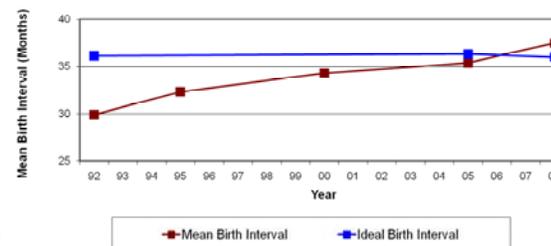


Figure 73: Infant Mortality Rate by Mother's Age at Birth, 2008

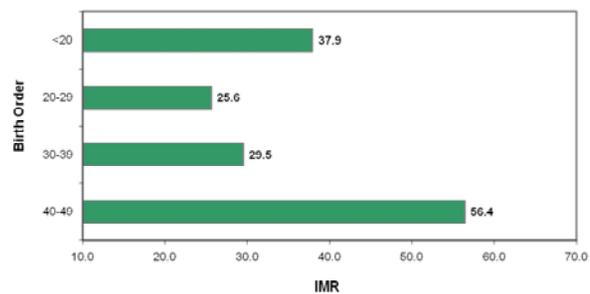
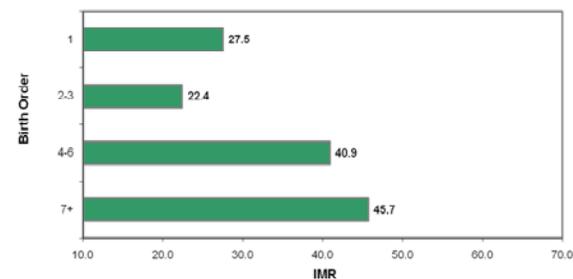
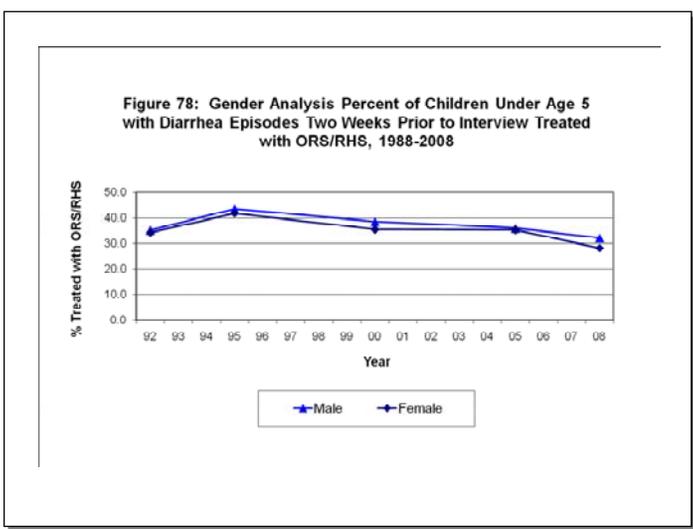
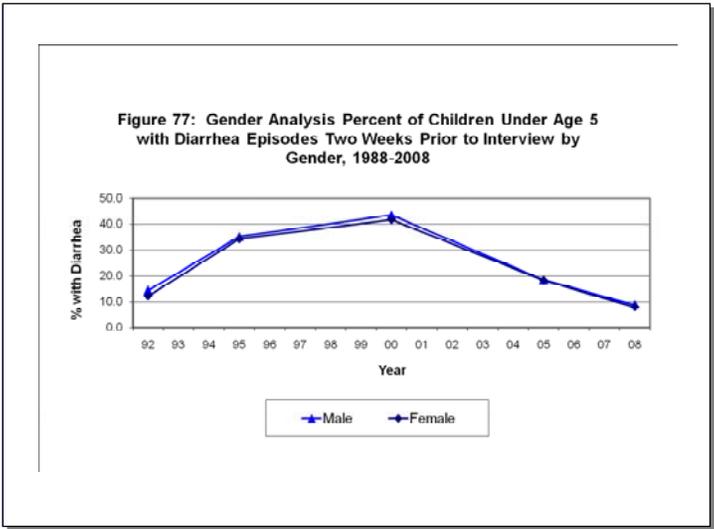
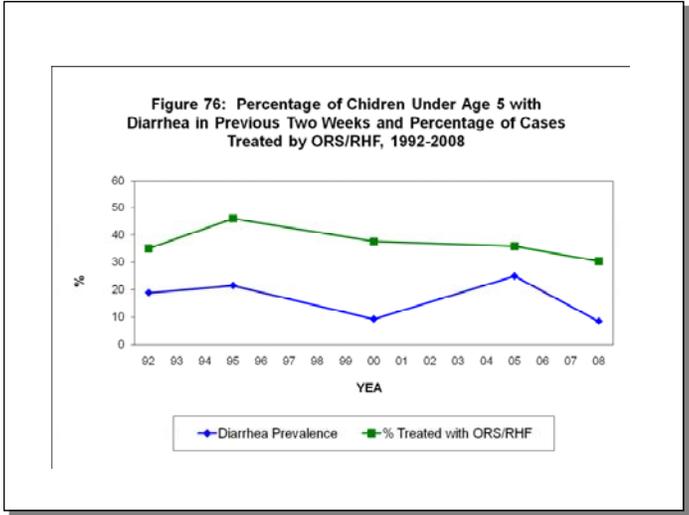
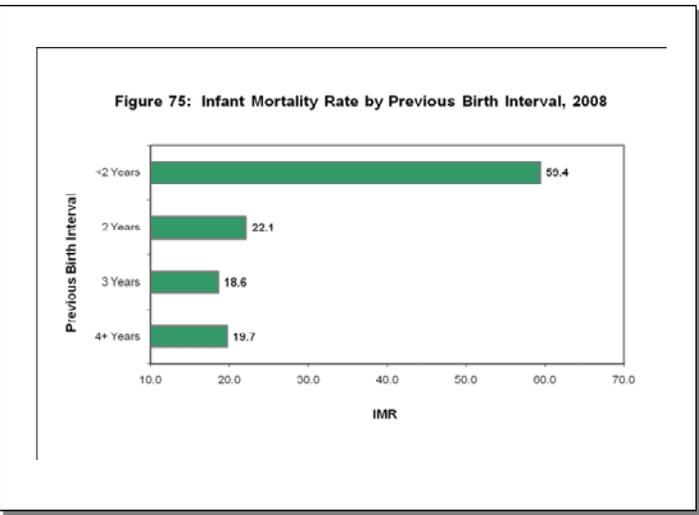
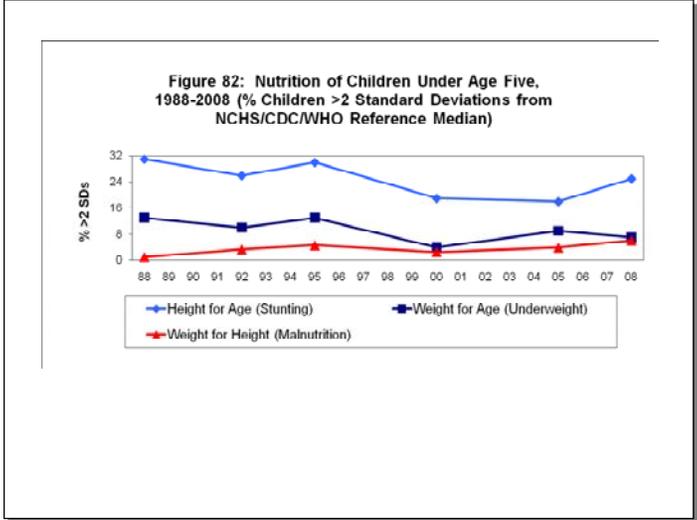
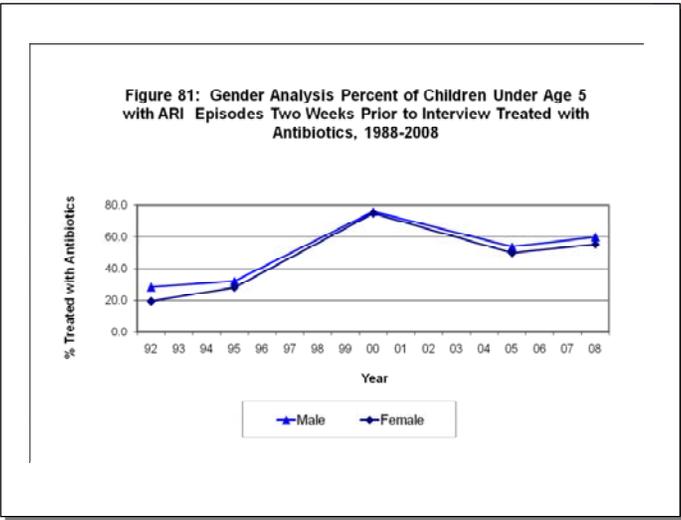
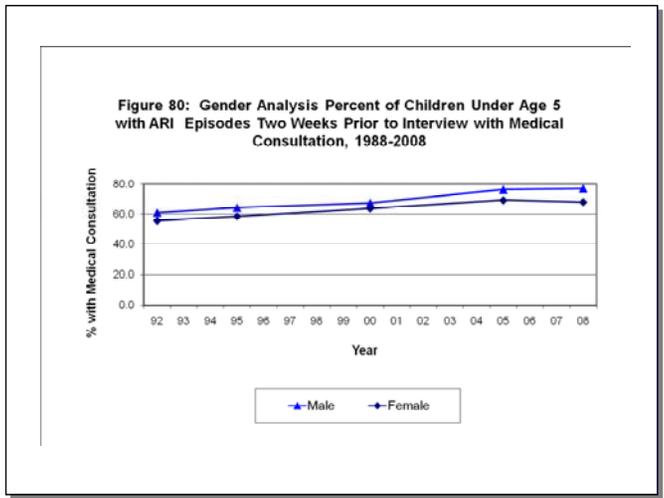
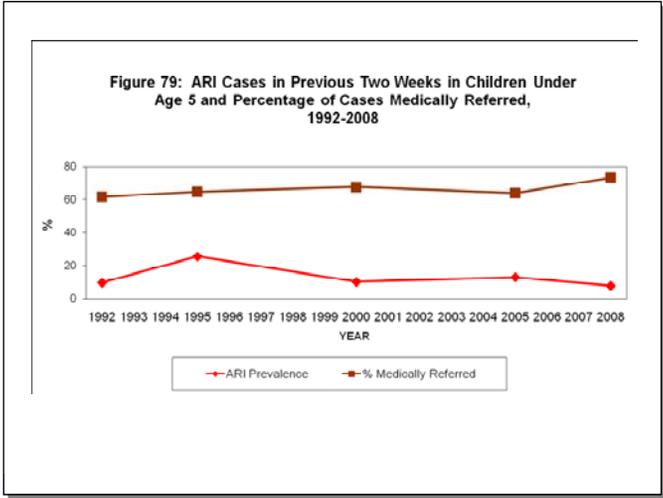
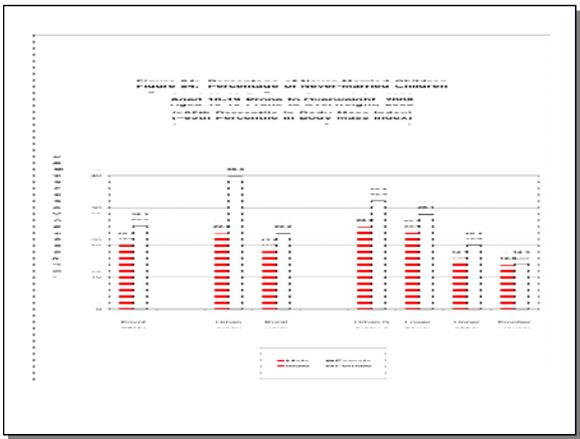
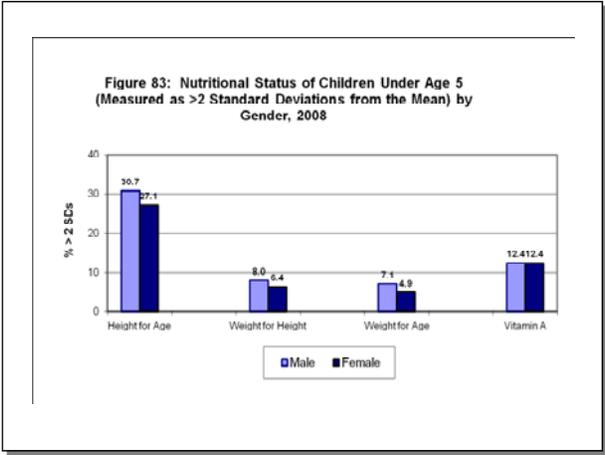


Figure 74: Infant Mortality Rate by Birth Order, 2008









Female Circumcision

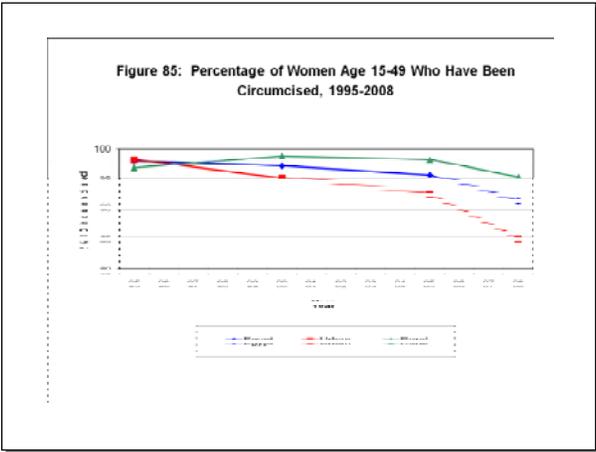


Figure 86: Percentage of Ever-Married Women Aged 15-29 Circumcised, 1995-2008

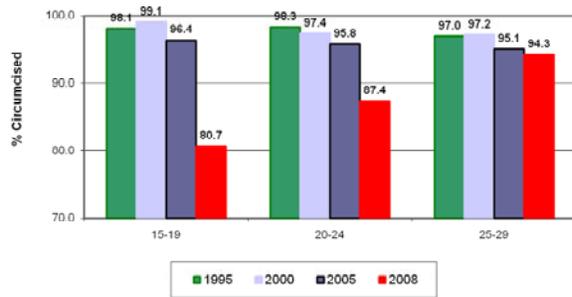
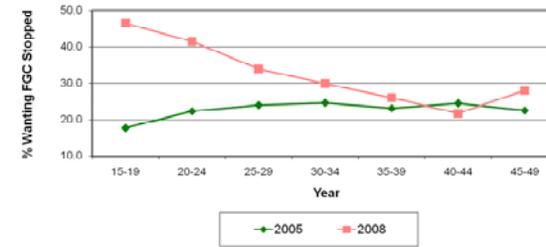
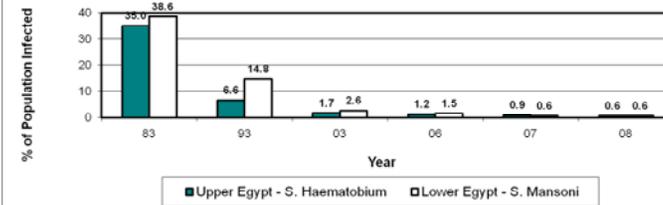


Figure 87: Percentage of Women Age 15-49 Who Want Female Genital Cutting Stopped, 2005-2008



Other Infectious and Communicable Diseases in Egypt

Figure 88: Prevalence of Schistosomiasis in Lower and Upper Egypt (Dominant Strains), 1983-2008



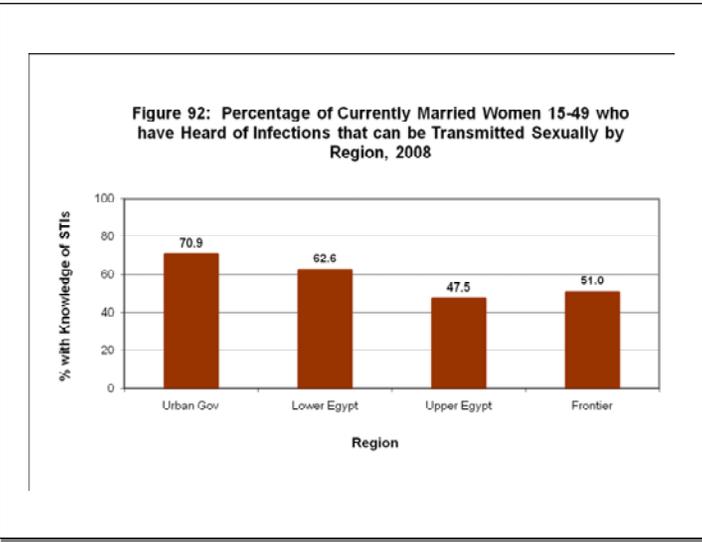
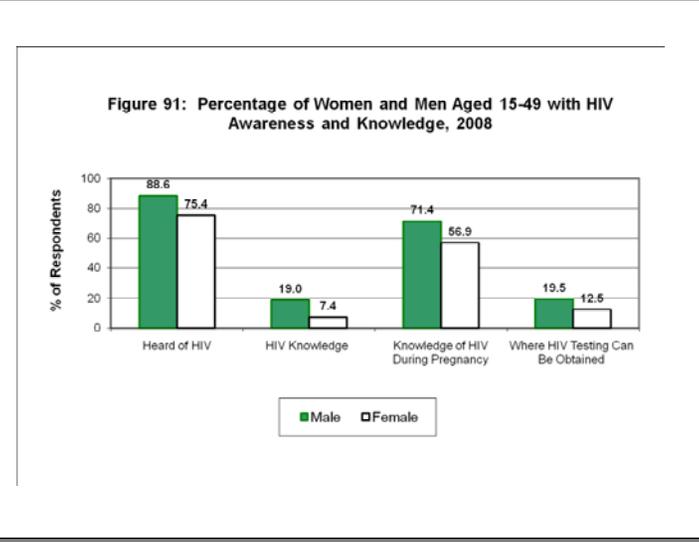
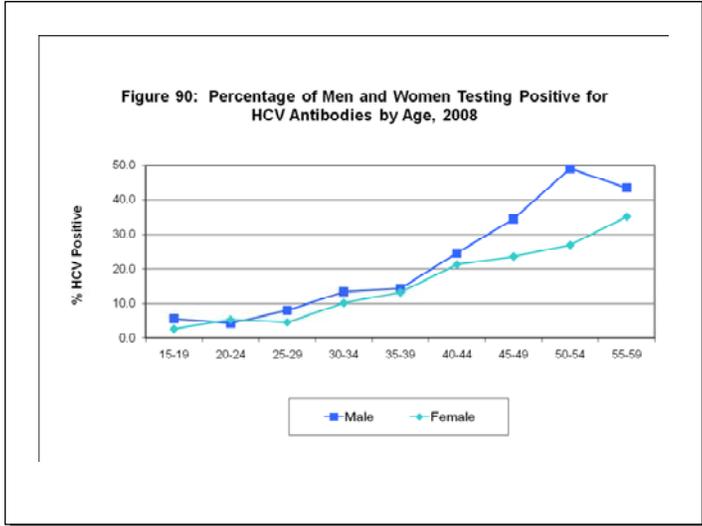
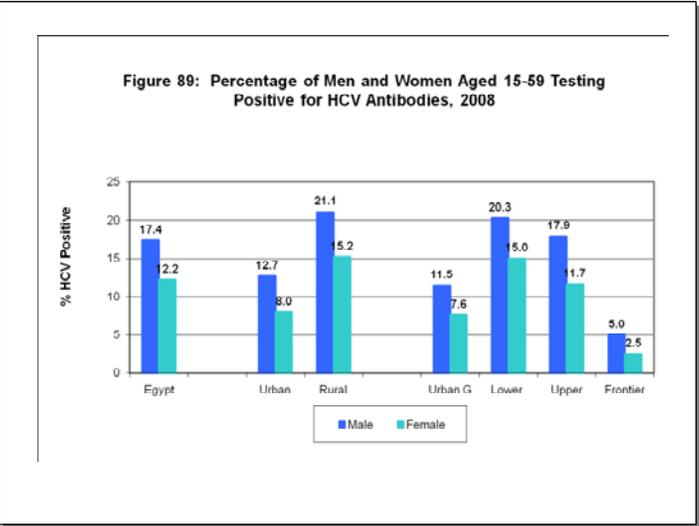


Figure 93: Percentage of Currently Married Women 15-49 with STI Symptoms in Past 12 Months and Percentage Treated by Any Medical Provider by Region, 2008

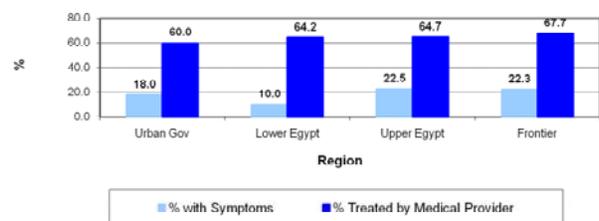


Table 3: Problems Accessing Health Care
(Percentage of Currently Married Women who Cite the Following Factors in Urban and Rural Areas, 2008)

	Egypt	Urban	Rural
1. Permission to Go	7.2	5.7	8.3
2. Getting Money to Go	44.3	34.5	51.2
3. Distance to Facility	17.1	12.4	20.4
4. Transport Problems	19.5	13.2	23.8
5. Difficulty Traveling Alone	26.2	23.3	28.2
6. No Female Provider	40.4	34.4	44.6
7. No Provider Available	63.1	57.1	67.3
8. No Drugs Available	64.3	59.8	67.4

Impacts of Government of Egypt-USAID Program

Key Outcomes

Reduction in Egyptian Fertility

1. Substantial decrease in the TFR from 5.5 in 1975 to 3.0 in 2008
2. Strong evidence that the family planning program in Egypt, with a concomitant drop in fertility, was a major contributor to steep declines in the infant mortality and maternal mortality rates

Increased Use of Modern Contraception

1. Improved access to family planning services and major increase in IUDs and uptake in injectables, but some decline in oral pill use
2. Contraceptive security achieved: Assumption by GOE of all contraceptive forecasting, commodity procurement, and logistics distribution
3. Improved quality of services in the public sector (MOHP Gold Star clinics), PVO (CSI clinics) and private sector (private physician and pharmacist training)

Recognition and Decrease in Incidence of Female Genital Mutilation (FGM)

1. Among currently married women in the EDHS, reduction in the percentage who say FGM should continue (from 82% in 1995 to 68% in 2005)
2. FGM now outlawed, although some attempts were made previously to "medicalize" the practice by requiring FGM be performed within health facilities
3. Evidence between 1995 and 2005 suggests some decline in FGM among girls under 18

Reduction in Egyptian Infant and Child Mortality

1. Infant mortality rate falls from 73 deaths per 1,000 births in 1988 to 24 by 2008
2. Neonatal mortality rate declines from 38 deaths per 1,000 births in first 28 days of life to 16 by 2008
3. Under 5 child mortality rate drops from 102 deaths per 1,000 births in 1988 to 28 by 2008
4. Major gains in family planning use reduces the number of high risk births (first births occurring to very young mothers, high parity births, and births spaced less than 24 months apart)

Reduction in Child Mortality due to Dehydrating Diarrhea

1. Reduction in diarrhea related infant death rates by 82% from 1982-1987 and 62% decline in child death rates
2. Estimated that 300,000 child diarrhea deaths averted between 1982 and 1989
3. Diarrheal disease mortality has continued to decline as percentage of infant and child mortality

Reduction in Child Mortality due to Acute Respiratory Infections (ARI)

1. Mothers recognizing ARI danger signs increased from 30% in 1990 to 72% in 1995
2. EDHS data indicate a steady decline in ARI prevalence in children to under 10% by 2008
3. ARI referrals for medical attention rose to 70% by 2008
4. ARI case registration system was operating in over 2000 clinics by 1996

Reduction in Child Mortality due to Immunizable Diseases

1. Impact of immunization was important factor in reducing infant and under five child mortality
2. Fully immunized child coverage increased from under 40% in 1988 to 92% in 2008
3. Polio eradicated in 2004
4. Measles and pertussis, major contributors to pneumonias and ARI, virtually eradicated
5. Neonatal tetanus, diphtheria, and tubercular meningitis nearly eliminated
6. Assumption by GOE of all vaccine procurement and distribution in 1992

Reduction in Maternal and Neonatal Mortality

1. Maternal mortality ratio falls from 174 per 100,000 live births in 1993 to 84 in 2000
2. Medically assisted deliveries increase from 35% in 1988 to 80% by 2008
3. Maternal mortality differentials between Upper and Lower Egypt substantially diminished
4. Emergency obstetric and neonatal care increasingly available

Communications and Behavior Change

1. High levels of knowledge about family planning and health issues documented in the EDHS
2. Sustainable capacity at State Information Service (SIS) achieved to effectively manage health communications
3. Egypt achieves success in rapid mobilization of knowledge and behavior change related to avian influenza pandemic and actions to control transmission

Survey/Operational Research Capacity Strengthened

1. Evidence on demographic, family planning/RH, and maternal and child health routinely generated, primarily through successive rounds of the EDHS
2. Capacity for undertaking demographic and health surveys established in Egypt
3. Operations research completed on priority issues pertaining to family planning and RH (e.g., post-abortion care, duration of IUD use, postpartum programs, FGM, and FP counseling)
4. Two maternal mortality surveys conducted and a national Maternal Mortality Surveillance System (MMSS) established

Disease Surveillance and Outbreak Response Capacity

1. Schistosomiasis prevalence dropped from 50% of population in 1980s to 2% in 2009
2. Effective H5N1 case finding and treatment program established by MOHP was linked to capacity built by USAID's Field Epidemiology Training Program (FETP)
3. Infectious and chronic disease research capacity in collaboration with Schisto Project and HCV work
4. Diarrhea and ARI surveillance and program research on treatment strengthened

Health Sector Reform and Health Systems Development

1. Health facility accreditation program currently being implemented for primary health clinics and hospitals
2. Health Management Information Systems (HMIS) strengthened at the MOHP, Egypt's Health Insurance Organization (HIO), and public hospitals
3. Capacity to conduct National Health Accounts well established in MOHP

Family Planning Impact Analysis 1976-2005 (Scott Moreland Projections)

Figure 94: Egypt Contraceptive Prevalence Rate (CPR), Actual and Counterfactual, 1976-2005 (Scott Moreland Analysis)

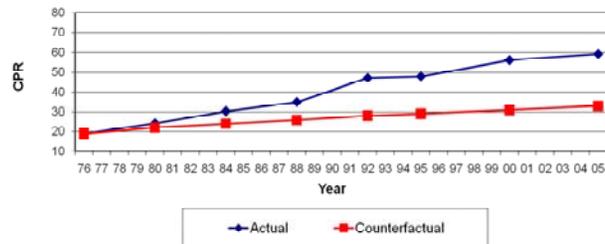


Figure 95: Egypt Total Fertility Rate (TFR), Actual and Counterfactual, 1976-2005 (Scott Moreland Analysis)

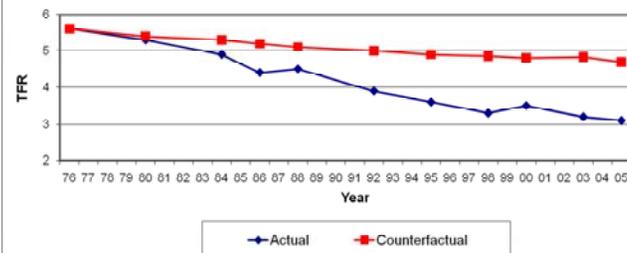
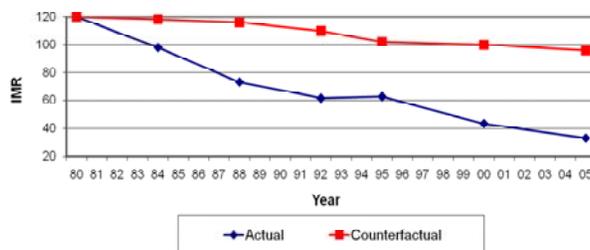


Figure 96: Egypt Infant Mortality Rate (IMR), Actual and Counterfactual, 1976-2005 (Scott Moreland Analysis)



Major Impacts of Egypt's Population Program, 1980-2005

1. Total Population in 2005 is 71.3 million compared to the counterfactual of 83.6 million (a difference equivalent to the present-day population of Cairo)
2. By 2005, there are 10 million fewer young people in the non-working ages 0-14 in comparison to the counterfactual projection – thereby reducing pressure on educational facilities and future employment generation.

Major Impacts of Egypt's Population Program, 1980-2005

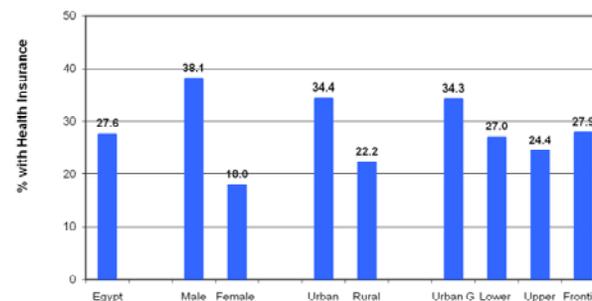
- 3. By 2005, Egypt experienced more than 3 million fewer infant deaths (1.3 million due to fewer births and 1.8 million due to lower risk)
- 4. By 2005, there were over 6 million fewer deaths among children under age 5
- 5. Over the 25 year projection period, 17,000 mothers' lives were saved

Major Impacts of Egypt's Population Program, 1980-2005

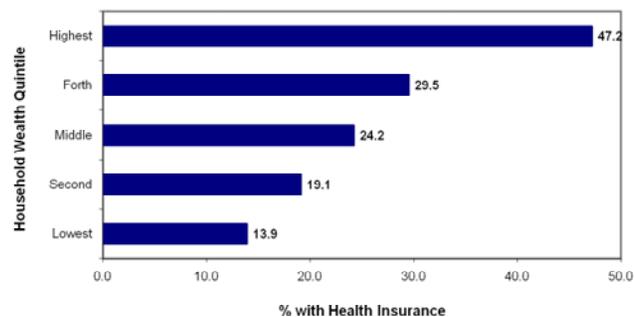
- 6. Moreland's cost-saving estimates resulting from Egypt's investment in family planning between 1980-2005 are as follows :
 - Education – LE 36,565 million
 - Immunization – LE 783 million
 - Food Subsidies - LE 8,489 million
 - Total - LE 45,838 million
- 7. Egypt's family planning program over the same period cost LE 2,402 million

Financial Charts

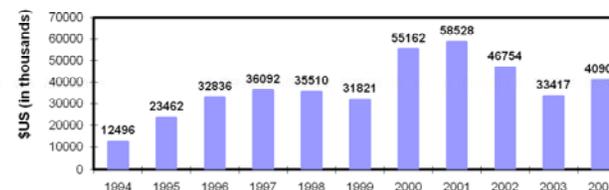
Percentage of Egyptian Population Aged 15-49 with Health Insurance, 2008



Percentage of Egyptian Population with Health Insurance by Wealth Quintile, 2008



Annual Primary Population Assistance for Egypt, 1994-2004 (UNFPA/NIDI Estimates)



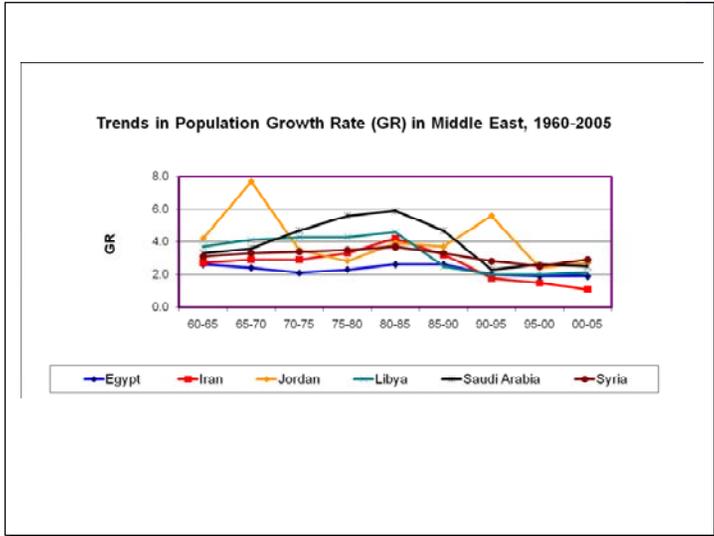
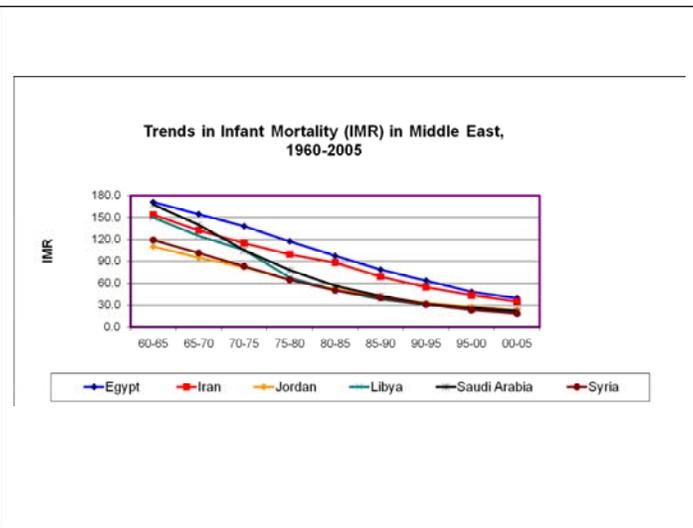
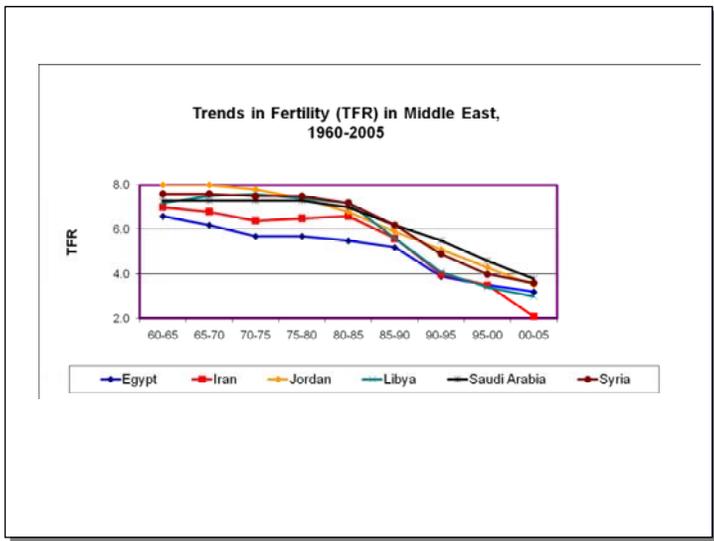
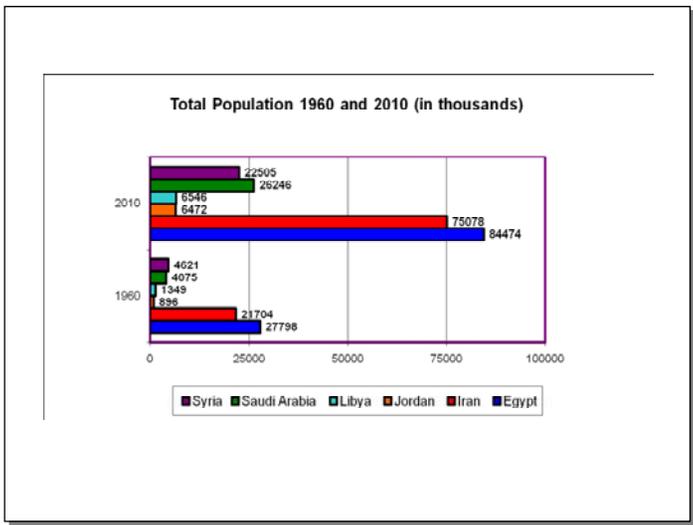
Cross-Country Comparisons

Demographic Trends in Egypt Compared to Other Middle East Countries

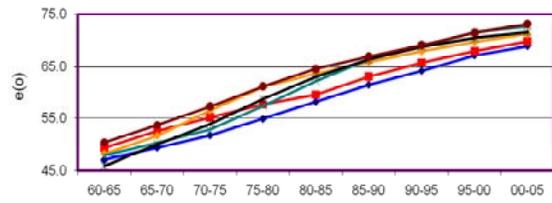
Gross National Product (GNP), Per-Capita National Income, and Percentage of GNP for Military Expenditures, 2007

Country	GNP \$US Dollars (billions)	Per-Capita GNI	Military Expenditures as % of GNP
Egypt	130.5	1,580	2.5
Bangladesh	68.4	470	1.1
Indonesia	432.8	1,650	1.2
Iran	286.1	3,540	3.0
Jordan	15.8	2,840	6.9
Libya	58.3	9,010	-
Saudi Arabia	381.7	15,470	9.3
Syria	37.7	1,780	3.9
Turkey	655.9	8,030	2.1

Source: World Bank, 2009, Key Development Data and Statistics, <http://web.worldbank.org/wbsite/external/datastatistics>



Trends in Life Expectancy in Middle East,
1960-2005



Legend: Egypt (blue line with diamond), Iran (red line with square), Jordan (orange line with triangle), Libya (green line with circle), Saudi Arabia (black line with cross), Syria (purple line with asterisk)

For more information, please visit:
<http://www.ghtechproject.com/resources>

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