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PROJECT PERFORMANCE ASSESSMENT REPORT

ARAB REPUBLIC OF EGYPT

POPULATION PROJECT
(CREDIT NO. 2830-EGT)

June 25, 2008

Sector Evaluation Division
Independent Evaluation Group

Currency Equivalents (annual averages)

Currency Unit = Egyptian Pounds (LE)

February 15, 1992
US$1.00 = LE 3.308
LE 1.00 = US$0.30

January, 1996
US$1.00 = LE 3.4
LE 1.00 = US$0.29

January 31, 2003 (end of four-month grace period)
US$1.00 = LE 5.370
LE 1.00 = US$0.19

July 29, 2005
US$1.00 = LE 5.780
LE 1.00 = US$0.17

Abbreviations and Acronyms

CBC	Communications for behavior change
CBO	Community-based organization
CDA	Community development associations
CI	Confidence interval
DHS	Demographic and Health Survey
EDHS	Egypt Demographic and Health Survey
EU	European Union
FP	Family planning
GoE	Government of Egypt
HSRP	Health Sector Reform Project
ICR	Implementation Completion Report
IEG	Independent Evaluation Group
IEGWB	Independent Evaluation Group (World Bank)
MoH	Ministry of Health
MoHP	Ministry of Health and Population
MoPFP	Ministry of Population and Family Planning
MoU	Memorandum of Understanding
MTR	Mid-term review
NGOs	Non-governmental organizations
PPAR	Project Performance Assessment Report
RH	Reproductive health
SCA	Social change agent
SDRs	Special Drawing Rights
SFD	Social Fund for Development
TAHSEEN	*Tahseen Sehetna Bi Tanzeem Usretna* (USAID-financed "Improving Our Health by Planning Our Families" Project)
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

Fiscal Year

Government: July 1 – June 30

Director-General, Evaluation	:	Mr. Vinod Thomas
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IEGWB Mission: Enhancing development effectiveness through excellence and independence in evaluation.

About this Report

The Independent Evaluation Group assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEGWB annually assesses about 25 percent of the Bank's lending operations through field work. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons.

To prepare a Project Performance Assessment Report (PPAR), IEGWB staff examine project files and other documents, interview operational staff, visit the borrowing country to discuss the operation with the government, and other in-country stakeholders, and interview Bank staff and other donor agency staff both at headquarters and in local offices as appropriate.

Each PPAR is subject to internal IEGWB peer review, Panel review, and management approval. Once cleared internally, the PPAR is commented on by the responsible Bank department. IEGWB incorporates the comments as relevant. The completed PPAR is then sent to the borrower for review; the borrowers' comments are attached to the document that is sent to the Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

About the IEGWB Rating System

IEGWB's use of multiple evaluation methods offers both rigor and a necessary level of flexibility to adapt to lending instrument, project design, or sectoral approach. IEGWB evaluators all apply the same basic method to arrive at their project ratings. Following is the definition and rating scale used for each evaluation criterion (additional information is available on the IEGWB website: http://worldbank.org/ieg).

Outcome: The extent to which the operation's major relevant objectives were achieved, or are expected to be achieved, efficiently. The rating has three dimensions: relevance, efficacy, and efficiency. *Relevance* includes relevance of objectives and relevance of design. Relevance of objectives is the extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). Relevance of design is the extent to which the project's design is consistent with the stated objectives. *Efficacy* is the extent to which the project's objectives were achieved, or are expected to be achieved, taking into account their relative importance. *Efficiency* is the extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. The efficiency dimension generally is not applied to adjustment operations. *Possible ratings for Outcome:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Risk to Development Outcome: The risk, at the time of evaluation, that development outcomes (or expected outcomes) will not be maintained (or realized). *Possible ratings for Risk to Development Outcome:* High Significant, Moderate, Negligible to Low, Not Evaluable.

Bank Performance: The extent to which services provided by the Bank ensured quality at entry of the operation and supported effective implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of supported activities after loan/credit closing, toward the achievement of development outcomes. The rating has two dimensions: quality at entry and quality of supervision. *Possible ratings for Bank Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower (including the government and implementing agency or agencies) ensured quality of preparation and implementation, and complied with covenants and agreements, toward the achievement of development outcomes. The rating has two dimensions: government performance and implementing agency(ies) performance. *Possible ratings for Borrower Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

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This report was prepared by Denise Vaillancourt, who assessed the project in November 2007. Marie-Jeanne Ndiaye provided administrative support.

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PRINCIPAL RATINGS

Population Project (Cr. 2830-EGT)

	*ICR**	*ICR Review**	*PPAR*
Population Project (Credit 2830)			
Outcome	Satisfactory	Satisfactory	Moderately Satisfactory
Sustainability[a]	Likely	Likely	_____
Risks to Development Outcome[b]			Substantial
Institutional Development Impact[a]	Substantial	Substantial	_____
Bank Performance	Satisfactory	Satisfactory	Moderately Satisfactory
Borrower Performance	Satisfactory	Unsatisfactory	Moderately Unsatisfactory

a. This rating was discontinued as of July 1, 2006

b. This rating was introduced as of July 1, 2006.

* The Implementation Completion Report (ICR) is a self-evaluation by the responsible Bank department. The ICR Review is an intermediate IEGWB product that seeks to independently verify the findings of the ICR.
**As of July 1, 2006, Institutional Development Impact is assessed as part of the Outcome rating.
***As of July 1, 2006, Sustainability has been replaced by Risk to Development Outcome. As the scales are different, the ratings are not directly comparable.

KEY STAFF RESPONSIBLE

Population Project (Cr. 2830-EGT)

Project	*Task Manager/Leader*	*Division Chief/ Sector Manager*	*Country Director*
Preparation	David Steel	Jacques Baudouy	Ram K. Chopra
Appraisal	David Steel	Jacques Baudouy	Inder Sud
Supervision	Alaa Mahmoud Hamed	George Schieber/Akiko Maeda	Mahmood Ayub
Completion	Alaa Mahmoud Hamed	Akiko Maeda	Emmanuel Mbi

PREFACE

This is the Project Performance Assessment Report (PPAR) for the Egypt Population Project, financed through IDA Credit No. 2830 in the amount of US$17.2 million (11.9 million SDRs), with planned government and community contributions of US$1.6 million and US$1.9 million, respectively. The credit was approved on March 21, 1996, became effective on June 24, 1998, and was 87 percent disbursed when it closed on March 31, 2005, three years and three months after the originally planned closing date.

The findings of this assessment are based on an Independent Evaluation Group (IEG) mission to the Arab Republic of Egypt carried out in November 2007. The mission met in Cairo with authorities and staff of: (i) the Ministry of Health and Population and the Social Fund for Development; (ii) research institutions; (iii) selected NGOs and civil society groups; and (iv) the development partners. The mission also visited the Urban Governorate of Alexandria, and districts and villages in the Upper Egypt Governorates of Menya and Qena, where it met with health authorities, health and family planning services providers, NGOs, civil society actors, social change agents and project beneficiaries to assess inputs and activities supported by the Bank. Key sources of evidence consulted include: (a) World Bank project files; (b) project-related reporting and evaluation; (c) health facility data; and (d) epidemiological data, studies, surveys and research on health, much of it generated in Egypt.

This PPAR is one of several conducted on the development effectiveness of the World Bank's support to health, nutrition and population in different countries. Evidence from these assessments and country case studies on the Bank's lending and non-lending support will contribute to a forthcoming evaluation by IEG of the World Bank's support to health, nutrition and population outcomes over the past decade. As such, more material has been presented in this "enhanced" PPAR than is the IEG standard.

This report draws on the technical inputs of Alejandra Gonzalez, mission member and author of a case study on the development effectiveness of the Bank's support to Egypt's HNP sectors over the past decade (to be issued under separate cover). The IEG team gratefully acknowledges the contributions of Ms. Nadia El Gohary and Ms. Ingy Halim, who provided logistical support to the IEG mission and assisted in the translation of key data. The IEG team also gratefully acknowledges all those who made time for interviews and provided documents and information.

Following standard IEG procedures, copies of the draft PPAR were sent to the relevant government officials and agencies for their review and feedback. Their comments are presented in Annex I.

SUMMARY

Egypt's resident population in 2006 was 72.6 million, some 20 million (or 37 percent) more than the population size just 15 years prior, and it is highly concentrated around the arable land around the Nile Delta and Valley. The annual rate of natural increase (currently estimated at 1.8 percent) appears to be slowing down as fertility has declined more rapidly than mortality over the past 15 years. The Government of Egypt (GoE) has supported a national population policy for well over 40 years, but increase in contraceptive prevalence rates and declines in fertility have been inequitable.

The *objectives* of the Egypt Population Project were "...to help Egypt: (a) better manage population growth and prevent avoidable population growth by giving the Ministry of Health and Population (MoHP) the institutional capacity to play the lead role in the population sector; and (b) improve the conditions and status of women and children in areas where fertility remains high, mainly in rural areas of Upper Egypt, by stimulating additional demand for smaller family size and for family planning services." Key performance indicators were established to track changes in attitudes (desired number of children, approval of family planning, and intention to use contraception), behavior (contraceptive prevalence) and outcome (total fertility).

The project's support was organized around two *components.* The *Capacity Building* component was designed to strengthen the strategic management capacity of the newly established Population and Family Planning Sector (PS) of the Ministry of Health and Population (MoHP). The *Population Activities Program (PAP)* component was designed as a small grants program to finance community-level subprojects, proposed and managed by NGOs and other civil society organizations, aimed at stimulating demand for family planning. Its geographic focus was on rural Upper Egypt, where fertility was high and demand for and use of family planning services were low.

A Project Implementation Unit (PIU), housed in the MoHP, was responsible for the implementation of the Capacity Building component. The PAP Small Grants component, which constituted 87 percent of the total project cost, was contracted to the Social Fund for Development (SFD).

Better management of population and family planning. No specific indicators for this objective were identified during project design. In line with a decision taken at the project's mid-term review (MTR), support to population capacity building was reoriented away from an initial focus on central MoHP, concentrating instead on the governorate, district and community levels within Rural Upper Egypt. The project provided training and technical assistance to various groups of local-level actors to strengthen their respective capacities in the planning, design, delivery and oversight of population and family planning activities. However, the impact of this training was not evaluated. The project developed a new cadre of social change agents, made up of respected women from the communities, which served as an effective interface between target women and family planning information and services. The project was instrumental in forging effective partnerships at the local level between MoHP, the SFD, NGOs and other community members in the design and delivery of population and family planning activities in selected districts and villages and at the governorate level. However, it was

less successful in supporting and institutionalizing MoHP partnerships with NGOs and civil society organizations at the national level. An NGO Support Department was created in MoHP/PS but never became fully functional. Notwithstanding its support to the implementation of project-specific M&E, the project was unsuccessful in strengthening MoHP/PS capacity to monitor and evaluate the overall progress of national population and family planning efforts. The project also contributed to increased contraceptive security and procurement capacity.

Changes in attitudes, behaviors and outcomes in Rural Upper Egypt. The project supported the implementation of fifty-five subprojects, designed and managed by community development associations, providing the poorest villages of Rural Upper Egypt with a package of information and services that are known to influence changes in desired family size and increased contraceptive use. During the period of subproject implementation, modest advances were made on women's literacy rates and employment rates in Rural Upper Egypt. It is plausible to assume that subprojects may have made some contribution to modest changes in these and other socio-economic indicators in Rural Upper Egypt. However, project attribution is difficult to establish given that (a) the coverage and impact of various demand-side interventions on socio-economic indicators were not evaluated and (b) numerous other socio-economic development activities were ongoing in the project area. Project investments in infrastructure, equipment, contraceptives and training supported improvements in the supply and quality of family planning services offered in or near villages benefiting from demand-side interventions.

Between 2000 and 2005 total wanted fertility (total actual fertility minus unwanted births) declined in Rural Upper Egypt from 3.7 to 2.6 children, a total decrease of 1.1 children. This decline is greater than what was achieved during the previous five-year period in Rural Upper Egypt and also more important than overall national declines between 2000 and 2005. During this period the use of family planning became even more acceptable. In 2005 85 percent of ever-married women residing in Rural Upper Egypt considered it appropriate to use family planning after the first birth compared with 70 percent in 2000. However, demand for family planning (met and unmet) increased only very modestly (from 60 to 63 percent).

Between 2000 and 2005, contraceptive prevalence rose from 40 to 45 percent in Rural Upper Egypt (compared with an increase from 56 to 59 percent for all of Egypt). It increased in all eight of the governorates in Rural Upper Egypt, ranging in 2005 from a low of 33 percent in Souhag to a high of 62 percent in Giza. The share of total demand for family planning which is satisfied increased slightly in rural Upper Egypt from 69 percent in 2000 to 73 percent in 2005, while it remained virtually unchanged for Egypt as a whole. Between 2000 and 2005 the total actual fertility rate (TFR) in rural Upper Egypt declined by 0.8 children, from 4.7 to 3.9, faster than the decline for country as a whole. The TFR in Upper Egypt is still high compared with other regions in Egypt, but the statistically significant change in this rate is a major accomplishment and has narrowed the gap across regions. Women's actual fertility is still greater than their desired fertility; and the gap between actual and desired fertility appears to be growing in Egypt, with the most rapid growth in Upper Egypt.

The changes in attitude, contraceptive use and fertility in Rural Upper Egypt cannot be solely or even primarily attributed to the project. First, only 9 percent of villages were covered. Second, two other major development partners were financing similar (demand- and supply-side) interventions, also targeted to rural Upper Egypt. Third, other development and poverty alleviation activities are also likely to have improved the economic opportunities of women and family wellbeing. Fourth, data on key indicators in the 148 villages of project intervention are incomplete, although they do provide partial evidence of some positive effects. Nevertheless, the project influenced changes in population indicators in Rural Upper Egypt beyond the villages of direct intervention. The multi-sectoral, demand-side approach developed under the project was an important departure from previous (supply-side) interventions in Egypt and influenced the design and implementation of interventions in Rural Upper Egypt financed by others.

The outcome of the Population project is *moderately satisfactory.* The outcome of the first (management capacity building) objective is *unsatisfactory*, based on its *modest relevance, efficacy and efficiency*. The outcome of the second (fertility decline) objective is *satisfactory*, based on its *substantial relevance, efficacy and efficiency*. The overall outcome of *moderately satisfactory* is a function of the heavier weight applied to the second objective. Risk to development outcome is rated as *substantial*. The Bank's performance was *moderately satisfactory* and the Borrower's performance was *moderately unsatisfactory.*

Lessons:

- Supply-side and demand-side interventions supporting population and family planning objectives can be truly synergistic when they are delivered through a well-defined and well-functioning partnership of local actors.
- An important element of any investment in management capacity building is the support of monitoring and evaluation activities. However, when the focus of M&E support is project-specific, rather than program-wide, an opportunity is missed to learn from experience across projects and to use evidence to fine-tune national policies and strategies. This lesson is especially relevant when innovative activities are supported in the same geographic area by different externally-financed projects.
- Demand-side interventions, though critical to achieving population and family planning goals, are not likely to be sustained or expanded in the absence of an institutional home for these activities and a well-defined, evidence-based program of activities.
- Efforts to ensure and improve the quality and client-orientation of family planning become all the more crucial when they are undertaken in the context of health sector reform program.

Vinod Thomas
Director-General
Evaluation

1. BACKGROUND AND CONTEXT

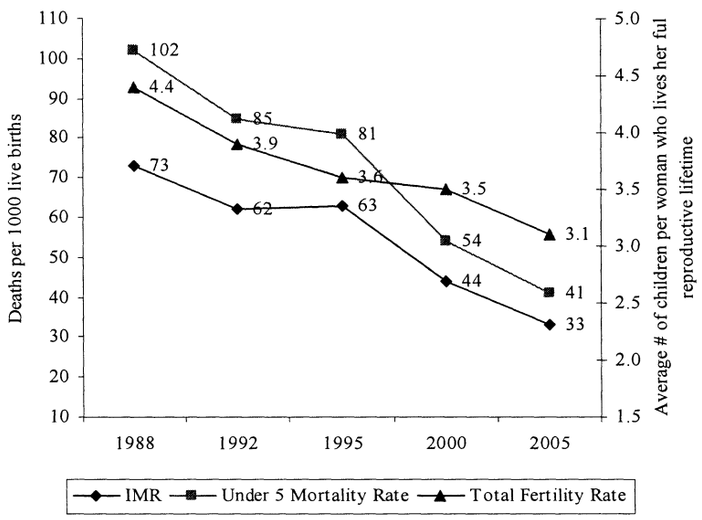
1.1 **General Country Information**. Only 6 percent of the total area of Egypt is inhabited. Despite the recently adopted Egyptian policy of reclamation and fostering of new settlements in the desert, the majority of Egyptians live either in the Nile Delta, located in the north of the country, or in the Nile Valley (south of Cairo).

1.2 Egypt is divided into 28 governorates and Luxor City. The five Urban Governorates (Cairo, Helwan, Alexandria, Port Said and Suez) have no rural population. Of the remaining 23 governorates, nine are in the Nile Delta (Lower Egypt Region), nine are in the Nile Valley (Upper Egypt Region) and five are Frontier Governorates located on the eastern and western boundaries of Egypt.

1.3 Egypt's economy expanded steadily during the 1990s. GDP per capita reached US$1,580 by 2006 (World Bank data, 2008). Annual growth of GDP averaged 4 percent during the period 1986-1996 and increased to an average of 4.4 percent the following decade (1996-2006), reaching 6.8 percent in 2006. Similarly, annual growth of GDP per capita averaged 1.9 percent during 1986-96, increased to an average of 2.4 percent the following decade, and reached a level of 4.9 percent in 2006 (World Bank, 2005). Between FY96-00 the poverty incidence rate declined from 19.4 percent to 16.7 percent, likely attributable in part to overall economic growth during that period. But there are important disparities across regions. Upper Egypt, the poorest region, grew at a slower rate than Lower and Metropolitan Egypt, and poverty increased there.

1.4 The last 20 years have also shown important gains in Egypt's human development indicators. Between 1980 and 2002, gross primary enrollment rates rose from 73 to 96 percent, gross secondary enrolment rates rose from 50 to 85 percent, and life expectancy increased from 55.5 to 68.9 years. Both infant and under five mortality rates, as well as total fertility, fell dramatically between 1988 and 2004 (Figure 1.1). However, significant inequities persist in health outcomes, among poorest income quintiles, rural areas and poorest regions. Further, the growth in non-communicable diseases and injuries present additional challenges to efforts to improve

Figure 1.1: Health and Fertility, 1988 – 2005



Source: DHS 1988, 1992, 1995, 2000 and 2005

health outcomes while containing the costs and improving efficiencies of health programs and services. The gender gap in school enrollments, participation in the labor force, access to credit, and women's rights has been closing (World Bank, 2005).

POPULATION IN EGYPT

1.5 According to the results of the most recent (2006) census, Egypt's resident population in 2006 was 72.6 million,[1] of which 31.0 million (43 percent) were urban and 41.6 (57 percent) rural. Between 1991 and 2006, Egypt's resident population grew by almost 20 million, a 37 percent increase, and the urban-rural breakdown of Egypt's population remained virtually unchanged. The rate of natural increase of Egypt's population appears to be slowing down. Between 1991 and 2004, the crude birth rate declined from 30 to 26 per 1000 population, while the crude death rate declined, mainly in the 1990s, from 7.2 to 6.4 per 1000.

GOVERNMENT'S RESPONSE

1.6 The Government of Egypt (GoE) has long recognized the implications of rapid population growth on the social and economic development prospects of Egypt and has supported a national population policy for well over 40 years.[2] Already in 1953 the National Commission for Population Affairs considered population growth to be an obstacle in raising overall standards of living. This view is also reflected in the GoE's 1995 Letter of Health Sector Policy, which stated that population growth is "...one of the central constraints to Egypt's per capita income, productivity, education and health" (World Bank, 1996). Growing pressure on Egypt's limited arable land and the high cost of bringing new land into production were also concerns (Cochrane and Massiah, 1994). Egypt was one of the first countries to adopt formal population policies and objectives and population continues to be accorded highest priority by the highest levels of government. National efforts, supported by bilateral and multilateral assistance, have culminated in well-documented increases in contraceptive prevalence rates and declines in fertility, but gains have differed: across regions, between urban and rural areas, across levels of education and across income groups. Poor, less educated women, rural residents and residents of the Region of Upper Egypt have much less favorable population indicators than the national average.

1.7 In 1993, the year prior to project preparation, a Ministry of Population and Family Planning (MoPFP) was created, giving population a direct voice in the Cabinet and the long-existing National Population Council (NPC) was reorganized to serve as a think-tank on population issues. This also facilitated the preparation of the landmark International Conference on Population and Development (ICPD), which was held in Cairo in 1994. In 1996 the MoPFP was merged into the Ministry of Health and the Ministry of Health and Population (MoHP) was thus created. This was in response to the

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[1] This figure excludes those living abroad, an estimated 3.9 million.
[2] A timeline of key landmarks in this long history is presented in Annex C.

ICPD declaration promoting the integration of family planning and maternal and child health services into a broad-based women's health program.[3]

Box 1-1. Nine Strategies of Egypt's Population Policy

Creating a social context conducive to fertility decline

- Population information and communications
- Family planning
- Maternal and child welfare
- Education and eradication of illiteracy
- Improving the status of women
- Youth involvement

Minimizing the negative consequences of population growth

- Labor and employment
- Land use and distribution
- Environmental protection

Source: World Bank, 1996

1.8 At the time of project design Egypt's 1986 Population Policy (which remains in effect) highlighted nine strategies, which also reflect the thrusts of the ICPD declaration emphasizing a broad-based, multi-sectoral approach to population (Box 1-1). The policy also articulated a number of principles that influenced program implementation, including (a) the encouragement of voluntary efforts and community participation in addressing population; and (b) the implementation of population programs through local government bodies.

SUPPORT OF OTHER PARTNERS

1.9 The three main partners financing population activities at the time of project design were: the United Nations Population Fund (UNFPA, supporting management capacity building); the United States Agency for International Development (USAID, supporting contraceptives and family planning services), and the European Union (EU, supporting reproductive health services).

WORLD BANK SUPPORT

1.10 IDA had financed two population projects in the late 1970s/early 1980s, whose main objectives (to improve and expand family planning services) were not achieved. Evaluation of the first Population Project (for which a US$5 million IDA credit was approved in October 1973 and closed in June 1979) was frustrated by the failure to define quantitative objectives. It was credited with having contributed to the development and maintenance of health infrastructure, the promotion of home-visiting and the strengthening of the MoH's capacity to formulate and implement projects. Serious cost over-runs were traced to implementation delays that ultimately led to reduction of the scale of the project. The completion report cited four lessons: (a) the Borrower and IDA should reach a clear agreement on the project log frame; (b) a time-phased implementation plan should be prepared; (c) an early reconciliation of Bank and Government procedures would avoid implementation delays; and (d) details of innovative

[3] The consensus of ICPD was to address population growth and fertility reduction through (a) a broader sexual and reproductive health agenda, delivered through primary health care services, including reproductive health services and family planning (including safe abortion and the elimination of FGM); and (b) interventions beyond health and family planning that would address determinants of high fertility, including: poverty eradication, sustainable economic development, girls education, gender equity and equality, food security, human resources development and human rights.

activities (in this case home-visiting) should be worked out in advance. These lessons are in part attributable to the Bank's relative inexperience in lending for population.[4]

1.11 The Second Population Project (for which a US$25 million IDA credit was approved in October 1978 and closed in March 1986) was cancelled due to limited progress after 7 years of implementation. It was plagued by a lack of commitment to the objectives among staff of the health service, managerial difficulties, and doubts among health officials about the importance of family planning and population objectives. The completion report drew a number of lessons : (a) IDA has limited leverage with which to redefine the priorities of the Government of Egypt;[5] (b) projects should start small and establish a solid base for reforms; (c) implementing agencies should be involved in planning and designing major innovations; (d) the implementation capacity of the MoH should be realistically appraised; and (e) the Bank should not expect intensive supervision to substitute for good planning and clear understandings with implementing authorities.

2. OBJECTIVES AND DESIGN

2.1 The Egypt Population Project was financed through an IDA credit of 11.9 million SDRs (US$17.2 million equivalent), approved on March 21, 1996, with planned government and community contributions of US$1.6 and US$1.9 million, respectively.

2.2 The **objectives** of the Population Project were "... to help Egypt: (a) better manage population growth and prevent avoidable population growth by giving the MoHP the institutional capacity to play the lead role in the population sector; and (b) improve the conditions and status of women and children in areas where fertility remains high, mainly in rural areas of Upper Egypt, by stimulating additional demand for smaller family size and for family planning services."[6] [7] Key performance indicators are shown in Box 2-1.

Box 2-1: Key Performance Indicators

• Changes in attitudes
  o Desired number of children
  o Approval of family planning
  o Intention to use contraception
• Changes in behavior: rate of contraceptive use
• Changes in fertility

Source:

[4] This project, the Bank's eight investment in population, was approved less than three years after the Bank's first population investment (Jamaica Population Project, approved in June 1970). The first five years of the Bank's work in population was characterized by "hardware" projects that emphasized the construction of facilities and development of post partum programs as channels for attracting family planning acceptors.

[5] In the 1970s Egypt's Family Planning Board introduced a program to encourage fertility decline by small-scale development projects, a reflection of the Bucharest Population Conference dictum that "development is the best contraceptive." An evaluation of this program several years later revealed that it had little impact on fertility (Cochrane and Massiah, 1994).

[6] World Bank, Project Appraisal Document, 1996.

[7] In the Development Credit Agreement between the Arab Republic of Egypt and IDA, July 1, 1996 the project objectives were stated slightly differently: "...to: (a) strengthen the organization and functions of the MoHP that relate to its population and family planning operations; and (b) finance population activities

2.3 The **logic** of this design (Table 2.1) is grounded in evidence documented in the World Bank's *World Development Report, 1984*, which addressed the theme of "Population Change and Development." It distilled research that pointed to factors which influence lower fertility, notably: reductions in infant and child mortality; increase in income; educated parents; women's employment and status; urban residence; efficient markets and security; increased age at marriage; breastfeeding; and access to quality family planning information and services (Annex D). It also emphasizes that demand-side and supply-side interventions are complementary and synergistic and, together, have had powerful effects on outcomes. The design logic also responds to the ICPD consensus (para. 1.7).

Table 2.1. Project Logic

Demand-side interventions	Subprojects to change socio-economic indicators and stimulate demand among poor rural women =>	Community-based, multi-sectoral approach for reaching women => Delivery of fp information and social services to women =>	Improved fp knowledge => Improved socio-economic indicators that influence demand =>	Changes in **attitudes** about family size and family planning => Accompaniment of interested women to local health facilities =>	Stronger links between rural women and health facilities resulting in increased visits =>	Increased **utilization of contraceptives** =>	Decline in total **fertility**
Supply-side interventions	Reliance on USAID investments in fp service quality and availability, filling gaps if needed =>	Increased outreach capacity of fp services through mobile units =>	Better outreach of fixed facilities through training and links with civil society organizations =>				

Source: World Bank, 1996
Note: Performance indicators are shown in bold.

2.4 The project's support was organized around two components (Box 2-2). The first component was designed to support the preparation and implementation of a business plan to define the work of the newly established MoHP and a strategy for building needed capacity to complement an ongoing UNFPA-funded Management Development Project, slated to be completed in 1997.[8] The second component was designed as a small grants program to finance community-level subprojects aimed at stimulating demand for family planning. Its geographic focus was on Rural Upper Egypt, where fertility was high and demand for family planning services was low. At appraisal it was estimated that the PAP would finance around 100 projects over five years. It was also assumed that USAID's substantial support to primary health care and family

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as will promote smaller families and create social conditions conducive to lower fertility, all in accordance with the Population Policy Statement."

[8] However, the PAD did not describe this support or how the project would complement it.

planning would cover the supply-side needs for the country. A more detailed inventory of planned support is presented in Annex F.

Box 2-2: Population Project Components

Capacity Building (US$2.6 million, 13 percent of total): This component aimed to enhance MoHP/PS capacity to: (a) conduct high level advocacy and research; (b) undertake strategic leadership of planning, management and interdepartmental coordination; (c) monitor and evaluate overall progress; (d) mobilize and allocate resources efficiently; and (e) support NGO and local community initiatives. Support included: training, technical assistance, policy studies, vehicles, office equipment, furniture and material.

Population Activities Program (PAP) (US$18.1 million, 87 percent of total): This component was designed to finance grants to NGOs, local community organizations and public sector agencies to support activities to: increase awareness, strengthen motivation for couples to plan smaller families and facilitate access to and use of reproductive health services.

Source: World Bank, 1996

PROJECT MANAGEMENT AND IMPLEMENTATION ARRANGEMENTS

2.5 ***Capacity Building.*** A Project Implementation Unit (PIU) in the Office of the Undersecretary for Population and Family Planning, MoHP, was given responsibility for implementation of this component. Functions included: recruitment and management of consultants, management of project-financed training, project procurement, financial management and reporting.

2.6 ***PAP Small Grants.*** The PAP was to be managed by a Population Program to be established within the Social Fund for Development (SFD). Its responsibilities included: funds management, management and support of grantees, promotion and outreach, subproject appraisal, field supervision, and regular reporting. In addition to Population Program staffing, a population officer was assigned to work in each of the eight governorate offices of the SFD in Upper Egypt. General management and oversight was to be provided by an Executive Committee chaired by (and accountable to) the Minister of Health and Population and comprised of four other committee members, including at least one representative of the SFD and others as seen fit by the Executive Committee. The Committee was also responsible for approval of the first 10 submitted subprojects and all those amounting to LE 65,000 or more.[9] Project Approval Committees were also to be set up at the Governorate level, responsible for: approval of projects less than LE 65,000 (after the initial 10 approved by the Executive Committee); promotion and outreach; and semi-annual portfolio reviews. Technical rigor of PAP subprojects were to be ensured by the population officers at the governorate level SFD offices and the family planning and reproductive health officers representing MoHP on these Committees. The SFD was responsible for reporting to the MoHP/PS, which, in turn, reported all of the project activities to the Bank.

2.7 Subproject proposals had to meet three essential criteria: (1) a reasonable probability to reduce fertility preferences and to be of sufficient scope and weight (by

[9] Equivalent to about US$20,000 at the time of project design.

themselves or in connection with other interventions) to affect fertility; (2) demonstration of community commitment; and (3) demonstration that the proposal would be effectively implemented. In addition, the following were to be favorably considered: targeting of lower-income populations; the presence of adequate contraceptive supply to ensure the satisfaction of increased demand; sustainability of activities and/or effects beyond grant termination; a favorable impact on health and welfare, in addition to fertility impact; and synergies of activities within a proposal or with other development initiatives. It was expected that most grants would not exceed LE 65,000 and would be implemented in two years or less.

2.8 **Risks.** The main risks identified during project design were: the difficulty of establishing an effective public sector organization in Egypt; insufficient subprojects demand, selectivity and/or implementation; and inaccessibility of effective family planning services to new clients. The project sought to mitigate these risks by: an up-front agreement on the functions, management and staffing of the new Population and Family Planning Department in the MoHP; the development of a pipeline of subprojects and clear criteria for their approval and implementation; the provision of technical support to NGOs; and expanding the role of NGOs and the private sector in family planning service delivery and reliance on significant USAID investment in MoHP clinics to strengthen the supply of family planning services.

3. IMPLEMENTATION AND COSTS

3.1 Appraised in July 1995, the Population project was declared effective on June 24, 1998, more than two years after its March 1996 approval by the Bank.[10] It was launched at a widely attended conference held in October 1998 and implemented over a period of six years and nine months, closing on March 31, 2005, after two extensions.[11] GoE requested a third extension to permit the use of cost savings due to exchange rate fluctuations, but this was denied by the Bank.[12] The mid-term review (MTR) was held in June 2002, almost four years later than the initial date of October 1998.

PLANNED VERSUS ACTUAL COSTS AND FINANCING

3.2 The total project cost is estimated at US$17.7 million or 86 percent of the cost estimated at appraisal (Table 3.1). The Capacity Building component cost over two and one half times the original estimate, while the actual cost of the PAP component was 65

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[10] The IDA credit was approved by the Prime Minister and sent for Parliamentary ratification in May 1997, but was not yet forwarded to the National Assembly by the third extension deadline. On February 25, 1998, on an exceptional basis, Regional management approved a fourth extension (to June 30, 1998). While effectiveness delays were common in Egypt's portfolio at the time, project files do indicate that the approval process was held up in the Prime Minister's office because of Government's concern about the use of an IDA credit for technical assistance and training. See also para. 3.3.

[11] The first extension (from December 31, 2001 to December 31, 2003) was granted around the time of project effectiveness to compensate for the delayed effectiveness. The second (15-month extension) extension was granted in late 2003 on the basis of QER recommendations and the satisfaction of a Remedial Action Plan to accelerate implementation and disbursements.

[12] Bank policy does not accept the utilization of savings by itself as a justification for credit extension.

percent of the estimate at appraisal. Of the original IDA credit amount of 11.9 million SDR, 87 percent (10.4 million SDRs) was disbursed and the remaining amount (1.5 million SDRs) was cancelled (Annex E, Table E-2).[13] Government counterpart funding amounted to US$1.9 million versus the planned amount of US$1.6 million. Beneficiaries contributed an estimated US$1.0 million equivalent. While this amount is about half of the planned beneficiary contribution (US$1.9 million), it does represent about 10 percent of the total costs of the subprojects financed, meeting the requirements under the project design.

Table 3.1. Planned vs. Actual Costs by Component (US$ millions)

Component	Planned	Actual	Actual/Planned (%)
Capacity Building	2.6	6.1	265
Population Activities Subprojects	18.1	11.6	65
Total project costs	**20.7**	**17.7**	**86**

PLANNED VERSUS ACTUAL INPUTS/ACTIVITIES BY COMPONENT[14]

3.3 The Population project was implemented largely as planned, with a few exceptions. ***First,*** at credit effectiveness (June 1998) the consultants and training category was decreased by 77 percent (from 0.9 million SDRs to 0.2 million SDRs) and the goods category was increased by 700,000 SDRs to provide for the financing of ambulances and technical equipment for maternal care and family planning services in Upper Egypt.[15] This amendment also specified that under Component B the project could finance small grants for micro development activities commensurate with population and family planning activities proposed by communities. ***Second,*** at the time of the MTR (June 2002) the Bank and the GoE agreed that capacity building efforts should be targeted more to the regional level instead of an almost exclusive focus on the central level.[16] ***Third,*** in 2003 another amendment provided for the procurement of several years worth of national needs for IUDs and insertion kits, in preparation for the withdrawal of USAID support to Egypt's population sector.[17]

3.4 ***Capacity Building.*** Chapter 5 reviews activities supported under this component in relation to their contribution to project objectives and Annex G provides an itemization of support delivered under this component compared with plans. Suffice it to

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[13] Because of exchange rate fluctuations actual disbursements are estimated at US$15.9 million, and cancelled amount at US$2.2 million (Source: World Bank Loan Department database).

[14] For more information, see Annex F, which details project implementation by component. Annex F is IEG's attempt to document and quantify project inputs, activities and outputs, based on evidence collected. However, some information gaps could not be filled, largely due to the fact that Government's project files could not be located and made available to IEG, despite several requests while in the field.

[15] IEG's review of evidence indicates that this reallocation was likely prompted by the Prime Minister's resistance to the use of the IDA credit for training and technical assistance and to the discomfort of the new Minister of Health and Population's about the small size and software content of the capacity building component (managed by MoPH) in contrast to the large size of the component to be managed by the SFD.

[16] This was based on experience of PAP implementation and needs identified at the regional level and on the reasonable decision not to invest heavily in MoHP/PS in general and in the NGO department in particular until the long-term vision of these structures would be laid out.

[17] The goods category was increased by SDR 3.62 million and the unallocated and subprojects grants categories were decreased by 1.07 million SDRs and 2.55 million SDRs, respectively.

say here that: (a) this component, as originally designed, was only partially implemented; (b) IEG was unable to find a quantification of actual consultant services, training and studies delivered; and (c) only 24 percent of the initial allocation for consultants and training (900,000 SDRs) was actually used for this purpose. Nevertheless, the actual cost of this component was two and one half times the original estimate because of greater than anticipated supply-side investments, specifically the procurement of contraceptives and the refurbishment and equipment of rural facilities (paras. 3.3 and 5.11).

3.5 ***Population Activities Program.*** Against an original estimate of 100, a total of 55 subprojects were implemented over four phases.[18] The activities and outputs of subprojects are discussed and linked to project objectives in Chapter 5, with further detail on the design, approach and content of subprojects provided in Figure D.1 in Annex D. While the first phase was initially slated to be launched in 1997, subproject proposal solicitation, appraisal and implementation were delayed, first due to the delayed effectiveness date and then due to delays in launching the process (training, information campaigns, identification of capable NGOs, etc., setting up proposal evaluation committees). Each phase employed a refined model for the collaboration with civil society, attempting to improve on the previous phases with regard to subproject management and oversight and efforts to improve community targeting and outreach (Table 3.2).

3.6 The subproject cycle evolved during the project life as refinements were introduced with experience and lessons. In general, deprived areas (with high fertility indicators) were identified on the basis of a population database. NGOs with relevant experience would be identified and encouraged to prepare and submit proposals, with technical assistance provided by SFD. Contracts would be prepared on the basis of approved subprojects.[19] Project identification, preparation, appraisal and approval were implemented with long delays and the roles of the Executive and Governorate committees were slow to activate.[20] By the time of Phase 4 the following steps had been distilled and now serve as a model for SFD: (i) project site identification; (ii) contracting the NGO/CBO; (iii) approval of subproject action plan; (iv) community profiling; (v) pre-intervention assessment (baseline data collection); (vi) scoping of priorities through joint

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[18] Fewer projects were implemented than planned because of (a) slower than anticipated start-up of initial subprojects approval and implementation; (b) the clustering in Phase 4 of a small network of community development associations and their activities into one subproject under the management of an experienced "umbrella" NGO; and (c) the reallocation of over 2 million SDRs away from the PAP component to support the purchase of contraceptive stocks (para. 2.3).

[19] Regional offices of the SFD carried out a number of key tasks: (i) selection of target communities, (ii) assessment of the active NGOs and provision of needed technical assistance in proposal writing; (iii) submitting valid proposals to the relevant committees' approval; (iv) monitoring implementation progress; and (v) reporting to SFD HQ on subproject activities.

[20] Improvements came about in 2003 when (a) MoPH decree No. 276 created a ministerial executive committee to (i) formulate comprehensive policies for the PAP; (ii) issue final approval of subproject proposals; (iii) develop determinants and broad outlines for the financial policies of projects to be implemented; and (iv) monitor and evaluate subproject activities; and (b) MoPH decree No. 279 established a steering committee in each of the selected governorates to: (i) review subproject proposals and their coherence with governorates population policy; (ii) conduct semi-annual revision of the financial status of subprojects under implementation; (iii) provide support to implementing agencies; and (iv) issue semi-annual reports on subprojects.

working groups, including community leaders; (vii) implementation of subproject activities; and (viii) quarterly monitoring of progress, post evaluation assessment and final evaluation.

Table 3.2. Overview of Subprojects Implemented under PAP

Phases	Timing	# Sub-projects	Model/Approach	Geographic areas
Phase 1	2000-2003	3	***Model 1:*** All 3 projects managed at district level by the Egypt Family Planning Association. Community level not effectively reached.	Sohag, Qena, Aswan governorates
Phase 2	2001-2004	11	***Model 2:*** Projects managed by 11 decentralized NGOs (Community Development Associations – CDAs).	(not specified)
Phase 3	2002-2004	23	***Model 2 refined:*** MoHP was a sponsor as well as an implementing partner. 23 subprojects implemented in partnership with the SFD, MoHP and CDAs. Information of communities and involvement of religious and community leaders found to be effective.	Seven governorates
Phase 4	2004-2005	18	***Model 3:*** Cluster system, with an NGO managing and supporting a small network of CDAs. Support encompassed support for RH services, FP, MCH care awareness, family and population development.	Eight governorates
Total		**55**		

Source: GoE/MoHP Project statistics, 2005

3.7 **Legal Covenants.** Of the four covenants specified in the DCA, three were fully satisfied (the maintenance of a PIU and implementation of key elements of capacity building, the periodic reporting of the SFD to the MoHP and the periodic reporting to the Bank on overall project performance). The remaining covenant was partially complied with. While the Operational Manual was respected, the MoHP was delayed in commissioning an independent evaluation of the program.

3.8 **Procurement.** Procurement under the *capacity building component* was initially found to be unsatisfactory because MoHP's Central Procurement Department confused IDA and Egyptian procurement guidelines and procedures, a phenomenon if its limited capacity in procurement and management. The Bank responded by providing needed training and workshops in procurement and continued with periodic reviews and feedback; and the PIU employed a qualified procurement expert, familiar with Bank procedures. These actions ultimately led to a satisfactory rating of procurement activities under this component. SFD, responsible for the PAP component, was found by a Bank post-review mission to have unsatisfactory procurement performance. The appointment of two seasoned procurement officers under the SFD's General Projects Department (responsible for supervision of the Population Unit of SFD) helped to improve procurement capacity. Procurement processes undertaken at the NGO level were examined by IDA at the MTR and found to be satisfactory. However, the following year SFD procurement activities were found again to be unsatisfactory. Simplified procurement procedures for NGOs, acceptable to IDA, were developed to expedite subproject implementation. This, combined with training for NGOs and SFD Population officers in regional offices on local shopping procedures, was effective in improving procurement performance

3.9 **Financial Management.** The PIU of MoHP had good performance with unqualified audit reports. In 2003 the PIU finance manager resigned to join another Bank-financed health project (Health Sector Reform Project -- HSRP) and a new finance officer was recruited to undertake project financial management. Weaknesses in the internal control system were identified in an audit, which the PIU undertook to resolve. In the early years of the project the financial management system at SFD was weak with regard to its: (i) reporting and recording capabilities; (ii) internal control systems; (iii) internal audit function; and (iv) compliance issues identified by external auditors. In 2002/03, following management changes at SFD, a number of steps were taken to address weaknesses, notably: hiring of competent manager and staff of internal audit department; the release of a complete set of financial management reports in accordance with Bank's guidelines; the recruitment of a new finance director and restructuring of SFD to enhance its autonomy. Continued efforts on the part of SFD to improve its financial management (hiring of more than 10 qualified internal auditors; creating a task force to generate financial management reports for the project; and receiving an unqualified audit report in 2003) caused the SFD financial system to be satisfactory in the end.

3.10 **Disbursements** were extremely slow, reaching a level of less than 30 percent some four years into project implementation. Improvements and streamlining in approval processes, withdrawal applications and procurement did serve to accelerate disbursements post-MTR.

4. MONITORING AND EVALUATION

DESIGN

4.1 The design of monitoring and evaluation (M&E) focused exclusively on the second objective of the project: to stimulate the desire for smaller families, an increased use of contraceptives and a decline in fertility. There was no specific design under the project to monitor or evaluate the objective to strengthen the role and functioning of the MoHP. As such, M&E design encompassed (a) the monitoring of individual subprojects; (b) the monitoring of subproject implementation as a whole; (c) the evaluation of subprojects' effects and cost-effectiveness; and (d) the distillation of lessons emanating from experience. Each grantee was responsible for subproject monitoring; and proposals were expected to include a monitoring plan and monitoring indicators specific to the particular activities proposed and their links to fertility-related objectives. Overall program monitoring was envisaged to track the coverage of villages, the number of proposals submitted and approved, the number of projects implemented/completed and projects' ratings (on the basis of criteria tailored for each individual project).

4.2 Six key performance indicators were identified in the design document (World Bank, 1996): three tracking fertility preferences (desired number of children, approval of family planning, and intention to use contraception among non-users); and three tracking resulting behavior and outcome (contraceptive prevalence, contraceptive discontinuation rate, and total fertility). DHS and other national survey data were envisaged to be exploited, and supplemented with two evaluation surveys tracking the impacts of

subprojects, the first to document progress at the mid-term review, and the second to feed into the end-of-project evaluation. The evaluation of program interventions was envisaged to assess the impact of local-level interventions in those communities and compare outcomes with communities in Upper Egypt not benefiting from projects through statistical analyses, drawing on DHS and other data sources and including multivariate analysis to isolate project effects. A few qualitative studies focused on particular communities were planned to supplement the two above-cited surveys, enabling the tracking of a project's intervention over time in selected communities to establish baseline conditions and assess how they changed over time. A review of relevant sociological literature on key determinants of fertility was also envisaged.

4.3 MoHP was responsible for supervising all monitoring and evaluation activities. It was to carry out the monitoring activities itself, with assistance from the SFD. The evaluation was to be contracted out to a well qualified agency that would carry out all aspects of the two surveys on subproject interventions: designing the sample and the questionnaire; recruiting, training and supervising field staff; data entry and verification; analysis; and report writing. The in-depth community studies were also slated to be contracted out.

IMPLEMENTATION

4.4 Implementation of M&E (a) proved to be more difficult than envisaged, (b) experienced significant delays, and (c) fell short of initial plans. Just after project effectiveness (late 1998) internal Bank reporting indicated that arrangements to render the M&E system operational were proceeding satisfactorily. Almost two years later, in August 2000 (when subprojects implementation was actually launched), the selection of indicators for subproject monitoring and evaluation was reported to be "still under discussion" and the M&E system had not yet been established. It was only in 2001, some three years after project effectiveness, that the PIU established a M&E unit with the mandate to develop an M&E system. That same year the SFD's Population Unit was reported to be developing an M&E system for the subprojects. In early 2002 the M&E system for the subprojects still had not been developed.[21]

4.5 The MTR took place in June 2002 without the benefit of planned studies (baseline surveys and compilation of lessons, among others), and noted the persistent lack of an adequately functioning M&E system and the failure to incorporate fully into the project appropriate (sub)project indicators. The intention to launch and implement an M&E system was again articulated at the MTR workshop and in Bank's communications with Government. Although the baseline surveys in subproject villages were not undertaken prior to the MTR, a consultant was recruited to assess the three ongoing pilot projects (under phase 1) and produced a review of experience as an input to the MTR. Finally, in 2003, some five years after effectiveness and three years after subprojects

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[21] Internal Bank reporting revealed that the estimated budget for the M&E consultant was limited and did not permit the identification/recruitment of a qualified M&E consultant, and, as a consequence, the SFD was pursuing the possibility of incorporating the subproject M&E requirements into an M&E tool that was being developed for the SFD as a whole. The Bank did not succeed in its effort to mobilize trust fund support for M&E.

launch (a) the baseline surveys in subproject villages were undertaken and (b) a consultant was recruited to document the lessons of experience under the subprojects. The second round of survey work was carried out in 2004. The 2003 and 2004 data sets cover only Phases 2 and 3 of the four phases of subprojects and were not in sync with the pre-project and end-project timeframes[22] and thus were unable to document evidence of subproject impact. Under the oversight of the PIU/MoHP, data on CPR and utilization of family planning services were compiled in all districts where the project intervened. However, district data is not disaggregated by village and thus does not reveal trends in villages (individually or collectively) covered by the subprojects, or compare them with trends in villages not covered by subprojects.

4.6 The two sets of data (project-level household survey and MoHP district data) have only two years (2003, 2004) and two indicators in common (contraceptive use and utilization of family planning services). The definition of these two indicators and the basis on which they are calculated (methodology for data collection, specification of the numerators and denominators) are not well documented, raising issues of data quality/reliability and comparability. Data were not collected on key components of the results chain that would have helped establish plausible links between project interventions, and the extent to which they influenced changes in attitude and behavior. Changes in attitudes were not systematically monitored, although some anecdotal information is available (perspectives of beneficiaries, social change agents, and service providers). The cost-effectiveness of subprojects was not assessed, as planned.[23] M&E efforts did not take into account other demand-side stimulation activities financed by other partners providing support in Upper Egypt[24] and/or other changes in socio-economic status that are likely also to have stimulated changes in attitudes or behaviors. An opportunity was thus missed to document the cost-effectiveness of demand-side innovations across projects that could have enhanced knowledge of what works in particular contexts and influenced programs and policies. At the project's end, the PIU did not commission an independent evaluation as had been envisaged under the design, nor was the planned literature review on key determinants of fertility ever carried out.

USE OF DATA FOR DECISION-MAKING

4.7 Because of issues in the choice of indicators and in the relevance of data, utilization of data for decision-making was limited. The evaluation of the lessons of each subproject phase commissioned under the project provided an opportunity for learning and fine-tuning the approach, which was well exploited, as evidenced in the refinements and improvements of the approach with each new phase. The collection of data on CPR and FP utilization kept activities and implementers focused on effecting changes in these indicators. But the failure to collect/analyze data on the various components of the results chain undermined the systematic documentation of project impact and, consequently, the use of data for decision-making.

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[22] Phase 2 and 3 subprojects were implemented during the respective periods of 2001-2004 and 2002-2004.
[23] An assessment of planned vs. unit costs was undertaken that calculated the number of beneficiaries covered, but effectiveness (number of beneficiaries adopting contraceptive use, for example) was not assessed.
[24] Particularly USAID and the EU.

5. OUTPUTS AND OUTCOMES BY OBJECTIVE[25]

OBJECTIVE #1: IMPROVE MOHP'S MANAGEMENT OF POPULATION/FAMILY PLANNING

5.1 No specific indicators for this objective were identified during project design. It was anticipated that they would be identified in Year 1 through the preparation of a three-year business plan for institutional strengthening of central-level MoHP. IEG was unable to obtain a copy of this document and found no evidence that it was ever produced. The following provides a summary of capacity and institutional strengthening support and outcomes.

5.2 ***In line with a decision taken at the project's mid-term review, project support to population capacity building was reoriented away from the initial design's support to central-level MoHP, focusing instead on the governorate, district and community levels within rural Upper Egypt.***

5.3 ***The project provided training and technical assistance to various groups of local-level actors to strengthen their respective capacities in the planning, design, delivery and oversight of population and family planning information and services.*** *With regard to MoHP staff*, some 683 doctors, nurses and midwives working in clinics responsible for serving clients in areas of subproject intervention received training under the project in family planning service delivery, which emphasized service quality and client orientation and working in partnership with community-based organizations and other civil society actors to achieve a better synergy between demand- and supply-side efforts. Reproductive health and family planning supervisors at the governorate and district level offices of MoHP also received training and technical support from the governorate-level SFD to enable them to serve as trainers and supervisors of these front-line service providers. *NGO administrators, financial officers and supervisors* were trained in the design, oversight and supervision of subproject activities. Close technical support and oversight of NGO staff provided by the SFD also contributed to the capacity building objective by facilitating a guided learning-by-doing approach. Unfortunately, IEG could not find a full quantification of project-financed training provided to staff and managers of decentralized levels of MoHP and of NGOs and other community-based organizations. Furthermore, ***there was no evidence that such training was ever evaluated to document its impact in terms of the acquisition and application of new knowledge and capacities.***

5.4 ***The project developed a new cadre of social change agents to serve as an interface between women living in target communities (potential clients) and front line services.*** The project recruited and trained 3,085 social change agents (SCAs). These women, selected from the communities in which they worked, had the credibility to reach the target women and link them with (a) the benefits of the subprojects (microcredits, literacy training, home visits, information and support regarding family health and wellbeing) and (b) the information, counseling and other services provided by local health and family planning clinics. Interviews with beneficiaries and field observations

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[25] Annex H presents a matrix of actual outcomes against objectives and targets set.

revealed that SCAs had established a high level of trust and credibility with the women they were serving and that their services were highly appreciated. Another significant indication of this level of appreciation (among many observed and expressed) is the women's decision at the end of the subproject support to increase the interest rate of the microcredits made available to them in order to continue the remuneration (and thus the services) of SCAs. An independent evaluation found SCAs to be a vital link between the community and the service points for the poor and key to increasing demand for services (Georgetown University, 2007).

5.5 ***By nature of its innovative design and approach, the project was instrumental in forging effective partnerships at the local level between MoHP, the SFD and NGOs and other community members in the planning, design and delivery of population and family planning activities in selected districts and villages in Upper Egypt.*** As illustrated in Figure D.1, Annex D, SFD and MoHP: (a) collaborated in the identification and selection of CDAs for implementing activities; (b) collaborated with the selected CDAs in a dissemination conference to inform and involve local leaders in population activities; (c) maintained effective partnerships during implementation addressing both supply and demand issues and ensuring their appropriateness to local needs and conditions; and (d) together with the CDAs collected data to evaluate subproject interventions. While, in the initial stages of project implementation, the MoHP was not fully convinced of the benefits of partnering with NGOs, partnership and collaboration between MoHP and NGOs at the local level have improved over time as the effectiveness of such collaboration was demonstrated. A review of lessons of the first three phases of subprojects documents the evolution towards regular meetings among the three main partners of the project (SFD, MoHP and the CDA[s]) and the resultant revival in MoHPs' role in technical supervision and implementation (Center for Development Studies, 2005). Field interviews and visits conducted in rural Upper Egypt revealed strong collaboration and synergy among these actors. Further evidence of improved partnerships is that, in more than 50 districts in Upper Egypt where the project intervened, annual population plans are routinely and jointly prepared by: local authorities, MoHP managers and staff, SFD and NGOs and civil society, including the SCAs.

5.6 ***The project has been less successful in supporting and institutionalizing MoHP partnerships with NGOs and civil society organizations at the central level.*** An NGO Support Department was created in MoHP for population, but never became fully functional. MoHP's current organigramme (source: WHO 2006) does include a General Department for Family Planning Services in the Private and NGOs Sector. This department has provided supply-side support to NGO family planning clinics operating in Egypt, including the establishment and dissemination of national service quality standards and the provision of trained physicians to some NGO clinics, at their request. On the other hand, the definition and institutionalization of the role of NGOs in planning and policy formulation and in demand-side stimulation were relatively neglected during the project period. The institutional home and accountabilities for demand-side interventions are still not specified in the organigramme. The intention to partner with NGOs is articulated in MoHP's April 2005 document, "Facing Population Challenges in

Partnership with NGOs," which draws on project experience.[26] Government has noted in its comments (Annex I) current activities of the NGO General Department to strengthen partnership and networking with NGOs, including ongoing efforts to involve NGOs more fully in policy formulation and implementation and in the stimulation of demand for family planning.

5.7 ***Notwithstanding its support to the implementation of project-specific M&E, the project was unsuccessful in strengthening MoHP's capacity to monitor and evaluate the overall progress of national population and family planning efforts.*** DHS data are used for tracking outcome (and some output) indicators, and MoHP data track a number of service provision indicators, but the components of a results chain appear to have been neither defined nor tracked. IEG's review of evidence has indicated that monitoring and evaluation of population and family planning interventions are largely undertaken at the level of externally-financed projects, but not for the program as a whole.

5.8 ***With project support MoHP acquired the capacity to procure contraceptives through a competitive process and enhanced its contraceptive security through the purchase of several years supply of contraceptives.*** In light of the gradual pulling out of USAID assistance from the population and family planning sector, the project's purchase of contraceptives avoided a possible rupture in the supply of contraceptives. MoHP procured the contraceptives for the first time with the intensive training, coaching and support of the Bank, which ultimately established their capacity to assume this responsibility. Previously, MoHP relied on UNFPA, which undertook procurement of contraceptives on their behalf, and on USAID, which supplied contraceptives in kind. It is significant to note that during this time MoHP benefited from supplemental support from USAID to help Egypt achieve sustainable contraceptive security (Ainsworth and Dickens, 2004).

OBJECTIVE #2: PROMOTE LOWER FERTILITY AND HIGHER CONTRACEPTIVE USE IN RURAL UPPER EGYPT

5.9 In assessing attribution of outcomes related to this objective, it is important to note, over and above the data limitations (Chapter 4), that (a) the project's coverage was modest, supporting activities in 148 villages or less than 10 percent of all 1700 villages in the Region of Upper Egypt; (b) the duration of the subproject intervention was short (two to three years) relative to the overall project life of seven years; (c) other partners were providing similar demand-side stimulation and supply-side interventions for advancing the population agenda in Rural Upper Egypt during time periods overlapping with the project;[27] and (d) other social development support that would have had an impact on attitudes and behaviors (poverty alleviation, employment/microcredit, literacy training, among other development activities) were also ongoing. Nevertheless, the project's contribution to outcomes in Rural Upper Egypt is greater than its impact on the 148

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[26] The document outlines four key objectives of partnership: to enhance community participation in health services decision-making; to enhance community capacity to address impediments to health services; to make services more responsible to families; and to ensure sustainability of positive behavior trends.
[27] USAID through the Tahseen project and the European Union.

villages of direct intervention. Prior to this project, population activities were largely limited to supply-side interventions. Evidence compiled by IEG suggests that the project's innovative design influenced other major demand-side interventions in Rural Upper Egypt (particularly those supported by USAID and the EU).[28] This section documents outcomes for Rural Upper Egypt. To the extent data permit it also documents changes in indicators in districts and villages of direct project intervention. Annex G presents a matrix summarizing outcomes against targets and objectives. For reasons noted in Chapter 4, these data must be interpreted cautiously.

5.10 ***The project was successful in establishing a community-based approach for reaching target groups with a package of information and support services that are known to influence changes in desired family size and increased use of modern contraception (WDR, 1984).*** Fifty-five subprojects, designed and managed by community development associations (CDAs), were implemented in the poorest villages of Rural Upper Egypt. These subprojects supported activities to improve the family planning and reproductive health knowledge base of women of reproductive age, especially younger, low parity women, and to stimulate a demand for smaller family size and the use of modern contraception. The four phases of project design and implementation permitted refinements in the approach as well as in the content of projects, but essentially the support consisted of the following elements. A dissemination conference held after contract signature with NGOs/CDAs was instrumental in catalyzing the support and collaboration of local level leaders, actors and stakeholders (including MoHP, local community and executive leaders, the SFD and the Association[s]) around the project objectives ensuring both coordination and synergy between those working on demand stimulation and those working on the supply of services. Training was provided to all critical actors involved in each project: service providers at local health facilities (doctors, nurses, midwives); community-based outreach workers and their field supervisors; and project administrators and financial officers. The main outreach activities included: home visits (targeting women of reproductive age [especially younger, lower parity women], and their husbands and mothers-in-law, whose influence on their reproductive health decisions is significant); the organization of health conferences in communities and the encouragement of healthy behaviors; the provision of microcredits for women; literacy classes and other activities to promote women's income generation (crafts, day care); and the encouragement of increased use of local health services for maternal and child health care, in addition to family planning. Subprojects ultimately supported 22,400 families in 148 villages in all eight governorates of Upper Egypt. This translates into a 9 percent coverage of all (1700) villages in Rural Upper Egypt. All combined, subprojects delivered a number of key outputs, including: 3.5 million home visits; 1,734 health education seminars at the village level; 9,320 microcredits for women and their families; 300 literacy classes attended by 5,640 women.

5.11 ***The project also improved the supply and quality of family planning services offered through the public health system in selected villages benefiting from demand-side interventions.*** While USAID and other bilateral donors were assumed at project

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[28] This finding is based on IEG's interviews with Bank and MoHP/project staff and with selected partners, as well as an assessment of the timeline of interventions in Upper Egypt based on documentation.

design to be covering the needed improvements in services access and quality, services were found not to be effectively responding to demand in areas of subproject intervention. Project support included the refurbishment and equipment of 105 clinics providing family planning services and the equipment of an additional 195 clinics, all serving in subproject areas. Equipment included 347 ultrasound scanners and 112 autoclave machines (for sterilization). The project also created and trained a pool of 63 family planning supervisory teams responsible for training, supervision and technical oversight of front-line service providers. The project also purchased 4.25 million IUDs and 12,812 IUD insertion kits in 2003 to cover the needs of Egypt's entire program for the following few years, at a time when USAID was gradually withdrawing its major support. Project investments in upgrading of staff skills and fixed facilities culminated in improved service availability and quality and incited an increase in the number of clients (MoHP end-of-project evaluation interviews with beneficiaries and service providers and IEG field visits and interviews). Establishment of RH/FP trainers at the district level left a viable and efficient capacity for monitoring and upgrading service delivery skills (interviews with SFD staff and MoHP managers and staff at the local level). The project's investments in mobile clinics were found to be particularly effective in reaching the poorest and most vulnerable women living in more remote locations with family planning information and services (Center for Development Studies, 2005; and interviews with SCAs and beneficiaries).

5.12 ***During the period of subproject implementation modest advances were made in Rural Upper Egypt on some factors known to influence fertility.***[29] Between 2000 and 2005 the percent of ever-married women who cannot read at all declined from 71 to 62 percent in Rural Upper Egypt. At the national level it also declined, but from a much lower starting point -- from 50 to 41 percent. During this same period, the percent of ever-married women reporting that they attended literacy programs increased from 7 to 13 percent in Rural Upper Egypt (compared with an increase from 9 to 13 percent, nationally). This level of attendance in Rural Upper Egypt is very low, considering the persistently high level of illiteracy there. The median duration of breastfeeding in Rural Upper Egypt increased modestly from 19.7 to 20.1 months, compared with the national level increase from 17.9 to 18.6 months. Unemployment of ever-married women has declined most rapidly between 2000 and 2005 among those from Rural Upper Egypt (from 93 to 84 percent), compared with the national trend of 82 percent in 2000 and 78 percent in 2005.

5.13 ***It is plausible to assume that subprojects supported under the Population project may have made some contribution to these modest changes in socio-economic indicators in Rural Upper Egypt. However, project attribution is difficult to establish, given that (a) the coverage and impact of various interventions were not evaluated and (b) numerous other investments and development activities were ongoing in that Region, both in the context of, and beyond, the population agenda.*** Changes in socioeconomic indicators have not been systematically recorded by the project in the villages of intervention. Nevertheless anecdotal information provides some evidence of

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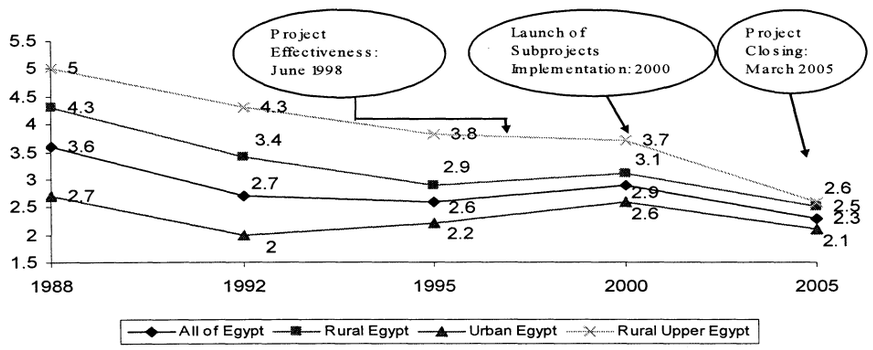
[29] All data cited in this section on factors influencing fertility are from the DHS 2000 and 2005. See also Annex H (statistical annex) for more details.

possible impact. Beneficiary feedback[30] has revealed that the microcredits, literacy training, marketable skills training, and health advice and information and social support provided by the social change agents (all of these financed under subprojects) have positively impacted the wellbeing of women living in target villages and that of their families. They also report positive changes in the attitudes of their husbands who benefited from information campaigns and were especially receptive to messages because of their appreciation of the microcredits. Anecdotal evidence should not, however, be used to draw firm conclusions about the project's impact, in the absence of systematic analysis of trend data.

5.14 ***Egypt has been successful in its efforts to change attitudes of women in Rural Upper Egypt about desired family size and the use of family planning services.*** *Between 2000 and 2005 total wanted fertility*[31] *declined in Rural Upper* Egypt from 3.7 to 2.6 children, a total decrease of 1.1 children (Figure 5.1). This decline was greater than what was achieved during the previous five-year period in Rural Upper Egypt and also more important than overall national declines between 2000 and 2005. -- Inequities in this indicator across regions and across levels of education decreased considerably between 2000 and 2005. The persistently higher levels among women living in Upper Egypt and among women with no education (Annex H, Figures H-1 and H-2) are a reflection of the realities of women, who may desire many children for their economic security.

Figure 5.1. Total Wanted Fertility: National Trends and Trends in Rural Upper Egypt, 1988-2005



Source: DHS 1988-2005

5.15 *Between 2000 and 2005 the use of family planning became even more acceptable.* In 2005 85 percent of ever-married women residing in Rural Upper Egypt considered it appropriate to use family planning after the first birth, a significant increase over the level of 70 percent in 2000. This increase was faster than that for Egypt as a whole (from 85 to 93 percent) (Annex H, Figures H-3, H-4 and H-5). Across education levels, the biggest increase in acceptance of family planning services was among women with no education (from 78 to 88 percent).

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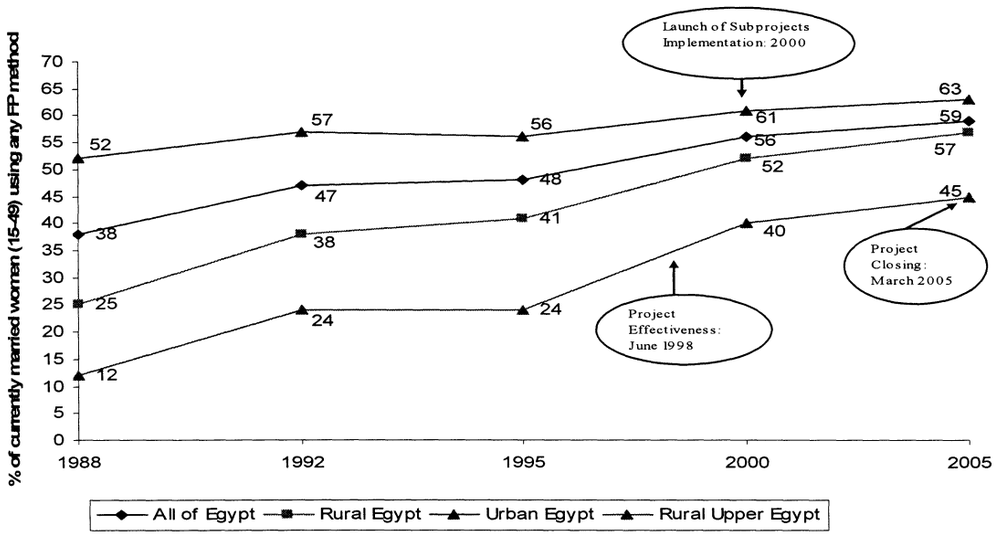
[30] Beneficiary feedback was provided directly to IEG on the occasion of its field visits to Qena and Menya governorates and is also documented in project reports based on surveys and other end-of-project evaluation work, carried out by the Borrower.

[31] Total wanted fertility is the TFR with unwanted births excluded from the numerator (EDHS, 2005).

5.16 *However, demand for family planning (met and unmet) increased only very modestly in Rural Upper Egypt.* Between 2000 and 2005 demand for family planning increased from 60 to 63 percent among women in Rural Upper Egypt, compared with an increase of 68 to 70 percent for all of Egypt (Annex H, Figures H-6 and H-7).

5.17 ***Trends in behavior have revealed an increase in the use of contraceptives in Rural Upper Egypt.*** Contraceptive prevalence rate in Rural Upper Egypt rose from 40 (CI: 37-43) to 45 (CI: 44-47) percent between 2000 and 2005. While this increase is greater than the national increase (from 56 [CI: 55-57] to 59 [CI: 58-60] percent), it is not as dramatic as the 16 percent increase (from 24 [CI: 22-26] to 40 [CI: 37-43] percent), which occurred during the previous five years (Figure 5.2 and Annex H, Figures H-8 and H-9). Contraceptive prevalence increased in all 8 of the governorates in Upper Egypt, whose current (2005) levels range from a low of 33 percent in Souhag to a high of 62 percent in Giza (Annex H, Figure H-10).

Figure 5.2. Contraceptive Prevalence Rate - National Trends and Trends in Rural Upper Egypt, 1988-2005 (Any Method)



Source: DHS 1988-2005

5.18 ***District-level data compiled from health facility data reveal mixed trends in contraceptive prevalence rates in districts where the project intervened*** (Annex J, Table 8). The three districts supported under Phase I (2000-2003) together had an average contraceptive prevalence rate of 30 percent in 1999, the year prior to the launching of subprojects. In the ensuing years the rate climbed, reaching 38 percent in 2001 and then gradually declined to the pre-project level in 2003 and 2004. Under Phase II (2001-2004) nine districts had a combined CPR of 17 percent in 2000, the year prior to implementation. During implementation the CPR hovered between 28 and 29 percent, rising to 33 percent in 2004. During Phase III implementation (2002-2004), the CPR in 23 districts increased only slightly during implementation over the baseline of 39 percent, rising to 42 percent by the end of that phase. Project support to these districts was limited in all phases, covering only one to two villages per district. These data thus do not provide sufficient evidence of project impact.

5.19 ***Project data collected in the villages of intervention for Phases 2 and 3 reveal increases in the current use of family planning that appear to be considerably higher than averages for the districts in which the villages are located.*** This would indicate that the subprojects may have had an impact. However, these data must be interpreted with caution. While the data are available for two consecutive years (2003 and 2004), they do not cover the entire implementation period, nor do they include a pre-intervention baseline. Furthermore, the methodology for collecting and compiling the data on contraceptive prevalence is not entirely clear. The household surveys to collect this data were conducted by the SCAs (who were supported under the project to work with the women who were the subject of the survey); and this may have introduced a bias into the questions and the responses. ***Notwithstanding these caveats, data from these surveys show that between 2003 and 2004 in villages benefiting from project support the use of family planning was higher than district averages and increased faster than it did for districts of intervention overall.*** Between 2003 and 2004, the CPR rose by 9 percentage points (from 46 to 55 percent of all women of reproductive age) in nine Phase 2 villages and by about 11 percentage points (from 45 to 56 percent of women of reproductive age) in 23 Phase 3 villages (Annex H, Tables H-2 and H-3). Anecdotal evidence collected through IEG field visits and discussions with beneficiaries, and through project monitoring and reporting, corroborates this evidence. Beneficiaries from some target villages have stated that microcredits, literacy training and family planning information, and facilitation, all provided through SCAs, have (i) stimulated women's interest in using family planning and (ii) prompted them to use contraception.

5.20 ***There is strong evidence that the synergy between supply-side and demand-side interventions was an important factor in influencing increased contraceptive use.*** Health facility staff interviewed by IEG noted that, over and above facility upgrading and staff training provided by the project, which improved the quality and user-friendliness of the services, the SCAs played a critical role in promoting these services and their utilization. Their accompaniment of women to facilities was noted by service delivery staff by service delivery staff to have filled an important void. An independent assessment of the SCAs in the project area noted that the SCAs overcame barriers to women's access to information and services, caused by the traditional and cultural environment, which prohibits women from seeking health care on their own and participating in health education sessions. SCAs were found to have: helped women increase their access to and utilization of health centers, influenced an increase in acceptance (by women and their families) of male physicians as caregivers for women, and empowered women to discuss health issues with their husband and other family members, including child spacing (Georgetown University, 2007). IEG's field visits to communities and health facilities and interviews with SCAs and beneficiary women corroborated these findings.

5.21 ***The share of total demand for family planning which is satisfied increased slightly in Rural Upper Egypt from 69 percent in 2000 to 73 percent in 2005, while it remained virtually unchanged for Egypt as a whole (84 percent in 2000 and 85 percent in 2005)*** (Annex H, Figure H-11). Across Egypt's Regions, only Upper Egypt and the Frontier Governorates had documented improvements in the satisfaction of existing demand, rising from 74 to 78 percent and from 75 to 85 percent, respectively. Lower Egypt registered no change at all (at a constant 88 percent) and the Urban Governorates

experienced a slight decrease from 90 to 88 percent (Annex H, Figure H-12). The demand of women with no education was the least satisfied (at 81 percent), while those with some, primary and/or secondary education all fared better at 87, 86 and 88 percent, respectively (Annex H, Figure H-13).

5.22 ***District-level MoHP data in districts where the project intervened show an increase in the utilization of public family planning clinics in the initial years of subproject implementation, followed by a subsequent decline.*** Districts under Phase 1 registered a utilization rate of 54 percent in the first year of implementation (2000), a doubling of the 1998 baseline of 26 percent.[32] With slight fluctuations, the rate in the final year of 2003 was 56 percent, but this rate declined to pre-project levels (28 percent) in 2004. Likewise, during Phase II, from a pre-intervention baseline of 32 percent, rates increased from 49 to 53 percent during the first three years, then fell to 31 percent in the final year of implementation (2004).

5.23 ***On the other hand, data drawn from the household surveys for villages where the project intervened show an increase in utilization of public family planning clinics between 2003 and 2004 from 55 to 61 percent for Phase II villages and from 63 to 69 percent for Phase III villages*** (Annex H, Tables H-5 and H-6). Without the benefit of a baseline and trend data for these villages over the entire implementation period (and preferably beyond), it is not possible to document systematically to what extent (a) the subproject supported increases in service utilization; and (b) such levels were sustained beyond the last year of the subprojects. During its field visit to a family planning clinic in rural Menya, near a village where the project intervened, IEG gathered evidence (through a quick review of clinic data and discussions with family planning service providers, SCAs and clients) of increased service utilization, linked directly to project support. Between 2003 and 2006 the proportion of women of reproductive age served by this clinic, who were using some kind of modern contraception, increased from 35 to 69 percent, an upward trend that transcends the project. Before the project (in 2001) the family planning clinic registered an average of about 50 visits per month. This rate increased during project implementation to about 100 per month in 2003 and increased further after project completion (187 per month in 2007). Both family planning service providers and clients interviewed attributed these increases to the work of the SCAs, who were instrumental in convincing women of the benefits of family planning services and in accompanying them to the clinic to ensure a positive, client-centered experience (para. 5.20).

5.24 ***Between 2000 and 2005 the total fertility rate (TFR)[33] in Rural Upper Egypt declined by 0.8 children, from 4.7 (CI: 4.44-4.88) to 3.9 (CI: 3.75-4.09). This statistically significant decline is greater than what was achieved for Egypt as a whole (0.4 children from 3.5 [CI: 3.43-3.62] to 3.1 [CI: 3.05-3.21]) and for Rural Upper Egypt during the preceding 5-year period (0.5 children from 5.2[CI; 4.98-5.40] to 4.7***

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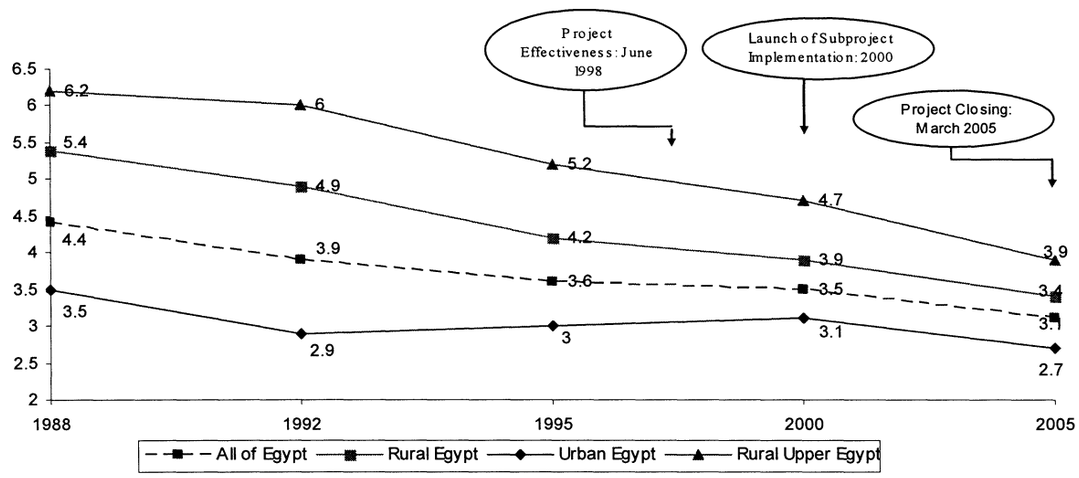
[32] It is not clear why utilization of family planning services doubled during the two years leading up to the start of project implementation. Data for 1999 (the year prior to Phase 1 launch) were not available.

[33] Total fertility rate is the total number of children a woman would have by the end of her reproductive period if she experienced the currently prevailing age-specific fertility rates throughout her childbearing life (WHO Definition of Indicators and Data Sources, 2006).

[CI: 4.44-4.88]) (Figure 5.3). The TFR in the region of Upper Egypt is still high compared with other regions in Egypt, but the change in fertility in this region is a major accomplishment and has narrowed the gap across regions (Annex H, Figures H-14 and H-15).

Figure 5.3. Total Fertility Rate - National Trends and Trends in Rural Upper Egypt



Source: DHS 1988-2005

5.25 ***The gap between actual and desired fertility appears to be growing in Egypt, with the most rapid growth in Upper Egypt.*** This means that, while there have been achievements in stimulating the desire of women for a smaller family size, women's actual fertility to date does not reflect their desired family size. In 2005, women in Rural Upper Egypt exceeded their desired fertility by 1.3 children, an increase of 0.3 over the already substantial gap of 1.0 child in 2000 (Annex H, Figure H-16). For Egypt as a whole, women exceeded their desired fertility by 0.8 children, up from 0.6 children in 2000. The 2000-2005 trends represent a reversal of trends for the previous 8 years (1992-2000) during which the gap between desired and actual fertility was narrowed. The closing of this gap represents both a challenge and an opportunity for furthering Egypt's population agenda.

6. RATINGS

6.1 The **outcome** of the Population project is *moderately satisfactory* overall (Table 6.1). The outcome of the first objective is unsatisfactory, based on its modest relevance, efficacy and efficiency. The outcome of the second objective is satisfactory, based on its substantial relevance, efficacy and efficiency. The overall outcome rating is a function of the heavier weight applied to the second objective, which is a core objective of Egypt's population policy and to which the bulk of project financing was devoted.

Table 6.1. Summary IEG Ratings* by Objective

Development Objectives	Relevance	Efficacy	Efficiency	Outcome
1. Improve MoHP's management of population and family planning	Modest	Modest	Modest	Unsatisfactory
2. Finance population activities in Rural Upper Egypt) to promote smaller families, increase contraceptive use and bring about a consequent decline in fertility	Substantial	Substantial	Substantial	Satisfactory
Overall Project Rating				**Moderately Satisfactory**

*See inside cover of this report for definitions of relevance, efficacy and efficiency.

6.2 The **relevance** of ***project objectives*** is *substantial.* "Managing population growth" was GoE's second key objective identified by the ruling party committee (World Bank CAS, 2005). Egypt's recently issued National Strategy for Population and Family Planning (2007-2012) seeks to lower TFR to 2.4 children by the end of 2012 in support of the medium-term national goal of reaching 2.1 children by 2017. National strategies for achieving these goals include: improvements in the quality and availability of reproductive health and family planning services; changes in attitudes in favor of small families; strengthened linkages with other efforts to improve socio-economic indicators which affect demand (women's education, economic opportunities, empowerment, child wellbeing, among others); and improved monitoring and evaluation of population and family planning efforts. This Strategy does not, however, include any objectives or actions to strengthen institutional capacity for strategic management and implementation of population/family planning activities, except for M&E capacity building.

6.3 The Bank's CAS for the period FY06 – FY09 is articulated around goals of facilitating private sector development, enhancing the provision of public services, and promoting equity. Public service provision goals include the decentralization of public services delivery, with a greater role for private sector, local authorities and civil society. Improving access to health care is an important component of efforts to promote equity and includes objectives to increase investments in priority under-served regions and to increase contraceptive prevalence rates. However, the CAS focuses on supply-side elements of population and family planning. It does not link the issue of population growth to the prospects of Egypt's economic development and poverty alleviation goals, nor does it specify or support the goal of fertility reduction to these ends. Furthermore, the CAS does not mention the importance of continued demand-side stimulation. The inclusion in the CAS of a "Health and Population Sector Strategy" is aligned with CAS supply-side goals of service availability, quality and efficiency. In short, the objectives of the Population project are very relevant to GoE's goals of achieving a TFR of 2.1 children by 2017. However, neither the Government's nor the Bank's strategies encompass all the essential elements to achieve this goal.

6.4 The **relevance** of the ***design of the capacity building component*** (supporting the first objective) is *modest.* This component: was excessively focused (up until the mid-term) on central-level capacity building; did not specify any key performance indicators and outcomes around which project interventions would be implemented and tracked; and failed to establish a clear results chain. The National Population Council, with its mandate for population policy formulation and research, was not involved in this

project. The **relevance** of the ***design of the PAP component***, which addressed the project's second objective and accounted for the bulk of project spending, is *substantial.* The strategic focus on demand stimulation made sense in light of substantial planned investments in supply-side support in Upper Egypt.[34] The targeting of pockets of high fertility and low demand for family planning within the Region of Upper Egypt, whose population indicators lagged behind all other regions in Egypt, was rational and consistent with GoE and CAS objectives to reduce regional inequities. Furthermore, the stimulation of attitudes and behaviors through efforts both to affect factors influencing fertility (women's economic opportunities and empowerment, and family and child wellbeing) and to link women to project benefits and FP information and services through SCAs, all were based on credible research, and validated through project experience.

6.5 The **efficacy** of the ***first objective*** is *modest.* MoPH management strengthening was not achieved at the national level (paras. 5.6 and 5.7), but some capacity building did occur in selected decentralized entities (paras. 5.3 – 5.5). The **efficacy** of the ***second objective*** is *substantial* and is weighted heavily given its importance, both strategically and in terms of its cost. Data and information on key population trends in the 148 villages benefiting from subprojects are incomplete. Two rounds of project survey data do provide some evidence of increased utilization of family planning services and increased visits to clinics in beneficiary villages, but this is documented only for one year (data sets having been collected in 2003 and 2004, respectively). Anecdotal evidence, including IEG interviews with beneficiaries, corroborates positive changes in attitudes and practices brought about by the project. The project's innovative design influenced other major demand-side interventions in Rural Upper Egypt and thus is likely to have contributed to positive trends in population indicators in Rural Upper Egypt documented in this report, beyond its impact in 148 villages.

6.6 The ***first objective's*** **efficiency** is *modest.* The Government failed to clarify the institutional and organizational framework for the management and oversight of population and family planning, which was to have been the basis for the project's support under the first component. The links between capacity building inputs and outputs (training, technical assistance, study tours), on the one hand, and intended outcomes, on the other hand, were not well established, undermining the full exploitation of project outputs to improve sector management. **Efficiency** of the ***second objective*** is substantial. Its targeting of "hot spots" of highest fertility, lowest CPR and strongest preferences for larger families, within Upper Egypt, whose population indicators are lagging vis-à-vis the rest of Egypt, constituted an efficient support to Egypt's national goal of achieving replacement-level fertility by 2017. The design was also efficient in its focus on demand-side interventions. It focused on improvements to selected socio-economic indicators for women that would stimulate their demand for smaller families and for family planning services. Beneficiaries have confirmed that the microcredits, literacy training and the development of marketable skills have been instrumental in

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[34] The project design did raise the inadequacy of supply in light of increased demand as a potential risk of the project. It is, nevertheless, possible that a more in-depth review of planned supply-side investments might have revealed gaps that could have been addressed by the project.

influencing their attitudes, preferences and behaviors with regard to family size and the use of family planning services. The provision of information about family planning evolved during the project life from one of IEC to a more efficient and results-oriented CBC. The project was also efficient in its use of SCAs. As trusted women of the communities, they were most effective in bringing project benefits to the women. Cost-effectiveness analysis of subproject interventions was not undertaken as envisaged under the M&E design. Nevertheless, an economic analysis of subprojects undertaken as part of the Implementation Completion Report revealed that actual costs per beneficiary were slightly lower than predicted. Still, the cost-effectiveness of various approaches and subprojects is not known, nor was it compared with that of interventions financed by other partners in the region (as had been initially planned).

6.7 The project was efficient in some of its institutional arrangements. The contracting of the PAP component to the SFD put these activities under the responsibility of an agency with relevant experience and a comparative advantage for the management of community-based activities. The support of subprojects managed by NGOs permitted an interface with the communities through community-based organizations. The partnerships developed between local level MoHP managers and staff and the SFD and NGOs and other civil society organizations helped to ensure that both supply and demand elements of population and family planning activities were incorporated into local-level planning and action. Inefficiencies of project institutional arrangements included: a centralization of disbursement authority and project approvals at the level of the Prime Minister's Office which took considerable time to resolve and caused implementation delays; lack of procurement capacity in the PIU in the initial years of the project; the failure on the part of Government to clarify the institutional/organizational framework for population and family planning, which undermined efforts to strengthen capacity in MoHP/PS.

6.8 **Risk to Development Outcome.** The risk that development outcomes will not be maintained or realized is *significant.* After the closing of the population project there was no follow-on financing from government or from external sources to sustain activities or to expand them to yet uncovered areas of low contraceptive use and high fertility. Communities which had benefited from project support decided, with the supporting NGO, to raise the interest rates of the microcredits that continue to be available to women, in order to support the costs of a small compensation to the SCAs. This is a clear indication of the value the beneficiaries place on these agents. However, according to SFD personnel, the funds raised from these rates have allowed the financing of only about one third of all SCAs initially engaged under the project. Some informants considered that this reduced number of SCAs would still allow for a continuation of critical operations in areas where subprojects already invested in demand-stimulation activities. However, other informants, corroborated by IEG's field visits and review of village-level data, suggest that the number of activities and gains in key indicators have been reduced after the completion of subprojects. No financing source has been identified to sustain and expand demand stimulation activities at a very critical juncture in the history of external financing of population activities. USAID is pulling out of its traditional role of financing population and family planning activities in Egypt. And now that Egypt has graduated to "Lower Middle Income Country" status, it is hesitant to

borrow from the World Bank Group to finance population and family planning investments at the rates of IBRD loans.

6.9 The risk to development outcomes is also a factor from an institutional perspective. Efforts to develop MoHP/PS capacity to strategically manage were undermined by a persistently unclear institutional/organizational framework. At the local level the regional offices of the SFD played a catalytic role in engaging NGOs in demand-side interventions and in linking the various local-level actors (communities, social change agents, health managers and service delivery staff, other sectors) in the design and implementation of activities. With no further financing available, it is not clear to what extent the SFD will continue to be engaged in population activities.[35]

6.10 There is also a technical dimension to the risks to development outcomes. Egypt is in the process of reforming its health sector. Under the health sector reform program, launched in the mid- to late-1990s and piloted thus far in five districts,[36] the GoE is attempting to separate three functions: service delivery, financing and stewardship. This reform entails the integration and delivery of a range of basic health services through a family health unit, delivered by generalist family health physicians. Incentive-based financing aims to reinforce quality, efficiency and equity in the delivery of these services. Research and studies undertaken in Egypt[37] and IEG field visits to reform and non-reform areas have revealed that reproductive health and family planning services were found to be diluted in the basic package. Family doctors are not as well trained as the specialists who had provided these services prior to the reform. The training they receive is much shorter. Assessments of family planning knowledge of physicians revealed that those trained by the MoHP through vertical programs had better knowledge and capacity in family planning service delivery than those who had been trained through the health reform training modules. Beneficiaries and Governorate-level MoHP staff corroborated these concerns. They also expressed concern that under the new family health clinic design there is no special room(s) designated for family planning clients. They were, rather, seen in any one of the regular service delivery rooms. Many believed that it was important for these services to understand and respond to the distinction between the health clinic patients and the family planning clients. Others revealed concern that there were fewer women physicians catering to family planning clients, which is an important factor to many clients and their husbands. Any perceived deterioration in the quality and availability of services poses the risk of a decline in the use of family planning services.

6.11 Overall **Bank performance** was *moderately satisfactory.* The **Bank's performance** during preparation was *satisfactory.* The project was fully supportive of the Government's national objectives, based on a sound analysis of key population trends, and well targeted to the areas where population indicators were most unfavorable.

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[35] As a result of this project the SFD has established a Population and Health Unit and assigned Population Officers in each of the eight governorates in Upper Egypt. It is not clear to what extent SFD financing might be earmarked or prioritized to continue or expand support to population activities.

[36] To date primarily in Alexandria, Menoufia, and to a lesser extent (and more recently) in Souhag, Qena and Suez

[37] Cite Hassan Zaky's work, Social Research Center, American University in Cairo.

Its readiness for implementation was supported with the production of an operational manual, guidelines and selection criteria soon after effectiveness to guide the approval of project sites and proposals. Moderate shortcomings of the Bank's preparation work are revealed in the facts that: (a) these tools could have been prepared prior to effectiveness, given the very long delay between Board approval and effectiveness; and (b) implementation might have been further accelerated and streamlined had project management and NGO capacity been more fully assessed and addressed prior to effectiveness.

6.12 The Bank's performance during supervision was *moderately satisfactory.* The project director and others involved in implementation (both those from MoHP and SFD) were unanimous in their appreciation of the pedagogical approach of the Bank's team, especially during the early years of implementation, when all actors were new to the Bank's procedures and the innovative nature of project design. Capacities in procurement, financial management, and reporting were built with the close supervision of the Bank and careful review and feedback on project implementation. The Bank was also flexible in adjusting the project and the allocation of resources to respond to evolving issues and needs, including, among others, the procurement of contraceptives in light of USAID's withdrawal from contraceptive financing and the strengthening of family planning service delivery in areas where increased demand was not being effectively met. Task team leadership was field based, which allowed for closer supervision and more frequent dialogue. There is evidence in project documentation of some collaboration with other donors supporting population, especially USAID and UNFPA. However, this collaboration was not systematic or programmatic. Two important shortcomings of the Bank's performance were: (a) its failure to make headway on the critical elements of the capacity building objective (improve strategic management of population activities, overall program monitoring and evaluation, and mobilization, coordination and allocation of resources for population);[38] and (b) the less than rigorous follow-up, guidance and support on project monitoring and evaluation. There is also no evidence of a strong link in the Bank's work and dialogue on population and family planning, and that on health sector reform. It is noteworthy that (a) the current CAS (FY96-09) does not raise the issue of population and its implications for Egypt's socio-economic development prospects; and (b) the Bank has never carried out or supported a Public Expenditure Review (PER) on the Population Sector.

6.13 **Borrower Performance** was *moderately unsatisfactory* overall. With regard to Government's performance, the project was developed in collaboration with the (former) Ministry of Population and Family Planning, which was merged into the Ministry of Health (becoming MoHP) in 1996. While reduction of population growth remained high among national priorities, population policy implementation under MoHP was limited,

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[38] At the MTR it was agreed with Government that, since the institutional/organizational framework for population and family planning had still not been completely defined, capacity building efforts would focus on local (governorate, district and community) capacity. There was still opportunity for the Bank to support some of the building blocks needed for the strategic management and financing of population. The Bank's agreement to dramatically decrease the IDA allocation for consultants' services (at the strong request of Government) may not have been an appropriate decision, given the need for technical assistance and capacity building.

due to an absence of capacity of elements of the policy not related to family planning service delivery. At the time of this merger MoHP was launching the Health Sector Reform Program, which commanded the time and attention of the MoHP leadership and staff. With the creation of the MoHP the NPC role in policy formulation and development became marginalized and focused almost exclusively on research activities. Government's failure to take decisions to restructure the institutional/organizational framework for the population sector undermined its capacity to strategically manage its entire program as well as the project therein. The MTR called for the collaboration of the population sector with other sectors, especially the (central-level) Technical Support Office and (governorate-level), with a view to implementing health sector reform. There is no evidence that this was done. The holding up of contract approvals and disbursements at the level of the Prime Minister's Office caused considerable delays in subprojects implementation, but this was resolved after the MTR.

6.14 The PIU in MoHP played an important role in complementing the subprojects. It successfully managed the contracts for the upgrading of the clinics, provision of equipment and supplies needed for improving family planning services in selected villages. It also managed well the contracting of various consultants. The Population Unit of the SFD made sound contributions to: the design of the subprojects; the monitoring of the phases of their implementation; and the technical backstopping of subprojects. The SFD also fulfilled its role as catalyst among many actors and implementers for forming partnerships in the planning and implementation of population activities. There also were a number of shortcomings in project implementation. The Executive Committee did not function during most of the project implementation period, causing the PIU to manage policy decisions through the PS Director. PIU procurement capacity was weak initially, but improved over time with on-the-job training and recruitment of specialized support. There were deficiencies in the financial reporting and monitoring of subprojects at the level of the implementing NGO and at the level of the SFD.

6.15 For reasons presented in Chapter 4, the design and implementation of project **monitoring and evaluation** and the utilization of data for decision-making were *modest*, overall.

7. LESSONS AND FUTURE DIRECTIONS

LESSONS

7.1 ***Supply-side and demand-side interventions supporting population and family planning objectives can be truly synergistic when they are delivered through a well defined and well functioning partnership of local actors.*** In Rural Upper Egypt the partnership between the SFD and the MoHP drew on their comparative advantages, the former linking with communities, community development associations and focusing on multi-sectoral interventions and the latter bringing its technical expertise both to service delivery and to reproductive health and family planning promotion and education. Together these two partners enlisted and involved local leaders, NGOs and community-based SCAs in the planning, design and implementation of interventions supporting

shared objectives. SCAs forged improved links between communities and services, and front-line service providers became more client-focused, together resulting in increased utilization of services by women from these communities and increased satisfaction of these clients.

7.2 ***An important element of any investment in management capacity building is the support of monitoring and evaluation activities. However, when the focus of M&E support is project-specific, rather than program-wide, an opportunity is missed to learn from experience across projects and to use evidence to fine-tune national policies and strategies. This lesson is especially relevant where innovative activities are supported in the same geographic area by different externally-financed projects.*** Demand-side interventions supported under this project were innovative and limited in their coverage, constituting in effect a pilot approach. During project implementation USAID launched the TAHSEEN project, also in Rural Upper Egypt, which embraced many of the demand-side approaches initiated under the Bank-financed project along with other innovations. While each of these projects was evaluated separately, the collective effects of these interventions in Rural Upper Egypt were not evaluated, nor was the cost-effectiveness of these projects' approaches compared and contrasted. Given that MoHP's recently issued population strategy emphasizes continued efforts to encourage attitudes favoring smaller family size, such cost-effectiveness analysis and evaluation would appear to be critical. An evaluation of all demand-side interventions in Egypt would have helped to determine what works "on the ground" and with regard to institutional and organizational arrangements.

7.3 ***Demand-side interventions, though critical to achieving population and family planning goals, are not likely to be sustained or expanded in the absence of an institutional home for these activities and a well-defined, evidence-based program of activities.*** The demand-side interventions supported under the project have been partially sustained through communities' decisions to raise the interest rate for microcredits, which has covered the costs of maintaining one third to one half of SCAs. The SFD has financed a few new community-driven population activities using its own funds, but there are large areas in need of such interventions that are not covered. There is no national plan or institutional home to promote and support the design and implementation of demand-side interventions. The "General Department for Family Planning Services in the Private and NGO Sector" within MoHP/PS appears to focus on NGOs involvement in services, not demand stimulation.

7.4 ***Efforts to ensure and improve the quality and client-orientation of family planning become all the more crucial when they are undertaken in the context of health sector reform program (HSRP).*** Field visits to reform governorates (Alexandria and Menoufia) and research have revealed that reproductive health and family planning services are somewhat diluted within the basic package of services delivered through new family health facilities and of lesser quality. A recent study (Zaky, 2008) has documented that family doctors are not as well trained as the specialists who provide family planning or reproductive health services. The training they receive is shorter and less in-depth. The study tested the family planning knowledge of physicians trained by MoHP vertical programs (reproductive health and family planning specialists) against those trained under the HSRP (reproductive health and family planning modules) and

found that the former were better trained and had better knowledge of family planning than the latter. Governorate-level reproductive health and family planning program managers have pointed to feedback received by clients on their perceptions of a possible decline in the quality of service, including: the absence of a special room/section of the family health facility for family planning clients; the frequent absence of a female physician/specialist to discuss family planning matters; the perception that family physicians have less specialized training and less time to devote to family planning clients. Opportunities within the health sector reform program might be exploited to address and correct these issues.

FUTURE DIRECTIONS

7.5 The Government has recently issued its National Strategy for Population and Family Planning (2007-2012), whose goal is to reduce total fertility to 2.4 by 2012 facilitating achievement of the national target of 2.1 by 2017. Strategic components aim to (a) improve the quality and availability of reproductive health services within primary health care; (b) change attitudes favoring small family size and meet growing demands for reproductive health and family planning services; (c) link population issues with comprehensive development frameworks; and (d) ensure more effective monitoring and evaluation.

7.6 The GoE is faced with a number of challenges if it is to implement this strategy successfully. Among these challenges are:

- The need to develop a financing plan for ensuring the coverage of all population activities. This is especially important in light of USAID's withdrawal of its assistance to the population sector and in light of Government's hesitancy to borrow for population on IBRD terms;

- The importance of maintaining and continually improving the quality and availability of reproductive health and family planning services in the context of the health sector reform program, under which there are indications of a deteriorating quality of these services;[39] and

- The need to clarify the institutional home, roles and responsibilities for sustaining demand-side interventions. Research undertaken in Egypt indicates that the critical focus of demand-side interventions must include: continued efforts to stimulate desire for smaller family size in pockets of resistance; renewed efforts to encourage birth spacing; and the closing of the gap between desired fertility and actual fertility.

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[39] To this end, the Government has noted in its comments (Annex I) that MoHP, with UNICEF support, is currently funding a program entitled, "Strengthening Supply, Demand and Utilization of Reproductive Health Services in the Context of Health Sector Reform."

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Annex A. Basic Data Sheet

POPULATION PROJECT (CR. 2830-EGT)

Key Project Data

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project costs (US$ million)	20.7	17.7	86%
Credit amount (millions of SDRs)	11.9	10.4	87%
Cancellation (millions of SDRs)		1.5	13%

Project Dates

	Original	*Actual*
Initiating memorandum	10/18/1994	10/18/1994
Negotiations	02/08/1996	02/08/1996
Board approval	03/21/1996	03/21/1996
Signing	07/01/1996	07/01/1996
Effectiveness	10/28/1996	06/24/1998
Closing date	12/31/2001	03/31/2005

Staff Inputs

Stage of Project Cycle	**Staff Weeks**	**Cost (US$ million)**
Identification/Preparation	28	115
Appraisal/Negotiations	30	120
Supervision	114	278
ICR	18	36
Total	**190**	**549**

Mission Data

	Date (month/year)	No. of persons	Specializations represented	Performance rating	Rating trend
Identification/ Preparation	10/13/1995	6	TTL; Principal Pop. Spec.; Human Resource Spec.; Sr. Demographic Spec.; Pop. And Health Spec; Instit. Dev. Spec	S	S
Appraisal/ Negotiation	06/30/1996	3	TTL; Principal Pop. Spec.; Pop. an Health Spec;	S	S
Supervision	07/24/1998	3	Mission Leader; Operations Officer; Economist	U	U
	10/23/1998	1	TTL	S	S
	11/02/1998	3	TTL; Economist; Sr. Pop. Spec.	S	S
	10/14/1999	4	Health Cluster Leader; TTL; Health Spec.; Implementation Spec.	S	S
	02/21/2000	5	Health Cluster Leader; TTL; Program Asst.; Implementation Spec.; Fms	S	S
	06/20/2000	6	Health Cluster Leader; TTL; Program Asst.; Fms.; Operations Officer; Sr. Portfolio Manager	S	S
	03/23/2001	4	Mission Leader; TTL; FMS; Operations Officer	U	S
	03/16/2003	2	TTL; Impl. Cons.	S	S
	08/31/2003	8	Health Sector Manager; Mission Leader; TTL; Lead Implementation Spec.; Project Mgt. Cons.; IT Cons.; FMS; Team Asst.	S	S
	11/15/2003		Mission Leader & TTL; Project Mgt. Consultant; It Cons.; M&E Cons.; Program Asst.	S	S
	06/30/2004		TTL; Project Mgt. Cons; Sr Fms; Communication Sp; M&E Cons.; Program Asst.	S	S
	06/06/2002		TTL; Lead Implementation Spec; Sr Fms; Resource Dev. Cons.; Team Asst.	S	S
Completion			Ttl; Public Health Spec.; Implementation Cons.; Communication Spec.; M&E Cons.; Program Asst.;	S	S

Annex B. Persons and Organizations Consulted

Egypt
Cairo

Ministry of Health
- Dr. Atef El Shitany, Population and Reproductive Health Specialist and Manager of UNFPA Project on Reproductive Health and Health Sector Reform, former Population Project Director
- Dr. Hala Massekh, General Director and Health Insurance Coordinator, Technical Support Office, Health Sector Reform Program
- Dr. Mohamed Mostafa Yousef, General Director, Schisto and Intestinal Parasite Control Department
- Dr. Zeinab M. Youssef, Undersecretary of Endemic Diseases
- Dr. Mohamad Atef Hassan, Director of National Schisto Projects
- Dr. Agat Atef Haggag, Director of Chemotherapy Department, Endemic Diseases
- Dr. Isaac, Family Health Fund, Technical Support Office, Health Sector Reform Program

Ministry of International Cooperation
- H.E. Fayza Aboulnaga, Minister of International Cooperation
- Souraya Abo El Saoud, Under Secretary of State, International, Regional and Arab Financing Organizations
- Dr. Talaat Abdel-Malek, Executive Director and Economic Advisor to the Minister of International Cooperation, and Head of the Center for Project Evaluation and Macroeconomic Analysis (PEMA)

Social Fund for Development
- Aliaa El Sherif, Manager, International Cooperation Group
- Hanaa El Hilaly, General Manager, International Cooperation Group
- Amany H. Youssef, Sector Head, International Cooperation Group
- Walid Mansi, Manager of the Monitoring Department, International Cooperation Group
- Engineer Medhat Masoud, Manager, Community Health and Education Department
- Howaida El Hawary, Deputy Manager, Community Health and Education Department
- Engineer Mohamed Hashem, Director, Community Infrastructure Sector
- Essam Elsayed, Population Officer

Other Public Sector Organizations
- Dr. Hassan Zaky, Social Research Center, American University of Cairo

Development Partners
- Holly Fluty Dempsey, Deputy Director, Office of Human Resources and Health, Chief, Health and Population, USAID/Egypt
- Dr. Zuhair Hallaj, Special Advisor, Communicable Disease Control, WHO Regional Office for the Eastern Mediterranean, and Acting WHO Representative
- Mona Moustafa, Program Officer, UNFPA
- Sharif Egal, Program Officer, UNFPA

The World Bank
- Emmanuel Mbi, Country Director for Egypt
- Dr. Alaa Abdel-Hamid, Senior Health Specialist for Egypt, and Task Team Leader of Population Project

Governorate of Alexandria

Directorate of Health – Governorate Level

Technical Support Team, Health Sector Reform Program
- Dr. Maha Hassieb, TST Coordinator
- Dr. Amiyra, TST Coordinator Alexandria, 1998-2007
- Dr. Hisham Bedeir, Family Health Fund Director

Family Planning
- Dr. El Moslemani Mohamed, Family Planning Director

Tropical Disease Control
- Dr. Saad Eldin Add Halim, Tropical Disease Director, Schistosomiasis Control

Health/Family Planning Facilities
St. Stefano Family Health Center
- Dr. Hala Moussa, Director

Governorate of Menoufia

Directorate of Health – Governorate Level

Technical Support Team, Health Sector Reform Program
- Dr. Mohamed El Hayatmy, TST Coordinator
- Dr. Ahmed Reda Ed-Dorghamy, Family Health Fund

Family Planning
- Dr. Afaf Mohammed Solyman, Director of Family Planning and Reproductive Health

Tropical Disease Control
- Dr. Samya Mohamed Shahin, Director of Schistosomiasis Program

Governorate of Menya

Directorate of Health – Governorate Level

Population and Family Planning
- Dr. Shantoury, Assistant Manager, Population and Family Planning
- Dr. Sawsan Nagib, Population Officer

Health Team, Matty District
- Dr. Atef Omar, Manager of a Health Unit
- Heba Ibrahim, Office Responsible for Change Agents within MoHP

Family Health Unit, Minya
- Head of the Family Health Unit
- Family Planning Nurse

Social Fund for Development
- Fayza Kamel Eltahnowy, Manager, Regional Office
- Montassar Rouchdy, Officer Responsible for Community Development

NGO
Rural NGO in Ebwan village in Matty district
- Hind Nashaat, Head of NGO
- Badar Mohamed, Media Officer
- About 10 social change agents
- About 20 women from the community who benefited from project interventions

Governorate of Qena

Social Fund for Development
- Amr Abdullah, Deputy Manager
- Mahmoud Hindaui, Responsible for Community Development Activities
- Mohamed Gabber, Responsible for Population Project

NGOs
Community Development Association for Rural and Urban Women
- Amal Eid, Director
- Hany Mohamed, Financial Director and Project Manager
- Mohamed Youssef, General Coordinator for NGO
- Three members of the NGO Board
- Abdul Fatch Mohamed, Head of committee for NGOs in Qena

Rural NGO in Gargouse
- NGO staff
- Board members
- Approximately 10 social change agents
- Approximately 20 women beneficiaries

Health/Family Planning Clinics
Dandara Hospital Family Planning Clinic
- Asna Hassan Gad, Family Planning Nurse
- Social Change Agent
- Family planning clients

United States of America

The World Bank, Washington, D.C.
- Francisca Ayodeji Akala, Senior Public Health Specialist, Author of ICR and current TTL of Egypt Family Health Insurance Project
- Jean-Jacques Frere, Public Health Specialist, Middle East and North Africa Region
- John Langenbrunner, Lead Economist, Health, former Task Team Leader of Family Health Insurance Project (under preparation)

Others

- Elsa Berhane, Senior Program Officer, Extending Service Delivery Project, Pathfinder International, Washington, D.C., formerly with the Catalyst Consortium for USAID-funded Tasheen Project
- Dr. Maggie Mohiey, Atlanta, Georgia, formerly Deputy Director of Population Project, MoHP

Annex C. Egypt Population Timeline

Date	National Egyptian Events (1)	Egypt Population Event (including support of other donors)	World Bank Support (9)
1950s	Nasser period (1952-1970): socialist regime, nationalized industry, pro-USSR, close to military.	Family planning are first offered through experimental and pilot projects under the auspices of the National Commission for Population Matters, and later transferred to established voluntary organizations (Egyptian Association for Population Studies, the forerunner of the Egyptian Family Planning Association. (2)	
1953		Establishment of the National Commission for Population Affairs to address population issues (one year after the revolution). (2)	
Early 1960s		Government states in the National Charter that "high growth rates represent the most dangerous obstacle that hinders efforts to raise the standard of living of the Egyptian people." (3)	
1962		President Nasser, originally opposed to family planning, was one of the first leaders of the developing world to recognize the population problem and its effect on development prospects. (10)	
1964		Formal population policy is issued.	
1965		Establishment of the Supreme Council for Family Planning (and its secretariat, the Family Planning Board) responsible for population policy formulation, coordination and evaluation, with branches in each of the 25 governorates (Governorate Family Planning Advisory Committee) (4)	
1966		President Nasser accords top priority to family planning in Egypt's national development plan. Egypt establishes a national family program aimed at fertility reduction. (10)	
1970	Sadat period (1970-1981): move away from Soviet influence and closer to Israel; cautious move towards multiparty system and economic liberalization.		
1973		Supreme Council for Family Planning issues the ***"first" National Population Policy*** in 1973, which aimed to reduce the CBR from 34 to 24 births per thousand in 1982 and emphasized socio-economic change as an element of population policy. It is accompanied by an implementation plan for the period 1973-1982. (5)	First IDA credit for a Population Project is approved (US$5 million) (October).
		Start of USAID support to PDP and the overall Egyptian population effort (6)	
1975		Policy refined to account for dimensions of population problems: growth, spatial distribution, characteristics and structure. (2)	
1978			Second IDA credit for a Population Project is approved (US$ 25 million) (October).

Date	National Egyptian Events (1)	Egypt Population Event (including support of other donors)	World Bank Support (9)
1979			First Population Project is closed (June).
1980		A new National Strategic Framework for Population, Human Resource Development and the Family Planning Program is issued as Egypt's ***second population policy document,*** emphasizing face-to-face communication and community-based promotion activities. (2)	
1981	Sadat is assassinated. Mubarak takes office and continues slow economic and political reform, with social programs lagging behind.		
Early 1980s		Family planning program efforts in Egypt are classified as "weak" in comparison to those in other countries (Mauldin and Lapham, 1984), with substantial difference in key indicators between Lower and Upper Egypt. (7)	
1984		A National Population Conference is held under the chairmanship of the President of Egypt. (2) From this point on President Mubarak began giving more attention to the population issue.	
1985		The National Population Council (NPC) is created, taking over the role of the Supreme Council, responsible for coordinating efforts in: family planning; child welfare; women's participation in the labor force; and literacy. (2)	
1986	Economic crisis ensues due to drop in oil prices.	The *third national population policy document* and plan, by the NPC, is adopted, including quantifiable objectives addressing growing concern that previous efforts had failed and emphasizing the interaction between population and development factors. This constitutes the only official document up to the present. (2)	Second Population Project is closed (March).
1989		From this year through to 2001 USAID supplied all contraceptive needs for Egypt (6)	
1990	Egypt becomes key mediator in new Middle East crisis, caused by the Gulf War. Egypt tourism suffers.		
Early 1990s	GoE embarks on IMF structural adjustment and socio-political unrest increases.		
1993 October		Creation of a Ministry of Population and Family Planning (Prof. Dr. Maher Mahran is named Minister of State for Population and Family Planning and has oversight responsibility for the NPC), giving population program a direct voice in the Cabinet; and Reorganization of the NPC – Technical Secretariat as a strategic think-tank on inter-sectoral population issues in close coordination with the MoPFP Several specific targets are set for the year 2007. (2)	
1994	GoE shifts from borrowing to grant and concessionary lending (largely from U.S.).	Egypt hosts the International Conference on Population and Development. (2)	Joint USAID, UNFPA, World Bank agreement reached in 1994, in the context of a

Date	National Egyptian Events (1)	Egypt Population Event (including support of other donors)	World Bank Support (9)
			Bank project preparation mission, to collaborate with Government and each other to support the Egyptian population program.
1995		A modified population strategy is developed based on the recommendations of the 1994 ICPD, emphasizing a comprehensive approach to population (reproductive health services, NGO involvement in community work, and closing the gender gap) and identifying a range of demographic and social goals for a 20-year period. (2)	Third Population Project is appraised (July).
1996	Egypt returns to macroeconomic stability and economic growth. Prime Minister El Ganzouri takes office (December).	MoPFP is merged into the Ministry of Health to create a new Ministry of Health and Population (MoHP), in response to the ICDP declaration for the integration of FP/MCH services into a broad-based women's health program and a new Minister of HP is named (January). (NPC to continue policy coordination and advocacy, but population questions brought directly to the attention of the Cabinet.) (2)	Third Population Project is approved by the Board of Executive Directors (March).
1997	Long-term 1997-2017 National Plan is launched. Terrorist attack on tourists in Luxor negatively impacts Egypt's tourism industry.		CAS is issued. Health component of human development pillar is heavily oriented around health sector reform, although the issue of high fertility and early marriage in Upper Egypt is raised and maintaining support for family planning

Date	National Egyptian Events (1)	Egypt Population Event (including support of other donors)	World Bank Support (9)
			activities is included. Contraceptive use and family planning approval are included among the benchmarks.
1998			Third Population Project becomes effective (June).
1999			Egypt graduates to middle-income country status and is no longer eligible for IDA credits.
2000	First fair general elections. Muslim brotherhood forms the first real opposition block with 17 seats. Prime Minister Obeid takes office. Social policy includes improving access to health care and relaunching of primary health care reform. Period of economic crisis (2000-2003) starts and there is no access to hard currency. Two devaluations of the Egyptian pound add up to a 60 percent devaluation.	Start of gradual withdrawal of USAID support to population and family planning. (6)	Start of PAP (demand-driven subproject) implementation in Rural Upper Egypt.
2001	There is concern with destabilizing effects of terrorism following the September 11 bombing.		CAS is issued, emphasizing support to health sector reform under poverty reduction pillar. HNP benchmarks

Date	National Egyptian Events (1)	Egypt Population Event (including support of other donors)	World Bank Support (9)
			include the expansion of community development programs in villages with very high fertility.
2002		Documents codifying the National Population Program are issued, articulating detailed population strategies and updating the still official 1986 national population plan. (2) UNFPA/MoHP National Population Strategy (2002-2007) is issued. (8) A New Minister of Health and Population is appointed (March 2002). (2) A new Managing Director for the SFD is appointed (June 2002). PM issues a decree creating a High Population Committee (HPC) in the Cabinet to have an oversight function over population policy, under the leadership of the Ministry of Information. (2) President issues a decree modifying the composition of the Population Council, under MoPH leadership with a mandate to formulate the national population plan that will be submitted to the HPC. (2)	Mid-term review of Population Project is held (June).
2003		CATALYST Consortium begins implementation of the last USAID-funded family planning and reproductive health program, TAHSEEN, which supports a new model for community mobilization and participation. (11)	
2004		A new Cabinet was appointed in July 2004 with Minister of HP keeping his position and portfolio. The President restated the priority of the pop growth management as one of the most important challenges facing Egypt. (2)	
2005			Third population project is closed (March). Health strategy and interventions within the new CAS (2005) is limited to the support of health sector reform in two governorates. There are no benchmarks or indicators for family

Date	National Egyptian Events (1)	Egypt Population Event (including support of other donors)	World Bank Support (9)
			planning.
2007	NDP assembly announces population, along with social security, as a key policy item.		
2008		National Strategic Plan for Population (2007-2012), developed by the NPC, is issued. (8)	

(1) "Egypt HNP Case Study on the Development Effectiveness of World Bank Support," (forthcoming, 2008).
(2) DHS, 2005.
(3) DHS, 2005 (quoting Ibrahim 1995).
(4) DHS 1988 and 2005.
(5) DHS, 1992 and 2005.
(6) USAID program documentation and staff interview.
(7) DHS, 1988.
(8) UNFPA program documentation and staff interview (by electronic mail).
(9) World Bank information system.
(10) Cochrane and Massiah, 1994.
(11) Pathfinder International, 2005.

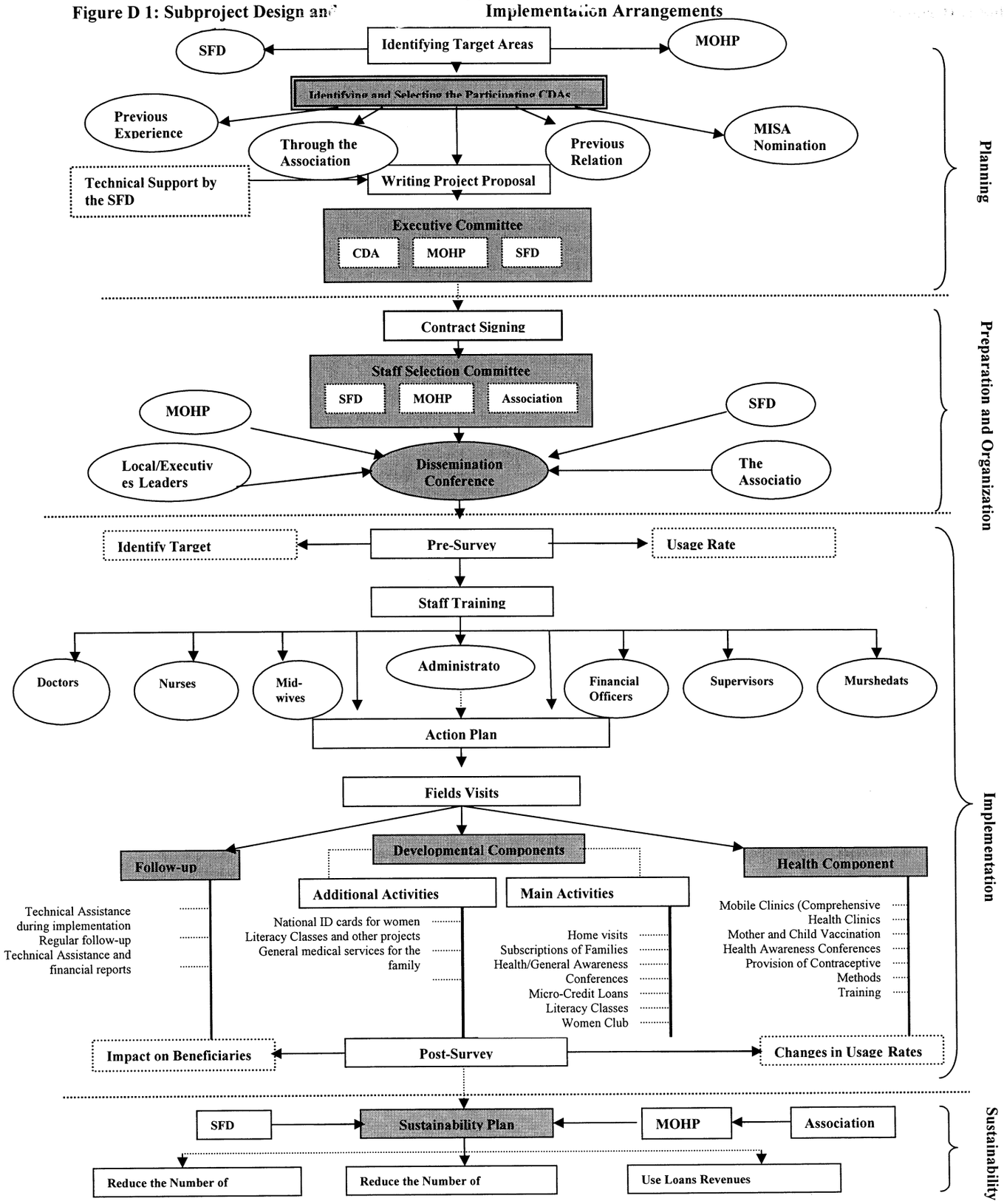
Annex D. Design and Implementation Features

Table D 1. Factors that influence lower fertility:

Factors	Reason
Demand-side:	
Reductions in infant and child mortality	In the short-term lower infant and child mortality leads to somewhat larger families and faster rates of population growth. But in the long-term, with improved chances of survival, children receive more attention from their parents, and parents are willing to spend more on their children's education. Lower mortality not only helps parents to achieve their desired family size with fewer births, it leads them to want a smaller family as well.
Increase in income	In the long-run, people with more income want fewer children. It is not higher income itself, but the changes it brings to people's lives that lowers fertility: alternative uses of time, particularly to women; desire for healthier and better educated, but fewer children; decreasing importance of children's work to family welfare; opportunities/entitlements that guard against destitution in emergencies or in old age.
Educated parents	In all countries (including Egypt) women who have completed primary school have fewer children than women with no education, and everywhere the number of children declines regularly (and usually substantially) as the education of mothers increases above the primary school level, with large differences between the highest and lowest educational groups.
Women's employment and status	Employment seems to have an independent effect on fertility for women in well-paid, modern jobs; more job opportunities should affect the fertility of all women indirectly by increasing the incentive to educate girls. Once women are able to earn an income, women may acquire higher status in the home, thus enabling them to talk more openly about birth control with their husbands, leading to longer and more effective contraceptive use.
Urban residence	Urban dwellers have better access to education and health services, a wider range of jobs, and more avenues for self-improvement and social mobility. They also face higher costs in raising children. In 10 of 14 developing countries studied, the urban woman marries on average at least one and a half years later than does the rural woman, and family planning information and services and their acceptability are more available. As a result, urban fertility is lower than rural fertility, on average by between one and two births per mother.
Efficient markets and security	Greater market efficiency makes clearer the logic of investing in children, especially in their education. Children also become less important as safeguards.
Increased age at marriage	Later marriage reduces population growth by lengthening the interval between generations; it also fosters a climate that encourages women to expand their horizons beyond the family (longer schooling and employment).
Breastfeeding	Breastfeeding reduces fertility by suppressing fecundity; it also reduces high infant mortality.
Supply-side:	
Access to quality family planning information and services	Good services reduce fertility significantly by closing the gap between actual and desired family size. By increasing the supply of services, family planning programs reduce the (financial and other) costs of using contraception to potential users. It has an immediate impact where there is underlying demand.

ANNEX D

Figure D 1: Subproject Design and Implementation Arrangements



Annex E. Program and Project Costs and Financing

Table E 1. Population Project - Planned vs. Actual Financing

(US$ million)

Financier	Planned	Actual	Actual/Planned
Government	1.6	1.9	119%
Beneficiaries	1.9	1.0	53%
IDA	17.2	14.8*	86%
Total	**20.7**	**17.7**	**86%**

Sources: World Bank, 1996 for "Planned," and World Bank 2007 and MoHP project data for "Actuals."
*: The US$ equivalent of the actual (10.36 million SDRs) contribution of IDA is reflected as US$15.8 million, according to the World Bank Loan Department's database.

Table E 2. Population Project - Planned versus Actual Use of IDA Financing by Disbursement Category

(millions of SDRs)

Disbursement Category	Initial Allocation	Revised Allocation (DCA Amendment of 2/98)	Revised Allocation by DCA Amendment of 11/03)	Actual Utilization	Actual as % of Initial Allocation
(1) Under Part A of the Project:					
(a) Goods	0.280	0.980	4.600	3.105	1110 (Eleven-fold increase)
(b) Consultants' services and training	0.900	0.200	0.200	0.214	24
(2) Sub-project Grants under Part B of the Project:	9.650	9.650	7.100	6.992	73
(3) Unallocated	1.070	1.070	0		-
Reconciliation of MoHP Special Account				0.004	-
Reconciliation of SFD Special Account				0.049	
Total	11.900		11.900	10.364	87
Amount cancelled: 1.54 million SDRs or 13 percent of the original credit amount					

Figure E 1: Total Expenditures on Family Planning by Type of Agency, 1988-2003

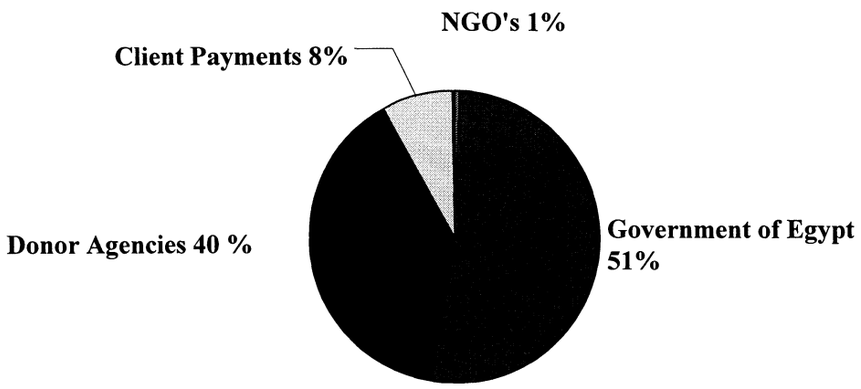


Table E 3. Donors' Financial Support to Population Reported in 1998

Donor	Financial Contribution	Timeframe	Geographic Area	Nature of Support
JICA	(not provided)	1989-1994	Upper Egypt	Family planning and maternal and child health project
		1994-1997	Not specified	Contraceptive provision program ("Neosampoon" Foaming Vaginal Tablets)
		1994	Not specified	Equipment to Egyptian Family Planning Association
EU	47.5 million LE	Reported as "current" assistance in 1998	Qena/Upper Egypt	20 new family planning clinics
			Upper Egypt	Support to population programme: education and productive opportunities for women, capacity building in FP training, FP service provision, community development)
Denmark	(not provided)	Reported as "current" assistance in 1998		One of main donors of UNFPA
		Not specified		Production of the "Islamic Manual of Family Planning" by support given to the Al-Azhar University
USAID	US$90 million	1998-2001		Population IV Programme, supporting: increases in FP/RH services, increases in demand for services, increases in financial self-sufficiency of FP systems, strengthening of institutional capacity, improvements to policy environment.
World Bank	US$20.7 million, of which US$17.2 million an IDA Credit	1998-2001	Rural Upper Egypt	Population Project: capacity building in the Population and FP sector of MoHP; and financing of Population Activities through grants to NGOs and communities
WHO	(not provided)	Reported as "current" assistance in 1998	Not specified	Several projects in RH, adolescent health, HIV/AIDS, environmental health.
Ford Foundation		Launched in 2001 (source: popcouncil.org)	El Minya/	Population Council and Caritas/Egypt: Intersectoral support to out-of-school adolescent girls
UNESCO		Reported as "current" assistance in 1998		"Environment and Population Education for Development"
UNFPA				Private Sector Initiative
				Market Segmentation Study Update of Contraceptive requirements and Logistics Management Needs in Egypt Coordination of donor efforts on demand creation for contraceptives and improvement in side effects knowledge and management

Source: Minutes of a December 1998 meeting of population donors, chaired by UNFPA.

Annex F. Planned vs. Actual Project Support

Table F 1. Population Project - Activities

Components/Activities	Planned inputs/activities *(Source: World Bank, 1996)*	Actual *(Source: MoHP Project Data, 2005 and World Bank Project Files)* ***Note: The Borrower's project files could not be located and made available to IEG, which is the reason for some gaps in the reporting of actuals.***	Comments
Part A: Capacity Building			
Project Management (MoHP)	Establish a PIU in the Undersecretary's Office • staffed by a Project Director, a Training Officer, an Administrative Officer, a Project Accountant, a Data Management Specialist and Support Staff • Supported under the project with: equipment, furniture, team-building training, local consultants, office supplies and operating costs.	Implemented. Capable project manager appointed in November 1998, who worked throughout project implementation. Contractual staff hired on a competitive basis.	
(for entire capacity building component)	Consultant services and training inputs envisaged in original project design amounted to an estimated IDA allocation of SDR 900,000 in support of capacity building	Only 24 percent (214,000 SDRs) of the original IDA allocation for consultant services and training was used. Project interventions supported: institutional development of central, regional and district levels (project management, service provision, partnerships, and M&E). Support for Communications for Behavior Change (CBC) was provided primarily with USAID financing, but coordinated with the Population Project.	
Business Planning	Build capacity in planning, management, advocacy, resource	Implemented in part.	No available itemization of actual project inputs/support to these activities.

Components/Activities	Planned inputs/activities *(Source: World Bank, 1996)*	Actual *(Source: MoHP Project Data, 2005 and World Bank Project Files)* ***Note: The Borrower's project files could not be located and made available to IEG, which is the reason for some gaps in the reporting of actuals.***	Comments
	mobilization, policy decisions and recommendations, and M&E.	Selected outputs: MoHP April 2005: "Facing Population Challenges in Partnership with NGOs" (a document that facilitates the planning of community-based population activities in collaboration with NGOs). Behavior Change monitoring tool Household survey tool for pre- and post-monitoring of subproject performance.	
	Provision of office equipment		
	Overseas Study Tour – Decision Support: Population Sector Staff, PIU Director, NPC (Year 2)		
	In-country training - staff upgrading: managers and decision support staff (Yrs 1, 2, 4)		
	In-country training in monitoring & evaluation:		
	International consultants		
	Local consultants		
	Studies: Policy Development (Central Administration – CA – for Training, Research and Population Statistics):		
	• Annual Report on Egyptian Population and Family Planning Achievements)		
Promotion & Communication	Overseas training for religious and community leaders	Implemented.	Training, consulting and research in advocacy and outreach were provided to a range of actors on a range of activities, but there is no itemized data on training, consulting and research delivered against original plans.
	In-country training for NGO leaders, community leaders, population sector staff:		
	Studies	CBC strategy adopted at the MTR to deliver key health and family planning messages in deprived areas, including the provision of mobile media vans and media equipment. Evaluation of CBC quality and effectiveness has been raised as needing more attention.	
	• Evaluation of Mass Communications (Year 2)		
	• Evaluation of Interpersonal Communications (Year 4)		
M&E and PAP Support	Vehicles for supervision and outreach	Implemented as envisaged with ongoing learning and refinement.	In line with agreements reached at the MTR, capacity building efforts during the second half of project implementation were much more focused on regional and district capacity building than the original project design, which was considerably more focused on central level capacity building.
	Equipment In-country training	The NGO Support Department was created and integrated within the organizational structure of the MoHP/PS.	
	• Monitoring & evaluation for		

Components/Activities	Planned inputs/activities *(Source: World Bank, 1996)*	Actual *(Source: MoHP Project Data, 2005 and World Bank Project Files)* ***Note: The Borrower's project files could not be located and made available to IEG, which is the reason for some gaps in the reporting of actuals.***	Comments
	Population Sector Staff (Years 3, 5) Furniture Studies: Mid-term evaluation (Unit for Administration and Decision Support) • Preparation (Year 2) • Follow-up Workshops (Year 3)	• Developed and uses a database of NGOs/CBOs working in the HP sector • Collaborates with MoHP FP services unit and SFD in the preparation of strategic plans. NGO department not considered to be fully functional in 2002. PIU played an important role in implementing subprojects, finalizing contractual procedures for upgrading of clinics, managing the contracting with training consultants and research/M&E contracts. MTR took place in June 2002.	
General Administration & Management	Office equipment and furniture	Implemented in part.	No itemization of project support available against original plan.
	In-country training • Management training for Population Sector Management (Years 2, 3, 4, 5) • Finance training workshop for Pop Sector Finance staff (Years 1, 4) Local consultants Studies Quality Improvement Research (CA for Training, Research and Population Studies): • Study on client satisfaction (Year 2) • Study of Provider KAP (Year 3)		
	• QOC Research (Year 4)		
		Improving the Quality of Family Planning Clinics in the Subproject Locations	Not included in the original project design. Equipment/upgrading were added to the project design by DCA amendment of 1998; and purchase of contraceptives was added

Components/Activities	Planned inputs/activities *(Source: World Bank, 1996)*	Actual ***(Source: MoHP Project Data, 2005 and World Bank Project Files)*** ***Note: The Borrower's project files could not be located and made available to IEG, which is the reason for some gaps in the reporting of actuals.***	Comments
		In subproject locations: • 105 family planning clinics were refurbished and equipped (vs. 100 planned when idea was introduced). An additional 195 clinics were equipped only. o 347 ultrasound scanners o 112 autoclave machines	by DCA amendment of 2003.
		In subproject locations: A pool of 63 family planning team supervisory teams was created and trained, which, in turn, supervised and trained health workers (physicians and nurses) on service provision and on client/provider interaction. A total of 653 doctors and nurses received training in family planning and reproductive health service delivery.	
		Provision of contraceptives to meet national needs: • 4.25 million IUDs • 12,812 IUD insertion kits	
		Capacity Building of regions and districts in population management, partnerships and institution building	Not emphasized in the original project design. By 2002, NGO Support Department of MoHP considered not to be fully functional, but further strengthening would need a long-term vision, especially in light of 2002 changes to population structures (creation of a High Population Committee in the Cabinet and modification of Population Council, headed by MoHP). Agreement was reached at the MTR to focus on regional and district capacity building.
		Training and consulting to support the development and utilization of tools and models for: partnerships between NGOs, health teams and service delivery, social change agents in: needs assessment, planning, implementation, M&E.	
		Governorate inter-sectoral population committees reactivated and functional.	

Components/Activities	Planned inputs/activities *(Source: World Bank, 1996)*	Actual *(Source: MoHP Project Data, 2005 and World Bank Project Files)* ***Note: The Borrower's project files could not be located and made available to IEG, which is the reason for some gaps in the reporting of actuals.***	Comments
		See also: investments in social change agents and training itemized under PAP component (below).	
Part B: Population Activities Program (PAP)			
Grants for small, decentralized projects	100 projects to be implemented over 5 years starting in 1996	55 projects implemented: • 3 in Phase 1 (00-03) • 11 in Phase 2 (01-04) • 23 in Phase 3 (02-04) • 18 in Phase 4 (2004-05)	
Implementing agencies:	NGOs	**Model 1** (Phase 1): All (3) projects managed at the district level by the Egypt Family Planning Association. Community level not effectively reached. **Model 2** (Phases 2 and 3): All projects managed by decentralized NGOs. **Model 3** (Phase 4): Cluster system, with an NGO managing and supporting a small network of CBOs. Subprojects were implemented by 105 NGOs.	
	Local community organizations		
	Relevant public sector agencies		
Technical/strategic areas of intervention:	Menu of possible projects: • Awareness creation • Development of a network of change agents • Development of capacity to produce IEC materials • Training for community leaders • Population education for religions leaders • Rural internships for urban youth and professionals • Other (experimental, innovative activities)	Four components of PAP subprojects implemented involved different types of activities to achieve developmental improvement in the economic, social, and cultural status of families: • Micro-credit: for women and their families, enhancing women's responsibilities and upgrading their status in their families • Women's clubs and illiteracy eradication: to eradicate illiteracy and enhance capacities through training on some small crafts • Home visits: to enhance awareness and knowledge of population issues in communities and address social and	During the MTR the GoE and the Bank agreed on a strategy to move from IEC to CBC for more effective and tailor-made messages for communities, with a more-results (behavior change)-based focus. Further analysis is recommended to determine the strengths and weaknesses in CBC activities for their further refinement.

Components/Activities	Planned inputs/activities *(Source: World Bank, 1996)*	Actual *(Source: MoHP Project Data, 2005 and World Bank Project Files)* ***Note: The Borrower's project files could not be located and made available to IEG, which is the reason for some gaps in the reporting of actuals.***	Comments
		cultural issues undermining reproductive health goals. • Training: targeting the supervisory teams, social change teams, district health staff and service providers at the subproject level to improve their skills and the delivery of better family planning and reproductive health services. ***Note:*** CBC activities were financed largely by USAID.	
Geographic areas of intervention	All 8 governorates of the Region of Upper Egypt: Giza, Beni Suez, Fayoum, Menya, Assuit, Souhag, Qena, Aswan	148 villages in the 8 governorates of Upper Egypt	USAID through the Tahseen project provided similar (supply- and demand-side) support using similar approaches in Upper Egypt (68 communities in five of eight governorates: Minia, Beni Suef, Fayoum, Giza and Cairo) during a period (2003-2005) overlapping with the PAP.
Coverage	No coverage targets quantified. Targeting of rural communities with high birth rates and low CPR ("hot spots") was encouraged.	22,400 families	
Key inputs and outputs		Aggregates for all subproject interventions (breakdown not available) • 3.5 million home visits • 1,734 health education seminars at village level • 9,320 microcredits to women (average of LE 500 per family) (US$2 million in seed monies – or revolving funds – to finance microcredit schemes within NGOs) • 300 literacy classes training about 5,640 (enrolled) women • Establishment of a cadre and training of 3,085 social change agents (SCAs) in reproductive health (six-day initial course, and three-day refresher training	Training of SCAs covered: dimensions of population problem, RH, FP, advocacy home visits, female circumcision, gender issues, reporting and record keeping, social marketing, community mobilization, communication and counseling. Additional training needs of SCAs identified by SCAs and community leaders: local communities needs assessment, monitoring behavior change, first aid, communicable disease, FGM, gender, reproductive rights, early marriage and pre-marriage examination. Moshrefat need more training on how to M&E morshedat performance and to train morshedat.

Components/Activities	Planned inputs/activities *(Source: World Bank, 1996)*	Actual *(Source: MoHP Project Data, 2005 and World Bank Project Files)* ***Note: The Borrower's project files could not be located and made available to IEG, which is the reason for some gaps in the reporting of actuals.***	Comments
		one year later)	
Implementation plan	Subproject appraisal and approval to start in Q1 of 1997 and finish in Q3 of 2000	Subproject approval and launch (Phase 1) in April 2000 and completion (Phase 4) in March 2005.	
	Subproject supervision to start in Q2 of 1997 and finish in Q4 of 2001		
Project management		New Population Unit created within the SFD with the mandate to improve health and population outcomes of the poor.	
		Population officer assigned to SFD office in each governorate.	
		Counterpart contributions to SFD administrative costs were delayed, but ultimately paid.	
		New Managing Director SFD appointed June 2002 and Population United upgraded to a Population Department, with positive effects on leadership and capacity for PAP implementation.	
		MoU and updated operational manual helped clarify roles and responsibilities and smooth/accelerate implementation.	

Annex G. Projects Outcomes

Table G 1. Population Project: Outcomes for Objective #1

To strengthen the organization and functions of MoHP that relate to its population and family planning operations *Note: No specific indicators for Objective #1 were identified during design. These were supposed to have been identified through the preparation in Year 1 of a three-year business plan for institutional strengthening of central-level MoHP. IEG was unable to obtain a copy of this document. IEG's review of project documentation provides no evidence that it was ever produced.*		
Project Objective/*Subobjectives*	**Outcome**	**Comments/Proxy Indicators**
Enable MoHP to play the lead role in the population sector	Modestly achieved.	Institutional/organizational context: In 1996 the Ministry of Population and Family Planning was merged into the MoH to create a new MoHP to facilitate the integration of FP/MCH services into a broad-based women's health program. In 2002 the President issued a decree creating a High Population Committee (HPC) in the Cabinet responsible for oversight of population policy, under the leadership of the Ministry of Information. The National Population Council (created in 1985) is under the leadership of the MoHP. Under the project the Social Fund for Development was contracted to manage the financing of community-based subprojects focused on demand-side stimulation in Upper Egypt. A Population Unit was established within SFD with the mandate to improve health and population outcomes of the poor; and population officers were assigned to the SFD office in each of Upper Egypt's eight governorates. Collaboration between MoHP and SFD was initially difficult, but has improved during the course of project implementation. However, the institutional/organizational framework for the management and oversight of population and family planning does not appear to be fully defined. It is not clear how the leadership of the Ministry of Information in the HPC is reconciled with MoHP leadership for population and family planning. The institutional home and accountabilities for demand-side interventions are not specified. Now that the project has been completed it is not clear to what extent the SFD's role in supporting/facilitating community-level population and family planning activities will be institutionalized, in the absence of major follow-up funding.
MoHP capacity developed to:		
• ***conduct high-level advocacy and research***	Modestly achieved, but low project attribution.	The National Population Council undertakes population and family planning research, under the overall leadership of the MoHP. Population research is also conducted by other research organizations, such as the Social Research Center of the American University of Cairo. Advocacy has been conducted at the highest levels of Government, by the Head of State, himself, who places population as an important development priority.
• ***undertake strategic leadership of planning, management and interdepartmental coordination for population growth***	Modestly achieved at the national level.	As of the end of the project, the official population policy document (the third ever) dated back to the year 1986. (A modified strategy was prepared in 1995 to reflect aspects of the ICPD conference, emphasizing a comprehensive approach, and identifying a range of demographic goals. But this revised strategy was not officially promulgated.) Egypt is in the process of updating its national strategy in preparation for a national population conference scheduled for some time in 2008. During the project life and up to the present, no multi-year national program of action has been prepared or costed to transform population strategy into a prioritized, actionable program or plan of action.
	Substantially achieved at the governorate, district and local levels.	Annual joint population plans are routinely prepared at the governorate and district levels (in more than 50 districts in Upper Egypt), by a number of local level partners: governorate and district authorities, MoHP managers and staff, SFD, and NGOs and civil society.
• ***monitor and evaluate the overall progress of population programs***	Modestly achieved.	***At the project level:*** M&E attempted to generate and use data for assessing the performance of the PAP component (subproject interventions in Upper Egypt). Implementation of the M&E design fell somewhat short of plans and efforts were not fully successful in documenting the results chain and component outcome. The lessons learned over

		the various subproject phases were documented and incorporated into subsequent phases. However, the capacity building component did not identify an M&E plan or performance indicators and it was never rigorously assessed. ***At the program level:*** IEG could find no evidence of an M&E system or capacity for monitoring and evaluating the progress of population and family planning program as a whole. DHS data are used for tracking progress and outcomes, and MoHP data track a number of service provision indicators, but the components of a program results chain appear to have been neither defined nor tracked. Monitoring and evaluation of interventions appear only to be undertaken at the level of externally-financed projects.
• ***mobilize and allocate resources for population programs in an efficient way***	Negligibly achieved.	The absence of a multi-year program of action (or prioritized action plan) for population and family planning, including the costs of its management and implementation, combined with the absence of systematic program M&E, has undermined Government efforts to mobilize and allocate resources efficiently.
• ***support NGO and local community initiatives***	Modestly achieved at the central level of MoHP.	An NGO support department was created to strengthen public-private partnerships for population, but never became fully functional. It is not clear to what extent this department has enhanced the involvement of NGOs and civil society in national debate and policy planning for population or provided an overall framework for the coordination of scattered population activities undertaken by NGOs and other civil society organizations in pursuit of the common goal of accelerating Egypt's demographic transition. MoHP's current organigramme (source: WHO, 2006) does not show an NGO support department, but does include a "General Department for Family Planning Services in the Private and NGOs Sector," whose title indicates a possible neglect of the role of NGOs in (a) planning and policy formulation; and (b) demand-side stimulation. There is no other provision in MoHP/PS organigramme for demand-side interventions. While it is not prominent in the organigramme, partnerships with NGOs have been articulated in MoPH's April 2005 document, "Facing Population Challenges in Partnership with NGOs," which draws on project experience. It out lines key objectives of this partnership: to enhance community participation in health services decision-making, to enhance community capacity to address impediments to health services; to make services more responsible to families; and to ensure sustainability of positive behavior trends. The extent to which this vision has been implemented is not documented.
	Substantially achieved in some districts/governorates in Rural Upper Egypt.	This was the essence of the PAP and it was successfully implemented. This approach recognized and demonstrated the value of collaborating with NGOs and designing and implementing community initiatives; and it has culminated in the establishment of partnerships between MoHP, SFD, NGOs and other civil society organizations in the design and implementation of population and family planning activities, addressing both supply and demand issues. Partnership and collaboration between MoHP and NGOs has improved over time. The PAP also established an outreach capacity to the communities in project areas through the mobilization and training of social change agents that provided an effective link between women and services.
Outcomes not anticipated at project design		
• *Improved supply and quality of clinical family planning services offered through the public health system*		USAID and other bilateral donors were assumed to be assisting MoHP and private sector providers to upgrade facilities and equipment and to introduce long-acting contraceptives new to the program (e.g., injectables and implants). The project enhanced the quality of service delivery in selected areas of demand-side intervention, where delivery was found not to be effectively responding to demand. Upgrading of staff skills and facilities culminated in improved service availability and quality and incited an increase in the number of clients (MoHP end-of-project interviews with beneficiaries and service providers). Establishment of RH/FP trainers at the district level left a permanent and efficient capacity for monitoring and upgrading service delivery skills.
• *Strengthened capacity for improved communications approach to enhance the effectiveness of demand-side interventions*		Capacity for information, education and communication (IEC) approaches was upgraded and transformed into a communication for behavior change (CBC) approach, which is more tailored to the interests and motivations of different target groups (based on operational research) and more focused on results. The technical work underlying this transformation was largely financed by USAID, but CBC was applied in subproject areas.
• *Improved contraceptive security and strengthened capacity for procurement of contraceptives*		With the gradual pulling out of USAID from the population and family sector, the project purchased several years worth of contraceptives. The intensive training and support to MoHP, which procured contraceptives for the first time under this operation, helped build their capacity to assume this responsibility on their own. Previously, UNFPA undertook procurement of contraceptives on their behalf and USAID supplied contraceptives in kind.

Table G 2. Achievement of Objective #2: Stimulate desire for smaller family size, greater contraceptive use and reduced fertility in Rural Upper Egypt

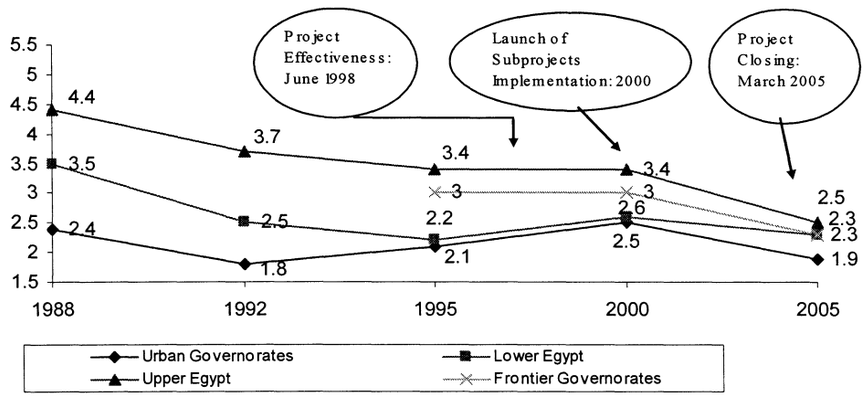
Indicator[1]	Baseline 2000 (year of subprojects launch)	Outcome 2005 (year of project closing)	Comments
Total wanted fertility (number of children)	3.7	2.6	Reduction of desired fertility by 1.1 children in rural Upper Egypt was greater than average reductions for all of Egypt or for any of the regions. While inequities still exist (urban/rural, region of residence, and level of education) they are not as acute as in 2000. Trends between 2000 and 2005 show more rapid decline than pre-project trends. Project attribution is tempered by the facts that the project (a) covered 9 percent of villages in rural Upper Egypt (148/1700 villages) and (b) did not measure this outcome in the villages of intervention.
Contraceptive prevalence rate (all methods)	40.2%	45.2%	Overall increase of 5 percentage points. CPR in rural Upper Egypt still lower than the national level (59.2%) and levels in other regions, but inequities have been reduced. Increases have been achieved in all 8 governorates in the Upper Egypt Region. Pre-project trends indicate more rapid growth in the 5 years preceding subproject intervention. CPR in districts which had villages targeted by subprojects increased as follows: Phase 1 districts from 18% in 1998 to 37% in 2002; phase 2 districts from 17% in 2000 to 29% in 2003; and phase 3 districts from 39% in 2001 to 41 percent in 2003. (A 2000 baseline for Phase 1 is not available.) Rates for Phase 2 and phase 3 villages increased from 45 to 55 % and from 44 to 55% respectively between 2000 and 2005. District-specific and village specific data do indicate a link between subproject interventions and CPR, since they show increases greater than the average for rural Upper Egypt.
Birth intervals (median # months since preceding birth)	31.5	31.4	No change in birth spacing, even though it went up by one month for all of Egypt (34.3 to 35.4) and for all other regions. An increase of 2.2 months is documented for Rural Upper Egypt in the 5 years preceding project intervention (1995-2000).
Total fertility rate	4.7	3.9	Reduction of 0.8 children greater than 0.4 reduction for all of Egypt (3.5 to 3.1). Level still higher than national level and other regions, but inequities have been reduced. The project intervened in 9 percent (or 148/1700) villages in rural Upper Egypt and thus is likely to represent a relatively small contribution to overall outcomes. For the region as a whole and for the targeted villages, there is incomplete information on the total number of interventions undertaken and supported by others during the project period, the level of coverage of the project and the plausible links between inputs, outputs, outcomes and impact.

[1] The project design did not specify quantitative targets for any of these indicators.

Annex H. Projects Statistics

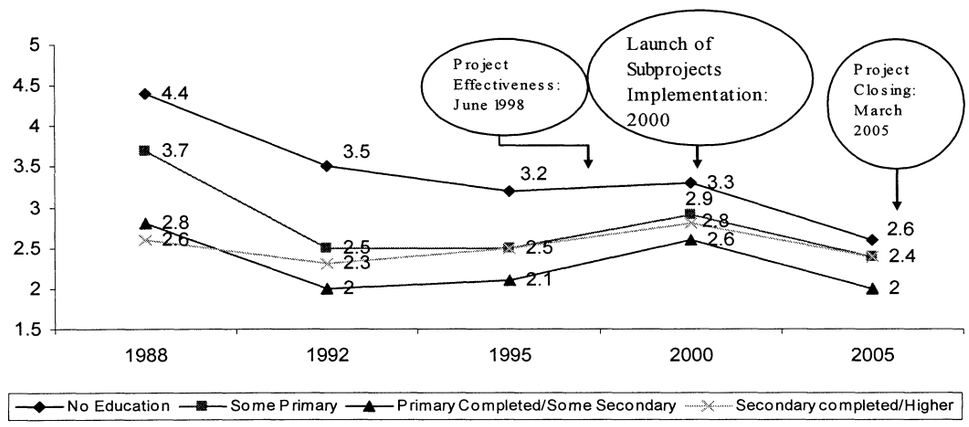
1. Population Project – Total Wanted Fertility

Figure H 1. By Region, 1988-2005



Source: DHS 1988-2005

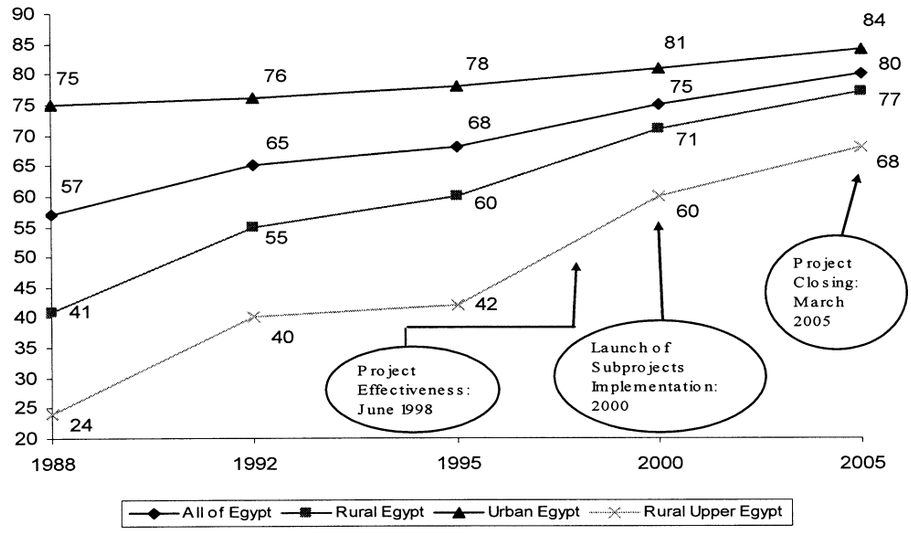
Figure H 2. By Level of Education, 1988-2005



Source: DHS 1998-2005

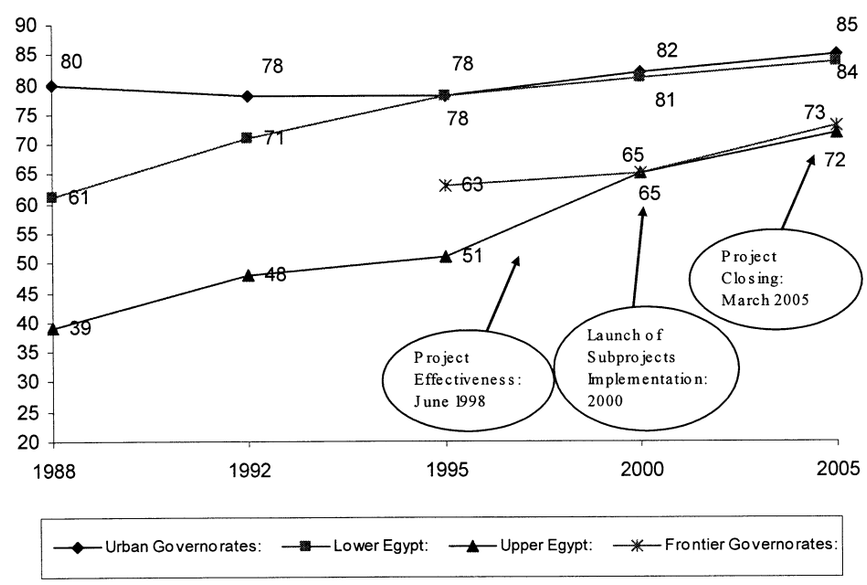
2. Population Project - Percent of Ever-Married Women who Consider it Appropriate to Use Family Planning after First Birth

Figure H 3. National Trends and Trends in Rural Upper Egypt, 1988-2005



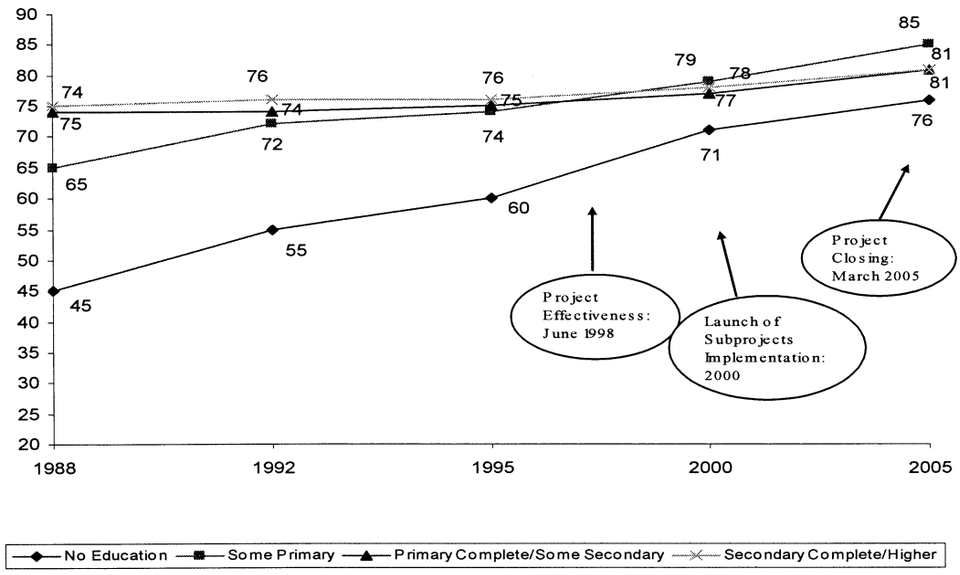
Source: DHS 1988-2005

Figure H 4. By Region, 1988-2005



Source: DHS 1988-2005

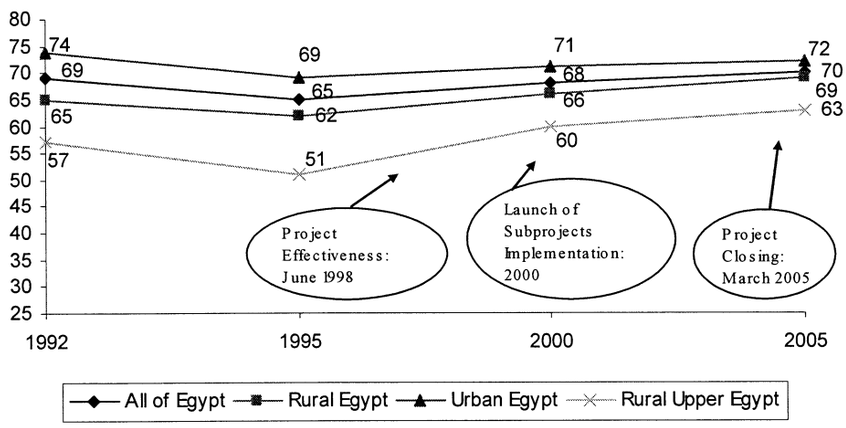
Figure H 5. By Level of Education, 1998-2005



Source: DHS 1998-2005

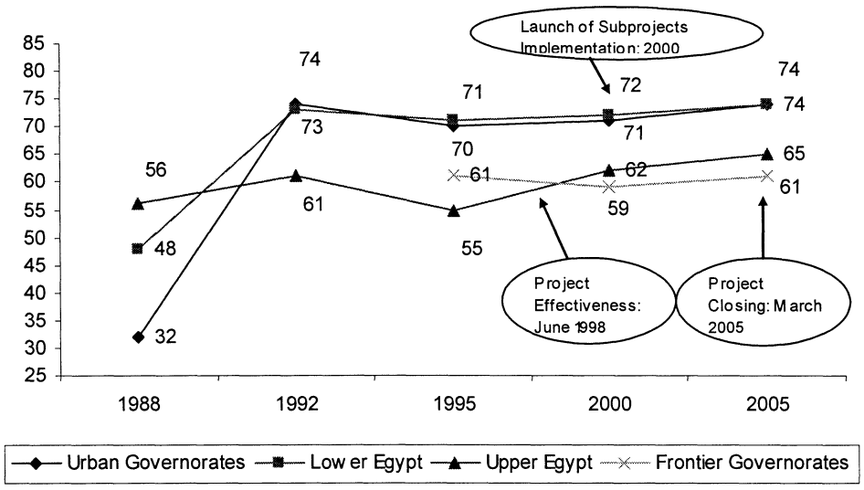
3. Population Project - Total Demand (met and unmet) for Family Planning

Figure H 6. National Trends and Trends in Rural Upper Egypt, 1992-2005



Source: DHS 1992-2005

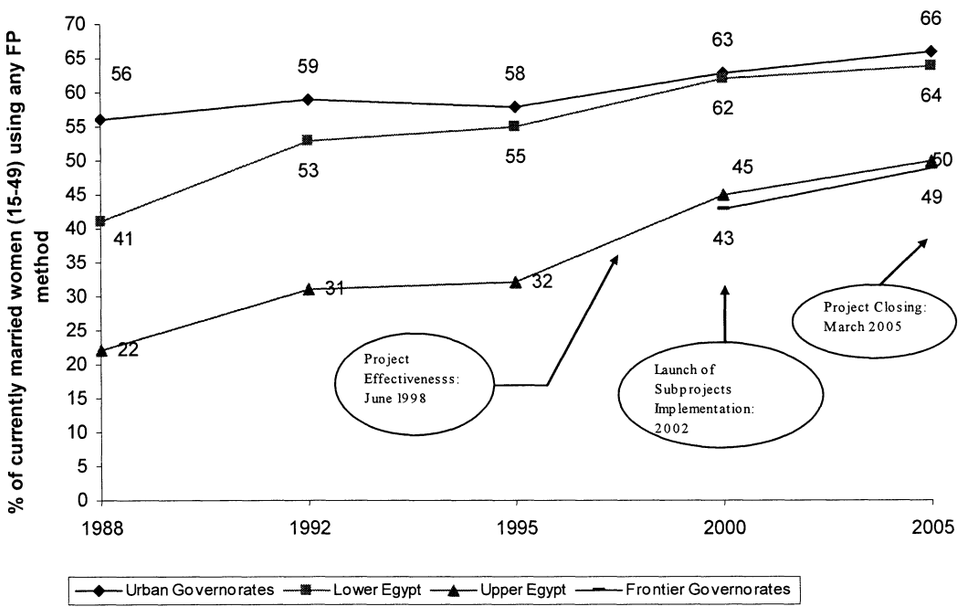
Figure H 7. By Region, 1992-2005



Source: DHS 1988-2005

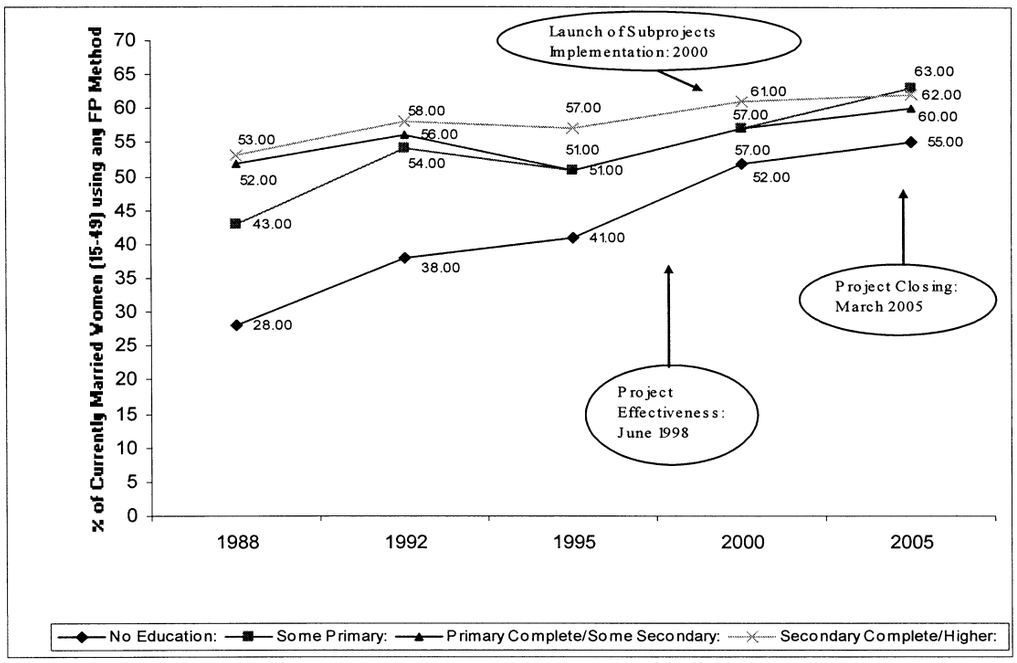
4. **Population Project - Contraceptive Prevalence Rate**

Figure H 8. By Region (Any Method), 1988-2005



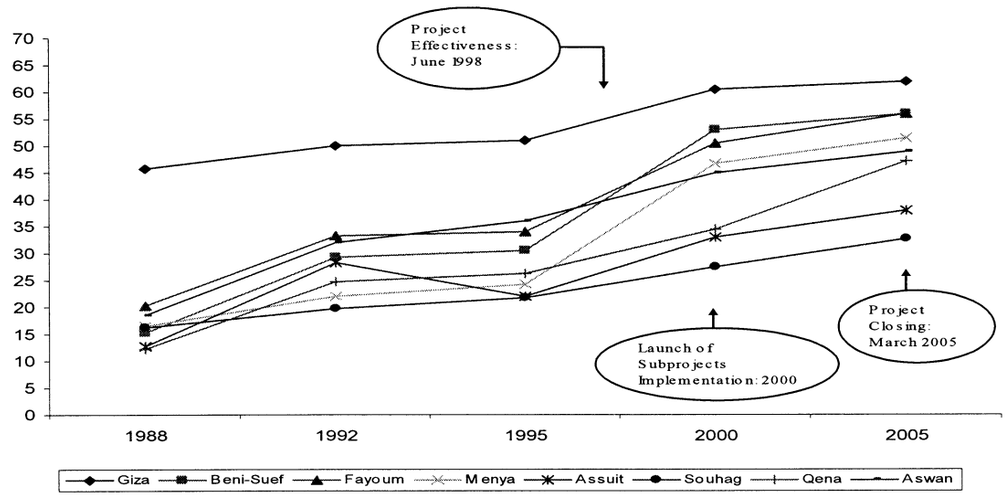
Source: DHS 1988-2005

Figure H 9. By Level of Education (Any Method), 1988-2005



Source: DHS 1988-2005

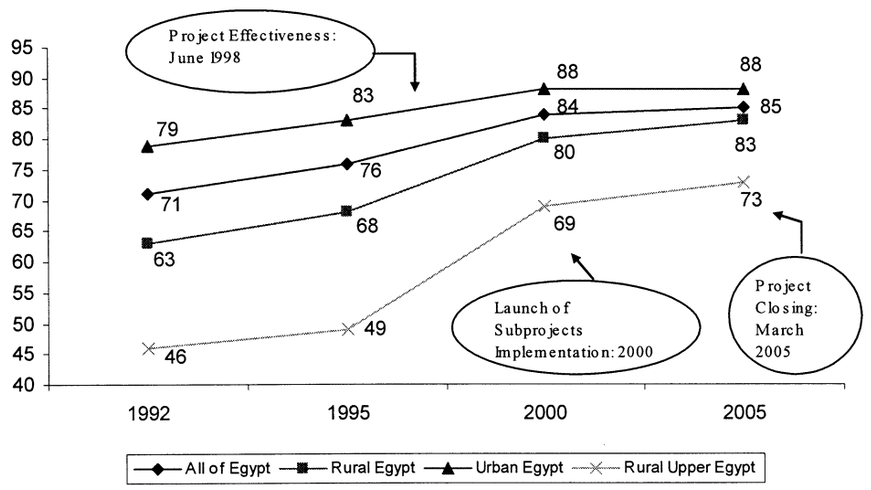
Figure H 10. In Upper Egypt by Governorate, 1988-2005



Source: DHS 1988-2005

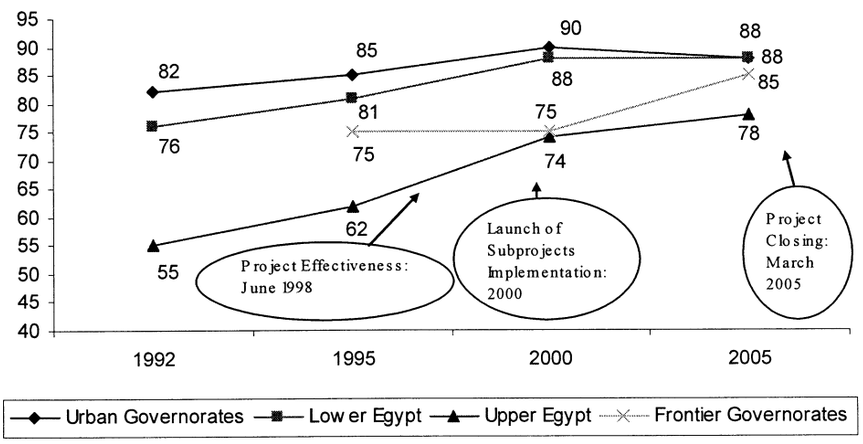
5. Population Project – Share of Total Demand for Family Planning which is Satisfied

Figure H 11. Share of Total Demand for Family Planning which is satisfied – National Trends and Trends in Rural Upper Egypt, 1992-2005



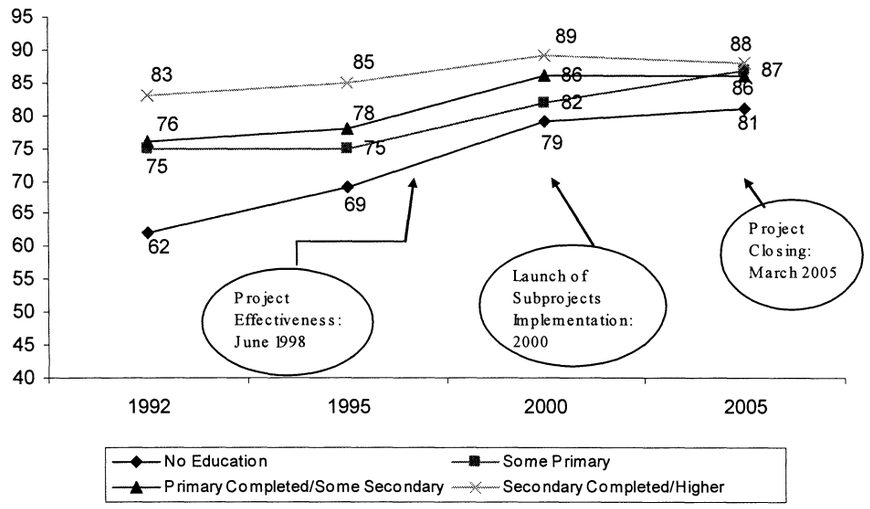
Source: DHS 1992-2005

Figure H 12. Share of Total Demand for Family Planning which is satisfied by Region, 1992-2005



Source: DHS 1992-2005

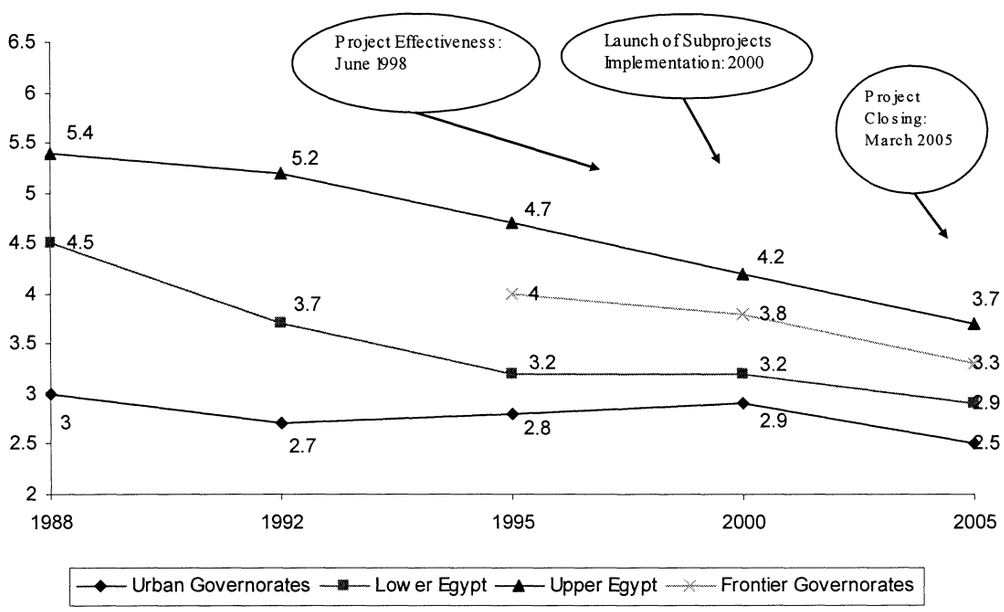
Figure H 13. Share of Total Demand for Family Planning which is satisfied by Level of Education, 1992-2005



Source: DHS 1992-2005

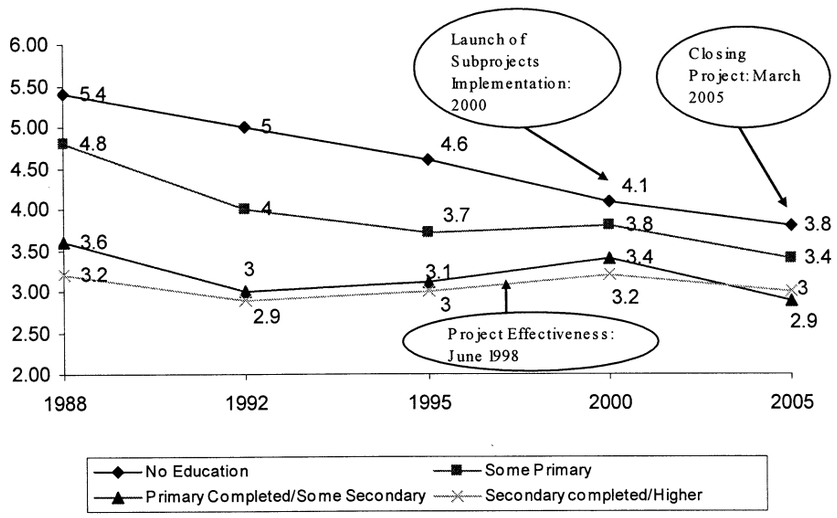
6. Total Fertility Rate

Figure H 14. Total Fertility Rate by Region, 1988-2005



Source: DHS 1988-2005

Figure H 15. Total Fertility Rate by Level of Education, 1988-2005



Source: 1988-2005

7. Gap between Desired and Actual Fertility

Figure H 16. Gap between Desired and Actual Fertility - National Trends and Trends in Rural Upper Egypt (Number of Children), 1988-2005

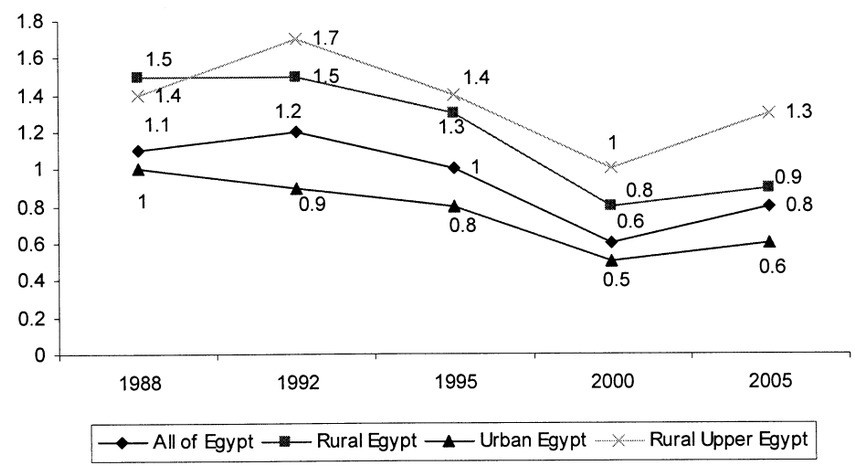


Figure H 17. Gap between Desired and Actual Fertility - by Region (Number of Children), 1988-2005

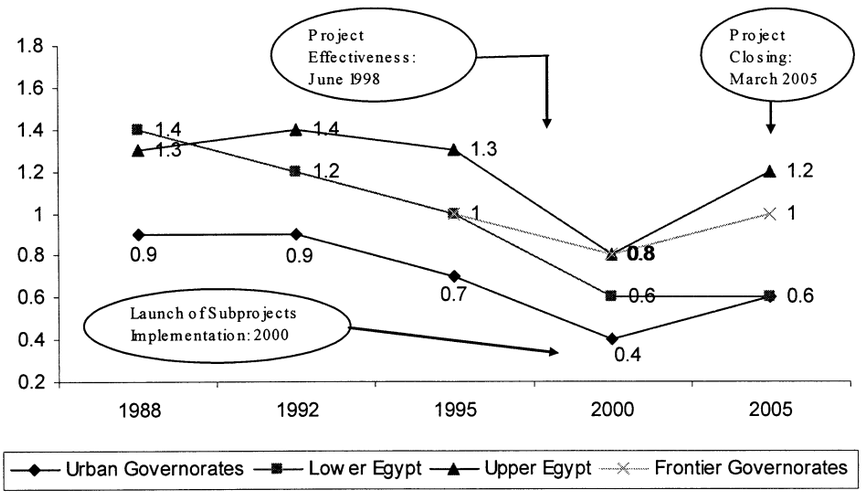
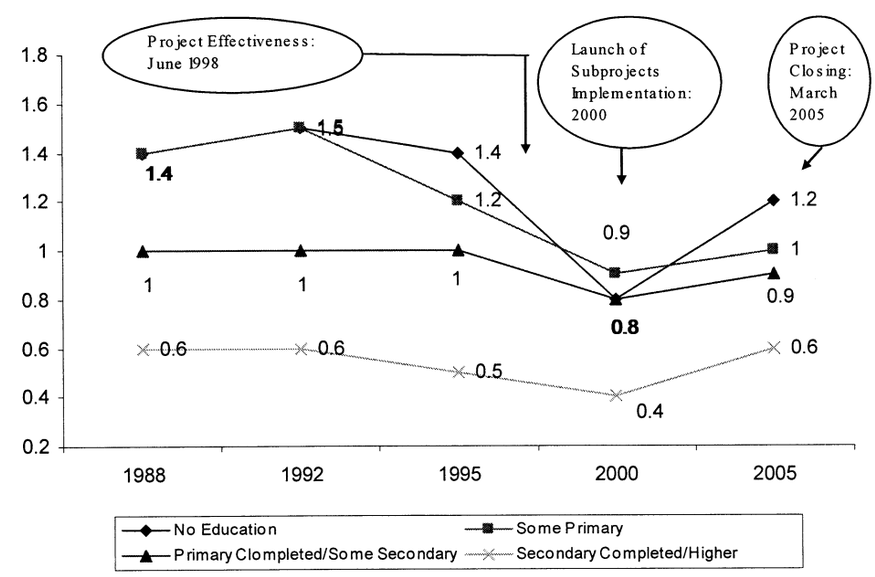


Figure H 18. Gap between Desired and Actual Fertility – by Level of Education (Number of Children) 1988-2005



Source: DHS 1988-2005

8. Current Use of Family Planning in Phase I Districts and Villages of Intervention: A comparison of MoHP district-level data and household survey village-level data (Household *survey data shown in bold italics.)*

Table H-1: Current Use of Family Planning in Phase I (2000 – 2003) Districts (percent)

District	Baseline 1998	1999	2000	2001	2002	2003	2004
Komombo	25	29	45	35	40	33	31
Sakulta	10	29	30	38	33	29	30
Arman	19	31	38	46	35	29	27
Average	**18**	**30**	**38**	**38**	**37**	**30**	**29**
No household survey data collected for Phase I villages							

Source: MoHP district data
Notes:
(1) MoHP district data shaded in gray.
(2) 1998 is specified by MoHP as the baseline year, but it is more appropriate to use 1999 as the baseline year, since Phase I subprojects were only launched in 2000. Increases between 1998 and 1999 should not thus be attributed to the Phase I subprojects.

Table H-2. Current Use of Family Planning in Phase II (2001 – 2004) Districts and Villages

District	Baseline 2000	2001	2002	2003	2004
Tahta district	9	24	21	24	23
Banga village				***39***	***62***
Gehena	26	27	25	23	23
Enebes village				***51***	***57***
Sohag	17	20	20	23	22
Balasfora village				***23***	***45***
Shandweel village				***51***	***51***
Keft	9	29	24	33	34
El-Zafria village				***54***	***61***
Naga-Hammady	14	28	25	24	29
Hew village				***44***	***54***
Khouzam village				***42***	***47***
Kous	4	20	21	21	19
Minia	29	49	48	45	55
El-Sawi village				***44***	***48***
Beni-Suef	20	40	42	45	47
Bani-Soliman				***58***	***63***
Assuit	23	25	26	25	25
El-Boura village				***52***	***64***
Unweighted average of district-level data	**17**	**29**	**28**	**29**	**33**

Sources: MoHP district data; and project-sponsored household survey in villages of intervention
Notes:
(1) Phase II subprojects were implemented over the period 2001-2004, so trends are measured against levels in 2000 as the baseline year.
(2) MoHP district data are shaded in grey and data on villages directly benefiting from subproject interventions are shown in bold italics.

Table H-3. Current Use of Family Planning in Phase III (2002 – 2004) Districts and Villages

District	2001	2002	2003	2004
Kous	18	21	21	19
Garagous village			***31***	***35***
Akhmeem	25	26	23	23
Akhmeem village			***39***	***48***
Abu Teeg	33	23	24	23
Nazlet Baqour			***37***	***41***
Badari	24	26	21	26
El-Eqal Bahary			***41***	***50***
El-Eqal Qebly			***24***	***29***
Ghanayem	32	30	45	32
El-Mashaia'a			***44***	***49***
Sahel Selim	34	37	45	31
El-Rowaigat			***37***	***48***
El-Shamia			***41***	***47***
Fath	36	37	32	32
El-Assara			***41***	***50***
Edwa	49	69	78	77
Malatia			***34***	***62***
Menya	50	48	50	55
Koum El-Loufy			***48***	***52***
Samalot	36	35	37	37
Koum El-Raheb			***41***	***47***
Malawi	40	35	35	42
Mallawy			***41***	***54***
Nazlet El-Fallaheen			***12***	***55***
Maghagha	39	36	34	38
Safania			***52***	***71***
Ashneen			***59***	***68***
Abu-Kurkas	42	39	39	40
Beni-Suef	40	42	45	47
Al-Daweya Wa Zaraby			***58***	***73***
Tameya	47	54	61	58
Tamia			***56***	***59***
Wahat	52	55	70	83
El-Wahat El-Baharia			***66***	***69***
Atfeeh	47	43	39	44
Atfeeh			***51***	***62***
Matai district	n.a.	n.a.	n.a.	n.a.
Koom Waly			***51***	***75***
Ahnasia	n.a.	n.a.	n.a.	n.a.
Nana			***59***	***62***
Unweighted Average of district-level data	**39**	**39**	**41**	**42**

Sources: MoHP district data; and project-sponsored household survey in villages of intervention

Notes:

(3) Phase III subprojects were implemented over the period 2002-2004, so trends are measured against levels in 2001 as the baseline year.

(4) MoHP district data are shaded in grey and data on villages directly benefiting from subproject interventions are shown in bold italics.

Table H-4. Service Utilization in Public Family Planning Clinics in Phase I (2000 – 2003) Districts

District	Baseline 1998	1999	2000	2001	2002	2003	2004
Komombo	29	n.a.	52	51	53	69	31
Sakulta	22	n.a.	51	50	47	48	35
Arman	26	n.a.	58	43	38	51	17
Average	**26**	**n.a.**	**54**	**48**	**46**	**56**	**28**
No household survey data collected for Phase I villages							

Source: MoHP district data

Notes:

(1) MoHP district data shaded in gray.

(2) 1998 is specified by MoHP as the baseline year, but it is more appropriate to use 1999 as the baseline year, since Phase I subprojects were only launched in 2000. Increases between 1998 and 1999 should not thus be attributed to the Phase I subprojects

Table H-5. Service Utilization in Public Family Planning Clinics in Phase II (2001 – 2004) Districts and Villages of Intervention

District	Baseline 2000	2001	2002	2003	2004
Tahta district	29	51	38	43	18
Banga village				***61***	***63***
Gehena	24	49	37	34	24
Enebes village				***67***	***70***
Sohag	20	55	60	48	32
Balasfora village				***56***	***60***
Shandweel village				***38***	***40***
Keft	39	38	40	47	21
El-Zafria village				***43***	***48***
Naga-Hammady	28	35	33	45	29
Hew village in				***52***	***55***
Khouzam village				***46***	***50***
Kous					
Minia	39	47	76	83	19
El-Sawi village				***72***	***86***
Beni-Suef	40	82	87	85	79
Bani-Soliman village				***66***	***67***
Assuit	34	34	34	39	22
El-Boura village				***62***	***7%***
Unweighted average of district-level data	**32**	**49**	**51**	**53**	**31**
Unweighted average of village-level data				***55***	***61***

Sources: MoHP district data; and project-sponsored household survey in villages of intervention

Notes:

(1) Phase II subprojects were implemented over the period 2001-2004, so trends are measured against levels in 2000 as the baseline year.

(2) MoHP district data are shaded in grey and data on villages directly benefiting from subproject interventions are shown in bold italics

Table H-6. Service Utilization in Public Family Planning Clinics in Phase III (2002 – 2004) Districts and Villages of Intervention

District	2001	2002	2003	2004
Kous	35	43	44	38
Garagous village			***66***	***69***
Akhmeem	36	49	46	45
Akhmeem village			***63***	***65***
Abu Teeg	46	46	42	40
Nazlet Baqour			***57***	***68***
Badari	29	27	42	23
El-Eqal Bahary			***74***	***75***
El-Eqal Qebly			***70***	***76***
Ghanayem	55	44	49	50
El-Mashaia'a			***48***	***62***
Sahel Selim	36	38	37	38
El-Rowaigat			***84***	***85***
El-Shamia			***69***	***75***
Fath	34	35	33	28
El-Assara			***77***	***79***
Edwa	47	76	83	53
Malatia			***45***	***57***
Menya	30	23	20	19
Koum El-Loufy			***65***	***70***
Samalot	35	33	45	32
Koum El-Raheb			***65***	***69***
Malawi	48	36	33	32
Mallawy			***56***	***64***
Nazlet El-Fallaheen			***69***	***75***
Maghagha	39	35	34	29
Safania			***83***	***83***
Ashneen			***70***	***79***
Abu-Kurkas	41	38	37	39
Mansafees villabe			***54***	***61***
Beni-Suef	82	87	85	79
Al-Daweya Wa Zaraby			***52***	***55***
Tameya	30	44	43	41
Tamia			***75***	***75***
Wahat	39	36	45	38
El-Wahat El-Baharia			***31***	***46***
Atfeeh	39	35	33	27
Atfeeh			***60***	***63***
Matai district				
Koom Waly			***59***	***63***
Ahnasia				
Nana			***62***	***67***
Unweighted Average of district-level data	**41**	**43**	**44**	**38**
Unweighted average of village-level data			***63***	***69***

Sources: MoHP district data; and project-sponsored household survey in villages of intervention

Notes:

(1) Phase III subprojects were implemented over the period 2002-2004, so trends are measured against levels in 2001 as the baseline year.

(2) MoHP district data are shaded in grey and data on villages directly benefiting from subproject interventions are shown in bold italics.

(3) MoHP district data is measuring "(fp) service utilization in public units."

(4) Local-level household survey data is measuring "service utilization in public family planning clinics."

Annex I. Borrower's Comments

جمهورية مصر العربية
وزارة الصحة والسكان
مكتب الوزير

Ms. Monika Huppi
Manager Sector Evaluation Division
Independent Evaluation Group

Cairo 26th, June 2008

Dear Ms. Huppi,

Pursuant to your letter dated on 10th, June 2008 regarding the Ministry Comments on the draft Project Performance Assessment Reports of Population & National Schistosomiasis Control Projects.

Please fined attached the comments.

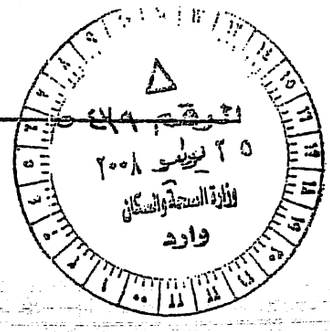
Please, accept the assurance of my highest esteem.

Best Regards,
Dr. Emad Ezzat

Acting Chief of the Cabinet of
Minister of Health & Population
Egypt

٣ش مجلس الشعب .ص.ب ١١٥١٦ – ت : ٧٩٢٢٩٠٤ (٠٢٠٢) – ٧٩٦٤٢٨١ – فاكس : ٧٩٢٢٩٠٤ (٠٢٠٢)
Cairo; 3 Magles EL Shaab St. P.O.Box:11516 - Tel (0202) 7922904 -7964281- Fax:(0202) 7922904
Email : Contact@moph.gov.eg.

Population and Family Planning Sector
Ministry of Health and Population



June 23, 2008

Ms. Monika Huppi, Manager
Sector Evaluation Division
Independent Evaluation Group
The World Bank

Subject: Comments on Draft Project Performance Assessment Report – Population Project (Cr. 2830-EGT)

Dear Ms. Monika,

Reference is being made to the Draft Project Performance Assessment Report on the Egypt Population Project (Cr. 2830-EGT). This is to acknowledge the professional work and effort exerted by the evaluation and assessment team, and to commend the insight included in the report which will help the Ministry of Health in envisioning its future policies and strategies based on the lessons learned from the past experience.

However, some comments came out after a thorough reading through the report. These are as follows:

Page (1) Background and Context:

Please update this paragraph. Egypt is now 28 governorates and Luxor City. Cairo became two governorates (Cairo and Helwan), also Giza became two governorates (Giza and 6th of October).

Page (15) Outputs and Outcomes by Objectives

5.6 First, the functions of the General Department Of Family Planning Services Of Nongovernmental And Private Sector cannot be judged only by its title. There is no evidence of possible neglect of the role of NGOs in planning and policy formulation or demand side stimulation. In fact, the MOHP/Population Sector through this General Dept. provided most of the NGOs having family planning clinics with the National integrated Standards of Practice to improve the quality of services, it also provides trained physicians to NGOs upon request. The NGO General Dept. is on its way to strengthen the process of partnership and networking with active NGOs, it conducted several workshops to identify NGO needs, and to involve these NGOs in the process of population policy formulation and implementation including stimulating demand for family planning practice.

5.11 DHS 2005 of Egypt (sources for modern family planning methods) shows an increase in the public sector contribution in methods dispensed (from 48.6% in 2000 to 56.6% in 2005). This may be an evidence of family planning service effectiveness during this period, and not the opposite mentioned in this paragraph .

Page (31)
7.6 Future Directions

MOHP has observed some gaps in the application of the Family Health Model as related to FP/RH services. As a response, and in order to bridge this gap, the population & family planning sector is currently implementing a program funded by UNFPA entitled "Strengthening Supply, Demand, and Utilization of Reproductive Health Services in the context of Health Sector Reform".

Thank you again for your continuous support.

Sincerely,

Atef El Shitany

24-Jun-08