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IMPLEMENTATION COMPLETION REPORT
(IDA-28300)

ON A

CREDIT

IN THE AMOUNT OF US$ 17.2 MILLION

TO THE

ARAB REPUBLIC OF EGYPT

FOR A

POPULATION PROJECT

October 21, 2005

CURRENCY EQUIVALENTS

(Exchange Rate Effective March 1996)

Currency Unit = Egyptian Pound (LE)
LE = US$
US$ = LE

FISCAL YEAR
July 1, 2005 to June 30, 2006

ABBREVIATIONS AND ACRONYMS

CAS	Country Assistance Strategy
CBC	Communication for Behavior Change
CBO	Community Based Organization
CPR	Contraceptive Prevalence Rate
DCA	Development Credit Agreement
DHS	Demographic and Household Survey
FP	Family Planning
ICR	Implementation Completion Report
IRR	Internal Rate of Return
IUD	Intra-uterine Device
MOHP	Ministry of Health and Population
MTR	Mid-Term Review
NGO	Non-Governmental Organization
PAP	Population Activities Program
PDO	Project Development Objective
PIU	Project Implementation Unit
QAG	Quality Assurance Group
QER	Quality Enhancement Review
RAP	Remedial Action Plan
RH	Reproductive Health
SCA	Social Change Agents
SDR	Special Drawing Rights
SFD	Social Fund for Development
TFR	Total Fertility Rate
USAID	United States Agency for International Development

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ARAB REPUBLIC OF EGYPT
Population Project

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Project ID: P005163	*Project Name:* Population
Team Leader: Alaa Mahmoud Hamed	*TL Unit:* MNSHD
ICR Type: Core ICR	*Report Date: November 2, 2005*

1. Project Data

Name: Population
L/C/TF Number: IDA-28300
Country/Department: ARAB REPUBLIC OF EGYPT
Region: Middle East and North Africa Region

Sector/subsector: Health (66%); Other social services (22%); Central government administration (12%)
Theme: Population and reproductive health (P); Participation and civic engagement (P); Gender (S)

KEY DATES		*Original*	*Revised/Actual*
PCD:	10/18/1994	*Effective:*	10/28/1996	06/24/1998
Appraisal:	07/25/1995	*MTR:*	10/01/1998	06/01/2002
Approval:	03/21/1996	*Closing:*	12/31/2001	03/31/2005

Borrower/Implementing Agency: GOE/MINISTRY OF HEALTH AND POPULATION; SOCIAL FUND FOR DEVELOPMENT
Other Partners:

STAFF	Current	At Appraisal
Vice President:	Christiaan J. Poortman	Kemal Dervis
Country Director:	Emmanuel Mbi	Inder Sud (Department Director)
Sector Manager:	Akiko Maeda	Jacques F. Baudouy (Division Chief)
Team Leader at ICR:	Alaa Mahmoud Hamed	David J. Steel
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2. Principal Performance Ratings

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HL=Highly Likely, L=Likely, UN=Unlikely, HUN=Highly Unlikely, HU=Highly Unsatisfactory, H=High, SU=Substantial, M=Modest, N=Negligible)

Outcome: S
Sustainability: L
Institutional Development Impact: SU
Bank Performance: S
Borrower Performance: S

	QAG (if available)	ICR
Quality at Entry:		S
Project at Risk at Any Time:	Yes	

3. Assessment of Development Objective and Design, and of Quality at Entry

3.1 Original Objective:

Context: Around the time of project inception, the Arab Republic of Egypt had made substantial progress with its family planning programs as evidenced by the increase in contraceptive prevalence rate (CPR) among women of child -bearing age from 24% in 1980 to 47% in 1992. However, this national level data masked regional disparities, especially in rural Upper Egypt where the CPR in 1992 was only 24% and the average total fertility rate was 6.0 per woman compared to 2.7 per woman in urban areas. The Government, through the National Population Council (NPC), identified the need to stimulate demand for family planning services in rural areas by increasing community outreach programs and supporting parallel and complimentary social programs for women's education and employment. This approach of simultaneously addressing supply and demand issues was new and untested within the health sector. The project was prepared with the NPC as the primary counterpart which fully recognized the importance of the Social Fund for Development (SFD) and NGOs/CBOs in the implementation of community outreach programs, although there was a lack of experience working in partnership with these institutions. Just before negotiations, the NPC was merged with the health ministry to form the Ministry of Health and Population (MOHP) along with a change of ministers. While Government commitment to the population goals was evident at this point in time, there was no clear consensus by the various stakeholders on the delivery mechanism to achieve these goals, in addition there was some initial reluctance of the MOHP to partner with the SFD and NGOs. Apart from these and other project specific challenges at the time of project preparation, there were portfolio-wide issues in the country that needed to be addressed and contributed to effectiveness and implementation delays discussed later.

The objectives of the project were to assist Egypt to: (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. With the growing population, the pressure on the Government to provide social services was likely to intensify and the Government therefore set a new national population goal of achieving an average of two children per couple by 2017 in order to slow down the population growth and to improve the welfare of families. The project was designed in conformity with the Bank's Country Assistance Strategy (CAS) of 1994 which pursued a two-track human resource development effort. The first track was to support the Government's efforts to strengthen its social safety net as it deepened its economic reform program and attempted to resume economic growth. The second track was to help achieve realistic progress in the longer term effort in population, health and education. This project was expected to address the longer term needs of the population sector and assist Government to incorporate more thoroughly the impact of population-related factors into development planning, play a larger leadership role at the national level, and encourage public and private interventions. The project would support the institutional development of MOHP and support NGOs and local community development activities, and provide an opportunity for dialogue between theGovernment and a group of stakeholders that had been largely ignored untill then.

The ICR assesses the project development objectives as relevant, realistic and important for the ongoing sector work and CAS during project preparation. The project's design to address demand-side issues through the SFD and NGOs was also innovative and well-targeted to rural Upper Egypt.

Project Timeline

- Project preparation commenced in October 1994 with Board Approval in March 1996

- Project Effectiveness in June 1998 with the onset of sub-projects (under component 2) in April 2000
- Mid-Term Review (MTR) in June 2002 (two years after onset of sub-projects)
- Project extended twice: first from December 31, 2001 to December 31, 2003 (in 1998) and then again to March 31, 2005 (in 2003)
- Project closed March 31, 2005

3.2 Revised Objective:

The original objectives of the project were not revised during the implementation period.

3.3 Original Components:

The two components of the project were: (i) Capacity Building - to address supply-side issues and to be implemented by the MOHP through a Project Implementation Unit (PIU); and (ii) Population Activities Program (PAP) - to stimulate the demand for family planning services and to be implemented by the SFD.

Component 1: Capacity Building (US$2.6 million) - Designed to support capacity building efforts in the Population and Family Planning Sector of the MOHP for a set of key functions, including policy and program development, business planning, sectoral manpower development and training, research programming, planning, resource mobilization, supervision, monitoring and evaluation, and public/NGO/local community program coordination. By project completion, the Population Department of the MOHP was expected to have the capacity to: (a) conduct high level advocacy and research; (b) undertake strategic leadership of planning, management and interdepartmental coordination for population growth; (c) monitor and evaluate the overall progress of population programs; (d) mobilize and allocate resources for population programs in an efficient way; and (e) support NGO and local community initiatives.

Component 2: Population Activities Program (PAP) (US$18.1 million) - Designed to stimulate demand for family planning services and smaller family size in rural areas of Upper Egypt where fertility remains high and demand for services low. The project would finance grants to NGOs, local community organizations and relevant public sector agencies for small decentralized proposals. Thsee sub-project proposals would target increasing the awareness of population issues, strengthening motivation for couples to plan their families, facilitating access to and use of reproductive health services, and educating and motivating people in such related areas as child nutrition, safe motherhood, male awareness and delayed age at marriage. In addition, the proposals could also include sub-projects to extend and improve the quality of social change agents (SCAs), develop capacity to produce local informational material, rural internships for urban youth and professionals, counselling and referral programs for youth, and youth-to-youth campaigns/programs. To ensure well-targeted activities, proposals would be evaluated using a strategic framework and a typology of interventions with clear, simple criteria, transparently applied and to monitor and evaluate activities against specified outcome indicators.

3.4 Revised Components:

The composition of the project components was largely maintained throughout implementation. Upon credit effectiveness, the Government requested that under Component 1, the amount allocated to goods be increased from SDR 280,000 to SDR 980,000 and the amount allocated to consultant services and training be reduced from SDR 900,000 to SDR 200,000 to allow for the purchase of additional goods (ambulances and medical equipment) for maternal and population services. In 2003, the credit amount allocated to the goods expenditure category (under component 1) increased by SDR 3.62 million to allow for the procurement of intrauterine devices (IUD) and insertion kits. This amount came from the previously unallocated Credit of SDR 1.07 million and reallocation from the sub-project grants expenditure category of SDR 2.55 million. During the project's mid-term review (MTR) in 2002, the Bank and the Government

agreed that the capacity building efforts under Component 1 should be targeted more at the regional level to better manage the family planning services because of the weak capacity at the regional level. Under the component, communication for behavior change was included along with mass communication to better understand the issues of the communities and allow for more community-sensitive messages.

3.5 Quality at Entry:

The project did not benefit from a quality-at-entry assessment by the Quality Assurance Group (QAG). The ICR rates the quality-at-entry as satisfactory especially considering the challenges faced by contextual issues (described earlier). The project was responsive to the Government's assessment of the actions needed to meet the national population goal. These actions were added to the project design and include: (i) increasing community outreach programs; and (ii) supporting parallel, complementary social programs for women's education and employment in rural areas, . The project was innovative in its approach of simultaneously implementing both supply and demand issues and identifying the SFD as the most appropriate institution to increase demand through community development approaches, and the implementation arrangements and project design took this into account. An operational manual was prepared and included details such as the types of proposals to be accepted, the application process and well-defined selection criteria for approval of proposals. The need to target the programs to the under-served areas in rural Upper Egypt was identified and appropriately included in the project design. Dialogue took place beyond the sector to include the SFD and other stakeholders. A memorandum of understanding between the MOHP and the SFD was prepared as a guide for the administration of the PAP which would require input from both agencies. The project adequately assessed the risks to both components of the project and the mitigating measures to address them were suitable. As an example, by devising clear criteria for project selection and entrusting implementation of the PAP to the SFD with its proven record in working with community level agencies, the project addressed the risk of poor targeting, lack of selectivity and ineffective project implementation. With the benefit of hindsight, the delayed process of ratifying projects by the Parliament could have been better anticipated and addressed since this was a portfolio-wide issue at the time of project preparation. The project could also have benefitted from a comprehensive assessment of NGO capacity, especially since implementation of population activities was a relatively new role for NGOs at the time.

4. Achievement of Objective and Outputs

4.1 Outcome/achievement of objective:

Considering contextual factors (see section 3.1) that led to delays in project effectiveness and implementation, the project achievements and outcome are commendable and rated satisfactory. The capacity building objective of the project was achieved and extended beyond the central level of the MOHP; it also included an expanded capacity to promote collaboration and partnership between the governorate and district level MOHP staff and the SFD and NGOs. Concrete evidence of this collaboration is the development of joint annual plans in over 50 districts of Upper Egypt. Beyond the MOHP, the project has also supported capacity building within the SFD, and to some extent, the capacity of NGOs and CBOs in the implementation of population related activities. Although the SFD had a population unit prior to the project, it lacked clearly defined roles. Under the project, the unit evolved with a specific mandate to improve health and population outcomes of the poor; in line with this expanded role, a population officer was assigned to the SFD office in each governorate. Additional benefits, beyond those expected during project design, are evident. The MOHP NGO Support Department was strengthened, particularly with development of a database of NGOs implementing population-related activities. The roles of the MOHP, SFD and NGOs in the population sector have been defined and institutionalized. The contraceptive procurement capacity developed under the project was an unexpected achievement with the population

department of the MOHP now capable of procuring contraceptives without donor assistance.

The second objective of stimulating demand for family planning was also achieved as evidenced by the increase in the CPR from 18% in 1998 to 37% in 2003 as well as an average four-fold increase in the utilization of family planning clinics in the targeted areas of rural Upper Egypt within the same time period. This progress is directly attributable to the project since it was the only new intervention in the targeted areas. Additional public health facility and project site data collected as a part of the monitoring and evaluation process of this project are presented in Annex 1.

4.2 Outputs by components:

Component 1: Capacity Building

Satisfactory

As described below, the ICR rates outputs based on an assessment of the achievements against expectations during project preparation.

- *High level advocacy and research*: Overall, there is a renewed appreciation in the MOHP of the importance of using a regional approach that is culturally sensitive and poverty targeted to address population and other health issues. Partnering with the SFD, a number of development tools were developed and took into consideration the regional differences. Using operational research methods, a communication plan for rural upper Egypt was developed based on a behavior change (BC) monitoring tool that was piloted under the project. Under the pilot, a community profile of rural Upper Egypt was created, SCAs were trained to use the tool, and an advocacy tool to target local leaders on family planning (FP) and reproductive health (RH) issues was developed.
- *Strategic leadership of planning, management and interdepartmental coordination for population growth:* In April 2005, the MOHP elaborated a national plan of action based on project experiences entitled "Facing Population Challenges in Partnership with NGOs". Key objectives of the plan include: enhancing community participation in decision-making as it relates to health services; enhancing capacity and organizational skills of communities to address challenges impeding health services; making service provision more responsive to the needs of families; and ensuring sustainability of positive behavior trends.
- *Monitor and evaluate the overall progress of the population program*: Various tools have been developed under the project for monitoring the population program, including the BC monitoring tool described above. A tool for conducting household surveys has been developed by the MOHP based on the project experience of supervising, conducting and analyzing baseline and post-intervention surveys. The national plan of action described above also has a monitoring and evaluation component to it.
- *Mobilize and allocate resources for population programs in an efficient way*: The MOHP is keen on integrating family planning and reproductive health services within a comprehensive family health service rather than implementing them as a vertical program as a means of ensuring sustained funding. Discussions are ongoing on this issue of the integration within the health reform efforts that are being supported by various donors, including the Bank.
- *Support NGO and local community initiatives*: The MOHP NGO Support Department uses a database of NGOs as a useful tool for planning support to NGOs/CBOs implementing health programs. The department works together with the MOHP Family Planning Services Department and the SFD on a regular basis in the preparation of strategic plans. The roles of the various partners (including NGOs) have been defined and reflect the agreements reached on the collaboration protocol.

The following achievements were not specifically anticipated during project design but have been achieved satisfactorily by the project:

- *MOHP Contraception Procurement Management*: Since 1989, USAID has procured and supplied all contraceptive needs for the country but by 2001, the agency gradually began withdrawing its support with a plan for full withdrawal by 2011. Condoms and contraceptive pills were the first to stop being procured by USAID, intrauterine devices (IUDs) were the next to be withdrawn, and by 2007, injectables will be added to the list. With the anticipated interruption in supply and the negative effect this would have on achievement of the PDO, the project allocated funds for the procurement of IUDs, IUD insertion sets, ultrasound and autoclave machines. The PIU developed the technical specifications and methodology for the process and was able to procure all the country's IUD needs for the next three years. The MOHP currently has the capacity to independently manage the entire contraceptive procurement process.
- *Effective Cooperation and Partnership:* In the last two years of project implementation there was a demonstrable improvement in the coordination of population activities between MOHP and SFD surpassing even the project's expectations. Contributing to this is the revitalization of the Executive Committee for the project which was delegated decision-making authority over project activities by the Minister of Health and Population. Similar committees were also established at the governorate and district level and are involved in both the planning and the monitoring and evaluation of these plans.

The capacity built within the MOHP and SFD went beyond the central level to include the governorate and district levels in Upper Egypt. Beyond the achievements described above, the MOHP now has a pool of trainers (63 FP Team supervisors) at the central and governorate levels that provide training for health workers (653 trained under the project) at the district level on the provision of reproductive health services. At the district level, district health teams have been established and are providing management training. Staff at the governorate level are included in the health teams that monitor and supervise district health plans. At the central level, the MOHP developed 92 different training aids related to reproductive health issues that are being used for ongoing training nationwide.

Component 2: Population Activities Program (PAP)

Satisfactory

This component was implemented in four phases, with each phase benefitting and building on the lessons from the previous one. This arrangement allowed for learning and innovation as well as development of a "model" that the MOHP and SFD plan to replicate more widely in the country. Each phase involved implementation of sub-projects that included various activities like outreach programs by networks of SCAs, health education, illiteracy elimination programs, micro-credits and vocational training, all of which were to increase the demand for family planning services. To complete the sub-project model, there was a service support component to address the supply aspects of services and this included contraceptive security, mobile support teams and clinics and service quality assurance. Phase 1 comprised 3 sub-projects and was managed at the district level by a national level NGO (Egypt Family Planning Association), which had the limitation of not effectively reaching the community level. Phases 2 and 3 (11 and 24 sub-projects respectively) involved decentralized NGOs and CBOs which were able to achieve better results. Phase 4 (18 sub-projects) used a cluster system with an NGO managing a small network of CBOs. Each sub-project went through a sub-project cycle which, by the time of implementation of Phase 4, had evolved and comprised the following steps: (i) project site identification; (ii) contracting NGO/CBO; (iii) approval of sub-project action plan; (iv) community profiling; (v) pre-intervention assessment (baseline data collection); (vi) scoping of priorities through joint working groups including community leaders; (vii) implementation of sub-project activities; and (viii) quarterly monitoring of progress, post evaluation assessment and final evaluation. This cycle has been adopted for ongoing use by the SFD.

By the end of the project, 22,400 families in 148 villages in Upper Egypt had been reached, with over 3

million home visits, about 2000 village level seminars, over 9,000 micro-credits to families (with an average 500 Egyptian Pounds per credit awarded), and about 300 literacy classes (with about 5,640 women enrolled). About US$2 million of the Credit remains as seed funds for microcredit schemes within NGOs supported by the project. This funding is available as a revolving fund. A network of 3,085 SCA were trained on RH (6-day initial course and 3-day refresher about a year later). The SCA conducted the household surveys under the project and interviewed about 230,000 women, which was even more representative than the national demographic household survey (DHS) conducted every three years (which surveys between 10,000 to 16,000 women).

4.3 Net Present Value/Economic rate of return:

During project preparation, the internal rate of return (IRR) was estimated at 19%. This was primarily based on the assumption that the project benefits would result from the number of births averted in rural Upper Egypt and that the public expenditure savings per birth averted would be US$470. It was acknowledged that this rate was conservative and underestimated since it assumed that the sole benefit was the birth aversion. The ICR assesses that there were other direct (included in the ICR analysis) and indirect benefits (difficult to quantify and not included in analysis). The quantified benefits include: consumer surplus from the usage of FP methods; consumer surplus from micro loans; cost savings from improvements in planning and managerial efficiency; income generated for the SCAs employed in the project; and public expenditures saved due to birth aversion (see Annex 3 for details). Indirect benefits include: impact of literacy classes provided; poverty reduction and employment creation from micro loans provided; increased awareness of women about reproductive health and their general health status; increased and improved access to health care services; the added societal value of women employed under the project (as SCAs or from microcredits); poverty reduction from improved health status; and higher per capita income from the smaller families. These difficult-to-quantify indirect benefits further render the ICR economic analysis as conservative.

The ICR assesses the project's IRR to be in the range of 22% to 30% (depending on the strength of assumptions used in the analysis) which is higher than the 19% estimated during project preparation. The project's total benefits were estimated to be between LE 100.3 million and 103.7 million; while total costs were estimated to be LE 87.2 million resulting in total net benefits of between LE 13.2 million and 16.5 million with a net present value of LE 7.3 million and 10.1 million respectively. The net present value was based on the real social discount rate of 4.55%. A positive net present value is indicative that the project was economically viable. People were willing to pay LE 6.0 for family planning methods while they were actually paying LE 3.0, and were willing to pay up to LE 390 for larger micro loans while they were actually paying LE 80 on average. Please see details of the analysis in Annex 3.

4.4 Financial rate of return:

Not Applicable

4.5 Institutional development impact:

Substantial

Impact on MOHP: Overall, the MOHP's institutional culture has positively changed as evidenced by the openness to collaborating with SFD and NGOs/CBOs on population issues; decentralization of service planning and provision; and the acknowledgement of the importance of involving communities in service provision planning. The contraceptive procurement capacity of the Ministry developed under the project is significant and key to achieving the national population goal with little or no dependence on donors. The MOHP through its NGO Support Department is now better at managing and targeting technical assistance to NGOs working on population issues. The MOHP has a number of implementation and monitoring tools

(e.g., CBC tool, household survey, training manuals) making it less dependent on donors for implementing key population activities tasks. Beyond the central level, governorate and district level staff have also acquired management skills (including planning, implementation and monitoring skills) for population activities with the establishment of district health teams. Staff at service delivery points are also better able to provide services that are responsive to client needs.

Impact on SFD: The capacity built within the SFD on population issues, including the expanded role of the Health and Population Department, has benefitted from the partnership with the MOHP. The adoption of a protocol of collaboration further strengthens the partnership which is key to reaching the national population goals. Based on experiences from the four sub-project phases, the SFD has also developed a Social Fund Tool Kit to be used for increasing demand for public health services. Simplified procurement procedures and guidelines developed under the project are being institutionalized by the SFD and will make implementation less bureaucratic and more effective.

Impact on NGOs, CBOs and communities: About 100 NGOs and CBOs have benefitted from the training and funding from this project and have developed important management skills that continue to be utilized beyond the project life. The MOHP NGO Support Department is an added resource available to these organizations. The relationship between the organizations and the communities they serve has been strengthened and will be essential for maintaining the benefits. The network of SCAs developed continues to facilitate the awareness of population issues beyond the traditional medical/health boundary to a wider social sphere where incentives and other socioeconomic factors influence population choices, especially those at the household level.

5. Major Factors Affecting Implementation and Outcome

5.1 Factors outside the control of government or implementing agency:

In 2003, the Bank's Task Team requested a Quality Enhancement Review (QER) as a means of addressing slow disbursements under Component 2 of the project. The review recommended a Remedial Action Plan (RAP) which subsequently led to improved implementation and a justification to extend the project's closing date to address various delays (discussed in the next section) in order to achieve the PDO.

5.2 Factors generally subject to government control:

The following factors affected project implementation:

- *Delayed project ratification by Parliament and amendments to Development Credit Agreement (DCA) as discussed in Section 3.1 under "Context"*: By project effectiveness, project staff had changed within Government, and without a historical perspective, it took another year for new staff to become fully familiar with the project design and consequently, implementation under Component 2 did not commence until April 2000.
- *Approval of project disbursements by SFD:* In 2001, there was a decree mandating prime-ministerial approval before disbursing funds under any SFD project over LE 50,000. This created an 18-month implementation delay for activities under Component 2, since the flow of funds from the SFD to the NGOs was affected.
- *MOHP and SFD internal investigation into NGO performance:* Supported by the recommendation of a Bank ex-post procurement review, the February 2002 Government investigation recommended the development of simplified procurement guidelines and a methodology for post review of NGO activities by SFD. Although there was a six-month delay, implementation of the recommendation subsequently resulted in improved procurement arrangements.
- *The devaluation of the Egyptian Pound*, which went through a series of phases ending with a floating rate in January 2003, and US dollar exchange rate fluctuations (in the latter part of the project), led to about a 50% increase in the finances available under the project and as a result a lower disbursement rate than had been planned.

5.3 Factors generally subject to implementing agency control:

Significant factors that contributed to project achievement were increased commitment and partnership between the MOHP, SFD and NGO/CBOs. Delays in the first part of project implementation can largely be attributed to the lack of experience of partnership between the MOHP and SFD and the difficulties of implementing an innovative concept. The understanding that supply and demand side issues needed to be addressed in an integrated manner as well as through decentralized decision making (through the delegation of authority by the Minister to a Project Executive Committee) led to a realignment of project implementation and improved coordination in the last two years of project implementation.

5.4 Costs and financing:

Total project cost was estimated at US$20.7 million equivalent at appraisal, with an IDA Credit of US$17.2 million equivalent, co-financing of US$1.9 million by the SFD (a quasi-government agency), and a Government contribution of US$1.6 million. At Project Closing Date, the actual total project cost was US$17.1 million, with an IDA Credit amount of US$14.8 million, SFD co-financing of US$1.0 million, and a Government contribution of US$1.9 million. During the course of the project, a combination of devaluation of the Egyptian Pound and exchange rate fluctuations between the SDR and the US dollar led to a total cost savings of about US$2.0 million. Costs by component and by financier can be found in Annex 2.

6. Sustainability

6.1 Rationale for sustainability rating:

Likely

The ICR rates the project's sustainability as likely, primarily because of the political commitment that exists to sustain benefits of the project as well as efforts that have been put in place by both the SFD and the MOHP for the joint implementation of population services beyond the project life. Capacity developed under the project will likely allow for continued implementation of activities. The National Population Policy continues to guide programs in all related ministries and agencies nationwide. Yearly briefs on progress towards achieving the national goal are presented to the Cabinet. The policy environment for achieving the national policy is also positive and, in addition to the ongoing partnership between the SFD and the MOHP, in 2004, the Prime Minister formed a high level committee on population that regularly reports to him. Political commitment is evident at the highest levels of government, including the appointment of an assistant minister of population within the MOHP specifically charged with ensuring the required inter-sectoral linkages needed to address population issues. Within the MOHP the NGO Support Department continues to provide technical assistance to about 100 NGOs implementing population activities in rural Upper Egypt with their own funds. All PIU staff have been retained by the MOHP and have added, among other competencies, the contraceptive procurement capacity. At the SFD, population focal points have been assigned to each governorate office. At the time of ICR preparation, the MOHP, realizing the importance of integrating family planning and population services within a more comprehensive family health program, was making arrangements to integrate the project's experiences in ongoing health reform efforts that are being supported by various donors including the Bank. This integrated approach would likely ensure funding of population services and sustain the achievements of the project. In addition, some of the lessons of this project are being incorporated into ongoing Bank-supported health and social protection projects. Other evidence of the likelihood of sustaining achievements of the project are discussed in Section 6.2 on transition arrangements.

The ICR acknowledges that there are fewer, although more qualified, SCAs (being sustained by incentives generated from microcredits) that continue to act as the needed link between the communities they serve

and the public health facilities. The SFD, under phase four of the project, piloted sustainability schemes (that will be assessed under the ongoing Social Fund III Project) geared towards providing incentives to support additional SCAs without the continuous influx of funds from donors. In addition to these efforts, the ICR recommends that the MOHP continue to support the SCA network, not only with refresher courses for current SCAs, but also with the training of new entrants to the network.

6.2 Transition arrangement to regular operations:

Most of the project activities have already been integrated into regular operations within the MOHP and SFD. All PIU staff were retained by the MOHP and the project trained about 63 supervisors of FP teams who are responsible for providing refresher courses for FP staff at the governorate and district levels, using training modules developed under the project. Lessons from the project sites have been integrated into services in other areas and the FP service model is being integrated in the Family Health Service model being implemented by the ongoing Bank-supported Health Sector Reform Project. Based on needs, the MOHP staff are now making the necessary contraceptive procurement plans, an activity which was previously carried out by donors. The protocol of collaboration between the MOHP and SFD has been adopted, as is evident from the development of Joint Annual Plans in about 50 districts in Upper Egypt.

7. Bank and Borrower Performance

Bank

7.1 Lending:

Satisfactory

On balance, the ICR rates Bank performance during project preparation and appraisal as satisfactory. The project, as designed, was responsive to the needs of Government's population goals as a result of a sectoral analysis conducted during project preparation. The need to address demand issues led to the incorporation of the SFD, an approach which had previously not been taken under a Bank-supported health sector project. Steps were taken during project preparation to ensure readiness for implementation shortly after effectiveness with the development of operational manuals and guidelines and selection criteria both for project sites and for the approval of sub-project proposals to be financed under the project. The lengthy project ratification process within the Egyptian Parliament should have been anticipated by the Bank but the ICR acknowledges that would have been difficult to mitigate due to unforeseen events and portfolio-wide issues at the time (see Section 3.1). A more detailed analysis of the feasibility of implementing Component 2 through NGOs could have been implemented. While the project design was innovative, the project could have been implemented faster if a comprehensive assessment of NGO capacity had been available and appropriate capacity building arrangements had been integrated in the early phases of project implementation.

7.2 Supervision:

Satisfactory

Despite the initial delays that were largely beyond the Bank's control, on balance Bank supervision performance was satisfactory. The task leadership of the project was largely maintained with only one change throughout the project life, which was beneficial to the continuity of the project. The skills composition of the task team was largely adequate throughout project life. Task management was also largely field-based, allowing for closer project supervision and more frequent interaction, which contributed to the partnership built between the Bank and the Government teams, a key factor that has been appreciated by the Government and has contributed to the project benefits. The Bank task team has been flexible and responsive to the Government's requests (e.g., reallocation requests, including IUD procurement under the project) and was able to effectively guide the phasing of sub-projects under Component 2. The PSR

ratings were mainly satisfactory although they could have been more candid, especially during the periods of implementation/disbursement delays. The Team was proactive, as evidenced by the independent reviews conducted by the task team at various stages of implementation. The procurement review of 2003 led to a recommendation to re-assess the procurement procedures being used by the SFD and NGOs under the project. The task team provided guidance to the SFD in developing simplified procurement guidelines. In 2003, the Bank task team requested an internal quality enhancement review (QER) of the project to address ongoing slow disbursements that had not responded to the earlier MTR recommendations and the recommendations from this review led to the development of a RAP with clearly demonstrable actions and triggers. A project extension request from the Government was approved only after the triggers set in the RAP were met by the Government. The ICR assesses the critical actions recommended by the RAP as appropriate and relevant for improving implementation progress.

7.3 Overall Bank performance:
Satisfactory

When viewed over the entire project life-span, the ICR rates overall Bank performance as satisfactory. This is based on the openness of the Bank to the innovative project design, good cooperation and responsiveness to the Borrower throughout the project cycle.

Borrower
7.4 Preparation:
Satisfactory

The ICR rates Government's project preparation performance as marginally satisfactory. While Government's commitment to population issues was evident, the effectiveness delays described in other sections of this ICR (that were largely under government control), suggest some reluctance and lack of preparedness to implement the innovations required under the project. On a more positive note, Government analysis during preparation revealed obstacles and challenges to achieving its population goal and proposed means to overcome these challenges and some of them (as earlier described) were integrated in this project's design. This was the first Bank-financed health sector project that included partnership with the SFD, a national institution known for managing community development programs through NGOs/CBOs. The SFD's experience, as well as its existing fund-delivery mechanism, made it the appropriate partner for the MOHP to achieve the projects goals. While it appears that the Government (as represented by the NPC) considered the inclusion of the SFD and NGOs during project preparation, it is not clear that the MOHP was fully comfortable with the idea of working with NGOs in the early phases. With the MOHP already having service points in almost every village, it likely did not fully appreciate the benefits of partnerships with NGOs at project onset until they were clearly demonstrated through the achievements under the sub-projects.

7.5 Government implementation performance:
Satisfactory

Overall, the ICR rates the Government's project implementation performance as satisfactory. While performance was at best marginally satisfactory in the first half of the project life, the situation was much improved in the latter half. Some implementation delays, like the internal investigation of NGO performance, were instituted to analyze NGO capacity and find ways to strengthen it as a means to improve project implementation and the Government is commended for the efforts. Implementation progress picked up and the Government's commitment to achieving the goals of the project led to requests to change the DCA in response to changes on the ground as well as extension requests to allow additional

time to achieve the PDOs. The Government's commitment to achieving the PDOs is also evident in the timely implementation of the critical actions proposed under the RAP as triggers for considering project closing date extension a second time.

7.6 Implementing Agency:
Satisfactory

The ICR rates the performance of both the MOHP PIU and the SFD as satisfactory. The hard work and commitment of these implementing agencies contributed significantly to the achievements of the project. The initial implementation delay was as a result of new implementation teams being appointed after the project became effective. As with the change in the Bank task management, it took some time for the teams to become conversant with the project design and implementation plans. Once this happened, implementation progress improved. After the initial changes to the PIU and SFD teams, staffing was largely maintained during the remaining implementation period. The two teams worked very well in partnership to implement the project. In addition, the most senior staff of both agencies were members of the Executive Committee delegated with decision-making authority by the Minister of Health and Population.

7.7 Overall Borrower performance:
Satisfactory

Viewed over the entire life-span of the project, the ICR assesses the efforts and achievements under the project were substantial and rates the overall performance of the Borrower as satisfactory.

8. Lessons Learned

- ***Population messages are more effective when incorporated within more comprehensive services.*** Population challenges have various dimensions (e.g. social, cultural and economic) that need to be addressed in a comprehensive manner to achieve desired goals. Linked with this is the importance of considering socio-economic factors as key to addressing family planning and reproductive health issues. Beneficiaries of this project were more receptive to FP/RH services that were integrated into more comprehensive community-based services and the approach was also useful in empowering women as well as in convincing men of their role in family planning.
- ***Where no single institution can adequately address both demand and supply issues simultaneously, effective partnerships at all levels of governance are important to achieving stated goals.*** This is particularly important for rural areas where the traditional approach of improving service delivery alone is not an effective mechanism for reaching the poor. Decentralized decision-making and collaborative planning is a prerequisite for effective and efficient implementation at lower levels of governance.
- ***Social Change Agents (SCAs) are a vital link between the community and the service points for the poor and are key to increasing demand for services.*** Under this project, the SCAs facilitated interpersonal communication and effectively placed the population issue within a wider socio-economic sphere of the communities they served. SCAs also need to be appropriately matched with target beneficiaries in order to be most effective (e.g., married SCAs selected to work with married beneficiaries).
- ***The Governorate rather than the national level of administration would be a more effective level at which to set population targets that are realistic and sensitive to cultural and economic realities.*** Anchoring population action plans at this level would make it more feasible to bring together all relevant stakeholders in each governorate (including other ministries, local government authorities and private sector) to plan and monitor activities to meet agreed targets.

- ***Sub-project cycles should be implemented over a longer timeframe of at least 3 years to allow adequate time for impact.*** Reaching the national goal of two children per couple will require behavior and attitude change, both of which are difficult to achieve in less than three years. This is particularly true for areas receiving this message for the first time. Subsequent sub-project cycles in the same target area could be of shorter duration since the foundation would already have been established.

9. Partner Comments

(a) Borrower/implementing agency:

Letter From Government

August 28, 2005
Ministry of Health and Population and Social Fund & Development
Review of Egypt-Population project (Cr. 2830-EGT)
Draft Implementation Completion Report

Based on the review of the draft copy of the Egypt-Population project (Cr. 2830-EGT), Implementation Completion Report presented to us for this purpose by the World Bank Director for Human Development Sector MENA, we would like to express our contentment with the report's findings.

Please find attached (see Annex 8 of ICR) a copy of an amalgamated summary of an independent evaluation and documentation assignment findings. This report has been tailored to complement the WB ICR findings.

Moreover, we have attached a copy of a comparison table of indicators reflecting EPP accomplishments. These indicators reflect a more accurate and affirmative situation in project locations, based on the results of the Pre and Post Survey compiled by the implementing NGOs, SFD and MOHP. These indicators were obtained through 240 thousand household surveys of target communities, thus displaying the projects execution more genuinely than more general indicators obtained through MOHP Health Unit records and illustrated in the report.

Another point that we need to add to the report is MOHP's efforts under the EPP to sustain quality family planning and reproductive health services by creating and institutionalizing core teams of service provider trainers in health district offices and vitalizing decentralized on the job training programs. This approach has proved to be cost effective, sustainable and highly efficient in responding quickly to direct and urgent training needs of service providers.

Finally, we would like to convey our sincere appreciation the WB mission's efforts and support in compiling such a praiseworthy report.

(b) Cofinanciers:

(c) Other partners (NGOs/private sector):

10. Additional Information

Annex 1. Key Performance Indicators/Log Frame Matrix

Outcome / Impact Indicators:

Indicator/Matrix	Projected in last PSR[1]	Actual/Latest Estimate
Mean ideal number of children among ever married women in Rural Upper Egypt (DHS)	3.5	3.3 (DHS* 2003)
Percentage of wives who approve family planning among currently married non-sterilized sterilized women in Rural Upper Egypt (DHS)	91.8	91.8
Total Fertility Rate in Rural Upper Egypt (15-49)	4.7 (DHS 2000)	4.3 (DHS 2003)
Percentage of currently married women, currently using any family planning method in Rural Upper Egypt	40.2 (DHS 2000)	44.7
% increase in service utilization in Family planning clinics in sub-project areas	See Tables Below	See Tables Below
% increase in CPR in sub-project districts	See Tables Below	See Tables Below

**: DHS: Demographic and Household Survey*

Contraceptive Prevalence Rate

Summary Table

Phase	District Level			Village (Project) Level		
	Baseline (Average)	End Project (Average)	Average % point Increase	Baseline (Average)	End Project (Average)	Average % point Increase
1	18% (1998)	37% (2002)	11	--	--	--
2	17% (2000)	29% (2003)	14	45% (2002)	55% (2003)	10
3	39% (2001)	41% (2003)	3	44% (2002)	55% (2003)	11

Service Utilization in Public Units

Summary Table

Phase	Baseline (Average)	End Project (Average)	2004 (Average)
1	26% (1998)	46% (2002)	28 %
2	32% (2000)	53% (2003)	31%
3	41% (2001)	44%(2003)	38%

Output Indicators:

Indicator/Matrix	Projected in last PSR[1]	Actual/Latest Estimate
Number of clinics functioning according to MOHP standards	100	105 clinics refurbished and equipped 195 clinics equipped only
Number of supervisory teams trained.	90	63
NGO Support Department is functional with developed systems, trained staff and equipped according to approved structure by the end of the project	On schedule	Partially completed
CBC National Strategy Developed and endorsed by the sector with focus on Upper Egypt by the end of the project.	On schedule	Completed
Number of effective messages developed	30	33

and delivered for behavior change		
Program Monitoring System Developed by the end of the project	On schedule	Developed
Number of outreach workers qualified to provide information on population and health issues	2651 actual at MTR	3085
Number of families received micro-credits that perceived benefit	3390 actual at MTR	9320
Number of doctors an nurses who received training	653	653
Number of IUD, insertion sets, ultrasound scanners & autoclave machines respectively	4.25 million, 12,812, 347 & 112 respectively	4.25 million, 12,812, 347 & 112 respectively

[1] End of project

Annex 2. Project Costs and Financing

Project Cost by Component (in US$ million equivalent)

Component	Appraisal Estimate US$ million	Actual/Latest Estimate US$ million	Percentage of Appraisal
Component 1: Capacity Building	2.30	6.10	265.2
Component 2: Population Activities Subprojects	18.00	11.61	64.5
Total Baseline Cost	20.30	17.71	
Physical Contingencies	0.10	0.00	0
Price Contingencies	0.30	0.00	0
Total Project Costs	20.70	17.71	
Total Financing Required	20.70	17.71	

Project Costs by Procurement Arrangements (Appraisal Estimate) (US$ million equivalent)

Expenditure Category	Procurement Method[1] ICB	NCB	Other[2]	N.B.F.	Total Cost
1. Works	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
2. Goods	0.24 (0.20)	0.00 (0.00)	0.35 (0.26)	0.00 (0.00)	0.59 (0.46)
3. Services Consultants, Technical Assistance	0.00 (0.00)	0.00 (0.00)	1.26 (0.93)	0.00 (0.00)	1.26 (0.93)
Training	0.00 (0.00)	0.00 (0.00)	0.75 (0.51)	0.00 (0.00)	0.75 (0.51)
PAP Subprojects Goods and Services	0.00 (0.00)	0.00 (0.00)	17.00 (15.30)	0.00 (0.00)	17.00 (15.30)
PAP Subproject Management	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	1.10 (0.00)	1.10 (0.00)
Total	0.24 (0.20)	0.00 (0.00)	19.36 (17.00)	1.10 (0.00)	20.70 (17.20)

Project Costs by Procurement Arrangements (Actual/Latest Estimate) (US$ million equivalent)

Expenditure Category	Procurement Method[1] ICB	NCB	Other[2]	N.B.F.	Total Cost
1. Works	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
2. Goods	5.10 (4.08)	0.00 (0.00)	0.64 (0.49)	0.00 (0.00)	5.74 (4.57)
3. Services Consultants, Technical Assistance	0.00 (0.00)	0.00 (0.00)	0.22 (0.20)	0.00 (0.00)	0.22 (0.20)

Training	0.00 (0.00)	0.00 (0.00)	0.14 (0.07)	0.00 (0.00)	0.14 (0.07)
PAP Subprojects Goods and Services	0.00 (0.00)	0.00 (0.00)	10.96 (9.96)	0.00 (0.00)	10.96 (9.96)
PAP Subproject Management	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.65 (0.00)	0.65 (0.00)
Total	5.10 (4.08)	0.00 (0.00)	11.96 (10.72)	0.65 (0.00)	17.71 (14.80)

[1/] Figures in parenthesis are the amounts to be financed by the IDA Credit. All costs include contingencies.

[2/] Includes civil works and goods to be procured through national shopping, consulting services, services of contracted staff of the project management office, training, technical assistance services, and incremental operating costs related to (i) managing the project, and (ii) re-lending project funds to local government units.

Project Financing by Component (in US$ million equivalent)

Component	Appraisal Estimate			Actual/Latest Estimate			Percentage of Appraisal		
	Bank	Govt.	CoF.	Bank	Govt.	CoF.	Bank	Govt.	CoF.
Component 1: Capacity Building	2.00	0.60	0.00	4.84	1.26	0.00	242.0	210.0	0.0
Component 2: Population Activities Subprojects	15.20	1.00	1.90	9.96	0.65	1.00	65.5	65.0	52.6
TOTAL PROJECT COSTS	17.20	1.60	1.90	14.80	1.91	1.00	86.0	119.4	52.6

Annex 3. Economic Costs and Benefits

Cost Benefit Analysis
(Egyptian Pounds, Base Year 2003)

During project preparation in 1996, the IRR was estimated at 19%. This was based on the assumption that the project benefits result from the number of births averted in rural Upper Egypt and that the public expenditure saving per birth averted was $470. It was acknowledged that this rate was conservative and underestimated since it held that the sole benefit was the birth aversion. At present, on calculating the project's IRR it was found to be in the range of 22% to 30% as shown below.

Benefits	L.E. 100,373,745.8 – L.E. 103,729,087.7
Costs	L.E. 87,204,813.51
Net Benefits (Benefits –Costs)	L.E 13,168,932- L.E. 16524274
Net Present Value (*social discount rate =4.55%*)	L.E. 7,295,547.85 –L.E. 10,088,467.26
IRR	22% -30%

This calculation was based on the following assumptions:

- All expenditures in foreign currency were transformed into LE (Egyptian Pounds) using the Shadow Exchange Rate (SER). Such transformation was necessary since the expenditures of Component 2 of the project were in LE. Also, the official exchange rate could not have been employed since it reflects the distortions in the exchange rate market. Thus, Egypt's SER was found to be $1 = L.E. 5.6 for the year 2004, with an annual devaluation of 3%.
- The public expenditure saving per birth averted remained constant at $470. This figure was transformed into LE using the shadow exchange rate in 1996 ($1=L.E. 4.42). This results in a value of L.E/2077.725. It should be noted that this was the main assumption during project preparation in 1996. Holding this assumption constant and adding to it the new assumptions results in an IRR of 22%. However, relaxing this assumption and assuming that the value of public expenditure changes with the change in the inflation rate in Egypt results in an IRR of 30%.
- One tenth of the beneficiaries of the project managed to avert the birth of one child. This assumption is very limited, since it attempts to take into account the least likely situation, which is the fact that the project was successful with only one tenth of the beneficiaries.
- The beneficiaries have had a consumer surplus (CS) out of the usage of family planning methods and micro loans. CS is the surplus that the consumer receives out of consuming a particular commodity that is offered at a price lower than the price the consumer is willing to pay (WTP) for. The usage of family planning methods and micro loans were considered the project's indirect benefits. These indirect benefits were calculated via the willingness to pay (WTP) approach.It was found that people are WTP L.E.6 the family planning methods while they actually paid L.E.3. As for the micro loans, they were willing to pay up to L.E. 390 on average in exchange for a larger amount of loan, while they actually paid L.E. 80 on average. The following was the equation used to calculate the consumer surplus: *CS= [(WTP-Actual Price) * Quantity sold * 0.5)]*
- The project resulted in cost savings (non-incremental costs) due to managerial efficiencies and improvements in planning. These cost savings were calculated via the projects' cost-benefit (effectiveness) analysis which will be shown below;
- Actual costs of the project were used as no price distortions existed. This assumption was made since

the majority of the expenditures of Component 1 of the project were imported (and the C.I.F. prices were used), while the expenditures of Component 2 were not traded/tradable so their domestic market prices (DMP) were used. Being not traded/tradable in this sense implies that their prices are not distorted.

- The only direct revenue from the project will come from the sale of IUDs purchased after the project ends. The project supplied the IUDs to be used over the coming two years. The assumption employed was that the project would result in the usage of the whole supply of IUDs in a period of three years, extending the amount stipulated by one year to account for any delays that may occur in supplying the IUDs.
- The real social discount rate employed to calculate the Net Present Value was 4.55%. The social discount rate (SDR) is the opportunity cost of capital to the society. The real SDR is adjusted for inflation and was calculated using the following formulas:

  *SDR = interest rate at which Egypt can borrow money from abroad * (1 + country risk) = 7% * (1.25) = 8.75%.*

  Real SDR = SDR - Inflation (in 2003) - Monthly Economic Digest, July 2004, Ministry of Foreign Trade, Egypt.=8.75-4.2% =4.55%

- The agreement for the project was signed prior to the implementation of the four phases. Hence, any prior expenses to the year 2000 (year of preparation of phase one of the project) was treated as the project's initial investment costs. The initial investment costs stood at L.E. 1,684,159. Initial investment costs were necessary to be able to calculate the project's net present value (NPV).

- The NPV of the project, was calculated using the following formula: Net PV (NB) = · Present Value (Net Benefits) - Initial Level of Investment.

- Data limitation resulted in having the data of Component 2 of the project by phase instead of by years as compared to Component 1. To get over this inconsistency, the data of Component 2 had to be transformed into years. Hence, it was assumed that the expenditure for each phase is divided equally over the years of that particular phase. According to the Ministry of Health and Population, the following were the dates of each phase: (Phase 1: 2000-2003; Phase 2: 2001-2004; Phase 3: 2002-2004; and Phase 4: 2004-2005).

Thus, the following table shows the total benefits, costs, and net benefits of the project discounted using the real social discount rate (4.55%), using the assumption of constant public expenditure saving per birth averted. This table results in an IRR value of 22%

	Total Benefits	Total Costs	Net Benefits (NB)	Present Value (NB)
2000/2001	1878177.917	3730863.705	-1852686	-1772057
2001/2002	4179882.158	5958936.141	-1779054	-1627575
2002/2003	18025347.45	15860163.52	2165184	1894622
2003/2004	14973467.58	14413766.31	559701.3	468446.7
2004/2005	42899567.13	47241083.83	-4341517	-3475532
2005/2006	6065396.102	0	6065396	4644243
2006/2007	6119857.985	0	6119858	4482013
2007/2008	6232049.464	0	6232049	4365546

The following table shows the total benefits, costs, and net benefits of the project discounted using the real social discount rate (4.55%), while relaxing the assumption of constant public expenditure saving per birth

averted, and assuming that this expenditure increases with the increase in inflation. This table results in an IRR of 30%

	Total Benefits	Total Costs	Net Benefits	PV (NB)
2000/2001	1918269.352	3730863.705	-1812594	-1733711
2001/2002	4276559.626	5958936.141	-1682377	-1539129
2002/2003	18473721.68	15860163.52	2613558	2286968
2003/2004	16514830.57	14413766.31	2101064	1758503
2004/2005	44128402.95	47241083.83	-3112681	-2491807
2005/2006	6065396.102	0	6065396	4644243
2006/2007	6119857.985	0	6119858	4482013
2007/2008	6232049.464	0	6232049	4365546

This economic analysis remains conservative since it did not take into account the project's indirect benefits which were difficult to quantify. Such benefits included increased awareness of the beneficiaries' reproductive health and their general health status, increased and improved access to health care services, poverty reduction due to improved health conditions and thus less expenditure on their behalf on medical treatment, poverty reduction as a result of the micro loans provided, employment creation for the beneficiaries in consequence of the micro loans (income and multiplier effects), illiteracy eradication, permanent job creation for 25% of the staff working in the governorates where the project was implemented (income effect), the belief that the beneficiaries have a value-added effect in the society by their employment, an increased demand on a better quality of life by the beneficiaries.

The following table represents the results of the cost effectiveness analysis.

Phase	Total Budget	Number of Murshedat (SCAs)	Number of Target Beneficiaries	Actual benef. number	Planned per unit cost for the phase	Actual per unit cost for the phase	Change rate %
Phase One							
One	7,969,886	266	25,000	25,260	318.18	315.51	-1
Phase Two							
Two	3,405,441	165	10,060	10,666	338.51	319.28	-5.7
Phase Three							
Three	21,508,771	947	48,480	57,212	443.66	340.2	-23.3
Phase Four							
Four	18,239,300	1,137	77,850	80,650	234.29	226.15	-3.47
Total	**51,123,398**	**2,515**	**161,390**	**173,788**	**333.81**	**300.29**	**8.38**

The actual per unit cost of all phases was less than planned with the greatest reduction occurring in Phase Three. Phase Four is ranked first in terms of cost effectiveness, although the duration of the fourth phase was short relative to the other phases. If this phase would have been extended to 24 or 36 months, the actual ratio of Per Unit Cost would have exceeded LE 226.15. As for Phase One, it had the highest actual ratio of Per Unit Cost for beneficiary, since this phase had the highest expenses from the large number of personnel working for the project at the Egyptian Family Planning Association and MOHP.

Annex 4. Bank Inputs

(a) Missions:

Stage of Project Cycle	No. of Persons and Specialty (e.g. 2 Economists, 1 FMS, etc.)		Performance Rating	
Month/Year	Count	Specialty	Implementation Progress	Development Objective
Identification/Preparation				
10/13/1995	*6*	TASK TEAM LEADER (TTL) (1); PRINCIPAL POPULATION SPEC. (1); HUMAN RESEROUCE SPEC. (1); SENIOR DEMOGRAPHIC SPEC. (1); POPULATION AND HEALTH SPEC. (1); INSTITUTIONAL DEVELOPMENT SPEC. CONS. (1)	S	S
Appraisal/Negotiation				
06/30/1996	*3*	TTL(1); PRINCIPAL POPULATION SPEC. (1); POPULATION AND HEALTH SPEC. (1)	S	S
Supervision				
07/24/1998	*3*	MISSION LEADER (1); OPERATIONS OFFICER (1); ECONOMIST (1)	U	U
10/23/1998	*1*	TTL (1)	S	S
11/02/1998	*3*	TTL (1); ECONOMIST (1); SR.POPULATION SPEC. (1)	S	S
10/14/1999	*4*	HEALTH CLUSTER LEADER (1); TTL (1); HEALTH SPEC. (1); IMPLEMENTATION SPEC. (1)	S	S
02/21/2000	*5*	HEALTH CLUSTER LEADER (1); TTL (1); PROGRAM ASST. (1); IMPLEMENTATION SPEC. (1); FINANCIAL MGT. SPEC (FMS) (1)	S	S
06/20/2000	*6*	HEALTH CLUSTER LEADER (1); TTL (1); PROGRAM ASST. (1); FMS. (1); OPERATIONS OFFICER (1); SR. PORTFOLIO MANAGER (1)	S	S
03/23/2001	*4*	MISSION LEADER (1); TTL (1); FMS (1); OPERATIONS OFFICER (1)	U	S
03/16/2003	*2*	TTL (1); IMPLEMENTATION CONS. (1)	S	S

	08/31/2003	*8*	HEALTH SECTOR MANAGER (1); MISSION LEADER (1); TTL (1); LEAD IMPLEMENTATION SPEC. (1); PROJECT MGT. CONS. (1); IT CONS. (1); FMS (1); TEAM ASST. (1)	S	S
	11/15/2003	*5*	MISSION LEADER & TTL (1); PROJECT MGT. CONSULTANT (1); IT CONS. (1); M&E CONS. (1); PROGRAM ASST. (1)	S	S
	06/30/2004	*6*	TTL (1); PROJECT MGT. CONS (1); SENIOR FMS (1); COMMUNICATION SP (1); M&E CONS. (1); PROGRAM ASST. (1)	S	S
	06/06/2002	*5*	TTL (1); LEAD IMPLEMENTATION SPEC (1); SENIOR FMS (1); HUMAN RESOURCE DEVELOPMENT CONS. (1); TEAM ASST.(1)	S	S
ICR			TTL (1); PUBLIC HEALTH SPEC.; (1) IMPLEMENTATION CONS. (1); COMMUNICATION SPEC. (1); M&E CONS. (1); PROGRAM ASST. (1)	S	S

(b) Staff:

Stage of Project Cycle	Actual/Latest Estimate	
	No. Staff weeks	US$ ('000)
Identification/Preparation	28	115
Appraisal/Negotiation	30	120
Supervision	114	278
ICR	18	36
Total	190	549

Annex 5. Ratings for Achievement of Objectives/Outputs of Components

(H=High, SU=Substantial, M=Modest, N=Negligible, NA=Not Applicable)

	Rating
☐ *Macro policies*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Sector Policies*	○ *H* ● *SU* ○ *M* ○ *N* ○ *NA*
☐ *Physical*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☐ *Financial*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☐ *Institutional Development*	○ *H* ● *SU* ○ *M* ○ *N* ○ *NA*
☐ *Environmental*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
Social	
☒ *Poverty Reduction*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☒ *Gender*	○ *H* ● *SU* ○ *M* ○ *N* ○ *NA*
☐ *Other (Please specify)*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*
☐ *Private sector development*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Public sector management*	○ *H* ● *SU* ○ *M* ○ *N* ○ *NA*
☐ *Other (Please specify)*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*

Annex 6. Ratings of Bank and Borrower Performance

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HU=Highly Unsatisfactory)

6.1 Bank performance	*Rating*			
☒ *Lending*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Supervision*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Overall*	○ *HS*	● *S*	○ *U*	○ *HU*

6.2 Borrower performance	*Rating*			
☒ *Preparation*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Government implementation performance*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Implementation agency performance*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Overall*	○ *HS*	● *S*	○ *U*	○ *HU*

Annex 7. List of Supporting Documents

1. Staff Appraisal Report for Arab Republic of Egypt Population Project, February 26, 1996 (Report No. 15046-EGT)
2. Development Credit Agreement for Egypt Population Project: Credit Number 2830 EGT
3. Aide Memoires/Memorandum of Understanding, Back-to-Office Reports, Project Status Reports, Implementation Status Report, Procurement Post Review Report, Official Correspondences
4. Project Progress Reports from PIU and SFD
5. Egypt Population Project Quality Enhancement Review: Panel Report, May 2003
6. Family Planning in Egypt, A Sound Investment: Summary Report of The Cost-Benefit Study of Family Planning in Egypt by National Population Council and Rapid IV, July 1994
7. The Egyptian Family Planning Success Story by National Population Council and Options II Project, September 1994
8. Egypt: Recent Changes in Population Growth. World Bank Human Resources Development and Operations Policy Working Paper by S. H. Cochrane and E.E Massiah, February 1995
9. Summary Report Documentation of Egypt Population Project Activities and Extraction of Lessons Learnt. Prepared by Center For Development Studies June 2005.
10. Implementation Completion Report Egypt Population Project. Prepared by Khaled El-Sayed Hassan, PHD, for MOHP, August 2005.
11. Analytical Report Baseline and Final Surveys-Phase 2. Prepared by Ayman Zohry, American University in Cairo for the MOHP Population and Family Planning Sector, Egypt Population Project. March 2005.

Additional Annex 8. Government's Project Evaluation Report

Introduction:

This report presents a detailed analysis and discussion to the information and observations delivered from the field visits; it's relation with the project's documentation and reports; the main points of weakness and strength in the implementation of the subprojects, in addition to the recommendations and suggestions.

1.1. Objectives of the report:

This is an analytical report highlighting the following:

1. The efficiency and effectiveness of subprojects implementation, and measurement of outputs and effects.
2. Lessons learnt during the implementation process.
3. Advantages and disadvantages of the models used for the implemented subprojects as a new approach for increasing contraceptive prevalence.
4. Problems encountered within the supply side related to service quality, which may affect the demand on family planning services.
5. The MOHP's capacity to play the lead role in the population sector and recommendations for more enhancements.

1.2. Methodology:
A qualitative approach was applied in collecting the main information for evaluation. The other supplementary quantitative data and information were deduced from the project documents, subprojects achievement documents, records, field observations and other conducted researches and studies.

1.3. Sampling:
The subprojects were implemented in four phases I, II, III and IV of the EPP. Three subprojects have been implemented in phase I, 11 subprojects implemented in phase II, 23 in phase III and 18 in phase IV. These subprojects are carried out by 105 NGOs and implemented in 8 governorates, namely Giza, Fayoum, Beni Suef, Menya, Asuit, Sohag, Qena, and Aswan. A random sample of one-third of all subprojects was selected representative for the 8 governorates and the four phases of the project.

1.4. Tools of Gathering Information:
The consultants depended mainly on field visits for gathering the required information. For this purpose, the following data collection activities were conducted:
1. Structured interviews to gather information from the professional service providers (physicians and nurses).
2. Open and structured interviews with the subproject's directors, Social Change Agents SCAs (*Morshedat* and *Moshrefat*), community leaders, and NGOs board members.
3. Open and structured interviews with the representatives of MOHP and SFD at the subprojects locations.
4. Open and structured interviews with the representatives of MOHP and SFD at central level.
5. Focus group discussions to collect the required information from beneficiaries of the subproject.

Part "A" of EPP

2.1. Improving the Quality of Services:
Many steps were taken to improve the level of family planning services provision. We can summarize these steps in the following:
- Upgrading the equipping of family planning clinics in subprojects locations.
- Training health workers (Physicians and nursing) on services provision and client/provider interaction.
- Provision of family planning methods.

The majority of *beneficiaries* in approximately all subprojects, over all phases, reported an improvement in the level of clinics equipment, cleanliness, furniture, waiting places, availability of family planning methods, and the client/provider interaction. This improvement occurred during subprojects' implementation and had a great impact on increasing the numbers of clients.

"Yes, all family planning methods are available, and will find somebody for counseling".

"I have a follow up record, my name is recorded, and they ask about me when I am not attending".

"Yes, there is upgrading in the equipment. Before, there were no equipments for measuring blood pressure, ultrasonic. Now all the equipments are available, and there is a care from the physician and Moshrafa".

"Good and cheap treatment".

The *services providers* explain that the improvement in the level of equipment, cleanliness of clinics, and the availability of waiting places reflected in increasing the numbers of clients, either for family planning services or advice and counseling.

2.2. Benefits of Improving the Services Provision:

In investigating the *physicians'* views about the impact of improving the level of clinics' equipment on facilitating their work, they mentioned that, it gives them the trust and help in accurate investigation. They added that the ultrasonic helps in determining the sex of fetal, which is reflected in increasing the attendance to clinics and improving the level of services. The improvement in client/provider interaction has an observed impact in creating a kind of understanding and mutual trust among them, which facilitates more the work, and created a sort of acceptance to their advices and recommendations.

Many *nurses* said that, the strong relation with clients, the good training on all methods especially the new methods, and the generosity of method mix has a significant return on the attendance of clients to clinics.

Developing and upgrading the clinics, availability of the commodities, and the low cost of the methods and services have resulted in increase in the number of clients, and, consequently, increased the Contraceptive Prevalence Rate (CPR). More than half of beneficiaries showed a good awareness of reproductive health issues, such as importance of Tetanus Anti toxin and screening for hypo thyroidism, follow up during pregnancy and after delivery, and neonatal care. In addition, some of beneficiaries demonstrated good knowledge about the usage and side effect of some modern contraceptive methods.

This is also reflected in the results of pre and post surveys, done by PIU at MOHP, in the locations of phase II and phase III subprojects. The surveys indicated that CPR achieved an observed increase in all subprojects' locations, however, the CPR in the subprojects' locations at the governorates of Sohag and Assiut is still less than 50%.

2.3. Improvement of Services Provision and Unmet Need:

The *beneficiaries* explained that, the improvement in the level of equipment attracted them and many other women in the subprojects' areas to attending the family planning clinics. Some *beneficiaries* indicated the change in their attitude and behavior toward family planning after the subprojects' implementation. Also, some beneficiaries reported similar experience of some relatives and neighbors.

In investigating the *nurses'* views in this regard, they referred to a lack in family planning methods, and counseling services as the reasons behind unmet need, before the subprojects' implementations. After the subprojects' implementations all methods, medical care, advice and

counseling are available. The availability of methods, medical care, advice and counseling has a great impact in meeting the need of the majority of women.
No quantitative measures could be obtained about the size of unmet need in the pre and post surveys. Nevertheless, it can be concluded that a reduction in the unmet need was occurred during the periods of subprojects' implementations. This is clear in the replies of many of *beneficiaries* in the focus group dissections. Most of those replied indicated a shortage in methods supply and medical counseling before the subprojects' implementations. Most of women used to go to pharmacies or relatives to get the information. After the implementation of subprojects, all contraceptive methods and counseling are available. This new situations must had an impact in meeting the needs of many ladies at the subprojects locations.

2.5. Phasing-out and Sustainability of Quality Services:
Despite the satisfaction observed among beneficiaries regarding the level of services, and relation with services providers, the majority of the respondents reported that the phasing out of subprojects' funds is leading to deterioration in the quality of services compared to the subprojects lifetime.
Although many of such subprojects introduced sustainability plans, but the only component that received a sort of planning to be sustained, is the small loans component. As for FP/RH service quality, no sustainability plans were observed in the communities.

> *"The doctor comes once every 15 days".*
>
> *"The (Morsheda) used to visit us once every month, now one time every two months".*

The evaluation study also showed that the rapid turn over of service providers had a negative impact on the performance of EPP. This is not restricted on service providers only indeed. This is also valid on the high-level administration, subprojects' mangers, and health and population directors at the governorates as well.

<u>Section III</u> Part "B" of EPP:

3.1. Introduction:
PAP subprojects under Part (B) of EPP operated through the provision of grants to local NGOs for carrying out specific activities to stimulate demand for family planning and smaller family size, mainly in rural areas in Upper Egypt with unfavorable demographic indicators.

3.2. Components of PAP subprojects:
The implemented subprojects involved different types of activities aims to achieving developmental improvement in the economic, social, and cultural status of families in the locations of subprojects, and consequently achieving qualitative improvement in family planning services.

- Micro credit component: directed to women in the locations of subprojects, aiming to achieve gradual improvement in the economic level of families; and enhance women's responsibilities and upgrade their status in their families.
- Women's clubs and illiteracy eradication component: established in subproject locations, aiming to eradicate illiteracy and enhance capacities through training on some small crafts.
- Home visits and Communication for Behavior Change (CBC) component: aims to enhance the awareness and knowledge of population issues in the subprojects' communities and answer to

many social and cultural issues, which remain as obstacles in achieving reproductive health goals. The implementation of this component required to establishing a network of Social change agents SCAs (Morshedat/Moshrefat).

- Training component: targeting the supervisory teams, social change teams, and services providers staff at the subprojects level to develop their skills and to achieve better family planning and reproductive health services.

3.3. Subproject Management :

The NGO's *subproject management teams* received several training programs on all the activities and responsibilities of managing the subprojects. The training programs had an affective impact on raising the administrative skills of the teams and it were very helpful for them to carry out their responsibilities with an adequate level of performance.

Many of *subproject management teams* interviewed indicated that they gained new skills through the training programs such as:

- Project management skills: planning, problem identification, decision making, teamwork, performance evaluation, reporting.
- Financial management skills: of micro credit schemes, accurate methods of documentation and auditing' management, and perfect documentary cycle.

Despite the benefits gained from these training programs, some representatives of the managerial units of the project indicate that, the returns of these training programs was weak, since there is no clear systems for applying these skills.

Another shortcoming of these trainings was in the field of subprojects' sustainability after the end of the funds. Reviewing the sustainability plans, it is clear that all the subprojects' sustainability plans depend on the micro credits scheme as the major component of sustainability. Most of subprojects' sustainability plans tended to increases the interest rate of the small loans from 7% to 12 or 13% and reducing the size if not totally elimination other subproject components, to face the administrative and managerial costs. Non of these plans emphasized any other financial source for sustainability, which reflects the great need of these *subproject management teams* for more training in special fields such as, fund raising, self finance, and sustainability of the projects.

3.4. Role of the Social Change Agents (SCAs):

The network of *SCAs* proved to be one of the most effective components of the EPP. This network represented the strongest factor attracting women to FP/RH clinics. The network, thus, contributed significantly to achievement of one of the principal EPP goals; that is increasing demand for family planning services. In remote and deprived areas, the *Morshedat* and *Moshrefat* are now regarded by the inhabitants as the reference persons who can provide counseling about any aspect of family planning and reproductive health.

Reviewing project's documents, it was found that the SCAs have executed 3,526,137 home visits, organized 1,734 health education seminars, helped 9,320 families to get micro credits, and attracted 5,640 illiterate women to be enrolled at illiteracy eradication classes.

The rate of change in CPR, during the time passed between the pre and post surveys of phase II subprojects (September 2002 - December 2004) is estimated to be 13% in Sohag, and 12% in Assuit. In phase III, there has been an increase in CPR by 18%, achieved by the subprojects implemented in Menia. This represents significant increase in areas that were always described as reluctant to family planning.

3.4.1. Selection Criterions of SCAs: The criterions adopted for selecting the *SCAs* in phase (I) were not quite appropriate. They were selected based on the education level, regardless of their cultural background, or readability to act in FP/RH related areas. A corrective approach of selection was adopted in the following phases. However, for building such a network in the future, selection must be based mainly on the desire to work in developmental and voluntary social works, and ability to convince people of new ideas.

3.4.2. Training of *SCAs:* *SCAs* received adequate training programs in the form of basic training once recruited and refresher training later on in the subproject's lifetime. Trainings covered the topics: dimensions of the population problem, reproductive health, family planning services and methods, how to negate and controvert rumors, how to pay home visits, female circumcision, some gender discrimination issues, reporting and record keeping, social marketing, community mobilization, communication and counseling. Both basic and refreshing training programs include applied practices.

Nevertheless, some of the SCAs themselves, and community leaders as well, reported that, SCAs are still need to receive training on the following areas: local communities' needs assessment, monitoring behavior change, first aids, communicable diseases, female genital mutilation, gender issues and reproductive rights, early marriage, marriage of relatives, and pre-marriage examination.

The *Moshrefat* need to receive more training on how to monitor and evaluate performance of the *Morshedat*. They also need to be qualified enough to provide TOT.

3.4.3. SCAs and the Changes in Behaviors and Attitudes: Almost all the beneficiaries interviewed in the field reported that SCAs are their main source of knowledge about legal and reproductive rights, importance of education to families and the children, and necessity to receive ante- and post-natal care. Some of the clients said that the *Morshedat* were visiting them during pregnancy and reminding of the dates of vaccination. They talked to them about the breastfeeding, childcare and reminded the mothers of the dates of immunization of their babies.

Many of the women who got micro credits said that the *Morsheda* helped them in finalizing the procedures, and in establishment of their small projects.

> *"During her visits to me at home, the Morsheda used to talk about importance of breastfeeding for the baby, and when to start giving him supplementary food".*
> *"I have two girls, and I intended to get them circumcised. When the Morsheda talked to me about female circumcision, I changed my mind".*
> *"My husband was rejecting family planning. The Morsheda sat with him and explained everything. Then his attitude was changed".*
> *"The Morsheda solve many problems. I tell her about my own secrets. She comes to my home, sits on the ground, and stay chatting with me. She's like my sister, even more..."*

Service Providers reported that the number of clients is steadily increasing due to the efforts of the SCAs and that the efforts of *Morshedat* have extended to include the husbands and the whole family. They added, men are now careful to attend the seminars organized in the villages on FP/RH issues, and they are encouraging their wives to attend adult education classes, to attend women clubs, and to get loans for small projects. The economic value of children in our village,

said the *nurses*, is being changed due to trials of the *Morshedat* and *Moshrefat*.
MOHP and SFD Staff at the central and district level as well perceive the network of SCAs as one of the most effective components of the subproject**.** Their efforts resulted in an improvement in child immunization rates, an increase in the use of family planning, enrollments in adult education classes and the success of the micro credit schemes.
Leaders of the community visited reported that the SCAs exerted good effort to change attitudes of the families towards female child, and to assure the duty of wives in supporting their husbands economically. Women participation in local elections has increased due to activities of this network.

3.4.4. Attitudes and Behaviors Still Need to Change: Community *leaders* and *service providers* met in the field highlighted the following areas that need more intervention:
- Harmful practices against women; namely circumcision.
- Influence of mothers-in-law in the decisions related to family size.
- Husband's rejection that his wife receives the service by a male physician.
- Early marriage, Marriage of relatives, Rare practice of pre-marriage examination.
- Poor usage of male contraceptives.
- High frequency of unwanted pregnancies.

3.4.5. Recommendations for Sustainability of the SCAs Network: Discussions and revision of the sustainability plans, showed difficulty of sustaining all the SCAs after the phasing-out of EPP fund. Sustainability plans prepared by the NGOs implementing the subprojects depend mainly on the recycled loans, with an increase in the rate of interest. This increase is required to cover the costs of running and administering the loans. In light of theses new circumstances, the total number of SCAs is expected to be reduced to 25% of its current size. This can jeopardize the results achieved by the project, and recession in the attitudes and behaviors corrected is highly expected. Some evidences showed fallback in the CPR after the end of phase I subprojects to its original rates at the beginning of the project.
An alternative way to maintain the network of SCAs effective, its administrative reliance and financial dependency is recommended to shift to the newly established general department for NGO support, at the MOHP. SCAs can replace the traditional body of *Raedat Reefiat*. Records utilized in monitoring and evaluating performance of the SCAs can be consulted if it is inevitable to reduce the total size. Better and most active members can be easily defined and appointed within the organizational structure of this NGO department and its branches in the governorates. The selected members can work for the department and receives some incentives based on their performance. Population department of the SFD can support this system as part of its population-related activities.

3.6. Innovative CBC Approaches:
Many of processes were done to activate the CBC program; it can summarize in the following:
- Preparing a training syllabus on Communications for Behavior Change (CBC).
- Preparing a manual of partnership in the field of CBC.
- Many workshops to identify and train workers on CBC activities were implemented.

The field visits and the interviews with the beneficiaries, services providers, and the supervisory teams of subprojects showed that, CBC program has a positive impact, leading to changes in the

behaviors and attitudes of local community.
Although the CBC activities are noticed to have appropriate objectives and contents, but further analysis is recommended to determine the main points of weakness and strength in CBC activities to be modified or reinforced.

3.7. Monitoring and Evaluation (M&E) Systems:

Several tools for monitoring and evaluation were applied in the subprojects. Reviewing samples of M&E reports from different locations and phases of EPP project, it was observed that the reports were prepared according to pre-designed formats.
Majority of the subprojects managers regarded the monitoring tools as relevant and satisfactory ones. They also see the evaluation indicators as suitable to the output of the subprojects' activities.
The M&E tools utilized depend, to a great extent, on quantitative indicators rather than the qualitative. For instance, no indicators were observed for assessing the changes in client behavior, other than the CPR. No indicators to assess the reasons of this change if any. In addition, no indicators to determine the main points of weakness in the implemented activities, especially for direct CBC activities.
Monitoring of *Morshedat'* work was the weak link in the evaluation and monitoring system. Efforts paid in facing resistance expected in rural communities are ignored. The current reporting system doesn't reflect the extent of change in the behaviors and attitudes of target women.
However, some new improved indicators, developed lately by the Monitoring and Evaluation Consultant are observed to be more suitable for the project activities. The *subproject management teams* should receive training on these developed indicators and how to measure it correctly
.

3.8. Subprojects Design:

Several factors have contributed to the population problem in Egypt and should be tackled simultaneously. Some of the factors include lack of support to the Family Planning services and awareness of the importance of the relationship between Family Planning, the available methods and the social level. Ignoring the various dimensions of the problem will not achieve the desired goals.
The theoretical idea behind the implemented subprojects under the EPP was the new integrated health and development approach in dealing with the population growth problem in Egypt. Such projects are able to create an increasing demand on family planning services through dealing with many of economic, educational, health and cultural aspects.
It is clear that the above-described model was applied in the four phases of EPP, with some variation regards the size of target societies, type of the partner NGO (either family planning association or community development association).
Despite the same concept the main differences between the various phases came in the implementation arrangements. Accordingly, we can conclude that, the subprojects of latter phases are better designed than their priors two phases.
The main components of the subprojects are:

- Micro credit component.
- Illiteracy eradication component.
- Communication for Behavior change (CBC) component.

- Women' clubs component.
- Training (of services providers – outreach - the supervisory teams) component.

From the majority of beneficiaries' views, the economic entrance through the small loans is ranked first as the most affective components in attracting them to other subprojects' activities. It followed by seminars and communication for behavior change activities. It is clear that SCAs played an important role in attracting women of local societies to the subprojects' activities. The good implementation of these two components had a great impact in increasing the women knowledge and participation in the subprojects' activities, including family planning and reproductive health services. There is no doubt that, the sustainability of these activities and the probability of achieving more success in increasing the participation of women, will depend in great extent on the sustainability and continuity of SCAs jobs and activities, with the same level of coverage, quality and performance.

"We bought two sheep with the loan, we took care of them until they grew up, then we sold them and gained double of their price".
"We bought materials with the loan; we sew and sold it as school uniforms".
"Yes. I took a loan and bought a cart. I worked on it with my husband. It covers the house expenses".
"The Morsheda, is the one who guided me to the small loans, we found something to do. It take me away of thinking in more kids, in addition, it increased the family income".

Many other beneficiaries reported that illiteracy eradication classes are the third most important component. They had an effective impact in increasing the awareness of women, and it, consequently, reflected in increasing the demand on family planning services.

"Before subproject, I could not read or write; now I write my name and my father's name. Even my old mother, she is attending the illiteracy eradication classes recently. Women become more aware of and know about family planning services".

Awareness seminars and communication for behavior change activities are ranked third as the most important components of the subprojects. They expressed its role in increasing the awareness with family planning methods and some of reproductive health components. More than half of interviewed ladies showed a good knowledge of different types of family planning methods, the possible side effect of some methods, and the usage procedure. They also explained good knowledge with some of reproductive health components such as, follow-up during pregnancies, maternal and child health, and the follow-up after delivery.

Some of the beneficiaries referred to the importance of women's clubs in increasing the family income through the women's acquirement of useful and income- generating skills, such as sewing.

The interviews with beneficiaries showed the needs for more awareness and communication programs, since many of the external effects on the couple's decision of family planning practice still exist. These external effects represents in the authority of mothers-in-law and their desires in extended families.

In general, it can be concluded that, all the subprojects' components are important in achieving the integrated health and developmental goals. Ignoring any of these components will lead to lower developmental achievements in one or more of the social, economic, cultural, healthy, and capacity building objectives.

3.9. Subprojects Implementation:

An accurate population database has been developed to identify deprived areas as for family planning and reproductive health (FP/RH) services and with higher fertility indicators.
Active NGOs working in population or population-related fields in these areas were identified. These NGOs were encouraged to prepare project proposals and submit them to the SFD. The NGOs received technical assistance from the regional offices of the SFD before and while drafting these proposals.
Then, these proposals were then sent to the relevant committees for their appraisal and contracting procedures.
Nevertheless, the long time period between the selection of the areas and the actual implementation of the subprojects is a disadvantageous point. Due to the delay in starting the projects and funding their activities, the lifetime of some subprojects has been shortened to 18 months instead of 3 years. This short lifetime is not quite enough to achieve the target goals of a project aims at improving the demographic characteristics of a certain community.
In addition, there has been a delay in activating the roles of the Executive and Governorate committees.

3.10. Subproject Models

Phase One

During this phase only one project out of the three implemented by the Egyptian Family Planning Associations of Sohag, Qena and Aswan, achieved sustainability and from this stems the importance of this phase. The following phases were altered according to the changes and observations that occurred during the implementation of this phase.

Phase Two

This phase witnessed the execution of 11 projects by 11 Community Development Associations. During this phase, mobile clinics, incentives and competitions were presented to beneficiaries to motivate them and seminars were held disseminate awareness about the family planning issues.
This phase was proven replicable and could be applied and accepted at any community level. Sustainability necessitates the provision of resources material, and human especially those trained on health issues.
The membership system did not accomplish the desired outcome and therefore was not implemented during the fourth phase. One of the reasons for such a failure was the absence of a mechanism to collect the membership fees from the beneficiaries. The National Identification Card was an important motivation for beneficiaries across all projects to participate in the project's activities. The association played an important role in motivating the doctors and this increased the potential to reach a large number of beneficiaries.

Phase Three

MOHP was a sponsor as well as an implementing partner during this phase. The projects were implemented in seven governorates and included 23 sub-projects implemented in partnership with the SFD, MOPH, and CDAs.
At this stage, the project reached maturity with the partners expertise put into action and the project expanded to reach seven governorates.
Holding dissemination conferences at the initial phases of the project was important to introduce the project to the local community. Inviting members from the community and especially religious leaders and gaining their support facilitated the promotion of the services and influenced the target group.

The number of projects was relatively higher at this phase, while the SFD administrators were few in number; which made it difficult to monitor and supervise the projects.

Phase Four

The sub-projects at this phase included support for reproductive health services, family planning and reduction of population growth rate, increase awareness of mother and child health care, family and population development.

The implementation has three pivotal stages: Planning, Preparation, Implementation

An important point of strength at this phase is the increase in the number of reproductive health service providers which reached 68 associations representing six times the number of associations participating during the second phase and three times the number of associations participating during the third phase. It is worth mentioning that at least 93% of these associations were entering the reproductive health field for the first time.

These associations were managed by larger more experienced "umbrella" NGOs. The sub-associations are located in the same area of the implemented projects and are in direct contact with the beneficiaries. This facilitated their performance and helped them provide direct support.

Some umbrella associations are experienced and can exchange know-how with sub-associations.

The participation of a large number of associations encourages competition between them which will eventually lead to the improvement of the overall performance of the associations.

The financial structure assisted in reaching the beneficiaries in as little time as possible.

3.11.Roles

Regional Offices of the SFD:

Regional offices of the SFD performed the tasks of i) selection of target communities, ii) assessment of the active NGOs, and providing technical assistance for them in writing proposals of their projects, iii) submitting valid proposals to the relevant committees approval, iv) monitoring implementation and progress of the subprojects, v)reporting to the head office on the subprojects' activities.

Ministerial Executive Committee (MEC):

H.E. the Minister of Health and Population issued the decree No. 276 in 2003 for the construction of a ministerial executive committee for the EPP to i)formulate comprehensive policies for the PAP, ii) issue final approval of the subproject proposals, iii) develop determinants and broad outlines for the financial policies of the small-scale projects (SCPs) and the developmental projects that will be implemented, iv) monitor activities of the subprojects, and evaluate to what extent outcome of theses activities meet the target goals and objectives.

The committee has had an effective role in the improving the project's performance, particularly at the late stages.

Governorate Steering Committees (GSCs):

A steering committee in each of the selected governorates was established according to the ministerial decree No. 279 in 2003 to i) review subproject proposals and make sure that the proposed project are consistent with the governorates population policy, ii) conduct semi-annual revision of the financial status of the subprojects being implemented, iii) provide the support required to the organizations implementing the projects, iv) submit semi-annual reports to the MEC on the working subprojects and the proposed ones as well.

Project Implementation Unit (PIU):
The PIU has played, and still playing, an important role in implementing the subprojects, and helped them to achieve the target goals and objectives. PIU successfully finalized the contractual procedures for the upgrading of the clinics the relatively recent medical equipment and supplies. Due to the gained experience in bidding and contractual negotiations, the unit could save lots of budget allocations.
In addition, PIU has managed the contracting with training consultants in various areas: service providing, CBC, as well as training on conducting field surveys and data collection and management. PIU also managed the contracting procedures with evaluators, and analysts.
PIU made better use of Part "A" resources, and supported the implementation of the projects of Part B.
There is a consensus of the persons met before drafting this report that PIU has performed its role perfectly. Documents reviewed also support this conclusion.

Population Department of the SFD:
Population Department of the Social Fund had a sound contribution in the design of the subprojects, and in monitoring the phases of their implementation. The department also monitored the financial procedures, and provided technical support for the subprojects.
Most of the respondent to the field survey praised the role of the Population Department of SFD, and described this role as an effective and efficient one.
Other respondents appreciated the technical assistance provided by the department to the subprojects, and the precise follow-up and monitoring paid to the subprojects.

3.12. Long-term Mechanism for Collaboration Between MOHP and NGOs:
EPP has enhanced the collaboration between the MOHP and the SFD, and created a long-term mechanism for collaboration of MOHP and the NGOs. To enhance this cooperation, a general NGO department was developed and integrated within the organizational structure of the population and FP sector of the MOHP.
Awareness needs to be developed, to advertise the responsibilities and objectives of this department to the organizations and individuals involved in population-related activities.
The department itself needs to have effective communication means with the NGOs working in population, RH, and FP related activities. It needs to establish a database on all the NGOs working in the field, and capabilities of each one.
During the field interviews and group discussions, some MOHP and NGO staff suggested that this general department must have branches in each governorate, so that it can easily cooperate with the large number of NGOs. The suggested branches are also recommended to conduct community needs' assessment, and act as connection point between the NGOs and the General Department. Activation of the roles of such branches will facilitate also the donors' activities, and will help the developmental agencies in assessing the needs of local communities.
Many of the respondents to the field interviews assured that the role of MOHP versus that of the SFD is quite clear. MOHP has committed to provide quality FP and RH services to the areas in which EPP subprojects are being implemented. MOHP also had the lead role in improving the conditions of the clinics, equipping them with medical supplies, and in training the service providers.

Respondents to the field interviews claimed that the SFD has successfully exchanged its experience in dealing with NGOs to the Population and Family Planning Sector of the MOHP.
More specific, loan management and adult education activities were that most sound experiences that MOHP has gained from the SFD. Integration of developmental projects into FP/RH programs is shown to be effective enough to achieve the targeted goals.
Egypt Population Project is seen by most of the respondents as an outstanding mechanism for cooperation between SFD and MOHP, and the positive results of this cooperation are quite obvious, thus they claim. All the respondents hope that such cooperation will continue after the phasing-out of EPP fund.

3.13. Cost Effectiveness Analysis

Among the different techniques to measure Cost Effectiveness, Per Unit Cost has been found the most suitable for the purposes of EPP. It is generally used to measure the effectiveness of projects which outcomes has not direct financial value. This technique is used on two levels:

- A comparison between the intended/expected and actual unit cost in one project.
- A comparison between unit costs of different but similar projects.

The Unit Cost Ratio of EPP has been measured by selecting a sample of 16 out of 54 developmental projects. The projects have been selected from the four different phases as follow: two projects from phase one; four projects from phase two; seven projects from phase three; and four projects from the fourth phase. An average Per Unit Cost Ratio has been calculated for the whole project.
According to the Cost Effectiveness Analysis, the following has been deduced:

- Planned/expected ratio of Per Unit Cost for the service model of Phase One is LE 343.83, while the actual ratio of Per Unit Cost decreased by 2.6% to reach LE 335.
- Planned/ expected ratio of Per Unit Cost for the service model of Phase Two is LE 268.99/beneficiary. This ratio decreased during implementation by 10.1% to reach LE 241.74, thus this phase could be described as cost effective.
- In the third service model that has been applied during the third phase, the actual ratio of Per Unit Cost for each beneficiary dropped by 24% to reach LE 296.39 compared to the planned/expected ratio of Per Unit Cost which was LE 389.76. This phase witnessed the highest decrease between the planned/expected and actual Per Unit Cost for beneficiary.
- The Unit Cost per Beneficiary Ratio also dropped by 13.03% during Phase Four from 249.53 to 217.01 for each beneficiary.
- During the four phases of the project, the cost effectiveness per beneficiary ratio decreased with varying rates. However Phase Three is the most cost effective with the largest difference between the planned/expected and actual Per Unit Cost for beneficiary.

When comparing the actual beneficiary cost ratio through the four phases, we will find that Phase Four should be ranked first in terms of cost effectiveness, since it is the least costly for each beneficiary with a Per Unit Cost of LE 217.01. This is only due to the fact that the duration of the fourth phase was very short compared to the other phases, only 12 months. If Phase Four has extended to 24 or 36 months, the actual ratio of Per Unit Cost would have definitely exceeded LE 217.
Furthermore, In Phase Four each umbrella association had to have two managers, two accountants, a Group Manager, a Project Manger, a Group Accountant, and a Project Accountant. This would definitely contribute to raising the cost of each project. However, this

administrative structure facilitated the role of monitoring and supervision of the SFD.

Providing the financial structure through the umbrella association and the sub-associations has helped in the rapid and wide dissemination and outreach of the service to the beneficiaries. Thus, the actual ratio of Per Unit Cost for beneficiary's efficiency elements includes reaching out beneficiaries in the least time possible.

The service model of Phase Two ranks second after Phase Four in terms of cost effectiveness, followed by the service model of Phase Three, and finally the service model of the Phase One. We can deduce that the ratio of Per Unit Cost in Phase Three was lower than Phase Two due to the fact that each of the Murshedat in Phase Two was targeting 65 beneficiaries, whereas in Phase Three the Murshedat were targeting only 50 beneficiaries.

As for Phase One, it has the highest actual ratio of Per Unit Cost for beneficiary; this is due to the fact that this phase had the highest expenses resulting from the large number of personnel working for the project at the association and MOHP. Furthermore, the preparation of the health clinics and buying a mobile clinic cost LE 700,000 thousands, plus the high expenses spent on improving the medical centers and the high operational expenses in general.