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DEVELOPMENT OF HEALTH SERVICES - SYRIA

276-11-570-006

PROJECT PAPER (PP)

Development of Health Services - Syria

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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE ("X" appropriate box)
[X] Original [ ] Change [ ] Add [ ] Delete

PP

DOCUMENT CODE 3

2. COUNTRY/ENTITY: SYRIA

3. DOCUMENT REVISION NUMBER:

4. PROJECT NUMBER: 276-11-570-006

5. BUREAU: a. Symbol: NE; b. Code:

6. ESTIMATED FY OF PROJECT COMPLETION: FY 79

7. PROJECT TITLE - SHORT (stay within brackets)
[Development of Health Services]

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION
a. INITIAL mo. 6 yr. 76 b. FINAL FY 78

9. ESTIMATED TOTAL COST ($000 or equivalent, $1 = 3.90)

a. FUNDING SOURCE	FIRST YEAR FY____ b. FX	c. L/C	d. Total	ALL YEARS e. FX	f. L/C	g. Total
AID APPROPRIATED TOTAL	400		400	749		749
(Grant)	(400)	( )	(400)	(749)	( )	(749)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
HOST GOVERNMENT						
OTHER DONOR(S)						
TOTALS						

10. ESTIMATED COSTS/AID APPROPRIATED FUNDS ($000)

a. Appropriation (Alpha Code)	b. Primary Purpose Code	c. Primary Tech. Code	FY 76 d. Grant	e. Loan	FY 77 f. Grant	g. Loan	FY 78 h. Grant	i. Loan	ALL YEARS j. Grant	k. Loan
SA			400		303		46		749	
		TOTALS								
11. ESTIMATED EXPENDITURES										

12. PROJECT PURPOSE(S) (stay within brackets) [X] Check if different from PID/PRP

[To improve the SARG's ability to provide effective health services for those Syrian;s unable to afford private health care and to plan and operate general public health programs.]

13. WERE CHANGES MADE IN BLOCKS 12, 13, 14, or 15 OF THE PID FACESHEET? IF YES, ATTACH CHANGED PID FACESHEET.
[ ] Yes [ ] No

14. ORIGINATING OFFICE CLEARANCE

Signature: Robert E. Ramos

Title: AID Representative, AID Office/ Damascus

Date Signed: mo. 05 day 19 yr. 76

15. Date Received in AID/W, or For AID/W Documents, Date of Distribution: mo. day yr.

AID 1330-4 (7-75)

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT IDENTIFICATION DOCUMENT FACESHEET

TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE (X' APPROPRIATE BOX)
[X] ORIGINAL [ ] CHANGE
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PID
DOCUMENT CODE 1

2. COUNTRY/REGIONAL ENTITY/GRANTEE
SYRIA

3. DOCUMENT REVISION NUMBER
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2760013

5. BUREAU
A. SYMBOL: NESA
B. CODE: 4

6. PROPOSED NEXT DOCUMENT
A. [ ] PRP [X] PP. B. DATE MO. 10 YR. 75

7A. PROJECT TITLE - SHORT (STAY WITHIN BRACKETS)
Health Services

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION
A. INITIAL FY 76 B. FINAL FY 79

7B. PROJECT TITLE - LONG (STAY WITHIN BRACKETS)
Development of Health Training Facilities for Providing Improved Health Services

9. ESTIMATED COST (LIFE OF PROJECT)
($000 OR EQUIVALENT, $1 = IS3.65)

PROGRAM FINANCING	AMOUNT
A. AID APPROPRIATED	4,250
B. OTHER U.S.	-
C. HOST GOVERNMENT	3,000
D. OTHER DONOR(S)	-
TOTAL	7,250

10. ESTIMATED COSTS/AID APPROPRIATED FUNDS ($000)

A. APPROPRIATION (ALPHA CODE)	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE	FIRST YEAR D. GRANT	FIRST YEAR E. LOAN	ALL YEARS F. GRANT	ALL YEARS G. LOAN
			1,250		4,250	
TOTAL			1,250	-	4,250	

11. OTHER U.S. ($000)

A. PROGRAM TYPE	B. FIRST YEAR	C. ALL YEARS
TOTAL		

12. PROJECT GOAL (STAY WITHIN BRACKETS)

To help the Syrian Government improve the delivery of health services, especially to the poorer people.

13. PROJECT PURPOSE(S) (STAY WITHIN BRACKETS)

To assist the Syrian Government's Ministry of Health upgrade the quality of health technician and paramedic training for use in integrated health centers and other health facilities around the country.

14. PLANNING RESOURCE REQUIREMENTS (STAFF/FUNDS)

Approximately two man-months of AID/W TDY services at an estimated cost of $5,000.

15. ORIGINATING OFFICE CLEARANCE

SIGNATURE

TITLE
Acting AID Representative
AID Office/Damascus

DATE SIGNED MO. 06 DAY 30 YR. 75

16. DATE RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MO. DAY YR.

AID 1330-2 (5-75)

B. RECOMMENDATION

It is recommended that this project and funds be approved for improving health services in Syria as follows:

Grant	$749,010
FY 76	399,810
FY 77	302,700
FY 78	46,500

C. POLITICAL/ECONOMIC BACKGROUND

Following General Hafez Assad's becoming President in 1970, the Syrian economy changed direction away from the complete centralization/socialist emphasis to more liberal policies with a better defined role for the Private sector. As a result, [redacted] performance has improved significantly since 1970. This rising [redacted] trend in output was interrupted by the October 1973 war, but the economy almost completely recovered in [redacted] and [redacted] when [redacted] increased by almost [redacted]% and [redacted], respectively, in real terms, as compared with 2% in 1973. [redacted] year between 1970-1975.

The agriculture sector is still key to the Syrian economy. As such, Syria's economy remains highly vulnerable to fluctuations in agricultural output brought about by variations in the amount and timing of rainfall. The SARG is attempting to better manage this problem through the increased use of irrigation, especially in the Euphrates River Basin, which, when completed, will more than double the amount of land now irrigated.

Agricultural exports have been dominated by cotton, followed by wool, tobacco and fruits and vegetables. The major non-agricultural export item in 1975 was crude oil valued at $650 million, accounting

for 55% of the value of all 1975 exports. Syria's import of agricultural items in 1975 more than doubled 1974's imports and consisted primarily of sugar, rice and flour, mostly from France and China, but recently more from the U.S., largely due to the Title I program (rice and wheat).

Recently, there have been significant changes in absolute and relative prices. The GNP deflator indicated a 37% increase in prices in 1974 with an estimated 30 percent increase in 1975, as compared with under 6% per year average inflation during the 1970-73 period. In spite of an improved external balance situation, the import liberalization policies have not so far been used effectively to increase the total supply of resources. These growing inflationary pressures may pose serious problems for the Syrian economy in the future.

Because of continuous trade deficits, a large part of Syria's development expenditures has been funded through external financing or through borrowings from the banking system. Since 1973 particularly, Syria has received substantial commitments of grants and loans from other Arab countries, so much so that there is now little need for the banking system to finance these activities.

Syria's external public debt amounted to $702 million by the end of 1974, and debt services payment on external public debt (excluding military) were estimated at about $60 million. This increased to about $1 billion and $100 million, respectively, in 1975. In view of the improved economic prospects and the relatively low debt service ratio, Syria can service substantial additional debt on conventional terms. However, Syria's gross reserves dropped in 1975

to about $590 million.

The strategy of the new Fourth Five-Year Plan (1976-80) may not differ substantially from the Third Plan, with a concentration on public sector investment in agriculture, irrigation, as well as extractive industries, particularly oil, phosphates and cement. The GDP is estimated to grow by about 8.5 percent per year between 1976 and 1980. This Fourth Five-Year Plan, like its predecessors, includes hundreds of new and ongoing projects requiring funding. However, in the past the rate of execution had not generally exceeded 25-30 percent of planned projects due to the unavailability of foreign exchange, weak project preparation and follow-up procedures and shortages of technicians and skilled manpower. Stronger performance is anticipated for 1975-76, but the implementation rate may still not exceed 40%. One of the current problems continues to be local budgetary shortages for development projects.

Despite its favorable economic position, Syria will continue to borrow abroad to finance development projects. Syria does not yet generate sufficient domestic resources or earn enough foreign exchange through trade to fund the development activities planned. In addition, Syria requires the large-scale injection of modern technology to increase agricultural production and productivity, diversify industry, improve its trade balance and raise the standard of living. At present, this technology must be supplied, in part, from foreign sources.

D. PROGRAM OBJECTIVES

The purpose of the A.I.D. program in Syria is to assist Syria in pursuing its economic development program and to help in

the further improvement of U.S.-Syrian relations and the cause of peace in the Middle East area.

Following the resumption of U.S. economic assistance to Syria in 1975, A.I.D. has worked with the Syrian Government in helping to meet the nation's priority development needs, particularly as outlined in the Fourth Five-Year Development Plan (1976-1980). In FY 1975, the A.I.D. program was financed from the Middle East Special Requirements Fund and totaled $83 million, consisting of a $48 million loan for the improvement and expansion of the Damascus water supply system; a $30 million loan for the import from the U.S. of agricultural and construction machinery; a $4 million grant to finance needed technical services and feasibility studies in essential areas; and a $1 million grant to fund technical training in the U.S. for Syrian Government officials.

In FY 1976, the A.I.D. program is financed from Security Supporting Assistance funds and is estimated to total $80 million. While not yet final, this money is expected to be used for an additional loan of $14.5 million for improvements of the Damascus Water Supply System, a $1.25 million grant for participant training, a loan to finance the construction of the Damascus-Derra highway, a loan for contract services and commodities for Euphrates Basin Maintenance project, a grant for financing the establishment of an English Language Training program, a grant-funded integrated health project and a further grant for technical services and feasibility studies. Plans for FY 1977 and 1978, while tentative at this time, included loans and grants for rural electrification, Euphrates

River Basin development, agricultural research and development, poultry production, general participant training and health.

E. DESCRIPTION OF THE PROJECT (Summary)

This project is designed to [redacted] As indicated more fully in the background section of this paper, the [redacted] through a system of hospitals, [redacted] (e.g., TB) [redacted]. The sy[redacted] The SARG is not unaware of these problems and has asked help from several donors to combat them. WHO is currently working on the problems of manpower and, additionally, in the burgeoning problem area of schistosomiasis in the Euphrates Basin. This project addresses three of the other priority areas which are:

1. Health Planning

While a position currently exists in the MOH titled health planning, in practice, the [redacted] to the requirements of capital budget requests and to immediate and obvious failures in the system. Planning as it is commonly done in the West, with an identification and prioritization of problems,

mobilization of resources, and evaluation of implementation, does not exist.

Since, at present, Syria has no professionally trained health planners or administrators on which to base initial institutionalization of planning, this project will provide a [redacted] full-time advisor for one year, to bridge the gap until a sufficient number of Syrian nationals have been trained and are in place within the ministry system. He/she will act as a counterpart to Ministry of Health personnel in carefully defining the planning needs of the current system and methods to implement a planning system, given the specific cultural factors involved in both the civil service system and within the medical profession. Short-term specialist advice for a total of six man months will be required after specific system gaps are identified. Training for four long-term MPA/MPH participants and eight short-term health administration personnel is intended to leave the MOH with its own planning and management capacity by the end of the project. The output at the end of the project should be an effectively functioning planning unit within the MOH and on a long-range plan concerning future needs and activities in this area.

Because of the small size of the Ministry and the difficulties of introducing a planning system from scratch, the first year of the project will be limited to the full-time advisor housed in the Ministry itself and with full secretarial, office, and internal travel support provided by the Ministry. The exact nature of training required and the specialties of the short-term experts will be determined during the first year of the project.

2. Health Survey

One of the principal reasons that health planning is so underdeveloped in Syria is the complete [redacted] Such data that exists generally comes from a compilation of hospital admission statistics and even there major statistical problems in coding result is unreliable data. It is [redacted] (See appendix B for the detailed survey description)

The principal A.I.D. input will be [redacted] specialist. Additional short-term assistance in data analysis will be provided during the first data analysis phase. Basic field use commodities will also be provided. The SARG will provide statistical staff, programmers, data analysts, field managers, interviewers and necessary printing costs, office supplies, and computer time.

At present, [redacted] of designing successful surveys [redacted] and under pressure to carry out other ongoing surveys. By providing a full-time counterpart and commodities and vehicles specific to this project, sufficient manpower should be mobilized within the SARG to initiate and carry out the first two years of a continuous survey. The information collected in each of the first two years will represent the first such data collected. It is hoped that as the data becomes available, and in concert with the health planning activity described above, the Syrians will continue the survey

after U.S. assistance ends.

The survey will be funded from Ministry of Health [redacted] designed and administered within the Central Bureau of Statistics (CBS), where trained survey staff already exist. CBS has its own computer and should have a later generation model by the time data analysis begins. In either case, needed computer time will be available.

The end of project status will be an ongoing continuous health survey, analysis of the first year's data, and an evaluation of the survey itself. This data will then be used by the new planning unit to formulate its plans.

3. Equipment Maintenance and Repair

Referral care from health centers and primary care in immediate cachement areas is provided free to all Syrians living in low-income areas or carrying welfare cards in urban areas. At present, this care is inferior both because of auxiliary manpower problems (which WHO is currently addressing), non-functioning or misfunctioning diagnostic and treatment equipment, and crumbling buildings. The poor state of equipment, much of which is almost new, is due to a complete lack of organized repair and maintenance. The SARG has requested assistance in salvaging what can still be salvaged and in introducing a preventive maintenance system to protect existing and future equipment investment and thereby improve hospital and health center treatment and diagnoses.

This activity will lead to the development of a centrally managed equipment repair and maintenance system for government hospitals and health centers in southern Syria. The system will be

administered by a unit within the Ministry of Health and will have a central workshop at the Damascus Hospital. An equipped mobile van [redacted] centrally located engineers to handle emergency repairs and special maintenance. A second van will permit an inspector to regularly visit all the hospitals to insure that work orders are being carried out and routine maintenance is being performed.

One U.S. hospital systems specialist will act as a full-time counterpart during the initial two years of the project during which a complete inventory of equipment, the location and translation of repair and maintenance manuals, and the short-term training of the central ministry unit will be accomplished. During the second year the system should begin to function and the U.S. advisor will assist in modifying the system and trouble shooting. The U.S. will provide the two vans and related equipment as well as some equipment for the central workshop.

Since there is no current maintenance and repair system either centrally or in the hospitals themselves, this project will have to both establish the basic system and the Syrian capacity to operate and administer it. By the end of the project the central Ministry of Health staff should be in full control and all hospitals and health centers carrying out regular maintenance work and repair requests. (See Appendix C for the detailed consultants report)

F. SUMMARY FINDINGS

The Syrian public health system is designed to insure adequate medical care for all Syrians. The current structure of service

delivery appears to be both possible and commendable if certain problems currently preventing effective implementation are solved. [redacted] is [redacted] and is implementing its own plans to provide potable water country wide, a sufficient number of physicians and nurses, and a sufficient number of hospital beds. The SARG is also receiving assistance from WHO in the areas of schistosomiasis, nursing education and paramedic education. The activities which A.I.D. is being asked to finance complement this other assistance, and in the case of both the health planning and the health survey activities should enhance the continued improvement of the system.

At present, [redacted] health system are the government civil service salary structure and a reliance on physicians to administer and manage the system. Since government salaries are completely out of line with possible private earnings, physicians and technical personnel generally hold outside private jobs which provide their main means of support. There are [redacted] incentives for physicians to specialize in public health at present. The SARG is aware of this problem and will be addressing it under the health planning activity.

Given the fairly non-complex nature of the project components, the project should be ready to implement as soon as official ratification by the government (approximately four months after the ProAg) occurs.

G. PROJECT ISSUES

There have been no prior issues raised concerning the project. The following issues should be discussed during the PP review.

1. [redacted]

The A.I.D. mission is currently restricted in staff size due to a necessary low profile. There is only one technical assistance officer and he has one PP for 1976 approval, several PRPs in process, and a large number of feasibility studies under the $1.25 million feasibility studies grant. While TDY personnel can alleviate this situation to some degree, the sheer documentation and monitoring requirements will be overwhelming and may result in poor mission control. It is [redacted] that an additional direct hire position [redacted] sought.

2. MOH Implementation Capacity

The Ministry of Health central staff consists of about twenty professionals. While they are hardworking and dedicated, they are already stretched very thin trying to cope with current operations. Any consultants selected would have to be able to be able to operate fairly independently. For this reason, intensive in-country language training may have to be included for long-term consultants. Facilities and costs should be investigated.

3. MOH Budgetary Constraints

The MOH central budget, currently $18 million, is tight and has just been further cut back in an overall government reduction exercise. While this appeared to pose a problem, particularly in the area of salaries and per diems for the large field survey staff, final meetings with the MOH and the Ministry of Plan indicated that the resources would be available.

PART 2. PROJECT BACKGROUND AND DETAILED DESCRIPTION

A. BACKGROUND

The Syrian Arab Republic has a well-established public health

system under the Ministry of Health delivering services at three levels -- hospitals, health centers, and dispensaries. [redacted] P[redacted] population, currently estimated at 75%, a[redacted] eligible by law for free care within the government system. The law provides this free care to low-income families, students, and some labor and civil service groups. In addition, the Ministry of Health is responsible for inspection and licensing of food preparation and marketing institutions and vaccination campaigns.

The Syrian health sector as a whole is difficult to define quantitatively because of the large private component, as well as because of the equally difficult to quantify but significant expenditures for health made by ministries other than the Ministry of Health, particularly the ministries of Higher Education, Education, Defense and Social Affairs and Labor. However, analyses of the 1976 Syrian National Budget shows S.P. 65 million ($US 17 million) allocated directly to the Ministry of Health. Ministry of Health figures show an additional S.P. 140 million ($US 36 million) going to health services in the mohafazats (provinces, of which there are fourteen; one of which, Kenitra, is not under Syrian control). The mohafazat figures are not combined with the Ministry of Health funding in the national budget because they are directly funded from general allocations made to each mohafazat and are under the control of the Director General of each mohafazat rather than the Ministry of Health. Taking these two diverse sets of budget projections, direct public health services related to the Ministry of Health totalS.P. 240 million, or 1·7% of the budget. If the University Hospitals are added, the total becomes S.P. 268 or 1.9% of the national

budget.

While the new five-year (1976-1980) government plan has not yet been published, our understanding is that the principal health objectives are: 1) to increase the hospital bed/patient ratio from 1.2 to 1.8 per 1,000 population; 2) the construction of 19 new health centers (increasing the number from 125 to 145); 3) to provide health insurance for about 2.5 million Syrian inhabitants, and 4) to provide potable water supplies for all villages with greater than 150 population.

Statistics on health facility utilization and population demographic and health characteristics are spotty and often inaccurate. Even the general magnitudes of some statistics do not support common viewpoints as to major causes of morbidity and mortality. The statistics presented below should be interpreted as reflecting existing data rather than as an accurate picture of the health situation.

1. Population Characteristics

The crude birth rate is [redacted]/1000 with a gross reproduction rate per woman of 3.68. The rate of population growth is currently estimated at 3.3 to 3.5%, down from an average of 3.8% in the period 1960-1970. The infant mortality rate is reported at [redacted]/1000 and may be considerably higher due to non-reporting of births and subsequent deaths within the first two weeks of life. Childhood mortality is high at about 14.5 deaths/1000. Morbidity statistics on hospital admissions indicate principally enteric, upper respiratory,

and viral disorders among children.

While common medical opinion, supported by hospital morbidity statistics, indicates serious malnutrition problems during the weaning period until about two years of age, no recent studies have been done on the problem. In 1973 a small, urban biased sample showed 6% of children at less than 60% of normal weight, 12-15% between 60-80% at less than 90% of normal, with female children having rates of malnutrition about twice that of males.

Hospital records for 1972 for all age groups indicate the following prevelance order: (Total cases 172,576)

Disease Group	% of Cases
Accidents, poisoning, and violence	18.0
Complications of pregnancy, childbirth	16.9
Diseases of the digestive system	13.3
Diseases of the respiratory system	9.4
Diseases of the Genito-urinary system	9.1

Iron deficiency anemia, hookworm disease, schistosomiasis, occasional leishmoniasias, malnutrition, typhoid fever, diptheria, whooping cough, diarrhea, and dehydration in infants and children, occasional neonatal tetanus, TB (very prevalent), trachoma, occasional malaria (largely imported cases), vast amounts of trauma secondary to vehicle accidents, bronchitis and pneumonia, ulcer disease, amegiasis, and rarely echinococcus were among the diseases commonly mentioned, and in many cases, seen by the team. Cholera has not occured in the country for the past two years. Accurate diagnosis is often difficult because laboratory facilities, particularly in rural ambulatory settings, are virtually non-equipped or unstaffed. Additionally, with some very impressive exceptions, basic laboratory diagnostic aids, even when

available, appear to be inappropriately utilized by physicians. The most serious laboratory deficiencies appear to be in clinical bacteriology, closely followed by parasitology.

2. Health Services

In 1974 there were [redacted] government hospitals, [redacted] private [redacted]pitals, and [redacted]ria. In addition, in 1972 there were [redacted] Ministry of health dispensaries and [redacted] (1974 data indicates 287 combined dispensaries, ministry of health clinics, and health centers). The [redacted] rate of existing facilities is low and the [redacted] rendered chiefly curative.

In 1971 a government decree laid out the system of services which should be provided. It basically relies on the government hospitals as referral centers and as out-patient clinics for the immediate area. The next level of service is provided at an integrated preventive/curative health center, designed to serve a population of no more than 25,000. A third level, that of dispensaries serving populations of 5,000 was mentioned to the team as being part of the overall plan.

The theoretical system seems logical and well designed. In practice, hospitals are poorly administered and maintained, health centers are understaffed, curative oriented, and ill equipped, and the system as a whole suffers from a lack of planning and administrative control. The SARG is currently working in a number of areas to improve the current situation.

3. Manpower

[redacted] over the past few years at Damascus and Aleppo, and Lattakia will graduate

its first class in 1979. By 1980, around 1,000 physicians a year should be graduating. Compulsory rural service for physicians and a high return rate to home areas seems to indicate that the physician supply should be adequate in both public and private clinical practice. Since civil service doctors supplement meager government salaries with legal outside private practice, the supply of public health physicians is not likely to be adequate. The Ministry of Health is working on several ideas to provide an attractive income to combat this problem.

There is widespread concern over the availability and quality of nursing. In general, nurses appear relatively unwilling to work in hospital situations and to provide hands on care. Cultural factors place the nurse in a position of being considered something less than a professional and the current nurses' syndicate seems more interested in insulating nurses from physician criticism than in upgrading the professionalism of its members. The World Health Organization is currently working with the Ministry of Health to improve nursing school curriculum and nursing services.

Auxiliary medical personnel are currently in short supply, and, when available, are utilized improperly. A key institution attempting to meet this need is the National Health Technical Institute. The NHTI graduates approximately 125 technicians per year and offers two-year courses in the fields of anesthesia, laboratory technician, x-ray technician, pharmacy, and environmental sanitation. Entrance requirements are a science division baccalaureate. The only other similar institution training mid-level technicians in Syria is the Intermediate Medical Institute

affiliated with the Aleppo Medical School. This institute offers training in anesthesia, laboratory, and x-ray and next year will graduate about 134 students.

The NHTI will soon move from three separate training facilities into a new, circa S.P. 5,000,000, six-story building devoted solely to the training of mid-level technicians. Class size and the number of courses offered can expand to allow up to 300 students per year.

There is a [redacted] Anaethesia technician production capacity now seems adequate with about 50 per year soon to be graduated between Aleppo and NHTI.

The World Health Organization is currently working with the Ministry of Health to improve the curriculum at the NHTI. There is some possibility of joint A.I.D. collaboration with the World Health Organization providing overseas training, the advisors and A.I.D. providing instructional equipment. A World Health Organization advisor should be in-country shortly to submit a complete project design for improvement of auxiliary manpower training.

4. Facilities and Equipment

The government health delivery system suffers almost universally from a lack of regular maintenance and timely repairs. Even installation of new equipment is sometimes hard to achieve. While both the hospitals and health centers appear to have the proper equipment for operation, a substantial amount of the equipment is currently non-functioning or has never functioned. The result is

that needed diagnostic tests are skipped or done poorly and patients lives endangered by misfunctioning equipment. The problem has been recognized by the Ministry of Health, who requested a WHO advisor to review the situation a year ago. The problems identified by the WHO expert were found to still exist by the A.I.D. health team in May of 1976. Since WHO seems to have decided to focus its aid in different areas, the SARG has requested technical assistance to establish a regular system of management and control in this area.

5. Management and Administration

Within the MOH public health system there is demonstrated capacity to design and implement construction projects and to administer personnel and supply systems. Beyond this, the system is almost totally lacking in information on which to base forward planning and in planning and control management capability.

There are [redacted] in the SARG associated with health planning [redacted], one in the MOH and one in the Ministry of Planning, neither of whom has been trained for this task. The health budgeting and programming system appears to function solely on the basis of hastily compiled estimates of annual requirements for existing programs in the case of annual operation budgets and a six-month programming cycle for the five-year capital development budget which is participated in by only a few MOH decision makers. The two budgeting processes are independent and result in capital development projects being proposed and implemented prior to consideration of their operational requirements.

Basic policy decisions in general appear to be made on the basis of very little study or analysis while actual operation of the system is done by health center and hospital directors (physicians)

who are not given performance objectives and are not adequately supervised. No component of the health delivery system appears to be systematically evaluated.

[redacted] and vital statistics are non-[redacted] A considerable capacity for collecting population characteristic information exists in the Central Bureau of Statistics but it is rarely applied to the health sector. A lesser capacity exists in the Ministry of Health itself where two trained professionals work at the central ministry level and eleven trained assistants work at the provincal level. At the current time they are being utilized solely to compile routine hospital statistics and mortality statistics supplied by the Ministry of Interior's department of civil registration.

6. Family Planning

While [redacted] was included in the 1971 decree as a service to be provided by health centers, in reality it [redacted] A [redacted] association was established only in 1974 and systematic delivery is now being [redacted] In general, population growth is not viewed by the Syrians as a problem and the current efforts in family planning are intended to improve mother and child health rather than reduce family size. UNFPA is currently advising the government on this matter. (For a detailed discussion on family planning, see "Population/Family Planning in Syria," Robert Grant, PHA/POP/NESA, 12/8/75.)

7. Nutrition

A relatively serious nutritional problem appears to exist

in Syria. Small preliminary surveys indicate that the incidence of acute nalnutrition may be as high as six percent in male children and 15 percent in female children. At the current time almost no programs address the problem. The sole exceptions being the individual studies of one displaced physician from AUB, who is currently serving in the Damascus Hospital pediatrics unit, and a government factory to produce weaning foods, scheduled to come on line in two to three years. To direct SARG policy toward this problem will require a vigorous agressive approach to defining the problem, identifying solutions, and implementing programs. One such proposal has been made in draft form and given to the MOH. It is hoped that a PRP will be developed for this activity shortly.

8. The A.I.D. Role

The 1977 ABS included a PID for health services training. The PID was approved in September of 1975 and at the request of the Syrian government a health reconnaisance team from AID/W visited Syria for two weeks in November 1975 to identify sector issues and areas of potential A.I.D. support, to confirm lines of action proposed in the PID, and to write a detailed scope of work for future project design efforts. From this report the Syrian government selected [redacted]: [redacted], [redacted], [redacted], and [redacted] In May, a team of five experts in these areas spent three weeks in Syria working on project design. The [redacted] was temporarily set aside at the end of the review in order to avoid duplication with [redacted] The other activities are described in detail in this paper.

Possible future projects in the areas of nutrition, schistosomiasis, and public health research were also investigated and will possibly be submitted in PRP form during FY 1977.

B. DETAILED DESCRIPTION

Log frame attached.

1. Program Goal

The sector goal for this project is the [redacted] delivery of both curative and preventive health services within the Syrian public health system.

2. Project Purpose

The purpose of this project is threefold:

a) to d[redacted]y for [redacted]y [redacted]s, p[redacted]g, [redacted]ing, and e[redacted] within the health sector;

b) to [redacted] for use by the SARG in planning and evaluation of health programs and policies; and

c) to d[redacted]

3. Planned Outputs

For purpose 2.a) above, the output will be trained health planners in an established planning unit in the Ministry of Health and possibly elsewhere in the system who are capable of: 1) analyzing health problems and recommending health policies to meet these problems, and 2) establishing a management control system.

For purpose 2.b) above, the output will be the successful completion of design, implementation, analysis, and evaluation phases of a continuous health survey.

For purpose 2.c) above, the output will be a functioning, centrally administered equipment repair and maintenance system with a central workshop in Damascus.

4. Planned Inputs

For 2.a) above, the U.S. will provide a general health planning expert to act as a counterpart in the Ministry of Health where he/she will carefully identify the major planning gaps and recommend solutions appropriate to the Syrian situation. He/she will further assist in identifying Syrians for U.S. training and in establishing a permanent planning unit in the Ministry. Two short-term specialist slots are provided although the exact needs will have to be determined during the first project year. The SARG will establish the positions in the Ministry, will pay participants' salaries, and will provide office and clerical support.

For 2.b) above, the U.S. will support the existing statistical capability at the Central Bureau of Statistics by providing a health survey design specialist and a data analysis specialist. The Syrian survey director and the MOH health planner assigned to the survey will be brought to the States to discuss current health survey procedures with the Center for National Health Statistics and several universities. The SARG will supply the full survey staff and field interviewer, computer time, and local currency costs. The U.S. will supply nine all-terrain vehicles and some support commodities.

For 2.c) above, the U.S. will provide a hospital equipment systems management specialist to help design and implement a centralized maintenance and repair system. Systems management training for the central director and specialized repair training for two experts will also be provided in the U.S. A heavy mobile repair workshop, a

smaller transport van, and central workshop equipment will also be supplied by the U.S. The SARG will create 16 new positions and central office and workshop space.

Assumptions:

In general the assumptions are:

1. That qualified U.S. experts can be found who are willing to live in Syria and who, preferably, speak Arabic;

2. That qualified Syrians for the proposed positions and training can be found;

3. That sufficient management capability and time are available in the Ministry of Health and the Central Bureau of Statistics to insure reasonably smooth progression through the various project stages; and,

4. SARG budgetary support.

PART 3. PROJECT ANALYSIS

A. TECHNICAL ANALYSIS INCLUDING ENVIRONMENTAL ASSESSMENT

The health planning component of the project has been carefully limited in scope to two components -- a long-term advisor and the training of central planning staff. During discussions with MOH officials it became clear that a small but solid technical base must be established and the current system reviewed with a heavy sensitivity to cultural factors before highly technical health planning and management techniques could be introduced into the system. Since the Ministry officials have demonstrated considerable capacity to manage and implement programs once they are worked out, the end product of the project should not be beyond the Ministry's capacity.

The health survey component of the project is completely within the capacity of the Central Bureau of Statistics to implement

given the guidance of an experienced health survey designer to make sure all relevant variables are properly identified and that interview techniques will produce accurate answers. Field pre-tests of the questionnaires should further insure the accuracy of the results. Two advisory committees, one at the ministerial level and one at the staff level are included to insure each health related agency will have proper input into the selection of data to be collected and to insure a knowledgeable set of contacts for the health survey designer with whom to discuss data needs. Proper use of the output of the survey -- data on the health status of the population -- will depend partly on the existence and effective operation of the central health planning staff at the MOH.

The equipment maintenance and repair component of the project, while technically not difficult to implement given the state-of-the-art in hospital/medical maintenance and repair systems, may be culturally the most difficult to sustain. The current lack of systematic maintenance is pervasive in not only public and private hospitals, but in industry and commercial establishments. Such maintenance and repair as is done in the hospitals seems to be in direct response to the personalities and influence of individual hospital directors, doctors, and nurses. It is for this reason that a central unit, removed from individual hospital pressures, is recommended rather than separate systems in each hospital. Each hospital will also have a maintenance supervisor who will report to the central MOH unit.

The project in itself will not have major environmental impacts in the immediate future. With the advent of accurate statistics and

planning capacity, preventive health measure having a positive environmental impact may be initiated, (e.g., improved sewerage handling, potable water, etc.)

The technical design is considered reasonable by both USAID and the Ministry of Health, who offered detailed comments which resulted in some simplifications concerning both the health planning and health survey components. The U.S. costs are considered to be accurate in respect to the inputs presented with the exception of possible wide variations in consultant salaries. SARG costs may increase considerably since their current civil service salary system is sufficiently low that the government may be forced at some point to make an across-the-board adjustment.

The described project represents a technically sound way to approach the specific problems it addresses within the Syrian context.

B. FINANCIAL ANALYSIS

Because there are no cost flows resulting from this project, the rate of return on the project cannot be formulated. However, the following cost analyses represents the A.I.D. and SARG costs over the life of the project.

The central budget for 1976 for the Ministry of Health is $31 million. The costs of continuing the project planning and survey activities should be about $460k in salaries and support and should be easily available. In the case of the maintenance and repair project, the savings produced in operating and capital expenditures should more than cover the recurrent operating costs of the system. Because of the short field preparation time of this paper the SARG contribution data should be viewed as the best estimates available in Washington.

SUMMARY COST ESTIMATE AND FINANCIAL PLAN

($ US 000)

Source	AID		Host Country		Total
	FX	LC	FX	LC	
AID Inputs					
A. Contract	482				
B. Training	127				
C. Equipment	56				
D. Vehicles	85				
Total AID					749
SARG Inputs					
A. Salaries & per diem				953	
B. Computor Time				20	
C. Office & workshop space and clerical support				90	
D. In-country travel				2	
E. Equipment and other			10	3	
Total SARG					1,078
Total	749		10	1,068	1,827

HEALTH SURVEY
(U.S. Dollars)

	Year 1	Year 2	Year 3	TOTAL
U.S. CONTRIBUTION				
Design Consultant				
12 m.m. @ $6500	[redacted]			
Mobilization and fare	10,000			
Demobilization and fare	10,000			
30 days per diem @ 34	1,020			
Education Allowance	2,000			
Housing	10,000			
	107,020			107,020
Design Consultant				
1 m.m. @ $6500		6,500		
1 m.m. per diem @ $1020		1,020		
1 R.T. Air Fare @ $1350		1,350		
		8,870		8,870
Data Analyst				
3 m.m. @ $6500		19,500		
3 m.m. per diem @ $1020		3,060		
1 R.T. air fare @ $1350		1,350		
		23,910		23.910
Training				
2 Professionals:				
2 m.m. @ 2000	4,000			
2 r.t. Air Fare	1,700			
	5,700			5,700
Commodities				
Key punch cards 100 @ 5	500			
Scales 16 @ 150	2,400			
English typewriter	500			
Scientific, prog. calc.	700			
4 Scientific calc. @ 200	800			
5 Desk calculators @ 200	800			
9 4-wheel drive vehicles	40,000	32,000		
	45,700	32,000		77,700
TOTAL U.S. CONTRIBUTION	158,420	64,780		223,200

HEALTH SURVEY
(U.S. DOLLARS)

SARG CONTRIBUTION	First Year	Second Year	Third Year	Total
Salaries and meetings	75,524	210,613	345,475	631,612
Per Diems	1,000	52,000	75,000	128,000
Computer Time			20,000	20,000
In-country travel of U.S. advisor	1,000			1,000
Office Support	4,000	4,000	4,000	12,000
TOTAL SARG CONTRIBUTION	81,524	266,613	444,475	792,612
TOTAL PROJECT	239,944	331,293	444,475	1,015,712

MEDICAL EQUIPMENT MAINTENANCE AND REPAIR
(U.S. DOLLARS)

U. S. CONTRIBUTION	First Year	Second Year	Third Year	Total
CONSULTANT				
Advisor 24 m.m.	78,000	78,000		
Mobilization	10,000			
Demobilization	10,000			
30 Days per diem	1,020			
Education allowances	2,000	2,000		
Housing	10,000	10,000		
	111,020	90,000		201,020
TRAINING				
Director (6 mos. at 2000)	12,000			
2 Specialists (3 mos. at 2000)		12.000		
3 R.T. Air Fare	1,350	2,700		
	13,350	14,700		28,050
COMMODITIES				
Heavy van	8,000			
Light van	5,000			
Van and Workshop equipment	5,000	45,000		
	18,000	45,000		63.000
TOTAL U.S. CONTRIBUTION	142,370	149,700		292,070

MEDICAL EQUIPMENT MAINTENANCE AND REPAIR
(SYRIAN POUNDS)

SARG CONTRIBUTION	First Year	Second Year	Third Year	Total
SALARIES				
Director @2000 SL/mm	24,000	24,000	24,000	
Eng. x-ray @ 1800 SL/mm	12,600	21,600	21,600	
Eng. med. @ 1800 SL/mm	12,600	21,600	21,600	
Hospital Inspector @1400 SL/mm	7,000	16,800	16,800	
Hospital Supervisors 12 @1100 SL/mm	27,500	158,400	158,400	
Subtotal Salaries	83,700	242,400	242,400	568,500
Per diems 21 man-days per mo. @35	2,940	8,820	8,820	20,580
Equipment			39,000	39,000
Other				
Printing of Inv.	12,000			12,000
[redacted]	50,700	101,400	101,400	253,500
Office & Clerical Supp.	7,800	15,600	7,800	31,200
TOTAL S.L.	157,140	368,220	399,420	924,780
TOTAL SARG CONTRIBUTION IN $ U.S.	40,292	94,415	102,415	237,122
TOTAL PROJECT ($)	182,662	244,115	102,415	529,192

HEALTH PLANNING

U.S. CONTRIBUTION:	Year 1	Year 2	Year 3	Total
CONSULTANTS				
In-Country				
12 m.m. @ 5,500	66,000			
Mobilization, fare	10,000			
Demobilization, fare	10,000			
30 days per diem	1,020			
Education allowance	2,000			
Housing	10,000			
	99,020			99,020
Short-term				
3 mos. each @ 5,500		33,000		
Per diem 6 mos. @ 1020		6,120		
2 R.T. Air Fares		2,700		
		41,820		41,820
TRAINING				
2 M.P.A./year & travel		17,100	17,100	
4 Short-term, travel/year		29,400	29,400	
		46,500	46,500	93,000
U.S. CONTRIBUTION	99,020	88,320	46,500	233,840

HEALTH PLANNING
(U.S. DOLLARS)

SARG CONTRIBUTION:	First Year	Second Year	Third Year	Total
Salaries	6,000	18,000	18,000	42,000
Office Space & Support	4,000	1,000		5,000
In-country travel	1,000	200		1,200
TOTAL SARG	11,000	19,200	18,000	48,200
TOTAL PROJECT	110,020	107,520	64,500	282,040

C. SOCIAL ANALYSIS

The Syrian Public Health system provides free curative services to all Syrians who cannot afford private service. Eligibility is determined in urban areas by the possession of a welfare card and in the poor rural areas no special identification is needed. Persons above the poverty line are charged set fees. Because of this focus on a system whose beneficiaries are already the poor population, any improvement in services brought about by the project will itself have the poor as beneficiaries. The poor will have representation during the final government ratification process through the various rural and workers committees which must approve and debate the project.

At this stage of improving the SARG's capacity to deliver services through the existing system, no cultural changes or special organization or motivation of the beneficiaries is foreseen. As services improve, it is hoped that some of the poor who are currently choosing to spend money they can hardly afford on private care (which is sometimes viewed as superior and may often be) will take advantage of the government system.

Since prenatal, childbirth, and perinatal complications are among the major incidences of hospitalization currently, women as a group should benefit from an improved planning system which is designed to prevent these problems. In terms of integration of women into the programs and projects, women professionals play a major role in the system already as physicians, MOH professionals, and CBS professionals. Health center personnel are mainly female already.

D. ECONOMIC ANALYSIS

Any activity which reduces morbidity in the general population will have the effect of decreasing lost-work time, increasing work effectiveness, and in general increasing productivity. To the extent that the activities in this project increase the effective delivery of services and increase the attention and policies concerning preventive programs there should be a positive reduction in morbidity. Measuring even the impact on morbidity at present is, however, impossible since base statistics of even the grossest nature are unavailable. With the introduction of the national health survey, it will be possible to measure improvements in health status, and therefore, at least theoretically, in economic productivity.

Since a cost-benefit analysis is not possible for this project, we cannot indicate whether the rate of return will be 15% or more. However, given the three limited areas this project addresses, it is felt that the combined inputs are the most cost effective way of addressing the immediate problems and that therefore the project may be considered to be economically sound.

[illegible] cost/benefit per person for medical [illegible]

PART 4. IMPLEMENTATION ARRANGEMENTS

A. Analyses of the Recipient's and AID's Administrative Arrangements

1. Recipient

Two organizations will be involved in the implementation of the project -- the Ministry of Health and the Central Bureau of Statistics. Since the project is divided into three discrete activities, it is easier to describe the organization relations by activity.

a. Health Planning: The Ministry of Health has three vice-ministers. The vice-minister in charge of administration will be in charge of this activity and the planning unit which will ultimately be established will fall under his direction.

b. Equipment Maintenance: The vice-minister for Medical Supplies and Hospitals will be directly responsible for this activity and the new maintenance and repair unit will be established under him.

c. Health Survey: The design and implementation of the survey will be done within the Central Bureau of Statistics with a director appointed to head the survey. Any additional staffing needed will be paid by the MOH. The Ministry of Health and other interested agencies will be represented on both a ministerial level committee and a staff level committee which will provide the policy guidance for the CBS.

The Ministry of Health has shown demonstrated capacity to implement projects. It is easily within their capacity to supply the office space and other support for the technical advisors and to successfully go through the bureaucratic processes of establishing and staffing two new units within the ministry. The only problem which can

be foreseen at this time is that the new planning unit, unless carefully structured to fit current operational processes, may not be utilized fully and effectively.

As far as the CBS's ability to design and conduct surveys, analyses by a consultant expert indicates that CBS has the professional capacity and experience. A critical problem may arise, however, in the collection of field data. Because of the low per diems paid the interviewers, there is some feeling that the interviewing may not be done properly. This problem has been discussed both with the CBS, the MOH, and the Ministry of Plan, who feel it can be resolved. It should, however, be kept in mind as the project progresses and a check system, such as is currently employed in other CBS surveys (5% double interviews) should be required.

2. A.I.D.

The project has been designed to minimize USAID monitoring responsibilities. The three key consultants who will live in-country will each be responsible for his/her activity and , in collaboration with MOH counterparts, for reports and evaluations. AID/W will be responsible for identifying these long-term consultants, commodity and vehicle procurement, and arranging for U.S. training.

B. Implementation Plan

See attached PPT and CPI for the timing of critical activities. It is recommended that, because of the vastly different skills needed by the three principal consultants, that personal services or other individual contracts be used rather than issuing an overall RFP.

The MOH is ready to begin implementation. MOH activities crucial to the project are the staffing of the various activities (see CPI),

the provision of office space and clerical support, the provision of central workshop space, and the rental, in the name of the Ministry, of apartments for the three long-term consultants.

C. Evaluation Arrangements

Evaluation does not appear to be a regular element of MOH activities so that MOH participation requirements in evaluation should be carefully spelled out in the ProAg.

1. Equipment Maintenance and Repair Activity

The present baseline data consists of general observations by a WHO representative and by a member of the A.I.D. May 1976 health team which visited Syria. It is planned that a complete inventory of equipment be conducted and thus baseline records established in the period 8/77 - 1/78. At this point, as part of the design of a management control system, an initial evaluation, to be carried out in [redacted] will be designed and submitted to both A.I.D. and the MOH for design approval. The evaluation designs will be the responsibility of the Director of the MOH unit and the U.S. counterpart, as will be the evaluation reports.

2. Health Planning

Since health planning, per se, does not exist, the baseline situation is close to zero. At the end of the U.S. long-term consultant's first six months, the MOH and the consultant will prepare a two-year plan which details steps toward establishing a health planning unit, relevant training for key personnel, and short-term expert advice. Prior to departure six months later (1/78), the long-term consultant will report on the progress in implementing the plan. In September of '78, the health unit itself will provide a second status report on implementation and

attempt to evaluate the changes in the system which can be directly attributed to the planning unit.

3. Health Survey

It is planned that the health survey have [redacted] different [redacted]. The [redacted] will take place [redacted] and will consist of the [redacted] which will be documented in a final report by the long-term consultant prior to departure in [redacted]. A [redacted] of the [redacted] will be conducted during the data analyses phase in [redacted] by the original survey consultant, the data analyses expert, the MOH health planning unit, and CBS staff.

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APPENDIX A

Department of State TELEGRAM

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ORIGIN AID-31

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NESA/CD:TPEARSON (DRAFT)
TA/HE:RBRITANIK (SUBS)
PPC:EGRIFFEL (DRAFT)
PPC/DPPE:JWELTY (DRAFT)
GC/NESA:CCOSTELLO (DRAFT)
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E.O. 11652:N/A

TAGS:

SUBJECT: PID-HEALTH SERVICES TRAINING, 276-0013

1. PID WHICH OUTLINES PROJECT TO ASSIST SYRIAN GOVERNMENT UPGRADE THE TRAINING OF MIDDLE-LEVEL HEALTH WORKERS IS HEREBY APPROVED. THE NESA ADVISORY COMMITTEE SUGGESTS THAT FURTHER PROJECT DEVELOPMENT BE UNDERTAKEN COLLABORATIVELY WITH SYRIAN GOVERNMENT PARTICIPATION, PERHAPS FROM STATE PLANNING COMMISSION AND MOH. SPECIFIC INTERVENTIONS TO STRENGTHEN HEALTH TRAINING SHOULD EMANATE FROM CLEAR UNDERSTANDING SYRIAN GOVERNMENT PRIORITIES AND RESOURCES IN HEALTH AND SHOULD FOCUS ON SOLVING HEALTH PROBLEMS OF URBAN AND RURAL POOR.

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PAGE 02 STATE 222091

2. PRIOR TO FIELDING A CONTRACT GROUP TO WORK SPECIFICALLY ON PROJECT DESIGN BELIEVE IT HIGHLY DESIRABLE THAT SMALL (2-3 PERSON) NESA TEAM SPEND TWO WEEKS IN SYRIA TO MAKE RECONNAISANCE OF SECTOR, TO IDENTIFY PRINCIPAL ISSUES AND AREAS FOR POTENTIAL AID-SUPPORTED ACTIVITIES, TO CONFIRM LINES OF ACTION PROPOSED IN PROJECT AND TO WRITE DETAILED SCOPE OF WORK FOR PROJECT DESIGN CONTRACT.

3. ON BASIS AID TEAMS' RECOMMENDATIONS AND USAID CONCURRENCE, WOULD PROPOSE FOLLOW ON QUICKLY WITH 4-6 WEEK PROJECT DESIGN TEAM MOST LIKELY DRAWN FROM PRESENT "QUICK RESPONSE" IQC RESOURCES IN HEALTH PROJECT PLANNING. ANTICIPATE BUREAU TEAM COULD ARRIVE END OCTOBER/EARLY NOVEMBER WITH CONTRACT DESIGN GROUP FOLLOWING OR 60 DAYS LATER.

4. IN DISCUSSIONS HERE, NESA ADVISORY COMMITTEE OBSERVED THAT PROJECT RATIONALE SHOULD CONSIDER MATERNAL HEALTH NEEDS INCLUDING FAMILY PLANNING SERVICES AS WELL AS URBAN AND RURAL CHILD HEALTH PROBLEMS AND PROBABLY HEALTH DELIVERY MECHANISMS UPON WHICH TRAINING SYSTEMS WILL DEVELOP. ADVISORY COMMITTEE ALSO FELT PRP SHOULD ALSO ARTICULATE THE EXTENT TO WHICH PROJECT WILL IMPACT ON RURAL WOMEN AND IMPROVE THEIR STATUS AS WELL AS HOW WOMEN WILL BE INVOLVED IN PLANNING AND IMPLEMENTATION BY PROGRAMS.

5. HAVE REQUESTED NEW PASA UNIT PREPARE DESCRIPTIVE STUDY ON SYRIAN HEALTH SYSTEM. WOULD APPRECIATE INFORMATION YOU CAN POUCH IN FRENCH OR ENGLISH ON SYRIAN HEALTH PROGRAMS OR ACTIVITIES.

6. REQUEST USAID CONSIDER THIS APPROACH, DISCUSS WITH SYRIANS AND ADVISE. KISSINGER

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ACTION AID-31

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EO 11652: N/A
TAGS:
SUBJECT: HEALTH/FAMILY PLANNING/NUTRITION TEAM

1. AID TEAM, CONSISTING OF GEORGE COLEMAN, NESA/TECH (TEAM LEADER); DR. NASSIR HEMAIDEN, USAID/TUNIS; ROBERT GRANT, PHA/POP; AND DR. JAMES BANTA, CONSULTANT FROM TULANE UNIVERSITY, RECENTLY COMPLETED REVIEW OF INTEGRATED HEALTH/FAMILY PLANNING/NUTRITION SECTOR IN SYRIA. DURING BUSY TWO WEEK PERIOD, TEAM MET WITH SENIOR SARG OFFICIALS, VISITED HEALTH FACILITIES AND TRAINING INSTITUTIONS AROUND COUNTRY AND DISCUSSED PRO
BLEMS AND POSSIBLE SOLUTIONS WITH NUMEROUS PROFESSIONALS IN PUBLIC AND PRIVATE SECTORS. GROUP WAS WELL RECEIVED BY SYRIANS AND ENGENDERED MUCH INTEREST IN POSSIBLE U.S. ASSISTANCE IN THIS SECTOR. TEAM ALSO PREPARED DRAFT REPORT GIVING BOTH GENERAL AND SPECIFIC RECOMMENDATIONS IN THIS INTEGRATED SECTOR, SOME OF
WHICH APPEAR LIKELY AREAS FOR AID
ACTIVITIES. REPORT NOW BEING FINALIZED AND COPIES WILL BE POUCHED ASAP. WHEN REPORT GIVEN TO SARG, AID OFFICE WILL FOLLOW UP WITH DISCUSSIONS WITH APPROPRIATE SARG OFFICES TO OBTAIN THEIR REACTIONS/DECISIONS RE REPORT RECOMMENDATIONS AND PLAN NEXT STEPS AS APPROPRIATE, SUCH AS REQUESTING "QUICK RESPONSE" CONTRACTOR SERVICES TO DESIGN PROJECT. WILL KEEP YOU ADVISED.

F-11

We should send this to Pawo where they love us less

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2. BELIEVE PURPOSE OF TEAM'S VISIT WAS ACHIEVED IN PROVIDING EXPERT RECONNAISSANCE OF HEALTH/FAMILY PLANNING/NUTRITION SECTOR AND IDENTIFYING POSSIBLE AREAS OF AID ASSISTANCE. REASON FOR SUCCESS OF ADVANCE TEAM LARGELY DUE TO MUCH HARD WORK BY AID/W-SELECTED EXPERTS WHO WELL INFORMED AND EXPERIENCED IN OWN SPECIALITIES, ABLE TO "HIT THE GROUND RUNNING" AND WRITE REPORT AND SCOPE OF WORK BEFORE LEAVING SYRIA. SUCCESS OF OTHER AID ACTIVITIES IN SYRIA AND ASSITING AID OFFICE'S LIMITED STAFF WILL VERY MUCH DEPEND ON BEING ABLE TO FIELD EQUALLY QUALIFIED TEAMS. APPRECIATE AID/W EFFORTS THIS REGARD.
MURPHY

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AIDAC

WASHINGTON FOR NE/TECH,NE/ME

TUNIS FOR NASSIB HEMAIDAN

E.O. 11652: N/A
TAGS:
SUBJECT: TECHNICAL SERVICES/FEASIBILITY STUDIES GRANT-INTEGRATED HEALTH/FAMILY PLANNING/NUTRITION PROJECT PROPOSAL

REF: DAMASCUS 4804; REVIEW OF SYRIAN HEALTH, FP AND NUTRITION BY AID RECONNAISSANCE TEAM, NOVEMBER 1975

1. AFTER REVIEWING REFERENCED REPORT, SARG HAS NOW REQUESTED THAT AID ASSTST IN NEXT STAGE OF PROJECT DEVELOPMENT BY PROVIDING EXPERTS TO DESIGN TECHNICAL ASSISTANCE PROJECT FOR FUNDING BEGINNING FY 76. SARG HAS PARTICULARLY REQUESTED ASSISTANCE IN HEALTH/PARAMEDIC TRAINING, NUTRITION AND NATIONAL HEALTH PLANNING. REQUEST MOST CLOSELY RELATES TO SUMMARY RECOMMENDATIONS NOSM (1), TWO (2), THREE(3), FIVE(5), NINE (9) AND TEN(10). (FYI. MINISTRY OF HEALTH INTERESTED IN WORKING WITH JOHNS HOPKINS UNIVERSITY ON NOS 1 AND 2 END FYI). SARG ALSO REQUESTED THAT PROJECT INCLUDE MAINTENANCE AND REPAIR OF MEDICAL EQUIPMENT.

2. AS DISCUSSED EARLIER WITH AID/W REPRESENTATIVES (PARTICULARLY GEORGE COLEMAN), WE NOW NEED SCOPE OF WORK FOR EXPERT(S) TO VISIT SYRIA ASAP TO DESIGN PROJECT AND, IN EFFECT, HELP WRITE

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PROJECT PAPER. REQUEST AID/W PROVIDE US SOONEST WITH DETAILED SCOPE OF WORK WHICH WE CAN DISCUSS WITH SARG AND OBTAIN THEIR CONCURRENCE IN PIO/T. IN MEANTIME, AID/W CAN MAKE NECESSARY ARRANGEMENTS WITH READILY AVAILABLE AND QUALIFIED CONTRACTOR UNDER EXISTING TASK ORDER OR WITH AID/W SPECIALIST TO VIST SYRIA IN NEAR FUTURE FOR THIS WORK.

3. ADVISE SOONEST RE SCOPE OF WORK, PROBABLY EXPERTS, PIO/T NO.(SUGGEST 50079) AND COSTS.
MURPHY

Department of State **TELEGRAM**

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APPROVED BY NE/TECH:JSALDEN
TA/H:JDAVIS (SUBS)
NE/DP:MHUNTINGTON (DRAFT)
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SUBJECT: TECHNICAL SERVICES FEASIBILITY STUDIES

REF: (A) DAMASCUS 0818 (B) HEALTH SECTOR AID RECONNAISS-
ANCE TEAM REPORT

1. AID/W WILL BEGIN IMMEDIATELY SCOPES OF WORK FOR EXPERTS TO VISIT SYRIA AND ASSIST IN PREPARATION OF PRP'S AND IF POSSIBLE PP'S. AREAS OF INTEREST ARE REITERATED BELOW TO INSURE AID/W CLEAR ON SARG/MISSION UNDERSTANDING.

2. DESIGN AND IMPLEMENTATION OF A NATIONAL HEALTH SURVEY LEADING TO THE DEVELOPMENT OF A COMPREHENSIVE HEALTH STRATEGY: SCOPE OF WORK WILL CALL FOR HEALTH STATISTICIAN,

UNCLASSIFIED

FORM

POSSIBLY IN CONJUNCTION WITH HEALTH PLANNER TO INSURE RELEVANCY OF SURVEY RESULTS.

3. MEDICAL EQUIPMENT MAINTENANCE AND REPAIR: SINCE THIS AREA WAS NOT DETAILED BY HEALTH TEAM, ADDITIONAL INFORMATION TO FORM BASIS FOR SCOPE IS NEEDED FROM THE MISSION.

4. NATIONAL TECHNICAL HEALTH INSTITUTE: EXPERT IN MANPOWER PLANNING/CURRICULUM DEVELOPMENT WILL BE SOUGHT. FINAL PROJECT DESIGN WILL DEPEND ON RELATION OF N.T.H.I. TRAINING TO 2) ABOVE.

5. PRESUME SYRIAN PARTICIPANT CANDIDATES FOR HEALTH PLANNING AND THE PHYSICIANS AND BIOCHEMISTS FOR THE DEPT. OF NUTRITION BECAUSE OF THE DEGREE TYPE AND LONG-TERM NATURE OF THEIR TRAINING, WOULD BE INCLUDED IN THE PARTICIPANT COMPONENT OF THE INTEGRATED HEALTH PROJECT(S). SHOULD OTHER SHORT-TERM TRAINING REQUIREMENTS BE FUNDED FROM THE EXISTING GENERAL PARTICIPANT TRAINING PROJECT? APPRECIATE HAVING YOUR THOUGHT ON THIS SOME TIME DURING THE PROJECT DEVELOPMENT STAGES. THE EXPERT FOR 4) ABOVE WILL BE ABLE TO ASSIST THE MISSION IN IDENTIFYING THESE AND THE IN-HOUSE TRAINING REQUIREMENTS ALLUDED TO IN RECOMMENDATION NO. 5 OF REF B. AT THIS STAGE AID/W BELIEVES ALL OUT-OF-COUNTRY PARTICIPANT TRAINING CAN BE PROGRAMMED IN THE U.S.

6. AID/W AWARE OF A NUMBER OF RESOURCES FOR SERVICES REQUIRED UNDER 2) ABOVE. JOHNS HOPKINS IS OF COURSE ONE OF THE HIGHLY QUALIFIED SOURCES, BUT AS YOU KNOW, SECURING THEIR SERVICES UNDER PROPRIETORY PROCUREMENT ONLY POSSIBLE WHERE STRONG AND WELL DOCUMENTED CASE CAN BE PRESENTED.

7. ADVISE. INGERSOLL

APPENDIX B

HEALTH STATISTICS AND SURVEY

I. Background

Responsibility for the collection and dissemination of statistical information is vested in the Central Bureau of Statistics (CBS), an autonomous organization reporting directly to the Prime Minister. The CBS conducts the Decenniel Census and occassional sample surveys related to a variety of subject matter areas such as agriculture, population, economics, etc. It appears to be staffed with technically qualified people, both in the central office in Damascus and in the regional offices at the mohafaza level.

The CBS is responsible for the quality of data collected and disseminated by any organ of the Syrian government. While a ministry may be permitted to gather statistical data on its own accord, the survey designs or plans for any data collection activities must first be approved by the Director of the CBS prior to implementation. In addition, approval by the Director of the CBS is required prior to the publication of any statistics. Statistical data may be published by the ministry itself,after such approval has been received, jointly with the CBS or by the CBS alone.

The organizational structure of the CBS reflects its broad responsibilities (see fig. 1.). There are nine subject matter divisions ranging from Planning and Research to Financial and Administrative Affairs, each staffed with people capable of planning and supervising the execution of surveys in their area. The subject matter areas have been subdivided into those related to 'Social Affairs' and those related to 'Economic Affairs' and an Assistant Director has been assigned to each of these two areas. The Center for Population Study and Research (CPSR) contains about nine demographers and currently is being assisted in its work by a United Nations PHD-level demographer who is also teaching a course several hours a week for the professional staff of the CPSR.

In an attempt to insure that staff members of its own organization and those with statistical responsibilities in other governmental bodies are properly trained, the CBS conducts a training program both in Damascus and in Aleppo. The two-year course provides three contact classroom hours a day, six days a week, with an emphasis on training in statistical applications. The enrollment in the training program is currently about 80 persons, which is double its usual size.

The statistical activities of the Ministry of Health (MOH) seem to be concentrated in two areas: 1) the collection of hospital statistics such as the number of admissions, number of discharges, types of operations performed, etc., and 2) the receipt and publication of death statistics obtained from the Civil Registration Department (CRD) of the Ministry of Interior (MOI). The Ministry of Health appears to be currently lacking a statistical capability, although two of its employees are currently attending the Statistical Training Program of the CBS. The central office currently has two employees performing statistical functions, one with an epidemiological background, the other a compiler of the death certificate summary tabulations provided by the CRD. (The latter employee was not concerned about the under-reporting of deaths because the responsibility for the quality of all data collected by the government has been vested in the CBS and therefore is not the concern of the Ministry of Health.)

The Civil Registration Department registers births, deaths, marriages and divorces and is the legal certifier of such documents. In each mohafaza there is a regional office of the CRD serving as a repository for the documents, although copies of death certificates are also kept at sub-mohafaza governmental levels.

The mohktar, a governmental official operating at the small village, subpart of a large village, or city block level, has the responsibility for collecting birth and death information and for seeing that such events are properly registered within the legally required time period at the appropriate office of the CRD. The family

has an incentive for registering births because the Syrian government allots to each person the right to purchase a given quantity of oil and sugar each month at a reduced price. Since the Syrian government takes as a tax a portion of the estate of each decedant, the government itself has an incentive to develop a complete death registration system. There appears to be some comparison of census records and vital registration records, and an effort made to late-register those events that were discovered to be unregistered. The CRD appears to exercise no control over the quality of information provided for cause of death. In 1972 the cause of death given on 55% of the death records was coded "symptoms and other ill-defined conditions". While many of the death certificates so classified may be associated with deaths that were not medically attended, it nevertheless indicates a possible need to train physicians how to fill out the cause of death portion of the death certificate. Such training could possibly be incorporated into the medical school curriculum.

Health related statistics may be found in 1) Population Census of the Syrian Arab Republic 1970 (2 volumes) published by the CBS and containing demographic characteristics of the population, 2) The Statistical Abstract of 1975, also published by the CBS and containing demographic characteristics such as population estimates by age and sex and statistics related to births, deaths, marriages and divorces, and 3) The Annual Statistical Report 1972 published by the MOH and containing population estimates by age and sex, statistics related to deaths, causes of death, incidence of certain notifyable diseases, hospital related statistics such as number of admissions and discharges, types of operations, etc., and health manpower statistics such as the number of technicians, midwives, nurses and doctors qualifying, and the population of doctors and dentists.

From the investigation made to date, it appears that the population estimates by age and sex are probably very good; births are probably

under-reported; deaths most assurely are under-reported; cause of death information is of very poor quality, health manpower data is lacking, and virtually no data exists on the health characteristics of the population other than those associated with hospitalization.

II. Proposed Intervention Program

The intervention proposed is the establishment of a continuous national health survey capable of producing estimates related to the health characteristics of the Syrian population, incidence of acute conditions (including estimates of seasonal variations), use of health care facilities, attitudes toward family planning, birth and child spacing characteristics, death rates, etc. and incidentally demographic characteristics of the population. It is proposed that the health survey be flexible in scope so that, in addition to basic core data that would be collected continuously, the survey could focus on various other health subject matter areas for fixed periods of time or at fixed time intervals.

It is proposed that the national health survey program be divided into three phases (see fig. 2.). The first is a design phase during which time the project staffing begins, the upper level staff receives refresher training, the scope of the study is defined, the questionnaire is constructed, a pilot test is carried out, the sample design, data collection strategy and estimation techniques are formulated, the sample is selected and additional personnel such as clerks, interviewers, etc. are hired and trained, and all necessary preparations for the execution of the survey are made, e.g. necessary equipment is obtained, computer time arranged for, etc. This phase will continue for eighteen months.

The second phase would be the execution stage during which the data are collected,tabulated and analysed. This phase would begin at the end of the design phase and continue indefinitely.

The third phase is the evaluation stage during which time the data based on the first year of data collection are analyzed from the point of view of the efficiency and adequacy of the study design and sample design. At the end of this phase changes in the questionnaire, sample size or sample allocation might be recommended. The evaluation

phase would begin soon after the data had been tabulated from the first year of data collection, and last approximately twelve months. Any recommended changes that are to be incorporated into the study could be implemented beginning with year 4 of the data collection.

It is anticipated that the content of the questionnaire will change periodically, to permit a wide range of health related information to be collected. Any such changes would be preceded by a pretest of the new questionnaire form. Such activities would be carried out as part of the execution phase and the planning, staffing, and budgeting of the execution phase of the project should include this capability. There also must be a continual monitoring of the quality of the data, development of appropriate estimation techniques, computations of estimates of sampling errors, etc. While such activities will take place on a larger scale during the evaluation phase, it is expected that constant monitoring and evaluation will take place on a continuing basis during the execution phase of the study.

III The Design of the Study

The exact details of the study design will, of course, be worked out during the design phase of the study. The study design described here is one that is felt to be close enough to what will be the final design to serve as a model for staffing and costing purposes.

The proposed study would be a continuous health survey. During each calendar week in the year a nationwide probability sample of households will be included in the study and interviews will be obtained. Demographic and health related characteristics of the family and its members will be obtained. Such a design would permit the unbiased estimation of month by month variation in the incidence of acute conditions. A home interview survey is limited in the type of diagnostic information that can be collected and much of the information about acute conditions will necessarily relate to symptoms.

It is also felt that the designated respondents would be the female heads of families. In the case of extended families living in the same household, it may be necessary to divide the household members into smaller family units, and interview the female heads of each such unit. The female head of a family is probably the most knowledgable about the health cahracteristics of the family, the births of children, the families food consumption, etc. and she would be the person from whom we would wish to obtain family planning knowledge and attitudes toward contraception. In addition she is very likely to be at home during hours available for interviewing, which has good cost implications. It is felt that with exclusive use of women interviewers bearing proper identification and an extensive advertising campaign, the response rate should be well over 90%.

1. The Sample Design

The CBS maintains a list of all dwelling units in the nation. The list was established during the decenniel census and is constantly updated using permits for demolition and construction. The list is used as a frame for selecting households for surveys conducted by the CBS and we propose that it be used as a frame for the national health survey. For planning purposes we are proposing the selection without replacement of an equal probability sample of households for each calendar week of the year. A yearly population survey conducted by the CBS selects urban households at twice the rate of rural households. The additional costs associated with data collection in rural areas make such a design appealing. Because of the special interest in the health characteristics of the rural population for the purposes of health planning, it was felt that in the national health survey, rural households would probably be selected at least at the same rate as urban households, in spite of the greater data collection costs associated with the former. The cities in Syria are small geographically, and, in view of the anticipated high 'at home' rate, it would be feasible to select dwelling units in cities singly (as has been

the proceedure for other surveys done by the CBS) rather than in clusters. Clustering within villages would be necessary for cost purposes but because of a relatively long anticipated interview time, part time interviewers and the anticipated high 'at-home' rate, clusters of two or three dwelling units per sample village probably will be adequate.*

2. Sample Size

The proposed sample size is 100 households per week, providing a yearly sample size of 5,200 households. As can be seen in Table 1, this sample size would result in the collection of information for about 31,000 persons each year. If approximately 57% of the population is rural, as was the case in 1970, the sample would include about 18,000 persons living in rural areas over the course of a one-year period. Table 2 shows the expected number of persons that will be included in a yearly sample by age and sex.

Assuming a near perfect response rate, and assuming that births and deaths occurring to residents of the household within the preceding year would be accurately reported, there should be approximately 1,476 births and 610 deaths reported each year. The expected number of deaths distributed by age and sex are presented in Table 3. The expected number of births distributed by sex is presented in Table 4.

3. Scope of the Survey

As was previously mentioned, it is anticipated that the scope of the survey will be broad over the long run, but somewhat restricted at any one point in time. If the personal interview is to average no more than about one hour per respondent, which is felt to be a realistic maximum, all areas of interest could not be covered on a single questionnaire. By changing the content of the questionnaire

* It is assumed that villages would be stratified at least by size prior to selection, or that villages would be selected with probability proportional to population size (PPS).

periodically, for example every year, it would be possible to retain certain items permanently, but retain other items for only a one or two year period. The removal of one set of items would make way for the addition of others, permitting the gathering of information on a variety of topics over the course of a several year period.

The types of items that should be considered for inclusion in the questionnaire are:

a) Demographic information would be collected for each resident of the household. This would include name, relationship to head (or to female head), sex, age, marital status, education and occupation.

b) Incidence information would be collected for each resident of the household. This would include recording conditions such as cough, sore throat, diarrhea, etc. which began during the calendar week prior to the week of the interview, for example. Information concerning whether medical attention was sought and was received for the illness could be obtained, as well as supplementary information about the medical care received, such as who rendered the care, what the charges were, and who paid for the visit. In addition information about the number of days that were missed from work or school the previous week because of illness could be obtained (regardless of the date of onset of the condition).

c) Prevalence information can be collected for each member of the household. Individuals who were blind, deaf or mute could be recorded, as well as those having such cronic conditions as diabetes, high blood pressure, etc. Whether or not children had received vaccinations or immunizations against specific communicable diseases could be determined as well.

d) Births or deaths occurring to residents of the household during the past year could be determined. (Because it is felt by many that a

substantial proportion of babies living less than two weeks are not registered as births or deaths, a survey proceedure may be the most accurate way to obtain birth and death statistics at the present time.)

e) A list of children ever born could be obtained from each married, widowed or divorced woman in the household. Supplementary information such as the date of the birth, who attended to the birth, whether the child is still alive, and if not, age at death, could be obtained. In addition, for recent births, the type of prenatal and postnatal care could be obtained.

f) Family planning information could be obtained from married women, including knowledge of and attitude toward contraceptive techniques.

g)Nutritional information could be obtained for the family and knowledge of nutrition and attitudes about dietary practices could be obtained from the repondent. If more extensive food intake studies were to be made, information obtained on the health interview survey could be used as a basis for subselecting families or individuals for more intensive study and for analysis in conjunction with the food intake data.

h)Height, weight, and arm circumference could be obtained for children under five years old.

i) Housing characteristics could be obtained for each household such as presence of water piped into the house, existance of a flush toilet for the family's use, etc.

4.Precision of Estimates

Precision of estimates from a sample of the specified size and design: Based on the results of surveys conducted in the United States, modified by the characteristics of the proposed sample design and the assumed characteristics of families in Syria, it is possible to make an educated guess about the magnitude of the precision of the estimates that would be produced from a one-year data

collection effort. If the crude birth rate was about 48 per 1000, the sampling error would be about 1,5 per thousand. The 95% confidence interval for such an estimate would be 45-51 per 1000.*

Approximate expected condifence intervals for death rates within age by sex groups are presented in Table 5. If the crude death rate were estimated to be 18 per 1000, the 95% confidence would be 16-20.

Expected sampling errors for other types of estimates are presented in Tables 6 and 7

If it were estimated that 50% of the children in the age group 1-4 years old had been vaccinated against smallpox, the expected sampling error would be approximately 1.0 percentage points. (See Table 6.) One could thus say with 95% confidence that the 'true' population figure fell in the range 50% $\pm$ 2(1.0%) or between 48% and 52%.

If the incidence of colds were estimated to be 50 cases per thousand for all age groups combined for the month of January, the expected standard error would be about 6. The 95% confidence interval would thus be 50 $\pm$ 2(6) or 38-62 per thousand.

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* A 95% confidence interval specifies the range within which a sample estimate can be expected to fall 95% of the time, if the same type of survey were to be repeated over and over again and there were no response error or error due to non-response. Another way to view a 95% confidence interval is that it provides a range which should span the 'true' population value 95% of the time with repeated samplings.

In computing the sampling error in this case, the following formula was used:

$$S.E.(p) = 1000\sqrt{\frac{p(1-p)}{n}} \quad \text{where } p = .048,$$

the ratio of the number of births expected to occur to the total population, and n = 30,896, the sample size.

The sample design proposed will actually be a stratified, clustered design and special formulas which reflect the stratified, clustered nature of the design should be used. For estimating birth rates during a one-year period, however, it is felt that the effect of the sample design would be such that the sampling errors would be equivalent to those of a simple random sample.

5. Staffing

A staff organization chart is presented in Figure 3. It is suggested that the National Health Survey be located in the CBS, and that the Director of the National Health Survey (NHS) report directly to the Director of the CBS. The Director of the NHS should have considerable experience (at least 5 years) in survey research and have a PhD in a relevant field such as Sociology, Demography, Public Health, or Statistics.

The Assistant Director should have at least 3 years experience in survey research, and a graduate degree in one of the related fields.

The Statistician should have both experience and professional training in survey sample design and data analysis in addition to a graduate degree in one of the related fields, and at least one degree in statistics.

The Data Collection Professional should have a college degree, preferably in one of the related areas, and should have at least 5 years experience in survey research, at least two years of which have been in a supervisory capacity.

The Health Professional should have at least 5 years experience in the area of Public Health, have at least 2 years experience with survey research or Public Health statistics, and a graduate degree in a health-related field.

It is assumed that all other positions will be filled by people who have demonstrated their ability in the area of work associated with the position.

It is essential that the field interviewer and the regional supervisor positions be staffed by women, preferably those with previous interviewing experience. Due to the fact that the repondents would all be women and that some of the areas of study would necessitate asking questions somewhat delicate in nature, it is felt that men would be unsuitable for any position that would involve interviewing or interviewer observation.

In addition to the top five professional positions described above, professional consultants would be used on a sporatic basis. Consultants would have specialties in the areas of sample design, data collection, and health survey design, implementation and analysis.

The coordinating committee could be made up of members from each of the ministries that might make use of the data from the survey and in addition would have the Directors of CBS and CPSR as members. The major purpose of the committee would be to offer overall guidance and assistance to the Director of the NHS in formulating the scope of the study and in securing any needed cooperation from other ministries. Such involvement of other ministries with the study would insure that the needs of their ministries would be made known at an early stage in the development of the NHS, and hopefully would improve the likelihood of the NHS data being used after it has been gathered and made available.

Figure 3

STAFFING OF THE NATIONAL HEALTH SURVEY

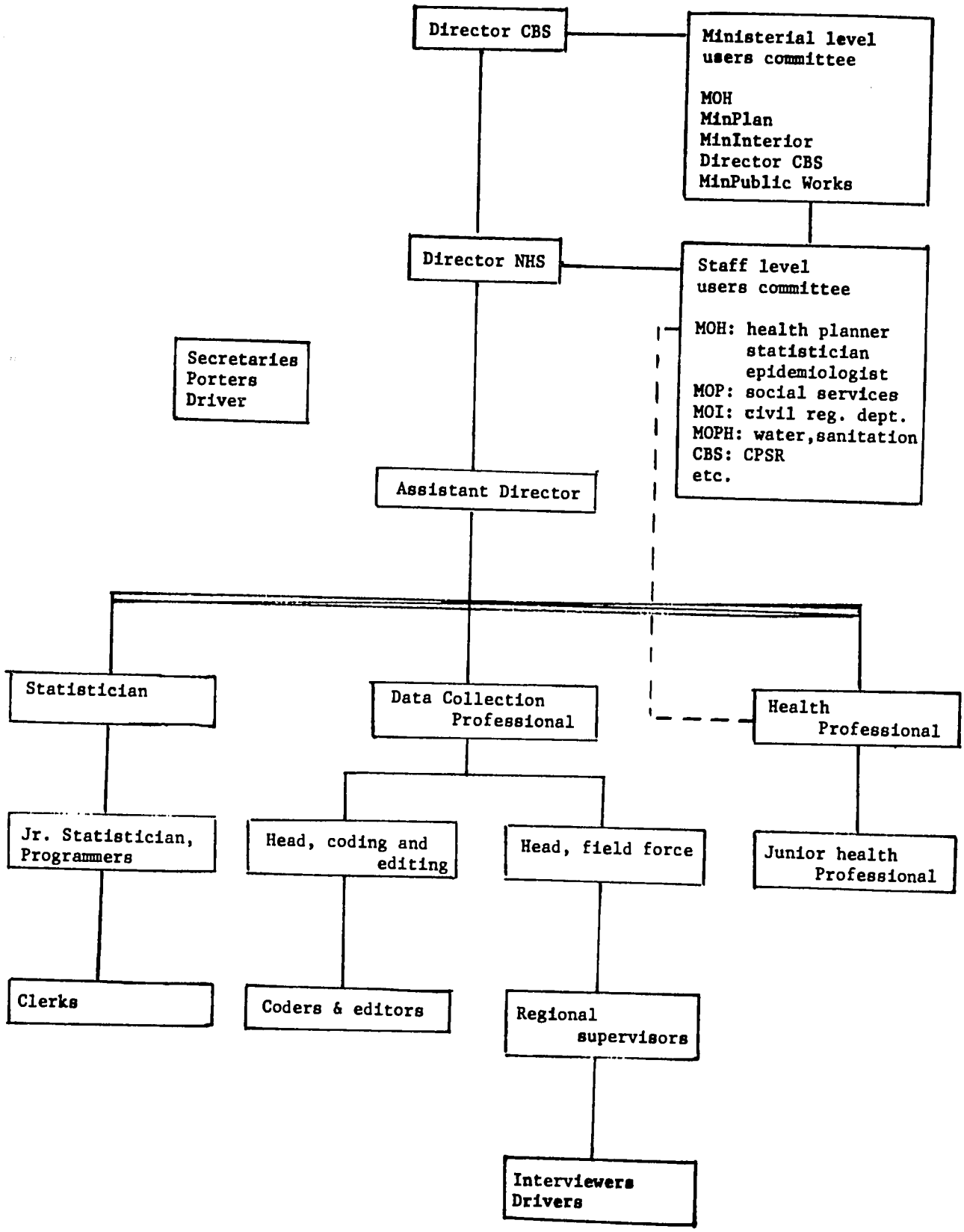


TABLE I

EXPECTED SAMPLE SIZE BY MOHAFAZAT BASED ON 100 INTERVIEWS PER WEEK

Mohafazat	Percent*	Number of Interviews Per Week	Number of Interviews Per Year	Number of Persons per Household**	Number in Interviewed Households
Damascus City	13	13	676	5.6	3,786
Damascus	10	10	520	5.9	3,068
Aleppo	21	21	1,092	5.9	6,443
Latakia	6	6	312	5.7	1,778
Homs	9	9	468	6.1	2,855
Hama	8	8	416	6.3	2,621
Hasakeh	7	7	364	6.1	2,220
Deir-ez-zor	5	5	260	6.6	1,716
Dara	4	4	208	6.0	1,248
Swayda	2	2	104	5.5	572
Idleb	6	6	312	5.6	1,747
Al-Razza	4	4	208	5.7	1,186
Tartous	5	5	260	6.0	1,560
Al-Quneitra	0.3	0.3	16	6.0	96
Total	100	100	5,216	5.9	30,896

* Annual Statistical Report 1972, Ministry of Health, SAR, Table 5, p. 16

** Statistical Abstract 1975, Central Bureau of Statistics, SAR, Table 8/2,p.93.

Table 2

Expected Sample Size by Age and Sex:
Based on 100 Interviewed Households Per Week

	Percent*			No. of Persons in Sample Per Year		
	Male	Female	Total	Male	Female	Total
Under 1	1.9	1.8	3.7	587	556	1,143
1-4	7.8	7.4	15.2	2,410	2,286	4,696
5-14	15.9	14.5	30.4	4,912	4,480	9,392
15-24	8.7	8.2	16.9	2,688	2,533	5,221
25-44	9.9	10.1	20.0	3,059	3,120	6,179
45-74	6.3	6.0	12.3	1,946	1,854	3,800
75 & over	0.8	0.8	1.6	247	247	494
TOTAL	51.3	48.8	100%	15,849	15,076	30,925

* Annaul Statistical Report 1972, Ministry of Health, SAR Table 1, p. 11.

Table 3

Expected Number of Deaths in Past Year in Sample Households by Age and Sex. Based on 100 Interviewed Households Per Week

Age	Death Rates* Male	Death Rates* Female	Expected Number of Reported Deaths Male	Expected Number of Reported Deaths Female	Expected Number of Reported Deaths Total
Under 1	119.29	105.80	172**	161**	333**
1-4	16.36	14.42	39	33	72
5-14	1.95	1.87	10	8	18
15-24	2.84	2.47	8	6	14
25-44	4.69	3.80	14	12	26
45-74	24.38	18.97	47	35	82
75+	150.48	137.58	37	34	71
TOTAL	18.35	17.03	327	289	616

*Statistical Abstract 1975, Central Bureau of Statistics, SAR Tables 15/2 and 14/2.

** Expected number of deaths based on number of expected births minus number of expected live children associated with sample households.

Table 4

Expected Number of Births in Past year in Sample Households by Sex Based on 100 Interviewed Households Per Week

Expected No. of Persons in Sample	Crude Birth Rate*	Expected Number of Reported Birt Male	Expected Number of Reported Birt Female	Expected Number of Reported Birt Total
30,896	47.78	759	717	1,476

*Statistical Abstract 1975, op cit.

Table 5

Interval Estimates of Death Rates for Age by Sex Groups:
Based on a Sample of 100 Households Per Week for a One-Year Period

Age	Death Rates per 100 Population* 95% Confidence Interval is**		
	Male	Female	Total
1	93-145	80-132	95-131
1-4	10-22	8-20	11-19
5-14	1-4	1-4	1-3
15-24	1-5	1-4	2-4
25-44	2-8	1-7	2-6
45-74	15-33	10-28	16-28
75+	106-194	96-182	112-176
TOTAL	15-21	14-20	16-20

* See Table 3 for death rates used in computations.

** Assumed that sampling errors would be equivalent to those of a simple random sample for this variable.

Table 6

Expected Standard Errors for Percentages of People Having a Given Characteristic: Based on a Sample of 100 Households Per Week for a One-Year Period.

For Estimated Percentages	0.1% or 99.9%	1% or 99%	5% or 95%	10% or 90%	20% or 80	50%
For Age Groups	Expected SE's in Percentage Point					
1. Under one Yr. or Over 75 yrs.	0.1	0.5	1.0	1.5	2.0	2.5

Table 6

2. 1-4, 5-14, 15-24, 25-44, or 45-74	0.1	0.2	0.5	0.8	1.0	1.0
Total Population	0.02	0.1	0.2	0.2	0.3	0.4

*Assuming a design effect (DEFF) = 2. This means that the error variance would be expected to be about twice that of a simple random sample of the same number of people. Such a condition results when clusters are somewhat homogenous with respect to the variable being measured.

Table 7

Expected Standard Errors for Incidence Per 1000 Persons Per Month: Based on a Sample of 100 Households Per Week for a One-Year Period.

Monthly Rate Per 1000 Population	1	10	50	100	200	500
Expected Standard Error*	1	3	6	8	11	14

*Assuming a Design Effect (DEFF) = 2. See footnote on Table 6.

MEDICAL EQUIPMENT AND HOSPITAL MAINTENANCE

A survey of MOH hospitals and health centers was made by on-site visits between 21 April 1976 and 5 May 1976. The purpose of the visit was to ascertain the problems of maintenance and develop a proposal to deal with those problems. The hospitals and centers visited are described in Appendix A.

Syria has made a major investment in hospitals and medical equipment throughout the country in the last fifteen years. However, very little has been spent to maintain and preserve the investment. In general, only the actual breakdown of equipment is dealt with, and even there somewhat unsuccessfully since repair manuals, spare parts, and trained manpower are not available. In the hospitals visited there was no evidence that planned maintenance programs existed either in theory or fact.

It is proposed that a project establishing a preventative maintenance program in the southern half of Syria be initiated. (If the program is successful if would be replicated in the northern sector with a center possibly in Aleppo.) The central workshops and major spare parts inventory would be located in Damascus, presumable in the new building at Damascus Hospital. Plans for the new building floor layout are given in fig. 1.

The program proposed is designed to protect the government's investment and to insure safe, dependable equipment for better patient care. It is hoped that by improving the hospitals an additional effect will be that government service by doctors will be more appealing.

System Prerequisites

The principle prerequisite is that both the MOH, the directors of Mohafazats, and the directors of hospitals accept the premise that preventative maintenance is worth the administrative time and manpower investment. In the sites visited, the interest of the Hospital Director in maintance appeared to be the factor most heavily influencing the state of buildings and equipment.

Phase I

In phase I of the project, two major functions would be carried out: staffing and the establishment of a management control system.

Staffing: (See organization chart, fig. 2) The first step requires approval of several new government positions starting with the creation of a new division or department in the MOH. This department would be headed by a director, which we have labled 'Director of Hospital Maintenance and Engineering.' In addition to the director, he would have as immediate staff, one specialist in the repair of medical equipment, and one hospital inspector.

The Director would be responsible for all maintenance, engineering, and alterations within the MOH system and would answer directoy to the Vice-Minister for Hospital Supplies. He would, with consultant assistance, establish the procedures and methods to implemnt the system. He would thereafter be responsible for updating and modifying the system over time. The person selected should be an electrical or mechanical engineer with management experience. Additional training in systems management in the U.S. is recommended.

An x-ray specialist and medical equipment specialist should next be selected. They would perform periodic maintenance on major pieces of equipment and repairs in the case of a breakdown. In addition they would instruct the maintenance people, in the hospitals served, how to trouble shoot and correct minor problems. The two specialists should be furnished a van outfitted with a small work bench, an air compressor, electronic test equipment, spare parts, and other related maintenance tools.

The building inspector should also be selected. He would travel to all the hospitals in the area on a routine, scheduled basis, and would make detailed inspections of all equipment and buildings. Where work requests had not been submitted to the ministry, and repairs were beyond the hospital's capability, he would write work requests to go to the MOH specialists. Where the hospital should be capable of handling a problem he would write a work request to the hospital maintenance supervisor and assist him if there were problems. He would further be responsible for following up on all work requests initiated by himself and those sent directly to the Ministry.

Inventory Control System: In order to implement the overall system as expeditiously as possible, both the AID health team and the WHO expert who visited Syria earlier feel that it is necessary to have accurate detailed information about the system. A complete inventory record card in duplicate should be made for each piece of medical and hospital equipment. A suggested format is presented in figure 3. This can be done on a hospital by hospital basis by the team of two specialists and the inspector from the MOH. The inspector should

additionally note structural damage to buildings and dangerous or unsightly rubble around the hospital grounds. (While the inventory is proceeding the Director should be in training in the U.S.).

When the master inventory list of all equipment is ocmpleted, each hospital will retain one copy of each of its own record card and the Ministry of Health will have a complete record for the southern region. The ministry team should then sort the cards into units of like items. For each like item (i.e. nine brand-x x-ray machines located in x, y, and z hospital) the record cards will indicate if a manual exists and what language the manual is in. Two separate procedures would then be initiated:

1) Where a manual exists: the ministry team should centrally collect the manual. If the manual is in Arabic, one copy (to go with the inventory card in the MOH), and one copy for each maintenance supervisor in each hospital that has such a unit should be reproduced, and the hospitals supplied with their copies which, with the inventory cards, will be the responsibility of the maintenance supervisor. If the manual is not in Arabic it should be translated under contract and reproduced as above.

2) Where a manual does not exist: the ministry team should write the manufacturer for a copy, preferably in Arabic. The procedure in 1) above would then be followed.

Phase II

In phase II an overall management control system would be designed and implemented, the main workshops and mobile van would be equipped, a spare parts inventory established, and a contract let for major repair to bring

the system up to working condition and to train maintenance employees in the hospitals.

Overall management control system. At this point in the project the Director from the MOH will have returned from training in the U.S. Working with a U.S. consultant in management systems design, and building on the experience of the ministry team during phase I and the inventory, the director will establish the procedures for work orders, emergency repairs, periodic maintenance (by the two specialists) and regular inspections (by the MOH inspector). He will additionally build on the existing inventory file recording maintance repairs done to each piece of equipment and what this information should be reported to the ministry for its own central files. He will establish with the procurement department of the MOH a procedure whereby each new piece of equipment has two inventory cards made up for it upon arrival in the country, the manual is duplicated (and translated if necessary) and a copy of the inventory card and an Arabic language manual sent to the hospital with the new piece of equipment.

Contract Services: The director will then design the scope of work for a Syrian contractor to go to each hospital and repair any equipment that can be repaired. The contractor will update each inventory card and compile a list of spare parts which are needed but unavailable for repair. The contractor will be assisted by the two specialists and the hospital inspector from the MOH, who will have on-th-job training through this process. The contractor will also demonstrate simple repairs and the regular maintenance procedures for each machine to the hospital maintenance employees while in the hospitals and should

follow with a training course for maintenance employees which should include the proper use of test equipment, calibration, reading of diagrams, and simple equipment repairs and how to follow a routine maintenance schedule.

Mobile Van and Workshop Equipment: The director, with the aid of the U.S. consultant, should review the current equipment available and then determine what is needed in addition for an effective mobile van and for well run central workshops at Damascus Hospital. This equipment should then be ordered.

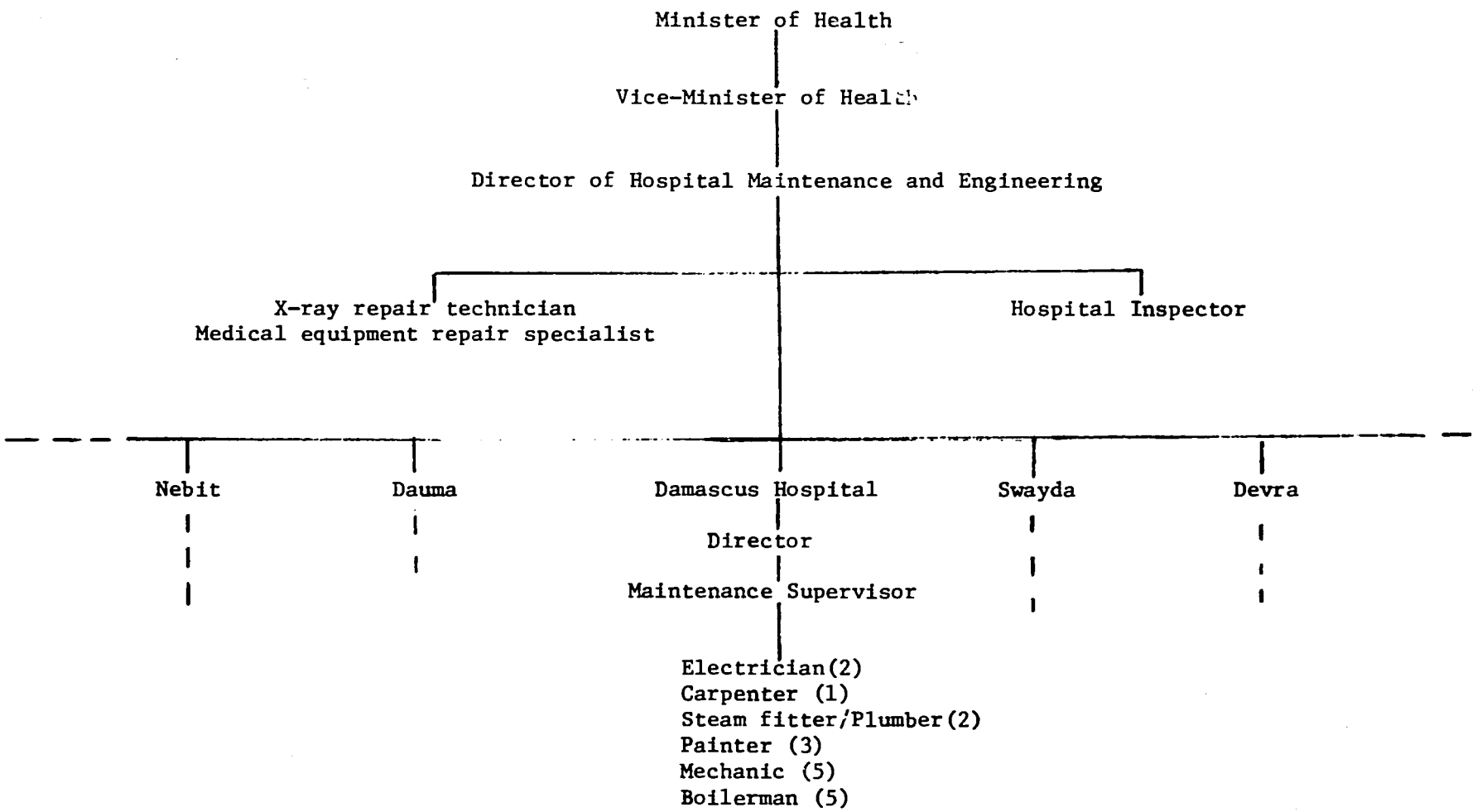
Spare parts inventory: Based on a compilation of spare parts needs from the MOH's central record manuals, spare parts should be ordered and a spare parts stock system with full financial controls established at Damascus Hospital. (It may be necessary to create an administrative position responsible for spare parts inventory control.) A control system similar to the one now in effect for hospital supplies at Damascus hospital should be established. Additional spare parts identified by the Syrian contractor should also be ordered.

Phase III. Operation.

In phase III the system designed in phase II will operate for one year. The U.S. consultant will assist during this time in designing an evaluation system to be used after the end of the first year of operations.

Phase IV. Evaluation.

Based on the evaluation designed on phase III, a Syrian contractor will be hired to work with a U.S. consultant to evaluate the effectiveness of the maintenance and repair system and to make recommendations concerning improvements in the system. These recommendations would go to the MOH and to USAID.


Minister of Health
Vice-Minister of Health
Director of Hospital Maintenance and Engineering
X-ray repair technician
Medical equipment repair specialist
Hospital Inspector
Nebit
Dauma
Damascus Hospital
Swayda
Devra
Director
Maintenance Supervisor
Electrician(2)
Carpenter (1)
Steam fitter/Plumber(2)
Painter (3)
Mechanic (5)
Boilerman (5)

INVENTORY CARD

HOSPITAL:

DATE:

ITEM:

LOCATION:

DATE INSTALLED:

MANUFACTURER:

MANUAL: YES?___ NO?___

COUNTRY OF ORIGIN:

MANUAL LANGUAGE:

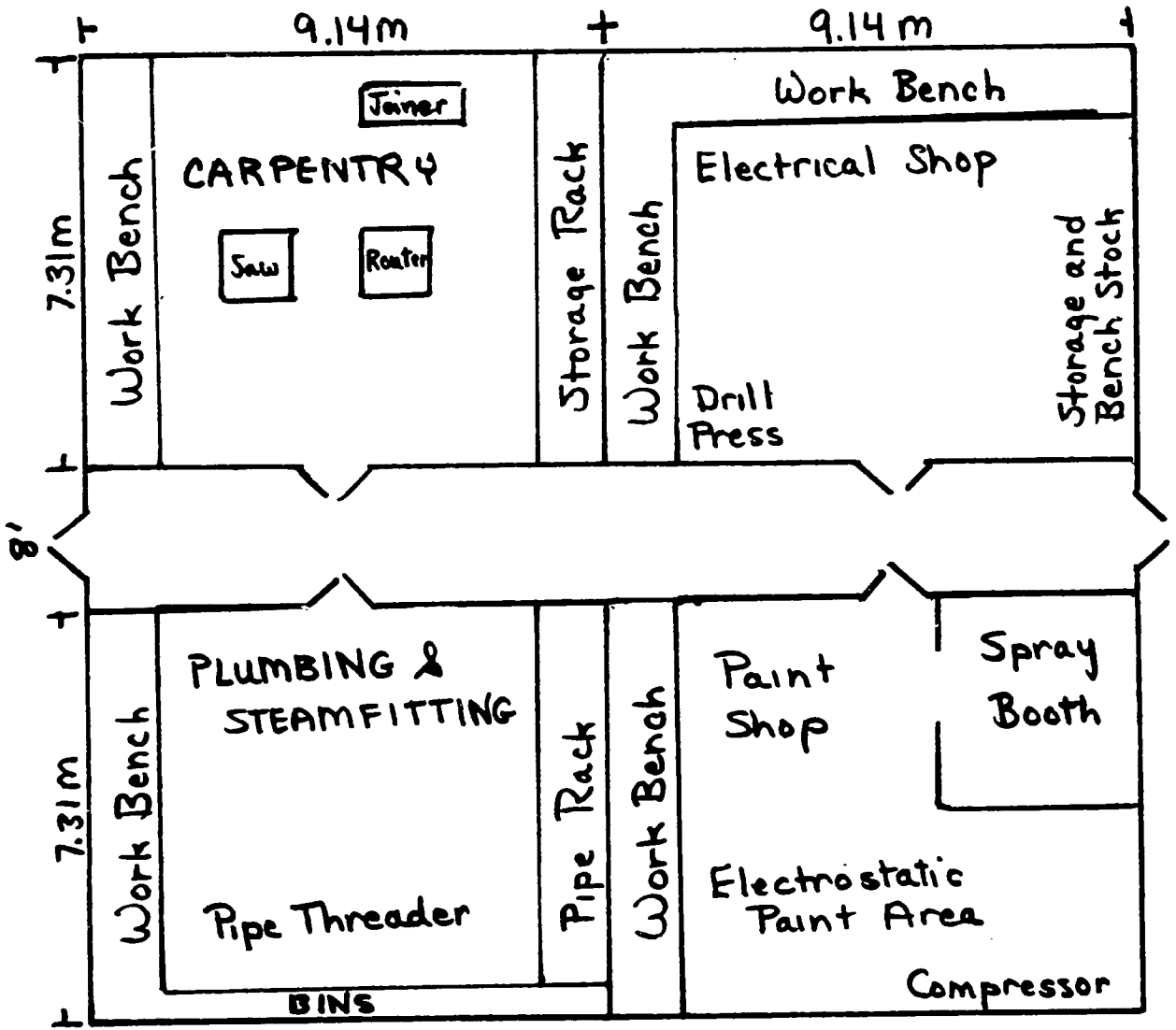
CONDITION OF EQUIPMENT:

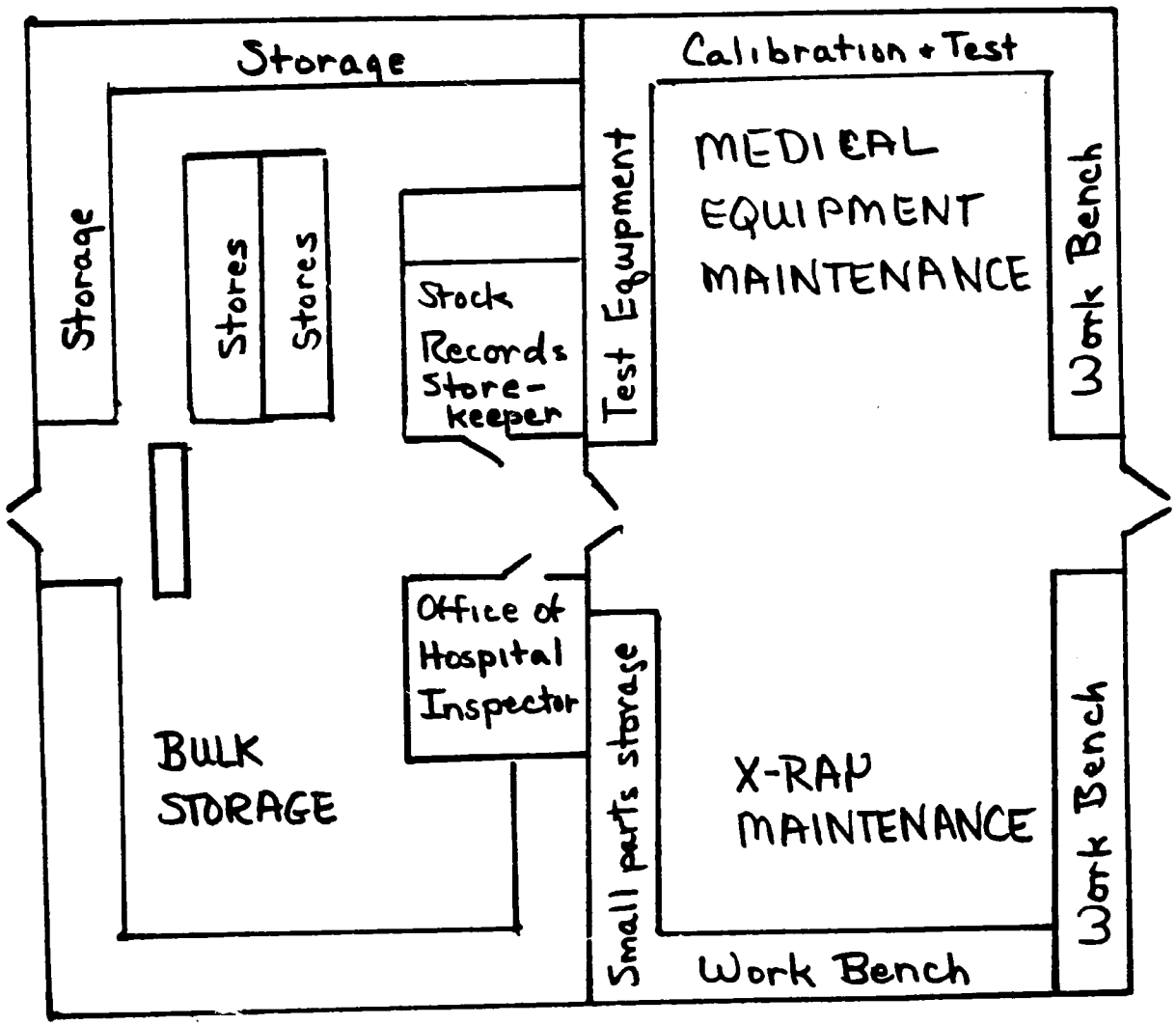
NAME PLATE DATA:

VOLTAGE:
HORSE POWER:
AMPERAGE:
KILOWATTS:
FREQUENCY:
PHASE:

SERIAL NUMBER:
RPM:
OTHER DATA:

REPAIRS AND OVERHAULS				
Date Inspected	Work Order Number	Repaired by	Nature of work performed	Material used


9.14m
9.14m
Work Bench
Jointer
CARPENTRY
Saw
Router
Storage Rack
Work Bench
Electrical Shop
Drill Press
Storage and Bench Stock
7.31m
Work Bench
8'
PLUMBING & STEAMFITTING
Pipe Threader
Pipe Rack
Work Bench
Paint Shop
Spray Booth
Electrostatic Paint Area
Compressor
BINS
7.31m
Work Bench


Storage
Storage
Stores
Stores
Stock Records Store-keeper
Office of Hospital Inspector
BULK STORAGE
Calibration + Test
Test Equipment
MEDICAL EQUIPMENT MAINTENANCE
Work Bench
Small parts storage
X-RAY MAINTENANCE
Work Bench
Work Bench

ESTIMATED COST

Short course--6 months at U.S. University		
180 days @ 40.00 per diem	7200.	
Travel	1000.	
Tuition	2000.	
		10,200
Contract training medical repairman		
24 weeks x 80 hours = 1920 x 3.00		5,760
Printing Inventory forms		~~100~~ 500
Large Motorized van		5,000
Equipment:		
Generator		200
Compressor		150
Bench Drill		80
Vice		30
Work Bench and drawers		50
Hand tools		200
Cabinets, Small parts		80
Small Van		3,500
File cabinet cardex		50
Visual Aids:		
Screen		30
Projector		100
Slides		100

Translators	2000.00
Operating instructions and manuels.	
Different languages into Arabic.	

Housekeeping Aids

Power floor scrubbers 12 @ 900.00	6300.00
Wet-dry vacuum cleaners 12 @ 500.00	3500.00

Special Shop Equipment

Oscilloscope	600.
Vacuum voltmeter	250.
Snap-on Ammeter	125.
Megger	125.
Tube tester	200.
Multi meter	150.
Pedestal drill	200.
Small lathe	300.
Tool Boxes	100.
Hand drill (2 ea.)	35.
Drill bits	150.
Sockets (Metric & Standard)	80.
Table saw	300.
Router	150.
Jointer	75.
Wood vise	60.
Machine vice	60.
Parts cabinet	150.
Air compressor	350.
Electro Static Paint gear	1200.
Uniforms for Inspector, two maintenance specialists	300.

Boiler Water Treatment 12 × 750 × 2 yrs = 18,000

WHAT IS PREVENTIVE MAINTENANCE

Preventive maintenance through a planned maintenance program is, in the simplest terms, advanced action designed to minimize or to prevent requested maintenance.

Schedules of inspection must be set up to periodically check, adjust, oil, and operate each peice of equipment in the hospital, whether it is in active use, on stand-by, or awaiting issue Records must be kept of work accomplished. Operating instruction and repair manuals need to be studied. Material and spare parts have to be available.

Finally, good cooperation between the Doctors, administrators, and maintenance supervisors is required to make any maintenance program run smoothly and operate efficiently.

JOB DESCRIPTIONS

Director of Hospital Engineering and Maintenance

This position is established for the purpose of overseeing and managing the preventive maintenance program for 30 hospitals and 60 (?) medical centers.

This position answers directly to the Vice Minister of Health. It is the responsibility of this section to institute and manage a preventive maintenance program throughout the MOH. An up-to-date inventory list with all pertinent information will be kept on file. Building blue prints will be kept and all alterations and changes added as they occur.

The purchase of medical equipment will be cleared through this office for safety orders and compatability with existing utility systems. A copy of the operating and maintenance instruction on all equipment will be kept as a permanent file.

Approves purchase orders for spare parts and inspects inventory list to make sure items are needed.

Receives copy of inspector's reports to ascertain what repairs are needed.

Handles contractual services on building repairs (plaster and painting and major alteration to utility systems.)

Monitors the medical repair technicians work for proper maintenance and repair.

Periodically visits outlaying hospitals and confers with directors and maintenance supervisors in problems they may be having.

Works closely with directos in the plans of alteration or changes being contemplated

Maintenance Supervisor

This position works under the supervision of the Director of the hospital in the preventive maintenance and repair of all hospital buildings and installed equipment.

Keeps uptodate inventory of all equipment on inventory cards.

Maintains operating and maintenance manuals for all equipment. Sets maint program for each piece of equipment and lists what to look for, what to do, how to do it and the frequency.

Orders material for the maintenance and repair of the equipment.

Sets work schedules ans supervises four to twenty men in the twenty four heur operation of the hospital

Receives work requests both orally and in writing from the heads of the departments within the hospital. Maintains a record of those received.

Schedules maintenance work on all equipment and spot checks to assertain if the work is being done.

Assists the building inspector on his periodic tours to his hospital

Plans and lays out work for employes. Trains and instructs new employes in the many complex systems within the hospital

Will initiate a visual aids training course in building maintenance. These slides or films will be shown throughout the ministry by the traveling building inspector an his scheduled tours.

Works closely with hospital directors and the MOH in solving problems that may occasionally arise in the operation and maintenance of their hospitals.

Qualification: Mechanical or Electrical Engineering Degree

Age Bracket: 35 to 45

Language: Arabic and English (if attending U.S. college)

Controls over work: Supervises 150 to 250 personnel in the maintenance of very complex hospital buildings and advanced medical equipment.

BUILDING INSPECTOR AND INSTRUCTOR

Works under the Director of Hospital Engineering and maintenance. Will schedule periodic inspection trips within the assigned territory. Will inspect all hospitals and health service centers for equipment maintenance, building maintenance and housekeeping. Is authorized to write job orders. Checks to see that work was accomplished. He would observe employees working and note areas where additional training might be needed. He would report this to the Director of Hospital Engineering and Maintenance and assist him in setting up a training program either with visual aids or short classes of instruction. (Repair plumbing fixtures, minor electrical work, proper way to a paint, and so forth.)

Qualification: Graduate of Technical School in "Building Maintenance" Well versed in building trades and construction. Have the ability to instruct small calsses of worker in proper maintenance procedures. Willing to travel between hospitals in his assigned district.

MEDICAL EQUIPMENT REAPIR SPECIALIST

This position works under the supervision of the Director of Hospital Engineering and Maintenance in the performance of preventive maintenance and repair of all medical equipment in the assigned district.

Work to consit of the maintenance, repair, testing, calibration, and adjustment of the many and varied types of medical euqipment used within the assigned territory.

Maintains up to date medical equipment record cards.

Keeps on file all operating and repair manuals of medical equipment.

Maintains a spare parts inventory for the immediate repair of critical items.

Will travel with the x-ray repairman on pre-scheduled maintenance program to the different hospitals in their territory. The main medical equipment repair shop will be at the Damascus _____Hospital.

Will work in close harmony with the x-ray technician if needed to help on large equipment.

Will instruct maintenance personnel to trouble shoot and make minor repairs on problems that may arise between scheduled visits.

QUALIFICATIONS: Mechanical or electronic degree in Engineering. Specialized training in medical equipment repair and calibration

Age: 25-35

RADIOLOGY REPAIR TECHNICIAN

1) This position works under the supervision of the Director of Engineering and Maintenance in the performance of preventive maintenance and repair of all radiological equipment in the assigned district.

2) Work is to consist of the repair, calibration and replacement of the many different types of x-ray equipment.

3) Keeps up to date equipment record cards.

4) Research parts manuals and writes purchase orders for replacement parts of the many different types of x-ray units.

5) Maintains a spare parts inventory of interchangeable parts of the many different manufacturers of x-ray equipment.

6) Position requires the traveling between hospitals on a pre-planned schedule, in a motorized shop-equipped van.

7) Main repair shops are to be set up at Damascus_____Hospital.

8) Will work in close harmony with the medical equipment specialist in assisting him in the repair of equipment that may require additional help.

9) Will instruct maintenance personnel in the proper method of trouble shooting minor problems and the repair of the same.

QUALIFICATION: Engineering degree in electronics. Specialized training in x-ray.

Age: 25 to 35.

Appendix D

DECISION NO. 14/T

The Health Minister,

In accordance with Regulatory Order No. 43/T dated 11/5/1970,

and Legislative Decree No. 111 dated 1/9/1966

and the Minutes of the Committee formed as per Administrative Order No. 5314/1/3 4/2 dated 17/5/1971,

DECIDES THE FOLLOWING:

Article 1 - Definition of Health Center: It is a health Unit providing preventive, curative and first aid health services within pending regulations for an agglomeration of people not exceeding /25/ thousand people in the countryside and in towns, and within the limits fixed by the Health Directorate. Accordingly, the building of this center shall be according to a special design adopted by the Ministry, and it can be connected with branch units (dispensaries), so that it may cover with its services an area with a diameter not exceeding (5-6) kilometers, and with a population not exceeding /5/ thousand people, which staff and obligations and duties shall be decided by a later Order.

Article 2 - Divisions and services of the health unit:

A - Prevention division, which shall offer the following services:

1 - Mother and child care, midwifery and family planning
2 - Environment control and coordination with labour health
3 - Prevention against contagious and endemic diseases
4 - Health education

B - Treatment division, which shall offer the following services:

1 - Medical examination
2 - Providing druges and medecines available at the unit
3 - First aid, bandaging and injection services
4 - Fighting and treatment of contagious and endemic diseases according to the Ministry's plan

.../2

C - Dental Services: which shall cover the preventative and treatment services in the dental field, within the unit scope of activity.

D - Training and formation: within the Ministry's plan.

Article 3 - Shall depend of the Health Unit:

A - a pharmacy,

B - a laboratory

C - an administrative office

Article 4 - Staffing of the Health Unit:

1 - Prevention physician, taking in charge the prevention department and its services

2 - Treating physician, taking in charge the treatment division and its services

3 - Dentist, for the dental prevention and treatment services.

4 - Midwife

5 - Nurses (3)

6 - Health assistant (3)

7 - Technical health assistant (2)

8 - Technical pharmacy assistant (1)

9 - Technical laboratory assistant (1)

10 - Clerk (1)

11 - Service personnel (3)

12 - Driver (1)

19

Article 5 - Staff duties of Health Unit:

1 - Unit head: The unit shall be headed by of the physisian thereof following appointed by the Health Director. He shall cooperate with him in procuring and hiring all technical and administrative personnel for all divisions. He shall assign duties and works on the unit staff, and draw the necessary programme thereof, according to the Ministry's plan for the development of health basic services. In addition, he shall, as physician, supervise one of the unit divisions in the training and education works according to the Ministry's plan. He shall also supervise

the good performance of the unit as well as the work and assiduity of the staff. He shall draw a monthly report on the work of the unit and its performance, according to the form blank adopted, and shall submit such report to the Health Directorate (Department of prevention services and contagious diseases), which shall study same and submit it to the Health Director who shall study and take the relative measures in connection thereof. He shall also supervise the health situation in his area, as he shall endeavour to improve same and to improve the health services extended to nationals in conjunction with the Health Director and the administrative departments of the government and the local department. He shall certify all official documents and minutes concerning dispensing, deterioration and consumption (of drugs), transfers and receipt vouchers, and all other documents.

2 - Treatment Divison:

- The treatment division physician shall be requested to check and treat patients calling at the unit, and to draw the form relative to the health situation of each patient. He shall issue the necessary prescription for a period in realtion to to the diagnosis, provided that it should not be for a period exceeding three days in ordinary cases, and according to the Ministry's plan for the treatment of endemic diseases (where special instructions exist).
- He shall send needing patients to laboratories and hospitals by official orders.
- He shall provide necessary first aid for urgent and special first aid calls.
- He shall supervise the distribution of drugs and injections.
- He shall treat contagious diseases patients according to the special instructions issued by the Health Ministry, as he shall inform the prevention division in the unit, who shall submit same to the Prevention and Contagious Diseases Services in the Health Directorate.
- He shall supervise nurses works and reports, as well as the work of the various staff personnel. He shall be responsible for their work performance and behaviour, and he shall submit

a monthly report according to the form shown at the end of this Decision to the Unit Head, together with his recommendations and suggestions for the improvement of the health situation.

- He shall issue medical reports to government employees in the region and areas, after transferring them to him through normal channels, according to rules and regulations.
- He shall prepare monthly programmes for health tours, in cooperation with the Health Director, and shall implement same.
- He shall perform forensic medecine when he is so requested.

3 - Prevention Division:

A - The physician in charge of the prevention division shall perform the following duties in the field of health improvement:

- Health checking tours on the health situation
- Health education programmes for citizens, according to the region's need. He shall implement same in cooperation with the health edecuation department and administrative services.
- Training programmes for licensed midwives in the area.
- Supervision of works and reports of health inspectors; programmes for their work and implementation thereof.
- Vaccination works
- Submit a monthly report to the Unit Head, containing adequate suggestions and recommendations for the improvement of the health situation and environment health programme, for the purpose of offering better health services.
- The physician shall be responsible of the health and performance of his staff and their conduct and behaviour towards citizens in the unit and outside same, during office hours.

B - The prevention physician in the mother and child care and family planning shall perform the following duties:

- Check-up of child and pregnant mother, after being prepared by health assistant, and transferring them to laboratories and hospitals whenever the need arises , and preparing the necessary form thefefor.
- Dispensing drugs and milk needed by children and mothers holding a health card, as well as those who are not requested to have such

a card, and registered at the unit.

- Supervision of vaccination works within the ministry's programme.
- Supervision of drugs and milk distribution, and injections.

C - The prevention division physician in charge of contagious diseases fighting shall perform the following duties:

- Detection of contagbus and endemic diseases.
- Transmitting results to the Prevention and Contagious Diseases Services in the Health Directorate, for further submitting to responsible parties at the Ministry.
- Taking prevention measures for fighting contagious diseases, such as diphteria, meningitis, cholera and others, and necessary qurantine, fumigation and sterilisation, etc..
- Necessary detection works to localise contagion and eradication thereof, to prevent generalisation and contagion.
- Participation in passive inpection programme in malaria eradication programme (taking blood samples from patients and analysis thereof), tuberculosis fighting programmes (BCG vaccines, patients and spit analysis, transmitting those hit to TB fighting centers).
- Participation in bilharsiosis and anglostoma fighting programmes within the Ministry's programme.

D - The prevention physician in charge or edecuation programme shall perform the following duties:

- Preparation of necessary programmes for the improvement of the health situation and diffusing health education among citizens in towns and countryside through the media; holding symposia and lectures to citizens, teachers and students.

4 - Dental Division

The physician in charge of the dental division shall perform the following duties:

- Treatment of dental cases reported to the unit; checking of dental health situation for the prevention and treatment, by detecting the percentage of cavities in the region, as well as tooth and gums diseases, and others. Such studies and detection shall be performed with the cooperation with school health

programme, among 6 to 12 years old children.

- Checking of children registered in the prevention divisions, mother and child care divisions, and their treatment up to age 5.
- Checking of all new students teeth at the first chool year, in cooperation with the school health programme; preparation of health card for each student and his treatment according to his individual case, as shown by the check-up.
- Preparation of a monthly programme on the division work, and submitting same to the Unit Head, together with the respective suggestions and recommendations for the improvement of dental health and the development of the dental services.

5 - Midwife duties:

- The midwife shall perform the necessary services in the field of care and education necessary to pregnant women, new mothers and infants.
- Supervision of delivery works, as performed by health assistants.
- Preparation of the pregnant mothers after due checking, and registration of all cases relating to their health and that of the foetus on their respective health card; submitting pregnant mothers to physician when the need arises.
- Preparation of a monthly report on the unit works in the field of mother and child care, and submitting same to the Unit Head.
- The midwife shall be requested to perform all health assistants works, when the latter is not available or absent.
-

6 - Duties of the Health Assistant:

The Health Assistant shall study family, social and economic cases of the family; she shall proceed therefrom to educating and helping same for the betterment of their lifes. She shall proceed with the education of mothers and pregnant women, and delivering health counselling and instructions in the unit and during house visits.

1- The female health assistant shall perform the following duties:

A - Preparation of health form for each pregnant woman wherein all remarks relating to the pregnancy are registered, such as personal

hereditary and natal history, together with the following details:

- Weight and Height - Blood tension - Urinalysis for the detection of diabetis and albumine - gynecologic check-up for the detection of the foetus age and condition - blood group - transfer to the dental division if needed.

B - Preparation of a special form for each infant, wherein weight, height, disease symptoms and abnormal conditions are registered.

C - Injections

D - Various regular vaccines.

E - Providing all necessary instructions for the improvement of the pregnant woman health, the child health, and their prevention of any diseases that may affect them, and especially for the prevention of miscarriage, and all that affect the mother and child health. Special care shall be given to new mothers and infants.

F - The health assistant acting as midwife shall be perform all all duties of the midwife whenever this latter is not available or absent from the unit.

2- The female health assistant performing her duties outside the health unit shall perform the following duties:

A - Performing normal deliveries at homes; preparing the birth certificate, and notifying civil registeration authorities within a week of same; providing the mothers with counsel concerning the infants health and food, rearing and food preparation.

B - Registering daily house calls, deliveries performed in and outside the unit in a special register submitted to the physician.

C - Preparation of a monthly report mentioning vaccinations and other duties for which she is responsible.

3- Duties of the Technical Health Assistant:

The Technical Health Assistant shall perform the following duties whenever no technical health inspectors are available at the Ministry of Rural Affairs. He shall prepare a monthly report

on his inspection works to the unit physician for submitting to the respective rural authorities and the Health Directorate, and in the following fields:

A - Drinking Water

1- Controlling all drinking water well boring

2- Inpection of public waters and ensuring their not being contaminated

3- Taking regular samples of drinking water and sending same to central laboratories for bacteriological analysis

4- Selection of the right places for wells

B - Proper disposal of human wastes

1- Encouraging people to build proper lavatories

2- Inspecting lavatories and their relative tanks

3- Selection of the proper place therefor

4- Discouraging people to use septic tanks contents in agriculture unless they are properly closed for an adequate period for a dissolution cycle; inspection of tank tanks disposal of wates in an adequate manner.

5- Orientation, counselling and inspection of animal wastes disposal; preparation of adequate garbage disposal in villages.

C - Sanitary garbage dosposal:

1- Advising people on the necessity of home garbage collection and putting same in securely closed receptacles.

2- Controlling final garbage disposal through incineration or dumping or speading over agricultural fields.

D - Food and Milk Health:

1- Health inspection of milk and dairy products production

2- Health inspection of milk and dairy products and food transportation and display

3- Regular inspection of workers in the food and milk and dairy products transportation and manipulation, to ensure

that they possess the proper health certificates and their being free of contagious diseases.

4- Regular inspection of factories, stores and sales outlets of foods and milk and dairy products.

5- Health inspection of slaughterhouses if they exist, and ensuring the proper disposal of animal wastes in villages.

6- Inspection of canned goods

E - Fighting insects and bugs

1- Familiarise himself with all kinds of medical insects and bugs and assessing their role in the disease and epidemic spreading

2- Pinpointing reproduction points of insects and bugs, and working toward their eradication

3- Preparing practical programmes to eradicate their reproduction areas

4- Preparing general plans for their fighting in their different life stages

F - School health environment improvement

1- Schools inspection to ensure of their proper aeration and lighting in classrooms; control of classrooms over-crowding

2- Inspection of sanitary plumbing and equipments in schools, of drinking water mains, lavatories, washbasins, and their proper and continuous adequacy

3- Inspection of playing grounds to ensure their being free of obstacles and hasards to students

4- Inspection of proper evacuation of wastes

5- Inspection of school buildings and ensuring their being free of dampness, and their adequacy

6- Inspection of preventive measures against hasards, such as ensuring the existence of handrails on stairs etc.. the propering covering of open holes, the existence of children equipments, etc...

7- Ensuring the proper and continuous existence of first aid kits and requisites

Remark: Insofar as the school health affairs are the responsibility of the Ministry of Education according to pending regulations, the health inspector shall draw his remarks and reports (in this field) and submit same to the Mouhafazat (district) health director, through the physician unit head, who shall transmit same to the Education Directorate to take the proper action.

G - Industrial Health in Factories and Plants

1- Controlling the existence of health conditions, and ensuring their adequacy and their being in proper order

2- Keeping a special register of the types of industrial plants

H - Housing health

1- Control of dwellings, and ensuring the adequacy of ventilation and lighting systems therein

2- Controlling the existence and adequacy of health conditions and requisites

3- Controlling the health situation of dwellings and their being free of hasards

I - Public Places

1- Proper application of health basic conditions on all Public Places, such as public buildings, clubs, cafes, restaurants, etc...

2- Control of animal stables, and their being adequately provided with basic health conditions.

3- General supervision of cleanliness of towns and villages

4- Education and orientation of public places, and control of health conditions in public transportation systems

J - Contagious Diseases Fighting

1- Sterilisation of dwellings in case of appearance of

contagious diseases

2- Controlling prpper quarantine of contagious diseases patients and quarantine quarters

3- Performing vaccination against contagious diseases according to health authorities instructions

4- Accompanying the physician in his health tours according to need.

K - Health Education

1- Participation in Public Health education programmes

2- Distribution of health leaflets and notices

3- Diffusion and spreading of public health instructions daily through his contacts with people, on an individual and public basis

4- Assisting in the projection of health ~~fim~~ films and diapositives

- The technical health assistant shall register daily all works duties performed by him during his tour outside the unit and in the unit on a special register, which he shall submit the morning of the following day to the physician in charge of the prevention division for his perusal

- He shall prepare a monthly report on all works performed and which he has been asked to perform.

8 - Duties of the male and female nurses

The male and female nurses shall receive all patients and prepare them for medical examination by the treating physician.

- Drawing and preparing the health form of each patient

- Taking patient temperature and registeration the prescription after writing the name and age of the patien t, health card number and address

- Performing nursing, bandaging, injections (hypodermic and subcuttaneal)

- Accompanying physician during his tours for prevention and treatment purposes, according to need.

- The male or female nurse shall perform all writing duties in case the clerk is not available or is absent from the unit
- He or she shall prepare a monthly report of all works performed and being requested to perform during the month in the unit.

9 - Duties of the Technical Assistant Pharmacist

A- Preparing all prescriptions given (tablets, creams, syrups, etc..)

B - Dispensing prescriptions after ensuring that the patient name and card name are registered, and a serial number on the respective examination register.

C- Preparing daily, monthly and quarterly sheets of dispensed drugs and medical products

D- Keeping ledgers and preparing drugs, milk, vaccine, equipments lists and requests; receipt thereof under the physician supervision; taking good care of same and their registeration in due course; preparation of reports of dispensing and consumption; their signing.

E- Stroing and savingemergency drugs; renewal of those with limited life span continuously and regularly.

F- Checking on the life span of drugs with limited life and informing physician of same three months before their validity; he shall also keep and maintain all drugs, equipments from ware and corrosion.

G- In case of the absence of the technical pharmacist assistant, the physician in charge of the prevention division shall appoint a technician from the staff, with adequate knowledge, to take care of the drugs temporarily.

10 - Duties of Technical Laboratory Assistant

A - Performing lab analysis of patients of the health unit and health centers, according to instructions from the Health Director

B - Preparing samples for analysis, their analysis and drawing results thereof

C - Preparing laboratory solutions as needed for the work

D - Registering results of lab analysis in a special register after taking the following information:
(patient name and age - card number - type of analysis requested - party requesting analysis - analysis result and date)

E - Preparing monthly report of analysis and tests, to be submitted to the Unit Head.

F - Preparing requests for lab materials and equipments needs for the proper work; receipt thereof under the physician supervision; taking care thereof, and especially materials with limited life span; preparing reports and forms of dispensing and consumption; signing thereof. This would submitted for approval of Unit Head.

11 - Clerk Duties

The unit clerk shall assigned the receipt and keeping of the following registers:

Health cards and registers - birth and child register for compulsory vaccination, names of parents failing to vaccinate children to be sued legally - incoming and outgoing mail - preparing and filling monthly and yearly reports after collecting all information from the unit and according to adopted form.

12 - Duties of Bellboy

A - Opening unit doors, cleaning same, arranging furnitures, arranging calling patients according to arrival, preparing same for registration.

B - Assisting in preparing and filling patient's health form

C - Keeping care of various unit divisions and furnitures, supplies; maintenance thereof

D - Receipt and care of unit supplies, furniture

E - Delivering mail to relative departments

F - Providing transportation of drugs, equipments and other unit requisites, incoming and outgoing

G - Closing doors and windows, turning off lights, air-condtionners, taps, heaters; cleaning unit before closing same.

Article 6 - Books and Registers Used in Unit

1 - Book for examination forms - health form - prescription

2 - Daily and monthly consumption of drugs and medical materials

3 - Forensic Medecine register

4 - Vaccination registers:
- Register for small pox vaccination of newborns
- Register for small pox vaccination of various age groups
- Register for polio, tri-vaccines and other vaccines

5 - Health Card register

6 - Health inspection of employers registers

7 - Contagious health and notification register

8 - School inspection register

9 - Deaths register

10 - Fixed assets register

11 - Consummable materials register

12 - Mail registers: Incoming - outgoing - delivery

13 - Technical health assistant duties register

14 - Midwife duties register

15 - Nursing duties register

16- Female health asistant duties register

17 - Technical ~~pharmacist assis~~ laboratory assistant duties

1 - Book of examination forms

This register shall bear the names of patients calling at the unit and outpatient pffices in hospitals. It shall also bear mention of health tours in a way such that it shows independently from the visits to the unit. On the outside cover of the register, the serial number of the examination forms book. On the top part of each page shall appear the number and date. The serial number of patients shall be started anew each month.

Nursing staff shall fill all blanks of the form, except those relating to the examination and prescription, which shall be left to the examining physician to write down the diagnosis and suggested medicines and the dose thereof. The physician shall sign each page.

Health Form: This form shall facilitate knowing the patient's history for the physician's perusal, and medicines prescribed before. This form shall be prepared at the patient's first call at the unit. The same serial number shall be reserved to the family members, where each member shall be assigned a special form with the siege number with the addition of a letter (A - B - C, etc..) for each member of the family. This number shall appear on the health card of calling patients who are not holder of a regular health card. On the visiting card of the patient shall appear the name, age and address of patient. On the form itself shall appear the date of the visit, diagnosis, prescriptions, doses, lab analysis results, or transfer to hospitals and date thereof.

Prescription: Of a form specially designed by the Ministry of Health, on which the name, age and address of patient shall be shown, his health card number, serial number of examination book, temperature of patient. The physician himself shall write the prescriptions and doses and figures and letters, and number of prescriptions.

2 - Daily and monthly consumption of drugs and medical materials

This register shall be kept by the person in charge of the pharmacy where he shall report daily consumption of drugs and medicines, which shall added together each month and reported into the consumed materials register in the blanks reserved for this use.

3 - Forensic medicine register

This register shall be supplied by the Public Prosecution Office after duly numbering its pages, and reporting same on the first page thereof. Forensic medicine is the responsibility of forensic physicians in towns and districts chieftowns; but in areas where such foremsic physicians do not exist, the examination physician in the health unit shall be responsible for the foremsic medicine during and outside office hours, and during official and other holidays. He shall examine victims after due transfer to him by the prosecution office or police posts officers by official delegation. Victims of criminal cases shall be examined at the site of the caseaccompahied by an official of the prosecutor's office, after receiving an official invitation for doing so. His remuneration shall be paid from the public crimes purse on the basis of the prosecutor's report.

Forensic examinations shall be performed at the unit; the result thereof shall be reported in detail on the official request and on the special register of the forensic medicine, with the serial number, time of examination, date thereof, name of examining physician, name of party requesting examination.

The physician shall perform first aid needed free of charge during and outside office hours, either in the unit's office or his own private office.

The Forensic physician can seek the help of specialists or laboratories or X-ray offices for the purpose of fulfilling the examination and preparing the final report.

The Forensic physician shall have to fulfill military courts' requests as well military judges' request for the purpose of performing examinations, in case no military forensic physician is available in the area.

4 - Vaccination registers

A - Newborns and infants smallpox vaccination:

Smallpox vaccination is compulsory and free for infants and newborns. The civil census office shall prepare lists of newborns on a monthly basis, showing names of infants, place and date of birth, address and present domicile. Infants shall be vaccined daily and regularly at the unit, and every six months for those whose parents are living far from the unit, at a distance of at least five kilometers. This would be performed by paying regular visits for vaccination by the person in charge of vaccination, on the basis of the lists of births of each village, such lists bearing the father and mother name, date of birth and address.

In case of the emigration of infant's parents to another place in the district or to another district, a letter shall be prepared mentioning the name of the infant to be vaccined, parents' names and address, place of birth, date of birth, new address, type of vaccine requested, such letter to be sent to the areas health director or unit head to fulfill the requested vaccination.

B - Smallpox vaccination to other age groups:

In this register shall be reported the names of children, students, travellers, vaccined against smallpox.

In the remarks blank, shall be reported the vaccinator's name, date or reason of non-vaccination, such as death or illness or change of

address, and in the latter case, the new address.

C - Other vaccination register

For each of the following vaccines a special register shall be kept where the names and address of vaccinators/vaccinated against polio, B.C.G., tri-vaccines, cholera, together with names and address of vaccined, ga age and date of vaccination.

5 - Health card and register

A - Health card shall be issued free of charge according to pending rules and regulations.

B - Services of the unit are available to citizens within rules and regulations in force. Free medical examination and services shall be made available to the following groups:

1 - Holders of health cards

2 - Employees, officers and retired government officers, their families living at their charge, provided they present their health card.

3 - Tuberculosis, anglostoma, bilharsiosis, tinea, Begel, trachoma, leprosis, and other contagious diseases patients

4 - Members of the Syrian Revolution and their legally supported families

5 - Mothers and children reporting to mother and child care centers at health centers

6 - Agrarian Reform beneficiaries, provided they present an official document proving their status from the Ministry of Agrarian Reform.

7 - Employees of Public Works and Natural Resources Ministries, on the basis of an official letter from the region's departments.

8 - Communications' Ministry employees and their legally supported families

9 - Employees of Civil Aviation Directorate at the Ministry of Defence, and their legally supported families

10 - Workers holding union's cards, on the basis of an official document showing their monthly salary, provided such salary does not exceed /200/ L.S., with 15 L.S. for each family member legally supported.

.../18

11- Military personnel holding military health cards showing his being sergent and below.

12- Students of official and private shhools

13- Police and Night Guards personnel

14- Prison inmates

15- Nationals calling at principal and branch health units in villages and districts.

Other Groups:

1 - Inhabitants of non occupied front villages

2 - Mental hospitals inmates

3 - Ministry of Finance officials, seconded for service in the Ministry of Health as accountants

4 - Arab Fedayeen

5 - Farmers holding farmers' trade union cards

6 - Disabled and incapacitaed looked after by benevolent societies

7 - Military personnel serving in Deraa and Soueida

8 - Evacuees from Kuneitra, medically treated under health cards issued to evacuees by the Directorate of Health of Kuneitra in Damascus.

Emergency cases are exempt from health card, except vistims of criminal cases, under regulations in force.

Other categories as specifed by Ministerial order.

? double check

6 - Health inspection of draftsmen register

Physician in charge of preventive medicine in areas and districts where there is no municipal clinics shall be considered charged with the medical supervision of restaurants, laboratories, coffee houses, baths, swimming pools, cinema houses and such persons dealing with the processing, preparation and sale of foodstuffs, and shall verify the safety of foodstuffs assigned for sale especially meat, bread, milk, refreshments and canned foods. He shall inspect the ingredients used in the processing and preparation of food to verify that they are in a sound condition. His is assisted in such duties by the health technical assistant.

- Medical examination and check-up shall be performed every three months. Results and dates thereof shall be entered on the ~~[illegible]~~ examination register and the health register. He who is certified to be suffering from any contagious disease shall be prohibited from perfoming and practicing the profession; offenders shall be referred to the competent judicial authorities.
- The physician and the health technical assistant shall not receive any wages or allowances for the health inspection within and without the unit, to the exclusion of cost of the health book, at the rate of /10/ S.P.
- The physician, the health technical assistant, the municipal police, or the police shall ~~[illegible]~~ make periodical health inspection tours, to verify the implementation of the health rules and to establish the necessary proces-verbaux against offenders. Such proces-verbaux shall be referred to the judicial authorities for legal action.

7 - Contagious Diseases register

Contagious diseases shall be entered in a special register, showing the patient name, age, residence, type of disease, date of the onset of disease, date of discovery of disease, and precautions taken and the date of implementing such precautions, such as, isolation, disinfection, vaccination and such other preventive measures. The immediate notice shall be given of any contagious disease immediately upon discovery on the assigned printed forms. These forms shall addressed free of ~~[illegible]~~ charge to the department of preventive services and contagious diseases~~,~~ in the Health Directorate, who shall in their turn send such forms to the Head of the statistics section ~~in~~ the Ministry of Health, after taking the appropriate measures.

8 - Schools Inspection Register

Physicians in areas and districts where there is no school health medical services shall be charged with the supervision of the health conditions in schools, and with the medical treatment of students, as well as with making the necessary vaccination.

9 - Deaths Register

Names of occuring deaths, ages, addresses, date of death, reason of death shall be reported in a special deaths register. Families of dead persons shall be issued x free death certificates showing the reason and date of death.

10- Incoming mail register

Incoming mail and papers shall be registered with serial numbers, showing incoming dates, reference numbers, and sending parties, with a digest of the subject. The remark blank shall show its whereabouts: Transfer with date of transfer, party transferred to, implementation of contents, implementation date, or filing after taking note of contents.

11- Outgoing mail register

Outgoing formalities and documents shall be entered in this register under serial numbers, showing date of issue, addressee, date of preparation and summary.

12- Mail delivery register

All formalities and documents issued by the Center shall be entered in this register under serial numbers, showing the number and date of the letter, the date of actual delivery, the name of the recipient, his signature and the organisation in which he is serving.

13- Fixtures Register

Fixtures in the center shall be entered in this register as extracted from the delivery notes issued by the stores, there shall be assigned a page for each item under a number with the counter page for the return of the same item. Each page may be assigned to two or three items at most, if the items are not frequently used. The first pages of the register shall be assigned as an index for the items registered, stating the name of the item and the page on which the item is entered. Letters shall be used for the registration of the items. Items admitted shall registered under serial numbers on each page, and on the delivery notes there shall be entered the page on which the items are entered, and the serial numbers. Consumed items shall be registered under issue or damaged or transfer or ~~xxxxxxxxxx~~ fixation or installation or taking over reports, duly certified on the page opposite the entry page, stating

the number and date of the damage or transfer or fixation or installation or taking over records, showing the quantity, damage and specification as shown on the delivery note and registered on the entry page. The delivery notes and all reports shall be kept separately and filed in a special file year after year, by keeping an index bool showing the number and date of the notes and reports received at the center, under serial numbers annually.

14- Furniture Register, Form No. [illegible]), Pharmacy Register (Form No. 3), or Consumed items Register (

This register shall be used for entry and dispensing of drugs and medecines, and medical items and other items consumed, such as stationary, printed matters, cleaning materials, and fuels. The first part shall be assigned for medicines and the last for consumed materials.

The first page shall be assigned as an index for the delivery notes of medicines received at the center (first half of the register assigned for medicines).

The first page of the register shall be assigned as an index for delivery notes of the consumed materials and fuels received at the Center (Second half of the register), stating the number, date and origin of the notes received during the fiscal year starting on the first of January and ending on the 31st of Demeber of everyyear. These notes shall be entered under the serial numbers as issued by the stores. The contents of the delivery notes shall be rehistered after classification into ampoules, pills, syrups, suppositories, drops, creams, solutions, powders, in alphabetical order; at the lower half of the page (issue section), quarterly issue reports stating date, number, date of certification and date of return or keeping at the center.

In the issue section, there shall be entered the total quantity of medicines and consumed materials issued monthly (as extracted from the daily issue register of medicines). A quarterly report of the total quantity of medicines, consumed materials and fuels, shall be prepared.

15 - Health Technical Assistant duties register

The health technical assistant shall keep and maintain a special register to enter therein the tours, visits, results with the dates of the commencement and completion of each duty, the place and the action taken. Further he shall keep the following registers: School visits register - Contagious disease information register - Trades health inspection register - Prisons visit register.

16 - Laboratory technical assistant duties register

The laboratory technical assistant shall keep and maintain a special register to enter therein daily the results of laboratory tests carried at the laboratory, the names, age and residence of the patients, the organisation referring the patient to the laboratory, the number and date of the health card.

17 - Nursing duties register

The male and female nurses shall maintain a special register to enter therein daily the names and ages of the patients and the services rendered to them such as dressing or injection, showing the type and quantity of the injection.

18 - Midwife and health Assistant (female) duties register

The midwife and the health visitor shall keep and maintain a special register to enter therein the names of children, mothers and pregnant women, the results of the examination at the center or at home, with observations, action taken and suggestions. Further, she shall register all services conducted at the center.

The midwife and the health visitor shall register the newly born in letters, stating the name, place of delivery, date and time of departure from and return to the center.

Article 7 - Reports and lists used at the health center

A - Stock taking
B - Lists of orders of medicines and materials
C - Reports of quarterly issue and consumption of medicines, materials and fuels
D - Fixation and installation reports
E - Transfer reports
F - Delivery Reports

..../23

G - Damage reports

H - List of annual carry-over

A - Stock taking

Delivery and receipt by and from former and successor clerks shall be performed on the basis of stock taking lists showing all center's assets by a committee charged with the inventory and check on the entry and issue notes, with checking the balance with the actual balance of the stock list.

- All delivery and receipt forms and lists shall be entered serially, with a certification on each list, showing the names of respective former and successor clerks
- Delivery notes as from the last inventory shall be entered, showing the number and date of each delivery note
- Registering all delivery notes (damage reports, sales reports, delivery notes, fixation and installation reports, transfer reports, consumption reports, issue reports), as from the date of the last inventory, with due mention of date and number of each report, and date of certification.

- Furniture Registers

Number	
Year	opposite each register, there shall be shown the number and date of the entry and issue notes separately.
Year	
.....	Total

a- Delivery notes (invoices) and issue notes (consumption, issue, damage, etc..) shall be checked with reference to the furniture register, as at the date of the last certified delivery (state date) up to the date of the present inventory. State if correct. Show discrepency if existing.

b- Inventories as shown on the lists of machines, apparatuses, medicines, furnitures, etc... shall be checked, allowing for reduction of issues from entries and after verifying the items carried forward from year to year. State if correct in number or weight, and any discrepency if any.

- **Official Registers** **Number** **Number**

Used for the year ..... (...)
serial number ..... date .....
and under use (...), serial number..... date .....
and (....) unused.

All books and registers ~~shall be~~ in the unit shall be mentioned as described.

- At the end of the inventory lists, the following statement shall be mentioned:

"In accordance with Decree (or Order) (or Decision) issued by ..... Number ..... Date ..... concerning the transfer of Mr. ..... from Center ..... to Center ..... in District ..... , and assigning Mr. ..... from Center ..... in District ..... , delivery and receipt operations have been completed between us, and all assets are now under my own responsibility. In withness thereof, this statement has been drawn and signed on four copies.

Name and signature (former clerk)

Name and signature (succeeding clerk)

Approved by Unit Head

Approved Director of Health

Date / / 19...

After aproval, copies shall be sent to:

- Interested Center, for filing
- Succeeding physician, as clearance
- Director of Health, for filing
- Ministry of Health - Directorate of Medical Services, for filing.

Delivery and receipt operations, inventory lists, shall be assigned serial numbers according to chronological order, starting by number (1). An index shall drawn therefor wherein the role

number, name of former clerk, name of successind clerk, date and of inventory and receipt shall be reported.

Remark: In case and inventory list is lost, according to new accounting procedures, reference shall be made to registers and entry and issue notes for the period between the date of the missing list and the date of the last ~~delivery~~ former delivery. If no discrepency shows in the articles and items mentioned therein and the following inventory lists, this would be mentioned in the proces-verbal of the following inventory sp that the loss of the former inventory list would have no bearing whatsoever. But in case a discrepency appears in the items according to the inventory list between the dates of the lost list and the last date, and no documents supporting this are found, or the place of the loss, the clerk receiving the stores on the basis of the lost list shall be held responsible of this loss which has appeared during his tour of duty.

B - Requests for delivering medicines, materials and equipments:

A request to thr stores shall be drawn every quarter on the needs of the center of medicines and all consumed articles according to the form adopted for this purpose, on two copies. Shall be mentioned therein the name of the article requested, description thereof, quantity requested, quantity and date of last delivery. This form shall be sent to the Health Directorate in the District for implementation.

C - Proces-Verbal of issue and consumption:

A proces-verbal shall be drawn every quarter for the issue and the consumption of materials. This would submitted to the Health Directorate after approval ny the physician head of the Center. Shall be mentioned therein the article name, page number in register, date and place of supply, description (manufacturer and dosage), number in digits and letters. The proces-verbal shall be assigned a serial number according to the year quarter when is has been drawn. This proces-verbal shall be drawn on two copies.

As to fuels, they shall be soncumed according to the preceding

issue proces-verbal, mentioning the number of stoves used number of days of use of fuels. The following statement shall appear at the end of each proces-verbal: Issue and consumption of mentioned articles has been effected; number ..... articles, during the quarter ..... of the year 19....., with my knowledge and under my responsibility. And in witness thereof, this proces-verbal has been drawn.

Name and signature of
responsible clerk.

D - Proces-verbal of fixation and installation

This shall be drawn according to the following specimen:

Serial Number	Name of Article	Number and date of receipt	In letters

(in full ..... articles only)

Fixation and installation of the above mentioned articles have been performed at ..... by (name of the technical clerk), and in witness thereof this proces-verbal has been drawn.

Technical clerk performing work
signature

Responsible clerk
signature

date / / 19.....

E - Proces-verbal of delivery

Shall be drawn according to the following specimen:

Number	Name of Article	Quantity in letters	No. and date of receipt	Name of receiving clerk	Date of receipt	signature
1	Summer suit	One	14/3 of 2/7/67	Hassan	1/7/67	

The above named summer suit has been delivered to .....
and in witness thereof, this proces-verbal has been drawn.

Damascus / / Receiving clerk Responsible clerk

F - Proces-verbal of works and ~~transfers~~ processing:

Shall be drawn according to the following specimen:

Qty	Name of material	No. and date of receipt	in letters
20 m.	Jute cloth, 200 mm width	11/2 of 1/7/67	Twenty meters only

The above goods have been processed to the works mentioned below, and has been entered as goods on the strength of the proces-verbal

Qty	T y p e	Qty used	Full quantity used
5	Doctor apron	200 cm	1000 cm
10	curtain 200x100	100 cm	~~????~~1000 cm
			2000 cm.

date / /

Clerk performing work Responsible clerk

A voucher covering the materials ~~remained~~ mentioned in the processing proces-verbal shall de drawn mentioning quantities and description . The shall be entered into the stores in a new register entry on the strength of this voucher, after being taken from the registers, on the basis of a work proces-verbal.

In departments where no voucher book for the repipt of goods is available, a proces-verbal shall be drawn in lieu thereof, where the clerks mentioned in the third article of these instructions. The articles transferred shall be deducted from the registers on the basis of the of the issue proces-verbal. Shall also be referred to the works proces-verbal in the registeration, and the

dispositions of Article 3 shall apply.

G - Proces-verbal of damage

Shall be drawn according to the following specimen :

Serial number	Name of Article	Quantity	In letters	No. and date of receipt	Reason of damage
1	Stapler	2	Two only	25/5 of 1/7/72	out-or-order
2	Floor broom	1	One only	15/1 of 3/4/69	worn out

..... articles only====

The above articles are out-of-order and worn out, and have no value whatsoever and cannot be sold, and in witness thereof the proces-verbal has been drawn.

Date / / Responsible clerk

Proces-verbaux of damages shall be drawn every six months regularly. Proces-verbaux for items which can no longer be used or sold shall be drawn. This proces-verbal is then referred to the committee in charge of damaged items, which shall check on the items and then proceed with the disposal thereof, either by incineration of breaking or dumping outside town. A certified copy shall be returned to the respective unit to deduct the quantity from the registers.

H - Yearly carried-forward

Shall be drawn at the end of each year according to the following specimen:

Serial Number	Name of Item	Carried-forward from proceeding year			Received this year			Total		
		qty	Kgs.	Grs.	Qty	Kgs.	Grs.	Qty	Kgs.	Grs.

Used this year			Carried-forward to this year		
Quantity	Kilos	Grammes	Quantity	Kilos	Grammes

The carried-forward shall be drawn on three copies, which shall be submitted to the Directorate of Health for approval after being checked against delivery vouchers by store-keepers, on the strength of the year's documents. A copy shall then be sent to the Ministry of Health - Medical Services. The second copy shall be kept at the Center, while thethird shall be kept by the Directorate of Health.

Article 8 - This Decision shall be published and notified to who it may concern for implementation.

Damascus, 12/3/1972

The Minister of Health

Copy to .....

Date / / 1972

Chief od Personnel Dept.

APPENDIX E

PROJECT PERFORMANCE TRACKING NETWORK

country:	project no:	project title:	date:	/ / original / / revision #	approvd:
Syria		Health (Planning Activity)	5/27/76		

CPI NARRATIVE

1. 06/76 - Project Agreement for '76 signed. (SARG and USAID)
2. 07/76 - Draft RFP or PIO/T. (AID/W)
3. 10/76 - Final RFP or PIO/T. (USAID, SARG)
4. 10/76 - Ratification. (SARG)
5. 11/76 - Identify principal consultant. (AID/W)
6. 11/76 - Project Agreement for '77 signed. (SARG and USAID)
7. 12/76 - Identification of Syrian counterpart. (SARG)
8. 02/77 - Principal consultant arrives. (AID/W)
9. 03/77 - Identify L.T. MPA/MPH candidates for academic year 77/78 training. (CONSULTANT, SARG)
10. 04/77 - Get L.T. candidates placed. (AID/W)
11. 06/77 - Two-year plan for developing health planning unit, training requirements and identification of timing and type of short term expert consultation. Report to SARG and AID. (Consultant, USAID and SARG)
12. 09/77 - L.T. candidates to U.S. (AID/W)
13. 11/77 - Health planning unit officially decreed and staffed. (SARG)
14. 01/78 - Evaluation of progress to date. (SARG, Consultant) Report to USAID, AID/W and SARG
15. 02/78 - Consultant departs. (AID/W)
16. 06/78 - First L.T. trainees return (AID/W) and are placed in proper positions. (SARG)
17. 09/78 - Evaluation of progress and modifications of further training and short-term consultation if necessary. (SARG)
18. 06/79 - Final evaluation of implementation of planning and specific, measurable effects on health delivery. (SARG, USAID)
19. 11/77 - Project Agreement for '78. (USAID, SARG)

Syria | Health (Planning Activity) | 5/27/76 | / / Revision

For FY: (CY:) Month: 1976 (J J A S O N D) 1977 (J F M A M J J A S O N D) 1978 (J F M A M J J A S O N D) 1979 (J F M A M J)

0 12 24 36

Prior Actions

Post Actions

1 PROAG 76

2 Draft RFP

3 RFP

4 RATIFICATION

5 IDENT. CONSULT.

6 PROAG '77

7 COUNTERPART ID

8 CONS. ARRIVES

9 ID L.T. PARTS

10 PLACE PARTS

11 2-YR. PLAN REPORT

12 L.T. PART TO US

13 HEALTH PLAN UNIT EST.

14 EVAL.

15 CONS. DEPARTS

16 L.T. PART RETURN

17 EVAL.

18 EVAL.

19 PROAG '78

TIMING OF REST OF TRAINING AND S.T. CONSULTS DEPENDS ON PLAN

Financial Plan

Actual

Evaluation Schedule

project no: project ti

Syria

Health (Survey)

5/27/76

1. 06/76 - Project Agreement for '76 signed. (SARG, USAID)

2. 08/76 - Draft PIO/T's and PIO/C's. (AID/W)

3. 10/76 - Ratification (SARG)

4. 10/76 - PIOT's and PIO/C's approved. (USAID, SARG)

5. 11/76 - PIO/C's issued. (AID/W)

6. 11/76 - PIO/T issued. (AID/W)

7. 11/76 - CBS design staff in place. (SARG)

8. 11/76 - Ministerial and staff-level advisory committees formed. (SARG)

9. 10/76 - Project Agreement for '77. (USAID, SARG)

10. 01/77 - Health survey specialist arrives. Design phase begins. (SARG, AID/W)

11. 09/77 - Commodities other than vehicles have arrived. (AID/W)

12. 10/77 - Field testing and revisions. (SARG)

13. 01/78 - Health survey specialist departs. (AID/W)

14. 02/78 - CBS Field staff selected. (SARG)

15. 06/78 - Vehicles arrive. (AID/W)

16. 07/78 - Field staff trained. Data collection begins. (SARG)

17. 08/79 - CBS Data analysis and programming staff in place. (SARG)

18. 07/79 - Second year data collection begins. (SARG)

19. 08/79 - Health survey specialist (one month), data analysis specialist (three months) arrive; data analysis begins. (AID/W, SARG)

20. 10/79 - Evaluation of survey. (SARG)

21. 11/79 - Data analyst departs. (AID/W)

22. 07/80 - Third year data collection begins, etc. (SARG)

Syria | Health (Survey) | 5/27/76 | / / Revision # | p. 1

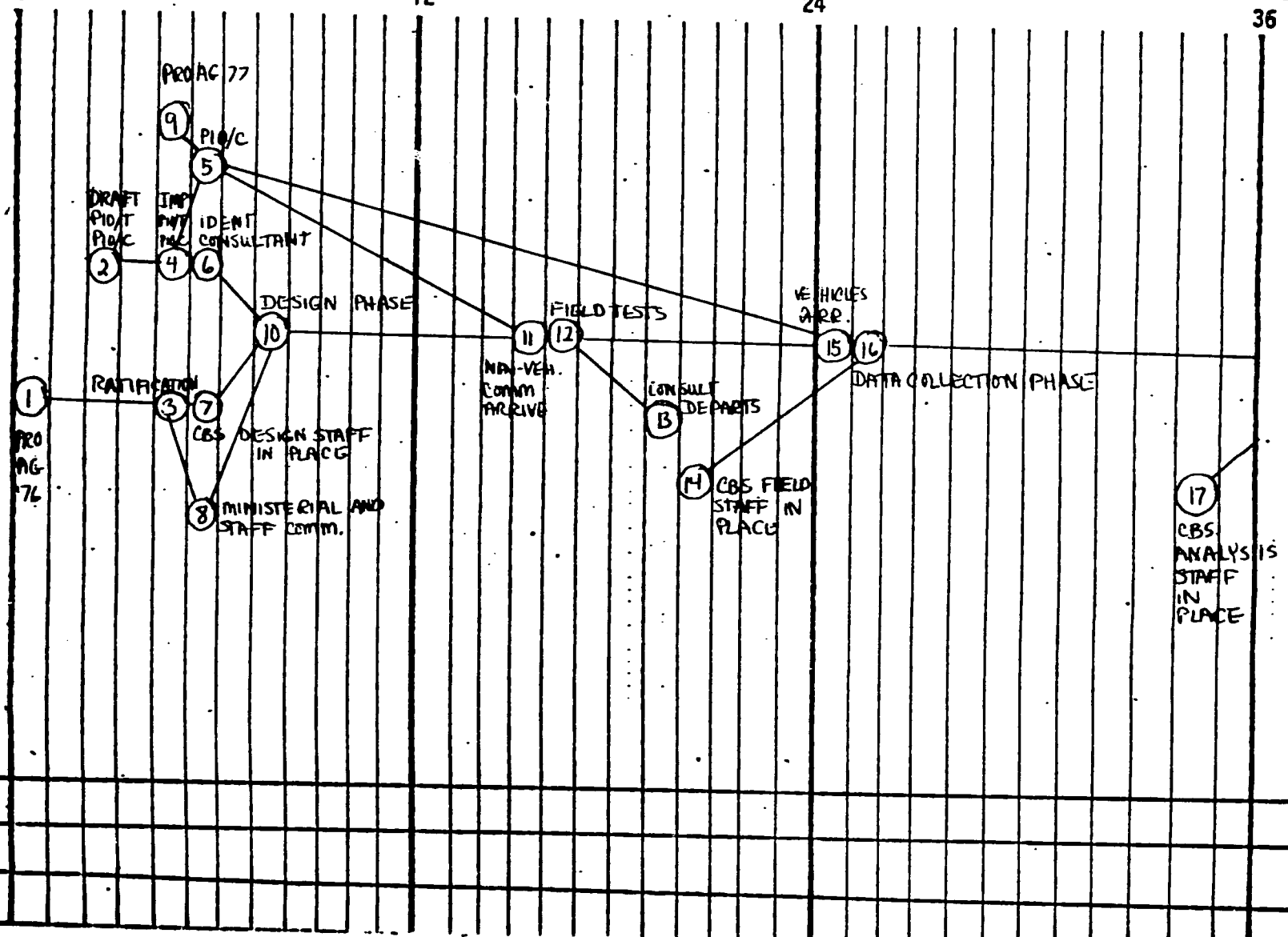
For FY: (CY:) Month:

1976: J J A S O N D | 1977: J F M A M J J A S O N D | 1978: J F M A M J J A S O N D | 1979: J F M A M

0 | 12 | 24 | 36

Prior Actions

Post Actions



Financial Plan

Actual

Evaluation Schedule

Syria	Health (Survey)	5/27/76	/ / Revision	p.2

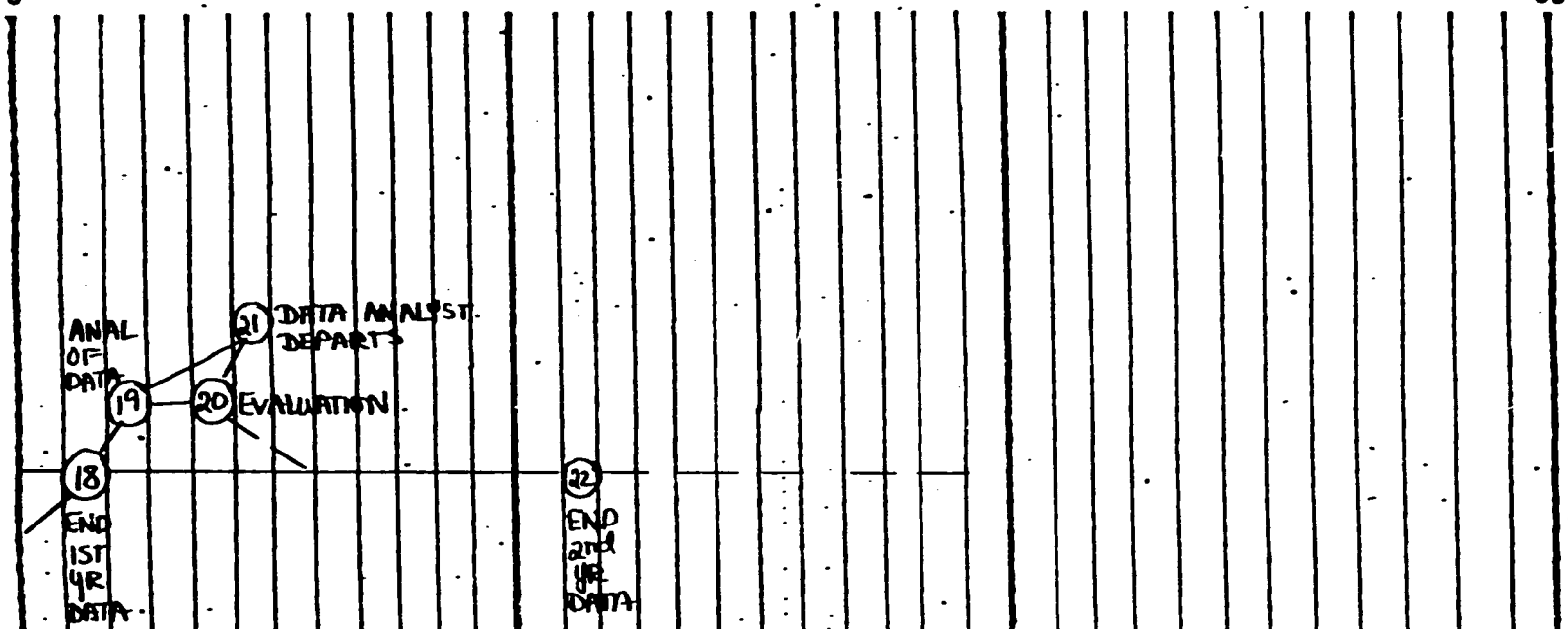
For:
Mar:

J J A S O N D J F M A M J J

0 12 24 36

Prior Actions

Post Actions



Financial Plan	
Actual	
Evaluation	

country:	project no:	project title:	date:	/ / original / / revision #	apprvd:
Syria		Health (Equipment Maintenance Activity)	5/25/76		

CPI NARRATIVE

1. 06/76 - ProAg signed by SARG and USAID for FY 76. (SARG AND USAID)
2. 10/76 - Ratification of whole project. (SARG)
3. 11/77 - Approval of 4 new MOH and 12 new hospital maintenance supervisor positions. Hiring of MOH unit director. (SARG)
4. 12/77 - Order vans. (AID/W)
5. 12/77 - Identify hospital systems expert for two-year posting. Get SARG approval. (AID/W, USAID, SARG)
6. 12/77 - MOH unit director begins two-month intensive language training. Two engineers begin as soon as on board. (SARG)
7. 02/77 - MOH unit director to U.S. for six month special training in systems management. (AID/W)
8. 05/77 - Two MOH engineers to U.S. for short-term structured exposure. (AID/W)
9. 07/77 - U.S. hospital systems expert arrives. (AID/W)
10. 07/77 - MOH unit director returns. (AID/W)
11. 07/77 - MOH engineers return. (AID/W)
12. 07/77 - Other 13 positions filled. (SARG)
13. 08/77--01/78 - Inventory, manual collection, and collection of baseline data implemented. (SARG)
14. 11/77 - Equipment ordered for mobile vans and central workshop. (USAID, AID/W)
15. 01/78--04/78 - Management control system designed. Evaluation criteria for initial and end first year evaluation designed. (SARG)
16. 02/78 - Vans and equipment arrive. (AID/W)
17. 04/78 - System initiated. Workshop set up. Training program initiated. (SARG)
18. 06/78 - System in full operation. (SARG)
19. 12/78 - Initial evaluation of system effectiveness and modifications made. (SARG)
20. 06/79 - Final project evaluation and decision whether to replicate in the Northern section. (SARG) Consultants final report and recommendations. (USAID)
21. 07/79 - Consultant departs. (USAID)
22. 01/77 - ProAg signed by SARG and USAID for FY 77 (SARG, USAID)

Syria | Health Equipment Maintenance Activity | 5/25/76 | / / Revision

For FY: (CY:) Month:

1976 | 1977 | 1978 | 1979

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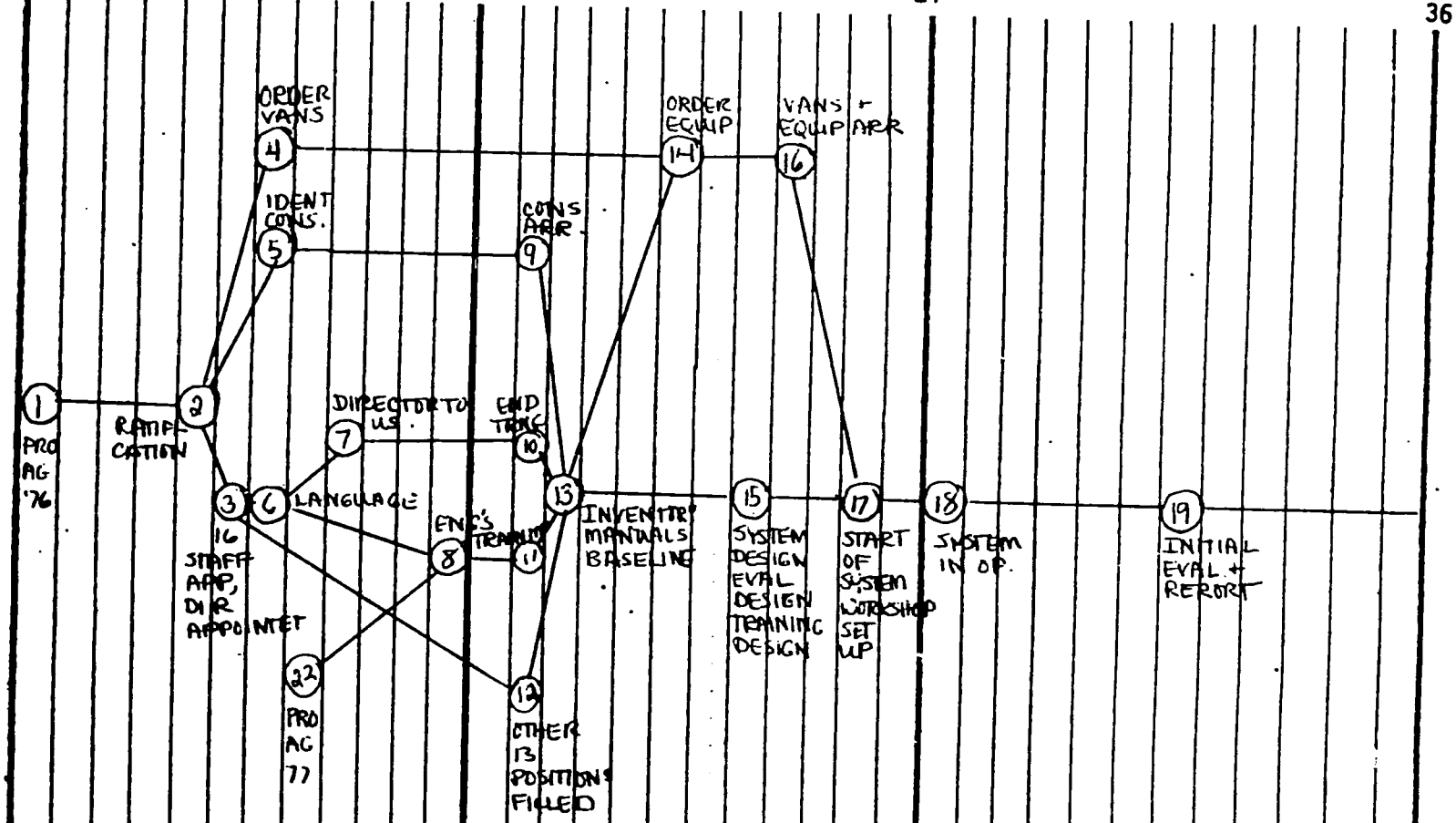
0 12 24 36

Prior Actions

Post Actions



Financial Plan

Actual

Evaluation Schedule

Syria | Health (Equipment Maintenance Activity) | / / Revision

For FY: 1979
(CY:)
Month: J J

0 12 24 36

Prior Actions

Post Actions

FINAL EVAL

20 21

CONS DEPARTS

Financial Plan

Actual

Evaluation Schedule

LOG FRAME

APPENDIX G

PROGRAM GOAL	MEASURES OF GOAL ACHIEVEMENT	VERIFICATION	ASSUMPTIONS
Effective preventive and curative health care available to all Syrians.	Decrease in preventible morbidity and mortality. Availability of services.	Health status time series Health service utilization statistics	Continued SARG commitment to providing free health care to all who need it. Increased SARG emphasis on preventive public health measures.

LOG FRAME

PROJECT PURPOSE	END OF PROJECT STATUS	VERIFICATION	ASSUMPTIONS
1. To develop an initial Syrian capability for policy analysis, planning, programming, and evaluation within the health sector.	An organizational unit within the MOH responsible and capable of studying problems and planning solutions.	Expert evaluation, quantification of problems studied, policies influenced.	The MOH decision making mechanism will allow a specialized unit to function effectively.
2. To develop a Syrian system for medical and hospital equipment maintenance and repair, management and implementation.	An established and on-going concrete maintenance and repair system.	An expert review of work orders, inventory cards, and repair records.	The Ministry will provide the central workshop space and will focus hospital priorities on establishing and maintaining the system.
3. To develop a health data base for use by the SARG in planning and evaluation of health programs and policies.	An established continuous health survey.	Completion of design, initial year data collection and analysis, an evaluation of the sample design, and the continuance of the survey.	1) The MOH will continue to fund the survey staff at its current level, and 2) the government will pay sufficient per diems to insure proper field interviews.

LOG FRAME

Outputs	Magnitudes of Outputs	Verification	Assumption of Implementation
1. Trained personnel in health planning systems	4 Master's level planners 8 public health trained staff	Direct measurement " "	Training candidates can be selected and made available and brought back to appropriate positions.
Health planning unit in MOH	One unit	MOH staffing pattern	
2. Trained hospital systems management director in place	One	Direct measurement	Training candidates can be selected and made available and brought back to appropriate positions.
Upgraded radiologist repair specialist in place	One	" "	" " "
Upgraded medical equipment specialist in place	One	" "	" " "
Central equipment repair workshop	One	" "	Provision of sufficient space by SARG
Central unit in MOH	One unit	MOH staffing pattern	Staff trained and in appropriate positions
3. Health survey design, data collection/analysis/evaluation completed	One full cycle	Review of data	Provision of adequate staff and field costs by SARG
Upgraded professional survey staff	2, one-month U.S. structured exposure	Direct measurement	Director of survey and health planner can be available for one month each

LOG FRAME

IMPUTS U.S. CONTRIBUTION	OBJECTIVELY VERIFIABLE INDICATORS	VERIFY	ASSUMPTIONS
1. One Health Planner	One year contract signed in early CY 77	Documentation complete and planner in place	That an Arabic speaking health planner can be found by early CY 77
Two health planning specialists	PIO/Ts and signed TDY contracts in CY 78	Documentation complete and experts in-country	That the specific type of specialists can be found in CY 78
Participant training	4 masters level and 8 short-term participants trained in CY 77 and CY 78	Participants in U.S. for training	That a sufficient number of staff will be willing to go to the U.S. and have sufficient English.
2. One hospital equipment systems manager	Two-year contract signed in early CY 77	Documentation complete and expert in place	That such a specialist can be found who is willing to work two years overseas.
Participant training	One 6-mo. course in systems management in CY 77	Participants in U.S. for training	Sufficient English.
	Two 3-mo. courses in specialized repair in CY 77		
Commodities	One large van and equipment by second year of project	Direct measurement	Procurement process in U.S. not slower than usual.
	One small van by second year of project	" "	
	Workshop equipment	" "	

LOG FRAME

INPUTS U.S. CONTRIBUTION	OBJECTIVELY VERIFIABLE INDICATORS	VERIFY	ASSUMPTIONS
3. One Health Survey Design consultant	One-year contract signed in early CY 77 plus one month TDY in CY 78	Documentation complete and survey specialist in place	That a survey specialist will be willing to go overseas for one year
One Data Analyses TDY	Three-month TDY contract signed in CY 78	Documentation complete and survey specialist in place	That data analyst can be found
Participant training	Two one-month guided programs set up	Participants in U.S.	That a special one-month program can be designed and implemented
Commodities	Key punch cards (100 boxes) Scales (16) English typewriter Calculators 9 all-terrain vehicles	Direct measurement " " " " " " " "	Procurement process in the U.S. can locate in a timely fashion

LOG FRAME

INPUTS SARG CONTRIBUTION	OBJECTIVELY VERIFIABLE INDICATORS	VERIFICATION	ASSUMPTIONS
1. **Salaries of health planning unit staff plus others during training**	Staff in place	Reports of long-term consultant	That staff can be found
Office space and clerical support for long-term consultant	Office space and clerical support	Reports of long-term consultant	That office space can be found on the new third floor or another building
In-country travel for long-term consultant	Actual visits outside Damascus	Reports of long-term consultant	That travel for foreigners remains open
2. **Salaries and per diems of central unit and hospital maintenance supervisors**	Staff in place and doing routine travel as scheduled	Consultant report	Staff can be found and budget/ or per diems allocated
Equipment	Shop fully equipped	Consultant report	Budgeted amount available
Printing of inventory cards	Inventory cards printed	Direct measurement	Budgeted amount available
Workshop facilities	Workshop space allocated	Consultant report	Damascus hospital building still available
Office space and clerical support for long-term consultant	Office space and clerical support	Consultant report	Office space can be found on the new third floor or in another building
3. **Salaries, meeting expenses, and per diems**	Staff in place and doing survey work	Consultant reports and evaluation	That staff can be found and sufficient funds budgeted for per diems
Computer time	All necessary data runs made	Data analyst report	Sufficient and timely access to computer
In-country travel of long-term consultant	Actual visits outside Damascus	Consultant report	Travel for foreigners remains open