UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D. C. 20523

PROJECT PAPER

EGYPT: Suez Community Health Personnel Training (263-0133)

December 1979

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

1. TRANSACTION CODE: [A] (A = ADD, C = CHANGE, D = DELETE) — PP

2. DOCUMENT CODE: 3

3. COUNTRY/ENTITY: EGYPT

4. DOCUMENT REVISION NUMBER: [ ]

5. PROJECT NUMBER (7 digits): [263-0136]

6. BUREAU/OFFICE: A. SYMBOL: NE; B. CODE: [03]

7. PROJECT TITLE (Maximum 40 characters): [Suez Community Health Personnel Training]

8. ESTIMATED FY OF PROJECT COMPLETION: FY [8 5]

9. ESTIMATED DATE OF OBLIGATION: A. INITIAL FY [8 0]; B. QUARTER [2] (Enter 1, 2, 3, or 4); C. FINAL FY [8 5]

10. ESTIMATED COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 80			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL						
(GRANT)	2,100	600	2,700	2,100	600	2,700
(LOAN)						
OTHER U.S. 1. PL 480		350	350		350	350
OTHER U.S. 2.						
HOST COUNTRY	2,000	9,600	11,600	2,000	9,600	11,600
OTHER DONOR(S)						
TOTALS	4,100	10,550	14,650	4,100	10,550	14,650

11. PROPOSED BUDGET APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY 80		H. 2ND FY		K. 3RD FY	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) ESF	529	561		2,700					
(2)									
(3)									
(4)									
TOTALS									

A. APPROPRIATION	N. 4TH FY		O. 5TH FY		LIFE OF PROJECT	
	O. GRANT	P. LOAN	Q. GRANT	R. LOAN	S. GRANT	T. LOAN
(1) ESF					2,700	
(2)						
(3)						
(4)						
TOTALS						

12. IN-DEPTH EVALUATION SCHEDULED: MM DD YY: 0 7 8 1

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA BLOCKS 2, 3, 4, 5A, 5B, 6, 7, 8, 9, 10, OR 11 OF THE PID FACESHEET? IF YES, ATTACH CHANGED PID FACESHEET.

[1] : 0 = NO, 1 = YES

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE: Owen Cylke

TITLE: Acting Director

DATE SIGNED: MM DD YY: 12 19 79

15. DATE DOCUMENT RECEIVED IN A.I.D. OR IN W.A.S.H. OR FOR AMENDMENTS, DATE OF DISTRIBUTION: MM DD YY: 12 21 79

AID 1330-4 (9-78)

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

ASSISTANT
ADMINISTRATOR

PROJECT AUTHORIZATION

Name of Country: Arab Republic of Egypt Name of Project: Suez Community Personnel Training

Project No.: 263-0136

1. Pursuant to Part II, Chapter 4, Section 531 of the Foreign Assistance Act of 1961, as amended (Ecomonic Support Fund), I hereby authorize Phase I of the Suez Community Health Personnel Training Project for the Arab Republic of Egypt ("Cooperating Country") involving planned obligations of not to exceed Two Million Seven Hundred Thousand United States Dollars ($2,700,000) in grant funds over a two year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing the foreign exchange and local currency costs of goods and services required for the Project.

2. The Project will assist Egypt to improve health services, particularly primary care, by developing and initiating in selected Governorates in the Suez Canal Area an integrated medical education and health services program which relates education investment directly to the health needs of the population.

Project elements will include primarily creation of a decentralized medical school and development of a new curriculum and mode of teaching focusing on primary health care designed to respond directly to the health needs of the populace. An institutional grant, including a cooperative agreement, between A.I.D. and Boston University (BU) may initiate implementation of the A.I.D. contribution to the Project.

3. The Project Agreement which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and delegations of authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4. a. Source and Origin of Goods and Services

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

b. Conditions Precedent to Disbursement

(1) Initial Disbursement

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as the parties may agree otherwise in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) A statement of the names and title with specimen signatures of the person or persons who will act as the representatives of the Grantee;

(b) Evidence of creation of a Dean's Planning Unit within Suez Canal University (SCU) to coordinate SCU and the Ministry of Health (MOH) objectives, including a description of MOH participation and a description of function of the Unit.

(c) Evidence of creation of a Medical Education Unit within the Dean's office at SCU Faculty of Medicine (SCU/FM) for implementing terms of curriculum development, with description of personnel to serve extra-mural consultant panels and intra-mural committees.

(d) Such other documentation and materials as A.I.D. may reasonably require.

(2) Conditions Precedent to Disbursement for Renovation

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for renovation the Grantee shall, in each case of renovation, except as the parties may agree otherwise in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) Evidence that Egyptian budgetary resources have been allocated for the ongoing operating costs of health facilities to be renovated before funds may be disbursed.

(b) Evidence of engineering designs, adequate supervisory services, and cost estimates for the planned construction.

(c) Evidence of execution of satisfactory construction contract(s) with firm(s) acceptable to A.I.D.

(d) Such other documentation and information as A.I.D. may reasonably require.

(3) Conditions Precedent to Disbursement for Equipment

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for the procurement of equipment, except as the parties may otherwise agree in writing, Grantee shall cause to be furnished to A.I.D., in form and substance

satisfactory to A.I.D., a procurement plan which will include identification of procurement procedures to be followed for the Project.

c. Covenants

The Grantee shall:

(1) Assure commitment by cooperating agencies, with responsibility to staff and operate facilities to be renovated as part of the project, to include in their future budget plans for the timely recruitment and funding of staff and provision of funds to meet other operating costs.

(2) Carry out the project with due diligence and efficiency, and in conformity with sound engineering, construction, financial, administrative and other professional practices.

(3) Cause the project to be carried out in conformance with all the plans specifications, and with all modifications therein approved by A.I.D. pursuant to the Agreement, including the provision, on a timely basis, of necessary local currency and in-kind support as specified in the Agreement and its annexes.

(4) Cooperate fully with A.I.D. to assure that the purpose of the grant will be accomplished and the GOE and A.I.D. shall from time to time, at the request of either party, exchange views through their representatives with regard to the progress of the project, the performance of consultants, contracts and suppliers engaged on the project, and matters relating to the project.

(5) Within six months of execution of the project grant agreement, in conjunction with BU, produce a detailed work plan, including a detailed plan for curriculum development for the first two years of classes, budget and plan of management approach for Phase I of the activity. The work plan will be updated every six months and will include discussions of site selection for clinical training, plans for faculty development and continuing medical education, training plans for the clinical staff, plans for assistance in architecture and health program design, meeting management needs of the Faculty of Medicine, library facilities and mechanisms for physicians' compensation.

(6) Make provision for adequate administrative arrangements and local currency from funds other than those provided by the Grant for any incentive payments to be made to personnel of the Government of Egypt engaged in project implementation.

5. Based upon the justification set forth in the Project Paper, I hereby determine, in accordance with Section 612(b) of the Act, that the expenditure of United States Dollars for the procurement of goods and services in Egypt is required to fulfill the purposes of this Project; the purposes of this Project cannot be met effectively through the expenditure of U.S.-

owned local currencies for such procurement; and the administrative official approving local cost vouchers may use this determination as the basis for his certification as required by Section 612(b) of the Act.

Alfred D. White (Acting)
Bureau for Near East

2-22-80
Date

Clearances:
NE/TECH:Charles B. Weinberg _____ Date 2-11-80
NE/DP:Bradshaw Langmaid _____ Date 2/19/80
NE/EI:Gerald Kamens _____ Date _____
GC/NE:John E. Mullen _____ Date _____

Drafter:GBisson:paj:GC/NE:2/20/80

UNCLASSIFIED

Department of State

OUTGOING TELEGRAM

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APPROVED BY AA/NE:A WHITE
NE/DP:B LANGHAID (DRAFT)
NE/PD:R BELL (DRAFT)/G SHIVERS (INF
NE/TECH:C WEINBERG/V OLDHAM
GC/NE:G BISSON (DRAFT)
NE/EI:J KAMENS (DRAFT)
PPC/PB:J SEGAL (DRAFT)
SER/CM:F MOULTON (DRAFT)
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E.O. 12065: N/A

TAGS:

SUBJECT: SUEZ COMMUNITY HEALTH PERSONNEL TRAINING (263-0136)

REF: CAIRO 25897

1. NEAC REVIEWED PP JANUARY 17. SUBJECT TO CONGRESSIONAL NOTIFICATION WAITING PERIOD, AA/NE PREPARED TO AUTHORIZE PHASE I OF PROJECT AT DGLS. 2.7 MILLION. NEAC CONCLUDED THAT PHASE II IS NOT SUFFICIENTLY DEVELOPED FOR AUTHORIZATION AT THIS TIME. HOWEVER, AA/NE HEREBY DELEGATES AUTHORITY TO USAID/CAIRO MISSION DIRECTOR FOR PP AMENDMENT, PROJECT AUTHORIZATION AS WELL AS PROJECT GRANT AGREEMENT AMENDMENT FOR PHASE II UP TO PROJECT TOTAL OF DGLS. 7.8 MILLION. AID/W PROJECT COMMITTEE SHOULD BE GIVEN OPPORTUNITY TO REVIEW AND COMMENT ON PHASE II PLAN. COOPERATIVE AGREEMENT WITH BOSTON UNIVERSITY WILL IDENTIFY 5 YEAR PROJECT FRAME, BUT WILL INCLUDE ONLY 18 MONTH FUNDING AND 18 MONTH INPUTS/OUTPUTS. ADDITIONAL ISSUES RELATED TO IMPLEMENTATION FOLLOW.

2. NEAC AGREED TO INCLUDE PHASE I RENOVATION IN BU AGREEMENT. HOWEVER, AID FUNDING IS NOT AVAILABLE TO FINANCE LOCAL EGYPTIAN TAXES AS PER GRANT ANNEX SECTION B.4. SOE, SCU OR MOH SHOULD BUDGET TO COVER ATTRIBUTION FOR SUCH LOCAL TAXES. SEPTEL FROM GC/NE TO LEG FOLLOWS ON THIS PROJECT.

3. THERE ARE THREE ISSUES BRIEFLY DISCUSSED IN PP AND PROPOSAL WHICH NEAC FEELS SHOULD RECEIVE MORE DETAILED ANALYSIS IN PHASE II PP AMENDMENT. (A) THE ROLE AND TRAINING NEEDS OF OTHER HEALTH TEAM PERSONNEL, INCLUDING NURSES, MIDWIVES AND OTHER SUPPORT SERVICES SHOULD BE EXPLORED IN PHASE II IN TERMS OF PROBLEMS, NEEDS AND ACTION STRATEGIES TO MAKE FULL TEAM EFFECTIVE. (B) /FINANCIAL ANALYSIS OF PHASE II BUDGET ITEMS, INCLUDING REASONABLENESS OF BOTH CAPITAL AND RECURRENT COST ESTIMATES AS WELL AS ASSESSMENT OF SCU AND MOH FINANCIAL CAPABILITY TO UNDERTAKE FULL IMPLEMENTATION SHOULD BE DETAILED IN PHASE II. (C) PHASE II SHOULD ALSO EXPLORE APPROACHES TO INTEREST OTHER EGYPTIAN MEDICAL SCHOOLS IN SCU EXPERIENCE TO FACILITATE REPLICATION OF APPROPRIATE ELEMENTS.

4. CONCUR IN PROPOSAL FOR EXTERNAL STUDY TEAM. HOWEVER, THERE MAY BE SOME PROBLEM IN QUICK IDENTIFICATION AND FIELDING OF TEAM. NATURE OF SCOPE SPREAD OVER 18 MONTHS DOES NOT FIT IQC LIMITATIONS ON 120 DAY TIMEFRAME FOR WORK ORDERS. NE/TECH IS EXPLORING APPROPRIATE FIRMS INCLUDING 8A FIRMS AND PSC ALTERNATIVES AND WILL ADVISE.

5. NEAC SUGGESTED REWORDING OF ANNEX H WAIVER FOR CONVERSION OF DOLLARS TO LOCAL CURRENCY TO REFLECT UNAVAILABILITY OF SUFFICIENT US OWNED LOCAL CURRENCY AND RELATE MORE DIRECTLY TO LOCAL COST OF ITEMS TO BE FINANCED WITH DOLLARS. WILL REDRAFT IN AID/W AND INCLUDE IN AUTHORIZATION.

6. SINCE NEGOTIATIONS WILL TAKE PLACE IN US, IT IS IMPORTANT THAT USAID PROVIDE DETAILS OF CONCERNS OVER BU BUDGET ITEMS, SCOPE, REPORTING, ETC., WITH PIO/T.

7. PLEASE CONFIRM RECEIPT OF FINAL GOE REQUEST FOR ASSISTANCE (DRAFT TRANSMITTED WITH PP). VANCE

UNCLASSIFIED

UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

CAIRO EGYPT

December 19, 1979

ACTION MEMORANDUM

TO : Mr. O. Cylke, A/DIR

THRU : The Executive Committee

FROM : M.M. Shutt, HP

SUBJECT : Suez Community Health Personnel Training Project, No. 263-0136: Request for Approval.

PROBLEM:

Your approval is sought for the attached transmittal cable requesting approval for the referenced project paper. In the Executive Review Committee meeting of December 5, 1979, additional information concerning implementation and evaluation of the project was requested. While developing this information it became clear that while we are responding to an unsolicited proposal, by deciding to involve the GOE by a grant arrangement, the basic form of the PP is really required rather than the less structured response to an unsolicited proposal. Consequently, the attached documentation is structured as dictated by Handbook III except for the financial plan which reflects the costs as submitted in the unsolicited proposal. Where sections were already covered adequately in the B.U. proposal, reference is made to those sections without repetition in the PP text. The B.U. proposal forms Annex A to the project paper. This format should make the project easier to review both in the Mission and/or Washington. The table of contents follows the PP format.

The PP calls for a Project Grant Agreement to be executed with the Ministry of Economy and Economic Cooperation, with the MOH and Suez Canal University to be co-signatories as implementing agencies.

Approval is sought for $7.8m LOP funding, with $2.7m to be obligated for Phase I (18 months). With regard to subsequent funding, a Phase II proposal will be submitted to AID for approval based upon B.U.'s plan, the evaluation and a special study.

A Cooperative Agreement grant will be given directly by AID to Boston University (B.U.), based on the unsolicited proposal from B.U.

Renovation can be accomplished by one of two methods:

A) B.U. subcontracting under fixed price arrangements, or,

B) SCU and the MOH subcontracting under the Grant to the GOE.

Determination as to which method will be used will be done in grant negotiation with B.U. An issue which either method must address is the principle of AID not paying identified taxes to foreign governments (the GOE currently withholds income taxes from payments it makes to Egyptian entities). The issue is discussed in the PP.

Procurement of equipment will be according to AID procurement regulations or the B.U. procurement procedures, if AID accepts the latter during sub-grant negotiations.

The evaluation section has been redone, and a technical analysis added.

The Executive Committee has now met again and reviewed the final Project Paper and recommends your approval. The SER/CM contracting officer, here on TDY, feels the PP as presented will serve well for the basis of a PIO/T from which a grant to B.U. can be negotiated.

RECOMMENDATION:

That you approve the project by signing below and by signing the attached transmittal cable to Washington.

Clear _____ Date 12/1/79
for the Executive Committee

Approve _____ Date 12/11/79

Disapprove _____ Date _____

SUEZ COMMUNITY HEALTH PERSONNEL TRAINING

PROJECT NUMBER 263-0136

TABLE OF CONTENTS

ANNEXES

PART I

A. Recommendations

B. Description of the Project and Relation to CDSS

A. RECOMMENDATIONS

USAID, based upon the discussion below, recommends the following determinations be made by the A.I.D. authorizing official:

1. That a Project Grant Agreement be authorized with the GOE to encompass all activities financed by A.I.D. and the GOE under the Project.
2. That A.I.D./W be authorized to negotiate an implementing Grant directly with Boston University (BU) on a non-competitive basis and reflecting the Cooperative Agreement mode as set forth in Handbook 1, Supplement B, Chapter 25, which Grant would encompass most of the activities financed by A.I.D. under the Project.
3. That the unsolicited proposal submitted by BU be the basis for non-competitive selection of BU as the implementing Grantee in that the proposal represents a unique, innovative and meritorious comprehensive project plan which has been originated and assembled by BU without A.I.D. involvement. This will be the first organized attempt in medical education in Egypt at curriculum design based on local community needs assessment, task-analysis and competency based training. The partnership with and the educational role to be played by the Ministry of Health is unique. Two other unique and innovative features are the strong emphasis on primary (vs. tertiary) preventive and curative services, and the intentional class size limitation to assure quality, responsive education. The Project Paper contains the certification of the A.I.D. Project Officer that no A.I.D. employee solicited the proposal from the Grantee or had other prior contact with the Grantee regarding the subject matter of the proposal other

than to convey to the Grantee an understanding of A.I.D.'s mission and needs relative to the type of effort contemplated in the offer. The substance of the proposal is not available without restriction for implementation by Grant with another source.

4. That a direct A.I.D. Grant (Cooperative Agreement) be utilized to implement Phase I rather than a host country implementing arrangement. The complexity of the BU proposal coupled with the broad sweep of project activities, including procurement responsibilities, set forth in the proposed Description of Project for the Grant shall require an extensive degree of procurement experience and familiarity with procurement procedures of U.S. universities. It is USAID's opinion that the depth of familiarity with such procedures does not exist in the Ministry of Health or the Suez Canal University, which otherwise would be the appropriate signatories for a host country implementing arrangement. Accordingly, the modality of direct A.I.D. grant is recommended for Phase I of this activity. Should Phase II be implemented, a host-country implementing Grant with BU is planned until completion of the Project.

B. DESCRIPTION OF THE PROJECT AND RELATIONSHIP TO CDSS

Purpose

The purpose of this project is to continue the development within Boston University of a capacity to assist GOE in improving health services and to assist BU and the GOE in improving ... health services, particularly primary care by initiating an integrated medical education and health services program which relates educational investment directly to the health needs of the population.

Description

The A.I.D. contribution to this project is to be implemented through a sub-grant to BU (a Cooperative Agreement) which will enable Suez Canal University (SCU) in cooperation with the Ministry of Health to be involved with the health needs and primarily serve a five governorate area comprised of three principal cities and a large rural population bordering on the Suez Canal.

A major attraction and unique feature of this proposal is that it plans to create a decentralized medical school which will fulfill some of the principal daficiencies in contemporary medical education in Egypt. Under this project a new curriculum and mode of teaching will be developed which focuses on primary health care designed to respond directly to the health needs of the populace. Special emphasis will be given to preventive and community-based health measures, including maternal and child health, nutrition, family planning and environmental sanitation.

The educational program will be conducted on campus in Ismailia and in community-based existing hospitals and health service centers in the governorates. This first-approach will provide the students with/hand exposure to the health problems and needs in the field, an experience which students in other Egyptian medical schools rarely get.

Emphasis will also be given to the managerial aspects of the physician's role as a health team leader when he begins practice after graduation. Student enrollment will be highly selective and intentionally limited to the numbers for which the institution can provide a quality, task-oriented education.

Phase I (the first 18 months) will comprise:

1) Curriculum development. Institution capacity for the SCU/FM to develop, implement and evaluate an innovative curriculum will be established. Complete course content for the first two years will be designed, along with major portions of the remaining years.

2) Identification and improvement of clinical training sites. Six sites for clinical training have been identified in the Ismalia area. During Phase,I design for renovation of these sites will be accomplished and renovation initiated. Additional training sites for clinical training in Port Said, Suez, and North and South Sinai Governorates will be identified for improvement during Phase II.

3) Primary care group practice development. At the request of the Governor of Ismalia to have direct university faculty input into health care of the community, and in recognition of the need for health professionals to augment government salaries, a group practice scheme (new to Egypt) will be developed.

4) Design (renovating) and partial equipping of building 29. This non-clinical building on the Ismalia campus will provide teaching, administrative, library and laboratory space for the Faculty of Medicine.

5) Staff development/continuing education: Staff development will be supported by short-and long-term formal and on-the-job courses in Egypt and in the United States.

6) Strengthening management systems. Assistance in this area is designed to assist SCU/FM meet immediate management needs evolving from start-up and the decentralized nature of the campus, and to meet operational and other managerial needs for the future.

7) Planning for Phase II. Planning for Phase II will begin within six months of project funding. The workplan, for Phase II, the first draft of which should be available one year from when the grant with B.U. is signed, will include descriptions of all activities which will continue from Phase I, all new activities contemplated, and a detailed budget and implementation timetable.

Phase II (42 months)

Activities for Phase II will be delineated in the plan produced in Phase I, and will be collaboratively fashioned by SCU/FM, BU and USAID. It seems now that the first six items listed in Phase I will continue, with varying emphases on each during Phase II.

AID does not approve at this time use of AID funds for collaborative research and other activities between Boston University and Suez Canal University (as listed on pages 89 - 91 of the Technical Proposal submitted by Boston University).

While such research and other activities may be appropriate for exploration between Boston University and Suez Canal University, they are beyond the range of the project which AID proposes to fund. Should funding for such activities be requested from AID, each request will be evaluated on its

merits and in compliance with governing AID procurement regulations.

The current interest of the SCU is to start the first class in the Suez Canal Faculty of Medicine October, 1980.

Relation to CDSS

This project is well within and fully supportive of USAID objectives in Egypt. Through the implementation of a medical education program which provides integration of medical education and health services and turns out doctors with a greater awareness and appreciation of rural health needs, including family planning, this project will contribute directly to CDSS health-related, quality of life objectives; i.e., improved health service outreach with special emphasis on family planning, child mortality, and environmental sanitation. Constraints analysis implicit in assessments done by USAID, UNFPA, the World Bank, the National Academy of Science and others constantly have identified the inadequately aware and inappropriately trained physicians as a prominent stumbling block to effective delivery of family planning, nutrition, and other basic maternal child care services through Egypt's national health care system. Properly motivated and technically competent community health team leaders - the expected end-product of this project - are essential to the achievement of these CDSS objectives.

Also, through its regional and rural orientation involving three major cities along the Suez Canal and five governorates, the project will be supportive of the decentralization of governmental administration objectives by involving and encouraging local government entities such as the Suez cities, governorates and communities to exercise a greater degree of autonomy and responsibility for the planning and implementation of programs designed to improve life in their areas of jurisdiction.

PART II

A. Background

B. Detailed Description

Part II

The background and detailed description of the project are covered in EU's unsolicited proposal, Volume I attached to this paper as Annex A.

PART III

A. Technical Analysis

B. Financial Analysis and Plan

C. Social Analysis

D. Economic Analysis

A. Technical Analysis

Summary:

The project as proposed is appropriate in the context of the Egyptian medical system and uses the most relevant current technology. The project responds to the problem that physicians training, as currently done, is inappropriate and inadequate for medical practice in a large, developing country. The technology proposed - based on needs assessment, task analysis, and competancy based training - has been developed by Boston University, and is ideally suited for the new faculty of Medicine at Suez Canal University. The emphasis on primary health care is in accord with world wide developments, and congruent with USAID's Health and Population objectives. Boston University's mix of technical advisors and plan of implementation appears to be well-directed toward achieving the project goals.

While there is room for negotiation of specific budget items in the Boston University proposal the overall mix of technical advisors and assistance and their estimated cost data provides a basis for negotiation.

TECHNICAL ANALYSIS

The project as proposed is appropriate technically to the needs of the health care delivery systems in Egypt and uses the most relevant current technology in medical education. Specifically:

Continuation of the model of the physician led health team is appropriate in Egypt, given the centuries of tradition of physician primacy, the high level of acceptance by the population of modern medicine, and the significant capital and social investments already made in medical education.

The need for radical changes in medical education is generally recognized by Egyptian health professionals and educators, as well as by international observers, to make the system responsive and appropriate to the unmet health and medical needs of Egypt. The technology proposed - education based on community needs assessment, task analysis and competancy based training - will lead to physicians skilled in specific performance requirements rather than to physicians trained to absorb a theoretical mix of conventional information from a curriculum basically unchanged in the past 50 years.

The innovative approach proposed by Boston University and Suez Canal University has been developed by the Center for Education in Development for Health (CEDH) and has been tested successfully in the United States and in other developing countries. The educational concept has been expanded in this project to increase maximally the involvement and coordination of the Ministry of Health's existing health care network in medical training and in services delivery. To test this concept in Egypt requires such sweeping changes to the current approach to Egyptian medical education, that application of the technology in existing medical schools would present a risk of such magnitude to be unacceptable to medical practitioners and medical educators alike. The test must be in a faculty of medicine starting de novo - a condition met ideally by Suez Canal University, whose leadership has recognized the need for and has been seeking just such a technology for its faculty.

The question of class size and replicability have been raised. The SCU/FM objective of 50-75 students per class likely will have to withstand heavy pressures to increase class size, given the current Egyptian educational system which gives relatively easy access to professional education to those qualified by examination. At the same time, there are strong efforts underway to pare down the unwieldy size of entering classes in existing medical schools. This reduction in class size is desired by the Medical Syndicate, the medical faculties, and the Ministry of Health for qualitative reasons - the system is overloaded, and the quality of medical education has deteriorated. While no one can predict precisely what will occur, it is USAID's "best guess" that SCU/FM has sufficient technical and political backing to hold its class size at or near the desired levels.

It is unlikely that existing medical schools will adopt an identical approach to the one SCU/FM is using, no matter how successful the approach may be. To do so would be impractical and unrealistic for political and other reasons. Once SCU/FM has demonstrated the validity of its approach, however, existing medical schools could adopt major parts of that approach as seems appropriate. The pattern of MOH/University collaboration, when refined, is transferable, as are the emphasis on primary health care and the technique of systematic course design. Once these techniques are developed in Egypt, the use of closed circuit TV and video tape, individualized self-instructional materials, slides, movies and lectures can be applied in classes of almost any size. Should the GOE approve development of additional medical schools, the SCU approach, when tested, could be replicated almost in its entirety.

The project emphasis on primary health care (PHC) is in lock-step with increasing world wide acceptance of the need for improved PHC in the developed and the developing world. This approach is congruent with USAID Egypt's assessment that reduction in the rates of population growth and in rates of infant and child mortality are Egypt's most pressing health

problems, and are best attacked through primary health care.

While there is room for negotiation of specific budget items in the Boston University proposal, the mix of technical advisors and other assistance, and their estimated costs, seem reasonable. At the end of the first phase (18 months) a more precise technical work plan continuing and building on first phase activities, accompanied by more accurate costing of the second phase, will be possible.

B. Financial Analysis

Because the core of this project is an unsolicited proposal, AID has not been involved in the development of the financing of the project. On review, the input level by BU, and also by the MOH and SCU seems appropriate for the tasks planned for at least the first phase of the project (eighteen months). Before Phase II can go forward, a more detailed set of cost figures needs to be drawn up.

The attached financial tables are for AID's use in reviewing the project. We have attempted to put BU's cost proposal in a format similar to that in Handbook III. In addition, separately from this project paper, we will transmit a list of comments to SER/CCM/ROD for use in negotiating a contract with BU.

SUMMARY OF EXPENDITURES AND AID OBLIGATIONS 1/
BY FISCAL YEAR

	PHASE I FY 80 Obligation			PHASE II FY 81 Obligation			TOTAL		
	FX	LC	TOTAL	FX	LC	TOTAL	FX	LC	TOTAL
Salaries & Fringe	378,857	17,622	396,479	961,002	40,582	1,001,348	1,339,869	58,204	1,398,063
Consultants & Fringe	225,289		225,289	449,077		449,077	674,366		674,366
Travel - Per Diem	132,127	207,932	339,959	248,611	391,644	640,255	380,638	599,576	980,214
Sub-Total T.A.	736,173	225,554	961,727	1,658,690	432,226	2,090,916	2,394,863	657,780	3,052,643
Renovation		357,560	357,560		238,000	238,916		595,560	595,560
Miscellaneous	30,160	28,600	58,760	40,212	38,134	78,346	70,372	66,734	137,106
Other Direct Costs	455,169		455,169	1,040,831		1,040,831	1,496,000		1,496,000
Equipment	156,023		156,023	356,096		356,096	512,119		512,119
Vehicles		14,569	14,569		33,995	33,995		48,564	48,564
Sub-Total	1,377,525	626,283	2,003,808	3,095,829	742,355	3,838,184	4,473,354	1,368,638	5,841,992
Overhead	643,952		643,952	1,233,455		1,233,455	1,877,407		1,877,407
Sub-total	2,021,477	626,283	2,647,760	4,329,284	742,355	5,071,639	6,350,761	1,368,638	7,719,399
Special Study	70,000		70,000				70,000		70,000
Total	2,091,477	626,283	2,717,760	4,329,284	742,355	5,071,639	6,420,761	1,368,638	7,789,399

1/ Detailed worksheet in Annex F

SUMMARY COST ESTIMATE AND FINANCIAL PLAN FOR BU GRANT

	AID			GOE		COMBINED		
	FX	LC	TOTAL	LE & Equiv.		FX	LC	TOTAL
Salaries & Fringe	1,339,859	58,204	1,398,063	3,506,000	5,008,577	1,339,859	5,066,775	6,406,634
Consultants & Fringe	674,366		674,366			674,366		674,366
Travel - Per Diem	380,638	599,576	980,214			380,638	599,576	980,214
Sub-Total T.A.	2,394,863	657,780	3,052,643	3,506,000	5,008,577	2,394,863	5,666,351	8,061,214
Renovation		595,560	595,560	8,500,000	12,142,857		12,738,417	12,738,417
Miscellaneous	70,372	66,734	137,106			70,372	66,734	137,106
Sub-Total Direct Costs	1,496,000		1,496,000	550,000	785,714	1,496,000	785,714	2,281,714
Equipment	512,119		512,119	13,017,000	18,595,714	512,119	18,595,714	19,107,833
Vehicles		48,564	48,564	50,000	71,429		119,993	119,993
Sub-Total	4,473,354	1,368,638	5,841,992	25,623,000	36,604,285	4,471,354	37,972,923	42,446,277
Overhead	1,877,407		1,877,407			1,877,407		1,877,407
Total	6,350,761	1,368,638	7,719,399	25,623,000	36,604,285	6,350,761	37,972,923	44,323,684

C. Social Soundness Analysis

As this project is a response to an unsolicited proposal, USAID did not prepare a separate detailed social soundness analysis. However, two principle aspects of the social soundness analysis are treated in the following sections:

1. The compatability of the project with the sociocultural milieu in which it is to be introduced. (Vol 1, Part II; and Vol II, attachment 5, BU proposal).

2. The likelihood that the new practices will be diffused: (See Part 3 (D) Project Paper).

Beneficiaries, Role of Women and Population

The immediate beneficiaries will be the estimated 50 doctors who will be graduated annually beginning in 1986, who will have received an education and training which prepares them to perform a more effective role in diagnosing and responding to the health needs in Egypt.

As these more professionally trained doctors are assigned to the field, eventually the entire population (estimated at 1.1 million) of the area to be served by the project will benefit by receiving better medical attention and treatment and a full range of preventive measures.

Women will benefit through an opportunity to attend the medical school (40% of each class) to become doctors, more acceptable culturally to administer to the health needs of females. Female patients who comprise a large portion of the patients reached and treated will benefit from better treatment and better health. Women will also benefit from better training and counseling on family planning and the resultant smaller and healthier families. (See also B.U. Proposal, Volume I, pages 6 and 13.)

D. ECONOMIC CONSIDERATIONS, INCLUDING REPLICATION

In terms of WHO standards for physician to population ratio, Egypt almost alone among developing nations has approached the"ideal"of one physician per 1,500 population (1977). Well over 100 years ago, Kasr El Aini (Cairo University) began training Egyptian physicians, and Egypt has long served as the provider of physicians for its own citizens and for those of most Arab and many African countries.

In Egypt's commitment to equity through universal access to higher education (for those students who academically qualify), production of all professional categories has mushroomed since the revolution of 1952. The annual production of medical graduates quadrupled without concurrent increases in teaching staff and facilities. Because of this political decision for mass education, individual classes of 1000 students are common. Access to clinical "hands-on" training has not kept pace, nor has the curriculum been modified significantly to produce much needed primary care physicians. Instead, existing schools concentrate on developing medical care specialists who are better prepared for service in an emergency room in Philadelphia or an operating room in London than they are to provide community level care in Egypt. There is general professional agreement that the quality of medical education has deteriorated severely in recent years (See Institute of Medicine Report, Chapter 5, Health Resources). The Egyptian Medical Syndicate has realized only limited success from its aggressive campaign to improve quality of medical education by reducing class size; however, the conservatism of established medical facilities has so far precluded radical turn

arounds from curative to preventive care, from individual patient to community concerns.

The GOE has made remarkable advances in achieving its goal of providing a fully trained physician to head a team of paramedical and ancillary primary health providers for every rural village. It is clear though, that the physicians so trained are not motivated to stay in rural villages. Their training is also more costly than would be the case for paramedics who also would be more likely to stay in the rural areas. None the less, it has long passed the decision point of whether or not to rely in large part on physicians for primary, secondary and tertiary care. Egypt has made its decision, and already has made most of the hugh investments inherent in such a decision - for laboratories, teaching hospitals, classrooms, etc. Concurrently it is training large numbers of supporting paramedical personnel, who in other developing countries provide the majority of primary and frequently secondary health services. Decisions for promotion of paramedics in the other countries is made largely upon consideration of three factors: financial (start up costs for conventional physician training are huge and continuing service payments to attract physicians are much higher than for paramedics); recognition that many tasks (formally considered the sole province of the physician), with <u>appropriate supervision</u> can be handled by lesser trained individuals; and the greater likelihood that paramedics will remain and work in a rural environment than physicians.

Given its policy decision and level of sunk investments, Egypt does not intend to dismantle its existing medical education infrastructure and policy of physician-staffed health services. The option of relying primarily on

paramedical personnel for the provision of Basic Health Services in MCH, nutrition, family planning and general hygiene is not open. It is willing in this project, to experiment with a radically new approach to educate physicians so that they will be much better qualified to head teams of ancillary personnel to provide preventive-oriented, community-based services, to preserve health rather than cure disease. Class size will be limited in order to improve teacher student relationships. Curriculum will be tailored to common community needs rather than to comparatively costly curative care. Start-up costs will be greatly minimized because existing "real life" health care facilities will be used for clinical and community training in lieu of costly teaching hospitals. The medical students will come from the Suez Canal area, be trained in the community to respond to the health needs of the community, and we are assuming will remain in the community after graduation. By the physician learning to direct paramedics under his charge (a skill currently not well developed in Egypt), being trained to marshall community resources, and emphasizing preventive and early treatment, quality of care will increase, morbidity and mortality averted, and unit costs of services provided will decrease. If the experiment - for which risk capital is needed - is successful, other medical schools in Egypt will be more likely to make changes in their policies and in their mode of teaching to incorporate the successful features of this project.

Given the GOE policy to train and distribute physicians to serve all its rural and urban population, no viable first step alternatives exist at this time.

COST EFFECTIVENESS CONSIDERATIONS

In terms of cost-effectiveness, any analysis of this project must deal with the ephemeral concept of quality rather than the normal analytic indicators of quantity. The use of quantity indicators assumes satisfactory quality. This project is premised on the observed lack of quality in terms of the government system's capability to affect morbidity, fertility and mortality levels in the community.

Realistically, quantitative analysis even at the simplest level, i.e. cost effectiveness, is not possible since we are not choosing either a specific cost limitation (i.e. 90¢/person/year) or a given level (400 physicians a year) which represents "effectiveness". The economics of the project relate closely to the assumption that when physicians are trained to manage health teams in the community setting the quality of care will show definite improvement and that this will result in improved health status for the community. At least initially it will cost substantially more to educate a physician under the methods described in the project than under the current system. However, quantifying a current graduate's value in the community on a scale of 1 to 10 at, say 2 (low quality), versus a physician graduating from Suez Canal University at, say 8 (high quality), and then comparing costs would be simply an exercise in guessing, since rigorous methods for analyzing quality of health service delivery and of team management in developing countries only exist insofar as competancy based testings can be said to be indicators.

Replication

The development of the Suez Canal University Faculty of Medicine (SCU/FM) holds the potential for introducing and stimulating needed changes in physician education and patterns of practice not only in the five Suez area governorates, but throughout Egypt.

The Suez area is characterized by diversity, from intensely urban through rural and agricultural to nomadic. Thus it is reasonable to project that physicians educated to work effectively in the Suez area can work effectively anywhere in Egypt.

A. Factors Fostering Replication

The process of involving medical educators from many other schools (e.g., Cairo, Ain Shams, El Azhar, Assuit) throughout Egypt in the development and implementation of the SCU/FM curriculum has begun and will continue. These educators from other schools can be expected to serve as messengers to, and catalysts within, their own schools in bringing about improvements and the adoption of aspects of the SCU curriculum and overall educational approach.

The Ministry of Health, with nationwide responsibilities and deep involvement in the development of SCU/FM (as codified by the 1979 establishment of the joint MOH-SCU Permanent Committee for Health Services and Medical Education in the Suez Area), will serve as an active disseminator and stimulator of change in other universities.

As physicians graduate from SCU/FM, some will go to universities in other areas of Egypt to teach and practice and some will enter the Ministry's health services. They will form a cadre of professionals who can be expected to show by their own commitment and performance the benefits of the SCU approach and to serve as articulate and informed change agents in the techniques and benefits of competency-based curriculum development, primary care and the integration of teaching and service.

B. What Will Be Disseminated?

The SCU/FM can be considered to have three products which in whole or in part can be adopted and adapted by other universities and supported by the Ministry of Health in other areas of Egypt. Specifically:

1) Curriculum materials - the curriculum itself.
2) The process of curriculum development - competency based, multidisciplinary and derived from the population's health needs.
3) A different approach to education and service - the integration of Ministry of Health service programs with university-based physician education programs, with services designed within existing policy constraints in recognition of the limited per capita investment available for health.

It is likely that individual institutions throughout Egypt will value developments at SCU/FM in different ways. Presuming success of this project, it is likely that portions of the approach (elements of the curriculum, or the community-attuned nature of the medical education) will be adapted by most existing schools in an incremental way to produce physicians more responsive to the basic health needs of Egypt. The Suez approach will result in a curriculum that is different in content and structure from existing curriculum and specific curriculum materials produced at SCU/FM will be disseminated to other schools of medicine in Egypt. The process by which the curriculum is developed (with great success in some other progressive countries) will be new to Egyptian medical education and could be applied to an entire faculty or to a single course in one department. Publications issued by the SCU/FM describing and analyzing its approach to medical education will serve as an excellent media for the dissemination of concepts, problem analysis and results. The mere existance of a school with a small class size will be very supportive of a movement already desired by the Medical Syndicate and by medical educators toward smaller class size in existing medical schools, reinforcing a desired downward trend in medical school admissions which began two years ago.

The SCU/FM, plans to hold annual or more frequent conferences, involving leading medical educators, senior MOH representatives, and well-known and respected practicing physicians from throughout Egypt with the specific objective of reviewing and presenting various

aspects of the SCU/FM in a context that is relevant to health service and medical education professionals throughout Egypt. These conferences/seminars will provide valuable input into the Faculty of Medicine development process, and serve as a vehicle for informing and involving others in the dissemination of specific approaches and the sharing of results.

C. The Costs of Replication

Generally, the direct additional cost of the proposed activities and processes is small. Basically costs will complement on-going programs and will capitalize on the general interest in Egypt in improving medical education. Admittedly a major curriculum change could be costly initially; however, smaller, incremental uses of the Suez approach and materials may well be accomplished at little or no additional cost by other institutions. Whatever the cost, it is reasonable to foresee that if the Suez experiment is successful, costs of replication and development are very likely to be more than offset by the very pervasive and profound favorable economic impact that will come as the result of at least four factors:

1) The pattern and content of practice in the Suez area should become more cost-effective within the next several years as improvements in service delivery, organization of services and physician performance take place as a result of SCU/FM and Ministry of Health cooperation.

2) There will be a clear demonstration that smaller class size produces better and more effective physicians. Overall operating costs of the health delivery system will be reduced as physician production declines, and production by the physician - led health team increases.

3) The primary care physician provider and manager trained in the Suez mode will be one who is a health team member. It is reasonably to assume that he will spearhead the recognition of the need for and role of non-physicians (nurses, paramedics, community volunteers) in the delivery of cost-effective health care, demonstrating a way to deliver more cost-effective health services of better quality.

4) The integration of education and existing health services reduces the need for teaching hospitals and new clinics, decreasing duplication of service and attendant unnecessary cost, while improving quality and acceptability of services in Ministry of Health rural and urban hospitals and clinics. (The need for existing teaching hospitals in Egypt for specialty training, will, or course, remain).

Some of the foregoing should actually lower total cost. Other factors will improve cost-effectiveness by improving relevance and productivity per unit of operating cost. In the aggregate, the economic benefits, though difficult to quantify and guarantee in advance, should ultimately be demonstrable and more than offset the economic cost of the

development and operation of the SCU/TM, as well as provide an example for improvements in other Egyptian medical schools.

Estimation of GOE Contribution to the Project (LE 000) 1/

Suez Canal University

Construction	8,500
Equipment	6,950
Vehicles	50
Salaries	2,100
Subtotal	17,600

Ministry of Health (Ismailia Health Centers) 1/

Equipment	6,067
Salaries	1,406
Current Expenses	532
Depreciation	18
Subtotal	8,023
Total	25,623
	($36,604)

1/ Please refer to Annex M & N for the details of the MOH and SCU contribution.

PART IV

A. Implementation Arrangements

B. Evaluation

C. Covenants and Conditions Precedent

A. IMPLEMENTATION ARRANGEMENTS

1. Analysis of the Recipient's and A.I.D.'s Administrative Arrangements Including Procurement

Implementation Responsibility

A recently established Permanent Committee for Health Services and Medical Education in the Suez area highlights the collaborative nature of the MOH relationship to the new Faculty of Medicine and Joint Committee's (i.e., EU and SCU/FM) efforts to utilize fully the faculties, programs and personnel of the MOH and the governorates in the medical educational process.

The Permanent Committee, as the Suez Area Working Group established by the SCU President, will be chaired by the Dean of the SCU/FM. This Committee will be comprised of: senior representatives of the MOH central office; Directors of Health of Suez, Ismailia, Port Said, and Sinai North and South; the Director of Medical Services, Suez Canal Authority; and selected senior faculty of SCU.

This Committee has the responsibility of assuring the fullest integration of education and health service facilities and programs and providing overall policy guidance and coordination in the implementation of the project.

Dr. Bicknell, who reports directly to the Academic Vice President for Health Affairs and Director of the EU/HPI, will serve as EU/HPI (US)Project Director. He will be based in Boston but will spend no less than 40 percent of his time backstopping the project. There will be a full-time project manager/ coordinator, reporting to Dr. Bicknell, who will have primary responsibility for assuring appropriate coordination of all contractor inputs and will serve as the immediate supervisor of all contractor-provided consultants and staff working on the project.

While the Ministry of Economy and Economic Cooperation will sign the Grant Agreement as the responsible GOE entity, the Ministry of Health and SCU/FM as implementing agencies and signatories will name Project Co-Directors for the GOE, who in cooperation with the Permanent Committee, will be

responsible for overall implementation of the project. They and the BU/HPI consultants will be assisted by various committees established to provide guidance in specific areas as indicated in the project proposal.

2. Implementation Plan 1/

It is recommended that A.I.D. directly negotiate a cooperative agreement grant with Boston University. It is USAID's desire to minimize A.I.D.'s direct involvement in this grant both because it is an unsolicited proposal, not an A.I.D. developed project, and because B.U.'s capacity to implement such a collaborative project with the Suez Canal University and the Ministry of Health seems quite adequate based on what it has achieved in the design stage of the project. The option of a collaborative assistance agreement has been rejected since the project design stage has been passed.

The grant to the government principally will provide financing for Boston University and funding will flow directly to B.U. for its LE and dollar costs. The former will flow in accordance with standard USAID procedures and the latter over a direct letter of commitment.

The special study effort is not included in the grant to B.U. A.I.D. will contract directly with an outside contractor for a special study of the potential fit between the Suez Canal University product and the organization and administration of the Ministry of Health facilities and personnel involved.

1/ See also B.U. Proposal Volume I

The renovation effort may or may not be included in the grant to B.U. depending on the results of negotiations. It could be handled in either of two ways:

a. Boston University could subcontract by competitive, fixed price contract(s) for renovation. That portion of the fixed price representing identifiable taxes for the contractor or its personnal would be the responsibility of the GOE. 1/

b. Where the government (Ministry of Health or Suez Canal University) contribution is of a sufficient level to insure that taxes are covered, a FAR procedure directly to either Suez Canal University or the Ministry of Health can be used.

The method of payments for renovations which have been selected take into account the following problems:

(1) Unless a FAR or fixed price contract is used, USAID will have to get involved in cost audits or vouchers of subcontractors and government entities, which is inconsistent with USAID's desire to stay removed from day-to-day management on the project.

(2) Currently when money from a government entity, including A.I.D. money channeled through that agency, goes to an Egyptian contractor, the government entity must first deduct taxes on that entity. This violates the A.I.D. principle of not paying identifiable taxes to foreign governments. This principle is not violated if non-A.I.D. contributions are equal to or greater than the tax burden.

1/ The NEAC approved this option, but Boston University will be prohibited from utilizing project funds for local taxes.

Equipment Procurement

Procurement by B.U. with both U.S. dollars and local currency shall be carried out pursuant to established B.U. procedures approved in advance by A.I.D. Precise details as to type, mode and competitive procedures shall be required in the Project Grant as a condition precedent to any disbursement for procurement of equipment. A.I.D. source and origin rules would apply to procurement of commodities and services.

The initial grant to Boston University shall be a direct grant from A.I.D. to the University; payment for specified project activities will be carried out through direct disbursement by the A.I.D. contractor.

B. Evaluation

The SCU/FM, MOH and USAID jointly will conduct an evaluation of Phase I activities fourteen months after initiation of project activities. The evaluation will follow the AID format. The objectives of the evaluation will be to:

1. Determine whether project objectives are being achieved.
2. Identify problem areas where project resources might be better utilized.
3. Recommend measures designed to see that implementation activities are supportive of project activities.
4. Review the draft workplan for Phase II.

In meeting the general evaluation objectives cited above, information should be prepared for the evaluators by SCU/FM to permit judgment of:

(1) Curriculum development

a) conceptual framework for courses required for each year of medical school

b) progress towards detailed course content for the first two years

c) status of course curricula design under progress

d) the extent to which the medical education unit in the Dean's Office of SCU/FM is participating in the curriculum design process

e) the methodology by which SCU/FM - MOH judge course design.

(2) Identification and improvement of clinical training sites

a) status of design/renovation of training sites in Ismailia

b) progress towards identification of sites in other governorates, and criteria for selection.

(3) Primary care group practice development

Status.

(4) Design (renovating) and partial equipping of Building 29

Status, including library development.

(5) Staff development/continuing education

a) numerical adequacy of staff against a staffing pattern

b) faculty training needs

c) cooperating MOH personnel training needs

d) relevance of overseas and in-country training underway or planned to the needs identified in 5b)and c) above.

(6) Strengthening management systems

a) progress towards specific management needs of the SCU/FM, with particular attention to the SCU/FM - MOH interface in the five governorates.

b) progress in the design and development of a management system and specific procedures to meet the needs of SCU/FM, including mechanisms to define management systems objectives, methods to meet these objectives, and methods to monitor SCU/FM performance.

(7) Planning for Phase II

Prior to the evaluation, SCU/FM will prepare a draft plan for Phase II to include all activities, new and continuing, for Phase II, with timetables and budgetary estimates. The adequacy of the plan will in large part be judged in light of evaluation findings of the first

six items above, and suggestions and recommendations will be made by the evaluating group to SCU/FM. The plan will include a suggested evaluation methodology for Phase II.

The evaluation will also consider findings from a special study to be conducted by an external organization on the potential fit between the SCU/FM product, and the organization and administration of the MOH facilities which will utilize that product.

Special Study Related to the Evaluation

The objectives of a special external study are three fold: First, to determine whether the work plan for Phase I has been effectively implemented and to identify problem areas where project resources might be better utilized. Second, to determine whether Phase I project objectives are being achieved, and to appraise both the actual and potential impact of the project's activity. This impact appraisal is to encompass both the SCU/FM and those secondary beneficiaries who will be affected by the project. Finally, the study will prepare a set of recommendations that will be useful in designing Phase II of the project. The study team is not to draft a project design for Phase II. The Mission believes that this work can best be done by separating this study and design functions.

The external study will focus closely on the links between project inputs and anticipated outputs: i.e., improvements in the urban and rural health delivery system in the Suez Canal area. The external observers will not be concerned with judgments on the technical quality of the project inputs (i.e., quality of curricula, etc.). Review of the technical inputs will be strictly the responsibility of the USAID project staff. For these

reasons it is intended that the external study contract will be awarded to an organization with substantial experience in analysis of service delivery to poor populations in LDC's and in the design of systems aimed at the measurement of impact of service delivery systems. The division of the project into two phases derives from a relatively high level of confidence that the contractor/grantee can produce a relevant redesigned curriculum for SCU Medical Faculty but a somewhat lower level of confidence that the links between the medical faculty and the health delivery system can be effectively forged. It is with an eye to improving the prospect of successfully making this link that the external study is targeted expressly on the <u>impact</u> of the modernized curriculum at SCU and the probable resultant improvements in the COE health delivery systems rather than on the medical faculty itself.

For the Phase I external study a three-man team of outside experts, assisted by one AID/Washington officer, is planned.

Initially, two members of the contract team are to come to Egypt prior to or within the first ninety days of project implementation. The team will: (1) determine appropriate baseline data useful in evaluating this project; (2) identify and recommend appropriate offices and persons to be responsible for the collection of these data (contractor, SCU, local MOH officials); and (3) prepare a format to be used in presenting the baseline data on a regularly scheduled basis. This data collection will have a direct correlation with the project design and have a logical relationship with the project's LOG FRAME. Collection of the baseline data will be undertaken and involve the same firm which will undertake the full in-depth external study. The two-man baseline team is expected to take three weeks in completing the above tasks. Following their departure, baseline data will be gathered by cooperating staff of SCU and MOH and presented to BU and USAID on a monthly basis.

Five or six weeks prior to commencement of the external study review, the leader of the three -man contract team will make a one-week visit to Egypt. The purpose of this visit is to thoroughly acquaint himself with project operations and the context in which the project operates. Further, the contract team leader is to survey the compiled project baseline data and other information data with an eye to determining its adequacy in meeting the in-depth study requirements.

The special in-depth study of Phase I will be held during the twelvth month of Phase I operations. The Special Study Team will be composed of a full contract complement of three men and one AID/Washington official. Expertise found within the team is expected to include:

1 - low cost services delivery specialist (LDC experienced)

1 - medical anthropologist/sociologist

1 - medical educator administration specialist

The AID/W officer, drawn from outside the Near East Bureau, is expected to be a senior officer thoroughly acquainted with Agency procedures and regulations. The team's study will work with GOE officials, the contractor and Mission personnel. Logistical support and monitoring functions for the team's activity will be the responsibility of the USAID Evaluation Officer.

The study will be completed within three weeks. Basically, the independent team will, as stated above:

a. Determine whether the workplan for Phase I has been effectively implemented, noting any problem areas that have arisen, if any, and the prospect of their continuing into Phase II;

b. Determine if the project design continues to be an effective means of reaching the project purpose. Further, the team will evaluate the prospects of the project making the impact on the GOE health delivery systems envisaged when the project was approved. This will call for an appraisal of conditions and GOE institutions with which SCU/FM would have linkage in improving Egypt's health delivery systems.

c. The team is to draw upon its findings and make a set of recommendations that will be useful in designing any "follow-on" project. The findings and recommendations also will list those condition precedents, covenants and governmental commitments for Phase II which should be met by the Government of Egypt if the project is to have any significant impact in improving the performance of the Egyptian health delivery system.

Schematically, the study plan is as follows:

PHASE I

MONTHS

1 2 3[a/] 4 5 6 7 8 9 10 11 12[b/] 13[c/] 14[d/] 15 16 17 18

a/ Baseline Data Exercise

b/ External Study Advanced Visit

c/ External Study Review

d/ Internal Evaluation

Estimated cost of implementing the special study is $70,000. Cost includes salaries for contract personnel, local and international travel, per diem and overhead and miscellaneous expenses.

Prior to their departure, the external study team will give the Mission, BU, SCU and the MCH an "exit" briefing covering all major findings and recommendations growing out of its study. Printed copies of the special study report will be available within sixty days following the team's departure from Egypt. Numbers and distribution of the printed report will be decided upon by AID and the consulting firm at the time of signing the contract.

C. COVENANTS AND CONDITIONS PRECEDENT

The following conditions precedent to disbursement and covenants will be included in the Grant Agreement:

A. Conditions Precedent

1. Conditions Precedent to Initial Disbursement

Prior to any disbursement or to the issuance by AID of documentation pursuant to which disbursement will be made, the Grantee shall, except as the parties otherwise agree in writing, furnish to AID in form and substance satisfactory to AID:

a. A statement of the names and title with specimen signatures of the person or persons who will act as representatives of the Grantee.

b. Evidence of creation of a Dean's Planning Unit within Suez Canal University (SCU) to coordinate SCU and MOH objectives, including a description of MOH participation and a description of function of the Unit.

c. Evidence of creation of a Medical Education Unit within the Dean's office at SCU Faculty of Medicine SCU/FM for implementing terms of curriculum development, with description of personnel to serve on extra-mural consultant panels and intra-mural committees.

d. Such other documentation and materials as AID may reasonably require.

2. Conditions Precedent to Disbursement for Renovation

Prior to any disbursement or to the issuance by AID of documentation pursuant to which disbursement will be made for renovation the Grantee shall, in each case of renovation, except as the parties may agree otherwise in writing, furnish to AID in form and substance satisfactory to AID:

*a. Evidence that Egyptian budgetary resources have been allocated for the ongoing operating costs of health facilities to be renovated before funds may be disbursed.

*b. Evidence of engineering designs, adequate supervisory services, and cost estimates for the planned construction.

*c. Evidence of execution of construction contract(s) with firm(s) acceptable to AID.

*d. Such other documentation and information as AID may reasonably require, or the issuance by AID of documentation pursuant to which disbursement will be made.

*3. Conditions Precedent to Disbursement for Equipment

Prior to any disbursement or to the issuance by AID of documentation pursuant to which disbursement will be made for the procurement of equipment, except as the parties may otherwise agree in writing, Grantee shall cause to be furnished to AID, in form and substance satisfactory to A.I.D., a procurement plan which will include identification of procurement procedures to be followed for the project.

* To be included in Authorization Document.

*4. Conditions Precedent to Disbursement for Phase II

Prior to disbursement for activities during Phase II of the Project, except as the parties may otherwise agree in writing, a Phase II funding proposal shall be prepared acceptable to and approved by AID, Grantee, SCU and the Ministry of Health which will include a workplan for all activities of Phase II (including those begun in Phase I and to be contained during Phase II), and a detailed budget and implementation timetable(s).

B. Covenants

In addition to the standard convenants which will be included in the Standard Provisions Annex to Grant Agreement and those Grant Covenants required by AID Handbook 3, the following special covenents will be included in the Grant Agreement:

1. Execution of the Project

The Grantee shall:

*a. Assure commitment by cooperating agencies, with responsibility to staff and operate facilities to be renovated as part of the project, to include in their future budget plans for the timely recruitment and funding of staff and provision of funds to meet other operating costs.

*b. Carry out the project with due diligence and efficiency, and in conformity with sound engineering, construction, financial, administrative and other professional practices.

*c. Cause the project to be carried out in conformance with all the plans specifications, and with all modifications therein approved by AID pursuant to the Agreement, including the pro-

* To be included in Authorized Document.

vision, on a timely basis, of necessary local currency and in-kind support as specified in the Agreement and its annexes.

*d. Cooperate fully with AID to assure that the purpose of the grant will be accomplished and the GOE and AID shall from time to time, at the request of either party, exchange views through their representatives with regard to the progress of the project, the performance of consultants, contractors and suppliers engaged on the project, and matters relating to the project.

*e. Within 6 months of signing of the Project Grant Agreement in conjunction with B4, produce a detailed workplan including a detailed plan for curriculum development for the first two years of classes, budget and a plan of management approach for Phase I of the activity. The workplan will be updated every 6 months and will include discussions of site selection for clinical training, plans for faculty development and continuing medical education, training plans for the clinical staff, plans for assistance in architecture and health program design, meeting management needs of the Faculty of Medicine, library facilities and mechanisms for physicians' compensation.

*f. Make provision for adequate administrative arrangements and local currency from funds other than those provided by the Grant for any incentive payments to be made to personnel of the Government of Egypt engaged in project implementation.

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* To be included in Authorization Document

*g. Limit the initial class size to no more than 60, and submit a plan within one year detailing how class size will be controlled for further years, with the goal being not to exceed 75 per class.

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* To be included in Authorization Document.

ANNEXES

Volume I
ANNEX 17

TECHNICAL PROPOSAL

MEDICAL EDUCATION AND HEALTH SERVICES

FOR THE SUEZ CANAL AREA

An Unsolicited Proposal for Collaborative Assistance

Prepared in collaboration with

THE SUEZ CANAL UNIVERSITY FACULTY OF MEDICINE

and

THE MINISTRY OF HEALTH

submitted by

BOSTON UNIVERSITY'S HEALTH POLICY INSTITUTE

to

THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D.C., U.S.A.

Ismailia and Boston
August 27, 1979

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Total Pages, Volume 1 - 107

I Introduction

This unsolicited proposal for collaborative assistance prepared in close cooperation and full consultation with Suez Canal University's Faculty of Medicine by Boston University's Health Policy Institute, (BU/HPI) will, within the framework of the formal agreement between the two Universities (attachments 1 and 2) with the cooperation and support of the Ministry of Health, when funded, facilitate the development of a new community based Faculty of Medicine at Suez Canal University which has as its major goal, in the words of Dean Nooman, producing "good physicians for Egypt" through:

1) The integration of the medical education and health service process, fully utilizing Ministry of Health personnel and facilities.
2) The education and training of primary care physicians as direct providers and health team managers to work effectively within probable future resource constraints (public and private per capita expenditure estimate: $8-12 per person per year).
3) The development of a curriculum and educational approach that derives from the populations health needs.

Suez Canal and Boston University urgently request approval of this five year project with funding for the first 19 months (Phase I). A detailed Phase II funding request will be developed during Phase I by Suez Canal University and Boston University who request at

this time, subject to availability of funds and a satisfactory performance evaluation, from USAID approval in principle of the entire project with continuity of contractor for the five year program.

This contract will be, when funded, a necessary component in the multi-faceted development and support plan for the Suez Canal University Faculty of Medicine:

1) Existing Suez Canal University and M.O.H. resources
2) Boston University Health Policy Institute funds (over $80,000 to date).
3) Public Law 480 Funds. Application approved for 250,000 L.E. (US $ 350,000) by the Health Resources Administration, Department of Health, Education and Welfare and the Egyptian-American Joint Working Group in July, 1979.
4) USAID
   a) This contract
   b) Various ongoing general support mechanisms, e.g., commodity import, traineeships, etc.
5) Other bilateral donors, e.g., British Health and Social Services.
6) World Bank
7) Private donors

With regard to items 2 through 7 the following applies:

2) Boston University's Health Policy Institute is unable to continue significant activities in support of Suez Canal University Faculty of Medicine, without external funding.

3) Favorable action was taken by the Joint Working Group in July 1979.

4) Self-explanatory.

5) This is discussed on pages 74 & 75 of this proposal

6) Initial explorations with the World Bank have begun (see Attachment 3).

7) Private donor support may be possible for specific modest items of equipment or activities, but cannot be expected to be sufficient in any signficant way to meet basic startup needs.

It is anticipated that the operating budget provided by the Arab Republic of Egypt to the Faculty of Medicine in five to six years will be sufficient to maintain the school at its planned level of effort without continuing external donor support.

However, startup resources, both money and manpower, are in short supply, making it very difficult to approach, let alone substantially achieve the goals and objectives of the faculty without substantial immediate infusions of new resources which will have to continue for about five years.

It is emphasized that Suez Canal University Faculty of Medicine recognizes that the faculty must be planned and managed in such a way that the steady state operating costs after five to six years are fully within the operating budget support capacity of the Arab Republic of Egypt. Thus, as the Faculty of Medicine is educating physicians to operate effectively as primary care providers and health team managers within the projected budgetary limits of the

nation, the faculty itself is being designed to operate within the real world of scarce resources with full recognition that to expect long-term continuing operating budget support from foreign donors is to plan for failure.

The entire SCU FOM development is dependent upon good and close working relationships with the MOH in Cairo, as well as in the five Suez area governorats. This project, as it is an integral part of overall FOM development also depends on such relationships, if its purposes are to be met. BU's HPI, rather than developing its own independent relationship with the MOH, has, in consultation with SCU/FOM, chosen to work with the Ministry through SCU and the Faculty of Medicine. Thus, in the development of this proposal, the bulk of the discussions between BU and the Egyptian side have been with SCU/FOM, particularly President Osman, Dean Nooman, and Dr. Ezzat. SCU and the FOM have assumed the ongoing and primary responsibility for coordination and collaboration with the MOH, including this particular project.

In a nutshell, the combination of Public Law 480 monies just awarded, and USAID funds requested in this proposal are of the utmost importance if the promise of the faculty is to stand a reasonable chance of soon becoming an operational reality.

II Overview

Egypt may be divided roughly into three major geographic areas: lower Egypt, upper Egypt, and the Suez area. The last comprises five gouvernorats or provinces (Port Said, Ismailia, Suez, Sinai-North and Sinai-South).

Perhaps the best and most current overview is provided by Dean Zohair Nooman's recently completed interim report to President Osman. It is (except for appendices, available upon request) reproduced in full as Attachment 4.

Suez Canal University is a recently chartered university and has incorporated some pre-existing programs into the university (e.g. shipbuilding and mining), and, in other areas of professional studies, is developing new faculties (e.g. medicine), and plan to develop additional faculties (e.g. nursing). The university is decentralized with existing or planned programs in the five gouvernorats (provinces) of the Suez area.

Doctor Abdel-Meguid Osman, President of Suez Canal University, emphasizes that a major goal of the University is to meet the needs of the people in the Suez area. The health and well-being of the population are major concerns and plans for the new Faculty of Medicine stress:

1) Building a curriculum that focuses on primary care and derives from an assessment of health needs and community resources. This will include an undergraduate medical curriculum, education and training in family planning, nutrition, maternal and child health and other preventive

services. Family planning is included,as it addresses one of the most pressing national problems facing Egypt. This approach will institutionalize family planning in the undergraduate medical curriculum and take into consideration the national health policy that family planning serves at the point of entry into the health system as a vital component of the solution to the population problem.

2) Utilizing existing facilities and staff of the Ministry of Health Service Delivery Programs as the primary teaching resource for medical education.

Boston University, through its Health Policy Institute, is collaborating actively with the community based Faculty of Medicine at Suez Canal University. Our collaboration stems from recognization within Egypt,that a new direction in medical education and service emphasizing primary care is urgently needed. At the present time, Egyptian medical education is characterized by extremely large class size, (often over 1,000) an outdated curriculum adopted in 1926 from a British model, the lack of any significant relationship between the process of medical education and the basic health needs of the people. This problem was thorougly addressed at the Fayoum Conference on Medical Education, in March of 1978 (Attachment 5), and many of the issues were also raised by the Royal College of General Practitioners in their February 1978 report to the Ministry

of Health (Attachment 6). The conclusions from the Fayoum Conference contributed to the conceptual underpinnings that lead to the establishment of the Faculty of Medicine at Suez Canal University emphasizing:

1) The training of physicians to be primary care providers and managers of the health team.
2) Full integration of education and health services, primarily utilizing Ministry of Health facilities and programs.
3) Small class size.

The Suez Faculty of Medicine plans to train physicians who will be able to minister, in a relevant way, to the basic health needs of the population at a cost that is affordable by the Arab Republic of Egypt and in a manner that is acceptable to the people.

The school will train physicians who can directly provide as well as manage the provision of primary care services. The student body will be small, with a first class of fifty entering in the fall of 1980, and a total projected student body of 300. Clinical training will be done at Ministry of Health and selected other public and private clinical facilities. Of the utmost importance, there will be no university teaching hospital.

Faculty of Medicine program development emphasizes education and service with service improvements in Ministry of Health facilities expected to occur in one to two years, well before the first graduates are produced. Clinical training will take place in the governorates of Suez, Ismailia, Port Said, Sinai-North and Sinai-South.

The three major cities of the Suez area, Port Said, Ismailia and Suez have populations of 266,285; 168,011 and 196,790, respectively. In the area, there are numerous hospitals, clinics and physicians. Each of the major cities has a several hundred bed general hospital, as well as specialty hospitals. For instance, in Port Said and Suez there are separate hospitals for the treatment of chest and infectious diseases. Throughout the area there are many rural and urban clinics and free standing urban emergency centers. However, the exact capacities of inpatient facilities, scope of services offered in all facilities, staffing, utilization, and cost is not yet sufficiently accurate for purposes of planning and program development for the Suez Canal University Medical school.

Major joint activities proposed for support during the next 18 months are, with the exception of Phase II planning, all clearly directed toward assisting in the timely opening and initial operation of the Faculty of Medicine.

Effective planning and development of the new Medical School must recognize the limited resources available for care in the public sector,as well as the role of the private sector, current and projected, in the provision of health services. (Public and private per capita health expenditures estimated $8-12, 1977; public per capita expenditures estimated $4.02, 1977 . - Attachment 7)

The concept of a community-based medical school is not new, but success is far from common. The Suez experiment contains within it the elements necessary for success:

1) Dynamic leadership of good quality.
2) Good relationships with providers of service -- particularly the Ministry of Health.
3) A new faculty unencumered by tradition.
4) A service population,(one million) large enough to be meaningful, but small enough to be manageable.
5) Sound basic educational and service concepts.
6) Support from leaders in the academic and medical community at other major universities in Egypt.
7) A geographic location that is of prime political and economic importance.
8) Support of national and local leaders.

Boston University's Health Policy Institute and Suez Canal University Faculty of Medicine, in close cooperation with the Ministry of Health, look forward to continued collaboration in what we feel is an extraordinarily exciting and important experiment in medical education with three levels and types of relevance:

1) Improving medical education and health service in the five Suez governorates.
2) By example, demonstrating the benefits and methods as well as the problems associated with curricular innovation and the integration of service and education to the other medical faculties throughout Egypt.

3) Serving as an example to the international medical education community in both developed and developing countries, vis-a-vis the education of primary care physicians in community settings.

The program and approach conceived in Egypt, implemented initially under the leadership of President Osman, Dean Nooman and Dr. Ezzat, stems from recognized deficiencies in Egyptian medical education, and can serve as a beacon for medical education reform within Egypt and as an illustration of value to others throughout the world.

III Background and Problem Statement

Today in Egypt there is widespread recognition that medical education requires improvement, and the health needs of the people, particularly primary care needs, which in the Egyptian context include family planning, preventive services, nutrition and maternal and child health, are not being adequately met. In recognition of this, the Ministry of Health has undertaken rural and urban initiatives to improve primary care, and fully supports the improvement and upgrading of primary care services throughout Egypt. The Fayoum Conference served as forum from bringing together members of the Medical Section of the Supreme Council of Universities, deans and professors of all of the medical schools, leaders of the MOH and leaders of the Doctors' Syndicate. There was a broad consensus that Egypt was producing too many physicians in classes of too large size, following a curriculum that was no longer sufficiently related to the health needs of the people.

It is within this context of national recognition of problems in both service delivery and medical education that the SCU/FM must be viewed. It is noteworthy that class size reduction of 15% at many existing faculties has taken place, and another similar reduction may again occur. Were it not, in fact, for this favorable climate for innovation in medical education and the fullest co-operation with the MOH, the new faculty could not hope to achieve its goals of relevant, community-based education of physicians, emphasizing primary care in the Egyptian context and the health team approach utilizing MOH facilities and programs for clinical training.

The evolution of the new SCU/FM is a significant step toward changing the approach to medical education in the Arab Republic of Egypt.

During the October conference on "Basic Health Needs and Education." (Attachment 8) jointly sponsored by the Ministry of Health (MOH), Cairo University and BU with attendance and participation by representatives of the SCU/FM, Dr. Almotz Billah Mobarek and Dr. Rhamses Goma of the MOH emphasized the importance of primary care, and Dr. Hamdi El-Sayed, President of the Egyptian Medical Syndicate suggested that the greatest opportunity for significant change in medical education in the Arab Republic of Egypt rests with the development of the new SCU/FM.

There is an additional urgent reason to address physician education. Why? In Egypt, as in many other countries of the world, physician behavior in aggregate is the power structure that controls the shape, cost and effectiveness of health care delivery. Unless the critical core problem of relevant training, employment and continuing education of physicians is addressed within the context of limited national resources and primary community needs, improvements in basic community health services will continue to be elusive. The SCU/FM recognized this as a fundamental raison d'etre and also recognizes the need not only for physician education, but for physician education within the context of related allied health manpower, as illustrated by President Osman's interest in establishing a Faculty of Nursing that closely relates to the Faculty of Medicine.

SCU is, as a general principal, seeking to relate its educational programs, not only to the Arab Republic of Egypt's needs, but specifically to the needs of the Suez area. The University is preferentially enrolling qualified students from the Suez area as well as utilizing community facilities and programs in the area as integral parts of its overall educational approach.

The Faculty of Medicine will impact favorably on the role of women in at least 4 ways:

1) Further recruitment and hiring of women Junior and Senior faculty -- now approximately 15%.

2) Admission of female medical students -- it is estimated that the first entering class will contain about 40% women with later classes having a similar percentage.

3) The integration of medical education and health services, and the very great emphasis on primary care, including maternal and child health, family planning, and a nutrition emphasis will directly address the health needs of women of reproductive age.

4) Primary care services that are widely and effectively available will benefit women of all ages.

It is a strong preference of the Dean, supported by President Abdel-Meguid Osman, to educate physicians in a manner that has the following characteristics:

1) Relates skills and knowledge acquired to current and probable future health care needs of the Suez Canal Zone population as a microcosm of the Arab Republic of Egypt's overall population.
2) Recognizes the limited resources, both public and private, available to pay for health care for the indefinite future.
3) Recognizes the central role of physicians in determining the content of care and, de facto, the cost of specific services and the extent to which basic care can be extended to the entire population.
4) Utilizes urban and rural MOH programs, facilities and staff, both clinical and public health, rural and urban, as key elements for the clinical training of medical students.
5) Recognizes primary care as the most basic and needed personal health service of the rural and urban population.
6) Recognizes primary health care to be most effective, accepted and affordable if provided by a multidisciplinary team.
7) Trains physicians to work with and take a professional and administrative leadership role in the team approach to the delivery of primary care services.

The goals of the SCU/FM are both visionary and sound. Of most importance they seek to relate educational investment directly to the health needs of the population. Existing Egyptian medical school curricula will not meet the needs of SCU. Development of a new curriculum deriving from current and projected basic health needs of the population that focuses on physician education and providing primary health care by teams of physicians and allied health professionals at a cost compatible with current and projected national resources requires an extraordinary staff with wide-ranging professional skills of the first quality. Some must be trained in the classical and very necessary basic pre-clinical and clinical disciplines. All must carry within them a full understanding of and belief in the goals of the faculty and have teaching skills that enable them to transmit their specific knowledge base to students in a manner that builds and reinforces the community emphasis of the medical school's overall approach. Some staff will need to be trained specifically in disciplines not emphasized in Egyptian medical education, such as health planning, health administration, family planning, public health, and family practice.

In June 1978, Dr. Esmat Ezzat, who is responsible for faculty development at SCU, visited BU. He and the new Dean of SCU/FM Dr. Zohair Nooman, are responsible for planning the innovative Faculty of Medicine and medical curriculum at SCU. Dr. Ezzat met with the deans of the BU health schools, Dr. Richard Egdahl,

academic Vice President for Health Affairs, and other key members of BU's administration. BU's strong emphasis on primary care and ongoing development of innovative primary care curricula prompted Dr. Ezzat to express her interest in the development of a joint working relationship between BU/HPI and the SCU/FM.

Dr. Jeannette Haase, Associate Academic Vice President for Health Affairs, Dr. Mohamed Gheith, Dr. William Bicknell, and Mr. Pierre Legere visited Egypt in September, 1978 and met with President Osman, Dr. Nooman, Dr. Ezzat, and other faculty members of SCU. An overall agreement between SCU and BU was drawn up, and a special agreement between the SCU/FM and BU/HPI was discussed. Both agreements were signed in final form in October, 1978 (Attachments 1 and 2).

A recent development - the establishment of the Permanent Committee for Health Services and Medical Education in the Suez area highlights the collaborative nature of the MOH relationship to the new Faculty of Medicine and the Joint Committee in their efforts to utilize fully the facilities, programs and personnel of the Ministry in the medical education process. The Permanent Committee - the Suez Area Working Group - established in December 1978 by President Osman with MOH representatives nominated by Minister Gabr, is chaired by Dean Nooman. The membership includes:

Senior Representatives of the MOH centrally,
The Directors of Health for the Governorats of Suez, Ismailia, Port Said, Sinai-North and Sinai-South, The Director of Medical Services - Suez Canal Authority, selected Senior Faculty from SCU (to be appointed by Dean Nooman).

This Committee has the responsibility of assuring that there is the fullest possible integration of education and health service programs in the Suez area and will have an oversight and coordination responsibility for this project. The Committee, and particularly the MOH participation and membership, indicates the direct concern and great priority the MOH gives to the SCU Faculty of Medicine development. The Committee will receive plans and progress reports covering all aspects of this project, and will have the responsibility for assuring the fullest integration of education and service programs that is critical for the ultimate success of the SCU/FM.

In February 1979, Doctor Abdel-Meguid Osman (President of Suez Canal University), Dr. Ahmed Sirry (First Undersecretary of the Ministry of Health), Dr. Zohair Nooman (Dean of the Faculty of Medicine, Suez Canal University) and Dr. Esmat Ezzat (Professor, SCU/FM) visited Boston University and worked closely with faculty and staff of the Health Policy Institute, planning program development activities and completing a request for Public Law 480 funding from the Health Resources Administration of the Department of Health, Education and Welfare.

In April, two related activities took place -- a survey of programs and facilities and a curriculum development workshop. The preliminary survey of programs and facilities in the Suez area was done by Dr. Nabil El-Ennah, Director designate of the Dean's Planning Unit, working with Dr. William Bicknell and Ms. Susan Christy Shaw and two junior faculty, Dr. Fathi Mahmoud el Gamal and Dr. Ismaile Sherine Hamed. This resulted in a preliminary

selection of clinical training sites* and a comprehensive report by Ms. Shaw entitled, "An Initial Report: Facilities Planning for the Community-Based Faculty of Medicine, Suez Canal University." Ms. Shaw's report analyzed many of the challenges facing the University and the MOH in the area of facility design and renovation in relationship to overall development of the Medical School and MOH program.

The initial impressions for the preliminary survey fed immediately into the Curriculum Development Workshop, under the direction of Dr. Ascher Segall of BU/HPI's Center for Educational Development in Health. This workshop was a major milestone in the development of the school. For the first time all the faculty, junior and senior, gathered and worked together in Ismailia and after a week's work decided on a curriculum approach and established working committees of the faculty. This workshop was followed by a several day meeting in Port Said of the coordinators of each committee. Detailed work plans were drawn up, and procedures for moving the curriculum development process forward were agreed to. The following committees, or working groups were established:

1) Health need and health services - this committee is essentially the functional link between the Dean's Planning Unit and the curriculum development process
2) Optimum physician performance - mastery description

*See Scope of Work - Component #2 for list.

3) First year and second year program of study
4) Six year curriculum projections
5) Library and learning facilities
6) Physical facilities
7) Staff recruitment
8) Student selection
9) Continuing education
10) Fund raising

The first committee whose coordinator is Dr. Nabil El-Ennah (Director Designate of the Dean's Planning Unit), will have as a major responsibility introducing planning, management, community resources and needed data into the curriculum development process.

An early priority of the curriculum development process is the establishment of the Medical Education Unit, responsible for overall coordination of the curriculum development process. Its Director Designate is Dr. Hassam Hamdy.

The initial collaboration between the two universities has been in three major areas:

1) Integrating Educational and Health Service (Planning and Management) -- the development of a Dean's Planning Unit for educational and health needs and resources, provide data for design of an innovative medical school curriculum for Suez Canal University, suggest approaches to facility and program improvement, assist in the development of management mechanisms and contribute to ongoing overall program monitoring and evaluation.

2) Curriculum Development -- Initiation of activities and provision of technical assistance leading to the choice of curriculum approach, and the design of a new curriculum for the Faculty of Medicine.

3) Post-Graduate Education -- A program to place junior staff members from the Suez Canal Faculty of Medicine in graduate training programs at BU in the basic sciences (funded by the Arab Republic of Egypt).

If the Faculty of Medicine is to achieve its goals, numerous problems must be overcome. However, three elements are most basic and must be satisfactorily addressed during the next few years, especially:

1) Effecting the MOH-FOM link

2) Cementing the committment to primary care through:

   a) Knowledge, skills and attitudes of faculty and selected staff.

   b) Curriculum development.

3) Compensating faculty so that a substantial number are truly full-time, or very nearly full-time.

Items 1 and 2 above are well under way and further addressed by Components 1, 2, 5 and 6 of the Scope of Work following.

Item 3 is mentioned here and again in the Scope of Work, (Component 3) as it is so important. This issue will require considerable thought and very carefully planned action if a permanent core of full-time

faculty, (perhaps 75-80% or more of their income derived from and time devoted to the Faculty of Medicine) is to be achieved. Now throughout Egypt, university salary scales are so low that it is expected that physician faculty members will have a substantial private practice. As physician income expectations may be 2 to 5 times their university salary, only a small amount of time remains for university business. A further complicating element is that practices tend to be specialty practices, and if most faculty practice in a specialty and spend most of their time thinking and working as specialists, this could undercut the teaching and service thrust of the SCU/FOM.

Perhaps equally complex is the compensation of physicians in the MOH. They too are, at least de facto, expected to have a private practice, and at present it is not possible to have a University appointment if one is on the staff of the Ministry of Health. This last point is particularly important to the medical school to address as it seeks to develop ongoing ties with physicians employed by and working in MOH facilities.

The appropriate place for private practice and its relationship to MOH staff and members of the Faculty of Medicine must be carefully and fully addressed.As a temporizing measure for some short-term compensation intended to deter new junior and senior faculty from beginning private practice may be possible through payment made from P.L.480 funds. However, these funds are limited and cannot handle the problem for everyone, even over the next few years. Any long-term solution may have national implications, as the compensation pattern and attendant problems are not unique to the Suez area. SCU and

BU/HPI realize that the area of physician compensation and private practice must be a subject of deep concern and will require substantial time and attention of Dr. Nooman and Dr. Bicknell, working with other University and Ministry staff, as well as selected consultants as outlined in the scope of work in the section entitled, "Primary Care Group Practice Plan".

IV The Scope of Work

Summary:

As described in detail in the management section, all work proposed for support within this contract will take place under the joint direction of Dr. Zohair Nooman, Project Director for Suez Canal University and Dean of the Faculty of Medicine, and Dr. William Bicknell, Project Director for Boston University and Coordinator of International Health Programs for Boston University.

Two major functional areas form the focus of action supported under this contract:

1) Integrating education and health services
2) Curriculum development

In support of the two broad fuctional areas mentioned above, it is critical that the Dean's Planning Unit and the Medical Educational Unit rapidly become operations, and by the end of 18 months, are functioning effectively. These units are described later in the scope of work, and will be the loci of support within the medical school for the 7 major activities proposed to take place during the first 18 months of this contract:

1) Curriculum development
2) Identification and improvement of clinical training sites
3) Primary care group practice development
4) Design, renovation and partial equipping of Building 29, (a non-clinical, Ismailia Campus Building, designated to have teaching, administrative, library, and laboratory space for the Faculty of Medicine)

5) Staff development/continuing education

6) Strengthening management systems

7) Planning for Phase II

The Dean's Planning Unit will be the primary focus of activities 2, 3, and 6. The Medical Education Unit will be the primary focus for activity #1. Activities 4, 5, and 7 will be shared responsibilities of the Dean's Planning Unit and the Medical Education Unit.

The specific activities mentioned above have, in July of 1979, been discussed fully with Dean Nooman and reflect priority activities that must be addressed if the medical school is to open in October of 1980 and be substantially prepared to accept its second class of students by the time the first phase of this contract is completed. An additional activity ,not mentioned above is being approached by the medical school, but does not involve Boston University. This is the provision of staff housing so that the faculty now recruited can begin to physically relocate to Ismailia and work together. This is in no sense a minor issue, and is being vigorously addressed by Dean Nooman, President Osman, The Governor of Ismailia, and other senior persons in Egypt; however, this issue is not further discussed as it is outside the scope of work proposed for this contract. It should be noted that, though difficult, Dean Nooman feels that sufficient housing will be available soon enough to allow the faculty to begin to relocate to Ismailia well before the October 1980 opening date.

Virtually all activities in Phase I of this contract, with the exception of the planning for Phase II, are specifically directed toward facilitating the timely opening of the medical school in

October of 1980 and providing additional resources to assist in assuring that the initial activities of the medical school, in terms of curriculum development, undergraduate medical education, continuing education and faculty practice are begun in a manner that:

1) Relates the educational process to the population's health needs and the resources available for health care.
2) Strives for full integration of Ministry of Health service programs with the educational programs of the Faculty of Medicine.
3) Emphasizes the education of physician to provide and manage the delivery of primary care services by a health team in a way that is relevant to the projected health needs of the Suez area population.

As the Dean's Planning Unit and the Medical Education Unit are viewed as of great importance to the successful and timely implementation of the Faculty of Medicine, each in described in the scope of work. The Dean's Planning Unit and its functions are outlined in the section immediately following. The Medical Education Unit-- the focal point for curriculum development -- is described in the curriculum development section of the scope of work.

IV-B The Dean's Planning Unit

A central structural element of the New Faculty of Medicine is the Dean's Planning Unit for Educational and Health Services.

In order to assess the quality and adequacy of Suez area health programs and personnel, it is necessary to gather and analyze service, cost and manpower data (some is already available) as it relates to community needs and services, developing new data only when necessary. In order to gather, analyze and interpret data and relate them to curriculum development, facility planning, continuing education, service improvement and evaluation, the Dean requires input and staff support from an educational and service planning and management unit that builds on Ministry of Health planning resources, but focuses on Faculty of Medicine and Suez area needs. Full knowledge of the teaching environment and community, coupled with a capacity to project trends in needs for services, costs of services and costs of education, are fundamental prerequisites for the fulfillment of the faculty's basic goals and assessment of progress toward these goals. Of equal importance is assisting in the development and implementation of effective management methods. Thus, planning, management, and evaluation are the basic functions of the Dean's Planning Unit.

The Dean's Planning Unit is the principle vehicle for facilitating the effective linkage of Ministry of Health programs with the Faculty of Medicine's educational process. In close cooperation with the Ministry of Health, the Dean's Planning Unit

for Educational and Health Services must become fully operational over the next two years. This will require that development of specific methods and techniques of data collection and analysis, development of management systems and the capacity to carry out, in substantial part, the functions described below.

In order for the Faculty of Medicine to relate to the needs of the people through and with existing health services and not create special programs and special problems, it is necessary to know precisely:

Who, does what, where, why and at what total cost?

This information is needed for:

1) Preventive services (personal and community).
2) Curative services (ambulatory and inpatient).
3) Public services.
4) Private services
   a) traditional, (e.g., dayahs).
   b) Informal modern (e.g., injectionists and barber surgeons.
   c) formal modern (e.g., physicians and midwives).
5) Mixed or para-statal services such as the insurance hospital and clinics, and the Canal Authority Medical Program.

After the foregoing is known, or as it is becoming better understood, the faculty, the Ministry and other relevant parties can consider who should be doing what, where, why and at what cost. This requires looking into the future and considering the proper role and relationship of health services to overall socio-economic development, trends

in rural and urban population growth, further urbanization of the major cities and probable development patterns in the Sinai.

Knowing where we are and where we would like to go allows consideration of alternative routes or strategies of implementation as well as refinement or even some changes in where we want to go as the problems inherent in implementation of any specific plan become more apparent.

Questions such as how should the school relate to which specific programs in each of the five governorats require practical information on utilization cost and need, as well as community perceptions and desires which can be fed into the decision-making process of the educational and service delivery systems.

The specific recent activities of Dr. Bicknell and Ms. Christy Shaw and Dr. Nabil El-Ennah, (Director Designate of the Dean's Planning Unit) and Dr. Zohair Nooman, are illustrative. A preliminary assessment of health program activities and need in Suez, Ismailia and Port Said was undertaken with a view toward:

1) Provisionally selecting initial sites for clinical training
2) Preliminary identification of areas where continuing education needs may exist for Faculty and Ministry of Health personnel, (physician, nursing, laboratory and environmental health) who will be involved in clinical experiences for medical students
3) Assessing and developing an approach to facility requirements for both renovation and new construction of Ministry of Health primary care sites as well as non-clinical space for the Faculty of Medicine of Ismailia.

As already mentioned, these activities and the overall preliminary assessment feed directly, immediately, and necessarily into the curriculum development activities led by Dr. Ascher Segall, Dr. Zohair Nooman, and Dr. Esmat Ezzat.

Of great importance, the Dean's Planning Unit will contribute to the development of a management system that can actively facilitate the start up and operation of a decentralized Faculty of Medicine.

The Planning Unit is not merely concerned with data gathering, but with using data and facilitating the effective use of data for planning, program development, management and evaluation.

In the development of the Planning Unit, the Health Policy Institute will work in at least the following specific areas:

1) Provide technical assistance to the staff of the Dean's Planning Unit and selected curriculum development working groups or task forces, specifically those dealing with the following content areas:
   a) community health services and health needs as they relate to the medical school.
   b) Development of a mastery description for physician performance.
   c) Curriculum development -- task forces charged with developing an overall outline of the full six-year curriculum and the detailed planning for the first year.

d) Facility design (currently two committees which may be merged into one committee).

2) Assist in the selection of sites for clinical training, as well as assist in the planning and design of facilities, particularly rural and urban primary care facilities. The Health Policy Institute will, from time to time within the overall program development plans of the Faculty of Medicine, provide technical assistance in the area of integrating health and architectural programs with the goal of having facility design maximally enhance overall program development.

3) Provide initial technical assistance, r.e., the evaluation of emergency medical services at the front line level in the Suez area governorats with a view toward planning for cost-effective improvements and better linkages with other primary care services.

In collaboration with the Medical Education Unit:

4) Assist in developing an approach to meeting specific continuing education needs of the SCU faculty and MOH staff, (e.g., physicians, midwives, nurses, laboratory technicians, environmental health and management personnel) with priority to those associated with the Ministry of Health ambulatory care sites selected as clinical training sites for the medical schools.

5) Develop a detailed work plan, a budget, management approach and evaluation methodology for all activities

of medical school development anticipated over the five year lifetime of this project. This will include the development of a specific work plan, budget and evaluation methodology, which will clearly specify Phase II activities, products and funding requested by Suez Canal University and Boston University for continuation and completion of this project.

Specific Sub-Activities and Products

In collaboration with the staff of the Dean's Planning Unit, other faculty and Egyptian consultants, Boston University's Health Policy Institute will assist in the following sub-activities:

1) Develop final criteria for selecting sites for clinical training.
2) Designate specific final sites for clinical training.
3) Develop a detailed continuing education approach to meet the needs of staff (physician and non-physician at clinical training sites).
4) Plan for and begin to meet the continuing education needs identified in 3 above.
5) In collaboration with the Medical Education Unit and the Dean's Planning Unit, identify continuing education needs of Suez Canal University faculty, plan for and begin to meet these continuing education needs.
6) Provide architectural and health program design assistance focusing on clinical sites for primary care training and related facilities of the medical faculty.

7) Provide initial technical assistance in the development of an evaluation plan and program approach for introducing cost-effective improvements in front line emergency medical services.

8) Specify a minimum data set relevant to clinical facilities to be used as teaching sites by the Faculty of Medicine. The minimum data set shall include information on utilization, staffing, scope and content of services, and operating costs.

9) For facilities and programs in the Suez area not currently used for teaching and not used as comparison sites, a basic data set will be developed that accurately identifies location and general class of service as well as selected utilization and staffing indicators.

10) In order to contribute to the goal of assuring that teaching facilities of the Medical School remain realistic, (e.g., operationally and fiscally similar to actual and projected worksites for graduates) sites comparable to those selected for clinical teaching will, to the extent that they are available, be identified. The feasibility of utilizing the full data set (see 7 above) to determine comparability will be assessed and, if feasible, a methodology developed for gathering and analyzing data on a periodic basis.

11) Identify specific management needs of the Faculty of Medicine, paying particular attention to the FOM/MOH interface in the five governorats.

12) Assist in the design and development of a management system and specific procedures to meed the growing and complex needs of a decentralized Faculty of Medicine.

13) Library planning -- BU/HPI has located and will provide an appropriate consultant skilled in the development of medical libraries. Also, initial contacts have already been made at the National Library of Medicine. This activity will result in a recommended approach to library development, detailing equipment and space requirements, and of utmost importance, a plan for acquisition of reference and other learning materials.

14) Assist in testing feasibility and, if warranted, developing an approach to physician compensation, teaching and service such as that outlined in component 3 of the scope of work entitled, "Primary Care Group Practice Plan."

Outcomes

Guaranteeing specific outcomes by a specific time is fraught with hazard, as the variables are many and not under the control of any person or organization. However, it is the objective of Suez Canal University and the Faculty of Medicine to have, at

the end of Phase I, a staffed, functioning Dean's Planning Unit for Educational and Health Services that, though still requiring external technical assistance and further staff development, can do the following:

1) Collect, array and begin to analyze for purposes of management, planning and evaluation data on the utilization and cost of health services in the five Suez governorates.

2) Maintain and revise an overall rolling five-year medical school/MOH development plan. Rolling implies not only revision, but the annual addition of a new plan year (e.g., 80 - 81, 81 - 85, 82 - 86, etc.).

3) Identify and manage technical assistance needs and substantially coordinate technical assistance as it relates to 2 above.

Work in progress relating to service improvement would include:

1) Continuing clinical education of selected physicians and non-physicians from MOH clinical training sites and selected Faculty.

2) Facility upgrading of primary care units has progressed to the point where an overall plan for facility improvement has been developed. Specific plans for the individual named facilities in all governorates have been made, and renovation for purposes of providing a realistic clinical teaching environment is under way at no fewer than 6 rural facilities.

3) Emergency Medical Care Primary Care (EMS) reconnaissance

visit for purposes of conceptualizing and initiating the development of an evaluation plan to assess the cost effectiveness and relevance of existing EMS services, the integration into overall primary care programs and identifying priority areas for EMS primary care service improvement and methods for improving such services has been completed.

Health services are not worth much if they are not acceptable to the population intended to receive services. In the case of primary care services containing a heavy leavening of personal preventive care such as material and child health nutrition education and family planning, great attention must be paid to social and cultural factors that affect acceptability: What are the social and cultural values that may impinge upon the people's perception of needed services? What attitudinal issues and needs of providers -- physicians, nurses, attendants -- should be considered during initial and continuing education? How should this be done? What social and cultural factors may affect facility location and design decisions? In what manner should the curriculum address behavioral science issues as they relate to medical education? It is questions such as these which need to be considered early in the course of Faculty of Medicine/Ministry of Health program development. To assist in this we look forward to the involvement of key faculty from the School of Public Health (Dr. Scotch and Dr. Meyers) and the Department of Sociology (Dr. Sol Levine).

In order to facilitate the appropriate initial laboratory experience of medical students at Suez Canal University, we propose to establish a pool of microscopes whose ownership remains with the Faculty of Medicine, to be distributed as follows: 50 for use in basic science instruction at Ismailia; 15 for student and faculty use at primary care clinical sites; and 10 for teaching demonstration and faculty use at Ismailia.

A necessary cornerstone of a good Faculty of Medicine is a basic library covering at least the following major topic areas:

Basic Medical Sciences

Clinical Medicine

Public Health and Community Medicine

Medical Education

It is especially true that current textbooks carefully selected in adequate supply are needed for students. However, working texts are too expensive for students to purchase.

To meet these two needs, we propose to assist in the selection of, and provide a basic library equivalent to 5,000 bound volumes, and a reserve shelf of working texts for students in the ratio of 1 text for every 3 students. All library materials will remain under the control of SCI/FOM.

The ratio of 1 to 3 was suggested by Dr. Ascher Segall as workable. The 5,000 volume figure was concurred in by Dr. Morton - Chief Librarian at the University of Massachusetts Medical School - itself a new Faculty of Medicine.

The vast majority of senior and junior faculty have been recruited, (about 70 junior faculty and 30 senior faculty as of August 1979); however, Dean Nooman reports that, at present, he has not been successful in recruiting a Senior Physiologist to participate in both curriculum development and teaching, therefore, he has requested of BU/HPI, assistance in obtaining for at least 6 months, and possibly longer, a Physiologist willing to live and work in Ismailia. Through the medical school, we have been able to locate two potential candidates and feel that, should this need still be present in early 1980, we will be able to meet it and, therefore, budget for such a person. Should other basic science faculty be needed and required by the Dean, we will seek to recruit first from within B.U., and then elsewhere. For additional persons, we will request supplemental funding from USAID.

IV-C Phase I Components

Phase I components are as follows:

1) Curriculum development
2) Identification and Improvement of clinical training sites
3) Primary care group practice development
4) Design renovation and partial equipping of Building 29
5) Staff development/continuing education
6) Strengthening management systems
7) Planning for Phase 2

The description of the Medical Education Unit is included in Component #2. Certain activities in addition to planning for Phase II that do not logically fit in within components 1-6 are included in Phase II planning. A detailed description of each component follows.

IV-C Component #1
Curriculum Development

The portion of the work to be conducted by the Health Policy Institute's Center for Educational Development in Health (CEDH) under the proposed contract, relates to the provision of technical assistance and support services to the new Faculty of Medicine at Suez Canal University, Ismailia, Egypt, re: curriculum development. These will be provided in a collaborative effort to achieve the following objectives:

1) To establish an intitutional capability at the Faculty of Medicine, Suez Canal University, for the development, implementation and evaluation of an innovative curriculum

2) To develop a curriculum for the program of medical studies.

The methods and procedure to be utilized for this purpose are described in the present document as are the inputs of CEDH in the collaborative effort and the anticipated outcomes. The role of CEDH will involve consultation, development of draft documents, review of recommendations developed at SCU/FM, training of members of the faculty in educational methods and assistance in mobilizing instructional resources. The methods of procedure were agreed upon by CEDH and faculty of SCU/FM at a workshop held in Ismailia in May, 1979. The level of effort of CEDH will be determined by the resources made available under terms of the proposed contract.

The timetable shown represents our best estimate at this time, with first class being enrolled in the fall of 1980. The full timetable, as well as specific methods of procedure, will be modified to reflect any changes in policy of the Medical School, as well as any unanticipated constraints or problems.

DESCRIPTION OF TECHNICAL STEPS (OBJECTIVE I)

1) Establishment of a Medical Education Unit

Rationale, and Method

The principle instrument for implementing the terms of the curriculum development component of this contract will be the Medical Education Unit to be established within the Dean's Office at the Suez Canal University Faculty of Medicine. The Unit will, as its purpose, provide staff support, mobilize instructional resources, conduct faculty development activities and assume operational responsibility for the curriculum development process, implementation of the program of studies and evaluation of student learning and performance. The Unit will be staffed by a small number of full-time professionals whose efforts will be supplemented by part-time operational consultants as well as a wider range of resource consultants who provide consultation on a continuous or ad hoc basis, but do not assume operational responsibilities. When fully established, the Unit will consist of three sections: curriculum planning and development, curriculum implementation and evaluation.

CEDH Inputs

a) Consultation on recruitment of staff for the Unit.

b) Recommendations concerning organizational structure and functional relationship.

c) Orientation of staff to their tasks

d) Ongoing consultation on the activities of the Unit.

Output

A Medical Unit staffed and functioning at a level appropriate to the stage of development of the Faculty of Medicine.

2) Development of a set of procedures for the process of curriculum development.

Rationale and Method

It is anticipated that the curriculum development process at the Faculty of Medicine, Suez Canal University, will consist of several stages:

Stage 1 An initial preparatory stage will be concerned with recruiting faculty, communicating the basic philosophy of the Faculty of Medicine and reaching consensus relative to institutional educational goals. The first step in this process will be development of a specification of optimal physician performance based on

a) recommendations of the 1970 Fayoum Conference,

b) national and regional health needs, and

c) recommendations by appropriate consultant panels.

The specification of optimal physician performance will provide criteria for the delineation of institutional educational goals.

Stage 2

During the second stage a projection of the six-year curriculum of medical studies will be prepared. Vertical projections of objectives related to major subject areas over successive years over the six-year program of studies will be formulated. Each year will then be considered separately in terms of the relationships among the various subject areas. The objectives for respective subject areas for each year will provide a frame of reference for determining the format, content and methods of instruction.

Stage 3

The third stage is one of detailed curriculum planning for each year, taken one year at a time. Subject area committees on the basis of competency-based objectives formulated in Stage 2 will select appropriate teaching methods and develop evaluation plans. The proposals of the various subject area committees will then be collated into a comprehensive program of studies for each year of the curriculum. The scope of work under the proposed amendment will include detailed curriculum for the first year of medical studies only.

Stage 4 — In a fourth stage the comprehensive program of studies for each year as prepared by staff of the Medical Education Unit will be reviewed and revised by coordinators for the respective years. The councils may require that instructional objectives be modified, redelineate subject area boundaries and allocate instructional resources.

Stage 5 — A fifth stage occurs after the completion of each course and addresses the need for curriculum modification in the light of feedback from evaluation.

CEDH Input

a) Recommendations concerning the procedures to be followed during the process of curriculum development.

b) Consultation on the practical aspects of implementing the procedures.

c) Assessment of the need for modifying the set of procedures in the light of changing resources and constraints.

Outcome — A set of procedures for the process of curriculum development.

3) Development of an organizational structure to implement the procedures for curriculum development.

Rationale and Method — The activities of the Medical Education Unit in implementing the procedures for curriculum will be supplemented by those of extra-mural consultant panels and intra-mural committees.

Stage 1 a) Faculty committees on:

a) Specification of optimal physician performance.

b) Institutional educational goals.

b) Extra-mural consultant panels, including:

a) MOH officials

b) Practicing physicians

c) Medical educators

d) Consumers of health care services

Stage 2 a) Disciplinary reference groups - for major curricular components to assume responsibility for vertical planning within disciplines over the six-year program of studies.

b) Interdisciplinary subject area committees to assume responsibility for subject area courses within successive years.

Stage 3 Same as Stage 2

Stage 4 Coordinating committees for each year

Stage 5 a) Disciplinary reference groups

b) Interdisciplinary subject area committees

c) Coordinating councils

The relationships, including those relating to matters of government, among the organizational units cited above, the Medical Education Unit, the faculty-wide curriculum committee and other components of the Faculty of Medicine will be elaborated.

CEDH Input

a) Development of a first approximation of an organizational structure to implement the procedures for curriculum development.

b) Ongoing consultation concerning modification of the organizational structure necessitated by changing resources and constraints.

Outcome

A flexible organizational structure to implement the procedures for curriculum development which is responsive to changing resources and constraints.

4) Preparation of faculty members to assume educational responsibilities.

ıtionale and Method

The development of faculty teaching competencies is essential to the creation at the Faculty of Medicine, Suez Canal University of an infra-structure capable of developing an innovative curriculum of medical studies. This will involve the following steps:

a) Identification of teaching responsibilities of faculty members of the Faculty of Medicine.

b) Determination of the most effective means, given the resources and constraints at the Faculty of Medicine, Suez Canal University, by which members of the faculty could acquire the competencies needed to fulfill the responsibilities identified.

c) Provision of opportunities for faculty to acquire these competencies.

d) Evaluation of outcomes of the faculty development program.

It is anticipated that methods for preparing faculty members to assume educational responsibilities may include:

a) Teacher training workshops. These may be given at the Faculty of Medicine, Suez Canal University. In this case, they will be designed to meet the specific needs of the Suez faculty. In addition, Suez faculty members may participate in appropriate workshops which are offered in other parts of Egypt or in other countries.

b) Inservice training. Due to external constraints, certain teachers may be unable to participate in formal workshops. To overcome this difficulty, inservice training will be provided for individual teachers and members of reference groups and subject area committees.

c) Visits to selected medical schools. Members of the Suez Faculty of Medicine will visit selected medical schools in Egypt and abroad. Emphasis will be on those schools which have developed and are implementing innovative curricula similar to the program of studies being developed at Ismailia.

d) Training at the Center for Educational Development in Health at Boston. Subject to the availability of funds, specialized training will be provided at CEDH for selected members of the Suez Canal University Faculty of Medicine. This will consist

of intensive training over a short period not to exceed several months.

CEDH Inputs

a) Ongoing consultation on faculty development programs

b) Participation in at least 2 teacher training workshops per year at the Suez Canal University Faculty of Medicine

c) Training of from 2-4 faculty members at the Center for Educational Development in Health, Health Policy Institute, Boston University;

d) Training in educational methods of faculty members from Suez Canal University who are pursuing post-graduate studies at Boston University in basic medical sciences.

Output

Faculty members at Suez Canal University who have acquired specific competencies in educational methodology.

5. Mobilization of instructional resources for implementation of the educational program.

Rationale and Method

In view of the limited resources available, it is critical that instructional resources available from a) other components of Suez Canal University, b) other universities in Egypt, c) medical schools in other countries and d) international and national organizations be mobilized. These resources may include: a) materials for use in the curriculum development process, (e.g., examples of specifications of physician performance, institutional

goals, subject area objectives, curriculum projections), b) actual instructional and, c) teachers willing and able to either provide consultation or participate directly in the teaching program. Such mobilization of instructional resources is important to avoid "reinventing the wheel" at Suez and to conserve limited resources for essential activities.

CEDH Inputs

a) Assistance in identifying instructional resources available outside of Egypt.

b) Assistance in mobilizing appropriate instructional resources for use at the Faculty of Medicine, Suez Canal University.

c) Assistance in orienting outside medical educators to their tasks at the Faculty of Medicine, Suez Canal University.

Outputs

Resources for implementing the educational program derived from sources outside of the Faculty of Medicine, Suez Canal University.

DESCRIPTION OF TECHNICAL STEPS (OBJECTIVE 2)

6) Specification of optimal physician performance

Rationale and Method

A specification of optimal physician performance (OPP) will be developed which reflects the type of physician which will be needed in Egypt over the next several decades. It will serve as the basis for formulating institutional educational goals for the Faculty of Medicine, Suez Canal University and for the subsequent development of instructional objectives for the various components of the curriculum. Methods for arriving at a specification of optimal physician performance will include:

a) Development of a <u>first approximation</u> of optimal physician performance based on: a) national health needs in the Suez region (if applicable) to be ascertained from published and unpublished eqidemiologic data,and a limited scale survey if required; b) consultation with a sample of practicing physicians (empnasis on primary care-related specialities -- e.g., general practitioners, internists, pediatricians), and d) recommendations of the Fayoum Conference.

b) Revision of the first approximation on the basis of a review of specifications of optimal physician performance developed elsewhere. This will lead to the preparation of a <u>second approximation</u>.

c) Review of the second approximation by consultant panels which may include:

1) panel of practicing physicians (in collaboration with the Egyptian Medical Syndicate)

2) panel of Ministry of Health officials

(national level directors of health manpower development, regional level MOH directors of the governorats involved)

3) panel of representatives of consumers of health care services.

4) panel of experts in medical education (primarily from Egyptian medical schools)

This process will result in a third approximation of the specification of optimal physician performance.

d) The third approximation will be submitted for consideration by the Faculty Council at the Faculty of Medicine, Suez Canal University. Following additional modifications based on recommendations of the Council, a fourth approximation will be prepared. This will constitute Operational Version I of the specification of optimal physician performance. This version will be used in all subsequent curriculum development activities.

CEDH Inputs

a) Assistance in developing the first approximation

b) Assistance in securing documentation required for development of the second approximation

c) Review of successive approximations

d) Consultation in formulating Operational Version I

Output

An operational version of the specification of optimal physician performance.

7) Verification of the specification of optimal physician performance.

Rationale and Method

Verification of the specification of optimal physician performance consists of determining the extent to which optimal performance standards are currently met by a representative sample of practicing physicians. Through survey methods, data concerning actual physician performance is obtained. This is then compared with optimal performance specification and performance discrepencies are identified. The performance discrepencies are analyzed in terms of: a) factors related to deficiencies in physician competencies, b) factors related to lack of physician motivation, and c) factors related to constraints within the clinical practice setting.

Identification of deficiencies in physician competencies are of particular significance in that they provide guidelines in all subsequent phases of the curriculum development process. New subject areas for inclusion in the curriculum are identified in this way and priorities in teaching can more closely reflect conditions in the world of professional practice. Factors related to lack of physician motivation can only be addressed partially at the level of undergraduate medical education. Of more importance is modification of the system of incentives for the practicing physician. Similarly, constraints within the clinical practice setting require changes in the organization of health services. Such problems are unlikely to be solved effectively by changes in undergraduate medical education.

CEDH Inputs

a) Assistance in planning a verification study.

b) Assistance in interpreting the results of the study.

Output

Analysis of performance discrepencies in physician practice.

8) Development of institutional educational goals

Rationale and Method

A set of institutional educational goals for the Faculty of Medicine, Suez Canal University, will be formulated. Those will derive in part from the specification of optimal physician performance and in part from the basic philosophy which underlies the establishment of the new medical school. These general goals will form the framework for consideration of the more specific instructional objectives relating to individual subject areas.

It is anticipated that methods for arriving at a set of institutional educational goals will include:

a) Development of a first approximation of the goals based on I) the specification of optimal physician performance, II) basic philosophical considerations relating to the establishment of the new medical school, and III) recommendations of the Fayoum Conference.

b) Revision of the first approximation on the basis of a review of institutional educational objectives formulated at other medical schools. This will lead to the preparation of a second approximation.

c) Review of the second approximation by consultant panels which may include:

1) panel of practicing physicians
2) panel of medical students (selected from among the students at existing Egyptian medical schools)
3) panel of Ministry of Health officials
4) panel of experts in medical education

This process will result in a third approximation of institutional educational goals.

d) The third approximation will be submitted for consideration by the Faculty Council at the Faculty of Medicine, Suez Canal University. Following additional modifications based on recommendations of the Council, a fourth approximation will be prepared. This will constitute Operational Version I.

CEDH Input

a) Assistance in formulating the first approximation.
b) Review of successive approximations.
c) Consultation in formulating Operational Version I.

Output An operational version of institutional educational objectives for the Faculty of Medicine, Suez Canal University.

9) Development of a curriculum projection for the six-year program of medical studies.

Rationale and Methods

A curriculum projection for the six-year program of medical studies will be developed. It will consist of objectives related to the major disciplines over successive years considered vertically, and objectives of subject areas within each year considered horizontally. The framework of objectives established in this manner will serve as the basis for subsequent development of curriculum for each of the years. The process of developing a six-year projection will include the following steps:

a) Review of current curricula at selected Egyptian medical schools. Criteria to be used in this review will include the institutional educational goals of the Faculty of Medicine, Suez Canal University and the specification of optimal physician performance. Curricula will be reviewed as to both content and teaching methods. Deficiencies in existing criteria will be identified.

b) Curricula options for correcting the deficiencies identified will be formulated. These will include modifications in sequencing, degree of integration, curriculum content and teaching methods.

c) These curricular options will be compared with innovative curricular patterns adopted at other medical schools. The initial set of options will

be modified as appropriate. This step will involve review of curricular materials published by selected innovative medical schools and visits by faculty members to several schools. A format for displaying the curricular options for a six-year program will be developed.

d) The various curricular options will be presented for consideration by the Faculty Council. The Council will select that option which, in its opinion, is most likely to achieve the institutional educational goals.

e) Disciplinary reference groups will be established. These groups will assume responsibility for vertical planning within major disciplines or clinical fields, (e.g., biochemistry, infectious diseases, pediatrics, etc.) over the six year program of studies. Their initial task will consist of developing instructional objectives for the entire six years and for each year separately. In so doing, they will be guided by the curricular framework adopted by the Faculty Council.

f) Once objectives for major disciplines and clinical fields have been set, interdisciplinary subject and area committees will be established to plan the curriculum in detail for each year of the program of medical studies. The coordinators

of the various subject area committees will for Coordinating Committees for the respective years.

CEDH Inputs

a) Consultation concerning deficiencies in current Egyptian medical school curricula and options for correcting them.

b) Support services in services in securing curricular materials from innovative medical schools.

c) Assistance in developing instructional objectives for the six year program which are integrated both vertically and horizontally.

d) Consultation on the logistics of the curriculum development process.

Output

A curriculum projection for the six year program of medical studies.

10) Development of detailed curriculum for successive years of the program of medical studies.

Rationale and Methods

A detailed curriculum for each year will be developed by the subject area committees concerned and will be reviewed by the respective Coordinating Committees. The Coordinating Committee may require that instructional objectives be modified, redelineate subject area boundaries and allocate instructional resources including curriculum time. At this point, each subject area committee will be in a position to develop a course syllabus which specifies course content and the teaching methods to be used.

The process for developing curriculum for successive

years will begin with the first year. It is anticipated that during the life of the proposed contract the process will be completed for the first 1½ years of medical studies.

CEDH Input

a) Consultation to the subject area committees in determining course content and selecting teaching methods appropriate to the instructional objectives.

Consultation to Coordination Committees on criteria for making decisions concerning the various subject areas.

Output

A detailed curriculum for the first 1½ years of medical studies.

Summary of Scope of Work and Projected Timetable for CEDH Component of BU/HPI Collaboration with the Faculty of Medicine, Suez Canal University (assuming starting date of 10/1/1979)

Technical Step #	Recipient of Consultation and Support Services (in addition to the Medical Education Unit	Month of Onset[1]	Month of Termination[1]	Anticipated Outcome
1.	Dean	01	ongoing	Functioning Medical Education Unit
2.	Dean, Curriculum Committee	01	06	Set of procedures for the process of curriculum development
3.	Dean, Curriculum Committee	01	06	Organizational structure for curriculum development
4.	Members of the Faculty	01	ongoing	Increase in competency of faculty members to assume educational responsibilities
5.	Dean, Faculty Committees	01	ongoing	Resources for implementing the curriculum
6.	Committee on Optimal Physician Performance	01	ongoing	Specification of Optimal Physician Performance
7.	Committee on Optimal Physician Performance	04	08	Verification of Optimal Physician Performance
8.	Curriculum Committee	03	06	Set of institutional educational goals
9.	Curriculum Committee Disciplinary Reference Groups	03	08	A six year curriculum projection
10.	Subject Area Committees	06	12	Detailed curriculum for first year
		12	18	Detailed curriculum for first h of second year

[1]Subject to modification with changing constraints

IV-C Component #2

IDENTIFICATION AND PREPARATION OF CLINICAL TRAINING SITES

Dr. Nooman, in consultation with Dr. Segall and Dr. Bicknell, has determined that by the fall of 1980, a minimum of six rural health units must be finally identified and suitably prepared to accept first year students for their initial clinical experiences. Further, there is agreement that the probable clinical training sites that will be used in the first several years of the medical school include the following:

I Port Said Governorat

A) Medical center for primary care now under construction in the western portion of Port Said City

B) The Port Said Fever Hospital

C) The Port Fouad Hospital and ambulatory care clinics scheduled to open in the next six months

D) A new urban medical center for primary care to be located in Port Fouad

II Ismailia Gouvenorat

A) The Abu Sultan Rural Hospital and Clinic

B) Three rural health units, reasonably proximate to the Abu Sultan Rural Hospital and Clinic

C) Ismailia General Hospital

a) Ambulatory care services, including primary care group practice (see component 3)

b) Inpatient services

III Suez Gouvenorat

1) Three rural health clinics, particularly the units at Genefa, El Ganian, and Gabelayet

2) The Chest Disease Hospital, Suez City

IV Sinai North and Sinai South

An initial inventory of health services and health needs in both Sinai gouvenorats is soon to be initiated by the dean's planning unit during the course of Phase I. A major effort will be made to identify appropriate training sites in both Sinai gouvenorats. This will probably be preceeded by an assessment of existing resources in full collaboration with the Ministry of Health, then development of a plan to strenghthen service delivery, particularly primary care service delivery in the Sinai.

Early in Phase I, a final decision must be made with regard to the training sites above and alternative sites selected if necessary. In the case of each site, the minimum renovations necessary to accommodate students must be determined, and those renovatior completed that are critical to make the facilities satisfactory for study for first and second year students. With regard to rural health units, this means there must be additional space constructed to allow students, as a minimum, a private area to interview and examinine patients. This gives the student an unhurried opportunity, with and without supervision, to develop initial clinical skills and does not interfere significantly with overall clinic operation.

A primary thrust of design and renovation activities in Phase I will be directed towards six rural health units. It is probable that they will be approached in a manner similar to that outlined in Susan Christie Shaw's June 1979 report which gave

examples of the following:

1) An existing clinic

2) A clinic modified to allow for teaching

3) A clinic modified to allow for improved efficiency of operation without traveling

4) A clinic modified for both teaching and improved efficiency

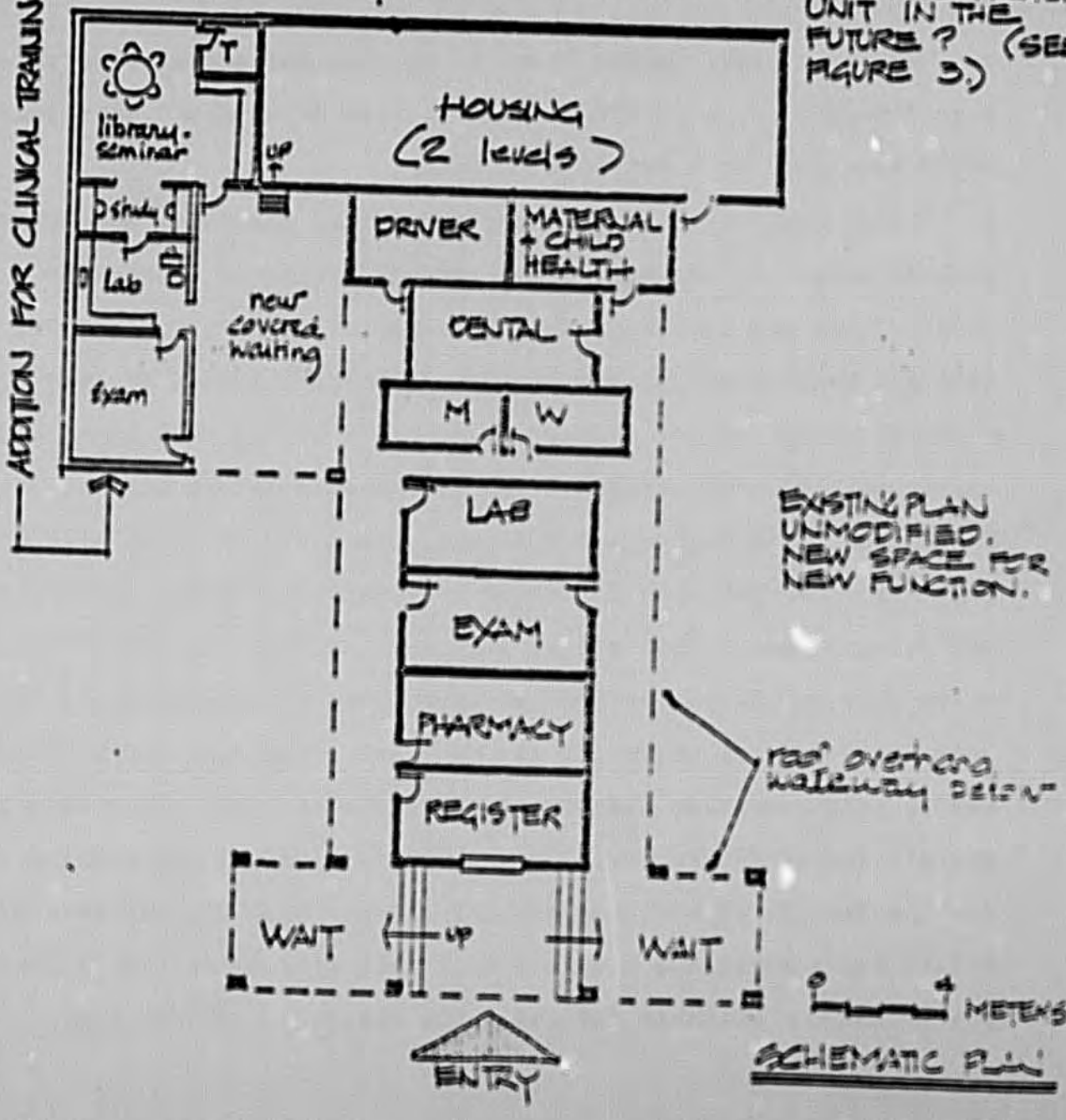
We would seek, during Phase I, to plan for and make renovations that directly spoke to number 2 above (see drawing) and hopefully, would also address improved efficiency.

Additional facility planning activities that will take place include observing and making suggestions for minor changes in organization and layout of the urban medical center for primary care now under construction in Port Said. What is learned from that experience will be one of the major inputs to the architects and others responsible for the design of the second such center for the Port Fouad area. The Port Fouad area includes a new hospital with ambulatory care space and a soon to be constructed urban medical center for primary care. This offers a unique, self contained service area where service innovation and new approaches to undergraduate and continuing medical education can be tried in an environment that has no past operating history in the sense that all the facilities and all the staff are new. This truly is a unique opportunity for the faculty of medicine working closely with the Ministry of Health representatives from the Port Said area to develop a demonstration area eminently suitable for realistic training, service and

FIGURE 2

RURAL HEALTH UNIT: MODIFICATIONS FOR 1980?

BY ADDING SPACE FOR CLINICAL TRAINING, THE CURRENT DAY-TO-DAY OPERATING CHARACTERISTICS NEED NOT BE ALTERED. ASSUMING THE PHYSICIAN BEING TRAINED IS LEARNING TO PROVIDE BASIC, INTEGRATED PREVENTIVE, PROMOTIVE, AND CURATIVE SERVICES TO ADULTS AND CHILDREN, WHAT MODIFICATIONS MIGHT BE MADE TO A RURAL HEALTH UNIT IN THE FUTURE? (SEE FIGURE 3.)



SCHEMATIC PLAN

research, vis-a-vis, urban health.

In addition to the rural health units in Ismailia and Suez gouvenorats, the rural hospital at Abu Sultan must be assessed as to its ambulatory care layout and what modification, if any, needs to be made to make it suitable for students. Implicit in the foregoing is a close working relationship between facility planners, service and administrative personnel of the Ministry of Health, and faculty involved in clinical education. In a very real sense one of the first and most major areas of interface and cooperation between the Ministry and the faculty of medicine will be in the selection, improvement and use of clinical facilities. Developing the criteria for the selection and modification of Ministry of Health facilities that will be used as sites for clinical training coupled with implementing the specific approaches for improving these facilities in a physical sense and providing any needed continuing education to staff associated with those facilities either Ministry of Health or faculty of medicine, as well as developing a program for conjoint use linking service and teaching will truly bring the Ministry and University together at the operational level.

Although inpatient teaching is, of course, a necessary component of medical education, it has been anticipated that little inpatient work that requires student space or modification of inpatient facilities will take place during or shortly after Phase I. This contract, thus, pays little attention to the inpatient component of facilities, except as needed for Ismailia General Hospital to be an acceptable inpatient component of

the primary care group practice described further on. It is also noted that the Chest Disease Hospital in Suez is an exceptional facility, and probably very little needs to be done, at least initially, to allow students to have a very good clinical experience here.

IV-C Component # 3

Primary Care Group Practice Plan

Throughout Egypt there is a serious problem with salaries paid to physicians by the government, whether university or Ministry of Health. The salary expectations of physicians may be more than double or triple the base pay offered by government employment. The difference between expectation and salary is traditionally made up by private, solo practice. In most cases, this is sanctioned, and in some cases though technically not allowed, informally sanctioned as is the case with the afternoon practices of physicians assigned to rural health units. The consequences to a medical school of physicians earning less than half of their income from their presumed primary employer are straightforward:

1) Clinical physicians, for the bulk of the day, are unavailable to students and postgraduates. Typically, the peak hours for clinical service with senior staff present in hospitals are limited and fall between nine and eleven in the morning. The consequences, in terms of both patient care and teaching, can be very adverse.

2) Basic science faculty are traditionally physicians, yet the opportunity for private practice income is limited as these disciplines do not lend themselves to private practice. The primary effect is to discourage physicians from entering basic medical sciences; the secondary effect is the development of private tutorial sessions for medical students on a pay as you go basis. This can certainly divert faculty from teaching activities in the medical school and

dilute content at the medical school. Such tutorials are said, in some cases, to have virtually supplanted formal curriculum offerings. One and two above, when taken together, in the case of a new medical school, mean that at the most critical time for the medical school development - during the formulation of the curriculum, the development of teaching approaches and the setting of overall policy - senior faculty are substantially unavailable to carry out the intellectually demanding and time consuming task required for the initial development and early implementation of a new faculty of medicine. If the faculty is to be anything other than a replica of the past, senior staff availability on a substantially full-time basis, particularly, but in no way limited to the start up period, is critical. The same arguments apply, of course, to junior faculty as they move from their own post-graduate training experiences to the Suez area and achieve the level of faculty status where private practice is allowed (or is traditionally begun even if earlier that when it is allowed). Ultimately,all faculty must be fully integrated into any attempt at solving this very complex problem of compensation.

One possibility presents itself and has been discussed initially with some senior representatives of the Ministry of Health and the faculty of medicine. This is the development of a primary care group practice plan for the clinical staff of the faculty of medicine.

At the present time, the Egyptian government is making a concerted effort to decentralize authority for much decision-making, to the level of the gouvernorats. In the case of Ismailia,(initially

proposed for the first faculty/ministry primary care group practice plan) with the agreement of the university, the Governor, the MOH director of health, the faculty of medicine clinical staff may conduct private practice that is physically and programmatically integrated with the Ministry of Health. This could mean in the case of Ismalia and Ismailia General Hospital, that a faculty/MOH initiated primary care group practice would be developed involving not only the clinical staff of the faculty of medicine, but eventually, if not initially, senior clinical physicians working at the Ministry Hospital.

What would be the characteristics of such a plan? What are its advantages? How would revenues flow? How might it stand a chance of solving a substantial part of the compensation problems of physicians?

1) Faculty of medicine staff based in Ismailia would agree, as a condition of employment, to undertake a private practice only if it is within the framework of the group practice plan.* Free-standing, private, solo practice by the faculty would, if the incentives proves sufficient, be substantially curtailed.

2) The Ministry and faculty of medicine would agree to use of space - initially existing space renovated, and ultimately, new space for outpatient care.

3) Private inpatients would be admitted to the Ministry Hospital and provisions would be made to upgrade selected aspects of inpatient facilities, to make them attractive to private patients. For instance, certin rooms and wards could be improved

* The framework of the plan could allow varying degrees of solo practice for example, the time spent in solo practice could vary with distance from Ismailia, so long as an agreed maximum time in solo practice was not exceeded

in terms of amenities so that several classes of service,on a graduated payment scale, were made available akin to the classes of service now available in insurance hospitals.

The effects of the above would be several:

A) Integration of private and public patients on an outpatient and inpatient basis would begin to occur, and the development of a more uniform standard of care would be facilitated.

B) Senior clinical staff would be in or near the hospital inpatient and outpatient facilities for the bulk of the day. This is a necessary prerequisite to good patient care and good teaching.

C) A model practice environment emphasizing primary care in an urban setting with an appropriate, but carefully thought out specialty and inpatient backup is provided.

As primary care and general practice in an operational sense are new to Egypt and the faculty, particularly senior faculty, are all specialists many of the concepts to be taught in the medical school can be developed and tested in the crucible of the group practice plan.

What about revenues and the dispursement of revenues? As a practical matter, private practice fees in a group practice plan must be set to be competitive with or, at most, only slightly above going rates elsewhere in the private sector. The perceived quality and content of service,coupled with the rate must, in the minds of the consumers, be sufficiently attractive to divert them from existing sources of private care. In many cases this means being able to successfully compete with the physicians located, not

only in the Suez area, but also in Cairo providing a service that, on balance, is viewed as fully competitive and often more convenient.

The overall costs and revenues of the group practice plan would have to be estimated considering as appropriate, costs and income attributable to the Ministry, the University and private patients. Many questions, of course, need to be answered to determine if such a plan is feasible. For instance:

1) What non-physician staff will the Ministry provide? Will the University provide? What non-physician staff will be hired de novo.
2) What is the private practice revenue potential?
3) For every pound of revenue brought in, a distribution formula would have to be developed - perhaps in the following categories:
   a) Clincal physicians practicing in the group practice plan - W%
   b) Basic science physicians in the medical school without private clinical or tutorial practive - X%
   c) Other group practice plan operating costs - Y%
   d) Fund for contingencies - Z%

   W + X + Y + Z = 100%

The fundamental principal is participating clinical physicians in the group practice plan retain less than 100% of their earnings. This is justified on several grounds:

1) A better practice environment
2) The plan's assumption of all overhead costs and expenses, (e.g., staff, space, supplies, equipment)
3) The plan participants recognize the need for integrating practive with teaching to assure sufficient full-time faculty.

Certainly in order to achieve a successful primary care group practice, a number of conditions must be met. Among them, faculty joining the new medical school must have a very real committment to the principals espoused by the dean and be willing to undertake a long-term clinical experience, substantially different in form from what they are used to. Of equal importance, the total compensation package must ultimately be viewed by faculty when coupled with the intangibles from participating in the development, implementation and ongoing operation of the Faculty of Medicine as more desirable than solo private practices. If not, the plan clinicians will either not join the plan, leave the plan or leave the faculty, and in all cases, expand their private solo practices.

In the immediate early stages of F.O.M. development, it is most important to initiate a plan before solo practices sponsored by the faculty members are established. This requires moving forward rapidly to develop and test the feasibility of such an approach, make appropriate modifications and move toward early implementation. It should be anticipated that in the early months, perhaps years of the plan's operation, there will be a shortage of income over expenses, and these cash needs must be met by supplementation - perhaps from a mix of already awarded PL-480 funds, and funds

requested in this proposal.

A critical element in assessing feasibility is determining the minimum compensation package that clinicians on the faculty will require to participate in the plan and carry on little or no private practice outside the plan. It is often useful to emphasize that a group practice plan is private practice. It is merely an altered form of private practice.

In a plan's early years, it is quite likely plan income from patient fees will be insufficient to meet plan costs. The reason is straightforward. It may take up to three - four years to attract a full load of patients. At the same time, the majority, if not all of the Faculty of Medicine clinicians in Ismailia, must be members as soon as they move to Ismailia, in order to deter their starting solo private practices. These two factors will require a short-term subsidy to the plan for from one - four years. Such a subsidy should not be paid directly to faculty, but rather, within the management framework of the plan.

Where could such a subsidy come from if it is not available from general Suez Canal University funds? There, of course, may be local resources within Egypt - Outside sources could include: the PL-480 funds, and/or funds from this proposed contract. However, the PL-480 funds are already less than requested and largely intended for other equally important purposes. Prior to a feasibility study with market analysis, as well as cost and revenue projections, the magnitude of a short-term, but multi-year subsidy can only be very roughly estimated. Perhaps it would initially amount to between 30 and 70 thousand pounds per year, with a break-even point reached around year 3 or 4.

If such a plan is going to be developed, feasibility and initial planning require market analysis, cost and revenue projections, assessment of administrative issues, structuring the content of the practice, developing the management system, locating initial and permanent space, design, renovation and equipping space, and the selective improvement of inpatient amenities.

Renovation costs estimated for the Primary Care Group Practice Plan are shown on the next page.

Primary Care Group Practice Plan

Renovation Cost Estimates

Approximately 1000 square feet/physician will allow space for approximately 25 physicians* If 3000 square meters is made available, this should be sufficient for 25-30 physicians. The building designated in Ismailia for the group practice is a newly constructed apartment block estimated to be 1800 square meters. We are assuming costs to adapt to group practice use will be one half the cost of renovating an older building. To clarify further, please note the following formulae:

1) New construction: 200 Egyptian pounds/sq. meter.
2) Renovation of an older building: 100 Egyptian pounds/sq. meter.
3) Adapting unused new space: 50 Egyptian pounds/sq.meter.
4) Improving in-patient amenities at Ismailia General Hospital: painting, patching walls and floors, lighting: 30 Egyptian pounds/sq. meter.

Thus: 50 Egyptian pounds/square meter x 3000 square meters = 150,000 Egyptian pounds or $210,000 (US).

It is <u>emphasized</u> that these cost estimates are based on widely varying figures that Susan Christie Shaw obtained from several sources when she was in Egypt.

*A US norm not necessarily applicable in Egypt, introduced <u>solely</u> for purposes of initial cost estimating.

IV-C Component #4

Building 29

Building 29 is a three story, bombed-out factory on the Ismailia campus, slightly in excess of 7,000 square meters, or about 65,000 square feet. At present, the building is a structurally sound shell which has been designated to house the non-clinical components of the faculty of medicine, specifically:

1) Faculty offices
2) Administrative space
3) Library and learning resource center
4) Laboratory space, particularly multi-purpose laboratories and gross anatomy laboratory for undergraduate teaching
5) Necessary support services and space

At the present time, Ms. Susan Christy Shaw, in consultation with Dr. William Bicknell and Dr. William McNary is preparing suggested alternative approaches to the renovation of this building that recognize the very limited funds available for renovation and equipment in the next two fiscal years, (5000,000 Egyptian pounds) and limited time abailable (14 months). The approaches being developed are all designed to be practical and provide what is minimally required to get the school operational on or about the starting date of October, 1980. The design finally chosen for the Faculty of Medicine in Building 29 is far from trivial,as the layout of the building can profoundly affect function.

It is possible that catalyzed by the Health building overseas program of The Department of Health and Social Security, design work will be assumed by a British architectural firm working in conjunction with British equipment suppliers to

provide a consortion capable of providing a turn-key development for a guaranteed firm fixed price of 500,000 pounds for equipping and renovating Phase I of the building.

Phase I has been agreed to by all to include that space necessary to allow the first and second years of the medical school to begin.

If the British, for whatever reason, do not participate in the Building 29 effort, there will be a need for the following:

1) Assisting in maximizing architectural design and educational program compatability

2) Developing an equipment list

3) Assuring the appropriate integration of building and equipment

by faculty of the Medical School, the Dean of the School of Engineering and the university architect, the bulk of the architectural work will be done in Egypt with the university architect adapting and refining one of the alternative approaches developed by Ms. Shaw. It should be emphasized that the alternatives being developed by Ms. Shaw are based on the probability that a vertical curriculum approach will be selected by the school, and a brief architectural program description provided by Dr. Nooman and Dr. Ezzat in late July of 1979.

The following individuals from BU/HPI (university staff and associates) are expected to contribute to the Building 29 component. Susan Christy Shaw,Dr. Ascher Segall, Dr. William Bicknell, Dr. William. Dr. Segall will be asked to critique plans

to assure that the physical spaces proposed fully support the curriculum approach given the contraints of time and money. Dr. McNary will pay particular attention to the design and layout of laboratories and the equipment required in the initial years of operation. Ms. Shaw's role will be to serve as architectural program consultant to Dean Nooman and the university architect, and assist in the timely and accurate translation of program concepts into a specific final facility design. Dr. Bicknell's role will be primarily one of coordinating the BU/HPI inputs into the very pressured facility development schedule.

In addition to providing assistence in the design of Building 29, certain specific equipment will be provided that is felt to be critical for successful teaching. The proposed equipment will remain permanently under the control of the medical school and is to be used by successive classes of students and as appropriate post-graduates and faculty, specifically:

1) Microscopes

2) Audio-visual equipment

3) A basic supply of library materials - text books, references, audio tapes

Microscopes

In addition to providing microscopes to the medical school, at each clinical training site a microscope used by students in a student laboratory would also be provided. The medical school will

retain control of all microscopes, and in the case of those used on the Ismailia campus, would make them available to students as needed during the course of their undergraduate education. It is estimated that the initial number of microscopes required are as follows:

A) Student use at Ismailia - 50

B) Faculty and demonstrator use of Ismailia campus - 10

C) Student laboratories and clinical training sites initially Suez, Ismailia and Port Said gouvenerats - 15

Audio-visual equipment:

1) 16mm sound projectors - 2 for Ismailia campus

2) Slide projectors, a Kodak carousel or equivalent

1 each for the following rooms: Multi- purpose laboratory - 1, gross anatomy laboratory - 1, large lecture hall - 1, library learning resource center - 1, seminar rooms - (1 per 2 rooms) - 2, total 6.

Videotape recorder, playback and viewing equipment (color).

This equipment will be used in Building 29 and in each gouvernorat at a site to be designated for continuing medical education. Building 29 equipment to include:

Videotape recorder and playback unit - 1

Editing equipment - 1

Portible cameras - 2

Fixed camera and microscope adapter - 1

Library and learning resource center - 1

Seminar room, multi-purpose laboratory, anatomy laboratory and large lecture room - a total of 4 (as the monitors will be semi-portable, they can be moved from room to room as necessary).

For El-Arish, Port Said City, Suez City and Ismailia City - 1 each - video playback unit and 1 color monitor - total 4 playback units and 4 color monitors, total video equipment:

video tape recorder - 1

portable cameras - 2

fixed camera - 1

editing unit - 1

videotape playback units - 4

video monitors - 9

Laboratory Equipment for Medical Student Use In Clinical Training Sites:

The laboratory capacity in Ministry of Health facilities that will be used for training of undergraduate medical students is not sufficient to handle their daily clinical burden and the needs of medical students.

The students will be in the early stages of learning to use the equipment and carry out specific procedures. This will require considerable time as will the interpretation of results, consultation with instructors, and possibly repeating a test several times over on one patient. All this requires that in each clinical training site, a student laboratory be available that is separate from, but has equipment similar to clinical laboratories students may reasonably expect to encounter after graduation. Equipment necessary to

perform the following procedures is required:

1) White blood count
2) Differential
3) Hemoglobin
4) Erythrocyte sedimentation rate
5) Gram staining
6) Thick and thin smears for malaria and filariasis
7) Initial preparation of smears for acid fast staining
8) Examination of urine and stool for ova and parasites
9) Determination/rough quantification of urine sugar and protein
10) Hematocrit for monitoring severe cases of dehydration and rehydration

The equipment required for the foregoing tests includes for each student laboratory the following (replacement glassware, reagents, consumable supplies provided by the Egyptian side):

1) A microscope with substage illumination replaceable by a mirror
2) Hand centrifuge
3) Sahli hemaglobinomit r with white blood cell pipette and counting chamber
4) Microhematocrit centrifuge
5) Erythrocyte sedimentation rate rack and tubes

Library

An initial basic working reference library for faculty and students of 5,000 volumes at an estimated U.S. cost of $ 40 per

volume, will be supplied. In addition to this, basic medical text books such as anatomy, physiology, biochemistry, internal medicine, pediatrics, public health, physical diagnosis, laboratory techniques and diagnostic methods, etc., will be provided in the ratio of one text for every three students. These texts will be owned by the university, kept on reserve to be a resource to be shared by the undergraduate student body. Texts for use in clinical training sites have already been provided by USAID for all rural health units throughout Egypt.

IV-C Component #5

Staff Development/Continuing Education

A basic principal will guide staff development/continuing education. To the maximum extent possible, it will be conducted in Egypt, close to actual work sites by faculty and staff of the Suez Canal University Faculty of Medicine, the Ministry of Health, and other Egyptian universities. Only when it is clearly necessary and mutually agreed to will actual continuing education be carried out by BU/HPI. In like manner, United States based continuing education will take place only if the need is clear and comparable offerings are not available in Egypt.

Staff development/continuing education may be provided for physicians and non-physicians employed by Suez Canal University or the Ministry of Health. Training may be short term, (under four weeks); medium term, (one to twelve months); long term, (over one year). Training may take place in or outside of Egypt and, depending on the specific staff development/continuing education need, be either a one-time event, take place intermittently over a defined period of time, or be intended to continue indefinately, though intermittent in nature.

Boston University Health Policy Institute's role in continuing education/staff development(CE/SD) will be as follows:

1) Assist in defining needs for CE/SD

2) Assist in developing approaches to meeting defined needs

3) Provide short, medium, and long term training at Boston University and as appropriate elsewhere

4) Assist, as needed, in the development of capacity to provide CE/SD in Egypt through such activities as: training of trainers, assisting in the development of continuing education curricula and training in techniques of media preparation.

5) Carry out certain continuing education/staff development efforts in Egypt when there is a critical need.

It is anticipated that during Phase I of this contract, that continuing education activities in the area of management, planning, epidemiology, development economics, medical education, and curriculum development, as well as selected aspects of clinical medicine, basic science, and public health and primary care, will take place in the United States. This will be divided among short, medium and long term training as estimated below:

1) Short term training, 8 persons for 21 days, tuition not required. Six of the 8 will be traveling to illustrative primary care sites outside of the New England area.

2) Medium term training, this will take place in groups of 4-6 persons for periods of 3-4 months with a tuition of $2,000 per person. It is anticipated that 2 short term training episodes will take place during the first phase of this contract.

3) Long term training beginning October 1980 is planned for 6 SCU faculty.* Four are expected to begin course work that could lead to a master's degree in public health, two are expected to pursue special studies in basic medical sciences. All activities would be designed in a manner that the work undertaken at Boston University would contribute toward the awarding of an appropriate advanced degree in Egypt. Tuition will be $7,080/student for the MPH and $5,000/year for basic sciences.

SD/CE, as well as all other components of the SCU/FOM - BU/HPI collaboration will stress the application of scientific method to meeting human needs and effective problem solving.

*Subject to acceptance by Boston University

IV-C Component #6
Strengthening Management Systems

Managing a medical school is complex and difficult. Successfully managing this new medical school that is starting up fast and plans to be different with a totally new curriculum and curriculum approach, as well as operate in a decentralized manner in five governorats and, on a daily basis, work closely with the Ministry of Health -- will be challenging in the extreme. What, in a management sense, needs to be done:

1) Coordination of inputs, basically money and people, to address such urgent start up issues as facilities development, equipment, staffing, curriculum and student selection, as well as the MOH interphase.
2) Develop a plan for establishing a dynamic system of management that will facilitate start up and foster flexibility, accountability and performance in the critical first five years of the faculty's active operation.
3) Assure that resources available and potentially available are realistically assessed, and objectives are achievable within probable resource constraints.
4) Monitor overall performance for the developing Faculty of Medicine to spot problems early so quick action can be taken to minimize complications.

And while all the foregoing is taking place:

5) Meet the immediate management needs of today and tomorrow.

The foregoing is a very tall order. Boston University's Health Policy Institute proposes to assist the Faculty of Medicine in the following ways:

1) Provide immediate full-time staff assistance led by the Special Assistant to the Dean/Deputy Project Manager.

The Special Assistant to the Dean/Deputy Project Manager will be assisted by full-time Administrative Officer/Management Specialist recruited in Egypt (see Project Management section).

2) Consultation and assistance with identifying and defining critical management systems objectives, and specific realistic management methods to meet these objectives. Any management method should also include a mechanism to monitor, not only Faculty of Medicine performance, but also the performance and effectiveness of the management system itself.

3) Targeted Assistance/Management consultation in key areas such as Primary Care Group Practice Development (Component 1).

A resume of Mr. William Dann is enclosed to illustrate the type of person we intend to employ as Special Assistant to the Dean/Deputy Project Manager. In fact, Mr. William Dann, in preliminary discussions, has shown considerable interest and, while funding is still pending, Boston University's Health Policy Institute will do everything possible to further cultivate his interest. Dr. William Bicknell, Project Director, will function as a major consultant in the area of stregthening management systems and will be working with Boston University's School of Management in Program in Health Administration, as well as Mr. Arthur Mushkin and Mr. Nicholas Brill. Even though the later two will be primarily focusing on Primary Care/Group Practice Plan development, they are bound to have insights about, and make contributions to overall management systems development as the Primary Care Group Practice Plan, or some derivative plan, however ultimately structured, must fit within the overall framework of the Faculty of Medicine. All consultants used will have had hands-on experience in analyzing management system needs, and developing management systems in large organizations and have a proven capacity to develop management approaches that work.

The Dean recognizes that the management demand on him and the Senior Faculty are enormous, and a general purpose administrative staff are not now available on a full-time basis to the Dean, nor can they be readily recruited within Egypt during this critical period in the faculty's development. This recognition underlies the Dean's wish to obtain the assistance of 1½-2½ years

of a Resident Special Assistant who is a real worker and full-fledged member of the Faculty of Medicine development team, not solely an advisor.

BU/HPI feels that good management serves as catalyst and lattice for the overall program for the Faculty of Medicine, and, however important any other component of the Faculty of Medicine Development Program is, without at least adequate management the overall program will falter. Thus, the BU Project Director and Deputy Project Manager will be giving this component great priority and devote a considerabe amount of their time to management systems development.

It is important for all to realize that in a project of this magnitude and complexity where time is very short, needs are great and multi-faceted that problems will occur. Sins of ommission and commission are a necessary price that must be paid if the Faculty is to meet its early objective. What we intend as a strong and practical management emphasis, both recognizes and seeks to minimize this price.

IV-C Component #7

Planning for Phase II and (other related activities)

The vast amount of work to be done in Phase I suggest that, however vigorous the effort, and however successful all Phase I activities are, it will be difficult to fully meet all Phase I objectives. Furthermore, it is not expected, proposed or otherwise planned that the medical school will be in a steady operational state at the end of Phase I. Rather, it will be in its early operational phases, still under intense development. Therefore, it is highly likely that the early Phase II activities will, in substantial part, be a continuation and elaboration of activities begun in Phase I, specifically:

1) Curriculum development
2) Identification and improvement of clinical training sites
3) Primary care/group practice development
4) Design, renovation and partial equipping of Building 29
5) Staff development/Continuing education
6) Stregthening management systems

During the course of Phase I, Dean Nooman has proposed the first of what, hopefully, will be an annual series of conferences to revue and present various aspects of the Suez Faculty of Medicine in a context that is relevant to health service and medical education professionals, throughout Egypt. Dean Nooman has proposed that these annual seminars on medical education for primary care might cover

such topics as:

1) Issues in integrating the Ministry of Health and Ministry of Education programs.
2) Social Science as applied to medical education and medical service in Egypt.
3) Private practice and medical education; a personal income and public policy dilemma.
4) The Arabic/English language conflict;issues and alternatives for nursing, medicine and the patient.

The input from the first such seminar, whatever the topic, should prove extremely valuable, and provide considerable guidance for Phase II planning, as it will help identify areas of both sensitivity and interest that may merit special further attention.

One of the intents of the collaboration between Suez Canal University and Boston University is to facilitate a truly enduring, long-term collaborative relationship in the area of teaching, service and research. Thus, Phase II planning will specifically address the identification of several areas where fruitful collaborative research, consistant with the goals of Suez Canal University Faculty of Medicine may take place, and where there is clear evidence of faculty interest on both sides. Specific areas to be considered for collaborative research would include:

1) Public health
2) Primary care
3) Basic medical sciences
4) Behavioral sciences
5) Infectious disease and clinical medicine

From the areas above, no less than 3 specific proposals will be developed for initiating collaborative research and be included in the Phase II proposal.

Planning for Phase II will specifically address the development of an evaluation plan which will have both internal and external phases. The internal phase will emphasize ongoing evaluation by the Faculty of Medicine for purposes of its own management, and planning. This will relate to the external phase, periodic external evaluation by skilled and interested individuals from within and outside of Egypt who have little or no prior contact with the project. The external phase should provide a periodic fresh look that seeks to relate actual performance to stated goals and objectives. However, it should go beyond that and, as appropriate, question premises, suggest alternative approaches, and bring to bear in a focused and defined way, a critical, new yet sympathetic intellectual resource to the process of development.

Additional areas that will be carefully considered for possible inclusion in Phase II, and thus will be a subject of the Phase II planning effort will include, in addition to those already mentioned:

1) Sinai rural health development.
2) Documentation and publication of the Suez Canal University Faculty of Medicine lessons of experience.
3) Faculty of Nursing feasibility study and program planning.

4) Emergency medical services,ongoing evaluation and improvement, emphasizing further integration with primary care services.

5) Data management and data needs for patient care and program management.

6) Reassessing the content of primary care, based on a fuller understanding of costs of care, health needs of the area and resources available.

7) Further consideration of stregthening critical supporting elements in primary care, such as basic laboratory services, an improved pharmacopia, environmental health and sanitation.

The Phase II planning effort will begin approximately 6 months after funding is received and will have 2 major related products:

A) The first multi-year development plan for the Faculty of Medicine.

B) As a derivative of the Multi-year Development Plan, a specific Phase II funding proposal.

The Phase II planning will be the joint responsibility of the Dean's Planning Unit and Medical Education Unit, working closely with both Project Directors, in full and close consultation with the Ministry of Health.

PROJECT DESIGN SUMMARY: LOGICAL FRAMEWORK Phase I - 18 months

Project Title: Medical Education and Health Services for the Suez Canal Area - Phase I

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program Sector Goal. The broader objective to which this project contributes: To improve the quality of life by making basic health services, particularly those related to primary care including MCH, nutrition and family planning available and accessible to the majority of the population of the Suez Area at an affordable cost	Measures of final achievement: 1. The increase in proportion of the population with access to the appropriate primary care services. 2. The change in the relevance of health programs to meet regional health problems. 3. The increased efficiency of utilization of all health resources.	1. Infant and maternal mortality statistics; school and industrial attendance records. 2. Community health, nutrition and population surveys. 3. WHO and LDC communicable disease statistic reports. 4. WHO Demographic and Statistics Yearbook 5. Special Surveys and reports.	Assumptions for achieving goal targets: 1. Local & National Government interested in improving the health status of the population. 2. Assistance in the health sector will be acceptable and will improve health status. 3. That the efficient utilization of trained manpower is a priority. 4. An extensive training program is necessary
Project Purpose: a. Integration of the medical education and health services. b. Education and training of primary care physicians as direct providers and health team managers to work effectively within resource constraints.	Conditions that will indicate purpose has been achieved. a. Suez U. Faculty of Medicine has begun operations - 6 yr. curriculum development and educational methods. Management system developed. Architectural plans developed	Reports by the contractor - a. On-site visits to assess the extent to which the new education system has begun to function b. Reports from the Suez U Faculty of Medicine.	1. The Ministry and University are willing to work together & make necessary changes in order to accomplish project purpose. 2. Primary responsibility for achieving project purpose rests with SCU/FOM.
Outputs: 1. Curriculum Development Curriculum developed for first 3½ years of Suez U Faculty of Medicine	Magnitude of outputs: At end of 18 month period, all courses for year 1 and year 2 semester one completed	Course materials including specification of optimal physician performance and competency-based objectives available.	Assumptions for achieving outputs: Curriculum is needed to teach.

NARRATIVE SUMMARY	OBJECTIVE IDENTIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
1. Curriculum Development (cont'd) Six year curriculum projection	1 set of materials	Six year planning document	Suez U Faculty of Medicine will open 1980 or 1981 Overall planning document is needed
Staff and faculty members trained in curriculum development and skills	60-80 staff and faculty trained in Egypt.	Semi-annual report	Curriculum development skills will help faculty develop and teach own curriculum
Library plans developed/books purchased	One library plan detailing equipment space requirements as well as specification of reference and learning material (4-5,000 volumes)	Library plan/site visit	A carefully planned library is needed by the U of Suez Faculty of Medicine
2. Clinical Training Sites Designated	10-15	reports/site visits	Clinical traing sites are needed for training medical students
Renovating rural health units	4-6 renovations in progress	reports/site visits	
3. Primary Care Group Practice Plan Initial actions	feasibility study completed and proposals made	Semi-annual report	substantially full-time faculty and limitation of solo private practice are necessary to success of the school
4. Design & Renovation - Building 29			
Renovation plans	Architectural plans, building renovation plans	Site visits, inspection of plans	Building #29 will provide adequate space for faculty and students Building can be renovated.
Equipment list	Equipment list		

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs (continued):			
5. Continuing Education	Magnitude of outputs:	Semi-annual reports	Assumptions for achieving outputs:
Plan developed for SCU faculty and MOH staff	One Plan		ONE will strengthen faculty and staff
6. Management System developed for Faculty of Medicine	One System	Semi-annual reports	
Data set on clinical facilities to be used at teaching sites developed	One Data set		Availability of data will improve planning and implementation of training
Management and evaluation plan for Medical School developed	One Plan	Semi-annual report	Management and evaluation plan will be useful in working toward project goals.
7. Planning for Phase II			
Evaluation of emergency medical services (EMS)	2-4 man weeks of technical assistance supplied	Semi-annual reports	EMS Service requires evaluation
Plan for Phase II	One plan completed	Semi-annual report	A 3 year project continuation is necessary
Inputs:			Assumptions for providing inputs:
1. Technical Expertise -	Salaries	Project expenditure records & input	
a) Primary care	Fringe Benefits		1. The contractor has the unique experience and special capability necessary to carry out the project.
b) Curriculum Development	Consultants		
c) Health Management	Goods & services purchased		
d) Public Health	International and domestic travel		
e) Facility design & Health planning	Total Direct Costs		
2. Faculty of Medicine and MOH staff	Indirect Costs		2. Egyptian side will provide trainees, facilities and other support.
3. Selected Support Construction materials	External Evaluation		
4. Project support in Boston & Egypt			

V Project Management

The project director/principal investigator for this project is Dr. William J. Bicknell, M.D., MPH. Dr. Bicknell has the primary responsibility for Boston University for all aspects of Boston University's collaboration with the Faculty of Medicine at Suez Canal University. Dr. Bicknell is director of Special Health programs for Boston University's Health Policy Institute, and coordinator of international health programs for the university. He reports directly to Richard H. Egdahl, M.D., Ph. D., Academic Vice President for Health Affairs and Director of the Health Policy Institute. By virtue of the structure of the Health Policy Insitutue and its innovative and integral relationship with the office of the Academic Vice President for Health Affairs, Dr. Bicknell has direct and ready access to all health schools of the university and, as necessary, other related schools and departments such as management, sociology and economics.

Dr. Bicknell is a full-time staff member of the Health Policy Institute and will devote no less than 40% of his time to this project. His activities will include overall direction and coordination of the program proposed herein, as well as technical assistance and consultation on selected components of the project, particularly components 2, 3 6, and 7.

As a practical matter, for the first eighteen months, and quite likely into the initial months or years of Phase II, Boston University is assuming responsibility for organizing a very broad-based,

extremely intensive technical assistance effort. The goal is very clear -- help get a new medical school operating quickly that will produce good primary care physicians. This requires a substantial core support staff at Boston University. In the initial months of our collaboration (October '78 - August '79), functioning at a far lower level of effort than proposed herein, we have been operating at between 1 and 2 full-time equivalent professionals with ½ to 2 full-time equivalent secretaries. The load at B.U. can only increase if the faculty of medicine in Suez is to receive the kind of collaborative assistance it needs. There is, thus, a very clear management requirement for a substantial core staff at Boston University, dedicated to this project and its successful implementation.

The project activities proposed herein will be carried out within the framework and intent of the overall program of collaboration with the SCU/FOM. The functional implication of this is that, although Dr. Bicknell is the legal project director for this proposed contract, there will be two co-project directors. For the American side, Dr. Bicknell; and on the Egyptian side, for the Suez Canal University Faculty of Medicine, Dr. Zohair Nooman. Activities, on a day-to-day basis that take place outside of Egypt, will be the responsibility of Dr. Bicknell. Comparable activities, within Egypt, will fall under the direction and guidance of Dr. Nooman. All international travel, and all consultants who will be used within Egypt, will require the prior approval of both co-project directors, or their designees. Furthermore, no significant changes in intent, direction or scope of work will be initiated without the agreement of both co-project directors.

Prior to making hiring commitments for Boston University staff resident in Egypt, the written concurrence of both project directors must be obtained. It is anticipated, in the case of non-Egyptian nationals, not personally known to the Egyptian side but proposed for employment in Egypt, that they will need to make a recognizance visit, prior to a final hiring commitment. In the case of all full-time employees, whether they are Egyptian nationals or non-nationals, continuing employment will be subject to satisfactory performance as judged by both co-project directors.

Wherever possible, because of the intent and nature of the agreements between the two universities, Boston University will seek to use resources within the university. However, our first goal is to do the best possible job in the shortest amount of time. This means that in assessing resources available to us within outside the university, our first concern will be the relevance and quality of the resource. In a very real sense, with regard to the technical assistance aspects of this project one of the Health Policy Institute's major functions is that of an honest broker whose job is to bring to bear the right combination of the right resources, orchestrated in a manner that gets the job done well, in a timely way.

I Internal Structure at Boston University

The project manager/project coordinator. This is a full-time position, and will report directly to Dr. Bicknell. In Dr. Bicknell's absence, this person will have the authority and reponsibility to function for the project director. The project manager will be a seasoned health professional, with substantial international experience, who has a proven capacity to work well in complex and dynamic professional environments. The project manager will be the immediate supervisor of all full- and part-time project staff, will participate in the recruitment and selection of consultants, and will have primary responsibility for assuring appropriate coordination of all consultant inputs. Consultant reports will be reviewed by the project manager for quality, relevance and usefulness (a routine requirement for all consultants, unless specifically waived by the BU project director or project manager.) Overall program and contract management, the bulk of relationships with USAID, oversight and responsibility for expenditure control and assuring that the project complies with applicable laws and regulations, as well as follows prudent management practices, particularly as they relate to the purchase of goods and services domestically and overseas, will fall within the purview of the project manager.

Fiscal Officer This person will have the day-to-day responsibility for developing and maintaining all financial records that relate to the project, and be able to relate actual expenditures to obligations and obligational authority, projecting, on a no less than monthly basis, the cash and accrual status of the contract, by program component, line item, and overall. The individual filling this position will be responsible for assisting in developing management procedures that relate obligations incurred to project components and line items. After such procedures are

developed, primary responsibility, under the supervision of the project manager for carrying out such procedures, will rest with the fiscal officer. Inputs from the fiscal officer constitute a substantial portion of the management information necessary to relate, on a periodic basis, initially proposed goals and objectives, to actual performance and expenditures.

Bibliographic Assistant/Librarian: This person will, under the overall direction of the project director and day-to-day supervision of the project manager, act as a staff back-up and personnel resource to full- and part-time professionals on the project, as well as consultants. He/She will assist in the assembly of background material, reference material and documents for consultants before or after their visits to Egypt, and follow-up consultant recommendations in terms of locating, assembling and organizing written graphics and audio-visual materials in a useful way for use in Egypt. An additional major role will be to function as principle coordinator and manager of literature searches (medlars, medline and other computer-based searches, as well as manual searches) organizing, selecting and obtaining relevant materials from such searches, (e.g., articles, reprints) and formating original and follow-up computer requests. He/She will devote 100% of his/her time to the project.

HOME OFFICE NON-PROFESSIONALS

Secretaries (HPI): These people are responsible for typing all documents with relation to components 2 - 7 of the project. They are also responsible for day-to-day secretarial duties such as

answering phones, maintaining files, scheduling appointments, travel arrangements, etc. It is estimated that one full-time person and one half-time person are needed to fulfill these tasks, at a yearly salary of $12,000/person.

Secretary (CEDH): This person will be working under the direction of Dr. Ascher Segall in connection with component 1, "Curriculum Development." As the paper work and actual production of materials associated with the curriculum development component may approach, or even exceed the volume of all other aspects of the project, a full-time dedicated secretary is minimally necessary, and it is anticipated that in times of an overload, part-time secretarial assistance will be required.

FIELD STAFF PROFESSIONALS

Special Assistant to Dean/Deputy Project Director: This person will be a seasoned health program development and management specialist, with a sound understanding of principals regarding the organization and delivery of health care, the relationship of financing mechanisms to the content of service and also have specific skills and experience in primary care, program planning and management. It will be the responsibility of the special assistant to the dean/deputy project manager working with both project directors, to develop and implement, in a very timely manner, a personnel policy related to Egyptian nationals, and other permanent residents of Egypt who will be either staff or consultants under this proposed contract. This person must have very substantial skills in management, program planning and health,

authority for project funds within Egypt. This person shall be responsible for the authority and responsibility to function for project director. He/she will be the immediate supervisor of all full- and part-time project staff, will participate in the recruitment and selection of consultants, and will have primary responsibility for assuring appropriate coordination of all consultant inputs. Consultant reports will be reviewed by the project manager for quality, relevance and usefulness, (a routine requirement for all consultants, unless specifically waived by the B.U. project director or project manager). Overall program and contract management, the bulk of relationships with USAID, oversight and responsibility for expenditure control and assuring that the project complies with applicable laws and regulations, as well as following prudent management practices, particularly as they relate to the purchase of goods and services domestically and overseas, will fall within the preview of the project manager.

Senior Research Associate: The senior research associate will work with Drs. Segall and Vanderschmidt on component 1, "Curriculum Development." He/She will function as Dr. Segall and Dr. Vanderschmidt's primary resource person in the United States. He/She will devote 100% of his time to the project.

Fiscal Officer, Geri Duffy: Geri Duffy will have the day-to-day responsibility for developing and maintaining all financial records that relate to the project, and be able to relate actual expenditures to obligations and obligational authority, projecting, on a no less than monthly basis, the cash and accrual status of the contract,

by program component, line item and overall. She will be responsible for assisting in developing management procedures that relate such obligations incurred to project components and line items. After such procedures are developed, primary responsibility, under the supervision of the project manager, for carrying out such procedures, will rest with her. Inputs from Mrs. Duffy constitute a substantial portion of the management information necessary to relate, on a periodic basis, initially proposed goals and objectives to actual performance and expenditures. She will devote 100% of her time to the project.

Consultant writer/editor: A very large volume of written materials will be produced by staff and consultants during the life of this proposed contract. To assure readability, reasonable consistency, appropriateness and quality, but not lockstep conformity, all reports and major written products of the project will be reviewed by th project director or project manager prior to final release. It is anticipated that a certain number of these reports and related written materials will, in consultation with the author, require editing, and possibly revision. The purpose of such review is to enhance the documents' clarity, and thus, their utility, particularly for readers whose second language is English.

Activity number one,curriculum development,will be the primary responsibility of Dr. Ascher Segall, in his role as Director of the Center of Educational Development in Health. In order to carry out the tasks specified and have the opportunity to meet the objectives outlined in the scope of work that relates to curriculum development, conducting workshops and ongoing training in the Suez area, supervising full-time personnel related to curriculum development in Egypt, and assuring that curriculum development is integrated into overall faculty of medicine development, the following staff will be required: Dr. Ascher Segall, 40%; Dr. Laurie Vanderschmidt, 40%; Senior Research Assistant, 100%; secretary, 100%. The professional medical education and curriculum development input into the project will be shared by Dr. Segall and Dr. Vanderschmidt, the research assistant will function as their primary resource person in the United States. As the paper work and actual production of materials associated with the curriculum development component may approach, or even exceed the volume of all other aspects ot the project, a full-time dedicated secretary is minimally necessary, and it is anticipated that overload, part-time secretarial assistance will be required from time to time.

II Organization within Egypt

The project staff within Egypt must be organized in a manner that is fully compatible with the overall organizational structure of the faculty of medicine, supports F.O.M. development and is consistent with the specific goals and objectives of this contract. We propose 6 full-time employees to be resident in Ismailia, 4 of whom will be Egyptian nationals. We anticipate that the need for all these individuals will extend well into Phase II of the contract and certainly through the third complete contract year.

and be ready to operate in at least three complementary ways simultaneously:

a) As Key Staff Assistant to the Dean

b) As Resident Management Specialist and Consultant

c) As Senior Health Planning and Program Consultant to the Dean's Planning Unit.

The special assistant to the Dean/Deputy Project Manager shall be designated as the senior BU staff person resident in Egypt, and shall have signature authority for project funds within Egypt. This person shall be responsible for assuring that the fiscal management system within Egypt that relates to project funds is an integral part of the overall fiscal and program management system of the project.

Management Planner/Fiscal Officer: The project will require, for implementation within Egypt, a person who cannot only be an integral part of the Dean's Planning Unit and assist its timely implementation and make a professional input in the areas of data collection and analysis and the development and monitoring of management systems, but can also work with the dean and the special assistantto the dean on day-to-day administration and management of the contract within Egypt. This person may ultimately function as a fiscal manager for the dean,and ultimately become the group practice and medical school financial manager. This person must be fluent in Arabic and English,with a master's level degree in management, business administration, or comparable disciple or equivalent, and have several years of relevant work experience of demonstrated high quality.

Project secretary: A bilingual (English and Arabic) secretary supporting all aspects of project development in Egypt, with a willingness and capability to use dictation equipment, a capacity to type rapidly and accurately in English and Arabic, and an ability to perform needed secretarial duties in the area of correspondence control, filing, telephone answering, making of reservation and travel arrangements, and such other similar duties from time to time assigned, will be required.

Driver Messenger: Driving of Consultants, providing messenger/ driving support to SU and FCM staff, particularly the Dean's Planning Unit and The Medical Education Unit require a full-time competitively paid, preferably bilingual persor.

The following staff and consultants have already been involved with SCU/FCM development, and all except Dr. McNary have been to Egypt since September of 1979 in relationship to this project:

Dr. Bicknell, 4 trips

Dr. Segall, 3 trips

Dr. Sol Levine, 1 trip

Dr. Scotch, 1 trip

Dr. McNary (domestic only to date)

Ms. Susan Shaw, 1 trip

All other consultants whose CVs are shown in Appendix have, subject to funding, agreed to participate as indicated in this project. Ms. Julia Terry has, subject to funding, been

offered the position of Project Manager. She is considering one other position, but has given strong indications that her preference would be to join the Health Policy Institute's staff. Mr. William Dann has been vigorously approached, and has indicated his willingness to give the position of special assistant to the Dean/ Deputy Project Director his most serious consideration, as soon as funds are awarded. Dr. Bicknell is meeting with Mr. Dann and his wife in early September in San Francisco to further explore and cultivate Mr. Dann's interest. Mr. Dann is fully aware that, even if he were to make a commitment, his hiring is contigent on Dr. Nooman's approval.

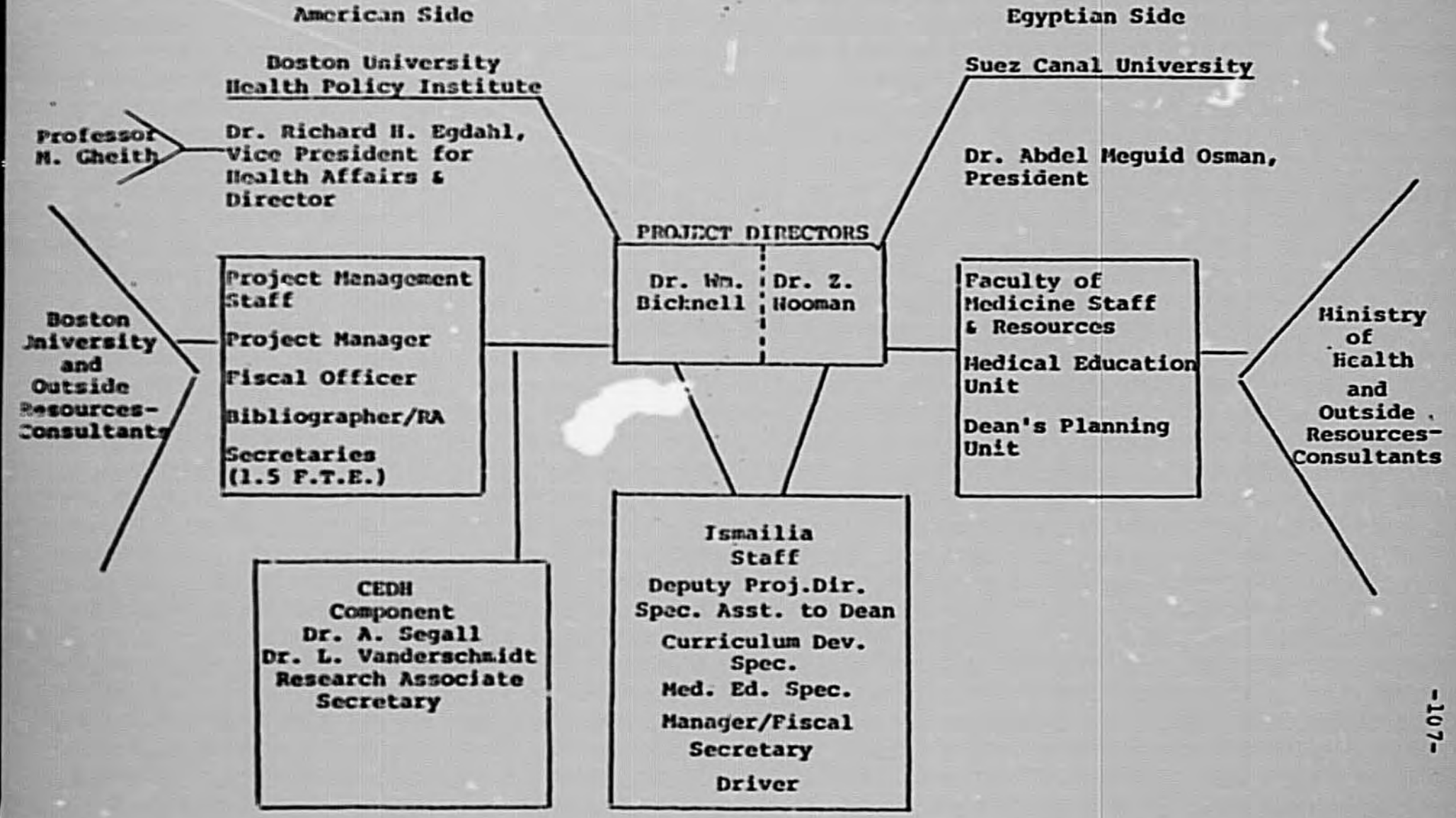
Consultants:

Consulting days and often specific consultants have been attributed to the 7 components within the proposed scope of work. Needs will change as the project moves forward. Thus, the projected consulting day allocations for each component will be viewed as a guide. Consultants will be deployed according to need and project purpose, with the co-project directors periodically allocating consultant days to the various components.

The attached organizational chart shows the structure desired in this section.

MEDICAL EDUCATION AND HEALTH SERVICES FOR THE SUEZ CANAL AREA

BU/HPI - SCU/FOM Project Organizational Chart



Environmental Concerns and I.E.E.

1. Land Use

The proposed renovations will take place on 9 sites for health facilities and 1 site for the administrative - classroom complex. The 9 sites for health facilities will occupy 3',802^{m2} while the administrative classroom complex will occupy 7,400^{m2}. The generally degraded environment surrounding these sites greatly reduces the impact of the temporary problems such as dust, noise and other effects from the renovation work.

Renovation will be aesthetically unattractive during the work period, but should not cause any disruption of traffic or other activities.

The land use effects of the proposed renovation would be of a minor nature, and because of the highly disturbed existing environment in most of the areas where project work will be implemented, the significance of slight increases in dust and noise for a short period of time would be small as compared to other similar disruptions.

The land clearning operations involved for the renovations will be minimal and will disturb little or no plant cover. Because only short periods of open foundation work will be required, the erosion and run-off problems should be minimal.

The land use classifications of all of the sites are residential or commercial. The project elements for which buildings are required are to be located in residential neighborhoods, with the exception of the administrative-classroom complex. This complex will occupy land set aside for the Suez Canal University campus near Ismalia. Alteration of land use other than temporary disturbances during construction would appear to be neither substantial nor important compared to existing environmental conditions.

2. Water Quality

The health units will serve some 2,500 patients daily. This use might increase the water utilization and sewage outflow over that occurring under the present use of the land. Adequate water and sewerage capacity for the new buildings will be provided.

Administrative-classroom complex will replace an existing facility inoperative because of war damage. Therefore, the water and sewerage use should increase, and will be provided for.

3. Atmosphere

Relatively minor and temporary renovation activities will add to the air pollution in the area. To minimize these effects, the construction contractor will be required to:

a. Keep construction equipment well tuned.

b. Service filters, blowers and injectors on gasoline and diesel engines with particular attention given to the reduction of emissions.

c. Remove all construction debris to approved dump sites -- no burning of refuse will be permitted.

d. Wet down all unimproved roads, and right-of-ways and other construction surfaces to prevent dust problems.

If possible the use of low sulfur fuels will be encouraged to alleviate the emission of sulfur oxides from construction equipment and vehicles.

Except for the small amount of air pollution from equipment during the renovation period, there would appear to be no other atmospheric disturbances which would result from the proposed project.

Hospitals and health centers generate toxic solid wastes in the form of contaminated syringes, used bandages, etc. The GOE will provide for disposal of these wastes in an approved manner.

4. Natural Resources

There are no effects on natural resources by this project.

5. Health

The prupose of this project is to make the existing health care delivery system more accessible and cost-effective to the residents of the Suez Canal area. The provision of improved clinical facilities, with the other elements of the proposed project, should result in improved health services for the affected population. In particular, health care based on community-based needs assessment will provide additional health knowledge to residents of the affected area and will make residents more conscious of the need for following good health practices.

6. Cultural

No Pharonic, Greek, Roman or late Islamic remains are expected to be encountered in the excavations needed during renovation. Because all excavations are rather shallow, the quantity of excavation is small, and the excavations in recent (less than 200 years) fill, the chances appear remote that any archaeological finds of importance will be uncovered. In the event they are, appropriate authorities will be contacted.

7. Threshold Decision

The project will not adversely affect the basic aspects of the human environment such as air, water, land, flora and fauna. Reasonably foreseeable effects of the Project on organisms in the biosphere, including human life, are not expected to be either adverse or significant. In the same manner, the precautionary measures to be taken during implementation should act to minimize the temporary adverse effects of actual renovation. The sum of the socio-economic and cultural effects of the project should be positive.

An Environmental Impact Identification and Evaluation form was completed on this project. The only significant environmental impact

of the project was found to be the temporary disruptions normally associated with renovation projects in rural areas. As a result, the Mission Director recommended that an Environmental Assessment not be required.

THRESHOLD DECISION BASED ON
INITIAL ENVIRONMENTAL EXAMINATION

Project Location: Five Governorates (Suez, Ismailia, Port Said, North Sinai, South Sinai), Egypt.

Project Title: Suez Community Health Personnel Training (263-0136)

Funding (Fiscal Year and Amount): FY 1980 $7.72 million

IEE Prepared By: M.M. Shutt
Health and Population Division

Date: 11/1/79

Environmental Action Recommended:
(Environmental Assessment, Negative Determination, etc.)

Negative Determination

Mission Decision:
(Approval/Disapproval of Environmental Action Recommended in the IEE)

Approved

Disapproved : _____

Date : 12/19/79

Clearances:
Environmental Coordinator Jack Snead Date 11/18/79
Other Mission Offices Ted Carrara Date 11/18/79

IMPACT IDENTIFICATION AND EVALUATION FORM

Impact Areas and Sub-areas	Impact Identification and Evaluation1/
A. LAND USE	
1. Changing the character of the land through:	
a. Increasing the population	N
b. Extracting natural resources	N
c. Land clearing	N
d. Changing soil character	N
2. Altering natural defenses	N
3. Foreclosing important uses	N
4. Jeopardizing man or his works	N
5. Other factors	
_____	_____
_____	_____
B. WATER QUALITY	
1. Physical state of water	N
2. Chemical and biological states	N
3. Ecological balance	N
4. Other factors	
_____	_____
_____	_____

1/ N -- No environmental impact
L - Little environmental impact
M - Moderate environmental impact
H - High environmental impact
U - Unknown environmental impact

IMPACT IDENTIFICATION AND EVALUATION FORM

C. ATMOSPHERIC

1. Air additives	N
2. Air pollution	L
3. Noise pollution	N
4. Other factors	
Limited dust and paint particles will effect air during renovation or construction.	-
No long term adverse effect.	

D. NATURAL RESOURCES

1. Diversion, altered use of water	N
2. Irreversible, inefficient commitments	N
3. Other factors	

E. CULTURAL

1. Altering physical symbols	N
2. Dilution of cultural traditions	N
3. Other factors	
	-

F. SOCIOECONOMIC

1. Changes in economic/employment patterns	M
2. Changes in population	M*
3. Changes in cultural patterns	M*
4. Other factors	

*Increased acceptance of family planning and behavioral changes related to personal and community hygiene, over the long term, will result from this project.

IMPACT IDENTIFICATION AND EVALUATION FORM

G. HEALTH

1. Changing a natural environment	N
2. Eliminating an ecosystem element	N
3. Other factors	
Improved Health Services	M

H. GENERAL

1. International impacts	N
2. Controversial impacts	N
3. Other factors	
	-
	-

I. OTHER POSSIBLE IMPACTS (not listed above)

	-

Prepared By: M.M. Shuff Date: 11/1/79

Project Location: Five Governorates (Suez, Ismailia, Port Said, North Sinai, South Sinai), Egypt

Project Title : Suez Community Health Personnel Training (263-0130

AID HANDBOOK 3, App 5C — Part I	TRANS. MEMO NO. 3:22	EFFECTIVE DATE April 12, 1978	PAGE NO. 5C(1)-1

5C(1) - COUNTRY CHECKLIST

Listed below are, first, statutory criteria applicable generally to FAA funds, and then criteria applicable to individual fund sources: Development Assistance and Security Supporting Assistance funds.

A. GENERAL CRITERIA FOR COUNTRY

1. FAA Sec. 116. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in consistent pattern of gross violations of internationally recognized human rights?

   Not all contemplated assistance will directly benefit the needy. The Department of State has not determined that the GOE has engaged in a consistent pattern of violation of human rights.

2. FAA Sec. 481. Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully?

   No such determination has been made.

3. FAA Sec. 620(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement?

   The Secretary of State has so determined.

4. FAA Sec. 620(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government?

   Yes.

5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?

   Not in recent years and all outstanding clai have been adjudicated.

6.	FAA Sec. 620(a), 620(f); App. Sec. 107, 113. Is recipient country a Communist country? Will assistance be provided to the Socialist Republic of Vietnam, Cambodia, Laos, Cuba, Uganda, Mozambique, or Angola?	a. No. b. No.
7.	FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression?	a. and b. It has not been determined that the country is involved in such conduct.
8.	FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property?	No.
9.	FAA Sec. 620(l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, inconvertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason?	The GOE has an Investment Guarantee Agreement with the U.S.
10.	FAA Sec. 620(o); Fisherman's Protective Act, Sec. 3. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters,	No.
	a. has any deduction required by Fishermen's Protective Act been made?	Not applicable.
	b. has complete denial of assistance been considered by AID Administrator?	Not applicable.
11.	FAA Sec. 620(q); App. Sec. 503. (a) Is the government of the recipient country in default on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds, unless debt was earlier disputed, or appropriate steps taken to cure default?	No.
12.	FAA Sec. 620(s). "If contemplated assistance is development loan (including Alliance loan) or security supporting assistance, has the Administrator taken into account the percentage of the country's budget which is for military expenditures, the amount of foreign exchange spent on military equipment and the amount spent for the purchase of sophisticated weapons systems?" (An affirmative answer may refer to the record of the taking into account, e.g.: "Yes as reported in annual report on implementation of Sec. 620(s)." This report is prepared at the time of approval by the Administrator of the Operational Year Budget.	Yes, as reported in annual report on implementation of Sec. 620(s).

	Upward changes in the Sec. 620(s) factors occuring in the course of the year, of sufficient significance to indicate that an affirmative answer might need review, should still be reported, but the statutory checklist will not normally be the preferred vehicle to do so.)	Agree.
13.	FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?	A new bilateral assistance agreement was signed 16 May 1978, and was ratified by the People's Assembly on 16 October 1978.
14.	FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget?	The Mission has no knowledge of any arrearages.
15.	FAA Sec. 620A. Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism?	The Mission has no knowledge of such action
16.	FAA Sec. 666. Does the country object, on basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. there to carry out economic development program under FAA?	No.
17.	FAA Sec. 669, 670. Has the country, after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards? Has it detonated a nuclear device after August 3, 1977 although not a "nuclear-weapon state" under the nonproliferation treaty?	No.
18.	FAA Sec. 901. Has the country denied its citizens the right or opportunity to emigrate?	No.

B. FUNDING CRITERIA FOR COUNTRY

1. Development Assistance Country Criteria

a. FAA Sec. 102(c), (d). Have criteria been established and taken into account, to assess commitment and progress of country in effectively involving the poor in development, on such indexes as: (1) small-farm labor intensive agriculture, (2) reduced infant mortality, (3) population growth, (4) equality of income distribution, and (5) unemployment.

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b. FAA Sec. 104(d)(1). If appropriate, is this development (including Sahel) activity designed to build motivation for smaller families in programs such as education in and out of school, nutrition, disease control, maternal and child health services, agricultural production, rural development, and assistance to urban poor?

c. FAA Sec. 201(b)(5), (7) & (8); Sec. 208; 211(a)(4), (7). Describe extent to which country is:

(1) Making appropriate efforts to increase food production and improve means for food storage and distribution.

(2) Creating a favorable climate for foreign and domestic private enterprise and investment.

(3) Increasing the public's role in the developmental process.

(4) (a) Allocating available budgetary resources to development.

(b) Diverting such resources for unnecessary military expenditure and intervention in affairs of other free and independent nations.

(5) Making economic, social, and political reforms such as tax collection improvements and changes in land tenure arrangements, and making progress toward respect for the rule of law, freedom of expression and of the press, and recognizing the importance of individual freedom, initiative, and private enterprise.

(6) Otherwise responding to the vital economic, political, and social concerns of its people, and demonstrating a clear determination to take effective self-help measures.

d. FAA Sec. 201(b), 211(a). Is the country among the 20 countries in which development assistance loans may be made in this fiscal year, or among the 40 in which development assistance grants (other than for self-help projects) may be made?

e. FAA Sec. 118. Will country be furnished, in same fiscal year, either security supporting assistance, or Middle East peace funds? If so, has Congress specifically authorized such use of funds, as is assistance for population programs, humanitarian aid through international organizations, or regional programs?

3. Security Supporting Assistance Country Criteria

a. FAA Sec. 502B. Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights? Is program in accordance with policy of this Section?	No.
b. FAA Sec. 531. Is the Assistance to be furnished to a friendly country, organization, or body eligible to receive assistance?	Yes.
c. FAA Sec. 533(c)(2). Will assistance under the Southern African Special Requirements fund be provided to Mozambique, Angola, Tanzania, or Zambia? If so, has President determined (and reported to the Congress) that such assistance will further U.S. foreign policy interests?	Not applicable.
d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?	They will be made in each applicable case under the terms of the project agreement.
e. Arm. Sec. 113. Will security assistance be provided for the purpose of aiding directly the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?	No.
f. FAA Sec. 620S. Will security supporting assistance be furnished to Argentina after September 30, 1978?	Not applicable.

5C(2) - PROJECT CHECKLIST

Listed below are, first, statutory criteria applicable generally to projects with FAA funds, and then project criteria applicable to individual fund sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Security Supporting Assistance funds.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? IDENTIFY. HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT.

1. App. Unnumbered; FAA Sec. 653(b); Sec. 671

(a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that figure

(a) Congressional notification will be submitted following AID/W approval of the project.
(b) Yes.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of $100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes.
(b) Yes.

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

None other than notification to the People' Assembly of the signing of the project agreement.

4. FAA Sec. 611(b); App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per *the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?*

Not applicable.

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?

Yes.

6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multilateral organizations or plans to the maximum extent appropriate?

No, it is area specific and is not susceptible to a regional approach.

7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusion whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

This is not a production project and therefore will affect trade, production, labor, etc., only through improved health services and a healthier populace.

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

This unsolicited project by Boston University to assist a local medical school is a prime example of U.S. private sector initiative in the promotion and conduct of foreign assistance. Most U.S. financed technical assistance and commodity procurement will be from U.S. sources.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

The project agreement will specify the financial obligations of the U.S. and host country in accord with the intent of this section.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

Limited U.S. owned excess foreign currency is available and will be used to the extent possible. A request for waiver in accord with standard procedures will be incorporated in the project paper.

11. ISA 14. Are any FAA funds for FY 78 being used in this Project to construct, operate, maintain, or supply fuel for, any nuclear powerplant under an agreement for cooperation between the United States and any other country?

No.

FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(c); Sec. 111; Sec. 281a. Extent to which activity will: (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

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b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: [Include only applicable paragraph -- e.g., a, b, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.]

(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;

(2) [104] for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;

(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

(a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(b) to help alleviate energy problem;

(c) research into, and evaluation of, economic development processes and techniques;

(d) reconstruction after natural or manmade disaster;

(e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

8ib

(5) [107] by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.

c. FAA Sec. 110(a); Sec. 208(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on: (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained workerpower in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

g. FAA Sec. 201(b)(2)-(4) and -(8); Sec. 201(e); Sec. 211(a)(1)-(3) and -(8). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

2. Development Assistance Project Criteria (Loans only)

a. FAA Sec. 201(b)(1). Information and conclusion on availability of financing from other free-world sources, including private sources within U.S.

b. FAA Sec. 201(b)(2); 201(d). Information and conclusion on (1) capacity of the country to repay the loan, including reasonableness of repayment prospects, and (2) reasonableness and legality (under laws of country and U.S.) of lending and relending terms of the loan.

c. FAA Sec. 201(e). If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds $100,000, has country submitted to AID an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner?

d. FAA Sec. 201(f). Does project paper describe how project will promote the country's economic development taking into account the country's human and material resources requirements and relationship between ultimate objectives of the project and overall economic development?

e. FAA Sec. 202(a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources?

f. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

J. Project Criteria Solely for Security Supporting Assistance

a. FAA Sec. 531. How will this assistance support promote economic or political stability?

(a) The project will promote both economic and political stability by providing medical education and training to doctors and other professional medical personnel which is concentrated on meeting the basic health needs of the poor with special emphasis on preventive and environmental health and family planning. (b) Not applicable.

b. FAA Sec. 533(c)(1). *Will assistance under the Southern African Special Requirements Fund be used for military, guerrilla, or paramilitary activities?*

4. Additional Criteria for Alliance for Progress

[Note: Alliance for Progress projects should add the following two items to a project checklist.]

a. FAA Sec. 251(b)(1), -(8). Does assistance take into account principles of the Act of Bogota and the Charter of Punta del Este; and to what extent will the activity contribute to the economic or political integration of Latin America?

b. FAA Sec. 251(b)(8); 251(h). For loans, has there been taken into account the effort made by recipient nation to repatriate capital invested in other countries by their own citizens? Is loan consistent with the findings and recommendations of the Inter-American Committee for the Alliance for Progress (now "CEPCIES," the Permanent Executive Committee of the OAS) in its annual review of national development activities?

5C(3) - STANDARD ITEM CHECKLIST

Listed below are statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by exclusion (as where certain uses of funds are permitted, but other uses not).

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed?

   Since this is an unsolicited proposal by a U.S. university, the principal contract for assistance will be awarded on a non-competitive bid basis; however, commodity procurement will be in accord with standard regulations which will assure equitable opportunity for participation by U.S. small business enterprises.

2. FAA Sec. 604(a). Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him?

   Yes.

3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the U.S. on commodities financed?

   Egypt does not discriminate. The agreement will require that U.S. insurance be utilized on U.S. commodity shipments.

4. FAA Sec. 604(e). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity?

   Not applicable.

5. FAA Sec. 608(a). Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items?

   Yes, wherever practicable.

6. CMA Sec. 901(b). (a) Compliance with requirement that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates.

   No bulk commodity procurement is planned. Commodity transport will be in accord with standard regulations.

7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the facilities of other federal agencies will be utilized,

   Yes.

A7

are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?	
8. International Air Transport. Fair Competitive Practices Act, 1974 If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?	Yes.
B. Construction	
1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?	Yes.
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?	Yes.
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million?	Not applicable.
C. Other Restrictions	
1. FAA Sec. 201(d). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?	Not applicable.
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?	Not applicable.
3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-Bloc countries, contrary to the best interests of the U.S.?	Yes.
4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the U.S. or guaranty of such transaction?	Yes.

C

5. Will arrangements preclude use of financing:

a. FAA Sec. 114. to pay for performance of abortions or to motivate or coerce persons to practice abortions, to pay for performance of involuntary sterilization, or to coerce or provide financial incentive to any person to practice sterilization? Yes.

b. FAA Sec. 620(g). to compensate owners for expropriated nationalized property? Yes.

c. FAA Sec. 660. to finance police training or other law enforcement assistance, except for narcotics programs? Yes.

d. FAA Sec. 662. for CIA activities? Yes.

e. App. Sec. 103. to pay pensions, etc., for military personnel? Yes.

f. App. Sec. 105. to pay U.N. assessments? Yes.

g. App. Sec. 106. to carry out provisions of FAA Sections 209(d) and 251(h)? (transfer to multilateral organization for lending). Yes.

h. App. Sec. 117. to finance the export of nuclear equipment, fuel, or technology or to train foreign nationals in nuclear fields? Yes.

i. App. Sec. 501. to be used for publicity or propaganda purposes within U.S. not authorized by Congress? Yes.

UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

CAIRO, EGYPT

ANNEX E

December 11, 1979

CERTIFICATION FROM THE PROJECT OFFICER

This certifies that neither I, nor to the best of my knowledge and belief, any other AID employee solicited the proposal for Medical Education and Health Services in the Suez Canal Area from the offeror, Boston University, or had other prior contact with the offeror regarding the subject matter of the proposal other than to convey to the offeror an understanding of AID's mission and needs relative to the type of effort contemplated in the offer.

Merrill M. Shutt, M.D.
Project Officer
USAID, EGYPT

ANNEX F

CERTIFICATION PURSUANT TO SECTION

611 (e) of FAA 1961 as AMENDED

I, Donald S. Brown, Director, the principal officer of the Agency for International Development in Egypt, having taken into account, among other things, the maintenance and utilization of projects in Egypt previously financed or assisted by the United States, do hereby certify that in my judgment Egypt has both the financial capability and the human resources to effectively install, maintain and utilize the capital assistance to be provided for renovation of (a) Guest Quarters, (b) Ismalia General Hospital, (c) six (6) Rural Health Units and, (d) a primary care group practice facility.

This judgment is based upon general considerations discussed in the capital assistance paper to which this certification is to be attached.

Owen Cylke
Acting Director

12/19/79
Date

DRAFT

Mr. Donald S. Brown
Agency for International Development
American Embassy
Cairo, Egypt

Dear Mr. Brown:

The Government of the Arab Republic of Egypt is desirous of taking additional steps to improve health services, particularly primary care, by initiating an integrated medical education and health services program which relates educational investment directly to the health needs of the population.

There has been concern expressed by medical educators and health care providers that the approach to medical education in Egypt should be examined, and innovative techniques tested. The Ministry of Health and Suez Canal University have undertaken an initiative partially funded by PL-480 funds, to create a decentralized medical school which would attempt to fulfill some of the apparent deficiencies in contemporary medical education in Egypt, and would involve and serve a five governorate area comprised of the principal cities and a rather large population bordering on the Suez Canal. We understand that the Ministry of Health and Suez Canal University have collaborated directly in discussions which have led to this request for additional U.S. assistance, and will be the two implementing agencies.

The current plan is to develop a new medical curriculum and mode of teaching which focuses on primary health care designed to respond directly to the health needs of the populace. Special emphasis will be given to preventive and community-based health measures, including maternal and child health, nutrition, family planning and environmental sanitation. The education program will be conducted on the campus in Ismailia and in community based existing hospitals and health service centers in the governorates. This approach will provide the students with first-hand exposure to the health problems and needs in the field, an experience which students in other Egyptian medical schools rarely get. Emphasis will also be given to the managerial aspects of the physician's role as a health team leader when he begins practice after graduation. Student enrollment will be highly selective and intentionally limited to the numbers for which the institution can provide a quality, task-oriented education. The current intent is to start the first class in Suez Medical School in October, 1980.

We hereby request AID assistance in our efforts to make medical education more relevant to the needs of the people.

Major elements of the proposed assistance will include: (a) curriculum development; (b) development of clinical training sites; (c, development of primary care group practice; (d) design for renovation of building 29

to be used for the non-clinical components of the faculty of medicine; design, renovation/construction of rural health units; renovation of guest quarters for visiting consultants and selected portions of the Ismailia General Hospital; (e) office, training and medical equipment; (f) staff development/ continuing education; (h) strengthening management systems.

We estimate the cost of a five-year project activity would be approximately equivalent to forty-five million one hundred fifty thousand dollars ($45,150,000).

We request that AID provide approximately seven million, eight hundred thousand dollars ($7,800,000) for: technical assistance; design/ renovation/construction of health facilities; commodities; training and other costs.

It is our understanding AID will directly contract with Boston University Health Policy Institute for the First Phase (18 months) for up to two million seven hundred thousand dollars ($2,700,000) and that Phase II (42 months) will be implemented with the same contractor under a host country contract.

The Government of the Arab Republic of Egypt's share of the project in cost or in kind, would approximate the equivalent of thirty-seven million dollars ($37,000,000). The Government of the Arab Republic of Egypt will pay the costs of all land, salaries and benefits for Egyptian Government personnel and operating expenses of the facilities which are part of the project.

Subject to favorable consideration of this request, we would like to initiate this project as soon as possible.

Sincerely yours,

Gamal El-Nazer
Minister of State for Economic Cooperation

ANNEX H 1

Recommendation to Purchase Egyptian Pounds with U.S. Dollars

Over the life of the project $3.0 mil. will be used to support local currency expenditures that the Egyptian Government will make for specific items in support of this project. Dollar funds will be used in association with GOE disbursement of Egyptian pounds for the costs of the travel, per diem, and shipment of household effects of project consultants; related project support costs such as the travel of Egyptian participants, rental of office space, and procurement of secretarial and interpreting services; special costs associated with training, facilities renovation and related miscellaneous costs. The Mission will purchase Egyptian pounds with U.S. dollars provided by the project. The Egyptian pounds will in turn be made available to the various appropriate Egyptian entity(s) responsible for project implementation for disbursement in accordance with the agreements reached between USAID and the GOE in the project agreement.

One reason for using dollar funds in conjunction with Egyptian pound costs is that this represents an additional real resource to the Egyptian economy and suports efforts by the Egyptian Government to implement new initiatives. The amount of U.S.-owned local currency available to A.I.D. is restricted to

that presently allocated by OMB and has been fully allocated for other priority purposes. Approximately half of the local currency costs to be financed by AID under the project are for per diem, travel and related costs of U.S. personnel collaborating under the project.

The Egyptian contribution to this project, $5 million in foreign exchange and $37 million equivalent in local currency, is evidence of their support of and interest in this innovative activity.

Given the above considerations and the fact that the Suez Community Health Personnel Training Project is fully consistent with the Congressional Mandate of the Foreign Assistance Act to undertake activities designed to improve the economic position and quality of life of the poor majority, we have concluded project costs should be dollar funded.

ANNEX I

A. INITIAL DEVELOPMENT

A.1 The Unanimous Awareness of the Necessity of Reforming Medical Education in Egypt:

The evolution of the Faculty of Medicine at Suez Canal University has been a natural product of the growing fecling which amounted to deep-rooted conviction among all parties concerned with health care in Egypt that a decissive change in the system of medical education has become mandatory to bring it in consonance with the actual needs of health care delivery in the country. Discussions and recommendations of meetings and conferences at all levels have been accumulating over the past twenty years overwhelmingly pointing towards the necessity of change, yet with little more product than the emergence of a few more medical schools following the same old pattern, probably adding to the size of the problem. The important recommendations adopted by the " Symposium on Medical Education in Egypt," held in Fayoum, March 1978, where of paramount significance, not only because they spelled out the rationale and the directions into which change in medical education should proceed in Egypt but also because this symposium represented the collective views of all the Egyptian medical schools, Ministry of Health and the Doctors syndicate, representing the medical profession at large. The program of development of the Faculty of Medicine at Suez Canal University stems largely from the recomendations of the Fayoum Symposium.

A.2 The Basic Defects in Medical Education in Egypt :

A.2.1. The notorious explosive growth in the numbers of students admitted to medical schools in Egypt, probably in excess of the national needs, and definitely in sharp disproportion with the available resources, is admittedly an important undermining factor which needs immediate remedial action. It is an over-simplification

however to consider it the main defect. Two other basic defects characterize our system of medical education.

A.2.2. The fact that the contents of the present curricula (actually the same curriculum is being followed in the nine medical schools) are incongrous with the actual health needs of the community in Egypt. There are simply no defined goals for the educaticnal process in the health fields in Egypt.

A.2.3. Both the nature of the curriculum and the educaticnal strategies applied fall for behind the requirements of the scientific progress in the contemporary would. The explosion in knowledge and the need for continuing self-learning have their implications which are far from being met.

A.3. Why in Suez Canal University ?

All that is mentioned above is common knowledge to workers in the health fields in Egypt. However, for the qualitative transition from the stages of frustration, adequate diagnosis and recomendation of the therapeutic strategies to actual implementation certain circumstances and conditions were required to provide the needed environment that could support the change. Such were provided by the Suez Canal University.

A.3.1. The Goals of the Suez Canal University :

The presidential Decree that authorized the establishment of the Suez Canal University stipulated that it should include a Faculty of Medicine. This by itself was no sufficient basis for developing an innovative medical school where it not for the deep sensitivity of this University to the needs of the community, meeting of which being one of the main stated goals of the University. It was "natural" therefore for the leadership of the Suez Canal University to adopt the difficult but challenging task of developing an innovative medical school that would address itself to the problems of

medical education in Egypt and the actual health needs of the community in the Suez Canal Zone and Sinai. The strong and continuing support of the University was decissive in the development of our Faculty.

A.3.2. The Community in the Suez Canal Zone :

An openness to change, and awareness of the challenging situation arising from geopolitical considerations are features of the rapidly developing community inhabiting the Suez Canal Zone. An appreciation of the need for scientific planning as a prerequisite for rational solutions has spared us the notorious pressure by the local authorities that has resulted in the premature, almost over night, opening of other Faculties in other situations.

A.4. The Ministry of Health :

During the last years, there has grown a strong emphasis in the Ministry of health on the development of a rational Health Manpower Development Policy that would meet the health needs of the country both quantitatively and qualitatively. The Universities have undoubtedly shared in these studies and plans. The bold invitation however to the Ministry of Health to actively share in the process of developing a Faculty of Medicine side by side with one of the Universities was yet to be contemplated. This step was probably inspired by the recommendations of the Ministerial Conference for Health and Education held in Tehran (Feb/March 1978). When the Suez Canal University offered this suggestion it was strongly welcomed by the Ministry of Health at all administrative levels. The Permanent Committee for Health Services and Medical Education in the Suez Canal Zone was formed as a directing body to this unique cooperation in developing the new Faculty. Membership from the Ministry of Health include the First Under secretary, the Ministry's Councellors, the Directors of Health Services in the three Suez Canal Governerates and the Governerates of North and South Sinai. This unprecedented cooperation is a credit to both the Ministry of Health and the Suez

Canal University and is a major contribution in the develcpment of the Faculty of Medicine.

A.5. The Medical Community: The Other Medical Schools and the Doctors Syndicate :

A real allergy, amounting to antipathy, has justifiably grown among most medical educators against the opening of further medical schools in Egypt. The president of the Doctors Syndicate, Professor Hamdy El-Sayed, himself a medical educator, has spared no effort in propagating this trend, much to the satisfaction of the majority of all those dealing with health and Medical education in Egypt. When we presented our program as a solution to the present situation, we had to live up with this atmosphere. To our great satisfaction, and according to our calculated expectation we were met by a thoughtful, critical, very responsible and ultimately a welcoming attitude that is at present so powerful that admittedly we are short of fully utilizing the expanding field of guidance, assistance and cooperation generously laid open ahead of us by our colleagues both in the "mother" and more recent sister medical schools.

A.6. International Cooperation and Foreign Aid :

The Faculty of Medicine at Suez Canal University is a national experience which is the product of a trial at a careful assessement of the needs of medical education and health care in Egypt, with awareness of the world progress in similar situations. Whether during development or implementation, this will depend primarily and mainly on the rational mobilization, and efficient utilization of our national resources, human and otherwise. At the same time however, we are intensely aware of the fact that we are stepping into a new field, practically with no precedent in which the limits of our available experience and resources should not be underestimated. Consequently, we welcomed the assistance and cooperation offered to us by our colleagues from the Health Policy Institute, Boston University, USA

in the development of our Faculty, particularly in the areas of the overall planning according to the health needs, curriculum development and post-graduate education of our prospective faculty members. Moreover, the development of this school has attracted a strong interest, so for largely missing in the area of medical education in Egypt from some international agencies, foremost the U.S. agency for International Development and the International Health Component of the U.S. Department of Health, Education and Welfare.

B. STEPS IN DEVELOPMENT

B.1. Appointment of the Dean :

The starting point was in November 1977. Two Professors of Medicine, Professor Zohair M. Nooman and Professor Esmat S. Ezzat were seconded from Assyut University to Suez Canal Univ. to initiate the foundation of the Faculty of Medicine . In October 1978 the former was appointed as Dean to that Faculty. The initial phase occupying most of the year 1978 was characterized by extensive discussions and innumerable meetings during which consultations with experts in medical education from most Universities, the Minister of Health and colleagues working at various levels in the Ministry, local authorities in the Suez Canal Governerates, local community leaders and health care providers etc... were conducted. As a product of this stage it was decided that the development of the Faculty of Medicine in its desired format is feasible. Moreover, the initial steps in the cooperation with the Ministry of Health were taken, and the broad goals of the Faculty gradually unfolded.

B.2. Definition of Institutional Goals :

The broad goals, derived as a mentioned above gained in definition as never faculty members joined us with contribution from the cooperating colleagues from the Health Policy Institute, Boston University. Five Institutional goals are recognized at present :

B.2.1. To qualify physicians whose primary objective will be to provide health care in a combined hospital-community system with major emphasis on primary care.

B.2.2. To relate medical education to the needs of the society so that the physician would be able to diagnose and manage the community health problems.

B.2.3. To develop and implement together with Ministry of Health and other health care delivery bodies an integrated system for comprehensive health care delivery and health manpower development in the Suez Canal Area and Sinai. Such system considers the limits of National per capita health expenditure at present and in the forseeable furture. The regional health service facilities will be used as the locus for education and training.

B.2.4. To develop and provide for health personnel programs of post-graduate training and continuing education.

B.2.5. To develop research programs that address primarily the actual health needs of the community.

B.3. Recruitment and Training of Teachers :

B.3.1. The guidlines that were put for the teaching staff recruitment and training policy were:

B.3.1.a. Sufficient numbers of teachers should be available at the time of arrival of students.

B.3.1.b. The introduction of newer essential specialities that serve the institutional goals e.g. general practice, community medicine, socio-medical sciences, and health administration.

B.3.1.c. Emphasizing the training of basic medical scientists, an area which has particularly atrophied in Egyptian medical education.

B.3.1.d. Prospective teachers should accept the new philosophy of the school and show readiness to perform the extra loads implicated in serving within its goals.

B.3.2. Steps accomplished so far (Appendix -1) :

B.3.2.a. Junior staff

Seventy graduates from other medical schools were selected from 700 applicants and appointed in September 1978 as demonstrators and assistant lecturers. They were placed as post graduate students starting from 1978/79 academic year in the parent medical schools at Cairo, Alexandria and Ein-Shams Universities to obtain their Ph.D. or M.D. in various fields. Forty other junior staff members (not included in Appendix 1) are being appointed to start their post-graduate studies in the academic year 79/80. Worthy to be mentioned is that this latter batch includes two demonstrators, who will be trained and qualified in General Practice to start this speciality for the first time in Egyptian Universities.

In August 1979, eight junior staff members will be sent for training and obtaining Ph.D. in selected basic medical sciences in Boston University. They were carefully selected by a joint panel from the Faculties of Medicine at Suez Canal and Boston Universities. A ninth member will join them as a fulbright fellow. The study program has been carefully designed to be consonant with the goals of the medical school in addition to particular exposure to the principles of medical education.

B.3.2.b. Senior Staff :

So far, Fifteen senior staff members, including the dean have been appointed (see Appendix 1). They are all clinicians. Within the next few months an additional number of

basic medical scientists will hopefully be appointed. There is a serious lack of suitable senior Public Health and Community Medicine applicants. This reflects the meagre attention given to this important area in our present educational system. The senior staff members are carrying out the following functions :

- Sharing in the developmental processes, e.g. curriculum development, preparation of teaching sites and material etc...
- Supervising the training of junior staff.
- Sharing in health care planning and delivery (see B-6 below).

B.3.2.c. An introductory workshop on medical education (see Appendix B) was held in the University campus in Ismailia in May 5-10 1979 conducted by Professor Ascher Seegall, Professor of Medical Education and Director of the Centre for Educational Development in Health, Boston University. All senior and junior Faculty members participated. Further workshops will be held for newer members and at higher levels.

Comment : We are aware of a basic contradiction in our staff recruitment policy. To "guarantee" the availability of adequate number of teachers to carry out the heavy duties of an innovative curriculum as the students arrive, we recruited a rather big number of junior staff which, besides being graduated from the traditional medical schools will have to continue their post-graduate training mainly in those schools. This is a particular requirement of the Egyptian situation which requires lengthy explanation.

But how are they going to implement an innovative curriculum in a community based medical school ? Carefully designed workshops and meetings with thorough mixing and interaction of thoughts and activities may partially solve the contradiction in the transitional stage.

B.4. Curriculum Development :

The corner stone of the whole program is the development of an appropriate curriculum. Major attention is being directed to this process which is still in its early phases.

B.4.1. Approach :

B.4.1.a. The curriculum should serve the institutional goals which should be observed both in the general design as well as in the details.

B.4.1.b. Competency-based objectives, derived from a task analysis of the optimal physician performance need to be first defined. These competencies, analysed as knowledge, skills and attitudes represent the curriculum objectives.

B.4.1.c. Problem solving and promotion of the ability at self-learning determine the educational strategies.

B.4.1.d. Integration of basic and applied medical sciences should be attempted as far as possible with early exposure to clinical medicine and public health from the first year.

B.4.1.e. The social and moral aspects of medical practice and the committment to community needs should permeate the whole educational process.

B.4.2. Steps accomplished :

The following activities committees are in progress :

B.4.2.a. Study of the health needs of the community. This is part of the activities of the Dean's Planning Unit working with consultation of Dr. William Bicknell, Director, Special Health

Programs, Health Policy Institute, Boston University.

B.4.2.b. The definition of the optimal physician performance, this is linked also with the previous activity.

B.4.2.c. The curriculum development unit, fed from the above two activities, is considering curriculum options and designing the 6 years curriculum with guidance and consultation by Prof. Ascher Seegall, Professor of Medical Education, Boston University.

B.5. Physical Facilities :

It is recognized that the buildings and equipments needed to accomodate and support the development of our program should observe-among others, the following important considerations :

- The general institutional goals
- The nature of the curriculum
- The limited construction and operational costs available.

B.5.1. The Basic Medical Sciences and Administration:

A large building (Building 29 within the Ismailia Campus) is being renovated to accomodate the basic medical sciences, library, medical education unit and learning resources centre, public health department and administration. It is a strong 3 story building with 7000+ M^2 area. It is planned to be ready by mid-1980.

B.5.2. Facilities for Clinical Training :

Clinical training will take place in selected regional health care delivery sites including Ministry of Health Hospitals, out-patients, polyclinics, rural hospitals and rural health units situated in the various Governorates of the Suez Canal Zone and Sinai. Ms. Suzan Christie Shaw, Special Consultant Architect in Health Facility Planning, supprcted by U.S. Agency for International Development, has conducted a valuable study

of facility development suited for the purposes of education and efficient health care delivery and produced important recommendations . Minor renovations now under consideration will be necessarily required.

B.5.3. Equipment :

The University will fund the equipment of the basic medical sciences facility. Teaching material which will include a substantial audio-visual component might need some additional funding.

The Ministry of Health will contribute largely to the equipment of the clinical facilities.

B.6. Sharing in Health Care Delivery :

Active participation of medical personnal from the Faculty of Medicine in the delivery of health care side by side with their colleagues from the Ministry of Health, who will also contribute to the educational process, is a basic component of the philosophy of the Faculty of Medicine at Suez Canal University. Accordingly, a high quality clinical service is starting to be delivered in the General Hospital at Ismailiah, which has been largely equipped by the Ministry of Health. Among the credits of this service, it is smoothing out the notorious incompatibilities between University and Ministry of Health personnel which undermined previous attempts at cooperation in other settings. It certainly creates the suitable pleasant atmosphere which the students will face when they arrive

Following the consolidation of the working conditions in Ismailiah General Hospitals, other sites in other Governerates will be the seat of similar cooperation in health care delivery.

C. ADMISSION OF THE FIRST CLASS :

October 1980 has been put as the target date. By that time, the basic sciences building should have been completed, selected clinical facilities prepared and most important, the curriculum should have been developed with detailed first and second year components. We are confident that by that time adequate number of staff members will be available.

D. PROJECTED NUMBER OF STUDENTS :

A limit of 50 students per class, selected from the Suez Canal and Sinai Areas, is our target, with a total student body of 300 in 6 classes.

E. THE DIFFICULT TASKS :

The whole thing is admittedly difficult. But we are measuring the validity and integrity of our program by our ability to overcome, circumvent and sometimes survive the difficulties. Funding is basically within the affordable resources of the cooperating parties, the University and the Ministry of Health, with good chances of foreign support being made available in the near future.

Two tasks however are felt to be particularly difficult and are worthy of mentioning :

E.1. Developing the Curriculum :

The type of innovative curriculum we are developing is very exacting and strains our resources and expertise. Inspite of our concentrated efforts, we feel that strong support in the area of curriculum planning is required both from the Egyptian and the international experts. This is if we are to finish with a solid curriculum within the targeted time.

E.2. Cooperation with the Ministry of Health :

Although we consider our experience of cooperation with

ANNEX I

THE FACULTY OF MEDICINE
AT SUEZ CANAL UNIVERSITY
INTERIM REPORT
(NOVEMBER 1977-JULY 1979)

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the Ministry of Health to be unprecedently successful, we do feel that this cooperation is so vital to the basic philosophy of our school that its continuity and further development should recieve the complete understanding and conviction of both the University and the Ministry of Health at all levels.

Mostly needed at present for the fulfillment of our program, besides continuous creative work on the part of all Faculty members, is to entertain the help and support of our seniors and colleagues in the other Universities and in the authorized University councils, and to the same extent, to institutionalize our cooperation with the Ministry of Health within a solid, stable framework.

Ismailiah, July 3rd, 1979.

PROFESSOR ZOHAIR M. NOCMAN
DEAN, FACULTY OF MEDICINE
SUEZ CANAL UNIVERSITY.

ANNEX J

بسم الله الرحمن الرحيم

SUEZ CANAL UNIVERSITY
FACULTY OF MEDICINE

INTRODUCTORY WORKSHOP
ON
THE BASIS OF MEDICAL
EDUCATION AT THE FACULTY
OF MEDICINE SUEZ CANAL UNIVERSITY

MAY 5 - MAY 10

1979

ANNEX

Day One

Saturday 5th May 1979

9.00 - 9.30	Health needs and health services in Egypt.	"Dr. A. Sirry"
9.30 - 10.00	Response of health service to health needs.	"Dr. M.Moubarak
10.00 - 11.00	Small groups discussion	
11.00 - 11.45	Plenary Session	"Dr. H.Hamdy"
11.45 - 12.45	Opening Ceremony	

Prof. Dr. A. Osman
Dr. A.Sirry
Prof. Dr. W.Bicknell
Prof. Dr. A.Segall
Prof. Dr. Z.Nooman

12.45 - 13.15	Lunch Break	
13.15 - 12.15	Response of Medical Schools to the health needs.	"Prof. Dr. Y.Batawy"
14.15 - 15.15	Small group discussion	
15.15 - 16.00	Plenary Session	"Dr. H.Hamdy"

Day Two

Sunday 6th May 1979

9.00 - 9.45	Health needs and services in Suez Canal Zone. Dr. S.Banoub "PortSaid" Dr. A.El Khazendar "Ismailia Dr. M.El Matary "Suez"
9.45 - 10.15	Response of S.C. Medical School to the area health needs "Prof S.Hoosman"
10.15 - 11.15	Small group discussion
11.15 - 12.00	Plenary Session "Dr. H.Hardy"
12.00 - 12.30	Lunch Break
12.30 - 13.30	Curriculum development: Different approaches "Prof. A. Segall"
13.30 - 14.30	Small group discussion
14.30 - 15.15	Plenary Session "Dr. H.Harry

Day Three

Monday 7th May 1979

9.00 - 9.30	Educational Objectives.	"Prof. Emad Fadly" "Dr. S. Bedeir" "Dr. M. Elias" "Dr. H. Hamdy" "Prof. A.Segall"
9.30 - 10.30	Small group discussion	
10.30 - 11.15	Plenary Session	"Dr. H.Hamdy"
11.15 - 11.45	Break	
11.45 - 13.45	Small group discussion. (Continued)	
13.45 - 14.30	Plenary Session	"Dr. H.Hamdy"

N.B:

Prepare objectives for unit of instructions.

ANNEX J

Day Four

Tuesday 8th May 1979

9.00 - 10.00	Educational Evaluation "Prof. M.Sabbour"
10.00 - 11.00	Small group discussion
11.00 - 11.45	Plenary Session "Dr. H.Hamdy"
11.45 - 12.15	Break
12.15 - 13.15	Teaching Strategies "Teaching Methods"
13.15 - 14.15	Small group discussion
14.15 - 15.00	Plenary Session "Dr. H.Hamdy"
17.00	Review of Educational Objectives.

ANNEX J

Day Five

Wednesday 9th May

9.00 - 10.10	Review of units of instructions in small groups.
10.15 - 11.30	Presentations at Plenary Session
11.30 - 12.00	Break
12.00	Opened

ANNEX. J

Day Six

THURSDAY 10TH MAY 1979.

WHAT NEXT ???

ANNEX. J

Day Six

TUESDAY 10th MAY 1979.

WHAT NEXT ???

ANNEX K

SUEZ CANAL UNIVERSITY

FACULTY OF MEDICINE

THE DEAN'S OFFICE

A. ACADEMIC STAFF MEMBERS

1-	Prof. Zohair Mohamed Nooman		Medicine (Dean)
2-	Prof. Essmat Sh. Ezzat		Medicine
3-	Dr. Fathy A. H. Mekledy	(Lecturer)	Medicine
4-	Dr. Hosny El-Rawady	(Lecturer)	Medicine
5-	Prof. Ahmed Magdy		Surgery
6-	Dr. Hossam Hamdy	(Lecturer)	Surgery
7-	Dr. Asad Amen Wahba	(Lecturer)	Surgery
8-	Dr. Haggag Gaber Hassan	(Ass. Prof.)	Aneathesia
9-	Dr. Nabil Mahmoud El- Ennah	(Lecturer)	Aneathesia
10-	Dr. Zeinab Abd El-Aziz	(Lecturer)	Pediatric
11-	Dr. Abd El-Malek Nassar	(Lecturer)	Chemical Pathology
12-	Dr. Fikry Goubran Esskandar	(Lecturer)	Clinical Pathology
13-	Dr. Ibrahim Rakha	(Lecturer)	Orthopedic
14-	Dr. Mohamed E. Azzam	(Ass. Prof.)	Obstet Gyn.
15-	Dr. Mohamed Refatt Ghoneim	(Lecturer)	Obstet Gyn.

ANNEX K

SUEZ CANAL UNIVERSITY

FACULTY OF MEDICINE

THE DEAN'S OFFICE

B. ASSISTANT LECTURERS

I - Fayez M. H. LABIB	PEDIATRIC
2 - Mohamed H. M. HOSSEIN	"
3 - Hesham A. F. MOHAMED	"
4 - Khalil O. KHALIL IBRAHIN	OBEST. & GYN
5 - Mamdouh E. Said	"
6 - Mohamed R. A. El SHAFIEY	"
7 - Hamed El Metwaly MEGAHED	"
8 - Samy M. SANY SHAABAN	UROLOGY
9 - Gamal El. DIN M. H. GHOUNEIM	"
IO- Mahmoud S. M. Abdel- Megid	ORTHOPEDICS
II- Allaa E. El ZOUHEIRY	"
I2- Adel A. S. GHOUNEIM	"
I3- Nasr El Din A.M. AMER	"
I4- Moussa A. MOUSSA	"
I5- Mohamed A. BISSAR	"
I6- Mohamed El S. MOUSSA	"
I7- Adel M. MAMAM	"
I8- El Said M. G. El DOSSOUKY	SURGERY
I9- Mostafa A. HOSSNY	"
20- Mostafa A. M. Abu ALY	"
2I- Ahmed M. E. ALLABAN	"
22- Nabil Hassan M. KHALIL	NEURO -SURGERY
23- Abdel- Rehiem I. Abu El AZAIEM	"
24- Mohamed Nabil S. ATA	MEDICINE
25- Mohamed M. GARBIAH	"
26- Abdel Raouf M. El DEEB	"
27- Naser El Din A. Abdel-KHFAR	"
28- Ibrahim Mohamed Bagdady	"
29- Mohamed Abd A. Abu El Makarem	ANEATHESIA
30- Magdy Ahmed CAF	E. N. T.
3I- Nashat M. Fahmy El Garia	PHYSICAL THERAPY

ANNEX K

SUEZ CANAL UNIVERSITY

FACULTY OF MEDICINE

THE DEAN'S OFFICE

C. Clinical Demonstrators

I- Gamal M. Osman Gad El Rab	Anatomy
2- Shams El Din S. Abbass	"
3- Aly S. A. El Minshawy	Physiology
4- Zeinab M. Abdel- Razik	"
5- Sofy A. Boktor	"
6- Essam A. S. Oaf	Biochemistry
7- Emad I. Abdel Fatah	"
8- Ahmed M. El Fassakhany	Histology
9- Mohamed F. A. Fahmy	Microbiology
IO- Ashraf S. Sliem	"
II- Zakaria A. Soliman	"
I2- Hassan Nasr ElEsslam	"
I3- Nader A. Mourad	Pathology
I4- Sherif I. Helmy	"
I5- Mohamed O. I. El Oada	"
I6- Salah El Din M. El Dorini	"
I7- Nadia M. Reda Hassan	"
I8- Nadia Hosny Rizkallah	Puplic Health
I9- Fathy M. M. El Gamal	"
20- Ismaiel Sh. Hamed abd alla	"
2I- Adel M. Meshreky	"
22- Mostafa A. Mostafa	"
23- Mohamed Samy M. Afify	Immunology
24- Aly abd ElMegid Elhagg	"
25- Youssef L. Tawfik	Parasitology
26- Ahmed Nabil M. Abu-Talib	Pharmacology
27- Mahmoud M. Farg Ali	"
28- Mohamed Saleh M. Hassan	"
29- Hoda W. Tawfik ElGavly	"
30- Mohamed A. Mahmoud Yousif	Obst&Gyn.
3I- Mohamed A. A. Zaatar	Medicine

ANNEX 2

SUEZ CANAL UNIVERSITY

FACULTY OF MEDICINE

THE DEAN'S OFFICE

C. Clinical ... [illegible]

32-Mahmoud Ahmed A. El-Sisy	[illegible]
33-[illegible]	"
34-Ahmed M. El-[illegible]	Urology
35-Mohamed Saleh El-Din Shidr	Laparoscopy Medicine
36-S. Islam Ahmed	"
37-A. Ahmed Serwat	"
38- M. S. Abdel Aziz	"
39- Seif El-Nasr Mahmoud	"

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ACTION: AID 6
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SUBJECT:HEALTH: SUEZ CANAL - BOSTON UNIVERSITY PROPOSAL
REF: CAIRO 19869

1. FOLLOWING COMMENTS REPRESENT INITIAL PROJECT COMMITTEE REVIEW OF PROPOSAL COMPONENTS AND RECOMMENDED PROCEDURES FOR REVIEW. IT DOES NOT REPRESENT NEAC LEVEL REVIEW OR IN-DEPTH TECHNICAL REVIEW OF PROPOSAL.

2. PROJECT COMMITTEE AGREED WITH PROPOSED USAID COURSE OF ACTION PER REFTEL AND THAT BASIC ELEMENTS OF PP ARE CONTAINED IN PROPOSAL WITH FOLLOWING EXCEPTIONS: (A) DISCUSSION OF CONSISTENCY OF THE PROJECT WITH CDSS, OVERALL HEALTH STRATEGY AND OTHER HEALTH/POPULATION PROJECT ACTIVITIES; B) INPUTS OF SCU AND MOH, PARTICULARLY FINANCIAL STATUS OF SCU FACULTY OF MEDICINE TO SUPPORT THEIR INPUTS AND SUSTAIN STAFF; (C) ECONOMIC IMPLICATIONS FOR GOE IF ACTIVITIES REPLICATED; (D) MISSION PLANS FOR IMPLEMENTING MECHANISM (DISCUSSED BELOW) AND (E ENVIRONMENTAL IMPACT AND STATUATORY CHECKLIST.

3. BELIEVE ABOVE ITEMS SHOULD BE READILY AVAILABLE AND COULD BE PREPARED AS BRIEF ANNEX OR INTRODUCTION TO PROPOSAL. SE NO NEED TO RESTRUCTURE PROPOSAL IN PP FORMAT.

4. REGARDING AN APPROPRIATE CONTRACTING MECHANISM, SUGGEST COLLABORATIVE ASSISTANCE APPROACH BE FOLLOWED QUESTION REMAINS AS TO WHETHER IT WOULD BE CONTRACT (ACQUISITION OF SERVICES) OR COOPERATIVE AGREEMENT (ASSISTANCE TO UNIVERSITIES TO IMPLEMENT THEIR PROPOSED ACTIVITY UNDER PRESCRIBED GUIDELINES). FYI PD-65 IS NOW APPLICABLE TO THE COOPERATIVE AGREEMENT AS DESCRIBED IN HANDBOOK 1, SUPPLEMENT B, PAGE 25-7. SUGGEST USAID REVIEW THESE REFERENCES AND MAKE RECOMMENDATIONS FOR APPROPRIATE MECHANISM IN PROJECT SUBMISSION. VANCE
BT
#3673

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ANNEX M

SUEZ CANAL UNIVERSITY
FACULTY OF MEDICINE
ISMAILIA — EGYPT

The Dean's Office

OCT 18 1979

ACTION TO HSTD DEPUTY

Dr. Merrill Shutt
Director, Health and
Population Office, USAID
American Embassy
Cairo.

October 9th, 1979.

Dear Bud,

I am responding to your enquiry about the budget allocated to the Faculty of Medicine.

1. I am enclosing a copy of the Memo presented by the University to the Ministry of Planning in July 15th 1979 concerning the budget requested and needed by the University during the years 1980-1984.

The table in the bottom of the 10th page (under the Faculty of Medicine) reads as follows (in thousand Pounds)

Year	Total	Construction	Equipment	Vehicles	Currency Local	Currency Foreign
1980	2500	1000	1450	50	1750	750
1981	2500	2000	500	-	2250	250
1982	4000	2500	1500	-	3250	750
1983	3500	2000	1500	-	2750	750
1984	1000	1000	2000	-	2000	1000
Total	15500	8500	6950	50	12000	3500

Please note :-

BEST AVAILABLE COPY

a. This represents the money requested and not that allocated.

b. The total LE 15,500,000 requested for the Faculty of Medicine amounts to 40% of the total budget requested for the whole University Le 38,370,000. The remaining 60% will be distributed to the other Faculties.

c. The sums mentioned represent the " Investment"section of the budget, so called " 3rd section " which is under the control of the Ministry of Planning. Sections I and II which concern salaries and current expenditure do not appear in this budget. In our case these will include items like salaries for faculty

SUEZ CANAL UNIVERSITY
FACULTY OF MEDICINE
ISMAILIA — EGYPT

The Dean's Office

members, non professional staff, student affairs etc.. Exact figures for the latter sections are not available now.

At present however, we have 15 Senior and 80 Junior faculty members on our pay roll. New members are progressively recruited and it is anticipated that a stable level of about 200 faculty members, Junior and Senior will be on the pay-roll with the full functioning of the School.

2. As of 1979, the University has allocated a 3 storey-building within its existing campus at Ismailiah. Total area 7400 meter square. Renovation has already started at an estimated cost of LE 750,000 renovation only.

Other expenses during 1979 include faculty members' salary and sending 8 Junior faculty members for Ph.D. training in USA which will take 4-5 years. Others will follow during 198- and subsequent years.

3. The share of the Ministry of Health :

This is an extensive share, although difficult to translate into specific budget items. Potentially all or any of the MCH facilities within the Suez Canal Area and Sinai, which cover 5 Governerates are available for utilization by our faculty members together with MCH colleagues who will share in our training / service program. The following facilities will be a made available for training by the time we start admitting students, hopefully October 1980 :

Ismailian Governerate : The Rural Health Units at: Sabe Sawasi El-Sharkian, Abu Sewair, Seradium, Abo-Atwa
The Rural Hospital at Abu Sultan.
The new Health Center in Ismailiah (under construction)

Port-Said : The Port-Foad General Hospital (140 beds)
The new Health Center in Port-Said.

As mentioned under the PL 480 agreement, signed by the Minister of Health on July 20 1979, page "2-b" " The MCH has assumed the obligation to upgrade MCH facilities and programs in the five Suez Area Governerates to meet the requirements of clinical training, continuing education of post-graduates and MCH physicians."

ANNEX M

SUEZ CANAL UNIVERSITY
FACULTY OF MEDICINE
ISMAILIA — EGYPT

The Dean's Office

Finally, strange enough, I am not aware of any medical school existing in Egypt, that had one year before its opening- the number of faculty members, facilities, budget or above all the planning which we have now.

We realize however that no governmental establishment is awarded the whole sum of money that is requested, also, because of the unique nature of our program, we do need technical assistance, hence our obvious need of foreign assistance for the timely and early activity accomplishment of the development of the Faculty of Medicine at Suez Canal University.

Thank you for your continuing interest and support.

Yours Sincerely,

Prof Zohair M. Nooman
Dean, Faculty of Medicine
Suez Canal University

الإدارة العامة

ACTION TO #STR #04
ACTION TAKEN DATE 11/24
MAN INITIALS

ANNEX N

تاريخ

Cairo, November, 9th, ...

Dr. Merril Shut
U.S. A.I.D.
Cairo.

Dear Dr. Shutt,

Reference to our meeting early this month, concerning the input of the Ministry of Health in the project "Medical Education and Health Services in Suez Canal Area", between the Ministry of Health, Suez Canal School, and Boston University.

As for the first phase of the project, it was agreed to concentrate ... upon Ismailia Province.

The chosen centers are :-

Item	Acits				Annual Expences	
Unit	Surface Area	Price By LE	Building	Equipment	Salaries	Current Expences
1- Abu Atwa Rural Health Unit.	...000 M²	40.000	......	4.000	.....	.....
2- El Sebur Cherbin Rural Health Unit	3.000 M²	60.000	.....	4....	.....	.....
3- Abu Sueer Rural Health Unit	..... M²	39.000	.....	4.000	.....	.....
4- Serabium Rural Health Unit	..... M²	45.000	.....	4.000	.....	.....
5- Abu Sultan Rural Health Unit	..... M²	800.000	.....	.....	.....	7.600
6- Ismailia General Hospital	..... M²	900.000	.....	.....	.....	75.000
7- Urban Health Center	..... M²	350.000	.....	30.000	.....	.....
Total		.....	.....	.....	.....	.....

الإدارة العامة ____

التاريخ ____

As for the second phase, it will be discussed according to the implementation of the first phase as agreed upon. In due time we will forward our comments.

I would like to draw your attention to two points raised in the project presented by Dr. Bicknell.

1- In the organization chart, he mentioned the two co-directors, one from Boston University (himself), the second from Suez Canal, (Dean [illegible]). It was agreed upon during the discussions that there should be third co-director from the Ministry of Health. You may remember the Minister himself nominated Dr. Abdel Ghaffar Khallaf as the third co-director.

2- It was not clear in the renovations of the premises to be carried during the first phase that the out patient department of Ismailia General Hospital is included. As you see from the [illegible] table that this hospital needs renovations so as to cope with the teaching program.

Yours Sincerely,

Dr. A. G. Khallaf
Under Secretary,
Foreign Health Relations

ANNEX O

DRAFT:Gary B. Bisson
December 10, 1979

PROJECT AUTHORIZATION

Name of Country: Arab Republic of Egypt Name of Project: Suez Community Personnel Training

Project No.: 263-0136

1. Pursuant to Part II, Chapter 4, Section 531 of the Foreign Assistance Act of 1961, as amended (Economic Support Fund), I hereby authorize the Suez Community Health Personnel Training Project for the Arab Republic of Egypt ("Cooperating Country") involving planned obligations of not to exceed Seven Million Eight Hundred Thousand United States Dollars ($7,800,000) in grant funds over a five year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing the foreign exchange and local currency costs of goods and services required for the Project.

2. The Project will assist Egypt to improve health services, particularly primary care, by developing and initiating in selected Governorates in the Suez Canal Area an integrated medical education and health services program which relates educational investment directly to the health needs of the population.

   Project elements involve two main phases and will include primarily creation of a decentralized medical school and development of a new curriculum and mode of teaching focusing on primary health care designed to respond directly to the health needs of the populace. An

institutional grant, including a cooperative agreement, between A.I.D. and Boston University (BU) may initiate implementation of the A.I.D. contribution to the Project.

3. The Project Agreement which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and delegations of authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4. a. Source and Origin of Goods and Services

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

b. Conditions Precedent to Disbursement

(1) Initial Disbursement

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as the parties may agree otherwise in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) A statement of the names and title with specimen signatures of the person or persons who will act as the representatives of the Grantee;

(b) Evidence of creation of a Dean's Planning Unit within Suez Canal University (SCU) to coordinate SCU and the Ministry of Health (MOH) objectives, including a description of MOH participation and a description of function of the Unit.

(c) Evidence of creation of a Medical Education Unit within the Dean's office at SCU Faculty of Medicine (SCU/FM) for implementing terms of curriculum development, with description of personnel to serve extra-mural consultant panels and intra-mural committees.

(d) Such other documentation and materials as A.I.D. may reasonably require.

(2) Conditions Precedent to Disbursement for Renovation

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for renovation the Grantee shall, in each case of renovation, except as the parties may agree otherwise in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) Evidence that Egyptian budgetary resources have been allocated for the ongoing operating costs of health facilities to be renovated before funds may be disbursed.

(b) Evidence of engineering designs, adequate supervisory services, and cost estimates for the planned construction.

(c) Evidence of execution of satisfactory construction contract(s) with firm(s) acceptable to A.I.D.

(d) Such other documentation and information as A.I.D. may reasonably require.

(3) Conditions Precedent to Disbursement for Equipment

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for the procurement of equipment, except as the parties may otherwise agree in writing, Grantee shall cause to be furnished to A.I.D., in form and substance satisfactory to A.I.D., a procurement plan which will include identification of procurement procedures to be followed for the Project.

(4) Conditions Precedent for Disbursement for Phase II

Prior to disbursement for activities during Phase II of the Project, except as the parties may otherwise agree in writing, a Phase II funding proposal shall be prepared, acceptable to and approved by A.I.D., Grantee, SCU and the Ministry of Health which will include a work plan for all activities of Phase II (including those begun in Phase I and to be continued during Phase II) and a detailed budget and implementation timetable.

c. Covenants

The Grantee shall:

(1) Assure commitment by cooperating agencies, with responsibility to staff and operate facilities to be renovated as part of the project, to include in their future budget plans for the timely recruitment and funding of staff and provision of funds to meet other operating costs.

(2) Carry out the project with due diligence and efficiency, and in conformity with sound engineering, construction, financial, administrative and other professional practices.

(3) Cause the project to be carried out in conformance with all the plans specifications, and with all modifications therein approved by A.I.D. pursuant to the Agreement, including the provision, on a timely basis, of necessary local currency and in-kind support as specified in the Agreement and its annexes.

(4) Cooperate fully with A.I.D. to assure that the purpose of the grant will be accomplished and the GOE and A.I.D. shall from time to time, at the request of either party, exchange views through their representatives with regard to the progress of the project, the performance of consultants, contractors and suppliers engaged on the project, and matters relating to the project.

(5) Within six months of execution of the project grant agreement, in conjunction with BU, produce a detailed work plan, including a detailed plan for curriculum development for the first two years of classes, budget and plan of management approach for Phase I of the activity. The work plan will be updated every six months and will include discussions of site selection for clinical training, plans for faculty development and continuing medical education, training plans for the clinical staff, plans for assistance in architecture and health program design, meeting management needs of the Faculty of Medicine, library facilities and mechanisms for physicians' compensation.

(6) Make provision for adequate administrative arrangements and local currency from funds other than those provided by the Grant for any incentive payments to be made to personnel of the Government of Egypt engaged in project implementation.

5. Based upon the justification set forth in the Project Paper, I hereby determine, in accordance with Section 612(b) of the Act, that the expenditure of United States Dollars for the procurement of goods and services in Egypt is required to fulfill the purposes of this Project; the purposes of this Project cannot be met effectively through the expenditure of U.S.-owned local currencies for such procurement;

and the administrative official approving local cost vouchers may use this determination as the basis for his certification as required by Section 612(b) of the Act.

Joseph C. Wheeler
Bureau for Near East

Date

Clearances:
A.
B.
C.
D.
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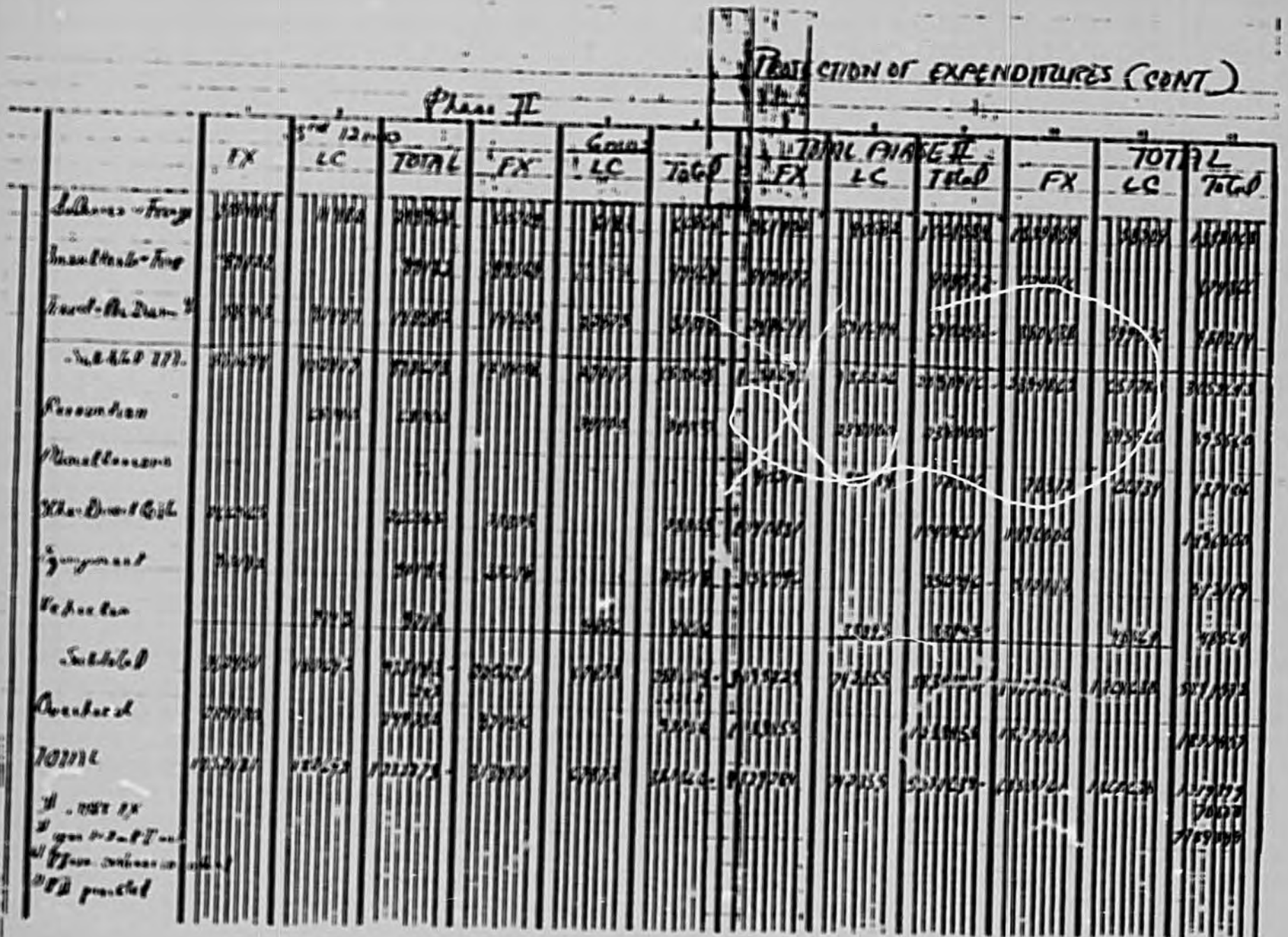
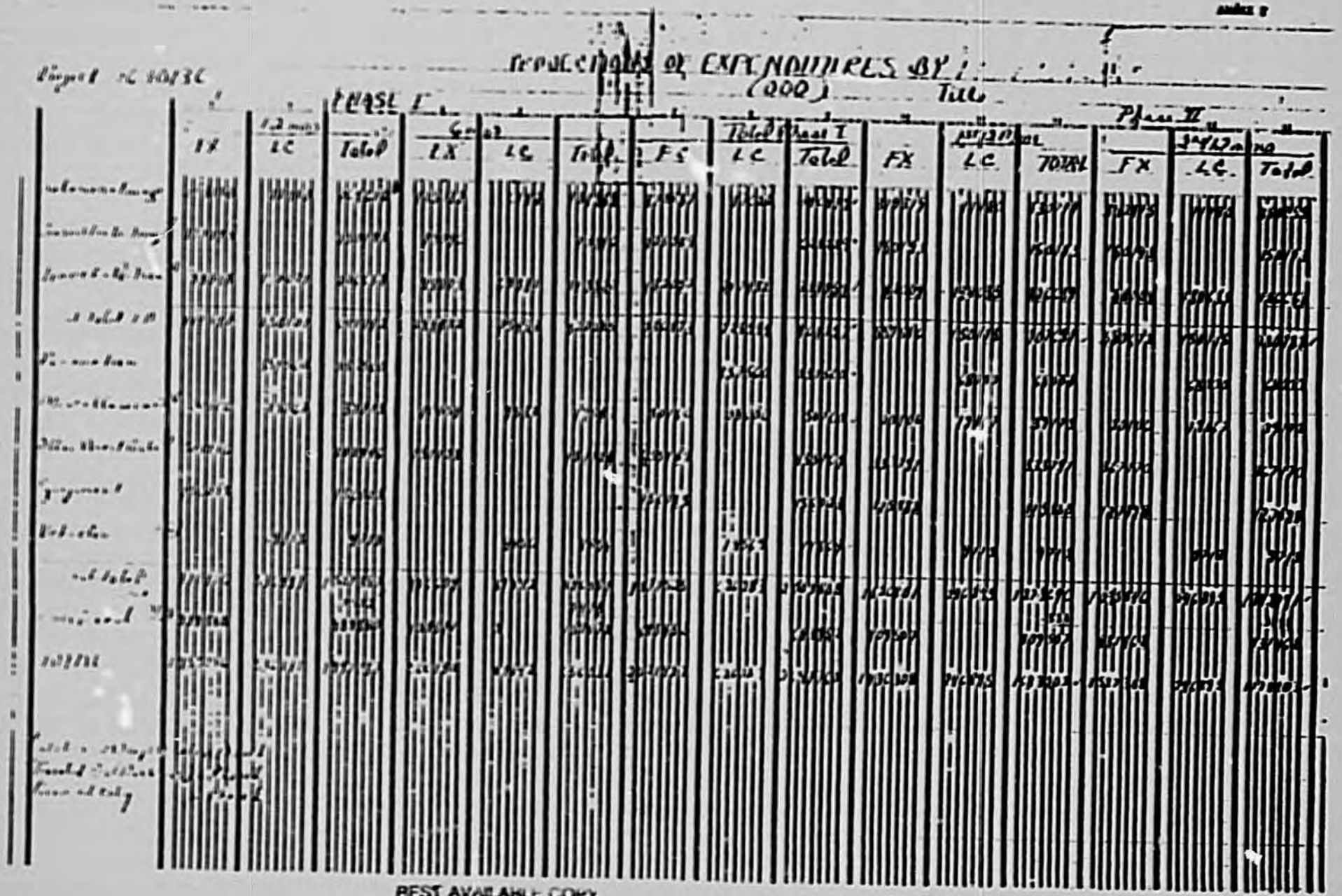
F.

PROJECTION OF EXPENDITURES (CONT)





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