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U N C L A S S I F I E D

PROJECT PAPER
Amendment No. 1

Egypt: Strengthening Rural Health Delivery
263-0015

January 1983

U N C L A S S I F I E D

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
 C = Change
 D = Delete

Amendment Number
1*

DOCUMENT CODE
3

2. COUNTRY/ENTITY

Egypt

3. PROJECT NUMBER

263-0015

4. BUREAU/OFFICE

NE

03

5. PROJECT TITLE (maximum 40 characters)

Strengthening Rural Health Delivery

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
05 01 86

7. ESTIMATED DATE OF OBLIGATION
(Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 76 B. Quarter 4 C. Final FY 85

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY 76			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	1,800	*2	1,800	12,130	2,770	14,900
(Grant)	(1,800)	(*2)	(1,800)	(12,130)	(2,770)	(14,900)
(Loan)	()	()	()	()	()	()
Other U.S. 1.						
Other U.S. 2.						
Host Country		720	720		29,293	29,293
Other Donor(s)						
TOTALS	1,800	720	2,520	12,130	32,063	44,193

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) SA	581	583		7,800		7,100		14,900	
(2)									
(3)									
(4)									
TOTALS				7,800		7,100		14,900	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code
B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

a. To identify, develop and validate a replicable and effective means to strengthen the rural health delivery program.

b. To institutionalize the Strengthening Rural Health Delivery (SRHD) project office as one of two units of the General Administration of Rural Health Services in the Ministry of Health.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY
0 8 8 4 | | | | 0 4 8 6

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 94 Local Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of 38 page PP A amendment)

(See PP pages 1 and 2 herein, for changes proposed).

Note: Although the Grant Agreement has been amended three times, twice adding additional project funds, this is the first amendment to the PP.

Note: Although the Grant Agreement gave LE 100 thousand from Trust Fund as U.S. Government contribution, it is shown here (and throughout the PP amendment) as a GOE contribution.

17. APPROVED BY

Signature
M.P.W. STONE
Title
Director

Date Signed
MM DD YY
0 11 21 8 3

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY
0 14 0 2 8 3

SECOND AMENDMENT
TO
PROJECT AUTHORIZATION

Name of Country: Arab Republic of Egypt Name of Project: Strengthening Rural Health Delivery

Number of Project: 263-0015

1. Pursuant to Section 532 of the Foreign Assistance Act of 1961, as amended (the "Act"), the Improvement of Rural Health Delivery Project for Egypt was authorized on September 13, 1976. That authorization was amended on December 16, 1976. I hereby authorize for the Project, in addition to amounts previously authorized and obligated, funding of an amount not to exceed Seven Million One Hundred Thousand United States Dollars (\$7,100,000) in grant funds over a three-year period from the date of this Amendment, 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, hereby renamed "Strengthening Rural Health Delivery," will identify, develop and validate a replicable and effective health service delivery program which, if replicated nationwide will improve the health status of the Egyptian rural population. In addition, it will

assist the Ministry of Health to institutionalize the Project Office as one of two units of General Administration of Rural Health Services, responsible for applied research and program planning.

3. The Project Grant Agreement Amendment, 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:

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.

4. The Authorization cited above remains in force except as hereby amended.

W. S. W. S. S. S.
Director, USAID/Castro

1-21-83
Date

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PROJECT PAPER AMENDMENT No. 1

STRENGTHENING RURAL HEALTH DELIVERY

PROJECT 263-0015

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ANNEXES

Annex I.	First Amendment to the Project Authorization (Inserted at beginning of Project Paper as page 11.)
Annex I a.	Delegation of Authority Cable - State 304245
Annex IV	Revised Log Frame - Three-Year Project Extension

I. Summary

- A. Grantee: The Government of the Arab Republic of Egypt.
- B. Implementing Agency: The Ministry of Health (MOH).
- C. Grant Amount: Adds US \$7.1 million to bring AID's life of project funding to U.S. \$14.9 million.
- D. Sector Goal: (As amended, see Section IV A.) To improve the health status of the Egyptian people and reduce population growth rate through improved family planning services.
- E. Project Purpose: (As amended; see Section IV B.)
1. To identify, develop and validate a replicable and effective means to strengthen the rural health delivery program.
 2. To institutionalize the Strengthening Rural Health Delivery (SRHD) project office as one of two units of the General Administration of Rural Health Services in the Ministry of Health. The SHRD component will be responsible for continuing research within a test area; the other component, Program Planning and Follow-up, will be responsible for nationwide replication.
- F. Purpose of the Project Paper Amendment: This amendment, with the corresponding amendment to the Grant Agreement is intended to revise:
1. Program: by amending project objectives to reflect both ongoing and future project activities as requested in this Amendment. (See Section IV);
 2. Area: by increasing the number of test districts from ten to twenty. (See Section IV);
 3. Duration: by extending the five-year project life by three years, extending the PACD from April 4, 1983, until May 1, 1986, and;
 4. Funding: by adding new funds (\$5.130 million and LE, equivalent of U.S. \$1.970 million) to support the project extension. New funds will be added in two 18-month increments: \$4.5 million and \$2.6 million.

II. Project Background:

A. Scheduled Events:

On September 30, 1976, AID signed a Grant Agreement providing \$1.800 million and LE 100 thousand (Trust Funds) to begin the SRHD project.

Subsequent amendments increased total project costs to \$7.800 million and LE 600 thousand in LE. Grant Agreement Amendment No. 1: added LE 100 (Trust Funds); Amendment No. 2: \$1,800 million and LE \$210 thousand (Trust Funds); and Amendment No. 3: \$4,200 million and LE 290 (Trust Funds). *1

The original project paper was approved in July, 1976. *2 There was a lengthy delay in the commencement of project implementation: a host-country contract, with Westinghouse, was not signed until December, 1977. The Westinghouse field staff did not arrive until April, 1978. The first implementation plan was developed July, 1978 - over two years following the design of the project; and it was approved by USAID October, 1978.

USAID conducted internal (PES) evaluations in 1978 and 1979; however, a major evaluation ("Special Evaluation") was not conducted until January/February, 1981.

Major findings of the Special Evaluation were as follows:

1. Although there had been significant accomplishments, there were delays in most areas of project implementation and data processing and analysis.
2. The originally planned tests of interventions have not progressed as intended, and implementation activities as carried out to date will not lead to clear answers to many key questions regarding the interventions proposed in the Project Paper (PP).
3. There were major differences between the stated project objectives given in the Project Paper and those given in the Implementation Plan. Project activities were targeted towards objectives given in the Implementation Plan.
4. Because the project had only been implemented in four of the ten programmed districts, the GOE's request to expand to 41 districts was not endorsed.

Note: *1 A total of LE 600 thousand (Trust Funds) was obligated and given as a U.S. Government project contribution in the Grant Agreement and subsequent amendments. This Amendment, however, shows the LE 600 thousand as a GOE project contribution.

*2 The original project paper was approved under the title of, "Improvement of Rural Health Delivery." This Amendment changes the title to, "Strengthening Rural Health Delivery," to conform to everyday usage over the last several years.

5. That the Life of Project (LOP) should be extended to assure adequate time for project completion. That long-term technical assistance provided by the Contractor be increased from the existing Chief of Party (COP) to include TA personnel in Planning, Training, and Evaluation.
6. No further project vehicles should be ordered. (One hundred and forty out of an originally planned 280 vehicles had been ordered and arrived in country prior to the Special Evaluation.)
7. No test of the use of a radio or telex communications system for rural health services should be carried out by the project. Such a system (as given in the original project design) could not be afforded by the MOH. Technical communication equipment is not high priority, at least not until other aspects of the health services are upgraded.
8. A revised Implementation Plan and schedule should be developed immediately (early 1981) by the MOH and the contractor for AID approval. The revised Plan was to be based upon basic evaluation recommendations and interpretation of project data gathered to date.

The MOH and USAID met on May 26 and 28, 1981, to discuss responses and proposals stemming from the Special Evaluation results. The following agreed upon recommendations (relevant to this PP amendment) were made during these meetings.

- It was recommended to extend the project by three years.
- It was recommended to expand the project area by 9 districts (later changed to 10).
- Contrary to the Special Evaluation recommendation, it was recommended that the project proceed with the purchase of the remaining 140 project vehicles. (See pages 8-9 for further details on project vehicles.)
- It was recommended that a modest commodity package would be developed for the project districts, and based on experience a nationwide needs assessment would be conducted by the MOH for possible funding at a later date.

A draft Implementation Plan was submitted to USAID on August 15, 1981. It was reviewed by the Project Committee (PC) on September 2 (and NE/TECH/HPN 9/21/81) and found not to be acceptable.

A revised Implementation Plan was submitted on November 3 and reviewed by USAID's PC on November 25, 1981.

The PC determined that there were major issues to be discussed with the MOH prior to development and consideration of a PP amendment. HRDC drafted a Discussion Paper (12/10/81), prior to discussions with the MOH. (NE/TECH/HPN reviewed the revised Implementation Plan and a Draft Discussion Paper 1/7/82.) Following a thorough review, HRDC began continuous discussions with the MOH (over a four-month time period) which led to a draft PP Amendment submitted to the USAID Executive Committee on 6/28/82. The Executive Committee recommended approval contingent upon selected major revisions: funds for project incentives were not approved; justification for an additional thirty project vehicles (subsequently disapproved); and more detail and justification for outside technical assistance and MOH staff.

AID/W's Project Review Committee (PRC) considered the draft PP Amendment on 7/15/82, resulting in a number of concerns being raised. PRC concerns were cabled to USAID/Cairo 7/17/82 (State 205558) and 8/3/82 (State 217649). Following additional discussion with the MOH over both Executive Committee and AID/W PRC issues, necessary revisions have been made, resulting in this PP Amendment.

B. Program:

As noted by the Special Evaluation, there are significant differences between the basic objectives presented in the Project Paper (PP) and those given in the Implementation Plan, developed two years later. This is not surprising, given the time gap and intervening inputs and more detailed problem assessment by a new set of personnel. A major change in project focus was noted by USAID in March, 1979. However at that time, the decision was made not to amend the PP or the Grant Agreement (GA) until there had been a major evaluation. (See USAID internal evaluation, April 1979.)

The Special Evaluation stated: "The differences among the documents, from the Project Paper to the approved Implementation Plan, are in (i) the relative emphasis placed on project components..., (and) (ii) the apparent change in project purpose,....The project shifted its major focus away from the original project objectives, testing of specified 'management' interventions, e.g. communication, incentives, etc. toward developing and testing components of a health service delivery package, e.g. diarrheal disease control."

The objectives, as given in the Project Paper, have not been the actual targets of project activities since very early in project implementation. As the Special Evaluation stated:

"A change in project purpose occurred with the GOE/USAID approval of the Westinghouse project implementation plan in 1978. Prior to that

point the project purpose (PP Log Frame) was to 'identify and validate through field testing, replicable methods to reduce... the major constraints to rural health delivery.'" The major constraints, as given in the original design, were: communication, management, supervision, motivation and incentives.

The Special Evaluation stated: "The actual targets, however, have been larger: To identify, develop and validate a replicable and effective health service delivery program..., through developing and testing health and integrated support ('management') services."

This PP Amendment, therefore, amends the project goal, purpose and certain output objectives to reflect actual project implementation directions, as given above, recommendations of the Special Evaluation, and subsequent decisions made between USAID and the MOH. (See Section IV, page 14 - 27.)

III. Progress to Date - Until April 1982:

A. Background: Redefined Project Objectives:

The project has completed four years of implementation.

In response to the MOH/Contractor perceived project objectives, the project attempted to strengthen the existing rural health delivery system in the following three dimensions:

1. Strengthening of Basic Community Health Services:

The SRHD Project has undertaken to establish and strengthen existing rural health services. To accomplish this, particular attention has been directed towards revising roles, responsibilities and standing orders of health facility staff in the priority areas of services affecting pre-school child mortality, the high birth rate, and selected child morbidities.

Maternal and child health (MCH) care services are central and provide a framework within which family planning; antenatal, obstetric and postnatal care; communicable and parasitic disease control; and environmental health services are integrated.

All services are being built upon the foundation of strengthened MCH service, which establishes a functioning home-visit program (already assumed to be the most effective delivery mode), and which is backed by the necessary, minimum support services.

2. Strengthening Support Services:

Several support services were identified as requiring

strengthening to bring these to a level necessary to enable the existing system to function. These include: 1. central level and peripheral level administration and supervision; 2. development of a health information system; 3. technical and management training capability; 4. transportation; 5. communication; and 6. community participation.

3. Applied Research:

Initial project applied research areas were: Diarrheal Disease Control and Lower Respiratory Tract Diseases. Applied research studies are required in order to resolve management questions critical to the success or continued delivery of the community health service programs developed. The research questions seek to answer problems of alternative modes of delivering well-established treatments. For example, given that oral rehydration therapy is the preferred, early method of treatment of children suffering from diarrhea, what is the most cost effective and safe way for the rural health service to get this therapy to children who require it - prepackaged ORT mixture through clinics and/or pharmacies, or home-made ORT mixtures prepared by mothers?

B. Specific Activities Completed:

1. Strengthening of Basic Community Health Services:

All developed strengthened community health services have been completely implemented in 10 districts of 4 governorates.

Specific accomplishments include:

- a. Development and implementation of a mapping system of villages in 10 districts with regular updating, household enumeration and census.
- b. Initiation of a regular home-visiting program by nursing staff in all of the health facilities in 4 test districts.
- c. Development and implementation of a versatile multi-topic health education/staff training component based on the "Visual Learning System" (VLS) kit in all health facilities of 4 districts.
- d. Redefinition of nurse roles and responsibilities, and partial completion of redefinition of those for the physicians and sanitarians.

- e. Inservice (pre-implementation) training of all physicians, nurses, and sanitarians in all 10 districts.
- f. Revision of the antenatal and postnatal care aspect of the MCH program.
- g. Revision of the in-facility MCH services and implementation in 10 districts.
- h. Development and approval of both Obstetric Care and Family Planning programs for project implementation.

While the SRHD Project effected a basic strengthening of rural health service, pivoting on MCH services, implementation of the family planning and development of environmental health services are the next priority areas. (Project implementation in the 10 new districts will not begin until December, 1984.)

2. Strengthening Support Services:

Strengthening the service support system was intended to focus on administration/supervision, a project health information evaluation system, training, incentives, transportation, communication, and community participation. The accomplishments in these areas include:

- a. Development and implementation of a plan to strengthen administrative/supervisory practices in 4 test districts. This includes the development of a transportation plan for use of vehicles mainly for supervision and training and an incentive system based on the extent to which staff fulfill their roles and responsibilities.
- b. All physician, nurse, sanitarian, and lab assistant supervisors in 4 test districts were trained in the new administrative/supervisory practices.
- c. Development and implementation of new MCH and FP services forms and records in the 4 test districts.
- d. Eighty percent of the health information/evaluation system, (HI/ES) as part of the project health information system (for project evaluation and rural health service delivery system management), has been designed and has been introduced in all MOH peripheral facilities in the 4 test

districts and in some facilities in the remaining 6 districts.

- e. Fifty-nine physicians, nurses, sanitarians, and sociologists have completed overseas participant training (short- and long-term).
- f. Completion of renovations of all 385 rural health units and health centers in the four project governorates. Renovations were funded through the Population Development Project (PDP).
- g. Transportation needs have been addressed by procurement of 140 vehicles, which are in place with the required maintenance system. An additional 140 vehicles are on order.

3. Transportation Support and Project Vehicles:

One of the original, purpose-level, project objectives was to test transportation as an element of strengthening the service support system. The MOH, with AID-supported technical advisors, chose a transportation plan based upon vehicles - rather than, say, bicycles - when the project was designed in 1976.

There was an extensive analysis of transportation needs done during the original PP design. The analysis looked at all aspects of project transportation requirements, including uses, types, maintenance requirements, and number of vehicles. The project designers, considering all factors, determined that a total of 280 vehicles (with appropriate spare parts) would be the optimum number for the original project area of eight (later changed to ten) districts.* The designers recommended that the vehicles be purchased in two increments of 140 each. The initial 140 vehicles were to be purchased and tested as part of a project-developed Transportation Plan (finalized March 1, 1979).

As noted earlier, the Special Evaluation team (February, 1981,) recommended that "no further vehicles be supplied as part of this project, and that vehicles already supplied (140) be shifted to provide tests of the effects of the presence of different numbers of vehicles at the governorate and district levels on the system's performance." To date the MOH has not

* Note: Refer to Annex F, pages 1-70 "Transportation Analysis for Pilot Project to Improve Preventive Rural Health Delivery"; June, 1976, by H. Hopper, R. Lockbourn, and K. Shryock.

refuted the Special Evaluation team's findings, which include:
"The vehicles provided through the project have not been used to the extent expected, and their availability may be of very little importance at the level of the health centers and units..."

The USAID Director and MOH Project Director met (5/81) to consider the Special Evaluation recommendations. At that meeting it was decided to proceed with ordering the second increment of 140 vehicles. This decision was based upon the following reasons: (1) USAID approved in principle the expansion of project testing areas from 10 to 20 districts, thus a doubling of the number of vehicles was required, and (2) the MOH desired to establish a simple patient evacuation system in the project area. (On the basis of this meeting, the Director signed the PIO/C for the second increment of 140 vehicles ordered in mid-1982.)

This Amendment, and subsequent Grant Agreement amendments, provides no funds for additional vehicles or spare parts.

This Amendment does, however, raise AID concerns over the utilization, testing, and cost effectiveness of the 280 project vehicles (funded in the original project design) vis-a-vis project efforts to design, test, and develop a replicable nationwide plan. AID will require that the MOH submit transportation test results and proof that these results are considered in the nationwide plan. (See Conditions Precedent, page 34.)

4. Applied Research:

The Diarrheal Disease Control Study (DDCS) was conducted during 1980. To date it is the only applied research study completed. It is an excellent, well documented study, which absorbed a large amount of the project efforts.

The major finding of the DDCS can be summarized:

"It was concluded by the study investigators that an oral rehydration solution (ORS), consisting of sugar, salt, and

water, prepared and administered by the mother of the sick child and backed by in-facility availability of a balanced electrolyte (Oralyte), was the most cost effective service delivery strategy for reducing child mortality (1 month to 5 years) due to diarrhea with resulting dehydration (approximately 40% of all deaths) as compared to all other delivery modes tested in the study."

Building upon the above results, AID has recently funded a five-year, nationwide project (AID funding, \$ 26 million), to ensure availability of prepackaged ORS sufficient to meet Egypt's present needs.

The Lower Respiratory Tract Disease Study was initiated in 1981 to answer questions about the most effective way to deliver routine treatment by the nurse (intramuscular injection of penicillin) to lower the child mortality from these diseases (the second major causes of child mortality after diarrheal diseases). The study will continue (Phase II) in 1982. Preliminary results indicate that:

- Nurses showed ability to differentiate between upper and lower respiratory infections during their regular home visiting program.
- Penicillin can safely be used as the drug of choice for routine use by the nurse on discovery of lower respiratory tract infections.
- Chlamydia trachomatis organisms are not, as originally thought, a major cause of pneumonia in the study area (at least during the winter season).

C. Project Effectiveness:

1. A Definition:

Following a redefinition of the project objectives in 1978

(MCH/Westinghouse Implementation Plan), the SRHD Project differentiated between two standard categories of measures of effectiveness: process indicators and impact indicators.

Process indicators are measured by output or changes in service user attributes. These are of importance to project staff as they suggest, at regular intervals, if the project-designed interventions are making progress toward the project goal. The project purpose, as well as some other objectives, are measured by impact indicators. Impact indicators in the SRHD Project include such items as specific mortality and birth rates. The SRHD Project objectives (purpose and output levels) are basically measured by process indicators, as it is not reasonable to expect more than an indication that project interventions can achieve reduced morbidity/mortality in a short period of time.

2. Means of Measurement Utilized and Preliminary Results:

- a. Process indicators are measured by a variety of project developed methods to evaluate output level activities. (These evaluative methods were developed in response to the original project purpose objective.) These include:

(1) Household Surveys (HHS): are regularly scheduled surveys to elicit how health services (in both implemented and non-implemented project areas) are affecting the knowledge, attitudes and practices of the general population. As well, HHS's may provide an indication of changing levels of morbidity and mortality (an impact indicator) over time. The HHS is important because of its capability to reveal changes in impact indicators over time which are measured through a community-based mechanism rather than through a health system service records-based mechanism.

A base-line HHS was completed in 1979. Five rounds of HHS have been completed through April, 1982.

Although most of the collected HHS data have not been processed or analyzed, analysis of a small amount of data has lead to the following findings: *

*Note: To date only two rounds of the HHS conducted in Dakahliyah as part of the DIC (Diarrheal Disease Control) study have been processed and analyzed. Findings, as given by the project, are derived from this data.

- (a) The data indicate that its major vehicle of program implementation, the outreach visit, can reach a sustained level of intensity consistent with that level thought by the MOH to be required to demonstrate a substantial effect.
 - (b) The SHHD Project's strengthened service delivery system (which includes content modifications of services, an incentive system, a supervision system, and a transportation component) indicates (to the MOH) that it can dramatically change knowledge, attitudes, and practices in the general population with regard to the major health problem of diarrheal disease. These changes occurred, however, only where there was an element of family participation coupled with continuous, simple, direct health education.
 - (c) That even families with a poor water supply, of the lowest educational status, and of the simplest employment status can benefit enormously from the SHHD Project activities (in terms of reduced infant and young child mortality with ORT).
 - (d) After the Diarrheal Disease (DDC) study, the targeted population when ill, would still consult a private doctor first. However, families indicated by the end of the study that for diarrhea among pre-schoolers (the single most important cause of death in all Egypt today), they would consult a rural health facility staff person before a private doctor. This represents a positive reversal as compared to the start of the DDC study.
- (2) Supervisory Feedback (SF) is used in the project, mainly by district supervisors to assess peripheral health staff.

While the main body of SF forms is not yet processed nor analyzed, central office staff have conducted several supervision visits using these forms and compared the results of these with results obtained by district supervisors. The preliminary results suggest that the SF system can help supervisors assess staff members in the rural health service, but that this success is variable across the project. (This variability is probably due to the fact that strong and effective supervision training was introduced only recently into the project areas.)

Overall, preliminary analysis of the SF-generated data indicates that the developed system of supervision, with its built-in system of incentive payments, has created a system which it is thought will ensure the continuation of the home-visiting program on which much of the improved rural health delivery system results are based.

(3) Pre/Post Training Tests

Training activities have absorbed a large portion of central office staff time over the past three years. Numbers trained can be classified as a legitimate process indicator; however, it will be important to demonstrate that levels of skill and knowledge of the health professionals have significantly changed after training, and that these levels have been sustained over time. The project has not yet done this.

(4) The other process evaluation formats are:

- (a) The Work Sampling Survey (WSS) which has been developed and implemented, but for which no analyzed data are available;
- (b) The Rapid Data Feedback (RDF) which has been developed but not implemented; and
- (c) The Cost Analysis Survey (CAS) which is planned but not designed to date.

D. Lack of Analyzed Data:

The project has developed numerous means to collect data, as described above, and large quantities of data have been collected over the past several years. Unfortunately, most of the collected data have neither been processed, analyzed and/or interpreted. Thus the indicators of project effectiveness given in Section C above are tentative. A major short-coming of the SRHD project to date, as pointed out early in 1981 by the Special Evaluation, has been the lack of analyzed data.

The project now has the in-house ability to process and analyze data: the project computer is operational; MOH project personnel have completed training in data analysis; in addition, the Contractor is providing a data analysis expert on TDY. Although a strong in-house capability now exists, all parties believe it is important that increasing project emphasis be focused immediately on data processing, analyzing, and utilization of project-generated data.

The project will expand into a larger area. Thus it is increasingly important that expanded project interventions be solidly based on data results.

Therefore, USAID/C, believes it necessary to include in the Grant Agreement Amendment, following the approval of this PP Amendment, a Condition Precedent (CP) requiring significant data collected as of May 1, 1982, to be processed, analyzed, and interpreted. Interpreted data will be reported to USAID/C prior to December 31, 1982, and prior to the release of any funds proposed in this Amendment. (See Section IX, Condition Precedent for detailed wording of CP.)

Scheduling prohibits processing, analyzing and interpreting all outstanding project-generated data prior to December, 1982. USAID agrees, however, that if the significant data given below is reported to USAID/C, this will be sufficient to allow the CP to be met. Significant data will include the following: three of the five rounds of the HHS; all Supervisory Feedback data for two quarters, spread a year apart for comparison (3rd quarter 1980 and 3rd quarter 1981); all pre-and post-training test data for all pre-implementation training in six districts; supervisor training for ten districts; and the first phase of the Lower Respiratory Tract Disease Study.

The remaining data collected prior to May, 1982, and not included in the proposed CP above, will be analyzed, interpreted and reported to USAID by June 1, 1983, and is the subject of a covenant to the Grant Agreement Amendment.

Analyzed data results collected following May, 1982, will be submitted to USAID on a regularly scheduled basis. A schedule for reporting all analyzed and interpreted data collected after May 1, 1982, is part of the Conditions Precedent to the Grant Agreement Amendment.

IV. The Amended Project:

A. The Project Objectives Are Amended As Follows:

1. Sector Goal is amended from:

"To improve the commitment and capacity of the MOH to provide broad access to preventive and curative health services at acceptable levels of quality."

to:

To Improve the Health Status of the Egyptian People and Reduce The Population Growth Rate Through Family Planning Services.

This amended sector goal better reflects the direction of AID's health sector assistance, which is aimed in part at promoting

preventive health and increasing adoption of family planning practices, and will provide assistance not only to the public (MOH) delivery system but also private delivery systems, as well.

2. Project Purpose is amended from:

"To identify and validate through field testing replicable methods to reduce or eliminate communication, management/supervision, motivational and incentive issues as factors limiting productivity of the rural health services -- particularly as these issues impact on prevention and outreach."

to:

- a. To identify, develop and validate a replicable and effective means to strengthen the rural health delivery program .
- b. To institutionalize the Strengthening Rural Health Delivery Project Office as one of two units of the General Administration of Rural Health Services, in the MOH.

The amended project purpose and outputs (see below) reflect actual project implementation targets given in the MOH's and contractor's Implementation Plan of 1978 (and as revised in 1980 and 1981). The 1981 "Phase II Implementation Plan" is attached as Annex V.

3. Project Output. The amended project output will be stated succinctly, then expanded and defined below:

To develop, test and replicate (in the project testing areas) Community Health Services and Integrated Support Services which will improve the Rural Health Service Delivery Program.

Most of the disagreement among project participants and observers (the MOH/Westinghouse, USAID, AID/W and evaluators) over the project objectives appears to be due to the differing concepts of Support Services (which include "management interventions") and Community Health Services. Early into project implementation the MOH and the Contractor decided that the two components were interrelated and inseparable; that to strengthen the rural health delivery system by targeting support services (management interventions) and not community health service (health interventions) would only be improving the delivery of a system that is presently promoting some health/medical practices that are not current and, at times, not effective. This was also pointed out in the 1981 Special Evaluation.

Therefore, the "packages" of community health and support services are interrelated; and specific interventions developed and tested include elements of both services "packages." For example, the testing of the ORT intervention included not only this health service element, such as sugar/salt or pre-packaged Oralte, but also included the project-developed system of supervision, transportation, and incentives, which in turn make it possible for the outreach aspect of the project to deliver ORT to the community.

Although community health and support services are interrelated, for clarity they are divided, and project components and elements are assigned to each in Figure I on pages 17 and 18. (Figure I provides all project components whether completed, ongoing or planned, in order to show the scope of project activities.)

The strategy of the SRHD project, since its commencement, has been to strengthen the existing MOH delivery system. The existing system consists of numerous components, including Maternal and Child Health/Family Planning (MCH/FP), School Health, Environmental Health, Communicable and Endemic Disease Control and Medical Care. Since the SRHD project could not hope to improve all components of the existing delivery system, it selected - following an early project assessment - those components which would likely have the greatest impact on the reduction of morbidity and mortality. Two Community Health Service components were chosen:

- a. MCH/FP (as seen by the MOH, family planning is an integral part of MCH); and
- b. Environmental health.

Further, the MOH selected critical components of the support services necessary to improve the health delivery system. Components selected are:

- (1) Health Information/Evaluation System;
- (2) Management Improvement (as given in the original project purpose);
- (3) Outreach;
- (4) Job Description Modifications, Training and Health Education.

FIGURE I: OUTPUT COMPONENTS AND ELEMENTS

<u>OUTPUT</u>	<u>A. COMMUNITY HEALTH SERVICES</u>		<u>B. SUPPORT SERVICES</u>	
	<u>COMPONENTS</u>	<u>ELEMENTS</u>	<u>COMPONENTS</u>	<u>ELEMENTS</u>
	1) <u>Antenatal Care</u>	a) Screening (I) b) Follow up (I) c) Tetanus (II)*	1) <u>Health Information System (HI/ES)</u>	
			<u>A. Functional Analysis</u>	a) Household Survey (I) b) Work Sampling Survey (II) c) Health Facility Records Abstraction Survey (I) d) Cost Analysis Survey (II)
<u>Maternal</u>	2) <u>Obstetrics</u>	a) Community Obstetrics (II)	<u>B. Rapid Data Feed Back</u>	a) Routine Output/Input Survey (I)
	3) <u>Postnatal Care</u>	a) Various Sub-Elements (I)	<u>C. Verbal Autopsy (I)</u>	
	4) <u>Child Health Promotion</u>	a) Vaccination (I) b) Nutrition Education (I)	<u>D. Supervisory Feedback</u>	a) Doctor (I/II) b) Nurse (I) c) Sanitarian (II) d) Lab. Assistant (II) e) Driver (I) f) Supervisors (I) g) Interviewers (I)
<u>Child</u>	5) <u>Child Surveillance</u>	a) Screening (I)		
	6) <u>Early Management of Childhood Diseases</u>	a) Oral Rehydration * Therapy (Diarrheal Disease Control) (I) b) Eye Infection* (I) c) Respiratory Tract * Infection (I/II)	2) <u>Special Surveys</u>	a) Service Records (Preliminary) (I) b) Drug Survey (I) c) Facilities/Household (Prelim) (I) d) Chem Analysis (ORT) (I) e) Anthropological (Neonatal Deaths)-(I) f) Vehicle/Eldg. Survey (I)
<u>Ad.</u>	7) <u>Family Planning</u>	a) Motivation * (II) b) Counseling (II) d) Practice (II)		

g) Future Surveys as Required (II)

MCH g) Environmental
 Health

a) Home Sanitation (I)
b) Community Participation (II)

*Legend

3) "Management" Improvement

a) Incentive System (I)
b) Supervision System Interrelated
 c/ a & c (I)
c) Transportation Plan (I). (Based
 upon Management Elements,
 above, and Training, below)
d) Job Description: Nurse (I), MD
 (II), Sanitarian (II), Lab.
 Assistant (II)

4) Outreach
5) Job Descriptions (Phase I)
6) Trainer and Trainee Manuals
7) Health Education

All Project Participants (I/II)
All Components and Elements of
Health Community Service Package:
MCH/FP & Environmental Health

*Legend

1. Those project output elements marked with an asterix (*) are subject to "Applied Research."
2. All project output components and/or elements are given as (I), (II), or (I/II), indicating when developed:
 - (I) - developed prior to 4/82
 - (I/II) - partially developed
 - (II) - will be developed during project extension period.

Those elements developed prior to 4/82 will, for the most part, continue to be tested during the project extension period.

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The project staff selected specific elements which it felt were critical to the development and delivery of effective MCH, FP Environmental, Community Health and interrelated Support Services.

Most of SRHD project activity over the last four years has been aimed at the development and testing of output elements. Many, but not all of the elements, were given as outputs in the original project paper logical framework, and many of these elements, as given in Figure I, have been developed and are being tested. Those elements followed by (I) have been developed and tested; those indicated by (II) will be developed; (I/II) means partially developed.

B. Amended Project Implementation Plan:

1. Achievement of Project Objectives:

Much has been completed during project implementation through April, 1982. What remains is to complete development and testing of those output elements given on page 20 in Figure II; packaging all output component elements, and testing the integrated packages; then, in the final step, inserting the developed and tested packages with other elements of the existing MOH system, in the extended project area (10 districts), and testing this "strengthened" health service delivery program for effectiveness and replicability. If tests are successful, this implementation process will lead to a plan (a written set of recommendations) for nationwide replication.

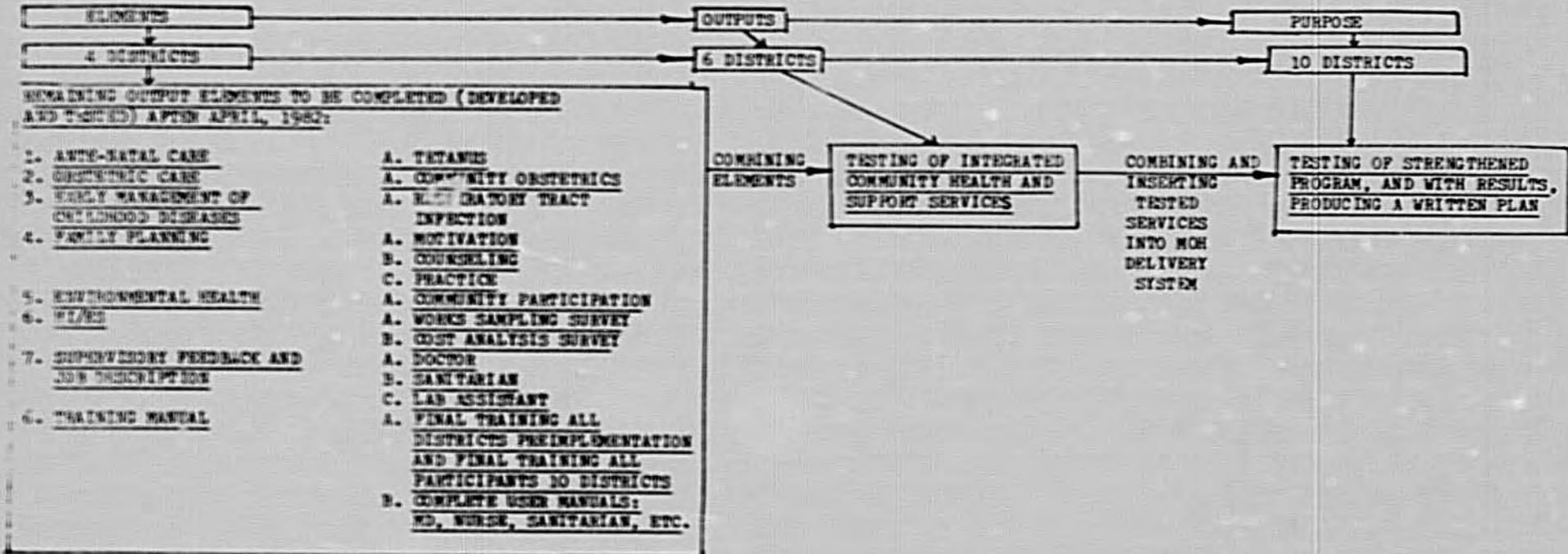
As a research project, it is outside the scope of this project and the responsibilities of the SRHD office to implement project activities on a nationwide basis (incrementally or completely). The MOH may, as it deems appropriate, implement certain project output elements in a larger area; however, this will be accomplished by other units of the MOH and will not be funded through the SRHD project.

Diagrammatically, the project elements remaining to be developed and tested, and the testing areas are represented on Figure II on page 20.

2. Amended Project Areas:

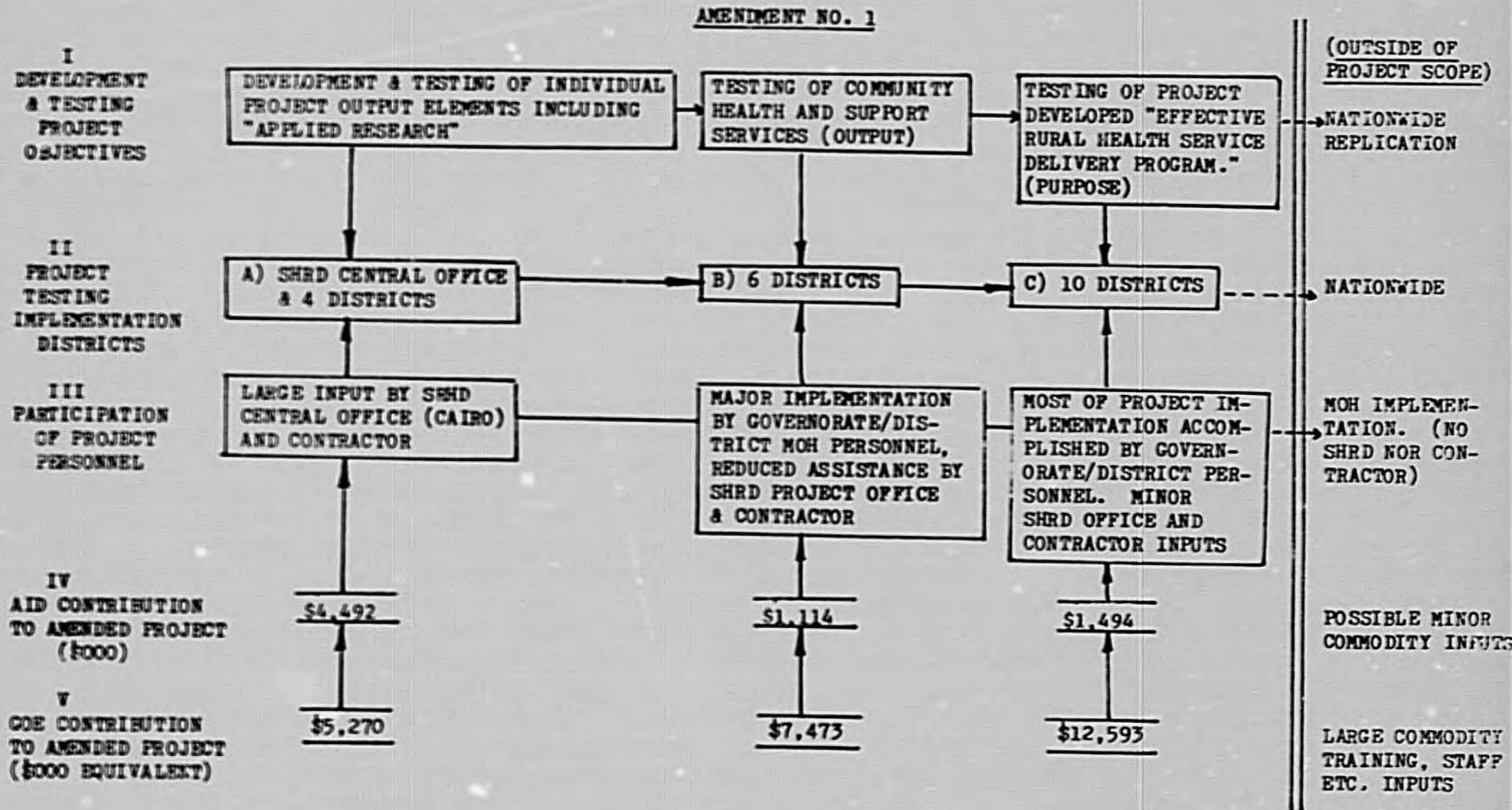
This Amendment expands the project into 10 additional districts, within the original project Governates of Dakahliya, Beheira, Fayoum and Assiut. (Maps of the participating governates and districts are given in Annex VII.)

FIGURE II SHHD PROJECT (263-0015) AMENDMENT # 1
PROJECT IMPLEMENTATION BY OBJECTIVES AND TEST AREAS



PROJECT IMPLEMENTATION BY STAFF AND FINANCIAL INPUTS

FIGURE III: STRENGTHENING RURAL HEALTH DELIVERY PROJECT (263-0015)



The twenty project test districts, in terms of project implementation, are broken down into three groups of 4, 6 and 10. As represented in Figure III, the initial 4 districts have been and will continue to be used as "pilot" testing areas, i.e. where individual output elements are researched ("applied") and/or tested, then developed into services: For example, ORT therapies were tested in part of Dakahliya Governorate, then a strategy was developed to provide an affordable/effective service. This strategy was tested in the 4 districts. Results were analyzed, then the strategy was inserted into the MCH training and services provided in the additional 6 districts. During the project extension, all developed/tested community health services (including ORT) will be combined with developed/tested and interrelated support services in 6 districts. Following the testing in the 6 districts the new packages will be integrated with all existing services and tested at the purpose level, in the 10 new districts.

In summary, the project implementation districts, totaling 20 in number, will be utilized to test project-developed interventions (both community health and support) at differing levels until an improved Rural Health Service Delivery System Program has been developed and tested.

3. Amended Project Management/Administration Staff Participation and Technical Assistance:

The SRHD Unit of the MOH will continue to serve as the implementing agency, and under a host-country contract, both long-and short-term technical assistance (TA) will be provided.

A. Technical Assistance:

Project Technical Assistance (TA) is provided through three systems: (1) through a Host Country Contract (HCC), currently with Westinghouse for both long-and short-term outside TA. (2) through direct MOH personal service contracts for in-country short-term TA, and (3) through AID personal service contracts for short-term, outside TA, such as for evaluations.

The above TA procurement system will be continued through the project extension. (The existing HCC with Westinghouse is valid until August, 1983. The MOH, at its option, may or may not extend this contract.)

(1) Host Country Contract

The MOH/Westinghouse Contract provides for two full-time professionals in Egypt: A Chief of Party (COP), who is a

physician, and an Administrator/Manager. The Contractor also provides the equivalent of one full-time professional backstop from the U.S. home office in the form of: a Project Director (15 percent); Project Manager (75 percent); Deputy Project Manager (10 percent).

The COP in Egypt will provide across-the-board technical assistance; however, she will concentrate on family planning. This person is responsible for providing advice and guidance in all areas of the project, including research, community services, project evaluation systems training, etc. The COP managerial and administrative responsibilities include supervision of all Contractor field staff, including short-term TA (provided through the HCC); and submission of all contract reports, and tracking of all HCC related logistical, contractual and financial support systems.

The Administrator/Manager position is a new one (not yet filled), which is required to reduce the burden on the COP. Tasks include: maintenance of program implementation schedules; monitoring consultancy progress; debriefing and reports; and assistance in coordinating resident training programs. (At this time, the MOH wants to fill this position with an Egyptian administrator/manager.)

The U.S. home-office staff supports the field staff in financial, contractual and logistical matters. It is also expected that the Project Director (present incumbent) will provide some TA in the area of nursing education and training.

A large amount of TA provided through the HCC will be short term. The MOH has estimated that it will require approximately 100 person/days of outside short-term TA during the project extension. (See Figure 2 of Annex V for details, which are subject to change as needed.)

Total estimated costs for the above services, provided through the HCC for the project extension, are \$2.3 million, of which approximately \$1.0 million is related to short-term TA.

(2) Direct MOH Personal Service Contracts

The MOH procures local consultants for short periods of time, six months or less. Consultants are paid in pounds at an established rate equivalent to GCE rates. This system allows the project to procure short-term assistance, in the areas of training, data analysis, etc., on quick

notice. Estimated costs for the project extension: \$42 thousand.

(3) USAID Personal Service Contracts

These contracts provide for occasional short-term technical assistance, such as for the Technical Advisory Committee of four members who meet once a year to review and make recommendations on project activities. Total estimated costs: \$67 thousand.

B. Technical Assistance and Project Objectives

Both USAID/C and AID/W reviews of a draft of this PP Amendment raised serious concerns over whether project staff - both outside long-term TA and MOH central staff - may be sufficient to ensure that all planned project activities can be acquitted, following the schedule in the MOH/Westinghouse Implementation Plan.

1. MOH Staff

The Special Evaluation team recommended that: "The MOH should assign additional personnel to the project unit who are fully qualified for their project roles. Particular Ministry staff shortages exist in training, test design, analysis, and management support systems."

MOH central project staff total 25, as given on page 18 of Annex V (The MOH/Phase II Implementation Plan 1982-1986). This new staffing pattern and numbers are a direct result of the Special Evaluation recommendation. The MOH's SHRD office staff size in many cases exceeds comparable MOH offices.

All SHRD office positions are filled, excepting the Section Chief for Implementation. The Deputy Executive Director is presently holding down the two positions until a Section Chief for Implementation is assigned. Other than filling this vacant position, the MOH will not assign additional staff to the SHRD office, believing that the present staff size is adequate for successful project implementation. The total MOH project staff picture includes those in the field: doctors, nurses, sanitarians, etc. assigned to participating MOH facilities and their supervisors at the Governorate and District levels. As the project expands geographically, more and more implementation responsibilities will be vested in the project field staff.

2. Outside Technical Assistance Staff

The Special Evaluation made the following recommendation: "Additional long-term U.S. technical assistance will be required if the project is to effectively contribute its potential benefits to the rural health service system. Since it is unlikely that experienced Ministry staff counterparts can be identified, the additional U.S. personnel will also need to serve as role models and on-the-job trainers for both existing and new Ministry project staff."

Following the evaluation, the MOH and SRHD Office and Westinghouse reviewed the project implementation plan. A draft of this plan following the evaluation recommendations presented four new, long-term positions in addition to the Chief-of-Party (COP). These positions were: Program Planner and three Technical Advisors in Training, Evaluation and Implementation. The MOH later revised its Phase II Implementation Plan to include only two long-term Technical Advisors, a COP, and an Administrative Assistant. The Program Planner and the Technical Assistant for Implementation, were dropped. The MOH stated that there is sufficient Egyptian project expertise in these areas. The MOH further decided that necessary outside TA in training and evaluation could be provided by frequent short-term advisors. This has been the practice over the last three years.

MOH project central staff, and especially, long-term TA staff levels and quality, remains an AID concern; and this issue will be a specific on-going evaluative topic. The MOH/Host Country Contract (HCC) will be renegotiated (or negotiated if the MOH selects a new contractor) on or about April, 1983, at the earliest. Thus there will be adequate time for USAID to monitor for any implementation problems related to insufficient outside TA, and to request that additional outside TA be provided through the HCC if needed.

(4) The MOH Implementing Office

The SRHD Unit of the MOH will continue to serve as the implementing agency.

It is important to note that the participation of both the MOH central staff and the contractors will be very significantly reduced as project activities expand into the 10 new districts. This phasing out of project staff inputs is necessary to assure that the project will test the MOH's ability to replicate its strengthened program nationwide. (See Figure III on page 21.)

The Project Director and/or his designees will continue implementation responsibilities as before. However, under the revised project, the MOH Project Executive Director might additionally be responsible for the following:

(a) The Project Executive Director could provide the only approval necessary for short-term (6 months or less), local-hire contractors. USAID's approval would no longer be required, as long as the terms of the contracts are within the payment and per diem schedules agreed upon by the Parties. (See Annex III.)

(b) The Project Director and/or his designees could be the MOH signators on all sub-obligating documents: including any Project Implementation Letters, (PIL's) and Purchase Orders. (Previously the Minister of Health was signator on some PIL's which sometimes caused delays in project implementation.)

The two above administrative changes may be accomplished by the GOE formally authorizing signators and notifying AID.

Direct responsibility for AID management will continue to be from USAID/C (HRDC/H). NE/TECH/HPN will continue to play an important monitoring and communication role in AID's management of the project.

The USAID/C Project Officer will meet periodically with the MOH Project Executive Director to review progress and assist in resolving implementation problems. A key element in monitoring project implementation plans and progress, however, will be the Implementation Plan/Status Report which will be prepared by the MOH every 6 months (as to be presented in the amended Grant Agreement). The first Report will be submitted for USAID review within three months following signing of the amended Grant Agreement. The Report will detail implementation plans for the up-coming six months. The format of the Report will follow the project objectives given in the logical framework and will be detailed in a PIL following approval of the Grant Agreement Amendment.

D. Revised Implementation Plan:

The revised Implementation Plan is presented in Figure IV on page 28. Implementation details are presented in Annex V, Table 2. It begins mid-1981, when project activities expanded to the remaining 6 districts in the original project. Implementation activities are simplified and keyed to the remaining activities left to be accomplished in the project. These activities are broken down by districts (where accomplished) and objective levels (output elements, output, and purpose). Vertical dotted lines indicate when output elements are integrated into packages and packages are inserted into the MOH program. It should be noted that prior to testing the improved Rural Health Delivery Program in the 10 new districts (scheduled to begin 1/85), a draft plan will be developed. This draft plan will be submitted for the Technical Advisory Committee (TAC) for review and to USAID/C for approval prior to its testing. The release of the planned funding (second increment) will be contingent upon the submission and approval of this draft plan and upon proof that the MOH has established and funded the Program Planning and Follow-up component of the General Administration of Rural Health Service Units. (The Program Planning and Follow-up component is responsible for nationwide implementation. If it is to make sense for the SRHD project to develop and test a nationwide plan to be tested in the 10 new districts, then there must be an established office within the MOH responsible for implementing this plan nationwide.) (See Section IX, Conditions Precedent.)

V. Project Assistance Completion Date (PACD):

The PACD will be extended from April 4, 1983, until May 1, 1986.

VI. Financial Plan:

A. Project Funding:

The total estimated cost of this Amendment is \$32.4 million. (This amount includes both AID and GOE contributions.) AID's contribution

of \$7.1 million will finance over 21% of total costs and 100% of the foreign exchange components of this Amendment. The balance of \$25.3 million will be contributed by the GOE in its LE equivalent as counterpart to the project.

The project funding period will be from April, 1983, through May, 1986. Tables I and II - Summary of Total Project Costs and Disbursement Schedule, and Summary Cost Estimate and Financial Plan - reflect total projected costs by time distribution, by input and by the foreign exchange and local currency requirements to finance these inputs.

Table III presents the financing plan for the additional project funds authorized with the approval of this Amendment (AID contribution) by development and testing objectives as a function of the input activities. Thus, project costs incurred under each objective activity can be monitored during project implementation and at a later date serve as a tool for evaluating project financial performance.

A summary of projected costs by input and source of funding follows:

INPUTS	(In U.S. \$000)		
	Original PP	This Amendment	Total
A. AID			
Technical Assistance	1,900	2,364	4,264
Equipment	4,600	1,154	5,754
Service Programs/Applied Research	800	232	1,032
Training	500	1,450	1,950
Evaluation	-	508	508
Inflation & Contingency	-	1,392	1,392
Sub-Total	<u>7,800</u>	<u>7,100</u>	<u>14,900</u>
B. GOE			
Vehicle Operation and Mainten.	1,900	904	2,804
Service Operations	800	8,181	8,981
Project Staff	800	16,058	16,858
Administrative Costs	457	93	550
Training Centers	-	100	100
Sub-Total	<u>3,957</u>	<u>25,336</u>	<u>29,293</u>
Project TOTAL	<u>11,757</u>	<u>32,436</u>	<u>44,193</u>

For budgeting purposes, an inflation index based on a 9% rate of inflation has been factored at 13.8% for the first 18 months and 33.0% for the second 18-month period. Contingencies were established for AID at 5% based on fluctuating market prices for goods and services and on the uncertainty of local training needs and related costs.

AID's \$7.1 million contribution to the extension of the project as shown in Tables I, II and III will provide for the following: (See detailed budget breakdown in Annex IV: "Inputs.")

1. Technical Assistance. Contingent on MOH decision, Westinghouse Health Systems will continue to provide long- and short-term TA, through a Host Country Contract. Outside assistance will be provided by the Technical Advisory Committee (TAC) through USAID/C PIO/T's, and local-hire short-term consultants through MOH contract. Costs of this Amendment, \$2,364 Million.
2. Equipment/Commodities. A variety of commodities will be provided as AID's contribution to operational research efforts in the original 10 and the additional 10 districts. See Annex IV B for a detailed list of commodities required during the project extension. (There are no funds for vehicles or spare parts.) Cost of this Amendment, \$1,154 million.
3. Service Programs/Applied Research will provide support to the MOH in its project implementation, operational research of service and support interventions. LE costs will cover the following: testing, interviews, monitoring and, collection of data. There will be no AID funds provided for incentives. The GOE will be the source of funds for all incentive payments during the project extension. Cost, \$232 thousand. (See Annex III for MOH per diem rates and locations.)
4. Training: Training opportunities in the United States, Egypt and elsewhere for approximately 89 persons in various specialties such as MCH, Family Planning Training, and Health Management and Administration. Cost: \$1,450 million to support training primarily for MOH personnel in the new 10 districts. (See Annex IV D.)
5. Evaluation costs will cover both support of on-going project evaluation formats (e.g. the HI/ES) and provide for outside evaluation. Major project evaluations will be conducted two months before the end of the first increment of the three-year project extension and at the end of the project when the Improved Rural Health Delivery Plan has been written. Cost, \$508 thousand.
6. Inflation and contingency: The basis used for costing this line item is provided above in this section. Total, this Amendment, \$1,392 million.

TABLE I: SUMMARY OF PROJECT COSTS AND DISBURSEMENT SCHEDULE
(In U.S. \$000)
PROJECT FUNDING

Inputs	Existing PP thru April 83	This Amendment			Project Total
		May 83 - Oct. 84	Nov. 84 - May 86	Total	
AID					
Technical Assistance	1,900	1,143	1,221	2,364	4,264
Equipment					
a. Vehicles and Spare Parts	3,500	-	-	-	3,500
b. Educational, Medical and Office	1,100	1,154	-	1,154	2,254
Service Programs/Applied Research	800	211	21	232	1,032
Training	500	965	485	1,450	1,950
Evaluation	-	291	217	508	508
Sub-Total	7,800	3,764	1,944	5,708	13,508
Contingency	*1	209	97	306	306
Inflation	*1	527	559	1,086	1,086
Total AID	7,800	4,500	2,600	7,100	14,900
GOE					
Vehicle Operation and Maintenance	1,900	509	395	904	2,804
Service Operations	800	3,662	4,519	8,181	8,981
Project Staff (Salaries & Fringe)	800	7,519	8,539	16,058	16,858
Administrative Costs	457	42	51	93	550
Training Centers	-	100	-	100	100
Total GOE	3,957 *2	11,832	13,504	25,336	29,293
PROJECT TOTAL	11,757	16,332	16,104	32,436	44,193

* 1 Funds provided for contingency and inflation were used during actual implementation to adjust other budget line item requirements.

* 2 Includes LE 600 thousand Excess Currency obligated under Grant Agreement and subsequent amendments previously, but erroneously, given as a U. S. Government contribution.

TABLE II SUMMARY COST ESTIMATE AND FINANCIAL PLAN
(In U.S. \$000)

AID	Existing PP			May 1983		Nov. 1984		This Amendment		Total	Amended Project		
	Inception Thru			-		-		-		Amend- ment	Total		
	FX	LC	Total	FX	LC	FX	LC	FX	LC		FX	LC	Total
Technical Assistance	1,900	-	1,900	903	240	981	240	1,884	480	2,364	3,784	480	4,264
Equipment													
a. Vehicles and Spare Parts	3,500	-	3,500	-	-	-	-	-	-	-	3,500	-	3,500
b. Education, Medical and Office	1,100	-	1,100	907	247	-	-	907	247	1,154	2,007	247	2,254
Service Programs/Applied Research	-	800*1	800	60	151	-	21	60	172	232	60	569	629
Training	500	-	500	815	150	383	102	1,198	252	1,450	1,698	252	1,950
Evaluation	-	-	-	39	252	48	169	87	421	508	87	421	508
Sub-Total	7,000	800	7,800	2,724	1,040	1,412	532	4,136	1,572	5,708	11,539	1,969	13,508
Contingency	-	2	2	150	59	70	27	220	66	306	220	86	306
Inflation	-	-	-	381	146	393	166	774	312	1,086	774	312	1,086
Total AID	7,000	800	7,800	3,255	1,245	1,875	1,060	5,130	1,970	7,100	12,130	2,770	14,900
GOE													
Vehicle Operation and Maintenance	-	1,900	1,900	-	509	-	395	-	904	904	-	2,804	2,804
Service Operations	-	800	800	-	3,662	-	4,519	-	8,181	8,181	-	8,981	8,981
Project Staff (Salaries & Fringe)	-	800	800	-	7,519	-	8,539	-	16,058	16,058	-	16,858	16,858
Administrative Costs	-	457	457	-	42	-	51	-	93	93	-	550	550
Training Centers	-	-	-	-	100	-	-	-	100	100	-	100	100
Total GOE	-	3,957	3,957	-	11,832	-	13,504	-	25,336	25,336	-	29,293	29,293
Project TOTAL	7,000	4,757	11,757	3,255	13,077	1,875	14,229	5,130	27,306	32,436	12,130	32,063	44,193

* 1 Includes all project dollars converted to pounds to date, and expected projected LC needs until April, 1983.

* 2 Funds provided for Contingency and Inflation were used during actual implementation to adjust the other budget line item requirements.

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TABLE III
SUMMARY COSTING OF THE PROJECT OUTPUT BY DEVELOPMENT AND TESTING AREAS
(In US \$000)

	THREE YEAR PROJECT EXTENSION				Total
	I	II	III	IV	
<u>AID</u>					
Technical Assistance	2,364	-	-	-	2,364
Equipment					
a. Vehicles and Spare Parts	-	-	-	-	-
b. Educational, Medical & Office	110	230	170	644	1,154
Service Programs/Applied Research	50	78	69	35	232
Training	195	350	440	465	1,450
Evaluation	<u>120</u>	<u>115</u>	<u>218</u>	<u>55</u>	<u>508</u>
Sub-Total	2,839	773	897	1,199	5,708
Contingency	154	40	47	65	306
Inflation	<u>539</u>	<u>147</u>	<u>170</u>	<u>230</u>	<u>1,086</u>
Total AID	<u>3,532</u>	<u>960</u>	<u>1,141</u>	<u>1,494</u>	<u>7,100</u>
<u>GOE</u>					
Vehicle Operation and Maintenance	10	179	268	447	904
Service Operation	-	1,600	2,454	4,127	8,181
Project Staff (Salaries & Fringe)	300	3,151	4,728	7,879	16,058
Administrative Costs	10	20	23	40	93
Training Centers	-	-	-	<u>100</u>	<u>100</u>
Total GOE	<u>320</u>	<u>4,950</u>	<u>7,473</u>	<u>12,593</u>	<u>25,336</u>
Project TOTAL	<u>3,852</u>	<u>5,910</u>	<u>8,587</u>	<u>14,087</u>	<u>32,436</u>

Development and Testing Areas

- I. - SHRD core staff/development of output elements/packages.
- II. - Testing output in 4 test districts.
- III. - Testing integrated health and support service packages in 6 districts.
- IV. - Testing strengthened Health Delivery Program in 10 districts.

B. Mode of Financing:

U.S. Funds for technical assistance will be made available to the MOH to negotiate an amendment to the existing Host Country Contract (HCC). The existing HCC is valid until August, 1983, and, at present, there are sufficient funds in the existing L/COM to fund all contractor costs (as amended by this document and subsequent Grant Agreement Amendment) until this date.

Local Currency funds for TA local purchases/rentals, in-country training, and all items required for research (See Table II) will be administered and accounted for by the MOH, SRHD Central Office accountant. Quarterly expenditure reports and quarterly advances, as needed, will be made.

All equipment, unless budgeted under the Local Currency Budget will be purchased in the U.S. USAID's HRDC/H office will assist the MOH in completing the necessary PIO/C's and effecting purchases.

Participant training funds will be subobligated through PIO/P's. USAID's HRDC/H office will assist the MOH in completing necessary documents and arranging tests, transportation and training schedules.

USAID, in concert with the SRHD office, will arrange the scheduled evaluations, including agreed upon outside evaluations.

VII. Grantee's Request:

The Arab Republic of Egypt, acting through the Ministry of Health, has requested authorization in the amount of the project to provide AID assistance in financing the foreign exchange and local currency costs for the three-year extension. (See Annex I.)

VIII. Conditions Precedent and Covenants:

It is proposed that the amended Grant Agreement will include Conditions Precedent and Covenants along the following lines:

A. Condition Precedent:

*Prior to disbursement of funds for the first increment (18 month's funding) of the project extension, or to the issuance by AID of documentation pursuant to which disbursement of said funds will be made, the Grantee will, except as the parties agree in writing, furnish to AID in form and substance satisfactory to AID:

1. Significant data collected by the project, up until May 1, 1982, which has been analyzed and interpreted to include: three of the five rounds of the Household Survey, Supervisory Feedback results and Pre- and Post-training data and results of the Lower Respiratory Tract Disease Study (Phase I).
2. The data analysis and interpretation will be accomplished in such a manner to demonstrate that the activities provided in the Project Implementation Plan (dated July 5, 1978), or as modified by later amendments of this Plan, are subject to well-designed analysis and interpretation, confirming that the project can produce scientifically valid test results.
3. All data (as given in No. 1 above) will be analyzed and interpreted and reported to USAID/C for approval before December 31, 1982.
4. A schedule for reporting analyzed and interpreted data collected following May 1, 1982, will be submitted to USAID prior to December 31, 1982."

B. Conditions Precedent:

"Prior to disbursement of funds of the second increment of the project extension, or to the issuance by AID of documentation pursuant to which disbursement of said funds will be made, the Grantee will, except as the parties may agree in writing, furnish to AID in form and substance satisfactory to AID:

1. A draft plan for the strengthening of the rural health delivery program nationwide. The plan will include: (a) identification of the specific components to be introduced, (b) the analytic bases on which these were chosen, and (c) a cost and utilization analysis of the major project tests to date, including transportation and family planning implementation. The draft plan will be submitted to USAID/C by August, 1984, prior to full implementation of project activities in the 10 new districts, expected to begin in December, 1984.
2. Proof that the MOH has established, staffed and funded the Program Planning and Follow-up component of the General Administration of Rural Health Services Unit."

C. Covenant:

"That all data collected by the project prior to May 1, 1982, but not included in the Condition Precedent ("A" above) will be

analyzed, interpreted and reported to USAID/C prior to June 1, 1983."

D. Covenant:

"Prior to release of funds for purchase of commodities listed in Annex IV of this Amendment (or as later revised), the MOH will submit to USAID/C an explanation of how the commodity quantities were derived, specifically in terms of their relation to staff and facility numbers."

VIII. Environmental Impact:

This Amendment is basically an extension of the original project activities. The terms of the original project paper still apply. No adverse environmental impacts will occur.

X. Role of Women:

The project will enhance the status of women in two major ways: by improving their physical well-being and by increasing their worth as health providers.

Women of childbearing age, estimated at 935,000 in the project-targeted 20 districts, will be among the primary target groups for attention in this project. They will derive direct health benefits through selected project health service interventions, such as obstetric care elements of the MCH package, and they will be better able to control their reproduction through an improved family planning delivery system developed by the project.

Women comprise a significant portion of the labor force that provides health care and which will be up-graded by this program. About 25% of physicians, 100% of nurses, 15% of other paramedical, and 100% of dayas are female. The project will help upgrade women's professional and vocational levels, and increase awareness of their worth, in terms both of self-imagery and in peer relationships.

XI. Beneficiaries:

There are three classes of beneficiaries associated with this project.

One is the bureaucracy of the Ministry of Health and all the pertinent professional and auxiliary health personnel related directly or indirectly to rural health services delivery. Directly, this comprises members of the Strengthening Rural Health Services Office at the Ministry level and the various counterpart personnel assisted either at the Governorate, District, Center, or Unit level. Approximately 5,000 personnel of varying degrees of responsibility and training would benefit from participation in this project.

A second beneficiary class consists of those individuals within the rural villages served by the rural health delivery system who make use of the facilities and care provided by that system. At this time this would include only those living within the 20 experimental districts chosen for this project. The number who may benefit is up to 2,993,600 (80% of the total population residing in the project-targeted districts). The MOH has estimated that over 400,000 have directly benefited to date by improved health delivery in the 4 project districts.

A third class consists of all the rural villagers of Egypt. These will be affected when replicable results of the experiments conducted under this project will be extended to the entire rural health delivery system.

XII. Evaluation:

Major evaluations are scheduled for August, 1984, and April, 1986.

The first evaluation will be two months before the end of the first 18-month increment of the three-year project extension.

The key document in the August, 1984, evaluation will be the draft nationwide replication plan. This plan will include (as given in the CP Section IX B, page 35: 1. specific community health and management components, 2. the analytic bases on which components were chosen, and 3. a cost analysis of major project tests to date. The key question to be answered is whether the specific components with their associated costs can be both justifiably and feasibly replicated nationwide.

The second major evaluation will be at the end of the project. It will focus on the analyzed, interpreted results of the tested draft nationwide plan in the 10 new districts.

The revised project logframe (Annex IV) will be utilized as a basis for evaluating specific components of the nationwide plan and test results.

Both major evaluations will be conducted by teams, whose members include at least one representative from the MOH, AID/W, USAID/C, the TA contractor, and one external health evaluator who has no experience with the project.

XIII. Conclusion:

The Project Committee concludes that the attached, revised

Implementation Plan, submitted by the Ministry of Health, (Annex V) with the additional and modified design and budget elements provided herein, are necessary for the three-year extension of the project and it is in the interest of the United States to provide funds in the amount of \$7.1 million for the completion of the project.

PROJECT COMMITTEE:

HRDC/H:	D. Palmer
CON:	R. Layton
LEG:	B. Bryant
DPPE/PAAD:	R. Rucker
HRDC/TRG:	H. Hudson

UNCLASSIFIED

Department of State

OUTGOING ANNEX
TELEGRAM Ia.

PAGE 01 STATE 050336
ORIGIN AID-00

6697 070764 AID2326

ORIGIN OFFICE NEIC-04

INFO NEPD-04 NEDP-03 GC-01 GCFL-01 GCNE-01 FM-02 OL-01 STHE-01
SAST-01 NEE-03 ES-01 AAID-01 RELO-01 STHP-01 MAST-01
E-01 7V-00 /028 A0

INFO OCT-00 INR-10 EB-08 H-01 NEA-07 /061 R

DRAFTED BY AID/NE/TECH/HPN: L MCINTYRE: L
APPROVED BY AID/NE/TECH/HPN: B. TURNER
AID/NE/E: B. PORTER (PHONE)
AID/NE/PD: A. MCMILLIAN (INFO)
AID/NE/PD: G. DONNELLY (DRAFT)

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UNCLAS STATE 050336

AIDAC

E.O. 12356: N/A

TAGS:

SUBJECT: HEALTH: STRENGTHENING RURAL HEALTH DELIVERY
(263-0015) - CONGRESSIONAL NOTIFICATION

REF: (A) STATE 038813 (B) CAIRO 2164

CONGRESSIONAL NOTIFICATION INCREASING LIFE-OF-PROJECT
FUNDING FOR SUBJECT PROJECT FROM 7.8 TO 14.9 MILLION
(4.5 MILLION TO BE OBLIGATED IN FY'83) WAS SENT TO
CONGRESS ON 02/07/82. WAITING PERIOD EXPIRED WITHOUT
CONGRESSIONAL OBJECTION ON 02/22/83. SHULTZ

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Strengthening Rural Health Delivery (263-0015)
(Revised for Project Extension (1983-1986))

Life of Project Annex IV
From FY 76 to FY 86 page 1 of 11
Total US Funding 14.9 million
Date Prepared 5/23/82

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	INDICATE ASSUMPTIONS
<p><u>Priority of Sector Goal: The broader objective to which this project contributes:</u></p> <p>To improve the Health Status of the Egyptian Population and reduce population growth rate through improved family planning services.</p>	<p><u>Measures of Goal Achievement:</u></p> <ol style="list-style-type: none"> 1. Progressive increase of life expectancy at birth. 2. Decreases in infant mortality. 3. Progressive reduction of age specific morbidity and mortality rates. 4. Achievement of national population goals. 5. Budget allocations for improved services. 	<p>GOE statistics/surveys/census; life tables, vital registration records.</p> <p>Clinic, health center, hospital records inspectors, surveys; analysis, planning documents.</p>	<p><u>Assumptions for achieving goal</u></p> <ul style="list-style-type: none"> Utilization of MOH services will improve health status. Accessible services will be utilized. Improvement in service delivery developed in this project one replicated nationwide. Economic growth will permit complementary urban/rural development, i.e. sanitation water, housing, etc. GOE will actively address population problem. GOE/MOH will devote adequate human, financial and other resources to realize this replication.

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Project Title: Strengthening Rural Health Delivery (263-0015)

FY 76 86
Date Prepared: 5/22/86

PAGE 2

Project Purpose (2-4)	Conditions that will indicate purpose has been achieved (2-3)	MEANS OF VERIFICATION (2-3)	IMPORTANT ASSUMPTIONS (2-4)
<p>A. To identify develop and validate a replicable & effective means to strengthen the rural health delivery program.</p>	<p>1. A written Health Service Delivery Plan.</p>	<p>Plan Document</p>	<p>A. Field tests, with high level of financial support and central MOH office inputs will allow for valid results vis-a-vis replicability of improved program on a nation-wide scale.</p>
<p>B. To institutionalize the SPED Project office as one of two units of the General administration of Rural Health Services. The SPED office will be responsible for operational research</p>	<p>2. Written analyses of test(s) of above plan, in 10 phase II districts. (By April, 86)</p>	<p>Test Results</p>	<p>B. Results of SPED Office will be seen by both the MOH and Min. of Finance as worthy of continuation Budget allocation and staff/facility support.</p>
	<p>3.1. MOH FY85/86 budget allocation as it applies to "SPED" Unit of general administration of rural basic health services office of MOE.</p>	<p>MOH Budget submission/allocations</p>	
	<p>3.2. MOH approved revised organizational plan including "SPED" office as responsible for applied Research.</p>	<p>MOE Organizational Plan</p>	

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 76 to FY 86
Total U.S. Funding: _____
Date Prepared: 7/22/82

Project Title & Number: SWHD (263-0015)

REVISED FOR PROJECT EXTENSION (1983-1986) ONLY

PAGE 4

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Output Elements (Extension only): See figure I for complete project output elements). Develop Test, and replicate (in the project test areas), two, integrated service packages which will improved the rural health delivery program: 1. Community Health Services, and 2. Support Services</p>	<p>Implementation Target (Type and Quantity) D-3 A. Two Basic integrated packages tested (Phase I districts) and developed into a program plan for testing (By Nov. 84)</p>	<p>(D-3) A¹. By ongoing Health information evaluation (HI/ES) Systems: functional analysis, rapid data feedback, supervisory feedback... A². Written Plan to be tested.</p>	<p>Assumptions for providing inputs (D-4) - NONE -</p>
<p>Project Output Elements (Project Extension Only): 1(a) Obstetrics care 1(b) Respiratory eye infection 1(c) Family Planning (Motivation, Counselling and Practice) 1(d) Environmental Health (Community Participation) 2(a) Cost Analysis Survey 2(b) Modified Job Descriptions for M.D.S, Sanitarian, Lab Assistants</p>	<p>1(a) Developed Services tested analyzed & written plan & Standing orders ready. (By Sept. 84). 1(b) " (By April 83) 1(c) " (By Sept. 84) 1(d) " (By Oct. 84) 2(a) Survey completed & provides results vis-a-vis ability of MOH to support improved services (By Sept. 84) 2(b) Written revised job descriptions/standing orders (By Sept. 84)</p>	<p>1(a) Written test results and plan. 1(b) " 1(c) " 1(d) " 2(a) Written Survey Analysis. 2(b) Written job descriptions compared to old ones.</p>	<p>- NONE -</p>

ANNEX IV

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LOGICAL FRAMEWORKINPUTSESTIMATED BUDGET FOR 3 YEARS
A.I.D. CONTRIBUTIONA. Technical Assistance

	<u>AMOUNT (in \$000)</u>						
	<u>May 83</u>		<u>Nov 84</u>				<u>TOTAL</u>
	<u>Oct. 84</u>		<u>May 86</u>		<u>Total</u>		
	<u>FX</u>	<u>LC</u>	<u>FX</u>	<u>LC</u>	<u>FX</u>	<u>LC</u>	
1. Contractor (as estimated from WHS cost proposal)	867	213	962	213	1,829	426	2,255
2. Technical Advisory Committee (one meeting a year)	36	7	19	5	55	12	67
3. Local Consultants	-0-	20	-0-	22	-0-	42	22
TOTAL	<u>903</u>	<u>240</u>	<u>981</u>	<u>240</u>	<u>1,884</u>	<u>480</u>	<u>2,364</u>

ANNEX IV

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PROJECT ESTIMATED BUDGET FOR 3 YEARS
(A.I.D. CONTRIBUTION)B. Illustrative Commodity Requirement (*)
(All Commodities To Be Ordered from May 83 - October 84)

No.	Item	Unit	Quantity	AMOUNT		
				FX	LC	Total (\$000)
<u>A. Educational/Medical/Office:</u>						
1.	Autoclave steam sterilizer. (No. of RHC's of Phase III + 20% of all RIU's x 1.1.)	ea.	48 54			
2.	Refrigerator, electric 220 V, 50 H. o/a 6 cu ft 20% of Phase III facilities	ea.	31			
3.	Scale, adult weighing & height measuring, metric 140 - 160 kg. in 100 gm. graduation, Detecto 2391 or equal. No of RHC's/U's x 0.4	ea.	62			
4.	Scale, infant 15 1/2 kg. in 10 gm. graduation, Detecto 250 RHC's/U's x 0.4	ea.	62			
5.	Salter scale. (No. of nurses x 1.1.)	ea.	660			
6.	Sphygmomanometer, Velcro cuff with zippered case. (No. of nurses x 1.1.)	ea.	660			

NOTE: The detailed financial inputs for commodities provided in the draft Amendment is not included in the final PP Amendment document available to the public because the Mission does not want to provide an unfair advantage to potential bidders who obtain a copy of the approved PP Amendment. An estimated commodity budget by line item is on file at the Mission.

(*) - Cost is estimated as for CIF.

- 1.1 or 1.2 factor increases quantity by 10 or 20% to allow for training, breakage, loss error, etc.

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ANNEX IV

5

PROJECT ESTIMATED BUDGET FOR 3 YEARS
(A.I.D. CONTRIBUTION)B. Illustrative Commodity Requirement (*)
(All Commodities To Be Ordered from May 83 - October 84)

.No.	Item	Unit	Quantity	AMOUNT		
				FX	LC	Total (\$000)
A. Educational/Medical/Office:						
1.	Autoclave steam sterilizer. (No. of NIC's of Phase III + 20% of all RHU's x 1.1.)	ea.	48			54
2.	Refrigerator, electric 220 V, 50 H. o/a 6 cu ft 20% of Phase III facilities	ea.	31			
3.	Scale, adult weighing & height measuring, metric 140 - 160 kg. in 100 gm. graduation, Detecto 2391 or equal. No of NIC's/U's x 0.4	ea.	62			
4.	Scale, infant 15 1/2 kg. in 10 gm. graduation, Detecto 250 NIC's/U's x 0.4	ea.	62			
5.	Salter scale. (No. of nurses x 1.1.)	ea.	660			
6.	Sphygmomanometer, Velcro cuff with zippered case. (No. of nurses x 1.1.)	ea.	660			

NOTE: The detailed financial inputs for commodities provided in the draft Amendment is not included in the final PP Amendment document available to the public because the Mission does not want to provide an unfair advantage to potential bidders who obtain a copy of the approved PP Amendment. An estimated commodity budget by line item is on file at the Mission.

(*) - Cost is estimated as for CIF.

- 1.1 or 1.2 factor increases quantity by 10 or 20% to allow for training, breakage, loss error, etc.

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7.	Stethoscope, bell-diaphragm type, single tube, stainless steel. (No. of nurses x 1.1.)	ea.	660
8.	Thermometer - oral, centigrade scale scale, color coded, BD 4348 or equiv. [(No. nurses x 4)] + no. RHC's/U's x 10] x 1.2 x 3 years.	bx. (144)	100
9.	Thermometer - rectal - as above, BD 4358 or equivalent	bx. (144)	100
10.	Easles, portable aluminum or steel display size 29 x 40 with clamp for paper pads. (No. of training centers Phase III x 5) + (No. of training centers Phase I & II x 3.)	ea.	40 30
11.	Paper pads for easles, plain min. 60 sheets/pad. (No. of easles x 5 pads x 3 years.)	ea.	1,050
12.	Cooler, urethane, insulated, rust-proof 1 cu. ft. (No. of RHC's/U's x 1.1.)	ea.	170
13.	Thermos bottles, wide mouth, 1 lit. (No. of RHC's/H's x 1.1.)	ea.	170
14.	Otoscope, AA or C battery operated with carrying case, with set of 5 specula. (No. of RHC's (all phases) x 1.1.)	ea.	120
15.	Hemocytometer (HRC's x 1.1)	ea.	52
16.	Cover glass, hemocytometer. No. of hemocytometer x 4 pkg. x 3 years x 1.2	pkg.	750
17.	Delivery bag. (No. of nurses (all phases) x 1.1.)	ea.	1,760
18.	Forceps, hemostatic, kocher 5 1/2" stainless steel 2 per delivery bag	ea.	3,520
19.	Bulb syringe 2 per bag x 1.1	(50)	77
20.	Tape, umbilical cord, cotton 3 mm. diameter	btl.	3,870

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21.	Catheter, straight, rubber, one eye 16 " length assorted sizes 3 per bag x 1.1	ea.	5,800
22.	Fetoscope, chrome plated or wooden bell, 1 per bag	ea.	1,760
23.	Scissors, bandage 7", stainless steel 1 per bag	ea.	1,760
24.	Lancet, blood collecting, sterile, disposable, individually packed stainless steel. (No. of births x 2) +(No. of children 2 - 5 yrs. x 3 years x 0.8 coverage x 1.2.)	5,000	420
25.	Hemoglobin scales (Tallquist) 50 sheets x 4 test each	bk.	10,500
26.	Albustics. No. of births x 1 x 3 years x 0.8 coverage x 1.2. (To be ordered each year.)	btl.	4,600
27.	Clinistix - as above	btl.	9,200
28.	Vision testing chart, pediatric 9 x 18 metric - 2 per RHC's x 1.2	ea.	370
29.	Tape measure 2 meters non tearing graduation 0.5 cm. & 1 mm 2 per bag x 1.2	pkg.	4,000
30.	Arm circumference tape, measures 25 cm. graduation 0.5 cm & 1 mm 2 per bag	ea.	3,520
31.	Home visiting bag	ea.	1,760
32.	Syringes, hypodermic, 2 cc with 23 G. needles, sterile, disposable individually packed	ctn. 1,000	1,000
33.	Syringes (as above but 5 cc with 21 G. needles)	ctn. 500	1,000
34.	Calculators 1 RHC's/U's 1 per supervisor x 1.1	ea.	240
35.	Visual learning systems materials	ea.	900
36.	Community obstetric models	ea.	5

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37.	Magnetic media for mini-computer		
	- disc reels 102	ea.	6
	- tapes	ea.	60
38.	Overhead projector & screen	ea.	8
39.	Other community obstetric teaching (to be specified)	ea.	50
40.	Purchase, rental & maintenance of office equipment (photo copiers, typewriters & airconditioners)		several
41.	Office paper and supplies		several
42.	Office furniture & equipment		several
	a. central office		
	b. district office desks, chairs		10
	c. file cabinets 1 per center - uni		100
43.	Card punching device and supplies		6
500			
44.	Binders for manuals		several
several			

TOTAL

907,000 247,410 1,154,410

(Rounded: 1,154,000)

ANNEX IV

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C. Estimated Service Programs/Applied Research

	A M O U N T						
	(\$000)						
	May 83		Nov. 84		Total		Total
	FX	LC	FX	LC	FX	LC	
1. <u>Tetanus Neonatorum Applied Research Study:</u>							
- test equipment/tools	20.0	-	-	-	20.0	-	20.0
- training of staff & interviewers 120 X 13 days X 6 days	-	9.4	-	-	-	9.4	9.4
- Records, training handouts and survey forms	-	7.2	-	-	-	7.2	7.2
- Interviewers/associates salaries (estimated)	-	9.6	-	-	-	9.6	9.6
- Data processing	-	2.4	-	4.8	-	7.2	7.2
- Study conferences	-	2.4	-	2.4	-	4.8	4.8
Sub-Total	<u>20.0</u>	<u>31.0</u>	<u>-</u>	<u>7.2</u>	<u>20.0</u>	<u>38.2</u>	<u>58.2</u>
2. <u>Family Planning:</u>							
- Test equipment/tools	20.0	-	-	-	20.0	-	20.0
- Supplies, records, etc	-	36.0	-	-	-	36.0	36.0
- Training	-	9.6	-	-	-	9.6	9.6
- Field monitoring	-	1.8	-	1.8	-	3.6	3.6
- Data processing	-	6.0	-	-	-	6.0	6.0
- Study conferences	-	2.4	-	-	-	2.4	2.4
Sub-Total	<u>20.0</u>	<u>55.8</u>	<u>-</u>	<u>1.8</u>	<u>20.0</u>	<u>77.6</u>	<u>77.6</u>
3. <u>Environmental Sanitation:</u>							
- Test equipment/tools	20.0	-	-	-	20.0	-	20.0
- Training	-	9.6	-	-	-	9.6	9.6
- Records	-	36.1	-	-	-	36.1	36.1
- Field monitoring	-	2.4	-	1.2	-	3.6	3.6
- Miscellaneous	-	2.4	-	1.2	-	3.6	3.6
Sub-Total	<u>20.0</u>	<u>50.5</u>	<u>-</u>	<u>2.4</u>	<u>20.0</u>	<u>52.9</u>	<u>72.9</u>
4. <u>MCH Program:</u>							
- Training	-	12.0	-	7.2	-	19.2	19.2
- Field monitoring	-	1.8	-	1.8	-	3.6	3.6
Sub-Total	<u>-</u>	<u>13.8</u>	<u>-</u>	<u>9.0</u>	<u>-</u>	<u>22.8</u>	<u>22.8</u>
TOTAL	<u>60.0</u>	<u>151.1</u>	<u>0</u>	<u>20.4</u>	<u>60.0</u>	<u>171.5</u>	<u>231.5</u>

(Rounded to \$232)

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D. Estimated Training Budget *

		A M O U N T						
		(\$000)						
		May 83		Nov. 84		Total		
		Oct. 84	May 86			FX	LC	
		FX	LC	FX	LC	FX	LC	
						Total		
I.	<u>Overseas Training:</u>							
1.	Long-term: 20 participants x 22,000/yr. x 1 1/2 yr. Travel: 20 x \$1,325 (LE 1,100)	550.0	-	110.0	-	660.0	-	660.0
		-	26.5	-	-	-	26.5	26.5
2.	Short-term: 69 participants x 3,900/mo. Travel: 69 x \$1,142 (LE 950)	265.2	-	273.0	-	538.2	-	538.2
		-	38.8	-	40.0	-	78.8	78.8
3.	Costs of briefing/debriefing conference 89 participants x \$16 (LE 13/day) x 4 days	-	2.8	-	2.9	-	5.7	5.7
	Sub-Total	<u>815.2</u>	<u>68.1</u>	<u>383.0</u>	<u>42.9</u>	<u>1,198.2</u>	<u>111.0</u>	<u>1,309.2</u>
II.	<u>Local Training:</u>							
	1. Community Obstetrics Training:							
	- Training of trainers: 30 x \$17 (LE 14) x 10 days	-	5.0	-	-	-	5.0	5.0
	- Training of staff: 30 x \$12 (LE 10) x 2 mo. x 6 rounds/yr. x 3 yr. x 4 Gov'tes	-	31.3	-	20.7	-	52.0	52.0
	- Curriculum materials for trainers 100 pages x 50 copies x 0.024	-	0.1	-	-	-	0.1	0.1
	- Trainees' manuals 30 x 6 rounds x 3 yrs. 4 Gov'tes x 1.2 (20% extra) x 50 pages x 0.02	-	1.6	-	1.0	-	2.6	2.6
	- Field monitoring & conferences	-	4.0	-	3.6	-	7.6	7.6
	2. Inservice Training:							
	- Training of trainers & supervisors 12 x 18 centers x \$12 (LE 10) x 6 days x 5 yrs.	-	24.0	-	22.7	-	46.7	46.7
	- Curriculum material for trainers: 3 programs x 50 pages x 216 copies x 0.02	-	0.7	-	-	-	0.7	0.7
	- Handouts for trainees: 25 pages x 1,100 x 3 yr. x 0.024	-	1.2	-	0.7	-	1.9	1.9
	- Staff inservice training: 120 (LE 100) x x 6 days x 10 days x 3 yrs.	-	13.0	-	8.7	-	21.7	21.7
	- Miscellaneous	=	1.4	=	1.2	=	2.6	2.6
	Sub-Total	<u>0</u>	<u>82.3</u>	<u>0</u>	<u>58.6</u>	<u>0</u>	<u>140.9</u>	<u>140.9</u>
	TOTAL	<u>815.2</u>	<u>150.4</u>	<u>383.0</u>	<u>101.5</u>	<u>1,198.2</u>	<u>251.9</u>	<u>1,450.1</u>

* Overall training cost which represents standard GOARE per diem, training aids, educational materials etc.

ANNEX IV

11

E. Estimated Evaluation Budget

	A M O U N T						
	(\$000)						
	<u>May 83</u>		<u>Nov. 84</u>		<u>Total</u>		<u>Total</u>
	<u>FX</u>	<u>LC</u>	<u>FX</u>	<u>LC</u>	<u>FX</u>	<u>LC</u>	
1. Computer extra terminals 3 x \$5,000	-	-	15.0	-	15.0	-	15.0
2. Computer sof. ware	15.0	18.0	10.0	12.0	25.0	30.0	55.0
3. BMDP lease \$866 a year x 3	1.6	-	1.0	-	2.6	0	2.6
4. Supplies	2.2	3.6	2.0	3.6	4.2	7.2	11.4
5. Computer maintenance \$8,400 (LE 7,000)	-	16.7	-	8.5	-	25.2	25.2
6. HIS 6 rounds x 1,000 RH x 20 pages x 0.02 x 2 years	-	2.3	-	2.3	-	4.6	4.6
7. Interviewers' salaries: 30 x \$120 (LE 100) x 6 rounds	-	10.8	-	10.8	-	21.6	21.6
8. Work sampling 2 surveys x 10,000 sheets x 0.024	-	0.5	-	-	-	0.5	0.5
9. Observers' salaries: 20 x \$120 (LE 100) x 2 rounds	-	2.4	-	2.4	-	4.8	4.8
10. Service records, modules and mapping costs	-	180.0	-	120.0	-	300.0	300.0
11. SF, RDF & V.A. forms	-	2.4	-	1.2	-	3.6	3.6
12. Cost analysis (2 survey)	-	1.0	-	-	-	1.0	1.0
13. Reports	-	2.4	-	-	-	2.4	2.4
14. Translation Services (6,000 x 3 yrs.)	-	10.8	0	7.2	-	18.0	18.0
15. Outside evaluators \$5,000 x 4 x 2 and \$250 (LE 208) x 4 x 2	<u>20.0</u>	<u>1.0</u>	<u>20.0</u>	<u>1.0</u>	<u>40.0</u>	<u>2.0</u>	<u>42.0</u>
TOTAL:	<u>38.8</u>	<u>251.9</u>	<u>48.0</u>	<u>169.0</u>	<u>86.8</u>	<u>420.9</u>	<u>507.7</u>

(Rounded to \$500)