PD-AAR-008

Attachment # 6

415 B

MINISTRY OF HEALTH
Rural Health Dept.
Strengthening Rural Health Proj.
Nutrition Institute Building
16 Kasr El — Ainy Street
CAIRO
Arab Republic of Egypt

July 18, 1978

First Quarterly Progress Report

Introduction :

This report summarizes project activities and project experience from the time of arrival of the Westinghouse consultants, commencement of the project, through July 4, 1978 .

A financial report covering the same period will be separately submitted by Westinghouse Health Systems, Columbia.

The project "Strengthening of Rural Health Services" was established to identify major constraints to the effective and efficient provision of health services to rural population groups. Major constraints to the effective delivery of services had earlier been identified by the MOH and included inadequate transportation and communications systems, lacking health care provider motivation, inefficient supervision and back-up of peripheral health staff and underutilization of the existing services by the rural population as principal components. Following and concurrent with further identification or verification of constraints, health service innovations are to be introduced and tested for their effects on the health service delivery system.

Prior to the arrival of the consultants arrangements had already been made to alleviate transportation constraints through import of 280 vehicles for distribution to mainly peripheral health care providers.

I) Project organization, activities and achievements up to date

Upon arrival of the consultants a tentative work plan for the first three months of project activities as well as an informal organizational framework for the execution of responsibilities were established .

1. Office organization and administration.

The office of the "Strengthening of Rural Health Service Delivery" (SRHD) Project occupies a spacious (aprox.) 250 square meters on the third floor of the Institute of Nutrition, 16 Kasr el Eini street.

The SRHD core staff consists of the two Westinghouse consultants, one Egyptian official specially deputed by the MOH to the SRHD for the life of the project - the executive project director.
These are assisted by a number of supportive staff; i.e. administrative assistant, accountant, clerical help etc.

Except for an additional bilingual secretary (to the project executive director and Deputy chief of Party) the SRHD staff is now complete. Most of the office equipment has been procured and is operative. Figure 1 shows the functional organization of the SRHD office.

2. Functional organization.

The Westinghouse consultants are responsible for the preparation of the implementation plans, for the planning and execution of evaluation activities; they assist with the overall management of project activities and plan and are responsible for periodic accounts and report on project progress and achievements.

At regular meetings, at least once a week, the SRHD core staff met with the Undersecretary of state for enderic diseases control sector (the project director) and with the Director general for rural health (the assistant project director) to review experiences and progress, and adapt or modify plans to locally prevailing conditions and constraints and to chart out future goals and activities. Once every two weeks a meeting between the AID project monitor and SRHD core staff was held to discuss relevant administrative or contract matter.

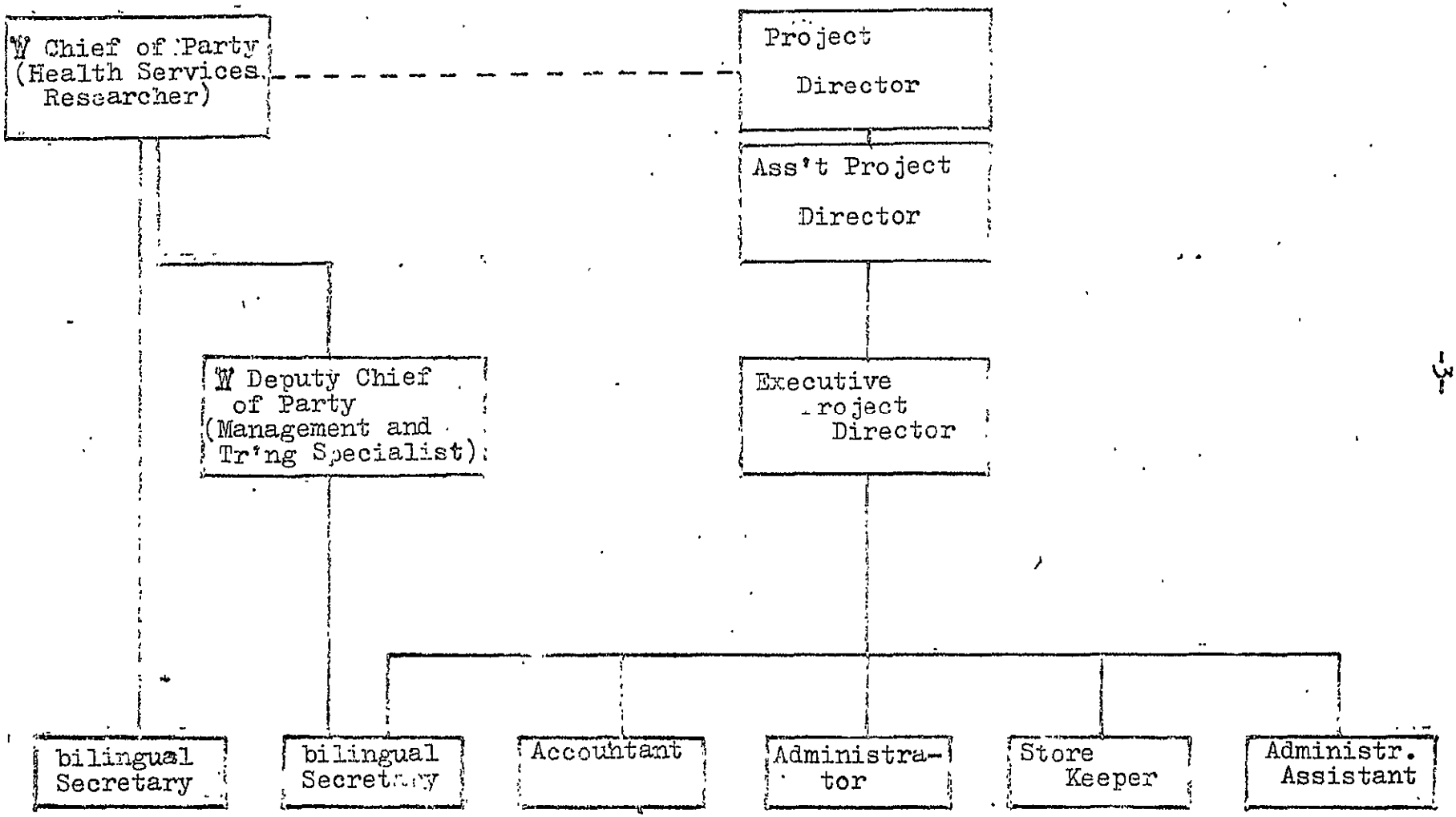
3. Project progress and achievements.

The workplan for the preparatory phase essentially foresaw three sequentially scheduled steps. Preliminary data collection and interpretation; problem identification and/or verification; development of implementation plan.

In the collection of background material we screened published of mimeographed material relevant to the project, gathered information in the course of discussions with MOH (and SRHD) key personnel

Figure 1

FUNCTIONAL ORGANOGRAM OF SRHD OFFICE



and undertook field trips as well as participated in a conference on rural health issues.

Preschool child mortality consisting mainly of a (conservatively) estimated Infant Mortality Rate of 150 to 180 and a second year mortality of 100 was identified as the single most important health problem. High child morbidity prevalence, especially of diarrheal disease (which alone accounts for approx. 70 % of all preschool child deaths), rapid population increase, prevalence of and disability from schistosomiasis in the adult and child populations, undernutrition including anemia, high prevalence of parasitic and endemic diseases (helminths, trachoma and Tb etc.) were other conditions identified, in decreasing order of priority. On the causal or contributory side, quality of health care delivery, poor environmental conditions, low levels of consumer knowledge about and inappropriate preparation of the health care providers for the management of simple childhood disorders, notably diarrheal disease, and a weak or inadequate logistic support system (transport and communication) were reaffirmed or newly identified.

Subsequently an implementation plan was prepared directly in response to these health needs and problem priorities.

The plan focusses on the preschool child and on the rural family's health needs through strengthening of existing MCH services as well as through newly developed outreach and health education components. Additionally all major health service programs (CDC, environmental sanitation etc) were strengthened through reorganization and integration with each other and with administrative or logistic support programs.

Major parts of the plan were dedicated to alleviation of logistic and administrative support and educational shortcomings.

Having completed the work plan consultant needs both with respect to area of expertise and required time could then be estimated more precisely than it was hitherto possible. In the selection of consultants care was taken to :

i. Fill a real need.

ii. Select persons on the merit of their expertise either if personally known (to SRHD core staff) or, if acknowledged experts in their fields according to peer review, publications etc.

iii. Use of local or regional experts especially in areas requiring familarity with customs, traditions and political constraints i.e. in the social sciences.

At the writing of this report the implementation plan still needs final editing and typing but is expected to be ready for distribution to USAID and to the Technical Advisory Committee members by July 25, 1978 .

II) Planned Activities

Following completion of the implementation plan a number of tasks need to be accomplished over the next 5½ months and prior to implementation of phase I. First and foremost is the task of preparing for project implementation. Activities in preparation for this event include but are not limited to :

1. Revision of , correction and additions to our workplan either because of Technical Review Committee suggestions more precise information collected during subsequent field visits or because of consultant inputs ;
2. fielding of consultants,
3. preparation for and holding of teaching sessions for health centre/unit and district personnel,
4. elaboration or modification of records and forms for the altered health service delivery, supervisory and logistic support systems,
5. build up of the logistic and supervisory support systems,
6. considerably more field visits by SRHD core staff to more precisely determine health needs, health care delivery practices and shortcomings in the biomedical , administrative and supporting sides than has been possible.

Next , we need to plan and develop a number of applied research proposals mainly to find ways to improve cost-effectiveness of health service delivery, to explain observed levels of health and health related behavioral patterns and to improve our knowledge about child growth and development in the rural Egyptian ecology.

Finally we have to anticipate and plan for implementation phase II and III.