

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

WASHINGTON, D.C. 20523

PROJECT PAPER

AMENDMENT #1

EGYPT: Control of Diarrheal Diseases
(263-0137)

July 12, 1987

UNCLASSIFIED

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
 C = Change
 D = Delete

Amendment Number

1

DOCUMENT CODE

3

COUNTRY/ENTITY

EGYPT

5. PROJECT NUMBER

263-0137

BUREAU/OFFICE

ASIA NEAR EAST

03

5. PROJECT TITLE (maximum 40 characters)

Control of Diarrheal Diseases

PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
09 30 90

7. ESTIMATED DATE OF OBLIGATION

(Under "B." below, enter 1, 2, 3, or 4)

A. Initial FY 81

B. Quarter 4

C. Final FY 86

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

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(8,164)	(17,836)	(26,000)	(10,856)	(25,144)	(36,000)
(Loan)	()	()	()	()	()	()
Other						
U.S.						
1.						
2.						
Host Country		500	500		26,300	26,300
Other Donor(s)						
TOTALS	8,164	18,336	26,500	10,856	51,444	62,300

9. SCHEDULE OF AID FUNDING (\$000)

A. APPRO-PRATION	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) ESF	510	550		26,000		10,000		36,000	
2)									
3)									
4)									
TOTALS				26,000		10,000		36,000	

10. SECONDARY TECHNICAL CODES (maximum 5 codes of 3 positions each)

510 550 560

11. SECONDARY PURPOSE CODE

530

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

A. Code TECH
 B. Amount 6,550

13. PROJECT PURPOSE (maximum 480 characters)

To reduce mortality from acute diarrheal disease by making rehydration services and materials (especially oral rehydration therapy) widely available and used through a national program.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY
05 84 07 90

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify):

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a 26 page PP Amendment)

Controller, USAID/Egypt concurs with the methods of implementation and financing proposed herein.

William A. Miller
 William A. Miller, Controller

17. APPROVED BY

Signature
 Arthur M. Handly
 Title
 Acting Director

Date Signed
 MM DD YY
07 12 87

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

MM DD YY

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CONTROL OF DIARRHEAL DISEASES
PROJECT 263-0137

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I. Summary and Recommendations:

A. Grantee:

The Government of the Arab Republic of Egypt (GOE)

B. Implementing Agency:

The Ministry of Health (MOH)

C. Grant Amount:

Adds \$10 million to bring AID's life of project funding to \$36 million, which will permit an extension of the grant agreement for thirty six (36) months of additional assistance.

D. Sector and Project Goal:

Improvement of the health of the Egyptian people especially children.

E. Project Purpose:

To reduce child mortality from acute diarrheal disease by making rehydration services and materials (especially oral rehydration therapy) widely available and used through a national program.

F. Purpose of the Project Paper Amendment:

This amendment recommends revisions in the following:

1) Project:

by amending certain project outputs to:

- a) facilitate the phased transfer of responsibilities for ORT program administration and implementation into the responsible units of the Ministry of Health and related parts of the Child Survival Project (No. 263-0203); and,
- b) respond to recommendations made by the July 1986 mid-term project evaluation team (see Sections II and III).

2) Duration:

Extend the project PACD from September 30, 1987 to September 30, 1990, to correspond with planned phased integration of activities and institutionalization into the MOH and appropriate Child Survival Project activities.

3) Grant Agreement:

Extend the grant agreement between USAID/GOE from September 30, 1987, to September 30, 1990.

4) Funding:

Provide new funds (US\$ 10 million) to support the project extension.

H. The Project Committee has reviewed the Project Amendment and recommends that it be approved. The committee found that the PP amendment was technically sound, carefully planned, contains adequate budget and comprises the optimal approach to achieving project objectives during the extension period.

II. Project Description

A. Background

On September 27, 1981, AID signed a Grant Agreement providing \$26 million to begin the National Control of Diarrheal Diseases Project (NCDDP). The GOE agreed to provide the equivalent of \$17 million for the project.

The project purpose was to reduce the high morbidity and mortality in young children from dehydration associated with diarrheal diseases within five years, through increased availability and usage of rehydration services and materials especially oral rehydration therapy (ORT).

There was a delay in the commencement of project implementation. A host country contract, with John Snow Inc. (JSI), was not signed until October 1982, which required that the original Project PACD be extended by one additional year. The JSI field staff arrived in Egypt in January 1983.

During Phase I, which began on January, 1983, the project was implemented on a pilot scale in preparation for national level implementation. The first implementation plan, for Phase II project activities, was not developed until February 1984. The original project design anticipated that implementation of the Phase I Pilot Project activities and subsequent planning for Phase II activities would all occur within the first year of the project, i.e. 9/81 - 8/82. This series of unexpected delays, however, resulted in the preparation of the Phase II plan taking place over two years later than originally planned.

In the four years since the NCDDP began, significant progress has been made in meeting the project purpose of reducing child mortality from diarrheal disease through ensuring widespread access to, acceptance of, and use of ORT, and through the upgrading of diarrhea case management. Sufficient quantities of ORS to meet demand are now available, and widespread services are in place throughout the country. 99% of all health facilities dealing with children in Egypt provide rehydration services. As of June 30, 1986, 85% of health facilities had functioning MOH rehydration centers. These centers were equipped and upgraded through grants provided to governorates by the project and trained staff run these centers. Annual in-country production of ORS has increased from 3 million-liter equivalents to 15 million. These packets are regularly distributed to 3,292 rehydration units, and to over 6,000 existing private pharmacies. Surveys and studies have shown that levels of knowledge of ORS among mothers are currently 96%. In the Joint Review/Evaluation survey of 161 mothers 82% had used ORS to treat diarrhea and 97% of these women could correctly mix ORS when asked. With 27,594 health personnel who have been trained in rehydration techniques, ORT is increasingly becoming standard treatment for childhood diarrhea in Egypt.

Project activities have been accomplished through the Project Secretariat's ability to obtain the right mix of skilled personnel through several sources. These include experienced MOH personnel seconded to the project, experts or specialists from the private sector, and medical specialists from university medical schools. The Secretariat has also contracted extensively with local private and public sector firms for studies, services, and commodities. Minimal use has been made of short term U.S. consultant services as most were available locally. MOH personnel in the project have received incentives and other personnel have been paid on a salary basis from USAID grant funds. Other incentives such as research grants and commodities have been provided to universities.

The project has had excellent U.S. technical assistance personnel, who from the beginning have enjoyed a very close collaborative and collegial role with the Secretariat personnel. The TA personnel have provided assistance in the development of the Secretariat administrative structure, planning of project activities, the development of training materials, and in evaluation.

Secretariat personnel have carried out all of the tasks required to implement the project: training of trainers; development of training programs and clinical services; clinical supervision; media development; supervision of ORS production and distribution; and evaluation and research. Activities related to training and services in the governorates have been implemented through the governorate ORT coordinators and Director Generals' of Health using local personnel.

A unique feature of the project has been the close cooperation between medical school faculties and the Secretariat. Senior pediatric professors have provided very strong support for ORT and have established ORT clinics in all of the medical faculties' teaching hospitals. These centers provide didactic and hands on clinical experience in ORT for thousands of medical students each year. This training is an essential element for integration of ORT in standard medical practice for the future.

An unplanned output of the project has been the development of an active research component mainly through the universities. Some of this research is receiving international attention and is serving to establish scientific links in diarrheal disease research between Egyptian and US researchers.

The Amendment will provide the expertise and funding to develop a sustainable national support system for the Egyptian ORT program in the Ministry of Health, and to strengthen a self financing support system for private sector ORT services.

The original PP touched on institutionalization but focused on the urgent need to make ORI widely available and used to rapidly reduce mortality from dehydration in young children. The project has been highly successful in making ORI the standard treatment for dehydration and has achieved the highest usage level in the developing world through a vigorous campaign effort.

However, experiences in the Gambia and Honduras have shown that when ORT campaigns end usage of ORT drops, and this is now a concern in the Egypt program.

Sustainability was identified as an issue for the 1986 mid term evaluation. The Joint Review Evaluation Team noted with concern that the NCDDP Secretariat had usurped the role of the National Control of Diarrheal Disease Programme which existed in the MOH prior to the CDD Project and that the national administrative body for ORT was now located in a temporary unit scheduled to phase out at the end of the project. The Evaluation Team stated that while the Secretariat had been highly effective it was now time to begin transferring the responsibilities back to the MOH vertical program.

Recognizing that insufficient time remained to carry out this task, the Evaluation recommended that:

"The NCDDP should be extended for at least two (2) years beyond September 1987. The current administrative structure should be maintained in the short term, but planning for phased transfer of all project activities to relevant sections of the Ministry of Health should be initiated as soon as possible."

Based on the mid-term evaluation recommendations, the MOH has requested assistance from USAID to extend the NCDDP Project a period of three (3) years to further strengthen its institutional capacity to implement an ORT program and to provide time for a phased integration of related ORT activities into the MOH and appropriate and Child Survival activities.

ORT services are delivered through governorate health units under the supervision of the governorate Director General of Health. However the governorate health services are dependent on the MOH for ORS and other rehydration supplies and are responsible for following guidelines for training and service delivery developed by the MOH as part of a national plan. Governorate health services also submit statistical records on ORI to the MOH.

A Central MOH Unit for the Control of Diarrheal Diseases would have the responsibility for planning the national ORT program on an annual basis. The unit would be responsible for determining national annual requirements for ORS based on statistical reports from the governorates; maintaining an adequate logistical system for support of ORT services; preparing annual statistical reports on ORI services; and setting quality care guidelines for training of personnel and delivery of ORT services. The Unit would also have responsibility for arranging public education programs on ORT.

Planning for this transfer of Secretariat functions to a permanent MOH unit has been complemented by the Child Survival Project now in the initial stages of implementation. ORT and Immunization are the two major components of Child Survival and the reporting of ORT activities is and will continue to be a requirement by AID/W, UNICEF, and WHO. Further ORT activities can be easily integrated into the Child Survival Project as designed. For example Child Survival will be working with the same health personnel now involved in ORT at the delivery and supervisory level and it would not be difficult to design basic and/or refresher training courses integrating ORT with other Child Survival interventions. A major support function of Child Survival will be the development of a management information system to include data on Child Survival morbidity, mortality, and interventions. When this reporting system is established, ORT will have to be included so it is reasonable to plan that statistical reporting and evaluation activities will be transferred to Child Survival to eventually provide an assessment of the impact of a Child Survival package.

It is particularly important that the mass communication activities for ORT be continued and transferred to Child Survival. Mass media has produced a demand driven ORT program and this must be maintained because each year there are several hundred thousand new mothers with young infants who are at a high risk from dehydration. As the Child Survival Project will also make extensive use of mass media, the messages must be designed and coordinated to reinforce important areas, to prevent information overload, and to avoid contradictory information.

The role of ORI in the Egypt Child Survival Project was left unresolved in the Child Survival PP with the statement that "Further activities in childhood disease control will be carried out either through an amendment to the present CDD Project or to the Child Survival Project." Since the Child Survival Project has not progressed to the stage where ORT can be integrated, the choice is to amend the CDD Project to maintain project momentum during this critical period of phase over from the campaign to a permanent program.

It is anticipated that CDD activities as described could begin phasing over to Child Survival by the second year of the Amendment as the other support functions are being re-established in the MOH.

A major task in the first month of the Amendment period will be the development of a master plan detailing the phase over for a two year period.

B. Project Strategy and Components

The original Project Paper stated that:

"The project strategy is to build and expand upon an existing infrastructure of private and public facilities and networks delivering health services (formal and informal). The strategy involves the Ministry of Health, universities, the Medical and Pharmacy Syndicates, CID, pharmacies, and local communities themselves to create awareness of and support for rehydration programs. Rehydration is an integral part of MCH services in Egypt. However, since utilization of services in fixed Government facilities is limited, the project will explore,

develop and refine alternative methodologies for broadening access to services, including commercial networks. While many of the interventions have been tested on a pilot scale, the establishment of an effective national program is, nonetheless, complex and will involve the testing and coordination of several sets of activities leading to achievement of the project purpose. These are:"

"1. Administration: This component of the design establishes the organizational structure necessary to plan, initiate, implement, and coordinate a national rehydration campaign. The design calls for a Steering Committee at a technical level including Ministry, university and private sector members to oversee rehydration policies and strategies; a Secretariat linked to the Ministry of Health with full-time staff assisted by Egyptian and U.S. contractors to develop, test and direct a national campaign; and full-time Governorate ORT Coordinators who will implement the project at the local level.

The first 18 months of the project will be directed to testing a coordinated strategy in one governorate and development of a comprehensive campaign plan to be carried out nationwide over the remaining 3 1/2 years.

2. Production and Distribution: This component deals with packaged ORS to be supplied by Chemical Industries Development (CID), with ORS availability through existing outlets (such as pharmacies) and distribution to new outlets (such as dukkans, or older mothers in each hamlet serving as a repository and teacher for other mothers). The component will also assure the distribution of a special intravenous rehydrating solution tailored to diarrheal disease, and scalp-vein needles necessary for infusion of infants.

3. Training: The project will develop Governorate ORT Coordinators and a core of trained staff (pediatricians from medical schools and general hospitals and senior nurses at the two existing rehydration centers). This group will teach governorate teams to provide training to Health Center and unit personnel who will in turn be responsible for face-to-face instruction of mothers. The training teams will also work with village councils, district hospital staff, CID detail salesmen and professionals, and dayas.

4. Information, education and communication (IEC) will build a national public education campaign to help create awareness of, demand for, and expertness in the use of ORT. The sub-components of public education include face-to-face and group training of include practitioners, village leaders, and parents; and a mass media campaign will reinforce these other forms of education and training.

5. Evaluation will provide data both for management purposes, that is, on-going decision-making; and for determination of outcomes. Market analysis, audience message testing, operational research, household and sentinel facility surveys will be used to track the progress of each component of the project, and to determine the further directions to take."

The original Project Paper, established four objectives that would indicate that End of Project Status had been achieved, these were: :

- 1) To reduce diarrhea-related mortality in the under 5 year olds by at least 25%;
- 2) To increase mothers' awareness of ORT to 90% and their understanding of its appropriate use to 75%;
- 3) To ensure that the health system treats more than 50% of its serious cases of diarrhea with ORT;
- 4) To reduce hospital diarrhea mortality rates to 5%.

There were a total of seven project outputs aimed toward achieving the above objectives. These original outputs will be continued and increased in magnitude (see log frame).

OUTPUT 1:

A national rehydration campaign plan successfully implemented by multi-channel Steering Committee.

OUTPUT 2:

Production and distribution of ORT materials to MOH and private sector in quantities of: 350,000 half-liter special intravenous fluid; 350,000 scalp-vein needles; 110,000,000 packets ORS (\$40 million at peak year) distributed.

OUTPUT 3:

Training of 25 Governorate ORT Coordinators, 180 senior pediatricians, 180 senior nurses, 750 MOH hospital physicians and nurses trained in ORT.

OUTPUT 4:

125 Governorate Training Teams (GITs) trained which will train Rural Health Unit (RHU) staff, village leaders and mothers in ORT in training courses held twice annually in each RHU.

OUTPUT 5:

Training of private sector physicians and pharmacists in CRT through 100 pharmaceutical detail men trained to inform their clients about ORT.

OUTPUT 6:

25 Governorate rehydration centers established and operational (1 per Governorate).

OUTPUT 7:

Mass media campaign with Radio, T.V. spots, posters, logos, and educational material reaching 90% of the population.

The original project strategy and design was based on what appeared to be the appropriate timing, phasing and mode of USAID inputs, given the GOE's then current functional and absorptive capacity. As a result, the project focused initially on a national campaign approach which would coordinate, facilitate, and enhance the diarrhea control activities of other organizations. The campaign approach HCDD required ongoing program activities to sustain impact. The design also envisioned program extension and expansion of project scope to include a preventive and promotive program approach.

There are differences between the outputs presented in the original Project Paper and those given in the Phase II implementation plan, developed two years later. This is not unusual, given the time gap, intervening inputs, and more detailed assessment of needs, available resources and existing capabilities made by MCH project staff and technical consultants.

C. Progress to Date

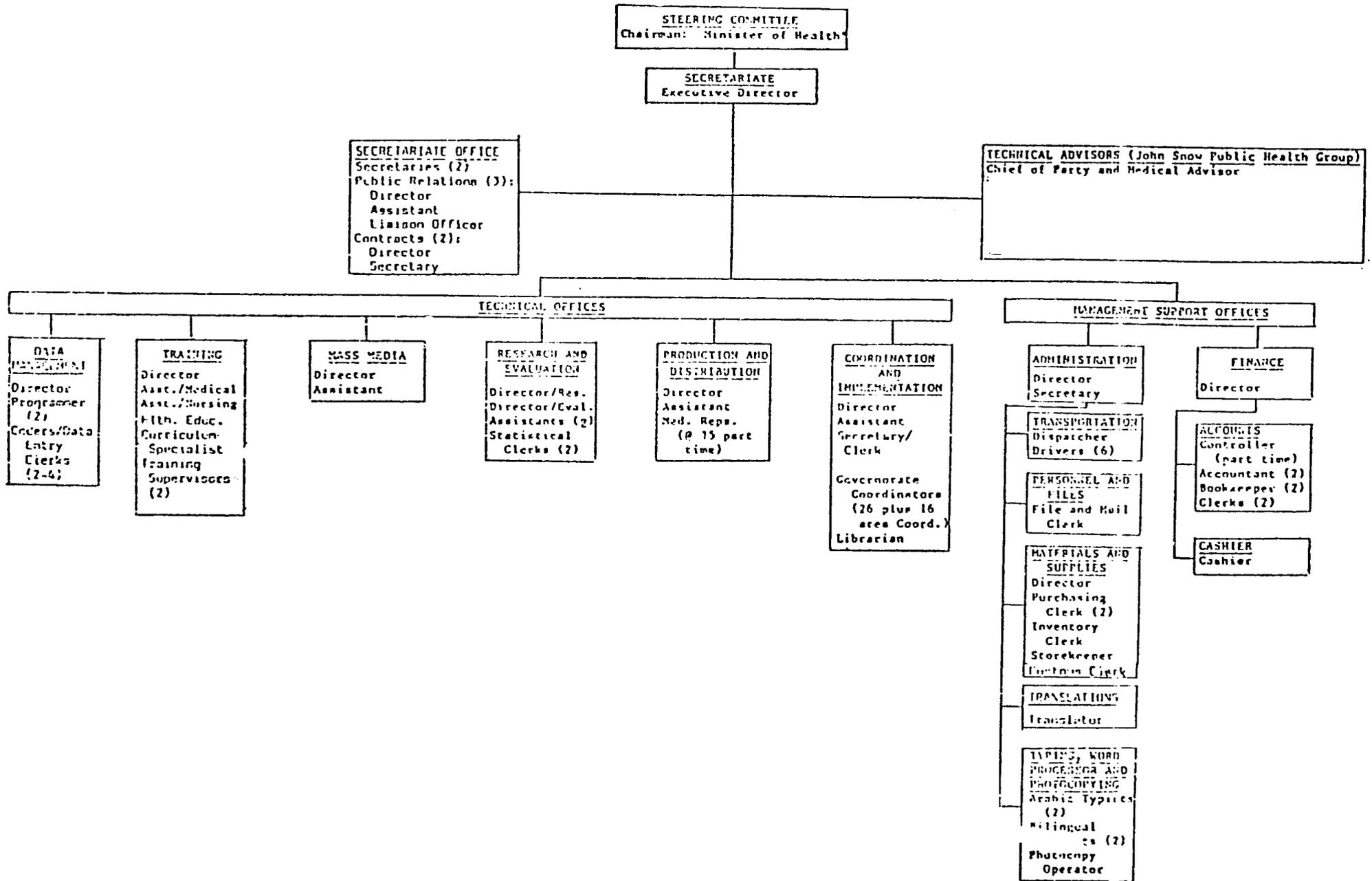
In 1978 the MCH started a national control of Diarrheal Diseases Program. This program was intended to work through the network of primary health care units in the country, and operated from the division of MCH. With the start of the NCDEP in 1983 a separate semi-autonomous secretariat was established. In functional terms, the national CDD Program for children was replaced by the NCDDP. The semi-autonomous Secretariat was designed and established in response to the Project's administrative objective, to develop an organizational structure necessary to plan, initiate, implement and coordinate a national rehydration campaign.

The NCDD Project is an organization established to coordinate, facilitate and enhance the activities of other organizations. It is not a vertical health program, because it provides no direct services, making it possible for other organizations to do this. At the policy making level, there is a steering committee chaired by the Minister of Health or his representative.

The committee members, represent various ministries, departments and other organizations who can facilitate the work of the Project. They determine the overall policy and ensure that the concerned organizations provide the required cooperation.

Management of the Project is provided by a Secretariat (Figure 1). The Executive Director is assisted by seven Coordinators, or Assistant Directors. Their respective responsibilities include administration, research, evaluation, training, production and distribution, mass media, coordination and implementation. Each unit has a staff to plan and implement its responsibilities. The technical assistance is provided by John Snow Inc. through a host country agreement. At the governorate level one assistant of Director of Health is nominated as NCDDP Government Coordinator, to coordinate CDD activities at this level.

Figure
NATIONAL CONTROL OF DIARRHEAL DISEASE PROJECT
ORGANIZATIONAL CHART



* Chairmanship delegated to Undersecretary of State.

Phase I of the project focused primarily on the organization, planning, and establishment of the project. More specifically, Phase I mandated the organization of a National Steering Committee, a National Secretariat, the establishment of the program on a pilot basis in one governorate (Alexandria), and the development and testing of feasible strategies and activities for national replication in Phase II. This was accomplished by January, 1984.

Phase II, which began in 1984, has focused on the national implementation of strategies and activities tested in the pilot campaign in Alexandria. Initial efforts involved the orientation and training of physicians in ORT, expansion of a production line for ORS packets, setting up ORT clinics in university teaching hospitals and MOH units, and developing media messages for national TV.

By mid 1986, the following progress had been made in meeting the outputs:

1. A National Rehydration Plan was developed in 1984, approved by the Steering Committee and under implementation. The plan is revised annually to meet expanding program needs.
2. ORS is being produced by a local company in adequate amounts to meet the demand in both the public and private sectors. The ORS is being distributed to commercial pharmacies by a private sector company with access to 90% of Egypt pharmacies, which are selling about 9 million liters per year or 60% of the production.
3. 25 Governorate ORT Coordinators, over 18,000 physicians, 10,000 nurses, and 828 pharmacists have been trained in ORT in 30 Training Centers throughout Egypt established by the project. These training centers were established in lieu of the Governorate Training Teams (GTTs).
4. ORS is available in all of Egypt's 3,292 health services delivery units. ORT rooms have been established in 2700 of these units (85%). Eleven of these units are in university teaching hospitals which train about 5000 medical students per year.
5. A mass media campaign has been designed and implemented on national TV reaching 96% of the population with 70% of the mothers surveyed reporting use of ORS in the latest KAP study.

The project has not concentrated on training detail men as a private company was contracted to distribute ORS to commercial pharmacies. This company which supplies 90% of all pharmacies in Egypt had detail men available.

The status of the Purpose Indicators or End of Project Status (EOPS) is as follows:

1. Diarrhea mortality in under 5's reduced by at least 25%.
Surveys and studies conducted by the Project have shown a decrease in reported infant deaths during the diarrhea season, most notably in Alexandria where reported deaths have decreased by 40% since 1983. The Joint Review/Evaluation noted that it was reasonable to assume that the Project has impacted on mortality. However the current data available does not support this assumption and the Project will undertake further studies to estimate the extent of this impact by appropriate demographic and epidemiological means. The studies completed by this project will serve as a baseline for the Child Survival Project as well as an epidemiological statistical model.
2. 90% of mothers are aware of ORT, 75% understand its use.
The Project has surpassed this EOPS through the use of mass media. Currently 96% of mothers know about ORS, 70% use it, and 97% of the users can mix ORS correctly.
3. More than 50% of serious cases seen by the health system get ORT.
In 1985, MOH clinics reported treating 1.3 million plus cases. Of this number 34,413 cases or 2.6% received IV fluids so that over 97% of children seen received ORS.
4. Hospital diarrhea mortality rates fall to 5%.
Reported deaths from dehydration in clinics and hospitals decreased from 5.5/1000 in 1983, to 2/1000 in 1985. These statistics require more analysis to be confirmed.

D. Mid-Term Evaluation

The 1985 Midterm Evaluation Report commended the CDD Project on the impressive levels of knowledge and use of ORS among mothers in Egypt; the production of adequate quantities of ORS locally; and the effective distribution of ORS to over 3000 GOE health units and 6000 commercial pharmacies. The report stated that it was noteworthy that this had been accomplished in just 3 1/2 years at a modest cost of little more than L.E. 1.00 for each mother gaining this benefit.

The report noted that while there was general agreement in the international health community that the use of ORT would reduce deaths due to dehydration, the data produced thus far by the Project on mortality reduction was not conclusive. It was recommended that

the Project undertake the necessary studies to estimate the impact of the project on mortality by appropriate demographic and epidemiological measures. The report also recommended revising the Project Management Information System to obtain more relevant information.

The major recommendations of the evaluation were as follows:

1. Extend the CDD Project for at least two years beyond September 1987, to permit phased transfer of administrative responsibility for all project activities to relevant sections of the Ministry of Health. See revised implementation schedule on pages 27 - 30.
2. Give priority to the training of health professionals in diarrhea case management skills based on the newly developed guidelines of the NCDDP. This training should be formally incorporated into the basic curricula of all health educational institutions.
3. Emphasize correct use of ORS, feeding during diarrhea, and the prevention of diarrhea in media messages; and strengthen health education in MCH facilities through improving the communication skills of health workers.
4. Simplify the routine reporting system of the NCDDP to collect only the information needed for project management. There should be a tiered reporting system with appropriate compilation and analysis of data at each level.
5. Undertake a variety of carefully planned and implemented research and evaluation studies that aim to measure the extent of the impact on infant and child mortality, especially that part attributable to dehydrating diarrhea, while also giving priority to effective use of ORT, diarrhea-preventing interventions, and health services management.
6. Improve monitoring of evaluation activities by contractors through the newly formed Scientific Committee and its sub groups.
7. Give consideration to employing an experienced epidemiologist/statistician to ensure appropriate statistical design and analysis for the large amount of quantified statistically based evaluation and research being undertaken.
8. Undertake efforts to limit the inappropriate use of drugs in the treatment of diarrhea. These may include the development of guidelines for health care providers on the correct indications for the use of antibiotics.

9. Link the payment of incentives to peripheral health personnel to objectively evaluated performance. To this end, the incentive system should be reviewed with the involvement of district level personnel. Non-financial incentives should also be considered.
10. Expand the ORS depot holder scheme to other rural areas to increase outreach to underserved areas.

III. The Amended Project

A. The Project Purpose for Amendment I is:

To reduce child mortality from acute diarrheal diseases by making rehydration services and materials (especially oral rehydration therapy) widely available and used through a national program.

B. Amended Project Description

Amendment I to the CDD Project will extend the project for three years to continue and expand current project efforts; and to further institutionalize and strengthen MOH administrative capacity to implement and sustain a national diarrheal disease control program through a phased transfer of programmatic responsibilities into relevant MOH units.

Internationally, CRT is considered as a major component of the overall Child Survival formula. The Child Survival Project, (CSP), Paper envisions the integration of CRT into Child Survival activities.

The NCDDP has paved the way for Child Survival activities, the vast amount of experience and knowledge gained from implementation of the NCDDP can serve as a guide for CSP activities.

Integration of NCDDP and CSP has already begun. During the current CSP planning phase, activities have been assessed and planned in a collaborative manner. The current network of NCDDP activities is being coordinated and in some cases used as a part of CSP activities. A joint NCDDP and CSP conference is planned for October, 1987 to develop an action plan for coordination and integration of activities.

The detailed plan of institutionalization will include a section on integration of CRT activities with the CSP.

Project activities and efforts during the Amendment will focus on the original five project components: Administration; Production and Distribution; Training; Information, Education, and Communication (IEC); and Evaluation. A component, Research, has also been added to contribute improved techniques for diagnosis, treatment, and prevention of diarrheal diseases. The original project outputs remain relevant for this amendment with changes in the magnitude of outputs which in most areas have exceeded those originally projected. See Amended Logistical Framework (Annex B).

1. Institutionalization

The institutionalization of NCDDP activities requires a systematic, well planned and organized transfer and/or strengthening of CRT administrative functions in government (MOH), public (CID) and private (pharmacies and physicians offices) organizations.

A number of administrative functions are already completely in place. Many activities have been firmly implanted and require strengthening and complete transfer of administrative responsibilities.

Prior to the start of the NCDDP in 1983 the concept of diarrheal dehydration and use of ORT was virtually unknown, i.e., less than 1% of mothers were aware of the concept of diarrheal dehydration and less than 5% knew about ORS. There were no rehydration units in MOH facilities, and ORT was not included as a part of health personnel training activities. Further, 3.5 million packets of ORS were locally produced under the name of Rehydran, 1 million 27.5 gm. UNICEF packets were imported and half a million locally produced.

Currently more than 96% mothers are aware of ORS and 70% have used ORS, 32 million packets of ORS were produced in 1986 and distributed to over 6,000 private pharmacies and 3292 MOH Health Services Delivery Units. Over 2,700 CRT rooms have been established in MOH facilities, and over 28,000 health personnel have been trained in ORT. The NCDDP has had the major administrative responsibility for managing the above activities.

The following summary delineates the current administrative responsibilities for ORT activities in the government, public and private sectors.

The NCDDP has sole responsibility for:

- The development production and management of the Control of Diarrheal Diseases (CDD) mass media and communications campaign.
- Contracting for:
 - . Production of ORS
 - . Distribution of ORS to private sector
 - . Production and distribution of cups and spoons
 - . Production and distribution of IV fluids
 - . Procurement and distribution of Rehydration unit equipment and supplies.

Provision of Financial Grants for:

- . Establishment and renovation of Rehydration units
- . Training of Health Personnel in ORT
- . Research Studies
- . Evaluation Studies
- . Improvement of Laboratory Diagnostic
- . Procedures

The NCDDP and Ministry of Health, (government sector) have shared responsibility for a number of activities. These activities have been implanted at the national and local level and are seen as:

- special NCDDP activities;

- NCDDP Steering committee
- NCDDP Secretariate staff
- NCDDP Governorate
- Coordinators
- Support of the Diarrheal Diseases information system.
- Support for procurement of Project Committees.
- Contracting with CID for continued production of ORS.
- Routine Work:
 - Training of MOH Health Personnel.
 - Distribution of ORS equipment and supplies to MOH and University Hospital facilities
 - Management Rehydration Centers

Public Sector (Parastatal) Companies have been responsible for:

- Production of ORS (CID)
- Distribution of ORS (Egydrug and CID).
- Production and distribution of OR IV fluids (El Nasr Pharmaceutical Co.)

Private Sector Organizations have been responsible for:

- Sales of ORS (Pharmacies). Distribution (Middle East Drug) and Sales of ORS (Pharmacies).
- Sales of OR IV fluid (pharmacies)
- Provision of ORT Services (private physicians).
- Research Studies (Sinai, SPAAC and MEAG).
- Evaluation Studies (RADAR, SINAI and SPAAC).
- Production and Supply of ORT Center equipment.

ORT activities will be strengthened in a decentralized manner, in order to be more responsive to local needs. Governorate district and community level in CDD activities will be assessed and a plan will be developed to strengthen these activities. This will be accomplished in collaborative with appropriate MOH, public and private sector representatives at each level.

In order to phase out the NCDDP Secretariat and transfer responsibilities to the MOH, public and private sector organizations a plan must be developed to accomplish a smooth, orderly phase out of the NCDDP's Secretariat, without jeopardizing the continuity and sustainability of ORT activities. This plan will be developed in close collaboration with the appropriate organizations.

A plan outline is based on an assessment of ORT activities which have been partly institutionalized as follows:

- The transfer of responsibilities to the MOH will entail the incorporation of the functions of the Steering Committee, Secretariate (Executive Director and staff) and Governorate Coordinators into the MOH system. See figure II.
 - Training of health personnel in ORT and rehydration center supervision will be transferred to the appropriate training activities into the MOH system which will include the adaptation and incorporation of training materials and methods.
 - The major responsibility for CDD activities (including issuance of technical guidance and monitoring of field work) will return to the MCH Department.
 - Data collection and analysis will be transferred to the Statistical Department.
 - CID will assume responsibility for the production and distribution of ORS, in collaboration with the Pharmaceutical Affairs Committee.
 - The MOH will develop a long term plan for CDD activities which will include a budget for purchase and distribution of ORS, ORT training of health personnel, supervision of ORT activities and integration of ORT with other Child Survival activities such as mass media and evaluation.
 - Coverage of the private sector with ORT supplies will take place through the parastatal company CID. CID will set the level of production and product price and will handle distribution to the private sector outlets. The training of detail men as part of NCDDP's institutionalization plan will be expanded with a view to reaching private sector physicians and pharmacists and monitoring distribution.
2. Administration: Annual implementation plans based on national ORT program objectives and data from ongoing evaluation studies will continue to be developed by the Secretariat with the assistance of the TA Contractor. Personnel from the governorate and district levels will participate in the development of the annual plans to strengthen support for ORT services by those personnel responsible for implementation of

ORT services. The Secretariat, again with the participation of governorate and district personnel, will develop and implement non financial and financial incentive schemes linked to performance that extend to the district level and serve to strengthen the delivery of CRT services. The Secretariat Staff with the assistance of the TA contractor, local contractors, and governorate personnel will expand the Depot Holders scheme, a community based ORT distribution system now operating as a pilot, and explore other community based ORT activities to provide improved ORS accessibility in areas underserved by rural health services. The Secretariat will also be responsible for developing the plan for the institutionalization of all project activities into the relevant sections of the MOH, with particular attention to phased integration into related Child Survival Project Activities, with the assistance of the TA Contractor.

3. ORS Production and Distribution:

Project support for ORS production will be phased out during the amendment period through the development of a strategy that will ensure production and distribution of adequate amounts of ORS for national requirements in both the public and private sector on a commercial self financed basis. The Secretariat pharmaceutical specialist will work with Chemical Industries in this phase over period. The Secretariat will also estimate requirements for ORS by the MOH and prepare funding estimates for the MOH budget requirements; and train MOH personnel in planning for ORS requirements and in ordering procedures for maintaining adequate supplies of ORS. In consultation with medical faculties and pharmaceutical experts, the Secretariat will issue guidelines for health providers in all sectors on the correct indications for use of drugs in the treatment of diarrhea.

The public, parastatal organizations, which the NCDDP has (CID) relations are, Chemical Industries Development Company, Egydrug, and El Nast pharmaceutical Co.

CID has been responsible for local production of ORS. The Pharmaceutical Affairs Committee is a government organization which is responsible for regulating the amount and prices of drugs produced in Egypt, as stated earlier a representative from this committee is a member of the Project Steering Committee therefore, they have been involved in the determination of the annual quantity of ORS required and the price setting of ORS.

These governmental controls on production and pricing ORS will continue after the project ends, as a part of the government drug control system.

The NCDDP has contracted with Middle East Drug, Egydrug and CID for distribution of ORS to private sector pharmacies. The project is in the process of phasing out distribution through Middle East and Egydrug.

CID, the producer of ORS, will then be responsible for distribution. This is considered to be normal part of their activities which also includes marketing.

CID has additional production capacity which is able to respond to any projected increase in demand for ORS. The MOH is responsible for distribution of ORS within the Ministry System.

The CDD Project has explored private sector participation in ORS production through an IFB. The IFB elicited some interest but no proposals. It appears that private sector companies are not interested in investing foreign exchange for materials and equipment to produce a product that is already available in sufficient quantities on the market at a regulated price. However private sector companies expressing interest during the amendment period will be encouraged to apply for MCH approval.

4. Training: Secretariat personnel in the Training Division will strengthen ORT pre service and in service training in diarrhea case management, health education, and communication skills through more intensive training courses for governorate and district personnel in the 30 training centers located throughout Egypt. The Secretariat will also assist medical, nursing, and pharmacy faculties to strengthen ORT training through the provision of guidelines and materials; and design ORT curricula for integration in MOH training courses. The Secretariat will also sponsor seminars, presented by the pediatric society, throughout Egypt for private physicians on diarrhea case management and the use of ORT. Training in supervision, the development of a system for supervision, monitoring of ORT activities within governorate services will also be established by Secretariat personnel.

5. Information Education, and Communication (IEC):

The Secretariat will continue to focus on TV as the major source of ORT information for mothers in Egypt. Messages will reinforce correct mixing and use of ORS, stress the importance of feeding during diarrhea and appropriate feeding during weaning, and teach mothers about diarrhea prevention. The technical content of these messages will be developed by the Secretariat clinical experts and the films produced by a local media contractor.

Emphasis will also be placed on developing alternate strategies for health education using health personnel in rehydration centers and educational materials for rehydration centers, and in providing information to pharmacists on use of ORT for treatment of diarrhea.

The Secretariat Training Division and local contractors will carry out studies, and design curricula and materials for health education.

6. Evaluation: Improved data collection and analysis will be emphasized during the amendment period through full time assistance of a TA contractor specialist and local contract personnel as available. The Project Management Information system will be revised to provide more relevant information for (1) the administration of project services; (2) to evaluate the impact and effectiveness of project activities; (3) coordinate information essential to program management and administration; and, (4) to ensure timely dissemination of this information to the appropriate sections of the MCH. The TA Contractor will also assist in analysis and verification of data relating to project impact on diarrhea mortality being collected through studies and surveys. The Scientific Committee appointed by the MCH will be responsible for establishing a system of monitoring and supervision of evaluation activities and providing appropriate clearance for evaluation study reports.
7. Research: Research funded by the NCDDP emphasizing: diarrhea interventions; ORT services; and effective use of ORT will be published and disseminated as appropriate by the Secretariat. The Secretariat with the assistance of the TA Contractor will develop guidelines for the institutionalization of service delivery methods developed from operational research. More effective guidelines for the diagnosis and treatment of diarrhea and management of malnutrition associated with diarrhea will be provided by university researchers working with Rotavirus and Super ORS and funded by the project.

C. Project Technical Assistance (Amended)

The MCH requests approval to 1) negotiate an amendment and extension of the current MCH/John Snow, Inc. (JSI) Host Country Contract for a two-year period, from September 1987, to August 1989; and 2) to increase funding over that previously included in the contract signed (amount to be negotiated-estimated to be \$ 1.7 million) by the MCH on October 13, 1982. This action will require the clearance of the Mission Non-Competitive Review Board per Mission Order 5-4 Item 37 (see Annex A and subsequent approval of the Mission Director).

TA for this Amendment will consist of a total of 48 months of long term assistance by 2 full time technicians: a medical administrator/public health specialist; and a demographer/statistician; plus 10 months of short term consultants for training, data analysis and clinical/laboratory specialities; and 20 months of local consultant time to assist with finalization of evaluation and research reports. TA for media will be provided through local sub-contracts.

During the Project Amendment period, the NCDDP Secretariat will continue to serve as the implementing agent seconding or contracting personnel as required to carry out project activities. Contractor TA personnel will work under the direction of the NCDDP Executive Director.

IV. Economic Analysis

The concept of cost per death averted put forth in the original PP is not valid since neither the value of a child's life nor the number of deaths averted can be measured.

The NCDD Project has been able to reach 96% of the mothers of the 4.5 million Egyptian children under 3, who are at the highest risk of dying from dehydration, with ORT services and information about care of their children during diarrhea episodes. These statistics are based on sample media surveys, KAP studies, and other evaluation surveys carried out in all areas of Egypt several times a year. The statistics were further confirmed by a sample of 161 mothers interviewed by the Joint Review Evaluation Team in July, 1986. This has been accomplished at a cost of \$ 5.77 per child reached with ORT services or information, based on total project costs.

Television has proven to be a cost effective method for rapidly disseminating the ORT message. In repeated surveys and studies 80% of the mothers state they learned about ORT from TV. Television has also been very effective in teaching illiterate and rural women about the correct use of ORT. These messages have cost about 50 cents US for each mother reached. A large percentage of these mothers have learned to correctly mix ORS with water from TV at a cost much less than that experienced in a pre-project pilot ORT intervention which found that nurses had to visit mothers an average of nine times to teach correct mixing. Expenditures on public billboards have been found to be less cost effective however they will continue to be used to identify ORT rooms in clinics, but produced by the MOH at a lower cost.

The NCDD Project has also firmly established ORT as an effective, inexpensive alternative to intravenous (IV) treatment. Hospitals and clinics report that 98% of all children can be rehydrated successfully with ORT. The cost of an IV treatment is estimated at LE 25 vs ORT at a little over than LE 1.00 in hospitals and clinics. One large Cairo teaching hospital estimates a saving of LE 25,000 each year effected through the use of ORT. In addition, mothers can now purchase ORT at a cost of about 20 US cents per treatment in pharmacies and begin treatment early at home. This has greatly reduced the number of severely dehydrated children seen in hospitals and other health facilities and is saving high treatment costs for very sick children. The savings in IV solution costs release MOH funds for the purchase of adequate amounts of ORS for national requirements. -

Lastly the promotion of ORT has greatly increased pharmacy sales and established ORS as a high volume sales item providing a reasonable profit for both the pharmacists and the producer. This will help to ensure continued production and sales of ORS for national requirements on a commercial self financing basis. The present price paid to the ORS manufacturer is LE 0.36 per carton of 2 liters (10 5.5 gram packets). This is a fixed GOE price which should be reviewed since the production volume has increased from 5 million to 15 million liters since 1983. This cost compares favorably with production in other countries (eg Indonesia) and with UNICEF's costs. Mothers pay LE 0.45 in pharmacies for the carton. Despite the fact that ORS is free in clinics, 60 per cent of all ORS (9 million liters) is sold in commercial pharmacies so that cost does not appear to be a barrier to access for the majority of mothers.

V. Financial Plan

A. Project Funding

The total estimated cost of this (Project) Amendment is \$19.3 million. The foreign exchange component is estimated at \$4.54 million or 24% of total project costs. AID's contribution of \$10 million will finance over 51% of total costs, and 100% of the foreign exchange component of this project. The balance of \$9.3 million will be contributed by the GOE as counterpart (cash and in kind) to the amendment.

The project funding period will be from October 1, 1987 through September 30, 1990. Tables A and B - Summary Cost Estimates, and Projections of Expenditures by Year, reflect projected costs by specific inputs, cost elements within those inputs and by foreign exchange and local currency.

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

<u>Inputs</u>	In U.S. (\$000)						<u>New Project Total</u>
	<u>Previous Budget As Amended</u>			<u>This Amendment</u>			
	<u>AID</u>	<u>GOE</u>	<u>Total</u>	<u>AID</u>	<u>GOE</u>	<u>Total</u>	
<u>Operational Costs</u>							
Honorariums	49	27	76	5	5	10	86
Office staff	1,072	148	1,220	60	84	144	1,360
Direct Training	-	-	-	2,500	6*	2,506	2,506
Incentives	2,362	2,629	4,991	-	593*	593	5,584
Other Local Costs	6,950	1,527	8,477	2,005	180	2,185	10,662
Final Eval. & Audit	-	-	-	94	-	94	94
Sub-Total	<u>10,433</u>	<u>4,331</u>	<u>14,764</u>	<u>4,664</u>	<u>868</u>	<u>5,532</u>	<u>20,296</u>
<u>Program Costs</u>							
Personnel	-	8,048	8,048	-	7,172	7,172	15,220
Technical Assist.	3,438	-	3,438	1,640	-	1,640	5,078
Participant Training	130	-	130	675	-	675	805
Commodities	<u>11,999</u>	<u>4,621</u>	<u>16,620</u>	<u>2,220</u>	<u>1,260*</u>	<u>3,480</u>	<u>20,100</u>
Sub-Total	<u>15,567</u>	<u>12,669</u>	<u>28,236</u>	<u>4,535</u>	<u>8,432</u>	<u>12,967</u>	<u>41,203</u>
Contingency	-	-	-	801	-	801	801
Project Total	<u>26,000</u>	<u>17,000</u>	<u>43,000</u>	<u>10,000</u>	<u>9,300</u>	<u>19,300</u>	<u>62,300</u>

* Partially funded from the Project Special Account.

B. USAID's Contribution

Of the US \$10 million, AID contribution for this Project Amendment approximately:

1. \$1.64 million will finance technical assistance. JSI will continue to provide long (48 person months) and short (10 person months) term TA, through a Host Country Contract. 20 person months of short-term Egyptian consultants TA will also be provided.
2. \$2.22 million will finance the following equipment and commodities:
 - the production of ORS (40 million sachets of 5.5 gm ORS)
 - procurement of laboratory equipment and supplies
 - production of 10 million cups and spoons.
 - procurement of teaching aids and training materials.
 - procurement of equipment and supplies for rehydration units.
3. \$2.06 million will finance staff office and other local costs:
 - final project evaluation
 - research, mass media (TV spots), and evaluation activities.
4. \$675 thousand will finance participant training for 20 Senior Egyptian Public Health Specialists and Clinicians for short-term training in areas such as:
 - Management Information Systems (MIS)
 - Project Management (Public Health Administration)
 - Statistical Analysis
 - Training Methodologies
 - Laboratory Diagnostic Techniques
5. \$2.5 million will finance local training costs for
 - Training of Trainers.
 - Pre Service and in-service training for health personnel.
 - Supervisory training.
 - Curricula and training materials development.
6. - The remaining \$ 895 thousand will finance the cost of the final evaluation, project audit and contingencies.

C. GOE's Contribution (See Table D)

Of the GOE's equivalent L.E. contribution of US \$9.3 million for this Project Amendment, approximately:

1. - \$7.2 million will finance personnel costs relating to salaries, local travel and per diem, for the Secretariat and Governorate ORT Coordinators;

2. \$1.2 million will cover the costs of commodities and costs related to health facilities for the establishment of rehydration centers and procurement of equipment and supplies as well as the distribution of CRS and related supplies and equipment;
3. \$600 thousand will finance incentives which will be paid to eligible personnel;
4. \$300 thousand will cover office staff and other local costs.

An Inflation and Contingency: Factor of 25% was factored into all local costs shown and 5% for dollar costs.

D. Method of Implementation and Financing:

1. The following table illustrates the methods of implementation and financing for AID contribution.

<u>Activity</u>	<u>Method of Implementation</u>	<u>Method of Financing</u>	<u>Estimated Amounts (\$000)</u>
Operational Costs	Commitment PIL to HC	Direct Reimbursement (Periodic Advances)	4,570
Technical Assist. Part. Trng. U.S.	HCC PIO/P's	Direct L/COM Direct Payment	1,640 675
Commodities	Commitment PIL to HC	Direct Reimbursement (Periodic Advances)	1,710
Commodities (PSA)	HCC	Direct & Bank L/COM	530
Evaluation & Audit	AID Direct Contracts	Direct Payment	94
			<u>\$9,219</u>

2. Justification:

The following are justifications for departing from the use of AID preferred methods of financing, namely, FAR or MFAR, FRLC, Direct Reimbursement, and Direct Payment.

a. Periodic Advance:

Because of the GOE budgetary limits, it is necessary to give local currency advances to the MCH. Replenishment of advances will be subject to liquidation of the previous advances, and review of actual expenditure vouchers by AID.

b. Direct L/COM:

The GOE does not have the financial resources to make dollar payments to contractors because of severe shortage of the foreign exchange.

c. Bank L/COM:

Bank L/COM will be used where multiple vendors are supplying commodities and where proliferation of invoices are anticipated.

E. Assessment of the NCDDP Contracting Capability:

An assessment of the NCDDP's contracting capability was made in accordance with the requirements of the Payment Verification Policy statements No. 5 and 9 (Assessment worksheets can be found in the project files). It was determined that NCDDP is capable of (a) advertising, awarding and negotiating contracts, and (b) monitoring contract implementation.

Some deficiencies were noted in NCDDP's examination of the U.S. Contractor John Snow Public Health Group, Inc. (JSI) corrective actions by new project management are anticipated. NCDDP will be encouraged to perform audits of JSI's records. In addition, the project budget also provides funds for audit by non-federal auditors.

F. Assessment of the CDD's Accounting and Internal Control Procedures:

An assessment of the NCDDP's accounting and Internal Control procedures was made to determine their ability to control and report on the receipt of local currency from USAID. This assessment was made in accordance with the requirements of the Payment Verification Policy Statement No. 5. It was determined that although weaknesses were noted in NCDDP's reporting of actual expenditures and in reconciling bank accounts, their overall accounting system and Internal Control procedures were satisfactory. Strengthening of the NCDDP's internal accounting control are anticipated by the project management and AID will verify the required corrections. Assessment work sheets are kept in the project files.

G. Audit Coverage: (Policy Statement No. 6)

The project has only one host country contract for technical assistance. The total value of this contract as amended will be approx. \$5,118,000. The PP amendment's budget include approx. \$40,000 to cover the auditing costs. It is estimated that 3 man months will be sufficient to perform the audit. The audit budget could be as follows:

Personnel Costs 3 mm X \$12,000 =	\$36,000
Other Costs	<u>4,000</u>
Total	\$40,000

ii. Recurrent Cost

The GOE contribution to the project entails ongoing expenditures for MCH project personnel and facilities that are already in place and budgeted for as a part of the MCH system, except for the purchase of ORS.

A finding of the recent mid-term Project Evaluation concluded that if the MCH were to buy ORS packets now paid for by the project, and UNICEF the total cost would be approximately LE 720,000 or about 0.2% of the 1985/86 GOE current expenditure for health. This expenditure will be phased in over a two year period. Given the GOE commitment to continuation of ORS and Child Survival activities and the estimated savings on IV fluids this financial cost represents an affordable and sustainable expenditure which can be absorbed by the GOE.

Incentives paid originally from the grant will be paid from the Project Special Account funds from the sales of ORS for the amendment period. Most of the personnel receiving incentives in the governorates will eventually be working under the Child Survival Project for which the GOE has agreed to fund incentives.

VI. Social Soundness Analysis

The assumptions of the original Social Soundness Analysis remain valid.

VII. Technical Feasibility Analysis

The original analysis remains valid. Oral Rehydration Salts (ORS) are now the accepted medical modality for the prevention of death due to diarrheal dehydration world wide. This has proven to be true under this project. The production and distribution of ORS will continue during the period of the project extension.

VIII. Environmental Impact

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

IX. Implementation Plan

A. Administrative Arrangements

The NCDD Project will continue to be administered through the semi autonomous Secretariat headed by the Ministry of Health Executive Director, who is responsible to the Undersecretary for Family Health, in the MCH. The Secretariat personnel consist of clerical and administrative personnel, and specialists in the project components seconded from the MCH or hired from the private sector on contract. Personnel from medical faculties also participate and are usually paid on an hourly basis. The Secretariat also has the capacity to contract for both services and commodities required for the project.

Secretariat personnel have the capacity to work directly with institutions and decentralized governorate health services in the establishment of CRT training and services. The ability to respond rapidly to institutions and governorates on a one to one basis has helped the project to expand rapidly and to seize targets of opportunity for the expansion of CRT services on a timely basis..

B. Contractor Support

The NCDDP is supported by a US Contractor expected to provide 58 person months of TA during the amendment period. Two full time resident technicians will assist with the administration and management of the phase over of project activities and the completion of data analysis for evaluation. Ten person months of US technical assistance will be provided for research, evaluation, and training. The contractor will also have 20 months of short term Egyptian consultants to assist with tasks required for an orderly phase over of project activities, and a local subcontractor for media.

C. USAID Monitoring

The USAID Office of Health will be responsible for the monitoring of all activities under the host country contract and in providing administrative approval for project actions as required.

D. Implementation Actions

During the first year of the Amendment, the NCDDP will continue to implement ongoing activities in all components as planned and listed in the implementation schedule.

The implementation plan for the institutionalization of the NCDDP activities will be approved by the Steering Committee and actions initiated to begin transfer of activities into relevant sections of the MCH and other public/private sector organizations.

E. REVISED IMPLEMENTATION SCHEDULE

The Revised Implementation Schedule begins in early 1987 when project activities were originally scheduled to start phasing out. It is keyed to the remaining and expanded activities which are to be accomplished in the Amended Project.

F. Project Assistance Completion Date (PACD)

The PACD will be extended from September 30, 1987 to September 30, 1990.

The Revised Implementation Scheduled is as follows:

<u>Major Actions Required</u>	<u>Estimated Date</u>	<u>Responsible Agency</u>
- Project Paper Amendment Signed	June 1987	USAID
- Grant Agreement Amendment Signed	June 1987	USAID/MPIC/MOH
- Host Country Contract Amendment Signed	July 1987	MOH/USAID
- Develop Plan for institutionalization of NCDDP activities into relevant Ministry of Health departments and activities of the Child Survival Project	December 1987	MOH/Contractor
- PSA selected-US Commodities ordered	December 1987	MOH/Contractor
- Support for OPS production/distribution phased out; media component transferred to CS Project; other components in process for transfer to MOH Units.	July, 1989	MOH/Contractor
- Final AID Evaluation completed	July, 1989	MOH/USAID/ Contractor
- TA Contractor departs	August, 1989	MOH/USAID Contractor
- Evaluation and Research Studies published	January, 1990	MOH/USAID
- Secretariat Phased Out by PACD	September 1990	MOH/USAID

A detailed schedule of project actions by project component and year are identified in Table I.

TABLE I
REVISED IMPLEMENTATION SCHEDULE DETAIL
TASK NARRATIVE BY YEAR AND PROJECT COMPONENT

<u>MONTH</u>	<u>YEAR FIVE 1987</u>
	<u>Administration:</u>
12/87	Develop plan and strategy for institutionalization of NCDDP activities into relevant GOE/MOH departments and private and public sector organizations.
09/87	Preparation of Annual Workplan
09/87	Procurement of laboratory equipment
09/87	Support and monitor activities of the Egyptian Society of <u>Breast Milk Friends</u> .
*	
	<u>Production and Distribution:</u>
12/87	Develop strategy for institutionalization of the Chemical Industries Chemical Company (CID) for ORS production and distribution activities into relevant (CID) and GOE/MOH departments.
12/87	Train MOH distribution and warehousing personnel in ORS supply and warehousing system.
12/87	Complete contract with CID for 1988 ORS production and distribution.
09/87	Contract for Project Cup and spoons Production.
12/87	Complete CID promotion sales team training.
*	Continue polyvalent I.V. fluid production and distribution by El Nasr pharmaceutical company.
	<u>Training:</u>
12/87	Develop plan for institutionalization and strengthening training of ORT training in appropriate MOH training departments.
12/87	Produce ORT orientation training materials
12/87	Strengthen MOH pre-service and in-service ORT training of health personnel.
10/87	Assist in the revision of the ORT curricula for nursing students.
12/87	Design task-based curricula for physicians and nurses.
12/87	Develop ORT trainer's manuals for physicians and nurses.
	<u>Evaluation:</u>
*	Evaluate the Project's effectiveness in reducing child mortality due to acute diarrhea.
*	Evaluate the impact of the Project's campaign on target audience's knowledge and practices regarding acute diarrhea, dehydration and ORT.
*	Analyze the cost effectiveness of the Project's activities.
	<u>Communication and Mass Media:</u>
*	Continue social marketing research studies to support mass media interventions.
12/87	Develop new messages and materials (TV/commercials)
*	Continue sponsorship of selected radio programs
12/87	Implement "The Aware Mother Contest"
*	Continue broadcast of TV spots.
12/87	Production of TV (Soap Opera) Drama on Diarrhea Prevention.
12/87	Production of video presentation "The ORT Project: Challenge and Response".
*	Continue public relations campaign.
	* Ongoing throughout the year.

MONTH

Implementation and Coordination

- 11/87 Revise plan for establishment of New ORT Centers in MCH facilities.
10/87 Follow-up of distribution of equipment and flow of ORs packets, I.V. fluid, cups and spoons to MCH facilities.
* Continue supervisory visits to ORT centers.
12/87 Organize regional seminars for district level pediatricians and health officers.
10/87 Expand the Depot Holders Project (community outreach services) in five governorates.
09/87 Complete procedures for upgrading in university/MCH laboratories.

Research:

- 10/87 Design and conduct additional studies in the areas of prevention, effective use of ORT and diarrhea case management.
* Continue research on causative agents (including zoonotics) and Super ORT.
12/87 Conduct Operations research workshops and studies.

Management Information System:

- 12/87 Establish Management Information System Unit in NCDDP.
12/87 Develop strategy and plan for collection, analysis and dissemination of information on ORT activities at the district, governorate and national levels.

*Ongoing through the year.

MONTH YEAR SIX 1988

Administration

11/88 Initiate implementation plan for institutionalization of NCDEP activities into relevant GOE/MOH departments and private/public sector organizations.

Production and Distribution

05/88 Develop guidelines for health care providers on the appropriate use of drugs in the treatment of acute childhood diarrhea.

01/88 Design and implement operation research activities to test the effectiveness of both private and public ORS distribution systems.

* Continue production and distribution of ORS, cups and spoons.

* Continue distribution of I.V. solution.

Training:

* Continue training of health professionals in acute diarrheal case management skills and diarrhea prevention.

05/88 Conduct workshops for physicians and nurses on the use of ORT curriculum.

03/88 Design ORT supervision plan

04/88 Revise and finalize supervision and monitoring instruments.

* Support pre-service orientation for rural physicians and nurses.

* Support in-service training for physicians and nurses.

* Support House-officers training in governorates and universities.

Evaluation

* Continue to evaluate the Project's effectiveness in reducing child mortality due to diarrhea.

* Continue to analyze the cost effectiveness of the Project's activities.

* Analyse data and report findings.

Communication and Mass Media:

* Continue national media activities directed at diarrhea prevention.

Implementation and Coordination:

* Continue supervisory visits to ORT centers.

03/88 Develop a supervisory follow-up system.

Research:

* Analyze and report findings from Operations Research Studies.

* Continue studies on prevention, effective use of ORT and diarrhea case management.

Management Information System:

03/88 Implement plan for collection, analysis and dissemination of information on ORT activities at the district, governorate and national levels.

* Ongoing throughout the year.

MONTH YEAR SEVEN 1989

Administration:

07/89 Continue implementation of plan for institutionalization of NCDDP activities into relevant GOE/MCH departments and private/public sector organizations.

06/89 Develop and implement plan for phase-out of contractor technical assistance team.

Production and Distribution:

03/89 Implement plan for phase-out of financial support for ORS production and distribution.

* Monitor production and distribution of ORS.

Training:

* Continue integration of training activities with MCH, universities and Child Survival Project.

Evaluation:

07/89 Conduct final evaluation of project's effectiveness on reducing child mortality due to diarrhea.

07/89 Conduct the final evaluation of the impact of the Project's activities on change of target audience's behaviours regarding, diarrhea prevention, dehydration, ORT, and feeding practices.

07/89 Analyze data and report findings.

Mass Media:

* Continue national media activities

Implementation and Coordination:

* Monitor supervisory follow-up system.

* Continue supervisory visits to ORT centers.

Research:

07/89 Analyse and report findings from studies on prevention, and effective use of ORT in diarrhea case management.

Management Information System:

08/89 Integrate collection, analysis and dissemination of information on ORT activities with appropriate departments in MCH.

YEAR EIGHT 1990

Administration:

01/90 Implement plan for complete transfer of all NCDDP activities to appropriate departments in MCH and Child Survival Project.

08/90 Preparation and submission of final reports; USAID, GOE monitoring.

* Ongoing Activities.

X. Evaluation Plan

The NCDD Project includes an Evaluation component as an integral part of the project. These activities include a double round census carried out semiannually and a taxonomy study that is ongoing to measure annual prevalence and mortality from diarrhea in under 3's. In addition media surveys are conducted regularly to assess the impact of TV spots on ORT, and KAP studies are conducted annually to determine mothers' knowledge and practice in the care of diarrhea. Activities to be strengthened during the Amendment period include data collection of service statistics to provide more relevant management information, improved supervision techniques to strengthen service delivery, and analysis of project evaluation data.

A major external AID evaluation is scheduled in the second year of the Amendment (1989) and will serve as the final evaluation.

XI Procurement Plan

A. Commodities and Services

The NCDDP has established a local contracting capability for the production and distribution of ORS, the production of cups and spoons, and purchasing equipment for rehydration centers. GOE and AID procedures are followed in these contracting procedures. These procedures will continue to be followed in the Amendment period to purchase supplies and equipment needed to complete project activities.

The procurement of training materials and teaching aids will be accomplished through local competitive procedures, again meeting US and GOE regulations, for the design, production, and printing of ORT materials and teaching aids. Approximately 90% of the local commodity costs are for items produced in Egypt.

The major equipment for laboratories to be purchased in the U.S. will be done through a host country procurement services agent (PSA) through advertising in the US and Egypt. This equipment will total about \$600,000 in value. The advertisement for a PSA will be initiated as soon as the Amendment is signed or o/a September, 1987, if not earlier. Specifications for the equipment will include a capability for service maintenance in Egypt. The NCDDP has had previous experience with PSAs and has the capability to manage this procurement. Table C in the Annex provides a description and budget for commodities.

B. Training

During the Amendment period, short term training in third countries and the U.S. will be provided for up to 20 Senior Egyptian Public Health Specialists and clinicians. For the majority of participants this training will be oriented toward clinical research in diarrhea and will take place in US institutions specializing in the participants' area of research. Most of the participants have established research links with these institutions and significant research work is emerging from these contacts. Other short term training will be focused on management and information systems and training methodologies for Child Survival interventions (which include ORT). The project will buy into centrally funded Child Survival training programs as

appropriate or request special programs tailored to the participants' needs. All participant training will be completed by the end of year two of the Amendment (1989). Arrangements for this training are managed by the HRDC Offices of Health and Training.

Local Training: Local training will be conducted in the 30 training centers located throughout Egypt and in other governorate training centers. Training will focus on improved case management, appropriate use of drug therapy, and communication skills. Secretariat personnel will assist in providing curriculum materials and in training of trainers. Training is being strengthened in accord with the Evaluation recommendations.

Training Schedule 1987 - 90

<u>Course</u>	<u>Participants</u>	<u>Purpose</u>
Pre Service	5000 physicians 3500 nurses per year	Orientation in ORT services for new MCH personnel.
In Service	10000 physicians 3000 nurses per year.	ORT refresher training and communication skills for MCH personnel.
Physician Seminars	1000 physicians per year in governorate seminars.	Diarrhea case management for private physicians.
Pharmacist Seminars	1000 pharmacists per year.	ORT and appropriate drug management for diarrhea.

XII. Beneficiaries

The primary beneficiaries and target population of this project will be children under five, who would be protected from prolonged illness and early death from dehydration. At the end of the project, a reduction child mortality from diarrhea is anticipated. Also benefiting will be the children's families, particularly mothers, who will gain greater self-sufficiency in caring for their children when ill.

XIII. Other Donors

As described in the original Project Paper, the Project will continue to coordinate and work closely with UNICEF and the World Health Organization, key donors in the field of oral rehydration.

XII. Grantee's Request for Assistance

The Arab Republic of Egypt, acting through the Ministry of Health NCDDP, has requested authorization for a three year extension of the project. (See Annex C. An authorization is being requested from MPIC.)

XV. Conditions Precedent and Covenants

This amendment adds the following covenant: "The MCH agrees to provide funds from the proceeds of CRS sales in the "Special Account" to pay incentives to eligible MCH project personnel."

TABLE "A"
SUMMARY COST ESTIMATE AND FINANCIAL PLAN
CONTROL OF DIARRHEAL DISEASES
IN U.S. (\$000)

<u>AID</u>	<u>Inputs</u>	<u>FX</u>	<u>LX</u>	<u>Total</u>
	<u>Operational Costs</u>			
	Honorariums	-	54	54
	Office Staff	-	1,132	1,132
	Direct Training	-	2,500	2,500
	Incentives	-	2,362	2,362
	Other Local Costs	-	8,955	8,955
	Final Eval. & Audit	<u>60</u>	<u>34</u>	<u>94</u>
	Sub-Total	<u>60</u>	<u>15,037</u>	<u>15,097</u>
	<u>Program Costs</u>			
	Technical Assistance	3,956	1,122	5,078
	Participant Training	805	-	805
	Equip. & Commodities	<u>5,234</u>	<u>8,985</u>	<u>14,219</u>
	Sub-Total	<u>9,995</u>	<u>10,107</u>	<u>20,102</u>
	Contingency	<u>801</u>	<u>-</u>	<u>801</u>
	<u>TOTAL AID</u>	<u>10,856</u>	<u>25,144</u>	<u>36,000</u>
<u>GOE</u>				
	<u>Operational Costs</u>			
	Honorariums	-	32	32
	Office Staff	-	232	232
	Direct Training*	-	6	6
	Incentives*	-	3,222	3,222
	Other Local Costs	<u>-</u>	<u>1,707</u>	<u>1,707</u>
	Sub-Total	<u>-</u>	<u>5,199</u>	<u>5,199</u>
	<u>Program Costs</u>			
	Personnel	-	15,220	15,220
	Commodities*	<u>-</u>	<u>5,881</u>	<u>5,881</u>
	Sub-Total	<u>-</u>	<u>21,101</u>	<u>21,101</u>
	<u>TOTAL GOE</u>	<u>-</u>	<u>26,300</u>	<u>26,300</u>
	<u>Project Total</u>	<u>10,715</u>	<u>51,585</u>	<u>62,300</u>

* Partially funded from the Project Special Account.

TABLE "B"
 PROJECTIONS OF EXPENDITURES BY YEAR
 CONTROL OF DIARRHEAL DISEASES
 IN U.S. (\$000)

<u>AID</u>	<u>Inputs</u>	<u>Previous Budget As Amended Inception to 09/30/87</u>	<u>From 10/01/87 To 09/30/88</u>	<u>From 10/01/88 To 09/30/89</u>	<u>From 10/01/89 To 09/30/90</u>	<u>Amendment Total</u>	<u>Project Total</u>
	<u>Operational Costs</u>						
	Honorariums	49	2	2	1	5	54
	Office Staff	1,072	15	23	22	60	1,132
	Direct Training	-	1,000	1,000	500	2,500	2,500
	Incentives	2,362	-	-	-	-	2,363
	Other Local Costs	6,950	1016	775	214	2,005	8,955
	Final Eval. & Audit	-	-	32	62	94	94
	Sub-Total	<u>10,433</u>	<u>2,033</u>	<u>1,832</u>	<u>799</u>	<u>4,664</u>	<u>15,097</u>
	<u>Program Costs</u>						
	Technical Assistance	3,438	832	782	26	1,640	5,078
	Participant Training	130	350	325	-	675	805
	Equip. & Commodities	<u>11,999</u>	<u>1,284</u>	<u>517</u>	<u>419</u>	<u>2,220</u>	<u>14,219</u>
	Sub-Total	<u>15,567</u>	<u>2,466</u>	<u>1,624</u>	<u>445</u>	<u>4,535</u>	<u>20,102</u>
	Contingency	-	387	290	124	801	801
	TOTAL AID	<u>26,000</u>	<u>4,836</u>	<u>3,746</u>	<u>1,368</u>	<u>10,000</u>	<u>36,000</u>
<u>GOE</u>	<u>Operational Costs</u>						
	Honorariums	27	1	2	2	5	32
	Office Staff	148	27	28	29	84	232
	Direct Training*	-	2	2	2	6	6
	Incentives*	2,629	205	198	190	593	3,222
	Other Local Costs	<u>1,527</u>	<u>50</u>	<u>57</u>	<u>73</u>	<u>180</u>	<u>1,707</u>
	Sub-Total	<u>4,331</u>	<u>285</u>	<u>287</u>	<u>296</u>	<u>868</u>	<u>5,199</u>
	<u>Program Costs</u>						
	Personnel	8,048	2,320	2,390	2,462	7,172	15,220
	Commodities*	<u>4,621</u>	<u>130</u>	<u>430</u>	<u>700</u>	<u>1,260</u>	<u>5,881</u>
	Sub-Total	<u>12,669</u>	<u>2,450</u>	<u>2,820</u>	<u>3,162</u>	<u>8,432</u>	<u>21,101</u>
	TOTAL GOE	<u>17,000</u>	<u>2,735</u>	<u>3,107</u>	<u>3,458</u>	<u>9,300</u>	<u>26,300</u>
	Project Total	<u>43,000</u>	<u>7,621</u>	<u>6,853</u>	<u>4,826</u>	<u>19,300</u>	<u>62,300</u>

* Partially funded from the Project Special Account.

Table C
Illustrative Budget
for
Commodities

I. Local Procurement

Rehydration Centers

<u>Items</u>	<u>No./Price/Units (l)</u>	<u>LE</u>	
Chairs*	10 x LE 25 x 250	62500	
Tables*	2 x LE 25 x 250	12500	
Thermos	1 x LE 25 x 250	6250	
Rx Tables*	2 x LE 100 x 500	100000	
Billboards			
With Logo*	1 x LE 100 x 250	25000	
Register Books*	LE x 12000	36000	
Thermometers	LE 1 x 15000	15000	
Cups & Spoons*	LE .13 x 5 million	650000	
ORS*	LE .050 x 50 million	2500000	
IV Fluid*	LE 1 x 3530	3530	
Scalp Needles*	LE 0.70 x 50000	35000	
Naso Gastric			
Tubes*	LE 0.60 x 50000	30000	
Training Materials*	LE 125 x 9000 Units	1,125	
Teaching Aids*	LE 5000 x 105	525	
Publications*	LE 0.75 x 125000	93220	
Subtotal		LE 5,249,000	\$ 1,690,000

II. US Procurement

Laboratory Equipment/Other

<u>Items</u>	<u>Price/Unit</u>	<u>US \$</u>
Diagnostic Lab		
Sets 8 Regional		
Labs (see p 2 Attach C)	\$ 42000 x 8	\$ 336,000
Lab Sets for		
11 Governorate Labs		
(See p 3 Attach C)	\$ 14000 x 11	\$ 154,000
Four Computers and		
Software for		
fieldwork		\$ 40,000
Subtotal		\$ 530,000
Total		\$ 2,220,000

*Produced in Egypt

Illustrative Budget
for
Regional Laboratories

<u>Item</u>	<u>No.</u>	<u>Price \$ U.S.</u>
<u>I. Equipment</u>		
Refrigerator (4-8 C) (12 feet)	1	741
Deep Freeze vertical (-20 C)	1	889
Centrifuge 1000 - 5000 rpm	1	1000
Incubator 37	1	889
Water bath variable range	1	518
Hot air oven	1	1481
Autoclave	1	1481
Flame-photometer	1	14815
Microcentrifuge for Hct. Determination	1	741
Binocular microscope	1	3704
Automatic dispenser	3	148
Automatic pipette	2	118
Transport ice chest	1	75
Subtotal		8556
<u>II. Chemical Reagents</u>		
<u>III. Disposables</u>		
Pipettes, plasticware Racks, Stickers etc.		6844
Subtotal per Lab		42000
Total \$ 42000 x 8		336000

Budget for Laboratory
Equipment/Supply Sets for 11
Governorate Laboratories

<u>EQUIPMENT</u>	US \$
Centrifuge	2899
Microcentrifuge	1499
Refrigerator	1499
Binocular microscope	3623
Transport Ice Chest	725
Subtotal	10245
<u>Supplies/Reagents/Disposables</u>	3755
Subtotal	13732
Total (11 sets x \$ 14000 per set) = \$ 14000	154000

TABLE "D"
GOE Contribution
In \$ Equivalents (\$ 000)

Operational Costs	<u>Previous Budget</u>			<u>This Amendment</u>			Project Total
	Cash	Inkind	Total	Cash	Inkind	Total	
Honorarium	27	-	27	5	-	5	32
Office Staff Salaries Supplies	-	148	148	-	84	84	232
Direct Training	-	-	-	6	-	6	6
Incentives	2,629	-	2,629	593	-	593	3,222
Other Local Costs	<u>-</u>	<u>1,527</u>	<u>1,527</u>	<u>-</u>	<u>180</u>	<u>180</u>	<u>1,707</u>
Sub-Total	2,656	1,675	4,331	609	264	868	5,199
<u>Program Costs</u>							
Personnel	-	8,048	8,048	-	7,172	7,172	15,220
Commodities	<u>4,621</u>	<u>-</u>	<u>4,621</u>	<u>1,260</u>	<u>-</u>	<u>1,260</u>	<u>5,881</u>
Sub-Total	<u>7,277</u>	<u>8,048</u>	<u>12,669</u>	<u>1,260</u>	<u>7,172</u>	<u>8,432</u>	<u>21,101</u>
Project Total	9,933	9,723	17,000	1,869	7,436	9,300	26,300



UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

CAIRO, EGYPT

ANNEX A.

ACTION MEMORANDUM TO THE MISSION DIRECTOR

FROM: Charles J. ^{EJ}Mantione, HRDC/H
THRU: Constance ^{Collins}Collins, HRDC/H
THRU: Bernard D. Wilder, AD/HRDC ^{File}
SUBJECT: Approval for Negotiation with a Single Source.

PROBLEM: Your approval is required to permit the Government of Egypt to negotiate with a single source for follow on work for the Control of Diarrheal Diseases Project (263-0137) extension. Under the Provisions of redelegation of authority 113.8 and M.O. 5.4 you have the authority waiver advertising and competition

BACKGROUND: The mid term evaluation for the Control of Diarrheal Diseases (CDD) Project which was conducted as a Joint Review by USAID, the Ministry of Health, WHO, and UNICEF in June, 1986, commended the project on the impressive levels of knowledge (96%) and use of ORS (82%) among mothers in Egypt; the production of adequate quantities of ORS locally; and the effective distribution of ORS to over 3,000 GCE health units and 6,000 commercial pharmacies. The report stated that it was noteworthy that this had been accomplished in just 3 1/2 years at a modest cost of little more than L.E. 1.00 for each mother gaining this benefit. However, the report noted that while there was general agreement in the international health community that the use of ORT would reduce deaths due to dehydration, the data produced thus far by the Project on diarrhea mortality reduction was not conclusive. It was recommended that the Project undertake the necessary studies to estimate the impact of the Project on mortality by appropriate demographic and epidemiological measures. The report also recommended revising the Project management Information System to obtain more relevant information.

The Joint Review Report recommended that the CDD Project be extended for a minimum of two years beyond the PACD date of September 1987, to permit phased transfer of administrative responsibility for all project activities to relevant sections of the Ministry of Health (MOH) and the Child Survival Project (CSP), and to complete the studies on diarrheal mortality.

USAID has conducted preliminary discussions with the Ministry of Health concerning the extension. The MOH has requested a three year extension with two years of technical assistance. The third year would permit the phase-over of the various components i.e. media, research, evaluation, and service delivery into appropriate sections of the MOH and the Child Survival Project.

The MCH has requested that the present contractor, John Snow Public Health Group Inc. (JSI), be retained as the technical assistance contractor. The proposed extension will involve two long-term technicians for two years, plus short term consultancies, and local hire under a technical assistance contract. The RFP issued in 1981 which resulted in the contract with JSI, did not provide for follow on work by the contractor. Therefore, the contractor for the proposed extension will have to be selected through competitive bidding or a waiver issued approving a Single Source Negotiated Contract as per AID Regulations Handbook 11, Section 2.4.2, Paras 3 and 4.

Discussion: JSI has gained, through its current contract, extensive knowledge and understanding of the special characteristics of the Egyptian health system, and of the cultural, social and economic factors that have an impact on the health of the Egyptian people, particularly children. This expertise, along with the collaborative relationships that have been established and the strong rapport developed with counterpart Egyptian officials, is vital to the acceptance and integration of technical advice, the development of appropriate training programs, and the rapid procurement of required equipment.

In addition, JSI has demonstrated the capability to successfully manage all the components of a national level, comprehensive diarrheal disease control program. In so doing, JSI has proven itself to be a contractor with a wide range of resources, capable of the careful and timely integration of several program elements: development, promotion, training and education, production and distribution, research, and evaluation. The Egyptian National Control of Diarrheal Diseases Project is now recognized as the largest and most successful CRT program in the world, and JSI has developed unique qualifications in providing technical expertise for CRT and in the management of a national CRT program.

The CDD Project is now at a critical stage. The activity momentum of the peak campaign years 1984 - 86, must now be sustained and institutionalized into a National CRT Program providing ongoing services to meet the demand created by the campaign. While it has been anticipated that some CRT components will be managed by the Child Survival Project (media, evaluation, services, and training) it will be at least 18 months before the Child Survival Project will be in full implementation and prepared to begin phasing in CRT activities.

The JSI Contract expires with the CDD Project PACD of September 30, 1987. Given the routine time required to write an RFP, publish it, prepare and review proposals, and negotiate a new contract it would be difficult, if not impossible, to get a new contractor on board by the current PACD. Further time would be lost in contractor orientation to the project and the Egyptian health system during a period when important and critical decisions need to be made concerning project activities.

JSI has expressed interest in a contract extension and the current Chief of Party who has had 18 months of experience with the project is willing to remain in Egypt for the duration of the proposed extension. A second technician, a demographer/statistician, will be recruited to assist with data analysis and project impact on diarrheal mortality. The pursuit of full and open competition for a contractor could have an adverse impact on the project progress by diverting MOH attention and time to the contractor selection process at a period when critical implementation decisions need to be made by personnel familiar with the Egyptian program. A continuity of technical assistance would enable the MCH to proceed with institutionalization of a program that is making an impact on a major cause of infant and child mortality in Egypt.

PRIMARY JUSTIFICATION: A contract amendment which increases the scope of work and level of effort, and is not based on an originally advertised option to increase services, requires a waiver of competition. Such a waiver to negotiate with a single source can be granted if any one of the criteria in Handbook 11, Section 2.4.2 Paras 1-5 are met. The criteria that best and most directly applies to this case is:

Para 4: "The borrower/grantee desires to utilize a contractor previously engaged in the project for follow-up work and the contractor clearly has special capability by virtue of previous experience in the work but the contractor was either not initially selected on a competitive basis or the contracting agency did not advise all competing firms that a follow-on contract might result. A waiver on these grounds should be granted only after careful review of all pertinent facts".

HRDC/H has carefully reviewed all the facts related to this request for a waiver of competition and advertising, and in our judgment, this criteria is fully satisfied. JSI's "special capability", obtained from its "previous experience" on the project is amply demonstrated above, so too are the reasons of sound and expeditious project implementation which underlie this recommendation.

RECOMMENDATION: That you approve the MOH's negotiation with a single source, John Snow Public Health Group, Inc., for a two-year follow-on contract to provide technical assistance to the CDD Project 263-0137.

NON-COMPETITIVE BOARD

Clearances: LEG: K. O'Donnell *KEM* 1/23/87
IS/CS: J. Dzierwa *J. Dzierwa* 1/23/87
IS/FI: W. Coles, *W. Coles* 1/23/87

drafted by: HRDC/H: C.Collins/C.Mantione, aa 1/26/87 doc. no. 3640H

MINNEAPOLIS
 AMENDED PROJECT
 LOGICAL FRAMEWORK
 Control of Diarrheal Diseases 263-0137

<u>NARRATIVE SUMMARY</u>	<u>OBJECTIVELY VERIFIABLE INDICATORS</u>	<u>MEANS OF VERIFICATION</u>	<u>IMPORTANT ASSUMPTIONS</u>
To improve the general health of the Egyptian people, especially children.	Progressive increase of life-expectancy at birth.	GOE statistics, the census.	Utilization of MOH services improves.
	Decrease in infant mortality.	Clinic and hospital records	Outreach capacity is strengthened.
	Progressive reduction of age-specific morbidity & mortality rates.		Disease-specific campaigns achieve targets.
	Achievement of national population goals.		

<u>PROJECT PURPOSE:</u>	<u>CONDITIONS THAT WILL INDICATE PURPOSE HAS BEEN ACHIEVED. END OF PROJECT STATUS:</u>	<u>MEANS OF VERIFICATION</u>	<u>ASSUMPTION FOR ACHIEVING PURPOSE</u>
To reduce Child mortality from acute diarrheal Disease by making rehydration services and materials (especially oral rehydration therapy widely available and used through a national program.	96% of mothers aware of ORT, 75% understand its use. More than 50% of serious cases seen by health system get ORT.	KAP/Ethnographic studies. MOH service statistics.	Medical profession accepts ORT as main method for treating acute diarrhea. Medical profession accepts wide RX of ORT by non-MD's. Parents accept ORT care from variety of sources.

PROJECT PURPOSE:

CONDITIONS THAT WILL
INDICATE PURPOSE HAS
BEEN ACHIEVED EDPS

MEANS OF
VERIFICATION

ASSUMPTION FOR
ACHIEVING PURPOSE

Diarrhea mortality
in under-2's reduced
by at least 25%.

Sentinel site
morbidity/
mortality
its surveys.

Mother motivated
to treat acute
diarrhea early
with ORT, feeding
and extra fluids.

Plan completed for
institutionalization
of ORT activities into
MCH and Child Survival
Project.

Plan for
institutionali-
zation.

Medical profession
educates mothers
regarding importance
of fluids and con-
tinued feeding
during diarrhea.

Cluster sampling
method valid for
determining IMR/
mortality rate in
under-2's.

ORT is a priority
program for MCH
Child Survival
services.

OUTPUTS:

National Rehydration Campaign Plan. Institutionalization of national rehydration campaign and program.

Production & distribution of sufficient ORT materials to meet MOH/private sector demand on a commercial self financing basis.

Training of MDS, RNS, pharmacists & Depot Holders in ORT, acute diarrhea case management and prevention of diarrhea, health education, and logistics.

Mass Media campaign undertaken.

Diarrhea-related research topics identified & grants awarded.

Governorate rehydration centers established.

Governorate training centers established & equipped and functioning with local trainers.

OVER LIFE OF PROJECT
MAGNITUDE OF OUTPUTS:

Plan implemented by multi sectoral Steering Committee.

110 million packets ORS, 100,000 1/2 liters special IV fluid, 100,000 scalp-vein needles distributed.

All Governorate Coordinators trained, 250 senior pediatricians, 2500 MOH doctors, nurses, & pharmacists trained refresher training provided are needed to 28,000 health providers. Depot Holders system in 5 governorates.

Media spots each 96% population.

25 research projects completed. Research reports.

250 hospital rehydration centers established and 2700 ORT service units in MOH Health Facilities.

30 training centers established and equipped and personnel trained.

MEANS OF
VERIFICATION

Logistics MIS set-up for project & existing in drug companies.

Project activity reports/KAP surveys of health providers.

MOH Reports

Audience Research

Research Reports

MOH reports.

MOH reports.

ASSUMPTIONS FOR
ACHIEVING
OUTPUTS

ORS Demand creator is as expected.

MOH recruits project staff to carry out tasks.

ORS is a commercial viable product.

Medical profession supports Depot Holders system.

Communities interested in carrying out ORT activities.

National media cooperative.

MOH has capability to implement ORT program.

MOH will support ORT training.

11

3. COMMODITIES AND MATERIALS

Local Procurement

- Rehydration Center Equipment and Supplies - 250 Centers equipped.
- 10 million cups and spoons
- 40 million sachets 5.5 gram ORS
- 50,000 half liter bags of IV fluids and scalp needles.
- Training materials, teaching aids, and public information materials for 30 training centers and 3000 health units.

US Procurement

- Laboratory Equipment and supplies for 12 regional labs and 26 governorate labs.

ASSUMPTIONS FOR PROVIDING INPUTS

Raw materials are available and Egyptian companies can meet production requirements.

Improved labs are essential for improving diagnosis and treatment of diarrheal disease.

1/5

INPUTS:

ASSUMPTIONS FOR PROVIDING INPUTS .

US 1. Technical Assistance

- Public Health Specialist
Chief of Party, 24 pm (expatriate)

- Evaluation/Research Specialist,
24 p.m. (expatriate)

Short Term 10 p.m. U.S., 20 p.m. Egyptian)
in following areas:

- Data Analysis/Survey Design
- Clinical Pediatrics
- Marketing Analysis
- Economics
- Evaluation
- Social Science
- Mass Media
- Administration/Management
- Implementation/Coordination/Supervision
- Laboratory Diagnosis and Training
- Training
- Demography/Statistics
- Research Methodology

Sub Contract

Media Firm (Egyptian) 12 p.m.

2. Participant Training

20 Senior Egyptian - Public Health
Specialists for and clinicians for
short-term training in areas such as:

- Management Information System (MIS)
- Public Health Administration
- Statistical Analysis
- Training Methodologies
- Research Laboratory Diagnostic Techniques



بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

ANNEX C

August 25th, 1986

Dr. William D. Oldham, M.D.
Director,
Office of Health

Dear Dr. Oldham:

As you are aware, the Joint Review team which evaluated the NCDDP in June recommended that the Project be extended for at least two years past its current completion date of September 1987.

I therefore request that USAID extend the project for at least a period of an additional two years.

Thank you for your consideration of the request, and I look forward to your reply.

Sincerely yours,

Dr. A. Hashem

Dr. A. Hashem
Executive Director
NCDDP

ANNEX D

5C (2) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only:
B.1. applies to all projects funded with Development Assistance loans, and
B.3. applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECK-
LIST UP TO DATE? Yes
HAS STANDARD ITEM
CHECKLIST BEEN RE-
VIEWED FOR THIS
PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1986 Continuing Resolution
Sec. 524; FAA Sec. 634A.

Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project.

Congressional Notification is required.

2. FAA Sec. 611 (a) (1). Prior to obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

a) Yes
b) Yes.

(b) Yes.

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

No further legislative action required except formal approval of the Grant Agreement, Amendment No. 1. Anticipate no difficulty.

4. FAA Sec. 611 (b); FY 1986 Continuing Resolution Sec. 501. If for water or water-related land resource constructed, has project met principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See AID Handbook 3 for new guidelines.) N/A
5. FAA Sec. 611 (e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project? N/A
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multi-lateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. No
7. FAA Sec. 601 (a). Information and conclusions whether projects will encourage efforts of the country to:
(a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. N/A

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| 8. | <u>FAA Sec. 601 (b)</u> . Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs including use of private (trade channels and the services of U.S. private enterprises). | U.S. private enterprise will be a source of procurement of goods and Technical Services. |
| 9. | <u>FAA Sec. 612 (b), 636 (h); FY 1986 Continuing Resolution Sec. 507</u> . Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other currencies owned by the U.S. are utilized in lieu of dollars. | The Grant Agreement will so provide, also see 212 (d) determination no US owned local currencies are available. |
| 10. | <u>FAA Sec. 612 (d)</u> . Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? | N/A |
| 11. | <u>FAA Sec. 601 (e)</u> . Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? | Yes. |
| 12. | <u>FY 1986 Continuing Resolution Sec. 522</u> . If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? | N/A |

13. FMA 118 (c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16. Does the project or program take into consideration the problem of the destruction of tropical forests? Yes and N/A
14. FAA 121 (d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)? N/A
15. FY 1986 Continuing Resolution Sec. 533. Is disbursement of assistance conditioned solely on the basis of the policies of any multilateral institution. No.
16. ISDCA of 1985 Sec. 310. For development assistance projects, how much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? N/A.