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REPORT ON A CONSULTANCY
TO REFINE A METHODOLOGY FOR
HEALTH SERVICES RESEARCH,
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ABBREVIATIONS

APHA	American Public Health Association
ECTOR	Health Services Research Group (Research and Training Division, Institute of National Planning)
HCDS	Health Care Delivery System
HSDS	Health Services Delivery System
HSR	Health Services Research
INP	Institute of National Planning
MCH	Maternal Child Health
MOH	Ministry of Health
MOPH	Ministry of Public Health
TFG	Task Force Group
UHP	Urban Health Project
USAID	United States Agency for International Development
WHO	World Health Organization

I. INTRODUCTION AND BACKGROUND

This is a report on a consultancy to the Egyptian Institute of National Planning Research and Training Division (hereafter termed ECTOR) health sector assessment component of the Cairo Urban Health Project (UHP). The UHP seeks to improve health services to the urban poor of Cairo through the assessment and organizational-architectural innovation of the health care delivery system. The project covers three predominantly low-income areas of Cairo: Helwan, South Cairo, and West Cairo. The target population is mothers and young children. The assessment and innovation of public Ministry of Health (MOH) and maternal-child health (MCH) clinics are stressed, although public and private clinics and hospitals are being assessed. Cairo has extensive public health care facilities, but they are hampered not only by customary health care delivery strictures, but also by the problems that affect all other elements of Cairo's overburdened infrastructure.

Cairo contains between eight million and nine million people (Egypt's total population is approximately 40 million), making it one of the most heavily populated cities in the world. This circumstance poses various problems, as a resident social scientist, J. Waterbury, has written:

Frequently one hears that Cairo and its facilities are designed to handle a population of about 1.5 million, a level exceeded during the Second World War with a massive influx of migrants (606,561 in the period 1937-1947)....If one pieces together various kinds of policy recommendations over recent years, a set of implicit assumptions seems to emerge. Cairo as a whole cannot be saved; there are too many people and too little money...to meet city needs... not to mention health, education, recreation, entertainment, [and] work opportunities [which] could absorb all the nation's resources.¹

In addition to the strain of heavy demand, one may note other patterns, such as underutilization of peripheral or primary care facilities and overutilization of central or popular facilities, like Qasr el-Aini Hospital. For instance, four years ago the author observed that clients gathered at Abu Risch Hospital for intravenous rehydration; with the introduction of oral rehydration programs at local clinics, this situation has begun to change. The author also noted the multiple utilization of clinics by clients seeking other doctors' opinions. These and other patterns may be changed to create a more efficient delivery system by completely reorganizing the clinics.

¹John Waterbury, Vol. XVIII, No. 5, 1973, p. 3; Vol. XXI, No. 2, 1976, p.2.

This would involve the use of health professionals and informal sector healers, and of fee schedules; the clinics' hours would have to be scheduled, and architectural changes might have to be made. One could assume that such innovations would affect client perception and use of health care facilities and services. The ECTOR assessment stresses those perceptions to obtain baseline data.

Within the UHP, ECTOR's task is assessment. The UHP and MOH components are directed by N. Fouad. An American consulting firm (Westinghouse) and two architectural firms (one is American, the other Egyptian) are also involved in this project.

The ECTOR Health Sector Assessment

The ECTOR health sector assessment focuses on client action (interface between institutional structures) and is based on interdisciplinary collaboration. It is modeled after other ECTOR projects, the most notable of which is the Coverage Study of Egypt, North Yemen and Bahrain. Sponsored by the World Health Organization (WHO), this study collects at the national level policy data and data on socioeconomic, demographic, and health indicators; surveys MCH clinics at the intermediate level; and examines at the community level the factors that affect coverage and use. Quantitative and qualitative techniques¹ are used to conduct the third part of the study. The coverage study, as well as the UHP assessment, seek to identify those factors that predict "whether or not the health services delivery system (HSDS) is poor or excellent."² ECTOR researchers consider clients, non-users, and suppliers of health services to be critical components in that prediction. They focus on clients' and suppliers' perceptions of illness, resources, and the HCDS. (The consultant's ethnographic expertise was particularly valuable for this study.)

ECTOR's UHP assessment teams depend on collaboration between social scientists and health care professionals. Collaboration is integral to the Health Services Research (HSR) Program of ECTOR, as W. Hassouna has observed:

HSR is an interdisciplinary affair in which health and other professionals (e.g., social scientists, including sociologists, anthropologists, economists,

¹See Health Services Research Group ECTOR/INP, Coverage Study: A Comparative Study in Three WHO/EMRO Countries, Final Report of Phase I, 1980, Section I, page 4.

²Ibid., Appendix V, p.2.

policy analysts, and others) bring their knowledge and expertise to focus on the problem of improving the effectiveness and efficiency of health services delivery. In seeking to improve effectiveness and efficiency of health service delivery, the HSR team assesses the extent of coverage, the availability and accessibility of the service, its organization and management, and its utilization and acceptability by the target population.¹

The consultant probed the interdisciplinary dynamics of teams of collaborating health professionals and social workers in accordance with ECTOR's goals: to benefit from multidisciplinary expertise and to examine behavioral-institutional interface.

Scope of Work

The consultant was to collaborate with ECTOR in refining the HSR methodology. Particular emphasis was to be given to the use of qualitative methodology and to the establishment of behavioral-institutional relationships as a subject of and topic for research. The consultant was to be involved in both training and analysis.

A. Training Sessions

The consultant was to continue the training sessions for researchers which began last summer. On the basis of the South Cairo survey, she was to:

- develop model strategies for health care resources;
- develop models of disease and of bodily processes that reflect the perceptions of clients in the assessment areas; and
- to lay the groundwork for an evaluation of the relationship between health care decision making and institutional function.

B. Data Analysis

The consultant was to meet with the leaders of task force groups (TFGs) and with senior and junior researchers of various teams to evaluate

¹W.A. Hassouna, "Health Services Research in Primary Health Care," The Health Services Researcher, Vol. I, No. 1, 1980, p. 8.

the results of the South Cairo Survey. In particular, she was to:

- coordinate the teams' work and to communicate their findings to each other;
- observe how researchers collect data in the field or to discuss data with researchers; and
- discuss the relationship between social research and institutional research, particularly as these relate to the issues of clinic use, perception, and accessibility.

Training and data analysis encompassed points A, B, and C of the consultant's scope of work (see Appendix C). The two components overlapped and often were addressed simultaneously. The consultant did not devote much time to point D ("monitor cultural components of administrative, organizational, and recordkeeping changes suggested to UHP by technical advisers") because of time constraints and because the introduction of technical innovations had only begun, although the assessment of collected data had entered a critical stage and required attention.

During the consultancy, ECTOR and Westinghouse met and decided that each would proceed on its own but "coordinate" wherever feasible. It was decided that technical innovations might be monitored at a later date.

Methodology for Consultation

The consultant worked with the following groups (in order of concentration):

- TFG 2, Socioculture, Z. Shaheen, leader;
- TFG 5, Maternal and Child Health, S. Abdel Azim, Leader;
- TFG 1, Socioeconomics, M. Safty, leader;
- TFG 4, Health Care Delivery System (HCDS) Infrastructure, S. Hakim, leader; and
- TFG-6, Private Health Care System, S. Galal, leader.

Several meetings were held with C. Nelson, the community team leader. The community team is composed of TFGs 1, 2, and 6 (see Appendix A).

This consultant's aim was to collaborate in the refinement of methodology, data analysis, and generation of theory. The consultant, an expert in ethnographic research, earlier acquired experience in MCH clinics in Cairo and was a consultant in applied social research. She is at this time pursuing theoretical interests. She selected as her two basic modes of collaboration and assistance conferences with team leaders and senior researchers and training and debriefing sessions and site visits with data collectors. She was involved not only in scholarly discussions; she also tried to discover and sensitize her collaborators to tactical hints.

TFG and team leaders were highly motivated and were oriented to the concept of HSR. They similarly motivated and oriented their data collectors. This facilitated the consultant's task. In addition, some of the leaders had extensive ethnographic experience and, as was appropriate, took advantage of the consultant's experience and knowledge to learn how to identify important data, revise or refine field techniques, and coordinate the efforts of different TFGs. In short, the consultant incorporated the following techniques into her approach:

- Data analysis in collaboration with research leaders to:
 - suggest revisions and shortcuts to data collection;
 - lay the groundwork for generation of applied theory;
- Sessions with data collectors to:
 - derive "between-the-lines" information from questionnaires or transcripts;
 - brainstorm with leaders and data collectors; and
- Conferences with individuals to discuss:
 - field techniques and possible revisions (to the approach or to data collection);
 - the coordination of TFG efforts and results.

II. SESSIONS IN TRAINING AND ANALYSIS

The scope of work emphasized methodology and analytic collaboration and assistance; therefore, training and evaluation are described in detail in this chapter.

Training Sessions with Sociocultural Data Collectors (TFG 2)

In training sessions conducted in the summer of 1980, researchers were sensitized to ethnographic technique and particularly to health care strategies and etiological and physiological perceptions. At an initial planning meeting with C. Nelson and Z. Shaheen, it was agreed that the January 1981 sessions would stress also the sensitization of researchers and the involvement of researchers in the development of models and especially in decision making. Those who participated in the 1980 sessions are members of several TFGs, including TFG 2. The consultant met with TFG 2 and other groups to follow up summer work.

The TFG 2 data collectors have experience in psychology and social work. Four have a bachelor's degree in psychology; three of these four are working on a master's degree in psychology or social psychology. Three have a bachelor's degree in social work and are working in Helwan Hospital, training Helwan factory workers, or teaching at the Social Work Institute (Garden City). One has a diploma in social work. One is a WHO counterpart from a MOH division, Social Work.

Although not all TFG 2 members attended the 1980 sessions, the new training session began with a discussion of the issues (e.g., local etiology and physiology) raised in the final summer session. (The researchers who had not attended the summer sessions had been in the field several months and had attended Z. Shaheen's training sessions; thus, the new session began where the summer session ended. This approach has exciting implications for stacking up levels of interpretation to provide ethnographic shortcuts.)

A. Preliminary Session

At the initial meeting with TFG 2, the objectives of the project were discussed. The consultant accompanied the researchers on their first visit to Tora (Helwan). Each researcher is responsible for a given number of interviews. Researchers work as two-person teams so that one person can focus on conversation while the other records the information. During a three-hour field visit, they cover approximately two households.

Members of the community help the researchers to locate addresses. The families are familiar with the research because they were visited by TFG 1. Problems have arisen, as the TFG 2 group noted. For example, when families went to the clinic with their examination cards, which had been distributed by TFG 1, they were treated poorly. (This problem was remedied by TFG 3.) Researchers also remarked that families need to be convinced of the study's benefit and to understand why a particular family is selected for a return visit. C. Nelson and M. Sayyid (TFG 1) have observed that communities need to be oriented to the goals of the UHP (see ECTOR report).

During the field visit with TFG 2, the consultant noted characteristic ethnographic problems which also appeared in the written transcripts. For example, when asked, "Why do you do this?" the interviewees responded, "We're accustomed to doing so." In subsequent training sessions researchers were encouraged to use variations of the question "Why?" to elicit richer responses. In some instances, researchers would pose a hypothetical question, forcing the interviewee to make a choice. ("If one child had a fever [needed medicine] and you had no money but could sell a bracelet, what would you do?" "If you could only get medicine for one sick child, would it be the one with colic, pneumonia, or an ear infection? Why?") Some used comparative examples of what others do. ("You would _____, but your neighbor would do _____.") Others sought descriptions of past experiences in context. ("When your child fell ill, your husband had just lost his job, and the next day relatives arrived from the village and then... what?")

B. First Training Session

The second meeting with TFG 2 was a formal training session. Three concepts were discussed: the role of the sick, the etiology and classification of disease, and curative strategy.

Role-playing was used to present concepts in both hypothetical and typical field situations (e.g., a husband or neighbors arrive midway through an interview). Role-playing was useful in working out ethnographic problems and in codifying extant data. These data were either in transcripts or "in the researchers' heads." Role-playing demonstrated the following points.

1. Use of the HCDS

In one situation, the dayya (midwife) is preferred because she comforts and stays by the mother and readily performs non-clinical services like the subuca (a ceremony performed seven days after birth).

An overwhelming majority of the Helwan sample uses the midwife for these reasons and gives ad hoc justifications for not using the clinic. ("The child of a neighbor who called the clinic died." "The clinic cuts the umbilical cord wrong.")

2. Resort Patterns

A common resort pattern for cases like diarrhea is to first use household remedies (wasfat baladiyya) and then the hospital. The prevalence of this resort pattern and the use of a posteriori explanations ("The hospital killed him.") were discussed.

At this point in the training, the consultant noted the usefulness of frequent sessions with data collectors to codify implicit themes in the data. When multiplied and analyzed, examples like those above become the essence of a formulation of "qualitative behavioral" theories.

C. Second Training Session

For this assignment, the participants were asked to review their field notes to determine informants' views on etiology (including critical symptoms) and the treatment of three childhood diseases and to find an example of a health care strategy. They also were asked to begin thinking about recurrent patterns of health care strategy and resort that are revealed in field notes.

As was expected, a discussion of childhood diseases revealed use of an informal system to organize symptoms into local categories and of an array of home remedies as a first-line defense. For example, a condition of swollen glands and fever is "recognized" as abu lukeim and is treated with black olives and lactuel, an ointment. Measles, which "must come to all children," is known to cause fever and spots. To cure measles, one isolates a child in a dark room, tells no one, and does not let the child smell food or have water, including a bath. Local categories are often congruent with cosmopolitan medicine. For example, gastroenteritis is classified as extremely dangerous, and high fever is considered to be the most critical symptom.

The consultant discussed the importance of analysis in integrating the local classification and treatment system after it has been codified into comprehensive paradigms (a straightforward task for which most data are available). An understanding of the local system is critical to an analysis of resort patterns in Cairo's HCDS, but, as Z. Shaheen pointed out in an

earlier session, research should not focus on the exotica of local remedies as ends in themselves.

Following the preliminary discussion of strategy and resort, the researchers were given a field assignment for that day.

D. Third Training Session

The third session followed the fieldwork. In this session, the participants were asked to identify the "most dangerous" childhood symptom and to determine during their visits why it was so dangerous. They were to be prepared to give the context of their discovery (i.e., how they broached the topic). They also were asked to elicit an account of a "real life situation" which encapsulates a health care resort strategy. They were to note how they asked this question. As a third task, they were to identify three hypothetical resort paradigms (steps x,y,z, etc.) suggested by the data and the health problems that are associated with each.

The focus was resort paradigms. Because it was difficult to elicit hypothetical paradigms, the session was used to derive strategy/perception paradigms from data on life situations. (The data were readily supplied by the researchers.) Two basic types of analysis were practiced. Researchers were encouraged to start using similar paradigms to organize their data.

1. Pattern of Information and Treatment Resort

An eight-step account of an infertile woman was analyzed. It was suggested that the woman resort to neighbors for advice about local practices like shrine-visitation; the midwife for suppositories; again to neighbors for mushahara-based explanations; and to a doctor. (The relationship between the social importance of fertility and socially-induced symptoms like mushahara (infertility caused by the improper action toward an afflicted woman of a person passing through a life crisis) was noted by the consultant in her remarks on sociocultural relations.)

2. Pattern of Information and Treatment Resort in the Context of the Actor's Life Situation and Perceptual Shifts

Here, analysis depended on a presentation of a detailed field account and codification of steps which differentiated the actor's situation (HCDS, personal life, etc.) from the actor's perceptions.

As an example, the case of an 11-year-old boy struck with polio was cited. Analysis indicated the following:

- a. Initial indexing ("At age two, the boy was dancing in the midst of women, one of whom said 'Isn't it enough?'");
- b. Resort to home remedy because of the constraint of the situation ("He had a fever and I gave him aspirin and waited for his father [from whom mother needed permission to go to clinic].");
- c. HCDS resort ("We took him to Abu Risch; they referred him to the Fever Hospital.");
- d. The first shift in etiological perception and the use of an informal information source ("A visitor told me that my son had paralysis, not fever; I made a big fuss and they transferred him to the Polio Hospital.");
- e. A HCDS/life situation constraint ("I was nursing another child and the Polio Hospital wouldn't admit me, so my son had to have outpatient therapy at Abu Risch.");
- f. HCDS resort and informal advice ("One of my friends told me about an operation that could help my son's legs, so I demanded that this operation be done at Qasr el-Aini.");
- g. Assignment of responsibility and perception of HCPS mistreatment ("But the operation at Qasr el-Aini ruined his leg; they did three more operations to try to correct it.");
- h. Perception of the life situation confused with the perception of HCDS ("Now my son is 11 years old and because of hospitals' mistreatment and neglect he has had no schooling. We can't afford a cart, so he must pull himself along the floor with his hands. All that he can look forward to is turning 12 years old, at which age he can enter a training program.").

The session ended with a discussion of the elicitation of narratives on illnesses to contextualize resort patterns. The researchers should be able to generate hypothetical paradigms in the next phase of research.

Sessions in Analysis

Meetings were held with TFG leaders and senior researchers to collaborate on analysis and to coordinate findings. The consultant was encouraged to say as much as possible, even if that meant recovering ground, rather than risk saying too little.

A. The Sociocultural Group (TFG 2)

The consultant met with Z. Shaheen and A. Mokhtar to consider the generation of ethnographic health perceptions and paradigms for health care, thematic analysis, and field technique.

TFG 2 compiled data for the report, including demographic information on households that were visited and the transcript of a typical case. Data analysis will be based on a thematic analysis of health practices and beliefs (particularly those about delivery and childhood diseases), perceptions of HCDS, household organization, social life, and the environment. Subsequent analysis will build on this thematic analysis, assuming basic belief and environmental patterns exist, and concentrate on social action.

The consultant discussed:

- data organization and topical entries;
- use of the third visit to corroborate information and to probe for details, particularly of disease-related experience;
- development of techniques to elucidate stock responses (Z. Shaheen worked on this task in training sessions);
- comparison of wife's and husband's views when alone as an insight to decision making; and
- relevance of household economic information to health care decision making.

B. The MCH Group (TFG 5)

TFG 5 and the consultant visited the Macasara polyclinic, where TFG 5 was completing surveys of personnel, clients, and institutions. The group has established a good working relationship with clinic staff. Predictably, the client interviews were the most difficult; clients hesitated to criticize, although researchers tried to question them when they were alone. Researchers had to suggest answers, particularly answers to questions on fees.

Clients recommended more medicine and earlier examination times. Staff recommended more equipment and a larger staff. The need for more nurses was cited frequently.

TFG 5 is absorbing information which may not be appearing in the compiled data. An example is the personal background of stellar HCDS personnel. The head nurse of the Macasara MCH component would have left that job if arrangements had not been made to allow her to work part-time as an inspector. In future evaluative sessions knowledge of ephemeral topics like motivation can be exploited.

C. The Socioeconomic Group (TFG 1)

TFG data for the Helwan area were being run through the computers at the time of the consultancy. M. Sayyid briefed the consultant.

TFG 2 census-takers (all male) obtained basic data from 3,500 households in Helwan. Approximately one-fourth of these households met the specifications for the target population: a woman 15 to 40 years old, a child 1 month to 6 years old, and a monthly income of 50 Egyptian pounds or less. (One U.S. dollar equals .70 Egyptian pounds.) Twenty-one data collectors (all women) completed approximately two target population cases each day to question a sample of 350. M. Safty and M. Sayyid met with the researchers after the consultant's session in August 1980 to discuss research aims, critique data collectors' practical experience, and to check questionnaires for missing questions.

As a response to interest in questions on accessibility and experience in pilot studies, four new questions (numbers 75-79) on hypothetical resort in case of the husband's or child's illness and an open-ended question (number 70; "What do you think the MCH clinics do?") were added for use in Helwan.

Other changes were made on the basis of the pilot study and the evaluation of the August 1980 questionnaire. Work and income were broken down finely to determine multiple breadwinners. The questions on the use of rooms (numbers 18-22) were revised to differentiate between apartments shared by several persons and apartments maintained by a single person. (The

question on the number of rooms for sleeping will probably differentiate the income level of those who can "afford" to have extra rooms that are not converted at night to sleeping quarters from the income level of those who need all rooms for sleeping. It will be interesting to see if this question proves to be critical to the differentiation of spare-room utilization.) A new question (number 32) was added to determine the floor-level of the apartment. Other new questions (numbers 51-53) were added to determine how people dispose of garbage (in street, municipal containers, or covered or uncovered containers at home).

On the basis of the pilot study, two changes were made in the questionnaire. Data on personal background and a pregnancy history were recorded on charts. This facilitated the organization of the data. Complete pregnancy histories are usually remembered by mothers, although they may index events in unorthodox terms. In past research the author noted the critical role of pregnancy histories in health care decision making.

On the basis of the Helwan survey, two changes will be made in the questionnaire. The four open questions will be closed. (For example, the significant answers to "Where would you go if your husband were sick?" were the hospital, a private doctor, and the doctor's work clinic.) Coding will be made easier with the introduction of marginal notations that are directly transferable to computer cards.

D. The HCDS Infrastructure Group (TFG 4)

The infrastructure group is divided into three subgroups, each of which is composed of a physician and two social workers. This means that each subgroup may be sensitive to both the medical and social and organizational aspects of health care delivery. Moreover, a balance is provided: social workers may feel that their expertise is underutilized, and physicians may feel that planners misunderstand the practice of medicine.

The group commented on a variety of topics, such as:

- structural relationships between clinics and hospitals;
- the internal division of space; and
- variations in staff relationships and the division of labor because of personality or structural differences

E. The Private Health Care System Group (TFG 6)

TFG 6 includes several physicians (general practitioners) and a number of social workers. They cover physician-clinics and hospitals, pharmacies, polyclinics (which have been a problem because they require permission and are open in the evenings), private MCH clinics, and curative organizations. Last summer they were concerned that they would have trouble contacting informal sector practitioners. This concern seems to have been valid. In the Helwan section, the group interviewed six midwives, but no herbal pharmacists or bonesetters. Collaboration with TFG 1 on accessibility was helpful. Certainly, collaboration with TFG 1 to "follow the informant to the clinic" should be encouraged.

Members of the group made interesting observations on resort patterns based on research to date. Their comments reveal the value of "evaluative sessions" to discussions of material not explicit in reported data. Private clinics run by benevolent organizations are often a first choice because they are private but not too expensive. Emergency rooms in government hospitals are often sought as well because the hospital seems to be efficient. This resource is ranked second. Private physician-clinics are a third choice. They are ranked low because they are expensive; however, clients are immensely satisfied with the personal attention they receive in these clinics.

III. OBSERVATIONS

Objectives of the Assessment

One of the major goals of the UHP is to improve the delivery of health care services to the urban poor of Cairo. The ECTOR study contributes to the achievement of that goal because it is an assessment of the HCDS, client perceptions, and the utilization of services. The ECTOR analysis assumes that an institutional operation is related inextricably to client perception.

The ECTOR assessment not only promises data on the HCDS and client perceptions; it also involves the development of a methodology for HCDS research which is based on collaboration between health care professionals and social scientists; considers both formal and informal healing activities and how each relates to the other; and uses both quantitative and qualitative (ethnographic) techniques to generate, test, and reformulate research designs and results.

As always, pitfalls may be expected; however, there should be few problems in this project. ECTOR should deliver both data and expertise.

To ensure success, W. Hassouna and team and group leaders will need to continue to monitor the decentralization and self-evaluation of the TFGs.

A. Decentralization of the Nine TFGs

A comprehensive and creative effort is ensured when each group is given the freedom to work on its own. Obviously, success depends on the quality of personnel and effective coordination.

ECTOR personnel are committed to developing a viable and replicable model for health services research. The results of their assessment will have a bearing on other projects (e.g., the tropical disease seminar). ECTOR has recruited some promising junior researchers to the TFGs. As the consultant remarked to AID and foundation officials in Cairo, there will not be a shortage of qualified researchers for expanding projects if junior ranks are successfully tapped and senior personnel, who are overcommitted, are used judiciously to supervise lower-level staff.

B. Continued Self-Evaluation of the TFGs

Self-evaluation is intimately related to decentralization. With independence come creativity and the need for self-evaluation. Again, with continued monitoring and coordination self-evaluation should occur.

TFG 1 was concerned about community involvement. Researchers indicated that Helwan was more rural than South and West Cairo. Some noted that "rural-like habits" were observable in the city. (Certainly, rural irrigation ditches, which have become open sewers, are common in Helwan.) But researchers also noted that the inhabitants of Helwan may be more open to research than the savvy "street-wise" residents of Sayyida Zainab. They recommended that communities be made aware of research. (This recommendation is listed in the report.)

Another concern of the community team, and of TFG 6 in particular, is whether enough informal private sector practitioners are being reached. As one approach to this problem, practitioners who were met by TFG 2 researchers were followed up. It appears that the best tactic may be to approach informal practitioners via clients. If herbal pharmacists (catārīh) can be approached via their clients, the study may acquire another valuable dimension.

In summary, the ECTOR assessment demonstrates commitment, coordination, and self-criticism. It promises to yield both applied and theoretical and methodological contributions.

The UHP

The consultant was impressed with the level of activity and commitment of the UHP.

Unfortunately, because the last week of the consultancy overlapped with several other activities of the UHP (Dr. Gold's presentation, a site visit to Alexandria, etc.), the consultant could not continue her discussions with Dr. N. Fouad. At an initial meeting she explained that the project had been reorganized into five functional units: organization and management; human resources; information, education, and communication; evaluation; and procurement, supply, and maintenance. She also talked about her efforts to stimulate medical school training in clinics. Earlier she discussed her plans for upgrading MCH clinics. Among them were the following topics, which are particularly interesting because of their sociocultural relevance:

- use of informal community leaders and practitioners;
- the phenomenon of "overutilization" of MCH clinics and its relationship to referral and organizational problems;

- reorganization of the recordkeeping system (until recently, MCH records were filed by a child's assigned day, which was based on age);
- increased use of the social worker and hakima; and
- the involvement of the tar margiyya and other community members in health education projects.

Dr. Fouad presented several ideas of his own, including:

- the organization of MCH clinics to separate immunization days from sick-baby days;
- the addition of a paid-service MCH clinic; and
- the distribution of growth charts to emphasize well-baby development.

The UHP seems to be coalescing. If this occurs, the project's various components will become complementary and mutually supportive.

IV. RECOMMENDATIONS

The Sociocultural Group (TFG 2)

Several interesting methodological and tactical issues of TFG 2 were raised during meetings with C. Nelson, Z. Shaheen, and A. Mokhtar.

A. Visitation Pattern

1. Spacing and Number of Visits

Both Z. Shaheen and A. Mokhtar indicated that the third visit may be a problem if the informants are bored or if the researchers are not convinced that the visit is necessary. C. Nelson suggested that visits be spaced. His suggestion led to a discussion of the usefulness of multiple visits for corroborating answers and developing theories.

2. Solicitation of Informants' Assistance

Researchers might leave questions which can be answered during subsequent visits or ask informants to keep notes in the interim between visits. C. Nelson suggested that this was one way to solve the issues raised in a discussion of the first point.

3. Real Versus Apparent Attitudes

In reading certain transcripts, the consultant noted discrepancies in answers on different visits, when different members of a family were present, and discussed the use of follow-up (second and third) visits to get "beyond" the answers that informants give to satisfy researchers. Subsequent meetings with researchers confirmed that such visits could be made.

B. Orientation of Researchers

1. Personal Opinion

The leaders are aware that it is possible to inject editorial comments in the field or in field transcripts because the work of TFG 2 is open-ended. They are monitoring this problem.

2. Collection of Exotica

Z. Shaheen noted that some researchers tend to focus on the practice of folk medicine and encourage discussion of folk remedies. This point was raised in subsequent meetings. It was agreed that all medical alternatives should be discussed in context and in relation to the importance of other alternatives.

C. Relationship of TFG 1 to TFG 2

The relationship between TFG 1 and TFG 2 and the advantage of using a subsample of 1 or 2 were discussed in meetings with Z. Shaheen and A. Mokhtar.

It seems that it would be helpful for TFG 1 to locate articulate, cooperative informants. The relationship of the two groups should be exploited for two reasons. One, TFG 2 needs basic demographic data on the family so that it will not repeat questions, although question-and-answer sessions do help to establish rapport. Two, TFG 2 can check the congruence between the questionnaire and ethnographic probes of a single issue. TFG 2 now asks questions on the hypothetical treatment of husbands or children and on nursing. (Few questions on health care decision making were included in the TFG 1 survey. This may be an esoteric methodological point, but it should be kept in mind.)

D. Evaluation and the Generation of Theory

Z. Shaheen has met intermittently with researchers to discuss reports and methodology. It was agreed that these discussions are important and should take place more often, even if fewer households are surveyed. (Thirty-two households were surveyed in the pilot study. Approximately 75 will be surveyed in the Helwan study.)

The sociocultural group's role in generating HCDS-relevant methodology and theory is unique among TFGs, because this is the only group that has no established research instruments. The group is to develop a replicable methodology which uses ethnographic technique as a short-cut to the formulation of critical questions about health care perceptions and decision making. Ultimately, the research process will be more important than the quantity of data obtained. TFG 2's priority should be quality data analysis, and not number of cases. Both W. Hassouna and C. Nelson concur with this observation. Assured of this priority, Z. Shaheen will be free to use her highly developed skills to pursue analysis with TFG 2. A foundation was laid in the January 1981 sessions for the generation of perceptual and strategic paradigms.

C. Nelson, Z. Shaheen, and A. Mokhtar indicated that the following emphases are appropriate for TFG 2 sessions in training and evaluation:

- Continued sensitization of researchers to:
 - emphasize the difference between quantitative and qualitative research;
 - increase the benefits of return visits to areas where rapport has already been established; and
 - increase researchers' role in analysis.

- Focus on topics, including:
 - illness perception;
 - health care decision making;
 - the health condition of family members and differential treatment, if any; and
 - use of household and other resources.

- Generation of a theoretical model which is:
 - based on the experience of the researcher; and
 - provides paradigms for short-cuts in future research.

Functioning of ECTOR TFGs

ECTOR TFGs are attuned to the sociocultural intricacies of health care behavior. This knowledge should continue to be exploited as much as possible.

One finds evidence of this awareness in the kinds of questions asked by non-sociologists during the consultant's presentation on the ethnography of health care decision making. The presentation was part of the Educational Seminar Series sponsored by the ECTOR Health Services Research Group. Non-sociologists asked about the differential health treatment of children according to age; the influence of the neighborhood setting on health care; the transfer of skills to the informal healing sector; and the possibility of generalizing from one low-income district to another.

At this time, all TFG leaders meet with their researchers and data collectors to evaluate results. The leaders of each team also meet as a group. These meetings are critical to the methodological innovation of the assessment and they should continue. The participants can evaluate data not contained in quantitative assessments; discuss the role and contributions of health practitioners and social scientists; codify methodology and models; and coordinate the work of TFGs.

The next consultancy should begin while data are being collected in South Cairo (February 1, 1981 - June 30, 1981). Data collectors will be able to meet with the consultant while they are working in the field. There is interest in collaborating on evaluation sessions.

Ideally, at the end of the ECTOR assessment, a workshop should be held to codify HSR expertise. This workshop need not take place during the presentation of the assessment data. Eventually, ECTOR could publish its information, including the data, in a handbook on HSR.

Appendix A
LIST OF CONTACTS

Urban Health Project

Dr. Nabahat Fouad, Executive Director

Ector Health Sector Assessment Group

Dr. Wafik A. Hassouna, Principal Investigator

Dr. Ahmed H. Gaber, Co-Principal Investigator

Ms. Gazabiyya Khaliffa, Administrative Assistant

1. Community Team

Dr. Cynthia Nelson, Team Leader

Socioeconomic Group (TFG 1)

Ms. Madiha el Safty, Group Leader

Dr. Fawzy Abdel Rahman, Senior Researcher

Ms. Abla Ibrahim, Junior Researcher

Mr. Medhat Abou el Nasr, Junior Researcher

Sociocultural Group (TFG 2)

Ms. Zeinab Shahin, Group Leader

Dr. Abdel Aziz Mokhtar, Senior Researcher

Private Health Care System Group (TFG 6)

Dr. Salma Galal, Group Leader

Ms. Iqbal Amir, Senior Researcher

Ms. Na'amat Dimirdash, Senior Researcher

2. Health Care Delivery System (HCDS) Team

Dr. Laila M. Kamel, Team Leader

Epidemiology Group (TFG 3)

Dr. Fatma Abou Hachima, Group Leader

HCDS Infrastructure Group (TFG 4)

Dr. Shadia Hakim, Group Leader

Maternal and Child Health Group (TFG 5)

Dr. Selwa Abdel Azim, Group Leader

Costing and Financing Group (TFG 7)

Ms. Nafisa E. Abou el Seoud, Acting Group Leader

3. Environmental/Urban Team

Dr. Mahmoud el Rifai, Team Leader

Environmental Group (TFG 8)

Dr. Ayman Zaki, Group Leader

Urban Group (TFG 9)

Dr. Mahmoud A. Reda Youssef, Group Leader

Information System Team

Dr. Mohamed F. Hassan, Team Leader

Policy Analysis and Development Team

Dr. Sara Loza, Team Coordinator

Other Personnel

Ms. Emily Leonard, UHP Program Officer, AID

Westinghouse Technical Assistance Project

Dr. Lyman Olson, Chief of Party

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Appendix B

SCHEDULE FOR CONSULTANCY
OF DR. EVELYN A. EARLY
(December 28, 1980 - January 17, 1981)

Appendix B

SCHEDULE FOR CONSULTANCY OF DR. EVELYN A. EARLY (December 28, 1980 - January 17, 1981)

Sunday, December 28, 1980

- General orientation with E. Leonard.
- Read UHP reports at AID.
- Socialized with UHP personnel at L. Olson's house; met A. Gaber and discussed aims of consultancy.

Monday, December 29, 1980

- Orientation with G. Khalifa on progress of TFG groups and format of report.
- Met with N. Fouad to discuss MCH reorganization and state of project.
- Met with A. Gaber to continue discussion of agenda for consultancy.
- Lengthy discussion with C. Nelson on applied anthropology in relation to UHP community group and on analysis of TFG 2 data. (Note: This discussion followed consultant's presentation to medical anthropology seminar.)

Tuesday, December 30, 1980

- Met with W. Hassouna for overview of UHP.
- Attended session with TFG 5 (MCH) to evaluate progress in Helwan (chaired by W. Hassouna).
- Read health coverage material.

Wednesday, December 31, 1980

- Informal discussion of UHP with S. Hakim.
- Attended meeting with W. Hassouna, A. Gaber, C. Nelson, and M. Taylor; discussion of approaches to health coverage (community, environmental, personnel, perceptual, etc.) in UHP and WHO projects; discussion of the question "How are we increasing information and its usefulness?"
- Attended training session run by S. Hakim for ECTOR clinic data collectors.

Thursday, January 1, 1981

- Spent morning at ECTOR.
- Met informally and separately with W. Hassouna, A. Mokhtar, and M. Khadri to discuss UHP, coverage, and sociology of development.
- Read product reports.

Friday, January 2, 1981

- Initial meeting with TFG 2; general discussion of ethnographic approach.
- Field trip to Tora (Helwan) with TFG 2.
- Observation of field situation and researchers' approach.
- Informal discussion with A. Mokhtar (chaired group for the day).

Saturday, January 3, 1981

- Spent entire morning contacting people (or leaving messages) to arrange appointments, field visits, and training sessions for the following two weeks; obtained documents, including content analysis.

- Departed at 3:00 p.m. for ECTOR tropical disease training session in Fayoum. (Note: Attendance at this session served two main purposes: (1) facilitation of work with ECTOR UHP personnel away from Cairo's hectic pace; (2) collaboration between ECTOR's UHP and tropical disease concerns vis-a-vis health service research (HSR).
- Attended with Fayoum representatives discussion on the problems of health service research (design, statistical accuracy, etc.) and the state of training programs.
- Attended opening session; Dr. Asin (director of public health in Fayoum) discussed preventative care (Bilharzia, malaria, and oral rehydration) and the environmental impact on health.

Sunday, January 4, 1981

- Visited rural health unit (discussion of family planning and nurse training), malaria station, and bilharzia unit (discussion of spraying program, effect of water distance on incidence, etc.).
- Attended workshop run by W. Hassouna and A. Mokhtar on social aspects of preventive medicine.
- Discussed design of project (role of clinic personnel in bilharzia prevention) with ECTOR personnel.

Monday, January 5, 1981

- Continued work on project design.
- Returned to Cairo.
- Read TFG content analysis reports.

Tuesday, January 6, 1981

- Field trip to MCH clinic postponed.
- Spent morning reading (mainly content analysis; this and transcripts in handwritten Arabic).
- Lengthy session with A. Mokhtar on progress of TFG 2 to date, including training and monitoring of researchers, present methodology, and mode of analysis and possible changes; need to emphasize illness perception and pattern of decision making.

Wednesday, January 7, 1981

- In Fom Khalig; read product reports and obtained questionnaires.
- Discussed HSR with W. Hassouna en route to and at Institute of National Planning (INP).
- Returned to Fom Khalig to meet with M. Sayyid about data analysis of TFG 1; topics included changes based on pilot study; closing of open questions based on Helwan study; monitoring and training of researchers.

Thursday, January 8, 1981

- Met with C. Nelson and Z. Shaheen; established training priorities and discussed ethnographic technique.
- Met with W. Hassouna before his departure to U.S. to confirm rest of program and to debrief Hassouna on work to date.

Friday, January 9, 1981

- Prepared training session.
- Ran training session with TFG 2.

Saturday, January 10, 1981

- Set up and confirmed appointments; attempted to locate researchers from TFGs 1, 5 and 6.
- Took half-day off for personal errands.

Sunday, January 11, 1981

- Met with Z. Shaheen; discussed analysis of TFG 2 data, collection and reporting procedure, training sessions run in fall 1980, and Helwan report.

- Read TFG 2 Arabic transcripts.

Monday, January 12, 1981

- Made field trip with TFG 5 to MCH clinic in the Macasara polyclinic.
- Observed field techniques and held informal discussions with clinic staff and team members.

Tuesday, January 13, 1981

- Meeting with C. Nelson and Z. Shaheen canceled.
- Read TFG 2 transcripts.
- Met with K. Hatley (Westinghouse).
- Attended Dr. Gold's presentation on family planning.
- Ran evaluation session with health care infrastructure group (TFG 4); chaired critique of research experience and the social/medical interface; probed hypothetical questions (e.g., reorganization of extant space).

Wednesday, January 14, 1981

- Prepared seminar.
- Met with Dr. Rakha (ECTOR).
- Met with I. Amir and N. Dimardash (TRG 6) to discuss activities of private sector group. (Both were in the summer 1980 training sessions.)
- Met with A. Ibrahim to discuss activities of TFG 1. (She was in summer 1980 training sessions.)
- Presented seminar to ECTOR group ("The Ethnography of Health Care Decision Making").

Thursday, January 15, 1981

- Debriefed with E. Leonard.
- Met with Z. Shaheen and A. Mokhtar; discussed product report and content analysis; outlined TFG 2 priorities.
- Held training session with TFG 2 and field site visit.
- Met informally with C. Nelson to replace January 13 meeting and to debrief Nelson.

Friday, January 16, 1981

- Held final training session with TFG 2.
- Read interview transcripts and reports to be returned before departure.

Saturday, January 19, 1981

- Finished reading and returned transcripts.
- Wrote short report for W. Hassouna to debrief him on last week.

Appendix C
SCOPE OF WORK FOR CONSULTANCY

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SCOPE OF WORK FOR CONSULTANCY

- A. The consultant will work with Dr. Cynthia Nelson, Dr. Fatma Abu Hashima, Madiha el Safty, and Zainab Shaheen to evaluate the results of the South Cairo Survey.
- B. The consultant will meet with the ethnographic researchers trained in the summer to:
 - 1. Monitor the data's quality and mode of recording;
 - 2. Lay the groundwork for an evaluation of the interface of individual health care action and institutional functioning to make ethnographic work relevant to health care delivery decisions.
- C. The consultant will work with Dr. Laila Kamel and Group II to evaluate data on clinic utilization, perception, and accessibility.
- D. The consultant will monitor cultural components suggested to UHP by technical advisers.

Appendix D

PROPOSED SCOPE OF WORK FOR FUTURE CONSULTANCY

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PROPOSED SCOPE OF WORK FOR FUTURE CONSULTANCY

The Arabic-speaking medical anthropologist will pursue three major goals during the consultancy:

1. In-depth work with Zainab Shaheen and TFG 2 (socio-cultural) based on past work to:
 - a. generate paradigms of health care resort strategy;
 - b. generate paradigms of disease perception; and
 - c. operationalize an ethnographic approach to health service research based on the experience of TFG 2 in the health sector assessment.

2. Follow up work with TFG leaders Mediha Safty, Selwa Galal, and Selwa Abdul Azim and their groups (socioeconomic, private sector, MCH clinics) on the relationships of institutional and social behavior to:
 - a. enrich the data with the sociocultural perspective where possible; and
 - b. collaborate to refine a methodology based on collaboration between the health service professional and the social scientist.

3. Collaborate with Wafiq Hassouna, Cynthia Nelson, and members of ECTOR in the analysis of data collected in the final two sections of the health sector assessment to:
 - a. codify information on the interface between the formal health care delivery system and the informal healing system;
 - b. assess implications of the assessment for HCDS innovations;

- c. coordinate findings with other parts of UHP; and
- d. refine a HSR methodology based on experience gained during the assessment.

The consultant will meet with other researchers and contractors as necessary.