

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

P R O J E C T P A P E R

AMENDMENT NO. 2

EGYPT: URBAN HEALTH DELIVERY SYSTEM
(263-0065)

June 1981

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET		1. TRANSACTION CODE A A = Add C = Change D = Delete	Amendment Number <u>2</u>	DOCUMENT CODE <u>3</u>
COUNTRY/ENTITY <u>EGYPT</u>		3. PROJECT NUMBER <u>263-0065</u>		
4. BUREAU/OFFICE <u>NE</u>		5. PROJECT TITLE (maximum 40 characters) <u>URBAN HEALTH DELIVERY SYSTEM</u>		
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY <u>011 3 0 86</u>		7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4) A. Initial FY <u>7 0</u> B. Quarter <u>2</u> C. Final FY <u>8 1</u>		

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)	(2,640)	(2,313)	(4,953)	(18,830)	(18,423)	(37,253)
(Loan)	()	()	()	()	()	()
Other U.S.						
1.						
2.						
Host Country		10,664	10,664		80,513	80,513
Other Donor(s)						
TOTALS	2,640	12,977	15,617	18,830	98,936	117,768

9. SCHEDULE OF AID FUNDING (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) SA	533	510		25,253		12,000		37,253	
(2)									
(3)									
(4)									
TOTALS				25,253		12,000		37,253	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)					11. SECONDARY PURPOSE CODE				
510	563	580	530	440	532				

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)									
A. Code	DEL	TNG							
B. Amount									

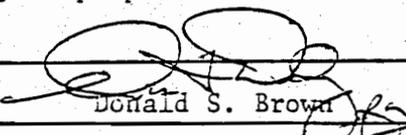
19. PROJECT PURPOSE (maximum 480 characters)

To make the existing urban health care delivery system more accessible and effective so that it better supports efforts at health improvement in the project area and could form the basis for Cairo-wide and other urban area replications.

14. SCHEDULED EVALUATIONS					15. SOURCE/ORIGIN OF GOODS AND SERVICES				
Interim	MM YY	MM YY	MM YY	Final	000	941	<input checked="" type="checkbox"/> Local	<input type="checkbox"/> Other (Specify)	
	06 82	06 84	04 85						

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a 12 page PP Amendment.)

The amendment provides funds to cover increases in estimated costs resulting from inflation reestimates based on actual experience. The amendment also provides funds for the expansion of the project to Alexandria and financing of innovative activities which support the project purpose.

17. APPROVED BY	Signature		18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
	Title	Donald S. Brown Director	

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

FIRST AMENDMENT
TO
PROJECT AUTHORIZATION

Name of Country: Arab Republic
Of Egypt

Name of Project: Urban Health
Delivery
System

Number of Project: 263-0065

Pursuant to Section 531 of the Foreign Assistance Act of 1961, as amended (the "Act"), the Project was authorized on November 15, 1978. The authorization is hereby amended as follows:

a. The first five paragraphs are deleted in their entirety and the following substituted therefor:

"1. Pursuant to Section 531 of the Foreign Assistance Act of 1961, as amended (the "Act"), I hereby authorize the Urban Health Delivery System Project (the "Project") for the Arab Republic of Egypt ("Cooperating Country") involving planned obligations of not to exceed Thirty-seven Million Two Hundred Fifty-Three Thousand United States Dollars (\$37,253,000) in grant funds ("Grant") over a three-year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing the foreign exchange and local currency costs of goods and services required for the Project.

"The Project will assist the Cooperating Country to improve the health of the Egyptian people, especially the low-income population of selected health zones of Greater Cairo and Alexandria, by making the existing urban health care delivery system more accessible and effective. The Project will conduct a health sector assessment of the Project area; institutionalize the planning process process within the Ministry of Health; provide for the construction or renovation and equipping of maternal-child health clinics, general urban

health centers, and a center for Preventive and Social Medicine; introduce innovative interventions into the health system to improve the delivery of health services; train health professionals, paraprofessionals, outreach workers, community leaders and other health-related personnel; provide technical assistance to the Governorates of Cairo and Alexandria; and provide technical assistance and commodities to the Health Insurance Organization.

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

2. The following covenant shall be added:

Covenants

The Cooperating Country shall covenant that none of the funds made available under this Project will be used to pay for (1) the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions or (2) the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to practice sterilizations.

3. Based upon the justification set forth in the Project Paper, I hereby determine, in accordance with Section 612(b) of the Act, that the expenditure of United States Dollars for the procurement of goods and services in Egypt is required to fulfill the purposes of this Project; the purposes of this Project cannot be met effectively through the expenditure of U.S.-owned local currencies for such procurement; and the administrative official approving local cost vouchers may use this determination as the basis for the certification required by Section 612(b) of the Act.

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

M. Peter McPherson
M. Peter McPherson
Administrator

Aug 15, 81
Date

AA/NE:WAFord WAF date 14 Aug '81
A-AA/PPC:LSmucker LS date 8-17-81
GC:JBolton ICCR date 8-17-81

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URBAN HEALTH DELIVERY SYSTEM

Project 263-0065

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I. Summary & Recommendations

1. Grantee: The Government of the Arab Republic of Egypt.
2. Implementing Agency: The Ministry of Health/Urban Health Delivery System Project.
3. Grant Amount: Adds U.S. \$12,000,000 to bring life of project funding to \$37,253,000.
4. Project Goal: to improve the health status of the Egyptian people.
5. Project Purpose: to make the existing urban health care delivery system more accessible and effective so that it better supports efforts at health improvement in the project area and could form the basis for Cairo-wide and other urban area replication.
6. Purpose of the Project Paper Amendment: This amendment is intended to provide funds to cover increases in estimated costs resulting from inflation and re-estimates based on actual experience. The recalculations are based on the assumption of the same activity levels as in the amended PP. In addition, \$2.5 million of the increased amount reflects a new concern which would fund innovative activities in the private and semi-private sectors in urban areas. Also \$3.14 million will fund an expansion of the Urban Health Project to Alexandria. The PACD is amended to January 30, 1986.
7. Project Description: In November of 1978, A.I.D. signed a Grant Agreement providing \$4,953,000 for the first year funding of a \$25,253,000 project. The balance of funding was provided in early 1980. The purpose of the project is

to make the existing health care system more accessible and effective, utilizing existing facilities and human resources. The target population of approximately 1.7 million people (of which 60% are low-income) resides in the South, West and Helwan zones of Cairo. The project was designed to include a health sector assessment, renovation and equipping of 10 Maternal Child Health Clinics, construction of 8 General Urban Health Centers, and a Center for Preventive and Social Medicine; technical assistance for innovative interventions and training of health professionals, para-professionals, outreach workers, community leaders and other health-related personnel. Renovation of 12 MCH Clinics in the North and Central zones of Cairo was added under the "Accelerated Programs" efforts of the Mission in August 1979 but no additional funds were provided..

II. Background and Progress to Date

When the Project Paper was approved in October 1978 and the Grant Agreement signed in November of the same year, it was envisioned that the four key contractors would be selected and in place by July of 1979. Instead the first contracts were signed in January/February 1980 with ECTOR for the sector assessment and Westinghouse Health Systems for technical assistance and were followed by contracts in April for Egyptian A & E services and in September for U.S. A & E services. The initial delays in contracting were due principally to an underestimation of the time required for the bid and award process. All contractors began work promptly and the projected key implementation targets parallel those of the original implementation plan except for the starting dates (with the exception of the Center for Social and Preventive Medicine design which is behind schedule). A revised implementation schedule is shown as Annex 1.

During the past two years, minor adjustments or modifications to the originally conceived project inputs have been made. They are:

1. Limiting the Health Sector Assessment to the demonstration area.
2. Including the majority of American consultant months under the U.S. technical assistance contract.
3. Increasing the number from 10 to 22 MCH centers to be upgraded/renovated. The 10 MCH centers whose renovation was planned in the original PP are in the project area which encompasses the South, West and Helwan zones of Cairo. Under the "accelerated activities" program of the Mission in 1979, the 12 remaining MCH centers in Cairo (North and East zones) were added to the project's MCH renovation and equipment activities. Any instructional materials, training and protocols which test out satisfactorily in the project area will be replicated in these additional centers. (This amendment adds an additional 11 centers in Alexandria in the same manner.)

As of May 1981 the following milestones have been reached:

1. The Sector Assessment of Helwan has been completed and the data analysis is expected in June.
2. Personnel, functions, and equipment needs for all MCH and GUHC's have been agreed upon.
3. A work plan, implementation plan and evaluation framework have been developed and submitted to A.I.D.

4. Final drawings and bid packages for MCH renovations have been completed for the Cairo test districts and tenders requested.
5. Functional programming for the GUHC's has been completed and the initial design has been reviewed by the MOH and A.I.D.
6. Approximately 1,600 people have received in-country training.

III. Rationale for Amendment

The funds requested in this amendment will permit the following:

- execution of the project as originally planned including funding of the 12 MCH center renovations added under the accelerated programs; and
- new activities.

Original PP Activities (\$+ \$4,299)

	(\$000)			
	<u>PP</u>	<u>Add-on</u>	<u>New Total</u>	
Technical				
Assistance	2,304	2,085	4,389	<u>1/</u>
Training	717	438	1,155	<u>1/</u>
Commodities	5,266	1,531	6,797	<u>1/ 2/</u>
A & E Renovations				
Construction	<u>7,889</u>	<u>6,904</u>	<u>14,793</u>	<u>1/ 2/</u>
	16,176	10,958	27,134	<u>1/ 2/</u>
Inflation				
Allowance in PP	--NA--	-6,659	-6,659	
Net Total	16,176	4,299	20,475	

The increased requirements over those estimated in the PP are due to slippage in implementation which, when

1/ Includes individual line item inflation allowances.

2/ Includes additional 12 MCH centers authorized in 1979 but not funded.

compounded at the inflation rate, adds substantial amounts over time. The slippage was due to an unrealistic estimate of the time required to solicit and evaluate bids and actually start contract work.

In addition to the time lag/inflation increases, the original estimates were substantially undercosted for both the U.S. Technical Assistance and the U.S. A & E contracts. Both of these contracts are cost reimbursable and the estimated costs are in direct relation to the permanent overseas staff and short-term consultant months requested in the RFP. The original estimates apparently underestimated both the level of effort and the support costs.

Construction costs were also underestimated, although not as severely as the contract costs, due to AID's lack of construction experience in Egypt at the time of project design. The figures used were for the most minimal standard design and would not now cover even severely modified (downward) U.S. standards for materials and structural safety and durability, particularly in multi-story buildings. (Because of land constraints, the GUHC's will be two stories and the CSPM 5 - 7 stories.)

New Activities (+\$5.64 million)

The PP envisioned both expansion and replication of project activities beyond the original project area but did not provide any funding for such activities. This amendment includes \$3.14 million for expansion to Alexandria, the second largest urban area in Egypt. The PP also limited project activities to the MOH delivery system, although this provides only a limited part of health care services to the urban poor. Two and a half million of this amendment would provide funds to increase project impact on the health care available to the poor by expanding project activities

beyond the MOH system. The new activities are described in more detail in the two sections which follow.

A ten percent contingency amount has been included to prevent having to seek additional funds later in the project if substantial delays occur in the implementation schedule. Experience to date has been that, because of the complexity of the project and the variety of activities, it is not possible to accurately project market shifts and implementation problems beyond the near future.

IV. Alexandria Urban Health Sub-Project

The project purpose clearly includes the idea of ultimate expansion and replication in Cairo and other urban areas. No particular areas or phasing were established and no funding specifically provided in the Grant. This part of the project amendment would provide for expansion to the Alexandria metropolitan area at an estimated cost of \$3.14 million.

Alexandria, with a population of approximately 3 million people, has indicated a strong desire to become part of the Urban Health Project in order to upgrade its MOH health services. As in Cairo, the MOH system directly serves the lowest income segment of the population. The MOH primary and secondary delivery system there consists of:

- 1 large modern polyclinic
- 3 General Urban Health Centers (eventually 10)
- 11 MCH Clinics
- 18 School Health Bureaus
- 2 Rural Health Centers
- 15 Rural Health Units (eventually 20)
- 2 T.B. referral clinics
- 4 Health Bureaus

8 Specialized referral clinics

It is not necessary to duplicate the Urban Health Project staff and technical assistance de novo for Alexandria nor has the GOE requested such an individually tailored program. The approach currently being used in the two districts of Cairo (North and East Cairo) which were added to the original three project districts under the accelerated projects mission activity is more appropriate. Under this approach, MCH clinic renovation will be conducted using the functional programming guidelines already established and equipment repair, replacement and additions will follow the project equipment protocols wherever possible by simply increasing the number of items in each category of procurement where the standard inventories show a need. No special waivers are foreseen. No new construction is included beyond minor additions which enhance the MCH renovations. Educational materials and printed matter from the central project will be printed in sufficient volume to cover Alexandria also. Replication of specific interventions which prove successful in the two pilot centers in Cairo will be replicated in Alexandria by the Ministry of Health with possibly outside technical assistance.

As a condition precedent for expenditures on renovations in Alexandria, the Undersecretary for Health of the Alexandria Governorate will establish a coordination office consisting of the following full-time personnel.

Director, Alexandria sub-project
Procurement counterpart
Intervention counterpart
Accountant

and such clerks and support personnel which are considered

necessary. Upon approval of the appointments by the Executive Director, UHDS and A.I.D., the condition shall be considered fulfilled.

Insofar as possible, the current and future contracting for A & E work, equipment surveys, and technical assistance will be amended to include Alexandria to avoid increasing the multi-contract management burden of the MOH. It is anticipated that this will speed up the renovation phase to overlap with the Cairo work so procurement can be done in bulk without the Alexandria equipment sitting in storage for a long period.

V. Innovative Activities and Technology Transfer

The urban health delivery systems which serve Egypt's urban poor include numerous service providers which are licensed by the MOH or the MOH and Ministry of Social Affairs but which are independently or privately run. The existence of such centers or systems relieves the MOH system of pressure for services in particular areas. In the absence of such institutions the Ministry would have to lease or construct more buildings and pay more staff; a difficult addition to an already financially strained system.

Most of the changes the Urban Health Project is trying to bring about in the MOH centers are equally useful for non-MOH centers. Their need for health education and family planning materials and training in how to use them is as great as that of the public system. Conversely, A.I.D is familiar with several private and semi-private organizations which are approaching problems common to private and public deliverers in innovative ways. Greater flexibility is provided by supporting and documenting their efforts for potential replication in the MOH system than to set up new "intervention" tests in the main pilot centers. In particular, innovative approaches in delivery and financing of health care being

developed in the private and semi-private sectors (e.g. health insurance) appear to offer attractive alternatives in the delivery of health care to urban populations.

This part of the amendment would provide \$2.5 million to be used to support improvements in the urban health delivery system as a whole, including entities outside of the formal MOH system, through the study, support, and replication of activities which have shown promise for improving accessibility and quality of services for the poor.

Examples of potential uses: Development of a health and management information system in the Health Insurance Organization that would make possible expansion of insurance coverage to dependents of insured urban workers; linkage of pharmacists with centers for referrals; daya training and participation; volunteer home visitor programs; youth involvement in family planning and health education activities; improved cross referral system (i.e. to social affairs, to community leaders); supervision of housekeeping staff; patient returned records; workshops, seminars and publicity.

These are examples of activities for which A.I.D. has already been approached for funding or advice and are only illustrative. Since it is expected that the Health Insurance Organization will request around \$1.5 million of the \$2.5 million requested for innovative activities, a brief description of this activity is attached as Annex 5 for information purposes. This annex also includes reports concerning the HIO by Dr. Carl Stevens. The HIO will be required to submit a proposal as described below.

Proposed activities will be identified by either the MOH or other entities. Proposals will be submitted to the Executive

Director, UHDSP, for screening. The proposals will be required to be in the format used for PVO activities with the level of detail dependent on the size of the subgrant and the complexity of the activity. The proposal will have to clearly spell out how the activity will contribute to improving the accessibility and quality of services to the poor. In cases where the request is simply for materials developed by the project, the proposal can be briefer, focusing on the beneficiaries and the institutional capability to utilize the materials. Because these requirements may prove difficult for many small groups, the project will hire a part-time coordinator as needed to help translate proposals into the AID PVO format. When the proposals are sufficiently developed and carefully costed, the Executive Director will submit them to A.I.D. for approval. If approved, they will be authorized as a sub-project activity through Project Implementation Letters.

A special unit will be set up in the UHDSP headquarters to deal with the flow of vouchers and advances for these sub-projects and the Alexandria sub-project. The unit will be headed by a contract Egyptian accountant assisted by one clerk/typist funded with AID funds. The unit will be responsible for reviewing the monthly expenditure reports for each sub-project, verifying the totals and the presentation, estimating the advance requirements with the sub-project directors, and working with the subgrantees to resolve any problems. The accountant will deal directly with the AID Controller's Office in straightening out problems and will act as an information point for commodity and services procurement according to AID guidelines. This unit will submit all documents to AID through the Executive Director.

VI. Project Activity Completion Date (PACD)

The contract with Westinghouse Health Systems to provide technical assistance to the project was signed in January 1980. The

contract provides five years of permanent staff attached to the project. Including the mobilization period and the cleanup of final accounts and overhead rate adjustments, the contract is for 72 months. This amendment would extend the PACD to January 30, 1986 to coincide with the term of the Westinghouse contract.

VII. Financial Plan

A summary of budget changes proposed is attached as Annex 2.

VIII. Justification for Section 612(b) Determination

The justification for dollar financing of local currency costs remains the same as originally presented in the Project Paper (Annex S of the Project Paper, here Annex 3). The dollars required would increase from \$12,650,000 to \$18,423,000 over the life of the project.

IX. Grantee's Request

The Arab Republic of Egypt, acting through the Ministry of Health, has requested authorization of an increase in the amount of the project to provide A.I.D. assistance in financing remaining LOP foreign exchange costs and some local currency costs (see Annex 6).

X. Covenants and Conditions Precedent

The Grant Agreement will contain the same covenants as were included in the August 17, 1978 Grant Agreement. An additional condition precedent concerning MCH renovation in Alexandria will be added. (See page 7.)

The Grantee will also be required to covenant that none of

the funds made available under this Project will be used to pay for (1) the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions or (2) the performance of involuntary sterilizations as a method of family planning or to coerce or provide any financial incentive to any person to practice sterilizations.

XI. Environmental Impact

The project is designed to improve the health of people. The renovation and construction elements will have a minor and temporarily negative impact on the environment principally through the noise of the construction. No other negative environmental changes will occur.

XII. Conclusion

In view of the above, the Project Committee concludes that to ensure successful completion of the project, it is in the interest of the United States to provide beyond the \$25,253,000 previously authorized for this project an additional \$12,000,000 in financing.

Implementation Schedule

			<u>Project Paper</u>		<u>May 1980 Review</u>
		<u>Responsible Organization</u>	<u>Est. Date Start/Completed</u>		<u>Actual</u>
<u>1. Preparatory Phase</u>					
A.	PP Approved	AID/W	11/78	11/78	11/78
B.	Grant Agreement Signed	MOH USAID	11/78	11/78	11/78
C.	<u>CP's Met</u>				
	(1) Formation of Implementation Organization	MOH	12/78	3/79	2/79
	(2) Designation of Executive Board of Project	MOH	12/78	3/79	2/79
	(3) Assignment of Project Executive Director	MOH	12/78	12/78	2/79
D.	<u>Preparation of RFP's</u>				
	(1) Contract for Health Sector Assessment	MOH	1/79	3/79	5/79
	(2) Egyptian A & E (MCH Units)	MOH	1/79	3/79	9/79
	(3) U.S. A & E (GUHC, Pediatric Hospital)	MOH	1/79	3/79	9/79
	(4) Contract for Technical Services	MOH	1/79	3/79	5/79
<u>2. Preliminary Studies</u>					
A.	Training Plan Approved	MOH	1/79	6/79	6/79
B.	Evaluation Plan Approved	MOH	1/79	6/79	5/81
C.	U.S./Egyptian Consultant Services Planned.	MOH	1/79	5/79	3/81
D.	Action Plan for First Two Years Prepared	MOH	1/79	5/79	3/81
E.	Project Statistical Collection Requirements Determined	MOH	3/79	6/79	5/81

3. Contractor Contracted

A. H.S.A.	MOH	-	7/79	2/80
B. Egyptian A & E	MOH	-	7/79	4/80
C. United States A & E	MOH	-	7/79	9/80
D. Technical Services	MOH	-	7/79	1/80

4. Activities Implementation

A. Sector Assessment	MOH		<u>Est. Start</u>	<u>Est. Comp.</u>
1. Helwan			3/80	6/81
2. South Cairo			7/81	12/81
3. West Cairo			1/82	6/82
B. MCH Units Renovated	MOH			
1. 22 units in Cairo				
a. A & E Studies			5/80	3/81
b. Tenders			6/81	6/81
c. Contractors Selected			6/81	7/81
d. Renovations			8/81	6/82
2. 11 Units in Alexandria				
a. C.P. Met			9/81	9/81
b. A & E Studies			10/81	1/82
c. Tenders			2/82	4/82
d. Contractors Selected			4/82	5/82
e. Renovations			6/82	3/83
C. GUHC Construction	MOH			
1. A & E Studies			7/80	7/81
2. Tenders			8/81	11/81
3. Contractors Selected			-	11/81
4. Construction			12/81	1/83
D. CSPM Construction	MOH			
1. A & E Studies			4/81	1/82
2. Tenders			3/82	6/82
3. Contractor Selected			-	6/82
4. Construction			7/82	8/83

A detailed implementation plan for all interventions, renovations, commodity procurement, evaluation and construction was submitted by the project March 15, 1981. Since the document is over 200 pages long, it has not been attached to the amendment and the above represents a brief outline. The complete document is available for review in the Health Division at USAID and in NE/TECH/HPN in Washington.

SUMMARY OF BUDGET CHANGES

	<u>PP</u>	<u>Current Est.</u>	<u>Change</u>
<u>Technical Assistance</u>			
U.S. TA Consultants	970	351	-619
U.S. TA Contractor	1,117	3,500	2,383
Egyptian Contractor	---	388	388
Support Costs	103	---	-103
Egyptian Consultants	<u>114</u>	<u>150</u>	<u>36</u>
Total TA	2,304	4,389	2,085
<u>Training</u>			
Long-Term Training	276	470	194
Short-Term Training	122	262	140
Observation Tours	99	170	71
Travel	58	91	33
In-Country Training	<u>162</u>	<u>162</u>	<u>---</u>
Total Training	717	1,155	438
<u>Commodity & Recurring Costs</u>			
Commodities	5,266	6,797	1,531
Other Recurring Costs	<u>1,215</u>	<u>1,215</u>	<u>---</u>
Total Other	6,481	8,012	1,531
<u>Construction</u>			
U.S. A & E	657	1,871	1,214
Egyptian A & E	60	75	15
MCH Construction	600	3,143	2,543
GUHC/Pediatric	<u>6,572</u>	<u>9,704</u>	<u>3,132</u>
Total Construction	7,889	14,793	6,904
<u>Expanded Activities</u>			
Innovative Activities	---	2,500	2,500
Alexandria Expansion	<u>---</u>	<u>3,140</u>	<u>3,140</u>
Total Inputs	17,391	33,989	16,598
Inflation	6,659	<u>1/</u>	(6,659)
Contingency	1,203	3,264	2,061
Project Total	25,253 <u>2/</u>	37,253	12,000

1/ Included in each line item total.

2/ 25,253 was authorized instead of the Project Paper total of 25,272 as a result of a mathematical error.

SUMMARY COST ESTIMATE & FINANCIAL PLAN
(\$000)

TITLE: URBAN HEALTH DELIVERY SYSTEM
Project 263-0065

SOURCE	AID			GOE	COMBINED		
	FX	LC	TOTAL	LE	FX	LC	TOTAL
<u>Use</u>							
Technical Asst.	3,392	997	4,389	2,703	3,392	3,700	7,092
Training	993	162	1,155	---	993	162	1,155
Commodities	6,293	504	6,797	---	6,293	504	6,797
A & E	1,191	755	1,946	---	1,191	755	1,946
Construction / Renovation	3,234	9,613	12,847	---	3,234	9,613	12,847
Other Recurring Costs	23	1,192	1,215	8,809	23	10,001	10,024
Land	---	---	---	8,022	---	8,022	8,022
Bldg. & Facilities	---	---	---	4,211	---	4,211	4,211
Alexandria	1,015	2,125	3,140	5,340	1,015	7,465	8,480
Innov. Act.	1,100	1,400	2,500	51,428	1,100	52,828	53,928
Subtotal	17,241	16,748	33,989	80,513	17,241	97,261	114,502
Contingency	<u>1,589</u>	<u>1,675</u>	<u>3,264</u>	---	<u>1,589</u>	<u>1,675</u>	<u>3,264</u>
Total	18,830	18,423	37,253	80,513	18,830	98,936	117,766

ANNEX 2

AID OBLIGATIONS BY FISCAL YEAR
(\$000)TITLE: URBAN HEALTH CARE DELIVERY SYSTEM
Project 263-0065

	<u>FY '79</u>			<u>FY ' 80</u>			<u>FY ' 81</u>			<u>ALL YEARS</u>		
	<u>FX</u>	<u>LC</u>	<u>TOTAL</u>	<u>FX</u>	<u>LC</u>	<u>TOTAL</u>	<u>FX</u>	<u>LC</u>	<u>TOTAL</u>	<u>FX</u>	<u>LC</u>	<u>TOTAL</u>
<u>AID INPUTS</u>												
Technical Assistance	1,627	677	2,304	1,765	320	2,085	---	---	---	3,392	997	4,389
Training	497	218	715	---	---	---	496	(-56)	440	993	162	1,155
Commodities	---	---	---	4,717	549	5,266	1,576	(-45)	1,531	6,293	504	6,797
Construction/ Renovation	---	---	---	2,191	8,328	10,519	1,043	1,285	2,328	3,234	9,613	12,847
A & E	493	224	717	698	531	1,229	---	---	---	1,191	755	1,946
Other Costs	23	1,192	1,215	---	---	---	---	---	---	23	1,192	1,215
Alexandria	---	---	---	---	---	---	1,015	2,125	3,140	1,015	2,125	3,140
Innovative Activities	---	---	---	---	---	---	1,100	1,400	2,500	1,100	1,400	2,500
Contingency	---	---	---	<u>601</u>	<u>602</u>	<u>1,203</u>	<u>988</u>	<u>1,073</u>	<u>2,061</u>	<u>1,589</u>	<u>1,675</u>	<u>3,264</u>
Total AID	2,640	2,311	4,951	9,972	10,330	20,302	6,218	5,782	12,000	18,830	18,423	37,253

7 Annex 2
Page 4

PROJECTION OF EXPENDITURES BY FISCAL YEAR
URBAN HEALTH PROJECT
Project 263-0065

	PRIOR YEARS			FY ' 81			FY ' 82			FY ' 83		TOTAL	FY ' 84			FY ' 85			TOTAL		
	FX	LC	TOTAL	FX	LC	TOTAL	FX	LC	TOTAL	FX	LC		FX	LC	TOTAL	FX	LC	TOTAL	FX	LC	TOTAL
	AID INPUTS																				
Technical Assistance	50	155	205	600	241	841	742	150	892	750	150	900	650	150	800	600	151	751	3,192	997	4,189
Training	184	50	234	46	25	71	160	25	185	240	25	265	280	25	305	83	12	95	993	162	1,155
Commodity	10	240	250	960	40	1,000	2,850	150	3,000	1,970	30	2,000	453	20	473	50	24	74	6,293	504	6,797
A & E Const. Rev.	100	105	205	645	3,143	3,788	2,480	4,120	4,600	1,200	3,000	4,200	---	---	---	---	---	---	4,425	10,160	14,793
Other Recurring Costs	23	10	33	---	177	177	---	300	300	---	300	190	90	25	115	50	10	60	1,015	2,125	3,140
Alexandria	---	---	---	25	50	75	700	2,000	2,700	150	40	600	100	150	250	---	50	50	1,100	1,400	2,500
Innovative Activities	---	---	---	800	300	1,100	100	400	500	100	500	1,700	365	300	665	126	73	199	1,509	1,675	1,264
Contingency	---	---	---	---	---	---	500	200	700	---	---	---	---	---	---	---	---	---	---	---	---
TOTAL AID	167	560	927	3,076	3,976	7,052	7,532	7,345	14,877	5,008	5,147	10,155	1,930	870	2,800	909	525	1,434	10,010	10,423	37,253
GOE INPUTS																					
Technical Assistance	---	239	239	---	203	203	---	488	488	---	516	516	---	563	563	---	614	614	---	2,701	2,701
Other Recurring Costs	---	1,151	1,151	---	942	942	---	1,416	1,416	---	1,621	1,621	---	1,761	1,761	---	1,910	1,910	---	8,009	8,009
Land	---	---	---	---	8,022	8,022	---	---	---	---	---	---	---	---	---	---	---	---	---	8,022	8,022
Equip. & Facilities	---	---	---	---	4,211	4,211	---	---	---	---	---	437	---	480	480	---	523	523	---	5,340	5,340
Alexandria	---	---	---	---	3,503	3,503	---	397	397	---	437	12,857	---	12,857	12,857	---	12,857	12,857	---	51,428	51,428
Innovative Activities	---	---	---	---	---	---	---	12,857	12,857	---	12,857	12,857	---	---	---	---	---	---	---	---	---
TOTAL GOE	---	1,390	1,309	---	16,961	16,961	---	15,158	15,158	---	15,431	15,431	---	15,661	15,661	---	15,912	15,912	---	80,513	80,513
TOTAL PROJECT	167	1,950	2,317	3,076	20,937	24,013	7,532	22,503	30,035	5,008	20,578	25,586	1,930	16,531	18,469	909	16,437	17,346	10,830	98,936	117,766

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Recommendation to Purchase Egyptian Pounds with U.S. Dollars

The original project authorization provided \$12,650,000 to be used to support local currency expenditures that the Egyptian Government will make for specific items in support of the project. This amendment adds \$5,773,000 for pound costs associated with the amendment. These funds will be issued in association with GOE disbursements of Egyptian pounds for the costs of the travel, per diem, and shipment of household effects of project consultants; related project support costs, such as the travel of Egyptian participants, rental of office space and procurement of secretarial and interpreting services; the cost of the Ministry of Health temporary supplementary staff; local costs to Cairo Governorate for an innovative integrated health service delivery system, special costs associated with training, facilities renovation and related miscellaneous costs. The Mission will purchase Egyptian pounds with U.S. dollars provided by the Project. The Egyptian pounds will in turn be made available to the various appropriate Egyptian entity(s) responsible for project implementation for disbursement in accordance with the agreements reached between USAID and the GOE in the Project Agreement.

All U.S.-owned Egyptian pounds available to the Mission have already been programmed and are not available for this project. Given this, and the fact that the Urban Health Delivery System project is consistent with the Congressional Mandate of the Foreign Assistance Act to undertake activities designed to improve the economic position and quality of life of the poor majority, we have concluded that Project costs should be dollar funded.



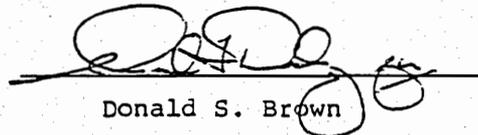
Donald S. Brown

Date: 6/25/81

CERTIFICATION PURSUANT TO SECTION
611 (e) of FAA 1961 as AMENDED

I, Donald S. Brown, Director, the principal officer of the Agency for International Development in Egypt, having taken into account, among other things, the maintenance and utilization of projects in Egypt previously financed or assisted by the United States, do hereby certify that in my judgment, Egypt has both the financial capability and the human resources to effectively install, maintain and utilize the capital assistance to be provided for renovation of and minor additions to 11 Maternal Child Health Clinics.

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


Donald S. Brown

INNOVATIVE ACTIVITIES

Innovative approaches in the delivery and financing of health care being developed in the private and semi-private sectors offer attractive alternatives to the delivery of services to urban populations, hopefully even to rural populations eventually. Of particular interest has been the success of the Health Insurance Organization (HIO) established in 1964 in Alexandria and now providing services in nine urban areas. The HIO is based on a prepayment model similar to that supported by the U.S. Health Maintenance Act of 1968. Two million Egyptian workers, in both the private and governmental sectors, receive health care services through a prepayment plan contributed to by the employee and the employer. (See attached memos by Dr. Carl Stevens for an in-depth discussion.)

The Government of Egypt has stated that it plans to concentrate on health insurance for the expansion of medical services in the future and has charged the HIO with a rapid expansion of its beneficiaries, geographically and category-wise. Currently, the HIO beneficiaries are only the workers themselves. The HIO has been instructed to enlarge the beneficiary base to include dependents, to provide MCH and clinical services to the total family. As a serious option, the Government is considering the expansion of insurance coverage to agricultural workers and a distinct possibility is subsidized health insurance coverage to the indigent, diverting the remaining health infrastructure not subsumed by HIO chiefly to the delivery of essential preventive health services. The expense of operating the current well-developed but costly and underutilized system will be greatly diminished. At the present time, only 11% of the population utilize the MOH system. Eighty percent purchase their health care by out-of-pocket expenditures, a process that is costly and highly variable in quality, particularly for the poor.

ANNEX 5

HIO requires minimal, but essential, assistance if it is to achieve its planned expansion. An improved health and management information system is essential for adequate planning and implementation of expanded services. Reliable data, based on a pilot expansion program of thirty thousand beneficiary families, must be obtained rapidly before a quixotic expansion is made, based on little or no valid experience. Expansion to cover a total of 1.5 million new beneficiaries over the next two years has been announced by the Government.

USAID will consider funding the expansion of the HIO information system with \$1.5 million for the computer hardware and software required and the limited short-term technical assistance required for the complex expansion envisioned.

Memorandum to: M.M. Shutt
HP/USAID/Cairo

Copy to: HIO/Heliopolis

From: C. M. Stevens
IPA NE/TECH/HPN/AID/W

Subject: THE HEALTH INSURANCE ORGANIZATION IN EGYPT (HIO)

Note: This memorandum will describe (and provide a few comments on) the organization and operation of the HIO. It is based upon my discussions with HIO officials and others here and some visits to HIO installations. This should be regarded as a preliminary account, there are some gaps in the information (these will be identified) and there may be some errors in my reporting (although I believe this to be an accurate account as far as it goes). I do have in my possession a good bit of data as yet untranslated from the Arabic.

General Organization

The HIO began operations in Alexandria in 1964, and the great majority of its approximately 1,400,000 beneficiaries (as of 1979) are still enrolled there. (See Chart I which exhibits the HIO GP case load by HIO branch).

The HIO now has six branches throughout Egypt: Alexandria and the north and west Delta, Canal Zone and the east Delta, Tanta and the center Delta, Cairo, Giza and upper Egypt and Assiut and upper Egypt. It now appears to be firmly established GOE policy that health-insurance coverage shall be extended to the population as a whole, including those who work and reside in rural areas.

It also appears generally to be assumed that the HIO is to provide the organization aegis for this extension. Thus, the current policy implies a very large expansion of the Organization.

The HIO provides a comprehensive range of inpatient and outpatient services. It is organized on the Health Maintenance Organization format in the sense that

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the financing of demand for health services is integrated organizationally with the delivery system to provide the insured services. Most of the services to beneficiaries are provided under the Direct Program in which the HIO owns its own facilities (by virtue either of construction or purchase).

Some services, however, are provided under the Indirect Program in which the HIO contracts with the Ministry of Health (MOH) system or with the private sector for the use of parts or all of other facilities, e.g., hospital beds. A disadvantage of the Indirect Program contract arrangements is that the HIO doesn't have the same kind of management/administrative control that it enjoys in its own facilities and hence experiences greater difficulties in maintaining standards. In addition to hospitals, the HIO operates various clinics and polyclinics. Some of these are located in plants where the number of employees enrolled as beneficiaries is sufficient to justify this.

The HIO operates clinic and hospital pharmacies which supply about half of the drugs and medications utilized by the beneficiaries. The other half is supplied under contract arrangement with private pharmacies. To obtain medications from this source, the beneficiary takes his prescription to the pharmacy to have it filled (retaining one copy of the prescription which is signed by the pharmacist and leaving one copy with the pharmacist). At the end of each month, the HIO reimburses the private pharmacies for the prescriptions each has filled. Drug prices in Egypt are effectively controlled by the government.

Each beneficiary receives a Health Insurance pass book which contains his beneficiary code number and his picture. To be eligible for services, the beneficiary must present this pass book. At each contact with the HIO, diagnostic and treatment information is entered into the pass book which thus contains a continuing medical history for each beneficiary. (I have not checked

a sample of these pass books to determine how detailed and complete these medical histories are). Most of the beneficiaries are acquired by group enrollment of employees. If a beneficiary leaves his job and hence is no longer a member of the enrolled group, he is supposed to turn in his pass book. Periodic checks are made to determine eligibility. The attempt by hand-recording methods to manage the beneficiary roster has, given the large number of enrollees, entailed a formidable mountain of paper work. In Alexandria, the HIO is now well along in computerizing this phase of its operations. Further steps in an overall computerization program for the HIO will follow.

The beneficiary's initial contact must be with a General Practitioner (GP) and access to hospital services or specialist services is only upon referral from the GP. Each GP is responsible for about 2,000 beneficiaries, and each beneficiary must use the services in his own service area.

Beneficiaries and Financing

The HIO enrolls several classes of beneficiaries under different financing arrangements.

As of 1979, 780,000 beneficiaries were enrolled under Law 79 (enacted 1964, amended 1975). These are employees in private sector or public sector firms or plants. Financing is from contributions set as a percent of wages, 3 percent paid by the employer and 1 percent by the employee. Under Law 79, employers of 500 or more workers were obligated either to enroll them under the HIO program or to provide an alternative plan for health care for their employees. Generally speaking, providing an option of this kind would seem to be a desirable feature of the insurance law. With this arrangement, the law mandates that all employees have health-plan coverage while at the same time permitting a pluralistic development of the health-services sector.

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In practice, however, there appear to have been problems. I have been told that the alternative plans provided by many employers fall far short of the standards set by the HIO, in terms both of quantity and quality of services. One answer to this kind of problem would be regulation of the alternative plans to insure that they meet adequate standards before they qualify for exemption from the HIO program. I am told, however, that this strategy may not be feasible. Most employer alternative plans do not require a direct contribution by the employees, a feature which has tended to discourage enrollment under the HIO program. The original 500-employee cut-off for mandatory coverage (HIO or alternative) has been lowered such that now, in Alexandria, employers of one or more employees come under mandatory coverage. (I do not know what the cut-off number of employees is in the other branches).

In 1979, 610,000 beneficiaries were enrolled under Law 32/1975. These are employees of the government, (government agencies and government service authorities). Here, the contributions have been set at 1.5 percent from the employer and 0.5 percent from the employee. Under this law (and unlike Law 79), there are copayments (out-of-pocket payments) by the beneficiaries, viz: 25 percent of the cost of drugs and appliances; 50 piasters for each day of hospitalization; 5 piasters for appointment with General Practitioner; 10 piasters for appointment with Specialist.

The great majority of the beneficiaries are enrolled under the foregoing provisions. There are, however, some additional classes of beneficiaries. Pensioners voluntarily may join the HIO program by paying a fee set as 1 percent of their pension, and there are now about 21,000 such enrollees. This category of beneficiaries entails some major problems for HIO. On average, the HIO realizes a revenue of only about LE 3.65 per pensioner per year. The cost of services provided, however, averages about LE 35 per pensioner

per year. Particularly as the number of pensioners participating in the program increases over the years, a difference between per-beneficiary revenue and cost of this magnitude could well imperil the solvency of the whole HIO program, unless some additional source of funding is found.

Egypt has a general workmens' compensation program for employees who are the victims of labor-related injuries (trauma and occupational disease), financed by an employer contribution of 3 percent of wages. Of this, the HIO gets a payment equal to 1 percent of wages to afford medical services to this category of beneficiary. There appears currently to be about 5,000,000 such beneficiaries. (I have no information about the utilization rate and cost per beneficiary under this program.)

In addition, the HIO is supposed to provide periodic medical exams for workers exposed to occupational disease, the intervals being every six months, one year or two years, depending upon the industry. (I have no information about the case load, utilization rates, costs etc. entailed by this program.)

As matters have stood, the HIO program has not afforded insurance coverage for the dependents of the worker beneficiaries. In Alexandria, a pilot project is underway to provide coverage for the dependents (wife and up to three children, as I understand it) of 30,000 worker beneficiaries. The HIO has contracted with the High Institute of Public Health to do a feasibility study to inform the design of this project. The initial plan is to finance coverage for the dependents under a Law 32-type program, i.e., with copayments. It appears that the pilot project is being launched in response to a request by the worker for such coverage, owing to the very high and increasingly higher cost of obtaining services in the private sector. Under the current policy of extending insurance to the population as a whole, dependents of worker beneficiaries are to be covered.

The Delivery System: Resources and Personnel Policies

In 1979, the HIO had 3,017 hospital beds, or about 2.2 beds per 1,000 beneficiaries under Law 79, Law 32 and the pensioners. In addition, the victims of industrial accidents would be generating some case load for these beds. The HIO has established specialized centers for the treatment of diabetes and its complications, heart and chest surgery, intensive care units, artificial kidney and dialysis, psychiatric diseases, plastic surgery, neuro surgery, optical and dental care. (I do not have information about the number or case-load capacity of such centers.)

With respect to health manpower, as has been mentioned, each GP is expected to handle about 2,000 beneficiaries. Additional manpower service standards provide a resident medical officer for every hospital department or for every unit of 40 beds, whichever is smaller; a nutrition specialist per 100 beds and assistant per 50 beds; a nurse/bed ratio not inferior to 1:4; a laboratory technician and an X-ray technician per every 50 beds; a social worker and public relations person for each 100 beds. (I do not have information about the number of physicians, nurses and other health-care personnel actually on the staff. This information should be obtained, by specialist category, etc., and in terms of full-time-equivalents (FTE) as well as head count.)

The HIO enjoys much greater flexibility with respect to personnel management and recruitment than does the MOH system. The basic salaries are set by the regular civil-service standards. However, the law allows an organization such as the HIO, with its own sources of funding, to supplement these salaries up to 100 percent. For the relatively few part-time physicians

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(they have their own private practices), HIO pays a salary supplement of 30 percent. Most of the physicians are full-time (no private practice), they get a salary supplement of 50 percent. Higher level administration and management people get a 70 percent supplement. All of the foregoing also get an annual bonus of one-month's salary. In addition to employing the services of salaried physicians, the HIO contracts with Specialists to provide services on a per-session (2-3 hours) basis, at a rate of LE 2-4 per session (depending upon specialty and case load). In addition to "outside" physicians, those who are on salary may also contract for sessions after their regular work hours and, as I understand it, many of these physicians contract for six such sessions per week. Unlike salary rates, there is no legal limit upon what the HIO may pay under these contracting arrangements. However, limits are of course imposed by the HIO's budget constraints. Also, there seems to be a policy that rates for contract services should not be "extreme" as judged by other remuneration standards.

The HIO is not free to recruit as many salaried physicians as it wants. It can recruit only to fill sanctioned "posts," and the number of such posts is controlled by the MOH. The HIO complains of something of a shortfall in salaried physician manpower. A remedy for the position would be for the MOH to allocate a larger number of the newly graduated physicians each year (they are obligated to a period of service in the government health services) to the HIO. The allocation of a physician also allocates a sanctioned post which remains after the physician leaves at the end of his required period of duty and which can subsequently be filled by the HIO. However, relatively few of the graduating physicians, I am told, express a preference for HIO.

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service. It is true that working for the HIO means extra remuneration (as contrasted with the MOH system) from the bonus and salary supplements. However, the extra pay is for extra work, the physician is expected to be full time and not engage in private practice. Thus, it appears that the extra remuneration paid by the HIO still does not meet the "supply price" for full-time physicians, i.e., working elsewhere with the opportunity for private practice is more attractive, at least for many of the new graduates. (As I understand it, whatever the preferences for service of the graduating physicians, the MOH has the authority to allocate them wherever it thinks will best serve the national interest.)

Because of the way in which medical records are kept, the HIO knows precisely what the output of each of its physicians is and is in a position to monitor physician performance. If the HIO is dissatisfied with the performance of its physicians on contract, it can terminate them on one month's notice. The HIO cannot terminate its physicians on salary, although, even in this case, it does control certain sanctions, e.g., it can transfer them to less desirable posts within the HIO system.

The Delivery System: Performance and the Question of Efficiency

I cannot, so far, say very much in this domain. I can report that the HIO installations I visited struck me as orderly, well functioning facilities. In particular, the HIO Gamul Abdul Naser Hospital in Alexandria struck me as a remarkably fine hospital in every way, e.g., range and quality of services, a sense of discipline and dedication in the staff, the excellent maintenance of the physical plant, and a model system for medical records.

Dr. A. El Nakeeb, Director General of this hospital with whom I talked, appears to be an uncommonly effective hospital administrator with the courage vigorously to implement those incentives and sanctions necessary to secure efficient performance.

I do have some utilization data, see Charts I and II and Tables I and II following. One may draw a few inferences from these data. For example, Table II exhibits, among other information, the number of visits to GP's, which in 1979 were 5,405,000. If one includes in the denominator Law 79, Law 32 and pensioner beneficiaries, this implies an average utilization rate of about 3.9 visits per beneficiary per year. This is a somewhat high estimate, since, to be commensurate with the denominator, one should subtract from the numerator those visits owing to the industrial accident case load. I do not know what this number is. Nevertheless, this figure does suggest a substantial utilization rate by beneficiaries who actively are utilizing the delivery system. On this same basis, the utilization rate for specialists services was about 1.3 visits per beneficiary per year. Since I do not know what the number of FTE physicians is, I do not know what these aggregate utilization rates imply about physician productivity (i.e., visit output per physician per year). One may infer something from the service standards, however. Each GP is supposed to be responsible for about 2,000 beneficiaries. At a visit rate of 3.9 per beneficiary per year, this would mean taking care of about 7,800 visits per year, or about 21 visits per day (assuming that the clinic, although not each GP, provides services 365 days per year). As I understand it, the HIO does compile data which provide direct measurements of physician productivity, utilization rates by kind of service and by class

of beneficiary, and the like. Rather than attempting to draw inferences from the data I have in hand, it will be better to wait for additional information.

I may note with respect to inpatient hospital services that I have been told that, although some hospitals operate with higher occupancy rates than others, the average occupancy rate for the system as a whole is about .70 -- a rate which would seem to suggest some excess capacity in the hospitals. Nevertheless, I also have the impression that the HIO feels that it has something of a bed shortage. I am not sure what these findings mean, perhaps there are structural problems in the match between facilities and beneficiary load in each service area such that some service areas do experience something of a shortage of beds whereas others experience some excess capacity.

Finally, I may draw your attention to Table I which shows average cost for beneficiaries under Law 79 and Law 32. As the table stands, it implies a much lower utilization rate under Law 32 than under Law 79. I have been told that this is misleading, however, because the costs therein reported for Law 32 beneficiaries do not include those costs defrayed by the beneficiaries copayments. I expect soon to have data which will show the actual utilization rates by these two classes of beneficiaries. These data are potentially of considerable interest because they may (along with some additional investigation) help to throw some light on the impact of copayments on utilization in this kind of system -- a finding which would be of considerable importance in thinking about the design of the financing package to extend health insurance to the population as a whole.

One thing which does stand out clearly in Table I is the importance of outpatient drugs in total costs -- namely, more than 50 percent for both classes of beneficiaries. Indeed, HIO officials characterize drugs as their "nightmare," in so far as the cost of the system is concerned. They ascribe what they regard as overutilization of drugs to several factors, viz: Beneficiaries may come for drugs which they intend not for use by themselves but for use by their families (who are not covered under the insurance program). It is felt that there is a rather high psychosomatic case load which may be expected to diminish with general economic improvements. Given heavy case loads and not as much time as could be desired, it is hard for physicians properly to screen their patients to determine which of them really are in need of certain drugs. There also appear to be some "drug sellers" among the beneficiaries, but this is apparently not regarded as a serious problem. If we assume that the drug cost of LE 3.6 shown for the Law 32 beneficiaries is the HIO's cost net of the 25 percent copayment for drugs, then these beneficiaries had an average drug cost of about LE 4.8 which is strikingly less than the LE 7.6 average for the Law 79 beneficiaries. This difference is, presumably, in good part owing to the impact of the 25 percent copayment. Of course, each of the copayments for each of the kinds of service may have an impact upon utilization rates for services in addition to those to which it is assigned. Thus, even allowing for the fact that the table does not report those costs for Law 32 beneficiaries defrayed by their copayments, the Law 32 beneficiaries appear to exhibit a significantly lower GP visit rate than do the Law 79 beneficiaries. This may be owing less to the modest (5 piasters) copayment for a GP visit than it is to the 25 percent copayment for drugs, i.e., patients who visit

their GP's mainly with the hope of getting prescriptions for drugs may reduce their visit rates when, owing to the copayment for drugs, they are not prepared to get such prescriptions filled at the same rates they would were there no copayment. The utilization rate difference for Law 79 and Law 32 beneficiaries warrants further investigation, e.g., what it really is, what precisely it is owing to, and so on. Nevertheless, prima facie, at least, it would appear that even relatively modest copayments may have considerable implications for the performance of a system such as that represented by the HIO.

CHART I

Source: Health Insurance Organization

FACTORY WORKERS 
GOVERNMENT EMPLOYEES 

PATIENTS
in Thousands

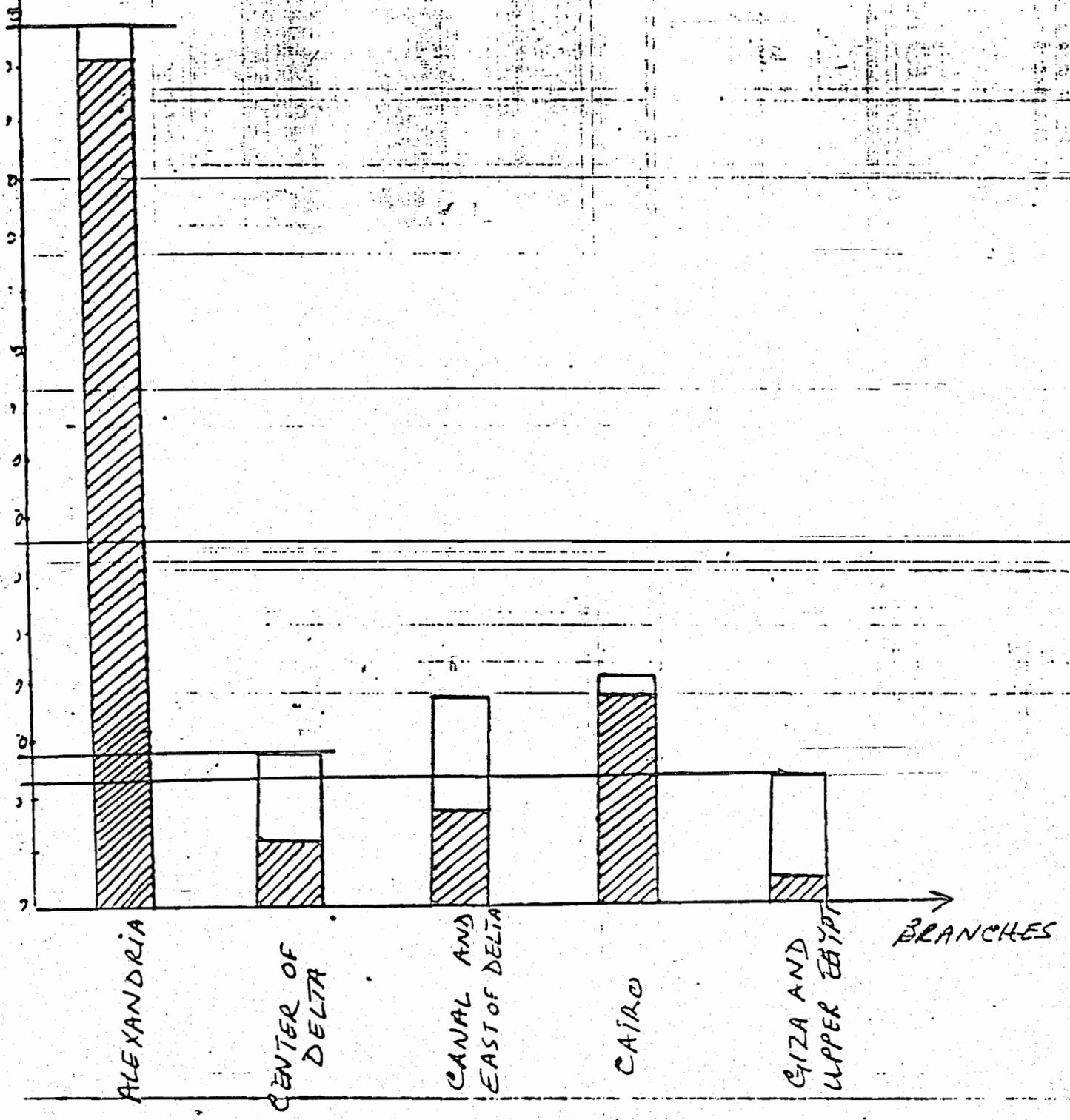


CHART II

Source: Health Insurance Organization

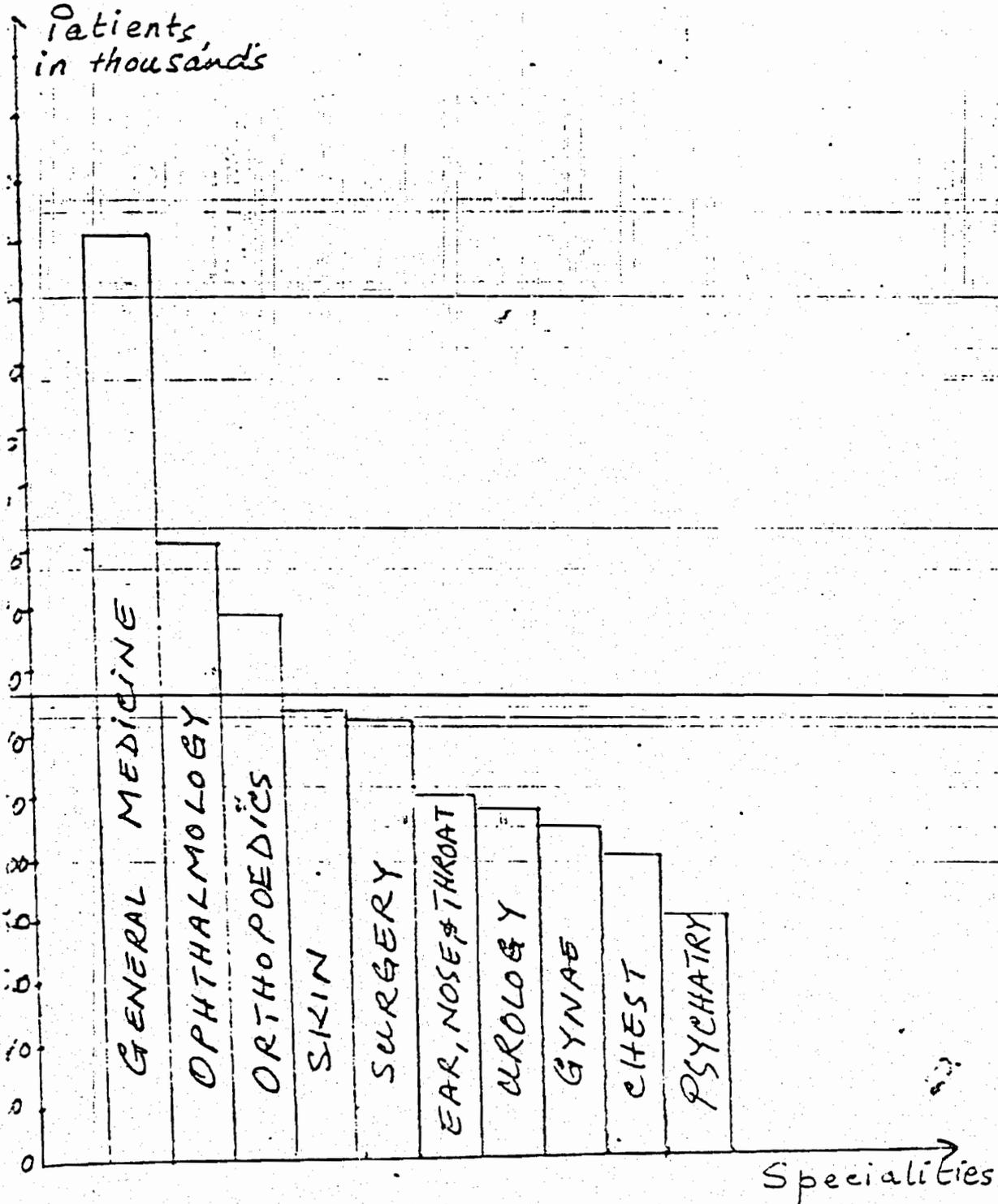


TABLE I

Source: Health Insurance Organization
Mean Coasts for One Beneficiary

in 1978

Items	Beneficiaries Under Law 79 in E.L.	Beneficiaries Under Law 32 in E.L.
1. <u>Outpatient Care</u>		
- General pract. Coast	0.733	0.297
- Specialists "	1.772	0.476
- Drugs	7.625	3.561
Total	10.130	4.334
2. Inpatient Care	3.521	0.359
3. Treatment Abroad	0.173	0.173
4. Applicancies & Acceseories	0.230	0.079
5. Adminstration	0.866	0.866
Mean Coast for one penific.	14.920	6.311

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TABLE II

Source: Health Insurance Organization

The medical services in 17 years

The year	Patients seen by G.P. (in thousands)	Patients seen by specialists (in thousands)	No. of Hospital beds	No. of Hospital (in thousands)	No. of Operations (in thousands)	Artificial Limbs (in thousands)	Optical glasses (in thousands)	Dentures (in thousands)
1966	1095	297	780	14	8	0.2	7.0	2.0
1967	1175	304	780	16	8	0.3	7.7	2.1
1968	1477	470	1142	24	13	1.0	17.7	3.7
1969	1816	575	1409	32	17	1.1	11.5	5.1
1970	1979	662	1377	33	21	1.8	11.4	6.1
1971	2293	873	1369	35	19	2.7	11.6	4.5
1972	2567	905	1553	39	20	2.9	11.3	4.3
1973	2534	844	1600	33	16	3.0	9.6	3.5
1974	2541	896	1564	38	21	3.7	11.9	4.1
1975	2784	1020	1574	42	24	4.9	10.4	3.4
1976	3012	1219	2831 [⊠]	45	26	5.2	14.3	3.8
1977	3597	1473	2934	54	31	3.2	13.6	4.4
1978	4199	1715	2988	63	36	4.9	13.9	3.4
1979	5405	1788	3017	74	43	5.4	14.5	5.1
	31069 36474	11253 13041	-	468 542	260 303	34.9 40.3	154.1 178.6	50.4 55.5

⊠ 20 Hospitals were added in Jan. 1976.

May 11, 1981

TO: Dr. William D. Oldham, HRDC/H

COPY TO: HIO/Heliopolis
MOH/Cairo

FROM: C. M. Stevens, IPA NE/TECH/HPN/AID/W

SUBJECT: Health Insurance in Egypt, Some Current Developments

Note: My 11/80 memorandum to M. M. Shutt provided a general description of the organization and operation of the Health Insurance Organization in Egypt (HIO). That memo noted some gaps in information, some of which are repaired by this memo. In the main, however, this memo is intended to trace developments since my report last fall.

Growth in Enrollment

The number of beneficiaries served by HIO is steadily increasing. Reported as about 1,400,000 last fall, the number of beneficiaries is now reported as about 2,000,000 with plans to reach about 2,500,000 by June of this year. And it is anticipated that during the following year, another 1.5 million beneficiaries will be added. The current rapid rate of growth appears to be responsive to the recently promulgated national policy that health insurance coverage shall be extended to virtually everybody in Egypt. This has prompted the HIO to aggressively market the product. It continues to be relatively difficult to sign up beneficiaries in Cairo. This is said to

be owing to several factors. One of these is an alleged negative attitude of many physicians who, observing the wide-scale coverage provided by HIO in Alexandria, fear that a similar development in Cairo would make inroads into the private-practice market. Also, it appears that many of the larger employers in Cairo have implemented their own health plans. Since these plans typically do not require any direct contribution by the employees, they appear to them more attractive than the HIO program which does require such a contribution.

I should note in this context that, contrary to the impression I had last fall, it appears that employer "contracting out" of the HIO program by the provision of alternative plans is not supposed to be a routine matter. Rather, requests to contract out are supposed to be considered on a case-by-case basis, with approval depending upon special factors, e.g., an employer who had a health plan in place before implementation of the HIO program. An employer contracting out of the HIO program still makes a contribution of 1 percent of wages to the Law 79 insurance fund, in the name of social solidarity. Since, were his employees enrolled in the HIO program under Law 79, the employer would make a contribution of 3 percent of wages, the implication is that contracting out will be financially attractive only if the employer can implement an alternative scheme at a cost to himself of less than 2 percent of wages. As I understand it, HIO's costs for the Law 79 beneficiaries are at least equal to the revenue they provide (3 percent of wages from the employer, 1 percent of wages from the employee). Consequently, it would appear that alternative employer health plans would have available to them financial resources per beneficiary of only on the order of half of those available under the HIO program.

per beneficiary (neglecting the possibility that the employer would be willing to pay more to implement his own plan than it would cost to join the HIO program).

Categories of Beneficiaries and Cross-Subsidization

The major categories of beneficiaries are those enrolled under Law 79 (industrial workers) and Law 32 (government employees). Contributions to the insurance fund for these employees are set as a percent of wages (a total of 4 percent under Law 79 and 1.5 percent under Law 32). According to the HIO, the revenues generated by these categories of beneficiaries are not keeping up with the expenses incurred on their account. This appears to be owing to an inflation situation such that money wages (of which the HIO gets a constant percent) are not keeping up with the prices the HIO must pay for its inputs.

The pensioners constitute another important category of beneficiaries. This category poses serious problems for the HIO. Pensioners may join the HIO program by paying a fee set at 1 percent of their pensions, yielding revenue on average of only about LE 3.65 per pensioner per year. The cost of the services provided, however, now runs at about LE 41 per pensioner per year. Reported as about 21,000 last fall, the number of pensioner beneficiaries is now reported as about 30,000. During the three-month period prior to their retirement, pensioners make the decision whether they will enroll in the HIO program. Under the regular procedures, pensioners who fail to enroll during this period cannot subsequently (i.e., after their retirement) enroll. An order will soon be issued, however providing a six-month period during which pensioners who neglected to enroll under the

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regular procedures may enroll (after that, the system will return to the regular procedures). This could result in a dramatic increase in the number of pensioner beneficiaries with ominous implications for the solvency of the HIO program, unless some additional sources of funding can be found. This is a problem which would seem to warrant immediate and serious attention.

Another category of beneficiaries is provided by Egypt's work accident and occupational health program. Industrial employers pay 3 percent of wages into this fund, 2 percent of this amount goes for disability payments and 1 percent goes to the HIO for medical care of the victims of work accidents. For government employees under this program, HIO gets 0.5 percent of wages. It appears that the HIO realizes substantial net revenues from participation in this program, in an amount just about sufficient to offset losses incurred with respect to other classes of beneficiaries.

Acquiring Additional Health Manpower and Facilities

To serve its expanding enrollment, the HIO must acquire additional health manpower services and additional facilities for services. The HIO acquires additional physicians services mainly by contract with physicians, i.e., rather than by adding salaried positions. The rate of compensation is LE 4 - 6 for each contracted two-hour session, the rate within this range depending upon the experience and the specialty of the physician. The physician is expected to see 15 patients per session and is compensated pro rata for any patients in excess of 15. So far, the HIO has been able to more or less satisfy its physician services requirements in this way. My impression

is, however, that it is not always easy to recruit physicians such that some GP's have patient loads in excess of the 1:1,500 beneficiaries standard and such that some specialists as well have excessive case loads. It is reported that heavy case loads tend to result in overloading of the referral system, i.e., unnecessary references from GP's to specialists and unnecessary references from specialists to inpatient hospital services. The physician supply may prove limitational over the longer run unless the HIO can obtain sufficient financing substantially to increase rates of physician compensation (the HIO is not limited by law with respect to rates of compensation for contracted services). Recently, in Alexandria, the HIO ran two advertisements indicating that they anticipated hiring additional physicians and describing the kinds of affiliation (but not the specific terms of affiliation) which were available (full-time salary, part-time salary, contract). Physicians were asked to indicate their potential interest in affiliation. Of some 2,000 physicians (registered with the Syndicate) in Alexandria, only 200 responded indicating potential interest. This result may be owing in part to a negative attitude on the part of many physicians to participating in the HIO type of delivery system. However, the general feeling is that more adequate compensation would overcome any such problems.

The acquisition of additional hospital capacity also confronts various problems. To accomplish this, the HIO has been contracting for beds in MOH hospitals, at a rate of about LE 200 per bed per year. While the use of additional beds can be obtained in this way, difficulties arise owing to the differences in service standards between those prevailing in the MOH hospitals and the higher standards the HIO tries to maintain in its own hospitals and for its patients in other hospitals. The HIO says that it attempts to upgrade service

standards in those MOH hospitals in which it has contracted for beds, an undertaking which is said to benefit not only HIO patients but others as well. At best, however, frictions arise in those situations in which the MOH and the HIO are attempting to share the same facilities. The HIO beneficiaries, who make contributions to the insurance fund, feel that they should enjoy a higher standard of service than that available to the regular clientele of the MOH system who make no payment. For services provided in MOH hospitals, however, this is not always easy to arrange.

Pursuant to national policy, over the long run the HIO will go on acquiring beneficiaries, eventually enrolling a substantial proportion of the population. This growth process will be accompanied by an ever increasing demand for utilization by the HIO facilities and manpower now employed in the MOH system (and perhaps in other systems). It also will be accompanied by a steady decrease in the clientele which must depend upon the MOH system for service. Regarding hospital capacity, the HIO standard is 2.0 beds per 1,000 beneficiaries. The total number of hospital beds in Egypt (of all kinds) is reported as about 80,000, i.e., about a 2:1,000 ration for the population as a whole. These beds are not, of course, so located as to be equally accessible by all numbers of the population and many of them are specialty beds. Nevertheless, in principle, at least, it ought to be feasible to provide hospital services for a large part of the increase in HIO beneficiaries by transferring the use of facilities from the MOH system (and perhaps other systems) to the HIO system. Working this kind of transfer out in practice, however, will involve numerous problems, e.g., relative to such matters as the relationship of the ownership of facilities to their control, etc. Beyond this, it will be necessary to finance the

capital expenditures required for upgrading of facilities as they are acquired and for such new construction as may be required. Now, and increasingly over the longer run, arranging the necessary financing for these purposes will pose serious problems for the HIO. My understanding is that, prior to 1979, capital expenditures could be financed by 6 percent loans from the government and also, I understand, from allocations to the HIO in the development budget. From 1979, these sources have been reduced (entirely eliminated?) such that the HIO must depend upon current revenue net of costs. But, the HIO now runs with close to zero net revenue and, indeed, foresees current account deficits in the near future. Thus, it would appear, a serious problem needing immediate attention is that of how the capital-financing requirements of the HIO are to be met.

Adding Dependents

It is now apparently mandated by law that the HIO must offer enrollment to the dependents of their principal beneficiaries. This development (as with the extension of coverage generally) will be phased in over time. An initial trial will soon begin in Alexandria with enrollment to be offered to the dependents of 30,000 beneficiaries there. The financing package has been set as follows: A 0.5 percent of wages contribution by regular beneficiary and by the employer for each dependent to be covered plus a schedule of copayments, viz: 35 percent of the cost of drugs, no limit; 50 percent of the actual cost of hospitalization, up to a limit of LE 5; 50 percent of the cost of X-ray, lab services, etc.; 15 PT per visit to the GP and 30 PT per visit to a specialist; LE 1.25 for home visits by the GP and LE 1.50 for home visits by a specialist.

The HIO contracted with Professor Mohamed El Amin of the High Institute of Public Health in Alexandria to conduct a feasibility study for the trial enrollment of beneficiaries. A demographic study was conducted to estimate the number of dependents who would be eligible for enrollment, concluding that there would be about 3.15 dependents per principal beneficiary (in some families, both husband and wife are principal beneficiaries). Estimates were then made of the facility capacities and health manpower that would be required to serve the dependents. Then a very detailed survey was made of the utilization (from 8:30 am to 8:30 pm) of HIO's existing (both owned and contracted) facilities and spaces. From this it appeared that, in terms of space, the dependent beneficiary load could be accommodated, but that additional equipment will be required. This will create a financing problem for the HIO.

The design of the beneficiary payment scheme was not a result of a market survey or other such study. It was, I gather, put together in a more or less ad hoc fashion, representing a compromise between different views about what would be an appropriate rate of copayments. In any event, it remains to be seen how attractive this package will prove to be to the prospective dependent beneficiaries. The payment scheme can subsequently be changed if experience under the trial program suggests that this would be in order.

The feasibility study has gone beyond the survey necessary just for the trial program. A survey has been made of all of the facilities (public and private) in Alexandria. The present condition of each facility has been catalogued and comparisons made with HIO facilities standards. In the longer run, the results of this survey will be required because if the HIO enrolled the dependents of all of its regular beneficiaries,

in Alexandria, it would enroll a substantial proportion of the entire population of the city. The results of this survey should be ready in a couple of months. As I understand it, the present plan is to publish the main body of the report in Arabic with a brief summary in English -- this owing to lack of resources for a complete translation. It would, of course, be of great interest to have an English translation of the entire study.

The Medical Information System

Several years ago, HIO's Alexandria branch (which has by far the largest enrollment) came to the conclusion that the increasing size of its operation required the installation of a computerized Medical Information System (MIS). A study to produce a design for the system was contracted to a local consulting firm, this work has been completed. The HIO feels that for the implementation of the MIS it will be best to contract with an outside firm. A pre-qualification questionnaire has gone out to prospective vendors. The hope is to get the implementation work on the MIS underway promptly. The system will be extended to all of the HIO branches as time and resources permit.

The HIO is now a very large organization serving millions of beneficiaries. Pursuant to national policy, it will experience very large-scale growth over the coming years. It is hard to exaggerate the importance of prompt implementation of the MIS for the efficient conduct of the business of the HIO. This is also a program development which will occasion serious financing problems for the HIO.

Flexibility in the Approach to Extending Coverage Under Health Insurance

The HIO is, of course, the organization which has had

the major operating experience and major responsibilities for health insurance in Egypt. And, as has been remarked foregoing, very substantial growth in HIO enrollments may be anticipated. The current thinking is, however, as I understand it, that the HIO will not necessarily be the only organization or agency administering health-services programs for insured beneficiaries pursuant to application of the health-insurance laws and the national policy to extend coverage. My impression is that thinking along these lines is now in the process of evolution without yet having reached the point of specific programmatic plans.

The Rural Areas

Although health insurance, financed by payments based on wages, is well established in urban areas, it does not now operate, for the most part, in rural areas where the majority of the population now lives and works. Extending health insurance to rural areas will entail developing new approaches, it will be the most difficult part of the job. So far, not much progress has been made in thinking about the design of the required new approaches. However, there is, I think, some agreement that it is important to begin now, with as much lead time as possible, some exploration of possible financing strategies to accomplish the extension of health insurance to rural areas. This will require feasibility studies of various kinds, some of which might appropriately be conducted by the HIO.

ARAB REPUBLIC OF EGYPT
MINISTRY OF HEALTH
MINISTER'S OFFICE

Mr. Donald S. Brown,
Director,
US AID
CAIRO.

Cairo, 22nd July, 1981.

Dear Mr. Brown,

Based on the current progress of the Urban Health Project (263 - 0065) and discussions with your staff, we hereby request AID assistance to increase funding for activities already envisioned in the original Project Paper and to add funding for expansion of project activities to Alexandria, for funding of computer hardware and software including limited technical assistance for the Health Insurance Organization and for innovative activities.

We estimate that the total costs of the amended project will now be approximately One Hundred and Eighteen Million Dollars (\$ 118,000,000.) and dollar equivalents in Egyptian Pounds. To achieve this level of funding, we request that AID provide approximately Twelve Million Dollars (\$ 12,000,000.) in addition to the Twenty-five Million Two Hundred and Fifty-three Thousand Dollars (\$ 25,253,000.) already provided under two previous obligations. This additional funding would be for technical services, renovation and minor additions to existing

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facilities, commodities, training, inflation, contingencies and other miscellaneous costs.

The Government of the Arab Republic of Egypt's total share of the project, in cost or in kind, would now approximate the equivalent of Eighty Million Dollars (\$ 80,000,000.). The Government of the Arab Republic of Egypt will pay the costs of all land, salaries and benefits of Ministry of Health personnel, clinical services under the Health Insurance Organization (through the use of member contributions), and operating expenses of the facilities which are part of the project. It will also provide any additional financial incentives to ministry of Health and other Government personnel which are required to assure project success.

We look forward to continued collaboration in improving the overall quality of health services in urban areas, particularly services to low-income segments of the population.

Yours, sincerely,

Prof. Dr. M. Gabr
State Minister for Health

H.A.

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June 22, 1981

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable generally to projects with FAA funds and project criteria applicable to individual funding sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Fund.

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

A. GENERAL CRITERIA FOR PROJECT

1. Continuing Resolution Unnumbered; Congressional notification is required.
FAA Sec. 634A; Sec. 653(b).

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

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

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3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? No further legislative action is required other than action ratifying the signed Grant Agreement Amendment.
4. FAA Sec 611(b); Continuing Resolution Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973? NA.
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 and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project? NA.
6. FAA Sec 209. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. No.
7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of This project does not directly affect any of the ones described in this.

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.

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

U.S. private enterprise will be a source of procurement of goods and technical services required for this project.

9. FAA Sec. 612(b), 636(h); Continuing Resolution Sec. 502. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

The Grant Agreement will so provide; also see 612(b) determination; no U.S. owned local currencies are available.

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

Yes. The funds have been fully committed for other purposes.

11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the

Yes.

awarding of contracts, except where applicable procurement rules allow otherwise?

12. Continuing Resolution Sec. 522. NA.
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?

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria NA.

- a. FAA Sec. 102(b), 111, 113, 231(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural

and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

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

The purpose of the Project is to make the existing health care delivery system more accessible and cost effective. The target group is composed of urban poor. Family planning is an important element in the health care provided.

- (1) [103] for agriculture, rural development; if so (a) extent to which activity is specifically designed to increase productivity and income of rural poor; 103A if for agriculture research; full account shall be taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made; (b) extent to which assistance is used in coordination with

programs carried out under Sec. 104 to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value, improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration of programs explicitly addressing the problem of malnutrition of poor and vulnerable people; and (c) extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

(2) [104] for population planning under sec. 104(b) or health under sec. 104(c); if so, (i) extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and

health posts, commercial distribution systems and other modes of community research.

(4) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development; and (ii) extent to which assistance provides advanced education and training of people in developing countries in such disciplines as are required for planning and implementation of public and private development activities.

(5) [106; ISDCA of 1980, Sec. 304] for energy, private voluntary organizations, and selected development activities; if so, extent to which activity is: (i) (a) concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test of suitable energy sources, and pilot projects to test new methods of energy production; (b) facilitative of geological and geophysical survey work to locate potential oil, natural gas, and coal reserves and to encourage exploration for

potential oil, natural gas, and coal reserves; and (c) a cooperative program in energy production and conservation through research and development and use of small scale, decentralized renewable energy sources for rural areas;

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

(iii) research into, and evaluation of, economic development process and techniques;

(iv) reconstruction after natural or manmade disaster;

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

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

c. [107] is appropriate effort place on use of appropriate technology? (relatively smaller, cost-saving, labor using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor.)

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has latter cost-sharing requirement been waived for a "relatively least developed" country)? The GOE has agreed to contribute 83.5% of the costs of the Project.

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? No.

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

g. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth? NA.

2. Development Assistance Project
Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, at a reasonable rate of interest.

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

3. Project Criteria Solely for
Economic Support Fund

a. FAA Sec. 531(a). Will this assistance promote economic or political stability? To the extent possible, does it reflect the policy directions of FAA Section 102?

b. FA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities?

Project will contribute to improved health and well being and thus productivity and will promote economic and political stability.

No.

5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

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

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Yes.
2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him? Yes.
3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will commodities be insured in the United States against marine risk with a company or companies authorized to do a marine insurance business in the U.S.? Yes.
4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be financed, is there provision NA.

against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

5. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates? No.
6. FAA sec. 621. If technical assistance is financed, to the fullest extent practicable will such assistance, goods and professional and other services be furnished from private enterprise on a contract basis? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes.
7. International Air Transport, Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will provision be made that U.S. carriers will be utilized to the extent such service is available? Yes.

8. Continuing Resolution Sec. 505. Yes.
If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

B. Construction

1. FAA Sec. 601(d). If capital Yes.
(e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interests?
2. FAA Sec. 611(c). If contracts Yes.
for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?
3. FAA Sec. 620(k). If for NA.
construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million?

C. Other Restrictions

1. FAA Sec. 122(b). If development NA.
loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?
2. FAA Sec. 301(d). If fund is NA.
established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? NA.
4. Continuing Resolution Sec. 514. If participants will be trained in the United States with funds obligated in FY 1981, has it been determined either (a) that such participants will be selected otherwise than by their home governments, or (b) that at least 20% of the FY 1981 fiscal year's funds appropriated for participant training will be participants selected otherwise than by their home government? No. Selection of participants is done jointly by AID, the U.S. contractor and the Government.
5. Will arrangements preclude use of financing:
- a. FAA Sec. 104(f). To pay for performance of abortions as a method of family planning or to, motivate or coerce persons to practice abortions; to pay for performance of involuntary sterilization as a method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization? Yes.
- b. FAA Sec. 620(g). To compensate owners for expropriated nationalized property? Yes.

- c. FAA Sec. 660. To provide training or advice or provide any financial support for the police, prisons, or other law enforcement forces, except for narcotics programs? Yes.
- d. FAA Sec. 662. For CIA activities? Yes.
- e. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained. Yes.
- f. Continuing Resolution Sec. 504. To pay pensions, annuities retirement pay, or adjusted service compensation for military personnel? Yes.
- g. Continuing Resolution Sec. 506. To pay U.S. assessments, arrearages or dues. Yes.
- h. Continuing Resolution Sec. 507. To carry out provisions of FAA section 209(d) (Transfer of FAA funds to multilateral organizations for lending.) Yes.
- i. Continuing Resolution Sec. 509. To finance the export of nuclear equipment fuel, or technology or to train foreign nationals in nuclear fields? Yes.
- j. Continuing Resolution Sec. 510. For the purpose of aiding the efforts of the government of No funds will be used for such purposes.

such country to repress the
legitimate rights of the
population of such country
contrary to the Universal
Declaration of Human Rights?

k. Continuing Resolution Sec. Yes.
516. For publicity or propaganda
purposes within U.S. not
authorized by Congress?