



## **Healthy Mother/Healthy Child Results Package**

*Improving Quality and Increasing Utilization of Maternal, Perinatal  
and Child Health Services in Egypt*

# **Annual Work Plan**

**Contract Year II**

**March 15, 1999 – March 14, 2000**



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**Arabic Software Engineering (ArabSoft)**

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**The Johns Hopkins University**

**The Manoff Group Inc.**

**TransCentury Associates**

**In collaboration with  
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**ACRONYMS**

ANC	Antenatal Care
ARI	Acute Respiratory Infection
AWP	Annual Work Plan
BASICS	Basic Assistance Supporting Institutionalization of Child Survival
CBC	Competency Based Curriculum
CBT	Competency Based Training
C-CDC	Central Curriculum Development Committee
CDC	Centers for Disease Control and Prevention
CDD	Control of Diarrheal Disease
CGC	Credit Guarantee Company
CHC	Community Health Committee
CME	Continuing Medical Education
CMEC	Continuing Medical Education Committee
COTR	Contracting Officer's Technical Representative
CSP	Child Survival Project
DANIDA	Danish International Development Agency
COP	Chief of Party
DCOP	Deputy Chief of Party
DDM	Data for Decision Making
DHSC	District Health Steering Committee
DT2	Development Training Two
DHT	District Health Team
DMT	District Management Team
EDHS	Egypt Demographic and Health Survey
ENMS	Egyptian National Medical Syndicate
ENPCP	Egyptian National Perinatal Care Program
EOC	Essential Obstetrical Care
EPI	Expanded Program of Immunization
EU	European Union
FETP	Field Epidemiology Training Program
FMT	Facility Management Team
GHSC	Governorate Health Steering Committee
GIS	Geographic Information System
GMT	Governorate Management Team
GOE	Government of Egypt
GTZ	German Development Agency
HIO	Health Insurance Organization
HM/HC	Healthy Mother/Healthy Child
HM/HC-RP	Healthy Mother/Healthy Child Results Package
HPSP	Health Policy Support Program
I-CDC	Institutional - Curriculum Development Committee
IEC	Information, Education and Communication
IL	Implementation Letter
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPC	Interpersonal Communication

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IR	Intermediate Results
IRM	Information Resources Management
IT	Information Technology
JHU	Johns Hopkins University
JSI	John Snow, Inc
KAP	Knowledge, Attitudes and Practices
LAG	Local Area Group
MCH	Maternal Child Health
MOHP	Ministry of Health and Population
MOI	Ministry of Information
MOSA	Ministry of Social Affairs
NCNW	National Council of Negro Women
NICHP	National Information Center for Health and Population
NICU	Neonatal Intensive Care Unit
NGO	Non Governmental Organization
NMMS	National Maternal Mortality Study
PES	Package of Essential Services
PHR	Partnership for Health Reform
PIL	Project Implementation Letter
PVO	Private Voluntary Organization
QA	Quality Assurance
QID	Quality Improvement Directorate
QPMR	Quarterly Performance Monitoring Report
RFP	Request for Proposal
RP	Results Package
SFD	Social Fund for Development
SIS	State Information Service
SMIP	Student Medical Insurance Program
SO	Strategic Objective
SPAAC	Social Planning Analysis and Administration Consultants
STTA	Short Term Technical Assistance
TA	Technical Assistance
TD	Tetanus Diphtheria
TOT	Training of Trainers
TT	Tetanus Toxoid
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

## INTRODUCTION

The Healthy Mother/Healthy Child Results Package (HM/HC-RP) is designed to meet USAID/Egypt's health sector Strategic Objective No Five (SO5) of *achieving sustainable improvements in the health of women and children* by improving the quality and increasing utilization of maternal, perinatal, and child health services. The specific focus of the HM/HC-RP is to reduce maternal and child mortality in high-risk districts of Upper Egypt by establishing an essential package of maternal and child health services in health facilities and promoting appropriate care in households. The HM/HC-RP interventions include a quality package of essential maternal and child health care services, service standards, health provider training, linkages to ongoing family planning services, community education and mobilization for health, and district level planning and monitoring systems.

The HM/HC activities are being implemented in large part through the Ministry of Health and Population (MOHP) at the central, governorate and district levels. John Snow, Inc (JSI), through its contract with USAID/Egypt, has primary responsibility for providing technical assistance on national level activities and implementation of program activities in 25 districts of five Upper Egypt governorates: Beni Suef, Fayoum, Aswan, Qena and Luxor. JSI's main counterpart within the MOHP is the Maternal and Child Health Department of the Basic and Preventive Health Care Division. In the governorates, JSI works with MOHP governorate and district management teams and community health committees. JSI is also responsible for coordinating activities of the other partners under the HM/HC-RP umbrella, including the State Information Service, UNICEF, Wellstart, and the Field Epidemiology Training Program.

Six major outcomes are to be achieved through JSI's input to the HM/HC-RP

- 1 All 25 HM/HC supported districts will become capable of planning, monitoring, budgeting, organizing, delivering and partially financing their own integrated quality maternal and child health services. Public and private health facilities in these districts will provide the essential HM/HC package and community health education programs.
- 2 Household members, particularly women, in the twenty-five HM/HC districts will have increased ability to provide and seek appropriate health care for themselves and their children through community mobilization.
- 3 The MOHP will have enhanced capacity nationally to set standards, policy, and management systems for cost-effective maternal and child health services. Its management and health information system will be consolidated so that all data essential for monitoring and management are collected, while reporting burdens on delivery units are minimized. Planning, budgeting, supervision, and support to districts at the governorate level will be strengthened.
- 4 Medical and nursing school graduates will have improved skills and knowledge for delivering the HM/HC package through the strengthening of curricula and training programs at all undergraduate health professional schools and the programs of national breastfeeding training centers.
- 5 National mass media campaigns will heighten popular awareness of avoidable health risk behaviors and increase demand for essential maternal and child health services.
- 6 Established national child survival programs shall be sustained. These include Expanded Program of Immunization (EPI), Acute Respiratory Infection (ARI), Control of Diarrheal Disease (CDD), neonatal care, and traditional birth attendant (daya) training.

These outcomes will contribute to achieving the following reductions in mortality by 2001, in the target districts

- ◆ Neonatal mortality reduced by 15%
- ◆ Infant mortality reduced by 20%
- ◆ Child mortality reduced by 15%
- ◆ Maternal mortality reduced by 40%

The USAID **Strategic Objectives Framework** is presented in Attachment A A **Contract Framework** which includes a summary of the goals, objectives and outcomes of the Healthy Mother/Healthy Child Results Package is provided in Attachment B

The JSI contract covers a 3 ½ year period, from March 15, 1998 to September 15, 2001 This Annual Work Plan (AWP) presents JSI's program of activities to be implemented in Year Two of the contract The AWP is divided into four Sections

- ◆ **Section I** provides background information on the maternal and child health situation in Egypt, with an emphasis on Upper Egypt,
- ◆ **Section II** describes the strategy and approach that JSI is taking to address the constraints to improving maternal and child health in Upper Egypt,
- ◆ **Section III** provides a brief summary annual report of the previous year's accomplishments, and,
- ◆ **Section IV** presents details of the specific tasks and activities to be implemented and their scheduling to meet contracting milestones and targets

## SECTION I

# Maternal and Child Health in Upper Egypt

Child survival and reproductive health programs, including maternal health, are among the most cost-effective investments in health. The Government of Egypt (GOE) is committed to improving the health status of women and children by increasing access to and improving the quality of primary health care services. In the last 10-15 years, mortality and morbidity have been substantially reduced among young children and women of childbearing age as a result of national programs supported by USAID and other donors in immunization, treatment of diarrheal disease and acute respiratory illness, and family planning.

Despite the progress, wide differences still exist in health conditions between rural and urban areas and Lower and Upper Egypt. Communities in rural Upper Egypt have the poorest health status of all regions, with maternal and child mortality levels two to three times higher than the national average. The under-five mortality rate is 126.1 in rural Upper Egypt, compared to 33.2 in urban governorates. Regional variations in access to and use of health care explain some of these differences. The pattern of maternal and child mortality and health care issues are examined in more detail below.

### Maternal Mortality

Maternal mortality accounts for a large proportion of the deaths occurring among women of childbearing age in most of the developing world. Each year, more than half a million women die from causes related to pregnancy and childbirth, with 99% of these deaths occurring in developing countries. The risk of death in pregnancy is exacerbated by high fertility, low literacy, poverty, short birth intervals, and lack of quality medical services. The 1992-93 National Maternal Mortality Study (NMMS) and other studies in Egypt show high mortality levels, with significant regional differences. The national maternal mortality ratio (MMR) was 174 maternal deaths per 100,000 live births, with 233 maternal deaths per 100,000 live births in metropolitan governorates, 217 in Upper Egypt, and 132 in Lower Egypt. Other studies documented MMRs as high as 323-471 deaths per 100,000 live births in three Upper Egypt governorates (Sohag, Assuit, Qena).

These studies indicate that the quality of health care in the public and private sector is not high enough to prevent avoidable maternal deaths. All of the three major causes of maternal mortality, hemorrhage, hypertensive disorders, and puerperal sepsis, are treatable. The NMMS determined that 92% of the deaths in 1992-93 were associated with one of three avoidable factors: delay in seeking care by the woman and her family was a factor in 42% of deaths, substandard delivery care in 47% of cases, and poor quality antenatal care in 47% of cases. The most critical time period was during delivery and the early postpartum period: 39% of deaths occurred during or within 24 hours after delivery, 35% occurred in the postpartum, and 25% of deaths occurred in early or late pregnancy before the woman delivered. Two-thirds of the women died in health facilities.

Fortunately, international experience indicates that maternal mortality is very sensitive to standards of obstetric care and is one of the health problems most directly influenced by the availability of modern medical care. The data suggest that reducing maternal mortality in Egypt, which has an extensive network of health facilities and an ample supply of medical personnel, should not require vast new finances, but rather targeted upgrading of obstetric care and re-organization of services to

best meet community needs. Increasing women's recognition of risk factors and use of appropriate care is also crucial.

### **Perinatal, Neonatal and Infant Mortality and Morbidity**

International research shows that 57% of all perinatal deaths are due primarily to inadequate maternal care during pregnancy and delivery, with the key factors being poor maternal health, inadequate care, poor hygiene and inappropriate management of delivery, as well as lack of newborn care. Many of these same risk factors exist for Egyptian women. Global research indicates that early identification of certain maternal conditions (e.g., hypertension and diabetes) can reduce perinatal deaths.

Almost 80% of deaths of Egyptian children under five occur before one year of age. Neonatal deaths account for approximately half of all infant deaths, nationally and in Upper Egypt. Post-neonatal mortality has declined significantly in recent years, but the rate of neonatal mortality has changed little. This trend corresponds to the global picture, as mortality in the perinatal and early infancy period is slower to respond to improvements in health care and socioeconomic status than mortality in later childhood. Previous programs were focused on the reduction of childhood (1-5 years) mortality.

Although infant mortality rates in Egypt have declined markedly over the last decade, levels still remain high, particularly in Upper Egypt (Table 1). The national infant mortality rate (IMR) is currently estimated at 52.7 deaths per 1000 live births (Egypt Demographic and Health Survey -- EDHS, 1997). In Upper Egypt the rate is 70% higher at 89.3 per 1000, and in rural areas the IMR is 97.5 per 1000 live births – almost one out of every ten infants dies before their first birthday.

<b>Region</b>	<b>Neonatal Mortality</b>	<b>Post-Neonatal</b>	<b>Infant Mortality</b>	<b>Childhood Mortality</b>	<b>Under-Five Mortality</b>
<b>Egypt</b>	32.4	29.7	62.1	17.4	78.4
<b>Urban</b>	22.3	20.0	42.3	7.7	49.6
<b>Rural</b>	39.0	36.2	75.2	24.2	97.5
<b>Upper Egypt</b>	40.5	45.6	86.1	28.3	111.9
<b>Urban</b>	26.8	36.4	63.8	12.0	75.0
<b>Rural</b>	45.6	49.0	94.6	34.7	126.1
<b>Lower Egypt</b>	30.3	22.5	52.9	12.7	64.9
<b>Urban</b>	23.8	19.5	43.4	8.3	51.3
<b>Rural</b>	32.4	23.5	55.9	14.3	69.4

National reports indicate that the main causes of infant deaths are respiratory tract infections, gastrointestinal disorders, and delivery complications. In the 1997 EDHS, 15% of children under age five reported to have diarrhea in the two week period before the survey, diarrhea was most prevalent among children aged 6-23 months. More than 40% of children were reported to have had a fever, and 32% had had a cough with short, rapid breathing in the two week period before the survey. The peak prevalence for both illnesses was among children 6-11 months old.

Mothers sought advice from a medical provider in 67% of cases when a child had symptoms of an acute respiratory infection and in 49% of cases with diarrhea (EDHS, 1997), with more than 40% of those with diarrhea treated with ORT.

The 1997 EDHS confirmed that full immunization coverage has greatly improved, climbing to over 83% at the national level. Only 2% of children had received no vaccinations of any kind. The proportions of children who received the BCG vaccination and three doses of DPT and polio vaccines exceed 90%. Upper Egypt is lagging somewhat behind, particularly in the rural areas, where one in four children were not fully immunized.

### **Primary Health Care Services**

Egypt's public sector health care system is hampered by inadequate funding, inefficient allocation and use of resources, and the lack of appropriate incentives to encourage productivity and quality care. With inpatient care consuming more than half the limited MOHP budget, too little is left to support wide coverage of the more cost-effective primary care services, including antenatal, maternal and child health services. Utilization of many facilities and services is low, particularly in the thousands of poorly equipped health clinics located in rural areas.

The public's perception, or experience, that public health services are of low quality leads many people to seek care from the private sector. Although private providers may be better equipped than public facilities, their technical competence and patient care practices are assumed to be similar to public providers, as private providers are often the same people that serve in MOHP clinics. One study estimated that in Upper Egypt, 63% of urban private physicians and 89% of rural private physicians also work in MOHP clinics. The lack of an effective accreditation system to regulate the quality of care provided in the private sector is a major concern. The poor, uneducated consumer is often unable to demand or choose quality, and because of lack of information and confidence, many people seek care from both public and private providers for the same condition or illness episode, switching back and forth to obtain the best results.

### **Antenatal and Postpartum Care**

Improving the quality and coverage of primary health care can reduce the risks of childbearing, as primary health care offers an opportunity to detect and treat problems in pregnancy, promote healthy practices using health education, and identify women at risk of complications. Women are usually advised to seek antenatal care early, and to have a minimum of four visits. Postpartum care is also advocated. The MOHP recommends three post-partum check-ups in the first week, one at two weeks and one at six weeks. Data collected under the MotherCare/Egypt project in Luxor and Aswan governorates showed that although there are sufficient numbers of MOHP facilities providing antenatal/postnatal care services, the services are available on a very limited basis usually one-two days a week for three to six hours a day with just one to two clients treated per day on average. The majority of the antenatal visits recorded appear to be primarily for tetanus toxoid immunizations only, or episodes of illness.

Use of antenatal care (ANC) is still low in Egypt. In 1997, national figures show that only 50% of pregnant women received ANC from a trained medical provider, 31% made the recommended four or more visits, and 16% had no medical contact during pregnancy. In Upper Egypt, 21% of rural women and 51% of urban women reported that they made ANC visits to a doctor, usually a private practitioner. Less than a quarter of the women in Upper Egypt used public sector ANC services (EDHS, 1995).

### **Obstetric and Neonatal Care**

All women with normal pregnancies and deliveries should receive the basic maternal care package, which includes antenatal care, clean and safe delivery, postpartum care, and care of the newborn. International studies indicate that having skilled attendants present at delivery is one of the key interventions for reducing maternal and perinatal mortality. To reduce the risk of adverse outcomes of normal deliveries, unnecessary interventions must be avoided and minimum standards of cleanliness and sterility must be ensured. The care can be provided at lower levels of the health care system or even at home.

The 1992-93 NMMS determined that substandard care by general practitioners and traditional birth attendants (dayas) contributed to 24% of deaths. In Egypt, the proportion of births assisted by a trained medical provider has increased gradually over time, from 35% in 1988 to 56% in 1997 (EDHS, 1997). In urban Upper Egypt, 66% of births in 1997 were attended by a trained medical provider, whereas only 32% were in rural areas. Only 15% of births in rural Upper Egypt took place in a medical facility, compared to 48% in urban areas of Upper Egypt.

Forty percent or more of pregnant women may experience acute obstetric problems during pregnancy, childbirth and the postpartum period, an estimated 15% of pregnant women develop life-threatening complications which cannot be predicted or prevented. Also, five to 15% of pregnancies will require C-section delivery. Quality health care during and immediately after the critical period of labor and delivery has been identified as the single most important intervention in preventing maternal and newborn mortality and morbidity.

In Egypt, many maternal deaths occur at the first referral level either because the women arrive too late, or because urgently needed essential obstetric care (EOC) is not available. The NMMS showed that 64% of maternal deaths occurred in health facilities (59% of those in hospitals), indicating that women do seek medical treatment in emergency situations. Other contributing factors to maternal deaths were lack of blood banks (6% of deaths), distance and lack of transportation (4% of deaths), and lack of drugs, supplies and equipment in health facilities (2% of deaths).

Under the MotherCare/Egypt project, observations carried out by Obstetrician-Gynecologist specialists on labor, delivery and neonatal care practices in general and at district hospitals in Luxor and Aswan governorates revealed the following problems:

- ◆ Health providers are unable to take adequate history
- ◆ Inadequate infection prevention procedures, even at specialist level
- ◆ Poor communication with patients
- ◆ Service protocols are not available
- ◆ No use of Partograph at any hospital
- ◆ Inappropriate use of syntocinon, abuse in some cases
- ◆ No recognition of risk factors during pregnancy
- ◆ Inadequate care given to women during labor

- ◆ Poor neonatal care including poor assessment and recording of neonatal conditions, especially umbilical stump care
- ◆ Early discharge of potentially infected cases with episiotomy
- ◆ No system for postnatal care
- ◆ Delay in transfer of patient from health center to hospital (obstructed labor, pre-eclampsia)
- ◆ Improper use of forceps
- ◆ No clear job descriptions or division of work among health provider team

MotherCare also collected MOHP facility data from Luxor and Aswan on the number of normal and complicated deliveries in 1996-1997, which were then compared to expected numbers of these events to get an estimate of "met need" provided by MOHP. These data show that MOHP central hospitals are currently only managing an estimated 15-20% of obstetric complications. The large number of lower level facilities in close proximity to communities -- Maternal Child Health (MCH) centers, rural units, rural hospitals, etc -- are providing little if any essential obstetric care. The MOHP's potential to provide basic maternity care, EOC and antenatal/postnatal services is clearly not being maximized.

### **Women's Knowledge and Practice**

Women's knowledge and recognition of danger signs and when to seek appropriate care is critical. Poor counseling skills and communication between providers and patients and a paucity of health education materials means that women are often unable to obtain the information they need. Low education levels compound the problem.

A community diagnosis study conducted by MotherCare/Egypt in 12 rural and six urban areas in Luxor and Aswan identified a number of perceived or actual barriers to care. In-depth interviews of women with young children, mothers-in-law and husbands revealed a lack of community knowledge about the nature and severity of danger signs of obstetric complications. This lack of knowledge is an important cause for delay in seeking care. Bleeding during pregnancy was a widely known danger sign, but blurred vision, dizziness and swelling of limbs were less widely known, and most respondents gave incorrect responses as to the causes of these signs. Community perceptions of poor quality of care at public facilities were a clear barrier to seeking care from these providers, even when they are located nearby. Distance and transport did not appear to be barriers in seeking care. Although cost was a barrier to choosing private physicians, they were generally preferred by women because they are better equipped (e.g. have ultrasound machines) and because women felt private physicians provide better care. Antenatal care from private providers and delivery at public facilities was a common pattern. Public hospitals are seen as uncaring, women are afraid of mistreatment, neglect, repeated pelvic exams by various doctors, and C-sections. Also, family and friends cannot be with them.

The belief that pregnancy is a normal condition for women, and that antenatal visits are only necessary if there is a problem, is another potential barrier, but the data suggested too that antenatal care with a trained medical provider is becoming more common. Also on the positive side was the evidence of strong community support, particularly in emergencies where blood and money are needed. The MotherCare study also showed that women spend considerable time sharing information on pregnancy, childbirth and care providers. Unfortunately, there are very few sources for women to get good information on pregnancy and newborn care. The majority of physicians give little explanation of the cause, implications and treatment of health problems, and most women don't ask about their conditions.

### Improvements in Access and Quality of Health Care

The MOHP, USAID and other international donors have in the last few years intensified their efforts to reduce maternal and infant mortality. The recently completed USAID-supported MotherCare/Egypt project was USAID's first health project to be implemented exclusively in Upper Egypt. The products and lessons learned from the two-year project were intended to and will be used by HM/HC-RP. These products include three packages of maternal and newborn care services defined for the various levels of MOHP facilities, standardized physician and nursing protocols and competency-based training modules for antenatal/postnatal care, normal pregnancy and delivery, and management of maternal and neonatal complications, and service standards for provision of essential obstetric and neonatal care.

The HM/HC-RP is also building upon and sustaining the achievements made in child health under the Child Survival Project, particularly in immunization coverage and management of diarrheal disease and acute respiratory illness. Having made great strides forward through vertically managed programs, the MOHP must now move in the direction of integration and decentralization to accelerate and sustain improvements in maternal and child health. To further this effort, HM/HCRP is working closely with the USAID-funded national projects in reproductive health and family planning and health policy reform.

### Mother/Child Life Phases

The phases of life that are of concern to the HM/HC Results Package have been carefully identified. Services are designed to deal with the health of mothers and children during the Life Phases listed below. These Phases are also presented graphically in Annex D.

#### ◆ Mother

- ◆ Pregnancy the gestational period of the fetus from conception to delivery
- ◆ Prenatal the gestational period from conception to delivery
- ◆ Perinatal the period from the 22<sup>nd</sup> week of pregnancy through the 7<sup>th</sup> day after delivery
- ◆ Postpartum the period from delivery through the 42<sup>nd</sup> day after delivery
- ◆ Inter-pregnancy the period from delivery until the next conception

#### ◆ Child

- ◆ Fetus the period of gestational development prior to birth
- ◆ Neonate the period from birth through the 28<sup>th</sup> day of life
- ◆ Infant the period from the 28<sup>th</sup> day through the first year (365<sup>th</sup> day) of life
- ◆ Child the period from the beginning of the first year through the end of the fourth year of life
- ◆ Adolescent the period from the beginning of the 11<sup>th</sup> year through the end of the 19<sup>th</sup> year of life

## SECTION II

# HM/HC Strategy—the Package of Essential Services

To reduce inequities in health status and access to health services in Upper Egypt, the overall strategy of the HM/HC Project is to work with the MOHP and target communities to establish a cost-effective package of public health and essential clinical services that will produce the largest health gain possible. The elements included in the HM/HC package of essential services (PES), are those proven to be the most cost-effective in addressing the most important health needs of Upper Egypt. This approach will improve health outcomes at modest cost while at the same time fostering an environment that enables households to improve their health.

The HM/HC package directly addresses a number of issues which have constrained the MOHP's ability to deliver MCH services in under-served areas of Egypt. These constraints include

- 1) traditional vertical organizational and staffing structures within the MOHP,
- 2) fragmented obstetrical/gynecology and pediatric services,
- 3) general underutilization of nurses and nurse-midwives,
- 4) weak public demand for some services,
- 5) weak referral between facility levels,
- 6) shortage of resources such as drugs and equipment, and
- 7) low priority given to preventive health services

The widespread adoption of the PES should have a significant positive impact on the health of mothers and children in Upper Egypt. The World Health Organization (WHO) estimates that providing quality essential obstetric and neonatal care can alone reduce maternal mortality by up to 40-50% and perinatal and neonatal mortality by 30-40%<sup>1</sup>. And, although it is difficult to quantify the health gains because of variations in the composition of service packages, the World Bank estimated that a similar minimum package of clinical services could reduce the disease burden by 25%, and a similar public health package by a further 8% (World Bank, 1993).

The currently defined HM/HC package of essential services is a combination of preventive and clinical care to be provided at the household/community level, rural health units, rural hospitals, and district hospitals. The package, defined partially by the MOHP, with input from MotherCare/Egypt project and from international research, will be implemented in the 25 target districts. The major areas of care in the package are shown in Table 2.

### The Pathway to Survival

The continuum of care represented in the HM/HC package of essential services is based upon a conceptual framework, "The Pathway to Survival," that follows the steps necessary to increase the likelihood of survival of a mother and her baby in the event of illness. The Pathway begins with recognition of the problem (Step 1) by the woman, her family and traditional birth attendants or health providers. If the woman is at home or a site where the problem cannot be managed, the decision to seek care (Step 2) must be made. A health-seeking decision is generally based on consideration of the perceived benefits versus the perceived barriers to action or inaction. Once a decision is made to seek care, barriers to reaching quality care must be overcome (Step 3). Cost,

<sup>1</sup> Mother Baby Package Implementing Safe Motherhood in Countries WHO 1994

transportation, availability of doctors, and the perceived poor quality of services and negative attitude of providers are often cited as barriers to access. Once services are reached, quality care must be available (Step 4). Here, the availability of essential drugs and equipment and the technical competence, efficiency and interpersonal communication skills of the provider are critical to increase mother/child survival, as are appropriate, timely care and correct diagnosis.

For maternal care, the primary focus of the PES is to improve the quality and timeliness of essential obstetric care for management of pregnancy and delivery-related complications. This will reduce the two major causes of excess maternal mortality: substandard obstetric care in facilities, which contributes to an estimated 47% of avoidable maternal deaths, and delay in seeking medical care by women/households, which contributes to 42% of deaths. Increased use of quality antenatal care can also contribute to improved pregnancy outcomes through health education and promotion of appropriate delivery care, especially for high-risk pregnancies.

<b>Reproductive Health Care</b>	<b>Maternal Health Care</b>	<b>Child Health Care</b>
<ul style="list-style-type: none"> <li>◆ Referral to/promotion of reproductive health and family planning services</li> <li>◆ Premarital exam and counseling</li> </ul>	<ul style="list-style-type: none"> <li>◆ Prenatal, delivery and postnatal care</li> <li>◆ Promotion of immediate and exclusive breast feeding</li> <li>◆ 40th day integrated visit for mother and infant</li> <li>◆ postpartum check-ups</li> </ul>	<ul style="list-style-type: none"> <li>◆ Peri/neonatal care</li> <li>◆ Children's preventive health services</li> <li>◆ Integrated management of childhood illness</li> </ul>
Nutrition Services Counseling and Health Education		

With respect to neonatal care, improving the quality and use of obstetric care will also reduce perinatal deaths, 57% of which are caused by poor medical care during pregnancy and delivery. Increasing coverage of tetanus toxoid immunizations will directly reduce the number of neonatal deaths from tetanus, a result of unclean delivery practices.

Increased family planning use will contribute to improved child survival rates by reducing the number of high risk births (i.e. mother too young or too old, high birth order, births too close together). The unmet need for family planning in Upper Egypt is almost 25% (EDHS, 1997). The health benefit of EPI immunizations is clear, and HM/HC efforts are to ensure the continuation of the MOHP immunization program.

The implementation strategy is to improve both the effectiveness and capability of "stakeholders" at each level in the continuum of care and to promote a close partnership between providers and communities at the district level. Each district will be supported/enabled to tailor a strategy to meet its own unique set of needs and challenges. The district strategy will be complemented and reinforced by key long-term national interventions to integrate the package of essential services and standards into medical and nursing schools and to further cost recovery and reform policies in support of cost-effective health care.

Table 3 shows how the Pathway to Survival steps are linked to HM/HC objectives and interventions.

**Table 3 Steps in the Pathway to Survival**

Problems	Pathway to Survival Steps	HM/HC Objectives	HM/HC Interventions (Task Number)
<b>Household &amp; Community</b>			
<b>Problems Mother</b> ♦ maternal mortality 217/100,000 ♦ 92% from avoidable causes ♦ 71% seek care ♦ 42% of deaths due to delay ♦ hemorrhage ♦ pre&/eclampsia ♦ genital sepsis  <b>Problems Neonate</b> ♦ mortality rate 40 5/1,000 ♦ 57% died ♦ asphyxia ♦ hypothermia ♦ sepsis/infection  <b>Problems Child (&lt;5's)</b> ♦ mortality rate 111 9/1,000 ♦ diarrhea ♦ ARI ♦ nutritional deficiencies ♦ immunizable diseases  <b>Problems Adolescent (11-19 years)</b> ♦ nutritional deficiencies (anemia) poor health knowledge	<b>Step 1 Recognition of Problem</b> ♦ Knowledge ♦ Awareness ♦ Effect/vulnerability	Increase knowledge and improve health behavior of households	♦ Establish community groups and train to assess needs (Task 7) ♦ Strategic design of health communications (Task 8) ♦ Strengthen school education, anemia control and tetanus immunization for girls (Task 9) ♦ IEC training for outreach workers (Task 8) ♦ Promotion & referral to family planning services (Task 1)
	<b>Step 2 Decision to Seek Care</b> ♦ Behavior (perception of benefit) ♦ Motivation to seek care ♦ Barriers	Increase knowledge and improve health behavior of Households	♦ Research health behaviors and motivation (Task 5) ♦ Sensitize health providers to community needs (Task 7) ♦ Organize community groups to provide social/community services to reduce barriers (Tasks 7, 10)
	<b>Step 3 Access to Care</b> ♦ Transportation ♦ Stabilization ♦ Referral ♦ Cost ♦ Availability	Strengthen district capability to provide essential maternal, perinatal and child health services	♦ Mobilize community resources for transport and other needs (Tasks 3, 7, 10) ♦ Establish facility referral system (Tasks 1, 3) ♦ Strengthen daya training and referral (Task 6) ♦ Train district supervisors and establish management and supervision systems (Task 3) ♦ Establish district health information system to provide service data for decision making and evaluation (Tasks 3, 4) ♦ Work with governorate to improve financial sustainability (Task 3) ♦ Test different provider community partnerships to improve access (Tasks 7, 10)
<b>Providers &amp; Facilities</b>			
<b>Problems Providers</b> ♦ substandard care  <b>Problems Facilities</b> ♦ limited services available in MOHP facilities ♦ lack of equipment, drugs, and supplies ♦ lack of management support systems to maintain quality and quantity of service ♦ low demand for services	<b>Step 4 Quality Care</b> ♦ Technical competence ♦ Effectiveness ♦ Efficacy ♦ Safety ♦ Interpersonal communication ♦ Continuity of care	Improve quality of essential maternal, perinatal and child health services  Sustain established child survival programs	♦ Select and upgrade anchor facilities (Tasks 1, 2, 3, 11) ♦ Establish service standards for PES (Tasks 1, 6) ♦ Monitor facility compliance to standards (Tasks 1, 3, 6) ♦ Assess efficacy and cost-effectiveness of PES (Tasks 1, 5) ♦ Provide competency-based training for district doctors, nurses, midwives (Tasks 1, 2) ♦ Train health providers in health education and counseling (Task 2) ♦ Adapt medical and nursing school curricula to include PES and standards (Task 2) ♦ Upgrade MOHP and faculty training skills and train Master Trainers (Task 1, 2) ♦ Develop national standards and improve supervision of PES (Task 1, 2, 3, 6) ♦ Train private providers and pharmacists in PES (Task 2) ♦ Conduct applied research to improve operations and service effectiveness (Task 5)

Defining and implementing the PES in the 25 target districts is the central task of the HM/HC-RP, with the other ten key tasks aimed at supporting this effort. A descriptive summary of these tasks is presented below. Details of each task and sub-activities are presented in the work plan in Section IV.

**Task One Basic Package of Essential Services Established and Standards Defined** Assess the cost-effectiveness and appropriateness of the elements in the PES, upgrade anchor facilities, provide competency-based training of service providers in PES, establish clinical protocols and service standards to ensure delivery of quality care, supervisors, and strengthen the management capability of the MOHP to sustain delivery of quality services.

**Task Two Training in Standards** Adapt medical and nursing school curricula to include the PES protocols, standards and competency-based curricula, provide in-service clinical training of private and MOHP physicians and other providers, in collaboration with the MOHP and professional syndicates, establish model clinical training sites, and create a cadre of Master Trainers in PES and management.

**Task Three Public and Private Provider Partnerships with Communities** Organize MOHP management teams and community advisory committees at the governorate, district and community levels, train teams in management and planning, and develop of district plans and monitoring/supervision systems.

**Task Four Monitoring System to Track Use and Impact and Provide Feedback** Establish district information centers, information system staff, and procure hardware/software, and design and install a district-wide management health information system to collect service statistics and provide data for supervisors and decision-makers, and for evaluation of program effectiveness and impact.

**Task Five Applied Research Activities** Identify behavioral, clinical and operations research topics to enhance HM/HC effectiveness, train personnel in research methods, and conduct studies, including a national maternal mortality survey, and disseminate findings.

**Task Six Sustain National Child Survival Programs** Assess current CSP program (ARI, EPI, CDD, neonatal care, day training program, model clinics), support governorate and district MOHP levels to improve planning, management, delivery and integration of CSP activities into HM/HC package at delivery points, test new or refined CSP interventions in target districts, upgrade and equip five neonatal units and train personnel.

**Task Seven Better Social Community Services** Assess and select community organizations to partner with health providers, form community health committees (also part of Task Three) and train in needs assessment, planning, problem solving and community mobilization, develop and test partnership schemes, and "sensitization" training of health providers.

**Task Eight Information, Education and Communication Campaign** Train district health educators and service providers in counseling and interpersonal communication skills, and develop IEC activities and materials for providers and clients/patients.

education of adolescent girls and delivery of iron supplements and tetanus immunization

**Task Ten Small Grant Program** Provide funding and technical assistance to small non-governmental organizations to carry out community activities in support of HM/HC activities in target districts

**Task Eleven Commodity Procurement Program** Procure the commodities identified by the other tasks to support the activities and expected accomplishments of those tasks

## SECTION III

### Summary Annual Report

In this Section of the Annual Work Plan, a brief summary of the accomplishments of the previous year are presented by Results Category. In addition, for each Results Category, there is a presentation of past constraints experienced in achieving intended results (i.e., the obstacles and problems faced during the year), and the corrective actions taken to overcome those constraints. To further summarize the achievements of the previous year, the lessons learned in the process are offered, which will guide activities during subsequent years of the Contract. Finally in this Section, fiscal data are presented in tabular form indicating expenditures by Result Category for the first Contract Year. Please note that at the time of finalizing this AWP for submission to USAID/Egypt (February 15, 1999), one month of the first Contract Year had not yet been completed (February 15 - March 14, 1999). Accordingly, some accomplishments have been included in this Section which may not have been fully realized by the time of submission, but which will likely be accomplished by March 14. A number of Performance Milestones were accomplished per the requirements of the Contract, Annex C contains a chart which summarizes the accomplishment of these Milestones.

#### **SUBRESULT 5.1.1 Quality of Essential Maternal, Perinatal and Child Health Services Improved Accomplishments**

- ◆ The Package of Essential Services to be delivered in the target districts has been defined and the major stakeholders have reached initial consensus on the composition of the package. The HM/HC Package of Essential Services addresses Upper Egypt's most important maternal/child health needs with the most cost-effective interventions. The composition of the package was finalized following a technical review of the efficacy and cost-effectiveness of interventions for reduction of maternal, neonatal and child mortality, and consensus meetings between the MOHP, USAID, WellStart and UNICEF.
- ◆ Standards for delivering basic and comprehensive obstetric and neonatal care have been finalized and baseline assessments made of anchor facilities in target districts. A total of six districts have selected anchor facilities which will serve as primary sites for implementing the HM/HC package of services and service standards (anchor facilities of three districts were previously chosen under MotherCare). Lists have been made of all the equipment, drugs, supplies, furniture and renovations needed to bring the facilities up to HM/HC standards.
- ◆ Existing MOHP standards for hospital-based neonatal centers, child survival services and reproductive health/family planning have been reviewed for integration into the umbrella HM/HC service standards.
- ◆ The comprehensive package of clinical protocols and competency-based training modules has been completed for upgrading physician and nurse skills in basic and comprehensive obstetric care, infection control and interpersonal communications. The protocols and training modules for Essential Obstetric Care (EOC) have been successfully used in training 18 Master EOC Trainers, 10 EOC physician trainer/supervisors, and 34 nurse supervisors.
- ◆ A clinical protocol for hospital-based neonatal units was introduced through the training of 50 MOHP Master Trainers and university professors from Upper Egypt and the national level.

- ◆ Improvements in the quality of maternal, perinatal and neonatal services are currently underway in hospitals and health facilities of Aswan and Luxor, where trained doctors, nurses and midwives are putting into practice their new skills after successfully graduating from HM/HC obstetric and maternal care training programs. Improvements are also being made in two neonatal units where Master Trainers are introducing the new neonatal unit protocol.
- ◆ Nationally, key steps were made towards ensuring good medical care for newborns throughout the country when the MOHP's Master Trainers for the national neonatal care program unanimously agreed to establish national clinical protocols for perinatal and neonatal care and to convert the current national curricula to a competency-based curricula.
- ◆ Quality obstetric care will also be available from private and MOHP physicians from around the country as they now have access to HM/HC's EOC competency-based training course through the National Medical Syndicate's in-service training program. Twenty-two MOHP and private physicians from Lower Egypt have so far been trained, and the Syndicate wants more courses.

#### **Past Constraints and Corrective Actions**

- ◆ Graduation from the essential obstetric care training program, which requires the management of a set number of complicated obstetric cases, takes longer for those physicians working in facilities with low caseloads of obstetric complications. Trainer/supervisors will now monitor this and temporarily transfer physicians to facilities with higher caseloads.
- ◆ Improving the quality of health services anywhere is a complex, time-consuming process, and the time period which HM/HC has to do this is short due to the delayed award of the contract. The work is continuing and will be completed in contract Year II.

#### **SUBRESULT 5 1 2 Districts Implementing Essential Maternal, Perinatal and Child Health Services in Target Governorates**

##### **Accomplishments**

- ◆ Governorate health executives and community leaders from Aswan and Luxor were oriented to the HM/HC objectives and plan of activities. The orientation program agenda and summary "Governorate Action Plan" developed for the presentation was refined and will be used to orient Phase II governorates.
- ◆ The management capacity of Aswan governorate MCH department and three district health offices in Aswan were assessed to identify what resources and activities (training, personnel and material, etc.) are needed to improve implementation and monitoring of HM/HC services. The information collected was used to develop related follow-on activities.
- ◆ An organizational structure for MOHP management teams at central, governorate and district levels was drafted for review by MOHP/HM-HC. The proposal outlines the membership of the management teams, responsibilities at each level and inter-relationships of the teams in planning and implementation of HM/HC activities.
- ◆ Formation of district management teams in all target districts has been initiated through official HM/HC Project channels.
- ◆ Governorate and District Management Teams have been trained in planning and implementation of HM/HC services. The *HM/HC Planning and Monitoring Guidelines* developed for district management teams were used to train five district management teams in how to develop their own annual plans, service targets and budgets. More than 100 governorate and district management team members were trained.
- ◆ Annual District Plans have been completed for five districts. The Annual Plan outlines the

activities to be carried out over the next 16 months to implement the HM/HC package of services, including service targets, training plans, establishment of management health information centers, and upgrading of anchor facilities

- ◆ Requirements were identified and procurement initiated for establishing District Health Information Centers in each of the target districts. Computer hardware specifications were developed, approved by USAID IRM and commodities ordered, office equipment, physical space renovations, and personnel training needs were identified and included in the annual plan
- ◆ Plans have been finalized for conducting the 1999-2000 National Maternal Mortality Survey. Technical and administrative preparations are underway for the London Institute of Hygiene and Tropical Medicine to conduct this important national survey

#### **Past Constraints and Corrective Actions**

- ◆ UNICEF has not yet committed resources required for establishing 35 district Health Information Centers in their three target governorates. Discussions continue with UNICEF and USAID to secure commitment of resources from the UNICEF grant

#### **SUBRESULT 5 1 3 Established National Child Survival Programs Sustained**

##### **Accomplishments**

District level planning, management and monitoring of an integrated package of child services has been initiated by the HM/HC-RP through the following accomplishments

- ◆ Target areas were identified and a joint work plan developed, with MOHP for HM/HC-RP assistance, in strengthening and integrating the existing child survival program at the district level. Joint workshops are scheduled with the MOHP to coordinate implementation of planned activities
- ◆ Improvements in neonatal care and better integration of neonatal and perinatal care are underway as a result of HM/HC-RP assessments of neonatal care units in Cairo, Luxor and Aswan, and senior staff agreement to recommended changes to training curriculum and facility organization. Fifty neonatal care specialists were trained in new clinical protocol and techniques. Data from 108 neonatal centers nationwide were also analyzed to identify strengths and weaknesses in performance. The assessments were conducted with staff from the MOHP Perinatal Care Program
- ◆ Recommended changes to improve the Daya Training Program have been reviewed with the MOHP and agreement reached to set up advisory and technical committees to coordinate implementation

#### **SUBRESULT 5 1 4 Increased Knowledge and Improved Health Behavior in Households**

##### **Accomplishments**

- ◆ One hundred "priority" community groups were selected from target districts of Aswan, Luxor and Beni Suef governorates as potential partners for health providers. Assessments of their capabilities and needs were completed. One hundred priority partners were selected as good potential partners, out of the total of 1,027 identified using a protocol developed for assessing community-based groups to partner with health providers. They include local councils, schools, youth and women's groups, religious groups, and non-governmental organizations offering a variety of services (Task Seven)
- ◆ The roles, responsibilities, membership and affiliation (private or public) have been proposed and submitted for health committees at the community, district and governorate levels. The health committees will work closely with MOHP management teams, health education officers, and outreach workers to plan, implement and manage community

activities to support the HM/HC package of services (Tasks Seven and Three)

- ◆ “Sensitization” workshops to improve health personnel understanding of local perceptions and attitudes of the community to local health services were held for a total of 58 managers and facility personnel in two districts in Aswan governorate. The workshop format and materials, including information from the national maternal mortality survey and results from MotherCare’s “community diagnosis” of beliefs and barriers to care in Upper Egypt, were well received and will be used in future workshops (Task Seven)
- ◆ Community promotion of HM/HC-upgraded obstetric and neonatal services in Biadiah district was initiated through a seminar for local leaders and community organization representatives. Participants agreed to “camel-back” promotion of the upgraded services onto their on-going activities. HM/HC-RP is now monitoring whether there is a change in service demand as a result of the promotion seminar (Task Seven)
- ◆ Formation of an IEC Working Group is underway to integrate/coordinate IEC activities among all agencies involved in supporting implementation of the HM/HC package (Task Eight)
- ◆ Inventory completed of existing IEC media materials and documents, e.g., research study reports, related to maternal and child health (Task Eight)
- ◆ Priority areas were identified for research in attitudes and health behavior of target groups (Task Eight)
- ◆ Agreement was reached with MOHP EPI Director on supplying tetanus vaccine and syringes for the school based SMIP immunization program for girls (Task Nine)
- ◆ Qualitative research underway on dietary habits of adolescent children. Results will be used to develop nutrition education materials for dissemination in schools (Task Nine)
- ◆ Agreement was reached on the type, dosage and frequency of administration of iron folate pill with the MOHP, the Student Medical Insurance Program and leading hematologists (Task Nine)
- ◆ The design and implementation schedule for operations research on iron supplementation has been approved and implementation has begun (Task Nine)

#### **Past Constraints and Corrective Actions**

- ◆ The original school-based program was to be implemented nationwide in less than 2 years. USAID informally agreed to reduce the geographic area to HM/HC-RP’s five target governorates and extend the time period for implementation to Sept. 2001, the end of Phase I
- ◆ Development and implementation of an effective national and district level IEC strategy to support the HM/HC program requires significant involvement and coordination with the MOHP. Mechanisms are being explored on how best to invest and coordinate available financial and technical resources

#### **SUPPORTING ACTIVITIES**

##### **Accomplishments**

- ◆ Life of Contract Procurement Plan is being finalized for USAID review and approval
- ◆ Specifications were approved and an invitation for bids issued for computers, computer-related equipment and audio-visual equipment for the JSI HM/HC Cairo office, five field offices and governorate and district level Health Information Centers. Offers were received by February 11, 1999
- ◆ Specifications and invitation for bids are being finalized for MOHP vehicles and spare parts, medical equipment, and training models
- ◆ Software for the MHIS has been procured

## SECTION IV

# Organization and Development of the AWP

This Section contains general information pertaining to the Results Package plan in its entirety. At the end of this Section there is a Gantt chart which shows the Task level summaries with Benchmarks, Performance Milestones and Performance Targets for the AWP period. The AWP includes a task-by-task detailed description of the annual plan for each of the eleven Tasks in the Results Package. These Tasks are organized according to the Results to which they contribute. Additionally, each Task is organized according to the Activities which are described in the Statement of Work in section "C" of the Contract. Each Task has a narrative which contains the following sections:

- ◆ **purpose** (the overall intended objective of the Task)
- ◆ **strategy** (the main approach to be employed in accomplishing the Task)
- ◆ **resources required** (an abbreviated, illustrative list of the resources required to accomplish the Task)
- ◆ **expected accomplishments** (a listing of the Performance Milestones, Performance Targets and Major Benchmarks that will be accomplished)
- ◆ **coordination** (a summary of significant inter-Task and inter-organizational coordination required to accomplish the Task)
- ◆ **constraints** (potential obstacles and problems which may impede the accomplishment of the Task, and suggested remedial actions to overcome the constraints)

Where appropriate, major accomplishments during the first contract year are highlighted, especially those accomplishments which are significant antecedents to activities planned in the second contract year. For a full account of contract accomplishments and activities during the first contract year, refer to JSI's Quarterly Performance Monitoring Reports for Quarters I through IV.

In Annex J are Gantt charts which describe the detailed activities, benchmarks, milestones and targets for each Task. The Gantt charts are organized by activities as presented in the strategy statement for each Task.

The AWP is the product of a collaborative effort of JSI and its partners and counterparts. After an initial draft was compiled by JSI Task Teams in consultation with their counterparts, a Workplanning Retreat was held from January 25-28, 1999, in Cairo which was attended by JSI/Egypt and JSI/Boston plus staff from JSI's subcontractors. At the conclusion of the Retreat, representatives of the MOHP and USAID attended a closing session designed to inform them of the content of the draft AWP. The AWP, which is based on JSI's contract, describes activities which will lead to the accomplishment of specific milestones and targets in a limited number of target governorates. The MOHP HM/HC Project, however, has a broader, national scope with a wider array of interventions to implement. Nevertheless, the HM/HC Project has included Upper Egypt as a priority area for further programmatic enhancements. After the conclusion of the Workplanning Retreat, a series of meetings were held with the Task Teams' counterparts to integrate their plans. This integration process has taken the form of synchronizing schedules so that activities are conducted in a complimentary fashion without duplication and inconsistency. The integrated schedules are still under development at the time of submission of this AWP, but will be available before the beginning of the AWP year (March 15, 1999).

The AWP is presented according to the USAID Results Framework (see Annex A), on which the HM/HC Results Package is based, and follows the organization of Intermediate Results and Subresults

**Strategic Objective No 5** Sustainable Improvements in the Health of Women and Children

**Intermediate Result 5 1** Improve Quality and Increase Utilization of Maternal, Perinatal and Child Health Services

**Subresult No 5 1 1** Quality of Essential Maternal, Perinatal and Child Health Services Improved (Includes Tasks 1 and 2)

**Subresult No 5 1 2** Districts Implementing Essential Maternal, Perinatal and Child Health Services in Target Governorates (Includes Tasks 3, 4 and 5)

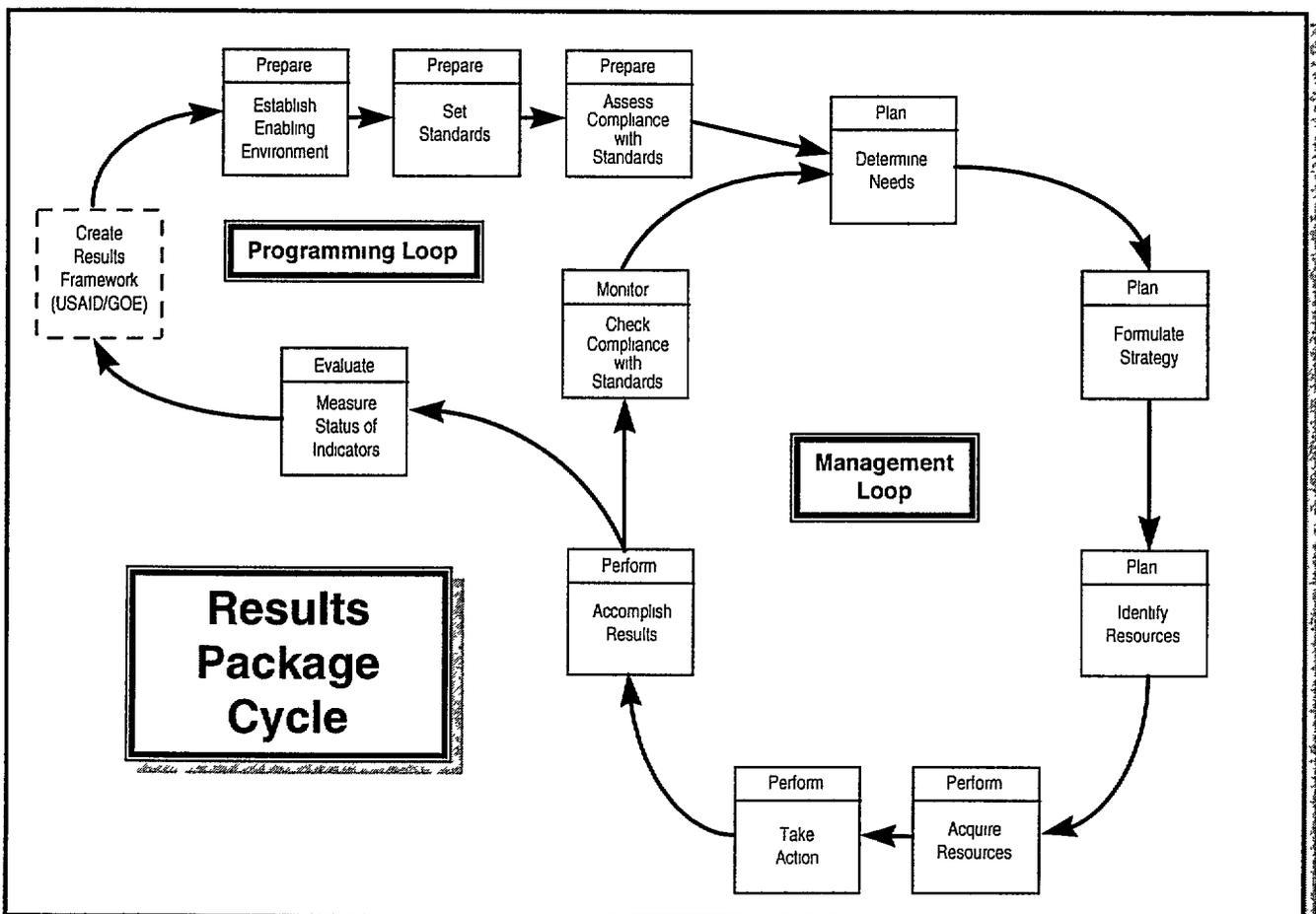
**Subresult No 5 1 3** Established National Child Survival Programs Sustained (Includes Task 6)

**Subresult No 5 1 4** Increased Knowledge and Improved Health Behavior in Households (Includes Tasks 7, 8 and 9)

(Tasks 10 and 11 are included as "Supporting Activities")

**The Results Package Cycle**

A sequence of steps in the development and implementation of the Results Package has been identified, as seen in the Figure below



The following is a brief explanation of the steps in the Cycle

The Healthy Mother/Healthy Child Results Framework and Package were created by USAID and the GOE to set the Cycle in motion. The Results Framework (see Annex A) describes the top level objectives as well as the key indicators which will measure the attainment of those objectives.

**Programming Loop** This series of steps involves the evaluation of outcomes as measured by indicators and allows the re-creation and re-direction of the results package.

- ◆ The *preparatory* first step in the Programming Loop is to **Establish an Enabling Environment** during which all partners are brought into discussion about the proposed accomplishments of the Results Package, their inputs solicited, responsibility for resources identified and a consensus reached as to the general strategy to be employed. Where appropriate, Memoranda of Cooperation are executed which delineate areas of responsibility of the parties to the memoranda,
- ◆ **Standards** are set which define the specific criteria that identify what something (a commodity, procedure, etc.) is supposed to be,
- ◆ **Assessments** are conducted to determine the level of compliance of the current situation with the standards that have been set.

**Management Loop** This series of steps represents a recurring cycle of planning, performing and monitoring. This loop will in most cases be repeated quarterly.

- ◆ The first *planning* step is to **determine needs** which were identified during the assessment process. Needs represent gaps – the difference between what should exist (standards) and what actually exists (as determined from assessments),
- ◆ A **strategy** is then formulated which defines the logical sequence of steps to be taken to accomplish the intended results,
- ◆ **Resources** are identified that are needed to implement the strategy. Such resources include commodities, personnel, training, funds, etc.,
- ◆ The first step in *performing* is to **acquire** the resources identified in the previous step and deploy them to the target areas,
- ◆ Taking **action** involves applying technical assistance to effectively utilize the resources to produce outputs,
- ◆ Once actions have been taken, the **accomplishment of results** should logically follow,
- ◆ The final step in the management loop is to check whether there is adequate **compliance** with the standards that were set earlier. If the standards have been met, the management loop may end at this point. If standards are not met, then the management loop recycles, with additional needs determined.

At the step where the management loop has produced results, the programming loop may be re-entered. At the appropriate stage of development, it may be decided to **evaluate** the outcomes of the Results Package by measuring progress against indicators. Based on the findings of the evaluation, the Results Package may be concluded, or re-created by USAID and the GOE, with goals and objectives renewed, so that a new programming loop would commence.

#### **The HM/HC Product**

The HM/HC Results Package is designed to accomplish Intermediate Result 5.1 of USAID/Egypt's Strategic Objective No. 5 "Improve Quality and Increase Utilization of Maternal, Perinatal and Child Health Services." Task One, which includes the development and

**The HM/HC product** *A sustainable array of maternal and child preventive and curative health services provided by a mix of public and private facilities supported by a decentralized management system*

implementation of the HM/HC Package of Essential Services, is seen as the basic product of the Results Package. All other Tasks are developed and implemented to provide support for this Package of Essential Services.

### Coordination

As mentioned above, each Task in the AWP contains a description of major coordination activities. The complexities of this Results Package necessitate almost daily efforts to coordinate actions. All partners engaged in HM/HC Results Package activities will be reminded to check frequently with their colleagues to determine points of coordination in their planned activities. Where feasible, the Gantt charts indicate linkages that are essential to effective coordination. There are several functional levels of coordination:

- ◆ The first level of coordination concerns **integration** between activities, where the partners must collaborate and work closely together to jointly develop and implement activities.
- ◆ The second level of coordination concerns **dependency** relationships between activities. Dependency relationships indicate that one activity cannot begin until another activity has been accomplished. This level of coordination is the significant since it implies a critical path arrangement.
- ◆ The third level of coordination involves prevention of **scheduling** conflicts. Such conflicts occur when two or more activities are planned to be conducted at the same time and/or in the same place and/or would potentially utilize the same resources.
- ◆ The fourth level of coordination is the need to share **information** so that all partners are working from the same base of knowledge about the plans and progress of the Tasks in the Results Package. Without information sharing there is a high probability that disconnected and potentially duplicative activities will take place.

The major **partners** with which JSI and its sub-contractors will coordinate include:

- ◆ Ministry of Health & Population
  - ◇ MCH Department
  - ◇ Primary, Preventive and Curative Sectors
  - ◇ National Information Center for Health and Population
  - ◇ Upper Egypt Governorate Health Directorates
  - ◇ District Health Offices
  - ◇ Facility Managers
- ◆ USAID (Office of Health, Office of Population, Office of Procurement)
- ◆ UNICEF
- ◆ Ministry of Information State Information Service
- ◆ Medical Syndicates
- ◆ Credit Guarantee Company
- ◆ Centers for Disease Control/Field Epidemiology Training Program
- ◆ Data for Decision Making
- ◆ Social Fund for Development
- ◆ Ministry of Social Affairs
- ◆ Ministry of Rural Development
- ◆ Secretariat General for Local Administration
- ◆ Television Union and Local TV/Radio Channels
- ◆ WellStart
- ◆ Family Planning/Population III & IV

- ◆ Local Councils and Administration
- ◆ Medical and Nursing Schools

### Competency Based Training

An important methodology which will be employed throughout the HM/HC Results Package implementation is Competency Based Training (CBT) to develop skills required to deliver the Package of Essential Services. The training of all categories of service providers and students will follow a CBT methodology. Training modules for each level of service provision will be developed based on the following:

- ◆ a **community health needs (diagnostic) assessment** of the target audience to receive services,
- ◆ a **job analysis** of the tasks, competencies and skills required of service providers to meet these needs,
- ◆ an **assessment of the management support requirements** for competent skill performance,
- ◆ a **training needs assessment** of service providers against the criteria in the job task analysis and the skill checklists, service standards or protocols

The contents of the HM/HC package of services will then be broken down into a series of prototype competency-based training modules (self-contained instructional units) which will be used as a basis for assessing the previous training activities. Each module will consist of a series of session plans. Each session plan will contain a clear statement of

- 1 learning objectives,
- 2 learner assessment,
- 3 learning activities,
- 4 supporting training materials

Service provider competence in mastering the skills associated with each module will be assessed against the providers' ability to meet the observable and measurable performance as stated for each skill.

### Assessments

Most tasks in the Results Package require initial assessments to provide a situation analysis and establish a baseline. Many assessments were conducted during the first Contract Year, with some continuation into the second year. These assessments include:

- ◆ Rapid assessment of governorate- and district-level clinics and hospitals (Task 1),
- ◆ Training needs assessments (Task 2),
- ◆ Assessment of district-level management and planning capabilities (Task 3),
- ◆ Assessment of current research needs (Task 5),
- ◆ Assessment of the current Child Survival Program, with specific reference to Neonatal Care Units (Task 6),
- ◆ Identification of stakeholders and interest groups (Task 7),
- ◆ Investigation of behavioral information (Task 8),
- ◆ Review the Health Insurance Organization's Student Medical Insurance Program policies and programs (Task 9), and
- ◆ Assessment of grant practices with respect to NGOs (Task 10)

The importance of these assessments must not be overlooked. The investment of time and resources in properly developing a solid analysis of the current situation will pay dividends in terms

of appropriate shaping of interventions and the establishment of a baseline against which to compare improvements

### **Decentralization**

Decentralization is a theme which permeates many aspects of the HM/HC Results Package. Task Three takes the lead in this area, with the establishment of district level management teams and steering committees, as well as facility level management teams and community committees.

The basic concept of decentralization is the devolution of authority and responsibility from higher, central levels of an organization to lower, more local levels, allowing all levels to deal with issues which they are most competent to handle. Local levels have an in-depth comprehension of the issues and constraints in their locality, a better grasp of personnel and organizational opportunities and constraints at their level and a fuller understanding of the communities in which they operate. This deeper understanding of the local situation allows managers at this level to make decisions which are more relevant to the day-to-day issues they face. Devolution of authority and responsibility to lower levels allows the central level decision-makers to concentrate more fully on broader policy issues, such as resource management, regulatory functions, and consideration of national level trends.

JSI plans to work with district- and community-level bodies, both inside the MOHP, and with representative members of the communities served by the MOHP. Community members, including private practitioners, will participate with MOHP district officials in planning and monitoring the appropriate mix of services required to fully implement the HM/HC PES. This planning and monitoring effort begins at the most local, community level, with plans and data passed up to the district and subsequently on to the governorate level. At each step of the way, lower level plans and data will be incorporated into the next level's plans and reports.

### **Sustainability and Institutionalization**

Sustainability is a complex issue within a complex activity such as the HM/HC Results Package. While sustainability strategies are incorporated into JSI's plans for each Task, there is no question that the improvement of MCH services will place a financial burden on the MOHP to maintain these services at an adequate quality level. The HM/HC approach to sustainability is 1) to maximize the transfer of skills, knowledge and attitudes to Egyptian technical and management staff to eventually eliminate the need for technical assistance, and 2) to receive the optimal level of benefit for the MOHP's financial outlay. The HM/HC activity must be seen within the context of USAID's entire Strategic Objective No. 5, in which Intermediate Result 5.3 includes activities that promote the allotment of a greater share of the MOHP's resources to primary care. The rationale is that resources are more efficiently utilized at the primary level of care as such investments eliminate a portion of the need for more costly secondary and tertiary level services.

The USAID-funded Health Policy Support Program (HPSP), supported through technical assistance from the Partnership for Health Reform (PHR), is currently implementing a pilot project in three districts in different governorates in Egypt. Part of this pilot will be to examine the provision of universal health coverage through insurance schemes. JSI has engaged PHR in substantive discussions to ensure coordination and collaboration so that MOHP policy changes involving health care financing can be incorporated into the HM/HC package of services to enhance sustainability. Furthermore, encouraging higher quality MCH services delivered by private practitioners may increase demand for and utilization of such services, thereby lessening the demand on public services.

### Monitoring and Evaluation

The monitoring and evaluation philosophy at JSI Healthy Mother/Healthy Child is founded on the identification of answers to three important questions

- 1 Are we doing what we planned?
- 2 Are we doing what we planned right?
- 3 Is what we planned the right thing to do?

*Tracking monitoring* answers the first question. Since JSI HM/HC is a performance-based contract, the successful completion of the contract is keyed to the achievement of prescribed and codified milestones, targets, or process outcomes for which JSI is held responsible. These process outcomes have been integrated into the JSI annual plan and form the foundation upon which the rest of the monitoring and evaluation activities hinge. Following the completion of contract activities comprises the tracking monitoring of JSI HM/HC. To monitor progress towards the achievement of targets and milestones, Task Managers have developed a series of benchmarks whose completion will signal significant and measurable progress towards targets and milestones. These benchmarks allow for a higher resolution of tracking progress.

*Performance monitoring* answers the second question. It is essential to performance monitoring that assessment activities be integrated into the achievement of targets and milestones. The basic theory behind performance monitoring is to run an assessment at the beginning of the activity to determine the status of the individual or system. The assessment is run again at the end of the activity to determine the changes that have occurred. Examples of performance monitoring include monitoring whether participants learned and are correctly practicing the skills from a training, whether the provision of equipment and supplies have brought facilities up to acceptable standards, and whether the exposure of the public to IEC programs has increased their knowledge.

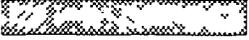
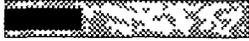
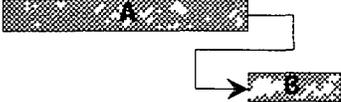
*Evaluation* answers the last question and reveals if activities are having the desired impact on the population. In evaluating JSI HM/HC activities, surveys, assessments and statistical analysis will correlate the process outcomes of targets and milestones with changes in indicators in the populations. JSI will evaluate its activities against the lower-level indicators most directly effected by its activities. The attribution of changes in higher level (or impact) indicators to JSI activities is beyond the manageable interest of JSI and will need to be evaluated by other sources. The achievement of outcomes is implicit in the changes of impact indicators.

Currently, JSI HM/HC is developing a comprehensive monitoring and evaluation plan for its proposed activities. This plan will be broken down by task and identify specific activities to monitor the performance of JSI implementation of the HM/HC contract. Additionally, the impact of JSI activities on lower-level indicators will be evaluated.

# TASK LEVEL GANTT CHART

### GANTT CHART LEGEND

The following symbols are used in the Gantt charts throughout the AWP

<b>Activities</b> are indicated in the Gantt charts as bars	
Within each Task, a number of <b>Activities</b> and <b>Subactivities</b> are identified which are indicated in the Gantt charts as bars	
<b>Summaries</b> of these activities and subactivities are indicated by solid bars	
<b>Percentage Completion</b> of activities is indicated by a solid bar inside of an activity bar	
<b>Progress Markers</b> which include Performance Milestones Performance Targets and Benchmarks are indicated in the Gantt charts with various symbols	
<b>Performance Milestones</b> are planned accomplishments that were specified by JSI in its proposal indicated by solid diamonds (once a planned milestone has been achieved it is indicated by a hollow diamond)	 
<b>Performance Targets</b> are planned accomplishments that were specified by USAID in the RFP, indicated by solid diamonds within circles (once a planned target has been achieved it is indicated by a hollow diamond inside a circle)	 
<b>Benchmarks</b> have been identified by JSI which represent the interim level of accomplishments required to achieve milestones and targets, indicated in the Gantt charts by solid stars (once a planned benchmark has been achieved it is indicated by a hollow star)	 
<b>Dependencies</b> between activities are shown in the Gantt charts by arrows which indicate the link between those activities	
<b>Finish-to-Start</b> dependencies exist when activity B cannot start until activity A finishes	
<b>Start-to-Start</b> dependencies exist when activity B cannot start until activity A starts	
<b>Finish-to-Finish</b> dependencies exist when activity B cannot finish until activity A finishes	
<b>Start-to-Finish</b> dependencies exist when activity B cannot finish until activity A starts	

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
1	1 TASK ONE Basic ES package of essential services established and standards defined	[Gantt bar from Feb to Mar]														
2	1 1 Activity 2 Finalize HM/HC Package of Essential Services consensus meeting	[Gantt bar from May to Feb]														
3	1 1 1 Quarterly meetings with the consensus group to review and follow up PES	[Vertical tick marks in May, Aug, Nov, Feb]														
9	1 2 Activity 3 Implement HM/HC Package of Essential Services in 10 Districts	[Gantt bar from Feb to Mar]														
10	1 2 1 Luxor and Aswan Districts 1 5	[Gantt bar from Feb to Mar]														
17	1 2 1 7 Stage 5 TOT for district level Trainers/Supervisors in Districts 1 5	[Gantt bar from Feb to Mar]														
18	1 2 1 7 1 EOC Training of Trainers	[Gantt bar from Feb to Mar]														
27	1 2 1 8 Stage 6 Quality assurance and service standards training for Governorate and District	[Gantt bar from Feb to Mar]														
33	1 2 1 9 MILESTONE Lead trainers trained in 5 districts and PES implemented in District 1 5	[Diamond marker in Feb]														
34	1 2 1 10 Stage 7 Training of service providers in Districts 1 5	[Gantt bar from Feb to Mar]														
67	1 2 1 11 Stage 8 Plan implementation in Districts 1 5	[Gantt bar from Feb to Mar]														
69	1 2 1 11 2 Monthly self assessment by the anchor facilities staff in Luxor & Aswan	[Vertical tick marks in Mar, Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec]														
82	1 2 1 11 3 Quarterly monitoring and evaluation visits by district management teams to the	[Vertical tick marks in Apr, Jul, Oct, Jan]														
87	1 2 1 11 4 Bi annually monitoring and evaluation visits by governorate management teams to the	[Vertical tick marks in Sep, Dec]														
92	1 2 2 Beni Suef Districts 6 10	[Gantt bar from Feb to Mar]														
93	1 2 2 1 Stage 1 Selection of the Anchor Facilities	[Gantt bar from Feb to Mar]														
98	1 2 2 4 BENCHMARK Selection of Anchor facilities in Districts 6 10	[Star marker in May]														
100	1 2 2 6 Stage 4 Upgrade Anchor Facilities in Districts 6 10	[Gantt bar from Jun to Mar]														
103	1 2 2 6 3 BENCHMARK Equipment and supplies for upgrading anchor facilities in 10	[Star marker in Mar]														
105	1 2 2 7 Stage 5 TOT for district level Trainers/Supervisors in Districts 6 10	[Gantt bar from Jul to Mar]														
106	1 2 2 7 1 EOC training of trainers (TOT)	[Gantt bar from Aug to Mar]														
110	1 2 2 7 2 TOT for physicians & nurses for midwifery program	[Gantt bar from Jul to Mar]														
113	1 2 2 7 3 Management & QA training of trainers (TOT)	[Gantt bar from Aug to Mar]														
116	1 2 2 8 Stage 6 Quality Assurance and Service Standards Training for Governorate & District	[Gantt bar from Sep to Mar]														
120	1 2 2 8 4 BENCHMARK 14 governorate and district level team members receive	[Star marker in Oct]														
121	1 2 2 9 Stage 7 Training of Service Providers in Districts 6 10	[Gantt bar from Oct to Mar]														
122	1 2 2 9 1 EOC training for service providers in Districts 6 10	[Gantt bar from Oct to Mar]														
126	1 2 2 9 2 Training of Service Providers (Nurses) on Infection Control (IC) and Interpersonal	[Gantt bar from Oct to Mar]														
130	1 2 2 9 3 Training of nurses for midwifery skills in Districts 6 10	[Gantt bar from Oct to Mar]														
135	1 2 2 9 4 Integrated training program for service providers	[Gantt bar from Oct to Mar]														
138	1 2 2 9 4 3 BENCHMARK Training of the Service Providers in Districts 6 10	[Star marker in Nov]														
139	1 2 2 10 Stage 8 Continuous improvement by facility teams and district/governorate management teams to	[Gantt bar from Nov to Mar]														
141	1 2 2 10 2 Monthly self assessment by the anchor facilities staff in Districts 6 10	[Vertical tick marks in Dec, Jan, Feb, Mar]														
155	1 2 2 10 3 Quarterly monitoring and evaluation visits by district management teams to the	[Vertical tick marks in Dec, Jan, Feb, Mar]														
165	1 2 2 11 MILESTONE Implement HM/HC Package of Essential Services in 10 Districts	[Diamond marker in Mar]														

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		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
166	1 3 Activity 4 Establish and strengthen a referral system for the HM/HC Package ( With Task 3 )														
173	1 3 7 BENCHMARK A referral system is developed, tested, and submitted														
174	1 4 Activity 5 Promotion of quality services The gold Star approach ( with task 8 )														
175	1 4 1 Explore the option of appending the Gold Star to HM/HC logo for facilities that meet criteria														
177	1 4 1 2 BENCHMARK Decision made about inclusion of the Gold Star approach														
179	1 4 2 Implementaion of the gold star														
182	1 4 2 3 BENCHMARK Gold Star module pretested														



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		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
186	<b>2 TASK TWO Design of Training System and Inclusion of ES Package/Standards in School Curricula</b>	[Shaded bar]														
187	2 1 Activity 1 Revision of med school curricula & upgrade faculty training skills to incorporate HM/HC Package (see	[Shaded bar]														
204	2 1 8 development of hands on training for clinicians	[Shaded bar]														
210	2 1 11 train high level faculty members out of country in new medical technologies	[Shaded bar]														
215	<b>2 2 Activity 2 Revision of nursing school curricula &amp; upgrade faculty training skills to incorporate HM/HC</b>	[Shaded bar]														
232	2 2 8 development of hands on training for clinicians	[Shaded bar]														
239	2 2 11 train high level faculty members out of country in new medical technologies	[Shaded bar]														
244	<b>2 3 Activity 3 In service clinical training (see Task 6)</b>	[Shaded bar]														
250	2 3 2 improve skills and competency of practicing OB/GYNs	[Shaded bar]														
253	<b>2 4 Activity 4 Improve training capabilities</b>	[Shaded bar]														
254	2 4 1 training of trainers	[Shaded bar]														
258	2 4 2 model clinics at each level of service delivery	[Shaded bar]														
263	<b>2 4 3 Activity 5 Training beyond the MOHP</b>	[Shaded bar]														
264	2 4 3 1 private providers	[Shaded bar]														
270	2 4 3 2 pharmacists	[Shaded bar]														
271	2 4 3 2 1 assess potential of HM/HC ES Package in pharmacy schools	[Shaded bar]														
275	2 4 3 3 dayas	[Shaded bar]														
276	2 4 3 3 1 adapt existing program to incorporate relevant HM/HC elements	[Shaded bar]														
280	2 4 3 4 mothers	[Shaded bar]														
283	<b>2 4 4 MILESTONE Lead trainers trained for 5 districts and package implemented in 5 districts</b>	[Shaded bar]														



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		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
366	<u>3 3 1 4 BENCHMARK 5 governorate assessments completed (cumulative)</u>															★
367	<u>3 3 2 Selection of Priority districts for implementation</u>															
371	<u>3 3 4 BENCHMARK (CI) 3 Governorate Health Committees established</u>			★												
374	<u>3 3 7 BENCHMARK (CI) 30 GMT/GHC members trained</u>					★										
376	<u>3 3 9 BENCHMARK (CI) 22 Governorate Team meetings held</u>												★			
377	<u>3 3 10 BENCHMARK (CI) 31 Governorate Team meetings held</u>															★
378	<u>3 3 11 Develop Governorate plans that incorporate District Plans</u>															
381	<u>3 3 11 3 BENCHMARK District Plans are incorporated into Governorate Plans</u>								★							
382	<u>3 3 12 Ongoing implementation and monitoring of Governorate plans</u>															
386	<u>3 3 14 Districts 1 5 Quarterly Review of accomplishments adjustments to plans and redirection of implementation</u>															
390	<u>3 3 15 Districts 6 10 Quarterly Review of accomplishments adjustments to plans and redirection of</u>															
394	<u>3 3 16 Develop and integrate a form of fee-for service system</u>															
399	<u>3 3 16 5 BENCHMARK Fee-for service system developed and submitted to MOHP</u>												★			
400	<u>3 3 17 Identify Private Providers of HM/HC Package who are eligible for CGC Loans</u>															
404	<u>3 3 17 4 BENCHMARK 20 private providers, in target district, identified and oriented to the loan program</u>															★
405	<u>3 3 18 Establish and strengthen a referral system for the HM/HC Package</u>															
414	<b>3 4 National Level Oversight</b>															
420	<u>3 4 6 BENCHMARK Governorate Plans are incorporated into the National Plan</u>												★			
422	<u>3 4 8 BENCHMARK HM/HC National Management Team participating and supporting the district planning process</u>			★												
423	<b>3 5 Establish JSI Field Offices in 5 Target Governorates</b>															
432	<u>3 5 9 BENCHMARK All 5 JSI field offices established</u>												★			

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		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
433	4 TASK FOUR Monitoring System in Place to Track Utilization and Impact and Provide Feedback	[Gantt bar from Feb to Jul]											
434	4 1 Activity 1 Assess and create an integrated and standardized nationwide MHIS system	[Gantt bar from Feb to Jul]											
470	4 1 5 Design for monitoring system	[Gantt bar from Feb to Mar]											
472	4 1 5 2 BENCHMARK Finalized report on proposed improvements to MHIS & Monitoring/Decision	[Star in Mar]											
473	4 1 6 Develop procedures of HM/HC monitoring	[Gantt bar from Mar to Apr]											
476	4 1 7 Activity 2 Assist the MOHP to set up 65 MHIS centers at district level	[Gantt bar from Feb to Jul]											
478	4 1 7 2 Establish 10 MHIS centers at district level	[Gantt bar from Feb to Jul]											
482	4 1 7 2 4 BENCHMARK 10 computers installed	[Star in Jun]											
483	4 1 7 2 5 Train Users	[Gantt bar from May to Jun]											
487	4 1 7 2 5 4 BENCHMARK 40 staff trained	[Star in Jun]											
490	4 1 7 2 8 BENCHMARK Collected first month's data from 10 MHIS centers	[Star in Jul]											
492	4 1 7 2 10 BENCHMARK Finalized report on Set up of 10 MHIS centers at district level	[Star in Jul]											
493	4 1 8 Activity 3 Design user friendly monitoring software for MHIS	[Gantt bar from May to Jul]											
499	4 1 8 6 MILESTONE District Information Centers established in districts 1-10	[Diamond in Jul]											

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		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
500	<b>5 TASK FIVE Research Activities</b>															
501	<b>5 1 Activity 1 Assessment of current research needs gaps in available clinical and operational information</b>															
505	<u>5 1 4 BENCHMARK Research consensus meeting held with the output being a draft Research Agenda</u>	★														
507	<u>5 1 6 BENCHMARK Research Agenda finalized</u>	★														
508	<b>5 2 Activity 2 Development of research proposals and identify departments a d/or institutions to conduct the</b>															
519	<b>5 4 Activity 4 Create findings dissemination strategy</b>															
521	<u>5 4 2 BENCHMARK Dissemination workshops held to present research findings</u>	★														
523	<u>5 6 TARGET the 1999/2000 Maternal Mortality Survey for Egypt and 12 operation research studies and surveys completed by</u>	◆														

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ID	Task/Activity/Sub activity	2000													
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Ncv	Dec	Jan	Feb	Mar
524	<b>6 TASK SIX Established National Child Survival Programs Sustained</b>	[Shaded bar]													
532	6 2 Conduct workshop to collectively plan integration of CSP activities into HM/HC	[Shaded bar]													
536	6 2 4 BENCHMARK Workshop held, report written & distributed	★													
537	6 3 Steering Committee to guide JSI TA inputs to CSP and facilitate integration of CSP activities into HM/HC established and	→ [Shaded bar]													
540	6 3 3 BENCHMARK First meeting of CSP HM/HC Steering Committee to guide and facilitate TA and CSP HM/HC	★													
543	6 3 6 BENCHMARK Quarterly meeting of Steering Committee to guide and facilitate TA and CSP HM/HC	★													
544	6 3 7 BENCHMARK Quarterly meeting of Steering Committee to guide and facilitate TA and CSP HM/HC	★													
545	6 3 8 BENCHMARK Quarterly meeting of Steering Committee to guide and facilitate TA and CSP HM/HC	★													
546	6 3 9 BENCHMARK Quarterly meeting of Steering Committee to guide and facilitate TA and CSP HM/HC	★													
550	<b>6 4 Activity 1 Strengthen immunization services</b>	[Shaded bar]													
554	6 4 4 BENCHMARK EPI assessment report prepared and distributed	★													
564	<b>6 5 Activity 2 Strengthen ARI and CDD programs</b>	[Shaded bar]													
568	6 5 4 MILESTONE Completion of Egypt specific Integrated Sick Child Management (IMCI) Plan	◆													
573	6 5 9 BENCHMARK ARI/CDD assessment report prepared and distributed	★													
583	<b>6 6 Activity 3 Support the neonatal program</b>	[Shaded bar]													
584	6 6 1 Sustain 100 neonatal centers	[Shaded bar]													
589	6 6 1 5 Training of staff	[Shaded bar]													
597	6 6 1 5 8 BENCHMARK Train at least 9 pediatricians in Neonatal Care and service	★													
600	6 6 1 7 Identification and procurement of additional equipment	[Shaded bar]													
604	6 6 1 7 4 BENCHMARK Additional Neonatal Center equipment procured	★													
611	<b>6 7 Activity 4 Strengthen the daya training program</b>	[Shaded bar]													
612	6 7 1 Conduct formative research	[Shaded bar]													
616	6 7 1 4 MILESTONE Daya training program modified and ready for implementation	◆													
618	6 7 3 Strengthen daya training	[Shaded bar]													
622	6 7 3 4 BENCHMARK Upgraded daya training course implemented in all 25 districts	★													
623	6 7 4 Strengthen daya supervision & monitoring	[Shaded bar]													
627	6 7 4 4 Train health workers and managers	[Shaded bar]													

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633	<b>7 TASK SEVEN Better Social Community Services</b>	[Shaded bar]														
634	<b>7 1 Activity 1 Establish community interest groups</b>	[Shaded bar]														
642	7 1 2 Phase II Qena & Fayoum	[Shaded bar]														
646	<u>7 1 2 4 BENCHMARK (CI) 66 Communities with active interest groups engaged in HM/HC</u>	★														
649	<b>7 2 Activity 2 Inventory of partners</b>	[Shaded bar]														
654	7 2 2 Utilize the Protocol	[Shaded bar]														
658	<u>7 2 2 4 BENCHMARK A priority list of potential community partners with health providers in Qena</u>	★														
659	<b>7 3 Activity 3 Development of a community needs identification and decision making tool</b>	[Shaded bar]														
662	<u>7 3 3 BENCHMARK draft tool developed</u>	★														
667	<u>7 3 8 MILESTONE 5 Communities with needs identification tool implemented</u>	◆														
668	<b>7 4 Activity 4 Health Care Provider Sensitization</b>	[Shaded bar]														
677	<u>7 4 9 BENCHMARK (CI) 150 health care providers/provider organizations participated in</u>	★														
678	<b>7 5 Activity 5 Testing different partnership schemes</b>	[Shaded bar]														
681	<u>7 5 3 BENCHMARK (CI) 25 community provider partnerships established and functioning with health care</u>	★														
682	<u>7 5 4 BENCHMARK (CI) 25 areas where emergency obstetrical transport is available for women</u>	★														
683	<u>7 5 5 BENCHMARK (CI) 25 communities where key child survival actions including nutrition actions are available</u>	★														
684	<u>7 5 6 TARGET community provider partnership services offered in 5 districts by end of Year 1</u>	◆														
686	<u>7 5 8 BENCHMARK (CI) 66 community provider partnerships established and functioning with health care</u>	★														
687	<u>7 5 9 BENCHMARK (CI) 66 areas where emergency obstetrical transport is available</u>	★														
688	<u>7 5 10 BENCHMARK (CI) 66 communities where key child survival actions including nutrition action are available</u>	★														
689	<u>7 5 11 TARGET community provider partnership services offered in 10 districts by the end of Year 2</u>	◆														
696	<b>7 7 Activity 7 Community Education</b>	[Shaded bar]														
701	<u>7 7 5 BENCHMARK (CI) 25 communities with HM/HC health communications activities underway</u>	★														
703	<u>7 7 7 BENCHMARK (CI) 66 communities with HM/HC health communications activities underway</u>	★														

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704	8 TASK EIGHT IEC Campaign	[Gantt bar spanning Feb to Mar]													
705	8 1 Activity 1 Reinforcing MOHP SIS collaboration	[Gantt bar from Feb to Sep]													
713	8 1 8 BENCHMARK (CI) 17 MOHP staff trained at Baltimore based Advances in FH Communication	[Star in Sep]													
722	8 3 Activity 3 Investigation of Behavioral Information	[Gantt bar from Feb to May]													
723	8 3 1 Review Existing Information	[Gantt bar from Feb to May]													
734	8 4 Activity 4 Strategic design for health communication	[Gantt bar from Feb to Jun]													
735	8 4 1 Draft Comprehensive Overarching Communication Strategy Design	[Gantt bar from Feb to Mar]													
739	8 4 2 Communicate with communities and health providers to identify appropriate local communication strategies	[Gantt bar from Mar to Jun]													
742	8 4 3 MILESTONE National IEC Strategy Developed	[Diamond in Jun]													
743	8 5 Activity 5 IEC Training	[Gantt bar from Feb to Mar]													
744	8 5 1 Updating the IEC protocol and modules	[Gantt bar from Feb to Sep]													
749	8 5 1 5 BENCHMARK IEC Training Package completed	[Star in Mar]													
754	8 5 2 Development of an IEC orientation package	[Gantt bar from Mar to Dec]													
763	8 5 2 9 BENCHMARK IEC orientation package completed	[Star in Nov]													
766	8 5 2 12 IC 100 Health educators and Others trained	[Star in Dec]													
770	8 5 2 16 BENCHMARK (CI) 200 Health educators and Others trained	[Star in Feb]													
775	8 6 Activity 6 development of interpersonal communication materials	[Gantt bar from Jul to Dec]													
776	8 6 1 Identificaton and development of IP materials	[Gantt bar from Jul to Dec]													
779	8 6 1 3 Production of Interpersonal Communication Materials	[Gantt bar from Sep to Dec]													
784	8 6 1 3 5 BENCHMARK (CI) 2,000,000 print materials produced	[Star in Dec]													
787	8 7 Activity 7 Develop demand generation campaign for HM/HC services and essential behaviors	[Gantt bar from Jul to Dec]													
788	8 7 1 Demand generation campaign development	[Gantt bar from Jul to Dec]													
792	8 7 1 4 MILESTONE National IEC campaign developed	[Diamond in Dec]													
793	8 7 2 Implementation of the campaign	[Gantt bar from Dec to Mar]													
797	8 8 Activity 8 Develop community support for essential behaviors and services	[Gantt bar from Dec to Mar]													
803	8 9 Activity 9 Promotion of quality services The Gold Star approach	[Gantt bar from Mar to Dec]													
804	8 9 1 Explore the option of appending the Gold Star to HM/HC logo for clinics that meet criteria	[Gantt bar from Mar to Apr]													
806	8 9 1 2 BENCHMARK Decision made about inclusion of the gold star approach	[Star in Mar]													
808	8 9 2 Implementation of the gold star	[Gantt bar from Jun to Dec]													
817	8 10 Activity 10 Female genital mutilation	[Gantt bar from Dec to Mar]													

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829	<b>9 TASK NINE Student Medical Insurance Program (SMIP)</b>	[Shaded bar]														
835	<b>9 6 Health and Nutrition education program initiated to support the anemia control and immunization activities</b>	[Shaded bar]														
840	9 6 5 Undertake qualitative research to fill gaps in the understanding of priority issues	[Shaded bar]														
846	<u>9 6 8 BENCHMARK Strategy approved</u>	★														
847	9 6 9 Materials development	[Shaded bar]														
853	<u>9 6 9 6 BENCHMARK Finalized pilot versions produced</u>	★														
866	<b>9 7 Activity 2 Anemia Control Program</b>	[Shaded bar]														
871	<u>9 7 5 BENCHMARK Coordinating committee meeting held</u>	★														
873	9 7 7 Prepare and conduct a pilot in selected districts	[Shaded bar]														
877	<u>9 7 7 4 BENCHMARK Staff trained</u>	★														
880	<u>9 7 7 7 BENCHMARK Report on pilot test completed</u>	★														
883	<u>9 7 10 BENCHMARK Revised policy approved</u>	★														
897	<b>9 8 Activity 3 Tetanus immunization</b>	[Shaded bar]														
900	9 8 3 Pilot Implementation	[Shaded bar]														
904	<u>9 8 3 4 BENCHMARK Staff trained</u>	★														
907	<u>9 8 3 7 BENCHMARK Report on pilot implementation completed</u>	★														
908	9 8 4 Develop and implement operational plans for 5 governorates	[Shaded bar]														
912	<u>9 8 4 4 BENCHMARK Staff trained</u>	★														

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917	10 TASK TEN Small Grant Program	[Shaded bar]													
924	10 3 Identification and Assessment of potential NGO partners in Target Districts	[Shaded bar]													
928	10 3 4 BENCHMARK Identification & assessment of potential NGO partners in Qena & Fayoum completed	★													
929	10 4 Obtain Official Approval and consent form MOHP and MOSA to approach NGOs for grant giving	[Shaded bar]													
934	10 5 Assessment of work currently being done and potential for future grants in the target areas	[Shaded bar]													
940	10 5 3 BENCHMARK Workshop to discuss lessons learned conducted	★													
955	10 9 Prepare and Approve the Invitation for Application	[Shaded bar]													
958	10 9 3 BENCHMARK Invitation for Application Template Approved By USAID	★													
959	10 10 Provide Grants to Capable Local NGOs through a standardized Mechanism	[Shaded bar]													
960	10 10 1 Phase I Aswan and Luxor	[Shaded bar]													
961	10 10 1 1 Conduct an Orientation Workshop to introduce the program explain our expectations to	[Shaded bar]													
965	10 10 1 4 BENCHMARK Workshop Conducted and Invitation for Application	★													
966	10 10 1 2 Selection and Award	[Shaded bar]													
974	10 10 1 2 8 BENCHMARK Approx. 25 30 Grants awarded to NGOs	★													
975	10 10 1 3 Work with NGOs that did not receive a grant through the last process in order to build their	[Shaded bar]													
976	10 10 1 3 1 Assessment and Training	[Shaded bar]													
982	10 10 1 3 3 Selection and Award	[Shaded bar]													
991	10 10 2 Phase II Beni Surf	[Shaded bar]													
992	10 10 2 1 Conduct an Orientation Workshop to introduce the program explain our expectations to	[Shaded bar]													
996	10 10 2 1 4 BENCHMARK Workshop Conducted and Invitation for Application	★													
997	10 10 2 2 Selection and Award	[Shaded bar]													
1053	10 11 Payment and Financial Monitoring for the Receptient Organizatons	[Shaded bar]													
1057	10 12 MILESTONE 20 small grants awarded to NGOs in target districts	◆													
1058	10 13 MILESTONE 55 small grants awarded to NGOs in target districts	◆													

**JSI HM/HC Year 2 Annual Workplan  
Summary Activities and Progress Indicators**

Fri 2/12/99

ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jui	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
1061	11 TASK ELEVEN Commodity Procurement Program	[Shaded bar]														
1063	11 2 Activity 1 Procurement of project equipment	[Shaded bar]														
1064	11 2 1 Tranche 1 Procurement of equipment to be installed 31/3/99	[Shaded bar]														
1073	11 2 2 Tranche 2 Procurement of equipment to be installed 30/6/99	[Shaded bar]														
1082	11 2 3 Tranche 3 Procurement of equipment to be installed 31/12/99	[Shaded bar]														
1091	11 2 4 Tranche 4 Procurement of equipment to be installed 31/1/00	[Shaded bar]														
1100	11 2 5 Tranche 5 Procurement of equipment to be installed 31/3/00	[Shaded bar]														
1109	11 2 6 Tranche 6 Procurement of equipment to be installed 30/6/00	[Shaded bar]														
1136	11 2 9 Generate quarterly progress reports															
1149	11 2 10 Generate semiannual procurement plan															

# INDIVIDUAL TASK PLANS

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## **SUBRESULT 5 1 1· Quality of Essential Maternal, Perinatal and Child Health Services Improved**

There are two Tasks included in this Subresult

**TASK ONE** Basic package of essential services established and standards defined

**TASK TWO** Training in standards included in medical and nursing curricula plus clinical practice and pre/in-service training system designed to disseminate standards to public and private providers

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### **TASK ONE· Basic package of essential services established and standards defined**

#### **PURPOSE**

The purpose of Task One is to design and implement a sustainable basic package of essential preventive and curative health services to reduce maternal and child mortality and morbidity. This HM/HC Package of Essential Services (PES) will be delivered through MOPH clinics and hospitals in Upper Egypt. These clinics and hospitals will be upgraded to provide quality services in compliance with the criteria in the Service Standards. Upgrading will involve a competency based training TOT for Master Trainers and district level trainers and supervisors. These district level trainers/supervisors will in turn train service providers and will monitor the implementation of the PES, physical improvements of service facilities, and provision of essential equipment and supplies according to the criteria in the Service Standards.

#### **STRATEGY**

##### Activity No 1 1 Assess efficacy and cost effectiveness of the HM/HC Package of Essential Services

This activity was completed during the first Contract Year and is therefore not included in this Second Contract Year Plan

- ◆ The assessment of the efficacy and cost effectiveness of the HM/HC PES is documented in the table entitled "Technical Analysis of Interventions for the Reduction of Maternal/Neonatal/Child Mortality" which is included in the MotherCare/Egypt Project's Annual Work Plan for 1997-98. This table was updated during JSI's First Contract year.
- ◆ Based on the above, a list of equipment and of medical and non-medical supplies for the different type of facilities was compiled and was reviewed by other Task Managers for eventual inclusion in the Comprehensive Essential Obstetric Care Service Standards and the Neonatal Care Service Standards.

##### Activity No 1 2 Finalize HM/HC Package of Essential Services

During year one, the HM/HC Package of Essential Services (PES) was clearly defined as illustrated in Table 4. The process of defining the PES included the formation and meeting of the *HM/HC Consensus Committee* during September, 1998. Committee membership includes representatives

from Health Services Reform Section of the Quality Improvement Directorate (QID), MOHP, HM/HC Project, Family Planning Division, Curative Medicine Division, UNICEF, WHO, Wellstart, and USAID. The Consensus Committee accomplished the following:

- ◆ set up a process to ensure consistency between the *Basic Benefit Package* of the Health Services Reform Section of QID, MOHP and JSI HM/HC Package of Essential Services
- ◆ clarified roles and responsibilities,
- ◆ established a method to coordinate follow-on activities, and
- ◆ defined the HM/HC Package of Essential Services

**Table 4 HM/HC Package of Essential Services**

HM/HC Package of Essential Services	Responsibility
1) Premarital examination and Counseling	◆ Family Planning Div , MOHP ◆ JSI (only collaborates with above)
2) Prenatal, delivery, and postnatal care (essential obstetrical care – basic and comprehensive)	◆ HM/HC Project, MCH Div , MOHP ◆ Curative Medicine Division, MOHP ◆ JSI
3) Peri/Neonatal care	◆ HM/HC Project, MCH Div , MOHP ◆ JSI
4) Promotion of immediate and Exclusive breastfeeding	◆ HM/HC Project, MCH Div , MOHP ◆ Wellstart ◆ JSI (only collaborates with above)
5) 40 <sup>th</sup> day integrated visit for mother and infant postpartum check-ups	◆ HM/HC Project, MCH Div , MOHP ◆ Family Planning Div , MOHP ◆ Wellstart ◆ JSI
6) Children's preventive health services	◆ HM/HC Project, MCH Div , MOHP ◆ JSI
7) Sick child case management	◆ HM/HC Project, MCH Div , MOHP ◆ UNICEF (IMCI) ◆ WHO (IMCI) ◆ JSI (plan and implement)
8) Reproductive health services	◆ Family Planning Div , MOHP ◆ JSI (only collaborates with above)
9) Nutrition services	◆ HM/HC Project, MCH Div , MOHP ◆ HIO/SMIP ◆ JSI
10) Counseling and health education on all the above	◆ As indicated above

The elements of the PES in Table 4 were reviewed and accepted by the Consensus Committee and will undergo periodic review during year two. These elements are going through the process of being converted to CBT materials (protocols and modules), which will be finalized during year two.

The groups responsible for each element in Table 4 will work together to develop the components of the PES and assess which elements of the PES require strengthening. They will then collaborate in PES planning, implementing and monitoring.

Quality Assurance Service Standards and Checklists for the following areas were used to assess and upgrade service facilities and provision of essential equipment and supplies during year one:

- ◆ Comprehensive Essential Obstetric Care,
- ◆ Basic Essential Obstetric Care,
- ◆ Neonatal Units,
- ◆ Child Survival, and
- ◆ Family Planning

This assessment/upgrading process will continue during year two.

### Activity No. 1.3 Implement HM/HC Package of Essential Services

An **eight stage process** of implementation was initiated in year one and will continue into year two. A key element in this process is the development of **Anchor Facilities** to serve as the focal training and demonstration sites within each target district. The delivery system for the PES in each district includes a number of anchor facilities determined by population and geographical considerations.

- ◆ The district hospital anchor facility will be up-graded to function as the comprehensive referral center for the PES,
- ◆ A number of other basic centers will be included as anchor facilities in the delivery system (there will be approximately one basic anchor facility for each 100,000 population in each district),
- ◆ All of the remaining MOHP health service facilities in the district capable of providing the PES will be included in the delivery system.

In brief, the following seven stages of the PES implementation process, initiated during year one, will continue during year two:

- 1 **Selection of prospective anchor facilities** based on set criteria
- 2 **Rapid assessment of prospective anchor facilities** to determine the level of compliance with the PES standards
- 3 Based on findings of the initial assessment, prepare a **plan for bringing prospective anchor facilities into compliance** with PES standards
- 4 **Upgrade anchor facilities** through limited renovation, commodities, training and reorganization to bring them into compliance with service standards
- 5 **Train Central Level Master Trainers**, who in turn will train district and governorate **management/supervisory teams** (Lead Trainers) to train service facility staff in PES standards and to use checklists to monitor compliance with PES service standards
- 6 District and governorate **management/supervisory teams perform routine monitoring of anchor service facilities** to determine level of compliance with service standards and prepare plans to take corrective actions to bring facilities into compliance
- 7 **Competency-based training conducted by Master Trainers and district level trainers/supervisors (lead trainers) at anchor facilities** for the staff of other MOHP facilities in the vicinity of the anchor facilities. Training interventions will be documented in the Training Report Form. This training will upgrade service facility staff skills, enabling them to meet the standards required to provide the PES. As part of their training, service facility staff will prepare plans for upgrading their respective facilities to meet PES standards
- 8 Once the training at the anchor facilities is complete, **service facility staff return to their**

**facilities and implement plans** they developed to bring their respective facilities up to PES standards

At the conclusion of this eight-step process each facility will receive quarterly visits by district level trainers/supervisors, bi-annual visits by governorate level supervisors and annual visits by Master Trainers, central MOHP or JSI HM/HC staff to determine and/or verify their continued compliance with PES service standards. Where facilities are failing to reach compliance supervisors will assist them in developing a problem-identification/practical-solution approach to correct their non-compliance. As part of this process, facility staff will perform monthly self-assessments in an on-going process of problem-identification and problem-solving so that continuous improvements are made to keep the facility in compliance with PES standards.

## RESOURCE REQUIREMENTS

**Commodities** Commodity requirements for implementing Task One activities include computers and printers available full time for materials production, access to photocopying and printing resources, and adequate copies of materials for distribution to target audiences. At governorate level training facilities, the following supplies are required for each site: overhead projector, screen, overhead transparencies, slide projector, flipchart stands, flipchart paper, marking pens, TV monitor, video cassette recorder/player, abdomen model, pelvis model, doll, and newborn resuscitation kits. All anchor level facilities will receive the required medical equipment and supplies as determined by the Rapid Assessment.

**Personnel** For successful implementation of HM/HC PES in additional districts, support is required for all Task Managers, trainers, local consultants and participants listed for Task One Year Two activities. The cadre of central level MOHP and JSI HM/HC Master Trainers needs to be expanded by twelve members to support both Task One and Two Activities. Lead trainers are required (governorate and district level managers/supervisors and senior specialists) for all additional districts.

## EXPECTED ACCOMPLISHMENTS

During the current AWP period, March 15, 1999 - March 14, 2000, the following accomplishments will be realized (some Year One Milestones and Benchmarks are included for clarity)

### Performance Milestone

- ◆ Health personnel implementing HM/HC PES in 5 districts by March 14, 1999 (Year One Milestone)
- ◆ Health personnel implementing HM/HC PES in 10 districts (cumulative) by March 15, 2000

### Performance Target

- ◆ Health personnel implementing HM/HC PES in 10 districts by March 15, 2000 (same as above milestone)

### Major Benchmarks

- ◆ One follow-up HM/HC PES Consensus Committee meeting held and PES reviewed by March 14, 1999 (Year One Benchmark)
- ◆ Eight governorate and district level team members receive Management/Quality Assurance training by March 14, 1999 (Year One Benchmark)
- ◆ Training of Service Providers in 5 districts in Aswan Governorate by March 14, 1999 (Year One Benchmark)
  - ◇ 30 Physicians (EOC, 6 per district)
  - ◇ 50 Nurses (infection prevention, ICP 10 per district)
  - ◇ 20 Nurses (midwifery skills, 4 per district)
- ◆ Four follow-up HM/HC PES Consensus Committee meetings held on a quarterly basis and PES implementation reviewed by March 15 2000

- ◆ Selection of anchor facilities in 5 new districts by May 15, 1999
- ◆ Remaining 6 of 12 additional central level MOHP and JSI HM/HC Master Trainers trained by December 30, 1999, in collaboration with Task Two
- ◆ Training of Service Providers in 5 districts in Beni Suef Governorate by March 15, 2000
  - ◇ 30 Physicians (EOC, 6 per district)
  - ◇ 20 Physicians (Integrated Package of Services, 4 per district)
  - ◇ 50 Nurses (infection prevention, IPC, 10 per district)
  - ◇ 20 Nurses (midwifery skills, 4 per district)
- ◆ 14 governorate and district level team members receive Management/Quality Assurance training by March 15, 2000
- ◆ Equipment and supplies for upgrading anchor facilities in 10 districts procured and delivered by February 15, 2000
- ◆ Referral system developed, tested and submitted by February 15, 2000
- ◆ Decision made about inclusion of the Gold Star approach by June 10, 1999

### COORDINATION

- ◆ There are linkages and cross-cutting relationships with all other tasks which will require close collaboration and coordination with Task Managers. The majority of cross-cutting activities are associated with Tasks 2, 6 and 8
- ◆ All activities will require close coordination with MOHP sectors, i.e., HM/HC Project, Population Division, Curative Medicine Division, and IEC personnel, IMCI (WHO and UNICEF) or with partner projects, i.e., Wellstart (breastfeeding) and Manoff (nutrition)
- ◆ Close coordination with the USAID Family Planning/Population Project IV, Family Planning Division, MOHP and Ministry of Information, will be required to implement the following PES Elements (see Table 4)
  - Element 1 Premarital examination and counseling,
  - Element 5 40<sup>th</sup> day integrated visit for mother and infant postpartum check-ups
  - Element 8 Reproductive health services
  - Element 10 Counseling and health education on the above

### CONSTRAINTS

- ◆ UNICEF has yet to clearly define its collaborative role in Upper Egypt PES interventions
- ◆ The time it will take to train service providers in all PES skills is still a concern
- ◆ Concern over the timely procurement/deployment of commodities
- ◆ Concern over the timely renovation of facilities through the PIL

## **TASK TWO: Training in standards included in medical and nursing curricula plus clinical practice and pre/in-service training system designed to disseminate standards to public and private providers**

### **PURPOSE**

To continue efforts begun under CSP, UNICEF, MotherCare and WellStart to strengthen the curricula of medical and nursing schools and for the basic health package of essential services

### **STRATEGY**

#### Activity No 2.1 Medical School Training Revision of medical school curricula and upgrade faculty training skills to incorporate HM/HC Package of Essential Services

- ◆ Based on the Package of Essential Services (PES) developed in Task One, a competency-based curricula (CBC) for medical and nursing schools will be developed. The CBC will be used to supplement existing curricula. To streamline the materials production process, the CBC for medical students will be the same as the PES technical materials, i.e., protocols to provide in-service training for service providers. Faculty will use the same modules as those used by Master Trainers and trainers/supervisors to conduct training courses for service providers.
- ◆ The Residency and 7<sup>th</sup> year House Officer programs will be the best time to integrate PES and essential obstetric care (EOC) CBC into the medical education system. There will probably be less resistance by medical school faculty to supplementing existing medical school curriculum with CBC at the House Officer level. It is likely that improved performance of Residents and House Officers could be demonstrated during the current three-year life of the JSI HM/HC-RP.
- ◆ A Curriculum Development Committee (CDC) will need to be established at each of the 13 participating medical schools. This committee will be chaired by the dean or his designate and comprised of two sub-committees, one for Obstetrics and the other for Neonatal and Pediatric curriculum development. A memorandum of cooperation will be signed between JSI and each medical school to specify the roles and responsibilities between the two organizations including curriculum development.
- ◆ Both medical (and nursing) students will develop skills through supervised, practical experience as they rotate through model clinics set-up in university hospital outpatient departments. Student rotations through district level "anchor hospitals" in Upper Egypt where the HM/HC PES is being implemented will also be explored.
- ◆ For students to master PES skills in an appropriate learning environment, university hospital-based model clinics must meet Quality Assurance/Service Standards criteria. A rapid assessment of potential clinical training sites will be done and recommendations for upgrading the facilities and strengthening staff skills will be made so QA/Service Standards criteria can be met. This could be done in conjunction with Task One facility rapid assessment and planning activities.
- ◆ The faculty and trainers/supervisors will be certified that they "mastered" their CBT methodology and PES skills when the students or health care providers they have trained demonstrate that they have "mastered" the technical skills included in the PES. In other words, trainers/faculty have only mastered PES skills when they can demonstrate a transfer and mastery of these same skills by their learners. Establishing this level of performance will bring more accountability and credibility to the teaching/learning environment.

Activity No 2 2 Nursing Schools Revision of nursing school curricula and upgrade faculty training skills to incorporate HM/HC Package of Essential Services

An approach similar to that described above for medical schools will be used in the nursing schools

Activity No 2 3 In-service clinical training

Activity No 2 4 Improve clinical training capabilities

Activity No 2 5 Training beyond the MOHP

Concerning in-service clinical training and training beyond the MOHP, continuing medical education (CME) for physicians in Egypt is organized and coordinated through the CME Committee (CMEC), Egypt National Medical Syndicate (ENMS) In-service training is also being provided to physicians in the area of Essential Obstetric Care, management systems, and quality assurance (QA) skills through the MotherCare/Egypt Project and in collaboration with the MOHP HM/HC This CME is to be continued with the JSI Healthy Mother/Healthy Child Results Package A close collaborative working relationship will be established with the ENMS and CME A similar strategy will be followed for other non-physician categories of health care providers covered under Task Two

## RESOURCES REQUIRED

### Commodities

- ◆ The following commodities are required two computers available full time for materials production, one printer available full time for materials production access to photocopying and printing resources, and adequate copies of the training material component of the PES for distribution to the target audience
- ◆ For the proposed 13 medical schools and seven nursing schools, the following supplies are required for each site overhead projector, screen, overhead transparencies, slide projector flip chart stands, rolls of flip chart paper and paper tape, marking pens, TV monitor, video cassette recorder/player, abdomen model, pelvis, doll and newborn resuscitation kit A limited number of PCs (3-5) will be provided as necessary to medical schools to set up an adequate MIS

### Personnel

- ◆ Support is required from all task managers, trainers, and local consultants
- ◆ In addition to the Task Two manager, two other personnel are required
  - ◇ A full-time nurse to coordinate activities related to seven nursing schools
  - ◇ A full-time physician to coordinate activities related to the private sector initiative

## EXPECTED ACCOMPLISHMENTS

During the AWP second year period, March 15, 1999 - March 14, 2000, the following accomplishments will be realized

### Performance Milestone

- ◆ HM/HC curricula taught in two medical and two nursing schools by September 15, 1999

### Performance Targets

- ◆ None during this period (Targets stated only for the "end of contract")

### Major Benchmarks

- ◆ Formation of curriculum development committee for two medical schools and one nursing school by March 15, 1999
- ◆ Training sites selected and equipped by June 15, 1999
- ◆ The core groups of Master Trainers trained by July 30, 1999

### COORDINATION

- ◆ There are linkages and cross-cutting activities which require close collaboration and coordination with Task Managers for Tasks 1, 3, 4, 6, 7, 8 and 9. The majority of cross-cutting activities are associated with Tasks 1, 6, 7 and 8.
- ◆ All activities will require close collaboration with HM/HC, MOHP, Population/Family Planning Project, Medical Sector of the Supreme Council of Universities, Ministry of Education, deans and department heads of cooperating medical and nursing schools, Egypt National Medical and Nursing Syndicates, Wellstart, Development Training II, UNICEF and WHO.

### CONSTRAINTS

- ◆ The DCOP for Technical Services has taken the responsibility of Task Two manager, so that no major delay occurred.

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## **SUBRESULT 5.1.2: Districts Implementing Essential Maternal, Perinatal and Child Health Services in Target Governorates**

There are three Tasks included in this Subresult

**TASK THREE Public and private providers in partnership with communities to develop and manage district plans**

**TASK FOUR Monitoring system in place to track utilization and impact and provide feedback**

**TASK FIVE Research Activities**

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### **TASK THREE: Public and private providers in partnership with communities to develop and manage district plans**

#### **PURPOSE**

The purpose of Task Three is to support the implementation of the HM/HC package at all levels in Upper Egypt by providing an enabling management environment. Initial efforts to provide this supportive management environment will focus on the development of district health plans and monitoring systems, which will have a solid foundation of local community participation. This participation will be highlighted by significant involvement of the private health care sector. At broader levels there will be policy and supervisory support from the national MOHP and respective governorate health directorates.

#### **STRATEGY**

The development of a decentralized, participatory planning, management, and monitoring process will take place through the community, facility, district, governorate and national levels. The aim of this approach is to enlist the support of stakeholders at these MOHP administrative levels in promoting a "bottom-up" planning approach, where one level sends their plans up to the next level to be incorporated in its wider plans. The sharing/incorporating process will enable health facilities and their catchment area communities to have input into the district, governorate and national levels. This will help ensure that facilities receive an appropriate share of resources to implement and monitor the HM/HC package at the "front line" of the provider-patient encounter. An annual "bottom-up input/top-down feedback" planning and monitoring loop will be supported. An important step in establishing an enabling environment will be the signing of a joint Memorandum of Cooperation between the Undersecretary (or Director General) of each of the target governorates and representatives of USAID/Egypt, the MOHP and JSI.

Activities will continue in the five districts in Aswan and Luxor governorates where activities have been initiated during the previous year. The HM/HC Results Package has already been active in

establishing a supportive management environment in these target districts. By the end of the first planning year (March 14, 1999), these five districts will have developed their plans and monitoring systems. Work will continue to further support these districts in effective planning and monitoring of the Results Package. During this planning year, five additional districts will be selected from Beni-Suef governorate for the next stage of district level development. Three of these districts will be phased in to the program by December 14, 1999, thus achieving the planned Performance Milestone for eight districts. The other two districts will follow shortly, reaching the cumulative Performance Target of 10 districts by March 14, 2000. During the last quarter of this planning year, activities will be initiated in a new set of 10 districts in Fayoum and Qena governorates in preparation for implementation during the following planning year.

#### Activity No. 3.1 Community level involvement

Community involvement will be addressed both at the Governorate and District levels by establishing respective Governorate and District Health Committees (see below). In addition, the feasibility of establishing community participation at a more peripheral through the establishment of Community Health Committees (CHCs) will be assessed. These committees will work closely with local anchor facilities and their representatives to conduct community needs assessments and to develop community plans that will support the implementation of the HM/HC results package. CHCs will receive appropriate training that will enable them to conduct this role and to mobilize local resources.

#### Activity No. 3.2 District Level Intervention

District Management Teams and District Health Committees (DHCs) will be established and trained on the district planning process using the developed planning guidelines. District assessments will be initially conducted to ascertain each district's management capacity. District Teams will work closely with DHCs in developing individual plans incorporating community/facility level plans. Membership of DHCs will include representatives of the MOHP, other key Ministries such as education and social work, local councils, private providers, local non-governmental organizations, and local community leaders. Technical assistance will be provided to these teams and committees during the implementation process and the management of the HM/HC results package locally.

#### Activity No. 3.3 Governorate Level Participation

Governorate Management Teams and Governorate Health Committees (GHCs) will be established to provide feedback to the district planning process and to support district-level implementation. GHC membership will be essentially the same as DHCs with the addition of representation from the local medical/nursing syndicates. Governorate Management Teams will have their own plans that reflect the needs of the affiliated districts. These teams and committees will be adequately trained to carry out their role in monitoring the implementation of the package at the governorate level. Technical assistance will also be provided for the establishment of referral systems and the identification of opportunities for financial sustainability and a fee-for-service structure to sustain the program. Also, assistance will be provided to promote the implementation of the package in the private sector. Working with syndicate representatives and in close collaboration with the Credit Guarantee Corporation, efforts will be made to identify private providers eligible for loans and facilitate their utilization of these funds in the promotion of the package of essential services.

#### Activity No. 3.4 National Level Oversight

Key to this plan is the continuous dialogue with the HM/HC Project to ensure the participation of the national level in the decentralized planning process. Governorate plans will be submitted to the national level to be incorporated in their five-year master plan. To ensure the sustainability of this

planning process, counterparts from the national level will participate with Task Three members in the delivery of training and in the standardization of planning and monitoring guidelines with the GOE cycle. The planning department of the MOHP will also be considered for the national oversight activity. The current mandate of this department is the planning and monitoring of the implementation of capital investments. Activity planning is the responsibility of the different technical departments. In this regard, a dialogue will be initiated with the Partnership for Health Reform Program to determine the mechanism and approach for standardizing the planning process within the MOHP.

### **RESOURCES REQUIRED**

A variety of resources is needed to support the different Task Three activities.

- ◆ The establishment of the JSI Field Regional Offices will require office space, equipment and furniture (such as desks, chairs, fax machines, photocopy machines, telephone systems, vehicles, computers, air conditioners, etc.) Training equipment such as flip charts, overhead projectors, screens, etc. will also be required at these sites.
- ◆ The refinement and expansion of the management guidelines and the development of further management training materials will require the use of short-term local consultants and translators. Also, short-term trainers will be needed to meet the anticipated increase in training activities. Training and implementation activities will require resources, whether derived from Contract funds or Implementation Letters to support travel expenses, per diem, and participants' training allowances. It is also expected that the different Teams and Committees will hold a large number of meetings, generating need for additional funding.

### **EXPECTED ACCOMPLISHMENTS**

During the current AWP period, March 15, 1999 - March 14, 2000, the following accomplishments will be realized.

#### **Performance Milestone**

- ◆ 8 District health plans and monitoring systems developed and implemented by 12/15/99

#### **Performance Target**

- ◆ 10 District health plans and monitoring systems developed and implemented by 3/15/00

#### **Major Benchmarks**

- ◆ 10 District Assessments completed by 4/15/99
- ◆ 60 Community Plans developed by 7/15/99
- ◆ District supervision guidelines completed by 7/31/99
- ◆ All 5 JSI Field Offices established by 11/30/99
- ◆ Fee-for-service system developed and submitted to the MOHP by 12/15/99
- ◆ A referral system developed, tested, and submitted by 2/15/00
- ◆ 5 Governorate assessments completed by 2/28/00
- ◆ 20 private providers, in target districts identified and oriented to the loan program by 3/15/00

**COORDINATION**

- ◆ Task Three will be coordinated with Task One ensuring that the Package of Essential Services is being effectively planned at the District level Also, close coordination will take place to ensure the selection process of anchor facilities and the involvement of the management teams
- ◆ Task Four, establishment of an effective MHIS, is integral to the success of Task Three, as it will ensure availability of appropriate quality data for all levels in the planning and monitoring system development process
- ◆ Close coordination will take place with Task Seven, which aims to establish better social community services Activities particularly relating to the establishment and training of Community Health Committees will be closely coordinated
- ◆ Task Ten, small grants program, can help identify NGOs and interest groups that could use small grants to enhance community participation in the HM/HC Package management process
- ◆ To facilitate the establishment of the JSI field offices, coordination will continue with Task 11 and Administration ensuring the timely procurement of equipment, furniture, and supplies
- ◆ Coordination with UNICEF will also take place to make sure that experiences are being shared and that lessons learned from the different governorates and districts are being communicated
- ◆ Coordination will be maintained with the Credit Guarantee Corporation as part of the Private Sector Initiative, ensuring mobilization of resources for the implementation of the package in the private sector

**CONSTRAINTS**

- ◆ One potential constraint deals with the yet-to-be-tested degree of commitment at the MOHP governorate, district and facility levels to participate, with their respective communities, in the development of plans and monitoring systems in the new set of districts

## **TASK FOUR: Monitoring system in place to track utilization and impact and provide feedback**

### **PURPOSE**

The purpose of Task Four is to install an improved Management and Health Information System (MHIS) in 65 Upper Egypt districts to enable a district-wide monitoring of process and outcome indicators. The MHIS will be used to monitor the implementation of the HM/HC district strategy and will provide data on indicators and strengthen vital statistics registration in target districts. The MHIS will gather, analyze and evaluate data which will be used for decision-making at all levels of service delivery and management.

### **STRATEGY**

Given the large number of districts to be automated in this Task, it is necessary to phase the MHIS implementation in to the 65 target districts. The following phases will be included in this Task:

Phase I March 15, 1998-December 14, 1999 – 10 districts

Phase II December 15, 1999-December 14, 2000 – 30 districts (20 additional districts)

Phase III December 15, 2000-September 15, 2001 – 65 districts (35 additional districts)

The districts included in each phase will be selected so that entire governorates will be implemented, rather than spreading the districts among all governorates. This will allow for a more efficient deployment of resources and emphasizes the need for governorates to operate their MHIS as a unified system.

#### Activity No. 4.1 Assess and create an integrated and standardized nationwide Management and Health Information System

The strategy to accomplish this Task begins with a thorough assessment of the existing Management and Health Information System. This assessment includes an examination of the governorate, district and facility level system for data gathering, processing, reporting and dissemination. From the assessment, detailed needs will be determined in terms of equipment, site preparation, personnel, training, etc. A plan for each district will be produced using the information from the assessment. During Year One an assessment of 14 districts was conducted in Beni Suef, Aswan and Luxor. The results of the assessment presented a very low score for Aswan, while Luxor and Beni Suef scored at an acceptable level. During Year Two, additional districts will be assessed in Minya and Qena governorates.

Activities will continue from year one to coordinate with the National Information Center for Health and Population (NICHP). The Health Information System (HIS) unit from the HM/HC Project headed by Dr. Hala Safwat is in the process of being moved to the NICHP, where Dr. Hala will be the head of their Directorate Support Unit. This linkage will ensure that the new District Information Centers (DIC) and the upgraded Governorate Information Centers (GIC) will maintain harmonious working relationships with the NICHP. Furthermore, coordination efforts at all levels will emphasize the need for software application compatibility.

Concurrent with the assessment of district MHIS capabilities, other assessments will be taking place, including

- ◆ A study of the use of data in decision-making at various levels of the MOHP, and
- ◆ An investigation of the use of a Geographic Information System for reporting and data display and other related assessments

The objective of each of these assessments is to make recommendations for further development and action to contribute to the accomplishment of the Task. Data flow mechanisms, especially data collection from NGOs and facilities, shall be assessed in coordination with tasks 3, 7, and 10.

Activity No. 4.2 Assist the MOHP to set up 65 MHIS centers at district level

After assessments have been completed and district MHIS development plans created, the work of district level MHIS implementation begins. The Phase I objective is to have 10 District Health Information Centers (DIC) established by June 14, 1999. Phase II objective is to have an additional 20 DICs established by June 14, 2000. Phase II will not be accomplished in Year Two of the contract, but major implementation steps will take place during that time. Implementation activities in Year Two include:

- ◆ the signing of a Memorandum of Cooperation with each district/governorate health officer to specify each party's responsibilities,
- ◆ interface with NICHP,
- ◆ sites designated for DIC establishment will be selected and prepared to bring them into compliance with standards (see DIC standards in Annex G). The renovation requirements are limited in most cases to painting, adding electricity outlets, improving lighting conditions, telephone upgrades, etc. Renovations shall be finished by April 1999.
- ◆ personnel identified for each district and individual training plans developed which will bring them to the standard of performance required to operate the DIC,
- ◆ coordination with DT2 Project & Conduct Training for district staff,
- ◆ personnel trained according to individual training plans (training for MHIS staff concentrates on basic computer skills and data management skills). Training will start by March 1999 and be concluded by May,
- ◆ computer and associated furniture, equipment and supplies will be procured and installed
- ◆ software applications installed. Hardware and Software installations will start by end of April 1999.

During the implementation phase, field visits shall be conducted to the DICs to monitor data conversion and testing.

Governorate information centers will be upgraded as well, so as to overcome the problem of Year 2000. Moreover, training for staff will be conducted to upgrade their skills in managing and supervising the new DICs.

Activity No. 4.3 Design user friendly software for MHIS

A systems analysis survey will be conducted to define user requirements at district, governorate and central levels. The design of the software will be based on a Geographic Information System approach. Maps for Upper Egypt are collected and will be scanned to MapInfo software. A user friendly interface will be designed to allow users to drill down to data details using a mapping interface. Data collection will be based on HIS database standards. Currently, the system will be limited to satisfy the requirements of HM/HC monitoring activities.

Activity No. 4.4 Establish monitoring data collection mechanisms at facility and community levels

A supervisory system will be instituted which involves governorate-level monitoring of data flow from facilities to the DICs, and subsequently from DICs to the governorate level. The criteria for considering a DIC to be fully functional is the electronic submission to the governorate level of summary data from the facilities within the district for at least two quarters. These data should be accurate, complete and timely. Data received at the governorate level will be aggregated and forwarded to the central level. Further training and supervision will take place at facility, district

and governorate levels to encourage direct use of an appropriate set of indicators for planning and decision making at those levels. Phases II and III will essentially follow the same strategy, with the benefit of lessons learned during Phase I.

A monitoring system for HM/HC activities shall be assessed and developed. A complete set of indicators concerning mothers and children will be developed. The set of indicators will include diagnosing community health, assessing problems, evaluating alternatives, and monitoring interventions and plans. Coordination with MCH and NICHIP is required. Currently, a detailed study for developing the monitoring software based on geographic maps is in process.

### RESOURCES REQUIRED

- ◆ Each of the 65 target district DICs will require a computer, printer, modem, UPS and associated furniture, equipment and accessories
- ◆ Each DIC will require site preparation to ready it to house the DIC
- ◆ Software applications capable of processing the required data and producing appropriate reports will need to be developed
- ◆ Adequate MOHP personnel to staff each DIC
- ◆ Transportation and other tools to support the supervision of the DICs and the facilities submitting data to them
- ◆ Training courses and training materials
- ◆ Governorate Information Centers will require hardware and software upgrading to handle the data submitted to them by the DICs
- ◆ Technical assistance to assist with computer programming, commodity procurement, training, site preparation, equipment installation, organizational development, etc

### EXPECTED ACCOMPLISHMENTS

The following accomplishments will be achieved during the AWP period (March 15, 1999-March 14, 2000)

#### Performance Milestone

- ◆ Assist MOHP/NICHIP to establish 10 MHIS centers at the district level (in Aswan, Luxor and Beni Suef governorates)

#### Performance Target

- ◆ (None scheduled)

#### Major Benchmarks

- ◆ MHIS Assessments for selected districts, governorates and facilities in Minya and Qena completed by 12/15/99
- ◆ Site preparation and renovations will start by March 1999
- ◆ Training for MHIS staff concentrates on basic computer skills and data management skills. Training will start by April 1999
- ◆ Hardware and Software installations will start by end of April 1999
- ◆ MHIS Assessments for selected districts, governorates and facilities in Menya and Qena completed by December 1999
- ◆ Development of computer based monitoring system for HMHC will be finalized by September 1999

### COORDINATION

- ◆ Collaboration with the International Institute for Education – DT2 Project is required to organize all activities related to training for district staff working within MHIS centers

- ◆ The most significant coordination required is between JSI, NICHP and UNICEF. JSI is responsible for ensuring that the DICs are established in all 65 target districts, but UNICEF will support the implementation work in 35 of the 65 districts. These 35 districts are located within Sohag, Assiut and Minya governorates. It is anticipated that UNICEF will support the NICHP and specifically the MOHP task force, to establish the 35 MHIS centers.
- ◆ Collaboration with the newly re-organized National Information Center for Health and Population (due to the transfer of MHIS unit of HM/HC project to the NICHP) will be required to ensure that data flows properly from governorate to central level, and that the software applications used for decentralized data processing are compatible with the applications used at the central level. Uniformity of indicators and the definitions that delineate these indicators will need close coordination between central and decentralized levels.
- ◆ Close inter-task coordination is required with Task Three. That Task will require data provided by Task Four to perform meaningful planning at the district and community level. Moreover, Task Four requires the involvement of the various facility and community teams and committees that Task Three will form to perform the actions necessary to use the data collected and processed for planning and decision making. The data generated by Task Four will also benefit all other Tasks in the Results Package, because of this, those Tasks should be involved in defining and shaping the indicators that are fed by the data.
- ◆ Coordination with the CDC/FETP and the Data for Decision Making (DDM) activity will also be required.

#### CONSTRAINTS

- ◆ Currently data collected by the CSP-developed HIS is forwarded from the 27 governorates to the MCH department at the central level. The plan of the reorganized NICHP is to have that data submitted directly to the NICHP. To avoid difficulties with this change-over, considerable discussion, definition of roles, responsibilities and protocols will be required.
- ◆ UNICEF stated in an official meeting that they have not acquired any resources for the establishment of MHIS centers at the district.
- ◆ Governorate Information Centers are utilizing equipment provided in past years by the Child Survival Project. The equipment is based on 486 CPU technology and will have difficulty running the Windows NT environment data base applications that will be developed for use for the district information centers. These Governorate level computers require replacement with Pentium based CPUs. JSI shall provide target governorates with new computers.
- ◆ Rapid developments in information technology make the development of information systems a challenging endeavor. Sudden advances in software and hardware technologies, as well as communications improvements, make system design difficult. Today's high-flying machine soon becomes obsolete and relegated to the equipment graveyard. During the 3½ year span of the Results Package it is anticipated that technological advances may create problems as well as opportunities in utility and compatibility. JSI will keep abreast of this rapidly changing technological environment to ensure maximum flexibility and upgradeability of all equipment procured. Additionally, as much as possible a just-in-time procurement process will be used to ensure that equipment with maximum performance features is obtained, considering value-to-budget constraints.

## TASK FIVE: Research Activities

### PURPOSE

JSI, with The Johns Hopkins University (JHU), its major subcontractor for this Task, will develop a research agenda in consultation with the HM/HC technical research committee to address applied research needs that respond to implementation issues. These may include, but are not limited to, the following:

- ◆ Operations research to answer implementation issues not covered by the MotherCare pilot situational analyses,
- ◆ Needs assessment for additional clinical studies for established programs such as CDD and ARI,
- ◆ Knowledge, Attitudes and Practices (KAP) studies to develop or modify health education messages, and
- ◆ Surveys at the district level to gather data not routinely collected by the vital registration systems to respond to Results Package indicators and/or proxy indicators, and verbal autopsy surveys for mortality that may need to be done due to delay in reporting or to underreporting of the vital registration system

JSI will also oversee the conduct of a 1999/2000 National Maternal Mortality Study (similar to the 1992/1993 Egypt study) to monitor mortality trends

### STRATEGY

#### Activity 5.1 Assessment of current research needs: gaps in available clinical and operational information

- ◆ The purpose of research is to improve policy and practice. Investments in research are only useful if the results are applied and used to influence standards and overall project direction. JSI's research agenda will be focused on providing scientifically sound results to enhance the successful implementation of the HM/HC package. The research paradigm will employ a standard criteria to determine the appropriate fit of proposed research topics with HM/HC objectives
- ◆ Research will address operational issues, reveal weaknesses in project implementation, and investigate clinical areas affecting maternal and child mortality. Emphasis will be placed on collecting useful data that is directly related to health outcomes and the efficient functioning of a decentralized HM/HC implementation and management system
- ◆ As appropriate clinical and operations research is essential in effective program planning and implementation, JSI and its subcontractors are placing special emphasis on identifying critical areas of research related to the HM/HC Package. During JSI's annual retreat, held January 25-28, 1999, JSI and Johns Hopkins University staff worked on the research agenda, identifying many potential operational research topics. Four of these topics were identified as priority, and will make up the initial topics for study:
  - 1 Infection control practices in health personnel
  - 2 Provider and client perceptions of quality of services of specific facilities and providers
  - 3 Functioning and perceptions of the referral system
  - 4 Problem identification/solving methods for use at community, facility, district and governorate levels for Package of Essential Services
- ◆ JSI and JHU staff will continue their collaboration this year in defining additional operation research topics, which will total 12 by the end of the project

Activity 5.2 Development of research proposals and identification of departments and/or institutes to conduct the research

- ◆ Development of proposals for the four priority studies will begin in March 1999 with literature reviews and designs. The target completion date for the proposals is June 1999.
- ◆ Applied research will be institutionalized in the HM/HC Package through training of local staff in standardized research protocols. By using research findings in HM/HC program management, Egyptian staff will recognize the importance and usefulness of research information. Use of a standardized protocol will ensure that research is consistent and practical in the provision of reproductive and child health services.
- ◆ Research skills will be taught and research conducted at all appropriate levels of the HM/HC Package system. Local Area Groups (LAGs) established under the CSP will be reactivated to conduct local research related to cases of maternal and child mortality at the community level. Such information will greatly increase the capacity of the HM/HC project to reduce these critical indicators.
- ◆ Project stakeholders will be involved in research activities, and findings will be disseminated widely through the HM/HC management information system and public research conferences and workshops. In this way, research findings will be actively utilized for program modification and decision-making at all levels of the decentralized project structure.
- ◆ The following are the major activities to be completed in this Task:
  - 1 Continued assessment of current research needs: gaps in available clinical and operational information
  - 2 Development of research methodologies and protocols
  - 3 Training of appropriate staff in applied research methodologies
  - 4 Implementation of three operational research studies
  - 5 Identification of departments and/or institutes to conduct studies
  - 6 Design and implementation of 1999-2000 Maternal Mortality Survey
  - 7 Initializing of an on-going surveillance system for maternal mortality in Egypt

## **EXPECTED ACCOMPLISHMENTS**

### **Performance Milestones**

- ◆ 3 operational research studies implemented by December 15, 1999
- ◆ Design and implementation of 1999-2000 maternal mortality study

### **Performance Targets**

- ◆ None in this planning period

### **Major Benchmarks**

- ◆ Research needs assessment and priorities identified by the end of April 1999
- ◆ Development of the proposal for the implementation of the national maternal mortality survey by May 1999
- ◆ Development of guidelines to implement operational research by July 1999
- ◆ Implementation of the national maternal/perinatal mortality survey (pilot in June 1999) to start by 15<sup>th</sup> of September 1999

## **COORDINATION**

With tasks 1, 2, 3, 4, 6, 7, 8, 9 and 10 to identify and prioritize their research needs

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## **SUBRESULT 5 1 3: Established National Child Survival Programs Sustained**

There is one Task included in this Result

◆ **TASK SIX National Child Survival Programs Sustained**

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### **TASK SIX National Child Survival Programs Sustained**

#### **PURPOSE**

The child survival project has been very successful in achieving most of its objectives, with significant improvement in the health of Egyptian women and children. JSI and its sub-contractors will assist MOHP in sustaining the accomplishments of the CSP and integrate these accomplishments into the HM/HC strategy, especially the gains made in the areas of the Expanded Program of Immunization (EPI), Control of Diarrheal Disease (CDD), Acute Respiratory Infection (ARI), Neonatal Care, Model Clinics and training.

#### **STRATEGY**

In Year One of the contract, meetings were held with staff of various elements of the Child Survival Program. From these meetings an Analysis Matrix was developed which specifies the limited areas in which the Contractor will provide technical assistance. A copy of this Analysis matrix is included in Annex H. In contract Year Two, as a follow-on to this process, Task Six will assist the MOHP to form a steering committee comprised of major stakeholders to monitor and support the TA processes. Task Six staff will then organize workshops for representatives of MOHP at all levels to plan for successful integration of activities at district service delivery levels. These workshops will identify ways in which the HM/HC project can assist in facilitating decentralized planning and integration of the previous vertical programs into one comprehensive HM/HC service package. At the districts and delivery point levels, in cooperation with other tasks (Tasks One, Two and Three), the various components of the child survival program (EPI, ARI, CDD, neonatal care program, Daya training program) will be folded into one integrated HM/HC package of essential services.

#### Activity No 6 1 Strengthen immunization service

Task Six staff will work with EPI to achieve the end of contract performance target (EPI coverage rates maintained at 90% for all 25 target districts for seven vaccines). Polio eradication is a national goal during the year 2000, JSI will work with the EPI program to achieve this in the target districts. JSI, in collaboration with EPI, will review the immunization coverage in the target districts in an effort to sustain routine immunization rates at 90% of eligible children.

#### Activity No 6 2 Strengthen ARI & CDD programs

JSI will work on the Integrated Management of Childhood Illness (IMCI) through revision of the plan of implementation, editing and translation of the adapted materials into Arabic, printing and implementation of IMCI in pilot districts (Alexandria, Menoufia and Sohag), in addition to the coordination with other future activities of IMCI.

Activity No 6 3 Support the neonatal program

JSI will continue to support the neonatal care program through training of Master Trainers. Training of nurses will also be considered as one of the strategies during this year. Data collection organization and management will be reviewed, including integration of obstetric and delivery room records. Outcome data including death records will be reviewed. Supplying of neonatal units with selected equipment is an important strategies, and periodic assessment of these units will be encouraged. The neonatal unit assessment tool will be revised to include provision for three levels of neonatal care units.

Activity No 6 4 Strengthen the Daya Program

The Daya's role covers both urban and rural areas. In rural Egypt the Daya's role exceeds the role of a birth attendant, she has a more important and critical role to play and she is an influential part of the community itself. The strategy will involve revision of the training curriculum to train Dayas to perform safe normal deliveries, basic care of the newborn, referral of complicated cases, and 40<sup>th</sup> day postpartum visits, and to stop harmful practices like use of oxytocins. Monitoring of Daya performance and inclusion of supervision activities data into the information system of the health facilities is important and should be linked to Daya licensing. According to the CSP final evaluation, there are still 60 districts in which Dayas have not received basic training. Although the training of these remaining Dayas is included in JSI's contract, this activity may not be advisable, the MOHP is currently reviewing its Daya training policy, and may discourage training of additional Dayas since they may be replaced with a more highly qualified cadre.

**RESOURCES REQUIRED**

**Commodities** Some additional equipment is needed to supply the neonatal units in target governorates, for example, pulse oxymeters, CPAP apparatus, training dolls, training materials for IMCI, etc.

**Personnel** Task Six staff will work with a neonatology consultant to revise the training manual for physicians, rewrite the nurse's manual, and conduct some training courses. A research consultant is needed to help facilitate research activities, such as a study on resistance to antibiotics.

**EXPECTED ACCOMPLISHMENTS****Performance Milestone**

- ◆ Completion of Egypt-specific integrated sick child management plan by March 15, 1999
- ◆ Daya training program modified and ready for implementation by September 15, 1999

**Performance Target**

- ◆ None due during the AWP period

**Major Benchmarks**

- ◆ Workshop held to plan integration of CSP activities into HM/HC, report written and distributed by April 20, 1999
- ◆ First meeting of steering committee held by May 20, 1999 to guide and facilitate TA and CSP-HM/HC integration process
- ◆ 12-20 pediatricians trained in neonatal care and service delivery in US-based university, by June 30, 1999
- ◆ Upgraded Daya training course implemented in all 25 districts by February, 2000

practice and pre/in-service training system designed to disseminate standards for public and private providers

- ◆ Task Three Public and Private Providers in partnership with communities to develop and manage district plans
- ◆ Task Four Monitoring system in place to track utilization and impact and provide feedback

### CONSTRAINTS

- ◆ With the wide range of activities and multiple programs included in this Task, it will not be practical to work on all these activities simultaneously Therefore it is important to set priorities for programs to work with and to prioritize the activities within each program
- ◆ The MOHP may institute a policy which does not support the training of additional Dayas If this occurs, then JSI's contractual requirement to "expand the Daya Training Program to 60 districts not covered by the CSP" will need to be modified to relieve JSI of that requirement

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## **SUBRESULT 5.1 4: Increased Knowledge and Improved Health Behavior in Households**

There are three Tasks included in this Result

### **TASK SEVEN Better Social Community Services**

### **TASK EIGHT IEC Campaign**

### **TASK NINE SMIP Program**

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## **TASK SEVEN: Better Social Community Services**

### **PURPOSE**

- ◆ Improve community/household knowledge of and access to accurate and culturally appropriate health information
- ◆ Modify health behavior
- ◆ Create a demand on health providers and increase women's use of antenatal, delivery and postpartum services
- ◆ Provide better community services to increase coverage and mobilize resources for health care services
- ◆ Engender a sense of community ownership of health care services

### **STRATEGY**

#### Activity No 7 1 Establish Community "Interest" Groups

After identifying a multitude of local actors, the goal of this activity is to assist groups working on different health activities to begin making demands for health services. This activity will be implemented in close collaboration with activity No 7 2 below

#### Activity No 7 2 Inventory of Partners

A protocol to define, assess and identify community-based groups that could partner with health providers was developed and field tested in Aswan, Luxor and Beni Suef last year. The protocol, which includes a set of criteria of "good" partnership, will be used during the second year to look for potential partners in the remaining districts

#### Activity No 7 3 Development of a Community Needs Identification and Decision-Making Tool

A community needs assessment and decision making tool, to be used by the Community Health Committees, will bring the voice of the community, particularly those members of the community with greatest need, to the attention of program managers and policy makers. HM/HC will continuously emphasize the benefits of community involvement in decision-making on major issues related to health care

Activity No 7 4 Health Care Provider Sensitization

Heightening the sensitivity of health providers to community needs, beliefs and perceptions will help to involve them in practical communications with communities and build trust. In close collaboration with activities under Task Eight and Task Two, sensitization work will continue in the targeted district this year. Results and conclusions of research, studies and surveys will be translated into sensitization materials to raise the awareness of several levels of officials and health providers to community perceptions and beliefs.

Activity No 7 5 Testing Different Partnership Schemes

During the second year of the project, several different community/health provider partnership schemes will be implemented and monitored carefully, with the goal of refining two or three models that address the majority of community situations. If possible, a cost-benefit analysis will be conducted for each model.

Activity No 7 6 Implementation of the Most Promising Partnerships

At the end of this year, there will be an analysis of methods to see what truly makes a good partnership and how to make a difference in communities that are very isolated and have poor community infrastructure. Once the partnership method is refined, it should be possible to go forward with more certainty on community partnership work in additional districts.

Activity No 7 7 Community Education

A key strategy to improving community knowledge and health practices is to strengthen the knowledge base of community representatives so that they can influence local health care practices, create a demand on health providers, and increase the participation of women in health services. Working closely with MOHP and its staff, as well as outreach workers from other sectors, JSI will disseminate information on available health services. An initial step was taken last year by involving leaders at the district level in discussions on mobilizing communities to demand improved maternal services in Aswan and Luxor. This year will witness a shift to personal communications through women-to-woman support groups and child-to-child programs. Child-to-parent education will also be tried.

**RESOURCES REQUIRED**

- ◆ A consultant to revise the qualitative research instruments for community diagnosis that were used by MotherCare in Aswan and Luxor
- ◆ A consultant to utilize the revised instruments to conduct rapid qualitative research on community perceptions and practices in a sample of communities in Beni Suef, Qena and Fayoum

**EXPECTED ACCOMPLISHMENTS**

By the end of the second year of the contract, the following accomplishments are expected

**Performance Milestone**

- ◆ Need identification tool implemented in five communities (12/15/99)

**Performance Target**

- ◆ Community-Provider partnership services offered in 10 districts (3/15/00)

**Benchmarks**

- ◆ 66 Communities with active interest groups engaged in HM/HC (4/6/99)
- ◆ 150 health care providers/provider organizations participated in sensitization orientation (12/1/99)
- ◆ 66 community-provider partnerships established and functioning with health care (3/15/00)

- ◆ 66 areas where emergency obstetrical transport is available (3/15/00)
- ◆ 66 communities where key child survival actions including nutrition actions are available (3/15/00)
- ◆ 66 communities with HM/HC health communications activities underway (3/15/00)
- ◆ A priority list of potential community partners with health providers in Qena and Fayoum (6/22/99)
- ◆ A draft tool for community needs assessment and decision making developed (5/6/99)

**COORDINATION**

**Linkages with other tasks**

Below are the Task Seven activities that need to be closely coordinated with the Tasks indicated

Activity	In Cooperation With
Activity 2 Inventory of partners	<b>Task 10</b> To identify eligible NGOs for small grant program
Activity 3 Development of Community Needs Assessment Tool	<b>Task 1</b> The development of the tool will be oriented by the agreed upon HM/HC of Package <b>Task 3</b> The structure and functions of the CHCs will guide the development and utilization of the tool Synchronization and compatibility with the District Planning and Management Guidelines <b>Task 4</b> To include information on the community-based organizations that share common interests with HM/HC
Rapid qualitative Research	<b>Task 8</b> This activity will be conducted in coordination with this Task The results and conclusions will benefit the development of IEC strategy, health care provider sensitization and community education activities
Activity 7 Community education	<b>Task 8</b> This effort will be carefully orchestrated with the mass media efforts A package of community interpersonal communications materials to be used by community agents/leaders will be developed
All Task 7 Activities	<b>Task 4</b> To build key indicators into MHIS for monitoring activities at the community level

**Coordination with Outside Partners**

- ◆ Social Fund for Development (SFD) and its branches at the local level
- ◆ Ministry of Social Affairs (MOSA) and its Departments at the local level
- ◆ National and Regional Federation of NGOs
- ◆ Ministry of Rural Development
- ◆ Secretariat General for Local Administration
- ◆ NCNW-USAID Supported Umbrella Grant Program
- ◆ Key international and national NGOs working in Egypt
- ◆ Key bilateral donors (DANIDA, GTZ, etc )
- ◆ Key multilateral donors (UN, EU, WB, etc )

**Constraints**

- ◆ The process of identifying community organizations that could partner with health providers has revealed that most of the NGOs that provide health service are licensed as providers of services without complete compliance with the conditions, rules and regulations of the MOHP. Furthermore, they are practicing in the absence of technical supervision of the Department of Health. Establishing partnership schemes will require strengthening the Department of Free/Private Practice to provide support to these schemes.
- ◆ Delay in setting up the management structure of the project at the different levels, including the Community Health Committees, has resulted in a delay in the development of official forums to establish and galvanize cooperation between health providers and community – based groups.
- ◆ Lack of community and household-level interpersonal communication materials that suit the different community groups is a critical issue that will be addressed early this year through reviewing previous work and filling in gaps.

## TASK EIGHT: IEC Campaign

### PURPOSE

The purpose of this task is to stimulate appropriate demand for and utilization of preventive and primary level curative maternal and child health services. In addition, this task will promote new perceptions and practices that will reduce the need for sophisticated and costly curative services. The task will be undertaken through a comprehensive approach that encompasses training providers and health educators to upgrade their counseling and motivating skills. In addition, informative materials for providers and clients/patients will be produced and replicable models developed for governorate and district initiatives. Furthermore, the judicious use of mass media will increase clinic attendance and promote other key behavior changes.

### STRATEGY

To implement this task, JSI will use state-of-the-art communication methods which carefully segment audiences, define feasible behaviors, and base a comprehensive behavior-change strategy on a thorough understanding of audiences' perceptions and practices. This task involves nine activities.

#### Activity No. 8.1 Reinforcing MOHP-SIS Collaboration

- ◆ A tentative agreement has been reached with the USAID COTR to replace the arrangement with the State Information Service (SIS) referred to in the contract statement of work (pending Contracting Officer approval). The potential agreement with SIS would be replaced with a direct relationship with the MOHP to produce the required IEC activities and materials.
- ◆ During the second contract year, some of the MOHP IEC personnel and health educators will undergo refresher IEC training, as well as selected senior and mid-level managers. This group will attend the annual IEC interactive training/workshop at the Johns Hopkins University Center for Communication Programs.
- ◆ An IEC working group will be formulated under this activity to further the development of a consensus among all partners working in the field of maternal and child health in Egypt. This group will be formed under the HM/HC Steering Committee. It will be responsible for coordination of various HM/HC IEC activities at both central and local levels.

#### Activity No. 8.2 Inventory of existing IEC Resources

This activity, which was completed during the first year of the HM/HC results package, involved a rapid assessment of existing Child Survival and Safe Motherhood print and mass media materials. This inventory was a crucial initial step in identifying IEC materials for the promotion of HM/HC services and behaviors.

#### Activity No. 8.3 Investigation of Behavioral Information

This activity, which involves a thorough understanding of current health care behavior, is the first step towards development of a National IEC Strategy. A communication strategy will be built on qualitative and quantitative research. This activity started during the first year of the project with a literature review of practices related to maternal and child health. During the second year, small scale research will be conducted in the target governorates, in coordination with Task Seven and the Community Specialist, to help identify current behaviors, reasons behind those behaviors and motivations to adopt more health-promoting behaviors.

Activity No 8 4 Strategic Design for Health Communication

Along with the previous activity, this activity aims to design an overarching communication strategy to support HM/HC service delivery To complete this activity, the following steps are necessary

- 1 Drafting a "Comprehensive Overarching Communication Strategy" This strategy will include specific proposed message strategies for mass media, print media, and community and household level interpersonal communication materials Input on this draft strategy will be solicited from other collaborating organizations
- 2 Communication with communities and health providers is essential to identify appropriate local communication strategies, activities, materials, channels/agents This will involve development of a forum to share local research results/conclusions with community groups and health providers The community/provider input will be incorporated into development of community component of national communication strategy

During this year, JSI will formulate the IEC working group (mentioned under activity No 8 1) This group will hold a continuous dialogue for development of a communication strategy that promotes healthy behaviors for maternal and child health To strengthen this working group additional maternal health communication experts will be recruited if required Successful implementation of this strategy will depend on continuous communication with counterparts involved in its implementation, such as MOHP, UNICEF and Wellstart

Activity No 8 5 IEC Training of Health Providers and Field Workers

IEC will work closely with Tasks One and Two to improve training in counseling and interpersonal communication During this year, the contractor will develop a protocol as well as various modules to improve such training In addition, and in close collaboration with Task Seven, a series of orientation workshops will be conducted at the local level These workshops will include health workers, NGOs and local influentials The purpose of these workshops is to actively involve locals in designing an IEC strategy that addresses local needs

Activity No 8 6 Print and Audio-Visual Materials for Providers and Their Clients

Production of support IPC materials is one of the major activities during this year These materials will build on previous experiences in Egypt as well as the national strategy developed under activity No 8 4 The materials will be designed, pretested and distributed in accordance with state-of-the-art communication methods and in coordination with both Tasks three and seven Mass and interpersonal media will be mutually supporting in implementing the National IEC Strategy JSI will follow the appropriate methodologies and techniques to produce communication materials that help disseminate maternal and child health messages

Activity No 8 7 Develop Community Support for Essential Behaviors and Services

At the governorate, district and village level, health-focused community participation interventions will play an important role A number of small grants described in Task Ten will go to NGOs for the implementation of innovative IEC interventions to complement the public sector program in the governorates and districts During this year's implementation plan, some of these NGOs will be identified JSI is planning to support these NGO with the appropriate training and technical assistance to be able to develop grant proposals for various IEC activities at the local level These local IEC initiatives will be coordinated with Tasks three, seven and ten

Activity No 8 8 Develop Demand Generation Campaign for HM/HC Services and Essential Behaviors

HM/HC will use high-visibility national campaigns and regional initiatives to increase the practice of positive health behaviors, enhance the image of health services and providers, and stimulate the demand for quality services where they are available. The first national demand generation campaign will be designed and implemented during this year.

Activity No 8 9 Promotion of Quality Services-the Gold Star Approach

During this year, JSI will explore the option of appending the Gold Star to the HM/HC logo for clinics that meet the predetermined criteria for quality. This initiative will be in close collaboration with MOHP, Task Three and the quality assurance consultant. During this year and in close collaboration with MOHP, JSI will develop and pretest the IEC Gold Star module. A pilot IEC Gold Star Initiative will be implemented towards the end this year.

Activity No 8 10 Female Genital Mutilation

Although this the IEC campaign against FGM will not start during this year, JSI is planning to collect relevant research and literature conducted in Egypt in relation to FGM. In addition, JSI is planning to be in continuous dialogue with its counterparts regarding their prospective FGM IEC activities. This will help establish grounds and develop consensus regarding this activity for its implementation during the third year of the project.

**RESOURCES REQUIRED**

A wide variety of resources will be required for fulfillment of this task, the following is an illustrative list.

**Commodity Requirements** For effective design and implementation of different IEC activities, each field office established under the project will have a video display set (television and multi-system VCR), a slide projector, and a screen for film projection during community meetings. The JSI headquarters will also include a video camera, video display set, a digital camera as well as professional camera, slide and film projectors, a cassette recorder/player, a scanner, a large screen and a data show for presentations.

**Personnel Requirements** The design, production and implementation of various IEC activities will require technical support from both local and international institutions/consultants. It is suggested that an IEC subcommittee be formed under the HM/HC steering committee. This committee will be responsible for coordination of various HM/HC IEC activities at both central and local levels.

**Training Requirements** IEC activities are broadly divided into mass media and interpersonal communication activities. Development and implementation of effective interpersonal communication activities will require training of key persons at the district level in communication and motivational skills. Two types of training will be conducted, the first is training of service providers as part of the EOC package, and the second would be the IEC orientation for all health educators, influentials and community outreach personnel.

**EXPECTED ACCOMPLISHMENTS**

During the current AWP period, March 15, 1999-March 14, 2000, the following accomplishments will be realized.

**Performance Milestone**

- ◆ National IEC strategy developed by June 15, 1999

**Performance Targets**

- ◆ None due during AWP period

**Major Benchmarks**

- ◆ IEC training package completed by April 11, 1999
- ◆ IEC orientation package completed by November 23, 1999
- ◆ 300 health educators, local influentials and others are trained by February 23, 2000
- ◆ 2,000,000 print materials produced by January 20, 2000
- ◆ Decision made about inclusion of the Gold Star approach by May 13, 1999

**COORDINATION**

- ◆ This task consists of two major components mass media and interpersonal communication To reach out to people, continuous coordination with both public and private sectors from national to district levels is crucial
- ◆ To design and implement mass media activities, coordination and close collaboration is required with the Ministry of Health, the Ministry of Information (the State Information Service and the Television Union) and local channels of television and radio working in Upper Egypt
- ◆ To conduct effective interpersonal communication activities, two levels of coordination are essential The first level of coordination is with other tasks under the HM/HC results package These tasks are mainly the first, third, seventh and tenth The second level of coordination is among other agencies conducting or planning IEC activities at both national and local levels Among these agencies are UNICEF, Well-Start and USAID results packages with IEC activities, e.g. Family Planning/Population III project
- ◆ Furthermore, coordination with consultants working for other tasks is crucial to identify common areas of interest and accordingly best use human resources This coordination would be necessary with tasks 1, 7 and 10

**CONSTRAINTS**

To execute this task, two types of constraints should be considered

- ◆ According to previous discussions with USAID, we believe that the involvement of the MOI/SIS is taking a different form and strategy JSI needs to get a clear understanding from USAID regarding the exact arrangements and time schedule to replace the SIS role and responsibilities
- ◆ Provision of free Airtime is crucial for successful implementation of this task The MOI were able to provide such free Airtime under several family planning projects in the past If MOI will not be involved in program implementation, an alternative strategy will be required to minimize cost implied in case of payment of Airtime

## **TASK NINE. Student Medical Insurance Program**

### **PURPOSE**

The Student Medical Insurance Program (SMIP), an expansion of the National Health Insurance Organization, provides comprehensive preventive and curative services to enrolled students. The purpose of task nine is to expand several of the critically important HM/HC activities to adolescent girls in the targeted districts and in so doing to influence SMIP national policy and provide long-term benefits to the participating adolescents. These benefits would include improved iron status and better health and nutrition knowledge and practices for boys and girls and improved immunological status for girls.

### **STRATEGY**

The strategy to accomplish the policy and program changes related to adolescent health is to begin with the SMIP and review their policies and programs nationally but then gradually incorporate other organizations working on adolescent health issues in the dialogue. Prior to pilot implementation, studies will be conducted in each component to clarify technical and operational issues. Upon completion of the studies, the scope of each activity will be refined and a strategy developed to guide the pilot implementation in one governorate. After pilot implementation HM/HC will work with the SMIP to analyze the results of the pilot. Each target governorate will then carefully analyze implementation requirements and conduct pilot programs in target districts. A sentinel school program will be developed to monitor the implementation and effectiveness of the 3-prong program.

However, the strategic policy work cannot reside solely in the HIO/SMIP. The MOHP and MOE will be brought into the discussions early on, as the health guidelines need to be in harmony with MOHP policy, and school-based activities could effect the MOE. This dialogue will be accomplished via an MOHP-sponsored national workshop to develop an integrated strategy for the health of all adolescents. This workshop would include research organizations, GOE, NGOs and other organizations working in communities, thus expanding policy changes and services tested with the SMIP to those adolescents not attending school.

#### Activity 9.1 Preventive services, especially health education

The strategy is to train SMIP staff to provide non-formal education to adolescent girls and boys related, initially, to the preventive nutrition services provided for anemia control, and then to add concepts as needed or requested by the adolescents or that emerge as key health concerns. Specific behavior-based messages will be determined by qualitative research conducted on nutrition in general and iron-related issues specifically. An educational strategy will then be developed and pilot education materials will be created.

#### Activity 9.2 Anemia control program

For anemia control the strategy is to conduct periodic de-worming when indicated and to deliver iron-folate pills to adolescent girls and boys in preparatory and secondary school throughout the school year. Prior to full implementation, a weekly supplementation program will be conducted to clarify operational issues and then the program will be piloted in one governorate. During that pilot a small efficacy study will also be conducted.

#### Activity 9.3 Tetanus Toxoid (TT) immunizations

The tetanus immunization scheme would follow the WHO guidelines, and protocols will be developed for the SMIP to provide secondary-school-age girls in the target governorates with three

boosters for tetanus and diphtheria immunity thus fully immunizing them

### **RESOURCES REQUIRED**

This task enters the implementation phase during this annual plan, it is essential to have two additional staff and an approved PIL budget supporting the activities. JSI will be hiring an Implementation Supervisor to work with the task manager. However, essential to the implementation of this field-based intervention is an additional staff person for Dr Rawia, Director of the Preventive Health Program of the SMIP. Since the national SMIP, Preventive Health office, will be involved in the research, policy changes, training, supervision and monitoring during the life of this task, an additional staff person funded under the PIL budget is essential.

### **EXPECTED ACCOMPLISHMENTS**

During the current AWP period, March 15, 1999 - March 14, 2000, the following accomplishments will be realized

#### **Performance Milestone**

- ◆ None during this period

#### **Performance Target**

- ◆ A health and nutrition education program and an anemia control program for adolescent girls shall be developed and implemented nationwide under the SMIP by the end of year 2

#### **Major Benchmarks**

- ◆ Nutrition education research completed to support the anemia control activity (5/30/99)
- ◆ Operations research completed resulting in a refined iron supplementation protocol (5/30/99)
- ◆ A strategy for adolescent girls shall be developed to ensure that they receive 3 TD immunizations during secondary school (5/30/99)
- ◆ Pilot implementation of all three components completed (January 2000)
- ◆ Completed operational plans for 5 governorate implementation (March 14, 2000)

### **COORDINATION**

- ◆ GOE, donor and NGO coordination will be facilitated through the workshop on adolescent health scheduled for March
- ◆ Frequent dialogues with others working in adolescent health in Egypt and iron supplementation worldwide are integral to this task
- ◆ Within HM/HC there is coordination with work underway in the maternal health package on anemia policy for women, with Task 7 focused on services at the community level and with Task 8 on communications

### **CONSTRAINTS**

- ◆ USAID has informally agreed to extend the period of completion for this Task to the end of the first option period for the contract (September 15, 2001) and to modify the implementation to the five target governorates, which is consistent with the HM/HC initiative. A contract modification is needed so that performance and contractual requirements are consistent. In addition, in order to provide the technical expertise required to maintain a quality deliverable, additional funds will be needed for this task
- ◆ A potential constraint may be the commitment of personnel and resources that the HIO can make available for this work. Lack of resources on their part may necessitate an Implementation Letter to assist the HIO with funds for implementation. An additional staff person for Dr Rawia to ensure that the program is successfully implemented in the field is essential

- ◆ The education component requires the development and duplication of educational materials. The target for this task is over 800,000 adolescents and while the proposed education further narrows the audience, the cost of providing materials for adolescents once during preparatory and secondary school are still high. A PIL budget line item or other earmarked funds are essential for this component to be successful.

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## SUPPORTING ACTIVITIES

There are two supporting activities

### **TASK TEN Small Grant Program**

### **TASK ELEVEN Commodity Procurement Program**

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## **TASK TEN: Small Grant Program**

### **PURPOSE**

The purpose of Task Ten is to provide funding and technical assistance for community activities in the target districts via a program that will provide grants to small Non-Governmental Organizations (NGOs) that are (or have potential for) working in areas complementary to the Healthy Mother/Healthy Child Package of Essential Services (HM/HC PES). This program will support and strengthen the capacity of these NGOs by developing their institutional, management and fund-raising skills so that these organizations will mature and become self-sustaining. The NGOs already working in target areas need reinforcement to more effectively meet community needs in health care.

### **STRATEGY**

The previous work of umbrella organizations in Upper Egypt (such as National Council of Negro Women "NCNW" and CARE International) will be assessed in order to develop lessons learned. The proper and effective utilization of the activities and resources of the NGOs should be based upon a needs identification exercise completed by the Community Health Committees who will use an assessment tool to identify their own community needs. Local solutions will be identified that will involve NGOs and the use of their strength and capabilities to help achieve the target results. Once needs are identified, workshops will be conducted for the NGOs, the objectives of these workshops will be to

- ◆ Introduce NGOs to the benefits of the HM/HC PES,
- ◆ Explain the expected requirements for offering the HM/HC PES,
- ◆ Work through the process of integrating the HM/HC PES into the NGOs current programs (activities),
- ◆ Present the CHCs identified needs, local solutions, and request NGOs' proposals for implementing these solutions, and
- ◆ Distribute the Invitation for Application (IA) for HM/HC grant funding and give guidelines on how to develop a project proposal and a proper budget

NGOs will be given a month to prepare a proposal that shows a problem statement (based on a needs assessment and preferably statistics), the target beneficiary group and the strategies and activities to be carried out to address and resolve the identified problem.

Through a selection process, a committee will review, refine and evaluate both the proposal and the NGO for final acceptance, award and contract.

JSI will monitor the recipient NGOs' performance in regard to the grant activities, both technically and financially.

JSI will also work with district level NGOs and the MOHP to increase the flow of public health information to the grant recipient NGOs

**EXPECTED ACCOMPLISHMENTS**

As explained in the Constrains section below, authority to issue small grants has not ben received from USAID at the time of submission of this AWP (February 15, 1999) Accordingly, it has been determined that the achievement of the Milestone of 20 small grant awards will take 36 weeks from the time of receiving such authority The table presenting the benchmarks below indicates the number of weeks from the authority to issue the small grants that the benchmark will take to accomplish

**Performance Milestone**

- ◆ 20 small grants awarded to NGOs in the target districts by October 15, 1999

<b>Benchmark</b>	<b>Number of weeks required to accomplish</b>
Review & Evaluation Panel for grant giving formed and approved by USAID	1
Grant award contract and annexes template developed and approved by USAID	2
Eligibility & Selection Criteria for NGOs to receive grants developed and approved by USAID	3
Letter from MOHP to MOSA to legitimize and facilitate our approach with NGOs sent	3
Invitation for Applications template developed and approved by USAID	5
Assessment of current and previous grant programs completed and workshop for lessons learned conducted	5
Workshop for selected NGOs to introduce the program & the HMHC PES, and to request applications conducted in Aswan & Luxor	12
Identification & assessment of potential NGOs partners in Qena and Fayoum completed	22
20 grants awarded in Aswan & Luxor	36
Workshop for selected NGOs to introduce the program & the HMHC PES, and to request applications conducted in Beni-Suef	44

**COORDINATION**

- ◆ Close coordination will take place with Task Three (Providers in Partnership with Communities), Task Seven (Better Social Community Services), and Task Eight (IEC Campaign) in order to identify and provide support to NGOs who would qualify as partners to those tasks' activities
- ◆ Further coordination will take place with collaborating organizations such as NCNW, Project HOPE and CARE International to benefit from their previous experiences in grant giving in Upper Egypt

- ◆ Additional coordination will take place with the USPVO umbrella that will give sub-grants to medium and large Egyptian NGOs when it is awarded and implemented

**RESOURCES REQUIRED.**

- ◆ STTA such as NCNW
- ◆ Overhead projector and data show

**CONSTRAINTS**

- ◆ The agreement between JSI and USAID concerning grants under the contract has not been finalized by USAID. We have been able to begin preparatory administrative work on the grant program, but will not be able to approach any NGO in Upper Egypt regarding grant opportunities until the agreement is executed
- ◆ Coordination with the USPVO umbrella is not possible, as the USPVO grant is not yet awarded

## **TASK ELEVEN: Commodity Procurement Program**

### **PURPOSE**

The purpose of Task Eleven is to procure commodities that will support HM/HC activities in Upper Egypt at the central, governorate, district, facility and community levels. Estimated at \$6 million for the contract base period, the commodities to be procured include, but are not limited to, vehicles, clinical, medical, office, IEC and computing equipment. Most of the procurement will be done in the U S. The procurement of the correct equipment in the right quantities, and the delivery of the commodities to the right place at the right time, is essential for the successful implementation of each Task. Under Task Eleven, special emphasis will also be made to train staff who are the intended users of the equipment in its proper purpose, operation, and maintenance. In-house systems to monitor and track the entire procurement process have been developed and shared with the MOHP.

### **STRATEGY**

- ◆ The Commodity Procurement Program is providing equipment necessary to achieve the results of the contract. There will be close coordination between the Procurement Team (Task Eleven) and the other ten Task Teams. The individual Task Teams are responsible for assessing the commodity needs at the central, governorate, district, facility, and community levels that will ensure successful completion of their Tasks. The individual Task Teams will then work with the Procurement Team to develop and refine technical specifications.
- ◆ Using the lists of procurement needs from each Task, the Procurement Team developed a Life-of-Contract Procurement Plan and schedule during the first Contract Year. The Procurement Plan included a budget for commodities to be procured and a procurement schedule. The Procurement Plan was submitted to USAID for approval. Further discussion with USAID indicated that expendable supplies would be procured by the PIL. This led to a revision of the Procurement Plan. Further revisions are anticipated in response to facility assessments and the submission of MOHP and community-level plans. The Procurement Plan will be officially revised on a semi-annual basis to reflect any changes and submitted to the USAID Contracting Office for approval. Semi-annual reports on the status of procurements will also be produced and submitted to the USAID COTR.
- ◆ TransCentury Associates (TCA) will conduct the actual procurement of commodities. For each category of commodity, TCA has established a procurement cycle that includes all required steps from identifying potential vendors to the distribution and installation of the commodity to the recipient location. Large procurements including several different categories of commodities are currently scheduled on a quarterly basis to allow for consolidation both on the US side and in deliveries to the recipient locations.
- ◆ In order to ensure that procurement is done in a systematic and timely fashion and to assist in the improvement of procurement practices within the Ministry, an in-house computerized tracking system will be developed and installed on HM/HC computers. The system will monitor and track the entire procurement process. This system will be linked to HM/HC MHIS and will provide up-to-date information at all levels of HM/HC down to the district.
- ◆ The procurement of project commodities is to be completed in the three phases:
  - ◇ 15% of commodities to be procured by September 15, 1999
  - ◇ 50% of commodities to be procured by September 15, 2000
  - ◇ 100% of commodities to be procured by September 15, 2001

**EXPECTED ACCOMPLISHMENTS**

During the current AWP period, March 15, 1999-March 14, 2000, the following accomplishments will be realized

**Performance Milestone**

- ◆ Procurement of 15% of commodities by 9/15/99

**Performance Targets**

- ◆ None during this AWP period

**Major Benchmarks**

- ◆ Development and installation of a computerized procurement tracking system by 3/1/99
- ◆ Submission of JSI HM/HC Semi-Annual Procurement Plan and Semi-Annual Procurement Status Report by 3/15/99
- ◆ Submission of JSI HM/HC Semi-Annual Procurement Plan and Semi-Annual Procurement Status Report by 9/15/99

**COORDINATION**

- ◆ Close coordination will take place with all Task Teams to ensure that the proper commodities are procured and delivered at the right time to ensure successful implementation of task activities
- ◆ Coordination with the MOHP and other USAID funded partners will also take place to develop commodity specifications and to ensure that there is no duplicate procurement of equipment

**CONSTRAINTS**

Finalization of the revised Life of Contract Procurement Plan was delayed and therefore some of the Year One commodities will not arrive in Cairo as originally scheduled. Special emphasis is being placed on completing the procurement for these commodities as soon as possible and to begin the procedures necessary for procurements in Year Two. Despite the delay, the performance milestone of procurement of 15% of commodities will be completed.

**ILLUSTRATIVE LIST OF COMMODITIES FOR YEAR TWO PROCUREMENT****District and Governorate Health Information Centers**

- ◆ Computers, printers, modems, Zip drives, UPSs, surge protectors, software, air conditioners

**District Hospitals/Basic Centers**

- ◆ Major medical equipment, medical tools, medical furniture, medical supplies

**District and Governorate Health Offices**

- ◆ Air conditioners, fax machines, photocopier machines, vehicles

**District Resource Centers and Governorate Training Centers**

- ◆ Overhead projectors, screens, slide projectors, TV monitors, video cassette recorders, abdomen models, newborn models, newborn resuscitation kits, pelvis models

**HIO/SMIP Centers**

- ◆ HemoCue blood analysis equipment, disposable cuvettes
- ◆ Computers, printers, modems, Zip drives, UPSs, surge protectors, software

**Medical/Nursing Schools**

- ◆ Overhead projectors, screens, slide projectors, TV monitors, video cassette recorders, abdomen models, newborn models, newborn resuscitation kits, pelvis models

## **Contract Administration**

### **PURPOSE AND STRATEGY**

The purpose of Contract Administration is to create internal management and administrative systems and processes that assure responsiveness, quality, productivity, and cost-effectiveness. The Administration Team will facilitate the work of all Tasks while ensuring contract compliance.

The Administration Team has established a personnel management system that includes clearly defined staff roles and responsibilities and standards and protocols for personnel issues and actions. The Administration Team has set up an orientation packet to train new staff on office policies and procedures and to introduce him/her to technical documents related to the JSI HM/HC Results Package.

The Administration Team manages the accounting system, both in the Cairo office and in the field offices of Upper Egypt, ensuring financial compliance with USAID and JSI rules and regulations. In an effort to streamline the accounting department, the accounting system used by JSI HM/HC was transferred in Year One from a manual "one-write system" to an automated system using QuickBooks Pro.

Expenditures are tracked by Task and proper invoices are submitted in a timely manner for processing. The Administration Team also monitors the budget per the budget obligations and produces financial reports. Inventory is tracked and a system is set up to produce the "Report of Government Property in Contractor's Custody" for submission to USAID on an annual basis.

Administration and monitoring of subcontractor services is also conducted by the Administration Team. Subcontracts for Arabic Software Engineering Incorporated, Clark Atlanta University, The Manoff Group, Inc., and TransCentury Associates were drafted, approved by USAID, and finalized in Year One. A subcontract for Johns Hopkins University will be finalized in the first quarter of Year Two. Local subcontracts between JSI and research organizations such as SPAAC are also written and administratively managed by the Administration Team. Subcontractor technical and financial reports are reviewed on a regular basis and a system for monitoring subcontractor technical performance and the achievement of contract milestones has been developed.

The Administration Team also conducts the administrative management of consultants. Required travel approvals are processed in advance and submitted to USAID for approval. Consultant trip reports are finalized, recorded in the consultant database, and available to be forwarded to USAID and/or collaborating partners upon request.

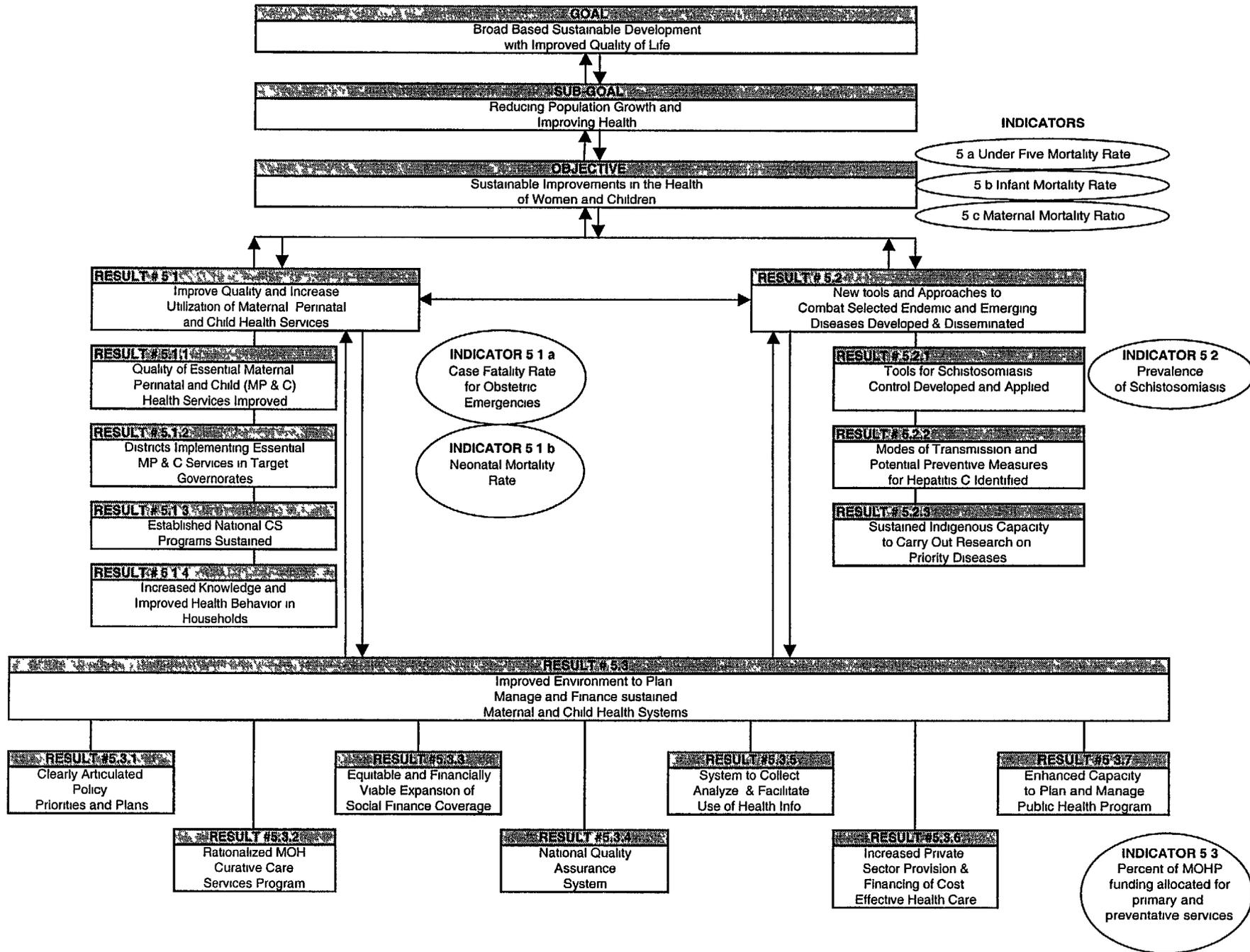
The Administration Team is also responsible for the compilation and production of the Quarterly Performance Monitoring Reports and Annual Workplans. The Administration Team works in close collaboration with the Task Managers and the JSI HM/HC Management Team to ensure that the required reports are submitted according to the contract schedule.

The coordination of work planning meetings is also the responsibility of the Administration Team. These meetings are scheduled to be held on an annual basis and will include representatives from JSI, the five subcontractors, USAID, MOHP, and collaborating organizations. The first JSI HM/HC Orientation and Planning Retreat was held in June, 1998. The second Annual Workplanning Retreat was held in January, 1999. Annual meetings are also scheduled for the end of Year One and Year Two.

# **ANNEX A**

## **USAID Results Framework**

# RESULT FRAMEWORK SO5



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# **ANNEX B**

## **JSI Contract Framework**

# Healthy Mother/Healthy Child Results Package

## GOAL

To improve quality and increase utilization of maternal, perinatal, and child health services

### Quantitative Objectives for Target Districts by 2001

- 20% decrease in infant mortality rate
- 15% decrease in neonatal mortality rate
- 15% decrease in child mortality rate
- 40% decrease in maternal mortality ratio

### QUALITATIVE OBJECTIVE

Improve the quality, effectiveness, and use of reproductive and child health services in public/private health facilities and households with emphasis on high-risk regions through the achievement of the following six process outcomes

#### Process Outcomes from JSI HM/HC Activities

1	All twenty five HM/HC supported districts will become capable of planning monitoring budgeting organizing delivering and partially financing their own integrated quality reproductive and child health services Public and private health units in these districts will be providing the essential HM/HC package and community health education programs	2	Household members particularly women in the twentyfive HM/HC districts will have increased ability to provide and seek appropriate health care for themselves and their children through social mobilization	3	The MOHP will have enhanced capacity nationally to set standards policy and management systems for cost effective reproductive and child health services It will have consolidated its management and health information system (MHIS) so that all data essential for monitoring and management are collected while reporting burdens on service delivery units are minimized Planning budgeting supervision and support to districts at the governorate level will also be strengthened	4	Medical and nursing school graduates will have improved skills and knowledge for delivering the HM/HC package through the strengthening of curricula and training programs at all undergraduate health professional schools and the programs of a national breastfeeding training center This activity will include all 13 medical schools in Egypt and all nursing schools in the target governorates	5	National mass media campaigns will have increased popular awareness of and demand for essential reproductive and child health services and avoidable health risk behaviors	6	Established national child survival programs shall be sustained These include EPI ARI Control of Diarrheal Diseases Neonatal Care and Daya Training
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#### Quantitative Outcomes for National Level Indicators

Indicator	Definition	Baseline	Baseline Year	Target (year 2001)	Percent Change
Under five mortality rate	(# of deaths of children < 5 years of age in a given period / # of children < 5 years of age in the same period) x 1 000	85	1992	73	14%
Infant mortality rate	(# of deaths of children < 1 year of age in a given period / # of live births in the same period) x 1 000	62	1992	53	15%
Maternal mortality ratio	(# of deaths from puerperal causes in a given area during a given period / # live births in the same area and period) x 1 000	174	1992	139	20%
Neonatal mortality rate	(# of deaths of infants < 28 days in a given area during a given period / # live births in the same area and period) x 1 000	33	1992	27	18%
Case fatality rate for obstetric emergencies	(# of deaths from obstetric emergencies in given area during a given period / # obstetric emergencies in the same area and period) x 1 000	47%	1992	35%	12%
Women receiving prenatal care	# of women receiving ≥ 4 prenatal visits in a given area during a given period / # live births in the same area and period	22%	1990	70%	+52%
Children fully immunized before 1st birthday	# children fully immunized < 1 year of age in a given period / # of live births in the same period	67%	1992	90%	+13%
Number of indigenous confirmed polio cases	Count	71	1995	0	100%
Neonatal tetanus cases	Count	790	1995	200	75%
Newborns exclusively breastfed for 4 5 months	# of newborns exclusively breastfed for 4 5 months in a given period / # of children aged >5 months and < 10 months in the same period	29%	1992	75%	+46%
Target districts implementing essential services	Count	0	1995	65	Undefined

## Strategic Objective 5 - Sustainable Improvements in the Health of Women and Children

### Intermediate Result 5 1 – Improve Quality and Increase Utilization of maternal, Perinatal, and Child Health Services

Subresult 5 1 1 Quality of Essential Maternal, Perinatal and Child (MP&C) Health Services Improved		Subresult 5 1 2 Districts Implementing Essential MP&C Services in Target Governorates			Subresult 5 1 3 Established National Child Survival Program Sustained	Subresult 5 1 4 Increased Knowledge and Improved Health Behavior in Households			Supporting Activities	
<b>Indicators of Achievement</b> <ul style="list-style-type: none"> <li>Percent of pregnant women receiving 4 or more prenatal examinations in a health facility by 2001</li> <li>Proportion of living children between the ages of 12 &amp; 23 months fully vaccinated before the first birthday with DPT (3) Polio (3) Measles, TB and Hepatitis B (3) by 2001</li> </ul>		<b>Indicators of Achievement</b> <ul style="list-style-type: none"> <li>Number of districts implementing essential Maternal Perinatal and Child Health Services in target governorates by 2001</li> </ul>			<b>Indicators of Achievement</b> <ul style="list-style-type: none"> <li>Number of confirmed indigenous polio cases by 2001</li> <li>Number of neonatal tetanus cases by 2001</li> </ul>	<b>Indicators of Achievement</b> <ul style="list-style-type: none"> <li>Percent of infants exclusively breastfed for the first 4 5 months of life by 2001</li> </ul>			<b>Indicators of Achievement</b> <ul style="list-style-type: none"> <li>None identified in contract</li> </ul>	
TASK 1 ES Package/ Standards Definition	TASK 2 Design of Training System and Inclusion of ES Package/ Standards in School Curricula	TASK 3 Public and Private Providers in Partnership with Communities to Develop and Manage District Plans	TASK 4 Monitoring System in Place to Track Utilization and Impact and Provide Feedback	TASK 5 Research Activities	TASK 6 Established National Child Survival Programs Sustained	TASK 7 Better Social Community Services	TASK 8 IEC Campaign	TASK 9 SMIP Program	TASK 10 Small Grant Program	TASK 11 Commodity Procurement Program

### Milestones and Targets for Healthy Mother/Healthy Child Results Package

*Milestones shown in italics in cases where milestones and targets are the same italics are used*

Due Date	Subresult 5 1 1 Quality of Essential Maternal, Perinatal and Child (MP&C) Health Services Improved		Subresult 5 1 2 Districts Implementing Essential MP&C Services in Target Governorates			Subresult 5 1 3 Established National Child Survival Program Sustained	Subresult 5 1 4 Increased Knowledge and Improved Health Behavior in Households			Supporting Activities	
	TASK 1 ES Package/ Standards Definition	TASK 2 Non MOHP Training and PES Standards in School Curricula	TASK 3 Develop District Management and Planning	TASK 4 Management and Health Information System	TASK 5 Research	TASK 6 Sustain National Child Survival Programs	TASK 7 Improve Social Community Services	TASK 8 IEC Campaign	TASK 9 SMIP Program	TASK 10 Small Grant Program	TASK 11 Commodity Procurement Program
June 15 1998				<i>Commencement of HMIS Assessment</i>				<i>Rapid Assessment of existing print and mass media conducted</i>			
September 15 1998	<i>One HM/HC Consensus Meeting held and Essential Services Package finalized</i>					<i>Assessment of neonatal centers conducted</i>					<i>Development of HM/HC Project Procurement Plan</i>
December 15 1998			<i>Completion of HM/HC management guidelines for district planning</i>				<i>Field test of protocol for linking community groups with providers completed</i>				
March 15 1999	<i>implementation of basic health package in 5 districts</i>		functional district health plans and monitoring systems developed and implemented in 5 districts			<i>Completion of Egypt specific Integrated Sick Child Management Plan</i>	Community provider partnership services offered in 5 districts			20 small grants awarded to NGOs in target districts	
June 15 1998				<i>Assist MOHP to establish 10 district MHIS</i>				<i>National IEC Strategy to support HM/HC developed</i>			
September 15 1999		<i>HM/HC Curricula taught in 2 medical and 2 nursing schools</i>				<i>Daya training program modified and ready for implementation</i>					<i>Procurement of 15% of Project commodities</i>
December 15 1999			<i>8 District health plans and monitoring systems developed and implemented</i>				<i>Needs identification tool implemented in 5 communities</i>				
March 15 2000	<i>Implementation of basic health package in 10 districts</i>		Functional district health plans and monitoring systems developed and implemented in 10 districts			<i>Three operations research studies completed</i>	Community provider partnership services offered in 10 districts		Develop & implement nutrition and health education program & anemia control program for adolescent girls	55 small grants awarded to NGOs / target districts	

### Milestones and Targets for Healthy Mother/Healthy Child Results Package

*Milestones shown in italics in cases where milestones and targets are the same italics are used*

Due Date	Subresult 5 1 1 Quality of Essential Maternal, Perinatal and Child (MP&C) Health Services Improved		Subresult 5 1 2 Districts Implementing Essential MP&C Services in Target Governorates			Subresult 5 1 3 Established National Child Survival Program Sustained	Subresult 5 1 4 Increased Knowledge and Improved Health Behavior in Households			Supporting Activities	
	TASK 1 ES Package/ Standards Definition	TASK 2 Non MOHP Training and PES Standards in School Curricula	TASK 3 Develop District Management and Planning	TASK 4 Management and Health Information System	TASK 5 Research	TASK 6 Sustain National Child Survival Programs	TASK 7 Improve Social Community Services	TASK 8 IEC Campaign	TASK 9 SMIP Program	TASK 10 Small Grant Program	TASK 11 Commodity Procurement Program
June 15 2000				<i>Assist MOHP to establish 30 district MHIS centers</i>				<i>National IEC campaign developed</i>			
September 15 2000		<i>HM/HC Curricula taught in 6 medical and 6 nursing schools</i>				<i>1999/2000 Maternal Mortality Survey completed</i>					<i>Procurement of 50% of Project commodities</i>
December 15 2000			<i>20 District health plans and monitoring systems developed and implemented</i>				<i>Social Community Services offered in 20 districts</i>				
March 15 2001	<i>Implementation of basic health package in 20 districts by end of Year 3</i>		<i>Functional district health plans and monitoring systems developed and implemented in 20 districts by end of Year 3</i>			<i>100 neonatal centers are linked with comprehensive perinatal programs in target districts</i>	<i>Community provider partnership services offered in 20 districts by end of Year 3</i>			<i>90 small grants awarded to NGOs in target districts</i>	
June 15 2001				<i>Assist MOHP to establish 65 MHIS centers</i>				<i>Develop national IEC campaign addressing HM/HC issues</i>  <i>FGM component integrated into overall HM/HC message package</i>			
September 15 2001	<i>Implementation of basic health package in 25 districts by end of Year 4</i>	<i>Complete training for all categories by end of contract</i>  <i>HM/HC Curricula taught in 13 medical and 13 nursing schools</i>	<i>25 District health plans and monitoring systems developed and implemented</i>	<i>Complete health management information system in all 65 districts by Year 4 Quarter 1</i>	<i>The 1999/2000 Maternal Mortality Survey for Egypt and 12 operation research studies and surveys completed by end of contract</i>	<i>EPI coverage rates above 90% for 25 districts for the seven vaccines</i>  <i>Effective ARI MIS in 27 governorates</i>  <i>100 neonatal centers providing acceptable care</i>	<i>Community provider partnership services offered in 25 districts by end of Year 4</i>  <i>Social Community Services offered in 25 districts</i>		<i>100 small grants awarded to NGOs in 25 target districts</i>	<i>Procurement of 100% of Project commodities</i>	

# **ANNEX C**

## **Milestone Status Chart**

### MILESTONE STATUS CHART

(as of March 14, 1999)

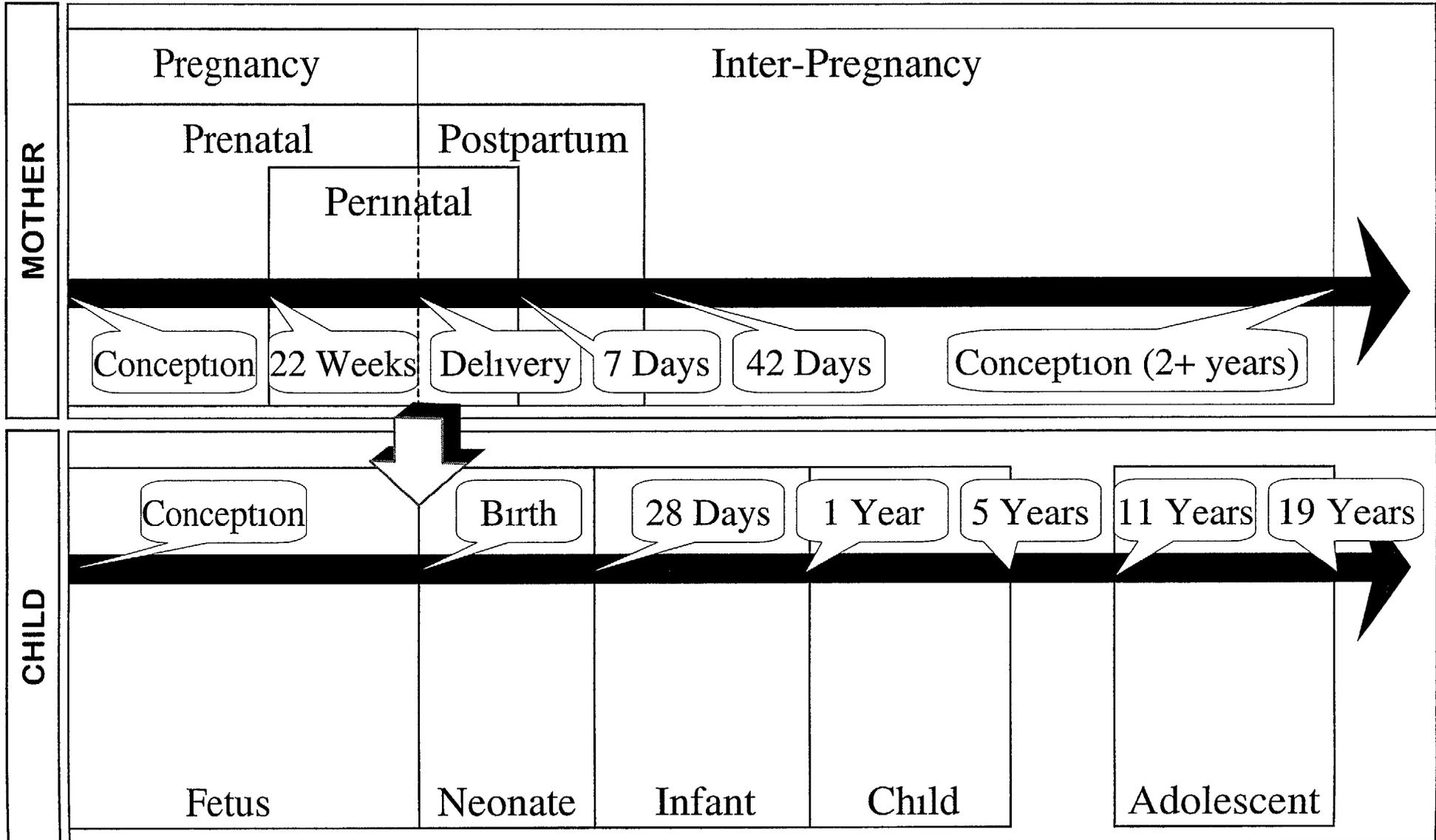
No	Date Due	Milestone	Task No	Outline	Draft	Finalized & Submitted	Validated	Approved	
								USAID	MOHP
1	6/15/98	Commencement of HMIS Assessment	4	✓	✓	✓	✓	✓	✓
2	6/15/98	Rapid Assessment of existing print and mass media conducted	8	✓	✓	✓	NA	✓	✓
3	9/15/98	One HM/HC Consensus Meeting held and Essential Services Package finalized	1	✓	✓	✓	✓	✓	✓
4	9/15/98	Assessment of neonatal centers conducted	6	✓	✓	✓	✓	✓	✓
5	9/15/98	Development of HM/HC Project Procurement Plan	11	✓	✓	✓	NA		
6	12/15/98	Completion of HM/HC management guidelines for district planning	3	✓	✓	✓	NA	✓	✓
7	12/15/98	Field test of protocol for linking community groups with providers completed	7	✓	✓	✓	✓	✓	✓
8	3/15/99	Lead Trainers trained & basic health package implemented in 5 districts	1 & 2	✓	✓	✓			
9	3/15/99	Completion of Egypt specific Integrated Sick Child Management Plan	6	✓	✓	✓	NA		
10	3/15/99	20 small grants awarded to NGOs in target districts	10						
11	6/15/99	Assist MOHP to establish 10 district MHIS	4						
12	6/15/99	National IEC Strategy to support HM/HC developed	8				NA		
13	9/15/99	HM/HC Curricula taught in 2 medical and 2 nursing schools	2						
14	9/15/99	Daya training program modified and ready for implementation	6						
15	9/15/99	Procurement of 15% of Project commodities	11						
16	12/15/99	8 District health plans and monitoring systems developed and implemented	3						
17	12/15/99	Needs identification tool implemented in 5 communities	7						
18	3/15/00	Implementation of basic health package in 10 districts	1						
19	3/15/00	Three operations research studies completed	5						
20	3/15/00	55 small grants awarded to NGOs in target districts	10						
21	6/15/00	Assist MOHP to establish 30 district MHIS centers	4						
22	6/15/00	National IEC campaign developed	8						
23	9/15/00	HM/HC Curricula taught in 6 medical and 6 nursing schools	2						
24	9/15/00	1999/2000 Maternal Mortality Survey completed	5						
25	9/15/00	Procurement of 50% of Project commodities	11						
26	12/15/00	20 District health plans and monitoring systems developed and implemented	3						
27	12/15/00	Social Community Services offered in 20 districts	7						
28	3/15/01	Implementation of basic health package in 20 districts by end of Year 3	1						
29	3/15/01	100 neonatal centers linked with comprehensive perinatal programs in target districts	6						
30	3/15/01	90 small grants awarded to NGOs in target districts	10						
31	6/15/01	Assist MOHP to establish 65 MHIS centers	4						
32	6/15/01	FGM component integrated into overall HM/HC message package	8						
33	9/15/01	Implementation of basic health package in 25 districts by end of Year 4	1						
34	9/15/01	HM/HC Curricula taught in 13 medical and 13 nursing schools	2						
35	9/15/01	25 District health plans and monitoring systems developed and implemented	3						
36	9/15/01	Social Community Services offered in 25 districts	7						
37	9/15/01	100 small grants awarded to NGOs in 25 target districts	10						
38	9/15/01	Procurement of 100% of Project commodities	11						



# **ANNEX D**

## **Mother/Child Life Phases**

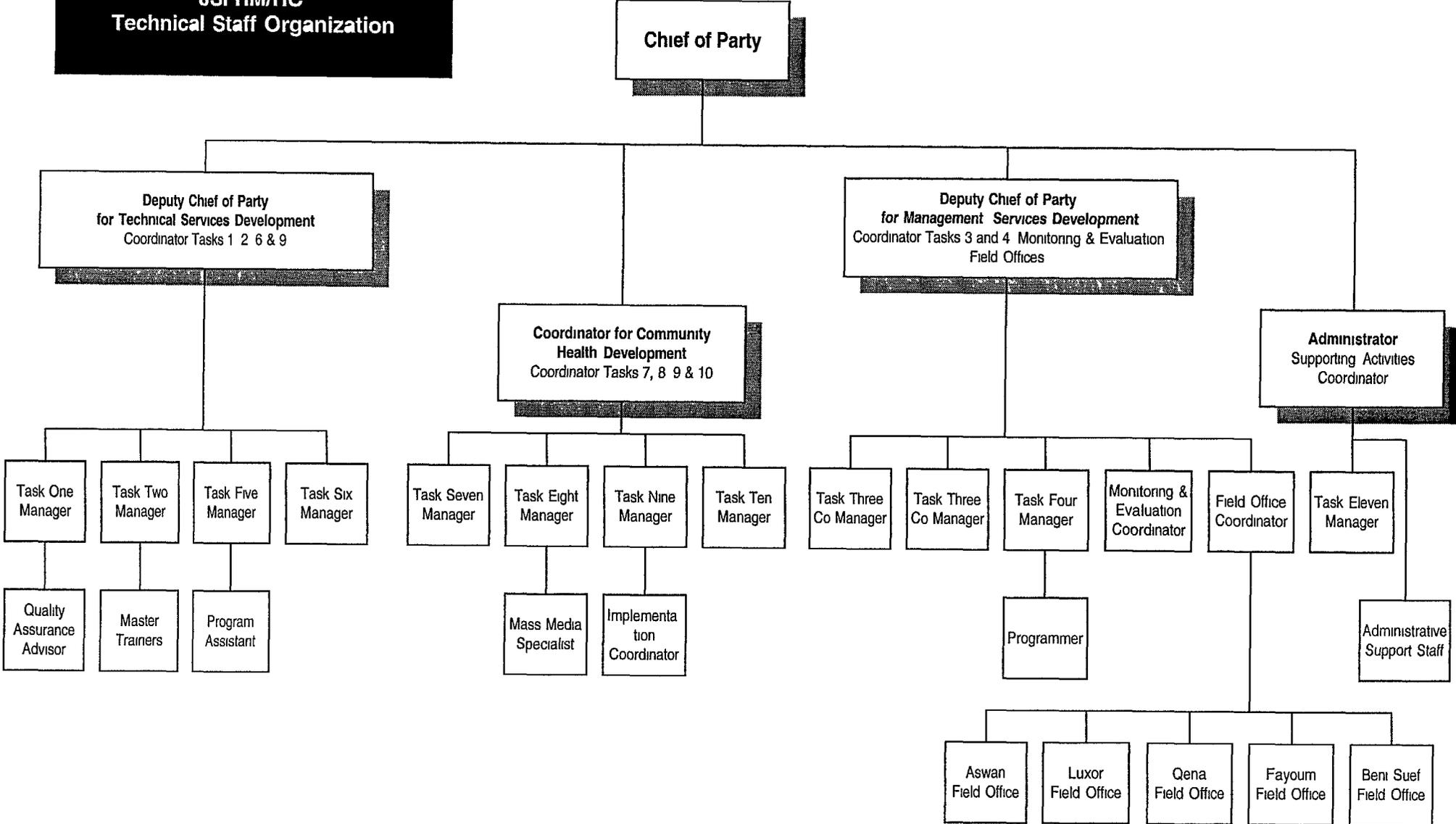
# Mother/Child Life Phases



# **ANNEX E**

## **JSI/Egypt Organogram**

**JSI HM/HC  
Technical Staff Organization**



# **ANNEX F**

## **Package of Essential Services**

Service Level	Management Support & Staffing	Maternal Services				Child Services		
		Pre-natal (conception to delivery)	Peri-natal (22 <sup>nd</sup> week of pregnancy – 7 <sup>th</sup> day after delivery)	Post-natal (delivery 42 <sup>nd</sup> day after delivery)	Inter-natal (from delivery to next conception)	Neonate (birth 28 days after delivery)	Infant – Child (28 days – 5 years)	Adolescent (11 – 19 years)
Household	Mother Daya Health facility personnel on outreach	Danger signs Seek antenatal care Proper antenatal nutrition FP promotion Immunization against tetanus E&I breastfeeding promotion	Normal delivery Recognize & refer complications	E&I breastfeeding promotion Child spacing Recognize & refer postpartum complications	FP promotion Nutrition support	Neonate care (drying and warming) Hygienic cord care Recognition of complications of pregnancy & delivery	Immunization promotion E&I breastfeeding promotion Vitamin A & iron intake Detect growth faltering & act Recognition of danger signs of illness & seek help soon Home care of diarrhea fever & malnutrition	Nutrition and Health Education FP/RH counseling FGM education
Community	Same as above	Community education with emphasis on preventive & household treatment behaviors Mothers are motivated to seek appropriate assistance when they or their children are sick Community support to assure ready access to services Community participation in the planning & management of both facility based as well as community health services				Assistance for sick children Effective mechanisms for increasing access to needed health services	- Motivate community to seek appropriate health services	Nutrition and Health Education FP/RH counseling FGM education
School	Student medical health insurance personnel							Nutrition and Health Education Immunization of girls (TT) Iron Supplementation De worming
PHC Level A (Rural Health Unit)	Bring facility up to Service Standards	<b>Basic Maternal Care</b>				Same as above plus referral Resuscitation Treatment of neonatal infection Immunization (BCG)	Immunization (polio DPT hepatitis) Growth monitoring / nutrition intervention ARI CDD (IMCI) Referral	Immunization
	General Practitioner Midwives Nurses Laboratory & Microbiology Technician	Immunization (TT) ANC services Fetal Growth Monitoring Nutritional status & blood pressure monitoring Urine analysis FP/ RH counseling E&I breastfeeding counseling	Same as above plus referral	E&I breastfeeding counseling postpartum care plus 40 <sup>th</sup> day integrated visit for mother and infant postpartum check ups FP/RH counseling	Immunization (TT) FP /RH Counseling  FP services Nutrition services			
PHC Level B (Rural Hospital, Maternity Centre Upgraded Health Unit)	Same as above plus	<b>Basic Essential Obstetric Care</b>				Incubation Treatment of neonatal tetanus	Same as above	Immunization
	OB/GYN Specialist	Same as above	Same as above plus referral Delivery with complication	Same as above	Same as above			
First referral Level (District Hospital)	Same as above plus	<b>Comprehensive Essential Obstetric Care</b>				Same as above  Treatment of high risk infants  Treatment and referral of complicated cases	Same as above	
	Blood Bank Technician Pediatrician Neonatologist Anesthesiologist	Same as above	Same as above plus referral Delivery with complications Requiring surgery and/or blood transfusion	Same as above	FP services Nutrition services			

25

# **ANNEX G**

## **District Information Center Standards**

## Required Minimum Standards for District Information Centers

### Personnel

- ◆ One Health Data Analyst (Information Center Manager) Public Health background, experience or training in data analysis and data management
- ◆ Two Data Entry Clerks trained to use MS Office and MHIS applications

### Office Space

- ◆ Minimum of 12 square meters usable floor space
- ◆ Intact plaster on walls
- ◆ No roof/ceiling water leakage
- ◆ Intact floor (vinyl or ceramic tile or equivalent)
- ◆ Minimum of one secure window
- ◆ All doors with secure locks

### Air Conditioner

- ◆ One unit of adequate capacity considering room volume and local climate

### Furniture

- ◆ Three desks and chairs
- ◆ One computer desk with chair
- ◆ Locking book shelf (for reference books)
- ◆ Locking paper cabinet (for forms and records)

### Electricity

- ◆ Three outlets with separate circuit breaker and adequate gauge wiring
- ◆ Grounding circuit available for computer

### Telephone Line

- ◆ One outlet
- ◆ One telephone set

### Light

- ◆ Adequate electrical light considering size of office space (minimum two 40 watt fluorescent tubes)

### Computer and Peripheral Equipment

- ◆ Computer (CPU, monitor, keyboard, mouse)
- ◆ Printer
- ◆ UPS
- ◆ Modem (internal or external)
- ◆ Necessary connecting cables

# ANNEX H

## Child Survival Program Analysis Matrix

## Task Six Analysis Matrix

Task Six Activity	Areas of Technical Assistance for JSI
<p>Activity 2 Strengthen ARI &amp; CDD programs</p>	<p>Consultant for translation of the WHO generic IMCI materials After the pilot test implementation of IMCI, JSI, will assist in the expansion of IMCI in 2-5 districts of target governorates</p>
<p>Activity 3 Support the Perinatal Care Program</p>	<p>Development or revision of training materials on some issues, which are not, covered in the neonatal care manuals (Infection Control, Convulsions, Essential Drug List, etc ) Training of some pediatricians on neonatal care (U S based training)</p> <ul style="list-style-type: none"> <li>◆ Revision and development of the Arabic manual for nurses</li> <li>◆ Convert training materials into competency based modules</li> <li>◆ Revision of standard checklist</li> <li>◆ Workshops on supervision for MCH directors, DHOs and assistant DHOs in the target governorates Development of checklists for supervision by the group</li> </ul>
<p>Activity 4 Strengthen the Daya Training Program</p>	<ul style="list-style-type: none"> <li>◆ Revision of 3-days daya training program</li> <li>◆ Development of standard protocol for training</li> <li>◆ Development of competency based training curriculum</li> <li>◆ Strengthen the supervision on Daya Performance by health workers and managers</li> </ul>

# ANNEX I

## Budget Data

# ANNEX J

## Contract Task Gantt Charts

# **GANTT CHART**

## **TASK 1**

**JSI HM/HC Year 2 Annual Workplan**

Fr 2/12/99

ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
1	<b>1 TASK ONE Basic ES package of essential services established and standards defined</b>	[Gantt bar: Feb-Mar]														
2	<b>1 1 Activity 2 Finalize HM/HC Package of Essential Services consensus meeting</b>	[Gantt bar: May-Jun]														
3	1 1 1 Quarterly meetings with the consensus group to review and follow up PES	[Vertical tick marks: Feb, Apr, Jun, Aug, Oct, Dec]														
9	<b>1 2 Activity 3 Implement HM/HC Package of Essential Services in 10 Districts</b>	[Gantt bar: Feb-Mar]														
10	1 2 1 Luxor and Aswan Districts 1 5	[Gantt bar: Feb-Mar]														
17	1 2 1 7 Stage 5 TOT for district level Trainers/Supervisors in Districts 1 5	[Gantt bar: Feb-Mar]														
18	1 2 1 7 1 EOC Training of Trainers	[Gantt bar: Feb-Mar]														
22	1 2 1 7 1 4 train service providers group by new trainers as a microteaching	[Gantt bar: Feb-Mar]														
27	1 2 1 8 Stage 6 Quality assurance and service standards training for Governorate and District	[Gantt bar: Feb-Mar]														
28	1 2 1 8 1 Preparation meeting for training course	[Gantt bar: Feb-Mar]														
29	1 2 1 8 2 Training course I for Management Teams (Aswan)	[Gantt bar: Feb-Mar]														
30	1 2 1 8 3 Training course II for Management Teams (Luxor)	[Gantt bar: Feb-Mar]														
31	1 2 1 8 4 Training course III for Management Teams (Aswan)	[Gantt bar: Feb-Mar]														
32	1 2 1 8 5 Training course IV for Management Teams (Aswan)	[Gantt bar: Feb-Mar]														
33	1 2 1 9 MILESTONE Lead trainers trained in 5 districts and PES implemented in District 1 5	[Gantt bar: Feb-Mar]														
34	1 2 1 10 Stage 7 Training of service providers in Districts 1 5	[Gantt bar: Feb-Mar]														
58	1 2 1 10 5 Implementation of corrective action by trained clinic/hospital staff to bring facility	[Gantt bar: Feb-Mar]														
59	1 2 1 10 6 Luxor District 1 Rural Hospital 1 Monitor develop basic competency skill	[Gantt bar: Feb-Mar]														
60	1 2 1 10 7 Aswan District 1 Rural Hospital 1 Monitor develop basic competency skill	[Gantt bar: Feb-Mar]														
61	1 2 1 10 8 Luxor Districts Monitor develop basic competency skill development at work	[Gantt bar: Feb-Mar]														
62	1 2 1 10 9 Aswan Districts Monitor develop basic competency skill development at work	[Gantt bar: Feb-Mar]														
63	1 2 1 10 10 Luxor District 1 Rural Hospital 1 Monitor practice for mastery skill development	[Gantt bar: Feb-Mar]														
64	1 2 1 10 11 Luxor Districts Monitor practice for mastery skill development at work site (3	[Gantt bar: Feb-Mar]														
65	1 2 1 10 12 Aswan District 1 Rural Health Unit 1 Monitor practice for mastery skill	[Gantt bar: Feb-Mar]														
66	1 2 1 10 13 Aswan Districts Monitor practice for mastery skill development at work site (3	[Gantt bar: Feb-Mar]														
67	1 2 1 11 Stage 8 Plan implementation in Districts 1 5	[Gantt bar: Feb-Mar]														
68	1 2 1 11 1 Deployment of teams	[Gantt bar: Feb-Mar]														
69	1 2 1 11 2 Monthly self assessment by the anchor facilities staff in Luxor & Aswan	[Vertical tick marks: Feb, Apr, Jun, Aug, Oct, Dec]														
82	1 2 1 11 3 Quarterly monitoring and evaluation visits by district management teams to the	[Vertical tick marks: Feb, Apr, Jun, Aug, Oct, Dec]														
87	1 2 1 11 4 Bi annually monitoring and evaluation visits by governorate management teams to the	[Vertical tick marks: Feb, Apr, Jun, Aug, Oct, Dec]														
90	1 2 1 11 5 Develop plans with facility staff and management / supervisory teams to correct	[Gantt bar: Feb-Mar]														
91	1 2 1 11 6 Implementation of the corrective action by management teams and facility staff	[Gantt bar: Feb-Mar]														
92	1 2 2 Beni Suef Districts 6 10	[Gantt bar: Feb-Mar]														
93	1 2 2 1 Stage 1 Selection of the Anchor Facilities	[Gantt bar: Feb-Mar]														
94	1 2 2 1 1 Review the selection process / criteria for the Anchor facilities	[Gantt bar: Feb-Mar]														
95	1 2 2 1 2 Selection of potential anchor facilities in 5 districts in Beni Suef Governorate	[Gantt bar: Feb-Mar]														

JSI HM/HC Year 2 Annual Workplan

Fri 2/12/99

ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
96	1 2 2 2 Stage 2 Rapid assessment of clinics and hospitals to determine level of compliance with															
97	1 2 2 3 Final selection of the anchor facilities in Districts 6 10															
98	1 2 2 4 BENCHMARK Selection of Anchor facilities in Districts 6 10															
99	1 2 2 5 Stage 3 Develop workplan to bring anchor facilities into compliance with standards for the															
100	1 2 2 6 Stage 4 Upgrade Anchor Facilities in Districts 6 10															
101	1 2 2 6 1 Physical renovation of facilities															
102	1 2 2 6 2 Installation of required equipment															
103	1 2 2 6 3 BENCHMARK Equipment and supplies for upgrading anchor facilities in 10															
104	1 2 2 6 4 Reorganization of facilities															
105	1 2 2 7 Stage 5 TOT for district level Trainers/Supervisors in Districts 6 10															
106	1 2 2 7 1 EOC training of trainers (TOT)															
107	1 2 2 7 1 1 Preparation of TOT workshop															
108	1 2 2 7 1 2 Training of trainers (TOT) master trainers train district level trainers															
109	1 2 2 7 1 3 Train service providers group by new trainers as microteaching															
110	1 2 2 7 2 TOT for physicians & nurses for midwifery program															
111	1 2 2 7 2 1 Preparaton of TOT workshops															
112	1 2 2 7 2 2 Conducting TOT workshop in Districts 6 10															
113	1 2 2 7 3 Management & QA training of trainers (TOT)															
114	1 2 2 7 3 1 Preparation for TOT															
115	1 2 2 7 3 2 Training of trainers (TOT) master trainers train governorate anf															
116	1 2 2 8 Stage 6 Quality Assurance and Service Standards Training for Governorate & District															
117	1 2 2 8 1 Preparation meeting for training course															
118	1 2 2 8 2 Training Course I for management teams															
119	1 2 2 8 3 Training Course II for management teams															
120	1 2 2 8 4 BENCHMARK 14 governorate and district level team members receive															
121	1 2 2 9 Stage 7 Training of Service Providers in Districts 6 10															
122	1 2 2 9 1 EOC training for service providers in Districts 6 10															
123	1 2 2 9 1 1 Planning of the EOC Training															
124	1 2 2 9 1 2 EOC Training Course I for Service Providers (Specialists/Residents)															
125	1 2 2 9 1 3 EOC Training Course II for Service Providers (Residents/GPs)															
126	1 2 2 9 2 Training of Service Providers (Nurses) on Infection Control (IC) and Interpersonal															
127	1 2 2 9 2 1 Planning for Infection prevention and IPCs Training for nurses															
128	1 2 2 9 2 2 Conduct Training course I for nurses on IC and IPCs															
129	1 2 2 9 2 3 Conduct Training course II for nurses on IC and IPCs															
130	1 2 2 9 3 Training of nurses for midwifery skills in Districts 6 10															
131	1 2 2 9 3 1 Planning for midwifery training															

JSI HM/HC Year 2 Annual Workplan

Fn 2/12/99

ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
132	1 2 2 9 3 2 Preparation for the training in Distrcs 6 10															
133	1 2 2 9 3 3 Conducting the midwifery training program for nurses (4 days) in															
134	1 2 2 9 3 4 Practical midwifery training in the hospitals for 4 months in Districts															
135	1 2 2 9 4 Integrated training program for service providers															
136	1 2 2 9 4 1 Collaborate in planing the integrated training program for sevice															
137	1 2 2 9 4 2 Conduct integrated training program for sevice providers for 14 days															
138	1 2 2 9 4 3 BENCHMARK Training of the Service Providers in Districts 6 10															
139	1 2 2 10 Stage 8 Continous improvement by facility teams and district/governorate management teams to															
140	1 2 2 10 1 Deployment of district management / supervisory teams in Districts 6 10 using															
141	1 2 2 10 2 Monthly self assessment by the anchor facilities staff in Districts 6 10															
155	1 2 2 10 3 Quarterly monitoring and evaluation visits by district management teams to the															
163	1 2 2 10 5 Develop plans with facility staff and management / supervisory teams to correct															
164	1 2 2 10 6 Implementation of the corrective action by management teams and facility staff															
165	1 2 2 11 MILESTONE Implement HM/HC Package of Essential Services in 10 Districts															
166	1 3 Activity 4 Establish and strengthen a referral system for the HM/HC Package ( With Task 3 )															
167	1 3 1 Identify current referral systems within the MOHP															
168	1 3 2 Develop a referral system that supports the HM/HC package															
169	1 3 3 Test the model in selected districts															
170	1 3 4 Refine the system as appropriate															
171	1 3 5 Submit the system to the MOHP for approval															
172	1 3 6 Orent DMTs and GMTs with proposed referral system															
173	1 3 7 BENCHMARK A referral system is developed, tested, and submitted															
174	1 4 Activity 5 Promotion of quality services The gold Star approach ( with task 8 )															
175	1 4 1 Explore the option of appending the Gold Star to HM/HC logo for facilities that meet crtena															
176	1 4 1 1 Consider making the Gold Star the symbol of integrated PES															
177	1 4 1 2 BENCHMARK Decision made about inclusion of the Gold Star approach															
178	1 4 1 3 Determine best approach in close collaboration with MOHP and USAID															
179	1 4 2 Implementaion of the gold star															
180	1 4 2 1 Design a HM/HC IEC Gold Star module															
181	1 4 2 2 Pretest the Gold Star module															
182	1 4 2 3 BENCHMARK Gold Star module pretested															
183	1 4 2 4 Implemet Gold Star in pilot governorate															
184	1 4 2 5 Identify lessons learned from implementaton															
185	1 4 2 6 Implement Gold Star in the remaining 4 governorates															

# **GANTT CHART**

## **TASK 2**

**JSI HM/HC Year 2 Annual Workplan**

Fn 2/12/99

ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
186	<b>2 TASK TWO Design of Training System and Inclusion of ES Package/Standards in School Curricula</b>	[Shaded bar]														
187	<b>2 1 Activity 1 Revision of med school curricula &amp; upgrade faculty training skills to incorporate HM/HC Package (see</b>	[Shaded bar]														
204	2 1 8 development of hands on training for clinicians	[Shaded bar]														
205	2 1 8 1 establishment of model clinics in university hospital outpatient clinics	[Shaded bar]														
206	2 1 8 2 establishment of training system for OB/GYN students in the areas of EOC and LSS	[Shaded bar]														
207	2 1 9 support to the implementation of MOHP recruitment policies for females into medicine esp OB/GYN	[Shaded bar]														
210	2 1 11 train high level faculty members out of country in new medical technologies	[Shaded bar]														
212	2 1 11 2 train high level faculty members	[Task box: Feb-Mar]														
213	2 1 11 3 newly trained high level faculty members disseminate and utilize new knowledge to in country	[Task box: Mar-Apr]														
215	<b>2 2 Activity 2 Revision of nursing school curricula &amp; upgrade faculty training skills to incorporate HM/HC</b>	[Shaded bar]														
232	2 2 8 development of hands on training for clinicians	[Shaded bar]														
233	2 2 8 1 establishment of model clinics in university hospital outpatient clinics	[Shaded bar]														
234	2 2 8 2 establishment of training system for OB/GYN students in the areas of EOC and LSS	[Shaded bar]														
235	2 2 9 support to the implementation of MOHP recruitment policies for females into medicine esp OB/GYN	[Shaded bar]														
239	2 2 11 train high level faculty members out of country in new medical technologies	[Shaded bar]														
241	2 2 11 2 train high level faculty members	[Task box: Feb-Mar]														
242	2 2 11 3 newly trained high level faculty members disseminate and utilize new knowledge to in country	[Task box: Mar-Apr]														
243	2 2 12 sponsorship of periodic conferences topical to the HM/HC Package	[Shaded bar]														
244	<b>2 3 Activity 3 In service clinical training (see Task 6)</b>	[Shaded bar]														
250	2 3 2 improve skills and competency of practicing OB/GYNs	[Shaded bar]														
251	2 3 2 1 public sector	[Task box: Feb-Mar]														
252	2 3 2 2 private sector	[Task box: Mar-Apr]														
253	<b>2 4 Activity 4 Improve training capabilities</b>	[Shaded bar]														
254	2 4 1 training of trainers	[Shaded bar]														
255	2 4 1 1 medical schools	[Task box: Feb-Mar]														
256	2 4 1 2 nursing schools	[Task box: Mar-Apr]														
257	2 4 1 3 in service training	[Task box: Apr-May]														
258	2 4 2 model clinics at each level of service delivery	[Shaded bar]														
261	2 4 2 3 upgrade	[Task box: Feb-Mar]														
262	2 4 2 4 set up of training unit	[Task box: Mar-Apr]														
263	<b>2 4 3 Activity 5 Training beyond the MOHP</b>	[Shaded bar]														
264	2 4 3 1 private providers	[Shaded bar]														
265	2 4 3 1 1 OB/GYN	[Task box: Jun-Jul]														
266	2 4 3 1 2 pediatric	[Task box: Jul-Aug]														
267	2 4 3 1 3 nursing	[Task box: Aug-Sep]														
268	2 4 3 1 4 medical	[Task box: Sep-Oct]														

JSI HM/HC Year 2 Annual Workplan

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
269	2 4 3 1 5 explore the potential for private provider self subsidization															
270	2 4 3 2 pharmacists															
271	2 4 3 2 1 assess potential of HM/HC ES Package in pharmacy schools															
272	2 4 3 2 1 1 ARI															
273	2 4 3 2 1 2 CDD															
274	2 4 3 2 1 3 appropriate referral															
275	2 4 3 3 dayas															
276	2 4 3 3 1 adapt existing program to incorporate relevant HM/HC elements															
277	2 4 3 3 1 1 strengthen relationship b/w dayas and MCH centers															
278	2 4 3 3 1 2 improve monitoring and supervision of daya activities															
280	2 4 3 4 mothers															
281	2 4 3 4 1 trained in HM/HC package through IEC and community outreach (see tasks 7 & 8)															
282	2 4 3 4 2 literacy training using materials related to HM/HC Package (see Task 7)															
283	<u>2 4 4 MILESTONE Lead trainers trained for 5 districts and and package implemented in 5 districts</u>															

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## **TASK 3**

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ID	Task/Activity/Sub activity	2000													
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
285	<b>3 TASK THREE Public and Private Providers in Partnership with Communities to Develop and Manage District Plans</b>														
286	<b>3 1 Community Level Involvement Beni Suef Districts 6 10</b>														
287	3 1 1 Establish 18 Community Health Committees and 3 facility teams in target districts and facilities in Districts 6 10	[Gantt bar: Feb-Mar]													
288	3 1 2 BENCHMARK (CI) 8 facility teams established (cumulative)	[Gantt bar: Mar-Apr]													
289	3 1 3 BENCHMARK (CI) 48 Community Health Committees established (cumulative)	[Gantt bar: Apr-May]													
290	3 1 4 Establish 12 Community Health Committees and 2 facility teams in target districts and facilities in Districts 6 10	[Gantt bar: May-Jun]													
291	3 1 5 BENCHMARK (CI) 10 facility teams established (cumulative)	[Gantt bar: Jun-Jul]													
292	3 1 6 BENCHMARK (CI) 60 Community Health Committees established (cumulative)	[Gantt bar: Jul-Aug]													
293	3 1 7 Adapt training materials for Community Health Committees	[Gantt bar: Aug-Sep]													
294	3 1 8 Train CHC and facility reps in community needs assessment community planning and resource	[Gantt bar: Sep-Oct]													
295	3 1 9 Conduct 18 community needs assessment in Districts 6 10	[Gantt bar: Oct-Nov]													
296	3 1 10 Analyze results of 18 community needs assessments	[Gantt bar: Nov-Dec]													
297	3 1 11 BENCHMARK (CI) 48 community needs assessments conducted and analyzed (cumulative)	[Gantt bar: Dec-Jan]													
298	3 1 12 Conduct 12 community needs assessment in Districts 6 10	[Gantt bar: Jan-Feb]													
299	3 1 13 Analyze results of 12 community needs assessments	[Gantt bar: Feb-Mar]													
300	3 1 14 BENCHMARK (CI) 60 community needs assessments conducted and analyzed	[Gantt bar: Mar-Apr]													
301	3 1 15 Develop 18 community plans in Districts 6 10	[Gantt bar: Apr-May]													
302	3 1 16 BENCHMARK 48 Community/Facility level plans completed (cumulative)	[Gantt bar: May-Jun]													
303	3 1 17 Develop 12 community plans in target districts in Districts 6 10	[Gantt bar: Jun-Jul]													
304	3 1 18 BENCHMARK 60 Community/Facility level plans completed (cumulative)	[Gantt bar: Jul-Aug]													
305	3 1 19 Submit community plans to DMTs and DHCs for incorporation into district plans as appropriate	[Gantt bar: Aug-Sep]													
306	3 1 20 Ongoing implementation and monitoring of community plans	[Gantt bar: Sep-Oct]													
307	3 1 21 Quarterly review of accomplishments adjustments to community plans and redirection of implementation	[Gantt bar: Oct-Nov]													
311	<b>3 2 District Level Interventions</b>														
312	3 2 1 Conduct 3 District Assessments for Districts 6 10	[Gantt bar: Feb-Mar]													
313	3 2 2 BENCHMARK 8 District Assessments completed (cumulative)	[Gantt bar: Mar-Apr]													
314	3 2 3 Conduct 2 District Assessments in for Districts 6 10	[Gantt bar: Apr-May]													
315	3 2 4 BENCHMARK 10 District Assessments completed (cumulative)	[Gantt bar: May-Jun]													
316	3 2 5 Formulate 3 District Management Teams for Districts 6 10	[Gantt bar: Jun-Jul]													
317	3 2 6 BENCHMARK 8 District Management Teams established (cumulative)	[Gantt bar: Jul-Aug]													
318	3 2 7 Formulate 2 District Management Teams for Districts 6 10	[Gantt bar: Aug-Sep]													
319	3 2 8 BENCHMARK 10 District Management Teams established (cumulative)	[Gantt bar: Sep-Oct]													
320	3 2 9 Formulate 3 District Health Committees for Districts 6 10	[Gantt bar: Oct-Nov]													
321	3 2 10 BENCHMARK 8 District Health Committees established (cumulative)	[Gantt bar: Nov-Dec]													
322	3 2 11 Formulate 2 District Health Committees for Districts 6 10	[Gantt bar: Dec-Jan]													
323	3 2 12 BENCHMARK 10 District Health Committees established (cumulative)	[Gantt bar: Jan-Feb]													



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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
363	3 3 1 1 Conduct governorate assessment for Beni Suef Governorate		■													
364	3 3 1 2 Conduct governorate assessment for Fayoum and Qenar Governorates															■
365	3 3 1 3 BENCHMARK 3 governorate assessments completed (cumulative)		★													
366	3 3 1 4 BENCHMARK 5 governorate assessments completed (cumulative)			★												
367	3 3 2 Selection of Priority districts for implementation															
368	3 3 2 1 Selection of priority districts for implementation in Beni Suef		■													
369	3 3 2 2 Selection of priority districts for implementation in Fayoum and Qena in Year 3															■
370	3 3 3 Formulate Governorate Health Committee for Beni Suef Governorate			■												
371	3 3 4 BENCHMARK (CI) 3 Governorate Health Committees established			★												
372	3 3 5 Adapt training materials for GMT/GHC orientation and training			■												
373	3 3 6 Orientation and training for key GMT and GHC members				■											
374	3 3 7 BENCHMARK (CI) 30 GMT/GHC members trained				★											
375	3 3 8 Support Governorate Team and Committee meetings															
376	3 3 9 BENCHMARK (CI) 22 Governorate Team meetings held															★
377	3 3 10 BENCHMARK (CI) 31 Governorate Team meetings held															★
378	3 3 11 Develop Governorate plans that incorporate District Plans															
379	3 3 11 1 Develop Governorate plans that incorporate District Plans for Aswan and Luxor															
380	3 3 11 2 Develop Governorate plans that incorporate District Plans for Beni Suef															
381	3 3 11 3 BENCHMARK District Plans are incorporated into Governorate Plans															★
382	3 3 12 Ongoing implementation and monitoring of Governorate plans															
383	3 3 12 1 Ongoing implementation and monitoring of Governorate plans in Aswan and Luxor															
384	3 3 12 2 Ongoing implementation and monitoring of Governorate plans in Beni Suef															
386	3 3 14 Districts 1 5 Quarterly Review of accomplishments adjustments to plans and redirection of implementation															
390	3 3 15 Districts 6 10 Quarterly Review of accomplishments adjustments to plans and redirection of															
394	3 3 16 Develop and integrate a form of fee-for service system															
395	3 3 16 1 Develop the tool for the identification of fee-for service practices and potential															
396	3 3 16 2 Apply the tool in a selected sample of facilities and districts															
397	3 3 16 3 Analyze collected data															
398	3 3 16 4 Develop recommendations incorporating fee for service opportunities and its implications															
399	3 3 16 5 BENCHMARK Fee-for service system developed and submitted to MOHP															★
400	3 3 17 Identify Private Providers of HM/HC Package who are eligible for CGC Loans															
401	3 3 17 1 Identify CGC policies for and procedures for guaranteeing loans															
402	3 3 17 2 Collaborate with local syndicates to identify private providers that can promote the HM/HC															
403	3 3 17 3 Facilitate orientation and promotion of loans for target private providers															
404	3 3 17 4 BENCHMARK 20 private providers, in target district, identified and oriented to the loan program															★
405	3 3 18 Establish and strengthen a referral system for the HM/HC Package															

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
406	3 3 18 1 Identify current referral systems within the MOHP															
407	3 3 18 2 Develop a referral system that support the HM/HC Package															
408	3 3 18 3 Test the model in selcted districts															
409	3 3 18 4 Refine the system as appropriate															
410	3 3 18 5 MOHP reviews and approves referral system															
411	3 3 18 6 Orient DMTs and GMTs with the proposed referral system															
412	3 3 18 7 DMTs conducting orientation session to service providers regarding referral system															
414	<b>3 4 National Level Oversight</b>															
415	3 4 1 Introduce the district process to the HM/HC National Team															
416	3 4 2 With DDM Project identify feasibility for developing and implementing an effective model for integrated															
417	3 4 3 Submit Governorte Plans to HM/HC National Team															
418	3 4 4 National Team submit feedback to Governorate Management Teams															
419	3 4 5 Incorporate Governorate plans into National HM/HC master plan															
420	<u>3 4 6 BENCHMARK Governorate Plans are incorporated into the National Plan</u>															
421	3 4 7 Assign National HM/HC staff to serve as Management/Planning Master Trainers															
422	<u>3 4 8 BENCHMARK HM/HC National Management Team participating and supporting the district planning process</u>															
423	<b>3 5 Establish JSI Field Offices in 5 Target Governorates</b>															
424	3 5 1 Selection and renovation of office space in Beni Suef															
425	3 5 2 Selection and renovation of officespace for Fayoum and Qena															
426	3 5 3 Procurement of furniture equipment and supplies for Beni Suef															
427	3 5 4 Procurement of furniture equipment and supplies for Fayoum and Qena															
428	3 5 5 Staff recruitment and hiring for Beni Suef															
429	3 5 6 Staff recruitment and hiring for Fayoum and Qena															
430	3 5 7 Staff orientation for Beni Suef															
431	3 5 8 Staff Orientation for Fayoum and Qena															
432	<u>3 5 9 BENCHMARK All 5 JSI field offices established</u>															

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## **TASK 4**

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ID	Task/Activity/Sub activity	2000											
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
433	<b>4 TASK FOUR Monitoring System in Place to Track Utilization and Impact and Provide Feedback</b>	[Shaded bar from Feb to Jul]											
434	<b>4 1 Activity 1 Assess and create an integrated and standardized nationwide MHIS system</b>	[Shaded bar from Feb to Jul]											
470	4 1 5 Design for monitoring system	[Task bar from Feb to Mar]											
471	4 1 5 1 Produce report on proposed improvements to MHIS & Monitoring/Decision support system	[Task bar from Feb to Mar]											
472	<u>4 1 5 2 BENCHMARK Finalized report on proposed improvements to MHIS &amp; Monitoring/Decision</u>	[Task bar from Mar to Apr with star]											
473	4 1 6 Develop procedures of HM/HC monitoring	[Task bar from Mar to Apr]											
474	4 1 6 1 Consultancy to perform detailed study of Indicators and Organizational Requirements	[Task bar from Mar to Apr]											
475	4 1 6 2 Develop manual of monitoring procedures	[Task bar from Mar to Apr]											
476	<b>4 1 7 Activity 2 Assist the MOHP to set up 65 MHIS centers at district level</b>	[Shaded bar from Feb to Jul]											
478	4 1 7 2 Establish 10 MHIS centers at district level	[Shaded bar from Feb to Jul]											
479	4 1 7 2 1 Procurement of HW and SW for target districts	[Task bar from Feb to Mar]											
481	4 1 7 2 3 Site Preparation	[Task bar from Mar to Apr]											
482	<u>4 1 7 2 4 BENCHMARK 10 computers installed</u>	[Task bar from Apr to May with star]											
483	4 1 7 2 5 Train Users	[Task bar from Apr to May]											
484	4 1 7 2 5 1 Conducted Training courses for district managers (10 trainees)	[Task bar from Apr to May]											
485	4 1 7 2 5 2 Conducted Training courses for district Physicians (10 trainees)	[Task bar from Apr to May]											
486	4 1 7 2 5 3 Conducted Training courses for district clerks (20 trainees)	[Task bar from Apr to May]											
487	<u>4 1 7 2 5 4 BENCHMARK 40 staff trained</u>	[Task bar from Apr to May with star]											
488	4 1 7 2 6 Equipment installation	[Task bar from May to Jun]											
489	4 1 7 2 7 Data Entry Trials	[Task bar from Jun to Jul]											
490	<u>4 1 7 2 8 BENCHMARK Collected first month's data from 10 MHIS centers</u>	[Task bar from Jul to Aug with star]											
491	4 1 7 2 9 Report on Set up of 10 MHIS centers at district level	[Task bar from Aug to Sep]											
492	<u>4 1 7 2 10 BENCHMARK Finalized report on Set up of 10 MHIS centers at district level</u>	[Task bar from Sep to Oct with star]											
493	<b>4 1 8 Activity 3 Design user friendly monitoring software for MHIS</b>	[Shaded bar from Feb to Jul]											
494	4 1 8 1 Defining development tools specs	[Task bar from Feb to Mar]											
495	4 1 8 2 Procurement of development tools	[Task bar from Mar to Apr]											
496	4 1 8 3 Develop a proto type	[Task bar from Apr to May]											
497	4 1 8 4 Develop beta version	[Task bar from May to Jun]											
498	4 1 8 5 Develop final version	[Task bar from Jun to Jul]											
499	<u>4 1 8 6 MILESTONE District Information Centers established in districts 1-10</u>	[Task bar from Jul to Aug with diamond]											

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## **TASK 5**

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jui	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
500	<b>5 TASK FIVE Research Activities</b>															
501	<b>5 1 Activity 1 Assessment of current research needs gaps in available clinical and operational information</b>															
502	5 1 1 determine information needs															
503	5 1 2 compare the needs to available information to identify gaps															
504	5 1 3 reach consensus on research to be pursued															
505	5 1 4 <u>BENCHMARK</u> Research consensus meeting held with the output being a draft Research Agenda															
506	5 1 5 determine research agenda for next 3 5 years															
507	5 1 6 <u>BENCHMARK</u> Research Agenda finalized															
508	<b>5 2 Activity 2 Development of research proposals and identify departments a d/or institutions to conduct the</b>															
509	5 2 1 identify appropriate researchers and technical counterparts															
510	5 2 2 develop research protocols															
519	<b>5 4 Activity 4 Create findings dissemination strategy</b>															
520	5 4 1 develop strategy with policy makers and researchers to disseminate research results to affect public health															
521	5 4 2 <u>BENCHMARK</u> Dissemination workshops held to present research findings															
522	<b>5 5 Activity 5 Complete the 1999/2000 Maternal Mortality Survey for Egypt</b>															
523	<b>5 6 TARGET</b> the 1999/2000 Maternal Mortality Survey for Egypt and 12 operaton research studies and surveys completed by															

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## **TASK 6**

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
524	<b>6 TASK SIX Established National Child Survival Programs Sustained</b>															
532	6 2 Conduct workshop to collectively plan integration of CSP activities into HM/HC															
533	6 2 1 Identify participants prepare materials and plan workshop															
534	6 2 2 Conduct workshop															
535	6 2 3 Prepare and distribute workshop report															
536	6 2 4 <u>BENCHMARK</u> Workshop held, report written & distributed															
537	6 3 Steering Committee to guide JSI TA inputs to CSP and facilitate integration of CSP activities into HM/HC established and															
538	6 3 1 Identify Steering Committee members															
539	6 3 2 Develop draft Terms of Reference for Steering Committee															
540	6 3 3 <u>BENCHMARK</u> First meeting of CSP HM/HC Steering Committee to guide and facilitate TA and CSP HM/HC															
541	6 3 4 Finalize Steering Committee Terms of Reference															
542	6 3 5 Refine Analysis Matrix with input from Steering Committee addressing specific program areas of EPI															
543	6 3 6 <u>BENCHMARK</u> Quarterly meeting of Steering Committee to guide and facilitate TA and CSP HM/HC															
544	6 3 7 <u>BENCHMARK</u> Quarterly meeting of Steering Committee to guide and facilitate TA and CSP HM/HC															
545	6 3 8 <u>BENCHMARK</u> Quarterly meeting of Steering Committee to guide and facilitate TA and CSP HM/HC															
546	6 3 9 <u>BENCHMARK</u> Quarterly meeting of Steering Committee to guide and facilitate TA and CSP HM/HC															
550	<b>6 4 Activity 1 Strengthen immunization services</b>															
551	6 4 1 Develop a list of EPI TA priorities according to the Analysis Matrix with input of Steering Committee															
552	6 4 2 Assess current status of EPI priorities missed opportunities and obstacles in target districts															
553	6 4 3 Prepare and distribute report of EPI assessment															
554	6 4 4 <u>BENCHMARK</u> EPI assessment report prepared and distributed															
555	6 4 5 Based on EPI assessment strengthen management, IEC and outreach activities and EPI integration into HM/HC															
556	6 4 6 Monitor reliability and quality of service delivery and coverage rates identifying corrective actions with input															
563	6 4 13 Collaborate on research of immunization and vaccine development topics / the feasibility of new vaccine															
564	<b>6 5 Activity 2 Strengthen ARI and CDD programs</b>															
568	6 5 4 <u>MILESTONE</u> Completion of Egypt specific Integrated Sick Child Management (IMCI) Plan															
569	6 5 5 Translation of IMCI Materials into Arabic															
571	6 5 7 Second central level course of IMCI															
572	6 5 8 Assess ARI/CDD priorities & obstacles in target districts to find ways to integrate ARI & CDD activities into															
573	6 5 9 <u>BENCHMARK</u> ARI/CDD assessment report prepared and distributed															
574	6 5 10 Based on ARI/CDD assessment & IMCI plan strengthen management MIS and integration of															
575	6 5 11 Assist MOHP with the integration of the ARI and CDD MISs in 27 Governorates															
576	6 5 12 Monitor ARI/CDD/IMCI strengthening activities identifying corrective actions with input from Steering															
583	<b>6 6 Activity 3 Support the neonatal program</b>															
584	6 6 1 Sustain 100 neonatal centers															
589	6 6 1 5 Training of staff															

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
594	6 6 1 5 5 Identify 15 20 pediatricians for U S faculty training	█														
595	6 6 1 5 6 Train pediatricians in neonatal care and service delivery with U S faculty				█											
596	6 6 1 5 7 Train at least 15 pediatricians in neonatal care service delivery at U S based				█											
597	6 6 1 5 8 BENCHMARK Train at least 9 pediatricians in Neonatal Care and service				█											
598	6 6 1 5 9 Organize in country nursing training program to be instituted in target governorates							█								
599	6 6 1 6 Review and revise the existing physician and nursing manuals for neonatal care	█	█	█	█											
600	6 6 1 7 Identification and procurement of additional equipment	█	█	█	█											
603	6 6 1 7 3 Procure equipment	█	█	█	█											
604	6 6 1 7 4 BENCHMARK Additional Neonatal Center equipment procured															
605	6 6 1 8 Establish a patient-care based data collection plan and train staff appropriately (added 6/16/98)															
606	6 6 1 9 Build capacity of health planners at all levels to plan manage and deliver integrated HM/HC															
607	6 6 1 10 Development of appropriate and effective systems to linking national programs to field															
608	6 6 1 11 Facilitate the inclusion of national program priorities in the development and implementation of															
609	6 6 1 12 Improve referral system linking the different program areas and the various levels of the health															
611	6 7 Activity 4 Strengthen the daya training program	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
612	6 7 1 Conduct formative research	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
613	6 7 1 1 Identify daya care and delivery practices	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
614	6 7 1 2 Assist in improvement of the 10 day daya training program															
615	6 7 1 3 Modification to training program as necessary															
616	6 7 1 4 MILESTONE Daya training program modified and ready for implementation															
617	6 7 2 Identify mechanisms for linking dayas to the formal health system (esp at the district level)															
618	6 7 3 Strengthen daya training															
619	6 7 3 1 Governorate level															
620	6 7 3 2 District level															
621	6 7 3 3 Facility level															
622	6 7 3 4 BENCHMARK Upgraded daya training course implemented in all 25 districts															
623	6 7 4 Strengthen daya supervision & monitoring															
624	6 7 4 1 Governorate level															
625	6 7 4 2 District level															
626	6 7 4 3 Facility level															
627	6 7 4 4 Train health workers and managers															
628	6 7 4 4 1 Gain support for daya involvement															

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## **TASK 7**

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
633	<b>7 TASK SEVEN Better Social Community Services</b>															
634	<b>7 1 Activity 1 Establish community interest groups</b>															
642	7 1 2 Phase II Qena & Fayoum															
643	7 1 2 1 Define and conduct an inventory of existing community groups															
644	7 1 2 2 Screen the inventory to identify groups of common interest with HMHC															
645	7 1 2 3 Conduct In depth Interviews and meetings to establish interest in HM/HC															
646	<u>7 1 2 4 BENCHMARK (CI) 66 Communities with active interest groups engaged in HM/HC</u>															
647	7 1 2 5 Develop and negotiate the establishment of CHCs															
648	7 1 2 6 Help facilitate the process of establishing CHCs															
649	<b>7 2 Activity 2 Inventory of partners</b>															
654	7 2 2 Utilize the Protocol															
657	7 2 2 3 Utilize the Protocol in Qena and Fayoum															
658	<u>7 2 2 4 BENCHMARK A priority list of potential community partners with health providers in Qena</u>															
659	<b>7 3 Activity 3 Development of a community needs identification and decision making tool</b>															
660	7 3 1 Review previous experience of donors and the governorates and identify lessons learned															
661	7 3 2 Develop a tool for needs assessment and decision making															
662	<u>7 3 3 BENCHMARK draft tool developed</u>															
663	7 3 4 Circulate draft for review and feedback															
664	7 3 5 Refine consolidate and finalize the tool															
665	7 3 6 Train CHCs to Utilize the tool in five communities															
666	7 3 7 Monitoring the utilization of the tool in the five communities															
667	<u>7 3 8 MILESTONE 5 Communities with needs identification tool implemented</u>															
668	<b>7 4 Activity 4 Health Care Provider Sensitization</b>															
673	7 4 5 Revise qualitative reasearch instrument for community diagnosis used by MC															
674	7 4 6 Conduct rapid qualitative research in a sample of communities in Beni Suef Qena and Fayoum on															
675	7 4 7 Developmen and testing of sensitization orientation materials based on the conclusions and results of the study															
676	7 4 8 Conduit sensitization orientation to health care providers to raise awareness of health problems and															
677	<u>7 4 9 BENCHMARK (CI) 150 health care providers/provider organizations participated in</u>															
678	<b>7 5 Activity 5 Testing different partnership schemes</b>															
680	7 5 2 Implement and monitor several different partnership schemes to provide health services at the community level															
681	<u>7 5 3 BENCHMARK (CI) 25 community provider partnerships established and functioning with health care</u>															
682	<u>7 5 4 BENCHMARK (CI) 25 areas where emergency obstetrical transport is available for women</u>															
683	<u>7 5 5 BENCHMARK (CI) 25 communities where key child survival actions including nutrition actions are available</u>															
684	<u>7 5 6 TARGET community provider partnership services offered in 5 districts by end of Year 1</u>															
685	7 5 7 Implement and monitor partnerships schemes in other districts															
686	<u>7 5 8 BENCHMARK (CI) 66 community provider partnerships established and functioning with health care</u>															

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
687	<u>7 5 9 BENCHMARK (CI) 66 areas where emergency obstetrical transport is available</u>															★
688	<u>7 5 10 BENCHMARK (CI) 66 communities where key child survival actions including nutrition action are available</u>															★
689	<u>7 5 11 TARGET community provider partnership services offered in 10 districts by the end of Year 2</u>															◆
690	<u>7 5 12 Conduct workshops with the interest community groups to review partnerships schemes established so far</u>															▶
696	<b>7 7 Activity 7 Community Education</b>															
701	<u>7 7 5 BENCHMARK (CI) 25 communities with HM/HC health communications activities underway</u>		★													
702	<u>7 7 6 Conduct a number of community education workshops to be phased in accordance with the</u>															▶
703	<u>7 7 7 BENCHMARK (CI) 66 communities with HM/HC health communications activities underway</u>															★

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## **TASK 8**

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
704	<b>8 TASK EIGHT IEC Campaign</b>															
705	<b>8 1 Activity 1 Reinforcing MOHP SIS collaboration</b>															
710	8 1 5 Identification of persons to be trained in Baltimore															
711	8 1 6 Confirmation of available space in JHU training															
712	8 1 7 Logistics for training															
713	8 1 8 BENCHMARK (CI) 17 MOHP staff trained at Baltimore based Advances in FH Communication															
722	<b>8 3 Activity 3 Investigation of Behavioral Information</b>															
723	8 3 1 Review Existing Information															
730	8 3 1 7 conduct area specific literature review of three project areas not yet investigated (Q B F) to															
734	<b>8 4 Activity 4 Strategic design for health communication</b>															
735	8 4 1 Draft Comprehensive Overarching Communication Strategy Design															
738	8 4 1 3 strengthen existing IEC task force with additional maternal health communication experts if															
739	8 4 2 Communicate with communities and health providers to identify appropriate local communication strategies															
740	8 4 2 1 develop forum to share local research results/ conclusions with community groups health providers															
741	8 4 2 2 incorporate community/provider input into development of community component of national															
742	8 4 3 MILESTONE National IEC Strategy Developed															
743	<b>8 5 Activity 5 IEC Training</b>															
744	8 5 1 Updating the IEC protocol and modules															
747	8 5 1 3 Develop IEC elements for in service training for physicians and other health professionals															
748	8 5 1 4 Finalize all components of the IEC protocol and modules															
749	8 5 1 5 BENCHMARK IEC Training Package completed															
750	8 5 1 6 IC 1 Counseling/interpersonal communication module upgraded															
751	8 5 1 7 Insure the integration of the IEC protocol into the EOC training package															
752	8 5 1 8 Develop a supervision tool															
753	8 5 1 9 conduct IEC training as part of the EOC training package															
754	8 5 2 Development of an IEC orientation package															
755	8 5 2 1 Identify elements of the package from the IEC strategy															
756	8 5 2 2 Identify target audience															
757	8 5 2 3 Review of available materials															
758	8 5 2 4 Design the package format															
759	8 5 2 5 Develop the package contents															
760	8 5 2 6 IC Two training videos developed and deployed															
761	8 5 2 7 Review package contents with other related Tasks															
762	8 5 2 8 Finalize IEC orientation package															
763	8 5 2 9 BENCHMARK IEC orientation package completed															
764	8 5 2 10 Set schedules for the orientation in collaboration with Task Seven															

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
765	8 5 2 11 Conduct first round of IEC orientation															
766	<u>8 5 2 12 IC, 100 Health educators and Others trained</u>															
767	8 5 2 13 Update package as necessary															
768	8 5 2 14 Set schedules for the orientation in collaboration with Task Seven															
769	8 5 2 15 Conduct second round of IEC orientation															
770	<u>8 5 2 16 BENCHMARK (CI) 200 Health educators and Others trained</u>															
775	<b>8 6 Activity 6 development of interpersonal communication materials</b>															
776	8 6 1 Identification and development of IP materials															
777	8 6 1 1 Develop a framework of materials in accordance with the strategy															
778	8 6 1 2 Draft materials															
779	8 6 1 3 Production of Interpersonal Communication Materials															
780	8 6 1 3 1 Identify firm for production															
781	<u>8 6 1 3 2 Materials design</u>															
782	8 6 1 3 3 pretest															
783	8 6 1 3 4 produce															
784	<u>8 6 1 3 5 BENCHMARK (CI) 2,000 000 print materials produced</u>															
785	8 6 1 3 6 Plan for distribution developed															
786	8 6 1 3 7 distribute materials to target governorates															
787	<b>8 7 Activity 7 Develop demand generation campaign for HM/HC services and essential behaviors</b>															
788	8 7 1 Demand generation campaign development															
789	8 7 1 1 Select creative resources															
790	8 7 1 2 Draft materials															
791	8 7 1 3 Pretest															
792	<u>8 7 1 4 MILESTONE National IEC campaign developed</u>															
793	8 7 2 Implementation of the campaign															
794	8 7 2 1 Identification of production firm(12 T V spots 12 radio spots and two ente-educate)															
795	8 7 2 2 Production executed															
796	8 7 2 3 Develop distribution/dissemination plan															
797	<b>8 8 Activity 8 Develop community support for essential behaviors and services</b>															
798	8 8 1 Select creative resources															
799	8 8 2 Assist NGO in development of grant proposals for IEC activities															
803	<b>8 9 Activity 9 Promotion of quality services The Gold Star approach</b>															
804	8 9 1 Explore the option of appending the Gold Star to HM/HC logo for clinics that meet criteria															
805	8 9 1 1 Consider making the Gold Star the symbol of integrated primary care services															
806	<u>8 9 1 2 BENCHMARK Decision made about inclusion of the gold star approach</u>															
807	8 9 1 3 Determine best approach in close collaboration with MOHP and USAID															

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
808	8 9 2 Implementation of the gold star															
809	8 9 2 1 Develop SOW for STTA															
810	8 9 2 2 Identification of STTA to develop IEC gold star criteria															
811	8 9 2 3 Design a HM/HC IEC Gold Star Module															
812	8 9 2 4 Pretest the IEC Gold Star Module															
813	8 9 2 5 Implement Gold star in pilot governorate															
814	8 9 2 6 Identify lessons learnt from implementation															
815	8 9 2 7 Implement Gold star in remaining four governorates															
817	<b>8 10 Activity 10 Female genital mutilation</b>															
818	8 10 1 Identify interested groups and resources															
819	8 10 2 Development of a separate communication component to promote the elimination of FGM															

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## TASK 9

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
829	<b>9 TASK NINE Student Medical Insurance Program (SMIP)</b>															
834	9 5 Assess HIO s MIS as related to HM/HC activities															
835	<b>9 6 Health and Nutrition education program initiated to support the anemia control and immunization activities</b>															
840	9 6 5 Undertake qualitative research to fill gaps in the understanding of prony issues															
841	9 6 5 1 Develop research plan															
842	9 6 5 2 Training															
843	9 6 5 3 Implementation															
844	9 6 6 Analysis of research and development of strategies for behavior modification and perception changes															
845	9 6 7 Strategy submitted for approval															
846	<u>9 6 8 BENCHMARK Strategy approved</u>															
847	9 6 9 Materials development															
848	9 6 9 1 Draft materials															
849	9 6 9 2 Pretest materials															
850	9 6 9 3 Modify materials based on pretest results															
851	9 6 9 4 Retest materials															
852	9 6 9 5 Finalize materials and produce final versions															
853	<u>9 6 9 6 BENCHMARK Finalized pilot versions produced</u>															
854	9 6 10 Complete training of pilot users															
855	9 6 11 Monitor pilot implementation															
856	9 6 12 Assess program impact															
857	9 6 13 Revise print and duplicate educational materials															
858	9 6 14 Develop operational plans protocols and training material with 5 governorates															
866	<b>9 7 Activity 2 Anemia Control Program</b>															
869	9 7 3 design and carry out needed research studies on anemia and intestinal parasitism															
870	9 7 4 establish a steering committee for strategy development in pilot areas and develop overall strategy															
871	<u>9 7 5 BENCHMARK Coordinating committee meeting held</u>															
872	9 7 6 Obtain approvals for strategy															
873	9 7 7 Prepare and conduct a pilot in selected districts															
874	9 7 7 1 Specify materials needed and order them															
875	9 7 7 2 Develop protocols and training materials															
876	9 7 7 3 Train staff															
877	<u>9 7 7 4 BENCHMARK Staff trained</u>															
878	9 7 7 5 Monitor implementation															
879	9 7 7 6 Develop and report results															
880	<u>9 7 7 7 BENCHMARK Report on pilot test completed</u>															
881	9 7 8 Conduct a meeting of the steering committee															

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
882	9 7 9 Revise strategy															
883	9 7 10 BENCHMARK Revised policy approved															
884	9 7 11 Develop operational plans with 5 governorates															
885	9 7 12 Develop protocols and training materials for governorates															
886	9 7 13 Specify materials needed for governorates and order them															
897	9 8 Activity 3 Tetanus immunization															
900	9 8 3 Pilot implementation															
903	9 8 3 3 Train staff															
904	9 8 3 4 BENCHMARK Staff trained															
905	9 8 3 5 Monitor implementation															
906	9 8 3 6 Develop and report results															
907	9 8 3 7 BENCHMARK Report on pilot implementation completed															
908	9 8 4 Develop and implement operational plans for 5 governorates															
909	9 8 4 1 Identify coordinators in governorates and conduct a planning workshop															
910	9 8 4 2 Develop tools to monitor coverage															
911	9 8 4 3 Train staff															
912	9 8 4 4 BENCHMARK Staff trained															
913	9 8 4 5 Monitor implementation															

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## **TASK 10**

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ID	Task/Activity/Sub activity	2000													
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
917	10 TASK TEN Small Grant Program	[Shaded bar]													
924	10 3 Identification and Assessment of potential NGO partners in Target Districts	[Shaded bar]													
927	10 3 3 Assess and identify potential NGOs in Gena and Fayoum	[Task bar with star]													
928	10 3 4 BENCHMARK Identification & assessment of potential NGO partners in Gena & Fayoum completed	[Task bar with star]													
929	10 4 Obtain Official Approval and consent form MOHP and MOSA to approach NGOs for grant giving	[Task bar]													
933	10 4 4 MOSA writes to its offices in the target districts	[Task bar]													
934	10 5 Assessment of work currently being done and potential for future grants in the target areas	[Task bar]													
939	10 5 2 Organize and conduct a workshop to discuss lessons learned and how to modify existing grant practices	[Task bar]													
940	10 5 3 BENCHMARK Workshop to discuss lessons learned conducted	[Task bar with star]													
955	10 9 Prepare and Approve the Invitation for Application	[Task bar]													
957	10 9 2 Submit IA Template to Contracting Officer for Comments Modifications and Approval	[Task bar]													
958	10 9 3 BENCHMARK Invitation for Application Template Approved By USAID	[Task bar with star]													
959	10 10 Provide Grants to Capable Local NGOs through a standanzed Mechanism	[Shaded bar]													
960	10 10 1 Phase I Aswan and Luxor	[Shaded bar]													
961	10 10 1 1 Conduct an Orentation Workshop to introduce the program explain our expectations to	[Task bar]													
962	10 10 1 1 1 Prepare for the workshop	[Task bar]													
963	10 10 1 1 2 Publishe Invitation for Application and Announce for the workshop in Aswan and	[Task bar]													
964	10 10 1 1 3 Conduct the Workshops (Probaply 3 2 in Aswan + 1 in Luxor)	[Task bar]													
965	10 10 1 1 4 BENCHMARK Workshop Conducted and Invitation for Application	[Task bar with star]													
966	10 10 1 2 Selection and Award	[Task bar]													
967	10 10 1 2 1 Recive proposals from NGOs Review and assign tech Staff to work on	[Task bar]													
968	10 10 1 2 2 Evaluate refined proposals according to selection crtena	[Task bar]													
969	10 10 1 2 3 Make field visits to ases the capacity of NGOs with successful proposals	[Task bar]													
970	10 10 1 2 4 discuss specific items in the proposals of selected NGOs that JSI/HMHC	[Task bar]													
971	10 10 1 2 5 Draft and Negotate the Contract with NGOs	[Task bar]													
972	10 10 1 2 6 Send final contract & amendments for approvals by USAID	[Task bar]													
973	10 10 1 2 7 Award the Grants (Sign Contracts with NGOs)	[Task bar]													
974	10 10 1 2 8 BENCHMARK Approx 25 30 Grants awarded to NGOs	[Task bar with star]													
975	10 10 1 3 Work with NGOs that did not receive a grant through the last process in order to build their	[Shaded bar]													
976	10 10 1 3 1 Assesment and Training	[Task bar]													
977	10 10 1 3 1 1 Identify the NGOs/Applications that did not qualify for	[Task bar]													
978	10 10 1 3 1 2 Determine the kind of assistance / training needed for each	[Task bar]													
979	10 10 1 3 1 3 Contract the appropnate Consultant/ Institution to give the required	[Task bar]													
980	10 10 1 3 1 4 Conduct the training	[Task bar]													
981	10 10 1 3 2 Request Applications	[Task bar]													
982	10 10 1 3 3 Selecton and Award	[Task bar]													



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## **TASK 11**

**JSI HM/HC Year 2 Annual Workplan**

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ID	Task/Activity/Sub activity	2000													
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1061	<b>11 TASK ELEVEN Commodity Procurement Program</b>														
1063	<b>11 2 Activity 1 Procurement of project equipment</b>														
1064	<b>11 2 1 Tranche 1 Procurement of equipment to be installed 31/3/99</b>														
1069	11 2 1 5 Consolidate goods at US freight forwarded warehouse (varies depending on suppliers lead time)	[Gantt bar from Feb to Mar]													
1070	11 2 1 6 Arrange for shipping	[Gantt bar from Mar to Apr]													
1071	11 2 1 7 Handle customs clearance and delivery (delivery to districts might involve more time)	[Gantt bar from Apr to May]													
1072	11 2 1 8 Coordinate installation and training if applicable and required	[Gantt bar from May to Jun]													
1073	<b>11 2 2 Tranche 2 Procurement of equipment to be installed 30/6/99</b>														
1077	11 2 2 4 Place orders and request L/C (when analysis is approved)	[Gantt bar from Jun to Jul]													
1078	11 2 2 5 Consolidate goods at US freight forwarded warehouse (varies depending on suppliers lead time)	[Gantt bar from Jul to Aug]													
1079	11 2 2 6 Arrange for shipping	[Gantt bar from Aug to Sep]													
1080	11 2 2 7 Handle customs clearance and delivery (delivery to districts might involve more time)	[Gantt bar from Sep to Oct]													
1081	11 2 2 8 Coordinate installation and training if applicable and required	[Gantt bar from Oct to Nov]													
1082	<b>11 2 3 Tranche 3 Procurement of equipment to be installed 31/12/99</b>														
1083	11 2 3 1 Refine specifications (when needs assessment is received from JSI)	[Gantt bar from Nov to Dec]													
1084	11 2 3 2 Solicit offers (when procurement plan is approved)	[Gantt bar from Dec to Jan]													
1085	11 2 3 3 Analyze offers received (varies from 10 - 15 days)	[Gantt bar from Jan to Feb]													
1086	11 2 3 4 Place orders and request L/C (when analysis is approved)	[Gantt bar from Feb to Mar]													
1087	11 2 3 5 Consolidate goods at US freight forwarded warehouse (varies depending on suppliers lead time)	[Gantt bar from Mar to Apr]													
1088	11 2 3 6 Arrange for shipping	[Gantt bar from Apr to May]													
1089	11 2 3 7 Handle customs clearance and delivery (delivery to districts might involve more time)	[Gantt bar from May to Jun]													
1090	11 2 3 8 Coordinate installation and training if applicable and required	[Gantt bar from Jun to Jul]													
1091	<b>11 2 4 Tranche 4 Procurement of equipment to be installed 31/1/00</b>														
1092	11 2 4 1 Refine specifications (when needs assessment is received from JSI)	[Gantt bar from Jul to Aug]													
1093	11 2 4 2 Solicit offers (when procurement plan is approved)	[Gantt bar from Aug to Sep]													
1094	11 2 4 3 Analyze offers received (varies from 10 - 15 days)	[Gantt bar from Sep to Oct]													
1095	11 2 4 4 Place orders and request L/C (when analysis is approved)	[Gantt bar from Oct to Nov]													
1096	11 2 4 5 Consolidate goods at US freight forwarded warehouse (varies depending on suppliers lead time)	[Gantt bar from Nov to Dec]													
1097	11 2 4 6 Arrange for shipping	[Gantt bar from Dec to Jan]													
1098	11 2 4 7 Handle customs clearance and delivery (delivery to districts might involve more time)	[Gantt bar from Jan to Feb]													
1099	11 2 4 8 Coordinate installation and training if applicable and required	[Gantt bar from Feb to Mar]													
1100	<b>11 2 5 Tranche 5 Procurement of equipment to be installed 31/3/00</b>														
1101	11 2 5 1 Refine specifications (when needs assessment is received from JSI)	[Gantt bar from Mar to Apr]													
1102	11 2 5 2 Solicit offers (when procurement plan is approved)	[Gantt bar from Apr to May]													
1103	11 2 5 3 Analyze offers received (varies from 10 - 15 days)	[Gantt bar from May to Jun]													
1104	11 2 5 4 Place orders and request L/C (when analysis is approved)	[Gantt bar from Jun to Jul]													

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ID	Task/Activity/Sub activity	2000														
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
1105	11 2 5 5 Consolidate goods at US freight forwarded warehouse (vaner depending on suppliers lead time)															
1106	11 2 5 6 Arrange for shipping															
1107	11 2 5 7 Handle customs clearance and delivery (delivery to districts might involve more time)															
1108	11 2 5 8 Coordinate installation and training if applicable and required															
1109	<b>11 2 6 Tranche 6 Procurement of equipment to be installed 30/6/00</b>															
1110	11 2 6 1 Refine specifications (when needs assessment is received from JSI)															
1111	11 2 6 2 Solicit offers (when procurement plan is approved)															
1112	11 2 6 3 Analyze offers received (vaner from 10 15 days)															
1113	11 2 6 4 Place orders and request L/C (when analysis is approved)															
1114	11 2 6 5 Consolidate goods at US freight forwarded warehouse (vaner depending on suppliers lead time)															
1136	11 2 9 Generate quarterly progress reports															
1149	11 2 10 Generate semiannual procurement plan															