



Healthy Mother/Healthy Child Results Package

Annual Work Plan

Contract Year IV

March 15, 2001 – September 15, 2001



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The Manoff Group, Inc.
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In collaboration with
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ACRONYMS

ANC	Antenatal Care
ARI	Acute Respiratory Illness
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
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
DHC	District Health Committee
DHSC	District Health Steering Committee
DHT	District Health Team
DMT	District Management Team
DT2	Development Training Two
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
GHC	Governorate Health Committee
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
IFA	Invitation for Application
IL	Implementation Letter
IMCI	Integrated Management of Childhood Illness

IMR	Infant Mortality Rate
IPC	Interpersonal Communication
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
LOI	Letter of Intent
MCH	Maternal Child Health
MCH BBP	Maternal and Child Health part of the Basic Benefits Package
MOHP	Ministry of Health and Population
MOI	Ministry of Information
MOSA	Ministry of Social Affairs
NCNW	National Council of Negro Women
NCU	Neonatal Care Unit
NICHP	National Information Center for Health and Population
NICU	Neonatal Intensive Care Unit
NGO	Non Governmental Organization
NMMS	National Maternal Mortality Study
BBP	Basic Benefits Package
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
SHIP	Student Health 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 UNICEF, Wellstart, Credit Guarantee Company, Hepatitis C Project, Partnership in Health Reform, Pathfinder International, National Information Center for Health and Population, NGO Service Center, Institute of International Education-Development Training Two, Healthy Egyptians 2010 and the Field Epidemiology Training Program.

As stated in the contract, there are six **major process outcomes**, to which JSI's technical assistance efforts will contribute:

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 thirty 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.

These outcomes will contribute to achieving the following quantitative outcomes by the year 2001:

<u>Baseline</u>	<u>Target</u>	<u>Indicator</u>
85 (1992)	73	Under five mortality rate
62 (1992)	53	Infant mortality rate
174 (1992)	139	Maternal mortality ratio
47% (1992)	35%	Case fatality rate for obstetric emergencies
33 (1992)	27	Neonatal mortality rate
22% (1990)	70%	Women receiving prenatal care
67% (1992)	90%	Children fully immunized before 1st birthday
71 (1995)	0	Number of indigenous confirmed polio cases
790 (1995)	200	Neonatal tetanus cases
29% (1992)	75%	Newborns exclusively breastfed for 4-5 months
0 (1995)	65	Target districts implementing essential services

The USAID **Strategic Objectives Framework** of the Health Office is presented in Annex A1. This is the original Strategic Objective No. 5 Framework developed by USAID, which has been revised and replaced by a Strategic Objective No. 20, which merges health and population sector activities; a copy of this revised Framework is in Annex A2. A **Contract Framework** which includes a summary of the goals, objectives and outcomes of the Healthy Mother/Healthy Child Results Package is provided in Annex 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 Four – the final six months of the base contract. Since USAID has expressed its intention of exercising the option of renewing the contract for an additional 3½ years, this AWP does not include contract close-out activities.

The AWP is divided into five Sections:

- Section I** describes the strategy and approach that JSI is taking to address the constraints to improving maternal and child health in Upper Egypt;
- Section II** provides a brief summary annual report of the previous year's accomplishments;
- Section III** explains the Organization and Development of the AWP;
- Section IV** contains integrated plans for each Target Governorate; and
- Section V** presents details of the specific tasks and activities to be implemented and their scheduling to meet contract milestones and targets.

SECTION I

HM/HC Strategy – the Basic Benefits Package

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 Maternal and Child Health part of the Basic Benefits Package¹ (MCH BBP), 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:

- lack of clear standards and protocols;
- fragmented obstetrical/gynecology and pediatric services;
- poor maternal health services in PHC hospitals and clinics;
- poor infection control practices;
- general underutilization of nurses and nurse-midwives;
- weak public demand for some services;
- weak referral between facility levels;
- shortage of resources such as drugs and equipment; and
- low priority given to preventive health services.

The widespread adoption of the MCH BBP 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%.² 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 MCH part of the Basic Benefits Package 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 3.

¹ To be consistent with other programs in the MOHP, this term, "MCH part of the Basic Benefits Package," replaces the "HM/HC Package of Essential Services" term used in the Contract based on the Consensus Meeting, 1999.

² Mother-Baby Package. Implementing Safe Motherhood in Countries, WHO, 1994.

The Pathway to Survival:

The continuum of care represented in the MCH part of the Basic Benefits Package 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, 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.

Table 3 Major Areas of Care in the Maternal and Child Health Part of the Basic Benefits Package

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

For maternal care, the primary focus of the MCH BBP 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.

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. The health benefit of immunizations is clear, and HM/HC efforts are to ensure the continuation of the MOHP EPI.

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 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 Basic Benefits Package and standards into medical and nursing schools and to further cost recovery and reform policies in support of cost-effective health care.

Table 4 shows how the Pathway to Survival steps are linked to HM/HC objectives and interventions.

Table 4. Steps in the Pathway to Survival

Problems	Pathway to Survival Steps	HM/HC Objectives	HM/HC Activities and Interventions (contract Task No.)	Coordination with Partners	
				MOHP	Others
Problems: Maternal ♦ 1992 MMR in UE 217/100,000 ♦ 92% deaths avoidable ♦ 42% deaths due to delay ♦ 71% sought care ♦ Major causes of death: Hemorrhage, Pre/Eclampsia, Sepsis	Step 1. Recognition of Problem ♦ Knowledge ♦ Awareness ♦ Effect / vulnerability	Increase knowledge and improve health behavior of households	♦ Support better antenatal care especially for high risk pregnancies (1) ♦ Support early postpartum home visits(1,6) ♦ Community education on danger signs ♦ Daya training on danger signs (1,6) ♦ NGO activities (10) ♦ Research on health knowledge (5) ♦ Research on nutrition knowledge (9)	MCH Dept Training Unit IEC Unit Daya program Social Services Research Unit HIO/SMIP	UNICEF NGO Service Center
Problems: Neonatal ♦ NMR in UE 40.5/1000 ♦ 70% died at home in 1 st week ♦ 40% received care ♦ Major causes of death: Asphyxia, Birth trauma, ARI and diarrhea	Step 2. Decision to Seek Care ♦ Behavior ♦ Motivation to seek care ♦ Barriers		♦ Daya and health provider links improved (6) ♦ Research on care seeking and barriers (5,7,8) ♦ Community groups and NGO activities to reduce local barriers (7,10) ♦ Sensitize health providers to community needs (7)	MCH Dept Training Unit IEC Unit Daya program Social Services Research Unit	UNICEF NGO Service Center FETP
Problems: Child (<5 yrs) ♦ Mortality 112/1000 ♦ Diarrhea ♦ ARI ♦ Nutritional deficiencies ♦ Immunizable diseases	Step 3. Access to Care (Logistics to reach) ♦ Transportation ♦ Cost		♦ Community resources mobilized for transport and other support (7,10)	Social Services IMCI	NGO Service Center UNICEF
Problems: Adolescent ♦ 50% school children anemic ♦ Poor health knowledge				♦ Improve quality and access to nutrition education, iron supplements and TT immunization in schools (9)	HIO/SMIP

<p>Problems: Providers and Facilities</p> <ul style="list-style-type: none"> ◆ 47% of maternal deaths due to substandard obstetric care ◆ 12% due to GPs and 12% to dayas ◆ 6% to lack of blood, 4%transport,2% drugs/supplies ◆ 25% NCU mortality ◆ Limited services available in MOHP facilities ◆ No referral system ◆ Lack of management systems to maintain quality of service ◆ Low demand for services 	<p>Step 4. Quality Care</p> <ul style="list-style-type: none"> ◆ Knowledge, skills, attitudes, behaviors ◆ Technical competency: training & experience, effectiveness, safety ◆ Ability to provide supplies, equipment, drugs ◆ Continuity of care 	<p>Improve quality of essential maternal, perinatal and child health services</p> <p>Strengthen district capability to provide essential MPC health services</p> <p>Sustain established child survival programs</p>	<ul style="list-style-type: none"> ◆ Upgrade selected anchor facilities (1,3) ◆ Establish national service standards for obstetric and neonatal care (1,6) ◆ Improve planning and management systems to ensure staff and resources available and in compliance to standards (3) ◆ Provide competency-based training for clinical trainers, doctors, nurses, midwives (1,2) ◆ Revise medical and nursing school curricula and improve training skills on include CBT methods and service standards (1,2) ◆ Develop and test maternal and neonatal referral system (1,3) ◆ Assist MOHP to improve ANC, PP, ARI, CDD, EPI services in target governorates (1,6) ◆ Train private providers in essential obstetric and neonatal care topics (1,2) ◆ Conduct research on mortality patterns and OR to improve service effectiveness (5) ◆ Improve nutrition education curricula and health educator skills (9) 	<p>Administration Engineering Dept QA unit MCH unit ARI,CDD,EPI IMCI NPCP Training Unit Medical education Research unit HIS/NICHIP POPIV HIO/SMIP</p>	<p>Pathfinder FETP PHR CGC DT2</p>
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Summary of Contract Tasks:

A descriptive summary of the tasks included in JSI’s contract is presented below. Details of each of JSI’s eleven tasks and sub-activities are presented in the work plan in Section V.

Task One: Basic Benefits Package Established and Standards Defined. Assess the cost-effectiveness and appropriateness of the elements in the MCH BBP; upgrade anchor facilities; provide competency-based training of service providers in MCH BBP; 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 included in Medical and Nursing Curricula plus Clinical Practice in Pre/In-Service Training System Designed to Disseminate Standards to Public and Private Providers. Adapt medical and nursing school curricula to include the MCH BBP 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 MCH BBP and management.

Task Three: Public and Private Provider Partnerships with Communities to Develop and Manage District Plans. 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 in place to Track Utilization 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: 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: National Child Survival Programs Sustained. Assess current CSP program (ARI, EPI, CDD, neonatal care, daya 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 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 (IEC) Campaign. Develop and implement an IEC 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.

Task Nine: School Medical Insurance Program. Review Health Insurance Organization (HIO) school health program policies and programs and strengthen activities for health and nutrition 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 II

Summary Annual Report

March 15, 2000 – March 14, 2001

As stated in JSI's contract with USAID, "...the annual work plan shall include a brief summary annual report on the previous year's activities and budget detail." This Section of the AWP contains the Summary Annual Report; Annex F contains the Budget Detail.

In October 2000, USAID modified the JSI contract to make several adjustments to the contract. Some of the changes were minor and addressed inconsistencies in the original contract. The following is a summary of the major changes made through the contract modification:

- Provision of architectural and engineering technical assistance services to facilitate MOHP renovation of facilities;
- Provision of on-the-job training and technical assistance in obstetrical and neonatal protocols by clinical supervisors;
- Addition of a perinatal/neonatal component to the maternal mortality study;
- Provision of technical assistance to strengthen the newly established maternal mortality surveillance system;
- Provision of technical assistance in the finalization of a daya refresher training course curriculum;
- Provision of technical assistance to the perinatal care program;
- Development of clinical protocols and service standards for all levels of neonatal care centers;
- Provision of technical assistance to the MOHP in establishing a neonatal screening program for congenital anomalies;
- Replacement of SIS with MOHP and other partners in the development and production of IEC materials and the development and implementation of IEC campaigns;
- Increased the level of effort for the iron supplementation and nutrition education program to include boys and expansion to include anti-smoking activities;
- Rescheduling of the milestones for the small grants program;
- Addition of funds to cover the procurement of additional commodities;
- Authorization to renovate district health information centers.

Changes in strategy and activities resulting from these modifications are included in this Annual Work Plan.

The HM/HCRP contributes to the MOHP and USAID goal of reducing mortality among women and children through its efforts in Upper Egypt to increase the supply, quality and utilization of maternal and child health services and to improve health knowledge and practices in the target populations.

Part I of this section summarizes the activities completed to-date in the five target governorates, other Upper Egypt governorates (selected activities only), and at the national level. In Part II we examine the data available for assessing the effectiveness to-date of HM/HCRP interventions towards achieving the overall program objective. Together, this information presents a comprehensive picture of the HM/HCRP accomplishments.

Part I. Summary of Activities Completed To-Date

I.A. Improving Obstetric Services

In the five target governorates, HM/HCRP personnel worked with MOHP staff from selected health facilities, and 25 District and Governorate Management Teams worked with MOHP staff to achieve the following, as summarized in Table 1:

- The obstetric services and physical plant of 102 facilities have been assessed to-date in the five governorates, including 5 general hospitals, 25 district hospitals, 44 integrated hospitals, 4 maternity centers, and 24 rural and urban health centers/units. Upgrading activities were completed or are in process as per the HM/HCRP phasing schedule (see Table 5 of Section III). In Phase I and II districts, 38 obstetric wards have been renovated and 30 have received equipment and supplies needed for quality obstetric services.
- A total of 227 Ob/Gyn Specialists and General Practitioners have been trained as part of the competency-based training program in essential obstetric care; 255 nurses have received training in infection control and interpersonal communication skills. In addition, 44 anesthesiologists have been trained on best practices for obstetrical cases. Delivery room staff now receive training in neonatal resuscitation skills.
- 33 district level obstetric clinical trainers/supervisors have been trained to provide ongoing support to trainees in the health facilities in achieve competency in clinical skills.

At the national level, six medical and six nursing schools have integrated the competency-based training curricula in their obstetrics, and maternal health education programs and students are now being taught using this curricula. Guidelines for postpartum care were revised and issued for national implementation to increase the proportion of women and newborns receiving care during this critical period.

Activity	Aswan	Luxor	Qena	Fayoum	Beni Suef	TOTAL
Obstetric facility assessments completed	19	7	35	20	21	102
Facility renovations completed	15	6	12	2	3	38
Facilities equipped	15	6	9	--	--	30
District Obstetric clinical supervisors trained	9	7	5	12	--	33
Physicians trained in essential obstetric care	65	40	56	41	25	227
Nurses trained in infection control, personal communications, obstetrics	138	42	66	9	--	255
Anesthesiologists trained in anesthesiology for obstetrics	9	11	16	8	--	44

I.B. Improving Neonatal Care Services

In the target governorates, implementation of a comprehensive perinatal program with multiple linkages at all levels is well underway as part of the MCH package of services. Hospital-based neonatal center services have been improved through physical facility renovations, new equipment, clinical training, and implementation of standardized protocols and service standards. A summary of activities follows:

- 19 neonatal care centers in the five governorates have been assessed, and all 7 centers in the Phase I and II districts have been renovated and equipped. In Phase III districts the centers have received equipment and supplies to enable them to provide appropriate care. Five more units are under renovation and commodities are being procured for all remaining centers. (See Table 2A)
- 33 neonatal care center assessments have also been completed in Sohag, Minya, Assuit and Giza (see Table 2B).
- A total of 134 physicians, 100% of the target, have received training in basic and advanced neonatal care as part of the competency-based training program. Nineteen neonatal centers now have a minimum of one or more trained physicians.
- Eight national-level and ten district-level neonatal clinical trainers/supervisors have been trained to provide ongoing clinical support and supervision to trainees as they work towards achieving competency.
- New hospital policies and procedures for integrating obstetrical and neonatal care have been developed by a special working group and 48 hospital staff members trained to-date on implementation.

Activity	Aswan	Luxor	Qena	Fayoum	Beni Suef	TOTAL
Neonatal unit assessments completed	3	2	6	4	4	19
Facilities renovated	2 1 in process	2	3 3 in process	2 in process (2 no renovations needed)	2 in process (2 no renovations needed)	7 8 in process (4 no renovations needed)
Facilities equipped	3	2	3 3 in process	2 2 in process	3 1 in process	13 6 in process
District neonatal clinical supervisors trained	1	2	4	2	1	10
Physicians trained in basic and/or advanced neonatal care	11	10	21	17	34	93
Hospital staff trained in integrated perinatal care	11	4	13	13	7	48

Activity	Assiut	Sohag	Menya	Giza	TOTAL
Neonatal unit assessments completed	9	6	8	10	33

At the national level, review and revision of the Egyptian Perinatal/Neonatal Care Program was completed and approved by the MOHP. In follow-up, 138 neonatal centers in 27 governorates were assessed and re-classified according to their level of care. A regional referral system for Upper Egypt has been developed to link NC Level II, III and IV services. Competency-based neonatal curricula have been integrated into 6 medical and 6 nursing schools, teaching staff trained and students are now being taught using the curricula. A team of obstetrics and neonatal staff of teaching hospitals received training in neonatal and maternal-fetal medicine in the U.S. to promote its development in Egypt.

I.C. Improving District Management, Supervision and Health Information

- Five Governorate (GMT) and 25 District Management Teams (DMT) have been established, and a total of 185 team members have been trained/ oriented in Management/Planning and Quality Assurance. This is 100% of the end-of-project target. The teams meet regularly on a quarterly and monthly basis, respectively.
- Five Governorate (GHC) and 25 District Health Committees (DHC) have also been established to coordinate with and support DMTs and GMTs in planning and building closer ties with communities. This is 100% of the end-of-project target.
- 37 Facility Management Teams (FMT) were established in district hospitals and upgraded facilities in four target governorates.
- District health plans were developed for FY 2000-2001, and the plans reviewed and approved by the GMTs.
- All district management teams have been trained in using the Quality Assurance checklists for basic MCH and Obstetric Care and five quarters of data have been collected for facilities in Luxor and Aswan governorates.
- 31 District Information Centers (DIC) in the five target governorates have been established and are functioning after receiving computer equipment, furniture and renovations. A total of 163 staff have been trained on computer skills and the MOHP computerized Health Information System. Five Governorate Information Centers (GIC) were also upgraded with new equipment and furniture. As for Menya, Sohag and Assiut Governorates, 13 DICs have been established and 52 staff were trained in Assiut. Work is also proceeding to establish 9 centers in Sohag and 11 centers in Menya in 2001 (Table 3B).

Table 3A. District/Governorate Management and Health Information Development Status

Activity	Aswan	Luxor	Qena	Fayoum	Beni Suef	TOTAL
Governorate Management Teams established	1	1	1	1	1	5
District Management Teams established	5	2	9	4	5	25
Governorate & District Health Committees established	6	3	10	5	6	30
Team members trained in mgmt & planning	68	50	114	45	71	348
Facility management teams established	19	7	10	1	-	37
District Information Centers established	5	2	11	6	7	31
Governorate Information Centers upgraded	1	1	1	1	1	5
MHIS staff trained in computer skills and HIS	24	8	41	24	27	124
Vehicles received for MCH supervision	6	3	12	7	8	36

Activity	Assiut	Sohag	Menya	TOTAL
District Information Centers established	13	9 in process	11 in process	33
Governorate Information Centers upgraded	1	1	1	3
MHIS staff trained in computer skills and HIS	52	--	--	52

I. D. Mobilizing the Community and Establishing Partnerships with Health Providers

- 53 Community Health Committees (CHCs) have been established with a total of 503 community leader members (the end-of-project target for CHCs to be established was 50). They have all been introduced to the project and oriented to services provided by the newly upgraded maternal and neonatal facilities.
- 53 CHCs have conducted community needs assessments and developed action plans based upon the priorities identified. This is more than 100% of the original target (see above). 887 outreach workers were trained to conduct the assessments.
- 401 health providers from the facilities in the 25 districts were sensitized to community beliefs, perceptions and knowledge related to maternal and child health care. Community attitudes and the concept of client rights and satisfaction were discussed and introduced.
- 52 local non-governmental organizations (NGOs) have been awarded small grants to conduct outreach activities in the target districts, primarily IEC activities in MCH. The end-of-project target is 100 NGO grants.
- A total of 487 NGO staff were trained on proposal writing and those with a grant were trained in financial management. The original target was 100 NGO staff trained.
- 280 outreach workers working for the 52 NGOs with grants were trained in MCH topics.

Activity	Aswan	Luxor	Qena	Fayoum	Beni Suef	TOTAL
Community Health Committees established	12	5	15	14	7	53
CHC members trained in community needs assessment	375	216	450	114	130	1,285
Outreach workers trained in community needs assessment	191	154	203	210	129	887
CHC Action Plans developed	12	5	15	14	7	53
Health providers participated in 'sensitization' seminars	92	20	158	89	42	401
Small grants awarded to NGOs	21	9	22	--	--	52
NGO staff trained in proposal writing and financial management	182	62	187	--	56	487
NGO outreach workers trained in MCH topics	214	66	--	--	--	280

I.E. Improving health knowledge and behaviors in households

- A national public awareness campaign was launched covering the elements of Birth Preparedness, Clean Chain, Three Delays, and Antenatal Care. Four TV spots, 4 radio spots, a song, 1.7 million print materials were developed, printed and distributed, and local community activities were conducted in all target governorates.
- To evaluate the effectiveness of the campaign, three population-based surveys were conducted in the target populations: a baseline survey, interim "snap shot" survey and post survey.
- A total number of 882,673 printed materials (posters, flyers, danglers, dispenser, and guide) have been distributed in the five governorates covering 3,186 different health units/centers, hospitals, private sector outlets, and NGOs. Printed materials were also distributed by the MOHP to all other governorates. The materials were also distributed by professional syndicates to the private sector pharmacists and physicians in the five target governorates.
- A total number of 31 community major local activities have been conducted and 109 smaller events in the five governorates; promotional activities made full use of campaign materials to support and reinforce campaign messages and behaviors.

I.F. Improving Adolescent Health with Nutrition Education and Anemia Control

During the year 2000 a pilot program was conducted in Aswan governorate. Based on the pilot, modifications were made in the Iron Supplementation (IS) and the Nutrition and Health Education program and a staggered implementation of the program in the five target governorates began in October 2000.

- Training was conducted for all governorates with 162 Health educators trained from which HIO selected the best-qualified 109 to hire. This is 100% of the end-of-project target.
- HIO printed and distributed all the educational materials required; 220,000 copies of a preparatory booklet, 220,000 copies of a booklet for preparatory parents, 145,000 copies of a secondary booklet and 75,400 copies of posters for the classrooms.
- An award winning TV spot was aired continuously on Channel 7 and 8 informing the community about the program.
- Almost 21 million iron and folic acid tablets and cups were purchased by the HIO for the school year 2000-2001. During the first semester of the school year almost eight million tablets were distributed. In the four governorates fully operating, on average, 827,915 students in 1264 schools participated each month.
- Training was also conducted for over 1,000 HIO and MOHP staff (in rural areas) on how to distribute, supervise and record iron tablet distribution.
- In Beni Suef a pilot of teachers conducting tablet distribution is being tested. This required over 5,000 teachers to be trained in addition to the 380 HIO/ MOHP staff to supervise the program.
- A School Sentinel Surveillance System was established to monitor the effectiveness of the program. Pretest data has been collected in all five governorates providing hemoglobin, heights, weights and knowledge, attitudes and practices on approximately 3,600 students.

Training on Program Implementation for Adolescent Anemia Prevention Program						
Activity	Aswan	Luxor	Qena	Fayoum	Beni Suef	TOTAL
Nutrition and Health Educators trained for 14 days	32	27	40	32	31	162
Nutrition and Health Educators hired by HIO	21	19	26	22	21	109
Trained to conduct Tablet Distribution	263	165	266	316	--	1,010
Teachers trained to conduct Tablet distribution	--	--	--	--	5,600	5,600
HIO/MOHP trained to supervise tablet distribution	--	--	--	--	380	380
Trained to conduct Surveillance	6	6	6	6	6	30
HIO Staff training on computer skills	1	3	2	3	--	9

Program Implementation Statistics						
Activity	Aswan		Luxor	Qena	Fayoum	TOTAL
Iron Supplementation	Pilot Feb.-Apr. 2000	Oct.-Dec. 2000	Oct.-Dec. 2000	Oct.-Dec. 2000	Oct.-Dec. 2000	
Average number of schools participating in Iron Supplementation	349	329	267	384	284	1,264
Average number of students participating in Iron Supplementation	140,291	151,787	158,908	277,411	239,809	827,915
Number of Iron Tablets distributed	1,424,763	1,797,530	1,914,109	2,820,052	1,262,786	9,219,240
Nutrition and Health Education	Feb-Apr. 2000	Oct.-Dec. 2000	Oct. 2000-Jan. 2001	Nov. -Dec. 2000	Dec. 2000	
Number of schools reached with Health Education	74	175	124	69	20	462
Number of students participating in Health Education	17,465	130,107	96,633	122,973	12,317	379,495
Number of Health Education Activities Conducted	1,325	5,166	3,702	2,909	308	13,410
Number of Brochures Distributed to Students	50,000	23,906	23,615	16,275	2,103	115,899
Number of Brochures Distributed to Parents	25,000	13,656	14,159	9,730	1,795	64,340

Part II. Improved Quality and Increased Utilization of Maternal, Perinatal and Child Health Services

In this next section, the data available are examined for assessing the effectiveness of HM/HCRP interventions to-date towards achieving the overall objective of "improved quality and increased utilization of maternal, perinatal and child health services". The main data sources reviewed are target governorate MOHP facility statistics, the IEC campaign population-based survey results, and the Egypt Demographic and Health Surveys.

Choosing a suitable baseline period of time from which to begin measuring change in service statistics is complicated by the phased implementation schedule of the various activities within districts and in some facilities. Where data are available, the calendar year 1999 is used as a baseline period for all Luxor, Aswan and South Qena districts for both obstetric and neonatal services. Difficulties were faced in obtaining 1998 and 1999 obstetric records from some hospitals, and thus only 2000 data are available for many hospitals. Neonatal data are available for all centers in 1999.

II.A. Obstetric services

In 2000, there were approximately 65,000 births in the ten target districts of Luxor, Aswan and South Qena. The great majority, approximately 70% were in rural areas where access to quality obstetric services, public or private, is more limited than in urban areas. Although most rural women still deliver at home with a daya, the recent EDHS shows this to be changing quite rapidly (see Table 5). The proportion of births delivered by a trained health provider is still only 38% in rural areas, but among urban women in Upper Egypt the proportion is approaching that of other urban areas in the country.

	1995	2000	Percent increase between the two surveys
National	46.3	60.9	31%
Urban	67.9	81.4	20%
Rural	32.8	48.0	47%
Upper Egypt	32.2	47.8	48%
Urban	59.6	74.7	25%
Rural	22.9	38.2	67%

* in five year period before survey.

The HM/HCRP efforts have focused on increasing the supply of basic delivery services in under-served primarily rural areas, and increasing the supply of quality services for managing obstetric complications in district hospitals. These facility-based interventions have been accompanied by activities in the community to increase demand for and use of appropriate maternal and neonatal health care in the surrounding communities.

The HM/HCRP priority is to ensure that women seek, and the public health system is able to provide, appropriate, safe obstetric care for normal and complicated pregnancies. All high-risk pregnancies and complicated deliveries should be managed in a facility by qualified personnel.

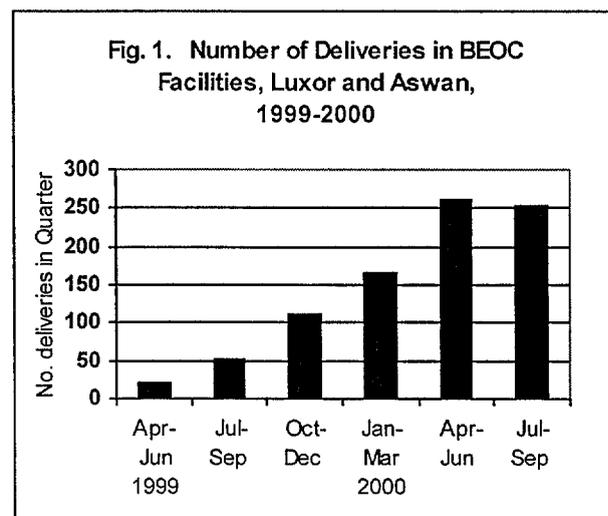
Facility deliveries are also promoted for normal deliveries where quality care is assured. Where quality of facility-based care is not assured, the priority is for deliveries to be assisted by a trained physician or nurse/midwife.

Delivery services

Increased supply. As a result of the sixteen new delivery units established in rural MOHP facilities in Luxor and Aswan districts, an estimated 135,000 women of reproductive age in rural areas now have greater access to quality delivery services.³ Another three delivery units established in urban facilities are currently providing women in these areas an alternative place to deliver other than the over-stretched obstetric wards in city hospitals. Only two of these 19 Basic Essential Obstetrical Care (BEOC) facilities had previously had delivery services and utilization was very low. The increased supply of public services means that more women can choose safe, clean delivery by a trained health provider.

Further, at the end of 2000, another seven MOHP health facilities were being prepared to provide delivery services for the first time to the 130,000 women of reproductive age in the three South Qena districts. (Because they were not yet open in 2000, these facilities are not included in the data presentation in the following section.)

The number of deliveries performed per month at the BEOC level continued to increase throughout 2000 as the number of operational facilities increased and their services become more widely known in local communities (Fig. 1). An average of 32 deliveries were performed a month in 1999, and this doubled to 61 deliveries per month in 2000. As expected, with a larger and more dispersed rural population, the caseloads in Aswan are higher than in Luxor, with some facilities averaging 15 deliveries a month, compared to 3-5 deliveries in Luxor BEOCs.



Importantly, the HM/HC-trained physicians are also providing delivery care to more women than those counted in the facility deliveries. Many of the physicians also do home deliveries in the communities around the BEOC facility. One physician in Aswan, for example, reported that he did 10-20 home deliveries for every one delivery in the BEOC facility. The emphasis now in these districts is on community and provider partnerships to increase demand and maintain the provision of quality services.

Meeting Population Needs for Obstetric Care.

While the level of utilization of the new BEOC facility services is increasing, district and general hospitals continue to provide the great majority of public sector delivery and obstetric services. Of the total 11,600 deliveries that took place in EOC facilities (BEOC plus CEOC) in Luxor and

³ Estimated total WRA 240,000 and 57% living in rural areas.

Aswan, 97% and 92% respectively took place in the district hospitals. Along with the aim of increasing the provision and utilization of safe delivery services, the intention over time is to shift more normal deliveries to BEOC facilities and Maternate centers, leaving district hospitals with more resources to manage complicated cases.

Altogether, the BEOC facilities and ten district CEOC hospitals managed a total of 18,560 obstetric cases in the period January-October 2000. The facilities met a varying proportion of their district population needs for delivery care (including C-sections) and treatment of obstetric complications.⁴ Table 6 presents the “met need” in each district, based upon the number of live births. It is clear from these figures that in MOHP facilities the provision of delivery services is of secondary importance to that of managing complicated obstetric cases. The only exception is seen in Luxor governorate, where delivery care is almost as high as care for obstetric complications.

District	Percent of total births delivered in all EOC facilities	Percent of estimated complicated cases in district treated in CEOC hospital
Luxor & Bayadeya	93%	107%
Aswan	31	79
Edfu	15	55
Kom Ombo	38	91
Daraw	33	NA*
Nasr	33	--
Aswan Governorate	28%	62%
Quos	15	39
Esna	4	23
Armant	17	57
South Qena Districts	11%	36%
Total 10 districts	28%	60%

* NA – not available

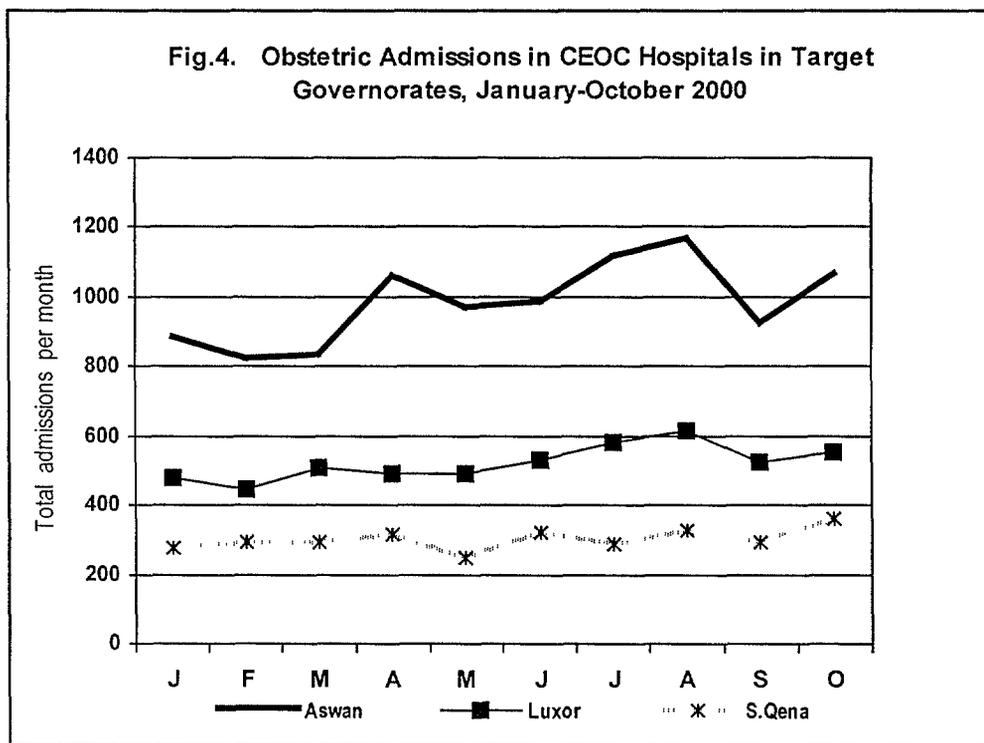
In Luxor governorate, BEOC and CEOC facilities together provided delivery care to an estimated 93% of births, and the two districts hospitals gave care to 107% of the estimated complicated obstetric cases. These very high numbers, reaching or exceeding 100% of estimated governorate need, suggests that Luxor hospitals are providing services to more than just Luxor residents, e.g. women from nearby Aswan and South Qena districts.

⁴ Complications included in the calculation are the same used by WHO/UNICEF hemorrhage, ruptured uterus, retained placenta, ectopic pregnancy, pre-eclampsia/eclampsia, and sepsis. Also included are C-sections, a proxy for obstructed or prolonged labor, and abortion-related cases. The denominator is live births instead of estimated total pregnancies (births +15%)

⁵ Covers 10 months (Jan-Oct) in which facility data are available. Denominators adjusted accordingly.

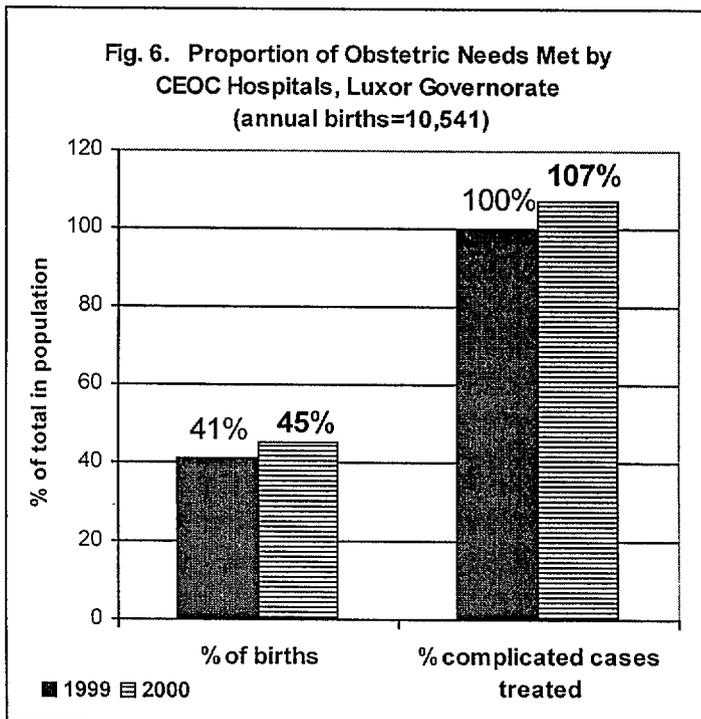
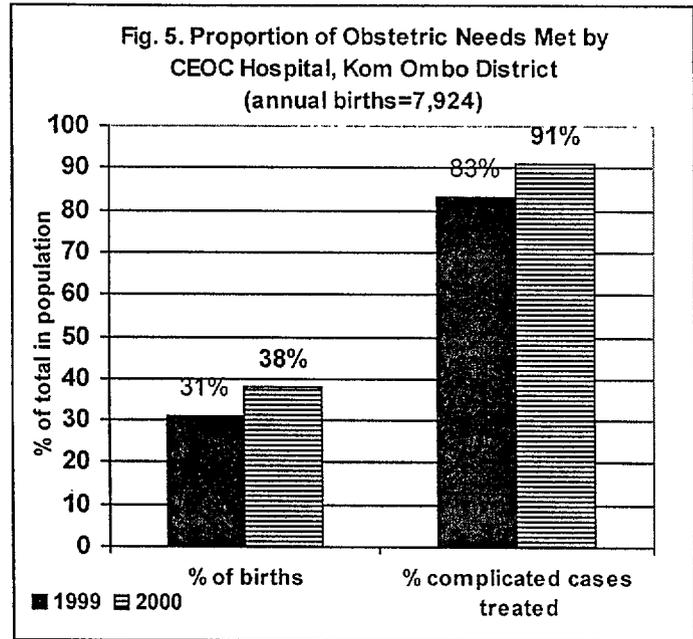
In Aswan governorate about a third of births were delivered in the EOC facilities. Kom Ombo facilities provided the highest proportion of care (38%) and Edfu the lowest (16%). Kom Ombo district hospital also had the highest level of “met need” for care of obstetric complications (91%), followed by Aswan Teaching hospital (79%), and Edfu district hospital (55%). The low figures for Nasr district are due to service limitations as a result of major construction work. South Qena hospitals were also operating on a limited basis, mostly for emergency cases, for the first part of the year due to renovations. Data are from Daraw are still being reviewed.

The data show a gradual increase in admission numbers over the year in Luxor and Aswan (Fig. 4). In another year or more, it will be possible to determine if this is a significant increase, and whether the HM/HCRP interventions will lead to any change in the level of obstetric admissions in CEOC facilities.



Importantly, available data indicate that some CEOC facilities are meeting an increasing proportion of the target population’s obstetric needs. Figures 5 and 6 present data from three district hospitals for which the HM/HCRP has two years of data. The hospitals are Kom Ombo district hospital, Luxor general and Bayadeya district hospital. The two Luxor hospitals are presented together.

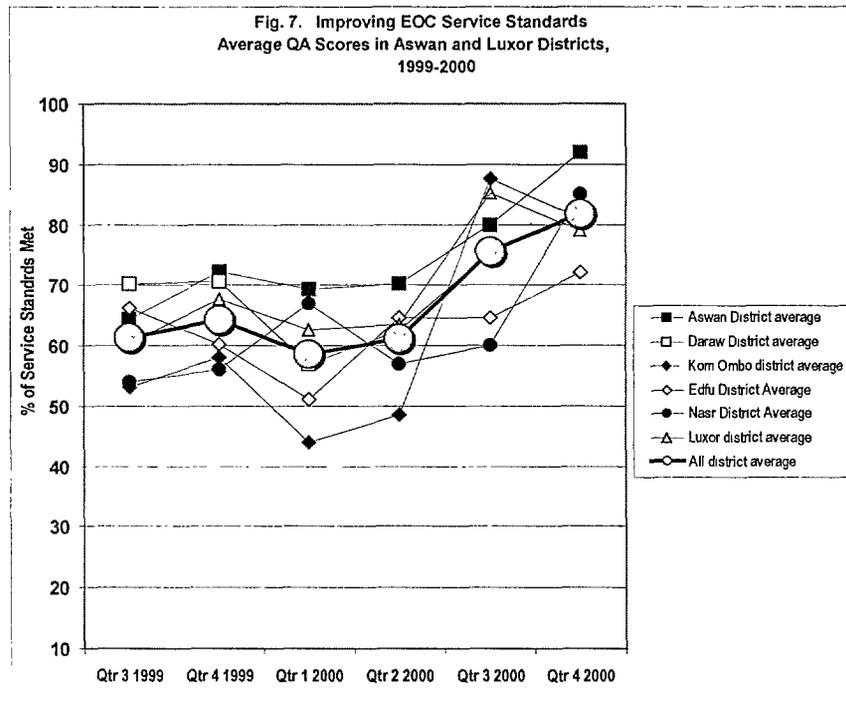
Kom Ombo district hospital provided delivery care to an estimated 38% of the annual total births in the district, up from 31% in 1999 (Fig. 5). Importantly, there was a more than 50% increase in number of C-section deliveries performed in the hospital, accounting for 7% of the hospital's deliveries in 2000, up from 5% in 1999. This positive trend is due to the department's adoption of the HM/HCRP protocols for management of pre-eclampsia/eclampsia and other conditions where C-section delivery is indicated. The fact that Kom Ombo managed 90% of the estimated obstetric complications (up from 83% in 1999) underlines the importance of its services in this large, predominately rural area.



Luxor's two district hospitals provided delivery care to 45% of the total births in the governorate, up from 41% in 1999 (Fig. 6). The big increase was in proportion of estimated complicated cases treated: 107% in 2000, up from 100% in 1999. Although Luxor General handled most of the 1,400 complicated obstetric admissions, the increase in "met need" comes from the contribution made by Bayadeya district hospital. This small hospital went from providing no obstetric services in 1999 to managing an average 77 cases a month. Because of the high "met need" figures in Luxor, one line of future inquiry will be to obtain information on the proportion of admissions that reside outside the governorate.

Data on the obstetric admissions in each district hospital during 2000 showed that average admissions per month ranged from 44 to 442. The majority of admissions, 65% to 82%, are for delivery care. The proportion of complicated cases managed ranged more widely, from 18% to 37%. The largest hospitals have the highest proportion of surgical interventions, e.g. C-section, and also managed the greatest number of complicated cases per month. Luxor General, for example, manages an average of 130 complicated cases and 335 deliveries a month. For comparison, the smaller Quos district hospital managed 49 complicated cases and 124 deliveries each month. Another year of data is needed in order to determine the pattern and level of change in obstetric service provision and utilization that may be due to the HM/HCRP interventions in these areas.

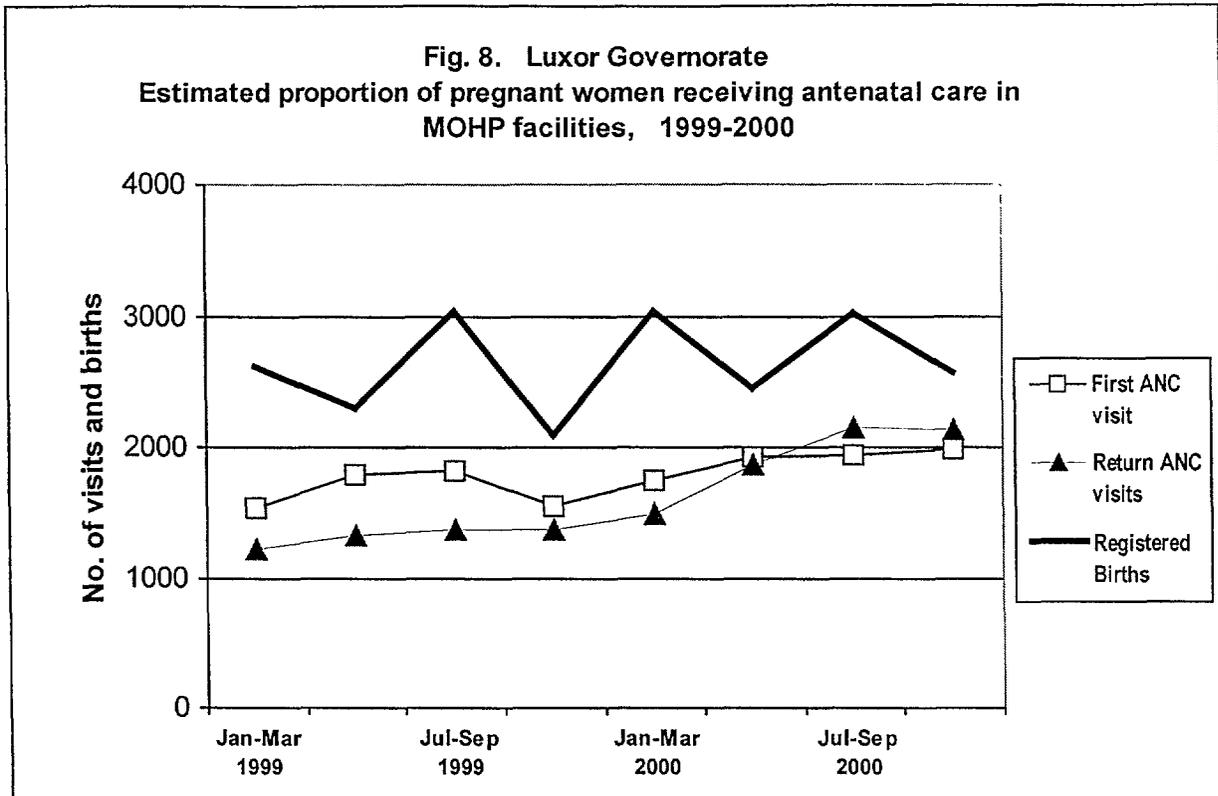
Improving Service Standards. BEOC and CEOC facility compliance with service standards for essential obstetric care began to be measured in Quarter III 1999 by District Management Teams. The average district scores at this time were between 50-70% of the total 100% compliance score, a big jump from the zero for those without services. As shown in Fig. 7, scores increased then dropped in the first quarter of 2000 as the start-up stock of new supplies and drugs ran out. By the next quarter, District and governorate teams had solved this and other problems. The third quarter of 2000 shows sharp increases in the scores, and preliminary scores from the 4th quarter show a continued rise in compliance. This is a good indication that DMTs are becoming more self-reliant.



Antenatal care

By strengthening the planning and supervision capability of DMTs and community mobilization with NGOs, the HM/HCRP aims to increase the utilization of MOHP antenatal care services. The national IEC campaign on 'Birth Preparedness' also promotes regular antenatal care. In addition to the population-based surveys, MOHP facility service statistics on antenatal care are being monitored to see if there is any change in utilization of public services.

Data from Luxor governorate show that in 2000 two-thirds of all births in the governorate received at least one antenatal visit to a MOHP facility. Although this proportion is only slightly higher than it was in 1999, there was a 44% increase in the number of return antenatal care visits made to MOHP facilities. For the first time since reporting began, the number of return visits exceeded first time visits (see last half of year in Fig. 8), indicating that more women are making a second or more return visit. These figures suggest that, although the MOHP may only be attracting a slightly larger pool of new pregnancies, they are successful in getting women to come back for follow-up visits.



In Aswan, first time antenatal care visits increased by 30% and return visits by 37%. In terms of population need met, however, only a third of the total number of births in the governorate reportedly made an antenatal visit to an MOHP clinic. This may be due in part to under-reporting by facilities in Aswan, as we know from the EDHS 2000 that approximately 68% of Upper Egyptian women receive tetanus toxoid shots. As the MOHP is virtually the only provider of the shots, they had to have made at least one visit to a clinic. Because of the possible reporting problems, these service statistics are presented with caution.

II.B. Neonatal care services

Following the revision of the national service standards and training curricula, intensive efforts to improve the quality of neonatal care services began in late 1999-early 2000 in Luxor, Aswan and South Qena district hospitals. Routinely reported MOHP data on individual newborns admitted to the neonatal care centers are used as the primary source of data to assess the effectiveness of the HM/HCRP efforts to improve access and quality of care. The basic data include weight, gestational age, place of delivery, and outcome. The calendar year 1999 is used as baseline for Phase I and II districts.

Table 7 compares 1999 and 2000 data for selected indicators, giving us an overall profile at the governorate level of the seven neonatal care centers that have received the full package of inputs for service improvement. Individual facilities are examined in detail later.⁶

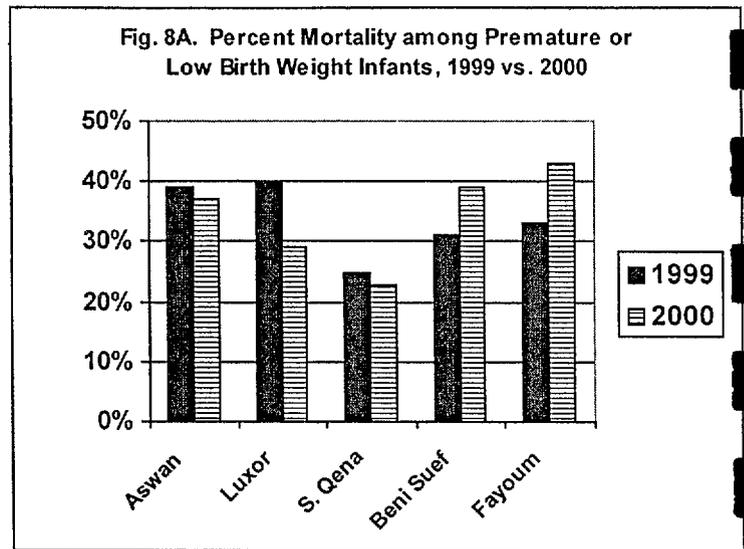
	A	B	C	D	E
Governorate	No. of NCU's	Average QA scores	Total admissions	Percent of admissions born inside the hospital	Percent of admissions that were premature or low birth weight
Aswan					
1999	3	58	711	71	47
2000	3	75	771	75	48
Luxor					
1999	1	49	277	56	51
2000	2	75	288	58	61
South Qena					
1999	2	65	324	23	47
2000	2	90	425	31	50

There are several points of note:

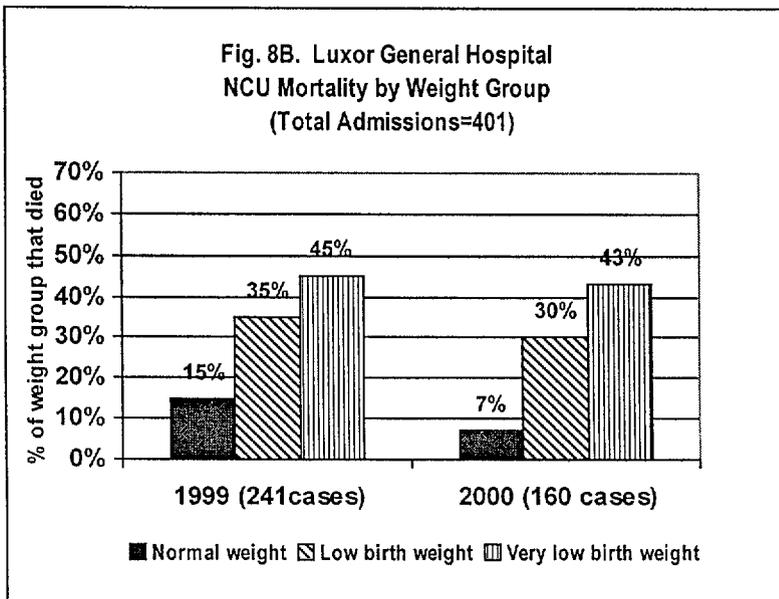
- ◆ Average QA scores for compliance to neonatal service standards increased from 15-25 percentage points over a one year period. The two NCU's in South Qena districts had the highest score with an average 90% in their standard of care (see *column B*).
- ◆ The South Qena neonatal units also had the largest increase in admissions between 1999 and 2000, even with the last two months of data (November and December) not counted yet. Admissions did not increase appreciably in the other two areas (see *column C*).
- ◆ The proportion of admissions born inside the same hospital increased noticeably in South Qena. This indicator is used as a measure of success in getting risk cases into district hospitals where appropriate care is available to deal with complications, instead of at home or small private clinics where delays in referral may mean death or disability to the newborn or mother (see *column D*). Although there was little change on a governorate level, Luxor General and Aswan Teaching hospitals both showed a big increase in "in-born" admissions. In Luxor General in 2000, 70% of were in-born, up from 56% in 1999, and in Aswan General the proportion went from 46% to 58%. No other district hospital showed such a level of change.
- ◆ Only in Luxor was there a difference between the two years in the proportion of newborn admissions that are preterm or of low birth weight (see *column E*). This is an overall measure of the severity of cases being handled by the facility and it has bearing on the mortality data to be presented below (see *column E*).

⁶ Admissions data for facilities are available for 10 or 11 months in 2000.

Mortality among admissions is a key indicator of quality of care, and decreasing the relatively high levels of mortality in the NCUs is the primary focus of improvement efforts. Figure 8A presents data from 1999 and 2000 on percent mortality among preterm and/or low birth weight admissions, which account for much of the overall mortality in the units. The seven Phase I and II centers are compared to the governorates of the later phases (Beni Suef and Fayoum). As the data show, mortality decreased significantly in those facilities with the full package of inputs, whereas the latter areas show the opposite trend. The change in Luxor, for example, is particularly striking with deaths among this group decreasing from 40% to 29%. These data suggest that decreases in mortality may be the result of direct intervention.



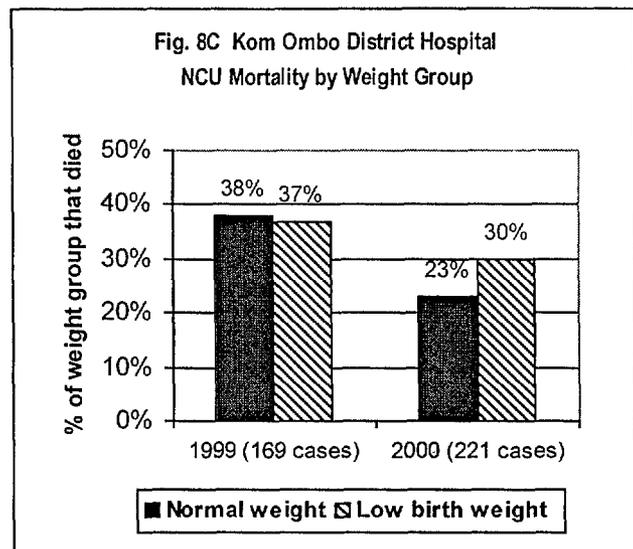
The proportion of infants dying among the different weight groups (full term with 'normal' weight, low birth weight, and very low birth weight) are sensitive to different aspects of the quality of care and can be seen to reflect the varying emphasis of improvements made in individual facilities. Improvements in general care such as infection control and nutrition should show itself in greater survival among the full-term newborns with birth weights of 2500 or more grams. For this group, the target is to reduce mortality to five percent or less. Greater availability and competency in using technology-based care, such as ventilators, should improve survival of small, low birth weight and very low birth weight babies (<1500 gms) who require more sophisticated care.



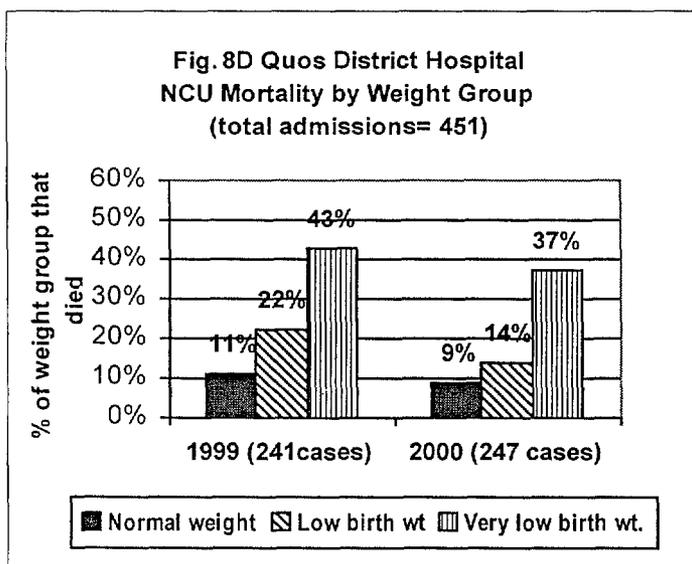
Mortality data from selected hospitals reflect these expected patterns. In Luxor General (Fig. 8B), where the focus of assistance was on improving general neonatal care, deaths were halved among the full-term 'normal' weight newborns, falling from 15% to 7%. Deaths in the low birth weight group fell from 35% to 30%, with little difference apparent in the babies of less than 1500 grams.⁷

⁷ The numbers in the weight groups are sometimes very small, particularly in the very low birth weight group. Where this is the case, caution must be used in interpreting the data. Groups may be combined if cells are too small.

In Aswan, the biggest change was seen in Kom Ombo district hospital (Fig. 8C), where in 1999 about 4 out of 10 full-term normal weight babies died, indicating overall substandard care. Although still unacceptably high, mortality in this group decreased by 50 percent. Gains were also made in care of the small, pre-term babies, with the proportion dying decreasing from 37% to 30%.



In South Qena, Qous district hospital started with one of the highest baseline scores for neonatal care standards. With a good starting level of general care, the primary focus of assistance was, therefore, on improving survival of the preterm and low birth weight babies. Fig. 8D shows that while little change is seen in the full-term group, significant decreases in mortality occurred in the low and very low birth weight groups.



Overall, the data show positive changes in key indicators of the quality of care and access to services. The level of mortality, however, needs to come down much further, particularly in the bigger, full-term babies who do not require sophisticated technical intervention. And not all centers showed positive change in the indicators, notably Aswan Teaching Hospital. Further, intensive efforts are needed in this facility which, like the others in the region, offer the only advanced level pediatric services and with it hope for those families with sick or vulnerable newborns. The clinical training/supervisory program for neonatal care was initiated at the start of 2001, with the

expectation that it will prove as effective as the similar program for essential obstetric care.

II.C. Health Knowledge and Practices in Households

The HM/HC Campaign One on Birth Preparedness was conducted between September – November 2000. At the end of November, a post survey was carried out by Zanaty & Associates using the latest EDHS-2000 sample frame, which was representative of urban and rural areas for five target governorates of Beni Suef, Fayoum, Qena, Luxor and Aswan. The survey included 1498 households from which 1601 eligible women and 558 husbands were selected.

The impact of the Campaign was measured in two ways: comparison between baseline and post survey where questions were repeated, and through comparison of those who were exposed and not

exposed to the campaign for questions that were only included in the post survey. The highlights of the findings are presented below.

Women-- Exposure

- 85% of women watch television and 31% listen to radio while 70% of husbands watch TV and 47% listen to radio.
- 60% of urban women and 45% of rural women who watch TV daily reported seeing the spots.
- The doctor was the most preferred character (50%) followed by Sabah (30%).
- 23% of husbands saw the TV spots.

Women-- Recall

- 94% of the women could recall main message – “seek early antenatal care” and 86% remember “know the danger signs” while 58% could remember the secondary message – “do not hesitate if any danger sign occurs”.
- 88% of husbands could recall the message – “seek early antenatal care” and 87% about danger signs.

Women-- Change in Knowledge

A shift in knowledge about birth preparedness between the baseline and post survey period occurred most significantly for “knowing danger signs”; for all governorates it increased from 7.5% to 26%, and in Aswan from 2% to 26%. For “acting quickly if danger signs occur”, knowledge increased from 3% to 18% for all governorates; in Fayoum it increased from 1% to 30%.

Impact on knowledge of ‘preparations for safe and clean delivery,’ was also noticeable between those who *were exposed* to the campaign and *those who were not exposed*, for messages such as “seek early antenatal care” (80% vs 54%); “household discussion” (17% vs 5%); “danger signs and acting quickly” (23% vs 9%). There was also an increase in knowledge of individual danger signs during pregnancy and delivery e.g. ‘severe headache and blurred vision’ (30% vs 16%); and ‘edema’ (28% vs 17%).

Women-- Impact on Practice

- Impact on practice was measured by comparison between *exposed* and *not exposed* pregnant or recently delivered women. This showed that for ‘ever been to antenatal the difference was 62% vs 49%; and for ‘had TT injection’, 59% vs 46%.
- Impact on practice was also measured through proxy indicators related to what women would do or advice others to do. The comparison between *exposed* and *not exposed* shows positive shifts e.g. “seek early antenatal care” (75% vs 54%).

The Post Survey for the first time also assessed the impact of the campaign on husbands who were considered an important secondary audience group.

Husbands-- Impact on Knowledge and Practice

Impact on knowledge and practice for husbands could only be measured by comparison of those *exposed* when compared to *those not exposed*.

- Differences between *exposed* and *not exposed* were noticeable for “know danger signs during pregnancy” (four times higher in the former group); “knowledge of danger signs during delivery” (6 times higher); and “seek early antenatal care” (twice as high).

- Responses to a proxy indicator related to practice of what pregnant women should do showed some important shifts, e.g. 'get health maternal health card' 22% vs 8%; 'seek early antenatal care' 92% vs 79%; and 'know danger signs and act quickly' 58% vs 28%.

II.D. Impact of Adolescent Anemia Prevention Program on Anemia and Knowledge, Attitudes and Practices

Summary of Program Impacts from the Aswan Pilot

Data collected from the Aswan pilot Sentinel Surveillance System showed that overall there was a significant decline in the prevalence of anemia, from 30% to 24%. Students with the lowest hemoglobin levels at the pre-supplement assessment benefited the greatest from the supplementation program. There was a significant increase in overall knowledge levels concerning foods that can affect iron levels and a significant increase in positive attitudes towards behaviors that can improve iron levels. Two practices targeted, eating more fruits and salads and reducing intake of sweets and low-nutrient snacks, also had significant improvements.

Prevalence of anemia among first level, secondary students; Aswan Governorate school-based iron supplementation program, Egypt, 1999-2000.		
(Bottom numbers in each data cell = Number of anemic children/sample population)		
	Pre-Supplement	Post-Supplement
Overall	29.8% 215/722	24.0% 155/646
Gender		
Male	36.4% 122/335	31.6% 95/297
Female	24.0% 93/387	17.5% 61/349
Age (Years)		
13-14	30.1% 176/585	24.3% 73/301
15	34.3% 34/99	27.3% 73/267
16	12.0% 3/25	8.1% 3/37
17-18	18.2% 2/11	8.3% 1/12
Urban/Rural		
Urban	29.2% 170/583	22.1% 113/512
Rural	32.4% 45/139	32.1% 43/134
Severity of Anemia - Definition 1		
Mild	19.0% 137/722	15.9% 103/646
Moderate	10.2% 74/722	7.7% 50/646
Severe	0.6% 4/722	0.3% 2/646
Severity of Anemia - Definition 2		
Mild	27.3% 197/722	22.6% 146/646
Moderate	2.5% 18/722	1.4% 9/646
Severe	0.0% 0/722	0.0% 0/646

SECTION III

Organization and Development of the AWP

This Section contains general information pertaining to the AWP in its entirety. 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)

The AWP covers the period of March 15, 2001 through September 15, 2001.

In Annex H 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. In addition to the individual Task plans, there are also Target Governorate Integrated Work Plans, which are described later in this section.

The AWP is the product of a collaborative effort of JSI and its partners and counterparts. 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 wide array of interventions to implement. Nevertheless, the HM/HC Project has included Upper Egypt as a priority area for further programmatic enhancements. A series of meetings have been 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.

Target Governorate Integrated Work Plans

The Integrated Work Plans include all of the significant activities that will take place in a manner which cut across Task boundaries. That is, they show the logical sequence of planned events in a way which identifies Task responsibilities, but concentrates on the "horizontal" nature of planned accomplishments, rather than the vertical.

Each Integrated Work Plan is presented in the form of a Gantt chart which shows the sequencing of all activities.

Some features of the integrated plans:

- There is a plan for each target governorate (Aswan, Luxor, Fayoum, Beni Suef and Luxor).

- The plans indicate for each activity the Task(s) which have responsibility for ensuring that the activity is accomplished, plus an indication of the organizational entity or entities which bear the main responsibility for the actual implementation of the activity.
- Only contract activities which take place within the target governorates are included in the plans. All other activities (e.g., national level activities) are shown in the respective individual Task plans in the AWP.
- Performance Milestones and Benchmarks are included in the plans at the appropriate places.

Each Integrated Work Plan contains identical major sections covering the various levels of involvement as specified in the Contract. The following sections and sub sections are represented in the Gantt charts:

1. Governorate Level

- Governorate Management Team/Health Committee
- Governorate Information Center
- Medical and Nursing Schools
- Small Grants
- IEC Campaign
- Private Sector Program

2. District Level

- District Health Planning
- District Information Centers

3. Community/Facility Level

- CEOC Centers (District & General Hospitals)
- Neonatal Care Centers
- BEOC Centers

The overall strategy of implementation is basically the same for each target governorate. Variation among the governorates is mainly due to the phasing in of activities and some differences due to the overall size of the respective governorates. Table 5 shows the phasing of major results in the target governorates and districts during the Contract. There is some staggering of the timing of the phases for different results due to the timing of their respective Performance Milestones. It should be pointed out that there are a total of 31 districts within the five target governorates. Only 25 of these are included in the implementation strategy since that is the number specified in the contract. Six districts (two each in Qena, Fayoum and Beni Suef) are not included, basically due to their smaller size or other such factors. However, the district hospitals in those six districts will receive upgrading. The 25 districts included are referred to as "Target Districts."

Task	Contract Year: Quarter: Ending:	One				Two				Three				Four		Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	
		6/15/98	9/15/98	12/15/98	3/15/99	6/15/99	9/15/99	12/15/99	3/15/00	6/15/00	9/15/00	12/15/00	3/15/01	6/15/01	9/15/01	
1	Districts delivering the Maternal & Child Health Care Part of the Basic Benefits Package	5 (7)*				5 (3)*				10				5		25
		Aswan (A) Daraw (A) Kom Ombo (A) Edfu (A) Nasr (A) Luxor (L) Bayadeya (L)				Esna (Q) Armant (Q) Qous (Q)				Fayoum Urban (F) Fayoum Rural (F) Etsa (F) Ibshwai (F) Beni Suef (BS) Ehnesia (BS)	El Wasta (BS) Qena (Q) Deshna (Q) Kift(Q)			Beba (BS) El Fashn (BS) Nageh Hamadi (Q) Abo Tesht (Q) Farshout (Q)		
3	District Health Plans & Monitoring Systems Developed & Implemented	8 (10)*				12 (10)*				5				25		
		Aswan (A) Daraw (A) Kom Ombo (A) Edfu (A) Nasr (A) Luxor (L)				Bayadeya (L) Esna (Q) Armant (Q) Qous (Q)				Fayoum Urban (F) Fayoum Rural (F) Etsa (F) Ibshwai (F) Beni Suef (BS) Ehnesia (BS)	El Wasta (BS) Qena (Q) Deshna (Q) Kift(Q)				Beba (BS) El Fashn (BS) Nageh Hamadi (Q) Abo Tesht (Q) Farshout (Q)	
7	Districts Offering Social Community Services	20				20				5				25		
		Aswan (A) Daraw (A) Kom Ombo (A) Edfu (A) Nasr (A) Luxor (L)	Bayadeya (L) Esna (Q) Armant (Q) Qous (Q)			Fayoum Urban (F) Fayoum Rural (F) Etsa (F) Ibshwai (F) Beni Suef (BS) Ehnesia (BS)				El Wasta (BS) Qena (Q) Deshna (Q) Kift(Q)			Beba (BS) El Fashn (BS) Nageh Hamadi (Q) Abo Tesht (Q) Farshout (Q)			
4	District MHIS Centers Established (Governorates)	10 (14)				20 (30)				35 (21)				65		
		Aswan Luxor Beni Suef				Qena Assiut Fayoum				Menya Sohag						
10	Small Grants Awarded	20				30				40				10	100	

Note: (A)=Aswan, (L)=Luxor, (Q)=Qena, (BS)=Beni Suef, (F)=Fayoum

* The first number indicates the contractual requirement; the second number (in parentheses) indicates the actual accomplishment.

Aswan and Luxor Governorates were the first to be phased into the implementation program since work had started there during HM/HC's predecessor project, MotherCare. The majority of the development work in those governorates (facility improvement and launching) has been accomplished and work is now focused mostly on consolidation and maintenance activities. There are a total of seven Target Districts within those two governorates. Many activities included in the Gantt charts have already been accomplished. To provide adequate resolution of Years Three and Four activities, only those years are indicated in the charts. Accordingly, activities accomplished in 1998 and 1999 are literally "off the chart."

Qena is the largest of the five Target Governorates, containing nine Target Districts. This has necessitated the scheduling of three separate phases within Qena. In the Gantt charts, these are

referred to as “District Groups”. Groups A, B and C each contain three districts, which makes implementation manageable and allows for the timely accomplishment of contract results.

Beni Suef, with five Target Districts, is the next largest. Two District Groups have been established, with three districts in Group A and two in Group B. The timing of activities of Groups A and B basically corresponds to the timing for Groups B and C of Qena, respectively.

Finally, **Fayoum**, which is the smallest of the newly added Governorates, has only one District Group of four Target Districts.

Please see Annex G for maps of the Target Governorates.

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)

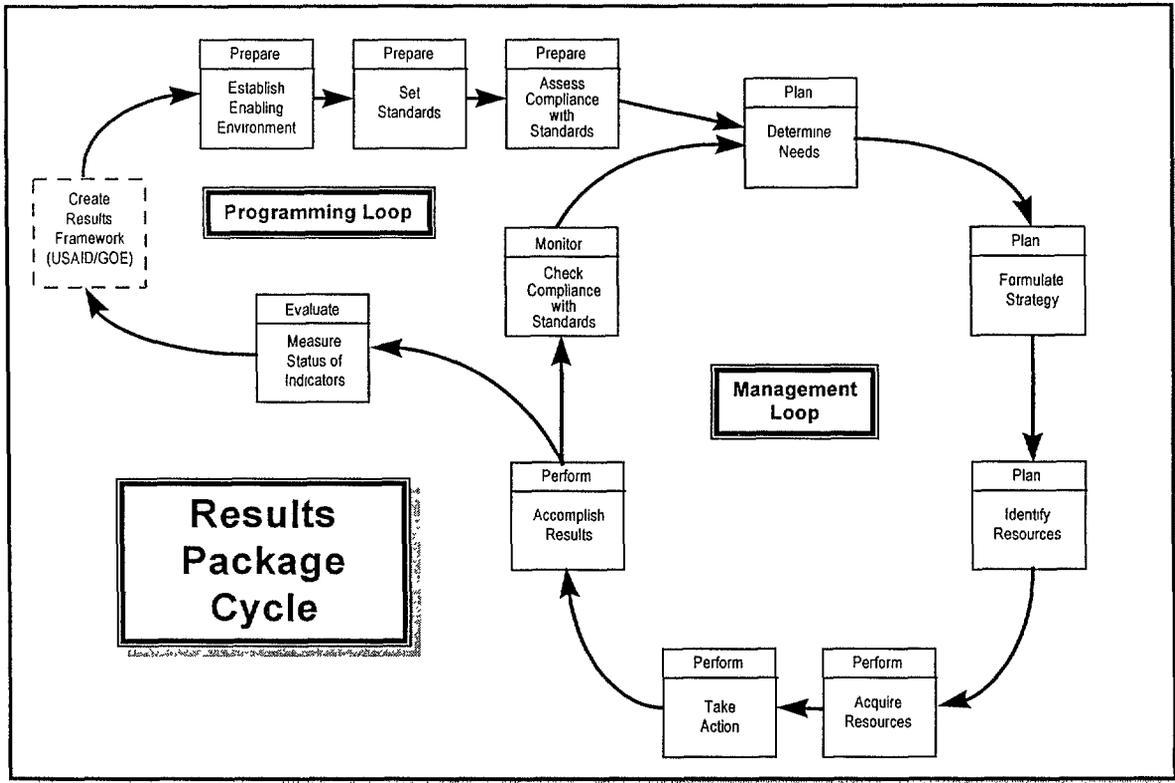
Subresult No. 5.1.4: Increased Knowledge and Improved Health Behavior in Households. (Includes Tasks 7, 8 and 9)

(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 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 implementation of the MCH part of the Basic Benefits Package, is seen as the basic product of the Results Package. All other Tasks are developed and implemented to provide support for this Basic Benefits Package.

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.

Coordination:

As mentioned above, each Task in the AWP contains a description of major coordination activities. The complexities of this Results Package necessitate very frequent efforts to coordinate actions. All partners engaged in HM/HC Results Package have plans 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 types of coordination.

- The first type of coordination concerns **integration** between activities, where the partners must collaborate and work closely together to jointly develop and implement activities.
- The second type 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 type 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 type 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.

As specified in the Contract, JSI "...shall be responsible for ensuring frequent communication and coordination among the organizations involved in the maternal and child health area especially for those receiving USAID funding...." JSI has been organizing semi-annual coordination meetings with such organizations. These meetings have included participation by the MOHP and USAID. Future plans include further coordination meetings with major coordination partners on a semi-annual basis.

The major partners receiving USAID funding (as mentioned in the contract) with which JSI and its sub-contractors coordinate include:

- UNICEF
- Wellstart International
- Centers for Disease Control/Field Epidemiology Training Program (CDC/FETP)
- NGO Service Center (USPVO Umbrella Grantee)
- Pathfinder International (POP IV)

Other coordination partners include:

- CAPMAS
- CARE International
- Credit Guarantee Company (CGC)
- Data for Decision Making (DDM)
- Directorate of Health Education
- Healthy Egyptians 2010 (HE 2010)
- Hepatitis C Project (HCP)
- Institute for International Education – Development Training 2 Project (IIE-DT2)
- Medical and Nursing Schools
- Medical Sector of the Supreme Council of Universities
- Medical Syndicates
- Ministry of Education (MOE)
- Ministry of Insurance and Social Affairs (MoISA)
- Ministry of Rural Development
- National and International NGOs
- National and Regional Federations of NGOs
- National Council of Negro Women (NCNW)
- National Information Center for Health and Population (NICHIP)
- Partnerships for Health Reform (PHR)
- Secretariat General for Local Administration
- Social Fund for Development (SFD)
- Student Health Insurance Program (SHIP)
- World Health Organization (WHO)
- Bilateral Donors (Danida, GTZ, etc.)
- Multilateral Donors (UN, EU, WB, etc.)

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 Basic Benefits Package. 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. 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 pays 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 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 fiscal management, resource allocations, 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 MEH BBP. 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/HP 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 is 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 HM/HCRP has two objectives with respect to data collection for monitoring and evaluation. The first objective is to document project compliance with the contract, specifically defining and collecting data on achievement of "completion indicators" and "desired outcomes". The second is to facilitate data use by district and governorate management teams as a part of the process of improving the quality and utilization of MOHP services.

The completion indicators have been operationally defined, the needed documentation identified, and JSI Task managers, with assistance of Field Office staff, are responsible for ensuring that documentation is up-to-date for all contract indicators and that relevant data are entered in the project tracking databases and files. Task managers are also responsible for extracting data from these databases to meet reporting requirements and ensuring that their filing systems allow for quick location of all supporting documentation regarding achievement of contractual indicators.

Achievement of "desired outcomes" will be assessed with data that measure changes in quality and utilization of services and changes in knowledge and behaviors in communities. The MOHP facility service statistics in the health information system and the district quality assurance monitoring system are two sources of data that will be used. These same data are used by district and governorate management teams to take action on the management of health facilities, and it is important that the availability and quality of data are adequate if they are to be useful means of assessment.

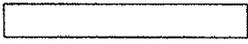
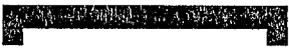
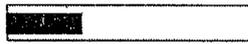
Indicators that provide additional evidence on effectiveness are needed by project management to make strategic decisions about the direction of project activities. Data collection also takes place through other project activities such as community surveys and operations research, and they can provide important information for indicators of baseline status and project effectiveness. Household surveys that will be conducted before and after the IEC campaign in all project districts will provide a unique opportunity to obtain high quality data on key indicators of "effectiveness" of a range of project activities. These surveys may provide the core of the project effectiveness data as they may be the only means of obtaining good data specifically for the project areas. (Other national surveys cannot provide information disaggregated to the level of project districts alone.). The best sources of data for these supporting indicators are being assessed, and once tested and refined, they can form the basis of reports not only for project management, but for district management teams as well.

**SECTION IV:

INTEGRATED
GOVERNORATE
PLANS**

GANTT CHART LEGEND

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

Activities are indicated in the Gantt charts as bars:	
Within each Task, activities and subactivities are represented as bars.	
Summaries of these activities and subactivities are represented by solid bars.	
Percentage Completion of activities is indicated by a solid bar inside of an activity bar.	
Progress Markers , which include Performance Milestones, Performance Targets and Benchmarks, are indicated with various symbols (the month and day are indicated to the right of each symbol):	
Performance Milestones -- contractually binding, planned accomplishments that were specified by JSI in its proposal are represented by solid diamond. Once a planned milestone has been achieved it is represented by a hollow diamond.	<p>◆ 11/15</p> <p>◇ 11/15</p>
Performance Targets -- contractually binding, planned accomplishments that were specified by USAID in the RFP are represented by solid diamonds within circles. Once a planned target has been achieved it is represented by a hollow diamond inside a circle.	<p>⊙ 11/15</p> <p>○ 11/15</p>
Benchmarks are interim accomplishments required to achieve milestones and targets; they are represented in the Gantt charts by solid star. Once a planned benchmark has been achieved it is represented by a hollow star.	<p>★ 11/15</p> <p>☆ 11/15</p>
Dependencies between activities are shown in the Gantt charts that indicate the link between those activities:	
Finish-to-Start dependencies exist when activity B cannot start until activity A finishes.	<p>A</p> <p>B</p>
Start-to-Start dependencies exist when activity B cannot start until activity A starts.	<p>A</p> <p>B</p>
Finish-to-Finish dependencies exist when activity B cannot finish until activity A finishes.	<p>A</p> <p>B</p>
Start-to-Finish dependencies exist when activity B cannot finish until activity A starts.	<p>A</p> <p>B</p>

Aswan Governorate

Target Governorate Integrated Work Plan

ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
1	Governorate Level			[Redacted]																																			
2	Governorate Management Team/Health Committee			78% [Redacted]																																			
3	Form Governorate Management Team (GMT)	FO, HMHCP	3	100% [Redacted]																																			
4	Train GMT	FO, HMHCP	3	100% [Redacted]																																			
5	Resource Request Developed & Submitted to Central Planning Departm	GMT, FO, HMHCF		100% [Redacted]																																			
6	<u>Benchmark: GMT Established</u>	FO, HMHCP	3	★ 9/12																																			
7	Form Governorate Health Committee (GHC)	FO, HMHCP	3	100% [Redacted]																																			
8	Orientation of GHC	FO, HMHCP	3	100% [Redacted]																																			
9	<u>Benchmark: GHC Established</u>	FO, HMHCP	3,7	★ 8/8																																			
10	GMT/GHC Monthly Meetings	FO, HMHCP	3,7	00% [Redacted]																																			
11	Review & Approve District Health Plans (DHP)	GMT, GHC	3	100% [Redacted]																																			
12	Develop Gov Health Plan (GHP) Incorporating DHPs	GMT, GHC	3	100% [Redacted]																																			
13	<u>Benchmark: DHPs Incorporated into GHP</u>	GMT, GHC	3	★ 10/18																																			
14	Quarterly Monitoring Review Meetings	GMT, FO	3	65% [Redacted]																																			
15	Bi-annual Supervisory Visits to Anchor Facilities	GMT, FO	3	65% [Redacted]																																			
16	Preparation for Management & QA TOT	FO	3	[Redacted]																																			
17	Management & QA TOT	FO	3	[Redacted]																																			
18	Governorate Information Center (GIC)	FO, HMHCP	4	[Redacted]																																			
19	Assess GIC	FO, HMHCP	4	[Redacted]																																			
20	Develop Plan to Upgrade GIC	FO, HMHCP	4	[Redacted]																																			

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ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
128	District Level			[Redacted]																																			
129	District Health Planning		3	71% [Redacted]																																			
130	<i>Aswan, Daraw, Kom Ombo, Edfu & Nasr Districts</i>																																						
131	Form 5 District Management Teams (DMT)	FO, HMHCP	3	100% [Progress Bar]																																			
132	Train 5 DMTs	FO, HMHCP	3	100% [Progress Bar]																																			
133	<u>Benchmark: 5 DMTs Established</u>	FO, HMHCP	3	★ 8/30																																			
134	Form 5 DHCs	FO, HMHCP	3,7	100% [Progress Bar]																																			
135	Orientation of 5 DHCs	FO, HMHCP	3,7	100% [Progress Bar]																																			
136	<u>Benchmark: 5 DHCs Established</u>	FO, HMHCP	3,7	★ 9/27																																			
137	Identify Catchment Areas in 5 districts	FO, HMHCP	1,3	100% [Progress Bar]																																			
138	Select Anchor Facilities	FO, HMHCP	1,3	100% [Progress Bar]																																			
139	Develop District Health Plans (DHP)	FO, HMHCP	3	100% [Progress Bar]																																			
140	<u>Benchmark: 5 DHPs developed</u>	FO, HMHCP	3	★ 10/7																																			
141	<u>Milestone: District Health Plans & Monitoring Systems</u>	FO, HMHCP	3,7	◇ 12/30																																			
142	Submit DHPs to GMT/GHC	DMT	3																																				
143	Implement DHP	DMT	3	70% [Progress Bar]																																			
144	Regular DMT Meetings to Monitor Implementation	DMT		70% [Progress Bar]																																			
145	Quarterly Joint DMT/DHC meetings to monitor implementation	DMT, DHC		70% [Progress Bar]																																			
146	On-going DMT supervisory visits to anchor facilities	DMT	3	74% [Progress Bar]																																			
147	Preparation for Management & QA TOT	FO	3	[Progress Bar]																																			

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ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
174	Community/Facility Level			[Redacted]																																			
175	CEOC Centers (District & General Hospitals)		1,3,7,11	[Redacted]																																			
176	<i>Aswan, Daraw, Kom Ombo, Edfu & Nasr Districts</i>			[Redacted]																																			
177	Preparation Stage	FO,GMT,DMT	1,3,7	[Redacted]																																			
178	Conduct District Hospital Assessments	FO,GMT,DMT	1,3	[Redacted]																																			
179	Develop Facility Improvement Plans	FO,DMT	1,3	[Redacted]																																			
180	<u>Benchmark: Facility Improvement Plans Incorporated into DHP</u>	FO,DMT	1,3,7	[Redacted]																																			
181	Improvement Stage			[Redacted]																																			
182	Facility Management	FO,DMT	3,7	[Redacted]																																			
183	Form Facility Management Team (FMT)	FO,DMT	3	[Redacted]																																			
184	Train FMT	FO,DMT	3	[Redacted]																																			
185	Sensitize Providers	FO,DMT	7	[Redacted]																																			
186	Improve Facility Management Systems	FO,DMT	3	[Redacted]																																			
187	<u>Benchmark: Management Systems Improved</u>	FO,DMT	3,7	[Redacted]																																			
188	Facility Renovation	HMHCP	1,3	[Redacted]																																			
189	Draw up Specifications	HMHCP	1,3	[Redacted]																																			
190	Award Contract	HMHCP	1,3	[Redacted]																																			
191	Construction Work	Contractor	1,3	[Redacted]																																			
192	Inspect Construction Work	HMHCP	1,3	[Redacted]																																			
193	Accept Renovated Facility	HMHCP	1,3	[Redacted]																																			

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ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
194	Benchmark: Hospitals Renovated	HM/HC	1,3	★ 3/21																																			
195	Commodity Procurement	FO	1,11	██████████																																			
196	Request Commodities	FO	1,11																																				
197	Receive & Install Commodities	FO	11	0% ██████████																																			
198	Benchmark: Commodities Installed	FO	1,11	★ 3/21																																			
199	Human Resources	FO,GMT,DMT	1,3	██████████																																			
200	Determine Facility Personnel Needs	FO,GMT,DMT	1																																				
201	Secure Additional Personnel Required	FO,GMT	1,3																																				
202	Plan & Schedule Workshops	FO	1																																				
203	Conduct Workshops	FO	1	██████████																																			
204	Select Lead Trainer Candidates		1																																				
205	Develop Basic Competencies	FO	1	██████████																																			
206	Benchmark: Personnel Available & Competent	FO,GMT,DMT	1,3	★ 3/21																																			
207	Launch Stage	FO,GMT,DMT	1,3,7	100% ██████████																																			
208	Launch preparation	FO,GMT,DMT	1,3,7	100% ██████████																																			
209	Launch	FO,GMT,DMT	1,3,7	100% ██████████																																			
210	Benchmark: District Hospitals Launched	FO,GMT,DMT	1,3,7	★ 4/11																																			
211	Service Stage	DMT	1,3	68% ██████████																																			
212	Provide Improved CEOC Services	DMT,FMT	1	59% ██████████																																			
213	QA Monitoring & Continuous Improvement	DMT,FMT	3	62% ██████████																																			

ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
214	Clinical Skills Mastery	FO	1	100%												[Bar chart showing 100% completion]																							
215	Neonatal Care Units (NCU)	FO, HMHCP, DMT	6,11													53%												[Bar chart showing 53% completion]											
216	<i>Aswan, Kom Ombo, & Edfu</i>																																						
217	Receive & Install Equipment	FO	6,11													100%												[Bar chart showing 100% completion]											
218	Basic Training of NCU Personnel	FO, HMHCP	6																									100%											
219	Advanced Training of NCU Personnel	FO, HMHCP	6																									[Bar chart showing 100% completion]											
220	Resuscitation Training of NCU Personnel	FO, HMHCP	6																									[Bar chart showing 100% completion]											
221	<u>Milestone: 3 NCUs Linked with Comprehensive Perinatal Program</u>		6																									[Bar chart showing 100% completion]											
222	Improve NCU Supervision System	FO, DMT	6													75%												[Bar chart showing 75% completion]											
223	Monitor & Evaluate Improvements	DMT	6																									40%											
224	BEOC Centers			[Bar chart showing 100% completion]												[Bar chart showing 100% completion]												[Bar chart showing 100% completion]											
225	<i>Aswan, Daraw, Kom Ombo, Edfu & Nasr Districts</i>																																						
226	Preparation Stage	FO, DMT	1,3,7																																				
227	Conduct Facility Assessments	FO, DMT	1,3																																				
228	Conduct Community Needs Assessments	FO, DMT	7																																				
229	Develop Facility Improvement Plans	FO, DMT	1,3,7																																				
230	Improvement Stage			[Bar chart showing 100% completion]												[Bar chart showing 100% completion]												[Bar chart showing 100% completion]											
231	Facility Management	FO, DMT	3,7	[Bar chart showing 100% completion]												[Bar chart showing 100% completion]												[Bar chart showing 100% completion]											
232	Form Facility Management Teams (FMT)	FO, DMT	3	[Bar chart showing 100% completion]												[Bar chart showing 100% completion]												[Bar chart showing 100% completion]											
233	Train FMTs	FO, DMT	3	[Bar chart showing 100% completion]												[Bar chart showing 100% completion]												[Bar chart showing 100% completion]											

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ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
254	Benchmark: Personnel Available & Competent	FO,GMT,DMT	1,3	★ 3/28																																			
255	Community Development	FO,DMT		████████████████████																																			
256	Conduct Community Meetings	FO,DMT	7																																				
257	Form Community Health Committees (CHC)	FO,DMT	7																																				
258	Train CHCs to Use Community Needs Identification Tool	FO,DMT	7																																				
259	Recruit & Train Community Workers for Rapid Household S	FO,DMT	7																																				
260	Conduct Rapid Household Survey & Community Interviews	CHC,FO	7																																				
261	Develop CHC Plans	CHC,FO	7	████																																			
262	Present CHC Plan to DMT for Incorporation into DHP	CHC,FO	7,3	████																																			
263	Benchmark: CHC Plans Developed and Presented to DMTs	FO,CHC,DMT	7,3	★ 3/28																																			
264	Mobilize Communities for Launch	FO,DMT	7	100% ██████████																																			
265	Benchmark: Communities Mobilized for Launch	FO,DMT	7	★ 5/9																																			
266	Launch Stage	FO,DMT,FMT		100% ██████████																																			
267	Launch Preparation	FO,DMT,FMT	1,3,7	100% ██████████																																			
268	Pre-Launch QA Assessment	FO,DMT,FMT	3	100% ██████████																																			
269	Launch	FO,DMT,FMT	1,3,7	100% ██████████																																			
270	Benchmark: BEOC Centers Launched	FO,DMT,FMT	1,3,7	★ 5/2																																			
271	Milestone: Implementation of Basic Health Package in 5 Districts		1,3,7,11	◇ 5/2																																			
272	Service Stage	DMT	1,3	80% ██████████																																			
273	Provide Improved BEOC Services	DMT	1	78% ██████████																																			

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Luxor Governorate

Target Governorate Integrated Work Plan

ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
1	Governorate Level			[Redacted]																																			
2	Governorate Management Team/Health Committ			[Redacted]																																			
3	Form Governorate Management Team (GMT)	LFO, HMHCP	3	[Redacted]																																			
4	Train GMT	LFO, HMHCP	3	[Redacted]																																			
5	Resource Request Developed & Submitted to Central Planning Departr.	GMT, LFO, HMHC	3	0%																																			
6	<u>Benchmark: GMT Established</u>	LFO, HMHCP	3	★ 3/14																																			
7	Form Governorate Health Committee (GHC)	LFO, HMHCP	3	100%																																			
8	Orientation of GHC	LFO, HMHCP	3	100%																																			
9	<u>Benchmark: GHC Established</u>	LFO, HMHCP	3,7	★ 4/4																																			
10	GMT/GHC Quarterly Meetings	LFO, HMHCP	3,7	75%																																			
11	Review & Approve District Health Plans (DHP)	GMT, GHC	3	100%																																			
12	Quarterly Supervisory Visits to Anchor Facilities	GMT, LFO	3	75%																																			
13	Preparation for Management & QA TOT	LFO	3	[Redacted]																																			
14	Management & QA TOT	LFO	3	[Redacted]																																			
15	Referral System			57%																																			
16	Identify existing referral systems in MOHP	FO, MOHP	3	100%																																			
17	Develop HM/HC Package referral system	FO, MOHP	3	100%																																			
18	Orient GMT/DMTs on proposed system	FO, MOHP	3	100%																																			
19	Train service providers	FO, MOHP	3	100%																																			
20	Prepare forms and registers	FO, MOHP	3	100%																																			

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ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
41	GIC Routine Supervision of DICs	FO, HMHCP	4													75%																							
42	Procedure Manual Workshop	FO, HMHCP	4													100%																							
43	Data Interpretation Workshop	FO, HMHCP	4																																				
44	Nursing Schools	FO, HMHCP	2																									29%											
45	Improve Training Capabilities (TOTs)	FO, HMHCP	2																									100%											
46	Usage of HM/HC Curriculum	FO, HMHCP	2																									10%											
47	<u>Milestone: HM/HC Curriculum Taught in 1 Nursing School</u>	FO, HMHCP	2																									◆ 9/15											
48	Small Grants	FO, HMHCP	10													61%																							
49	Advertise Small Grants Program	FO, HMHCP														100%																							
50	Receive Letters of Intent to Submit Proposal	FO, HMHCP														100%																							
51	Conduct Proposal Preparation Workshops	FO, HMHCP														100%																							
52	<u>Benchmark: Proposal Preparation Workshop Conducted</u>	FO, HMHCP														★ 8/27																							
53	Receive Proposals	FO, HMHCP														100%																							
54	Evaluate Proposals & Submit Recommendations to USAID	FO, HMHCP														100%																							
55	Award Grants	FO, HMHCP														100%																							
56	Monitor Implementation of Grants	FO, HMHCP														40%																							
57	<u>Benchmark: 20 Small Grants Awarded to NGOs</u>	FO, HMHCP														★ 11/15																							
58	IEC Campaign															58%																							
59	IEC Campaign		8													73%																							
60	Establish Governorate IEC Task Force	FO, HMHCP, GM1	8													100%																							

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ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
129	District Level			[Redacted]																																			
130	District Health Planning		3	[Redacted]																																			
131	<i>Districts (2): Luxor & Bayadeya</i>																																						
132	District Management Teams (DMT)			[Redacted]																																			
133	Form District Management Teams (DMT)	FO, HMHCP	3	[Redacted]																																			
134	Train DMTs	FO, HMHCP	3	[Redacted]																																			
135	<u>Benchmark: 2 DMTs Established</u>	FO, HMHCP	3	★ 2/21																																			
136	District Health Committees (DHC)			00% [Redacted]																																			
137	Form DHCs	FO, HMHCP	3,7	00% [Redacted]																																			
138	Orientation of DHCs	FO, HMHCP	3,7	100% [Redacted]																																			
139	<u>Benchmark: DHCs Established</u>	FO, HMHCP	3,7	★ 3/25																																			
140	District Health Plans (DHP)			99% [Redacted]																																			
141	1999-2000 DHPs			99% [Redacted]																																			
142	Identify Catchment Areas in 2 districts	FO, HMHCP	1,3	100% [Redacted]																																			
143	Select Anchor Facilities	FO, HMHCP	1,3	100% [Redacted]																																			
144	Develop District Health Plans (DHP)	FO, HMHCP	3	100% [Redacted]																																			
145	<u>Benchmark 2 DHPs developed</u>	FO, HMHCP	3	★ 4/28																																			
146	Submit DHPs to GMT/GHC	DMT	3	100% [Redacted]																																			
147	<u>Milestone: 2 District Health Plans & Monitoring Systems</u>	FO, HMHCP	3,7	◇ 12/15																																			
148	Implement DHP	DMT	3	100% [Redacted]																																			

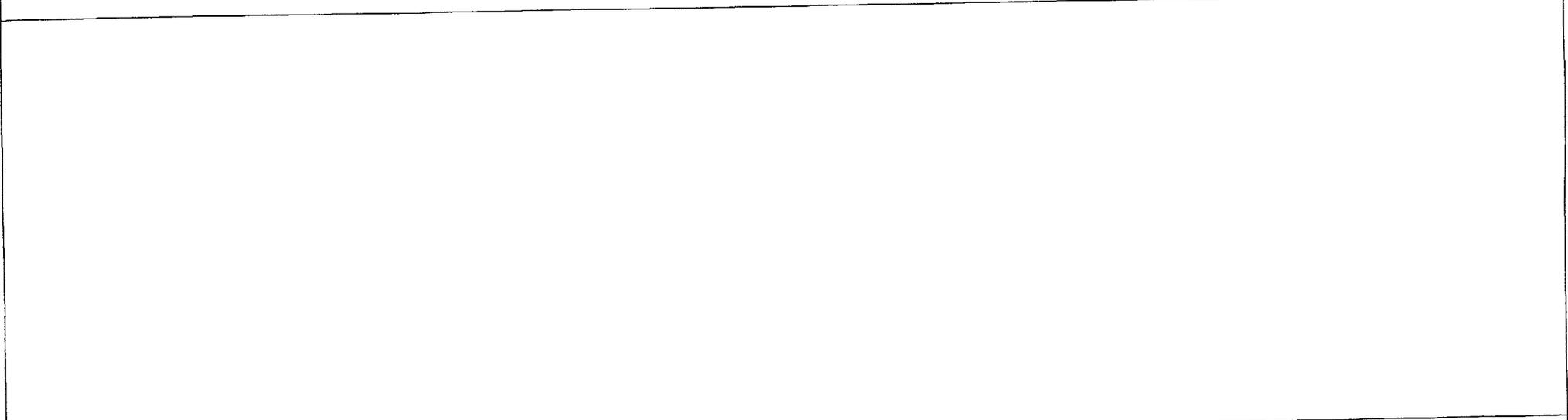
ID	Activity	Responsible	Task	1999												2000												2001												
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	
169	Award Contract	HMHCP	4	100%	[Progress bar]																																			
170	Monitor Performance of Renovation Work	HMHCP	4	100%	[Progress bar]																																			
171	Inspection & Acceptance	HMHCP	4	100%	[Progress bar]																																			
172	Commodity Procurement	FO, HMHCP	4		[Progress bar]																																			
173	Identify Commodity Needs	FO, HMHCP	4																																					
174	Order Commodities	FO, HMHCP	4	100%	[Progress bar]																																			
175	Receive & Install Commodities	FO, HMHCP	4	100%	[Progress bar]																																			
176	Human Resources	FO, HMHCP	4		[Progress bar]																																			
177	Training Needs Assessment	FO, HMHCP	4																																					
178	Schedule Training Workshops	FO, HMHCP	4																																					
179	Conduct Training Workshops	FO, HMHCP	4	00%	[Progress bar]																																			
180	<u>Milestone: MHIS Centers Established in 2 Districts</u>	FO, HMHCP	4																																					
181	Routine Data Entry	FO, HMHCP	4	65%	[Progress bar]												[Progress bar]																							
182	Routine Submission of Reports to DMT	FO, HMHCP	4	65%	[Progress bar]												[Progress bar]																							
183	Data Interpretation Workshop	FO, HMHCP	4																																					
184	<u>Benchmark Annual Statistical Report Submitted to DMT</u>	DIC	4																										 3/25											

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ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
185	Community/Facility Level			[Redacted]																																			
186	CEOC Centers (District & General Hospitals)		1,3,7,11	[Redacted]																																			
187	<i>Luxor & Bayadeya Districts</i>																																						
188	Preparation Stage	FO,GMT,DMT	1,3,7																																				
189	Conduct District Hospital Assessments	FO,GMT,DMT	1,3																																				
190	Develop Facility Improvement Plans	FO,DMT	1,3																																				
191	Improvement Stage			[Redacted]																																			
192	Facility Management	FO,DMT	3,7	0% [Progress Bar]																																			
193	Form Facility Management Team (FMT)	FO,DMT	3	0% [Progress Bar]																																			
194	Train FMT	FO,DMT	3	100% [Progress Bar]																																			
195	Sensitize Providers	FO,DMT	7	100% [Progress Bar]																																			
196	Improve Facility Management Systems	FO,DMT	3	100% [Progress Bar]																																			
197	<u>Benchmark: Management Systems Improved</u>	FO,DMT	3,7	★ 3/28																																			
198	Facility Renovation	HMHCP	1,3	100% [Progress Bar]																																			
199	Draw up Specifications	HMHCP	1,3	100% [Progress Bar]																																			
200	Interim Relocation of OB Services	HMHCP,FO	1,3	100% [Progress Bar]																																			
201	Award Contract	HMHCP	1,3	100% [Progress Bar]																																			
202	Construction Work	Contractor	1,3	100% [Progress Bar]																																			
203	Inspect Construction Work	HMHCP	1,3	100% [Progress Bar]																																			
204	Accept Renovated Facility	HMHCP	1,3	100% [Progress Bar]																																			

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ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
265	Select Lead Trainer Candidates		1	100%																																			
266	Develop Basic Competencies	FO	1	100%																																			
267	<u>Benchmark: Personnel Available & Competent</u>	FO,GMT,DMT	1,3																																				
268	Launch Stage	FO,GMT,DMT	1,3,7													100%																							
269	<u>Benchmark: BEOCs Ready for Launch</u>	FO,GMT,DMT	1																																				
270	Launch preparation	FO,GMT,DMT	1,3,7													100%																							
271	Launch	FO,GMT,DMT	1,3,7													100%																							
272	<u>Benchmark: BEOCs Launched</u>	FO,GMT,DMT	1,3,7																																				
273	Service Stage	DMT	1,3													70%																							
274	Provide Improved BEOC Services	DMT,FMT	1													75%																							
275	QA Monitoring & Continuous Improvement	DMT,FMT	3													75%																							
276	Clinical Skills Mastery	FO	1													45%																							



<p>Tue 3/13/01 Luxor Integrated Plan</p>	<p>Task Progress Benchmark Completed Benchmark Milestone Completed Milestone Summary Summary Progress</p> <p>FFO=Fayoum Field Office AFO=Aswan Field Office LFO=Luxor Field Office BSFO=Beni Suf Field Office</p>		<p>QFO=Qena Field Office HMHCP=HM/HC Project GMT=Governorate Management Team GHC=Governorate Health Committee DMT=District management Team DHC=District Health Committee FMT=Facility Management Team CHC=Community Health Committee DIC=District Information Center GIC=Governorate Information Center BEOC=Basic Essential Obstetric Care CEOC=Comprehensive Essential Obstetric Care NCU=Neonatal Care Unit</p>
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Qena Governorate

Target Governorate Integrated Work Plan

Beni Suef Governorate

Target Governorate Integrated Work Plan

ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
1	Governorate Level			[Redacted]																																			
2	Governorate Management Team/Health Committee		3,7	[Redacted]																																			
3	Governorate Management Team (GMT)		3	[Redacted]																																			
4	Form GMT	FO, HMHCP	3	[Redacted]																																			
5	Train GMT	FO, HMHCP	3	[Redacted]																																			
6	Resource Request Developed & Submitted to Central Planning Dep	GMT, FO, HMHCP	3	[Redacted]																																			
7	<u>Benchmark GMT Established</u>	FO, HMHCP	3	[Redacted]																																			
8	Governorate Health Committee (GHC)		3,7	[Redacted]																																			
9	Form GHC	FO, HMHCP	3	[Redacted]																																			
10	Orientation of GHC	FO, HMHCP	3	[Redacted]																																			
11	<u>Benchmark GHC Established</u>	FO, HMHCP	3,7	[Redacted]																																			
12	Governorate Health Plans (GHP)	GMT, GHC	3	[Redacted]																																			
13	2000-01 GHP	GMT, GHC	3	[Redacted]																																			
14	Review & Approve Group A Districts DHPs	GMT, GHC	3	[Redacted]																																			
15	Develop 2000-01 GHP Incorporating DHPs	GMT, GHC	3	[Redacted]																																			
16	<u>Benchmark 2000-01 GHP Developed</u>	GMT, GHC	3	[Redacted]																																			
17	Submit 2000-01 GHP to National Level	GMT, GHC	3	[Redacted]																																			
18	Implement & Monitor 2000-01 GHP	GMT, GHC	3	[Redacted]																																			
19	2001-02 GHP	GMT, GHC	3	[Redacted]																																			
20	Review & Approve Groups A & B Districts DHPs	GMT, GHC	3	[Redacted]																																			
21	Develop Gov Health Plan (GHP) Incorporating DHPs	GMT, GHC	3	[Redacted]																																			
22	<u>Benchmark 2001-02 GHP Developed</u>	GMT, GHC	3	[Redacted]																																			
23	Submit 2001-02 GHP to National Level	GMT, GHC	3	[Redacted]																																			
24	Implement & Monitor 2001-02 GHP	GMT, GHC	3	[Redacted]																																			

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ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
158	District Level			[Redacted]																																			
159	District Health Planning		3	39% [Redacted]																																			
160	<i>Group A Districts (3): Beni Suef, Ehnasia, Wasta</i>			[Redacted]																																			
161	District Management Teams (DMT)		3	45% [Redacted]																																			
162	Form Group A District Management Teams (DMT)	FO, HMHCP	3	100% [Redacted]																																			
163	Train Group A DMTs	FO, HMHCP	3	100% [Redacted]																																			
164	Benchmark: Group A DMTs Established	FO, HMHCP	3	★ 5/25																																			
165	District Health Committees (DHC)		3,7	99% [Redacted]																																			
166	Form Group A DHCs	FO, HMHCP	3,7	100% [Redacted]																																			
167	Orientaton of Group A DHCs	FO, HMHCP	3,7	100% [Redacted]																																			
168	<u>Benchmark: Group A DHCs Established</u>	FO, HMHCP	3,7	★ 6/27																																			
169	District Health Plans (DHP)		3	43% [Redacted]																																			
170	2000-01 DHPs		3	61% [Redacted]																																			
171	Identify Catchment Areas in Group A districts	FO, HMHCP	1,3	100% [Redacted]																																			
172	Select Anchor Facilities	FO, HMHCP	1,3	100% [Redacted]																																			
173	Develop District Health Plans (DHP)	FO, HMHCP	3	100% [Redacted]																																			
174	<u>Benchmark: Group A Districts 2000-01 DHPs developed</u>	FO, HMHCP	3	★ 8/17																																			
175	Submit DHPs to GMT/GHC	DMT	3	100% [Redacted]																																			
176	Implement 2000-01 DHP	DMT	3	50% [Redacted]																																			
177	2001-02 DHPs		3	[Redacted]																																			
178	Develop District Health Plans (DHP)	FO, HMHCP	3	[Redacted]																																			
179	<u>Benchmark: Group A Districts DHPs 2001-02 developed</u>	FO, HMHCP	3	★ 6/14																																			
180	Submit 2001-02 DHPs to GMT/GHC	DMT	3	[Redacted]																																			
181	Implement 2001-02 DHP	DMT	3	[Redacted]																																			

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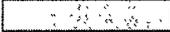
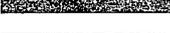
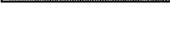
ID	Activity	Responsible	Task	1999												2000												2001											
				J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
230	Monitor Performance of Renovation Work	HMHCP	4	100% ██████████																																			
231	Inspection & Acceptance	HMHCP	4	██████████ 100%																																			
232	Commodity Procurement	FO, HMHCP	4	██████████ 100%																																			
233	Identify Commodity Needs	FO, HMHCP	4	██████████ 100%																																			
234	Order Commodities	FO, HMHCP	4	██████████ 100%																																			
235	Receive & Install Commodities	FO, HMHCP	4	██████████ 100%																																			
236	Human Resources	FO, HMHCP	4	██████████ 100%																																			
237	Training Needs Assessment	FO, HMHCP	4	██████████ 100%																																			
238	Schedule Training Workshops	FO, HMHCP	4	██████████ 100%																																			
239	Conduct Training Workshops	FO, HMHCP	4	██████████ 100%																																			
240	Develop Basic Competency	FO, HMHCP	4	██████████ 100%																																			
241	Master Competency	FO, HMHCP	4	██████████ 100%																																			
242	Routine Data Entry	FO, HMHCP	4													██████████ 75%																							
243	<u>Milestone: MHIS Centers Established in 9 Districts</u>	FO, HMHCP	4													◇ 7/22																							
244	Routine Submission of Reports to DMT	FO, HMHCP	4													██████████ 75%																							
245	<u>Benchmark: Annual Statistical Report Submitted to DMT</u>	DIC														★ 3/1																							
246	<u>Benchmark: Annual Statistical Report Submitted to DMT</u>	DIC	4																									★ 3/1											

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Fayoum Governorate

Target Governorate Integrated Work Plan

Tue 3/13/01 Fay00m Integrated Plan

- | | | |
|---------------------|--|---|
| Task |  | FO=Field Office |
| Progress |  | HMHCP=HM/HC Project |
| Benchmark |  | GMT=Governorate Management Team |
| Completed Benchmark |  | GHC=Governorate Health Committee |
| Milestone |  | DMT=District management Team |
| Completed Milestone |  | DHC=District Health Committee |
| Summary |  | FMT=Facility Management Team |
| Progress |  | CHC=Community Health Committee |
| | | DIC=District Information Center |
| | | GIC=Governorate Information Center |
| | | BEOC=Basic Essential Obstetric Care |
| | | CEOC=Comprehensive Essential Obstetric Care |
| | | NNCC=Neonatal Care Center |

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SECTION V:

INDIVIDUAL TASK PLANS

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 Benefits Package 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.

TASK ONE: Basic Benefits Package established and standards defined

PURPOSE:

The purpose of Task One is to assist the MOHP in finalizing the protocols and standards for the Maternal and Child Health part of the Basic Benefits Package (MCH BBP)⁸. This assistance began during the MotherCare Project. After this process of finalization, JSI will assist the MOHP to implement this sustainable basic package of essential preventive and curative health services to reduce maternal and child mortality and morbidity. The MCH BBP will be delivered through MOPH clinics and hospitals in Upper Egypt which will be upgraded to provide quality services in compliance with the criteria in the Service Standards. Upgrading will involve a competency-based Training of Trainers (TOT) for Master Trainers, central hospital and district level Lead Trainers/Supervisors. These Lead Trainers/Supervisors in collaboration with representatives of the District Management Team (DMT), Governorate Management Team (GMT), Department of Clinical Services, and Clinical Supervisors, will in turn train and supervise service providers and monitor the implementation of the MCH BBP, 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 MCH part of the Basic Benefits Package

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

Activity No. 1.2 Finalize MCH part of the Basic Benefits Package

During the first year of the Contract, the MCH BBP was clearly defined as illustrated in Table 6. The process of defining the MCH BBP included the formation and subsequent meeting of the *HM/HC Consensus Committee* starting in 1998. In March, 1999 consensus was reached concerning the contents of the MCH BBP. Consensus 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,

⁸ To be consistent with other programs in the MOHP, this term "MCH part of the Basic Benefits Package," replaces the "HM/HC Package of Essential Services" term used in the Contract.

UNICEF, WHO, Wellstart, and USAID. The Consensus Committee has 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 the MCH BBP;
- Clarified roles and responsibilities;
- Established a method to coordinate follow-on activities; and
- Defined the MCH part of the Basic Benefits Package.

Table 6. The MCH part of the Basic Benefits Package

MCH part of the Basic Benefits Package	Responsibility
1) Premarital examination and counseling	<ul style="list-style-type: none"> • Family Planning Div., MOHP • JSI (only collaborates with above)
2) Prenatal, delivery, and postnatal care (essential obstetrical care – basic and comprehensive)	<ul style="list-style-type: none"> • HM/HC Project, MCH Div., MOHP • Curative Medicine Division, MOHP • UNICEF • JSI
3) Peri/Neonatal care	<ul style="list-style-type: none"> • HM/HC Project, MCH Div., MOHP • JSI
4) Promotion of immediate and exclusive breastfeeding	<ul style="list-style-type: none"> • HM/HC Project, MCH Div., MOHP • National Breastfeeding Program - MOHP (Wellstart) • JSI (only collaborates with above)
5) 40 th day integrated visit for mother and infant postpartum check-ups	<ul style="list-style-type: none"> • HM/HC Project, MCH Div., MOHP • Family Planning Div., MOHP • National Breastfeeding Program – MOHP (Wellstart) • JSI
6) Children's preventive health services	<ul style="list-style-type: none"> • HM/HC Project, MCH Div., MOHP • UNICEF • JSI (collaborates)
7) Sick child case management	<ul style="list-style-type: none"> • HM/HC Project, MCH Div., MOHP • UNICEF (IMCI) • WHO (IMCI) • JSI (collaborates)
8) Reproductive health services	<ul style="list-style-type: none"> • Family Planning Div., MOHP • JSI (only collaborates with above)
9) Nutrition services	<ul style="list-style-type: none"> • HM/HC Project, MCH Div., MOHP • HIO/SHIP • UNICEF • JSI
10) Counseling and health education on all the above	<ul style="list-style-type: none"> • As indicated above

The elements of the MCH BBP in Table 6 were reviewed and accepted by the Consensus Committee and underwent periodic review during year two. The elements that are the primary responsibility of JSI are going through the process of being converted to CBT materials (protocols and modules). This process continued during year two and materials were scheduled for completion in year three since more topics have been added to the list. i.e., anesthesia, operating room, emergency room and central supply department, etc. The soon to be published EOC Protocol Reference Manual will be an important reference document for service providers.

The groups responsible for each element in Table 6 will continue to work together to develop the components of the MCH BBP and assess which elements of the MCH BBP require strengthening. They will then collaborate in MCH BBP planning, implementing and monitoring.

Quality Assurance Service Standards and Checklists for the following areas will continue to be used during the third year to assess, upgrade and monitor service facilities and the provision of essential equipment and supplies:

- Comprehensive Essential Obstetric Care,
- Basic Essential Obstetric Care,
- Neonatal Units,
- Child Survival, and
- Family Planning (covered by POP IV).

In recognition of the fact that the great majority of maternal deaths occur in district and general hospitals, emphasis on the early improvement of these facilities in Years Two and Three will be a programmatic priority. Developing their Comprehensive Essential Obstetric Care (CEOC) services should significantly impact on maternal mortality by providing quality obstetric referral services. Each district/general hospital typically serves a referral catchment area of approximately 500,000 people. CEOC facilities are designed to handle the full range of obstetrical complications. Early improvement of district/general hospitals will also allow providers to practice their newly acquired skills since there is a high volume of obstetrical services provided. The second area of programmatic emphasis will be on the development of intermediate, Basic Essential Obstetric Care (BEOC) facilities. Such facilities are usually established in rural or integrated hospitals and provide a service point closer to most communities than the district/general hospital. BEOC facilities are designed to serve a catchment area of 100,000 persons by providing services for less serious obstetrical complications. In most of these facilities, care for normal and complicated deliveries is a new service, it is therefore necessary to generate demand for such services. These CEOC and BEOC facilities are referred to as "anchor" facilities since they will serve as the focal point for training and demonstration of quality services. As a third programmatic priority, primary care centers which provide Basic Maternal and Child Care (BMCC) services will be developed. These are referred to as "non-anchor" facilities and provide basic Antenatal Care (ANC). These facilities deal with preparation for and follow up of normal deliveries and referral of high-risk pregnancies to higher level facilities. This three tier linked system of services forms the basic strategy of improving services to reduce maternal mortality.

Activity No. 1.3 Implement MCH part of the Basic Benefits Package

An **eight-stage process** of implementation was initiated in year one, and will continue into all subsequent years. 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, especially for non-anchor Basic Maternal and Child Care (BMCC) facilities. The delivery system for the MCH BBP in each district includes a number of anchor facilities determined by population and geographical considerations:

- The district/general hospital anchor facility will be up-graded to deliver CEOC services and function as the comprehensive referral center for the MCH BBP in the remaining Governorates of Fayoum, Beni Suef and Qena;
- A number of other basic centers will be included as anchor BEOC 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 BMCC facilities in the district capable of providing the MCH BBP will be included in the delivery system in collaboration with the HM/HC Project team, Governorate and District Management Teams.

Upgrading of facilities includes improvements to meet service standards in the following areas:

- Upgrading of human resources through training and mastery skills and competencies.
- Renovation of the physical facility.
- Upgraded equipment and furniture.
- Improved facility management.
- Active community mobilization.

In brief, the following eight stages⁹ of the MCH BBP implementation process will continue, with emphasis in target districts within Beni Suef, Fayoum and Qena governorates:

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 MCH BBP standards.
3. Based on findings of the initial assessment, prepare an immediate and long-term **plan for bringing prospective anchor facilities into compliance** with MCH BBP 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 central level and district level hospital Lead Trainers/Supervisors to train service facility staff in MCH BBP standards and to use checklists to monitor compliance with MCH BBP service standards.
6. Governorate Management Teams (GMTs) and District Management Teams (DMTs) **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 (CBT) conducted by Master Trainers, Clinical Supervisors, HH/HC Project supervisors and Lead Trainers at anchor facilities** for the staff of MOHP BMCC facilities ("non-anchor facilities") in the vicinity of the anchor facilities. Training interventions will continued to be documented in the Training Report Form. Weekly supervisory visits will be made by members of the above mentioned team to monitor and document the development of basic competencies. This supervised CBT system will upgrade service facility staff skills, enabling them to meet the standards required to provide the MCH BBP. As part of their training, service facility staff will prepare plans for upgrading their respective facilities to meet the MCH BBP standards.

⁹ The Contract includes a *ten* stage process. Stage No. 1 above was added (selection of facilities), and previous stages eight through ten have been combined in the paragraph following stage eight since they deal with the replication of the eight stage process and the continuous improvement of the facilities.

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 MCH BBP standards.

This eight-stage process will be **repeated** and **replicated** within the target districts according to the District Health Plan. At the conclusion of this eight-stage process, each facility will receive quarterly visits by members of the DMT, biannual visits by GMT and annual visits by Master Trainers, Clinical Supervisors or HM/HC project supervisors to determine and/or verify their continued compliance with MCH BBP 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 MCH BBP standards.

It should be pointed out that the improvement of *non-anchor facilities* in stage eight will be basically the responsibility of the MOHP HM/HC Project, with technical assistance inputs from JSI in the form of assessment, planning and limited training.

The above eight-stage process has been incorporated into the **Preparation, Improvement, Launch and Service Stages of the Integrated Work Plan.**

Activity No. 1.4 Architectural and Engineering Services

- The contractor shall provide technical assistance, in the form of architectural and engineering services. This includes assessment of current physical structure of selected facility, developing plans to propose the ideal architectural design to meet the standards, blue prints, bills of quantities, estimated cost and description of work for OB/Gyn Department, Neonatal Units, Operating Room, and CSSD Department.
- Technical assistance for selection of the interim space in which services will be provided during renovation of OB/Gyn or Neonatal units, including recommendation of the critical improvements required to meet minimal standards.
- Architectural and engineering recommendations for anchor facilities that require renovation by MOHP.
- A set of standard physical structure plans for OB/Gyn Departments and Neonatal Units.

Activity No. 1.5 Performance Evaluation instrument utilized for training physicians on Essential Obstetric Care (EOC) services

In collaboration with Task Three and Task Six Managers, teams of Clinical EOC and Neonatal Care Unit Supervisors consisting of obstetric/gynecologist, neonatology, anesthesiology, nursing and infection control specialists will make bi-monthly supervisory and on-the-job training (OJT) to anchor facilities in support of local Lead Trainers/Supervisors. During these visits, the Clinical Supervisors will monitor skill performance of health/nursing care providers against the criteria stated in EOC and Neonatal protocols and service standards. Performance Evaluation instruments will be used to document the "development of basic competency" and "mastery" of essential skills by health/nursing care providers as part of the OJT process.

RESOURCE REQUIREMENTS:**Commodities:**

Commodity requirements for implementing Task One activities include:

- 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 facilities will receive medical equipment and supplies according to the required standards.

EXPECTED ACCOMPLISHMENTS:

During the current AWP period, March 15, 2001 - September 15, 2001, the following accomplishments will be realized.

Performance Milestones:

- Health personnel implementing MCH BBP in 20 districts (cumulative) by March 15, 2001.
- Health personnel implementing MCH BBP in 25 districts (cumulative) by September 15, 2001.

Performance Targets:

- Same as above milestones.

Major Benchmarks:

In Beni Suef, Fayoum and Qena governorates, major benchmarks for provision of the MCH BBP include:

- Preparation Stage: Facility Improvement Plans Incorporated into DHP
- Improvement Stage: Facilities Renovated
- Improvement Stage: Commodities Installed
- Launch Stage: CEOC and BEOC Launched

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 Basic Benefits Package, and to improve the quality, effectiveness and use of maternal and child health services in private sector facilities.

STRATEGY:

Activity No. 2.1 Medical School Training: Revision of medical school curricula and upgrade faculty training skills to incorporate MCH part of the Basic Benefits Package

- The first step in securing full cooperation with the medical schools chosen to be involved in this task is to arrange the signing of a Memorandum of Cooperation amongst the parties (Dean of the Medical School, USAID, and JSI). This agreement sets forth the overall framework under which implementation will take place, and the respective responsibilities of the signing parties. The following is a list of the 13 medical schools which are involved. Memoranda of Cooperation have been signed with the following schools:

1. Cairo Medical School
2. Beni Suef Medical School and Fayoum Medical School
3. Alexandria Medical School
4. Assiut Medical School
5. Mansoura Medical School
6. El-Azhar Medical School
7. Menoufia Medical School
8. Ain Shams Medical School
9. Menya Medical School

The following medical schools have been selected for inclusion in the program and Memoranda of Cooperation will be signed with them in 2001:

10. Suez Canal Medical School
 11. Sohag Medical School
 12. Benha Medical School
 13. TBD (either El-Azhar Medical School for Girls or Tanta Medical School)
- Based on the MCH part of the Basic Benefits Package (MCH BBP) developed in Task One, a competency-based curricula (CBC) for medical and nursing schools has been developed. The CBC is used to supplement existing curricula. To streamline the materials production process, the CBC for medical interns is the same as the MCH BBP 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 Seventh Year House Officer programs offer the best opportunity to integrate MCH BBP and Essential Obstetric Care (EOC) CBC into the medical education system. This is the time when physicians are engaged in the actual practice of their skills and best suited for CBT interventions. There is 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 life of the HM/HC-RP.

- A Curriculum Development Committee (CDC) is established at each of the other participating medical schools once a Memorandum of Cooperation is signed. This committee is 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. The Memorandum of Cooperation is between USAID, JSI and each medical school specifies the roles and responsibilities among the organizations included in the curriculum development effort.
- For students to master MCH BBP skills in an appropriate learning environment, university hospital-based model clinics must meet Quality Assurance Service Standards. 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 can be met. This will be done in conjunction with Task One and Three facility rapid assessment and planning activities.

Activity No. 2.2 Nursing Schools: Revision of nursing school curricula and upgrade faculty training skills to incorporate MCH part of the Basic Benefits Package

- As with the medical schools, a similar approach of securing a Memorandum of Cooperation with nursing schools is used. The following is a list of nursing schools which are involved.

Memoranda of Cooperation have been signed with the following schools:

1. Alexandria Faculty of Nursing
2. Cairo Faculty of Nursing
3. El-Mansoura Faculty of Nursing
4. El-Menoufia Faculty of Nursing
5. Ain Shams Faculty of Nursing
6. Menya Faculty of Nursing

Memoranda of Cooperation will be signed with the following schools in early 2001 (the secondary schools of nursing have not yet been selected):

7. Assiut Faculty of Nursing
8. Suez Canal Faculty of Nursing

With the following secondary schools of nursing, a Memorandum of Cooperation will be signed with the MOHP Human Resources Department in early 2001:

9. Secondary school of nursing in Aswan
10. Secondary school of nursing in Luxor
11. Secondary school of nursing in Qena
12. Secondary school of nursing in Beni Suef
13. Secondary school of nursing in El-Fayoum

- An approach similar to that described above for medical schools is used in the implementation of the revised curriculum and faculty skills upgrading in the selected nursing schools.

Activity No. 2.3 In-service clinical training

Concerning in-service clinical training, continuing medical education (CME) for physicians in Egypt is organized and coordinated through the CME Committee of the Egypt National Medical Syndicate (ENMS). In-service training was 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 continuing with the 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 and in collaboration with Tasks One and Six.

Through the HM/HC Project, primary health care (PHC) physicians are trained through their Coordinated Training Course which address PHC related skills.

Activity No. 2.4 Improve clinical training capabilities

In collaboration with Tasks One and Six, an initial core group of Master Trainers and Clinical Supervisors have been trained. The Master Trainers and Clinical Supervisors have in turn trained MOHP Lead Trainers/Supervisors at the central and district hospital levels. Working with the MOHP Lead Trainers/Supervisors, service providers are trained and supervised at hospital and non-hospital facilities.

In collaboration with Tasks One and Three, the above mentioned facilities were first assessed, scored against the criteria in the Quality Assurance and Service Standards and up-graded to serve as anchor facilities for their catchment areas. It is through these anchor facilities that service providers from non-anchor facilities will be trained.

Activity No. 2.5 Training beyond the MOHP

Private Sector Activity:

Recognizing the importance of the private health sector as the predominate provider of outpatient health care in Egypt and also recognizing the involvement of most physicians in both the public and private sectors, the Private Sector Activity (PSA) was created to support, enhance and promote Egypt's private health services. The goal of this activity is to improve health services provided by the private sector in the field of maternal and child health care, through implementation of the MCH BBP by private sector providers. Through the implementation of various activities, PSA seeks to upgrade the skills and standardize the services in the field of maternal and child health.

The overall objective of the Private Sector Activity is to improve the quality, effectiveness and use of maternal and child health services in private health facilities and households. PSA involves a commitment to share in decreasing maternal and neonatal child mortality.

PSA will carry out the following seven strategies within the target area:

- ◇ **Information on Providers:** Contact information will be obtained on private sector providers (physicians, pharmacists, dayas) for future training opportunities. A sample of each type of provider will be contacted regarding service activities.
- ◇ **Research:** A research study will be conducted to determine quality of care by provider, referral practices, define priority topics for training, and recommendations for accreditation. The study will include measures both before and after interventions.
- ◇ **Training:**
 - Physicians (OB-Gyns, GPs, Pediatricians): Two days of training will be provided to private sector physicians who have completed the EOC or Neonatal training. Topics such as ethics, private practice quality assurance standards, record keeping, referrals etc. will be presented.
 - Pharmacists: One day seminars will be conducted for a selected number of pharmacists concerning topics such as referrals, role of pharmacists in MCH, drugs and antenatal care issues etc.
 - Dayas: Coordination with Task 6 activities.

- ◇ **Promotion:** Client oriented IE&C materials that are being produced by HM/HC will be provided to private sector providers for distribution to clients. In addition, the Credit Guarantee Corporation (CGC) may provide signage for private providers who complete HM/HC training.
- ◇ **Upgrading Private Provider Facilities:** HM/HC will coordinate with the CGC to provide information for private sector providers in obtaining loans to upgrade private clinic and pharmacies facilities. The CGC will be invited to present this information in one of the sessions during the private sector training conducted by HM/HC.
- ◇ **Quality Assurance:** Quality assurance standards and a quality checklist will be adapted for private sector use. Discussion will take place with the MOHP to have such standards and QA system officially endorsed for use by the private sector. This will be introduced in the training courses.
- ◇ **Networking:** Linkages will be strengthened among private providers, medical syndicates, pharmacy syndicates, and the MOHP. District and governorate health committees will have representatives from the private sector to help ensure cooperation and coordination of MCH activities.
- ◇ **Infection Control:** The Private Sector Specialist coordinates the Infection Control Program at HM/HC JSI where this program includes the following activities:
 - Formulation of infection control committees and teams at the Governorate, district and facility levels.
 - Development and dissemination of health communication materials.
 - Development of training materials.
 - Integrated training of Infection Control committees and teams on infection control.
 - Problem solving on implementation of infection control policies and procedures.
 - Monitoring of compliance with infection control policies and procedures.
 - Operational Intervention Research for Infection Control Practice.

RESOURCES REQUIRED:

Commodities:

- Adequate materials production equipment. Adequate copies of the training material component of the MCH BBP for distribution to the target audience.
- For the 13 medical schools and 13 nursing schools, the following commodities are required for each site: overhead projector, screen, slide projector, flip chart stands and paper, television monitor, video cassette recorder/player, abdomen and pelvis models, doll and newborn resuscitation kit. A limited number of computers will be provided as necessary to medical schools to set up an adequate MIS.

EXPECTED ACCOMPLISHMENTS

During the AWP fourth year period, March 15, 2001 - September 15, 2001, the following accomplishments will be realized:

Performance Milestone:

- HM/HC curricula taught in 10 medical and 10 nursing schools by March 15, 2001
- HM/HC curricula taught in 13 medical and 13 nursing schools by September 15, 2001

Performance Targets:

- Complete training for all categories of personnel by the end of the contract.
- Training needs assessment and training plan will determine numbers and categories of personnel to be trained.

COORDINATION:

- There are linkages and crosscutting activities, which require close collaboration and coordination with Task Managers for Tasks 1, 3, 4, 6, 7, 8 and 9. The majority of crosscutting activities are associated with Tasks 1, 3, 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, and WHO.

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

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. An annual "bottom-up input/top-down feedback" planning and monitoring loop will be supported. An important step in establishing an enabling environment is the signing of a joint Memorandum of Cooperation between the Governor and Undersecretary (or Director General) of each of the target governorates and representatives of USAID/Egypt, the MOHP and JSI.

Activities will continue in twenty districts in Aswan, Luxor, Qena, Beni Suef and Fayoum governorates (5 districts in Aswan, 2 districts in Luxor, 6 districts in Qena, 3 districts in Beni Suef and 4 districts in Fayoum) 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 third planning year (March 14, 2001), these twenty 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. These districts were phased into the program by December 15, 2000, thus achieving the planned

Performance Milestone for twenty districts. During the last quarter of the previous planning year, activities were initiated in a new set of 5 districts in Beni-Suef and Qena governorates in preparation for implementation during the following planning period. By September 15, 2001, a total of 25 districts will have implemented district planning and monitoring capabilities (see Table 5 in Section III above).

Activity No. 3.1 Community Level Involvement

Community involvement will continue to be addressed both at the Governorate and District levels by establishing Governorate and District Health Committees (see Figure 1 below). In addition, community participation is ensured at a more peripheral level through the establishment of Community Health Committees (CHC). These CHCs 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 received appropriate training that enables them to perform this role and to mobilize local resources. Facility level involvement is accomplished through establishment of Facility Management Teams (FMT). Each FMT is responsible for implementation of the HM/HC MCH/BBP (package of services), self-assessing their facility's compliance with HM/HC service standards, and for implementation of facility management systems. Facility Management Systems guidelines were developed to guide the FMTs in the management of their facilities. For the most part, Basic Essential Obstetric Care (BEOC) is established in Integrated Hospitals. Due to the lack of such hospitals in some catchment areas, however, it has and will be necessary to choose smaller Rural Health Units for BEOC facilities. In such cases there are small FMTs, which have a responsibility for establishing and operating the required facility management systems.

Activity 3.2 District Level Interventions

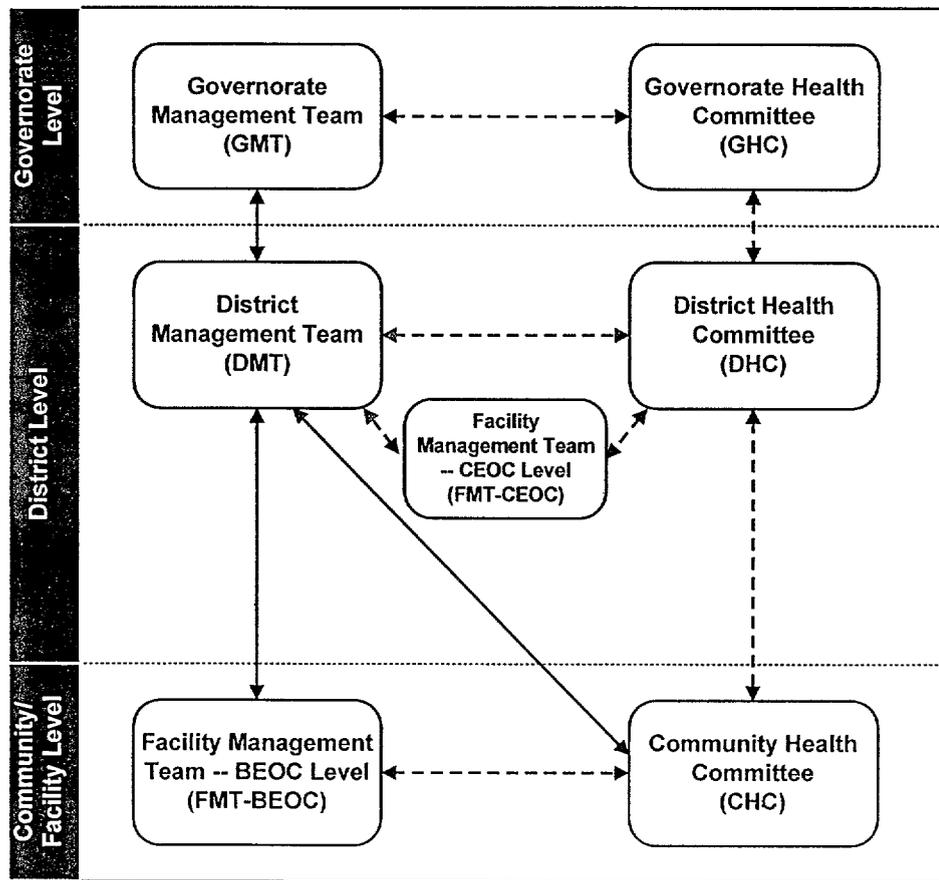
District Management Teams (DMT) and District Health Committees (DHC) will continue to be established and trained on the district planning process using the Planning and Monitoring Guidelines developed in 1998. District assessments were conducted to ascertain each district's management capacity. District Teams work closely with DHCs in developing individual plans incorporating community/facility level plans. As mentioned earlier, the DMT/DHCs send these plans to their respective GMT/GHCs. This sharing/incorporating process enables health facilities and their catchment area communities to have input into the district, governorate and national levels. This helps 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. Membership of DHCs includes 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 is provided to these teams and committees during the implementation process and the management of the HM/HC results package locally. A key activity of DMTs is the monitoring of compliance of facilities with Quality Assurance (QA) service standards. DMTs measure and score QA compliance through the use of checklists on a quarterly basis. The information gained from these checklists enables the DMTs and FMTs to engage in a problem solving process to uncover the root responsibility for problems and determine and implement a course of action to correct such problems.

Activity No. 3.3 Governorate Level Participation

Governorate Management Teams (GMT) and Governorate Health Committees (GHC) were established to provide feedback to the district planning process and to support district-level implementation. GHC membership is essentially analogous to that of DHCs, with the addition of representation from the local medical/nursing syndicates. GMTs have their own plans that reflect

the needs of the affiliated districts. These GMTs and GHCs are trained to carry out their role in monitoring the implementation of the package at the governorate level. Technical assistance is also provided for the establishment of referral systems and the identification of opportunities for a financial sustainability structure to support the program. Also, assistance is 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 are made to identify private providers eligible for loans and facilitate their utilization of these funds in the promotion of the Basic Benefits Package.

Figure 1. Management Relationships



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. To ensure the sustainability of this planning process, counterparts from the national level participates with Task Three members in the delivery of training and in the supervision of planning and monitoring activities of both governorate and district levels. Coordinated activities with different departments in MOHP and other related projects, e.g. PHR, POP IV, will continue. This coordination varies from exchange information, joint meetings to exchange experiences, lessons learned and field implementation visits. Coordination also takes place with the Egyptian Medical Syndicate to develop a National Accreditation System for private facilities.

RESOURCES REQUIRED:

A variety of resources is needed to support Task Three activities:

- Short-term trainers are needed to meet the anticipated increase in training activities.
- Training and implementation activities require resources to support travel expenses, per diem, and participants' training allowances.
- The different Teams and Committees hold a large number of meetings, generating need for additional funding.

EXPECTED ACCOMPLISHMENTS:

During the current AWP period, March 15, 2001 - September 15, 2001, the following accomplishments will be realized:

Performance Milestones:

- 5 additional district health plans and monitoring systems developed and implemented by September 15, 2001, plus 20 previously developed plans updated.

Performance Targets:

- 25 District health plans and monitoring systems developed and implemented by September 15, 2001.

Major Benchmarks:

- 60 Community Plans developed by July 15, 2000
- A referral system developed, tested, and documented by July 31, 2001
- Facility Management Systems developed and implemented in 25 districts by Sept. 15, 2001

COORDINATION:

- Task Three coordinates with Task One to ensure that the Basic Benefits Package is being effectively planned at the District level. Also, close coordination takes 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 ensures availability of appropriate quality data for all levels in the planning and monitoring system development process. Also, coordination takes place to train GMTs and DMTs in data use and interpretation for better decision-making.
- Close coordination takes place with Task Seven, which aims to establish better social community services. Activities particularly relating to the establishment and training of Community Health Committees are closely coordinated.
- Coordination with Task Nine (HIO/SHIP) to implement an iron supply program through and under supervision of the District Management Teams in the target governorates.
- 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.
- Coordination with UNICEF and other related projects e.g. PHR, Pop IV, also takes place to make sure that experiences are being shared and that lessons learned from the different governorates and districts are being communicated.
- Coordination with the Egyptian Medical Syndicate to develop an Accreditation System for the private facilities.
- Coordination will be maintained with the Credit Guarantee Corporation as part of the Private Sector Activities, ensuring mobilization of resources for the implementation of the package in the private sector.

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 in 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 – 14 districts

Phase II: December 15, 1999-December 14, 2000 – 44 districts (30 additional districts)

Phase III: December 15, 2000-September 15, 2001 – 65 districts (21 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 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 is 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 provided the information required to develop a plan to prepare the physical facility to house the information centers, provide the necessary training and human resources development, and procure and install the required equipment and other commodities. During Year Two, 30 districts were assessed in Fayoum, Qena and Assiut governorates. During Year Three, MHIS assessment took place in Menya and Sohag.

Activities are accomplished in coordination with the National Information Center for Health and Population (NICHP). This linkage ensures 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.

Based on investigation of the use of the Geographic Information System (GIS) for reporting and displaying data, a GIS component is developed to be used through MS-Excel to present generic data in spreadsheets as maps of Egypt.

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

After assessments are completed and district MHIS development plans created, the work of district level MHIS implementation begins. During Phase I, 14 District Health Information Centers (DIC) were established. During Phase II, an additional 30 DICs were established by June 15, 2000. During the final Phase III, a addition 21 DICs will be established in Menya and Sohag.

It was realized that district MHIS centers needed new procedures, job description and defined roles of the MHIS center in relation to all other parties in the district, directorate and the facilities. This led to the expansion of the level of activities and the development of a Manual of Procedures for MHIS activities. The Manual focuses on district and directorate levels. It defines organization charts, job descriptions, and mechanisms for data flow, data analysis and reports, levels of supervisions and tools for supervision and control. The Manual was approved by NICHIP and implementation of the manual started in four governorates in Lower Egypt. HM/HC RP has begun to implement the Manual of Procedures in Aswan, Luxor, Beni Suef, Fayoum, Qena and Assiut.

Implementation activities in Year Four include:

- Sites designated for DIC establishment will be upgraded to bring them into compliance with standards. The renovation requirements are limited in most cases to painting, adding electricity outlets, improving lighting conditions, telephone upgrades, etc. Renovations will be finished by May 2001;
- Personnel identified for each district and individual training plans developed which will bring them to the standard of performance required to operate the DIC;
- Coordinate with DT2 Project and conduct training for information center 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 and be concluded by May 2001;
- Computer and associated furniture, equipment and supplies will be procured and installed;
- Software applications installed. Hardware and Software installations will start by end of May 2001.
- Development by May 2001 of standards for information centers and a system for monitoring compliance with those standards.
- Continue implementation of the quality assurance monitoring system for information centers in June 2001.

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

Governorate Information Centers will be upgraded as well with new computer equipment and training for staff to improve their skills in managing and supervising the new DICs.

Activity No. 4.3 Design user friendly software for MHIS

A systems analysis survey was conducted to define user requirements at district, governorate and central levels. Software is developed to allow data entry at district level for QA checklists and district plans. The software is designed to allow the user to print out the QA checklists and district plans and specific data analysis reports. Moreover, it allows the user to produce indicator reports out of the HIS database. In addition, another application is developed to allow ad hoc queries from the HIS database. This is developed to improve the reporting system at the district and

directorates levels. Workshops for Data Use will be held to start implementation of the Monitoring System and to train DMTs on data analysis.

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.

A monitoring system for HM/HC activities will be developed, including a complete set of indicators concerning mothers and children. 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.

Activity No. 4.5 Upgrading MHIS centers at Governorate level

During Years Two and Three, the MHIS centers at the governorate level were provided with the same set of equipment and furniture that was provided to the district level. The set included an air conditioner, computer, UPS, laser printer, computer table, and chairs. Also, the training program included some of the governorate MHIS centers staff members in PC support, supervision skills, data analysis and monitoring activities.

Year Four will include the upgrading of Menya and Sohag governorates.

The training for the governorate MHIS center includes:

1. Training of trainers on HIS application data management
2. Training on PC support and troubleshooting
3. Training on district level supervision

The main objective of the training program is to upgrade the skills of the governorate level to be able to provide technical support and supervision to the district level MHIS centers.

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 (renovation) to prepare 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, 2001 - September 15, 2001):

Performance Milestone:

- Assist MOHP/NICHP to establish 65 MHIS centers at the district level (in Aswan, Luxor, Beni Suef, Qena, Assiut, Menya and Sohag governorates) by June 15, 2001.

Performance Target:

- By September 15, 2001, 65 districts will have a complete health management information system providing information on vital events, health indicators, mortality, service statistics and program management.

Major Benchmarks:

- Training for MHIS staff for 20 new DICs concentrates on basic computer skills and data management skills. Training will start by March 2001
- Hardware and Software installations for 20 new DICs will start by end of April 2001
- Computer based monitoring system for HM/HC will be installed for 20 new DICs by end of June 2001
- Training for district managers and deputies on analysis and interpretation of HM/HC data produced from HIS will be finalized for target districts during 2001

COORDINATION:

- Collaboration with the International Institute for Education (IIE) – DT2 Project is required to organize all activities related to training for district staff working within MHIS centers.
- 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 Menya governorates. UNICEF hired an implementation field officer for at least one year to support the MHIS implementation in Assiut in 2000 and beyond.
- Complete coordination with NICHP, regarding all activities of Information centers assessment and establishment, and the implementation of the monitoring system. Moreover, full integration regarding the implementation of the MHIS Manual of Procedures.
- The Population IV Results Package is planning the automation of all districts in Egypt to enable computerized data processing of family planning information at the district level – a program similar to that of HM/HC. Close coordination with these activities is taking place in the HM/HC target districts to avoid or minimize duplication of efforts. Discussions are ongoing with the MOHP Family Planning and Reproductive Health Department and Pathfinder International. There is concern that the computers should all be housed in the same District Information Center facility to facilitate coordination. In some cases the same staff will be responsible at the district level for data entry, management and reporting of family planning and MCH data. A Memorandum of Cooperation is being prepared to document faces of coordination between MCH and Family Planning Departments.
- 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, including revision of the communicable disease surveillance system and developing materials for the Data Use Workshops.

TASK FIVE: Research Activities

PURPOSE:

The following are the major activities to be completed as regards operations research:

- Continued assessment of current research needs: gaps in available clinical and operational information.
- Development of the remaining research methodologies and protocols.
- Training of appropriate staff and community workers in applied research methodologies.
- Implementation of twelve operations research studies.
- Identification of personnel, departments and/or institutes to conduct studies.
- Initializing an on-going surveillance system for maternal and perinatal mortality in Egypt.

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:

- Knowledge, Attitudes and Practices (KAP) studies to develop or modify health education messages;
- 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;
- Studies concerning neonatal care could be the main target for operational research, since not many studies have been completed and more information is needed in this area;
- Operation research will focus also, not only on the mortality of the neonate, but also on the mild morbidity that may pass unnoticed by the public as well as health providers; and
- Behavior of health providers especially concerning infection control practices and procedures has already started, and will be studied in depth to improve the quality.

STRATEGY:

Activity No. 5.1 Assessment of Current Research Needs

- The purpose of research is to provide information 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 the 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 are directly related to health outcomes and the efficient functioning of a decentralized the 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. See Table 7 for a listing of the topics for which studies have begun, or are being considered.
- 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.

Table 7. List of research activities

No.	Proposal No.	Proposal	Comments
1	PR-4	Neonatal care practices in the home during the first week of life	Completed
2	PR-5	Neonatal and obstetrical assessment and care practices in health care facilities	Completed
3	PR-6	Birth attendant practices during the antenatal, intrapartum and early neonatal periods	Completed
4	PR-7	Standards of care in the private sector	Data analysis, report writing
5	PR-13	Topical Therapy for Prevention of Infections in Preterm Infants	Started Dec. 15, 2000
6	PR-20	Impact of introduction of birthing kits in Beni Suef Governorate	Base line done, intervention to start
7	PR-12	Development and pilot-testing of interventions to promote compliance with standard infection control procedures by health care providers	Protocol writing is waiting for the final IC plan
8	PR-8 and PR-14	Postnatal and Neonatal home care package (feasibility, acceptability and Impact on morbidity and mortality)	Collaboration with task 8.
9	PR-17	Assessment of the impact of training of private physicians on performance	
10	PR-11	Assessment of feasibility and acceptability of emolliation and skin care practices in premature infants in neonatal care units	
11	PR-18	Assessment of the impact of training on delivery room practices for decreasing neonatal asphyxia	
12	PR-21	Reasons for differences of facility utilization by women especially after renovation.	
13	PR-22	Impact of NGO intervention on the community practices	

Activity No. 5.2 Development of Research Proposals and Identification of Departments and/or Institutes to Conduct the Research

- Development of proposals for the priority studies will continue after March 2001, with more analysis of research data reviews and designs. The target completion date for the studies is September 2001.
- Applied research will be institutionalized 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 maternal and child health services.

Activity No. 5.3 Train appropriate staff in "applied research" methodologies

- 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.
- Research skills will be taught to the community workers to be able to formulate the research questions and collect data, as well as involvement for data analysis and interpretation.
- Principles of operation research skills will also be taught to some health providers in the target governorates.

Activity No. 5.4 Create research findings dissemination strategy

- Findings and data will be analyzed in depth, reported and disseminated. 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.

Activity No. 5.5 Conduct the 1999/2000 Maternal and Perinatal Mortality Survey*Collection of data on maternal deaths during a one year period in the 27 governorates:*

- JSI, in collaboration with MOHP, the Central Agency for Public Mobilization and Statistics (CAPMAS) and the London School of Hygiene and Tropical Medicine, used up-to-date data on female deaths and death registration points as a sampling frame to draw the maternal death sample. 149 selected health bureaus in the 27 governorates were chosen to be the death registration points for the collection of maternal deaths.
- In collaboration with JSI, the MOHP and CAPMAS will recruit and train household interviewers and supervisors, and then pilot-test the questionnaires in 3 governorates.
- JSI will assist the MOHP to train the 149 selected health bureau directors and the 108 Local Advisory Group (LAG) members. The CAPMAS interviewers will visit the households of the deceased women within one month of death to interview the families of the deceased women using special household questionnaires.
- Supervision and fieldwork check of quality of data will be conducted on a regular basis. Each completed household questionnaire will be delivered to the LAG committee in each governorate for confirmation of medical causes and avoidable factors of maternal death.
- All completed LAG questionnaire forms (physician form and LAG report form) and household questionnaires from the 27 governorates will be delivered to JSI in Cairo. CAPMAS will report to JSI on the work status quarterly, and any identified field work problems will be solved promptly by JSI research team.

Collection of data on stillbirths, neonatal deaths and live births for living women in the 27 governorates:

- The Egyptian Demographic and Health Survey (EDHS) will identify the relevant sample from births in the three years prior to the 2000 EDHS. This sample will consist of all stillbirths and neonatal deaths, and a subsample of three live births selected randomly for each death, and matched with year of birth. These data will be obtained by linking to the EDHS planned for early 2000.

- The sample of women who had births in the three years prior to the year 2000 will be re-interviewed. The EDHS team will recruit and train household interviewers and supervisors, pilot test the questionnaire and supervise the quality of data including field checks, and solve any problems with field work in collaboration with JSI research team. The EDHS team will report to JSI on implementation status according to the agreed upon schedule.

EXPECTED ACCOMPLISHMENTS:**Performance Milestones:**

- 2000/2001 Perinatal/Neonatal Maternal Mortality Study (PNMMS) completed by June 15, 2001

Performance Targets:

- PNMMS will be completed by the end of the contract and the report will be submitted to MOHP and USAID by June 15, 2001.
- A Maternal Morality Surveillance System will be developed and functioning in the Upper Egypt governorates.
- Twelve operations research studies completed by the end of the contract.

Major Benchmarks:

- All maternal deaths in one-year period in the 27 governorates will be ascertained by March 14, 2001.
- All live births during the same one year period of maternal death will be determined by March 14, 2001 (live births will be used as the denominator for the calculation of maternal mortality ratio).

COORDINATION:

- With all tasks to identify and prioritize their research needs.
- With FETP of MOHP on the maternal mortality study. Three physicians from FETP were assigned to work with the study.
- With HM/HC project at MOHP on the maternal mortality study.

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

TASK SIX: National Child Survival Programs Sustained

PURPOSE:

The child survival project (CSP) was successful in achieving most of its objectives with significant improvement in the health of Egyptian women and children. The MOHP will be assisted in sustaining the accomplishments of the CSP and integrate those accomplishments into the HM/HC strategy, especially the gains made in the areas of the expanded program of immunization (EPI), the control of Diarrheas Diseases (CDD), Acute Respiratory Infection (ARI), Neonatal care, Model clinics and training.

STRATEGY:

Workshops will be organized for representatives of MOHP at all levels to plan for successful integration of activities at districts and delivery points levels. These workshops will identify ways in which the HM/HC project can assist decentralized planning and integration of the previous vertical programs into one comprehensive healthy child 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 MCH part of Basic Benefit Package. This will help to strengthen the health management, MIS logistics and referral system in the districts to be reflected on the quality of services at the facility level.

Activity No. 6.1 Strengthen immunization service

Expanded Program of Immunization (EPI) is one of the well-established health programs in MOHP. Immunization coverage for all vaccines is over 90% nationwide. EPI has achieved most of its objectives with support from many national and international organizations further technical assistance required through Task 6 is minimal. Nevertheless, Task 6 will work with MOHP, the HM/HC Project and Task 3 through the management teams at the target governorates at different levels to identify targets and coordinate work on in different EPI activities and to help ensure that vaccination coverage reaches the planned performance target. Plans are developed to assist with achieving Neonatal Tetanus elimination in Egypt. There are several strategic opportunities to pursue:

1. Highlight Tetanus Toxoid (TT) immunization issues during training interventions of all categories: physicians, nurses, managers and Dayas;
2. Include health messages on TT during training of health educators, community and health committees;
3. Include TT activities as part of the Post-Partum Campaign.

Activity No. 6.2 Strengthen ARI & CDD programs

The current health policy is to integrate services provided to the sick child. World Health Organization (WHO) and UNICEF adopted a new strategy for management of sick children under 5 years, the Integrated Management of Childhood Illness (IMCI) Program. ARI and CDD are two of the major components of the IMCI. The MOHP has adopted this strategy and many steps have been taken to implement it. JSI during the last year shared in some of these steps, mainly in the area of providing technical assistance to shorten the curriculum and translate materials into Arabic. JSI, also, shared in central level activities like evaluation of the early implementation phase of the IMCI and the plan for expansion to new districts. Furthermore, JSI shared in the regional meeting conducted during November 2000 to assess the current status of IMCI and the future plan. Nationally, JSI staff have provided technical assistance to IMCI by:

- Working with the MOHP sector Program to integrate ARI and CDD training and programming with other health components to form an integrated HM/HC package of essential services.
- Assisting in adaptation and implementation of the IMCI Program developed by WHO/UNICEF.
- Assisting in implementation of essential child health services in target districts and IMCI program.
- Sustaining the National Child Survival Program.
- Involving community to increase knowledge and improve health behavior in households for IMCI.

At the Governorate and District level, JSI technical assistance staff, in coordination with IMCI Program staff, will work with local trainers/supervisors to implement the “nine step IMCI program development process” in the three target governorates of Fayoum, Beni Suef and Qena in six districts. This process includes:

1. Select districts,
2. Conduct a situation analysis,
3. Orient supervisory teams at the governorate and district levels,
4. Conduct district level planning workshops,
5. Provide equipment at districts,
6. Conduct with districts drug availability,
7. Conduct IMCI training workshops for service providers,
8. Conduct IMCI follow-up workshop at facilities providing IMCI services, and
9. Conduct a community program to improve key family practices.

IMCI training and support equipment will be procured and provided: audiovisual equipment to three universities, Menya, Alexandria, El Azhar and Assiut and central IMCI office to support the implementation of the IMCI Program.

Task 6 will also work with MOHP, the HM/HC Project and Task 3, through the management teams at the target governorates at different levels, to identify targets and coordinate work on different ARI and CDD activities and to help ensure that training coverage reaches the planned accessibility to the health units.

Activity No. 6.3 Support the neonatal program

The MOHP, with assistance from JSI, is improving the services for newborns in over 100 Neonatal Care Units (NCUs). JSI's assistance is more intensive in 16 NCUs which are located within the five target governorates. These 16 NCUs are serving as demonstration sites where the full array of inputs and processes are being provided and implemented. During Year Four, JSI's contribution to the MOHP's development of the NCUs outside of the Target Governorates is in the form of assistance in developing of a NCUs improvement plan, standards and quality assurance program, protocols for service delivery, training curricula and materials, and other advanced methodologies.

According to the previous plan, development of Competency-Based Training (CBT) modules for both physicians and nurses were finished. Training of physicians on basic and advanced neonatal care covered most of the neonatal physicians, and the remaining will be finished during this upcoming period. Classroom training of nurses started and it is planned to finish within April-May 2001. A group of clinical supervisors has been recruited for On-the-Job (OJT) training in the target governorates. Each supervisor is assigned to one or more neonatal units to work with the unit team to reach mastery level in their performance. During the year 2000 general assessment of all neonatal units in Egypt was conducted by the MOHP and JSI. Analysis of data and report writing are still in process. Based upon the results of this assessment, a plan of improvement of the assessed units can be developed and implemented. An additional assessment will be conducted for 100 neonatal centers within April 2001 to meet the requirements of the next milestone (Services improved in 100 MOHP neonatal centers) which should be submitted on July 15, 2001.

There are plans to involve the three governorates of Assuit, Menia, and Sohag in neonatal activities. A Memorandum of Cooperation will be signed with each governorate as was done with the other five target governorates. Twenty-two neonatal units will be included in these governorates. The required equipment and supplies was estimated and a list of the essential needs have been submitted. Identification of the numbers of physicians and nurses in each unit and whether they were trained will take place. Priority for training will be given to those who were not trained before. Training will be competency-based and will be the same as that applied in the initial five target governorates. As it is stated in the contract, JSI is responsible to give technical assistance (TA) for 100 neonatal units. It has been decided to include Giza (10 units) to complete the whole of Upper Egypt, and the rest will be selected according to specific criteria. JSI will provide TA to the MOHP through training of a group of master trainers on CBT methodology, and assist them with the first one or two workshops, as well as help them in conducting OJT training by the assigned clinical supervisors.

Activity No. 6.4 Strengthen the Daya Program

Work on the Daya program is one of the main strategies of this plan. 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. Revision and modification of the Daya's five-day refresher course curriculum was completed during the last year as a joint effort between MOHP, UNICEF, and JSI. Training courses were conducted in the target governorates in collaboration with HM/HC Project. These courses will be continued in the target governorates, but because of the large number of target Dayas for training, it was decided that Daya training will be selected to be for the districts with a high incidence of tetanus neonatorum, a high neonatal morbidity and mortality, and in the catchment areas of anchor facilities. Monitoring of Daya performance and inclusion of

supervision activities data into the information system of the health facilities is important and it should be linked to the Daya licensing.

RESOURCES REQUIRED:**Commodities:**

Required equipment and supplies for 22 NCUs in Assuit, Menia, and Sohag governorates were submitted. Also a list of equipment and supplies for the remaining 78 neonatal units was also submitted.

Personnel:

More clinical supervisors are needed in the current five target governorates and the three new governorates.

EXPECTED ACCOMPLISHMENTS:**Performance Milestones:**

- Services improved in 100 MOHP neonatal centers by July 15, 2001.

Performance Targets:

- EPI coverage rate above 90% for 25 districts for the 7 vaccines by September 15, 2001.
- Effective ARI MIS in 27 governorate by September 15, 2001.
- 100 neonatal centers providing acceptable care by September 15, 2001.
- Upgraded Daya Training Course implemented in all 25 districts by September 15, 2001.

Major Benchmarks:

- Finish training of Menya, Sohag, and Assuit by June 30, 2001.

COORDINATION:

- Close coordination with the HM/HC Project in different activities is required.

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: SHIP Program

TASK SEVEN: Better Social Community Services

PURPOSE:

- Improve community/household access to accurate and culturally appropriate information and modify health behavior.
- Create a demand on health providers and increase women 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

This activity was implemented in close collaboration with activity No 7.2 below. The Protocol to define, assess and identify community-based groups that could partner with health providers was used to work with a multitude of local persons in the five target governorates. Groups working on different objectives were assisted to support maternal and childcare activities and to begin generating demand for health services.

Activity No. 7.2 Inventory of Partners

An inventory was conducted to define, assess and identify community-based groups that could partner with health providers. A set of criteria was established of "good" partnerships that were used to identify partners at the community level in the five target governorates.

Activity No. 7.3 Development of a Community Needs Identification and Decision-Making Tool

The *Community Needs Identification and Decision-Making Tool* (CNI-DMT), an essential activity to accomplish sub-result 5.1.4, was developed and implemented to increase the effectiveness of facility-based interventions. This is accomplished by involving communities in planning actions to promote key preventive and care seeking behaviors. The process is also used to bring the voice of the community, particularly those members of the community with greatest need, to the attention of program managers and policy makers. During the third year, the tool will be implemented in another 20 communities in the remaining target districts of Upper Egypt.

Activity No. 7.4 Health Care Provider Sensitization

Heightening the sensitivity of health providers to community needs, beliefs and perceptions is another way to involve them in practical communications with communities and build trust. Sensitization work will continue in the targeted ten districts 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 of community perceptions and beliefs.

Activity No. 7.5 Testing Different Partnership Schemes

Establishing community/health provider's partnership schemes will help increase service coverage, especially in hard-to-reach with services. Community resources mobilization will be emphasized throughout the partnership process. The last two years witnessed the establishment and testing of several different community/health provider's partnership schemes. These schemes covered areas related to creating demand for the newly renovated quality services, community health communications and removing logistical barriers to access health care. These schemes were monitored carefully over the past two years with the goal being to refine two or three models that address the majority of the community situations.

Activity No. 7.6 Implementation of the Most Promising Partnerships

Experience gained so far with the community/provider partnership schemes over the last year indicates that the CHC is the promising model for overall partnership. A CHC, which is empowered with the Community Needs Identification and Decision-Making Tool, is the basis for several different partnerships that could emerge and functioning based on truly identified community needs.

Activity No. 7.7 Community Education

A key strategy to improve community knowledge and health practices is to strengthen the knowledge base of the community representatives in the Community Health Committees, District Committees and Governorate Committees so that they can influence health care practices in their own communities. Activities during the last two years involved wider sections and leaders at the community, district and governorate levels. They were able to determine (in a participatory approach) their roles and secure their commitment to support the project activities. Accomplishments in Aswan and Luxor during the last two years covered a wide range of areas including mobilizing community to raise health awareness, create a demand on the renovated maternal services, increase the participation of women in health services and remove social and logistic barriers to access health services. This year these activities will continue in the remaining target governorates.

This year will focus on reviewing Community Action Plans (CAP) developed and utilizing the community/NGOs outreach workers, to empower and enable them through pre-packaged intensive training courses to create efficient and effective community workers. They need practical experience, which could only be achieved through developing ties and regular working relations with the health providers at the community level. This process should be supplemented and supported by intensive effort to change the attitudes of the health providers to treat and accept community outreach workers as helpful auxiliaries.

RESOURCES REQUIRED:

- A consultant to develop Community Outreach Workers manual.
- A consultant to develop curriculum for Literacy/Health teachers.

EXPECTED ACCOMPLISHMENTS:

By the end of the fourth year of the contract, the following accomplishments are expected:

Performance Milestones:

- Community Action Plans developed and implemented in 25 districts by September 15, 2001.

Performance Targets:

- Community Action Plans developed and implemented in 25 districts by the end of Year 4 (September 15, 2001).

Benchmarks:

- 68 Communities with active interest groups in engaged in HM/HC (September 15, 2001).
- 68 Communities with HM/HC health communications activities underway (September 15, 2001).
- 68 Communities that have undertaken a community HM/HC health needs assessment and prioritize actions based on findings (September 15, 2001).
- 450 health care providers/provider organizations participated in sensitization orientation (September 15, 2001).
- 68 Community-provider partnerships established and functioning with health care (September 15, 2001).
- 68 Areas where emergency obstetrical transport is available (September 15, 2001).
- 68 Communities where key child survival actions including nutrition actions are available (September 15, 2001).

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 3: Development of Community Needs Assessment Tool	Task 3: Synchronization and compatibility with establishment of Community Health Committees
Activity 7: Community education	Task 8: This activity will be carefully orchestrated with mass media efforts. A package of community Interpersonal communications materials to be used by Community agents/leaders to be developed
All Task 7 Activities	Task 4: 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
- NGOs Support Service Center
- Key international and national NGOs working in Egypt
- Key bilateral donors (DANIDA, GTZ, RNE, etc.)
- Key multilateral donors (UN, EU, WB, etc.)

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 may reduce the need for sophisticated and costly curative services. This will be undertaken through a comprehensive approach to increase timely and appropriate and promote other key behavior changes, that encompasses:

- training providers and health educators to upgrade their counseling and motivating skills;
- IEC materials for use by providers for counseling and interpersonal communication with clients/patients; and
- focused campaigns that combine use of mass media, print materials and local mobilization activities.

The target area for this task is Upper Egypt with emphasis on Aswan, Luxor, Beni-Suef, Qena and Fayoum.

STRATEGY:

Implementation of Task 8 is guided by the approved HM/HC IEC Strategy which covers national, governorate and local level activities, focuses on behaviors at the household level, and aims to improve behaviors of health providers and their interactions with clients/patients. The HM/HC IEC strategy emphasizes:

- the promotion of the Maternal and Child Health component of the Basic Benefits Package;
- improving access to accurate and culturally appropriate information;
- creating awareness of and demand for improved and appropriate services;
- improving care-seeking patterns and ability to practice healthy behaviors in the household through application of 'communication for behavior change' approach; and
- strengthening counseling and interpersonal skills of providers and encouraging community/provider partnerships.

Therefore, three IEC objectives have been identified for the implementation of HM/HC IEC Strategy:

1. Influence practices of individuals (especially women) in the household or collectively in the community.
2. Improve health providers' ability and behavior to work effectively with clients and community to increase demand and utilization of services.
3. Promote policies and norms.

Seven priority themes, which emerged from existing research and previous experience in Egypt, were identified for the implementation of the IEC Strategy and will be addressed during this workplan period with a special focus on postpartum and newborn care:

- Birth Preparedness for a Safer Birth;
- The 'Clean Chain' – Cleanliness, Asepsis and Infection Control at Household and Facility Level;
- The 'Three Delays' in Obstetric and Newborn Complications and Emergencies;
- Early Postpartum Care for Mother and Newborn and 40th day postpartum care;
- Patterns of Antenatal Care Use;
- MCH related Social Norms, Provider Behavior; and
- Caring for Your Child

A full range of available media will be used in the program in a strategic manner to address each of these themes. Up-to-date information on media habits and preferences will be used to position HM/HC messages to reach the intended audiences effectively. Mass media will be the base of this media strategy since television and radio coverage is so high. Stand-alone print media will be used in a limited fashion due to low literacy levels, but may be helpful in advocacy efforts and for reminders of actions and take home materials that are well illustrated. Interpersonal communication through health facility personnel, health educators and community agents will be an important overlay to the mass media program to offer the specific, tailored messages and reinforce the media messages. Facility-based materials will be developed and distributed to promote healthy behaviors and routine care, which describe danger signs of potential complications during pregnancy, labor, early postpartum and for the newborn. These materials could include counseling cards, reminder inserts and take-home pamphlets or leaflets.

Activity No. 8.1 Improving IEC Capacity (Reinforcing MOHP-SIS Collaboration)

The focus is on improving capacity in the MOHP, where possible and the private sector to improve IEC capacity that will be long-term and sustainable to support behavior change programs and campaigns in the future. MOHP personnel especially from the HM/HC Project will be engaged in each stage of development and implementation of the IEC campaigns, media and materials. Behavior change and social marketing concepts and skills will be developed through IEC training at different levels in the system.

In addition, private sector will be strategically encouraged to partner HM/HC in the development, implementation, monitoring and evaluation of IEC campaigns, media and materials. Increasing the number of private sector agencies participating in the competitive process for these services will encourage the development of interest in and improvement of abilities to work in the social sector; and provide MOHP and its partners a greater choice of private sector agencies for future behavior change programs. HM/HC's campaigns will engage a number of private agencies in the development of media materials, pre-testing of materials, and monitoring and evaluation of the campaign through pre and post surveys (see also Activity 8.8 below).

Activity No. 8.2 Investigation of Behavioral Information

The application of 'communication for behavior change' (CBC) approach has led to the identification of the ideal main behaviors and sub-behaviors for each HM/HC priority theme. Existing research is being used to identify gaps between these ideal behaviors and practices at the household and community levels. Qualitative research was carried out in Qena, Fayoum and Beni Suef to provide necessary information that is currently only available from Luxor and Aswan. Qualitative information from focus group discussions and in-depth interviews will be used for the development of evidence-based behavior change strategies and materials for each HM/HC theme and related behaviors.

Activity No. 8.3 Strategic Design for Health Communication

The HM/HC IEC Strategy has been approved and during this workplan period efforts will be made to inform and engage partners in the implementation of the HM/HC IEC Strategy. The purpose of orientation meetings with partners is to coordinate message strategies and IEC activities to avoid duplication and avail opportunities. POP IV, UNICEF and other MCH projects and programs will be especially engaged in this process.

Activity No. 8.4 IEC Training of Health Providers and Field Workers

The IEC Training for Health Educators and Field Workers commenced with Orientation and Planning Meetings for National Coordinators and for Governorate Facilitators for Competency-based Workshops. This was followed by 8 workshops at the governorate level covering 162 participants who would partner health education and communication personnel from the five governorates. This series of competency-based IEC Workshops will continue during 2001 to cover additional 5 workshops to be held in Aswan, Qena, Fayoum and Beni Suef.

The primary aim of these workshops for Health Educators and Field Workers is to develop their competencies and abilities to plan, organize and implement HM/HC IEC activities; in particular, implementation of campaign activities in their areas and local mobilization in consonance with HM/HC objectives, priority behaviors and messages. Greater emphasis is placed on 'behavior change' strategy and social marketing concepts.

Activity No. 8.5 Print and Audio-visual Materials for Providers and their Clients

Community assessments had shown a need for information related to complications especially during delivery, postpartum and for the newborn. In response to this need priority IEC materials focusing on complications during pregnancy, delivery, postpartum and newborn are being developed as a series. These materials have been developed, pretested, and were widely distributed at the local level in the five governorates; and made available for partners to distribute in other areas.

Facility-based assessments have also shown the need to focus on infection control. Posters and signs promoting infection control behaviors were designed, pretested and produced and distributed and displayed at appropriate places within health facilities.

Breastfeeding materials developed under Wellstart were further tested with health providers, revised and reproduced for distribution to health facilities. Additional print and audio-visual materials based on needs will be developed.

Print, media and other materials will also be produced as part of each of the second HM/HC campaign (see also Activity 8.8 below).

Activity No. 8.6 Promotion of Quality Services – the Gold Star Approach

The initial emphasis is on using the experience of quality assurance and quality improvement program (Gold Star) and the relevant methods and materials to strengthen the supervisory system and improvement in the quality of services. Public promotion of a quality symbol will be carried after the supervisory and quality assurance systems are fully in place.

Activity No. 8.7 IEC Demand-generation Campaigns for HM/HC Services

The first campaign that was launched and implemented focused on the 'Birth Preparedness' theme but also included certain complementary components of 'Clean Chain' as described in the HM/HC IEC Strategy. These themes were chosen together for the first campaign as they help to:

- emphasize responsibility and role of the family in protecting the life of the mother and baby;
- encourage planning for a safe birth and also planning for an emergency;
- stress the importance of a clean birth as a safe birth; and
- launch a key new initiative, the Birth Preparedness Guide.

The overall aim of the first campaign was to influence and promote healthy behaviors of primary audience groups related to Birth Preparedness and encourage them to take the necessary actions for a healthy and safe birth.

The second Campaign will focus on postpartum and newborn care, Behavioral analysis of key behaviors for the two themes has been carried out and a detailed Request for Proposals was developed for response by private sector agencies. The schedule for development and launch of the second Campaign includes: preliminary concept, approach, story boards, scripts, slogans; TV and radio spots pretested and finalized, and media plan developed, and final print ready formats finalized. The second Campaign includes development of four TV and four radio spots, posters, flyers and take-home materials, and counseling cards. All campaign materials will be developed and ready for the Campaign media launch and implementation during 2001.

The effectiveness of the campaign will be measured through baseline and post campaign surveys conducted by an independent private agency. The objective in undertaking these surveys is to evaluate exposure, recall of key messages, and changes in knowledge, attitudes and practices related to the campaign.

Activity No. 8.8 Female Genital Mutilation

Initial meetings and discussions are being held with other organizations and donors working in the elimination of female genital (mutilation) cutting (FGC) to conduct an assessment that was completed. HM/HC strategy and activities were finalized, and through concurrence with partners FGM/FGC activities are likely to include:

- HM/HC Strategy for integrating ant-FGM activities into HM/HC Components.
- A shortened version of the documentary "*The Season for Planting Girls*".
- A facilitators' guide to accompany the short version of the video.
- Through the NGO grants Program, training for NGOs selected and given the grant to work on FGM.
- Review of FGM section in ongoing training for Dayas.
- Adding an FGM section in the Physicians EOC Training, Nurses Training, and Health Educators Training.
- Conceptualizations of FGM low literate materials.

RESOURCES REQUIRED:

Commodity Requirements: The implementation of the IEC strategy will require the development, production and printing of IEC media and materials.

Personnel Requirements: The design and production of IEC media and materials will require agencies and personnel with experience in developing and coordinating campaign activities; creative skills, media development, testing and production capabilities. These requirements will be addressed through use of creative agencies, marketing and production companies and through international and local consultants.

Training Requirements: The emphasis of interpersonal communication in the IEC strategy requires the development and implementation of effective interpersonal communication training activities. Training in interpersonal communications will continue as part of EOC training for health personnel. In addition, health educators, at different levels, will also require training.

EXPECTED ACCOMPLISHMENTS:

During the current AWP period, March 15, 2001 - September 15, 2001, the following accomplishments will be realized:

Performance Milestones:

- FGM component integrated into overall HM/HC message package by June 15, 2001

Major Benchmarks:

- IEC Training Package completed.
- Print materials developed and distributed.
- IEC Orientation Package completed.
- Counseling/interpersonal module upgraded.
- Health educators and field workers trained.
- Governorate level community mobilization initiatives developed for the campaign.
- Television spots developed and aired.
- Radio spots developed and aired.
- National HM/HC motivational campaign developed and implemented.
- FGC component HM/HC plans developed and implemented.

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 HM/HC Project and Directorate of Health Education, Ministry of Health, and other partners such as Population Project IV, UNICEF and MCH projects.
- Coordination with other tasks is essential especially Task 1 and 2 for the finalization and integration of interpersonal communications protocols and modules for medical and nursing curricula and for EOC training. Task 7 & 8 will continue to strength coordination of strategy, approach, methods and materials focusing on reaching women and households and community leaders through orientation, community education and development of IEC materials.
- Coordination will be further strengthened at the Governorate and District level with the existing committees for local campaign and mobilization activities.

TASK NINE: Student Health Insurance Program

PURPOSE

The Student Health Insurance Program (SHIP), an expansion of the National Health Insurance Organization, provides comprehensive preventive and curative services to enrolled students. The purpose of Task 9 is to expand several of the critically important HM/HC activities to adolescent girls in the targeted governorates, and in so doing to influence SHIP national policy and provide long-term benefits to the participating adolescents. These benefits 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 SHIP and review its policies and programs nationally, and then gradually incorporate other organizations working on adolescent health issues in the dialogue. Prior to pilot implementation, studies were conducted in each component that clarified technical and operational issues. Upon completion of the studies, the scope of each activity was refined and policies and procedures were developed to guide the pilot implementation in one governorate. A pilot of a sentinel school program was also developed to monitor the implementation and effectiveness of the program. Operations research will be conducted to help objectively assess implementation changes needed. After pilot implementation HM/HC will work with the SHIP to analyze the results of the pilot. Each target governorate will then carefully analyze implementation requirements and conduct programs in their governorate.

However, the strategic policy work cannot reside solely in the HIO/SHIP. The MOHP and MOE will be brought into the discussions early on as the health guidelines need to be in harmony with MOHP policy, also school-based activities could effect the MOE. This dialogue was accomplished via an MOHP-sponsored national workshop to develop an integrated strategy for the health of all adolescents and a nutrition education committee established to inform the educational component of the project. This workshop included research organizations, GOE and NGOs and other organizations working in communities, thus potentially expanding policy changes and services tested with the SHIP to those adolescents not attending school.

Activity 9.1 Preventive services, especially health education

The strategy is to train SHIP 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. SHIP has hired for each target governorate a coordinator for nutrition and health education and 20 nutrition and health educators. After intensive training they conducted campaign style education in target schools. The educational program focuses on four behavior-based messages that were determined by qualitative research. The educational strategy was developed and approved and pilot education materials created. Based on the pretest and operations research results, pilot materials and protocols have been revised. Final camera-ready art for the educational materials was provided to SHIP for duplication. Materials were duplicated to all governorates. A revised training curriculum and a health educator's guide are the backbone of the education program. All target governorates will conduct the education program during the final year of the contract.

SHIP plan to expand all aspects of implementation to the rest of Upper Egypt and then implement throughout Egypt.

Activity 9.2 Anemia control program

For anemia control, the strategy is to deliver iron-folate pills to adolescent girls and boys in preparatory and secondary school weekly through out the school year. SHIP is responsible for all implementation cost associated this component. SHIP staff and contracted MOHP staff will deliver pills, keep records and report regularly. Based on operations research conducted on the pilot, final policies and procedures have been established and approved. Training programs have been developed and trainers trained in each target governorate. Supervision is established within the program and also integrated into the district management plans. In Beni Suf Governorate, the MOE is testing tablet distribution by class teachers.

Activity 9.3 Tetanus Toxoid (TT) immunizations

The tetanus immunization scheme of SHIP will be reviewed based on the current WHO guidelines. WHO and EPI staff will be closely involved in all aspects of this activity. Current immunization status of Egyptian adolescents and SHIP reporting procedures have been assessed. Recommendations will be made for protocols that SHIP can implement. SHIP will determine implementation schedules based on their budget cycles, and equipment and training needs that go beyond the scope of this task.

Activity 9.4 Anti-smoking Messages for Adolescents

A school-based anti smoking prevention program will be developed for adolescent boys and girls in preparatory and secondary schools in the 5 target governorates in Upper Egypt. Qualitative research will be undertaken in order to develop a strategy, educational approaches and messages for adolescents. Messages will be pre-tested and a curriculum / educator's guide will be developed in accordance with the strategy and the anti smoking messages. Starting in school year 2001-2002, the SHIP nutrition and health educators will be responsible for implementation of the anti smoking program.

RESOURCES REQUIRED

This task enters the implementation phase during this annual plan; the JSI Task Manager and the Implementation Supervisor will provide the leadership. They will be supported by a newly hired training supervisor and short term consultants. Essential to the implementation of this field-based intervention is the continuation of support under the PIL budget for the additional staff person for the Director of the Preventive Health Program of the SHIP. SHIP has also agreed to hire a central-level coordinator to lead the newly established Nutrition and Health education activity. PIL budget support is also needed for the transportation, per diem and training honorarium expenses for the five-governorate nutrition and health education training provided under the USAID funded DT2 project. Continuation of PIL budget funded for categories currently specified in the PIL budget are also needed for full task implementation.

EXPECTED ACCOMPLISHMENTS

During the current AWP period, March 15, 2001 - September 15, 2001, the following accomplishments will be realized:

Performance Milestones:

- SHIP nutrition education and anemia supplementation program implemented in five target governorates and national SHIP plan developed by September 15, 2001.

Performance Target:

- A nutrition and health education program and an anemia supplementation program, for adolescent boys and girls, developed, pilot tested and implemented in the five HM/HC target governorates by September 15, 2001.
- A national nutrition and health education program implementation plan developed for implementation under SHIP by September 15, 2001.

Major Benchmarks

- Qualitative research report by May 20, 2001
- Anti-smoking Strategy meeting by May 22, 2001
- Educational messages and curriculum by September 1, 2001

COORDINATION

- The Nutrition and Health Education Committee with membership from SHIP, MOHP, MOE, USAID, UNICEF and JSI provides continuity to ensure that the educational component benefits from advice for all sectors.
- Within HM/HC there is coordination with work underway in the maternal health package on anemia policy for women, Task 3 for District management, with Task 7 focused on services at the community level, Task 10 small grants and with Task 8 on communications.
- At all stages of the JSI's anti-smoking program development, Healthy Egyptians 2010 will be briefed.

SUPPORTING ACTIVITIES

There are two supporting activities:

TASK TEN: Small Grant Program

TASK ELEVEN: Commodity Procurement Program

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 Small Grants Program aims to encourage mobilization of community resources to assess their own needs and develop local solutions to address local health problems. It will also assist in bringing health awareness and improving services to the most underprivileged communities in Upper Egypt.

STRATEGY:

The previous grants given in the target districts in the field of Maternal and Child Health will be assessed in order to develop lessons learned.

An NGO seeking a grant is required to complete an application in which a proposal and a budget are presented. The application should reflect the results of a careful planning process. Priority for grant funding will be given to NGOs who provide clearly defined details regarding proposed activities which will achieve clear and measurable results. Each application will provide details of the proposed activities and the costs of these activities. The application will also provide sufficient information about the organization applying for the grant to enable JSI to assess the organization's experience and capabilities.

An Invitation for Application (IFA) is developed by JSI, approved by USAID and then published and distributed in the target governorates through JSI Field Offices, the local Offices of the Ministry of Insurance and Social Affairs (MoISA) and the NGOs Regional Federation. After reading the IFA, interested NGOs submit letters of intent to JSI along with any questions or queries they may have about the Program.

JSI invites the NGOs who sent letters of intent to a workshop that has the following objectives:

- Introduce the Healthy Mother Healthy/Child Project and the Small Grants Program
- Provide training on how to write the proposal according to requirements of the IFA
- Answer any questions or queries received from the NGOs

After the workshop, NGOs continue working on their proposals to submit to JSI by the closing date and time as mentioned in the IFA.

All applications received by the closing date are reviewed by a Panel Committee using the selection criteria outlined in the IFA. The Committee reviews and evaluates the proposals in order to produce a short list of the technically competent ones. These competent NGOs are then field visited in order to discuss and further refine their proposals as well as to assess their financial management capacity.

After the NGOs refine and re-submit their proposals, and if they pass the pre-award assessment, the Review Panel makes a final evaluation of the refined proposals before they submit them to USAID for approval. When approved by USAID, JSI signs contracts with and advances money to the successful NGOs.

Activity No. 10.1 Assessment of work currently being done and potential for future grants by umbrella and local organizations in target area

Done. --

Activity No. 10.2 Grants provided to capable organizations through standard mechanism

A blanket Invitation for Application (IFA) was developed by JSI and approved by USAID. JSI has also proposed a Review Panel to assess and evaluate Proposals according to the selection criteria and scoring scheme approved in the IFA. The Review Panel was approved by USAID.

Fifty-two grants were awarded in ten districts in Aswan, Luxor and Qena Governorates, as presented in the following table:

Grant No.	Governorate	District	NGO Name	Grant Topic	Amount in LE
1	Luxor	Luxor	El-Tod CDA	Female Genital Cutting	32,450
2	Luxor	Luxor	Odaysat Quebly, Naga Elwan CDA	Prenatal care	18,540
3	Luxor	Luxor	El-Akalta CDA	Diarrhea control	11,340
4	Luxor	Luxor	El-Aqarba CDA	Prenatal / Delivery	18,210
5	Luxor	Luxor	Naga Abu Anan CDA	Prenatal / Nutrition	22,960
6	Luxor	Luxor	El-Sheikh El-Eraqy Charity Association	Pre-Postnatal care	23,540
7	Luxor	Luxor	Hager El-Odaysat Islamic Charity Association	Pre-Postnatal care	20,850
8	Luxor	Luxor City	Egyptian Red Crescent Association	Breast-feeding	26,150
9	Luxor	Luxor City	Sunshine Luxor	Reproductive health	77,250
10	Aswan	Nasr	Dar El-Salam El-Nobeya CDA	Breast-feeding	20,270
11	Aswan	Aswan	Family Planning Association - Aswan	Breast-feeding	33,510
12	Aswan	Aswan	Comprehensive DA	Pre-Postnatal care	26,380
13	Aswan	Aswan	Christian Youth Association	Pre-Postnatal care	26,300
14	Aswan	Nasr	Nasr El-Noba CDA	Breast-feeding	23,220
15	Aswan	Nasr	Toshka Gharb CDA	Breast-feeding	16,275
16	Aswan	Aswan	El-Aakab El Kobra CDA	Prenatal care	25,420
17	Aswan	Aswan	El-Nahda Women DA, Nasria	Prenatal Care/ Breast-feeding	49,020
18	Aswan	Kom Ombo	Maniha CDA	Nutrition	46,800
19	Aswan	Kom Ombo	El-Kagoug CDA	Pre-Postnatal care	33,580
20	Aswan	Daraw	Ahmed Taha CDA	Nutrition	45,468
21	Aswan	Daraw	Naga Wanas CDA	Prenatal / Nutrition	28,520

Grant No.	Governorate	District	NGO Name	Grant Topic	Amount in LE
22	Aswan	Daraw	El-Gaafra CDA	Pre- Postnatal care	32,700
23	Aswan	Edfu	Naga Helal CDA	Prenatal / Nutrition/ Breast-feeding	21,400
24	Aswan	Edfu	Wadi Ebadi CDA	Prenatal care	15,435
25	Aswan	Edfu	Ezbet El-Masry CDA	Pre- Postnatal care / Breast-feeding	11,470
26	Aswan	Edfu	El Kanadelah CDA	Pre- Postnatal care	28,695
27	Aswan	Edfu	El-Gam'aweya CDA	Prenatal Care	6,525
28	Aswan	Edfu	El-Mahameed CDA	Prenatal Care	7,975
29	Aswan	Edfu	El-Atwani CDA	Prenatal Care	24,950
30	Aswan	Edfu	El-Dakdik CDA	Prenatal Care	16,955
31	Qena	Armant	Social Welfare Charitable Association - Armant	Prenatal Care	12,225
32	Qena	Armant	St. Mansour Association - Armant	Neonatal Care	15,625
33	Qena	Armant	Key of Life Association - Al-Marees	Child Care (3-5 Years)	20,695
34	Qena	Armant	Al-Rayania CDA	Prenatal Care	11,290
35	Qena	Armant	Awlad El-Sheikh CDA	Prenatal Care	12,350
36	Qena	Armant	Moslem Youth Association - Armant	Child Care (3-5 Years)	19,520
37	Qena	Qous	Social Services Association. - Naga Quebly - Garagous	Pre- Postnatal / Safe Delivery	14,490
38	Qena	Qous	Al-Shaarani CDA	Prenatal Care	21,420
39	Qena	Qous	Hagaza Kibly CDA	Prenatal Care	16,695
40	Qena	Qous	Al-Makrabia CDA	Prenatal Care / Safe Delivery	22,510
41	Qena	Qous	Al-Hegazeya Charity Association	Pre- Postnatal Care/ Safe Delivery	28,265
42	Qena	Qous	Women Development Association - Hagaza Quebly	Prenatal Care/ Breastfeeding	15,665
43	Qena	Qous	El-Kalalsa CDA	Breastfeeding	13,990
44	Qena	Qous	Al-Amal Charity Association	Prenatal Care	13,480
45	Qena	Qous	Hagaza Bahary Women Development Association	Prenatal Care	18,875
46	Qena	Esna	Abna' Mahiga Charity Association	Pre-post natal Care/ Safe Delivery	23,735
47	Qena	Esna	El-Deir CDA	Prenatal Care/ Safe Delivery	48,900
48	Qena	Esna	Ezbet El-Borg CDA	Female Genital Cutting	36,320
49	Qena	Esna	El-Deir Islamic Charity Association	Pre-Postnatal Care/ Safe Dlevirey	27,280
50	Qena	Esna	Adayma CDA	Pre- Postnatal Care	25,860
51	Qena	Esna	Naga Abu Hemeid CDA	Prenatal Care	12,695
52	Qena	Esna	Esna CDA	Prenatal Care	13,355
GRAND TOTAL in LE:					1,237,398
GRAND TOTAL in USD:					363,941

The IFA was also published in Beni Suef and Middle Qena Districts. Training was done for the interested NGOs, Proposals received which are now under review and evaluation by the Review Panel.

EXPECTED ACCOMPLISHMENTS:

During the current AWP period, March 15, 2001 – September 15, 2001 the following accomplishments will be realized:

Performance Milestones:

- 90 small grants awarded to NGOs in the target districts by March 15, 2001.
- 100 small grants awarded to NGOs in the target districts by September 15, 2001

Benchmarks:

- Submit Recommendations on 40 grants to USAID for approval February 28, 2001
- Conduct the Proposal Writing Workshops in Fayoum and North Qena March 1, 2001
- 40 grant contracts signed with NGOs in target districts (Beni Suef and Middle Qena) March 15, 2001
- Submit Recommendations on 10 grants to USAID for approval May 17, 2001
- 10 grant contracts signed with NGOs in target districts June 15, 2001

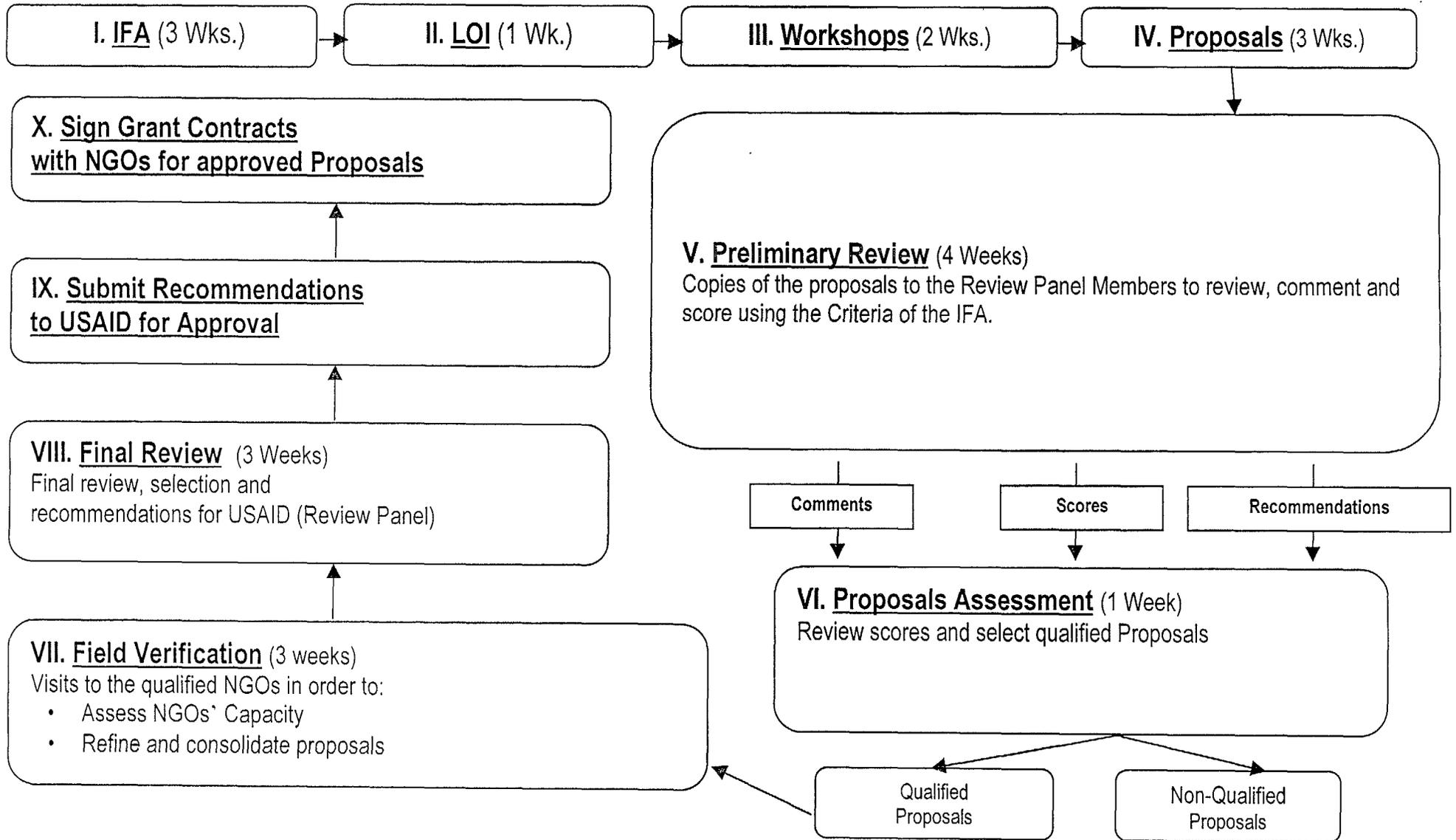
COORDINATION:

- 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 the NGO Service Center that will provide sub-grants, networking, training, technical support and operational support to Egyptian NGOs.

RESOURCES REQUIRED:

- Short Term Technical Assistance for developing the curricula and training recipient NGOs on the technical content of their proposals.
- Short Term Technical Assistance for Financial Capacity Assessment before the final selection of grant recipient NGOs.

Small Grant Program Grant Giving Process



TASK ELEVEN: Commodity Procurement Program

PURPOSE:

The purpose of Task Eleven is to procure commodities that will continue to support HM/HC activities in Upper Egypt at the central, governorate, district, facility and community levels. Estimated at \$9,362,000 for the contract base period, the commodities being procured include, but are not limited to, utility vehicles, medical commodities, audio-visual equipment, training models, computing equipment, office equipment, and office furniture. The commodities will be distributed and installed in GOE facilities such as General/District Hospitals and Basic Centers (Ob/Gyn, Neonatal, CSSD, and OR/ER Departments), Governorate and District Health Offices, Governorate and District Health Information Centers, Medical and Nursing Schools, the IMCI Program, and the Health Insurance Organization. Limited commodities may also be distributed to NGOs in the target governorates as required. Supplemental physical improvements to various MOHP district health facilities and Health Information Centers in the HM/HC target governorates will also be funded under the Commodity Procurement Program in a total amount not to exceed \$300,000. All procurement and renovations will follow USAID regulations with the majority of the procurement from the United States. Under Task Eleven, special emphasis will also be made to train GOE facility staff in the proper purpose, operation, and maintenance of procured equipment. In-house systems to monitor and track the entire procurement process have also 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 and approved by USAID. After the JSI contract modification, additional funds were allocated to Task Eleven for commodity procurement. A Procurement Plan for the Additional \$3,362,000 in Commodities was prepared by TCA/JSI in conjunction with the Task Managers and GOE counterparts. This Plan was approved by USAID. Annual reports on the status of procurement will be produced and submitted to the USAID COTR as part of the Performance Milestone Documentation.
- 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. Local procurement will proceed for eligible commodities.

- 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 has been developed and installed on JSI computers. The system monitors and tracks the entire procurement process. This system will provide up-to-date information at all levels of HM/HC down to the facility. This system has been shared with the MOHP and discussions are being held regarding incorporation into their general inventory and record keeping system.

EXPECTED ACCOMPLISHMENTS:

During the current AWP period, March 15, 2001-September, 2001, the following accomplishments will be realized:

Performance Milestones:

- Procurement of \$6,181,000 by March 15, 2001.
- Procurement of \$9,362,000 by September 15, 2001.

Performance Target:

- 100% of procurements in place on time based on JSI's procurement plans.

Major Benchmarks:

- Submission of Semi-Annual Procurement Status Report by March 15, 2001.
- Submission of Semi-Annual Procurement Status Report by September 15, 2001.

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.

ILLUSTRATIVE LIST OF COMMODITIES FOR YEAR THREE PROCUREMENT:

District and Governorate Health Information Centers:

Computers, printers, modems, Zip Drives, UPSs, Software, Air Conditioners

District Hospitals/Basic Centers:

Major medical equipment, medical tools, medical furniture, medical supplies for the OB/Gyn, Neonatal, OR/ER, and CSSD Departments

District and Governorate Health Offices:

Air conditioners, fax machines, photocopier machines

Medical/Nursing Schools:

Overhead projectors, screens, slide projectors, TV monitors, video cassette recorders, computers, office furniture, training models

IMCI Program:

Audio-visual equipment

NGOs:

Audio-visual equipment

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. The Administration Team is responsible for the submission and tracking of budget requests to the PIL for coordinated training activities.

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. Inventory reports and vehicle maintenance forms are also submitted to the HM/HC Project on a monthly basis.

The Administration Team has developed Policy and Procedure Manuals for the Cairo office and for the five field offices. Extensive training has been conducted for the original offices and will be held for the new offices. Follow-up training and on-site reviews will also be conducted.

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., TransCentury Associates, and The Johns Hopkins University were drafted and approved by USAID. Local subcontracts between JSI and research organizations and media firms such as AUC, SPAAC, Intermarkets, Promoseven, and El Zanaty and Associates 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 manages the administrative aspects of consultants. Required travel approvals are processed in advance and submitted to USAID for approval. Consultant trip reports are finalized 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 Work Plans. 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.

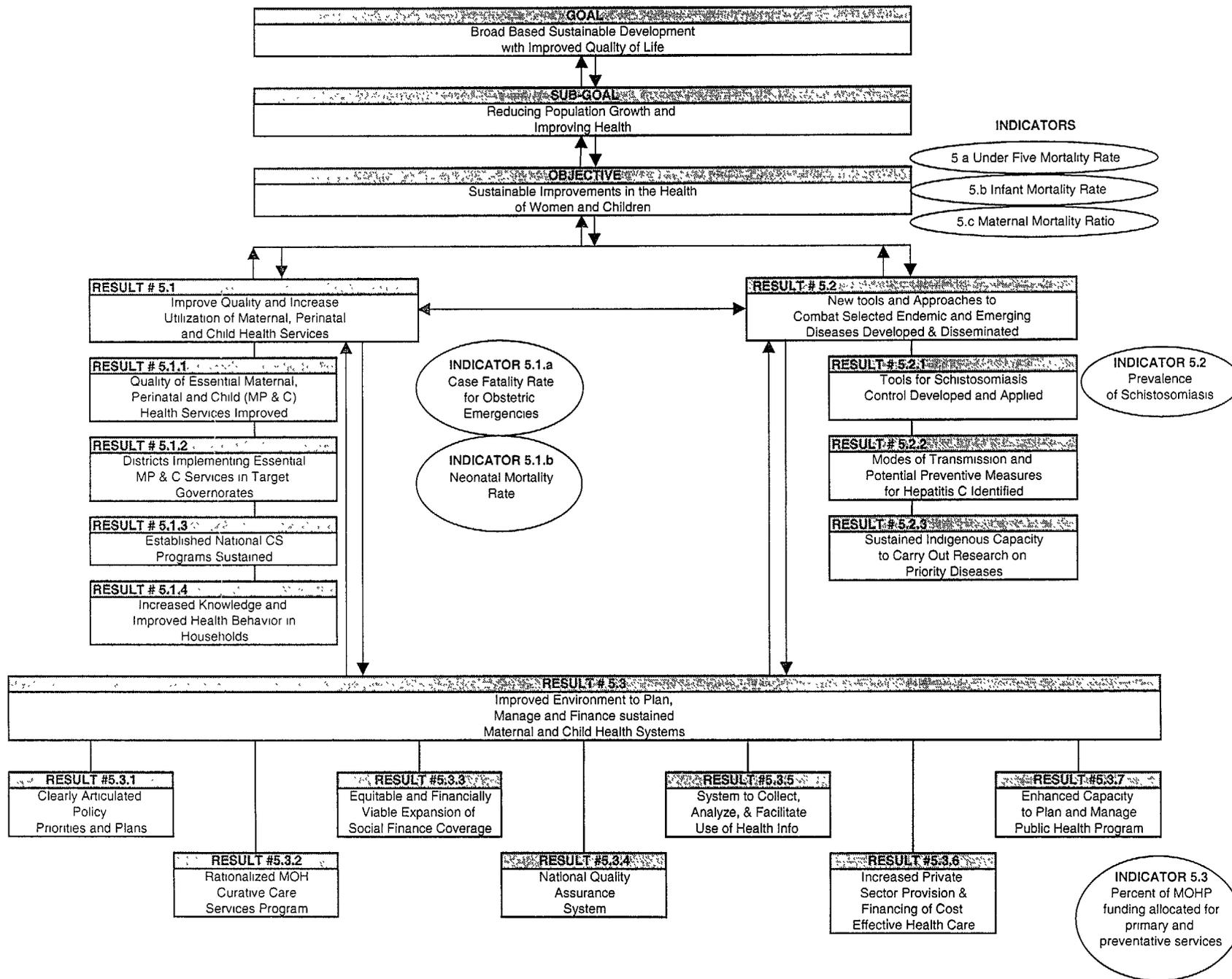
The coordination of work planning meetings is also the responsibility of the Administration Team. These meetings are scheduled to be held on an annual basis and include representatives from JSI, the five subcontractors, USAID, MOHP, and collaborating organizations. The first JSI HM/HC Orientation and Planning Retreat was held in June, 1998. The second and third Annual Retreats were held in January 1999 and 2000, respectively.

ANNEXES

ANNEX A1

USAID's Results Framework
(Original Version from Contract)

RESULT FRAMEWORK SO5



ANNEX A2

USAID's Results Framework
(Revised)

SO 20: HEALTHIER, PLANNED FAMILIES

- *Total of Fertility Rate*
- *Infant Mortality Rate*

**IR 20.1
Increased Use of Family
Planning, Reproductive
Health and Maternal and
Child Health Services by
Target Populations**

- *Contraceptive prevalence rate for modern methods*
- *% of births whose mothers received 4 or more antenatal visits*

**IR 20.1.1
Enhanced Supply of Quality
Services**

- *Percent of births attended by trained providers*
- *% of children 12-23 months fully immunized with seven vaccines*

**IR 20.1.2
Increased demand for quality
services**

- *Extended use failure rate*
- *Percent of pregnant women with tetanus toxoid coverage*

**IR 20.2
Healthy Behaviors Adopted**

- *% of children 0-23 months with diarrhea in past two weeks who received ORT*
- *Percent births within last 2 years spaced > 23 months*

**IR 20.2.1
Increased Knowledge of
Health Risks and Healthy
Practices**

- *% of men/women who know how blood borne diseases are transmitted*
- *Percent of women who recognize the symptoms of high risk pregnancy*

**IR 20.3
Sustainability of basic health
services promoted**

- *MOPH expenditures for primary, preventive health care per capita*
- *% of population covered by insurance*

**IR 20.3.1
Private sector
participation enhanced**

- *Commercial sale of contraceptives.*
- *No. of entities contracted for public health services*

**IR 20.3.2
Health sector capacity
strengthened**

- *Systems assessment Matrix*
- *MOHP allocation for recurrent costs for FP/RH/MCH services and commodities*

**IR 20.3.3
Improved policy and
regulatory environment**

- *PH Policy Environment Score*
- *Sector Reform Benchmarks Matrix*

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 Day 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	
Indicators of Achievement <ul style="list-style-type: none"> Percent of pregnant women receiving 4 or more prenatal examinations in a health facility by 2001 Proportion of living children between the ages of 12 & 23 months fully vaccinated before the first birthday with DPT (3), Polio (3), Measles, TB and Hepatitis B (3) by 2001 		Indicators of Achievement <ul style="list-style-type: none"> Number of districts implementing essential Maternal, Perinatal and Child Health Services in target governorates by 2001 			Indicators of Achievement <ul style="list-style-type: none"> Number of confirmed indigenous polio cases by 2001 Number of neonatal tetanus cases by 2001 	Indicators of Achievement <ul style="list-style-type: none"> Percent of infants exclusively breastfed for the first 4-5 months of life by 2001 			Indicators of Achievement <ul style="list-style-type: none"> None identified in contract 	
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

ANNEX C

Milestone Status Chart

MILESTONE (MODIFIED) STATUS REPORT

3/14/01

No.	Date Due	Milestone	Task No.	Submitted	Validated	Approved		Comments
						USAID	MOHP	
1	6/15/98	Commencement of HMIS Assessment	4	6/25/98	9/16/98	9/20/98	8/30/98	Completed
2	6/15/98	Rapid Assessment of existing print and mass media conducted	8	8/13/98	N/A	10/4/98	9/9/98	Completed
3	9/15/98	One HM/HC Consensus Meeting held and Essential Services Package finalized	1	9/30/98	3/8/99	3/16/99	10/15/98	Completed
4	9/15/98	Assessment of neonatal centers conducted	6	10/15/98	3/4/99	2/17/99	10/24/98	Completed
5	9/15/98	Development of HM/HC Project Procurement Plan	11	4/22/99	N/A	4/26/99	N/A	Completed
6	12/15/98	Completion of HM/HC management guidelines for district planning	3	12/15/98	N/A	3/16/99	10/5/00	Completed
7	12/15/98	Field test of protocol for linking community groups with providers completed	7	12/15/98	3/4/99	2/17/99	10/5/00	Completed
8	3/15/99	Lead Trainers trained & basic health package implemented in 5 districts	1 & 2	3/15/99	12/27/99	12/31/99	N/A	Completed
9	3/15/99	Completion of Egypt-specific Integrated Sick Child Management Plan	6	3/15/99	N/A	4/7/99	10/5/00	Completed
10	6/15/99	Assist MOHP to establish 10 district MHIS	4	6/15/99	12/27/99	12/31/99	N/A	Completed
11	6/15/99	National IEC Strategy to support HM/HC developed	8	6/15/99	N/A	6/28/99	10/5/00	Completed
12	9/15/99	Daya training program modified and ready for implementation	6	9/15/99	1/4/00	10/28/99	10/15/99	Completed
13	9/15/99	Procurement of \$900,000 of Project commodities	11	9/15/99	1/4/00	10/28/99	N/A	Completed
14	12/15/99	8 District health plans and monitoring systems developed and implemented	3	12/15/99	✓	11/15/00	✓	Completed
15	12/15/99	Needs identification tool implemented in 5 communities	7	12/15/99	1/4/00	2/29/00	2/28/00	Completed
16	3/15/00	Three operations research studies completed	5	3/15/00	9/1/00	9/12/00	N/A	Completed
17	6/15/00	20 small grants awarded to NGOs in target districts	10	6/14/00	1/4/00	7/6/00	N/A	Completed
18	6/15/00	Assist MOHP to establish 30 district MHIS centers	4	6/14/00	✓	12/20/00	N/A	Completed
19	6/15/00	National IEC campaign developed	8	6/18/00	12/13/00	1/21/01	N/A	Completed
20	7/15/00	HM/HC Curricula taught in 2 medical and 2 nursing schools	2	7/16/00	✓	12/13/00	N/A	Completed
21	9/15/00	Procurement of \$3,000,000 of Project commodities	11	9/7/00	✓	12/4/00	N/A	Completed
22	9/15/00	Health Education Guide and education materials for use in schools developed	9	10/15/00	N/A	12/5/00	N/A	Completed
23	10/15/00	HM/HC Curricula taught in 6 medical and 6 nursing schools	2	10/15/00			N/A	
24	10/15/00	SMIP nutrition education and anemia supplementation program implemented in one governorate	9	10/15/00	✓	12/10/00	N/A	Completed
25	11/15/00	Development of HM/HC Procurement Plan for additional \$3,362,000 in commodities	11	11/27/00	N/A	12/10/00	N/A	Completed
26	11/15/00	Implementation of basic health package in 10 districts	1	11/15/00	✓	2/26/01	N/A	Completed
27	11/15/00	50 small grants awarded to NGOs in target districts	10	11/15/00	✓	12/20/00	N/A	Completed
28	12/15/00	20 District health plans and monitoring systems developed and implemented	3	12/18/00				
29	12/15/00	Community Action Plans developed and implemented in 20 districts	7	12/12/00	✓	2/26/01	N/A	Completed
30	12/15/00	Neonatal centers linked with comprehensive perinatal programs in 25 target districts	6	12/13/00			N/A	
31	12/15/00	Procurement of \$4,500,000 of Project commodities	11	9/7/00	✓	12/4/00	N/A	Completed
32	3/15/01	Implementation of basic health package in 20 districts	1				N/A	
33	3/15/01	HM/HC Curricula taught in 10 medical and 10 nursing schools	2				N/A	
34	3/15/01	Procurement of \$6,181,000 of Project commodities	11				N/A	
35	3/15/01	90 small grants awarded to NGOs in target districts	10				N/A	
36	6/15/01	Assist MOHP to establish 65 MHIS centers	4				N/A	
37	6/15/01	FGM component integrated into overall HM/HC message package	8				N/A	
38	6/15/01	2000/2001 Maternal Mortality Survey completed	5				N/A	
39	7/15/01	Services improved in 100 neonatal centers	6				N/A	
40	9/15/01	Implementation of basic health package in 25 districts	1				N/A	
41	9/15/01	HM/HC Curricula taught in 13 medical and 13 nursing schools	2				N/A	
42	9/15/01	25 District health plans and monitoring systems developed and implemented	3					
43	9/15/01	Community Action Plans developed and implemented in 25 districts	7				N/A	
44	9/15/01	100 small grants awarded to NGOs in 25 target districts	10				N/A	
45	9/15/01	Procurement of \$9,362,000 of Project commodities	11				N/A	
46	9/15/01	SMIP nutrition education and anemia supplementation program implemented in 5 governorate & national SMIP plan	9				N/A	

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ANNEX D

JSI/Egypt Organogram

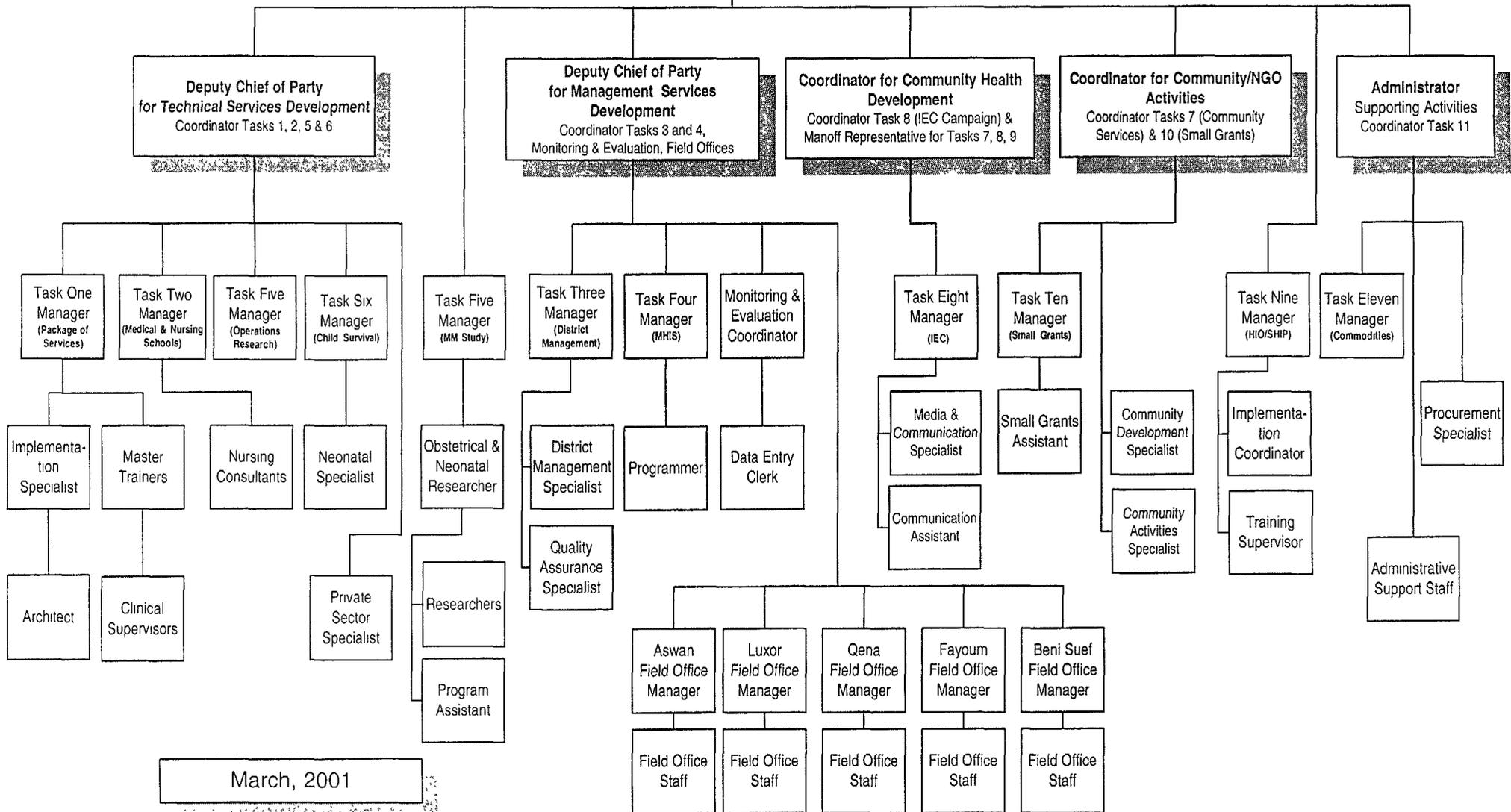
**JSI/Egypt
Technical Staff Organization**

Chief of Party

Legend

Senior Staff

Supervisory Responsibility
 Coordination Responsibility



March, 2001

ANNEX E

Basic Benefits Package

MCH part of the Basic Benefits Package Delivery and Support System

Service Level	Management Support & Staffing	Maternal Services				Child Services		
		Pre-natal (conception to delivery)	Peri-natal (22 nd week of pregnancy – 7 th day after delivery)	Post-natal (delivery - 42 nd 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	<ul style="list-style-type: none"> - Mother - Daya - Health facility personnel on outreach 	<ul style="list-style-type: none"> - Danger signs - Seek antenatal care - Proper antenatal nutrition - I P promotion - Immunization against tetanus - E&I breastfeeding promotion 	<ul style="list-style-type: none"> - Normal delivery - Recognize & refer complications 	<ul style="list-style-type: none"> - E&I breastfeeding promotion - Child spacing - Recognize & refer postpartum complications 	<ul style="list-style-type: none"> - FP promotion - Nutrition support 	<ul style="list-style-type: none"> - Neonate care (drying and warming) - Hygienic cord care - Recognition of complications of pregnancy & delivery 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - Nutrition and Health Education - FP/RH counseling - FGC education
Community	Same as above	<ul style="list-style-type: none"> - Community education about emphasis 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 				<ul style="list-style-type: none"> - Assistance for sick children - Effective mechanisms for increasing access to needed health services 	<ul style="list-style-type: none"> - Motivate community to seek appropriate health services 	<ul style="list-style-type: none"> - Nutrition and Health Education - FP/RH counseling - FGC education
School	<ul style="list-style-type: none"> - Student medical health insurance personnel 							<ul style="list-style-type: none"> - Nutrition and Health Education - Immunization of girls (TT) - Iron Supplementation - De-worming
PHC Level A (Rural Health Unit)	<ul style="list-style-type: none"> - Bring facility up to Service Standards - General Practitioner - Midwives - Nurses - Laboratory & Microbiology - Technician 	Basic Maternal Care				<ul style="list-style-type: none"> - Immunization (TT) FP/RH Counseling - FP services - Nutrition services 	<ul style="list-style-type: none"> - Immunization (polio, DPT, hepatitis) - Growth monitoring / nutrition intervention - ARI, CDD (IMCI) - Referral 	<ul style="list-style-type: none"> - Immunization
PHC Level B (Rural Hospital, Maternity Center, Upgraded Health Unit)	<ul style="list-style-type: none"> - Same as above plus - OB/GYN Specialist 	Basic Essential Obstetric Care				<ul style="list-style-type: none"> - Treatment of neonatal tetanus 	Same as above	<ul style="list-style-type: none"> - Immunization
		Same as above	<ul style="list-style-type: none"> - Same as above plus referral - Delivery with complication 	Same as above	Same as above			
First referral Level (District Hospital)	<ul style="list-style-type: none"> - Same as above plus - Blood Bank Technician - Pediatrician - Neonatologist - Anesthesiologist 	Comprehensive Essential Obstetric Care				<ul style="list-style-type: none"> - FP services - Nutrition services 	<ul style="list-style-type: none"> - Incubation - Treatment of high risk infants - Treatment and referral of complicated cases 	

ANNEX F

Budget Data

ANNEX G

Maps

MAPS OF TARGET GOVERNORATES

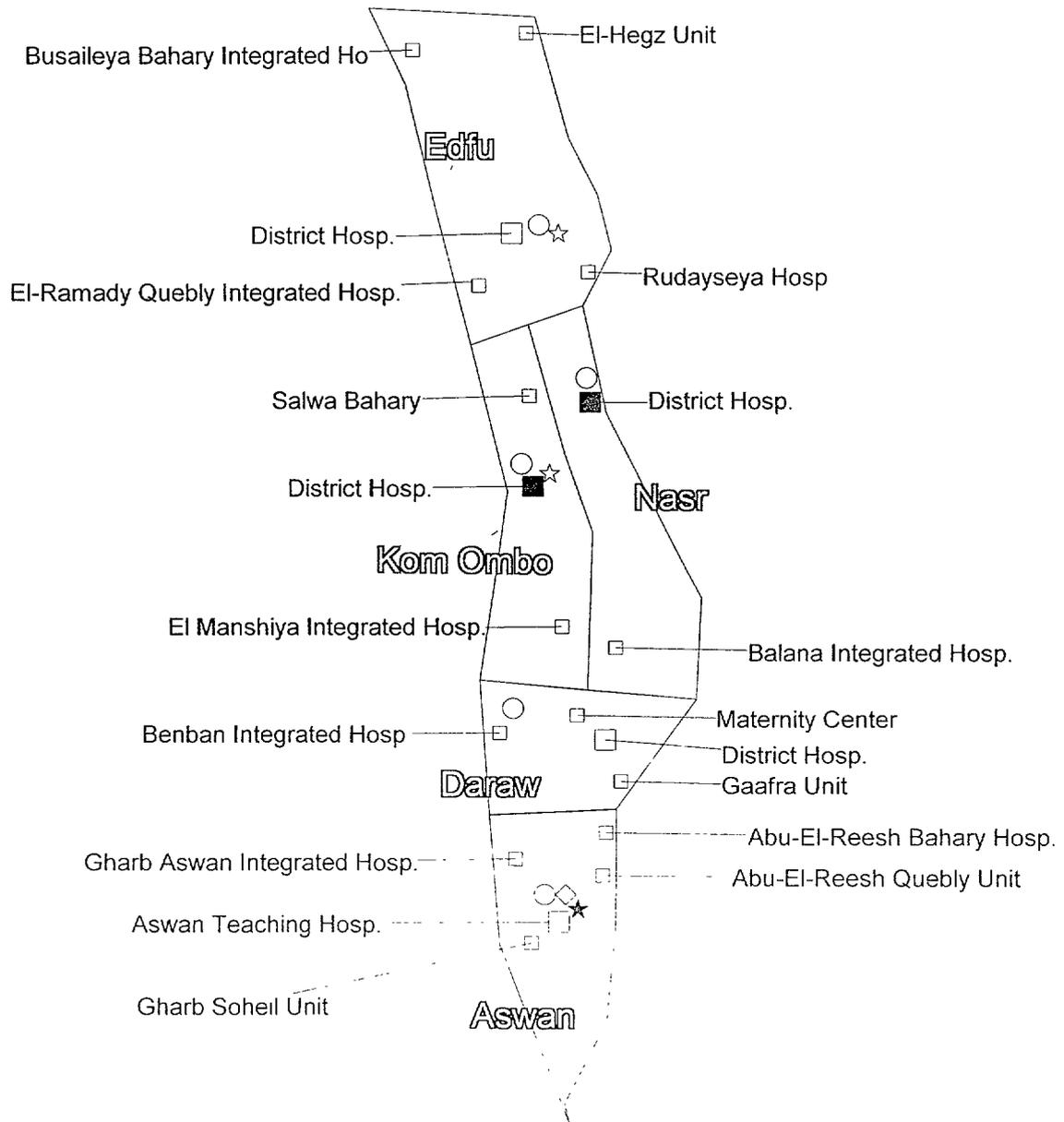
The maps on the following eight pages provide a schematic representation of the location of the target districts and facilities (CEOC, BEOC and MHIS centers). The maps are computer generated and will form part of the Geographic Information System (GIS) which is currently under development. The following information should prove useful when reviewing the maps:

- ♣ Only the maps for Aswan, Luxor and the southern part of Qena are complete since the exact target facilities have been identified for those governorates only.
- ♣ In the northern part of Qena, Beni Suef and Fayoum, the district/general hospitals are indicated (CEOC centers), but not the BEOC centers since the exact facilities have yet to be identified.
- ♣ The maps for Assiut, Menya and Sohag indicate only the MHIS centers since that is the extent of programmatic involvement in those governorates.

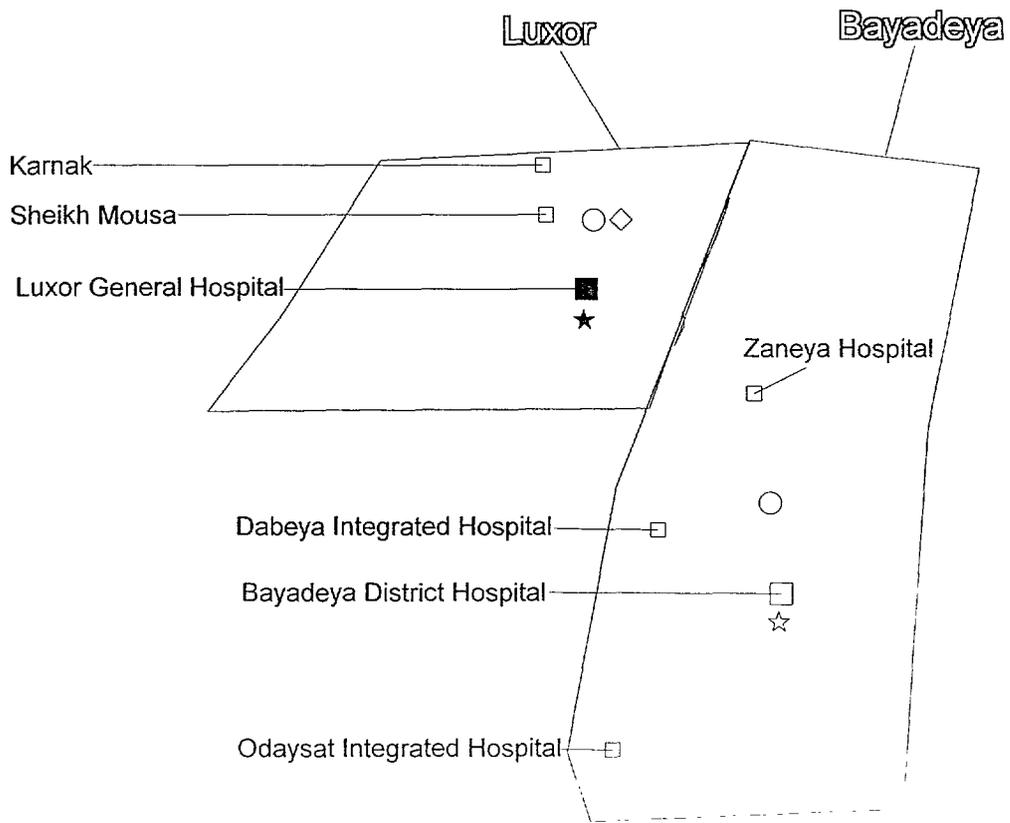
The Legend below pertains to the maps.

LEGEND	Yes	No
Directorate MHIS Center Upgraded	◆	◇
District MHIS Center Established	●	○
Neonatal Care Center Upgraded	★	☆
CEOC Center Upgraded	■	□
BEOC Center Upgraded	■	□

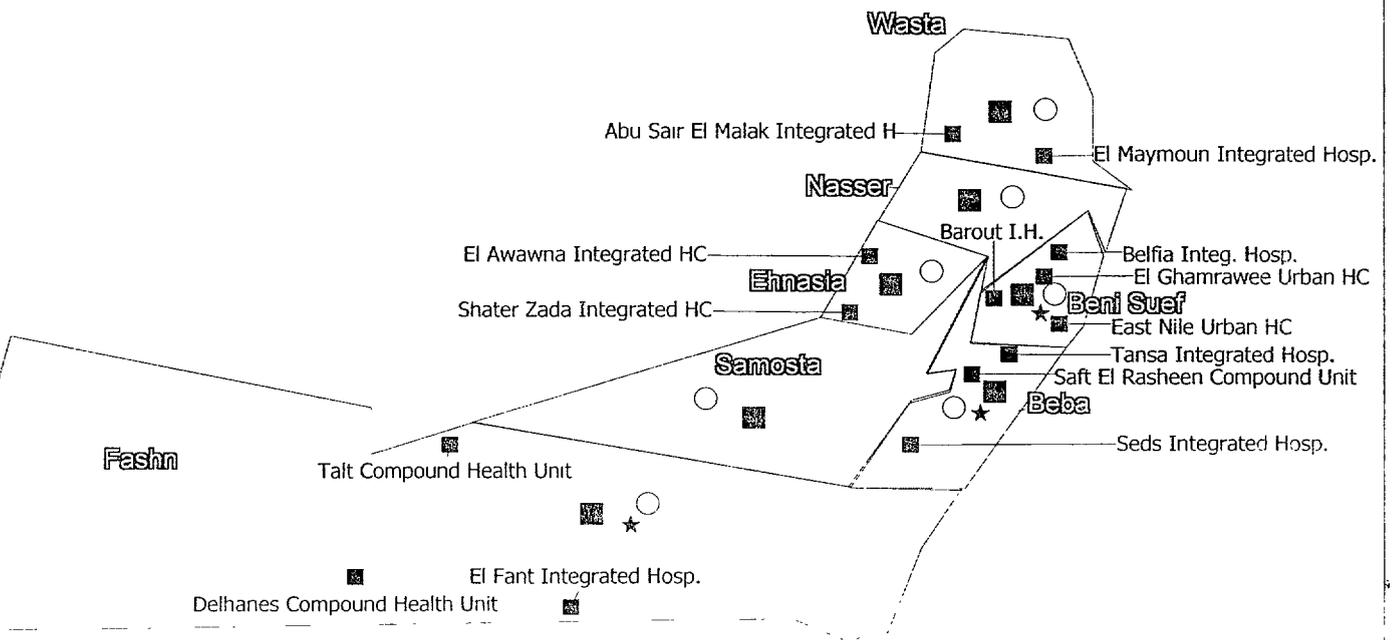
ASWAN



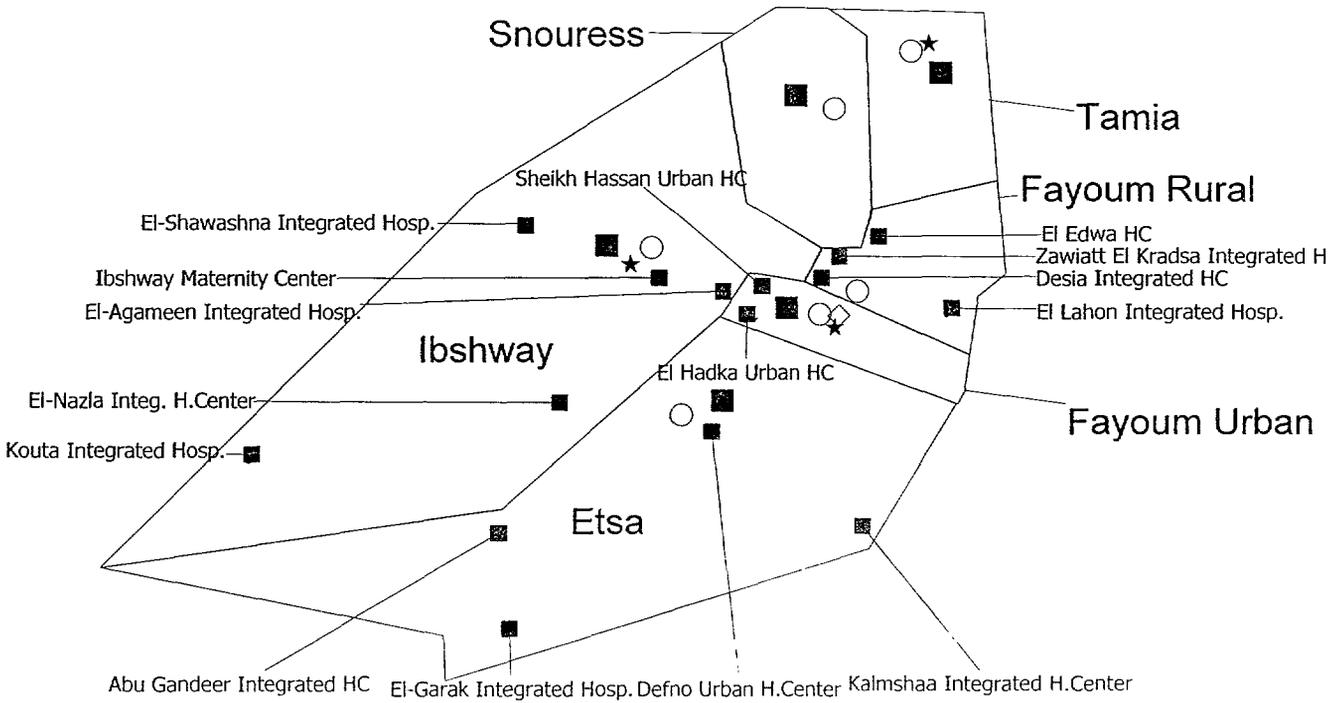
LUXOR



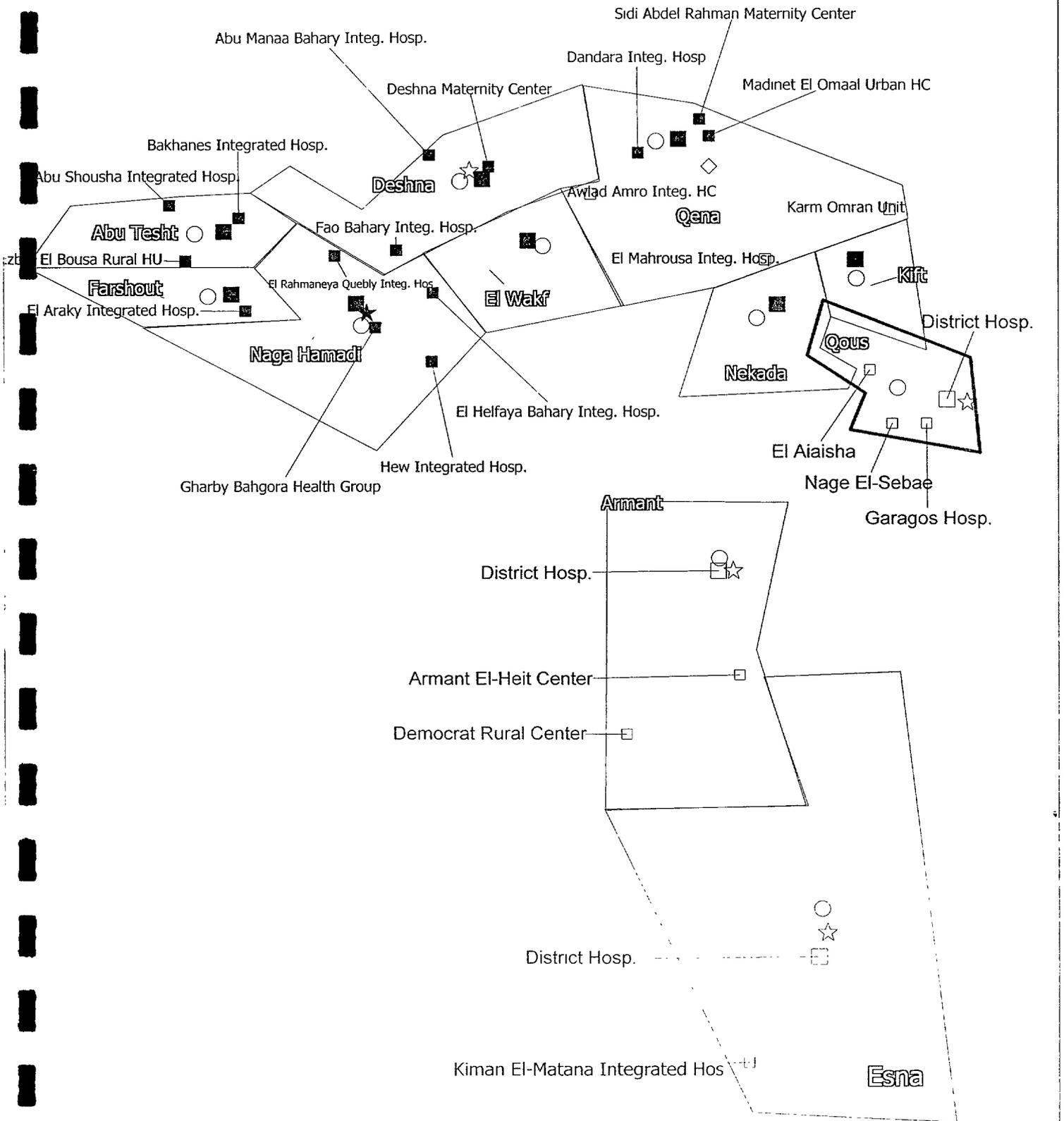
BENI SUEF



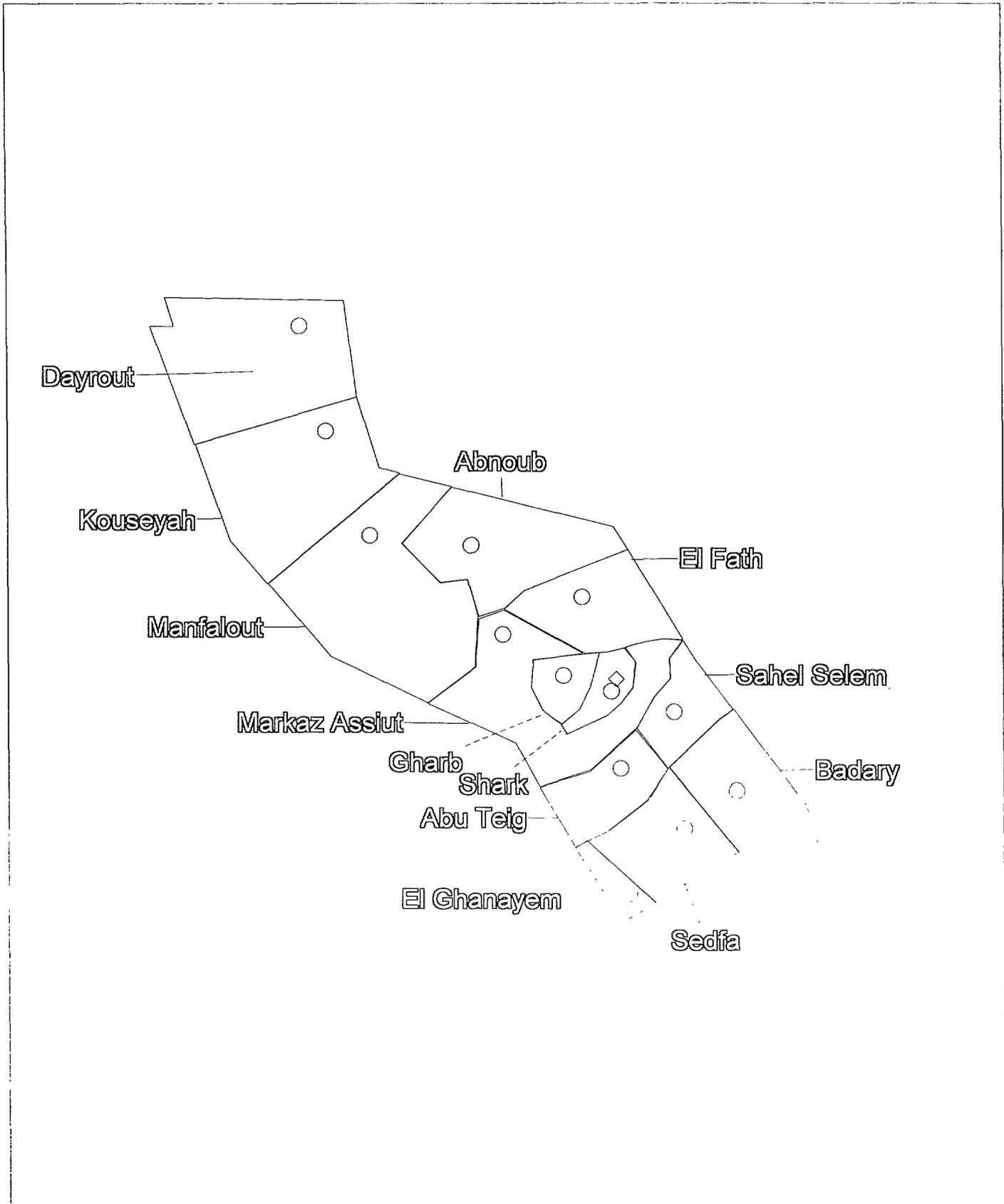
FAYOUM



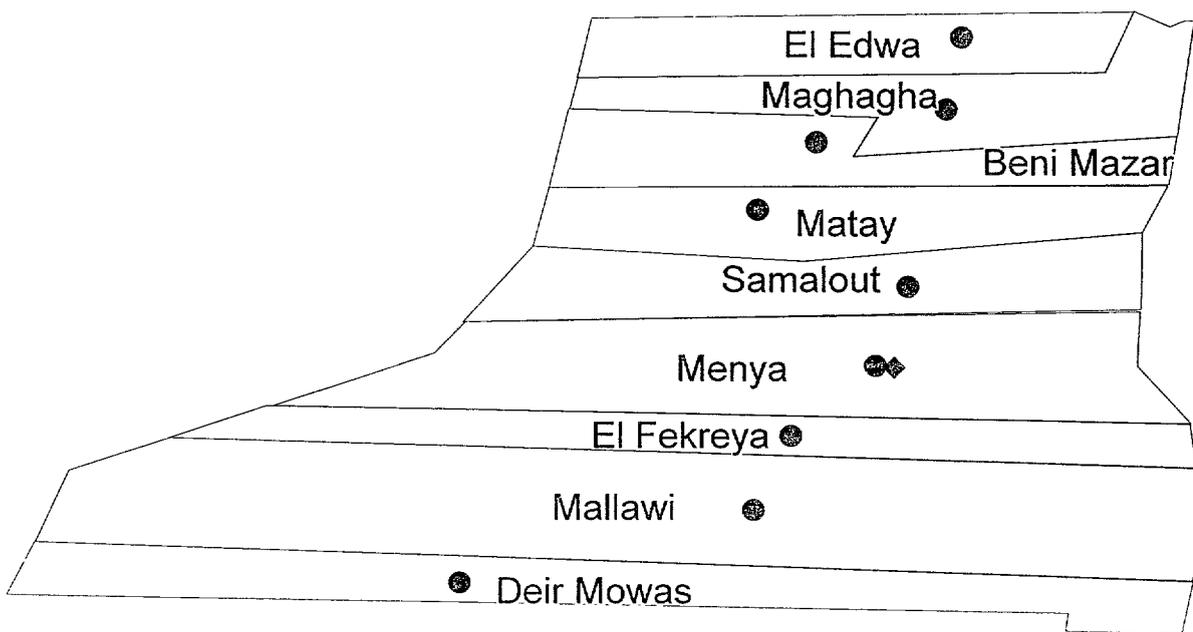
QENA



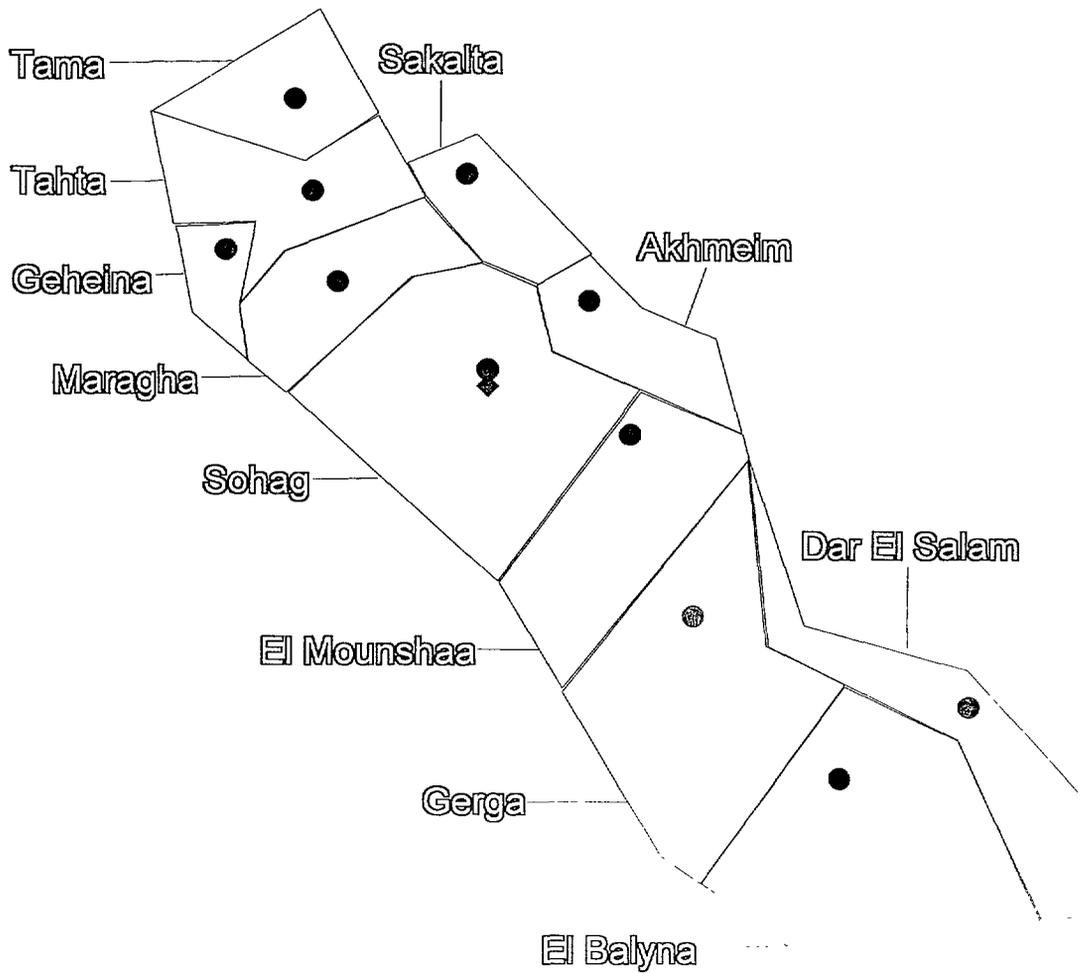
ASSIUT



MENYA



Sohag



ANNEX H

Contract Task Gantt Charts

ID	Activity	Resp	% Complete	Start	Duration	Finish	1999												2000												2001											
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F
1	1 TASK ONE: Basic ES package of essential services established and standards defined		80%	Sun 3/15/98	947 days	Sat 9/15/01	[Gantt bar spanning from Sun 3/15/98 to Sat 9/15/01]																																			
2	1.1 Activity 1 Assess efficacy and cost effectiveness of the MCH part of the Basic Benefits Package		100%	Sun 3/15/98	262 days	Mon 3/15/99	[Gantt bar spanning from Sun 3/15/98 to Mon 3/15/99]																																			
3	1.2 Activity 2 Finalize HM/HC Package of Essential Services consensus meeting		100%	Thu 5/6/99	210 days	Tue 2/15/00	[Gantt bar spanning from Thu 5/6/99 to Tue 2/15/00]																																			
4	1.2.1 Quarterly meetings with the consensus group to review and follow up PES		100%	Thu 5/6/99	210 days	Tue 2/15/00	[Gantt bar spanning from Thu 5/6/99 to Tue 2/15/00]																																			
10	1.3 Activity 3: Implement HM/HC Package of Essential Services		88%	Sun 5/17/98	902 days	Sat 9/15/01	[Gantt bar spanning from Sun 5/17/98 to Sat 9/15/01]																																			
11	1.3.1 Luxor and Aswan: Districts 1-7		100%	Mon 6/8/98	464 days	Tue 3/7/00	[Gantt bar spanning from Mon 6/8/98 to Tue 3/7/00]																																			
69	1.3.2 South Qena. Districts 8-10		100%	Sun 5/17/98	894 days	Mon 9/3/01	[Gantt bar spanning from Sun 5/17/98 to Mon 9/3/01]																																			
125	1.3.3 Milestone: Implement HM/HC Basic Benefits Package in 10 Districts		100%	Wed 3/15/00	0 days	Wed 3/15/00	[Milestone diamond at Wed 3/15/00]																																			
126	1.3.4 Fayoum, Beni Suef and Qena: Districts 11-20		79%	Wed 11/15/00	91 days	Thu 3/15/01	[Gantt bar spanning from Wed 11/15/00 to Thu 3/15/01]																																			
127	1.3.4.1 Stage 1: Selection of the Anchor Facilities		100%	Wed 11/15/00	91 days	Thu 3/15/01	[Gantt bar spanning from Wed 11/15/00 to Thu 3/15/01]																																			
130	1.3.4.2 Stage 2 Rapid assessment of clinics and hospitals to determine level of compliance with service standards	AH	100%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
131	1.3.4.3 Final selection of the anchor facilities in Districts 11-20		100%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
132	1.3.4.4 Benchmark Selection of Anchor facilities in Districts 11-20		100%	Tue 3/13/01	0 days	Tue 3/13/01	[Milestone star at Tue 3/13/01]																																			
133	1.3.4.5 Stage 3 Develop workplan to bring anchor facilities into compliance with standards for the delivery of the services	AH, SK	100%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
134	1.3.4.6 Stage 4 Upgrade Anchor Facilities in Districts 11-20	AH, SK	92%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
135	1.3.4.6.1 Physical renovation of facilities		90%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
136	1.3.4.6.2 Installation of required equipment		90%	Wed 11/15/00	20 days	Tue 12/12/00	[Gantt bar spanning from Wed 11/15/00 to Tue 12/12/00]																																			
137	1.3.4.6.3 Benchmark Equipment and supplies for upgrading anchor facilities in districts 11-20 delivered		0%	Tue 12/12/00	0 days	Tue 12/12/00	[Milestone star at Tue 12/12/00]																																			
138	1.3.4.6.4 Reorganization of facilities (FMTs)		100%	Wed 11/15/00	20 days	Tue 12/12/00	[Gantt bar spanning from Wed 11/15/00 to Tue 12/12/00]																																			
139	1.3.4.7 Stage 5. TOT for district level Trainers/Supervisors in Districts 11-20	TC	100%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
147	1.3.4.8 Stage 6: QA and service standards training for GMTs/DMTs in Districts 11-20		100%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
151	1.3.4.9 Stage 7: Training of service providers in Districts 11-20	MT	94%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
152	1.3.4.9.1 EOC training for service providers in Districts 11-20	TC; MTs	100%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
156	1.3.4.9.2 Training of Service Providers (Nurses) on Infection Control (IC) and Interpersonal Communication skills (IPCs)	TC; MTs	95%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
157	1.3.4.9.2.1 Planning for EOC for nurses		100%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
158	1.3.4.9.2.2 Conduct Training course for nurses on EOC		90%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
159	1.3.4.9.3 Training of nurses for midwifery skills in Fayoum	DCOP; C	88%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			
160	1.3.4.9.3.1 Planning for midwifery training		100%	Wed 11/15/00	89 days	Tue 3/13/01	[Gantt bar spanning from Wed 11/15/00 to Tue 3/13/01]																																			

ID	Activity	Resp	% Complete	Start	Duration	Finish	1999												2000												2001											
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S					
199	2 TASK TWO: Design of Training System and inclusion of ES Package/Standards in School Curricula		41%	Wed 7/15/98	861 days	Sun 9/16/01	[Gantt bar spanning from July 1998 to September 2001]																																			
200	2.1 Activity 1: Revision of med. school curricula & upgrade faculty training skills to incorporate HM/HC Package		43%	Thu 4/15/99	665 days	Sun 9/16/01	[Gantt bar spanning from April 1999 to September 2001]																																			
201	2.1.1 Revision of 8 medical schools curricula & upgrade faculty training skills		82%	Thu 4/15/99	665 days	Sun 9/16/01	[Gantt bar spanning from April 1999 to September 2001]																																			
202	2.1.1.1 Signing of Memorandum of Cooperation with 8 Medical Schools		90%	Thu 4/15/99	385 days	Thu 9/14/00	[Gantt bar spanning from April 1999 to September 2000]																																			
203	2.1.1.2 Training of faculty members in CBT methodology		90%	Thu 4/15/99	385 days	Thu 9/14/00	[Gantt bar spanning from April 1999 to September 2000]																																			
204	2.1.1.3 Curricula Development Committee (CDC)		92%	Thu 4/15/99	385 days	Thu 9/14/00	[Gantt bar spanning from April 1999 to September 2000]																																			
205	2.1.1.3.1 Establishment of committee		90%	Thu 4/15/99	385 days	Thu 9/14/00	[Gantt bar spanning from April 1999 to September 2000]																																			
206	2.1.1.3.2 Gathering of input from department faculty		90%	Thu 4/15/99	385 days	Thu 9/14/00	[Gantt bar spanning from April 1999 to September 2000]																																			
207	2.1.1.3.3 Finalization HM/HC medical school curricula design		100%	Thu 4/15/99	247 days	Wed 3/15/00	[Gantt bar spanning from April 1999 to March 2000]																																			
208	2.1.1.3.4 Development of HM/HC medical school curricula implementation plan		90%	Thu 4/15/99	385 days	Thu 9/14/00	[Gantt bar spanning from April 1999 to September 2000]																																			
209	2.1.1.4 Improve the pre-service training period		90%	Thu 4/15/99	385 days	Thu 9/14/00	[Gantt bar spanning from April 1999 to September 2000]																																			
210	2.1.1.4.1 Incorporation of HM/HC package into pre-service training program		90%	Thu 4/15/99	385 days	Thu 9/14/00	[Gantt bar spanning from April 1999 to September 2000]																																			
211	2.1.1.5 Train high-level faculty members out-of-country in new medical technologies		81%	Wed 9/1/99	563 days	Thu 9/13/01	[Gantt bar spanning from September 1999 to September 2001]																																			
212	2.1.1.5.1 Identify high-level faculty members		100%	Wed 9/1/99	22 days	Thu 9/30/99	[Gantt bar spanning from September 1999 to September 1999]																																			
213	2.1.1.5.2 Train high-level faculty members		100%	Sun 10/3/99	114 days	Tue 2/29/00	[Gantt bar spanning from October 1999 to February 2000]																																			
214	2.1.1.5.3 Newly trained high level faculty members disseminate and utilize new knowledge to in-country trainees		75%	Wed 3/1/00	405 days	Thu 9/13/01	[Gantt bar spanning from March 2000 to September 2001]																																			
215	2.1.1.6 Establishment of HIS in medical schools		41%	Thu 4/15/99	665 days	Sun 9/16/01	[Gantt bar spanning from April 1999 to September 2001]																																			
216	2.1.1.6.1 Reviewing the present HIS system		100%	Sun 4/2/00	116 days	Thu 8/31/00	[Gantt bar spanning from April 2000 to August 2000]																																			
217	2.1.1.6.2 Identify HIS faculty members		50%	Thu 4/15/99	385 days	Thu 9/14/00	[Gantt bar spanning from April 1999 to September 2000]																																			
218	2.1.1.6.3 Train selected HIS faculty members		0%	Mon 9/18/00	57 days	Thu 11/30/00	[Gantt bar spanning from September 2000 to November 2000]																																			
219	2.1.1.6.4 Follow-up for HIS and its impact on services		0%	Wed 1/17/01	188 days	Sun 9/16/01	[Gantt bar spanning from January 2001 to September 2001]																																			
220	2.1.1.7 Establishment of maternal and child health library		97%	Thu 4/15/99	397 days	Sat 9/30/00	[Gantt bar spanning from April 1999 to September 2000]																																			
221	2.1.1.7.1 Select proper sources and reference materials		100%	Thu 4/15/99	385 days	Thu 9/14/00	[Gantt bar spanning from April 1999 to September 2000]																																			
222	2.1.1.7.2 Distribution of reference to all medical schools		90%	Thu 4/15/99	199 days	Sat 9/30/00	[Gantt bar spanning from April 1999 to September 2000]																																			
223	2.1.2 Revision of remaining 5 medical schools curricula & upgrade faculty training skills		0%	Wed 10/4/00	265 days	Sun 9/16/01	[Gantt bar spanning from October 2000 to September 2001]																																			
224	2.1.2.1 Signing of Memorandum of Cooperation with 8 Medical Schools		0%	Wed 10/4/00	265 days	Sun 9/16/01	[Gantt bar spanning from October 2000 to September 2001]																																			
225	2.1.2.2 Training of faculty members in CBT methodology		0%	Wed 10/4/00	265 days	Sun 9/16/01	[Gantt bar spanning from October 2000 to September 2001]																																			
226	2.1.2.3 Curricula Development Committee (CDC)		0%	Wed 10/4/00	265 days	Sun 9/16/01	[Gantt bar spanning from October 2000 to September 2001]																																			

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ID	Activity	Resp	% Complete	Start	Duration	Finish	1999												2000												2001											
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F
559	4 TASK FOUR: Monitoring System in Place to Track Utilization and Impact and Provide Feedback		81%	Sun 5/17/98	833 days	Thu 6/14/01																																				
560	4.1 Activity 1: Assess and create an integrated and standardized nationwide MHIS system		100%	Sun 5/17/98	236 days	Sun 4/11/99																																				
561	4.1.1 Assessment of existing MHIS		100%	Sun 6/21/98	42 days	Mon 8/17/98																																				
568	4.1.2 Mobilization of Assessor Assistants		100%	Sun 5/17/98	77 days	Mon 8/31/98																																				
572	4.1.3 Conduct MHIS assessment		100%	Mon 8/31/98	95 days	Sun 1/10/99																																				
581	4.1.4 Develop Assessment Reports		100%	Mon 1/11/99	15 days	Sun 1/31/99																																				
596	4.1.5 Design for monitoring system		100%	Mon 2/1/99	25 days	Sun 3/7/99																																				
599	4.1.6 Develop procedures of HM/HC monitoring		100%	Mon 3/8/99	25 days	Sun 4/11/99																																				
602	4.2 Assist MOHP to set-up 65 MHIS centers at district level		90%	Mon 8/17/98	767 days	Thu 6/14/01																																				
603	4 2 1 Conduct start-up workshop	KAF	100%	Mon 8/31/98	7 days	Tue 9/8/98																																				
604	4 2 2 Establish 10 MHIS centers at district level		100%	Mon 8/17/98	238 days	Wed 7/14/99																																				
620	4.2.3 Establish 30 district MHIS centers and Upgrade 3 directorate MHIS Centers in Qena, Fayoum and Assiut		99%	Tue 2/15/00	93 days	Thu 6/15/00																																				
621	4 2 3 1 Renovation of target MHIS centers in Qena, Fayoum and Assiut		95%	Tue 2/15/00	23 days	Wed 3/15/00																																				
622	4 2 3 2 Conduct Training for Qena Fayoum and Assiut		100%	Thu 3/16/00	48 days	Mon 5/15/00																																				
623	4 2 3 3 Benchmark Training of MHIS staff for 30 new DICs		100%	Tue 5/16/00	0 days	Tue 5/16/00	★ 5/16																																			
624	4 2 3 4 Hardware and Software installations in Qena, Fayoum and Assiut		100%	Mon 5/1/00	23 days	Wed 5/31/00																																				
625	4 2 3 5 Benchmark Hardware and Software installations for 30 new DICs		100%	Thu 6/1/00	0 days	Thu 6/1/00	★ 6/1																																			
626	4 2 3 6 Benchmark Computer based monitoring system for HM/HC will be installed for new DICs		100%	Thu 6/15/00	0 days	Thu 6/15/00	★ 6/15																																			
627	4.2.3.7 Milestone: Establish 44 MHIS centers		100%	Thu 6/15/00	0 days	Thu 6/15/00	◇ 6/15																																			
628	4.2.4 Establish 20 district MHIS centers and upgrade 2 directorate MHIS centers in Menya and Sohag		78%	Sun 9/3/00	172 days	Sun 4/15/01																																				
629	4 2 4 1 Procurement of H/W and S/W		90%	Tue 9/19/00	66 days	Thu 12/14/00																																				
630	4 2 4 2 Assessment of Menya MHIS Centers		100%	Sun 9/3/00	22 days	Sat 9/30/00																																				
631	4 2 4 3 Prepare H/W and S/W Requirements for Menya		100%	Mon 10/2/00	23 days	Tue 10/31/00																																				
632	4 2 4 4 Renovation Assessment for Menya		100%	Mon 10/2/00	23 days	Tue 10/31/00																																				
633	4 2 4 5 Assessment of Sohag MHIS Centers		100%	Mon 10/2/00	23 days	Tue 10/31/00																																				
634	4 2 4 6 Prepare H/W and S/W Requirements for Sohag		100%	Thu 11/2/00	22 days	Thu 11/30/00																																				
635	4 2 4 7 Renovation Assessment for Sohag		100%	Thu 11/2/00	22 days	Thu 11/30/00																																				
636	4 2 4 8 Prepare Training Plan for Menya and Sohag		80%	Sun 12/3/00	21 days	Sun 12/31/00																																				

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ID	Activity	Resp	% Complete	Start	Duration	Finish	1999												2000												2001											
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F
668	5 TASK FIVE: Research Activities		59%	Sun 1/3/99	738 days	Sun 9/16/01																																				
669	5.1 Activity 1: Assessment of current research needs: gaps in available clinical and operational information		48%	Sun 1/3/99	607 days	Wed 3/28/01																																				
670	5.1.1 Determine information needs	JHU	50%	Sun 1/3/99	584 days	Wed 2/28/01																																				
671	5.1.2 Compare the needs to available information to identify gaps	JHU	40%	Mon 3/1/99	543 days	Wed 2/28/01																																				
672	5.1.3 Reach consensus on research to be pursued	JHU, RG	50%	Tue 4/6/99	540 days	Wed 3/28/01																																				
673	5.1.4 Benchmark: Research consensus meeting held with the output being a draft Research Agenda		100%	Sun 6/6/99	0 days	Sun 6/6/99	★ 6/6																																			
674	5.1.5 Determine research agenda for next 3-5 years	JHU	100%	Mon 6/7/99	44 days	Thu 8/5/99																																				
675	5.1.6 Benchmark: Research Agenda finalized		100%	Thu 8/5/99	0 days	Thu 8/5/99	★ 8/5																																			
676	5.2 Activity 2: Development of research proposals and identify departments and/or institutions to conduct the research		67%	Tue 12/14/99	490 days	Sun 9/16/01																																				
677	5.2.1 Identify appropriate researchers and technical counterparts	JHU	30%	Wed 2/21/01	30 days	Sat 3/31/01																																				
678	5.2.2 Develop research protocols	JHU	70%	Thu 2/10/00	328 days	Thu 4/19/01																																				
679	5.2.3 Benchmark: Research protocols developed		0%	Tue 12/14/99	0 days	Tue 12/14/99	★ 12/14																																			
680	5.2.4 Milestone: Three operations research studies completed		100%	Wed 3/15/00	0 days	Wed 3/15/00	★ 3/15																																			
681	5.2.5 Target: Twelve operations research studies completed		0%	Sun 9/16/01	0 days	Sun 9/16/01	★ 9/16																																			
682	5.3 Activity 3: Train appropriate staff in "applied research" methodologies		26%	Thu 2/1/01	91 days	Thu 5/24/01																																				
683	5.3.1 Identify appropriate community assessment methods and training materials	JHU	60%	Thu 2/1/01	22 days	Wed 2/28/01																																				
684	5.3.2 Adapt materials to local needs	JHU	20%	Thu 2/15/01	22 days	Thu 3/15/01																																				
685	5.3.3 Benchmark: Materials produced		0%	Thu 3/15/01	0 days	Thu 3/15/01	★ 3/15																																			
686	5.3.4 Identify trainers and participants	JHU	20%	Sun 4/1/01	22 days	Mon 4/30/01																																				
687	5.3.5 Conduct training	JHU	0%	Tue 5/1/01	20 days	Thu 5/24/01																																				
688	5.3.6 Benchmark: Participants trained and utilizing new applied methodologies		0%	Thu 5/24/01	0 days	Thu 5/24/01	★ 5/24																																			
689	5.4 Activity 4: Create findings dissemination strategy		60%	Thu 2/1/01	65 days	Sun 4/22/01																																				
690	5.4.1 Develop strategy with policy makers and researchers to disseminate research results to affect public health decision making	JHU	60%	Thu 2/1/01	61 days	Sun 4/22/01																																				
691	5.4.2 Benchmark: Dissemination workshops held to present research findings		0%	Sun 4/22/01	0 days	Sun 4/22/01	★ 4/22																																			

ID	Activity	Resp.	% Complete	Start	Duration	Finish	1999												2000												2001											
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F
813	6.6 Activity 4: Strengthen the Daya training program		46%	Sun 1/10/99	733 days	Sun 9/16/01																																				
814	6.6 1 Conduct formative research		100%	Sun 1/10/99	178 days	Tue 9/14/99																																				
819	6.6 2 Identify mechanisms for linking dayas to the formal health system (esp. at the district level)	MS	100%	Tue 9/14/99	40 days	Mon 11/8/99																																				
820	6.6.3 Strengthen Daya training		72%	Tue 11/9/99	515 days	Sun 9/16/01																																				
821	6.6 3.1 Governorate level	MS	80%	Tue 11/9/99	20 days	Mon 12/6/99																																				
822	6.6 3.2 District level	MS	70%	Tue 12/7/99	30 days	Sat 1/15/00																																				
823	6.6 3.3 Facility level	MS	70%	Tue 1/18/00	40 days	Tue 3/7/00																																				
824	<u>6.6 3.4 Target. Upgraded Daya training course implemented in all 25 districts</u>	MS	0%	Sun 9/16/01	0 days	Sun 9/16/01																																				
825	6.6.4 Strengthen Daya supervision & monitoring		48%	Tue 11/9/99	178 days	Wed 6/28/00																																				
826	6.6 4.1 Governorate level	MS	50%	Tue 11/9/99	20 days	Mon 12/6/99																																				
827	6.6 4.2 District level	MS	50%	Tue 12/7/99	30 days	Sat 1/15/00																																				
828	6.6 4.3 Facility level	MS	50%	Tue 1/18/00	40 days	Tue 3/7/00																																				
829	6.6 4.4 Train health workers and managers		46%	Thu 3/9/00	85 days	Wed 6/28/00																																				
830	6.6 4.4.1 Gain support for Daya involvement	MS	50%	Thu 3/9/00	20 days	Tue 4/4/00																																				
831	6.6 4.4.2 Improve skills in managing, supervising and monitoring Daya activity	MS	50%	Thu 4/6/00	30 days	Thu 5/11/00																																				
832	6.6 4.4.3 Strengthen reporting system to monitor Daya activity	MS	40%	Thu 5/18/00	30 days	Wed 6/28/00																																				
833	<u>6.6 4.4.4 Benchmark: Collaboration between dayas, health workers and health managers strengthened and improved</u>	MS	0%	Wed 6/28/00	0 days	Wed 6/28/00																																				
834	<u>6.6.5 Benchmark. Reach a consensus about the duration and contents of the daya refresher course</u>		100%	Thu 3/30/00	0 days	Thu 3/30/00																																				
835	6.6 6 Expansion of Daya training program to 60 districts not covered by CSP	MS	0%	Thu 6/29/00	314 days	Tue 8/14/01																																				
836	<u>6.6.7 Target. Upgraded Daya Training Course implemented in all 25 districts</u>		0%	Sat 9/15/01	0 days	Sat 9/15/01																																				

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ID	Activity	Resp	% Complete	Start	Duration	Finish	1999												2000												2001											
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F
837	7 TASK SEVEN: Better Social Community Services		41%	Sun 7/12/98	862 days	Sat 9/15/01	[Gantt chart for 837: 7 TASK SEVEN: Better Social Community Services]																																			
838	7.1 Activity 1: Establish community "interest" groups		8%	Sun 7/12/98	862 days	Sat 9/15/01	[Gantt chart for 838: 7.1 Activity 1: Establish community "interest" groups]																																			
839	7.1.1 Phase I. Aswan, Luxor & Beni-Suef		100%	Sun 7/12/98	54 days	Wed 9/23/98	[Gantt chart for 839: 7.1.1 Phase I. Aswan, Luxor & Beni-Suef]																																			
846	7.1.2 Phase II. Qena & Fayoum		3%	Sun 3/21/99	581 days	Thu 5/3/01	[Gantt chart for 846: 7.1.2 Phase II. Qena & Fayoum]																																			
847	7.1.2.1 Define and conduct an inventory of existing community groups	SM, FO	100%	Sun 3/21/99	5 days	Thu 3/25/99	[Gantt chart for 847: 7.1.2.1 Define and conduct an inventory of existing community groups]																																			
848	7.1.2.2 Screen the inventory to identify groups of common interest with HMHC	SM, FO	100%	Sun 3/28/99	3 days	Tue 3/30/99	[Gantt chart for 848: 7.1.2.2 Screen the inventory to identify groups of common interest with HMHC]																																			
849	7.1.2.3 Conduct In- depth Interviews and meetings to establish interest in HMHC	SM, FO	100%	Wed 3/31/99	5 days	Tue 4/6/99	[Gantt chart for 849: 7.1.2.3 Conduct In- depth Interviews and meetings to establish interest in HMHC]																																			
850	7.1.2.4 Benchmark (CI): 66 Communities with active interest groups engaged in HMHC	SM; FO	100%	Tue 4/6/99	0 days	Tue 4/6/99	[Gantt chart for 850: 7.1.2.4 Benchmark (CI): 66 Communities with active interest groups engaged in HMHC]																																			
851	7.1.2.5 Develop and negotiate the establishment of CHCs	SM	1%	Wed 4/7/99	552 days	Thu 4/12/01	[Gantt chart for 851: 7.1.2.5 Develop and negotiate the establishment of CHCs]																																			
852	7.1.2.6 Help facilitate the process of establishing CHCs	SM	3%	Wed 4/14/99	563 days	Thu 5/3/01	[Gantt chart for 852: 7.1.2.6 Help facilitate the process of establishing CHCs]																																			
853	7.1.3 Milestone: Community Action Plans developed and implemented in 20 districts		100%	Thu 12/14/00	0 days	Thu 12/14/00	[Gantt chart for 853: 7.1.3 Milestone: Community Action Plans developed and implemented in 20 districts]																																			
854	7.1.4 Target: Community Action Plans developed and implemented in 20 districts by the end of Year 3		0%	Thu 3/15/01	0 days	Thu 3/15/01	[Gantt chart for 854: 7.1.4 Target: Community Action Plans developed and implemented in 20 districts by the end of Year 3]																																			
855	7.1.5 Milestone: Community Action Plans developed and implemented in 25 districts		0%	Sat 9/15/01	0 days	Sat 9/15/01	[Gantt chart for 855: 7.1.5 Milestone: Community Action Plans developed and implemented in 25 districts]																																			
856	7.1.6 Benchmark (CI): 75 Communities with active interest groups engaged in HMHC		0%	Sat 9/15/01	0 days	Sat 9/15/01	[Gantt chart for 856: 7.1.6 Benchmark (CI): 75 Communities with active interest groups engaged in HMHC]																																			
857	7.1.7 Target: Community Action Plans developed and implemented in 25 districts by the end of Year 4		0%	Sat 9/15/01	0 days	Sat 9/15/01	[Gantt chart for 857: 7.1.7 Target: Community Action Plans developed and implemented in 25 districts by the end of Year 4]																																			
858	7.2 Activity 2: Inventory of partners		100%	Sun 8/9/98	229 days	Tue 6/22/99	[Gantt chart for 858: 7.2 Activity 2: Inventory of partners]																																			
868	7.3 Activity 3: Development of a community needs identification and decision making tool		100%	Sun 3/21/99	194 days	Wed 12/15/99	[Gantt chart for 868: 7.3 Activity 3: Development of a community needs identification and decision making tool]																																			
877	7.4 Activity 4: Health Care Provider Sensitization		99%	Sun 12/13/98	752 days	Sat 9/15/01	[Gantt chart for 877: 7.4 Activity 4: Health Care Provider Sensitization]																																			
878	7.4.1 Conduct sensitization orientation for health care providers /organization providers in Aswan and Daraw districts using MC study results	SM	100%	Sun 12/13/98	5 days	Thu 12/17/98	[Gantt chart for 878: 7.4.1 Conduct sensitization orientation for health care providers /organization providers in Aswan and Daraw districts using MC study results]																																			
879	7.4.2 Conduct sensitization orientation for health care providers/organizations providers in Luxor and Byaddiah districts using MC	SM	100%	Sun 2/7/99	3 days	Tue 2/9/99	[Gantt chart for 879: 7.4.2 Conduct sensitization orientation for health care providers/organizations providers in Luxor and Byaddiah districts using MC]																																			
880	7.4.3 Conduct sensitization orientation for health care providers provider organization in Kom Ombo, Edfu and Nasr districts using MC study results	SM	100%	Sun 2/14/99	9 days	Wed 2/24/99	[Gantt chart for 880: 7.4.3 Conduct sensitization orientation for health care providers provider organization in Kom Ombo, Edfu and Nasr districts using MC study results]																																			
881	7.4.4 Benchmark (CI): 75 health care providers / provider organizations that participated insensitization orientation	SM	100%	Wed 2/24/99	0 days	Wed 2/24/99	[Gantt chart for 881: 7.4.4 Benchmark (CI): 75 health care providers / provider organizations that participated insensitization orientation]																																			
882	7.4.5 Revise qualitative research instrument for community diagnosis used by MC	C	100%	Sun 3/21/99	10 days	Thu 4/1/99	[Gantt chart for 882: 7.4.5 Revise qualitative research instrument for community diagnosis used by MC]																																			
883	7.4.6 Conduct rapid qualitative research in a sample of communities in Beni Suef , Qena and Fayoum on community perceptions and practices	C	100%	Sun 4/4/99	90 days	Wed 8/4/99	[Gantt chart for 883: 7.4.6 Conduct rapid qualitative research in a sample of communities in Beni Suef , Qena and Fayoum on community perceptions and practices]																																			
884	7.4.7 Development and testing of sensitization orientation materials based on the conclusions and results of the study	C	100%	Sun 8/8/99	15 days	Thu 8/26/99	[Gantt chart for 884: 7.4.7 Development and testing of sensitization orientation materials based on the conclusions and results of the study]																																			
885	7.4.8 Conduct sensitization orientation to health care providers to raise awareness of health problems and barriers to health care in Beni Suef	SM	100%	Sun 10/31/99	24 days	Wed 12/1/99	[Gantt chart for 885: 7.4.8 Conduct sensitization orientation to health care providers to raise awareness of health problems and barriers to health care in Beni Suef]																																			
886	7.4.9 Benchmark (CI): 225 health care providers/provider organizations participated in sensitization orientation	SM	100%	Thu 11/2/00	0 days	Thu 11/2/00	[Gantt chart for 886: 7.4.9 Benchmark (CI): 225 health care providers/provider organizations participated in sensitization orientation]																																			
887	7.4.10 Benchmark (CI): 375 health care providers/provider organizations participated in sensitization orientation	SM	0%	Sat 9/15/01	0 days	Sat 9/15/01	[Gantt chart for 887: 7.4.10 Benchmark (CI): 375 health care providers/provider organizations participated in sensitization orientation]																																			

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ID	Activity	Resp	% Complete	Start	Duration	Finish	1999												2000												2001											
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F
888	7.5 Activity 5: Testing different partnership schemes		73%	Sun 12/20/98	747 days	Sat 9/15/01	[Gantt bar from Sun 12/20/98 to Sat 9/15/01]																																			
889	7.5.1 Review previous experience collect and analyze donors and government experience with partnership schemes	SM	100%	Sun 12/20/98	10 days	Thu 12/31/98	[Gantt bar from Sun 12/20/98 to Thu 12/31/98]																																			
890	7.5.2 Implement and monitor several different partnership schemes to provide health services at the community level	SM	100%	Sun 1/3/99	50 days	Thu 3/11/99	[Gantt bar from Sun 1/3/99 to Thu 3/11/99]																																			
891	7.5.3 Benchmark (CI): 25 community-provider partnerships established and functioning with health care providers who work in community as needed	SM	100%	Thu 3/11/99	0 days	Thu 3/11/99	[Star icon 3/11]																																			
892	7.5.4 Benchmark (CI): 25 areas where emergency obstetrical transport is available for women	SM	100%	Mon 3/15/99	0 days	Mon 3/15/99	[Star icon 3/15]																																			
893	7.5.5 Benchmark (CI): 25 communities where key child survival actions including nutrition actions are available	SM	100%	Mon 3/15/99	0 days	Mon 3/15/99	[Star icon 3/15]																																			
894	7.5.6 Target: community-provider partnership services offered in 5 districts by end of Year 1	SM	100%	Mon 3/15/99	0 days	Mon 3/15/99	[Circle icon 3/15]																																			
895	7.5.7 Implement and monitor partnerships schemes in other districts	SM	70%	Wed 1/5/00	50 days	Tue 3/7/00	[Gantt bar from Wed 1/5/00 to Tue 3/7/00]																																			
896	7.5.8 Benchmark (CI): 66 community-provider partnerships established and functioning with health care		0%	Tue 3/14/00	0 days	Tue 3/14/00	[Star icon 3/14]																																			
897	7.5.9 Benchmark (CI): 66 areas where emergency obstetrical transport is available	SM	0%	Tue 3/14/00	0 days	Tue 3/14/00	[Star icon 3/14]																																			
898	7.5.10 Benchmark (CI): 66 communities where key child survival actions including nutrition action are available	SM	0%	Tue 3/14/00	0 days	Tue 3/14/00	[Star icon 3/14]																																			
899	7.5.11 Target: community-provider partnership services offered in 10 districts by the end of Year 2	SM	100%	Tue 3/14/00	0 days	Tue 3/14/00	[Circle icon 3/14]																																			
900	7.5.12 Conduct workshops with the "interest" community groups to review partnerships schemes established so far	SM	60%	Sun 3/26/00	5 days	Thu 3/30/00	[Gantt bar from Sun 3/26/00 to Thu 3/30/00]																																			
901	7.5.13 Identify 2 or 3 models that address the majority of community situations for application and replication	SM	100%	Sun 4/16/00	10 days	Wed 4/26/00	[Gantt bar from Sun 4/16/00 to Wed 4/26/00]																																			
902	7.5.14 Conduct a cost-benefit analysis for each model	SM	0%	Sun 4/30/00	22 days	Mon 5/29/00	[Gantt bar from Sun 4/30/00 to Mon 5/29/00]																																			
903	7.5.15 Benchmark: 75 Community-provider partnerships established and functioning with health care		0%	Sat 9/15/01	0 days	Sat 9/15/01	[Star icon 9/15/01]																																			
904	7.5.16 Benchmark: 75 areas where emergency obstetrical transport is available		0%	Sat 9/15/01	0 days	Sat 9/15/01	[Star icon 9/15/01]																																			
905	7.5.17 Benchmarks: 75 communities where key child survival actions including nutrition actions are available		0%	Sat 9/15/01	0 days	Sat 9/15/01	[Star icon 9/15/01]																																			
906	7.6 Activity 6: Implementation of the most promising partnerships		75%	Tue 5/30/00	142 days	Tue 12/5/00	[Gantt bar from Tue 5/30/00 to Tue 12/5/00]																																			
907	7.6.1 Develop a methodology to help ensure that partnerships maximize impact in isolated areas with poor infrastructure	SM	100%	Tue 5/30/00	22 days	Wed 6/28/00	[Gantt bar from Tue 5/30/00 to Wed 6/28/00]																																			
908	7.6.2 Implement partnerships schemes in the remaining targeted districts	SM	70%	Thu 6/29/00	120 days	Tue 12/5/00	[Gantt bar from Thu 6/29/00 to Tue 12/5/00]																																			
909	7.7 Activity 7: Community Education		85%	Sun 10/18/98	651 days	Thu 3/15/01	[Gantt bar from Sun 10/18/98 to Thu 3/15/01]																																			
910	7.7.1 Develop and test a package of community/household interpersonal communication materials to be used by the community leaders/actors	SM	100%	Sun 10/18/98	20 days	Thu 11/12/98	[Gantt bar from Sun 10/18/98 to Thu 11/12/98]																																			
911	7.7.2 Conduct community education to raise awareness and increase demand in Luxor and Byadiah district	SM	100%	Sun 11/29/98	5 days	Thu 12/3/98	[Gantt bar from Sun 11/29/98 to Thu 12/3/98]																																			
912	7.7.3 Conduct community education to raise awareness and increase demand in Byyadiah district	SM	100%	Sun 2/14/99	5 days	Thu 2/18/99	[Gantt bar from Sun 2/14/99 to Thu 2/18/99]																																			
913	7.7.4 Conduct community education to raise awareness and increase demand in Odayssat Rural Hospital	SM	100%	Sun 2/21/99	5 days	Thu 2/25/99	[Gantt bar from Sun 2/21/99 to Thu 2/25/99]																																			
914	7.7.5 Benchmark (CI): 25 communities with HM/HC health communications activities underway	SM	100%	Sun 3/14/99	0 days	Sun 3/14/99	[Star icon 3/14]																																			
915	7.7.6 Conduct a number of community education workshops to be phased in accordance with the implementation in the remaining districts of Aswan and	SM	75%	Wed 1/5/00	50 days	Tue 3/7/00	[Gantt bar from Wed 1/5/00 to Tue 3/7/00]																																			

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ID	Activity	Resp	% Complete	Start	Duration	Finish	1999												2000												2001											
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F
919	8 TASK EIGHT: IEC Campaign		43%	Thu 7/16/98	848 days	Thu 8/30/01																																				
920	8.1 Activity 1: Improving IEC capacity		5%	Thu 1/13/00	455 days	Thu 8/30/01																																				
921	8.1.1 Establish IEC Committee at National level		0%	Thu 1/13/00	87 days	Sun 4/30/00																																				
922	8.1.2 Benchmark IEC subcommittee established		0%	Thu 3/2/00	0 days	Thu 3/2/00	★ 3/2																																			
923	8.1.3 Establish IEC Task Force at Governorate level		14%	Tue 2/15/00	80 days	Wed 5/31/00																																				
924	8.1.4 Overseas training for IEC Managers - Group 2/3		0%	Sun 7/1/01	45 days	Wed 8/29/01																																				
925	8.1.5 Benchmark Overseas training for IEC Managers		0%	Thu 8/30/01	0 days	Thu 8/30/01	★																																			
926	8.2 Activity 2 Inventory of existing IEC resources		100%	Thu 7/16/98	20 days	Thu 8/13/98																																				
930	8.3 Activity 3: Investigation of behavioral information		85%	Mon 1/10/00	113 days	Wed 5/31/00																																				
931	8.3.1 Qualitative Research Study		85%	Mon 1/10/00	109 days	Wed 5/31/00																																				
932	8.4 Activity 4: Strategic design for health communication		100%	Mon 1/4/99	117 days	Tue 6/15/99																																				
935	8.5 Activity 5: IEC Training for Health Providers and Field Workers		71%	Sun 1/17/99	672 days	Sun 7/1/01																																				
936	8.5.1 Module on counseling and interpersonal communication finalized		60%	Sun 1/17/99	585 days	Thu 3/29/01																																				
937	8.5.2 HM/HC IEC curriculum for health educators developed		90%	Wed 9/15/99	332 days	Thu 11/30/00																																				
938	8.5.3 Benchmark IEC Training Package completed		0%	Tue 5/1/01	0 days	Tue 5/1/01	★ 5/1																																			
939	8.5.4 Training of trainers on HM/HC IEC curriculum		100%	Tue 1/25/00	29 days	Mon 2/28/00																																				
940	8.5.5 Training of health educators		70%	Wed 3/1/00	368 days	Sun 7/1/01																																				
941	8.5.6 Benchmark MOHP Health Educators and Field Workers trained		0%	Sun 7/1/01	0 days	Sun 7/1/01	★ 7/1																																			
942	8.5.7 Benchmark IEC orientation package completed		0%	Sun 7/1/01	0 days	Sun 7/1/01	★ 7/1																																			
943	8.5.8 Benchmark 250 Health educators and Others trained		0%	Sun 7/1/01	0 days	Sun 7/1/01	★ 7/1																																			
944	8.6 Activity 6: Print and Audio-visual Materials for Providers and their Clients		30%	Thu 1/20/00	428 days	Tue 7/31/01																																				
945	8.6.1 Benchmark Print materials developed and distributed		0%	Thu 1/20/00	0 days	Thu 1/20/00	★ 1/20																																			
946	8.6.2 Counseling booklet and cards		45%	Mon 2/7/00	360 days	Wed 5/30/01																																				
947	8.6.3 Take home reminder leaflets and pamphlets		45%	Mon 2/7/00	360 days	Wed 5/30/01																																				
948	8.6.4 Posters		45%	Mon 2/7/00	360 days	Wed 5/30/01																																				
949	8.6.5 Benchmark Counseling/interpersonal communication module upgraded		0%	Wed 5/30/01	0 days	Wed 5/30/01	★ 5/30																																			
950	8.6.6 IEC training videos		0%	Thu 3/23/00	355 days	Sat 6/30/01																																				
951	8.6.7 Benchmark Training videos developed		0%	Sat 6/30/01	0 days	Sat 6/30/01	★ 6/30																																			

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ID	Activity	Resp	% Complete	Start	Duration	Finish	1999												2000												2001											
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S					
973	9 TASK NINE: Student Medical Insurance Program (SMIP)		85%	Mon 6/15/98	882 days	Sun 9/16/01																																				
974	9.1 Preventive Services, especially Health Education		84%	Tue 9/1/98	826 days	Sun 9/16/01																																				
975	9.1.1 In collaboration with SMIP, develop workplan, select pilot areas, identify coordinators, define activities and enumerate budgets	JR	100%	Tue 9/1/98	30 days	Mon 10/12/98																																				
976	9.1.2 Benchmark Workplan developed	JR	100%	Mon 10/12/98	0 days	Mon 10/12/98																																				
977	9.1.3 Disseminate and obtain approval for revised workplan	JR	100%	Tue 10/13/98	13 days	Thu 10/29/98																																				
978	9.1.4 Coordinate Task 9 activities with Tasks 2, 5, 7 and 8 to identify opportunities for collaboration on research, community involvement, and IEC	JR	65%	Tue 10/13/98	13 days	Thu 10/29/98																																				
979	9.1.5 Assess HIO's MIS as related to HM/HC activities	JR	40%	Sun 11/1/98	175 days	Thu 7/1/99																																				
980	9.1.6 Health & Nutrition education program initiated to support anemia control and immunization activities		90%	Tue 9/1/98	826 days	Sun 9/16/01																																				
981	9.1.6.1 Assess and analyze SMIP policies and programs related to health education	JR	100%	Tue 9/1/98	13 days	Thu 9/17/98																																				
982	9.1.6.2 Review educational programs and materials targeted at adolescents world-wide	JR	100%	Tue 9/1/98	30 days	Mon 10/12/98																																				
983	9.1.6.3 Review research on adolescent women and men and their families	JR	100%	Tue 9/1/98	30 days	Mon 10/12/98																																				
984	9.1.6.4 Establish a coordination mechanism with USAID, HM/HC, HIO, MOHP, MOE and NGOs	JR	100%	Tue 10/13/98	90 days	Mon 2/15/99																																				
985	9.1.6.5 Undertake a qualitative research to fill gaps in the understanding of priority issues		100%	Tue 2/16/99	61 days	Tue 5/11/99																																				
989	9.1.6.6 Analysis of research and development of strategies for behavior modification and perception changes	JR	100%	Tue 4/27/99	68 days	Wed 7/28/99																																				
990	9.1.6.7 Strategy submitted for approval	JR	100%	Sun 8/1/99	11 days	Sun 8/15/99																																				
991	9.1.6.8 Benchmark Strategy approved	JR	100%	Tue 1/4/00	0 days	Tue 1/4/00																																				
992	9.1.6.9 Materials development		100%	Tue 6/1/99	251 days	Mon 5/1/00																																				
998	9.1.6.10 Develop training for health educators	DT2	90%	Wed 9/1/99	132 days	Thu 2/24/00																																				
999	9.1.6.11 Complete training of pilot users	JR	100%	Sat 2/26/00	15 days	Wed 3/15/00																																				
1000	9.1.6.12 Monitor pilot implementation	JR, DT2	100%	Mon 2/7/00	68 days	Mon 5/1/00																																				
1001	9.1.6.13 Revise, print and duplicate educational materials	JR	100%	Thu 6/8/00	40 days	Mon 7/31/00																																				
1002	9.1.6.14 Develop operational plans, protocols and training material for 5 governorates	JR	100%	Tue 3/14/00	197 days	Tue 11/28/00																																				
1003	9.1.6.15 Milestone: Health Educator's Guide and education materials for use in schools developed	JR	100%	Thu 9/14/00	0 days	Thu 9/14/00																																				
1004	9.1.6.16 Benchmark Final education materials, training manual and educator's guide ready for duplication		0%	Tue 7/31/01	0 days	Tue 7/31/01																																				
1005	9.1.6.17 Conduct implementation in 5 governorates		72%	Thu 8/17/00	299 days	Thu 9/13/01																																				
1006	9.1.6.17.1 Train staff	JR	100%	Thu 8/17/00	133 days	Thu 2/15/01																																				
1007	9.1.6.17.2 Benchmark Staff trained	JR	100%	Thu 2/15/01	0 days	Thu 2/15/01																																				
1008	9.1.6.17.3 Monitor implementation	JR	60%	Tue 9/19/00	174 days	Tue 5/15/01																																				

ID	Activity	Resp	% Complete	Start	Duration	Finish	1999												2000												2001														
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M
1063	10 TASK TEN: Small Grant Program		57%	Sun 3/15/98	950 days	Mon 9/17/01	[Gantt bar spanning from Sun 3/15/98 to Mon 9/17/01]																																						
1064	10.1 Small Grants Agreement between JSI and USAID finalized		100%	Sun 3/15/98	260 days	Thu 3/11/99	[Gantt bar from Sun 3/15/98 to Thu 3/11/99]																																						
1065	10.2 Develop Training Curricula for NGOs on USAID Financial Management and reporting		100%	Sun 7/12/98	60 days	Thu 10/1/98	[Gantt bar from Sun 7/12/98 to Thu 10/1/98]																																						
1070	10.3 Identification and Assessment of potential NGO partners in Target Districts		91%	Sun 8/9/98	241 days	Thu 7/8/99	[Gantt bar from Sun 8/9/98 to Thu 7/8/99]																																						
1071	10.3.1 Assess and identify potential NGOs in Aswan, Luxor and Beni-Suif		100%	Sun 8/9/98	45 days	Thu 10/8/98	[Gantt bar from Sun 8/9/98 to Thu 10/8/98]																																						
1072	10.3.2 Benchmark: Identification & assessment of potential NGO partners in Aswan, Luxor & Beni-Suif completed		100%	Thu 10/8/98	0 days	Thu 10/8/98	[Star icon at Thu 10/8/98]																																						
1073	10.3.3 Assess and identify potential NGOs in Qena and Fayoum		75%	Sun 6/6/99	25 days	Thu 7/8/99	[Gantt bar from Sun 6/6/99 to Thu 7/8/99]																																						
1074	10.3.4 Benchmark: Identification & assessment of potential NGO partners in Qena & Fayoum completed		0%	Thu 10/8/98	0 days	Thu 10/8/98	[Star icon at Thu 10/8/98]																																						
1075	10.4 Obtain Official Approval and consent form MOHP and MOSA to approach NGOs for grant giving		100%	Thu 4/15/99	1 day	Thu 4/15/99	[Star icon at Thu 4/15/99]																																						
1077	10.5 Assessment of work currently being done and potential for future grants in the target areas		88%	Mon 11/16/98	195 days	Thu 8/12/99	[Gantt bar from Mon 11/16/98 to Thu 8/12/99]																																						
1078	10.5.1 Send a letter to USAID to provide us with the Progress, Final and/or Evaluation reports of current and previous USAID grants		100%	Mon 11/16/98	1 day	Mon 11/16/98	[Star icon at Mon 11/16/98]																																						
1079	10.5.2 Prepare an RFP for Umbrella Management Institutions (UMIs) to do the Assessment		100%	Sun 12/13/98	10 days	Thu 12/24/98	[Gantt bar from Sun 12/13/98 to Thu 12/24/98]																																						
1080	10.5.3 Send an RFP for Umbrella Management Institutions (UMIs) to do the Assessment		100%	Sun 4/4/99	3 days	Tue 4/6/99	[Gantt bar from Sun 4/4/99 to Tue 4/6/99]																																						
1081	10.5.4 Receive proposal. Evaluate and Award		100%	Sun 5/2/99	10 days	Thu 5/13/99	[Gantt bar from Sun 5/2/99 to Thu 5/13/99]																																						
1082	10.5.5 UMI Conducts the assessment		100%	Sun 5/16/99	50 days	Thu 7/22/99	[Gantt bar from Sun 5/16/99 to Thu 7/22/99]																																						
1083	10.5.6 Assessment done and final copy of the report received		100%	Sun 7/25/99	1 day	Sun 7/25/99	[Star icon at Sun 7/25/99]																																						
1084	10.5.7 Organize and conduct a workshop to discuss lessons learned and how to modify existing grant practices, if necessary, for future grant giving		0%	Sun 8/1/99	10 days	Thu 8/12/99	[Gantt bar from Sun 8/1/99 to Thu 8/12/99]																																						
1085	10.5.8 Benchmark: Workshop to discuss lessons learned conducted		0%	Thu 8/12/99	0 days	Thu 8/12/99	[Star icon at Thu 8/12/99]																																						
1086	10.6 Nominate a Review & Evaluation Panel Committee that will be in charge of Reviewing and Evaluating the NGOs Proposals		100%	Mon 11/2/98	108 days	Thu 4/1/99	[Gantt bar from Mon 11/2/98 to Thu 4/1/99]																																						
1090	10.7 Develop the grant award Contract and Annexes template		100%	Sun 8/9/98	40 days	Thu 10/1/98	[Gantt bar from Sun 8/9/98 to Thu 10/1/98]																																						
1093	10.8 Establish Eligibility Qualifications and Selection Criteria for NGOs to Receive Grants		100%	Sun 11/1/98	130 days	Thu 4/29/99	[Gantt bar from Sun 11/1/98 to Thu 4/29/99]																																						
1098	10.9 Prepare and Approve the "Invitation for Application"		100%	Tue 9/1/98	168 days	Thu 4/22/99	[Gantt bar from Tue 9/1/98 to Thu 4/22/99]																																						
1102	10.10 Provide Grants to Capable Local NGOs through a standardized Mechanism		81%	Sun 11/7/99	516 days	Sat 9/15/01	[Gantt bar from Sun 11/7/99 to Sat 9/15/01]																																						
1103	10.10.1 Luxor		100%	Sun 11/7/99	171 days	Thu 6/15/00	[Gantt bar from Sun 11/7/99 to Thu 6/15/00]																																						
1118	10.10.2 Aswan		100%	Sat 1/1/00	197 days	Thu 9/14/00	[Gantt bar from Sat 1/1/00 to Thu 9/14/00]																																						
1133	10.10.3 Beni Suef and Middle Qena		72%	Sat 10/21/00	111 days	Thu 3/15/01	[Gantt bar from Sat 10/21/00 to Thu 3/15/01]																																						
1134	10.10.3.1 Advertise the Program and distribute the IFA		100%	Sat 10/21/00	11 days	Thu 11/2/00	[Gantt bar from Sat 10/21/00 to Thu 11/2/00]																																						
1135	10.10.3.2 Receive Letters of Intent to submit a proposal		100%	Thu 11/2/00	1 day	Thu 11/2/00	[Star icon at Thu 11/2/00]																																						

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ID	Activity	Resp.	% Complete	Start	Duration	Finish	1999												2000												2001											
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F
1165	11 TASK ELEVEN: Commodity Procurement Program		66%	Mon 6/22/98	878 days	Sun 9/16/01																																				
1166	11.1 Needs assessment and schedule to TCA		100%	Mon 6/22/98	60 days	Sun 9/13/98																																				
1167	11.2 Activity 1: Procurement of project equipment		69%	Wed 9/30/98	804 days	Thu 9/13/01																																				
1168	11.2.1 Tranche 1: Procurement of equipment to be installed 3/13/99		100%	Wed 9/30/98	132 days	Thu 4/1/99																																				
1177	11.2.2 Tranche 2: Procurement of equipment to be installed 30/6/99		100%	Wed 12/30/98	133 days	Thu 7/1/99																																				
1186	11.2.3 Tranche 3: Procurement of equipment to be installed 31/12/99		100%	Thu 7/1/99	132 days	Sat 1/1/00																																				
1195	11.2.4 Tranche 4: Procurement of equipment to be installed 31/1/00		100%	Sun 8/1/99	134 days	Sun 1/30/00																																				
1204	11.2.5 Tranche 5: Procurement of equipment to be installed 31/3/00		100%	Wed 9/29/99	135 days	Mon 3/27/00																																				
1213	11.2.6 Tranche 6: Procurement of equipment to be installed 31/6/00		100%	Wed 12/29/99	140 days	Mon 6/26/00																																				
1222	11.2.7 Tranche 7: Procurement of equipment to be installed 31/12/00		100%	Thu 6/29/00	138 days	Sun 12/31/00																																				
1231	11.2.8 Tranche 8: Procurement of equipment to be installed 31/1/01		100%	Sun 7/30/00	136 days	Mon 1/29/01																																				
1240	11.2.9 Tranche 9: Procurement of equipment to be installed 3/15/01		89%	Mon 1/1/01	58 days	Thu 3/15/01																																				
1241	11 2 9 1 Refine specifications (when needs assessment is received from JSI)		100%	Mon 1/1/01	56 days	Tue 3/13/01																																				
1242	11 2 9 2 Solicit offers (when procurement plan is approved)		100%	Mon 1/1/01	56 days	Tue 3/13/01																																				
1243	11 2 9 3 Analyze offers received (varies from 10 - 15 days)		100%	Mon 1/1/01	56 days	Tue 3/13/01																																				
1244	11 2 9 4 Place orders and request L/C (when analysis is approved)		100%	Mon 1/1/01	56 days	Tue 3/13/01																																				
1245	11 2 9 5 Consolidate goods at US freight forwarded warehouse (varies depending on suppliers lead time)		100%	Mon 1/1/01	56 days	Tue 3/13/01																																				
1246	11 2 9 6 Arrange for shipping		100%	Mon 1/1/01	56 days	Tue 3/13/01																																				
1247	11 2 9 7 Handle customs clearance and delivery (delivery to districts might involve more time)		75%	Mon 1/1/01	8 days	Thu 3/15/01																																				
1248	11 2 9 8 Coordinate installation and training if applicable and required		25%	Mon 1/1/01	56 days	Tue 3/13/01																																				
1249	11 2 10 Tranche 10: Procurement of equipment to be installed 6/15/01		35%	Thu 3/15/01	73 days	Thu 6/14/01																																				
1250	11 2 10 1 Refine specifications (when needs assessment is received from JSI)		100%	Thu 3/15/01	68 days	Fri 6/8/01																																				
1251	11 2 10 2 Solicit offers (when procurement plan is approved)		100%	Thu 3/15/01	68 days	Fri 6/8/01																																				
1252	11 2 10 3 Analyze offers received (varies from 10 - 15 days)		50%	Thu 3/15/01	68 days	Fri 6/8/01																																				
1253	11 2 10 4 Place orders and request L/C (when analysis is approved)		0%	Thu 3/15/01	68 days	Fri 6/8/01																																				
1254	11 2 10 5 Consolidate goods at US freight forwarded warehouse (varies depending on suppliers lead time)		0%	Thu 3/15/01	68 days	Fri 6/8/01																																				
1255	11 2 10 6 Arrange for shipping		0%	Thu 3/15/01	68 days	Fri 6/8/01																																				
1256	11 2 10 7 Handle customs clearance and delivery (delivery to districts might involve more time)		0%	Wed 3/21/01	8 days	Thu 6/14/01																																				

Wed 2/28/01

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ID	Activity	Resp.	% Complete	Start	Duration	Finish	1999												2000												2001											
							M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F
1298	12 Management and Administration Activities		84%	Sun 6/14/98	883 days	Sat 9/15/01	[Gantt bar from 6/14/98 to 9/15/01]																																			
1299	12.1 JSI HM/HC Orientation Meeting	KK	100%	Sun 6/14/98	5 days	Thu 6/18/98	[Vertical bar at 6/14/98]																																			
1300	12.2 Benchmark: Orientation meeting held	KK	100%	Thu 6/18/98	0 days	Thu 6/18/98	[Star at 6/18]																																			
1301	12.3 JSI HM/HC Planning Retreat	KK	100%	Sun 1/10/99	5 days	Thu 1/14/99	[Vertical bar at 1/10/99]																																			
1302	12.4 Benchmark: Planning Retreat held	KK	100%	Thu 1/14/99	0 days	Thu 1/14/99	[Star at 1/14]																																			
1303	12.5 Inventory Submission	KK	100%	Sun 2/28/99	10 days	Thu 3/11/99	[Vertical bar at 2/28/99]																																			
1304	12.6 Benchmark: Inventory submitted	KK	100%	Thu 3/11/99	0 days	Thu 3/11/99	[Star at 3/11]																																			
1305	12.7 Quarterly Performance Monitoring Report		77%	Mon 6/15/98	836 days	Thu 7/12/01	[Gantt bar from 6/15/98 to 7/12/01]																																			
1306	12.7.1 Quarterly Performance Monitoring Report 1	RA	100%	Mon 6/15/98	22 days	Tue 7/14/98	[Small bar at 6/15/98]																																			
1307	12.7.2 Quarterly Performance Monitoring Report 2	RA	100%	Tue 9/15/98	22 days	Wed 10/14/98	[Small bar at 9/15/98]																																			
1308	12.7.3 Quarterly Performance Monitoring Report 3	RA	100%	Tue 12/15/98	22 days	Wed 1/13/99	[Small bar at 12/15/98]																																			
1309	12.7.4 Quarterly Performance Monitoring Report 4	RA	100%	Mon 3/15/99	22 days	Tue 4/13/99	[Small bar at 3/15/99]																																			
1310	12.7.5 Quarterly Performance Monitoring Report 5	RA	100%	Tue 6/15/99	22 days	Wed 7/14/99	[Small bar at 6/15/99]																																			
1311	12.7.6 Quarterly Performance Monitoring Report 6	RA	100%	Wed 9/15/99	22 days	Thu 10/14/99	[Small bar at 9/15/99]																																			
1312	12.7.7 Quarterly Performance Monitoring Report 7	RA	100%	Wed 12/15/99	22 days	Wed 1/12/00	[Small bar at 12/15/99]																																			
1313	12.7.8 Quarterly Performance Monitoring Report 8	RA	100%	Wed 3/15/00	22 days	Mon 4/10/00	[Small bar at 3/15/00]																																			
1314	12.7.9 Quarterly Performance Monitoring Report 9	RA	100%	Thu 6/15/00	22 days	Thu 7/13/00	[Small bar at 6/15/00]																																			
1315	12.7.10 Quarterly Performance Monitoring Report 10	RA	100%	Sun 9/17/00	22 days	Sun 10/15/00	[Small bar at 9/17/00]																																			
1316	12.7.11 Quarterly Performance Monitoring Report 11	RA	0%	Sun 12/17/00	22 days	Mon 1/15/01	[Small bar at 12/17/00]																																			
1317	12.7.12 Quarterly Performance Monitoring Report 12	RA	0%	Thu 3/15/01	22 days	Tue 4/10/01	[Small bar at 3/15/01]																																			
1318	12.7.13 Quarterly Performance Monitoring Report 13	RA	0%	Sun 6/17/01	22 days	Thu 7/12/01	[Small bar at 6/17/01]																																			
1319	12.8 Annual Workplan Submission		100%	Mon 2/1/99	560 days	Sun 2/25/01	[Gantt bar from 2/1/99 to 2/25/01]																																			
1320	12.8.1 Annual Workplan Submission 2	RA	100%	Mon 2/1/99	20 days	Sun 2/28/99	[Small bar at 2/1/99]																																			
1321	12.8.2 Annual Workplan Submission 3	RA	100%	Tue 2/1/00	20 days	Thu 2/24/00	[Small bar at 2/1/00]																																			
1322	12.8.3 Annual Workplan Submission 4	RA	100%	Thu 2/1/01	19 days	Sun 2/25/01	[Small bar at 2/1/01]																																			
1323	12.9 Annual Report Submission		99%	Mon 3/15/99	687 days	Sat 9/15/01	[Gantt bar from 3/15/99 to 9/15/01]																																			
1324	12.9.1 Annual Report 1	RA	100%	Mon 3/15/99	22 days	Tue 4/13/99	[Small bar at 3/15/99]																																			
1325	12.9.2 Annual Report 2	RA	100%	Wed 3/15/00	22 days	Mon 4/10/00	[Small bar at 3/15/00]																																			

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Project JSI HM/HC Results Package
Date Wed 2/28/01

Task
Progress

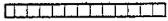


Milestone
Summary



Completed Milestone
Benchmark



Progress Summary 
Completed Benchmark ☆

Wed 2/28/01

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