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UNCLASSIFIED

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PD-AAC-270-81

DEPARTMENT OF STATE
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D. C. 20523

58p.

PROJECT PAPER

EGYPT: Urban Health Delivery System

~~263-0065~~

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AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT PAPER FACESHEET

1. TRANSACTION CODE
 A ADD
 C CHANGE
 D DELETE

2. DOCUMENT CODE
 PP
 3

3. COUNTRY/ENTITY
 Egypt

4. DOCUMENT REVISION NUMBER

5. PROJECT NUMBER (7 digits)

6. BUREAU/OFFICE
 A. SYMBOL: NE
 B. CODE:

7. PROJECT TITLE (Maximum 40 characters)

8. ESTIMATED FY OF PROJECT COMPLETION
 FY

9. ESTIMATED DATE OF OBLIGATION
 A. INITIAL FY:
 B. QUARTER:
 C. FINAL FY: (Enter 1, 2, 3 or 4)

10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$) -

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL						
GRANT	2,640	2,313	4,953	12,622	12,650	25,272
LOAN						
OTHER						
U.S.						
HOST COUNTRY		10,664	10,664		19,388	19,388
OTHER COUNTRIES						
TOTALS	2,640	12,977	15,617	12,622	32,038	44,660

11. PROPOSED BUDGET APPROPRIATED FUNCS. (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY 79		H. 2ND FY 80		K. 3RD FY 81	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) SA	533			4,953		20,319			
(2)									
(3)									
(4)									
TOTALS				4,953		20,319			

A. APPROPRIATION	N. 4TH FY 82		O. 5TH FY 83		LIFE OF PROJECT		12. IN-DEPTH EVAL. SCHEDULED
	C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	
(1)							MM YY <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="8"/> <input type="text" value="1"/>
(2)							
(3)							
(4)							
TOTALS							

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PIO FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PPP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PIO FACESHEET.

2 YES
 1 NO

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE: *[Signature]*

TITLE: Director, USAID

DATE SIGNED: MM DD YY
 | |

15. DATE DOCUMENT RECEIVED IN AID/W. OR FOR AID/W OCCUMENTS. DATE OF DISTRIBUTION
 MM DD YY
 | |

PROJECT AUTHORIZATION
AND REQUEST FOR ALLOTMENT OF FUNDS

PART II

Name of Country: Arab Republic of Egypt Name of Project: Urban Health Care
Delivery System
Project No: 263-0065

Pursuant to Part II, Chapter 4, Section 531 of the Foreign Assistance Act of 1961, as amended (Economic Support Fund), I hereby authorize a Grant to the Arab Republic of Egypt ("Cooperating Country") of not to exceed Four Million Nine Hundred Fifty-three Thousand United States Dollars (\$4,953,000) to assist in financing the foreign exchange and local currency costs of goods and services required for the Project as described in the following paragraph:

The Urban Health Care Delivery System Project will assist Egypt to meet the goal of improving the health of the Egyptian population. The target group of the project is the low-income population in three health zones of Greater Cairo (approximately 1.7 million in 1976). The purpose of this project is to make the existing urban health care delivery system more accessible and effective. The project will utilize, as a base, existing facilities and resources. It will conduct a health sector assessment of the project area and of the Great Cairo area and will institutionalize the planning process in the Ministry of Health; provide for construction/renovation and equipping of Maternal Child Health Clinics, General Urban Health Centers, and a Center for Preventive and Social Medicine; introduce innovative interventions into the health system to improve the delivery of health services; and offer

training for health professionals, paraprofessionals, outreach workers, community leaders and other health-related personnel.

I hereby approve the total level of A.I.D. appropriated funding planned for this project of not to exceed Twenty-Five Million, Two Hundred Seventy-Two Thousand United States Dollars (\$25,272,000) of which \$4,953,000 is authorized above and the remainder will be available for additional increments in succeeding fiscal years (1980-83) subject to availability of funds and in accordance with A.I.D. allotment procedures.

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

I hereby authorize the initiation of negotiation and execution of the Project Agreement by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority subject to the following terms, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Goods and Services

Except as A.I.D. may otherwise agree in writing, goods and services financed by A.I.D. appropriated funding shall have their source and origin in the United States or in the Arab Republic of Egypt.

b. Conditions Precedent to Disbursement

(1) Initial Disbursement

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as the parties may agree otherwise in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

- a. A statement of the names and title with specimen signatures of the person or persons who will act as the representatives of the Grantee;
- b. Evidence of establishment of an implementation organization acceptable to A.I.D. under the jurisdiction of the MOH, to include an Executive Board, Executive Director and adequate staff for the implementation of the project as described in the Project Paper; and
- c. Such other information and documents as A.I.D. may reasonably require.

(2) Disbursement for Architectural and Engineering Services

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for architectural and engineering design and supervisory services, the Grantee shall, except as the parties may agree otherwise in writing; furnish to A.I.D. in form and substance satisfactory to A.I.D.;

- a. Evidence of an executed contract for design and supervisory services with architectural and engineering services contractors acceptable to A.I.D.

b. Evidence of establishment of the Executive Council of the Center for Social and Preventive Medicine with evidence that its authorities and responsibilities are to be shared by the Ministry of Health and Cairo University.

c. Such other information and documents as A.I.D. may reasonably require.

(3) Disbursement for Renovation

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for renovation of a particular facility to be assisted under this project, the Grantee shall, in each case of renovation, except as the parties may agree otherwise in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

- a. Evidence that Grantee budgetary resources have been allocated for the ongoing operating costs of health facilities to be renovated.
- b. Evidence of execution of renovation contract(s) with firm(s) acceptable to A.I.D.
- c. Evidence of engineering designs and adequate supervisory services for the planned renovation.
- c. Such other information and documents as A.I.D. may reasonably require.

(4) Disbursement for New Construction

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for new construction of a particular facility to be assisted under this project, the Grantee shall, in each case of construction, except as the parties may agree otherwise in

writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

- a. Evidence that Grantee budgetary resources have been allocated for the ongoing operating costs of health facilities to be constructed.
- b. Evidence of execution of construction contract(s) with firm(s) acceptable to A.I.D.
- c. Evidence of engineering designs and adequate supervisory services for the planned construction.
- d. An implementation plan to include a training plan for in-country training and participant training, job descriptions for project personnel, and a description of interventions to be introduced for the management and provision of innovative health services.
- e. Such other information and documents as A.I.D. may reasonably require.

c. Convenants

(1) Execution of the Project

The Grantee shall:

- a. Assure commitment by cooperating agencies with responsibility to staff and operate facilities to be constructed as part of the project to include in their future budget plans the timely recruitment and funding of staff and provision of other operating costs.
- b. Carry out the project with due diligence and efficiency, and in conformity with sound engineering, construction, financial, administrative and other professional practices.

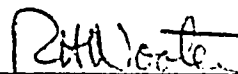
c. Cause the project to be carried out in conformance with all the plan's specifications, and with all modifications therein approved by A.I.D. pursuant to the Agreement, including the provision, on a timely basis, of necessary local currency and in-kind support as specified in the Agreement and its annexes.

d. Submit for A.I.D. approval prior to implementation, issuance or execution, all plan specifications, construction schedules, bid documents, documents concerning solicitation of proposals relating to eligible items, contracts, and all modifications to these documents.

e. Except as A.I.D. may otherwise agree in writing, update the implementation plan furnished under paragraph b.(4)d., above, every six months over the life of the project.

f. Make provision for adequate administrative arrangements and local currency from funds other than those provided by the Grant for any incentive payments to be made to personnel of the Grantee engaged in project implementation.

g. Furnish to A.I.D. within 24 months of the date of the Project Agreement, or such other date as A.I.D. may agree in writing, an implementation plan, in form and substance satisfactory to A.I.D., to make provision for institutionalizing planning and development capabilities within the Ministry of Health. Such plan will include staffing, budget, training requirements, and lines of responsibility of such a unit within the Ministry.



Acting Administrator

11/15/78

Date

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT IDENTIFICATION DOCUMENT FACESHEET
 TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE
 A = ADD
 C = CHANGE
 D = DELETE

PID
 2. DOCUMENT CODE
 1

3. COUNTRY/ENTITY: Egypt
 4. DOCUMENT REVISION NUMBER: 1

5. PROJECT NUMBER (7 DIGITS): 263-0065
 6. BUREAU/OFFICE: A. SYMBOL: NE, B. CODE: 03
 7. PROJECT TITLE (MAXIMUM 40 CHARACTERS): Urban Health Care Delivery Systems

8. PROPOSED NEXT DOCUMENT: A. 2 = PRP, 3 = PP; B. DATE: 11/17/81
 10. ESTIMATED COSTS (\$000 OR EQUIVALENT, \$): \$44,660
 FUNDING SOURCE: 6865c84
 A. AID APPROPRIATED: 25,272

9. ESTIMATED FY OF AUTHORIZATION/OBLIGATION: a. INITIAL FY: 710, b. FINAL FY: 83
 B. OTHER: 1, 2, 3
 C. HOST COUNTRY: 13,388
 D. OTHER DONOR(S):
 TOTAL: 44,660

11. PROPOSED BUDGET AID APPROPRIATED FUNGS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. FIRST FY - FY 79		LIFE OF PROJECT	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	H. GRANT	I. LOAN
(1) SA	R-333	533		2,600		25,272	
(2)							
(3)							
(4)							
TOTAL				2,600		25,272	

12. SECONDARY TECHNICAL CODES (maximum six codes of three positions each): 583, 560

13. SPECIAL CONCERNS CODES (MAXIMUM SIX CODES OF FOUR POSITIONS EACH)
 14. SECONDARY PURPOSE CODE

15. PROJECT GOAL (MAXIMUM 240 CHARACTERS):
 To improve the health status of the Egyptian people.

16. PROJECT PURPOSE (MAXIMUM 400 CHARACTERS):
 To make the existing urban health care delivery system more accessible and effective so that it better supports efforts at health improvement in the project area and could form the basis for Cairo-wide and other urban area replications.

17. PLANNING RESOURCE REQUIREMENTS (staff/funds)

18. ORIGINATING OFFICE CLEARANCE
 Signature: [Signature]
 Title: Director, USAID
 Date Signed: MM DD YY
 19. DATE DOCUMENT RECEIVED BY AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

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II. INTRODUCTION

A. BACKGROUND

The Government of Egypt (GOE) has developed a very extensive health care system with far greater physical facilities and human resources than most countries at a similar stage of development. There are some 75 hospital beds available for every 1,000 Egyptians and 1 doctor for every 2,000 Egyptians, both very high figures for developing countries. Furthermore, each year, approximately 8,500 new doctors, nurses, midwives and other health care personnel enter into service.

In spite of the apparent availability of human and physical resources, the system has not functioned to its full potential. Some facilities are greatly underutilized; for example, some maternal child health (MCH) Clinics operate at only 60-70% of capacity. In contrast, large central hospitals are severely overcrowded. The national infant mortality rate of 116 for every 1,000 live births is about six times the rate of a developed country. Gastroenteritis and other environmentally controllable diseases continue to take a heavy death toll, especially among infants and children under five. Life expectancy is 52.3 years for males and 56.6 for females, which is about two decades below developed countries. Furthermore, the population growth rate exceeds 2.5% and nationwide the numbers of fertile couples practicing family planning probably does not exceed 20%. Thus, although the GOE has invested substantially (from 1.5 to 2.0% of the GNP) in health activities, the health service needs of low-income families are not being met.

Recent U.S. assistance to Egyptian health programs was initiated in 1974 with the establishment of the US-Egyptian Joint Working Group (JWG), which provides for cooperative efforts in the health sector. A.I.D. financed assistance projects were initiated in rural health and in family planning and in 1976 the JWG endorsed the concept of initiating a project to improve health services in the urban areas. The PID proposing a comprehensive demonstration activity to address the key areas in the urban health system needing improvement was approved by AID/W in July 1977.

Greater Cairo, with about 21% of Egypt's population and a density as high as 136,000 per square kilometer, serves as an excellent example in both depth and magnitude of the more serious urban health problems to be addressed. Therefore the demonstration activities will be carried out in the Cairo Governorate.

In December, 1977, the Minister of Health established an inter-organizational committee, comprised of representatives from various sectors of the MOH, the Director of each of the three major Cairo university hospitals, and chaired by the First Undersecretary of the MOH, which was assigned the responsibility of developing a project design. The committee and USAID agreed that a preliminary survey of the Cairo urban health situation was required before determining specific project parameters. This survey was performed by the Experimental Center for Training and Operational Research (ECTOR) of the Institute of National Planning.

In April, 1978, ECTOR published, "Perception and Utilization of Health Care Services in the Greater Cairo Area: A Preliminary Investigation," the summary and recommendations of which are presented as Annex R. The major findings of this survey provided a better definition of the more acute problems which this project is designed to address. Project development benefited from discussions with experts from the Institute of Medicine (IOM) of the National Academy of Sciences, which performed an extensive Health and Population Sector Study in the spring of 1978. Many of the recommendations made as a result of the above studies and much of the data assembled were utilized in the preparation of the project paper which was prepared in collaboration with the MOH, and with the assistance of ECTOR and One America, Inc. (USAID-funded contractors).

B. THE PROJECT

This project is planned as a demonstration effort designed to make the urban health system more accessible and effective. It is concentrated in an area encompassing Helwan, South and West Cairo health zones of the Cairo Governorate, with an estimated population of 1.7 million, 66% of whom are in the low-income bracket, where health problems are numerous and highly representative of other urban areas. A major thrust of the project is to upgrade and modify the existing maternal child health and family planning delivery system to respond to the needs of the universally recognized most vulnerable low-income population segment, and particularly women of child-bearing age and children, which are the target group to be reached under the project. Approximately 625,000 women of child-bearing age and children 5 years and under reside in the area.

Within this target group the infant mortality rate exceeds 150 per thousand, compared to the 116 national average, which is unacceptably high. The incidence of gastroenteritis and bronchial disorders far exceeds minimally acceptable levels. Only some 35% of births are attended by trained midwives or doctors; ante-natal and post-natal visits by health personnel have decreased to an average of 1.2 per birth. Nutritional standards are low.

Poor environmental sanitation, the lack of adequate water and sewage facilities, cultural practices and other considerations contribute to this overall low level of general health. However, a most significant reason is the lack of an effective and accessible urban health system with well-trained and highly motivated personnel providing outreach services and health care education in the target communities.

The project will attempt to correct the major problems in the current delivery system, which include:

- Fragmentation of services (as many as six health service delivery systems are represented in some areas).
- Poor distribution of personnel resources.
- Poorly maintained and deteriorated physical facilities.

- Low public acceptance and utilization of peripheral health care units.
- Poor control and management of the system.
- Lack of motivation and skills on the part of health personnel and lack of practical experience available to them within the medical education system.
- Inadequate outreach of health services from clinics.

For a fuller explanation of the major problems, see Annex G-3.

The project will fund:

- Technical assistance.
- Architectural and engineering services.
- Renovation and construction of health facilities.
- Commodity inputs.
- Participant and in-country training.
- Other costs such as: feasibility studies, innovative interventions, and information, education and communication (IE&C) activities.

III. DESCRIPTION OF PROJECT

A. GOAL

The project contributes to the overall goal of improving the health status of the Egyptian people. Forty-four percent live in urban areas, the majority of whom are in the low-income segment.

B. PURPOSE

The purpose of this project is to assist the GOE to make the existing urban health care delivery system more accessible and effective so that it better supports efforts at health improvement in the project area and could form the basis for Cairo-wide and other urban area replication.

C. STRATEGY

The strategy of this project is to modify the current marginally functioning health delivery system and to improve the delivery of health, nutrition and family planning services to low-income families in the project area.

The assumption is that if higher quality (more effective) health services are made easily available locally, the services will be utilized and the health status of the consumers will improve, as measured over time by increased life expectancy, decreasing infant mortality and reduction of fertility rates.

A demonstration activity will be carried out which will coordinate the delivery of health services by the two major health systems providing free care in Cairo, i.e., the Ministry of Health and Cairo University. Through the experience gained in implementation of the selected approach and using the information gained in an accompanying sectoral assessment and periodic evaluations, a long-term strategy for improving the health system of Greater Cairo will be prepared and adopted. The project will focus on improving the Government's free health services, although representatives from other health service providing organizations, e.g., the Health Insurance Organization, will participate in the monitoring of the project so that information generated and lessons learned can be applied more widely throughout the Egyptian health system.

The implementation strategy will focus on changing the existing pattern of consumer utilization of health services. Providing more effective services at the primary and secondary levels (i.e., Maternal Child Health Clinics and General Urban Health Centers) which are capable of tapping most of the potential demand for health services and meeting these needs, should relieve the tertiary level (i.e., university hospitals that are geographically isolated from the target group) from unnecessary over-utilization. If properly managed, such a system is expected to affect both the efficiency and effectiveness of the present service system with the addition of reasonable amounts of incremental resources.

This approach is consistent with the strategy of the Egyptian Five-Year Health Plan which stresses prevention, planning, making services more readily available, and community participation in health care.

D. LOCATION AND MAJOR ELEMENTS

1. Location

The project will be carried out in three health zones of Cairo, the densely populated and very poor zones of West and South Cairo and the heavily industrialized area of Helwan, approximately 10 miles southeast of downtown Cairo. For maps see Annex B.

2. Major Elements

The following are the main elements of the project:

- a. Developing within the MOH the capability to perform on a continuing basis, assessments of the health sector designed to provide the data and information required to plan, implement, and evaluate delivery of health services which are more relevant to the needs of consumers.
- b. Establishing and testing of a pyramidal system of health care delivery and referral that will involve local Maternal Child Health Clinics (MCHC's), General Urban Health Centers (GUHC's) and a specialty pediatric hospital.
- c. Establishing within Cairo University Pediatric Hospital a Center for Social and Preventive Medicine in order to bring together the medical teaching and service delivery functions of the university with the health delivery responsibility of the Ministry of Health.
- d. Training and educating health service providers in order to upgrade the services they deliver.
- e. Developing community participation, motivation and health services outreach.
- f. Other activities, such as conducting feasibility studies and introducing low-cost innovations to improve the delivery of health services.

E. RELATIONSHIP TO OTHER HEALTH PROJECTS

There are other health-oriented activities in the Greater Cairo area that relate in varying degrees to this project. The World Bank (IBRD) is supporting a project in Community-Based Integrated Family Planning and Maternal and Child Health for North Cairo and several rural areas. The Bank project design incorporates components similar to those in this Urban Health Project, but differs in that it confines itself exclusively to MCH activities, strengthens information, education and communications (IE&C) capabilities at the MOH level, and will experiment with a community incentive package. Within the MOH, comparisons of the two projects will be made and beneficial experiences gained in either project area can be transferred to the other. — RP

The USAID-funded Family Planning Project supports the family planning efforts of the MCH Clinics, as well as assists in the upgrading of the Al-Galaa Maternity Hospital, which will serve as a tertiary referral point for obstetrics and gynecology patients from the demonstration area facilities.

The USAID-financed Rural Health Project is attempting to overcome constraints in the delivery of rural health services. Interventions and practices developed in the Rural Health Project might be applicable to this project.

Annex T provides more details on other assistance activities in the urban health area, including information about the USAID-supported Cairo Metered Water Service Connection, Cairo Sewerage, and Public Water Fountain Projects.

I. PROJECT SPECIFIC ANALYSES

A. ECONOMIC ANALYSIS

The current health services delivery system is not effective. People are not receiving the desired services when and where it is most appropriate. The project is designed to provide better services at appropriate levels for more people in order to improve their health status.

The project will be implemented in selected areas on a demonstration basis: to test various innovations; to devise appropriate training/re-training courses necessary to achieving the project objectives; and to determine through the health sector assessment built into the project, if the proposed system is the most effective in providing health services.

There is insufficient data developed on pre-project and expected post-project conditions to permit a full quantitative economic analysis of the project's cost effectiveness. Therefore, the project's basic justification must rest on a qualitative assessment. The essence of the assessment is that the provision of significantly improved quality and quantity of services, delivered at more appropriate levels to more than double the people previously served, will probably increase the cost per beneficiary, but this increased cost would be more than offset by tangible and intangible increases in benefits from the improved health status of the people and communities in the demonstration area.

The cost of achieving the project's objectives are summarized in Table I, page 9, on a per patient basis and compared with available data on costs per patient in the existing system. However, since not all patients and other beneficiaries of the system were known, these costs are overstated. Based on incomplete information available, as a result of the project costs per patient will be actually higher (although when MCHC costs are on a per minute of service basis, pregnancy delivery costs are 33% less and consultation costs are 15% less as a result of increased time spent per patient under the project). Whether this result is necessary to provide better and more health services will have to be addressed in the context of the health sector assessment and other evaluations under the project. However, based on a qualitative assessment of expected benefits from the project, it can be concluded that the improved services will be provided at reasonable costs per patient (see Annex E for details of the economic analysis).

Benefits from the project are summarized below. In most cases they could be quantified only by making numerous assumptions which would lead to rather unproductive discussions of their validity. However, the fact that the benefits are not quantified does not lessen the social or economic value of improved health status in the demonstration area.

A. BENEFITS TO HEALTH SERVICE PROVIDERS

- higher technical capabilities improves income earnings potential over productive life.
- greater job satisfaction from a more efficiently run system should lead to increased productivity.
- increased awareness of needs of users.

B. BENEFITS TO HEALTH SERVICE USERS

- decrease in maternal and child mortality.
- increased income due to longer working lives and higher productivity.
- savings from reduced waiting and travel time.
- earlier detection of illness reduces patient treatment costs.
- through family planning, savings from undesired births.
- savings from averted inappropriate treatment expenses of traditional system.
- reduction in morbidity.

C. BENEFITS TO HEALTH DELIVERY SYSTEM

- capacity of existing MCHC system for deliveries increased 36%, and capacity of total system increased 134%.
- capacity of existing MCHC outpatient system increased 27%, and capacity of total system increased 118%.
- reduced costs per patient by diverting demand to lower cost MCHC's or GUHC's rather than seeking services at the pediatric hospital.
- more appropriate services delivered at lower level will mean better service provided to more seriously ill at higher level.
- earlier detection and treatment of illnesses will reduce demand for services at higher levels.

D. BENEFITS TO COMMUNITY

- reduced morbidity and mortality rates.
- improved planning, research and implementation of health services.
- improved sanitary conditions
- more community control and involvement in delivery system to affect change.

In order to insure that the project was not oversupplying services, demand was analyzed (Annex E). The results are summarized in Table 2, page 9, and show that the minimum potential demand at the end of the project exceeded each of the supply of services. The excess demand initially will have to be satisfied through alternative systems. However, if the project is successful, a plan will have been devised to replicate and expand the system to meet a greater portion of the excess demand.

TABLE 1
Comparative Costs Per Patient

<u>Unit</u>	<u>Service</u>	<u>Total Cost in LE</u>		<u>Operational Costs in LE</u>	
		<u>Pre-Project</u>	<u>Post-Project</u>	<u>Pre-Project</u>	<u>Post-Project</u>
MCHC	Delivery ^{1/}	6.91	8.27	3.73	5.07
	Outpatient ^{2/}	.46	.59	.25	.36
GUHC ^{3/} (excl. MCHC)	Specialty Outpatient	NA	.81	NA	.53
Pediatric Hospital	Outpatient	NA	1.20	.40	.72
	Inpatient	NA	191.80	NA	130.40

^{1/}Delivery inpatient costs per minute of service are LE .06 and LE .04 respectively for pre-and post-project. Total outpatient costs per minute of services are LE .20 and LE .17 respectively for pre-and post-project.

^{2/}No data available on current or future level of dental care so costs are overstated by some factor.

^{3/}No data available on other GUHC beneficiaries from dental services, school health programs, and health bureau services, such as community sanitation and food inspection; therefore costs per beneficiary are overstated.

NA = Not applicable.

TABLE 2

Total Health System Capacity and Demand in the Demonstration Area
 (000 People)

<u>Unit</u>	<u>Service</u>	<u>Existing Capacity</u>	<u>Capacity After Project (1983)</u>	<u>Minimal Potential Demand 1983</u>
MCHC	Delivery	15.4	36.0	53.0
	Outpatient	439.3	957.5	1,224.0
GUHC (excl. MCHC)	Outpatient	NA	806.4	1,200.0
Pediatric Hospital	Outpatient	300.0	300.0	NA

In the present Five-Year Plan, the MOH has allocated LE 12,500,000 to establish GUHC's. These centers will incorporate MCHC's, School Health and Public Health Bureaus. The MOH is not planning to build any more independent MCH Clinics, School Health or Public Health Bureau facilities. However, if the health sector assessment and evaluations performed by the project determine the project pyramidal health services delivery system to be the most cost effective method, then these resources can be reallocated to replicate the system in other urban areas.

B. SOCIAL ANALYSIS

In January, 1978, a preliminary investigation of health care services in the Greater Cairo area was undertaken by the Ministry of Health to determine (a) utilization patterns of beneficiaries, (b) assessment of beneficiaries' views on existing health services, and (c) collection of socio-cultural data relevant to individuals' perceived notions of disease, nutrition and health. A team of fifty-seven social workers using questionnaires surveyed the Greater Cairo area. In June and July of 1978, a follow-up anthropological study was conducted in the demonstration area. On-site fieldwork observations were carried on in 14 centers and the Cairo University Pediatric Hospital. A battery of methods that included interviewing both beneficiaries and health practitioners (doctors, dentists, pharmacists, nurses, nurse/midwives, social workers, dayas and health barbers, etc.) was used. Moreover, statistical data were collected by the researchers that participated in the study. The social analysis (Annex F) is based upon these studies.

The physical environment of the project area, as well as the cultural milieu vary considerably from one district to another. This diversity is due to the historical occupational specialization of each district. For example, South and West Cairo are the oldest districts of the city where many craftsmen and traders have opened shops and small factories. Helwan is a relatively new industrial area with numerous factories. This area draws recent migrants from rural parts of the country seeking better employment opportunities.

The project area includes some of the most densely populated areas in the world. The number of persons per square kilometer ranges from not quite 50,000 in Helwan to over 136,000 in West Cairo. This high density is coupled with deteriorating physical structures and very poor hygienic conditions.

1. Community Attitudes

In the old districts of the demonstration area in South and West Cairo, traditional values of gallantry and strong community ties still prevail and can be traced back to Cairo's medieval tradition. Communal social activities take place in the small alleys of the districts, and a strong sense of belonging characterizes these districts. In contrast to this feeling of social solidarity, Helwan manifests weaker community ties since it is a sprawling industrial area and many of the workers are non-resident and commute daily from their places of residence.

Some of the deeply rooted beliefs affecting utilization of health facilities are concepts of illness from both natural and supernatural causes. Dual systems of formal and informal health practitioners exist. The usefulness of both folk and modern medicine is perceived by many in the target group.

Most of the users of the MCH Clinics in the project area are women of child-bearing age who occasionally frequent MCH Clinics seeking medical treatment, medications, assistance in deliveries and health information.

2. Consumer Perception of the Health Delivery System

The target group hold the following attitudes and beliefs concerning health:

- a. Many urbanites have demonstrated a more flexible attitude than rural dwellers towards family planning and modern medicine.
- b. The poorer the urban resident, the more likely he/she is to seek initial medical care at a local health center.
- c. A pregnant woman is not considered sick; hence, she should not see a physician until she develops a medical problem.
- d. Perceptions of the quality of service at a health center influence heavily the degree of utilization of the facility.
- e. The concept of preventive health is recognized, but rarely practiced.
- f. Hospitals are preferred for primary health care because the group perceives it receives better treatment from them than from other Government facilities.
- g. Many are receptive to health education but feel that it is not provided in most facilities.
- h. The group believes that the health status of an individual is the result of both natural and supernatural agents.
- i. Health education and information is obtained first from family members, community friends, and locally recognized wiser and older people, rather than the formal health system.
- j. Beneficiaries tend to evaluate health care services in terms of visibility and use of technological equipment.
- k. Personalized care, whether in the form of treatment by medical personnel or in the prescription of medicine, is highly regarded.
- l. The sex of the doctor is not as important a factor in the evaluation of health care as is the quality of humanized care and trust/confidence in the medical personnel.
- m. Many mothers complain about the informal fee that midwives ask from them and resent the harsh treatment and attitudes they experience when they cannot afford to pay.

n. Some believe that the health personnel withhold medical provisions from them.

o. Many believe that inadequate records of their cases are kept.

p. Many feel that the health system is dominated by the providers and that there is little they can do to influence the style, quality or method of health delivery designed for them.

3. Health Provider Perception of the Health Delivery System

Sociological and anthropological studies during project development surveyed the attitudes of health administration and program direction personnel, doctors, nurses, midwives, assistant midwives and other health providers. They revealed the following provider attitudes concerning the urban health system:

a. There is a need for more resources, including additional health units and additional equipment.

b. There is a need for additional human resources, particularly auxiliary personnel and nursing staff.

c. Patient caseloads could be eased by the additional use of auxiliary personnel.

d. Resources are maldistributed and physical facilities are poorly located in the various health zones.

e. There is a low level of health awareness on the part of the public.

f. The system is poorly administered and managed.

g. There is a lack of service integration.

h. Health personnel lack popular support.

i. There is a lack of personal incentives to provide better health care.

J. Most participants believe that the administration of the system could be improved.

4. Compatibility of the Project

None of the attitudes held by either health providers or consumers is incompatible with the intents and purposes of the project. The project will not introduce any new features disruptive to the socio-cultural beliefs of the people living in the demonstration area. Some of the beliefs, in fact, reinforce the decision to move toward a pyramidal health delivery system with primary care being provided at the local level.

While the project is socially and culturally feasible, many of the elements of this project will be of critical importance in order to capitalize on consumer beliefs toward health care. Consumer participation in the project and better communication between consumers and providers is an example.

To accommodate these practices and beliefs to the project, the following guidelines will be adhered to:

- A community leader from each of the three areas will be invited by the zone health Director to represent the zone on the Executive Board of the project.

- Interested local women who have their networks of friends, neighbors and relatives will be encouraged to cooperate with the MCH. A system of incentives that might include small gifts can be most effective in encouraging the participation of these women.

- Local dayas and other traditional health practitioners will be encouraged to cooperate with the MCH Clinics.

Other actions that will be taken under this project to ensure compatibility with socio-cultural beliefs will include:

- Testing innovations such as pre-packaged individual prescriptions.
- Improved record keeping.
- Fully provisioning health centers' pharmacies with medical supplies so that they are continually available.
- Using clinic reception areas to provide nutrition, family planning and health education for waiting health consumers.
- More efficient operations permitting more time per patient and more personalized health care.

Just as this project is designed to take into account health consumers' attitudes, it also is constructed to take into account health providers' perceptions and beliefs. The health sector assessment and resulting better planning should help alter the misallocation of resources involving both physical facilities and manpower resources. The training program should help improve the level of skills as well as provide additional auxiliary personnel. This program should have a significant impact on the quality of service being provided as lower level personnel gain the opportunity to improve themselves and advance upward in the system. Greater efficiency and better care should result from improved organization and more concise job descriptions. Training, better supervision and improved staff management and motivation also should help achieve this goal. This should free more highly skilled personnel for more sophisticated tasks and fully use the talents of auxiliaries and paraprofessional staff. Better incentives, newly designed information programs and the use of local community residents and traditional practitioners should improve the community outreach of the system. This will stimulate greater attention to preventive medicine practices as well as encouraging greater acceptability of the local health unit.

5. Role of Women

The project will enhance the status of women in two major ways: by improving their physical well-being and by increasing their worth as health providers.

Women of childbearing age (estimated between 340,000 and 425,000) in the demonstration area will be among the primary target group for attention in this project and will derive direct health benefits from this project; mortality and morbidity will be reduced, and they will be better able to control their reproduction.

Women comprise a significant portion of the labor force that provides health care. About 25% of physicians, 100% of nurses, 40% of pharmacists, 15% of other paramedical, and 100% of dayas are female. The project will upgrade women's professional and vocational levels, and increase awareness of their worth, in terms both of selfimagery and in peer relationships.

C. ADMINISTRATIVE FEASIBILITY

The Ministry of Health has had experience in conducting activities of a similar nature to this project. Currently it is carrying out a rural health project, and the MOH is administering a host-country contract with a U.S. firm to implement the project. USAID believes that the MOH is satisfactorily administering this contract and fully capable of insuring that it is carried out. The MOH is implementing an IBRD-funded family planning project. Under previous IBRD-funded family planning activities, the MOH has had considerable experience in contracting, contract administration and working with local and foreign A & E firms. Based on its past performance and additional staff available for this project, USAID believes that the Ministry should have the capacity to deal with the A & E firms and the long-term host country contractor needed for this project.

In the past the Ministry of Health has found that where other agencies are involved, an Executive Board can be successfully utilized for overall project management. This system will be used for this project. Annex H provides further details of administrative arrangements, which are summarized below.

1. Organization

a. Central Administration

The Ministry of Health will be the implementing organization for this project. An Executive Board, chaired by the First Undersecretary of the Ministry of Health, will be comprised of representatives from the Cairo Governorate, Cairo University, Health Insurance Organization, Cairo Medical Care Organization, Ministry of Social Affairs, and one resident representative from each of the three health zones involved in the project. The Board will have overall responsibility for establishing policy, coordinating activities between agencies and overall management of the project. An Executive Director, appointed by the Ministry of Health, will serve as the Manager and will have overall responsibility for the day-to-day management of the project. He/she will also serve as a member of the Executive Board and will operate under the direction of the Chairman of the Board. A technical office will be established to assist the Executive Director in undertaking the managerial duties and responsibilities of project implementation.

b. Administration in the Health Zone

Within the South and West Cairo and Helwan health zones the management of the project will be the responsibility of the

Director of Health Services in each zone, who will be designated as an Assistant Executive Director in addition to his regular duties and responsibilities. He will be advised by a steering committee of zone local officials and two residents of the zone. Technical guidance for project activities will come from the Executive Board.

c. Cairo University Pediatric Hospital Participation

The Center for Preventive and Social Medicine will be managed by a Council of five members representing the Ministry of Health (the Project Executive Director), Cairo University (Faculty of Medicine) West Cairo health zone, a nutrition specialist, and a resident of the project area. A full-time Director of the Center will be appointed by Cairo University and will be directly accountable to the Council. The Executive Director of the Project will serve as the coordinating link between the Center and the other project participants.

The outpatient and inpatient facilities of the hospital will be under the operational control of Cairo University. The Director of the Center will provide the coordinating link between the project activities and the hospital.

2. Health Sector Planning Capability

The technologies of health sector assessment, planning and evaluation are well known to scattered Egyptian health professionals, but the institutional capability to adequately perform these functions does not currently exist within the Ministry of Health's Department of Planning. The project will develop the institutional capability within the MOH.

3. MOH Manpower

There are presently 478 persons assigned to the Maternal Child Health Clinics and General Health Centers in the project area. These include: 42 physicians, 12 dentists, and 202 nursing personnel. The Pediatric Hospital now has 51 university staff (professors, lecturers, etc.), 16 residents, 116 interns, 20 visitors (one-year term professionals) and 80 post-graduate students on its professional staff. It also has one matron, one assistant matron, 5 supervisors, 90 nurses and 130 auxiliaries.

The new primary (MCHC) and secondary (GHEC) facilities to be opened as part of this project will require some 721 additional personnel. Of the additional personnel, 48 will be physicians, 12 dentists, 10 pharmacists, and 190 nursing personnel. The pediatric outpatient portion of the complex will require one matron, one assistant matron, 2 supervisors, 40 nurses, and 20 auxiliaries. The Center staff will require an additional 5 management staff, 15 researchers, 10 social workers, and 10 clerks. Annex I provides a breakdown of personnel needed at each facility.

The professional faculties in Egypt graduate more than 3,000 physicians, 400 dentists and 800 pharmacists each year. Nursing Higher Institutions produce some 160 graduates per year; nursing technical schools produce about 3,500 graduates; and Technical Health Institutes produce more than 600 graduates per year. Out of those graduating classes the project will have no difficulty in filling the new positions for those requiring professional health training.

The GOE will covenant to provide adequate staff for the project activities.

Short-term consultants will be provided to make technical and advisory inputs into project operations. In addition, a training program will offer training for personnel who are not adequately prepared to perform the functions for which they are responsible. (Annex L.)

4. Summary

While many of the project activities will be at the governorate and sub-governorate level, GOE and USAID experience indicates that central-level coordination must be formally established in order to achieve coordination of representatives of different agencies at the local level. In this project coordination has been enhanced by the active participation of the Cairo Governorate and Cairo University in the planning of the project.

The implementation of the project through strengthened existing lower MOH administration levels is consistent with the GOE's increasing emphasis on decentralization.

The Center for Social and Preventive Medicine is an innovation. Its proper functioning will be dependent on effective coordination between the MOH and Cairo University. This coordination is more feasible than otherwise might be the case if the prototype relationship were initiated at a different university. This is because of the prestige and respect Cairo University enjoys as it contains Egypt's oldest (150 years) Faculty of Medicine. Its graduates through the years have been leaders in the evolution and formulation of the MOH and most MOH senior officials are alumni.

D. TECHNICAL FEASIBILITY AND CONSIDERATION OF ALTERNATIVES

1. Health Services

The ECTOR survey described the problems and needs in health care delivery in Cairo. In addition to the requirements for improving health planning through urban health sector analysis, the report recommended several possible approaches for developing more efficient and cost-effective health care services in Greater Cairo. (See Annex R for the report's summary and recommendations.) In making the recommendations, the report took cognizance of the six separate and parallel, but loosely related formal health delivery systems. These alternative approaches were developed by a number of top-level Egyptian health service directors and policy-level officials. Based upon the findings in the ECTOR report, the possible approaches recommended were:

- a. To allow the six health service systems to remain independent but to establish a planning body for Greater Cairo health services to guide the development of the six systems in response to market needs and demands.
- b. To set up a demonstration or pilot project in one or more districts to integrate MOH services with university health services.
- c. To provide the Greater Cairo region with a chain of small polyclinics, one for each 100,000 citizens in which specialized services would be offered in addition to generalized health care services.

d. To establish a functional rather than a sectoral approach to health care. This approach would involve the upgrading of MCH/FP and school health peripheral facilities and would include additional staffing, equipment, supplies and the provision of incentives.

e. A final recommendation to be incorporated with any of the approaches mentioned above, called for the development of a Center for Social and Preventive Medicine to provide multidisciplinary activities including services, education, training, research, and planning. The Center should be attached to a university hospital, preferably a children's hospital, and should be jointly managed by both the MOH and the university.

An alternative approach not mentioned in the report would be to concentrate on supporting development of informal community systems of improving health care, with minimal or no attention to the existing formal health delivery system. But while the GOE appears receptive to increased community participation, such an approach would be unacceptable in the absence of improvements in the obvious deficiencies in the delivery of services through the formal system, and probably would not be supported by the GOE. The GOE would prefer to develop mechanisms to strengthen community participation as an extension of the formal system.

The project is a technically feasible blend of most of the underlying principles of these recommendations. The only recommendation which is not reflected in this project is the costly development of a chain of polyclinics in the Greater Cairo area.

The proposed project responds to the needs expressed by these recommendations in the following ways:

a. On the need for basic and continuing planning for the proper development of health services, the project supports a health sector analysis activity for the demonstration area and the Greater Cairo area. This will develop and institutionalize planning capabilities in the MOH, and should assist in rationalizing expenditures on health services and assist in reducing the unjustifiable duplication and waste in some services.

b. On the need for contributing to the coordination of the six health systems, the project will provide a coordinating mechanism through the Executive Board in which the various health systems in the demonstration area will be represented, as will be the Ministry of Social Affairs and consumers' representatives.

c. The proposed pyramidal health system responds to the suggestion for upgrading peripheral MCH/FP services and establishing a referral system within both the MOH and university tertiary health services. In addition, the project is supporting an intensive outreach home visiting program using health personnel, natural leaders, and traditional health workers.

d. On integrating MOH and university services, the project supports the development of a Center for Social and Preventive Medicine to serve as a link between both health systems and to provide a mechanism and facility for manpower development through education and training.

e. On the need for manpower development, the project is supporting an extensive and comprehensive training program directed to all categories of personnel in the project area.

f. On the need for health education programs, the project will develop an information, education and communication program for all health personnel to disseminate information on MCH/FP, nutrition, environmental health and sanitation.

The major innovations of this activity are in the realm of administration, management, supervision and community linkages rather than in introduction of new medical technology. Oral rehydration, home visiting, nutrition education and a full portfolio of non-surgical contraceptive services are theoretically now available in MCH Clinics. In fact, however, few Clinics are functioning well in these areas. The means of teaching these technologies are available in Egypt, and no legal changes are required to have them adopted. The same applies to the provision of other non-oral forms of rehydration to be established at each GUHC, all outpatient contraceptive services, and improved pre- and postnatal services. Another major innovation will be the cooperation of the Ministry of Health and health educators to better relate medical education to service needs. For some 30 years this gap has been recognized, but few attempts to bridge it have succeeded. The lines of communication that will be formed in the Cairo University Pediatric Hospital and Center for Social and Preventive Medicine should stimulate greater efforts in the critical area of family planning and maternal and child health care.

One final different course of action has been suggested. For some time the Egyptian Government has been seeking A.I.D. assistance for the construction of a large university teaching hospital. Because of the extensive needs of the health system and the decision to pursue the development of a project activity responding to needs at the lowest local level, USAID has rejected the financing of such a hospital in favor of this more comprehensive, appropriate and technically feasible project.

E. CONSTRUCTION FEASIBILITY

Two Egyptian engineers performed the basic analysis of construction needs in July, 1978. The analysis was examined by USAID engineers and concurred in except for the amounts of funds recommended for A & E fees. The A & E fees were increased to reflect USAID experience in other contracts. Detailed analysis is contained in Annex K.

Based on this analysis and Mission review, the proposed renovation and construction are feasible and the adjusted costs are reasonable. This information meets the requirements of Section 611 a(1) of the Foreign Assistance Act.

Three categories of construction related activities will be undertaken through this project:

- Renovation of 10 MCHC's.
- Construction of 8 new GUHC's.
- Construction of a new central pediatric unit in Abou El-Rish Pediatric Hospital.

1. Maternal Child Health Clinics

All existing MCHC's are of varying ages and states of disrepair. They average 700 square meters in size. Structurally all centers are sound, but need maintenance and renovation, which may include extensive reallocation of space, repairs to sanitary and electrical facilities and painting. The survey classified the centers in the following categories:

- Category I - no renovation needed for 2 clinics.
- Category II - medium renovation needed for 4 clinics at an estimated cost of L.E. 40/square meter
- Category III - extensive renovations needed for 6 centers at an estimated cost of L.E. 70/square meter.

Total costs for all renovations of MCH Clinics is estimated to be L.E. 420,000.

2. General Urban Health Centers

Fourteen GUHC's will be needed, of which six already exist. This project provides for the construction of 8 new GUHC's.

Approximately 1,300 square meters of space will be required to make these units viable and efficient. The base cost of the units is estimated to be L.E. 230/square meter, or approximately L.E. 300,000 per unit. For eight units the total cost is L.E. 2,400,000.

The buildings will be of a construction type standard to Egypt; no technical problems are anticipated.

3. Pediatric Hospital Unit

This unit will be a four-story outpatient annex to an existing pediatric hospital; however, facilities for 50 beds will be provided. A total area of approximately 7,500 square meters will be needed. Similar buildings cost approximately L.E. 300 per square meter. The total building cost is estimated to be L.E. 2,250,000 (\$3,217,500.)

Construction may be of a standard reinforced concrete frame type, or of imported prefabricated steel frame. Since the complex must be available early on during project implementation, a decision as to reinforced concrete or steel design will be based on cost and benefits available to beneficiaries from early completion.

4. Architect and Engineering Services - Construction Supervision

An Egyptian architectural and engineering firm will be contracted by the MOH for renovation of the MCH clinics.

An American architectural and engineering firm will be contracted by the MOH for the design of the GUHC's and Central Pediatric Unit. It will also supervise construction and renovation of these facilities.

Final designs and firm cost estimates will be available before IFB's for construction will be issued.

5. Equipment Requirements

Equipment, furniture and medical supply needs have been estimated during the engineering survey of the proposed new facilities. These requirements have been reviewed by the Ministry of Health and are in line with standard provisions for MCH and GUHC's and taking into account supplemental needs resulting from this project. Annex K provides preliminary information on supply needs. Approximately \$4.8 million will be needed for equipment and supplies for the newly constructed or renovated facilities included in this project. The technical services contractor for this project will be responsible to work with the MOH in developing technical specifications for the equipment, arranging for its procurement, and coordinating this with the A & E and construction activities. The contractor will monitor the procurement of materials available in Egypt as well as those which must be procured in the United States. The Mission has reviewed the general equipment needs and they are feasible and cost estimates are reasonable.

F. ENVIRONMENTAL IMPACT

An Environmental Impact Identification and Evaluation form was completed for this project. (See Annex J.) The only significant environmental impact of the project was found to be the temporary disruptions normally associated with construction projects in urban areas. As a result, the Mission Director recommended that an Environmental Assessment not be required.

V. FINANCIAL PLAN

A. SOURCE AND APPLICATION OF FUNDS

The total cost of the project is estimated at \$44.6 million. A.I.D. will provide a grant of \$25.3 million. The GOE will contribute \$19.3 million equivalent in kind and cash, or 43% of total project costs. The A.I.D. input will be provided as follows: \$2.6 million in FY 1979 and the remainder, subject to the availability of funds, in accord with the proposed budget shown in block 11 of the facesheet.

A.I.D. funds will be utilized for all foreign exchange requirements, which are estimated to be approximately 50 percent of the U.S. cost of the project. Major components of those costs will be the procurement of technical and A & E contract services, participant training, and commodities from the U.S. Types of materials which will be imported for the project include building materials, medical equipment and supplies, vehicles, training equipment, and IE&C materials.

Approximately 50% of the U.S. input to this project will be utilized for local currency funding. This will support such items as the construction and renovation of health center facilities, the health sector assessment, and training and upgrading of staff. By the time this project begins full implementation and heavy local currency expenditures will be required, Egypt will be leaving the status of an excess currency country. A.I.D. has determined that for certain types of projects it will provide dollar funding to purchase Egyptian pounds. The type of projects include those that would have a significant impact on meeting the needs of the poor majority or that would encourage the Egyptian Government to undertake new policy initiatives affecting the country's poor that it otherwise would not initiate. The Urban Health Project meets both these criteria. Justification for the use of dollar funds in association with local currency expenses is provided in Annex S.

B. FINANCIAL VIABILITY OF THE PROJECT

Most institutions in the project already exist and operating budgets are being funded. Additional costs of the project which are of a recurring nature will represent about three percent of the 1978 MOH annual budget. For those new entities that will be created for this project, the Ministry of Health should be able to budget for them given the extremely small amount of MOH resources that they will require. The GOE will covenant that it will provide all necessary resources for new and ongoing operating expenses.

C. PAYMENT OF FUNDS AND AUDIT

The specific procedures for payments under the project will be detailed in the Grant Agreement or in Project Implementation Letters (PIL's). Payments will be made in accordance with U.S. Government regulations and policies. Payment in dollars will be either through direct letters of commitment or letters of commitment to a U.S. bank. It is probable that payments for local costs will be handled by an initial advance to the Grantee for expenses anticipated for a period of three months. Accountability would be every three months, and additional advances would be subject to the acceptability of such accountability by A.I.D. The MOH will develop a regular system and schedule to audit the financial accounts established under the project. This audit function will be the sole responsibility of the MOH, with such GOE audit assistance

as appropriate. In keeping with standard U.S. G. procedures, A.I.D. reserves the right to audit U.S.G. financed goods and services.

Three tables follow, "Summary Cost Estimate and Financial Plan," "Projection of Expenditures by Fiscal Year," and "Costing of Project Inputs/Outputs." Additional financial information is found in Annex M.

SUMMARY COST ESTIMATE AND FINANCIAL PLAN
(\\$000)

Project 263-0065

Title: Urban Health Care Delivery System

SOURCE	AID			GOE	COMBINED		
	FX	LC	TOTAL		FX	LC	TOTAL
<u>USE</u>							
Technical Assistance	1,627	677	2,304	1,326	1,627	2,003	3,630
Training	497	220	717	-	497	220	717
Commodities	4,717	549	5,266	-	4,717	549	5,266
Construction	2,510	4,662	7,172	-	2,510	4,662	7,172
A & E	493	224	717	-	493	224	717
Other/Recurring Costs	23	1,192	1,215	4,506	23	5,698	5,721
Land	-	-	-	6,538	-	6,538	6,538
Buildings & Facilities	-	-	-	3,432	-	3,432	3,432
<u>Sub-Total</u>	9,867	7,524	17,391	15,802	9,867	23,326	33,193
<u>Inflation</u>	2,154	4,524	6,678	3,586	2,154	8,110	10,264
<u>Contingency</u>	601	602	1,203	-	601	602	1,203
<u>Project Total</u>	12,622	12,650	25,272	19,388	12,622	32,038	44,660

PROJECTION OF EXPENDITURES BY FISCAL YEAR
(000)

Project: 261-0065

Title: Urban Health Care Delivery System

	Fiscal Year																		
	1			2			3			4			5			Combined			
	FX	LC	TOT	FX	LC	TOT	FX	LC	TOT	FX	LC	TOT	FX	LC	TOT	FX	LC	TOT	
AID Inputs																			
Technical Assistance	345	137	482	418	194	612	288	118	406	288	108	396	288	120	408	1,627	677	2,304	
Training	59	67	126	94	42	136	99	41	140	106	41	147	139	29	168	497	220	717	
Commodities	407	29	436	1,411	63	1,474	2,715	404	3,119	92	27	119	92	26	118	4,717	549	5,266	
Construction	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
A & E	296	134	430	174	82	256	275	511	786	-	-	-	-	-	-	2,510	4,662	7,172	
Other Costs	3	221	224	-	218	218	23	8	31	-	-	-	-	-	-	493	224	717	
Sub-Total	1,110	588	1,698	4,332	4,750	9,082	3,420	1,331	4,751	486	418	904	519	477	996	9,867	7,524	17,391	
Inflation	111	118	229	833	2,846	3,679	812	913	1,725	170	280	450	228	367	595	2,154	4,524	6,678	
Contingency	61	35	96	273	406	679	197	86	283	33	35	68	37	40	77	601	602	1,203	
Total-AID	1,282	741	2,023	5,438	8,002	13,440	4,429	2,330	6,759	689	733	1,422	784	844	1,628	12,622	12,650	25,272	
GOE Inputs																			
Personnel	-	79	79	-	160	160	-	183	183	-	438	438	-	466	466	-	1,326	1,326	
Land	-	6,538	6,538	-	-	-	-	-	-	-	-	-	-	-	-	-	6,538	6,538	
Building & Facilities	-	3,432	3,432	-	-	-	-	-	-	-	-	-	-	-	-	-	3,432	3,432	
Other Recur. Costs	-	499	499	-	651	651	-	719	719	-	1,216	1,216	-	1,421	1,421	-	4,506	4,506	
Sub-Total	-	10,548	10,548	-	811	811	-	902	902	-	1,654	1,654	-	1,887	1,887	-	15,802	15,802	
Inflation	-	116	116	-	308	308	-	469	469	-	1,108	1,108	-	1,585	1,585	-	3,586	3,586	
Total-GOE	-	10,664	10,664	-	1,119	1,119	-	1,371	1,371	-	2,762	2,762	-	3,472	3,472	-	19,388	19,388	
Total-Project	1,282	11,405	12,687	5,438	9,121	14,559	4,429	3,701	8,130	689	3,495	4,184	784	4,316	5,100	12,622	32,038	44,660	

COSTING OF PROJECT INPUTS/OUTPUTS
(\$000)

25

Project: 263-0065

Title: Urban Health Care Delivery System

	1			2			3			4			5			6			Combined			
	FX	LC	TOT	FX	LC	TOT	FX	LC	TOT	FX	LC	TOT	FX	LC	TOT	FX	LC	TOT	FX	LC	TOT	
AID-Inputs																						
Tech. Assist.	325	135	460	244	102	346	162	68	230	82	34	116	407	169	576	407	169	576	1,627	677	2,304	
Training	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	497	220	717	497	220	717	
Commodities	-	-	-	204	36	240	1,363	-	1,363	2,639	377	3,016	466	50	516	45	86	131	4,717	549	5,266	
Construction	-	-	-	210	390	600	1,200	2,229	3,429	1,100	2,043	3,143	-	-	-	-	-	-	2,510	4,662	7,172	
A & E	-	-	-	-	60	60	257	85	342	236	79	315	-	-	-	-	-	-	493	224	717	
Other	23	325	348	-	-	-	-	-	-	-	-	-	-	867	867	-	-	-	23	1,192	1,215	
Sub-Total	348	460	808	658	588	1,246	2,982	2,382	5,364	4,057	2,533	6,590	873	1,086	1,959	949	475	1,424	9,867	7,524	17,391	
Inflation	86	227	313	151	348	499	646	1,562	2,208	883	1,607	2,490	194	579	773	194	241	435	2,154	4,524	6,678	
Contingency	25	36	61	42	48	90	180	199	379	246	207	453	54	77	131	54	35	89	601	602	1,203	
Total-AID	459	723	1,182	851	984	1,835	3,808	4,143	7,951	5,186	4,347	9,533	1,121	1,702	2,823	1,197	751	1,948	12,622	12,650	25,272	
GOE-Inputs																						
Personnel	-	30	30	-	105	105	-	878	878	-	169	169	-	72	72	-	72	72	-	1,326	1,326	
Land	-	-	-	-	1,367	1,367	-	4,228	4,228	-	943	943	-	-	-	-	-	-	-	6,538	6,538	
Build. & Fac.	-	-	-	-	1,716	1,716	-	1,716	1,716	-	-	-	-	-	-	-	-	-	-	3,432	3,432	
Other Recur. Costs	-	3	3	-	1,472	1,472	-	2,386	2,386	-	629	629	-	8	8	-	8	8	-	4,506	4,506	
Sub-Total	-	33	33	-	4,660	4,660	-	9,208	9,208	-	1,741	1,741	-	80	80	-	80	80	-	15,802	15,802	
Inflation	-	-	-	-	1,040	1,040	-	2,080	2,080	-	396	396	-	35	35	-	35	35	-	1,586	1,586	
Total-GOE	-	33	33	-	5,700	5,700	-	11,288	11,288	-	2,137	2,137	-	115	115	-	115	115	-	19,388	19,388	
Total Project	459	756	1,215	851	6,684	7,535	3,808	15,431	19,239	5,186	6,484	11,670	1,121	1,817	2,938	1,197	866	2,063	12,622	32,038	44,660	

1. Health Sector Assessment; 2. MCH Clinics; 3. General Urban Health Clinics (GUHC); 4. Pediatric Hospital and Center for Social and Preventive Medicine; 5. Other Activities (Information & Communication (IE&C), Innovative Interventions (II) and Feasibility Studies; 6. Training.

IMPLEMENTATION PLAN

A. OVERALL RESPONSIBILITY

1. GOE

The Ministry of Health (MOH) with advice and assistance from the Executive Board, will be responsible for carrying out the project.

The Executive Board, chaired by the First Undersecretary of the MOH, will provide inter-agency policy and managerial guidance to the Project Executive Director, to be appointed by the Minister of Health, who will be in charge of day-to-day operations, coordination and timely utilization of the inputs from the various participants and assurance of implementation in accord with the implementation schedule.

The Minister of Health or his designee will serve as contracting and procurement officer for the procurement of technical services, architectural, engineering and construction services, and commodities financed under the project, except in those cases where A.I.D. may in the Grant Agreement reserve the right to contract. All Ministry contracts will be in accord with A.I.D. regulations and will be approved in advance by A.I.D.

Additional administrative details of project management are found in the Administrative Analysis Section, and in Annex E.

2. A.I.D.

An A.I.D. Project Officer will be designated whose primary responsibility will be to monitor project implementation to assure A.I.D. regulations and policies are complied with, and to serve as A.I.D. liaison with the GOE Project Director. In the latter function, the A.I.D. Project Officer will be an observer on the Project Executive Board. A regular reporting system will be devised.

The A.I.D. Project Officer will be the chairman of the USAID Project Committee consisting of representation from the USAID Program, Engineering, Financial Management, Legal and Health and Population Division staff. The Committee will assist the Project Officer in reviewing project implementation, GOE performance in meeting conditions precedent and fulfilling covenants implementing the project, and in performance evaluation.

B. IMPLEMENTATION OF MAJOR ELEMENTS

The major elements of the project will be carried out as follows:

1. Planning, Evaluation and Health Sector Assessment

Although health planning methodologies are known in Egypt, the capacity to perform them is not institutionalized; therefore, Egyptian contract assistance will be provided to the MOH in developing the techniques and conducting the assessment, which is phased as described in Annex D. The contractor may utilize U.S. consultants as considered appropriate by the MOH and USAID.

The planning, programming, and evaluation functions will be coordinated by the Office of the Executive Project Director, but will be located in the MOH Department of Planning and will have access to the highest policy-making levels within the Ministry. An initial assessment in the demonstration area will help rationalize health services delivery within the demonstration area (and later in Greater Cairo). It will provide information and make recommendations for implementing innovations over the life of the project, establish benchmarks against which results of the innovations can be evaluated and assist in their evaluation.

While the initial assessment will provide valuable data for the project, a procedural manual will be developed as a part of this exercise to guide in future assessments, and the results of the assessment will be published to provide decision-makers with a rational basis for planning health service activities and allocating resources for investment in the health sector in Greater Cairo. This process will institutionalize a badly needed technology to continually evaluate and improve health services. This will be a major step forward since health planning in Egypt currently is primarily a budgeting process, largely because the analytical process to produce information permitting a choice between various alternative courses of action to achieve specific health objectives and targets has never been accomplished.

2. Pyramidal Services Delivery

While the Egyptian clinic system for health care delivery was well conceived and may have functioned effectively in the past, it is totally inadequate for the current rapidly growing population. Although Maternal Child Health Clinics (some of them 30-40 years old), Health Bureaus (for vital registration, immunizations, and food sanitation), and school health units are currently operating in the demonstration area, the burgeoning urban growth, inadequate management of resources for social services (including health), inadequate incentives to stimulate personnel performance, insufficient maintenance and inadequate supervision and administration have all taken their toll.

Under this project, the MOH will establish and test a pyramidal system of health care delivery and referral that will involve local Maternal Child Health Clinics (MCHC's), General Urban Health Centers (GUHC's), and a specialty pediatric hospital. With better staffed and functioning local MCHC's, increased community knowledge of and confidence in them resulting from greater outreach efforts and involvement of community leaders, the involvement of traditional health care and professional medical care personnel, and a referral system for sophisticated needs, people in need of health care will be encouraged to seek it from local facilities better able to provide low-cost care. Only those patients with needs that cannot be met at the local and intermediate levels will be referred to hospital facilities. Stimulating community interaction with the Clinics will encourage expanded community participation in family planning activities, increased attention to preventive measures such as better nutrition, immunization and vaccination, and better sanitation.

The project will actively seek ways to improve the deteriorated sanitation and environmental condition in the project area. This will be done in part by improving the food and sanitation inspection functions of the Health Bureaus and by emphasizing sanitation in health education to be provided by

health service personnel and Home Visitors. Additional ways will be sought to instill concepts of proper water usage and solid waste disposal, and to mobilize community efforts for neighborhood clean-up campaigns.

a. Primary Level Care

At the primary level, Maternal and Child Health Clinics will provide the following services with primary emphasis on preventive medicine and on maintenance of health: (i) ante- and post-natal care of mothers and infants; (ii) well baby and "under five" clinics; (iii) childhood immunization; (iv) nutritional advice and interventions, including oral rehydration; (v) preventive dental care and simple general dentistry; (vi) family planning services excluding surgical interventions; (vii) simple clinical laboratory services; (viii) general health education and community outreach by visiting nurses and social workers. (See Annex G-1.)

In the demonstration area there are currently fourteen free standing MCH Clinics, each designed to serve a population of 50,000 people. In addition there are four MCH units incorporated in existing GUHC's described below. With the proper upgrading of facilities and equipment, and qualification of staffs, the MOH is convinced that it can serve an ever larger number of mothers and young children. At the present time Egyptian health officials are not sure of the ultimate fate of the peripheral MCH Clinics. Some feel their functions can be completely absorbed by the General Urban Health Centers; others feel there will be a continuing need for these simpler, easily accessible MCH facilities. Experience gained in the project will contribute to resolution of this issue. Of the fourteen free standing MCH Clinics in the project area, ten need various levels of renovation, repair, and equipping. Two will be upgraded in the context of the GUHC's to which they are attached and two others aren't worth repairing. The project will finance the needed physical upgrading to these facilities through MOH contracts with Egyptian firms for both the A & E services and renovation. See Annex K.

b. Secondary Level Care

The secondary or intermediate level of care will be provided by GUHC's. They provide the following services: (i) all the functions of the Health Bureaus; (ii) all the functions of the MCH Clinics; (iii) all school health functions; (iv) appropriate therapeutic interventions at the general practice physicians' level including, first aid, diagnosis and treatment of the majority of illnesses; treatment of early and moderately severe malnutrition, including rehydration; and appropriate referral to the tertiary level institutions; (v) all family planning services which can be performed on an outpatient basis; (vi) clinical diagnostic laboratory services including screening procedures for diabetes, etc; (vii) diagnostic x-ray; (viii) pharmacy; and (ix) health education.

The GUHC's are designed to serve a population of 150,000 people, and 14 centers will be required for the demonstration area to accommodate the estimated 1983 population of 2.1 million. Six centers already exist or are planned; but need some additional equipment and vehicles. Eight additional GUHC's will be constructed and equipped. (See Annex K.) In the Helwan health zone, A.I.D. is supporting a project for Housing and Community Upgrading for Low-Income Egyptians. A GUHC will be constructed under that project in the housing project area in accordance with the functional and space specifications of the GUHC's to be constructed under this project; it will be administered by this project.

In order to insure that equipment and facilities in the project area will be repaired and maintained, the project will finance the provision of three Maintenance Centers. The Centers will be attached to one GUHC in each of the three zones served by this project, but will be separately managed. These maintenance facilities will serve the GUHC's and the MCH Clinics. The project will finance spare parts for equipment provided under the project, during the demonstration. The GOE will provide for the normal operating and maintenance costs of the Centers and will be responsible for the provision of spare parts after A.I.D. assistance is terminated.

Fifty four personnel will be needed to repair and maintain medical equipment and to staff the Maintenance Centers. Equipment repair technicians will be secured from the graduates of the Center for Biomedical Technology in Abbasiya. Facility maintenance personnel are already available on the MOH staff.

U.S. short-term contract personnel to train the supervisory maintenance staff in the care and operation of equipment will be provided as required. In turn, the Maintenance Centers will develop an on-going maintenance training capability.

c. Tertiary Level Care

Tertiary level pediatric services will be provided by referral from lower level institutions to the Cairo University Pediatric Hospital (Abou El-Rish). Many of the referrals of obstetric and gynecology patients will be to Al-Galaa General Maternity Hospital, which is receiving assistance from the USAID Family Planning Project.

A unit to house additional outpatient facilities at the Cairo University Pediatric Hospital will be constructed. The new unit will be composed of an outpatient clinic occupying the ground floor, the Center for Social and Preventive Medicine (described below) occupying the first floor, and 50 beds for inpatients on the second and third floors.

3. Center for Social and Preventive Medicine

The Center for Social and Preventive Medicine will serve an entirely new function in the Egyptian health field. It will bring together the medical teaching function of the University of Cairo with the health delivery responsibility of the Ministry of Health.

Currently there is little interaction between medical education and health services delivery. Upon graduation, most medical doctors have little practical "hands-on" experience, particularly with pregnant women and children. Even if they do have practical training, they often lack experience in working with the urban poor, whose cultural perceptions of health care and attitudes towards modern and folk medicine may be radically different from their own. They have almost no training in family planning counseling or contraceptive technology. Other health sector personnel also suffer from a significant lack of practical experience upon their entrance into the health system. There is no existing mechanism that equips service providers with working opportunities to understand the basic health problems of the urban poor.

A systematic means of providing constant feedback into the medical education system is needed also. This would permit the modification of education and training programs to take into account practical field experience in such areas as patient perceptions and practices and how to modify them; how to encourage greater attention to preventive measures, motivation to provide family planning practices, understanding conditions in the poorer urban areas, and greater cultural sensitivity on the part of service providers.

Finally, there is a need for a system to provide continuing education to doctors, nurses, midwives, auxiliaries and other health system personnel. Once out of the formal education system, these health providers normally have little opportunity for refresher training and education in new medical technology, or in supervisory and service motivation practices. For example, intravenous rehydration is practiced only in the large pediatric hospitals because this simple technology has not been taught to the medical personnel in peripheral health units.

The Center will attempt to bridge these gaps between medical education and health delivery. It will serve the following purposes:

- a. As a service center, it will function as part of the Cairo University Hospital Complex. The staff and professional students will assist in the provision of general and specialized pediatric services, emphasizing MCH and nutrition.
- b. As an education center, pre- and post-graduate students from the facilities of medicine, nursing and social service will be rotated through the Center as part of their scholastic programs. MOE and Cairo University personnel will serve as faculty. Through the Center the students will be assigned to peripheral health units, including MCH and GUEC units, for clinical clerkships and first-hand experience in the social aspects of medicine and in public health. Staff from the Center will participate with the students in these activities. Emphasis will be upon making formal education relevant to the social and basic health needs of the population.
- c. As a training center, it will provide in-service training for MOH personnel and the community.
- d. As a research center, it will conduct investigations into the social aspects of health care and the problems of applying public health measures.

The Center will be staffed by Cairo University Faculty of Medicine and MOH personnel. Cairo University will designate the Director of the Center and will provide for all operating and maintenance costs. The MOH will provide funds for office space for MOH personnel. Short-term researchers, trainers and consultants to the Center will be drawn from the Ministry of Health, Cairo University teaching staff, and other agencies. Additional details on Center functions are provided in Annex G-2.

The MOH will contract with an American firm for the A & E work and to supervise the construction of the GUEC's, the pediatric outpatient unit, and the Center for Social and Preventive Medicine. While Egyptian A & E

capability exists, the firms are weak on supervision; therefore, to insure compliance with time schedules and with A.I.D. regulations concerning construction, USAID and the MOH have agreed to utilize a U.S. A & E firm.

4. Training and Education of Service Personnel

The low efficiency and effectiveness of health services in the project area are due in part to managerial difficulties. This plays a crucial role in the quality of services rendered, which results in lowering the confidence of the public, and thereby low and unbalanced utilization. In addition to managerial problems, the lack of an adequate in-service training and accessible continuing education program are responsible for the major part of technical deficiencies in services rendered; thus the need for comprehensive training activities to deal with these deficiencies. See Annex L.

In this project major attention will be given to upgrading managerial and technical capabilities of all levels of health workers. Special attention will be given to developing training capabilities within the project system and both local and external training resources will be utilized.

A research, development and training unit in the Executive Director's Office will establish a detailed training plan during the first 6 months of the project. The unit will assess pre-service and in-service training needs, coordinate the development of courses, seminars and workshops to meet the needs, and insure development of training materials and provisions of instructors, supplies and equipment necessary for the presentation of courses.

Central level courses will be given by the MOH and Cairo University. When the Center for Social and Preventive Medicine is functioning, it will also conduct sessions for the training of trainers for courses to be given at the peripheral facilities. The Center also will design in-service training courses for personnel at the local units.

The service units (GUHC's and MCHC's) will utilize existing staff to conduct in-service training, as well as to conduct information, motivation, and technical training courses for local leaders, home visitors, and dayas from the community.

Practical experience will be provided for medical, social workers and nursing pre-and post-graduate students as they rotate through the Center for Social and Preventive Medicine. Basic curriculum revision may be stimulated by this experience, but is not a specific objective of this project.

Participants (2 per year) will be selected for long-term U.S. academic training in fields such as health planning, statistics, preventive medicine and health service management. Four participants annually will be selected for short-term (3 months) academic training in similar areas. Six personnel per year will be provided trips of up to 2 months each to observe urban health practices in the U.S. and elsewhere.

Selection of the participants will be the responsibility of the research, development and training unit in the Executive Director's Office. The participants will be approved by USAID and managed by the A.I.D.

Participant Training Program. A U.S. technical services contractor (described later) will assist in participant selection, placement and evaluation.

5. Community Participation, Consumer Motivation and Health Outreach

Decisions on the delivery of health services in Egypt traditionally have been overwhelmingly dominated by the providers. Consistent with worldwide experience, health policy makers in Egypt increasingly have become aware of the desirability, even the necessity, of obtaining much greater community participation in decision making, and in sharing the responsibility for health care and complementing clinic outreach services. While urban community groups are not a salient feature of Egyptian culture, there is no lack of community members who, properly motivated, can contribute markedly to improvement of health status. Project management will attempt to involve community representatives at all levels of decision making, and will strengthen community ties to and participation in local health center activities.

Community involvement will be established first through an initial intensive communications campaign about the project. General meetings open to all zone residents will be held in each of the three project zones. Two local leaders will be invited to be members of zonal steering committees formed in each of the three project zones. One of the members from each zone will become a member of the overall project Executive Board. The six representatives will select one of their members to represent health consumers on the board of the Center for Social and Preventive Medicine. These general meetings will be held at least once each year during the life of the project and they will provide a general forum for community review of the health care system.

The second method of establishing greater community participation will be through the testing of a home visitors program. Each MCH Clinic in one zone will use home visitors to work part-time in providing domiciliary maternity and post-partum activities, motivation for personal and community sanitation, and in encouraging registration drives to get mothers to enroll at the MCH Clinics. The visitors will also provide information and instructions concerning family planning and nutrition services. Participants in the home visiting program will include traditional service personnel such as dayas and health barbers, natural community leaders, and community service personnel such as teachers and social workers. They will be trained in courses set up in each of the MCH Clinics, which will provide supervision of these services. Annex G-5 provides additional details on training, staffing and financial requirements for this program.

The third element of the community participation aspect of this project will be an information, education and communications program. This program will be designed to motivate fertile couples to practice family planning and provide additional motivational support to overcome certain inhibiting measures associated with the practice itself. The program will make use of audio visual aids of all kinds, ranging from posters to slide sets for use in clinics and schools. Seminars, workshops, informal gatherings as well as existing communications networks within the community such as youth and women's groups will be employed. The use of folk media will be encouraged and the health centers themselves will be used as they offer a captive audience for motivational messages.

6. Other Activities

Feasibility studies will be conducted and a number of low-cost innovations will be tested within the project area in order to develop a series of health provider practices that stimulate attention to preventive measures, concern with family planning and greater consumer acceptance of local health care facilities. Examples of these may include studies to determine use of appropriate technology, (such as better weight scales or drug packaging), campaigns to promote infant vaccination and immunization programs, neighborhood clean-up campaigns, and more specific information programs on preventive health, sanitation and nutrition education.

Proposals for these activities will be approved by the Project Executive Board and concurred in by A.I.D.

C. TECHNICAL ASSISTANCE

The MOH will contract a U.S. firm to arrange for U.S. technical assistance. The contractor will provide two consultant residents in Egypt, one as a Technical Services Administrator, who will work with the Executive Project Director to define U.S. consultant requirements and to secure short-time U.S. advisory services to the project in such areas as health sector analysis, training, administration, planning etc. (See Annex I for anticipated U.S. consultant requirements.) The contractor will also assist in preparing time-phased action plans for the project. In consultation with the MOH and the A & E contractor, he will assist in developing specifications for supplies and equipment, preparing IFB's, selecting successful vendors, and monitoring shipments and installation of commodities. Additionally, the contractor will assist in the identification and placement of the participant trainees managed through A.I.D.'s participant training program.

Certain consulting and advisory services will be procured from Egyptian sources. These include an Egyptian organization to mount the health sector assessment and advisors in other areas (See Annex I.) These services will be procured directly by the Executive Director's staff, and concurred in by USAID. No U.S. project funds will be used for Ministry of Health or Cairo University project personnel.

D. PROCUREMENT OF COMMODITIES AND EQUIPMENT

All commodities and equipment funded under the project will be procured in accord with A.I.D. procurement regulations and procedures.

It will be necessary for the MOH to procure certain local materials and equipment directly from vendors rather than through the contractors. Such procurement will be by the Executive Director's Project Office.

The U.S. technical assistance contractor will assist in preparing and reviewing requirements for supplies and equipment for offshore procurement, preparing IFB's, selection of successful vendor, and monitoring of shipment and installation of commodities.

E. LOGISTIC SUPPORT

Outside of the A & E contracts, which will be self-contained with respect to logistic support, the U.S. technical assistance contractor will be

provided office space by the MOH. However, when there are logistic problems in the GOE offices that may adversely affect the performance of U.S. technicians/consultants, the contract should provide financing for supplemental office space, equipment, supplies, transportation and secretarial and other personnel.

F. IMPLEMENTATION SCHEDULE

After signing the Grant Agreement, Egyptian Government efforts will be directed first toward the establishment of the Executive Board, delineation of its authority, and assignment of needed personnel to it and its subsidiary units. The Executive Board will prepare the scope of work for the contracts for long-term technical assistance, architecture and engineering, and the health sector assessment.

Approximately seven months after the project is initiated, host country contracts for all the major project architectural and engineering and technical services will be signed. A preliminary action plan for the first two years' work will be prepared by the Executive Project Director and staff within 6 months after project initiation; a training plan, job descriptions, personnel requirements, the outreach program, the involvement of traditional practitioners and dayas, supervisory development, delegation of authority to nurses and auxiliaries, and possible innovative interventions will be included. A time-phased action plan for these system modifications will be developed and Egyptian and U.S. technical assistance inputs will be related to them. This plan will be updated formally every six months over the life of the project. It will begin to make use of information generated in the sector assessment approximately 12 months after the assessment begins. The plan will be reviewed by the Executive Committee and concurred in by A.I.D.

The Cairo University Pediatric Hospital Complex and related Center for Social and Preventive Medicine will be organized and functions and activities established soon after the Project Agreement is signed. Lines of communication between it and the Ministry of Health will be opened, and early efforts will be directed toward preparing training programs for pre- and post-graduate students based on data available on currently existing needs. Full involvement of the Center, however, will depend upon the completion of the program intervention action plan that the Executive Director's staff and technical assistance contractor will prepare.

Construction plans and A & E design for the MCH Clinics should be available three months after the A & E firm receives notice to proceed. The GOE will engage a contractor for MCHC renovation and construction immediately thereafter and begin procuring needed supplies and equipment. The MCH Clinics should all be renovated within ten months after the general construction contractor is selected.

Construction plans and A & E design for the GUEC's and the Pediatric Hospital should be completed seven months after the A & E firm receives notice to proceed. The A & E firm will prepare IFB's for construction which will be advertised locally and a contract awarded on the basis of lowest responsive bid. Equipment and supplies will be procured over a two-year period. All construction and renovation activities should be completed approximately 45 months after the Project Agreement is signed.

Training, supervisory development, testing of innovative interventions, the health outreach program, etc. will continue over the life of the project after the action plan is completed. Annex U contains a general implementation schedule.

VII. EVALUATION PLAN

The MOH and USAID jointly will conduct or contract for evaluation of project progress and final results as mutually agreed to support timely implementation and assurance of accomplishment of agreed objectives. In support of this work, the Executive Director's Office will have sections devoted to collection of statistics and to follow-up on evaluation recommendations. The Executive Director's Office will be responsible for implementation of the evaluation studies, and for developing the statistical collection process in order to more effectively measure the effect of the project. Training of personnel to carry out continuous evaluation and reporting procedures are described in the training annex (Annex L).

A. EVALUATION OBJECTIVES

The objectives of evaluation in this project will be to:

1. Determine whether project objectives are being achieved.
2. Identify problem areas where project resources might be better utilized.
3. Measure experimental interventions for effectiveness so that a determination can be made on whether or not to extend an intervention to the other areas of the project.
4. As appropriate, recommend measures designed to see that implementation activities are supportive of project objectives.

B. EVALUATION SCHEDULE

Baseline data will be collected in the course of the health sector assessment which will be carried out in the first two years of this project. Personnel will be trained and procedures developed for maintaining the collection of necessary data throughout the life of the project, and the system will be institutionalized in the Ministry of Health so that such collection and reporting will continue. Assessment data will be made available for distribution to the GOE and to A.I.D.

Sources of data will include collection and analysis of utilization statistics of the MCH Clinics, GUHC's and the outpatient department of Abou El-Rish Pediatric Hospital. Other sources of information for evaluation will include such items as surveys and interviews, which will be collected by sampling methods from the population of beneficiaries and other concerned personnel.

The Project Executive Director and staff, with appropriate consultation, will draft a full evaluation plan during the first six months of the project. This plan will be reviewed and jointly approved by the MOH and USAID.

The MOH, USAID and appropriate contractors will conduct an evaluation annually to review project progress and problems in achieving input and output level indicators and the process of evaluation.

Major evaluation of project progress will be done at approximately the 24th and the 48th month of the project and a terminal evaluation will be conducted three months prior to project completion.

In meeting the general evaluation objectives cited above, evaluation will include measurement of:

1. Health Status

- a. Mortality rates, particularly of mothers and infants.
- b. Percentage of professionally attended births.
- c. Maternal and infant anemia rates.
- d. Utilization of infant and children's growth charts.
- e. Inpatient and outpatient rates of rehydration visits.
- f. Family planning prevalence.
- g. Fertility rates.
- h. Immunization rates.

2. Facility Performance

- a. Facility utilization rates.
- b. Referral rates.
- c. Absenteeism rates.
- d. Home visiting measures.
- e. Facility unit service delivery rates.
- f. Measures of quality of statistical collection by facilities.
- g. Measure of staff interchange between MOH and university facilities.

3. Training

- a. Training attendance rates.
- b. Performance improvements.
- c. Increase in practical teaching.
- d. Increase in percentage of group discussions and seminars.

4. Community Participation
 - a. Citizens' representatives participation rates.
 - b. Representatives' influence in decision making.
 - c. Ability to respond to community needs.
 - d. Community program support (material/efforts).
5. Project Management
 - a. Increase in rates of implementation.
 - b. Rate of flow of funds.
 - c. Rate of delays in decision making.
 - d. Quality and regularity of reporting.
 - e. Ability to respond in unplanned situations.
6. Cost Effectiveness
 - a. Reduction in infant mortality rate per unit of expenditure.
 - b. Reduction in maternal mortality rate per unit of expenditure.
 - c. Facility unit service costs per unit of expenditure.

VIII. COVENANTS AND CONDITIONS PRECEDENT

A. CONDITIONS PRECEDENT

The following conditions precedent to disbursement and covenants will be included in the Grant Agreement.

1. Conditions Precedent to Initial Disbursement

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as the parties may agree otherwise in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

a. A statement of the names and title with specimen signatures of the person or persons who will act as the representatives of the Grantee.

b. Evidence of establishment of an implementation organization acceptable to A.I.D. under the jurisdiction of the MOH, to include an Executive Board, Executive Director and adequate staff for the implementation of the project as described in the Project Paper.

c. Such other documentation as A.I.D. may require.

2. Conditions Precedent to Disbursement for Architectural and Engineering Services

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for architectural and engineering design and supervisory services, the Grantee shall, except as the parties may agree otherwise in writing; furnish to A.I.D. in form and substance satisfactory to A.I.D.:

a. Evidence of an executed contract for design and supervisory services with architectural and engineering services contractors acceptable to A.I.D.

b. Evidence of establishment of the Executive Council of the Center for Social and Preventive Medicine with evidence that its authorities and responsibilities are to be shared by the Ministry of Health and Cairo University.

c. Such other documentation as A.I.D. may require.

3. Condition Precedent to Disbursement for the Center for Social and Preventive Medicine

Prior to the disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for training, staff development or research, the Grantee shall, except as the parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.

a work plan prepared by the Center's Director and approved by the Executive Project Director which will include a statement of health service functions, job descriptions, schedule of education and training activities, and description of research activities to be carried out.

4. Conditions Precedent to Disbursement for Construction

Prior to any disbursement or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for renovation or construction of a particular facility to be assisted under this project, the Grantee shall, in each case of renovation or construction, except as the parties may agree otherwise in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

- a. Evidence that Egyptian budgetary resources have been allocated for the ongoing operating costs of health facilities to be renovated or constructed before funds may be disbursed for construction activities.
- b. Evidence of firm reservation of land for the site of any new construction to be financed by the project.
- c. Evidence of execution of construction contract(s) with firm(s) acceptable to A.I.D.
- d. Evidence of engineering designs and adequate supervisory services for the planned construction.
- e. Such other documentation as A.I.D. may require.

B. COVENANTS

In addition to the standard covenants which will be included in the Grant Agreement, the following special covenants will be included in the Grant Agreement.

1. Execution of the Project

The Grantee shall:

- a. Assure commitment by cooperating agencies with responsibility to staff and operate facilities to be constructed as part of the project to include in their future budget plans for the timely recruitment and funding of staff and provision of other operating costs.
- b. Carry out the project with due diligence and efficiency, and in conformity with sound engineering, construction, financial, administrative and other professional practices.
- c. Cause the project to be carried out in conformance with all the plans specifications, and with all modifications therein approved by A.I.D. pursuant to the Agreement, including the provision, on a timely basis, of necessary local currency and in-kind support as specified in the Agreement and its annexes.

d. Submit for A.I.D. approval prior to implementation, issuance or execution, all plans specifications, construction schedules, bid documents, documents concerning solicitation of proposals relating to eligible items, contracts, and all modifications to these documents.

e. Cooperate fully with A.I.D. to assure that the purpose of the grant will be accomplished and the MOH and A.I.D. shall from time to time, at the request of either party, exchange views through their representatives with regard to the progress of the project, the performance of consultants, contractors and suppliers engaged on the project, and matters relating to the project.

f. Furnish to A.I.D. within 180 days, or such other time as A I.D. may agree in writing, from the date of this Agreement, an implementation plan in form and substance satisfactory to A.I.D., to include a training plan for in-country training and participant training, job descriptions for project personnel, and a description of innovations to be introduced for the management and provision of services. The plan shall be updated every six months over the life of the project.

g. Make provision for adequate administrative arrangements and local currency from funds other than those provided by the Grant for any incentive payments to be made to personnel of the Government of Egypt engaged in project implementation.

ANNEX A

LOGICAL FRAMEWORK

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

INSTRUCTIONS: THIS IS AN OFFICIAL
FORM WHICH CAN BE USED AS AN AID
IN ORGANIZING DATA FOR THE PAR
APPLICANT IT NEED NOT BE RETURNED
ON SUBMISSION.

Life of Project: 79-81
Fiscal Year: 79-81
Total U.S. Funding: \$25,272
Date Prepared: 11/78

Project Title: Urban Health Care Delivery System (263-0065)

ALTERNATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	METHODS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The best for objective to which this project contributes: (A-1)</p> <p>To improve the general health of the Egyptian people.*</p> <p>44% are urban. The majority are in the low income segment.</p>	<p>Measures of Goal Achievement: (A-2)</p> <p>A. 1. Progressive increase of life expectancy at birth.</p> <p>2. Decrease in infant mortality.</p> <p>3. Progressive reduction of age specific morbidity mortality rates.</p> <p>4. Achievement of national population goals.</p> <p>5. Budget allocations for improved services.</p>	<p>(A-3)</p> <p>GOE statistics/surveys/census; life tables, vital registration records.</p> <p>Clinic, health center, hospital records, inspections, surveys; analysis, planning documents.</p>	<p>Assumptions for achieving goal targets: (A-4)</p> <ul style="list-style-type: none"> - Utilization of services will improve health status. - Accessible services will be utilized. - Economic growth will permit complementary urban development, i.e., sanitation water, housing, etc. - GOE will actively address population problem. - GOE will give priority to primary Health Care at periphery of system. - GOE/MOH will devote adequate human, financial and other resources to realize objectives.

PROJECT DESIGN SUMMARY
 LOGICAL FRAMEWORK

Title of Project: _____
 From FY: 79 to FY: 80
 Total U.S. Funding: \$25,272
 Date Prepared: 11/78

Project Title & Number: **Urban Health Care Delivery System (263-0065)**

ITERATIVE SUMMARY

Project Purpose: (B-1)

To make the existing urban health care system more accessible and effective.

OBJECTIVELY VERIFIABLE INDICATORS

Conditions that will indicate purpose has been achieved. End of Project status. (B-2)

- A. Pyramidal comprehensive cost effective health services delivery organized and tested in the demonstration area with physical, personnel and institutional infrastructure, and appropriate referral.
- B. Training and educational program designed, tested, and self sustaining.
- C. GOE has managerial and administrative capacity to expand the system.
- D. Major evaluations completed at 24 and 48 months with results applied to delivery systems.
- E. Percentage of outpatient visits at C.U. Pediatric Hospital from residents of demonstration area for rehydration diminished by 25%.
- F. The percentage of deliveries with three or more prenatal visits by health system personnel from the demonstration area will have increased by 25%

MEANS OF VERIFICATION

(B-3)

- Evaluation reports.
- Inspections/surveys.
- Consultant/contractor reports.
- Clinic records and GOE reports.
- Health Sector Analysis

IMPORTANT ASSUMPTIONS

PAGE 2

Assumptions for achieving purpose: (B-4)

- Cairo University, MOH, Governate of Cairo and private health services coordinated, and the legal/institutional framework of the Health community will permit and support trial interventions and testing.
- It can be demonstrated that modified health delivery systems can improve health/nutritional status.
- The GOE will agree that women and children should receive primary emphasis.
- Conditions of service can be improved to attract, retain and motivate qualified personnel to give better service.
- Evaluation and research can be integrated within the project as part of process of improving health care.
- Urban poor will perceive improvements in peripheral units and will seek health care in them.

and related forms
Supplement 1

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Life of Project: _____
From FY. 79 to FY. 83
Total U.S. Funding \$75,272
Date Prepared: 11/78

Project Title & Number: Urban Health Care Delivery System (263-0065)

NARRATIVE SUMMARY	OBJECTIVELY MEASURABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Outputs (C-1)</p> <p>A. Urban health sector assessment of the demonstration area and greater Cairo.</p> <p>B. Upgraded/renovated (primary level) MCH clinics. <u>1/</u></p> <p>C. Multipurpose (intermediary level) general urban health centers (GUHC) constructed/renovated. <u>2/</u></p> <p>D. Coordinating central point for health and social aspects of MCH services, education, training and research.</p> <p>E. Innovative interventions in primary health care and community participation identified and tested.</p> <p>F. A referral system of primary, intermediate and tertiary services developed and tested.</p> <p>G. Training programs for personnel required to meet the needs and objectives of the established.</p>	<p>Magnitude of Outputs: (C-2)</p> <p>A. Health Sector Assessment procedure manual and a Comprehensive assessment document of alternative plans of action for short-term/long term programs.</p> <p>B. Up to 10 MCH clinics in demo area providing clinic and outreach services.</p> <p>C. Up to 14 GUHC in demo areas as PHC referral point and service units.</p> <p>D. Center for Social and Preventive Medicine in CU Pediatric Hospital</p> <p>E. Established neighborhood services in health education, basic sanitation, nutrition, family planning and other preventive measures.</p> <p>F. Pyramidal service package designed and tested for PHC, MCH, FP, nutrition, vital records, school health and other health services.</p> <p>G. <u>1,500</u> people trained.</p>	<p>(C-3)</p> <p>- Analysis report recommendations accepted by appropriate GOE officials.</p> <p>- Consultant/contractor reports/evaluation.</p> <p>- Inspections/surveys.</p> <p>- Statistical data.</p> <p>- Implementation of plan and reports of staff and resource exchange between Cairo University and MOH.</p> <p>- Facilities for service, research education and training.</p> <p>- Surveys, records and observation of community action.</p> <p>- Training plans, reports evaluation.</p>	<p>Assumptions for achieving outputs: (C-4)</p> <p>- Qualified professional, para-professional and managerial staff available as needed for program.</p> <p>- Other resources/materials for capital projects, available as needed (includes land.)</p> <p>- Consumer demand/utilization of service network and community cooperation can be increased.</p>

1/ A free standing unit offering well baby care, domiciliary care, non-surgical F.P. services, and primary pediatric care, including oral rehydration.

2/ A unit offering MCH services, including rehydration, nutrition education, surgical contracept. .; school health; preventive outreach; and vital registration.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Urban Health Care Delivery System (263-0065)

Life of P: ...
From FY: 72 to FY: 83
Total U.S. Funding: \$25,272
Date Prepared: ...

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Inputs: (D-1)</p> <p>Technical Assistance Training Commodities Construction Other Costs</p>	<p>Implementation Target (Type and Quantity) (D-2)</p> <p>(\$000)</p> <p>A. U.S. Grant of \$25,272 Million</p> <p>\$2,304 Technical Assistance \$ 717 Training \$5,266 Commodities \$7,889 Construction \$1,215 Other Costs \$7,881 Inflation and Contingency</p> <p>B. GOR contribution of \$19,388 direct or in kind.</p>	<p>(D-3)</p> <p>U.S. and GOR Budget data Statistical data Consult and/Contractor reports</p>	<p>PAGE 4</p> <p>Assumptions for providing inputs: (D-4)</p> <p>Adequate GOR and U.S. resources will be available to finance service in a timely fashion.</p>

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PD.AAC-270-61

UNCLASSIFIED

DEPARTMENT OF STATE
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D. C. 20523

14p.

PROJECT PAPER
AMENDMENT NO. 1

EGYPT: Urban Health Delivery System

~~263-0065~~

265-0065

August 1979

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

1. TRANSACTION CODE

C A ADD
C CHANGE
D DELETE

PP

2. DOCUMENT CODE
3

3. COUNTRY ENTITY
EGYPT

4. DOCUMENT REVISION NUMBER

1

5. PROJECT NUMBER (7 digits)

263-0065

6. BUREAU/OFFICE

A. SYMBOL
NE

B. CODE
03

7. PROJECT TITLE (Maximum 40 characters)

URBAN HEALTH DELIVERY SYSTEM

8. ESTIMATED FY OF PROJECT COMPLETION

FY 84

9. ESTIMATED DATE OF OBLIGATION

A. INITIAL FY 79
C. FINAL FY 80

B. QUARTER 1
(Enter 1, 2, 3 or 4)

10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$) -

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. C	D. TOTAL	E. FX	F. C	G. TOTAL
AID APPROPRIATED TOTAL	2,640	2,313	4,953	12,622	12,650	25,272
GRANT	2,640	2,313	4,953	12,622	12,650	25,272
LOAN						
OTHER U.S.						
HOST COUNTRY		10,664	10,664		19,388	19,388
OTHER COUNTRY						
TOTALS	2,640	12,977	15,617	12,622	32,038	44,660

11. PROPOSED BUDGET APPROPRIATED FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY 79		H. 2ND FY 80		K. 3RD FY 81	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) SA	533			4,953		20,319		-	-
(2)									
(3)									
(4)									
TOTALS				4,953		20,319		-	-

A. APPROPRIATION	N. 4TH FY 82		O. 5TH FY 83		LIFE OF PROJECT		12. IN-DEPTH EVALUATION SCHEDULED
	P. GRANT	Q. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	
(1)					25,272		
(2)							
(3)							
(4)							
TOTALS						25,272	

MM YY
12 81

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA BLOCKS 12, 13, 14, OR 15 OR IN PPP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

2 1 = NO
2 = YES

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE

TITLE

Director, USAID/Egypt

DATE SIGNED

MM DD YY
8 30 79

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

MM DD YY
09 12 79

URBAN HEALTH DELIVERY SYSTEMS

Project Paper Amendment No. 1

The original Project Paper for this activity was authorized on November 15, 1978 and a Grant Agreement signed November 20, 1978. The Project is designed to improve delivery of urban health services particularly maternal and child health, family planning and nutrition services in three zones (Helwan, South and West) of the Cairo Governorate. The activity emphasizes community involvement, the use of home visitors, the delivery of health services in the neighborhoods where people live (outreach) and cooperation between the health services of Cairo University and the Ministry of Health. The project will demonstrate an improved system of delivering basic health services in these urban zones of Cairo with the objective of replication by the MOH of successful elements to greater Cairo and other urban areas. Toward this end, the health sector assessment component of the project will provide data on greater Cairo following an initial assessment in the demonstration zones.

One important thrust of the project is the renovation and equipping of neighborhood Maternal-Child Health Clinics (MCHC) which are the base for outreach services and the initial health services contact for the community. Of the 14 MCHC units in the 3 zones, 10 have been selected for renovation.

This amendment proposes to expand the renovation and equipping of MCHC units to 2 more zones (North and East) of the Cairo Governorate including an additional 12 MCHC units. This will bring the total number of MCHC units for renovation and equipping to 22. As anticipated in the original PP, architectural and engineering services will be performed by an Egyptian firm.

This proposed expansion of MCHC units will speed up the replication features of the Urban Health project activity by the Ministry of Health. Given the vital role these units play in representing Ministry health services at the primary level, USAID plans to expand MCHC unit renovation to the entire Metropolitan Cairo area during the life of the project. Funding implications of that second expansion will be reviewed following the first year's experience.

The Ministry of Health has conducted an initial Architectural and Engineering Survey to determine the status of the 12 additional MCHC units to be renovated. A copy of this report is attached as Annex A.

USAID anticipates that additional costs for renovating and equipping these units can be accommodated within the funds available in the original Project Paper. Therefore, this PP amendment requests authorization to permit expansion in geographical boundaries of the project and increase in the number of MCHC units to be renovated and equipped. All other provisions of the original PP remain the same.

ANNEX - A

Ministry of Health

Maternal & Child Health Centre
Cairo

وزارة الصحة

مركز تنمية صحة المرأة
القاهرة

A / E STUDIES

RENOVATION COST OF THE
EXISTING MCH CLINICS IN NORTH & EAST CAIRO

PREPARED by the
A/E group - ECTOR.

August 1979

METHODOLOGY

The following steps has been followed :

1. Fields survey for all the MCH centers in north and east Cairo.
2. Completion of the survey data into the presented tables . The analysis of the collected data led to categorizing the visited MCH clinics into four main categories:
 - Category I: units in very good condition, very limited physical upgrading is needed. The basic need is for good maintenance and organization .
 - Category II: units in reasonably good condition , which could be greatly improved by minor alterations in the building, equipment, or personnel.
 - Category III: units in fair condition, but need major alterations and/ or additions which may include some construction work, reallocation of space, - addition of more facilities,...
 - Category IV: Units in completely inadequate buildings which makes them very difficult to be economically upgraded using the existing premises. New building is needed.
3. The basis of costing of this process has been based on the following:
 - Average area of any MCH clinic is around 700 square meters.
 - Category I does not need any upgrading in the buildings.
 - Category II will cost about £40/ square meter to do the required repairs in the sanitation, flooring, painting, electrical installations, ...
 - Category III will cost about £ 70/ square meter to do

the major repairs in the building which may include some reconstruction.

- Category IV will be transferred under the costing of the GUHC.
 - The costing of furniture and equipment will vary from one unit to another.
-

I SURVEY OF MCH CENTERS
IN NORTH CAIRO

I. 1. Building

No.	MCH Clinic	Place	Building Condition	Functional Layout.
1.	Gezerat Badran	A separate rented Building	Old, very poor conditions needs major repairs.	Needs major changes, additional functional area is needed in the free space available.
2.	El Tera El Boulakia	A Separat rented Building.	Good conditions, minor repairs are requires especially electrical connections, sanitary and water.	Adequate layout.
3.	El-Assal	A separate rented Building	Good conditions, minor repairs are needed in electrical sanitary and water connection.	Adequante layout
4.	Shoubra 1.	A separate rented Building.	Old, needs major repairs in some parts.	Needs addition functional area in the available free space.
5.	Shoubra 2.	Low income housing complex	Good conditions, minor repair for electrical sanitary and water connections	Adequate layout except for the waiting area.

1. 2. Equipment.

Item	MCH Clinic	Gezerat Badran	El Tera El bou- laqia.	El Assal	Shoubra 1;	Shoubra 2.	NOTES
Instruments.	-	-	-	-	-	-	inadequate
Autoclave	x	x	x	x	x	x	
Laboratory	x	+	+	+	+	+	
Dental clinic	+	+	+	+	+	+	Old
Demonstration kitchen	x	+	+	+	+	+	
Refrigerator	+	+	+	+	+	+	
Furniture	x	x	x	x	x	x	Inadequate
Health educat- ion facilities	x	x	x	x	x	x	
Record keeping facilities.	x	x	x	x	x	x	

Ministry of Health

Project

وزارة الصحة

مشروع تنمية صحية

I. 3. Renovation Requirements
(North Cairo)

er MOH	Grade	Building	Furniture & Equipment	Transportat
Gezerat Badran	III	£ 50,000	\$ 25,000	\$ 4000
El Tera El - Boulacgia.	II	30,000	20,000	4000
El - Assal	II	30,000	20,000	4000
Shoubra 1.	III	50,000	25,000	4000
Shoubra 2.	II	30,000	20,000	4000
Total		£ 190,000	\$ 110,000	\$20,000

II. Survey of MCH Centers
 in East Cairo
 =====

II. i. Building
 =====

Ser.	MCH clinic	Place	Building condition	functional layout
1.	El Zawia El Hamra	Health Complex	Needs major repairs in some parts.	Adequate
2.	Monshiat El Sadr	A rented separate Building	Good conditions, minor repairs are needed.	Adequate
3.	El- Amerya	Health Complex	Good conditions minor repairs are needed.	Adequate
4.	El- Snarabya	Health complex	Good conditions, minor repairs are needed.	Adequate
5.	El- Matarya 1.	A separate rented Building	Fairly good, needs some major repair in Sanitary. Other repairs are minor.	Adequate
6.	El- Mataria2.	Health complex	very good conditions few minor repairs are needed.	Adequate
7.	El- Zailon	A separate rented building	Needs major repairs in some parts.	Needs additional functional areas in the space available
8.	El- Shams	A separate rented building	good conditions. minor repairs are needed.	

II. 2. Equipment

MCH Clinic Item	El Zawia El Hamra	Manshiat El Sader	El-Amerya	El-Sharabia	El-Mataria I.	El-Hab N°	El-Zap	El-Hab S	Remarks
Instruments	+	+	+	+	+	+	+	+	inadequate
Autoclave	+	+	+	+	+	+	+	+	Old
Laboratory	X	X	X	X	✓	X	X	X	
Dental Clinic	X	X	+	+	+	+	+	X	
Demstration kitchen	X	X	X	X	+	X	X	X	no space
Refrigerator	+	+	+	+	+	+	+	+	
Furniture	X	X	X	+	+	+	+	X	x inadequate
Health education facilities	X	X	X	X	X	X	X	X	
Record keeping facilities	X	+	+	+	X	✓	✓	X	

II. 3. Renovation Requirements
 (East Cairo)

Ser	MCH	Grade	Building	Furniture Equipment	Transportation
1.	El Zawla El Hamra	II	£ 30,000	\$ 20,000	\$ 4000
2.	Manshait El Sader	II	£ 30,000	\$ 20,000	\$ 4000
3.	El Amerya	II	£ 30,000	\$ 20,000	\$ 4000
4.	El Sharabya	II	£ 30,000	\$ 20,000	\$ 4000
5.	El Matarial.	II	£ 30,000	\$ 20,000	\$ 4000
6.	El Matarya 2	I.	£ 000000	\$ 5,000	\$ 4000
7.	El Zayton	III	£ 50,000	\$ 25,000	\$ 4000
8.	Ein Shams	II	£ 30,000	\$ 20,000	\$ 4000
Total			£ 250,000	\$ 150,000	\$ 32,000

III Summary
Total Renovation Cost:

	Buildings L.E.	Furniture & Equipment \$	Transportation \$
North Cairo	190,000	110,000	20,000
East Cairo	250,000	150,000	32,000
Total	440,000	260,000	52,000