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SOCIAL ANALYSIS CONSULTANTS

TNO Prevention and Health
Division Public Health and Prevention

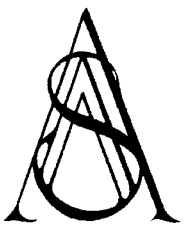
FINAL EVALUATION

PRIMARY HEALTH CARE PROJECT RURAL DAMIETTA (PHCP/RD)

EGYPT. 6-15 NOVEMBER 1995

PRIMARY HEALTH CARE PROJECT
RURAL DAMIETTA (PHCP/RD)

CLIENT
THE MINISTER FOR DEVELOPMENT CO-OPERATION
MINISTRY OF FOREIGN AFFAIRS
THE HAGUE



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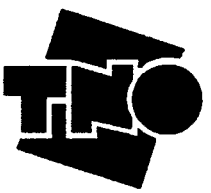

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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

1. In 1984, the Governments of Egypt and The Netherlands signed an agreement regarding the technical support of a primary health care project in the rural areas of the Governorate of Damietta, which began to be implemented in 1985. The project, known as PHCP/RD and which has undergone a number of phases, is due to end in December 1995.

2. The aim of the PHCP/RD has remained unchanged throughout the process of its implementation, namely: Improvement of the quality of the rural health system in the Damietta Governorate, and, by implication, the health status of the rural population, in particular women, children and the less privileged.

3. The PHCP/RD focused on a number of objectives: maternal & child health (MCH), training, outreach (specifically home visits and health education), management and planning capacity (including the rural health information system [RHIS] and the integrated approach [IA]), infrastructure and maintenance as well as developing a project model. During Phase III (1991-1993), a women & development (WID) approach was added which focused on health aspects, specifically reproductive health and care of poor elderly rural women.

4. The terms of reference for the final evaluation of the last phase of the PHCP/RD (see Appendix E), referred to here as Extended Phase III (1994-1995), aimed to assess the relevance of the project's objectives and its performance, the value added by the PHCP/RD, the role of the implementing agencies and the question of sustainability after the phasing-out of The Netherlands' support.

5. During a ten-day stay in Egypt, the two Consultants of the Evaluation Mission reviewed all accessible documentation in relation to the PHCP/RD and carried out field visits and group discussions with health staff in the Damietta Governorate, as well as held briefing meetings with the authorities concerned in Damietta and Cairo.

6. Though the Consultants operated under some time constraint, including the absence of an Egyptian counterpart due to the very much regretted death of the designated person, all of which had implications for attempts to gather some of the pertinent quantitative and qualitative information on the PHCP/RD, this fact does not diminish the validity of conclusions and recommendations.

7. The Mission Report begins with some background information on macro-economic transformations in Egypt during the decade of PHCP/RD implementation (1985-1995), as well as on available socio-economic indicators on the Damietta Governorate. This is deemed relevant to assessing the sustainability of the project after the phasing-out of The Netherlands' support.

8. The Consultants note that the objectives of the PHCP/RD have been relevant to the health policies of the Government of Egypt, specifically in terms of strengthening the medical services provided by the rural health units (RHUs) as well as the outreach programme, and the up-grading of the skill levels of health service providers through culturally appropriate training.

9. It can also be maintained that the aims and objectives of the PHCP/RD are by and large in line with the development policies of The Netherlands. However, there remains the question whether the choice of the Damietta Governorate, which already in the mid-1980s was ranked relatively positively in terms of various socio-economic indicators, was in line with the policy of poverty alleviation.

10. The assessment of the project's performance has been somewhat constrained by some inconsistencies in the PHCP/RD documentation regarding the definition of areas of intervention and objectives, as well as the relatively limited information on monitoring indicators.

11. The Consultants assess the project's performance with regard to objectives which are continuing to be implemented during Extended Phase III, including those who have ceased to receive funding support: maternal & child health, training of health staff, reproductive health, care of poor elderly rural women, management and planning, infrastructure and maintenance, and the project model. While there are some problems, specifically in relation to the incentive and per diem systems respectively, the indications are that the implementation of the above project components are more or less continuing on track.

12. With regard to the assessment of the implementing agencies, time constraints impeded the Consultants from any in-depth evaluation. The impression which emerges from various project documents and discussions indicate that the agencies concerned, i.e. the project management, the Royal Tropical Institute as well as local consultants, have largely fulfilled their designated roles and functions. However, there are some queries with regard to the incorporation of the WID component and the presentation of pertinent project documentation.

13. The assessment of the value added by the project, interpreted to mean transformations in the rural health system during the period 1985-1995 as a result of the implementation of the PHCP/RD, concludes that the latter has undoubtedly had a positive impact on the rural health delivery system in the Damietta Governorate. However, it should be kept in mind that it is difficult to analytically separate the impact of factors external to the project, more specifically the socio-economic transformations which have taken place in the Damietta Governorate over the past decade. In any case, the value added is measured by the situation prior to the project's implementation as indicated in various project documents, as well as by various project management staff who have been involved with the health sector over the past decade.

14. While time constraints also impeded the Consultants from gathering pertinent quantitative information, the following observations regarding the value added by the PHCP/RD to the rural health delivery system are pertinent:

14.1. The up-grading of the RHU infrastructure has been successfully completed and the premises visited by the Consultants appeared to be kept in good order.

14.2. The rural health care providers have received training appropriate to the up-grading of their skills with positive implications for RHU-based health services, the outreach programme, the referral as well as the supervision systems respectively. These developments have also had positive implications for the quality of health care, the utilisation of RHUs as well as the general health of the rural population.

14.3. The group targeted by the PHCP/RD has remained the same throughout, and has benefited from the up-grading of skills and RHU premises. The inclusion of additional target groups in the last phase, i.e. women with reproductive health problems and poor elderly rural women, has been a positive response to hitherto neglected health needs in the village communities.

14.4. The Project Model developed by the PHCP/RD is a valuable contribution, though its dissemination, specifically in terms of highlighting factors of, and constraints to, project sustainability, requires more concerted effort.

15. The women in development project component has, surprisingly, only recently been added to the PHCP/RD, and the manner of its incorporation has apparently had some implication for acceptance by the project management staff. While the WID approach has focused on two particular health related aspects, the Consultants believe that projects such as the PHCP/RD need to adopt a gender sensitive approach from the outset.

16. The PHCP/RD's attempt to promote the concept of community participation as part of an integrated approach (IA) to rural health service delivery has generally been unsuccessful. Partly this is due to the fact that this is a longer term process, but there is also the fact that the process is affected by a complexity of factors external to the project.

17. The assessment of the sustainability of the PHCP/RD after the phasing-out of The Netherlands' technical support needs to be viewed from two perspectives:

17.1. The PHCP/RD's conceptualisation of sustainability:

a. The project documentation reviewed by the Consultants indicates that the question of sustainability has not been a particular focus. Here and there the issue is

addressed, but then tends to disappear from view without much explanation.

b. This fact is surprising given the attention accorded to the issue of sustainability in the documentation presented during the National Conference on Project Model Development (1993). The pertinent papers point out the requirements of sustainability in relation to each project objective (but excluding those implemented during the Extended Phase III (1994-1995). It should also be added that a special workshop on the issue of sustainability was held earlier on in 1993.

c. Nevertheless, though these requirements are presented in some detail, little attention has been accorded to the question of the feasibility of sustainability after 1995. Nor is the issue of sustainability addressed in relation to the socio-economic context within which the PHCP/RD is being implemented.

d. Furthermore, while the project management indicated to the Consultants that the question of sustainability is periodically addressed during meetings, no official strategy has been formulated for the post-project phase.

17.2. While the Consultants would concur with many of the PHCP/RD's views on sustainability, the following are also deemed relevant:

a. The rationale for the continuation of the PHCP/RD should include the following:

* The positive link between the home visiting programme (HVP) and health education (HE) on the one hand, and the increased utilisation of RHU-based health services on the other hand.

* Maximisation of benefits from invested efforts in the training of health staff.

* Meeting the health needs of the rural community, specifically the less privileged.

* The need for the continuing up-grading of skill levels of health staff so as not to erode past achievements.

* The need to tackle more effectively constraints to community participation, which has implications for an integrated approach to rural health service delivery.

* The need to invest more efforts in streamlining and improving the operationalization of the RHIS.

* The motivation of health staff and the use of the incentive system as a management tool to improve job performance.

* The contribution of the PHCP/RD to national efforts to improve MCH services and to promote family planning as part of family welfare.

b. Sustainability of the PHCP/RD therefore requires the following feasible factors:

* Adequate numbers of trained health care providers.

* Encouraging the motivation of health care providers through appropriate training, optimal conditions of service, availability of necessary equipment and support, regular and objective supervision as well as salaries which reflect skill levels and job performance.

* Effective policy support by the Ministry of Health (MoH), since sustainability is not only a financial and managerial issue.

* Reviewing the incentive system and its role as an effective management tool.

c. Sustainability needs to be also viewed within the context of the socio-economic transformations which have been taking place in the Damietta Governorate over the past decade; specifically the fact that the latter is ranked third on the human development index.

18. The Consultants conclude that the PHCP/RD can be deemed an achievement in terms of:

a. improving the quality of health services provided to the rural population in the Damietta Governorate through the strengthening of the RHUs and the up-grading of the skill level of health staff;

b. responding to the health needs of the rural population targeted by the project.

19. However, the budget constraints of the DoH are expected to have some implications for various project components, notably:

a. Training: There are no earmarked funds for the continuation of refresher courses, and there appears to be a risk that the Abadeyyah Training Centre (ATC) may not continue its role and functions.

b. Home Visiting Programme (HVP): While the HVP can be deemed to be an achievement, the fact remains that the discontinuation of the incentive system is expected to have some adverse effect in terms of frequency and content. However, the DoH is tackling the issue by instigating action against RHU health staff whose job performance evaluation reveals shortcomings.

c. The Incentive System: It is evident that the chronic problem of incentives needs to be tackled, and more effectively linked to job motivation and performance, which

in turn implies viewing incentives as a management tool.

d. Reproductive Health: The implementation of this project component as a pilot in two RHUs indicates that it is addressing a hitherto neglected health need of women, and the Consultants regret that it has not been taken on board earlier in the project. In any case, this is related to the previously mentioned fact that, surprisingly, a women in development (WID) approach was not deemed an essential component by the donors from the outset, and that, moreover, the latter has been confined to a relatively narrow focus on women's health.

e. Care for Poor Elderly Rural Women: This particular project component, viewed as part of a WID approach to women's health, is deemed to be successful in terms of addressing a neglected female population group, and the fact that it has been implemented in all districts of the Damietta Governorate during a relatively short period of time.

f. Management and Planning: Though there have been some developments with regard to simplifying the RHIS, this has not entirely succeeded; the same applies to the integrated approach and, by implication, community participation. There has also been the problem that the DoH has not been able to support the effective link between the RHIS and planning at the RHU level.

g. Infrastructure and Maintenance: The objective of renovating RHUs and providing them with basic equipment has been achieved, though plans to establish a training sub-centre had to be abandoned. A revolving fund for spare parts has been established, and this project component is now fully integrated into the DoH structure.

h. Project Model: While the model development can be considered a particular project achievement, with the publication of the papers presented to the National Conference in 1993 facilitating dissemination, the Consultants note that progress on the latter has remained relatively limited.

20. In the main sections of this Mission Report, sustainability issues have been widely discussed. The Consultants have a number of recommendations on how to operationalize sustainability, each of which is considered to be feasible. These are addressed to the following parties:

a. The Ministry/Department of Health in Egypt:

* Explore possibilities for innovative solutions to the DoH's budget constraints to ensure the continuing up-grading of skills of rural health staff and, by implication, support the quality of RHU-based health services and the outreach programme.

* Ensure that the ATC continues to function as a centre for training for all DoH training activities as is feasible. This includes maintaining current training schedules.

* Explore alternative cost-free sources for training materials.

* Continue to support the supervision system to ensure that the phasing-out of incentives does not have too many adverse implications.

* Evaluate the use of the incentive system as a management tool, but also ensure that it is fairly applied.

* The DoH needs to develop a better strategy for the introduction of newly graduated RHU physicians to the village community as part of the aim to promote community participation.

* The co-ordination system between RHU nurses and social workers needs to be strengthened to ensure that both the medical and social needs of patients are effectively addressed.

* More concerted efforts need to be expended on targeting the at risk group during the HVP.

* Given the importance of the reproductive health project component to an integrated approach to women's health, the relative success of its implementation on a trial basis, the interest expressed by project management staff in the continuation of this project component, as well as the fact that there are no earmarked funds in the DoH budget to implement this pilot on a wider scale in the Damietta Governorate, the Consultants recommend that a project proposal be formulated for securing the necessary donor funding and technical support.

* The evident success of home visits to poor elderly rural women, which has been cost-effectively integrated into the HVP, needs to be sustained and, where feasible, replicated in other governorates. The MoH needs to ensure that this receives the required policy and budget support.

* While the MoH indicated to the Consultants that serious efforts are being expended in tackling the RHIS, the fact remains that this is a longer term process. Meanwhile, the DoH/MoH should invest further efforts in streamlining the RHIS by developing a realistic strategy.

* It is also recommended that, in view of its relevance to project sustainability, the integrated approach and its link with community participation be revived and realistic implementation strategies developed.

* The sustainability of the PHCP/RD requires policy, managerial and training support. While this implies careful reconsideration of the MoH/DoH budgets, the fact remains that the health authorities need to overcome the tendency to view sustainability primarily if not exclusively in terms of financial inputs, and to invest efforts in identifying innovative ways of overcoming budget constraints.

* The preventive maintenance programme needs to be continued and strengthened as part of a strategy of cost-effective implementation of health services.

b. The Netherlands Ministry of Foreign Affairs/DGIS:

* The Consultants strongly recommend that the DGIS co-operate in the organisation of a workshop in the Damietta Governorate to evaluate the first year after the phasing-out of The Netherlands' support. This should be viewed by the donor, the Egyptian counterpart and the implementing agency as a contribution to the support of the project's sustainability, keeping in mind the Consultants' view that the latter is not only a question of funding, but also a matter of management and policies.

* It is also recommended that the DGIS review the system of incorporating WID in project formulation, planning and implementation to ensure the effective and timely integration of a gender sensitive approach. This is in view of the fact that this approach has been introduced relatively late into the PHCP/RD, thus perpetuating the problem of gender neutral project planning. Not surprisingly, this has had various implications for the manner in which the Egyptian counterparts have taken WID on board.

* For a better understanding of the Mission Report, the Consultants recommend that at least the Executive Summary, the Conclusions as well as the Recommendations be translated into Arabic.

c. The Royal Tropical Institute (KIT):

* Though it is noted that the DGIS had not requested the incorporation of WID from the outset of the project, and notwithstanding the effective implementing role played by KIT, it is recommended that the latter also review its system of incorporating a gender sensitive approach to women's health in projects such as the PHCP/RD. This is in view of the complex link between health and gender, and the implications of this link for effective health planning as well as for responding to community health needs.

* Given the relative success of the PHCP/RD and the Consultants' view that it should be replicated, and notwithstanding the effective role played by the implementing agency, it is recommended that more care be invested in developing a more consistent framework for the presentation of planops, yearplans, progress and evaluation reports. Though the experience of the PHCP/RD until 1993 is documented in the 1993 National Conference papers, this is deemed insufficient for an in-depth assessment of the project.

LIST OF ACRONYMS

ATC	Abadeyyah Training Centre
CP	Community Participation
DoH/D	Department of Health/Damietta
DoSA	Department of Social Affairs
EC	Executive Council
FF	Family Folders
FFHE	Face-to-Face Health Education
GDP	Gross Domestic Product
GHE	Group Health Education
HE	Health Education
HVP	Home Visiting Programme
IA	Integrated Approach
IEC	Information/Education/Communication
IMF	International Monetary Fund
KAP	Knowledge/Attitude/Practice
LPC	Local Popular Councils
LDP	Local Development Project (USAID)
LPDP	Local Participation Development Council
LPVC	Local Popular Village Council
MCH	Maternal and Child Health
MCC	Model Co-ordinating Committee
MoH	Ministry of Health

MoP	Ministry of Population
MoSA	Ministry of Social Affairs
MWS	Maintenance Workshop Staff
NGO	Non-Governmental Organisation
PHC	Primary Health Care
PHC/PMD	Primary Health Care/Project Model Development
PHCP/RD	Primary Health Care Project/Rural Damietta
PlanOps	Plan of Operations
RHC	Rural Health Centre
RHIS	Rural Health Information System
RHMCH	Rural Health Maternal & Child Health
RHU	Rural Health Unit
RH	Rural Hospital
RTI	Royal Tropical Institute (KIT)
TBA	Traditional Birth Attendant (Daya)
ToR	Terms of Reference
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHP	Village Health Planning
WHO	World Health Organisation
WID	Women in Development

I. INTRODUCTION

A. TERMS OF REFERENCE FOR THE CONSULTANCY MISSION 6-15 NOVEMBER 1995

The Terms of Reference for the final evaluation of the Primary Health Care Project/Rural Damietta (PHCP/RD) have been interpreted by the Mission as follows:[1]

1. The relevance of project objectives with regard to the health policies of the Arab Republic of Egypt and the development policies of the Government of The Netherlands.

2. An assessment of the performance of the PHCP/RD's project components.

3. An assessment of the performance of the implementing agencies.

4. The value added by the project.

5. An assessment of the sustainability of the project.

6. Conclusions and recommendations.

B. METHODOLOGY

1. Documentation

1.1. The Consultants' terms of reference entail not only the evaluation of the last phase of the PHCP/RD, but also the discussion of the sustainability of the project after The Netherlands' support comes to an end in December 1995.

1.2. In effect, this implies obtaining an overview of the different phases of the PHCP/RD to follow the process of project implementation and to identify points of relevance to the issue of sustainability. To this end, the Consultants studied the available documentation, focusing in particular on Phase III (1991-1993), since a number of objectives of the latter have continued to be implemented during the current Extended Phase III (1994-1995).

[1] See Appendix E for the detailed Terms of Reference.

1.3. The Consultants note that, regrettably, some of the documentation relevant to Phase III and Extended Phase III respectively was not made available prior to the field visit to the Damietta Governorate. Moreover, there does not appear to be a complete list/set of all the documentation produced in connection with the PHCP/RD in any one place, i.e. either in the project management office in Damietta city or the Abadeyya Training Centre (ATC) in Faraskour district, or in The Netherlands Embassy in Cairo. Due to time constraints, the Consultants were unable to ascertain whether the complete set of documentation is available in the Ministry of Health (MoH) in Cairo, at least up to 1993 after which the PHCP/RD was transferred to the Department of Health (DoH) in Damietta.[2]

1.4. It is also noted that much of the documentation available on the PHCP/RD is presented in a vacuum, giving little indication where the project is located within the overall health service delivery system in the Damietta Governorate, and in particular in relation to the health projects of other donors and local NGOs. Nor does this documentation offer much insight into the socio-economic transformations which have taken place during the decade of project implementation, and which can be assumed to have some relevance to the question of sustainability of the PHCP/RD.

1.5. Another constraint was the very much regretted death of the designated Egyptian counterpart, Dr. Ahmad Hanafi Mahmoud, on the first day of the Mission. He was not replaced by another counterpart and the Mission consisted of the two independent Consultants.

2. Field Visits

2.1. The Consultants originally planned to spend two days in Cairo, one day for the briefing in The Netherlands Embassy prior to departure to the Damietta Governorate, and one day for the de-briefing in the MoH and The Netherlands Embassy prior to departure from Egypt. In the event, the Consultants had to cut short their stay in Damietta by one day due to the appointment schedule of the Under Secretary at the MoH in Cairo. This meant that the Mission had a total of six working days for contacts and field visits in the Damietta Governorate (keeping in mind Friday which is the official public sector's day off in Egypt).[3]

2.2. Apart from the study of available documentation, the Consultants obtained as much information as was feasible from focus group discussions with health care

[2] The list of PHCP/RD documents to which the Mission had access is presented in Appendix D. The evaluation of the contents of relevant documents is addressed in the pertinent sections of this Mission Report.

[3] See Appendix B for the Mission's Itinerary, and Appendix C for the list of persons met in Egypt.

providers, the project management staff as well as from field visits to rural health units (RHUs), a rural health centre (RHC) and rural hospital (RH) respectively, home visits to RHU clients as well as to the Abadeyyah Training Centre (ATC).

3. Structure of the Mission Report

3.1. The Mission Report is divided into a number of sections related to the above presented interpretation of the terms of reference, though the sequence of sections is in some parts different to that laid down in the latter. Some of the sections include introductory remarks explaining how particular issues have been dealt with/analysed.

3.2. The Consultants have also added a section on macro-economic transformations in Egypt, and in particular available socio-economic indicators on the Damietta Governorate. This is deemed relevant to a better understanding of the process of PHCP/RD implementation as well as to the issue of sustainability. The Consultants note that the available project documentation has tended to provide minimal information on the socio-economic context within which the PHCP/RD has been implemented.

II. BACKGROUND INFORMATION

A. MACRO-ECONOMIC DEVELOPMENTS IN THE ARAB REPUBLIC OF EGYPT

1. Since the inception of the Primary Health Care Project/Rural Damietta (PHCP/RD) in 1985, there have been far-reaching macro-economic developments in Egypt with some implications for the implementation and sustainability of the project.[4]

2. Briefly, the Egyptian macro-economy during the 1980s was characterised by large budget deficits, relatively high inflation rates, and the reliance on a limited number of foreign exchange sources (labour migration remittances, tourism, the Suez Canal and oil).

3. While the Open Door Economic Policy (Infitah) provided some impetus for the revitalisation of the private sector, the public sector continues to play a large role in the economy.

4. Though economic reform programmes were initiated by the late 1980s, in fact the macro-economic stabilisation and structural adjustment programmes were actually embarked upon in 1991 with the IMF stand-by agreement and a structural adjustment loan from the World Bank.[5]

5. Of particular interest to the context of the final evaluation of the PHCP/RD is the reorganisation of the public service sector in the direction of cost-recovery, as well as the trend towards decentralisation and privatisation.[6]

6. The Ministry of Health (MoH) plays a pivotal role in Egypt's health system in

[4] The following raises some points relevant to the brief overview of the socio-economic situation in the Governorate of Damietta. See Appendix A for a more detailed overview of macro-economic transformations in Egypt over the past decade.

[5] See The Economics and Politics of Structural Adjustment in Egypt: Third Annual Symposium, Cairo Papers in Social Science, Vol. 16, Monograph 3, Fall 1993, American University in Cairo Press; also various issues of Al-Ahram Al-Iqtisadi on public debates over the implications of structural adjustment programmes.

[6] See A. E. H. Dessouki, 'The Public Sector in Egypt: Organisation, Evolution and Strategies of Reform', in H. Handoussa and G. Potter, eds., Employment and Structural Adjustment: Egypt in the 1990s, ILO/World Employment Programme, Cairo: The American University in Cairo Press.

terms of the number of health facilities and health care providers under its jurisdiction. While services are nominally free to all citizens, in fact a minimal user fee is the practice unless clients are registered with the Ministry of Social Affairs (MoSA) as social welfare recipients or with low income, or unless they are targeted as part of the MCH and/or family planning (FP) programmes respectively.[7]

7. While the different levels of health care provision will be dealt with in section III/A of this Mission Report, it should be pointed out here that in spite of the trend towards decentralisation (every Governorate has its own Directorate of Health/DoH), managerial and other constraints continue to hamper the effective delivery of health services. A related and continuing problem is the health information system which, though there are some signs of improvement, nevertheless requires more concerted efforts to tackle fragmentation and information gaps.

8. Parallel to the public health system is a vast network of other health care providers, notably private medical practitioners and private clinics/hospitals (whose fees have increased markedly during the past decade), non-governmental charitable organisations, paramedics (notably nurses, nurse/midwives and TBAs [dayas]) as well as pharmacists.

B. THE GOVERNORATE OF DAMIETTA

1. Among the 26 governorates in Egypt, Damietta -- situated in the north-eastern part of the Delta -- is one of the smallest with an estimated population of around 830,000 in 1991 (expected to reach over one million by the year 2001) and a population density of 1,382/km2.[8] The annual population growth rate is estimated to be 2.1% (compared with a national average of 2.4%). Though around three quarters of the population is classified as rural, this varies by district. In fact, many parts of the Governorate can be classified as peri-urban, due not only to the blurring of boundaries between urban and rural settlements, but also to the inter-mingling of economic activities.[9]

[7] Currently, the price of the tazkara (ticket) in the RHU for patients not exempt from payment is E£ 0.50 (one US$ is around E£ 3.00).

[8] This represents an increase of around 70% relative to the population density in the mid-1970s (978/km2). See G. M. Craig, ed., The Agriculture of Egypt, Oxford: Oxford University Press, 1993, p. 88.

[9] Thus, for example, male civil servants may be working in the public sector during the morning hours and work on their small plot of land the rest of the day. Similarly, multiple jobs may combine work in one of the many small furniture production workshops and

2. Of equal interest is the fact that the current rate of rural unemployment is believed to be among the lowest in Egypt and that Damietta ranks third among the governorates on the human development index. This trend is reflected in the following indicators:[10]

2.1. The life expectancy rate at birth in 1990 was 64.8 years (compared with 56.4 years in the Governorate of Minya which is ranked 20th).

2.2. Around 99% of the Damietta population had access to safe water by 1986.

2.3. The adult literacy rate was 49.1% in 1986 (compared with 28.2% in Suhag which is ranked 21rst). Differentiated by area, the urban adult literacy rate in Damietta was in 1986 58.8% compared with 45.5% in rural areas. This compared favourably with Qena, where the urban/rural ratio in 1986 was 48.7% to 23.1%.

2.4. The mortality rate of children under five years was 80/1000 live births in 1989 (compared with 97/1000 in Minya which is ranked 20th).

2.5. The infant mortality rate in 1989 was 21/1000 live births (compared with 64/1000 live births in Aswan which is ranked 14th).

2.6. Around 26/1000 children were in 1990 not enrolled in basic or secondary education (compared with 279/1000 in Giza which is ranked 8th).

2.7. The combined basic and secondary school enrolment in 1990 was 86.7% (compared with 58.6% in Beni Suef which is ranked 19th).

2.8. The adult literacy rate (as a percentage of those aged 15 years and above) was in 1986 56.1% for males and 41.8% for females (compared with 44.2% for males and 14.5% for females in Qena which is ranked 16th).

2.9. Around 10% of the female population over 25 years had in 1986 secondary or higher education (compared with 2.8% in Qena which is ranked 16th).

2.10. The life expectancy rate at birth for girls was in 1989 65.6 years (compared with 59.7 years in Suhag which is ranked 21rst).

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cultivating subsistence and/or cash crops. In any case, Damiettans (or Doumyatis) have a reputation for industriousness in Egypt, and this has no doubt had some implication for the implementation of the PHCP/RD.

[10] See UNDP, Egypt: Human Development Report 1994, UNDP/ Institute of National Planning. The comparison is with other governorates which rank relatively lowest on the national human development index and/or where indicators are less positive.

2.11. The maternal mortality rate in 1992 was 102/100000 live births (compared with 655/100000 live births in Aswan which is ranked 14th).

2.12. However, the average age at first marriage in 1987 was 20.8 years (compared with 23 years in Ismailiya which is ranked 6th).

2.13. The literacy rate for women in the age group 15-24 years was in 1986 65.1% (compared with 29.8% in Fayoum which is ranked 17th).

2.14. Women in the labour force (as a percentage of the total) were in 1986 10.5% (compared with a high of 13.6% in Gharbiyya and a low of 4.2% in Qena).[11]

2.15. Around 94% of children one years old were in 1990 immunised (compared with 69% in Suhag which is ranked 21rst).[12]

2.16. In 1992, there were 14.3 physicians per 1000 people (compared with one physician/1000 in Giza which is ranked 8th).

2.17. Also in 1992, there were 118.8 nurses per 1000 people (compared with 3.6/1000 in Qena which is ranked 16th).

2.18. The total number of hospital beds in 1992 was 32/1000 people (of which 30 were MoH) (compared with nine in Menoufia which is ranked 11th).

2.19. The number of health units per 100000 population in 1992 was 3.6 (compared with 2.5 in Qena which is ranked 16th).

2.20. The income per capita in 1990 was US$ 1039 (compared with US$ 530 in Minya which is ranked 20th).

2.21. In 1990, 5.3% of the population was classified as poor and less than one per cent as ultra poor (compared with 51.7% poor and 17.2% ultra poor in Assyout which is ranked 18th).

3. Administratively, Damietta is divided into four separate districts: Damietta (37%

[11] However, it should be noted that these data are believed to be a vast under-estimate due to the fact that actual female economic participation in Egypt continues to remain largely invisible in the national statistics. See R. Anker & M. Anker, 'Measuring Female Labour Force With Emphasis on Egypt', in N. Khoury & V. Moghadam, eds., Gender and Development in the Arab World: Women's Economic Participation, UNU/WIDER, Helsinki, London: Zed Press 1995.

[12] However, it is not clear if this refers to full immunisation.

urban/63% rural), Faraskour (20% urban/80% rural), Kafr Saad (11% urban/89% rural) and El-Zarka (15% urban/85% rural), though keeping in mind the above observation the blurring of boundaries between the two sectors. Each district (markaz) has a main town/capital and a system of mother and satellite villages. There are at present 24 local popular village councils (LPVC) which serve 63 villages.

4. Production in the agricultural sector, which depends on irrigation, includes rice, cotton, wheat, clover, maize and some vegetable and fruit crops. There is also some livestock production (mainly cattle and buffalo), though small farmers generally sell little of the milk surplus. Donkeys/mules remain a means of transportation. Poultry production, which had been decreasing due to the lifting of subsidies on feed, appears to be on the increase with rising cereal production. In some parts of the Governorate, fish farming has become an important economic activity.

5. Furniture production, mainly by small enterprises, is a primary economic activity for which the Governorate is famous nationally. Other important small enterprises are confectionery and leather production, as well as fish canning. There is also an industrial complex near New Damietta (a new town) where a number of economic enterprises have been established. The new harbour is also expected to have positive economic impacts.

III. POSITION OF THE PHCP/RD IN THE DAMIETTA RURAL HEALTH SYSTEM

A. STRUCTURE OF THE RURAL HEALTH SYSTEM

1. There is a system of primary health care centres (also referred to as basic health centres) in all rural areas in Egypt, which are administratively linked to the sub-district, district and Governorate levels respectively. With regard to the rural health sector in the Damietta Governorate, there are at present three rural hospitals (RHs), four rural health centres (RHCs) and 47 rural health units (RHUs), with the latter in particular relatively evenly distributed among the villages.[13]

2. RHU medical/paramedical staff include physician(s), dentist, MCH/FP nurses, sanitarian and laboratory assistants. The RHCs have the same staff composition, but also provide in-patient care (the maximum number of beds generally being 14). As for the RHs, these have more facilities than the RHCs, which usually includes x-ray, operating room and in-patient wards (with a maximum of 24 beds).

3. The number of nurses is considered to be more than adequate, to a great extent due to the existence of nursing schools in all four districts and the fact that nursing has come to be viewed as a respectable profession for rural girls. While the number of physicians is also deemed adequate, the demand for female physicians nevertheless continues to exceed supply. In any case, while the PHCP/RD has undoubtedly had a positive impact on the quality of rural health service delivery, the fact remains that similar to the case in other governorates of Egypt, the health sector in Damietta is affected by lack of adequate funding to ensure the necessary level in service provision and maintenance of standards.

4. The Director General of the Directorate of Health (DoH) in Damietta is presently the officially designated Director of the PHCP/RD.[14] Up to the end of Phase III (1991-1993), the PHCP/RD was subject to the MoH which functioned as the implementing agency and controlled the project's budget. The Project Director, his Deputy and the Executive Director were all located in Cairo, while the Project Field Executive Directors were in Damietta. During the Extended Phase III (1994-1995), the PHCP/RD was decentralised and the project budget transferred to the DoH. There are now two Field Executive Directors (one for training, the other for basic health services) who are responsible for the implementation of the PHCP/RD under the Director General of the DoH. In reality, the link with the central level continues to be decisive in terms of policy decisions, while the overall management of the project is the responsibility of the DoH in Damietta.

[13] Verbal information from the PHCP/RD project management staff.

[14] At the time of the Final Evaluation Mission's field visit in November 1995, the General Director had been less than a year in his post.

B. OTHER AGENCIES' HEALTH PROJECTS

1. There are a number of donor funded projects in the Damietta Governorate which, in contrast to The Netherlands funded PHCP/RD after 1993, have been or continue to be managed from the central level, i.e. from the MoH.[15] These include:

1.1. The Child Immunisation Project (UNICEF).

1.2. The National Control of Diarrhoeal Disease Project (USAID).

1.3. The Schistosomiasis Control Project (WHO).

1.6. The Child Survival Project (USAID).

1.7. The Strengthening Rural Health Development Project (USAID).

2. An important project from the perspective of the PHCP/RD is the USAID funded Family Planning Systems Development implemented through urban and rural health units. As indicated in other sections of this Mission Report, there is a direct link with the PHCP/RD in relation to MCH RHU-based activities as well as the outreach programme. Moreover, since all RHU nurses receive training through the PHCP/RD, the skills of those implementing the FP component have obviously also been up-graded, keeping in mind that RHU nurses are apparently rotated between MCH and FP service delivery.

C. THE PRIVATE HEALTH SECTOR

1. The history of the private health sector in Egypt is inextricably linked to the public health system by virtue of the fact that physicians generally start their medical career in the latter. Moreover, the link tends to remain even when physicians work in the private health sector (either in private clinics/ hospitals or in their own private medical practice) since they generally continue to serve in the public health system. In any case, private physicians need to obtain a license from the MoH, which obviously implies that the latter

[15] Due to time constraints, the Consultants were unable to gather any detailed information on these donor funded projects implemented in the Damietta Governorate. Surprisingly, the latter barely receive a mention in the PHCP/RD documentation reviewed by the Consultants, not even the USAID family planning project even though it is very much linked to the RHU based MCH programme as well as to the HVP.

has a wide-reaching influence on the set-up and operations of private medicine in Egypt.

2. It is common knowledge in Egypt that this duality is one of the factors which have had/are continuing to have adverse effects on the public health sector in terms of the quality of service delivery. Thus, for decades the trend has been (and continues to be) a preference for the services of the private health sector whenever feasible. In fact, patients may go to a physician's private clinic in the afternoons even though they avoid that same physician in his/her capacity as a public health sector employee in the mornings.

3. Another important point are the networks of paramedical staff, i.e. nurses, TBAs and pharmacists, which play an important role in the private health sector. Thus, the work of TBAs links the public and private sectors respectively through the TBA training. The TBAs' work can be identified as an informal sector activity which also has an important social dimension (i.e. the role they play in traditional rituals such as the naming ceremony of new-borns, and preparation of brides for their wedding night). Pharmacists also play an important role as more or less surrogates of physicians, while nurses, specially if they have acquired a good reputation, will generally be sought out by their communities. This indicates the importance of training these paramedical service providers.

4. The on-going restructuring of the Egyptian economy has further stirred up public debates about the much needed reform of the public health sector and the latter's link with private medicine, a debate that remains largely unresolved. In any case, the introduction of cost recovery in the public health sector can be expected to have various implications for service delivery through the private sector.

5. However, the Consultants believe that the crucial issue in this context is not so much a question of public over private, or vice versa. Rather, the issue is and should be that the private health sector cannot replace public health services but should in fact complement the latter. Much will obviously depend on the manner in, and the extent to, which the policy of cost-recovery will be implemented, and the effect this will have on the quality of services provided by the public health sector.

6. In any case, the relevant point here is that the PHCP/RD in the Damietta Governorate has served to strengthen the capacity of the public health sector --in this case the RHUs -- to deliver better quality health services to a section of the population which may be unable/unwilling to resort to the private health sector.[16]

[16] The fact that, according to various discussions the Consultants had with health staff in the Damietta Governorate, there appears to be a trend of, for example, preferring private obstetricians in many village communities, is not a contradiction. It could very probably be related to the education level of patients, to their disposable income as well as decreasing fertility levels in the Damietta Governorate, keeping in mind that patients apparently generally remain only one night after child birth. In any case, this issue, including the fact that RH hospital beds apparently have a low occupancy, are in need of research, in particular the link between income levels, the use of private health services,

7. Another point pertinent to the context of this Mission Report is that, by virtue of the fact that the majority of RHU physicians are newly graduated and serving their obligatory year, they may not be involved with the private health sector. However, this is very much a tentative observation, since, similar to the private services offered by nurses and TBAs, physicians may be unwilling to disclose their private medical services due to the question of income tax.

8. According to data made available to the Consultants, there are currently 199 private physicians practising in the Damietta Governorate, of whom nine per cent are female; around 61% practice in the Damietta district, 20% in Faraskour district, 9% in Zarka district and the rest, i.e. 10%, in Kafr Saad district. This distribution may well have some implications for the use of RHUs in districts with relatively less numbers of private physicians, but is obviously a point also in need of further research. In any case, there are three private hospitals with a total of 270 beds in the Damietta Governorate, though the Consultants were unable to obtain accurate data regarding their distribution among the four districts.

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the gender/age of patients and the type of ailments. It should be added here that the low occupancy/non-use of beds in RHCs is due to the fact that the latter lack the necessary specialised medical personnel and equipment.

IV. BRIEF OVERVIEW OF THE HISTORY OF THE PHCP/RD 1985-93

A. PHASE I: 1985-1986

1. In 1982, a Dutch technical mission on health recommended the acceptance of an MoH project proposal which aimed to improve the rural health services in the Damietta Governorate.[17]

2. The bilateral agreement, signed in 1984, specified the general aim of the project, namely improvement of the quality of rural health services and, by implication, the health status of its rural population, in particular women and children as well as the less privileged.

3. The main objectives of the Primary Health Care Project Rural Damietta (PHCP/RD) were as follows:

3.1 strengthening the rural health information system (RHIS) and planning;

3.2. education and training;

3.3. field studies to supplement available information;

3.4. public health programmes which also aim to promote community participation;

3.5. renovation of health service facilities;

3.6. provision of vehicles and other equipment.

4. Though a number of difficulties were identified during Phase I, in particular with regard to administration, various achievements were also recorded:

4.1. improvement of some aspects of the RHIS;

4.2. carrying out of field studies;

[17] The Consultants could not elicit any satisfactory answer to the question why the Governorate of Damietta was chosen for the implementation of the PHCP/RD, other than the fact of its relatively small population size which implies that the project could eventually be implemented at the governorate level rather than being confined to a particular area/target.

4.3. improvement of communication channels between health service providers and local communities;

4.4. establishment of the training programme;

4.5. renovation of health facilities;

4.6. completion of the design of the Abadeyyah Training Centre.

5. It should be added that activities during Phase I were limited to the Faraskour district in the Damietta Governorate, and that the project management was based in Cairo (Nutrition Institute of the MoH).

B. PHASE II: 1987-1988

1. The PHCP/RD had from the outset planned a second phase, during which the following objectives were to be achieved:

1.1. introduction of/training in new MCH/FP registration;

1.2. establishing a regular supervision system;

1.3. implementation of PHC oriented refresher courses for all rural health service providers;

1.4. promoting community participation;

1.5. renovation of RHUs;

1.6. provision of basic medical equipment for RHUs;

1.7. establishment of the ATC.

2. Project activities were extended to include the district of Zarka.

3. A baseline survey involving 1300 households in each of the four districts of the Damietta Governorate was carried out (the findings of which were made available in 1989).

4. An evaluation of Phase II concluded that the PHCP/RD continued to be relevant and that, in view of budget availability, an extension was warranted.

C. EXTENDED PHASE II: 1989-1990

1. The Extended Phase II aimed to strengthen and consolidate achievements of the preceding phase.

2. The aims and objectives remained essentially the same but were more explicitly spelt out:

2.1. upgrading the RHIS;

2.2. strengthening MHC and FP through related health education activities;

2.3. promoting the use of the Family Folder (FF);

2.4. developing the home visiting programme (HVP);

2.5. supporting supervision activities, including those pertinent to TBAs (Dayas);

2.6. training TBAs;

2.7. training in health education;

2.8. strengthening the management of the PHCP/RD;

2.9. developing existing channels of community participation;

2.10. strengthening the infrastructure of rural health facilities.

3. The strategy for this phase included the extension of activities to new additional districts, namely Damietta and Kafr Saad.

4. An Evaluation Mission in August 1990 made a number of recommendations with regard to the Extended Phase II. It also recommended the extension of the PHCP/RD for a third phase of two years duration, i.e. 1991-1993.

5. The above Evaluation Mission also recommended that the proposed Phase III (1991-1993) initiate preparations for the phasing-out of The Netherlands support during 1992.

D. PHASE III: 1991-1993

1. While the aim and specific objectives of the previous phases remained unchanged, a number of new elements were added to the original objectives, namely:

1.1. promoting the active involvement of RHU physicians in the PHRP/RD activities;

1.2. promoting an integrated approach (IA) in selected RHUs;

1.3. including a focus on women's health as part of the incorporation of a women and development approach.

2. Reports on and evaluations of Phase III point to a number of achievements, notably:

2.1. improved communication between RHU health staff and the local community;

2.2. satisfactory implementation of the HVP;

2.3. strengthening of the supervision system;

2.4. satisfactory implementation of training courses;

2.5. improvements in the quality of services;

2.6. increased recruitment of Egyptian expertise;

2.7. integration of the PHCP/RD into the DoH system.

3. However, a number of constraints and problems were also noted, notably:

3.1. relatively high turn-over of RHU physicians;

3.2. a continuing focus on the curative rather than the preventive health aspects of the PHCP/RD;

3.3. slow process of decentralisation;

3.4. information delivered during the HVP was not always factually correct and indicated the need for more rigorous training in health education and communication skills;

3.5. outreach and training programmes continued to be dependent on the incentive system, and little effort was made in 1992 to initiate the phasing-out process;

3.6. the system of Family Folders (FF) was not always being optimally applied;

3.7. no realistic activities had been formulated for the integrated approach (IA);

3.8. implementation of a WID approach continued to be problematic;

3.9. the apparent decreasing frequency of project management meetings;

3.10. training of the project management staff had not led to the anticipated effect of adopting new approaches to management stressing teamwork, community participation and the importance of effective monitoring;

3.11. continuing emphasis on the quantitative at the expense of the qualitative aspects of project activities.

V. FINAL EVALUATION OF THE PHCP/RD
EXTENDED PHASE III (1994-1995)

A. PROJECT AIM AND OBJECTIVES

1. Introduction

1.1. Initially Phase III, the final stage of the project, was to last from the beginning of 1991 until the end of 1993, with a phasing out of The Netherlands' support by the end of this period. However, during 1993 it was decided to prolong Phase III for another two years -- 1994 and 1995 -- which in this Mission Report is referred to as Extended Phase III.

1.2. There were two reasons for this extension: First, the fact that part of the Phase III budget had remained unspent.[18] Secondly, the recognition that the DoH budget was constrained and therefore could not support:

a. maintaining the PHC training and the HVP;

b. shouldering the costs of the needs assessment of the reproductive health component.

1.3. However, the set-up of the PHCP/RD has undergone a change during Extended Phase III. Thus at the end of 1993, the PHCP/RD was officially integrated into the DoH system; i.e. the maintenance/renovation, the PHC training, the Home visiting Programme (HVP) and management/planning. As part of the process of decentralisation, the PHCP/RD management was transferred from the MoH to the DoH in the Damietta Governorate.

1.4. This change had some implications for the incentive system. Thus, while the MoH requires all donor funded health projects to include such a system, the latter is apparently paid out of the MoH budget. With the transfer of the PHCP/RD management to the DoH in the Damietta Governorate, there was apparently the decision on the part of MoH to consider incentive payments to be the responsibility of the project budget (which in turn explains why incentive payments were confined to the two most recent districts in which the project was implemented, i.e. Damietta and Kafr Saad).

1.5. In any case, The Netherlands' support during the Extended Phase III consists of the following:

[18] Apparently this was due to a miscalculation of costs.

a. supplementary financing for the implementation of the PHC training by the Abadeyya Training Centre (per diem for trainers and trainees in all four districts);

b. incentive payments for RHU nurses in the districts of Damietta and Kafr Saad;

c. technical and financial support for two innovative pilot activities geared to women: reproductive health care and home visits to poor elderly rural women.

2. Project Aim

Throughout the phases of the PHCP/RD, the aim of the project has remained unaltered, namely: to contribute to the improvement of the health status of the rural population of the Damietta Governorate, particularly of its women, children, and less privileged population, by improving the quality and utilisation of the existing rural health services and the orientation of health service providers.

3. Project Objectives

The assessment of the various objectives of the project during Extended Phase III (which are discussed under section C below), and which by implication includes the analysis of the implementation process during the previous phase (1991-1993), has not been facilitated by the following factors:

3.1. The terminology used in the various project documents (yearplans, progress and evaluation reports) regarding project objectives is not always consistent and is at times confusing.

3.2. Nor is there much consistency with regard to the way project components are analysed: at times they are discussed under a particular subject heading, while in other cases they are discussed individually, often without indicating any explicit link between them.

3.3. There is also the fact that the yearplans and progress reports do not consistently provide the quantitative information necessary for adequate monitoring.

3.4. Furthermore, no explicit monitoring and evaluation indicators appear to have been formulated and applied, a fact apparently linked with the unachieved aim of developing a consistent and effective rural health information system (RHIS).[19]

[19] Information given to the Consultants by the Royal Tropical Institute technical

B. RELEVANCE OF PROJECT OBJECTIVES

1. Health Policies of the Arab Republic of Egypt

1.1. The support of rural health services, viewed as part of the constitutional right of the rural population to adequate health services, has been a focus of the MoH for decades. However, there have been calls for the MoH to focus more attention on investing in preventive health care while at the same time ensuring the efficiency of the curative health system, and promoting the private health sector as part of economic reforms.[20]

1.2. As the UNDP Egypt Human Development Report 1994 points out, the health sector is constrained by a number of factors: First, there is a serious deficiency in managerial skills, which is at least partly related to the fact that posts are often occupied by physicians with limited management experience. Second is the 'absence of clear-cut policies, strategies and plans except for those initiated through investments'. Third, the information system remains inadequate in terms of being fragmented and incomplete.[21]

1.3. Given the above realities and constraints, one may conclude that the aims and objectives of the PHCP/RD have been relevant to the Egyptian rural population's health needs in terms of strengthening managerial capacity, supporting the development of an effective health information system and improving the quality of health services through the training of health service providers. This also includes the concept of preventive care, specifically with regard to MHC, immunisation and reproductive health care (though the implementation of the latter has been so far limited).

1.4. Much will obviously depend on the way a cost-recovery system will be operationalised, and to what extent this will affect the quality of health care.

2. Development Policies of The Netherlands

2.1. The development policies of the Kingdom of The Netherlands can be summarised as follows:

a. Over the years, poverty alleviation has been a constant feature of The

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assistant who had been involved in the PHCP/RD until 1993.

[20] See UNDP, Egypt Human Development Report 1994, op. cit., p. 61.

[21] Ibid. p. 31.

Netherlands' development policy, with the aim of enabling poor population groups to actively participate in economic and social life.

b. A sectoral approach is deemed necessary to pay closer attention to institutional aspects, and to emphasise the participation of the target groups in the design and development of rural programmes. Specifically with regard to longer term integrated and inter-disciplinary programmes, the aim is to foster autonomy and up-grade capacity.

c. Programme activities are expected to emphasise improving the position of women.

d. In light of projections for the most common diseases and child mortality, and given the relatively disadvantaged position of the poor in urban and rural areas, there is a clear need to continue to give high priority to 'Health for All' and to the extension of primary health care coverage.

e. Co-operation will seek to improve the quality of care in terms of both technical provision and achieving a better match between supply and demand. To this end, The Netherlands will contribute to the support of management, training, logistics and equipment.

f. The health care policy aspect of The Netherlands' development co-operation places emphasis on the harmonisation with the national policy of developing countries, as well as with the general strategies formulated by WHO, UNICEF and UNFPA.

g. In terms of implementation, this implies bilateral co-operation at district level to elaborate and put into effect a health care model, policy and methodology agreed upon at national level.

2.2. Taking the above as guidelines, it can be maintained that the aim and objectives of the PHCP/RD are by and large in line with the development policies of The Netherlands given the following characteristics of the project:

a. It is a longer-term rural development project (which in effect covered a period of ten years).

b. It is a sectoral project (health) which has been implemented in close co-operation with the Egyptian national and district authorities and which, moreover, is in line with the latter's health policies.

c. The project activities, based on a primary health care approach, have become an integral part of the existing health care delivery system in the targeted Damietta Governorate, specifically in the RHUs.

d. The development of human resources through formal and on-the-job training has been an important component of the PHCP/RD.

e. Attention has been given to cost control and efficiency (strengthening management capacity and the information system, developing and improving the maintenance system, developing the project model).

f. There has been an attempt to address community participation as part of an integrated approach to rural health service delivery.

g. Attention has also been accorded to women's health beyond the traditional focus on MCH.

2.3. However, it should be pointed out that the policy of poverty alleviation has not been strictly adhered to given the Damietta Governorate's rank in terms of per capita income and other socio-economic indicators (see section II/B). Though this does not negate the fact that there are relatively poor population groups in the rural areas targeted by the PHCP/RD, the question nevertheless remains why the project was not implemented in a poorer governorate.

2.4. Moreover, the WID approach was incorporated relatively late into the PHCP/RD, and has been confined to a relatively narrow health perspective.

C. ASSESSMENT OF PROJECT PERFORMANCE

1. Introduction

1.1. As indicated earlier, The Netherlands' input during Extended Phase III (1994-1995) focuses specifically on supporting training, the HVP in two districts, as well as the reproductive health component in two RHUs. In order to address the question of sustainability, the Consultants deem it important to discuss all project components of the PHCP/RD regardless of whether or not they are receiving funding until the end of 1995. To this end, outputs and activities during Phase III (1991-1993) are taken as a point of reference.

1.2. Keeping in mind the comments in section V/A/3 above, the assessment of project performance will focus on the following components which obviously interlap at various points: Maternal and Child Health, Training of Health Staff, Reproductive Health, Care of Poor Elderly Rural Women, Management and Planning, Infrastructure and Maintenance, as well as the Project Model.

2. Maternal & Child Health

2.1. Objective

From the inception of the PHCP/RD in 1985, strengthening MHC services was and has remained a major part of the project. The objective is the upgrading of MCH services through a number of inter-related project components:

a. training nurses, nurse supervisors, TBAs (Dayas), trainer of trainers as well as physicians through in-service training and refresher courses;

b. developing an effective home visiting programme;

c. establishing an effective supervision system involving governorate and district nurse supervisors.

In this section, the focus will be on MCH related RHU-based activities as well as the home visiting programme (HVP), both of which are linked to the supervision system. The related improvement of the rural health information system (RHIS), the up-grading of the RHU infrastructure and the training of health service providers are discussed in separate sections.

The objective of the MCH related RHU-based activities is up-grading the quality of ante- and post-natal health services and strengthening the link with child health care (including immunisation) as well as with family planning (FP). In turn this is linked with the HVP through the referral system and health education.

The objective of the outreach programme, which, as an official MoH policy, is the backbone of the MCH programme, aimed to:

a. promote a relationship of mutual trust between health care service providers and receivers;

b. increase the utilisation of RHU health services, in particular MCH and FP;

c. improve the village community's knowledge/attitude/practice (KAP) of preventive health care;

d. promote community participation in health programmes as part of encouraging self-reliance;

e. strengthen the capacity of health service providers to assess the health needs of rural communities and to develop appropriate health care programme planning.

In reality, the outreach programme has confined itself to two specific activities, namely the home visiting programme (HVP) and health education (HE), and this has remained the case throughout Phase III (1991-1993) and the Extended Phase III (1994-1995) respectively.

With regard to the supervision system, while this is an integral part of the DoH, the fact remains that it has been strengthened by the PHCP/RD through training and refresher courses. In fact, the supervision system has played an important part in the upgrading and maintaining the quality of outreach services.

2.2. Output

MCH related HVP incorporating FP and health education (HE) implemented in all four districts of the Governorate of Damietta by RHU nurses who have received appropriate training and refresher courses.

Face-to-face health education carried out by RHU nurses as part of the HVP, and group health education carried out in the RHUs.

Regular evaluation of RHU nurses by nurse supervisors.

A functioning referral system which has increased the utilisation of the RHUs.

2.3. Activities

The 1993 Yearplan indicated that the HVP is to adopt a different approach by focusing on 'at risk' families (reaching a coverage of 80% in all four districts) and reducing the number of routine visits.

The Evaluation Report of Phase III (1991-1993) indicates that the HVP can be considered a success in terms of the improved relationship between health care provider/consumer, increased utilisation of the RHUs, and that it had been implemented in all four districts with minor delays.

However, apparently there remained an ambivalent attitude on the part of RHU nurses towards the emphasis on promoting the utilisation of the RHU since this conflicted with the fact that the incentive system is tied to the number of actual home visits carried out.

It was also noted that the potential of the Family Folders (FF) was not being optimally utilised and thus its use by RHU physicians to strengthen preventive health services has remained limited.

An Evaluation of the HVP (September-December 1993) concluded that the outreach programme being implemented was not actively encouraging community participation,[22] that there was an inadequate understanding of the importance of the HVP by some health service consumers, and that the overloading of RHU nurses had some implication for job performance. It was also pointed out that the communication skills of RHU nurses required further up-grading, that there was a problem of transportation facilities/ costs in some of the districts, and, moreover, in some cases there appeared to be short-term shortages of necessary drugs in the RHU dispensary.

It was also noted that home visits by RHU nurses in the districts of Zarka and Faraskour, where incentive payments had been phased out, were noticeably less regular than the other two districts (Damietta and Kafr Saad) where incentive payments were continuing (until the end of 1995).

During the period January-June 1995 the HVP continued to be implemented in all four districts of the Damietta Governorate. The Progress Report for this period indicates that around 225 nurses in all four districts carried home visits to around 20 homes/week and that they were giving priority to at risk cases and reducing the number of routine visits.

MCH related home visits in all four Districts were incorporating
a focus on ante-natal care, child health care and FP.

2.4. Comments:

The Mission accompanied some of the RHU nurses during visits to homes in the districts of Damietta and Zarka. The impression is that the RHU nurses are well received and appreciated, and that the relationship is informal and friendly.

It is clear that, similar to the case of per diem payments for training, the incentive system has played an important role in encouraging the RHU nurses to take on what are essentially perceived to be additional activities even though they have now become part of the MoH/DoH health policy for outreach programmes.

The incentive system for family planning (FP) is continuing in all four districts, which implies the following:

a. RHU nurses are rotated so that each has a chance to benefit from the FP incentive system.

b. The FP incentive system is calculated on the basis of actual contraceptives distributed to women; i.e. the cost of the contraceptives is the sum which is divided

[22] The issue of community participation is discussed in a separate section, see V/E/5.

between the RHU doctor and the RHU FP nurse, with the share of the latter apparently higher.

c. This implies that in the two districts where the PHCP/RD incentive system is still operating (i.e. Damietta and Kafr Saad), RHU nurses are receiving two types of incentives, though not at the same time due to the rotation system in operation.

d. It appears that the target of reaching 80% of the at risk women during the HVP has not been reached. The project management staff estimate that the figure is nearer 30-50%, while other sources indicate a figure nearer 60%, with obvious variations between districts. No accurate data are available on the actual targets achieved.

e. There is no shortage of nurses in the Governorate of Damietta and, as indicated earlier, the supply exceeds the demand. In any case, while it is the PHCP/RP which has introduced the system of dividing the RHU catchment area in sectors of a maximum of 500 families, the DoH has no problem in providing the necessary number of nurses for these sectors. The advantage is that RHU nurses can be allocated to sectors in villages where they live, a fact which has played no small part in their acceptability by the village community and very probably in encouraging enrolment in nursing schools.

f. The above fact is used in dealing with unsatisfactory job performance of RHU nurses; i.e. the threat of being moved to another area which implies some hardship in terms of time and cost of transportation.

g. The Consultants' discussion with the project management staff concerning the incentive system revealed that the latter should not simply be viewed as an additional though obviously irregular income. Equally if not more importantly is the fact that it is actually a management tool, since the payment of incentives is linked to job performance which is evaluated by the nurse supervisors.

h. The Consultants' are of the view that given the above mentioned fact that the incentive system can function as an effective management tool, the MoH should explore innovative ways to ensure the continuity of the latter. However, it should be kept in mind that, if it continues, the incentive system should be fairly applied. For its part, and until this issue is resolved, the DoH should continue to strengthen the supervision system to ensure the continued effectiveness of the HVP. Moreover, strengthening the effectiveness of the HVP requires more concerted effort on the part of the DoH to reach the at-risk group.

3. Training of Health Staff

3.1. Objective

Training of health staff is an integral and on-going part of strengthening the RHU service delivery. As the Final Evaluation of Phase III (1991-1993) indicates, the activities related to this objective entailed training and refresher courses for:

a. nurse/TBA (Daya) supervisors;

b. trainers;

c. RHU nurses;

d. RHU physicians;

e. TBAs.

3.2. Output

The continuity and improved quality of MCH RHU-based activities, the HVP and health education supported through the training of health service providers.

The establishment of the Abadeyyah Training Centre (ATC) in Faraskour which is integrated in the DoH system, though training activities continue to receive funding support until the end of the Extended Phase III (i.e. December 1995).

Training curriculum and guidelines have been developed and applied during the training courses.

3.3. Activities

The Final Evaluation of Phase III (1991-1993) pointed to a number of positive developments including:

a. the formation of a Damietta-based group of trainers;

b. improved training methodology, curricula and training guides;

c. the integration of training activities in the DoH training department;

d. the financial commitment by WHO to support the training programme after the end of Extended Phase III (1994-1995).

However, the Evaluation also pointed to various constraints/ problems such as:

a. the focus on the quantitative rather than the qualitative aspects of training activities;

b. the inflexibility of training due to the on-going incentive system (e.g. outside expertise is difficult to recruit);

c. inadequate support of the HVP activities of RHU nurses by RHU physicians.

The Support Plan for Extended Phase III included the continuing funding of training activities, more specifically the implementation of refresher courses for trainers, RHU physicians, nurse supervisors, nurses, TBA (Daya) supervisors and TBAs.

According to the Support Plan, the planned number of 'person refresher days' for the targeted participants was 650.

In the Training Yearplan for 1994 it was planned that throughout the year a total of three courses (duration: 20 days) would be organised for PHC nurses; four one-day refresher courses for nurse supervisors; 12 two-day refresher courses for RHU nurses; four three-day refresher courses for new physicians; 10 one-day refresher courses for TBAs; two 10-day courses for TBAs; and 15 one-day refresher courses for training of trainers.

The Progress Report for the period March-September 1994 provides some information on training activities, but does not indicate whether the target number of courses/refresher courses had been implemented during the prescribed period. Nor is there any indication of the number of participants. However, the summary overview of 1994 (included in the 1995 Yearplan) indicates that training activities appear to have been implemented as planned.

The Yearplan 1995 includes PHC training and refresher courses for nurses, TBAs and trainers; introduction courses for nurses; workshops for physicians and nurse supervisors. Activities are specified by district.

A detailed plan of implemented activities[23] for the period January to mid-November 1995 indicates that: 243 nurses from all districts participated in refresher courses; 53 nurse supervisors attended refresher courses or workshops; 69 TBAs and TBA supervisors

[23] Hand-written report prepared by the ATC Director for the period January to mid-November 1995 and presented to the Consultants.

attended refresher courses; 31 trainers attended courses covering PHC and home visits to poor elderly rural women; 58 new nurses attended Introduction courses; and 22 physicians attended courses on HVP as well as on PHCP/RD activities.

3.4. Comments

The at times fragmented documentation made available to the Consultants, as well as the previously mentioned time constraints, rendered it difficult to obtain quantitatively accurate information on achievements in the area of training up to the time of the Mission's field visit in the Governorate of Damietta in November 1995.

However, from the available information on the number of courses and participants during the period January to mid-November 1995, and which indicates that a total of 476 health providers received training/refresher training, as well as from discussion with the project management staff, the Consultants conclude that this particular objective and its diverse activities appear to be more or less implemented according to schedule and content. More specifically, targets for 1994 are said to have been achieved and those for 1995 appear to be on schedule.

One of the Consultants participated in part of a refresher course for RHU nurses and concluded that these were well attended, that participants appeared interested in refreshing their skills and that they appeared aware of the importance of the latter to their RHU-based as well as HVP activities.

Nonetheless, it should be kept in mind that the financial support for training, more specifically per diem for trainers and trainees, has been assured until the end of December 1995, and that this fact obviously has positive implications for the implementation of planned training courses.

It should also be kept in mind that training for nurse midwives has been discontinued. This is due to the fact that practical training opportunities are apparently limited. Thus, according to project management staff, of 36 nurses recently trained by the PHCP/RD as midwives, only six are believed to be carrying out deliveries. The rest apparently lack confidence due to insufficient practical experience.

The following problems are expected to arise after the phasing-out of The Netherlands support:

a. There is no budget allocated for per diem payments for trainers and trainees or for training material. This means that PHCP/RD refresher courses will cease to be held, even though they are officially considered to be part of the DoH training policy.

b. It remains unclear if and when the financial commitment by WHO to continue to support the training component of the PHCP/RD will materialise, and DoH staff appear to

have conflicting information on this issue. In any case, this is understandably causing much concern among the PHCP/RD project staff and the ATC Director.

c. Previous experiences of other donor projects (for example the USAID funded rural health development project) point to the risk that stopping the incentive/per diem system has implications for attendance unless it is perceived as a compulsory requirement of the post and as a management tool for up-grading job performance. However, this fact should not be separated from the real problem of relatively low salaries of health service providers.

In any case, the Consultants believe that there is a real risk that the ATC may effectively cease to function after 1995 as long as there are no earmarked funds within the DoH budget to ensure continuity, and unless there is an explicit DoH policy to support its role as a training centre for as many health related activities as is feasible.

However, it should be kept in mind that this pertains to refresher courses only, since introduction courses for new physicians and nurses is part of the DoH policy and strategy and should continue on the basis of earmarked funds. Here the DoH can exert some pressure, since non-attendance implies no appointments to posts.

A rough calculation indicates that, given the number of nurses, a minimum of 4-5 refresher courses of two days duration is necessary twice a year, which requires per diem for trainers and trainees, training material and refreshments.

Until the issue of per diem for trainers and trainees is resolved (i.e. until the funding said to be committed by WHO for this purpose has been clarified, the DoH should attempt to explore innovative ways of ensuring that refresher courses continue to be regularly held. One effective means is to ensure that attendance continues to be obligatory and linked to the evaluation of job performance; another is to reduce transportation costs by de-centralising the courses and holding them in each district (e.g. in nursing schools). The DoH should also explore ways of ensuring that the ATC is not closed down after the end of The Netherlands' support in December 1995; rather its existence should be viewed as part of effectively integrating the PHCP/RD in the DoH system.

4. Reproductive Health

4.1. Objective

The PHCP/RD component on reproductive health, based on the Giza Reproductive Health Model[24], was introduced for the first time during the PHCP/RD Extended Phase III

[24] The Model piloted in Giza (one of the rural governorates south-west of Cairo) is part of a multi-disciplinary research by the Population Council in West Asia and Africa

(1994-1995) as part of the implementation of health-related aspects of a women in development (WID) approach. The specific objective included:

a. up-grading the quality of services of RHUs to meet the reproductive health needs of women;

b. promoting mutual trust between health care providers and the target population in the selected pilot area;

c. promoting a better understanding of/attitudes towards reproductive health and related problems at the community level;

d. implementing a reproductive health component in two pilot villages in the Damietta Governorate.

4.2. Output

Reproductive health incorporated into the health services of two RHUs (El-Bustan and El-Dahra) in the District of Damietta.

Reproductive health incorporated into the HVP of the above mentioned RHUs.

Selected women in the targeted villages with increased awareness of reproductive health.

Increased utilisation of the selected RHU by women with reproductive health problems.

Increased referrals of women with reproductive health problems to rural hospitals.

4.3. Activities

Distribution of the DGIS paper 'Women and Health' to PHCP/RD staff and interested RHU female physicians.

Commissioning a local consultant in 1993 (female professor in community medicine) to

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Region. The conceptual framework on reproductive morbidity includes women's own perceptions and the ability of health services to meet their needs. See H. Zurayk, N. Younis and H. Khattab, 'Rethinking Family Planning Policy in Light of Reproductive Health Research', in C. M. Obermeyer, ed., Family, Gender and Population in the Middle East, Cairo: The American University in Cairo Press.

mobilise women in a selected village.[25]

Workshop on Women and Reproductive Health Care in the Context of the PHCP/RD (Amsterdam 1994).

A local consultancy firm (Delta Consultants) was commissioned to carry out action research in two villages in two rural districts in Damietta with the following specifications:

a. a village population of 5-10 thousand;

b. a female physician in the selected RHU serving for at least one year;

c. the involvement of two gynaecologists from district hospitals to train the RHU physicians;

d. a sample of 100 ever-married women in each pilot village, and a sub-sample of 50 women for further in-depth research;

e. easy access for the research team;

f. acceptance by the village population, to be achieved through co-operation with social workers and information sessions with husbands of the randomly selected target group;

g. the participation of the target population (200 randomly selected women of reproductive health age) would be encouraged through free medical examinations, laboratory analysis and
treatment, and the provision of free follow-up services.

The pilot implementation of the reproductive health component entailed:

a. the incorporation of reproductive health as part of health education delivered through the HVP;

b. the provision of necessary medical equipment for gynaecological examinations.[26]

[25] However, it appears that no documentation has been forthcoming on this particular activity.

[26] For detailed information of the planning of this project component, see Reproductive Health Care: PHCP/RD 1994-1995 (Phase 3), April 1994.

4.4. Comments

The Consultants visited one of the RHUs (El-Bustan, Damietta District)[27] where the reproductive health project component is being implemented as part of the MCH RHU-based activities as well as the HVP.

The implementation appears to be proceeding smoothly even though the input from the Delta Consultants has come to an end.

It is evident that the female physician in El-Bustan RHU is enthusiastic about this project component which she feels has added to her skills and has increased demand for her services by women with reproductive health problems.

However, the Consultants noted that the filing system requires attention, since no cross-reference appears to have been established between the patients' cards on reproductive health and the FF and/or FP files of these patients where applicable. In effect, the opportunity to strengthen the RHIS is being neglected.

The RHU nurses appeared equally enthusiastic. The additional workload is being balanced by the more rigorous focus on at risk groups and the reduction of routine home visits.

The Consultants note that the smooth implementation of this project component is obviously also facilitated by the continuing payment of incentives (as part of the HVP).

The Consultants accompanied some of the nurses from the El-Bustan RHU during home visits related to the reproductive health project component and notes that the HVP is crucial to the follow-up of women with reproductive health problems. This is particularly apparent in relation to the fact that a number of women continue to neglect their reproductive health problems and need to be regularly followed up.

The Consultants also noted during the home visits that not only do women require more information on the subject of reproductive health and that RHU nurses could benefit from further up-grading of their communication skills. There is also the fact that husbands need to be reached more effectively to ensure, for example, that uro-genital diseases do not keep recurring.

It is also noted that there do not appear to be any plans to implement this project component in other RHUs/districts due to DoH budget constraints.

[27] In the other RHU (El-Dahra), the female physician has left and been replaced by another female physician who has not received training as part of the implementation of the reproductive health project component. However, the Consultants were given to understand that the latter continues to be implemented, since the RHU physician can refer cases to the RH.

However, the Consultants note that linking the implementation of this project component to the presence of a female physician in the RHU actually implies that its possible replication in other RHUs in the Governorate of Damietta would remain limited. In other words, it is important to evaluate whether the absence of a female physician is indeed a constraint, given the fact that RHU male physicians insert IUDs and the equally important trend of preferring the services of the private sector for deliveries, which in fact is dominated by male obstetricians.[28]

Finally, it appears that the issue of female circumcision is not being explicitly addressed as part of reproductive health. While this continues to be a culturally sensitive issue in Egyptian society, the fact remains that a number of women activists and women's NGOs (many of them based in Cairo) have become more vocal in their attempts to discourage this ritual (which is not religiously sanctioned as is so often erroneously claimed). In any case, the Consultants believe that this issue should be part of the agenda of addressing women's reproductive health problems.

Given the importance of the reproductive health component to an integrated approach to women's health (a fact taken on board in the project being funded by The Netherlands in the Fayoum Governorate), the Consultants believe that the pilot trial should be replicated. In view of budget constraints, the DoH should consider formulating a project proposal to this effect. However, the strategy of linking this project component with the presence of a RHU female physician needs to be reconsidered.

5. Care of Poor Elderly Rural Women

5.1. Objective

The PHCP/RD objective of targeting poor rural elderly women over 60 years of age as part of the Home Visiting Programme (HVP) was introduced for the first time during the Extended Phase III (1994-1995). Similar to the reproductive health objective, it was conceived as part of a more explicit approach to women in development:

a. to promote access to needed health services of poor elderly rural women over 60 years of age, who had no or limited kin support, who were on low incomes/social

[28] Various conversations and focus group discussions with RHU health staff on this subject indicate that the issue is not only the sex of the RHU physician, but also the anonymity of treatment received in health facilities outside the village community. This points to the fact that reproductive health related ailments and diseases largely continue to remain a taboo subject. However, as the project management staff rightly indicated, this cannot be generalised and will tend to differ from one village community to the other.

benefits and whose mobility was constrained by physical or other reasons;

b. to develop the HVP in terms of integrating the health needs of poor rural elderly women.

5.2. Output:

Selected poor elderly rural women in all four rural districts in the Governorate of Damietta with access to social support and medical care.

Increased utilisation of RHU services by elderly rural women.

A more diversified HVP responding to felt needs in the rural community.

RHU nurses trained in medical support skills targeting the elderly.

5.3. Activities:

Workshop to develop training curriculum for service providers.

Courses for the training of trainers.

Introduction courses for RHU physicians, nurse supervisors and nurses.

Information day for social workers to introduce the new RHU project objective.

Development of a geriatric drugs list and case cards/files.

Home visits targeting poor elderly rural women started at the end of 1994 in the District of Kafr Saad. By June 1995, all four districts in the Damietta Governorate had incorporated this activity as part of their outreach programme. The target group currently involves around 5000 poor elderly rural women, which means an average case-load of 20 per RHU nurse.

The evaluation study 'Health Care for the Aged', Kafr Saad, Damietta, 1995 (in Arabic and English) confirmed that the selection of the target group had been effective (in terms of being poor and with no/limited kin support).

The DoH Seminar on Health in October 1995 had as one of the two focal points the targeting of poor elderly rural women, and the PHCP/RD experience was upheld as role model worthy of replication.

The production of a video (in Arabic and English) as part of the aim of disseminating

information on this project component.

5.4. Comments

The Mission attended part of a refresher course (held once/year) for nurses in the Damietta district, which also focused on the project component targeting poor elderly rural women. In addition, a focus group discussion was held with both the nurse/ participants attending this course, as well as with the nurses in one of the RHUs visited in the Damietta district where this project component is being implemented.

It was evident from the discussion that the nurse/participants were enthusiastic and motivated about this 'new' activity, and that they felt they were providing much needed support to a target group which had hitherto generally been neglected and which, due to transformations in Egyptian rural society, was not receiving the traditional support of kith and kin.[29]

The most common diseases identified by the nurses with regard to the poor elderly rural women are diabetes, asthma, high blood pressure, rheumatism and eye problems (in order of priority).[30]

However, though the nurses indicated their satisfaction at being able to offer emotional support and advice/counselling to the target group, and that they did not mind the additional workload, they also feel frustrated at not always being able to follow this up with the needed practical help in terms of access to affordable medication. The RHU drug dispensary apparently does not always have the necessary medicines (in particular for the treatment of diabetes).

Though, on principle, the Directorate of Social Affairs (DoSA) would, in the case of poor patients who could not afford the market price, provide financial or other help, the fact remains that there is no guarantee that such aid will be accorded and, furthermore, there can be quite a time gap until it is forthcoming. In any case, it requires the nurse to contact the social worker to activate this kind of support, and much will depend on the established system of co-operation between the two types of service providers.

There is also the fact that RHU physicians are generally disinclined to visit the elderly,

[29] However, it should be kept in mind that the targeted poor elderly rural women do not necessarily live alone or in isolation; i.e. they may be living within the extended family but not receiving adequate attention and/or their kin are unable/ unwilling to finance the necessary medical treatment.

[30] However, the Consultants note that the diagnosis of diabetes appears to be relatively high and that this may indicate a need to check on diagnostic procedures practised by the RHU nurses.

mainly because of the rule that they cannot leave the RHU without prior notification of their superiors. While the RHU nurse is instructed to refer serious cases to the RHU, some of the target group are unable to attend due to physical disability or other constraints.

The Consultants' findings reconfirm the conclusions of the above mentioned evaluation study on 'Health Care for the Aged', specifically with regard to the drug list and medical services for geriatrics. The DoH should therefore ensure that RHU dispensaries receive the appropriate geriatric drugs on a regular basis. In any case, the evident success of this project component, which has been implemented in all four districts of the Damietta Governorate, should encourage the MoH to consider its replication in other governorates in Egypt.

The above mentioned evaluation also pointed to the need for the Department of Social Affairs (DoSA) to more effectively target the elderly. To which should be added the need to ensure more effective co-ordination between RHU nurses and social workers, a strategy which requires an input from both the DoH and DoSA.

However, the Consultants also note that there is a need to mobilise other sources of support to the elderly; for example through the identification of actual or potential activities by NGOs targeting the elderly, as well as through the mobilisation of community support as part of the PHCP/RD's aim to promote community participation. This becomes all the more crucial at a time when the HVP programme is under pressure due to the phasing out of the incentive system.

6. Management and Planning

6.1. Objective

The original PHCP/RD PlanOps in 1985 specified the strengthening of the management and planning capacity of the rural health system in the Damietta Governorate. This component, which has remained a focus throughout the history of the project, entails the following objective:

a. To develop and evaluate a simplified set of forms for the RHIS that is fully implemented in a few selected units. This set of forms should after data-processing at RHU level be useful for the RHU as a management tool. At the same time, the forms should present a true reflection of the health standards and health care situation at RHU and community level and be acceptable to the MoH.

b. Enhance relations between six selected RHUs and communities who will have the capacity for planning health services, expressed through the listing of health

priorities in which gender related aspects are included and which are agreed on by RHU staff and the community.

c. Conduct an operational baseline study for the implementation of the integrated approach. The outcome of this study is to serve as a comparison for a further operational evaluation study at the same RHU after six months of implementation of the integrated approach.

d. Assess the possibilities for the integration of TB control in the rural health services.

e. Have a full documentation and a set of manuals and guidelines regarding relevant project activities.

f. Furthermore, by the end of Phase III the implementation responsibilities for management and planning were to be integrated into the DoH, and RTI staff were to limit themselves to an advisory function.

6.2. Output

A relatively more efficient filing system through the development of the Family Folders (FF) with retrievable information, and linked with the family planning activities in the same RHU though the process continues to require attention.

The planned baseline household field study was conducted during Phase III in the Districts of Kafr Saad and Damietta, and provided much useful background information on the areas concerned and for the planned evaluation of project activities.

Furthermore two internal evaluations of some project components/sub-components were conducted (TBA training, home visits to poor elderly rural women).

Vertical links between the FF with the National TB Control Programme.

The responsibility for health management and planning was integrated as planned into the DoH by the end of 1993.

6.3. Activities

During Phase III (1991-1993), and in spite of the efforts expended, development and implementation of a simplified set of forms for the RHIS did not completely succeed (even with the help of consultants). Three serious attempts were made to:

a. develop and test a limited number of simplified health

information forms;

b. link the RHIS with the family folder filing system, used and maintained by the nurses who made the home visits;

c. develop the family folder system into one for general use in the RHU.

Much effort was put into the development of the so called 'integrated approach' (IA), i.e. an integration of Village Health Planning (VHP) within the RHU, upgrading of the RHIS, community participation and women's health. The rationale for this approach was that the RHU was not approached as a functional entity, neither by the project, nor by the supervising health structures. Moreover, the RHU staff did not tend to see themselves as a functional team with shared responsibility.

The integrated approach was implemented as a trial with physicians in six selected RHUs. The physicians held regular meetings in order to:

a. develop a checklist on RHU data and activities and use the list in their own RHU for baseline data and evaluation;

b. analyse the situation at RHU level, with special attention for those activities where the project experienced problems in giving effective support;

c. bring the results of the discussions to the monthly physicians meetings with the DHD.

In the Revised Year Plan/Phasing-out Plan of the PHCP/RD 1/7/-31/12/1993, the upgrading of the RHIS was considered not to be sustainable in the post-project phase.

During the Extended Phase III, though the development of the RHIS, as well as the question of effective community participation, remained of concern to the DoH which continued to put effort into both areas (although not vigorously), no new objectives were formulated for this project component for the period 1994-1995.

6.4. Comments

The relative failure of the attempts to simplify the RHIS indicates that obstacles had been underestimated. The expansion of the FF system into one for general use was more complicated than expected. The design of new forms and their acceptance in the MoH took longer in spite of earlier assurances.

The trial implementation for the integrated approach was deemed not to be successful and has since been discontinued for the following reasons:

a. The DoH was not in a position to give effective support to planning efforts at RHU level, as at district level no formal planning of activities had been taking place.

b. The RHU physicians responsible for unit activities were mostly young and in their one year obligatory public health service. Only a few of them remained after their obligatory period.

c. The desired link between health information and planning at RHU level could not be realised during the time available.

d. The democratic institutions at village level were not always active and there was little that young doctors could do to revitalise existing channels for participatory decision-making. Though some had regular contacts with the (appointed) village officials of the Local Popular Village Council (LPVC), they still experienced problems in establishing effective links which would have been conducive to promoting village health planning.

e. Though the physicians involved in the trials highly appreciated the meetings and claimed to have gained a different perspective on their work, they nevertheless believed that it would take some time to change customs and attitudes at the village level, as well as achieve the necessary changes in the university education system and the government health system.

f. Unfortunately, the project did not systematically follow-up the results and recommendations of the baseline household studies as indicated in the PlanOps 1991-1993. This was due to time constraints in general, but also because it proved to be very difficult to properly analyse the operational situation at RHU level and to determine approaches for improvement.

g. The Mission's discussion of management and planning with the project management staff confirms the above observations. More specifically, the latter pointed out that:

* The concept of village health planning (VHP) as part of community participation continues to be misunderstood by the LPVC, who look at meetings as a forum for focusing on problems rather than discussing possible solutions.

* A big obstacle is the policy of appointing newly graduated physicians to serve one year in the RHUs. The reality is that these physicians are viewed by the village community as outsiders who are not serving out of choice. In fact, some physicians may not spend the obligatory year in one RHU but are moved elsewhere, often due to complaints by the LPVC.[31]

[31] An example of the positive implications when RHU physicians enjoy the trust of the

* Conversely, RHU physicians also view themselves as outsiders biding their time until they can proceed with further training to specialise in a particular medical field. Their alienation from the village community is often inadvertently encouraged by the neglect to formally introduce them and to set up mechanisms of communication.

* The above observations obviously also have implications for the co-operation between the RHU physician and RHU staff, who tend to view the latter as young and relatively inexperienced.

In any case, the Mission noted that there is no consensus regarding the need for further attempts to develop and implement the IA, and, by implication, strengthen the RHIS.

The DoH needs to give careful attention to the manner in which newly appointed RHU physicians are introduced to the village community, and to avoid transferring them during their obligatory year of service.

The DoH/MoH also need to expend continuous efforts in devising new strategies to overcome the problems encountered in the implementation of a more effective RHIS. By implication, this requires re-evaluating the constraints encountered in the implementation of the integrated approach and the related issue of community participation, particularly given the latter's link with the sustainability of the PHCP/RD after the end of The Netherlands' support in December 1995.

7. Infrastructure and Maintenance

7.1. Objective

This component has been part of the PHCP/RD from its inception in 1985, the objective of which included:

a. renovating the physical structures of RHUs and providing the latter with basic medical equipment;

b. developing a maintenance scheme as part of a maintenance workshop;

c. providing the necessary vehicles.

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village community is the El-Bustan (Damietta District) RHU where the reproductive health component is being implemented and where the female physician is a member of the village community.

By the end of Extended Phase II (1989-1990), the objective of providing all health units in the four districts with basic medical equipment had been achieved.

The remaining activities spelt out for Phase III (1991-1993) included:

a. renovate five RHUs;

b. establish a training sub-centre in Kafr Saad district;

c. set up a maintenance programme;

d. purchase equipment for the maintenance workshop;

e. replace three project vehicles;

f. provide two computers for the project management.

By the end of Phase III, the project component infrastructure and maintenance was, as planned, integrated into the DoH structure.

No new objectives were formulated by the DoH for the years 1994 and 1995.

7.2. Output

Renovated RHUs ready according to plan.

Regular (preventive) maintenance scheme for five facilities implemented as a pilot project, and tools and spare parts purchased for the maintenance workshop.

Three new vehicles purchased.

7.3. Activities

The plan to establish a training sub-centre was found difficult to implement for the following reasons:

a. it proved difficult to find an alternative location to the one agreed to after the refusal by the village council on the grounds that beds would be lost;

b. a possible location in a new district hospital was not acceptable to the project management as these hospitals are not part of the rural health system;

c. the problem of staffing the centre;

d. the focus on the ATC was believed to be the best insurance for consistency and quality of training.

At the end of 1991 during an external consultancy ideas for a pilot maintenance scheme was developed and five RHUs selected.

A revolving fund for spare parts was established.

The PHCP/RD paid incentives to maintenance staff.

7.4. Comments

By 1992, the buildings of all RHUs in the four districts were deemed to be of an acceptable standard.

The budget funds which had been allocated for the training sub-centre were made available for other renovation purposes.

During Phase III, regulations were changed which made it possible for the maintenance workshop to carry out repairs to buildings (up to a ceiling of E£ 500.-) as well as equipment.

After the integration of this project component into the DoH structure by the end of 1993, the renovation of health units stopped. Since then, all RHUs have been included in a quarterly maintenance scheme and incentives have been phased out.

The DoH needs to ensure that the preventive maintenance programme will continue and is further strengthened as part of the strategy of reducing unnecessary costs.

8. Project Model

8.1. Objective

One of the objectives formulated in the PlanOps of Phase III (1991-1993) concerns the development of a project model which aimed to produce a set of manuals and guidelines

regarding project activities by the first quarter of 1993.

The rationale for the development of a project model was based on the MoH's perception of the PHCP/RD as a pilot project, with integrated activities in the field of training, management and planning, which can be replicated in other governorates in Egypt. To this end, documentation in terms of guidelines and manuals was required.

8.2. Output

A National Conference in 1993 during which papers on the various project activities were presented.

Documentation, comprising eight booklets, on each project objective (but excluding the two added during Extended Phase III).

8.3. Activities

In March 1992, a consultant from the Royal Tropical Institute (KIT) visited the PHCP/RD to assist in the development of the project model, which entailed preparing proposals on form and content of papers on the various project objectives.

These proposals were also viewed as part of the external mid-term evaluation carried out in 1992.

In November of that year, the KIT consultant revisited the project and formulated the 'Amended Plan of Action for the Model Development of Rural Damietta PHC Project'.

Based on this plan of action, the model was developed between the end of 1992 and the summer of 1993 by a team consisting of participants from the MoH and DoH, as well as external consultants.

Another activity in relation to the development of the project model was a seminar on sustainability during 1993.

The booklets presented to the National Conference in 1993 covered the following areas:

a. Project Design and Organisation.

b. The Outreach Programme.

c. Maintenance, Equipment and Renovation.

d. Training.

e. Health Information System.

f. Community Participation.

g. Daya Programme.

h. Unit Management and Supervision.

The booklets, available in Arabic and English, contain relevant information on programme objectives, activities, achievements, constraints and lessons learnt, as well as the requirements for sustainability.

8.4. Comments

From discussion with the project management staff, the Consultants concluded that the process of developing a project model was perceived as an important and rewarding exercise.

More specifically, the mobilisation of the interest of many officials in health related issues addressed by the project model proved to be stimulating. It demonstrated the potential for raising awareness of concepts, problems and possibilities of the implemented approach.

The project model development also contributed to the process of phasing out The Netherlands' support. The principle of integrating project objectives into the DoH system was accepted, in particular training and the HVP. However, there was awareness that funding constraints affecting continuity needed to be addressed, and to this end several possibilities were discussed and pertinent recommendations presented.

By all accounts, participants in the National Conference were appreciative of the efforts which went into the project model development, specifically the open manner in which constraints were discussed, and there are a number of references in the pertinent documentation to this effect.

D. ASSESSMENT OF THE IMPLEMENTING AGENCIES

Here again time constraints impeded the Consultants from gaining an in-depth overview of the performance of the implementing agencies. The following comments are therefore necessarily presented in rather general terms, though this does not diminish their

validity.

1. PHCP/RD Project Management Team

1.1. One positive aspect of the PHCP/RD is that a number of the management staff, notably the Field Executive Directors as well as at least one of the District Medical Directors, were involved more or less from the outset. This has obviously had implications for continuity, given the fact that the post of Director General is generally subject to relatively frequent turn-over.

1.2. Here and there in the PHCP/RD documentation there is mention of the fact that adoption of a more team oriented management style by the project management team has not been taken on board to the extent desired and anticipated.

1.3. The Consultants were unable to pursue the above observation further for reasons mentioned earlier. However, the fact remains that it should be kept in mind that, for example, the Field Executive Directors actually shoulder a double responsibility, i.e. those related to the PHCP/RD, and those related to their original posts in the DoH (in this case being the Heads of the Department of Training and Basic Health Services respectively). While it remains difficult to analyse the specific implications of this duality without further pertinent insights, the Consultants nevertheless would like to point out that the effect of the prevalent management style as well as bureaucratic pressures of the DoH should not be under-estimated.

1.4. In any case, based on the discussions with the project management staff in the Damietta Governorate, both individually and as part of focus group discussions and briefing meetings, the Consultants were left with a favourable impression. In particular, the project management staff appear to be genuinely concerned over the sustainability of the PHCP/RD, and to be prepared to invest much effort in ensuring its continuity.

2. Royal Tropical Institute (KIT)

2.1. The overview of the PHCP/RD and evaluation of objectives points to the impressive achievement of the Royal Tropical Institute (KIT) in implementing the PHCP/RD, for which the Consultants would like to commend them. The relative lack of success in implementing a few of the project components, notably the RHIS and the integrated approach, was more or less beyond the control of KIT.

2.2. The KIT was positively evaluated by the project management staff and other health authorities, and it is obvious that a good working relationship was established between the latter and KIT technical staff who have contributed substantially to the

PHCP/RD's achievements. KIT also received a favourable rating by The Netherlands Embassy in Cairo.

2.3. While the incorporation of the WID approach was by all accounts at the instigation of the donor, the Consultants nevertheless note that the onus was perhaps on KIT to tackle this matter in a more effective way: Firstly, a WID approach should have been part of programme planning in the mid-1980s; secondly, the grounds for incorporating WID should have been better prepared.

2.4. While the individual KIT reports and evaluations are of good quality, the Consultants nevertheless note the need to define more explicit monitoring and evaluation indicators, and to formulate a framework which facilitates the comparison of the activities of the different phases of the PHCP/RD.

3. Local Consultants

3.1. A number of local/Egyptian consultants (individuals as well as firms) have been involved in one or the other capacity in the PHCP/RD. This can be considered a positive aspect since it addresses the issue of involving Egyptian expertise as part of project continuity and sustainability.

3.2. Thus, a number of studies, notably on the RHIS and on WID, were commissioned over the past few years, and there has also been a local input in the field of training. According to various sources questioned by the Consultants, some of these inputs have been of a high standard, others less so.

3.3. The Consultants are obviously not in a position to evaluate these inputs other than as part of the project documentation to which they had access. However, it is striking that a recurrent issue raised during the pertinent discussions was the fact that local consultants, be they individuals or firms, apparently neglected to ensure sufficient communication and co-operation either with the health authorities or with the target population in the field. The project management staff in particular voiced the criticism that they felt they were insufficiently consulted during the planning and implementation of some of the commissioned consultancy work.

3.4. Be this as it may, the fact remains that communication needs to be singled out as a particular problematic which is obviously also subject to the intricacies of the bureaucracy. In any case, the Consultants are of the view that valuable lessons can be derived from this experience for the on-going Netherlands funded health project in the Fayoum Governorate, and which is also being implemented by the Royal Tropical Institute. In particular there appears to be a need to set up a formal framework for communication and co-operation, and not to rely on ad-hoc discussions which are not minuted or in which not all pertinent actors have participated.

E. VALUE ADDED BY THE PROJECT

1. Introduction

Time constraints also impeded the Consultants from gathering quantitative data to assess the value added by the PHCP/RD. However, the review of project documentation, the focus group discussions with health staff as well as field visits to RHUs, a RHC, a RH as well as home visits to patients have provided the Consultants with some, albeit general, insights into this issue.

2. Rural Health Service Delivery

It is obviously difficult to isolate the direct impact of the PHCP/RD from other impacts external to the project. As the socio-economic indicators in section II/B indicate, the Damietta Governorate is presently ranked third on the human development index and there are a complexity of factors which account for this development. However, it can generally be maintained that, compared with the situation prior to the implementation of the PHCP/RD, i.e. the mid-1980s, the present rural health service delivery system in the Damietta Governorate exhibits a number of positive developments a number of which can be directly linked to the project.

2.1. Infrastructure

a. One of the PHCP/RD's objectives was the up-grading of the infrastructure of RHUs. In effect, this objective has been achieved and all pertinent RHUs have been renovated. By all accounts, the DoH is continuing to invest an effort in maintaining standards and has in fact been building new RHUs
(with some input by local communities).

b. The RHUs visited by the Consultants, some of them without prior notification, exhibit quite an acceptable standard of cleanliness and organisation, both within as well as outside the premises.

c. The medical equipment, some of which has been provided by the PHCP/RD, appeared to be put to good use and to be generally in good order.

2.2. Rural Health Care Providers

a. The effect of training and supervision of RHU nurses is evident in the latter's clean uniforms, well-maintained HVP kits, as well as in the individual log books (in which weekly home visits are registered in advance and serve as a basis of the evaluation of job performance), the Family Folders (FF) and the Family Planning (FP) files.

b. To anyone familiar with conditions in other parts of rural Egypt, notably the southern governorates, the demeanour of RHU nurses is as striking as are the relatively well-kept RHU premises.

c. These facts also largely apply to the two districts where the PHCP/RD related incentive system has been phased out, and in spite of the apparent trend that RHU nurses have been reducing the number of their home visits. As indicated earlier, this development is being tackled by the health authorities through the supervision/evaluation system and the threat of transfer to another RHU, which implies a disadvantage in terms of distance and transportation costs.

d. With regard to RHU physicians, the difference in attitude and motivation between those who are serving their obligatory year and those who are longer-term and, in some cases, part of the village community, is in some cases evident. Nonetheless, by all accounts, the introductory training which RHU physicians receive as part of the PHCP/RD, as well as serving in relatively well-kept surroundings and with well-trained health staff, do tend to have some positive effect.

2.3. Quality of Care

a. The attendance of RHU nurses in training and refresher courses, further encouraged by the per diem system, has undoubtedly had positive implications for the quality of health care both within the RHU as well as part of the outreach programme. This trend is also further entrenched by the fact that there is no shortage of RHU nurses, and that each is allocated a relatively manageable target group.

b. These facts have been confirmed by various evaluations as well as by DoH staff who have been involved with the PHCP/RD for many years and are familiar with the situation in the mid-1980s.

c. However, it is also evident that the incentive system has some implications for maintaining the quality of health care standards, specifically in relation to the outreach programme. As indicated in previous sections of this Mission Report, ways must be found to ensure that this system continues to be implemented as an effective management tool.

d. It is also evident that the quality of care is directly linked with an effective

supervision system as well as regular refresher courses. While the first mentioned factor is part of the DoH strategy, and as such can be expected to continue its designated role, the continuity of the latter is in doubt due to budget constraints.

2.4. Referral System

a. While the outreach programme, focusing on MCH, has generally been part of the MoH policy, by all accounts it was not systematically implemented nor did there appear to be an explicitly formulated strategy for its promotion and support. In any case, the PHCP/RD can be credited with having effectively developed and strengthened the outreach programme through the addition of health education and, more recently, the care of poor elderly rural women in all districts and reproductive health in two RHUs. To which may be added the innovative targeting of households in the catchment areas.

b. By implication, the PHCP/RD can also be credited for strengthening the referral system through the training of RHU nurses, as well as through the support of the supervision system through appropriate training.

c. However, as some evaluations have pointed out, referrals have tended to be affected by the incentive system in the sense that the latter is directly linked to the number of home visits carried out by RHU nurses.

d. The Consultants also note from their own observations that the referral system is affected by the extent to which the RHU nurse has mastered the health education related facts, as well as the extent of her communication skills. In turn this is linked with the effectiveness of the supervision system and the regular attendance of refresher courses.

e. With regard to the referral system between the RHU and RH, this also appears to be functioning and has been more or less positively affected by the up-grading of the RHU-based services.

2.5. Utilisation of Rural Health Services

a. While there is some data on the number of patients/year which resort to the RHUs, it is difficult to ascertain their accuracy. Nor do RHUs appear to keep account of the annual number of 'ticket' patients, i.e. those who are not part of the group targeted by the PHCP/RD and the FP, and who pay a minimal user fee.

b. This is the area where the PHCP/RD has been relatively less successful, since attempts to improve the RHIS have been constrained by bureaucratic and other factors.

c. However, the system of Family Folders (FF) introduced by the PHCP/RD, and its

link where pertinent with the files on Family Planning (FP) (project funded by USAID), as well as the link between both the latter and the HVP, can be taken as an indication that the utilisation of the RHUs, at the very least by the target groups, has been developing in the desired direction.

d. This development cannot be separated from another innovation introduced by the PHCP/RD, namely the division of the RHU catchment areas into sections and the allocation of one or more RHU nurses to each section.

2.6. Target group

a. From the outset, the groups targeted by the PHCP/RD have been married women of reproductive age and children under five years, and this has remained unchanged up to the present. However, by Phase III (1991-1993) it was decided that ante-natal health services as part of the HVP would focus on the so-called at risk
groups who require particular medical attention and follow-up. By implication this not only means that routine visits are more carefully scrutinised; in addition, it has also strengthened the referral system as well as the utilisation of the RHUs.

b. Though there is conflicting information regarding the extent to which at-risk groups have been included (the objective laid down 80%), the fact remains that the PHCP/RD can be said to have been largely successful in terms of reaching the designated target group. Again the strategy of dividing catchment areas into sections and allocating a designated number of households per RHU nurse has contributed to this achievement.

c. During the Extended Phase III (1994-1995), two additional target groups were added: The first, which actually overlaps with the focus on women of reproductive age, aims to identify women with reproductive health problems and target them for follow-up treatment following two stages: referral to the RHU physician and referral from the latter to the RH. While it is still early days to give a comprehensive judgement on the reproductive health component which is being carried out on a trial basis in two RHUs, the fact remains that this should be viewed as an integral part of a gender sensitive approach to women's health and, as such, requires further promotion and support.

d. With regard to the care of poor elderly rural women, it is evident from the fact that this project component has been implemented in all four rural districts of Damietta in a relatively short time that it is uncontroversial and has not required cost inputs other than training. The DoH has firmly established itself as more or less a pioneer in adapting the HVP to felt needs in the village community, with the DoH video on the subject also serving as a means of disseminating this experience.

2.7. General Health of the Rural Population

a. The available socio-economic indicators on the Damietta Governorate presented in section II/B of this Mission Report reflect the relatively high standard of living of the population relative to most other governorates in Egypt. However, these are aggregate figures, and information on the breakdown by rural districts/areas is not accessible.

b. It is only relatively recently (i.e. in 1990) that the DoH has embarked upon the process of entering health related data into its computer software programme. These data give some indication on trends with regard to live births, infant/child mortality, immunisation coverage, dental treatment, infectious diseases and number of patients receiving MCH related services. However, due to the fact that the number of indicators have been added to over the past five years, it remains difficult to attempt any meaningful comparison.[32]

c. Nonetheless, if the issue of the general health of the rural population is considered in relation to the wide coverage of PHCP/RD (with the exception of reproductive health), the evident success of the outreach programme and its implications for RHU-based health services and a functioning referral system, then it can be concluded that the project has made a difference compared with the situation in the mid-1980s, even if the actual impact cannot be quantified or separated from overall socio-economic developments in the Damietta Governorate.

3. The PHC Project Model

a. The process of developing a project model, which included identifying all the pertinent project components and the factors which ensure the latter's implementation and sustainability, can be considered a particularly successful contribution of the PHCP/RD. To which one may add the organisation of the National Conference in 1993, and the publication of the conference papers, both of which played an important role in disseminating this experience.

b. However, it appears to the Consultants that the process of development and presentation of the project model was perhaps of greater value than the application of the actual model itself. Although the eight booklets give an interesting insight into the project, they are not detailed enough to be used as pragmatic guidelines for the replication of the PHCP/RD, which was the actual primary aim of the whole exercise.

c. Moreover, a question to which the Consultants were unable to secure a satisfactory answer is: What has happened to the project model after 1993? While, by all

[32] This observation is based on print-outs provided by the DOH Statistics Units on a number of health indicators requested by the Consultants. It generally confirms the conclusion of various PHCP/RD documentation that the RHIS requires strengthening.

accounts, it is being taken on board in The Netherlands' supported health project currently being implemented in Fayoum, there is little indication that the project model is being given any particular attention within the MoH.

4. Women in Development

4.1 Women in Development (WID) was only introduced as a specific project objective during Phase III (1991-1993) at the instigation of the DGIS/Netherlands' Ministry of Foreign Affairs. Since this perspective had not been incorporated into the PHCP/RD from the outset, and given the project's managerial capacity as well as the (at the time) plan to phase out by the end of 1993, it was deemed necessary to narrow the focus on particular health-related aspects.

4.2. The objective of the WID project component entailed:

a. raising awareness of gender related issues among PHCP/RD staff through formal/informal discussions;

b. developing a pilot study of the health needs of women in selected areas;

c. developing a pilot proposal on reproductive health care (implemented during Extended Phase III [1994-1995]).

4.3. There have been a number of WID related activities including:.

a. a sector Paper 'Women and Health', (DGIS, The Netherlands, 1989).

b. a Consultancy Report: Village Health Planning and Women and Development Approach (November-December 1991).

c. a position paper on WID: 'Women and Development in the Damietta Rural Primary Health Care Project' (Matrix Consultants, Utrecht, August 1992).

e. a study of 'Women's Health Needs in Rural Damietta: The Relationship Between Women's Position, Available Health Services and Women's Health Needs' (August 1993, implemented by a local consultant group).

f. a workshop on 'Women and Health' (Damietta, August 1993).

g. a workshop on 'Women and Reproductive Health Care in the Context of the PHCP/RD in Damietta, Egypt' (Amsterdam, August 1994).

4.4. The history of the project during its earlier phases (1985-1990) indicates that while the focus on women as target beneficiaries was explicitly mentioned in relation to the MCH project component, in particular the outreach programme (HVP and HE), there was no explicit WID orientation in this approach. More specifically, women were incorporated as passive participants in the project, and there was no gender sensitive approach which targeted them beyond their reproductive role.

4.5. In fact, the WID project objective was added after the formulation of the PlanOps for Phase III (1991-1993), and was to appear for the first time in the 1992 Yearplan. The difficulty of reaching a consensus among project management staff over the WID issue (largely related to the fact that this was perceived to be an externally imposed project component) led to delays and to the commissioning of local and external consultants.

4.6. The Extended Phase III (1994-1995) introduced two new components deemed to address the WID issue, namely targeting poor elderly rural women over 60 years, and reproductive health. However, while the first component appears to be progressing, the implementation of the second has remained limited (see section V/C/4).

4.7. Though the above mentioned WID briefing papers identified a number of pertinent concerns, including health-related issues and means of strengthening the active participation of the female target beneficiaries, it was clear that the PHCP/RD did not have the managerial capacity to proceed beyond the above mentioned new objectives. Partly this is related to inadequate funding and staffing, as noted in some of the evaluations of and reports on the PHCP/RD.

4.8. However, there was (and continuous to be) the problem of how WID is conceptualised, particularly among the professional project staff. While the distinction between sex- and gender- specific needs is helpful (as discussed in one of the above mentioned WID briefing papers), it would also have been helpful to introduce the differentiation between women's practical and strategic gender needs in order to conceptualise specific health-related interventions and to link these with the general objectives of the PHCP/RD.[33]

4.9. Part of the difficulty of conceptualisation may be related to the fact that the WID paradigm is based on a gender relations model which stresses equality, while the prevailing gender ideology in Egyptian society, and in particular in the rural areas, is based on gender complementarity.[34] Moreover, traditional Egyptian women do not view

[33] Practical gender needs are related to culturally defined concepts of women's existing socio-economic status and reproductive role (e.g. access to safe water, child health care); strategic gender needs refer to interventions necessary to tackle women's disadvantaged status relative to their male peers (e.g. changes in discriminatory legislation).

[34] See S. A. Morsy, Gender, Sickness and Healing in Rural Egypt: Ethnography in Historical Context, Boulder,Co.: Westview Press, 1993.

themselves as individuals separate from their families and households.[35] Rather, while the latter may be the source of inequality, it is also perceived in terms of physical and emotional security.

4.10. As numerous studies on the 'woman's question' in Egypt reveal, women's reproductive/domestic and productive roles respectively are the subject of divergent discourses which cannot be separated from the social and economic transformations taking place. While many Egyptian women are actively involved in these discourses, equally many tend to remain passive by-standers.[36] It is in this context also interesting to note that a study of family planning services in Egypt found that while male physicians were generally in favour of women's higher education, around 40% were against women working after marriage.[37]

4.11. Another point which may conceivably have had implications for the lack of consensus among project staff is the apparent neglect to present WID in terms of a practical development tool; i.e. to link it with programme sustainability and project efficiency. Nor does WID appear to have been explicitly linked with the operationalization of the link between gender and poverty alleviation, which could well have been another means to conceptualise the issue.[38]

4.12. Finally, it should be added that while the approach of choosing RHUs with a female physician as an entry point for WID is important given female patients' apparent preference for same-sex physicians, this does not diminish the fact that a gender sensitive approach to reproductive health should also encompass male physicians. Moreover, as the Consultants noted from home visits to RHU clients, husbands may have been targeted during the pre-project activities prior to the implementation of the reproductive health programme, but this approach does not appear to be followed up by the RHU nurses during outreach activities.

4.13. The Consultants raised the issue of WID during a focus group discussion with the project management staff, and where the above observations were more or less confirmed. An understanding of WID does not appear to go beyond women's health, and

[35] See L. Nawar, C. B. Lloyd and B. Ibrahim, 'Women's Autonomy and Gender Roles in the Egyptian Family', in C. M. Obermayer, ed., Family, Gender and Population in the Middle East: op. cit.

[36] See V. Moghadam, Modernising Women: Gender & Social Change in the Middle East, Boulder & London: Lynne Rienner Publishers, 1993.

[37] See Central Agency for Public Mobilisation and Statistics (CAPMAS), Assessment of Quality Family Planning Services in Egypt, Occasional Paper No. 2, 1992, p. 35. (However, the response is not gender disaggregated).

[38] See W. Harcourt, ed., Feminist Perspectives on Sustainable Development, London & New Jersey: Zed Books Ltd., 1994.

nor does there appear to be any interest in the topic beyond this focal point.

5. The Question of Community Participation

5.1. Conceptualisation

a. Community participation (CP) in the development process is generally defined as a 'bottom-up approach' which explicitly focuses on the needs of the target population, and promotes their involvement in the assessment of the identified problems/ solutions as well as their self-reliance. Another important principle of CP is its engenderment, i.e. the integration of women in all stages of programme/project development. The operationalization of such a strategy entails the inclusion of participation as an explicit component in project planning and implementation.[39]

b. While current development discourses include multi-faceted analyses of the meanings of CP, and its implications for effective economic policies including poverty alleviation, there is nevertheless some consensus that the promotion of this process continues to remain problematic.[40]

c. With regard to the PHCP/RD, the first PlanOps (1985) explicitly refers to the objective of 'eliciting, promoting and supporting community participation'. However, throughout the different phases of the project, this objective appears here and there but is never actually addressed in terms of a concrete definition and operationalization. For example, in the Report of the Joint Evaluation Mission (August 1990), channels of communication are discussed and the problem of training in communication skills is mentioned, but again without actually defining CP in the sense identified above in the development literature.[41]

d. Various other PHCP/RD documents to which the Consultants had access raise the issue of CP and make some recommendations, but without identifying any operational strategies.

[39] See P. Oakley et. al., Projects With People: The Practice of Participation in Rural Development, ILO, Geneva, 1990; also M. Bamberger et. al., Gender Issues in Participation, World Bank, May 1994..

[40] See M. Rahnema, 'Participation', in W. Sachs, ed., The Development Dictionary, London & New Jersey: Zed Books Ltd., 1992.

[41] It should also be added here that none of the PHCP/RD documentation to which the Consultants had access make any reference to the USAID project which aimed to promote community participation.

e. As far as the Consultants could ascertain, the first explicit discussion of the issue of community participation is in the pertinent paper presented at the National Conference for Project Model Development (August 1993). However, it is clear that this actually refers to community involvement rather than the participation of the community in needs assessment, planning and implementation of programmes and projects.

f. In any case, the activities enumerated under the PHCP/RD CP component in the above mentioned conference paper include: The Home Visiting Programme (HVP), the TBA (Daya) Training Programme, Group Health Education (GHE), Village Health Planning (VHP) and Women & Development (WID).

5.2. Institutional Aspects

a. The analysis of the impact of the PHCP/RD on CP requires an appreciation of the process of participation at the grassroots level. Briefly, the system of local popular councils (LPCs) (at the village, district and governorate levels respectively) were designed with the aim of promoting a sense of popular participation. Parallel to this institutional framework through which local demands are channelled is the Executive Council (EC), which also operates at all the three levels referred to above, and which includes government-appointed representatives from the different ministerial departments.[42]

b. In turn, an appreciation of the development of LPCs over the past decade requires the analysis of the USAID Local Development Project (LDP) (initiated in 1983), and which focused on the provision of infrastructural support to both urban and rural sectors. This development intervention was an explicit part of USAID's support of a decentralised and participatory system. A recent analysis of the USAID concluded that the latter has generally not had the anticipated results due to LDP's main focus on technical rather than institutional aspects, with the effect that the 'basic ingredients for local participation and independent decision-making were provided, but without the proper guidelines for their application'.[43]

[42] See H. H. Radwan, Democratisation in Rural Egypt: A Study of the Village Local Popular Council, Cairo Papers in Social Science, Vol. 17, Monograph 1, Spring 1994, American University in Cairo Press.

[43] Ibid., p. 60. By the end of 1992, the USAID/LDP had withdrawn its technical assistance and had confined its support to the disbursement of annual funds (following the principle of promoting the role of local authorities) and it was renamed the Local Participation and Development Project (LPDP). Funding was discontinued after September 1993 (p. 5).

5.3. Implementation Reality

a. The mid-term evaluation of Phase III (1991-1993)[44] points in its various sections to positive developments, notably the improved relationship between RHU nurses and TBAs and the target population, in particular women.

b. But it was also noted there were a number of constraints which were continuing to hamper the effective implementation of the PHCP/RD community participation (CP) component:

* Though the aim of supporting the capacity of the DoH/D to take over the responsibility for the PHCP/RD has been more or less achieved, nevertheless the decentralisation process has been moving at a relatively slow pace, which in turn has implications for the limited participatory decision-making at the village level.

* The neglect to develop the TBAs' role as key-informants as part of promoting CP.

* The need to develop a realistic activity programme for the implementation of the integrated approach (IA), which also needed to take better account of the experience level of RHU physicians and staff. In fact, similar to CP, the issue of IA appears here and there in the project documentation, but has not been systematically addressed.

* The continuing tendency to target women as passive rather than active participants in the health system, to which one can add the asymmetrical socio-economic status of women within the traditional rural household, and customary attitudes towards women's health in general and their reproductive health in particular.

* The fact that the WID component was under-funded and under-staffed, and was introduced at a relatively late stage into the PHCP/RD.

* Traditional attitudes in the health delivery system which have had an effect on the project staff's concept of community participation.

* The neglect to explicitly spell out the link between HVP and CP.

c. The reality that the implementation of the CP project component continued to be perceived as problematic is noted in the October 1992 Mission Report[45], where effective

[44] See Report of the Joint Mission of the Arab Republic of Egypt and the Kingdom of The Netherlands: Primary Health Care Project Rural Damietta. External Midterm Evaluation 16 August- 2 September 1992.

[45] See Report of a Consultancy Mission to the PHC Project of Rural Damietta, 17-29 October 1992, by K. H. Eggens, RTI.

RHU management planning is linked with CP. Thus, membership of RHU physicians in the local popular village councils (LPVCs) has generally not led to stronger links between the latter and the village population. In fact, the Report, acknowledging that community participation is a longer-term process, recommended that, in order to avoid raising the target community's expectations, very specific activities should be aimed for and constraints to CP should be tackled during the planned National Conference on Project Model Development.

d. However, and as indicated earlier, while CP was indeed one of the focal points of the National Conference, subsequent available documentation on the PHCP/RD indicates that the subject ceased to be seriously addressed.

Thus the Final Evaluation of Phase III (1991-1993) makes a passing reference to CP, and then only in the context of the integrated approach (IA) which is deemed not to have led to the anticipated effect among the six RHU physicians who had been selected to participate in a trial of this approach (strengthening RHU management, community participation and RHIS).

e. In fact, the latest available documentation on the Extended Phase III (1994-1995) refers only minimally to the issue of community participation.

f. In any case, community participation is a very important supporting factor in the attainment of sustainability. However, the Consultants note that this requires a clear definition of the term as well as the strategies required to promote it and, by implication, contribute to sustainability.

F. SUSTAINABILITY OF PHC SERVICE DELIVERY

1. The PHCP/RD and Sustainability

The overview of the project documentation made available to the Consultants indicates that the question of sustainability has not been a particular focus. Here and there the subject surfaces, but only to disappear again without much explanation.

In fact, the only documentation where this issue appears to be explicitly raised in relation to each project component is in the papers presented to the PHCP/RD National Conference of Project Model Development (Cairo, August 1993).

In any case, the Consultants deem it relevant to present an overview of how the above mentioned conference papers have dealt with sustainability before discussing this issue in relation to the post-project phase. It should be kept in mind that sustainability in these conference papers is discussed in relation to the situation during Phase III (1991-1993),

and does not include the project components reproductive health and care of poor elderly rural women introduced during the Extended Phase III.

1.1. Home Visiting Programme:

a. The HVP programme is considered to be sustainable after termination of external inputs, though it is recommended to:

* create an ongoing system for updating the 1986 Census;

* review supervisory checklists to enable the objective qualitative assessment of nurses' performance for incentive payment; performance assessment should be semi-annually rather than quarterly;

* simplify the recording system, and tie the information generated by supervisory checklists to the overall system;

* ensure continued provision for home visiting as well as the supply of supervisory vehicles.

b. The financial requirements for sustainability of the HVP are limited to:

* incentives for nurses, doctors and supervisors;

* fuel for vehicles and transportation costs for nurses visiting far-off communities;[46]

* costs for printing records and forms, and replacement of basic equipment;

* training.

c. Potentially, co-operation is considered at three levels:

* local health programmes, primarily PHC programmes such as MCH, etc. where co-operation can be achieved through interaction of the PHC section with others within the DoH via periodic meetings organised by the Director General;

* other service departments at governorate and district levels respectively;

* central MoH projects, which is mandatory for national projects such as family

[46] This is defined as those three km or more distant from the RHUs.

planning (FP), acute respiratory infections (ARI) and TBA training;

* external agencies, through the Rural Health Department at the MoH, which can support replacement of basic HVP equipment.

1.2. TBA (Daya) Programme

a. The present organisation structure is deemed appropriate since:

* at the governorate level, the overall responsibility for the TBA programme is with the nurse supervisor (who in turn is part of the PHC department in the DoH);

* the support system is implemented by the TBA supporter at RHU level, backed by the district nurse supervisor;

* refresher courses fall under the DoH Training Department and are implemented by the district nurse supervisor.

b. Financial aspects:

* training costs can be absorbed by including refresher training in the DoH annual training plans;

* other local resources, such as the Governorate Services Funds, as well as the National Child Survival Programme, can be explored for the cost of TBA skill upgrading courses;

* the estimated budget for TBA training amounts to LE 5000 annually: LE 4500 for refresher courses for TBAs and their supporters, and for upgrading courses for untrained Dayas (LE 25/ person/day includes per diem for trainers and trainees, educational materials, administrative support and refreshment), and LE 500 for transport and stationary.[47]

c. Co-operation:

Collaboration with UNICEF and the Child Survival Programme has been and will be very helpful for exchange of experiences and supply of materials, such as teaching aids and TBA delivery bags.

1.3. Infrastructure and Maintenance:

[47] Keeping in mind that these are 1993 estimated costs/ prices.

a. Organisation:

* maintenance has to be organised by paying regular visits to health care facilities;

* preventive maintenance is more important than renovation;

* a maintenance programme requires frequent visits to the health facilities according to a fixed schedule.

b. Maintenance is divided into three categories:

* simple small repairs (by the district health facilities);

* medium size repairs (by the governorate maintenance workshop);

* large repairs (according to national rules, through the DoH and Department of Construction and Buildings).

c. With regard to maintenance visits:

* a visit to every facility every two months (a most likely scenario) means 60 facilities require 360 visits per year, which is roughly 1.25 visit per day.

* checklists remain important and should be effectively used;

* it is important that RHU staff and MWS staff agree on the outcome of the visit and sign the checklist together.

d. Financial requirements:

Four staff members of the Maintenance Workshop are needed per visit, the cost of transportation and incentives can be worked out.

e. Cost of repairs:

* simple small repairs: LE 100 per RHU per year from local resources (1993 costs/prices);

* medium size repairs: from the governorate maintenance budget;

* large repairs need external funding.

f. Incentives for staff of the maintenance workshop according to the workload.

1.4. Training Programme

a. Organisation:

* The Training Programme falls under the Training Department of the DoH. The PHCP/RD activities are thus additional to the current ones, which include nurse training schools and pre-service training for physicians among others.

* Consequently additional staff is required, notably a course co-ordinator/facilitator, administrator and unskilled workers. In fact the staff are available, and only need to be transferred from the Department of Basic Health Services to the Department of Training (in the DoH).

* Training could take place in the well equipped Abadeyya Training Centre.

b. Financial Aspects:

Additional financial requirements have been requested from the Ministry of Finance through the MoH (in July 1994).[48]

c. Co-operation:

* Co-operation with other departments and projects such as Family Planning and Child Survival, which undertake training activities with the target groups of the PHCP/RD, should result in complementarity and avoid duplication of training activities.

* UNICEF, as well as the Child Survival and Family Planning projects and the MoH produce and supply various educational materials which have proved useful in the PHC/RD project.

2. Rationale for Sustainability

The above summarised points reflect the understanding of the PHCP/RD Model of the main factors which may contribute to sustainability, and with which the Consultants concur. However, the fact remains that neither these conference papers nor, for that

[48] As indicated earlier, there is conflicting information about these funds which have been pledged by WHO for the purpose of training.

matter, the project documentation made available to the Consultants, explicitly address the rationale or the feasible requirements for ensuring sustainability.

In the view of the Consultants, the rationale for sustainability needs to be argued in the following terms:

2.1. Home Visiting Programme:

a. Though the HVP was an official MoH policy prior to the implementation of the PHCP/RD, it tended to be haphazardly carried out and lacked a coherent strategy.

b. Undoubtedly, the HVP has had positive impacts in terms of qualitative and quantitative outputs and activities.

c. Maximisation of benefits from invested efforts in staff training which need to be periodically up-graded.

d. Continuing to meet community needs and expectations.

e. Contributing to national efforts to promote the Decade of the Egyptian Child, and the action plans of the World Summit for Child Care as well as of the Fourth World Conference For Women in Beijing.

f. Contributing to the national population programme which stresses the link between family planning and family welfare, in particular maternal and child health.

g. Providing employment opportunities for women in jobs deemed culturally acceptable, specifically in traditional rural communities.

2.2. TBA (Daya) Programme:

a. To maintain and strengthen what has been built up, i.e. continuous education for TBAs and their supporters, as well as a supportive system in general.

b. To provide upgrading in midwifery and health education for TBAs who have hitherto not participated in the PHCP/RD training.[49]

[49] Given the apparently disappointing results with regard to the training of nurses in delivery skills, and the fact that, in spire of the expansion of the private health sector, specific strata of women will continue to demand the services of TBAs, the Consultants deem it important that Daya training not be abandoned, at least for the foreseeable future. It should also be kept in mind that there may be some link with poverty, i.e. in terms of the inability to pay private health sector costs, a point which requires some serious attention.

2.3. Infrastructure and Maintenance:

a. The importance of 'preventive' maintenance for the avoidance of costly renovations is a concept which continues to need reinforcement within the public sector in Egypt.

b. It pays to invest regularly small amounts of resources to ensure efficiency and avoid the high costs of replacement.

c. Promoting a 'preventive mentality' also has implications for encouraging health staff to invest more care in the use and handling of public sector property.

d. Well maintained RHU premises undoubtedly have positive implications for health staff morale and motivation.

2.4. Training Programme:

a. Refresher training of health care providers is essential to sustain and strengthen staff motivation and quality of performance.

b. In addition to refresher training for the trained staff, newly posted nurses also require regular PHC refresher training to ensure the smooth functioning of RHUs which depends to a large extent on good co-ordination between RHU health staff.

c. The training programme under the PHCP/RD has contributed to the improved quality of services and increased utilisation of preventive health care services, with the latter in turn being supported by an effective HVP and supervision system.

2.5. Community participation:

a. Community participation is of the utmost importance to guarantee, or at least to encourage, continuation of project activities.

b. However, it is evident that this is a problematic issue which requires a long-term process of encouraging changes in attitudes. It also cannot be isolated from political variables (such as the role of Local Popular Village Councils and the continuing top-down approach to development, for example). Meanwhile, the way community participation is actually defined is in fact the community's involvement. The latter appears to be viewed in terms of participation in needs assessment and cost contribution, but not necessarily in planning and implementation.

c. In this context, the TBA skill upgrading programme as well as the HVP can be considered a type of community involvement which continues to require support.

2.6. Integrated Approach

a. The reasons for the problems encountered by the PHCP/RD to promote the integrated approach (IA), defined as an integration of Village Health Planning (VHP) within the RHU, up-grading of the RHIS, community participation and women's health, have been addressed in Part V/6/6.3. and 6.4.

b. Even though it was noted that there does not appear to be a consensus within the DoH regarding further attempts to develop and implement the IA, the Consultants note that this does not imply a resistance to the issue. In any case, the IA should not be neglected given its importance to the question of overall sustainability of the PHCP/RD beyond December 1995 (when The Netherlands support comes to an end), and also keeping in mind that the IA is identified as an important aspect in the Project Model. The DoH should therefore persist in pursuing ways and means of tackling constraints to the implementation of the IA in order to ensure that the latter is very firmly entrenched as part of project sustainability, and as set down in the project model.

3. Feasible Requirements for Sustainability:

Following on from above, there are a number of feasible requirements to ensure the sustainability of the PHCP/RD.

3.1. Number of Health Service Providers:

a. A successful continuation of project activities after termination of external technical support and funding depends to a great extent on the availability of sufficient health staff. Nurses in particular play a crucial role, both in outreach as well as RHU, based activities.

b. Since the beginning of the PHCP/RD the number of nurses has risen considerably, due to a combination of training opportunities, rising female education as well as changing attitudes within rural Damietta society towards culturally appropriate female employment. This trend should be further promoted, since a reduction in the number of RHU nurses would hamper the effective implementation of outreach activities.

c. It should also be added that the MoH plans to up-grade the skills of nurses to take on more medically related responsibilities, and which is to be accompanied by the reduction in the number and upgrading of the quality of training of medical students.[50]

[50] Information given to the Consultants during the briefing session in the MoH in Cairo.

3.2. Motivation of Health Service Providers:

Health service providers need to be sufficiently motivated, and this depends on several factors:

a. an explicit job description which incorporates the activities implemented as part of the PHCP/RD;

b. appropriate training to be well prepared to perform the various tasks related to the job;

c. job satisfaction (in terms of conditions of service);

d. availability of pertinent equipment, medicines etc. to make it possible to execute the tasks related to the job (e.g. HV kit, drugs);

e. regular and objective supervision;

f. salaries which reflect the skill level of health service providers rather than the years of service in the public health system.

3.3. Effective Policy Support by the MoH:

a. It is evident that the continuity of the PHCP/RD hinges on the recognition of its value by the MoH (the DoH in Damietta is obviously convinced and can be rightly gratified by the PHCP/RD's achievements).

b. While the PHCP/RD Model has been disseminated to a wider audience beyond the Governorate of Damietta, and has been the topic of discussion in a number of seminars and meetings, this has unfortunately not led to the earmarking of funds/budgets to ensure the sustainability of the project.

3.4. The Chronic Problem of Incentives:

Whatever the rationale behind the incentive system, the fact remains that this is a reality the implications of which cannot be ignored. It is evident that while, objectively, health service providers should not have to receive an incentive to carry out the tasks related to their job description, the fact remains that:

a. incentives (and per diems) will continue to remain important as long as public sector salaries remain substantially below those paid in the private health sector;

b. incentives appear to be currently the only feasible way to encourage health service

providers to accept the additional tasks which projects such as the PHCP/RD introduce as part of improving the health care system; i.e. tasks which were not part of the original job description/training of health service providers.

c. incentives appear destined to remain part of the system as long as :

* there is no explicit MoH policy to reformulate training requirements and job descriptions to include the tasks introduced by projects such as the PHCP/RD as an integral part of the pertinent job;

* donor agencies do not co-ordinate their incentive systems, which in effect means that a system of unfairness prevails;

* salaries in the public health sector do not match the cost of living.

d. There is a need to promote the view of the incentive system as a management tool to influence job performance, which in turn is evaluated though effective supervision.

3.5. The Socio-Economic Context of the Damietta Governorate:

a. As the available socio-economic indicators on the Damietta Governorate indicate (see II/B), the latter is ranked third on the human development index. This fact can be expected to have positive implications for the sustainability of the PHCP/RD, though taking into consideration the above mentioned feasible requirements, in particular the reality that sustainability is dependent on a combination of financial, managerial and policy variables.

b. On the other hand, this positive fact does not necessarily negate the reality that there are relatively less privileged rural population groups in the Damietta Governorate who will continue to depend on the public health sector to meet their health needs and concerns, and who generally lack the financial ability, and perhaps knowledge, to seek out the services of the private health sector.

c. It is therefore also in this context, which fits in with The Netherlands' development policy of addressing poverty, that the feasibility of the sustainability of the PHCP/RD needs to be addressed and supported.

VI. CONCLUSIONS

A. GENERAL

1. The Consultants note that in spire of the constraints mentioned in the various sections above, the PHCP/RD can be deemed a success in terms of:

1.1. improving the quality of health services provided to the rural population in the Damietta Governorate through the strengthening of the RHUs;

1.2. up-grading the skills of health service providers;

1.3. responding to the health needs of the rural population served by the RHUs.

2. The Consultants also note that in spire of the financial and managerial constraints of the DoH (which is not specific to Damietta but also discernible in other governorates), the PHCP/RD has been integrated into the DoH health system and is now functioning as an integral part of the latter. This includes the project components which are continuing to receive Netherlands support during Extended Phase III, namely training and elements of the outreach programme (reproductive health and home visits to poor elderly rural women).

B. SPECIFIC

1. Training of Health Service Providers

1.1. Due to financial constraints of the DoH/MoH, the refresher courses for nurses, TBAs (Dayas) and TBA supporters will be discontinued in the Abadeyya Training Centre (ATC), and will be replaced by on-the job training (as was the case before the PHCP/RD started).

1.2. This entails the risk that the ATC will not continue to play the role it had in the past.

1.3 Although there are funds for per diem payments for trainers of introductory courses (which are on-going as part of the DoH health policy), there are no earmarked funds for training materials and per diem for trainees.

1.4. The problem partly seems to be that essentially attendance of refresher courses is not obligatory, though the DoH has indicated that participation is taken into account in the evaluation of the performance of RHU nurses.

1.5. The Consultants note that the training targets for 1994 and 1995 appear to have been implemented on schedule.

1.6. The Consultants attended part of a refresher course in the ATC and noted that this was well attended, the participants were interested in refreshing their skills, and that they appeared aware of the importance of the latter to their RHU-based as well as HVP activities.

1.7. The Consultants also had the opportunity to look at some of the training material and noted the culturally appropriate relevance of the latter.

1.8. However, it appears that the DoH budget does not stretch to further developing training materials or printing the necessary numbers.

2. Home Visiting Programme (HVP)

2.1. It is evident that the HVP has been considerably strengthened through the PHCP/RD (given the fact that prior to 1985 home visits were confined to ante- and post-natal as well as child care activities, including immunisations), and that the system of dividing the village into sectors (a maximum of 500 families/RHU nurse though the target group/RHU nurse is obviously less) has greatly contributed to the effectiveness of the outreach programme.

2.2. It is also evident that the MCH programme has been strengthened by the training received by the RHU nurses who carry out home visits.

2.3. Moreover, relations between RHU nurses and the village community have benefited from the improved skills of the former, and this has undoubtedly had a positive effect with regard to the utilisation of the RHUs.

2.4. But the Consultants note that the problem of relatively high turnover of RHU physicians may in some cases have some adverse implications for the relationship between the latter and the other RHU health staff, as well as with the village community.

2.5. However, it should be added that, according to discussions with the MoH, the 'unofficial' policy is to reduce the number of entrants into medical schools, and to up-grade the training of nurses to carry out more paramedical services as a means of further improving the quality of health service delivery by the RHUs.

2.6. It is evident that the on-going incentive system in two districts (notably Damietta and Kafr Saad) plays some part in the effectiveness of the HVP in the RHUs concerned. It is the Consultants' view that the incentive system is actually being used as a management tool, since the payment of incentives is linked to performance. Based on evaluations by nurse supervisors, on average 5-10% of the RHU sector nurses in the

HVP do not receive incentives at any one time.

2.7. Conversely, where the incentive system has been phased out (i.e. in Faraskour and Zarka), the Consultants were given to understand that though there was reluctance on the part of RHU nurses to keep up the previous number of home visits, this was in fact a transitionary problem. The DoH exerted pressure, in some cases through disciplinary measures, with the effect that RHU staff in the districts concerned have apparently understood that the HVP is an integral part of their job responsibilities.

2.8. But it should be added that the fact that the PHCP/RD incentive system is still operating in two districts is perceived by RHU nurses in the other two districts as unfair (even though all RHU nurses are eligible to receive incentives through the USAID funded family planning programme, and in fact involvement in FP is rotated to ensure every RHU nurse's chance to benefit from the incentive system).

2.9. While the medical skills of RHU nurses are of an acceptable standard (and, in fact, are a tremendous improvement relative to the situation in the mid-1980s), the Consultants were given to understand that the communication skills of these health service providers do require some strengthening.

2.10. Moreover, while the relationship between RHU nurses and social workers of the Ministry of Social Affairs is generally positive, the fact remains that the system of co-ordination between them requires further strengthening to ensure that medical and social needs of patients are adequately addressed.

2.11. The Consultants note that though the at-risk approach is being implemented, the aim of reaching 80% of the target group has not yet been achieved. There are no accurate data available, though the project management staff estimated that the figure is nearer to 30-50% but obviously varies by district.

3. Women in Development

3.1. The Consultants note that WID was introduced into the PHCP/RD as a project component which, however, does not seem to have been optimally communicated to the project management staff.

3.2. This has implied that the project management staff have remained ambivalent towards WID and do not seem to be able to relate to the subject other than through a limited women and health approach.

3.3. This is reflected in the fact that the implementation of a WID perspective has been confined to two activities introduced during Extended Phase III, namely reproductive health and home visits to the aged.

3.4. The Consultants believe that WID should have been given more serious thought earlier on in the PHCP/RD, and not added on, almost as an afterthought. Moreover, the

fact that WID was introduced relatively late in the project, i.e. in 1992 (keeping in mind that at the time there were no plans for the Extended Phase III) has not really ensured the necessary conditions for continuity and sustainability.

4. Reproductive Health

4.1. This project component is currently being implemented in two RHUs (El-Bustan and El-Dahra) in the Damietta district which have female physicians.

4.2. It is evident that the female physician in El-Bustan RHU (visited by the Consultants) is enthusiastic about reproductive health and the fact that the training she has received has up-graded her skills and increased the number of female patients attending the RHU with reproductive health related ailments.

4.3. The RHU nurses in El-Bustan appear to be equally enthusiastic, though it should be kept in mind that the incentive system in this RHU is still on-going.

4.4. The Consultants note that this project component, which is being implemented on a pilot basis, is addressing hitherto unmet needs of rural women, and as such is an important part of the general health of the rural female population.

4.5. Due to financial constraints of the DoH, this project component will not be introduced to other RHUs in the Governorate of Damietta, and there appears to be some doubt about its continuity in the pilot area. The Mission regrets this development, since this innovative approach to women's health appears to be very much under-valued in the health system in particular, and in the approach to WID in general.

4.6. In this context, the Consultants note that the prerequisite of implementing reproductive health activities in RHUs with a female physician should be re-evaluated. In certain village communities trained male physicians may be equally acceptable.

4.7. Moreover, the reproductive health project component requires further strengthening. In particular, to treat certain uro-genital tract infections effectively requires the treatment of both wives and husbands, and the latter need to be followed up as necessary.

5. Care of Poor Elderly Rural Women

5.1. Though home visits to poor elderly rural women were only introduced during the Extended Phase III, it is evident that this project component is a relative success and is addressing a very much felt need in the village community, which in turn is indicative of socio-economic transformations in Egyptian rural society.

5.2. While the incentive system obviously plays a part, it is also evident that the fact

that it has been implemented in all four districts within a relatively short span of time is related to the relatively low costs involved (relative to the cost of the reproductive health project component). In turn this explains why this project component can be expected to continue after the end of The Netherlands support.

5.3. While the RHU nurses are enthusiastic about this new activity, they are apparently at times frustrated that they are not able to provide the variety of geriatric drugs needed by the elderly through the RHU dispensary.

5.4. However, the project management informed the Consultants that the allocation of necessary drugs from the Regional Medical Store to the RHU is in the process of being implemented, and that present constraints will shortly be resolved.

5.5. The Mission notes the need to widen the perspective of care for the elderly by mobilising the village community to address the non-medical needs of poor women with limited or no support.

5.6. There is also a need for a more effective co-ordination system between RHU nurses and social workers to ensure that the medical and social support needs of the target group are equally addressed.

6. Maintenance and Infrastructure

6.1. The programme has been relatively successful, and all the planned renovations of the RHUs have been accomplished.

6.2. The Maintenance Workshop is operating and the schedule for preventive maintenance has been introduced.

7. Management and Planning

7.1. The PHCP/RD is credited with attempting to simplify the RHIS. However, this has not always been successful due to the under-estimation of obstacles. For example, expansion of the Family Folder (FF) system for general use was more complicated than expected. The design of new forms and their acceptance by the MoH took longer than anticipated.

7.2. While there does not seem to be much consensus within the DoH regarding the need for further attempts to develop and implement a streamlined RHIS, the Consultants were informed during meetings with MoH staff in Cairo that efforts are underway to up-grade the system. However, no deadline appears to have been set for its implementation.

7.3. Part of the problem of effectively tackling shortcomings in the RHIS is that most RHU physicians are in their obligatory one-year health service, and few stay beyond this

period.

7.4. The trial implementation of the integrated approach (IA) has not been successful and has been discontinued.

7.5. Furthermore, institutions at the village level have not always been as active as anticipated and there appears to be little that young RHU physicians can do to promote participatory decision-making in health issues.

7.6. The PHCP/RD did not systematically follow up the baseline households study and recommendations as envisaged in the PlanOps of 1991-1993.

7.7. The concept of village health planning (VHP) appears to be misunderstood by the Local Popular Village Council, and this has had some implications for efforts to promote community participation.

7.8. The desired link between RHIS and planning at RHU level has not been achieved due to the fact that this is a much longer process than the time available during the PHCP/RD.

C. SUSTAINABILITY

1. The overview of the project documentation made available to the Consultants indicates that the question of sustainability has not systematically been a particular focus. Here and there the subject surfaces, but only to disappear without explanation.

2. In fact, the subject is only really explicitly dealt with in the 1993 Conference papers. However, it appears that even here it has not been dealt with in terms of suggesting practical solutions. Thus, these papers focus on the requirements for sustainability, but not on the feasibility to meet these requirements.

3. Although the project management staff have indicated that the subject of sustainability has been periodically addressed during Extended Phase III, no practical solutions have been forthcoming.

4. However, the Consultants note that the sustainability of the PHCP/RD is not only a financial issue, but to a large extent also a managerial and policy matter. This implies that the PHCP/RD has a very good chance of continuity especially with regard to the training and HVP, if the long experience of this project is given its due credit.

VII. RECOMMENDATIONS WITH REGARD TO SUSTAINABILITY

The successful continuity of project activities after termination of external technical support and funding is considered to be very important by the various parties involved in supporting and implementing the PHCP/RD, as well as by the Consultants. Accordingly, sustainability has been widely discussed in the various sections of this Mission Report.

In the following paragraphs, the Consultants present their recommendations on how to operationalize the sustainability of the various project components after termination of The Netherlands' support.

Each of these recommendations is considered by the Consultants to be feasible.

A. SPECIFIC TO THE MoH/DoH

The sustainability of the PHCP/RD requires policy, managerial and training support, all of which need to be ensured. While this implies careful consideration of the MoH/DoH budgets, the fact remains that the health authorities need to overcome the tendency to view sustainability primarily if not exclusively in terms of financial inputs, and to invest efforts in identifying innovative ways of overcoming budget constraints.

1. Training

1.1. The per diem system for trainers as well as trainees of the refresher courses will end in December 1995. Given the importance of these courses to RHU-based and HVP activities, it is recommended not to replace these by on-the-job training as has been suggested. The Consultants believe that an alternative solution to the DoH's financial constraints (until the issue of WHO funding is sorted out) could be the following:

* Attendance of refresher courses should continue to be obligatory and explicitly linked to evaluation of job performance.

* In order to reduce transportation costs, decentralise the training venues of refresher courses to the four districts; e.g. central district hospitals, nursing schools etc.

* Additionally or alternatively, use could be made of the PHCP/RD mini bus to transport participants and/or trainers to the training venues, though this will require earmarking funds for petrol.

1.2. The Abadeyya Training Centre (ATC) with its facilities should be used as efficiently as possible, which implies for all possible training courses in the field of health care. In the Consultants' view, this is part of effectively integrating the ATC in the DoH system. This requires the support of the MoH who need to balance the effect of closing down the ATC against the relatively small costs required for its continued operations (keeping in mind the promised training support by WHO).

1.3. It is recommended that the schedule for training health service providers (both introductory and refresher courses) should not be reduced in order to maintain the current level of skills.

1.4. The Consultants suggest that training curricula for RHU nurses pay some more attention to up-grading communication skills.

1.5. In order to reduce costs related to training activities, whenever possible use should be made of free training material (e.g. WHO, UNICEF, OXFAM, UNFPA etc.).

2. Maternal & Child Health

2.1. As the experience of phasing out the incentive system in two districts has shown, though there are inevitably transitional problems, an effective supervision system can ensure that the outreach programme remains more or less on target.

2.2. However, the Consultants believe that the incentive system has proved to be an effective management tool to motivate health staff and to improve the quality of health care. It is therefore recommended that the MoH seek innovative ways to ensure the continuity of this management tool.

2.3. But the Consultants also recommend that if the incentive system is to be continued, it should be more fairly applied, i.e. equally in all four districts.

2.4. There is a need for strengthening the formal co-ordination system between RHU nurses and social workers, specifically with regard to strengthening the HVP.

2.5. More serious effort needs to be expended to reach the at -risk group in order to attain the aim of targeting at least 80% of this group.

2.6. The MoH/DoH need to seriously consider the above points given the crucial importance of training and of the HVP to the sustainability of the PHCP/RD after the phasing out of the Netherlands' support.

3. Management and Planning

3.1. Another problem which the MoH needs to give careful consideration to is the policy of appointing newly graduated physicians for a one-year obligatory service in RHUs and some of the adverse implications this appears to have in terms of motivation and links with the community. While the present strategy of reducing the intake of medical students appears to be viewed by the MoH as one way of tackling this problematic, it does not solve the latter in the short- or even medium-term. One means of reducing some of the above indicated adverse effects is for the DoH to avoid transferring RHU physicians during the one year obligatory service as apparently seems to be the case.

3.2. Related to the above point is the fact that the onus is on the DoH to ensure that the introduction of new RHU physicians is handled in an optimal manner to ensure the good relationship between the latter and the village community. In case there are problems, efforts should be expended in solving these rather than opting for the solution of a transfer to another RHU.

3.3. Serious efforts should continue to be expended on devising strategies to overcome constraints to the implementation of the RHIS, in order to improve monitoring, evaluation and planning capacity and thereby contribute to the sustainability of the PHCP/RD.

3.4. The optimal planning of health services for the rural community requires an input from the latter. It is therefore recommended that the MoH/DoH re-evaluate the integrated approach (IA), possibly through a series of workshops which identify constraints and formulate planning and implementation strategies. In any case, care should be taken that the plan of action be less ambitious and more realistic than in the past.

3.5. Related to the above point is the reconsideration of the issue of community participation, and to identify ways and means with the help of the village communities to ensure that RHUs function in the most optimal way feasible.

4. Reproductive Health

4.1. The Consultants believe that reproductive health is an important innovative approach to women's health and therefore deserves to be continued. It is evident that the DoH budget will not cover the costs of project activities, and that the implementation of this component on a wider scale will need to be supported by external sources. It is therefore suggested that the MoH/DoH formulate a project proposal for possible donor funding which should take into account the experiences of the current pilot project and also reconsider the strategy of linking the implementation of reproductive health with the presence of a female physician in the RHU.

5. Care of Poor Elderly Rural Women

5.1. The evident success of home visits to poor elderly rural women needs to be sustained and, where feasible, replicated in other governorates. The MoH needs to ensure that this receives the required policy and budget support.

5.2. Related to the above, it should also be pointed out that while the health authorities are prepared to ensure that geriatric drugs are made available on a regular basis to RHU dispensaries, the fact remains that the latter do not always seems to be aware of this fact. Thus more effort needs to be expended to ensure that care of poor elderly rural women is not undermined by the lack of necessary geriatric drugs.

5.3. In this context, there is also a need to study possibilities of mobilising village communities to address the non-medical needs of poor women (and poor men) with limited income as a complementary support to services provided by the RHU and by social workers.

6. Infrastructure and Maintenance

6.1. It is recommended that the preventive maintenance programme be continued and further strengthened as part of a strategy of reducing unnecessary costs. In this context, the link with promoting community involvement should be further explored.

B. SPECIFIC TO THE NETHERLANDS' MINISTRY OF FOREIGN AFFAIRS/DGIS

1. The Consultants recommend that a workshop be organised at the end of 1996 to study the continuity of the PHCP/RD and to identify constraints and solutions. This should be viewed as part of the donor's support of the project's sustainability after the phasing-out of technical and financial inputs, as well as in terms of deriving lessons for project replicability.

VIII. OTHER RECOMMENDATIONS

A. SPECIFIC TO THE NETHERLANDS' MINISTRY OF FOREIGN AFFAIRS/DGIS

1. The Consultants recommend that the DGIS review its system of incorporating WID in project formulation, planning and implementation to ensure the effective and timely integration of a gender sensitive approach. This would enable the implementing agency(ies) to invest sufficient time and effort to prepare the groundwork for this approach, and to ensure that its various components are understood and acceptable to the counterparts.

2. To ensure a better understanding of the Mission Report, the Consultants recommend that at least the Executive Summary, the Conclusions and Recommendations be translated into Arabic.

B. SPECIFIC TO THE ROYAL TROPICAL INSTITUTE (KIT)

1. Given the complex link between health and gender, and the implications of this link for effective health planning as well as for responding to community health needs, it is recommended that a gender sensitive perspective be incorporated into projects such as the PHCP/RD from the outset and that the appropriate project components be taken into account and planned for.

2. While the PHCP/RD can be viewed as a success, the Consultants would nevertheless like to recommend that an explicit framework for monitoring and evaluation be formulated from the outset to ensure that pertinent indicators can be easily identified and compared over the duration of the project. This includes ensuring the consistent use of terminology.

VIII. APPENDICES

APPENDIX A: BRIEF OVERVIEW OF MACRO-ECONOMIC DEVELOPMENTS IN EGYPT

1. The following is some additional information on macro-economic developments in Egypt since the 1980s, some of which can be deemed relevant to the socio-economic context within which the PHCP/RD has been implemented.

2. In addition to the points raised in section II/A, there is the focus on streamlining public social services and the drive to improve the efficiency of the bureaucracy. However, the administrative reform continues to be problematic, not least due to the continuing growth of the bureaucracy and uncompetitive salaries/incentives.[51]

3. While there are efforts to ensure that the social dimensions of adjustment policies are taken into consideration, the fact remains that those on fixed low incomes and public sector wages/ salaries continue to be adversely affected. The Social Fund for Development Program was established to address this problematic. One of its focal points is adult education combined with income generating activities.[52]

4. The subsidy of basic food has a long history in Egypt, and various studies indicate that poor urban and rural household budgets depend on this system as a form of income transfer. However, while there has been criticism of the subsidy system in terms of price distortions and inefficient targeting, and the system is being overhauled as part of the structural adjustment programme, the fact remains that poor households continue to depend on this system.[53]

5. Another point of relevance to the Final Evaluation Mission Report, in particular the project component on reproductive health, is the question of population growth and its link with sustainable human development in Egypt:

5.1. The population growth rate has been estimated at 2.8-3.0% annually, though there are perceptible differences in fertility trends between Lower and Upper Egypt, as well as between urban and rural areas.[54] In any case, given Egypt's geographic

[51] See N. N. Ayubi, The State and Public Policies in Egypt Since Sadat, Reading: Ithaca Press, 1991.

[52] See UNDP, Egypt: Human Development Report 1994, op. cit.

[53] Ibid.

[54] See F. H. El-Zanaty, et. al., Egyptian Demographic and Health Survey 1992, Cairo: National Population Council, 1993.

characteristics, this trend remains unsustainable.

5.2. While national food security is influenced by a complexity of factors, there is also a clear link with population growth as well as poverty.

5.3. The importance accorded to the issue of population is reflected in the 1991 strategy of the National Population Council which includes the aims of reducing the rate of natural population increase, and the promotion of contraceptive prevalence.

5.4. An important development has been the establishment by presidential decree of the Ministry of Population (MoP) in January 1994, though the Ministry of Health (MoH) continues to play a role, not least because it functions as the implementing agency for a number of family planning related projects.[55]

6. Available indicators point to the fact that while health coverage is officially estimated to be universal and supported by the constitutional right to free health services, in fact there is a complexity of factors affecting the health system (though keeping in mind that there are differences between urban/rural areas and between regions in Egypt):[56]

6.1. The relative under-utilisation of public health facilities, though there is no accurate information regarding the impact of structural adjustment programme, in particular in terms of the extent to which low income population groups rely on the public health sector.

6.2. The relatively low coverage of ante-natal care.

6.3. Slightly over half of children under five years of age receive medical services not only from the public but also from the private health sector respectively.

6.4. The apparent discrepancy between the number of registered and actual health service providers.

6.5. Though the infant and child mortality rates have
decreased over the past few decades, there are indications that under-registration continues to be problem. However, there has been a remarkable decline in diarrhoea-related illnesses, attributed to the launching of a national programme during the mid-1980s.

[55] For example, the MoH is the implementing agency of the UNFPA funded Project for Strengthening/Expansion of Family Planning Services, and the USAID funded Family Planning Systems Development, with a sub-project focusing particularly on linking the provision of family planning services with poverty.

[56] See UNDP, Egypt: Human Development Report 1994, op. cit., pp. 27-32.

6.6. Similarly, data on immunisation indicate progress, though more efforts are needed to reach rural areas and poor population groups, specifically in Upper Egypt.

6.7. While the maternal mortality rate as an indicators of reproductive health has also been exhibiting an improvement, this varies by region/area, and surveys indicate that it still remains relatively high.

6.8. The changing health situation is reflected in various infectious diseases leading to early death, as well as chronic diseases indicative of longer life expectancy in Egypt.

7. Given that the PHCP/RD focuses on the four rural districts of the Governorate of Damietta, a brief overview of changes in the agricultural sector over the past decade is also deemed relevant.

8. As a 1993 World Bank Report notes, the 'three main pillars' for promoting economic growth in Egypt are the agriculture, industry and tourism sectors respectively. The focus on agriculture is deemed justified by the traditional reliance of the Egyptian economy on this sector, which, though declining, still accounts for around 20% of GDP and 36% of employment. In fact, in spire of the pace of urbanisation, the rural population by the early 1990s was estimated to be 53% of the total population.[57]

9. Also of relevance are the following facts:[58]

9.1. Increasing pressure on urban areas in Egypt necessitates the revitalisation of the rural economy, and indeed this is part of the current structural adjustment policies.

9.2. A substantial number of rural households derive part of their income from off-farm economic activities, though there are obviously regional and intra-governmental variations.

9.3. Rural women play an important role in the rural economy and in agricultural production, even though this fact continues to be largely invisible in the national statistics. This role is at least partly related to the pattern of rural male labour migration which, though exhibiting a decline compared with the 1980s, nevertheless continues to be significant in parts of rural Egypt.

9.4. Another relevant point is the relatively small size of land holdings. Government efforts to counter fragmentation (due to inheritance customs) has focused on the

[57] See Arab Republic of Egypt: An Agricultural Strategy for the 1990s, World Bank Country Study, 1993.

[58] Ibid.

grouping of small plots (generally one feddan/1.038 acres) into blocks subject to the same crop rotation. However, recent legislation has eroded tenants' traditional security with regard to leased land.

10. The sub-sectoral reform strategies identified as part of the liberalisation of the agricultural sector include:[59]

10.1. Improving the management of water and land resources, including changes in cropping patterns and livestock production.

10.2. Tackling constraints which impede the development of trade, agricultural markets and agro-industries.

10.3. Strengthening agricultural extension policies.

10.4. Promoting channels of credit to the agricultural sector.

11. Another relevant issue is rural poverty. While there is consensus over the fact that the number of rural households has declined during the 1980s, not least due to rising farm wages, labour migration, increasing off-farm economic activities as well as the growth of livestock production, there are nevertheless indications that poverty is on the rise in rural Egypt.[60] In fact, the latest estimate (for 1990) indicates that 34% of the rural population in Egypt live in poverty (though regional variations need to be taken into consideration).[61]

12. Related to the above is the equally important aspect of rural women and poverty. While limited data is available on this issue, anecdotal and other evidence point to what has come to be termed the feminisation of poverty. This is held to imply that relative to their male peers, the number of poor women tends to be quantitatively higher and that, moreover, due to a complexity of variables, women tend in many ways to experience and be affected by poverty differently relative to men. There is also evidence that the feminisation of poverty is to some extent linked with the increase in the number of rural female-headed households.[62]

[59] Ibid.

[60] See G. M. Craig, ed., The Agriculture of Egypt, op. cit.

[61] See United Nations Development Programme (UNDP), Human Development Report 1995, p. 178.

[62] It is estimated that by the late 1980s, female-headed rural households as a percentage of total rural households was 30% in Egypt. See I. Jazairy et. al., The State of World Rural Poverty, Rome: International Fund for Agricultural Development (IFAD), pp. 406-407.

APPENDIX B: ITINERARY OF THE MISSION IN EGYPT

Sunday evening
5 November 1995 Arrival of Consultants in Cairo.

Monday
6 November Morning:

Briefing at the Netherlands Embassy with the First Secretary/WID, General Director of the Directorate of Health, Governorate of Damietta, and members of the project management of the PHCP/RD in Damietta.

Afternoon:
Travel to Damietta.

Evening:
Working session to finalise programme for field visits.

Tuesday
7 November Morning:

* Briefing at the Directorate of Health, Damietta City.

* Visit to El-Sayala RHU in the Damietta District: Discussion of activities and
management/information system with the RHU physician; focus group discussion with RHU nurses; inspection of the premises.

Afternoon and evening:
Study of documentation not previously made available to the Mission.

Wednesday
8 November Morning:

* Visit to the Abadeyya Training Centre, Faraskour:
Dr. Rijsemus: Discussion of training
activities with the ATC Director and visit to adjacent RHU.

Dr. El-Solh: Attendance of part of a refresher course on MCH and home visits to poor elderly rural women.

Afternoon and evening:
* Study of additional documentation.

* Report writing.

Thursday
9 November

Morning:

* Visit to Medical Director of Damietta District.

* Dr. Rijsemus: Visit to Rural Hospital (RH).

* Dr. El-Solh: Visit to El Bustan RHU, Damietta District; discussion with RHU physician; accompanied nurses on house visits related to reproductive health project component.

Afternoon and evening:

* Study of additional documentation.

* Report writing.

Friday
10 November

All day:

* Further study of documentation.

* Report writing.

Saturday
11 November

Morning:

* Visit to Mit Aboul-Kholi RHU, Zarka District.

* Dr. Rijsemus: Discussion with RHU physician and staff; inspection of RHU premises.

* Discussion with Nurse Supervisor of Damietta District.

* Dr. El-Solh: Accompanied nurses on home visits related to MCH, care of poor elderly women and reproductive health.

* Both consultants: Visit to Abadeyya Training Centre to see Video on Home Visits to Poor Elderly Rural Women.

Afternoon and evening:
Report writing.

Sunday
12 November

Morning:
Focus group discussion with project management staff.

Afternoon and evening:
Report writing.

Monday 13 November	Morning and afternoon: Finalisation of the Briefing Report. Evening: * Briefing meeting with the General Director of the DoH, Governorate of Damietta and PHCP/RD project management staff. * Incorporation of comments of above meeting in the Briefing Report.
Tuesday 14 November	Morning: * Travel to Cairo * Briefing meeting with the Under-Secretary of Rural Health Services and other staff in the MoH, Cairo. Afternoon and evening: Work on the Draft Mission Report.
Wednesday 15 November	Morning: Briefing meeting in the Netherlands Embassy Afternoon and evening: Work on the Draft Mission Report.
Thursday 16 November	Travel back: Dr. C. El-Solh to England Dr. A. Rijsemus to the Netherlands.
Tuesday 21 November	Dr. A. Rijsemus briefing meeting with pertinent staff in the Royal Tropical Institute, Amsterdam.

APPENDIX C: LIST OF PERSONS MET DURING THE MISSION

Dr. Mohamad Abdel-Hadi, Physician, Mit Al-Kholi RHU, Zarka District, Damietta.

Mrs. Tayseer Abou Ismail, Nurse Supervisor, Damietta District, Damietta.

Dr. Rabi' Abol-Khair, Field Executive Director PHCP/RD, Director of Basic Health Services, Directorate of Health, Damietta.

Mrs. Hiyam Al-'Ayshi, Nurse Supervisor, Directorate of Health, Damietta.

Mrs. Azza Badawi, Nurse Supervisor, DoH, Damietta.

Ms. Joke Buringa, First Secretary, Women & Development, Embassy of the Netherlands, Cairo.

Mr. Jarl Chabot, Head of Department of Health Care and Disease Control, Royal Tropical Institute, Amsterdam.

Dr. Moustafa Darwish, Director of Family Planning, Directorate of Health, Damietta.

Dr. Ibrahim El-Kemami, Director General, Directorate of Health, Damietta.

Dr. Mohamed Fayed, RHU Physician, Damietta District, Damietta.

Dr. Ibrahim Gaissa, General Director, Rural Health, Ministry of Health, Cairo.

Dr. Ahmad H. Mahmoud, Professor of Public Health, Cairo University.[63]

Dr. Tareq Mourad, Senior Project Officer, The Netherlands Embassy, Cairo.

Dr. Mary Naguib, Director, Abadeyya Training Centre, Faraskour District, Damietta.

Dr. Nabil Nassar, First Under Secretary of Basic Health Services, MoH, Cairo.

Dr. Mansour Quwaita, RHC physician, Faraskour District, Damietta.

Dr. Hassan Sayegh, Medical Director, Damietta District, Damietta.

Dr. Hosni Tammam, Under Secretary of Rural Health, Ministry of Health, Cairo.

[63] Regrettably, Dr. Mahmoud died on the first day of the Mission's visit to Egypt, but was not replaced by anyone else.

Dr. Leila Tewfik, Field Executive Director PHCP/RD, Director of Training, Directorate of Health, Damietta.

Ms. Wil van Steenbergen, Technical Adviser, Royal Tropical Institute, Amsterdam (currently working in the Fayoum Governorate, Egypt).

Dr. Magda Zaki, physician, El-Bustan RHU, Damietta District, Damietta.

APPENDIX D: LIST OF PHCP/RD DOCUMENTS CONSULTED

* PHC/RD: Execution Document (1985).

* PHCPRD: Problems and Progress by J. N. Van Luijk, May 1986.

* Results of a baseline Community Survey of Health Related Variables, by Dr. N. Nassar, Dr. C. Sellens & Dr. J. N. Van Luijk, Damietta, March-April 1987.

* PHC/RD: Execution Document 2nd phase, January 1987-December 1988.

* Damietta RPHC: Report of an Evaluation Mission by A. Crowley et. al., October 1988.

* Report on Introduction Visit in Faraskour and Zarka, by I. Niebor, September-November 1989.

* Workshop on Local Health Planning: Evaluation Report by E. A. Burger, February 1990.

* General Backstopping for the DPHC-Project and Consulting Activities for the Planning of the Evaluation of the Outreach Programme, by J. N. Van Luijk and J. W. Harnmeijer, April-May 1990.

* Report of the Joint Evaluation Mission 1990, by Prof. S. M. Wassif and C. J. Royer, August 1990.

* Progress Report 3rd Quarter 1990.

* Assisting in Development Yearplan 1992 and General Backstopping Activities: Report of a Mission by J. N. Van Luick, September-October 1991.

* Renovation of Buildings, Maintenance of Buildings and Equipment: Report of a Mission by J. Woudsma, October-November 1991.

* PHC Project Rural Damietta Short Term Consultancy Report: Village Health Planning Women and Development Approach by K. H. Eggens and R. Van Roemburg, November-December 1991.

* Internal Evaluation of the Daya Programme in Zarka and Faraskour Districts by W. Van Steenbergen, December 1991.

* PHCPRD: Yearplan 1992.

* Mission Report of the Model Development for the Damietta Rural PHC Project by P. Schothorst, March 1992.

* Briefing Paper: Women and Development in the Damietta Rural Primary Health Care Project by Matrix Consultants, August 1992.

* PHCP/RD: External Midterm Evaluation 1992: Report of a Mission, August-September 1992.

* Report of the Consultancy Mission to the PHC Project of Rural Damietta by K. H. Eggens, October 1992.

* Damietta Rural PHC Project Short Term Consultancy Report: District Health Care Management Training by D. Burck and P. Schothorst, November 1992.

* Amended Plan of Action for the Model Development of Rural Damietta PHC Project by A. Nagaty, W. Van Steenbergen et. al., November 1992.

* Memorandum of Agreement Between the Ministry of Health and the Royal Tropical Institute, June 1993.

* PHCP/RD: Yearplan 1993.

* Summary Report: Women's Health Needs in Rural Damietta: The Relationship Between Women's Position and Available Health Services and Women's Health Needs, by M. M. Kamal, CDS, August 1993.

* PHCRD: Draft Report on the Workshop on 'Women and Health', August 1993.

* Outline of Conference Papers on Project Model Development (nodate, presumably 1992/1993).

* Summaries of Conference Papers on Primary Health Care Rural Damietta (Project Model Development), August 1993.

* PHCP/RD: Evaluation of Home Visiting Programme: An Internal Evaluation by A. Nagaty, M. El-Laithy and project staff, September-December 1993.

* Final Report of the PHCP/RD, Phase III, January 1991-December 1993.

* Proposal for the Support Programme for PHCP/RD 1994-1995, October 1993.

* PHCP/RD 1994-1995 (Phase 3): Report of a Backstopping Mission, by W. Van Steenbergen, March 1994.

* Reproductive Health Care PHCP/RD 1994-1995 (Phase 3), April 1994.

* Workshop on 'Women and Reproductive Health Care', Amsterdam August 1994.

* Progress Report PHCP/RD 1994-95 (Phase 3), March-September 1994.

* PHCP/RD 1994-1995 (Phase 3): Report of a Backstopping Mission, January 1995.

* PHCP/RD: Yearplan 1995.

* Primary Health Care Rural Damietta Project: Progress Report January-June 1995.

* Evaluation of Health Care for the Aged Women in Kafr Saad District, July 1995.

* Primary Health Care Rural Damietta Project (Phase 3: 1994-1995): Report of Visit, July 1995.

APPENDIX E

versie 4 october 1995

DAMIETTA PRIMARY HEALTH CARE PROJECT III
end of project evaluation
Terms of Reference

I: BACKGROUND

In June 1982 the Egyptian and Netherlands Government agreed in principle to execute a joint technical assistance project aimed at the improvement of the Rural Health Services in Damietta Governorate. The first phase of the project was implemented in 1985 and lasted two years. The activities were started in the district of Faraskour and further expanded to the district of Zarka. As the implementation was lagging behind, mostly because of institutional bottle necks, a second phase was formulated until 1988. This second phase was then extended until 1990 on the basis of the recommandations of a joint evaluation mission (1988). This mission also adapted the project objectives which were deemed too ambitious. The second joint evaluation in 1990 recommanded an extension in a final phase III until the end of 1993. This final phase should aim at quality improvement of the MCH programme and phasing out of the technical assistance. During this last phase the project also expanded its activities to the districts of Damietta and Kafr Saad. The external mid term evaluation of 1992 positively evaluated the project. The mission assesed i.a. adjustments and additions in the project objectives and concluded that they were justified. The most important change was adding the objective of the development of a Project Model to have full documentation and a set of manuals and guidelines regarding relevant project activities. At the end of 1993 funds remained unspent and it was decided to extend Phase III until the end of 1995 to assure sustainability of the project achievements and to give extra attention to some innovative activities such as reproductive health and home visits for the aged.

Damietta is one of the smaller governorates of Egypt located in the Nile Delta, at the northern sea boundary of the country with a population of approx. 850.000. Three quarters of the population is rural. The governorate is divided in four districts: Damietta, Kafr Saad, Fariskour en El Zarka. The governorate is considered as having an economic status above the average in Egypt.

According to the national priorities the rural PHC is anchored in the Rural Health Services. In the Damietta Governorate these services consist of:

- 45 Rural Health Units: (physician, dentist, MCH nurses or nurse-midwives, sanitarian, laboratory assistant, clerk, cleaner and guard);
- 5 Rural Health Centre: similar to a Rural Health Unit, but with a maximum of 14 beds. In Damietta these beds remain largely unused.
- 4 Rural Hospital: basically like a Rural Health Centre, with extended facilities and more services (X-ray, operating room) and up to 24 beds with a generally low occupancy;

specialists come on a consultative basis from the district hospital.

An important componant within the rural health services is the outreach programme consisting of:

- home visits (MCH-team);
- school visits (school health-nurse);
- inspection of public places (sanitarian);
- interaction with village council and development agencies (physician).

II: OBJECTIVES

The overall objective of the mission is to obtain an independent view of the project achievements to date.

This view should include at least an appreciation of the impact of PHC services, as delivered by the project, on health status and family welfare (and especially of women) created among the [total] population of Damietta Governorate. In other words the aim of this evaluation is obtain an independent view on the value added by this project on the existing system of health services in the Damietta Governorate. Furthermore an answer should be given to the question whether the demand for sustainable PHC services in the Damietta Governorate is adequately and cost-effectively met through improved quality and reliability of the PHC delivery system and whether the Directorate of Health (DOH) in the Damietta Governorate is now organized along the lines of PHC functions. Also it should be assessed whether the PHC model developed by the project can be sustained by the Damietta Governorate after the end of this project. Moreover special attention should be given to the question of community participation in the organization and functioning of the PHC services at Damietta Governorate facility-level.

III: TASKS AND FURTHER PARTICULARS

The tasks of the mission are:

1 to assess the relevance of the project objectives and their successive steps of operationalization (development objective, immediate objective, detailed objectives).

Relevance of project objectives is to be assessed against the Egyptian policies (macro-economic, health, institutional), in general and specifically for the Damietta Governorate, and against the Netherlands development cooperation policies, in general (the three criteria of poverty reduction, environment and gender & development) and specifically for Egypt. Special attention is to be paid to:

- coherence, completeness and adequacy of immediate and detailed objectives, and the situation analysis on which they are based,
- recent developments in Egyptian policies and practices in health ,
- DOH specific tasks, its institutional capacity and performance.

II to assess the overall achievements of the project and to identify and analyse major constraints which hampered the progress and/or the quality of the project;

a) to assess the progress made in the different project components in general, following the methodology and the language of the Logical Framework (LF) as used by the consultants and measure the outputs to date of the project activities;
b) to analyse the causes and justifications of any delays and deviations in the implementation of the different project activities;
c) to assess the achievements of the building component;
d) to assess the project performance of the Consultant 'Royal Tropical Institute' in general and that of the local managementteam in particular.

III to review in light of the experience of the project over the last two years, the feasibility of attaining, according to schedule, the general aim and the specific objectives set by the Consultant being:

General aim: to contribute to the improvement of the health status of the rural population of the Governorate of Damietta, particularly of its women, children, and less privileged population, by improving the quality of the existing Rural Health Services, the orientation of the personnel, and their utilization.

Specific objectives:
a) Strengthening of the MCH-programme, including family planning;
b) Strengthening of management and planning capability;
c) Strenghtening of infrastructure and material support;
d) Project Model Development: to have full documentation and a set of manuals and guidelines regarding relevant project activities.

IV to review in more detail and make recommandations for:

a) the collaboration between the Directorate of Health (DOH) in the Damietta Governorate and the projectstaff in the planning and implementation of the project activities;
b) the role of the project in the existing health care system of the Damietta Governorate and the collaboration with other actors in the system, including the private sector.
c) the process of community participation in the project planning and implementation, including the introduction of cost sharing systems and the construction of health units;
d) the impact of the project on women in their role as health care providers as well as - consumers and to assess the accessibility of the latter to the health services provided by the project;

APPENDIX E

IV: THE METHODOLOGY OF THE MISSION

The mission should obtain an independent view of the project achievements to date by conducting discussions with the relevant Egyptian national and local authorities, with the beneficial population and their representatives, with the managementteam of the project, with representatives of the contractor (in the Netherlands) and with representatives of the Netherlands Embassy, as well as by the study of relevant project- and other documents, i.a. the original Project Proposal, the Evaluation Reports of 1988, 1990 and 1992, the Plan of Operation and the proposal for the extension of phase III (1994-1995).

Furthermore:

- All relevant project documents will be made available by the project and DGIS.
- The production of the draft version of the evaluation report will be the responsibility of the mission.
- The consultants will prepare a draft report and an executive summary in Egypt containing the conclusions and recommendations.
- The draft mission report and recommendations should be presented to and discussed with the relevant local and central authorities of the Ministry of Health to obtain their views and comments. These comments should then be incorporated in the final draft presented to Netherlands Ministry of Foreign Affairs within fourteen days upon return from Egypt.
- The final version of the report will only be accepted by the Ministry after the final comments have been received.

V: MISSION TEAM

The mission team will consist of three members from the Netherlands side:

- Dr. Camllia El-Solh (Public Health Consultant and proposed teamleader);

- Dr. Ton Rijsemus (PHC-doctor);

The mission members from the Egyptian side are to date unknown.