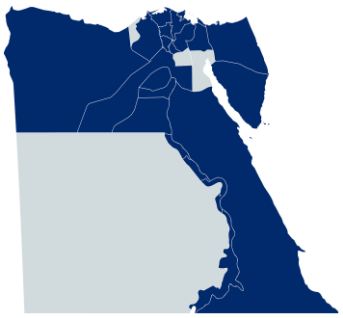
Egypt
EOP Summary & Results



Geographic Implementation Areas

Governorates
- 23/27 (85%)—9 in Upper Egypt (Aswan, Assiut, Beni Suef, Faiyum, Giza, Luxor, Minya, Qena, Sohag); 9 in Lower Egypt (Al Sharqia, Beheira, Dakahlia, Damietta, Gharbia, Ismailia, Kafr el-Sheikh, Monufia, Qalyubia); 5 border governorates (Matruh, Port Said, North Sinai, Red Sea, South Sinai)

Districts
- 216/308 (70%)

Facilities
- 4,839/5,098 (95%)

Population

Country
- 91.5 million

MCSP-supported areas
- 15.3 million

Technical Areas

Program Dates
April 1, 2015–August 15, 2019

Total Funding through Life of Project
$5,915,635

Demographic and Health Indicators

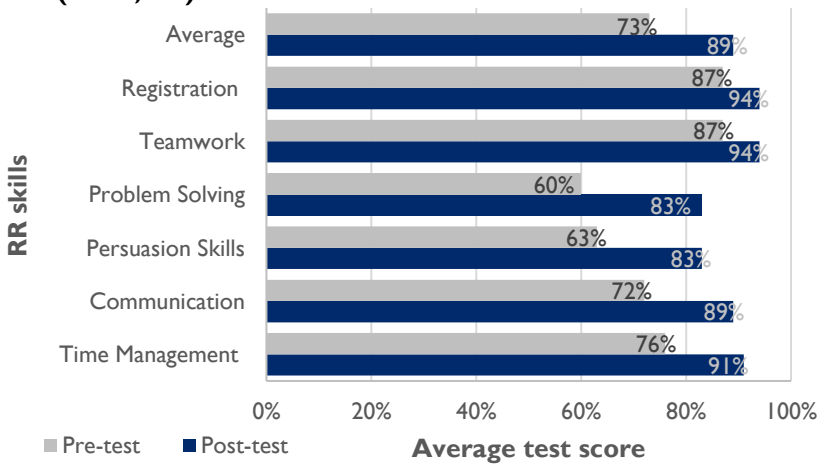
Indicator	# or %
TFR[2]	3.5
MMR (per 100,000 live births)[1]	33
NMR (per 1,000 live births)[2]	14
U5MR (per 1,000 live births)[2]	27
TFR (births per woman)[2]	3.5
CPR (modern methods)[2]	54%
ANC 4+[2]	82.8%
SBA[2]	91.5%
Postnatal care < 48 hours of birth[2]	14%
Stunting (height for age < 5)[2]	21%

Sources: [1] World Bank 2015, [2] Egypt DHS 2014

Strategic Objectives through the Life of Project
- Provide technical assistance to the Ministry of Health and Population to develop a national strategy for Egypt's CHWs, *Raedat Refiats* (RRs) that reflects the Family Health Package and will support the ministry to reach Sustainable Development Goal targets.
- Provide technical assistance to the Ministry of Health and Population to develop a national training system for the RR program and implement it at scale in 23 governorates.

Highlights through the Life of Project
- Assisted Egypt's Ministry of Health and Population to develop and validate a national strategy for its approximately14,000 RRs, promoting them as key actors in Egypt's journey to self-reliance through the increased reach of community-based services.
- Strengthened the skills and knowledge of more than 10,000 frontline RRs in 23 governorates, who are now better equipped to provide Egyptian households with timely and accurate health information.
- Launched a digital HMIS to enable more than 1,200 RRs in five pilot governorates to capture and manage program data, eliminating cumbersome paper-based reporting and saving RRs time that they can use to provide services to families in their communities.

Figure 1. Across 23 governorates, a matched sample of average RR skills test scores revealed the greatest growth in problem-solving skills (N = 2,024)



Egypt

Background

Egypt established the RR CHW cadre in 1994 to increase demand for FP services. From an initial 5,000 positions in 1994, the RR workforce has grown to 14,000+ RRs, tasked with promoting a range of health services reflective of the national Family Health Package. In 2015, at the request of the Ministry of Health and Population and with support from USAID, the Ministry of Health and Population and MCSP—led by a team of international and local researchers, including experts in the Egyptian health system—assessed the RR program and found that, although RRs are essential members of Egypt's frontline health team and the government has invested significant financial resources, the program as designed could not demonstrate desired results or impact. MCSP, in collaboration with the Ministry of Health and Population, thus undertook a two-pronged approach to strengthen the RR program: develop a new national strategy and an updated training program targeting RR knowledge and skills development to better meet the health needs of women of reproductive age in 23 of Egypt's 27 governorates.

Key Accomplishments

Established Strategic Goals, Objectives, and Indicators for the National RR Program

The findings and recommendations of the Ministry of Health and Population and MCSP-led 2015 RR program assessment directly informed the design of a new national strategy and the implementation phase of MCSP's program in Egypt. MCSP served as secretariat for a technical advisory group established by the Minister of Health and Population for the development of the national strategy. In keeping with recommendations 1 and 2 from the assessment, MCSP supported the Ministry of Health and Population to establish explicit strategic goals, objectives, and performance management indicators for the RR program within the context of the Ministry of Health and Population's full Family Health Strategy, with its targets linked to Egypt's Sustainable Development Goal for MCH.

As Box 1 indicates, MCSP led or directly supported implementation of six of the 11 assessment recommendations. Throughout the course of the national strategy development process and dissemination at events in Cairo and Assiut, MCSP also sought to catalyze and mobilize the central-level Ministry of Health and Population, donors, and other resource partners to support the new concepts, interventions, and actions described in the five remaining recommendations. Using the data and insights garnered from the assessment and relevant experiences from other countries' CHW programs, MCSP advocated for more than just additional traditional training to address RR program needs. Rather, MCSP collaborated with the Ministry of Health and Population to inform design of a fit-for-purpose national program that draws upon evidence, engages in long-term thinking, and promotes sustainability.

Box 1. The 2015 RR assessment yielded 11 recommendations. (MCSP led or supported implementation of those in bold.)

1. **Confirm or reverse the strategic direction of the RR program toward a full family health strategy.**
2. **Establish explicit strategic goals, objectives, and performance management indicators.**
3. Establish clear and recognized operational management and control of the RR program through a management unit at governorate level.
4. **Provide practical and operational guidance to RRs at governorate level to more strategically balance their activities between home visits and community outreach, and mobilization and support of community groups for health promotion and social change.**
5. **Establish, resource, and implement a state-of-the-art training strategy adapted to the ambitions of the RR program.**
6. **Make use of mobile technology.**
7. **Improve the RR and community health promotion information system.**
8. Involve communities in setting and achieving health objectives with the RR program through systematic engagement of local leaders and organizations as partners.
9. Start planning for a future with RR career advancement opportunities.
10. Improve the RR motivation and incentive system.
11. Cost these recommendations and options to move the RR program forward in the next 5 to 10 years.

The success of the technical advisory group in part inspired the Ministry of Health and Population to expand the committee's scope to include M&E of the strategy's implementation. Through this Ministry of Health and Population-led "High Committee," MCSP introduced a matrix for a unified RR evaluation process at the governorate level, ultimately reaching multistakeholder consensus on indicators, milestones, and timelines aligned with the four pillars of the RR strategy and Egypt's MCH targets. MCSP's support enabled the Ministry of Health and Population to bring the right information to the right people at the right time, facilitating sustained monitoring of strategy implementation.

Developed National RR Curriculum to Provide Practical and Operational Guidance

As the technical advisory group was revising the RR strategy, MCSP facilitated the establishment of technical committees and subgroups to lead the development of a new training system, including a modular approach to technical content areas, revised operational guidelines, and a focus on skills acquisition, particularly in areas deemed to be core RR competencies. The subgroups developed four training modules reflective of the Ministry of Health and Population's Family Health Package—newborn and child health, reproductive health, communicable and noncommunicable diseases, and nutrition—incorporating social and behavior change approaches within each. A fifth module, the operational guidelines, outlined RR qualifications, the reporting structure, household registration, and a revised RR job description. In October 2017, MCSP received Ministry of Health and Population approval for the revised training modules.

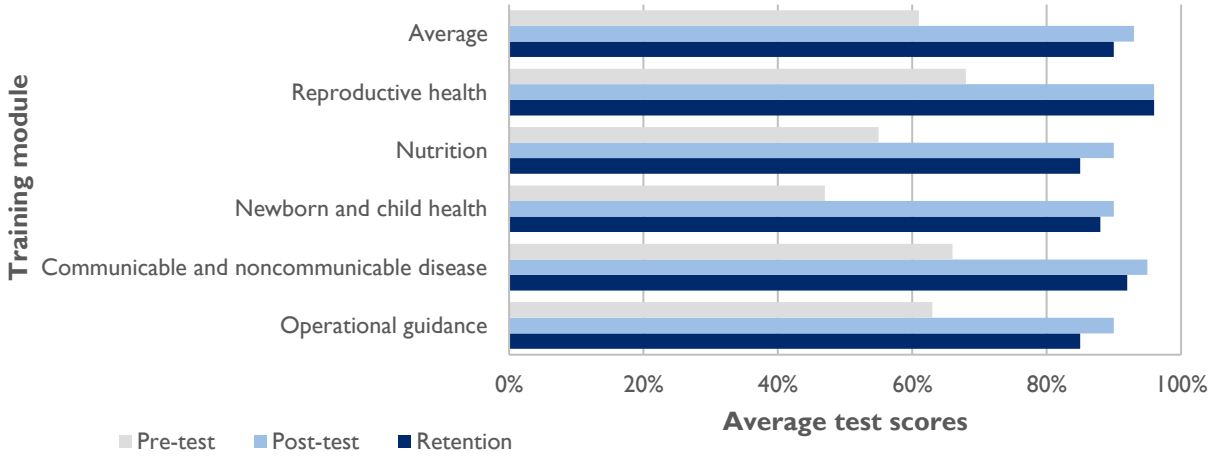
With the approved training modules as a guide, MCSP then built out a comprehensive training resource package, including training manuals, visual aids, monitoring tools, and job aids corresponding to the four technical content areas and revised operational guidelines. Each resource was developed and refined through an iterative process with the Ministry of Health and Population and relevant stakeholders. The complete training resource package is available on the Ministry's national RR website for reference and continued use, as well as on each RR tablet (see next section). For a durable, on-the-job reference, MCSP also provided RR supervisors and RRs in 23 governorates with printed copies of training modules (for RR supervisors), training manuals (for RRs), job aids, and the Ministry of Health and Population's family demographic register and daily home visit register.

Established and Implemented a Training Strategy Adapted to RR Program Ambitions

Beginning in mid-2017, MCSP introduced the training modules to 63 master trainers and 132 lead trainers. These new trainer cadres cascaded the training to 1,280 RR supervisors, who in turn built the capacity of 10,183 RRs in 23 governorates using a hands-on and interactive LDHF approach. Rather than didactic training in a classroom environment, the LDHF approach focuses on team- and workplace-based learning and practice. The LDHF learning activities, spaced over the course of approximately 5 months, consisted of one primary health care unit training day per week, followed by daily practical application during which RRs conducted home visits with real-time coaching from an RR supervisor. At the end of each month, RR supervisors met with their supervisees to share feedback on the RR's performance and discuss challenges faced in the course of the RR's work.

Across the 23 governorates, RRs who participated in the LDHF sessions consistently demonstrated improvements in thematic knowledge from pre-test to post-test and at 6 months post-training completion. MCSP conducted a knowledge retention test with a matched sample of RRs in 15 governorates, as shown in Figure 2. Although experience shows that a reduction in knowledge is to be expected, retention assessment results demonstrated an average retention of 90% across thematic areas.

Figure 2. At 6 months post-training, a matched sample of average RR knowledge retention test scores remained nearly on par with their post-test scores (N = 1,633)



These demonstrated increases in RR knowledge of reproductive health, nutrition, newborn and child health, and communicable and non-communicable diseases enable RRs to serve as key actors in Egypt's efforts to better meet the health needs of women of reproductive age and their families. As one RR reported, "[After the training,] ladies were asking me in all topics, not only FP. While the ladies followed my advice, their lives became better. For me, I became more precisely able to answer and keep trust with the women."[6]

Designed and Launched a Model HMIS for the RR Program

In response to two recommendations from the RR program assessment—to make use of mobile technology and improve the RR and community health promotion information system—MCSP collaborated with the Ministry of Health and Population to design, launch, and refine a digital community HMIS to capture program data from more than 1,200 RRs in five pilot governorates.[7] In collaboration with the Ministry of Health and Population, MCSP developed the system to reduce the time RRs spend on paper-based reporting and free up more time for them to serve families in their communities, and to enable the ministry to manage the RR program more effectively by capturing data, including workforce data, to guide trainings and service planning and support.

MCSP distributed tablets and durable user manuals, and developed a cadre of 15 trainers and 29 facilitators from Ministry of Health and Population information technology and technical staff in Luxor, Ismailia, Assiut, Damietta, and Port Said governorates to lead the training of RR supervisors and RRs in these five governorates. These master trainers cascaded the training to 1,128 total RRs, comprising 250 RRs in Luxor governorate, 103 RRs in Ismailia governorate, 523 RRs in Assiut governorate,[8] 207 RRs in Damietta, and 45 RRs in Port Said governorate.

Meaningful engagement of Ministry of Health and Population staff early on and throughout the process fostered ownership, increasing the likelihood of the system being sustained after MCSP ends. To this end, MCSP purchased and installed a server at the Ministry of Health and Population to host the HMIS. The server will securely store national RR program data, demonstrating the ministry's commitment to moving another step closer to a paperless HMIS. (For more information, see MCSP's brief on National Community Health Information Systems.)

[6] *Raedat Refiat* focus group participant. Giza, Egypt. March 2019.
[7] Luxor and Ismailia were initially envisaged as the two pilot governorates. In consultation with the Ministry of Health and Population and USAID, MCSP later expanded the pilot to three additional governorates owing to changes in RR availability during the Ministry of Health and Population's national hepatitis C campaign.
[8] MCSP collaborated with Save the Children's sponsorship program to pilot the HMIS in Assiut governorate, where sponsorship programming is active, using sponsorship funds.

Recommendations for the Future

Building on successes and lessons learned over the last 4 years, MCSP offers the following recommendations to the Ministry of Health and Population and its partners as it supports the government of Egypt writ large in its journey to self-reliance:

- **Review the national RR strategy for its applicability in the five border governorates, given their distinctive epidemiological, geographic, and cultural profile.** As needed, develop a differential strategy, substrategy, and/or implementation plan aligned with the needs of these governorates.
- **Review, validate, and cost the World Bank-developed national RR strategy implementation plan to facilitate advocacy and fundraising.**
- **Continue to convene regular meetings of the High Committee.** This will allow for sustained monitoring of the strategy's implementation, including use of the RR evaluation matrix.
    - **Replicate the application of the LDHF approach as an initial training for RRs across the remaining governorates of Alexandria, New Valley, and Suez.** The approach has demonstrated effectiveness in improving RR knowledge and skills, and ranked highly in terms of satisfaction among those RRs surveyed.
    - **Conduct interactive, hands-on refresher trainings at the primary health care unit for RRs as outlined in the operational guidelines module.** This should be done twice a year through a 1-day session for each technical content area and should also incorporate continuous regular supportive supervision and coaching visits to RR supervisors and RRs.
    - **Ensure the continued engagement of the Ministry of Health and Population's technical and information technology staff to promote sustainability of future iterations of the RR HMIS.** These stakeholders should be actively involved in the thoughtful redesign, resourcing, technical support, and maintenance of the electronic information system.
    - **Plan for initial trainings in information technology skills and basic hardware use before moving to more complex tasks and operations.** This is crucial as Egypt continues to iterate and scale digital health models, such as those currently being designed by USAID's Strengthening Egypt's FP Program. The Ministry of Health and Population and its partners should also keep an eye to systems interoperability, with the aim of more efficient and effective management and timely decision-making for the national RR program.

Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	**Achievement (Target)**
Number of trainers who completed TOTs	1,475 (target: 1,460; target exceeded)
Percentage of improvement in RR knowledge	47% (target: 25%; target exceeded)
Percentage of improvement in RR skills	22% (target: 25%; 88% achieved)
Number of governorates that piloted the electronic HMIS	5 governorates: Luxor, Ismailia, Assiut, Damietta, and Port Said (target: 2 governorates [Luxor and Ismailia]; target exceeded)

For a list of technical products developed by MCSP related to this country, please click here.