

エジプト・アラブ共和国  
上エジプト学校保健サービス促進  
プロジェクト  
終了時評価調査報告書

2012年7月

独立行政法人  
国際協力機構（JICA）  
人間開発部

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## 序 文

本プロジェクトは、エジプト・アラブ共和国政府からの要請に基づき、農村部における学齢期児童の健康改善を目的として2008年11月に開始され、本調査実施時点で約3年半が経過しました。この間、エジプト・アラブ共和国では急速な経済発展に伴い、健康ニーズも感染症対策から生活習慣病の予防へと変化しつつあります。エジプト・アラブ共和国全体としてみれば健康水準は改善傾向にありますが、同時に都市部と農村部、富裕層とそうでない層の健康水準の差は拡大しつつあります。今後、若いうちから健康的な生活習慣を身につけることは重要な課題となり、その点で学校保健の役割はさらに重要になっていくことが予想されます。

今般、本プロジェクトの終了を約5カ月後に控え、2012年6月16日から7月7日まで終了時評価調査団を派遣しました。同調査は、これまでのプロジェクト活動の実績、成果を評価するとともに、終了までのプロジェクト活動に対する提言及び今後の類似事業にあたっての教訓を導くことを目的としています。本報告書は同調査団が実施した調査結果を取りまとめたものです。

エジプト・アラブ共和国においては、2011年1月に政治的変革を求める革命が発生し、本調査期間中の2012年6月には新大統領が選出され、現地は大きな変化の時を迎えています。エジプト・アラブ共和国と日本国が長年にわたり築いてきた協力関係が、今後もよい形で継続されることを願っています。そして、子どもの健康に焦点を当てた本プロジェクトが、将来的な両国の友好関係に何らかの形で寄与するものとなれば幸いです。

最後に、本調査にあたりましてご協力を賜りました関係各位に深甚なる謝意を表しますとともに、今後ともプロジェクト実施・運営のため、引き続きご指導、ご協力いただけますようお願い申し上げます。

2012年7月

独立行政法人国際協力機構

人間開発部長 萱島 信子



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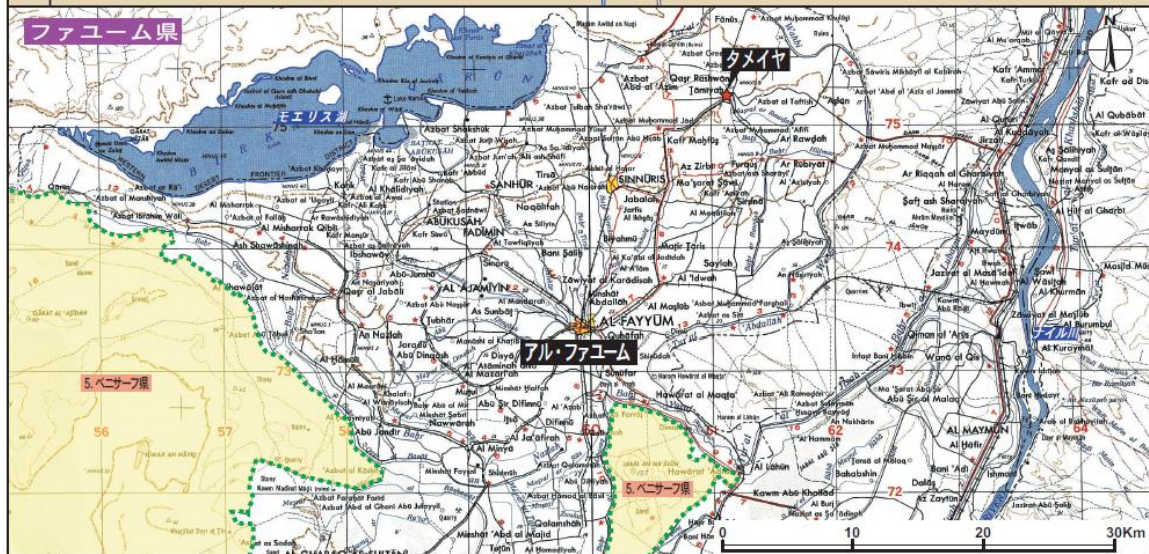
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# プロジェクト対象地域図





写 真



スクールクリニックの前に並んだ生徒たち



ヘルスビジターによる身長測定



学校看護師による体重測定



学校医による問診



研修を通じた健康教育教材の開発



コミュニティ参加型活動



## 略語一覧

略語	正式名	日本語
C/P	Counterpart	カウンターパート
HIO	Health Insurance Organization	健康保険庁
HPS	Health Promotion School	ヘルス・プロモーション・スクール
ISHC	Internal School Health Committee	学内保健委員会
JCC	Joint Coordination Committee	合同調整委員会
JICA	Japan International Cooperation Agency	独立行政法人 国際協力機構
M & G	The Implementation Manual for School Health Services and the Guidelines of Monitoring and Supervision for School Health Services	学校保健実践マニュアル及び学校保健サービスに関するモニタリング・指導監督ガイドライン
MOE	Ministry of Education	教育省
MOHP	Ministry of Health and Population	保健人口省
MT	Monitoring Team	モニタリング・チーム
NGO	Non-Governmental Organizations	非政府組織
PDM	Project Design Matrix	プロジェクト・デザイン・マトリックス
PHC	Primary Health Care	プライマリ・ヘルスケア
R/D	Record of Discussions	討議議事録
SACHD	School Aged Children Health Care Department	保健人口省学齢期児童健康部
SHC	School Health Committee	学校保健委員会
TT	Trainer's Team	トレーナーズ・チーム
WHO	World Health Organization	世界保健機関



## 評価調査結果要約表

<b>1. 案件の概要</b>	
国名：エジプト・アラブ共和国	案件名：上エジプト学校保健サービス促進プロジェクト
分野：保健	援助形態：技術協力プロジェクト
所轄部署：人間開発部 保健第一課	協力金額（評価時点）：3.29 億円 （2008 年度～2011 年度の実績額合計）
協力期間：2008 年 11 月～2012 年 11 月 （R/D 締結：2008 年 9 月 16 日）	先方関係機関：保健人口省（Ministry of Health and Population：MOHP）、健康保険庁（Health Insurance Organization：HIO）、教育省（Ministry of Education：MOE）
他の関連協力：特になし	日本側協力機関：システム科学コンサルタンツ株式会社、特定非営利法人 HANDS
<p><b>1-1 協力の背景と概要</b></p> <p>エジプト・アラブ共和国（以下、「エジプト」と記す）における保健をとりまく状況は全般的に改善傾向にあるものの、地方や農村部の貧困層では保健医療サービスへのアクセスがいまだに低く、特に、貧困層の学齢期の子どもの間では、貧血、発育不良、寄生虫症等の発生が健康上の大きな課題となっている。</p> <p>エジプトでは、1993 年に、すべての学生の健康保険加入が制度化され、「学校保険法ガイドライン」が定められた。同ガイドラインでは、健康保険庁の管轄するクリニックに所属する学校医・学校看護師等によって、定期健康診断、予防接種、健康的な学校環境の維持、保健教育等の学校保健サービスが実施されることが規定されている。しかしながら、エジプトでは保健人材（特に学校医）が不足しているため、1 名の学校医や学校看護師が複数の学校を担当していることが多い。また、健康保険庁により指定された学校医・学校看護師がいない学校では、保健人口省が管轄する一次医療施設の医師・看護師が学校保健サービス業務を担うことになっているが、他業務との兼ね合いにより、学校保健サービスは十分に提供されていなかった。さらに、学校保健活動は、教師や生徒自身が主体的に行っていかなければならないという意識が教員や生徒の間で醸成されていなかったため、学校をベースとする保健教育や保健活動はほとんど行われていなかった。</p> <p>このような状況に対し、より効率的な学校保健サービス実施体制の整備を図るとともに、地域の医師・看護師、教員、学生、保護者、その他のコミュニティメンバーを巻き込んだ形での学校保健活動の実践が必要であるとして、エジプト政府から日本側に協力要請がなされ、2008 年 11 月から本プロジェクトが開始された。</p> <p><b>1-2 協力内容</b></p> <p>本プロジェクトは、上エジプト地域の学校保健サービスの質の向上をめざし、上エジプト地域に位置するファユーム県タメイヤ郡の 20 の小中学校をパイロット校として、ヘルス・プロモーション・スクール（Health Promotion School：HPS）という実践的な学校保健モデルを開発し、そのモデルの普及基盤を構築することを目的とする。</p> <p>(1) 上位目標 上エジプト地域におけるヘルス・プロモーション・スクールと学校保健サービスの拡大を通じて、学校保健が推進される。</p> <p>(2) プロジェクト目標 1) ヘルス・プロモーション・スクールの普及を通じて、タメイヤ郡において学校保健サービス</p>	

の質が向上する。

2) 上エジプト地域においてヘルス・プロモーション・スクール普及の基盤が整う。

### (3) 成 果

- 1) 学校保健モニタリング・指導監督の仕組みが、郡レベルで開発・設置されるとともに、中央・県レベルで強化される。
- 2) タメイヤ郡において、学校保健サービスの提供が促進される。
- 3) 学校保健にかかわる人材が強化される。
- 4) 教員や保護者などによるヘルス・プロモーション・スクールを支援する活動が強化される。

### (4) 投入（評価時点）

#### 1) 日本側

専門家派遣：1年次（17.00MM）、2年次（28.40MM）、3年次（17.97MM）、4年次（25.13MM）、合計 88.50MM（法人契約）

機材供与：1,090 万円

研修員受入れ（本邦）：12 名

#### 2) 相手国側

カウンターパート（Counterpart：C/P）配置：38 名

土地・施設提供：首都とプロジェクト対象県に 2 カ所のプロジェクト事務所、20 パイロット校のスクールクリニック（保健室）

## 2. 評価調査団の概要

調査者	総 括	瀧澤 郁雄	JICA 人間開発部 保健第一課長
	協力企画	松山 勇樹	JICA 人間開発部 保健第一課
	評価分析	鹿糠 説子	有限会社アイエムジー
調査期間	2012 年 6 月 16 日～2012 年 7 月 7 日		評価種類：終了時評価

## 3. 評価結果の概要

### 3-1 実績の確認（成果及びプロジェクト目標の達成状況）

#### (1) 成果の達成度

本プロジェクトでは、HPS モデルの普及ツールとなる「学校保健サービスに関するモニタリング・指導監督ガイドライン」「学校保健実践マニュアル」<sup>1</sup>、健康診断にかかわる視覚教材（DVD/CD）、及び 3 種類の保健サービス促進用リーフレットが開発された。中央政府・地方政府・学校現場レベルで学校保健サービス業務を担当する 3 省庁（保健人口省、健康保険庁、教育省）の政府職員の技術的インプットを包括的に取り入れながら普及ツールの開発作業を進めることにより、人的・物的・財的資源の限られたエジプトの村落部の学校の現状を十分に勘案した実践的なモニタリング及び指導監督の仕組みや学校保健実施体制が構築された。

HPS モデル開発のプロセスとして、中央政府及び地方政府の行政官や学校現場において保健サービスの提供に直接的にかかわっている学校医、学校看護師、校長、教師、ソーシャル・ワーカーなどの幅の広い関係者に対して各種研修やワークショップを実施し、ガイドラインやマニュアルの内容に沿った保健教育やコミュニティ参加型学校保健活動をはじめとする学校保健サービスをパイロット校で実施したことにより、学校保健関係者の能力が全体的に強化された。その結果、タメイヤ郡における学校保健サービスが促進され、学校保健活動へのコミュニティ参画促

<sup>1</sup> 「学校保健サービスに関するモニタリング・指導監督ガイドライン」は、「学校保健実践マニュアル」と合わせて、一つの資料として 2012 年 6 月にアラビア語版が印刷された。資料名は、「学校保健実践マニュアル及び学校保健サービスに関するモニタリング・指導監督ガイドライン（The Implementation Manual for School Health Services and the Guidelines of Monitoring and Supervision for School Health Services）」であり、英語名称を略して「M&G」と呼ばれている。



進を含めた学校保健サービス実施体制が強化された。

具体的には、2009年に実施されたベースライン調査で集められた指標の変化を確認するために2012年に実施されたエンドライン調査において、これまでに健康診断を受けたことのある生徒の割合が、パイロット小学校では44.5%から77.3%、パイロット中学校では39.1%から87.2%に大きく増加したものの、パイロット校に指定されておらず、本プロジェクトの活動や投入の対象にならなかった小中校（以下、「ノン・パイロット校」）では、さほど大きな変化は確認されなかった。同じく、過去1年間で一般的な保健教育を受けたことのある生徒の割合が、パイロット小学校では46.0%から58.1%、パイロット中学校では38.3%から57.6%に増加しているものの、ノン・パイロット小中学校ではさほど大きな変化は確認されなかった。

これらの実績をもって、四つの成果はすべて「達成」または「一部達成」されていると判断される。その一方で、より高い成果の達成度を得るには、モニタリングされる情報の質の改善、学校医不足に対応するための継続的な努力、プロジェクト期間内に予定されている普及ワークショップ型研修の着実な実施、コミュニティ参加型学校保健活動の継続的な実施によるコミュニティメンバーの保健教育の重要性への理解の深化が求められる。

## (2) プロジェクト目標の達成度（見込み）

エンドライン調査によると、パイロット校における生徒の半数以上（小学生の59.5%、中学生の48.4%）並びに、教師及び学校役員会のメンバーのほとんどが、この2年間で学校保健サービスが改善したと考えている。それに加えて、2012年に本プロジェクトにより、学校現場レベルの学校保健活動実施機関である学内保健委員会のメンバーを対象に実施した調査結果によると、全20パイロット校の回答者（114名）が過去2年で学校保健サービスの質が向上したと考えている。また、3省庁関係者間の協議及びパイロット校での活動を通じて、HPSの概念が確立され、普及活動のツールとなるガイドラインやマニュアル、DVD/CD、リーフレットが開発された。このような指標達成度や終了時評価調査で行ったインタビュー結果などを総合的に考慮すると、二つのプロジェクト目標はプロジェクト終了時までに達成される見込みは高いと判断される。

## 3-2 評価結果の要約

### (1) 妥当性：高い

学校保健サービスの促進は、エジプト政府の開発政策、日本政府の援助政策との整合性が高く、エジプトの国民のニーズにも合致していることから、本プロジェクトの妥当性は「高い」と評価される。

エジプトでは、急速な経済成長に伴い、肥満や喫煙、高血圧などの健康リスク要因の流行が拡大の傾向にあり、疾病構造が急速に変化している。この変わりゆく健康上の課題に効果的に対応していくには、子どものころから健康的な生活習慣を身につけ、日常から病気への予防的ケアを行っていくことが必要とされているものの、特に村落地域では学校保健サービスが十分に提供されていない。2012年に保健人口省が策定した「エジプトにおける保健医療・看護サービス改善のための戦略的ビジョン」には、学校保健サービス促進活動による児童の健康増進が、戦略の一つとして明記された。

わが国の「対エジプト国別援助計画」（2007年度改訂）では、貧困層の医療サービスへのアクセス向上支援は、公共サービスの拡充・改善を通じて貧困削減と生活水準を向上させる一つの戦略として位置づけられている。加えて、「『保健と開発』に関するイニシアティブ（2005年）」や「国際保健政策 2011-2015」においても、保健サービスへのアクセスを向上させるために、分野横断的アプローチを用いることの重要性が謳われている。

## (2) 有効性：高い

プロジェクト目標の達成見込みは高く、成果とプロジェクト目標の因果関係も明確であることから、本プロジェクトの有効性は「高い」と評価される。

本プロジェクトでは、中央政府・地方政府・学校現場レベルの幅広い学校保健関係者に対して、HPS モデルの開発・普及に必要な各種研修やワークショップを行い、モニタリング・指導監督ガイドラインや学校保健実践マニュアルに沿った学校保健サービスが 20 パイロット校で実施された。その結果、エンドライン調査の結果では、パイロット校における個人の衛生や学校環境などの主要な保健指標が改善していることや、パイロット校の多くの教師や生徒、学校役員会のメンバーが過去 2 年間でサービスが改善したと考えていることが確認された。加えて、HPS 普及ガイドライン以外の HPS モデルの普及ツールは、中央政府・地方政府・学校現場レベルで学校保健サービス業務を担当する 3 省庁の政府職員の技術的インプットを包括的に取り入れながら、開発された。また、学校から学校へ HPS モデルを普及するアプローチが五つのノン・パイロット校に対して成功裏に実施された。これらにより、プロジェクト目標の達成見込みは高いと判断される。

本プロジェクトの四つの成果は、タメイヤ郡において学校保健サービスの質を向上し、他の地域に普及できる実践的かつ効果的な HPS モデルを開発するために必要な要素（モニタリング・指導監督の仕組みの構築、学校保健活動へのコミュニティの参加促進を含めた学校保健サービス実施体制の構築及びパイロット校での HPS モデル試行に基づく学校保健サービス促進活動の実績づくり、学校保健にかかわる人材の強化）を含んでいる。

## (3) 効率性：中程度

投入は効果的に実施かつ有効活用され、成果達成に寄与したが、一部の投入が計画どおり行われなかったことやタメイヤ郡における HPS 普及活動の規模が限定的であったことから、本プロジェクトの効率性は「中程度」と評価される。

本プロジェクトでは、活動や投入を 20 パイロット校に絞って実施することにより、HPS モデルを上エジプトの他の県に普及することのフィージビリティを十分に検証することができた。しかしながら、HPS モデルを学校から学校へ普及するアプローチを用いた普及活動は、これまでに五つのノン・パイロット校に対してしか実施されなかったため、効率性を低下させる要因となった。効率性を高めるには、他の補足的な普及アプローチを勘案する必要があったといえよう。

2011 年 1 月にエジプトで生じた政治的革命及びその後の不安定な政治・社会情勢により、本プロジェクトは同年 1 月末から 5 月までの 4 カ月間、やむを得ず一時的に停止となったものの、HPS モデルの普及ツール開発に現地専門家を積極的に活用し、活動の迅速化を図るなど柔軟な対応がとられたため、計画した成果が成功裏に発現した。

## (4) インパクト：中程度

プロジェクト・デザイン・マトリックス（Project Design Matrix：PDM）において設定された指標の評価結果に基づく上位目標の技術面での達成見込みは高いと判断されるものの、プロジェクト後の明確な活動計画がまだ作成されていないことから、本プロジェクトのインパクトは「中程度」と評価される。

エンドライン調査の結果では、パイロット校における個人の衛生や学校環境などの主要な保健指標が改善しており、校内における生徒や教員の行動変容が確認されていることから、HPS モデルを用いた学校保健サービス促進の技術的なフィージビリティは高いと判断される。また、ノン・パイロット校においても、個人の衛生や（学内）学校保健委員会<sup>2</sup>の設立など幾つかの主要指

<sup>2</sup> エンドライン調査で確認されたノン・パイロット校の（学内）にある学校保健委員会は、本プロジェクトで開発・発足された学内保健委員会（Internal School Health Committee：ISHC）と必ずしも同じ活動を行っているものではなく、何らかの保健や健康に関する活動を行っている校内保健委員会を指す。

標が改善していることが確認されている。ファユーム県の地方政府レベルの本プロジェクト調整機関である学校保健委員会（School Health Committee : SHC）によると、ノン・パイロット校における指標の改善は、パイロット校のモニタリング・指導監督を担当している3省庁の政府職員が自発的に学校保健活動をノン・パイロット校に普及させているためであるとのことである。具体的には、食事前に必ず手を洗う生徒の割合は、パイロット小学校では、43.5%から68.3%、パイロット中学校では36.1%から57.9%に増加しており、ノン・パイロット小学校でも42.1%から59.2%、ノン・パイロット中学校でも37.3%から50.5%に増加している。

終了時評価の時点では、HPSモデルを上エジプト地域に普及するプロセスはまだ始まったばかりであるが、プロジェクト終了時（2012年11月）までには本格的な普及活動が予定されており、上エジプト地域にHPSを普及させる基盤が着々と形成されている。

一方、3省庁が合意すべきプロジェクト終了後のHPSモデル普及計画がまだ作成されていないことは、上位目標達成の見込みを不確実なものにしている。3省庁間における協力体制の構築は、本プロジェクトの最大の正のインパクトの一つとしてプロジェクト関係者間で広く認識されており、共同活動計画が作成され3省庁間で合意されれば、プロジェクト終了後も3省庁の協力により学校保健サービスが実施・普及されていくであろうと考えられる。

#### (5) 持続性：中程度

制度面では学校保健サービス活動を継続するうえでの政策的基盤が確立されており、技術面では活動を継続的に実施し上エジプトの他の地域にサービスを拡大するための中核となる人材が質と量の両面で育成されたものの、組織面及び予算面では人材と予算の確保に不安があることから、本プロジェクトの持続性は「中程度」と評価される。

制度面では、2012年に保健人口省が策定した「エジプトにおける保健医療・看護サービス改善のための戦略的ビジョン」に学校保健促進活動による子どもの健康改善の必要性が明記されており、保健人口省、健康保険庁、教育省をメンバーに含む中央政府レベルの学校保健促進委員会が保健人口省の省令396番（2012年）により再発足されたことから、制度面での自立発展性は高いと評価される。

組織面では、本プロジェクトを通じて学校保健サービスの提供における中央政府レベルと地方政府レベルの3省庁の役割と責任が明確化されたものの、C/Pやその他の関係者（学内保健委員会のメンバーを含む）のなかには、学校保健サービス提供を通常業務の範囲として認識していない者が少なからず存在することから、組織面での自立発展性は中程度と評価される。

予算面では、保健人口省が負担する学校保健や関連サービスの研修費用が2010/2011年度の約9万4,000エジプト・ポンド（LE）から2011/2012年度の約48万6,000LEに急増している。また、2012/2013年度にはHPSモデルを上エジプト地域に普及させる学校保健研修予算として83万LEが申請されている。研修費用の負担実績が増加している傾向は、予算面での自立発展性の確保に向けた強いコミットメントの表れであると判断される。しかし、プロジェクト後の予算を伴う明確な学校保健サービス促進活動計画が3省庁間で合意されていないことから、予算面での自立発展性は中程度であると評価される。

技術面では、中央政府及び地方政府レベルの学校保健サービスにかかわる人材が、各種研修とパイロット校におけるHPSモデルの実施を通じて、タメイヤ郡で学校保健サービスを継続的に実施し最終的には上エジプト地域の全県へHPSモデルを普及していくうえで必要な技術を習得したことから、技術面の自立発展性は高いと評価される。

### 3-3 効果発現に貢献した要因

#### (1) 計画内容に関すること

- 分野横断的アプローチの適用：本プロジェクトでは、中央政府及び地方政府（県・郡）の学

校保健サービスにかかわる3省庁の職員がC/Pとして配置された。学校保健という教育セクターと保健セクターの両セクターが絡む分野で、横断的なアプローチを取り入れることにより、3省庁間での協働体制を新たに構築することができた。

- トップダウンとボトムアップの融合：本プロジェクトでは学校保健にかかわる各種研修・ワークショップを、中央政府職員のみを対象にして行うのではなく、すべてのレベルの人材（中央政府や地方政府の行政官や学校現場で活躍する校長、学校看護師、ソーシャル・ワーカー等）に対して行うことにより、オーナーシップを全体的に醸成した。
  - 実践性に焦点を置いたHPSモデルの開発：本プロジェクトでは、学校現場アプローチ（school-based approach）を取り入れることにより、学校現場の現状（エジプトの村落部の学校におけるリソースの充足状況）を十分に勘案した、実践性の高いHPS普及ツールが開発された。
- (2) 実施プロセスに関すること
- エジプト側プロジェクト関係者の強いコミットメント：本プロジェクトは、エジプト側（特に地方政府レベルのC/P）が強いコミットメント及びオーナーシップをもって実施した。
  - コミュニケーション改善及び強い信頼関係の構築に向けた継続的な努力：エジプト側と日本側が、コミュニケーションの改善及び強い信頼関係の構築に向けた継続的な努力を行ったことで、プロジェクト実施が促進された。

### 3-4 問題点及び問題を惹起した要因

#### (1) 計画内容に関すること

- 投入に関する責任の所在の不明瞭さ：本プロジェクトでは、エジプト側の投入（研修費）に関する3省庁の責任が明確に定められていない。このことはプロジェクト終了後の財政的な自立発展性にも影響を及ぼしている。

#### (2) 実施プロセスに関すること

- プロジェクト投入に関する認識の相違：プロジェクトの前半期には、C/Pと日本人専門家チームの間で事務的な管理事項に関する認識の相違があり、それを解決するために幾度にわたる協議及び交渉が行われた。課題の合意に至るために要した時間はプロジェクト実施を阻害したといわざるを得ない。

### 3-5 結論

本プロジェクトでは、多くの実施上の課題が柔軟な対応をもって克服されたため、期待されたプロジェクト目標はおおむね達成される見込みである。中央政府から地方政府、学校現場レベルにまたがる3省庁の協力体制がとられたことにより、HPSモデルの導入は成功した。加えて、既存リソースを最大活用するアプローチは、人的・物的・財的資源が限られた上エジプトの現状を十分に勘案した実践的な学校保健サービス実施体制をつくりあげることにより資した。現在のHPSモデルの活動範囲は既存のリソースで実施可能な範囲にとどまっているため最低限に限られているが、追加リソースの有無に応じて今後、拡大していくことが可能である。

今後、学校保健サービスをさらに促進させていく技術的基盤やオーナーシップが保健人口省、健康保険庁、教育省で形成されたことにかんがみて、本プロジェクトは予定どおりに終了することが妥当であると、調査団は結論づけるものである。

### 3-6 提言（当該プロジェクトに関する具体的な措置、提案、助言）

エジプト側関係者と日本側調査団は協議のうえ、上エジプト地域におけるHPSと学校保健サービ

スの継続的な実施及び拡大に向けて、プロジェクト終了時までにはプロジェクト（エジプト政府及び日本人専門家チーム）側が実施すべき事項とプロジェクト終了後にエジプト側が実施すべき事項を以下のとおり整理した。

- (1) プロジェクト終了時までにはプロジェクト側が実施すべき事項
  - 1) プロジェクト終了後の学校保健サービス促進のための活動計画の策定
  - 2) HPS モデルの普及に向けたドナーや NGO との協調
  - 3) マニュアル並びにガイドライン及び他の普及ツールの 3 省庁のウェブサイトへのアップロード
  - 4) 情報共有とコミュニケーションの改善への継続的努力
- (2) プロジェクト終了後にエジプト政府が実施すべき事項
  - 1) 県レベルにおける学校保健委員会と学校レベルにおける学内学校保健委員会の制度化
  - 2) エジプトにおける学校保健の重要性への認識の醸成
  - 3) 医師不足にかかわる問題を解決するための継続的努力

### 3-7 教訓（当該プロジェクトから導き出された他の類似プロジェクトの発掘・形成、実施、運営管理に参考となる事柄）

#### (1) 組織間の調整と協力の重要性

リソースが限られた環境において学校保健プログラムを成功に導くには、中央政府、地方政府、学校現場のすべてのレベルにおいて保健と教育を担当する関係者間で効果的な協力・調整が行われることが必要である。多くの組織がかかわるプロジェクトでは、プロジェクト実施の開始前または開始直後の段階で、各関連組織の役割と責任が明確に定義されることが望ましい。

#### (2) マニュアル及びガイドライン開発における適切な手順

技術的に妥当性が高く、かつ実践的なマニュアルやガイドラインを開発するには、政策レベルから実務レベルまでにわたる広範囲の関係者のインプットを取り入れる参加型プロセスが求められる。多くの関係者を巻き込む参加型プロセスは多大な時間と労力を要するものの、完成度の高い成果品がつくられる可能性が高いため、最終的には有効性と効率性が高くなる。本プロジェクトでは、学校保健実践マニュアルやガイドラインの開発作業と最終化作業にかなりの時間が費やされたものの、実践的な内容と使い勝手の良さは高く評価されている。類似プロジェクトを形成する際には、参加型アプローチを用いることの必要性和それに要する時間を十分に考慮すべきである。ガイドラインとマニュアルの開発における現地専門家の活用は、そのような人的資源が存在する国の場合、現地の社会状況や文化背景を十分に配慮した現地の人々にとってより分かりやすく、受け入れやすい成果品をつくるために有効な手段となり得る。

#### (3) 既存人材の最大活用

リソースが限られた環境において、既存のリソース（特に人的資源）は、「チーム・アプローチ」を通じて最大限に活用されるべきである。本プロジェクトでは、学内保健委員会を通じた校長のリーダーシップの下、学校内の既存の教育、保健人材及び父母を動員することに成功した。他方で学校保健サービス提供を通常業務の範囲として認識していない者が少なからず存在することが、組織面での自立発展性を不確実なものにしていることから、類似プロジェクトにおいて既存の人材に新たな役割を追加する場合は、その役割の制度化を促進する活動もプロジェクト活動に取り入れるべきである。

#### (4) ベースライン及びエンドライン調査の適切な活用

ベースライン及びエンドライン調査を適切にデザインすることにより、プロジェクトの評価と支援アプローチの有効性検証に有益な情報が得られる。それらの情報は、エビデンスに基づいた政策提言に不可欠であり、将来の拡大展開を想定したパイロット活動に焦点を当てたプロジェクトには積極的に適用されるべきである。本プロジェクトで実施されたエンドライン調査では、指標の変化により本プロジェクトのインパクトを定量的に分析する材料が得られた。他方で、幾つかの指標は、本プロジェクトの活動内容と関係なく、指標の解釈も不十分なものであったため、プロジェクトのインパクトに関する誤解や混乱を招いた。このような事態を防ぎ、妥当性の高い情報を確実に入手するためには、これらの調査は慎重にデザインされる必要がある。また、データ収集と分析はリサーチ専門機関に外部委託できるものの、調査結果の解釈にはプロジェクトの実施と背景にかかわる十分な知識をもつ者の直接的な関与が求められる。

### 3-8 フォローアップ状況

当該案件終了後に、新たな投入を伴う協力は実施しない予定である。

## Summary of the Terminal Evaluation

<b>1. Outline of the Project</b>	
<b>Country:</b> The Arab Republic of Egypt	<b>Project Title:</b> The Project on the Promotion of School Health Services in Upper Egypt.
<b>Issue/Sector :</b> Health	<b>Cooperation Scheme :</b> Technical Cooperation
<b>Division in Charge:</b> Health Group 1, Human Development Department	<b>Total Cost: Approx.</b> 329 million yen (the actual cost spent from FY 2008 to FY2011)
<b>Period of Cooperation:</b> November 2008-November 2012 <b>(R/D)</b> September 16, 2008	<b>Partner Country's Executing Organizations:</b> Ministry of Health and Population (MOHP) and Health Insurance Organization (HIO), (Relevant Agency: Ministry of Education [MOE])
<b>Related Cooperation:</b> -	<b>Supporting Organization in Japan:</b> System Science Consultants Inc., Nonprofit Organization HANDS
<p><b>1-1. Background of the Project</b></p> <p>The overall health indicators in the Egypt have been improving; however, the improvements vary from governorate to governorate depending on their locality, economic situation, and the educational background of the residents. The gap between rural and urban areas, as well as an economic divide, still exists in Egypt. In particular, the prevalence of anemia, poor growth and parasitic diseases are present as a large problem among school children in poor communities.</p> <p>In 1993, the Student Health Insurance Program for school children under Law 99 (enacted in 1992) was introduced to expand the provision of healthcare insurance to all school students. In the same year, the "Manual of Student Health Insurance Act" was issued; in which it stipulates that doctors and nurses working for Health Insurance Organization (HIO) clinics should provide school health services such as: periodic health check-up; preventive inoculation; maintenance of school environment; and health education. Despite all these exerted efforts to provide adequate and reliable health services for all school students, challenges concerning accessibility, quality and other aspects have still persisted. Due to medical human resources shortages (especially doctors) in Egypt, in many cases, a HIO doctor and/or nurse are assigned to several schools. While it is stipulated that doctors and nurses under the Primary Health Care (PHC) Sector of the Ministry of Health and Population (MOHP) cover schools without assigned HIO doctors and nurses they have not been able to allocate sufficient time to provide adequate school healthcare services. This has been compounded by teachers and school children having deficient awareness of the necessity for them to be actively involved in carrying out school health activities.</p> <p>Against this background, to establish a more efficient school health service implementation mechanism and to provide school health services involving doctors, nurses, teachers, students, parents and community members, the Government of Egypt requested technical assistance from the Japanese Government and, as a result, the Project on the Promotion of School Health Services in Upper Egypt was commenced in November 2008.</p> <p><b>1-2. Project Overview</b></p> <p>To attain quality improvements of the school health services in Upper Egypt. The Project aims to develop a practical school health service model [referred to as the Health Promotion School (HPS)] by trialing the HPS model at 20 pilot schools in the Tammia District, Fayoum Governorate in Upper Egypt; it also aims to setup a foundation for disseminating the model across the Upper Egypt.</p> <p>(1) <b>Overall Goal:</b> School health is promoted by expanding Health Promotion School and school health services in Upper Egypt.</p> <p>(2) <b>Project Purposes:</b></p> <ol style="list-style-type: none"> <li>1) The quality of school health services in Tammia district is improved through the dissemination of the concept of Health Promotion School</li> <li>2) The framework to disseminate Health Promotion School in Upper Egypt is prepared.</li> </ol> <p>(3) <b>Outputs</b></p> <ol style="list-style-type: none"> <li>1) Monitoring and supervisory mechanism on school health is developed at district level and is strengthened at governorate/central level.</li> </ol>	

- 2) The provision of school health services is facilitated in Tammia district.
- 3) Human resources for school health are strengthened.
- 4) Supporting activities of Health Promotion School by supporters such as teachers and parents are strengthened.

#### (4) Inputs (As of the Terminal Evaluation)

##### Japanese side :

Experts: 88.5 MM in total (1st year: 17.00MM, 2nd year: 28.40MM, 3rd year: 17.97 MM, and 4th year: 25.13 MM [corporate contract])

Equipment: JPY 10.9 mill. Training in Japan: 12 persons

##### Egyptian Side :

Counterpart 38 persons

Land and facilities:

- Two project office space in Cairo and in the Fayoum Governorate.
- School clinics at the 20 pilot schools

## 2. Evaluation Team

<b>Members of Evaluation Team (Japanese side)</b>	[Leader]	Mr. Ikuo Takizawa, Director, Health Division 1, Health Group 1 Human Development Department, JICA
	[Evaluation Planning]	Mr. Yuki Matsuyama, Health Division 1, Health Group 1 Human Development Department, JICA
	[Evaluation Analysis]	Ms. Setsuko Kanuka, IMG Inc.

<b>Evaluation Period</b>	16th June 2012 – 7th July 2012	<b>Type of Evaluation</b> : Terminal Evaluation
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## 3. Results of Evaluation

### 3-1. Achievement of the Project

#### (1) Achievement of the Outputs

The Project has developed the following HPS model dissemination tools: “Guidelines of Monitoring and Supervision for School Health Services<sup>1</sup>,” “Implementation Manual for School Health Services;” a DVD/CD on comprehensive medical examination; and three leaflets on school health service promotion. By taking into the HPS dissemination tool development process technical inputs from personnel related to the project – from the three relevant governmental organizations (i.e. MOHP, HIO, and MOE) responsible for the provision, monitoring, and supervision of school health services at the central, governorate, district and school level – the Project has developed practical mechanisms for the monitoring/supervision and the implementation of school health services, through fully reflecting the resource-limited conditions (i.e. human, material and financial constrains) of schools located in rural areas of Egypt

As a part of the HPS model development process, the Project has provided various training courses and workshops to a wide range of people: administrative government officers for school health services both at national and governorate/district level and those who are directly involved in the provision and self-monitoring of school health services at the school level (i.e. school principals, social workers, teachers, school doctors and school nurses). Through the provision of these training courses, workshops, and the implementation of school health services – including health education and health activities involving community members at the 20 pilot schools – the Project has strengthened Egyptian school healthcare human resources.

More specifically, according to the End-line Survey – which was conducted in 2012 to compare the changes with health indicators collected in the Baseline Survey in 2009 – while the proportion of students who had ever received health check-ups has drastically increased from 44.5% to 77.3% at pilot primary schools and from 39.1% to 87.2% at pilot preparatory schools, no significant change has been observed at other primary and preparatory schools where the Project did not provide any special inputs or conduct any activities (non-pilot schools). Similarly, while the proportion of students who reported that they were taught on students’ health in general in the last year has increased from 46.0% to 58.1% at pilot primary schools and from 38.3% to 57.6% in pilot preparatory schools, no significant change has also been observed in non-pilot primary and preparatory schools.

Based on these accomplishments, all four Outputs have been assessed to be “partly achieved” or

<sup>1</sup> The Guidelines of Monitoring and Supervision for School Health Services was combined with the Implementation Manual for School Health Services and printed in June 2012 (Arabic version). The document is titled, “the Implementation Manual for School Health Services and the Guidelines of Monitoring and Supervision for School Health Services,” and is referred as M&G in short.



“achieved.” In order to increase their achievement levels, more efforts need to be exerted in the following areas: a quality improvement of the information monitored; a continuous search for viable solutions for doctor shortages; the successful implementation of workshop training (planned to be conducted in the remaining project period); and increasing the community members’ awareness toward the importance of health education through continuous implementation of school health activities participated by community members.

## **(2) Prospect of Achieving the Project Purposes**

According to the results from the End-line Survey, more than half of the students (59.5% of primary school students and 48.4% of preparatory school students), and the majority of teachers and Board of Trustees (incl. some parents) from pilot schools consider that school health services have improved in the last two years. In addition, the ISHC Survey shows that all 114 respondents from 20 pilot schools, who are members of ISHCs, also consider school health services at their schools had improved in the last two years. The concept of HPS has been established through a series of discussions between MOHP, HIO and MOE, and the trial implementation of the model at the 20 pilot schools. The HPS dissemination tools discussed above have been developed. The two Project Purposes are assessed as most likely to be achieved by the end of the project period based on the achievement levels of the Project Purposes’ indicators and the interviews conducted by the terminal evaluation team.

### **3-2. Summary of Evaluation Result**

#### **(1) Relevance: High**

The Relevance of the Project has been assessed as high because the improvement of school health services are in line with the Egyptian Government’s development policy, the Japanese Government’s aid policy to Egypt, and the needs of Egyptian people.

Egypt is currently facing an epidemiological transition characterized by a rising prevalence of risk factors such as obesity, smoking and hypertension. These new health challenges require preventive care starting at a young age; however school health services to school children in Egypt, especially in rural areas, have not been sufficiently provided. In response, MOHP developed the *Strategic Vision for Improving Health Care Services and Nursing in Egypt in 2012*, which includes a strategy to improve children’s health through school health service promotion activities.

The Japanese aid policy towards Egypt identifies the support for improving the access of the impoverished to medical care services, to enhance and improve public services, as one of its poverty reduction and improvement of living standards strategies. Furthermore, the *Health and Development Initiative (2005)* and *Japan’s Global Health Policy (2011-2015)* also state the importance of adopting a multi-sectoral approach in improving the access to health services.

#### **(2) Effectiveness: High**

The Effectiveness of the Project has been evaluated as high because the prospect of the Project Purposes being achieved by the end of the project period is deemed as highly likely and there is a clear linkage between the achievement of the Project Purpose and the successful production of its Outputs.

The Project conducted various training courses and workshops necessary for the development and dissemination of the HPS model, to a wide range of people involved in school health services at all central, governorate, district, and school level. At the 20 pilot schools, health promotion activities have increased and monitoring has been appropriately conducted. As a result, it was confirmed in the End-line Survey that some of key indicators in such areas as personal hygiene and school environment have improved, and many students, teachers, and Board of Trustees (incl. some parents) from pilot schools consider that school health services have improved in the last two years. Additionally, HPS model dissemination tools, except for the Dissemination Guidelines, have been developed by taking technical inputs from Egyptian project related personnel, from MOHP, HIO, and MOE, involved in school health services. Furthermore, the planned approach to disseminate the HPS model from school to school has been conducted successfully at the 5 non-pilot schools.

The four Outputs cover all components (the development of mechanisms for the monitoring/supervision and implementation of school health services, including the promotion of community participation in school health activities, and the strengthening of human resources related to school health services) that are necessary to improve school health services in the Tammia District and develop a practical and effective

HPS model that can be disseminated across Upper Egypt.

### **(3) Efficiency: Medium**

The Efficiency of the Project has been assessed as medium because inputs have been effectively allocated and efficiently used to contribute to the production of its Outputs; however, a portion of inputs have not been allocated as planned, and HPS dissemination activities in the Tammia District were limited in scale.

The Project has focused its activities and inputs on the 20 pilot schools, which made it possible to test the feasibility of the HPS model that can be disseminated to other governorates across Upper Egypt. Though the Project's trial dissemination of the HPS model using the "school-to-school approach" has only been conducted at five non-pilot schools. In order to increase efficiency, some other complimentary dissemination approaches may need to be considered and put in place.

From January to May 2011, the Project was suspended for four months, following the Egypt's Revolution in January 2011 and the socio-political insecurity that occurred as an aftermath of the event. Despite the unexpected suspension, the Project has responded flexibly to the situation and produced planned Outputs, by taking such measures as the use of technical inputs from local experts in school health services to produce the dissemination tools and accelerate the implementation of project activities.

### **(4) Impact: Medium**

The Impact of the Project has been assessed as medium because, judging from the achievement level of indicators, the technical feasibility of achieving the Overall Goal is high; however, the prospect for achieving the Overall Goal within three to five years after the completion of the Project is uncertain since there is no explicit post Project plan for the dissemination of the HPS model.

Since the End-line Survey shows that some key indicators at pilot schools in the areas of: personal hygiene and school environment have improved - which indicate behavioral changes among students and teachers have occurred - it is evaluated that these improvements ensure the technical feasibility of the promotion of school health services using the HPS model. The improvements of some key indicators are also observed in the End-line Survey within non-pilot schools in the areas of personal hygiene and the establishment of an (Internal) School Health Committee<sup>2</sup>; according to members of the Fayoum Governorate's School Health Committee (SHC) – a governorate level coordination body for school health services established as part of the Project – the improvements in indicators are partially attributable to the proactive actions in disseminating school health activities, played by monitoring/supervisory personnel from MOHP, HIO, and MOE. More specifically, for example, the proportion of students who always wash their hands before eating has increased from 43.5% in 2009 to 68.3% in 2012 within pilot primary schools and from 36.1% to 57.9% within pilot preparatory schools; regarding that the proportion has increased from 42.1% to 59.2% at non-pilot primary schools and 37.3% to 50.5% at non-pilot preparatory schools.

At the time of the terminal evaluation, the dissemination process had only just begun but many dissemination activities are planned to commence before the end of the Project period (November 2012), steadily leading to the establishment of a foundation for disseminating the HPS model to the Upper Egypt. The absence of an explicit post-Project plan for the HPS model dissemination agreed by MOHP, HIO, and MOE makes the prospect for the Overall Goal's achievement uncertain.

The establishment of a cooperative working relationship among the three governmental organizations has, been widely recognized among all the people related to the project, as the most notable positive impact of the Project. Thus, it is projected that if the joint activity plan is developed and agreed upon, school health services will continue to be implemented and disseminated through their concerted efforts even after the end of the Project.

### **(5) Sustainability: Medium**

The Sustainability of the Project has been assessed as medium because an institutional ground has been established (trained sufficiently in number and quality), to continue the provision of school health services and core human resources, which will continuously implement school health services and expand them to other areas in Upper Egypt. But, it is still uncertain whether sufficient human and financial resources will be secured to enable the expansion of the Project's effects.

The Project's institutional sustainability is assessed as high because the *Strategic Vision for Improving*

<sup>2</sup> The school health committees found at non-pilot schools in the End-line Survey may not be the same internal school health committees (ISHC) established in the Project, but a type of internal school entity that conducts health related activities.

*Health Care Services and Nursing in Egypt*, developed by MOHP in 2012, includes the ministry's strategy to improve children's health through school health service promotion activities and the School Health Promotion Committee – a committee for school health services at the central government level, which includes MOHP, HIO, and MOE at the central level in its members – has been re-established by the MOHP's Ministerial Decree of 396/2012.

The Project's organizational sustainability is assessed as medium because the roles and responsibilities of MOHP, HIO, MOE and their local offices in the implementation and monitoring/supervision of school health services have been clearly defined in the *Implementation Manual for School Health Services and the Guidelines of Monitoring and Supervision for School Health Services*, but some Egyptian project personnel and project related personnel (including ISHC members) consider school health services as "extra" tasks beyond their regular duties and responsibilities.

The Project's financial sustainability is assessed as medium because there has been a drastic increase in expenses incurred from training in school health and related services conducted by MOHP, but no post-Project activity plan for school health service promotion, with a clear budgetary arrangement, has been agreed upon between MOHP, HIO and MOE. The training expenses by MOHP have increased from approx. LE 94,000 in FY 2010/2011 to approx. LE 486,000 in FY 2011/2012. MOHP has proposed LE 830,000 for the FY 2012/2013 training for dissemination of the HPS model to other governorates. This trend indicates a strong commitment from MOHP to ensure financial sustainability.

The Project's technical sustainability is assessed as high. The Project has trained a sufficient number of core personnel, at the governorate level in the Fayoum Governorate and at the central level, to continue the implementation and dissemination of school health services in the Tammia District and eventually throughout other governorates. The number of core personnel is also expected to increase with the upcoming four training workshops for dissemination in the remaining period of the Project.

### **3-3. Factors that Promoted Realization of Effects**

#### **(1) Factors Concerning to Planning**

- Adoption of the Cross-Sectoral Approach: Egyptian government personnel involved in school health services at the central, governorate, and district levels from three governmental organizations, MOHP, HIO, and MOE have been assigned as counterparts (C/Ps) to the Project. The Project has established a cooperative working relationship among three organizations, by adopting a cross-sectoral approach in the school health sector that involves both education and health sectors.
- Combination of the Top-Down and the Bottom-Up Approaches: The Project's training courses have targeted those involved in school health at all levels (i.e. administrative government official from the central, governorate, district level, and those who are directly involved in providing school health services at schools, such as, school principals, school nurses, and social workers). By targeting all level, the Project has fostered an all-round ownership toward the Project among all those involved.
- Focus of the Practicality of the Health Promotion School Model: By taking a "school-based approach," the Project was able to develop practical HPS dissemination tools that reflected the actual conditions of schools (the availability of material, financial and human resources at rural schools in Egypt) in the development of dissemination tools.

#### **(2) Factors Concerning to the Implementation Process**

- Strong Commitment by the Egyptian Project Personnel: The Project has been implemented with a strong sense of ownership by the Egyptian project personnel (especially, C/Ps at the governorate/district level).
- Continuous Efforts to Improve Communication and Establish a Trust Relationship: The Egyptian and Japanese sides have exerted continuous efforts to improve communication and to establish a strong trust relationship, which have facilitated the implementation process.

### **3-4. Factors that Impeded Realization of Effects**

#### **(1) Factor Concerning to Planning**

- Unclear Placement of the Responsibility Regarding Inputs: In this Project, the three organizations' responsibilities regarding project input (i.e. training expenses) have not been clearly defined. This affects the Project's financial sustainability.

## **(2) Factor Concerning to the Implementation Process**

- Difference in Understanding about Project Inputs: In the first half of the project period, the project implementation was delayed because of the time required to resolve differences in understanding of administrative management issues between the Egyptian project personnel and the Japanese expert team. While the issues were resolved eventually, after a series of discussions and negotiations, the time taken to reach an agreement delayed the project implementation.

### **3-5. Conclusion**

By overcoming many implementation challenges through the application of flexible measures, the Project is most likely to achieve its Project Purposes. The Project was successful in introducing the HPS model based on the team approach, which has transcended from the central governmental organizations (i.e. MOHP, HIO and MOE) to the governorate, district and school levels. By maximizing the utilization of existing resources, the approach provided a practical solution to make school health program operational in the Upper Egypt resource-constrained setting. The scope of the current HPS model is limited to essential activities but it can be expanded depending on the availability of additional resources.

In consideration of the technical foundation and the ownership by MOHP, HIO, and MOE to promote school health further, it is concluded that the Project should be terminated as planned.

### **3-6. Recommendations**

Based on the evaluation, recommendations are made for measures to be taken by both the Project (the Egyptian project related personnel and the Japanese expert team) before the end of the project period, and the Egyptian Government after the project.

#### **(1) Measures to be taken by the Project Before the End of the Project Period**

- 1) Development of a Post-Project Activity Plan for School Health Service Promotion
- 2) Coordination with Other Development Partners for the dissemination of the HPS model
- 3) Uploading the Manual, Guidelines, and Other Dissemination Tools onto the MOHP, HIO, and MOE's Websites
- 4) Continuous Effort to Improve Information Sharing and Communication

#### **(2) Measures to be taken by the Egyptian Government After the Project**

- 1) Institutionalization of the School Health Committee at the Government Level and the Internal School Health Committee at the School Level
- 2) Recognition of the Significance of School Health in Egyptian Context
- 3) Continuous Search for Solving the Issues of the Shortage of Doctors

### **3-7. Lesson Learned**

- (1) Importance of Inter-organizational Coordination and Collaboration: Success of a school health program in a resource limited setting depends on a good degree of coordination and collaboration between stakeholders in charge of health and education at all levels. In a project where inter-organizational coordination and collaboration is essential, it is desirable that roles and responsibilities of each organization are defined before the commencement or at very early stage of project implementation.
- (2) Appropriate Procedure for the Development of Manuals and Guidelines: Development of technically sound and operationally feasible manuals and guidelines requires a rigorous and participatory process of incorporating inputs from a diverse range of stakeholders – covering policy to operational levels. Such process is time consuming but will improve the overall effectiveness and efficiency, as acceptability of the end product is likely to be high. Need for such rigorous participatory process and extensive time allocation required to enable this should be taken into consideration in designing similar projects. Utilization of local expertise in the production and publication of guidelines and manuals, in a context where such resources are available, may be a viable option to improve communicability and the socio-cultural acceptability of such documents.
- (3) Maximum Utilization of Existing Human Resources: In a resource-limited setting, maximum utilization

of existing and available resources, especially human resources, should be encouraged through a team approach. The Project was successful in mobilizing existing personnel such as social workers, population and environment teachers, computer teachers, and the parents for the purpose of promoting school health under the leadership of the school principals through ISHCs. However, the procedure for institutionalization of such newly added functions need to be incorporated in/under the project activities in order to ensure sustainability.

- (4) Appropriate Use of Baseline and End-line Surveys: Appropriately designed baseline and End-line surveys can provide valuable information for the evaluation of projects and the verification of project approaches. Such information is essential for evidence-based policy recommendations and should be applied to projects focusing on any pilot activities. However, these surveys need to be carefully designed in order to obtain relevant information and avoid undue confusion. The results of the End-line survey in this Project were valuable in providing information on changes associated with the project implementation in the pilot schools, but there were some queries raised as to the relevance of some of the results. It should be also noted that, while data collection and analysis can be out-sourced to institutions that are specialized in research; interpretation of the results requires direct involvement of the personnel who have hands-on knowledge and experience of a project's implementation and context.

### **3-8. Follow-up cooperation**

A follow-up cooperation with new inputs will not be implemented after the Project.



# 第1章 終了時評価調査の概要

## 1-1 調査団派遣の経緯と目的

エジプト・アラブ共和国（以下、「エジプト」と記す）における保健をとりまく状況は全般的に改善傾向にあるものの、地方や農村部の貧困層では保健医療サービスへのアクセスがいまだに低く、特に、貧困層の学齢期の子どもの間では、貧血、発育不良、寄生虫症等の発生が健康上の大きな課題となっている。しかし、これまでエジプトにおける他ドナーの支援は、主に乳幼児や妊産婦を対象としたものであり、学齢期人口が全人口の20%（約1,700万人）を占めているにもかかわらず、この年齢層を対象とした健康改善・保健医療サービス向上に向けた支援はほとんど行われてこなかった。

エジプトでは、1957年に大統領令第273号により、学校保健部門が教育省より保健省<sup>1</sup>に移管され、1993年に、すべての学生の健康保険加入が制度化され、「学校保険法ガイドライン」が定められた。同ガイドラインでは、健康保険庁の管轄するクリニックに所属する学校医・学校看護師等によって、定期健康診断、予防接種、健康的な学校環境の維持、保健教育等の学校保健サービスが実施されることが規定されている。しかしながら、エジプトでは保健人材（特に学校医）が不足しているため、1名の学校医や学校看護師が複数の学校を担当していることが多い。また、健康保険庁により指定された学校医・学校看護師がいない学校では、保健人口省が管轄する一次医療施設の医師・看護師が学校保健サービス業務を担うことになっているが、他業務との兼ね合いにより、学校保健サービスは十分に提供されていなかった。さらに、学校保健活動は、教師や生徒自身が主体的に行っていかなければならないという意識が教員や生徒の間で醸成されていなかったため、学校をベースとする保健教育や保健活動はほとんど行われていなかった。

このような状況に対し、より効率的な学校保健サービス実施体制の整備を図るとともに、地域の医師・看護師、教員、学生、保護者、その他のコミュニティメンバーを巻き込んだ形での学校保健活動の実践が必要であるとして、エジプト政府から日本側に協力要請がなされ、2008年11月から本プロジェクトが開始された。

今般、プロジェクト終了を2012年11月に控え、これまでの事業実施による成果、今後の課題を確認することを目的として終了時評価調査を実施することとした。本調査では、本プロジェクトの目標達成度や成果等を確認するとともに、プロジェクト終了後を含む今後の課題及び方向性について協議し、その結果を評価報告書に取りまとめ、関係者間で合意することを目的とする。

## 1-2 調査団の構成

担当業務	氏名	所属
総括	瀧澤 郁雄	JICA 人間開発部 保健第一課長
協力企画	松山 勇樹	JICA 人間開発部 保健第一課
評価分析	鹿糠 説子	有限会社 アイエムジー

<sup>1</sup> 現在の保健人口省を指す。

### 1-3 調査日程

2012年6月16日（土）～7月7日（土）

（評価調査日程の詳細は「付属資料1．ミニッツ Annex 1」を参照）

### 1-4 主要面談者

調査団は、以下の主要面談者に対してインタビューを行った（面談者リストは、「付属資料1．ミニッツ Annex 3」を参照）。

- エジプト中央政府及び地方政府の保健人口省、健康保険庁及び教育省に所属し、本プロジェクトにカウンターパート（C/P）として配置されている行政官
- パイロット校において保健サービスの提供に直接的にかかわっている学校看護師、校長、教師及びソーシャル・ワーカー等<sup>2</sup>の学内保健委員会のメンバー（学内保健委員会については、「2-2 プロジェクト実施体制」を参照）
- 日本人専門家
- 学校保健分野で活動するドナーや非政府組織（Non-Governmental Organizations : NGO）等の開発パートナー

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<sup>2</sup> 教育省から学校に配置されているソーシャル・ワーカーの業務内容には、学校内や家庭で問題を抱えている生徒やその保護者に対するカウンセリングや予防的ケア、学校とコミュニティ（保護者）の良好な関係構築への協力、課外活動の実施などが含まれており、担当している学科はない。



## 第2章 プロジェクトの概要

### 2-1 プロジェクトの基本計画

プロジェクト名	エジプト・アラブ共和国上エジプト学校保健サービス促進プロジェクト
協力期間	2008年11月（2008年12月現地作業開始）～2012年11月
対象地域	上エジプト地域（人口約4,500万人） *パイロット地域は、ファユーム県タメイヤ郡（人口約35万人）。
相手国関係者	<p>〈関係機関〉 保健人口省</p> <hr/> <p>〈C/P 機関〉 1) 保健人口省プライマリ・ヘルスケア（PHC）セクター学齢期児童健康部（SACHD） 2) 健康保険庁</p> <hr/> <p>〈関係機関〉 教育省</p>
受益者	<p>〈直接受益者〉 1) 中央政府レベル：保健人口省学齢期児童健康部、健康保険庁の行政官 2) 県・郡：保健人口省、健康保険庁の行政官 3) 学校：ファユーム県タメイヤ郡の小中学生（約1万人*）、教員</p> <hr/> <p>〈間接受益者〉 1) 中央：教育省の行政官 2) 県・郡：教育省の行政官 3) 学校：上エジプト地域他県の小・中学生（約500万人*）、教員 *本プロジェクト形成当時の学生数</p>
上位目標	上エジプト地域におけるヘルス・プロモーション・スクールと学校保健サービスの拡大を通じて、学校保健が推進される。
プロジェクト目標	<p>1) ヘルス・プロモーション・スクール*の普及を通じて、タメイヤ郡において学校保健サービスの質が向上する。 2) 上エジプト地域においてヘルス・プロモーション・スクール普及の基盤が整う。</p> <p>*ヘルス・プロモーション・スクールとは以下の四つの基準を満たす学校を指す：①学校保健室に機材が揃い機能していること、②学校保健サービス実践マニュアル及び学校保健サービスモニタリング・ガイドラインに沿い、a) 保健教育、b) 家族とコミュニティ参加、c) 学校環境、d) 水と衛生、e) ヘルスケアサービスにおいて、学校保健サービスが行われていること、③学校保健モニタリングシステムに支えられていること、④教師、保護者、コミュニティが参加していること。</p>
期待される成果	<p>1) 学校保健モニタリング・指導監督の仕組みが、郡レベルで開発・設置されるとともに、中央・県レベルで強化される。 2) タメイヤ郡において、学校保健サービスの提供が促進される。 3) 学校保健にかかわる人材が強化される。 4) 教員や保護者などによるヘルス・プロモーション・スクールを支援する活動が強化される。</p>

上位目標、プロジェクト目標、成果の指標及び具体的な活動等については、「付属資料1. ミニッツ Annex 2」を参照。

## 2-2 プロジェクトの実施体制

本プロジェクトは、保健人口省、健康保険庁、教育省の3省庁の中央・地方政府職員がC/Pとなり実施された。プロジェクトの実施体制として、中央・地方政府レベルのプロジェクト諮問機関として、合同調整委員会（Joint Coordination Committee : JCC）が設置され、地方レベルのプロジェクト調整機関として、学校保健委員会（School Health Committee : SHC）が設立された（JCCとSHCの開催実績は、「付属資料1. ミニッツ Annex 6-4」を参照）。加えて、学校現場レベルでは、学校保健活動の実施機関として学内保健委員会（Internal School Health Committee : ISHC）が設立された。そのほかにも、学校保健サービスのモニタリングの実施機関として、モニタリング・チーム（Monitoring Team : MT）が設立され、学校保健サービスに行う人材を強化する研修の実施機関として、トレーナーズ・チーム（Trainers' Team : TT）が設立された（MTとTTの開催実績は、「付属資料1. ミニッツ Annex 6-5」を参照）。

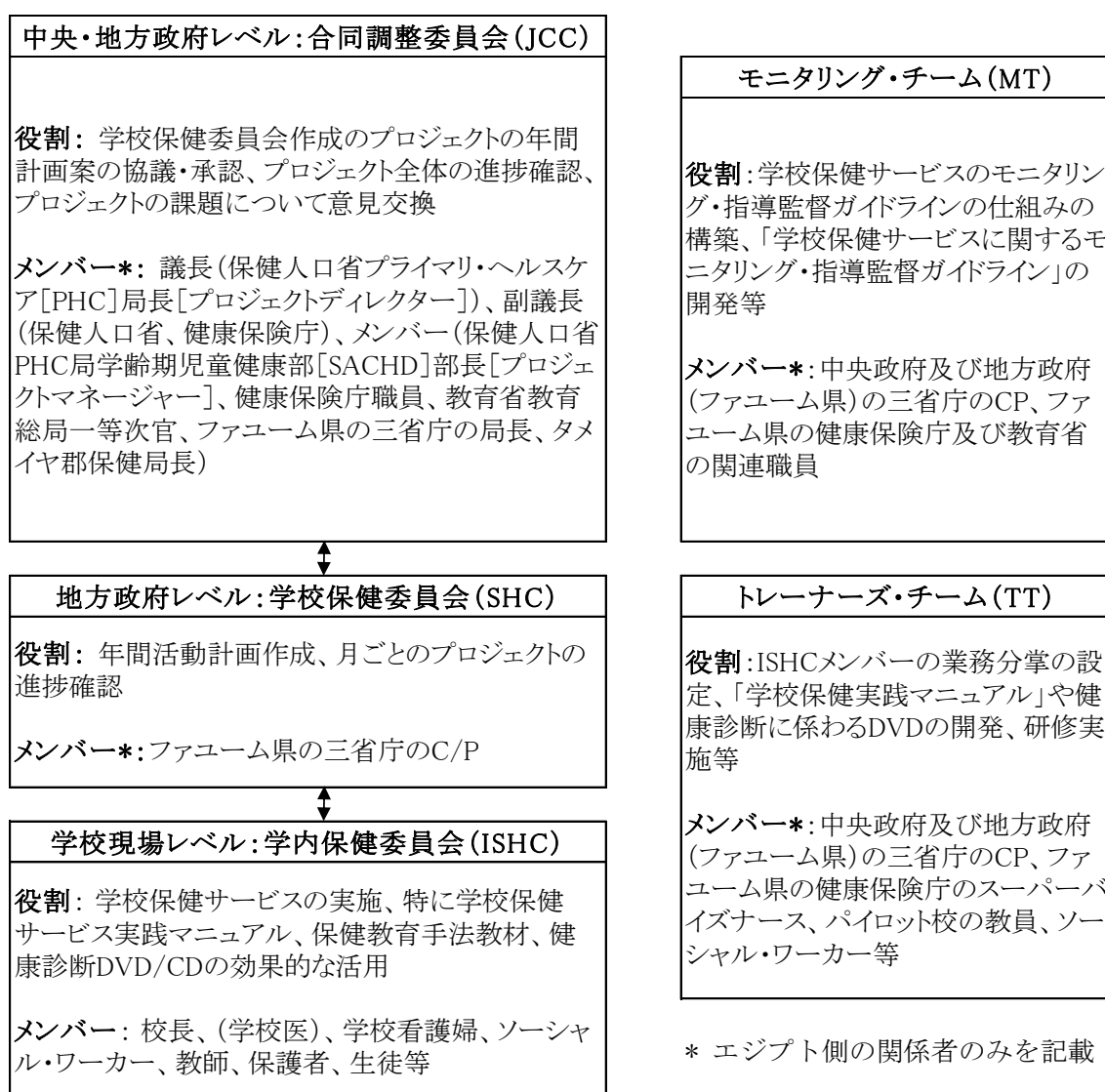


図-1 プロジェクト運営実施体制

### 2-3 ヘルス・プロモーション・スクールの将来モデル

本プロジェクトでは、ヘルス・プロモーション・スクール（HPS）という実践的な学校保健モデルを開発し、普及することによって、学校保健サービスの質の向上をめざしている。以下が HPS の将来のモデル図である。

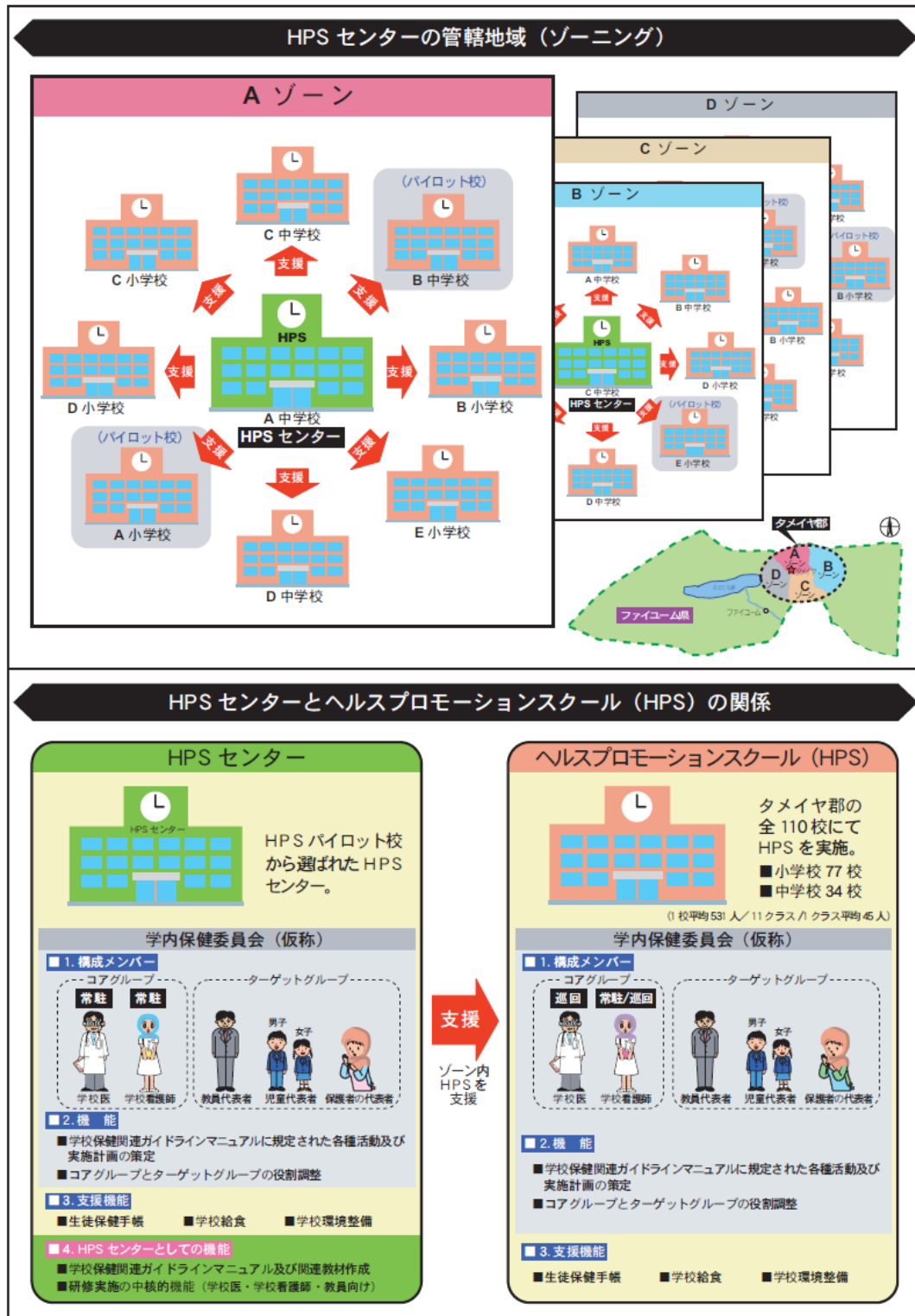


図-2 HPS の将来のモデル

## 第3章 評価の方法

### 3-1 終了時評価の手順

本終了時評価調査は、「新 JICA 事業評価ガイドライン 2010 年 6 月」に基づき、以下の手順で実施された。

- ① 本プロジェクトに関する既存資料をレビューしたうえで、プロジェクトの実績、実施プロセス、評価 5 項目にかかわる詳細な評価設問と評価指標・データ収集方法等を記述した評価グリッド案を作成する（評価グリッドに基づく評価結果は、「付属資料 1. ミニッツ Annex 6」を参照）。
- ② 評価設問に基づき、本プロジェクトに関する情報・データを収集・分析し、包括的に評価を実施する（プロジェクト関連情報・データの入手方法は「3-4 データ収集方法」を参照）。
- ③ 評価結果に基づき、プロジェクト終了時（2012 年 10 月）までに取り組むべき課題及び、より長期的にエジプト側が取り組むべき事項を整理し、エジプト政府との協議を踏まえ、提言の策定、教訓の抽出を行う。
- ④ 評価・協議結果を評価報告書として取りまとめる。

### 3-2 終了時評価のデザイン

本終了時評価調査では、2010 年 10 月に改訂合意されたプロジェクト・デザイン・マトリックス (PDM) (Ver. 1) に基づき、評価が実施された（本終了時評価に使用された PDM は、「付属資料 1. ミニッツ Annex 2」を参照）。

### 3-3 主な調査項目

本終了時評価調査では、以下の調査項目に関して評価が実施された。

#### (1) 実績の検証

- 1) 上位目標、プロジェクト目標の達成見込みはあるか（目標値との比較）
- 2) 成果は計画どおり発現したか（目標値との比較）
- 3) 活動は計画どおり実施されたか（計画との比較）
- 4) 投入は計画どおり実施されたか（計画値との比較）

#### (2) 実施プロセスの検証

- 1) 実施機関のプロジェクトに対する意識（オーナーシップ）は高いか
- 2) プロジェクト関係者間におけるコミュニケーションは適切に行われているか
- 3) 実施プロセスで生じている問題や効果発現に影響を与えた要因は何か、等

#### (3) 評価 5 項目の検証

##### 1) 妥当性

プロジェクト目標や上位目標がエジプトの開発政策やわが国の援助政策との整合性がとれているか、ターゲット・グループのニーズと合致しているかなど、プロジェクトの正当性・必要性を検証・評価する。

## 2) 有効性

プロジェクト目標がプロジェクト終了時まで計画どおり達成されるか、また、プロジェクト目標の達成が成果の達成によって引き起こされたのかを検証・評価する。

## 3) 効率性

プロジェクトが効果的に投入資源を活用したかという観点から、投入実績と成果達成の状況を踏まえて、投入（インプット）がどのように効率的に成果（アウトプット）に転換されたかを検証・評価する。

## 4) インパクト

上位目標達成の見込みとプロジェクト実施によりもたらされる長期的・間接的な効果や波及効果の有無を検証し判断する。

## 5) 持続性

政策・制度面、組織面、財務面、技術面の観点から、プロジェクト終了後、プロジェクトで発現した効果がどのように定着・持続していくかについて検証・評価する。

### 3-4 データ収集方法

本終了時評価では、既存資料レビュー、質問票調査・インタビュー調査、現地踏査の手法を用いて、情報・データ収集作業が実施された。

#### (1) プロジェクト関連資料レビュー

##### 1) 本プロジェクトにかかわる報告書

- 事前評価調査報告書（2008年9月）
- 中間レビュー調査報告書（2012年1月）
- プロジェクト事業進捗報告書（第1号～第6号）
- 業務完了報告書（第1年次～第4年次中間期）

##### 2) プロジェクト作成資料

- 着手報告書（2008年12月）
- ベースライン調査報告書（2009年3月）
- エンドライン調査報告書（2012年6月）
- 学校保健実践マニュアル及びモニタリングガイドライン（案）（The Implementation Manual for School Health Services and the Guidelines of Monitoring and Supervision for School Health Services）等

##### 3) エジプトの開発政策文書

- 学校保健法ガイドライン（Manual of Student Health Insurance Act and Executive Decrees Thereto）（1993年）
- エジプト保健セクターリフォームプログラム（Egypt Health Sector Reform Program）（2003年）

- 国家保健戦略計画 (National Health Strategic Plan) (2007 年)
- 第 6 次 5 カ年計画 (Sixth Five-Year Plan) (2007/08～2011/12 年度)
- エジプトにおける保健医療・看護サービス改善のための戦略的ビジョン (Strategic Vision for Improving Health Care Services and Nursing in Egypt) (2012 年)
- 保健人口省省令 396 番 (Ministerial Decree of 396/2012) (2012 年) 等

#### 4) 日本政府の保健セクターにおける援助政策文書

- 「保健と開発」に関するイニシアティブ (2005 年)
- 対エジプト国別援助計画 (2008 年)
- 国際保健政策 2011-2015 等

#### 5) その他関連資料

- 世界保健機関 (World Health Organization : WHO) 年間計画 2012 年～2013 年
- 開発パートナーグループ:保健及び人口課題別グループの実施要項 (Terms of Reference: DPG Thematic Group for Health & Population) (2012 年) 等

#### (2) 質問票調査・インタビュー調査

国内準備作業として、評価グリッドに基づき、C/P 及び日本人専門家に対して質問票を作成・配布した。質問票への回答結果及び上記 (1) のプロジェクト関連資料を基礎情報として、個別またはグループによるインタビュー調査を行い、追加情報の収集と分析を行った (面談者リストは「付属資料 1. ミニッツ Annex 3」を参照)。

#### (3) 現地踏査

パイロット校を訪問し、スクールクリニックをはじめとする校内施設環境、供与資機材の維持管理状況を確認した。そのうえで、上記 (1) のプロジェクト関連資料を基礎情報として、ISHC のメンバーに対して、グループインタビュー調査を行い、追加情報の収集と分析を行った。

## 第4章 プロジェクトの実績と実施プロセス

### 4-1 投入実績

プロジェクトの投入の実績に関する詳細は、「付属資料1. ミニッツ Annex 5」を参照。

#### (1) エジプト側の投入

##### 1) C/P の配置

エジプト側の投入として、合計 38 名の C/P が中央政府及び地方政府（ファユーム県及びタメイヤ郡）の保健人口省、健康保険庁、教育省から配置された（C/P リストは、「付属資料1. ミニッツ Annex 5-1」を参照）。

表-1 C/P 配置実績

所属機関		人 数	
保健人口省	中央政府	5 (3) *	18 (9)
	地方政府	13 (6)	
健康保険庁	中央政府	2 (1)	8 (5)
	地方政府	6 (4)	
教育省	中央政府	2 (2)	12 (7)
	地方政府	10 (5)	
合 計		38 (21)	

\* ( ) : 終了時評価時点で C/P として活動中の人数

出所：プロジェクト資料

##### 2) 施設の提供

エジプト側の投入として、プロジェクト実施に必要な以下の施設が提供された（パイロット校のリストは「付属資料1. ミニッツ Annex 5-2」を参照）。

- 保健人口省内のプロジェクト・オフィス・スペース（首都カイロ及びパイロット県であるファユーム県に合計2カ所）
- 20パイロット校のスクールクリニック（保健室）

##### 3) 研修費用（交通費・日当）

2008年12月24日に実施された第1回JCCで、プロジェクト活動として実施される研修やワークショップの費用は、プロジェクトの初期段階では日本側が負担するものの、プロジェクト開始から2年以内には研修費用の負担責任はエジプト側に移行されることが合意された。しかし、終了時評価時点においても研修費用は日本側が負担していた。

プロジェクト研修ではないものの、学校保健サービス促進業務の一環として、保健人口省はガルビーヤ県（Gharbia）<sup>3</sup>をはじめとする他の県において、本プロジェクトで開発されたHPSモデルによる学校保健サービス促進活動を参考に、学校保健に従事する人材を対象とした研修

<sup>3</sup> 下エジプト地域に位置する県である。

を実施しており、その研修費用は同省の予算にて負担している（保健人口省が実施した研修リストは「付属資料1. ミニッツ Annex 5-3」を参照）。

(2) 日本側の投入

1) 専門家派遣

日本側の投入として、プロジェクト実施に必要な多岐にわたる専門分野〔総括、副総括、組織強化、学校保健モニタリング、保健教育、小児保健/栄養、健康診断、保健教育/情報・教育・コミュニケーション活動（IEC）、遠隔技術協力、学校環境、研修企画、情報システム整備、業務調整〕において、日本人専門家が派遣された（日本人専門家リストは「付属資料1. ミニッツ Annex 5-4」を参照）。

表－2 日本人専門家派遣実績（人月）

1年次	2年次	3年次	4年次	合計
17.00	28.40	17.97	25.13*	88.50

\*2012年7月5日の時点まで

出所：プロジェクト資料

2) 現地専門家の雇用

日本側の投入として、健康保険庁コンサルタント1名及び現地の民間会社の現地専門家チームが雇用された（現地専門家リストは「付属資料1. ミニッツ Annex 5-5」を参照）。

3) 資機材の供与

日本側の投入として、約65.5万エジプトポンド（LE）（日本円1,093万6,000円<sup>4</sup>）の資機材が供与された（供与資機材のリストは「付属資料1. ミニッツ Annex 5-6」を参照）。

表－3 資機材供与の実績

内 訳		金額（LE）
1	オフィス機材（ノートパソコン、プリンター等）	204,160
2	パイロット校への基礎保健器具・用具	115,000
3	その他（車両等） <sup>5</sup>	335,730
合計		654,890

出所：プロジェクト資料

<sup>4</sup> 決算確定値

<sup>5</sup> ミニッツ Annex 5-6 の3) Provision of Other Equipment に記載されている以下の3品目の単価が和文報告書作成の時点で間違いであると判明したため、3)その他（車両等）の合計は、LE335,730となる。

	品 目	修正前の単価（LE）	修正後の単価（LE）
1	Car (sedan)	92,000	89,500
2	Car (van)	172,000	171,000
3	SPSS Software	18,889	13,340



#### 4) 本邦研修

日本側の投入として、合計 12 名の C/P 及びプロジェクト関係者が学校保健にかかわる本邦研修に参加した（本邦研修の参加者リストは、「付属資料 1. ミニッツ Annex 5-7」を参照）。

### 4-2 活動実績

本プロジェクトは、PDM に基づき、おおむね計画どおりに活動が実施された。

中間レビュー調査では、「学校保健実践マニュアル及び学校保健サービスに関するモニタリング・指導監督ガイドライン<sup>6</sup>」の作成の遅れが指摘されたが、中間レビューの提言に基づき、現地のコンサルタントと現地民間会社の学校保健専門家チームを効率的に活用し、マニュアル及びガイドラインの質を担保しながらも、より早いペースで活動が実施された。

### 4-3 成果の達成度

#### (1) 成果 1 の達成度

**成果 1：学校保健モニタリング・指導監督の仕組みが、郡レベルで開発・設置されるとともに、中央・県レベルで強化される。**

#### 指標 1-1 定期的なモニタリング及び指導監督を実施する。

〈指標 1-1 の達成度：おおむね達成〉

本プロジェクトでは、2010 年 6 月に実施された第 10 回 SHC<sup>7</sup>において、モニタリング・チームが発足し、「学校保健サービスに関するモニタリング・指導監督ガイドライン」が開発された。同ガイドラインでは、学校保健活動のモニタリング・指導監督に従事する中央政府、地方政府、学校現場レベルのすべての関係者の役割や責任が明記されており、タメイヤ郡の 20 パイロット校では、同ガイドラインに沿ったモニタリングと指導監督活動が年に 2 度（学期内に 1 度）、各担当省庁により実施されている。

以下が、同ガイドラインで定められた HPS モデルの学校保健活動 5 項目におけるモニタリング・指導監督の担当省庁である。

表-4 学校保健サービス 5 項目のモニタリング担当省庁

HPS モデルの学校保健サービス 5 項目		担当省庁
1	保健教育 (Health Education)	健康保険庁
2	地域参加促進 (Family and Community Participation)	教育省
3	学校環境 (School Environment)	健康保険庁、教育省
4	水と衛生 (Water and Sanitation)	保健人口省、健康保険庁、教育省
5	保健サービス (Health Care Services)	保健人口省、健康保険庁

出所：「学校保健実践マニュアル及び学校保健サービスに関するモニタリング・指導監督ガイドライン」

<sup>6</sup> 「学校保健サービスに関するモニタリング・指導監督ガイドライン」は、「学校保健実践マニュアル」と合わせて、一つの資料として 2012 年 6 月にアラビア語版が印刷された。資料名は、「学校保健実践マニュアル及び学校保健サービスに関するモニタリング・指導監督ガイドライン (The Implementation Manual for School Health Services and the Guidelines of Monitoring and Supervision for School Health Services)」であり、英語名称を略して「M&G」と呼ばれている。M&G は、HPS 普及ツールの一つである（本プロジェクトにおける印刷資料のリストは、「付属資料 1. ミニッツ Annex 6-1」を参照）。

<sup>7</sup> SHC の設立は、成果 2 の活動に含まれる（SHC 及びモニタリング・チームの役割、構成メンバーについては、「2-2 プロジェクトの実施体制」を参照）。

本プロジェクトでは、HPS モデル普及の基盤構築に向けた活動の一環として、パイロット校のなかでも特に活動実績が優秀な五つの学校が、「HPS センター校（学校保健サービスのモデル校）」として選定され、パイロット校に指定されておらず、本プロジェクトの活動や投入の対象にならなかった小中校（以下、「ノン・パイロット校」と1校対1校でペアを組み、ペアを組んだノン・パイロット校に対して、自己モニタリングの実施、ISHC の設立、保健教育活動の実施などの HPS モデルに基づいた学校保健活動に関する研修を行った（「図-2 HPS の将来のモデル」を参照）。

#### 成果1の総合評価：おおむね達成

上記の指標の達成度及び学校保健モニタリング・指導監督の仕組みの強化の度合いをかんがみると、成果1はおおむね達成されていると判断される。

本プロジェクトでは、パイロット校におけるモニタリング活動の実施経験及び中央政府・地方政府・学校現場レベルで学校保健サービス業務を担当する3省庁の政府職員の技術的インプットを包括的に取り入れながら、ガイドライン開発作業を進めたことで、実践的で使い勝手の良い、質の高いガイドラインが開発された。同ガイドラインは、学校保健サービスを担当する政府職員の数やモニタリング・指導監督活動に充てられる予算が限定的であることを十分に勘案して作成されており、学校の自己モニタリングの役割が最大限に生かされるようなモニタリング・指導監督の仕組みを定めている。この仕組みでは、学校は実施したすべての保健サービス活動の結果を記録し、実績や課題を評価し、活動改善計画を考案することになっている。

2012年6月にガイドラインの最終化及び印刷が行われ、中央・県レベルで効果的なモニタリング・指導監督が実施される基盤が確立された。パイロット県であるファユーム県では、学校保健に関するモニタリング・指導監督の仕組みが強化されたといえるものの、モニタリングで集められる情報の質については、記録する情報の内容をより詳細に標準化するなど、学校保健モニタリング・指導監督の仕組みがより強化されるための継続的な努力が必要である。

#### (2) 成果2の達成度

**成果2：タメイヤ郡において、学校保健サービスの提供が促進される。**

**指標 2-1 ヘルス・プロモーション・スクールの数が以下の指標に基づき 20 校以上に増加する。**

- 1) 保健教育の数
- 2) コミュニティが参加する支援活動の数
- 3) 学校環境改善活動の数及び定期的メンテナンスの実施
- 4) 水、衛生環境改善活動の数及び定期的メンテナンスの実施
- 5) 学校健康診断の実施率

〈指標 2-1 の達成度：達成〉

本プロジェクトで設定された HPS の五つの基準を、すべてのパイロット校と一つのノン・パイロット校が満たし、合計 21 校の HPS が設立された。各基準の定義と 20 のパイロット校とセンター校から研修を受けた五つのノン・パイロット校の基準の達成度は以下のとおりである（各基準の達成度に関する詳細なデータは、「付属資料 1. ミニッツ Annex 6-2」を参照）。

- 1) 保健教育の数：一つ以上の保健教育手法を用いて保健教育が行われていること  
結果：すべてのパイロット校と四つのノン・パイロット校では、一つ以上の手法を用いて保健教育活動が行われている。

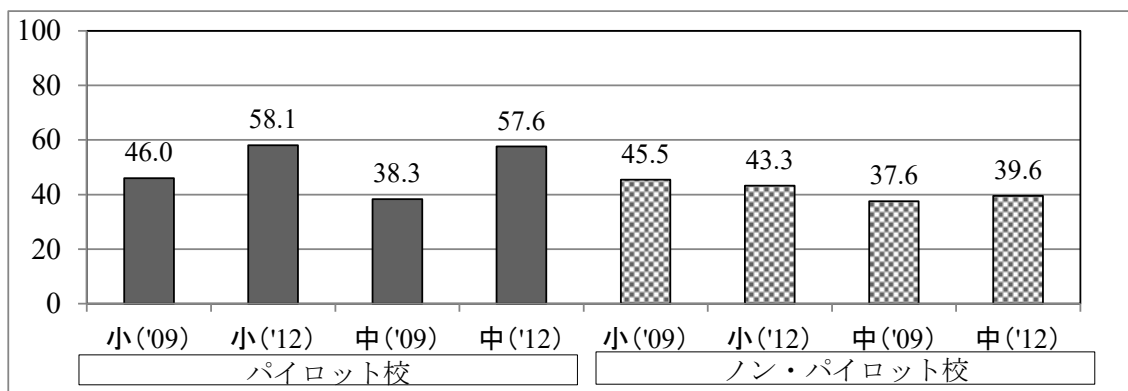
表－5 保健教育手法を導入している学校の数（2012年）

保健教育手法数	0	1-2	3-4	5-6	7-8	合計
パイロット校	0校	12校	3校	4校	1校	20校
ノン・パイロット校	1校	3校	1校	0校	0校	5校

出所：プロジェクト資料

上記のパイロット校及びノン・パイロット校で、最も多く用いられている保健教育手法には、健康に関するレクチャー、健康を増進する行動に関するアンケート調査、少人数のグループディスカッションが含まれる<sup>8</sup>。

エンドライン調査によると、過去1年間で、一般的な保健教育を受けたことのある生徒の割合が、パイロット校ではノン・パイロット校に比べ著しく増加していることが確認された。具体的には、過去1年間で、一般的な保健教育を受けたことのある生徒の割合がパイロット小学校では2009年の46.0%から2012年の58.1%、パイロット中学校では38.3%から57.6%と著しく増加しているものの、ノン・パイロット小学校では45.5%から43.3%に減少しており、ノン・パイロット中学校では、37.6%から39.6%に多少増加しているが、さほど大きな変化は確認されなかった。



図－3 過去1年間で一般的な保健教育を受けたことのある生徒の割合 (%)

出所：エンドライン調査報告書（2012年）、68ページ

- 2) コミュニティが参加する支援活動の数：生徒、保護者、コミュニティメンバーが参加する学校保健活動が一つ以上実施されていること  
結果：すべての対象校（20パイロット校と5ノン・パイロット校）では、生徒、保護者、コミュニティメンバーが参加するコミュニティ参加型の学校保健活動が一つ以上

<sup>8</sup> 表－5に載っている学校のほとんどは、朝礼の時間に保健に関するアナウンスメントを行っているものの、モニタリングの記録フォームに「朝礼における保健に関するアナウンスメント」という選択欄がないため、あえて記録していない学校が多くあり、表－5の結果には同手法を含んでいる学校と含んでいない学校がある。

実施されている。

表一六 コミュニティ参加型の学校保健活動を実施している学校の数（2012年）

活動数	0	1-2	3-4	5-6	7-8	合計
パイロット校	0校	3校	12校	4校	1校	20校
ノン・パイロット校	0校	2校	3校	0校	0校	5校

出所：プロジェクト資料

最も多く実施されたコミュニティ参加型の学校保健活動には、セミナー、学校清掃活動<sup>9</sup>、健康に関する意識向上のためのポスターやちらし作り等が含まれる。

- 3) 学校環境改善活動の数及び定期的メンテナンスの実施：学校環境のあるべき状態（教室の換気及び清潔さ、校庭内のごみ箱の有無、校門が壊れていないか等）を確認するチェックリストにおいて、全項目の7割以上が満たされていること

結果：すべての対象校が、学校環境に関するチェックリストの項目の7割以上を満たしている。

表一七 学校環境に関するチェックリストの結果（2012年）

達成度	<69%	70-79%	80-89%	90-95%	96-100%	合計
パイロット校	0校	1校	4校	6校	9校	20校
ノン・パイロット校	0校	0校	0校	1校	4校	5校

出所：プロジェクト資料

- 4) 水、衛生環境改善活動の数及び定期的メンテナンスの実施：校内の水・衛生環境のあるべき状態（飲料水の質、石けんの有無、手洗い場やトイレの清潔さ等）を確認するチェックリストにおいて、全項目の7割以上が満たされていること

結果：すべての対象校が、水・衛生環境に関するチェックリストの項目の7割以上の項目を満たしている。

表一八 水・衛生環境のチェックリストの結果（2012年）

達成度	<69%	70-79%	80-89%	90-95%	96-100%	合計
パイロット校	0校	2校	4校	10校	4校	20校
ノン・パイロット校	0校	0校	0校	2校	3校	5校

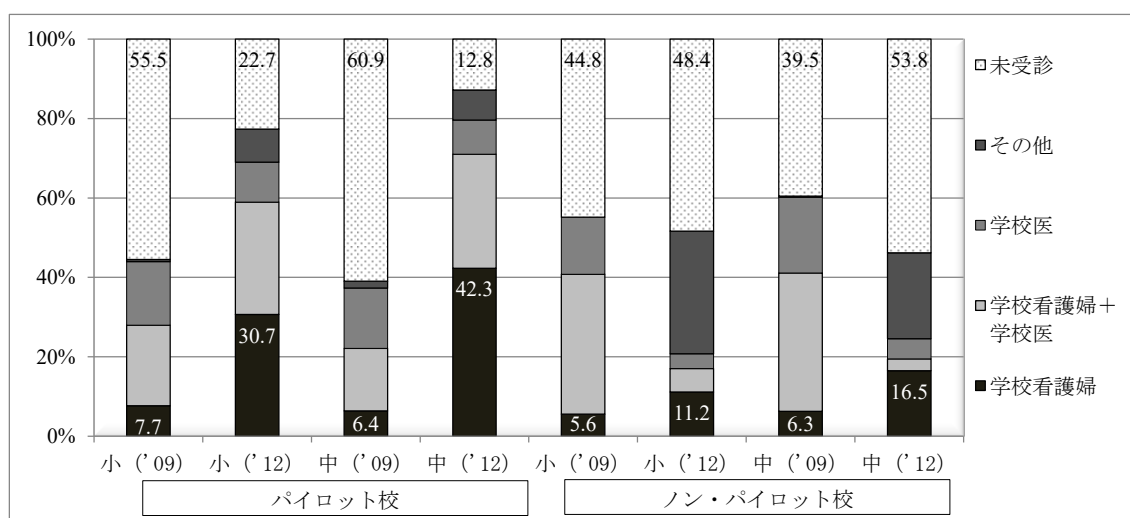
出所：プロジェクト資料

- 5) 学校健康診断の実施率：身長、体重、視力の測定が対象生徒<sup>10</sup>の大半に対して実施されていること

<sup>9</sup> エジプトでは、通常、学校内の掃除は清掃員の業務であり、生徒や保護者、コミュニティメンバーが参加する学校清掃活動には「キャンプ (Camp)」という言葉が使われている。

<sup>10</sup> 本プロジェクトの健康診断の対象は、小学校1年・4年、中学校1年の生徒である。

結果：20パイロット校及び一つのノンパイロット校で、身長、体重、視力の測定が、対象生徒の大半に対して実施された。



図－4 これまでに健康診断を受けたことのある生徒の割合及び健康診断の実施者の内訳  
出所：エンドライン調査報告書（2012年）、80ページ

本プロジェクトの実施により、パイロット校では身長、体重、視力の測定が学校看護師<sup>11</sup>の通常業務の一部となったことが確認された。エンドライン調査結果によると、健康診断を受けたことのある生徒の割合が、パイロット小学校では2009年の44.5%から2012年の77.3%に増加したことに対し、ノン・パイロット小学校では、55.2%から51.6%に減少している。同様に、パイロット中学校においても、39.1%から87.2%に増加したのに対し、ノン・パイロット中学校では60.5%から46.2%に減少している（エンドライン調査の主要指標の結果に関しては、「付属資料1. ミニッツ Annex 6-3」を参照）。

加えて、エンドライン調査では、学校看護師によって実施された健康診断の割合が大きく増えたことが確認された。パイロット小学校では、これまでに健康診断を学校看護師のみから受けたことのある生徒の割合<sup>12</sup>が2009年の7.7%から2012年の30.7%に増加したのに対し、ノン・パイロット小学校では5.6%から11.2%への比較的緩やかな増加が確認された。また、パイロット中学校では、その割合が6.4%から42.3%に増加しているのに対し、ノン・パイロット中学校では6.3%から16.5%に増加した。

パイロット校では学校看護師による健康診断が増加している一方で、学校医による健康診断の実施状況はあまり改善されていない。2011年10月に開催された第13回SHCでは、2011年の11月から12月にかけて実施予定の健康診断に、保健人口省または健康

<sup>11</sup> 本プロジェクトでは、学校看護師を指す英単語には school nurse と health visitor が互換的に使用されている。本プロジェクトの事前評価調査報告書（2008年）によると、「ヘルスビジター（訪問看護師）」として存在している保健人材は、その養成学校が既にすべて閉鎖されており、この名称の保健スタッフは今後いなくなり、保健看護師がヘルスビジターの役割にとって代わることになっている。

<sup>12</sup> 学校医及び学校看護師が一緒に健康診断を行った場合の、健康診断を受けた生徒の割合はここで記載している数字に含まれていない（図－4参照）。

保険庁<sup>13</sup>から各パイロット校へ学校医を配置することが合意されたものの、配置された半数の学校医は学校を訪問しなかったため、予定の半数の健康診断しか実施されなかった。

表－9 学校医による健康診断の実施率（2011年）

実施状況	全対象生徒に対して実施	一部に対して実施	実施されず	合計
パイロット校	7校	2校	11校	20校
	35%	10%	55%	100%
ノン・パイロット校	0校	0校	5校	5校
	0%	0%	100%	100%

出所：プロジェクト資料

### 成果2の総合評価：達成

上記の指標の達成度及びタメイヤ郡で学校保健サービスの提供を促進させるために行われた活動各種を考慮すると、成果2は達成されていると判断される。

本プロジェクトでは、地方政府レベルの学校保健サービス促進活動の調整機関のモデル機関としてファユーム県にSHCが設立され、パイロット校のスクールクリニックに基礎保健器具が整備された。2010年6月に実施された第10回SHCにおいて、中央政府と地方政府レベルの3省庁のC/Pと学校現場レベルのプロジェクト関係者により構成されるトレーナーズ・チームが発足し、「学校保健実践マニュアル」、健康診断にかかわる視覚教材（DVD/CD）、及び3種類の保健サービス促進用リーフレット<sup>14</sup>が開発された（トレーナーズ・チームの会議、研修・ワークショップの実績は、「付属資料1. ミニッツ Annex 6-5」を参照）。モニタリングガイドラインと同様に、これらの教材は中央政府、地方政府及び学校現場レベルで学校保健サービス提供にかかわる関係者の技術的インプットを包括的に取り入れて作成された。

HPSモデルの学校保健サービスの実施方法は、学校医の不足を配慮し、既存人材を最大限に活用するように開発されており、エンドライン調査や終了時評価調査団が行ったインタビュー調査では、学校看護師、ソーシャル・ワーカー、教員が、健康診断や保健教育など学校保健サービスの提供に中心的な役割を果たしてきたことが確認された。また、保護者の代表や環境人口教師<sup>15</sup>やコンピュータ教師などの他の教師も、ISHCを通じて校長のリーダーシップの下、重要な役割を果たしている。学校保健実践マニュアルに沿った学校保健サービスの実施により、タメイヤ郡において学校保健サービスの提供が促進されたといえる。

<sup>13</sup> 学校医の派遣は都市部では健康保険庁が行っているものの、村落部では保健人口省が行っている。

<sup>14</sup> マニュアル、DVD/CD、及びリーフレットはHPSモデルの普及ツールの一部である。リーフレットは、「保護者・コミュニティ参加」「学内保健委員会」「健康診断」の三つのトピックについて開発された。

<sup>15</sup> 校内環境の整備等を担当する教員を指す。通常は他の学科を教えている。

(3) 成果3の達成度

成果3：学校保健にかかわる人材が強化される。

指標3-1 研修終了後の自己評価が向上する。

〈指標3-1の達成度：達成〉

合計4回の研修後にそれぞれ行われた自己評価アンケート調査に対し、ほぼ全員の参加者が、研修内容に満足した、または研修の内容は役に立つものであったと回答している。

表-10 保健教育研修の自己評価結果

研修実施期間	講師	満足度 <sup>16</sup>					合計人数
		5 (高)	4	3	2	1 (低)	
2009年 2月15日～17日	日本人専門家	52 (87%)	7 (11%)	1 (2%)	0 (0%)	0 (0%)	60

研修実施期間	HPSモデル 5項目	講師	満足度			合計人数
			3 (高)	2	1 (低)	
2010年10月24日～25日	-	トレーナーズ・チーム	52 (93%)	4 (7%)	0 (0%)	56
2012年3月13日	1-4		76 (88%)	10 (12%)	0 (0%)	86
2012年3月18日	5		77 (91%)	8 (9%)	0 (0%)	85

出所：プロジェクト資料

成果3の総合評価：達成

上記の指標の達成度、HPSモデルを開発・試行・普及するために行われた各種会議・ワークショップ・研修の実績、終了時評価調査団によるインタビューの結果及び、2012年6月末に開催された普及ワークショップにおけるエジプトプロジェクト関係者のトレーナーとしてのパフォーマンスを総合的に考慮すると、成果3はおおむね達成されていると判断される（会議、ワークショップ、研修の実績は「付属資料1. ミニッツ Annex 6-5」を参照）。

本プロジェクトでは、中央政府及び地方政府の行政官や学校現場において保健サービスの提供に直接的にかかわっている学校医、学校看護師、校長、教師、ソーシャル・ワーカーなどの幅広い関係者に対して各種研修やワークショップを実施しており、その結果、ガイドラインやマニュアルの内容に沿った学校保健サービスやモニタリング・指導監督活動がパイロット校で着実に実施されたことにより、学校保健関係者の能力が全体的に強化された。

プロジェクト終了時までには学校保健サービス、モニタリングなどが継続的に実施され、今後計画されている普及ワークショップ型研修が確実に実施されることにより、保健人材の技術レベルがさらに向上されることが期待されることから、成果3の達成が確実となると考えられる。

<sup>16</sup> 研修後のアンケートで使用された5段階評価の選択肢は以下のとおり：5（非常に満足 [very satisfied]）、4（満足 [satisfied]）、3（中程度 [fair]）、2（不満足 [unsatisfied]）、1（非常に不満足 [very unsatisfied]）  
3段階評価の選択肢は以下のとおり：3（非常に役に立つ [very useful]）、2（多少役に立つ [somewhat useful]）、1（役に立たない [No]）

(4) 成果 4 の達成度

成果 4：教員や保護者などによるヘルス・プロモーション・スクールを支援する活動が強化される。

指標 4-1 パイロット校が最低一つのコミュニティとの協力によるヘルス・プロモーション・スクールのグットプラクティスを実施する。

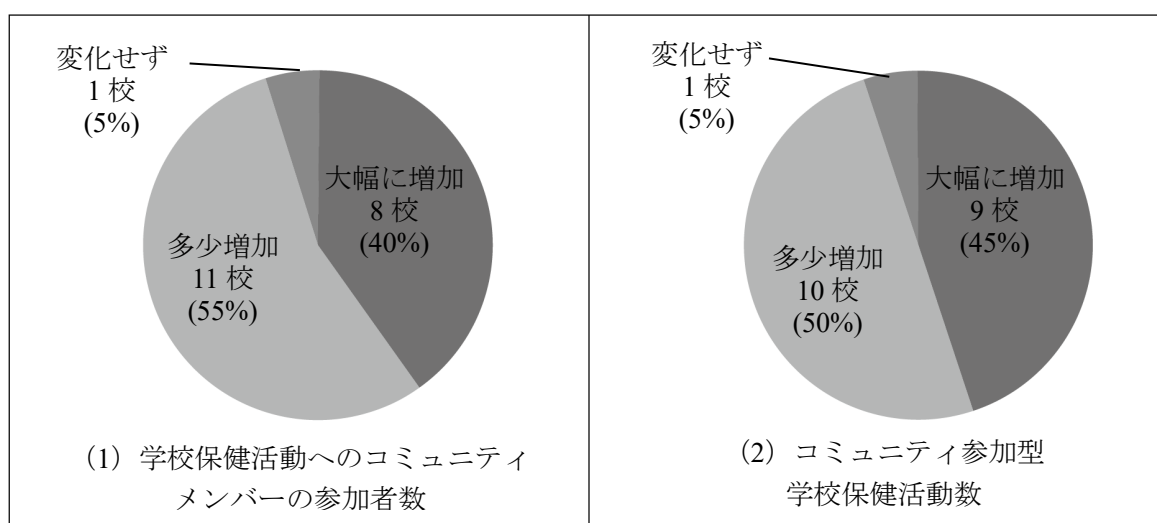
〈指標 4-1 の達成度：達成〉

2012 年の 5 月から 6 月にかけて、本プロジェクトが実施した ISHC のメンバーを対象にした調査（以下、「ISHC 調査」）によると、すべてのパイロット校で保護者やその他のコミュニティメンバーが参加する健康関連活動が実施された。コミュニティ参加型の学校保健活動には、保健に関するレクチャーやセミナー、学校清掃活動、子どもの健康に関する親への問診票調査などが、HPS の保健活動のグットプラクティスとして実施されている。

指標 4-2 パイロット校において支援活動に参加する地域住民の数が増加する。

〈指標 4-2 の達成度：おおむね達成〉

ISHC 調査によると、20 のパイロット校のうち 19 校では、学校保健活動に参加するコミュニティメンバーの数及びコミュニティ参加型学校保健活動の数が 2 年前より増加した。そのうちの 8 校ではコミュニティメンバーの参加者数が大幅に増加し、9 校ではコミュニティ参加型学校保健活動数が大幅に増加したと回答している。



図ー5 コミュニティ参加型の学校保健活動に関する ISHC 調査結果（2012 年）

出所：プロジェクト資料

成果 4 の総合評価：おおむね達成

上記の指標の達成度及び終了時評価調査団により行われたインタビュー調査結果にかんがみて、成果 4 は達成されていると判断される。学校保健実践マニュアルには、さまざまな実践的なコミュニティ参加型学校保健活動の実施方法が紹介されており、終了時評価調査団がパイロット校で行ったインタビューでは、ソーシャル・ワーカーより、本プロジェクトを通じて、健康やコ



コミュニティ参加に関する彼らの知識を学校保健活動に応用するノウハウが得られたというコメントが寄せられた。

その一方で、エンドライン調査、学校保健活動計画記録、及び終了時評価で行われたインタビュー調査では、パイロット校における学校保健活動へのコミュニティ参加は過去2年間で増加したものの、その活動は保護者や他の教師から広く認識されるレベルには至っていないことが確認された。学校保健活動の重要性に対する理解度は、コミュニティメンバーの間で依然限られているが、この状況は ISHC による継続的な学校保健活動の実施により改善されると予想される。

#### 4-4 プロジェクト目標の達成度

プロジェクト目標 (1) : ヘルス・プロモーション・スクールの普及を通じて、タメイヤ郡において学校保健サービスの質が向上する。

指標 1-1 学校保健サービスに対する教員、児童、保護者の半数以上において満足度が增加する。

〈指標 1-1 の達成度 : ある程度達成〉

エンドライン調査結果によると、パイロット校における生徒の半数以上（小学生の 59.5%、中学生の 48.4%）と大多数の教師、両親を含む学校役員会が、この2年間で学校保健サービスが改善したと考えている。

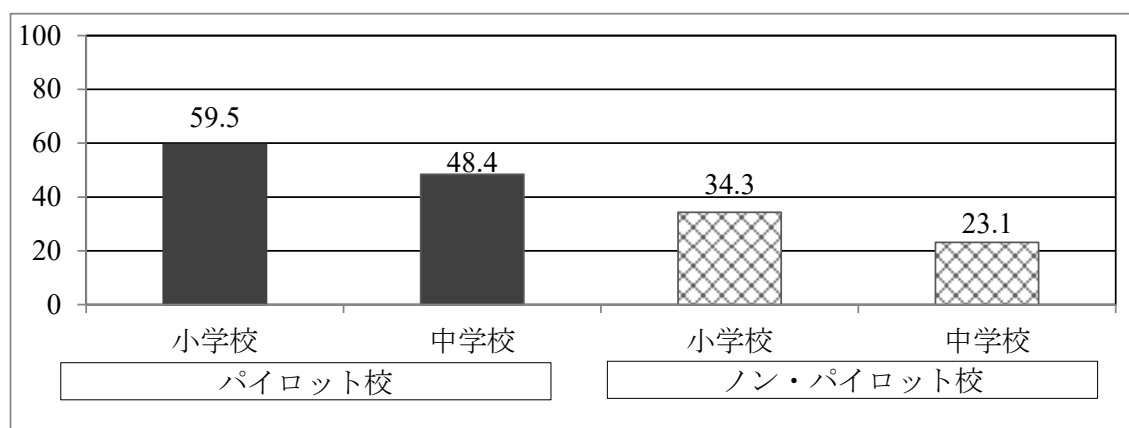


図-6 過去2年で学校保健サービスが改善したと回答した生徒の割合 (%)

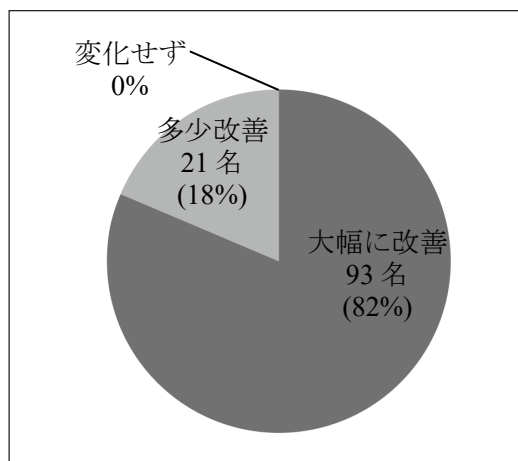
出所 : エンドライン調査報告書 (2012 年)、96 ページ

エンドライン調査で行われたフォーカス・グループ・ディスカッションによると、学校保健サービスの主な改善点として、ISHC による保健に関連する情報提供やその他の学校活動の増加、スクールクリニックの保健器具や緊急薬品の整備状況の改善、学校看護師や学校医の訪問回数の増加等が挙げられている。一方で、パイロット校の生徒の保護者のほとんどは、過去2年で学校保健サービスは改善されていないと回答しており、この認識の差は、学校と保護者のコミュニケーション不足や、学校保健活動の進捗状況に対する保護者の認識不足に起因するものと考えられる。また、同調査では、生徒、保護者、教員は、学校保健サービスにはまだ十分に満足しておらず、特に一部の学校医による健康診断の質の低さが問題であると考えている。

**指標 1-2** パイロット校の学内保健委員会が保健サービスの質が向上したと判断する。

〈指標 1-2 の達成度：達成〉

2012 年に本プロジェクトが実施した ISHC 調査によると、20 パイロット校の全回答者（114 名）が過去 2 年で学校保健サービスの質が向上したと考えている。そのうち、93 名（82%）が学校保健サービスの質が「大幅に改善した」と回答しており、21 名（18%）が「多少改善した」と回答している。



図ー7 過去 2 年における学校保健サービスの質に関する ISHC 調査結果（2012 年）

出所：プロジェクト資料

**プロジェクト目標 (2)：上エジプト地域においてヘルス・プロモーション・スクール普及の基盤が整う。**

**指標 2-1** ヘルス・プロモーション・スクールの概念が確立する。

〈指標 2-1 の達成度：達成〉

プロジェクトの開始初期に行われたエジプト側のプロジェクト関係者と日本人専門家間の協議において、HPS の概念の定義が、すべてのプロジェクト関係機関間で合意され、2010 年 10 月に改訂された PDM に明記された。

PDM に明記されている HPS の定義は以下のとおりである。

ヘルス・プロモーション・スクールとは以下の四つの基準を満たす学校を指す。

- ① 学校保健室に機材が揃い機能していること
- ② 学校保健サービス実践マニュアル及び学校保健サービスモニタリング・ガイドラインに沿い、a) 保健教育、b) 家族とコミュニティ参加、c) 学校環境、d) 水と衛生、e) ヘルスケアサービスにおいて、学校保健サービスが行われていること
- ③ 学校保健モニタリングシステムに支えられていること
- ④ 教師、保護者、コミュニティが参加していること

## 指標 2-2 ヘルス・プロモーション・スクール普及のためのツールが開発される。

〈指標 2-2 の達成度：おおむね達成〉

本プロジェクトでは、以下の HPS 普及ツールが開発された（普及ツールの印刷数については、「付属資料 1. ミニッツ Annex 6-1」を参照）。

- 冊子：「学校保健実践マニュアル及び学校保健サービスに関するモニタリング・指導監督ガイドライン（The Implementation Manual for School Health Services and the Guidelines of Monitoring and Supervision for School Health Services：M&G）」
- 健康診断に関する DVD/CD
- 学校保健サービス促進に関する 3 種類のリーフレット

普及ツールには、上記の 3 点以外に、HPS モデルの実施方法（実施体制や普及に必要な活動等）がまとめられている「普及ガイドライン（Dissemination Guidelines）」が含まれる予定である（普及ガイドラインは現在作成中であり、プロジェクト終了時までに最終化される予定である）。

### プロジェクト目標の総合評価：プロジェクト終了時までに達成される見込みは高い

上記の指標達成度及び終了時評価調査で行ったインタビュー結果を考慮すると、プロジェクト目標はプロジェクト終了時までに達成される見込みが高いと判断される。

本プロジェクトでは、エジプトの村落部における学校医の不足や、モニタリングや指導監督を行う政府の限られたリソースを十分配慮して、既存の人材（学校看護師、ソーシャル・ワーカー、教師、コミュニティメンバーや生徒自身）がより多くの役割と責任を担い、学校保健サービスを促進できるような HPS モデルが開発された。

学校保健サービス促進において、既存の学校関係者を動員することにおおむね成功したものの、多くの学校における学校医や救急薬品の不足は今後も引き続き対応していかなければならない課題として残っている。

## 4-5 上位目標の達成見込み

上位目標：上エジプト地域におけるヘルス・プロモーション・スクールと学校保健サービスの拡大を通じて、学校保健が推進される。

### 指標 1 上エジプト地域 5 県以上でのヘルス・プロモーション・スクールの導入

〈指標 1 の達成度：ある程度達成〉

2012 年 6 月に、カイロで実施された普及ワークショップ<sup>17</sup>において、タメイヤ郡の 20 パイロット校で HPS モデルを試験的に実施した結果の説明が、中央レベル及び上エジプト全 9 県の保健人口省、健康保険庁、教育省の代表者に対して行われた。同ワークショップでは、参加者に HPS モデルの実施方法が説明され、既に開発された 3 点の HPS 普及ツールが配布された。プロジェクトの残りの期間では、以下の普及活動が予定されている。

- 2012 年 7 月～8 月：アスワン、ルクソール、ファユーム、アシュートにおいて、普及ワークショップ型の研修を実施し、各県のトレーナーとなるべき人材を育成する。

<sup>17</sup> 2012 年の普及ワークショップは 2 度目の普及ワークショップであり、2010 年に実施された 1 度目の普及ワークショップでは、全 9 県の代表者にプロジェクトの概要、HPS モデルのコンセプト及びプロジェクト期間中に予定されている活動計画等の説明が行われた。本質的な普及プロセスは 2012 年から始まった。

開催地	参加県
アスワン	アスワン
ルクソール	ルクソール、ケナ
ファユーム	ファユーム、ギザ、ベニ・スエフ
アシュート	アシュート、ミニヤ、ソハグ

- 2012年8月～9月：各県1校において、HPSモデルの試験的導入（トライアル）を行う（上記のワークショップ型研修に参加したトレーナーがHPSモデルを導入するため、各県から一つの学校がパイロット校として選定される）。
- 2012年9月：上エジプト地域の全9県の代表者が参加し、上記の試験的導入の結果の報告及び経験の共有を目的としたフォローアップ・ワークショップをカイロにて実施する。
- 2012年10月：HPSモデルに関する情報、M&G、普及ガイドラインの共有のため、ドナーなどの開発パートナーを対象にHPS普及ワークショップを実施する。

## 指標2 保健人口省学齢期児童健康部による定期的な研修の実施

〈指標2の達成度：達成〉

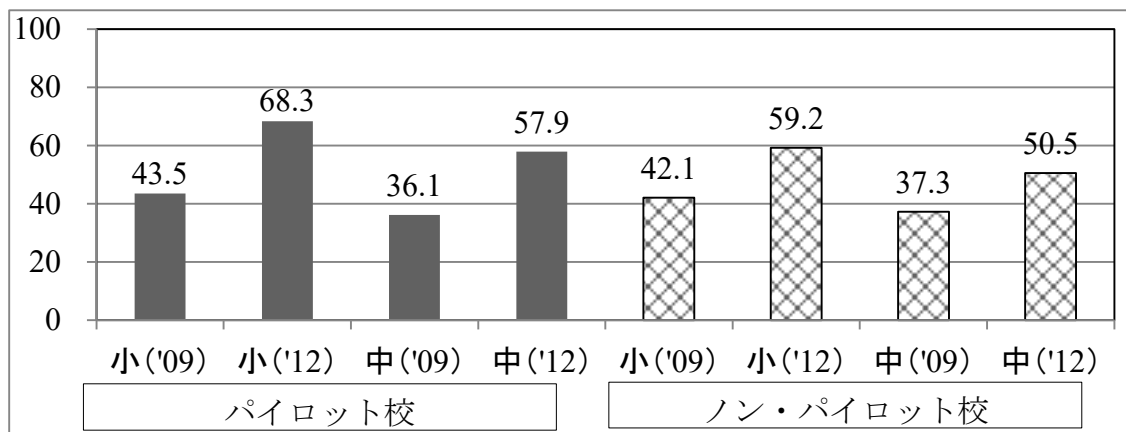
プロジェクト終了後は、半年に1度の頻度で、学校医及び学校看護師を対象とした研修が保健人口省と健康保険庁により共同実施される予定であり、同様の頻度で、ソーシャル・ワーカーや教師を対象とした研修が教育省により行われる予定である。

また、本プロジェクトのC/P機関である保健人口省の学齢期児童健康部は、学校保健サービスの促進にかかわる研修を既にガルビーヤ県をはじめとする他県で実施している（保健人口省が本プロジェクトの範囲外で実施した2010/2011年～2011年/2012年の学校保健関連研修のリストは「付属資料1. ミニッツ Annex 5-3」を参照）。

## 指標3 モニタリングで収集される保健指標が改善する

〈指標3の達成度：達成〉

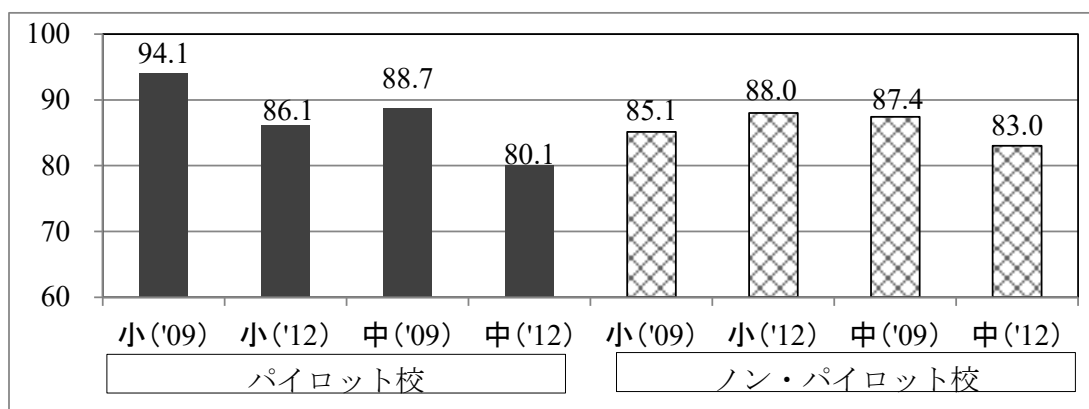
2009年に実施されたベースライン調査と2012年に実施されたエンドライン調査の結果を比較すると、パイロット校における保健指標が改善している。指標が改善された分野には、個人の衛生（例：食事前及び便所使用後に必ず手を洗う生徒の割合、毎日歯を磨く生徒の割合）、学校環境（例：校内で喫煙している者がいると回答した生徒の割合）などが含まれる（エンドライン調査の主要な指標の結果は、「付属資料1. ミニッツ Annex 6-3」を参照）。



図－８ 食事前に必ず手を洗う生徒の割合 (%)

出所：エンドライン調査報告書 (2012年)、38 ページ

図－８のとおり、食事前に必ず手を洗う生徒の割合は、パイロット小学校では、2009年の43.5%から68.3%、パイロット中学校では36.1%から57.9%に増加している。増加の度合いはパイロット校に比べれば多少少ないが、個人衛生については、パイロット校だけでなく、ノン・パイロット校でも改善されており、ノン・パイロット小学校では、2009年の42.1%から59.2%に増加しており、ノン・パイロット中学校でも37.3%から50.5%に増加している。終了時評価調査団がファユーム県のSHCのメンバーに対して行ったインタビューによると、ノン・パイロット校における指標の改善は、保健人口省、健康保険庁や教育省のモニタリング及び指導監督担当の政府職員が自発的に学校保健活動を普及させていることに一部起因しているとのことである。



図－９ 校内で喫煙している者がいると回答した生徒の割合 (%)

出所：エンドライン調査報告書 (2012年)、35 ページ

校内で喫煙している者がいると回答した生徒の割合も、パイロット小学校では、2009年の94.1%から86.1%、パイロット中学校では88.7%から80.1%に減少し、学校環境がわずかではあるが改善されている。ノン・パイロット校においては、特段の変化はない。

上位目標の総合評価：達成される見込みは定かではない

上記の指標の達成度をかながみれば、プロジェクト終了後3年から5年以内に上位目標が達成さ

れる技術面での可能性はあるものの、プロジェクト終了後の HPS モデル普及の具体的な計画がまだ作成されていないため、上位目標の達成の見込みは定かではない。上位目標が達成されるためには、保健人口省、健康保険庁、教育省の3省庁間で合意された予算や運営管理の責任が明確に示されたプロジェクト終了後の学校保健サービス促進活動計画並びに地方政府レベルにおける SHC と学校現場レベルにおける学内保健委員会の制度化が必要である。

#### 4-6 実施プロセスに関する特記事項

2011年1月に起きたエジプトの革命及びその後の不安定は政治・社会情勢により、プロジェクト活動は4カ月間中断された。この予期せぬプロジェクトの一時的な停止により、プロジェクトの実実施スケジュールが当初予定よりも遅れることとなった。

## 第5章 評価結果

### 5-1 評価結果

#### 5-1-1 評価5項目による評価

##### (1) 妥当性

学校保健サービスの促進は、エジプト政府の開発政策、日本政府の援助政策との整合性が高く、エジプトの国民のニーズにも合致していることから、本プロジェクトの妥当性は「高い」と評価される。

エジプトでは、1993年にすべての学童の健康保険加入が制度化され、「学校保険法ガイドライン」が定められた。それに加え、2012年に保健人口省が策定した「エジプトにおける保健医療・看護サービス改善のための戦略的ビジョン」には、学校保健サービス促進活動による児童の健康増進が、戦略の一つとして明記された。また、エジプトでは、急速な経済成長に伴い、肥満や喫煙、高血圧などの健康リスク要因の流行が拡大の傾向にあり、疾患構造が急速に変化しており、この変わりゆく健康上の課題に効果的に取り組んでいくには、若いころから健康的な生活習慣を身につけ、日常から病気への予防的ケアを行っていくことが必要とされている。学校は、子どもたちに健康的な生活習慣を身につけるよう働きかけるには最適の場所であるものの、特に村落地域では学校保健サービスが十分に提供されていなかった。

わが国の対エジプト援助政策の重点分野の一つは、貧困削減と生活水準の向上であり、貧困層の医療サービスへのアクセス向上支援は、公共サービスの拡充・改善を通じて貧困削減と生活水準を向上させる一つの戦略として位置づけられている。加えて、『『保健と開発』に関するイニシアティブ（2005年）』では、学校保健教育が、保健医療分野の支援を補完する関連分野の支援及び分野横断的取り組みの一例として挙げられている。「国際保健政策 2011-2015」においても、質の高い保健サービスへのアクセスを向上させるために、分野横断的アプローチを用いることの重要性が謳われている。

##### (2) 有効性

プロジェクト目標の達成見込みは高く、成果とプロジェクト目標の因果関係も明確であることから、本プロジェクトの有効性は「高い」と評価される。

一つ目のプロジェクト目標（「ヘルス・プロモーション・スクールの普及を通じて、タメイヤ郡において学校保健サービスの質が向上する」）は、中央政府・地方政府・学校現場レベルの幅広い学校保健の関係者に対して、多岐にわたる研修やワークショップを行った結果、20パイロット校及び、HPSセンター校（パイロット校のなかでも特に活動実績が優秀な学校）から研修を受けた五つのノン・パイロット校で、学校保健活動やモニタリング・指導監督が適切に行われていることから、おおむね達成されたと評価される。20のパイロット校では、エンドライン調査で主要な指標の改善が既に確認されているものの、学校保健サービスが満足できるレベルに達するには、学校医と学校看護師がさらに技術を向上していくための継続的な研修の実施、救急箱や救急薬品の備え付け状況の改善、学校医と学校看護師の配置状況の改善、学校保健サービス促進の重要性に対するコミュニティの理解の深化への取り組みが必要である。

二つ目のプロジェクト目標（「上エジプト地域においてヘルス・プロモーション・スクール普及の基盤が整う」）に関しては、普及ガイドラインを除くすべての HPS モデルの普及ツール（①学校保健実践マニュアル及び学校保健サービスに関するモニタリング・指導監督ガイドライン、②健康診断に関する DVD、③学校保健サービス促進に関する 3 種類のリーフレット）が開発され、学校から学校へ HPS モデルを普及するアプローチが、既にタメイヤ郡で成功裏に試行された。このことから、HPS モデルの普及の基盤が確立しつつあると判断される。また、プロジェクトの残りの期間に、一連の普及ワークショップが予定されており、プロジェクト終了までに普及ガイドラインが開発され、普及ワークショップが成功裏に実施されれば、二つ目のプロジェクト目標達成の見込みは非常に高いと判断される。

本プロジェクトの四つの成果は、タメイヤ郡において学校保健サービスの質を向上し、他の地域に普及できる実践的かつ効果的な HPS モデルを開発するために必要な要素（モニタリング・指導監督の仕組みの構築、学校保健活動へのコミュニティの参加促進を含めた学校保健サービス実施体制の構築及びパイロット校での HPS モデル試行に基づく学校保健サービス促進活動の実績づくり、学校保健にかかわる人材の強化）を含んでいる。

### (3) 効率性

投入は効果的に実施かつ有効活用され、成果達成に寄与したが、一部の投入が計画どおり行われなかったこと、及びタメイヤ郡における普及活動の規模が限定的であったことから、本プロジェクトの効率性は「中程度」と評価される

PDM に計画されていた投入はおおむね実施されたが、「4-1 投入実績」で述べたように、エジプト側の研修費用は、第 1 回 JCC で本プロジェクトの研修やワークショップの費用の負担責任は、プロジェクト開始から 2 年以内にエジプト側に移行されることに合意されたものの、終了時評価時点においても該当費用は日本側のみにより負担されていた。

本プロジェクトでは、HPS モデルの試行を 20 パイロット校に集中した。活動や投入を 20 パイロット校に絞って実施することにより、HPS モデルを上エジプトの他の県に普及することの実行可能性を十分検証することができた。しかしながら、HPS モデルを学校から学校へ普及するアプローチ（図-2 「HPS の将来のモデル」参照）を用いた実験的な普及活動が、これまでに五つのノン・パイロット校でしか実施されなかったことは効率性を低下させる要因となった。効率性を高めるには、他の補足的な普及アプローチを練る必要があったといえよう。

「4-6 実施プロセスに関する特記事項」で述べたように、2011 年 1 月から 5 月までの 4 カ月間、プロジェクトは一時的に停止となったものの、HPS モデルの普及ツール開発活動に現地専門家を雇用し、活動の迅速化を図るなど柔軟な対応がとられたため、計画した成果が成功裏に発現した。

### (4) インパクト

PDM において設定された指標の評価結果に基づく上位目標（「上エジプト地域におけるヘルス・プロモーション・スクールと学校保健サービスの拡大を通じて、学校保健が推進される」）の技術面での達成見込みは高いと判断されるものの、プロジェクト後の明確な活動計画がまだ作成されていないことから、本プロジェクトのインパクトは「中程度」と評価される。

「4-5 上位目標の達成見込み」で述べたように、2009 年に実施されたベースライン調



査と 2012 年に実施されたエンドライン調査の結果を比較すると、パイロット校における個人の衛生や学校環境などの主要な保健指標が改善しており、校内における生徒や教員の行動変容が確認されていることから、HPS モデルを用いた学校保健サービス促進の技術的なフィージビリティは高いと判断される。また、ノン・パイロット校においても、個人の衛生や（学内）学校保健委員会<sup>18</sup>の設立など幾つかの主要指標が改善していることが確認されている。ファユーム県の SHC によると、ノン・パイロット校における指標の改善は、パイロット校のモニタリング・指導監督を担当している 3 省庁の政府職員が自発的に学校保健活動をノン・パイロット校に普及させているためであるとのことである。具体的には、食事前に必ず手を洗う生徒の割合は、パイロット小学校では、2009 年の 43.5%から 68.3%、パイロット中学校では 36.1%から 57.9%に増加しており、ノン・パイロット小学校でも 2009 年の 42.1%から 59.2%、ノン・パイロット中学校でも 37.3%から 50.5%に増加している。

対照的に、今学年度に病気のために学校を欠席した生徒の割合や毎日 1 時間以上運動しない生徒の割合など生徒の身体的な状態に関する指標の改善は確認できなかった。この結果は、2011 年の革命で生じた不安定な政治・社会情勢が、2012 年に実施されたエンドライン調査の結果に影響を及ぼしたためであると考えられる。また、本プロジェクトの効果が生徒の身体的な状態に影響を及ぼすには時期尚早であるため、長期的に主要指標をフォローアップしていく必要がある。

終了時評価の時点では、HPS モデルを上エジプト地域に普及させるプロセスは、2010 年 3 月と 2012 年 6 月に HPS モデルのコンセプトとタメイヤ郡における経験を紹介するワークショップが行われただけであるが、プロジェクト終了時（2012 年 11 月）までには、四つの 2 日間普及ワークショップ型研修、上エジプト地域の各県における HPS モデルのトライアル、トライアルのフィードバックを得て、それを普及ガイドラインに反映させることを目的としたフォローアップ・ワークショップ、普及ガイドラインの最終化、ドナーや NGO 等を対象とした普及ワークショップ等の本格的な普及活動が予定されており、プロジェクト期間内では、上エジプト地域に HPS を普及させる基盤が着々と形成されている。

一方、3 省庁が合意すべきプロジェクト終了後の HPS モデル普及計画がまだ作成されていないことは、上位目標達成の見込みを不確実なものにしている。保健人口省、健康保険庁、教育省の 3 省庁の協力体制の構築は、本プロジェクトの最大の正のインパクトの一つとしてプロジェクト関係者間で広く認識されており、共同活動計画が作成され 3 省庁間で合意されれば、プロジェクト終了後も 3 省庁の協力により学校保健サービスが実施・普及されていくであろう。

また、本プロジェクトと学校保健に関係している他の開発パートナーとのコンタクトは限定的なものであった。エジプトでは、WHO の学校保健プログラムや、アラブ医師会 (Arab Medical Union) の学校健康診断プログラムなど学校保健関連プログラムが行われているため、これらの開発パートナーとの協力は今後学校保健サービスの改善において相乗効果が期待され、上位目標の達成を促進するものと考えられる。

<sup>18</sup> エンドライン調査で確認されたノン・パイロット校の（学内）にある学校保健委員会は、本プロジェクトで開発・発足された学内保健委員会 (Internal School Health Committee : ISHC) と必ずしも同じ活動を行っているものではなく、何らかの保健や健康に関する活動を行っている校内保健委員会を指す。

## (5) 持続性

制度面では学校保健サービス活動を継続するうえでの政策的基盤が確立されており、技術面では活動を継続的に実施し上エジプトの他の地域にサービスを拡大するための中核となる人材が質と量の両面で育成されたものの、組織面及び予算面では人材と予算の確保に不安があることから、本プロジェクトの持続性は「中程度」と評価される。

制度面では、2012年に保健人口省が策定した「エジプトにおける保健医療・看護サービス改善のための戦略的ビジョン」に学校保健促進活動による子どもの健康改善の必要性が明記されており、保健人口省、健康保険庁、教育省をメンバーに含む中央政府レベルの学校保健促進委員会が保健人口省の省令 396 番（2012年）により再発足されたことから、制度面での自立発展性は高い。

組織面では、本プロジェクトを通じて作成された M&G に学校保健サービスの提供における中央政府レベルと地方政府レベルの 3 省庁の役割と責任が明記されたものの、学校保健サービスにかかわる C/P やその他のプロジェクト関係者（学内保健委員会のメンバーを含む）のなかには、学校保健サービス提供を通常業務の範囲として認識していない者が少なからず存在することから、組織面での自立発展性は中程度と評価される。

予算面では、保健人口省が負担する学校保健や関連サービスの研修費用が 2010/2011 年度の約 9 万 4,000LE から 2011/2012 年度の約 48 万 6,000LE に急増している。2012/2013 年度には HPS モデルを上エジプト地域に普及させる学校保健研修予算として 83 万 LE が申請されている。研修費用の負担実績が増加している傾向は、予算面での自立発展性の確保に向けた強いコミットメントの表れであると判断される。しかし、プロジェクト後の予算を伴う明確な学校保健サービス促進活動計画が 3 省庁間で合意されていないことから、予算面での自立発展性は中程度であると評価される。

技術面では、中央政府及び地方政府レベルの学校保健サービスにかかわる人材が、各種研修とパイロット校における HPS モデルの実施を通じて、タメイヤ郡で学校保健サービスを継続的に実施し最終的には上エジプト地域の全県へ HPS モデルを普及していくうえで必要な確固たる技術を習得したことから、技術面の自立発展性は高いと評価される。HPS モデル実施及び普及の中核となる政府職員の数、今後プロジェクト期間内に予定されている四つの HPS モデル普及のワークショップ型研修で増えることが想定される。

### 5-1-2 貢献・阻害要因

#### (1) 効果発現に貢献した要因の分析

##### 1) 計画内容に関すること

- **チーム・アプローチの適用**：本プロジェクトは分野横断的アプローチ、トップダウンアプローチ、ボトムアップアプローチを組み合わせることにより、3 省庁を巻き込んだ中央政府、地方政府、学校現場の 3 層にまたがった「チーム・アプローチ」が取り入れられた。
- **分野横断的アプローチの適用**：本プロジェクトでは、中央政府及び地方政府（県・郡）の学校保健サービスにかかわる 3 省庁の職員が C/P として配置された。学校保健という教育セクターと保健セクターの両セクターが絡む分野で、横断的なアプローチを取り入れることにより、3 省庁間での協働体制を新たに構築することができた。
- **トップダウンとボトムアップの融合**：本プロジェクトでは学校保健にかかわる各種研

修・ワークショップを、中央政府職員のみを対象にして行うのではなく、すべてのレベルの人材（中央政府や地方政府の行政官や学校現場で活躍する校長、学校看護師、ソーシャル・ワーカー等）に対して行うことにより、オーナーシップを全体的に醸成した。

- **実践性に焦点を置いた HPS モデルの開発**：本プロジェクトでは、学校現場アプローチ（school-based approach）を取り入れることにより、学校現場の現状（エジプトの村落部の学校におけるリソースの充足状況）を十分に勘案した、実践性の高い HPS 普及ツールが開発された。

## 2) 実施プロセスに関すること

- **エジプト側プロジェクト関係者の強いコミットメント**：本プロジェクトは、エジプト側（特に地方政府レベルの C/P）が強いコミットメント及びオーナーシップをもって実施した。オーナーシップが醸成された要因にはトップダウンとボトムアップの融合したアプローチが用いられたことが挙げられる。
- **コミュニケーション改善及びより強い信頼関係の構築に向けた継続的な努力**：プロジェクト当初の中央政府レベルの C/P と日本人専門家チーム間におけるコミュニケーションと情報共有の問題はプロジェクト実施の阻害要因であったものの、エジプト側と日本側が、コミュニケーションの改善及び強い信頼関係の構築に向けた継続的な努力を行ったことで、プロジェクト実施が促進された。

## (2) 効果発現を阻害した要因の分析

### 1) 計画内容に関すること

- **投入に関する責任の所在の不明瞭さ**：本プロジェクトの投入（研修費）に関する 3 省庁の責任が明確にされていない。このことはプロジェクト終了後の財政的な自立発展性にも影響を及ぼしている。

### 2) 実施プロセスに関すること

- **プロジェクト投入に関する認識の相違**：プロジェクトの前半期には、C/P と日本人専門家チームの間で事務的な管理事項に関する認識の相違があり、それを解決するためにプロジェクトの活動実施が遅れることがあった。幾度にわたる協議及び交渉を経て、認識の相違は解決されたものの、合意に至るために要した時間はプロジェクト実施を阻害したといわざるを得ない。

## 5-2 結 論

本プロジェクトでは、多くの実施上の課題が柔軟な対応をもって克服されたため、期待されたプロジェクト目標（①ヘルス・プロモーション・スクールの普及を通じて、タメイヤ郡において学校保健サービスの質が向上する、②上エジプト地域においてヘルス・プロモーション・スクール普及の基盤が整う）はおおむね達成される見込みである。

プロジェクト目標達成をもたらすために、本プロジェクトでは、保健人口省、健康保険庁、教育省の 3 省庁との綿密な協議を通じて、学校保健サービスのための実践的なモニタリング及び指導監督の仕組みが開発された（成果 1）。また、地方政府レベルの学校保健サービスの調整機関である SHC を

設立し、20 のパイロット校クリニックに基礎医療機器を供与し、HPS モデルの学校保健サービス活動を実施することで、タメイヤ郡における学校保健サービスの提供が促進された（成果 2）。成果 1 及び 2 を発現するための活動において、三つの普及ツール（①「学校保健サービスに関するモニタリング・指導監督ガイドライン及び学校保健実践マニュアル」、②健康診断のための DVD/CD、③学校保健サービス促進のための 3 種類のリーフレット）が開発された。HPS モデル開発に必要な多岐にわたるトピックに関する各種研修やワークショップをさまざまな関係者に対して実施し、学校保健サービスをパイロット校で実施したことにより、全体的に学校保健関係者の能力が強化された（成果 3）。最後に、各 20 のパイロット校で校内保健委員会を設立し、学校保健へのコミュニティ参加を促進することで、コミュニティ参加型保健活動の種類とそれに参加するコミュニティメンバーの数が増え、教員や保護者などによる HPS を支援する活動が強化された（成果 4）。

本プロジェクトでは、中央政府 3 省庁から地方政府及び学校現場レベルにまたがる「チーム・アプローチ」に基づいた HPS モデルが成功裏に導入され、リソースが限られた上エジプトの環境において、既存リソースを最大限に活用することで実践性の高い HPS 普及ツールが開発された。本プロジェクトは、既存の行政構造における 3 省庁の中央政府、地方政府、学校現場の 3 層にまたがったチーム・アプローチを制度化する課題に直面しているものの、プロジェクト期間中に強化された組織内及び組織間の協力・協働体制を用いることにより今後の対応が可能であると考えられる。現在の HPS モデルの範囲は既存のリソースで実施可能な範囲にとどまっているため、追加リソースの有無に応じて拡大することが可能である。

今後、学校保健サービスをさらに促進させていく技術的基盤と保健人口省、健康保険庁、教育省のさらなる学校保健の促進にかかわるオーナーシップをかんがみ、プロジェクトは予定どおり終了すると結論づける。

## 第6章 提言と教訓

### 6-1 提言

前述までの分析を踏まえ、エジプト側関係者と日本側調査団は協議のうえ、上エジプト地域における HPS と学校保健サービスの継続的な実施及び拡大に向けて、プロジェクト終了時までにプロジェクト（エジプト政府及び日本人専門家チーム）側が実施すべき事項とプロジェクト終了後にエジプト側が実施すべき事項を以下のとおり整理した。

- (1) プロジェクト終了時までにプロジェクト（エジプト政府及び日本人専門家チーム）が実施すべき事項

- 1) プロジェクト終了後の学校保健サービス促進のための活動計画の策定

3 省庁間で合意されたプロジェクト終了後の学校保健サービス促進のための明確な活動計画、予算的調整及び管理責任がないことが、プロジェクトの自立発展性を阻害している。全関係組織との協議を経て、次年度以降必要な予算が割り当てられるように、年間活動計画の策定プロセスをプロジェクトが促進するよう提言する。また、パイロット校からノン・パイロット校への普及戦略についても、やはりプロジェクトの終了時までに、タメイヤ郡での経験の分析に基づき、保健人口省、健康保険庁、教育省のモニタリング及び指導監督の担当者が HPS モデルの普及において担い得る役割をプロジェクトが考察し、複数の実践的アプローチを提案すべきである。

- 2) HPS モデルの普及に向けた他のドナーや NGO との協力・協調

終了時評価チームは、プロジェクトが、エジプト側プロジェクトメンバーのリーダーシップの下で、WHO をはじめとする他のドナーや NGO と直接的な協議及び「開発パートナーグループの保健人口テーマグループ」の会合への参加による情報共有を通じて、HPS モデルの普及に向けたドナーや NGO との協力を行うことを提言する。ドナーとの協議を通じて、ドナーや NGO が HPS モデル普及に貢献できる具体的な方法を探していけるように努力すべきである。

- 3) マニュアル&ガイドライン及び他の普及ツールの 3 省庁のウェブサイトへのアップロード

プロジェクトはアラビア語版のマニュアル&ガイドラインと三つのリーフレットをそれぞれ 1,000 部印刷した。学校保健サービスにかかわる行政官、ドナー、NGO 及び研究者等が各普及ツールに容易にアクセスできるように、これらの資料は、保健人口省、健康保険庁、教育省のウェブサイトへアップロードされるべきである。普及ツールをアップロードすることは、本プロジェクトに直接関係してこなかったエジプトの学校保健関係者や開発パートナー（潜在的需要者）に、幅広く活用してもらうためにも有効な手段といえ、今後関係者が資料のハードコピーを紛失した際の事前対策ともなる。

- 4) 情報共有とコミュニケーションの改善への継続的努力

本プロジェクトでは、プロジェクト終了までの限られた期間に、HPS モデルの普及にかかわる多くの活動実施を計画している。これら活動を成功裏に実施するためには、日本人専門家

チームと C/P の良好な協働関係が不可欠である。終了時評価調査団は、残されたプロジェクト期間中に予定されているすべての業務を着実に実施するため、より綿密なコミュニケーション及びより確固たる「チームワーク」精神を構築するように双方が継続的な努力を行うことを提言する。

## (2) プロジェクト終了後にエジプト政府が実施すべき事項

### 1) 県レベルにおける学校保健委員会と学校レベルにおける学内学校保健委員会の制度化

エジプト側プロジェクトメンバー及びプロジェクト関係者（ISHC メンバー及び学校医）には、学校保健サービス提供を通常業務の範囲として認識していない者が少なからず存在する。持続性の観点から、学校保健サービス促進が通常の職務にきちんと組み込まれ、サービスの実施やモニタリングを担当する者にとって義務的な職務とみなされる必要がある。そのためには、保健人口省、健康保険庁、教育省による省庁間合同の条例によって、県レベルでの学校保健委員会と学校レベルでの学内学校保健委員会が制度化されることが望ましい。本件については保健人口省の省令 396 番（2012 年）により再発足された学校保健促進委員会において協議されることを提言する。

### 2) エジプトにおける学校保健の重要性への認識の醸成

エジプトでは、急速な経済成長に伴い、肥満や喫煙、高血圧などのリスク要因の流行が拡大の傾向にあり、疾患構造が急速に変化している。中間レビューで強調されたように、学校保健はエジプトにおける新たな保健課題を取り扱う長期的戦略として認識されるべきである。学校は、子どもたちの長期的な健康状態に影響を及ぼす健康的なライフスタイルの選択（健康的な食生活、個人の衛生、禁煙、日ごろの運動等）を促したり、子どもたちを通じて健康的なライフスタイルに関するコミュニティメンバーの認識を向上したりするために最適な場所である。いわば、子どもたちは、保健に関するメッセージを保護者やその他のコミュニティメンバーに伝える「保健大使」として触媒的な役割を担うことができる。

特に予防的ケアと保健教育などの学校保健プログラムを促進することは、学力の向上や将来の医療費の削減につながる「投資」として広く認識されるべきであることを提言する。パイロット校における主要な保健指標は、この投資戦略をサポートするために、また、保健人口省、健康保険庁、教育省による学校保健に対する継続的なコミットメントの確固たる基盤を維持するために、フォローアップされるべきである。

### 3) 医師不足にかかわる問題を解決するための継続的努力

エンドライン調査により、生徒や生徒の保護者が、学校における医師不足と緊急医薬品の供給不足にかかわる問題が解決されることを喫緊の課題ととらえていることが明らかになった。エジプト政府は、引き続きこれらの問題に取り組み、解決に向けて努力することを提言する。

## 6-2 教訓

### (1) 組織間の調整と協力の重要性

リソースが限られた環境において学校保健プログラムを成功に導くには、すべての行政レベルにおいて保健と教育を担当する関係者間で効果的な協力・調整が行われることが必須である。本

プロジェクトの実施期間を通じて、保健人口省、健康保険庁、教育省の3省庁の良好な協働関係がすべての行政レベルで培われたことが、期待されていた結果を生み出すのに不可欠であった。組織間における調整や協調が必要不可欠であるプロジェクトでは、プロジェクト実施の開始前または開始直後の段階で、各関連組織の役割と責任が明確に定義されることが望ましい。また、プロジェクト活動の持続性を担保するため、プロジェクトへの将来的な投入の可能性を含むドナーやNGOとの協働体制も明確化されるべきである。

#### (2) マニュアル及びガイドライン開発における適切な手順

技術的に妥当性が高く、かつ実践的なマニュアルやガイドラインを開発するには、政策レベルから実務レベルまでにわたる広範囲の関係者のインプットを取り入れる参加型プロセスが求められる。多くの関係者を巻き込む参加型プロセスは多大な時間と労力を要するものの、完成度の高い成果品が作成される可能性が高いため、最終的には有効性と効率性が高くなる。本プロジェクトでは、M&Gの開発作業と最終化作業にかなりの時間が費やされたものの、M&Gの実践的な内容と使い勝手の良さは高く評価されている。類似プロジェクトを形成する際には、参加型アプローチを用いることの必要性和それに要する時間を十分に考慮すべきである。ガイドラインとマニュアルの開発における現地専門家の活用は、そのような人的資源が存在する国の場合、現地の社会状況や文化背景を十分に配慮した現地の人々にとってより分かりやすく、受け入れやすい成果品をつくるために有効な手段となり得る。

#### (3) 既存人材の最大活用

リソースが限られた環境において、既存のリソース（特に人的資源）は、「チーム・アプローチ」を通じて最大限に活用されるべきである。本プロジェクトでは、学内保健委員会を通じた校長のリーダーシップの下、学校内の既存の教育、保健人材及び父母を動員することに成功した。他方で学校保健サービス提供を通常業務の範囲として認識していない者が少なからず存在することが、組織面での自立発展性を不確実なものにしていることから、類似プロジェクトにおいて既存の人材に新たな役割を追加する場合は、その役割の制度化を促進する活動もプロジェクト活動に取り入れるべきである。

#### (4) ベースライン及びエンドライン調査の適切な活用

ベースライン及びエンドライン調査を適切にデザインすることにより、プロジェクトの評価と支援アプローチの有効性検証に有益な情報が得られる。それらの情報は、エビデンスに基づいた政策提言に不可欠であり、将来の拡大展開を想定したパイロット活動に焦点を当てたプロジェクトには積極的に適用されるべきである。本プロジェクトで実施されたエンドライン調査では、指標の変化により本プロジェクトのインパクトを定量的に分析する材料が得られた。他方で、幾つかの指標は、本プロジェクトの活動内容と関係なく、指標の解釈も不十分なものであったため、プロジェクトのインパクトに関する誤解や混乱を招いた。このような事態を防ぎ、妥当性の高い情報を確実に入手するためには、これらの調査は慎重にデザインされる必要がある。また、データ収集と分析はリサーチ専門機関に外部委託できるものの、調査結果の解釈にはプロジェクトの実施と背景にかかわる十分な知識をもつ者の直接的な関与が求められる。





## 付 属 資 料

### 1 . Minutes of Meeting



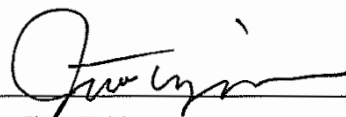
**MINUTES OF MEETING  
BETWEEN  
JAPAN INTERNATIONAL COOPERATION AGENCY  
AND  
MINISTRY OF HEALTH AND POPULATION OF THE ARAB REPUBLIC OF  
EGYPT  
ON  
TECHNICAL COOPERATION PROJECT  
FOR  
THE PROJECT ON THE PROMOTION OF SCHOOL HEALTH SERVICES IN  
UPPER EGYPT**

The Japanese Terminal Evaluation Team (hereinafter referred to as “the Team”) organized by the Japan International Cooperation Agency (hereinafter referred to as “JICA”) visited the Arab Republic of Egypt (hereinafter referred to as “Egypt”) from June 17 to July 6, 2012 for the purpose of the terminal evaluation on “The Project on Promotion of School Health Services in Upper Egypt” (hereinafter referred to as “the Project”).

During its stay in Egypt, the Team exchanged their views and had a series of discussions with the project personnel of the Ministry of Health and Population (hereinafter referred to as “MOHP”), Egyptian authorities concerned and other relevant parties.

As a result of discussions, both parties agreed to the matters referred to in the document attached hereto.

Cairo, July 5, 2012



Mr. Ikuto Takizawa  
Terminal Evaluation Team Leader  
Japan International Cooperation Agency  
Japan



Dr. Emad Ezzat  
Head of Primary Health Care and Nursing Sector  
Ministry of Health and Population  
The Government of the Republic of Egypt



**The Terminal Evaluation Report  
for  
the Project on the Promotion of School  
Health Service in Upper Egypt**

**Ministry of Health and Population, the Republic of Egypt**

**Japan International Cooperation Agency**

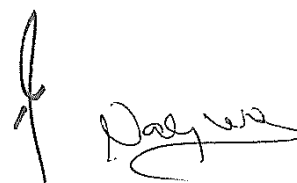
**July 5, 2012**

A handwritten signature in black ink, appearing to be a stylized 'J' followed by some illegible characters.

A handwritten signature in black ink, appearing to be a stylized 'A' followed by the name 'Wagdy'.

## List of Abbreviations and Acronyms

B. ED	Basic Education
C/Ps	Counterparts
CDS	Center for Development Services
E&P	Environment and Population
HIO	Health Insurance Organization
HM	Head Master
HPS	Health Promotion School
HV	Health Visitor
IEC	Information, Education, and Communication
ISHC	Internal School Health Committee
JCC	Joint Coordination Committee
JICA	Japan International Cooperation Agency
M & G	Implementation Manual for School Health Services and Guidelines of Monitoring and Supervision for School Health Services
M/M	Minutes of Meeting
MOE	Ministry of Education
MOHP	Ministry of Health and Population
MT	Monitoring Team
ODA	Official Development Assistance
OVI	Objectively Verifiable Indicator
PDM	Project Design Matrix
PHC	Primary Health Care
R/D	Record of Discussions
SACHD	School Aged Children Health Care Department
SD	School Doctor
SHC	School Health Committee
SHIP	Student Health Insurance Program
SM	School Manager
SN	School Nurse
SW	Social Workers
TT	Trainer's Team
WHO	World Health Organization



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## **1. Outline of the Terminal Evaluation**

### **1-1. Background of the Evaluation**

The four-year Japanese technical cooperation project “the Project on the Promotion of School Health Services in Upper Egypt” was launched in November 2008 and is scheduled to be completed in November 2012. As the end of the scheduled project period is approaching – as laid out in the Record of Discussions (R/D) between the Government of the Arab Republic of Egypt and the Government of Japan signed on September 16, 2008 –Japanese terminal evaluation team organized by the Japan International Cooperation Agency (JICA) was dispatched to conduct a terminal evaluation of the Project.

### **1-2. Schedule of the Terminal Evaluation**

The evaluation was conducted from the 17th of June 2012 to the 6th of July 2012 (See Annex 1 for the Detailed Schedule of the Terminal Evaluation).

### **1-3. Objectives of the Evaluation**

The objectives of this evaluation are as follows:

- (1) To review the project implementation process; and the project inputs, the progress of the project activities, and achievement levels of the intended outputs based on the most recently revised Project Design Matrix (PDM) (See Annex 2 Project Design Matrix);
- (2) To confirm project achievements and issues with the project implementation based on the review of project process and achievements and to evaluate the project using the five evaluation criteria (Relevance, Effectiveness, Efficiency, Impact, and Sustainability), defined in 1-6 Method of Evaluation;
- (3) To clarify necessary measures to be taken for further improvement of the Project’s quality by the end of the project period (November 2012) and draw up recommendations for future direction of the Project upon consultation with the Egyptian side, as well as lessons learned that will be useful for similar projects in Egypt and other countries; and
- (4) To form consensus on recommended measures by summarizing them in the Terminal Evaluation Report.



#### 1-4. Members the Evaluation Team

The members of the Evaluation Team were as follows:

Name	Title	Organization
Mr. Ikuo Takizawa	Leader	Director, Health Division 1, Health Group 1 Human Development Department, Japan International Cooperation Agency
Mr. Yuki Matsuyama	Evaluation Planning	Health Division 1, Health Group 1 Human Development Department, Japan International Cooperation Agency
Ms. Setsuko Kanuka	Evaluation Analysis	IMG Inc.

#### 1-5. List of Main Interviewees

During the evaluation, the Evaluation Team interviewed Egyptian Project Personnel or Counterparts (C/Ps), Japanese experts, and stakeholders (See Annex 3 List of Main Interviewees).

#### 1-6. Method of the Evaluation

Based on the PDM and other information and data relevant to the Project, the Evaluation Team assessed the Project from the following perspectives: (1) achievements of the Project, (2) implementation process, and (3) five evaluation criteria of the Development Assistance Committee.

Five evaluation criteria are defined as follows:

- (1) **Relevance:** Relevance is assessed in terms of Project Purposes and Overall Goal's validity in relation to the development policy of the Egyptian Government at the terminal evaluation stage, Japan's Official Development Assistance (ODA) policy, and the needs of the Project beneficiaries;
- (2) **Effectiveness:** Effectiveness is assessed based on whether the Project Purposes are being achieved as expected and whether this is due to the Project's Outputs;
- (3) **Efficiency:** Efficiency is assessed by focusing on the relationship between Outputs and Inputs in terms of timing, quality and quantity of Inputs. It measures to what extent Project Inputs have economically been converted into Outputs in consideration of the achievements of both Inputs and Outputs;

- (4) **Impact:** Impact is assessed on the basis of what both positive and negative changes have been produced, directly or indirectly as a result of project implementation, including those not anticipated in the planning stage of the Project;
- (5) **Sustainability:** Sustainability is assessed in terms of institutional, organizational, financial and technical aspects, by examining the extent to which the achievements of the Project will be maintained or further expanded by the Egyptian side after the project period.

As a preparatory work for the evaluation, a list of questions and information, data and documents required for evaluation were summarized in the "Evaluation Grid." Findings from the evaluation were summarized in the Evaluation Grid (See Annex 4), which was used as a base-material for development of the terminal evaluation report and discussions between the Japanese terminal evaluation team and the Egyptian authorities concerned.

## 2. Outline of the Project

### 2-1. Background of the Project

The health indicators across Egypt have been improving. However, health indicator improvements vary from governorate to governorate depending on their locality, economic situation and the educational background of the residents. The gap between rural and urban areas, as well as an economic divide between the rich and the poor, still exists in Egypt. Most external health sector assistance provided to the country has mainly focused on pregnant women/nursing mothers and their children under five. As a result, health services that directly contribute to the improvement of the health status of school-aged children are currently weak in rural areas – especially in Upper Egypt.

In 1992 Law 99 was enacted, expanding health insurance to all school students through the Ministry of Health and Population as the Ministry responsible for school health. In February 1993, the Student Health Insurance Program (SHIP) was created to cover all students and school-aged children. Despite all exerted efforts to provide adequate and reliable health services for all school students, challenges concerning accessibility, quality and other aspects still persisted. To improve the health situation of school children in Upper Egypt, the Government of Egypt requested the technical assistance through the project "Promotion of School Health Services in Upper Egypt" to the Government of Japan.

## 2-2. Project Outline

The outline of the Project is as follows:

### (1) Executing Ministry

Ministry of Health and Population (MOHP)

### (2) Counterpart Agencies

- a. Preventive and Primary Health Care Sector, School Aged Health Care Department (SACHD), MOHP
- b. Health Insurance Organization (HIO)

### (3) Relevant Agency

Ministry of Education (MOE)

### (4) Beneficiaries

- 1 Direct beneficiaries
    - Central level: Central government staff in SACHD, MOHP and HIO
    - Governorate and district level: Government staff in MOHP and HIO
    - School: Primary and preparatory school students and teachers in the Tammia District, Fayoum Governorate (No. of students: about 10,000)\*
  - 2 Indirect Beneficiaries
    - Central level: Central government staff in MOE
    - Governorate and district level: Government staff in MOE
    - School: Primary and preparatory school students and teachers of other areas in Upper Egypt (No. of students: approximately 5 million\*)
- \* At the time of the beginning of the Project

### (5) Target Areas

Upper Egypt (population: approximately 45million)

\* The Tammia District, Fayoum Governorate (population: approximately 350,000) is selected as the pilot district for developing the Health Promotion School (HPS) model.



**(6) Super Goal**

Health status of school children in Upper Egypt is improved.

**(7) Overall Goal**

School health is promoted by expanding Health promotion school\* and school health services in Upper Egypt.

\* Health promotion school is defined as those schools that (1) being equipped with appropriately functioning school clinic, (2) provide the school health services in the fields of (a) health education, (b) family and community participation, (c) school environment, (d) water and sanitation, and (e) health care services, in accordance with the developed guidelines, manuals and plans, (3) supported by monitoring and supervisory systems of the school health, and (4) with participation of teachers, parents, students and communities.

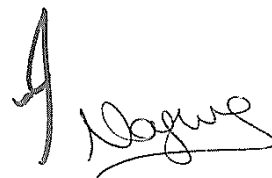
**(8) Project Purposes**

1. The quality of school health services in Tammia district is improved through the dissemination of the concept of Health Promotion School.
2. The framework to disseminate Health Promotion School in Upper Egypt is prepared.

**(9) Project Outputs**

1. Monitoring and supervisory mechanism on school health is developed at district level and is strengthened at governorate/central level.
2. The provision of school health services is facilitated in Tammia district.
3. Human resources for school health are strengthened.
4. Supporting activities of Health Promotion School by supporters such as teachers and parents are strengthened.

(See Annex 2 Project Design Matrix for details of project activities.)



### 3. Achievements of the Project

#### 3-1. Achievement of Outputs

##### (1) Achievement of Output 1

**Output 1: Monitoring and supervisory mechanism on school health is developed at district level and is strengthened at governorate/central level**

OVI	Achievement Level
1-1 Monitoring and supervision are conducted regularly (frequency and the contents are based on the guideline of monitoring/supervision by schools and administration)	<p>&lt;Achievement level: Mostly Achieved &gt;</p> <ul style="list-style-type: none"> <li>The Project developed the <i>Guidelines of Monitoring and Supervision for School Health Services</i><sup>1</sup>, which clearly define roles and responsibilities of all those who are related to the monitoring and supervision of school health activities at the central, governorate, and school level.</li> <li>The monitoring and supervision of the 20 pilot schools have been conducted twice a year; once in every school semester as per the guidelines in the Tammia District (See Annex 5-2 List of Pilot Schools), MOHP, HIO, and MOE. The monitoring is covered by each organization.</li> <li>Top performing five pilot schools were selected as “center schools” (or model schools) of school health services. Each center school trained one non-pilot school on activities related to the Health Promotion School (HPS) model, including establishing an internal school health committee (ISHC), implementing health education activities and self-monitoring.</li> </ul>

**Overall Assessment: Mostly Achieved**

- Output 1 is assessed to be mostly achieved judging from the OVI’s achievement level and the extent to which the monitoring and supervisory mechanism has been strengthened.
- The guidelines were successfully prepared in high quality in terms of the practicality and user-friendliness. This was made possible by taking inputs from actual experience of implementation in the pilot schools and from those who were involved in school health services at all central, governorate, district and school level.
- The guidelines were developed with due consideration for the limited availability of resources in terms of government staff responsible for school health services and budgets for monitoring and supervision, by maximizing the roles played by schools through self-monitoring. Schools are instructed to record the results of each health service activity, assess accomplishments and

<sup>1</sup> The *Guidelines of Monitoring and Supervision for School Health Services* was combined with the *Implementation Manual for School Health Services* and printed in June 2012. The title of the document is “the *Implementation Manual for School Health Services and The Guidelines of Monitoring and Supervision for School Health Services*(M&G)”. It is a part of the dissemination tools for the HPS model (See 6-1 the List of Publications).

challenges, and come up with an improvement plan.

- With the finalization and printing of the guidelines in June 2012, the Project has come to the level where the foundation for conducting an effective monitoring and supervision is laid at the central and governorate level.
- While the monitoring and supervision mechanism has been strengthened in the Fayoum Governorate (the pilot governorate); continuous effort is needed for the standardization of data recording to further improve quality of information.

(2) Achievement of Output 2

**Output 2: The provision of school health services is facilitated in Tammia district.**

OVI	Achievement Level
2-1. The number of the Health Promotion School is more than 20 on the basis of the following indicators. a. Number of health education activities b. Number of community participation activities c. Number of environment activities/Regular maintenance d. Number of water and sanitation activities/Regular maintenance e. Health examination coverage	<p>&lt;Achievement level: Achieved &gt;</p> <ul style="list-style-type: none"> <li>• As of the time of the evaluation, 21 schools in total (all the 20 pilot schools and one non-pilot school) met the criteria of the Health Promotion School defined in the Project.</li> <li>• The criteria and the achievement level of each criteria by the 20 pilot schools and 5 non-pilot schools trained by the center schools are as follows (See 6-2 for Achievements Under the Five Criteria for Health Promotion School):               <ul style="list-style-type: none"> <li>a. <b>Health education:</b> Implementation of at least one health education method <b>Result:</b> All 20 pilot schools and 4 non-pilot schools have used more than one method in their health education activities.</li> <li>b. <b>Community Participation:</b> Implementation of at least one activity, in which students, parents, and/or community participate <b>Result:</b> All 20 pilot schools and 5 non-pilot schools have conducted at least one activity involving students, parents, and community members.</li> <li>c. <b>School Environment:</b> Fulfillment of more than 70% of check-items for required school environment conditions (conditions of school building, playground, and classrooms) <b>Result:</b> All 20 pilot schools and 5 non-pilot schools fulfilled more than 70% of required school environment conditions.</li> <li>d. <b>Water and Sanitation:</b> Fulfillment of more than 70% of check-items for required water and sanitation conditions (conditions of water facilities in the school and toilets for boys and girls) <b>Result:</b> All 20 pilot schools and 5 non-pilot schools fulfilled more than 70% of required water and sanitation conditions.</li> </ul> </li> </ul>

- 2-1. The number of the Health Promotion School is more than 20 on the basis of the following indicators.
- Number of health education activities
  - Number of community participation activities
  - Number of environment activities/Regular maintenance
  - Number of water and sanitation activities/Regular maintenance
  - Health examination coverage

(continued)

- e. **Health Care Service:** measurements of height, weight and vision for the majority of target students

**Result:** At all 20 pilot schools and only 1 non-pilot school, the measurements of height, weight and vision were conducted to the majority of target students.

- The measuring of school children's height, weight and vision by health visitors have become a regular practice among the pilot schools.
- According to the End-line survey, the proportion of students who had ever received health checkup increased from 44.5% in 2009 to 77.3% in 2012 in the pilot primary schools while there was a decrease from 55.2% to 51.6% in the non-pilot primary schools. The proportion increased from 39.1% to 87.2% in the pilot preparatory schools while it decreased from 60.5% to 46.2% in non-pilot preparatory schools (See Annex 6-3 Results of Key Indicators in the End-Line Survey)
- Complete medical examination by school doctors was conducted only at 7 pilot schools. While it was decided in the 13th SHC in October 2011 to allocate a doctor from MOHP or HIO to each of the pilot schools for medical check-ups during Nov. to Dec., 2011, only about 50% of the allocated doctors actually turned up and conducted the medical examinations.

	Pilot Schools	Non-Pilot Schools
Fully Conducted	7	0
	35%	0%
Partially Conducted	2	0
	10%	0%
Not Conducted	11	5
	55%	100%
Total	20 Schools	5 Schools

- While availability of doctors is still a constraint, the End-line survey revealed increased role of school nurses in conducting health checkups. Among the students who had ever received health checkups, those received from school nurses increased from 7.7% in 2009 to 30.7% in 2012 in the pilot primary schools, while there was a change from 5.6% to 11.2%. The proportion increased from 6.4% to 42.3% in the pilot preparatory school, compared to the change from 6.3% to 16.5% in the non-pilot preparatory schools (See Annex 6-3 Results of Key Indicators in the End-Line Survey).

---

**Overall Assessment: Achieved**

- Output 2 is assessed to be achieved judging from the OVI's achievement levels and activities conducted to facilitate the school health services in the Tammia District.
  - The Project established the School Health Committee (SHC), a coordination body for school health promotion activities at the governorate level. With the appropriate coordination by SHC, the Project successfully developed an *Implementation Manual for School Health Services*, a DVD on complete health examination, and three educational leaflets<sup>2</sup>. These items were developed with technical inputs from those who are involved in the provision of school health services at all central, governorate, district and school level and used for a trial at pilot schools.
  - The implementation procedures of school health services are developed with due consideration of the shortage of school doctors and emphasizes the roles and responsibilities of available human resources. From the interviews by the terminal evaluation team and the End-line Survey, it was confirmed that school nurses, health visitors, and social workers, have played the central roles in implementing school health services such as health checkups and health education. Other teachers such as population and environment teachers and computer teachers, and representatives of parents also played significant role under the leadership of the school principals through ISHC.
  - Through implementing school health services in accordance with the implementing manual, the provision of school health services has been facilitated in the Tammia District.
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**(3) Achievement of Output 3**

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**Output 3: Human resources for school health are strengthened.**

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Verifiable Indicators	Achievement Level
3-1 Self-Evaluation after the training (number of personnel trained, post training/workshop evaluation by the trainees)	<Achievement level: Achieved > <ul style="list-style-type: none"><li>• In the self-evaluation surveys conducted after three health education training courses (provided in February 2009, October 2010, and March 2012), participants responded that they were satisfied with the courses; the share of those who reported positively were 98%, 100%, and 100%, respectively.</li></ul>

**Overall Assessment: Achieved**

- Output 3 is assessed to be mostly achieved judging from: the OVI's achievement level; the records of meetings, workshops and training on development, implementation and dissemination of the HPS model (See 6-4 Records of Meetings, Workshops and Training); and interviews conducted by the terminal evaluation team and performance as trainers by Egyptian project personnel at the dissemination workshop in June 2012 observed by the terminal evaluation team.
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<sup>2</sup> The manual, DVD, and leaflets are also part of the dissemination tools for the Health School Promotion model.



- The Project trained a wide range of people: administrative government officers for school health services both at the national and governorate level and members of Internal School Health Committees (i.e. school principals, social workers, teachers, school doctors, school nurses and health visitors). Training covering extensive topics for the establishment of the HPS model and the implementation of school health services in accordance of the implementation manual has been successfully conducted.
- The technical capacity of core personnel who are capable of implementing and disseminating the HPS model to other governorates has been built, and will be strengthened further, through these training courses and the implementation of school health services, and/or monitoring and supervision by the end of the Project.
- Output 3 will be achieved upon the successful implementation of dissemination training workshops.

**(4) Achievement of Output 4**

**Output 4: Supporting activities of Health Promotion School by supporters such as teachers and parents are strengthened.**

Verifiable Indicators	Achievement Level
4-1 At least one good practice of Health Promotion School is conducted in collaboration with schools and communities among 20 pilot schools.	<p>&lt;Achievement level: Achieved&gt;</p> <ul style="list-style-type: none"> <li>• According to the ISHC Survey conducted by the Project from May to June 2012, all of the 20 pilot schools have carried out health-related activities in which parents and community members participated. Most common activities included health lectures and seminars and school clean-ups joined by students and parents.</li> </ul>
4-2 Number of community people who attend supporting activity is increased among 20 pilot schools.	<p>&lt;Achievement level: Mostly Achieved &gt;</p> <ul style="list-style-type: none"> <li>• The ISHC Survey results indicates that among the 20 pilot schools most (19 schools) of the 20 pilot schools reported that the number of community members who participated in school health activities and the number of health-related community activities had increased in the last two years. Among them 8 schools (40%) reported that community members' participation had greatly increased and 9 schools (45%) reported that the number of community activities had greatly increased.</li> </ul>

**Overall Assessment: Mostly Achieved**

- Output 4 is assessed to be mostly achieved judging from the OVI's achievement and the interviews conducted by the terminal evaluation team.
- The Implementation Manual for School Health Services introduces a variety of practical school health activities for family and community participation. According to one social worker interviewed, the Project has enabled her to apply the knowledge she had about health issues and

community participation into school health activities.

- The team also acknowledged from the interviews, the End-line survey, and School Health Activity Records that while community participation has increased in the last two years at the pilot schools, the increase is not to the level that is widely recognized by most parents and teachers. While there is still a limited appreciation for the importance of school health among community members, the situation is expected to improve through continued functioning of ISHCs

### 3-2. Prospect for Achieving the Project Purposes

**Project Purpose (1): The quality of school health services in Tammia district is improved through the dissemination of the concept of Health Promotion School.**

Verifiable Indicators	Achievement Level
<p><u>By the end of the project.</u></p> <p>1 More than half of students, parents, and teachers are satisfied with the school health services.</p>	<p>&lt;Achievement level: Achieved to Some Extent&gt;</p> <ul style="list-style-type: none"> <li>• According to the results from the End-line Survey, more than half of the students (60% of primary school students and 48% of preparatory school students), and the majority of teachers and the Board of Trustees (incl. some parents) from pilot schools consider that school health services have improved in the last two years.</li> <li>• The positive changes reported are: (1) the increased provision of health-related information and activities by the ISHC, (2) the greater availability of equipment and medicines in school clinics; and (3) the increased frequency of school visits by health visitors and doctors.</li> <li>• In the same survey, most parents of the students from pilot schools did not concur with the above, claiming that there was no improvement in school health services, which could be due to limited communication and awareness among the parents of the progress made in school health programs.</li> <li>• The survey also shows that students, parents, and teachers are not fully satisfied with the school health services, especially in regard to the performance of medical examinations by some of the doctors.</li> </ul>
<p>2 Internal School Health Committee Members at 20 pilot schools judge that the provision of school health services is improved.</p>	<p>&lt;Achievement level: Achieved&gt;</p> <ul style="list-style-type: none"> <li>• According to the ISHC Survey, all 114 respondents from 20 pilot schools reported that school health services at their schools had improved in the last two years (82% of the respondents [93 persons] reported that “school health services have improved very much” and 18% [21 persons] answered “school health services have fairly improved.”).</li> </ul>

**Project Purpose (2): The framework to disseminate Health Promotion School in Upper Egypt is prepared.**

2-1 The concept of Health Promotion School is elaborated	<p>&lt;Achievement level: Achieved&gt;</p> <ul style="list-style-type: none"> <li>Based on the discussions held in the first year between the Egyptian Project personnel and Japanese expert team, the definition of the HPS concept was agreed upon among all relevant organizations, which was inserted in the PDM revised in October 2010 (See Annex 2 Project Design Matrix)</li> </ul>
2-2 The tools for dissemination of Health Promotion School are developed.	<p>&lt;Achievement level: Mostly Achieved&gt;</p> <ul style="list-style-type: none"> <li>The following HPS dissemination tools have been developed by the Project: (1) a publication, titled "Implementation Manual for School Health Services and Guidelines of Monitoring and Supervision for School Health Services" (M&amp;G), (2) a DVD/CD on comprehensive medical examination, and (3) three leaflets on school health service promotion (See Annex 6-1 List of Publications).</li> <li>The Dissemination Guidelines that summarize how to implement the HPS model are in the process of being developed.</li> </ul>

**Overall Assessment: Most Likely to be Achieved by the end of the Project Period**

- The Project Purposes are assessed to be most likely to be achieved by the end of the project period judging from the OVI's achievement and the interviews conducted by the terminal evaluation team.
- In due consideration of the shortage of school doctors and the government's limited budget and human resources available for monitoring and supervision in rural areas of Egypt, the Project has created the HPS model that emphasizes the roles and responsibilities that school nurses, health visitors, social workers, teachers, community members, and students themselves play in promoting school health services.
- While the greater involvement of all school related people in the school health promotion has been mostly successful, the issues of the school doctor shortage, and the insufficient supply of the first-aid medicines at many schools still remain.

**3-3. Prospect for Achievement of the Overall Goal**

**Overall Goal: School health is promoted by expanding Health Promotion School and school health services in Upper Egypt.**

Verifiable Indicators	Achievement Level
1. Health promotion schools are introduced to more than 5 governorates in Upper Egypt.	<p>&lt;Achievement level: Achieved to Some Extent&gt;</p> <ul style="list-style-type: none"> <li>On the 27th and 28th of June, 2012, the second dissemination workshop was held in Cairo to explain trial results of the HPS model at the 20 pilot schools in the Tammia District to MOHP,</li> </ul>

	<p>HIO, and MOE representatives from their headquarters and all Governorates in Upper Egypt. The training covered how to implement the HPS model and to distribute HPS dissemination tool packages.</p> <ul style="list-style-type: none"> <li>• For the remaining project period, the Project plans to conduct the followings: <ul style="list-style-type: none"> <li>- From July to August 2012: training workshops for dissemination in Aswan, Luxor, Fayoum, and Asyut, with the participation of nine Governorates;</li> <li>- From August to September 2012: trial operations of the HPS model at each governorate (one school will be selected from each Upper Egypt governorate for implementing the HPS model by those who are trained in the training workshop mentioned above.);</li> <li>- In September 2012, a follow-up workshop in Cairo for the above-mentioned trial operations with the participation of representatives from all governorates in Upper Egypt; and</li> <li>- In October 2012: the HPS Dissemination Workshop for development partners to share information, M&amp;G and the Dissemination Guidelines.</li> </ul> </li> </ul>
<p>2. SACHD, MOHP is providing regular training on school health based on monitoring on pilot schools in Tammia.</p>	<p>&lt;Achievement level: Achieved&gt;</p> <ul style="list-style-type: none"> <li>• Bi-annual training sessions targeting school nurses and doctors are planned to be conducted by MOHP and HIO, and other bi-annual training sessions targeting social workers and teachers are planned to be conducted by MOE.</li> <li>• SACHD, MOHP has been providing training on school health in other governorates, most notably the Gharbia Governorate (See Annex 5-3 Training Expenses by the Egyptian Side for the list of training conducted by MOHP).</li> </ul>
<p>3. Some health indicators that are collected in the proposed monitoring mechanism are improved.</p>	<p>&lt;Achievement level: Achieved &gt;</p> <ul style="list-style-type: none"> <li>• Comparing the results of the End-line Survey conducted in 2012 with those of the Baseline Survey conducted in 2009, some health indicators at pilot schools have improved in the areas of personal hygiene (e.g. the percentages of students who wash their hands before eating and after using bathroom and of students who brush their teeth) and school environment (the percentage of students who reported that people smoke inside classrooms.) (See Annex 6-3 Results of Key Indicators in the End-Line Survey).</li> </ul>

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**Overall Assessment: Uncertain**

- Judging from the OVI's achievement level, the Overall Goal has potential to be achieved within three to five years after the completion of the Project, but the prospect is still uncertain since there is no explicit plan prepared for the dissemination of the HPS model after the Project.
  - In order for the Overall Goal to be achieved, there must be a post-Project activity plan for school health service promotion with a clear budgetary arrangement and management responsibilities agreed upon among MOHP, HIO and MOE and the institutionalization of the SHC at the governorate level and the ISHC at the school level.
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**3-4. Implementation Process of the Project****3-6-1 Promoting Factors****(1) Effective Horizontal Cooperation and Collaboration**

- There has been an effective horizontal cooperation and collaboration among the three organizations at all central, governorate, district and school level.
- Especially the cooperative working relationship fostered among ISHC committee members at each pilot school has facilitated project implementation.

**(2) Strong Commitment by the Egyptian Project Personnel**

- The Egyptian project personnel at the governorate level have shown a strong commitment in implementing project activities. They have actively contributed their technical inputs for developing dissemination tools and facilitating the development of the HPS model.
- Through more frequent interaction, the relationship between the Egyptian project personnel at the central level and the Japanese expert team has substantially improved in the year preceding the terminal evaluation. They have demonstrated a strong commitment and leadership in revising and finalizing M&G.

**(3) Focus of the "Practicality" of the Health Promotion School Model**

- The project has taken a "school-based approach" to focus on the practicality of the HPS model. Using the approach, the Project was able to reflect actual conditions of schools (the availability of material, financial and human resources at rural schools) in the development of dissemination tools. The bottom-up approach encouraged ISHC members, especially social workers and school nurses, to be resourceful and proactive in school health activities and the Egyptian project personnel at the governorate level to fully contribute their technical inputs.

**(4) Continuous Efforts to Improve Communication and Establish Trust Relationship**

- While there was a problem of communication and information sharing between the Japanese expert team and the Egyptian project personnel at the central level, greater efforts to improve the relationship have been made by both sides.



- The Japanese expert team has increased the frequency of project progress reporting to The Egyptian project personnel at the central level from every two to three weeks before the Mid-term Review to every one to two weeks after the Mid-term Review. Both side's continuous efforts to create an open line of communication facilitated the project implementation.

### 3-6-2 Impeding Factors

#### (1) Difference in Understanding about Project Inputs

- In the first half of the project period, the project implementation was delayed because of the time required to resolve the difference between the Egyptian project personnel and the Japanese expert team in the understanding of administrative management issues. While the issues were resolved eventually after a series of discussions and negotiations, the time taken for reaching agreement delayed the project implementation.

#### (2) Social Political Insecurity

- The Project activities were suspended for four months following the Egypt's Revolution in January 2011 and the socio-political insecurity occurred as an aftermath of the event. The unexpected temporary halt of the Project delayed the project implementation process.

## 4. Evaluation Results

### 4-1. Evaluation by Five Criteria

<p><b>Relevance: High</b></p> <p>The Relevance of the Project has been assessed as high because the improvement of school health services are in line with the development policy of the Egyptian Government, the Japanese Government's aid policy to Egypt, and the needs of Egyptian people.</p> <ul style="list-style-type: none"> <li>• Egypt has a national policy that the health-insurance system covers all citizens. In 2012 MOHP developed the <i>Strategic Vision for Improving Health Care Services and Nursing in Egypt</i> which included its strategy to improve children's health through school health service promotion activities.</li> <li>• The Japanese aid policy towards Egypt, discussed in the <i>Country Assistance Program for the Arab Republic of Egypt</i>, includes poverty reduction and improvement of living standards, which encompasses an assistance policy for the enhancement and improvement of public services, particularly the support for the improvement of impoverished medical care services. This project is also in line with the <i>Health and Development Initiative (2005)</i> and <i>Japan's Global Health Policy (2011-2015)</i>.</li> <li>• Egypt is currently facing an epidemiological transition characterized by a rising prevalence of risk factors such as obesity, smoking and hypertension. The new health challenges require preventive care starting from the youth; however school health services to school children in Egypt, especially in rural areas, have not been sufficiently provided.</li> </ul>
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**Effectiveness: High**

The Effectiveness of the Project has been assessed as high, judging from the achievement level of the Project Purposes.

- The first Project Purpose (improvement of school health services in the Tammia district) is assessed to be mostly achieved. The Project has achieved this through a series of workshops and training conducted to a wide range of people involved in school health services at all central, governorate, district and school level. At the 20 pilot schools and the 5 non-pilot schools that have been paired with center schools, health promotion activities have increased and monitoring has been appropriately conducted.
- While tangible improvements of school health services are observed from the Base-line survey to the End-line survey in key indicators at the 20 pilot schools, there are still issues to be addressed for the services to be truly satisfactory.
- The issues that need to be addressed are: continuous service training of school doctors and school nurses to improve their technical capacity, an increase in availability of first-aid kits, medicines, and school doctors and nurses, and an increase in public awareness of school health promotion.
- The second Project Purpose (the development of the framework to disseminate the HPS model in Upper Egypt) is assessed to be most likely achieved by the end of the project period. Most of the components of the dissemination tool package (M&G, DVD/CD on comprehensive medical examination, and three leaflets on school health service promotion) have been developed. The Project piloted school-to-school approach for dissemination, in which 5 non-pilot schools were trained on HPS by the paired center schools. Elaboration on the framework for dissemination has been started and series of dissemination workshops are already scheduled. With the development of the Dissemination Guidelines, and successful implementation of dissemination training workshops, the prospect for achieving the second Project Purpose is highly promising.

**Efficiency: Medium**

The Efficiency of the Project has been assessed as medium, judging from the extent to which project inputs have economically converted into outputs.

- Inputs planned in the PDM have mostly been allocated by the Egyptian and Japanese sides.
- The Project focused on its trial implementation of the HPS model to the 20 pilot schools. The concentration of the activities and inputs on the 20 pilot schools enabled the Project to fully test the feasibility of the HPS model that can be disseminated to other governorates across Upper Egypt. However, the Project's trial dissemination of the HPS model has been conducted to only five non-pilot schools using school-to-school approach. Other complimentary approach of dissemination may need to be elaborated to increase efficiency.
- From January to May 2011, the Project was suspended for four months. The Project has responded flexibly to the situation and has successfully converted Inputs into planned

Outputs. One of notable flexible actions taken by the Project includes the use of technical inputs by local experts in school health services to produce the dissemination tools.

**Impact: Medium**

The Impact of the Project has been assessed as medium because the prospect for achieving the Overall Goal (promoting school health in Upper Egypt through the expansion of the HPS model and school health services) within three to five years after the completion of the Project is still uncertain.

- Comparing the results of the End-line Survey in 2012 with those of the Baseline Survey in 2009, some key indicators at pilot schools have improved. Positive changes are observed in the areas of: personal hygiene (e.g. the percentages of students who wash their hands before eating and after using bathroom, and of students who brush their teeth) and school environment (the percentage of students who reported that people smoke inside classrooms.) The improvement in key indicators provides a positive prospect for school health promotion in terms of technical feasibility.
- The improvements of some key indicators are also observed in non-pilot schools in the areas of personal hygiene and the establishment of an (internal) school health committee. According to the interviews conducted to the SHC members in the Fayoum Governorate, the improvements are partially attributable for proactive roles in disseminating school health activities played by monitoring/supervisory personnel from MOHP, HIO, and MOE.
- No positive changes are observed among indicators for students' physical conditions, such as the percentage of students who missed classes because of sickness in the current school year and the percentage of students who never do physical activities for more than 60 minutes per day. The terminal evaluation team ascertains that this is likely that the socio-political insecurity affected the results in 2012. Since it is too premature to observe the Project effects' on children's physical conditions, key indicators need to be followed-up over a long time span.
- The process for dissemination has only begun with two introductory workshops conducted in March 2010 and June 2012. By the end of the project period (November 2012), the Project plans to conduct: four two-day-training workshops for dissemination; trial operations of the HPS model in each governorate in Upper Egypt; a follow-up workshop to receive feedback from the trial operations and reflect it to the Dissemination Guidelines; the finalization of the Guideline; and a dissemination workshop for development partners.
- The main inhibiting factor that makes the prospect for the Overall Goal's achievement uncertain is that explicit plan is yet to be developed for the dissemination of the HPS model to be conducted after the Project. It should be noted that one of the most positive changes created by the Project is a cooperative working relationship among MOHP, HIO, and MOE. Thus, there is a ground on which the provision of school health services will be expanded through joint efforts by the three organizations if a joint activity plan is developed and agreed upon.



- There has been limited contact with other development partners involved in school health. Since there are other school health related programs in Egypt, such as the school health program by WHO and a proposed medical examination program by the Arab Medical Union, there is an opportunity whereby cooperation with other partners creates synergetic effects for the improvement of school health services and facilitates the achievement of the Overall Goal.

**Sustainability: Medium**

The Sustainability of the Project has been assessed as medium from the intuitional, organizational, financial, and technical perspective.

- The Project's institutional sustainability is high. MOHP developed the *Strategic Vision for Improving Health Care Services and Nursing in Egypt (2012)*, which includes the ministry's strategy to improve children's health through school health service promotion activities. The inclusion of school health service promotion activities in its policy paper indicates the Egyptian Government's institutional commitment to school health.
- Furthermore, the MOHP issued the Ministerial Decree of 396/2012, which provides for the re-starting of activities of the School Health Promotion Committee, which includes MOHP, HIO, and MOE at the central level in its members. The re-establishment of a non-project-based coordination body for school health services strengthens institutional sustainability.
- The Project's organizational sustainability is medium. Roles and responsibilities of MOHP, HIO, MOE and their local offices in the implementation of school health services have been clearly defined in M&G, which ensures organizational sustainability to some extent. However, the terminal evaluation team found in the interviews that some Egyptian project personnel and project related personnel (including ISHC members) consider school health services as "extra" tasks, not part of their regular tasks. There is a need to ensure that the promotion of school health services is fully integrated to regular tasks and is regarded as "must-do" tasks for those who are in the positions to implement or monitor the services.
- The Project's financial sustainability is medium as there is no post-Project activity plan for school health service promotion with a clear budgetary arrangement agreed upon among MOHP, HIO and MOE. There has been a drastic increase in expenses covered for training in school health and related services by MOHP. The training expenses were increased from approx. LE 94,000 in FY 2010/2011 to approx. LE 486,000 in FY 2011/2012. Furthermore, MOHP has proposed LE 830,000 for the FY 2012/2013 training for dissemination of the HPS model to other governorates. The total budget requested by SACHD, MOHP for the promotion of school health services in FY 2012/2013 is LE 2 million and for monitoring and evaluation of SACHD's projects including school health services is LE 1 million. This trend indicates a strong commitment from MOHP to ensure financial sustainability.
- The Project's technical sustainability is high. The Project has trained a sufficient number of core personnel at the governorate level in Fayoum Governorate and at the central level to continue the implementation and dissemination of school health services in the Tammia

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District and eventually throughout other governorates. The number of core personnel is also expected to increase with upcoming four training workshops for dissemination in the remaining period of the Project.

#### 4-2. Conclusion

Overcoming many implementation challenges, the Project is most likely to achieve its stated purpose of (1) the improvement of the quality of school health services in the district through the dissemination of the concept of Health Promotion School, and (2) the development of the framework to disseminate Health Promotion School in Upper Egypt.

Firstly, the Project developed a practical monitoring and supervisory mechanism for school health services with a close consultation among MOHP, HIO, and MOE (Output 1). Secondly, it facilitated the provision of school health services in the Tammia District through: the development of the School Health Committee (a coordination body at the governorate level); the provision of the basic medical equipment to the pilot schools' clinic; and the implementation of health education activities (Output 2). From the activities conducted under Outputs 1 and 2, the Project developed the most components of a dissemination tool package: (1) a publication, titled "Implementation Manual for School Health Services and Guidelines of Monitoring and Supervision for School Health Services" (M&G), (2) a DVD/CD on comprehensive medical examination, and (3) three leaflets on school health service promotion. Thirdly, it strengthened human resources for school health at the central, governorate, district and school level through various training courses covering extensive topics for the establishment of the Health Promotion School model and implementation of school health services (Output 3). Lastly, the Project established an Internal School health Committee at each of the 20 pilot schools, which led to an increase in the number and variety of health-related community activities.

The Project was successful in introducing HPS model based on the team approach, which transcends from the central ministries (i.e., MOHP, HIO and MOE) to the governorate, the district and the school level. By maximizing the utilization of existing resources, the approach provided a practical solution to make school health program operational in a resource-constrained setting in the Upper Egypt. The Project faced a challenge of institutionalizing such team approach in the existing government structure, but the inter- and intra-organizational cooperation and collaboration is strengthened over the course to make it possible. The scope of the current HPS model is limited to essential activities but it can be expanded depending on the availability of additional resources.

In consideration of the solid technical foundation and the ownership by MOHP, HIO, and MOE to promote school health further, it is concluded that the Project be terminated as planned.

## **5. Recommendations and Lessons Learned**

### **5-1. Recommendations**

Taking the above analysis into consideration, the following measures are recommended to be taken in order to ensure the achievement of the Project Purpose and to increase the sustainability of the Project:

#### **(1) Development of a Post-Project Activity Plan for School Health Service Promotion**

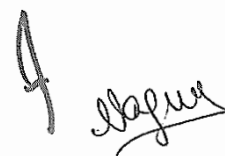
The Project's sustainability is negatively affected by the absence of an explicit post-Project activity plan for school health service promotion and a clear budgetary arrangement and management responsibilities agreed upon among MOHP, HIO and MOE. It is recommended that in consultation with all relevant organizations, the Project facilitates the development process of the annual activity plan so that necessary budgets will be earmarked for the next fiscal year and onward. In consideration of the dissemination strategy from pilot to other schools, it is further recommended that the Project should consider several practical approaches based on the analysis of experiences in the Tammia District, taking due consideration of the potential roles that monitoring and supervisory personnel from MOHP, HIO, and MOE can play in the dissemination of the HPS model.

#### **(2) Coordination with Other Development Partners**

The terminal evaluation team recommends that the Project, under the leadership of the Egyptian project personnel, seek cooperation with other donors and prospective partners, especially with the World Health Organization (WHO), through direct consultation and information sharing in the Donor Assistant Group-Thematic Group for Health and Population. Through such consultation, the project should endeavor to find a way in which other development partners contribute to the dissemination of the HPS model while the Project provide technical inputs.

#### **(3) Uploading M&G and Other Dissemination Tool onto the Websites**

The Project printed 1,000 Arabic copies of M&G and each of three leaflets. It is recommended that M&G and leaflets be uploaded onto the websites of MOHP, HIO and MOE so that any interested parties, such as any government officials responsible for school health services, donors, NGOs, and researchers, have an access to the materials. This measure also serves as a measure taken in advance for loss of distributed copies.



#### **(4) Continuous Effort to Improve Information Sharing and Communication**

The Project plans to conduct many activities related to the dissemination of the HPS model within the limited time period until the end of the Project. In order to ensure successful implementation of these activities, a cooperative working relationship between the Japanese expert team and C/P is indispensable. The terminal evaluation team recommends that both sides make continuous efforts to build even closer and more open communication and a stronger “teamwork” spirit in order to successfully complete all the remaining tasks.

##### **5-1-1 Measures to be Taken by the Egyptian Government after the Project**

#### **(1) Institutionalization of the School Health Committee at the Government Level and the Internal School Health Committee at the School Level**

Some Egyptian project personnel and project related personnel (including ISHC members and school doctors) consider the promotion of school health services as “extra” tasks, not part of their regular tasks. From the perspective of the sustainability, the promotion of school health services need to be fully integrated into their regular tasks and is regarded as a mandatory task for those who are in the positions to implement or monitor the services. It is recommended that the School Health Committee at the governorate level and the Internal School Health Committee at the school level be institutionalized, possibly by a joint ministerial ordinance by MOHP, HIO, and MOE. It is recommended that this issue be discussed by the School Health Promotion Committee re-established through the Ministerial Decree of 396/2012.

#### **(2) Recognition on Significance of School Health in Egyptian Context**

Egypt is currently facing an epidemiological transition characterized by a rising prevalence of risk factors such as obesity, smoking and hypertension. As stressed in the Mid-term Review, school health should be recognized as a long-term strategy to deal with new health challenges in Egypt. The school is an ideal place to educate children on healthy lifestyle choices (e.g. healthy diet, personal hygiene, non-smoking, and regular physical exercise) that affect their long-term physical well-being and increase the public awareness for healthy lifestyle choices through children. Children can play the catalytic role of a “health ambassador” to transmit health-related messages to their family and community members.

It is recommended that promoting school health programs, especially preventive care and health education, should be widely-recognized as an investment to improve the current academic performance and to cut the future medical expenditures. Key health indicators at the pilot schools should be followed-up to support this strategy/investment and to maintain a strong basis for continuous commitment for school health services by MOHP, HIO, and MOE.

### **(3) Continuous Search for Solving the Issues of the Shortage of Doctors**

The result of the End-line Survey shows that in order for school health services to be truly satisfactory to the parents and students, the issues of the school doctor shortage and the insufficient supply of the first-aid medicines at schools must be solved. It is recommended that the Egyptian Government continue its efforts to address and resolve these issues.

#### **5-2. Lessons Learned**

##### **5-2-1 Importance of Inter-organizational Coordination and Collaboration**

Success of a school health program in a resource limited setting depends on the good coordination and collaboration between stakeholders in charge of health and education at all levels. In the case of Egypt, good tripartite working relationship among MOHP, HIO and MOE, which was strengthened over the project period at all level, was critical in producing expected results. In a project where inter-organizational coordination and collaboration is essential, it is desirable that roles and responsibilities of each organization be defined before the commencement or in the early stage of project implementation. Roles and responsibilities of development partners, including prospective inputs to the project and need for cost-sharing, should be clarified in accordance with their respective regulations to ensure sustainability of project activities.

##### **5-2-2 Appropriate Procedure for the Development of Manuals and Guidelines**

Development of technically sound and operationally feasible manuals and guidelines requires rigorous and participatory process of incorporating inputs from diverse stakeholders, from policy to operational levels. Such process is time consuming but will improve the overall effectiveness and efficiency as acceptability of the end product is likely to be high. The Project spent considerable amount of time for the development and finalization of M&G and its practicality and user-friendliness is highly appreciated. Need for such rigorous and participatory process and time required should be taken into consideration in designing similar projects. Utilization of local expertise in documentation of guidelines and manuals, in a context where such resources are available, may be a viable option to improve communicability and socio-cultural acceptability of such documents.

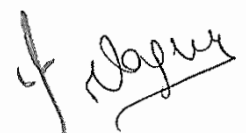
##### **5-2-3 Maximum Utilization of Existing Human Resources**

In a resource-limited setting, maximum utilization of existing and available resources, especially human resources, should be encouraged through team approach. The Project was successful in mobilizing existing personnel such as social workers, population and environment

teachers, computer teachers and the parents for the purpose of promoting school health under the leadership of the school principals through ISHCs. However, the procedure for institutionalization of such newly added functions need to be incorporated in project activities in order to ensure sustainability.

#### **5-2-4 Appropriate Use of Baseline and Endline Surveys**

Appropriately designed baseline and endline surveys can provide valuable information for the evaluation of projects and the verification of project approaches. Such information is essential for evidence-based policy recommendations and should be applied to the projects focusing on pilot activities. However, such surveys need to be carefully designed in order to obtain relevant information and to avoid confusion. The results of the endline survey of the Project were valuable in providing information on changes associated with the project implementation in the pilot schools, but questions were raised over relevance of some of the results. It should be noted also that, while data collection and analysis can be out-sourced to institutions specialized in research; interpretation of the results requires direct involvement of the personnel who has hands-on knowledge about the project implementation and its context.



### Annex 1: Detailed Schedule of the Evaluation

Day	Date	Activities	Location
17-June	Sun	Arrival in Cairo (Ms. Setsuko Kanuka [Evaluation Analysis]) • Meeting with the JICA Egypt Office • Meeting with Japanese experts	Cairo
18-June	Mon	Interviews with: • MOHP at the central level • MOE at the central level	Cairo
19-June	Tue	Interviews with: • HIO Fayoum • MOE Fayoum	Fayoum
20-June	Wed	Interviews with: • MOHP Fayoum • Saleh Salem Primary School	Fayoum
21-June	Thu	Interviews with: • Menshat El Gamal BE School • Kafr Mafouz BE School	Fayoum
22-June	Fri	Data analysis	Cairo
23-June	Sat	Data analysis	Cairo
24-June	Sun	Interview with: • World Health Organization	Cairo
25-June	Mon	Interviews with: • HIO at the central level • Arab Medical Union	Cairo
26-June	Tue	Interviews with: • MOHP at the central level (Head of the Primary Health Care and Nursing Sector) • Japanese experts	Cairo
27-June	Wed	Participation in Dissemination Workshop	Cairo
28-June	Thu	Participation in Dissemination Workshop	Cairo
29-June	Fri	Report Writing	Cairo
30-June	Sat	Report Writing	Cairo
1- July	Sun	• Arrival in Cairo (Mr. Ikuo Takizawa [Leader], Mr. Yuki Matsuyama [Evaluation Planning]) • Meeting with JICA Egypt Office	Cairo
2-July	Mon	Interviews with: • Tammia School for Girls (primary) • Saweris BE School	Fayoum
3-July	Tue	• SHC meeting • Finalization of the Evaluation Report	Fayoum
4-July	Wed	• Discussions on the draft terminal evaluation report with Egyptian Project Personnel at the Central Level	Cairo
5-July	Thu	• JCC meeting • Report to JICA Office and Japanese Embassy	Cairo
6-July	Fri	Departure from Cairo	Cairo

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## Annex 2: Project Design Matrix

**Project Title:** Promotion of School Health services in Upper Egypt  
**Target Area:** Tammaia District in Fayoum Governorate  
**Duration:** November 2008–November 2012

Prepared on October 27, 2010

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
<p><b>Super Goal:</b> Health status of school children in Upper Egypt is improved.</p> <p><b>Overall Goal:</b> School health is promoted by expanding Health promotion school* and school health services in Upper Egypt.</p>	<p>Health indicators</p> <ol style="list-style-type: none"> <li>1. Health promotion schools are introduced to more than 5 governorates in Upper Egypt.</li> <li>2. SACHD, MOH is providing regular training on school health based on monitoring on pilot schools in Tammaia.</li> <li>3. Some health indicators that are collected in the proposed monitoring mechanism are improved.</li> </ol>	<p>Record of school physical check-up</p> <ol style="list-style-type: none"> <li>1. Records of monitoring/supervisory at district, governorate and central level.</li> <li>2. Interview with school doctor, nurse, teacher, and representative of parents committee</li> <li>3. Health survey data</li> </ol>	
<p><b>Project Purposes:</b></p> <ol style="list-style-type: none"> <li>1. The quality of school health services in Tammaia district is improved through the dissemination of the concept of Health Promotion School*.</li> <li>2. The framework to disseminate Health Promotion School in Upper Egypt is prepared.</li> </ol>	<ol style="list-style-type: none"> <li>1-1 More than half of students, parents, and teachers are satisfied with the school health services.</li> <li>1-2 Internal School Health Committee Members at 20 pilot schools judge that the provision of school health services is improved.</li> <li>2-1 The concept of Health Promotion School is elaborated</li> <li>2-2 The tools for dissemination of Health Promotion School are developed.</li> </ol>	<ol style="list-style-type: none"> <li>1-1 Baseline Survey, Endline Survey (both quantitative and qualitative survey)</li> <li>1-2 Project records (monitoring and supervision records)</li> <li>2-1 The concept of Health Promotion School</li> <li>2-2 The tools of dissemination (The national action plan, the Implementation Manual, Monitoring Guidelines, training modules etc.).</li> </ol>	<p>Strong commitment by the Government of Egypt is maintained.</p>

\* Health promotion school is defined as those schools that (1) being equipped with appropriately functioning school clinic, (2) provide the school health services in the fields of 1) health education, 2) family and community participation, 3) school environment, 4) water and sanitation, and 5) health care services, in accordance with the developed guidelines, manuals and plans, 3. supported by monitoring and supervisory systems of the school health, and 4. with participation of teachers, parents, students and communities.



Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
<b>Outputs:</b> 1. Monitoring and supervisory mechanism on school health is developed at district level and is strengthened at governorate/central level.	1-1 Monitoring and supervision are conducted regularly (frequency and the contents are based on the guideline of monitoring/supervision by schools and administration)	1-1 Record of the project (monitoring and supervision records.)	a. The personnel trained in the Project are not transferred to other positions. b. Serious epidemic outbreaks do not occur.
2. The provision of school health services is facilitated in Tammia district.	2-1 The number of the Health Promotion School is more than 20 on the basis of the improvement of the following indicators. a. Number of health health activities b. Number of community participation activities c. Number of school environment activities/Regular maintenance d. Number of water and sanitation activities/Regular maintenance e. Health examination coverage	2-1. Record of the Project	
3. Human resources for school health are strengthened.	3-1 Self-Evaluation after the training (number of personnel trained, post training/workshop evaluation by the trainees)	3-1 Training/workshop records 3-2 Self-evaluation 3-3 Minutes of ISHC, attendance of ISHC meetings	
4. Supporting activities of Health Promotion School by supporters such as teachers and parents are strengthened.	4-1 At least one good practice** of health promotion school is conducted in collaboration with schools and communities among 20 pilot schools. 4-2 Number of community people who attend supporting activity is increased among 20 pilot schools.	4-1 Record of the Project 4-2 Record of the Project	

\*\* "Good practice" means that some activities collaborate with community.

Narrative Summary	Inputs	Pre-Conditions
<p><b>Activities:</b></p> <p>1-1 To select pilot Health Promotion Schools</p> <p>1-2 To conduct the baseline survey</p> <p>1-3 To analyze the baseline survey data</p> <p>1-4 To comprehend the actual situation of the monitoring and supervisory mechanism on school health</p> <p>1-5 To organize taskforces and conduct training/workshop to develop and use guidelines and practical manual for the monitoring of school health services</p> <p>1-6 To draft the Guidelines of Monitoring and Supervision for School Health Services</p> <p>1-7 To draft the plan of monitoring and supervision of school health services</p> <p>1-8 To implement the draft Guidelines of Monitoring and Supervision for School Health Services</p> <p>1-9 To revise the draft Guidelines of Monitoring and Supervision for School Health Services</p> <p>2-1 To establish School Health Committee (SHC) for coordination of the Project</p> <p>2-2 To ensure and prepare the core place (school clinic) at each pilot school</p> <p>2-3 To provide the basic medical equipment for the school clinics of the pilot schools</p> <p>2-4 To organize taskforces and conduct training/workshop to develop and use school health manual</p> <p>2-5 To draft the Implementation Manual for School Health Services</p> <p>2-6 To provide school health services in accordance with the draft Implementation Manual for School Health Services</p> <p>2-7 To revise the Implementation Manual for School Health Services</p> <p>2-8 To develop health education materials and leaflets for community awareness raising</p> <p>2-9 To implement health education at schools</p> <p>2-10 To finalize health education methods and health education materials</p> <p>2-11 To discuss flexible allocation of school health service providers, such as school doctors and health visitors with SHC</p> <p>3-1 To conduct training on school health to administrative officers at national, governorate and district levels</p> <p>3-2 To conduct regular training/workshop to school health personnel (health visitors, teachers, social workers etc.) of the pilot schools</p> <p>3-3 To conduct training/workshop for the school doctors and nurses in Tammia district</p> <p>3-4 To conduct training on the use of the Implementation Manual for School Health Services and the Guidelines of Monitoring and Supervision for School Health Services</p> <p>3-5 To develop job description for school doctors and health visitors</p> <p>3-6 To discuss the pre-service training curriculum for school doctors and health visitors</p> <p>3-7 To implement the training/workshop for the dissemination of school health activities of Health Promotion School</p> <p>3-8 To implement the dissemination seminar of school health activities of Health Promotion School</p> <p>3-9 To formulate a national action plan, based on the experiences in Tammia district, in order to apply the practical model of Health Promotion School to other governorates</p> <p>3-10 To conduct the distant technical cooperation</p> <p>4-1 To run a school health campaign for awareness raising among parents and community</p> <p>4-2 To activate internal school health committees of each pilot school</p>	<p><b>Egyptian Side</b></p> <ol style="list-style-type: none"> <li>1. Assignment of counterpart personnel</li> <li>2. Provision of administration facilities (Office Space)</li> <li>3. School clinic space of 20 pilot schools</li> <li>4. Expense for Training (transportation, per diem)</li> </ol> <p><b>Japanese Side</b></p> <ol style="list-style-type: none"> <li>1. Japanese experts</li> <li>2. Local experts</li> <li>3. Equipment</li> <li>4. C/P training</li> </ol>	<ol style="list-style-type: none"> <li>a. Changes of MOHP Policy (Health Sector Reform) do not hinder Project's activities.</li> <li>b. Other organizations do not oppose the cooperative relationship with Project.</li> <li>c. Target area (district) accepts the Project.</li> </ol>

### **Annex 3: List of Main Interviewees**

#### **(1) MOHP**

##### **MOHP-Central Level**

- Dr. Emad Ezzat, Head of the Primary Health Care and Nursing Sector
- Dr. Nagwa El Ashry, Project Manager, General Director of the School-Age Health Care Department (SACHD), Primary Health Care (PHC)
- Dr. Sahar M. Ahmed, Specialist, SACHD, PDC

##### **MOHP-Fayoum Level**

- Dr. Emam Mohamed Mousa, Undersecretary of Health
- Dr. Anwer El-Sewafey, Director of Preventive Department, Deputy of Underscretary
- Dr. Farag Abd El Moaez, Director of Health Education
- Dr. Mohamed Tharwat, General Director of Endemic Disease Control

#### **(2) HIO**

##### **HIO-Central Level**

- Dr. Elsaka Abdel Irahman Mohamed, Chairman
- Dr. Mohsen George, Chairman of Medical Officer
- Dr. Wefky Fouad Wefky, School Health
- Dr. Nasr Diab, in Charge of School Health
- Dr. Nierin Labib, General Manager of Medical Service

##### **HIO-Fayoum Level**

- Dr. Hosam El Saka, General Director
- Dr. Mohsen Gonnaa, Director of School Health
- Dr. Fakhry Farag, Director of Health Education
- Dr. Osama El Garhy, Manager of School health Insurance in Urban Fayoum

#### **(3) MOE**

##### **MOE-Central Level**

- Mr. Mosad Maklad, Expert in Environmental and Population Education Department

##### **MOE-Fayoum Level**

- Mr. Hassan Hegazy, Undersecretary of Education
- Mr. Gamal Abdel Hakem, General Director of Education Service
- Ms. Zeinat Yuusef, Director of Environmental and Population Education Department

##### **Saleh Salem Primary School**

- Mrs. Huda Sayed Mohamd, School Principal
- Mrs. Magda Shaker Slama, Social Worker
- Mr. Gama Atyya Mohamd, Computer Teacher
- Mr. Abdulla Mostafa Mohamed, Health and Population Teacher



**Menshat El Gamal BE School (Center School)**

- Mr. Awad Mohamed Abdel Salam, School Principal
- Mrs. Souad Mohamed Saleh, Health Visitor
- Mr. Mohmoud Atyya, Social Worker
- Mr. Mohamed Rabia, Computer Teacher

**Kafr Mafouz BE School**

- Mr. Sayed Mohamed Ismail, School Principal
- Ms. Afaf Abdullah, Health Visitor
- Mr. Mohamed Sayed Abdulsalim, Social Worker

**Tammia School for Girls (Center School)**

- Mr. Aluned Fahmy, School Principal
- Mrs. Ahadia Thabet Othman, Health Visitor
- Mrs. Asma Fathy Ali, Social Worker
- Mr. Ali Sayed Ali, Environment and Population Teacher
- Mr. Usama Abdel Sattar, Computer Teacher
- Mr. Ali Malunoud Mahamed Ahmed, parent

**Saweris BE School**

- Mr. Mohmed Mahdy Hussein, School Principal
- Mrs. Hanan Shaaban Mohamed, Health Visitor
- Mr. Mustafa Abdel Hameed, Social Worker
- Mr. Ragab Mouwad, Environment and Population Teacher
- Mr. Hussein Masoud, Computer Teacher

**(4) Japanese expert team**

- Mr. Tateo Kusano, Project Chief Advisor/School Health Monitoring
- Ms. Akiko Hayashi, Health Education and Information, Education and Communication (IEC)
- Ms. Mami Ishii, Training Programme
- Ms. Maki Tanaka, Institutional Development

**(5) World Health Organization**

- Dr. Nacema Hassan Al. Gasseer, WHO Representative for Egypt (Acting)
- Dr. Hala El Hennaway, National Professional Officer
- Dr. Amira El Malatawy, Technical Officer

**(6) Arab Medical Union**

- Dr. Ebrahim El Zaafarani, General Secretary of the Arab Medical Union
- Dr. Abdel Rahim Mohamad, General Manager of Internal Projects
- Mrs. Nermine Yousri El Chechtawy, Public Relations Manager



## Annex 4: Evaluation Grid

This evaluation grid is comprised of three sections: (1) project achievements, (2) project implementation process, and (3) evaluation by five criteria (Relevance, Effectiveness, Efficiency, Impact, and Sustainability).

### SECTION I: PROJECT ACHIEVEMENTS

Evaluation Questions		Results
Main Questions	Sub Questions	
<p>Achievement level of the Overall Goal</p>	<p>To what degree has the Overall Goal been achieved?</p> <p><u>Overall Goal:</u> School health is promoted by expanding Health Promotion School and school health services in Upper Egypt.</p>	<p><b>OVI 1: Health Promotion Schools are introduced to more than 5 governorates in Upper Egypt</b></p> <ul style="list-style-type: none"> <li>• On the 27th and 28th of June, 2012, the second dissemination workshop was held in Cairo to explain trial results of the HPS model at the 20 pilot schools in Tammaia District to MOFP, HIO, and MOE representatives from their headquarters and all Governorates in Upper Egypt. The training covered how to implement the HPS program and to distribute HPS dissemination tool packages.</li> <li>• For the remaining project period, the Project plans to conduct the followings:               <ul style="list-style-type: none"> <li>- From July to August 2012: training workshops for dissemination in Aswan, Luxor, Fayoum, and Asyut, with the participation of nine Governorates;</li> <li>- From August to September 2012: trial operations of the HPS model at each governorate (one school will be selected from each Upper Egypt governorate for implementing the HPS model by those who are trained in the training workshop mentioned above.);</li> <li>- In September 2012, a follow-up workshop in Cairo for the above-mentioned trial operations with the participation of representatives from all governorates in Upper Egypt; and</li> <li>- In October 2012: the HPS Dissemination Workshop for development partners to share information, M&amp;G and the Dissemination Guidelines.</li> </ul> </li> </ul> <p><b>OVI 2: SACHD, MOHP is providing regular training on school health based on monitoring on pilot schools in Tammaia.</b></p> <ul style="list-style-type: none"> <li>• Bi-annual training sessions targeting school nurses and doctors are planned to be conducted by MOHP and HIO, and other bi-annual training sessions targeting social workers and teachers are planned to be conducted by MOE.</li> <li>• SACHD, MOHP has been providing regular training on school health to the other governorate, most notably the Gharbia Governorate.</li> </ul> <p><b>OVI 3: Some health indicators that are collected in the proposed monitoring mechanism are improved.</b></p> <ul style="list-style-type: none"> <li>• Comparing the results of the End-line Survey conducted in 2012 with those of the Baseline Survey conducted in 2009, some preventative health indicators at pilot schools have improved in the areas of personal hygiene (e.g. the numbers of students who wash their hands before eating and after using bathroom, and the number of students who brush their teeth) and school environment (percentage of students who reported that people smoke inside classrooms.) (See Annex 6-3 Results of Key Indicators in the End-Line Survey).</li> </ul>

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Evaluation Questions		Results
Main Questions	Sub Questions	
<p>Achievement level of the Project Purposes</p> <p>To what degree have the Project Purposes been achieved?</p> <p>Project Purposes:</p> <ol style="list-style-type: none"> <li>The quality of school health services in Tammia district is improved through the dissemination of the concept of Health Promotion School.</li> <li>The framework to disseminate Health Promotion School in Upper Egypt is prepared.</li> </ol>	<p>To what degree has Output 1 been achieved?</p> <p>Output 1: Monitoring and supervisory mechanism on school health is developed at district level and is strengthened at governorate/central level.</p>	<p><b>OVI* 1-1: More than half of students, parents, and teachers are satisfied with the school health services.</b></p> <ul style="list-style-type: none"> <li>According to the results from the End-line Survey, more than half of the students (60% of primary school students and 48% of preparatory school students), and the majority of teachers and the Board of Trustees (incl. some parents) from pilot schools consider that school health services have improved in the last two years. The positive changes reported are: (1) the increased provision of health-related information and activities, (2) the greater availability of equipment and medicines in school clinics; and (3) the increased frequency of school visits by health visitors and doctors.</li> <li>In the same survey, some parents of the students from pilot schools did not concur with the above, claiming that there was no improvement in school health services.</li> <li>The survey also shows that students, parents, and teachers consider that school health services have not achieved the satisfactory level, especially in regard to medical check-ups.</li> </ul> <p><b>OVI 1-2: Internal School Health Committee Members at 20 pilot schools judge that the provision of school health services is improved.</b></p> <ul style="list-style-type: none"> <li>According to the ISHC Survey, all 114 respondents from 20 pilot schools reported that school health services at their schools had improved in the last two years (82% of the respondents [93 persons] reported that "school health services have improved very much" and 18% [21 persons] answered "school health services have fairly improved.")</li> </ul> <p><b>OVI 2-1: The concept of Health Promotion School is elaborated.</b></p> <ul style="list-style-type: none"> <li>Based on the discussions held in the first year between the Egyptian project personnel and the Japanese expert team, the definition of the HPS concept was agreed upon among all relevant organizations, which was inserted in the PDM revised in October 2010 (See Annex 2 Project Design Matrix).</li> </ul> <p><b>OVI 2-2: The tools for dissemination of Health Promotion School are developed.</b></p> <ul style="list-style-type: none"> <li>The following HPS dissemination tools have been developed by the Project: (1) a publication, titled "Implementation Manual for School Health Services and Guidelines of Monitoring and Supervision for School Health Services" (M&amp;G), (2) a DVD/CD on comprehensive medical examination, and (3) three leaflets on school health service promotion (See Annex 6-2 List of Publications). The Dissemination Guidelines that summarize how to implement a HPS model are in the process of being developed.</li> </ul> <p><b>OVI 1: Monitoring and supervision are conducted regularly (the frequency and contents are based on the guideline of monitoring/ supervision by schools and administration)</b></p> <ul style="list-style-type: none"> <li>The Project developed the Guidelines of Monitoring and Supervision for School Health Services, which clearly define roles and responsibilities of all those who are related to the monitoring and supervision of school health activities at the central, governorate, and school level. The guidelines were developed as follows: <ul style="list-style-type: none"> <li>The Project formed five theme-based taskforces in August 2009 to prepare a draft of the Guidelines of Monitoring and Supervision for School Health Services. Each taskforce consists of 9-10 members: 1 leader (school manager [SM]), two or three (Egyptian project personnel), and five members (teachers, social worker [SW], health visitor [HV], school doctor [SD], and school nurse [SN]).</li> <li>The draft was printed in December 2009. In June 2010, the Monitoring Team (MT) was formed to revise and finalize the guideline. The MT is composed of the Egyptian project personnel from HIO Fayoum, MOE Fayoum, MOHP Fayoum, MOE Tammia, and MOHP Tammia, and one project coordinator. The finalized guideline was combined with the Implementation Manual for School Health Services and printed in June 2012.</li> </ul> </li> </ul>
<p>Achievement levels of the Outputs</p>		

Evaluation Questions		Results																																									
Main Questions	Sub Questions																																										
Achievement levels of the Outputs	To what degree has Output 1 been achieved? Output 1: Monitoring and supervisory mechanism on school health is developed at district level and is strengthened at governorate/central level.	<ul style="list-style-type: none"> <li>The monitoring and supervision of the 20 pilot schools have been conducted twice a year, once in every school semester as per the guidelines in the Tammia District (See Annex 3-2 for the List of Pilot Schools), MOHP, HIO, and MOE. The monitoring is covered by each organization.</li> <li>Top performing five out of the 20 pilot schools were selected as "center schools" (or model schools) of school health services. Each center school trained one non-pilot school on activities related to the Health Promotion School (HPS) model, including establishing an internal school health committee, implementing health education activities and self-monitoring.</li> </ul>																																									
	To what degree has Output 2 been achieved? Output 2: The provision of school health services is facilitated in Tammia district.	<p><b>OVI 2: The number of the Health Promotion School is more than 20 on the basis of the improvement of the following indicators: number of health education activities, number of community participation activities, number of school environment activities/regular maintenance, number of water and sanitation activities/regular maintenance, and health examination coverage.</b></p> <ul style="list-style-type: none"> <li>All the 20 pilot schools and one non-pilot school met the criteria of the Health Promotion School (HPS) defined in the Project. The criteria defined and the achievement level of each criteria by the 20 pilot schools and 5 non-pilot schools trained by the center schools are as follows:</li> </ul> <p>a. <b>Health education:</b> Implementation of at least one health education method</p> <p><b>Result:</b> All 20 pilot schools and 4 non-pilot schools have used more than one method in their health education activities.</p> <table border="1"> <caption>Table 1: Number of Health Education Methods Employed. (2011-2012)</caption> <thead> <tr> <th>No. of Methods</th> <th>0</th> <th>1-2</th> <th>3-4</th> <th>5-6</th> <th>7-8</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>No of Pilot Schools</td> <td>0</td> <td>12</td> <td>3</td> <td>4</td> <td>1</td> <td>20</td> </tr> <tr> <td>No. of Non-Pilot Schools*</td> <td>1</td> <td>3</td> <td>1</td> <td>0</td> <td>0</td> <td>5</td> </tr> </tbody> </table> <p>*5 non-pilot schools that have been paired up with central schools.</p> <p>The most commonly used health education methods are: lecture, health behavior questions, small group discussions and demonstrations. Pilot schools also provide health announcements at school morning gatherings. Since the morning gather announcement is not indicated in the record form, it is not being counted as one of the methods by most pilot schools.</p> <p>b. <b>Community Participation:</b> Implementation of at least one activity, in which students, parents, and/or community participate.</p> <p><b>Result:</b> All 20 pilot schools and 5 non-pilot schools have conducted at least one activity involving students, parents, and community members.</p> <table border="1"> <caption>Table 2: Number of Family and Community Participation Activities Conducted (2011-2012)</caption> <thead> <tr> <th>No of Activities</th> <th>0</th> <th>1-2</th> <th>3-4</th> <th>5-6</th> <th>7-8</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>No of Pilot Schools</td> <td>0</td> <td>3</td> <td>12</td> <td>4</td> <td>1</td> <td>20</td> </tr> <tr> <td>No. of Non-Pilot Schools</td> <td>0</td> <td>2</td> <td>3</td> <td>0</td> <td>0</td> <td>5</td> </tr> </tbody> </table> <p>The most common activities are: content, health seminars, awareness raising material making (e.g. posters), school cleaning, and awareness-raising of food safety.</p>	No. of Methods	0	1-2	3-4	5-6	7-8	Total	No of Pilot Schools	0	12	3	4	1	20	No. of Non-Pilot Schools*	1	3	1	0	0	5	No of Activities	0	1-2	3-4	5-6	7-8	Total	No of Pilot Schools	0	3	12	4	1	20	No. of Non-Pilot Schools	0	2	3	0	0
No. of Methods	0	1-2	3-4	5-6	7-8	Total																																					
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Main Questions	Evaluation Questions																																																										
	Sub Questions																																																										
Achievement levels of the Outputs	<p>To what degree has Output 2 been achieved? Output 2: The provision of school health services is facilitated in Tammaia district.</p>																																																										
	<p style="text-align: center;"><b>Results</b></p> <p>c. <b>School Environment:</b> Fulfillment of more than 70% of check-items for required school environment conditions</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <caption>Table 3: Result of School Environment Report (2011-2012)</caption> <thead> <tr> <th>Score</th> <th>&gt;69%</th> <th>70%-79%</th> <th>80%-89%</th> <th>90%-95%</th> <th>96%-100%</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>No of Pilot Schools</td> <td>0</td> <td>1</td> <td>4</td> <td>6</td> <td>9</td> <td>20</td> </tr> <tr> <td>No. of Non-Pilot Schools</td> <td>0</td> <td>0</td> <td>0</td> <td>1</td> <td>4</td> <td>5</td> </tr> </tbody> </table> <p>The conditions of school building, playground and classrooms were reported by schools themselves. Eighteen (18) pilot schools and 5 non-pilot schools were reported to have "clean" classrooms and playgrounds.</p> <p><b>Result:</b> All 20 pilot schools and 5 non-pilot schools fulfilled more than 70% of required school environment conditions.</p> <p>d. <b>Water and Sanitation:</b> Fulfillment of more than 70% of check-items for required water and sanitation conditions (conditions of water facilities in the school and toilets for boys and girls)</p> <p><b>Result:</b> All 20 pilot schools and 5 non-pilot schools scored more than 70%.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <caption>Table 4: Result of Water and Sanitation Report (2011-2012)</caption> <thead> <tr> <th>Score</th> <th>&gt;69%</th> <th>70%-79%</th> <th>80%-89%</th> <th>90%-95%</th> <th>96%-100%</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>No of Pilot Schools</td> <td>0</td> <td>2</td> <td>4</td> <td>10</td> <td>4</td> <td>20</td> </tr> <tr> <td>No. of Non-Pilot Schools</td> <td>0</td> <td>0</td> <td>0</td> <td>2</td> <td>3</td> <td>5</td> </tr> </tbody> </table> <p>The conditions of water facilities for hand-washing and toilets were surveyed. In the survey, only 12 out of 20 pilot schools reported that all drinking water taps work and only 15 out of 20 schools reported that hand-soap is available.</p> <p>e. <b>Health Care Service:</b> measurements of height, weight and vision for the majority of target students</p> <p><b>Result:</b> At all 20 pilot schools and only 1 non-pilot school, the measurements of height, weight and vision were conducted to the majority of target students.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <caption>Table 5: Medical Examination Conducted by Doctors</caption> <thead> <tr> <th></th> <th>Fully Conducted</th> <th>Partially Conducted</th> <th>Not Conducted</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Pilot Schools</td> <td>7 35%</td> <td>2 10%</td> <td>11 55%</td> <td>20 100%</td> </tr> <tr> <td>Non-Pilot Schools</td> <td>0 0%</td> <td>0 0%</td> <td>5 100%</td> <td>5 100%</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>• The measuring of school children's height, weight and vision by health visitors have become a common practice among the pilot schools.</li> <li>• The Project established the School Health Committee (SHC), comprised of the Egyptian project personnel from MOHP, HIC, and MOE, to coordinate the health promotion activities at the governorate level.</li> </ul>		Score	>69%	70%-79%	80%-89%	90%-95%	96%-100%	Total	No of Pilot Schools	0	1	4	6	9	20	No. of Non-Pilot Schools	0	0	0	1	4	5	Score	>69%	70%-79%	80%-89%	90%-95%	96%-100%	Total	No of Pilot Schools	0	2	4	10	4	20	No. of Non-Pilot Schools	0	0	0	2	3	5		Fully Conducted	Partially Conducted	Not Conducted	Total	Pilot Schools	7 35%	2 10%	11 55%	20 100%	Non-Pilot Schools	0 0%	0 0%	5 100%	5 100%
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Evaluation Questions		Results												
Main Questions	Sub Questions													
Achievement levels of the Outputs	<p>To what degree has Output 2 been achieved?</p> <p>Output 2: The provision of school health services is facilitated in Tanumia district.</p>	<p>With the appropriate coordination by SHC, the Project has successfully developed an Implementation Manual for School Health Services. The manual was developed as follows:</p> <ul style="list-style-type: none"> <li>Between June and July 2009, five theme-based taskforces were formed to develop the Implementation Manual for School Health Services (draft). Each taskforce consists of 9-10 members: 1 leader (SM), two or three (Egyptian project personnel), and five members (teachers, SW, HV, SD, and SN).</li> <li>Based on the manual developed in December 2009, a Trainers' Team (TT) was formed in June 2010 to implement training programs, develop training materials and revise the manual. TT is comprised of: school doctors, health visitors, social workers, environment and population teacher, and Egyptian project personnel from MOHP, HIO, and MOE.</li> <li>The finalized manual was combined with the Guidelines of Monitoring and Supervision for School Health Services and printed in June 2012.</li> <li>According to the End-line survey, the proportion of students who had ever received health checkup increased from 44.5% in 2009 to 77.3% in 2012 in the pilot primary schools while there was a decrease from 55.2% to 51.6% in the non-pilot primary schools. The proportion increased from 39.1% to 87.2% in the pilot preparatory schools while it decreased from 60.5% to 46.2% in non-pilot preparatory schools (See Annex 6-3 Results of Key Indicators in the End-Line Survey)</li> <li>While availability of doctors is still a constraint, the End-line survey revealed increased role of school nurses in conducting health checkups. Among the students who had ever received health checkups, those received from school nurses increased from 7.7% in 2009 to 30.7% in 2012 in the pilot primary schools, while there was a change from 5.6% to 11.2% The proportion increased from 6.4% to 42.3% in the pilot preparatory school, compared to the change from 6.3% to 16.5% in the non-pilot preparatory schools (See Annex 6-3 Results of Key Indicators in the End-Line Survey).</li> </ul>												
	<p>To what degree has Output 3 been achieved?</p> <p>Output 3: Human resources for school health are strengthened.</p>	<p><b>OVI 3: Self-Evaluation after the training (number of the personnel trained, post training/workshop evaluation by the trainees)</b></p> <ul style="list-style-type: none"> <li>The Project trained a wide range of people: administrative government officers for school health services both at the national and governorate level and members of Internal School Health Committees (i.e. school principals, social workers, teachers, school doctors and school nurses). Training covering extensive topics for the establishment of the HPS model and school health services have been successfully conducted at the 20 pilot schools and 5 non-pilot schools, but training for the dissemination of the HPS model has just started.</li> <li>In the self-evaluation surveys conducted after three health education training courses (provided in February 2009, October 2010, and March 2012), participants responded that they were satisfied with the courses; the share of those who reported positively were 98%, 100%, and 100%, respectively.</li> </ul> <p><b>Table 6: Result of Self-Evaluation of Health Education Training by a Japanese Expert (Feb. 15-17, 2009)</b></p> <table border="1"> <thead> <tr> <th>Very Satisfied</th> <th>Satisfied</th> <th>Fair</th> <th>Unsatisfied</th> <th>Very Unsatisfied</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>54 (87%)</td> <td>7 (11%)</td> <td>1 (2%)</td> <td>0(0%)</td> <td>0(0%)</td> <td>60</td> </tr> </tbody> </table>	Very Satisfied	Satisfied	Fair	Unsatisfied	Very Unsatisfied	Total	54 (87%)	7 (11%)	1 (2%)	0(0%)	0(0%)	60
Very Satisfied	Satisfied	Fair	Unsatisfied	Very Unsatisfied	Total									
54 (87%)	7 (11%)	1 (2%)	0(0%)	0(0%)	60									

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Evaluation Questions		Results	
Main Questions	Sub Questions		
Achievement levels of the Outputs	To what degree has Output 3 been achieved? Output 3: Human resources for school health are strengthened.	Table 7: Result of Self-Evaluation of Health Education Training by TT (Oct. 24-25, 2010)	
		Very Useful 52 (93%)	Not Useful 0 (0%) Total 56
	To what degree has Output 4 been achieved? Output 4: Supporting activities of Health Promotion School by supporters such as teachers and parents are strengthened.	Table 8: Result of Self-Evaluation of Refresher Training by TT (Themes 1-4: March 14, 2012, Theme 5: March 18, 2012)	
		Very Helpful 76 (88%)	Helpful 10 (12%)
Implementation of Activities	To what degree have project activities been implemented as planned?	Very Helpful 77 (91%)	Not Helpful 0 (0%)
		8 (9%)	0 (0%)
<p><b>OVI 4-1: At least one good practice of Health Promotion School is conducted in collaboration with schools and communities among 20 pilot schools.</b></p> <ul style="list-style-type: none"> <li>According to the ISHC Survey conducted by the Project in May 2012, all 20 pilot schools have carried out health-related activities in which parents and community members participated. Most common activities included health lectures and seminars and school clean-ups joined by students and parents.</li> </ul> <p><b>OVI 4-2: Number of community people who attend supporting activity is increased among 20 pilot schools.</b></p> <ul style="list-style-type: none"> <li>The ISHC Survey results indicates that among the 20 pilot schools most (19 schools) of the 20 pilot schools reported that the number of community members who participated in school health activities and the number of health-related community activities had increased in the last two years. Among them 8 schools (40%) reported that community members' participation had greatly increased and 9 schools (45%) reported that the number of community activities had greatly increased.</li> <li>According to the End-line Survey, teachers, the board of trustees, and parents reported that there is no participation by the parents or the local community in any school health activities.</li> <li>Project activities, listed in the PDM, have been successfully conducted to produce the four Outputs.</li> <li>Following the recommendation set forth in the Mid-term review, working relationship between the Egyptian project personnel and the Japanese expert team has improved and the local human resources have been effectively utilized, which accelerated the implementation of project activities.</li> </ul>			

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Evaluation Questions		Results
Main Questions	Sub Questions	
Achievement of Inputs	Have the Egyptian side's inputs been allocated as planned?	<p>The Egypt side has allocated inputs mostly as planned.</p> <ul style="list-style-type: none"> <li>• <b>Assignment of C/Ps:</b> The Egyptian side has assigned 38 project personnel in total from MOHP, HIO, and MOE (See Annex 5-1 List of Egyptian Project Personnel (C/Ps) Assigned to the Project).</li> <li>• <b>Provision of administration facilities (office space):</b> The Egyptian side provided an office in Cairo and a field office in the Fayoum Governorate.</li> <li>• <b>School clinic space of 20 pilot schools:</b> Twenty (20) schools which are equipped with school clinics and fulfill other pre-determined criteria were selected as pilot schools to implement project activities (See Annex 5-2 List of Pilot Schools).</li> <li>• <b>Expense for Training (transportation, per diem):</b> In the first JCC on the 24th of December 2008, it was agreed that the Japanese side would cover necessary project training and workshop expenses at the initial stage of the Project and the responsibility for the payment of the expenses would be transferred to the Egyptian side within two years from the commencement of the Project. However, expenses for project training and workshops have been covered solely by the Japanese side up until now. It should be noted that MOHP has covered the expenses for school health training courses in Gharbia Governorate and other governorates; although the training courses covered by the Egyptian side is not part of project activities, it will contribute to the achievement of the Overall Goal (Annex 5-3: Training Expenses by the Egyptian Side).</li> </ul>
	Have the Japanese side's inputs been allocated as planned?	<p>The Japanese side has allocated inputs as planned.</p> <ul style="list-style-type: none"> <li>• <b>Japanese Experts assigned to the Project:</b> The Japanese side assigned experts in various fields related to the improvement of school health services. (See Annex 5-4 List of Japanese Experts Assigned to the Project.).</li> <li>• <b>Local Experts:</b> The Japanese side assigned one HIO consultant and a team of experts from the Center for Development Services (CDS) to the project (See Annex 5-5 for the List of Local Experts.).</li> <li>• <b>Equipment:</b> The Japanese side provided equipment necessary for the project implementation – totaling LE approx. 670,000. (Annex 5-6 Provision of Machinery and Equipment.)</li> <li>• <b>C/P Training:</b> A total number of the Egyptian project personnel and project related personnel received training on school health in Japan (See Annex 5-7 C/P Training in Japan).</li> </ul>

**SECTION II. IMPLEMENTATION PROCESS**

This section examines factors that have positively or negatively affected the implementation of the project activities.

Evaluation Questions		Results
Main Questions	Sub Questions	
Proactive Involvement	<p>Has the PDM regularly been used as a project management tool? Do the project members fully understand the PDM contents?</p> <p>Have the Egyptian project personnel been able to act proactively in implementing project activities and overcoming challenges?</p>	<ul style="list-style-type: none"> <li>The PDM was only used to explain the Project at the initial stage of the Project and when it was revised, but has not been fully used to monitor project progress. The Project has been using a daily work schedule calendar of planned project activities instead.</li> <li>The Egyptian project personnel at the governorate level have shown a strong commitment in implementing project activities. They have actively contributed their technical inputs for developing dissemination tools and facilitating the development of the HPS model.</li> <li>Through more frequent interaction after the Mid-term Review, the relationship between the Egyptian project personnel at the central level and the Japanese expert team has substantially improved. As the communication with the Japanese expert team has improved, the Egyptian project personnel at the central level have demonstrated a strong commitment and leadership in revising and finalizing M&amp;G.</li> <li>In the first half of the Project period, there were differences in understanding between the Egyptian project personnel and the Japanese expert team about administrative arrangements regarding project inputs.</li> </ul> <p><b>&lt;Follow-up on Mid-Term Review (MTR) 's Recommendation (1): Communication among the project personnel&gt;</b></p> <ul style="list-style-type: none"> <li>Communication and information sharing between the Egyptian project personnel and the Japanese expert team have improved since the Mid-term Review. Two factors have significantly facilitated the improvement in communication. First, the Japanese expert team has increased the frequency of reporting project progress to the Egyptian project personnel at the central level from every two to three weeks before the Mid-term Review to every one to two weeks after the Mid-term Review. Secondly, M&amp;G development activities have required substantial inputs from the Egyptian project personnel at the central level. With the greater direct involvement in project activities and the more open line of communication created with the Japanese expert team, the Egyptian project personnel at the central level have become more proactive in implementing project activities.</li> </ul>
Work relationship / communication	<p>Has there been effective communication among MOHP, HIO, and MOE as well as between government officials at the central and governorate levels?</p>	<p>Through implementing its activities, the Project facilitated cooperation among MOHP, HIO, and MOE. While the Project's main C/P organizations are MOHP and HIO, school health services require cooperation among school personnel on the ground, such as school principals, teachers and social workers. The cooperative working relationships fostered in the Project have facilitated the production of project outputs.</p> <p><b>&lt;Follow-up on MTR's Recommendation (4): Strengthening linkage between the activities at central and governorate levels&gt;</b></p> <ul style="list-style-type: none"> <li>The monitoring results of 20 pilot schools were analyzed and shared with the Egyptian project personnel at the central level in February 2012 as recommended in the Mid-term Review.</li> <li>At the MTTT joint meetings in January 2012, the Egyptian project personnel from the central and governorate levels were informed of the contributions made by both levels to the M&amp;G development. The meetings created opportunities, in which each other's contributions were openly recognized lead to the improvement of the working relationship among the Egyptian project personnel at all levels.</li> </ul>

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Evaluation Questions		Results
Main Questions	Sub Questions	
Work relationship / communication	Has there been effective communication among MOHP, HIO, and MOE as well as between government officials at the central and governorate levels?	<p><b>&lt;Follow-up on MTR's Recommendation (6): Assigning a focal person for the school health activities at governorate level&gt;</b>            At the 13<sup>th</sup> SHC in October 2011, focal persons have been appointed for the Project and for monitoring and school health services at the central and governorate levels. For the monitoring and school health services, six positions (chief and a focal person for each of the five themes) have been appointed at both levels.</p> <p><b>Positive factor:</b></p> <ul style="list-style-type: none"> <li>• Cooperation among three agencies: The terminal evaluation team confirmed that the Project has fostered a good relationship among three agencies at all central, governorate, district, and school levels. Especially the cooperative working relationship fostered among ISHC committee members at each pilot school has facilitated the implementation of school health activities.</li> </ul> <p><b>Negative factors:</b></p> <ul style="list-style-type: none"> <li>• <b>Difference in Understanding about Project Inputs:</b> In the first half of the project period, the project implementation was delayed because of the time required to resolve the difference between the Egyptian project personnel and Japanese expert team in the understanding of administrative management issues. While the issues were resolved eventually after a series of discussions and negotiations, the time taken for reaching agreement delayed the project implementation.</li> <li>• <b>Social Political Insecurity:</b> The Project activities were suspended for four months from January to May 2011 due to the Egypt's Revolution in January 2011 and the socio-political insecurity occurred following the event. The unexpected temporary halt of the Project delayed the project implementation process.</li> </ul>
Other contributing and/or hindering factors to project implementation	Are there any other factors that have positively or negatively affected project implementation?	

### SECTION III: EVALUATION BY THE FIVE CRITERIA

This section examines and analyzes the project based on various questions set under the five evaluation criteria, i.e. Relevance, Effectiveness, Efficiency, Impact, and Sustainability.

Evaluation Criteria	Evaluation Questions		Results
	Main Questions	Sub Questions	
Relevance	Relevance with the Government policy of Egypt	<p>Is the Overall Goal of the Project in line with the priority of development policies of the Government of Egypt?</p> <p><u>Overall Goal:</u> School health is promoted by expanding Health Promotion School and school health services in Upper Egypt.</p>	<p>The Overall Goal of the Project in line with the priority of development policies of the Government of Egypt.</p> <ul style="list-style-type: none"> <li>• Egypt has a national policy that the health-insurance system covers all citizens. The <i>Manual of Student Health Insurance Act (1993)</i> provides that all school-age children (6-18 years old) should benefit from the institutionalized health insurance.</li> <li>• In 2012 MOHP prepared the <i>Strategic Vision for Improving Health Care Services and Nursing in Egypt</i> which included its strategy to improve children's health through school health service promotion activities.</li> </ul>
	Relevance with beneficiaries' needs	<p>Are the Project Purposes in line with the target groups' needs?</p> <p><u>Project Purposes:</u></p> <ol style="list-style-type: none"> <li>1. The quality of school health services in Tamma district is improved through the dissemination of the concept of Health Promotion School.</li> <li>2. The framework to disseminate Health Promotion School in Upper Egypt is prepared.</li> </ol>	<p>The Project Purposes are in line with the target group's needs.</p> <ul style="list-style-type: none"> <li>• School health services in Egypt have not been sufficiently provided both in quantity and quality due to: a lack of coordination among relevant agencies; a shortage of medical personnel for the service implementation, especially in rural areas; and an absence of a practical model of the school health service implementation. The Project Purposes were set to solve these three challenges.</li> </ul>
	Relevance with the Japan's ODA policy	Is the Project in line with the Japanese Government's assistance policies in general and for Egypt?	<p>The Project is in line with the Japanese Government's assistance policies for Egypt.</p> <ul style="list-style-type: none"> <li>• Japan's ODA policy towards Egypt, set in the "<i>Country Assistance Program for the Arab Republic of Egypt (2009)</i>", is comprised of three priority areas: (1) realization of sustainable growth and employment creation; (2) poverty reduction and improvement of living standards; and (3) promotion of regional stabilization. This Project falls under the second priority area, which includes an assistance policy for the enhancement and improvement of public services, particularly the support for the improvement of impoverished medical care services.</li> <li>• This project is also in line with the <i>Health and Development Initiative (2005)</i> and <i>Japan's Global Health Policy (2011-2015)</i>.</li> </ul>
Appropriateness of the Project Strategy	Was the project strategy appropriate for improving the health of school children in Egypt? More specifically, was the target region appropriately selected? In the scope of donor cooperation, what synergistic effects with other donors' school health related activities were planned?	<p>The project strategy is appropriate for improving the health of school children in Egypt.</p> <ul style="list-style-type: none"> <li>• Egypt is currently facing an epidemiological transition characterized by a rising prevalence of risk factors such as obesity, smoking and hypertension.</li> <li>• The new health challenges require preventive care starting from the youth</li> <li>• Health education is a part of the Ministry of Education's mandate. The inclusion of the Ministry of Education in project activities is/was highly appropriate.</li> <li>• The Project used the School Health Manual developed by WHO and MOHP when selecting the themes of HPS. The Project was designed to build on the foundation laid by WHO and MOHP's previous work and make the WHO/MOHP's manual more practical and result-oriented.</li> </ul>	

Evaluation Criteria	Evaluation Questions		Results
	Main Questions	Sub Questions	
Relevance	Appropriateness of the Project Strategy	Are there any other specific aspects of the project design that has increased or decreased the project's relevance?	<ul style="list-style-type: none"> <li>The Project's conceptual framework was created using comparative analysis between the Japanese and Egyptian school health service models as a reference.</li> </ul>
Effectiveness	Achievement level of the Project Purposes	To what degree have the Project Purposes' OVs been achieved?	See Section 1: Project Achievement
		What is the prospect of achieving the Project Purposes by the end of the project period?	<ul style="list-style-type: none"> <li>The first Project Purpose (improvement of school health services in the Iammia district) is assessed to be mostly achieved.</li> <li>The Project has achieved this through a series of workshops and training conducted to a wide range of people involved in school health services at all central, governorate, district and school level. At the 20 pilot schools and the 5 non-pilot schools that have been paired with center schools, health promotion activities have increased and monitoring has been appropriately conducted.</li> <li>While tangible improvements of school health services are observed from the Base-line survey to the End-line survey in key indicators at the 20 pilot schools, there are still issues to be addressed for the services to be truly satisfactory.</li> <li>The issues that need to be addressed are: continuous service training of school doctors and school nurses to improve their technical capacity, an increase in availability of first-aid kits, medicines, and school doctors and nurses, and an increase in public awareness of school health promotion.</li> <li>The second Project Purpose (the development of the framework to disseminate the HPS model in Upper Egypt) is assessed to be most likely achieved by the end of the project period.</li> <li>Most of the components of the dissemination package (M&amp;G; DVD/CD on comprehensive medical examination, and three leaflets on school health service promotion) have been developed. With the development of the Dissemination Guidelines, and successful implementation of dissemination training workshops, the prospect for achieving the second Project Purpose is highly promising.</li> </ul>
		To what degree is the achievement of the Project Purposes attributable to the successful achievement of the Outputs?	<ul style="list-style-type: none"> <li>The Project Purposes are comprised of two components: (1) the improvement of the quality of school health services in the Iammia District and (2) the development of HPS dissemination framework. All outputs are indispensable for developing a practical HPS model for quality school health services that can be disseminated in other areas in Egypt; however in order to reach a high achievement level of Project Purpose (1), other critical issues need to be addressed, such as the establishment of an organizational mechanism in HFO to ensure the placement of school doctors and nurses.</li> </ul>
		Have the Project Purposes' Important Assumptions been realized?	<p><b>Assumption 1: The personnel trained in the Project are not transferred to other positions.</b></p> <ul style="list-style-type: none"> <li>This assumption has not been fully realized. There have been some transfers of project related personnel, especially school doctors and the Egyptian project personnel.</li> </ul> <p><b>Assumption 2: Serious epidemic outbreaks do not occur.</b></p> <ul style="list-style-type: none"> <li>The occurrence of an outbreak rather facilitated the project implementation. In 2010, there was an outbreak of a swine flu in Egypt. This health incident increased public awareness toward hygienic practices and the need for school clinics.</li> </ul>

Evaluation Criteria	Evaluation Questions		Results
	Main Questions	Sub Questions	
Efficiency	Contributing factors	To what degree has each Output been produced?	See Section 1: Project Achievement
		Have there been any other factors that contributed to the achievement of the Project Purposes?	<ul style="list-style-type: none"> <li>Cooperation among three agencies as discussed in Section II.</li> </ul>
	Hindering factors to Effectiveness	Have there been any factors that impeded the achievement of the Project Purposes?	<ul style="list-style-type: none"> <li>There are no other factors that impeded the achievement of the Project Purposes.</li> </ul>
	Causality of Inputs and Outputs	Were the implemented activities sufficient in quality and quantity to produce planned Outputs?	<ul style="list-style-type: none"> <li>The activities are sufficient in quality and quantity to produce planned Outputs.</li> <li>The Project focused on its trial implementation of the HPS model to 20 schools. On one hand the number of the pilot schools is considered small, especially by the Egyptian side, for a four year project aimed to improve school health services of one whole District. On the other hand, the concentration of the activities and inputs on the 20 pilot schools enabled the Project to fully test the feasibility of the HPS model that can be disseminated to other governorates across Upper Egypt.</li> </ul> <p><b>&lt;Follow-up on MTR's Recommendation (2): Acceleration of implementation&gt;</b></p> <ul style="list-style-type: none"> <li>The Project sub-contracted the Center for Development Services (CDS), a local editing/printing company, to finalize M&amp;G. M&amp;G was carefully prepared to ensure that its contents would be accepted by all three relevant ministries by actively soliciting their inputs through MI and IT meetings. While the development process required a lot of time and effort, the end-product was of high quality, especially from the perspectives of the practicability of its usage and its applicability to all regions.</li> </ul> <p><b>&lt;Follow-up on MTR's Recommendation (3): Strengthening monitoring and supervisory mechanism&gt;</b></p> <ul style="list-style-type: none"> <li>Through a series of MI meetings from June to October 2011 and a joint MI/IT meeting in January 2012, the Project strengthened the monitoring and supervision mechanism by maximizing the roles played by schools through self-monitoring. Schools are instructed to record the results of each health service activity, assess accomplishments and challenges, and come up with an improvement plan. This change was from due consideration for the limited availability of government officials responsible for school health services and budgets for monitoring and supervision.</li> </ul> <p><b><u>Assumption 1: Changes of MOHP Policy (Health Sector Reform) do not hinder Project's activities.</u></b></p> <ul style="list-style-type: none"> <li>This assumption has been met.</li> <li>The health sector reform programme initiated in 1997 and due to continue through 2018 reflects five guiding principles (universality, quality, efficiency, and sustainability) which are in line with the promotion of school health services. The project encompasses many important features of the reform, including the cooperation and integration with different ministries, agencies and organizations, the promotion of preventative care, and the expansion of health insurance to cover new population groups, especially vulnerable groups, the poor and underserved rural areas.</li> </ul> <p><b><u>Assumption 2: Other organizations do not oppose the cooperative relationship with Project.</u></b></p> <ul style="list-style-type: none"> <li>There were no joint activities conducted with other donors.</li> </ul> <p><b><u>Assumption 3: Target area (district) accepts the Project.</u></b></p> <ul style="list-style-type: none"> <li>This assumption has been met.</li> </ul>
	Have the Important Assumptions for Outputs been met?		



Evaluation Criteria	Evaluation Questions	Results
Efficiency	<p>How appropriate has the provision of facilities (i.e. administration facilities and school clinic space of 20 pilot schools) and equipment by the Egyptian side been?</p> <p>How appropriate has the provision of the Egyptian budget for the Project (i.e. expense for training) been in scale and timing?</p>	<p>The provision of facilities and equipment by the Egyptian side has been appropriate to some extent.</p> <ul style="list-style-type: none"> <li>The Egyptian side provided an office in Cairo and a field office in the Fayoum Governorate.</li> <li>Neither office had enough space so that experts had to work from their hotel rooms, which compromised day-to-day communication with the Egyptian project personnel.</li> <li>The Egyptian side has not been allocated training expenses as per the PDM.</li> <li>In the first JCC on the 24th of December 2008, it was agreed that the Japanese side would cover necessary project training and workshop expenses at the initial stage of the Project and the responsibility for the payment of the expenses would be transferred to the Egyptian side within two years from the commencement of the Project.</li> <li>However, expenses for project training and workshops have been covered solely by the Japanese side up until now.</li> <li>It should be noted that MOHP has covered the expenses for school health training in the Gharbia Governorate; although this training is not part of project activities, it will contribute to the achievement of the Overall Goal.</li> </ul>
Appropriateness of Inputs by Japan	<p>How appropriate has the assignment of experts been in terms of their number, expertise and capabilities, and the assigned periods (durations) and timings?</p> <p>How appropriate has the arrangement of training in Japan been in terms of its content, timing and period?</p>	<p>The assignment of experts has been appropriate in terms of their number, expertise and capabilities, and the dispatched periods (durations) and timing.</p> <ul style="list-style-type: none"> <li>The Japanese side assigned experts in various fields of expertise related to the school health service improvement. Their total Man Months (MM) up until the terminal evaluation is 88.5 (See Annex 5-4 Japanese Experts Assigned to the Project).</li> </ul> <p>The arrangement of training in Japan has been appropriate.</p> <ul style="list-style-type: none"> <li>The training was instrumental not only in the broadening of the Egyptian project personnel technical knowledge but also in the building of a good working relationship between the Egyptian project personnel and the Japanese experts as those who attended gained a deeper appreciation towards the needs of school health services.</li> </ul>
Appropriateness of Inputs by Egypt	<p>How appropriate has the provision of equipment by the Japanese side been in terms of its quality, quantity, and timing?</p> <p>How appropriate has the assignment of the Egyptian project personnel been in terms of the number of the Egyptian project personnel, placement (i.e., balance between their regular tasks and Project activities) and their capacity?</p>	<p>The provision of equipment by the Japanese side has been conducted in an appropriate manner.</p> <ul style="list-style-type: none"> <li>Equipment was provided based on the results of the survey on the conditions of school clinics at the 20 pilot schools. The survey was conducted by HIO Tamnia School Health Supervisor Nurses, School Master (and health visitor), and the Project Team.</li> </ul> <p>The assignment of the Egyptian project personnel has been appropriate to some extent.</p> <ul style="list-style-type: none"> <li>The Egyptian project personnel were assigned from MOHP, HIO, and MOE. Since a successful delivery of school health services require inputs from all these organizations, it was appropriate to have the Egyptian project personnel from all three organizations.</li> </ul>

Evaluation Criteria	Evaluation Questions	Results
Efficiency	<p>Project Management</p> <p>Have the Joint Coordination Committee (JCC) and the School Health Committee (SHC) been utilized as effective and efficient forums for sharing information and solving challenges of the Project?</p> <p>Are there any other factors that increased the efficiency of the Project?</p>	<ul style="list-style-type: none"> <li>• Since the Project activities rely on active involvement of many organizations of various administrative levels (central, governorate, district, and school levels), all-around consensus and support for upcoming project activities build during these meetings, especially SHC meetings, has been an essential instrument in project implementation.</li> </ul>
Contributing factors to Efficiency	<p>Contributing factors to Efficiency</p>	<p>&lt;Follow-up on MTR's Recommendation (7): Involving ISHC members for the expansion of the project experience&gt;</p> <ul style="list-style-type: none"> <li>• The center schools were selected from those that have ISHCs with high performance records.</li> <li>• &lt;Follow-up on comments made by the Egyptian side after the MTR&gt;</li> <li>• Following the comment made by the Egyptian side after the Mid-term review on the use of Egyptian personnel in training, training roles were handed over to the Egyptian personnel.</li> </ul> <p>&lt;Contributing Factors&gt;</p> <ul style="list-style-type: none"> <li>• From January to May 2011, the Project was suspended for four months. The Project responded flexibly to the situation and successfully produced the Outputs as planned. It made the best use of technical inputs by local experts in school health services to produce the dissemination tools.</li> <li>• The Project focused on its trial implementation of the HPS model to 20 pilot schools. The concentration of the activities and inputs on the 20 pilot schools enabled the Project to fully test the feasibility of the HPS model that can be disseminated to other governorates across Upper Egypt.</li> </ul>
Hindering factors to Efficiency	<p>Are there any factors that decreased the efficiency of the Project?</p>	<ul style="list-style-type: none"> <li>• Hindering factor: the Project's trial dissemination of the HPS model have been conducted to only five non-pilot schools, which is still limited in scale.</li> </ul>
Prospects of achieving the Overall Goal	<p>Will the Overall Goal be achieved within 3 to 5 years after the completion of the Project?</p>	<p>See Section 1: Project Achievements</p> <ul style="list-style-type: none"> <li>• The prospect for achieving the Overall Goal (promoting school health in Upper Egypt through the expansion of the HPS model and school health services) within three to five years after the completion of the Project is still uncertain.</li> <li>• The achievement levels of OVI's show some progress made toward the achievement of the Overall Goal, but there is no activity plan that has been developed for the dissemination of the HPS model to be conducted after the Project.</li> </ul>
Prospects of achieving the Super Goal	<p>What is the prospect of the Important Assumption for the Overall Goal being realized?</p> <p>What is the prospect of the Super Goal (Health status of school children in Upper Egypt is improved.) being achieved?</p>	<p><b>Important Assumption: Strong commitment by the Government of Egypt is maintained.</b></p> <ul style="list-style-type: none"> <li>• MOHP has already shown initiatives to disseminate the HPS model in the Gharbia Governorate.</li> </ul> <p><b>OVI: Health indicators</b></p> <ul style="list-style-type: none"> <li>• The project focused on the improvement of school health services in the Tamma District. Considering that there were positive results in preventative health indicators among pilot schools in comparison with non-pilot schools in the End-line Survey, the Project will most likely contribute to the improvement of health conditions of school children in Upper Egypt should the HPS model developed in the Project be disseminated to Upper Egypt.</li> </ul>

Evaluation Criteria	Other aspects	Evaluation Questions	Results
<b>Impact</b>	Have and/or will there be any synergistic effects in relation with other donors' school health related activities for achieving the Overall Goal and Super Goal?	Are there any unexpected impacts (positive and negative)?	<ul style="list-style-type: none"> <li>There has not been any tangible cooperation between the Project and donor agencies (i.e. WHO, WFP and UNICEF) and NGOs (Care International, Save the Children, etc) as of yet, but the Project has planned the following to increase its cooperation with donors.               <ul style="list-style-type: none"> <li>The Project invited WHO to the second Health Promotion School Dissemination Workshop in Cairo from the 27th to 28th of June 2012 to involve WHO in the dissemination process.</li> <li>A School Dissemination Workshop for Development Partners is planned to be held in October 2012.</li> </ul> </li> <li>Since there are other school health related projects in Egypt, such as the School Health Programme by WHO and a medical examination program by the Arab Medical Union, there is an opportunity whereby cooperation with donors and NGOs creates synergistic effects for the improvement of school health services and facilitates the achievement of the Overall Goal.</li> </ul>
<b>Sustainability</b>	Institutional aspect	What is the prospect of the Egyptian Government to continue its policy on the promotion of school health services through the expansion of Health Promotion Schools and school health services?	<ul style="list-style-type: none"> <li>There most positive impact of the Project is that it fostered cooperation and collaboration among them to the level that did not exist before.</li> <li>The improvements of key indicators are also observed in non-pilot schools in the areas of personal hygiene and the establishment of an (internal) school health committee. According to the interviews conducted to the School Health Committee members in the Fayoum Governorate, the improvements are partially attributable for proactive roles in disseminating school health activities played by monitoring/supervisory personnel from MOHP, HIO, and MOE.</li> <li>The Project's institutional sustainability is high. MOHP developed the Strategic Vision for Improving Health Care Services and Nursing in Egypt (2012), which includes the ministry's strategy to improve children's health through school health service promotion activities. The inclusion of school health service promotion activities in its policy paper indicates the Egyptian Government's institutional commitment to school health.</li> <li>Furthermore, the MOHP issued the Ministerial Decree of 369, which provides for the re-starting of activities of the School Health Promotion Committee, which includes MOHP, HIO, and MOE at the central level in its members. The re-establishment of a non-project-based coordination body for school health services strengthens institutional sustainability.</li> </ul>
	Organizational aspect	What is the prospect of the Egyptian Government to continue its policy on the promotion of school health services through the expansion of Health Promotion Schools and school health services?	<p><b>&lt;Follow-up on MTR's Recommendation (9): Recognition on significance of school health in Egyptian context&gt;</b></p> <ul style="list-style-type: none"> <li>Through implementing project activities, the Egyptian project personnel and other project related Egyptian personnel have deepened their appreciation towards the significance of school health in preventive health care.</li> <li>There have not been any activities involving the media to increase public recognition of the importance of school health.</li> </ul> <p><b>&lt;Follow-up on MTR's Recommendation (5): Defining roles and responsibility of each organization and personnel&gt;</b></p> <ul style="list-style-type: none"> <li>In the meetings following the Mid-term Review, roles and responsibilities of focal persons in school health services in the ISHC were clarified and agreed upon among all relevant project members in September 2011.</li> <li>The national version of M&amp;G clearly defines different roles and responsibilities of MOHP, HIO, MOE and their focal offices in the implementation of school health services. These definitions have been shared among these organizations in the course of the M&amp;G development and revision.</li> </ul>

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Evaluation Criteria	Evaluation Questions	Results
Sustainability	<p>Organizational aspect</p> <p>Is there an organizational mechanism within MOHP to continuously address the shortage of doctors and clinics for the implementation and dissemination of school health activities?</p>	<p><b>&lt;Follow-up on MTR's Recommendation (8): Addressing shortage of doctors&gt;</b></p> <ul style="list-style-type: none"> <li>According to the interviews conducted by the terminal evaluation team, HIO at the governorate level has organized teams of school doctors, comprised of two to three doctors per team per district to solve the issue of the school doctor shortage since 2012. On the other hand, the terminal evaluation team could not confirm from interviews with schools that the shortage of school doctors has been alleviated yet.</li> <li>The allocation of school doctors to the 20 pilot schools was proposed for the development of the health promotion school model and approved at the 13th SHC in October 9, 2011. A doctor from MOHP or HIO was allocated to each of the pilot schools and conducted medical examination during Nov. to Dec., 2011. However, only about 50% of them actually conducted the examination, and the issues related to the present administrative system were highlighted. A mechanism to solve these issues will be discussed in the coming dissemination workshops.</li> <li>The Project's financial sustainability is weak. Since there is no annual activity plan for the dissemination of the HSP model after the Project, no budget has been earmarked.</li> </ul>
Financial aspect	<p>What is the prospect of securing sufficient budget to continue the implementation and dissemination of school health services in Tammia District (and eventually throughout Upper Egypt)?</p>	<ul style="list-style-type: none"> <li>The Project's technical sustainability is high. The Project has trained a sufficient number of core personnel at the governorate level in Fayoum Governorate and at the central level to continue the implementation and dissemination of school health services in the Tammia District and eventually throughout other governorates.</li> </ul>
Technical aspect	<p>Have core staff members been trained sufficiently in number and quality to continue the implementation and dissemination of school health services in Tammia District (and eventually throughout Upper Egypt)?</p>	<ul style="list-style-type: none"> <li>Some of the Egyptian project personnel and other project related personnel (incl. ISHC members) consider school health services as "extra" tasks, not part of their regular asks. According to interviews conducted, there is no incentive for a HPS Center to support other schools in the promotion of school health services.</li> </ul>
Other factors	<p>Are there any other possible factors that will increase or decrease the sustainability of the Project?</p>	

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## Annex 5: Project Inputs

### Annex 5-1: List of Counterpart Assigned to the Project

No.	Name	Position	Period
1. Ministry of Health and Population			
[Central Level]			
1	Dr. Nasr El Sayed	Project Director, Minister's assistant for PHC, Preventive Medicine & Family Planning Sector	Nov. 2008-June 2012
2	Dr. Emad Ezzat	Head of Primary Health Care and Nursing Sector	Apr. 2012-Present
3	Dr. Khalid Nasr	Undersecretary of IHC Sector	Nov. 2008- May 2011
4	Dr. Nagwa El Ashry	Project Manager, Director of SACHD, PHC	Nov. 2008- Present
5	Dr. Sahar M. Ahmed	Res & Training Coordinator SACHD, PHC	Nov. 2008- Present
[Fayoum Governorate]			
6	Dr. Hussein Abu Taleb	Undersecretary of Health & Population	Nov. 2008 - Feb. 2010
7	Dr. Emam Mohamed Mousa	Undersecretary of Health & Population	Feb. 2010 - Present
8	Dr. Zienab Sakran	Director of Rural Sector in Primary Health Care	Nov. 2008 - Present
9	Dr. Anwar El-Sewafey	Director of Preventive Department, Deputy of Undersecretary	Nov. 2008 - Present
10	Dr. Mohamed Tharwat	General Director of Endemic Disease Control	March 2010 - Present
11	Dr. Farag Abd El Moaez	Director of Health Education	Aug. 2010 - Present
12	Dr. Mona Fouad Ass Manegen	Director of Primary Health Care	Nov. 2008 – Mar. 2009
13	Dr. Doaa Mohammed	Manager of School Health	Mar. 2009 - Aug. 2010
[Tammia District]			
14	Dr. Abdel Kawi Lawag	Director	Nov. 2008 - Nov. 2009
15	Dr. Farag Abd El Moaez	Director	Nov. 2009 - Aug. 2010
16	Dr. Amal Hashem	Director	Aug. 2010 - Feb. 2011
17	Dr. Ibrahim Desoky Abd Allah	Director	Feb. 2011 - Aug. 2011
18	Dr. Amgad Abd El Zaherg	Director	Aug. 2011 - Present

No.	Name	Position	Period
2. Health Insurance Organization			
[Central Level]			
19	Dr. Omayma Mostafa	Deputy Project Manager, Officer HIO	Nov. 2008- Feb. 2012
20	Dr. Wefky Fouad Wefky	Responsible for School Health	Feb. 2012-Present
[Fayoum Governorate]			
21	Dr. Salah Abou Talib	General Director	Nov. 2008 - Feb 2010
22	Dr. Omar Tayel	Undersecretary of Health & Population	Feb. 2010 - June 2010
23	Dr. Hosam El Saka	General Director	June 2010 - Present
24	Dr. Mohsen Gomaa	Director of School Health	Nov. 2008- Present
25	Dr. Fakhry Farag	Director of Health Education	Nov. 2008- Present
26	Dr. Osama El Garhy	Manager of School Health Insurance in Urban Fayoum	July 2009 - Present
3. Ministry of Education			
[Central Level]			
27	Ms. Elham Abu El Kheir	Director of Environmental and Population Education Department	Nov. 2008 – Present
28	Mr. Mosad Maklad	Expert in Environmental and Population Education Department	May 2009 – Present
[Fayoum Governorate]			
29	Ms. Salwa Amin	Undersecretary of Education	Nov. 2008 - Sep. 2009
30	Mr. Hassan Hegazy	Undersecretary of Education	Sep. 2009 - Present
31	Mr. Gamal Abdel Hakem	General Director of Education Service	Feb. 2011 - Present
32	Ms. Zeinat Yuusef	Director of Environmental and Population Education Department	Nov. 2008 - Present
[Tammia District]			
33	Mr. Saleh Bl Beltagy	Director of Education	Nov. 2008- April 2011
34	Mr. Abdel Abd El Hamed	Director of Education	April 2011- Feb. 2012
35	Mr. Seliman Almshawy	Director of Education	Feb. 2012 - Present
36	Mr. Ibrahim Elbehery	Director of Training Department	Nov. 2008 - Feb. 2011
37	Ms. Sahar Abd El Sattar El Gamal	Director of Education, Social Disease Control, Directorate of Health	Nov. 2008 - Dec. 2009
38	Mr. Mahmoud Abdel Aziz	Head of Environment and Population Sector, Tammia District	Nov. 2008 - Present

## Annex 5-2: List of Pilot Schools

The following 20 pilot schools were selected based on the following pre-determined criteria:

- Having a medical doctor and/or a health visitor (school nurse);
- Being equipped with a school clinic or having a plan to construct one; and
- Distribution of population, schools, health/medical facilities, and accessibility of transportation network.

No.	Name of Pilot Schools	Area	Center Schools
1	Menshat El Gamal School (B.ED*)	Gammal	*
2	Saweris School (B.ED)	Saweras	
3	Mogama Sersena Primary School	Sersena	
4	Sersena School(B.ED)	Sersena	*
5	Al Mokatla Primary School	El Makatla	
6	Fathy Ali School (B.ED)	Robciat	
7	Abu Taleb School (B.ED)	Abotalb	*
8	Kafr Mahfoz School (B.ED)	Kafermahfoze	
9	Tammia Primary School for Girls	Tammia	*
10	Salah Salem Primary School	Tammia	
11	El Rodda School for Boys	Roda	*
12	Dawar El Wabor Primary School	El Barany	
13	Kadry School (B.ED)	El Mazatthy	
14	Hassan Abd El Aziz (B.ED)	Darelsalam	
15	Dar El Salam Preparatory School	Darelsalam	
16	El Galaa Primary School	Tammia	
17	Abo Rehab Primary School	Fannose	
18	Kom Oshem Primary School	Komoshem	
19	Kasr rashwan Preparatory School	Kasroshwan	
20	Saad Roby Preparatory School	Said El Roby	

\* B. ED = Basic Education (Primary & Preparatory School)

**Center Schools:** Top performing five pilot schools were selected as “center schools” (or model schools) of school health services. Each center school trained one non-pilot school on activities related to the Health Promotion School (HPS) model.

No.	Center School	Non-Pilot Pair School
1	Menshat El Gamal School (B.ED)	Menshat El-Gamal Preparatory and Secondary School
2	Sersena School (B.ED)	Al-Mokatla Preparatory School
3	Abu Taleb School (B.ED)	Kafer Emera Preparatory School
4	Tammia Primary School for Girls	Old Tammia Preparatory School
5	El Rodda School for Boys	Mogamaa El-Rodaa School

### Annex 5-3: Training Expenses by the Egyptian Side

#### 1. Training Expenses for FY 2010/2011

Targeted Category	Training Session Period	Governorate	No. of Training Sessions	Participants (Actual)	Cost (LE)
Nurses & Health Visitors	5days	Fayoum	1	28	53,350
		Dakahlia	1	28	
		Dakahlia	1	29	
		Gharbia	1	29	
		Gharbia	1	31	
		Fayoum	1	29	
	3days	Fayoum	1	30	21,340
		Fayoum	1	29	
	3days	Kafr el Sheikh	1	30	14,916
		Kafr el Sheikh	1	30	
Persons in Charge of Primary Health Care, Motherhood & Childhood Care and Students Affairs at the HIO in the Governorate	1 day	Gharbia	1	19	2,519
		Cairo	1	16	1,529
<b>Total in the year of 2010:</b>			<b>12</b>	<b>328</b>	<b>93,654</b>

Note: These expenses are covered by the Egyptian side (SACHD, MOHP) for school health promotion activities; however, the courses covered by the Egyptian side are not project activities.

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## 2. Training Expenses for FY 2011/2012

Targeted Category	Training Session Period	Governorate	No. of Training Sessions	Participants (Actual)	Cost (LE)
Nurses & Health Visitors	3 days	Gharbia	8	Approx. 30	54,120
	5 days	Gharbia	5	Approx. 30	55,000
	3 days	Gharbia	8	Approx. 28	50,160
	3 days	Gharbia	10	30	49,368
Nurses & Health Visitors from Gharbia Governorate	3 days	Cairo	2	30	7,590
Training of Trainers in the Skills of Dealing with Street Children	3 days	Cairo	5	22	33,000
Primary Health Care Doctors	2 days	Gharbia	6	20	18,480
Training of Social Workers	3 days	Cairo	4	15	15,180
Nurses & Health Visitors in Gharbia to be trained in the Electronic Program of School Health	3 days	Gharbia	6	30	34,782
Health Units Doctors in Samanoud, Gharbia	1 day	Gharbia	1	30	2,134
Directors of Health, Directorates & Health Insurance Officers	1 day	Gharbia	1	30	2,134
School Health Inspectors & Health Visitors Inspectors	1 day	Gharbia	1	30	2,134
Nurses & Health Visitors in Gharbia to be trained in the Electronic Program of School Health	4 days	Cairo	4	30	75,184
Nurses & Health Visitors	3 days	Kalyobyya	2	30	86,262
	3 days	Asyut	2	30	
	Nurses & Health Visitors for Training in the Electronic Program	3 days	Kalyobyya	2	
3 days		Asyut	2	30	
3 days		Gharbia	2	30	
Health Units Doctor	2 days	Kalyobyya	3	38	
	2 days	Gharbia	3	40	
	2 days	Asyut	2	24	
<b>Total:</b>			79	607	

Note: These expenses are covered by the Egyptian side (SACHD, MOHP) for school health promotion activities; however, the courses covered by the Egyptian side are not project activities.

3. Training Budget Proposed by SACHD, MOHP for Training in FY 2012/2013

Targeted Category	Training Session Period	Governorate	No. of Training Sessions	Participants (Plan)	Budget (LE)
Training Doctors in the School Health Services Manual (3-day training)	Jul.-Sep	Asyut	1	60	32,000
	Jul.-Sep.	Kalyobyya	1	60	24,000
	Jul.-Sep.	Matruh	1	30	16,000
	Oct.-Jun.	Sohag	1	60	32,000
	Oct.-Jun.	Luxor	1	60	32,000
	Oct.-Jun.	Ismailia	1	60	24,000
	Oct.-Jun.	Dakahlia	1	60	28,000
		<b>Sub-total:</b>	<b>7</b>	<b>390</b>	<b>188,000</b>
Training School Health Nurses & Health Visitors in the Manual of School Health Services (4-day training)	Jul.-Sep.	Asyut	1	120	40,000
	Jul.-Sep.	Kalyobyya	1	120	36,000
	Jul.-Sep.	Matruh	1	60	20,000
	Oct.-Jun.	Sohag	1	120	40,000
	Oct.-Jun.	Luxor	1	120	40,000
	Oct.-Jun.	Ismailia	1	120	36,000
	Oct.-Jun.	Dakahlia	1	120	38,000
		<b>Sub-total:</b>	<b>7</b>	<b>780</b>	<b>250,000</b>
Training School Health Nurses & Health Visitors in the Electronic Program of School Student Comprehensive Examination (3-day training)	Jul.-Sep	Asyut	1	120	32,000
	Jul.-Sep	Kalyobyya	1	120	28,000
	Jul.-Sep	Matruh	1	60	16,000
	Oct.-Jun.	Sohag	1	120	32,000
	Oct.-Jun.	Luxor	1	120	32,000
	Oct.-Jun.	Ismailia	1	120	28,000
	Oct.-Jun.	Dakahlia	1	120	28,000
		<b>Sub-total:</b>	<b>7</b>	<b>780</b>	<b>196,000</b>
Training Social Workers & Environment and Population Teachers in School Health Programs (3-day training)	Jul.-Sep.	Asyut	1	120	32,000
	Jul.-Sep.	Kalyobyya	1	120	28,000
	Jul.-Sep.	Matruh	1	60	16,000
	Oct.-Jun.	Sohag	1	120	32,000
	Oct.-Jun.	Luxor	1	120	32,000
	Oct.-Jun.	Ismailia	1	120	28,000
	Oct.-Jun.	Dakahlia	1	120	28,000
		<b>Sub-total:</b>	<b>7</b>	<b>780</b>	<b>196,000</b>
<b>Total Budget Proposed:</b>			<b>28</b>	<b>2,730</b>	<b>830,000</b>

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### Annex 5-4: Japanese Experts Assigned to the Project

Position	Name	Year (M/M)				Total
		1st	2nd	3rd	4th*	
Project Chief Advisor / Monitoring on School Health	Mr. Tateo Kusano	3.00	3.67	2.70	3.60	12.97
Institutional Expert (1)	Mr. Atsushi Takahashi (Dec. 2008 - Mar. 2009)	1.80	—	—	—	1.80
	Ms. Maki Tanaka (Apr. 2011 - )	—	—	—	3.17	3.17
Vice Project Chief Advisor/ Institutional Expert (1)	Dr. Allapichay (Apr. 2009 - Mar. 2010)	—	5.00	—	—	5.00
	Dr. Kikuo Oishi (Apr. 2010 - Mar. 2011)	—	—	2.03	—	2.03
Institutional Expert (2)	Ms. Hikari Morikawa	0.90	1.00	0.47	—	2.37
Institutional Expert (2)/ Health Education		—	—	—	1.00	1.00
Child Health/Nutrition (1)	Dr. Yoshihisa Yamazaki	1.00	1.40	1.10	1.77	5.27
Child Health/Nutrition (2)	Ms. Tomoyo Wada	0.50	0.50	0.33	—	1.33
Health Examination	Dr. Takeo Mori	—	0.50	—	0.43	0.93
Health Education	Ms. Akiko Hayashi	2.30	—	—	—	2.30
Health Education/IEC		—	6.00	3.07	—	9.07
Monitoring/Evaluation		—	—	—	6.00	6.00
Distance Technical Cooperation		Ms. Yoko Akasaka (Dec. 2008 - Mar. 2010)	—	1.00	—	—
School Environment	Mr. Shinichiro Takeda (Apr. 2010 - Mar. 2011)	—	—	1.97	—	1.97
	Ms. Mika Nishihara (Dec. 2008 - Mar. 2010)	2.00	1.50	—	—	3.50
Training Programming	Ms. Sachiko Miyake (Jun. 2010 - Mar. 2011)	—	—	1.00	—	1.00
	Ms. Madoka Mori (Dec. 2008 - Mar. 2011)	3.50	5.83	3.90	—	13.23
Information System Enforcement	Ms. Mami Ishii (Apr. 2011 - )	—	—	—	4.93	4.93
	Mr. Daigo Sano	—	—	1.40	—	1.40
Information System Enforcement/Liasion Officer	Mr. Daigo Sano	—	—	—	4.23	4.23
Liasion Officer	Ms. Yoko Akasaka (Dec. 2008 - Jan. 2009)	0.97	—	—	—	0.97
	Dr. Allapichay (Feb. 2009 - Dec. 2009)	1.03	0.43	—	—	1.46
	Ms. Izumi Yoshioka (Apr. 2009 - Mar. 2010)	—	1.00	—	—	1.00
	Mr. Daigo Sano (Dec. 2010 - Mar. 2011)	—	0.57	—	—	0.57
Total		17.00	28.40	17.97	25.13	88.50

\* Up until July 5, 2012

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## **Annex 5-5: List of Local Experts**

The following local experts were contracted for the period from October 26, 2011 and June 18, 2012.

### **1) HIO Consultant**

1. Dr. Nasr Eldin Sayed Hassan Diab (Senior Technical Expert)

### **2) Center for Development Services (CDS) Team**

2. Dr. Mervat Nessiem (Lead Technical Expert)
3. Dr. Hamdy Samuel (School Health Expert)
4. Dr. Marianne Milad (School Health Expert)
5. Dr. Ahmed Hussein (Health Education Expert)
6. Ms. Zeinab Farahat (Health Education Expert)
7. Ms. Wafaa Afifi (Supporting team member)
8. Mr. Reda Hassan (Supporting team member)
9. Eng. Milad Moawad (Art Director)

### **3) CDS Associates**

10. Mr. Hamdy Abd Rabbou (Editor)
11. Mr. Khaled (Translator)
12. Eng. Mostafa, Eng. Amira and their team, supervised by Prof. Eng. Ehab Eltoukhy



## Annex 5-6: Provision of Machinery and Equipment

### 1) Provision of Office Equipment (Total: LE 204,160)

Description	Specification	Qty	Unit Price (LE)	Date
Lap top computer	Toshiba Tecra A10-11L	2	14,850	Jan. 2009
Portable ink jet printer	HP Officejet Hp 470wbt	2	2,500	Jan. 2009
Laser printer	Canon i-sensys MF 4690	2	6,000	Jan. 2009
Photocopy machine	Canon iR 3035N	2	50,000	Jan. 2009
Potable projector	Panasonic PT-LB75EA	1	8,800	Jan. 2009
Phone and fax machine	Canon Jx 200	1	2,300	Jan. 2009
Handy video camera	Sony AVCHD-HDD-HDR-SR10E	1	8,020	Jan. 2009
Digital camera	Canon power shot G10	1	5,000	Jan. 2009
USB hard disk drive	Seagate, 1TB	1	1,280	Jan. 2009
AVR for computer and printer	Stvol Stabilizer 1000VA	4	1,000	Jan. 2009
UPS for computer	APC	2	1,600	Jan. 2009
Screen with three legged support	VGA	1	3,510	Jan. 2009
White Board on wheel	made in China	1	5,000	Jan. 2009
Wireless Amp with a built-in speaker	Mipro 707	1	9,250	Jan. 2009
Wireless microphone	Mipro MR515/MH203	1	2,500	Jan. 2009
Scanner	Fujitsu Scanner model S 300	2	2,300	Jan. 2009

2) Provision of Basic Medical Equipment and Devices to the 20 Pilot Schools  
(Total: LE 115,000)

Description	Specification	Qty	Unit Price (LE)	Date
Desk for nurse/doctor	W120, D60, H80cm	20	600	Jun. 2009
Chair for nurse/doctor	Steel with backrest, no caster	20	300	Jun. 2009
Chair for patient	H50-60cm, wood without backrest, no caster	20	250	Jun. 2009
Examination bed	W180, D60, H60cm, steel pipe (legs), reclining type	20	550	Jun. 2009
Cabinet for records of patients	W45, D60, H105cm, 3 drawers steel	20	600	Jun. 2009
Cabinet for medicine and equipment	W50, D27, H140cm, steel and glass with lock	20	550	Jun. 2009
Height meter	Ranged up to 200cm wooden, scale range 1mm	20	250	Jun. 2009
Weight scale (analog) portable	ranged up to 130kg, scale range 1kg	20	150	Jun. 2009
Medical lamp-stand type	Stand type-single, electronic power, steel 100-150cm	20	350	Jun. 2009
Tape measure	Scale range, range up to 200cm	20	50	Jun. 2009
Eyesight test chart	Plastic, L65, W35cm	20	100	Jun. 2009
Stethoscope	Double head, aluminum, about 80 cm, about 100g	20	200	Jun. 2009
Dental mirror	Diameter 2.2cm, length 15cm, round handle	20	50	Jun. 2009
Dental tweezers	Stainless steel, length 15cm	20	50	Jun. 2009
Medical treatment tweezers	Stainless steel, straight, length 15 cm	20	50	Jun. 2009
Trash basket (type1)	5-liter red color	20	75	Jun. 2009
Trash basket (type2)	5-liter another color	20	75	Jun. 2009
Clinical thermometer	Mercury thermometer,	20	75	Jun. 2009

Description	Specification	Qty	Unit Price (LE)	Date
	scale range 0.1C			
Sphygmomanometer	Mercury, aneroid desktop	20	375	Jun. 2009
Wash stand and wash basin	Stainless steel, single type	20	350	Jun. 2009
Screen	W100, H150cm	20	350	Jun. 2009
First aid kit only case	Metal W33, D45, H15cm	20	350	Jun. 2009

**3) Provision of Other Equipment (Total: LE 350,328)**

Description	Specification	Qty	Unit Price (LE)	Date
Car (sedan)	Nissan Sunny Ex Salon	1	92,000	Jan. 2009
Car (van)	Toyota Hiace Commuter DLX15	1	172,000	Jan. 2009
Lap top Computer	HP Pavilion DV6-2150	2	11,150	Feb. 2010
Desk top Computer	HP 6000 Pro Micro Tower	3	8,750	Feb. 2010
SPSS Software	PASW statistics base PASW custom tables	2	18,889	Mar. 2010

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### Annex 5-7: C/P Training in Japan

Training			Participants	
No.	Training Title	Period	Name	No.
1.	School Health Training Course in Japan	May 14 – Jul. 4, 2009	1) <b>Dr. Mohsen Goma</b> Director of School Health, Health Insurance Organization, Fayoum Governorate 2) <b>Dr. Doaa Mohmoud</b> Manager of School Health, Ministry of Health, Fayoum Governorate	2
2.	Country Focused Training Course "School Health"	Sep. 23 – Oct. 9, 2009	1) <b>Dr. Omayma Mostafa</b> Position: Deputy Project Manager / Director of Specialized Center, Health Education and Nutrition Department in School Health Insurance Program, Health Insurance Organization 2) <b>Ms. Elham Mohamed Abul Khair</b> General Manager of Environment and Population Department, Ministry of Education	2
3.	School Health Training Course in Japan	May 16 - July 3, 2010	1) <b>Dr. Farag Abdel Moeaz</b> Health Directorate, Tammia District, Ministry of Health 2) <b>Dr. Osama El Garhy</b> The Manager of School Health Insurance in Urban Fayoum, Health Insurance Organization, Fayoum Governorate	2
4.	Country Focused Training Course "School Health"	Sep. 26 – Oct. 9, 2010	1) <b>Dr. Abdel Rahman El Saqa</b> Head of Central Administration, the Central Department of Medical Affairs, Health Insurance Organization 2) <b>Dr. Salah Abu Taleb</b> General Director of Health Insurance Organization, Fayoum Governorate	2
5.	School Health Training Course in Japan	Aug. 21 – Oct. 7, 2011	1) <b>Dr. Sahar M. Ahmed</b> Research and Training Coordinator, Doctor in SACHD, PHC, Ministry of Health	1
6.	Country Focused Training Course "School Health"	Feb. 12 – Feb. 28, 2012	1) <b>Mr. Maklad Mossad Mostafa Abdou</b> Specialist, General Department for Environmental & Population Education, Ministry of Education 2) <b>Dr. Boles Fakhky Farag Mikhuel</b> Medical Manager Division, School Health Division, Health Insurance Organization Fayoum Branch 3) <b>Ms. Matouk Eman Ahmed Hamed</b> Director of Primary Care in the Gharbia Governorate, Directorate of Health Affairs, Gharbia Governorate / Ministry of Health	3
Total:				12

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**Annex 5-8: Implementation Budget by the Japanese Side**

Currency: Yen

	Item	1st Year		2nd Year		3rd Year		4th Year		Grand Total	
		Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual*	Budget	Actual
Local Cost	Printing of Educational Materials	1,629,400	327,896	2,302,100	1,782,506	202,270	170,655	4,056,700	441,772	8,190,470	2,722,829
	Training	687,920	103,056	2,837,138	2,612,219	1,384,770	1,139,786	2,918,380	1,109,852	7,828,208	4,964,913
	Total	2,317,320	430,952	5,139,238	4,394,725	1,587,040	1,310,441	6,975,080	1,551,624	16,018,678	7,687,742

\* As for March, 2012

## Annex 6: Achievement of Project Activities

### Annex 6-1: List of Publications

#### (1) Dissemination Tool Package

No.	Title	The Number of Copies	Date
(1)	Implementation Manual for School Health Services and Guidelines of Monitoring and Supervision for School Health Services (final)*	1,000 Arabic, 1,000 CD-ROM 500 English, 500 CD-ROM	Arabic: Jun. 2012 English: Sep. 2012
(2)	DVD/CD Comprehensive Medical Examination: Healthy Children Learn Better	DVD 1,500 incl. Arabic program CD 500 incl. Arabic program	Arabic: Jun. 2012 English: Sep. 2012
(3)	Leaflet – School Comprehensive Medical Examination for Health Children	1,000 Arabic 500 English	Arabic: Jun. 2012 English: September 2012
(4)	Leaflet – School, Family and Community	1,000 Arabic 500 English	Arabic: Jun. 2012 English: Sep. 2012
(5)	Leaflet – The Internal school Health Committee	1,000 Arabic 500 English	Arabic: Jun. 2012 English: Sep. 2012

\* Implementation Manual for School Health Services and Guidelines of Monitoring and Supervision for School Health Services (M&G) encompasses three items: (1) the Implementation Manual for School Health Services, (2) the Guidelines of Monitoring and Supervision for School Health Services Monitoring Guideline, and (3) Health Education Training and Development of Health Education Materials. The drafts of first two items were printed in December 2009 and the third item was printed in April 2010.

#### (2) Survey Reports

No.	Title	The Number of Copies	Date
1.	Baseline Survey-Final Report	20 Arabic, 20 English, 5 CD-ROMs incl. Arabic, English and Japanese	Mar. 2009
2.	End-line Survey – Final Report	20 Arabic, 20 English, 5 CD-ROM incl. Arabic, English and Japanese	Jun. 2012

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### Theme 3: School Environment

School Health Activity Records 2011-12 School Year

No	Check items	Theme 3														Total Score
		School building				Play ground					Classroom					
		Good wall condition	School gate functioning	Sufficient corridor Space	Sufficient classroom space	Sufficient space	Good ground condition	Clean play ground	Waste baskets in the play ground	Trees	Clean classrooms	Good lighting in a classroom	Appropriate desks and chair	Good Ventilation	Stable electricity supply	
<b>Pilot Schools</b>																
1	Abu Rehab	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
2	Abu Tabb	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
3	Al-Mokatla	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
4	Dar El-Salam	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	93%
5	Dawar El-Wabor	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
6	El-Galaa	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes	No	Yes	Yes	86%
7	El-Rodaa	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
8	Fathy Ali	NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
9	Hassan Abdel Aziz	NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
10	Kadry	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No	Yes	Yes	Yes	71%
11	Kafr Mahfouz	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
12	Kasr Rashwan	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	86%
13	Kom Oshem	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
14	Menshat El-Gamaal	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes	Yes	Yes	Yes	93%
15	Mogamaa Sersena	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	93%
16	Saad Roby	Yes	Yes	NA	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	86%
17	Saweris	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
18	Salah Salem	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	86%
19	Sersena	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
20	Tammia For Girls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
Number of schools with positive records		15	20	19	20	19	20	18	19	18	18	19	18	20	19	
% of schools with positive records, i.e., good conditions		75%	100%	95%	100%	95%	100%	90%	95%	90%	90%	95%	90%	100%	95%	
<b>Non-Pilot Schools</b>																
1	Kafr Emera	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
2	Mogamaa El Roda (Nagaty)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
3	Menshat El-Gamaal	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
4	Al Mokatla	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
5	Old Tammia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%

Grey background means records are missing.

## Theme 4: Water & Sanitation

School Health Activity Records 2011-12 School Year

No	Pilot Schools	Theme 4														Total Score	
		Water for Drinking / hand washing						Toilets									
		Regular water supply	All drinking water taps working	Good drinking water quality	Clean drinking water basin	Hand soap availability	Water basin drainage	Boys				Girls					
								All latrines for boys working (Stool)	All latrines for boys working (Urine)	Clean latrine	Water availability	Smooth drainage	All latrines for girls working	Clean latrines	Water viability		Smooth drainage
1	Abu Rehab	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	87%
2	Abu Taleb	Yes	NA	Yes	Yes	Yes	Yes	NA	NA	Yes	Yes	Yes	NA	Yes	Yes	Yes	73%
3	Al-Mokatla	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
4	Dar El-Salam	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	87%
5	Dawar El-Wabor	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes	93%
6	El-Galaa	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
7	El-Rodaa	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes	Yes	93%
8	Fathy Afi	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
9	Hassan Abdel Aziz	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
10	Kadry	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
11	Kafr Mahfouz	Yes	Yes	No	Yes	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	87%
12	Kasr Rashwan	Yes	No	Yes	Yes	No	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	73%
13	Kom Oshem	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
14	Menshat El-Gamaal	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	87%
15	Mogamaa Sersena	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
16	Saad Roby	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
17	Saweris	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
18	Salah Salem	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
19	Sersena	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
20	Tammia For Girls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
Number of schools with positive records		20	12	18	20	15	20	18	17	20	20	19	17	19	20	19	
% of schools with positive records. i.e., good conditions		100%	60%	90%	100%	75%	100%	90%	85%	100%	100%	95%	85%	95%	100%	95%	
No	Non-Pilot Schools																
1	Kafr Emera	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
2	Mogamaa El Roda (Nagaty)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
3	Menshat El-Gamaal	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%
4	Al Mokatla	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
5	Old Tammia	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93%

Grey background means records are missing.

## Theme 5: Comprehensive Medical Examination

### Comprehensive Medical Examination Coverage School Year 2011/12

Type of examination	Type of schools	Height	Weight	Vision	Urine Analysis	Medical Examination
<b>Pilot Schools</b>						
1	Abu Rehab	Primary	100%	100%	100%	100%
2	Abu Taleb	BE	97%	97%	97%	97%
3	Al-Mokatla	Primary	67%	67%	67%	67%
4	Dar El-Salam	Preparatory	99%	99%	99%	0%
5	Dawar El-Wabor	Primary	99%	99%	99%	99%
6	El-Galaa	Primary	133%	133%	133%	0%
7	El-Rodaa	Primary	90%	90%	90%	90%
8	Fathy Ali	BE	90%	90%	90%	90%
9	Hassan Abdel Aziz	BE	131%	131%	131%	131%
10	Kadry	BE	108%	108%	partially	108%
11	Kafir Mahfouz	BE	83%	83%	83%	83%
12	Kasr Rashwan	Preparatory	115%	115%	115%	0%
13	Kom Oshem	Primary	88%	88%	88%	partially
14	Menshat El-Gamaal	BE	111%	111%	111%	111%
15	Mogamaa Sersena	Primary	99%	99%	99%	99%
16	Saad Roby	Preparatory	80%	80%	80%	0%
17	Saweris	BE	92%	92%	92%	92%
18	Salah Salem	Primary	102%	102%	102%	0%
19	Sersena	BE	86%	86%	86%	27%
20	Tammia For Girls	Primary	118%	118%	118%	118%
<b>Total</b>			99%	99%	94%	70%
<b>Non-Pilot Schools</b>						
1	Kafir Emera	Preparatory	0%	0%	0%	83%
2	Mogamaa El Roda (Nagaty)	Primary	0%	0%	0%	100%
3	Menshat El-Gamaal	Preparatory	116%	116%	116%	116%
4	Al Mokatla	Preparatory	0%	0%	0%	100%
5	Old Tammia	Preparatory	87%	0%	87%	98%
<b>Total</b>			40%	16%	40%	100%

Primary: Average of 1st grade and 4th grade students

BE: Average of 1st grade and 4th grade primary students, and 1st grade preparatory students

Preparatory: Coverage of 1st grade students

#### Medical Examination by doctors

	Done	Partially	Not done	Total
Pilot schools	7	2	11	20
	35%	10%	55%	100%
Non-pilot schools	0	0	5	5
	0%	0%	100%	100%

### Annex 6-3: Results of Key Indicators in the End-Line Survey

Key Indicators		Primary				Preparatory			
		Pilot		Non-Pilot		Pilot		Non-Pilot	
		2009 <sup>1/</sup>	2012 <sup>2/</sup>	2009	2012	2009	2012	2009	2012
Personal Hygiene	% of students who wash their hands using soap for more than 3 times a day	82.6	92.7	81.6	89.8	81.5	90.2	82.8	86.9
	% of students who always wash their hands before eating	43.5	68.3	42.1	59.2	36.1	57.9	37.3	50.5
	% of students who always wash their hands after using bathroom	47.8	62.1	47.5	55.2	47.3	65.8	46.5	57.4
	% of students who brush their teeth at least once a day	52.3	65.5	45.7	62.0	39.3	49.9	43.1	52.8
Dietary Habits	% of students who <b>never</b> eat breakfast before going to school	18.7	28.3	12.8	19.9	22.4	31.0	17.6	32.0
	% of students who <b>did not</b> eat any fruits last week	2.1	0.8	3.5	1.9	1.7	1.5	2.5	2.0
	% of students who <b>did not</b> eat any vegetables last week	0.3	0.0	0.8	0.3	1.2	0.7	0.5	1.0
Physical Exercise	% of students who <b>never</b> do physical activities (more than 60 min per day) <sup>3/</sup>	9.6	30.4	14.7	42.8	53.8	7.6	16.9	41.9
School Environment	% of students who reported that people smoke inside classrooms	94.1	86.1	85.1	88.0	88.7	80.1	87.4	83.0
Students' Physical Conditions	% of students who <b>never</b> got sick in the current school year	61.9	62.7	69.1	83.2	60.2	75.4	73.6	81.0
	% of students who missed classes because of sickness in the current school year <sup>3/4/</sup>	34.9	37.6	33.2	31.7	23.5	34.7	26.8	26.6
Health Check-up	% of students who have <b>ever</b> received health check-ups (by a school doctor, a school nurse or both)	44.5	77.3	55.2	51.6	39.1	87.2	60.5	46.2
	% of students who have ever received health check-ups <b>by a school nurse</b>	7.7	30.7	5.6	11.2	6.4	42.3	6.3	16.5
Others	% of students who reported that there is a school clinic	66.7	100.0	13.3	86.7	45.5	100.0	18.6	93.7
	% of students who reported that they were taught on students' health in general	46.0	58.1	45.5	43.3	38.3	57.6	37.6	39.6
	% of students who reported that school health services has improved in the last two years	NA	59.5	NA	34.3	NA	48.4	NA	23.1

<sup>1/</sup> 2009: Baseline Survey

<sup>2/</sup> 2012: End-line Survey

<sup>3/</sup> It is speculated that the socio-political insecurity in 2011 affected the results.

<sup>4/</sup> Calculated using proportion of children ever missed classes and proportion of children who missed classes because of sickness among those who ever missed classes.



## Annex 6-4: Project Coordination and Management

JCC (Joint Coordination Committee):	Advisory board at the central level
↓	
SHC (School Health Committee):	Coordination body at the governorate level
↓	
ISHC (Internal School Health Committee):	Intra-school implementation body

### (1) Joint Coordination Committee

#### Functions

- To approve the Annual Work Plan of the Project developed by School Health Committee
- To review the overall progress of the Project as well as the achievements of the above-mentioned Annual Work Plan
- To review and exchange pinions on major issues that arise during the implementation of the Project

JCC		No. of Participants				
No.	Date	Egyptian Project Personnel	Japanese Experts	JICA Egypt	Others	Total
1.	December 24, 2008	10	4	2	0	16
2.	May 26, 2009	7	3	3	0	13
3.	July 6, 2010	11	5	2	0	18
4.	June 27, 2011	7	4	4	1	16

### (2) School Health Committee (SHC)

#### Function

- Develop an annual plan and monitor the progress of the Project periodically at district and governorate level

SHC		No. of Participants				
No.	Date	MOHP	HIO	MOE	Project	Total
1.	Jan 4, 2009	5	1	3	7	16
2.	Jan 22, 2009	6	3	4	13*	26
3.	March 10, 2009	5	0	1	9*	15
4.	May 14, 2009	8	3	3	-	14
5.	July 12, 2009	6	3	3	6	18
6.	Aug 16, 2009	5	4	4	6	19
7.	Oct 20, 2009	5	3	5	6	19
8.	Dec 13, 2009	5	2	5	3	15
9.	March 9, 2010	4	3	4	7	18
10.	June 16, 2010	6	3	5	6	20
11.	Oct. 27, 2010	5	5	5	3	18

SHC		No. of Participants				
No.	Date	MOHP	HIO	MOE	Project	Total
12.	June 23, 2011	6	4	5	6	14
13.	Oct. 9, 2011	6	3	3	4**	16
14.	Feb. 8, 2012	8	3	4	3	18
15.	May 10, 2012	3	3	4	4	14

\* includes staff from the baseline survey sub-contractor and a JOCV.

\*\* includes 2 JICA personnel.

### (3) School Health Committee (SHC)

ISHC consists of a head master, social worker, a health visitor, students, parents, and a school doctor if available.

## Annex 6-5: Records of Meetings, Workshops and Training

### (1) Meetings

#### (a) Monitoring Team Meetings

\* The Monitoring Team (MT) was formed in the 10<sup>th</sup> SHC Meeting on June 16, 2010. MT's responsibilities include:

- collection of information on the existing monitoring and supervisory systems;
- review of the organizational structure, demarcation, functions and work flow;
- training of ISHC members concerning recording and reporting of school health activities, and
- modification of the draft Guidelines of Monitoring and Supervision for School Health Services.

MT is comprised of: 13 Egyptian project personnel (C/Ps) from MOHP, HIO, and MOE at the central and governorate level; one Health Manager of the Nursery Branch, one Director of the Technical Office, one Director of the Information and Documentation Department from HIO Fayoum, and one government official from MOE Fayoum.

MT Meeting		No. of Participants			
No.	Date	HIO and MOE	C/Ps	Project	Total
1	Jun. 17, 2010	-	6	6	12
2	Jun. 28, 2010	-	11	6	17
3	Jul. 15, 2010	-	11	6	17
4	Aug. 1, 2010	2	11	5	18
5	Nov. 11, 2010	2	10	5	17
6	Nov. 23, 2010	3	19	5	27
7	Jun. 7, 2011	-	10	1	11
8	Jun. 29, 2011	2	10	-	12
9	Oct. 12, 2011	3	12	1	16
10	Oct. 20, 2011	2	11	-	13
11	Oct. 25, 2011	2	10	2	14

#### (b) Trainers' Team Meetings

\* The Trainers' Team was formed in the 10<sup>th</sup> SHC Meeting on June 16, 2010. TT's responsibilities include:

- development of a set of job descriptions for school doctors, health visitors, social workers and teachers;
- creation of a DVD on health examination;
- revision of Implementation Manual for School Health Services, and
- modification of the draft Health Education Materials.

TT is comprised of: 10 Egyptian project personnel from MOHP, HIO, and MOE at the central and governorate level; one Health Manager of the Nursery Branch and three supervisory nurses from HIO Fayoum, and three environment and population teachers and two social workers from pilot schools.

TT Meetings		Topic	No. of Participants <sup>1/</sup>
No.	Date		
1	Jul. 6-8, 2010	Preparation of School Health Examinations	18
2	Jul. 20-21, 2010		18
3	Oct. 26, 2011	TT Methods on School Doctors	21
4	Nov. 22, 2011	Preparation of Computer Training	21
5	Mar. 7, 2012	Dissemination to non-pilot schools	22
6	Apr. 7, 2012	Preparation of the Evaluation Workshop on Dissemination Activities	1

1/ Participants include the Egyptian project personnel, school nurse, project members.

(c) Others

• MT/TT Joint Meetings

MT/TT Joint Meetings			No. of Participants				
Date	Topic	MT/TT	C/Ps	Project	Others	Total	
1	Oct. 26, 2010	Review on TT and MT Activities	11	6	3	-	20
2	Jan. 27, 2011	Health Check-up Review	14	6	2	-	22
3	Jan. 10, 2012	Pre-test on the Manual	12	17	1	26 <sup>1/</sup>	56
4	Jan. 12, 2012	Pre-test on the Guidelines	7	16	1	1 <sup>2/</sup>	25
5	Feb. 6, 2012	Implementation on the Guidelines	17	-	3	-	20

<sup>1/</sup> Schools

<sup>2/</sup> information officer from MOE

• Kick-off Meetings

Kick off Meeting for Internal School Health Committee

Date	No of Pilot Schools	No. of Participants				
		HM/SM <sup>1/</sup>	Teachers	C/Ps	Project	Total
Jul. 12, 2009	20	17	3	5	8	33

<sup>1/</sup> HM/SM: Head Masters / School Managers

Kick off Meeting for Monitoring Team

Date	No. of Participants			
	MT	School Personnel	Japanese Experts	Total
Nov. 3, 2010	11	62	4	77

Kick off Meeting for Trainer's Team with Heads of ISHC Members

Date	No. of Participants					
	HM/SM	MOH	HIO	MOE	TT (non-C/P)	Total
Oct. 11, 2010	19	4	2	3	5	35

### Kick off Meeting for School Health Activities for the Pilot Schools

Date	No. of Participants				
	C/Ps	PC Teachers	SW	Other School Personnel	Total
Oct. 13, 2011	7	2	2	99	110

### TV Conference Connecting Five Countries (Egypt, Ghana, Cameroon, Nepal and Laos) and Japan

- Follow-up for the participants in the School Health Training in 2010
- Follow-up for the participants in the School Health Training in 2011 (February 16, 2012)
- Follow-up for the participants in the Country Focus Training in 2012 (May 29, 2012)

### (2) Workshops

#### (a) Workshop on the Development of the Monitoring and Supervisory Guidelines of School Health

Theme		No. Participants <sup>1/</sup>
		Aug. 3-5, 2009
1	Health Education	9
2	Community Participation	8
3	School Environment	9
4	Water and Sanitation	9
5	Health Care Services	8
Total:		43

<sup>1/</sup> Each taskforce consists of 9-10 members, Leader (school manager), coordinators (Egyptian project personnel, 2-3 persons), and members (teachers, SW, HV, SD and SN, 5 persons),

Note: The taskforces prepared the draft of the guideline, which was finalized by the Monitoring Team.

#### (b) Workshop on the Development of School a Health Manual

Theme		No. Participants <sup>1/</sup>		
		June 15-17, 2009	July 14-16, 2009	July 20-22, 2009
1	Health Education	8	9	-
2	Community Participation	8	8	-
3	School Environment	9	9	-
4	Water and Sanitation	8	9	-
5	Health Care Services	-	1	11
Total:		33	36	11

<sup>1/</sup> Each taskforce consists of 9-10 members, Leader (school manager), coordinators (Egyptian project personnel, 2-3 persons), and members (teachers, SW, HV, SD and SN, 5 persons),

(c) Workshop for Planning the Awareness Raising Campaign and Dissemination Workshop

Workshop		No. Participants				
Date	Days	HV	SN	SD	C/P	Total
Feb. 8, 2010	1	21	3	17	5	46

(d) Health Promotion School Dissemination Workshop

Date		No. Participants					Total
		C/P		School Personnel in Tammia district	Other Districts in Fayoum	Upper Egypt Govern- orates	
		Cairo	Fayoum				
Mar. 2-3, 2010 (2 days)	MOH	3	5	-	7	9	24
	HIO	1	2	-	5	11	19
	MOE	3	4	4	5	9	25
	<b>Total</b>	<b>7</b>	<b>11</b>	<b>4</b>	<b>17</b>	<b>29</b>	<b>68</b>

Date		Gharbia	Fayoum	Cairo	Donors*	Project	Upper Egypt**	Total
Jun. 27-28, 2012	Day 1	6	11	14	5	8	45	89
	Day 2	6	6	10	1	8	44	75

\* Representatives from JICA, the Japanese Embassy, WHO, and the Arab Medical Union

\*\* Excluding Fayoum

(e) Workshops for the M&G revision

Date		No. Participants				Total
		MI/TT	C/Ps	Project	Others*	
1	Jun. 16, 2011	19	2	4	1	26
2	Jun. 19, 2011	17	1	4	1	23
3	Jun 21-22, 2011	16	-	4	4	24

\*Others include school teachers and supervisory nurses.

(f) Center Schools' Kick-off Workshop for Dissemination Activities for 5 Non-Pilot Schools

Date	No. Participants			
	MI/TT	C/Ps	School Personnel	Total
Mar. 15, 2012	11	16	45	76

(g) Workshop on "Summarizing Dissemination Activities: Lessons Learned"

Date	No. Participants				
	MI/TT	C/Ps	SN	School Personnel	Total
Apr. 17, 2012	23	7	5	48	83

### (3) Training

#### (a) Training on School Health to Administrative Officers

Level (Location)	Training Period		No. of Participants				
	Date	Day	MOH	HIO	MOE	Others	Total
National Level (Cairo)	Dec. 30, 2008	1	3	1	2	-	6
Governorate and District Level (Fayoum)	Jan. 4, 2009	1	5	1	3	2	11

#### (b) Training on Use of the Implementation Manuals and the Monitoring Guidelines for School Health Service

Themes	Training Period		No. of Participants					
	Date	Days	HM/SM	Teachers (Eand P)*	SW	HV	SN	Total
1-4	Nov 14-15, 2009	2	20	20	19	23	3	86
Themes	Date	Day			SD	HV	SN	Total
5	Nov. 17, 2009	1	-	-	17	21	3	41

\* Environment and Population

#### (c) Regular Training on School Health to School Health Personnel

Training Period		No. of Pilot Schools	No. of Participants				
Date	Days		Teachers and HM	SW	HV	SN/SD	Total
Mar. 3-4, 2009	2	5	11	6	6	8	31
May 6-7, 2009	2	11	30	15	15	3	63
Oct. 17-18, 2010 <sup>1/</sup>	2	8	14	8	9	3	34
Oct. 20-21, 2010 <sup>1/</sup>	2	5	10	5	6	2	23
Oct. 31-Nov.1, 2010 <sup>1/</sup>	2	7	14	7	7	-	28

1/ Training on Comprehensive Health Examination by TT

#### (d) Training on Health Education

Training Period		No. of Participants					
Date	Days	HM/SM	Teacher (E&P)	SW	HV	SN/SD	Total
Feb. 15-17, 2009 <sup>1/</sup>	3	-	20	19	22	3	64
Oct. 24-25, 2010 <sup>2/</sup>	2	19	19	19	22	3	82

<sup>1/</sup> Conducted by Japanese experts

<sup>2/</sup> Conducted by the Trainers' Team

#### (e) School Health Examination Field Practicum in Tammia

Training Period		No. of Participants						
Date	Days	MOH	HIO	SN	Abu Taleb School			Total
					SD	HV	Teachers	
Feb. 23-24, 2010	2	2	3	2	1	1	1	8

(f) Training for Health Care Service Providers in Tammia

Date	Days	C/Ps	HV	SN	SD	Total
Nov. 17-18, 2010	2	5	21	3	17	46
14-Jun-11	1	-	17	2	2	21
15-Jun-11	1	1	18	2	3	24
20-Jun-11	1	1	-	4	7	12

(g) Training for Health Care Service Providers in Cairo: Lecture on the New Influenza

Training Period		No. of Participants				HIO Branches connected via TV Conference System
Date	Day	C/Ps	Doctors	Non-Medical Officers	Total	
Nov. 22, 2010	1	1	13	3	11	20

(h) OJT for Health Visitors and School Nurses on How to Conduct a Questionnaire Survey to Students' Parents in Tammia

Training Period		No. of Participants		
Date	Day	C/Ps	SN	Total
Jul. 6, 2011	1	5	4	9

(i) Medical Examination Training in Tammia

Training Period		No. of Participants				
Date	Days	TT	C/Ps	SD	HV	Total
Oct. 30, 2011	1	16	1	6	1	24
Oct. 30-Nov. 1, 2011	2	16	1	6	1	24

(j) Computer Training on School Health Activities

Training Period		No. of Pilot Schools	No. of Participants			
Date	Day		TT	C/Ps	School Personnel	Total
Nov. 23, 2011	1	20	19	-	41	60

(k) Capacity Building Training on School Health Activities (Self-Evaluation and Community Participation)

Training Period		No. of Pilot Schools	No. of Participants				
Date	Day		TT	C/Ps	SN	School Personnel	Total
Jan. 5, 2012	1	20	22	5	5	98	130

(l) Refresher Training on Five Themes

Training Period		No. of Pilot Schools	Themes	No. of Participants				
Date	Day			ME/TT	C/Ps	SN	School Personnel	Total
Mar. 14, 2012	1	20	1-4	12	19	4	101	136
Mar. 18, 2012	1	20	5	13	18	4	103	141





