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Evaluation of the Fayoum Rural Health and Family Planning Project

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EXECUTIVE SUMMARY

Introduction

On request of the Royal Netherlands Embassy in Cairo, a mission consisting of four members evaluated the Fayoum Rural Health and Family Planning project (FaRHFP project). The mission lasted from Wednesday 20 November 1996 until Sunday 1 December 1996. The purpose of the evaluation was to assess the impact and sustainability of the FaRHFP project since its beginning in 1992 with regard to its aim to improve the health and wellbeing of rural Egyptian families, with special emphasis on the health of women and children.

For an assessment of the actual project activities, the mission focused its attention on three of the nine Village Council Areas (VCA's) in Itsa District, where the project is being implemented. Given the time constraints, the mission team decided to perform a complete and comprehensive evaluation of project activities in only three VCA's, rather than a more superficial evaluation in all nine. For the selection of the three VCA's the following criteria were applied:

- the VCA's should be evenly spread in Itsa District;
- the various phases of implementation of project activities should be reflected.

The following three VCA's were selected: Kalamsha, Meniet-el-Heit and Toutoun.

The report consists of three parts. Part I, the introduction, gives background information concerning health and population issues in Egypt and Fayoum, discusses the context in which the project is being implemented, describes the history, aims and general objectives of the project, and gives an overview of the project Organization. Part II reports on the findings of the mission team. Seven different areas are being covered, varying from the HP system to project sustainability after the Netherlands support has been phased out. For each area the main characteristics, specific objectives and progress made until the time of the evaluation are being presented subsequently, followed, finally, by a discussion section. In part III the conclusions and recommendations are being presented.

This executive summary mainly focuses on the mission's findings, conclusions and recommendations.

Project objectives

The FaRHFP project is a decentralized technical cooperation project between the Egyptian and Netherlands Governments operating in the Fayoum Governorate. Since its initiation, the project has undergone considerable development in response to significant changes both within the Egyptian context and in relation to changes in international developments, family planning (FP), and women's health. The process-oriented approach embodied in the project has allowed for the flexibility necessary to effectively respond to these changing contexts as well as to capitalise on the increasingly rich accumulation of experience and expertise gained during the project's years of operation. However, because of the duration of the project and the extensive range of input and participation from various individual experts and concerned parties, the process of continuous project development has been a complex and complicated one.

The first Phase of the project started in June 1992 and lasted until May 1995. It was extended by three consecutive Interim Periods covering a total of eight months, from June 1995 until January 1996. In July 1994 a monitoring mission concluded that the project had demonstrated considerable success and that promising results were already apparent. The team strongly recommended to extend the project for a five-year period, and proposed an extension of project activities. In November 1994 the extension was agreed in principle between all parties concerned. A project formulation mission assisted in the further development of the second phase. The second phase of the project started February 1996 and will end in January 1999. During the first three years of the second phase, the RTI remains the implementing agency. A decision on the remaining two years will be taken later.

Project management and organization

The number of project staff has increased considerably during the past years. This has led to an organization structure which is rather complex. It comprises a steering committee, an executive committee, an executive director, national and foreign technical advisors, seconded staff, contracted staff, BAE's and local and foreign consultants. Furthermore, for the implementation of its activities project staff works closely together with various governmental and non-governmental organizations.

It is felt by the evaluation team that, along with the growth of the project, organizational and managerial development has lagged behind. There is need for a thorough analysis of the project's organization and management structure. Special attention needs to be given to the project structure, (delegation of) responsibilities, lines of communications and decision making processes.

The evaluation team recommends that a team of (health) management consultants (national and international) is assigned to analyse the present organizational structure and management practices and to propose new designs. This should be done as soon as possible.

Project model

Theoretically, the three components of the project are relevant to the realization of aims and objectives. In practice, the second component (i.e. the upgrading of health services) is the bottleneck in this project. The HP's and HPS's are raising health awareness and expectations of health services among the beneficiaries but they are not being backed up by the upgrading of the health services. The project has been successful in increasing FP use and child immunization, but less successful in increasing the utilisation of curative health services. In fact, what the HP's are doing is helping the private health sector. The beneficiaries have more health awareness, but do not receive satisfactory services especially in the curative sector from the formal health system. Even the very poor now collect money to be able to see specialized private physicians usually in Itsa City or Fayoum City.

The "empowerment of women" is much more evident among the HP's themselves than among the beneficiaries who are the target group of this whole project.

The project has been partially successful in implementing its selected approaches and strategies. It has succeeded in the "integrated sustainable and comprehensive development approach" and the "utilizing of a community-based approach". We can not comment on the "process-oriented approach" because the subject was not raised in discussions. It has possibly succeeded in the "gender-sensitive approach and the empowerment of women" but often HP's had to be reminded of this objective. It has also only partially succeeded in the "reproductive health approach" because while it addresses "maternal child services, gender-sensitive focus . . . and sensitivity to the availability of female physicians," it has not directly addressed "maternal morbidity and mortality" nor "the desegregation of quantitative data on health status by sex".

This project should clearly define what it means by the "empowerment of women" and should develop new, more relevant indicators to measure the realization of this objective. The documents for Phase I of the project hardly address the issue while the document for Phase II concentrates on the role of HP's as "development brokers" and lists indicators that measure this rather than whether women have a better status and more decision making power in the family and in the community.

The mission members are aware that indicators for the "empowerment of women" are a problem in many projects. Recently the Prime Minister's information centre has organized a seminar on the subject and has divided participants into various groups to develop indicators in the various areas (political, economic etc.). Maybe this initiative can be of help.

The health promoter system

The major achievement of this project is the establishment of a functional HP system. Through utilization of this community-based approach, FaRHFP was designed to complement the Egyptian health facility based model. However, based on FGDs with beneficiaries (women/men), and the HP's, our impression was that the health infrastructure represented in different levels of rural health facilities usually run short of medicines and laboratory materials. These, in addition to poor managerial and administrative skills of some health team members, are all potential threats for this community-based project.

The target audience expects both governmental and nongovernmental health agencies to improve not only existing preventive health services but also curative ones before building communication channels with them. This in itself carries a potential threat of implementation instabilities and lack of project credibility to its HP system.

Although the HP's are considered as 'development brokers' or multi-purpose outreach workers, their primary focus of work is to disseminate information regarding family health, including FP and MCH issues to the community. While the community coverage (home visits) of the HP's is highly successful, their specific communication objectives are not clearly stated in terms of measurable changes in RH/MCH-related KAP. Therefore, a clear, specific FP/IEC strategy is needed for the HP system, one that should be reflected in HP training and field operations.

The second phase of the project must work to strengthen the HP system and maximize the opportunities it provides by:

- focusing on improving the quality of community health services;
- continue further strengthening the role of HP's;
- effectively integrating project activities into existing Egyptian systems in order to ensure sustainability.

Upgrading health and family planning services

The schedule and budget for:

- renovation of the 22 of the 23 RHF's and all 4 EFPA FPC's;

- procurement of basic medical equipment and office furniture for the RHF's and FPC's;
- procurement of furniture appliances for the 23 houses of the physicians working in the RHF's;
- distribution of equipment, furniture and appliances to the RHF's, FPC's and houses of the physicians; and
- establishment of 3 NS's

had to be adopted several times during the first project phase and the three interim periods. However, at the time of the evaluation, all these activities had been completed.

1 RHosp, 3 RHU's, 1 NS and 1 FPC (EFPA) and three physicians' houses were visited by the evaluation team. As far as the members could judge (none of them was a building and equipment expert), the renovations and equipment were of a good quality. These findings are in line with those of a building and renovation coordinator of the RTI, who visited the project in 1993 and 1995.

Maintenance remains a concern. The available DoH budget for maintenance is small, and the present DoH organization is not much geared towards maintenance. Therefore the evaluation team is very much in support of the planned development of a preventative maintenance plan and establishment of a district maintenance workshop during the second phase of the project.

The evaluation would like to emphasize that an adequate infrastructure is only one of the prerequisites for a good functioning health system. Motivated health staff is an important second. Despite incentives the motivation of especially the physicians working in the rural health facilities is far from optimal. Although the performances of the physicians is the main concern of the DoH, the project should put a greater effort in seeking ways to stimulate the physicians to perform better. It is recognized by the evaluation team that the MOHP is currently implementing a new incentive system for physicians working in the rural areas.

Although the performances of the physicians are the main concern of the DoH, the project should put a greater effort in assisting the DoH in seeking ways to positively influence the performances of the physicians. A more systematic supervision of the physicians in combination with, if reasons exist, withholding of incentives should be seriously considered.

Socioeconomic activities

The socioeconomic component was implicitly included at the end of phase I, i.e. documents for that phase do not include it as a separate component, but starting in 1995 and 1996 it is mentioned as 'ongoing activities'. This component is clearly defined for phase II.

The ISL system has a budget of LE 10,000 per VCA while the credit system has a budget of LE 20,000 per VCA. The remaining LE 10,000 go to covering expenses of group activities. There are criteria for the selection for ISL recipients (e.g. family income not more than LE 10 a month) but there are no similar criteria for the selection of the recipients of loans from the credit system. If the project is targeting the needy women then criteria should be developed for the selection of the latter group.

The range of economic activities for both the ISL and credit systems are very limited.

The issue of sustainability of this component is being addressed. Currently the project is assessing the various community organizations e.g. CDAs, and local councils, and scoring them to select which should take over the ISL component once the project phases out. The likelihood is that they will create a women's club under the auspices of the CDAs. They are also considering adding interest to the ISL's. However, we have no assurance that the selected solutions will be implemented.

Social group activities are quite successful, especially the sewing classes. There are approximately 100 women who have been trained on sewing and 49 of them received sewing machines on loan and have started their own businesses. Also, some of them have been employed by the 6th of October Cloth Factories. The literacy classes are rather limited in number (beneficiaries only 82 women) and there is a possibility that they relapse into illiteracy if they do not use their newly acquired ability to read and write.

The socioeconomic component and the "empowerment of women" should be revised and more clearly defined in project documents. Relevant indicators for the "empowerment of women" should be developed.

The allocation of funds for the three subcomponents of the socioeconomic component should be revised if the major target group is needy women.

There should be more cooperation between FaRHFP and similar projects for e.g. Women's Initiative Fund of CIDA, SPUF of CARE and SAP activities in the socioeconomic component.

Particularly in sustainability of the socioeconomic component there should be closer cooperation and integration with the SPUF project implemented by CARE and also funded by the Netherlands Embassy.

Information, monitoring and research

During Phase I of the project, the management information system was not fully developed and the monitoring system was not given priority as were other components.

Audience baseline data were not available during development of the training curriculum for HP's.

Considerable time invested in the development of step-by-step procedures for community appraisals in project catchment areas has resulted in production of several high-quality appraisals as well as other issue-specific studies and research manuals.

The management information system needs to be improved and updated for project strategy formulation and evaluation of the impact of ongoing activities.

The new initiative of the project to build up a monitoring system at the district level based on specific selected indicators should be strengthened in order to improve problem-solving skills of DHMT.

A mix of research methods should be specified and additional qualitative research on the audiences' attitudinal barriers, information needs and missed opportunities in the area of RH should be collected and analysed during the course of the project.

Additional community based research is needed to measure the impact and quality of HP system in health promotion and in coordination with RHF's.

FaRHFP should develop a coherent IEC plan to reach special target audiences. IEC consultancy should be sought from a recognized expert with previous experience in Upper Egypt. IEC interventions must aim at achieving behaviour and attitude changes of a specific segment of beneficiaries based on a study of their needs and perceptions. Its integrated components are:

- Information: generation and dissemination of technical information, facts and issues to create awareness among different target groups;
- Communication: a planned process aimed at motivating people to adopt new attitudes or behaviour, or to utilize existing services;

- Education: the process of facilitating learning, to enable people to make rational and informed decisions and to influence their behaviour over a long term, either formal or informal.

Training courses, seminars and workshops

The success of the FaRHFP in training has been observed in messages on home visits, family planning, counselling on MCH, immunization, small loan and credit. The HP's were the medium to communicate these messages to the women in the villages they work in. They were consistent at all levels from project management to the women beneficiaries in the villages.

The project has the potential of forming a professional training team of a good quality. It has the expertise in public health, research, sociology, and field work. However, this potential has not been exploited yet by the project management as each section is doing their own part of the training i.e. training coordinator does some training, senior social worker, monitoring and research does others. The socioeconomic expertise in the project especially in the market supply and demand is not there yet.

A number of project and non-project staff participated in different courses organized by the FaRHFP. This training method was mainly classroom sessions in the project premises. The characteristics of the training courses were mostly theoretical and the duration varied from one day to 6 weeks. The exceptional training which has both six weeks theory and two weeks field work, was for the HP's course. The latter was focused on the socioeconomic component of the project. Other short courses or tours were organized in the Arab World and Holland. No candidate is identified yet for higher education fellowship.

The threat to the existing training efforts are the fragmentation of the training by different sections in the project, the top down approach, and the focus on theoretical training. There are HP's who communicate messages exactly in the way they were trained. Sometimes these messages do not make sense. An example of a HP who was giving hygiene education in an area where sewerage was all around the clinic and houses. She was not given the training to examine the reality before communicating unrealistic message.

The use of simple audiovisual training, the situation analysis by the HP's and HPS can make a difference in development and future Sustainability. These cadres should understand what the situation is, why is it that way, what could be done to make a difference. Many of them at the time being respond automatically on how the situation should be (the idle way).

The focus of the FaRHFP project has been reaching women recipients by the HP's system. Men have been left aside for one reason or another. In many of the project's documentation and the present evaluation, it has been suggested that men involvement was essential. Men were and still are the major decision makers in the family. They could enhance the HP's strategy or go against it. They needed to be equally informed and involved. Threats to HP's by men who are against FP may not be taken seriously and could damage the HP's confidence.

Training should be coordinated among the different sections in the project. The expertise of the project should be maximized in different participatory settings. These efforts need management commitment to build trust among the expertise in order to work together.

The research component of the project should be one of the main tools to build and develop the training curriculum. Relevant textbook manuals should be used to develop the field manuals. Emphasis should be given to practical training more than to the theoretical one.

The HP's and HPS's should not only be told what to do but be given the opportunities to present their work to others, a two way learning. They need guidance what to do once they are given the chance to use their minds and capabilities. This can be hard in a society where the educational system is theoretical and hierarchical in nature. But a move has to start.

Women empowerment is still a vague concept. This vagueness could be part of the role women will play in educating others about their situation, their achievements and get education from others. The only way of achieving this is through giving them the opportunity to debate their role in the society instead of accepting blind instructions from others. In this way they will influence decisions and make decisions themselves.

Training should be made simple, practical and fun. Some simple visual aids such as circles to represent the catchment areas, should be made available to the HP's. From these circles or whatever visual aid, the HP should be encouraged to think how she could reach the intended women or children in that catchment area. In this way, she could assess her own achievements.

If the HP's were trained to assess themselves, they would be in a position to communicate their achievements to others at different levels in the rural areas and the region. The continuous training and education may be used as rewards for better achievements and not routine. For example those who achieved

better will be taken to training courses in Fayoum or outside it. The information of these activities could be shared with others in the field and elsewhere through a circular or a regular low cost newsletter.

The position of the trainer coordinator should be given a priority for higher education in training methodology. Candidates for higher education fellowship in public health should be seriously sought. Candidates would have time to acquire the qualification and apply it before the Dutch withdrawal to sustain some of the project activities. The project consultant will then have ample time to give training for the new graduates in the project site.

The project should consider a male and female team in the HP system. This will enhance the present strategy and future sustainability.

Phasing out and sustainability

Sustainability at this stage may have different interpretations by different players at the FaRHFP. If it means the project will continue to function once the Dutch input stops as it is now without any external financial input, we are talking fairy tales. If this concept was taken seriously for development, there might be a number of activities that might have a chance to continue after the Dutch input stops. These could be developed through rigorous involvement and continuous field training and presentations of achievements between project staff and HP's in the field and the region.

Until now sustainability focused on the permanent employment of the HP's. The Governorate of Fayoum was in the process of responding positively to this arrangement. The supply of family planning and immunization could be secured through the responsible agencies. Whilst the project components i.e. the support system to the HP's in supervision, training, research were still under consideration, there were plans under development for the sustainability of the socioeconomic component.

The HP's were trained to create awareness among women on a number of services which the project and non project agencies were providing. The balance between service demands and supply has to be seriously considered. If the HP's continued promoting services that can not be met, their efforts will be seriously undermined and the trust of the community will be lost.

Recently, team work within the DHMT was getting more attention. It has a potential in tackling the different preventive and curative care. However, their role and interaction among one another was still unclear. Their

involvement with FaRHFP might be positive in working together. But it may create unrealistic expectations which the project could not fulfil.

There are a number of bottle necks which the project suffers from before expanding to the Ibshaway area. The range is quite wide, curative care, belief and attitude towards FP, the involvement of men, loan and poor families, overemployment and ineffective performance, training and management. All these problems build up and can be a serious threat to the present success of the project.

There is the attitude that things will work as long as the project is there, once it is gone another project will take place. This and another threat which is the employment of HP's that may add new governmental employees with little support and supervision. Hence a new system is dissolved and become ineffective in the old system.

Sustainability of the project has been focused on the permanent employment of the HP's. The Governorate of Fayoum is in the process of responding positively to this arrangement. The supply of FP and immunization could be secured through the responsible agencies. Whilst the project different components i.e. the support system to the HP's in supervision, training, research are still under consideration, there are plans under development for the sustainability of the socioeconomic component.

The HP's system can make a difference in programme development of preventive care. But if it is not supported by curative care which is very ineffective at the time, the confidence of the population towards the HP's will soon be lost. Recently, team work within the DHMT is getting more attention. It has a potential in tackling the different preventive and curative health care. However, their role and interaction among one another is still unclear. Their involvement with FaRHFP might be positive in working together. But it may create unrealistic expectations which the project could not fulfil.

There is the attitude that things will work as long as the project is there, once it is gone another project will take place. Another threat is the employment of HP's that may add new governmental employees with little support and supervision. Hence, a new system is dissolved and becomes ineffective in the old system.

Serious thinking should be given to the development of the role of the DHMT in tackling the different issues of sustainability. The role of the FaRHFP should act as a catalyst, advisory in nature but not the executive role in financing activities.

LIST OF ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
CAFE	Community Action for the Environment
CDA	Community Development Association
CEW	Community Extension Worker
CRM	Community Resource Mobilisation
CU	Combined Unit
DANIDA	Danish International Development Association
DHD	District Health Department
DHMT	District Health Management Team
DMHT	District Mobile Health Team
DOH	Directorate of Health
DSS	Decision Support System
EAAE	Egyptian Authority on Adult Education
EDHS	Egyptian Demographic and Health Survey
EFPA	Egyptian Family Planning Association
FaRHFP project	Fayoum Rural Health and Family Planning project
FP	Family Planning
FPC	Family Planning Committee
GDP	Gross Domestic Product
GSME	Growth in Small and Micro Enterprises
HIV	Human Immunodeficiency Virus
HP	Health Promoter
HPS	Health Promoter Supervisor
ICDA	Itsa Community Development Association
ICPD/POA	International Conference on Population and Development/Programme of Action
IEC	Information, Education and Communication
ISL	Individual Small Loans
IMR	Infant Mortality Rate
IMRU	Information, Monitoring and Research Unit
IUD	Intra Uterine Device
IWA	Islamic Welfare Association

MCH	Maternal and Child Health
MIS	Management Information System
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MOPFP	Ministry of Population and Family Planning
MOSA	Ministry of Social Affairs
MWRA	Married Women of Reproductive Age
NCCM	National Council for Childhood and Motherhood
NGO	Non-Governmental Organization
NPC	National Population Council
PHC	Primary Health Care
RH	Rural Hospital
RHF	Rural Health Facility
RHU	Rural Health Unit
RTI	Reproductive Tract Infection
SFD	Social Fund for Development
SPUF	Small Projects Umbrella Fund
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TT	Tetanus Toxoid
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VCA	Village Council Area

LIST OF TABLES

PART I: INTRODUCTION

1 INTRODUCTION

1.1 Purpose of the evaluation

On request of the Royal Netherlands Embassy in Cairo, a mission consisting of four members evaluated the Fayoum Rural Health and Family Planning project (FaRHFP project). The mission lasted from Wednesday 20 November 1996 until Sunday 1 December 1996.

The purpose of the evaluation was to assess the impact and sustainability of the FaRHFP project since its beginning in 1992 with regard to its objective to improve the health and wellbeing of rural Egyptian families, with special emphasis on the health of women and children. In line with the Terms of Reference the following tasks were performed:

- Assessment of the conceptual framework and project model, and review of the different components of the project as to the internal consistency with the project objectives as well as the strategies used to implement these components. Particular emphasis was given to the socioeconomic activities.
- Review of the progress made so far.

The evaluation on which this document reports, was the first external evaluation of the project since its inception in 1992. In 1994 a monitoring mission was fielded. However, this mission was not independent as it included some members who had been involved in the project earlier.

The full text of the Terms of Reference is presented in Appendix 1.

1.2 Methodology

The evaluation comprised five elements:

- A preparatory meeting with staff of the Royal Tropical Institute (RTI) in Amsterdam;
- Briefing and debriefing meetings at the Royal Netherlands Embassy in Cairo (in fact, the latter took place at the residence of the First Secretary Gender and Development, Mrs. Joke Buringa);
- Interview meetings with representatives of the Ministry of Health and Population (MOHP) in Cairo, as well as with representatives of several Egyptian and international (governmental and non-governmental) donor Organizations;

- A visit to project sites in Fayoum Governorate, which included meetings with His Excellency the Governor of Fayoum, representatives of the Directorate of Health (DOH), project staff and management, and beneficiaries.

For an assessment of the actual project activities, the mission focused its attention on three of the nine Village Council Areas (VCA's) in Itsa District, where the project is being implemented. Given the time constraints, the mission team decided to perform a complete and comprehensive evaluation of project activities in only three VCA's, rather than a more superficial evaluation in all nine. For the selection of the three VCA's the following criteria were applied:

- the VCA's should be evenly spread in Itsa District;
- the various phases of implementation of project activities should be reflected.

The following three VCA's were selected: Kalamsha, Meniet-el-Heit and Toutoun.

To gather data the mission made use of five methods:

- Meetings with His Excellency the Governor of Fayoum, and the Executive and Steering Committees of the project;
- Analysis of project documents, which were made available by the RTI and the project management.;
- Focus group discussions with health promoters (HP's), beneficiaries (being rural men, rural women, and receivers of small loans and credit), the Itsa District Health Management Team (DHMT), and the Meniet El-Heit Family Planning Committee (FPC);
- In-depth interviews with health promoter supervisors (HPS's), project staff and management, foreign and local consultants to the project, and representatives of the DOH;
- Observational visits to six rural health facilities (RHF's), a sewing class, and a training course for clerks.

The workplan of the evaluation mission is presented in Appendix 2.

1.3 Structure of the report

The report consists of three parts. Part I, the introduction, gives background information concerning health and population issues in Egypt and Fayoum, discusses the context in which the project is being implemented, describes the history, aims and general objectives of the project, and gives an overview of the project organization.

Part II reports on the findings of the mission team. Seven different areas are being covered, varying from the HP system to project sustainability after the Netherlands support has been phased out. For each area the main characteristics, specific objectives and progress made until the time of the evaluation are being presented subsequently, followed, finally, by a discussion section.

In part III the conclusions and recommendations are being presented.

1.4 General observations

The findings of the mission presented in this report tend to focus on the weaknesses of the project, rather than the strengths. However, the evaluation team strongly believes that the project on the whole is successful and effective. Rural women have a positive impression of the HP system and the FP and MCH services provided in the RHF's. The small loan and credit system is helping rural women in solving their economic problems. Project staff, consultants and HP's and HPS's are over all devoted to their work and carry out their responsibilities with high motivation. Readers are requested to keep this in mind when reading the pages to follow.

Furthermore, the mission would like to stress here that it found the project to be very well documented, which certainly facilitated the work of its members.

2. BACKGROUND INFORMATION

2.1 Health and population policy in Egypt

In January 1996 the Ministry of Health (MOH) and the Ministry of Population and Family Planning (MOPFP) merged into the MOHP.

Health policy in Egypt is based on the right of the public on free (unpaid) basic health services, for which the government is responsible. Objectives of health services are health promotion, prevention and control of health hazards, and rehabilitation of the handicapped. The MOHP continues to retain *Health for all by the year 2000* as the main health objective. The Government of Egypt's five year health plan for 1992 to 1997 enunciates policies and strategies in which subsidized health care will be targeted for the needy and fees for services will be introduced for those who can pay. The plan encourages community participation in health, and emphasizes the continuous upgrading of health information systems.

The MOHP has developed national programmes to control childhood diarrhoea and acute respiratory infections and instituted an expanded childhood immunization programme. Targets to eradicate poliomyelitis and eliminate neonatal tetanus before the year 2000 have been set. Progress is being made in these areas, with eradication of polio possible by 1997. The MOHP has also identified maternal and child health (MCH) and FP as priority areas and has directed attention to improve maternal health through integrated reproductive health programmes as well as reducing neonatal mortality through improving the quality of care given to newborns at home and in health facilities.

The MOHP is stressing the importance of integrating FP and MCH. Emphasis is being placed on improving health services in underserved areas such as rural Upper Egypt. A policy reform agenda is under discussion which includes alternatives for health financing and expansion of health insurance to more beneficiaries, control and improvement in the quality of health, health manpower distribution and the means to improve compensation for health workers. The importance of strengthening the information system to provide the capacity to collect, analyse, and facilitate the use of health information at all levels is recognized and steps are being taken to address this task. These health reform plans are intended to have a positive impact on the health of women and children.

The adoption of Egypt's first population policy in the 1970's was accompanied by increased governmental activities relating to FP. The MOH established a department of FP, and government personnel received training in FP programme management.

During 1980, a population policy was issued which placed greater emphasis on interpersonal communication and community-based activities to promote FP and in 1986 the current national population policy was formulated and adopted by the National Population Council (NPC). This policy emphasizes the seriousness of population problems and recognizes the interaction between population and development.

Following the International Conference on Population and Development (ICPD) that was held in Cairo in 1994, a modified population strategy was developed, which placed greater emphasis on providing reproductive health services and supporting nongovernmental organization in the development of local communities. The new strategy included statements supporting female education and the provision of employment opportunities to reduce the gender gap. The population sector in the MOHP plans to integrate FP and MCH services into a broad women's health programme, and is adopting targets for contraceptive prevalence in the coming decades.

The MOHP has primary responsibility for the national population and reproductive health programme, working to operationalize population policy for Egypt in conjunction with related ministries and other (nongovernmental) organizations) involved with issues of population, women's reproductive health, and FP. The imbalance between population growth and economic development is a main challenge and problem that faces the country. The population problem will not be solved unless efforts in the health and social sectors recognize women are the focal point of the programme; acknowledging the role of men and the family in addressing the problem.

The population development programme is vitally important to Egyptians, so it is vitally important to support projects in women's development, youth, and income generation. To address population issues successfully, coordination between participating ministries is critical.

2.2 International Conference on Population and Development/Programme of Action

The Programme of Action of the International Conference on Population and Development (ICPD/POA) endorses a new strategy that emphasizes the numerous linkages between population and development and

focuses more on meeting the need of individual women and men rather than on achieving demographic targets. Key to this new approach is empowering women by providing them more choices through expanded access to education and health services and by promoting skill development and employment.

The POA identifies the main issues related to population and development, including gender equality and equity and the empowerment of women; the integration of population into sustainable development policies and programmes; poverty eradication; access to reproductive health care and FP; the roles of the family; the right to education; the situation of children, the rights of migrants and refugees, and the population and development needs of indigenous people.

The POA recognizes that, over the next 20 years, governments are not expected to meet the goals and objectives of the ICPD single-handedly. All stakeholders in society have the right and the responsibility to play an active role in efforts to achieve those goals.

Chapter XVI of ICPD/POA includes the actions which should be taken to achieve the POA objectives and implement activities at the national level; paragraph 16.7 of this chapter states that 'Governments should: (a) commit themselves at the highest political level to achieving the goals and objectives contained in the present POA, and (b) take a lead role in coordinating the implementation, monitoring and evaluation of follow-up actions'.

Implementing the ICPD/POA will:

- ensure that people, not numbers, are at the heart of population and development policies and programmes;
- bring women into the mainstream of development; protect their health, promote their education, and encourage their economic contribution;
- ensure that every pregnancy is intended and every child is a wanted child;
- protect the health of adolescents, and encourage responsible behaviour;
- promote education for all and close the gender gap in education;
- combat infection with human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) and sexually transmitted diseases (STD's);
- protect and promote the integrity of the family.

Attaining ICPD goals depends on:

- strengthening political commitment;

- strengthening the role and status of women;
- strengthening reproductive health and FP programmes;
- mobilizing resources;
- heightening community awareness and participation at all levels;
- intensifying international cooperation in population activities; and
- having the support of men both within the family and at the community and national level.

Empowerment and the status of women

Despite their significant roles in the home, the workplace and the community, women are too often valued primarily for their reproductive role while their social and economic contributions are overlooked and undervalued.

The ICPD/POA has accorded reproductive health the status of a human right, acknowledging that the right of each woman to make her own decisions concerning her own fertility is of the utmost importance in empowering women.

Without the full and equal participation of women, there can be no sustainable development, including the early stabilization of population:

- Full and equal participation means widening women's choice of strategies and reducing their dependence on children for status and support;
- Full and equal participation means granting women equal access to land, to credit, to rewarding employment, establishing effective personal and political rights, as well as access to reproductive health care, including FP information and services;
- Education of girls and young women is the key intervention for the empowerment of women. At the same time, women need support in their reproductive role.

Donor experience in implementing the ICPD/POA

The traditional definition of a population project is becoming broader with the growing recognition of the interrelationship between population and other aspects of development. The extent to which donors are employing a broader working definition varies greatly. It is possible to find two projects that are very similar in purpose and approach and find that different donors classify them in entirely different sectors. This suggests that a more uniform categorization would enhance the analysis of population work in Egypt and would promote enhanced cooperation between and among donors.

The ICPD/POA suggests that population be viewed as an issue that cuts across sectors. The possibility of assessing the impact of development activities on population, as some donors now do with WID and the environment opens up the possibility of integrating population into many different sectors in Egypt. To date, some donors have started this process to accommodate their internal structures or operating mechanisms to integrated activities.

Most donors seem to accept the recommendations put forward in the ICPD/ POA. However, their response to it has varied both on the policy and the practical level. Overall, donor interest in population issues in Egypt seems to have increased, much of which can be attributed to the ICPD and its POA. The ICPD stimulated the interest of not only the donors but also the Government of Egypt, the private sector and the non-governmental organizations (NGO's). The interested parties, in turn, have stimulated each other's interest. Part of increased donor interest in population has been a reaction to the interest displayed by the Government of Egypt.

Insufficient time has passed for the donor community as a whole to incorporate the ICPD/POA recommendations into their policies and programmes. It is expected that in the next two to three years, more specific and substantial results in these areas will be visible.

The multilateral donor community in Egypt includes the European Union and various United Nations Organizations, like UNDP, UNFPA, UNICEF and WHO, as well as number of other agencies. In addition 16 countries serve as bilateral donors with offices in Cairo.

All donors have acknowledged the importance of coordinating donor inputs. To this end, representatives of individual donor countries, the European Union and the UN agencies have created a donor coordinating mechanism called the Donor assistance Group (DAG), which meets monthly to discuss common interests and to share information related to their individual development assistance efforts, which are offered upon the request of the Government of Egypt.

Some donors in Egypt are working mainly in the field of rural health, but in governorates other than Fayoum. Examples are DANIDA, Finland and Italy.

DANIDA is working in Edfu in the Aswan Governorate. The duration of the project is five years and its total budget is DK 40 million. It started in February 1995. The project has the following components: building a nursing school, training for nurses, motivating medical personnel in preventive rather than

curative medicine, rehabilitating health clinics, improving water and sanitation, and promoting health awareness. DANIDA works in 14 villages in Edfu. It does not offer incentives as a policy, but expects the CDA's it works with to contribute to the expenses of the services provided. It believes that it thus ensures sustainability once it phases out.

Finland has a primary health care project in Beni Suef in Upper Egypt. It started in 1985 and is now in its second phase. The project has four main components: community mobilization for involvement in health and curative care; institutional capacity building (a health management training centre was set up), training for health staff including medical training, and support to infrastructure and the environment (upgrading of health units, installing water lines and water pipes). Its budget for the second phase is FM 8.7 million plus 30 percent Egyptian contribution.

Italy is conducting three projects in Qena, Beheria and Daqahlia. The components of the projects are: infrastructure, re-equipment, training of personnel on MCH, and the conduction of operational research and cluster surveys at the governorate level.

2.3 Socioeconomic characteristics of Fayoum Governorate

Fayoum Governorate is one of the eight governorates of Upper Egypt. It is the one closest to Cairo. Its total population was 1,803,000 in 1992 and is expected to reach 2,265,000 by 2001. 23.2 percent of the population was urban in 1986 (last census). Population density was 987 persons per km^2 in 1992.

Fayoum is predominantly agricultural with many small landowners (5 feddans or less). One third of the land (1,324 km^2.) is cultivated. It produces fruits, vegetables, rice, medicinal and aromatic plants and chicken. Fishing is an important source of livelihood for inhabitants in the villages on Lake Qaroun. Industry (building and small to medium size) plays a limited role in the economy. Fayoum has a few touristic sites and attracts day trippers from Cairo because of its proximity.

Environmental degradation is a problem due to the closed nature of the irrigation and drainage systems. Salinisation in Lake Qaroun in decreasing fish yields.

Birth, death, population growth and population density are higher than national figures. Life expectancy at birth was 65.6 years in 1992. First, second and third level gross school enrolment ratio was 52.7 percent

in 1992/93. Real gross domestic product (GDP) per capita was USD 1,460 in 1992/93. In terms of development, Fayoum ranks 19 among Egypt's 26 governorates.

Unemployment rates are high, reaching 41.4 percent among females and 19.8 percent among males in 1993. IMR decreased from 151 births per 1000 in 1961 to 42.8 in 1991. 84 Percent of the population have access to piped water. The percentage of the population over 25 years with secondary or higher education was 9.8 overall in 1986 and 5.1 among females for the same year. 10.5 Percent of the total employed population were professional and technical staff in 1992. Among women this percentage was 12.3 percent for the same year.

Women lag behind men in certain respects. Female life expectancy at birth was 65.2 years in 1991. The MMR was 174 per 100,000 live births in 1992. Average marriage age was 19.9 years in 1988.

Primary school enrolment among females was 64.8 percent in 1992. It was 54 percent and 34.1 percent in the preparatory and secondary levels for the same year. Overall female enrolment in the three levels was 61.8 percent in 1992. Women constituted 21.8 percent of the labour force in 1993. Contraceptive prevalence was 33.3 percent in 1992.

Overall, the crude birth rate (CBR) in Fayoum governorate was 37.5 in 1991 and the crude death rate (CDR) was 7.7 in 1991.

2.4 Health and population situation in Fayoum Governorate

The Fayoum Directorate of Health (DOH) service statistics for 1995 indicate relatively high overall CBR's for both Itsa (31.48) and Ibshaway (31.35) Districts as compared with national figures (28.6). IMR's are closer to national figures.

Vaccination coverage (for BCG, polio, triple and measles) is high in both Itsa (90 to 95 percent) and Ibshaway Districts (85 to 90 percent). On the other hand, an estimation of the percentage of pregnant women attending the antenatal care was higher in Ibshaway (52 percent) than in Itsa District (40.3 percent).

For FP services, the EDHS sequential surveys indicate a substantial increase in the percentage of married women aged 15 to 49 using FP in the Governorate of Fayoum, from 20.2 percent in 1988 to 33.3 percent in 1992, and a further increase to 34 percent in 1996.

Table 1: Birth and mortality rates for Fayoum Governorate

	Fayoum Governorate	Itsa District	Ibshaway District
Crude Birth Rate	31.36	31.48	31.35
Crude Death Rate	6.44	6.43	6.08
Annual Natural Growth Rate	24.92	25.05	25.23
Infant Mortality Rate	35.63	39.57	29.23
Child Mortality Rate	3.88	5.10	4.66

3. POSITION OF THE PROJECT IN THE FAYOUM HEALTH SYSTEM

3.1 Structure of the Fayoum health system

PHC services in Fayoum are offered by urban health centres, MCH centers, and health bureaus. Specialized curative care is served by the district hospital. At the village level all PHC services are offered by different types of RHF's, including rural hospitals (RH's), combined units (CU's), and rural health units (RHU's).

The Fayoum Governorate's DOH supports, supervises, and provides technical assistance to the various District Health Departments (DHD's). The district health approach adopted within the MOHP's national policy in 1996, has yet to be developed. Each DHD is responsible for all health facilities within its district. A department is headed by a director and two assistant directors, one for PHC and preventive services and the other for curative care.[1] A third physician has been assigned to each district to assist in the supervision of the MOHP's population and FP activities.

Other posts within each DHD include:

- Director of Administration and Logistics;
- Senior Chief Nurse, who supervises the MCH, FP, population and nursing activities;
- Senior Sanitarian, who supervises preventive activities including communicable disease control, and environmental and food control activities;
- Senior Laboratory Technician, who supervises the laboratory activities;
- Statistical Technician, who is responsible for service statistics.

Health services at the district level are primarily provided through the MOHP, and are supported by numerous projects and programmes of various donors and agencies. These are designed to tackle specific health problems and generally work through existing structures. FP and MCH services are provided by a range of NGO's, e.g. the Egyptian Family Planning Association (EFPA) and the Islamic Welfare Association (IWA).

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In fact the only assistant director for curative care that is currently in place in all Egypt, is the one in Itsa District.

Efforts by MOHP are in progress to increase the capabilities of the district health system in the areas of management information systems and a district health referral system.

3.2 Links between the project and the Fayoum health system

Phase I of the project has been implemented in Itsa, a poor underserved district of Fayoum. Each district consists of Village Council Areas (VCA's) which include villages and hamlets. For phase II, the Ibshaway district is proposed as a project site.

A recent report from the EDHS stated that the 1996 figure for contraceptive prevalence in Fayoum is 34 percent. This figure indicated that there is an improvement from the previous 1992 EDHS figure of 33.3 percent. The success can be attributed to many factors including the use of HP's in reaching rural women.

In Fayoum's rural areas, conservative attitudes complicate the issue of female education and employment. In recent years, extremist religious groups find fertile grounds in Upper Egyptian rural area. Promoters of FP, female education and female participation in decision making face many challenges from conservative elements in rural areas of Egypt.

The FaRHFP project addresses many of the problems of the rural poor: high infant, child and maternal mortality, low contraceptive prevalence rate, and high female illiteracy. The project is designed with strategies which maximize the following:

1. Establishing opportunities for interpersonal communication between HP's and rural women;
2. Establishing an intensive network of support for women and by women to address rural health issues;
3. Participation of local government and local communities in solving their own health and socioeconomic problems;
4. Empowering women to seek skills and to improve their status in their community by using literacy programmes or starting entrepreneurial ventures;
5. Establishing intersectoral linkages between the Governorate of Fayoum, the MOHP, the MOSA, NPC and local NGO's;
6. Investing in human resource development by training a large number of personnel who serve rural poor populations.

3.3 Relationships with other projects in Fayoum Governorate

There are two main donor organizations working in Fayoum who are conducting projects similar to the FaRHFP. These donors are CARE (an international development cooperative) and the Social Fund for Development (SFD).

CARE

CARE is conducting five main projects in Fayoum Governorate: Growth in Small and Micro Enterprise (GSME), Community Resource Mobilization (CRM), Small Projects Umbrella Fund (SPUF), Community Action for the Environment (CAFE)), and the Farm Link. CARE has been in Fayoum for several years (starting in the early nineties) and, among other donors, receives funding from USAID, CARE USA, and the Netherlands Government.

Two of the above mentioned projects, CRM and SPUF, address rural health, FP and income generating activities. GSME disburses loans and offers technical assistance to small and medium-sized entrepreneurs. All three are gender sensitive.

CRM aims to train Egyptian NGO's to assess community needs and identify appropriate development activities. Each NGO draws a socioeconomic, health and environmental profile of the community it serves. In collaboration with the MOSA, CARE has focused on key problems such as the role of women in development, increased functional literacy, environmental improvement and increased access to FP and other health services. Once community needs are identified, CARE helps NGO's to write and submit proposals to relevant donors either directly or through SPUF (to be discussed below). FaRHFP can benefit from the community profiles and the community needs assessment of CRM especially in the new district it is planning to move into (Ibshaway).

CRM has a total budget of USD 6,650 million for four governorates (Aswan, Qena, Sohag and Fayoum), of which is USD 4,974 million provided by USAID.

SPUF is also conducted in collaboration with MOSA and aims to link donors with an interest in supporting community activities with NGO's in Upper and Middle Egypt. It works directly with Community Development Associations (CDA's), empowering them by giving them training on community needs and proposal writing. It mainly addresses problems such as health, environment, income security (micro enterprises), FP, education and is gender sensitive, i.e. the situation of and the impact on women is taken

into account in developing its activities. SPUF provides grants ranging from LE 2,000 to LE 50,000 directly to CDA's. It is jointly funded by DANIDA and the Netherlands Government. Its total budget for four governorates is USD 809,300. It started in July, 1994.

SPUF has disbursed grants in Itsa: a credit programme (LE 20,000) in Hamidia village, a centre for exchange of gas cylinders in Touton village, and literacy classes for 9,160 women in Bahr Abu El Meir village. The latter in collaboration with the Egyptian Authority for Adult Education (EAAE). FaRHFP can link up with the CDA's empowered by SPUF especially for the sustainability of its socioeconomic component.

GSME was developed in 1993 to promote community economic growth and generate employment among the rural and urban communities in Egypt. It seeks to help already existing entrepreneurs to have access to loans and training in the four governorates of Qena, Sohag, Fayoum and Aswan. Its total budget for the four governorates is USD 3,638,600 part of which is provided by USAID. The project commenced in January 1994 in Qena and Sohag and has only recently started in Fayoum.

The Social Fund for Development (SFD)

The SFD started work in Fayoum in March 1995. Nationwide, including Fayoum, the SFD works in five main areas: community development, public works, small enterprise development, training to mitigate the effects of the structural adjustment policy, and institutional capacity building. Only two of these areas are relevant to FaRHFP project. These are community development and small enterprise development.

The budget of the SFD for community development in Fayoum is LE 7.5 million. This component offers grants, health services, as well as educational and social services to certain classes of youth especially the unemployed and female heads of household. The SFD cooperates with CARE and works through the CDA's. It empowers (SPUF) as well as uses the community profiles it prepares (CRM).

Of the LE 7.5 million, LE 4.5 million are used for the running of 1,500 training and adult literacy courses. The duration of the courses is nine months and each participant receives two such training courses. This is done in collaboration with the EAAE.

Another part of the budget goes to MOSA for the Productive Families Project. The families who benefit from this project are given loans up to LE 5,000 and engage in a variety of income generating activities, such as animal husbandry, alimentary industries (e.g. cheese making), handicrafts, making ropes, carpets,

and mats, growing palm trees for the protection of the environment, maintaining beehives, setting up kiosks for cigarettes and poultry. The SFD has also set up a training centre for porcelain and pottery making. It also trains young men and women on combatting illiteracy as a means of providing them with skills that would enable them to find jobs.

The SFD uses LE 1,670,000 of the budget for community development to improve women's health in two districts in Fayoum: Tamiya and Senoris. It has deliberately avoided Itsa and Ibshaway because FaRHFP is functioning there. To reach this objective, it has upgraded ten RHU's, trained 50 nurses and 20 doctors and selected and trained 208 social workers to become HP's. Their criteria for the selection of social workers is that they have to come from the community they serve, should at least have a secondary school diploma, should not be older than 35 years and should be unemployed. The social workers receive five training courses, each for six days. Each social worker visits 30 families.

Through the community development component, the SFD also works with the Egyptian Family Planning Association (EFPA) in Fayoum to promote FP. It granted EFPA LE 96,000 and loaned it LE 300,000. The EFPA has been involved in the training of 20 midwives in four villages, one of them being Gharaq in Itsa.

Also, through the community development component, the SFD rehabilitates the disabled by training them for suitable jobs according to their disability (e.g. computer training for those unable to walk).

As for small enterprise development, its aim is to provide employment opportunities for university graduates, especially the unemployed. The fund gives loans up to LE 50,000 per beneficiary and up to LE 200,000 for collective enterprises. They work through banks, companies and NGO's such as the Businessmen's Association. They hold weekly meetings for applicants and then help selected candidates to conduct feasibility studies on the economic activities they are proposing to undertake. The range of economic activities in this component includes ice cream factories, packaging of alimentary products, making ready-made clothes, embroidery and animal husbandry. Engineer Ahmed El Naggar, the representative of SFD in Fayoum, has already held three meetings with Dr. Ahmed Abdel Hakim for the purpose of coordination.

4. PROJECT HISTORY, AIM AND GENERAL OBJECTIVES

4.1 Project history

The history of the project is very well documented in the various project documents. The summary of the project history given in the paragraphs below is extracted from the *Plan of Operations August 1996 to January 1999.*

The FaRHFP project is a decentralized technical cooperation project between the Egyptian and Netherlands Governments operating in the Fayoum Governorate. Since its initiation, the project has undergone considerable development in response to significant changes both within the Egyptian context and in relation to changes in international developments, family planning (FP), and women's health. The process-oriented approach embodied in the project has allowed for the flexibility necessary to effectively respond to these changing contexts as well as to capitalise on the increasingly rich accumulation of experience and expertise gained during the project's years of operation. However, because of the duration of the project and the extensive range of input and participation from various individual experts and concerned parties, the process of continuous project development has been a complex and complicated one.

Since the 1980's, population issues have become more and more central in both the Egyptian development policy and the Netherlands policy on development cooperation. Thus, in 1988 both governments agreed to cooperate in the field of population and FP. Bilateral development cooperation between Egypt and the Netherlands had started eight years earlier in 1975.

The formulation of (the first phase) of the FaRHFP project lasted several years. In 1988, during bilateral policy discussions on technical cooperation the official of the Government of Egypt submitted an oral proposal for a project in Fayoum. The proposed project emphasized community participation, and included the creation of a system of voluntary female extension workers, the development of model (mobile) clinics and improved basic rural health facilities.

Later a written proposal was submitted to the Netherlands Embassy in Cairo, where it was positively assessed. After a pre-feasibility study in September and October 1989, two project formulation missions took place in August 1990 and February 1991. Following the recommendations of the second formulation mission, The Netherlands Ministry of International Cooperation invited bids from several Organizations

interested in serving as the implementing agency of the FaRHFP project. The RTI was granted the contract. In its proposal the RTI offered a full description of aims, objectives and outputs as well as an explanation of approaches and methodologies.

The first Phase of the project started in June 1992 and lasted until May 1995. It was extended by three consecutive Interim Periods covering a total of eight months, from June 1995 until January 1996. In July 1994 a monitoring mission concluded that the project had demonstrated considerable success and that promising results were already apparent. The team strongly recommended to extend the project for a five-year period, and proposed an extension of project activities. In November 1994 the extension was agreed in principle between all parties concerned. A project formulation mission assisted in the further development of the second phase.

The second phase of the project started February 1996 and will end in January 1999. During the first three years of the second phase, the RTI remains the implementing agency. A decision on the remaining two years will be taken later.

4.2 Project aim and general objectives

The project aim remained unchanged throughout the various phases of the project, namely to promote the health and well-being of families, in particular women and children, through a community-based approach which emphasizes FP and MCH, responds to needs felt and strengthens existing capacity.

In the *Plan of Operations 1992 to 1995* five specific objectives are formulated which are derived from the aim:

1. Develop, organize and implement a community-based system of HP's who are linked in with the existing health facilities or, where appropriate, with satellite facilities.
2. Upgrade services, in coordination with other programmes, of MOH and EFPA facilities through improvement of premises, completion of equipment and PHC oriented job-specific training for the health team.
3. Promote family health, including FP, through community mobilization, and home visits and consequently increased use of existing health facilities, especially in the preventive areas of MCH and FP.

4. Encourage locally initiated community development by stimulating the establishment of Village Support Groups for the HP and by providing funds from the Local Initiative Fund to complement the communities' efforts.
5. Involve village women in health and FP activities not only as passive recipients of services but particularly as active participants in assessment of demands, in target setting, and implementation of project activates at community level.

In the *Plan of Operations August 1996 to January 1999* the project objectives were formulated differently:

1. Strengthening the linkages between the community, particularly women, on the one hand, and health services and community organizations on the other, through the development of a sustainable HP system.
2. Upgrading the (formal) health and FP services within the rural community, with specific attention to the medical and social aspects of good quality reproductive health care.
3. Contributing to rural women's empowerment, through selective technical and financial support to various local institutions and organizations.

During the first phase of the project and the three interim periods project activities were implemented in Itsa District. During the second phase the project activities will be extended to Ibshaway District.

PART II: FINDINGS

5. PROJECT MANAGEMENT AND ORGANIZATION

5.1 Implementing and executing bodies

During the first phase of the project (including the three interim periods) the Fayoum Regional Population Council (RPC) and the RTI, respectively the Egyptian and Netherlands agencies, were responsible for the implementation of the project. As far as the Fayoum RPC is concerned this will remain the same during the entire second phase of the project. As mentioned before, so far the RTI has only been designated as implementing agency for the first three years of the second phase.

Because a large number of local institutions and organizations work together in the project, His Excellency the Governor of Fayoum has appointed a Steering Committee, which has the following tasks:

- assess and approve the annual plan submitted by the Executive Committee;
- submit these plans to and discuss them with the Fayoum RPC;
- coordinate between agencies and governmental structures taking part in project activities;
- assess and authorize the decisions of the Executive Committee;
- assess and approve the quarterly and annual reports before submission to the competent authorities.

In its functioning the Steering Committee is being assisted by an Executive Committee, which has amongst others the following operational tasks:

- develop quarterly and annual plans to be submitted to the Steering Committee;
- coordinate the implementation of the activities agreed upon in these plans;
- prepare the budgets and allocate funds accordingly;
- take measures and/or propose solutions for constraints and problems identified in the implementation of the project;
- prepare quarterly progress reports for submission to the Steering Committee;
- take any decision deemed necessary to reach the aims and objectives of the project.

The Executive Committee meets at a weekly basis.

5.2 Organizational structure

The number of project staff has increased considerably during the past years. This has led to an organization structure which is rather complex. It comprises a steering committee, an executive committee, an executive director, national and foreign technical advisors, seconded staff, contracted staff, BAE's and local and foreign consultants. Furthermore, for the implementation of its activities project staff works closely together with various governmental and non-governmental organizations.

It is felt by the evaluation team that, along with the growth of the project, organizational and managerial development has lagged behind. There is need for a thorough analysis of the project's organization and management structure. Special attention needs to be given to the project structure, (delegation of) responsibilities, lines of communications and decision making processes.

6. PROJECT MODEL

6.1 Implementation approaches

The FaRHFP project has five main key strategies. These are:

- an integrated, sustainable and comprehensive development approach;
- a community based approach;
- a process oriented approach;
- a gender sensitive approach and the empowerment of women;
- a reproductive health approach.

6.2 Relevance of implementation approaches

An integrated, sustainable and comprehensive development approach

Theoretically, the project adopts an integrated and comprehensive development approach. The choice of components covers the improvement of health of the community members, especially women and children, the improvement of health facilities, and improvement of the socioeconomic conditions of poor and middle-class women. The HP also makes beneficiaries aware of the services available to them, including the financial support offered by MOSA to the widowed, disabled, and wives of recruiters. It works with the government and district level representative of two ministries: MOHP and MOSA. It works through existing organizations and NGO's, especially the ICDA and EFPA.

The project is currently preparing the phasing out of three VCA's in Itsa District and starting activities in Ibshaway District. In terms of sustainability of the HP system, the executive director of the project, Dr. Ahmed Abdel Hakim, informed us that the governorate has already signed a decree with the representatives of MOHP whereby the current and future HP will become regular employees of the ministry once the project phases out. In terms of the upgrading of health services, members of the FaRHFP project steering committee have informed us that the MOHP is ready to allocate funds to continue the renovation of and provision of equipment to existing health facilities. They did not specify the amount. Consequently, also theoretically the sustainability of the project is not viewed as impossible by project members or members of the steering committee.

A community based approach

The choice of HP's from among the village inhabitants of the areas they work in is a successful approach to implement community involvement in the project. The HP's are very happy with their jobs, even if some complain that the salaries are low and the workload high. They are highly motivated and said they would continue working with the project even if they are offered government jobs which have permanency as opposed to their short-term (three to five years) contracts with the project. Many of the HP's were unemployed diplomaed girls who had graduated maybe ten years ago and have been waiting for government appointments as decreed by the law. In many ways, one of the side effects of the project is that it has partially solved the unemployment problem (around 40 percent among females) in the VCA's where it is being implemented.

The community based approach means involvement of beneficiaries, local leaders and existing popular organizations in the implementation of the project. We were informed that for a variety of reasons, the project team had to do all the implementing themselves in Itsa and in phase I of the project. All this is supposed to change in phase II and especially in Ibshiaway district. The project team is now redefining the role of the HP's to make them more development brokers rather than providers of services. Their job will mainly be to inform the beneficiaries of all the services and organizations already existing in the community.

A controversial issue is the campaigning for the project. We were informed that after the training of the HP's and before starting their field visits, seminars and meetings were held in the health units and in the mosques where religious leaders were present and during which the HP's were introduced to the community leaders especially with regard to FP. Focus group discussions with the beneficiaries (both female and male, but separately) revealed that especially men have never heard religious leaders support FP and that in fact they were dead set against it. Some of the female beneficiaries we met said there had been introductory seminars and meetings, although some came to know the HP's only after they started their visits.

A process oriented approach

By process oriented approach is meant that the project is implemented through a flexible, managerial, process oriented approach which is used in making decisions about project activities (Stolba et al, 1995).

Members of the evaluation team met with the FaRHFP project executive committee, steering committee and project team, especially the executive director Dr. Ahmed Abdel Hakim. One of the major concerns of the team based on the discussions with beneficiaries in focus group discussions was the success of the second component of the project, i.e. the upgrading of the health services through renovation, provision

of equipment and training of health staff. According to the beneficiaries, the quality of especially curative health services provided by the upgraded facilities was (still) rather poor. When members of the executive committee were asked to comment, they adamantly said that what beneficiaries were saying is not true. They defended the upgrading of the health facilities and said everything was going on smoothly in this area. A process oriented approach means willingness to change implementation strategies and approaches based on feedback and monitoring. The refusal of executive committee members to admit that there is a problem in this respect means that they are not really process oriented.

One of the issues raised with the steering committee members was sustainability of the project after the Netherlands phase out. Again, we were assured that there was no problem whatsoever. We asked each of the members to comment individually and they all said the same thing. No one had any doubts or expressed any kind of scepticism regarding the plans for sustainability (some mentioned above) for the near or distant future. Again a reluctance to be critical or self evaluating or objective in their assessment of the success of the project. Whether it was the presence of members of the evaluation team what brought about this reaction is difficult to assess. Members of the evaluation team were given the minutes of past meetings to read. The minutes include topics for discussion and decisions made, but do not clarify the process of decision making.

By contrast to both the executive committee and steering committee, the executive director was much more open and was willing to admit there were serious problems in the provision of health services. He knew that the doctors were often absent, that the drugs were given primarily to relatives and friends and that generally it were only the very poor who could not afford to visit private physicians, and went instead to the formal health system. He was also very realistic about it and said that the role of the project in this component was mainly supportive and that he had no authority whatsoever over the physicians or district health supervisors. All the project could do in this respect was to renovate the facilities, provide it with equipment, train all the staff and then to hand over the upgraded health units to the health directorate or in essence the MOHP. What happens after that is something over which he has no control.

A gender sensitive approach and the empowerment of women

The project starts with the assumption that high health awareness and economic independence will lead to the empowerment of women. In other words once these women are, for instance, convinced of FP, then they are better able to confront their husbands and in turn convince the nonacceptors among them also, women who receive small loans become independent, acquire a higher status in the family and play a bigger role in decision making. Other indicators of the empowerment of women is their increased involvement

in activities outside the home whether economic (selling vegetables, eggs, sweets or raising goats and selling their offspring) or social (attending sewing classes and adult literacy classes). Another indicator should be their increased involvement in existing community organizations, e.g. the CDA's.

Focus group discussions with HP's and female beneficiaries revealed the following:

1. The HP's themselves were the major group among which the empowerment of women became a reality. Both within their own families and within the VCA's where they work, they have become recognized, highly appreciated, highly recognized leaders. The HP's were now contributing in a major way to family income. The husbands of the HP's that we met were deferential in their attitude towards their wives. They were willing to assist them in their activities as HP's. For example, when the evaluation team members conducted focus group discussions with beneficiaries, the husbands of the HP's were willing to recruit the husbands of the selected participants. Consequently, while the evaluation team members were meeting with female beneficiaries, the husbands of selected HP's were busy recruiting the men from their homes. When we had focus group discussions with the HP's they were usually in the morning. Some of the husbands took the day off from their jobs to sit with children.
2. Women who received small loans have also been empowered. They said they experienced some degree of independence now. The problem is that inadvertently the female receivers of the small loans were most of the time female heads of households. They were women whose husbands were unemployed or disabled (blind or too old), were widowed or whose husbands were in the army. They are for the most part illiterate, they have a large number of children (10 to 11) and were the sole providers for their families. Their attitude was that they were extremely grateful to the HP's, the project, and even to the members of the evaluation team. Empowerment is difficult to assess with regard to this group. The project probably solved their economic problems and there were many other women who wished to receive loans. Assessment of empowerment here is tricky, due to extenuating circumstances related to the absence of a husband and lack of education.
3. Apparently the HP's stressed the health component much more than the socioeconomic component of the project. While all beneficiaries and even HP's stressed the role of HP's in increasing health awareness and FP use, many of the women said they had not even heard about the loans. In focus group discussions with HP's, the discussion leader had to remind them of their role in the socioeconomic component and of empowerment of women component of the project. The Arabic word for empowerment of women did not mean much to the HP's, but when the concept was explained, they quickly caught on and said that, of course, part of their role was to make the female beneficiaries more aware of their worth, identity and that they can influence the decision making process within their families.

4. One problem is that sometimes the poor and needy women who knew about the small loans were very reluctant to make use of them. They were afraid to do so mostly because they were not at all sure that they would be able to repay the loan. It took a lot of convincing from the HP's to abate the fears of these women.
5. The small loan system whose major objective is the empowerment of women, was commenced in the six VCA's in Itsa where the project is already being implemented at different phases and times of the project. In one VCA it started only four months ago. The reason for the delay is that the two week training course for the selection of needy women is conducted by one woman, Mrs. Anhar Hussein, Senior Social Worker, and is usually conducted separately and long after the introductory eight week training which only peripherally focuses on socioeconomic activities. This factor makes the assessment of the empowerment of women a bit complicated because the mechanism for it has not been in effect for long.
6. The credit system empowers women, but the women who can afford to take advantage of these loans are middle rather than lower-class women who are usually educated and may be also empowered.
7. The social group activities, particularly the sewing classes have been empowering women because once these women finish the four month sewing course, they receive a diploma and are able to secure jobs in textile and related factories.

Reproductive health approach

The activities which constitute the reproductive health approach according to Stolba, et al (1995) are: '... a focus on maternal/child services, a gender sensitive focus, approaching women at times of their reproductive functions, concern about female morbidity and mortality, desegregation of quantitative data on health status by gender, and sensitivity to the availability of female physicians, etc.'

Our assessment of this approach is that the project has succeeded in increasing MCH services. This is indicated by a system of visits of the HP's to pregnant women (once a month until the sixth or seventh month, then once every 15 days during the eight month, once a week during the ninth month, then four visits after delivery), their follow-up of tetanus injections for pregnant women, their follow-up of women using contraceptives and their follow-up of infant and child immunization.

HP's sometimes take advantage of delivery problems to convince the women to use FP contraceptives. So, they do approach the women at times of their reproductive functions.

Female morbidity and mortality, in our understanding, encouraging women to have antenatal and postnatal care and to deliver in the health facilities rather than at home with the help of nurses and *dayat,* does not seem to take priority in the project. The relationship between HP's and *dayat* has been the subject of a very recent seminar (one month ago) but there has been no active integration of the *dayat* in the project. As for female morbidity, particularly in the curative sector it has not been successful mainly due to the limited success of the upgrading of health facilities mentioned above.

Desegregation of quantitative health data by sex has not been sufficiently addressed by the project. In one report only literacy rates were divided by sex, but not the total population, for the CBR, CDR etc.

Sensitivity to the availability of female physicians is an activity HP's, project team and others are aware of and there have been attempts to make these physicians available, but if male doctors are reluctant to go to the rural areas, female doctors are even more so. What is interesting in this respect is that once a male physician is available and is known to be competent and conscientious then the women will walk long kilometres to reach him. So the quality of the services is enough to encourage these women to overcome their internalized inhibitions.

7. THE HEALTH PROMOTER SYSTEM

7.1 Main characteristics

In the three and a half year duration of phase I of FaRHFP project, an extensive system of trained and active HP's was established in nine of Itsa's VCA's. These HP's promote health awareness and health supervision within their communities. They encourage women to use the health and FP services provided by RHF's and inform women about relevant services available through the Social Affairs Department, respective CDA's, and other local village institutions.

The FaRHFP project HP system differs from most other community extension systems currently operating in rural Egypt in several ways. FaRHFP project HP's are recruited from the communities they serve. They also participate in a training course which is designed for and involves the women HP's who will work together in their specific communities. Moreover, the HP's serve a relatively smaller number of families than other community workers (about 400). Traditional outreach workers (*raidat*) usually cover 50 percent of a village of different sizes. This, combined with emphasis on home visits ensures that HP's maintain regular contact with, and knowledge of the specific needs and conditions of the families they serve. FaRHFP project HP's are trained to promote health and FP issues, and they receive training in how to address the socioeconomic and environmental needs of the community. They work to assist community members, and women in particular, in more effective use of health and social services available at the community level.

7.2 Specific objectives

According to the *Plan of Operations 1992 to 1995*, the specific objectives of the HP system are to:

1. Develop, organize and implement a community-based system of HP's who will provide support to the existing services of the RHF's or, where appropriate, satellite facilities.
2. Promote family health, including FP, through community mobilization and home visits and consequently increase use of existing health facilities, especially in the preventive areas of MCH and FP.
3. Involve village women in health and FP activities not only as passive recipients of services but particularly as active participants in assessment of demands, in target setting, and implementation of project activities at community level.

The system includes both HP's and HPS's. The function of the HP is to convey or transfer the projects' aims, goals and services to the community through home visits. Their job tasks mainly include general administrative work, FP duties, MCH care duties, improvement of home environment, and socioeconomic activities and strengthening of the role of rural women. The HPS's provide guidance to HP's, follow up their activities and participate in their evaluation. They also function as a liaison between the project central staff and the RHF and each of HP's, the governmental and nongovernmental organizations related to other project activities. HPS job tasks include technical, administrative, and organizational duties of the HP system.

7.3 Progress to date

The *Plan of Operations 1992 to 1995* states clearly the following expected outputs and indicators for each of the previously mentioned specific objectives as follows:

Objective 1

Output 1.1.: A network of 125 to 150 well trained HP's with community support and support from the Rural Health Services (RHS) is established and functioning in Itsa district.

Indicators:
- Community involvement in identifying role, function and selection criteria of HP (needs assessment).
- Community involvement in actual assessment of HP's.
- Number, content and quality of curricula developed and/or used for training HP.
- Number of selected, trained and functioning HP's.
- Community satisfaction with HP.
- HP's own satisfaction with role, functioning and actual operation of the system.

Output 1.2.: A network of at least one well trained HP supervisor per health and EFPA facility, functioning as a supportive supervisory system for the HP and functioning also as a link between the HP and the RHS.

Indicators:
- Quality (implementing feasibility) of the job description of HPS.
- Selection of criteria of HPS's.
- Number of selected, trained and functioning HPS's.
- Quality of functioning HPS's.
- Number of supervisory activities and HP's supervised.

- Satisfaction of HP and HPS functioning.
- Type and number of clients referred by the HP to the RHF's.
- Satisfaction of clients, referred by the HP with the services of the HPS at the facility as well as with the staff by whom they have helped.
- Number, content and quality of the curricula developed and used for the training of HPS's.

Objective 2

Output 2.1.: Family health among high risk groups has improved significantly.

Indicators:
- Reduction in morbidity and mortality (particularly infant and childhood and maternal mortality).
- Vaccination coverage.
- Use of MCH services.

Output 2.2.: The effective and continuous use of FRM has increased significantly

Indicators:
- Number of counselling and follow up sessions.
- Contraceptive prevalence rate with particular attention for continuity of use and reasons for discontinuity.
- Decrease in birth rate, and in the long run decrease in total fertility rate (TFR).

Objective 3

Output 3.1.: Strengthening the functioning of traditional women's groups.

Indicators:
- Number and type of functioning women's groups.
- Percentage of village women who are actually a member of or are taking part in the activities of such groups.
- The outcome of the activities of women's groups.
- Number of grants provided by LIF for women in development (WID) activities.

Output 3.2.: Increase of involvement of women in the decision making process to improve their own and their children's health.

Indicators:
- Involvement of village women in planning, implementation and evaluation of project activities.
- Increase in awareness and personal and group involvement in MCH and FP.
- Number of female members of VSG.

The role of the HP's is widely recognized as the most important achievement of phase I of the FaRHFP project. Physicians, nurses, governmental officials and international consultants in the health, population and social affairs sectors at the local and national levels have attested to many contributions HP's have made to the health and well-being of their villages. Women beneficiaries in particular emphasize the invaluable role of HP's in providing basic health and FP education and facilitating access to health and social services in the community.

Actual project outputs achieved to date

According to project documents, the HP system has involved or contributed to the following achievements:

- Training of 195 HP's and 31 HPS's, who are now operating in 9 Itsa VCA's. In 1995, HP's carried out over 149,000 home visits to discuss health and FP issues with household members (see table 2).
- Development of a project specific training manual for the introductory HP training.
- Provision of 504 small interest free loans for economically underprivileged women to assist in starting small scale income generating activities.
- Provision of 321 ICDA loans to assist villagers in starting small businesses.
- Sponsoring of skill training courses in sewing, literacy and other areas as part of complementary socioeconomic group activities in which 88 women from Itsa VCA's have participated.
- During 1995, identifying 437 families eligible to receive social benefits.

Table 2: Distribution of HP's and HPS's

Village Council	Health Unit	Number HP	Number HPS
1. Moutoul	Moutoul	3	1
	Menshiat Rahmy	4	1
	Bahar Abo El Mair*	2	1
2. Kalhana	Kalhana	5	1
	Ezbet Kalamsha	5	1
	Abou Deffia*	2	
	MCH centre	5	1
3. Meniet El-Heit	Meniet El-Heit	15	1
	Shedmouh	7	1
	Mawara	5	1
	El Gaafra	4	1
4. Abou Gandeer	Abou Gandeer	13	2
	El Wanisa	5	1
	M. Fesal	7	1
5. Kalamsha	Kalamsha	13	2
	Kaser El Basel	10	1
	El Hamidia*	3	1
6. Garadou	Garadou	10	2
	Atamnet El Mazaraa	7	1
7. Toutoun	Toutoun Rural Hospital	17	2
	El Seida	5	1
8. El Hagar	El Hagar	8	1
	M. F. El Said	5	1
	El Mouhmodia	3	1
9. El Gharak	El Gharak Rural Hosp.	20	2
	M. Abdel Mageid	8	1
	Danial	4	1
Total	27	195	31

* Nursing stations

7.4 Discussion

The FaRHFP project phase I was successful in establishing the HP system and creating essential links and procedures for cooperating with Egyptian governmental organizations, as well as supporting a wide range of training activities. The role of the HP's and their activities should be more clearly defined and integrated within the role of development broker.

In order to determine the nature and quality of the performance by HP's and HPS's, the evaluation team conducted qualitative field studies. These included four focus group discussions with the target audience (public), four focus group discussions with HP's and various in-depth interviews with HPS's and project staff. The studies show that the results achieved by the HP's in the social area are remarkable. Due to collaboration with social workers, a substantial number of poor families were allocated social benefits (loans) by the District Social Affairs Department. The work of the HP's and the HPS's appears to have helped strengthen the functioning of local social units.

During focus group discussions conducted with HP's, they mentioned that their primary role is to disseminate information about both preventive health measures and reproductive health including FP. HP's use direct, face to face communication with MWRA on topics such as contraception, maternal health, vaccination and protection from early childhood diseases. However, additional community based research is needed to measure the impact and quality of the HP system in health promotion and in coordination with RHF's. This indicates HP activities regarding information dissemination is effective, but we still have to measure the attitude and behaviour change among beneficiaries as a result of this information.

HPS's mentioned that they assist the HP's in preparing a plan of action to follow up with MCH activities conducted through home visits. In this respect, they mainly advise women to seek health services in case of complications in delivery. HPS's also give advice to pregnant women and mothers with children for immunizations. Our FGD's revealed that there are few regular meetings between HP and senior project staff, except during the initial training course and the monthly meeting with their HPS. Also, there seems to be no clarity among HP's with regard to identification of what facility or organization they belong to, and they are highly concerned about their job stability and security.

Obstacles in carrying the workload

In responding to obstacles faced either by HPS's or HP's, the response was extremely diverse. Many were very reluctant to talk about difficulties in their work. For example, one HPS said that she had no problem

at all, while other responses were related to the physical building, attitude of women in the field to health education, vaccinations, poverty or loans. Communication is considered effective only if highly motivated community IEC efforts are integrated with suitable quality services. The job conditions and environment of HP's and HPS's must be maintained in defined standards in order to keep and reinforce their motivation.

Several HP's complained of poor water and toilet facilities in RHU's, lack of antiseptics and drugs or the physician's poor manners when inserting an IUD. Some HP's are of the impression that women in their community are not interested in health education, as they are extremely poor and are more concerned with employment. Beneficiaries honour home visits but credibility of outreach efforts are valued by their personal benefits and service satisfaction.

Performance of HP 's at the community level as seen by HPS's and beneficiaries

Many HPS's see the HP's as a woman member in the village who is known and respected by her people. Some HPS's said that the loan and credit play an important role in gaining this community respect. They stated that people heard about HP's either from the HP's themselves, from neighbours or from the RHU. Many HPS's described the HP's as sympathetic, positive and content with their job, and said that they function as a liaison between the public and the health unit.

In focus group discussions conducted with female beneficiaries, participants mentioned that the main role of HP's is being an advisor to women about FP and child immunization as well as being the key person for keeping detailed records of families in her community. The men were of the opinion that the HP's role is mainly to give FP advice and they were largely unaware of any other role she performs.

Several men stated that they need information about the advantages of using FP in terms of family health and development, and they are interested to know what FP options are available. Few made suggestions, such as involving religious men in FP through seminars and group meetings.

Also, dynamic and lively discussion with the beneficiaries about health services in Kalamsha's RHU, where HP's advise women to go for medical examination and treatment, revealed that all participants unanimously agree that the clinic provides them with nothing, although they feel that the HP tries her best to help them. This is one of the few RHU's that need immediate attention and upgrading.

An example of this is that one of the women went to the clinic for bleeding due to an IUD. She was not feeling well and almost fainted but the physician refused to do anything for her until her husband paid LE 8 in advance.

Those who can not afford it, do not seek medical treatment at all and those who do, go to private clinics in Fayoum, because the RHU closes after official working hours.

Integrating HP 's communication efforts with local health services

The community coverage of the HP's (measured by number of home visits) was highly successful. Analysis of focus group discussions with HP's showed that their primary focus was increased FP use and MCH awareness. This was clearly indicated by HP's quick recall of their tasks in these areas, through frequent visits to pregnant women (once a month till the seventh month, then twice a month during the eighth month and once a week in the ninth month, then postnatal visits). They also educate pregnant women about the TT injection, follow up on vaccination schedules and report drop outs. Regarding FP, HP's motivate and encourage non-users MWRA to seek FP counselling in the RHU, and follow up on MWRA who are contraceptive users.

All the above IEC interventions assist the beneficiaries to adopt the project messages of raising awareness and motivation in FP and MCH care. However, this adoption process should end in action. The true success of any effective communication effort is measured by positive changes in human behaviour. The project management is challenged to formulate immediate IEC objectives in terms of measurable changes in RH related KAP, and the desired amount of change should be established and adjusted periodically on beneficiaries baseline data.

By itself, however, HP's IEC efforts alone can not solve problems such as low rate of contraceptive use, high discontinuity rate, unmet needs, and female morbidity and mortality. IEC activities can not compensate for inadequate services and supplies at RHF, nor can they produce self-sustaining change. The project management again has another challenge, to request and enforce governorate and district health authorities to make services readily available. Health workers must be able to provide correct and easily understandable information, excellent service and regular follow up.

Management responsibilities

Managers of community based projects are responsible for planning, organizing, supervising and evaluating the project's communication interventions. In-depth interviews with the project management and consultants

indicated their need to familiarize themselves with the IEC process by obtaining appropriate technical assistance in order to ensure cost effective implementation. Also, if the project aims to conform to the ICPD/ POA, it is advisable for the project management staff to become familiar with the universal IEC and technical language used in the UN document and incorporate it into their official reports and evaluations.

The cycle of effective communication in the HP system must be evaluated and compared at 3 points:

1. Number of HP's home visits (extent of coverage).
2. Number of referred cases (or reported in their cards).
3. Number of beneficiaries who actually utilized the available services (complete health protective behaviour).

FaRHFP project documents frequently stated that all kinds of IEC methods and techniques would be used, but a clear IEC strategy is not yet developed. An IEC strategy is a commitment to achieve measurable effects. Lacking a specific strategy can result in indistinct audiences and objectives that are difficult to measure, or in ad hoc activities that have no sustainable impact.

A strong management system is an essential element to the project's stability, and perhaps the most important activity of management is strategic planning. It will clarify project objectives, define the potential target audiences and identify strategies to create demand for services.

Male advocacy

The project management has not trained male HP's. Male family responsibilities, husband-wife communication, and influential male figures to serve as advocates must be considered in Upper Egyptian communities where men make at least 50 percent of the decisions concerning their wives, children and sometimes even their mothers.

8. UPGRADING OF HEALTH AND FAMILY PLANNING SERVICES

8.1 Main characteristics

Since its inception in 1992 the project has been contributing to the upgrading of the health and FP services in Itsa District through:

1. Improving the infrastructure:
   - renovation of RHF's;
   - procurement of basic medical equipment and office furniture for RHF's;
   - procurement of furniture and appliances for the houses of physicians working in the RHF's.
2. Increasing the number of service points:
   - establishment of NS's;
   - initiation and support of a District Mobile Health Team (DMHT).
3. Improving the capacity of the DHMT with regard to planning, organization and management.
4. Establishing a community based outreach system of HP's and HPS's.
5. Training of RHF staff.

The project has not been involved in supervision of the health teams in the RHU's, supply of pharmaceuticals or FP methods, or any other more direct activity to influence the quality of the health and FP services positively.

This section of the report deals with all activities regarding the upgrading of health and FP services, except the community based outreach system and training, which are being discussed in paragraphs 7 and 11 respectively.

8.2 Specific objectives

Phase I

In the *Plan of Operations 1992 to 1995* the specific objective for this project component is formulated as follows: upgrade services of DoH and EFPA facilities through improvement of premises and completion of equipment.

The same plan sets targets for the renovation of and procurement of furniture for the various facilities. The project planned to renovate and furnish 22 out the 23 DoH RHF's, the only DoH FP/MCH Clinic, and all three EFPA FPC's in Itsa District between October 1992 and March 1994. The one RHF that will not be renovated is located in the village of Danial in El-Gharak VCA. This facility is not in need, because it was only recently constructed.

The facilities will be renovated in two batches. The first batch consists of the 14 facilities located in the VCA's Garadou, El-Hagar, Qualamsha, Toutoun and El Gharaq, including two CU's, nine RHU's, two FPC's and the one FP/MCH Clinic. The remaining 12 facilities of the second batch are located in Abou Gandeer, Kalhana, Meniet El-Heit and Moutoul VCA's. These include two Rural Hospitals, two CU's, seven RHU's and one FPC. Renovation of the first batch of facilities was scheduled for the period October 1992 to June 1993, of the second batch for the period July 1993 to March 1994.

Furthermore, the renovation and procurement of furniture of the Nursing School in Itsa Town was planned for between October 1992 and March 1993. The school, located at the compound of the Itsa District Hospital, had been selected as the site for training activities, the project office and the meeting place of HP's.

First Interim Period

The *Plan of Operations First Interim Period* sets the following targets for the period June to September 1995:

- Finalization of the renovation of a total of four RHF in Kalamsha, El Hagar and Garadou VCA's;
- Finalization of the renovation of one FPC in Meniet El-Heit VCA;
- Finalization of the renovation of a total of three (newly established) NS's in Abou Gandeer, Moutoul and Qualhana VCA's;
- Procurement of furniture and appliances for the houses of 23 physicians working in the RHF's;
- Procurement of basic medical equipment and office furniture for 3 NS's;
- Continuation of support of the District Mobile Health Team, which will implement ten visits per month to those RHF's where there are no physicians, or of which the physicians have not yet been trained in FP.

Second Interim Period

The *Plan of Operations Second Interim Period* sets the following targets for the period October to December 1995:

- Start of the renovation of a total of four RHF's in Toutoun and El-Hagar VCA's;

- Start of the renovation of (the newly established) FPC of the EFPA in El-Gharak VCA;
- Finalization of procurement of basic medical equipment and office furniture for the three NS's in Abou Gandeer, Moutoul and Qualhana VCA's;
- Finalization of procurement of furniture and appliances for the houses of 23 physicians working in the RHU's;
- Continuation of support of the District Mobile Health Team, which will implement ten visits per month to those RHF's where there are no physicians, of which the physicians have not yet been trained in FP, or where for one reason or the other the use of FP services is less than in comparable units.

Third Interim Period

The *Plan of Operations Third Interim Period* sets the following targets for the month of January 1996:

- Continuation of the renovation of a total of four RHF's in Toutoun and El-Hagar VCA's;
- Finalization of procurement of furniture and appliances for the houses of 23 physicians working in the RHU's, and distribution of furniture and appliances to the houses;
- Continuation of support of the District Mobile Health Team, which will implement 12 visits in January 1996 to those RHF's where there are no physicians, of which the physicians have not yet been trained in FP, or where for one reason or the other the use of FP services is less than in comparable units.

8.3 Progress to date

All renovations and procurements have taken place according to plan.

8.4 Discussion

Benefit of the community

The upgrading of the RHF's by the FaRHFP project has brought some positive gains. This benefit was recognized by both the recipients and providers. From the focus group discussions women, and to some extent men, stated the activities which the HP's do in their areas. The small loan (LE 150) and the credit system (maximum LE 1,000) were also mentioned. Women bought ducks, geese, chickens, goats and vegetables with the money they borrowed from the HP's.

Many of the beneficiary and non-beneficiary women were using FP. However, no one knows how much was project related effect. For example one woman said that she had an intrauterine device (IUD) for the last seven years.

There was agreement among focus group discussion women, HPS's and project supervisors that the community has benefitted from immunization, home visits follow up visits, and the advice given to women from the HP's. One HPS said that she did not see poliomyelitis anymore. Many women in the focus group as well as the HPS's valued the role of the HP's. Being a woman member in the village was an advantage. Some HPS's related this respect to the small loan and the credit system. Few HPS's said that if her role was merely health education no one would take her seriously.

While the HPS's thought that people heard about the role of the HP's from different sources, women in the focus group said that they go from door to door to register family members in the family cards. The HPS's described the HP's as sympathetic, positive, content with her job and function as a liaison between people and the health unit.

The HPS's thought that the project lowered the price of FP from LE 20 in private clinics to LE 2 in public clinics. This made it accessible to many.

There was also the personal gain by the HPS's and HP's which strengthens the community benefit. If the HP's gained confidence by working with the project this would enable HP's to give guidance to people in her own village. This view was expressed by HPS's and some project staff.

Service priorities

Unemployment and the improvement of the economic situation in the areas was mentioned in the focus group discussions and by the HPS's. The vast majority of young women and men who finished the school were without jobs, some HPS's said. Men in the focus group discussed unemployment and the decline of the economical situation more than women. Many argued that the present economic hardship dictates the importance of using FP services.

One HPS said that much of the vaccine was wasted because there was no fridge to keep the vaccine. Electricity was her first priority.

that drugs availability and accessibility was too complicated to be provided by the public health facilities. Therefore, the tendency was to leave it altogether to the private sector to handle it.

This argument paves the way that the present project's intervention with the HP's strategy was nothing but a promotion for the private health sector to advise patients to go to doctor's private clinics and pharmacies. This argument was strongly supported by the focus group discussions, stating that the present public curative services were poor or not available. The private services were therefore for people who could afford to pay the private clinics.

The HPS's though, refraining from saying something that may damage their future, had recognized their importance in promoting the unwritten policy towards private practices. Some of these HPS's said that the health facilities were dependent on the HP's activities. HP's were able to convince women to take their children to the units and hospitals for vaccination and other services. In this respect, the mission voiced their concern during the debriefing session stating that poor curative care can jeopardize the sustainability of the project. This argument was based on two reasons: service users' dissatisfaction about curative care, and HP's role to refer patients to clinics for treatment may lose the trust of the HP's in the long run.

Even though the Egyptian sided at some times opposed to any unwanted comments about the curative care, they responded half heartedly by acknowledging part of the problem. In this respect, the MOHP has issued a decree to increase the salary for doctors as incentives to encourage them to work in rural Egypt. This shortsighted solution assumed that the problem was a doctor problem. Once that was solved, the problem would have been solved. All other managerial questions, human and financial resources, supply and logistics were not addressed.

9. SOCIOECONOMIC ACTIVITIES

9.1 Main characteristics

The FaRHFP project started approximately three years ago with the aim of promoting the health and well-being of families, particularly women and children.

The project started with two components. First a community based system of HP's and upgraded rural health facilities. Subsequently, a socioeconomic component was added as part of an integrated health approach that would promote the well-being of families.

Financially, the socioeconomic component consisted of the allocation of LE 40,000 per VCA. This amount is used for three kinds of activities:

1. Small interest-free loans ranging from LE 50 to 150 for very poor women, mostly female heads of household (i.e. widowed and divorced women) and women whose husbands were unemployed or incapacitated. These loans are distributed by the project and take up one quarter (LE 10,000) of the total budget of the socioeconomic component.
2. LE 20,000 were allocated per VCA and to the Itsa Community Development Allocation (ICDA) which established a revolving fund to be used for the disbursement of loans at an 8 percent interest rate to women. The ICDA started its activities in August 1994 with funds for four LCA's on a pilot basis. After an evaluation was carried out in the project's second interim period, the activities of the ICDA were consequently expanded to cover all six VCA's in Itsa District.
3. The remaining LE 10,000 per LVC were used for group activities, mainly training and skill development for women through sewing and literacy classes and a minor variety of other activities such as the renovation of a library or a kindergarten.

9.2 Specific objectives

The overall specific objective of the socioeconomic component is contributing to rural women's empowerment, through selective technical and financial support to various local institutions and organizations.

According to the *Plan of Operations August 1996 to January 1999*, the expected outputs of this component are:

1. At community level: increasing women's active participation in targeted community organizations and ensuring that services delivered by these organizations meet women's felt needs.
2. At the level of beneficiaries:
   - women's increased awareness of existing organizations and the kinds of services they can offer them, also leading to their increased participation in these activities;
   - improving the skills among rural women empowering them to better meet their needs.

Indicators for the success of this component include:

- percentage of women leaders trained and providing services relative to target figures;
- percentage of women operating as leaders or trainers relative to number trained;
- service provision of targeted community organizations relative to user-defined needs and user satisfaction;
- percentage of increase in number of women utilizing community services and relevance of activities in targeted community organizations; and
- results of trainer and trainee evaluations.

9.3 Progress to date

According to project documents, the following has been accomplished to date:

1. For the Individual Small Loans (ISL), the HP's and HPS's nominate the clients, fill in the loan applications and follow up the implementation of the small economic activities by the clients. Progress up to date in 6 VCA's in Itsa District:
   - Project capital: LE 63,000
   - Number of beneficiaries: 625
   - Value of disbursed loans: LE 80,955.
2. In the credit system the maximum loan size is LE 1,000 per client. As mentioned above the credit system is managed by the ICDA with the support of the Social Affairs Department in Itsa District. Progress up to date in 6 VCAs, starting August 1996:
   - Project capital: LE 120,000
   - Number of beneficiaries: [illegible]58
   - Number of women beneficiaries: [illegible]

- Amount of loans distributed: LE 218,400.

3. To date 97 women in six VCA's completed a training course in sewing of four months duration:
   - Kalamsha (El-hamidia): 12
   - Garadou: 24
   - Abu-Gandeer: 12
   - Meniet El-Heit: 12
   - Kalamsha: 13
   - Moutoul: 24.

   Out of the 97 women 49 received sewing machines and started their own sewing business. They paid back the cost of the sewing machine on instalment bases.
   - Abou Gandeer: 12
   - Meniet El-Heit: 12
   - Kalamsha: 13
   - Moutoul: 12.

   Some other women, who were previously trained, have been employed by the 6th of October Cloth Sewing Factories.

   At present, 40 women attend a sewing training course:
   - Kalamsha: 12
   - El-Ghab: 12
   - Nawara: 16.

   A training of trainers course in sewing of 45 days was held, to create a cadre of sewing trainers. This course was attended by 2 to 3 trainees from each VCA. Most of these trainees are currently working in different community based organizations, to train rural women in sewing.
4. Four literacy classes are effectively being implemented. Each class will last nine months. A total of 82 women are attending these literacy classes:
   - Nawara (Meniet El-Heit): 20
   - Kalhana: 20
   - Garadou: 22
   - Toutoun: 20.

   A training trainers course has been held to train nine literacy teachers to take over the responsibility for sustainable literacy classes at community level.
5. Two nurseries (in Abou Gandeer and El Hamedia) have been renovated and supported with necessary equipment by the FaRHFP project. Each nursery is occupied by 50 children.

6. Ten young women in Garadou VCA have been trained in making carpets. Currently, they are working in the same training centre and their wages are paid according to their amount of production.
7. The Moutoun village library has been renovated and supported with furniture and books. The library is used by all community leaders.

9.4 Discussion

Introduction

The socioeconomic component was not part of the objectives, aims or components of FaRHFP project from its inception. It is not mentioned in the *Plan of Operations 1992 to 1995*. It is first mentioned in the *Plan of Operations for the Second Interim Period*, but not as an independent component or part of the aims and objectives. It is included under activities to be continued. The same applies to the *Plan of Operations for the Third Interim Period.*

It is only in the *Plan of Operations August 1996 to January 1999* that the socioeconomic component is incorporated in the project objective. In Annex 3 of this plan it is defined as one of the three main components of the project and a number of quantitative indicators of its success are also listed. The main objective of the socioeconomic component as defined in this last document is the empowerment of women, but we find that the selected indicators (listed above under 10.2) for the success of this component are not directly related to, or accurate indicators for the empowerment of women.

Further, the report on the progress to date (listed above under 10.3) does not really follow these indicators. It gives size of capital, number of beneficiaries and total loan disbursement for the ISL and the credit system and the number of women who attended sewing training, literacy classes and a number of other group activities. Hence, we find that the documents available tell us little about whether or not the socioeconomic component has empowered women.

In the focus group discussions with HP's, beneficiaries and the recipients of both ISL and credit system loans, the team members responsible raised the issue of empowerment and defined it as higher status and more decision making power within the family and within the community.

With the above in mind, the following discussion will address the three main components of the socioeconomic component separately pointing out points of strength and points of weakness.

The ISL

Points of strength:

1. The HP's are doing an excellent job. On the one hand, the recipients of these loans are indeed needy women and in most cases female heads of household, and on the other hand the HP's really follow up the progress of the economic activities the women have chosen and give them advice and help when they can do so.
2. The number of recipients of ISL are much higher than the recipients of loans from the credit system, 625 and 358 women (and a few men) respectively. Recipients of loans from the credit system have to have access to government employees to act as guarantors for them. We get the feeling that this last category is not really the poorest of the poor, they are more like middle-class. One such recipient said she borrowed LE 800 from the project but had to add to it another LE 800 from her own resources to be able to buy a cow. If the project's target group are needy women, then it is good that the numbers of beneficiaries of ISL is higher than the number of beneficiaries of the credit system.
3. The recipients of the ISL are very grateful to the project for helping them out economically. They are very happy with the loans they received and are working conscientiously on the economic activities they have selected. The debt repayment rate is quite high, but this will be discussed further below.
4. The ISL women say they have gained some degree of independence because now they can fulfil the needs of their children and themselves without having to wait for the husband or male provider, if he exists, to hand over money to them.
5. Once the women repay the debt, they still have an ongoing income generating activity so there is sustainability and they have a more or less permanent source of income.
6. The project team is already considering the issue of sustainability and examining a number of community organizations that can take over this component once the project phases out.

Points of weakness:

1. The HP's consider themselves guarantors for the recipients of ISL's (see paragraph 7.1). This is neither part of their job description nor their predefined roles.
2. The types of economic activities the women engage in are very limited, namely goat raising, selling vegetables, sweets, eggs and opening small grocery shops. The SFD and CIDA are implementing credit projects for poor women and they have developed a much wider range of economic activities the women can engage in. The FaRHFP project should benefit from the activities of other donors and development agencies in this respect.

3. It is very difficult to assess the empowerment of women within the family since in most cases they are originally heads of household. If their husbands are around they are either unemployed or handicapped so they are already at a disadvantage and have little say in the running of family affairs.
4. There are problems with the registration system because only one project member was responsible to keep the records for the number of recipients, rate of debt repayment etcetera. So to date the project can not accurately assess the percentage of debt repayment. One record keeper now has an assistant and the record keeping has now been revised to ensure more accuracy in the future.
5. The HP's don't have a very high profile in the socioeconomic component. Team members often had to remind beneficiaries of their existence.
6. There is only one trainer for the HP's on how to select needy families which has meant that in some VCA's this component was introduced only three or four months ago. Currently, the trainer has been assigned an assistant so possibly her workload will decrease.
7. In terms of sustainability, the most likely community organizations to take over running this component are CDA's. However, instead of attempting to increase the empowerment of women by promoting the representation of women on the boards of the CDA's, the project team plans to create a completely new entity, a women's club, which will be under the auspices of the CDA, but not really part of it. Further, CARE is implementing the SPUF which major aim is empowerment of CDA's. Gender is one of the issues they address. SPUF is also funded by the Netherlands Embassy but there has been no mention of cooperation with this project to ensure sustainability.
8. Beneficiaries complain that there is a long period, sometimes reaching eight months, between the time they are selected and the time they actually receive the loan.

The credit system

Points of strength:

1. The credit system is being implemented by the Itsa CDA in collaboration with MOSA, so there is no problem of sustainability or more specifically, finding an organization to take over this component once the project phases out.
2. The size of the loan is larger (maximum of LE 1,000) which allows recipients more leeway and better chances of making a good profit.

Points of weakness:

1. This component does not target the poorest of the poor, but the lower middle to middle-classes. If the LE 20,000 per VCA are used for ISL's, many more needy women could benefit.

2. The range of economic situation is very limited, not innovative and in essence the same as the economic activities in the ISL component.
3. The women are not given technical assistance or training nor are they trained to conduct feasibility studies.
4. There is centralization in implementation since the Itsa CDA is a district level CDA, while maybe attempts should be made to involve CDA's at the village level.

Group Activities

Points of strength:

1. The project has trained a total of 97 women on sewing (a four-month course after which they receive a diploma). 49 of these women were given sewing machines by the project for which they have to pay back in instalments and have started their own sewing business. Also, some other women were employed by the 6th of October Cloth Sewing Factories.
2. Four literacy classes are being implemented. Each class will last 9 months. 82 Women are currently attending these classes.

Points of weakness:

1. The scale of group activities is very small. For example, the SFD has been in Fayoum City for only one year and it has now 1,500 literacy classes in addition to another 80 specifically for women which are being implemented in cooperation with the National Council for Childhood and Motherhood (NCCM).
2. Some of the women from the sewing classes do not know what to do with their newly acquired skills and may forget their training if they do not quickly do something about it.
3. Women who attend literacy classes may relapse into illiteracy if they do not use their abilities to read and write.

10. INFORMATION, MONITORING AND RESEARCH

10.1 Main characteristics

The project has recognized the importance of information as fundamental to project monitoring and evaluation and the process of community development. The project's Information, Monitoring and Research Unit (IMRU) has a twofold approach for collecting qualitative and quantitative data at the village level, although the process is still in a developmental stage. Step by step procedures are being developed for community appraisals in project catchment areas. In addition, the HP's are being trained in data collection and interpretation of these appraisals in order to develop their communication and leadership skills, as well as to improve their relations within the community.

10.2 Specific objectives

In 1994, the project's Executive Committee assigned a task force to develop the preliminary design of a comprehensive monitoring system. The objectives of the monitoring system are:

1. To provide monthly and/or quarterly data on some activities and results which are related to the objectives of the project as reflected in the *Yearplan 1995*.
2. To form the basis for the comprehensive monitoring system of the project's second phase.

10.3 Progress to date

To date, the IMRU has produced a series of village appraisals and several issue-specific studies and research manuals which include:

- A series of four village appraisals, providing basic data on communities served by the project;
- A step by step manual for developing and implementing research appraisals;
- A detailed manual providing guidelines for data management and statistical analysis for appraisal preparation and processing;
- An evaluation of project funded ICDA loans;
- An assessment of HP and HPS training needs.

10.4 Discussion

External evaluation of the FaRHFP project's communication activities is important in order to identify areas in need of correction as the activities are implemented, and later to determine whether the activities have been effective.

It is known from other health and social experiences that communication activities are difficult to evaluate, as they do not easily lend themselves to quasi experimental designs of operations research or its clear findings. It is similarly difficult to document that a particular set of activities has led to a more favourable climate for area of study, e.g. FP, safe motherhood or women empowerment. This is because it is difficult to isolate effects of different formats or factors that influence the target audience (project beneficiaries).

In assessing the quality and impact of the project's community efforts, it is important to understand first the various evaluation approaches which fall into 3 categories:

- Performance evaluation (process evaluation): a familiar part of all activity monitoring and external evaluations, the process evaluation is conducted to determine if IEC activities are being implemented well and proceeding as planned. It includes reviewing the quantity of work and whether it is delivered as planned in the numbers, locations, and in the timing;
- Outcome evaluation: it is not enough to know whether IEC activities have been well planned, implemented and timed, it is also important to know whether they have been effective. Have they brought about the desired changes that will help the IEC efforts achieve their objectives? Outcome evaluation for the FaRHFP project depends first on a clear understanding of the objectives and identifying indicators of success in progressing toward these objectives;
- Impact evaluation: the impact of the activities' outcomes, then, can be examined in relation to objectives. Outcome and impact indicators (changes in knowledge, attitudes and practices) should be clearly specified in advance and flow from the objectives.

The evaluation team assessed the IMRU by conducting:

- Discussions with project decision makers;
- Interviews with project consultants;
- Secondary data analysis (review of available reports);
- Qualitative research (focus group discussions and depth interviews with field workers).

Information

In the report *Development of a Monitoring System* (1995) it is stated that during the two weeks of intensive discussions it became apparent that information should be part and parcel of monitoring and research. Thus it was decided that a new unit for information, monitoring and research would be established during the second phase of the project. During our evaluation the project's senior staff, manager and consultants were requested to clarify reasons and identify what they mean by information. Overall, there was wide variation in their meanings of information, as some interpreted information as data needed to be collected for research and monitoring purposes, while others defined it as part of the communication process or IEC, and IEC was misunderstood as an initial step for the monitoring system.

Quality management performance depends on an in-depth knowledge on the part of management staff of what makes things work and how they work. A general misunderstanding of standard IEC processes by the management of community development projects represents a continuing threat to performance and quality.

In spite of some confusion about what to do with information, the *Plan of Operations August 1996 to January 1999* positively confirms that the cycle of information, monitoring and research is envisioned as an integral, ongoing process whereby community needs inform both service plan and the assessment of operations and activities.

A brief description of different uses of information is presented below:

1. Monitoring and research information: the combination of research data which are formally gathered from the field, then stored, analysed and distributed to managers in accord with their informational needs on a regular planned basis. This information may be part of internal continuous data (management information systems or monitoring reports), internal ad hoc data (monitoring reports), community (environmental) scanning, and field research (continuous or ad hoc data of rapid appraisals and surveys).
2. IEC and advocacy information: A process of generating facts and issues, and disseminating them to target audiences to create awareness, sensitize or motivate them as part of the communication and education process in order to adopt new attitudes or behaviour. The type of information, provided to a specific audience, is based on a study of their needs and perceptions, which are in fact another type of information gathered by researchers. IEC information can be provided to the target audience through either interpersonal communication (HP system) or through mass media.

Monitoring system

The design of the FaRHFP project monitoring system was formulated by a task force in October 1994, and pilot implementation started in February 1995. The report *Development of a Monitoring System* (1995) states clearly the objective of the monitoring system and all its components and mandates. It also shows the information flow chart. It did not, however, show how it will measure its efficiency as a management tool.

As cited in the *Technical Proposal* (November 1995), priority will be given to development of a standard baseline study to provide appropriate baseline data on all VCA's where project activities are to be initiated in phase II. And according to the *Monitoring Mission Report* (Stolba, June 1996), the FaRHFP project has assigned an elaborate monitoring system for project outputs, especially the HP system, but unfortunately it depends on sources of data which are often dispersed, inaccurate or unreliable.

This was confirmed by the evaluation team, during interviews with project staff and through our review of project appraisals and monitoring progress reports. The general impression is that the project monitoring system proved to be a successful community participatory approach. However, caution should be taken when interpreting qualitative data of appraisals and attempting to use them quantitatively.

Review of the *Monitoring Progress Report for the Third Quarter 1996*, showed positive improvement in its performance and outcome evaluation. The authors offered solutions to the problem of low polio vaccine coverage and antenatal coverage.

Research

On reviewing project documents, it appears that the project management did not consider the importance of designing the appropriate research methodologies and monitoring system needed for early stages in the development of the project, although initial situational analysis revealed the need for both a quantitative and qualitative research approach.

For example, the *Plan of Operations 1992 to 1995* states that there is a lack of information about what is actually happening at grassroots level, as well as about a comprehensive picture of the health and disease status, the socioeconomic status and the detailed FP activities (and outcomes) in Fayoum Governorate and particularly in Itsa District. Also, stated in the same document is that no large scale district wide scientific surveys will be conducted, but a relatively large number of village (participatory) appraisals will be

implemented to provide baseline, monitoring and evaluation data. In this way, in a process approach, project activities will be adapted according to outcome indicators and local circumstances.

The project management, in studying the health status of the community, obviously did not use sample survey methodology to obtain accurate statistics on a small number of carefully chosen demographic variables. Rather, they relied only on qualitative studies especially participatory rapid appraisal methods which would be used to obtain only a differential understanding of the population's attitude, beliefs and behaviour (e.g. towards disease and health care).

When the project staff were interviewed, they failed to explain scientific objective reasons for depending only on participatory rapid appraisals to establish their data baseline. The question is whether participatory rapid appraisals are enough to establish a data baseline.

Participatory rapid appraisal techniques complement, and in many ways substitute, other research methods, but they do not make redundant more formal and detailed surveys and analyses. Participatory rapid appraisal methods and quantitative methods do not exclude each other and can be used simultaneously. The choice of methods depends on the kind of information required and the availability of resources (e.g. staff, time, funds, vehicles). Particularly when accurate quantitative data are needed, or when sophisticated statistical analysis is required, participatory rapid appraisal methods can not replace more formal survey techniques. On the other hand, if the main objective is to learn about community members' attitudes and opinions, participatory rapid appraisal would be the method of choice.

Also, when deciding whether or not participatory rapid appraisal is appropriate for the project, certain considerations should be taken into account:

- Availability of appropriate staff to conduct the study;
- The degree to which project structure and decision making are sufficiently flexible to make use of new information;
- Intended use of findings.

When flexibility is abused it may allow individuals to do anything and call it participatory rapid appraisal, and if done in a hurry and constrained too much by circumstances, participatory rapid appraisal become development tourism which relies largely on initial findings and merely conforms biases, preconceptions and stereotypes.

On reviewing *VCA Appraisal reports* of Moutoul and Meiniet El-Heit (1995), one can see that the above mentioned considerations were not taken seriously into account, in addition to the misunderstanding of the main features and conditions of implementing participatory rapid appraisal.

The project participatory rapid appraisals have identified the research methodology (sampling, tools, etcetera) which are used for quantitative surveys. They also reported the results using heavy statistical analysis and even compared some of the results to other national surveys which had different research approaches and designs.

The table below shows some of the main differences between participatory rapid appraisal and quantitative research methods, which project management and research teams should recognize and apply.

Table 3. Participatory rapid appraisal versus other research methods

Participatory Appraisal	**Questionnaire Research**
Short time	Long time
Low cost	High cost
Flexible	Fixed
High participation	Low participation
On the spot analysis	Analysis in the office
Little statistical analysis	Heavy statistical analysis
Semi-structured interviews and group discussions	Formal questionnaires
Opportunity sample	Random sample
Multi-disciplinary team	Enumerators
Non-hierarchical	Hierarchical
Best for learning and understanding rural peoples' opinions, behaviours and attitudes	Best for gathering representative quantitative data and statistical analysis

Other qualitative research activities

The FaRHFP project had conducted high quality research by two consultants and their assistants, who joined the project recently and had great impact on developing innovative approaches that addressed new areas for study. Four qualitative studies were conducted to gain more understanding of the current situation of reproductive health. A total of 13 women beneficiaries were included in focus group discussions, and in-depth interviews were held with two MCH nurses, two FP nurses, three *dayat* and two midwives. Results were presented to project management and DHMT in a two day's workshop.

Further was the district health approach introduced to the project and as well as a set of 20 indicators (see below). In response to the finding of low vaccination coverage due to high drop out (1700 children), and an increase in Bilharzia prevalence (3.5 percent), which were presented in an orientation workshop, the DHMT reacted quickly and positively.

The DHMT workshop held in September 1996, addressed topics for additional research:

- Reproductive health needs assessment at the community level;
- Reproductive health supply assessment regarding coverage and supplies at RHU level;
- Mobile team rationale, objectives, and perspectives;
- Baseline survey for Ibshaway District;
- Role of HP's in health promotion and support provided by RHU's.

Research information and management information

To review the project's management information system (MIS) and assess staff capabilities to implement the system, the evaluation team held an interview with the project's computer system specialist. He explained that his tasks include computer system control, data management, data handling (e.g. statistics), and MIS automation. The MIS automation as he described it, will serve all divisions of the IMRU, but the concerned project staff will require specialized training in using MIS applications.

MIS can improve decision making by clarifying raw data. However, it is limited in the amount and nature of information it provides and the way this information can be used by the decision makers. This is because of its rigid structure which relies only on reports. Decision Support Systems (DSS), can overcome the limitations of MIS by enabling decision makers to interact directly with databases and analysis models. They can adapt to changes in the environment, and in addition to improving efficiency, DSS can also enhance decision making effectiveness by using *what if* analysis.

Research provides information about beneficiaries, services and other aspects of the project's external environment, with its main purpose being to help project management make informed decisions. Therefore, research should be systematic and objective in its quest to identify and help solve field problems. Information obtained from research can become an integral part of the MIS and DSS systems. More and continuous information can be obtained from both systems than from ad hoc research studies.

Outcome and impact evaluation indicators

The indicators are those changes that the project activities were designed to bring about. The FaRHFP project management has identified different sets of indicators, e.g. about 30 project output indicators in the *Plan of Operations August 1996 to January 1999*, about 21 indicators in VCA appraisal reports, and about 20 RHU monitoring and evaluation indicators. All these indicators should be reviewed and integrated.

The FaRHFP project output indicators identified in the *Plan of Operations August 1996 to January 1999* are broad in definition and need to be clearly specified in advance and flow from the objectives. They should also focus on the quality of care and not merely on the outcome of it.

Also, during the design of VCA appraisals and in order to avoid confusion during field work, the project should distinguish clearly between different levels: priority research topics, subtopics, key questions and indicators. However, the project has successfully established a set of 20 indicators for monitoring and evaluation of RHU activities which were reviewed with the DHMT.

To select and develop the proper indicators it is necessary to:

- Identify available data sources and quality of data collected;
- Identify priorities of project components;
- Define some qualitative and quantitative indicators that can be used by the project's MIS for both monitoring and evaluation (indicators must be relevant, sensitive to changes, well understood, simple to measure, accessible, reproducible and of high validity).

District Health Management Team

The project is successfully progressing in upgrading formal health and FP sources within the community, and in facilitating sustainability through support of DHMT approach. The DHMT was positively involved in solving problems (see above). Planning and monitoring considered low among DHMT responsibilities (15 and 20 percent respectively). Absence of local health planning and monitoring systems at the RHU level, led to a failure in identifying community health needs. The utilization of a governorate level information system is inadequate. There is absence of a standard checklist and poor feedback at different levels.

Also, there seems to be a shortage of means of transport for field monitoring. The project is challenged to improve DHMT status to enhance its active role in district services.

Family Planning Committee

An interview with the Family Planning Committee (FPC) at Meniet El-Heit village showed the successful reaction and coordination of the local influentials with the project's HP's. The FPC president stated the roles of FPC as:

- Follow-up of FP activities;
- Checking birth and death rates;
- Checking with health authorities for any shortage of supplies or lack of providers.

Internal and external monitoring and evaluation reports

The project library contains many reports that were written by different experts in various project areas or components. It is important that the project's senior staff review these documents and utilize their recommendations. To make an accessible tool, the monitoring staff can compile all reports in such a way that all chapters in the different reports addressing the same components can be compiled and presented for review by each component's coordinator.

11. TRAINING COURSES, SEMINARS AND WORKSHOPS

11.1 Main characteristics

The characteristics of the training courses thus far are basic knowledge and skills for the HP's, and HPS's, four weeks theoretical and two weeks practical. Other short training courses are provided for project and non-project staff. The duration of these courses ranges from one day to six weeks. The six weeks course is organized for training of trainers.

11.2 Specific objectives

The *Plan of Operation August 1996 to January 1999* stated that the investment in human resources is important to secure the sustainability of activities following the project withdrawal. Therefore, in addition to the training courses for HP's, the project intended to run courses in management staff. The areas covered were introductory courses for HPS's, HP's, doctors and nurses. Other specialized courses were infection control for nurses, English and computer courses, training of trainers and courses in management, women in development and community development and family planning abroad. The *Annual Report 1995* mentioned the adaptation of the HP's and HPS's curricula and refresher courses through focus group discussion and analysis of existing curricula. The people involved were project staff, trainers and consultants. The report concludes that participatory training requires more time, training of staff abroad is difficult due to English language and vested interests of doctors, and routine training is not the optimal goal of the project.

On the other hand workshops and seminars were described as effective means for participation, exchange of opinion and mobilization. Another report suggested down to earth practical approach in training, which meant workshops and participatory training. The emphasis was on the trainer who should have a highly specialized field approach with support from the project. The supervisors should be trained in principle on the importance of guidance and support. In this respect, the report on assistance to the training programme of May 1993 identified and trained 27 trainers. Of these 13 were doctors, 10 directors or occupants of high managerial posts, two nurse supervisors and two nurse trainers. Another report on training needs assessment for HP and HPS courses, which appeared in 1995, intended to assess further training needs. Among other

tools, focus group discussions were used to collect data from the HP's and HPS's. The concept and methodology of focus group discussions was grossly misused.

The *Plan of Operation August 1996 to January 1999* stated that the investment in human resources is important to secure the sustainability of activities following the project withdrawal. Therefore, in addition to the training courses for HP's, the project is intending to run courses in management and supervision, development issues, credit systems, and other relevant topics for specific target groups. These groups included the project staff, project consultants and advisors, CDA staff, and the Directorate of Social Affairs staff. A regional study tour was also planned for staff to visit specific programmes relevant to FP, women and gender issues, and rural development. There was also a budget set aside for fellowships for selected senior staff to do relevant courses within and outside the region.

11.3 Progress to date

A number of courses have been implemented according to the stated training objectives of the plan. These courses were intended for HPS's, HP's, medical, support, and management staff. The areas covered were introductory courses for HPS's, HP's, doctors and nurses. Other specialized courses such as infection control for nurses, English and computer courses, training of trainers and courses in management, women in development and community development and FP abroad.

11.4 Discussion

This evaluation is focused on the type and approach of training and the impact of this training on the trainees. The project has tried different methods to either assess the training needs or to conduct training courses. But, since there were no targets stated in the plan of action, it will not be possible to assess the number of courses that have been achieved. The other problem in assessing the achievement of training are the vague objectives stated in the plan. For each group in paragraph 11.2 above, there is supposed to be a purpose for doing the training. The only area which has not been touched upon in the training is the fellowships for higher education. There are however, a number of observations the evaluation team has made from the service users, HPS's, HP's, staff in the project and available documents.

Training approach

The findings from the situation analysis in May 1996 is still valid in terms of the quality of training. There was too much emphasis on the top down theoretical training (two thirds of the courses) which does not serve the purpose of the FaRHFP project. It was also a risk of losing the opportunity of making changes towards appropriate development in approach and style of training.

There is, however, another side to this type of training. Part of it reflected the rigid top down approach in training. It seemed like each category memorized the messages by heart without thinking about the meaning and implications. For example, one of the HPS's emphasized her role in teaching or doing hygiene education in the village. That village was surrounded by pools of sewer all around. She was asked how she could advise women on hygiene education when water was not available in many of the houses in the village, many were without toilets and those who had toilets, had the sewerage around from neighbours. Her answer was that this was what she had been taught to do in the course.

The mission had an opportunity to participate in a two day training course for 12 male clerks. The course supposed to assist these men in supporting the project in promoting FP. When they were asked what they gained from the course, the response was a repetition of the growth rate formula. They could not translate it into something simple to assist them in carrying it out to the ordinary people. However, they had the overall idea that overpopulation is a big problem for health and wealth of the population in the country. Even the trainer coordinator had difficulty to understand the importance of these practical ideas. Her concern was that the clerks will be able to tell whoever they meet that overpopulation is not good for the country.

The clerks sat in the class room formally around the table with their note books in front of them. They were supposed to absorb what they were told. These were men with long experience in their own field. If something were expected of them to support the work of the project, it should be explored around their capacity, practicality and possibilities. Visual and written material could be part of their course design. None of these were noticed.

One of the KIT consultants said that participatory training was already in action. While the other one said that it has taken them a long time to accept this type of training. In Egypt, many think that participatory training workshops and group discussions are not considered as useful as traditional lectures. This was partly supported by the director of the project. But there was consensus that once HP's and HPS's are trained to present to others results of their work at different levels within the project, DOH and Fayoum Governorate

they will gain skills and confidence in what they do. This may contribute to the sustainability of their activities. This will also improve women empowerment to take an active role in development issues.

Most of the HPS's, project supervisors, doctors, DHMT, and FPC assumed that they have the right to supervise the poor HP's in the field. Yet neither they nor the HP's whom the evaluation mission talked to could tell what they were trying to achieve in their areas. In other words many could not tell what they were supposed to achieve with the activities they carried out.

This could be resolved through follow-up and reinforcing the skills gained during training, by monitoring the roles and activities in the field at both output and impact levels. Trainees should be informed of what is expected from them, how well they perform, and should be oriented on how they will be monitored and evaluated at the above mentioned levels in order to achieve the project objectives, both effectively and efficiently. Prior and clear understanding of this process will help improve everyone's performance and standardise means of either correcting mistakes or rewarding successful achievements. Accordingly, refresher or advanced training courses can be designed for selected candidates. Successful achievements may also be published in a newsletter using testimonials or personal photographs as examples.

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Women empowerment

All HPS's did not know the Arabic term *tamkeen almaraah* (women empowerment). After more explanation, many find their own explanation. Some of these related to more resources for women in need. Others related it to the loan they give to women. The overall activities of the HPS's in education and social activities, and the use of FP, were all seen by HPS's as a positive development to give them better status in the community. Women support one another in health and sickness. In their opinion, giving advise to a woman with a sick child or on vaccination gives them great respect among community members.

One HPS said that empowerment of women means knowing the interest of the family and her husband's needs and also how to take care of the house property. Another HPS said women development is equal to empowerment through literacy classes, raise chicken and sewing sessions. Women without work needed more business to acquire empowerment.

The concept of empowerment was not only the problem of the HPS's. It was daunting for others. There was a feeling of suspicion about it being imposed from outside. Others were cynical about it, especially men. An article in Al-Fayoum newspaper, November 1996, on the FaRHFP project described it as the *Al-Jendariah*, in their meaning the Dutch language. In other words it has not entered the Arabic language and culture in meaning and acceptance. There is a need to develop better strategies to make improvement for women issues without marginalizing them or making them even more vulnerable. There was a consensus that women empowerment was relatively new to the Arab world in general and Egypt in particular.

Involvement of men

Men involvement was discussed mainly among the male and female focus group discussions and the HPS's. There was unanimous agreement that men should be involved as recipients of health services especially with FP. Almost all women acknowledged that the husband's consent was necessary. One focus group discussion in Kalamsha though, accepted husband's consent but they did not think it was a major obstacle in using FP services. They felt capable of convincing them.

Few men in the focus group discussions had the opinion that the final decision in contraceptive was in the hands of the husband. Others counter debated this opinion and considered it as an *old style domination of women that is gone*. Those men considered the wife-husband relationship to be about mutual understanding for the future of the family. Men domination in such decisions was not seen as healthy for the family.

Men related FP to the present economical situation and the religious teaching. They consider so many people in one family which many heads of the household could not afford to feed. If that was not the case people would continue to have as many kids as they liked. This view was supported by the religious view, a statement by prophet Mohammed: Get married and have as many children as possible because I will be proud of you on *Youm Al-Qiama* (Doom's Day). The facilitator indicated that this same statement was used for FP promotion in some parts of the Arab world. There, the interpretation for many children means many strong children but not many weak and hungry children. There was no reaction.

Some men blamed health staff for not making available verses of the *Quran* or of *Prophet Sayings* which support the use of contraceptives. Other men thought that the religious leaders were against FP anyway. Only one mosque leader in one of the focus group discussions in Toutoun said that he was promoting FP. The rest of the men in the focus group discussions said that they had never heard anything about FP from religious leaders in the mosques.

Some HP's mentioned how they get intimidated by men who do not want to hear or use FP services. Therefore, they strongly recommended to involve men actively in the programme. The HPS's do not think that it was their role to involve men or ask their assistance even when they faced these threats.

A man in one of the focus group discussions strongly rejected the idea of someone talking to him about FP. He wondered how others could expect him to accept another man presenting three different contraceptives, and ask him to take one and give it to his wife.

In one focus group discussion in Toutoun men said that FP was a must. People have already too many children and they could not afford to raise seven or ten children in a family. The mass media, TV, radio and newspapers, were the sources of their knowledge, they said. The wives of two of the nine men used FP services. They had not met with local health workers or other local leaders on the subject in the area. The men thought that the project was part of the MOHP.

12. PHASING OUT AND SUSTAINABILITY

12.1 Main characteristics

The question of sustainability was not given a serious discussion until the fifth year of the project, the beginning of 1996 (see paragraph 14.3).

12.2 Expected outputs

The *Plan of Operations August 1996 to January 1999* aimed at strengthening the linkages between the community, particularly women on the one hand and health services and community organizations on the other through the development of a sustainable HP system.

12.3 Progress to date

The formulation mission of August 1990 linked the *raidat* system with cost recovery but did not elaborate on the idea. On sustainability, it stated that the Governorate of Fayoum was willing to take responsibility for the budget after the Dutch funding ends.

In the *First Interim Period Report* nothing was mentioned about sustainability, while the *Annual Report January 1995-January 1996* stated that in the second phase of the project, activities should be sustainable after the end of the project. But there was no further explanation on what activities.

The report June 1996 elaborated more on sustainability of the HP's system. The main focus was on ensuring the employment of the 500 or so HP's by the Egyptian counterpart, be it Fayoum Governorate or the central MOHP. The report explored different alternatives related to the role of the HP's and how to modify it. Three areas were identified, a holistic approach, evolving HP's job description and reexamining the curriculum. Then it recommended that the work of the HP's should be properly monitored to convince the governmental officials to sustain it (i.e. to pay the salary for the HP's).

The *Situation Analysis for the FaRHFP Project* (July 1996) further examined the ingredients for sustainability. This report pointed out that the HP's were primarily in search of job security, the condition and the status which accompany it. It examined eight areas relevant to sustainability including the employment of the HP's. In this matter HP's stated that they wanted to receive the same benefits as other governmental employees to secure their future and sustainability of their work.

However, it concluded that hierarchical working relationships, job differentiation, status and aspiration of the public sector run counter to basic principles of PHC and the role envisioned for the HP's. Past experiences have shown that sustainability of extension work programmes require ongoing supervision as well as training and development opportunities.

The report continued, that failure of the RHU to provide the services HP's promote, will create serious repercussions. This will not only make sustainability difficult but community confidence will be lost. The report emphasized that project plans should develop clear strategies for ensuring a balance between supply and demand to avoid raising expectations which can not be met. And the project's sustainability involves cost. Therefore, costs must include training, continuing education, support and supervision.

The *Plan of Operation August 1996-January 1999* stated that formalizing the HP's position, and securing the financing of the system on a permanent basis were promising. This promise was based on the incentives which were paid by the Fayoum Governorate for 200 HP's in Itsa District. There were also plans and discussion under development for sustaining the socioeconomic components of the project.

12.4 Discussion

Sustainability of the present HP system relies solely on the role of the HP's. These cadres were trained to raise awareness among women to demand services of FP, MCH services, immunization, curative care, better sanitation, literacy and sewing classes, small loan and credit system. The supply of these services requires in the first place the availability of the products, finance, a functional management system, regular support and supervision and continuous training to improve or adapt performance. Each of these issues will be examined to predict the likelihood of sustainability after the Dutch financial input ends.

The HP's have been successful in creating the awareness. Women in the focus group discussions expressed their satisfaction with the HP's. Home visits, health messages, small loans and the credit system were the

reasons for this satisfaction. Some of them even felt happier that they borrowed money and paid it back already. They felt that by doing so they were sure to get more. But to their surprise, when they applied again they were refused to get more loans. Some of these women could not understand why they did not get it, others thought that they should give others a chance.

There were HP's who reasoned in exactly the same way as the ordinary women and said that as long as people pay their debt, this service will continue. Another stated that the loyalty to the RHU was a guarantee for continuation. A third opinion was that the recruitment of new needy women was the guarantee to sustain the activities. One HPS said that her contribution to make this happen was to be conscious and act as a good role model, have good intentions, do not cheat and keep in mind that the money was government money and has to be taken care of.

Most of the small loans were given to women who were heads of the households. Their husbands or male relatives had either died, were handicapped or too old to do anything. The economic activities they show, were typical to poor families. These included raising goats, selling vegetables and small grocery items. The supervisors at the project felt that there was a need for a marketing expert to guide the project staff and the beneficiaries on socioeconomic matters, especially on market supply and demands. This advisory role will help women avoid trading the same things.

Thus far the demand for the small loan services was quite high but the supply was very slim. The small loan system was not a sustainable service because of the financial loss in inflation, no interest payment and it was not institutionalized. The HPS were lead to believe that by doing their job properly this system would continue. Sooner or later they and their clients will know that this is not the case.

The credit system with eight percent interest repayment went only to those who had access to governmental employees. A situational and financial analysis in November 1996 found that loan beneficiaries tend to have a higher than average educational and socioeconomic status compared to the communities as a whole. The role of the HP's was limited to identify loan candidates but was excluded from any major decisions in the credit system. Therefore, credit could be granted without the involvement of the HP's. The loan was also given through ICDA, a recognized institutional system. The chances of sustainability through the present social fund was quite good.

The HP's main concern was to secure their governmental employment to enjoy the benefit of the governmental system like everyone else. This process was already in motion. The Fayoum Governorate

already paid incentives and paper work was in progress to get the HP's governmental employees. Sustainability in terms of paying HP's their salary was promising. However, their future role under governmental employment was debatable.

In one of the hospitals visited by the mission, there were 136 employees and the number of patients was between 50 and 60 per day. In other words, a ratio of more than two staff members per health attendance into the hospital. So what happens when the HP's become a governmental employee? What prevents them from following the same route as the rest of the public health employees?

A health office manager described this phenomena as *qowa atila wa moattila* (unemployed and corrupted human resources). With this term he meant that there were governmental employees who were not only employed and not doing anything, but also discouraged others who were willing to do the job. There were other managers in the project, health office and outside health who shared similar views. What will be sustainable and what will prevent the HP's from falling into the employed and corrupted category? Bearing in mind that their status would be at the bottom of the employment hierarchy and they are women, their chances of sustaining the HP system are slim.

In this respect, the Egyptian side realized these facts and insinuated that it was the Dutch side who pushed for the employment of the HP's. While the Dutch consultants saw no flexibility for any other experimental strategy other than the present one, namely using the HP's in achieving the objectives of the plan. It was also a bilateral agreement between the Government of Egypt and The Netherlands. This process has taken a long time and no one could afford to start something new.

The HPS's and HP's were trained to refer their clients to the health facility for both preventive and curative care. It was recognized at the MOHP, the Fayoum Governorate and the project that the curative care in public health facilities was not encouraging. It was argued that this was not the responsibility of the project. But as long as it was part of the HP's work to advise their clients to go to public health facilities, it remained connected to the project activities. Public health curative care was already going downhill. This in turn jeopardized the trust of the community in the HP's. A sustainable HP system is then at risk. People would like to be treated once they get sick. Therefore, the demand for curative care was very high and the supply was low.

The awareness on FP and immunization was increasing. Health education was an important tool to influence people's behaviour. It could be through different strategies such as mass media, schools and face to face

education, like the HP's system. These strategies required preventive orientation in health service provision. They also required constant adaptation and development to match the changes in people's attitude and behaviour. The people's demand for these services was not quite as forceful as the demand for treatment. People will pay for curative care but would not pay as much for immunization or FP. Sustainability of this strategy depends on future central MOPH policy in Egypt towards the reorientation of medical training to balance curative and preventive health care. Another difficulty for decision makers to support this strategy is that they often cost money and it is hard to quantify the benefit (see also 12.3 above).

The project was also supporting literacy and sewing classes. Literacy classes outside the project have been going on for years in Egypt. There were lessons to be learned from these activities. The sewing classes were under demand because participants aimed at gaining new skills for job prospect. These activities required capital fund and running cost. They can be sustainable only if some agency supports them.

Obstacles

The following are additional examples of the obstacles facing the HP system that may threaten its continuation after the Dutch input stops.

In one female focus group discussion, there was unanimous agreement that the RHU provides them with nothing, even though many said that the HP in their area was trying her best to help them.

Some men and women in the focus group discussions had their own opinion about FP and contraceptives. A male group discussed risks associated with contraceptives. Pills cause low blood pressure, IUD bleeding and injection blood coagulation. Many of the people do not know what these risks are.

Two of the women in Toutoun had many children at home, ten and nine respectively. The first was afraid of the FP because she was told that she needed an operation beforehand and was too scared to undergo an operation. The other gave no reasons. One used IUD and the other used injections as FP method.

The FPC mentioned transport as one of the bottle necks in FP provision. The female doctor could not move between clinics because she did not have a car. The local administration pays her fees for taxi at the time being. But they did not think that this was appropriate.

HPS's saw different bottle necks in their working situation. One said that the examination room for women in the RHU was without water or toilet. She had no antiseptic either. The HPS buys antiseptic from her own

money. They have no drugs whatsoever except vaccination once a week and contraceptives. The doctor inserts the IUD while the window is open and the women do not like it.

Another HPS talked about the fact that many people are extremely poor, they want employment. What is the use of health education if people do not have an income? Two HPS's said that women do not believe in health education anyway. One HPS said that two women in her area could not pay their debt. Then the HPS had to pay the debt from her own salary. Another HPS said that women refused immunization and men wanted more children. A third one said that there was a lack of immunization in the RHU.

The lack of drugs in RHU and the hospital were cautiously mentioned by the HPS. One of the problems in one unit was the female doctor accepting only women. This caused some problems when the HP's advised people to go to the RHU.

At the project level, local and international consultants considered some of the bottle necks in management style and differences in running the project affairs which needed urgent considerations.

The local consultant being from outside Fayoum will leave as soon as the project ends. Candidates for higher education especially in public health were seen as difficult to recruit. The reason given was that doctors did not want to leave their private clinics and the non medical staff could not speak English.

DHMT could not do their job properly because they did not have transport. The HO had cars but now they were out of order. Cars need capital and running cost. If these could not be sustained in the past, how could they be now? The attitude of the manager in charge was that this matter should not be of concern. If the Dutch input provides the cars, other projects will provide similar cars in the future, once the Dutch input ends.

PART III: CONCLUSIONS AND RECOMMENDATIONS

13. CONCLUSIONS

Organization and management

The number of project staff has increased considerably during the past years. This has led to an organization structure which is rather complex. It comprises a steering committee, an executive committee, an executive director, national and foreign technical advisors, seconded staff, contracted staff, BAE's and local and foreign consultants. Furthermore, for the implementation of its activities project staff works closely together with various governmental and non-governmental organizations.

It is felt by the evaluation team that, along with the growth of the project, organizational and managerial development has lagged behind. There is need for a thorough analysis of the project's organization and management structure. Special attention needs to be given to the project structure, (delegation of) responsibilities, lines of communications and decision making processes.

Project Model

Theoretically, the three components of the project are relevant to the realization of aims and objectives. In practice, the second component (i.e. the upgrading of health services) is the bottleneck in this project. The HP's and HPS's are raising health awareness and expectations of health services among the beneficiaries but they are not being backed up by the upgrading of the health services. The project has been successful in increasing FP use and child immunization, but less successful in increasing the utilisation of curative health services. In fact, what the HP's are doing is helping the private health sector. The beneficiaries have more health awareness, but do not receive satisfactory services especially in the curative sector from the formal health system. Even the very poor now collect money to be able to see specialized private physicians usually in Itsa City or Fayoum City.

The "empowerment of women" is much more evident among the HP's themselves than among the beneficiaries who are the target group of this whole project.

The project has been partially successful in implementing its selected approaches and strategies. It has succeeded in the "integrated sustainable and comprehensive development approach" and the "utilizing of a community-based approach". We can not comment on the "process-oriented approach" because the subject was not raised in discussions. It has possibly succeeded in the "gender-sensitive approach and the empowerment of women" but often HP's had to be reminded of this objective. It has also only partially

succeeded in the "reproductive health approach" because while it addresses "maternal child services, gender-sensitive focus . . . and sensitivity to the availability of female physicians," it has not directly addressed "maternal morbidity and mortality" nor "the desegregation of quantitative data on health status by sex".

Health Promoter System

The major achievement of this project is the establishment of a functional HP system. Through utilization of this community-based approach, FaRHFP was designed to complement the Egyptian health facility based model. However, based on FGDs with beneficiaries (women/men), and the HP's, our impression was that the health infrastructure represented in different levels of rural health facilities usually run short of medicines and laboratory materials. These, in addition to poor managerial and administrative skills of some health team members, are all potential threats for this community-based project.

The target audience expects both governmental and nongovernmental health agencies to improve not only existing preventive health services but also curative ones before building communication channels with them. This in itself carries a potential threat of implementation instabilities and lack of project credibility to its HP system.

Although the HP's are considered as 'development brokers' or multi-purpose outreach workers, their primary focus of work is to disseminate information regarding family health, including FP and MCH issues to the community. While the community coverage (home visits) of the HP's is highly successful, their specific communication objectives are not clearly stated in terms of measurable changes in RH/MCH-related KAP. Therefore, a clear, specific FP/IEC strategy is needed for the HP system, one that should be reflected in HP training and field operations.

Upgrading health and FP services

The schedule and budget for:

- renovation of the 22 of the 23 RHF's and all 4 EFPA FPC's;
- procurement of basic medical equipment and office furniture for the RHF's and FPC's;
- procurement of furniture appliances for the 23 houses of the physicians working in the RHF's;
- distribution of equipment, furniture and appliances to the RHF's, FPC's and houses of the physicians; and
- establishment of 3 NS's

had to be adopted several times during the first project phase and the three interim periods. However, at the time of the evaluation, all these activities had been completed.

1 RHosp, 3 RHU's, 1 NS and 1 FPC (EFPA) and three physicians' houses were visited by the evaluation team. As far as the members could judge (none of them was a building and equipment expert), the renovations and equipment were of a good quality. These findings are in line with those of a building and renovation coordinator of the RTI, who visited the project in 1993 and 1995.

Maintenance remains a concern. The available DoH budget for maintenance is small, and the present DoH organization is not much geared towards maintenance. Therefore the evaluation team is very much in support of the planned development of a preventative maintenance plan and establishment of a district maintenance workshop during the second phase of the project.

The evaluation would like to emphasize that an adequate infrastructure is only one of the prerequisites for a good functioning health system. Motivated health staff is an important second. Despite incentives the motivation of especially the physicians working in the rural health facilities is far from optimal. Although the performances of the physicians is the main concern of the DoH, the project should put a greater effort in seeking ways to stimulate the physicians to perform better. It is recognized by the evaluation team that the MOHP is currently implementing a new incentive system for physicians working in the rural areas.

Socioeconomic Activities

The socioeconomic component was implicitly included at the end of phase I, i.e. documents for that phase do not include it as a separate component, but starting in 1995 and 1996 it is mentioned as 'ongoing activities'. This component is clearly defined for phase II.

The ISL system has a budget of LE 10,000 per VCA while the credit system has a budget of LE 20,000 per VCA. The remaining LE 10,000 go to covering expenses of group activities. There are criteria for the selection for ISL recipients (e.g. family income not more than LE 10 a month) but there are no similar criteria for the selection of the recipients of loans from the credit system. If the project is targeting the needy women then criteria should be developed for the selection of the latter group.

The range of economic activities for both the ISL and credit systems are very limited.

The issue of sustainability of this component is being addressed. Currently the project is assessing the various community organizations e.g. CDAs, and local councils, and scoring them to select which should take over the ISL component once the project phases out. The likelihood is that they will create a women's club under the auspices of the CDAs. They are also considering adding interest to the ISL's. However, we have no assurance that the selected solutions will be implemented.

Social group activities are quite successful, especially the sewing classes. There are approximately 100 women who have been trained on sewing and 49 of them received sewing machines on loan and have started their own businesses. Also, some of them have been employed by the 6th of October Cloth Factories. The literacy classes are rather limited in number (beneficiaries only 82 women) and there is a possibility that they relapse into illiteracy if they do not use their newly acquired ability to read and write.

Information, Monitoring and Research

During Phase I of the project, the Management Information System (MIS) was not fully developed and the monitoring system was not given priority as were other components.

Audience baseline data were not available during development of the training curriculum for HP's.

Considerable time invested in the development of step-by-step procedures for community appraisals in project catchment areas has resulted in production of several high-quality appraisals as well as other issue-specific studies and research manuals.

Training

The success of the FaRHFP in training has been observed in messages on home visits, family planning, counselling on MCH, immunization, small loan and credit. The HP's were the medium to communicate

these messages to the women in the villages they work in. They were consistent at all levels from project management to the women beneficiaries in the villages.

The project has the potential of forming a professional training team of a good quality. It has the expertise in public health, research, sociology, and field work. However, this potential has not been exploited yet by the project management as each section is doing their own part of the training i.e. training coordinator does some training, senior social worker, monitoring and research does others. The socioeconomic expertise in the project especially in the market supply and demand is not there yet.

A number of project and non-project staff participated in different courses organized by the FaRHFP. This training method was mainly classroom sessions in the project premises. The characteristics of the training courses were mostly theoretical and the duration varied from one day to 6 weeks. The exceptional training which has both six weeks theory and two weeks field work, was for the HP's course. The latter was focused on the socioeconomic component of the project. Other short courses or tours were organized in the Arab World and Holland. No candidate is identified yet for higher education fellowship.

The threat to the existing training efforts are the fragmentation of the training by different sections in the project, the top down approach, and the focus on theoretical training. There are HP's who communicate messages exactly in the way they were trained. Sometimes these messages do not make sense. An example of a HP who was giving hygiene education in an area where sewerage was all around the clinic and houses. She was not given the training to examine the reality before communicating unrealistic message.

The use of simple audiovisual training, the situation analysis by the HP's and HPS can make a difference in development and future Sustainability. These cadres should understand what the situation is, why is it that way, what could be done to make a difference. Many of them at the time being respond automatically on how the situation should be (the idle way).

The focus of the FaRHFP project has been reaching women recipients by the HP's system. Men have been left aside for one reason or another. In many of the project's documentation and the present evaluation, it has been suggested that men involvement was essential. Men were and still are the major decision makers in the family. They could enhance the HP's strategy or go against it. They needed to be equally informed and involved. Threats to HP's by men who are against FP may not be taken seriously and could damage the HP's confidence.

Sustainability

Sustainability at this stage may have different interpretations by different players at the FaRHFP. If it means the project will continue to function once the Dutch input stops as it is now without any external financial input, we are talking fairy tales. If this concept was taken seriously for development, there might be a number of activities that might have a chance to continue after the Dutch input stops. These could be developed through rigorous involvement and continuous field training and presentations of achievements between project staff and HP's in the field and the region.

Until now sustainability focused on the permanent employment of the HP's. The Governorate of Fayoum was in the process of responding positively to this arrangement. The supply of family planning and immunization could be secured through the responsible agencies. Whilst the project components i.e. the support system to the HP's in supervision, training, research were still under consideration, there were plans under development for the sustainability of the socioeconomic component.

The HP's were trained to create awareness among women on a number of services which the project and non project agencies were providing. The balance between service demands and supply has to be seriously considered. If the HP's continued promoting services that can not be met, their efforts will be seriously undermined and the trust of the community will be lost.

Recently, team work within the DHMT was getting more attention. It has a potential in tackling the different preventive and curative care. However, their role and interaction among one another was still unclear. Their involvement with FaRHFP might be positive in working together. But it may create unrealistic expectations which the project could not fulfil.

There are a number of bottle necks which the project suffers from before expanding to the Ibshaway area. The range is quite wide, curative care, belief and attitude towards FP, the involvement of men, loan and poor families, overemployment and ineffective performance, training and management. All these problems build up and can be a serious threat to the present success of the project.

Sustainability of the project has been focused on the permanent employment of the HP's. The Governorate of Fayoum is in the process of responding positively to this arrangement. The supply of FP and immunization could be secured through the responsible agencies. There are plans under development for the sustainability of the socioeconomic component.

The HP's system can make a difference in programme development of preventive care. But if it is not supported by curative care which is very ineffective at the time, the confidence of the population towards the HP's will soon be lost. Recently, team work within the DHMT is getting more attention. It has a potential in tackling the different preventive and curative health care. However, their role and interaction among one another is still unclear. Their involvement with FaRHFP might be positive in working together. But it may create unrealistic expectations which the project could not fulfil.

There is the attitude that things will work as long as the project is there, once it is gone another project will take place. Another threat is the employment of HP's that may add new governmental employees with little support and supervision. Hence, a new system is dissolved and becomes ineffective in the old system.

14. RECOMMENDATIONS

Organization and management

The evaluation team recommends that a team of (health) management consultants (national and international) is assigned to analyse the present organizational structure and management practices and to propose new designs. This should be done as soon as possible.

Project Model

This project should clearly define what it means by the "empowerment of women" and should develop new, more relevant indicators to measure the realization of this objective. The documents for Phase I of the project hardly address the issue while the document for Phase II concentrates on the role of HP's as "development brokers" and lists indicators that measure this rather than whether women have a better status and more decision making power in the family and in the community.

We are aware that indicators for the "empowerment of women" are a problem in many projects. Recently the Prime Minister's information centre has organized a seminar on the subject and has divided participants into various groups to develop indicators in the various areas e.g. political, economic etc. Maybe this initiative can be of help.

Health Promoter System

The second phase of the project must work to strengthen the HP system and maximize the opportunities it provides by:

- focusing on improving the quality of community health services;
- continue further strengthening the role of HP's;
- effectively integrating project activities into existing Egyptian systems in order to ensure sustainability.

Upgrading health and FP services

Although the performances of the physicians are the main concern of the DoH, the project should put a greater effort in assisting the DoH in seeking ways to positively influence the performances of the physicians. A more systematic supervision of the physicians in combination with, if reasons exist, withholding of incentives should be seriously considered.

Socioeconomic Activities

The socioeconomic component and the "empowerment of women" should be revised and more clearly defined in project documents. Relevant indicators for the "empowerment of women" should be developed.

The allocation of funds for the three components of the socioeconomic component should be revised if the major target group is needy women.

There should be more cooperation between FaRHFP and similar projects for e.g. Women's Initiative Fund of CIDA, SPUF of CARE and SAP activities in the socioeconomic component.

Particularly in sustainability of the socioeconomic component there should be closer cooperation and integration with the SPUF project implemented by CARE and also funded by the Netherlands Embassy.

Information, Monitoring and Research

A Management Information System (MIS) needs to be improved and updated for project strategy formulation and evaluation of the impact of ongoing activities.

The new initiative of the project to build up a monitoring system at the district level based on specific selected indicators should be strengthened in order to improve problem-solving skills of DHMT.

A mix of research methods should be specified and additional qualitative research on the audiences' attitudinal barriers, information needs and missed opportunities in the area of RH should be collected and analysed during the course of the project.

Additional community based research is needed to measure the impact and quality of HP system in health promotion and in coordination with RHF's.

FaRHFP should develop a coherent IEC plan to reach special target audiences. IEC consultancy should be sought from a recognized expert with previous experience in Upper Egypt. IEC interventions must aim at achieving behaviour and attitude changes of a specific segment of beneficiaries based on a study of their needs and perceptions. Its integrated components are:

- Information: generation and dissemination of technical information, facts and issues to create awareness among different target groups;

- Communication: a planned process aimed at motivating people to adopt new attitudes or behaviour, or to utilize existing services;
- Education: the process of facilitating learning, to enable people to make rational and informed decisions and to influence their behaviour over a long term, either formal or informal.

Training

Training should be coordinated among the different sections in the project. The expertise of the project should be maximized in different participatory settings. These efforts need management commitment to build trust among the expertise in order to work together.

The research component of the project should be one of the main tools to build and develop the training curriculum. Relevant textbook manuals should be used to develop the field manuals. Emphasis should be given to practical training more than to the theoretical one.

The HP's and HPS's should not only be told what to do but be given the opportunities to present their work to others, a two way learning. They need guidance what to do once they are given the chance to use their minds and capabilities. This can be hard in a society where the educational system is theoretical and hierarchical in nature. But a move has to start.

Women empowerment is still a vague concept. This vagueness could be part of the role women will play in educating others about their situation, their achievements and get education from others. The only way of achieving this is through giving them the opportunity to debate their role in the society instead of accepting blind instructions from others. In this way they will influence decisions and make decisions themselves.

Training should be made simple, practical and fun. Some simple visual aids such as circles to represent the catchment areas, should be made available to the HP's. From these circles or whatever visual aid, the HP should be encouraged to think how she could reach the intended women or children in that catchment area. In this way, she could assess her own achievements.

If the HP's were trained to assess themselves, they would be in a position to communicate their achievements to others at different levels in the rural areas and the region. The continuous training and education may be used as rewards for better achievements and not routine. For example those who achieved

better will be taken to training courses in Fayoum or outside it. The information of these activities could be shared with others in the field and elsewhere through a circular or a regular low cost newsletter.

The position of the trainer coordinator should be given a priority for higher education in training methodology. Candidates for higher education fellowship in public health should be seriously sought. Candidates would have time to acquire the qualification and apply it before the Dutch withdrawal to sustain some of the project activities. The project consultant will then have ample time to give training for the new graduates in the project site.

The project should consider a male and female team in the HP system. This will enhance the present strategy and future sustainability.

Sustainability

Many of the recommendations under training apply for the sustainability section. In addition, the project should try to dissect problems in their merit to change, problems they can influence to change and problems they can not touch at all to avoid being in the middle i.e. responsible not responsible.

The bottle necks mentioned in 12.4 above should be considered and the right strategy should be designed to tackle them before moving to the Ibshaway area.

Serious thinking should be given to the development of the role of the DHMT in tackling the different issues of sustainability. The role of the FaRHFP should act as a catalyst, advisory in nature but not the executive role in financing activities.

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APPENDICES

APPENDIX 1

Terms of reference

draft TERMS OF REFERENCE
for a mission to evaluate the
Fayoum Rural Health and Family Planning Project

Background
The first phase of the Fayoum Rural Health and Family Planning project which was implemented from June 1992 - January 1996 was designed as a pilot project. The overall objective was to improve on the health and wellbeing of rural people in Fayoum, with particular emphasis on women and children.

Specific objectives of the project concerned the establishment of a community-based system of Health Promoters (HP), the upgrading of health service delivery, the improvement of family health status, the implementation of local socio-economic activities and the active participation of women in project-related activities.

The internal evaluation report of June 1995 observed that a major achievement of the first phase has been the establishment of a functional HP system. The HP's act as intermediaries/facilitators between the rural people and the staff of rural health facilities, the Department of Social Affairs, the Community Development Associations (CDS's) and other local governmental institutions.

FaRHFP II (1996 - 2001) is designed for a period of 5 years. The objectives for this phase have remained unchanged. Additional tasks include the finalisation of a project model, a project monitoring system and the extension of project activities to the whole of Itsa and Ibshaway districts. Next to the geographical extension phased withdrawal is also foreseen in parts of Itsa.

The issue of sustainability has been given full recognition in the Technical Proposal FaRHFP II of November 1995. The project is to streamline the development of the HP system in the project area with the 1994 national outreach programme of the Ministry of Population and Family Planning. In January 1996 however, this Ministry has ceased to exist and its tasks have been integrated in the Ministry of Health.

From February - July 1996 the project is in the inception period where the PLANOPS for the period up to 31 January 1999 have been formulated. An important component is constituted by the need for an early understanding to be reached between all parties concerned with respect to the issue of institutional and financial sustainability of project activities, after withdrawal of technical and financial assistance by the Netherlands.

A formal evaluation of project progress since 1992 has been planned for October 1996.

Objective
To assess the impact and the sustainability of the project since the beginning in 1992 with regard to its objective to improve the health and wellbeing of rural Egyptian families, with special emphasis on the health of women and children.

Tasks
The mission will be asked to:

1. Review the progress made so far

2. Assess the conceptual framework/projectmodel and review the different components of the project as to the internal consistency with the project objective as well as the strategies used to implement these components. Particular emphasis will be given to the socio-economic activities.

3. Determine the nature and the quality of the performance by the health promoters and their supervisors

4. Assess the quality and flexibility of the training curricula and the teachers

5. Review and describe the performance of the national and international consultants and the effectiveness and efficiency of the Steering Committee as well as Executive Committee

6. Analyse the nature of the research undertaken by the project and its relevance to other project activities, in particular the monitoring system but also the training activities

7. Determine the past, present and desired future position of the project in the implementation of the ICPD Plan of Action and the link between population and development in Egypt

8. Assess the gender-sensitive approach adopted in the different project components

Mission composition
The mission will take place for a period of 16 working days: 1 day for preparation, 12 days in the field and 3 days for writing in October 1996. The mission will brief and debrief at the Netherlands Embassy separately or together with the Executive Committee of the project. The Netherlands Embassy will make available all documents at its disposal. The project will provide for the transportation.

The mission will consist of 4 people: 2 international and 2 local experts. At least one of the international experts will be fluent in Arabic.

1. The teamleader will be a social scientist with public health training and experience, preferably in the region.

2. The international expert will be a medical professional with public health experience, preferably in the region.

3. One local expert will be a specialist on socio-economic activities for women and gender issues.

4. The other local expert will a medical doctor with affinity to community participation in health/population issues.

APPENDIX 2

Workplan

Tuesday, 19 November 1996

09:30-15:00	KIT/RTI	Meeting	Staff
Evening	Travel Amsterdam-Cairo		

Wednesday, 20 November 1996

09:00-11:00	Netherlands Embassy	Briefing	J. Buringa
11:00-13:00	Travel Cairo-Fayoum with J. Buringa		
13:00-13:30	DoH	Welcome	EC/J. Buringa
13:45-15:15	Governors Office	Welcome	Governor/EC/J. Buringa
15:30-17:30	Queen Hotel	Lunch	EC/J. Buringa
19:00-22:00	Queen Hotel	Planning/reading/discussions	

Saturday, 23 November 1996

09:00-11:30	CHU Kalamsha	1 FGD	HP's
		2 IDI	HPS's
		1 OV	Facility
12:00-13:00	NS El-Hamdia	1 IDI	HP
		1 IDI	HP
		1 IDI	HPS
		1 OV	Facility
13:30-14:00	Project Office	Miscellaneous	
17:00-20:30	Kalamsha VCA	1 FGD	Rural women
		1 FGD	Rural men
17:00-20:30	Queen Hotel	Discussions/reading/analysis	

20:30-22:00	Queen Hotel	Discussions/reading/analysis	

Sunday, 24 November 1996

09:00-11:00	RH Toutoun	1 FGD	HP's
		2 IDI	HPS's
		1 OV	Facility
11:30-13:00	RHU El-Seida	1 FGD	HP's
		1 IDI	HPS
		1 OV	Facility
13:30-14:00	Project Office	Miscellaneous	
16:30-17:30	Queen Hotel	Discussions	
18:00-20:30	DoH	Meeting	EC
18:00-21:00	Queen Hotel	Reading/analysis	
21:00-22:00	Queen Hotel	Discussions	

Monday, 25 November 1996

08:00-10:30	Queen Hotel	Discussions/planning	
11:00-13:30	Kalamsha VCA	1 FGD	Credit/small loan women
		1 OV	Sewing class
11:00-15:00	Project office	Discussions/planning/miscellaneous	
17:00-20:00	Kalamsha VCA	1 FGD	Rural women
		1 FGD	Rural men

Tuesday, 26 November 1996

09:00-11:00	RHU Nawara	1 FGD	HP's
		1 OV	Facility
11:30-12:30	Project Office	1 IDI	Ehab Abdel-PS

		1 IDI	Nabila Azmi-PS
		1 OV	Clerk trainees/Sanaa Farag
		Miscellaneous	
12:45-13:45	Project Office	1 IDI	Abdul Sala-former Director RONPC
		1 IDI	Mona Aziz-Director FP DoH
13:00-15:00	Toutoun VCA	1FGD	Small loan women
17:00-19:00	Queen Hotel	Analysis/writing	
19:00-20:30	Queen Hotel	Discussions	
20:30-22:00	Queen Hotel	Analysis/writing	

Wednesday, 27 November 1996

09:00-10:00	Project Office	1 IDI	Anhar Hussein/Amani Ahmed/Zakaria Gaber-PS
		1 IDI	Wil van Steenbergen-PS
		1 IDI	Emad Farouk-PS
		1 IDI	Han van Luijk-PS
10.15-11:15	Project office	1 IDI	Insherah Rajeb/Rokia Rabeea-PS
		1 IDI	Ahmed Abdel-PS
		1 IDI	Anhar Hussein/Amani Ahmed/Zakaria Gaber-PS
		1 IDI	Wil van Steenbergen-PS
11:30-12:30	Project Office	1 IDI	Ahmed Radwan/Hemeida Abdel Hakim Executive Director/ Financial Manager ICDA
		1 IDI	Anhar Hussein/Amani Ahmed/ Zakaria Gaber-PS
		1 IDI	Sanaa Farag-PS
		1 IDI	Ahmed Abdel-PS

12:30-14:00	Project Office	Meeting	SC
12:45-13:45	Project Office	1 IDI	Bassiouni Zaki-PS
14:00-16:00	Travel Fayoum-Cairo		
17:00-19:00	EFPA Clinic	1 OV	Facility Maasarat Arafa
20:00-22:00	Queen Hotel	Analysis/writing	
17:00-22:00	Cairo	Analysis/writing	

Thursday, 28 November 1996

09:00-10:00	Project office	1 IDI	Rosan Aalbers/Marian Adel-PS
		1 IDI	Ahmed Abdel-PS
10:00-11:00	Netherlands Embassy	1 IDI	Claudio Detoigni/Toni Michelson/Matti Norio-Italian/Danish/Finnish Embassies
10:15-11:15	Project Office	1 IDI	Anwer El-Swafy
		1 IDI	Osama Yusif-Director RONPC
11:30-12:30	Social Fund	1 IDI	Mohammed A. Bakry-Manager Projects and Planning Unit Social Fund
11:30-11:45	Project Office	1 IDI	Manal Achmed Gaber-Gynecologist Mobile Team
		1 IDI	Sanaa Farag/Insherah Rajeb-PS
12:45-13:45	Project Office	1 IDI	Ahmed Abdel-PS
		1 IDI	Foxy El-Demerdash-Director of Training DoH
13:00-14:00	MoHP	1 IDI	Nabil Nassar/Hassan El Gebaly-First Under Secretary BHS/Executive DirectorFP Systems Development Project MoHP
14:00-17:00	Queen Hotel	1 IDI	Han van Luijk/Wil van Steenbergen-PS
14:15-15:15	CARE	1 IDI	Ahmed Abdel Karim-CARE

16:00-18:00	Travel Cairo-Fayoum	
20:00-21:00	Queen Hotel	Discussions
21:00-22:00	Queen Hotel	Writing

Friday, 29 November 1996

All day	Queen Hotel	Writing

Saturday, 30 November 1996

09:00-10:00	Project Office	1 FGD	DHMT
		1 IDI	Han van Luijk
09:30-10:30	CARE	1 IDI	
10:15-11:15	Project Office	1 IDI	Ibrahim Daker/Mahmoud Anwar-Director General/Director BHS DoH
10:30-11:30	Meniet El-Heit	1 FGD	Meniet El-Heit FPC
11:30-12:30	Project Office	1 IDI	Mohamed Abdel Fattah

Sunday, 1 December 1996

09:00-11:00	DoH	Debriefing	EC
11:30-12:30	Project Office	Debriefing	Project staff
13:00-14:30	Governors Office	Debriefing	RPC
17:00-17:30	Residence J. Buringa	Debriefing	J. Buringa

APPENDIX 3

Key issues in Egypt's health and population programmes

About 90 percent of Egypt's rural population now has access to a health facility within a distance of less than five kilometres, with the ratio of one health facility to every 1.5 villages or one health facility to every 11,600 inhabitants. One physician and one nurse are available for every 4,800 and every 2,050 persons respectively.

The MOHP is responsible for staffing a health team for each rural health facility (RHF), headed by a physician and including a nursing staff, an assistant laboratory technician, and a sanitarian among others. All health professional and paraprofessional graduates are subjected to a two year obligatory service in the public sector. Placement of all graduates, except secondary nursing schools graduates, in the nation's 26 governorates is managed centrally. Placement is based primarily on each governorate's relative needs as well as each graduate's grades and desires, subject to the limitations of available numbers of graduates. Specific placement within each governorate is the responsibility of that governorate's directorate of health.

District Health Care

A national policy for promoting a district health approach in health service provision was endorsed by Egypt's Health Council 1996. In accordance with the strategy outlined in this policy, a decree was issued by the Minister of Health to the Central Agency of Organization and Administration for strengthening the role of health directorates by increasing their technical administrative, and managerial authority.

Family planning and reproductive health services

MCH, which included FP service, is an integral component of the national primary health care (PHC) approach and MCH-related service are among the basic services offered by the MOHP through its RHFs, urban centres, and out-patient clinics.

To date, reproductive health services to women have been limited primarily to antenatal, natal, postnatal and FP services. Increasingly, more attention is being given to women's health needs between successive pregnancies as well as other aspects of reproductive health such as maternal morbidity and sexually transmitted diseases.

In June 1996, the MOHP announced that a network of women's health centres will be established throughout Egypt. The introduction of these centres is designed to upgrade the provision of health care for women of all ages, especially in rural areas. The programme promises to include the establishment of new women's health centres and the upgrading and conversion of rural health units into women's health centres. Mobile unit services are also planned for remote villages. In support of these centres, female physicians and health extension workers will be appointed and women's health training centres established. An information, education and communication (IEC) programme will also be developed in collaboration with local leaders.

National outreach services

National PHC outreach services are limited to follow-up and IEC services, and do not involve actual care provision. Egyptian government support for PHC outreach has included training activities for traditional birth attendants (TBA's) in the use of community extension workers (CEW's) to promote FP.

Dayat (the Egyptian name for TBA's) are officially recognized as part of the national PHC services. They are trained and licensed by the MOHP under a UNICEF-funded programme.

The Ministry of Social Affairs (MOSA) has trained and supported *raidat* (the Egyptian word for CEW), to promote FP methods and participate in community development activities. A small number of MOSA's raidat still serve in rural Fayoum. The Family of the Future project funded by The United States Agency for International Development (USAID) trained HP's in creating an awareness about FP methods in both rural and urban areas. However, when the project ended the entire pool of these trained HP's disbanded. The Coptic Evangelical Organization for Social Services (CEOSS) is another organization which has successfully utilized the *raidat*.

In early 1996, the former MOPFP appointed the first set in a group of 4,000 demographic/population educators and *raidat* who were to serve in communities throughout Egypt under the MOPFP. The demographic/population educators are graduates of the Faculty of Social Works. As a result of these various experiments in outreach programmes for health and FP services, a number of different types of community health extension workers are still operating in various Egyptian governorates.

National health status and utilization indicators

One of the main achievements of Egypt's extensive system of rural and urban PHC services to date has been a more than 80 percent immunization coverage, a reduction of infant mortality (IMR) and maternal

mortality rates (MMR), an increase in life expectancy at birth, and a decrease in the prevalence of schistosomiasis and intestinal parasites.

Despite its reduction, maternal mortality in Egypt is still relatively high, estimated at 174 maternal deaths per 100,000 deliveries in 1992. Indicators show that utilization of safe motherhood services remains low. According to preliminary results of Egyptian Demographic and Health Survey (EDHS) for 1995, only 39 percent of mothers who gave birth nationwide received antenatal care and in rural Upper Egypt this figure falls to just 21 percent. Mothers who had four or more antenatal visits did not exceed 28 percent nationwide and in rural Upper Egypt this figure reached only 10 percent. Physicians or trained nurses or midwives assisted in only 46 percent of all births during the five year period 1991 to 1995. In rural Upper Egypt only 23 percent of all deliveries during the same period were assisted by formally trained health providers. Most deliveries were assisted by *dayat*. Some progress has been achieved with regards to tetanus toxoid (TT) coverage. Mothers who received at least one TT dose reached 70 percent in 1995, as compared to 57 percent in 1992. In rural Upper Egypt the coverage was 66 percent by 1995.

Knowledge of FP methods, particularly oral contraceptives and the IUD is widespread in Egypt. CPR increased from 37.8 percent in 1988 to 47.1 percent in 1992 and 47.9 percent in 1995. CPR in rural Upper Egypt in 1995 was only 24 percent, with those using a modern contraceptive method reaching just 22.3 percent. The IUD is the most commonly used method nationally (30 percent of currently married women), including rural Upper Egypt (11.9 percent). Nearly two-thirds (64.1 percent) of MWRA nationwide state they do not want any more children and an additional 14.8 percent wish to postpone pregnancy for two years or more. In other words, 31 percent of the married women of reproductive age (MWRA) in Egypt do not want to become pregnant immediately but are not practising any method of fertility control, indicating that usage remains lower than expressed need.

National data on reproductive morbidity is lacking. However, and indicative study in two villages in Giza Governorate in 1988 and 1989 found that 85 percent of women 14 to 60 years of age suffered from gynaecological or closely related problems and almost half of them (48 percent) suffered from two or more problems. The most common problems were anaemia (63 percent), genital prolapse (56 percent), and reproductive tract infections (RTI) (51 percent).

The underutilisation of services reflected in national statistics and rural areas in particular is the result of limited demand combined with inadequate quality of services. Outreach and community based IEC services should generate greater demand for services.

Another challenge facing the Egypt health care system is the lack of formal PHC services in underserved villages which form about one third of Egypt's nearly 4500 villages. A recent study conducted by UNFPA/NPC in 1996 revealed that if effective IEC activities are provided to people in these villages they are more likely to leave their village to seek FP.MCH and other health services. The study also indicates that the role of doctors, nurses, religious leaders, mothers in law, and other opinion leaders in providing IEC needs to be considered. Due to high costs of building RHF's in underserved villages, the MOHP is currently implementing a mobile clinic project to reach these areas with PHC services.

Quality of services

Despite the extensive health related infrastructure, Egypt's reproductive health and general health services suffer from a number of inadequacies. The national health system is constrained by ineffective management and limitations in financial resources. While the MOHP is currently attempting to address these issues, difficulties related to staffing of RHF's as well as the physical maintenance and equipping of RHF's continue to significantly affect the quality of services provided.

APPENDIX 4

Training course between June 1993 - January 1996

Target Group	No. Course	Duration Days	Duration Weeks	No. Participants
HP's				174
Introductory	12		6	
Refresher	6	4		
HPS's				
Introductory	6	6		33
Refresher	1	1		
Rural Health Services Doctors				
Pre-service	1	1		22
Introductory	2		2	17
Nurses				
Infection control	1	1		11
Introductory	2		2	25
Sanitarians	2			28
Lab. Technician	1	4		15
Cleaning staff	2	4		21
Training of Trainers	3		6	33
English	4	10 Hours		
Computer	5			15, DOS, Excel & EP Basics
Training abroad				
Management (Amsterdam)	2			3
WIDE (Amsterdam)	1		10	2
Community Development & FP				
Jordan	1			15
Tunis	1			13

Training course between June 1993 - January 1996

Target Groups	No. Course	Duration		No. Participants
		Days	Weeks	
HP's				
Introductory	12		6	174
Refresher	6	4		95
HPS's				
Introductory	6	6		33
Refresher	1	1		
Rural Health Services Doctors				
Pre-service	1	1		22
Introductory	2		2	17
Nurses				
Infection control	1	2		11
Introductory	2		2	25
Sanitarians	2			28
Lab. Technician	1	4		15
Cleaning staff	2	4		21
Training of Trainers	3		6	33
English	4	10 hours		26
Computer (DOS, Excel & WP Basics)	5			15
Training abroad				
Management (Amsterdam)	2			3
WIDE (Amsterdam)	1		10	2
Community Development & FP				
Jordan	1			15
Tunis	1			13

Reprografie: TNO-PG
Projectnummer: 40296