Save the Children

District Health through a Living University

Egypt CS-14
Report of the
Midterm Evaluation

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Executive Summary

The Child Survival 14 (CS-14) project *District Health through a Living University* is implemented by Save the Children – USA and its partners in the District of Samalout, Governorate of Minya, Upper Egypt. The CS-14 goal is to improve the health status of mothers and children under 5 through improved health behaviors and use of key health services in five areas of Samalout District. The "Living University" (LU) strategy, developed by SC in Vietnam, is to pilot a development program with a few communities, the LUs. After measurable effects are demonstrated, other communities learn from the initial LU sites, implement the program with support from the LUs, and then become LUs themselves when the program is expanded to new sites. CS-14 applies this model to establish a district-level mechanism for replication and expansion of safe motherhood and child survival services.

The Midterm Evaluation (MTE) of the CS-14 project was conducted in Minya from August 29 to September 7, 2000. The MTE team was composed of a "core MTE team" of three external members and three SC/Minya staff, and of all the other CS-14 staff and selected partner representatives. The "Extended MTE team" of 21 members participated in most meetings, group work, field visits, and in discussions about the findings and recommendations of the evaluation. The present report represents the synthesis of the various contributions of the team members.

The work plan in the DIP describes three implementation phases: phase 1, framework development (10 months), to establish the office, human resources and partnership infrastructure needed to implement the project; phase 2, model development (18 months), to implement the LU strategy in two rural villages and one urban slum of Samalout City; and phase 3, model replication (20 months), to implement the LU strategy in two additional villages. The CS-14 project began September 30, 1998 and will end in September 29, 2002. By and large, the implementation schedule is in accordance with that in the DIP. The MTE took place at month 23, just a few months before the transition from phase 2 to phase 3.

Building on past and current projects and its long-term presence in Minya governorate, CS-14 is successful in implementing the Living University strategy to improve maternal and child health in three project areas of Samalout District. CS-14 has identified strong community-based partners. In June 2000, three Community Development Associations (CDA) were supervising a total of 103 Community Health Workers (CHW) who were covering 72% of the children under five in the project areas. CS-14 has also been successful in setting up various Local and District Health Action Committees in which community-defined problems are presented, discussed, and often adequately addressed or solved.

A fundamental strategy of CS-14 is to use CHWs and MOHP health workers to promote healthy practices among pregnant women and mothers of children under five. The MTE team found a lack of focus on key strategic messages, and a lack of communication materials to support the behavior change activities conducted by CHWs during their home visits.

The effectiveness of most of the CS-14 interventions depends at least partially on the availability, accessibility, and quality of facility-based health services. The MTE found that CS-14 had not begun to systematically work with the MOHP and the private providers to develop standards of quality of care, conduct systematic health facility assessment or joint supervisory visits, establish effective referral linkages between communities, health centers, and hospitals, and begin building quality improvement systems in health services.

CS-14 and its partners have secured competent and motivated personnel who are now carrying out intensive field activities. This active base of operation provides opportunities for SC senior executives to provide high-level technical and managerial support and ensure that both the impact and model development objectives of CS-14 are met by September 2002.

The MTE team formulated three main recommendations:

1. **To ensure effectiveness and efficiency of CHWs' work, CS-14 should:**
   - Review and refine its communication objectives, strategies, and key messages for each intervention.
   - Identify a limited but complete set of communication materials for CHWs and health workers to use and distribute to mothers.
   - Focus CHW home visits on households with pregnant women and/or infants.
2. **To strengthen the Maternal and Newborn Care intervention, CS-14 should:**
   - Review the objectives and strategies of this important component of the project, then the related work plan and budget.
   - This work plan should build on achievements in the project area, and consider how to cover deliveries that occur without trained attendants; set up a system of emergency transport and referral; ensure the quality of emergency obstetrical services; and monitor and learn from maternal and infant deaths.
3. **To further develop cooperation with Ministry of Health and Population, CS-14 should:**
   - At the Governorate level, maintain close contact with key technical officials to facilitate the introduction in Samalout District of selected programs such as Integrated Management of Childhood Illness, Emergency Obstetrical Care, and Quality Assurance.
   - At the District level, propose participation and assistance in the development of comprehensive health development plans involving communities and partners, and develop a comprehensive community-defined plan to improve quality of care.
   - At the health unit level, facilitate communication between health workers, private providers, and communities.

In addition, CS-14 should:

4. **Carefully plan the transition from phase 2 to phase 3,**
5. **Develop an explicit "exit strategy," and**
6. **Consider applying for a cost extension.**

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Acronyms

AC	Advisory Committee
ANC	Antenatal Care
ARI	Acute Respiratory Infections
BCC	Behavior Change Communication
BHR/PVC	Bureau of Humanitarian Response, Office of Private & Voluntary Cooperation
CDA	Community Development Association
CDD	Control of Diarrheal Diseases
CHW	Community Health Worker
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DPT	Diphtheria/Pertussis/Tetanus Vaccine
EFO	Egypt Field Office
EmOC	Emergency Obstetrical Care
EPI	Expanded Program for Immunizations
FP	Family Planning
HAC	Health Action Committee
HIS	Health Information System
IEC	Information, Education, Communication
KPC	Knowledge, Practice, and Coverage
LU	Living University
MCH	Maternal Child Health
MIS	Management Information System
MNC	Maternal and Newborn Care
MOHP	Ministry of Health and Population
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PCM	Pneumonia Case Management
PD	Positive Deviance/Positive Deviant
PVO/CS	Private Voluntary Organizations Child Survival Grants Program
RC	Red Crescent
SC	Save the Children Federation (USA)
TA	Technical Assistance
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
USAID	United States Agency for International Development

I. Introduction and Midterm Evaluation process

The Child Survival 14 project *District Health Through a Living University* (CS-14) is implemented by Save the Children – USA (SC) and its partners in the District of Samalout of the Governorate of Minya, Upper Egypt. CS-14 is jointly funded by the USAID Bureau of Humanitarian Response, Office of Private and Voluntary Cooperation (BHR/PVC) through its PVO Child Survival Grants (PVO/CS) program ($0.50 million), by USAID/Egypt ($0.50 million), and by SC ($.34 million). It began on September 30, 1998 and will end on September 29, 2002.

The CS-14 goal is to improve the health status of mothers and children under 5 through improved health behaviors and use of key health services in five areas of Samalout District with the poorest health indicators. The total population of these areas is about 220,000 inhabitants. The overall design of the project is to link the families in the project areas to eight local Non Governmental Organizations (NGOs)--Community Development Associations (CDAs); to one governorate-level NGO--the Red Crescent (RC) Society; and to the local health services of the Ministry of Health and Population (MOHP). The "Living University" (LU) strategy is to pilot a development program with a few communities, the LUs, until measurable effects are demonstrated; other communities can then actively participate, learn from the initial sites, and become LUs themselves. CS-14 applies this model to establish a district-level mechanism for replication and expansion of child survival services. The specific child survival interventions supported by the project are maternal and newborn care (MNC), pneumonia case management (PCM), control of diarrheal diseases (CDD), nutrition, and immunization. Baseline information from the Detailed Implementation Plan (DIP) is provided in Attachment 1, and a map of the Samalout District and the three current project areas in Attachment 2.

The Midterm Evaluation (MTE) of the CS-14 project was conducted in Minya over a ten-day period from August 29 to September 7, 2000. SC had developed the scope of work for the MTE Team Leader (Attachment 3) and selected Dr Marc Debay, Assistant Scientist at The Johns Hopkins School of Public Health, Division of Community Health and Health Systems. The MTE Team Leader proposed to follow the PVO/CS MTE guidelines as much as possible because of the valuable expertise involved in their preparation, the potential benefits to the PVO/CS program from having evaluation reports comparable across projects, and the need to continuously test and improve such guidelines. In accordance to principles highlighted in the MTE guidelines, all partners in the project were invited to participate in the evaluation design, data collection, and discussions of findings and recommendations; the DIP was translated and distributed to all MTE members as the reference for the project design; and project monitoring and managerial data were used whenever possible to answer the evaluation questions. Finally, the outline proposed for the MTE report and related questions were systematically used to organize the teamwork. In addition to coordinating this process, the MTE Team Leader served as the author and editor of the present report.

The MTE team included two other members external to the project implementation in Minya: Dr Eric Starbuck, Child Survival Specialist, Office of Health, Save the Children-USA; and Della Dash, Child Survival Technical Advisor, USAID/BHR/PVC. On their first day in Cairo on Tuesday 8/29, the three external members met with Dr Attalah Khuttab, Director of SC Egypt Field Office (EFO). This meeting was an opportunity to learn about the decentralized management of SC programs in Egypt, and that of CS-14 in particular. General personnel and financial issues were also briefly discussed. Arrangements for travel to Minya were finalized in coordination with those for two USAID/Cairo staff members who were able to join the team in Minya for two days. Dr Khuttab also proposed to join the MTE team in Minya for a final debriefing.

In the evening of their arrival in Minya, the three external team members and the two USAID/Cairo staff members were welcomed in meeting organized by SC/Minya that included all CS-14 staff and partners representatives. During that meeting, SC/Minya presented the CS-14 project and its achievements. Then the first two days of the MTE were intentionally spent with the entire CS-14 staff and several partner representatives on establishing the participative approach and clarifying the PVO/CS MTE guidelines. During the first meeting in the SC/Minya office on Wednesday morning (8/30), the CS-14 staff and partner representatives willing to participate in the MTE were identified. Then, a first field visit previously planned by SC/Minya took place: the participants to this visit had the opportunity to see one clinic, interview health workers, and meet with CDA members and community health workers. This early field visit provided the external team members with a feeling for the local context and culture that turned out to be very useful for planning the MTE. It also gave the opportunity to have an immediate and very informative feedback from the two USAID/Cairo staff members before their return to Cairo. On Thursday morning (8/31), the PVO/CS MTE guidelines were presented and discussed with all CS-14 staff. After a visit to a LU CDA training event and a meeting with MOHP officials in Minya, these discussions resumed in the afternoon with the CS-14 partners representatives.

The final composition of the MTE team was only defined at the end of the second day (Attachment 4). A “core MTE team” of six persons included the three external members and three SC/Minya staff: Dr Samir Khamis, SC/Minya Program Management and CS-14 Project Manager, Ms. Samaa Sayed, SC/EFO Technical Unit Training & Institutional Development Officer, and Mr. Wael Zaki, SC/Minya CS-14 Team Leader. This core MTE team met regularly to discuss the MTE process and make the necessary arrangements to maximize the participation of the other team members. The “extended MTE team” included the 6 members of the core team, 7 CS-14 staff members, and 8 partner representatives. The MTE team of 21 participated in most meetings, group work sessions, and field visits, and therefore in all discussions about the design, schedule, data collection, findings and recommendations of the evaluation.

The remaining of the MTE program was established on an ongoing basis with all the team members (Attachment 5). Overall, the various field visits that SC/Minya had scheduled were maintained but postponed to allow prior discussion of the purpose of the MTE with all team members. As this participatory approach was unfamiliar to most CS-

14 staff and partners' representatives, the planning process took more time than expected, in particular at the beginning. Also, the contribution of most team members remained limited and hesitant during the first few days, but increased enormously as soon as the participatory process appeared more clearly.

At the end of the second day in Minya, the six core MTE team members met for the first time to assign discussion topics and distribute all the MTE team members into working groups (Attachment 6). Each group included one external and one SC/Minya core team member. On Friday and Saturday, three groups worked on the project "technical" and "cross cutting" approaches, and on Sunday, two groups worked on the "program management." An Arabic translation of the DIP was distributed to all team members who were asked to review the sections relevant to their topics and provide answers to a list of questions adapted from the MTE guidelines. As most participants were not familiar with the DIP, the time allocated to the workgroup sessions turned out to be too short to cover all the questions. However, the participative approach and information sharing resulted in very valuable and productive exchanges among CS-14 staff and partner representatives.

Most field visits were conducted from Sunday 9/3 to 9/6. The sites visited and people met are in Attachment 7. After discussing the main MTE questions and issues, each group defined the data needed from these field visits. One observation and interview guideline was developed for each type of site and informants: health facilities and staff; CDA offices and members; groups of CHWs and mothers. The groups' composition varied for each visit to ensure that each member had the opportunity to conduct each type of visit and interview, and to encourage exchange among all team members. The goal of these visits was not to collect quantitative, reproducible, and representative data but to build a common understanding of the project and its achievements among the team members, and to allow constructive discussions leading to concrete, agreed-upon recommendations. During each visit, one Arabic-literate recorded the group observations and interviews; these records were then translated into English and discussed in plenary meetings held on a daily basis. At the same time as the field visits, a few team members stayed in the SC/Minya office to gather and review project records, materials, and reports, or to write-up various notes from the group discussions and field visits.

At the end of the 9th day on the MTE, the core team members prepared a first draft of the main findings and recommendations. On the 10th and last day, a whole-day synthesis meeting was organized for about 30 persons, that is, the entire extended MTE team and a few more SC/Minya and CS-14 partner staff. The meeting was intentionally structured in a rather formal way, with a president of the meeting, various session chairs, recorders, translators, and a timekeeper. This was to ensure that all the key points would be covered in a timely manner and that the discussions would remain focused and constructive. The agenda followed the main outline of the report. Each session was introduced by a bilingual Power Point presentation of the draft prepared by the core team. Then questions, clarifications, and a general discussion followed. During the last session of the meeting, the various remaining tasks to complete the report were discussed and responsibilities assigned. These tasks included the preparation of a few additional

documents to include as attachment to the report, the discussion with partners about some of the findings and recommendations, writing success stories and a "Results Highlight" section, and reviewing the draft report to be prepared by the MTE Team Leader. The minutes of the meeting were translated into English and sent to the MTE Team Leader.

The present report represents the synthesis of these various contributions. Its primary audience includes the local partners (MOHP, RC, and CDAs), Save the Children staff from headquarters, Egypt Field Office and Minya offices, USAID/BHR/PVC, and USAID/Egypt. It is hoped that it will also used by a wider audience.

II. Assessment of Progress Towards Achieving Program Objectives

A. Overview

The CS-14 "Program Goals and Objectives" section of the DIP includes one "Results Framework" and one "End-of-Project Objectives" table (both are reproduced in Attachment 1). The Results Framework constitutes a good summary of the rationale of the project: it explains how intermediate results lead to the result of Improved Health Behaviors and Use of Key Health Services and contribute to the overall goal of Improved Health Status of Mothers and Children Under 5. However, the Results Framework remains general and does not provide indicators. The End-of-Project Objectives, on the other hand, are directly related to the table of indicators in the Monitoring and Evaluation section of the DIP, which includes health outcome indicators. However, these objectives and indicators are so specific that they do not adequately capture the entire scope of the project as needed for the MTE.

Therefore in the present assessment of the progress towards achieving CS-14 objectives, the results and intermediate results from both the Results Framework and the End-of-Project Objectives are used. All the relevant results are listed at the beginning of each sub section below before presenting the findings of the MTE team. The results and intermediate results from the End-of-Project Objectives are listed (bulleted) first because they are more specific and they are proposed in the DIP as quantitative measures of the success of the project. Then the related intermediate results from the Results Framework are listed (numbered) because they clarify the rationale for the proposed activities.

The MTE team assessment of the progress towards achieving CS-14 objectives is presented in three steps. First, the various "technical" interventions proposed in the DIP are examined. Here the assessment focuses on the changes expected at the individual level (mother or children under five) in terms of health behavior or use of health services. The findings are observations about the adequacy of the CS-14 activities directly related to these changes. Second, the "cross-cutting" activities are examined. These activities are critical to achieving the health objectives of the project but relate to all technical interventions. Finally, the findings related to the management of CS-14 by SC are presented. There are no objectives for this aspect of the project. In addition to the findings of the MTE team, a few "success stories" reported by the CS-14 staff are presented here and there as they related to a particular finding.

The work plan in the DIP describes three implementation phases:

1. *Phase 1- Framework development* (10 months): establishment of the infrastructure needed to implement the project: human resources and management capacity; partnerships agreements; preparation of project sites; and baseline assessments.
2. *Phase 2- Model development* (18 months): implementation of the LU strategy and child survival interventions in two rural villages (Taha and Bayhoo) and one urban slum of Samalout City (Maasara Shark);
3. *Phase 3- Model replication* (20 months): two sites of the previous phase, the "Living University," now implement the strategy in two additional villages (Shosha and Estal).

The CS-14 project began September 30, 1998 and will end in September 29, 2002. The MTE was conducted at month 23 of implementation, that is, nearly at the end of phase 2.

Attachment 8 presents the major CS-14 activities by month from October 1998 to August 2000. During the first quarter of project implementation, SC/Minya rented, equipped and furnished office space and hired staff for CS-14. In addition, the project Advisory Committee was established, and the roles and responsibilities of all project Partners were agreed upon. The five project sites were selected according to MOHP statistics at the end of the first quarter. At the end of the second quarter, the LR CDAs were selected in each site according to criteria established by the Ministry of Social Affairs, and local Health Action Committees were created. Then the CHWs were selected and trained, and by the third quarter, began their monthly home visits. The District Health Management Committee was created during the first quarter of the project, but regular meetings only began six months later. Training of MOHP health workers occurred just a few months after the CHWs began their home visits, and MOHP facilities received supplies during the same period. By and large, this implementation schedule is in accordance with the DIP.

B. Technical Approach

(1) Maternal and newborn care

Results
- 80% of TBA-assisted deliveries in past 6 months are performed by CS-14 trained TBAs
- Clean birth kits are used in 80% of home births in past 6 months

Intermediate Results
- 90% of women with infants under age 6 months know two or more obstetric danger signs

IR 1.1: Essential drugs and medical supplies available at health facilities
IR 1.2: Increased community-based access to information and services, including **clean birth kits**, PCM, and ORS
IR 1.3 Referral linkages between communities, health centers, and hospitals established and/or strengthened
IR 2.1 Active surveillance of infant/maternal mortality and EPI-preventable diseases
IR 2.3 Quality of care standards developed, tested, and applied
IR 3.1: Enhanced recognition of pregnancy-related danger signs by TBAs, CHWs, and adults in the community

- CS-14 has conducted training of CHWs, MOHP health workers, and LR CDA members in communication skills for health education in all the project interventions including maternal and neonatal health care. These activities are discussed in section C(1).

- CHWs are identifying pregnant women in the community, and during their home visits, they are encouraging them to register to an antenatal clinic (ANC). Table 4 in Attachment 9 shows the number of new and total ("registered") antenatal visits in all three CS-14 areas in the periods January-June 1998 and January-June 2000. The number of new visits increased slightly in Taha and El Bayhoo and doubled in El Maasara Shark. The proportion of new pregnancies diagnosed as dangerous remains the same in the three areas. The number of visits per pregnancy increased from 1 in 1998 to 3 and 4 in El Bayhoo and Taha, respectively, but only to 1.5 in El Maasara Shark.

  The effect of CS-14 on this increase in the number of visits per pregnancy is supported by the data presented in Attachment 10 on the utilization of antenatal services in three CS-14 and three non CS-14 areas of Samalout District between August 1998 and August 2000. The coverage of pregnant women increases slightly in all six villages, but the number of visits per pregnancy remains stable in the non CS-14 villages while it is increasing in the three CS-14 villages.

Although this increase in the number of visit per pregnancy is in accordance with the MOHP policy of recommending 14 antenatal visits per pregnancy (1 per month during months 1 to 6, 2 per month during months 7 and 8, and 4 during month 9--the MOHP registers "at least 5" visits during pregnancy as completed antenatal care), CS-14 has not made any assessment of the quality and potential effectiveness of these services. CS-14 contribution to the quality of antenatal services so far has been through the training of health workers, primarily in health education, and provision of limited medical equipment.

"In El Maasara Shark (Samalout city), a woman living near the CDA delivered five times without going to any health facility. She delivered her sixth child alone. During her last pregnancy she went to the health facility with a CS-14 CHW, got a monitoring card, and went back regularly until delivery."

In Etsa-El Mahata (El Bayhoo area), many women had no information about ANC services. One woman had four deliveries and never went to a health facility to monitor her pregnancies. In her fifth pregnancy, the CHW provided her with health education during home visits. This woman then registered in a health unit and went regularly to monitor her pregnancy because she knew that she would get many benefits.

- CS-14 did not conduct several MNC activities included in the DIP, as explained below. Therefore the related objectives in the DIP must be changed or these activities must begin.
  1. There has not been any training of TBAs because the MOHP's policy is now to promote the use of trained health workers (physicians or nurses/midwives) rather than TBAs for assistance in home deliveries. Table 2 in Attachment 9 shows the number of deliveries by type of attendance and place of deliveries in the three CS-14 areas during the periods January-June 1998 and January-June 2000. Although the number of deliveries attended by doctors or nurses or that occurred in a clinic did increase, still 54% of the births were attended by TBAs during the first semester of 2000. Therefore a strategy must be developed and implemented to ensure that these deliveries are attended by qualified or trained persons, and conducted in the best conditions.
  2. There has not been any distribution of clean birth kits because the MOHP and UNICEF planned to conduct this activity. However, CS-14 should ensure that these or similar delivery kits are available to women who plan to deliver at home.
  3. Except for the establishment of Emergency Funds with the CDAs and HACs, there has not been any development of community-based system for referral and emergency transport of obstetrical complications and severe childhood diseases. Also, there has been some promotion of the concept and tools for developing birth plans with pregnant women, but these are not linked to practical solutions in case of emergency. CS-14 should make a careful assessment of the current situation with respect to Emergency Obstetrical Care services.
  4. There has not been any systematic assessment of the availability and quality of obstetrical care. This will be further discussed in section C(6).

5. There has not been any active surveillance and inquiries into maternal and infant deaths.

- The DIP proposes an "Estimated Project Effort and USAID Funding by Intervention" of 40% for the MNC intervention (see Attachment 1). Although this measure is poorly defined, the MTE team concluded that CS-14 has not achieved this relative effort so far.

(2) Pneumonia case-management

Results
-

Intermediate Results
- 85% of mothers with children <36 months report that rapid breathing is a sign of pneumonia

IR 1.1: Essential drugs and medical supplies available at health facilities
IR 1.2: Increased community-based access to information and services, including clean birth kits, **PCM**, and ORS
IR 2.1: Improved diarrheal disease and **ARI** case management
IR 3.2: Increased correct knowledge among caretakers about ORS preparation and use, and signs of **pneumonia**

- During interviews of CHWs and mothers the MTE team observed a fair knowledge of the appropriate home management acute respiratory infections. CHWs are promoting related messages based on existing materials from the MOHP and UNICEF. Communication materials and message contents are discussed in section C(1). The baseline value of the knowledge indicator for this intervention is low at 26%, and therefore achieving the objective of 85% will require focused and sustained efforts.

- Table 3 in Attachment 9 shows that the number of visits for Acute Respiratory Infections increased between January-June 1998 and January-June 2000, but that the number of visits for pneumonia decreased.

- CS-14 has not systematically assessed the quality of pneumonia case-management in MOHP and private health facilities, and the accessibility to antibiotics in particular. This question of availability of antibiotics in health facilities was brought at least once to a District Health Committee meeting. The MOHP provides some antibiotics to MCH clinics on the basis of the number of registered women, but the quantity available is usually insufficient. The prescription practice of the private providers and the type and cost of antibiotics available in pharmacies are unknown. One suggestion for mothers who cannot pay for antibiotics has been the use of the Emergency Funds by the CDAs.

(3) Diarrheal diseases

Results
- 90% of mothers of children <36 months with diarrhea in the previous month report feeding **fluid** (other than breast milk) during diarrhea
- 85% of mothers of children 6-36 months with diarrhea in the previous month report feeding **foods** (other than breast milk) during diarrhea

Intermediate Results
- 90% of CHWs correctly teach ORT & ORS preparation

IR 1.1: Essential drugs and medical supplies available at health facilities
IR 1.2: Increased community-based access to information and services, including clean birth kits, PCM, and **ORS**
IR 2.1: Improved **diarrheal disease** and ARI case management
IR 3.2: Increased correct knowledge among caretakers about **ORS** preparation and use, and signs of pneumonia

- CHWs are promoting nutritional messages to mothers during their home visits. These messages are based on existing materials from the MOHP and UNICEF. Communication materials and message contents are discussed in section C(1).

- As the baseline value of the two above indicators of mothers' practice of appropriate feeding patterns during diarrhea are high (80% and 70%, respectively), achieving the proposed results will require careful identification and targeting of the mothers who have not adopted these practices.

- CHWs distribute limited amount of ORS packets along with demonstration of use during their home visits. These packets are given for educational purposes as on-hand supply for emergency (average about 5 packets per house.) These packets are also given free of charge at MOHP units.

- CS-14 has not systematically assessed the quality of diarrheal disease case-management in health facilities and the accessibility to ORS.

- There is no baseline and target for the indicator of mothers' knowledge of ORS use. There is no indicator of ORS use.

(4) Nutrition

Results
- 80% of mothers report providing at least one Positive Deviant food to their 6-35 month old child and following at least one key PD child care practice

Intermediate Results
-

IR 3.4: Mothers know "Positive Deviant" foods and child care practices

- CHWs are promoting nutritional messages to mothers during their home visits. These messages are based on existing materials from the MOHP and UNICEF. Communication materials and message contents are discussed in section C(1).

- Building on the earlier UNICEF-funded Positive Deviance Project that demonstrated an impressive decline in malnutrition in non-CS-14 areas in Samalout District, SC/Minya conducted Positive Deviance Inquiries (PDI) in several CS-14 villages (Taha, El Ameda, Hassan Basha, and El Hatahta). The findings have then been generalized to other CS-14 villages, and a PDI consultant introduced the information and messages about "Positive Deviant" foods and child care practices in the training provided to CHWs. The MTE did not examine these messages and assess the potential effectiveness of their delivery outside a growth monitoring and nutritional education and rehabilitation program (NERP) such as that included in the Positive Deviance Project mentioned above.

- Although nutrition is one of CS-14 interventions, the project staff and partners have often expressed the need for more resources in this area, and in particular to support NERP sessions. In the meantime, with financial and technical support from UNICEF and Tufts University, respectively, SC/EFO continues to test, refine, and document its Positive Deviance nutrition model with the aim of expanding such interventions in the future through the Living University program including CS 14 villages in Area 2.

(5) Immunization

Results
- 85% of mothers of children <36 months have received two or more doses of TT
- 80% of 12-23 month old children have received three or more doses of DPT

Intermediate Results
-

IR 1.4: Expanded access to EPI services through mobile outreach
IR 3.3: Enhanced caretaker knowledge of EPI schedules

- CS-14 made an effective use of CHWs to help the MOHP achieve universal coverage in DPT and OPV coverage rates. During home visits, CHWs are encouraging mothers to bring their children to the health facilities for immunization. CHWs are also systematically contacting health workers in MOHP facilities to have the names of children to bring for a first contact or for a follow up visit. Several MOHP officials and health workers confirmed to the MTE team the valuable contribution of the CHWs to the recent increase in childhood immunization rates in the project areas. Table 5 in Attachment 9 shows the DPT3 and OPV3 immunization coverage estimated through health services statistics in the three CS-14 areas in the periods January-June 1998 and January-June 2000. These coverage rates increased in all three areas, and in particular in the El Maasara Shark, the slum area in Samalout city. These results are impressive but need to be interpreted with caution because the estimate of DPT3 coverage is 46% in the baseline household survey and the CHWs only started their home visits program in July 1999.

- CS-14 also contributed in increasing neonatal tetanus immunization coverage among women of reproductive age. Table 1 in Attachment 9 shows a major increase in the number of tetanus toxoid doses provided in all three CS-14 areas between the periods January-June 1998 and January-June 2000. Here also, the increase is the largest in El Maasara Shark (235%). This result is at least partially related to Tetanus Toxoid (TT) doses provided during antenatal visits, and if sustained, will directly affect the value of the indicator for this intervention (67% at baseline). It probably also reflects a better implementation of the MOHP policy of immunizing all women of reproductive age through five TT injections, and therefore part of this increase in the number of TT doses (those given to women who will not be pregnant in the coming three years or all the third or subsequent doses) will not affect the specific End-of-Project Objective of 85%.

  "In El Maasara Shark, there was a woman who had eleven children who had never immunized any of them except when health workers came to her home during national campaigns. When she had her twelfth child and a CS-14 CHWs provided her with health education, not only did she go to the health facility and get her child immunized, but she also participated in health education seminars held in El Rahman CDA."

- CS 14 received a 'Thank You' letter from MOHP officials for effective participation in national EPI mobile outreach campaigns through coordination of the CHWs, CDAs and health units' work.

C. Cross Cutting Approaches

(1) Behavior Change Communications

- All CS-14 safe motherhood and child survival results and many intermediate results relate to specific behavior or knowledge changes, and have been discussed under the corresponding interventions in the previous sub sections. Only general findings are discussed here.

- CS-14 has conducted training for MOHP health workers and CHWs in communication skills and health education messages related to the various project interventions. The number, type of persons trained, and content of training are discussed in section II.C(3) below. These skills are applied during the interactions between CHWs and mothers during home visits, and between health workers and mothers during clinic visits.

- At the end of the MTE, CS-14 staff prepared a list of Key messages by technical interventions (Attachment 11). These Key messages must be considered as "positioning statements" to be broken down into specific messages by the CHWs or other health educators according to individual cases of maternal or child health. The Key message for pneumonia case management for instance, indicates that all mothers should know the danger and the importance of early diagnosis and treatment of pneumonia. In addition, CHWs should be teaching mothers the specific signs of pneumonia (rapid breathing, chest in drawing) in newborns, older infants, or children, as the case maybe, and exactly when, where and how to seek care. For immunization, every mother should know that complete and timely immunization protects children from serious diseases. In addition, CHWs should elaborate more specific messages about the different types of vaccines for children or pregnant women, and when and where to obtain them. The MTE team did not examine the specific messages taught to CHWs and other health educators. These can probably be found in various training documents (most of them in Arabic). During interviews with CHWs and mothers, the MTE noticed a generally sound understanding of specific health messages.

- The MTE team gathered the various health education materials available at the SC/Minya office and that CHWs or health educators use to communicate key messages to mothers. In accordance with the DIP, all these materials are borrowed from the MOHP, UNICEF, or other organizations working in Egypt. CS-14 has very limited amount of these materials (in type and numbers) and CHWs generally do not have materials to support their talk and demonstration or to distribute to mothers.

- Although most of the project activities relate to the work of the CHW and in particular to that of health education of mothers and caretakers, CS-14 has not adopted any indicators for monitoring behavioral change yet (see discussion on

information management in section D(2). Such indicator should be related to the training, the competency, and the activities of the CHWs and other health educators.

(2) Community Mobilization

Results
- All 5 HACs report MOHP has effectively addressed > 50% of concerns raised in quarterly meetings

Intermediate Results
-

IR 2.5 Increased community participation in defining and monitoring quality of care

IR 4.3 Scheduled, regular MOHP/community problem-solving

- CS-14 has established effective community-defined problem solving mechanisms using CHWs, CDAs, LHAC, and DHAC.

"*In El Shaarawya (El Bayhoo area),* the government had refused to open a health unit that was built on cultivated land. In cooperation with the local community leaders, this problem was presented to the first DHAC meeting and the unit was soon opened and provided with water and electricity. It then appeared that the unit was not assigned any health staff, faced regular shortage of equipment and supplies, and remained dependent on the Medical Center in Samalout. All these problems were presented again to the DHAC, and the DHMT then provided a resident doctor and a complete health team from the nearby units and villages. As the unit was also recognized as separate from the Medical Center, the health district delivered a MCH register to the MCH, the nurse was trained by the RC, some simple equipment was provided, and the unit started to provide the needed medical services."

"*In El Hatahta (El Bayhoo area),* the health unit was open but was not provided with electricity. The problem was presented to the DHAC and this unit now has electricity."

"*In Al Amoudeen (Taha area),* the CDA began motivating the local community to define and solve their health problems. They soon identified a sewage canal in the village as a major cause of nuisance and health problems in the community. The issue was presented to the DHAC and to the Taha Local Council, and the village obtained support to cover the canal."

(3) Training

Results
-

Intermediate Results
- 90% of CHWs correctly teach ORT & ORS preparation

- SC/Minya estimates that about 80% of the training activities included in the DIP were successfully conducted. The table below gives the number of training recipients and topics by professional categories. The same recipients may have been trained several times. The CHWs, for instance, received training during 3 days in communication skills, 3 days in CDD, 6 days in ARI, ANC, EPI, and nutrition, and 2 one-day refresher training seminars (see Attachment 8).

Training recipients	Number	Subject
CHWs	103	Communication skills and CS-14 interventions
LR CDA members	33	
Primary Health Care Units:		CS-14 interventions
Physicians	20	
Nurses	20	
DHMT members	20	Training of trainers

- Consultants and partner organizations conduct most of the CS-14 training. During discussions within the MTE team, both CS-14 staff and partners' representatives have expressed the need for a establishing a comprehensive system including design, implementation and evaluation of training activities in order to ensure the best quality.

- The DIP includes one quantified End-of-Project Objective of competency directly related to the result of training activities. This and similar competencies for other interventions could be standardized to help focus the training and monitor its impact on the recipients. The related behavior among caretakers (correct use of ORS, in the example above) can then also be measured and monitored.

- CS-14 has contributed to the establishment of a training hall in the Health District office in Samalout. All CDAs would like to have their own training hall with modern training equipment.

- The MTE team has recorded many requests for further training. The MTE team found that CS-14 should indeed respond to the needs below:
  - CHWs on communication skills but with clearer emphasis on specific health messages
  - LR CDA on financial and administrative management, to better prepare them to become LU CDA
  - LU CDA on training of trainers
  - MOHP physicians in the CS-14 areas on project interventions, and specially MNC

  Other frequent requests such as training of CHWs in first aid and injections techniques did not meet the approval of the MTE team.

(4) Partnership with Community Development Associations

Results
-

Intermediate Results
- Both CS-14 LU CDAs have experienced trainers, curricula, & materials
- Both CS-14 LU CDAs provide training & TA to Learner CDAs

- CS-14 has identified strong community-based partners and used them effectively to implement the Living University strategy. Early in its implementation, CS-14 has defined adequate roles and responsibilities for the LR CDA supervisor, coordinators, and training coordinators, as well as those of SC (Attachment 12).

- One of the main functions of the LR CDA in CS-14 is to select, coordinate, and supervise the CHWs. In June 2000, the three LR CDAs were supervising a total of 103 CHWs in 16 villages and who covered 13,067 children under five. This represents 72% coverage of the target population of children under five. Typically, each CHW conducts about 6 visits a day and covers about 100 households. She also visits the local health facility three times a week, attends Local Health Action Committee meetings once a month, and attends District Health Action Committee meetings once a quarter. Each CHW receives a supervisory visit from the LU CDA coordinator every month.

- Both LU and LR CDAs have managed their CS-14 sub grants adequately. The LU grants cover the cost of training activities, of a coordinator, and some office support. The LR CDA grants cover the cost of the CHWs incentives, of one person, and of some office support. The three LU CDAs have been responsive and effective in building the capacity of the three LR CDAs through training, weekly technical assistance and monitoring visits, and exchange of experience. The three LR CDAs have shown dynamism and determination in building their managerial capacity, in supervising CHWs, and in working with the communities, the Local Health Action Committee, and the MOHP.

  "In El Bayhoo, the LR CDA already submitted a number of proposals after receiving technical assistance on project design and proposal writing from the LU CDA Zohra. One proposal was to provide clean drinking water to poor families; another one was to carry out an environmental project. CARE recently approved one health project, and the CDA board members are now being trained for its implementation."

  "*In Al Ameda (Taha area),* the LR CDA El Fath received training from the LU CDA Taha on how to write and present project proposals. The LR CDA presented a proposal to SC and got support to open two nursery classes in its building and four nursery classes in private homes. This was because of the CDA believed in the importance of early childhood development."

- Despite the progress, the LR CDAs are not ready to become LU CDAs and begin sponsoring other CDAs. LR CDA members expressed the need for enhanced skills in financial and managerial management, and for more opportunities to visit and learn from LUs' experiences. During their supervisory visits to the LR CDAs, the three LU CDAs have identified many training needs that for budgetary reasons cannot been addressed. This leaves the three LR CDAs unready to act as LU CDA during the next phase of the project.

- CS-14 has strengthened the capacity of the LU CDAs by providing them the opportunity to train, mentor, and work with the LR CDAs. Their role in phase 3 of CS-14 now raises unresolved questions. CS-14 is assisting the LU CDA board members in defining themselves their future role in CS-14 and in their communities. One suggestion has been to train some members of the LU CDA as trainers who could be used in some of the CS-14 activities. SC could also assist them in developing health-related proposals to submit to other agencies, and offer technical and executive backstopping.

(5) Partnership with the Red Crescent Society

- CS-14 has strengthened the capacity of RC to provide training primarily through the opportunities to coordinate such activities. There has not been any assessment of the quality of the training provided and of the possible need for training of RC staff and consultants in training skills and in CS-14 interventions.

- There has not been other activity to strengthen RC's technical and managerial capacity to play a leadership role in health development in Minya, as indicated in the DIP. CS-14 could involve RC in other activities than training such as baseline surveys, needs assessments, participation in the DHMT and the AC meetings. The agreement between SC/Minya and RC may need to be revised to explicitly include such activities.

(6) Partnership with MOHP

Results
- DHMT has quarterly action plans which reflect community feedback and facility assessments

Intermediate Results
-

IR 1.3 Referral linkages between communities, health centers, and hospitals established and/or strengthened
IR 2.1 Active surveillance of infant/maternal mortality and EPI-preventable diseases
IR 2.3 Quality of care standards developed, tested, and applied
IR 2.4 Supportive supervisory skills transferred and applied
IR 2.5 Increased community participation in defining and monitoring quality of care
IR 4.2 District Health Management Team independently continues planning cycle
IR 4.4 MOHP using revised MIS

- The DHMT does not have its own comprehensive plan of activities for the district. The Health District in Samalout primarily uses plans and directives from Minya and Cairo, and does not engage in a local planning and coordination process with health workers, partners, and communities. Building on the successful organization of District Health Action Committees for problem solving (see section II.C(2)), CS-14 could propose their participation and assistance in such planning and coordination process, as suggested in the DIP.

- CS-14 has not developed standards of quality of care, conducted systematic health facility assessment or joint supervisory visits, established effective referral linkages between communities, health centers, and hospitals, and begun building quality improvement systems in health services. The MTE team noticed that the MOHP has not begun quality improvement activities in Samalout either.

- CS-14 has distributed minor medical equipment to 14 health facilities (Attachment 13). The items were selected through some consultations with MOHP officials in charge of the project areas facilities but without explicit technical assessment related to specific CS-14 interventions. MOHP heath workers and officials have often expressed needs for more equipment and supply during the MTE visits and meetings.

- CS-14 prepared a training room of 20-person capacity in the health district in Samalout and provided tables and chairs, a white board, a flip chart holder. The Health District has provided a TV/ video and an overhead projector.

(7) Sustainability Strategy

Results •

Intermediate Results •

IR 4.1 Living University "campus," "faculty," "curriculum," and Community Trustee in place

IR 4.2 District Health Management Team independently continues planning cycle

IR 4.5 Communities independently supporting community-based providers

- The Living University strategy underlying CS-14 builds local capacity and involves communities. The overall design appears sustainable. The challenge is to ensure that the LU CDAs, LR CDAs and CHWs continue their activities at the end of the project.

- The three LU CDAs that have been working during the present model development phase should be able to sustain their capacity and possibly their activities at the end of this phase. This should occur outside of CS-14 since the DIP does not include a grant for the initial LU CDAs in phase 3. As mentioned in section II.C(4), LU CDAs are now questioning their role in phase 3 of CS-14. A sound solution should be developed and that will be applicable to the three new LU CDAs (current LR CDAs) at the end of the project.

- Activities of CHWs in the five CS-14 areas should continue beyond the end of the project. On several instances during meetings with the MTE team members, CDAs members discussed the possibility of cost recovery of the CHWs' incentives and transportation costs through a fee-per-visits scheme. A fee of 1 Egyptian Pound is often proposed as acceptable by mothers. On the other hand, the current incentive given to CHWs is often considered "too low." These issues should be further explored, and possible solutions tested in the three first areas before the end of the project.

- SC/Minya has not clearly defined a "CS-14 exit strategy" yet. However, the MTE team noticed a good awareness of sustainability issue among SC/Minya and partners staff.

D. Program Management

(1) Planning

- The MTE reviewed the various weekly and other work plans used by CS-14 Field Coordinators. These detailed plans allow careful coordination and monitoring of their activities.

- Overall, there seems to be a good participation from the various CS-14 partners in the definition of their respective roles and responsibilities, and in the preparation of the work plans. As noted before, however, there is no DHMT level comprehensive planning system that involves all partners and encourages coordination and collaboration.

- The USAID/Egypt Mission, which funds half of the CS-14 project, has not received the DIP, annual report, or other relevant planning documents.

(2) Information Management

- CS-14 and its partners routinely collect or has access to a wealth of information that is not fully used for decision-making and program design. Typical examples of data available from the MOHP facilities were presented earlier (see Attachment 9 and Attachment 10). The DIP suggests the active use of the MOHP vital registration data for the detection and systematic inquiries into cases of maternal and child deaths. Others sources of information are the good records that the Field Coordinators and Team Leader keep about their various activities (monthly, weekly, and daily work plans, meeting minutes, correspondence with partners) and those of the CHWs. The latter data can give information on the coverage of the home visits program.

- CS-14 is revising the CHWs reporting system. New forms have been designed to provide epidemiological and behavioral, in addition to programmatic, information. The aim is to provide better information to prioritize interventions, monitor the impact of these interventions, and communicate with the communities and MOHP facilities. The new system proposes to use printed rather that hand-written forms for CHWs. A complete review of the feasibility (time, cost) and usefulness (indicators obtained) of the proposed system should be done, maybe with external experts from the MOHP or other project in Egypt or from SC/HO. This review should include assessment and analysis of the existing data.

(3) Human Resources Management

- Attachment 14 presents the current staff of SC/EFO and Minya supported by CS-14. Most of this staff including the project manager is based in Minya. Most of CS-14 staff has remained stable and this has contributed to building good relationship with the various partners. The CS-14 project manager, who is also the SC/Minya Program Manager, has been replaced with a senior public health physician with extensive

experience in public health and communication programs, and in Minya in particular. The transition was smooth and the new management style welcome. SC/Minya recently recruited a new senior public health physician with previous experience in similar community-based project, and more recent experience in several critical areas for CS-14 such as information systems and quality assurance. SC/Minya also recently recruited a new training and institutional development specialist with obvious competence for improving current training and capacity building strategies. This new personnel will certainly give new directions and impetus to the CS-14 project. There is no obvious need for additional long-term personnel on the project.

- The CS-14 Team Leader and Field Coordinators reported that their salaries are lower than those of staff with similar qualifications in other SC projects. The Program Manager recognized that, with overtime pay, errand boys in SC's Minya office earn more than the Field Coordinators who do not receive payment for overtime work.

- The CS-14 Team Leader and Field Coordinators noted that CS-14 will expand into two new sites during the next phase of the project and asked whether all three teams of Field Coordinators would be retained during this phase. A review of the CS-14 budget revealed that seven Field Coordinators are budgeted for during the last two years of the project.

- The CS-14 Team Leader and six Field Coordinators request English language and Internet training. The MTE team also identified training needs in technical areas such as quality assurance, behavior change communication, financial management, and project interventions. These training should be defined and provided soon to ensure benefits during the final two years of the project.

(4) Financial Management and Logistics

- There has not been overspending in any of the main CS-14 budget categories. During group discussions about CS-14 financial management, various misconceptions about the flexibility of the budget lines appeared that were clarified by the SC/HO and USAID/BHR/PVC MTE team members. It turned out that only minor change might be necessary and these within the main budget categories (changing the topic of training seminars, for instance). In any case, SC should refer to the cooperative agreement with respect to this issue and make the relevant section of this document available to CS-14 staff in Minya before budget changes are proposed as a result of the MTE.

- The need for all CS-14 staff to be well-aware of the budgetary issues was also raised and discussed: program managers and field coordinators need to know the financial constraints of the project and financial managers need to know the program needs to achieve the project objectives.

- The CS-14 Team Leader and six Field Coordinators used to share two rooms in SC/Minya offices. Currently, the Team Leader and three male Field Coordinators each have a desk and share one room. Two female Field Coordinators share a room with three nutrition program staff. The third female Field Coordinator is on maternity leave. Two weeks before the start of the MTE work in Minya, SC's Program Manager asked the female Field Coordinators to join the male CS-14 staff and share desks in one room. The CS-14 staff refused to share desks in one room workspace, noting that even though they spend much of their time in the field, their fieldwork schedules require them to be in the office at the same time early each morning and late each afternoon. They report that they each need their own desk to do their required written work. After the MTE and the time of writing this report, the CS-14 staff had been provided with a special place for filing and records keeping in addition to a health library and Internet service and all staff is satisfied with the new upgrade and reseating in the current office.

- The Team Leader and six Field Coordinators currently use two computers purchased with CS-14 funds. They are requesting a third computer. Alternatives to purchase of a third computer include a reduction in the amount of written work required from the Team Leader and Field Coordinators, use of other SC staff to do some of this work while the Field Coordinators are in the field, and provision of training in word processing to Field Coordinators to enhance their efficiency in using the available computers.

- Overall, field coordinators all recognized having adequate transport support to conduct their field activities.

(5) Technical and Administrative support

Through the various reviews presented above and the related discussions with CS-14 staff and partners, the MTE team identified three main areas for which SC/Minya may benefit from technical support (in addition to training in the related areas):

- Review of the existing BCC messages and materials, and development of strategic communication plans for each interventions
- Development of a strategy for quality of care improvement with involvement of the community and the MOHP service providers.
- Review of and training in project financial management.

E. Conclusions

- SC/Minya is successful in implementing the Living University strategy to improve maternal and child health in Samalout District, building on its past and current projects and on its long-term presence in Minya governorate. This strategy is promising in terms of community involvement and potential for scaling up.

- CS-14 made an effective use of CHWs to help the MOHP increase the utilization of MCH services. The MTE team identified several opportunities for improving the effectiveness and efficiency of the current activities, as noted in the MTE recommendations.

- A fundamental strategy of CS-14 is to use CHWs and MOHP health workers to promote healthy practices among pregnant women and mothers of children under five. SC/Minya intentionally decided to use the large amount of health education materials existing in Egypt for the interventions proposed in the DIP. The MTE team did not disapprove of this approach, but found that it may have resulted in a lack of focus on key strategic messages. The MTE team also found that CHWs lack materials to support their behavior change activities during their home visits.

- CS-14 has been successful in setting up various Local and District Health Action Committees in which community-defined problems have been presented, discussed, and often adequately addressed or solved. The MTE team found that these community mobilization and participation mechanisms have not been fully used to develop a more comprehensive district-level health planning and coordination system with the DHMT and its partners.

- The effectiveness of most of the CS-14 interventions depends at least partially on the availability, accessibility, and quality of facility-based health services. The MTE found that CS-14 had not begun to systematically work with the MOHP and the private providers to assess and improve the quality of care offered to its target population.

- SC/Minya and its CS-14 partners have secured competent and motivated personnel who are now carrying out intensive field activities. At midterm of implementation, this active base of operations provides opportunities for senior executives at SC/Minya, EFO, and HO to provide high-level technical and managerial support to these personnel and ensure that both the impact and model development objectives of CS-14 are met by September 2002.

F. Recommendations

1. Ensure effectiveness and efficiency of CHWs' work

- Undertake a systematic review of the specific health education messages used within CS-14 (in current training materials, in MOHP health facilities, etc) and other settings accessed by CHWs and mothers (television, private providers, etc). Define explicit communication objectives and strategies for each intervention. Identify among existing materials a limited set for CHWs and health workers to use and distribute to mothers. Identify the materials that are missing or inappropriate and need to be found somewhere else or redesigned. Estimate the number of each item needed and the potential sources of supply during the CS-14 and after. Define objectives and measurable indicators for the specific communication competencies expected from CHWs for each intervention (one example available for CDD, for instance, is: "90% of CHWs correctly teach ORT & ORS preparation").

- Define a few priority criteria for home visits by CHWs. Given the limited time and number of CHWs, there is a risk that the same households with well-known mother and children under five are visited every month while other households with greater risk and need for health education and advice remained uncovered. Priority criteria should include households with pregnant women or infants, with sick children (follow up), and with immunization dropouts. In addition, CHWs should give priority to first visits to household with a newly identified pregnant woman or child under five, and high-risk households (poor, illiterate, known health problems). CS-14 should use the available data collected by the CHWs to assess the current pattern of visits and activities (age distribution of children visited, activity conducted, other available information) and to define these priority criteria. CS-14 should incorporate the related information in the new CHW HIS, as appropriate.

2. Strengthen the Maternal and Newborn Care intervention

- As several MNC activities planned in the DIP have intentionally been dropped or have not begun, CS-14 and its partners should first thoroughly review the objectives and strategy of this component, then the related work plan and budget. This review should build on the achievements in the other aspects of the project and take the other MTE recommendations into consideration. Except for training of TBAs and the distribution of clean delivery kits, most of the plans in the DIP still seem appropriate. Among elements to consider in this review are how to cover the 54% of deliveries that currently occur without trained attendants; how to set up a system of emergency transport and referral; how to ensure the quality of emergency obstetrical services in the areas; how to monitor and learn from maternal and infant deaths occurring in the project area.

3. Further develop cooperation with MOHP

- Different types of activities can be conducted at different level of the health system:

- At the Governorate level, maintain close contact with key technical officials by exchanging information and inviting participation in key project decision-making and activities, as appropriate;
- At the District level, propose participation and assistance in the development of comprehensive health development plans involving communities and partners;
- At the health unit level, facilitate communication between health workers, private provider, and communities.

- Facilitate the introduction in Samalout District of selected programs sponsored by the MOHP and its partners at the national or governorate levels:
  - Integrated Management of Childhood Illness
  - Emergency obstetrical care
  - Quality assurance

- Develop a comprehensive community-defined plan to improve quality of care, building on the network of CHWs and CDAs, the system of Local and District Health Action Committees, and the collaborative relationship with the MOHP.

4. Plan CS-14 transition from phase 2 to 3 carefully

- This transition is critical to the success of the project. This has to be considered as a test of the "Living University" model. SC/Minya should expect resistance at various levels, recognize it objectively, and address it constructively. The current LR CDAs' capacity to become a LU CDAs should be assessed according to explicit criteria. SC/Minya should continue assisting LU CDAs in defining their role and contribution to better health in their areas.

5. Develop an explicit "exit strategy"

- This strategy should be formulated and tested before the end of the project. Such strategy and its implementation does not imply that SC will leave Minya but that it will choose to work on different activities or geographical areas. The exit strategy should be specific to project activities and have a timeline. The question of incentives to CHWs is one example of such activities needing a specific exit strategy. The successful implementation of these strategies will be an indicator of success of the project and model.

6. Consider applying for a cost extension

- CS-14 is at least partially about model development, and it is necessary that the entire cycle be completed. A cost extension application, if necessary, should demonstrate the good results so far and the benefits for PVOs and for other child survival projects in Egypt and elsewhere. CS-14 should be prepared to apply in about a year to ensure a smooth transition. SC/Minya and the EFO should keep USAID/Cairo well informed of these developments.

G. Results Highlight

The Living University:
Addressing Community-Defined Problems, Disseminating Healthy Practices, and Scaling-Up Child Survival Activities in Upper Egypt

The Living University approach was developed by Save the Children (SC) in Vietnam as a mechanism for program expansion and for fostering local capacity to implement and sustain development projects, built on the principle of "learning by doing." The LU began in a few communities to pilot and closely monitor an innovative nutrition program. Upon demonstrating measurable effects, the initial site became a "Living University," a "laboratory" where those wishing to learn about the program actively participated in its protocols and activities. Upon "graduation," LU students returned home and began program implementation. After refinement, their areas became LUs, from which further expansion occurred. This approach enabled the SC nutrition program to expand from a population of 40,000 to 1.5 million, while maintaining program quality and impact.

In Upper Egypt, through the USAID Mission-funded "Partnering for Institutional Development" (P/ID) project in Minya Governorate, the LU has enabled Community Development Associations (CDAs, government registered local NGOs) to plan, implement, and manage economic opportunity, education, early childhood development, and primary health programs, employing local expertise and resources.

SC's child survival project in Minya (CS-14) is employing this successful model to address community-defined problems, disseminate healthy practices throughout communities, and scale-up the project to reach new areas. Currently, three experienced LU CDAs from the P/ID Project are training and supporting three new CS-14 "Learner" ("LR") CDAs to assess health needs, to mobilize communities, and to plan and manage development activities. Each CDA receives a sub-grant from SC, with each LU CDA mentoring one LR CDA. LU CDAs and SC are working with LR CDAs to train, support, and monitor female Community Health Workers (CHWs) to provide CS services in their communities, and to link these community health activities to government health services. Following CS-14 expansion into two new areas, two of the current LR CDAs will become LU CDAs to build capacity of two new LR CDAs.

In CS-14, CDAs and CHWs have been particularly effective in increasing antenatal visits and tetanus immunization. Before CDAs had taken up the issue with local health services, it had been common practice for pregnant women not to be registered or receive ANC booklets unless they were at least four months pregnant. CDAs where informed of this practice by CHWs who learned during their work about community concerns regarding the quality of ANC services at health facilities. Following several meetings in which CDA members and SC staff brought these issues to the attention of health facility staff, the number of ANC visits has increased 265%, TT immunizations by 67%, and pregnant women now receive ANC booklets during their first visit to a health facility. Joint problem solving by CDAs and district health staff has also led to several other improvements, including a closed health facility being opened and staffed. SC-supported CDAs are now writing proposals and receiving funds for community development activities from other donors, suggesting important implications for the sustainability of this approach.

III. The Action Plan

This section will be completed collaboratively by SC and partners soon after the MTE report is approved. It may be in the form of a separate document. It will address all the MTE recommendations, provide a discussion about whether they will be implemented or not (and if not, why not), and specify what actions will be taken by which date and by whom. It will include a short written plan and budget amendment, as necessary.

INSERT SC ACTION PLAN HERE

IV. Attachments

Attachment 1 Baseline information from the DIP

The text and tables below primarily comes from the CS-14 DIP and constitutes a summary of the key points in the DIP relevant to the MTE. Only minor changes in the formulation and presentation have been made to ensure coherence and clarity. For more detail, please refer to the original DIP document. The present summary follows the outline below:

A. Field Program Summary
B. Program Goals and Objectives:
C. Program Location
D. Program Design
E. Partnerships
F. Health Information System

A. Field Program Summary

Estimated Project Effort and USAID Funding by Intervention

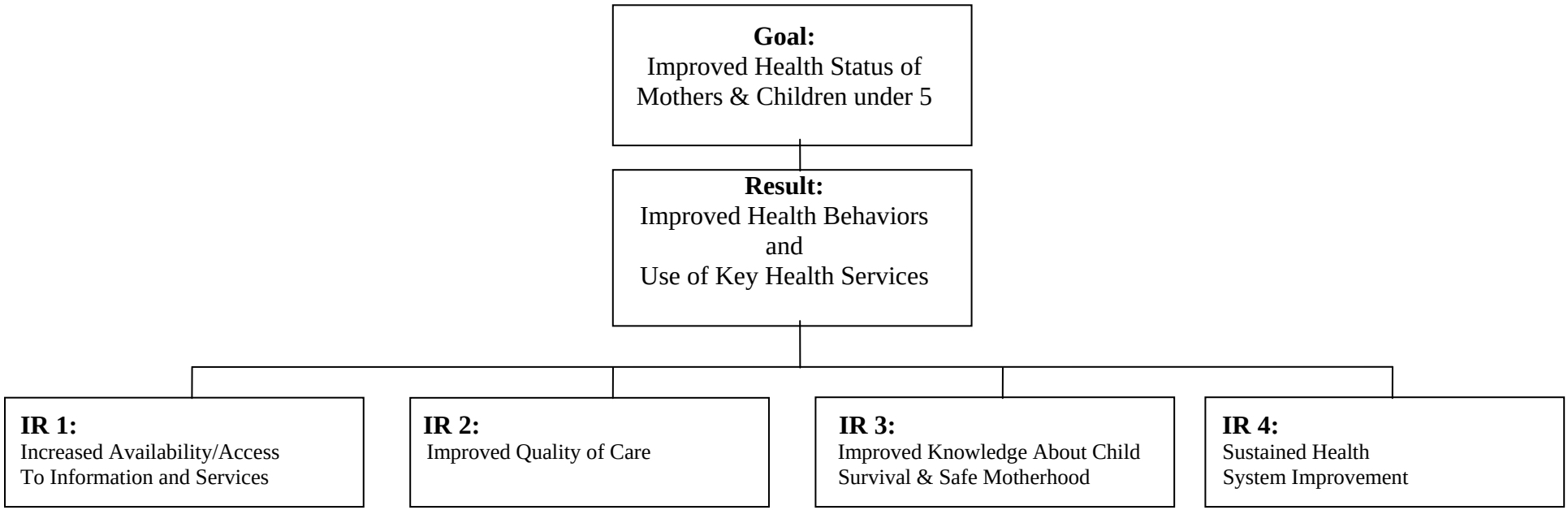
Intervention	Effort	Funding
√ Immunization	10%	$100,000
√ Nutrition and Micronutrients	10%	$100,000
Breastfeeding Promotion	0%	$0
√ Control of Diarrheal Disease	20%	$200,000
√ Pneumonia Case Management	20%	$200,000
Control of Malaria	0%	$0
√ Maternal and Newborn Care	40%	$400,000
Child Spacing	0%	$0
STI/HIV/AIDS Prevention	0%	$0
Others (specify)	0%	$0
Total	100%	$1,000,000

Project Site Population: Children and Women

Population Age Group	Number in Group
Infants (0 – 11 months)	> 7,000
12 – 23 Month Old Children	7,000
24 – 59 Month Old Children	< 21,000
Total 0 – 59 Month Olds	35,000
Women (15 – 49 years)	46,000

Estimated annual number of live births in the site: 8,654. Numbers of live births, children under five, and women 15 to 49 based on 1998 information obtained from the MOHP in Minya.

B. Program Goals and Objectives



1. Essential drugs and medical supplies available at health facilities
2. Increased community-based access to information and services, including clean birth kits, PCM, and ORS
3. Referral linkages between communities, health centers, and hospitals established and/or strengthened
4. Expanded access to EPI services through mobile outreach

1. Improved diarrheal disease and ARI case management
2. Active surveillance of infant/maternal mortality and EPI-preventable diseases
3. Quality of care standards developed, tested, and applied
4. Supportive supervisory skills transferred and applied
5. Increased community participation in defining and monitoring quality of care

1. Enhanced recognition of pregnancy-related danger signs by TBAs, CHWs, and adults in the community
2. Increased correct knowledge among caretakers about ORS preparation and use, and signs of pneumonia
3. Enhanced caretaker knowledge of EPI schedules
4. Mothers know "Positive Deviant" foods and child care practices

1. Living University "campus," "faculty," "curriculum," and Community Trustee in place
2. District Health Management Team independently continues planning cycle
3. Scheduled, regular MOHP-Community problem-solving
4. MOHP using revised MIS
5. Communities independently supporting community-based providers

End-of-Project Objectives for Safe Motherhood, Child Survival, and Capacity Building & Sustainability

Level	Safe Motherhood	Child Survival	Capacity Building & Sustainability
Results	• 80% of TBA-assisted deliveries in past 6 months are performed by CS-14 trained TBAs • Clean birth kits are used in 80% of home births in past 6 months	• 90% of mothers of children <36 months with diarrhea in the previous month report feeding fluid (other than breast milk) during diarrhea • 85% of mothers of children 6-36 months with diarrhea in the previous month report feeding foods (other than breast milk) during diarrhea • 85% of mothers of children <36 months have received two or more doses of TT • 80% of 12-23 month old children have received three or more doses of DPT • 80% of mothers report providing at least one Positive Deviant food to their 6-35 month old child and following at least one key PD child care practice	• DHMT has quarterly action plans which reflect community feedback & facility assessments • All 5 HACs report MOHP has effectively addressed > 50% of concerns raised in quarterly meetings
Inter-mediate Results	• 90% of women with infants under age 6 months know two or more obstetric danger signs	• 90% of CHWs correctly teach ORT & ORS preparation • 85% of mothers with children <36 months report that rapid breathing is a sign of pneumonia (or a serious sign for a child with a cough)	• Both CS-14 LU CDAs have experienced trainers, curricula, & materials • Both CS-14 LU CDAs provide training & TA to Learner CDAs

C. Program Location

Selected Characteristics of Samalout District and the CS-14 Project Site

Characteristic	Samalout District	Project Site
Population	480,000	220,000
Village Areas	8	4
District Hospitals	1	0
Rural Hospitals	2	2
Basic/Rural Health Units/Centers	36	17
MOHP Doctors	228	41
MOHP Nurses/Midwives	251	31

D. Program Design

CS-14 seeks to reduce infant, child, and maternal mortality, and introduce a sustainable district health model for introduction and expansion of safe motherhood and child survival services. The overall design of the CS-14 *District Health Through a Living University* project is to link Ministry of Health and Population (MOHP) facilities, staff, and systems; the Red Crescent (RC) Society; Community Development Associations; and families; for improved caretaker practices, access to care, and quality of care, through an approach which builds capacity at the individual, family, community, NGO, and facility levels through mobilization, organization, partnering, training, and support for measurable, replicable, sustainable health improvement.

The "Living University" (LU) strategy begins with a few communities to pilot and closely monitor a quality program. Upon demonstrating measurable effects, the program and its principal actors become a LU where those wishing to access the model can actively participate in its activities. Since July 1998, SC has been implementing this strategy in Samalout and other districts of Minya Governorate through the USAID/Egypt-funded "Partnering for Institutional Development" (P/ID) project. In this project, LUs have enabled local NGOs to plan for, implement, and manage economic opportunity, education, early childhood development, and primary health programs employing local expertise and resources. CS-14 will employ this successful model to establish a district-level mechanism for replication and expansion of Child Survival services. In a first "model development" phase, three CDAs from the LU Project (LU CDA) will work with three CS-14 Learner (LR) CDAs to mobilize the communities, assess needs, and to plan and manage activities. In a second "model replication" phase, two of these three LR CDAs will become LU CDA and will work with two additional CS-14 LR CDAs.

Other key CS-14 strategies are:

- Health Action Committees to broker the interface of MOHP services and the community by guiding behavior change communication (BCC) efforts, identifying local providers for training/retraining, arranging emergency transport for patients and transport for MOHP partners, and for quarterly review of services with MOHP;

- Community Health Workers and TBAs who facilitate access to health services and community participation;
- Public/private collaboration through TBA retraining and through "infiltrating" the private sector with improved skills by training public providers who also run part-time private clinics;
- Strengthening the Red Crescent, which will identify and support female CHWs and train and support TBAs and MOHP staff;
- BCC with carefully chosen, consistent messages targeting caretakers, decision-makers, religious leaders, and other influential people through multiple channels;
- Combined training where appropriate (i.e., nurses and CDA personnel) to build trust and cement community/MOHP links; and
- A sustainable health information system which relies on population estimates, outputs, a newly introduced MOHP home-based health booklet, mortality surveillance, and occasional community- and household-level tallies.

Project decision-making, coordination with partners, and oversight is achieved through three structures:

- The Advisory Committee (AC) includes the SC Project Manager; Community Trustees from the LU; and representatives of the Governorate and District MOHP, the Red Crescent, and CDAs. The committee reviews Project development, cultivates political will, fosters integration, and links with key partners and programs outside Samalout. It directly advises the District Health Management Team (DHMT).
- The DHMT includes the head of the district health department; the manager of the district hospital; representatives of rural hospitals and rural health centers; three elected members of the Health Action Committees; and the Community Trustee of the LU. This body executes the program plan, scheduling training, supervision and problem solving, including reviewing HIS and Quality Of Care data.
- Internal coordination involves the Project Manager overseeing administration and logistics personnel, the training coordinator, the LU Community Trustee, and the Field Team Leader who supports the Field Coordinators.

The Project shares with MOHP the vision of improved public health. CS-14 will train MOHP health facility staff, selected private practitioners, and TBAs through Red Crescent trainers, provide orientation and health education materials to private pharmacists, and provide some basic MCH equipment and supplies to MOHP facilities and clean birth kits to TBAs. The MOHP will support CS-14 activities by providing facility-based services; trainers, venues and materials for training TBAs, nurses, and doctors; meet quarterly with Health Action Committees for problem-solving/case review; and co-implement with SC a Quality Assurance approach to monitor and improve the quality of clinic services.

CS-14 CHWs will visit all targeted households in the project site (those with pregnant women or children under five) and orient household members to Project objectives and activities. CHWs will then visit targeted households on a monthly basis for health education and follow-up regarding illness, immunization status, use of health services, and practice of emphasis behaviors. Access to and use of important health services by

mothers and children will be facilitated by the Health Action Committees. The HACs will facilitate referral and transportation of women and children to health facilities and transportation of MOHP EPI outreach teams to the more remote communities. TBAs will be trained and supported to assist with clean deliveries, recognize and promptly facilitate referral to appropriate facilities of all women with danger signs, and conduct follow-up visits during the first 40 days after the delivery.

The Project interventions are:

- *Maternal and Newborn Care* is the central intervention because of demonstrable health and social need, and the existence of key health system elements, which, if strengthened, supported, and coordinated, are likely to contribute to substantial impact.
- *Control of Diarrheal Diseases (CDD) and Pneumonia Case Management (PCM)*: Although the MOHP is committed to the gradual introduction of integrated management of childhood illness, implementation in Minya is not expected to commence before several years. In the meantime, CS-14 will support MOHP CDD and PCM activities, and seek to improve care in the home and by private providers.
- *Immunization* is included because complete DPT3 coverage among 12-23 month old is under 46% in the Project site; the MOHP aims to eliminate target diseases and this requires strengthened services and surveillance; and the EPI program has public's trust and can leverage other activities.
- *Family Planning*: CS-14 decided not to include a FP intervention because services are available in the project area, supplies appear adequate, staff are in place, and many facilities have a "Health Promoter" for community follow-up and referral**.** The Project will conduct an assessment of availability, access, use, and quality of FP services in the project area, and seek funding for SC FP activities if the assessment indicates a need for this.
- *Nutrition and Micronutrients*: The focus of this intervention is education for better child nutrition based on the findings of Positive Deviance Inquiries. CS-14 will address the substantial childhood protein-energy malnutrition in the Project site by building on the experience gained through implementation of the UNICEF-funded SC Positive Deviance Pilot Nutrition Intervention project in nearby areas of Minya Governorate since September 1998. In addition, CS-14 will encourage mothers to seek concurrent immunization and vitamin A supplementation for their children as soon as possible after they reach 9 and 18 months of age, according the current MOHP policy.

E. Partnerships

The Project depends on a partnership with the (MOHP), and on sub-grant partnerships with a governorate-level NGO, the Red Crescent (RC), and with eight local NGOs, the Community Development Associations (CDAs).

MOHP: Important roles of the MOHP in CS-14 include identifying staff roles, training and supporting staff to provide services, and collecting and sharing health data with Project management and coordinating bodies. Joint data collection and Project monitoring activities will promote improved "data for decision making" in the MOHP.

Through joint training and training of trainer activities, SC and the Red Crescent will build the capacity of the MOHP to provide effective training to their staff in MCH topics. Joint supervisory visits to MOHP health facilities and the application and promotion of quality assurance methods will be important components of the CS-14 SC/MOHP partnership to build MOHP capacity to deliver high quality MCH services. MOHP linkages to CDAs and HACs will promote increased MOHP contact with community organizations to further promote community-defined quality of care. Finally, SC will provide some key MCH supplies to MOHP facilities in Samalout District.

Red Crescent Society: A CS-14 sub-grant will support RC to provide training to groups of MOHP physicians and nurse-midwives in project interventions. The Project will enhance the RC's management and technical capacity through joint implementation of these activities, and impart community medicine and epidemiological principles through "learning by doing" participation in baseline, mid-term, and other assessments. Consultant trainers for unfamiliar content will also upgrade RC members' skills. The sub-grant to RC will also support some office expenses such as photocopying and transportation. SC will enhance the management and technical competence of RC by:

- modeling state-of-the-art management (such as "action-oriented" meetings and minutes);
- including them in key activities (needs assessments, surveys, evaluations) and in routine activities (quarterly meetings with rotating chair);
- tracking mutually agreed-upon time-dependent deliverables; and
- critical thinking and creative problem-solving through the environments of the Living University, Advisory Committee, and DHMT.

Community Development Associations: Community-level partners will include five Community Development Associations (CDAs), which are already established in each of the Project's five areas, and three CDAs from the current SC Living University P/ID Project. All eight CDAs (three LU CDAs and five CS-14 CDAs) will receive sub-grants to carry out Project related activities.

The LU CDAs will build capacity of the initial three CS-14 CDAs, which will then build capacity of the remaining two CDAs following expansion of the CS-14 Project. The major task of the three LU CDAs will be training and support of the initial three CS-14 CDAs in community mobilization and Project planning and management. Each LU CDA will mentor one CS-14 CDA. In addition, LU CDA board and staff members will work with the selected CS-14 CDAs' boards and staff and SC field coordinators to identify and train suitable women as CHWs. The Project will partner with the LU CDAs to build capacity of CS-14 CDAs in needs assessments, data analysis and data-based decision-making, planning and management, CHW support, and dialogue with the MOHP to improve quality of services from the community perspective.

Current experience in Minya shows that CDAs are well motivated by learning, by community service, and especially by dialogue with government officials. Technical knowledge will be upgraded through scheduled, responsive, on-the-job, and peer training

(both as trainer and trainee). SC and the LU CDAs will also support and monitor the activities of the CS-14 CDAs to:

- Coordinate, motivate, monitor, and supervise CHWs;
- Provide incentives for CHWs on the basis of number of visits made and quality of work;
- Maintain linkages between individual CHWs and trained TBAs;
- Participate in quarterly Health Action Committee meetings with MOHP staff from the local health facility to discuss quality of care from the community perspective.
- In cooperation with HACs, set up emergency referral/transport for obstetric emergencies/sick children (for example, a list of taxis/drivers available in an emergency and a revolving fund to pay the driver if the family could not immediately find the money).
- Work with CHWs on mortality/morbidity surveillance for problem-solving review at the quarterly meetings with MOHP.
- Conduct community inquiries into health practices and health needs for discussion and feedback with MOHP.

F. Health Information System

The CS-14 Project will rely on the health information system of the MOHP, on community and household measurements, as well as standard baseline and final surveys in each Project area. Project-specific, community-based records include: CHW rosters and activity records, TBA activity records, HAC surveillance records, and Field Coordinator activity records.

Each CHW will have a simple roster of 100 families, giving the name of the head of household; mother's name; each child's name (under age 5), birth date, and gender; and the total number of people in the household. The roster will record the visit date, BCC subject covered, and any important observations or vital events involving mothers or children. CHWs will complete activity tally sheets to track the number of homes visited and BCC topics covered.

CS Field Coordinators and CDA members will monitor the CHW activities. All SC field staff and NGO partners will have activity records with flow sheets to track common activities, and check-lists to regularize support and supervision. LU Community Trustee, initially with SC support, will oversee use, feasibility, and sustainability of each record.

Community and facility-based mortality surveillance will identify cases for review, targeting remediable health system weaknesses and/or caretaker practices. The surveillance will first identify some child and all maternal mortality. With experience, the MOHP will strengthen surveillance to add morbidity from EPI-preventable diseases. CHWs, TBAs, and community members will report mortality and morbidity from EPI-preventable diseases to HACs, which will note it on a surveillance record for review with MOHP and action to address any identified problems.

The Project will monitor and improve the coverage of CS services using service output data and community-based tallies to focus Project efforts on those households, communities, and providers which are not benefiting fully from CS-14 activities and services. MOHP output-based estimates will be used for quarterly estimates of EPI coverage, using estimated catchment area populations. MOHP tallies will also measure births (including complications), and ANC and Post Partum Care visits. Providers will record diarrheal diseases and acute respiratory infections treatments in booklets. The new MOHP mother's health booklet will be an important Project monitoring tool to track antenatal visits and immunization status. All pregnant women and newborns will receive a health booklet on their first visit to the health center. The Project will work with the MOHP to train facility staff to accurately update booklets and to encourage mothers to bring them. Older children, born before the booklets, have a birth certificate with an attached immunization schedule, which will also be reviewed. CHWs will record children under five on rosters to track key variables, and track the progress of pregnancy and neonate. TBAs will use either non-literate or literate activity tally forms to record deliveries and outcomes, supervised by MOHP nurse-midwives. "Rolling surveillance" performed by CHWs will measure ORT usage and knowledge concerning prompt recognition and care seeking for pneumonia, during alternate rounds of monthly home visits. Baseline and final surveys will quantitatively determine key coverage and practice variables.

CS-14 will monitor and improve quality of CS services and performance of MOHP staff, CHWs, and TBAs through assessments of training needs, training, regular reporting, supportive supervision, and post-training assessments of health facility, CHW, and TBA performance, and by supporting a continuing dialogue between Health Action Committees and the MOHP to improve the quality of services from the perspective of the communities. SC and MOHP staff and CDAs will provide quarterly village area support and supervision, including monitoring CHW activity (e.g., ANC visit tallies), and knowledge (e.g., danger signs, ORS preparation and use), TBA activity (e.g., deliveries, early breast feeding tallies) and knowledge (e.g., danger signs), and HAC activities (e.g., perceived MOHP quality of care, emergency transport arrangements). SC, in cooperation with the MOHP/Minya, will apply the Quality Assurance indicators, tools and methods which were developed and adopted by the Ministry and are currently being used in one of the Minya districts north of Samalout.

Quarterly field coordinator visits to HACs will monitor MOHP participation in quarterly Project area support and supervision. SC will also monitor the activities and performance of the CDAs and the Red Crescent through regular meetings and reviews of reports. The Advisory Committee will track important aspects of quality at the Project-level, such as the performance of the District Health Management Team.

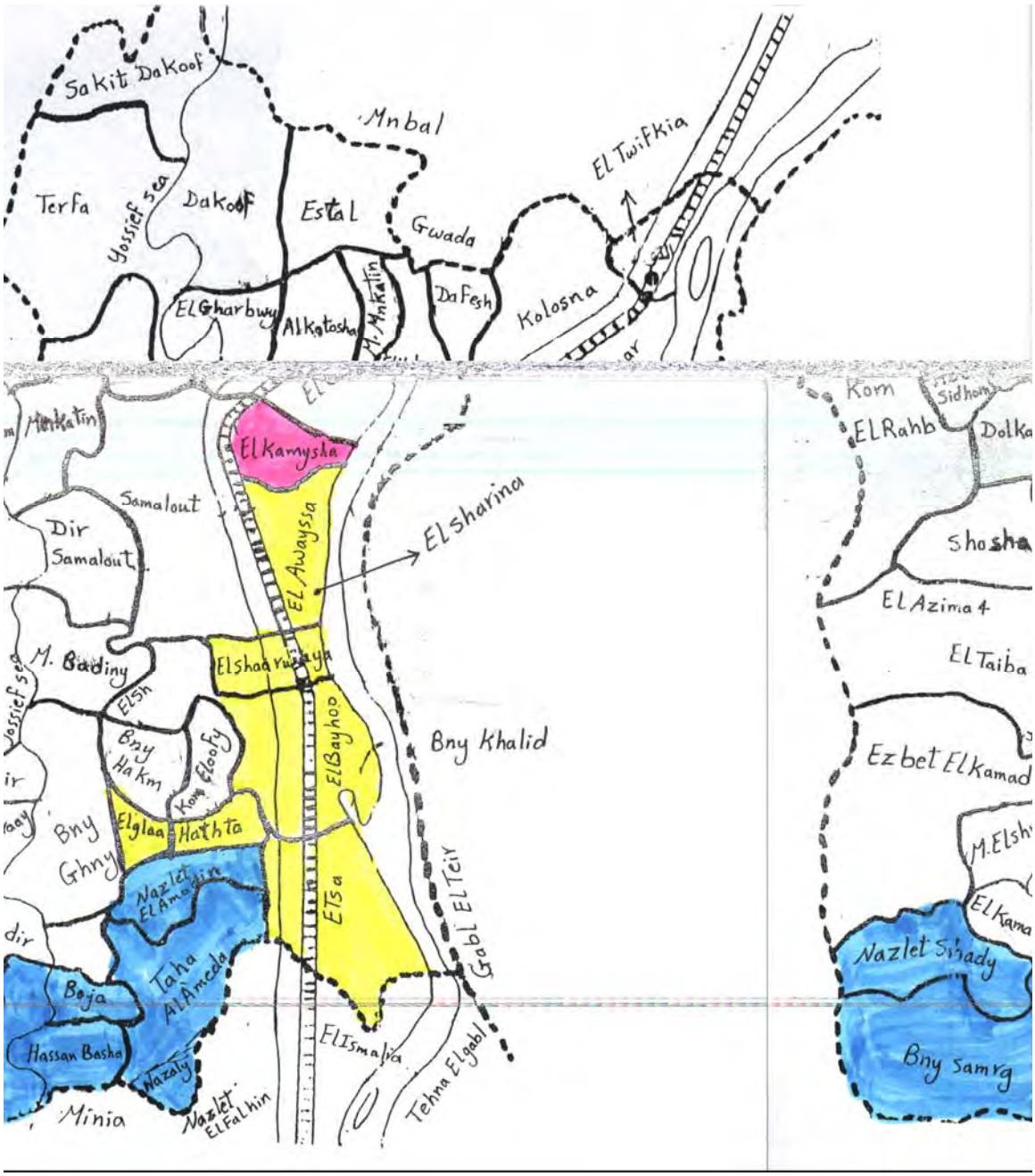
The monitoring and evaluation indicators proposed for the CS-14 are presented in the table below.

CS-14 Indicators: Baseline Values, Mid-Term and Final Targets, Sources of Data, and Frequency of Collection

Indicator	Base	Midtm	Final	Method (by/from whom)	Freq.
% of TBA-assisted deliveries in past 6 months performed by CS-14 trained TBAs	NA*	50%	80%	KPC with mothers of children <6 months (by SC, CDAs, CHWs)	Twice
% of home deliveries in past 6 months in which a clean birth kit was used	NA*	70%	80%	KPC with mothers of children <6 months (by SC, CDAs, CHWs)	Twice
% of women with infants under age 6 months who know two or more obstetric danger signs	NA*	75%	90%	KPC with mothers of children <6 months (by SC, CDAs, CHWs)	Twice
% of mothers of children <36 months with diarrhea in previous month who report feeding fluids (other than breastmilk) during diarrhea	80%	85%	90%	KPC with mothers of children <36 months (by SC, CDAs, CHWs)	Thrice
% of mothers of children 6-36 months with diarrhea in previous month who report feeding foods (other than breastmilk) during diarrhea	70%	75%	85%	KPC with mothers of children 6-36 months (by SC, CDAs, CHWs)	Thrice
% of mothers of children <36 months who have received 2 or more doses of Tetanus Toxoid	67%	75%	85%	KPC with mothers of children <36 months (by SC, CDAs, CHWs)	Thrice
% of 12-23 month old children who have received three or more doses of DPT	46%	60%	80%	KPC with mothers of children 12-23 months (by SC, CDAs, CHWs)	Thrice
% of mothers who report feeding at least one Positive Deviant food to their 6-35 month old child and following at least one key PD child care practice	NA*	60%	80%	KPC with mothers of children 6-35 months (by SC, CDAs, CHWs)	Twice
% of CHWs correctly teaching ORT & ORS prep.	NA*	80%	90%	Evals. of CHW skills, Supervision	1/4ly
% of mothers with children <36 months who report that rapid breathing is a sign of pneumonia	26%	60%	85%	KPC with mothers of children <36 months (by SC, CDAs, CHWs)	Thrice
DHMT has quarterly action plans which reflect community feedback & facility assessments	NA*	Yes	Yes	Mid-term and Final Evaluations	Twice
HACs report MOHP has effectively addressed >50% of concerns raised in quarterly meetings	NA*	All 3 HACs	All 5 HACs	Mid-term and Final Evaluations	Twice
LU CDAs have experienced trainers, curricula, & materials	NA*	NA*	2 LU CDAs	Final Evaluation	Once
LU CDAs provide training & TA to Learner CDAs	NA*	NA*	"	Final Evaluation	Once

* NA = Not yet applicable/available (Clean birth kits are rarely used. Baseline data on danger signs was obtained only through focus groups)

Attachment 2 Map of Samalout District



Source: SC/Minya

Attachment 3 Scope of Work for the MTE Team Leader

Egypt CS-14 Midterm Evaluation

1. The Evaluation Team Leader shall, following AID/BHR/PVC CS-15 guidelines for midterm evaluations, lead the evaluation team in conducting evaluation fieldwork of Save the Children's CS-14 project in Egypt, and write a report of the evaluation, synthesizing the findings and inputs from members of the team.

More specifically, the Evaluation Team Leader will:

2. Design/revise appropriate tools to answer questions relating to midterm evaluations (MTE) in the AID/BHR/PVC CS-15 evaluation guidelines.

3. Coordinate activities of the MTE team for evaluation fieldwork.

4. Compare project plans with actual implementation, based on a review of CS-14-related documents (including: baseline survey, DIP, DIP review comments, annual report), and project archives (training inputs and reports, project studies, project budget, etc.).

5. Interview people associated with the project (such as MOH, USAID, and counterpart staff, and community members) to review project activities, achievements, constraints, project sustainability, and lessons learned.

6. Analyze information on project interventions and progress toward achievement of objectives, and highlight strong and weak points of implementation strategies.

7. Assess the potential for sustainability of project benefits.

8. Seek to develop a consensus on key findings and recommendations with the rest of the MTE team members.

9. (If feasible) Debrief project, SC, MOH, and USAID staff re. the MTE.

10. Write the report of the MTE (submitting a complete draft of the report to SC for comment by October 15, 2000).

Attachment 4 MTE team composition

#	NAME	TITLE / ORGANIZATION
Core MTE team		
1.	Dr. Marc Debay	Team Leader
2.	Dr. Eric Starbuck	Child Survival Specialist, Office of Health, Save the Children-USA
3.	Ms. Della Dash	Child Survival Technical Advisor, USAID/BHR/PVC /CSH
4.	Dr. Samir Khamis	SC/Minya Office, Program management and CS-14 project manager
5.	Ms. Samaa Sayed	SC/EFO Technical Unit located in Minya, Training & Institutional Development Officer
6.	Mr. Wael Zaki	SC/Minya Office, CS-14 team leader
Extended MTE team		
7.	Mr. George Aiad	SC/Minya Office, CS-14 field coordinator
8.	Ms. Gihan Shawkhy	SC/Minya Office, CS-14 field coordinator
9.	Mr. Mahmoud El-Shaal	SC/Minya Office, CS-14 field coordinator
10.	Mr. Mohamed Nagi	SC/Minya Office, CS-14 field coordinator
11.	Ms. Mona Aid	SC/Minya Office, CS-14 field coordinator
12.	Ms. Reham Osama	SC/Minya Office, CS-14 field coordinator
13.	Dr. Seham Yasain	SC/Minya Office, Health Officer
14.	Mr. Kotb	LU coordinator, Talla CDA
15.	Mr. Adel	LU coordinator , Zohra CDA
16.	Mr. Ali	LU coordinator, Samalout El-Balad CDA
17.	Mr. Aiad	LR supervisor, Bayahoo CDA
18.	Mr. Osama	LR supervisor, El Amoudain CDA
19.	Ms. Salwa	LR supervisor, El Massarah CDA
20.	Dr. Medhat	MOHP-Minya Governorate, Deputy Director, MCH
21.	Mr. Aziz	Coordinator, Red Crescent
Additional resources persons		
22.	Mr. Ahmed Farouk	SC/Minya Office, financial manager
23.	Mr. Attalah Khuttab	SC/EFO, Director
24.	Mr. Hazem Shawky	SC/EFO, Financial manager
25.	Dr. Omnia	MOHP
26.	Dr. Helda	MOHP

Attachment 5 MTE program

DAY	TIME	AGENDA
Tue 29/8	19:00	Arrival of MTE external team members and two USAID/Cairo officials to Minya
	20:30-22:30	Project presentation meeting with CS-14 staff and key partners representatives
Wed 30/8	09:00-10:30	Planning meeting with SC/Minya and CS-14 staff: MTE participative process and team composition
	11:00-03:30	**Field visit in Taha-El Ameda**: clinic (health workers) and the LR CDA (supervisor and CHWs)
	04:00-06:30	Recap meeting with USAID/Cairo officials
Thur 31/8	09:00-11:00	Planning meeting with SC/Minya and CS-14 staff: MTE guidelines
	11:15-12:45	Visit to CDA LU Visioning Exercise and Positive Deviance training
	13:00-14:00	Meeting with MOHP officials in Minya
	14:30-17:00	Partners meeting to present MTE guideline and set Friday work plan
	17:00-18:00	Recap meeting with SC CS-14 staff and identification of the core MTE team (Marc, Eric, Della, Samir, Samaa, Wael)
	21- 23:30	Planning meeting of the core MTE team: Guidelines for group work
Fri 1/9	09:30-15:00	Entertainment: A trip to Tall El-Amarna organized by the partners
	17:00-17:45	Planning meeting: work group composition and discussion topics
	18:00-21:30	Group work 1 on the ***Technical Approaches*** of CS-14
	22:00-23:00	Plenary for brief reporting of the group work and for setting the work plan for Saturday
Sat 2/9	11:00-11:45	Planning meeting: work group discussion topics
	11:45-16:00	Group work 2 on the ***Cross-cutting Approaches*** of CS-14
	16:00-16:45	Planning meeting: work plan for Sunday and LU visits schedule
	17:15-19:30	Meeting of CS-14 seven staff members and MTE external team
	21:00-22:00	Presentation of USAID BHR/PVC/CS program and its international resources by Della Dash for CS-14 staff.
Sun 3/9	09:00-10:30	Planning meeting: work group discussion topics and composition, site visits
	10:45-13:00	Group work 3 on the ***Program Management*** of CS-14
	14:00-15:30	Plenary meeting: work group reporting on cross cutting and program management, setting a preliminary field visit plan for Monday to Wednesday, and group composition for field visits

DAY	TIME	AGENDA
	16:00-17:00	Review of the product of the group work from the three sessions to identify the data needs and their sources (field visits or office documents)
	17:00-18:30	Group work: development of data collection tools for health facilities, CDAs LU & LR, and CHWs & mothers
	18:30-19:40	Presentation and discussion of evaluation tool for the LU CDAs
	20:30-22:30	**Field visits to Talla & Zohra**: LU CDAs
Mon 4/9	09:00-11:00	Group work: finalizing the data collection tools
	11:30-15:30	**Field visits in Bayhoo:** • Health Facilities: Bayhoo integrated health hospital, Itsa El Mahata and Itsa El Balad health unit. LR CDA: Bayhoo board and CS-14 supervisor CHWs: Bayhoo and Itsa ElBalad.
	16:00-18:00	Plenary meeting: sharing results from interviews and experiences with the data collection tools; finalizing the site visits schedule and team composition for Tuesday
	18:00-19:30 19:30-23:00	Group work: revising the health facilities data collection tool and designing a tool for the CHW coordinator; cleaning up the field notes
	20:30-22:30	**Field visit in El Ameda**: LR CDA
	09:00-10:30	Discussion about Health Information System with SC/Minya Health Officer
	11:00-14:30	**Field visit in Taha:** HF: Taha health group CHW: CHW coordinator and mothers
	11:00-15:00	**Office work at SC/Minya**: documents review and translation
	16:30-18:00	Sharing results from field visits & office work
	18:15-19:30	Planning meeting: the last two days of the MTE (Wed and Thur)
	20:00-22:00	Preparation of logistics for MTE synthesis meeting
Wed 6/9	10:00-15:00	**Field visit in Samalout**: DHMT meeting, Samalout health center, CHW (one focus group for CHWs and one for mothers)
	10:30-16:00	**Office work at SC/Minya**: Finalizing document review and translation
	16:00–17:00	Sharing results from field visits and office work
	18:00-19:00	Finalizing logistics for the MTE synthesis meeting
	19:00-23:30	Preparing MTE synthesis meeting: presentation of preliminary findings and recommendations
Thur 7/9	09:00-16:15	**MTE synthesis meeting**
	16:15-17:15	Final meeting with MTE external team members and SC staff
	18:00	Departure of the MTE external team

Attachment 6 Group discussion topics and composition

GROUP 1	GROUP 2	GROUP.3
Discussion topics: Technical and cross-cutting approaches		
MNC Strengthening Partner Organizations, Sustainability	PCM, CDD Community Mobilization BCC	Immunization, Nutrition Training Health Facility Strengthening Health worker performance
Group composition		
MOHP: Medhat Field coordinators: Mona, Mahmoud CDA LR: Ousama CDA LU: Ali Red Crescent: Aziz Save Management: Sama External: Marc	MOHP: Holda Field coordinators: George, Riham CDA LR: Aiad CDA LU: Adel Save Management: Samir External: Eric	Field coordinators: Gihan, Mohamed CDA LR: Salwa CDA LU: Kotb Save management: Wael External: Della

GROUP 1	GROUP 2
Discussion topic: Program Management	
Planning Human Resources Supervision Staff Training Capacity Building of RC	Financial Logistics Technical & Administrative Support
Group composition	
MOHP: Medhat Field Coordinator: Mona, Mahmoud, George LR CDA: Ausama LU CDA: Ali, Adel RC: Aziz SC/Minya: Sama, Seham External: Eric	MOHP: Omnia Field Coordinator: Reham, Gihan, Mohamed LR CDA: Salwa, Aiad, Kotb SC/Minya: Samir, Wael, Seham External: Marc

Attachment 7 Site visits group composition and interviewees

DATE	SITE	GROUP COMPOSITION	INTERVIEWEES
3/9	Tallah LU CDA	Marc, Samaa, Nagy, Reham	LU CDA Board Members
3/9	Zohra LU CDA	Eric, Samir, Wael, Mahmud,George, Mana	LU CDA Board Members
4/9	HF El Bayhoo	Marc, Samir, Wael, Medhat	Dr Abdallah MCH ward Ebrahim
4/9	HF Etsa Albald	Samir, Mana	Dr Abdellah MCH nurse: Fatma Abd Elfadil
4/9	Al Bayhoo	Eric, Seham, George, Gehan	CHW: Monira,Esha, Hanaan
4/9	Etsa Albald	Eric, Seham	CHW: Mansoura-Amna-Zeinab
4/9	Al Bayhoo	Sama, Nagy	CDA Board Members
4/9	Taha	Marc, Medhat, Reham, Iman	LU CDA El Fath Al Amadin
4/9	(Al Bayhaa) Itsa Al Mahta	Marc, Medhat, Wael, Samaa, Nagy	Dr AhmEd Eliwa , MCH Nurse Hania Abd Elhamid
5/9	Taha	Samir, Reham	Nemot Abd Elkafy Ibrahim
5/9	Taha	Nagy, Reham	7 Mothers
5/9	Taha	Seham, Nagy	2CHWs; Laila – Eman
5/9	Taha	Eric, Samaa, Sayd, Mahmud Yaussif, Medhat, Atto, Mana Eid	Dr Khalil, MCH nurse Zeinb Abd Elfatah
6/9	LR CDA El Maasara	Nagy, Marc, Seham	6 mothers
6/9	LR CDA El Maasara	Reham, Seham	CHWs coordinator Mana Gamaa
6/9	LR CDA El Maasara	George, Medhat	CHWs
6/9	LR CDA El Maasara	Marc, Seham, Medhat, George, Reham	Medical Center

Attachment 8 Major CS-14 activities by month, October 1998 – August 2000

Activity	1998			1999												2000							
	Framework Development (10 months)										Model Development (18 months)												
	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8
Formation of CS-14 Advisory Committee (9/98)	←																						
CS-14 office space rented, equipped, and furnished	X																						
SC CS-14 staff hired (11/01/98)		X																					
Selection of 5 CS-14 Phase II & III areas			X																				
Baseline assessments & writing of DIP					X	X																	
Selection of 3 CDAs for Phase II						X																	
Formation of Health Action Committees								X															
Training of 3 CS-14 CDAs										X													
Selection of CHWs					X	X	X																
Training of CHWs (see note below)							1		2							3					4	4	
Monthly home visits by CHWs										X	X	X	X	X	X	X	X	X	X	X	X	X	X
Formation of District Health Management Committee			X																				
Meetings of District Health Management Team									X			X				X		X		X			
Training of MOHP health facility staff												X	X										
MOHP facilities receive CS-14 equipment/supplies														X		X				X			
Midterm evaluation team in Minya (8/30 – 9/7)																							→

CHW Training Course:

1. 3 day training in communications skills
2. 3 day CDD training
3. 6 day training in ARI, ANC, EPI, and nutrition
4. 2 days (total) refresher training (2 one day programs)

Attachment 9 Selected health services statistics in the three CS-14 project areas

1. New and registered antenatal visits and TT immunizations in the three CS-14 project areas during the periods January-June 1998 and 2000

Area	1998				20000			
	New	Dangerous	Registered	TT immunization	New pregnant	Dangerous	Registered	TT immunization
Taha	580	253	545	682	557	298	2385	766
El Bayhoo	483	195	621	564	590	200	1902	787
El Maasara Shark	254	90	221	313	520	180	770	1048
Total	1317	538	1387	1559	1667	678	5057	2601

2**. Total, type of attendance, and place of deliveries in the three CS-14 project areas during the periods January-June 1998 and 2000**

Area	1998								2000							
	Total	Type of attendance				Place			Total	Type of attendance				Place		
		TBA	Doctor	Nurse	Other	Home	Clinic	Other		TBA	Doctor	Nurse	Other	Home	Clinic	Other
Taha	773	452	196	100	25	632	66	75	733	391	230	81	31	563	88	82
El Bayhoo	768	460	174	94	40	613	123	32	793	398	202	180	13	615	130	48
El Maasara Shark	261	156	75	30	-	217	31	13	286	188	85	13	-	193	64	29
Total	1802	1068	445	224	65	1462	220	120	1812	977	517	274	44	1371	282	159

3. Registered ARI and pneumonia cases in the health units in three CS-14 project areas during the periods January-June 1998 and 2000

Area	1998			2000		
	ARI	Pneu.	ENT	ARI	Pneu.	ENT
Taha	1067	179	163	1140	144	160
El Bayhoo	600	194	62	1005	166	80
El Maasara Shark	41	13	28	105	20	85
Total	1708	386	253	2250	330	325

4. Registered cases of diarrhea and dehydration and number of ORS packets distributed in health units in the three CS-14 project areas in the periods January-June 1998 and 2000

Project Area	1998			2000		
	Diar.	Dehyd	ORS pckts	Diar	Dehyd	ORS pckts
Taha	690	134	6770	720	114	4736
El Bayhoo	724	281	7050	734	253	5698
El Maasara Shark	146	38	1460	67	11	670
Total	1560	453	15280	1521	378	11104

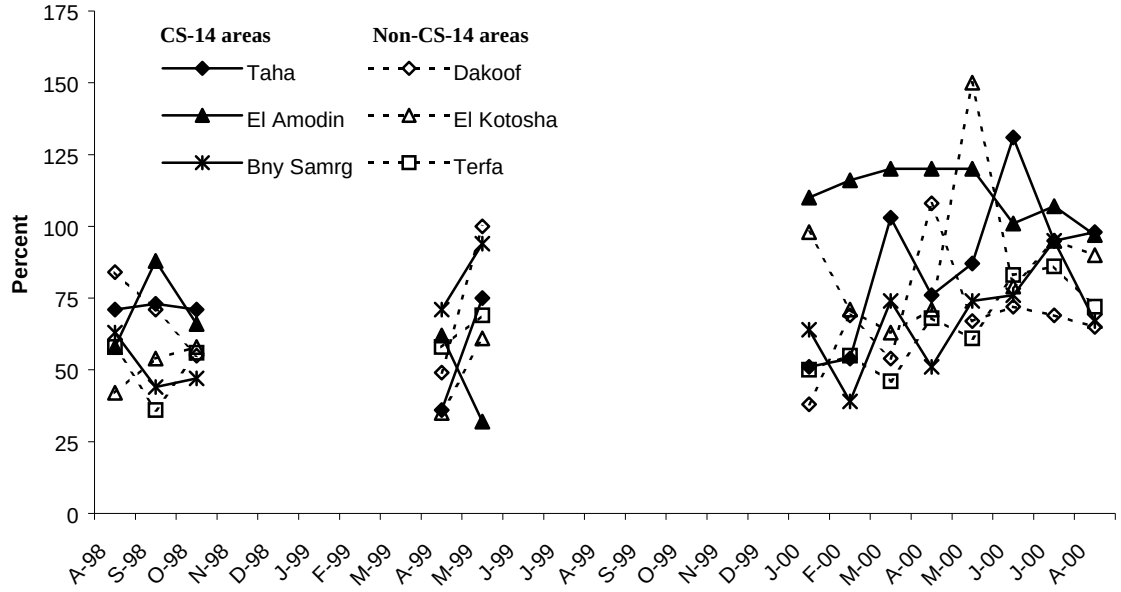
5. Immunization (DPT3 and OPV3) coverage in the three CS-14 areas in the periods January-June 1998 and 2000

Project Area	1998		2000	
	OPV3	DPT3	OPV3	DPT3
Taha	98%	98%	100%	99%
El Bayhoo	96%	96%	99%	99%
El Maasara Shark	87%	86%	98%	98%
Total	97%	93%	99%	99%

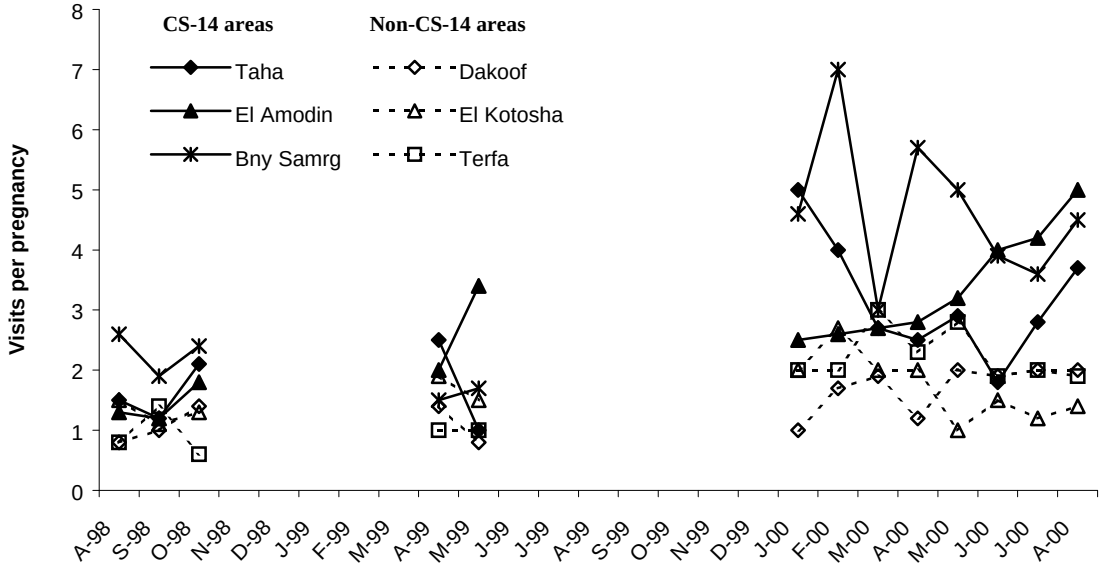
Source: Samalout Health District, MOHP

Attachment 10 Antenatal services utilization in three CS-14 and three non CS-14 areas of Samalout District, 8/1998-8/2000

1. Coverage of pregnant women



2. Number of visits per pregnancy



Source: Data collected from MCH register by MTE team during visit in Samalout Health District, MOHP. Data for some months were not collected because of lack of time.

Attachment 11 Key messages by technical interventions

Maternal and Newborn Care (MNC)

Key Message 1:
Visit the health unit to have the highly trained nurse and doctor take good care of your pregnancy needs, through helping you to get your TT shot, examine you, and provide you with your personal Follow-up Card.

Key Message 2:
In order to be healthy, and your pregnancy and delivery be safer, you should eat a balanced integrated and affordable meal; meaning a meal that contains three items together: one that make your pregnancy grow (such as…), another that make you active and agile (as…), and one that protects your body from diseases (as…)

Key Message 3:
We are here to serve you and meet your pregnancy information needs.
Do : wear wide clothes, get enough sleep, etc.
Don't: Carry heavy loads, peel nipples scabs with your hand (visit the doctor), etc.

Key Message 4:
When you suspect or recognize any of the pregnancy/delivery danger signs (swollen legs, bleeding or discharge, persistent headaches, etc.), visit the health unit's doctors that you trust, for personal counseling and examination.

Key Message 5:
It's wise for your health and your new baby's health to visit the health unit doctor to provide you both with comprehensive post-partum care (immediate breastfeeding, postpartum/newborn danger signs, birth planning).

Pneumonia case management

Key Message:
It's important to save your child and protect his health, and learn how to early recognize pneumonia and other severe infections, you must promptly visit the doctor to provide appropriate care and learn how to care promptly

Control of Diarrheal Diseases
Key Message 1:
It's important to protect your child's health and learn how to early recognize dehydration, dysentery, and persistent diarrhea, and learn how to care promptly to save her/his life, (ORS preparation and use, continued breastfeeding, other DO and DON'T.)

Key Message 2:
When your sick child has these serious signs (Diarrhea over three days, vomit more than four times/hour, has fever,...) you must promptly visit the doctor to provide appropriate care.

Nutrition

Key Message 1:
In order for your child to grow, play, and be healthy, you should feed her/him a balanced integrated and affordable meal; meaning a meal that contains three items together: one that make her/him grow (such as…), another that make him/her play and agile (as…), and one that protects his body from diseases (as…)

Key Message 2:
Your child health and nutrition is better ensured through maintaining good child-care and health-care practices (as…)

Immunization

Key Message:
Complete and timely immunization of your child will protect her/him from serious but preventable diseases.

Attachment 12 Partner's roles and responsibilities in CS-14

First: The Project LR CDA supervisor

- Monitoring the CHWs' work through field follow-up visits (at least four field visits to the project villages a month) to follow-up their home visits.
- Selection of CHWs in coordination with CDA board and Sc.
- Periodically Presentation of the project activities to the CDA board.
- Coordination with the CDA to overcome any constraints and problems that may the CHWs and the coordinator face during their work.
- Coordination in preparing training workshops and meetings to exchange experiences with the LU CDA training coordinator.
- Accessing the effect of the project in the community.
- Participating in identifying the health committee members arranging for holding periodical meetings and writing reports to be presented to the central committee.
- Coordination with the board in participating in supervising the emergency funds.
- Preparing the reports and the monthly plans to the whole project activities in coordination with the project CDA coordinator, presenting them to the board, sending a copy of them to SC and keeping a copy in CDA file.
- Preparing all the project files in the CDA (administrative, Financial, activities)

Second: The project LR CDA coordinator

- Field Monitoring of the CHWs through preparing a monthly plan to monitor the CHWs through gathering there home visits monthly plans, reports, and through assessing the performance – review of their home visits registers.
- Preparing and coordinating with the CHWs to prepare for meetings with SC coordinators and writing reports of these meetings.
- Visiting the health visits to know how far the coordination between the CHWs and the Health Units is.
- Coordination and Coordination between LU CDA training coordinators and the project supervisor in the LR CDA in preparing the monthly plan.
- Presenting the problems and constraints the CHWs face during their work to the SC Coordinators and the CDA project supervisor.
- Training of new CHWs on the Health messages and the ways of communicating them in cooperation and Coordination with a coordinating.
- In forming the CHWs about the urgent meetings whenever needed in Coordination with the CDA supervisor.
- Preparing the project Fields in cooperation and Coordination with the CDA supervisor. These files are for [CHWs meetings – Finance and administration – Meetings between the emergency fund and the Health Committee - Reports and monthly plans – Letters: IN\Out – Files of recruiting CHWs].

Third: The LU CDA training Coordinator

- Monitoring the CHWs' performance to identify their training needs at least six times a month through [the monthly plans – the monthly reports].
- Assessing the training needs periodically [CHWs – CDA board].
- Assessing, Preparing and Implementing the CHWs and CDA board training programs.
- Monitoring of the CDA files and register in coordination with the CDA supervisor.
- Coordinating with the CHWs coordinator and CDA supervisor to prepare and present the monitoring monthly plan – the monthly plan of what have been accomplished.
- Preparing for meetings of the CDA board with SC.
- Motivating of the LR CDA through encouragement, meetings and exchanging experience visits from four to six times a month.
- Training of new CHWs in Coordination with LR project coordinator.
- Attending Health committee meeting.

Fourth: Save the children roles and responsibilities

- Field monitoring of the CHWs through [reports – plans – data and statistics – coordination with health unit – performance a assessment meeting].
- Coordination with CDA coordinator and CHWs the transportation allowance monthly.
- Coordination with the CDA board in selecting the new CHWs.
- Supervising the preparation and implementation of the CDA board members and CHWs trainings.
- Monitoring of the CHWs coordinator in the CDA through [reports – plan – statistics – coordination between the health offices – meetings – performance assessment].
- Cooperation and Coordination with the CDA supervisor in [problem – solving – presenting the project activities to the CDA board – preparing the monitoring plan].
- Monitoring of the LU CDA Training coordinator in [the monthly plan for monitoring CHWs – the monthly plane for exchanging experiences visits with the LR CDA - the quarterly plane for assessing the training needs – preparing the suggested financial plan for training].
- Supervising the extended of coordination between LU CDA training coordinator and LU CDA supervisor and CHWs supervisor and CHWs coordinator.
- Coordination between SC consultants, LU CDAs and LR CDAs in providing the technical support.
- Coordination between SC projects for improving the complementation of the project.

Attachment 13 List of equipment provided to health facilities

No	Type	Total No	Taha village council					Bayhoo village council								Medical center
			Taha	Ameda	Bani smrg	hasan	total	byho	Itsa	Itsa	Shaa	Hath	Galaa	Aways	Totl	
1	Nebulizer 3 speeds	12	1	1	1	1	4	1	1	1	1	1	1	1	7	1
2	Centrifuge	7	-	-	1	-	1	-	-	1	1	1	1	1	5	1
3	Brick pin (box)	40	3	3	5	3	14	4	4	4	2	2	2	3	21	5
4	Tongue depressor (box)	80	6	6	10	6	28	5	5	4	4	4	4	4	30	22
5	Paterry thermometer	12	1	1	1	1	4	1	1	1	1	1	-	1	6	2
6	Thermometer	60	5	5	5	5	20	4	4	4	4	4	4	4	28	12
7	Tongue depres. Holder	12	1	1	1	1	4	1	1	1	1	1	1	1	7	1
8	Sphygmomanometer	3	-	-	1	-	1	-	-	-	1	-	-	-	1	1
9	Surgical gloves (box)	8	-	-	2	-	2	1	0.5	0.5	0.5	0.5	0.5	0.5	4	2
10	Disposable gloves (box)	60	5	5	5	5	20	6	6	5	5	5	5	6	38	22
11	Test tubes	400	-	-	50	-	50	30	29	29	28	28	28	28	200	150
12	Centrifuge test tubes	120	-	-	20	-	20	12	12	11	10	10	10	10	75	25

No	Type	Total No	Taha village council					Bayhoo village council								Medical center
			Taha	Ameda	Bani smrg	hasan	total	byho	Itsa	Itsa	Shaa	Hath	Galaa	Aways	Totl	
13	Slides (box)	20	-	-	2	-	2	3	3	2	1	2	1	2	14	4
14	Slides cover (box)	20	-	-	2	-	2	3	3	2	1	2	1	2	14	4
15	Stick for sugar analysis	24 box	2	2	2	2	8	3	3	1	1	1	1	2	12	4
16	Benedict solution (leter)	5	0.5	0.5	0.5	0.5	2	0.5	0.25	0.25	0.25	0.25	0.25	0.25	2	1
17	Coolman	2	-	-	1	-	1	-	-	-	1	-	-	-	1	-
18	Silk threads (roll)	8	-	-	2	1	3	1	1	1	-	-	-	1	4	1
19	Needle (dozen)	12	1	1	1	1	4	1	1	1	0.5	1	0.5	1	6	2
20	Dissectors (box)	12	1	1	1	1	4	1	1	1	0.5	1	0.5	1	6	2
21	Jars	4	-	-	-	-	-	1	1	1	1	-	-	-	4	-
22	Tube holder	16	-	1	1	1	3	3	2	1	1	1	1	1	10	3
23	Forceps holder	12	1	1	1	1	4	1	1	1	1	1	1	1	7	1
24	Stethoscope	3	-	-	1	-	1	-	-	-	1	-	-	-	1	1
25	Scales	4	-	-	1	-	1	1	-	-	1	-	-	1	3	-

Attachment 14 CS-14 staff in Cairo and Minya

CS-14 Cairo staff

NO	NAME	POSITION TITLE	PERIOD	TIME %
1	Jerry Sternin	FOD	10/98-3/99	5
2	Golda El-Khoury	FOD	3/99-4/99	5
3	Attalah Khuttab	FOD	5/99-9/99	5
4	Attalah Khuttab	FOD	10/99-8/00	18
5	Hazem Shawky	Finance & Admin Manager	10/98-9/99	10
6	Hazem Shawky	Finance & Admin Manager	10/99-8/00	18
7	Mohamad Safwat	Admin Officer	10/98-9/99	5
8	Mohamad Safwat	Admin Officer	10/99-8/00	18
9	Samahar Momtaz	Accountant	10/99-8/00	18
10	Farouk Salah	MIS	10/99-8/00	18
11	Said Ibrahim	Driver	10/99-8/00	18
12	Zakaria Abdel-Fattah	Office Boy	10/99-8/00	18

CS-14 Minya staff

NO	NAME	POSITION TITLE	HIRE DATE	TIME
1	Dr. Samir Khamis	Minya Director	15/9/99	50%
2	Wa'el Hoseen Zaki	Team Leader	1/11/98	100%
3	Mahmoud Yoseef	Field Coordinator	1/10/99	100%
4	Reham Usama	Field Coordinator	1/11/98	100%
5	Mohamad Nagi	Field Coordinator	1/2/99	100%
6	Mona Eid	Field Coordinator	1/11/98	100%
7	George Wahba	Field Coordinator	1/11/98	100%
8	Gihan Shawki	Field Coordinator	1/11/98	100%
9	Ahmed Farouk	Accountant	1/11/98	50%
10	Howida Hosni	Admin Assistant	7/11/99	50%
11	Abdel-Fattah Mohamad	Driver	1/11/98	100%
12	Yehia Hassan	Driver	7/11/99	50%
13	Zeen Abdel-Salam	Office Helper	1/11/98	50%
14	Sayed Mohamed	Office Helper	1/11/98	50%