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THE LIFE CYCLE HEALTH EDUCATION PROJECT
in
JERUSALEM, WEST BANK, AND GAZA

Mid-Project Evaluation
(Focusing on Impact and Institutionalization)

Prepared for Catholic Relief Services

by

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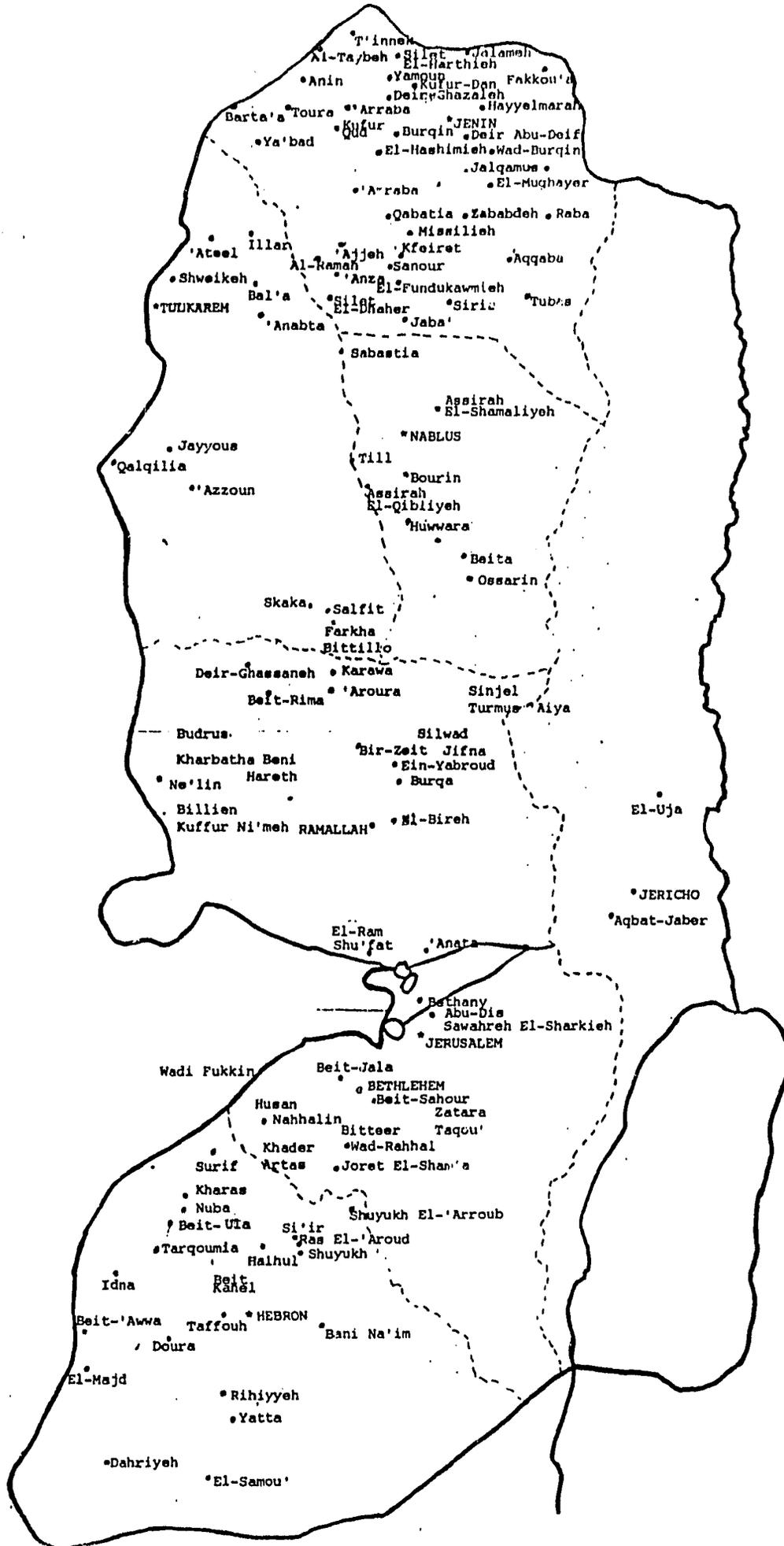
CONTENTS

Map	
I. EXECUTIVE SUMMARY	1
Basic Project Identification Data	4
II. SUMMARY OF MAJOR CONCLUSIONS AND RECOMMENDATIONS	
Achievement of Project Objectives	5
Impact	8
New Strategy for Institutionalization	10
III. PROJECT SETTING AND BACKGROUND	
The Setting: West Bank and Gaza	12
Health Status and Services	15
Project Description and Background	19
IV. ACHIEVEMENT OF PROJECT OBJECTIVES	
Project Objectives and Strategy	24
The "Health Education Objective": West Bank	26
The "Institutionalization Objective": West Bank	39
Reduced Distribution of PL480 Food Commodities	43
Gaza	45
V. IMPACT AND IMPACT MEASUREMENT	
Health Impact	46
Spread Effect	57
Impact on Women	58
Other Development Impact	60
VI. INSTITUTIONALIZATION: SUSTAINING PROJECT ACHIEVEMENTS	
Essential Elements for Institutionalization	61
Are PL-480 Food Commodities Essential?	65
Is "Institutionalization" of the Project Feasible?	67
A New Strategy for Institutionalizing Health Education	72
Additional Personnel Matters	78

APPENDICES

A. Acronyms and Arabic Terms	82
B. Logframe: West Bank	83
Logframe: Gaza	90
Statement of Work (Narrative Accompanying Logframe)	94
C. Life Cycle Curriculum, Table of Contents	97
D. Health Education Centers in the West Bank	99
E. In-service Training and Seminars	100
F. PL-480 Commodities and Teachers' Pay	101
G. CRS Questionnaire Administered to Women Before and After Health Education	105
H. Scope of Work for This Evaluation	106
I. Methodology for This Evaluation (& Interview Guide)	108
J. Key People Interviewed	113
K. References	119

MAP OF WEST BANK SHOWING CRS-ESTABLISHED HEALTH EDUCATION CENTERS



MAP OF REGION



- * JERUSALEM: (2 centers)
 - Sapfford
 - Greek Catholic.
- * HEBRON : (2 centers)
 - Hebron Ladies
 - Red Crescent.
- * NABLUS : (2 centers)
 - Nablus Community Center
 - Cultural Club.
- * TULKAREM : (2 centers)
 - Red Crescent
 - Dar El-Yatim.
- * JENIN : (3 centers)
 - Asdika' El-Marid
 - Red Crescent
 - Jenin Charit.Soc.

WEST BANK AND GAZA: LIFE CYCLE/HEALTH EDUCATION PROJECT
EXECUTIVE SUMMARY

Problem and Overview. The poverty that characterizes the West Bank and Gaza Strip predisposes to a multiplicity of social and health problems. Infant mortality remains high (probably about 70 to 75/1000 live births), with the chief causes of child mortality being diarrheal diseases and acute respiratory infections. Under Israeli military occupation since 1967, the combined Palestinian population of the West Bank, Gaza Strip, and Arab East Jerusalem is now about 1.5 million. The setting is radically different from most situations in which AID and CRS work, as there is no indigenous "host country" government providing health or other services to the local population. Health services are provided instead by three major sources: (1) UNRWA; (2) the Israeli government; and (3) the private sector, including individuals and private voluntary organizations (PVOs). In the majority of Palestinian villages, however, there is no health care provider at all, referral from the primary health care level to secondary or tertiary care facilities is erratic, and many children and pregnant women do not reach the health system for systematic surveillance. Under the current situation, it will be many years before modern health service coverage can be expected to reliably reach the poorest and most remote villages. Under such circumstances, maternal education remains a major hope for improving the survival of young children and the health of rural families.

U.S. Development Assistance to the West Bank and Gaza is provided through eight private voluntary organizations, including Catholic Relief Services (CRS). The Agency for International Development (AID) has no bilateral assistance program and no AID mission.

The Life Cycle/Health Education Project. Origins of this project go back to 1961 when Catholic Relief Services (CRS) began distributing PL-480 food commodities in Jordan and to Palestinian villagers on the West Bank of the Jordan River who had lost much of their land when the state of Israel was founded. In 1975, CRS, to enhance the impact of its food distribution, began a Nutrition Education Project funded by a grant from AID. The project goal was to improve the health of poor village mothers and young children through better dietary practices. CRS trained instructors who in turn trained village women as teachers who then held classes for mothers in their respective villages and monitored the growth of their young children. PL-480 food commodities were distributed to the participating mothers. Through a follow-on project, Health Education (1979-85), CRS added knowledge in hygiene, child development, and first aid to what has become known as "the CRS Health Education Program."

The Life Cycle/Health Education Project began in February, 1985 with a planned completion date of January 31, 1988. The overall goals remain the same but the emphasis has changed to include expansion of services and "institutionalization" of the program. The project goal is stated as "to develop programs to improve the

health of Palestinians in the West Bank and Gaza." The stated project purposes are: (1) the "health education objective"--to assist Charitable Societies [village organizations] in creating awareness, increasing knowledge, influencing attitudes, and fostering adoption of appropriate preventive health behavior; and (2) the "institutionalization objective"--to transfer to a Palestinian organization (the Union of Charitable Societies) financial and management responsibility for continuing the Health Education Program after the Life Cycle Project has ended. The project is funded by an AID grant (AID/NEB-0159-G-SS-5065-00) of \$1,521,249.

Purpose and Methodology of the Evaluation. This evaluation was conducted at mid-project to: (1) assess the process of institutionalization (transfer of the project to a local organization); (2) judge the quality and analysis of impact data being collected; and (3) make appropriate recommendations. An additional purpose of this report is to provide a comprehensive overview of the project from which both CRS and AID can derive "lessons learned" to use in designing and implementing other projects. Methodology consisted of site visits, observation of the data collection process, interviews, and document and data analysis.

Major Findings

1. General conclusion. There is suggestive evidence that the Life Cycle/Health Education Project may be one of the most successful AID-supported projects in the Near East and perhaps anywhere. With its focus on maternal child health and child survival, it may be one of the most successful primary health care efforts and it may be one of the most successful projects in terms of beneficial impact on women. Systematic quantified data is not yet available or at a sufficient state of analysis to confirm this definitively, but may be by the end of the project. The program is by far the most extensive primary health care initiative on the West Bank. Whether it can be sustained after the end of this project is uncertain but may be possible.

2. Achievement of the "health objective." The project is definitely meeting its "health education objective." On the West Bank, most quantitative training and teaching targets have been met ahead of schedule or will be met before the end of the project. The quality of these "outputs" and the new knowledge they offer to thousands of village mothers throughout the West Bank are widely admired by everyone familiar with the project.

3. Achievement of the "institutionalization objective." There has been little progress here, largely because of financial and political constraints facing Palestinian organizations on the West Bank. The Union of Charitable Societies in Nablus has just now agreed to take over the program in the northern region of the West Bank. The Nablus Union appears to have the will, although not presently the means, to sustain a quality program.

4. In Gaza, CRS has made some progress, but is far from having an impact or a program to institutionalize.

5. Health Impact (West Bank). Observations and questionnaire data suggest that the project has improved mothers' health knowledge and actually changed health behaviors, but firm data to confirm and quantify project impact on health status are not now readily available. With changes in the data-collection system, such information may be obtained before the end of the project.

6. The CRS questionnaire designed to measure impact provides useful information, but not reliable data as to changes in health status attributable to the project.

7. Criticisms concern chiefly the project's provision of PL480 food commodities and inadequate linkages with the medical system.

Project Design and Policy Implications. The overall time-frame for a project involving behavior change must be longer than just three years or so. The success observed here is the result not of a brilliant initial project design, but of persistence over a decade to elicit community participation and to improve the product being offered. Important lessons regarding project sustainability are in the making.

Major Recommendations

1. Make "institutionalization" the first priority. Initiate immediately a new strategy for transferring the program to the Union(s) of Charitable Societies, based on the following:

- a. A sub-contract to one or more of the three Unions of Charitable Societies, beginning with the Nablus Union;
- b. A no-cost extension (minimum one year) by AID;
- c. The hiring of a Palestinian program manager responsible for "institutionalization";
- d. Technical assistance to the Union(s), facilitated by CRS, for management skills and related training; and
- e. Gradual phase-out of PL-480 food commodities by the end of the Life Cycle Project (as extended).

2. Curriculum and training materials. Proceed vigorously to produce printed materials for use under the Union(s) and by other primary health care providers in West Bank, Gaza, and elsewhere.

3. The questionnaire. Design a new questionnaire and supplement this with other data collection techniques.

4. Gaza. Respond if requests come from other organizations, but no longer invest energy in trying to initiate activities in Gaza.

Evaluation Team: Barbara Pillsbury, Ph.D. (team leader); Larry Afifi, R.N. Ph.D.; Sally Stansfield, M.D. Report dated March 1987.

BASIC PROJECT IDENTIFICATION DATA

1. "Country": West Bank and Gaza Strip
2. Project title: Life Cycle/Health Education Project
(Catholic Relief Services, Jerusalem/West Bank/Gaza)
3. AID project number: 298-0333 (298-0159.19)
Grant no. AID/NEB-0159-G-SS-5065-00; CRS/JWB 4D/004)
4. Mode of implementation:
 - * Grant to Catholic Relief Services, implementation by CRS staff based in Jerusalem
 - * Local counterpart agency: Department of Social Welfare, Government of Israel
5. Project duration: Three years
Starting date: February 1, 1985
Planned end date: January 31, 1988
6. Funding:

AID grant	\$1,521,249
CRS	199,000
Local community contributions	195,300
GOI (customs & tax exemptions)	61,000
Total	\$1,915,610
7. Evaluations:
 - * Ongoing monitoring and collection of baseline and impact data, but no previous evaluation.
 - * End-of-project evaluation of preceding grant (see "Final Evaluation of Health Education Project CRS/JWB 79/2 Grant No. AID/NE-G-1652," May 1, 1985).
 - * Evaluation of Health Education Project (by Anne Hammond Roberts), June 21-July 11, 1983.
8. Responsible personnel:

For CRS:

 - Sr. Barbara Cline, Health Education Project Director, 1980-1984; CRS JWB/Director (Country Rep.) 1984-1986.
 - Mr. Daniel Carr, Project Director, 1984 - present.
 - Mr. Joe Curtin, CRS/JWB Acting Representative, 1987.
 - Ms. Grace Hauck, Contract Administrator, CRS/NY

For AID: Kristen Loken, ANE/TR/HPN (no AID mission).
9. Direct beneficiaries to date: 11,864 children & mothers.
Total direct beneficiaries of CRS/Jerusalem/West Bank/Gaza Health Education Program: 65,464 children & mothers.
10. Currency exchange rates (as of February 1, 1987)
Two forms of currency are used on the West Bank and in Gaza: the Jordanian dinar ("JD") and the Israeli sheqal
 - 1 JD = approximately \$US 3; \$US 1 = .35 JD
 - 1 Israeli sheqal = appr. \$US .60; \$US 1 = 1.6 Israeli sheqal
 - 5 Israeli sheqals = 1 JD.

Part II

SUMMARY OF MAJOR CONCLUSIONS AND RECOMMENDATIONS

I. GENERAL CONCLUSION

The Life Cycle/Health Education Project is an excellent primary health care project which concentrates on maternal/child health and child survival. There is strong suggestive evidence this project may well be one of the most successful AID-supported projects in the Near East, and perhaps anywhere. It may be one of the most successful primary health care efforts and one of the most successful projects in terms of beneficial impacts on women. The project has also had a significant "spread effect," or positive impact beyond its immediate beneficiaries. Systematic quantified data is not yet available or at a sufficient state of analysis to confirm this definitively, but may be by the end of the project.

The Health Education Program supported by the project is popular and has generated a high level of good will throughout the West Bank and Gaza toward its sponsor(s). This is a major accomplishment in the political setting in which it operates. What criticism there is concerns chiefly the provision of PL 480 food commodities and inadequate linkages with the medical system.

Whether this extensive program can be "institutionalized"--sustained by local Palestinians--after the end of CRS involvement is less certain.

Major Recommendation: CRS should make "institutionalization" its first priority from now until the end of the project if successes achieved to date are to be sustained.

II. ACHIEVEMENT OF PROJECT OBJECTIVES

1. Achievement of Project Goal. On the West Bank, the Life Cycle Project is definitely having a widely appreciated impact and is clearly meeting its overall goal: "to develop programs to improve the health of Palestinians on the West Bank of the Jordan River and in Gaza." This project has resulted in a successful health education program that is the most extensive preventive health program and network on the West Bank and the only village-based child survival effort that extends throughout the West Bank. Many other local health care activities have benefited from this program and used its network to distribute their health care messages and services.

2. Achievement of the "Health Education Objective": West Bank. The project is proceeding superbly toward meeting its "health education objective."

- o It is working effectively with more than 150 charitable societies and similar village organizations throughout the West Bank;
- o It is creating awareness, increasing knowledge, and positively influencing attitudes among village women, and their families and neighbors, concerning preventive health behavior; and
- o It is fostering the adoption of appropriate preventive health behavior, especially as concerns the care of infants and children.
- o Most quantitative training and teaching targets have been met ahead of schedule, or will be met before the end of the project. The project now provides basic health education in 157 locations in 5 cities and 152 villages throughout the entire West Bank. This is over a third of the West Bank's 424 villages, and an additional 53 villages have asked CRS to provide them with "health education" (taskhif as-saha). In addition to village teachers trained in earlier projects, the Life Cycle Project has trained an additional 118 village teachers and provided a four-month course in basic health education to about 5000 village mothers.
- o The quality of these "outputs" is high. The CRS Life Cycle curriculum, the CRS-trained village teachers, and the new knowledge they offer to thousands of village mothers, illiterate and literate alike, are all widely admired by everyone familiar with the project.

Two elements in particular are responsible for the success of the Life Cycle Project to date: (a) the "Life Cycle curriculum," and (b) the dynamic, participatory teaching techniques (methodology) used to present it.

Recommendation: During the remainder of the project, CRS should proceed vigorously to capitalize on this success by producing written materials that can be shared with other primary health care providers on the West Bank and in Gaza as well as in the world at large.

a. The Life Cycle Curriculum. The Life Cycle curriculum is an outstanding teaching tool which corresponds directly to the daily needs of village mothers. It is an effective foundation for training village teachers and an excellent manual for village teachers to use in teaching village mothers. Regular in-service (continuing) education for the village teachers is essential, however.

Recommendations: CRS should

- 1) Proceed with its plans to revise the Life Cycle curriculum in accord with feedback and experience during the past two

years, while preserving the general approach that makes it so successful. The initial training period of six months should not be extended.

- 2) Consider, with local specialists, the desirability and feasibility of producing additional teaching modules to complement, for continuing education purposes, the existing curriculum.
- 3) Regard in-service (continuing) education for both village teachers and supervisor/instructors as an essential part of the program. In-service training should be planned on a yearly basis.
- 4) Continue to make available for any interested parties, at no cost, the Life Cycle curriculum and related materials. AID should facilitate sharing of this curriculum with AID-funded programs elsewhere.

b. Teaching methodology and techniques developed by CRS for presenting the Life Cycle curriculum are excellent. The teaching is lively and participatory. Teaching techniques (e.g., participatory discussion, role play, audio-visual aids) are all aimed at capturing village mothers' interest and making the participants feel that the classes are immediately rewarding and even (!) fun. Unfortunately, however, nothing exists on paper to permit people outside the CRS/Jerusalem to replicate or carry on the teaching techniques that make the Life Cycle curriculum so effective.

Recommendation: CRS should produce and make available to others a Guide to Using the Life Cycle Curriculum.

c. Advanced Skills Training. CRS has developed an "Advanced Training Curriculum for Village Teachers," but abandoned its plan to use this for training village teachers in advanced skills. It is unclear why this was done.

Recommendations. CRS should reconsider making the Advanced Curriculum (or selected portions thereof) available for use in villages with inadequate physician services and train village teachers in those villages to provide ante-natal monitoring.

d. Medical Linkages and Support. CRS recognized before the project began that it needed to develop on-going linkages with service providers in order to achieve its objectives of education, monitoring, and identification of high-risk groups and individuals. This has not been accomplished, but remains an important need.

Recommendation: CRS should actively investigate ways to develop links to health care providers, particularly for

initial pregnancy checks and selected common village problems that directly affect mothers and children that could be monitored by village teachers.

e. CRS Staff. The CRS instructors and field supervisors are well-trained and knowledgeable in their jobs; in general, they appear conscientious and hard-working. Despite strengths, the present combination of personnel is not sufficient, however, for the task of "institutionalization."

Recommendation: CRS should hire a Palestinian program manager and provide training for the present supervisors/instructors as described in section VI, "Additional Personnel Matters."

3. Achievement of the "Health Education Objective": Gaza. Objectives have not been achieved in Gaza and almost certainly cannot be achieved by the end of the project. CRS has offered one successful health education class in Gaza, but it has not carried out all anticipated Gaza activities, nor is this planned. Provision of services in Gaza was from the outset a lower-level objective, and this should not be considered a major failing of the project.

Recommendation: Given that conditions in refugee camp-dominated Gaza differ radically from West Bank villages, and are far less amenable to efforts at improvement at the level CRS can provide, CRS should concentrate its efforts on the West Bank during the remainder of the project if it is to succeed in meeting the institutionalization goal there. CRS should still respond to requests that might come from other organizations in Gaza, but it should no longer invest energy in trying to initiate a program in Gaza.

4. Achievement of the "Institutionalization Objective." There has been little progress here, in large part because of financial and political constraints facing Palestinian organizations identified to take over financial and management responsibility for continuing the health education program after the end of the Life Cycle project. After many discussions, one organization (the Union of Charitable Societies in Nablus) has agreed to take on this responsibility for the northern region of the West Bank. It appears to have the will, although not the means at present, to sustain a quality program.

Recommendation: Adopt a new strategy for "institutionalization" as summarized under item IV below.

III. IMPACT

1. Health Impact (West Bank). Observations of village teachers, supervisors, and virtually everyone familiar with the

Life Cycle Project attest to its effectiveness. Observations and questionnaire data suggest that the project has improved mothers' health knowledge and actually changed health behaviors, but more information is needed to confirm this. Firm data to confirm and quantify project impact on health status (i.e., reductions in morbidity and mortality) are not now readily available. Such information may well be obtained before the end of the project, provided changes are made in the data-collection system.

2. The CRS questionnaire administered to mothers before and after the health education course provides useful information. This information does not constitute reliable data as to changes in health status attributable to the project, however, because of problems with its design, administration, and the software for its analysis.

Measuring Impact after "Institutionalization." No local organization is likely to have sufficient surplus resources to meet the costs of measuring impact after the Life Cycle Project ends.

Recommendations

1. Discontinue administration of the current questionnaire. Use other data collection techniques (e.g., focus groups, key informant interviews) to complete ad hoc qualitative studies of project effectiveness, beneficiary satisfaction, and other indicators that can be used to guide program management.
2. Obtain epidemiologic technical assistance (for example, a consultant from a local university) in the design and field-testing of a new questionnaire which is more responsive to evolving information needs.
3. Once the new questionnaire is developed and adequately field tested, use periodic sample surveys for data collection.
4. Current project staff are well suited to complete these field surveys, but need careful training for the task to assure consistent interview methodology.
5. Provide simple narrative summaries of the results of data collection efforts to the Unions and the villages.
6. Use locally obtained technical assistance to shift control and responsibility for this management information system to the Union(s) before the end of the project.

3. Spread Effect. The project has had a definite positive impact on numerous other health education and primary health care efforts here and elsewhere.

4. Impact on Women. In the process of providing village women with meaningful, easily utilized health education, the project has also had a "capacitizing" effect on many of its participants by virtue of encouraging decision-making and problem-solving -- and has also stimulated some income-generation. The Life Cycle Project may even be among the most successful AID-funded projects in benefitting village women whose options are otherwise very limited.

Recommendation: CRS and A.I.D. should consider funding a study (or studies) to determine the extent and nature of the program's impact on women. This should be undertaken, however, only if it does not hinder progress toward transferring program responsibility to the Union(s).

IV. STRATEGY FOR INSTITUTIONALIZATION

This is the first time that either AID or CRS has tried to "institutionalize" a project on the West Bank or in Gaza with a local Palestinian organization. No other project supported by AID or CRS on the West Bank or in Gaza has ever been established or carried out with this goal in mind. Thus the Life Cycle Project is attempting to do something that no other CRS or AID-supported project has ever tried or succeeded in doing. Other foreign organizations working in the West Bank and Gaza have tried to find indigenous organizations to take over their projects, but have been unsuccessful in this.

Yet, there are indications that CRS could succeed. This will require a shift in strategy. The main difference in the strategy proposed below is that CRS gives the Union(s) of Charitable Societies funding with which to carry out the work of running the health education program during an initial transition period. (Previously CRS asked the Unions to take on this immense task using their own resources which, given that the Unions are volunteer organizations, do not presently appear adequate.) The assumption on which the new strategy for "institutionalization" is predicated is that, with funding and technical assistance from CRS during a transition period of about 18 months, the Union(s) will be able to develop the administrative capacity to manage the program and to raise funds to support it from other sources.

Elements of this revised strategy include:

1. A sub-contract to one or more of the three Unions of Charitable Societies, beginning with the Nablus Union;
2. A no-cost extension (minimum one year, possibly 18 months) of the AID grant to CRS;
3. The hiring of a Palestinian program manager (or coordinator) responsible for "institutionalization" aspects of the project;

4. Technical assistance to the Unions facilitated by CRS (to include training in managerial skills as well as technical upgrading for health education personnel); and
5. Gradual phase-out of PL-480 food commodities by the end of the Life Cycle Project (as extended).

A four-stage process is recommended for transferring management of the program to the Union(s). This provides for the possibility that the Hebron and Jerusalem Unions decide to join the Nablus Union in taking over the program in their regions. If they do not decide to join in, CRS should proceed with the Nablus Union alone. If a quality program can be sustained in the northern region (where 70 communities are already participating and more have asked to join), this will still be a very major achievement.

Part III

PROJECT SETTING AND BACKGROUND

THE SETTING: WEST BANK AND GAZA

The Life Cycle Health Education Project serves Palestinians in the two discontinuous territories, the Gaza Strip and the West Bank of the Jordan River. Both have been occupied by Israel for the two decades since the Six-Day War in 1967 and are under the control of the Israeli Ministry of Defense. The setting is thus radically different from most situations in which CRS and AID operate, as there is no indigenous "host country," no Palestinian government, to which project personnel and beneficiaries relate in the classic manner. An organization working in the West Bank and Gaza confronts not only the complex challenges of social and economic development that prevail throughout the Third World, but also a highly-charged political environment in which the constituents are Palestinians, final authority is in the hands of the state of Israel, the U.S. Congress is a major provider of program funding through private and voluntary organizations (PVOs), and local Palestinians continue to hope for long-awaited development assistance from Jordan. In the absence of an indigenous government, some 200 charitable organizations and PVOs work to provide services that in most countries are the responsibility of the country's government; about 70 of these are involved in health activities.*

The West Bank and the Gaza Strip differ from each other in several ways that directly influence development activities. The West Bank is predominantly rural with classic villages inhabited for generations by the same lineages (families). The Gaza Strip is about ten times more densely populated, is predominantly urban, and is dominated by refugees and UNRWA (United Nations Relief and Works Agency) refugee camps. Refugees equal approximately 25 percent of the West Bank population, about 75 percent of the population in the Gaza Strip.

The West Bank has been the chief focus of the Life Cycle Project (and of the entire CRS West Bank/Gaza program). Because of differences in the two territories, project strategies developed for West Bank villages are not directly transferable to Gaza.

No census has been completed since 1967. Health, demographic, and similar statistics for the West Bank and Gaza Strip are politically sensitive issues, are not systematically available, and are not agreed upon. The combined population, however, is probably about 1.5 million persons (including some

* On American voluntary organizations on the West Bank, see Richardson, 1985.

113,000 Arab inhabitants of East Jerusalem). The populations are rapidly growing, with an estimated annual population increase of about 2.7 percent, among the highest in the world (cf. Vermund et al. 1985, p.115).

The West Bank population is variously estimated as between about 750,000 and 925,000 persons. It is estimated that about 10 percent of the population lives in refugee camps, 60 percent in rural areas, and 30 percent in towns or cities over 20,000. The West Bank comprises an area of about 5,600 square kilometers and has a population density of 140 persons per square kilometer. There are three regions--north, central, and south--divided into seven administrative districts.

The Gaza Strip is about 45 kilometers long by 6 kilometers wide with a population variously reported as over 500,000 to about 620,000 persons. This is a population density of about 1400 per square kilometer. This population, largely rural before being engulfed by about 180,000 refugees in 1948 following the creation of Israel, is now 85 percent urban. The indigenous population (those who lived or whose parents lived in Gaza before 1948) is now only about 25 percent of the total; most are poor and crowded into the Shajaiya and Zaitoun quarters of Gaza town. Conditions in those quarters are materially worse than in the eight refugee camps where UNRWA provides basic social and medical services.* Occasionally it is said that Gaza is "becoming the Soweto of the State of Israel" and even many Israelis are critical of Israeli policy there (as well as on the West Bank) (cf. Lesch 1985:44-45, 59).

Religion is not a major factor in the provision of services by CRS. The Palestinian population is about 80 percent Muslim and 20 percent Christian, but the Muslim/Christian distinction pales alongside the Palestinian/Israeli distinction. CRS provides its services according to its basic philosophy "Need, not creed." Palestinian Christians live chiefly in the cities, however, while villages are chiefly Muslim.** Thus, because a goal of the Life Cycle Project is to assist less-advantaged rural people, most people it serves are Muslim. CRS' Jerusalem-based staff is mixed Muslim and Christian.

* See: United Nations Relief and Works Agency for Palestine Refugees in the Near East, "UNRWA: A Survey of United Nations Assistance to Palestine Refugees." March, 1986.

** The cities of Bethlehem, Ramallah, and Jerusalem (the Arab population) are predominantly Christian; the city of Hebron is nearly all Muslim; Nablus and other remaining West Bank cities are predominantly Muslim. Nearly all villages on the West Bank are predominantly Muslim (with the exception of Zabadeh village in Jenin district).

The role of Jordan. Jordan continues to be a major factor in West Bank development considerations. The Jordanian government provides development assistance through its Ministry of Occupied Territories. Jordanian administrative practices function side-by-side with the Israeli. The educational system on the West Bank is in many regards a continuation of the Jordanian system. Program costs are expressed in terms of Jordanian currency (dinars). Many Palestinians have family in Jordan, and occasionally more affluent Palestinians living in Jordan make donations to West Bank groups for development or humanitarian purposes. Of direct importance for the future of the Life Cycle Project is the quasi-governmental General Union of Charitable Societies, headquartered in Amman.

"Charitable societies". Throughout the West Bank are many village and community voluntary organizations that carry out educational, health, and other social service activities. Some are rather traditional village organizations while others are better understood as "indigenous PVOS," private voluntary organizations. Leaders of these organizations are usually, but not always, older men from the leading village families or younger but more educated and progressive members of the local community. The leaders are all volunteers.

"Charitable societies" (sing. jami'a il-qariya) are one type of village voluntary organization (and the main one through which the Life Cycle Project is carried out). "Charitable society" is a formal status, conferred after a group of village leaders has applied to and become registered with the General Union of Charitable Societies in Amman. The charitable societies are thus all registered with the Union of Charitable Societies in Amman (they must be so registered in order to operate legally) and function with the permission of the Israeli government. To be registered as a "charitable society" certain criteria must be met: the village must have a population of more than 1,000; there must be an acceptable administrative board; and this board must propose to sponsor appropriate charitable activities. Most common are literacy classes, health education classes, income generating activities, and kindergartens. The "society" has, builds, or acquires a building in which these activities are offered to villagers. In some villages, the leaders (administrative board) of the society apparently come from only one leading village family, while in other villages several families are represented in a more inclusive leadership group. Some are retired, many are school teachers, some are agricultural workers.

The charitable societies do not have a great deal of contact with each other, although some linkage is provided by three "Unions of Charitable Societies."

The Unions of Charitable Societies (sing. Ittihad al-Jamiat). Under the General Union of Charitable Societies in Amman are 12 regional Unions of Charitable Societies, established in the 1950s. Nine are in Jordan. Three are in the West Bank,

located in the cities of Nablus (northern region), Jerusalem (central region), and Hebron (southern region). It is with these three "Unions" that CRS seeks to "institutionalize" the Life Cycle Project.

These "Unions" are not unions in the American sense of labor union but can be regarded as indigenous PVOs -- local charitable organizations whose members are volunteers and whose work centers on community social services for disadvantaged communities. In particular, they provide an official structure for supporting activities of the village-based "charitable societies." A charitable society seeking to register with the General Union in Amman must apply through one of the three West Bank Unions of Charitable Societies.

The West Bank Unions occasionally receive funds from the General Union in Amman to help support the activities of the charitable societies on the West Bank. This support, although much appreciated, is by no means adequate for the social service goals of the Unions. At present, the three Unions have been waiting many months for long-anticipated financial assistance from Amman.

HEALTH STATUS AND SERVICES*

Health Status

The poverty that characterizes the villages of the West Bank and especially Gaza predisposes to a multiplicity of social and health problems. The health problems associated with the geographic and economic isolation of the smaller villages are exacerbated by lack of telephones or means of transportation to gain access to health service resources in the towns and cities. Although food is usually quite plentiful and healthful, sanitation problems result in frequent enteric diseases, including outbreaks of cholera.

Infant mortality is high. The infant mortality rate (IMR), a classical indicator of health status, is of particular interest for the Life Cycle Project which has infants and children as its major beneficiaries. However, along with other health statistics for the occupied territories, IMR has been a subject of much sensitivity and controversy. Attempts to calculate the IMR for the West Bank and Gaza are complicated by the lack of adequate census data in the villages and camps. Government of Israel (GOI) estimates have been based on recorded births and deaths and undoubtedly are an underestimate. Recent IMR estimates vary

* Information presented in this section derives chiefly from the following sources: American Public Health Association (3 vols) 1985-86; Sabella, 1986; Vermund et al., 1985; Gaza Medical Relief Committee, 1986; Israeli Ministry of Health, 1985-1986; and Israeli Ministry of Defense, 1986.

widely from those based on birth records (e.g., 27.9/1000 in 1984, according to the GOI/MOH) to those obtained by demographic modeling techniques (e.g., low seventies per 1000 in 1984, according to the GOI/Central Bureau of Statistics). The actual IMR is probably closer to the latter figure--that is 70 to 75/1000--in view of UNICEF's estimated IMRs for adjacent Jordan (55), Syria (60), and Egypt (100). Another recent analysis of IMRs from all sources concluded the IMR to be 53 to 63/1000 live births (Vermund et al. 1985, p.26).

The major causes of mortality among children under five are acute respiratory infections and diarrheal diseases. Neonatal mortality rates in the Gaza Strip are increasing (said by some authorities to be about 63/1000) because health services are not growing as fast as and cannot cope with the rapidly increasing population.

High fertility is culturally valued. It was traditionally and remains so under the present political situation. Women still bear, on average, more than six children. Estimated total fertility rates on the West Bank and in the Gaza strip in 1983 were 6.12 and 6.69 respectively, down from a high of about 8 in 1974-75 (Vermund et. al, 1985, Table I-6).

Health Services

Since the occupation of the West Bank in 1967, the administration of health services has been assumed by the Israeli Civil Administration of the military occupation government. Actual delivery of health services is, however, accomplished by a confusing patchwork of public and private agencies.

Health services in the West Bank and Gaza are provided by three major sources: (1) government of Israel, (2) UNRWA, and (3) the private sector, including individuals and over 70 private volunteer organizations (PVOs). All three sources provide a mix of preventive and curative health services, although immunization services are provided almost exclusively by the Israeli government (cf. APHA, Kessler and Hamlin, 1985, p. 6). The hospitals, approximately half of which are private and half of which are administered by the Israeli government, vary widely in the breadth and quality of services provided. Tertiary care is virtually unavailable in the West Bank and the referral process to Israeli hospitals difficult. The budget for all West Bank health services, both preventive and curative, was noted in 1975 to be about 60 percent of the budget of one Israeli hospital. And this budget has been cut progressively since that time (Sabella 1986).

Estimates of the proportion of the population with access to or utilization of key services remain difficult to obtain in an environment characterized by an absence of accurate census data and less than systematic coverage by a multiplicity of providers. In the majority of villages, there is no health care provider at

all, with many villages not even having a traditional midwife (daya). One recent and probably reliable estimate is that nearly two thirds of the West Bank population lacks adequate coverage with MCH services (APHA, 1985-86).

Officially, preventive services are free and curative care is provided by the Israeli government for children under 18 months. Provision for referral from the PHC level to secondary or tertiary care facilities, however, is erratic at best. The "patchwork" of service providers has resulted in frequent failures of referral networks such that women may be turned away from facilities to which they have been referred. Mothers referred to hospitals for evaluation or inpatient care often face ridicule for their child care practices. Childspacing is not widely or actively promoted, although UNRWA and a few private-sector organizations do provide childspacing services on request.

For adults and children over 18 months of age, health care is financed on a fee-for-service basis or through a GOI insurance program, both of which make health care difficult to afford for the bulk of the population. It is estimated that 25 to 35 percent of the population is insured, although the proportion is considerably lower in the rural areas.

Most basic primary health care (PHC) services are provided in varying degrees in the West Bank and Gaza. Vaccinations are apparently quite efficiently provided by mobile teams such that coverage appears to be approximately 90 percent. Tetanus toxoid administration to pregnant women, however, appears to be sporadic so that older mothers, in particular, may deliver infants at risk for neonatal tetanus. Oral rehydration therapy (ORT) is taught by some providers as "home mix" or "special drink" of SSS, while others providers encourage the use of packets. Availability of the packets is quite variable geographically, however, and at times no supplies are available even to the government health services. Similar failures are observed in the supplies of essential medications. (See Sansur 1987.)

Estimates of the proportion of the target population whose children are born in a hospital are probably much higher than in actual fact. (Estimates are 45 to 54 percent in the West Bank and up to 74 percent in Gaza.) High-risk infants with low birth weights (as well as children with growth faltering) are undoubtedly those least likely to be identified by such erratic monitoring systems.

Dayas (traditional birth attendants) still deliver the majority of children on the West Bank, an estimated 55 percent of all deliveries on the West Bank (APHA 1985, vol. I, p.44). Many dayas have received training through UNRWA and UNICEF and work with programs sponsored by these two agencies. Upon completion of a training program, dayas are licensed by the GOI district Public Health Department. Since 1983, a midwife supervisor in each district is responsible for monitoring and upgrading their performance. (This program is currently being evaluated by the

newly-established WHO Collaborating Centre in Health Service Research.) At present there are about 350 licensed dayas who perform more than half of all deliveries (APHA 1986, vol. III, p.6). Other traditional health practitioners are no longer so numerous or frequently sought out as in previous years. Many Palestinians, however, still turn to bonesetters, herbalists, and traditional home remedies to meet needs.

In summary, as the recent and comprehensive APHA study concluded:

"While there has been some expansion of MCH centers and primary care clinics on the West Bank, many children and pregnant women do not yet reach the health system for systematic surveillance. In 1980, only about 16 percent of children under age 1 were seen in GOI MCH centers. UNRWA and other non-governmental organizations provide services to an additional segment of the population, but there continues to be a significant unserved population. Children and women of childbearing age are particularly in need of higher-quality services" (APHA 1985, vol. 1, p. 12).

With the current political climate, it will be many years before modern health service coverage can be expected to reliably reach the poorest and most remote villages. The family will remain the primary guardian of its children's health for the foreseeable future. Maternal education, known to be a predictor of children's health status, becomes under these circumstances a major hope for improving the survival of children under five. Only mothers empowered by appropriate health education can be expected to seek preventive health services and provide appropriate "first-line" curative care.

PROJECT DESCRIPTION AND BACKGROUND

Project Description

CRS' Life Cycle/Health Education Project is the third health and nutrition education project implemented by CRS, with AID support, on the West Bank. Together this series of projects, and the resulting services created, are referred to as the "CRS Health Education Program." The term "child survival" had not been created when this program was being established, but it is a child survival program par excellence.

The name "Life Cycle" refers to (1) the present project and (2) the teaching curriculum produced for the project which is the heart of the project. The phrase "health education" (Arabic: taskhif as-saha) is commonly used to designate the services that, through CRS, have been established in the villages. These consist of:

1. A basic health education class offered to village mothers, focusing on the pregnant woman and her resulting young children, which is taught by a village woman ("village teacher," referred to in Arabic as mualima il-'ailiy -- literally "teacher of the family");
2. Monthly weighing and growth monitoring by the village teacher of babies and other under-five children of mothers who are currently or were recently in the class;
3. Occasional home visits by the village teacher and referrals to health care providers; and
4. Distribution of PL-480 food commodities to mothers who are currently or were recently in the class.

This CRS Health Education Program is by far the most extensive primary health care initiative on the West Bank. It provides basic health education in 157 locations throughout the entire West Bank. This is an accomplishment that could never have been achieved within project of only three years duration, but builds on a decade of continued effort to identify the needs of village mothers and their children and to refine an approach to meet them. This history is outlined below.

The Project Background*

Distribution of Relief Commodities in the 1960s. In 1961, CRS signed a country agreement with Jordan, primarily for a food

* This section derives in large part from "Catholic Relief Services Health Education Program Innovations in Primary Health Care in the West Bank" by Daniel Carr, forthcoming in World Health Forum (draft 1986).

commodity distribution program to provide relief commodities supplied under the U.S. Public Law 480 (Title II). CRS' head office was in Amman (Jordan's capital, east of the Jordan River) with a field office in Jerusalem. CRS directed much of these relief commodities to villages on the West Bank of the Jordan close to the border with Israel, many of which had lost a great deal of their land when Israel was created. Palestinians in these villages had not been displaced (as were the Palestinian refugees resettled in refugee camps), but many suffered economically from the loss of the land on which their livelihood had depended.

In the aftermath of the Six-Day War in 1967 and the occupation of the West Bank by Israel, CRS/Jordan found itself split into two programs: CRS/Jordan (East of the Jordan River) and CRS/Jerusalem (West of the river). The Israeli government agreed to abide by the 1961 agreement by which CRS had been entitled by the Jordanian government to the duty-free importation and distribution of relief commodities. Food distribution continued to be the principle activity of CRS in Jerusalem and the West Bank. Up to 1973 a yearly average of over 43,000 recipients benefitted from this program.

Nutrition Education, 1975-1979. CRS involvement in health education on the West Bank began in 1975 with a Nutrition Education Project funded by an AID grant of U.S.\$375,820. The goal of this project was to improve the health of poor village mothers and their young children through better nutrition and dietary practices.

A basic strategy was developed in which CRS trained instructors who in turn trained selected village women to serve as village teachers and hold nutrition classes for mothers in their respective villages. Enrollment in the classes was limited to mothers with children five years and under. Their children's growth was monitored by monthly weighing. PL-480 food commodities were distributed to the participating mothers as an incentive to continue attending the classes and have their children's growth monitored. Commodities were given according to the mothers' class attendance and the number of children weighed.

At this time, 1976, there was little interest in the concept of preventive health and major efforts were necessary just to convince the local communities and health personnel (physicians in particular) of the value of preventive health care. The project was introduced to the villages in the following manner:

1. A CRS field supervisor visited all villages in an assigned area to identify the power structure and influential people in each village.
2. The supervisor then requested a meeting with village leaders.

3. The supervisor explained the project, describing what CRS would offer and what the village would be expected to provide. CRS would provide initial training for a village teacher and on-going supervision thereafter. CRS would also provide PL-480 food commodities for the teacher to distribute to mothers who attended the class. The village was to select a village woman to become the village teacher, provide some salary for her and a room for her class (plus transportation costs in those few cases where the teacher had to come from a nearby village). The village would also be responsible for transporting the food commodities from a central distribution point and storing them in the village until time for the monthly distribution to the enrolled mothers.
4. Village leaders discussed the proposal and either accepted it, rejected it, or were unable to agree. In the latter 2 cases, CRS dropped discussions with that village.
5. Once a village identified a village teacher candidate, a classroom, and a strategy for paying the teacher, CRS interviewed the candidates and held a training course for those selected.

Local "charitable societies" (jami'a il-gariya) emerged as the main village organizations willing to support the classes. The Unions of Charitable Societies became involved too in helping the local charitable societies provide salary and other support.

A total of 46 villages agreed to give the course a try. By the end of the project, 323 courses were offered attended by 6,739 mothers and growth monitoring was provided to 15,112 children.

Health Education, 1979-1985. When the Nutrition Education Project came to a close in 1979 there was great local demand to expand the program. Based on questions from mothers attending the classes, CRS designed a more comprehensive follow-on Health Education Project. This was supported by an AID grant of \$742,000. The goals remained the same (to improve the health of poor village mothers and their young children) but the teaching was broadened to include modules on first aid and child development. The project began in October 1979 and was amended in 1982 to include a training module on hygiene. As explained by the current project director:

"Three new curricula were thus designed to address the specific needs of the West Bank mothers and their families. Each subject -- Nutrition, Hygiene, First Aid, and Child Development -- was taught separately. Each course ran from 4 to 6 months. This became a burden for the mothers who usually came with small children and had to walk great distances. Food commodities were linked to these classes making it possible for a mother to schedule herself for food commodities for five years or more if she attended all four courses. The

combined text of the four curricula totaled almost 500 pages, which proved to be an inordinate amount of information for the village mothers. By this time the program had grown to 111 villages or a quarter of the West Bank. The demand for CRS Health Education classes continued to increase and the program became cumbersome and expensive to run. Eleven supervisors and field workers were trying to monitor the entire West Bank while CRS instructors were scrambling to keep up with changes in the curriculum. This period in the life of the project was a time of spectacular increase in size and complexity. It seemed as if no one could keep up with the changes. New villages were continually approaching CRS to train a teacher for their own Health Education classes. By the end of 1984, over 200 villages -- almost half of the West Bank population -- had expressed interest in the project. Despite the time and resources allocated to the project and the high interest, it became evident that it needed reassessment. The time had come to synthesize a new, comprehensive, and simple approach to Health Education which could serve a larger population more effectively" (Carr 1986, p.2).

The Life Cycle/Health Education Project, 1985-present. The Life Cycle Project began on February 1, 1985. Its overall goals again remain the same, but the emphasis has changed to include expansion and institutionalization of the project. The curriculum and teaching methodology were also significantly revised in several major ways. The project is funded by an AID grant of \$1,521,249.

Basic data for the three projects are summarized in the chart below.

NUTRITION EDUCATION PROJECT (No. 79/2; AID/NE-G-1182)			
HEALTH EDUCATION PROJECT (No. 79/2; AID/NE-G-1652)			
LIFE CYCLE PROJECT (No. 4D-004; AID/NE-G-5065)			
	Nutrition Education	Health Education	Life Cycle
Years	1975-1979	1979-1985	1985-1987
Budget	\$375,820	\$1,823,929	\$1,521,249
Villages	44	111	153
Direct beneficiaries (children & mothers	21,851	31,749	11,864
Training provided to:			
*CRS staff (instructors and supervisors)	7	30	12
*Village teachers	147	250	118
*Village mothers	6,739	12,454	4,926

Village sponsors. CRS generally uses the term "charitable society" to designate all of the village-based societies which sponsor the health education program. In reality, sponsoring organizations at the village level are of several different types and vary also in terms of age, size, composition, cohesiveness, and financial and administrative ability. The most common type is the officially registered "charitable society" (jami'a il-gariya, see p. 13 above). A second type, in smaller villages, is the less formal "village society" organized around the mukhtar, the traditional village leader, which is not officially recognized. In a few communities, a women's organization (charitable society) is the sponsor. In some villages in the central region, the sponsoring organization is the village "club" (sing. nadi); most such "clubs" were established by men of the younger generation as a sports club and then subsequently expanded into social service activities.

Key personnel. One individual has played a major role in developing and carrying out CRS' West Bank Health Education Program. This is Sister Barbara Cline who, with a Ph.D. in child development, joined CRS in July, 1980, to design the child development curriculum for the Health Education Project. She later became project manager of the Health Education Project and then the Life Cycle Project and, finally, director of CRS' entire Jerusalem/West Bank/Gaza program through December, 1986. Others who have been responsible for project design or management include: Darline Ramage, who designed the original Nutrition Education Project; former project managers Elsa Haglund and Dana Sams; Anne Hammond Roberts, who helped design the Life Cycle curriculum and training; and the present project manager, Daniel Carr.

Part IV
ACHIEVEMENT OF PROJECT OBJECTIVES

PROJECT OBJECTIVES AND STRATEGY

The stated objectives of the Life Cycle Project are as follows:

Project goal: "To develop programs to improve the health of Palestinians on the West Bank of the Jordan River and in Gaza."

Project purposes: West Bank

1. "To assist Charitable Societies in creating awareness, increasing knowledge, positively influencing attitudes, and fostering adoption of appropriate preventive health behavior."

It is useful to think of this as the "health education" objective. What is meant here is for CRS to expand and improve the health education program created through the two projects that preceded the Life Cycle Project. ("Charitable societies" are the individual village organizations that support health education in the individual West Bank villages. [See section III above].)

2. "To institutionalize Health Education as part of the service of the Union[s] of Charitable Societies."

This is the "institutionalization" objective. What is meant here is for CRS to transfer to a Palestinian organization, or organizations (tentatively designated by CRS to be the Unions of Charitable Societies) financial and management responsibility for continuing the health education program after the end of the present CRS Life Cycle grant and to do so in such a way that this organization will be able to keep the program running effectively.

Project purposes: Gaza

1. "To assist local agencies in creating awareness, increasing knowledge, positively influencing attitudes, and fostering adoption of appropriate preventive health behavior."
2. "To institutionalize Health Education as part of the service structure of a local agency."

The objectives are thus slightly different for the West Bank and Gaza for two reasons. First, the CRS Health Education program had already been operating in the West Bank for about eight years when the Life Cycle Project began, but had not yet been initiated in Gaza. Second, in the West Bank CRS was already working with local village organizations ("charitable societies") and, at the regional level, the three Unions of Charitable Societies. In urban Gaza, however, this "charitable society"

structure does not exist and there is no Union of Charitable Societies. Thus a local agency, or agencies, with which to work and "institutionalize" health education had to be found.

Project strategy. Specific outcomes, or outputs, were planned through which the purposes above would be achieved. These intended outcomes were the following.*

1. A new standardized curriculum (the "Life Cycle" curriculum) and improved teaching materials;
2. Trained staff (CRS instructors, supervisors, and a community development specialist);
3. Training for new village teachers who would be qualified to present Life Cycle materials in new locations;
4. Advanced skills training, based on a new "advanced curriculum" which would be developed to expand the risk-identification capabilities of the present village teachers; and
5. Medical linkages to facilitate referrals of participating mothers and their children to service providers.
6. District-based service strategy and logistical support and salaries for health education personnel in the process of institutionalization;
7. A commodities distribution system congruent with the program goals of:
 - o focus on greatest need, and
 - o development of village self-reliance and independence;

While the Life Cycle Project is indeed a "follow-on" project to CRS' earlier Nutrition Education and Health Education projects, it is definitely not just a "business-as-usual" continuation of the two earlier projects. Five major new objectives were:

1. To develop a new and more effective curriculum and an interest-holding methodology for teaching it;
2. To initiate advanced skills training for village teachers;
3. To institutionalize the program into the local societies on the West Bank; and
4. To establish CRS' Health Education in Gaza (an objective apparently initiated by AID.)
5. To collect data for evaluating the impact of the program (also urged by AID).

* Outcomes 1,2,3,6, and 7 are specified in the project logframe (see Appendix B). Outcomes 4 and 5 are outlined in the grant proposal ("Statement of Program Intention," pp. 4-5).

THE "HEALTH EDUCATION OBJECTIVE": WEST BANK

- * Are the health education objectives, as outlined in the logframe, being met?
- * Will they be met by the end of the project?
- * What is the quality and relevance of the training?

Achievement of Project Goal

On the West Bank, the Life Cycle Project is definitely having a widely appreciated impact and is clearly meeting its overall goal: "to develop programs to improve the health of Palestinians on the West Bank of the Jordan River and in Gaza." (For Gaza, see the final part of section IV.) This project has resulted in a successful health education program that is the most extensive preventive health program and network on the West Bank and the only village-based child survival effort that extends throughout the West Bank. Many other local health care activities have benefitted from this program and used its network to distribute their messages and services. The CRS Health Education Program has been instrumental, for example, in promoting immunization against polio, tetanus, and typhoid.

The program is popular and has generated a high level of good will toward its sponsor(s). This is a major accomplishment in a setting where the United States government is widely criticized for its massive financial support to the occupying Israeli government.

Achievement of First Project Objective

The project is proceeding superbly toward meeting its "health education objective."

- o It is working effectively with more than 150 charitable societies and similar village organizations throughout the West Bank (see Appendix D);
- o It is creating awareness, increasing knowledge, and positively influencing attitudes among village women, and their families and neighbors, concerning preventive health behavior; and
- o It is fostering the adoption of appropriate preventive health behavior, especially as concerns the care of infants and children.
- o Most quantitative training and teaching targets have been met ahead of schedule, or will be met before the end of the project. The project now provides basic health education in 157 locations in 5 cities and 152 villages throughout the

entire West Bank. This is over a third of the West Bank's 424 villages, and an additional 53 villages have asked CRS to provide them with "health education" (taskhif as-saha). In addition to village teachers trained in earlier projects, the Life Cycle Project has trained an additional 118 village teachers and provided a four-month course in basic health education to about 5000 village mothers. (See CRS/JWB Fourth Semi-Annual Report.)

- o The quality of these "outputs" is high. The CRS Life Cycle curriculum, the CRS-trained village teachers, and the new knowledge they offer to thousands of village mothers, illiterate and literate alike, are all widely admired by everyone familiar with the project.

Two elements in particular are responsible for the success of the Life Cycle Project to date: (1) the "Life Cycle curriculum," and (2) the dynamic, participatory teaching techniques (methodology) used to present it. Both are widely praised by persons throughout the West Bank who are involved in preventive health care. Even people who criticize the program's distribution of food commodities speak highly of the curriculum and teaching techniques.

Village women are excited about their new knowledge and state that they are doing things differently and adopting many of the new health behaviors. The very excitement, plus the ability and willingness of the village women to discuss this new knowledge with a variety of people, points to at least a new awareness and in many cases new behaviors, even though data has not yet been collected that prove this statistically (see section V). There is active weight monitoring of the participants' children; the mothers carefully keep the weight charts with them (protected by plastic envelopes) and are eager to discuss the implications of the chart with the teacher or CRS field supervisor.

Recommendation: During the remainder of the project, CRS should proceed vigorously to capitalize on this success by producing written materials that can be shared with other primary health care providers on the West Bank and in Gaza as well as in the world at large.

How the Project Functions

The generally successful operating manner of the Life Cycle Project is as follows.*

The project is managed from the CRS office in East Jerusalem with a staff of 20. This includes a project manager, a community relations specialist, six instructors (trainers of village teachers, six field supervisors (two for each of the three regions of the West Bank), and support staff. The project manager is American; all others are Palestinian.

* See also Carr 1987 from which some of this description derives.

How a village begins health education. CRS "health education" has become so widely known and respected in West Bank villages that, since the Life Cycle Project began in 1985, CRS no longer approaches new villages asking them to join the program. Instead, CRS now receives requests initiated by villages themselves who have heard of the program from other villages. This in itself is a measure of the program's success.

Once CRS learns of a village's interest in "starting health education," a CRS field supervisor from that region goes to study the appropriateness of extending the program into that village. If CRS/Jerusalem decides that the village is a good candidate for a successful health education program, the supervisor verifies with the local "society" that it is able to provide a room suitable for instruction and pay the salary for a part-time village teacher. For many small villages and societies this is not an easy task. If agreement is reached, however, the society selects one or more candidates from the village who fulfill four criteria.

Criteria for selecting village "family teachers," (mualima il-'ailiy), and CRS' rationale for these criteria, are as follows:

1. The candidate must be a woman, preferably a mother. Women, especially mothers, from the same or nearby village are more approachable and less threatening than more educated persons from distant villages, experts, or foreigners. These women know personally and are able to sympathize with the real problems of the village and therefore able to stress those areas of greatest need in each village in a way that no outsider could.
2. The candidate should have passed the tawjihi (comprehensive end-of-high school examination). Village teachers must be able to pass a rigorous course in preventive health. As educational levels in Palestinian villages are relatively high, it is reasonable to expect that several young women will have passed the tawjihi. Too much education, however, may have the opposite result--an unapproachable teacher with an attitude of "knowing more than the rest."
3. The candidate must show good leadership qualities. The village teacher must be able to speak out in front of people, yet be sensitive to their feelings. She must be willing to learn from the mothers as well as teach.
4. The candidate must show interest in improving the conditions of her people. No one will be a good village teacher without a basic desire to help others. If the teaching is motivated by anything else, it becomes self-serving and destructive.

The training course for village teachers. CRS staff interview and select one candidate to represent the village in the new training course. From 20 to 25 new trainees participate in one course. The course lasts six months. It takes place at a central location (in the north, central, or south part of the

West Bank) from which the women trainees can return home to their villages at night. This is essential for securing permission of husbands and fathers for the trainees to attend the course. Space for the course is donated by institutions (e.g., Caritas Baby Hospital) that have come to value the service the CRS health education program performs for people in their communities.

The village health education class. After successfully completing the training course, the new teachers identify and register village women for the health education class. A requirement for enrolling is that the woman be a mother or pregnant (which includes most married village women). In most villages the new teacher goes door to door to talk with young mothers about the class. By this time, many of the women have already heard about "health education" and are quite eager to sign up. The village society may play an active role in registering mothers and starting up the class. It provides the classroom, all or part of the teacher's small salary, and perhaps also materials to use as teaching aids. The CRS field supervisor actively assists in this process (and also, at this time, interviews mothers and society leaders to collect baseline data for CRS monitoring and evaluation).

Once there are enough interested mothers (20 is considered the optimal number), the village teacher and the enrolled mothers decide together on a convenient time for the class to meet. They usually agree on one or two one-hour classes per week depending upon the size of the village. The course lasts four months if it meets consistently one time per week. Often, however, the course is interrupted (for example, during the busy olive harvest season when women are in fields all day), and so extends over a longer period of time. This is one of many reasons that salaries for village teachers are irregular and differ from village to village.

Progress Toward Achieving the Project's "Intended Outcomes"

Planned Outcome One: A New Standardized Curriculum and Improved Teaching Materials

The Life Cycle Curriculum. The Life Cycle curriculum is an outstanding teaching tool which corresponds directly to the daily needs of village mothers; it is an effective foundation for training village teachers and an excellent manual for village teachers to use in teaching village mothers. This curriculum is a 307-page volume in Arabic, with an English version available for non-Arabic speakers (CRS/JWB, Fundamentals of Health Education: Life Cycle, 1984). It was designed to help village mothers see that nutrition, hygiene, child development, and first aid are all part of their daily lives. It begins with marriage, following events in the life of a village mother until her children are grown and the cycle begins again (see Appendix C). It centers on knowledge and skills village woman need to meet their daily responsibilities. Local foods are used to demonstrate good nutrition. Pictures and examples all come from the local culture in order to base

discussion on current beliefs and practices and distinguish good practices from negative ones.

This Life Cycle curriculum was developed with input from village mothers and village teachers as well as from health professionals working in the Middle East, a combination that has resulted in a level of both quality and relevance that would have been impossible drawing on only one segment of the population. It has much in common with health promotive sections of David Werner's pioneering Where There Is No Doctor, from which CRS acknowledges having adapted certain sections.

As the curriculum has been used during the past two years, CRS staff have become aware of further modifications and topics that could make this resource even more effective both on the West Bank and for health education programs elsewhere. The teachers and instructors have also identified the need for continuing in-service education on a regular basis as essential to a continued quality program.

Recommendations:

1. CRS should proceed with its plans to revise the Life Cycle curriculum in accord with feedback and experience during the past two years, while preserving the general approach that makes it so successful. CRS should not add any additional material to this basic curriculum. (It should remain a curriculum that trainers--"instructors"--of village teachers can absorb in six months and that village teachers can present in a basic four-month course.)
2. CRS should consider, with local specialists, the desirability and feasibility of producing additional teaching modules that could be used to complement the existing curriculum for continuing education purposes. Among topics suggested by village teachers and mothers are:
 - o family relations,
 - o care of elderly family members, and
 - o care of the handicapped.*
3. Continuing in-service education, for both village teachers and supervisor/instructors, should be an essential part of the village health program.
4. CRS should consider producing the curriculum in a loose-leaf format to allow other organizations using these materials to add or subtract modules as appropriate for the particular context.

* The frequency of handicapped children due to birth defects is striking. Most village teachers are asked by mothers for information on dealing with handicapped children. Marriage among cousins (meaning also second and more distant cousins) is fairly common, but there is as yet little discussion of the relationship between this marriage pattern and birth defects.

5. CRS should continue to make available for any interested parties, at no cost, the Life Cycle curriculum and related materials. AID should facilitate sharing of this curriculum with AID-funded programs elsewhere.

Teaching Methodology and Techniques. The teaching techniques developed by CRS for presenting the Life Cycle curriculum are excellent and quite unique in several ways. Above all, the teaching is lively and participatory. Teaching techniques (e.g., participatory discussion, role play, audio-visual aids) are all aimed at capturing village mothers' interest and making the participants feel that the classes are immediately rewarding and even (!) fun.

This new participatory methodology is a definite departure from the dull, pedantic, and condescending lecture mode that unfortunately typifies many if not most other training projects. Part of the attraction in the classes, in fact, seems to be this engaging approach. Mothers say they come partly for the health knowledge and partly also just because the classes are an enjoyable learning opportunity -- and for many of them the only such opportunity in a context that is otherwise very limited.

The CRS instructors have been trained to encourage dialogue in the classroom and to use demonstrations and visual aids, many of which they prepare themselves. (Other health personnel praise CRS for having introduced visual aids as a novel health education strategy on the West Bank and Gaza and have begun to adopt it in their programs.)

Many lessons are taught using role-play techniques. The entire first aid unit uses role-play to demonstrate the effect of fear and the need for quick response in emergency situations. Village teachers participating in the training course show remarkable enthusiasm for the subject content. They respond with delight and assertiveness in classes led by male as well as female CRS instructors (cf. Hamilton 1984, p. 6).

In nearly all villages where classes were observed, village women were invited to the front of the class -- for example, to present a review of material covered in the previous meeting or to role-play the mother of a sick baby or a pregnant woman with complications. Even babies are brought forward to illustrate a point. Women call out answers in a dialogue with the village teacher (for example, to her "And then what do you do when your baby is this way for several days?"). The use of humor by some teachers (such as to imitate the conservative views of a stodgy neighbor, or of a husband who doesn't believe that the sex of a child is determined by the father) is met with laughter and clearly appreciated (cf. Hamilton 1984, pp. 6-7).

All the village teachers interviewed during this evaluation say they are in general very comfortable presenting the Life

Cycle material. At times they are faced with a village mother who is sceptical about information they present, but usually the mothers respect and believe the teacher. Since she has left the village to get training and education outside, other village women believe she must be knowledgeable. This is buttressed by reports of mothers who have used information presented in the class and seen success in the fact that their child remains healthier. The material presented is perceived as the most relevant by the supervisors, the teachers, and the mothers. The majority of the teachers observed present their material well, using participatory techniques and engaging the mothers easily in discussion. The mothers seem to enjoy the class, even in the one class observed where the teacher was hesitant and appeared the least prepared.

Unfortunately, nothing exists on paper to permit people outside CRS/Jerusalem to replicate the teaching techniques that make the Life Cycle curriculum so effective. The actual printed curriculum (Fundamentals of Health Education: Life Cycle) contains only subject but not "process" material. That is, there is no guidance on the crucial techniques for presenting the subject matter in the captivating manner for which "CRS health education" has become known. Thus, without such a guide, traditionally trained health professionals are likely to present the content in the usual inappropriate "turn-off" lecture mode that is well known to fail in most village environments. This is likely to happen after "institutionalization" as well, if no such guide is prepared.

Recommendations:

1. "Guide to Using the Life Cycle Curriculum." CRS should produce and make available to others a guide (manual) to assist in training health educators with the Life Cycle curriculum. A loose-leaf format might be best. The following sections should be included:
 - o An introduction explaining the general spirit and philosophy of health education for village and urban poor mothers through the use of village women as teachers;
 - o The purpose, importance, and details of the key teaching techniques (participatory discussion, role play, etc.);
 - o Materials design for simple teacher-made teaching aids;
 - o The use of available audio-visual aids;
 - o Illustrative lesson plans for the Life Cycle curriculum.
2. Take-home reference materials for mothers. CRS should make available health education materials for each lesson to send home with the mothers. Mothers who are illiterate usually have children or male family members who can read. If no suitable materials exist already, CRS should consider design-

ing and producing such materials. Some such materials have already been prepared by the Union of Palestinian Medical Relief Committees. Others may be available from WHO, UNICEF, and other Arab countries.

3. Increase the use of audio-visual equipment (e.g., films and microscopes) by village teachers. This should be encouraged by CRS as additional motivation for class participation. Investigate the need to design or purchase additional relevant materials to enable the creation of good audio-visual libraries in each of the three regions.

Planned Outcome Two: Trained Staff

The CRS instructors and field supervisors are well-trained and knowledgeable in their jobs; in general, they are conscientious and hard-working. The current staff has many strengths and seems very appropriate for expanding and strengthening village health education. The instructors appear excellent and able to instill a high degree of confidence and motivation in the village teachers, and the supervisors generally appear to perform their important field support with competence. Over a dozen in-service training workshops or seminars have been held to upgrade staff skills (see Appendix E). Evidence of local appreciation for the CRS program is the fact that other institutions and their staff have donated time and space for these in-service training sessions.

The present combination of personnel is not sufficient, however, for the task of institutionalization. The project proposal envisaged an assistant project manager, in addition to two Community Relations Specialists. Subsequently CRS/JWB decided to eliminate the assistant project manager position, along with one of the community relations specialist positions, on the grounds that the staff should not be so top-heavy, especially as it faced the need to phase itself out of business by the end of the project. With the advantage of hindsight, it is easy to say that CRS should have stuck to its original plan and recruited at the outset a Palestinian assistant project manager who, with experience in community development or rural health-related work, could have taken responsibility from the start for "institutionalization" aspects of the project. This would also have helped send the message to the Palestinian community at large that CRS was indeed serious about its support of village health education coming to an end.

The present staff of supervisors and instructors (trainers of village teachers) will, in addition to supervisory and training skills, also require management skills in order to carry out their expected tasks. The village teachers as well as the supervisor/instructor staff have all indicated the need for ongoing continuing (in-service) education to keep them knowledgeable or new developments and current in their techniques.

Recommendations:

1. CRS should regard continuing (in-service) education for both the village teachers and the supervisor/instructors as an essential part of the village health program and should work with the Unions to identify ways this can be carried out.
2. CRS should provide additional training to the present staff members to enable them to more adequately fulfill their roles (see section VI, "Additional Personnel Matters").

Planned Outcome Three: Training for New Village Teachers

Many additional villages have requested "CRS health education" and CRS has successfully trained women from these or nearby villages to serve as village "family teachers." CRS has trained 118 new village teachers since the beginning of the Life Cycle Project and the introduction of the new curriculum and teaching methodology in January 1985. More than 50 additional villages have put forth candidates who are still waiting for training, however. CRS has been reluctant to meet the requests of all these villages because of uncertainty about the future of the village teachers after the project ends.

The village teachers generally appear to be respected and appreciated by the women in their classes. Several aspects of this are worth examining further. For example, conventional wisdom regarding this type of health activity maintains that the person selected to dispense advice on matters relating to reproduction and child care should be an experienced mother herself, or at least a married woman. Evidence here does not support this idea. Although CRS has generally sought to recruit as village teachers women who are mothers, or at least married, many are not. Often other characteristics (selection criteria 2, 3, and 4 above) have ended up being more important. Many of the village teachers are young unmarried women (in their 20s and some even not yet 20). When women (mothers) in the classes are asked how they can respect a young woman who is not even a mother, their prompt, emphatic response is that they respect the knowledge and skills that the young teacher has been able to acquire by going outside the village for training--something most village women have not had the privilege of doing.

There are, however, several areas in which many village teachers could benefit from additional (in-service) training.

Recommendations:

1. Conduct in-service training for the present village teachers. Topics might include:
 - o How to make home visits more effective (including how to do so successfully without appearing to be snooping, spying, critical, or violating other village norms).

- o How to communicate with and get proper care from doctors (who often intimidate village women or give them advice contrary to what the course presents -- e.g. "Stop breastfeeding if your baby has diarrhea").
 - o How to make the classroom environment more conducive to good learning.
 - o Other topics listed above under discussion of the curriculum and below under "Advanced Curriculum."
2. Train more teachers? Decide with the Unions whether to train a new class of village teachers, recognizing the added burden this will impose for the Unions if they are taking over the program. (Decide with them also whether or not to introduce food commodity distribution in the "new" villages). 20 villages in the northern region have identified candidates for training. The Nablus Union might consider announcing to them that commodities would not be available in their villages and ask them to determine whether enough motivation remains to justify the course--possibly with some other motivational scheme to take the place of commodities.

Growth monitoring. The effectiveness with which the village teachers conduct growth monitoring was not a priority for this evaluation. Nevertheless, the evaluators did attend "baby weighing" sessions in eight villages. The teachers all appeared confident in knowing how to weigh the babies brought in and how to mark their weights on the charts each mother brought with her. None of the children were judged or recorded as underweight (and no advice was given). But how accurate were the weighings? With temperatures at this time of the year near freezing, babies came bundled up in many layers of clothing. (Frost was on the ground in one village, there was light snow elsewhere, and bone-chilling drizzle was falling in other villages). With no heating in the rooms used for weighing, teachers and mothers were all reluctant to expose the babies to the cold and only removed the heavier outer layers. To arrive at the weight for recording on the chart, the teacher then subtracted a bit to adjust for the clothes remaining on the baby. Metal infant scales, fabric sling scales, and bathroom scales were used in the different villages. In some villages, a baby that cried to protest being put in or on the scale was then held by its mother who stood on the bathroom scale and her weight was then subtracted to arrive at the baby's weight. (These mothers were, of course, also bundled up against the cold.)

Planned Outcome Four: Advanced Skills Training

CRS has developed an Advanced Training Curriculum for Village Teachers, but abandoned its plan to use this for training village teachers in advanced skills.

The objective was to provide advanced training to selected village teachers who have taught successfully for a minimum of one year. The advanced skills training was to prepare them to: (1) recognize at-risk populations and refer people for appropriate services; and (2) provide emergency first-aid care in the village. In the grant proposal, "750 pregnant mothers given counseling, screened for high risk, appropriate referrals made" was written as one of the verifiable indicators for "fostering the adoption of appropriate preventive health behaviors."

During the first year of the project, Life Cycle staff, with a consultant, produced an "Advanced Curriculum"* focusing on pregnancy monitoring. Some village teachers received training in pregnancy monitoring and began including information on the importance of pregnancy monitoring in their village classes. However, following advice from a consultant (apparently the same consultant who co-authored the "Advanced Curriculum"), no monitoring was begun in the villages.

It is unclear why this advice was given. Some people say "the Advanced Curriculum" did not equip village teachers to do much more than they were already doing. It may also be that the consultant who co-authored the Advanced Curriculum, or other health professionals advising CRS, advised that "non-medical" village women should not be acquiring health care skills but "just stay with education."

Experience and the literature from throughout the world, however, have shown that such pregnancy monitoring and first-aid services as CRS had planned can be adequately performed by village workers with much less prior education than these West Bank village teachers. In Palestinian villages and towns where there are dayas (traditional birth attendants) or a physician, this is a less needed service. However, many villages do not have either a daya or an easily accessible physician. Many village women now know that they need monitoring during pregnancy but are not able to receive this care. When a high-risk pregnant woman is identified, it is important for a physician or MCH facility to follow her.

Recommendations. CRS should reconsider:

1. Making the Advanced Curriculum (or selected portions thereof, revised if necessary) available for use for in villages with inadequate physician services; and
2. Training the village teachers in those villages to provide ante-natal monitoring.

* CRS/JWB, Advanced Training Curriculum for Village Teachers. Prepared by Ni'meh Michael and Daniel Carr for CRS/JWB Health Education/Life Cycle grant. 1986.

Planned Outcome Five: Medical Linkages and Support

CRS recognized before the project began (as early as June, 1984) that it needed to develop on-going linkages with service providers in order to achieve its objectives of education, monitoring, and identification of high-risk groups and individuals. The grant proposal stated that CRS would develop a referral network of local providers of primary health care services, specialists, and hospitals and that it would develop a training and inservice program for health care personnel. This has not been accomplished, but remains an important need.

Three strategies, or models, have emerged among local and foreign organizations seeking to help improve the health of the rural West Bank population. One of these might be called the "medical model" in which physicians and nurses (or nurse-aids) offer curative and preventive services in a limited number of clinics. These may be in fixed clinics (by preference), but may also be provided through the use of mobile clinics on a sporadic basis.

A second strategy is the "health and development model" in which a small number of clinics provide physician-based curative and preventive care complemented by assistance in income-generating and related social or developmental activities (e.g., literacy, kindergarten, home economics).

Both of these strategies require a clinic attended by a physician. While there is a large number of physicians on the West Bank (many of whom are unemployed or under-employed), establishing a clinic with its resultant staff and equipment needs is expensive. Therefore, the number of clinics supported by any one project is relatively small (ranging from one to about a dozen clinics). It is also possible with both of these strategies to have satellite clinics radiating from a base. However, even with satellite clinics, access to health information and facilities is available to only a minority of the rural population. The health care for that minority is fairly complete. In these approaches, services are usually provided close to a larger town and do not reach the smaller more remote towns and villages.

The third "health education model" provides basic preventive and home-based health measures through the use of village women trained in basic preventive knowledge who teach other women in the village and encourage adoption of this knowledge. World literature has shown that, with adequate teaching and monitoring, this is an effective way to reach any village--including smaller and more remote villages-- quickly and at a relatively low cost. Disadvantages are that the complementary curative and health monitoring services may not be available or provided and referral systems may be difficult, since most physicians do not consider village women an legitimate referral system.

All three of these strategies offer needed services, and no one is by itself adequate for meeting the population's health

care needs. The strategy an organization chooses depends on its own philosophy, goals, personnel, and resources.

CRS chose the third "health education model." At the same time, it recognized the need to develop linkages with on-going service providers. A 1984 "Statement of Work"* for the Life Cycle Project discussed the objective of training village teachers to educate, monitor, and identify high-risk groups and individuals. This document stated "To achieve the last task, CRS will develop a referral network of local providers of primary health care services, specialists, and hospitals" and, it continues, "A training and inservice program will be developed for health care personnel." CRS' use of several West Bank physicians and nurses as consultants and providers of in-service training shows a definite sensitivity to this problem.

There is a clear need for this type of medical linkage. Village teachers and mothers discussing their "felt needs" often mention issues of pregnancy monitoring and monitoring of identified common adult ailments, such as diabetes and high blood pressure. Many village women also tell of difficulties in getting seen by a physician or in a clinic (even for services that are supposed to be provided free) after the village teacher has identified a problem and advised the mother to consult a physician for herself or her child. The problem is often one of the village mother going to a doctor, being treated poorly (or perceiving that she is treated poorly) and, consequently, an ineffective outcome.

Recommendation: CRS should, especially in the context of institutionalization (see section VI), actively investigate ways to develop links to health care providers, particularly for initial pregnancy checks and selected common village problems that directly affect mothers and children (such as diabetes and high blood pressure) and that could be monitored by village teachers. Suggested source: Palestinian Medical Union** in cooperation with the Unions of Charitable Societies.

* CRS/JWB grant proposal, pp. 4-5; also Statement of Work (cover letter dated June 25, 1984).

** The Palestinian Medical Union ("Nakabi") is an organization to which physicians must belong before they may practice medicine on the West Bank. It functions under the same regulations as the Jordanian Medical Union. It does not provide health care service per se, but it does provide to young physicians who have recently completed training some salary support to work in designated clinics.

THE "INSTITUTIONALIZATION" OBJECTIVE: WEST BANK

- * Are the objectives, as outlined in the logframe, being met?
- * Will they be met by the end of the project?
- * Are the original assumptions valid at this time?

Progress Toward Meeting the "Institutionalization" Objective

This part of the project was behind schedule before the grant even began and remains far behind schedule with no possibility of being achieved by the planned end of the grant (January 31, 1988) as things are presently structured. It may still be possible to initiate the process but, with less than a year remaining, the "institutionalization" initiated will still be tenuous, fragile, and may not be sustainable. Some of the original assumptions remain valid; others were overly optimistic.

CRS has used "institutionalization" to mean transferring the health education program to one (or more) Palestinian organizations who would be able to keep the program operating more or less as it does at present. As stated in the Logframe (see Appendix B, p.85), CRS anticipated that by the end of the project:

1. The Union* of Charitable Societies will be able to provide leadership, salaries, office space, and transportation for 6 supervisors;
2. 200 villages, through local societies, will be able to maintain the cost of a village teacher and provide a classroom and needed equipment; and
3. New village will request of the Union of Charitable Societies* to become involved in the health education program.

Stated as a major "important assumption" was: "That the political and security situation will allow the institutionalization of the project" (Logframe, p.85).

This part of the project is behind not because CRS has not tried. The task is immensely difficult and complex. This is, in fact, the first time that either AID or CRS has tried to "institutionalize" a project with a local Palestinian organization. No other project supported by AID or CRS on the West Bank or in Gaza has ever been established or carried out with this goal in mind. Thus the Life Cycle Project is trying to do something that no other CRS or AID-supported project has ever attempted.

* The Logframe says Union. There is no single West Bank "Union," but rather three regional Unions. See section III above.

It was in late 1984, while finalizing the Life Cycle grant proposal, that CRS/Jerusalem apparently initiated discussions with the Unions about taking over responsibility for the program. In March 1985, CRS gave a "discussion paper" to each of the three Unions setting forth details for the "proposed takeover of the supervisory component of the Health Education Program."* This included a 5-year cost projection and a suggested timetable as follows:

March-August 1985	Preliminary discussion between CRS, Unions, and Amman [General Union of Charitable Societies]
August 1985	Final agreement drafted and approval requested
September 1985	CRS-sponsored inservice training [for personnel involved in the takeover of this component]
September 1985	CRS supervisors transferred to Unions
Sept. 85-Dec. 87	CRS monitor takeover

To pave the way for transferring the program to Palestinian management, CRS also reduced the size of its health education staff, revised all staff job descriptions, and adjusted salaries downward toward levels paid by local organizations--these being considerably lower than paid by foreign organizations (see Hamilton, 1984).

In May, 1985, CRS received a response from one of the three Unions which included the following points:

1. The Union cannot and does not wish to be a substitute for Catholic Relief Services on the West Bank.
2. The Union also sees that circumstances are not suitable for local institutions to take over the work of foreign societies.
3. The Union hopes that your society, and similar ones, will continue providing human services on the West Bank.**

Throughout 1985 and 1986, the CRS project director and staff continued to discuss "institutionalization" with all three Unions, but their position has remained essentially as outlined

* See CRS/JWB First Semi-Annual Report on Life Cycle/Health Education Program (Attachment 6a).

** See CRS/JWB First Semi-Annual Report on Life Cycle/Health Education Program (Attachment 6b).

above. In part the refusal may be based on the belief that CRS does not really intend to stop funding this program that it has worked so hard to build up and that is now so popular.

The three Unions differ in their situations and, accordingly, in the reasons they have given for not being able to take over the program. A major reason all three have consistently cited, however, is inadequate finances. This is a very legitimate concern. First, they are volunteer organizations with very meager resources. Second, whether they will receive funds for the program from the General Union in Amman is unclear. At least one of the Unions (Nablus) has asked the General Union for funds to support the program, and the General Union has expressed intent to provide funds, but the amount is uncertain and there is no assurance as to when it might come. Constraints imposed by the military occupation are also a major factor.

Are There Other Organizations That Could Take Over the Program?

No, none that are acceptable.

When the Unions were not forthcoming, CRS approached several other Palestinian institutions or organizations proposing that group take over the Health Education program. One organization approached CRS asking to take over the program. None of these alternatives are appropriate candidates, however. CRS considered the two most promising alternatives to be the Arab College of Nursing and Bethlehem University.

The Arab College of Nursing: In February, 1986, CRS submitted a working paper to the Arab College of Nursing.* Up to that time, the college had shown the most interest in taking over the program and was viewed by CRS as the most promising candidate. It subsequently became worried about the financial implications and cooled to the idea.

Bethlehem University has already cooperated with the CRS Health Education program (for example, by providing in-service training) and the head of the nursing faculty has shown considerable interest on the grounds that the university badly needs an outreach program. It is clear, however, that the university is not able to take on so extensive a program; it could do outreach in perhaps 3 to 5 villages (and would like to), but not 144). Nor, wanting to remain a high-quality academic institution, could it provide six-month training at the lower level of the village teachers (many of whom would not meet the standard admission criteria and some of whom are not even high school graduates). The nursing faculty would like to provide

* See CRS Third Semi-Annual Report, p. 13 and Attachment 7.

occasional specialized seminars to CRS health education personnel, but at the level of CRS' instructors and other more senior staff.

In addition to Bethlehem University, there are three other universities on the West Bank--Hebron University, Bir Zeit University (in Ramallah), and An-Najah University (in Nablus). CRS has contacts at all three, but none are appropriate for the task. Caritas Baby Hospital in Bethlehem, which actively supports the village health program (e.g., by providing free space for the teacher training course), is also not appropriate or able to assume management responsibility for the program.

Government of Israel officials have expressed interest in taking over this village health education program. This is not acceptable, however, to Palestinians involved in the program.

Back to The Unions

The Unions of Charitable Societies remain the most promising of West Bank organizations for assuming management support for the village health education program created by CRS. They value the work of the village teachers and, while eager to have CRS remain the sponsor of the program, at least one Union (Nablus) has now (during the course of this evaluation) indicated intent and anticipated financial ability to assume responsibility for the program in the northern region. The other two Unions (Jerusalem and Hebron) may also be or become interested in joining in.

The Nablus Union remains hopeful that the General Union in Amman will eventually supply the money needed to fund the program in the north. This is estimated to be about 5,000 Jordanian dinars (J.D.) per month, including payment for all village teachers. This is 60,000 J.D. per year--equivalent to about U.S.\$180,000. While waiting for Amman, however, the Nablus Union has now earmarked 5,000 J.D. of its own budget for the program. The head of the Union knows this is not enough but says "It is an important program for our people and we will do the best we can do."

Previously leaders of the Unions had told CRS that no single Union would take on the project without all three agreeing to do so collectively. This no longer appear to be a condition.

Recommendation. CRS should proceed immediately with steps to turn management of the program in the northern region over to the Nablus Union (see section VI below). CRS should hope that the other two Unions eventually decide to join in, but it should not wait for all three in order to proceed.

REDUCED DISTRIBUTION OF PL-480 FOOD COMMODITIES

The project has cut back its distribution of food commodities, but it has not yet met the stated objective of changing the use of commodities to become "congruent with program goals of: focus on greatest need and development of village self-reliance and independence." Food commodities (mu'an in Arabic) are still distributed to all women who enroll in the course and participate in the growth monitoring, regardless of their nutritional or economic need. Commodities distributed are rice, corn oil, and powdered non-fat milk. (All are provided through the maternal-child component of the PL-480 program).

Before the Life Cycle Project began, it was possible for a woman to continue receiving commodities for up to five and even as long as nine years.* Many did. CRS judged this to be inappropriate and, at the beginning of the Life Cycle Project, changed its policy and scaled back the distribution of commodities. Now a course participant may receive commodities only for the six months while attending the class and thereafter, while participating in the weighing, for an additional six months -- that is, for a maximum of one only year.

Food commodities play a questionable role in the program. It appears that the commodities were important as an incentive for participation when the Nutrition Project was being established in 1975, and they were probably important for nutritional reasons as well. Today, however, the situation is different. First, the nutritional need is no longer so acute. Second, the course content and approach has been improved to the point that many if not most women come to it for the knowledge and skills they can learn, not for the food. Critics also charge that handing out food commodities fosters an undesirable dependency orientation, perpetuating the "UNWRA dependency mentality." (It is this aspect of the program, in fact, that seems most criticized.) At the same time, many villagers (female participants and male sponsors alike) argue that the food distribution is still a useful motivator and should be retained. The issue is not clear-cut (see Appendix F).

In any case, CRS' scaling back to a one-year maximum of food distribution was a significant and positive change. CRS has not developed any additional plans, however, for further modifying

* This was possible because mothers were encouraged to bring their children in for growth monitoring (weighing) until the age of five, and could receive commodities during that period. If a mother thereafter enrolled in one of the other three CRS-introduced courses, and brought a younger sibling in for weighing, this again entitled her to commodities until that child reached age five. (See: "Commodities" in Addendum materials to Life Cycle/Health Education grant proposal, 1984.)

the commodities distribution to achieve its stated objective of focusing on need and development of village self-reliance.

Recommendation: CRS, in accord with its original objective, should phase out the commodities distribution as it presently exists (going to all health education participants without consideration of need). Phase-out should be gradual, however (see section VI below).

ACHIEVEMENT OF PROJECT OBJECTIVES: GAZA

Objectives have not been achieved in Gaza and probably cannot be achieved by the end of the project. CRS has succeeded in conducting one successful six-month health education training course in Gaza for young women interested in becoming community health educators. This training was well-presented and has attracted the interest and admiration of other donor personnel working in health in Gaza. But CRS has not carried out all anticipated Gaza activities, nor is this planned.

Initiating and instituting a CRS health education program in Gaza appears from the outset to have been a lower-level objective of the project. The fact that this objective is not being achieved should not be considered a major failing of the project, however, for several reasons.

First, as noted above (see section III), Gaza and the West Bank are radically different in major ways, necessitating different development strategies. Second, the CRS Health Education program had already, at the outset of the Life Cycle Project, established a good basis of operations throughout the West Bank. For the West Bank, the project objectives were to strengthen, expand, and "institutionalize" this program. In Gaza, the program had not yet been introduced and the project objectives were to start from scratch to do so. Third, with the majority of Palestinians in Gaza being poor refugees, there are no Palestinian organizations able to take on such an effort as the West Bank's village-based charitable societies and Unions have done.

CRS recognized these obstacles before the project began. According to Sr. Barbara Cline, then project manager for the Health Education Project and author of the Life Cycle grant proposal:

"Concerted effort has been made to identify an organization or agency in Gaza through which to operate a Health Education Program. Nearly all health care services are rendered through the government [of Israel] or UNRWA. There are a couple of other programs, but they are not far-reaching in their service population.

The government clinics are not appropriate because of the political situation, even though they are interested. Contact has been made with UNRWA which is interested in strengthening

its nominal health education program. Many questions arise regarding involvement with UNRWA, however none that are unanswerable. Over half the population of Gaza are living in refugee camps and are in need of health education. The major area of need appears to be in nutrition and hygiene."*

The present and previous project directors have made on-going efforts to find organizations in Gaza with which to launch health education activities. The present project director, Daniel Carr, appears well known by principal personnel of the leading relevant organizations in Gaza and they speak openly with him of their esteem for the Life Cycle curriculum and participatory teaching techniques. It has been hard for all, however, to envision a way in which the CRS health education program could be worked into the programs of these other foreign organizations. CRS' recently concluded Gaza training course was a breakthrough but it is hard to see how this could result in an ongoing health education program.

The Gaza training course.* This course came about when, after much discussion, the director of the Near East Council of Churches (NECC) Committee for Refugee Work in Gaza, asked CRS if three of his current staff could be provided with CRS health education training. It was eventually agreed that NECC would make available a good classroom for this training if CRS could find at least 10 participants in order to constitute one course as a model for possible follow-up later.

The problem here was that, unlike on the West Bank, the trainees (except for the three NECC staff) would have no promise whatsoever of employment in health education following the end of the course. Eventually 15 young women applied, were interviewed, and were all told clearly that this was not a promise of work. The course began on July 1, 1986, with no assurance that any of the young women would even show up; 27 showed up.**

Following completion of the course in February 1987, three of the major health providers in Gaza (the NECC, Red Crescent, and UNRWA) have employed, either with pay or as volunteers, all of the CRS trainees. Another institution (the Child Development Center) requested more CRS health education teachers. Some of the course graduates had also arranged with local mosques to provide health education to neighborhood women. Even though some of the graduates are now working on only a volunteer basis, this constitutes a major and promising achievement, given that only three of the trainees had any promise of employment at the outset. It is also significant that no food commodities were linked in any way to this course.

* CRS, Addendum materials to Life Cycle/Health Education grant proposal (identified in cover letter to AID, as "responses to questions on the Health Education Project," 1984).

** See Third Semi-Annual Report on Life Cycle/Health Education Program, CRS/JWB, 1986 (pp. 8-11 and Attachment 5).

Part V

IMPACT AND IMPACT MEASUREMENT

- * Is the quality of data being collected on the project sufficient to evaluate its impact?
- * Can it be said at this time that the project is having a positive health impact?
- * Will it be possible at the end of the project to determine whether it has had a positive health impact?
- * What other impacts is the project having?
- * Should other data be collected and other methods used to supplement the present questionnaire?
- * What minimal data are required for measuring health impact at the village level, now and after "institutionalization"?

There is suggestive evidence that this may well be one of the most successful AID-supported projects in the Near East, and perhaps anywhere. It may be one of the most successful primary health care efforts and it may be one of the most successful projects in terms of its beneficial impacts on women. It has also had a significant "spread effect," or positive impact beyond its immediate beneficiaries. There are serious shortcomings, however, with the present impact measurement strategy.

HEALTH IMPACT

Observations of people familiar with the Life Cycle project, including descriptions of its direct benefits as well as its use as a model for other health projects, attest to the project's effectiveness. Firm impact data, however, do not exist. Systematic quantification of the impact of health education or other primary health care projects is notoriously difficult to achieve.

The Life Cycle Project's Monitoring and Evaluation System

A monitoring and evaluation system was devised at the outset of the Life Cycle Project. The village health teachers routinely record information regarding sites offering health education and numbers of women taught and children weighed (as well as child-specific growth monitoring data). In addition, a questionnaire is administered to women before and after health education to document changes in health knowledge and practices (see Appendix G).

This monitoring and evaluation system provides data for assessing the effectiveness, if not the impact on health, of the project. In addition to providing information on the project's current status, this system was intended to permit decisions regarding mid-course corrections. One of the two main purposes of this evaluation was to determine whether changes should be made in this system, including whether new or more useful indicators should be selected for measuring effectiveness and impact.

The project's "logical framework" (see Appendix B) specifies the "objectively verifiable indicators" which form the basis of the project's evaluation strategy. These indicators are specified in the grant as the criteria for reporting to AID and for evaluation of the project. This section of the report focuses on CRS's collection and handling of data for the evaluation of project impact as required by the grant.

However, the principal purpose of a monitoring and evaluation system should be to guide management decisions. Any alterations in the project's monitoring and evaluation system may well be chosen to facilitate reporting or end-of-project evaluation. But, in view of the goal of "institutionalization," it is also important to consider the perhaps different needs for information to guide decision-making after the end of the grant.

Data from project and other sources may be used to monitor and evaluate the Life Cycle Project at three levels, including:

1. Project outputs, such as whether the levels attained achieve those projected in the logical framework (presuming project inputs were adequate);
2. Project effectiveness, including changes in the prevalence of health knowledge and target health behaviors; and
3. Project impact, including reductions in morbidity and mortality in the beneficiary population which may be attributable to project interventions.

Presently available sources of information that may be tapped to evaluate the Life Cycle Project at one or more of the above levels are:

1. Project management data (project outputs);
2. The project's evaluation questionnaire (administered to mothers in participating villages before and after taking the Life Cycle course); and
3. Growth monitoring data (maintained by village health teachers and mothers, twice monthly if underweight, monthly if <1 year of age).

Additional potential sources of evaluation data which may be used to document project effectiveness and/or impact include:

1. Special surveys or studies conducted by Life Cycle staff, such as observational studies, interviews, focus groups, sample surveys, or case-control studies.
2. Data from other health service providers or planners who provide services and/or collect information in geographic areas which overlap those of the Life Cycle project.

Uses of such data, whether collected from such ad hoc studies or routinely through the monitoring and evaluation system, must define the nature and the methods of collection. Considerations in the collection and use of information include the following:

- o Processing of data, including entry and analysis, can be quite costly, whether in personnel time or software development costs. Slick software and fancy analysis do not atone for poor design of questionnaires or other survey instruments. Although the costs of software development may be warranted for continuous handling of large volumes of data, the smaller volumes of data from sample surveys can generally be managed with commercially available software packages.
- o Decision-making must drive the data collection process, and information management must be constantly reviewed to confirm the utility of the information for project management.
- o Reporting needs should guide selection of software for statistical analysis and/or graphics as well as types of data to be collected. The reporting needs may in turn be defined by planned dissemination of results as well as the character of the information collected.
- o Dissemination of results must also guide methods of data collection and well as reporting format. Primary data gathering is difficult in the West Bank and Gaza, and care should be taken to assure maximal use of this information by others concerned with advancing the health status of the people in these areas. For example, agencies concerned with water and sanitation or health may be encouraged to make use of the data. Too frequently neglected are the health workers and villages themselves when reports of such data are assembled. They have a vital interest in such information and must be assured that they have not simply been exploited once again by the "data parasites" who use information only to advance their own purposes.

At Present

Conclusions about current achievements in project outputs can be drawn from information available in existing project records. Questionnaire data gathered before and after a health education course is held in a village suggest that the project has altered health knowledge (and probably health behaviors) in the beneficiary villages. More information is needed, however, to strengthen the argument that the positive changes observed are attributable to the project.

Project Outputs

The project records provide the following data regarding outputs as of the time of this evaluation. Also included are projections established in the project proposal and anticipated levels of these outputs at the end of the Life Cycle Project. See chart below: "Project Outputs: Current and End-of-Project Projection."

PROJECT OUTPUTS: CURRENT AND END-OF-PROJECT PROJECTION

Output	Current Level	Initial EOP Projection
Village teachers trained	118	100
Sites of active health education	146	200
Courses taught	621	---
Mothers completed new curriculum	13,304	17,000
Children <5 weighed/month	16,312	12,000
Referrals for antenatal care] total of all referrals	750
Birthweights] 681 900	
Referrals for growth failure] (advanced curriculum never implemented as planned)	1000

Project Effectiveness

Observations of village teachers, supervisors, and others suggest that the health education has improved mothers' health knowledge and actually changed health behaviors. Systematic quantitative assessment of changes in health knowledge and behaviors is more complex.

The CRS questionnaire (see Appendix G) administered to mothers by CRS supervisors before (N=838) and after (N=1012) the health education course was introduced in their village responds to donor pressure to provide a quantitative assessment of project effectiveness or "impact." Although this questionnaire provides some useful information, problems with its design and administration, as well as the software for its analysis, limit the utility of the results. Difficulties include:

- o No documentation of current pregnancy (only if the numbers fail to add up is there the implication of either current pregnancy or history of multiple births).
- o Failure to include a time frame for reproductive history makes it impossible to calculate fertility rates or infant mortality rate.
- o Reporting of pre-natal care for all pregnancies induces a similar "wash-out" of any impact of the project on proportions of respondents seeking such care.
- o Self-reporting of health behaviors introduces bias, particularly as the CRS field supervisors administering the questionnaires are "invested" in results.
- o Although there are no obvious cultural barriers to the frank reporting of responses to the questions by mothers, there is confusion regarding some questions (e.g., does "Did you take your child to the doctor?" refer only to the response to the child's diarrheal disease in the preceding questions, or for any reasons?)
- o Some of the CRS field supervisors ask the questions methodically, while others fill in the form after the visit based on a combination of direct observation (as of living conditions) and open questions (regarding health attitudes and practices). Some supervisors administer the questionnaire to women individually in their homes; others do it to women in a group who have the opportunity to discuss the questions asked with women who have just been interviewed. These widely differing methodologies introduce obvious geographic biases as each interviewer covers a separate area.
- o Heavy emphasis on collection of sanitation and other socioeconomic indicators which are not likely to change promptly in response to health education.

- o "Convenience" rather than systematic sampling of mothers as respondents introduces potential selection bias.

The information provided by these questionnaires is useful background information on the population served. This information gathered does not constitute reliable data as to changes in health status or mortality attributable to the project, however, because of the limitations noted above.

Although comparison of the groups with and without health education is hampered by the nature of the sampling process, the two groups do appear to be roughly comparable in terms of the indicators of living conditions and socioeconomic status. Women who have completed the health education course have a larger mean number of pregnancies, but this is likely to reflect a difference in age, rather than fertility, between the two groups. That the group with health education is more likely to report births in hospital (46% vs. 37% among women without) may reflect the fact that the Life Cycle Project is more recently reaching the smaller villages, with the result that more baseline questionnaires have been collected from among women who live in more remote areas. That there is no significant difference (45% with, 42% without) between the two groups for reports of prenatal care suggests that the women are not likely to be reporting prenatal care or hospital deliveries to please the interviewer after they have completed the health education. As noted above, these indicators are not likely to reflect actual changes with health education since they include all past pregnancies.

Whatever the data show, the questionnaire as currently designed offers the following "best hopes" of documentation of differences in health behaviors among those with and without health education for:

- * reduction in the prevalence of bottlefeeding,
- * average age of introduction of semi-solids, and
- * proportion of women who have ever used ORT.

The data now available from the questionnaire suggest that the following improvements in health practices may (with caveats noted above) be attributable to the project:

REDUCTION IN PREVALENCE OF BREASTFEEDING		
Indicator	Before Health Ed.	After Health Ed.
Number of respondents	838	1012
Percent of women who did not bottlefeed last child	38%	46%
Percent reduction in use of bottle since previous child	4.6%	11.5%

In view of the frequency of transmission of enteric diseases through the use of bottles for infant feeding, this change in health behavior can be expected to have a positive impact on health status among those women with health education. No significant difference was noted between those groups with and without health education with respect to average number of months breastfed prior to introduction of weaning foods, or proportion of women reporting ORT use. The failure to demonstrate these differences reflects difficulties with the questionnaire design, and does not imply that the project has had no impact on these health behaviors.

Another potential use of the data from the questionnaire is in the development of risk indicators or a risk index. The available information, notably the pregnancy and infant and child mortality histories and the socioeconomic indicators, are known predictors of subsequent infant and child mortality. Such information could be used by the village teachers and supervisors to identify target populations for intensive education or other interventions.

Although not to be mistaken as a current infant mortality rate (which is reported for a single calendar year), it is interesting to note that the rate of mortality among infants through the entire pregnancy history for these women is 64.2 per thousand live births. Given the usual difficulties in ascertainment of IMR, this number is probably an underestimate. However, it is interesting to note its comparison with those noted or estimated by others (see section II "Health Status" above).

Project Impact

Data to support project impact on health status (i.e., morbidity and mortality) are not now readily available from project records, but may well be obtained before the end of the project.

At the End of the Project

Project Outputs

An update of the matrix above based on outputs specified in the logframe will undoubtedly document that the project achievements are in proportion to the outputs promised at the end of the project. Such information will again be easy to abstract from project records through the existing data collection system.

Project Effectiveness and Impact

Additional or corroborative sources of information, including from non-CRS sources and special surveys, may well

be important for end-of-project evaluation. However, the feasibility, desirability, and costs of such efforts deserve careful consideration. Abstraction of information from non-CRS sources is attractive because of limited cost and the desirability of independent corroboration of the findings of project effectiveness or impact. Because of the frequent discontinuity of areas served, poor documentation of the population size in villages or camps, the multiple potential confounding variables, and the other difficulties attendant with health service-based statistics, care should be taken in interpreting these data. Yet, the external sources noted below in the Summary of Recommendations appear hopeful enough to warrant an attempt at abstraction before the end of the project.

Population registration or census data are out of date or often grossly inaccurate in the West Bank and Gaza. In view of this lack of "denominator" data, figures such as the percent of the population served in any given area are not readily obtainable. The indicators selected for measuring project effectiveness or impact should therefore be readily obtainable by sample surveys, and preferably not based on externally obtained census data.

Special surveys conducted by CRS personnel represent perhaps the best hope of documenting project effectiveness. In view of the difficulty of documenting true impact on either morbidity (particularly in view of the projects lack of association with a curative care network) or mortality, intermediate indicators may be selected which will permit estimates of cases or deaths averted. The following list of suggested indicators is an attempt to provide a balanced collection of relatively sensitive measures of effectiveness with a few indicators which are less likely to reflect significant change but are worth the attempt to link program interventions to changes in the indicators that have a proven relationship with reductions in morbidity and mortality:

- o ORT knowledge and use
- o Percent of children <5 enrolled in growth monitoring, or families with children <5 with growth monitoring charts on hand
- o Percent of children breastfed and eating semisolids at 6 months
- o Percent of children weighed in last two months
- o Percent of children malnourished by grade
- o Percent of women receiving prenatal care during their last pregnancy
- o Percent of women who delivered their last child in hospital

These indicators are all readily reportable, comparable across programs, and have the additional advantage of being consistent with those required by AID's reporting system for its Child Survival Action Program projects.

It may be advisable to include additional questions to assess health knowledge. Those questions should be designed to measure achievement of the learning objectives outlined in the curriculum. Although the indicators listed above are attractive since they can be linked to health status and, indirectly, to mortality, questions like the following examples may be more likely to reflect exposure to health education:

- o Percent of women who can name one of the EPI vaccines
- o Percent of women who can select from a list of foods that which is calcium rich ("good for bones")
- o Percent of women who can identify which parent determines the sex of the baby
- o Percent of women who can select from a list one of the signs of toxemia of pregnancy

After "Institutionalization"

There will be continued need for information to guide management after CRS is no longer primarily responsible for administration of the program. Data collection need no longer respond to the constraints imposed by the original project design, but similar information will be needed regarding "outputs" as indicators of program effectiveness. Alterations in the design of the current data collection strategy must take this evolution into account, and the Palestinian Program Manager (see section VI) should be involved as early as possible in the process.

Although AID reporting requirements will continue through the rest of the project (including the subcontract proposed below), the transition period after the end of the grant will be greatly facilitated if a "post-institutionalization" management information system (MIS) is well in place at that time. This system may best be limited to one which gathers simple process information (numbers of women trained, children weighed, etc.) that is required to manage the program. Additional information needs for specific management decisions may then be met through simple ad hoc studies completed by the supervisors or selected consultants in just a few days.

Summary of Recommendations

- o Discontinue administration of the current questionnaire. Use other data collection techniques (e.g., focus groups, key informant interviews) to complete ad hoc qualitative studies of project effectiveness, beneficiary satisfaction, and other indicators that can be used to guide program management.
- o Obtain epidemiologic technical assistance (for example, by a consultant from a local university, preferably with the concurrence of the Unions) in the design and field-testing of a new questionnaire which is more responsive to evolving information needs. The consultant should work with CRS and the Unions to design this component of the MIS including establishing a system for data processing (e.g., pre-coded forms and software selection) and format for reports. The consultant should have epidemiologic, statistical, and data management expertise and be able to work with CRS field staff in pilot-testing and administering the questionnaire.
- o Select new indicators of project effectiveness and impact that will provide a balanced "portfolio" of sensitive indicators (such as of knowledge change) and more difficult to obtain measures such as of health behaviors or disease incidence which may permit estimation of morbidity or mortality reductions due to project interventions.
- o Additional indicators of project effectiveness should select operationally definable learning objectives (from the curriculum) such as health knowledge or behaviors which can be reported as a binary response (i.e., present/absent) or which are quantifiable. Open questions are of little utility except in preliminary or exploratory studies.
- o Once the new questionnaire is developed and adequately field tested, periodic sample surveys would be a preferable method for data collection. Cluster or other sampling techniques in villages with and without health education will probably provide similar numbers of "cases" and "controls" to assess project effectiveness (and possibly impact) with a few days work. The consultant selected for the above activities may also address recommendations for sample size and sampling technique.
- o Current project staff would be well suited to complete these field surveys, however careful training for the task will assure consistent interview methodology. In addition, interviewers should be "blinded" such that they are not aware of whether the respondent has completed health education.
- o Information from the existing data base or from future surveys could be used to identify high risk households or geographic areas for targeting of services. Information on

age of mother, parity, past history of infant and child mortality or socioeconomic indicators could be used to increase program impact in needy areas.

- o An assessment of the feasibility of using data abstracted from the Caritas Baby Hospital and the Hebron Rehydration Center for impact evaluation should be conducted. If numbers of cases of severe dehydration due to diarrhea are adequate over the past 3-4 years and if geographic data are specific enough to correlate with CRS records for villages with and without health education in the Hebron area, numbers of cases by month and by village may be listed. If reasonably accurate village population data cannot be obtained, there is no reason to proceed. The consultant identified for the survey activities could perform the feasibility assessment and coordinate the abstraction of records if indicated.
- o Records of patient contacts for prenatal care in the Ramallah area for the Lutheran World Federation's outreach program will be forwarded to CRS (as arranged per meeting of February 13th). These records should be reviewed to see if they will provide an opportunity to compare numbers of women seeking prenatal care in areas with and without health education. Again, the denominator data on populations served will be of great importance such that the information need not be further analysed if population data are not available. If populations can be reasonably well ascertained, the epidemiologic consultant may be requested to examine the records further.
- o An extensive data base is being compiled based on household surveys in the Hebron area by UNICEF and the GOI. Although data entry and analysis has not been completed at this time, an effort may be made prior to the end of project to collaborate with the Ramallah Health Services Research Center (RHSRC) in the use of the data for project evaluation.
- o Existing information should be disseminated to benefit other health-related activities in the West Bank and Gaza and to inform the contributors (including villages) of the results of the data analysis:
 - 1) Improve procedures for systematic feedback to mothers of the results of growth monitoring through explanation of the findings at the time of the weighing. Also consider use of a village "scattergram" on which markers for individual children can be moved with each weighing. Such a chart, particularly if posted where it can be viewed by all, may provide additional motivation to families with growth-faltering children.
 - 2) Simple narrative summaries of the results of data collection efforts (such as the questionnaire) should be distributed to to the unions and the villages. A

format may also be devised for reporting village-specific information on a few selected indicators that may be of importance to village leaders (e.g., sanitation or utilization of key health practices in their village relative to the median) if village samples are large enough to warrant some generalizations.

- 3) Maximize the use of project information by presenting results to other CRS projects. For example, a stratified analysis of the data on diarrheal disease by sanitation practices and facilities may be useful to CRS' Rural Development Project in prioritizing or reporting the expected impact of its activities.
 - 4) Dissemination of reports to other organizations with health-related activities in the West Bank will also be important. Primary data collections based on such household surveys are not frequent in the West Bank, and sharing of such information may aid others in optimizing their resource allocation.
- o Use locally obtained technical assistance and the subcontract mechanism (see Section VI) to shift control and responsibility for this management information system to the Union(s) prior to the end of the project. As reporting requirements will cease at the end of the subcontract period, special attention must be paid to devising an MIS which is inexpensive and yields only that information which will be key to project management after project funding ends.

SPREAD EFFECT

The CRS West Bank Health Education Program is also noteworthy for its "spread effect." It has had a definite positive impact on numerous other health education and primary health care efforts here and elsewhere. This includes the following.

1. The Life Cycle curriculum (in entirety or in part) has been adopted by several other primary health care projects and programs in the West Bank and Gaza (e.g., Caritas, NECC Gaza, and the Union of Palestinian Medical Relief Committees).
2. Many other primary health care providers have hired CRS course graduates trained with the Life Cycle curriculum, and are continuing to do so; some organizations (e.g., NECC, Gaza) have arranged for their employees to take the six-month CRS training course.
3. Other organizations (e.g., UNRWA in Gaza) have adopted teaching techniques introduced to the West Bank and Gaza by the Life Cycle Project for use in their programs.
4. The Ministry of Health of the government of Israel, with UNICEF, has initiated an "Expanded Primary Health Care

Project" in the Hebron region modeled in large part after CRS' West Bank Health Education program.*

5. The government of Jordan, with CRS/Jordan, has just (in 1986) initiated a project modeled after the CRS West Bank Health Education program using its Life Cycle curriculum and the same dynamic, participatory teaching approach.
6. CRS receives, and complies with, requests from other countries (even outside the Near East) for the Life Cycle curriculum and related materials. Recent examples include Egypt, Jordan, the Philipinnes, and Indonesia.
7. Finally, many other local organizations use this network to distribute their health care messages and services. For example, the CRS program has been instrumental in promoting immunization against polio, tetanus, and typhoid. CRS has distributed flyers in Arabic for Bir-Zeit University depicting local health problems. Hospitals and other agencies use the CRS health education network to distribute information about the incidence of diseases or potential epidemics.

IMPACT ON WOMEN

It is generally recognized that this program has been highly successful in providing village women with meaningful, easily utilized health education. In the process, it has also had a "capacitizing" effect on many of its participants by virtue of encouraging decision-making and problem-solving -- and, for a few poor village women, some income-generating activities. In fact, the Life Cycle Project may even be among the most successful AID-funded projects in benefitting village women whose options are otherwise very limited. This project :

- o has trained 118 women to become health educators ("family teachers") for the mothers in their communities, chiefly villages. This has taught them not only health-specific information but also broader skills in decision-making and problem-solving as well as income generation, entrepreneurship, and experience in working with men, medical personnel, and other professionals from outside the community.

* The Director of Personal and Community Preventive Health Services for Israel's Ministry of Health indicates that the success of the Life Cycle Project inspired the design of the Expanded Primary Health Care (EPHC) project which the GOI has initiated with support from UNICEF. This project was introduced on a pilot basis in 29 villages in the Hebron area in 1985. Following the model of the Life Cycle Project, it also selects young village women to be trained as village health workers, trains them using a curriculum adapted from the Life Cycle curriculum, and asks villagers to provide a room for village health activities.

- o has provided over 13,000 village women with approximately 40 hours of innovative, participatory instruction (the "Life Cycle" curriculum) in basic hygiene, family nutrition, maternal reproductive health, infant and child care, child development, and first aid.
- o has won the wide support of husbands, mothers-in-laws, village leaders (men), and male-led village organizations.

It is no small feat that this has been achieved in a cultural context in which many men do not let their wives leave the village and village women do not have many opportunities for education or mobility. The explanation is that, while most men do not let or like their wives, daughters, and daughters-in-law to leave the village, they do value their children intensely and are pleased to have their wives attending a class, in the village that provides new, modern knowledge about how to take better care of their children. While this is a capacitating, even perhaps even "liberating" class for the women, is not opposed by the men because of these two facts: (1) it is in the village, and (2) it is for the sake of their children.

One of many examples of the project's "capacitating" effect on women is provided by Jemaileh, a village teacher in Jericho district. Several women in the health education class Jemaileh teaches had complained to her that a local doctor was giving advice that contradicted what Jemaileh taught in class. Specifically, Jemaileh had told women in the class that, even when their infants have diarrhea, they should continue breastfeeding throughout the diarrhea. The doctor, however, had told the women to stop breastfeeding. Jemaileh, upset, went to the doctor to learn why he was giving women incorrect advice.

The doctor reportedly asked Jemaileh: "Who are you? Are you a nurse? How do you know about these things?" Jemaileh explained that she is a health education teacher and told about the class. She reproached the doctor, asking "Why do you tell these women to stop breastfeeding? You know this is the wrong advice." Eventually the doctor responded: "Those village women are illiterate, stupid, and often very stubborn. I don't want to get in any fight or argument with them. So when they ask 'Doctor, is it my milk that's making my baby sick?' I just agree and tell them to use a bottle instead."

Jemaileh says she scolded the doctor, telling him that even though some village women cannot read and write, they are not stupid, and that he should give them the advice--to continue breastfeeding during diarrhea--that he knows professionally to be the right advice. This the doctor now does, says Jemaileh proudly. And recently when some of her "pupils" went to the same doctor, he asked them: "Are you in Jemaileh's health education class?" "I thought so, because you ask such good questions."

Recommendation: CRS should consider funding a study (or studies) to determine and document the extent and nature of the program's impact on women, provided that this can be done in a manner that supports other objectives. An in-depth qualitative methodology (e.g., anthropological, focus-group) should be used. Ideally, CRS staff or other Palestinians in each region should take the lead, but apply a common methodology. A possible model is the in-depth study of Caritas' project in Nahaleen (see Giacaman 1986).

OTHER DEVELOPMENT IMPACT

The project is said to be having a significant developmental impact among the village population in general. In particular, it has been said that villagers are becoming more skilled in identifying their own needs and in finding ways to meet them. This appears to be true. It is also said that this project has contributed to growth in self-reliance and entrepreneurship. This is possible, although more definitive evidence is needed to confirm this. If this question is explored further, it will be important to ask which segments of the village populations are benefitting from the project (e.g. less advantaged villagers as well as elites).

Part VI

INSTITUTIONALIZATION: SUSTAINING PROJECT ACHIEVEMENTS

- * What are the essential elements for institutionalization?
- * Is PL-480 food essential for program operation?
- * Is the CRS/JWB institutionalization plan adequate?
Which aspects of the current plan need to be changed and how?
- * Is the current level of motivation of the participating charitable societies enough to sustain institutionalization?
If not, what are some ideas to increase this motivation?
- * Is the current level of managerial skills sufficient for the local societies to take over supervision for the Life Cycle Project?
If not, what can be done to improve them?

ESSENTIAL ELEMENTS FOR INSTITUTIONALIZATION

Strategies for Institutionalization and Sustainability

There are several alternative strategies from which a donor organization can choose in establishing a project whose benefits will be sustained -- "institutionalized" -- after the end of the donor-funded project. In the case of a service-delivery project (which is what the Life Cycle/Health Education Project is), there are two main strategies.

Following one strategy for "institutionalization," the donor organization creates a system or an institution with the hope that, once this system has been established and taken hold, some host-country organization will be able to sustain the system once the donor's project has ended. This is what CRS has done in its Life Cycle/Health Education Project on the West Bank. This form of "institutionalization" may be defined as transferring responsibilities and operations from the donor-organization to local host-country people or institutions in such a way that services and other benefits established by the project are perpetuated after the end of the project --that is, after financial and technical assistance provided by the donor have come to an end.

Once a service delivery project (such as the Life Cycle Project) has been established, the feasibility of "institutionalization" depends on several important conditions: first, the continuing motivation of a local organization to adopt and carry on the donor's project as its own program; and second, the ability--financially, managerially, and technically--to

sustain the project as its own program.

A second strategy to provide for a donor-initiated project being "institutionalized" with a host-country organization after the donor's project has ended is to lodge the project from the outset in a host-country organization. This means that the donor begins with an existing service-delivery system (e.g., the clinic system established by the host-country government's Ministry of Health, or even a single already-existing university) and then provides financial and technical assistance to strengthen selected aspects of the already-existing institution or program. In this case, the process of "institutionalization" goes on automatically throughout the course of the donor's project. This is what CRS originally (in 1984) proposed for the Gaza component of the Life Cycle Project -- namely that it would be "administered from the outset by a local agency in a cooperative format that will eventually lead to assumption of the project by that agency."* This, CRS found, was not possible, given the circumstances under which organizations function in Gaza. (Some Palestinians say that the Life Cycle Project should have adopted this approach on the West Bank as well, but no one can point to an existing Palestinian organization that would have been feasible and appropriate for this back in the mid-1970s.)

A third strategy for "institutionalizing" project achievements might be called the "quality products" approach. The project, during a limited period of time, simply produces its "outputs" as well as possible--be they new techniques or technologies, printed materials, or trained manpower--and makes them available to benefit appropriate existing institutions. (In this case, CRS would be responsible for producing the quality products.) The approach does not depend on any organization taking responsibility for the continuing provision of any services.

Essential Elements for Institutionalization

Elements for Institutionalizing Service Delivery Projects. Certain essential elements are required for institutionalization of any service delivery project (such as the Lifecycle Project). First is that the project has been successfully established. Then essential elements for institutionalization include the following:

1. At the beneficiary level: Service providers must continue to provide services to beneficiaries. For this they need:
 - a. transportation (if required initially),
 - b. supplies,
 - c. technical support and supervision,
 - d. in-service "refresher" training (continuing education),
 - e. salary or other compensation adequate to provide motivation.

* Catholic Relief Services-USCC, Jerusalem/West Bank Project No. 4D-004, Project Title Life Cycle Health Education, 1984, p. 23.

2. At the technical supervisory/support level: Technical personnel must remain able to provide technical assistance. For this they need:
 - a. transportation (if required initially),
 - b. some supplies,
 - c. time,
 - d. continuing in-service "refresher" training, and
 - e. salary or other compensation adequate to motivate them.
3. At the project management level: A local organization must provide administrative support and managerial guidance. For this is needed:
 - a. money to pay for the above,
 - b. time,
 - c. motivation,
 - d. in-service training, and
 - e. adequate political support.

Elements for "Institutionalization" in Primary Health Care

In primary health care projects, this list of essential elements required for institutionalization can be defined more precisely as follows:

1. At the community level: Community health workers must continue providing services to community members. For this they need:
 - a. transportation (if required initially),
 - b. supplies,
 - c. medical and other technical support and supervision,
 - d. in-service training, and
 - e. salary or other compensation adequate to provide motivation for the work required.
2. At the technical supervisory/support level: Medical or other technical personnel must remain able to provide:
 - a. technical back-up support and assistance for the community health workers,
 - b. in-service training for the community health workers, and
 - c. training for new community health workers (in the event of expansion and to replace those who quit)
 For this they need:
 - a. transportation (if required initially),
 - b. some supplies,
 - c. time,
 - d. in-service training, and
 - e. salary or other compensation adequate to motivate them.
3. At the project management level: A local (host-country) organization must provide administrative support and managerial guidance. This requires:
 - a. money to pay costs for the community health workers,

- instructors, and supervisors,
- b. time,
- c. motivation,
- d. in-service training, and
- e. adequate political support.

Elements for "Institutionalization" in the Lifecycle Project

For the Life Cycle Project in particular, this list of essential elements are required for institutionalization can be defined more precisely as follows:

1. At the village level: Village teachers must continue teaching classes and giving health and nutrition advice to village women. This requires:
 - a. Transportation (No cost, or minimal cost, since the village teacher usually works in her own village, within walking distance from the mothers she teaches and visits. Her work does not normally require travel outside the village.)
 - b. Supplies (No cost anticipated for initial two years or so. CRS will provide the local managing organization with teaching aids to be kept in a resource center to meet requests from village teachers.)
 - c. Technical support and supervision. This will require:
 - (1) "supervisors" as at present
 - (2) medical doctors or other medical personnel
 - d. In-service "refresher" training. This will require:
 - (1) instructors and pay/honoraria/transportation costs/per diems for them;
 - (2) supplies (teaching aids);
 - (3) teaching site (no cost);
 - (4) transportation costs;
 - (5) planning by the local managing organization and good relations between that organization and personnel providing the training.
 - e. Training of new village teachers (to replace those who quit, and possibly to permit expansion of the program to other villages--which the Nablus and Hebron Unions plus many others in those regions say they want, including villages that don't yet have a village teacher).
 - f. Salary or other compensation adequate to motivate the village teachers to do the work specified. Village teachers currently receive a monthly salary which usually ranges from about 15 to 40 dinars per month (about U.S.\$45 to \$100). The precise amount and its source vary from place to place. In many villages, about half of this is provided by the village (the

charitable society and mothers enrolled in the class) and about half by the Union in that region.

2. At the technical supervisory/support level: Instructors and supervisory personnel must remain able to provide training and technical assistance for community health workers. For this they need:
 - a. transportation (if required initially),
 - b. some supplies,
 - c. time, and
 - d. salary or other compensation adequate to provide motivation for the work required.
3. At the project management level: Some local organization must provide administrative support and managerial guidance. For this is needed:
 - a. money to pay costs for the village teachers, instructors, and supervisors,
 - b. time,
 - c. motivation, and
 - d. adequate political support.

ARE PL-480 FOOD COMMODITIES ESSENTIAL TO THE PROGRAM?

General conclusion

There is no clear answer as to whether food distribution is "essential." Evidence suggests that the commodities are useful as a minor incentive for participation but are probably not essential, although participation might drop somewhat without them. The original grant proposal specified developing a system "to identify and deliver commodities to needy families" (as opposed to all participants). (See Appendix B: Logframe). This still seems the appropriate course to take.

Recommendation: The distribution of commodities (to all health education participants) should be phased out on a gradual basis. Work with the participating organizations to develop a plan for this gradual phase-out.

Study the experience of CRS in Morocco (and other countries, if relevant) where a phase-out of PL-480 commodities from similar nutrition and health education programs has been advised.*

* See, for example, Judith Gilmore and Carol Adelman, et al., 1980; and A.I.D., Office of the General Inspector, 1983.

Basic Facts About the Current Commodities Distribution
(See also Appendix F: PL-480 Commodities and Teachers' Pay)

1. Distribution of food commodities was the base on which the program was established in 1975 and was an incentive that attracted villagers to participate in "health education" at that time when the program was just beginning and had not developed either the reputation nor the effective teaching approach that characterizes it since the mid-1980s.

2. Now that the program has a wide reputation plus offers valued new knowledge in a manner that is enjoyable and even fun, receipt of food commodities appears to be only a minor incentive for participation and, for many women, not an incentive at all.

3. The food is not nutritionally needed by most of the recipients (although it was in earlier years and still is needed by some poorer families).

4. Commodities distributed are rice, corn oil, and powdered non-fat milk (provided through the PL-480 maternal-child program). Recipients do not consider these products particularly desirable; they prefer the local olive oil and do not like the lumpy non-fat milk.

5. The food is not used specifically for mothers and children, but goes into general family-meal use.

6. Recipients generally do not give the milk powder to babies as a substitute for breast milk. Because of its lumpiness, they use it chiefly for making yogurt-type products.

7. There is little "leakage" into the market or sale by recipients of the commodities received).

8. Mothers pay a small fee to participate in health education. Most apparently believe they pay this "for the weighing." Some think they pay it "to help the society" [sponsoring health education]. Some think they pay it for the teacher. A few think they pay it for the food, or to transport the food.

9. The sponsoring village "society" pays about half the teacher's salary (the other half comes from the Union). Some of the mothers' fees thus re-circulates to pay the teacher's salary.

10. If the mothers did not pay the fee, the society would have to look elsewhere for money with which to pay the teacher. Most of the teachers will not work for free or for too little.

11. Some village societies say they do not need the food and would be willing to offer health education without it, especially if something else (e.g., sewing machines) were provided instead. Other village societies say they must have the food. (They point to the example of the literacy program originally implemented by CARE, which also distributed food commodities. When CARE support

stopped and the commodities were eliminated, attendance in the literacy classes is said to have dropped sharply (by as much as by 50% according to some Palestinians).

12. Most women interviewed by outsiders on this subject say they do not come to the class for the food, but for the knowledge, enjoyment, and because their husband and families encourage it. Only a minority say openly that the food is a factor in their coming.

13. The only way to determine for certain whether the food commodities are essential would be an experiment that offers health education without commodities in a few trial villages. What people say and what they actually do under changed circumstances differs.

14. Some Palestinians analysts of development issues criticize CRS for the food distribution saying that it "perpetuates the UNWRA dependency" and arguing that villages should become self-reliant (which is also what the Life Cycle Project logframe states).

IS "INSTITUTIONALIZATION" OF THE PROJECT FEASIBLE?

Whether a project such as the Life Cycle project can be institutionalized depends on several important factors: first, the original and continuing motivation of local organizations toward the project and, second, the ability--financially, managerially (administratively), and technically--to sustain the project. The Life Cycle Project involves several layers of West Bank society--the micro level of the village, the intermediate layer of the district or region, and the higher layer of the West Bank/Gaza superstructure--all of which is currently, of course, under the Israeli occupation and military government. Finally, the project also involves governmental and quasi-governmental entities in Jordan.

General conclusion. Institutionalization does appear feasible, if CRS provides adopts a new strategy as recommended in this evaluation. It appears that motivation to continue the program exists in most of the participating villages, although the sponsoring village organizations will continue to need external support. It appears that the Nablus Union of Charitable Societies has the motivation to assume responsibility for the program and may indeed be able to continue it if offered interim assistance as outlined in the recommendations of this evaluation. The other two Unions, in Jerusalem and Hebron, have still been hoping that CRS will continue the program but may become motivated to assume responsibility for it once they believe CRS will not continue its support.

Motivation of Palestinian Organizations to Take Over the Health Education Program

How motivated and able to take on and sustain the health education program are Palestinians? The answer is not immediately clear. There is a real desire at all levels to have this successful program continue. Many Palestinians involved, however, emphatically express their preference that CRS continue supporting the program as at present, do not yet accept that CRS funding will soon stop, and hope that CRS will change its mind and continue on. (CRS is much appreciated for this program and there is virtually none of the resentment toward U.S.-government-funded development assistance that is common elsewhere in the Near East.) The desire of participating Palestinian organizations to have CRS continue the program as is has been an additional factor influencing many of them to say that they are not able to continue the program without CRS. This makes it difficult to determine exactly how motivated they will actually be to carry on the program once they are convinced that CRS is indeed going to stop supporting it.

To understand what motivates people and groups on the West Bank or elsewhere, it is essential to identify basic cultural values within the society. Major values within Palestinian culture are the family, education, and health. Under the current political situation, emphasis on the family and education may be even greater than traditionally (cf. Pedersen 1983, p. 173). Palestinians value education to a high degree. There are four universities on the West Bank*, and many educated Palestinians. While very few Palestinians have degrees in public health or health education (perhaps only a dozen at most), there is obvious motivation among Palestinians to improve the status of the people on the West Bank. Therefore among the general population there is major motivation for a program such as village health education. However, for CRS to generate effective Palestinian management participation in the program, Palestinians must perceive that this is a Palestinian program. At this time, it is not yet perceived as such.

At the Village Level

Since the Life Cycle Project began in 1985, CRS no longer approaches new villages asking them to join the program. Instead, requests are now initiated by villages themselves who have heard of the success of the program from other villages. Discussions with village leaders indicate that the motivation in asking to join the program is not the food commodities, but rather the success of the educational process--the learning and enjoyment by the women.

The motivation for the village health education at the village level thus appears to be the actual learning that is taking place and the enjoyment that the women are getting during the learning process. Initially, the food commodities were a

motivating factor. Discussions with village women indicate clearly that the amount of food received is not considered significant. However, with large families, a poor economy, lack of safety and security, and a perceived non-responsive health care system, any additional help is appreciated. The food commodities appear to come into that category, more than into the category of a major motivator.

The health education classes are seen as important by the men of the village. Village men state that the classes are a chance for the women (who have had little opportunity to become educated) to learn to take care of their families. Since health is also of major value to the Palestinians and since the women are the major provider of health care at home, husbands and fathers-in-law are generally supportive.

Is there sufficient administrative and financial ability at the village level to continue health education? In the majority of villages, there is no medical presence at any level with many villages not even having a daya. The military occupation has not encouraged the creation of decision-making bodies or self-sufficiency and in smaller more isolated villages there is very little perceived power. Of course, villagers have always been engaged in some form of group decision-making. The health education program has required some community organization and decision making to select a teacher and set up a room for classes. In many villages, the health education classes have been a welcome addition to other on-going community projects. Administrative abilities vary according to the history and power constellation present in the village. Financial ability is directly linked to administrative ability. Those villages that have stronger administrative abilities are able to identify financial resources to cover the needs of the program. The majority of the villages at this time are not able to cover the costs of running the health education program and rely on the region's Union for supplementary funding.

At the District/Regional Level: The Union

The Unions, which have existed since the 1950s, are widely respected and represent stability among many on the West Bank. Since most village organizations supporting village health education are registered with the regional Union as a charitable society, the Unions are the logical organization to continue village health education after the Life Cycle Project has ended. The Union leaders have expressed solid interest in the health education, stating that they believe that health education for village women is essential.

* The four universities are: Bethlehem University, Bir Zeit University (in Ramallah), An-Najah University (in Nablus), and Hebron University.

However, the Unions are run completely on a volunteer basis and are already involved in the majority of the social and health activities in the West Bank. While their officers are concerned active individuals, they are probably over-extended. In addition, although extremely supportive, none are knowledgeable in the basic tenets of health education and village primary health care. While they are all proven administrators, they will need through understanding about the basic elements of the village health education success.

A second major concern is whether the Unions will be able to identify sufficient funds on a continual basis to allow this program to continue. The Unions' funding appears to be somewhat precarious. The Unions receive much of their funding from Jordan and through the General Union. While relatively certain, there are times when these funds are not available. Other individuals interviewed believe that funds would be available from other Arab sources if project proposals were prepared by a Palestinian. The Nablus Union has indicated that it would try to continue the program with its own funds if necessary, but that this would require paying the teachers and supervisors less than what they presently receive. The CRS supervisors emphasize that, although they very much believe in the program, they are unable to afford to work for it without adequate pay. Realistically, this would result in a poorer quality program.

The additional concern of whether the Unions are stable enough has also been raised. It appears that the Unions are among the most stable of Palestinians organizations on the West Bank (and are definitely more "stable" than the universities which suffer from severe restrictions and are frequently closed down by the occupation authorities).

Recommendations:

1. Having identified family, education, health, family, and enjoyment as major factors motivating participation in and support of village health education, the project must identify ways to utilize these motivators to help sustain the program.
2. CRS should put into action its "community development seminar plan" to work with Union leaders and leaders in each village to identify their own particular learning needs in administration or community development and ways to meet those needs. Workshops (probably a better term than seminars) must be presented with the exciting, processual techniques for which the CRS Health Education Program has become known. Topics should include: organizational and management skills, funding techniques, communication linkages, and training. CRS should proceed with its plans to secure local technical assistance for these workshops.

Are There Any Precedents for the Institutionalization of Donor-Initiated Projects?

This is the first time that either CRS or AID has tried to "institutionalize" a project on the West Bank or in Gaza with a local Palestinian organization. It appears that no other project supported by AID or CRS on the West Bank or in Gaza has ever been established or carried out with this goal in mind. Thus the Life Cycle Project is attempting to do something that no other CRS or AID-supported project ever attempted.

"Institutionalization" is something that AID usually does through the host-country government. The West Bank/Gaza situation is unique in that there is no indigenous host-country government. Elsewhere AID occasionally seeks to "institutionalize" its projects through non-governmental organizations or indigenous PVOs. Here such organizations have a greater burden than elsewhere; with no representative government, the local Palestinian charitable societies struggle to provide minimal services for the local populations that in a sovereign state would be provided by a government.

Are there any projects that have been successfully turned over from a foreign donor to a local organization? If any other donors have succeeded in this, they are certainly only few; no ready examples can be found.

In 1985, the Near East Council of Churches Committee for Refugee Work in Gaza attempted to find local organizations able to assume responsibility for the family health service centers it had established in Gaza. It finally concluded: "there is no possibility to hand over the centres to the local communities under the prevailing situation."* Likewise, on the West Bank where the NECC (ICC/MECC) has established four "Family Service Centers," it has concluded: "The principle of handing over the Centers to the local population is upheld, but it is nevertheless clear that such a move at the present time is neither practical or possible."** (And this was only four centers compared to the Life Cycle Project's 157 locations.)

A similar conclusion was reached concerning the future of a village outreach project (the Caritas/VCKB Rural Health Project) sponsored by the Swiss-funded Caritas Baby Hospital in Bethlehem:

* Near East Council of Churches Committee for Refugee Work, Gaza Area, Annual Report 1985, p.4 (Gaza, February 1986).

** International Christian Committee, West Bank Area Committee, Middle East Council of Churches Annual Report 1986, p. 2 (Jerusalem, 1986).

"To international aid agencies, self-reliant health care means the channeling of funds into the country for a limited amount of time, with the expectation of a hand over to the local population following a few years of support. Although the need for self-reliant health care is not being questioned, the way in which this concept is translated by aid agencies is. The peculiar conditions of military occupation make it practically impossible to deliver health services to those who need them most without the continuous financial and other types of support from outside the region. The West Bank lacks a state structure that could filter money from the rich to the poor through taxation, as is the case in the Western world. As long as such structures continue to be nonexistent, the need for outside funding shall remain.... This factor necessitates the continuous involvement of agencies such as Caritas/VCKB in providing financial and other types of support to the local population."*

One project that has become institutionalized is the literacy program formerly implemented by CARE. This literacy program now continues, in reduced form, sponsored by the village charitable societies assisted by the Unions of Charitable Societies. While CARE managed the program, it distributed PL-480 food commodities as an incentive for attendance in the literacy classes. When CARE support ended and the commodities were eliminated, attendance in the literacy classes dropped sharply (in the North, for example, by as much as by 50 percent--from about 12,000 to 6,000 persons--according to a leader of the Nablus Union). Thus, while this program suffered a considerable drop in quality and participation of villagers, it nevertheless does continue under local Palestinian management.

Recommendation: CRS should study the example of the literacy program formerly implemented by CARE. Certainly there are some important lessons here.

A NEW STRATEGY FOR INSTITUTIONALIZATING HEALTH EDUCATION

"Institutionalization" does not mean that a local organization (Unions, university, or any other) will "take over" the CRS Health Education Program exactly as it is and assure that it goes on as it has. Nothing can guarantee that the program will survive as it is at this time. In fact, the natural process of planned change is that changes will, and should, continue to take place over time.

The Life Cycle Project is the result of an ongoing process during the past decade. Changes will continue. The aim of "institutionalization" is not that a project should remain

* Giacaman, 1986, p. 16.

static, but that it change and grow to meet the needs and situation of the people being served and the abilities of the indigenous organizations serving them. Hopefully, indigenous organizations will be capable of the task.

The North (Nablus) Region. At present one of the three Unions of Charitable Societies (Nablus in the north) has indicated its intent and some anticipated financial ability to assume responsibility for continuing village health education (see section IV above). The Nablus Union says it anticipates receiving about 50,000 Jordanian dinars from the General Union of Charitable Societies in Amman. This amount is in the vicinity of what the Union needs to continue the program in the north (70 communities participating with about 20 more requesting to "start health education"). It is unclear, however, when this Jordanian money will be available and what its provision hinges upon. (It is also unclear how the Jordanian government's projected five-year-plan, which is contingent upon U.S. financing, to pump \$1.2 billion into the West Bank and Gaza in the form of loans, grants, and wage supplements will affect the situation.)

In the meantime, the Nablus Union says it is willing to make available for health education about 5,000 dinars of its own budget, taking this from other activities -- which indicates seriousness of intent but is inadequate in amount. (The Union presently contributes 5,000 dinars per year to support 75 literacy classes, which provides pay for literacy teachers and three supervisors.)

The Jerusalem and Hebron Regions). The intent of these two Unions is much less certain. Both have insisted they want CRS to continue funding the program and cannot do it themselves. But it is also reported that they too, having apparently just received word that some funds may be provided by the General Union in Amman, may also be willing to take on the project in their regions. Even so, the amount and timing of funding from Amman remains uncertain and apparently beyond the control of the Unions.

What appears most promising, therefore, for CRS in seeking to perpetuate what it has created through the Life Cycle Project is a two-part strategy focusing on:

- * One: The Unions of Charitable Societies
Gradual transfer to the Unions of Charitable Societies, assuming their willingness, of management responsibility for continuing the Health Education Program; and
- * Two: The "world at large"
Measures, not contingent upon progress with the Unions, to strengthen personnel and material outputs of the project for the benefit of primary health care efforts in general--West Bank, Gaza, and elsewhere.

The rationale for this two-part strategy is the desire to be certain that when the Life Cycle Project ends, something of value has been left behind. There is a good possibility that a quality Health Education Program can be continued in the northern region of the West Bank (and, perhaps, throughout the whole West Bank). But it is also possible, however, that constraints imposed by the current political-military situation will prove too overwhelming. In this latter case, Part Two of the institutionalization strategy proposed below is intended to at least make available quality products that extend the "spread effect" of the project to benefit other primary health care efforts here and elsewhere.

What is recommended here is thus a strategy change. The goals and objectives of the project remain the same, as does the overall budget.

PART ONE: THE UNIONS

CRS' original "institutionalization plan" envisaged that all three Unions would already have begun, as of 1985, to take on major responsibilities for the Health Education Program and during 1986 would be spending increasingly larger amounts from their own budgets to finance activities. As outlined above (section IV, pp. 37-40), this did not even begin to happen--the Unions stating, among other reasons, that they did not have adequate funds, that funds might come from Amman, but that when they would come was uncertain.

A chief difference here from the original CRS strategy is for CRS to provide funds directly to the Unions (through one or more sub-contracts) so that the Unions will have a period of 12 to 18 months when they actually have the money with which to do what CRS is asking them to do (rather than depend on funds from Jordan that may or may not come through). The premise is that, after that time, the Unions will have developed both the necessary commitment to village health education and the skills with which to raise funds to continue it as a program of their own.

A second major difference is that this new strategy provides for a Palestinian to join the American Life Cycle project manager in making decisions about and managing the process of institutionalization.

The transfer of management to the Union(s) might best be achieved through a four-stage process comprising the measures suggested below. This outline below provides for the possibility that the Hebron and Jerusalem Unions decide to join the Nablus Union in taking over the program in their regions. It is also possible, however, that they do not decide to join in, in which case CRS should proceed with the Nablus Union alone. If a quality program can be sustained in the northern region after the Life Cycle Project ends, this will still be a very major achievement.

I. Preparation for management by the Union(s) (present to mid-1987)

Tasks for CRS:

1. Clarify with the Unions what the new strategy for "institutionalization" involves; verify willingness of at least one Union (Nablus) to proceed with the new strategy.
2. Revise the budget and prepare sub-contract(s).
3. Hire a Palestinian Program Manager for Institutionalization (or Program Coordinator, exact title to be determined) who will be responsible to CRS for successfully transferring management of the program to the Union(s) (see section "Palestinian Program Manager for Institutionalization" below).
4. Help the Union leaders to understand more clearly the essential ingredients in the Health Education Program (at present, some do but most don't).
5. Conduct needs identification workshop/analysis with the Unions (securing local technical assistance as needed).
6. Conduct community development/management workshops (securing local technical assistance as needed).
7. Decide future of all present CRS staff; prepare to train/treat them accordingly.

II. Transition phase: assumption of management by one Union
(mid-1987 to end of 1987)

CRS, working with the Palestinian "Program Manager for Institutionalization" to help one Union (Nablus) to:

1. Set up a health education resource center.
2. Develop a system for working with personnel.
3. Conduct workshops and in-service training for various categories of personnel (using local technical assistance as needed).
4. Strengthen home visiting and referral.
5. Initiate in-depth village studies to understand the impact and operations of the project at the village level and possible alternatives to food (securing local technical assistance as needed).
6. Initiate pilot projects to explore alternatives to food distribution.

7. Decide about village data collection (following recommendations in section V).
8. Begin looking for funding for future years and developing skills needed for securing funds from outside sources.
9. Carry out activities involving the other two unions in anticipation of Phase III.
10. CRS staff should all be in process of transition to their various new statuses at end of grant.

III. Assumption of Management by All Unions
(January 1988 to January 31, 1989)

1. CRS has no-cost extension of one year (possibly 18 months; see below).
2. All three unions are carrying out activities begun by Nablus union during Phase II.
3. CRS continues to:
 - a. Facilitate technical assistance for unions as requested;
 - b. Provide food commodities on phase-out basis.
4. CRS Life Cycle staff is now minimal, consisting of the Project Manager (Daniel Carr continuing on), Palestinian Program Manager for Institutionalization, possibly one other (responsible for materials).

IV. Unions totally on their own without commodities
(January 31, 1989)

* * *

PART TWO: THE WORLD AT LARGE

Here the intent is to capitalize on the excellent training capacity and materials developed by the project and to document the experiences and impact of the project. This is in line with the "quality products" approach to institutionalization outlined above and will maximize the "spread effect" that has begun to take place already. The purpose is to make available:

- * Resources (personnel and printed materials) for use in any primary health care effort in the West Bank and Gaza following the end of this project.
- * Printed and related materials that can be used by CRS and other primary health care efforts anywhere.

This will involve the following by CRS:

1. Revision and finalization of the Life Cycle curriculum and related support materials as recommended in section IV above.
2. Facilitation of in-service and community development training for various categories of personnel.
3. Follow-through on data collection and analysis as recommended in section V above.

Part Two should proceed independent of progress in transferring the program to the Union(s). It is preferable that the Unions be involved, especially in sponsoring training activities, but such activities should not be held up indefinitely waiting for Union participation. In some cases (e.g., in-service training for village teachers) other institutions may even be more appropriate.

The Need for A No-Cost Extension

More time is needed if CRS is to leave behind a quality program that can be sustained by local organizations after the Life Cycle Project ends. CRS' initial assumptions were overly optimistic as to the desire of the Unions to assume management and financial responsibility for the program and the speed with which they could do so, if willing. Now that one Union at least has expressed this will, less than one year remains in the project as initially planned. This is too little time to effect the transition, given that the Union leaders who are being asked to take on the program are only volunteers, most of whom are busy professionals with little or no village health care experience.

More time is needed to build up expertise in the Unions for carrying on the program, including securing funding for future years. For this purpose, a one-year extension of the grant appears appropriate. Once a contract has been worked out with the Union(s), this would leave about 18 months as a transition period (about a half-year until the initial end of project, plus the one-year extension). It may be that an 18-month extension is even more appropriate, given the tasks to be accomplished and prevailing situational constraints--providing that the locus of activities shifts from CRS/Jerusalem to the Union(s). This will have to be determined as talks with the Nablus Union and the hiring of a Palestinian Program Manager proceed.

ADDITIONAL PERSONNEL MATTERS

"Palestinian Program Manager for Institutionalization"

CRS should proceed immediately to hire a Palestinian "Program Manager for Institutionalization"--finding a better title in the process (perhaps "Program Coordinator" with the idea that this title becomes "Health Education Program Manager" once the Life Cycle Project has ended). It is urgent that all three Unions be contacted concerning the new plan and asked for nominations for this position. As noted above (p. 33), the Life Cycle grant proposal prepared in 1984 called for hiring, and budgeted for, a Palestinian assistant project manager, to which this position is essentially equivalent. Within the West Bank population there are definitely many individuals with good management skills. The challenge will be to identify a sufficiently motivated person who also has health care and rural development skills.

Position Description. A job description for this position might contain the following type of information:

The objective of this position will be to help CRS transfer management of the Health Education Program to the Unions of Charitable Societies in such a way that the program continues to operate successfully after the end of the Life Cycle Project.

Qualifications: This position is open to both women and men. It will be filled by a Palestinian with an appropriate combination of knowledge, demonstrated competency, or familiarity in the following areas:

- o community relations,
- o community development,
- o public health,
- o health education, and
- o management.

Responsibilities of this position will be to:

1. Work with the Unions to help Union personnel understand the Health Education Program;
2. Work with the village societies to help them identify their needs for continuing the program in their village and ways to meet these needs;
3. Work with villages and Unions to identify needs for in-service training (in health education, management, and community development) and to arrange for these needs to be met;
4. Identify problem areas in the program and work with community members to identify a solution;
5. Identify sources for future funding and write appropriate grant requests;
6. Interact with health care professionals and universities to secure technical support for the program and medical linkages to improve the referral process.

Assuming the person hired as program manager has performed well during this transitional period, he or she will ideally continue on as program manager after the CRS Life Cycle Project has ended and there is no longer an American project manager.

Suggested Process for Selection

1. Each Union is invited to submit names to a search committee composed of representatives from the Unions and CRS.
2. The search committee interviews applicants and recommends a candidate to CRS and the Union boards.
3. The successful candidate is hired by the Union(s), provided this is contractually possible, as soon as agreed upon and approved by CRS (salary to be paid by the Union with funds provided by CRS).

Initially the Palestinian Program Manager will report to and be responsible to: (1) the CRS Life Cycle/Health Education Project Manager; and (2) a Health Education Program Board of Directors (Palestinians). After the end of the Life Cycle Project, the Palestinian Program Manager will report to and be responsible to only the Palestinian Board of Directors.

Logistics. Office space should be provided for the Palestinian Program Manager in the Nablus Union to establish that he or she is working with the Union and not continuing a CRS project based in Jerusalem. To facilitate communications with the villages as well as medical linkages, CRS should also consider providing a vehicle, or vehicles, to the Palestinian Program Manager and participating Unions (and, as such a transfer apparently requires paying a substantial GOI customs tax, also seek approval from AID to pay this tax on behalf of the participating institutions).

The Health Education Board of Directors

The purpose of this Board is to advise and support the Health Education Program Manager in carrying out the responsibilities of the position. This Board will differ from the board of directors of each Union; whereas the Union's board of directors has responsibility for all Union matters, this Board will have the Health Education Program as its sole concern. (To keep the two boards straight in peoples' minds, it may be desirable to call this an Advisory Board.)

Composition of the Board: Board members should be respected members of the community who are knowledgeable about community resources. Skills and expertise to be represented on

the Board should include but not be limited to health professionals, and educators. A CRS representative (the Life Cycle Project Manager or his designee) will be an ex-officio member of this Board.

If a point is reached when all three regions have taken over management of the program, it would seem desirable for there to be one single Board made up of persons from the three regions, rather than three separate regional boards. This would permit an easier relationship with educational and medical institutions to which the program turns for in-service training and other assistance. In the interim, if the Nablus Union proceeds first, it seems appropriate for this Board to consist of persons from the northern region.

Supervisors and Instructors

The need for competent field supervisors will remain once the program is under management by the Union(s). There will be much less need for instructors, since the program will have moved from an "expansion" mode (involving training of large numbers of new instructors) to a "maintenance" mode that requires in-service training of current instructors plus only occasional training of new instructors. The Life Cycle staff currently includes six supervisors and six instructors. Clearly it will not be possible or necessary for the Union(s) to employ all 12. Instructors who have previously been trained and worked as supervisors should also be considered for employment by the Union(s) in a newly-defined supervisor role that includes some responsibilities for training village teachers. The three men who are presently Life Cycle staff instructors (2) and supervisors (1) have performed well, and even outstandingly, in their positions but the contact with village women required once the program is managed by the Union(s) will make it preferable to have these positions by female staff.

Recommendations:

1. Combine the present roles of supervisors and instructors and add a manager component. Provide necessary training for the staff members moving into this combined role.
2. Strongly encourage the Union(s) to retain the CRS-trained supervisors or instructors in the position of supervisor. Personnel trained by other programs lack knowledge of and experience with the approach and techniques that are the basis of this program's success; they should not be considered more appropriate simply because they may have higher academic degrees.
3. Criteria for the selection of supervisors by the Union(s) should be as follows:

- a. Training and previous employment by CRS as a supervisor;
 - b. Demonstrated competence and desire to serve in this capacity; and
 - c. Residence in the region being served.
4. Assist (including with in-service training) the instructors and supervisors to, as appropriate, secure positions with the Unions or otherwise move into appropriate positions.
 5. In-service training for all personnel should be an essential part of the on-going village health education program. Appropriate subjects for the newly-defined supervisor-instructors might include:
 - o Management skills (working with people, needs assessment, record keeping, report preparation, grant writing, etc.);
 - o Teaching skills;
 - o Community development skills.

Life Cycle Project Manager

Recommendation: The present project manager should remain in this position through the end of the grant. This is important for continuity when so much else is in transition. Should it not be possible for him to remain in this position, and providing that the Palestinian "Program Manager for Institutionalization" is proving successful in that capacity, it may be preferable for the latter person to move into the position of Life Cycle project manager rather than recruit a new American for the time remaining.

Appendix A

ACRONYMS and ARABIC TERMS

Acronyms

AID	Agency for International Development
AMWA	Arab Medical Welfare Association
APHA	American Public Health Association
CARE	Cooperative American Relief Everywhere
CRS	Catholic Relief Services
CRS/JWB	Catholic Relief Services/Jerusalem-West Bank
CRS/NY	Catholic Relief Services/New York
EPI	Expanded Program of Immunization
GOI	Government of Israel
IMR	Infant mortality rate
MOH	Ministry of health
NECC	Near East Council of Churches
PHC	Primary health care
ORT	Oral rehydration therapy
PL-480	U.S. Public Law 480
PVO	Private voluntary organization
UNRWA	United Nations Relief and Works Agency

Key English-Arabic Terms

health education	<u>taskhif as-saha</u>
traditional birth attendant	<u>daya</u>
village	<u>qariya</u>
village head	<u>mukhtar</u>
village teacher	<u>mualima il-'ailiy</u> (lit. "teacher of the family")
(village) charitable society	<u>jami'a khayriya (il-qariya)</u>
Union of Charitable Societies	<u>Ittihad al-Jamiat</u>

Exchange Rates (as of February 1, 1987)

Two forms of currency are currently used on the West Bank:
the Jordanian dinar ("JD") and the Israeli sheqal

1 JD = approximately \$US 3.00
\$US 1 = .35 JD

1 Israeli sheqal = appr. \$US .60
\$US 1 = 1.6 Israeli sheqal

5 Israeli sheqals = 1 JD

Appendix B

LOGFRAME: WEST BANK & GAZA

PROJECT DESIGN SUMMARY

LOGICAL FRAMEWORK - WEST BANK

PROJECT TITLE & NUMBER LIFE CYCLE : HEALTH EDUCATION, 4D-004

Life of Project: 3 Years

From Feb. '85 to Jan. '88

Total US Funding: _____

Date Prepared: May 1, 1984

Revised : Nov. 29, 1984

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>PROGRAM GOAL (A-1)</p> <p>Development of programs to improve the health status of Palestinians on the West Bank.</p>	<p>Decreased rates of morbidity and mortality especially among infants</p> <p>Increased percentage of children showing adequate and consistent weight gain.</p> <p>Decreased number of low-birth-weight children.</p>	<p>Baseline, mid-project and post-project surveys.</p>	<p>Behavioral changes can be produced by Health Education .</p> <p>The program is seen as valuable to the villages.</p> <p>Village-teachers show adequate skills in teaching.</p>

PURPOSE	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p>1. To assist Charitable Societies in creating awareness, increasing knowledge, positively influencing attitudes and fostering the adoption of appropriate preventative health behavior</p>	A. Direct Contact	Attendance records	
	<p>17,000 W.B. mothers have attended classes in the revised Health Ed. Program</p>	Weight Charts	
	<p>12,000 of their children 0-5 have been weighed monthly.</p>		
	B-2.	<p>750 pregnant mothers given counseling, screened for high risk, appropriate referrals made.</p>	Follow-up and referral records.
	<p>900 newborns weighed, monitored for weight gain; assessed for risk, defects; appropriate referrals made</p>	Home-visit reports	
	<p>1000 underweight children, or failure to thrive children identified; mothers counseled; appropriate referrals made</p>	Newborn and pre-natal weights	
	B. Collection of necessary background data- establishment of baseline	Analysis of behavioral aspects of situation	
		assessment of beliefs and values underlying the behaviors	<p>That mothers continue to attend class and bring their babies for weighing. That behavioral change can be measured and causality attributed to this project</p>

PURPOSE	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p>2. To institutionalize Health Education as part of the service of the Union of Charitable Societies</p>	<p>A. The Union of the Charitable Societies will be able to provide leadership, salary office space and transportation to 6 supervisors</p>	<p>Written agreements Expert assessment Budgets</p>	<p>That the Union of Charitable Societies will be able to administer and support the Health Ed. Program</p>
	<p>B. 200 villages through local societies will be able to maintain the cost of a village teacher; provide a classroom and needed equipment</p>	<p>Expert assessment Financial records On-site visits</p>	<p>That competent evaluators will be available That the Charitable Societies ascribe to principles of preventive health and education and non-medical health ed. teachers</p>
	<p>C. New villages will request of the Union of Charitable Societies to become involved in the Health Ed. Program</p>	<p>Record of new villages</p>	<p>That the political and security situation will allow the institutionalization of the Health Ed. Project</p>

OUTCOME	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTION
1. Trained Staff	A. Instructors responsible for teaching life Cycles of Health Ed. using a participatory approach will be trained	Expert assessment of adequacy of training in terms of content and individuals trained	Well-qualified staff can be recruited
	B. Supervisors of village teachers		
	C. Community Dev. Specialist		
2. Training	A. Village teachers 25 new teachers are qualified to present Life Cycle material in 15 new locations	Training records Class attendance	That new villages are interested and meet criteria for inclusion
	B. Development of training and Inservice Programs for : . Health Care Personnel . Members of local Charitable Societies		
3. Standardized curriculum and materials	A. Development of <u>Life Cycle Health Education Curriculum</u> for village teachers	Evaluation of Expert in terms of effectiveness and applicability	That satisfactory materials can be developed and refined with relevance beyond the Grant and Gaza
	B. Development of appropriate media for instruction . visual aids . teaching aids		

OUTCOME	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
4. District based service strategy and logistical support and salaries for Health Ed. personnel in the process of institutionalization	Coordination with village societies to insure consistent payment of salaries for village teachers	Response to workshops given	That local agencies can finance the program
	Coordination with district programs to provide the supervisory base for the Health Ed. program	Budget records	That local agencies remain committed to the program
	Coordination with in-country programs to provide administration, training and coordination of the Health Ed. program		
5. Commodities system is congruent with program goals of :-	A commodity system in place that satisfies program's goals and local sensitivities	Existence of new system for commodity use	That commodities are needed by a segment of the W.B.
Focus on greatest need Development of village: .self reliance .independence			That a system can be developed to identify and deliver commodities to these needy families

EXAMPLE OF EVALUATION OBJECTIVES/INDICATORS AND INSTRUMENTS

G O A L	O B J E C T I V E S	I N D I C A T O R S	I N S T R U M E N T S
<u>INSTITUTIONALIZATION:</u>			
Local Agency has capability to take over Health Education Program	Societies will show:		
	1. Admin. Capability to incorporate Health Education into their service structure	a) Hiring or replacement of necessary staff b) Provision of inservice training for supervisors	
	2. The Unions will demonstrate the ability to supervise adequately the Health Education Program	a) Capacity of staff to recognize areas of weakness in village programs b) Village contact: how often; for what reason c) Problem solving ability	Supervisory Records
	3. The Unions will show Financial Capability for supporting Health Education	a) Ability to pay salaries	Account records
<u>TEACHER TRAINING:</u>			
Village teachers will possess adequate skills to teach effective lessons and produce positive changes in behaviour of village mothers	Teachers will use:		
	1. Participatory techniques while teaching	a) Score on teaching scale	Teacher rating scale
	Teachers will show		
2. Ability to persuade	a) Mothers are enthusiastic and eager for class	Observation	
3. A change of behaviour will be shown by the mothers	a) Nutritious meals b) Presence of first aid kit c) Presence of toys for Children d)	Discussion with mothers Observation in home	

G O A L

O B J E C T I V E S

I N D I C A T O R S

I N S T R U M E N T S

WOMEN'S BEHAVIOUR:

Village women will demonstrate better health care techniques

1. Mothers will know how to make and administer ORS

a) Less seriously ill babies at rehydration Center

Demonstration making and use of ORS

2. Mothers will choose to breast feed rather than bottle feed

a) No. of mothers breast feeding vs bottle feeding

Interview

3. Mothers will obtain pre-natal care.

a) No. of mothers receiving pre-natal care

a) Records of visits

b) Weight of newborn i.e. "Small for age, etc..."

b) Weight charts

PROJECT DESIGN SUMMARY

LOGICAL FRAMEWORK : GAZA

Life of Project: 3 Years

From Feb.'85 to Jan.'88

Total US Funding: _____

Date Prepared: Nov.29, 1984

PROJECT TITLE & NUMBER LIFE CYCLE : HEALTH EDUCATION, 4D-004

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>PROGRAM GOAL (A-1)</p> <p>Development of programs to improve the health status of people living in the Gaza Strip.</p>	<p>Decreased rates of morbidity and mortality especially among infants</p> <p>Increased percentage of children showing adequate and consistent weight gain.</p> <p>Decreased number of low-birth-weight children.</p>	<p>Baseline, mid-project and post-project surveys.</p>	<p>Behavioral changes can be produced by Health Education .</p> <p>The program is seen as valuable to the villages.</p> <p>Village-teachers show adequate skills in teaching.</p>

PURPOSE	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS	
<p>1. To assist local agencies in creating awareness, increasing knowledge, positively influencing attitudes and fostering the adoption of appropriate preventative health behavior</p>	A.	2000 mothers will understand and know how to mix and administer correctly the ORS	Observation	
	2000 mothers will complete Health Ed. classes and show evidence of behavioral change	Impact results		
	2000 children followed in monthly weighing	Weight Charts		
	B. Collection of necessary background data - establishment of baseline	Analysis of behavioral aspects of situation		<p>That mothers continue to attend class and bring their babies for weighing. That behavioral change can be measured and causality attributed to this project</p>
	Assessment of beliefs and values underlying the behaviors			
<p>2. To institutionalize Health Ed. as part of the service structure of a local agency</p>	A. A local agency will be able to provide leadership salary, office space and transportation for one supervisor	Written agreements Budgets Evaluation		
	B. 25 locations will be able to maintain the cost of a teacher, a classroom and needed equipment	On-site visits		
	C. New locations will request of the agency to become involved in the Health Ed. program	Records of new villages		

OUTCOME	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
1. Trained Staff	<p>A. Instructors responsible for teaching life Cycles of Health Ed. using a participatory approach will be trained</p> <p>B. Supervisors of village teachers</p> <p>C. Community Dev. Specialist</p>	<p>Expert assessment of adequacy of training in terms of content and individuals trained</p>	<p>Well-qualified staff can be recruited</p>
2. Training	<p>A. Village teachers 25 new teachers are qualified to present Life Cycle material in 15 new locations</p> <p>B. Development of training and Inservice Programs for : . Health Care Personnel . Members of local Charitable Societies</p>	<p>Training records Class attendance</p>	<p>That new villages are interested and meet criteria for inclusion</p> <p>That candidates for training can be found</p>
3. Standardized curriculum and materials	<p>A. Development of <u>Life Cycle Health Education Curriculum</u> for village teachers</p> <p>B. Development of appropriate media for instruction . <u>visual</u> aids . teaching aids</p>	<p>Evaluation of Expert in terms of effectiveness and applicability</p>	<p>That satisfactory materials can be developed and refined with relevance beyond the Grant and Gaza</p>

OUTCOME	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
4. District based service strategy and logistical support and salaries for Health Ed. personnel in the process of institutionalization	Coordination with local agencies to insure consistent payment of salaries for village teachers	Response to workshops given	That local agencies can finance the program
	Coordination with district programs to provide the supervisory base for the Health Ed. program	Budget records	That local agencies remain committed to the program
	Coordination with in-country programs to provide administration, training and coordination of the Health Ed. program		
5. Commodities system is congruent with program goals of :-	A commodity system in place that satisfies program's goals and local sensitivities	Existence of new system for commodity use	That commodities are needed by a segment of the Gaza Strip
Focus on greatest need Development of vill : .self reliance .independence			That a system can be developed to identify and deliver commodities to these needy families

From: CRS/JWB Health Education Program, New Proposal
(Transmittal letter dated June 25, 1984; CRS/NY to AID/W)
Accompanies Logframe

Statement of Work

A. Objectives:

1. Building on seven years of experience, Catholic Relief Services (CRS) will focus efforts of health education program to:

- increase its effectiveness and visibility
- increase village participation and support
- develop linkages with on going service providers
- establish a managerial and economic structure needed to institutionalize the program beyond the grant period

2. The goal of the health education program will be to improve the health status of Palestinians in the West Bank and Gaza through decreased rates of mortality and morbidity, increased percentage of children showing adequate and consistent weight gain, and decreased number of low birth weight children.

3. CRS will assist local agencies in Gaza and the West Bank to create awareness, increase knowledge, influence attitudes, and foster the adoption of appropriate preventive health behavior focusing on the following areas:

- identification of groups and individuals at greatest risk
- weight monitoring
- breast feeding
- oral rehydration therapy
- nutrition
- hygiene
- infant feeding practices
- pre-natal care
- referral for early treatment

4. Under this grant, 17,000 mothers in the West Bank and 2,000 mothers in Gaza will attend classes. 12,000 West Bank children (0 to 5 years) and 2,000 children in Gaza will be weighed monthly.

CRS will submit semi annual reports on progress of institutionalization.

5. Village teachers, in addition to holding classes, will be responsible for weighing and monitoring children, identifying high risk groups and individuals, providing emergency first aid, carrying out special public health campaigns, and referral for special treatment and care, when needed. To achieve the last task, CRS will develop a referral network of local providers of primary health care services, specialists, and hospitals.

6. During the grant period CRS will continue to utilize and monitor PL 480 Title II food commodities in accordance with the plan presented in the revised proposal.

7. CRS will be responsible for continuous program monitoring. Formal evaluations will take place mid way through the grant and at the end of the three years. At least one of these evaluations will be carried out by external sources in consultation with A.I.D. concerning consultants selection and scope of work. These evaluations will cover:

- meeting of objectives in the log frame
- teacher performance
- curriculum quality and appropriateness
- institutionalization objectives at the village, district, and regional levels
- establishment and utilization of local referral network
- appropriate monitoring of food commodities, the effects of the new commodity distribution criteria, and recommendations for the role of commodities after the termination of the Grant.

In addition, baseline information will be collected in new villages prior to program start up and impact will be measured on:

- mothers' ability to prepare and administer ORS
- breastfeeding
- pre-natal care
- nutritional status of children

8. CRS will carry out a cost effectiveness comparison of CRS

5. Over the three year period the health education program will be institutionalized as part of the service structure of local agencies at the regional, district, and village levels.

B. Scope of Work

To achieve these objectives the Grantee shall carry out the following activities with funds provided by this grant.:

1. CRS will maintain a project staff at a level which is consistent with the level of activity, the number of villages served, and the level of institutionalization. This staff will include a project manager, an assistant project manager, two community development specialists, eight instructors, a nurse, accountant, secretary, translator and five drivers. Consultants and part-time staff may be used as necessary for training, surveys, evaluation, data analysis, curriculum development, special studies, etc. as needed to accomplish project goals.

2. CRS will train 50 new teachers who will carry the program to 15 new locations in the West Bank and 15 locations in Gaza. A training and inservice program will be developed for health care personnel and members of local charitable societies. Eight instructors will be trained to teach Life Cycles Health Education.

3. CRS will develop standardized Life Cycle Health Education curriculum and appropriate teaching aids.

4. During the term of the grant (three years) CRS will coordinate with local institution(s) for the phaseover of the overall administration, training, and coordination of the health education program. The following will be in place by the end of the project:

A. Village societies will pay the salaries of village teachers, classrooms, and needed equipment.

B. District level local agency will pay the salaries of eight supervisors, develop district service strategy, provide office space and logistical support.

C. One regional level institution will pay salaries of central staff needed for training, program administration, planning, and coordination.

LIFE CYCLE CURRICULUM

TABLE OF CONTENTS

	<u>Page</u>
1. Introduction	3
2. <u>Stage I: BRIDE</u>	8
- Foods for the family	10
- How to stop the spread of disease	22
- Safety in the home environment	34
- Human reproduction	41
3. <u>Stage II: PREGNANCY AND PRENATAL DEVELOPMENT</u>	48
- Pregnancy and Prenatal Development	52
- Birth	63
- Care of the newborn at delivery (Neonatal)	78
4. <u>Stage III: MOTHER OF AN INFANT 0-2</u>	91
- Advantages of breast-feeding	97
- Supplementary foods and weaning	109
- The importance of weight charts	117
- Immunization	125
- Illness in a child - Feeding a sick person	130
- Diarrhea and Dehydration	148
- Child Development from 0-2	161
- Some Organs of Body Systems	166
- The Ear	167
- The Eyes	173
- The Teeth and Gums	180
- The Breathing Organs	188

	<u>Page</u>
5. <u>Stage IV: MOTHER OF CHILD 3-5 and 6-12</u>	197
- A child develops: 3-5 years	199
- Feeding pre-school children	205
- A child develops: 6-12 years	209
- Feeding school children 6-12 years	213
6. <u>Stage V: MOTHER OF THE ADOLESCENT</u>	215
- Adolescence	219
- Needs of adolescents	219
- Nutritional needs of male and female adolescents	220
- Other needs	221
- Common characteristics of adolescents	221
- Parents' responsibilities towards adolescents	222
7. <u>Stage VI: ADULTHOOD AND OLD AGE</u>	223
- Adulthood and Old Age	227
- Behavior in Old Age	228
- Needs of the Old Age	228
- How to stay healthy when older	228
- Feeding adults	229
- Feeding Old Age (above 60 years)	230
- Food diet	231
- Changes in Middle Age	233
- Clothing for Old Age	236

Appendix D

HEALTH EDUCATION CENTERS IN THE WEST BANK
JULY 31, 1986

NAME OF CENTERS	NAME OF CENTERS	NAME OF CENTERS
JERUSALEM AREA	HEBRON AREA	TULKAREM AREA (cont.)
1 SPAFFORD CHILDREN'S CEN./J'LEM	1 HEBRON LADIES CHAR. SOCIETY	11 TULKAREM RED CRESCENT SOCIETY
2 GREEK CATHOLIC INF./J'LEM	2 HEBRON RED CRESCENT CHAR. SOC.	12 SHWEIKEH CHARITABLE SOCIETY
3 EL-AMAL CHAR. SOCIETY/ABU-DIS	3 AL-MAJD SUB-CENTER	13 JAYYOUS CHARITABLE SOCIETY
4 ARAS EL-DAHOUK & KURSHAN	4 HARET EL-SHEIKH SUB-CENTER	14 HABLA CHARITABLE SOCIETY
5 AQBAT JABER SUB-CENTER	5 HALHUL LADIES CHAR. SOCIETY	15 SEIDA CHARITABLE SOCIETY
6 SUDA CHAR. SOCIETY/BETHANY	6 BANI MA'IM CHARITABLE SOCIETY	16 BAQA EL-SHARQIYEH CHAR. SOC.
7 AL-JAHALEEN SUB-CENTER	7 DOURA CHARITABLE SOCIETY	
8 BETHANY HOUSING PROJECT	8 DAHRIYEH CHARITABLE SOCIETY	JENIN AREA
9 SILWAN CHARITABLE SOCIETY	9 BEIT-ULA CHARITABLE SOCIETY	1 TUBAS CHARITABLE SOCIETY
10 SHU'FAT CAMP CHAR. SOCIETY	10 HUDA CHARITABLE SOCIETY	2 AQAABA SUB-CENTER
11 SAMAHREH EL-SHARQIYEH CHR.SOC.	11 YATTA CHARITABLE SOCIETY	3 ZABABDEH CHARITABLE SOCIETY
12 EL-RAM CHARITABLE SOCIETY	12 SAMOU' CHARITABLE SOCIETY	4 MISSILIEH SUB-CENTER
	13 RAFAT SUB-CENTER	5 RABA SUB-CENTER
RAMALLAH AREA	14 SI'IR CHARITABLE SOCIETY	6 JALQANUS SUB-CENTER
1 EL-BIREH RED CRESCENT SOCIETY	15 RAS EL-'ARROUB SUB-CENTER	7 QABATIAH CHARITABLE SOCIETY
2 FRIENDS OF THE COM./EL-BIREH	16 BEIT-KAMEL CHARITABLE SOCIETY	8 EL-HARA EL-GHARBIYEH SUB-CENT
3 NE'LIN SUB-CENTER	17 TARQOMIA CHARITABLE SOCIETY	9 YA'BAD CHARITABLE SOCIETY
4 KARAWAT BANI-ZEID CHAR. SOC.	18 IDNA CHARITABLE SOCIETY	10 TOURA SUB-CENTER
5 DEIR-GHASSANEH SUB-CENTER	19 KHARAS CHARITABLE SOCIETY	11 ARRADA CHARITABLE SOCIETY
6 AROURA CHARITABLE SOCIETY	20 SURIF CHARITABLE SOCIETY	12 BURQIN CHARITABLE SOCIETY
7 EIN YABROUD CHARITABLE SOCIETY	21 SHUYUKH CHARITABLE SOCIETY	13 KUFUR-RUD SUB-CENTER
8 BURQA CHARITABLE SOCIETY	22 BEIT 'AMWA CHARITABLE SOCIETY	14 EL-NASIMIEH SUB-CENTER
9 BEITILLU CHARITABLE SOCIETY	23 SHUYUKH EL-'ARROUB CHAR. SOC.	15 WAD-BURQIN SUB-CENTER
10 JIFNA CHARITABLE SOCIETY	24 RIHNIYEH CHARITABLE SOCIETY	16 YAMOUN CHARITABLE SOCIETY
11 SILWAD CHARITABLE SOCIETY	25 TAFFOUH CHARITABLE SOCIETY	17 SILAT EL HARTHIEH CHAR. SOC.
12 KUFUR-NI'MEH CHAR. SOCIETY		18 ASDIKA' EL-MARID CHAR. SOCIETY
13 TURNUS-'AYYA CHAR. SOCIETY	NABLUS AREA	19 JABA' CHARITABLE SOCIETY
14 SINGEL CHARITABLE SOCIETY	1 TILL CHARITABLE SOCIETY	20 FAKKOU'A CHARITABLE SOCIETY
15 BUDRUS CHARITABLE SOCIETY	2 ASSIRA EL-RIBLIYEH CHAR. SOC.	21 SAMOUR CHARITABLE SOCIETY
16 KHARBAT BANI HARETH CLUB	3 BEITA CHARITABLE SOCIETY	22 JENIN CHARITABLE SOCIETY
17 BEL'EEN CHARITABLE SOCIETY	4 BOURIN CHARITABLE SOCIETY	23 JALAMEH SUB-CENTER
	5 NABLUS COMMUNITY CENTER	24 KUFUR -DAN CHARITABLE SOCIETY
BETHLEHEM AREA	6 ASSIRA EL-SHAMALIYEH CHAR.SOC.	25 JENIN RED CRESCENT CHAR. SOC.
1 BEIT-JALA LADIES SOCIETY	7 HUNHARA CHARITABLE SOCIETY	26 ANZA CHARITABLE SOCIETY
2 CARITAS/BETHLEHEM ASSOCIATION	8 OSSARIN CHARITABLE SOCIETY	27 DEIR ABU-DEIF CHARITABLE SOC.
3 WAD-RAHHAL SUB-CENTER	9 ARAB WOMEN'S UNION/NABLUS	28 AL-'ARAKA CHARITABLE SOCIETY
4 JORET AL-SHAM'A SUB-CENTER	10 SABASTIA CHARITABLE SOCIETY	29 ANIN CHARITABLE SOCIETY
5 MAHALIN SUB-CENTER	11 URIEF CHARITABLE SOCIETY	30 KFETRET CHARITABLE SOCIETY
6 ARAB WOMEN'S UNION/BEIT SAHOUR	12 EINABOUS CHARITABLE SOCIETY	31 BARTA'A CHARITABLE SOCIETY
7 ISLAMIC CHAR. SOC./BETHLEHEM	13 KUSRA CHARITABLE SOCIETY	32 AJJEH CHARITABLE SOCIETY
8 HUSSAN CLUB	14 BEIT-WAZAN CHARITABLE SOCIETY	33 AL-TAYBEH CHARITABLE SOCIETY
9 WAD-FOUKKIN CLUB	15 KARYOUT CHARITABLE SOCIETY	34 T'INNEK CHARITABLE SOCIETY
10 BATTIR CLUB		35 SILET EL-DAHER CHAR. SOCIETY
11 EL-KHADER CLUB	TULKAREM AREA	36 AL-FUNDUKAWNIEH CHAR. SOCIETY
12 ARTAS CLUB	1 SALFIT CHARITABLE SOCIETY	37 DEIR-GHAZALEH CHARITABLE SOC.
13 ZA'TARA CHARITABLE SOCIETY	2 FARKHA SUB-CENTER	38 EL-MUGHAYER CHARITABLE SOCIETY
14 TAQU'A CHARITABLE SOCIETY	3 SKAKA SUB-CENTER	39 AL-RANAH CHARITABLE SOCIETY
	4 AL-MURABITAT CHAR.SOC/QALQILIA	40 SIRIS CHARITABLE SOCIETY
JERICHO AREA	5 DAR AL-YATIN CHAR.SOC/TULKAREM	41 HAYYELHARAH CHARITABLE SOCIETY
1 JERICHO LADIES CHAR. SOCIETY	6 BAL'A CHARITABLE SOCIETY	42 MAYTHALOUN CHARITABLE SOCIETY
2 EL-UJA SUB-CENTER	7 ANABTA CHARITABLE SOCIETY	
3 AL-HILAL CLUB	8 ATEEL CHARITABLE SOCIETY	CENTERS : 118
	9 ILLAR CHARITABLE SOCIETY	SUB CENTERS: 26
	10 AZZOUN CHARITABLE SOCIETY	-----
		TOTAL : 144

Appendix E

IN-SERVICE TRAINING & SEMINARS FOR CRS STAFF AND VILLAGE TEACHERS
FEBRUARY 1985 - DECEMBER 1986

<u>DATE</u>	<u>ACTIVITY</u>	<u>STAFF</u>
April - June 1985	First Aid Practicum (Red Cross Practitioner)	Instructors
July - Aug. 1985	Marasmus, Cold Injury, Microscope (Bethlehem University nurses)	Instructors, Supervisors
August 1985	How to Save an Eye (St. John's Hospital)	Instructors, Supervisors
Sept. 9-19, 1985	Materials workshop	Village Teachers
Oct. 28-Nov. 14, 1985	First Aid, Eye, Equipment (CRS Instructors)	Village Teachers (Hebron - 20)
Nov. 18-Dec. 5, 1985	First Aid, Eye, Equipment (CRS Instructors)	Village Teachers (Ramallah - 14)
Dec. 10 - 31, 1985	First Aid, Eye, Equipment (CRS Instructors)	Village Teachers (Jenin - 31)
Jan. 6 - 28, 1986	First Aid, Eye, Equipment (CRS Instructors)	Village Teachers (NabluS - 19)
Nov. 85 - Aug. 86	English Language	All Staff
Dec. 4, 1985	"Identification and Management of Risk Preg- nancies" (Bethlehem 11)	Instructors, Supervisors
April 1986	ORT Conference, Cairo (USAID - sponsored)	Instructors, Supervisors
April - May 1986	"Genetics and Birth Defects" (Sr. Barbara PhD)	Instructors, Supervisors

Appendix F

PL-480 COMMODITIES AND TEACHERS' PAY

Overview

A major concern with regard to the ability of the Union(s) to take over and continue CRS' health education program is paying the salaries of the village teachers. The issue is complicated because of great variation in:

1. The amount of salary a village teacher receives,
2. The sources of this salary, and
3. The regularity with which she receives it.

Most teachers receive a salary of 20 to 30 dinars per month, although a few sometimes receive no pay and another small minority may receive about 40 dinars a month. In most villages, it appears, about half the salary comes from within the village and about half is a supplement from the Union. In the majority of villages, mothers attending classes pay a nominal fee to the village organization sponsoring the class. This then goes to pay the teacher, sometimes with a supplement from other village funds.

A major unresolved question is whether mothers attending the classes will continue to attend and, especially, if they will be willing to pay the fee, if they no longer receive the food commodities. Some evidence says yes, because they value the learning. Some knowledgeable people say no, and point to the decline in attendance in the literacy program after CARE-provided food commodities were discontinued (see page 72).

One thing that is clear is that arrangements concerning pay for the village teachers vary tremendously. It should not be expected that pay arrangements can be standardized, given the number and diversity of villages participating in the program.

Examples of Village Variation

T'inek village (Jenin District, population: 450)

- Organization sponsoring health education: T'inek Social Center (established in mosque classroom by the mukhtar; not a legal organization with links to outside organization).
- Mothers attending the class pay: 1/2 JD/month (x 20 mothers = 10 JD/month); mothers believe they are paying for the food.
- Salary of health education teacher: 10 JD/month (the money paid by the mothers), plus her salary from also teaching kindergarten (2 JD/month per child).

El-Duyuk village (Jericho District, population: 1000)

- Organization sponsoring health education: El-Duyuk Charitable Society
- Salary of health education teacher: nothing. Health Education class is just starting. Teacher says she doesn't expect any pay since her brother is president of El-Duyuk Charitable Society; she used to work for him in his office.

Deir Abu-Mish'al village (Ramallah District, population: 2000)

- Organization sponsoring health education: Deir Abu-Mish'al [Sports] Club (nadi)
- This is first time health education is offered. There are two classes of 20 each, thus 40 mothers enrolled.
- Mothers attending the class pay: 1 JD/month (x 40 mothers = 40 JD/month); mothers pay the club.
- Salary of health education teacher: 35 JD/month. This is paid by the club; no pay to her from outside.

Kharbata Bani Hareth village (Ramallah District, population: 1300)

- Organization sponsoring health education: Kharbata Club (nadi)
- Mothers attending the class pay: 5 sheqals. Say they are paying "to help the club"; don't know what the club pays the village teacher.
- Salary of health education teacher (paid her by the Club): 20 JD/mo. She says this is fine, that she doesn't do it for the money. The president of the Kharbata Club is a teacher.

Findings and Conclusions Concerning Teachers' Pay

1. The teachers must be paid; they will not work as volunteers. Most would eventually, if not soon, stop working in this capacity if not paid. Reasons include:

- "If they're paid, they're obliged to do a good job; otherwise not. They might have a good intention and try hard at first, but then they would lose interest."
(Same is said of the volunteers who constitute the boards of the Unions.)
- "Teachers who get paid teach better."

Only one teacher was found among those interviewed who receives no salary. She is the sister of the president of the village charitable society and she is just now, with his help, starting the first health education class to be taught in the village.

Nevertheless, most of the teachers are motivated to teach health education, not because of the salary (which they say is not great anyway), but because they: (1) want to help the people of their village; (2) like to acquire new knowledge and skills; and (3) want to "get out of the house" and do something broader than the village woman's traditional wife-and-childbearing role. There are few opportunities available

to them. The only common alternative opportunities are becoming a village literacy teacher, a village kindergarten teacher, or pursuing some additional education that they can get while still living at home with their parents or husband.

2. The teachers' salaries vary considerably. The salary for teaching health education appears to range from about 20 to 40 JD/month. It depends:

- on how good she is. "If a teacher is good, she will get paid more." When she is good, more mothers will come to the class. The village organization or the mothers will be willing to pay her more.
- on whether the union adds to what is paid from within the village.
- on the relationship (kin or other) of the teacher to the leader(s) of the village organization sponsoring HE.
- on whether she also teaches some other class for the village organization (e.g., some are also the kindergarten teacher)
- on how poor or relatively affluent the village is.
- on the access of village women to doctors.

3. The means of paying the teacher's salary also varies. In all cases the mothers attending the class pay something. Mothers generally pay 1/2 J.D. per month (about U.S. \$1.50), but this varies too. In some villages the mothers think they are paying the village organization, in others they think they are paying the teacher. The mothers' understanding of what they are paying for varies from village to village, although they are generally the same within a village. In some villages women think they are paying:

- for weighing their babies;
- for the food;
- for transporting the food from the district city to the village;
- to belong to the village organization;
- to help the village organization, since it helps their village;
- for the teacher's salary.

The teacher's salary may then:

- be equal to what the mothers pay;
- be less than what the mothers pay, a small amount having been retained by the village organization;
- be more than what the mothers pay, being augmented by the village organization;
- be more than what the mothers pay, being augmented personally by the head of the organization; or
- be more than what the mothers pay, being augmented by the Union.

If augmented by the Union, the Union generally provides about half, plus or minus, of the teacher's salary.

4. The teacher does not always receive her salary, or the full amount, each month. It may be less if the mothers do not pay the full amount asked of them. (Poorer mothers are often excused from always paying the full amount.) In some villages the teacher may go without pay for several months and be reimbursed later. In some areas the Union has stopped its contribution. In at least one village the local organization has not been able to pay for several months but plans to reimburse the teacher "when the money comes from Jordan." (44,000 JD are supposed to be coming to the organization from the Jordanian government, along with 50,000 to electrify the village.)
5. Standardization of village-level financing arrangements for health education (sponsorship, pay, etc.) is neither possible nor desirable. (Nor should the absence of standard arrangements be interpreted as evidence that the food commodities are have a negative impact on the program.) In a country where health workers are government civil servants such standardization might be realistic, but not under the current West Bank situation in which local organizations in are held responsible for the functioning of the program. Any effort to force standardization would be contrary to the goal of institutionalizing the project with local organizations.

Appendix G

CRS QUESTIONNAIRE ADMINISTERED TO WOMEN BEFORE AND AFTER HEALTH EDUCATION

Name: _____

Village: _____

Date: _____

_____ Total number of pregnancies
 _____ Number of miscarriages
 or still births.
 _____ Number of live births.

_____ Number of neonatal deaths (0-28 days)
 _____ Number of infant deaths (29 days-11 mos.)
 _____ Number of child deaths (1-4 years).

Had prenatal care for _____ pregnancies.

How many children born at home: _____ in the hospital: _____

	Youngest child male/female	Second youngest child male/female
1. How many months breastfed before giving any other food.	_____	_____
2. At what age stopped breastfeeding completely.	_____	_____
3. Did you ever use a bottle.	_____	_____
4. What did you usually put in the bottle.	a. _____ b. _____	a. _____ b. _____
5. How many months did you give a bottle.	_____	_____
6. What were the first foods you gave.	_____	_____

1. Has your child ever had diarrhea _____ How long did it last _____
2. What do you think caused the diarrhea _____
3. How did you treat the diarrhea _____
4. Did you take the child to the doctor _____
5. What do you put into the special drink _____

Do you have: Electricity _____ Refrigerator _____
 Radio _____ Kerosene burner _____
 Television _____ Butane gas _____

Water Supply: Piped in _____
 Outdoor faucet _____
 Cistern _____
 Other _____

Waste Water (Kitchen/bath-not toilet):
 Empties into cesspit _____
 Empties into yard _____

Sewage disposal:
 Cesspit _____
 Yard _____

Toilet : Indoor - water seal _____
 Indoor - turkish _____
 Open pit latrine _____
 None - open field _____

Garbage : Put in cans _____
 Dumped close to house burned later _____
 Put in village dump _____
 Thrown into hills _____

Livestock : None _____
 Neat - properly kept in pens _____
 Penned but still a problem _____
 Wandering livestock - serious problem _____

What causes disease: _____

Health Education classes completed:
 _____ Nutrition _____ First Aid _____ Child Development _____ Hygiene _____

Appendix H

SCOPE OF WORK FOR THIS EVALUATION

LIFE CYCLE PROJECT IN JWB

REVISED STATEMENT OF WORK

1.) KEY QUESTIONS/ACHIEVEMENT OF PROJECT OBJECTIVES

- A. Are the objectives of project (EOPS), as outlined in the logframe, being met, and will they be met by EOP, in the West Bank and Gaza? Barbara
- B. What is the quality and relevancy of training? Larry
- i. Once returned to their village, how well prepared do the trainees feel in delivering the material they learned during their training?
How relevant is the material?
Are there some health issues that they could use further training in to be a more effective health educator in their community?
How do the village mothers feel about village teachers?
Is the material they are being taught relevant to their life?
Is it presented in a way that is understandable?
What suggestions can the mother make to help the teacher be more effective and responsive to their needs?
Larry
- ii. To what extent are mothers that are educated by village teachers actually using and practicing the principles they are taught?
What are some of the problems and what can be done to resolve them?
Larry
- C. Are the original assumptions valid at this time?
Barbara

2.) KEY QUESTIONS/INSTITUTIONALIZATION

- A. What are the essential elements for institutionalization?
Barbara
- B. Is the CRS/JWB institutionalization plan adequate?
Barbara
- i. Is current level of motivation of the participating charitable societies enough to sustain institutionalization?
If not, what are some ideas to increase this motivation?
Larry
- ii. Is the current level of managerial skills sufficient for the local societies to take over the supervision of the Life Cycle Project?
If not, what can be done to improve them? Larry

- iii. Which of the following aspects of the current institutionalization plan need to be changed, and how?
- Method of contacting societies.
 - Timetable for turnover/supervision and instruction.
 - Proposed inservice follow-up in Community Development and home visits.
 - Plan for future financing (recurrent costs).

Larry and Barbara

- iv. Food: PL 480, is it essential for program operation?

Larry

3.) KEY QUESTIONS/PROJECT IMPACT

- A. Does the questionnaire ask the right questions?
What should be added or deleted? Sally
(With input from Barbara and Larry)
- B. Current data input and processing are clumsy and time consuming. What are recommended changes? Sally
- C. Is current data sufficient to evaluate the program's health impact? How? Sally
(With input from Barbara and Larry)
- D. What is the best format for this impact data reporting? Sally (Barbara)
- E. What are the simplest and most essential (minimal) data required for measuring health impact at the village level?
How can this be done? Sally
(Barbara and Larry)
- F. What is the quality of the data already being collected? Sally
- G. What other impacts is the project having? Larry
- H. Should other data be collected and other methods used to supplement questionnaire? Sally
(Larry and Barbara)

4.) KEY QUESTIONS/PROJECT MANAGEMENT

- A. Are the current level of expenditures and proposed future achievements consistent with program achievements and goals? Barbara
- B. Is current staffing sufficient for the work? Barbara
- C. Are current office systems sufficient and appropriate? Barbara
- D. What is CRS's relationship to local communities and CRS's effectiveness at generating participation from community members (nature and level). Larry

Appendix I

METHODOLOGY

Overview. The methodology for this evaluation consisted of a formal Team Planning Meeting at CRS in New York followed by site visits, interviews, observation of the data collection process, and document and data analysis in Jerusalem, the West Bank, and Gaza during the four-week period of January 17-February 18, 1987.

Team Planning Meeting. This was a two-day meeting at CRS headquarters in New York. Participants were key CRS and AID personnel and two of the three team members. During this meeting, the purpose of the evaluation and scope of work were clarified, a strategy for the evaluation was developed, and basic working relationships were established. The consensus was that this team planning meeting was extremely valuable in sending the team to the field fully briefed on the project and able to begin immediately with substantive discussion, thus eliminating the need for project personnel to spend valuable time introducing the team to the project and setting.

Document review. The team reviewed all CRS documentation on the project (including planning documents, the grant application and grant, annual reports, and other interim reports and notes in the files) as well as relevant AID documents and other reports and publications on health and the general context in the West Bank and Gaza.

Site visits and interviews. The team visited the major cities and a cross-section of villages in each district. Villages included both large and small, poor and wealthier, some where health education classes had been ongoing for several years and some in which they were just starting. Observations were made of the following village activities: health education classes in session, mothers coming for baby weighing, food commodity distribution, home visits by village teachers, baseline interviewing of mothers by the CRS field supervisors, and meetings of village mothers to decide on when to begin a health education class. Observations were also made of training courses (in which CRS instructors train village teachers) at the Caritas Baby Hospital in Bethlehem and at NECC in Gaza.

In the villages, semi-structured interviews were conducted with several categories of key personnel:

- o village teachers,
- o village women in the health education class,
- o leaders of village charitable societies and other community leaders,
- o CRS staff instructors and field supervisors.

For each of these categories, an interview guide of three to five pages in length was developed by the evaluation team. This was used to their interviewing and to record responses. When time permitted, responses recorded on the guides were transferred into more detailed field notes at the end of the day. (A condensed version of the Interview Guide for Village Teachers is attached at the end of this section.)

Interviews were also conducted with:

- o key personnel in the three Unions of Charitable Societies, universities, and other organizations to whom CRS had proposed transferring the program;
- o leading and local health personnel in the West Bank and Gaza, both those who have collaborated with CRS on the Life Cycle Project and others;
- o government of Israel officials in the three major cities (Jerusalem, Hebron, and Nablus); and
- o U.S. consulate general and embassy personnel in Jerusalem and Tel Aviv.

Data collection. CRS' collection and analysis of baseline and impact data was examined in all stages from village interviewing of mothers enrolling in the classes to the processing of the data in the CRS/Jerusalem office. Interviews were held with all personnel involved in the process as well as with non-CRS personnel knowledgeable about health data in the West Bank and Gaza.

This report was presented in draft form to CRS in Jerusalem and finalized upon return to the United States.

INTERVIEW GUIDE FOR VILLAGE ("FAMILY") TEACHERS
(Prepared for Use During Evaluation)

PERSONAL

Name:

Village:

Number inhabitants:

How long a village teacher?

Age:

Married: yes / no

Children:

MOTIVATION OF VILLAGE TEACHER

When did this health education begin in the village?

Who had the idea of having this health education in the village?

How many mothers have taken the classes?

Why did you become a village teacher?

Is it as you expected? yes / no

Explain:

Who recruited you, and how?

What do you like best about the work?

What do you like least about the work?

VILLAGE HOUSEHOLD COMPOSITION

Average number of children?

Proportion of young couples living with [husband's] parents?

MOTIVATION OF MOTHERS (present)

Why do they come?

Why don't other mothers in village also come?

Payment: When do they pay?

What are they paying for?

What do they think they are paying for?

BEHAVIOR CHANGE

What do most people in the village think causes disease?

How do you attempt to change attitudes of mothers?

IMPACT: What do mothers do differently after being in the class?

What do they think about weighing their babies?

How do village mothers treat diarrhea?

What do you think about ORS packets vs home-prep?

Is there a difference between young/older mothers?

Any other differences?

NATURE OF THE WORK / PROBLEMS

What are the most difficult things in the job?

Is anyone opposed to this health education?
(And, if so, what do you do about it?)

Husbands?

Mothers-in-law?

Village leaders?

Traditional health practitioners

Sheyukh?

Dayas?

Doctors?

How many hours per week do you spend on this work?

Should any part of your work be changed?

What other things could you do in your role as health educator?

What do you do the rest of the time?

SUPPORT

Who helps you the most, and how?

What other people help you, and how?

Where is the class held?

What does the supervisor do?

How often do you think she should come to see you?

Is there some support you need but don't get now?

SALARY

What is your salary?

Who pays it?

Where does that money come from?

Do you get paid every month?

THE FUTURE

What is necessary to keep health education going in the village?

Food and mothers:

Would mothers come without the food?

Could mothers afford to pay (or would they pay) for the class without getting the food?

What could you (or others) do that might replace the food as a motivation?

Food and the teacher:

If there were no food to give out, would you continue this work?

If there were no pay for village teachers, would you continue to do this work?

If the pay were less, would you continue?

[What would you do instead?]

When CRS money for Health Education runs out, who can run the Health Education program?

Do you have any ideas on what should be done?

END ON UPBEAT NOTE ABOUT THE IMPORTANCE OF HER WORK!

Appendix J

KEY PERSONS INTERVIEWED

CRS/Jerusalem, West Bank and Gaza

Mr. Joseph Curtin, Representative
Mr. Douglas Broderick, Deputy Representative
Mr. Daniel Carr, Health Education Project Manager
Ms. Shoushan Franji, Community Relations Specialist
Ms. Nora Kort, Social Worker
Ms. Aida Alawi, Secretary (computer data inputer)

Supervisors:

Ms. Ibtisam Khatib
Ms. Tammam Shalaby
Ms. Iman Da'doush
Ms. Subhieh Ghanem
Mr. Akef Zeitawi
Ms. Bassimeh Jagoub

Instructors:

Mr. Abdel Rahim El Assad
Mr. Nader Hajmeer
Ms. Rufaida Khatib
Ms. Mariam Hamarsheh
Ms. Mufida Sakman
Ms. Fatmeh Abed

Sr. Leona Donahue, CRS/Jordan Representative

WEST BANK, CENTRAL REGION

Jerusalem

Union of Charitable Societies: Dr. Amin El-Khatib, President

Arab Medical Welfare Association (AMWA):

Dr. Isa Salti, President
Dr. Yasir Olaid, Chairman, Joint Planning Commission for Health

Union of Palestinian Medical Relief Committees: Dr. Umaiye Khamash

Spafford Children's Center Association:

Ms. Anna Grace Lind, central member of Board of Directors
Ms. Mary Franji, Matron

International Christian Committee, MECC (or NECC):

Mr. Elias Khoury, Executive Secretary

Lutheran World Federation:

Mr. Ahmed Nasser, Director of Village Health Program

Augusta Victoria Hospital: Dr. Amin Majaj, Medical Director

Community Development Foundation:

Mr. Philip Davies, Director, Jerusalem
Ms. Karen Assaf, Health Projects Coordinator, Jerusalem

Government of Israel

Mr. Eli Tsur, Director, Department of Social Welfare
Dr. Ted Tulchinsky, MD, MPH, Director of Personal and Community
Preventive Health Services, Health Department

Jerusalem District

Abu Dees village:

Iman Muheissen, Health Education Teacher

Bethlehem District

Bethlehem University:

Brother Cyril Litecky, Academic Vice President
Sister Caroline Agravante, Dean, Faculty of Nursing
Sister Theophane Wurtzer, Faculty of Nursing

Caritas Baby Hospital:

Dr. Emile Jarjoui, Medical Director
Mr. Anton Dabdoub, Hospital Administrator
Ms. Honey Kawas, Pediatric Nurse
Ms. Risala Yacoub Shomaly, Social Worker

Wad Fukkeen village:

Hanan Manasra, Health Education Teacher
8 mothers bringing babies for weighing

Beit Fajjar village:

Naela Takatka, Health Education Teacher
15 mothers attending health education class

Ramallah District

Ramallah Hospital, Dr. Isa Salti, Medical Director

Bir Zeit University:

Dr. Gabbi Baramki, President
Prof. Rita Giacaman, Community Health
Ramzi Sansur, Ph.D., Center for Environmental and Occupational
Health Sciences

Deir Abu-Mish'al village:

Mrs. Abir 'Isa, Health Education teacher
Mothers attending health education class
Mr. Husein Abid-Yusuf, farmer and President, Deir Abu-Mish'al Club
Mr. Hussein 'Abed Yussef, past-president of Deir Abu-Mish'al Club
Dr. Adel 'Arouri, M.D., mobile clinic physician

Kharbata Bani Hareth village:

Miss Maha Abdel-Jalil, Health Education Teacher
Mothers present for distribution of powdered milk
Mr. Abdallah Nimer, teacher and president of Kharbata Club
Mr. Mahmud Yussef, vice-president of Kharbata Club

Bodros village:

Ms. Wahibi 'Isa, Health Education teacher
Mothers bringing babies for weighing
Mr. Mohammad Marrar, teacher and president of Bodros Club

Deir Qiddees village:

Mr. Mohammad 'Abd el-Ruhman, school principal

Ne'leen village:

Ms. Fariha 'Issa, health education teacher

Kufur 'Ein village:

Ms. Samia Rifa'i, health education teacher

Jericho District

El-Duyuk village:

Ms. Rihab Srur, Health Education teacher
Mothers being interviewed by CRS supervisor prior to new class
Mr. Mohammad Abu Srur, president of El-Duyuk Charitable Society
Dr. Jihad Mish'al, M.D., clinic physician

El-Oja village:

Miss Jamileh Njum, Health Education teacher
Mothers being interviewed by CRS supervisor prior to new class
Mothers and families in their homes

WEST BANK, NORTHERN REGION

Nablus District

Nablus

Union of Charitable Societies:

Mr. Fathi Shadid (Abu-Fawaz), Secretary

Office of Social Welfare: Ms. Fadia El-Masri, Director

Al-Najah University, Mr. Najeh Jarrar, Lecturer, Dept. Sociology

Beita village:

Ms. Mufida Hamdan, Health Education teacher
Mothers bringing babies for weighing

Qaryut village:

Ms. Maha Al Qaruti, Health Education teacher
Mothers attending health education class

Jenin District

Jenin

Office of Social Welfare: Ms. Maha Jarrar, Director

Deir Abu-Da'if village:

Ms. Zeinab Abu-Taleb, Health Education teacher

Mothers attending the Health Education class

Mr. Haj Farhan Mohammad, merchant and president of the Deir
Abu-Da'if Society

T'inek village:

Ms. Kamleh el-Muhur, Health Education teacher

Mothers attending the Health Education class

Mr. Abu 'Adel, mukhtar and supervisor of T'inek Social Center

'Aqqaba village home: Mother, her husband, and 8 children

Tulkarem District

Tulkarem

Office of Social Welfare: Mr. Abdel-Kader 'Arafah, Director

Dar Al-Yateem Al-Arabi:

Ms. Susanne Awwad, President

Ms. Na'imeh Habib, Secretary

Ms. Najwa Ta'ibiy, Health Education teacher

'Anabta village:

Ms. Amal Yussef, Health Education teacher

Ms. Amineh Hijazi, President, 'Anabta Society

Mothers attending health education class

Baqa El-Sharqiyeh village:

Ms. Hussneyeh Mas'ad, Health Education teacher

Mothers bringing babies for weighing

WEST BANK, SOUTHERN REGION

Hebron District

Hebron

Union of Charitable Societies:

Mr. Mohammad Mousa El-Amleh, Vice President

Mr. Mohammad Roumy, Secretary

Mr. Samih Abu E'sheh, Board Member

Office of Social Welfare:

Mr. Mch'd Fatafta, Director

Hebron District Health Department:

Dr. Abdel Majid, Director of Hebron Health Department and Mayor
Ms. Zahiyeh Othman, Head Nurse, Hebron District Health
Department and GOI/UNICEF Primary Health Care Project
Ms. Takrid, Project Coordinator, GOI/UNICEF PHC Project

Hebron Red Crescent Society:

Dr. Jihad Iwiwi, M.D.
Dr. Lena Nather, Director, Oral Rehydration Center
Ms. Haiah Awad, Nurse
Ms. Sarah Harb, Nurse

Halhoul village:

Zuhur Abu Shkedem, Health Education Teacher & Board member
Sadia Madegh, Health Education teacher
Society Board member
6 mothers coming for food distribution

Beit Kahel village:

Ms. Raja' Madyeh, Health Education Teacher
6 mothers bringing babies for weighing

Hart El-Sheikh village:

Ms. Mo'mineh Kawasmi, Health Education Teacher
11 mothers attending health education class

Taffouh village:

Ms. Salwa Manasra, Health Education teacher
Mothers bringing babies for weighing
Mr. Mohammad Khamaishe, teacher and president of Taffouh Society
Kindergarten teacher
Sewing and knitting teacher

Bani-Naim village:

Ms. Shadia El-Manasra, Health Education teacher
Mothers coming for powdered milk distribution
Kindergarten teacher

El-Sammu' village:

Mr. Ya'cub Hawamdeh, teacher and president of the El-Sammu' Society

Beit Ummar village:

Mothers and children in their homes

GAZA

UNRWA:

Samir Badre, M.D., Chief for Medical Services
Elias Rayes, M.D., Chief for Preventive Health Services

Near East Council of Churches Committee for Refugee Work:

Mr. Constantine Dabbagh, Executive Secretary
Rafiq Zanoun, M.D., Zeitun Family Health Service Centre

Community Development Foundation:

Mr. Chris George, Director for Gaza
Mr. Ali Mansour, Coordinator for Health Projects, Gaza

U.S. State Department

Mr. Nicholas Burns, Economic Officer, American Consulate-
General, Jerusalem
Mr. Scott Loney, Second Secretary, American Embassy, Tel Aviv

CRS/New York

Mr. Robert Quinlan, Director, Eurasia Regional Office
Msgr. Robert Charlebois, past director, Eurasia Regional Office
Ms. Grace Hauck, Contract Administrator
Sister Mary Clennon, Deputy Director, Eurasia Regional Office
Ms. Kate Cerwe, Desk Officer, Jerusalem, West Bank and Gaza
Ms. Pauline Wilson, Resource Administrator
Dr. Helen Bratcher, Nutrition Adviser
Sister Eileen Fane, Evaluator/Planner, Office of Policy and Planning
Ms. Jeanette North, Eurasia Regional Office
Ms. Denise McGuire, Desk Officer, Asia and Pacific

AID/Washington

Ms. Kristen Loken, ANE/TR/HPN, Project Backstop Officer
Ms. Anne Dammarell, ANE/DP/E, Team Planning Meeting Coordinator
Mr. Paul Bisek, ANE/TR, PVO Liason Officer
Ms. Carla Maged, ANE/TR, Assistant PVO Coordinator

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