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**EVALUATION OF THE
POPULATION AND FAMILY
WELFARE PROJECT
OF THE
COPTIC ORTHODOX CHURCH**

by

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Fieldwork
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Glossary

AED	Assistant Executive Director
AO	Authorized Official
BPESS	Bishopric of Public Ecumenical & Social Service
CABU	Coptic Orthodox Association for the Brotherhood of the Underprivileged
CBD	Community-based distribution
CS	Center Supervisor
ED	Executive Director
EM	Education Manager
FHCC	Family Health Care Center
FLEP	Family Life Education Program
FPIA	Family Planning International Assistance
FW	Field Worker
GOE	Government of Egypt
GSA	U.S. Government Supply Agency
IEC	Information, education, and communication
JHU	The Johns Hopkins University
MD	Medical Doctor
MFM	Medical Field Manager
MWCA	Married women of childbearing age
NE	Nurse Educator
ORT	Oral rehydration therapy
PCS	Population Communication Services

PFAD	Planning, Financial and Administration Director
PFWP	Population and Family Welfare Project
RS	Regional Supervisor
STD	Sexually transmitted disease
USAID	United States Agency for International Development (Mission)
WID	Women in Development
£E	Egyptian Pound (US\$1 = £E 2.40)

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Executive Summary

Overview

This evaluation of the FPIA/USAID-supported Population and Family Welfare Project (PFWP) of the Coptic Orthodox Church was undertaken in order to guide future program direction and assistance. The project, which began in 1975, is administered by the Bishopric of Public Ecumenical and Social Services (BPESS) from its Cairo headquarters and provides clinical services and family planning education and support to 43 Family Health Care Centers (FHCCs) located throughout Egypt. All of these centers offer family planning services and education. Some of the centers also offer a variety of community services including day care, family life education, job training, youth student facilities and studies in Coptic language and history. Referrals are made by a large network of Field Workers; three centers also have Mobile Units to reach outlying areas. The project coordinates with the Government of Egypt (GOE) and other family planning programs both at the national and local levels and has developed training and research relationships with academic and professional institutions.

Project Impact

The PFWP is reaching populations with limited, if any, social services -- ranging from rural villages, whose only health services contact is with the project's Mobile Units, to a center in Cairo, where a population of garbage collectors receive a variety of social services including clinical as well as family planning services. While provision of these services to communities -- both Christian and Moslem -- is impressive, the number of acceptors is less than could be achieved. As of January 1989 there were 29,549 actual acceptors representing only about one-fourth of a target population of 112,000 to be served.

Project Constraints

This low acceptor rate is due, in part, to a lack of accurate reporting by the FHCCs to the BPESS. To a greater extent, however, it reflects a need for strengthening the project management and service delivery components.

The most critical shortcomings in project management are determined to be the following:

- Clear lines of authority and supervisory responsibilities have not been established;
- Field-level personnel do not participate in project planning;
- Senior staff have not had management training; and
- Income generation activities are not systematically monitored.

In the area of service delivery, the major shortcomings are the following:

- Not all FHCCs have adequate equipment and supplies and not all tests are conducted and records maintained;

- Training for some FHCC personnel is not long enough to cover all necessary topics;
- The number of Field Workers is insufficient and the turnover rate is high; and
- IEC materials are sometimes inappropriate for the target groups.

Recommendations

In light of these needs in project management and service delivery, the following recommendations are made to strengthen project performance:

1. Improve the management and project effectiveness by
 - a. Developing clear lines of PFWP authority and supervisory responsibilities through project reorganization, improved personnel and financial management and reallocation of resources;
 - b. Encouraging the participation of FHCC personnel and Regional Supervisors in project planning;
 - c. Providing management training for senior staff; and
 - d. Tightening controls for income generation activities.
2. Strengthen service delivery by
 - a. Ensuring availability of equipment and supplies at all FHCCs, and that all necessary tests are being conducted and that records are being maintained;
 - b. Conducting longer training for physicians and Nurse Educators and refresher courses for Field Workers;
 - c. Increasing the number of Field Workers, their hours worked and providing financial or other incentives;
 - d. Improving IEC by obtaining additional materials or developing an IEC capability; and
 - e. Considering incentives for acceptors.

1. Introduction and Background

1.1 The Coptic Orthodox Church and Family Planning

The Coptic Orthodox Church dates back to early Christianity. Its members are the native Christians of Egypt and the direct descendants of the ancient Egyptians. The Church flourished as Christian monasticism arose in Egypt and it became a focus for Egyptian nationalism. Today, the Church comprises 33 dioceses headed by a patriarch, the Pope of Alexandria, with a membership of approximately eight million out of a population of 55 million. Members are drawn from the wealthy and educated business and professional class, as well as from the middle and poorer sectors of society. The Church operates its own primary, secondary and technical schools throughout Egypt and the Theological University College and the Institute for Coptic studies in Cairo. Lay members are active in Church life and each church has its own parish council, which cooperates with the clergy in covering the pastoral and social needs of the community.

The Church's protocol on family planning has been clearly stated on several occasions. In November 1986, and in January 1987, respectively, the Egyptian magazines *Al-Mosawar* and *October* carried the remarks of Pope Shenouda III wherein he stated that

"Family Planning is an economic and social necessity required for our country in which the population has increased to an extent that it has become an alarming burden on the state with regard to food, jobs, housing and other necessary services."

Additionally, the Pope received a delegation of some hundred journalists in February 1987, and discussed the necessity of family planning

"... that has become a national social and economic necessity ... and that the solution to the economic problem is not the responsibility of the government alone, but the responsibility of everyone that lives in this nation."

1.2 Overview of Project Implementation

The Population and Family Welfare Project (PFWP) is managed by the Bishopric of Public Ecumenical and Social Services (BPSS), a department of the Coptic Orthodox Church, whose main function is to provide social and ecumenical services to the underprivileged.¹ The BPSS has successfully managed a Family Life Education Program (FLEP) since 1973 reaching people in several areas of Egypt and the PFWP was introduced as a complement to that program. Over the years, the PFWP has initiated activities in areas where there were few, if any, service providers and today counts 43 Family Health Care Centers (FHCC) providing family planning services throughout Egypt.

Culturally appropriate assistance is provided at several levels including infrastructure

¹The BPSS has been the grantee of FPIA support except for the period 1980 to 1986. After the assassination of President Anwar Sadat and the Bishop who headed the BPSS in 1980, the Pope departed Cairo and was under police guard at a desert monastery. A committee of five bishops was then appointed to administer the Bishopric. After several months, the committee appointed another Bishop to head the BPSS, but by that time the GOE had taken over administration of the project by placing it under the direction of the Coptic Orthodox Association for the Brotherhood of the Underprivileged (CABU), a Christian organization working under the Ministry of Social Affairs. Disagreement arose between the BPSS and CABU in 1986 concerning which agency should be the grantee; the matter was resolved by FPIA when it issued a continuation proposal with the BPSS again named as the project grantee.

Culturally appropriate assistance is provided at several levels including infrastructure development, training of family planning service providers, community contact through the Church's development worker pool, and medical and social services through the FHCCs and churches. The Church also contributes to the project through the provision of physical facilities.

1.3 Scope of Work

The program issues to be examined as stated in the scope of work include the adequacy of local project management and technical assistance, as well as the quality and scope of clinical family planning service delivery (see Appendix A). These issues are discussed in the following pages under the headings of Project Management, Service Delivery, Training and Information, Education, and Communication (IEC). Recommendations for strengthening the quality and scope of the current and new project activities are contained in a final chapter.

1.4 Evaluation Methodology

A two-person team consisting of Thomas D. Murray, management consultant and team leader, and Laura Evison, nurse midwife with expertise in family planning clinical services, conducted the evaluation during the period February 20 through March 13, 1988.

The scope of work originally called for a review of the progress of the project since its inception in 1975; however, given the constraint of a lack of project documentation, this was revised to a review of the project only since 1986. The team studied the available project documentation at the USAID/Cairo Population Office and at the Bishopric center and the field offices where visits were conducted. Interviews were held with USAID staff and with officials and staff of the BPSS and other family planning projects. Observations were made of the delivery of services to the client population, the adequacy of the project centers and clinic facilities, the storage of commodities and the availability of visual materials at the family planning centers. Based upon all these activities, the team assessed project management, external technical assistance, the quality and scope of clinical family planning service delivery, and arrived at specific recommendations for strengthening the current and proposed new project activities and for working toward sustainability.

1.5 Role of FPIA

Family Planning International Assistance (FPIA) has provided support to the project since its inception in 1975. FPIA has monitored the project by tracking the grantee's submission of required reporting documents; has conducted site visits including the project's service delivery points; and has assessed the project's significance, effectiveness, and performance prior to preparing continuation proposals.

1.6 Role of USAID/Cairo

The PFWP is one of many population projects under the Population Office of USAID/Cairo. As a buy-in project, however, it does not receive as much of USAID's attention as would a bilateral project.

2. Project Management

2.1 Organization

Central Level

Management of the PFWP is highly centralized at the Bishopric level reflecting, in part, the Church's structure and lines of authority. The organization chart (Appendix B) shows a Board of Directors whose role is to establish policy and provide guidance to the Authorized Official (AO), a Bishop of the Church who devotes 40 percent of his time to the project. The Board is composed of seven members including the AO: one Bishop (along with a priest assistant) in charge of program development activities; one Bishop in charge of youth activities; a well-known lawyer; a respected Church leader active in youth activities; and both the Planning, Finance and Administration Director (PFAD) and the Executive Director (ED) of the PFWP. In addition, there is a Technical Committee composed of four persons which assists both the AO and the ED. The ED reports directly to the AO and spends 100 percent of his time on the project. The organization chart shows the PFAD responsible for all financial and personnel management (with the exception of administration support staff, which reports to the Executive Director).

The AO has frequent contact with the Executive Director and is well informed regarding the project. The Board of Directors, on the other hand, has not met formally in the past 18 months, and the Technical Committee, although formed in 1987, has never held a meeting.

It is important to note that the project does not operate full-time -- that is, 30 to 40 hours or so per week -- but varies according to location and hours of clinic operation. For example, most clinics conducting family planning activities are operating three days weekly for two to four hours per day. Thus, "full-time" for clinic operations, including the family planning at the Family Health Care Centers (FHCCs) means approximately 12 hours weekly. Given this, the amount of time spent by the top management in the project is roughly five and nine hours per week for the AO and PFAD, respectively. The exception to this is the present Executive Director who devotes, at a minimum, 40 hours per week to the project.

Middle management at the BPSS comprises Medical Field Managers (MFMs), an Education Manager (EM) and assistant, a Data Analyst, and an Accountant. Four MFMs are budgeted for 1989, but only two work at present; the MFM for upper Egypt retired in November 1988 and that position has not been filled. The MFMs and the EM are shown reporting directly to the Executive Director. The organization chart is unclear concerning the lines of authority for the Data Analyst who analyzes the monthly reports from the Regional Supervisors (RSs) and designs evaluations for training activities. The RSs are shown reporting only to the Data Analyst. The accountant is responsible only to the PFAD and has no relationship to the Executive Director.

The project organization chart lacks clear lines of authority and in some areas does not show reporting or supervisory responsibilities. For example, the PFAD's role seems to be that of consultant to the Bishopric and the PFWP, with supervisory responsibility for the accountant and cashier only.

Family Health Care Center (FHCC) Level

There are currently 43 FHCCs in the project and each is considered autonomous by the BPSS although all receive support through the PFWP as well as other assistance from the BPSS. There are two organizational levels at the FHCCs: the center itself and the field activities.

The Center Supervisor (CS) is usually a priest in charge of the parish church, whose duties include the religious guidance of his parishioners along with a variety of other social

activities. The latter range from training courses in secretarial skills to weekly meetings concerning Family Life Education to the delivery of clinical services including family planning. The CSs are budgeted at 100 percent time on the project.

Each FHCC also has at least one Medical Doctor (MD) who is paid under the project and who is budgeted at 100 percent time. The MDs are supervised by the CSs.

There are 43 Nurse Educators (NE) (also supervised by the CSs) whose responsibilities include, but are not limited to, the intake of family planning clients, supervision and distribution of commodities, performing IEC activities and assisting the MDs.

The Field Workers (FW) are said to number presently 195 (although in a recent salary distribution document, only 152 were listed) and are divided among the 43 clinics and the three Mobile Units. They work 100 percent of the time conducting home visits, counseling, and referring new clients to the MD at the FHCC. They are women, both single and married, some of whom devote part of their time to the Church on a voluntary basis in addition to their work with the PFWP. They are supervised by the Regional Supervisor, the Center Supervisor, the Medical Doctors and the Nurse Educators. The organization chart shows a linkage between the NEs and the Field Workers (FWs), but there is no mention of a supervisory relationship with the FWs in the NE job description.

Recommendations

1. The project should be reorganized with clear lines of authority showing reporting and supervisory responsibilities.
2. The Board of Directors should consider expanding the Board to include members of other family planning organizations and Board Members should receive Board Member training.

2.2 Personnel

The PFWP has some 900 positions in its budget planned for 1989. Total salaries for these positions amount to £E 1.8 million, or about half of the total FPIA project budget. The BPESS is shown contributing to the project in the areas of fringe benefits, supplies, and office space.

Discussed below are those positions that have been examined in detail and for which recommendations are made.

Planning, Finance & Administrative Director (PFAD)

As it stands in the organization chart, the PFAD is essentially the project director as he has complete control over project finances, and is one of the three signatories on the project bank account (the other two being the AO and the former accountant now employed by the BPESS). The PFAD is a highly qualified accountant and the director of his own accounting firm with offices both in and outside of Cairo. He is an elected member of the Board of the Coptic Church, which represents the Christian Orthodox population to the GOE. Either he or the Bishop must give approval to the Executive Director for the purchase of any commodity or service.

The PFAD is often unavailable to the project because of frequent travel.

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Executive Director (ED)

The ED position is filled by an MD trained in cardiology who occupies his present job at the request of the Bishop. A professed non-manager, the ED has held the position since mid-1987 and is both devoted to his job and aware of the project's strong and weak points. He is extremely knowledgeable about the Church and its FHCCs and has excellent relationships with all project personnel. He negotiates well and is very sensitive to the different personalities among the FHCCs. Most staff report directly to him as there is no Assistant Director. His estimated work week is between 70 and 80 hours. His current salary is less than that of the PFAD. He shares one office and only one telephone line with the MFMs, the EMs and any priest or other FHCC supervisors who happen to visit.

The ED has a great deal of responsibility but very limited authority.

Technical Committee

There are four members on the Technical Committee according to the 1989 budget. Their job is to review and advise on program performance. They are scheduled to meet weekly and each member is budgeted at £E 50 per week or £E 2,600 annually.

Although formed in 1987, the committee has never met.

Medical Field Managers (MFM)

There are four MFMs budgeted for 1989 in the FPIA document. Each is budgeted at £E 495 per month. (Another BPESS document lists three such positions at a monthly salary of £E 536.) Presently, there are two MFMs. A third, residing in Upper Egypt, retired in November. The main responsibility of the MFMs is to ensure that there is quality service delivery at the FHCCs, which is accomplished through training and on-site visits.

The MFMs are also responsible for the training of the various Diocese Committee members. These Diocese Committees are composed of business and professional persons who (under the supervision of Center Supervisors) provide counseling and advice to church members on a variety of subjects not necessarily related to family planning. (Committee members number 300, each of whom is budgeted at £E 40 per month; they are, however, not functioning as planned and there is a question as to what extent they assist the PFWP.)

At the present project level (43 FHCCs), three MFMs are sufficient.

Regional Supervisors (RS)

There are six RS slots in the budget for 1989, although only five are presently filled. The RSs are essentially the BPESS's linkage to the FHCCs. They are responsible for an average of 9 centers and collect reports, handle the delivery of needed commodities, and meet regularly with FHCC supervisors and staff. They use public transportation and taxis. The RS job description indicates that they are to submit monthly reports to the Assistant Executive Director; however, no such position exists in the 1989 budget modification. Their job description also indicates that they are to collect and deliver locally generated income. The RSs perform other functions besides those in their job descriptions. One is the verification of family planning acceptors by randomly sampling the FHCC center files and conducting home visits. Another is the IEC activity that some RSs carry out at the FHCCs and church meetings. Also, since all RSs are male, they are called upon by the

The RS is key to successful project implementation as he has direct contact with both the FHCCs and the BPSS on a regular basis. His many and varied responsibilities, however, are restricting effective program management.

Medical Doctors (MD)

Presently 43 MDs at the FHCCs are paid for under the project. One half of the MDs are female. Some clinics have additional MDs and these are paid by the BPSS. The 1989 FPIA project document shows MDs budgeted at £E 150 per month although they are presently paid largely on an incentive basis. Their base salary is £E 20 per month. In addition, they receive £E 5 for each clinic session, 40 Piasters for each acceptor, and 20 Piasters for a general client. Thus, their present salary amounts roughly to £E 120 per month. Their hours vary depending on the location and hours of the FHCC, their private practices, and other interests. Some are residents at hospitals in the general area of a clinic. They provide a variety of services at the clinic and average seven clients during a two-hour session, 10 percent of whom are estimated to be family planning clients.

Nurse Educators (NE)

The NE is also central to successful project implementation. There are presently 43 NEs provided for under the project whose duties include registering new clients at the clinic, maintaining records and commodities, banking generated income, and implementing IEC. The NEs also direct the FWs by identifying new clients and providing assistance when problems arise. Their job descriptions do not indicate that they supervise the FWs although they do meet with the FWs on a weekly basis.

The NEs are highly motivated in their jobs and are well informed concerning the constraints to family planning in their villages. Their knowledge of the experiences and the problems that FWs face in their jobs, along with their own varied experience in the clinics, are the basis for improving program management.

Field Workers (FW)

There are 290 FWs budgeted in the project. FW base salaries are £E 83. In addition, most, though not all, receive a bonus for registering new acceptors (this policy depends on the FHCC).

Their backgrounds and educational levels vary as does their marital status. Field Workers are married or single women who serve the Church, promoting family planning in the community by means of person-to-person contacts and home visits. The church has a tradition of pastoral visiting and family counseling, so that Field Workers are welcomed in most homes. The FWs make home visits in pairs and have a variety of initial approaches depending on the family's religion, the presence of other family members, etc. They either walk or use local transportation in their jobs. All have received training, but express a need for more (see Section 5.1). They work on average 12 to 15 hours weekly.

Field Workers also function as limited community-based distribution agents, but they are not permitted to prescribe pills in the field or to counsel clients on resolution of side effects.

The salary for some FWs, such as those with family support or those who are attending school, is adequate, but for others -- especially single women -- the salary is insufficient. Job turnover usually occurs between 1.5 and 2 years.

attending school, is adequate, but for others -- especially single women -- the salary is insufficient. Job turnover usually occurs between 1.5 and 2 years.

Recommendations

- 3.² The PFAD should be assigned the role of consultant to the AO and not occupy his present position which is essentially that of Project Director.
4. The ED should be given authority for project finances. His position should be strengthened with improved facilities and assistance with administrative responsibilities. Remuneration for this position should not be less than that of the PFAD. He should receive management training.
5. Payment to Technical Committee members should be stopped and the Technical Committee role reexamined.
6. One of the MFMs should be designated as the Assistant Executive Director. The other should be attached to the BPSS and work with the FHCCs in lower Egypt. A third should be hired for Upper Egypt. The MFMs should not be required to train the Diocese Committees and these committee members should be paid by the Church and not by the project.
7. The Regional Supervisors should receive training in management and planning. Their jobs should focus more on staff development and management assistance than on policing the FWs and verifying employee attendance. Planning sessions should be held in conjunction with NEs and FWs. The RSs should be employed on a full-time basis.
8. The Nurse Educators should likewise receive training in planning and participate in regional workshops along with the RSs and FWs. They should also be trained in IEC techniques.
9. Field Workers should, where possible, be employed on a full-time basis.

2.3 Supervision

Supervision at all levels is carried out informally. Personal evaluations are not conducted and job descriptions, although included in the FPIA project descriptions, are lacking in detail. At present, supervision consists of weekly meetings at FHCCs during which staff members discuss problems and advice is given through home visits.

As stated earlier, the RSs conduct random sampling of the FWs' reported acceptors to verify that they are users and then sends the findings to the ED. In some instances, the FWs record as users women who have had the IUD inserted outside the FHCC. In the case of falsification of acceptor numbers by the FW, if the amount is minor, it is discussed with the FW; if the number is great, say 20 or so, and if the falsification is a repeated offense, then the ED writes to the AO requesting dismissal of the FW. The RS role in effect has become one of auditor in which he is viewed as constantly verifying and confirming the number of acceptors to BPSS headquarters, thus creating a distance between himself and those he is intended to help.

Field Workers are supervised by all other staff members, including the CS (some

²Recommendations are numbered consecutively throughout the report and correspond to the numbering used in Chapter 6.

Overall, supervision is lacking and poorly understood because basic personnel procedures have not been established, and in some cases supervisory roles have been assigned to personnel who do not appear in the original project document (see Section 2.4).

Recommendation

10. Basic personnel management systems including proper job descriptions and periodic personnel evaluations should be established. Personnel reviews should be conducted semi-annually and merit increases awarded where they are justified. Staff development programs should be initiated in order to provide a career ladder for project personnel.

2.4 Planning

Project planning is greatly emphasized by FPIA in its work with the BPESS. Available reports show the target populations the project intends to reach in a given period as well as the work required to reach those populations. However, there is no indication as to how the figures were arrived at or who participated in the planning process. It has been determined that neither the RS nor the NEs were involved in the planning of the most recent project document (Egypt 07, Modification #7). This is unfortunate as both have a great deal of first-hand experience in the project and know which goals are attainable given the available resources. (Plans appear to be prepared, in part, to meet donor requirements).

The document also lists an Assistant Executive Director (AED) whose responsibilities include 1) overseeing the day-to-day project activities; 2) supervising Cairo field activities; and, 3) visiting the FHCCs and mobile clinics -- activities which make sense and relieve the ED of many time-consuming, yet necessary responsibilities. However, there is no line item in the budget nor a job description for the Assistant Executive Director and the position is not included in the organization chart.

Recommendation

11. Project planning should involve all levels of staff and planning sessions should be carried out regionally as well as in the BPESS. Participation with other agencies in planning activities, at, say the level of the Governorate, should also be explored and closer programmatic linkages to the National Population Council developed.

2.5 Communication and Coordination

The FHCCs submit monthly reports to the BPESS through the RS. The RSs use a standardized reporting form showing the number of clients and acceptors, commodity stock on hand, and any problems that need to be addressed. The forms are delivered to the ED and then sent to the Data Analyst who records the information in a data bank. These reports are the basis for the information submitted by the project to FPIA.

Meetings of the CSs in Cairo are held on the first Wednesday of each month, whereas the regional CSs meet irregularly. The CSs and other staff attend an Annual Meeting in Cairo at which they are asked to evaluate and discuss the project. For example, at the Annual Meeting in November 1987, the participants made a number of points: that they wanted the Church's opinion on family planning; that they did not feel the project was reaching enough young people; that users appear to prefer the IUD; and that all the FHCCs were in need of laboratories.

FWs are not required to submit reports; rather their impressions and experiences are given orally to the NE and others at the FHCCs.

Reporting from the field to the BPESS is generally good, and reports are usually received from the centers in Cairo and Lower Egypt the first Wednesday of the month. The exception to this schedule is Upper Egypt, where the reporting period is usually the latter part of the month.

In addition to the coordination that is taking place at both the headquarters and field levels, good working relationships have also been established with the National Population Council and its Alexandria branch has invited the RS to participate at the Governorate level. Likewise, relationships have been developed with the Family of the Future, the Ministry of Health, the Islamic Center for Population Studies, and Ain-Shams University. The PFWP also has an excellent relationship with the Egyptian Fertility Care Society.

The ED has managed to arrange for the University of Alexandria Medical Faculty to train the project MDs. This required many trips to Alexandria and meetings with members of the Board of Regents who are Moslem and extremely cautious about dealing with a Christian organization. The ED has also appeared on the local TV news regarding project activities.

2.6 Logistics for Supplies and Vehicle

Procurement Process

The present procurement process is unnecessarily time-consuming for the ED and is lacking in sound management practices. The procurement process begins with a written request for purchase submitted to the ED who takes the request either to the AO or the PFAD and explains why the commodity is needed. The approval is given orally or in writing and a copy is sent to the accountant who then signs and forwards it to the cashier. An estimate of the purchase price is made and cash given to the originator of the purchase request who then selects and pays for the merchandise and returns to the cashier with a receipt of purchase. Any cash remaining from the purchase is given to the cashier. If the merchandise is shipped, the storekeeper notifies the ED upon arrival. There is no multi-paged purchase order used in the procurement process.

Vehicle

A Ford van was purchased for the project around 1980. The van is used by the Bishopric which, in return, makes two sedan cars available to the project. The sedans are used by the ED and the MFMs for project business. The van receives regular maintenance checks at the center garage and the van driver is said to record mileage and the purpose of use.

Contraceptives Storage and Distribution

Contraceptives are stored in a warehouse located at the St. Mark's Center, Cairo. The warehouse has an outer office for the storekeeper and a large well-ventilated and well-lighted storage area. Commodities are located on steel shelves set on wooden pallets. Commodities are arranged by type and are easily accessible. The storekeeper maintains an inventory of contraceptives as well as other clinical and IEC equipment and supplies. (Appendix C lists the contraceptives on hand as of February 22, 1989. Appendix D shows other supplies and equipment belonging to the project that are stored in the warehouse.)

Two contraceptives in stock -- Delfin foam and the spermicides -- have now expired (some 4,500 altogether). FPIA was notified about these expired commodities six months ago and the project is still awaiting word regarding their destruction.

The storekeeper is under the supervision of an MFM. Stock reports are submitted to both the MFM and the PFAD monthly. Requests for supplies are usually contained in the FHCCs monthly report.

Contraceptives are distributed to the FHCCs by the RS. They are kept in unlocked cabinets at the FHCCs. The NE is responsible for them and issues them according to client need. Some NEs are maintaining accurate files on the distribution of contraceptives.

While the storage facility for the contraceptives in the central warehouse is excellent, storage at the FHCCs varies according to the center and the NE.

Recommendations

12. The ED should be authorized to make decisions about purchasing himself without seeking the approval of the PFAD or the AO. A purchase order mechanism should be established whereby the ED, the accountant and the storekeeper all have copies of the merchandise order form and are informed when it is received.
13. RSs should ensure that commodities at all the FHCCs are properly stored and inventoried.

2.7 Financial Management

The PFAD, who is actually a consultant to the Bishopric supervising some 15 projects for the Church, manages project finances and has authority to transfer 20 percent from one line item to another. An accountant and a cashier report directly to the PFAD. The PFAD maintains an office at the BPESS; the accountant and cashier are located at the project office in St. Mark's Center, Cairo. The cashier's office is next to the large room accommodating the ED, MFMs, EMs and visitors. The cashier disburses money from a large safe. Project cash amounting to over £E 4,000 was observed and was said to be kept separately from other cash located in the safe.

The project operates on a cash basis with all expenses including salaries paid monthly in cash. The method of operation is as follows: Each month the cashier cashes a check for £E 25,000 from which he makes "advances" to the RSs for their respective FHCCs, and the RSs deliver the salaries to their FHCCs. When the money is given to the RS by the cashier, the accountant records the transaction in a "Salary Journal" as a cash advance. Upon receipt of a signed salary voucher, the accountant offsets the advance and enters the amount as an expense in the Book for Cash Control (Receipts and Disbursements). A third journal, Book for Advance Payments, lists the monies advanced to each center (from £E 1,000 to 1,500 monthly) for purposes other than salaries, usually for the purchase of materials and supplies. A fourth journal, Book for Stocks, lists the project commodities including contraceptives and equipment and supplies. (Appendix E contains samples of the reporting forms as well as cash payment and receipt forms along with an explanation of their use.)

This cash advance system allows for errors. On one occasion, a Regional Supervisor lost the salaries intended for his region and had to make repayment himself. The salaries paid are not recorded as such until the voucher is returned to the BPESS.

A Cairo-based auditing firm, which has audited the project previously whenever there has been a project modification, recently undertook an audit of the project covering the period June 1985 through September 1988. The firm found the project accounts generally satisfactory (although time did not allow the evaluator to review their report completely). The warehouse stock was the only category not examined in the audit.

The project bank account has been maintained since 1986 at the Bank du Caire under the title BPESS Family Planning Account #8046. (It was with another bank when the project was administered by the CABU and was moved to the present bank when the BPESS resumed management. Purportedly, there was financial mismanagement under the CABU.) Signatories to the account are the AO, the PFAD and the former project accountant now working directly for the Bishopric.

Salary Issues

In 1987, President Mubarak requested that salaries throughout the country be increased by 20 percent. FPIA has informed the Church that it is to pay the increases (considering them as incentives); the Church, however, believes that the increases are salaries and should be paid for by FPIA. This matter has yet to be resolved. In addition, there is a matter of employee insurance which, according to the PFAD, should be paid by FPIA as well.

Salaries are the only category currently being paid by the PFWP. A computer printout of salaries paid by the BPESS during 1989 shows the amounts budgeted in the FPIA Modification #7 for 1989. These, along with the BPESS salaries budgeted for 1989 and the actual monthly salaries paid, are shown in Table 1 (see next page).

Table 1 indicates that salaries paid to two individuals on the Technical Committee and the accountant exceed the amount budgeted by FPIA. As mentioned previously, the Technical Committee has not held any meetings since it was formed.³ (This, of course, raises a question concerning payment of salaries during all of 1988 and early 1989.) There is also a difference in the amount budgeted for the MFMs by FPIA and the BPESS. (Although not indicated in the table, the printout also shows seven NEs for Mobile Units being paid, whereas only three Mobile Units are currently in operation.)

Income Generation

In an effort to work toward sustainability, three means of increasing income generation have been devised: 1) Mobile Units that visit outlying villages at which clinical and family planning services are available at a fee; 2) clinic laboratories where a variety of analyses can be conducted, again for a fee; and, 3) the sale of contraceptives, which has been an on-going activity for several years now.

The PFAD position was created, in large part, to develop a long-range plan for project sustainability but he has not yet begun work on this plan. This may have been a priority when Modification #7 was prepared, but is no longer viewed as such.

Project sustainability is not presently a priority at the field level although the FHCCs believe they could generate income if they had laboratories and Mobile Units (only three such units are currently in operation).

³The matter of payment to members of the Technical Committee was raised with the PFAD who indicated that they were being paid more, as they were doing the work of four members.

are currently in operation).

Mobile Units can be an effective means of generating income to sustain the project if the monies received are deposited with the BPESS and not kept by the FHCC or the Mobile Unit itself for salary payments or supplements. For example, where income has been generated through the fees charged for clinical services and the sale of contraceptives,⁴ the fees received were only reported to the BPESS; the monies themselves were retained at the centers or were paid to the staff as salary supplements. This corresponds to other findings obtained during this evaluation indicating that, in most instances, MDs were paid a supplement whenever they had a new family planning client and FWs were likewise paid for referrals to the clinic.

Table 1
Comparison of Monthly Budgeted and Actual
Salaries in 1989 (£E)

Line	Budgeted FPIA (Mod #7)	Budgeted BPESS	Actual
PFAD	824	824	712
ED	812	812	547
Member Tech C.	196	207	207
Member Tech C.	196	400	400
MFM	495	536	228
MFM	495	536	228
EM	619	619	259
Accountant	495	495	505
Data Analyst	467	467	330
Reg. Supvr (3)	310	310	183
Reg. Supvr (1)	310	310	138
CS	123	123	50-70
MDs	150	150	32-129
NEs	94-144	94-144	35-55
FWs	83	83	45-55

Recommendations

14. The project should use bank account checks for salary payments and advances. The ED should have responsibility for the payment of salaries and other operation costs. Regulations regarding employee insurance should be reviewed.
15. Project income generation activities should be planned and implemented by both the BPESS and the FHCCs. Rules should be clearly established concerning how the monies generated should be deposited and tight accounting controls established. A full-time field accountant should be employed to assist the FHCCs in this endeavor.

⁴In 1987 there was approximately £E 36,060 reported from 41 clinics with a low of £E 36 (Baliana) to a high of £E 4,680 (St. Marks, Shoubra). (Appendix F contains a breakdown by clinic of income generated in 1987.)

3. Service Delivery

Family planning service delivery was assessed in 14 FHCCs by inspecting the consulting rooms, equipment and supplies; interviewing the Center Supervisor, MD, Nurse Educator and Field Workers; studying the medical records and analyzing service statistics; visiting a village with a Mobile Unit; and occasionally observing client visits and interviewing clients.

3.1 Space, Equipment and Supplies

All centers visited have the basic equipment and space to do a fair job of service delivery. More than half the centers, however, lack a gynecology examining table and must use the general examining table, a disadvantage for the clinician and the client. In some centers, the sterilizer looked dusty and infrequently used. Many centers do not have sufficient instruments to insert IUDs for two or three clients during a session without sterilizing between clients. Screens were universally used to maintain the privacy of the client. Lights and other equipment were in working order (sterilizers were not checked). All centers had a cabinet for storage, but the glass door was sometimes broken, and equipment and supplies poorly organized inside. Some centers were generally very neat and clean, but many were not very clean and were somewhat disorganized. One or two centers may have a clientele large enough to justify equipping a second consulting room.

Mobile Units consist of rented vans, which are poorly equipped and heavily used; and an MD, a Nurse Educator and three Field Workers. On the observed visit, the service was inundated with clients. Space with a plain table and a few chairs was volunteered in a local residence. Clients are examined and treated (including IUD insertions) under these minimal conditions.

Recommendations

16. Sterilizers should be checked and repaired as necessary. Sterilization procedures should be reviewed (see training) and enforced by the Center Supervisor.
17. Every center should have a gynecological examination table. Mobile Units should have folding tables.
18. Cabinets purchased in the future should be sturdier, perhaps without glass in the doors. Broken cabinets should be repaired or replaced.
19. IUD insertion kits should be purchased in sufficient quantity to allow centers and Mobile Units to have two to three kits, thereby avoiding re-sterilization between insertions (which are often hurried and poorly done).

3.2 Interviews with Staff

Staff in general are enthusiastic about their work and answered questions candidly. Center Supervisors described the population of the catchment area clearly, noting the approximate numbers of Christian and Moslem families, socio-economic levels, needs, etc. Staff are also aware of other health and family planning centers in the area. They described the social outreach activities of the centers, which included (but were not limited to) the following:

- Nursery/day care centers,
- Family life education activities,
- Job training and Women in Development (WID) activities, and
- Youth/student housing (hostel) facilities.

Nurse Educators described their work and the health care and education activities of the center. Centers provide several health services, usually including

- family planning and gynecology,
- general medicine,
- pre- and post-natal care,
- pediatrics, and
- treatments and injections.

Some centers also have small laboratories, which generate income; many have specialists, such as a dentist or an oculist. In addition to clinical care, centers offer health education talks (including family planning) given by the Nurse Educator and the Field Workers. (See Section 5.1 for more information on IEC activities).

The Nurse Educator described the "path" of a typical new client: She is registered by a receptionist or Field Worker, and at this time may pay a fee for services; she then sees the Nurse Educator, who discusses family planning methods with her, including correct use, advantages and disadvantages; then on to the doctor, who examines her and prescribes a method; finally, after the examination, the Nurse Educator or a Field Worker arrange for follow-up in the form of a home visit or a clinic visit (if an IUD has been or is to be inserted).

Interviews with staff indicate that clients are getting good service. All staff members were asked to relate problems and needs, and to suggest ways in which the work could be improved. Doctors usually requested gynecological examination tables, additional instruments, improved sterilization procedures, and the addition of a small laboratory. Nurse Educators and Field Workers noted that clients are not given follow-up method instructions after the doctor's examination. Center Supervisors frequently requested a small laboratory.

Recommendation

20. Nurse Educators should review method use with clients after prescription.

3.3 Community-based Distribution (CBD)

The project's CBD effort is conservative because of fears that it could be charged with unsafe service delivery if Field Workers were permitted to distribute pills or manage side effects. This fear may be due in part to the fact that the doctors participating in management and service delivery are relatively inexperienced in family planning, as well as to the friction existing between Moslems and Christians. The prevailing standard of safe practice, however, should be the basis on which to make this decision.

3.4 Service Statistics

Service statistics were reviewed briefly in the centers, and in much more detail with the Data Analyst and the Executive Director. The centers had record cards and notebooks in good order. Monthly reports are prepared at each center and sent to headquarters, where the data are

entered into a computer and descriptive statistics are prepared. Center Supervisors, however, while well informed about the target population, do not set service delivery goals.

The Data Analyst reported that when he started with the project in 1986, reports from the field were often incomplete and incorrect, and that data have improved since he retrained personnel and improved the system in 1987. He noted that although the typical FPIA funding period is 12 months, for the PFWP project the funding periods have ranged from 3 months to 24 months. Generally, three Progress Reports are required in a 12-month funding period (four months per reporting period). The table below summarizes service statistics for the five funding periods of this project. (Acceptors were recorded according to definitions used by FPIA).⁵

Table 2

New Acceptors and Continuing Users: 1982-1989

<u>Funding Period</u>	<u># Months</u>	<u>New</u>	<u>Continuing</u>	<u>Total</u>
1) 8/82 - 7/84	24	24,121	5,222	29,343
2) 12/84- 5/86	18	20,421	4,643	25,064
3) 6/86 - 9/87	16	16,045	21,557	37,602
4) 10/87- 12/87	3	2,850	19,361	22,211
5) 1/88 - 1/89	13	10,072	19,477	29,549

For the first two funding periods, it would appear that the project was not retaining acceptors very well, since the figure for continuing acceptors is relatively low compared to the figure for new acceptors. In fact, however, the Data Analyst and the project staff believe that field personnel had difficulty in counting clients according to the FPIA system, and that these figures may not be very accurate.

During the third funding period, the current project staff took over and the field staff were retrained on data collection and reporting. According to the Data Analyst and the Project Director, these figures reflect both an improved rate of retention of clients, and improved reporting and data collection.

The reduced figures for periods four and five (which added together can be compared with period three) reflect problems experienced by the project in expanding and maintaining services in a time of decreased support and funding by FPIA.

In Table 3, the figures for acceptors in 1987 and 1989 have been broken down by method (see next page):

⁵A new acceptor is defined as a person receiving contraceptives from the agency's FPIA project for the first time (even if she/he has received contraceptives elsewhere in the past). A continuing acceptor is one who receives contraceptive services from the agency's project during the current funding period and who also had a contraceptive contact with the same project during the prior funding period. If a person received services in funding period one, dropped out for funding period two, and again received services in funding period three, she/he becomes a new acceptor again in funding period three.

Table 3

Family Planning Acceptors by Method: 1987 and 1989

<u>Method</u>	<u>1987</u>	<u>1989</u>
Pill	80%	72%
IUD	11%	16%
Condom	8%	10%
Other	1%	2%

The relative growth of IUD use at the expense of pill use reflects the modest success of a conscious policy to shift the method mix toward increased IUD use, especially for older women at risk for pill complications. IUD training for project physicians has encouraged them to insert more IUDs. The condom is relatively unpopular in Egypt, perhaps because most people believe that sexually transmitted diseases, as well as premarital and extramarital sexual activity, are very rare.

If the general target population is taken to be Christian married women of childbearing age (MWCA) in the six governorates served by the project, the project should be reaching 112,000 clients.⁶ The figure of 29,549 actual acceptors as of January 1989, represents 26 percent of this target. The project must increase acceptors to reach the national 38 percent coverage rate.

An increase in clientele occurred just after the newer staff members began work following a large staff turnover in 1986, which tends to demonstrate their efficacy, but since figures prior to 1986 are of dubious quality, no real conclusion can be drawn.

Recommendations

21. Center staff should set goals and prepare an action plan for each center, based on the population served and the needs assessed.
22. While it may not be feasible at this time to further development of CBD efforts, a small experimental CBD operations research project should be considered, as it could be both supported and justified.

3.5 Medical Records

A brief review of client medical record cards revealed that weight and blood pressure were usually not recorded, which could indicate that these data were not collected. Staff, however, stated that these were recorded only if abnormal. The age of the client was recorded, and in two or three cases (out of about 50), women over 40 were still using oral contraceptives.

⁶The number is calculated by making the following assumptions:

Total population in six governorates = 19.6 million

Percent Christian = 10%

Percent MWCA = 15% (approximately)

National coverage rate = 38%

Recommendation

23. Information on blood pressure and weight should be recorded. Nurse-educators and Regional Supervisors should conduct a simple records review at least twice yearly.

18-

4. Training

4. Training

4.1 Overview

The training program met most of the project's training needs during 1988. All center personnel interviewed at the 14 centers had received training for their jobs, with the exception of one or two physicians who had had family planning training previously in other projects. Many of the personnel interviewed had suggestions for future training -- suggestions that should be considered as part of an on-going evaluation of the training program. It is axiomatic that quality training is associated with quality service delivery.

The project trained a total of 327 persons in seven different training programs during the last funding period, which corresponds approximately to the 1988 calendar year. This resulted in a total of 58.6 person-months of training, broken roughly into three categories:

Table 4

Training Output: 1988

IEC	39.0 pm
Family Planning	12.5 pm
Management	<u>7.1 pm</u>
	58.6 pm

All training was organized by the Education Manager (EM), who is the training coordinator, and her assistant, and carried out primarily by guest lecturers with the assistance of the coordinator. Four to six weeks (including the time of the training itself) were required to prepare and present each training program. Most sessions were held at St. Mark's Center in Cairo, which has the facilities necessary for residential training. The course contents and programs (translated into English) were well organized and appropriate. Participants were asked to evaluate courses on a form provided by the Data Analyst, who then compiled the responses and reported to the coordinator. (Copies of these evaluations were available in Arabic only.) The evaluations are used in planning future courses.

None of the project staff, however, have had a course in training of trainers or in academic skills. This kind of training would enable the training coordinator to improve the quality of the training courses and to better assess the training needs of the project and of individual participants.

The main weakness in the training program is in the area of management training. Although Nurse Educators and Center Supervisors had some elements of management training in their courses, neither Regional Supervisors nor the senior management staff had this training in 1988. The rapid growth of the clinical system and the recent creation of some management roles, as well as the inexperience of some of the staff, suggest that management training has the potential to strengthen the project (particularly if combined with planning activities), and to promote collaboration between managers and supervisors at all levels. (See Section 2.4).

Recommendations

24. All training should be planned on the basis of an assessment of needs of potential trainees.

25. The training coordinator should receive a training-of-trainers course.
26. A management training program should be developed to provide in-country training as follows:
 - a. A training course for upper and middle management to cover various management and supervision strategies should be conducted with outside technical assistance. Trainees should make short- and long-term plans with reasonable objectives as a training exercise.
 - b. A second (overlapping) course for regional and Center Supervisors should be conducted using the same technique, with the same technical assistance. Output of the training should be short- and long-term regional plans and guidelines for centers to help them make their own action plans.
27. The Executive Director should have a two- to three-month intensive management training course, possibly in the U.S.

4.2 Field Workers

Training for Field Workers included techniques and problems of home visits, the population problem in Egypt, contraceptive methods, basic reproductive anatomy and physiology, family life education, nutrition, hazards of multiparity and female circumcision, and antenatal and neonatal care. Ninety-three Field Workers participated in Cairo for six days, for a total of 18.6 person-months.

The current initial Field Worker training is appropriate, including health interventions other than family planning and the art of communication, as well as information on contraception. Feedback from Field Workers and principles of effective home visiting programs suggest the following training needs:

- help to deal with feelings about embarrassing topics,
- more information on communication techniques,
- ways to combat rumors and traditional practices, and
- more information on lactation and contraception, nutrition and weaning, vaccination, ORT, and other simple primary health care measures.

Recommendation

28. Field Worker training is satisfactory, but in-service training updates should be scheduled as Field Worker needs indicate.

4.3 Family Counselors

The objectives of training for Family Counselors (these are priests) were to strengthen the family life education program, to promote the exchange of ideas between urban and rural groups, and to make use of the family life education effort for the promotion of family planning. Thirty-five Family Counselors were trained in Damanhour city, El-Behera province for three days, for a total of 3.5 person-months.

4.4 Nurse Educators

Twenty-four Nurse Educators were trained for six days in Cairo, for a total of 4.8 person-months. Topics covered were reproductive anatomy and physiology, contraceptive methods, family life education, overpopulation in Egypt, reporting and record-keeping, common summer diseases, how to give talks on family planning, and how to lead small group discussions on convincing lower socio-economic groups of the need for family planning.

Because the role of the Nurse Educator includes IEC, clinical work, and management, the training usually touches on all of these functions, but lacks the time necessary to cover them in sufficient depth. Currently, the Nurse Educator's training is quite similar to that of the Field Worker, although her role is more complex. Sterilization of instruments, cleaning the consulting room, and prevention of infection are important topics not currently covered. Information on the counseling process and teaching of adults is needed to ensure effective client education. Finally, the inclusion of discussions of supervision, and management of stock, petty cash, etc., could improve management skills.

Recommendation

29. Nurse Educator training should be expanded to include more content on supervision, petty cash management, contraceptive side effects and counseling, and quality assurance. Separate one- to two-day in-service programs should be held for experienced personnel (these could be programmed during the Annual Meeting).

4.5 Center Supervisors

Center Supervisors received five days of training in Cairo on various topics: overpopulation, family life education, management of integrated family planning services, center finance, counseling, use of audio-visual equipment, and contraception. Thirty-three supervisors were trained for a total of 5.5 person-months.

4.6 Medical Doctors

Physician training was divided into two parts: 1) fifty MDs (at least one from every center) were trained in contraceptive technology with brief sessions on population problems, social welfare, the Christian point of view, and acceptor counseling; and 2) forty-six physicians participated in three days of clinical practice, concentrating on IUD insertion, over a period five months, divided into small groups in three centers. A total of 10.9 person-months of training was completed. Each participant received a copy of Hatcher's *Contraceptive Technology* (13th Edition, 1986-87), which is the definitive handbook on family planning for clinicians.

The clinical IUD training for physicians, which probably contributed to the increased IUD use (see Section 3.4), was a highlight of the program in 1988. Doctors interviewed in the 14 centers were very happy with the training, and stated that they were inserting more IUDs. Physician training overall, however, seems too brief to cover fully all aspects of reproductive health care.

An evaluation of training content was undertaken with two of the trainers, the Director of the model clinic of the Family Planning Association of Alexandria, and a professor of medicine from the University of Alexandria. Both have lectured in the theoretical portion of the training and have supervised trainees during the clinical portion. (The University has a connection with JHPIEGO's laparoscopy and reproductive health program.)

The professor of medicine was asked about adding topics to the training, specifically sexually transmitted diseases (STD), management of complications and high-risk cases (contraceptors with or at risk for diabetes, hypertension, etc.), and more information on hormonal contraception. He indicated that STDs are not prevalent in Egypt, but that trainees could benefit from additional content if the length of the training were increased. Both he and the Director of the model clinic stated that trainees each inserted five to ten IUDs during their three-day practicum, but did not have the opportunity to manage complications or high-risk contraceptors.

Recommendation

30. Physician training for new physicians should be increased to 10 to 14 days. Information on hormonal contraception, high-risk contraceptors and infertility should be increased. Sexually transmitted disease should be covered at least in the theoretical training. Practical training should include 10 supervised IUD insertions and management of some contraception complications. These topics should be covered in separate one- to two-day in-service education sessions for experienced physicians.

4.7 Annual Meeting

In addition to the above training activities, an Annual Meeting was held, whose subject was "IEC Services, a Church Point of View". Examples of IEC efforts in several centers were also presented and discussed and Church experiences with IEC activities for family planning were shared by representatives of the Evangelical and Orthodox churches. Ninety-two persons participated in the five-day meeting, for a total of 15.3 person-months.

5. Information, Education and Communication (IEC)

5.1 Role of Field Workers

The project's single greatest asset may be its network of Field Workers, who function both as motivators and as community-based distribution workers. A rough analysis of service statistics and Field Worker procedures indicates that the Field Workers should be given credit for most of the new clients at the FHCC level. During the 13-month period, January 1988 through January 1989, the 43 centers averaged 18 new clients per center, per month. Field Workers in each of the 14 centers visited made 80 to 160 visits per month. If 50 percent (or about 60 visits) are to new prospects, it would take about three (60/18) visits to convince each new client, as stated by the Field Workers interviewed.

In most of the clinics visited, Field Workers in teams of two make 20 to 30 visits per week. Visits are made in the afternoon, when women have more personal time. Some visits are to existing clients to resupply oral contraceptives, others are contacts with potential new clients. Clients having side effects or problems are referred to the doctor at the FHCC. Field Workers also conduct group meetings to promote family planning, and assist the Nurse Educator during clinic sessions.

Field Workers were interviewed as a group in all 14 centers visited. Most centers have three to four Field Workers (many villages, however, lack local Field Workers); all participated vigorously in the discussion and appear very committed to their work. They were asked to describe their work, identify problems, and suggest needs or solutions to resolve them.

The most common problems identified were

- Embarrassment in discussing these sensitive topics, especially on the part of unmarried workers;
- Low pay;
- Difficulty of convincing men; and
- Women who refuse to come to the center for an examination, but want to use oral contraceptives.

The Field Workers most often suggested the following measures to help them in their work:

- Information (more training) to help convince special groups, e.g., lactating mothers, or older women to use an IUD;
- A food distribution or other incentive program to encourage acceptance;
- More and better handout IEC materials, especially for illiterate women;
- More health knowledge; and
- More Field Workers.

Field Workers report that it often takes as many as four visits to convince new clients. During the first visit to a Christian family, the workers talk in a general way about the family, the church, and the social welfare services available. Shared religious beliefs provide common ground on which to establish a relationship with the family. During the second visit, workers strengthen this relationship and introduce the subject of family planning, describing the methods and FHCC services. One or two additional visits are often necessary to overcome objections raised by the woman, her husband, or her mother-in-law. The Center Supervisor (usually a priest) or a male physician may be called upon to help convince reluctant husbands.

When Field Workers visit Moslem families, because the common ground of shared religious beliefs cannot be used to establish a relationship, workers rely on promoting health care services and family planning, and are careful never to proselytize. (All centers visited have some Moslem clients; in many centers the Moslem:Christian ratio is 50:50 or greater.)

It is reasonable to conclude that the Field Workers are usually effective, if it is assumed that most new clients come to the center as a result of the home visits. This is a fair assumption, as very little information reaches this population from other IEC efforts. Field Workers stated that some clients were already familiar with modern contraception, usually through television, but required persuasion to try a method. Positive information, they stated, was frequently offset by the strength of traditional practices and frightening rumors and stories about modern contraception.

Home visit programs in other African countries have significantly improved the family planning acceptor rate by training Field Workers to counsel families on other simple health measures such as ORT, vaccination, chloroquinization, nutrition, and general hygiene. Visitors were more welcome when perceived as health care counselors, rather than family planning sales persons. The Church already promotes integrated health care and the project teaches a few non-family planning interventions. The success of the Field Workers indicates that this aspect of the program is working.

Recommendations

31. Field Workers should be increased in number, work more hours, and be given greater financial rewards or other incentives.
32. Field Workers should be recruited in outlying villages.
33. Incentives for acceptors should be considered.

5.2 Other IEC Activities

Other IEC activities include group meetings of various kinds, conducted once or twice weekly at the center or the church by the Center Supervisor, the doctor, the Nurse Educator, or the Field Workers. Such meetings are held for men, women, youth groups, and the general church congregation. These meetings usually focus on family life education or on health, and often include information and discussions about family planning. If possible, the project video is shown to stimulate discussion.

Centers visited sometimes had family planning posters displayed. Although these posters always improve the appearance of the room, in conservative areas women find some pictures to be "shameful," so posters are not displayed. The same problem occurs with respect to brochures with pictures. The project obtains both these materials from the national family planning program, but not all centers have an adequate supply. IEC workers would like to have more visual aids and better materials for illiterates. The Church itself has the facilities to publish good quality pamphlets, and might be able to produce IEC materials.

Recommendation

34. The project should continue to obtain IEC materials from the national family planning program. JHU/PCS should be consulted for additional materials in Arabic and for illiterates, as well as for A-V materials. If production of materials should prove necessary, JHU/PCS could provide technical assistance.

6. Recommendations

Management

1. The project should be reorganized with clear lines of authority showing reporting and supervisory responsibilities.
2. The Board of Directors should consider expanding the Board to include members of other family planning organizations and Board Members should receive Board Member training.

Personnel

3. The PFAD should be assigned the role of consultant to the AO and not occupy his present position which is essentially that of Project Director.
4. The ED should be given authority for the project finances. His position should be strengthened with improved facilities and assistance with administrative responsibilities. Remuneration for this position should not be less than that of the PFAD. He should receive management training.
5. Payment to Technical Committee members should be stopped and the Technical Committee role reexamined.
6. One of the MFMs should be designated as the Assistant Executive Director. The other should be attached to the BPESS and work with the FHCCs in lower Egypt. A third should be hired for Upper Egypt. The MFMs should not be required to train the Diocese Committees and these committee members should be paid by the Church and not by the project.
7. The Regional Supervisors should receive training in management and planning. Their jobs should focus more on staff development and management assistance than in policing the FWs and verifying employee attendance. Planning sessions should be held in conjunction with NEs and FWs. The RSs should be employed on a full-time basis.
8. The Nurse Educators should likewise receive training in planning and participate in regional workshops along with the RSs and FWs. They should also be trained in IEC techniques.
9. Field Workers should, where possible, be employed on a full-time basis.

Supervision

10. Basic personnel management systems including proper job descriptions and periodic personnel evaluations should be established. Personnel reviews should be conducted semi-annually and merit increases awarded where they are justified. Staff development programs should be initiated in order to provide a career ladder for project personnel.

Planning

11. Project planning should involve all levels of staff and planning sessions should be carried out regionally as well as in the BPESS. Participation with other agencies in

planning activities, at, say the level of the Governorate, should also be explored and closer programmatic linkages to the National Population Council developed.

Logistics for Supplies and Vehicles

12. The ED should be authorized to make decisions about purchasing himself without seeking the approval of the PFAD or the AO. A purchase order mechanism should be established whereby the ED, the accountant and the storekeeper all have copies of the merchandise order form and are informed when it is received.
13. RSs should ensure that commodities at all the FHCCs are properly stored and inventoried.

Financial Management

14. The project should use bank account checks for salary payments and advances. The ED should have responsibility for the payment of salaries and other operation costs. Regulations regarding employee insurance should be reviewed.
15. Project income generation activities should be planned and implemented by both the BPESS and the FHCCs. Rules should be clearly established concerning how the monies generated should be deposited and tight accounting controls established. A full-time field accountant should be employed to assist the FHCCs in this endeavor.

Service Delivery

16. Sterilizers should be checked and repaired as necessary. Sterilization procedures should be reviewed (see training) and enforced by the Center Supervisor.
17. Every center should have a gynecological examination table. Mobile Units should have folding tables.
18. Cabinets purchased in the future should be sturdier, perhaps without glass in the doors. Broken cabinets should be repaired or replaced.
19. IUD insertion kits should be purchased in sufficient quantity to allow centers and Mobile Units to have two to three kits, thereby avoiding re-sterilization between insertions (which are often hurried and poorly done).
20. Nurse Educators should review method use with clients after prescription.
21. Center staff should set goals and prepare an action plan for each center, based on the population served and the needs assessed.
22. While it may not be feasible at this time to further development of CBD efforts, a small experimental CBD operations research project could be supported and justified.
23. Information on blood pressure and weight should be recorded. Nurse Educators and Regional Supervisors should conduct a simple records review at least twice yearly.

Training

24. All training should be planned on the basis of an assessment of needs of potential trainees.
25. The training coordinator should receive a training-of-trainers course.
26. A management training program should be developed to provide in-country training as follows:
 - a. A training course for upper and middle management to cover various management and supervision strategies should be conducted with outside technical assistance. Trainees should make short- and long-term plans with reasonable objectives as a training exercise.
 - b. A second (overlapping) course for regional and Center Supervisors should be conducted using the same technique, with the same technical assistance. Output of the training should be short- and long-term regional plans and guidelines for centers to help them make their own action plans.
27. The Executive Director should have a two to three month intensive management training course, possibly in the U.S.
28. Field Worker training is satisfactory, but in-service training updates should be scheduled as Field Worker needs indicate.
29. Nurse Educator training should be increased to include more content on supervision, petty cash management, contraceptive side effects and counseling, and quality assurance. Separate one to two day in-service programs should be held for experienced personnel (these could be programmed during the annual meeting).
30. Physician training for new physicians should be increased to 10 to 14 days. Information on hormonal contraception, high-risk contraceptors and infertility should be increased. Sexually transmitted disease should be covered at least in the theoretical training. Practical training should include 10 supervised IUD insertions and management of some contraception complications. These topics should be covered in separate one to two day in-service education sessions for experienced physicians.

Information, Education, and Communication (IEC)

31. Field Workers should be increased in number, work more hours, and be given a greater financial or other incentive.
32. Field Workers should be recruited in outlying villages.
33. Incentives for acceptors should be considered.
34. The project should continue to obtain IEC materials from the governmental project. JHU/PCS should be consulted for additional materials in Arabic and for illiterates, as well as for audio-visual materials. If production of materials should prove necessary, JHU/PCS could provide technical assistance.

Appendices

Appendix A
Scope of Work

Appendix A
Scope of Work

ACTION
COPY

UNCLASSIFIED
Department of State JAN 17 1989

INCOMING
TELEGRAM

PAGE 01 CAIRO 08926 121849Z

6305 08178 A184233

CAIRO 08926 121849Z

6305 08178 117

BEEN COMPLETED.

ACTION OFFICE POP-04
INFO ARMS-01 SAST-01 POPR-01 PPR-02 AMPO-03 AMEG-02 ANTR-06
ES-01 SINE-03 SEOP-01 SERP-01 SECS-02 HNS-09 FELO-01
ARAD-01 ONB-02 /043 AB

3. PLEASE ADVISE CONCURRENCE, CONSULTANT NOMINEES AND
PROPOSED ETA SOONEST.
VISMER

INFO LOG-08 NEA-04 SES-05 /013 V
118182 121854Z /38

P 121811Z JAN 89
FM AMEMBASSY CAIRO
TO SECSTATE WASHDC PRIORITY 8888

UNCLAS CAIRO 08926

AIDAC

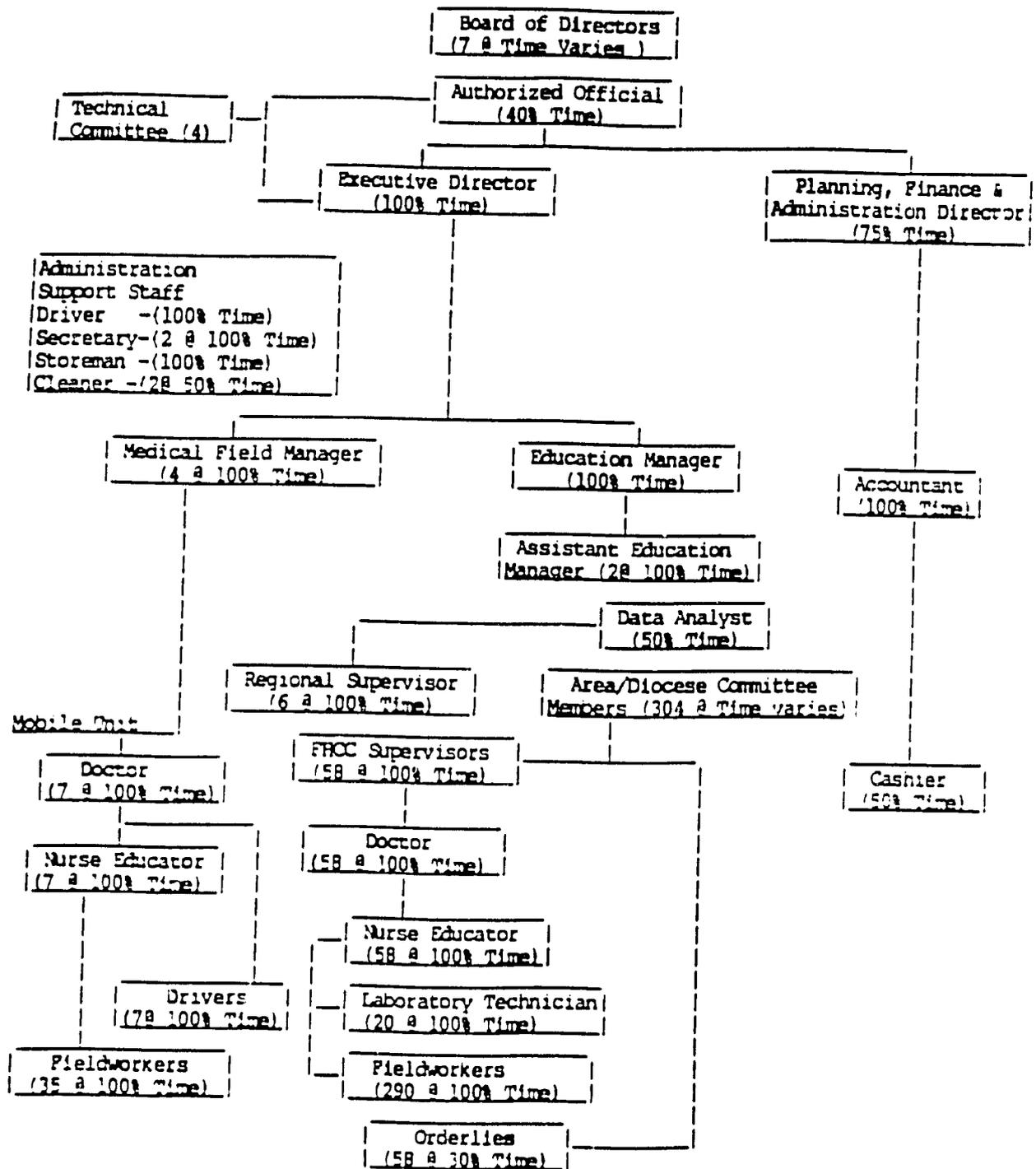
FOR ST/POP/PPSD IRENE XOKR

C.O. 12356: N/A
SUBJECT: POPULATION REQUEST FOR TECHNICAL ASSISTANCE
UNDER POPTECH PROJECT NO. 836-3874

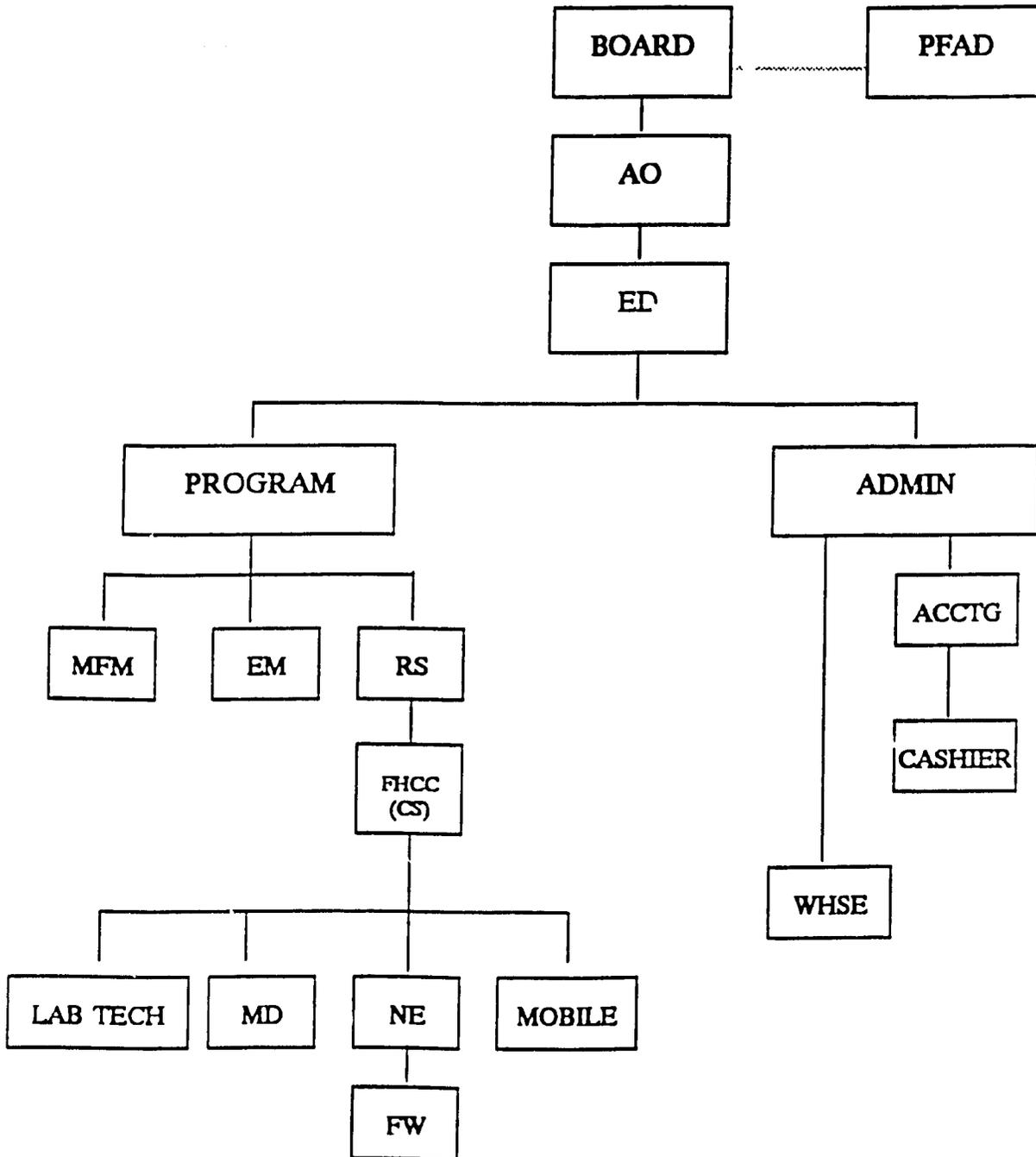
1. MISSION REQUESTS THE ASSISTANCE OF 2 PERSON POPTECH TEAM FOR APPROXIMATELY 3 WEEKS IN LATE JANUARY/EARLY FEBRUARY 1989 TO CARRY OUT A DETAILED EVALUATION OF THE FP/IA MISSION SUPPORTED FP PROGRAM OF THE COPTIC ORTHODOX CHURCH BISHOPRIC OF PUBLIC, ECUMENICAL AND SOCIAL SERVICES.
2. THE CONSULTANT TEAM SHOULD CONSIST OF PERSONS WITH EXPERIENCE AND EXPERTISE IN THE ORGANIZATION AND DELIVERY OF FP CLINICAL SERVICES PREFERABLY IN THE NEAR EAST AND EGYPT. IT IS PROPOSED THAT ONE MEMBER OF THE TEAM BE AN EXPERIENCED MANAGER WITH KNOWLEDGE OF FP MANAGEMENT SYSTEMS DESIGN AND OPERATIONS WHILE THE OTHER MEMBER BE A PUBLIC HEALTH PHYSICIAN OR NURSE WITH EXPERIENCE IN CLINICAL ASPECTS OF FAMILY PLANNING INFORMATION, COUNSELLING AND SERVICE DELIVERY.
3. THE BISHOPRIC HAS BEEN IMPLEMENTING A USAID/FP/IA SUPPORTED FAMILY PLANNING SERVICES PROJECT FOR SEVERAL YEARS IN OVER 40 CLINICS LOCATIONS IN 12 OF EGYPT'S 26 GOVERNORATES. THE BISHOPRIC HAS PROPOSED A MAJOR EXPANSION OF ITS PROGRAM INTO 6 ADDITIONAL GOVERNORATES BEGINNING IN 1989. THE MISSION AND THE GOE NATIONAL POPULATION COUNCIL ARE COMMITTED TO MEETING THE BISHOPRIC'S REQUEST SINCE THE BISHOPRIC IS AN IMPORTANT ELEMENT IN EGYPT'S POPULATION SECTOR STRATEGY. THE MISSION IS IN URGENT NEED OF A DETAILED ASSESSMENT OF THE STRENGTHS AND WEAKNESSES OF THE CURRENT PROJECT IN ORDER TO PROPERLY PLAN FOR ITS CONTINUATION. THE SOV FOR THE EVALUATION IS:
 - A. REVIEW THE PROGRESS OF THE BISHOPRIC FP PROJECT SINCE ITS INCEPTION AGAINST ITS STATED GOALS AND OBJECTIVES.
 - B. IDENTIFY STRENGTHS AND WEAKNESSES OF THE PROJECT, WITH PARTICULAR ATTENTION TO THE ADEQUACY OF LOCAL PROJECT MANAGEMENT AND EXTERNAL TECHNICAL ASSISTANCE AS WELL AS THE QUALITY AND SCOPE OF CLINICAL FP SERVICE DELIVERY.
 - C. DRAFT SPECIFIC RECOMMENDATIONS FOR STRENGTHENING THE QUALITY AND SCOPE OF CURRENT AND PROPOSED NEW PROJECT ACTIVITIES. RECOMMENDATIONS SHOULD INCLUDE CONSIDERATION OF SUSTAINABILITY ISSUES.
4. MISSION BUY-IN PROJ NO. 283-0184-1-88006 IN THE AMOUNT OF USD. 100,000 FOR POPTECH TECHNICAL SERVICES WAS SENT TO RFD/W IN SEPT. 1987. IN JULY 1988 THE MISSION WAS NOTIFIED THAT THE PROJ/HAD BEEN SENT TO ST/POP FOR APPROPRIATE ACTION. WE AGREE THAT SUCH ACTION NO. AT NOW

Appendix B
Organization Chart

Appendix B
Organization Chart



RECOMMENDED PFWP ORGANIZATION CHART



Appendix C
Inventory of Commodities

Appendix C

Inventory of Commodities (as of February 22, 1989)

<u>TYPE</u>	<u>NO</u>	<u>UNIT</u>
<u>Contraceptive Pills</u>		
1. Normnest	3780	Strip
2. Microvlar	309	-
3. Primovlar	50	-
4. Amovlar	0	-
5. Oural	348	-
6. Ovulin 1/2 mgf	616	-
7. Ovulin 1 mg J		
<u>Foaming Tablets (Locally used)</u>		
1. Cosncepral F. Tablets	27700	Tab
<u>Loops</u>		
1. Cu.t 200	474	Loop
2. Cu.t 380	4060	Loop
<u>Diaphragms</u>		
1. Diaphragm 75	1796	Dia.
2. Diaphragm 80	1741	Dia.
3. Diaphragm 85	946	Dia.
<u>Condoms</u>		
1. Size 52	160800	Condom
<u>Creams, jelly</u>		
1. Delfen	690	Bottle
2. Ramses	0	Tube

25

Appendix D
Inventory of Equipment and Supplies

Appendix D

Inventory of Equipment and Supplies
(As of March 10, 1989)

<u>ITEM</u>	<u>QUANTITY</u>
1. Chairs	10
2. Desk	1
3. Dressing Table	1
4. Projector Set	9
5. Sphygmomanometer	9
6. Pregnancy Test Set	6
7. Stethoscope	2
8. Vaginal Speculum	22
9. Goose-neck Lamp	9
10. Television Set	3
11. Video Set	3
12. Tape Recorder	2
13. Video Tape (Recorded)	7
14. Insertion Kit	51
15. Back-up Kit	20
16. Gloves	1900 pairs

Appendix E
Financial Management Forms

Appendix E
Financial Management Forms

بمقريرية الأناط الأرثوذكس
المقفية الخدمات العامة والاجتماعية
لجنة الأسرة

L. E. P. T. ٠٠٠٤١٣ نم قيمة خزينة جنب قروش

Received form Mr./ _____ استلمنا من السيد/

The Sum of Only _____ مبلغ وقدره

In settlement _____ وذلك سداداً

Date / / 19- _____ التاريخ ١٩ / /

Cashier

أمين الخزينة

أسففة الخدمات العامة والابتماعفة

طلب صرف م. انتقال وبدل سفر

تحريراً فى / / ١٩٨

المشروع التابع له الخادم محل إقامته

اسم الخادم وظيفته

موضوع المأمورة

١ - بدل السفر المستحق

إجمال المستحق	نفة اللبال	عدد اللبال	بدافة ونهافة المأمورة		الجهة اى قفى الموظف بها اللبل
			من	إل	

٢ - معارف الانتقال

إجمال المستحق	نوع الانتقال	الطرق		اتاريخ
		إل	من	

إمضاء الطالب

إقرار

أمر أنا الموقع عابه بصحة اللبانات المدونة بهذه الاسارة وأن المأمورة اى قف بها تسلزم ملى وانقالاتى وكاات ضرورية للخدمة إمضاء المقررة تتخذ صحة المأمورة

إجمال المستحق عن المأمورة

بدل سفر
م. انتقال
م. أخرى

فقط

ملى	جه

الرئيس المباشر

أسففة الخدمات

مدير الشؤون المالية

المراجع

١٩ من شهر

اسم المركز الكنيسة الايثارشية
(حالات تنظيم الأسرة الجديدة) (حالات تنظيم الأسرة المنقذة)

حالات انقطعت	المجموع	فترة امان	عائلة	كربان موضعية	رائق ذكرى	و.ب.	أ.ب.	المجموع	فترة امان	عائلة	كربان موضعية	رائق ذكرى	و.ب.	أ.ب.	كثف عام

..... خدمات طبية أخرى :

..... الأسباب التي أدت إلى انقطاع بعض الحالات :

.....

(برامج التوعية الاسرية)

(برامج التوعية للصحية)

عدد المتركين	للموضوع	نوع الخدمة	عدد المتركين	للموضوع	نوع الخدمة

..... الزيارات :

..... مشكلات واجهت الخدمة :

.....

.....

..... اقتراحات لنمو الخدمة وتطويرها :

.....

Amounts to be received by the Cash Office. A receipt with serial number should be given to the "Payer". The Cashier signs every receipt, and writes the number of the receipt in the specified part of the voucher.

The Voucher has to be registered in the Ledger "In" (credited) - R.T.P. Account under the heading "Local Donations".

✠
COPTIC ORTHODOX CHURCH
BISHOPRIC OF PUBLIC, ECUMENICAL & SOCIAL SERVICES

✠
بفكر كنيسته الأقباط الأرثوذكس
أمانة الخدمات العامة والاجتماعية

COPTIC ORTHODOX CHURCH
BISHOPRIC OF PUBLIC, ECUMENICAL & SOCIAL SERVICES

✠
بفكر كنيسته الأقباط الأرثوذكس
أمانة الخدمات العامة والاجتماعية

L. E.	P. T.	CASH RECEIPT VOUCHER	رقم	سنة
_____	_____	قبضة خزينة	_____	_____
Received from Mr. / _____		تامن السيد / _____		
The Sum of Only _____		بفقره _____		
In settlement _____		سداداً _____		
Date / / 19_____	تاريخ / / 19 _____			
Cashier	أمين الخزينة			
_____	_____			

(B) When donations are received by cheques, they have to be registered in Bank R.T.P. account. A receipt should be given to the donor.

✠
COPTIC ORTHODOX CHURCH
BISHOPRIC OF PUBLIC, ECUMENICAL & SOCIAL SERVICES

✠
بطريركية الأقباط الأرثوذكس
إسقفية الخدمات العامة والاجتماعية

} (توقيع رقم ١٠-٢٠٠٠)		بطريركية الأقباط الأرثوذكس إسقفية الخدمات العامة والاجتماعية	
٠٩٩٩٥٢		إجمالي استلام شيكات	
CHECKS RECEIPT VOUCHER			
Date / / 198		١٩٨ / /	تاريخ
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Received from Mr. / Messrs	نشأ من السيد /		
The Sum of only	المبلغ ونسبه فقط		
by Check No.	Dated	تاريخ	تاريخ رقم
Drawn on	سحب على		
Amount of	رقم مبلغاً : فقط		
TOTAL	الإجمالي		
Cashier	أمين الخزانة	Received by	للمسلم

The necessary repass has to be made to the items and credited to concerned Consortium Programme Account.

Part two:

Payments "Our" Vouchers Circulation.

The main points are as follows :-

- a) Payments happen according to a "payment order" signed by His Grace the Bishop. The Payment Order means to take the necessary steps to pay the amount mentioned in the said "Payment Order" after revision and complete all supporting necessary voucher for the correct payment. In any case, for any explanation needed for the payment His Grace the Bishop should be the source.

COPTIC ORTHODOX CHURCH
BISHOPRIC OF PUBLIC, ECUMENICAL & SOCIAL SERVICES

بفكر كنيسته الأقباط الأرثوذكس
تقنية بمخرجات العامة والاجتماعية

أمر دفع Payment Order

L E [REDACTED]

Pay to Mr. _____ إنضموا لـ
L E [REDACTED] مبلغ
in settlement of _____ ذلك سداداً لـ

Signature		التوقيع
Date		التاريخ

- b) Cash Payments orders accompanied by related supporting vouchers, payment happens , if vouchers are revised audited before payment by an accountant and the approval of both of the Financial Manager of the R.T.P. accounts and His Grace the Bishop. These are considered, General Cash payment orders. Cash payment orders are issued for projects signed by the of development unit.

Payments paid as liabilities, to be in charge for a temporary time for certain purpose to be kept in suspense till final documents are presented. Payments may be in cash, a cash money order is needed. If payments are by cheques a cheque order is needed also.

The items are to be debited to an in charge suspense account till final settlement.

The "In charge" should be given payment orders receipts for the use of the temporary loan. Also statements to be prepared at the end when the aim of the loan is fulfilled.

In case of a demand for a temporary loan from the Cashier not exceeding L.E. 100 to face actual or sudden expenses, to be settled within 3 days.

The loaner signs a temporary loan in charge receipt and undertakes to settle the amount during the specified period in the receipt.

✠
COPTIC ORTHODOX CHURCH
BISHOPRIC OF PUBLIC, ECUMENICAL & SOCIAL SERVICES

✠
بفكر كنيسة الأقباط الأرثوذكس
إستشفية الخدمات العامة والاجتماعية

التاريخ رقم الحساب : _____

بفكر كنيسة الأقباط الأرثوذكس
إستشفية الخدمات العامة والاجتماعية

رقم : ٩٩٩٨٢ إيصال عبده مؤقتة

التاريخ : _____ سنة 198 _____

لمستلم المبلغ وتسلمه : _____
As A Temporary Cash fee : _____

أنا بعد تسلمه المبلغ وتسلمه للمستندات من مبادأة تمامه من تاريخ _____
I Undertake to Reconcile this Amount and Adjou (Ogtra) according
to documents not later than _____ Starting to day

Cashier : أمين الخزينة Received ٧٧ : المسلم

Appendix F
Income Generation by FHCC in 1987

No	Name of Centre	Diocese	Executed by	Date centre was founded & support percentage	average of monthly Med Exams	Monthly average of brothers of Christ Actual	Monthly average of F.P. Actual	Medical Fees	Average Monthly Income Actual	Average Annual Income
25	Maadi	Cairo	St. George Ch. Teret El Khasat	March 83 100 %	35	10	23	LE.1	35	420
26	Ezbet El-Nakhl	Cairo		Dec. 84 100 %	29	20	10	LE.1	29	348
27	Absiry	Cairo	St. Virgin Ch.	Dec. 81 100 %	30	7	34	LE.1	30	360
28	Tera Boulakia									
	a) St. Mark Shoubra	Cairo	St. Mark Society	Dec. 82 100 %	269	9	11	LE.1.5	390	4680
	b) Abu. Sefein Sb.	Cairo	Dr. Isia Mashad	Dec. 82 100 %	---					
29	El - Nahda	Cairo	El-Nahda Soc.	Dec. 84 100 %	150	15	5	1.5	202	2424
30	Angel	Cairo	Angel Ch. Abu El-Parag	Dec. 84 100 % Trans. 1/5/87	---	22	11	LE.2	156	1872
31	El-Salam	Helwan	Deir Banat Mariam	May 84 75 %	125	6	5	1.25	156	1872
32	Yosh	Cairo	St. George Ch.	July 83 75 %	---			1.25		
33	Beni-Souef Caravan	Beni-Souef	Deir Banat Mariam	1/9/85 100 %	---	280	3	Free		
34	El-Wayli	Cairo	El-Anba Ruseif	Jan. 83 100 %	400					
35	Motmadia	Giza	Bishopric of Public, ecumenical & Social Services	Dec. 84 100 %	120			PT.50	60	720
36	Old-Cairo	Cairo	Deir ElMalak El Kebly	Dec. 84 100 %	---			LE.1		
37	Shark-El-Saka-El-Hadid	Cairo	St. Virgin Kosayarin	Dec. 84 100 %	36			LE.1	36	532
38	Shoubra-El Khema (Ezbet Rostom)	Kaliohia		Q. X. nearly	---					
39	Dababa	Giza	Mikhail Angel Church	June 85	---					
40	Mokattam	Cairo		Dec. 84	---					
41	Kolali	Cairo		Dec. 84	---					
	H.Y.									

Income Generation by FHCC in 1987

Appendix F

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No	Name of Centre	Diocese	Executed by	Date Centre was founded and support percentage	Average Monthly Medical Exps	Monthly average of brothers of Christ Medical exms (Actual)	Monthly average of family plan. (Actual)	Medical fees	Average Monthly Income Actual	Average Annual Income
1	Gheit El-Enab	Alexandria	St. George Church	Dec. 82 50 %	30	18	26	E. ordinary	21	252
2	Matal	Beni Souef	St. George Church	July 83 75 %	22	40	33	PT50-Ordinary LE.1	22	264
3	Beni-Hazar	Beni Souef	St. Virgin Church	July 83 50 %	40	40	7	M11		
4	El Masaria	Beni Souef	St. Virgin Church	Oct. 83 50 %	94	20	19	LE.1	94	1128
5	Beni Ahmed	Minia	St. Virgin Church	Dec. 83 50 %	182	70	3	LE.1	118	1416
6	St. Mina	Minia	St. Mina Church	Dec. 83 50 %	228	215	17	LE.1		
7	St. Antonios	Minia	St. Antonios Church	Dec. 83 50 %	88	83	5	LE.1 PT.50 Sometimes	5	60
8	Kallini	Beni Souef		50 %						
	a). Deir. El-Garnous	Beni Souef	Deir. El-Garnous Ch.	July 83	50	12	5	LE.1	38	456
	b). Ashnia El-Masara	Beni Souef	St. George Church	Oct. 83	112	15	15	LE.1	87	1044
9	Belt. El-Azraa	Beni Souef	St. Virgin Church Maghaha	Oct. 83 50 %	264	158	24	LE.1	106	1272
10	Belt. El-Azraa Caravans	Beni Souef	St. Virgin Church	Mar. 84 50 %	152	91	31	LE.1	61	732
11	Deir. Abu Hennes	Mallawi	St. Yostos	Aug. 83 35 %	132		25	PT75Ordinary PT35 F. P.	107	1284
12	a). Deir. El-Barsha	Mallawi	St. Bishoy	Nov. 83 50 %	200	6	8	PT50Ordinary PT25-P.P.	99	1188
	b). El-Barsha	Mallawi	St. Bishoy	Nov. 83 100 %	120		16	PT50Ordinary	64	768
13	a). El-Boda	Mallawi	St. Virgin	Jan. 83 25 %	240		10	LEOrdinary	245	2940
	b). El-Mahras	Mallawi	St. George	Jan. 83 100 %	120		12	LEOrdinary	126	1512
14	a). Ezbet. Sadek	Mallawi	St. George	Jan. 83 100 %	170		5	PT50Ordinary PT25 F.P.	86	1032
	b). Ezbet. Abdel Aziz	Mallawi	St. Virgin	Dec. 83 25 %	60	12	3	PT50Ordinary PT25 F.P.	30	360
15	Dairout	Dairout	Dairout Bishopric St. Virgin Church	April 87 100 %	80	30	8	LE.1	80	960
16	Manfalout	Manfalout	Manfalout Bishopric St. Virgin Church	May 87 100 %	35		8	LE.1	35	420
17	Abnoub	Abnoub	Abu Sefein Church El - Haman	May 87 100 %	9		39			
18	Tema	Tema	St. Demiana Church	Aug. 85 75 %	75	100	57	LE.1	75	900
19	Tahta	Tahta	St. Kyrincos Church his mother Yulitu	Aug. 83 50 %	192			PT. 110	211	In 3 years 2532
20	Tahta Caravans	Tahta	St. Kyrincos Church	100 %	200	2		PT. 50	100	1200
21	Baliana	Baliana	Baliana Bishopric	1/5/87 100 %	40	37		LE. 1	3	36
22	Edfu	Aswan	St. Virgin Church	Feb. 83 50 %	105	50	10	LE. 2	110	1320
23	St. George	Zena	St. George Church	1/5/87 100 %	15			LE. 1	15	180
24	St. Peter	Zena	St. Peter+Paul Ch.	Aug. 85 100 % Transferred in 1/5/87	10	20		LE. 1	10	120

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Appendix G
List of Persons Contacted

Appendix G

List of Persons Contacted

USAID/CAIRO

T. Tiffany	HRDC/POP
M. Schmidt	HRDC/P
C. Cromer	HRDC/P
L. Stino	HRDC/P

BPESS

Bishop Serapion	AO
Adel R. Gaid	PFAD
Dr. Hany Samir	ED
Dr. Amgad A. Farhan	MFM
Dr. Emad Mansour	MFM
Dr. Maha M. Anis	EM
Gihan Ishak	EM
Michel Aziz	Acct.
George Naguid	RS
Sameh Wahba	RS

In addition to the above headquarters staff, interviews were held with CSs, MDs, NEs and FWs at the FHCCs listed in Appendix H.

Dr. Hassan Yousuf, Head	Model Clinic, Alexandria
Mary McGovern	Pathfinder
Mohammed Kamal	Family of the Future (FOF)
Kamal El Bagoury	FOF
Dr. Sami Said	Vice Dean, Univ. of Alexandria

Appendix H
Family Health Care Centers Visited

Appendix H

Family Health Care Centers Visited

1. Model Clinic of Dr. Hassan Youssouf, Alexandria
2. Dept. of OB/GYN, University of Alexandria
3. FHCC St. George, Alexandria
4. FHCC Al-Karma, Cairo
5. FHCC Bait El-Adra, Maghaghah (Mobile Unit)
6. FHCC Mar Mena, El Minia
7. FHCC El Nasseriah, El Nasseriah
8. FHCC Auba Antonious, El Minia
9. FHCC Assuit City
10. FHCC Manfalot, Manfalot
11. FHCC El Boutrossia, Kena
12. FHCC Mar Gerges, Kena
13. FHCC Edfu, Edfu
14. FHCC El-Balya, El-Balya
15. FHCC Mo'attamadia, Cairo