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The Life Cycle Health Education Project
In
West Bank
Mid-Project Evaluation

Prepared for Catholic Relief Services
by
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Notes:

1. Throughout this report the terms health workers, health teachers, village workers and community-based health workers are inter-changeable.
2. The village rehabilitation teacher in the village-in-reach program are called in the present project community-based rehabilitation workers.

Summary of Major Findings And Recommendations

Project Description

The Catholic Relief Services (CRS) has administered two separate programs in health services. The Life Cycle/Health Education Program (LC) has been implemented, though in different formats, since 1975. The second, the Village-In-Reach Program (VIP) was introduced in 1984. Both programs have worked toward being institutionalized. However, due to various political and economic factors, it became obvious that the process of institutionalization will be hindered. Therefore, the LC grant was extended until January 1992. The VIP program was combined into the LC, but its operation was limited to the northern regions of Nablus, Tulkarem, and Jenin of the West Bank.

The LC project is needed. The West Bank is an occupied developing land. When CRS started its pioneering program in health education, this type of preventive health care was absent. On the other hand home-based early intervention is a new concept in rehabilitation even in developed societies. Both programs now operate, under Palestinian management, in the rural areas. About 44.4% of localities that lacked any sort of health service in 1987 were in the northern regions of the West Bank. About 67.3% of the health centers in the LC program are in the same regions.

Purpose and methodology of the evaluation

This evaluation was done about ten months after the implementation of the grant extension. It was looked upon by the evaluator and the CRS administration as a formative evaluation conducted to monitor the process of the Life Cycle program, to determine whether it is achieving its goals, and to make appropriate recommendation. Methodology consisted of:

- i. site visits to the different regions.
- ii. observation of the different processes of teaching, weighing, intervention, counselling, and supervision.
- iii. interviews with community workers, regional supervisors, specialists, and administrators at CRS, the regions, and the villages.
- iv. questionnaires administered to the workers and the supervisors.

Major Findings

1. CRS has successfully transferred the administration of the program at the village level to six societies operating throughout the West Bank (Jenin, Tulkarem, Nablus, Ramallah, Bethlehem, and Hebron). Each society performs as a regional center, and has employed at least one supervisor responsible for the village health education programs.
2. About 156 village programs are operating throughout the West Bank. Each center is manned by a health worker who was trained in the curriculum of health education.
3. The basic health education program being used in the training has not been changed since 1985. However, upon the recommendations of the 1987 evaluation additional material was produced and made available to teachers for optional use.
4. Since the grant extension in 1989 four training sessions were organized and implemented by the regional centers to qualify new health workers. The present training arrangement is a new organization devised by the CRS to build up the institutionalization process. To ensure the success of the new design CRS should have more quality control.
5. Societies are to assume increasing financial responsibility toward the cost of the program. As of 1990 they are to contribute about 10% of the salary of the health worker. So far plans were not made by the societies to meet this goal.
6. Mothers in four regions in the West Bank receive food aid during the health education program. Although CRS directs village workers to distribute food for needy families regardless of the participation of mothers in the program, they tend to use the aid as an incentive to increase mothers participation in their programs.
7. CRS has organized several in-service workshops during 1987 and 1988. However, none has been done this year. Supervisors are assuming a very vital role in the program. Their supervisory skills need further development.

8. Many village health workers have problems with attracting mothers to the program, or with the high rate of drop outs. These problems may be symptoms of their failure to make the process of learning as the major motivator for mothers' participation. Though the program is based upon using the dynamic participatory teaching techniques, workers' teaching skills are not always well developed. Further in-service training is needed in this area.
9. Mothers attendance is monitored. Children growth patterns are effectively monitored through weight charts. However, the accumulative records and the histories of both mothers and children are not maintained.
10. About 47 handicapped children are visited weekly by three rehabilitation workers (core staff) in the villages of the three northern regions of the West Bank. Generally speaking mothers are happy with their services. These workers are supported and supervised by CRS resource team. This team is composed of a psychologist, a physiotherapist, and a special educationist.
11. Thirty health village workers are planned to participate in three rehabilitation courses in the three northern districts of the West Bank. Upon graduation they will be involved in rehabilitation work through the home-based early intervention program, in addition to their health education activities. One training course is already taking place. It's coordinated by a local core staff from Jenin. Rehabilitation training is supported by the CRS resource team.
12. The process of combining the rehabilitation and health education components of the project is being implemented as planned. One potential problem may arise in Nablus due to the fact that village workers are supervised by one society, while the resource center is located with another society in the city.
13. The new management of the project, headed by a Palestinian psychologist, has been functioning successfully as one team. Hopefully, further role definition will be done for the members of the team to maintain its future success.

14. Two clinics have been established in two remote villages in the West Bank with assistance by the CRS. There is some coordination between these clinics and the health education program. CRS should use these clinics to experiment linking health education with curative health services.
15. A practical nurse training course is going on at St. Luke Hospital in Nablus. About one half of the 17 students in this course come from rural areas.

Recommendations

1. CRS should continue with its implementation of the programs on the same line. However, problems that have been identified in this evaluation should be addressed to increase its effectiveness.
2. Linkage of the health program with the available curative services in the villages of its operation should have a priority during the coming two years.
3. Though the principle of sharing the cost of the program is essential for its sustainability, CRS should reconsider the schedule of the local contribution outlined in the grant extension in view of the current economic conditions.
4. Measures should be taken to enhance the administrative infrastructure of the Life Cycle project. One such measure is the creation of health committees in each region to secure consistency and stability.
5. Emphasis should be given to the development of both the supervisory skills of the regional supervisors, and the teaching skills of the village workers.

Part 1: Project Setting

Introduction

The current extension to the Life Cycle Health Education Project was conceptualized by the Catholic Relief Services, Jerusalem (CRS) and submitted in October 1988 to United States Agency for International Development (AID) in October 1988. Basically, the Project was an attempt, in response to a request from AID, to extend the duration of two grants that were to end by 1988. These two projects were:

- a. Life Cycle Health Education Program (LC)
- b. Village-in-Reach rehabilitation Program (VIP)

The first project, LC, concentrates on maternal/child health and child survival. It dates back to a 1975/1979 grant. Based upon CRS experience during that grant, the health education project was designed in 1979. Several modifications and changes were introduced into the content of the project and its implementation. However, in September 1987 a new amendment was introduced. The purposes of this amendment were:

1. To develop the skills and capabilities of the CRS Supervisory staff and local societies in community development issues.
2. To develop new curriculum, to be used by supervisory staff in areas such as home-visits, referral and weighing procedures, family relations, and teaching related activities (see Fifth Semi-annual report).
3. To institutionalize the LC Project through the smooth transfer of its activities and personnel to Palestinian societies (especially the Unions of Charitable Societies).

The VIP, which was contracted in 1984, is based upon the concept that the need for prevention and early identification of handicapping conditions is met through the use of a rehabilitation worker who lives and works in the village. By 1988 the VIP had failed to realize its most important objective, i.e., the training of village workers. However, the higher level of training, the core staff (or say the regional resource persons), and its development of a curriculum was accomplished (see Evaluation of the Home Based Rehabilitation Programs for disabled children in the

West Bank and Gaza, 1988). The recommendation of the assessment team, then, was that AID extend the life of the Project for three years. The built-in design of the VIP was to get it institutionalized.

During the final year of both projects several political and economic events have taken place in the area that have severely curtailed the capabilities of the local societies to take over the project. Some of these are:

1. The Intifada (the uprising of the Palestinian against occupation). Although the Intifada erupted in December, 1987, its economic impact was felt late in 1988. Its leadership has instituted several forms of protest such as early closure of shops and factories, boycott of Israeli goods and jobs, and comprehensive strikes for two or three days every month. Though these measures have helped in solidifying Palestinians and enhancing their goals, they have impoverished an already poor economy; and lead directly to the weakening of the local resources that might have been employed in social work.
2. The decision of Jordan to disengage all administrative ties with the occupied West Bank. This decision led to the loss of substantial supplementary incomes to several thousands of Palestinians, and the loss of funding to most of the activities of the Union of Charitable Societies. For example, Dr. Amin El-Khatib, the president of the Union of Charitable Societies (UCS), told the evaluator, that it was decided to withhold the operation of the Illiteracy classes throughout the West Bank (a personal interview on November 20, 1989). Throughout the sites visited by the evaluator, it was observed that the operation of the illiteracy classes was "temporarily" withheld for the last two months.
3. The introduction of restriction on money brought in by Palestinian institutions and agencies by military occupying authorities. The Israelis have issued directives not to allow any Palestinian to bring in more than \$500.00 (or its equivalent value of JD 200.00) from abroad without the prior permission of the "civil" administration. However, such permissions are not easily obtained. This measure has deprived private Palestinian voluntary organizations from an important potential sources of funding.

4. The sudden drop in the value of the Jordanian dinar (in October, 1988 it was equivalent to \$2.8). The Dinar has lost almost 75% of its value. Most Palestinians in the West Bank used the Jordanian currency for their savings and transactions. Almost all locally salaried Palestinians are paid in Dinars (or its equivalent in Israeli Shekels). It is needless to describe the effect of this sudden drop of its value on both organizations and the individuals in the West Bank.

The CRS administration, has sensed the hardships of the local Palestinians, and felt the need to both help local economies and support local societies to take the responsibilities of running both projects. The already established network of health programs in more than 150 locations throughout the West Bank was the logical choice for use by the rehabilitation project. Thus, the present grant extension combines both projects into one network (see table 1 for further elaboration).

Description of the Project

The current project, as mentioned earlier, is composed of two kinds of services, namely, health education through the Life Cycle component, and the home-based rehabilitation Program. The core of the Life Cycle Program consists of the following functions:

- a. Health Education classes offered to village women in general, and mothers in particular. The major components of the taught curriculum are: nutrition, hygiene, child development, and first aid (see Appendix E for table of content of the course).
- b. Monthly weighing and growth monitoring by the village teacher of babies and other under-five children of mothers who are currently in the class.
- c. Referral to health care providers and consultation services of mothers and their children upon the request of these mothers.
- d. Home-visits to promote the health program to mothers, and to investigate reasons for frequent missing/or dropping out of classes.

The health workers (sometimes they are called teachers) manage the distribution of food commodities to needy mothers who are currently in the class. This service is limited to the districts of Jenin, Tulkarem, Ramallah, and Bethlehem only.

The second component of the Project is the home-based rehabilitation services to children in villages and deprived areas. Rehabilitation workers perform the following services:

- a. Home care and early intervention services for the handicapped children. These services are based upon the conceptualization of the Portage Program.
- b. Referral services of both children who are in the program, and others whose parents consult with the rehabilitation workers.

The rehabilitation component of the present project is designed to be limited to 30 locations in the northern districts of the West Bank (Jenin, Tulkarem, and Nablus).

Project Objectives

According to the grant extension, the basic objective of the project is to consolidate its past activities and expand services. Its specific objectives are to:

1. Combine and expand support of the network of health education programs and Village-In-Reach program for the handicapped children developed under the two previous projects; Village-In-Reach Program for handicapped children (JWB 3D 0003) and Life Cycle/Health Education Project (JWB 4D-004 - USAID Grants 4068 and 5065).
2. Address acute and chronic health problems in specific sectors through training and the provision of referral and primary level health services.
3. Maintain minimal private sector health and social services on the West Bank.
4. Provide financial support to charitable societies and to trained personnel within the previously established Life Cycle/Health Education System.

Project Outputs

It is expected, according to the grant extension, that by January 1992 the following outputs will be in place:

Six regional resource centers will be coordinating the CRS-sponsored health activities generated through the project.

- Six regional supervisors will oversee the Life Cycle program, one in each region operating from the resource centers. In addition the three northern resource centers will include the rehabilitation services for the handicapped children.
- Two hundred villages in the West Bank will be actively involved in the Life Cycle training courses and 30 of the same villages in the rehabilitation handicapped training.
- As pilot sub-projects, two to five new pilot health centers in isolated areas will be operative and will have been joined to the Life Cycle System.
- St. Luke Hospital, a nurse training center in Nablus, will have trained 20 selected village women/men every 18 months to upgrade the present level of service in villages currently lacking health care facilities.
- Thirty Life Cycle village teachers currently operating programs in the Northern region will be trained as Home visitors to work with the handicapped using VIP methods.
- Three VIP core staff/trainer will have trained and will be supervising the 30 home visitors involved in working with the handicapped. Two additional core staff will be working directly with handicapped children in five villages.

Part 2: Project Evaluation

Purpose of the Present Evaluation

According to the grant, the project should be evaluated twice. This evaluation, initiated by the CRS will help to:

1. Identify the major weaknesses and strengths of the process of implementing the combined programs which includes:
 - its effectiveness.
 - its problems or potential problems.
 - the degree of integration of both health and home-based rehabilitation components in the designated areas.
2. Determine the relevance of the curriculum of the health programs, as given to the mothers.
3. Determine the level of success of the institutionalization of the Project.
4. Determine the level of success in establishing the pilot clinics and their intergration into the Life Cycle Program.
5. Identify the degree of success in relating St. Luke nursing program to serving the population being addressed by the other components or the project, namely, the poorer rural areas of the West Bank.
6. Investigate the degree to which the recommendations from previous evaluations (the February 1987 for Life Cycle and July 1988 for the VIP) are implemented.

These objectives are based upon the scope of work for the evaluation of the Life Cycle Project as agreed upon with the CRS administration (see appendix B).

In view of these objectives the following areas were examined by the evaluator:

- a. The Life Cycle CRS management
- b. The regional supervisors
- c. The village health programs, including the community based health workers performance.
- d. The Life Cycle curriculum and relation teaching material

Table 1: Summary data for the four project since 1975

	<u>Period</u>	<u>Budget</u>	<u>Locations</u>	<u>Personnel</u>	
				<u>CRS</u>	<u>Societies</u>
Nutrition Education	1975-79	375.82	44	7	147
Health Education	1979-85	1,823.93	111	30	250
Life Cycle	1985-89	1,521.25	153	12	118
Life Cycle/ Home Based Rehabilitation	1989-92	2,091.89	200	9	213

1. In thousands of US dollars
2. Extended by \$175,000 in 1987
3. Previously named village-in-reach program (VIP) with grant of \$887,000 (CRS project) 1984-1988
4. They are distributed as follow:
 - 200 community based health workers out of which 30 will serve as general rehabilitation workers.
 - 7 Supervisors
 - 3 core staff
 - 3 trainers.

- e. The regional centers: facilities, operations and capabilities.
- f. The core staff performance
- g. The training of community based health and rehabilitaiton workers (village workers)
- h. The pilot clinics that have already been established
- i. The nurses training course at St. Luke Hospital, Nablus.
- j. The implementation procedures of the Life Cycle program since February 1987.

Methodology and Data Collection

Data was collected by the evaluator through:

- i. Visits to sampled location in each region. The researcher has visited:
 - The six regional centers.
 - Seven village societies or centers in the different regions of operation.
 - Deir Samet pilot clinic in the Hebron Region.
 - Two families of handicapped children, accompanied by the core workers, one in Tulkarem and the other at Boureen (Nablus).
 - St. Luke training school.
- ii. Interviews. All interviews were done in Arabic in a very non-threatening situations, (see appendix A for the list of individuals that were met). These interviews included:
 - 1. Board members of the societies or unions that have assumed the responsibilities of managing the programs in their regions (i.e. the resource center).
 - 2. Chairpersons of seven of the village societies or centers that have established health programs (see appendix F).
 - 3. Three leaders in health or social work in the country who are familiar with the CRS-sponsored health operation.
 - 4. Two mothers of handicapped children and mothers in the health education classes that were visited. (see Appendix G).
 - 5. The administrator of St. Luke Hospital and the Nursing School Principal.
 - 6. The seven regional supervisors (see Appendix H)
 - 7. CRS Country Representative, Life Cycle program manager, the resource persons at the CRS office, and the support staff.

8. The ex-implementor of the health education program and ex-instructor.
 9. Two core staff and the trainer at Jenin.
 10. Seven community-based health workers (see Appendix I).
- iii. Questionnaires. Two questionnaires were devised by the evaluator, in consultation with Dr. Michael Sansur, program manager. One was designed for the community-based health workers (CBHW). The second was given to the regional supervisors. Both questionnaires were in Arabic.

The CBHW questionnaire was administered to all workers who have been working with the LC program for more than one month. Thus 140 forms were distributed. Two CBHW have not returned their questionnaire and two questionnaires were disregarded for the loss of parts of the questionnaire. The valid rate of return was 97.1%.

Questions were designed to gather:

1. Biographical information and professional history.
2. Conception of the program objectives and methods of implementation.
3. Problems being met by the CBHW.
4. Present and accumulated to date size of the CBHW operation.
5. Job knowledge and practices.

The second questionnaire was administered to all supervisors. The rate of return was 100%. It has the same components as in the CBHW but adapted to the supervisor's role. In addition it has a sixth component to evaluate:

- a. The performances of each of the CBH workers in her/his region.
- b. The need of the existing centers for the health program.

Part 3: Findings, conclusions Recommendations

1. The need for the health education program

At present the program is operating in 154 centers spread in the six regions of the West Bank. Data for the present evaluation was based on 136 centers. Both of the supervisors and the health workers were asked about the need of the program in their localities. About 95% of the workers thought that the need for the program is essential, while the rest described it as "not essential". The supervisors described that:

- 61.5% of the centers will need the health education for long time.
- 37.9% of the centers will need the health education for a short period of time (at least for the next 5 years).
- 0.6 % (i.e. one center) the need was not urgent.

Dr. Khatib, President of the Charitable societies, who have been involved in voluntary work for more than a decade thought that there is a great need for this program. He mentioned that the program should be expanded to include men as well as schools. All the chairpersons of the societies that were met indicated the need for the program.

It is very difficult in most developing countries to obtain objective data on their health status (see How They Grow p. 196). In the West Bank, a developing society under occupation, the difficulties are compounded. One can not get independent and objective measure on such internationally-recognized indicators such as Infant Mortality Rate (IMR). Israeli statistics for 1983 claimed that the IMR was 29% (A Review of Health and Health Services in Judia, Samaria and Gaza, 1983-86, p. 7). Palestinian sources do not accept that rate. Some sources believe that the rate of 70/1000 is more realistic. A report on the health status in the West Bank and Gaza Strip conducted an American group (Vermund, S., 1985) has pointed to the inconsistencies in the official figures. Due to such difficulty, the evaluator of the LC project is looking for other indicators to determine the health status in the West Bank.

According to a survey conducted by the Physicians Union, Jerusalem in 1986, 50.7% of 489 surveyed localities lacked any form of medical services (Huseini, 1987, p. 4.). This survey has indicated that most of the services are placed in larger localities. i.e. towns and cities. The poorer, smaller, and more distant localities are deprived of such

Table 2: Localities with health services in the West Bank

<u>Size of the Population</u>	<u>Number of the Localities</u>	<u>Number with Health S.</u>	<u>% of localities with Health S.</u>
Less than 500	120	11	9.20%
500 - 999	66	14	21.20%
1,000 - 2,999	147	77	52.40%
3,000 - 10,000	124	104	86.30%
More than 10,000	32	32	100.00%
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TOTAL	489	241	49.30%
	===	===	=====

Source: Health Survey in the West Bank, Physician Union, Jerusalem, 1987.

Table 3: Distribution of localities without any sort of health services
Localities without health services

<u>District</u>	<u>Frequency</u>	<u>Percentage</u>
Jenin	53	21.4%
Tulkarem	36	14.5%
Nablus	21	8.5%
Ramallah	33	13.3%
Jerusalem	09	3.6%
Bethlehem	15	6.0%
Hebron	79	31.9%
Jordan Valley	02	0.8%
	---	-----
	248	100.0%
	===	=====

Source: same as in table 1

Another indicator which is being used in this evaluation is that of the most common causes of death among infants. The official statistics have shown that the most common causes of infant death in 1985 are (see MOH, 1985-86).

1. Respiratory
2. Prematurity
3. Gastro Enteritis
4. Congenital
5. Cold injuries

The evaluator was informed by the local physician at Beita village, Nablus that he has noticed an outbreak of scabies among the school-age children in his village (interview conducted on November 14, 1989).

Conclusion: Though it is difficult to come up with objective and valid indicators for health status in the West Bank, available evidence indicates that the need is acute especially in smaller rural areas in the West Bank. The existing network of health centers, assisted by the CRS through the present grant concentrates on such villages. About 50.4% of the existing centers are in localities with less than 3,000 individual (see table 4).

Table 4: Frequency distribution of centers by size of the population and the duration of the period.
Duration of the program (in years).

<u>Locality Size</u>	<u>Less than two years</u>	<u>Two to Five</u>	<u>Six to Nine</u>	<u>Ten or more</u>	<u>Total</u>
Less than 3,000	7	15	18	26	66
3,000 - 5,000	3	7	8	5	25
5,001 - 8,000	3	3	3	4	13
8,001 - 10,000	2	1	2	2	07
more than 10,000	11	4	3	4	22
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TOTAL	26	30	34	41	131
	===	===	===	===	===

Source: Present evaluation

Note 1: missing data is 4

services. This survey has shown that Hebron, Jenin and Tulkarem are the most deprived districts in the West Bank (see table 3). The available services are administered by government authorities (68.9%), UNRWA (11.1%) and other private societies or agencies (20.0%).

2. Criteria being used for assisting rural areas in establishing health education programs

Supervisors and chairpersons of the different regional centers indicated that they use the following criteria when they recommend the establishment of a new center:

1. A society/club to undertake the health program.
2. The need of mothers for the services of the health program.
3. The absence of similar services
4. High mortality rate among children.

However no evidence has been produced to support their use of any scientific tool to determine that need especially for the second and third point. The present data revealed that the program was established in 21 villages where there is no local society or club to undertake. In most of these centers the health workers have indicated that their major problem is the unavailability of a proper room and/or the shortage of furniture, especially chairs to seat the mothers.

Recommendations:

1. Emphasis should be place on assisting villages with smaller population that lack similar health facilities. However, the program should be, as much as possible, be tied in with an existing local bodies.
2. Supervisors should be trained to conduct informal surveys to obtain valid background data on the proposed centers. Such data should help them in the organization and the implementation of the program to be as relevant to the population as possible.

3. Institutionalization of the Life Cycle Project

Prior to 1988 CRS efforts were concentrated on transferring the operation of the program to the Unions of Charitable Societies, especially that of Nablus. Due to prevailing circumstances, outlined above, these efforts were not successful. On the basis of the past experience CRS decided to change their approach. They have divided the operation into six regions. Each region, acting as an independent resource center, undertakes to support the programs within its region. Contracts were made with the following societies:

- a. Friends of the Sick, Jenin
- b. Dar Al-Yateem, Tulkarem
- c. The Union of Charitable Societies, Nablus
- d. Friends of the Community, Ramallah (to assume the operation in Jerusalem as well)
- e. Ladies Child Care Society, Biet Jala, (for Bethlehem region)
- f. The Union of Charitable Societies, Hebron

According to the project, these regional centers will assume the responsibility of providing local village programs with technical and financial support. Villages' contribution is scheduled to increase to 10% in 1990, 50% in 1991, and 100% in 1992 if conditions permit. As of 1992 regional centers should assume the salaries of the supervisor and other involved personnel, as applicable to their operation.

The evaluator has investigated the following issues that he felt are related to question of institutionalization:

- a. Has it been clearly explained to the societies their responsibilities toward the program?
- b. Are the regional centers' other major operations and activities consistent with the objectives of the Life Cycle Project? How do they raise funds to meet the obligation of such activities?
- c. Have the societies made plans to meet their financial contributions toward the salary of the workers in their programs?
- d. Do the facilities required for the operation of the program (such as the resource center and properly furnished village health education centers exist?
- e. Has the administrative infrastructure for the operation of the program in each region been defined?

Observation:

- 3:1. Board members in the regional and village societies that were interviewed have clearly understood and accepted their undertaking toward the program. However, no written contracts were made between regional centers and the societies in the villages.
- 3:2. No arrangement has so far been made, by any of the societies to meet their financial obligation. The positions taken by the chairpersons of the local societies vary. The evaluator felt that there is a tendency, especially in Jenin and Hebron, for the resource centers to help villages financially.
- 3:3. The available budgets of the village societies that were visited are small. Most of their projects are self-funded. These projects normally include:
- Kindergarten/nursery
 - Vocational workshops for women such as tailoring or embroidery.

Other projects are mainly funded by other private PVO or the Union of Charitable Societies (UCS) in the region. The two most common funded projects in these villages are:

- The health education, assisted by the CRS.
- The illitracy program, funded by the UCS.

The last project is at present on hold in most of the locations (see table 5), due to the lack of funds. This program used to get funding through the UCS/Jerusalem from Amman. Since the administrative disengagement with the West Bank these funds were not secured.

Table 5: Status of projects that are maintained by local village societies, visited for evaluation

No. of Programs run by the society that are:

	No. of programs run by each society are:		Reasons for on-hold status
	<u>In operation</u>	<u>On hold</u>	
	<u>self</u>	<u>funded</u>	
Beit Ula/Hebron	3	-	2
Burqin Ladies/Jenin	2	1	Funds were not sent by the Union
Housan Cultrual Club/Beth.	1		
Battir Sports Club/Beth.			
Beita Society/Nablus	3		
Einebous Society/Nablus	1		1
Turmos Ayyah	2		1
			No paying beneficiaries
			Funds were not sent by the Union

-
1. Other than the Life Cycle
 2. Mainly self-funded through payment of fees by the beneficiaries
 3. Funds are secured through grants from foreign PVO, UCS, or donations.

- 3:4. Prior to this present grant extension, villages used to raise the salaries of their health workers through fees paid by the mothers. However, the payment of such fees were coupled with the food distribution (PL-480 food commodities). Towards the end of 1988 the distribution stopped as the Life Cycle project was phasing out. This has led to the disruption of classes in most of the villages. Wherever, health education classes were carried out it was mainly due to either the enthusiasm of the individual health worker or the hope of getting further funds through CRS or the UCS.
- 3:5. The regional centers that have undertaken the program can be categorized into three groups (see table 6):
1. Societies or organizations that are heavily dependent upon outside funds either from Arab or International sources. The UCS in both Nablus and Hebron are placed in this category. These societies represent administrative set-ups that channel funds and technical services from foreign or Arab sources to the societies in the different towns and villages in their regions of operation. UCS were hard hit by the administrative disengagement decision with Jordan.

Taking in view their services, and their history with the illiteracy program, it is doubtful that they will be able to financially back local societies by 1992.

- ii. Societies that have health-related services and cover 40% of their expenses through fees collected for such services. These include the regional centers of both Jenin and Ramallah. Health education is viewed as an integral part of their primary care services. Besides, both societies operate large clinics in their main center and offer medical curative services to some villages in their area (through branches of their operation or their mobile clinics). On the basis of such observation the evaluator tends to predict that both centers will be able to maintain or assist at least some of the health programs in their area.

- iii. Societies that are socially active, and are headed by chairpersons who have both the skills to raise funds, and the drive to extend their voluntary services to wider population. These include Biet Jala and Tulkarem. This category does not have the advantage of the administrative recognition of the UCS by Jordan, nor the medical services offered by category ii. However, the future of their support to the villages will depend on the success of their chairpersons in obtaining funds.

Table 6: Types of operation/activities run by regional and village societies

Type of services or activities available					
<u>Visited Charitable Societies/Unions</u>	<u>Curative Health</u>	<u>Type of Handicapped</u>	<u>Cultural or Educational</u>	<u>Social</u>	<u>Others</u>
Friends of the Sick *	X	X		X	
Dar El-Yateem **			X	X	X
UCS/Nablus			X	X	
Friends of the Community*X			X		X
Beit Jala Ladies *			X	X	X
UCS/Hebron			X	X	
<u>Villages (sample only)</u>					
Beit Ula	X		X	X	X
Burqin	X		X		X
Housan			X		
Battir	X		X		X
Beita	X		X	X	X

* These societies have income-generating projects that cover part of their expenses.

** These societies are introducing income-generating projects.

- 3:6. The major complaint of the supervisors in four of the regions was the lack of facilities at their centers. In most of the regions that were visited, the regional center does not exceed a desk and a cabinet to keep curriculum material and forms. The problem of having a suitable classroom or center is faced by many teachers. Many village societies have failed to provide proper rooms to house the program.
- 3:7. The evaluator has failed to sense the existence of any administrative structure for the program both at the regional and the village levels. More often the interest that is being shown by the board members of these societies does not exceed a casual one. Only about 39.9% of the workers felt that their societies interest is strong enough to expect them to support the program.
- 3:8. Food distribution is tied to the program in all regions except for Nablus and Hebron, where the UCS refused the food aid. Previous evaluation of 1987 have recommended to phase out food distribution. Though the amount of food being distributed is meagre, there is an actual need for it due to the present economic hardships. The only objective that is raised here is the coupling of health education with food distribution. CRS directives are clear to the village workers. They state that food should be given to the needy mother whether enrolled in the health education program or not. However, wherever the food is available it goes to all mothers in the class. At Turmos Ayya, for example, a dispute was created between the worker and the village society on the issue of who should receive the food aid. This has lead to denying her a proper classroom to house the program.

Recommendations

- 3:1. To increase the likelihood of the program sustainability, it should be linked with medical services available in the village. In about 80% of the villages (included in the study) workers indicated that they have clinics. Moreover, in about 34% of the cases, there is some sort of cooperation between the clinic and the program has been established. CRS should enhance and encourage such cooperation. CRS should investigate the possibility of establishing the medical linkages with the private bodies that supervise such village clinics. In about 30.6% of the cases, the clinic is affiliated with the same society that holds

the health program. If this linkage was established health workers, could be trained to assist in the clinic and in return her salary can be secured. To encourage mothers to attend classes or benefit from the health workers services, medical fees for her could be reduced. The evaluator has investigated such linkages in Beita and Beit Ula. In both places he received positive feedbacks from the physicians and the chairpersons of these societies.

- 3:2. Where-ever medical linkage is impossible, the health education program might be linked with teaching crafts to the participating women. The health worker could arrange the sale of the production in return of certain fees to raise her salary. In such cases mothers could pay small fees for their craft training. The training could be performed by the teacher, if she is able, one of the women in the village, or a resource person provided by the regional center.

Given CRS present work load, it will be impossible to investigate these issues in every village. However, if efforts are concentrated on a few of them and their efforts succeed, the process can be institutionalized. Societies, under the leadership of their supervisors and health workers can implement these processes and ideas.

- 3:3. It is recommended to establish a health education committee in each region. This committee could help in:
- a. Providing stability to the program. Presently, the supervisor is the sole implementor of the program in the region. The committee can provide him/her with guidelines for operation, and maintain administrative control over his/her work.
 - b. Locating/raising funds for the program to solidify and expand its operations.
 - c. Increasing the probability of its sustainability.

The composition of the committee could regionally vary. However it is suggested to be composed of:

- i. The regional supervisor
- ii. A board member in the regional center
- iii. Representatives for village societies and workers. These can be appointed on rotating basis.

- 3:4. Regional center and villages should be approached to provide proper places for the program operation.
- 3:5. CRS should enforce its directives regarding the food distribution. Workers should be advised with methods of raising the social awareness of participating mothers so that they realize that the food aid should go to those who are really in need.

4. The Training of the Health Workers

A. Pre-service training

The majority of the 136 health workers that were surveyed received their training prior to 1988 (see table 7)

Table 7: Frequency distribution of health worker by year of graduation.

<u>Year of graduation</u>	<u>Frequency</u>	<u>Percentage</u>
Prior to 1982	15	11.4%
1982 - 1983	37	28.0%
1984 - 1985	22	16.7%
1986 - 1987	13	9.8%
1988 - 1989	45	34.1%
	---	-----
TOTAL	132	100.0%
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Observations:

4:A:1. Both old and new workers are trained using the same material, i.e. the Life Cycle Curriculum. This includes the following volumes:

- a. Fundamentals of Health Education
- b. First Aid
- c. Life Cycle Lesson Plan.

The material in the basic volumes (a and b) have not been modified at least since 1985. However, upon the recommendations of the previous evaluation new materials were produced in separate volumes. Refresher courses were given to health workers who were affiliated with active centers prior to 1989. Some courses were designed to introduce the newly produced material. Present training courses are limited to the original material.

4:A:2. To comply with the objective of institutionalization of the health program, training have been decentralized. CRS supports new training courses but does not run them.

Training at present is assigned to one or two village teachers who have excellent records (see Appendix C). This new arrangement has both its advantages and disadvantages. The major advantages are:

- The enhancement of the process of institutionalization of the Life Cycle Project.
- The repossibility of tailoring the program toward regional needs.
- The incentives offers to excellent teachers and the fact that it can be carried on by a person who has a practical experience as a health work.

The major disadvantages are the difficulty to control the quality of the presentations and the possibility of the shallowness of the content at the theoretical level.

4:A:3. The evaluator had the opportunities to monitor two training sessions. In both opportunities he was not satisfied. At one session he witnessed a gross mistake committed by the teacher. In the second he was dismayed at the absence of concentration on skill building. In fact about 28.7% of the surveyed workers felt that their training was lacking emphasis on the practical aspect.

4:A:4. The most frequent subjects that workers suggested (see Appendix L for complete list) to be included in their training are:

- First Aid with emphasis on practical experience
- Basic practical nursing
- Disability
- Common illnesses
- Community services.

Recommendation

4:A:1. If further health education training courses are held, they should be given in the new regional format. However the role of the selected workers should not exceed:

- i. Coordination of the course
- ii. Supervision of the practicum.

Experienced lecturers in the different topics should be invited to conduct classes. However, such instructors should be familiarized with the philosophy of the health education program and its strategy especially the emphasis on participatory teaching.

- 4:A:2. More emphasis should be given toward skill building in both peer-teaching format and the actual village teaching.

B. The Curriculum

Observations:

- 4:B:1. As mentioned above, present training concentrates on topics in the volumes of the Fundamentals and First Aid. This material, which is later conveyed to the mother, has not been revised. The changes that were introduced during the last grant were the production of the curriculum in a new format and the addition of new materials given on optional basis. Dr. Hodali, a specialist in Public Health, has reviewed the material with the evaluator. He believes that the curriculum more than sufficient for the preparation of health workers to help them to achieve the objectives of the program. But he thought that the First Aid curriculum contains procedures, that health workers are not qualified to handle. He states that workers will not be able to diagnose fractures, bites, and unconsciousness. However, he believes that the book is well written and supported with illustrations.
- 4:B:2. The Fundamentals curriculum was designed to meet common health misconceptions and practices that were traditionally prevalent a decade ago. Some of these misconceptions and practices may have persisted others may have diminished, and new ones may have been acquired. Therefore, the evaluator feels that there is a need to review some of the material in the curriculum to reflect newly identified misconceptions and needs. This view is shared by some of the health workers. About 25% of them felt that the curriculum does not always meet the needs of mothers or women they are working with. However, it is important to emphasize that the curriculum is well presented and illustrated.

Recommendation:

- 4:B:1. CRS should periodically survey the needs of families in rural areas, and the prevalent related misconceptions that they may have. The collected data should help in the revision of the curriculum.
- 4:B:2. Emphatic messages should be given to workers as well as mothers not to handle serious first aid cases. Workers should be clearly told that some of the first aid material they have in their curriculum are informative and it does not qualify them to practice it.

C. Inservice TrainingObservations:

- 4:C:1. CRS should be commended on the extent of inservice training that was conducted during the past few years. However, no plans have been produced for such training, except for the village rehabilitation workers. Since 1989, no inservice training was held.
- 4:C:3. One of the more frequent causes of mothers drop out, as perceived by supervisors as well as by workers is their relationship with mothers. Within the duration of this evaluation, the evaluator has come across two workers without classes because they failed to attract any mother. One of the most frequent complaints of the workers is that mothers are not interested in health education.

In about three of the classes that were visited by the evaluator, the workers conveyed wrong facts to the mothers. The average score on the short test for workers designed on the basis of the Fundamentals (see Appendix I) was 72.0%. The evaluator has divided the respondents, according to their score on the short test, into poor, (for score below 67.0%) average (for scores between 68 and 80), good (for scores between 81 and 90) and excellent (for scores above 90) (see table 8). He found that 43.4% of the workers was below the cut-off score. The evaluator does not claim that test is a highly-valid one, but it does reflect some useful knowledge, especially where it deals with child and mother nutrition and diarrhea.

4:C:3. The supervisors have indicated that workres do not use home visits effectively. The supervisors are not satisfied with home visits. (The average number of home visits, as reported by the workers themselves is 10.3 per month/worker).

Recommendation:

4:C:1 Workshops and inservice training courses should be constantly held. Areas that should be addressed are: home visits strategies of promoting health education, workers-mother relationship, and refresher courses on different aspects of the curriculum.

Table 8: Distribution of respondants by academic degree and performance

	Academic Level (degree)			
<u>Performance</u>	<u>High School</u>	<u>Community</u>	<u>University</u>	<u>Total</u>
Poor	45	11	3	59
Average	61	11	3	75
Good	0	0	1	1
Excellent	00	00	00	00
	---	---	---	---
TOTAL	106	22	7	135
	===	===	===	===

5. Regional Supervisors

Supervisors represent the core concept in the process of the institutionalization of the project. They represent the strategy for ensuring its sustainability and effective functions. Therefore it is very crucial to have the right individuals in this position. CRS has recommended the most qualified individuals for those positions.

Observations

- 5:1. The average CRS experience with the health education program is about 9.4 years, with a range of 5 and 13 years. Their supervisory experience range between 3 and 12 years as stated by them.
- 5:2. Almost all of them have good perceptions of the program major objectives.
- 5:3. Almost all the supervisors have attended at least one refresher course in the curriculum of health education. Three of them according to their own statements, have attended a course in community development held in 1988.
- 5:4. Some of the supervisors were involved in the training courses that are held in their regions.
- 5:5. None of them was really trained in supervisory functions. The evaluator noticed that they are not sensitive to classroom problematic behaviour nor are they skilled enough to observe it. They lack essential skills like task analysis, and problem solving approaches. Some of them lack initiative tendencies, as observed by the evaluator, though they tend to be sincere. Their average performance on the short job-knowledge test (see Appendix K) was within the "average" range, according the cut-off scores established by the evaluator.

Recommendation:

- 5:1. CRS should immediately hold in-service training for the regional supervisors. The training should concentrate on the meaning and the philosophy of supervision and its contrast to inspection, the process of supervision and its strategies, and the skills of observing, interpreting data, planning action, and implementing it. These processes, strategies, and skills should be taught within the context of community based health services.

5:2. CRS should help in devising several forms to be used by the supervisors to observe the performance of the health worker. It is recommended to come out with purpose-oriented forms (i.e. forms that serve specific functions such as child weighing or home visit or well-defined aspect of the classroom performance such as use of teaching materials or involving mothers in the classroom). These forms need not be rigid or complicated. It is recommended to use descriptive rather than numerical assessment of the intended performance with enough room for flexibility.

6. Program Implementation at the region and village Level

Present program management has successfully adhered to the objective of institutionalization. This planning and implementation is carried out by the workers themselves and monitored by the supervisors.

Observations

6:1. The program is being implemented at three levels. Level one is the village. Currently, 156 centers operate in the West Bank. Their distribution is summed up in Table 9. Each village worker meets one or two classes for a period of four months. The average class size is about 19.1 mothers. Most workers specify one or two days for weighing the children.

The second level of operation is at the regional level. Each region has one supervisor, except for Jenin, where two supervisors are stationed. According to the health workers, supervisors visit them twice per month. Regional supervisors perform also managerial duties within their regions. They serve as the linkage between program centers and their resource centers in one direction, and with CRS on the other.

Table 9: Distribution of Village health Programs by region (district) *

<u>District</u>	<u>Frequency</u>	<u>Percentage</u>
Jenin	54	34.6%
Tulkarem	22	14.1%
Nablus	29	18.6%
Ramallah	19	12.2%
Bethlehem	18	11.5%
Hebron	14	9.0%
	---	-----
TOTAL	156	100.0%
	===	=====

* About 20 centers were added during the month of November 1989 after the onset of this evaluation.

The third level of operation, is that of the CRS. The program is managed by a Palestinian who holds a Ph.D in Psychology. He is assisted by an administrative support staff of one aide, informational specialist, a secretary, and a driver. A team of three resource persons, a psychologist, a physiotherapist, and a special educationist offer the academic support to the rehabilitation component of the Project.

- 6:2. Mothers' classes are conducted through the participatory method. Some teachers excell in their performance. The evaluator was impressed by the performance of the Einabous worker for example. All the elements of successful performance was in her class. On the other hand, he witnessed a very poor class management at Burgeen. The teacher there failed to communicate with the women. She lacked all the elements of good teaching. Infact some of the women in her class had much better knowledge than she.

It should be noted here that the use of teaching material is not extensive, judging by the available charts, posters, slides, and other A/V aids. However about 66.9% of the workers felt that the teaching aid they have is sufficient. The evaluator feels that workers lacked the criterion to judge their needs of teaching equipment.

Regional centers are provided with A/V equipment such as projectors (see Appendix N for a complete list). CRS loan, upon demand, mainly to workers training courses, the available sets are in English and produced abroad. Workers at the village level have hardly used them. Supervisors could put more efforts into encouraging workers to use them. On the other hand CRS should produce locally made slides to accompany important parts of the curriculum.

Three of the most common problems that workers face, in their relation with women who participate in their classes are related to the lack of incentives and workers classroom performance. These problems are:

1. Frequent absence thus disrupting the sequence of the curriculum.
2. Late arrival to the session.
3. Mothers dropping out of the program.

4. Mothers are not really interested in the curriculum.
5. Bringing children to the class sessions (see Appendix M For complete list of problems).

The act of learning by itself should be a good reinforcer to the mothers. Workers could be more resourceful in creating rich and attractive environments. They could be more flexible in their class formats. For example, if a group of mothers have difficulty coming to the center why not hold sessions at their homes on rotating basis.

- 6:3. A sizable percentage of the women repeat the course. About 54.4% of the workers have indicated that a sizable number of women in their classes have previously attended the program. One will not be surprised to note that these repeaters will drop out once they receive their food aid, as classes have nothing new to offer.
- 6:4. Grouping on the basis of women's needs and levels of education is not practiced. Expectant mothers, older women, and students are combined as observed by the evaluator, in one class. In one case a university graduate was attending the program. She started asking sophisticated questions on child delivery far beyond the skills and the knowledge of the teacher. In that case, the evaluator felt that this participant had become a disruptive element during the session. Workers should try to deliver their message to those women that are in need. Measures should be taken to group women according to their needs and abilities.
- 6:5. Workers keep three types of records.
 - Charts.
 - Class attendance
 - Child records.

CRS should revise the last two records. The evaluator feels that separate files (or cards) should be kept for each mother. This may be more beneficial to build individuals profiles and to reflect the impact of the program.

- 6:6. About 37.8% of the surveyed workers hold another job beside the health education. CRS requires each worker to accumulate 40 hours of work per month to earn full salary. Thus workers have free time to do other jobs. This arrangement is problematic, especially when the CRS financial assistance is phased out. One of these problems was sensed at the site visits in the Nablus region. Societies demanded full day work between eight and one, six days a week. Workers who were met complained that they do nothing during the extra hours they spend at the societies because they are required to put in 40 hours a month only.

The second potential problem was felt in the Hebron region. The worker that was visited there was also a Kindergarten teacher. The job required her time between eight and eleven. Therefore her classes in the health education program were at 12:00. One wonders if that is the most suitable time for mothers and if it has any adverse impact on mothers attendance.

Recommendations:

- 6:1. CRS should revise the formula of 40 hours/month in consultation with the societies and the regional centers, in view of the objective of getting local societies to assume full responsibility for the program.
- 6:2. CRS should produce enough posters, charts, and other means of illustrations to sustain all major concepts in the program. It is advisable to have them locally, but professionally made. They should reflect indigenous culture and characteristics. CRS should use slides/pictures of successful health classes in the villages they serve. Workers have asked for brochures, and pamphlets with lessons of the major concepts to be produced as hand-outs for women. CRS should look into this idea and examine its viability.
- 6:3. Emphasis should be given to Train teachers in lesson planning, classroom management, use of teaching aids, and record keeping.
- 6:4. Supervisors should be asked to pursue workers skills in lesson planning. Each teacher should plan her lesson to reflect the different procedures and styles that are to be used, teaching materials, and the objectives of the lesson.

- 6:5. Supervisors should plan to develop the child weighing process, keeping records on the charts, and interperating the collected information.
- 6:6. CRS should review the need to have the mothers attendance books, and the children records. It is recommended to use individual one-page accumulative records for each child, and each mother. However it is recommended to field test the merits of such accumulative records at a sample of village programs before taking any further action.
- 6:7. It is recommended to test the viability of:
- a. Holding periodical seminars or workshops for new fathers by the village teacher to discuss related health issues.
 - b. Establishing at each village some sort of association for mothers who benefited previously from the program. This should help in fostering healthy practices and attitudes. Such association should be easier to establish once the program is coupled with curative health services.

7. The Rehabilitation component of the Life Cycle Project

As indicated above, CRS administration combined the rehabilitation program with the Life Cycle in one project motivated by:

- a. The complementary nature of both programs. They deal with the same age group in rural and deprived areas.
- b. The advantage of hiring village health workers with their background and experience to become rehabilitation workers as well, thus they can assume the proper role of the community based workers.

The major steps so far, taken by CRS toward implementing the rehabilitation component of the project are:

1. Ensuring the willingness of the regional centers in Jenin, Tulkarem, and Nablus to adopt this program.
2. Maintaining the work of the ex-core staff at Jenin and Tulkarem.

At Nablus the designated core staff has resigned, she was replaced by an ex-core staff who is completing her practical training under the supervision of the CRS resource persons.

3. Miss Haifa Irsheid, an ex-core staff with extensive experience in social work and special education was hired to train the Jenin course (see Appendix C). Fourteen village health workers are undergoing training at Jenin's society.

Observations:

- 7:1. About 47 handicapped children receive home-based rehabilitation services in the three northern areas (see table 10)
- 7:2. Files are being kept on each child by the rehabilitation workers. Such files have the assessment data, the baseline of the child performance, medical reports (though not always complete) progress reports, and CRS resource persons' comments.
- 7:3. The average case load for the rehabilitation worker is 15, which is the normal load, according to the portage model.

Table 10: Distribution of handicapped children who are being served by the rehabilitation worker.

	<u>Jenin</u>	<u>Tulkarem</u>	<u>Nablus</u>	<u>Total</u>
Rehab. & Educational Referral	16	16	15	47
Advise/consultation	26	19	05	50
	17	09	00	26
	---	---	---	---
TOTAL	59	45	20	123

	<u>Jenin</u>	<u>Tulkarem</u>	<u>Nablus</u>	<u>Total</u>
Physical	04	11	07	22
Mental	00	04	04	08
Hearing/speech	05	00	00	05
Multiple	07	01	04	12
	---	---	---	---
TOTAL	16	16	15	47
	===	===	===	===

Age range	1-13	1-0	1-10	yrs
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- 7:4. The services being given by the resource persons, especially that of the physiotherapist is excellent, as perceived by both the workers themselves and the evaluator. The impact of the special education resource person has not been felt as yet. She has joined the program as of mid October, 1989 (i.e two weeks before the onset of this evaluation).
- 7:5. The age-range of the handicapped children in the program is not always within 0-8 years.
- 7:6. Most of the cases that are presently in the program are those with moderate to severe disability. One part of the philosophy of the home-based intervention program is to get to children with marginal disability as early as possible to get them ready for normal schooling. In fact the screening test that was adopted in the previous grant, the DDST is designed to identify children with developmental delay. The need of the moderate to severely handicapped is recognized and should be addressed, but more attention should be given to marginally handicapped as well. This last group go undetected early in life and lead to their dropping out of school and other maladjustment problems.

- 7:7. Due to the unfamiliarity of the CRS resource group with the philosophy and the strategy of the home-based early intervention model, there has been several attempts to devise new assessment tools. The evaluator feels that the existing tools that were developed by the previous resource group are excellent and should be maintained. Besides there is no need to add to the paper work of the rehabilitation workers.
- 7:8. The combination process of both components of the project, i.e. health and rehabilitation is so far on the right track. However, the only potential problem is in Nablus. The current rehabilitation worker and the resource material are located at the Red Crescent Society. While village workers are supported through the UCS. The arrangement may lead to problems, and should be addressed early enough to remove any discrepancies.
- 7:9. The major complaint of the rehabilitation worker is transportation. They serve children in several villages. Once the training of village workers is completed they should be able to work in their own villages. The current rehabilitation workers should partly, work with children within their own localities, and partly serve as resource persons to help regional supervisors.
- 7:10 The training that is being carried out for the village workers is outlined elsewhere (see Appendix D). It has both theoretical and practical components, and it is faithful to the original plan. The trainer feels that it would be more effective to give the trainees a refresher in biology and psychology. She felt that most of the trainees have had difficulty in classes due to the fact that most of them have been out of school for several years.

Recommendations:

- 7:1. To better combine both components of the Life Cycle project, supervision should be assigned to current regional supervisors. This will require training them through the Nablus and Tulkarem courses. Current rehabilitation workers assisted by CRS resource person should work as technical support to them
- 7:2. A refresher in biology and psychology should be added to the rehabilitation training program.

- 7:3. Emphasis should be given to the potential problem of having two centers responsible for the same program, as in Nablus.
- 7:4. The CRS resource team, especially the psychologist and the special educationist should develop better conceptualization with the philosophy and strategies of the home-based early intervention, and the different screening and assessment tools in the program. It is essential for the team to develop proficiency in the portage program. It is recommended that they visit the Sun Day home-based intervention center in Gaza.
- 7:5. CRS needs to develop proper evaluation tools to assess the performance of the village rehabilitation workers. This tool can be used by the regional supervisors and the resource team.
- 7:6. The evaluator feels that the experience that the rehabilitation trainer has gained during the Jenin training should be exploited in the other two workshops to be held later during the grant period. It is recommended to put her in charge of all training.
- 7:7. For future training courses for the rehabilitation, it is recommended to select village workers who live in the same village. This measure should reduce the cost of implementation, save workers the hardships of moving from one place to another, and expands the potential of the hours of the daily work.

8. Program Administration

CRS should be commended on its efforts to run the two components of the Life Cycle smoothly. The evaluator feels that the team spirit which is strongly evident in the program is behind its smooth management especially on the issue of institutionalization. Although the present program management as a whole lacks solid experience in community-based operation, their sincerity and eagerness to learn make-up partly for that.

Observations:

- 8:1 Management problems and conflict that plagued the previous village-in-reach program has been overcome. Societies understand very well their responsibilities and obligations toward the project.
- 8:2 CRS staff members perform their duties under very difficult and life-threatening situations. Often they are harassed, or hindered by military roadblocks at the outskirts of the towns and the villages they visit; and quite frequently, their cars are stoned in areas of disturbances. The evaluator feels that the quality of their work is better appreciated when such risks are taken into consideration.
- 8:3 The program is meeting its projected outputs (see table 11). Many of the outputs especially in the Life Cycle/health education have been met. The slow start of the rehabilitation component is due to the fact that the village infrastructure was non-existent at the village level.
- 8:4 Although the program management is functioning as one team, the evaluator feels that some of the positions are not well-defined. For example it is difficult to draw a line between the responsibilities of the psychologist and that of the special educationist. Such an overlap is expected to be a source of tension and conflict, in the future.
- 8:5 The job description of all the resource persons call for conducting base line surveys. Though this aspect has not been done, the evaluator does not feel that they should conduct such studies. However, they should informally collect certain indicators, and assimilate existing information in the fields.

Table 11: Project outputs: current and end of Project Projection

	<u>December 1989</u>	<u>January 1992</u>	<u>Percentage of achievement</u>
<u>Personnel</u>			
Trained community workers	156	200	78.0%
Trained workers in Rehabilitation	0	30	00.0%
Core Staff	3	3	100.0%
Rehabilitation Trainers	1	3	33.3
Palestinian Resource Person	3	3	100.0
Regional supervisors	7	6	116.7
<u>Training Courses</u>			
Health Education	4	4	100.0%
Rehabilitation	1	3	33.3%
Village classes	222	not stated	----
<u>Facilities</u>			
CRS assisted clinics	2	5	40.0%
Regional Resource Centers	6	6	100.0%
<u>Direct Beneficiaries</u>			
Mothers	4,089	5,000	81.8%
Children	4,451	6,000	74.2%
Handicapped Children	123	612	20.1%
First Aid Cases	no available evidence	500	000.0%

8:6 The responsibilities of running the health education component in this grant is carried out mainly by Dr. Sansur, the program manager, and his administrative aid. Both of them hold monthly meetings with the supervisors to discuss administrative problems and needs, and introduce new ideas. Supervisors usually bring in their plans of action. The responsibility of the technical support for the program should be shared with a specialist in this area. Although there is no slot in the grant extension for another resource person who is specialist in community health services, the need is there. The grant was written with the conception that the current regional supervisors are fully-trained to assume the responsibility of the program in their areas. The evaluator does not feel that is the case. They are still in need for further training.

8:7. The resource team at CRS have put extensive efforts into the rehabilitation component of the project. They have assessed and reviewed all the handicapped children in the program. They meet monthly with the core workers and the trainer. During these meetings each core worker discusses his/her cases, problems, and their future plans.

At present the resource person support the health education training courses with lectures in the area of handicapped children. However, they carry a substantial role in the training of village rehabilitation workers at Jenin.

Recommendations

8:1. CRS should appoint a new resource person with a specialization in community health services. This specialist can help in the different inservice training needed by supervisors and health workers.

8:2. More emphasis should be given by the resource team to the health component of the program. However, the team should plan all its weekly operation more specifically with clearly-stated objectives so as to work effectively without violating the institutionalization of the project.

8:3. The program manager, with his team, should redefine their job description, especially that of the psychologist and the administrative assistant.

9. Other operations in the Grant Extension

A. St. Luke's Nursing Training

About 17 students are currently taking this course to be trained as practical nurses. Half of them come from rural areas. The quality of the program is ensured by the fact that it is recognized by Jordan's Ministry of Health. Graduates of the program are employed by major hospitals in the West Bank.

Observations:

- 9:1. About half of the students come from the rural areas. However, the other half come from deprived areas such as Balata Refugee Camp.
- 9:2. The training is coordinated by a qualified physician employed by St. Luke's hospital.
- 9:3. The program admits students with a high school certificates to ensure the quality of its graduates.
- 9:4. No coordination exist or is expected to exist between the health component and the St. Luke's program in terms of employing graduates in village clinics. However, some of the physicians working in the hospital have helped in the training of the Nablus group.
- 9:5. St. Luke's program graduates are expected to be trained in the villages with the health education program.

B. Rural Clinics

Two clinics have been assisted by the CRS. Both are located in rural and remote areas. The health worker in the village which was visited was cooperating, within the present requirements of the health program, with the physician.

Recommendation:

- 9:1. Nablus supervisor should be encouraged to further use the resources of the ST. Luke's program, especially for the inservices training.
- 9:2. Once the five clinics are established, they should be used experimentally to test the best measures and format for the linkage between the health education program and the curative medical services.

10: Degree to which recommendations from previous evaluations were implemented

The Life Cycle project was evaluated in February 1987. The Village-In-Reach Program was evaluated in July, 1988. The major recommendation of the VIP was to restrict the program to two areas namely Nablus and Hebron.

The LC recommendations can be grouped into the following categories:

- A. Institutionalization. The evaluation team recommended the transfer of management of the program to the Unions and the appointment of a Palestinian program manager.
- B. The training. The evaluation team recommended that CRS should proceed in training new teachers, and inservice training to the supervisors and the practicing teachers.
- C. The curriculum. The evaluation team recommended that CRS should proceed with its plans to revise the Life Cycle, but not add any additional material to the basic curriculum. However, the team recommended that CRS should make available health education material for each lesson to send home with the mothers.
- D. Impact study. The team recommended that a new study should be developed. They suggested that data be collected periodically.

Observations:

- 10:1 The VIP component of the program is restricted to the northern regions of Nablus, Tulkerem, and Jenin. The evaluator feels that the present arrangement have the advantage of using the available resources more effectively, as it exploits the geographical proximity to the advantage of the program.
- 10:2 The LC is being managed by local societies as indicated above, in six regions. CRS supervisors and instructors were employed by these societies.
- 10:3 As indicated earlier, training for new workers have been carried out by the regional centers in Nablus, Tulkerem, Ramallah, and Bethlehem. CRS semi-annual reports indicate that inservice workshops were carried out for teachers and supervisors.

- 10:4 The curriculum was reproduced in a new format. Additional material was made available to teachers, but were not included in the basic training.
- 10:5 A new one-time study was designed to reflect the impact of the program. This new study has followed the criterion group design (see report No. 6th semin annual report).

This appears to be a weak design (Vockell, 1983). Its main difficulties are:

- a. Groups are not randomly assigned. The fact that the subjects are randomly selected from the two groups (program and experimental) does not help in equating them. There is no control group. Its internal validity is seriously threatened.
- b. The fact that the groups are self-selected, i.e. the program group has chosen to be in contact with CRS to establish a health program is a telling story by itself.

General Recommendations

1. CRS should continue with the program on the same lines of operation. However, problem areas identified above should be addressed to increase its effectiveness.
2. Linkage of the Health program with curative services should have a priority during the coming two years.
3. Though the principle of sharing the cost of the program with local societies is essential towards achieving sustainability, CRS should increase its share during year III to 70% to 75% of the cost, in view of the current economic difficulties.

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Appendix A

Key persons interviewed during the evaluation:

CPS/Jerusalem, West Bank and Gaza

Sr. Leona Donahue, Director
 Dr. Michael Sansur, Program Manager
 Dr. Francis Azraq, Program Psychologist
 Mr. Anton Ayyad, Administrative Assistant
 Mr. Sa'adeh Sahouri, Resource Person, Physiotherapist
 Ms. Nadia Hazboun, Resource Person, Special Education
 Mr. Abdel Rahim Al-Ass'ad, (former program instructor and coordinator)

Community leaders in health education

Mr. Edmond Shehadeh, Director, Bethlehem Arab Society
 Dr. Amin El-Khatib, President, Union of Charitable Societies
 Dr. Umadiyah Khammash, Medical Relief Committees
 Dr. Degouille S. Hodali, Research Center, Ramallah

Regional Centers (Societies)

Mr. Samih Abu Eiseh, Union of Charitable Societies, Hebron
 Mr. Fahmi Shilaldeh, Secretary, Union of Charitable Societies, Hebron
 Mr. Moussa El-Amleh, V. President, Union of Charitable Societies, Hebron
 Dr. Ghalib Abu Baker
 Dr. Yousef Sadek
 Mr. Fathi Shadid, Secretary, Union of Charitable Societies, Nablus
 Ms. Salwa Saba, Treasurer, Beit Jala Ladies Society, Beit Jala (Bethlehem)
 Mr. Kamel Jbeil, Chairperson, Friends of the Community, Ramallah
 Mr. Jamil Mohanna, Administrator, Dar Al-Yateem Society, Tulkarem

St. Luke's Hospital

Mr. Marwan Khader, Administrator, St. Luke's Hospital, Nablus
 Dr. Mona Tarbeh, School Principal, St. Luke's Hospital, Nablus

Local (village) Societies

- Mr. Mohammad Suleiman Abu Saleh, Secretary, Deir Samet Society, Hebron
- Mr. Ismail Mohanna El-Amleh, Chairperson, Beit Ula Charitable Society (Hebron)
- Dr. Jamal Abdel Hafeth, Physician, Beit Ula clinic (volunteer)
- Ms. Nadira Jara, Chairperson, Burqin Ladies Charitable Society, Burqin (Jenin)
- Mr. Salim Deeb Atiyeh, Housan Cultural Club, Housan (Bethlehem)
- Mr. Elyyan El-Shami, Chairperson, Battir Sports Club, Battir, (Bethlehem)
- Mr. Mohammad Abu Hassan, Vice Chairperson, Battir Sports Club, Battir (Bethlehem)
- Mr. Su'ood Jaber, Chairperson, Beita Charitbale Society Beita (Nablus)
- Dr. Na'el Allawineh, Physician, Beita
- Mr. Mahmoud Abdallah Rayyan, Einabous Society Einabous (Nablus)
- Mr. Mohammad Ali Ahmad, Chairperson, Turmos Ayya Society, Turmos Ayya (Ramallah)

Program Regional Supervisors

- Ms. Lina Hamzah Zahran, Dar, Al-Yateem, Tulkarem
- Ms. Ibtisam Musa El-Khatib, Union of Charitable Societies, Hebron
- Ms. Tamam Shalabi
- Ms. Subhieh Ghanem Friends of the Sick, Jenin
- Mr. Akef Zeitawi, Beit Jala Ladies Society
- Ms. Basimeh Rajeh Jaghoub, Union of Charitable Societies, Nablus
- Ms. Hana Jbeil, Friends of the Community, Ramallah
- Ms. Najah Ahmad Ali, Turmos Ayya Society, Turmos Ayya (Ramallah), acting supervisor

Community Based Health Workers

- Ms. Nuha El-Amleh, Beit Ula Program, Hebron
- Ms. Aida Shalabi, Burqin Program, Jenin
- Ms. Amineh Abu Nasser, Housan Program, Bethlehem
- Ms. Jihad Abu Hassan, Battir Program, Bethlehem
- Ms. Mufida Hamdan, Beita Program, Nablus
- Ms. Nimat Odeh, Einabous Program, Nablus
- Ms. Najah Muhanna, Deir El-Ghusoun, Tulkarem

Instructors

- Ms. Mufida Salman, Dar Al-Yateem Society, Tulkarem - Health
Education Instructor
Ms. Haifa Irsheid, Friends of the Sick, Jenin -
Rehabilitation Instructor

Home Based Rehabilitation Program

- Mr. Ahmad Zibdeh, Dar Al-Yateem, Tulkarem
Ms. Wafa El-Shakhsheer, Red Crescent, Nablus

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Appendix B

Scope of Work for the Evaluation
of the Life Cycle Project
(April 1987 until the present)

Key question for evaluation

1. Are the objectives of the project as outlined being met?
2. How relevant are ongoing health education classes and information given, to health and social conditions on the West Bank at this time?
3. Are village health workers effective in their approach towards improving and upgrading the quality of health practices on the West Bank?
4. Are village health workers addressing health issues of major concern at this time? Have additional measures been taken to reduce the incidence of the most common conditions contributing to child mortality and morbidity in the West Bank?
5. Are the general rehabilitation workers (previously Core Staff) reaching out to the most deprived of disabled village children?
6. How effective are these rehabilitation workers in improving awareness of the rights and needs of the handicapped and improving their level of independence environment?
7. To what extent have the health education and community based rehabilitation programmes been combined at the village level? What steps have been taken towards achieving this combination?
8. Investigate the health clinics established to date and type of services given. Are these clinics established in isolated rural areas serving large population with no other medical services?
9. Are these clinics in any way connected with the project's other programmes, in particular, health care and rehabilitation services?

10. What measures have been taken towards increasing the number of villages with CRS health education to 200?
11. How does St. Luke's Hospital nurse's training programme relate to the above. How many of its students come from rural areas deprived of medical facilities.
12. Include investigation of the degree to which recommendations from previous evaluations are implemented.

Appendix C

List of Training courses as of November, 1989A. Health Education courses

	<u>Location</u>	<u>Started on</u>	<u>Completed on</u>	<u>No. of Participants</u>	<u>Trainer</u>
1.	Nablus	July 1, 89	November 3, 89	40	Nimat Odeh & Nadia Salim
2.	Ramallah	August 16, 89	In progress	11	Naja Ali & Raghda Salem
3.	Tulkarem	August 19, 89	In progress	32	Mufida Salman
4.	Beit Jala	November 8, 89	In progress	18	Jihad Abu Hassan & Abla Mkarkar

B. Home Based Rehabilitation Courses *

	<u>Location</u>	<u>Started on</u>	<u>Completed on</u>	<u>No. of Participants</u>	<u>Trainer</u>
1.	Jenin	July 24, 89	In progress	14	Haifa Irsheid

* Two more courses are planned, one in Nablus, and the other in Tulkarem

C. St. Luke's Nursing Program *

	<u>Location</u>	<u>Started on</u>	<u>Completed on</u>	<u>No. of Participants</u>	<u>Trainer</u>
1.	Nablus	April 1, 89	In progress	17	Dr. Mona Tarbeh

* Two more courses are planned, as in the grant, to follow.

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Appendix D

Rehabilitation Training

Village Workers

1989-1991

Number of training Days: 60

1. Mentally Disabled Children:
 - What is a Disability?
 - What are the causes, signs of a Mental Disability?
 - Specific Mental Disabilities.
2. Multiply Disabled Children:
 - Understanding the Child with Several Disabilities.
 - Understanding the Child who cannot See or Hear.
3. Assessment:
 - Identification and Referral
 - Informal Assessment and VIP family history
 - DDST
 - Portage Manual, Checklist, Card File
4. Teaching the Disabled Child:
 - Way of teaching in the Home
 - Ways the Disabled Child learns
 - Ways to Guide the Behavior of a Disabled Child.
5. Helping the Parents Learn:
 - Communicating with Parents
 - Helping Parents Understand their Disabled Child.
 - Helping Parents become Successful Teachers.
6. Physically Disabled Children:
 - Body Structure and Function
 - Physical Disabilities
 - Physical Assessment
 - Motor Development
 - Developmental Activities
 - Positioning and Handling
 - Exercises
 - Evaluation

Teacher's Guide

1. Community Development
2. Teaching Methods
3. The Creative process
4. The four levels of Creative Process
5. Teaching Techniques
6. Evaluation and Reinforcement
7. The Lesson Plan
8. Writing Lesson Plans/Goals and Objectives
9. Overhead Projector
10. Slide Projector

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Appendix E

I. Life Cycle Curriculum: Table of contents

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- How to stop the spread of disease	22
- Safety in the home environment	34
- Human reproduction	41
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- Pregnancy and Prenatal Development	52
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- Care of the new born at delivery (Neonatal)	78
4. <u>Stage III. Mother of an Infant 0-2</u>	91
- Advantages of breast-feeding	97
- Supplementary foods and weaning	109
- The importance of weight charts	117
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- Illness in a child - feeding a sick person	130
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- Some organs of body systems	166
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-	A child develops: 3-5 years	199
-	Feeding pre-school children	205
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7.	<u>Stage VI. Adulthood and Old Age</u>	223
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II. First Aid: Table of Contents

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Foreign objects and choking	36
Mouth-to-mouth breathing	43
Electrical Injuries	49
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Appendix F

Catholic Relief Services
Evaluation of Life Cycle Program

For the officials of the Charitable Societies and resource centers.

1. What made you adopt this program?
2. What are the goals of the program in your opinion?
3. Do you feel that the goals of the program and its way of organization agrees with the other programs that you are sponsoring?
4. What is the most important project that your institution is giving?
5. Does your society cooperate with other societies in the administration of this project. Since when?
6. What is the percentage of your institution in financing these programs (local or foreign)? How do you invest the funds? Do you have productive projects to fund your activities?
7. You know that your society will fund this program on increasing basis, what measures have you taken to guarantee such funds?
8. What is your perception of the program continuity when CRS withdraws?
9. Please give me a brief description of your relations with the societies that work with the same project? Are these societies able to fund this program financially?
10. What is the degree of priority you give to health education in comparison to your other activities?
11. Please tell me to what extent do you monitor the health education supervisor? Who is the immediate supervisor on the health education supervisor?
12. What are the problems that you face in administering this program?
13. Do you have a supervisory committee for the program?

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Appendix G

Mothers InterviewA: Handicapped children

- Since when is the home visitor working with your child?
- How did he contact you?
- What was your first reaction of this contact?
- When did you first notice the problem with your child?
- What did you do to treat the problem?
- Was there any improvement since you began applying the objectives (or activities)?
- How do you read the objectives (or activities)?
- Do you find any difficulty in doing what you are asked to do?
- What is the average time of your performing the activities weekly?
- Does the home visitor visit you regularly?
- If there was no service offered by the home visitor and there was a center to care for children in your village, would you take your child to such center?

Mothers InterviewB: Health Education Mothers

1. Why do you attend the health education classes? How did the classes help you?
2. How did you hear about the health education classes?
3. Has the health worker visited you? At home? Why? How often?
4. Can you mention a topic of interest to you that was brought up during the classes?
5. Give me an example of how you have made use of the information you received during the health education classes.
6. Do you understand the worker's explanation?
7. (If the woman is nursing a child), Do you bring in your child for monthly weighing? Why? What you get out of monitoring your child growth?
8. How did your husband feel about your attendance? Do you have difficulty coming over here?

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Appendix H

Supervisors Interview Form

1. Name: _____ Date: _____
2. Regional Center: _____
3. Qualifications: _____
4. Kind of training that you have received?

5. Experience? In health education? In supervision?

6. Have you been specifically trained as a supervisor?
When? By whom?

7. Do you have monthly and daily plans? Show me examples?

8. Describe a typical work day? (When do you start? when
do you start your visit? What you do?)

9. How many workers do you supervise?

10. Describe your relationship with them?

11. Describe your difficulties with:
The worker? _____
Societies? _____
CRS? _____
Your center? _____

12. Tell me as much as possible about:
- The clinics you cooperate with?
 - The referral system?

13. Do you work on strike days?

14. How do you evaluate the new arrangement with the old one?

15. What criteria you use when you:

- Select a new trainer? _____
- Decide upon a new health program? _____

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Appendix I

An Interview Form
For The
Community-based Health Worker

1. Name: _____ Date: _____
2. Society: _____ Village: _____
3. Qualifications: _____
4. Experience: _____
5. Workshops that you have attended:

6. Describe your work (tasks, daily hours in the program, number of mothers, number of classes)

7. How do you contact mothers? Describe your style? Problem?

8. What do you think of the curriculum you teach? Describe your difficulties with it? How about your training?

9. Who pays your salary? How much are you paid?

10. Your difficulty or relationship with:
CRS? _____
Regional Center? _____
Your Society? _____
The supervisor? _____
The mothers? _____
11. How do you handle absences?

12. Do you work during strike days?

13. Do you meet any kind of difficulties in your work?

14. What have you done with your classes during the break between the two grants?

15. Do you feel that your work has improved with the new arrangements?

16. Is there a medical doctor in your village? Do you have any contact with? Do you refer mothers and children to him?

17. Do you keep records? Do you have lesson plans? Show examples of both?

18. Do you feel that the health program will last beyond CRS assistance?

Appendix J

Catholic Relief Services
Health Education Program/Jerusalem

Dear Health Worker,

Catholic Relief Services is currently evaluating the health education program in your village in order to improve the components of the program and to increase its capacity. So please fill in the attached questionnaire accurately. The analysis of the questionnaire will not be used to evaluate you personally. An expert in program evaluation has been contracted to analyze the questionnaire. Your answers will not be reported to use on individual basis.

Sincerely,

Dr. Michael Sansur
Project Manager
Health Education Program

Catholic Relief Services
 Evaluation of the Life Cycle Program
 November 1989
 Health Worker Questionnaire

1. Name: _____
2. Place of Residence: _____
3. Location of work: Village: _____
 Society: _____
4. Name of your supervisor: _____
5. Your highest qualification _____
6. Did you attend health education course:
 - a. No
 - b. Yes. Place _____ Year _____
7. Workshops/courses that you attended since 1987:

<u>Course Name</u>	<u>Place</u>	<u>Duration</u>	<u>Time</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
8. Years of work with health education program. _____ years.
9. Your work before joining the health education program

10. Years of work outside the health education program.
 _____ years.
11. Do you have another job other than health worker.
 - a. No
 - b. Yes. State it _____
12. What are the goals that health education program is trying to achieve?
 1. _____
 2. _____
 3. _____
 4. _____

(Use back of paper to add other goals)

13. Data concerning your present job (this month and during 1989 as a whole).

	<u>This month</u>	<u>1989</u>
1. Number of classes	_____	_____
2. Number of mothers	_____	_____
3. Number of children for weighing	_____	_____
4. Number of underweight children	_____	_____
5. Number of home visits	_____	_____
6. Number of periodic meetings	_____	_____
7. Number of visits of supervisor	_____	_____
8. Number of visits of CRS personnel	_____	_____
9. Number of mothers referred to clinic by you	_____	_____
10. Number of children referred to clinic by you	_____	_____

14. What are the difficulties that you face (please write a brief and clear description of the problem and the proposed solution. Use the back page to write additional problems).

	<u>Problem/difficulty</u>	<u>Proposed Solution</u>
1. With society	1. _____	_____
	2. _____	_____
	3. _____	_____
2. With the resource center	1. _____	_____
	2. _____	_____
	3. _____	_____
3. With CRS	1. _____	_____
	2. _____	_____
	3. _____	_____
4. With Mothers	1. _____	_____
	2. _____	_____
	3. _____	_____

15. After reading each sentence, put a circle around the appropriate rate:
1. Need of your village to health education
essential not essential no need at all
 2. Topics meet the needs of mothers
suitable somewhat suitable not suitable
 3. Number of weekly classes
enough somewhat enough not enough
 4. Posters and visual aids
available little not available
 5. Number of home visits
Enough somewhat enough not enough
 6. Interest of local society in the project
enough somewhat enough not enough
 7. Your level of academic preparation
appropriate somewhat appropriate not appropriate
 8. Attendance of mothers
frequent few seldom
 9. Technical instructions of supervisors
useful somewhat useful not useful
 10. A high proportion of mothers in current class
attended previous courses
yes sometimes no
16. Do mothers who attend classes receive commodities.
- a. No
 - b. Yes, number of mothers _____
17. Will mothers' participation be influenced by stopping food aid?
- a. Yes, there will be a drop
 - b. Yes, most of the mothers will not participate
 - c. No, there is no connection.
18. What techniques/methods do you suggest to support these classes?
1. _____
 2. _____
 3. _____
 4. _____

19. Is there a clinic in your village
- Yes, I have full cooperation with the clinic
 - Yes, but there is no cooperation with this clinic.
 - No.
20. Who runs this clinic?
- Same Society
 - Government
 - Other agencies/societies
 - There is no clinic in the village
21. Do you keep the following records?
- | | | |
|----------------------------------------|--------|-------|
| a. Attendance booklet | A. Yes | B. No |
| b. Weighing booklet | A. Yes | B. No |
| c. Weighing Chartd | A. Yes | B. No |
| d. Files for each mother you deal with | A. Yes | B. No |
| e. File for each child | A. Yes | B. No |
22. What are the three most common causes of mother's drop out?
- _____
 - _____
 - _____
23. What do you think of your training during the health education course?
- Appropriate
 - Not appropriate
 - I need of additional training in the following topics
 - _____
 - _____
 - _____
24. Do you use any aids during the class.
- Yes, I get these aids from the supervisor.
 - Yes, I get these aids on my own
 - No, I do not need them
 - No, It is impossible to find them
25. How do you convince the mothers to come to health education class (please choose one answer) through:
- Home visits
 - Encouraging the members of the society
 - Relatives and friends
 - Personal intiative.
26. What is the expected increase in mothers' weight at the end of the pregnancy period? _____

27. What is the best method to wean a child?
a. Abruptly
b. Gradually
c. Depends upon the circumstances of each child and mother.
28. How do you determine the growth pattern of the child.

29. Is it essential to perform lab tests for expectant mother? _____
30. What procedures/measures you take if you notice a drop in the child weight?
1. _____
2. _____
3. _____
31. What is the population of the village that you are working in? _____
32. When was health education program established in your village? _____
33. State the three most important responsibilities toward your village outside the classroom.
1. _____
2. _____
3. _____
34. If a mother approaches you for an antibiotic drug, will you dispense the medicine? How do you handle the situation?

35. What measures do you take when you notice that an expectant mother develops swollen feet, with pale face.

36. What measures do you take when you notice that the child you are attending has a swollen belly?

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Appendix K

Catholic Relief Services
 Evaluation of the Life Cycle Program
 November 1989
 Supervisors' Questionnaire

1. Name: _____
2. Place of Residence: _____
3. Resource Center: _____
4. Highest academic level: _____
5. Workshops/courses attended since 1987:

	<u>Course Name</u>	<u>Place</u>	<u>Duration</u>	<u>Time</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

6. Years of experience in the Health Education program?

7. Years of experience in the supervision of the Health Education Program? _____

8. What are the objectives of the Health Education program?
1. _____
2. _____
3. _____
4. _____

(use back of this paper for further elaboration)

9. What are the difficulties you meet in you work? What are your suggested solution?

	<u>Difficulty</u>	<u>Suggested Solution</u>
At your resource center	1. _____	_____
	2. _____	_____
	3. _____	_____
With local collaborating Societies	1. _____	_____
	2. _____	_____
	3. _____	_____

	<u>Difficulty</u>	<u>Suggested Solution</u>
With the Health workers	1. _____	_____
	2. _____	_____
	3. _____	_____
With CRS	1. _____	_____
	2. _____	_____
	3. _____	_____

10. Use the following scale to describe each sentence in the following list:

The scale: 1. Appropriate
 2. Partly appropriate
 3. Not appropriate

1. Topics that are covered in mothers' weekly meetings. _____
2. Number of weekly meetings with mothers. _____
3. Posters, charts, and other teaching aids available to the village health worker. _____
4. Number of home-visits initiated by health workers. _____
5. Your previous academic preparation in health education curriculum. _____
6. Your previous preparation in supervisory procedures. _____
7. Counselling services given to the mothers by the health workers. _____
8. Number of monthly visits you initiate. _____

11. What actions do you suggest to improve and maintain the health education program.

1. _____
2. _____
3. _____
4. _____

12. Give me the most important reasons for mothers drop out?
1. _____
2. _____
3. _____
13. What is the expected increase in mother weight at the end of the pregnancy period? _____
14. What is the best method to wean a child?
a. Abruptly
b. Gradually
c. Depends upon the circumstances of each child and mother.
15. How can you determine the growth pattern of the child.

16. Is it essential to perform lab tests for expectant mother. _____
17. What procedures/measures you take if you notice a drop in the child weight.
1. _____
2. _____
3. _____
18. If a mother approached you for some antibiotic drugs, will you dispense the medicine? How do you handle the situation.

19. What measures do you take when you notice that an expectant mother has developed swollen feet, and pale face.

20. What measures do you take when you notice that the child you are attending has a swollen belly?

21. Assess each health worker you supervise using this scale.

- a. Her work is acceptable
- b. Her work needs to be improved
- c. I recommend replacing her

	<u>Name of the Worker</u>	<u>Your assessment</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

22. Assess the need of each health program you work with using this scale:

- a. There is a great need for the program
- b. There is a great need for the program for a short period of time
- c. There is no real need for the program.

	<u>Name of the Village</u>	<u>Assessment</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

23. What are the criteria that you use when you propose a new health education program?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

24. What are the criteria that you use when you recommend a new health worker?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Appendix L

List of subjects/topics requested for training by health workers

1. First Aid.
2. Basic Practical Nursing.
3. Disability.
4. Common Diseases.
5. Community Services.
6. Basic Knowledge on Common Medications.
7. Physiotherapy.
8. Psychology.
9. Counselling.
10. Herbal Medications.
11. Toy making for children.
12. How to approach/deal with fathers on issues of public health.
13. Family Planning.
14. Methods of storing/preserving food.
15. Latest medical innovations.

Appendix M

Most Common Problems that
Teachers Perceive in their Programs

A. With the Local Societies:

	F	%
1. No independent or suitable room	29	21.3
2. Little interest on the part of the Society in the program	16	11.8
3. The H.E. center is distant from the village	6	4.4
4. Difficulty with transportation	5	3.7

B. With the Resource Centers

1. Irregularities with salary	18	13.2
2. No proper meeting place	5	3.7
3. Not paying attention to the program	4	2.9

C. With the CRS

1. Not enough teaching material	12	8.8
2. No paid annual leave	11	8.1
3. Food is not distributed	10	7.4

D. With the mothers

1. Missing classes frequently	40	29.4
2. Late for classes	20	14.7
3. Bringing in children to classroom	10	7.4
4. Mothers dropping out	9	6.6
5. Mothers not interested in the curriculum	9	6.6

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Appendix N

List of Equipment Supplied to
Each Regional Center by CRS

- Microscope
- Camera
- Blood pressure meter
- Slide projector
- Over head projector
- Two first aid kit
- Eight different posters (according to the number of program centers)
- Records (attendance and weighing)

Appendix O

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