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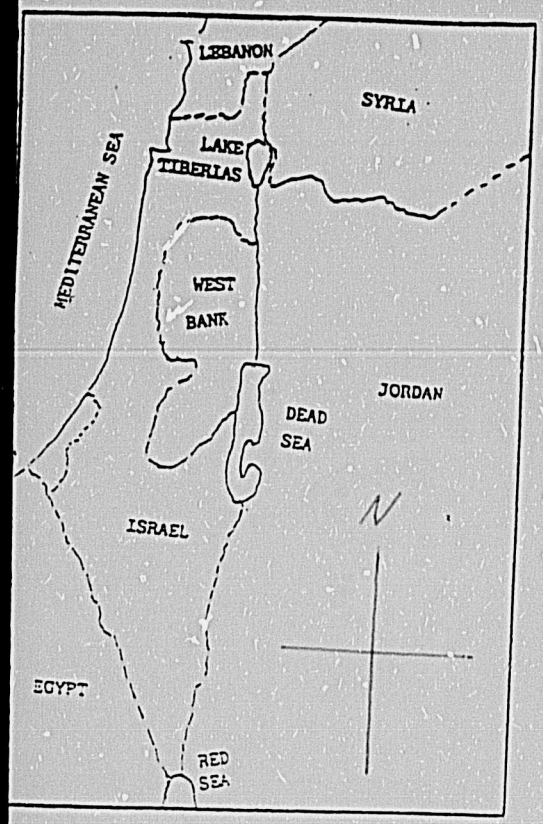
ELEVENTH SEMI-ANNUAL PROGRESS REPORT

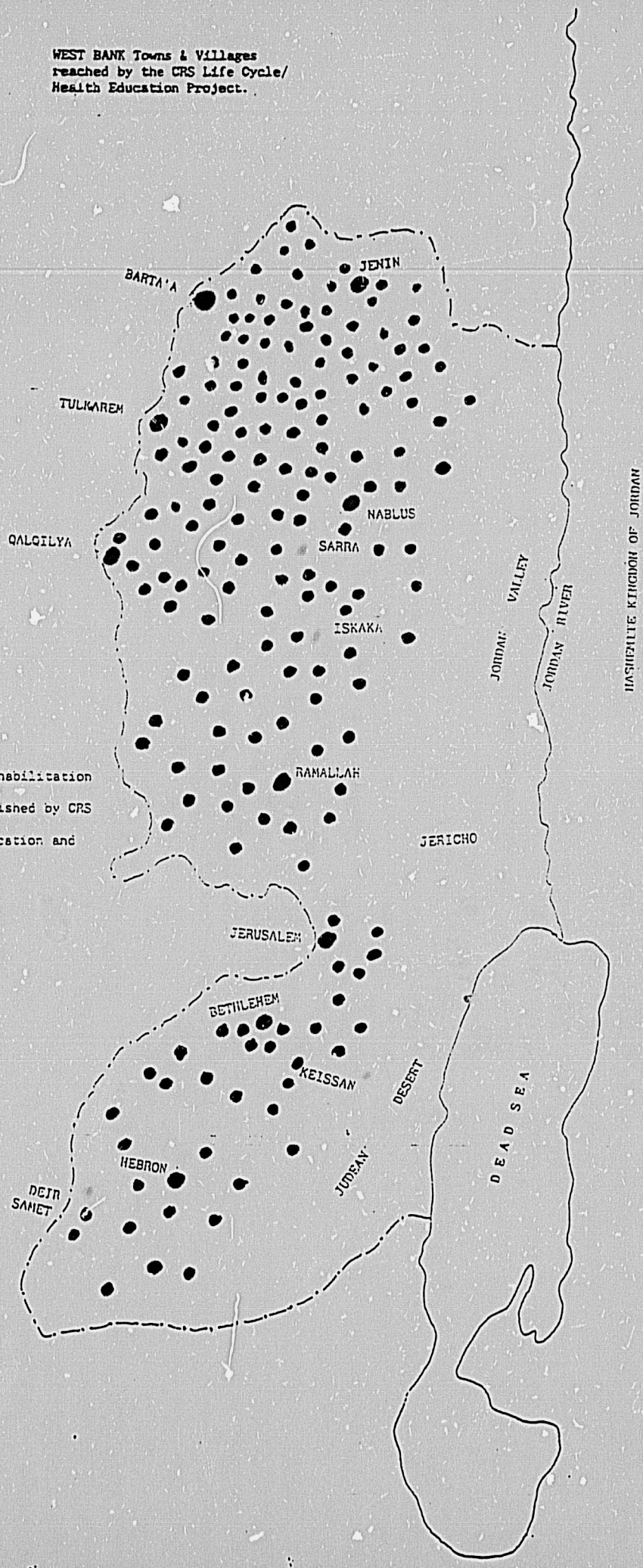
LIFE CYCLE/HEALTH EDUCATION PROGRAM
CRS/JWB 4D-004

GRANT NO. AID/NEB-0159-G-SS-5065-00

APRIL 1ST, 1990 - SEPTEMBER 30TH, 1990



WEST BANK Towns & Villages reached by the CRS Life Cycle/ Health Education Project.



- Village with CRS Health Education
- Village with health education and Home-based Rehabilitation
- Village with health education and clinic established by CRS
- Village with CRS established clinic, health education and home-based rehabilitation.
- Major Town or City

Scale: each cm = 6 km.

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LIFE CYCLE/HEALTH EDUCATION PROGRESS REPORT

General Goal: To improve the health of Palestinian families in 200 West Bank villages reached by the CRS Health Education Program, and to increase the knowledge and involvement in the development of the disabled children of families participating in the CRS Home-Based Rehabilitation Program.

Objectives:

1. To make available health education classes to the majority of women (ages 16-40) in 200 designated villages.

2. To improve preventive health care and nutritional practices by mothers participating in the Life Cycle/Health Education program.

3. To train 200 village women to be health education workers and 30 from that group to be home-based rehabilitation workers.

4. To identify and serve 1,000 West Bank children (ages 0-8) with various disabilities.

5. To involve families enrolled in the home-based rehabilitation program in the growth and development of their disabled children.

6. To improve self help, communication, socialisation, learning and motor skills of disabled village children enrolled in the CRS home-based rehabilitation program.

7. To establish five clinics in rural areas serving a minimum of 1,000 patients a month.

8. To financially assist the nurses' training program at St. Luke's Hospital/Nablus in training a minimum of 30 practical nurses during the grant amendment period.

Present Status:

CRS health education is now established in 201 West Bank towns and villages benefiting a total of 6,476 families. Of the 200 health educators now employed, 14 have completed training in home-based rehabilitation and 16 others will have completed the same training by February, 1991. One hundred fifty five families with disabled children are being served by 17 rehabilitation workers (14 of whom are also health educators), in 40 northern West Bank towns and villages.

Five rural health clinics have been established serving approximately 1,000 patients monthly. These clinics work closely with the CRS health education network. Sixteen men and women have completed an 18 month nurses' training program at St. Luke's Hospital, Nablus and will all be employed in private hospitals across the West Bank. An

extensive survey on the status of the health educators in their villages was undertaken to identify strengths and weaknesses and forecast possibilities for increased sustainability.

UPDATE ON THE CURRENT SITUATION (11/15/90):

Worsening conditions in the Occupied Territories may cause a slow-down or revision of some of the grant activities planned for the next six months. Increased violence following the October 8 killings of Palestinians inside the Dome of the Rock compound in Jerusalem have resulted in tightened security measures and more curfew days. While the complete sealing off of the Occupied Territories was formerly considered an extraordinary and unusual measure, it is now becoming commonplace. Such closure not only prevents 90% of CRS employees from reaching the CRS office, but it effectively cuts the southern West Bank from the northern part, thereby preventing the staff from doing most field work. In addition, over 10,000 "green cards" have been issued to Palestinians with records of arrests in the past, greatly restricting their movement, and barring their entry inside East Jerusalem or the 1948 borders of Israel.

These new security measures contribute to a lessening of mobility and accessibility for CRS staff and members of our Palestinian counterpart organizations. On the other hand, CRS employees have adapted to difficult conditions in the past by developing alternative means of communication and implementation, and will try to continue doing so in the future.

Actions during next 6 months:

1. Complete training course in general rehabilitation in Tulkarem.

2. Increase the number of families served by the rehabilitation program to at least 267 by April, 1991.

3. Assist in the provision of emergency first aid supplies to at least 100 towns and villages within the health education network.

4. Organise short refresher courses for the health educators.

5. Implement recommendations for improvement of the health education program as indicated by results of the village survey.

I. Introduction:

The latest amendment to the Life Cycle health education Prcject is now in its 21st month and thriving. In an atmosphere of increasing hardship, tension and uncertainty, the project is fulfilling and maintaining its objectives. It has also proven to be of vital importance to the local communities in these most difficult of times. In the following pages ongoing activities, achievements and future plans of each component of the Life Cycle project will be discussed together with impact analysis of some of the services emanating from this project.

II. Health Education

In June, 1990, the assistant project manager was assigned to carry out a survey of all the villages reached by the project. The purpose of the survey was to find out the conditions in which health education is given, the nature and extent of the interest in this program shown by the local counterparts that work with CRS, the nature and extent of the cooperation with medical facilities, if available, and whether health education is really needed and should continue in each of the villages concerned.

The results of this fact-finding mission showed that various groups (counterparts) are in charge of the health education program in different villages as shown in table (1).

Table (1)

Individuals, Groups & Organisations responsible for CRS Health Education

Responsible Entity	No. of Villages
Charitable societies and sub-centers in neighbouring villages	154
Village Heads (Mukhtar)	15
Village Councils or Committees	7
Women's Committees	8
Medical Facilities	6
Health Educators working on their own	11
T O T A L	201

This table shows that there are 145 villages with health education administered and managed by Charitable Societies either in the same village or in a neighbouring village, while in the remaining villages other groups or committees are responsible for health education. The table also shows that 11 CRS-trained and sponsored health educators are working independently in their own villages. Four of these may soon be employed by medical committees working in the villages.

Of the various charities and groups responsible for CRS health education, 138 (68%) cooperate with the health educator and supervisor and show general interest in this program. They facilitate the health educator's work and provide her with all necessities. They also intend to continue with the health education program if and when CRS withdraws funding because 93% of them are convinced of the need for health education in their respective villages. However, the majority of these village groups, including the Charitable Societies, would face financial difficulties should they be required to pay the full salary of the health educator as planned. Even now only 11% of these committees and societies pay the 10% of the health educator's salary as specified in the grant amendment proposal. Of the 89% who do not pay the 10%, 20% argue that the health educator's salary is not compatible with their own salary scales (salaries are fixed to Jordanian currency which has lost 50% of its value over the past 2 years). Twenty eight percent of the societies and committees claim to have no budget for any of their programs and services, while 12% have no interest in continuing with the health education program once funding stops.

It is noteworthy that any financial burdens faced by CRS local village counterparts have been exacerbated by the Gulf Crisis. Most societies and institutions in the West Bank were supported by Gulf funding in the form of remittances and government aid. This funding has virtually stopped since the crisis began. A a result, some counterpart institutions have lost up to 80% of their funds for recurrent expenses.

It should also be mentioned that the remaining 40% of the villages who do not pay the 10% of worker's salary are not requested to do so because the latter are currently receiving complete salaries from CRS. This is because these health educators, recently graduated, have been employed for less than one year (in 1991 all salaries will drop by 50% as planned). It is also noteworthy to mention that 176 (87%) of the 201 villages reached have medical services of one kind or another. For example, 57% of these services are permanent government-run clinics or medical centers. The remaining medical services are run by one of the following groups: The Union of Palestine Medical Relief Committees, the Health Services Union, the Doctors' Association, charitable societies, private practices and/or other private voluntary organisations including, of course CRS/JWB, which helps support 5 rural clinics.

Of these medical facilities, 66.6% sometimes work in close collaboration with the health educator in the village. For example, talks may be given to the women enrolled in the health education program by the doctor or nurse about topics such as disease prevention, vaccinations, pregnancy and child care, gastrointestinal disorders, etc.. CRS encourages such close cooperation because it emphasises the role of the health educator in the village, it encourages people to enroll in health education and it adds to the hopes for the sustainability of the program.

The health program itself is not lacking in popularity. In fact, over the past six months, 6,476 women have attended CRS-sponsored health education sessions in 201 towns and villages across the West Bank. Eighty five percent of these women are young mothers while the rest are single women, some of whom are still at high school. (The total number of new women enrolled in the health education program this reporting period amounts to 2,275. This is 1495 persons less than the previous reporting period. This attributed to the fact that the health education network has increased by only one village during the past 6 months.

The percentage of babies weighed, however, has risen from 96% to 96.7% (see summary chart). These are the babies officially registered for weighing by the health educator. Only the youngest child of each mother enrolled in the health education program is registered for weighing. On the other hand, if all children below five years of age of the mothers enrolled in the program are taken into consideration, the percentage of children weighed is 67%. This percentage applies to the children of mothers attending health education that has been going on in the village for 18 months or more. In villages with health education programs of less than one year (since January 1990), only 51.5% of the total number of children below five years are actually weighed. This is shown in Table (2) which examines health indicators in two categories of villages reached by the CRS health education program as stated above.

Table (2)

Percentages showing health status in 129 villages with health education of over 18 months' duration (category 1), and 72 villages with health education of less than one year's duration (category 2).

Village Category	% of Children Weighed	% of Underweight Children	% of Low Birth Weight	% of Dehaydrated Children Referred	% of Children with Respiratory Infection Referred	% of Mothers Introducing Solid Foods at four months	% of Mothers Breast-feeding up to six months
1	67.00	1.80	.15	2.20	1.60	74.00	50.00
2	51.50	4.67	.64	1.97	2.47	40.00	43.00

The table above shows clearly that in older programs the numbers of underweight children, babies with low birth weight, and referrals of children with respiratory infections are less than corresponding figures for programs of less than one year. This suggests that older programs of health education which have been in existence for a number of years in a village have a greater impact on decreasing the percentage of underweight children and low birth weight babies. The existence of the program may have also contributed to the increase in the percentage of mothers introducing solid foods to babies by four months and the percentage of mothers breast-feeding up to six months.

In the category of villages with health education programs of less than one year, the percentages for introducing solid foods and breast-feeding are much reduced. In addition, more children are underweight (4.67% as opposed to only 1.80% in the villages with older health education programs). More babies are born with low birth weight (0.64% as opposed to only 0.15%), while the incidence of referrals for respiratory infections has also increased. In only one indicator, percentage of dehydrated children referred, is the result reversed (i.e. more children are referred where older programs exist). It is suggested, therefore, that in villages with health education programs of many years' duration, the health educator is more experienced in recognising the first signs of dehydration and is more likely, as a result, to refer a dehydrated child to the doctor or hospital.

Results of this small study give a rough indication that the presence of the CRS health education program in a village does assist in improving health conditions.

III. Home-based Rehabilitation of Disabled Village Children

Over the past six months, two major developments have occurred in this program:

1. The graduation of 14 rehabilitation workers originally trained as health educators and,

2. The establishment of a second training course for general rehabilitation.

The 14 health and rehabilitation workers, as they are now called, have been working in villages in the Jenin region since June, 1990. Upon qualifying, each of these 14 women began with one or two cases of mildly handicapped village children aged 1 to 8 years. Now each health and rehabilitation worker has a case load of seven children with mild to moderate handicapping conditions. Thus a total of 98 children and their families are now being regularly rehabilitated and trained in the Jenin region, in addition to 19 moderately to severely handicapped children already being trained by the first CRS trained rehabilitation worker (formerly Core Staff) in the area.

SUMMARY CHART
PROGRAM PERFORMANCE INDICATORS

General Goal of the Program: To improve the health of Palestinian families in 200 West Bank villages reached by the CRS Health Education Program, and to increase the knowledge and involvement in the development of the disabled children of families participating in the CRS Home-Based Rehabiliation Program.

Objectives	Indicators	Performance this Reporting Period	Since beginning of Grant Amendment Period February 1989	Since Beginning of Grant 1985
1. Make available health education classes to the majority of women (ages 16-40) in 200 designated villages	a. At least 2,000 women attend health education courses every reporting period	6,476 village women have attended health education courses	17,009 village women have attended health education classes	51,460 village women have attended health education courses
	b. At least 500 new women (ages 16-40) who have never before attended health education classes are enrolled in new classes every reporting period	2,275 new women were enrolled in new health education classes in 201 West Bank villages		
2. To improve preventive health care and nutritional practices by mothers participating in the Life Cycle/Health Education program	a. At least 90% of babies of mothers attending health education in designated villages are brought to health workers for weighing monthly	96.7% of babies registered for weighing were brought to the class by the mothers for weighing	94% of babies of mothers attending health education classes were brought for weighing	Complete information is not available
	b. At least 80% of babies weighed maintain progressive growth during the reporting period and fall within acceptable weight norms for the West Bank	Completed information is not available until April 1991	95.1% of these babies maintained progressive growth (until March 31, 1990)	Complete information is not available
3. To train 200 village women to be health education workers and 30 from that group to be home based rehabilitation workers	a. 200 women successfully complete health education courses	Target reached	97 trainees successfully completed Health Education courses	200 women have been trained as health workers
	b. From the 200 health workers trained, 30 successfully complete home-based rehabilitation courses.	14 health workers were trained as home-based rehabilitation workers, 16 more are being trained	14 health workers trained in home-based rehabilitation	37 persons trained in home-based rehabilitation
4. To identify and serve 1,000 West Bank children (ages 0-8) with various disabilities over the course of the grant amendment	a. At least 165 children (0-8) with various disabilities will be assisted (through referrals one-time consultations, and home-based rehabilitation), each reporting period	220 children assisted through referrals and consultations 155 children enrolled in home-based rehabilitation program	508 children assisted through referrals and consultations 208 children enrolled in home-based rehabilitation program	789 children assisted through referrals/ and consultation 497 children enrolled in home-based rehabilitation program
	b. 5-10% of disabled children discharged from home-based rehabilitation program each reporting period	7% of children discharged this period	9% children discharged	26% children discharged from program
5. To involve families enrolled in the home-based rehabilitation program in the growth and development of their disabled children	At least 1 member in 90% of participating families will be trained and demonstrate active involvement in their disabled child's rehabilitation program	1 member in 71% of participating families trained to carry out rehabilitation for their disabled children	1 member in 74.5% of participating families trained to carry out rehabilitation for their disabled child	1 member in 87.6% of participating families trained to carry out rehabilitation for their disabled child
6. To improve the self help, communication, socialization, learning and motor skills of disabled children enrolled in the CRS home-based program	At least 65% of the disabled children in the home-based program show improvement in at least two of the five main areas of development outlined in the Portage test, in each reporting period	57% of disabled children in program showed improvement in at least two main areas of development, 80% showed improvement in one area	55% showed improvement in at least one area of development	Complete information is not available
7. To establish five clinics in rural areas serving a minimum of 1,000 patients a month	6,000 patients served by 5 CRS-established clinics each reporting period	6,438 patients served by 5 CRS-established rural clinics	9,877 patients served by 5 CRS established rural clinics	9,877 patients served by 5 CRS established rural clinics

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A second training course in general rehabilitation is now being offered to 16 health educators from both the Tulkarem and Nablus regions. The course, which is being given at the Arab Orphan's Home in Tulkarem, began on the first of June, 1990. It is expected to end by late January, 1991. The trainer is the same person who gave the Jenin course which ended earlier this year. She is assisted by the CRS resource personnel two days a week. This trainer also supervises the 14 newly-qualified health and rehabilitation workers in the Jenin area.

At present, 155 children are regularly seen by the rehabilitation workers (see summary chart). Eighty percent of these children are below five years of age. Among the disabling conditions faced, cerebral palsy, mental handicap (including Down's Syndrome), muscular dystrophy and physical disability resulting from poliomyelitis are perhaps the most prevalent.

Of the 155 children currently enrolled in the program, 11 (7%) have been discharged during this reporting period. It is noticed that the percentage of children who have left the program has dropped this period (see summary chart) because of the large increase in children who have recently joined the rehabilitation program. By contrast, 220 children were assisted through referrals and one-time consultations, 96 of whom have actually been admitted to general hospitals, neurology departments, pediatric hospitals and referrals for psychiatric or psychological assessments.

There is a waiting list at centers for mentally handicapped children in need of special education services. Such centers, however, are too few and too far from villages, according to a survey conducted recently by the CRS special education resource person. This same survey also showed that the majority of mentally handicapped children in the villages, who are educable and have potential to develop, are being deprived of basic educational opportunities because of lack of services and community awareness.

Increasing community awareness of the needs and rights of the handicapped is one of the major aims of the CRS rehabilitation program. The main feature of this program is the home visit. Each rehabilitation worker spends about 45 minutes with each family with a disabled child. The rehabilitation worker visits an average of four families each day. During the visit rehabilitation programs previously planned to suit individual needs are applied while families, particularly mothers, join in the planning and execution of the programs. However, not all families are as cooperative as they should be, hence not all individual rehabilitation programs are successful. More attention in re-education is paid to families who do very little for their children in between visits.

The rehabilitation workers are supervised and evaluated by the multi-disciplinary team from the CRS office (see 9th semi-annual report). Members of this team visit each child in the program once to twice monthly and assess the following:

1. The suitability of the individual activity chart for the child and the parents.
2. Interaction between the child, the rehabilitation worker and the parents, and
3. The achievements of the child since the last visit.

The efforts of the rehabilitation workers and the CRS resource personnel have so far resulted in the training of 110 family members in rehabilitation (one member in 71% of participating families) and the improvement of 57% of the children in at least two of the four main areas of development (see summary chart and 10th semi-annual report). The percentage of those children who show an improvement in at least one area is 80% of the total number of children rehabilitated.

IV. Rural Health Centers:

Two more new health centers were added to the list of clinics established and assisted by CRS. There now exist five rural clinics assisted by CRS/USAID. In addition to the Barta'a, Iskaka, and Deir Samet clinics (see 10th semi-annual report), a mobile clinic has been established by CRS in collaboration with the Friends of the Patients Society in Jenin, which also runs the Barta'a clinic.

The idea of a mobile clinic in the Jenin region emerged in the wake of information that of the 80 villages in this region, at least 30 have no medical services of any kind. Furthermore, each of these 30 villages has a population of 500 people or less which makes it impractical to establish a permanent medical facility in any of them.

The mobile clinic, which has been in operation since the beginning of May, 1990 now reaches 14 of the 30 villages mentioned above. The clinic is closely joined with the Life Cycle network which facilitates referrals and access to the patients. A team composed of two doctors and two nurses travelling together (two at a time), see patients in the same room used by the health educator on other days. A total of 2,850 patients, the majority of whom were women and children, were assisted by the clinic between May and September, 1990. A minimal fee is collected from the patients. The mobile clinic has so far proven successful not only in reaching deprived patients but also in enhancing the health educator's role and her importance in the village.

The latest clinic to be established by CRS is at Sarra, a village of 2,000 inhabitants 10km south west of Nablus in the rolling hills of Samaria. This village lacked any sort of medical services and no doctor is available from the village itself.

The villagers, with assistance from the village council, took the initiative and built a facility to house the much needed clinic and CRS sponsored health education, and have provided the necessary furniture. As in other clinics, CRS pays monthly running costs for nurse's salary and first aid material, while the Benevolent Society for Health Institutions in the Nablus District (the same society that runs the Iskaka clinic), pays for the doctor and provides medicines. This project is a good example of a community-based and initiated service which, in a few months, will expand to include home-based rehabilitation. The health educator of this village, (herself physically handicapped) is also among the trainees at the Tulkarem course.

Another development in the CRS-assisted health services is at Keissan, a tiny Bedouin community of some 300 people in the Judean wilderness overlooking the Dead Sea. Among the many developmental and relief works conducted by CRS over the past two years at this settlement is the establishment of a small, one-room clinic built of rough stone and wood. This room, ingeniously partitioned from the inside, now houses much needed health education classes to the local women, and a once-weekly clinic run by the Friends of the Patient Society in Bethlehem. An average of 18 patients are seen each time by the visiting doctor and nurse. CRS is considering the possibility of sharing (from grant funds) in some of the running costs for one year.

All medical services are established and assisted in close collaboration with well-reputed and recognised medical establishments who have the capability of continuing the work initiated by CRS and the local community.

V. St. Luke's Hospital Nurses Training Program:

Sixteen men and women have completed 18 months of training in practical nursing on October first. At the time of this writing, these nurses are sitting for the hospital's final exams. Ten of these newly qualified nurses will be immediately employed by St. Luke's Hospital. The remaining six will be absorbed by various private hospitals across the West Bank. None will work in rural clinics because, for the time being at least, there is a grave shortage of nurses in the hospitals. The next training course sponsored by CRS/USAID at St. Luke's will begin in late November, 1990.

VI. Other Life Cycle/Health Education Activities and News in Brief:

1. The Most Reverend Francis Anthony Quinn, Bishop of Sacramento and a member of the CRS Board of Directors visited CRS/JWB in July, 1990. Bishop Quinn visited several Life Cycle Project sites including the Tulkarem training course for rehabilitation, the Barta'a clinic, the home of one disabled child, St. Luke's Hospital and Keissan.

2. Assessments of all the village health educators have been carried out by each supervisor in her/his region. The health educators were evaluated in such areas as the accuracy of their information, approach and teaching methods, and initiative. The main purpose for these assessments was to find the strengths and weaknesses of the health educators and to find ways to remedy any short comings.

3. Instructions on simple physiotherapy to village health educators and ways of coping with physical disability, as well as first aid for fractures, were initiated by the CRS physiotherapist in various localities reached by the program.

4. A study day on diarrhea and oral rehydration was hosted by the Palestine Medical Relief Committees in Jerusalem. It was attended by all CRS-sponsored health education supervisors and some health educators.

5. Two large meetings with groups of parents of disabled children were held at resource centers in the north. Smaller, less-formal meetings are held regularly in the villages. Needs and problems were discussed.

VII. Conclusion:

The Life Cycle/Health Education project is achieving its objectives through its numerous outputs over the past eighteen months. Health education has been made available to the majority of women in approximately half the West Bank villages, where it has been indicated that preventive health care and nutritional practices are improving. In twenty percent of those villages children with various handicapping conditions are being cared for and professionally rehabilitated at home by health/rehabilitation workers and members of the CRS/JWB multi-disciplinary team. Such work is contributing to the development of the social and personal competence of both the disabled child and members of his/her family.

All the above, in addition to the latest increase in the number of newly qualified practical nurses and the establisment of rural health clinics, is adding to national and international efforts to improve the quantity and quality of primary and secondary health care and rehabilitation services in the occupied West Bank.

STATUS OF FINANCES AND EXPENDITURES

NAME OF BUDGET ITEMS UNDER GRANT:	TOTAL AMMENDED AID FUNDING US$ 02.01.89 TO 01.31.92	EXPENDITURE US$ 04.01.90 TO 09.30.90
I. CRS supervisory costs		
a. Personel & Fringe Benefits	358,654.00	55,982.72
b. Vehicle Operating Costs	42,300.00	12,228.95
c. Vehicle Purchase	45,000.00	.00
d. Other Costs (office supplies, rent, fuel, printing costs)	102,000.00	4,333.82
II. Resource Centers Costs		
a. Personnel (health & rehabilitation workers & Supervisors)	1,056,933.00	174,547.36
b. Transportation (supervisors, rehabilitation workers and trainees)	99,000.00	11,684.09
c. Equipment & supplies	103,000.00	1,481.34
III. Training		
a. Nurses	135,000.00	22,500.00
b. Village health/rehabilitation workers	31,000.00	6,149.86
IV. Assistance/establishment of clinics	54,000.00	12,136.77
V. Consultancy	10,000.00	300.00
VI. Evaluation	55,000.00	.00
GRAND TOTAL	2,091,887.00	301,344.91