
Situation Analysis of Family Planning and Reproductive Health Outreach Workers in Egypt

January 2004

Project Funded by the United States Agency for International Development





The CATALYST Consortium is a global reproductive health activity initiated in September 2000 by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development (USAID). The Consortium is a partnership of five organizations: the Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International and PROFAMILIA/Columbia.



This publication was made possible through support provided by the Office of Population and Health, United States Agency for International Development, under the terms of contract No. HRN-A-00-00-00003-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the United States Agency for International Development.



Table of Contents

ACKNOWLEDGMENTS	III
ACRONYMS	V
BACKGROUND AND JUSTIFICATION	1
STUDY OBJECTIVES	2
METHODOLOGY	2
RESULTS	3
COMMUNITY HEALTH WORKER SYSTEMS: AN HISTORICAL PERSPECTIVE	3
SCOPE OF WORK AND DISTRIBUTION	4
SELECTION CRITERIA	8
TRAINING	8
REMUNERATION	10
SUPERVISION AND EVALUATION	10
HEALTH CARE PERSONNEL/COMMUNITY PERCEPTIONS	11
IMPACT ON COMMUNITY KNOWLEDGE, AWARENESS AND PRACTICES	12
JOB SATISFACTION	14
CONCLUSION AND RECOMMENDATIONS	17
ANNEX 1 RESOURCE MATERIALS	21
ANNEX 2 ORGANIZATIONS CONTACTED	23
ANNEX 3 MINIA CHWS ROUND TABLE DISCUSSION PARTICIPANTS	25
ANNEX 4 COMMUNITY HEALTH WORKER JOB DESCRIPTIONS	27



Acknowledgments

TAHSEEN is grateful to Dr. Maha El-Rabbat, Assistant Professor of Public Health at Cairo University, for conducting this *Situation Analysis of FP/RH Outreach Workers in Egypt*. Special thanks go to Dr. Amal Zaki, Executive Director of Raedat Rifiat Program at MOHP for her continuous support and assistance.

This study would not have been possible without the valuable input of the officials interviewed during the course of the study and, the officials, outreach workers and supervisors who participated in the Minia roundtable discussion

Last but not least, the TAHSEEN would like to thank Dr. Nahla Abdel-Tawab, TAHSEEN Behavior Change Communication Specialist, for managing this study and for reviewing and editing earlier drafts of this manuscript.



Acronyms

CEOSS	Coptic Evangelical Organization for Social Services
CHW	Community Health Worker
CSI	Clinical Services Improvement Project
EFPA	Egyptian Family Planning Association
EWSO	Egyptian Women Speak Out
FaRHFP	Fayoum Rural Health and Family Planning Project
FP	Family Planning
IEC	Information, Education and Communication
IPEE	Integrated Population and Environmental Education into Agriculture Extension Project
KAP	Knowledge, Attitude and Practices
MOP	Ministry of Population
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MOLA	Ministry of Local Affairs
MOSA	Ministry of Social Affairs
MMS	Male Mothakef Sokany
NPC	National Population Council
PDP	Population and Development Project
PHCUP	Primary Health Care Upgrading Project
RH	Reproductive Health
RHU	Rural Health Unit
RR	Raedat Rifiat
SDP	System Development Project
TBA	Traditional Birth Attendant
VEW	Village Extension Worker



Background and Justification

Over the past four decades, Egyptian governmental and non-governmental organizations have used community health workers (CHWs) to provide outreach services to communities throughout the country. As a result, there are currently over 30,000 community health workers serving as frontline health care and social service professionals for the Ministries of Health and Population (MOHP), Social Affairs (MOSA), Agriculture (MOA), Local Affairs (MOLA), various NGOs including the Coptic Evangelical Organization for Social Services (CEOSS), and bilaterally-funded projects such as the Fayoum Reproductive Health and Family Planning Project (FaRHFP) and the Primary Health Care Upgrading Project (PHCUP).

The Egyptian health care system has experimented with an assortment of community health workers who serve as liaisons between the health care system and the community. Most community health workers are women recruited within their local communities to visit women and their families at home and convey family planning / reproductive health messages and refer women with health problems or who want to use contraception to the clinics where they can secure needed FP/RH services. Some CHWs workers are also involved in literacy, income-generating or other developmental activities.

Community health workers are known by a variety of names, the most common of which are *raedat rifiat* or rural pioneers, *murshida* (guide), *al-qua'ida* (leader), *muthakifa* (educator) and *al-munasika* (coordinator). Some programs use male outreach workers, like the MOHP male *mothakef sokany* (MMS), to directly target men.

Despite the central role that FP/RH outreach workers could play in raising awareness and motivating couples to use family planning methods, evidence suggests that these important human resources are severely underutilized. The Egypt Demographic and Health Survey 2000 (EDHS)¹ collected data regarding contact between community health workers/health care providers and family planning (FP) non-users. Results revealed that relatively few women had been reached through community outreach efforts, with only four percent of FP non-users reporting that they have been visited at home by a field worker.

This situation analysis was undertaken to gain a better understanding of the FP/RH outreach system in Egypt, take stock of current CHW program status, identify MOHP *raedat rifiat*'s (RR)² system strengths and weaknesses and propose feasible and sustainable solutions to enhance the utilization and effectiveness of these valuable human resources. It is timely in light of the Prime Minister's announcement of MOHP's recent recruitment of some 7000 new *raedat rifiat*.

¹ El Zanaty and Way. *Egypt Demographic and Health Survey 2000*. Calverton, Maryland: Ministry of Health and Population, National Population Council and ORC Macro, 2001.

² MOHP *raedat rifiat* and RR will be used interchangeably



Study Objectives

The objectives of this study were to:

- Identify the types, roles, responsibilities and socio-demographic characteristics of community health workers involved in reproductive health activities;
- Examine existing CHWs training, supervision, and remuneration systems;
- Assess CHWs' system effectiveness, strengths and weaknesses; and
- Present policy recommendations that will lead to MOHP *raedat rifiat* program sustainability, enhance their effectiveness and identify areas for future research.

Methodology

This study was implemented in three phases. In the initial phase –RR related literature including prior research, training manuals and technical reports was reviewed to provide insights into past and present RR programs. A bibliography of reference materials is attached as Annex 1. Following this review, interviews were held with government and NGO officials from institutions and organizations using community health workers and with a group of RR. This stage afforded additional insights on the different CHW systems. Results of the above review were shared with 26 CHWs with different affiliations, supervisors and health officials during a round table discussion in Minia governorate. Opinions were solicited on the best ways to improve the utilization and effectiveness of FP/RH outreach workers nationwide. Lists of organizations contacted and round table participants are included as Annex 2 and 3 respectively.



Results

Community Health Worker Systems: An Historical Perspective

During the past four decades various organizations have used community health workers to provide FP outreach services to community members. The Ministry of Social Affairs (MOSA) was the first to introduce a volunteer CHW program in 1964. Community health workers were recruited to act as liaisons between the population and the governmental services provided by the local MOSA unit, encouraging rural women to participate in literacy classes or other socio-economic activities. Their role has been expanded to carry FP messages to the community and encourage women to seek preventive services.

In 1981 the Supreme Council of Family Planning pioneered a program in 12 governorates known as the Population and Development Project (PDP). An estimated 2,780 CHWs were recruited, trained and deployed in communities to promote contraceptive methods use. After the PDP ended, the National Population Council (NPC) continued working with these CHWs, known as *raedat rifiat*, in rural family planning programs, focusing primarily on FP issues. Many governorates still have *raedat* who started with the PDP project in the 1980's.

The Ministry of Local Affairs has operated a nationwide program covering rural Egypt, called *Shourouk*, since 1994. Execution of MOLA developmental activities depends on community participation. Some 23,000 elected volunteer male and female CHWs (representatives) liaise at the rural level between the rural committee and the women's committee (women's and family issues), the numerous program activities and the local communities.

Early in 1994, Ministry of Population appointed two categories of male and female community health workers as government employees; *raedat rifiat* and male and female *demographic / population educators*. Later in 1996 with the integration of the Ministries of Population and Health, the female *raeda rifiat* and male *mothakef sokany* became MOHP employees.

National health and development programs and projects utilize community health workers in various capacities. Some use MOHP *raedat* while others recruit their own CHWs to work as development brokers, change agents and promoters of women's reproductive and family health, addressing a range of health, population and development issues. Examples include the *murshidat*, or guides, of the Fayoum Rural and Family Health Project (FaRHFP) and the *muthakifa*, or educators, of the Primary Health Care Upgrading Services Project (PHCUP 1 and 2).

In an attempt to change the role of MOHP *raedat rifiat* from awareness-raising to advocacy, two initiatives were undertaken by the Policy Project and the Egyptian Women Speak Out Project (EWSO). The Policy Project expanded *raedat rifiat*



training to include 19 RR from ten governorates and trained them to identify the FP/RH needs of youth and newly married couples. The EWSO Project, implemented in collaboration with John Hopkins University Center for Communication Programs, provides leadership training for RR. Each *raeda* subsequently trains and addresses RH and empowerment issues with 20 community women, according to an annual training plan. To date the program has trained 150 RR and “empowered” 1840 women.

CEOSS community health workers are volunteers affiliated with the Coptic Evangelical Organization for Social Services. They are known as *al-qua'ida* or leaders, and work predominantly in the lesser developed communities of Minia, Beni Suef and Cairo governorates. They serve in a variety of health and development related capacities in response to community needs.

A collaborative project between the Ministry of Agriculture and the MOHP initiated the first phase of the Integrated Population and Environmental Education into Agriculture Extension Project in 1999. During this phase, six governorates were selected for inclusion in project activities. Within each governorate, five districts and 25 villages were selected. Male and female volunteer village extension workers (VEWs) were recruited to expand agricultural activities to include population issues in each village. The RR have become an integral part of this team.

Scope of Work and Distribution

“It would be better if we could team up with other CHWs to render counseling more comprehensive.” CHW
comment at Minia Round Table

The primary role of all CHWs is to raise community awareness about health issues. The MOHP *raedat rifiat* home visit program targets women of reproductive age. Each RR is assigned 30 home visits per month, during which the main activities include FP counseling and referral to MOHP clinics. The RR are expected to provide FP counseling to postpartum and breastfeeding women as well as FP discontinuers. RR activities have recently been expanded to include RH promotion and family health issues. Despite this expansion, family planning topics have remained the key topics discussed in 86 percent of the home visits. Reproductive health, antenatal care (ANC), breastfeeding and immunizations were discussed during less than five percent of the home visits.³

CHWs with other organizations often have a broader scope of work and may not be limited to working only with women. The RR working with Improving Health Practices Inside the Family and Community Program discuss family health issues including integrated management of childhood illness in addition to family planning,

³ Zaki et al. *Study of the Evaluation of the Performance of Raedat Rifiat*. Cairo, Egypt: Ministry of Health and Population and Pathfinder, 2000. This study was an evaluation of RR performance in Menoufia, Sharkeya, Alexandria, Minia, and Qena.



while those CHWs with the MOSA, CEOSS, FaRHFP, PHCUP 1 and 2 participate in literacy, income generation and women's empowerment activities. The VEWs and RR with the Integrating Population and Environmental Education into Agriculture Extension Project address families as a team, with the VEW providing agricultural extension messages and the RR reinforcing those messages with a unique twist, making an analogy, for example, between spacing two crops and spacing children.

Generally speaking, each CHW is responsible for a geographic quadrant or for a number of families ranging between 400 (FaRHFP) and 600 (MOHP). The number of planned home visits varies among programs, from 8-18 home or field visits per month for Integrated Population and Environmental Education into Agriculture Extension Project teams to 30 home visits per week for MOHP *raedat rifiat*. Overall, the RR home visit system is ambiguous. The Zaki et al study reported that approximately 40 percent of the women interviewed were not visited by RR.

The MOHP MMSs are responsible for delivering ten seminars/awareness sessions per month for men and youth in schools, coffee shops, public markets, and other venues. Their role was recently modified to include backup for IEC officers and to aid mobile clinic teams to motivate communities. This modification is considered a deviation from the program's original intent to support men's involvement in RH issues and to complement the role of RR.

The FaRHFP Project *murshidat* appear to have the most systematic program of all the community health workers. *Murshidat* schedule 25 home visits per week, visiting some 400 families. According to their weekly workplan, *murshidat* spend three days conducting home visits, one day recording visit results and preparing their weekly workplan, one day holding seminars at the rural health unit on vaccination day and the last day of the week visiting families with urgent needs.

MOHP *raedat rifiat* are expected to recruit 14 new IUD cases monthly. The PHCUP 2 *muthakifat* or educators are required to conduct 100 home visits and two seminars as well as recruit and refer a certain number of clients to women's clubs every month. The RR and PHCUP 2 *muthakifat* monthly payments are linked to their targets. The correlation between the defined targets, the number of women of reproductive age and the RR's length of experience has not been identified.

CHWs from various organizations explained that they often meet with important community civic and religious leaders including the *sheik el balad*, village council, doctors and nurses, to solve problems or clarify technical information. They refer clients to MOHP health units, NGO clinics, CSI clinics or private physicians, according to their affiliation. Officials commented that client referral should not be tied to one type of facility, but rather CHWs should support individuals not organizations, and therefore link clients to any available health service without favoring those to which they are affiliated.

During the Minia round table discussion, CHWs stressed the importance of developing a unified training program and maximizing available resources. They suggested distributing their geographical areas and workload. One CHW stated, "*The same woman could be visited by a number of health visitors who might be repeating*



the same messages. We need to coordinate our work so as to avoid boring the woman and at the same time to increase coverage."

When asked about the possibility of expanding their roles, most RR welcomed the idea of expanding to include other aspects of maternal and child health care. They believed this would enhance their credibility and acceptance by community women. The RR quickly emphasized that if they adopted an expanded role, their incentives should not only be linked to the number of family planning acceptors recruited, but to all activities performed. As one participant noted, *"Expanding our role would give us credibility, but at the same time, lack of incentives for discussing non-FP topics would be a barrier."*

Reflecting on the need to expand their knowledge and provide other services, some CHWs declared, *"Our knowledge and information about different topics could be expanded to be used to open discussions with women who have become bored by our repeated messages."* Another added, *"Sometimes I go to a woman who does not want to practice FP but who has a sick child. She needs me to tell her what to do."*

The following table summarizes CHW distribution and activities.



Table 1 Community Health Worker Distribution and Activities

Organization	CHW Type	Number	Distribution	Activity
MOHP	Raedat rifat (RR)	6,345 additional 7,000 since July 2003	27 governorates	FP
			Cairo 910	
			Kafr El Sheikh 544	
			El Behira 556	
			Giza 536	
MOHP	Mothakef Sokany (MMS)	224	21 governorates	Awareness- raising of RH issues for youth and men Assist mobile clinic teams
MOSA	Raedat	1,684	Nationwide	FP, health, development
CEOSS	Al qua'ida	3,750	Minia, Beni-Suef, Cairo governorates	Health, development
CEOSS	Al qua'ida	250	Minia, Beni-Suef, Cairo governorates	RH
FaRHFP	Al murshida	458	Fayoum governorate	Family health, population, development
PHCUP 1	Al muthakifa	100	Giza governorate: 2 districts, 50 per district	Family health, population, development
PHCUP 2	Al muthakifa	350	5 governorates	Family health, population, development
MOA and MOHP Integrated Population and Environmental Education into Agricultural Extension Project	Village extension workers and RR	600 Phase 1	25 villages in 5 districts in 6 governorates	Agricultural , environment and population
		160 Phase 2	25 villages in 5 districts in 4 governorates (3 male/ 2 female VEW/ 3 RR per village)	
MOLA- SHOUROUK		23,000 or 2 per village quadrant	Nationwide	Development, women's issues, family issues
MOHP- EWSO	Raedat rifat	150 RR		Women's empowerment, FP/RH
		1,840 community women		



Selection Criteria

While selection criteria differ among organizations, most require CHWs to have an education level that is, at minimum, higher than the average educational level of the community served. MOSA volunteer leaders are required to be literate. Ideally, the CHWs are recruited from within the same communities they serve, hold cultural values similar to those of the population served, possess leadership qualities, and are good FP role models with less than three children, although in practice these criteria were not always realized. Personal interviews are also an essential part of the selection process for almost all of the organizations.

Individual programs had their own additional criteria. The FaRHFP *murshidat* are selected by a committee composed of community, Directorate of Health and Population and Department of Social Affairs representatives. To assure sustainability, married candidates are required to have their husband's consent.

The *Shourouk* program has an innovative selection process whereby young, educated male and female volunteers are elected by the communities themselves. This helps to mitigate barriers to their acceptance, as CHWs are already perceived as valuable community members.

MOHP *raedat rifiat* supervisors reported difficulties recruiting RR in more conservative communities noting, "*In certain communities, it is difficult to recruit RR. Therefore, leaders and other influentials should be approached to motivate women leaders from these communities to volunteer.*"

A study conducted in five governorates revealed the mean age of MOHP *raedat rifiat* to be 29.9 years (\pm 6.3 years). Some 76 percent were married and 30 percent were FP non-users. Some 83 percent had three children or less. Additional socio-demographic data collected revealed that 59 percent of RR had attained an intermediate education level, with 18 percent achieving above an intermediate education and 12 percent completing their higher education. Only 10 percent reported a lower level of attainment, below the intermediate level. Although residence was considered an important criterion for RR selection, it was found that only 38 percent work in their own villages, with the remainder residing outside the community they served.⁴ The study further found that neither the RR's education levels nor social status had an effect on increasing the number of FP users.

Training

"I am not trained to excel in my work. How can I do that when training is only theoretical?" CHW at Minia Round Table

There are no standards governing the content or duration of CHW training. While the mean duration of basic training varied from two days to six weeks, funding seemed to

⁴ Zaki et al. ,2000.



be the determining factor affecting length of training. Surprisingly, CHWs trained years ago received longer training courses than those trained today despite course content modifications that have expanded the number of topics. The following table summarizes the CHW training topics and duration covered by various organizations.

Table 2 Training of Community Health Workers

Organization	Training Length	Topics Covered
MOHP RR	5 days	FP, family health, record keeping, communication skills
MOHP MMS	5 days	Family health, record keeping, communication skills, youth, adolescence, male involvement in FP/RH, gender
MOSA	2 weeks	Family health, record keeping, communication skills, community development, fund raising, integration with other organizations, socio-economic factors, leadership
CEOSS	2 days	Family health, record keeping, communication skills, community development, fund raising, integration with other organizations, socio-economic factors, leadership
FaRHFP	6 weeks	Family health, record keeping, communication skills, community development, fund raising, integration with other organizations, socio-economic factors, leadership
PHCUP 1	2 weeks	Family health, record keeping, communication skills, community development, fund raising, integration with other organizations, socio-economic factors, leadership
PHCUP 2	2 weeks	Family health, record keeping, communication skills, social marketing, community mobilization, environmental health, elderly and disabled care
IPEE	about one week	Environmental, agricultural, population problems, , home visits , communication skills, program planning
MOLA-SHOUROUK	2 days	Family health, record keeping, communication skills
MOHP-EWSO	6 days TOT, 4 days for women	Communication skills, women's empowerment issues, RH

Basic CHW training programs are decentralized, theoretical and typically lack audio-visual aids. Communication skills are learned and practiced through role playing rather than during actual client home visits. One CHW shared her experience saying, *"Training is theoretical. Even role playing is not the same as practical training."*

Initial training is usually held once a year on a prearranged date, regardless of hiring dates. MOHP *raedat rifat* may typically wait three to five months between their appointment and commencement of basic training. For most CHWs refresher training is haphazard and often carried out as part of the monthly supervision meetings when



CHWs and supervisors discuss ongoing and/or emerging problems. The FaRHFP, EWSO and Integrated Population and Environmental Education into Agriculture Extension Project trainings are exceptions to this norm.

The quality of CHW training has not been systematically assessed. Many officials contacted felt CHWs were deficient in technical knowledge about contraceptives and their side effects and lacked sufficient practical training and refresher courses. Officials also perceived CHWs and RR to lack the communication skills required to empower women and affect attitude change.⁵

Remuneration

Most community health workers are volunteers. The MOHP *raedat rifiat* are the only government employees among the different categories of CHWs. They may be hired as either temporary or permanent employees. The Zaki et al study reported that some 33 percent are hired on a permanent basis with 67 percent on a temporary basis.⁶ All MMSs were hired as permanent employees. Basic salaries range between LE 90 and 120/month with permanent employees receiving all allowable benefits based on their level of education. RR hired on a temporary basis receive no benefits, vacation or sick leave; their salaries are proportionally reduced for absences. Salaries of contract RR are often delayed and may be cut if they do not achieve their targets. Some RR have double affiliations and reportedly encourage women to use private clinics in order to earn extra incentives. Other CHWs working with NGOs and projects may be compensated by monthly stipends ranging from LE 90-150 or be compensated for referrals on a case-by-case basis (LE 2/case).

Besides low and irregular salaries, RR complained about the lack of opportunity and upward mobility. As one *raedat rifiat* commented in Minia, “*Once you are hired as a raeda you remain a raeda for the rest of your life.*”

When asked about their motives for working as community health workers, income was not the only motivating factor. The majority said they like to serve people while others said that they like to keep busy in their spare time.

Supervision and Evaluation

There are no standards for monitoring or evaluating community health worker performance or systems. Existing monitoring and evaluation systems differ substantially among organizations. A monthly or bi-monthly review of activity records and to a lesser extent, field visits to a sample of women, commonly pass as supervision. Health care personnel do not have a specific role in any of the existing

⁵ Gumei, M. et al. *Development Approaches to Community Based Family Planning Outreach in Egypt: Assessment of Raedat Rifiat Programs*. Alexandria, Egypt: University of Alexandria and Faculty of Nursing; 1995 and Zaki et al., 2000.

⁶ Zaki et al., 2000.



supervision systems (except in the *murshidat* system) although they frequently assign themselves a role.

Community health workers may be supervised by field supervisors only or by a multi-tiered system of vertical supervision at the peripheral, district, governorate and central levels. MMS supervision differs from governorate to governorate. They may be supervised either by MMS supervisors or IEC officers.

FaRHFP *murshidat* are supervised by both nurse and Directorate of Health and Population supervisors. Project officials have found nurse supervisors to be the weakest link in the supervisory chain. They tend to be poorly motivated, improperly selected and lack capacity-especially when compared to the *murshidat* themselves.

MOHP *raedat rifiat* are not evaluated on the quality of their interactions with clients nor on the variety of topics addressed in addition to family planning. Evaluation of most CHWs including RR is essentially based on detailed and comprehensive record keeping, the number of home visits and new FP acceptors, and monthly targets achieved. However, FaRHFP *murshidat*'s evaluation is done on the job , through regular performance evaluations and at monthly meetings.

Health Care Personnel/Community Perceptions

"When the raedat first started their work, we thought that they were going to eclipse our role as nurses and would accordingly take some of our benefits. Over time, during our community visits, we found many changes had occurred with community women and their children. They started to find their way to the RHU for vaccinations and treatment. It was then that I decided to help the raedat with all my power." **Nurse from Minia** ⁷

Awareness of community health workers' activities by health care personnel and officials was found to be generally low⁸. Although the majority acknowledged the importance of the CHWs' role, only 60 percent were able to comment on the CHWs' scope of activities or selection criteria. A third of the officials contacted were unable to define the CHWs role. Results were similar, though not exact, in the study conducted by Zaki et al .

One physician from Minia stated, "*At the beginning the raedat tried to convince me of their usefulness to my work as a physician. They said they had appropriate emergency care knowledge, but I didn't believe them. One day I needed them to conduct a health education session about child vaccinations. After the session, I was surprised to find*

⁷ Haddad, May, Nawal Najar, and Alia El Mohandes and community health workers, *Enhancing the Capabilities of the Female Health Worker: A Thousand and One Tales from Arab Communities* (Cairo, Egypt: ARC).

⁸ Gumei, 1995.



that the number of vaccinations increased, and that I had underestimated their capabilities.”⁹

Some village women felt the CHWs' focus on family planning was too narrow, and that this limited their role. One Minia woman commented that CHWs didn't take individual client circumstances into consideration stating, *"She came and asked me to use pills when I was already using them. I did not benefit from her visit."*¹⁰ Other women noted that they received home visits infrequently, perhaps only twice or three times annually, whereas some of their relatives and friends received repeated visits.

Women indicated a need for information on marital relations, problem-solving, child care, income generation and literacy in addition to FP/RH information related to the side-effects of contraceptive methods. One Minia woman expressed the CHW's incompetence in handling method side-effects, *"If you were tired of the pill, she would tell you to use an IUD, and if you were tired of the IUD, she would tell you to use pills."*

CHW acceptability within a community was negatively affected if they came from outside the village. Many clients viewed them as government employees, rather than community members.

The usefulness of CHWs was confirmed by many community women, with another Minia woman reporting, *"She even talks to our men about FP methods. She tells them, 'Your wives are overburdened with pregnancies and deliveries. You have to support them.'"* Referring to a CEOSS CHW another woman praised, *"She is like a mother. She does everything for our benefit. If I get sick I can consult her and she advises me. I trust her word."*

Impact on Community Knowledge, Awareness and Practices

Very few studies have evaluated the impact of CHWs on community awareness or behavior. A study conducted to assess the overall effectiveness of MOSA, National Population Council (NPC) and CEOSS community health workers found that awareness-raising was one of their weakest areas. They were found to be weak in following up FP acceptors since their visits were usually irregular and infrequent given their high workload and transportation difficulties.¹¹ RR were reported to be

⁹ Haddad, May, Nawal Najar, and Alia El Mohandes and community health workers. (Cairo, Egypt: ARC).

¹⁰ All individuals quoted on this page from study by Gumei, 1995.

¹¹ Gumei, 1995.



the main source of FP information for 15 percent of the women interviewed. Women's RH knowledge was found to be very low, ranging from 0.9 percent in Qena Governorate to a high of 17.5 percent in Minia Governorate.¹²

¹² Zaki et al.,2000.



Another study assessing the knowledge, attitudes and practices of women in the FaRHFP project found women to have reasonably good knowledge about FP methods, but not about their use. The impact of *murshidat* messages seemed favorable on a number of issues, but inadequate on tetanus toxoid, vaccination during pregnancy and antenatal care.¹³

Job Satisfaction

"At the beginning when my children asked me about my work I felt uncomfortable because people annoyed me because of it. Then one day, a man approached me and told me that his wife refused to use family planning. He asked me to talk to her. I went to the woman and used all my communication skills to convince her of FP's benefits. Later that day when the couple went to the FP clinic, her husband came directly to me and thanked me in front of my children. That was the day when I was proud to stand in front of everyone and talk about my job as a raeda."

RR from Menoufia governorate

While some MOHP *raedat rifiat and* MMSs were satisfied with their position within the community and their abilities to help others and contact hard to reach people, reasons for low job satisfaction included a heavy workload, the repetitive nature of FP messages, inadequate incentives, promotion opportunities or remuneration systems, transportation difficulties, poor communication skills training, negative community attitudes, a lack of coordination between RR and clinic staff and ineffective training and supervision.

The level of job satisfaction was low among RR with higher education levels who were more willing to change jobs.¹⁴ Some RR with university degrees were sensitive about sharing the job title with colleagues having lower education levels. They expressed interest in differentiating themselves by using the title of social worker rather than *raeda*.

Most MMSs were dissatisfied with the supervision system. In cases where the supervisor was an IEC officer there was duplication of the scope of work between MMS and IEC officers, with IEC officers receiving more incentives and visual aids, such as leaflets, booklets and illustrative films. This inequality often resulted in a sense of inferiority, helplessness and dissatisfaction among MMSs.

During the Minia round table discussion, some RR commented on the lack of respect for their work by clinic staff. One RR observed, "*Sometimes I refer cases to the clinic and give my clients a slip of paper (referral) to present on arrival, but the clinic nurse*

¹³Fayoum Reproductive Health and Family Planning Project. Results of a study on the Knowledge, Attitudes and Practices of Women in Itsa District. Cairo, Egypt: 1997.

¹⁴Zaki et al.,2000.



makes fun of the women with comments such as, ‘This slip is nonsense. Who is this raeda who sent you?’

Regarding the workload another stated, *‘I’m overburdened with work. Sometimes I don’t even have time to think of the quality of what I’m doing.’*



Conclusion and Recommendations

Community health workers are an important component of the health care delivery system in Egypt. They serve as a link between the health care system and the community. Although the current RR system is severely underutilized, there are potential resources in the system that could be capitalized on in order to increase their utilization and effectiveness. This study has identified some of the strengths, challenges and gaps in the RR system. In order to close these gaps and to maximize system strengths it is suggested that policy and decision makers consider the following recommendations:

1. Selection and distribution of *raedat rifiat*
 - ▶ Emphasis should be placed on recruiting RR from the local community in order to enhance credibility and acceptance, and reduce transportation costs. Community involvement in selection and distribution should be encouraged. RR should be good role models for the community. Personal interviews can aid in selecting RR with good interpersonal skills, a spirit of volunteerism and a belief in FP / RH. **Strength: Many possess a spirit of volunteerism.**
2. Roles and responsibilities
 - ▶ Roles should be expanded to include other aspects of health and development such as family health, socio-economic development, communication within the couple, etc. RR roles and responsibilities should be adapted and tailored to the individual communities served and community health service providers should be aware of the RR's role. Expanding the role and number of male CHWs is required to address male issues. Job descriptions should be modified to reflect these changes. **Strength: RR eager to have their roles expanded.**
3. *Raedat rifiat* training
 - ▶ Existing training curricula should be used and modified as required. Training programs should be planned in a way to ensure continuous on the job training, updating and feedback with development of localized training strategies. Training should be both theoretical and practical and should be expanded to include topics that are the community's concern especially, management of FP methods side effects, and behavior change communication. To ensure sustainability clinic staff should be involved in RR training. **Strength: Existing cadre of trained RR and training curricula.**
4. *Raedat rifiat* management and supervision
 - ▶ Management and supervisory systems should be decentralized to the governorate level to facilitate decision making by officials implementing the program. Facilitative supervision practices should be instituted



involving the health team at the unit level .Standards of practice for RRs should be developed and incorporated within the health team and facility supervision checklists. Activities should be strengthened through the provision of job aids, enhanced use of available resources and experience exchange. RR performance should be evaluated on quantitative and qualitative indicators including client satisfaction, quality of home visits, and degree of RR motivation. **Strengths: Policy makers ready to implement change to increase program effectiveness.**

5. Working conditions

- ▶ Creating a clear career structure for upward mobility and personal advancement for RR is recommended .Thus issues related to temporary and permanent employment status should be considered addressing the pros and cons of both situations. The high spirit of volunteerism should be acknowledged using financial or non-financial rewarding systems.

6. Relationship with the clinics

- ▶ RR should be accepted as part of the clinic team. Regular meetings between clinic health care professionals and RR would provide on the job training on a regular basis, and permit RR to update clinic staff on community needs, common health problems, rumors, misconceptions and trends. A referral mechanism should be established rewarding referred clients with an extra advantage. **Strengths: Current health care infrastructure includes network of FP/RH services.**

7. Relationship with the community

- ▶ RR should be involved on local committees to facilitate their integration, enhance their credibility and increase their acceptance as important community resources. The mass media could be tapped to polish the CHWs' image and explain their role within the community. **Strengths: Many CHWs well accepted by hard to reach populations.**



8. Coordination among organizations with CHW programs

- ▶ Increased coordination would minimize duplication of visits, reduce workload, reduce message inconsistency and increase geographic coverage. Regular meetings of senior community officials are recommended to define roles and responsibilities for each organization and assign CHWs to villages. Creation of a database including all organizations working with CHWs could be shared among the various health and community groups.

9. Modeling successful programs

- ▶ A mechanism for exchanging experiences and sharing lessons learned should be developed. Successful programs and projects such as the Fayoum Project should be studied and modeled. **Strengths: Several projects successfully utilizing community health workers already.**

10. Research Recommendations

- ▶ Operations research need be conducted to evaluate effective interventions that might enhance the role of RR and affect their outputs and outcomes e.g. distribution of contraceptive pills – impact of possible integration of traditional healers with conventional RR system- changing workload and its effect on RR performance.
- ▶ Cost benefit studies are needed to examine questions related to the use of *raedat* as an effective alternative to other comparable interventions and whether it is appropriate to use cost as a measure of success.
- ▶ Further studies are needed to evaluate the impact of various supervisory, remuneration and training systems on RR performance and client outcomes.



Annex 1 Resource Materials

- Abdel Razik, Madiha, M. S Amin, and E. Abbas," *Study of the Effect of the New Training System for Raedat Rifiat on Promoting their Role in Family Planning within the National Population Council Program.*" Cairo, 1991.
- Berman, P. A., D. R. Gwatkin, and S. E. Burger. "Community-based Health Workers: Head Start or False Start towards Health for All?" *Social Science Medicine* (1987): 25(5): 443-459.
- El Shaffei, M. and Madiha Abdel Razik, "Family Planning Home Visiting Program" Cairo: Ministry of Health and System Development Project, 1994.
- Fayoum Reproductive Health and Family Planning Project." *Results of a Study on the Knowledge, Attitudes and Practices of Women in Itsa District.*" Cairo, Egypt, 1997.
- Gumei, M. et al., "Development Approaches to Community-based Family Planning Outreach in Egypt: Assessment of Raedat Rifiat Programs." Alexandria, Egypt: University of Alexandria and Faculty of Nursing, 1995.
- Haddad, May, Nawal Najar, and Alia El Mohandes and community health workers, "Enhancing the Capabilities of the Female Health Worker: A Thousand and One Tales from Arab Communities." (Cairo, Egypt: ARC)
- Report on TAHSEEN / Policy's Activities with Raedat Rifiat from MOHP on Advocacy for Reproductive Health and Family Planning. Cairo, Egypt: 2002.
- Stolba, S. "Sustainability of the Health Promoters System." *Monitoring Mission Report* (Cairo, Egypt: Fayoum Rural Health and Family Planning Project, 1996.)
- Zaki, A. et al, "Study of the Evaluation of the Performance of Raedat Rifiat: 2000." Cairo, Egypt, Ministry of Health and Population and Pathfinder, 2000.



Annex 2 Organizations Contacted

Organization	Contact Person
MOHP	Dr. Amal Zaki
MOHP	Dr. Fatma Barakat
PHCUP	Dr Magda El Sherbini
JSI	Mr. Khaled El Sayed
EFPA	DR. Mohamed Farid
CEOSS	Mr. Nadi Kamel
MOSA	Mrs. Sadya Zaki
Dutch Embassy	Ms. Arlette Osseiran
SPAAC	Dr. Sarah Loza
Frontiers in Reproductive Health Project	Dr. Laila Nawar
Fayoum Health Project	Dr. El-Saadi Faisal
Fayoum Health Directorate	Dr. Mona Aziz
RR	Menoufia Governorate
Ministry of Agriculture	Dr. Ahmed Hiba
Ministry of Local Affairs	Dr, Mostafa Abd Elfatah
CSI	Ms. Afaf El Gohary
Ford Foundation	Dr. Maha El Adawy



Annex 3 Minia CHWs Round Table Discussion Participants

#	Name	Position	Organization
1	Hanan Ali Abou – Zeid	RR supervisor	MOHP
2	Ibtisam Kamel Nakhla	RR supervisor	MOHP
3	Nagat Zeinhom Mohamed	RR supervisor	MOHP
4	Sylvia Sadek	RR supervisor	MOHP
5	Wafika Matar	Nurse inspector	MOHP
6	Hayam Atteya Abbas	Health visitor	NGO
7	Zeenat Mohamed Ali	Health visitor	NGO
8	Hoda Mohamed Rateb	RR	MOHP
9	Fatma Waguih Abdel-Monein	RR	MOHP
10	Feryala Ibrahim Ahmed	Health volunteer	NGO
11	Samia Mahmoud Marzouk	Clinic director	CSI
12	Naglaa Fathi Mohamed	Technical specialist	CSI
13	Amira Abdel-Fattah	Director of Women's Affairs	Minia Governorate
14	Ragaa Mohamed Abdel-Meguid	Director of Women and Development	MOSA
15	Dr. Marcelle Labib	MCH director	MOHP
16	Dr. Atef Ezzat	FP director	MOHP
17	Azza Foud Mandy	Mobile clinics officer	MOHP
18	Sabreen Ali Mohamed	Supervisor of women's clubs	MOHP
19	Amal Mohamed Fathi	Supervisor of squatter areas	MOHP
20	Nadia Mohamed Eisa	Rural development officer	MOA
21	Amal Boshra Ayad	Director of health project	NGO
22	Raymonda Waheeb Wahba	Director of women's affairs	MOSA
23	Amal Ayad Yousef	Health coordinator	NGO



Situation Analysis of FP/RH Outreach Workers in Egypt

	Name	Position	Organization
24	Dr. Iman Helmy Sadek	Program specialist	NGO
25	Mona Wadee Ibrahim	Rural development officer	MOA
26	Badreya Ramadan Badawy	Rural development officer	MOA
27	Dr. Amal Zaki	RR officer	Population Sector
28	Dr. Maha El-Rabbat	Assistant Professor of Public Health	Cairo University
29	Dr. Mawaheb El-Mouelhy	NGO specialist	Tahseen Project
30	Dr. Nahla Abdel-Tawab	BCC specialist	Tahseen Project



Annex 4 Community Health Worker Job Descriptions

MOHP RR

- Collection of demographic data for the geographical area for which she is responsible
- Development of a monthly plan for home visits to cover the geographical area with the approval of the supervisors
- Advertising for RH and FP services
- Advertising for the MOHP services
- Supporting FP methods users with information regarding method use, referrals for supporting continuation and decreasing side effects
- Targeting FP non users with continuous advertisement to encourage their reuse or to attract new users
- Visiting recent discontinuers to provide them with information and support and refer them if needed
- Conducting postpartum home visits to help and support FP needs by supplying information and referring them if needed
- Record keeping
- Referring of cases that require health services and RH services as antenatal, child vaccination and ARI cases in children

Female Population Educator

- Liaising between MOHP FP units and the surrounding area to help and support FP users, motivating new users and advertising for FP and RH in the surround area.
- Working under supervision of the urban unit physician and nurse, the district supervisory team, and the educators' supervisor
- Implementing all previously mentioned MOHP RR responsibilities
- Disseminating information inside the unit for small client groups and within community with small groups of women of reproductive age to curb rumors and inaccurate perceptions and encourage correct use of FP methods



Male Population Educator

- Community identification
- Designing a monthly plan and seminar timetable
- Advertising and implementation of health and population education activities; awareness-raising and motivation of newly married men to the use of FP/RH services
- Spreading information and correcting knowledge of men and youth in the field of RH and FP
- Raising awareness about health units
- Supporting FP male users with information in order to decrease the related side effects of contraceptive methods to insure sustainability
- Approaching non-users communities with proper information about FP methods and motivating their use
- Collaborating with RR to approach male FP refusers
- Implementation of seminars for school and other youth and adolescent groups to curb rumors and inaccurate perceptions
- Coordinating with other RH advocates
- Coordinating the work with community leaders and local authorities

FaRHFP Murshidat in Rural Health Units

- Performing quarterly home visits to approximately 400 families
- Advising on a broad array of RH issues
- Giving advice on child care
- Providing nutrition and breastfeeding education
- Promoting sanitation and hygiene
- Making health care and other referrals
- Assisting in rural health facility activities
- Helping in eradication campaigns
- Conducting IEC sessions on reproductive health at rural health facilities
- Supporting women in empowerment endeavors

