Extending Service Delivery Project

Best Practices Series Report #3

The TAHSEEN Model for Reaching the Urban Poor in Egypt

A Promising Practice

May 2007

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What is ESD?

The Extending Service Delivery (ESD) Project, funded by the United States Agency for International Development (USAID) Bureau for Global Health, is designed to address unmet need for family planning (FP) and increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, in order to improve health and socioeconomic development. To accomplish its mission, ESD strengthens global learning and application of best practices; increases access to community-level RH/FP services; and improves capacity for supporting and sustaining RH/FP services. ESD works closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associates Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
BCC	Behavior Change Communication
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
HTSP	Health Timing and Spacing of Pregnancy
MCH	Maternal and Child Health
MOHP	Ministry of Health and Population
MOU	Memorandum of Understanding
NCCM	National Council for Childhood and Motherhood
NGO	Nongovernmental Organization
OB/GYN	Obstetric/Gynecology
P/BPs	Promising/Best Practices
RH	Reproductive Health
RH/FP	Reproductive Health and Family Planning
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

The Extending Service Delivery (ESD) project works to expand access to Reproductive Health and Family Planning (RH/FP) services among poor and underserved groups at the community level. ESD is mandated to identify, document, and disseminate Promising and Best Practices (P/BPs) in RH/FP for application at the community level and for a broader exchange. ESD has identified the TAHSEEN model for reaching the urban poor in Doweika, Cairo, Egypt as a successful model and P/BP for reaching urban poor communities with needed health and social services.

In 2004 and 2005 the TAHSEEN project (2003-2005)—a USAID-funded RH/FP project managed by the CATALYST Consortium (2000-2005)—adapted and implemented an integrated, multisectoral RH/FP model in Doweika, an impoverished urban settlement on the outskirts of Cairo. TAHSEEN implemented the project in partnership with the Egyptian Ministry of Health and Population (MOHP); the National Council for Childhood and Motherhood (NCCM)—a quasi-governmental agency that works in the area of mother and child protection and development; Asheera Mohamedia—a faith-based Nongovernmental Organization (NGO) with a long presence in Doweika; and other private sector partners, including the German University of Cairo, and the Heliopolis Rotary Club.

The project strengthened and expanded the health services available at the Asheera Mohamedia clinic and added new social services such as literacy, sewing, and needlework classes. It mobilized the community to use the services available at Asheera Mohamedia and increased community awareness about harmful practices and support for healthy behaviors such as delaying age at marriage and first pregnancy and healthy timing and spacing of pregnancies (HTSP).

TAHSEEN renovated the Asheera Mohamedia site. The NCCM conducted literacy, sewing, and needlework classes and trained outreach workers in RH/FP and interpersonal communications skills. At the community level, the project partners raised awareness about RH/FP issues and mobilized residents to use the health and social services available at Asheera Mohamedia. They conducted seminars for parents and youth on RH/FP and other social issues, organized a child, environment, and community health program to engage local youth in community service projects, conducted Behavior Change Communication (BCC) activities such as plays and puppet shows that addressed various RH/FP and gender topics. They also initiated the Arab Women Speak Out program to help women build their self esteem, start income generating activities, and develop negotiation skills to better communicate with their families.

Results from service statistics and pre- and post-knowledge tests demonstrated an increase in the total number of clients served from 602 in September, 2005 to 1096 in April, 2006. The total number of clients accessing OB/GYN services also increased from 135 clients to 242 clients during the same period. Results obtained through knowledge tests administered before and after the literacy class facilitators training events, BCC activities, and youth activities also demonstrated statistically significant knowledge gained about RH/FP topics.

Interviews with key informants also showed positive effects of the TAHSEEN intervention.

Literacy class participants indicated that the RH/FP messages they received as part of their literacy education improved their knowledge and attitudes regarding RH/FP and social issues such as the health benefits of birth spacing and delaying age of marriage. The NCCM Doweika manager and Asheera Mohamedia manager emphasized that the TAHSEEN intervention successfully addressed the community's need for new clinical services and social programs.

This report describes the process and the specific activities undertaken by TAHSEEN to improve health and social standards of Doweika residents and determines whether the TAHSEEN model for reaching the urban poor is a promising or a best practice. The challenges and lessons learned from the implementation experience to guide adaptation in other settings are discussed. Several programmatic activities have been proposed as a result of this report, including linking health and non-health activities to maximize local resources and enlisting the support of religious leaders for community buy-in.

BACKGROUND

Introduction

The Extending Service Delivery (ESD) project works to expand access to Reproductive Health and Family Planning (RH/FP) services among poor and underserved groups—including the urban poor—at the community level. To this end, ESD is mandated to identify, document, and disseminate Promising and Best Practices (P/BPs) in RH/FP for application at the community level and for a broader exchange. ESD has identified the TAHSEEN model for reaching the urban poor in Doweika, Cairo as a successful model for reaching urban poor communities with needed health and social services.

The TAHSEEN project - *tahseen sihitna bi tanzeem usritna* or improving our health by planning our families - was designed to address the service-delivery gaps that persist across income levels and geographic regions in Egypt by increasing the use of RH/FP services among underserved populations, including the rural and urban poor. TAHSEEN (2003-2005) was managed by the CATALYST Consortium, a global RH/FP activity funded by USAID.

TAHSEEN developed an Integrated Multisectoral RH/FP Model that focused on

- Strengthening clinics' quality of care through integrated RH/FP and Maternal and Child Health (MCH) services, pre- and in-service trainings, clinic renovations, and trainings in management and technical skills for service providers;
- Community mobilization through involvement of key stakeholders to increase awareness of and support for RH/FP; and
- Sustainability efforts including, training of clinic providers in evidence-based medicine, revitalization of clinic boards, creation of a clinic service improvement fund, expansion of the private sector's role in service provision and community mobilization, and corporate social responsibility activities.

TAHSEEN introduced and tested the Integrated Multisectoral RH/FP Model in five prototype communities in the Minia governorate in Upper Egypt. As the model took hold, lessons learned from the initial five communities were used to refine the model for scale-up. By June 2005, the model was scaled up to a total of 69 communities in 5 governorates (Minia, Beni Sueif, Fayoum, Giza, and Cairo) including 3 urban poor areas in Cairo. The TAHSEEN project covered approximately 1.5 million people. The sequence, pace, and variety of activities within the model were adapted to suit the particular needs of each governorate and target community.

In 2004, the Egyptian Ministry of Health and Population (MOPH) requested that TAHSEEN implement its model in three urban poor areas of Cairo. TAHSEEN established a partnership with the National Council for Childhood and Motherhood (NCCM) to implement the Doweika intervention.

ESD uses the following definitions, which take into account definitions established by other projects and collaborating agreements such as Advance Africa, Implementing Best Practices/WHO consortium, and USAID/Washington:

Best Practice: A specific action or set of actions with proven evidence of success and the ability to be replicated or adapted. Evidence of success is demonstrated through qualitative and quantitative information regarding the practice.

Promising Practice: A specific action or set of actions that has the potential to become a BP but requires further evidence of success.

According to ESD's definition, "a specific action or sets of actions," may include program models as well as technical guidelines and protocols.

Documentation Strategy

Information for this report was gained through review of programmatic reports and site visits to project implementers and beneficiaries.

Context

Egypt has faced rapid urbanization in the last two decades. Primarily the result of migration from rural to urban areas, this urbanization has led to the creation of informal settlements[1] on the outskirts of larger cities such as Cairo, Alexandria and the North Delta, and Suez. Most migrants are young and poor and have traveled to cities in search of employment. Seventy percent of the Cairo population lives in more than 79 informal settlements.[2] Mansheit Nasser, one of the largest informal settlements in Cairo, has a population of 2.1 million.[3] The majority of its residents migrated from Upper Egypt in the 1960s, but the settlement continues to absorb newcomers. In recent years, people driven from Central Cairo by increasing housing costs have settled in Mansheit Nasser.

Doweika, the area within Mansheit Nasser where the TAHSEEN project implemented its integrated model for reaching the urban poor, has a population of 64,000.[4] It meets the United Nations criteria for urban slum: the population in Doweika has no access to potable water, the area has no closed sewage system, living areas are overcrowded (4.3 individuals per room), many of the building are dilapidated, and some residents are living in tents. There are no social services available, few schools, and few common areas for the community to socialize. The area suffers from chronic unemployment, and for the few that are employed, work is not regular and often presents occupational safety concerns. Most men work in tile making, marble work, carpentry, plumbing, mechanics, and auto body repair. Doweika has one government health center that provides basic health services. Two comprehensive hospitals serve as referral centers.

[1] *Informal settlement* is defined as an area developed without plans nor construction permit on land owned by the State.
[2] Cairo Healthy Neighborhood Program: Situation Analysis with Literature Review and Stakeholder Meetings. Environmental Health Project (EHP). USAID Activity Report 123. 2004.
[3] *Preliminary Situation Analysis: Doweika Mainsheet Nasser Slum Area. USAID/TAHSEEN. August 2004.*
[4] Ibid.

There is a high prevalence of domestic and gender-based violence, crime, drug addiction, and related problems, a high illiteracy rate as many children are sent off to work to complement family income, and poor health. The primary health issues affecting the Mansheit Nasser residents are summarized in Table 1.

Table 1: Primary health issues affecting the Mansheit Nasser residents

	Mansheit Nasser (1)	All Egypt Urban (2)	All Egypt (2)
Health issues affecting children < 5 years:			
% with Acute Respiratory Infection (ARI) in 2 weeks prior to study	49%	8%	**9%**
% with diarrhea in 2 weeks prior to study	42%	6%	**7%**
% underweight for age	18%	3%	**4%**
RH/FP			
% birth at home	80%	30%	**52%**
% live births assisted by trained health provider	63%	81%	**61%**
% mothers that made at least 4 ANC visits	0%	54%	**37%**
% use of any FP method	**46%**	**61%**	**56%**

1. Cairo Healthy Neighborhood Program: Situation Analysis with Literature Review and Stakeholder Meetings. Environmental Health Project (EHP). USAID Activity Report 123. 2004
2. Egypt Demographic and Health Survey (DHS), 2000

To better understand these health statistics, TAHSEEN conducted a preliminary situation analysis and carried out Focus Group Discussions (FGDs) with community residents to tailor the project intervention to address the specific health and social needs of the community residents.

Preliminary Situation Analysis[5]

The primary purpose of the situation analysis was to identify the range and assess the quality of health services provided at the public sector health center. The main findings were:

- The health center provides a range of primary health care services including family medicine, immunizations, Antenatal Care (ANC), family planning, dental, and laboratory services, .
- RH/FP, ANC, dental, and laboratory services are all operational (i.e., clean, well equipped, and staffed);
- Family medicine, emergency care, pharmacy, and referrals either do not function or are limited in scope (e.g., poor quality, no assigned medical staff, shortages of essential drugs, no referral system, limited equipment and supplies).

[5] *Preliminary Situation Analysis: Doweika Mansheit Nasser Slum Area. USAID/TAHSEEN. August 2004.*

Focus Group Discussions with Doweika residents[6]

The results of 4 FGDs conducted with a representative sample of men and women ages 18-60 are summarized in Table 2.

Table 2: Key findings from FGDs with Doweika residents

Knowledge of existing health services
Aware of the area health facilities and services they offer
Use of area health facilities
Use the major Government hospitals in Cairo for emergency services, and the Government mobile clinics and hospitals for RH/FP services due to perception that quality of care is better at these facilities
Perceptions about the quality of health services provided at area health facilities
Poor quality, inconvenient hours of operation, and not affordable with the exception of FP services available from mobile clinics
Community needs for RH/FP services
Overall positive attitude toward RH/FP
Most use FP after the second or third child mostly to limit the number of children they have
Many believed that proper birth spacing interval is 4 to 6 years
Most had their first child 10 to 12 months after marriage
Community willingness to use a clinic operated by an NGO
Overall supportive of Asheera Mohamedia NGO clinic providing affordable health services with evening hours for working residents
Mentioned pediatrics, OBGYN, and internal medicine as most needed services

[6] Results of Mansheit Nasser *Focus Group Discussions. USAID/TAHSEEN. June 2004*

Focus Group Discussions with working adolescents[7]

The results of 6 FGDs conducted with working males and females between the ages of 12 and 18 years are summarized in Table 3.

Table 3: Key findings from the FGDs with working adolescents

Occupational health hazards
Long working hours (>10 hrs./day) in unsafe environment: poor ventilation, poor lighting; exposure to chemicals such as textile fibers in garment factories or chlorine in dry-cleaning industries, and other occupational hazards they are exposed to in metal, mechanics and wielding workshops
Existing health and safety measures at the workplace
No measures are in place to enforce safer work environments
Health needs of working adolescents
Requested more information about adolescent health especially STI transmission and health risks associated with smoking and drug use
Forms of violence affecting adolescents at home, in the workplace and in the community
Expressed concerns about existence of physical and verbal abuse at the workplace, at home, and in the community with some variations between boys and girls with regards to the type of violence they face
Perceptions about quality of services offered in the community
Expressed overall satisfaction with the health services provided in the area Voiced some concerns about the cost of services for adolescents over 18 years of age and drug shortages
Requested expansion of health services to include pediatrics, RH/FP, ophthalmology, and dermatology

[7] Assessment of the Health Needs of Working Adolescents. Results of Focus Group Discussions in El Herafeyeen Area, El Salam City. USAID/TAHSEEN. October 2004.

Focus Group Discussions on Gender Based Violence (GBV)[8]

TAHSEEN conducted 12 FGDs concerning GBV, divided by sex and age: 15-24, 25-45, and 45 years and above for men and 15-24, 26-43, and 44-62 years for women. The key findings are summarized in Table 5 below.

Table 5: Key findings from the FGDs on GBV with women and men

Women	Men
Knowledge of forms, causes and perpetrators of GBV	
Identified domestic violence including verbal and physical violence, beating of girls, sexual harassment, cursing, forced sex within marriage, forced marriage, Orfi or common law marriage; polygamy, rape, honor killing as forms of GBV Perceived FGC to be a violent act (26-43 years) Did not perceive FGC to be a violent act (15-24 years and 44-62 years)	Mentioned beating, sexual harassment, cursing, extra-marital affairs, early and forced marriage, and defloration of the hymen as forms of GBV (all men.) Did not perceive FGC and polygamy as forms of violence against women (all men) Perceived defloration of hymen and FGC were justified to verify a woman's virginity (all men)
Mentioned unemployment, financial constraints (all women) Identified men as perpetrators of GBV and listed work, financial stress, and being threatened with polygamy as contributors (26-43 years) Cited women's behavior such as talking back, neglecting household cleanliness, and going out without a man's permission as main causes for domestic violence (15-24 years) Identified cultural norms that accept men's dominance and beating (44-62 years) Identified in-laws as inciting domestic conflict (44-62 years)	Younger men more likely than older men to use physical violence. Low socio-economic status, stress, use of alcohol and drugs mentioned as contributing factors to GBV (all men) Beating and cursing acceptable ways for disciplining a woman who "misbehaves" e.g., does not obey orders from a man, mistreats her children, discusses private matters with other family members, engages in a relationship with a man without parental consent, spends husband's money on family (15-24 years) Working adolescent female perceived as contributing factor to GBV (25-44 years)

[8] Gender Based Violence (GBV) in Manshiet Nasser. USAID/TAHSEEN. February2005.
Gender Based Violence: Results of the Focus Group Discussions in Herafeyeen Area-Manshiat Nasser. USAID/TAHSEEN. July 2004

Ways to address GBV	
Cited lack of alternative economic support (i.e., income) and concerns for children as main reason for women not taking any action (15-24 years) Mentioned fighting back, keeping quiet, and negotiating with men (25-43 years) Seek help from a religious leader to resolve marital conflict (25-43 years) Mentioned reliance on neighbors; negotiation with men	Educate women on how to deal with men and fulfill their requirements (15-44 years) Provide services to GBV victims, and offer activities to improve the socio economic status of the community (15-44 years) Address social issues such as drug and alcohol addictions, and provide education and other social services to help minimize social problem (all men) Involve religious leaders in discussing GBV (15-25 years) Create social clubs (<45 years) Create income generating activities to address unemployment (15-44 years)
Services available to address GBV	
No organization exists that provide services to address GBV.	No organization exists that provide services to address GBV. GBV is addressed within the family, or with assistance of neighbors and friends (all men).
Perception about what the community needs from government, NGOs, and residents to stop GBV	
Create employment opportunities for youth and women (small home projects) Involve community leaders Provide community services; create playgrounds Implement activities to empower women: sessions on GBV and communications skills Monthly lectures for residents and religious leaders, doctors, policemen on communication skills, interpersonal relationships, equal treatment of boys an girls, dealing with husbands; violence; etc.	GBV awareness sessions for men and women at NCCM (15-24 years) or at the health center (25-44 years) during hours where it will not interfere with women's work. Services to increase socio economic status of men (15-24 yrs.) Train women as community leaders and provide advice to their peers (<45 yrs.) Social clubs for youths that teaches them life skills (25-44 yrs. and <45 yrs)

PROGRAM DESCRIPTION

Description

The primary objective of the TAHSEEN intervention was to improve the RH/FP status of Doweika residents. The intervention had three specific objectives:

- Strengthen health services at Asheera Mohamedia,
- Mobilize the community to use the health and social services at Asheera Mohamedia, and
- Increase community awareness about selected health practices.

A memorandum of understanding (MOU) was negotiated and signed between TAHSEEN, the Egyptian MOHP, and the NCCM that laid out the roles and responsibilities of each partner.

TAHSEEN renovated the Asheera Mohamedia premises, conducted seminars on RH/FP for parents and youths, and, in coordination with the NCCM, trained outreach workers (*raidat hardariat*) on RH/FP topics and communications skills. It also led Behavior Change Communication (BCC) and youth activities in the community. The Egyptian MOHP staffed the Asheera Mohamedia NGO clinic with health care providers and supplied drugs and contraceptive methods. The NCCM – a quasi-government agency that works in the area of mother and child protection and development – was responsible for assuring the clinic physicians' salaries and clinic staff supervision. It coordinated the literacy classes and women's club activities, including sewing and needle work classes at the Asheera Mohamedia NGO site. It is important to understand that the NCCM had already established a strong presence in Doweika where it had been implementing another project called Towards the Progressive Elimination of Child Labor, with funding by the Italian Cooperation, and in collaboration with Asheera Mohamedia NGO.

Collaboration with private sector partners

Other private sector partners that did not sign the MOU but also contributed to the project intervention through in-kind donations included Asheera Mohamedia, a faith-based NGO who provided the premises and assisted NCCM with the management of project activities. The Heliopolis Rotary Club contributed tables and chairs for the literacy classes and Women's club, as well as sewing machines. The German University of Cairo sent some of its art students to paint the Asheera Mohamedia outdoor playground and courtyard.

TAHSEEN contributed $93,103 in cash toward this project. The total non-USAID contribution was $82,138 in kind.

Program activities were implemented at both the Asheera Mohamedia site and in the community. For a detailed activity timeline see Annex 1.

Activities implemented at the Asheera Mohamedia site

Prior to the TAHSEEN intervention, Asheera Mohamedia had an on-site day care and provided services to support orphans and their families. It also offered religious classes and health services (internal medicine, dental care, and laboratory services) at the NGO clinic.

Renovation of Asheera Mohamedia

TAHSEEN began the renovation of the Asheera Mohamedia premises, including its clinic, in September 2004. It added OB/GYN, pediatrics, ophthalmology, and dermatology services (the needs that had been identified during focus group discussions). TAHSEEN completed the NGO renovation, including procurement of medical equipment, in December 2004. The MOHP staffed the clinic with physicians and provided contraceptive supplies. TAHSEEN worked with Asheera Mohamedia to form a clinic board comprised of clinic staff and men and women from the Doweika community, and trained the clinic board members in clinic management and RH/FP. The Clinic Board played an important role in assuring that the clinic addresses community needs. The NGO was open from 10:00 AM to 10:00 PM, seven days a week, and the clinic from 9:00 AM to 2:00PM. Clients paid a 3LE fee for health services most days, but only 1LE on Wednesdays.

Literacy classes and Women's club classes

NCCM organized and conducted literacy classes, sewing, and needlework classes at Asheera Mohamedia beginning February 2005.

To be able to participate in these sewing and needle work classes, the women and girls first had to graduate from the literacy class.

NCCM identified the literacy teachers, and TAHSEEN trained them in RH/FP messages using a five-module curriculum that incorporated RH/FP messages. Classes took place throughout the day (between 10:00 AM and 10:00 PM) so that working men, women, girls, and boys could participate. There were a total of 8 classrooms, holding 20 students each. Classes were held in two-hour sessions, 5 days a week, up to a maximum of 12 weeks. Female students who graduated from the program were awarded a sewing machine, a gift from the Heliopolis Rotary Club.

The literacy classes were free, but the sewing and needlework classes were offered for 4LE per month. The NGO also charged a 25LE monthly fee for day care.

Training of outreach workers or Raidats Hadariat *in RH/FP messages and communication skills*

NCCM trained seven female outreach workers in RH/FP messages and communications skills using a curriculum developed by TAHSEEN.

Through household visits, the outreach workers brought men and women from the community to seminars on RH/FP and other social issues (e.g. drug addiction, domestic and gender based violence, female genital cutting, school drop out, etc.). The outreach workers also informed the community about the services available at Asheera Mohamedia NGO. They received a small stipend from NCCM.

Activities implemented at the community level

The project implemented four programs at the community level to raise awareness about RH/FP issues and to mobilize the community to use the health services available at Asheera Mohamedia. These programs included seminars for parents and youth, Child, Environment, and Community Health Programs, BCC activities such as plays and puppet shows, and Arab Women Speak Out. The four programs are described below.

Seminars for parents and youth

NCCM organized seminars for parents and youth to increase awareness about RH/FP and issues such as drug addiction, school drop out, female genital cutting (FGC), and early marriage. The program began in February 2005 and operated four days a week.

Child, Environment, and Community Health Program

Youth activities began in December 2004, and were modeled after the *Shabab* (youth) Week program TAHSEEN implemented in Upper Egypt[9]. The Child, Environment, and Community Health Program engaged local youth in community service projects such as tree planting, classroom furniture repair, and painting of schools. During the program, youth also participated in health-related seminars on topics such as personal hygiene, early marriage, FGC, Healthy Timing and Spacing of Pregnancies (HTSP), and drug addiction. These were conducted by TAHSEEN staff in collaboration with NCCM.

Twenty-one boys and girls participated in the first Child, Environment and Community Health Program, and the program continued on a bi-weekly basis through January 2005. During that period, 102 youth from Doweika participated in the program. NCCM replicated the program with European Union donor funds in three other Mansheit Nasser districts.

Because of the sensitivity of some of the RH/FP topics addressed during the youth program, TAHSEEN and NCCM decided to include parents in some of the discussions to ease their concerns.

[9] Best Practices in Egypt: Youth Awareness and Action (Shabab Week). TAHSEEN. 2005

Behavior change communication (BCC) program

TAHSEEN developed and produced a play called The Correct Decision to increase community awareness about topics of concern to Doweika residents such as substance abuse and HIV/AIDS. The play also addressed various RH/FP topics (e.g., premarital counseling and HTSP) and other gender issues (e.g., early marriage, preference for boys) and reached 2,000 residents during the initial five performances. TAHSEEN also developed and conducted a puppet show to inform youth about various RH/FP issues. The puppet show was performed on three occasions in conjunction with other youth activities.

Arab Women Speak Out

TAHSEEN originally implemented the Arab Women Speak Out program to empower women in Upper Egypt. It helped women build their self esteem, develop negotiation, networking and decision-making skills, identify sources of information and support, access resources, participate in public life, and safeguard their own health. TAHSEEN replicated the program in Doweika with 30 outreach workers and women in the community to build their confidence so they could better negotiate with their husbands and families and start income-generating activities in their communities.

RESULTS

To validate the TAHSEEN model for reaching the urban poor as a P/BP, ESD reviewed programmatic documents to identify the program's impact and conducted meetings with key informants to collect additional qualitative information needed to strengthen the evidence. The findings are summarized in the section below.

Results from service statistics and pre- and post-tests

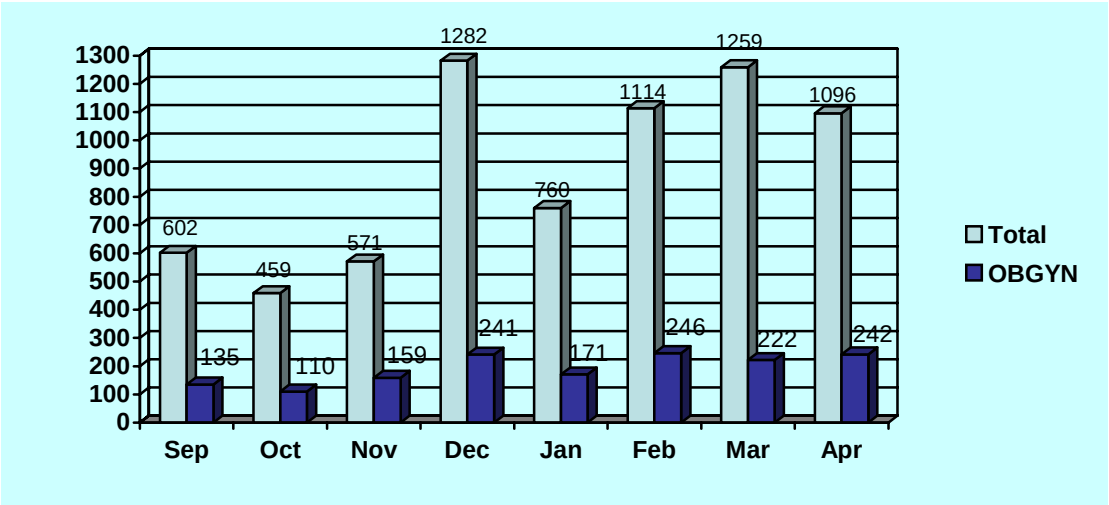
TAHSEEN relied on health statistics collected through an assessment carried out by USAID in 2004 for baseline data.[10] It collected service statistics from the Asheera Mohamedia clinic and used pre- and post-test scores to determine the success of community mobilization activities.

Increase in utilization of Asheera Mohamedia NGO clinic services

Service statistics were available from September 2005 on, after TAHSEEN support ended. As demonstrated in Graph 1, the total number of clients served at the Asheera Mohamedia clinic increased from 602 in September 2005 when the clinic began to operate to 1096 in April 2006. The total number of clients accessing OB/GYN services (gynecological exam, ANC, and FP) increased from 135 clients to 242 clients during the same period.

[10] Cairo Healthy Neighborhood Program: Situation Analysis with Literature Review and Stakeholder Meetings. Environmental Health Project (EHP). USAID Activity Report 123. 2004.

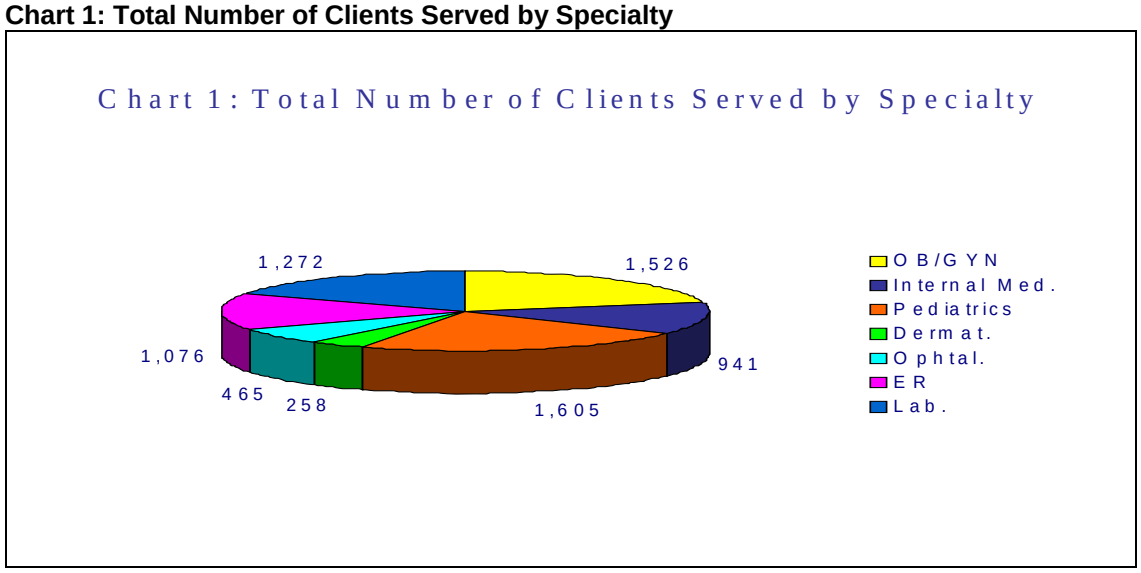
Graph 1: Total and OBGYN Visits at Asheera Mohamedia Clinic in 2005-2006



Source: Asheera Mohamedia service statistics. September 2005 to April 2006

As demonstrated in Chart 1, the most sought-after services during the reporting period were, in decreasing order, pediatrics (1605 clients), OB/GYN services (1526 clients), laboratory services (1272 clients), emergency care (1076 clients), internal medicine (646 clients), ophthalmology (465 clients), and dermatology (268 clients).

Chart 1: Total Number of Clients Served by Specialty



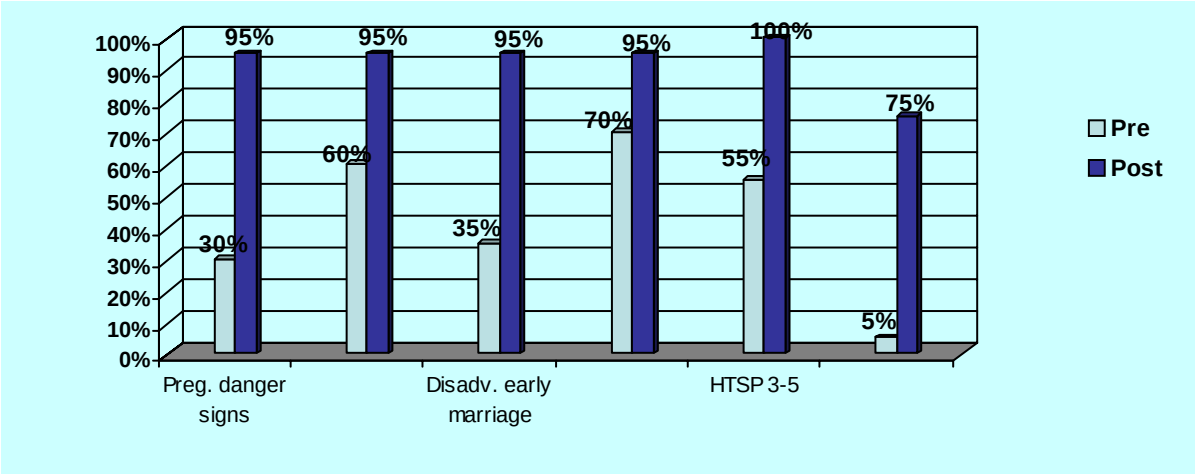
Increase in knowledge about RH/FP topics

The TAHSEEN intervention sought to develop awareness about different RH/FP issues among the Doweika residents. Graphs 2 through 4 present the results of knowledge tests administered before and after the literacy class facilitators training events, BCC, and youth activities. All knowledge gains detected are statistically significant. Except for play attendees, who represent a randomly selected sample of individuals, all other responses include the universe of beneficiaries.

Increase in knowledge about RH/FP topics among literacy class facilitators

TAHSEEN trained 20 literacy class facilitators on RH/FP using a five-module curriculum, incorporating RH/FP messages. A pre- and post-training knowledge test conducted with 20 literacy class facilitators demonstrated an increase in knowledge about RH/FP topics, as demonstrated in Graph 2.

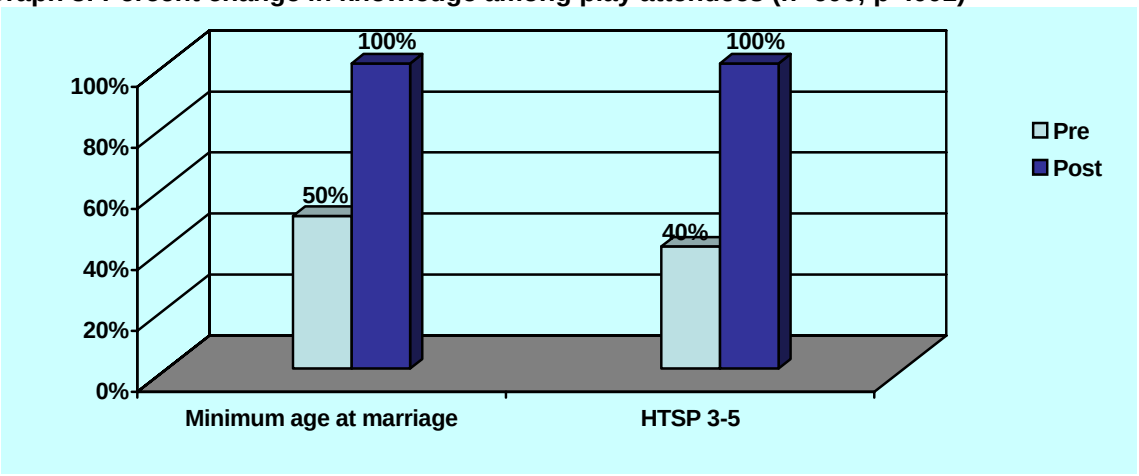
Graph 2: Percent change in knowledge among literacy class facilitators (n=20; p<.05)



Increase in knowledge about ideal age of marriage and HTSP among play attendees

TAHSEEN produced plays and puppet shows to reinforce key RH/FP messages. Graph 3 shows an increase in awareness about ideal age of marriage and HTSP among The Correct Decision attendees.

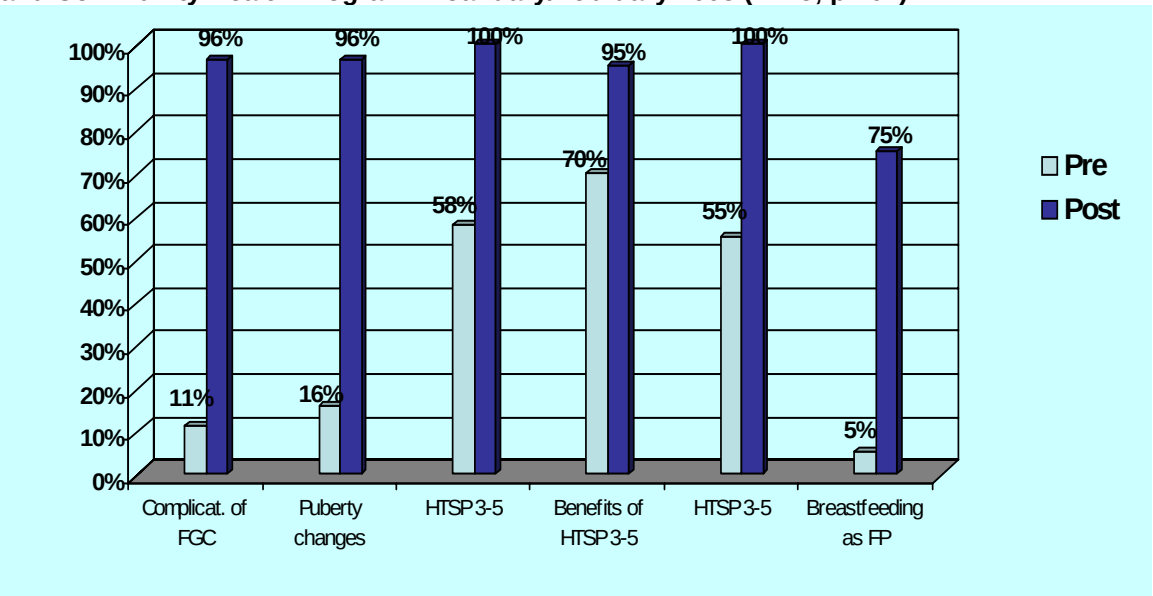
Graph 3: Percent change in knowledge among play attendees (n=600; p<.001)



Increase in knowledge about RH/FP topics among youth beneficiaries

The Child, Environment, and Community Health Program introduced young people to RH/FP issues and community service. As demonstrated in Graph 4, pre- and post-tests conducted with 45 youth demonstrated an increase in knowledge about RH/FP topics.

Graph 4: Percent change in knowledge among youth that participated in the Child, Environment, and Community Health Program in January/February 2005 (n=45; p<.01)



Results from meetings with key informants

To complement the monitoring and evaluation data collected and further understand the project, including achievements, challenges, and lessons learned, ESD staff interviewed three different categories of key informants:

- Literacy class beneficiaries;
- The manager of the Asheera Mohamedia; and
- The NCCM Doweika project manager.

Interview methodology

To guide the discussions with the key informants, ESD staff developed three sets of questionnaires (see Annex 2) with technical input from TAHSEEN staff. The questions were developed in English and later translated into Arabic at the meetings. At the meetings, key informants' responses were translated from Arabic to English for ESD staff who took notes of the discussions. The discussions were tape recorded and were later compared with the written notes for accuracy.

Meeting with literacy class beneficiaries

The meeting took place at the Asheera Mohamedia premises where literacy classes were conducted. The meeting was conducted with 10 literacy students and one NCCM outreach worker. The literacy teacher was also present. Six of the participants were young women in their twenties, three were in their forties, and one participant was 15 years old.

Participants learned about the literacy classes from announcements made by NCCM outreach workers after Friday prayers and during the NCCM organized seminars for parents and youths on RH/FP and social issues. Also, outreach workers spoke to the women in the community about the new health and social services available at Asheera Mohamedia. Support received from family members, peers, and literacy teachers encouraged the continued participation of women in the literacy classes. Participants emphasized that the teachers and the teaching approach were conducive to learning: "Teachers took time to explain the alphabet and lessons and treated us with respect." Women were very appreciative of the computer literacy sessions and Koranic teachings that they received as part of their literacy education.

Some of health messages that the women heard during the literacy classes included messages about the disadvantages of early marriage and the benefits of child spacing.

"Twenty years is the ideal age of marriage, the girl is capable of carrying out the pregnancy."

"I will not have my daughter married till she graduates from the university."

"I had 10 pregnancies and have 7 living children. I did not know about the benefits of spacing my pregnancies. Now, I tell my daughters, don't have another baby till the first one goes to school."

- Literacy class students in Doweika

The messages about the practice of FGC generated a great detail of discussion during the meeting. There were mixed views about the practice, some were in support while others opposed it. One participant stated that even though she had learned about the harmful effects of FGC, she could not stop it alone and that she needed the whole community to support halting the practice. Another participant stated that her husband tells her that the United States wants FGC to be stopped so that Egyptians "can be like them," like the Americans. This statement illustrates the perception that "Western" value systems challenge traditional beliefs.

"I am not going to lie to you and say that I will not circumcise my daughter. Yes, we did learn about the dangers of circumcision, but I was circumcised, I got married and had children, nothing happened to me. If I see the harmful results of circumcision, maybe I will be convinced."
- Literacy class student in Doweika

Participants who opposed the practice said that they are convinced from the awareness classes that they attended that circumcision does not guarantee chastity but proper upbringing does.

"It is a matter of upbringing [morals] that protects the girls [keeps her chaste]."

- Literacy class student in Doweika

TAHSEEN and NCCM staff took the opportunity to provide further clarifications about the practice. They emphasized that FGC is not mandated by Koran or the bible, but rather is a cultural practice and that the female genitalia is like any body organs that need to be kept intact.

"If we cut that body organ [genitalia], then we need to cut other body organs that cause us to make mistakes, like our tongue or hands; God created that part in us to satisfy our marital needs."
- NCCM Raeda

The participants also discussed the following gender-related ideas.

"I learned about gender equality. When we were growing up, we used to tell the girls to get things done for their brothers. Now, I involve my boys with everything in the house, so that later on they can help their wives."

"I found out that my older son is not helping his wife because I brought him up as such and I feel bad about it."
- Literacy class student

In addition, participants learned about the health services available at the clinic. Overall, literacy class beneficiaries had a very positive experience.

Meeting with the manager of Asheera Mohamedia

The next meeting was conducted with the Asheera Mohamedia manager. According to the manager, the perceived problems facing the population of Doweika are unemployment and lack of general cleanliness. The NCCM representative present said that the problems in Doweika can be divided into two kinds: 1) problems affecting the displaced population and 2) problems related to the *herafeyeen*—people working in marble making, plumbing, car body repairs, and other physical labor. The displaced population has been living in buildings for more than a decade that were meant for temporary housing. The major issues faced by the *herafeyeen* are related to industrial hazards and work safety issues.

Through its day care centers, the NGO is teaching children how to communicate with their families and peers in to resolve arguments. Children were also taught how to take care of their environment, for example, keeping their classrooms clean. The NGO manager articulated that the Asheera Mohamedia founder believed in reaching young children through social programs that foster their growth. The NGO also provides financial support to orphans and their families. To sustain some of its services, the NGO charges 4 LE for the sewing classes and 25 LE per child for enrollment in its day care centers.

The strengths that the NGO brought to the project partnerships included being a faith-based NGO with a long presence in the community and having a service commitment mentality. The

NGO manager pointed out that the NGO enjoys community trust and credibility because it is an Islamic institution with long service history in the community.

Meeting with NCCM doweika program manager

ESD staff developed a detailed questionnaire to be used with the NCCM representative. However, due to some scheduling conflicts, the NCCM representative could not answer all of the questions.

The NCCM representative managed several projects for the organization, and the Doweika project was just one of the projects under her supervision.

She started the meeting by providing a thorough overview of the NCCM project "Towards Progressive Elimination of Child Labor" in Doweika, through which TAHSEEN implemented the Doweika project intervention.

The NCCM Project Manager discussed the initial inception phase of the project where both formal (i.e., focus groups discussions) and informal (general observations) community assessments were done. When asked about the strengths that NCCM brought to the partnership; several strengths were pointed out. First was the financial support: NCCM paid for clinic staff salaries; for literacy facilitators, for *raedat* training and their monetary incentives. NCCM also paid for the participation of the community members (10 LE) at the awareness sessions.

NCCM played the role of coordinator between the local NGOs and the TAHSEEN project. They supervised the performance of the staff working at the Asheera Mohamedia NGO, since the Asheera had limited supervision and management experience. Some of NCCM lessons learned in Doweika included the importance of involving religious leaders from the beginning. The project faced some resistance from the religious community when RH issues such as FGC were discussed at the community awareness sessions. Another challenge was the lack of coordination among local NGOs. (This will be further elaborated.)

"We felt the needs of the community, we were there every day with the people…… to the extent that people did not distinguish who was NCCM and who was TAHSEEN. We all worked as one team and that's why I think we succeeded."
- NCCM Doweika Program Manager

In summary, NCCM manager credits the success of the intervention to the fact that the project directly addressed community needs that arose at different points of the project implementation phase and to the positive working relationship with the TAHSEEN project team.

DISCUSSION

Challenges

All of the implementation challenges that arose caused TAHSEEN and its partners to review and adjust their activities accordingly. Some of the most important challenges faced included:

Difficulties in staffing the Asheera Mohamedia clinic with public sector physicians

After the clinic renovation was completed it took eight months for the MOHP to staff the clinic with public sector physicians. Egyptian physicians are required by law to work in government hospitals in the morning. Hence, the MOHP realized after signing the MOU with USAID/TAHSEEN and NCCM that it could not staff the NGO clinic with public sector physicians. With support from Egypt's First Lady, TAHSEEN and NCCM were able to negotiate with the MOHP to allow public sector physicians to work at the NGO clinic for a six-month period. NCCM worked to identify private sector physicians to replace MOHP physicians after their contract ended. Asheera Mohamedia plans to tap into its own savings and rely on local donations and *zaka* (alms giving) to continue supporting its clinic and social programs - this strategy might not be sustainable in the long term.

Asheera Mohamedia's limited knowledge of development-related issues

Asheera Mohamedia staff had a limited knowledge of development issues. For example, they did not understand the concept of 'integrated approach' advanced by TAHSEEN, nor did it understand why NCCM, which was implementing a child labor prevention project in Doweika, was also organizing discussions on RH/FP. When NCCM and TAHSEEN facilitated the first discussions on these topics during the FGDs and the seminars for parents and youths, it encountered great resistance and created confusion among community members and the NGO staff. Ongoing discussions and engagement of local leadership among community members helped to ease some of the tension.

Short project implementation timeframe

The project activities were implemented over a short (14-month) period in the last year of the TAHSEEN project. Moreover, the NGO clinic was only staffed with public sector physicians supported by NCCM for 6-month contracts in the first month after USAID/TAHSEEN support ended. Hence TAHSEEN was not able to evaluate the longer term effect and impact of its project activities in the community.

Long term sustainability

NCCM's support of Asheera Mohamedia activities and overall presence in Doweika will end in 2007 when the Towards Progressive Elimination of Child Labor project ends. Asheera Mohamedia plans to tap into its own savings and rely on local donations and *zaka* (alms giving)

to continue supporting its clinic and social programs. Asheera might have to explore other strategies to sustain its program.

Limited coordination efforts between NGOs in Doweika

Coordinated efforts to provide health and social services to residents in Doweika were almost nonexistent between NGOs. The NGOs were not aware of the services each provided nor did they know how to coordinate their activities to address community needs. Also, there was little dialogue between the community and the NGOs. When moving to a new site, NCCM plans to work with NGOs to help them coordinate activities and build partnerships to maximize the use of local resources.

Lessons learned

- Applying a multisectoral approach that integrates RH/FP services and information into other health and social services and engages the public and private sectors to support RH/FP, allowed TAHSEEN to introduce RH/FP services and information in hard-to-reach and poor communities while simultaneously addressing other community concerns (e.g., violence, drug addiction, gender issues).

- Identifying the right partners from different sectors (government, quasi-government, NGO, and private sectors) and discussing what each has to gain from and contribute to the partnership is key to the achievement of the project objectives and goal.

- Involving the community in all stages of the project from the identification of problems to their resolution, builds community support for the project and thus contributes to its programmatic sustainability. The community can be involved by using local labor for renovations, identification of women community leaders to serve as community outreach workers, and involvement of youth in local community projects.

- Engaging the community's religious leaders from the beginning of the project may be critical to the acceptance of RH/FP messages in hard-to-reach and poor urban settings. When TAHSEEN began implementing activities in Doweika, it did not involve religious leaders because it had assumed religious leaders did not play a key role in urban poor communities, where social networks are often weaker than in rural communities. However, when TAHSEEN began initiating discussions on RH/FP including FGC, it encountered great resistance from religious leaders and Asheera Mohamedia, and had to engage these key players in discussions to gain their support.

- Ability to adapt activities rapidly and produce quick tangible results helps build support for the project among community members (e.g., renovation of the entire NGO instead of the clinic alone, availability of literacy classes to both men and women during evening hours so that working individuals can benefit from them, involvement of parents in youth RH/FP seminars).

- Endorsement of a project by a public figure brings attention to an issue and a community; helps build additional support for the project among community members, and may attract additional

financial support from donors. For example, the Doweika intervention benefited from the strong support from Egypt's First Lady who inaugurated the Asheera Mohamedia NGO and clinic with other government dignitaries, thus bringing attention to the health and social needs of Doweika residents.

- Managers who lead by engaging and mobilizing a team toward the achievement of a common vision, act quickly, adapt activities as needed, and transform challenges into opportunities are key to the achievement of a project's objectives and goal.

Sustainability

Project sustainability strategy

TAHSEEN defined sustainability as "an institution's capacity to continue delivering services that meet defined norms, standards of quality, and are responsive to client and/or community needs once donor support has ended."

TAHSEEN's sustainability strategy for the Doweika intervention focused on increasing the NGOs' roles in service provision and community mobilization and establishing a new clinic board.

Increasing NGOs' roles in service provision and community mobilization

TAHSEEN strengthened Asheera Mohamedia service delivery capacity by renovating the main clinic, adding medical specialists, purchasing medical equipment, and by providing management training to clinic staff. By renovating the main NGO premises, TAHSEEN allowed the NGO to expand its social service portfolio to include literacy and sewing classes. These gains will assist the NGO to generate more income to address the long-term sustainability of its services.

Establishing a new clinic board

In Doweika, TAHSEEN adopted and adapted the MOPH clinic board management system to the Asheera Mohamedia clinic, where a new clinic board was established. The eight board members included three women and five men and were drawn from the clinic staff and community members. TAHSEEN trained the board on clinic management using the project's Clinic Board Training Curriculum. The clinic board members are tasked to ensure continued quality improvement at the clinic. The board will continue to function after TAHSEEN's intervention ends.

Asheera Mohamedia and NCCM are committed to support the program activities. Asheera Mohamedia plans to rely on its own savings, on local donations of drugs and medical equipment, and on alms-giving to continue supporting its clinic and social programs. NCCM is also exploring other funding mechanisms to sustain the program activities.

Classification of the model

One of the key objectives for the documentation exercise is to assess whether the TAHSEEN Model for reaching the urban poor is a promising or a best practice.

Through its integrated model, TAHSEEN strengthened the health services available at Asheera Mohamedia, mobilized the community to use these services, and increased community awareness regarding selected health practices.

Due to the short implementation timeline in Doweika, TAHSEEN was not able to collect the needed data to evaluate the longer term effect and impact of its intervention. In addition, limited data was available regarding the ability to replicate the model in other poor urban settings within the TAHSEEN project. For this reason, it has been decided that the model is a promising practice.

Programmatic implications

The TAHSEEN model provides interesting approaches that can be utilized by ESD and other projects working in poor urban communities. The approaches include:

Linking health to non-health activities

Linking or integrating FP messages into social programs such as literacy, women's empowerment, and youth reinforces FP messages through various channels. This approach also facilitates meeting other existing demands beside FP.

Creating a win-win partnership

Partnering with diverse sectors such as government, private, commercial, and education increases potential for program success. The key is to identify the right partners that can benefit from the intervention and whom the community can trust.

Involving community leaders

Enlisting the support of community leaders (e.g., religious leaders) facilitates community buy-in to the program.

Investing in project leadership

Having a charismatic leader or manager that identifies with local needs, speaks the local language, and connects with the community is critical to programs' success. The project leadership dynamic was reported by key informants and community members as a major component to the success of the TAHSEEN Doweika intervention.

CONCLUSION

TAHSEEN implemented an integrated FP model in Mansheit Nasser, Doweika, Egypt to bring about positive health and social changes that were urgently needed. This model allowed the project not only to address local RH/FP needs but also important social needs such as literacy education.

Through the combined efforts and support of community outreach workers, community leaders, and local residents, the project met its program objectives. In the past, Doweika residents traveled outside of their community for health services. Now the clinic is fully operational and used by community members. The social programs offered by Asheera have provided men and women with an opportunity to learn how to read and write, to receive Islamic and health education, and to engage in income-generating activities. Judging from the service statistic records, TAHSEEN was successful in mobilizing the community to use the services available at the NGO premises. Through community mobilization and BCC efforts, community knowledge about RH/FP improved. All these positive changes would not have been possible without TAHSEEN's integrated and flexible model.

The project intervention continued to receive support and commitment from Asheera Mohamedia and NCCM, even after TAHSEEN ended its involvement in Doweika.

TAHSEEN's intervention in Doweika has brought about positive changes in the community that will be felt and remembered for a long time to come.

ANNEX 1

Major Activities May 2004 – August 2005

Main Activities	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
MOU signed between USAID/TAHSEEN, NCCM, and Egypt MOHP	X															
FGDs and site visits to health facilities as part of preliminary situation analysis		X	X	X	X											
Training of outreach workers or Raidats Hadariat in RH/FP messages and communication skills			X	X	X											
Asheera Mohamedia NGO site renovation					X	X	X	X								
NCCM conducts literacy classes, and sewing and needle work classes										X	X	X	X	X	X	X
Seminars for parents and youth on RH/FP and other social issues										X	X	X	X	X	X	X
Behavior change and communication (BCC) program								X	X	X						
Child, Environment and Community Health Program								X	X							
Clinic opening																X
Clinic staffed and operational																X

ANNEX 2

Key Informants Questionnaire

For Program Manager of the Asheera Mohamedia NGO[11]

1. What is the mission of the Asheera Mohamedia NGO?

2. What do you perceive are the key problems and issues facing the population in Doweika today? (Probe; any other problems and issues?)

3. How does the Asheera Mohamedia NGO address these problems and issues?

4. Can you describe to me briefly what programs and services the Asheera Mohamedia NGO provides in Doweika? Can you specify (in years) when these programs and services were initiated and who are your target populations?

5. Are there any fees to participate in your social programs (e.g., literacy classes, women's clubs-sewing classes) (if yes, specify _____ L.E)

6. Do women in the sewing classes earn any income from their selling sewing products?

YES NO (if NO skip to Question 8)

7. How has the income that these women earn helped them develop themselves further?

8. Where did people in the community go to receive health services before the clinic renovations and expansion of services?

   I understand that you have collaborated with the TAHSEEN project, NCCM, and the MOHP to strengthen and expand the health services and social programs that you provide at the Asheera Mohamedia NGO.

9. Can you describe to me what were Asheera Mohamedia NGO's responsibilities in the collaboration with TAHSEEN and the MOHP on the Doweika project?

10. What do you perceive are the strengths you brought to the collaboration?
11. How has the collaboration with these partners impacted the **health services** that you provide and what has been the impact, if any, on the target populations (women, men, youth, orphans, widowed)?

[11] This is the NGO that runs the Doweika community center that houses the clinic, nursery, literacy classes, sewing classes and where the community awareness raising sessions are conducted.

12. How has the collaboration with these partners impacted the **social programs** that you provide and what has been the impact, if any, on the target populations (women, men, youth, orphans, widowed)?

13. What do you think are the key elements (e.g., practices, actions, approaches, steps) that are making your health services and social program work? (Probe: any other elements?)

14. What would you do differently to improve the effectiveness or increase the impact of your services?

15. What are the challenges that your NGO is currently facing? (Probe: any others)

16. What is the NGO source of funding? Does the NGO receive "ZAKA" (almsgiving)?

17. In terms of sustainability, what are the steps you have taken and/or planning to take to ensure the NGO can continue to provide the needed health and social services?

18. Do how you insure the availability of contraceptives and providers?

19. Is the NGO currently a member of the Egyptian Family Planning Association (EFPA)?

YES (if NO, Skip to question #22)

20. If you are a member of EFPA, what have been the benefits of being a member?

21. Is there anything more you would like to add?

Thank you for your time. We will be analyzing the information you provided and will be happy to send you copy of the draft report to review at that time if you are interested.

Key Informants Questionnaire

For the National Council for Childhood and Motherhood
Doweika Program Manager

1. What do you perceive are the key problems and issues facing the population in Doweika today? (Probe; any other problems and issues?)

2. How does the NCCM address these problems and issues?

   We understand that the activities you conducted in partnership with TAHSEEN, Asheera Mohamedia NGO, and the MOHP was within the NCCM Project "Towards Progressive Elimination of Child Labor" in Mansheit Nasser.

3. Can you describe to me briefly what the main objectives of the "Towards Progressive Elimination of Child Labor" project? Who is the donor? When was the Project initiated? Who are your target populations?

4. Can you describe what were NCCM's responsibilities in implementing the Doweika Project in partnership with TAHSEEN and the MOHP?

   Reaching women and men in **poor urban setting** and **poor rural setting** present different challenges. Urban settings often lack the underlying social fabrics needed to improve the well-being of the underserved.

5. Can you tell me what specific community mobilization activities NCCM has carried out to reach the underserved populations in Doweika?

   Now I would like to speak with you more into depth about the specific community mobilization activities that NCCM conducted to reach the urban poor in Doweika, and specifically discuss your activities with the raedat hadariat, the awareness raising sessions for parents and children, the literacy classes, the women's club and sewing classes, and any other community mobilization activities you may have conducted.

Raedat hadariat (outreach workers)

6. What was the role of the NCCM raedat hadariat in reaching and mobilizing community members?

7. How did NCCM select the raedat hadariat?

8. How successful were the raedat hadariat in mobilizing community members to utilize the health and social services provided at the Asheera Mohamedia NGO? Please provide evidence, examples, and anecdotes for each?

Health services:

Social services:

9. What other referral mechanisms exist - from the community to the Asheera Mohamedia NGO beside radedat hadariat (for e.g. private providers, CDAs, male outreach workers)? How was these other referrals mechanism effective?

Community awareness sessions

10. What were the primary objectives of the community awareness sessions? Who did they reach?

11. How effective were the sessions in raising awareness about health and other social issues of concern (e.g. female genital cutting, risks of early marriage, school drop out, drug addiction) to parents and children in the community? Please, provide some evidence, examples, and anecdotes.

12. Have there been any noticeable changes in behaviors among parents and children as a result of the community awareness sessions? If YES, Please provide evidence, examples, anecdotes for each the following issues:

Female genital cutting:

Risks of early marriage:

School drop out:

Drug addiction:

Literacy classes

13. What were the primary objectives of the literacy classes? Who did they reach?

14. Please describe how the literacy program impacted the utilization of other social programs and health services provided at the Asheera Mohamedia NGO? Please, provide some evidence, examples, and anecdotes.

Women's Club sewing classes

15. What were the primary objectives of the Women's Club sewing classes? What were the socio demographic characteristics of the women they reached?

16. Please describe how the Women's Club sewing classes impacted the utilization of other social programs and health services provided at the Asheera Mohamedia NGO? Please, provide some evidence, examples, and anecdotes.

17. Do women in the sewing classes earn any income from their selling sewing products?

YES NO (if NO skip to Question 19)

18. How has the income that these women earn helped them develop themselves further?

Arab Women Speak Out program

19. What were the primary objectives of the Arab Women Speak Out program? Who do they reach?

20. Can you describe how the Arab Women Speak Out program impacted the women that the program reached? Please provide evidence, examples, and anecdotes.

21. What were NCMM's responsibilities in conducting the Shabab (youth) Week TAHSEEN program? Describe the socio economic characteristics of the population it reached?

22. How has Shabab (youth) Week TAHSEEN program impacted youth and families' awareness, attitudes, knowledge, and/or behaviors about youth related RH/FP topics, and other social issues of concern to the community? Please provide evidence, examples and anecdotes.

23. Does NCCM charge any fees to participate in its community mobilization activities? (if yes, specify _____ L.E)

In this last section, we will ask you a few questions to help us summarize your overall experience and lessons implementing the Doweika project with TAHSEEN and the MOHP.

24. What do you perceive are the strengths that NCCM brought to the partnership with TAHSEEN and the MOHP in implementing the Doweika project?

25. Please describe what was your experience working with each of the partners:

TAHSEEN:

MOHP:

Asheera Mohamedia NGO:

26. Is there anything that you would do differently to improve the partnership with these partners?

We understand that the Doweika project had three main objectives: 1) Improve health and social services available at Doweika NGO; 2) Mobilize the community to utilize available services; 3) Raise community awareness about healthy practices.

27. Overall, to what extend do you feel the intervention implemented through the partnership with TAHSEEN and the MOHP was effective in achieving these program objectives? Please share with us evidence/examples/anecdotes that demonstrate that the intervention was effective, somewhat effective, or not effective?

28. How has the Doweika project intervention helped NCCM achieve the objectives of the "Towards Progressive Elimination of Child Labor" Project?

29. What do you think are the key elements (e.g., practices, actions, approaches, steps) that need to be present for such an intervention as the Doweika project to be effective?

30. What are some lessons learned that you can draw from your experience in implementing the Doweika project?

31. Is there anything else you would like to add?

Thank you for your time. We will be analyzing the information you provided and will be happy to send you copy of the draft report to review at that time if you are interested.

Key Informants Questionnaire

For Literacy Class Beneficiaries

1. How did you hear about the Doweika NGO literacy classes?
2. Do any of your family members attend the literacy classes? If yes, specify?
3. Is your family supportive of your participation in the literacy class? How so?
4. What do you like most about the literacy classes? Anything else?
5. What specific messages did you hear in the literacy classes?
6. How has the knowledge you gained in the literacy classes impacted your life? Please describe.
7. Do you use any other services available at the Doweika NGO? Please specify which ones.
8. Where did you seek health services before coming to the Doweika NGO?