STUDY ON REPRODUCTIVE HEALTH IMPACT OF FAMILY HEALTH MODEL PILOTS IN EGYPT

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TABLE OF CONTENTS

LIST OF ABBREVIATIONS

ADB	African Development Bank
ANC	Antenatal Care
AP	Accreditation Program
ARI	Acute Respiratory Infections
BBP	Basic Benefit Package
CAPMAS	Public Agency for Public Mobilization and Statistics
CCO	Curative Care Organization
CDD	Control of Diarrheal Diseases
CHD	Coronary Heart Diseases
DDM	Data for Decision Making
DEC	District Executive Council
DOTS	Direct Observation Therapy of Short Duration
DPO	District Provider Organization
EDL	Essential Drug List
EPI	Expanded Program for Immunization
ENT	Ear, Nose and Throat
EU	European Union
EOC	Emergency Obstetric Care
FGDs	Focus Group Discussions
FHF	Family Health Fund
FHC	Family Health Center
FHM	Family Health Model
FHU	Family Health Unit
FP	Family Planning
GDP	Gross Domestic Products
GIT	Gastro Intestinal Tract
GM	Growth Monitoring
HDA	Health District Administration
HDD	Health District Director
HDS	Health District System
HDD	Health District Director
HI	Health Insurance
HIO	Health Insurance Organization
HIV	Human Immunodeficiency Virus
HSR	Health Sector Reform
HSRP	Health Sector Reform Program
ICPD	International Conference for Population and Development
IDIs	In-depth Interviews
IMCI	Integrated Management of Childhood Illness

INP	Institute of National Planning
IRHSP	Integrated Reproductive Health Services Projects
IUD	Intra Uterine contraceptive Device
JICA	Japan International Cooperation Agency
LPC	Local Peoples' Council
MCH	Maternal and Child Health
MD	Ministerial Decree
MDGs	Millennium Development Goals
MIS	Management Information System
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MMR	Maternal Mortality Ratio
MN	Micronutrients
NHIF	National Health Insurance Fund
NGOs	Non-Governmental Organizations
PHC	Primary Health Care
PM	Prime Minister
PVOs	Private Voluntary Organizations
QID	Quality Improvement Department
RH	Reproductive Health
RHU	Rural Health Unit
RR	Raida Refia (Community Workers)
RTI	Reproductive Tract Infections
SDP	Systems Development Project
STI	Sexually Transmitted Infections
STSP	Sector for Technical Support and Projects
TB	Tuberculosis
TFR	Total Fertility Rate
THO	Teaching Hospitals Organization
TSO	Technical Support Office
TST	Technical Support Team
UHA	Undersecretary for Health Affairs
UNICEF	United Nations Infant and Children Fund
UNDP	United Nations for Development Program
UHC	Urban Health Center
UNFPA	United Nations Fund for Population
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
YFS	Youth Friendly Services

EXECUTIVE SUMMARY

The Health Sector Reform Program (HSRP) is promoting the Family Health Model (FHM) as the new system of family-based Primary Health Care (PHC). The FHM offers families a basic package of integrated services i.e. the Basic Benefit Package (BBP) in the PHC facilities which become Family Health Units and Centers. The MOHP is currently preparing to rollout the FHM nationwide and therefore it is pertinent that FHM succeeds in increasing the utilization of Reproductive Health (RH) Services. Thus, before expansion of the FHM, it is necessary to address and recognize the impact of the FHM on utilization of RH-services and indentify potentials for improvements.

The current study is designed in order to document and explain the impact of the FHM on RH-services and to suggest interventions to promote the role of FHM in increasing the utilization of RH-services. The findings of this study are essential to support the MOHP and UNFPA in their efforts to strengthen the RH impact of the FHM. Those efforts are directed towards creating a number of model districts where quality integrated RH-services are not only available and accessible, but also have the support from the local communities who are familiar with the key concepts of RH and the available RH- services.

The study included both quantitative and qualitative data collected from MOHP-HSRP published documents, key persons in charge of RH programs and HSRP at MOHP central level, and from the 5 HSRP-pilot Governorates. The study included data collection from 50 health facilities (5 FHM and 5 control PHC facilities from each governorate). The sources of data collected from the pilot governorates included service statistics, quality checklist, and exit interviews at FHM facilities as well as in-depth interviews with health directorates, districts and health facilities staff.

Community-based survey was conducted in the catchment areas of the FHM facilities, and covered 60 households in each catchment area (1500 families). FGDs and IDIs were carried out with women, men, male and female youth in the communities served by FHM facilities. Data collection took place during the period January – March 2008.

KEY FINDINGS AND RECOMMENDATIONS

The study findings showed that the FHM compared with PHC has challenges that restrict its role in making substantial positive impact on RH-services utilization at the health facility level or at the community level. This situation is due to the articulation of different factors at the policy, programmatic, operational and community level.

The following are the key findings, suggestions and guidelines to develop interventions at the policy, programmatic and operational level that aim at increasing the utilization of RH-services in the FHM clinics.

I POLITICAL AND PROGRAMMATIC SUPPORT TO RH-SERVICES PROVISION THROUGH FHM

1- FHM does not offer enough support to improve RH-services utilization during the transition phase from donor-supported to self-reliant programs

- In the current transition phase from the donor-dependent to self-reliant RH-programs, both the FHM and PHC facilities had static profile of low efficiency in RH-service utilization. The current political support to RH programs is included as implicit policy in the FHM. Therefore, RH-issues which were having explicit policy and targets had lost advocacy at both the health facility level and community level.
- There is no updated HSRP document that includes all RH-program goals, targets, strategies, after 9 years of experience (1999-2008) in the pilot governorates. The available HSRP documents include compiled MOHP/vertical programs' goals and strategies set in year 2000. Vertical programs' documented strategies which had been set in year 2000 do not consider the principles of HSRP.
- The Egyptian community believes in specialization in medical practice. The non-acceptance of receiving services from unspecialized physicians (general practitioners of family physician) is one of the major causes of not using the different types of PHC services. The FHM facilities which apparently organize their clinics as: clinic 1, clinic 2, clinic 3 etc., operationally work as specialized clinics for FP, child care, maternal care etc., to be accepted by the community.
- There is no clear role for the MOHP staff working in the vertical RH-programs (at the central, governorate, and district level) in the HSRP.
- It is difficult to find out in any of the 5 HSRP pilot governorates a FHM capable in demonstrating increased efficiency of the health facilities in providing RH-services. The situation is attributed to lack of enough flexibility in operational policies and planning in the FHM facilities as demonstrated in the following examples:
    - FHM consider fixed targets for the family physician according to the system of the "performance based incentives".
    - FHM operational policies do not consider variability across governorates so as to design mechanisms to increase RH-services utilization in priority governorates that have challenges in implementation of RH-programs as Upper Egypt Governorates.
    - The policy of restriction of free-RH services to those included in the FHM- roster, with annual payment system for health insurance, limits accessibility to RH-services.

2- There is no adequate preparation of the environment within the MOHP to support RH-services through the FHM

- There is no enough involvement of the MOHP-staff at all levels, especially those involved in the RH- programs, during setting plans and targets for FHM-RH services.
- The general perception of the MOHP staff that the HSRP program is a new vertical program that merges all MOHP services in the FHM, with subsequent reduction of interest to support the national RH-programs.
- There is inadequate information about the ideology of the FHM and health insurance among health program's managers at all levels including the pilot governorates as well as the served community.

- There is no unified FHM applied in the 5 HSRP pilot governorates regarding the staff pattern (Figure 6), availability of some drugs, equipment, etc. This issue raises the question of what is the profile of the FHM that intended to be rolled out.
- There is incomplete implementation of the FHM to cover one district or a whole governorate to demonstrate a unique model capable in overcoming the challenges related to provision of quality integrated services. At the same time dependence of the FHM facilities on the vertical programs (e.g. supply of FP methods) and exposure of the FHM to vertical program activities (e.g. supervision), had made confusion and conflicts at all levels. This could also result in difficulty in measuring the impact of "pure FHM" on RH-services utilization.

II UNIVERSAL COVERAGE WITH RH- SERVICES THROUGH FHM

1- There is inadequate coverage with RH-services through the FHM

- FHM is population-based planning (i.e. one family physician for each 1000 families) and not catchment areas-based planning (i.e. a PHC facility serves a specific catchment area). Therefore, good proportion of the urban families, who are resident within FHM-catchment areas that have high population density, could not be included in the FHM-roster, with less opportunity to access to RH-services (Figures 2).
- Low demand and underutilization of some RH-services as postnatal care, premarital care, adolescent and men reproductive health problems are attributed to non-inclusion of some services in the BBP, as well as lack of adequate promotion for such services.
- There is low coverage with ANC services especially in the urban governorates (Figures 2).
- Health Insurance (joining the FHM-roster) is a prerequisite to get free RH-services.
- Some families do not know about the FHM-fee exemption system.
- Women in governorates as Souhag and Menofia prefer monthly injectable contraceptives which are not provided at the public sector facilites and not included in the Essential Drug List (EDL). Also, IUD coper not included in the EDL.
- Girls expressed their dissatisfaction from the way they had been treated by service providers in the FHM facilities. Girls conveyed that service providers have not been properly prepared to deal with adolescent's health problems.
- The topic of Adolescents' health problems is included with the adult problems in the BBP.
- Health services as management of RTIs and services provided to adolescents are not included in the performance based indicators. Therefore, service providers pay less interest to such cases and there is no effort to raise demand for those who need the service.
- Cultural factors play a role in restricting access of girls to FHM services. Also cultural factors hamper seeking services for RTIs management among men in a health facility in the same village.
- Females who have RTIs do not seek care due to financial constraints for medical consultations and the cost of the drugs. Management of female RTI had been provided freely in the FP-PHC clinics.
- Despite the needs for active contribution of NGOs and the private sector in the FHM to cover the population with BBP, there are some limitations to build up this partnership in the pilot governorates.

III IMPROVE ORGANIZATION AND MANAGEMENT OF THE HEALTH SYSTEM

1- There is no clear role for the MOHP- technical departments (population/FP and MCH) in the FHM

- MOHP-HSRP documents do not include information about contraceptive security and the role of MOHP-PS in FP methods contraceptive logistic management.
- MOHP-HSRP documents do not include information about the mechanisms of continuous updating the national standard of practice in RH-services.
- MOHP staff members affiliated to FP and MCH departments is working according to MD 75. This restricts their role in supporting RH-programs based on their professional experience.

2- The District Provider Organization (DPO) has many challenges to support FHM-RH services

- The Health District represents the mid-level management and its involvement in the FHM is pivotal for decentralization of management of health services. However, the profile of this system is not clear in the pilot governorates due to lack of commitment to major principles.
- The DPO organogram varies across the HSRP pilot governorates, which raises the question about "the successful model" to be rolled out in Egypt 260 health districts (Figure 6).
- DPO confront many internal challenges related to the organizational structure and the needs for capacity building and to have new skills in marketing and negotiations,
- DPO confront many external challenges due to less autonomy, exposure to pressure from local authorities in addition to the shortage of the DPO resources.
- The DPO has negligible role in decision-making regarding the allocation of service providers, distribution of drugs and equipment across the health districts' facilities.
- The previous role of the district in supervision, MIS, on-the-job training in RH-vertical programs is no more operating within the FHM regulations.
- About 29% of the family physicians are not trained in family medicine. The service providers are not aware about their job description.

3- There are challenges confronting FHM for efficient management of human resources to improve RH Services utilization

- FHM allows training of physicians from different specialties (e.g. tropical medicine, internal medicine) to be family physicians. Those physicians show interest to provide care to cases related to their original specialty, with minimal care for RH-cases especially FP that needs skills for IUD insertion.
- The FHM pre-service training allocates one week for training in FP, with 2 days for practical training, which are not enough to develop skills in IUD insertion.
- The job description of the family physician in RH-services is not clear for the items related to FP services,
- The community members consider having specialized physician and not family physician, is necessary to receive quality services (Figure 4). In some communities, FHM-rostered

families prefer female physician to receive RH-services, and husbands prefer male physicians to deal with men's problems

- The community workers play an active role in informing the people about FHM-RH services. However, they are not included in the organizational structure of the FHM facilities (Figure 7).
- The FHM had selected some nurses to work as team members within the health facilities. The extra nurses had been directed to conduct specific assignments outside the health facilities i.e. conduct home visits for health educators and to provide postnatal care. However, nurses with "new assignments" had proved their ineffectiveness (e.g. only 15% of mothers in the FHM served community had received post-natal care, and 41% of those services were through the FHM facilities' activities.
- Physicians are severely involved in paper work. Therefore, they become unable to keep active interaction with the clients and the time allocated for providing quality clinical services is reduced.
- There is high turnover of the FHM staff.
- The "performance-based payment mechanism" could result in loss of transparency in recording of patients' visits. Additionally, families have been exposed to pressure from the service providers to be FHM-rostered. RH-services clients are directed to use paid curative care services.

4- The FHM supervision system is inefficient to ensure constructive supervision in RH-services

- There is no clinical supervision to PHC or FHM staff.The current supervision system in MOHP depends on using the checklist for integrated services that consider the whole facility condition (MD 75), with no in-depth supervising the performance of the service providers while delivering services to any type of the clients. The supervision system of the FHM done by district staff and FHF is "supervision to control" rather than supervision to help.
- Exposure of the health facility staff to about 15 types of supervisors from the different levels and from all vertical programs in addition to FHF. There is no supervisor who is considered expert in family medicine to transfer experience to the FHM service providers.
- FHM did not build on experience of the MOHP vertical programs of involving district hospital specialists as "clinical supervisors" in the on-the-job training and updating clinical skills of the service providers.

5- FHM -Management Information System is not efficient to support RH-services

- There is no MIS specialist in both the DPO or FHM facilities.
- The performance- based-payment mechanism with fixed targets makes the physicians' output to be static at a certain level for RH-services. This reduces the opportunities for increasing service output for the priority service e.g. RH and priority geographic areas e.g. rural Upper Egypt.
- The issue of linking between the incentives and the physicians quantitative output, could influence the reliability of MIS data of FHM facilities.
- Having double MIS (for vertical program indicators and FHM indicators) overloads the MIS system at all levels.

- The heavy involvement of physicians in paper work beside the clinical services, could influence the quality of recoded data.
- There is no published FHM monitoring and evaluation reports which include time series/trend analysis to provide information about the impact of the FHM on RH-services utilization. Therefore, there is always needs to conduct specific studies in this context.
- Unfortunately, there is controversy regarding the role FHM in increasing the utilization of PHC services. Some studies demonstrate improved performance of the FHM and others are not. This is due to sampling techniques and duration covered in the study.
- FHM –MIS indicators are physician-based output indicators, while PHC indicators are facility-based output indicators. Therefore, in case of having fixed target for each family physician, the facility output could not be increase except by increasing the number of physicians. Consequently, FHM facilities' output indicators reflect input (number of physicians) and not the efficiency of the facility staff (process) (Figure 9).

IV IMPROVE HEALTH SERVICES PROVISION

1- Physical infrastructure of the health facility restricts proper provision of some RH-services

- The HSRP-policy of having more than one family medicine clinics allows for providing RH-services in more than one clinic in the same facility. However, having a clinic that provide all services to all members of the family reduces privacy especially for RH-services.
- There is no room for FP counseling.
- No room for oral rehydration of the children.
- The lab is located in an ill-ventilated place in the facility.

V RAISING DEMANDS FOR RH-SERVICES IN THE FHM FACILITIES

1- The community is unaware about the concept of the FHM and Health Insurance and the included RH-services

- The concept of health insurance and cost- sharing is not clear to many families. This is because the new system is implemented in MOHP governmental PHC facilities which usually provide free health services,
- Those who join the FHM-roster are those with high "socioeconomic risk". This indicates that middle and high socioeconomic classes do not financially support the FHM. This could negatively affect the financial sustainability of the FHM.
- The High and middle socioeconomic classes utilize the PHC facilities for public health services as immunization and health office services. However, there are no mechanisms to involve them in the health solidarity program of the FHM.
- The topic of adolescent health problems is covered in the "practice guide" for family physicians as part of topic on school health program. However, based on findings of the current study, the role of mothers is pivotal in informing their daughters about adolescent health.
- Both the community and service providers are not accommodating the concept of drug rationalization. Doctors in the FHM prescribe 2 drugs according to the FHM regulations,

but asking the patients to buy more drugs from the private pharmacy. The patients expressed their dissatisfaction from prescribing/dispensing two drugs only.

- Cultural factors reduce the opportunity for access of girls to FHM-RH services
- The mass media does not have any role in preparing the environment to accept the concepts of social health insurance and integrated services through family physicians. HSRP advocates consider that FHM is in its "trial" stage", and involvement of the mass media could increase demand for services which is not available in its final form.
- The mass media does not have any role in informing the people about HSRP-integrated health system "health services pyramid". The people usually prefer to go directly to the hospital and by-pass the PHC level, with subsequent underutilization of PHC-RH services. This is obvious in FHM facilities which do not apply referral system at the district level.

2- FHM outreach program is not efficient for raising demands for RH-services

- The majority of the families joining the FHM-roster (66% of the target community) get their information about RH-services from the community worker (RR) (Figure 8). At the same time, FHM depends on RR in implementing the community-related administrative component of the FHM i.e. enlistment of families and informing about the folders. However FHM did not consider adequate preparation of the RR in introducing the concept of FHM/Family Folder to the community. Therefore, the community is not well-prepared to accept the idea of family folder which is linked with "paying the premium to get health services, which were previously provided freely in the MOHP facilities".
- Involvement of RR in demand raising activities for multiple health programs could have negative effects on all the programs especially RH-program, and reduction of RR credibility by the community.
- The changing role of some nurses in the FHM, who become involved in home-visiting health education activities had resulted in exposure of the families to two different sources of information about FHM-services (i.e. nurses and RR) with subsequent duplication and/or contradiction of information. However, the influential role of RR on the community is usually dominating.

INTRODUCTION AND METHODOLOGY 1

The Health Sector Reform Program (HSRP) is promoting the *Family Health Model* (FHM) as the new system of family based primary health care. The FHM offers families a basic package of integrated services (called the basic benefit package) in PHC-facilities called Family Health Units/Centers. The basic benefit package includes basic FP/MCH/RTI/STI and youth friendly services, while physicians are to act as gatekeepers to the higher levels of care. Pilots have been running in 5 different governorates[1] since 1997 affecting more than 800 facilities and the MOHP is planning to attain national coverage by 2010[2].

The WB/MOHP evaluation of the impact of the HSRP-pilots (2006) concludes that implementation has resulted in a shift from secondary to primary care in treatment of children for fever/cough, an increase in the child vaccination rate, and a reduction of female malnutrition. These are applaudable outcomes, but where Reproductive Health (RH) is concerned the report notes that implementation has not led to increasing usage of (ante)natal care and only marginally increased the share of couples using modern contraception. The report gives no insight into the impact of the pilot on utilization of EmOC- services, RTI/STI-services, or uptake of RH-services among youth. Moreover, a study commissioned by the Ford Foundation (2004) found that tow-third of women seeking RH-services in Family Health Units/Centers reported they intended to go to private physicians at some point in the future.

In line with the ICPD- and MDG-goals, Egypt's strategic targets are to reach replacement level fertility in 2017, stop the spread of HIV by 2015 and reduce the maternal mortality rate (MMR) to 44/100,000 in 2015. Currently, Total Fertility Rate (TFR) stands at 3.0 births, while the incidence of reported HIV-cases increases annually and MMR is 67.6/100,000. Increased uptake of FP, MCH, RTI/STI and youth friendly services (YFS) is required if Egypt has to achieve its strategic targets.

The MOHP is currently preparing to rollout the FHM nationwide and therefore it is pertinent that the FHM succeeds to increase utilization of Reproductive Health Services. UNFPA is committed to supporting the MOHP in its efforts to strengthen the reproductive health impact of the FHM by creating a number of model districts where quality integrated reproductive health care services are not only available and accessible, but also where local communities are supportive of the local health care system and familiar with the available reproductive health services and key concepts of their personal reproductive health. To that affect, the project will target a number of the pilot districts (in rural Upper Egypt or those covering urban slums) that have already initiated the HSRP and adopted the FHM. In time, these districts should become a national reference for delivery of integrated RH-services within the context of Health Sector Reform (HSR). Initially the project selected are 1 district in each of the following governorates; Qena, Souhag and Alexandria. Depending on the available resources, then the project should expand to additional districts in 2008 or 2009.

It is necessary to identify and address prior to expansive of FHM the impact of the FHM on utilization of RH-services and identify it's gaps. A number of issues have already been identified, but a comprehensive analytical evidence base is lacking. Therefore, this study is needed to document and explain the limited RH-impact of the FHM and recommend strategies to increase its effect.

1.1 OBJECTIVE

The overall purpose of this study is to support the MOHP and UNFPA in their efforts to strengthen the reproductive health impact of the Family Health Model. This will be achieved by creating a number of model districts where quality integrated reproductive health care services are not only

[1] Alexandria, Menoufiya, Suez, Qena & Sohag.
[2] Approximately 4,000 facilities.

available and accessible, but also where local communities are supportive of the Family Health Model and familiar with the available reproductive health services and key concepts of their personal reproductive health.

The specific objectives of this assignment are:

1. Identify, document, fill gaps and update previous findings regarding the impact of Health Sector Reform on utilization of Reproductive Health Services (i.e. Family Planning services, Mother & Child Health services, RTI/STI-services & Youth Friendly Services) in pilot reform areas.
2. Identify, document, fill gaps and update previous findings regarding community-level familiarity with the reproductive health services (i.e. Family Planning services, Mother & Child Health services, RTI/STI-services & Youth Friendly Services) available through the Family Health Model as well as community-level views and perceptions of the quality, accessibility, relevance and comprehensiveness of these services.
3. Identify, document and analyze the impact of the Family Health Model on the supply (i.e. availability, quality & accessibility), demand and utilization of Reproductive Health services (i.e. Family Planning services, Mother & Child Health services, RTI/STI-services & Youth Friendly Services) in pilot reform areas.
4. Identify, recommend, justify and recommend cost strategies to strengthen the impact of the Family Health Model on utilization of Reproductive Health services (i.e. Family Planning services, Mother & Child Health services, RTI/STI-services & Youth Friendly Services) in pilot reform areas.

1.2 STUDY DESIGN

The study included data collection at different levels:

- MOHP head quarter, and
- The Health Sector Reform piloted governorates: Alexandria, Menoufia, Suez, Quena and Souhag (Port Said governorate included as a control to Suez because HSR covered all Suez governorate):
  - MOHP Health Directorates
  - MOHP Health Districts
  - MOHP – Family Health Units/centers (Test group)
  - MOHP-PHC centers (Control group in reform areas & control areas)
  - Exit interviews in the selected facilities (25)
  - Community-based survey among men, women and youth (questionnaires, IDIs & FGDs) within the catchment area of the test facilities group (25)

In order to fulfill the study objectives many tools were used to collect the required data.

- **Review** of all the documents related to the HSRP and all the studies done and related to the reform was carried out. Additionally, the utilization pattern of RH-services at district and facility (FHU/C & PHC) level was studied through review and analysis of the FHM and PHC facilities.
- **Service statistics** to provide trends over time (before and after introduction of FHM).
- **Community-based survey** in the catchments areas served by FHM facilities was carried ant.
- **Focus Group Discussions** and IDIs were carried out with women, men and youth in the served communities
- **Quality checklist** was used to assess the standard of health services-by quality items in FHM facilities versus PHC facilities.

- **FGDs and in-depth interviews with health authorities/officials** and staff at all levels were done to provide information about the supply side. To assess the perspectives of the FHM beneficiaries towards the quality of FHM services versus PHC services exit interviews in the selected FHM were carried out.

In the following the details of the study activities:

1- Sampling techniques and sample size

Selection of facilities

The FHM facilities and PHC facilities were selected using two stage sample technique:

First Stage: selection of districts: two districts were selected from each governorate; one district applied FHM and another control district with no FHM facilities. The districts were selected by the study coordinator and the HSRP staff. The criteria for the selection of FHM district was the early introduction of the model. The control district was selected to be similar in characteristics with the FHM district.

Second Stage: selection of facilities. Five facilities were selected from each district by the HSRP staff and the study coordinator. A sample of the 25 FHM facilities (five from each governorate) were selected. The control facilities were also selected using the same approach.

The following table presents the 5 HSRP Pilot governorates: Research areas and the control facilities

Governorates	HSRP Research Areas	Control Areas
Alexandria		
District	**Montazaa**	**Amria**
Facilities	Mohsen	Palastine
	Khorshed	King Marout
	El-Montazaa El-Refi	Al-Wady Gidid
	Elgon	Albasra
	Derbala	Amria
Menofia		
District	**Menof**	**Quesna**
Facilities	Alhamol	Shobra Bakhom
	Tamly	El-Ramaly
	Barahim	Sharanis
	Bahwates	Shobra Quabala
	Sengerg	Mastai
Souhag		
District	**Maragha**	**Tahta**
Facilities	Alokhaidar	Shatora
	El-Sheikh Yousef	El-Sheikh Zein El-Abdeen
	Bahta	Arab Bekhwag
	Nagh Taieh	Gizerat Shatora
	Nagh Helal	El-Sheikh Rahoma
Quena		
District	**Nagh Hammady**	**Qous**
Facilities	Nagh Al-Baraka	El-Tawab
	El-Saiad	El-Hogiarat
	El-Shaweria	El-Mafragia
	El-Negahia	El-Makhzan
	El-Semania	El-Homer and El-Gaafra
Suez	**Suez**	**Port-Said**
District	**Suez**	**Port-Said**
Facilities	El-Mothalath	El-manakh
	October	Teby Al-Arab
	Suez	Fatma El-Zaharaa
	El-eman	Amr ben Assh
	Al-Sadat	Al-Gawhara

Selection of women in the community

A total of 60 women in the catchment area of the FHM facility were selected for interview. The selection was carried out in the filed by the field supervisor (there was no available listing) using random walk technique. The team supervisor selected the households through adopting the following steps then identify eligible women in the selected households from each catchment area:

1. The supervisor has to find a landmark area (school, market, health facility, Mosque…) from which he has to start.
2. The supervisor determined the interval of household selection by dividing the total number of households in the catchment area by the number of households need to be selected from the catchment area (I= no. of HH in the catchment area /no. of HH to be selected). Then He selected a random number between 1, and I (For Example if I=6 he will select a random number between 1, and 6) using random number table.
3. He stands by the landmark and let households on his right hand side. He then numbering HHs from 1 then the first selected household will be household number = random number (i.e. if the random number selected was 3 then the first household selected will be the third household).

4. The second selected household was 1st household + I (i.e. if the 3rd households was selected and I=6 them the next household selected will be number 9). This procedure continued till a 60 eligible women were identified in the households in the catchment area.

2- Development of Data collection instruments

Many instruments were developed to be used in data collections which are:

Exist questionnaire

This questionnaire was developed to collect information from clients(after getting their services at the facility) about the main following topics:

- Client experience and accessibility to the facility,
- Client satisfaction
- Client background characteristics

Woman questionnaire for community data collection

This questionnaire was developed to collect information about the following topics from women in the catchment area of the FHM facilities:

- Background characteristics
- Reproduction
- Antenatal care, postnatal care and breastfeeding
- Family planning and RTI/STI
- Child health
- Knowledge of sources provide health services
- Community Knowledge about Family Health Model Facilities

Service statistics spreadsheet

A spread sheet was developed to collect the service statistics data from the directorate and facilities for the last 8 years (2000 till 2007) by quarter(the only available data). This sheet was used to collect the data from FHM facilities and the control facilities

Checklist quality form

A checklist was developed to assess the quality of FHM facilities selected for the study. Many items were included in the checklist covering the following main areas:

- Demographic data
- General resources, procedures and services
- Primary health care programs
- Services directed toward the community

FGD's guideline, and IDI guideline.

Two discussion guides were developed to conduct FGDs with women, men, and youth , staff at the facility as well as the key persons at the directorate level.

Discussion Guide with community

The FGDs guide for women, men and youth mainly focused on their knowledge about health services available and FHM, opinion on the services provided by the family health model, their assessment to the services provided suggestions to improve services.

Discussion guide with facility staff

The FGDs guide for facility staff mainly focused on the training of FHM for the staff, their assessment to the services provided at the facility, evaluation of supervision and accreditation and suggestions for improving services.

Discussion guide with Undersecretary of Health Affairs

The discussion guide covered mainly the positives and negatives of the FHM, what the effect of FHM on reproductive health services at the governorate, directors prospective in FHM and its role in attracting the private and NGOs to provide the FHM.

1-3 Data Collection

Prior to data collection one week training for field staff was carried out with participation of 30 personnel.

The field staff was divided into five teams, each team work in one governorate with exception to one team (worked in Suez and Port Said). Each team was responsible of collecting the service statistics data from the FHR facilities and the control facilities, conducting 25 exit interviews from FHM facilities, 60 woman questionnaire in the catchments area of the selected FHM facility. In addition, FGDs carried with the facility staff and IDIs whenever possible.

The data collection stage took around 10 days work at the facilities. However, IDIs were carried at the directorate in each governorate in around additional 5 days.

Around 5 IDIs were conducted at the central level by the study coordinator.

1-4 Operational Definitions of Variables and Terms

- **Youth RH problems:**

  This group of health problems is related to different health disorders associated with adolescent stage of the life cycle and extend throughout the age period 15-24 years. RH problems of female youth include: delayed puberty, delayed menarche, dysmenorrheal, skin disorders, urinary tract disorders, and others as endocrinal and psychological disorders. Male youth RH problems include: delayed puberty, skin disorders, urinary tract disorders, and others as endocrinal and psychological disorders.

- **Maternal health care:**

  This group includes antenatal care, natal care and postnatal care. Postnatal care includes postpartum care to the mother and neonatal care for the newborn.

- **Child Health care**

  This group includes children immunization, growth monitoring, management of childhood illness especially diarrhea and acute respiratory tract infections

- **RTIs/STIs**

  This group includes: health problems for females: pelvic inflammatory diseases, vaginal discharge, bacterial vaginosis and vaginal discharge syndrome, inguinal bubo, HIV/AIDS and genital ulcers

  Questionnaire include questions about RTIs include history of vaginal, itching and ulcers.

  RTIs for males include: uretheral discharge syndrome, scrotal swelling, inguinal bubo, HIV/AIDS and genital ulcer syndrome.

  In the questionnaire asking the interviewee about RTIs include history of : uretheral discharge, and genital ulcers

- **Utilization of RH services**

  The term utilization of RH-service will be used of this study for service statistics of the FHM and PHC facilities. It is the recorded data about the clients utilized the health facilities. The use of term clients when we describe the volume of services.

  The number of clients exceeds the number of individuals who attend the clinic, because the individual could receive more than one service during single visit (FP client could attend the clinic for IUD removal and use Pills, therefore she received two services). In case of describing the clients as distribution by age, this includes the actual number of individuals attending the clinic).

- **Demand for RH services**

  The term "demand" in this study includes the history of utilization of a specific service irrespective to the source. The demand in this study is used to describe the "community utilization of different RH-services" from different sources including FHM facilities. The time linked with the demand vary according to the life cycle: premarital care is general and is done once in life, for MCH it is concerned with all births in the 5 years preceding the survey (2002-2007), for FP the demand questions are related the last FP method used continuously among current users.

- **Needs for RH services**

  The need for RH services is a term related health planners' assessment of the required services. For example in case of having 100 births, there are needs for 100 mothers need postnatal care and 100 newborns need neonatal care. However, if only 50 mothers sought postnatal care, the demand is considered 50%.

1-5 Data Analysis

Three different types of analysis were used

1- Qualitative data: The qualitative data (FGDs and IDIs) had been analyzed according to the categories and the study participants:

- MOHP-RH-services program managers in MOHP-HQ (MCH Department and Population/FP sector (IDIs).
- MOHP-CDTSOP (IDIs).
- First Undersecretaries of Health Affairs-at the governorate level (5 FHM pilot governorates) (IDIs).
- Health District Directors (IDIs).
- Physicians in the FHM facilities (IDIs).
- FHM facilities-service providers (nurses, social workers, sanitarians, lab technicians, etc.
- Women in the community (within the catchment area of the FHM facilities) (FGDs).
- Married men in the community (within the catchment area of the FHM facilities) (FGDs).
- Female youth (within the catchment area of the FHM facilities) (IDIs).
- Male Youth (within the catchment area of the FHM facilities) (IDIs).

2- Quantitative data: According to the sources, tools and methods of data collection, quantitative data analysis has been done for:

- Observation checklist for the 25 FHM facilities.
- Utilization pattern of RH services at the district level and the FHM facilities level (service statistics) for FP indicators (2003-2007 and Maternal care indicators (2000- 2007

- Exit interview with FHM clients (women).
- Community based survey

3. SWOC Analysis

Situation analysis regarding identify strengths (S) of the current FHM to build on, weaknesses (W) to correct, opportunities (O) for timely capitalize on, and finally challenges (C) to overcome utilization both the quantitative and qualitative data.

BACKGROUND ON HSRP IN EGYPT 2

In 1997 the government of Egypt officially launched the HSRP that is to reform the Health Sector over a period of 15-20 years [1]. The HSRP has 4 major objectives [2] :

- Achieving universal coverage with basic health services,
- Improving the organization and management of the health system,
- Improving health services delivery,
- Improving the pharmaceutical system

This chapter provide a general understanding of the HSRP's objectives and of the strategies developed to achieve those objectives. The chapter is composed of seven sections. The first will focus on the needs for the reform. The second section will present the HSRP goal, its guiding principles and its objectives. The subsequent four sections will each correspond to one of the 4 major objectives of the HSRP. Finally, the last section will provide an understanding of how HSRP has been piloted since 1997 and how it will be rolled out to expand nationally by year 2020.

2.1 THE NEED FOR HSRP

The idea of health reform was raised as a vision of the National Party in 1986. Preparations for health reform strategies started in 1995. In 1996 a situation analysis was conducted and the strategies of the reform were drafted [3]. The MOHP published a report "Egypt Health Service Analysis and Future Strategy" in 1998, which was updated by the HSRP in December 2003[4]. The situation analysis report had identified the challenges that confront the health system to achieve the goal of the MOHP of improving health of all citizens, and necessitates launching the HSRP. Those challenges are:

- **Inadequate expenditure on health:** The overall spending on health represents 3.7% of the GDP. MOHP budget forms 3.3% of the governmental budget (2000/2001) and MOHP expenditure per capita per year was LE 56.7 in year 2001 [4].
- **Expenditure on health indicates the presence of open-ended market-based systems** where private finance and delivery systems have dominant role. The expenditure on health in 1995/96 was distributed as governmental (35%), households (51%), HIO (6%), firms (5%) and donors (3%)[3] .
- **Inefficient health insurance system:** The profile of HI program in Egypt 2005 regarding coverage and eligibility of HIO beneficiaries indicate that about 50% of the population are covered with health insurance and include: school children (24%), under 5 children (13%), workers (10%) and pensioners (3%)[5]. According to the current HIO situation, there are vulnerable segments of the population which are not covered by HI i.e. non-working mothers, university students, adolescents and adults (18-24) who are university students and the non working people[6] . Women in the reproductive age who are working in some private factories have no access to RH services through the health insurance program[7] .
- **Inefficient management of the health system at MOHP level** due to the centralized control, extensive infrastructure, governmental responsibility for health care for all individuals and extensive governmental involvement in the pharmaceutical sector [3].
- **Complex organizational structure of the health system:** There are multiple public and private sources of finance and delivery of health care. At the same time there is limited governmental oversight of the private sector [4].
- **Inefficient health services delivery:** Shortcomings in human resources include low capacities and skills, mal-distribution of physicians across geographic regions, and specialties and insufficient salaries and incentives [4]. Additionally, the health facilities' infrastructure (building, furniture and maintenance) is deteriorating [8].

- **Reliance on vertical-donor-supported PHC programs:** vertical programs as FP, MCH have shortcomings related to their being fragmented with lack of coordination at the planning and implementation levels, negligence of necessary support system as district hospital/referral services, overlapping activities as training, spending of the projects' budget at the central or regional level and not at the service delivery points, missing coverage of some population categories with specific health services as adolescent and management of RTIs [8].
- **Disease Burden:** Due to demographic and epidemiologic and nutrition transition, Egypt has a very long list of health problems: high rate of population growth, endemic and infectious diseases, high maternal and child morbidity and mortality, chronic/non-communicable diseases [9]. Chronic diseases as hypertension (prevalence 26%), diabetes (prevalence about 14%) [10]. WHO had declared that, by year 2030, Egypt will be one of the top ten countries regarding the number of diabetics [11]. Additionally, Egypt has public health problems related to injuries and accidents, smoking, addiction, disabilities and congenital anomalies [4]. This pattern of disease burden necessitates having a strong health system that deal with prevention/communication for behavior change and secondary care programs.
- **Shortage in Basic public services:** unsatisfactory environmental indicators related to housing, slums, shortage of safe water, sewage disposal, and air pollution contribute in increasing morbidity and mortality [4].

Egypt Health Sector Reform Program:

The Egyptian HSRP went through several stages including the preparatory stage 1994-1996. During this stage valuable studies were conducted and synthesized in one document "Egypt Health Sector Analysis and Future Strategies". Health Master Plans have been designed for 5 pilot governorates. Experimenting stage of the FHM took place in one of the PHC facilities, and for two years (1996-1997). This was followed by piloting stage of the model in 5 governorates and included activities such as: building staff pattern, designing the contents of the essential basic health services, and essential drug list other components of integrated primary health care services. In March 2003, the HSRP has shifted its strategy from health facility-oriented approach to district approach. In 2005, the HSRP has gradually expanded its operations to ten additional governorates, with a total 15 involved governorates (50% coverage of the country) [12] .

2.2 HSRP Objectives and Guiding Principles

HSRP is a program to transform Egypt's health sector between 1997 and 2020 with the overall goal of shifting the focus of health care from a heavily reliance on vertical programs and inpatient care to a more integrated and less costly, quality, universally accessible and sustainable primary health care model.

The HSRP has 4 main objectives(13) :

1. ***Ensuring universal coverage with Basic Health Services:***

To achieve this objective the following strategies were set:

- Expansion of social health insurance coverage from 45% (in 1997) of the population to universal coverage by 2020, based on the family as the basic unit (through family health models). The coverage is by population groups (e.g. employees in specific organizations) and/or geographical regions (e.g. families within districts);
- Provision of an affordable and cost-effective package of basic health services that responds to priority health needs of the population with regard to health promotion, primary prevention, curative care and rehabilitation services;
- Ensuring equal access to health care based on needs and ability to pay;
- Ensuring financial sustainability of the basic package of health services by public and private sources through the National Health Insurance Fund (NHIF) that will purchase health services on behalf of the insured;

- Reallocation of the governmental expenditure on health with emphasis on primary health care and geographic adjustment (e.g. more resources to governorates with high needs).

2. Improving organization and management of the health system

To achieve this objective the following strategies were set:

- Reforming the organizational structure of the health system, with effective management systems, an enabling policy environment and clear institutional relationships,
- Strengthening of the MOHP role in strategic planning and coordination of the health sector at the central, governorate and district levels
- Ensuring that the health workforce is of appropriate size and adequately distributed across medical specialties and geographic areas,
- Rationalizing the resource allocation with more emphasize on priority problems

3. Improving health services delivery

To achieve this objective the following strategies were set:

- Decentralization of MOHP service provision management to the district level;
- Organize the public and private service delivery to be centered on family health and to provide the basic-benefit package,
- Consolidation of MOHP health facilities at the district level into three types: FHU, FHC and District hospital;
- Integration of PHC services provision through family physician, with effective referral system in the three types of health facilities as well as higher levels of health care,
- Ensuring that both the public and private providers have to work through the NHIF and according to the incentive-based provider mechanism.

4. Improving the pharmaceutical system

To achieve this objective the following strategies were set:

- Ensuring that quality and affordable drugs are available to entire population, through rational prescription, dispensing and consumption,
- Development of the domestic pharmaceutical industry and reducing governmental involvement in the production of pharmaceuticals and strengthening its role as a financier of the pharmaceutical sector
- Egypt HSRP **guiding principles** are: Universality (covering the entire population with a basic package of priority services). Quality (improving and updating technical performance of the health services providers, and ensuring public satisfaction from the delivered health services). Equity (All people of different income level have fair share in the health system). The financing for health care services has to be based on ability to pay and service provision is based on needs. Efficiency (allocation and mobilization of resources for health care according to population needs and cost-effectiveness) and sustainability (self-sufficiency, continuity, and institutionalization of the effective health care system).

2.3 HSRP OBJECTIVE 1: ACHIEVING UNIVERSAL COVERAGE WITH BASIC HEALTH SERVICES

The first objective of the HSRP is to achieve universal coverage with basic health services. To meet this objective the MOHP aims to make a basic package of health care services accessible to all Egyptians through a system of universal health insurance. This basic package of care services is referred to as the BBP and will be addressed in paragraph 2.3.1. The system of universal health insurance will receive further attention in paragraph 2.3.2.

2.3.1 Basic benefit package (BBP)

The BBP is the minimum package of basic health care services that have to be available at all FHM facilities (FHU, FHC, outpatient clinics in the district hospitals) and accessible to all Egyptians through the universal health insurance system. The BBP integrates the previous major vertical public health programs at the PHC-level (e.g. FP, IMCI, ANC, etc.) [14].

The BBP is designed to provide services to prevent and control the most prevalent and pressing health problems of individuals at the community level. The inclusion of health services in Egypt's BBP is based on four criteria: common health needs of the population, severity of illnesses and diseases afflicting the population, cost-effectiveness of the interventions, and availability of financial resources. The BBP includes 26 health service categories for child health (6 categories of services) women health (5 categories of services), and health services for all age groups including young adolescent, adult and elderly (15 categories of services) [14] .

The scope of the BBP is dependent on the health facility type. The BBP in the FHU includes 26 services, while in the FHC it includes 16 services and in referral hospital it includes 21 health services (Annex I).

2.3.2 National health insurance (NHI) and family health fund (FHF)

Traditionally, there have been three types of health insurance in Egypt [6] :

- **Social health insurance (governmental)** is part of Egypt's public social security system. It is mandatory to all governmental employees who have bodies to pay a certain percentage of their salary for health insurance.
- **Private health insurance** is organized by commercial private companies and professional syndicates.
- **Health Maintenance Organization (HMO):** some institutions /companies act as insurer and provider (e.g. Egypt Air), with no third party involved.

In combination the above 3 systems have managed to cover no more than 45% of the Egyptian population and made coverage unattainable for many of the remaining 55%. That is why the Government/MOHP decided to establish FHF in 2001 as precursor to a system of National and Universal Health Insurance, with other 3 funds continue to exist in parallel to FHF[3] .

The FHF is based on separation of financing from service provision. According to HSRP, FHF has been established to become the main purchasing and contracting agency for quality PHC and secondary health care services, provided by HSRP-accredited public, private and NGOs facilities. FHF is a mix between insurance and cost-recovery scheme and it is considered a step towards national budgeting [15 & 16].

It is planned that FHF will provide means for further development of FHM using the model implemented in the five pilot governorates which were mainly selected to present different geographic and socioeconomic variations in the country. All health services as defined in the BBP should be financially viable with the ultimate objectives that 100% of the population has access to BBP through the FHM, an important stage for Universal Health Insurance System [17].

FHF Legal frame: FHF is a financial account, which started according to the MD 294 of 1999. FHF has been approved by the Minister of Finance after setting FHF structure and regulations according to MD 160 of 2001 (central FHF and FHF branches at the governorate level) . The MD 109 of 2003 included the Funds' by laws (administrative structure and internal organization). MD 147 of 2003 is concerned with introducing the concept of cost-sharing at the level of MOHP-PHC facilities [16]. According to MOHP data there are branches to the FHF in the HSRP-pilot governorates [3] .

Formally an independent fund does not exist. FHF is currently integrated within the structure of the MOHP and constitutes part of the STSP. The fund is currently still in a development phase, not

financially sustainable yet [2 & 16].

FHF Sources of Fund:

The sources of FHF are:

- **MOHP** (from the budget allocated from the MOF to MOHP).
- **HIO** (fund derived from insured individuals through contract between HIO and health directorates, this fund account for LE 13 per individual per year).
- **Foreign donations**.
- **Other internal** and **external** donations(3).

FHF Incentive Policy (Payment Mechanisms to Service Providers)

MOHP/HIO fund salaries and medicines while, FHF funds staff incentives [2]. The incentive system is characterized by being "Performance Based Payment Mechanism" [3] .

The percentage of the incentive is based on the monthly performance of the heath team, whose performance is appraised through a set performance indicators (table 2.1). Those indicators cover all aspects of service provision, whether curative or the preventive, and maintain the efficiency and quality. The performance indicators have standard/target and weights. The weights set for the indicators that reflect the relative importance of each indicator. Indicators related to national issues such as FP and immunization were given higher weights, so as to encourage the service providers to pay more attention to priority services [4].

Table (2.1) HSRP- Performance Indicators and weight percentage[4]

No	Indicator	Target Standard	Weight percent
1	Number of visits per day	20-48	30.0
2	Number of drugs per visit	< 3	30.0
3	Referral rate	1.0 – 8.0	30.0
4	Completion of visit encounter forms	Over 98.0	20.0
5	Patient satisfaction rate	Over 90.0	30.0
6	Completion of medical record data	Over 90.0	20.0
7	Family Planning protection years	Over 50.0	35.0
8	Immunization	95.0	35.0
9	Patient waiting time	< 20 minutes	20.0
10	ANC (visit/pregnant woman)	Over 0.5 visit per month	-
11	Following medical protocols	Over 98.0	-

The incentives ranges from 50% to 250% of the basic salary. which is flexible and could accept reasonable improvement [3].

FHF Contract Policies:

FHF has special policies to contract with public, private and NGOs facilities. To be legible for FHF contracts, the health facility should be accredited by the MOHP "General Directorate of Quality" and according to set standards. There are also different types of contracts to be issued between FHF and service providers working in public, private and NGOs facilities. According to contract items, the health facilities have to submit periodical reports including service statistics and indicators for subsequent analysis and interpretation to estimate the amount of incentives [3] .

The contracted health facilities should have MOHP license to practice and the capacity to provide health services to a specific number of families in the catchment area according to standards and regulations of HSRP to deliver PHC, secondary and other health services related to BBP [16].

According to HSRP-pilot governorate master plan, 35%-40% of the urban population will be covered with BBP through MOHP facilities, while the rest (60%-65% of the urban population) will be covered by private/NGOs facilities who will contract with FHF [18].

Initially the FHF will act as the purchaser of health care services and will contract with the Health District Authorities which later become DPO by providing a global budget based on DPO needs [15 &18].

In the future the contractual obligations with DPO will depend on a series of negotiations, which are based on health needs assessment and business planning cycle, taking into account the cost-effectiveness and efficiency. Additionally FHF will contract with DPO on the basis of other payment mechanisms e.g. per-capita system considering the age distribution and other risk factors of roster population [15 &18].

Central FHF

Central FHF is an autonomous body within the MOHP. The organizational structure of the FHF includes: General Director, deputy general director, business manager, research manager, financial manager and technical assistance team [16]. The Central FHF is responsible for:

- Supervision of the peripheral level FHF to ensure adherence to HSRP policies.
- Monitoring and evaluation of performance of peripheral FHF in the governorates.
- Supervise the contracting process between FHF and the health care providers.
- Supervise and approve the appointment of the peripheral level staff.
- Fund raising of necessary resources for FHF and allocating them to peripheral FHF.
- Conduct necessary research studies to assess needs for health services for different beneficiaries in different areas.

FHF at the Governorate Level:

The Governorate FHF works as a purchaser of the service on behalf of the district population. Governorate FHF has to sign a contract with the DPO (working as a service provider) [16 &18]. The contract includes terms and conditions for health services provided by DHA. The DHA has to develop signed Service Level Agreement (SLA) with family Health facilities, Private and NGOs facilities

The Governorate FHF has four main sources of fund: MOHP, Decree 147 and multi-donors.

MD 147 is applied to FHUs and FHCs that fulfill the criteria of implementing HSRP, accredited and contracted with FHF. According to the MD 147 (see chapter 3).

The **poor** are exempted from payments. The poor people have to be indentified after conduction of **socioeconomic investigations** at the facility level (FHU). Once identified, poor families could be enrolled in the FHU services, have folders and to get specific number of tickets annually to get free medical consultations and drugs. The percent of exempted families should not exceed 15-20% of the families served by each FHU.

Each FHF at the governorate level is operated by a director and 6 support units: policies and planning unit, monitoring and evaluation unit, information systems unit, finance, administration and legal unit, Marketing and communication unit, and contract and insurance procedure unit.

The Quality Improvement Department (QID) is responsible for offering accreditation certificate to the health facilities. The Monitoring and Evaluation system provides feedback to Health Directorate, DPO and Governorate FHF [16 &18].

2.4 HSRP Objective 2: Improved Organization and Management of the Health System

The second objective of the HSRP is to improve organization and management of the health system. To meet that objective the MOHP aims to:

- Centralize policy making and regulating,
- Decentralize the management of health service delivery through DPO,
- Reorganize the health system to be facility-oriented levels of care (e.g. FHU level, FHC level, hospital level)

- Improve the supervision system, and MIS
- Promote continuous quality improvement.

These different goals will be elaborated upon in the following sections.

2.4.1 Centralizing policy making and regulating

The STSP coordinates the development and implementation of the HSRP at the national level and is responsible for development of corresponding annual work-plans, oversight of financial management, procurement and logistics. In its capacity as HSRP-coordinator, the STSP provides technical guidance and supervision to FHF which is a semi-independent part of MOHP.

At the central level, the roles of the FHF and the MOHP with regard to the HSRP are defined as follows:

- **The Family Health Fund:** At the central level, the FHF is responsible for defining policies and prepare plans to finance the health services and ensure achieving the objectives of the HSRP regarding separating service finance from service provision [15 &16].
- **The MOHP:** At the central level the MOHP role will be health sector analysis, policy making and regulating, setting strategic planning framework, planning for public health programs and health promotion, monitoring of health goals, achievements and outcome indicators [1].

HSRP while separating the public functions of financing from delivering care has **two management entities:** One entity specializes on efficiently delivering more and better quality services according to accepted standards. The other entity concentrates on efficiently operating the insurance system, creating payment incentives for providers to adhere to set standards, fair prices and cost-effective treatment [1].

Currently the MOHP central organizational structure is headed by the minister, and employs about 5000 personnel, who are in charge of main central functions such as planning, supervision, program management and maintenance. At the central level, the MOHP is divided into board of functional divisions including six sectors: (a) The Minister's Office Affairs Sector, (b) The Training and Research Sector, (c) The Primary Health Care and Nursing Sector, (d) The Preventive Affairs and Endemic Diseases Sector (e) The Curative Health Care Sector, and (f) The Health Regions Sector. In addition to those six sectors, there is the Central Department for General Secretariat and the Sector for Technical Support and Projects (STSP) directly accountable to the Minister. The seven functional sectors embrace 23 central departments and 73 general departments at the central level. The seven sectors' heads and the central department heads report directly to the Minister. These includes the heads of: preventive care, laboratories, PHC, endemic diseases, technical support and projects, curative care, research and development, pharmaceuticals, dentistry, family planning and nursing. The MOHP central organizational structure is replicated at each governorate level. The governorate level health directorates are responsible for technical issues, but report to the Governorate Executive Council (headed by the Governor) for day-to-day management activities.

Each governorate health directorate is headed by an Undersecretary for Health Affairs **(UHA)**. The UHA supervises the Health District Directors **(HDD)**. The Health District organizational structure is a replication of the health directorate, where the basic functions are implemented on a smaller scale [4]. The total number of Egypt's Health Districts is about 260 in 27 governorates in 2008 [19].

2.4.2 Decentralization through district provider organizations (DPO)

Egypt health district system approach has been established since the early 1960s. District Health Authorities (DHAs) have been established in each of Egypt's governorate and traditionally they have been responsible for management of PHC facilities located within their geographical boundaries. DHAs have to report to the governorate health directorates. The HSRP is aiming to decentralize planning and management and financing of health care services by entrusting the

DHAs to carry out this role. Upon assumption of these new responsibilities DHAs will be referred to as District Provider Organization (DPO) and no longer DHAs.

The **DPO** approach is based on building local capacity and autonomy to plan and manage services focused on each district using local knowledge and skills to create health sector which meets the needs of local population. Each plan will include public, private/NGO sectors' services and facilities to be managed to support the mixed-economy model [(1)] .

DPO Objectives [(12)] :

- Decentralization of the health planning.
- Separation between regulatory, provisional and finance of health services.
- Improvement and maintenance of the quality of health care services.
- Maintaining the financial sustainability of health services.

DPO Organogram:

According to DPO organizational structure, there are five professionals:

- PHC director: This post is responsible for all the family health units and centers at the district.
- Curative care director: This post is responsible for district hospital and the other hospitals at the district.
- Nursing director.
- Finance and admin director.
- Communication and training director: this post is responsible for training programs and marketing plans for family health program.

The number of the staff members in each post is based on: Number of population per district, Number of MOHP, public, private and NGOs facilities and DPO plan for covering the population with FHU. DPO staff receives training programs in: orientation about HSRP, management, monitoring and supervision, financial management, quality and accreditation, and decree 147.

The DPO responsibilities (12) :

- DPO maintains the log-term implementation of HSRP: DPO is the official link between individual health facilities and decision makers at the central level. DPO develops plans and determines actual needs of communities located within the service range. DPO coordinates health activities and promote health programs through working with the members of the District Executive Council **(DEC)** and Local Peoples' Council **(LPC)** at the district level. DPO monitors health, social and environmental conditions of the served communities for priority settings and problem solving.
- Integration of PHC programs through organizing all MOHP/PHC projects including RH-services projects to be implemented according to district-base approach.
- Building up the Family Physician Roster (FPR), through managing the process of houses enumeration and roster (list) of all families residing in these houses.
- Involvement of the private health practice providers to have proper public-private market share.
- Development of the referral system which could be apt to work in case of complete involvement of all PHC facilities with HSRP model.
- Implement Quality Standards model, which should cover all PHC facilities within the district to prevent having two groups of facilities with different quality standards and subsequent client "move" towards quality facilities with over-utilization.

- Facilitate institutionalization of accreditation mechanisms.
- Monitoring and Evaluation of HSRP's effectiveness using indicators measuring disease burden, immunization coverage, patients' satisfaction, marketing, family planning, maternal care and community participation.
- Introduction of Training Practice Model through having a training center in one of the PHC facilities in each district to provide training services to PHC facilities' staff (HSRP policies consider that, having this training center ensures integration of the training process, prevention of overlapping, and support continuous education.
- Act as a contract point with FHF to provide FHM through governmental, NGOs and private sectors to cover the entire district population with BBP.
- Ensure community participation.
- Data analysis at the district level.
- Inter-sectoral cooperation at the district level.
- Supervision of FHU, FHC and district hospital's staff.

District Health Profile and Business Plan

The district health profile and business plan has to be completed by the District Health Authority (DHA). The contents of the plan and its cost are the foremost topic of negotiation between DHA and Governorate FHF. The district health plan has two main components:

1. ***Assessment of Health Services Delivery:*** This component is situation analysis and include the following information:
    - Assessment of how manpower and facilities can be restructured and strengthened at the district level.
    - Physical assessment of MOHP primary and secondary health care facilities at the district level: building suitability, functionality, infrastructure systems.
    - Enlist the available health facilities at the district: MOHP (PHC and curative), HIO, NGOs.
    - Determine the number of facilities to be included in the contract with Governorate FHF.
    - Determine the percentage of the district population coverage with family health model for the next fiscal year (July 1st to June 30th).
    - The data derived from the situation analysis form the basis for evaluation of utilization, revenue and visit-cost before and after implementation of HSRP.
2. ***Cost of service:*** This component includes
    - Costing of staffing, essential drug list, maintenance, minor renovation, equipment and furniture replacement and other cost centers.
    - Incorporation of the financial plan with the business plan to illustrate the main sources of fund and items of expenditures with the net balance of all operations of the plan.
    - Setting the details of each line item in budget/plan, and include the proposed budget for the mentioned activities and the overhead cost up to district level.
    - The financial plan presents the global budget with separation between the resources from governmental budget (Bab I and II), FHF, co-payments and others. FHF payments are expected to be on quarterly basis, depending on certain health and performance indicators, number of roster population and contracted facilities.

However, the MOHP-HSRP documents do not include clear mentioning of the role of the DPO in recruiting the FHM facilities' staff, role in maintenance, procurement, setting plans with well

defined targets at the district or facilities' level. There is no enough information about the mechanisms of supervision, how, who, frequency etc.,

2.4.3 Reorganization of the health care system

Egypt has an extensive health service network of primary, secondary and tertiary facilities (See panel 2.1) where *95% of the population lives within distance not exceeding 5 km from PHC facilities, or can reach the facility by public transport within a time of half an hour* [20] . It does however, not guarantee the availability of universally accessible quality services and its inefficiency can be illustrated by the fact that secondary levels of care practically consume two-thirds of the entire MOHP budget [21 & 22] .

Panel (2.1) Egypt Health Care System: Availability of Public, Private and NGOs Organizational Structure[2, 21 & 22]

Governmental sector:

- MOHP facilities, according to year 2001 data, include 4300 **PHC facilities**: 2837 RHUs, 555 UHC, 363 integrated hospitals, 346 health offices, 199 MCH centers. **Secondary health care**: district and general hospitals, tertiary health care/public hospitals in the governorates (277) and specialized curative and research /education institutions (199)[2].
- University Hospitals (16 university hospitals).
- Health Care facilities affiliated to other ministries (Ministry of defense and Ministry of Interior).

Public Sector (parastatal):

- Governmental health facilities managed by public sectors' organizations such as HIO and Curative Care Organization.
- Health care facilities owned and managed by public enterprises.

Private Sector:

The private sector includes private clinics, private hospitals, investment hospitals, NGOs and PVOs, private insurance, traditional healers. The total number of licensed private facilities which provide in-patient services are 2024 facilities [2].

To rationalize expenditure and harmonize service provision with the need for services, the MOHP has decided to use the HSRP to reorganize the Health Care Facility Model and shift the focus of care from high reliance on vertical programs and inpatient care to a more integrated and less costly PHC.

Panel 2.2: Levels of care and functions at each level according to Egypt HSRP(23)
Level 1 *Family Health Units (FHU) *First level of contact with the formal health care system with outpatient and public health services*
Level 2 *Family Health Centers (FHC) *Secondary level of care with outpatient specialist services, normal deliveries and emergency in-patient services*
Level 3 *District Hospitals (DH) *Tertiary level of care with in-patient and outpatient services within the main specialties (Internal Medicine, surgery, Gynecology & Obstetrics and pediatrics)*
Level 4 Specialized hospitals *Quarterly level of care with specialized medical care and specialized outpatient services*
Level 5 Specialized Institutions, centers of excellence, teaching hospitals and centers *Fifth level of care with highly specialized medical care*
**Family Health Model includes levels 1,2 and 3*

HSRP defines 5 different levels of health care that have to be provided in 5 different types of health facilities. Preventive, promotive and curative health services have to be provided in FHUs, FHCs and district hospitals (DH). Those facilities are public –private mix and constitute the **first three levels** of a 5 level system **(P*anel 2.2)***. On the governorate level, public and private service delivery focusing on specialized curative care have to be provided through general and specialized hospitals, and constitute level 4 of health care. The level 5 health facilities are highly specialized centers (e.g. Cardiac Institute), teaching hospitals and centers of excellence (e.g. Naser Institute) and are subject to direct supervision by MOHP-HQ.

The HSRP is adopting the following plans to reform the levels of health care (MOHP, 2005a):

a. Developing and institutionalizing systems, policies and procedures to rationalize health sector infrastructure:

- Adapting investment planning based on priority population health needs through strong health information system which provide data for planning and mapping the available and needed health resources.
- Rationalize the development and distribution of health infrastructure through establishment of "certification of need" function at MOHP to set guidelines for investment in facilities, maintenance and technology for the health sector.
- Adjust bed capacity to actual needs of the different communities through national facility survey, regional planning, facility planning, renovation of facilities, certificate of need process, and incentives to encourage redistribution of providers in underserved areas.
- Rationalization and efficient use of medical technology and equipment through surveying the available equipment and application of certificate of need program.

b. Reorganizing of the service delivery infrastructure

Reorganize the currently complicated health system of MOHP, HIO and private infrastructure ***(Panel 2.2)*** along the holistic "family health model". The health services delivery infrastructure will be consolidated into three levels of service/4 types of facilities including ambulatory clinics[4 & 24] . Those health facilities are:

- **FHU:** it is the basic health infrastructure unit in the PHC system in all districts. It is staffed by family physicians nurses and adequate number of paramedic and administrative staff. The number of FHU's staff members depends on the size of the served population ***(Annex .II)***. FHU will provide general outpatient services as defined in the PHC package. FHUs will evolve from RHUs. *HIO general practitioners clinics will be upgraded to function as FHUs and offer the BBP.*

  In the Urban FHU, each family doctor has to serve 750 families in a catchment area of around 15,000 – 20,000 population (3000 -4000 families) at < 2.5 Km distance. The number of family physicians is 4-5 physicians.

  In the Rural FHU, each family doctor has to serve 1000 families in a catchment area of around 5000 population < 2.5 Km distance.

- **FHC:** It provides limited specialized outpatient/inpatient services. It is to be staffed by at least six specialists (internist, surgeon, obstetrics & gynecology specialist, pediatrician, dentist and radiologist) in addition to 20 nurses and adequate number of paramedic and administrative staff. FHC will evolve from rural hospitals, rural health centers and urban health centers (MCH center, GUHCs, Polyclinics).

  The FHC may include within the same facility a FHU, which is administratively separate to ensure autonomy. HIO polyclinics will be upgraded to function as FHCs. Each FHC serves a population of 50,000 to 100,000 (10,000 -20,000 families) at <5km distance, which is the cumulative population of 5-6 FHUs.

  The private clinics may function as FHUs, while polyclinics may function as FHCs. The private facilities have to be organized to provide the full basic benefit package and be able to compete for National Health Insurance Fund participation.

  CCO will be incorporated and merged with HIO. THO will not be submitted to restructuring according to the reform.

- **District and general hospitals** will be prepared to provide services to cases referred from the FHC or FHU. HIO hospitals will receive cases from FHUs and FHCs.

District hospitals provide in-patient services, outpatient services and referral services to the quarterly level of care. The four main specialty services delivered in the district hospital include: internal medicine, surgery, pediatrics and obstetrics and gynecology as represented at level 3 district level of care. District hospitals refer patients to level 4 for specialized care(23) .

District level hospitals have the function of pre-service and in-service training as well as postgraduate training for medical personnel. Operations research could be conducted to identify interventions needed to improve the managerial performance of the hospital(23).

Usually there is one District Hospital for each administrative district. Sometimes one referral hospital could cover 2 districts. District hospital should offer a capacity of 200-500 beds.

c. Family Health Model

FHM is a network of public and private FHUs and FHCs that, together with the district referral hospital, can offer comprehensive package of integrated health services to all members of the family with continuous improvement of quality and access to PHC.

The FHM approach incorporates principles of PHC and the specialty of integrated family medicine. FHM provides continuing care through a definite basic package to each enrolled family. The facilities included in the model are renovated and accredited according to the set national quality standards. FHU and FHC staff receives special training in clinical and managerial skills to assure high quality of technical performance, proper management of the facilities, and the clients' satisfaction [(25)] .

The family health unit physician is a medical graduate with special training, according to contents in the HSRP-practice guidelines for family physicians (or has a master degree in **Family Medicine**) to give personal, primary, comprehensive and continuing care to individuals, families and communities. He/she undertakes work according to guidelines and protocols provided set out by the Health District. He/she also monitors the staff's performance who works under his/her supervision. He/she has the responsibility to maintain his/her continuing medical education and participate in all relevant training activity [(26)] .

2.4.4 Human resources management

One of the critical interventions of HSRP is the efficient management of the human resources.

a. Organizational structure of the health facility staff

The health facility staff is composed of 20 posts. The number of personnel within each post category varies across the facilities. **Annex II** shows that the number of the staff depends on number of families within the catchment area of the facility. It could be observed also that the **traditional community outreach workers** are <u>not</u> included in the organizational structure of the health facility, but there are social workers.

b. Job description and terms of reference

According to HSRP Job descriptions for 15 posts have been presented in details for (***see Annex V for Job***):

1. Family Health Unit Physician.
2. Family Physician/Director of Family Health Unit.
3. Family Physician/Director of a Family Health Training Practice.
4. Family Physician Training Manager.
5. Family Physician/Part- time Trainer in Family Health Training Practice (FHTP).
6. Family Health Unit Dentist.
7. Head Nurse of the Family Health Unit/Center.

8. FH and PHC Nurse.
9. FHU/FHC Nurse and Trainer.
10. FHU/FHC Pharmacist.
11. FHU/FHC Pharmacy Clerk.
12. FHU/FHC Lab Technician.
13. FHU/FHC Laboratory Assistant.
14. Health Sanitarian.
15. FHU Social Worker.

c. Capacity building of the health facility staff (training):

All the FHU, FHC, DPO, FHF, TSD staff are submitted to training to fulfill their job responsibilities. All training programs are provided in the HSRP governorates (2).

According to the accreditation system, each employee's competence is assessed at time of hire, and any time there is a change in job and annually. There is continuous education and training program for all employees, including the applicable physicians.

HSRP training courses to the facility staff include: introduction to family medicine, family folders, basic computing, family practice nurse training, dental services, pharmacy and logistic system, lab services at FHU, vital event registration and immunization, health education and communication, Housing enumeration and family registration, quality and accreditation, nurse training to be trainers, introduction of hygiene/safety, FHU orientation, Introductory management, head nurse management program (26).

The health facility, DPO, FHF, TSP staff participation in HSRP training courses, depend on their job description.

In 2007, the MOHP-CDTSP had introduced the training in family medicine and the training topics are covered in six volumes of "Practice Guidelines for Family Physicians"(See Panel 2.3).

As depicted from the health facility staff job descriptions and terms of reference the health facility staff includes Family Medicine Trainer and Nurse Trainer. According to the job description of those trainers, they have to provide health services to rostered families as well as providing role-model and trainers to the junior staff, and ensuring continuous education and management of training programs with the district staff.

d. Motivation of facility staff

The incentive system for the FHM staff has been described in details in section 2.3.2

e. Redistribution of human resources/Working hours/Working Days(26)

There are three criteria for deciding on the ***number of family physicians and other staff*** in each family health facility. Based on these criteria, the number of family physicians and other staff in each family health facility ranges from 24 personnel in facility with one clinic up to 48 personnel for facilities with three clinics. The three criteria are:

- Population of the catchment area: In urban areas, MOHP plans to cover 35%-40% of the population and the rest will be covered by other types of facilities (e.g. private and NGOs). In rural areas, MOHP has to cover 100% of the population. However, for public health services e.g. immunization services MOHP covers 100% of the population.
- Size of the facility: The number of clinics is 1-3 clinics according to the availability of space and the catchment population.
- The expected number of daily visits, which is based on 1.9 visits per year per family member.

Annex II shows that there is no specific physician: nurse ratio at the facility level.

Number of registered families per each family physician: This number was decided to be 500 families per physician (in year 1999). However, due to the lower than projected utilization rate, this number of registered families/physician has been increased to be 750-1000 families/ physician. This number of families/physician is based on:

- The average number of visits per family physician is 24 visits per day. This is based on the quality standards that estimate the average time required for patient examination to be 10-15 minutes.
- Average annual number of outpatient visits per family member is 1.9 (at the national level).
- The average size of the Egyptian family is 4.8 members.
- Average annual working days per physician is 250 days.

Social workers are assigned on the basis of one social worker per 10,000 populations (about 2000 families). All FHUs must have a social worker.

2.4.5 Improve clinical supervision system

The traditional model includes multiple supervision systems due to the vertically-oriented programs. Service providers at the health unit level are supervised by the district, governorate and central supervision teams for PHC, FP and MCH.

The HSRP supervision system is based on "integrated supervision" and improving quality of all components of the health programs. The supervisors are from the DPO (see DPO organogram) who are trained in supervision skills [(12)]. This type of supervision does not include clinical supervision, and it is just monitoring. There are no specialists in family medicine who are included in DPO organogram [(12)] , or FHF organogram[(15)]

2.4.6 Improve management information system

Traditionally, vertical programs have strong MIS, with specific input, process, output and outcome indicators as for example FP program [(27)]. However, due to being program-oriented, information derived from MIS of the vertical programs is fragmented, does not reflect the whole situation at the facility level, and there is missing information about services not included in the vertical programs e.g. non-communicable diseases[(1)].

HSRP information systems support the operational aspect of the reform. MIS provides health managers with administrative and financial information. MIS is based on: identification of needed data, development of indicators, designing software to process the data into information and training/capacity building.

At the facility level, the records derived from MIS allow the providers to track treatments and services for patient care in family context. The managers could track costs and utilization for planning. FHF uses clinical data to manage performance-based provider incentives, monitor facility cost, efficiency and quality and make capitates reimbursement.

MIS Patient-Based System (PBS):

PBS is the current **computerized** information system used in the **family health facilities**. PBS has been developed by the National Information Center for Health and Population (NICHP), with further upgrading by STSP-MIS team and FHF-MIS team.

PBS is using a **local area network** with a minimum of three workstations in the registration room, filing room and family physician room. The source of data for PBS is the various forms enclosed in the family folder. The system is extremely flexible and easily adaptable to the conditions and needs of each facility. This is achieved through flexible setup menus for all main variables within the system[(28)].

Physicians, nurses and admin support staff dentists/pharmacists/pharmacist clerks are responsible for data entry and analysis. The categories who receive "**Basic Computing**" are dentists/pharmacists/pharmacist clerks/nurses/ admin support staff.

HSRP MIS had defined 26 modules with conceptual, module, data dictionary, class diagram and sequence diagram. The analysis phase depends on the family folders data, but there is no community-based data [28].

HSRP document on MIS includes 28 "computer screens/templates" that could be used for FHUs and FHCs. The physician is responsible for computer data entry (in health facilities that have computers, otherwise it is done manually). Information about drugs is recorded by pharmacist etc. The data derived from the health facility are fragmented into family physicians' output, rather than health facility output [28].

The FHF uses data recorded at the facility level to determine the performance-based provider incentives, monitor facility cost, efficiency and quality, and make capitated reimbursement.

Due to incomplete coverage of the district's facilities with FHM, it is difficult to have indicators at the district level that presents all its facilities' output. Currently there is more than one information system in addition to the HSRP. MIS of the vertical programs (FP, MCH and PHC) covers all the health facilities to develop indicators at PHC and FHM facilities levels as well as the district, governorate and national levels.

2.4.7 Continuous quality improvement of health care

The MOHP has the General Directorate of quality which carries the responsibility of coordination of the HSR accreditation program. Accreditation process is the way by which the organization is required to demonstrate the provision of safe, high quality of care, as determined by compliance with the standards, evaluated by surveyors on-site of the organization [29 & 30].

Steps of the Accreditation Program (AP):

1- Preparation of an AP guidelines and procedures/mechanisms by MOHP General Directorate of Quality (GDQ), CDTSP, and international technical advisors (accreditation standards have been developed in 2007 for PHC centers and units [29] and ambulatory clinics [30]).

2- Orientation of service providers about the importance and application of the AP through the working group formed of MOHP (GDQ) and Technical Support Teams (CDTSP) at the governorate level.

3- Primary testing of FHU according to the accreditation standards to contract with FHF, and prepare report on each FHU including defects for further planning for improvement.

4- Periodic evaluation of the health facility according to the accreditation standards, and set recommendations for continuous improvement.

The quality dimensions included in the accreditation program includes: patient's rights, patient care, safety, support services, management of information, QI program, family practice model and management of the facility [17].

2.5 OBJECTIVE 3: IMPROVED HEALTH SERVICE DELIVERY

The third objective of the HSRP is improvement of health service. To meet that objective, the MOHP aims to:

a- Institutionalize an accreditation system.

b- Improve performance of the facility staff.

c- Ensure integration of service delivery.

d- Establish a well-functioning referral system.

These different goals will be elaborated upon in the subsequent sub-paragraphs.

2.5.1 Accreditation of FHM facilities

Accreditation system has been established in 1998 as part of HSRP and managed by the MOHP-General Department for Quality (GDQ). Its aim is to garner a minimum threshold level of care across the board and across Egypt. Accreditation is a formal organized process to evaluate the health care facilities according to a set of quality standards that define activities and structures that directly contribute to the improvement of health care outcomes. Facilities get accredited for a maximum of 2 years after which they need to be re-assessed. As a result, the accreditation process stimulates the service providers to improve their performance and ensures continuous quality improvement [31].

The MD 147 will be applied to FHUs and FHCs which have accreditation and contracted with FHF [3]. In case any health facility does not fulfill the accreditation criteria, after being previously accredited, the staff will not receive FHF incentives, but the health facility has to work as usual, at the same time continues trial for re-accreditation.

Role of MOHP-GDQ in the Accreditation Program

HSRP-accreditation program is designed as a "quasi-public" model, where the MOHP has the main responsibility of the program through the GDQ. MOHP-GDQ has the direct responsibility for setting standards, coordinating the monitoring process, and in awarding accreditation status. **GDQ** has to work closely with the Governorate/Directorates for Health Affairs (DHA) to implement the program. The program at the national level shall take place at the governorate level, where DHA will have the responsibility of conducting the accreditation survey, report on findings, and issue the accreditation status and develop the business plan to help achieving accreditation by the facilities [31].

To achieve accreditation, MOHP facilities receive support from GDQ in the form of equipment and training. Private/NGOs facilities have to pay for accreditation visits and action plans. Therefore, private/NGOs are hesitant to commit to accreditation-quality standards which are costly procedures with subsequent reduction in the number of private/NGOs facilities who enter into contractual agreements with FHF [18].

The HSRP follows the following steps to ensure providing quality services in health facilities with satisfactory infrastructure [23] :

- Location of the facility: nearby the residential areas, good accessibility, part of the social-environmental center, functional, hygienic, of high building standard, clean/pleasant surrounding environment and provide good services by qualified staff.
- Location in case of new facilities: good roads, surveyed land, electricity supply, availability of transportation, other public services (e.g. communication) and available facilities for waste disposal.
- Accommodations: The FHU accommodations include: waiting area, reception, consultation clinics (**Family Physician Clinic**: the number of clinics 1-3, depends the size of the served community), Immunization clinic, emergency room, delivery room (optional), dirty utility room, clean store/sterilizing room, dental clinic, lab, pharmacy, sanitarian office, administration and financial office, medical records room, registration office, health education/social work room, Women's club, general store, cleaner's room/janitor, male staff facility room, female staff facility room, maintenance/store, gate entrance, toilet/public/male, toilet/public/female, storage area for waste, circulation (corridors/ staircase/ covered area).

According to HSRP there are standards for the equipment and furniture document which include list of names and number of items per family health facility room, and description of equipment/furniture for each item[1] .

Maintenance of the accredited facility is the responsibility of the head nurse and the health facility director.

According to the accreditation system, specific requirements related to the facility and environmental system included 69 items related to planning and implementation activities, safety

and security, emergency/disaster management, management of hazardous material and waste, fire safety, maintenance of the medical equipment, and availability of utility system [29 & 30] .

Client/patient Flow

Patient/client flow: To maintain smooth patient flow, reallocation of the activities has been considered to achieve the least conflict and interaction among patients. The patient flow in the FHU follows the following steps [23] :

1. On arrival, the patient has to show the health card, pays for clinical examination fee (visit) at the registration and stay in the main waiting area.
2. Emergency cases have the priority (on average , there are 5 emergency cases per day for a unit serving 5000 population).
3. Patients coming for the first time have to fill their medical history and social sheets through the nurse and social worker (later on, this step will be canceled when all families are registered).
4. There are no bases, on which the patient selects his family physician for the first time during registration. It is mainly based on the physician time schedule during the day.
5. Registration office issue the family folder.
6. Family physician spends 10-15 minutes, on average, for patient examination. After the examination, the physician, completes the Encounter Form(diagnosis, lab investigations needed, and prescribed drugs) and the individual examination sheet of the family folder.
7. Physician keeps the original copy of the encounter form, give the second copy to the patient to do lab investigations and get their medications.

   For cases in need to referral, the physician issues the referral form. The Registration Office at the outpatient department at the district hospital is responsible for dealing with referral cases. This office is accountable for sending the referral sheet back, through District Referral Office, to the family health facility.

2.5.2 Improve performance of the facility staff

In 2007, MOHP-HSRP had developed the "practice guidelines for family physicians", which include all topics related to family medicine. The practice guidelines are used during training of the family physicians (see Panel 2.3).

According to the accreditation system, each employee's competence is assessed at time of hire, and any time there is a change in job and annually. There is continuous education and training program for all employees, including the applicable physicians [29 & 30].

Panel 2.3: HSRP Integrated curricula and standard of practice 2007

In late 2007 MOHP-The Sector of Technical Support and Projects developed "Practice Guidelines for Family Physicians" in collaboration with the faculties of medicine staff, other MOHP staff at the central and local levels. The guidelines presented in six volumes cover essential topics as follows:

- Volume 1 includes 5 topics: Introduction to HSRP and family practice, Working with the community, Neonatal care, Child health and IMCI [32] .
- Volume 2 includes 5 topics: Management of rheumatic fever and complications, Adolescent & school Health, Family planning, Reproductive health (early detection of cancer breast and cancer cervix, Pap smears), Reproductive tract infections[33] .
- Volume 3 includes 9 topics: Infertility, preconception care, The pregnant mother and antenatal care, The pregnant mother & associated diseases, natal care, Postpartum care, Post-abortion care, Menopause, the elderly [34] .
- Volume 4 includes 6 topics: Communicable Diseases DOTS/treatment of tuberculosis, Helminths, Urinary tract infections, Management of respiratory tract diseases & ENT, Management of GIT, Skin infection and allergy [35].
- Volume 5 includes 6 topics: Management of diabetes mellitus, Management of Hypertension, Coronary heart disease (CHD) & chest pain, Joint diseases, Mental health in primary care, Mental disorders [36] .
- Volume 6 includes 7 topics: Eye problems, Dental care & oral medicine, surgical emergencies, Medical emergencies, Food poisoning, Minor surgery, Management of liver diseases [37] .

2.5.3 Integration of service delivery through FHM

Traditionally, services were delivered vertically in PHC facilities. Through the FHM, integration of PHC services has become a top priority of HSRP.

"Integration" has different levels. At the health facility level integration means providing all PHC services by the family physicians. Additionally, integration means availability of different essential basic health services (BBP) within the same facility and at any time to serve the people of different needs. The service is comprehensive that the client could get clinical consultation, lab investigations and drugs from the same facility and during single visit. Integration includes also referral services across FHU, FHC and District Hospital. Integration guarantees effectiveness and efficiency of health services. MOHP consider that integration could improve effectiveness of health services through[12] :

- Providing interventions that complement each other (e.g. antismoking interventions preserve health of the children and mothers).
- Unify the system of data collection, analysis and dissemination allows for providing comprehensive data about all services, and help in decision-making and timely intervention in case of defects in service delivery and for any specific type of service.
- Better quality of health services through using one set of quality indicators and quality accreditation system that deal with FHU services as a whole.

MOHP is aiming to achieve more efficiency by having facilities change to integrated delivery of health services and expect:

- Less time wasted for families to receive different services from different providers at the same unit.
- Reduce time for recording data.
- Reduce duplication of some services within the same unit.
- Avoid repetition of physicians training on similar services or skills.
- Better use of the FHU's infrastructure with regard to proper distribution of time period for outpatient clinic use.

2.5.4 Establishment of referral system

Traditionally, there was no organized referral system. As part of the HSRP, MOHP has decided to formalize for effective and integrated referral systems and considers them essential for satisfying the needs of the basic health care services. MOHP-HSRP referral system has the following principles:

- The FHU has to examine all cases during working hours of the day through the family physician services, and refer cases who need higher level of services to FHC or the hospital.
- The emergency department in the hospital works 24 hours.
- The fee for service system at the hospital outpatient clinics remain as it is (no change).
- The morning sessions of the hospital outpatient clinics have to operate as specialized clinics for cases referred to them from FHUs and FHCs.

HSRP-Referral manual had identified cases to be referred at the three levels of health care, as well as the mechanisms of the referral cycle [23 & 38] .

2.6 OBJECTIVE 4: IMPROVING THE PHARMACEUTICAL SYSTEM

This objective includes ensuring that quality and affordable drugs are available to the entire population, with a rational prescription, dispensing and consumption [2]. Rationalizing the prescription of drugs is liked with the incentive system to the service providers, where the number of drugs per visit has to be less than 3 drugs (see table 2.1 for the performance indicators). The essential drugs should be available in the FHM facilities [39] (see chapter 3, Panel 3.2 for the summary of the essential drug list).

This objective also includes development of the domestic pharmaceutical industry and reducing governmental involvement in the production of pharmaceuticals and strengthening its role as a financier of the pharmaceutical sector [2] .

2.7 RAISING DEMANDS FOR FAMILY HEALTH SERVICES

The HSRP is adopting specific interventions to increase demand for family health services. Those interventions include marketing for family health services in the pilot areas, outreach services and community participation.

2.7.1 HSRP marketing activities

The proactive management of the family registration rosters by the FHU teams, allows contact/communication with the served community. HSRP has special approach for integration of IEC. FHF- IEC unit is responsible for production and dissemination of IEC material which include different services delivered in the FHM facilities[16] .

The marketing for FHM services considers promotion for a system of integrated family medicine and health insurance.

The FHF-IEC unit conducts marketing activities through the following [16]:

- Communicating and raising awareness of HSRP to both service providers and beneficiaries.
- Dissemination of information about family medicine and its potential advantages of alleviating financial burden due to expenditure on health, especially for the poor.
- Producing IEC materials for advertisement and social marketing of HSRP.
- Marketing and advocacy for new insurance scheme to increase the contribution in financing health care services as stated in MD 147.

2.7.2 HSRP outreach activities

MOHP –vertical programs had used different outreach activities through mobile teams, conveys, mobile clinics, community workers (Raida Refia, Raida Hadaria). However, HSRP have different strategy. HSRP follows the principles of community survey and enlistment of families. There is no enough information about HSRP outreach activities, apart from the home visits that have to be conducted by the FHU nurses, and social workers who display the different services delivered in the FHM facilities[26].

According to MOHP-HSRP documents there is **no community outreach workers in the organizational structure of the FHM facilities**. However, there is a "social worker" (one social worker per 2000 families[26]).

2.7.3 HSRP community participation activities

The HSRP strategy related to decentralization creates more opportunities for direct involvement of different community official and non-official sectors in the RH programs at the district level. The objective of such strategy is to get more support from local population councils, NGOs and other sectors to HSRP[12].

The practice guidelines for family physicians [32] includes a chapter on: "working with the community" which explains how to know and work with the community and the mechanism of working with community. The FHU board includes two members from the community who could provide strong link between FHU and the served community, and advocate for FHU services [32] . The same document raised the issue of activation of the Community Health Committee, which includes representatives for women, youth club and natural/non-official community leaders. This committee sometimes called "Clinic Board". The function of the committee is discussing health demands of the served community with the FHM team members. The inclusion of women and youth in the Community Health Committee could ensure the inclusion of RH-issues in the clinic board agenda.

2.8 HSRP FROM PILOT TO NATIONAL ROLL OUT

HSRP Strategic Plan

The comprehensive HSRP strategies are planned to be completely implemented over a period of 15-20 years (1997-2020) in three overlapping phases [2 & 40] :

Phase One (1997 -2010)

(1) Development of the basic benefit package of services to be available to all population through Family Health Model (Finalized 2006/2007).
(2) Redefine the role of MOHP and HIO and pooling their curative care budgets into the NHIF (In progress).
(3) Design policies related to the pharmaceutical sector especially those related to the essential drug list and rationalization of the drug use (In progress).
(4) Development of a master-plan for each governorate, especially in the area of health workforce, and physical resources (In progress, but completed in the 5 pilot governorates).
(5) FHM has to be implemented first in the selected pilot governorates (Alexandria, Menofia, Souhag, Quena and Suez).
(6) Specific pilot districts are selected within the pilot governorates, to maximize population coverage and eliminate regional disparities i.e. in Alexandria (Montazaa district), in Menofia (Menof District), in Souhag (Maragaa District), in Quena (Nagah-Hammady) in Suez (Suez is considered as one district).
(7) Allocate the required insurance fund for implementing the FHM in the pilot districts, (In progress).
(8) Rationalizing the service delivery system in ambulatory care up to the general hospitals (In progress).
(9) Monitoring and evaluation of the HSRP in the pilot area, and abstract learned lessons for subsequent improvement before expansion (In progress).

Phase Two: Fundamental changes in the medical education and planning systems (In progress).

Phase Three: Expansion of HSRP allover Egypt (In progress, see next subparagraph)

The HSRP implemented the FHM in 5 pilot governorates, and FHM has been implemented in selected one district / governorate, to test the model in the primary health care facilities [13].

The Egyptian HSRP is carried out as a National Policy on a pilot basis. Pilot testing of FHM on a complete district-basis facilitates is guiding towards fine-tuning of the reformed health care model that is affordable, effective and efficient for further expansion [1].

According to MOHP data HSRP is working in 5 governorates:

- Phase 1 (since 1999): Alexandria (Urban Governorate), Menofia (Lower Egypt Governorate), Souhag (Upper Egypt Governorate).
- Phase 2 (since 2003): Quena (Upper Egypt Governorate), Suez (Urban Governorate).

The phase covering the five pilot governorates is called the "F*amily Health Project"* and it has been planned to come into a close over in 2006 [41] , but it extended to be in 2008[42].

National HSRP Rollout

According to HSRP strategy, the HSRP model has to be completely functioning within 15-20 years. This means that by year 2020 HSRP has to be the national health system. The approved MOHP five-year plan 2006-2010 includes complete coverage of the Egyptians by health insurance, with extensive support from the high policy level as urgent intervention to improve health services [4 & 40].

HSRP is still under construction and there are certain components in the development and trial stage (e.g. McKinsey firm testing the Health Insurance program and Procurement of Services through FHF in Suez).

In July 6th ,2005 President Mubarak has declared the "National Plan for Improving the Health Sector" which include six strategies for universal coverage of the Egyptians with health insurance by the year 2010 :Improving the managerial and administrative capacity of the HIO; establishing FHF in each governorate; coverage of the currently non-insured people; nation-wide **rolling out** of FHM with adequate contribution of the private and NGOs sectors; improving the secondary level of care; Consolidate all the current health care providers under one entity to provide universal health insurance by year 2010.

According to the MOHP five year plan (2006/2010) for rolling out the FHM included the estimated budget at LE 2.9 billion, with 48% of the budget has to be allocated for maintenance of the quality services in PHC. The Prime Minister approved the plan and the plan was presented to the People's Assembly in December 12, 2004. Phase one of the plan included improving PHC services at the national level. The plan illustrates shift of the government's investment towards integrated family medicine, rather than the expensive curative services. FHU facilities are described as empowered facilities that have high autonomy, stronger economy, efficient physician and nurse staff, who provide comprehensive health care services to all Egyptian families [(4)].

At the implementation level, there are extensive efforts for horizontal roll out of the program through helping the development accredited FHUs and FHCs in **16 governorates**. According to MOHP-General Directorate of Quality (March 2008) [(42)], there are 965 facilities (FHU and FHC) which have been accredited. It is planned to include all health units (4300 units) by the accreditation program by year 2010 and to cover 80%-85% of the population by health insurance (50% of the population are already covered by health insurance, 15%-20% have to be exempted/receive free services, 30%-35% have to have folders/co-payment) [(44)] . However, there is no clear published plan that shows which governorates/districts/units, at what time the health facilities will adopt the FHM.

The Minister of Health (**2007**) announced the vision that "**all health facilities have to achieve accreditation by 2020**" [(29 & 30)].

POLICY ON RH-SERVICE PROVISION THROUGH THE FHM 3

The previous chapter provided a general understanding of HSRP's objectives and of the strategies developed to achieve those objectives. It became clear that the reform is to result in an overhaul of the entire health sector, however its initial focus will be on establishing a more equitable, efficient and effective, sustainable and accessible PHC-services.

Traditionally, PHC in Egypt relied heavily on vertical programs. The Health Sector Reform is steering away from that vertical approach by introducing the Family Health Model as the new standard for PHC in Egypt. All PHC-facilities are expected to adopt the FHM before 2020 which means that they will be offering an integrated package of 26 basic health care services to their clients. The package includes a wide range of PHC services including minor –surgery, nutrition supplementation, immunization, mental health, reproductive health, etc.

This report is specifically concerned with delivery of Reproductive Health Services through the FHM, and with the factors affecting it. The interpretation of Reproductive Health will be limited to Family Planning, Maternal & Child Health, RTI/STIs and Youth Friendly Services.

This chapter will focus on the FHM-policies with regard to RH and will provide in-depth understanding of RH-service provision as it is supposed to be according to the HSRP-master plan. The chapter is composed of 5 sections. The first section presents RH goals and targets as defined in the HSRP. The subsequent 3 sections correspond to HSRP objectives relevant to RH services i.e. universal coverage with basic health services, improved organization and management of the health system and improved health services delivery. The fifth section presents HSRP-policies to raise demand for RH services in FHM facilities

3.1 REPRODUCTIVE HEALTH GOALS AND TARGETS AS DEFINED IN THE HSRP

The goals, strategies and targets of RH programs (i.e. FP, mother and child health, RTI/STI services and youth friendly services) are included in the document: "**Health Sector Analysis and Future Strategies**"[2] issued by the MOHP-Central Department for Technical Support and Projects in 2003. The document includes compilations of the strategies and targets set by the vertical programs.

The RH-goals and targets as set in MOHP-HSRP document include:

- Reduce maternal mortality ratio to no more than 50 per 100,000 live births by year 2010.
- Reduce infant mortality rate to no more than 12 per 1000 live birth by year2010.

The 29 targets related to Maternal and Child Health includes 21 targets for child health and 8 targets for women's health, and those targets are to be achieved by year 2010.

However, it could be observed from the MOHP [2] document the absence of any targets for some issues as for example family planning, youth health problems and RTIs/STIs. However, the "Practice Guidelines for Family Physicians" volume 2 [33] includes the goal of Egypt FP program of achieving the replacement level fertility by year 2017.

On the other hand the MOHP document[2] includes the eleven strategies related to population issues: Family planning and reproductive health strategy, Child health and child survival strategy, Education and illiteracy elimination strategy, Women's empowerment strategy, Adolescents and youth strategy, Family support and protection strategy, Information, education and communication (IEC) strategy, Environmental protection strategy, Population redistribution strategy, Elimination of disparities strategy, and Support information and research strategy. Those eleven strategies have been published by MOHP/PS in year 2001 [43].

In 2001, MOHP had issued the National Population Strategic Plan 2002-2017 [43]. The plan

presents the quantitative targets for RH programs. MOHP document[2] included the population strategies but not the targets.

Table (3.1) Strategic Plan for FP and RH: Quantitative Targets (2000 – 2017)

Indicator	2000	2007	2017
Family Planning			
Crude Birth Rate (Per 1000 population)	27.5	24.6	17.3
Contraceptive Prevalence Rate (%)	56.1	63.1	73.1
FP Unmet needs (%)	11.2	6.0	0.0
CYP (Million)	7.67	9.79	13.34
TFR	3.5	2.5	2.1
Maternal Health			
Maternal Mortality Ratio (per 100,000 live birth)	84.0	65.9	40.0
Births Assisted by Medical Personnel (%)	60.9	72.9	90.0
Percent coverage of mothers with ANC (%)	36.7	54.5	80.0
Median age at first birth	21.6	22.0	22.4
Youth Health			
Percent of women with early marriage (<16 Ys) to total women 25-45) (%)	11.5	8.0	0.0
TFR 15-19 years old /1000 women	51.0	33.0	6.0
CPR (15-19) (%)	23.0	26.0	30.0
Child Health			
Infant mortality rate (per 1000 live birth)	42.5	33.3	24.7
U5 mortality rate (per 1000 live birth)	52.0	43.1	30.4
U5 with stunted growth (%)	18.7	15.1	10.0
Fully immunized children 12-23 months) (%)	93.2	96.0	100.0
Exclusive breast feeding for 6 months or more (%)	56.0	65.0	80.0

Source: Egypt National Population Strategic Plan, 2002-2017): MOHP (2001)

3.2 ACHIEVING UNIVERSAL COVERAGE WITH REPRODUCTIVE HEALTH SERVICES

One of the four overall HSRP objectives is to achieve universal coverage with basic health services. To meet that objective the MOHP aims to make a basic package of health care services available to all Egyptians through a system of universal health insurance. The general principles behind that strategy have been presented in section 2.3. The current section will highlight the RH-aspects of that strategy. Subsection 3.2.1 will focus on the availability of RH-services through the FHM, and sub- section 3.2.2 will concentrate on accessibility of RH-services through the FHM.

3.2.1 Availability of RH services through FHM

Geographic Availability of the health facilities: coverage of the population with the FHM facilities is a priority for DPOs that should be reflected in their business plans (see section 2.4.2). To ensure adequate geographical availability of basic health services (including RH-services) the home- clinic distance should not be more than 5 Km [12].

Availability of the services: All FHM facilities provide a pre-determined BBP to all families [14] . Panel (3.1) shows that out of the total services included in the BBP (26 services), there are 14 major RH services to be provided at the FHU, FHC and district hospitals. The BBP includes all services that could be delivered along the life cycle, for different age groups. In addition to MCH & FP-services, the BBP includes management of RTIs/STIs for men and women and providing services to adolescents, such services were not considered in the vertical programs [8 & 14].

Panel (3.1) Basic Benefit Package related to RH Services[14]			
Services	FHU	FHC	Referral Hospital
a. Child Health Services			
Neonatal care	✓	✓	✓
Management of young infants	✓	✓	✓
Immunization services and vitamin A suppl.	✓		
Monitoring of growth and development	✓	✓	✓
Management of childhood illness 2m-5 years	✓	✓	✓
Management of Rheumatic fever and complications	✓		✓
b. Women's Health Services			
Family Planning	✓	✓	✓
Antenatal care	✓	✓	✓
Delivery services	✓	✓	✓
Postnatal and post-abortion care	✓	✓	✓
Reproductive Tract Infections	✓	✓	✓
Cancer breast and cancer cervix (early detection	✓		
c. Health Services for all age groups (including young adolescents, adult and aging)			
Management of UTI and STDs	✓	✓	✓
Minor surgeries e.g. breast abscess	✓	✓	

Availability of the Service providers: Doctors and nurses are available during the morning shifts in types I and II FHM facilities, and in three shifts in the other facilities [23]. Night shifts in any type of FHUs in rural and urban areas are based on availability of the physician and nurse who live in the first floor of the facility and are on duty for the night shift. Therefore, services could be available in any type of the health facilities for 24 hours. Morning and afternoon shifts are for normal and routine health services, while night shifts are for emergency health services. The morning shift starts from 8 am to 2 pm, afternoon shift starts from 2 pm to 8 pm and night shift starts from 8 pm to 8 am the next day [23].

Table (3.2) FHUs Working Shifts and Number of Physicians by Type of Health Facility

Working Shifts \ Type of Facility	I	II	III	IV	V	VI
Morning	1	2	2	2	3	3
Afternoon	*	*	1	2	2	3
Night	*	*	1	1	1	1
Total Physicians	**1**	**2**	**4**	**5**	**6**	**7**

Source: MOHP and Central Department for Technical Support and Projects (2004): *Levels of care and Scope of Services (Chapter 1): Family Health Facility Implementation Manual. Version 2, May 2004.*

3.2.2 Accessibility of RH services through FHM

Geographic Accessibility: DPOs should ensure that the home-clinic distance should not exceed 5 Km [12]. However, according to HSRP master plan of the FHM pilot governorates, the MOHP-FHM services will cover 35%-40% of the urban population, while the rest of the population (60%-65%) within the catchment area of the MOHP-FHCs will be covered by the private/NGOs facilities. Therefore, to have complete coverage of the population with BBP in the urban areas, partnership between HSRP and private/NGO sector is mandatory [18].

Financial Accessibility All health services defined in the BBP should be financially accessible with ultimate objective that 100% of the population have access to BBP through the FHM [17]. The BBP-services (including RH-services) are all covered through the FHF-insurance.

In accordance with MD147, people could access to FHM –BBP services only after registering at particular facility by way of opening family folder (at a cost of LE 10 per family member and a maximum of LE 30 per family) and making an annual payment to the facility (LE 5 per individual

with a maximum LE 15 per family) [15]. There is a well-defined system for exemption of the poor people (see chapter 2 section 2.3.2).

Institutional Accessibility: According to the HSRP performance indicators, the **waiting time** should not exceed 20 minutes (see table 2.1, chapter 2). Facilities should welcome all people, irrespective of age, sex and socio-economic background.

3.3 HSRP OBJECTIVE 2: IMPROVED ORGANIZATION AND MANAGEMENT OF THE SYSTEM FOR REPRODUCTIVE HEALTH

One of the four overall HSRP objectives is to improve organization and management of the health system. To meet that objective the MOHP aims to:

- Centralize policy making and regulating.
- Decentralize the management of health services delivery.
- Reorganize the health system.
- Improve supervision and strengthen MIS.
- Promote continuous quality improvement.

The general principles behind that strategy have been presented in section 2.4. The current section will highlight the RH-aspects of that strategy.

3.3.1 HSRP/RH-related central policy making and regulation

Traditionally policy making and regulating including setting RH- goals and targets are the responsibility of the MOHP-vertical programs in MOHP-Population Sector for FP/RH, MOHP-Central Department for Maternal and Child Health MOHP-General Directorate for PHC. Currently, in the transition phase from vertical programs to integrated FHM, the MOHP-STSP is reforming the organizational structure at the central and peripheral level, and work with the NHIO to set the policies related to universal coverage with BBP –including RH-services. The future organizational structure of MOHP-HQ and the role of the vertical programs are included in MOHP –strategies 2006-2011[34], (***see Annex VI***).

3.3.2 HSRP/RH-related decentralization through DPO

HSRP decentralization, through DPO, indicates the transfer of decision-making authority and management with respect to health facilities within the districts from the MOHP central level to the district level. The implication of decentralization on RH program is proper response to local community needs, better community participation, monitoring and evaluation. However, the role the central MOHP is crucial to ensure that all districts are supporting the national health programs related to RH[8] (for more details about DPO see chapter 2, subsection 2.4.2).

3.3.3 HSRP/RH-related reorganization of the health system

Traditional Providers for RH-services:

Traditionally there are multiple sources for different RH services:

Family Planning: FP services are provided in FP clinics distributed in all PHC and other facilities. The study conducted in 2008 [44] showed that the number FP clinics had increased by 123% from 2255 in 1996 to 5034 clinics in 2008. This increase in number of FP clinics is due to establishing of FP clinics in all hospitals and health offices at the national level, in addition to those present in the PHC facilities. Therefore, it is possible to find FP clinics in the fever hospitals, ophthalmology hospitals, endemic diseases hospitals etc. [19]

MCH: MCH services (e.g. antenatal care, natal care, child care, immunizations) are available in PHC facilities: RHUs, MCH centers, Urban Health Centers. Maternal care services and sick-baby care are also available in public hospitals and specialized maternity hospitals. Immunization

services are also available in the health offices.

RTIs/STIs: In year 1996, management of RTIs has been included within the package of FP services provided in all MOHP-family planning clinics. Those services are provided to females attending PHC facilities and FP clinics distributed all over the country. According to Service Provision Assessment (SPA) Survey, 2005[45], RTIs/STIs management services are provided in PHC facilities (to women attending for ANC and FP services) in the outpatient clinics (in hospitals and polyclinics). According to SPA (2005), 89% of the health facilities provide medical services to RTIs/STIs cases in 2004, versus 62% of the facilities in 2002[45]. Despite MOHP-fever hospitals are the priority facilities for training providers and management of HIV/AIDS[46], only less than half of the fever hospitals offer services to RTIs/STIs cases[45].

Youth Friendly Services: This service is not known by this name. Youth could access any facility for any disease condition. Premarital counseling services are available in any facility. However, the study conducted in 2008 on youth perspectives to premarital examination had reported acceptance by 75% of the interviewed youth. However, those rejecting the idea of premarital examination (25%) had mentioned their fearfulness from discovery of any health problem that could prevent their marriage [47].

RH-services providers according to HSRP:

According to HSRP, RH-services e.g. FP, MCH, RTI/STIs, youth-friendly services are delivered as integrated services by the family physician. There are opportunities to referral to specialists from FHU to FHC and district hospital. EOC are to be delivered in the district hospital. All types of RH-services are delivered as a component of BBP in the FHU, FHC and district hospital (see panel 3.1).

3.3.4 Costing, financing and purchasing RH-services

Costing: RH-services included in the BBP have cost at a standard rate set by the FHF for the insured clients (those having family folder). The FHM-facilities have to adhere to these rates. However, there is no document that mentions the price of each type of RH-services. There is no document that identify the RH-services that should be delivered freely e.g. immunizations, FP counseling, FP methods, ANC, vitamin and mineral supplementations to the pregnant women etc.

Purchasing: Clients purchase RH-services included in the BBP when in a FHM facility either on their own or according to doctors' advice.

Financing: Uninsured clients will have to pay out of pocket for BBP-including RH services and drugs unless they are eligible for exemption of payment because they are too poor (see MD 147 in chapter 2).

Clients insured by the FHF, according to FHM, have to pay LE 3 for each medical consultation and one third of the price of the dispensed drugs as in case of management of RTIs for males and females.

3.3.5 HSRP/RH related human resources management

One of the critical interventions of HSRP is the efficient management of the human resources. Redistribution of human resources across the facilities, as well as working hours and the number of registered families per family physician are mentioned in chapter 2 .

a. RH-Knowledge and RH-skills of the facility staff

The health facility, DPO, FHF, TSP staff participation in HSRP training courses, depend on their job description. According to the accreditation system, each employee's competence is assessed at time of hire, and any time there is a change in job and annually. There is continuous education and training program for all employees, including physicians [29 & 30]. The practice guides includes different RH services (see chapter 2 subsection 2.5.2).

b. Job-Description and terms of reference

The job description/technical duties and responsibilities of doctors include tasks related to RH e.g. management of patients/clients according to MOHP guidelines and protocols and in accordance with the BBP, growth monitoring of the children, ANC, and provide advice and assistance with FP, supervise normal delivery and follow up the referred cases, supervise vaccination settings, plan and participate in health education and awareness activities and to work with the community and community leaders to maximize the benefits of the health unit services to the served community [(26)].

The nurses RH-related tasks are supervising the delivery of care at specialized clinics: MCH, healthy/sick child care, family health clinic of all age groups and FP clinic, ensure that the clients are provided informed choice in relation to the provision of FP method and conduct home visits (MOHP, 2004c).

The job description of the social worker includes outreach services for enumeration of houses, social research. Her job related to RH-services includes "*Assisting in providing more awareness and educating the women visiting the unit regarding serious and important topics such as family planning and importance of breast feeding"* [(26)].

c. Motivation of Facility staff:

Incentive system to the staff is based on "performance –Based Payment Mechanism" and according to achievement of specific indicators. There are three indicators related to RH: *FP protection years 50%, Immunization (95%) and ANC (visits/pregnant woman is over 0.5 visit per month).*

d. Appropriate allocation of the staff:

Reallocation of the staff allows all the staff to provide integrated family health services including RH-services. The number of physicians is determined according to the size of the served population i.e. one physician for 1000 families (or 5000 populations) (see chapter 2.5.2). This means that each physician has to provide RH-services to 833 married women in the reproductive age included in the roster.

3.3.6 HSRP/RH-related supervision system

The health facility staff is supervised by three supervision teams: FHF, Governorate TST, and DPO.

According to the job description, the FHU/FHC director and Head Nurse supervise the FHU/FHC staff and provide mentoring and in-service education.

The HSRP-does not have specific supervision system to RH-services that consider on-the job training in RH-services. The supervisors from FHF and DPO focus on the health facility achievements on-monthly basis to set the incentives. The incentive –based check list used during supervision include indicators related to RH-services (see section 3.3.4). Therefore, supervision is looking at records, general/common items to all services, with no specific guidance, on-the job training in RH-services.

3.3.7 HSRP/RH-related management information systems (MIS)

According to HSRP-MIS, there are quarterly and annual family health facilities performance indicator reports. Indicators on maternal and child health are included in the quarterly report. Indicators on FP (target CYP and achieved CYP) are included in the annual report.

The HSRP- MIS had defined 26 modules with conceptual, module, data dictionary, class diagram and sequence diagram. The analysis phase depends on the family folders data. The MIS has four modules related to RH [(28)] :

- Mother care Module (Sub-modules: ANC, delivery, postnatal).
- Child care Module (Sub-modules: Newborn, healthy child, sick child).
- FP Module (Coding of FP method, the first visit, the follow up lab test and investigations for each period of follow up, ordering of FP method, dispensing and receiving the family planning method).

Immunization Module (The immunization code and child age to have this immunization, immunization schedule, beneficiary immunization record)

There are no modules on RTIs/STIs and youth friendly services. There are other indirect MIS managerial modules related to human resources, equipment and maintenance, procurement, etc.

3.3.8 HSRP/RH-related promotion of continuous quality improvement:

According to HSRP facilities will need re-accreditation every two years, which is important for those facilities to guarantee their client flow and increase their incentives through maintaining their contract with the FHF. This will guarantee at least a minimum threshold quality of RH-service delivery and will provide an incentive for improvement.

The FHUs have to send to FHF the money they collect (enrollment fees and co-payments). The FHF would return 40 percent to the FHU for supplies, special equipment for ***continuous quality improvement***. The remaining 60 percent would be retained by FHF for provider payments as incentives [48].

3.4 HSRP OBJECTIVE 3: IMPROVED HEALTH SERVICES PROVISION

One of the four overall HSRP objectives is improvement of health service delivery. To meet that objective the MOHP aims to:

a. Institutionalize an accreditation system.
b. Strengthen performance of the facility staff.
c. Insure integration of service delivery.
d. Establish a well-functioning referral system.

The general principles behind that strategy have been presented in section 2.5 (chapter 2).

The current section will highlight the RH-aspects of that strategy:

3.4.1 HSRP RH-related physical infrastructure of health facilities

It is obvious from chapter 2, subsection 2.5.1 that HSRP ensures that the health facility location and accommodations should fulfill specific standards within the frame of the accreditation system. The accommodations related to RH-service delivery are characterized by the following:

- Most of the RH-services are delivered in the family physician clinic: ANC, FP, Sick-baby care, well-baby care, care for youth/outpatient services, and clinical examination for RTIs/STIs. The RH-services are provided in the same Family physician clinic, with other medical services for communicable and non-communicable disease for males, females of different age groups.
- There are 1-3 family physician clinics according to the size of the served community. Therefore, RH-services could be delivered in more than one clinic within the same facility.
- There is special room for immunization services.
- Delivery room is optional.
- There is only one waiting area for all patients whether attending for RH-services or other services.

- There is no room for FP-counseling where the nurse could provide this service.
- There is no room for oral-rehydration services for children.

3.4.2 Reproductive health drugs and commodity system

HSRP policies and regulations include the availability of the essential drug list (EDL) [39] where medications should be available at both the FHUs and FHCs in a continuous basis. Such situation supports RH services because the wide-spectrum of the drugs included in the EDL (78 types at the FHU level and 103 types at the FHC level) covers the need to provide specific RH services. EDL includes vitamins and minerals, vaccines (for mothers and children) and antibiotics and chemotherapeutics (some of them are specific for management of UTI and RTI) and FP methods.

According to the accreditation system, there are specific item related to "medication and immunization management". Such item includes requirements for the pharmacy regarding medication use practices, availability of patient specific information, specific policies related to selection and procurement, storage, prescribing , ordering and transcribing, preparing, dispensing, administration, monitoring, and evaluation of medication use [29 & 30]. (**MOHP, 2007a and b**).

Panel 3.2 Summary of EDL-Related RH-drugs and Contraceptives

Therapeutic group	No. of drugs	Use in RH
Anesthetics	4	Emergency management of minor surgery
Analgesics, Antipyretics, non-steroidal Anti-inflammatory drugs	10	Fevers
Anti- infection drugs	43	IMCI, UTI/STD (Metronidazole, Penicillin), skin diseases and ANC (Antivirus: ACYCLOVIR)
Anticoagulants and thrombolytics	4	Emergency management
Anti-allergics	5	Skin diseases, IMCI, Emergency
Diuretics	4	Hypertension (Pregnancy induced hypertension)
Cardiovascualr	18	Emergency management
Cathartics e.g. lactulose	2	Ante partum and postpartum hemorrhage
Skin disorders drugs	15	IMCI, UTI/STD (Povidone Iodine, antifungal), skin disorders
Anti-hemorrhoidals	1	Postpartum
Contraceptives	4	FP (three types of OCs) and Depoprovera injectable
Endocrine system disorders	3	Female hormones for female endocrine disorders
Anti-diabetics	4	Diabetics mothers (2 types of insulin preparations
GIT disorders drugs	5	Hyperemesis Gravidarum (ANC), Antiacids (ANC)
Hemostatics	4	Emergency
Ophthamics	5	IMCI/eye infection
Garles, mouthwashs	1	ANC
Ocytoxics & Myotonics	2	Normal delivery
Respiratory system drugs	13	IMCI -ARI
Vitamins and Minerals	12	ANC, postnatal care, Well-baby Care, IMCI
Blood restoratives	5	IMCI , emergency management
CNS drugs	3	IMCI :convulsions
Muscle relaxants	2	Emergency
Sera and vaccines	11	Emergency, EPI: children and mothers (ANC)
Miscellaneous e.g. Oxygen	2	IMCI

The EDL is classified according to therapeutic group, generic name, dosage form, concentration, tender price and package, trade name, level of facility (FHU, FHC, emergency room, delivery room), retail price and remarks. Panel 3.2 presents an abstraction from the EDL which is presented in MOHP document in 25 pages [39] to focus on RH-services related medications including contraceptives.

It is important to mention that IUD is not mentioned in the EDL (with group K of contraceptives). Monthly contraceptive injectables are not included in the EDL. Some governorates e.g. Souhag women prefer monthly injectables due to the frequent travelling of their husbands [49]. There no document in the HSRP that describe the logistics management for contraceptives.

3.4.3 HSRP/RH-related quality of health services

Traditionally, vertical programs have specific quality improvement program including the "Gold Star Program in FP". In such programs supervision visits have to be done quarterly to FP clinics and standard checklist has to be completed. However, the quality score and achieved "gold star" indicates that the FP clinic and not the whole facility is fulfilling the quality standards[44].

The HSRP has the potential for continuous quality improvement of all types of RH-services, through the following regulations:

- Improving the infrastructure of the health facilities at all levels and improving the quality dimension related to amenities with subsequent improvement in the quality of RH services[23].
- Intensive restructuring of the process of application of quality in FHUs and FHCs with initial start by accreditation of the facility before contracting with FHF and after introductory training about quality for the facilities' team[8].
- The strong quality and accreditation program, which conduct periodic evaluation of the quality of services delivered at the FHUs, FHCs and hospitals, ensures comprehensive quality services especially infection control related to RH-services[4 & 17].
- FHF/DPO/FHM have impact on self-regulate the service providers' performance through monetary incentives for quality and penalties for over-prescription and over-referral [8 & 51, 52].
- Client feedback, in the form of satisfaction surveys, is used to assess performance to modify performance behavior as appropriate. Such types of surveys empower the families and stimulate responses to their needs[8 & 51,].
- Studies showed that higher utilization rates of health services are associated with high quality of services measured by both the accreditation scores and client satisfaction and innovative outreach of the facilities[51].
- The outcome indicators which are set by HSRP include all priority national RH program objectives (e.g. decreasing the unmet needs in FP, increase contraceptive use among the underserved hard to reach groups in the community) could be met more easier under the quality control of the HSRP[8].
- HSRP measures the quality of performance on a monthly basis[8 & 17].

3.4.4 HSRP/RH-related health facility staff terms of reference /job description

All the FHU, FHC, DPO, FHF, TSD staff has to be submitted to training to fulfill their RH-related job responsibilities. The HSRP had issued the practice guidelines for family physicians which include all the components of RH services (***see panel 2.3 in chapter 2)***. However, there is no specific topic on Youth-Friendly Services, but there are specific topics on: Adolescent and school health (***volume 2)*** [33], and pre-conception care (***volume 3)*** [34].

3.4.5 HSRP/RH-related integration of services

The HSRP policy of family medicine approach in health care reflects integration, continuity and comprehensive services. As mentioned earlier, integration of PHC services including RH takes place in the FHM facilities through the family health services providers. Integration takes place across the district facilities between FHU, FHC and district hospital [12]. (**MOHP, 2004 -DPO**). There is no special protocol for integration of RH-services. In the job description [26], there is only one statement related to integration of RH-services in the job description of the family health unit physician, No. 7 include (***Annex V)***:

*"Care for **the pregnant** women during the whole pregnancy period and provides advice and assistance with **Family Planning**"*

3.4.6 HSRP/RH-related referral services

According to HSRP policies for referral services there is specific basic package of health services including RH services to be delivered at the three ambulatory levels of care in FHU, FHC and district hospital [50]. Panel 3.1, shows that most of RH served clients could have access to FHCs and referral hospital. District hospitals for example, will receive referred cases for emergency obstetric care, post-abortion care, RTI/STDs, children health problems and infertility management. Referral is mentioned in the different documents of MOHP-HSRP: the principles of referral services ***(see subsection 2.5.4)*** and the BBP includes the list of services that the FHU physicians have to refer cases to FHC and district hospital. Referral is included in the incentive system ***(subsection 2.3.2, table 2.1)*** where the referral rate should be within 1% to 8%. Referral protocols for each "health problem category" are present in the practice guidelines [32-73]. Referral protocols are included in the job descriptions of the FHM facilities staff as follows:

- Family Health Unit Physician/ Technical duty No.3: *Cases, which need special capabilities or expertise, are to* ***be referred*** *by him/her with a completed referral form to the family health center or district hospital. He/ She must follow up patients referred until the completion of their treatment.*
- Head Nurse of the FHU/FHC/Technical duty No. 30: Coordinate ***referrals*** with physicians and nurses in unit/center.
- The social worker: duty No. 16 :*Assisting the patient when* ***referred*** *to a specialist at the Family Health Center or when referred to hospital and can help in completing all procedures of admission to the hospital.*

3.5 RAISING DEMANDS FOR FAMILY HEALTH SERVICES AND ITS IMPLICATION ON RH SERVICES

The HSRP is adopting specific interventions to increase demand for family health services (see chapter 2, section 2.7) . Those interventions include marketing for family health services in the pilot areas, outreach services and community participation.

3.5.1 HSRP/RH-related marketing activities

The proactive management of the family registration rosters by the FHU teams, allows contact/communication with the served community [52 & 53] . This will facilitate dissemination of information about the FHU services including RH. Additionally, it will identify the eligible members of the families for RH services to be motivated to get RH services in the FHM facilities.

HSRP has special approach for integration of IEC. FHF- IEC unit is responsible for production and dissemination of IEC material which include different services delivered in the FHM facilities[16] (see chapter 2, subsection 2.3.2).

The marketing for FHM services considers promotion for a system of integrated family medicine and health insurance and not social marketing for specific health programs as RH-services.

3.5.2 HSRP/RH-related outreach activities

MOHP –vertical programs had used different outreach activities through mobile teams, conveys, mobile clinics, community workers (Raida Refia, Raida Hadaria) [54]. However, HSRP have different strategy (see chapter 2 section 2.7).

According to MOHP-HSRP there is a "social worker" (one social worker per 2000 families)[26]. The social worker's job description -duties as presented in point to some RH- services as vaccination (duty number 8). The social worker responsibility in the field of FP includes the following task, which does **not reflect any outreach activities** (duty no.17).

"Assisting in providing more awareness and educating the women visiting the unit regarding serious and important topics such as ***Family planning and the importance of breast feeding*** *and*

trying to overcome all common diseases in the catchment area of the unit".

It is important to mention that, MOHP-HSRP document –the section on social worker job description (no. 18) had mention "He" and not "She" [26].

3.5.3 HSRP/RH-related community participation

According to HSRP set strategies[2] which are derived from Egypt National Population Strategic Plan 2002-2017[43], the RH/FP strategies include raising community awareness and encourage positive attitudes towards FP&RH issues and problems through collaboration and coordination between different agencies, institutions and sectors in the field of RH.

The HSRP strategy related to decentralization creates more opportunities for direct involvement of different community official and non-official sectors in the RH programs at the district level. RH programs could find more support from local population councils, NGOs and other sectors [12& 55& 56].

IMPACT OF FHM ON SUPPLY OF RH-SERVICES 4

This chapter is concerned with analysis of the impact of FHM on supply of RH-services. The objective is to identify the extent at which FHM-guidelines developed at MOHP-HQ are implemented in the field. The sources of information in this chapter are MOHP policy makers, planners, managers and family physicians and other service providers as well as the analyzed data derived from observation quality checklist for FHM facilities (FHU and FHC) which had been completed by the researchers.

4.1 VIEWS OF MOHP RH-PROGRAMS' MANAGERS

The information presented in this section is derived from in-depth interviews with MOHP/PS/FP staff and MOHP/MCH Department staff at the central level. The term RH-Advocates will be used to present the two categories of the interviewees from FP and MCH departments. The data collected during the interviews had been analyzed and categorized to delineate the current situation regarding political support to RH programs, coverage with RH-services, management systems, service provision and suggestions to improve RH-services delivery through the FHM.

Political support to RH-programs

There is a consensus among RH-advocates that RH-programs, especially FP program have no more political support. RH-issues become no more a priority in the policy makers' agenda because there are emerging issues that includes focusing on FHM and its administrative aspects, rather than the technical components including RH-services.

> ***Quotation (1):*** High Policy levels do not pay any more interest to FP issues. There is deep involvement of the high political level/stakeholders in the emerging problems as Avian Flu, ambulance services, renovation of the health facilities, solving the problems of shortage in children's milk formula and the health insurance system.
>
> ***MCH advocates***

Same this situation noticed at the governorate level where population issues become no more priority topic in the governors' and local councils' agenda.

> ***Quotation (2):*** There are no more meetings of local councils in the governorates to discuss populatio issues
>
> ***FP advocates***

FP advocates consider that lack of leadership for FP program, and lack of coordination between the different ministries regarding population policies has negative effect on FP program.

> ***Quotation (3):*** The Ministry of Solidarity's policy of financial support of pregnant and lactating women had been interpreted by the public as "the GOE is supporting high fertility".
>
> The policy of allowing part-time job for women in the governmental jobs makes women re-thinking about having more children and the culture of the "having the third child" is propagating.
>
> ***FP- Advocates***

FP advocates mentioned that FP program; which has long been dependent on donors' support, is now in critical situation due to phasing out of the donors' support.

RH-advocates consider that the health policy reform with introduction of FHM had negative impact on RH-programs.

Quotation (4): The policy of paying for family folders as a prerequisite to receive RH-services, and paying for follow up visits in FP and maternal care had reduced the utilization of RH services in MOHP facilities.

RH-Advocates

FP-advocates mentioned that: despite the success of having governmental budget to support procurement of contraceptive methods, other FP activities are not supported. The MOHP/PS plan, which was usually financially supported by USAID, and includes 12 activities (as training, supervision, IEC, quality, women's clubs, slum areas etc.,) have severe financial shortage to be sustainable during this transition phase of the donors' phasing out.

Coverage with RH-Services

- ***Coverage with health facilities:***

RH-advocates had mentioned that; there is adequate coverage of the country with accessible governmental PHC facilities and they are increasing overtime. Additionally, after the MD 75-2006, which is concerned with providing incentives to the service providers who achieve satisfactory score for all health services as well as the incentives to the supervisors, has resulted in re-opening of the closed and activated the non-functioning facilities.

MOHP staff mentioned that all the "integrated hospitals" (600 hospitals all over the country) will work as "family health centers", because they do not fulfill the technical requirements to function as hospitals (e.g. no surgical theaters).

The RH-advocates revealed the current deviation of the mobile clinics from its role in RH-service delivery in the service deprived areas to provide curative services nearby the fixed facilities including the FHM facilities as in Alexandria.

Availability and Coverage with Service Providers

RH-advocates consider that, the approach of the HSRP of training physicians to be family physicians and to provide FP services has many shortcomings.

Quotation (5): Physicians, who are specialized in tropical medicine or pediatrics and trained to be family physicians, usually focus on cases related to their original specialty, and pay minimal interest to FP clients. Malpractice could happen as: uterine perforation in case of IUD insertion and prescription of injectables to women who chose IUD/and legible to use IUD.

FP-Advocates

Despite the success of the MOHP-PS in building generations of FP well-trained physicians, many of them left the facilities, as they do not like to work in family medicine. Additionally, the trained FP supervisors (who provide on-the job training) become less in number and there are no attempts to build another generation of supervisors. RH-advocates mentioned that "working in FP becomes no more attractive to physicians". MCH supervisors' role become reactive to the urgent problems as they become highly involved in political issues as responding to shortage in milk formula, rather than comprehensive MCH services.

Now all the physicians in the facilities and all the supervisors at all levels are working according to MD 75, with minimal interest to RH-services.

- ***Availability of RH-services:***

RH-services are available in all the facilities. All FP methods are available. MOHP/PS has strong procurement and logistic systems to ensure having strategic stock at the central, governorate, district and facility level for 2-3 months. The GOE allocates LE 29 million annually for FP methods.

However, in the transition phase from donor-supported system to self-reliance system, some constraints could happen. Long/complicated procedures for bedding and delay in receiving the imported FP methods, could threaten the logistic system. Frequent change of the source of FP methods could result in importing FP methods that fulfill the required specifications, but have some modifications. Those modifications could be bypassed by the "FP Methods' Checkup Committee", and result in problems at MOHP facilities including the FHM facilities as well as NGOs facilities which receive FP methods from MOHP.

> ***Quotation (6):*** The "X" lot of IUDs was not good, or the doctors could not use it. For a doctor to insert one IUD she has to discard three IUDs. Unfortunately, we have extra amount that could cover our needs for the coming 8 months. To use them we have to train all doctors in all the health facilities.
>
> ***FP-Advocates***

- ***Health Systems' Management***

Planning for RH-programs:

Planning for RH services was linked with projects that are financially supported by donors. Throughout the period 2002-2007, there was gradual cutting in budget support with subsequent reduction in budget allocated for supervision, training and IEC.

RH-advocates claimed that HSRP documents include compilation of all the already available vertical programs' documents including the RH-goals and targets (set in year 2000) , without having a system at the local level (governorates and districts) to update, monitor, or evaluate such goals and targets. Additionally, RH-advocates mentioned that HSRP is working as a vertical program. MOHP-STSP did not involve MOHP /RH-planners and managers during preparation of the RH-goals and targets, at least for updating.

Cost-sharing in RH-services:

Despite the known FHM policy of "providing free services to FP, ANC and immunization services", the situation is ambiguous for many of those involved in service delivery. RH-advocates mentioned that FHM service providers put pressure on women to pay for the family folder (LE 30) to get any RH-services.

> ***Quotation (7):*** The woman has to pay for the folder LE 30 to get medications during ANC.
>
> ***MCH-Advocates***

The woman could get the FP method freely, but she has to pay for follow up visits (LE 3).

> ***Quotation (8):*** It is less costly to the woman to get OCs, and injectables from the private pharmacy. Because the lady has to pay LE 3 each time she visits the FHM facility to get the FP method.
>
> *Additionally, the exemption procedures for the poor are very complicated and time consuming. Such situation had resulted in reducing RH clients in FHM facilities.*
>
> ***FP-advocates***

Decentralization through Health District Approach

The views of the RH-advocates towards decentralization through health district approach indicate the lack of support to RH-programs at district level due to the following reasons:

- Health district staff has no experience in forecasting and assessment of needs for the amount and FP method mix.
- No experience in contraceptive technology, procurement and finance, to conduct international and national biddings.
- Variation across districts and across governorates in the types/specifications of the

contraceptive methods, with subsequent difficulties in standardization in training and MIS across the country.

- Variations in the types/generic names of FP methods across governorates, could result in FP discontinuation in case of moving of women from one governorate to another.
- Availability of strategic stock from different FP methods depends on the level of interest/political support from policy makers at the governorate level.
- The health district cannot redistribute the extra amounts of FP method stocks to other places, with high probability of waste.

Health Manpower Management and Training:

RH-advocates stated that the current situation regarding the number and distribution of physicians is very stable, with less probability for turnover of physicians. They attributed this stable situation to working in FHM facilities and MD 75 which provide good incentives to physicians, as well as the high opportunities for physicians and nurses to work in their home governorates. The problems of having surplus number of nurses in the PHC facilities was solved through transfer of nurses to work in the hospitals, and close of some nursing schools to reduce the number of nurse graduates.

The HSRP policy of contracting limited number of service providers, had negative impact on FHM and RH-services. The affiliated to the FHM facilities, but not included in the incentive/contracting system become opponents to the FHM services including RH-services.

RH-advocates affirmed that ***HSRP system is not effective in capacity building of the service providers in RH-services,*** and they gave the following evidence:

- Despite the GOE had allocated LE 12 millions for pre-service training in integrated PHC services /family medicine, to be implemented in the governorates, the training is not enough to build skills in RH-services delivery. The training is focusing on theoretical topics rather than practical training.

> ***Quotation (9):*** The training in family medicine is like the university. They use text books and not protocols
>
> ***MCH advocates***

- The time allocated for pre-service training is 6 weeks. The time allocated for training in FP is only one week. Practical training in FP is only covered in 2 days and for 30 participants. This training is not effective, if compared with the MOHP/PS training in FP in 10 days with 5 days allocated for practical sessions and for 10 participants.
- There is no on-job training to the service providers due to the specific approach of integrated supervision, with no enough time to train individuals on specific RH-services.
- Inadequate training has negative impact on RH-services with different forms of malpractice as non-response to women choice for IUD, and other problems.

Incentive System

The incentive system –which is linked with output indicators could guide to wide room for malpractice, RH-advocates had mentioned the following examples which they observed during their field visits:

- Having fixed number of cases per day (24 case per physician), could make the doctor reject service provision to cases. FP clients who are extra of the daily quota of 24 cases, may leave the clinic and do not come back (this usually happen in facilities with high FP-caseload).
- Doctors could record factitious names and pay from their pocket money for the cost of unreal visits, to get the incentives, same applied for CYP incentives.

- Incentive linked with CYP could make doctors buying IUDs and record factitious names.

Supervision System:

RH-advocates mentioned the following drawbacks of the current supervision system in the FHM:

- Disappearance of the constructive supervision system of the vertical programs which includes on-job training, and they attributed the situation to the shortage of funds and reduction in the number of the technical/clinical supervisors.
- Integrated supervision through MD 75 –is incentive oriented rather than quality of service oriented.
- The FHM service providers are exposed to supervisors from the central, governorate and district level (according to MD 75)as well as the FHF and CDTSP staff (central and governorate), and none of all the supervisors provide on-the job training in RH-services.
- There are limited number of quality items related to FP services in all the checklists used in all types of supervision.
- A health facility could have high score according to MD75 checklist, but very low score in FP.
- There is no system that compiles and analyzes the information derived from the supervisory reports.

Some RH-advocates consider that the introduction of MD 75 has many advantages to the FHM rolling out:

- It ٍcreates the culture of "integrated quality" that consider all the services in MOHP facilities.
- It allows coverage of all MOHP-PHC facilities with standard integrated supervision checklist, that all MOHP departments use during supervision.
- Institutionalization of the sustainable supervision system in MOHP, where the budget allocated for supervision visits is completely covered by the GOE.
- Motivation of service providers to continue work in the PHC facilities, and keep the momentum of quality improvement to keep gaining the incentives. The turnover of the physicians showed reduction due to MD 75.

Management Information System

RH-advocates mentioned that FHM is characterized by static MIS, because it fixes the target for the number of cases per physician per day at 24 cases. During field visits, FP supervisors observed that the achievements of all FHM service providers are static at 3-4 IUDs per month, according to the set target.

RH-advocates consider that the data in the family folder is not enough for FP program. Therefore they added the FP form to the folder, with subsequent more paper work and increased load on the service providers.

Monitoring and Evaluation System:

RH-advocates consider that the lack of M&E system that uses sensitive indicators is a major shortcoming for FHM. M&E system is physician/folder–incentive-oriented, rather than facility-community oriented.

RH-Services provision

Health facilities' Infrastructure/ accommodations and Equipment:

RH-advocates mentioned three major comments on FHM facilities:

- Privacy for FP clients is not ensured, where there is no waiting area for women, and FP

services are delivered in the family medicine clinic, in which services for men and children are delivered. FP-advocates mentioned that, women cannot declare their dissatisfaction from lacking of privacy, and express the issue as absence of specialized physicians.

- There is no special room for the nurse to provide FP counseling.
- Some of FHM facilities have no gynecology examination beds, and the internal medicine examination bed is used during IUD insertion, and this is uncomfortable for the client and the provider.

Job description of the service providers:

In the FHM facilities, there is no clear job description for physicians and nurses in RH services. Moreover, the service providers are unaware about the FHM-job description document.

It is supposed that the nurse provide counseling services in FP, but there is no special room for counseling. The nurse provides ANC services, and the doctors focus on curative care services.

The involvement of physicians in extensive paper work reduces the time allocated to provide quality services.

The FP trained physicians, who become family physicians loss credibility to provide services to all members of the family in the same facility. People feel that the doctor who was providing FP services, (which is a gynecological specialty) is not competent to provide health services to men.

RH Client cycle in the health facilities

The RH-advocates had raised three issues that restrict the efficiency of the FHM in ensuring satisfactory RH-client cycle/flow:

- The practice guidelines present the theoretical background of the medical topic. However, there are no **protocols and standard of practice** guide that demonstrate the sequential steps that should be followed during providing services to RH-client, and the role of the doctor and the nurse in each step.
- The counseling services for FP clients are usually overlooked, and there is no special room for the nurse to provide counseling services.
- RH-clients, being the "free service receivers", and do not add revenues to the facility are usually postponed to be served at the end of the shift. This situation makes the clinics loss their FP clients.

Quality of services and RH-clients' Rights :

RH-advocates appreciated the FHM interventions relating to documenting the consent of the FP client in case of IUD insertion, implanon insertion and the use of injectables. Nevertheless, the service providers do pressure on RH-clients to pay for the family folder.

> ***Quotation (10):*** Some women who demand FP use have to go into debt due to the need to pay for the family folder
>
> ***FP-advocate***

FP-advocates consider that standard of practice in FP manual, is no more used by service providers, despite its importance for providing quality services to FP clients. Consequently, the service providers deal with FP clients as any patient, and not as a client asking for preventive services.

The integrated approach in supervision and accreditation allow for ensuring continuous quality improvement for all services. However, lack of privacy in the waiting area, and not having a clinic specialized for FP services are major threats to quality FP services.

- ***Community mobilization:***

IEC programs : RH-advocates consider that the general shortage in IEC programs about RH-services could influence utilization of RH service in FHM and non-FHM facilities.

Outreach programs through Community Workers: FHM facilities have no community worker/Raida Refia (RR) in their organizational structure. However, HSRP is highly depending on RR for enlistment of the families, completing the folders, in addition to their role in communication in FP. The total RR is 13000, and only 2500 are hired in the MOHP health facilities. The response of HSRP to RR is not clear, and the future of RR in the HSRP is not identified.

RH-advocates mentioned that there is overuse of RR in outreach communication and for many health programs: Avian flu, TB, filaria, HIV/AIDS, FGC, FP, MCH, and HSRP. Therefore, RR lost their credibility as advocate for RH- programs.

Religious Leaders: After phasing out of the foreign fund for RH-services, there is no training to religious leaders to support RH-services. Additionally, there is no control to the mass media, especially in satellites, that disseminate statements against FP method use.

- ***Suggestions to improve RH-services through FHM:***

RH-Advocates had suggested the following to improve RH-services delivery through FHM:

- Introduce mechanisms to ensure political support to RH-programs at the central and governorate level including the local councils.
- Strengthen the role of MOHP/PS in contraceptive security and ensure the availability of quality FP methods.
- Strengthen the role of the MOHP-MIS system, to monitor the role of FHM on the RH-services output with more transparency.
- Strengthen the IEC programs in RH-services.
- Strengthen the package of training in family medicine and allocate more time for practical training in RH-services, with reduction of the number of trainees per session.

4.2 VIEWS OF THE MOHP/STSP-FHM PROGRAM MANAGERS

In-depth interviews with the MOHP-STSP staff (**FHM-advocates**) had provided information about the impact of the FHM on supply of RH-services, and "***MOHP strategic plan 2006-2011***".

- ***Planning for RH-services through FHM***

FHM-advocates affirmed that HSRP is "reform of the mechanisms by which quality health services including RH-services are provided". Reform is integration of vertical programs through family medicine. Therefore, HSRP is adopting the goals and the strategic objectives of the vertical RH-programs.

- ***Universal coverage with RH-services through FHM***

Availability of health facilities: HSRP has a comprehensive plan to establish new facilities and renovate health facilities. However, there are some obstacles related to shortage in availability of land space to build new facilities that fulfill the geographic accessibility item. Additionally, in case of rebuilding collapsed facilities, there are complicated procedures to get license from local authorities.

Currently the **mobile clinics** provide curative services as well as RH-services in all the governorates. But this is a ***temporary role*** because universal coverage with fixed clinics is included in the MOHP plan.

All FHM-facilities have adequate stocks of FP methods. MOHP/PS has a major role in satisfying

the needs of all health facilities with FP methods. However, in this transition phase, experiences should be strengthened to establish FP procurement and logistic system.

FHM-advocates affirmed that "***all the facilities have SONAR***".

Financial accessibility*:** FHM-advocates mentioned that: despite the complaints from the high cost of medical consultation fees, and the annual premium the services are ***subsidized. FHM have dropped the fees for RH-services. There is fee -exemption for 15% of the families (to ensure access of the poor/equity). Salaries of all workers in the FHM as well as FP methods are completely covered by the governmental budget.

The major problem confronting the FHM is failure to communicate with the community and to inform them about the concept of health insurance, and transfer the message/concept of solidarity/risk-sharing among families. Additionally, some of MOHP-staff at different levels is not aware with the importance of health insurance and cost-sharing.

Service accessibility:

FHM-advocates have addressed the issue of the client cycle within the facilities, and how it reduces the waiting time. They mentioned that, with an average number of 24 clients/patients per family physician per day, there will be no caseload, no crowdedness in the facility and less waiting time.

The client has free choice of the doctor. In case of dissatisfaction from the family doctor, the family could be included to the roster of another doctor, but after 6 months.

Currently, in Suez a new electronic system is under trial. This new system depends on using special cards by the family members to get access to different health facilities and in any governorate.

- ***Improving Health Systems for RH-Services***

Costing and Financing of RH-services:

FHM-advocates mentioned that, MOHP had conducted many studies to identify the best health insurance system all over the world and could be more suitable to the Egyptian community. MOHP discovered that the policies and regulations included in Egypt Health Insurance System are the best, because they depend on social insurance. This system is more matched with Egypt society, compared with UK system which depends on taxes. The problems of the NHI system in Egypt are related to its application. Therefore, HSRP had built on strengths of the old system and added the following modifications which all provide good environment for financial sustainability of RH-services:

- Separation of funding from service provision.
- Create the new independent organization "FHF" for funding and contracting with health organizations, facilities, governmental, NGOs, private as well as individuals to provide the basic health services.
- FHF is characterized by pooling of fund of the currently health insured people (employees, school students, U5 children) as well as the money collected by cost-sharing of those who receive the service. The positive issue is that the fund will remain at the FHF (not to go to the national governmental budget as in NHI). Therefore, FHF has independence and autonomy to contract with different organizations, wider scope of services and allow for competition to select the best package of quality services.
- FHF works according to specific regulations so as administrative budget should be kept at less than 10% for salaries and incentives (compared with 60% in the previous NHI).

FHM-advocates mentioned the following obstacles for the Health Insurance in FHM which could negatively affect FHM-RH services:

- The private and NGOs sectors have limited experience in negotiations and bidding and in making balance between the package of services, quality, marginal profit, sustainability. Those issues need time and training.
- The bad experience about the previous NHI makes people resist the idea of health insurance. Therefore, during this transition phase, the FHF is suffering from shortage of resources.
- Despite the needs for being highly dynamic, FHF is still working within the frame of the governmental bureaucracy, with subsequent delay in progress and delay in incentive payment to service providers in the FHM facilities.
- Currently, there is no governmental financial support to FHF, which suffer from shortage in revenues. Additionally, the current FHF accounting system is a manual system that takes time to develop financial statements with subsequent delay in providing incentives to the service providers.

Decentralization through DPO

FHM-advocates mentioned the importance of the role of the DPO for decentralization of management of health services at the district level through contracting with FHF. However, it is considered the difficult component of FHM due to introduction of new system with modernized concept into an old system with static thinking, and resisting environment at all levels.

There is no true decentralization through DPO. Decentralization means independence and autonomy in decision making. However, the Health District Authority still affiliated/under the control of the Health Directorate and MOHP-HQ, and DPO has no complete authority/responsibility towards the health facilities.

> ***Quotation (11):*** Up till now, there are supervisory visits from the vertical programs at the central, governorate and district levels to the FHM facilities, in addition to FHF supervisors, and DPO supervisors. This multiple supervision disrupts service delivery at the facility level

The FHF has to supervise/monitor the contracted facilities. However, being located at the governorate level and the number of its staff is about 20 personnel, they are not able to do monthly supervision to all the health facilities in the governorate. Therefore, FHF should depend on DPO in supervision of health facilities, and the FHF has to do spot-check for some selected facilities.

Human Resource Management

FHM-advocates mentioned that the total family physicians needed to work in the FHUs is 14000, where the roster per each physician includes 1000 families.

FHM-advocates consider that FHM is effective in building the capacity of the service providers through:

- Preparing the service providers to be fully aware about the package of health services that they are responsible for and according to the standard of practice.
- Guiding the service providers towards the objectives of health programs that are integrated/complementary to each other e.g. postpartum FP.
- The current training program "Integrated training in family medicine" is organized and coordinated by STSP and includes training in RH-services has the following advantages:
    - *It is **33-days** in duration, and cover all integrated PHC services.*
    - *It is one of **sustainable** activity as it is institutionalized in MOHP, it is not project-dependent.*

- *Being a **pre-service training**,* it maximizes the benefits of training throughout the working duration of physicians in PHC-facilities, with minimal distraction to attend different training courses of the vertical programs.
- *It is standardized to all trainees all over the country.*
- *It includes required standards for quality services.*
- *It considers sequences of the administered information.*
- *The training contents are prepared by experts and the experienced trainers **in the vertical programs**.*
- *It considers both practical and theoretical components.*
- *It is conducted in the governorates.*

One of the important HSRP-interventions is the introduction of ***family medicine*** specialty in the medical schools in Egypt. Physicians having this specialty, have their salaries higher than other specialties.

Management Information System

FHM-advocates mentioned privileges of the FHM-information system compared with vertical programs:

- FHM succeeded in providing database that describes the profile of the served community, through enlistment of 100% of the families. Through this database, the women eligible for RH-services could be identified.
- It provides clinical information about the family members being recorded in the family folders.
- The limited precise M&E indicators are prepared to reflect performance of all services (compared with the huge number of indicators used by the different vertical programs).

Supervision System

FHM-advocates affirmed that, supervision according FHM depends on ensuring that the health facility team works according to specific standards that could be assessed during supervision visits. In FHM the supervision process is different from that of the vertical programs:

- The performance in all services is supervised.
- Both clinical and support services are supervised including the work environment.
- The points included in the performance checklist are changed each visit. For example, the eleven indicators used during supervision visits could be replaced with another eleven indicators and depending on findings of the previous visits. This is to emphasis on weak points and to give push for improvement.
- There is a link between supervision and incentives. Therefore, supervision has to be done on monthly basis, and to ensure that the staff is continuously improving.

The FHM-advocates mentioned the major obstacle for supervision according to FHM is the persistence of the supervision by the vertical programs, and re-exposure of the facility staff to fragmented information, with subsequent dispersion/and confusion in performance.

- ***Improving Health Services Provision***

Physical Infrastructure of the Health Facilities

Building new facilities and renovation of the present facilities is done according to specific plans, to cover the whole population with essential health services. However, FHM-advocates mentioned three obstacles: First: the time and financial constraints to complete renovation, new buildings, furniture and equipping. Second: non-cooperation of the local authorities to get licenses for new buildings. Third: difficulties to involve the private and NGOs sectors in the HSRP.

Service providers:

According to the set standards of the work requirements, and the size of the served community, the organizational structure of the health facility staff should fulfill specific number of personnel and well-defined job description. However, to fulfill this requirement, redistribution of physicians and nurses was one of the major obstacles.

> ***Quotation (12):*** Many physicians and nurses resist being moved to other facilities. In facilities which has over with staff, health facility personnel do not recognize that, with the increase in the number of personnel, the incentive per person gets less.

RH Commodity System including FP methods supply

FHM-advocates mentioned that; currently the MOHP provides all RH-commodities including FP methods to all FHM facilities. However, in the future, DPO will be the responsible body to satisfy the needs of the health facilities, and it will pay more concern to the package of services with needed commodities, and be able to compete to get contracts with FHF.

Standard of Practice (SOP)

In FHM, there is one SOP that includes all services that have to be delivered in the health facilities. The FHM-SOP is concise and includes the entire SOP in the vertical programs in addition to other important services as first-aid and others. FHM-advocates consider that FHM-SOP is the best to the physician, because instead of revising many sources related to vertical programs, the physician has to review one comprehensive source that does not include repeated topics.

Client Flow

Due the fact that having 1-2 family medicine clinics with no of client each physician is 24 per days as maxim; this allows for providing quality services around 10-15 minutes per cases, and comfortable patient cycle in the health facility with no over crowdedness.

Integration of Services

FHM-advocates mentioned that integration of health services is the core of the FHM. The tools of the integration are: the ***family folder*** (which link the whole family members with the health facility), the ***family physician*** (who provide all services, preventive and curative, to all the family members and throughout the lifecycle of each member) and the ***package of health services provided in the same facility*** on daily-bases (clinical/preventive/curative and ancillary services as lab, drugs, SONAR). It is important to notice that FHM provides more services which are not included in the vertical programs.

The advantages of integration of services are investing one visit to get informed and receive more than one service.

> ***Quotation (13):*** Patients attending on regular basis to receive medications for diabetes and hypertension become informed about other services delivered in the same clinic by the same physician. They consequently inform their families and others about such services, with subsequent increase demand for different FHM services.

For integration of services, it was necessary to have integrated supervision. Now, FHM supervisors emphasize on all the components of services including RH-services.

FHM-advocates mentioned the ***obstacles to integration****:* The persistence of the role of the vertical programs in fragmented supervision, and the current USAID project that focus on piecemeal integration through integrated "FP-MCH" supervision.

Referral Services

The current FHM as mentioned by FHM-advocates includes FHU, FHC, and the district hospital

outpatient clinic and emergency care.

The referral services are not working as planned, simply there are no restrictions for any individual to receive the hospital services, irrespective of being referred from other levels or not.

Quality of RH-Services

HSRP- program considers that the accreditation system is the best approach for continuous quality improvement. Through the link between quality score and incentives it is possible to stimulate the team spirit for problem solving and continuous quality improvement. FHM-advocates added that, the principles and indicators used in the accreditation program are the outcome of experiences gained from all vertical programs as for example: the "FP-QIP-Gold Star" program, the MOHP-SIF/PHC-Efficiency Improvement Project, MOHP-Quality Programs including Infection Control Program designed by Infectious Diseases Control Department.

- ***Marketing Activities***

Social marketing for FHM has special characteristics, as stated by FHM-advocates. There is no mass media marketing for FHM, but personal communication is the only approach to raise demands. They described the marketing activities according to the following points:

- No attempts for marketing through mass media because the FHM is in its pilot stage, and any marketing could increase demand with no enough supply in the current phase.
- FHM-social marketing depends on the role of the health team to provide quality services that attract more clients.,
- The extra-nurses who are excluded from the health facility organizational structure are assigned to conduct home visits and inform families about the package of services delivered in the FHM facilities.
- Community workers (RR) through outreach home visits inform families about the FHM.
- The process of enlisting 100% of families in the rural area, inform the public about the FHM.
- The change in the PHC facility function, where family folder is introduced, and cost-sharing become one of the health facility policy makes people ask and know about the FHM.

- ***Sustainability of RH-services through the FHM***

FHM-advocates raised the issue that vertical programs, especially FP, are depending on foreign funds for almost all their activities which intimidate their sustainability by phasing out of foreign support by year 2011. FHM-advocates mentioned many examples for the collapsing vertical programs' activities which are showing up in this stage of phasing out of the donors' support.

MOHP Strategy for Sustainability of FHM including RH-Services

FHM –advocates mentioned the new concept in partnerships with foreign donors through *"**Budget Support**"*. Egypt has its clear strategic plan for health care. The donors' support should be directed to help in achieving the set specific objectives in specific area in the set plan. The role of donors is to make sure that the sponsored objectives have been achieved.

Strategies for Institutional Sustainability

There was a consensus among the ID-interviewees that major changes will happen at the MOHP level. According to the HSR, there will be reforming the role of the MOHP, and its organizational structure at the central level. The role of MOHP will have four major roles. First set policies related to: public health, service provision, drug & price policies, and license for medical practice and health facilities. Second: strategic planning for health programs. Third: set standards of quality in health care including infection control. Fourth: Monitoring and evaluation of health programs especially preventive medicine programs.

At the MOHP institutional level, the role of the STSP will be limited after rolling out the FHM across the country. The MOHP will not be responsible for health services delivery any more. Therefore, the MOHP-governmental structure change to be a group of Technical Departments.

4.3 VIEWS OF UNDERSECRETARIES FOR HEALTH AFFAIRS

In-depth interviews had been conducted with the first Undersecretaries of the Directorate for Health Affairs (UDHA) in the 5 HSRP pilot governorates. The objective of the in-depth interview was to identify the perspectives towards the impact of FHM on RH-service delivery. The analysis of the collected information is focused on two issues: the supply and demand sides of RH-services in the FHM facilities.

1 General Advantages of FHM

There is a consensus that HSRP had made radical changes in health services delivery to ensure proving quality package of basic health services to the people. The potential of success of HSRP are due to success in institutional reform of the health units and demand creation intervention.

Institutional reform of the health facilities

UDHA identified several parameters for the success of the FHM facilities: physical design of the FHM facilities, Equipment supply, Quality Improvement, Organizational structure, Pharmaceutical system, Information System, outreach system, referral system, Infection control system, financial system/health insurance and incentive system.

Management system: Decentralization is one of the key successes of the HSRP. The presence of very supportive management system at the clinic level is a main feature of FHM facilities.

***Physical design of the FHM facilities*:** In Menofia, FHM facilities have special design to be distinguished from the "old design". Consequently, for ensuring coverage with the "new design", it was mandatory to demolish collapsing health units and building new ones. Internally, the clinics are well designed, for example, the immunization room has entrance and exit doors. The health units' furniture is properly selected especially in the waiting area and in the employees' offices. The clinics are prepared to ensure audio and visual privacy. Souhag UDHA highlighted the fulfillment of security measures in the health facilities.

> ***Quotation (14):*** Well-defined working hours of the service providers and rationalization of description of medicines are the major advantages of HSRP".
>
> ***Alex UDHA***

Equipment supply: FHM facilities are well-equipped. HSRP introduced new equipment in the health units as SONAR, SONOCADE, ECG, more than one stethoscope and sphygmomanometers. The labs are redesigned to have three sections for different types of investigations to blood, urine and stool. The lab services fulfill the requirements of rural PHC facility (*Menofia UDHA)*.

Capacity Building and Training System: There is focusing on continuous education and training. Additionally, protocols and manuals for practice are available and include all reproductive health services.

Quality Improvement System: Guide lines and quality of care protocols are available in all FHM units. Quality improvement includes patients' privacy, confidentiality of patients' data, and patients' rights. Menofia UDHA, raised the issue that clinical examination become no more "verbal examination", but the patient should be exposed to full clinical examination according to the standard of practice.

The MOHP staff members working in the different components of RH programs are **very supportive to FHM** through participation in the training programs for the health facility staff and their constructive supervision.

Organizational structure: HSRP strategy is to have a suitable number of health unit's staff and according to the size of the served population. This necessitates mobilizing the manpower resources already available in the facilities to fit to the new mission of the health unit. In Menofia, there were redistribution of the extra nurses, changing their job to be outreach workers to market for FHM facilities, family medicine and RH services.

Pharmaceutical system: HSRP showed success in ensuring continuous supply of essential drugs. The health unit pharmacy becomes equipped with computer, has pharmacists to dispense medications. The dispensed medications are "packed" to be in small "respectable boxes", rather than giving the patient's medications from big containers of tables and/or syrups which is unsanitary and not humanitarian process (the condition before FHM). Iron, folic acid and vitamin A preparations are available for MCH clients and all FP methods are available in sufficient amounts, and in strategic stocks.

Information System: There is a database for information derived from the family folders. Service statistics are analyzed to provide indicators for continuous monitoring and evaluation of performance at the health facilities, including RH services. The clinical information system is used to assess the needs for health services (Suez).

Outreach system: extra number of nurses, who are beyond the organizational structure of the FHM facilities are involved in the outreach home visiting services. The role of community workers/Raida Refia (RR) had changed to include raising awareness about family medicine services especially law No. 231, family planning and avian flu *(Menofia UDHA)*.

Referral system: Vitalization of the referral system is one of the major interventions of the HSRP. The referral services include referral of cases of obstructed labor. The cost of obstetric care becomes accessible. The mothers having family fold pay half the price of normal delivery in the hospital (i.e. LE40 instead of LE80) and for caesarean section it costs the mother LE 175.

Infection control system: Properly functioning infection control system become a norm in the FHM facilities. Menofia UDHA mentioned the current initiatives of introducing the new programs for electronic measures for infection control.

Incentive system: The distinguished incentive system through FHF to the FHM facilities' staff motivates health workers to improve their performance in all services including RH-services.

Monitoring and Evaluation System: Monitoring and evaluation are continuous processes. Menofia UDHA talked about the special output target for each physician. The doctors are evaluated according to the percent achievement of the targeted number of family folders. Special targets for RH services have to be monthly achieved. UDHA consider monitoring and evaluation by both the FHM and vertical programs supervisors improve the performance of the health facility staff.

Demand creation to Family Health Services

UDHA mentioned the causes of increasing demand for FHM services:

- Quality services: Both clients' and providers' satisfaction are tools for marketing the service. Patients' rights for privacy during examination, and rights to get quality consultation and treatment, are fundamentals in all FHM clinics' operations.
- The family folders play an active role in establishing links between the families and the health clinics. Raising awareness about the role of the health unit in health promotion and disease prevention is one of the marketing mechanisms.

> ***Quotation (15):*** Now people know that the role of the health unit is not only to be sought in case of sickness, but it has an important role in health education".
>
> ***Quena UDHA***

- Menofia UDHA listed the FHM facilities' amenities which attract the clients: The "new design" of the health units, which is easy to be kept clean and organized and good furnished waiting area.
- To motivate families to have family folders, small premiums were allowed to be paid over a longer time (Menofia).
- Paying for the service is perceived by the public as crediability of the delivered services (Souhag).

The involvement of NGOs in FHM had started in some covernorates.

In each health facility, the clinic board members include represnentative from the local councils.

2 Challenges confronting FHM:

Institutional reform of the health facilities

- Introduction of the "new system" into an "old system", results in implementation of incomplete models. Due to introduction of the accreditation program, some of the FHM facilities are accredited and others are not.
- There is no clear definition of authority and responsibility for the DHA, FHF, and TSO regarding the health facilities.
- Some conflict could happen between FHM strategies and vertical program strategies i.e. counseling in FP for example.
- There are ineffective interventions to integrate the information system at the health facility level. Vertical programs still focus on the use of their formats for monitoring and evaluation, and there is problem of duplication of work, and more paper work.
- Physicians working in the public facilities, and have private practice clinics, resist and oppose the FHM.
- The health staff does not implement the FHM exactly as it is set in the MOHP plan.
- High turnover of the physicians.
- Inefficient and ineffective training of the staff.
- To achieve the target (to get incentives), some physicians issue tickets and fabricate data.
- Having double system for hiring health unit staff.

> ***Quotation (16):*** In a health unit that has 36 staff members, and only 17 individuals have contract with FHF and get incentives, and the others are not. Non-contracted individuals work against the model and try to ensure its failure.
>
> ***Menofia***

- The two experiences related to inclusion of NGOs in FHM (in Menofia and Alexandria) did not show any fruitful results. In Menofia after selection and contracting with some NGOs, the FHF was not able to sustain the financial commitments, and the contracts were terminated. In Alexandria there are 13 NGOs included in the FHM, but the situation is not clear.

Create demand to Family Health Services

(1) No-marketing to FHM: All the UDHA affirmed the shortage in social marketing for FHM.

(2) Lack of Understanding the health insurance mechanism/cost sharing

- Rumors about FHM facilities include: statements as "health units become privatized" (*Menofia).*
- Due to inadequate marketing: people link between "health insurance annual premium" which is LE 10 per individual and the fee for services (LE 3). This misinformation makes people disseminate wrong information that the cost per visit is LE 13.
- The added policy of increasing the annual premium LE10/individual for "specialist services" resulted in rejecting the idea of utilizing the FHM facilities.

(3) Improper selection of approaches for social marketing the FHM: Marketing for FHM at the district level was through personal communication with members of the local councils and religious leaders. This approach is unsuccessful (Menofia).

(4) Dissemination of incomplete unacceptable information about FHM: The personnel involved in community awareness focus on statements that could be perceived by the public as privatization of MOHP governmental facilities: "paying for the folder to get services in governmental health unit, which is used to provide free services long time ago". Such situation leads to spread of rumors against FHM.

3 Suggestions to promote the role of HSRP in improving RH services

- **Institutional reform of the health facilities:** Complete the updated health insurance system and services has to be delivered 24 hours per day.
- **Health workforce:** Improve training of the staff and overcome the drawbacks of having two systems in hiring the staff (staff with incentives and staff without incentives).
- **Create demand:** through: Extensive marketing for FHM at all levels, Find mechanisms to mobilize the local communities to support HSRP, Awareness programs to the served community, and *make enrollment in FHM insurance system/family folders to individuals with chronic diseases only* !!

4.4 VIEWS OF THE HEALTH DISTRICT DIRECTORS

The views of HDD towards the impact of FHM on RH-services utilization are analyzed within the frame of the role of the health district in the HSRP.

4.4.1 DPO Organogram and job description

According to the organizational structure of the DPO in each of the studied governorate, it could be concluded, that there are 4 models (Souhag, (Quena /Alexandria), Menofia and Suez), and none of them fits into the organogram set by the HSRP (Seem panel 4.4.1). Each of the 5 interviewed district directors had mentioned the advantages and shortcomings of each district specific oranogram (see section 4.4.5).

The HDD perception towards the impact of FHM on the relation between the district and the other organizations indicated the consensus that no changes, compared to the situation before the FHM. However, the role of FHF become dominating through the direct relation between the FHM and health facilities through the incentive system.

Panel (4.1) Profile of the DPO organogram as set by HSRP versus the pilot governorates

	Souhag	Quena	Alexandria	Menofia	Suez
HSRP Organogram					
PHC Director	✓	✓	✓	✓	✓
Curative Care Director	✓	✓	✓	✓	
Nursing Director	✓			✓	
Finance and Admin Director	✓	✓	✓	✓	✓
Communication and training director				✓	
Not in the HSRP Organogram					
District director's assistant	✓	✓	✓		✓
Pharmaceuticals' director	✓			✓	
Contract and Procurement director	✓				✓
Quality Officer		✓	✓		
Manpower Officer		✓	✓		✓
Maintenance Officer		✓	✓		
M&E officer		✓	✓		
Preventive medicine director				✓	
MCH director				✓	
FP director	✓			✓	
Dentistry director	✓			✓	
Training director				✓	

4.4.2 Perception of the DPO directors to strategic planning for RH-services

HDD had described the impact of FHM on strategic planning as being positive of having shortcoming. The **p*ositive impact of FHM*:** The DPO develops the strategic plan, and action plan develops from the strategic plan at a level of 90%. FHF financially support the planned activities (Alexandria), strategic plans and action plans develop at the district level (Menofia), the strategic plan of the HSRP had been prepared by the training team of the DPO, according to the available resources, and both the private and NGOs are involved in the plan (Quena) There is a two-year strategic plan based on SWOC analysis, and needs assessment, with specific targets related to infant mortality and FP etc.,. (Suez).

Shortcomings of FHM: The business plan was previously prepared and funded by FHF, but in June 2007, FHF stopped its support for planning (Souhag), and no specific budget allocated for the plan (Quena), the strategic plan is not transformed into action plan and there is no budgetary support from either the MOHP or FHF (Suez)

4.4.3 Perception of the impact of the FHM on for RH-services within the HSRP objectives

- **HSRP Objective 1: Achieving Universal coverage with RH services:**

Availability and accessibility of RH services

Positive impact of FHM: There are no changes in the utilization pattern of FP services, because it is delivered freely in the FHM facilities, there is marked improvement in chronic disease management due to the availability of drugs (Souhag).

Shortcomings of FHM: There is reduction in the number of ANC services users due to high cost per visit (Souhag) ***Quotation 17*.** The district hospital is more accessible to all villages and has different specialties. Therefore people go directly to the hospital and bypass the FHU. There are no records in the hospital or any system for feedback to the health unit. The referral service for chronic disease is not active (Souhag). The district hospital is not included in the FHM (Souhag). The current situation demonstrates two types of quality services, PHC unit which cost LE1 per visit and the FHU "style unit" which cost LE3 per visit. There is high utilization of the low cost, but quality PHC services (Suez).

> ***Quotation (17):*** There are no changes/differences in the utilization of FP and RH services in the FHU and non-FHU. However, there is reduction in the volume of ANC services, due to the high cost per visit.
>
> ***DPO Souhag***

- **HSRP Objective 2: Improved organization and management of the system for RH services delivery**

A-Costing, financing and purchasing RH-Services

Positive impact of FHM: Some women are exempted from paying to the family folder. Therefore, *there* are no barriers to get MCH services (Menofia).

Shortcomings of FHM: There is a negative correlation between cost-sharing and volume of utilization of the health facilities. The high cost pushes the clients out of the facilities (Menofia). The policies of procurement require having three offers, which is very difficult procedure (Menofia).

B-Decentralization through DPO and DPO organogram

Positive impact of FHM:

The job description is clear, and it was set by the STSP. There is training for DPO staff, and STSP organizes the training (Alexandria). The organogram is very successful to achieve the objective of

the family medicine program. The staff is grouped into 6 supervision teams to cover 25 health units. The supervision team is composed of physician, administration officer and a nurse (Menofia). The DPO organizational structure indicates more specialization, job description, and update in the administrative cadre (Souhag).

The DPO staff had received training in management skills for 3 weeks in 2003. The DPO staff had previous experience through "improving efficiency project". The FP director had received training in "policy support" in the supply/demand-in HSRP-UNFPA project, and he trained service providers. The DPO staff has been trained in quality, TOT, family medicine, monitoring and evaluation and computer skills. DPO has successful role in management of on-the job training of the service providers in RH-services (Souhag).

Shortcomings of FHM

There are no advantages for DPO organogram (Alexandria, Quena, Suez). There is no enough district staff for monitoring and evaluation, supervision and training (Alexandria). There is no true decentralization (Souhag). There is no financial/accounting unit at the district level. The accounting unit had been transferred to the FHF. The reform of the health facilities is not coupled with reforming the district (Suez).

> ***Quotation (18):*** They said that there is decentralization. However, they enforce us to receive drugs that we do not need.
>
> ***DPO director -Souhag***

The job description is not clear for the DPO junior staff, and there is high workload on the senior staff. Canceling the role of DPO in accreditation (June 2007) had resulted in lack of cooperation between the health facilities and DPO. No incentives to DPO staff, with subsequent negative effect on the role of the DPO staff in supervision, monitoring and evaluation of the health facilities (Souhag). Exclusion of important posts and specialties as MCH, preventive medicine and health education has negative effect on supervision. No fairness in wages/salaries among the DPO staff. There are many responsibilities on DPO staff for implementing the **plans set by the FHF**. The extensive registrations/paper work at the health facility level and the folders' cycle drain time and effort and influences the supervision process. ***DPO losses control over the health unit, because FHF predominates and control everything in the health facility (Quena)***.

C-Human Resources management

Positive impact of FHM: The work with the service providers is very smooth (Alexandria). It has been easy and well-organized process of contract with physicians. Physicians are trained in family medicine and on how to use equipment and the practical training is in the public hospital (Menofia).

Shortcomings of FHM

There is high turnover of physicians after their training. Unfair distribution of nurses across the health units is mainly due to the un-responsible pressure from local councils/authorities. Such situation reduces the opportunity to achieve accreditation. The policy of reducing the number of nurses working as family health nurse to 4 nurses per facility has many limitations. Despite the facility has many other nurses, the law enforces the non-family health nurses to work as health educators. The health facility needs more teams of nurses per service (e.g. the immunization session needs at least three nurses) and some services suffer from shortage of nurses supply due to changes in job description (Menofia).

> ***Quotation (19):*** The nurse, who is responsible for family planning methods logistics, is the one who is responsible for health education. Therefore women attending to the unit do not receive the method because the nurse is not in the health unit- the nurse is doing home visits
>
> ***Menofia DPO***

The companies which supplied the equipment do not provide guidance/training/maintenance (Menofia).

The doctors lost the relation with the community because his/her focus is to increase the quantity of completed family folders. Management of nurses is very difficult for their re-distribution across the facilities and in applying the standards of practice (Quena).

D-Management Information System MIS

Positive impact of FHM: There is marked improvement of the MIS. There is compiling of data collected during supervision of the FHM facilities. There are computers in the health facilities (physician clinic, pharmacy, folders room). Currently, a special network will be developed to link between districts.

There are special training programs for physicians, nurses, statisticians, clerks on computer skills (Souhag).

Documentation of all activities including supervision and monitoring is the major character of the FHM (Suez).

Shortcomings of FHM: There are many indicators for quality monitoring and for the FHF (Alexandria, Suez), The training in computer skills is not satisfactory.

E-Supervision

Shortcomings of FHM: The FHF was providing financial support for transportation of the district supervision teams to cover the remote health facilities. However, after terminating this support, proper supervision could not be implemented (Menofia). The supervisors become highly involved in recording data, and not true supportive supervision.

- **HSRP Objective 3: Improved Health Services Provision**

A-Physical infrastructure of the health facilities

Positive impact of FHM: There is marked improvement of all the health facilities' infrastructure. In Menofia, all the FHUs within the district are accredited (25 units). The district hospital (Harmen) , and special university hospital are working according to FHM. Those facilities fulfill the standard requirements regarding infrastructure and equipment (Menofia).

Shortcomings of FHM: NGOs working according to FHM have unsatisfactory location. However they provide services according to rules and regulations of the FHM (Menofia).

B-Reproductive health Commodity System

Positive impact of FHM: There is special clinic for safe-delivery, which is equipped with updated facilities, with special resuscitation room and facilities for infection control (Menofia). However, there are no delivery rooms in all family health units.

C-Terms of Reference and standard of practice

Positive impact of FHM: the terms of reference for family physicians are acceptable (Alexandria, Suez). There is an effective training program to the service providers especially in primary health care, communication and physician-patient interaction (Menofia). The family physicians have to provide integrated family medicine services, because the incentive system is liked with the scope of delivered services (Souhag).

Shortcomings of FHM: Involvement of doctors in computer data entry for all cases limits the time that should be devoted for providing clinical care according to standards (Menofia, Quena).

D-Integration of services

Positive impact of FHM: The concept of having family physician ensures that FHM provides integrated services (Alexandria, Menofia).

HSRP-supportive projects (UNFPA-Supply/Demand Project) improve integration through training in evaluation of performance using specific formats, training of physicians and nurses and through adding new ideas for evaluation of the performance of the health facilities (Souhag, Quena, Alexandria).

Shortcomings of FHM: The performance of the service providers in the FHM facilities is not good compared to the non-FHM facilities, because the training of family physicians is not of acceptable quality and there is no referral system (Quena).

E-Referral Services

Positive impact of FHM: Referral system is implemented (Alexandria). There are views that referral system is working, because it is linked with the FHU physician incentive system (Menofia).

Shortcomings of FHM: The referral system is not working efficiently due to the high cost of the referral process. The doctors do not know the standards/requirements for referral of cases. People do not understand the benefits of referral process: enrolment for specialist services, follow up, and feedback services (Menofia). In Quena the referral system is not working due to non-receiving/delay in receiving fund from FHF and the hospital staff is not motivated to provide care to referred cases (Quena). In Suez there are no changes in the current system of referral from the health unit to the general hospital.

> ***Quotation (20):*** people do not like referral to hospital through FHU. There are many steps: folder, heath unit visit payment, cost of enrolment for specialist services etc. The private physician is one step/less cost service.
>
> ***DPO Menofia***

There is no relation between the DPO and the hospital, because the hospitals are affiliated to the MOHP-curative care sector. The health district is concerned with the health units which are affiliated to MOHP- preventive medicine sector. In either case the district cannot support the hospital or the health units due to lack of resources at the district level (Suez).

F-Quality of RH services

Positive impact of FHM: The staff is aware about accreditation process, and how to achieve, and the indictors used for periodic evaluation (Alexandria, Souhag) and the links between accreditation and getting financial support (Suez).

Shortcomings of FHM: The quality indicators are set by the STSP without involvement of the health district staff (Alexandria). The indicators used to monitor performance are concerned with quantitative performance rather than quality (Quena). STSP does not provide enough support in order to setting plans and providing resources to facilities to achieve accreditation (Quena). The units are selected for accreditation by the health directorate, which provide resources to the selected units. However, this support is incomplete and sporadic (Suez).

The allocation of 36% of the health facility revenue for maintenance of equipment, building of the health facility etc., is not enough.

Cost-sharing policy limits the utilization of the health facilities, irrespective to quality services (Menofia).

> ***Quotation (21):*** Utilization of health services is related to cost rather than the quality. Out of the 26 FHUs, there were 4 non-accredited facilities. Non-accredited facilities had high case load due to low cost of service
>
> ***DPO Menofia***

G-Community Participation and Demand creation

Positive impact of FHM: There is cooperation between the district staff and the local official and natural leaders of the community, especially in case of avian flu, immunization campaigns. There is cooperation with NGOs, and there are 4 NGOs working according to family health model. There are well-equipped women's clubs which are supervised by a nurse supervisor at the district level (Menofia).

Shortcomings of FHM: All participates confirmed that there are no special well-defined mechanisms for community participation. There is no participation of health-related sectors during planning for health programs. The cooperation and community participation is "*on papers only" (Suez)*. The local councils do not show any cooperation for problem solving of health issues raised during the local council's meeting (Suez). *There* is no cooperation with NGOs (Suez, Quena).

Despite the establishment of women's clubs, there are no enough resources for their operation (Souhag). The mission of the women's clubs is not matched with the community demands. Poor people need clothes and food (Suez).

4.4.4 Suggestions to improve the impact of FHM on RH-services

HSRP Program policies and regulations and planning: Increase the number of FHM facilities (Alexandria), have clear policies, regulations and rules, fixed to all, and for both the central and local policies (Souhag), strengthen the role of the health district in HSRP, the supply of resources to health units should be fair (equity) across units (Quena) and having active steps for involvement of the private sector in the FHM (Alexandria).

Manpower resources: Set clear rules for contracts with physicians and support staff at the district level, have clear role of FHF, especially that there is gradual shrinkage in the staff size (the new doctors are not trained and the support staff is going to be retired) (Souhag), create new job/physician post to manage family folders (Quena), having physicians specialized in reproductive health (Quena), Improve training of physicians in RH (Quena), control turnover of physicians through having rules to keep the physicians to work at least 2 years in the PHC facility (Quena).

Drug supply and other supplies: Update the essential drug list (Souhag) and ensure the continuous supply of drugs and FP methods (Suez).

Supervision system: Strengthen the role of the health district in supervision (Alexandria), Strict regulations to follow policies that RH services should be delivered freely to clients (Suez).

MIS: Unification of the MIS system to include those of the vertical programs and family medicine program in the family folders (Souhag).

Demand Side: Increase community participation through motivating NGOs to be involved in the FHM (Alexandria) and awareness campaigns in the health facilities and outside the health facilities including the mass media to inform people about family medicine and family folders (Menofia).

4.5 PHYSICIANS' PERCEPTION TO THE IMPACT OF FHM ON RH-SERVICES

This part delineates the information derived from focus group discussions/IDIs with physicians working in the health units in the 5 HSTP pilot governorates. The discussions are directed to specific 4 points within the frame of the FHM: Capacity building of the family physician in RH services, the process RH-service delivery (family medicine approach/integration/client flow/cycle), supervision and accreditation.

4.5.1 Capacity building of FHM facilities' physicians in RH-services delivery

Most of physicians mentioned that:

The family physicians had received training courses on Law 147, Folder cycle, early detection of

handicapped child, improving RH (Souhag), RH services and management of health services.

Perception of the received training in RH services: Limitations

However they reported that the training courses duration is not enough, with high turnover, and training in RH was before the HSRP, and it doesn't include RTIs or management of youth problems, fewer the training covers administrative issues and no include clinical training in family medicine (Suez).

4.5.2 Perception of the impact of FHM on the process on RH services delivery

When the impact of FHM on the process on RH services delivery discussed many of them mention the following:

- ***Advantages***
  - Organization of services as: One family medicine clinic (for all family members, and ANC services), FP clinic, Child clinic and immunization clinic (Souhag), (Quena) (Alexandria) (Suez).
  - All RH-services are delivered in the family medicine clinic (Menofia).
  - Privacy of the service (Souhag), (Menofia).
  - The family folder links the families with the health unit (Quena) (Alexandria) (Menofia). (Menofia) and increase the clinic output (Alexandria) (Suez).
  - Family folder helps in organizing drug dispersion (Alexandria) (Suez).
  - Family folder consider the socioeconomic status of the family (Alexandria).
  - Issue of family folder is coupled with screening tests and early detection of some diseases (Menofia).
  - Issue of family folders is coupled with complete enumeration of houses, and needs assessment for health services (Menofia).
  - It is not essential to have family folder to get RH services and the services are delivered freely (Menofia).
  - The family folder facilitates access to integrated information about the case and follow up services (Souhag) (Quena) (Alexandria).
  - The family folder improves the patient cycle in the facility (Souhag).
- ***Limitations:***

Most of physician's wasting of physicians' time in paper work which threaten quality of services.

- Difficulty in convincing people to have family folders(Menofia), especially for renewal.

> ***Quotation (22)***: people saying that why do you ask for paying to update the folder? we did not get any of the health unit's benefits during the last year !!!
>
> ***Souhag***

- Long patient cycle inside the health facility(Quena) (Menofia).
- Some RH services are not available i.e. Premarital examination, semen analysis d management of infertility and management of endocrinal disorders (Menofia).
- High cost of issuing and updating the folder.
- Cultural factors limit access of youth and men to seek RH services (Menofia).
- Limited role of the waiving system to protect the poor: complicated social investigations, poor people receive only 4 tickets per year (3 for GP services and one for specialist service). Those with chronic diseases receive 12 tickets per year (Menofia).
- Presence of 4 forms of cost-sharing: the waiving system, the health insured (i.e. employees, U6 children, school students receive free services), FHF insured (i.e. each person pays LE

10 per individual per year, and LE 3 for each visit, and one third of the price of the drugs, and receive the service of specialist) and the uninsured (i.e. the individual pays LE 5 per visit and all the price of drug cost, and no benefits of referral to specialist) (Menofia).

4.5.3 Perception of the FHM supervision system

Advantages: problem solving, more commitments to provide quality care (Souhag), cooperation between doctors and the supervision teams (Quena). Constructive supervision resulted in improving performance (Alexandria). Supervision is comprehensive because it considers the physicians' performance, cleanliness and security of the health unit (Menofia).

Limitations: There are no well-defined items for supervision, (Souhag), not constructive supervision/insisting on detection of any shortcomings in performance to reduce the incentives (Souhag) (Suez). There is no relation between supervision and FHF (Quena).

4.5.4 Perception of the FHM accreditation program

Limitations: Setting non-valid indicators/non-applicable (Souhag). Accreditation makes doctors continuously under stress (Souhag). It focuses on superficial things (e.g. posters) rather than the quality of health services (Souhag). Some of the accreditation items are not well-defined (Suez) especially in case of referral (Souhag). Physicians cannot respond to some accreditation items as shortage in equipment (Quena). The incentives do not include all the staff (Menofia). The doctors are not trained to understand items of accreditation (Suez).

4.5.5 Suggestions of family physicians to improve RH-services through the FHM

Manpower Management: Increase the number of physicians (Menofia) and other staff (Quena), training courses (Menofia), (Souhag), Incentives should be not much delayed (Souhag), emergency services should have separate incentive system (Quena), Incentives for working 24/day (Quena), more dignity for physicians (Alexandria), (Souhag), and more vacation times for female physicians (to be at intervals less than 40 days) (Souhag), Having specialists in the health unit, for at least two days per week (Menofia), Have a special facility director for administrative activities (Menofia), Have female gynecologist (Menofia), Having permanent staff for equipment maintenance (Menofia), Incentives for all the staff and only the physicians.

Policies and procedures: Continuous supply of resources to cover the recurrent cost needed for maintaining quality services (Menofia), Reduce the cost of the family folder (Menofia), (Quena) (Souhag), Include the hospitals in the FHM to improve services provided to the referred cases (Souhag), Modify the referral procedures to reduce steps (Quena), Modify the patient cycle to reduce the time needed to receive health services (Menofia) (Alexandria), Reduce the procedures for updating the family folder (Souhag) (Quena), Control the price system of drugs (because some drugs are more expensive in the facility than in the pharmacy) (Souhag), Increase the scope of exemptions and the exempted patients should receive more than 3 tickets (Souhag).

Health facilities infrastructure: Have more clinics in the health unit (Alexandria), Have dental clinics (Menofia) (Souhag), Have delivery clinic in the health unit (Alexandria), Improve communication services with the district and directorate (Fax and Internet) to save time and efforts (Menofia).

Drugs: Increasing the drug categories to serve newborn children, chronic diseases, (Menofia) (Quena) and Ensure the availability of the drug list (Alexandria).

Equipment: Increase equipment as SONAR motivate physicians (Suez), especially to increase ANC services utilization (Menofia), Update lab facilities (Suez), Update equipment for emergency/casualty cases(Suez), have equipment Maintenance system (Suez) ,(Souhag).

Supervision System: Improve the supervision system and ensure good communication with higher levels (Souhag).

Creating Demand for RH-service in the FHM: Health awareness through community and social workers (Menofia), Advocacy for the health units services through community leaders (Menofia) and conduct seminars to inform the community about the health unit services (Menofia).

4.6 VIEWS OF FHM -SERVICE PROVIDERS (NON PHYSICIANS)

This part is concerned with the views of nurses, FHM facilities technicians, and community workers towards the impact of FHM on RH-service utilization.

4.6.1 Perception of service providers to impact of FHM on RH-services utilization

The FHM facilities' staff members had identified the causes of increase/decrease in the different components of RH-services as an impact of FHM.

Premarital care: **Causes of no change in Utilization** are related to the community negative attitude/unawareness towards such service (Souhag), (Suez). Causes of increased Utilization are due to: Awareness seminars, facilities for Rh testing, female physicians, more drugs and more equipments (Quena).

ANC: **Causes of Increased Utilization** include: More investigations, more equipment, iron tablets freely, insisting on scheduled visits, trained nurses, quality services (all governorates). Awareness about the dangerous results of seeking advices of TBAs, providing ANC services every day (Quena).

Causes of decreased Utilization are due to: Mothers starts visiting the unit after the forth month to receive TT vaccine. Therefore, the first contact between the pregnant women and the health unit is the nurse. Mothers prefer to receive ANC services from physicians. Therefore they prefer to seek services of private physicians (Menofia).

Natal Care: **the increase in delivery in health facilities are due to:** proper training of nurses, and the successful referral system, it becomes easier to refer cases of obstructed labor/complicated cases to hospital and their follow up (Souhag, Suez). Availability of delivery room encourages the staff to assist deliveries in the health facilities (Quena). In Menofia, there is no delivery room, but women attend the health unit to be referred to the hospital, because the hospital does not accept cases without referral form from the health unit (Menofia).

Postnatal care: **Reasons of Increased Utilization are:** The home visits conducted by the nurse to provide free services to the mother (vitamin A, clinical examination), and to the newborn (examine for thyroid function, immunization) ensure coverage with the service. The visits conducted by the community worker to motivate women to attend the clinic and inform the mother about postpartum FP use (Souhag, Quena, Alexandria, Menofia). The referral of cases to be examined by physicians in the health units is an integral part of the postpartum home visits (Menofia). Postpartum home visits do not require having family folder (Menofia).

Post-abortion Care: **Reasons of Increased Utilization are:** Community workers inform the mothers about the importance of post-abortion care. Having female physician working one day per week had increased the utilization of such service (Souhag, Quena, Menofia). The incentive is linked with the number of cases attending for care (Menofia).

Family Planning: **Reasons of Increased Utilization are:** The FP methods are always available. There is effective training of the staff, and good service provider-client relationship (all governorates).

Causes of decreased Utilization: Payment for FP method could reduce the number of acceptors (Alexandria). Having other PHC facilities providing all types of services at a cost of LE1 motivate people to use the low price services (Suez).

Immunization: **Reasons of Increased Utilization include:** follow up of missed cases/defaulter, it become easier to cover all the children with immunization services (All governorates). The

immunization services are delivered once every week (Tuesday) instead of one day per month. The presence of family folders motivates mothers to attend for immunization of their children and to get other services.

Child Care: **Reasons of Increased Utilization are:** The comprehensive package of service which includes nutrition care, growth monitoring, lab investigations as hemoglobin and others (Souhag).

Management of RTI (females): **Reasons of Increased Utilization:** Women become more aware, privacy, available drugs at reasonable cost, short waiting time in a comfortable waiting area, have motivated women to receive the service (Souhag), and having female physicians (Quena). Receiving the clinical service and drugs for RTIs from the same facility as well as paying the one third of the price of drugs, motivate women to attend the health unit for that service. Before the HSRP, the women could receive the clinical service, but she has to buy the drugs from a private pharmacy. **Reasons of decrease in Utilization:** Despite drugs for RTIs are available in the stores, the pharmacist does not request it because there is no female gynecologist to prescribe such medications (Menofia). Before HSRP, management of RTIs were delivered in the FP clinics, and the drugs were available freely also. After HSRP, the drugs are not available, or the woman has to pay for the drugs (Menofia).

Management of RTI (males)**: Reasons of Increased Utilization:** Having male physicians, available drugs, more awareness through seminars had motivated men to use the service (Souhag).

Causes of decrease in Utilization: Cultural reasons (All governorates).

4.6.2 RH-Services provision in FHM facilities

A- Physical Infrastructure of the health facilities

All of the service providers in the five governorates affirmed that all health facilities (except one) have great improvement in the infrastructure.

B- Availability and accessibility of RH-services and commodities

All service providers in the five governorates affirmed that RH services are available, and accessible in a very good quality; they mentioned also that there is general increase in the amount and types of drugs, all FP methods are available, vaccines are available, and the lab equipment had been increased and updated. Few mentioned equipment had been increased like sonocade, women clubs have been equipped, increase in the types of investigations: Rh, blood sugar and hemoglobin (Quena). Due to the availability of good package of lab investigations, drugs and quality services in the facility, people get comprehensive service in the same place and in a very short time (Suez).

C- Standard of practice

All the service providers in the 5 governorates provided evidence that all of them had received training and they work according to the set standards. The family nurse receives the client, register personal data, measures vital signs, weight and height. The nurse is responsible for registration of FP data and ANC data in specific forms. However, the physician is responsible for registration of information in the family folder for all cases (All governorates).

D- Referral services

Referral of cases especially the emergency obstetric care is one of the successful services delivered in the FHM facilities (All governorates).

E- Integration of RH services

There is a consensus that integration of health services is through providing all health services including RH services in one clinic: the family medicine clinic. The FP program managers have insisted on having a special room for FP services. Therefore, IUD insertion takes place in

the FP clinic. But, acceptors of other FP methods e.g. pills and injectables receive the service in the family medicine clinic.

F- Client Cycle

There is a consensus that the client cycle in the health facility is very tedious and time consuming (about 30 minutes).

G- Community outreach program

All service providers acknowledged the role of the community workers (Raia Refia) in the FHM, and they mentioned their scope of services and mechanisms of communication with the served community through:

- Home visits to inform families about the package of health services delivered in the FHM facilities, and the importance of the family folder.
- Contact husbands to inform them about the importance of FP use after delivery.
- Increase awareness about adequate nutrition of the mother during pregnancy and lactation.
- Increase awareness about the importance of child care including breast feeding and proper weaning.
- Increase awareness about antenatal care services in the health unit.
- Organize health education seminars inside and outside (schools, factories etc.,) the health unit.
- Social research to identify families that should be exempted from paying to the folder.
- Surveys and health education for prevention of avian flue.

4.6.3 Suggestions to improve RH-services through the FHM

All service providers in the five governorates affirmed that the utilization pattern of family planning and maternal and child health care had shown significant increase after introduction of FHM. They attributed the increase in the volume of utilization to the improved quality of services, satisfactory performance of the trained physicians and nursed, the services are provided freely, the cost of FP methods and curative services are reasonable, presence of equipment, good infection control and cleanliness of the facilities. The quality of services motivates clients to market for the service through the clients who tell their relatives and neighbors to come to the health unit. The following are the service providers' suggestions to improve the impact of FHM on RH-service utilization:

HSRP Program policies and regulations and planning

1. Reduce the cost of the family folder (Souhag) (Suez) (Menofia).
2. The enrollment/payment in the family folders should be for individuals, because some family members are working outside Egypt (Souhag) (Suez).
3. Reduce the cost of lab and x-ray services (Souhag) (Suez) (Menofia).
4. Increase the number of free tickets for the exempted cases, especially those with chronic diseases (Souhag) (Suez) (Menofia).
5. SONAR services to pregnant women have to be free of charge (Souhag) (Suez).
6. Emergency services should be provided freely (Menofia).
7. Reduce the paper work(Souhag) (Suez).
8. Setting reasonable evaluation standards used by physicians to evaluate the facility staff, to be more objective and not subjective (Souhag) (Suez).
9. Having the official decrees in a "written clear form" rather than verbal decrees (Souhag) (Suez) (Menofia).

10. Two services should be delivered outside the family medicine clinic: IMCI (because management of diarrhea requires oral rehydration settings) and FP (because counseling is an essential component of FP services, that should be provided on individual basis by the nurse) (Menofia).

Health Facility Infrastructure:

1. The Lab should be in a good well-ventilated place, and with more wider space (Menofia).
2. The folders' room should be beside the pharmacy (Menofia).
3. Proper use of the "closed-unused rooms" in the hospital, where the first floor could be used as FHU and the other two floors for in-patient services (Menofia).

Manpower resources

1. Have female physicians (Souhag), (Suez) (Menofia).
2. Have dentist (Souhag) (Suez).
3. Increase the number of nurses (Souhag) (Suez).
4. Have social affairs specialist (Souhag) (Suez).
5. More training to the staff (Souhag) (Suez) (Menofia).
6. Find mechanisms to reduce the turnover of the physicians (Menofia).
7. Have specialists (Souhag) (Suez) (Quena) (Menofia) (Alexandria).
8. Training on use of equipment (Quena).
9. Monthly salaries to community workers, instead of 3-month salaries (Souhag) (Suez).
10. Have more cleaning workers (Souhag) (Suez).

Drug supply and other supplies

1. Increase drug amount and reduce cost (Souhag) (Quena) (Menofia) (Alexandria).
2. Drugs prescribed by specialists have to follow the same price policy of one third of the price (Menofia).
3. Amount of drug supply to the clinic should be matched with the caseload (Menofia).
4. Increase facilities for premarital care (Menofia).

Equipment

1. Maintenance system to equipment especially the SONAR(Souhag) (Suez).

4.7 HEALTH SERVICES PROVISION AT THE FACILITY LEVEL

This part is concerned with assessment of the supply side of health services at the health facility level. The assessment is based on comparing the current situation in relation to the HSRP set standards, as well as the set standards for RH services as set by the vertical programs.

The information presented in this part of the chapter is derived from data collected at the FHM facilities in the HSRP- pilot governorates, by using special checklist (*Annex, 2)* that covers specific data on: served population, manpower resources, clinic management and quality items (18 items and 307 sub-items). The achieved total quality score represents the degree (percent) of availability of service/equipment/procedures compared to the standards (Total quality services: 307 sub-items and RH quality services include 126 sub-items).

Different levels of quality indicators/indices have been developed: Simple quality indicators (percent achievement of the quality items at the facility level), compound indices at the district level (percent achievement of the quality items for 5 facilities in the same district) and compound indices at the programmatic level (percent achievement of the quality items by groups of health facilities admitted to HSRP and/or accreditation program at a certain point of time).

The simple indicators and compound indices are further categorized into: unacceptable quality level (<65%), acceptable (65%-74%), Good (75%-79%), and very good (80% -84%) and excellent (≥ 85%).

4.7.1 Manpower resources in FHM facilities

Data about selected categories of manpower resources at the FHM facilities (22 FHUs and 2 FHCs) are illustrated in table (4.1). As depicted from the table, there are variations in the size of the population served by the health facilities. About one third of the facilities (9 FHUs) has catchment area with population size at 5000 - <10,000.

The total hired physicians in those FHM facilities are 106 physicians, but the currently working are 86 physicians, with predicted turnover rate at 19%. The female to male physicians' ratio is 21:10 (for the hired physicians), and 23:10 for the currently working physicians. The turnover rate for female physicians is 17% and for male physicians is 24%.

The physician to nurse ratio is 10:23, where there is more than two nurses for each physician.

The population per physician ratio is not constant across the facilities which serve catchment areas with different population sizes. There is more tendency to have one physician serves 1294 population (or about 260 families) in health units with small catchment area. However, in health facilities with catchment area serving 20,000 and more population, each physician has to serve about 2122 families.

All physicians working in facilities serving < 5000- < 10, 000 populations, are working according to family physician post. However, family physicians are not available in enough numbers in facilities serving 10,000 and more populations.

There is one community worker per 260 families in facilities with small catchment area. However, in health facilities serving 20,000 and more population, there is one community worker per 17472 population (or 3494 families on the average).

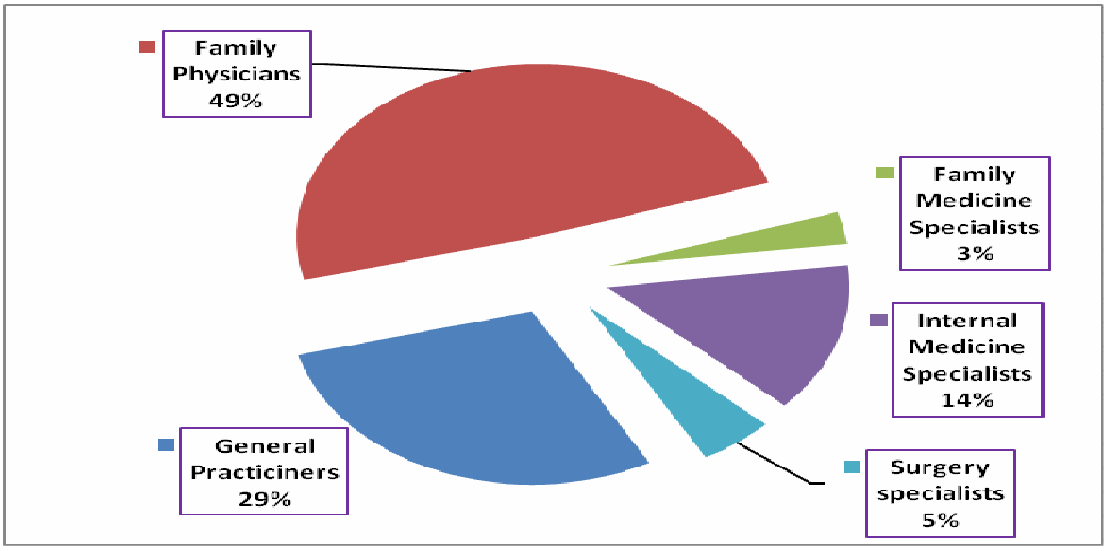
Table (4.1) Distribution of Manpower Resources at the FHM facilities according to Population Size in the Catchment areas

Population Served per facility (no of Health Units)	H. Units	Actually Working Physicians	Population per working physician	Population per working family physician (no. 45)	Actually working nurses	Population per working nurse	Actually working Community Workers	Population per social worker
<5000	2	4	1294	1294 (4)	8	647	4	1294
5000-	9	9	7925	7925 (9)	32	229	16	4458
10,000-	4	11	4490	12347 (4)	44	1122	19	2599
15,000-	2	6	6022	12043 (3)	11	3285	3	12043
20,000+	4	56	10608	23762 (25)	101	5882	34	17472
Total (24)	24	86			196		76	

For the total hired physicians (106) there are 34 males and 72 females. For the actually working physicians (86) there are 26 males and 60 females. The total hired family physicians (45) there are 22 males and 23 females. For the actually working family physicians there are 20 males and 22 females.
There is one FHU with lack of information about the served population due to the change location of the facility

Figure (4.1) shows the distribution of the currently working physicians (86 physicians) by their specialty. As depicted from the figure, about half of the physicians are family physicians (49%) i.e. have the post of family physicians, and only 3% have family medicine specialty (diploma or master degree). The distribution of physician specialists in each of the studied 2 health centers is 1-2 Family Medicine specialists, one Pediatrician, 6 Internal Medicine specialists, and one Surgeon. However, there are no Obstetrics and Gynecology specialists in either of the two FHCs. Out of the total family physicians (42 physicians), only 29% had been trained in family medicine.

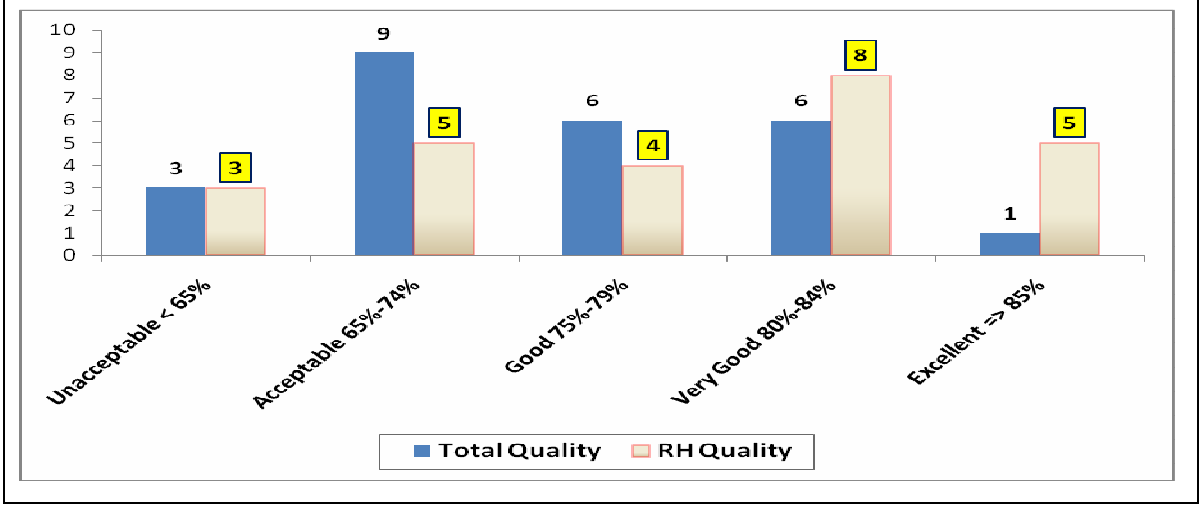
Figure (4.1) Percent Distribution of FHUs' Physicians by specialty



4.7.2 Quality of health services at the facility level

Figure (4.2) displays the 25 FHM facilities categorized according to the quality standards (total quality and quality of RH services). It is obvious that only one FHM facility had achieve the level of excellence (4% of the total facilities), versus 5 facilities who achieved the level of excellence in RH services quality.

Figure (4.2) Distribution of HSRP-FHM facilities according to achieved quality scores: total quality and RH services quality



4.7.3 Quality of health services at the district level

Table 4.2 demonstrates quality achievements at the district level, where one compound quality index had been developed for each 5 health facilities located in the same district/governorate. Additionally, a total compound quality index has been developed to define the quality in 25 FHM facilities. The table shows that, the overall quality status of the 25 FHM facilities could be described as acceptable (73%). Menofia, ranked the first governorate regarding the highest quality index (84%), followed by Souhag Governorate (77%).

Service items that reported the excellent quality are: success of the accreditation process (96%), family planning services (88%), and physical infrastructure of the facilities (85%). The items categorized as very good quality are institutionalized infection control procedures (83%), lab

services (82%) and immunization services (80%).

None of the studied FHM facilities reported any achievement in community participation item. Such situation indicates that, the "clinic board" is not actively work to link between the facility and the served community through its members.

The achievement of 100% for quality scores varies by service item and governorate. For example; in Alexandria there is one facility which is not accredited at all. Three health facilities in Souhag succeeded in achieving 100% of quality score (6 points) in the item related to "providing special types of RH services: Premarital care, Post-partum care for the mother and the newborn, post-abortion care, management of RTI (males), management of RTIs (females)". Two health facilities succeeded in achieving 100% of quality score in ANC services (one facility in Suez and one facility in Menofia) (**micro analysis at the facility level, not presented in the table**).

The percent achievement of the total quality standards in RH shows that, for all the studied FHM facilities, the achievement was 75%. Menofia ranked the first governorate regarding the highest percent achievements in quality RH services (88%) followed by Souhag governorate (78%).

Table (4.2) Percent Achievement of Standard Quality Scores for the FHM Facilities, including RH Services in the 5-studied HSRP Pilot Governorates

Quality Item (scores/ assessment points)	Alexandria	Menofia	Souhag	Quena	Suez	Achievement Of Quality Score
working hours/scope (29)	58.0	71.0	77.0	72.0	77.0	71.0
Special RH services*(6)	60.0	60.0	90.0	60.0	70.0	68.0
Accreditation &Patient Satisfaction Monitoring (3)	87.0	100.0	100.0	100.0	93.0	96.0
Physical Infrastructure (14)	71.0	93.0	90.0	84.0	89.0	85.0
Infection control (11)	62.0	84.0	98.0	91.0	78.0	83.0
Lab Services (31)	77.0	89.0	83.0	76.0	83.0	82.0
Essential drugs (41)	66.0	81.0	57.0	45.0	61.0	62.0
RTI drugs* (6)	63.0	70.0	50.0	27.0	50.0	52.0
Outpatient (7)	66.0	77.0	63.0	54.0	51.0	62.0
Referral Services (17)	68.0	75.0	76.0	75.0	62.0	72.0
ANC*(28)	61.0	90.0	71.0	93.0	59.0	75.0
Natal Care* (12)	50.0	67.0	77.0	72.0	52.0	63.0
Family Planning *(18)	76.0	93.0	88.0	94.0	88.0	88.0
Child Care*(18)	60.0	89.0	82.0	71.0	53.0	71.0
Immunization* (38)	73.0	98.0	80.0	67.0	82.0	80.0
Health office (22)	64.0	86.0	89.0	50.0	51.0	68.0
Community participation (4)	0.0	0.0	0.0	0.0	0.0	0.0
Health Facility Plan of action (2)	50.0	100.0	100.0	100.0	100.0	90.0
Compound Total Quality Index (307)	65.0	84.0	77.0	69.0	69.0	73.0
Compound RH Quality Index (126)	66.0	88.0	78.0	76.0	68.0	75.0

* RH Items

4.7.4 Quality of health services at the programmatic level:

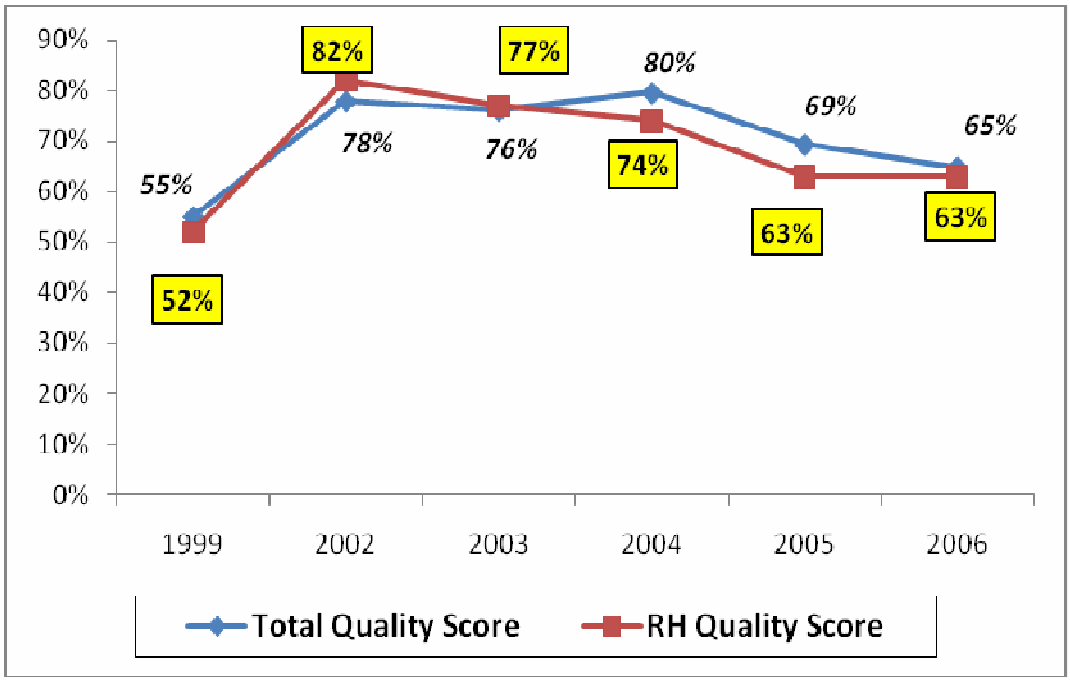
Table (4.3) summarizes interventions of the HSRP in the studied FHM facilities. The table shows that, out of the total 25 facilities admitted in the HSRP, only 24 had been accredited. The accreditation process had excluded another health facility, after its first acceptance as accredited facility (one facility in Suez has been accepted for accreditation in 2004). Only 11 facilities had been exposed to accreditation survey in 2007.

Table (4.3) Scheduled activities of HSRP at the facility level for the studied 25 facilities								
Activities	1999	2000	2002	2003	2004	2005	2006	2007
Admission in HSRP (25 Facilities)	3	-	4	7	5	5	1	-
First Accreditation (24 Facilities)	1	1	4	3	7	6	2	-
Last Accreditation (23 Facilities)	-	-	-	1	5	2	4	11
Duration of Exposure of the health facilities to HSRP interventions	9 Years	8 Years	6 Years	5 Years	4 Years	3 Years	2 Years	<1 Year

Figure (4.3) illustrates the current status (snapshot, in 2008) of quality of health services in the studied FHM facilities according to the time of admission in the HSRP. As shown from the figure, exposure to HSRP interventions for 4 years is considered a cut-off point, before which quality of services is gradually improving to reach its maximum level (after completing 4 years of exposure) to be followed by very slow decrease in quality level, to be the lowest after 9 years of exposure to HSRP interventions. The cohort of 3 facilities admitted to HSRP in 1999 and exposed to HSRP interventions for 9 years are currently demonstrated the lowest level of compound quality index for both the total quality (55%) and RH services quality (52%). Additionally, one of the three facilities was not accepted for accreditation.

Facilities which showed the highest compound index for RH services (82%) had been exposed to HSRP interventions for 6 years.

Figure (4.3) Pattern of Compound Quality Indices (total quality and RH services quality) for the studied FHM facilities by time of admission in the HSRP



FHM AND FACILITY LEVEL UTILIZATION PATTERNS OF RH-SERVICES 5

This chapter is concerned with examination of utilization pattern of RH-services in MOHP facilities in the five HSRP-pilot governorates, at both the district and health facility levels. The selection of the health facilities was done by the STSP, and includes the first FHM facilities participated in the HSRP in each governorate. The quasi control PHC facilities are also identified by STSP, as being from different health district in the same governorate (except in case of Suez where the quasi control facilities were from Port-Said Governorate). The populations served by the FHM and non-FHM facilities have approximately the same population size and socioeconomic background characteristics. The source of data for this chapter is the RH-vertical programs MIS, because it provides service statistics for both HSRP-pilot facilities as well as the control facilities in standardized form. This could allow for standardized comparison between the two studied groups at both the district and facility level.

This chapter will provide quantitative assessment of RH-services utilization patterns at two levels to identify:

1. The annual increase (or decrease) in the RH-services utilization in the HSRP pilot districts versus control districts.
2. The annual increase (or decrease) in RH-services utilization in the FHM facilities versus PHC/control facilities in the studied health districts.

Due to the HSRP plans of gradual inclusion of health facilities in the pilot districts in the HSRP, the pilot districts include both FHM facilities as well as the traditional PHC facilities. Therefore, analysis of the RH-services utilization pattern at the district level reflects the impact of introduction of FHM concepts at the health district authority level, irrespective to the number of FHM facilities within the district. Additionally, there are variations in the time of introduction of the FHM in each of the pilot HSRP governorates. Therefore, analysis of service statistics is presented separately for each of the 5 HSRP pilot governorates.

5.1 IMPACT OF FHM ON FP-SERVICES UTILIZATION

According to MOHP/PS –MIS, women attending the FP clinics receive any of the six types of services recorded as "reasons of seeking FP clinic's services" (i.e. to use FP method, to change FP method, to seek management of FP methods' side effects, to follow up the IUD use, and management of RTIs). According to MOHP/PS services statistics, the total number of women attending the FP clinics in year 2003 was 161485 women in the HSRP pilot districts versus 183848 women in the control districts. However, women usually receive more than one service during each visit. Consequently, the case-load for FP/RH services (clients) exceeds the number of registered women. For example the case-load (clients for different FP/RH services or the volume of service) in 2003 was 168201 clients in the pilot district versus 199920 clients in the control districts. In 2003, the average number of services received per woman attended the FP clinic was 1.04 services/woman in the pilot district versus 1.09 services/woman in the control districts.

Impact of FHM on FP-services utilization in Alexandria governorate:

FHM has been introduced in Montazaa District in **1999**. The FP indicators had been used to assess the performance after 4 years of introducing FHM, and for the following 5 years (2003 -2007). Table (5.1) shows the percent annual change in the volume of FP/RH services in the FHM district (Montazaa) versus PHC district (Amria). It is obvious from the table that both (FHM and PHC districts) had reported increase in the volume of FP/RH services in year 2004 compared with 2003, with higher output for PHC district (30%) than FHM district (24%). However, FHM district continued to show small annual increase in the volume of RH-services to reach 7% increase in 2007 compared with output in 2006. For the corresponding period, PHC districts had demonstrated

progressive annual decrease in the volume of FP-services. The snap shot comparison between FP-service output in year 2007 compared with 2003 for FHM and PHC districts indicates successful achievement in increasing the volume of FP/RH services by 55% in the FHM district versus 15% in the PHC district.

The average number of FP clients per physician per day in the studied FHM and control districts in Alexandria governorate is illustrated in table 5.1. It could be noticed that, throughout the period 2003-2007, the PHC district FP-service output gives the indication of high efficiency of physicians' performance, with an average 3 clients per physician per day (versus less than two clients/physician/ day in the FHM district).

According to MOHP/PS-MIS, on the average, there are ***3 physicians per health facility in the PHC district*** versus ***7 physicians/health facility in the FHM district*** in year 2007. The average number of clients/facility/day in 2007 was 11 clients in the FHM district versus 7 clients/facility/ day in the PHC district (not presented in the table).

At **the health facility** level, MOHP-PS statistics show fluctuations in the percent annual change in the volume of FP services for both FHM and PHC facilities 2003-2007. The volume of FP services had increased by 20% points in FHM clinics in 2004 compared with that in 2003, versus 7% increase in the volume of FP/RH services in the PHC clinics for the comparable years. Considering, the current situation, FHM had showed success in increasing the volume of FP services by 23 percent points in 2007 compared with 2003, versus the reported decrease in the volume of FP service by 5 percent points in the PHC facilities for the corresponding study years.

Table (5.1) Trend in Utilization Pattern of FP services (2003-2007) at the District and Facility Level in FHM versus Non-FHM Facilities in the Pilot HSRP Governorates: Alexandria

Indicators	Type of Facilities	2003	2004	2005	2006	2007	2003-2007
Percent annual changes in the volume of FP/RH services	FHM District	Base	24.0	10.0	6.0	7.0	55.0
	Control District	Line	30.0	-1.0	-6.0	-5.0	15.0
Average daily number of FP/RH clients/Physician/day	FHM District	2.1	1.9	1.7	1.5	1.8	1.8
	Control District	3.8	3.0	3.2	2.9	2.6	3.1
Percent annual changes in the volume of FP/RH services	FHM Facilities	Base	20.0	-19.0	13.0	12.0	23.0
	Control Facilities	Line	7.0	-30.0	20.0	6.0	-5.0
Average daily number of FP/RH clients/facility/day	FHM Facilities	11.0	13.0	10.0	12.0	13.0	12.0
	Control Facilities	6.0	6.0	4.0	5.0	5.0	5.0

Impact of FHM on FP-services utilization in Menofia governorate:

FHM has been introduced in Menofia Governorate/ Menof District in year 2002 in one PHC facility, and then started expansion to other facilities in 2004. According to in-depth interview with district director, in 2007, all facilities in Menof district are operating according to FHM.

Table (5.2) highlights the percent annual change in the volume of FP services in FHM district (Menof) and PHC district (Quesna). The data shows that the FHM district had recorded annual increase in the volume of FP services throughout the period 2003-2007, this increase ranged from 1.4% (in 2004 compared with 2003) and 8.5% (in 2006 compared with 2005). However for the same reference periods 2003 -2007, PHC district reported drop in the volume of FP services by 0.1% in 2004 compared with 2003 and another drop by 5.1% in 2007 compared with 2006. The overall output of FP services indicates that the recorded FP service output (2007) was more than that reported in year 2003 by 16% in the FHM district, versus 6% in the PHC district.

Compared with PHC district, FHM district reported higher efficiency of physicians' performance in FP services delivery throughout the period 2003-2007. The average number of FP clients per physician /day was about 3 clients /physician/day in the FHM district. However, it was less than two FP clients /physician/day in the control district.

Table (5.2) illustrates that the FHM **facilities** had reported annual increase in the volume of FP

services. In 2007, the FHM reported an increase in the FP service output that exceeds FP output reported in year 2006 by 17 percent points. For the same reference years, PHC facilities had reported 8% decrease in FP service output.

The table shows also progressive increase in the average number of FP clients /facility/ day in both the FHM and PHC facilities. However, there is tendency to have about 4 FP clients / facility /day on the average, throughout the period 2003-2007 in both FHM and PHC facilities.

Table (5.2) Trend in Utilization Pattern of FP services (2003-2007) at the District and Facility Level in FHM versus Non-FHM Facilities in the Pilot HSRP Governorates: Menofia

Indicators	Type of Facilities	2003	2004	2005	2006	2007	2003-2007
Percent annual change in the volume of FP/RH services	FHM District	Base Line	1.4	3.3	8.5	2.5	16.0
	Control District		-0.1	3.9	7.1	-5.1	6.0
Average daily number of FP/RH clients/Physician/day	FHM District	3.3	2.5	2.1	2.7	2.5	2.6
	Control District	2.2	1.6	1.7	1.7	1.4	1.7
Percent annual changes in the volume of FP/RH services	FHM Facilities	Base Line		5.0	6.0	17.0	8.0
	Control Facilities			1.0	9.0	-8.0	1.0
Average daily number of FP/RH clients/facility/day	FHM Facilities		3.5	3.8	4.4	4.7	3.9
	Control Facilities		3.8	3.9	4.3	4.0	4.0

Impact of FHM on FP-services utilization in Souhag governorate:

FHM has been introduced in Souhag District in year 2002 in three PHC facilities, and then started expansion to other facilities in 2003.

Table (5.3) exemplifies the percent annual change in the FP service output in FHM-District (Maragha) and PHC District (Tahta) and FHM and PHC facilities in Souhag Governorate 2003-2007. It is obvious from the table that both districts showed the same pattern in annual increase or decrease in the volume of FP services. However, at any point in time, there are variation in the degree of change in the FP service output in both FHM and PHC districts. FHM district had demonstrated high efficiency than the PHC district in years 2005 by 7 percent points. However, in year 2007 the PHC district had demonstrated higher efficiency than the FHM by 3 percent points.

The table displays also the average number of FP clients per/physician/day in the FHM and PHC districts in Souhag Governorate 2003-2007. It is clear from the table that the FHM district had shown decrease in the average number of FP clients/physician per day from 1.8 in 2003 to be 1.1 in 2005, but to showed increase again in 2007 to be 1.4 clients in 2007). The PHC district data had shown constant pattern at 1.4 FP clients /physician/day throughout the studied period.

The percent annual change in the volume of FP services in the FHM facilities versus PHC facilities in Souhag governorate 2003-2007 is illustrated in table 5.3. The table demonstrates failure of the FHM to make any improvement in the volume of FP services delivered in the FHM facilities. However, it is obvious that, at any point of time PHC facilities had reported increase in FP service output, which showed a peak in 2006 (41%) compared with FP output in year 2005. Comparing district and health facility data, it could be concluded that the achievement of Maragha /FHM district in increasing the volume of FP services could be due to having PHC facilities within the same district that reported high output. This situation raises the question of shifting the clients from FHM to PHC facilities within the same district.

Regarding the average number of FP clients per clinic per day in FHM versus PHC facilities in Souhag Governorate 2003-2007, it is obvious that FHM facilities have less productivity than PHC facilities. Throughout the last five years, there were 1.7 FP clients /clinic/day in the PHC facilities versus 1.2 FP clients /clinic/day.

Table (5.3) Trend in Utilization Pattern of FP services (2003-2007) at the District and Facility Level in FHM versus Non-FHM Facilities in the Pilot HSRP Governorates: Souhag							
Indicators	Type of Facilities	2003	2004	2005	2006	2007	2003-2007
Percent annual changes in the volume of FP/RH services	FHM District	Base	-3.0	17.0	5.0	1.0	20.0
	Control District	Line	-2.0	10.0	5.0	4.0	18.0
Average daily number of FP/RH clients/Physician/day	FHM District	1.8	1.5	1.1	1.2	1.4	1.4
	Control District	1.4	1.5	1.5	1.4	1.4	1.4
Percent annual changes in the volume of FP/RH services	FHM Facilities	Base	-8.0	1.0	-1.0	1.0	-7.0
	Control Facilities	Line	5.0	22.0	41.0	8.0	95.0
Average daily number of FP/RH clients/facility/day	FHM Facilities	1.3	1.2	1.1	1.0	1.2	1.2
	Control Facilities	1.4	1.4	1.7	2.2	1.7	1.7

Impact of FHM on FP-services utilization in Quena governorate:

FHM has been introduced in Nagah-Hammady District in Quena in year 2005 in five facilities and then started expansion to other facilities.

Table (5.4) demarcates the percent annual change in the volume of FP services in the FHM district (Nagah-Hamady) and PHC district (Qous) 2003-2007. The figure shows that in 2005 (the time of introduction of FHM in the district), there were decrease in the volume of FP services by 3% compared with the volume of services in 2004. However, in 2007, FHM facilities had recorded increase in the volume of FP services by 7% compared with 2006. The sharp decrease observed in the volume of FP services in the PHC district in 2006 had been followed by sharp increase in 2007 to reach 7% compared with the level in 2006. Comparing the situation in 2007 with 2003, it is estimated that PHC district had recoded increase in FP services output by 10 percent points versus 4% for the FHM district.

The FHM districts data reflect also low efficiency in physicians' performance expressed as the average number of FP clients per physician/day. Throughout the study period, the estimated average number of clients per physician per day was less than two FP clients per day in both the FHM and the PHC districts. However, the situation is better in the PHC facilities (cumulative index is 1.6 clients/physician/day in 2003-2007) than FHM facilities (cumulative index is 1.1 clients/physician/day in 2003-2007).

At the health facility level, the percent annual change in the volume of FP services showed that FHM facilities reported success in increasing the volume of FP services between 2006 and 2007 by 30 percent points versus 3 percent points for the PHC facilities. Considering the whole period 2004-2007, FHM had raised the volume of FP services by 22% in 2007 compared with the level in 2004. However, the counterpart figure for the PHC facilities was only 10 percent points.

However, Table (5.4) shows that the average number of FP clients per clinic per day had shown significant gradual increase over the period 2004-2007 in the PHC facilities to reach 2.8 clients/clinic/day in 2007 versus 2.6 clients/clinic/day in the FHM facilities. However, for the whole study period 2004-2007 the clinic productivity was 2.2 clients /clinic/day in the FHM facilities versus 2.6 clients /clinic/day in the PHC facilities.

Table (5.4) Trend in Utilization Pattern of FP/RH services (2003-2007) at the District and Facility Level in FHM versus Non-FHM Facilities in the Pilot HSRP Governorates: Quena Governorate							
Indicators	Type of Facilities	2003	2004	2005	2006	2007	2003-2007
Percent annual changes in the volume of FP/RH services	FHM District	Base	2.0	-3.0	-1.0	7.0	4.0
	Control District	Line	11.0	4.0	-10.0	7.0	10.0
Average daily number of FP/RH clients/Physician/day	FHM District	1.7	1.3	1.2	1.1	1.2	1.1
	Control District	1.6	1.9	1.7	1.4	1.6	1.6
Percent annual changes in the volume of FP/RH services	FHM Facilities			-6.0	-0.3	30.0	22.0
	Control Facilities			7.0	-0.1	3.0	10.0
Average daily number of FP/RH clients/facility/day	FHM Facilities		2.1	2.0	2.0	2.6	2.2
	Control Facilities		2.4	2.7	2.6	2.8	2.6

Impact of FHM on FP-services utilization in Suez governorates:

FHM has been introduced in Suez Governorate in 2003 in three PHC facilities. In 2004 and 2006 another two facilities had been involved in the FHM. Post-Said Governorate PHC data had been used as control.

Table (5.5) illustrates the annual changes in the volume of FP services in the studied governorates Suez/FHM and Port-Said/PHC. It is obvious that in Suez, there were reported decrease in the FP service output in 2004 compared with 2003 and this time corresponds with the first introduction of HSRP in Suez. However, after 2004 there was increase at a rate of 4%-8% annually in 2005-2007. In Post-Said, there were severe drop in the FP output by 17% in 2005 compared with FP output in year 2004. However, after year 2005, Port-Said data had shown progressive annual increase in the volume of FP/RH-services. The estimated achievement in FP output reflects increase by 8.5% in 2007 compared with 2003 output in Suez, versus 15% in Port-Said.

The percent annual change in the volume of FP services in FHM/Suez and PHC/Port-Said facilities is shown in table 5.5. The table illustrates that in 2004 FHM had demonstrated decrease in the volume of FP/RH services by 6% compared with the level in 2003. And this decrease in the FP service output continued in 2005 to record a decrease by 5% compared with that in 2004. However, in 2007 FHM reported marked increase in FP service output to be 11% more than that recorded in 2003.

The FP service output in the counterpart PHC facilities had demonstrated different picture, where sever decrease in FP service output (14%) was observed in year 2005. The situation in 2007 reflects a decrease in FP output in 2007 compared with 2003 by 10 percent points.

The same table 5.5 shows that PHC facilities are more efficient than FHM facilities where the average number of FP clients per day per facility was kept at a level of 13 clients per day versus 4 clients per day in the FHM facilities.

The shortage in the availability of data at the facility and district levels had resulted in missing the demonstration of the indicators related to average number of FP clients / physician/ day at the district level (in Suez). Three health facilities had been excluded from the analysis due to their recent establishment i.e. the health unit "October" started to provide data about FP in 2006. In Port-said "Fatma Al-Zaharaa" Center started activities in 2005, and 'Algawhara" Center in 2006.

Table (5.5) Trend in Utilization Pattern of FP/RH services (2003-2007) at the District and Facility Level in FHM versus Non-FHM Facilities in the Pilot HSRP Governorates: Suez (FHM)and Port-Said Control

Indicators	Type of Facilities	2003	2004	2005	2006	2007	2003-2007
Percent annual changes in the volume of FP/RH services	FHM District	Base Line	-7.6	4.3	8.4	3.8	8.5
	Control District		18.4	-17.0	1.6	15.3	15.1
Percent annual changes in the volume of FP/RH services	FHM Facilities		-6.0	-5.0	2.0	21.0	11.0
	Control Facilities		3.0	-14.0	3.0	-1.0	-10.0
Average daily number of FP/RH clients/facility/day	FHM Facilities	3.8	3.6	3.5	3.5	4.3	3.8
	Control Facilities	13.8	14.1	12.1	12.5	12.3	13.0

General impact of FHM on FP services:

Figure (5.1) illustrates a summary on the impact of FHM on FP services utilization expressed at the percent increase in FP services output in 2007 compared with 2006. When considering all the studied 25 FHM and 25 PHC facilities, it could be concluded that FHM succeeded in increasing FP services output by 15% versus 4% in the PHC facilities. However, are variations across the governorates regarding the FP services output in 2007. Quena, Suez, Menofia and Alexandria FHM facilities had reported increase in FP services utilization, but PHC facilities in Souhag had demonstrated success in increasing FP services output.

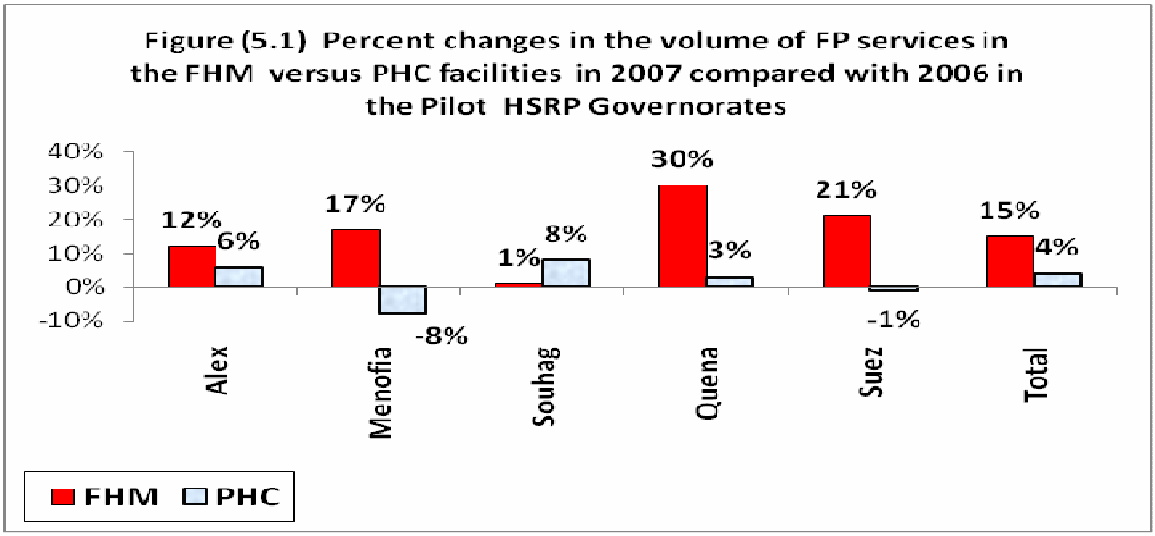
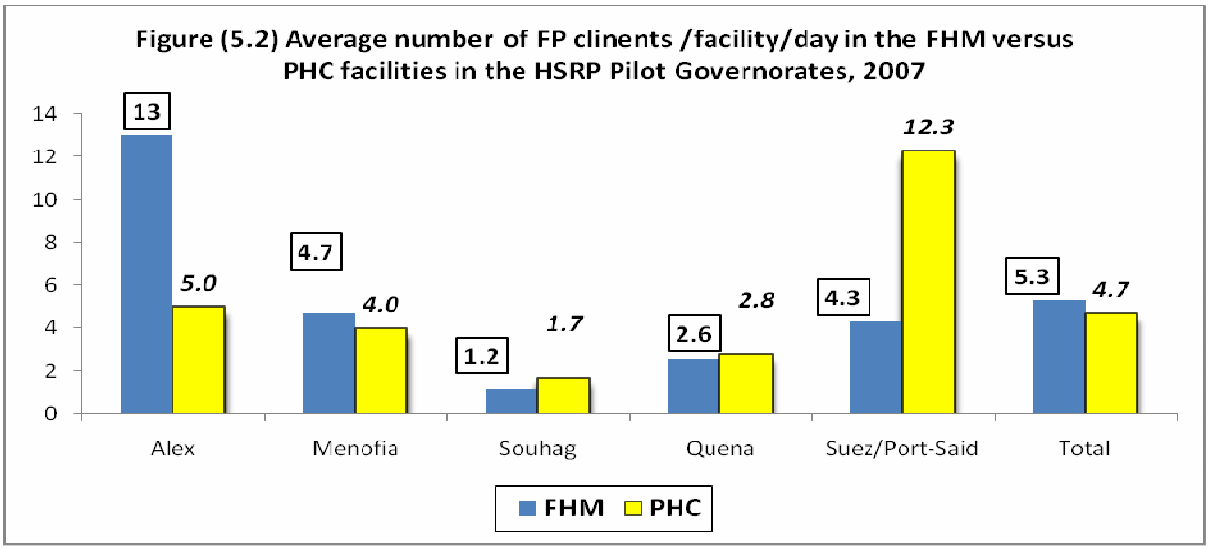


Figure (5.2) shows that the average number of FP clients / facility/ day in year 2007 for the studied facilities was 5.1 clients in the FHM and 4.3 clients for PHC facilities. For the whole period 2004-2007, the average number of FP clients per facility per day was 4.7 clients in the FHM and 4.6 clients in the PHC facilities. Additionally, there were only two governorates who reported efficiency of FHM facilities i.e. Alexandria and Menofia, while PHC facilities in the other three governorates had demonstrated high level of efficiency in FP services utilization.



5.2 Impact of FHM on Maternal Care-Services Utilization

This section will demonstrate the impact of FHM on maternal care services utilization expressed by two indicators: ANC coverage and average number of ANC visits per mother at both the health district and facility levels.

ANC coverage is the percent ratio of mothers registered for ANC in the health facility to total live births in the catchment area of the same facility and in the same year. According to HSRP policy, FHM services have to cover 35%-40% of the urban population and 100% of the rural population. According to EDHS, 4 ANC visits per mother is considered to be the minimal acceptable standards for regular ANC.

Impact of FHM on maternal care services utilization in Alexandria governorate

Table (5.6) shows that throughout the period 2000 – 2007, the health district adopting FHM had covered less than one third of mothers (31%) with ANC services. Yet, the health district operating

according to the traditional PHC had succeeded in covering more than half of mothers within the district with ANC services (54%). Despite the tendency for gradual decrease in coverage with ANC services in both PHC and FHM throughout the period 2000-2007, FHM continued to cover less than 30% of the mothers, and PHC facilities serve more than 45% of the mothers.

The average number of ANC visits per mother for the period 2000-2007 in the studied FHM and PHC districts in Alexandria Governorate showed gradual increase in the average number of ANC visits /mother i.e. In FHM district the increase was from 2.9 visits/mother in year 2000 to 4.4 visits/mother in year 2007, and in PHC district the increase was from 2.5 visits/mother in year 2000 to 3.2 visits/mother in year 2007. The cumulative average number of ANC visits per mother 2000-2007 in the FHM district was 3.6 and it was 3.2 visits /mother in the PHC district.

At the health facility level, it is obvious that PHC facilities cover a wide base of mothers, with a cumulative coverage rate in 2000-2007 at 81% versus 28% for FHM facilities. Comparing ANC coverage rate at both the district and facility level, it could be observed the general tendency of having ***similar figures*** for both the district and its corresponding facilities. This indicates that the introduction of FHM in some facilities did not lead to shift of the ANC clients to other PHC facilities within the same district. However, for the PHC district, there are variations across the PHC facilities regarding ANC coverage rate. The studied 5 PHC facilities had shown high ANC coverage rate (63% in 2006) compared with the average at the district level (52% in 2006). This indicates that other non-studied facilities have lower ANC coverage rate than the studied facilities, which are located within the same PHC district. Such findings reflect the free access of mothers to receive ANC services in any of the MOHP facilities located within the district.

Table (5.6) Trend in Utilization Pattern of Maternal Care Services (2000-2007) at the District and Facility Level in FHM versus Non-FHM Facilities in the Pilot HSRP Governorates: Alexandria

Indicators	Type of Facilities	2000	2001	2002	2003	2004	2005	2006	2007	2000-2007
ANC coverage	FHM District	33.0	41.0	38.0	28.0	30.0	26.0	25.0	26.0	31.0
	Control District	61.0	57.0	59.0	57.0	56.0	52.0	52.0	46.0	54.0
Average number of ANC visits per mother	FHM District	2.9	3.5	3.9	3.4	3.5	3.6	3.9	4.4	3.6
	Control District	2.5	3.2	3.2	3.3	2.9	3.4	3.5	3.7	3.2
ANC coverage	FHM Facilities	27.0	38.0	30.0	20.0	31.0	29.0	26.0	26.0	28.0
	Control Facilities	100.0	83.0	99.0	86.0	91.0	68.0	63.0	69.0	81.0
Average number of ANC visits per mother	FHM Facilities	3.2	3.0	3.5	3.4	2.8	3.2	4.5	4.9	3.5
	Control Facilities	2.2	2.8	2.8	2.5	2.9	3.3	3.7	3.5	3.0

Table (5.6) shows also that the average number of ANC visits per mother 2000-2007 was 3.5 visits /mother in the FHM facilities, versus 3 visits /mother in the PHC facilities. Therefore, with the progressive decrease in the ANC coverage rate in the FHM facilities, there were progressive increase in the average ANC visits/ mother to be 4.9 visits in FHM versus 3.5 visits in the PHC facilities.

Impact of FHM on maternal care services utilization in Menofia governorate

Table (5.7) illustrates the percent coverage of mothers with ANC and average number of ANC visits per mother at both district and facility levels in Menofia Governorate 2000-2007. At the FHM district level, the period before 2004 had demonstrated progressive increase in ANC coverage rate from 78% in 2000 to 86% in 2003. However, throughout the period 2004-2007 there were decrease in ANC coverage from 80% in 2004 to 77% in 2007. In the PHC district ANC coverage had shown progressive increase from 78% in 2004 to 84% in 2007. Therefore, in the FHM district the ANC cumulative coverage rate before 2004 was 82% and became 71% after 2004. The counterpart figures for ANC coverage in the PHC districts were 71% before 2004 and 82% after 2004.

At the health facility level, ANC coverage could exceed 100% in the studied FHM and PHC facilities. This indicates that the health facilities could receive mothers for ANC services from other facilities' catchment areas. The figures indicate gradual increase in the volume of ANC services delivered in both types of the studied FHM and PHC facilities, but with higher level of

ANC coverage for PHC facilities than FHM facilities. Comparing ANC coverage for the two reference periods (before and after 2004) it could be concluded that ANC coverage had shown increase from 91% to 109% in the FHM facilities and from 90% to 134% in the PHC facilities.

The quality of ANC services expressed as the average number of ANC visits per mother had shown improvement overtime for both the FHM and PHC facilities. However, this improvement could be observed more in the FHM than PHC facilities, if we compare the average number of ANC visits /mother before and after 2004. FHM facilities reported increase in the average number of ANC visits per mother from 3.6 visits before 2004 to 4.5 visits after 2004, versus 3.9 and 4.4 visits /mother in the PHC facilities for the studied reference periods.

Table (5.7) Trend in Utilization Pattern of Maternal Care Services (2000-2007) at the District and Facility Level in FHM versus Non-FHM Facilities in the Pilot HSRP Governorates: Menofia

Indicators	Type of Facilities	2000	2001	2002	2003	2004	2005	2006	2007	2000-2007
ANC coverage	FHM District	78.0	82.0	80.0	86.0	80.0	76.0	79.0	77.0	80.0
	Control District	73.0	76.0	51.0	83.0	78.0	82.0	82.0	84.0	76.0
Average number of ANC visits per mother	FHM District	3.8	3.4	3.7	3.9	3.9	3.6	3.4	3.4	3.6
	Control District	3.6	3.6	3.4	3.5	3.7	3.9	3.6	3.3	3.6
ANC coverage	FHM Facilities	80.0	99.0	86.0	99.0	105.0	102.0	113.0	114.0	101.0
	Control Facilities	82.0	97.0	68.0	111.0	156.0	128.0	119.0	131.0	109.0
Average number of ANC visits per mother	FHM Facilities	3.7	3.3	3.4	3.9	4.8	4.5	4.4	4.4	4.1
	Control Facilities	3.8	4.1	3.9	3.9	4.3	4.7	4.7	3.8	4.2

The estimated average number of ANC visits per mother at the FHM district and PHC district as well as their corresponding facilities indicates analogues level of the average number of ANC visits per mother. Therefore, there is no added privilege (no change) for introduction of FHM to increase the ANC visits per mother or increasing coverage with ANC.

Impact of FHM on maternal care services utilization in Souhag governorate

Table 5.8 illustrates ANC utilization pattern in the FHM district and PHC district in Souhag Governorate 2000-2007. Data derived from the FHM district show that ANC coverage in year 2000 was 71% and showed progressive increase to be 76% in 2007 i.e. the increase in ANC coverage is by **5 percent** points. However, for the PHC district the increase in ANC coverage rate was **23 percent** points (from 55% in year 2000 to 78% in year 2007). At the health facility level, there was decrease in the ANC coverage rate in both FHM and PHC facilities. The decrease in ANC coverage rate was **20 percent points** in the FHM facilities (from 97% in year 2000 and 77% in year 2007). Yet, the decrease in ANC coverage rate was **7 percent points** in the PHC facilities (from 75% in year 2000 and 68% in year 2007).

The average number of ANC visits per mother had shown a decrease in the FHM district from 3.4 visits / mother in year 2000 to 2.8 visits per mother in years 2002, 2003, 2004. However, in the PHC district, the average number of ANC visits per mother had shown progressive increase from 2.1 visits year 2000 to 3.9 visits per mother year 2007.

At the health facility level, FHM had shown increase in the average number of ANC visits by 1.4 visits /mother (from 3.8 visits in 2000 to 5.2 visits per mother in 2007). The counterpart figures for the PHC facilities indicate an increase in the average number of ANC visits by **2.1 visits** /mother (from 1.9 visits in 2000 to 4 visits per mother in 2007).

Table (5.8) Trend in Utilization Pattern of Maternal Care Services (2000-2007) at the District and Facility Level in FHM versus Non-FHM Facilities in the Pilot HSRP Governorates: Souhag									
Indicators	Type of Facilities	2000	2001	2002	2003	2004	2005	2006	2007
ANC coverage	FHM District	71.0	74.0	76.0	77.0	80.0	80.0	77.0	76.0
	Control District	55.0	59.0	69.0	69.0	70.0	72.0	76.0	78.0
Average number of ANC visits per mother	FHM District	3.4	3.0	2.8	2.8	2.8	2.9	3.2	3.2
	Control District	2.1	2.4	2.5	3.1	2.9	2.8	3.7	3.9
ANC coverage	FHM Facilities	97.0	84.0	85.0	99.0	91.0	84.0	83.0	77.0
	Control Facilities	75.0	61.0	71.0	69.0	95.0	73.0	78.0	68.0
Average number of ANC visits per mother	FHM Facilities	3.8	3.4	3.9	3.5	3.6	4.3	4.7	5.2
	Control Facilities	1.9	1.8	1.9	2.6	3.8	3.4	4.2	4.0

Impact of FHM on maternal care services utilization in Quena governorate

Table (5.9) illustrates the ANC coverage and the average number of ANC visits per mother in the FHM and PHC districts and facilities in Quena Governorate 2000 - 2007. As depicted from the table, both the FHM and PHC districts and facilities had shown progressive improvement in ANC service output. For the FHM district, there was increase in the ANC coverage rate by 14 percent points (from 68% in year 2000 to 82% in 2007). However, the improvement in ANC service output reported at PHC district was estimated at 17 percent point due to the increase of ANC coverage rate from 71% in year 2000 to 88% in year 2007. The advancement regarding the increase in the ANC coverage rate in 2007 versus 2000 was noticeable for both FHM facilities (37 percent points) and PHC facilities (38 percent points).

The average number of ANC visits per mother had shown increase by 0.2 visits per mother in the FHM district (from 2.2 visits /mother in year 2000 to 2.4 visits /mother in year 2007). Nevertheless, the increase in the average number of ANC visits / mother was 0.4 visits in the PHC district (from 2.0 visits /mother in year 2000 to 2.6 visits /mother in year 2007). At the health facility level counterpart figures for the increase in the average ANC visits /mother between 2000 and 2007 were 0.7 visit/ mother at the FHM facilities and 0. 2 visit / mother at the PHC facilities. However, neither FHM nor PHC facilities had succeeded in increasing the average number of ANC visits per mother to be 4 visits.

Table (5.9) Trend in Utilization Pattern of Maternal Care Services (2000-2007) at the District and Facility Level in FHM versus Non-FHM Facilities in the Pilot HSRP Governorates: Quena									
Indicators	Type of Facilities	2000	2001	2002	2003	2004	2005	2006	2007
ANC coverage	FHM District	68.0	68.0	74.0	74.0	80.0	75.0	78.0	82.0
	Control District	71.0	74.0	78.0	77.0	76.0	79.0	83.0	88.0
Average number of ANC visits per mother	FHM District	2.2	2.1	2.3	2.3	2.3	2.1	2.2	2.4
	Control District	2.0	2.1	2.1	2.2	2.2	2.1	2.3	2.6
ANC coverage	FHM Facilities	65.0	68.0	85.0	84.0	91.0	88.0	92.0	102.0
	Control Facilities	69.0	68.0	72.0	67.0	82.0	82.0	67.0	107.0
Average number of ANC visits per mother	FHM Facilities	2.0	2.2	2.5	2.6	2.7	2.5	2.3	2.7
	Control Facilities	2.3	2.2	2.3	2.1	1.9	2.2	2.5	2.5

Impact of FHM on maternal care services utilization in Suez and Port-Said governorate

Table (5.10) presents the ANC coverage and the average number of ANC visits per mother in FHM (Suez Governorate) and PHC (Port-Said Governorate) facilities 2000 - 2007. The table points to year 2004, as a cut-off point of time at which ANC coverage had showed decrease in both the FHM and PHC facilities. This time corresponds to the second year after introduction of HSRP in Suez in year 2003. During the period 2000-2003 ANC coverage rate was 73% and showed decrease to be 58% in 2004-2007 in Suez Governorate. Corresponding figures for Port-Said Governorate were 49% and 50% for the same reference periods. Therefore, it could be concluded that the introduction of FHM in 2003 in Suez was associated with reduction in ANC coverage rate by 15 percent points.

Data on ANC coverage at the FHM facilities had shown decrease from 79% for the period 2000 - 2003 to 69 % as an average for the period after introduction of HSRP in Suez (2004-2007). In Port-Said health facilities, ANC coverage was kept to be at a level of about 90% on the average throughout the period 2000-2007.

Table (5.10) Trend in Utilization Pattern of Maternal Care Services (2000-2007) at the District and Facility Level in FHM versus Non-FHM Facilities in the Pilot HSRP Governorates: Suez (FHM) and Port-Said Control

Indicators	Type of Facilities	2000	2001	2002	2003	2004	2005	2006	2007
ANC coverage	FHM District	54.0	73.0	85.0	80.0	57.0	65.0	50.0	58.0
	Control District	46.0	44.0	51.0	54.0	46.0	50.0	49.0	53.0
Average number of ANC visits per mother	FHM District	3.4	3.8	4.1	3.7	3.7	3.5	3.5	4.0
	Control District	2.6	3.0	3.1	3.1	3.2	3.1	3.3	3.1
ANC coverage	FHM Facilities	88.0	81.0	76.0	70.0	74.0	75.0	66.0	62.0
	Control Facilities	98.0	71.0	103.0	108.0	*	*	86.0	112.0
Average number of ANC visits per mother	FHM Facilities	3.1	4.2	3.6	3.4	3.3	2.6	2.3	3.1
	Control Facilities	3.0	3.1	3.3	3.5	3.2	3.4	3.7	3.5

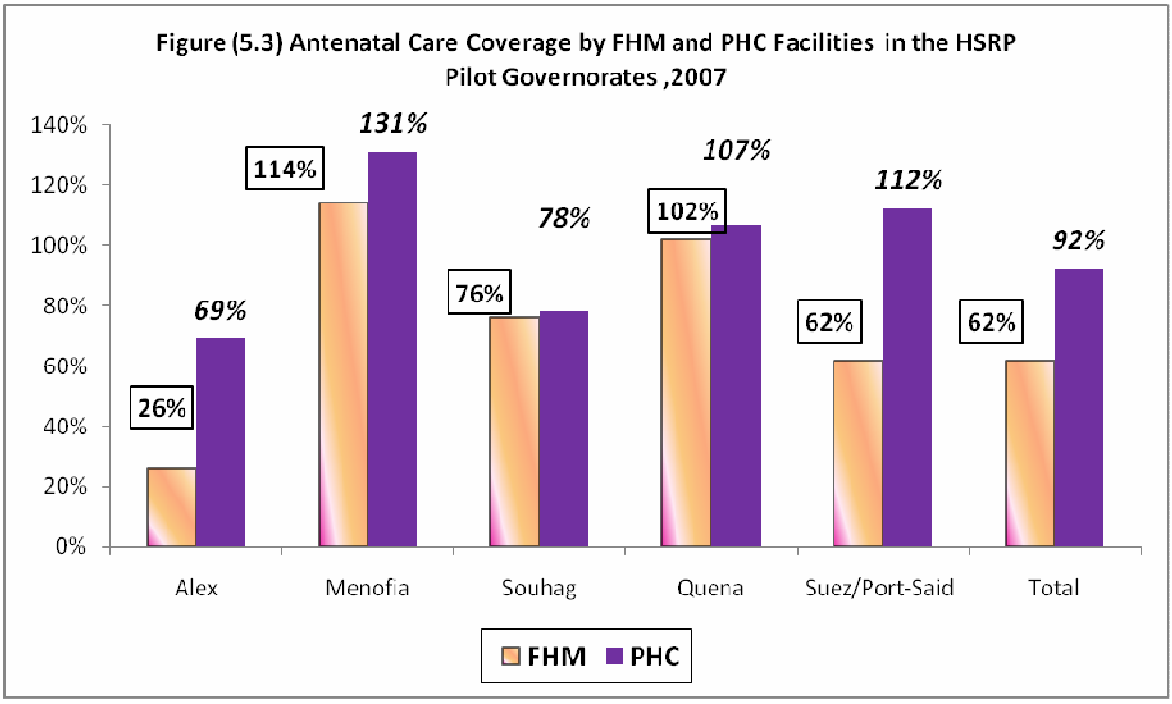
** Missing data*

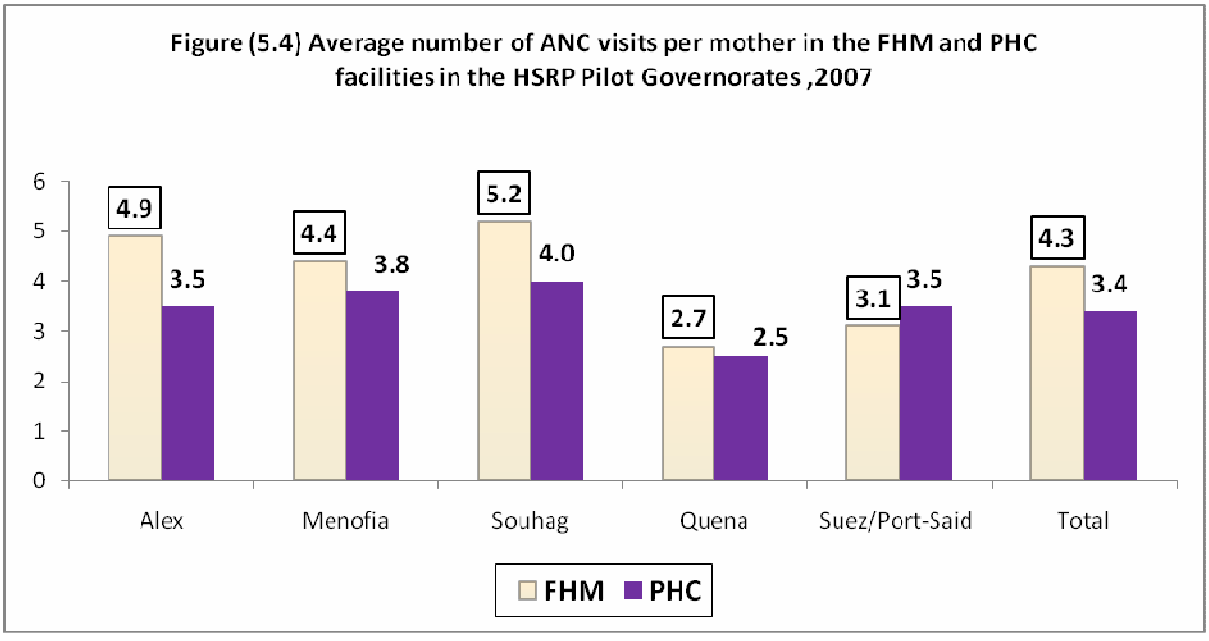
Table (5.10) demonstrates the average number of ANC visits per mother in FHM (Suez) and PHC (Port-Said) health facilities in 2000-2007. In Suez and throughout the 4 years before introduction of FHM (2000-2003), the average number of ANC visits/mother was 3.6 visits /mother. The 4 years following the introduction of FHM in Suez (2004-2007), the average ANC visits per mother showed decrease to be 2.8 visits /mother. Counterpart figures in Port-Said PHC facilities for the two reference periods had shown increase from 3.3 ANC visits /mother (2000-2003) to be 3.5 ANC visits /mother (2004-2007).

Summary of the utilization pattern of maternal care services in FHM versus PHC facilities in 2007:

Figure (5.3) illustrates the ANC coverage in the FHM and PHC facilities in the 5 pilot HSRP governorates in year 2007. It is obvious that, there is a tendency for having **low ANC coverage** rates in all FHM facilities compared to control facilities in all governorates. There are trivial differences between ANC coverage rate in FHM and control facilities in the three rural governorates (Menofia, Souhage and Quena). However, traditional **PHC facilities** compared to FHM in the urban governorates (Alexandria and Suez) had succeeded in achieving **more than double** the achievements of the FHM facilities regarding coverage of mothers with ANC services.

Figure (5.4) presents the average number of ANC visits/mother in the pilot HSRP governorates in year 2007. It could be noticed that FHM succeeded in achieving high efficiency in recording more ANC visits per mother compared to control facilities. However, this increased efficiency in the FHM facilities is estimated to be less than one ANC visit (0.9) per mother. In Alexandria governorate FHM succeeded in increasing the ANC visits per mother by 1.4 visits. However, Suez is the only governorate in which FHM was not successful in increasing the ANC visits / mother in 2007.





Impact of FHM on utilization pattern of r5eproductive health services:

From the demonstrated results, the observed higher efficiency in FP service output in the FHM facilities compared with PHC facilities has many limitations. **FHM did not make substantial difference** in FP services utilization compared with traditional PHC facilities. **FHM was not associated with improvement in maternal care services utilization**. At different points of time, it is possible to find positive impact of FHM and in other times it is possible to find negative impact or no difference. This situation varies across the governorates, and reflects the inability of the HSRP to demonstrate well-defined model that support RH-services.

The following key findings reflect the limited impact of FHM in improving FP services utilization in Egypt:

- It is not satisfactory to achieve only **11** percent points as a difference between FHM and

PHC facilities regarding the increase in FP services output in 2007 compared with FP output in 2006 (figure 5.1).

- It is not satisfactory to achieve efficiency difference between FHM and PHC facilities at a level of **0.1** clients per facility per day throughout the period 2004-2007 (figure 5.2).
- It was expected for the FHM to have positive impact on FP service output in Upper Egypt Governorates who have rigorous challenges. But, the current situation raises many questions about the role of FHM in confronting those challenges.
- In Alexandria, FHM is working for more than **10 years**. It is not satisfactory to achieve **6** percent points as a difference between FHM and PHC facilities regarding the increase in FP services output in 2007 compared with FP output in 2006 (figure 5.1). FHM capitalizes on **increasing the number of physicians** in the facilities (see comments on table 5.1), with the result of increasing FP services output at both the district and facility level. However, the **efficiency of physicians' performance** in FP was kept at less than **2 clients /physician/day** in the FHM versus more than **3 clients /physician/day** in the PHC facilities.
- In Menofia, FHM is working for 5 years and FHM covered all the district's facilities in 2007. Despite the PHC facilities achieved 3 percent points more than FHM facilities regarding the increase in FP services output in 2006 (compared with FP output in 2005) (table 5.2), there were satisfactory achievements in the FHM facilities in 2007. This achievement is estimated at 25 percent points as a difference between FHM and PHC facilities, regarding the increase in FP services output in 2007 compared with FP output in 2006 (figure 5.1). Keeping both the FHM and PHC facilities at an efficiency level of ***4 FP clients per facility per day***, indicates that FHM is capitalizing on increasing the efficiency of physicians' performance (about three cases per physician per day) rather than increasing the number of physicians per facility. However, this approach has its limited effects, where ***there is no positive impact*** **at the** ***facility level*** regarding the increase in the average FP clients/facility/day to show any improvements in the FHM –FP output in contrast with the PHC facilities (table 5.2).
- In Souhag, the FHM is working for 5 years, however it reported **sever failure** in producing substantial achievements in FP services output. Throughout the period 2003 -2007, FHM facilities had shown gradual loss of their FP clients. At the same time, PHC facilities were attracting clients to show increase at a level of **95%** in FP output in 2007 compared with 2003. In Souhag, FHM was not successful in either increasing the efficiency of performance of the physicians in FP or increasing the FP output at the facility level (Table 5.3).
- In Quena, the FHM had been introduced in 2005. The partial introduction of FHM in Nagha –Hamady district was associated **with trivial** increase in FP output in 2007 compared with 2003 (4%in FHM versus 10% in PHC district). However, there was achievement at a level of **12** percent points as a difference between FHM and PHC facilities regarding the increase in FP services output in 2007 compared with FP out in 2004. This situation could be attributed to the increase **in the number of physicians per facility**, but keeping ***low level of efficiency of the physicians' performance***.(Table 5.4).
- In Suez, the FHM has been working science 2003. However, FHM **was not able to show** any detectable **progress in FP service** output throughout the period 2003-2007 at the **governorate/district** level if compared with Port-Said Governorate. The observed improvement in FP output at the FHM facility level compared with PHC facilities in 2007 is limited. This is because **the efficiency of the FP service output was kept at a level less than 4 FP clients** per day versus ***13 clients*** per day in the control PHC facilities throughout the period 2004-2007 (Table 5.5).

The following key findings reflect the limited role of FHM in improving maternal care services utilization in Egypt:

- The introduction of FHM in the pilot governorates is associated with decrease in ANC

coverage, especially in Urban Governorates. The problem with expansion of the FHM to cover the entire health district's facilities with subsequent restricting the opportunity of shifting of mothers from FHM to the traditional PHC facilities within the district (table 5.6).

- The observed minimal increase in the average ANC visits / mother and decrease in the ANC coverage, indicates that, FHM provides efficient services but to fewer number of mothers (figures 5.3 and 5.4).
- In Alexandria FHM, which represent a mature-10 year pilot model, ANC coverage is kept at about 30% at both the facility and district level. This means that the MOHP-health system is missing 70% of the opportunities to cover mothers with ANC. This raises the questions of shifting to health facilities other than MOHP or not receiving ANC for mothers resident in the FHM district (table 5.6).
- In Menofia FHM did not add any privilege at both the district or facility level regarding ANC coverage or the average number of ANC visits per mother. Both the FHM and PHC facilities showed the same pattern of maternal care utilization.
- In Souhag, HSRP had selected active districts and facilities to adopt the FHM. The profile of ANC utilization pattern in Maragha FHM facilities in year 2000 showed that ANC coverage was 97% and the average ANC visits /mother was 3.8 visits. In same year (2000) Tahta PHC facilities had reported underutilization levels for ANC coverage (75%) and the average ANC visits per mother (1.9 visits). However, the situation in 2007 showed that Tahta facilities succeeded in overcoming challenges and reported successful achievements in ANC utilization pattern that surpass that reported for Maragha facilities in years 2000 and 2007 (table 5.8).
- In Quena, both the FHM and PHC facilities have the same ANC utilization pattern. Both types of facilities were not able to increase the average number of ANC visits per mother to be at-least 3 visits. Therefore, the introduction of FHM was not coupled with strategies that could overcome underutilization of maternal care services in Quena (Table 5.9).
- In Suez, the introduction of FHM was associated with decrease in ANC coverage and keeping constant pattern regarding the average ANC visits/mother at less than 4 visits. At the same time, the control PHC facilities (in Port-said) had shown also constant pattern regarding the average ANC visits/mother at less than 4 visit, but demonstrated increase in ANC coverage to be 112% in 2007 (versus 62% in the FHM facilities).

COMMUNITY LEVEL DEMAND FOR RH-SERVICES 6

The objective of this chapter is to provide quantitative and qualitative information about the perception of the served communities in the catchment areas of the five FHM facilities towards RH-services provided in the FHM facilities. The presented in this chapter derived from information **Exit Interview,** quantitative data collected during the **community- based survey** and included 1500 households in the five communities, and finally **FGDs and in-depth interviews** with women, men, girls and male youth in the FHM-facilities' communities.

6.1 FINDINGS OF THE EXIT INTERVIEW

The total interviewed clients in the studied 25 FHM facilities, in the five HSRP pilot governorates, were 515 clients (about 20 clients per facility). The clients were purposefully selected to be females who attended the health units to seek different types of services. The objectives of the exit interview was to identify the perspectives of the clients towards the received services. The analysis and presentation of data were designed to measure the perceived impact of FHM on RH-services in terms of equity, accessibility, acceptability, integration, comprehensive services, continuity of care and technical quality.

Awareness about the health unit:

Owing to the HSRP strategy of "renovation/reforming of clinics' operation" of the already present PHC facilities, people affirmed that they know the facility and had used its services before it became a FHM facility.

Table (6.1) shows that 91% of the clients declared their previous utilization of the health unit. The physical existence of the renovated health unit near home had raised awareness that there is something new as expressed by 50% of the interviewed clients. Propagation of information among people (relatives, friends, husbands) ranked the second source of information about the FHU (42%). The FHU plays a very minor role in marketing for its services (7.7%) either through the home visits (5.8%) or announcing about its services (1.6%). **The geographic accessibility** of the heath unit has been asserted, where 81.4% of the clients stated that they usually come to the health facility on foot.

Table (6.1) Percent distribution of the interviewed clients according to previous utilization of the health unit and geographic accessibility

Accessibility Determinants	No	%
Previous utilization of the health unit		
Yes	470	91.30
No	45	8.70
Total	515	100.0
Sources of knowledge about the FHU		
Near house	255	49.50
Neighbors/Friends	106	20.60
Relatives	90	17.50
Personnel from the clinic during home visits		
Husband	30	5.8
Announcement from the clinic	21	4.10
Others	8	1.60
Total	5	0.90
	515	
Geographic accessibility		
Coming on foot	419	81.40
Transportation	96	18.60

Table (6.2) illustrates that the interviewed clients are acquainted with the package of health services delivered by the FHM units. On the average, each client could mention at least 4 types of services. The package of reproductive health services ranks the first type of service in the memory of the clients (75%), with less tendency to mention other services as management of chronic diseases (10%). Regarding the components of RH services (13 components), 75% of the clients mentioned immunization, 68% mentioned FP, and 58% mentioned ANC and 45% mentioned sick baby care. The rare mentioning of services as premarital care, management of RTIs (especially among males), as well as health services directed to youth, could indicate lacking demand for such services.

Table (6.2) Frequency distribution of the FHM services as mentioned by the interviewed clients			
Types of health services	Frequency of mentioned services	% of mentioned services	Percent of the Clients
Reproductive health services	1544	74.7	
Premarital care	3	0.1	0.6
ANC	299	14.5	58.1
Natal Care	92	4.5	17.9
Postnatal care	28	1.4	5.4
FP	352	17.0	68.3
Management of RTI –females	61	3.0	11.8
Management of RTI-males	4	0.2	0.8
Management Infertility	2	0.1	0.4
Management Female adolescent problems	9	0.4	1.7
Management Males adolescent problems	6	0.3	1.2
Children immunizations	386	18.7	75.0
Sick baby care	233	11.3	45.2
Well baby care	69	3.3	13.4
Chronic Diseases	210	10.2	40.8
Lab Services	144	7.0	28.0
Others	169	8.2	32.8
Total frequencies of mentioned services	2067	100.0	

Perspectives of the clients towards received services in the FHM facilities:

Table (6.3) illustrates a snap shot view about the pattern of health services received in the day of the interviews. It is obvious that 26% of the clients had received more than one service during a single visit to the FHM facilities. Two thirds of the received services were related to RH (63.9%). The profile of the received services in the FHM facilities indicates that out of each 10 delivered services, 6 cases receive RH services, 2 cases receive services for chronic diseases, one case receive lab services and one case receive other services as health office services. Within the RH services, children immunization ranked the first regarding the volume of the received services (18.4%), followed by ANC services (14.8%) and FP (11%).

Table (6.3) Percent distribution of the services received by the clients in the day of the interview		
Types of health services	No	%
Reproductive health services	414	63.9
ANC	96	14.8
FP	69	10.6
RTI	13	2.0
Female adolescent problems	5	0.8
Children immunizations	119	18.4
Sick baby care	86	13.3
Well baby care	26	4.0
Chronic Diseases	114	17.6
Lab Services	58	9.0
Others	62	9.6
Total Services Received	648	100.0

The interviewed clients were asked several questions to inquire about the most important reasons of choosing the FHM unit to get services in the day of the interview. The responses have been grouped to reflect the quality of health care dimensions:

- **Geographic acceptability** (The unit is near to home, easy transportation).
- **Affordability** (Cheap, reasonable cost, cheapest place, insurance system).
- **Accessibility to service** (suitable working times/shifts, organization of services, availability of all types of needed services all the time).
- **Interpersonal relation/Social acceptability** (high acceptability by all people in the community, knowing the doctor, female physician, outreach home visiting, good nurses and support staff).
- **Technical quality** (skilled physicians).

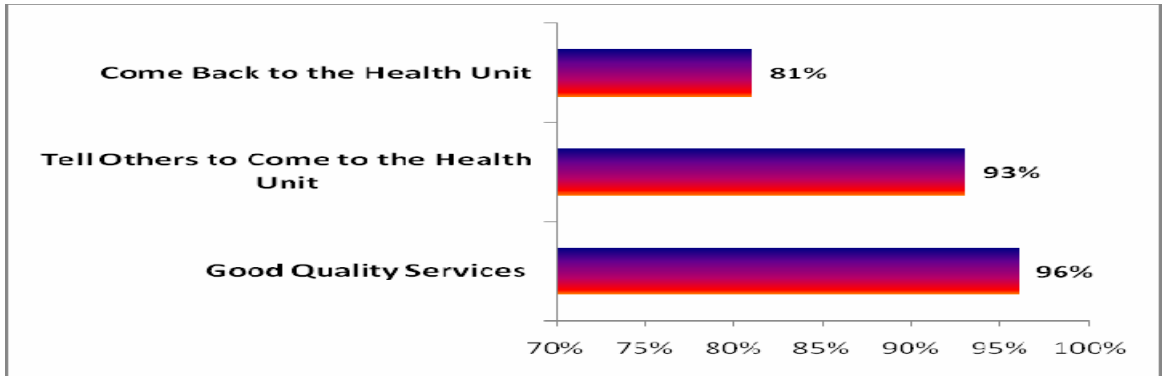
Table (6.4) shwos that the major deriving factor for choosing the FHM unit is its geographic accessibility (71%), while other quality dimensions have limited role to attract people to seek the FHM facility services.

Table (6.4) Percent distribution of the interviewed clients according to reasons of choosing the health unit to seek care

Quality items	No	%
Geographic accessibility	366	71.1
Financial Acceptability/Affordability	39	7.6
Accessibility to service	11	2.0
Interpersonal relation/social acceptability	41	8.0
Technical competence	41	8.0
Overall quality is accepted	17	3.3
Total	515	100.0

To investigate the perspectives towards the quality of the services received in the day of the interview, the clients were asked one direct question to reflect views towards the quality of services, and two indirect questions to reflect their attitude towards telling others about the health unit's services and intensions to come back to the health facility, and the responses of this questions are displayed in Figure (6.1). Despite the expression of satisfaction was declared by 96% of the clients, only 93% of the clients will tell others about the health unit services, and 81% have the attention to come back to the clinic.

Figure (6.1) Percent of the interviewed clients according to expressions reflecting satisfaction from the received services



To elaborate on the reasons of satisfaction from health services provided by the FHM facilities the questionnaire included questions covering all elements of quality in health care. The clients' answers were further grouped to reflect the quality of health services dimensions, and the findings are displayed in Table (6.5). On the average each client had mentioned three reasons of satisfaction from the delivered health services. Additionally, it is obvious from the table that the facility staff-client relationship is the major cause of satisfaction (33.5%), followed by accessibility to services (26.7%), then the amenities (24%). Technical quality was the least reason for clients' satisfaction (15%).

For further confirming the set reasons of satisfaction, the clients who said that they are going to tell others about the facility's services (n= 478) had been asked to mention the satisfactory elements to tell others about, and the results had been illustrated in table (6.5). It is obvious that the clients will disseminate their conclusion about the quality of service and they are going to market for the ability of the health facility staff to create good staff-client relationships.

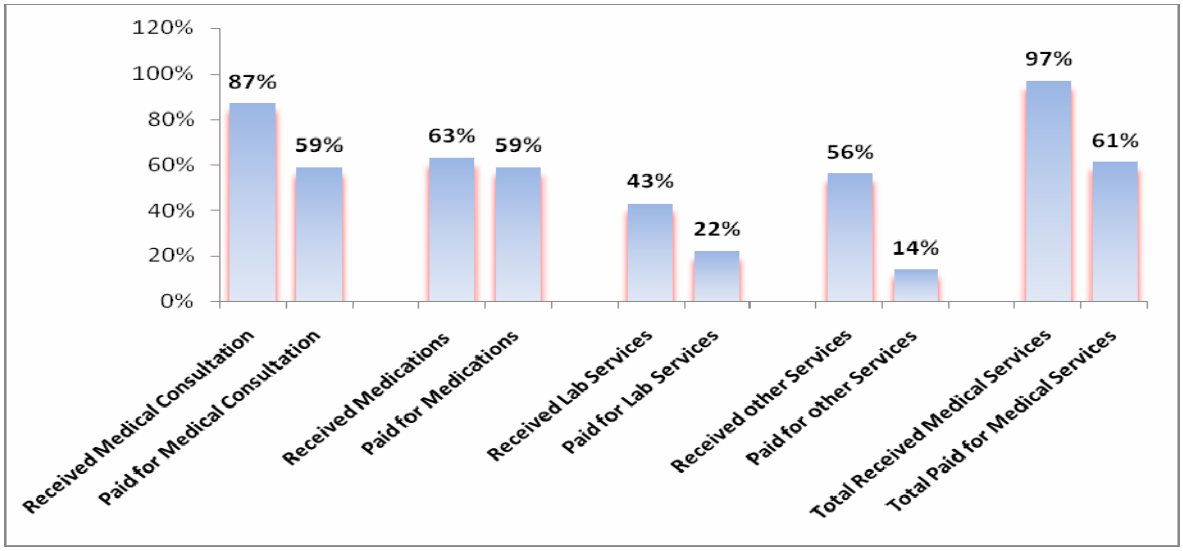
Services received and cost-sharing

Figure (6.2) displays the volume of services received by the interviewed clients, and the percent of clients who received and paid for the service. In general, almost all clients received medical service (97%), and 61% of those who received the service had paid for the service.

Table (6.5) Percent distribution of the reasons of the clients' satisfaction from the received services in the FHM facilities, and the satisfactory elements of quality that they are going to tell others about

Quality items	Perspective to services		Marketing for services	
	No	%	No	%
Access to service:	380	26.7	330	26.2
Reasonable waiting time	61	4.3	60	4.8
Reasonable cost	96	6.8	85	6.8
Availability of medicines	68	4.8	59	4.7
Suitable working hours	18	1.3	14	1.1
Proving different types of needed services	13	0.9	8	0.6
Availability of all FP methods	21	1.5	20	1.6
The doctor is always present	46	3.2	32	2.5
Provide services in a short time	57	4.0	52	4.1
Facility staff-client relationship	476	33.5	457	36.3
Staff teat clients well	273	19.2	274	21.8
Good physician-client interaction	116	8.2	109	8.7
Female doctor	38	2.7	29	2.3
Nurses have positive interaction	49	3.4	45	3.6
Technical competence	215	15.1	187	14.9
Satisfactory clinical examination	106	7.5	85	6.8
Technical competence of the doctor	109	7.7	102	8.1
Amenities:	337	23.7	271	21.5
Comfortable waiting place	32	2.3	22	1.7
Privacy	29	2.0	15	1.2
Cleanliness	143	10.1	121	9.6
Organized clinic	84	5.9	71	5.6
Receiving services according to organized roll	49	3.4	42	3.3
Others including having family file	13	0.9	13	1.0
Total	1421	100.0	1258	100.0

Figure (6.2) Percent of clients according to received services and payment for the service



6.2 FINDINGS OF THE COMMUNITY-BASED SURVEY

This section is providing quantitative information about interviewed ever-married women in reproductive age in 1500 households in the FHM facilities' catchment areas in the 5 pilot governorates. The objective of this section is to provide information about the users and non-users of the FHM facilities' services.

1- Socio-demographic background characteristics of FHM communities

Table (6.6) illustrates the socio-demographic background characteristics of the interviewed women in the reproductive age (WRA) in the studied 5 communities in the five governorates. As depicted from the table, teenagers represent a minority (3%), and those 45-49 years of age formed 15% of the studied women. Illiteracy rate is 32% and 92% of women are currently married and 59% had married before completing 20 years old (mean 19 years). Ten percent of the interviewed WRA have no children and 15% have ≥ 5 children (mean= 2.75 children per woman).

Table (6.6) Percent age distribution of interview ever-married women, of communities served by FHM facilities by background characteristics.

Characteristics	Alexandria	Menofia	Souhag	Quena	Suez	Total No	Total %
Age							
15-19	6.0	5.0	3.0	3.0	1.0	52	3.0
20-24	14.0	19.0	15.0	11.0	9.0	206	14.0
25-29	21.0	17.0	24.0	19.0	17.0	293	20.0
30-34	20.0	22.0	18.0	15.0	17.0	276	18.0
35-39	14.0	14.0	13.0	21.0	16.0	235	16.0
40-44	12.0	12.0	13.0	16.0	18.0	212	14.0
45-49	14.0	11.0	15.0	15.0	22.0	226	15.0
Education							
Non educated	30.0	37.0	34.0	43.0	15.0	473	32.0
Primary/Preparatory	41.0	24.0	17.0	35.0	20.0	412	27.0
Secondary and more	29.0	39.0	49.0	23.0	65.0	615	41.0
Marital Status							
Currently Married	93.0	92.0	93.0	93.0	89.0	1380	92.0
Widowed/married divorced	7.0	8.0	7.0	7.0	11.0	120	8.0
Age at first marriage							
< 20 years	53.0	70.0	57.0	69.0	43.0	878	59.0
20 years and more	47.0	30.0	43.0	31.0	57.0	622	41.0
Mean	19	17	19	18	20	19	
Number of children							
None	11.0	14.0	8.0	7.0	9.0	148	10.0
1-2	41.0	32.0	40.0	32.0	41.0	554	37.0
3-4	40.0	28.0	37.0	46.0	42.0	579	39.0
5 and more	8.0	26.0	15.0	16.0	8.0	219	15.0
Mean	2.46	2.98	2.73	3.01	2.58	2.75	
Total	301	300	300	300	300	299	1500

There are variations across the studied WRA in the five governorates regarding socio-demographic characteristics. Interviewed women in Suez tend to be older (56% are ≥35 years of age), more educated (65% had completed secondary and/or higher education) with higher proportion (11%) is not currently married (widowed, divorced, separated), and only 8% of them have ≥ 5 children. WRA in Quena tend to be less educated (illiteracy rate is 43%) and the mean number of children per woman is 3 children. WRA interviewed in Alexandria , tend to have mid-level education (41% had completed primary/preparatory) and to have smaller number of children (mean 2.46 children per woman). WRA interviewed in Menofia tend to be younger (63% of WRA are 15-34 years of age), marry earlier (mean age at first marriage is 17 years). In Souhag, about half (49%) of interviewed WRA had attained secondary/high education and have on the average 2.73 children per woman. It could be concluded that, the study includes three groups of women distributed across three categories of socio-demographic risk-determinants: Low risk group (Alexandria and Suez), high risk group (Menofia and Quena) and medium risk group (Souhag).

2- Community general knowledge and attitude towards RH-services

Assessment of the level of knowledge of the community (presented by WRA) about the different components of RH services are illustrated in Table (6.7). The table displays 12 components of RH services, and responses of the interviewed WRA regarding knowledge (affirmed by mentioning at least one information about the specific RH topic), and attitude (feeling the importance of specific types RH services). The table illustrates that there is universal knowledge about children immunization (100%), FP methods (99%), and ANC (97%). There is also universal positive attitude towards management of childhood illnesses (91% -95%) across all interviewed WRA in the 5 governorates. High proportion of WRA knows about premarital care (85%) especially in Quena (100%) and Suez (95%). However, only 7% of interviewed women in Alexandria mentioned knowing about premarital care. Low proportion of the interviewed WRA knows about health care to male youth (47%), especially in Menofia (13%) and Souhag (20%).

Table (6.7) Percent of interviewed women according to knowledge and attitude towards RH-services by governorate

RH-topics	Alexandria	Menofia	Souhag	Quena	Suez	Total	
Premarital/Post-marital care							
-Know about premarital care	7.0	82.0	80.0	100.0	95.0	1270	85.0
-Know about post-marital care	39.0	50.0	22.0	6.0	44.0	484	32.0
Youth Health care							
-Know about Youth Females health care	91.0	73.0	49.0	84.0	83.0	1140	76.0
-Know about youth male health care	66.0	13.0	20.0	59.0	77.0	705	47.0
ANC							
Know about ANC	97.0	95.0	91.0	100.0	99.0	1449	97.0
Safe delivery							
Know about safe delivery	69.0	60.0	34.0	97.0	40.0	884	59.0
Post-natal care							
Know about post natal care	49.0	39.0	28.0	97.0	39.0	755	50.0
FP methods							
Know at least two FP methods	99.0	99.0	99.0	100.0	98.0	1487	99.0
STDs							
Know about STDs	82.0	52.0	63.0	79.0	84.0	1078	72.0
Children Immunization							
Know about children immunization	100.0	100.0	100.0	100.0	100.0	745	100.0
Diarrhea Management:							
Know importance of child examination in case of having diarrhea	92.0	98.0	92.0	93.0	99.0	705	95.0
ARI management							
Know importance of child examination in case of having ARI	87.0	90.0	95.0	97.0	96.0	676	91.0
Total	301	300	300	300	299	1500	

3- Acceptability of FHM versus other MOHP, private/NGOs facilities: Health facilities of first choice to receive RH-services

There are different driving forces that lead to acceptability of a specific health facility to be the first choice to seek specific RH-services. Table (6.8) shows specific pattern of selecting health facilities for RH-services among women who could easily access to FHM facilities (86%). The table shows that FHM ranks the first choice facility for child care, FP and ANC. Private facilities outside the village is usually decide on in case of sensitive issues as management of RTI for women (29%), management of infertility (28%), management of adolescent girls' health problems (22%) and adolescent male problems (19%). Natal care is usually preferred to be out the FHM (73%), and to be in MOHP facilities outside the village (35%) or in a private facility (22%). Views towards some RH-services is not clear regarding where to go to seek services as premarital care (40%), management of RTI for men (28%), and management of infertility (26%).

Table (6.8) Acceptability of FHM facilities to seek RH-services versus other facilities: Percent of interviewed women according to health facility of first choice to receive the different components of RH services

Health services \ Health Facilities	FHM	MOHP in the village	Private in the village	MOHP outside the village	Private outside the village	Others /do not know	Total
Premarital Care	29.0	5.0	6.0	12.0	11.0	40.0	1500
ANC	75.0	2.0	8.0	4.0	11.0	1.0	1500
Natal Care	27.0	5.0	10.0	35.0	22.0	2.0	1500
FP	81.0	2.0	5.0	4.0	8.0	1.0	1500
Children Immunization	97.0	0.0	1.0	1.0	1.0	1.0	1500
Diarrhea management	73.0	2.0	10.0	4.0	10.0	1.0	1500
ARI management	70.0	2.0	10.0	5.0	12.0	1.0	1500
Growth Monitoring	77.0	1.0	6.0	3.0	8.0	5.0	1500
Management of RTI Women)	41.0	3.0	15.0	10.0	29.0	3.0	1500
Management of RTI (Men)	21.0	4.0	11.0	16.0	19.0	28.0	1500
Management of Infertility	9.0	3.0	14.0	20.0	28.0	26.0	1500
Management of AHP (females)	37.0	5.0	11.0	10.0	22.0	16.0	1500
Management of AHP (males)	36.0	5.0	9.0	12.0	19.0	20.0	1500
Management of Chronic Diseases	38.0	6.0	12.0	18.0	19.0	7.0	1500
Nearest Facility (%)	86%	2%	5%	1%	1%	4%	1500

4- Pattern of community utilization of RH-services in FHM versus other facilities (2002-2008)

Table (6.9) illustrates the community demand for RH-services (utilization RH-services from different sources) and percent of those demanding the service who sought the FHM facilities. It is obvious from the table that FHM response to community demands for child care services was the highest for children immunization (98%), and well-baby care (89%), but it was the lowest for natal care (3%) and male RTIs (9%).

Table (6.9) RH-Services sought at different health facilities 2002-2007: Percent of RH-services received by 1500 families according to source of Service

Health services \ Health Facilities	FHM	MOHP in the village/ city	Private in the village	PHC outside the village	MOHP outside the village	Private outside the village	Others	Total Received services (demand %)
Premarital Care	17.4	0.0	8.7	8.7	13.0	47.8	4.3	**23 (2%)**
ANC	61.0	1.4	11.5	1.9	1.1	22.7	0.3	**902 (60%)**
Natal Care	2.8	4.3	10.6	1.0	38.8	36.5	5.9	**762(51%)**
Postnatal care /mother	40.6	4.5	9.0	3.2	11.6	3.9	27.1	**155 (10%)**
Neonatal care	57.4	24.0	18.6	0.0	0.0	0.0	0.0	**366 (24%)**
FP	55.0	2.5	17.6	0.0	9.8	13.7	1.4	**796 (53%)**
Children Immunization	97.8	0.5	0.0	1.0	0.4	0.0	0.4	**1025 (68%)**
Diarrhea management	52.5	5.0	17.5	0.0	7.5	16.3	1.3	**80 (5%)**
ARI management	55.2	6.3	19.5	0.0	5.9	13.1	0.0	**221 (15%)**
Growth Monitoring	88.9	0.6	5.1	0.6	0.6	3.6	0.6	**333(22%)**
Management of RTI (Women)	26.5	1.5	15.8	4.0	2.1	27.2	22.9	**581(39%)**
Management of RTI (Men)	8.7	8.7	26.1	4.3	8.7	43.5	0.0	**23 (2%)**
Management of AHP (females)	36.5	10.1	17.6	2.0	10.1	23.6	0.0	**148 (10%)**
Management of AHP (males)	30.9	6.2	21.0	1.2	11.1	29.6	0.0	**81 (5%)**
Total RH-services	**2983**	**217**	**624**	**72**	**468**	**890**	**242**	**5496**
Percent	54.3	3.9	11.4	1.3	8.5	16.2	4.4	100.0

Table (6.10) presents a retrospective follow up of information related to utilization of ANC, natal care, postnatal care, and newborn care and FP services throughout the period 2002-2008. For the total interviewed WRA, the total live births were 4125. Out of the total births, 1028 (25%) occurred in 2002-2007.

It is obvious from the table that around 89% of mothers had received ANC during pregnancy occurred in 2002-2007. The pattern of receiving ANC care according to the source of service was constant, with percent contribution of the FHM facilities at a level of 61% on the average.

FHM facilities contribution in natal services is negligible (3%) and the major sources of natal care

were MOHP facilities outside the village (39%) and private facilities outside the village/city (37%).

Table (6.10) shows that 155 women (20.3%) had received postnatal care. FHM facilities had contributed in postnatal care by 41%.

Health care for the newborn was reported by 366 of the interviewed women who gave births 2002-2007 (48%). The table shows that more than have of the babies had received services in the FHM facilities (57%).

The table shows that the pattern of FHM facilities utilization for maternal care services did not show substantial change throughout the period 2002-2007.

The current use of modern FP methods among the currently married women is 57.7% (796/1380). The percent contribution of the FHM facilities as source of FP method is fluctuating between 66%-48% throughout the period before 2002 -2008. However, during the period 2006-2008, the percent contribution of FHM in FP services was less than 60%. It could be observed from the table that, at times of decreasing role of FHM facilities in FP, private facilities in the village and MOHP facilities outside the village showed increasing contribution as source of FP methods.

From tables (6.8), (6.9) and (6.10), it could be concluded that the high acceptability of the FHM facilities is not coupled with high utilization levels.

Figure (6.3) shows the trend in utilization of the FHM facilities 2002-2008 for ANC and FP. It is obvious from the figure that there is no change /or slight decrease in utilization of FHM facilities for ANC and FP services throughout the period 2002-2008.

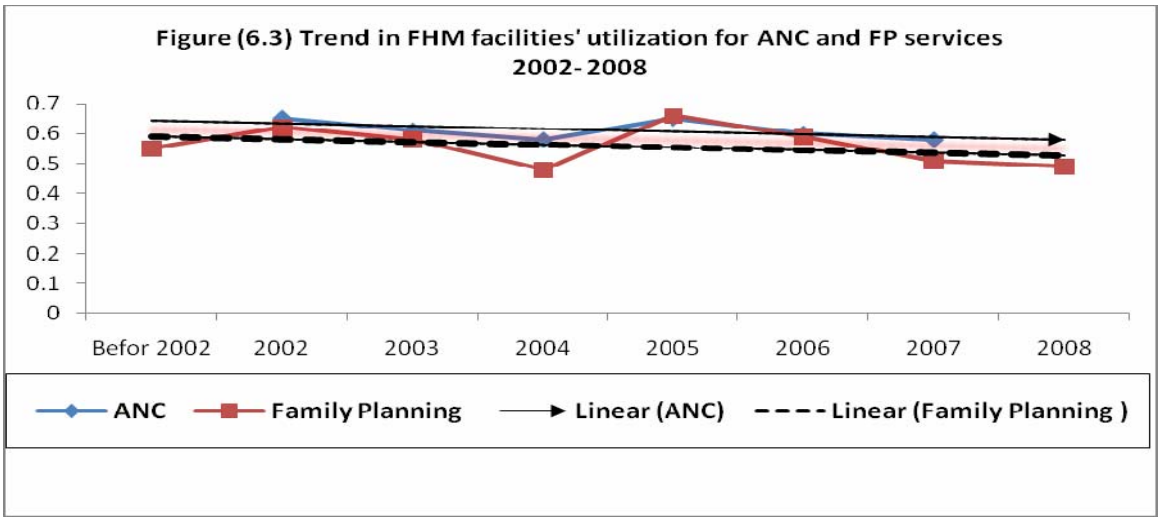


Table (6.10) Pattern of utilization of RH-services in the FHM versus other facilities throughout the period 2002-2008: Percent of families according to utilized RH-services in the FHM versus other facilities

Health Facilities / Health services/Year	FHM	MOHP in the village	Private in the village	PHC outside village	MOHP outside the village	Private outside the village	Others*	Total No	Total %
ANC									
2002	65.0	1.0	8.0	3.0	0.0	23.0	0.0	135	100.0
2003	61.0	0.0	10.0	4.0	1.0	25.0	0.0	136	100.0
2004	58.0	1.0	12.0	1.0	1.0	25.0	1.0	146	100.0
2005	65.0	2.0	11.0	1.0	1.0	19.0	1.0	153	100.0
2006	60.0	2.0	12.0	1.0	2.0	23.0	0.0	143	100.0
2007	58.0	2.0	15.0	2.0	2.0	22.0	0.0	189	100.0
Total (ANC) No	550	13	104	17	10	205	3	902	
Total (ANC) %	61.0	1.0	12.0	2.0	1.0	23.0	0.0	100.0	
Natal Care									
2002	3.0	3.0	7.0	1.0	27.0	21.0	38.0	155	100.0
2003	4.0	2.0	8.0	1.0	22.0	31.0	33.0	170	100.0
2004	3.0	3.0	8.0	2.0	31.0	25.0	29.0	163	100.0
2005	3.0	6.0	6.0	0.0	25.0	29.0	33.0	178	100.0
2006	4.0	3.0	9.0	0.0	38.0	28.0	18.0	160	100.0
2007	1.0	2.0	10.0	1.0	32.0	29.0	24.0	202	100.0
Total (NC) No.	28	33	83	8	298	279	298	1028	
Total (NC) %	3.0	3.0	8.0	1.0	29.0	27.0	29.0	100.0	
Post-natal care									
2002	32.0	8.0	16.0	4.0	12.0	24.0	4.0	25	100.0
2003	46.0	5.0	9.0	5.0	9.0	27.0	0.0	22	100.0
2004	17.0	4.0	13.0	8.0	21.0	25.0	13.0	24	100.0
2005	58.0	4.0	0.0	4.0	8.0	27.0	0.0	26	100.0
2006	57.0	0.0	4.0	0.0	13.0	26.0	0.0	23	100.0
2007	37.0	6.0	11.0	0.0	9.0	31.0	6.0	35	100.0
Total (PNC) No	63	7	14	5	18	6	42	155	
Total (PNC) %	41.0	5.0	9.0	3.0	12.0	27.0	4.0	100.0	
Newborn care									
2002	67.0	19.0	14.0	0.0	0.0	0.0	0.0	52	100.0
2003	56.0	27.0	17.0	0.0	0.0	0.0	0.0	59	100.0
2004	50.0	17.0	33.0	0.0	0.0	0.0	0.0	46	100.0
2005	67.0	25.0	8.0	0.0	0.0	0.0	0.0	63	100.0
2006	58.0	21.0	21.0	0.0	0.0	0.0	0.0	66	100.0
2007	49.0	30.0	21.0	0.0	0.0	0.0	0.0	80	100.0
Total (PNCN) No Total (PNCN) %	210 57.0	88 24.0	68 19.0	0 0.0	0 0.0	0 0.0	0 0.0	366 100.0	
Family Planning									
Before 2002	53.0	3.0	16.0	0.0	12.0	13.0	3.0	177	100.0
2002	62.0	3.0	14.0	0.0	7.0	12.0	2.0	58	100.0
2003	58.0	2.0	17.0	0.0	4.0	17.0	2.0	60	100.0
2004	48.0	1.0	24.0	0.0	17.0	10.0	0.0	84	100.0
2005	66.0	2.0	11.0	0.0	8.0	13.0	0.0	106	100.0
2006	59.0	2.0	12.0	0.0	7.0	17.0	3.0	97	100.0
2007	51.0	3.0	24.0	0.0	7.0	14.0	0.0	181	100.0
2008	49.0	0.0	18.0	0.0	15.0	15.0	3.0	33	100.0
Total (FP) No	438	20	140	0	78	109	11	796	
Total (FP) %	55.0	3.0	18.0	0.0	10.0	13.0	1.0	100.0	

Table (6.11) shows that the FHM facilities are the major source of FP method for injectable users (95%). However, out of the total IUD users, MOHP facilities outside (17%) and inside (4%) the village were the sources of the method.

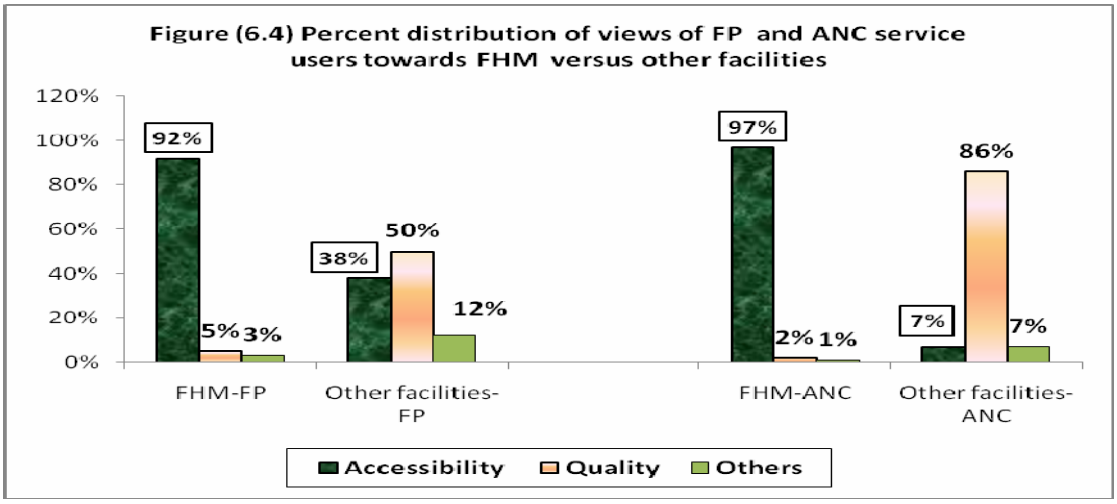
Table (6.11) Percent distribution of the current FP users by type and source of the FP methods								
Health Facilities / Health services/Year	FHM	MOHP in the village	Private in the village	MOHP outside the village	Private outside the village	Others	Total	
OCs	43.0	0.0	41.0	2.0	14.0	0.0	206	26.0
IUD	54.0	4.0	10.0	13.0	17.0	2.0	461	58.0
Injectables	93.0	1.0	1.0	5.0	0.0	0.0	105	13.0
Others	17.0	4.0	42.0	29.0	8.0	0.0	24	3.0
Total	438	20	140	78	109	11	796	
	55.0	3.0	18.0	10.0	13.0	1.0	100.0	

5- Perceived accessibility, quality, integration, continuity of care and comprehensiveness of RH-services in FHM versus other facilities (MOHP, private/NGOs)

Information pertaining to describing the perception of the community towards RH services provided in the FHM versus other facilities is based on answers to the close- ended questions that aim at identifying the reasons for selecting a specific health facility for specific RH-services. The responses measuring the **geographic accessibility** of the facility are: near to home and easy transportation. Those measuring **financial accessibility** include: reasonable price of the service, cheaper than other places and coverage by health insurance. **Service accessibility** is measured by: the service is available all the time, and drugs are available all the time. **Social acceptability** is measured by: having female physician. **Quality of care** is measured by: good reputation among the community, strong client/patient-doctor communication, technical competency of the physician, the nurse and support staff are very cooperative, organization of work in the facility, reasonable waiting time and the service in general is very good. **Integrated service** is measured by: availability of all the services every day in the facility. **Comprehensiveness** is measured by availability of all services every day including drugs and lab. **Continuity:** is measured by having the system of outreach home visits to insure continuity in ANC visits, postnatal care, immunization and FP.

The data were analyzed for the 23 RH-services and the analyzed data showed constant pattern of perception of FHM facilities' RH- services versus other facilities: ***"people prefer the FHM due to geographic accessibility, and prefer other facilities due to high quality of services".***

Figure (6.4) illustrates an example for the perception of the community to RH-services (FP and ANC) delivered in FHM versus other facilities. It is clear from the figure that, geographic accessibility of FHM is the most driving privilege for the FHM facilities' utilization, and quality is the most attracting advantage of other health facilities, irrespective to their geographic accessibility. Other issues related to acceptability, integration, continuity and comprehensiveness of the service do not form a major concern for the served population.



6- Differentials between families joining the FHM-roster versus those not joining the roster regarding socio-demographic characteristics and knowledge of FHM-RH services

Table (6.12) illustrates that out of the total interviewed women (1500), 98.5% had utilized the FHM services at any point in time. Out of all interviewed families within the catchment areas of the FHM facilities, 983 families (65.5%) are joining the FHM-roster, 33% did not join the FHM-roster, and 1.5% did not utilize the FHM. The table shows that, those joining the FHM-roster have different socio-demographic and economic background characteristics. Women joining FHM-roster tend to be younger (57% are 15-34 years of age versus 51% of those not joining FHM-roster). Women joining the FHM-roster are less educated (illiterate form 33% and those of high education form 39%) compared with those who do not join the FHM-roster (illiterate form 28% and those of high education form 45%). Women joining FHM-roster tend to marry earlier (62% married in the teenage), and of high parity (57% have 3 children and more). According to background characteristics of the two groups, it is clear that FHM succeeded in including beneficiaries who are at-socioeconomic risks to achieve the objective of equity.

Table (6.12) Differentials between Families joining FHM-roster and Families not joining FHM-roster by socio-demographic characteristics: Percent distribution of interviewed women by socio-demographic characteristics

Characteristics	Women Joining FHM-Roster	Women Not-Joining FHM-Roster	Total	
			No	%
Age				
15-19	3.0	4.0	50	3.0
20-24	13.0	15.0	200	14.0
25-29	21.0	17.0	290	20.0
30-34	20.0	17.0	274	19.0
35-39	16.0	15.0	230	16.0
40-44	14.0	15.0	211	14.0
45-49	13.0	19.0	223	15.0
Education				
Non educated	33.0	28.0	465	31.0
Primary	28.0	26.0	404	27.0
Secondary and more	39.0	45.0	609	42.0
Marital Status				
Currently married	93.0	90.0	1361	92.0
Not married	7.0	10.0	117	8.0
Age at first marriage				
< 20 years	62.0	53.0	866	59.0
20 years and more	38.0	47.0	612	41.0
Number of children				
None	5.0	18.0	140	9.0
1-2	37.0	37.0	547	37.0
3-4	41.0	34.0	573	39.0
5 and more	16.0	12.0	218	15.0
Total	983	495	1478	100.0

The interviewed women were asked specifically about 15 RH-services (which are included in the BBP) regarding their knowledge about the availability of the service in the FHM facility and the source of such knowledge and the findings are illustrated in Table (6.12). The knowledge about FHM services could be the outcome of actual receiving of the service at the personal/family level, or the service is concerned with specific public health issues/national program.

In general, the prevalence of knowledge about FHM-RH services ranges from 60% to 100% for national RH-programs (immunizations, ANC, postnatal, FP, immunizations, management of childhood illness). There are limited proportion (less than 60%) of interviewed women know about the sensitive RH-services as premarital care, management of infertility, adolescent health problems and management of RTIs among men.

The information derived from table (6.13) delineates that women joining the FHM-roster, usually receive information about FHM-RH services from the community/people. This indicates that families with socioeconomic risks (Table 6. 12) believe in information which has high community acceptance and culturally supported, even for those related to sensitive issues as management of infertility (60%). The second influential source of information is the RR, who were the source of information about premarital services (46%) and adolescent male and female health problems (37%).

The situation is different for women who do not join the FHM-roster. Besides getting information about FHM-RH services from people, there is high tendency to get information from doctors. Community workers ***(RR) have less influential effect*** on such population segment, as a source of knowledge about FHM-RH services.

The current study is looking also to the economic or financial aspect of the FHM, which could influence the utilization of RH-services in the FHM facilities. Alongside the annual premium for health insurance and enrolment in FHM –roster, there is cost-sharing for health services. The study questionnaire included questions about cost-sharing/fee for medical consultation visits for 15 RH services included in the BBP. Table (6.13) presents the women's responses regarding the fee per consultation visit, which are categorized into: the fee, free, or do not know the fee.

Table (6.13) Percent of families joining the FHM-roster versus those not joining FHM-roster, according to their knowledge about FHM facilities' RH-services and sources of knowledge

		Source of knowledge				Total	
Health services at FHM facilities	Know the Service	Doctor	Nurse	RR	People	%Have Knowledge	Total
Premarital Care							
Having family folder	381	15.0	10.0	46.0	29.0	39.0	983
Do not have family folder	110	61.0	6.0	6.0	27.0	22.0	495
ANC							
Having family folder	968	13.0	16.0	29.0	42.0	98.0	983
Do not have family folder	474	24.0	11.0	13.0	52.0	96.0	495
Natal Care							
Having family folder	491	16.0	19.0	33.0	31.0	50.0	983
Do not have family folder	227	23.0	18.0	13.0	46.0	46.0	495
Postnatal care							
Having family folder	770	14.0	24.0	54.0	7.0	78.0	983
Do not have family folder	302	11.0	11.0	50.0	30.0	61.0	495
FP							
Having family folder	970	11.0	18.0	31.0	40.0	99.0	983
Do not have family folder	478	18.0	17.0	17.0	48.0	97.0	495
Children Immunization							
Having family folder	980	11.0	20.0	28.0	41.0	98.0	983
Do not have family folder	479	20.0	19.0	13.0	47.0	87.0	495
Diarrhea management							
Having family folder	959	15.0	16.0	27.0	43.0	98.0	983
Do not have family folder	431	27.0	12.0	13.0	48.0	87.0	495
ARI Management							
Having family folder	925	16.0	17.0	27.0	41.0	94.0	983
Do not have family folder	408	28.0	13.0	13.0	47.0	82.0	495
Growth Monitoring							
Having family folder	870	15.0	23.0	25.0	37.0	89.0	983
Do not have family folder	396	21.0	16.0	16.0	48.0	80.0	495
Management of RTI (Women)							
Having family folder	688	22.0	17.0	22.0	38.0	70.0	983
Do not have family folder	334	35.0	8.0	8.0	45.0	67.0	495
Management of RTI (Men)							
Having family folder	314	11.0	20.0	34.0	35.0	32.0	983
Do not have family folder	90	36.0	12.0	10.0	41.0	18.0	495
Management of Infertility							
Having family folder	166	17.0	8.0	15.0	60.0	17.0	983
Do not have family folder	62	43.0	9.0	7.0	41.0	13.0	495
Management of AHP (females)							
Having family folder	510	10.0	19.0	37.0	35.0	52.0	983
Do not have family folder	160	36.0	10.0	17.0	38.0	32.0	495
Management of AHP (males)							
Having family folder	481	11.0	20.0	37.0	32.0	49.0	983
Do not have family folder	137	43.0	12.0	13.0	32.0	28.0	495
Management of Chronic Diseases							
Having family folder	641	17.0	22.0	20.0	41.0	65.0	983
Do not have family folder	177	23.0	8.0	16.0	54.0	36.0	495

As portrayed in the table the ***price policy of all RH-service is not clear***, neither for those joining nor those not joining the FHM-roster. Additionally, those who do not join the FHM-roster tend to overestimate the price of the services. For services that are supposed to be dropped from fees (i.e. immunization, ANC and FP), 95%, 56% and 42% of rostered families and 85%, 36% and 36% of

the non-rostered families had mentioned that immunization, ANC and FP are delivered free in the FHM facilities. This indicates that about have of rostered families pays for ANC and FP services.

Table (6.14) Percent of families joining the FHM-roster versus those not joining FHM-roster , according to their knowledge about fee for RH-services in the FHM facilities

Health services at FHM facilities	Mentioned the fee	Mean fee	Free service	Do not know the fee	Total respondents
Premarital Care					
Having family folder	64.0	2.8	9.0	27.0	983
Do not have family folder	82.0	4.8	7.0	11.0	495
ANC					
Having family folder	26.0	3.7	56.0	18.0	983
Do not have family folder	34.0	3.8	36.0	30.0	495
Natal Care					
Having family folder	54.0	59.3	13.0	33.0	983
Do not have family folder	59.0	64.1	9.0	32.0	495
Postnatal care					
Having family folder	38.0	3.0	30.0	31.0	983
Do not have family folder	57.0	3.0	14.0	28.0	495
FP					
Having family folder	38.0	3.1	42.0	20.0	983
Do not have family folder	38.0	3.2	36.0	26.0	495
Children Immunization					
Having family folder	2.0	3.9	95.0	3.0	983
Do not have family folder	8.0	3.0	85.0	7.0	495
Diarrhea management					
Having family folder	73.0	2.9	13.0	14.0	983
Do not have family folder	67.0	3.3	10.0	23.0	495
ARI Management					
Having family folder	75.0	2.9	10.0	14.0	983
Do not have family folder	69.0	3.2	8.0	22.0	495
Growth Monitoring					
Having family folder	44.0	2.9	36.0	20.0	983
Do not have family folder	41.0	3.1	39.0	21.0	495
Management of RTI (Women)					
Having family folder	82.0	3.0	5.0	13.0	983
Do not have family folder	74.0	3.4	6.0	19.0	495
Management of RTI (Men)					
Having family folder	86.0	2.9	1.0	13.0	983
Do not have family folder	89.0	4.0	2.0	9.0	495
Management of Infertility					
Having family folder	93.0	2.7	12.0	6.0	983
Do not have family folder	91.0	3.7	12.0	6.0	495
Management of AHP (females)					
Having family folder	79.0	2.8	1.0	18.0	983
Do not have family folder	83.0	3.4	2.0	14.0	495
Management of AHP (males)					
Having family folder	79.0	2.8	3.0	18.0	983
Do not have family folder	84.0	3.5	3.0	13.0	495
Management of Chronic Diseases					
Having family folder	87.0	2.9	3.0	10.0	983
Do not have family folder	85.0	3.3	2.0	13.0	495

7- Perception of the women joining the FHM-roster to FHM facilities' services

What makes women joining the FHM-roster to be satisfied from FHM services?. Or What is the first thing (s) come to women's mind when they are asked about the advantages of FHM services?. The answers to these questions are analyzed and displayed in Table 6.15. It is obvious from the table that women consider that the FHM facility services are good (91%). Geographic accessibility is considered a major privilege of the FHM (67%), physician-client interaction is appreciated by 21% of the interviewed women. Women who are going to do marketing to FHM services had formed 52% of rostered women.

Table (6.15) Percent of women joining FHM-roster according to their perception to FHM services		
Perception of FHM Services	No.	%
Accessibility of the facility:		
Geographic accessibility	663	67%
Accessibility to services		
All services every day	12	1%
Morning and night shifts	53	4%
Drugs are available all the time	36	4%
Reasonable fee for the service	60	6%
Cost of drugs is less than other sources	35	4%
RH services are free	40	4%
Quality of the service		
Skillful doctors	112	11%
Physicians-client interaction	206	21%
Providing information about drug use	4	1%
Similar/better than private services	6	1%
Clean and organized facility	13	13%
Integration		
More than one service from the family physician	22	2%
All services every day	12	1%
Family folders facilitate follow up services	17	2%
Comprehensiveness of the services		
More than one service from the family physician	22	2%
All services every day	12	1%
Follow-up the referred cases	15	2%
Continuity of care		
Family folders facilitate follow up services	17	2%
More than one service from the family physician	22	2%
Provide information about the drug use	4	1%
Appointment for the next visit	3	1%
Follow up of the referred cases	15	2%
Overall Satisfaction and Marketing to FHM		
Everything is good	892	91%
Telling others about FHM facility services	510	52%
Total respondents	983	

The views of women towards the reasons for not using FHM services are demonstrated in Table (6.16). The information derived from the table highlight two major issues that make people refrain from utilizing the FHM facilities: Unavailability of specialized physicians (66%), and high cost of the fee (31%). People consider that, the private physicians are more specialized and less costly than FHM physicians' services (34%). Information derived from Table (6.17) affirms that, having specialized physicians (45%) and reduce the cost of FHM services (32%) are the major issues to accept the FHM services.

Table (6.16) Percent of interviewed women according to their views towards the reasons of not using FHM facilities' services		
Service Items	No	%
Accessibility of the service		
High cost of the folder	307	31.0
High cost of medical consultation	309	31.0
High cost of drugs	293	25.0
Private physicians is more cost-effective than FHM	335	34.0
More accessibility to other sources of services	78	8.0
Access to other MOHP facilities with free services	104	11.0
Inconvenient working hours	149	15.0
No enough drugs	228	23.0
Doctors are not available all the time	238	24.0
Acceptability		
Governmental facilities do not improve their quality	191	19.0
The community considers FHM facilities is for people	40	4.0
No female physician	177	18.0
No privacy	105	11.0
Service Providers' performance		
Unspecialized physicians	644	66.0
Total	983	

Table (6.17) Percent of interviewed women according to their suggestions to improve FHM services		
Service Items	No	%
Accessibility of the service :		
Reduce cost of the folder	239	24.0
Reduce cost of medical consultation	314	32.0
Reduce cost of the lab services	169	17.0
Reduce cost of drugs	217	22.0
Availability of more drugs	254	26.0
Acceptability		
Separate clinics for males and females	29	3.0
Separate waiting area for males and females	17	2.0
Have female physician	160	16.0
To prescribe more than two drugs	41	4.0
Service Providers' performance		
Have specialized physicians	445	45.0
Have technically competent physicians	229	23.0
Improve nurse communication behavior with clients	45	5.0
Continuity of care		
Improve referral services	41	4.0
Clinic Environment		
More cleanliness	45	5.0
More organization to the service	41	4.0
Inform people about the FHM services		
Personal communication (through RR)	18	2.0
Mass media	8	1.0
During receiving the service	12	1.0
Total	983	

6.3 FINDING OF THE FGDS AND IN-DEPTH INTERVIEWS

This section addresses the community knowledge, perception and utilization of RH-services delivered at the FHM facilities. The information present here is derived from qualitative data collected through FGDs and in-depth interviews carried out with selected population categories identified during the household survey conducted in three governorates: Alexandria , Menofia and Souhag. Those population categories include: married women in the reproductive age (MWRA), married men, female and male youth. In-depth interviews had been conducted with men, male and female youth each of three governorates.

The FGD/in-depth interview participants have been selected among those who have history of utilization of FHM facilities. The qualitative data were analyzed to reflect the community perception to RH-services delivered in the FHM facilities regarding availability, quality, as well as the community attitude towards FHM services compared with other sources of health services. Additionally, the suggestions to increase utilization of RH-services delivered in the FHM facilities have been considered.

1- Perception of women to FHM RH-services

- ***Community General Perception of RH - services delivered in the FHM facilities***

FGD participants had articulated their information about the scope of health services, availability of services and quality of care provided by FHM facilities before and after the reform. They expressed great appreciation to the general improvement of the **quality** of FHM facilities' services.

All MWRA (Souhag, Menofia and Alexandria) claimed that the scope of services delivered in the FHM clinics is the same as in the PHC clinics, but the differences is in the HOW the services are delivered. The major changes are in the manner of the facility management and service provision. There are improvement in the clinic environment (cleanliness), client flow, technical competency and the more respect and care to the client/patient, and continuity of care through the family folder.

Quotation (1): Now there is more care during clinical examination, the doctor listen to the patient, more time is allocated to the clinical examination and the bed is clean

MWRA, Souhag

Quotation (2): Now the doctor uses the family folder, knows what the condition of the case was, and records the current complaint. Now the doctor knows us by name. Before being family medicine facility, we were coming and leave without being known by the doctor or the health facility staff.

MWRA, Souhag

However, MWRA (Alexandria) added that having the concept of family approach, should consider having male physicians to provide health services to men.

- ***Availability of health services:***

FGDs participants have demonstrated perception toward availability of health services in relation to: scope of RH services, manpower resources, equipment supply, drug supply, lab services, follow up services and services to special population groups.

Scope of RH services:

There is a consensus among women that the presence of enough equipment and medications are the major contributing factor for refining the package of RH services delivered in the FHM facilities. MWRA, comments on the RH-services delivered in the FHM are very specific, as they raised the following points: increased utilization of MCH services, registration of mothers for ANC in earlier phases of pregnancy, more care for monitoring growth and development of the children. Despite, the common expression *"no change in the availability of the immunization services",* there is an addition of the service of informing the mothers about the specific times for children's immunization.

MWRA (Souhag) considered that the availability of drugs has contributed to increase the utilization of the clinics by men and youth.

However, MWRA in Alexandria and Menofia reported that, there are no changes regarding the scope of service/utilization of services delivered to men and male and female youth. The available services are the same as in PHC facilities i.e. simple medical conditions and no RH services to men or youth.

Integration of the service through family physician was not appreciated by MWRA in Menofia, as they prefer specialized physicians.

Manpower resources:

MWRA (Souhag) mentioned that, now, doctors are available at any time, doctors sometimes do completely free of charge home visits. MWRA (Menofia) added that before FHM, there were two physicians (i.e. GP and FP specialist). In FHM, there is facility director, more specialties as for example internal medicine specialist and dentist. However, there is ***high turnover*** of the specialists.

MWRA (Menofia) mentioned that, more and efficient nurses are now available in the FHM facilities.

Equipment supply:

MWRA had provided evidence that the facilities' equipment had showed improvement in the FHM facilities. There are more sphygmomanometers, children's and mothers' scales, lab facilities to measure hemoglobin level, and SONAR (Souhag, Alexandria).

Quotation (3): Now there is more equipment in the clinics. There is SONAR, but the SONAR is not working now.

MWRA, Souhag

MWRA (Menofia) added that, there is updating for all the equipment, and there is a fully equipped dental clinics.

Drug supply:

Contradicted views were mentioned by ever-married women reproductive health, MWRA (Souhag) demonstrated the marked improvement in the drug availability in FHM facility. They mentioned three positive changes: more types of drugs are available, iron and vitamin tables are available freely for pregnant women, and there is no need to buy drugs from outside pharmacies. While, MWRA (Menofia) added that, now the drugs are more effective, new medications are added (i.e. transfusion fluids, drugs for chronic diseases). However, the amount of drugs is reduced.

MWRA (Alexandria) mentioned that, the drug supply was better before becoming FHM, there were plenty of drugs dispensed freely to patients.

Lab services:

MWRA (Souhag) appreciated the improvement in the lab services, as FHM added new services as testing for blood sugar. MWRA in Menofia added that, the lab is working all the time, there are more types of lab tests, and there is more utilization of lab services. However, MWRA (Alexandria) observed no improvement in lab services. Still they have to wait longer, and suffer from high cost of lab services.

Follow up services/continuity of care:

Women in the three governorates expressed the improvement of follow up services, as the doctor could review the medical history from the folder and always gives appointment for the next visit.

Referral Services:

MWRA (Souhag and Menofia) mentioned that referral to hospital becomes easier and smooth. Having the family folder and availability of ambulance facilities ensures timely interventions especially for major surgery and obstructed labor. However, MWRA (Menofia) mentioned that the severe limitation of referral service is related to **restriction of referral services to those having family folder**, and the paid premium for specialist services. However, MWRA in Alexandria mentioned that there are no referral services at all.

- ***Accessibility of the service***

MWRA (Souhag and Menofia) consider that access to the service within the clinic become faster. The service is composed of three steps: getting the folder, clinical examination, and receiving the medications. MWRA (Menofia) added that the service is available all the day and according to the system of shifts. MWRA (Alexandria) expressed that the organization of client flow, regular/ordered receiving of medical consultation are the major positive changes that facilitated access to service in a very short time.

- ***Cost of health services***

All interviewed MWRA were disgruntled with the high cost of services related to paying one third of the price of the medication (Souhag), Cost of lab services (Alexandria) cost of the family folder, cost per visit (LE 3.25 versus LE 1.10 before FHM), medication (one third of the price, versus free before FHM) (Menofia).

- ***Quality of RH-services:***

Beside the general expressions about improved quality of services, MWRA (Souhag and Menofia)

affirmed that nurses become more efficient. Being from the same village, nurses know lot about women, they do services during home visits more efficiently, and those services include postnatal care, and informing about times for ANC visits and children immunization. MWRA (Menofia) added the shift from private to FHM facilities due to the high quality of FHM services.

> ***Quotation (4):*** Before becoming FH facility we preferred to go to private clinic, but now, we come to the FHM facility due to the high quality of service
>
> ***MWRA, Menofia***

However MWRA (Alexandria) expressed their dissatisfaction from nurses' performance, and bad behavior of the employees during receiving the folders.

RH-services delivered in FHM facilities compared to other sources of services

There was a consensus that FHM facilities' services are better than any source of services.

MWRA (Souhag) mentioned the advantages of the family folder for follow up of the case, short waiting time and geographic accessibility. MWRA (Alexandria) identified three advantages of FHM: competent physician, paying one third of the drug cost, and availability of SONAR.

MWRA (Menofia) mentioned the advantages of FHM compared to hospitals:▪more care ▪ no waiting list ▪low cost per visit as in the hospital the visit costs LE 10.5, ▪low cost of medications as the cost of medication in the hospital is the same as the private pharmacy. Compared to private practice physicians, the cost per consultation and medication is more in the private clinics.

Other sources of health services are better than FHM facilities due to:

MWRA (Souhag) mentioned the limitations of FHM services due to ***fewer types of specializations.*** MWRA (Alexandria) referred to the cost of lab services in other facilities which is not as much as that of FHM facilities, it is faster to receive lab results, and nurses provide quality care, and good equipment is available. MWRA (Menofia) mentioned the limitations of FHM compared to hospitals, where in the hospital there are *more medical specialties* and equipment. Compared to FHM, there is more care in the private clinics, *specialization*, more equipment available, follow up services and comprehensive services i.e. ANC-Natal care-postnatal care and referral services. NGOs clinics have *all specialties*, accessible cost and no payment to folders.

- ***Community Perception to the components RH services delivered in the FHM facilities:***

The perceptions of MWRA to the RH services in the three governorates are demonstrated in panel 6.1. It is obvious that there are variations among women interviewed in the three governorates regarding their views towards RH-services delivered in the FHM facilities. It is obvious that there are variations regarding the views of women towards the qualitative and quantitative aspects of RH-services delivered in the FHM facilities.

Panel (6.1) Community Perception of RH-Services Delivered in FHM facilities in the three Pilot Governorates			
RH-Service Items	Alexandria	Menofia	Souhag
FP	Available in acceptable condition	**** There is no monthly injectables,*** ****Some FP methods are prescribed to be brought from private pharmacy*** ****No female physician***	All FP methods are available and free of charge There is no monthly Injectables
ANC	Available in acceptable condition	****The nurse provide the service not the doctor*** ****The SONAR is not working***	Free comprehensive services including iron and vitamin supplementations
Natal Care	***Not available, no emergency obstetric care or referral***	****Not available*** ****There is no female obstetrician*** ****To be referred for emergency obstetric care the mothers should have to be enrolled in the health insurance(pay for the folder LE30, and pay for specialist LE10)***	Safe delivery services are available in the health unit, and ambulance transportation services are available for emergency obstetric care
Post Natal Care	***People are not informed about such service***	Available in acceptable condition, and it has to be done by the nurse during home visits	Postpartum home visits include service provision to the mother and the newborn. Testing for thyroid function is included in the package of child care services
TT to pregnant women	Available in acceptable condition	Available in acceptable condition	Well organized and implemented schedule for TT immunization
Children immunization	***Available, but without proper nursing care***	Available in acceptable condition	All vaccines are available, strict tracking system for dropouts through community workers' home visits
Sick Baby care	***Available, but without proper medical care***	Available in acceptable condition. Good care is given to the child	Available in good quality and free of charge
Well-baby care	***Growth monitoring, just once. There is much negligence in this service***	Growth monitoring is done according to a well-defined schedule, good quality, free of charge, done by the nurse	Growth monitoring is done according to a well-defined schedule, good quality, free of charge
RTI women	Available, ***but there is no medications***	***There is no female gynecologist***	Clinical care is available, ***but there are no medications. Women have to buy the medication from the private pharmacy, which could be at far distance. Therefore, usually, women do not buy drugs for RTIs.***
RH-Service Items	Alexandria	Menofia	Souhag
Husband's health services, including RTIs	***There is no male physician***	***There is no specialist***	Available services, but there is ***no enough specific medications***
Care for male and female youth	***Youth male and females do not need health services***	***There is no specialist***	Available services, but there is ***no enough specific medications***
Lab services	***High cost, long time to receive lab results***	***There is shortage in some lab services***	Excellent services
Referral services	***No referral in emergency obstetric*** *cases* There is referral in case of need for SONAR	***▪Enforcement to pay for application to specialist services*** ***▪Bad management in the referral hospital***	Excellent service
Follow up of chronic diseases	Available	Good follow up services -***Shortage in some drugs as insulin, and drugs for management of liver diseases***	Excellent services
IE&C seminars	***Few number of women mentioned attendance of IEC seminars***	Seminars covers FP , nutrition and maternal care, and Avian Flue The nurse and community workers are responsible for IEC	Seminars covers FP , nutrition and maternal care
Other services	None	None	Women's club and social, educational and vocational training services

- ***Marketing for FHM-services:***

All MWRA mentioned that the sources of knowledge about the FHM services are: community workers and nurses during issuing the family folders, people tell each other, the nurse and physicians during receiving medical care.

- ***Community Perception to FHM- health services provision: The best services***

Community perception of services delivered in FHM facilities in the three Pilot Governorates- as Best Services- varies from one governorate to another.

In **Souhag** the perceived best services are: ANC (free of charge, regular visits, and medications/vitamins /iron tables for free), lab services and child care (growth monitoring and immunizations), family folder, FP, the SONAR and care for female adolescents (in case of delay in puberty/menarche). In **Alexandria** the best services are: general technical competency of the staff, availability of drugs at one third of the price, and availability of the SONAR at low price. In Menofia the best services are: Child care, internal medicine services, dental care, referral services and exemption of poor people from cost of health care.

- ***Community Perception to FHM- health services provision: Shortcomings***

MWRA perception of services delivered in FHM facilities in the three Pilot Governorates- as shortcomings - varies from one governorate to another. In Souhag the mentioned shortcomings are: lack of maintenance of the SONAR, unavailability of some drugs, and high cost per visit.

> ***Quotation (5):*** The available drugs are those of low price, and the doctor prescribe the expensive drugs to buy them from the private pharmacy
>
> ***MWRA: Souhag, Menofia and Alexandria***

In Alexandria the mentioned shortcomings are: ***Enforcing families to be enrolled in the health insurance*** and to have family folder, no dentist and dreadful management of the clients by the staff, and drug shortage.

In Menofia the mentioned shortcomings are: lack of maintenance of the SONAR, unavailability of some drugs, no gynecologist, no natal care, and the nurse is the provider of ANC.

- ***MWRA suggestions to improve utilization of RH-services delivered in FHM facilities:***

MWRA (Souhag) suggested increasing equipment supply especially SONAR, supplying more drugs, more specialization in medical care, more facilities for emergency care, increasing awareness about the scope of FHM facilities services, reduce the cost of care, ***unify the cost of care (e.g. the cost per visit is LE 3 in the morning, LE 6-6.5 in the afternoon sessions)***. MWRA (Menofia) mentioned the importance of having ***gynecologists***, and improving the doctor-patient communication, increase the availability of drugs and equipment and reduce the cost of the folder. MWRA (Alexandria) mentioned that drugs should be available at the facility, reduce cost of the folder and lab, having male physicians, more health care to children.

2- Perception of married men to FHM services

Panel (6.2) shows the advantages and shortcomings of FHM services as expressed by men during FGDs in the three governorates.

Panel (6.2) shows the advantages and shortcomings of FHM services as expressed by men during FGDs in the three governorates			
Facility Items	Alexandria	Menofia	Souhag
Facility location	***Not accessible after changing location***	Accessible	Accessible
Facility Infrastructure/cleanliness	Good and clean, but disorganized	Good and clean and organized	Good and clean
Family Folder	***The HIGH COST of updating the family folder***	***Doctors do not inform them about the importance of the family folder. The HIGH COST of updating the family folder***	***Doctors do not inform them about the importance of the family folder. The HIGH COST of updating the family folder***
Working Hours	***Not reasonable from a. m. 8 to p.m. 1***	Reasonable from a. m. 8 to p.m. 2	Reasonable from a. m. 8 to p.m. 2
Cost of the service	***Not reasonable at all***	***Not reasonable at all***	***Not reasonable at all***
Knowledge about BBP-free services	***•Know that Immunizations are free, but MCH and FP are not free •Men should pay for any health service***	***Know that MCH and FP are free services, but men should pay for any health service***	***Know that MCH and FP are free services, but men should pay for any health service***
Exemption system	***Nobody knows about exemption***	***Nobody knows about exemption***	***Nobody knows about exemption***
Equipment	***No X-ray in the dental clinic***	***No X-ray in the dental clinic***	***No X-ray in the dental clinic***
Drugs	Available	Available	Available
Quality of the service	***Dreadful quality***	Good quality	Good quality
Manpower: Physicians	***•The need for a doctors working for 24 hours •Having only one female physician***	***•The need for a doctors working for 24 hours •High turnover of physicians***	***•The need for a doctors working for 24 hours •High turnover of physicians***
Manpower: Nurses	***Unsatisfactory performance***	Effective communication especially during home visits	Effective communication especially during home visits
Technical competence	***Not good due to shortage in specialists***	***Not good due to shortage in specialists***	***Not good due to shortage in specialists***

- ***Men suggestions to improve utilization of RH-services delivered in FHM facilities :***

Men suggested reduction of the cost of health care, having dentist, more drugs, male specialist (at least for one day per week) (Souhag). Men in Alexandria added the presence of doctors for emergency care. Men in Menofia added the increase in the role of the community workers to inform the families about the family health services.

3- Perception of Female Youth to FHM facilities' Services

- ***Female Youth Background information about FHM facilities:***

Female youth (FY) had defined the scope of FHM facilities' services in different ways in the studied 3 pilot governorates. FY (in Souhag and Alexandria) mentioned premarital care, clinical examination, health education (avian flu and personal hygiene), FP and children immunization, vocational training for women and girls. All community categories could be benefited from the FHU services (young, old, males and females). FHU responds to FY needs for health services to manage acute infections, eye diseases and dysmenorrhea. FY (in Menofia) mentioned different views towards the scope of health services delivered in the FHM facilities. They mentioned that FHU *serves the poor people*, those with chronic diseases, children (for immunization) and women (for ANC and FP).

- ***Attitude toward Reproductive Health Disorders of Girls:***

Data derived from interview with female youth in the three communities indicated that there are un-met needs for RH services. Causes of unmet needs could be grouped into cultural factors,

unawareness of parents (clinical examination has to be postponed till after marriage), female youth personality (shame feelings), unavailability of service (no access to female physician) and cost of services (seeking health services in severe conditions only, due to financial constraints).

> ***Quotation (6):*** The society considers the female youth who go to a gynecologist for clinical examination, as ill-mannered girl !!!!!
>
> ***All interviewed female youth***

- ***Utilization of FHM facilities by Female Youth/Girls:***

Female youth in Souhag prefer private physicians due to technical competency, specialized and quality services (being private-paid- service). However, they also prefer the FHU because of the good care, warm relations with the staff and access to female physician. The presence of family folder, including all information about the family, motivates girls to seek health services in the FHU. Female youth in Alexandria consider FHU is the best source of service due to technical competency, ***and prescription of good drugs that the patient can buy from private pharmacy.***

Female youth in Menofia usually prefer to go directly to the pharmacy (the most financially accessible service). However, in severe cases, girls prefer to go private physicians as the first choice (due to more care, specialization, quality and effective service, and rapid response). Seeking district hospital is the second choice due to availability of services all the times, all specialties, facilities for surgery and low cost. Additionally, because the health unit refer cases to the hospital, it is easier to go directly to the hospital.

> ***Quotation (7):*** Usually the health unit refers us to the hospital. Therefore to save time and effort we go directly to the hospital and forget the health unit.
>
> ***Female youth from Menofia***

Potentials of FHM facilities to provide youth-friendly services

FY (Souhag and Alexandria) mentioned that they visit the FHM facilities with their brothers and sisters for immunization and health care services. The way the service providers manage them is very motivating to girls to come back to the health unit to get personal health services.

The situation in Menofia is different. The majority of girls prefer not to seek FHU services due to improper management of girls by the staff, long waiting time, and the attitude of the service providers which does not show any interest to be kind and descent with female youth.

> ***Quotation (8):*** Waiting for immunization services (to complete the quota number of children) is very long, and sometimes immunization services are postponed to the next day
>
> ***Female youth from Menofia***

> ***Quotation (9):*** Ensure feeling of security/safety is necessary to girls to seek the FHU services. And not to deal with them as persons coming for injections !!!!!
>
> ***Female youth from Menofia***

FY (Souhag and Alexandria) affirmed that the improved quality of services delivered in the FHU has made good reputation, and motivate families to utilize the FHU services. The seminars conducted in the FHU provide comprehensive information about health issues and health services. ***However, there is no enough dissemination of information about the package of services to girl beneficiaries.*** In Souhag, girls mentioned the role of the community workers in communication with girls to get curative care services. However, in issues related to RH, ***cultural factors*** play strict role to talk about or seek any related health services, and ***the mother is usually the referral person to girls***, not the health facility staff.

Female youth in Menofia claimed that neither families nor community workers play any role in

marketing for FHU services. Families do not motivate their daughters to seek health services delivered in the FHU, and prefer seeking care at private clinics or hospitals due to trust, confidence, effectiveness, rapid response and the quality of services. Families are obligated to seek the FHU services in case of financial constraints.

Female youth (Menofia) identified three factors that restrict their participation in the RH seminars that usually conducted in the FHUs. The first factor is related to the female youth personality as fearfulness from parents/society attitude, shame, and lack of trust to the health unit and lack of enough time to participate in the seminars. The second factor is related the families who consider that their daughters should not sacrifice the precious time (devoted for studying) to attend such seminars, and the social/cultural factors related to informing female youth about sensitive issues related to RH. The third factor is related to the lack of active role of the health unit in announcing for the health education seminars for female youth, and the inactive role of the service providers to motivate female youth to attend such seminars.

Suggestions to improve the FHM to motivate seeking medical services by girls:

Interviewed female youth mentioned the following to improve the FHM supply components:

- Availability of female physician (Souhag, Menofia).
- Availability of special clinics for female youth only (Alexandria).
- Training of service providers on how to be friendly with female youth.
- Social activities, vocational training activities to female youth (Souhag).
- *B*etter to have girl service provider to talk with female youth clients (Menofia).
- Reduce the cost of the folder and the visits (Souhag and Menofia).
- General measures to improve the quality of services: having more specialist, more lab services, dentist (Souhag and Menofia).
- Improve emergency services (Menofia).
- Improve the methodology by which the family folder is completed.

> ***Quotation (10):*** The way they record data in the folder, makes us feel that we are in a police station !!!!
>
> ***Female youth from Menofia***

> ***Quotation (11):*** The service provider should show interest to the patient and focus on providing clinical services, rather than doing this paper work, while the patient is suffering from severe pain.
>
> ***Female youth from Menofia***

Improve regulations related referral services *Quotation (12).*

> ***Quotation (12):*** Regulations that restrict referral, with 15 days interval should elapse between two referrals, does not respect the condition of the patient who may die while waiting for referral.
>
> ***Female youth from Menofia***

Interviewed girls mentioned the following to improve the FHM demand components:

- Marketing for health services package directed to female youth/girls (Alexandria).
- Raise awareness of girls for the importance of early detection of RH problems (Menofia).
- Raise awareness and combat false traditions that restrict access of girls to RH information and services (Menofia).
- Promote the role of the nurse in communication during home visits to inform the public about the role of the health unit in service delivery to female youth.

4- Perception of male youth to FHM facilities' services

The change of the mission of the PHC facility to family health facility is ***not known by all the*** interviewed male youth. In Souhag, MY knowledge about the situation is that the PHC facilities had been renovated, and the name has changed to be FHU. The scope of the FHU services include children immunization, internal medicine to adult and elderly, and FP to women, and there is no specific services to MY. In Alexandria , MY have mentioned that the scope of services of the FHU includes first aid, immunizations, outpatient services and vocational training for women. In Menofia, MY have provided more information about the scope of services delivered by the FHM facilities. They mentioned the family folder, first aid and curative care, nominal fees for curative services, ANC and children immunizations.

Personal experiences with seeking medical care among male youth are very limited. Almost of MY claimed that they go to the health unit in case of injuries/wound dressings, or rarely with their brothers and sisters for immunization. In case of their illness (i.e. acute infections) they go to private physicians.

There is no direct communication between the FHM facility and male youth at the time of issuing the family folder. MY have declared that, their families informed them about the family folder. Such situation indicates that, MY had not been exposed to the initial clinical examination which is an integral activity during issuing the folders.

> ***Quotation (13):*** Our families told us that we have family folder in the health unit, and our names are recorded in that folder
>
> ***Male Youth in the 3 governorates***

Despite the short contact between the MY and the FHM facility (immunization of their brothers and sisters), MY have good impression expressed as positive attitude towards good physicians and nurses. However, some of the interviewed MY in Menofia mentioned the problem of the long waiting time

SWOC ANALYSIS OF RH-SERVICES PROVISION THROUGH FHM 7

This chapter is concerned with analysis of the articulation and association between three major parameters: supply, demand and utilization of RH-services within the frame of FHM as well as identify strengths (S) of the current FHM to build on, weaknesses (W) to correct, opportunities (O) for timely capitalize on, and finally challenges (C) to overcome. First the impact of FHM on supply, demand and utilization of RH-Services will be discussed. Then the current FHM situation regarding SWOC to suggest recommendations to improve its role in improving supply and demand for RH services will be discussed.

7.1 IMPACT OF FHM ON SUPPLY, DEMAND AND UTILIZATION OF RH-SERVICES

Analysis of the articulation and association between three major parameters: supply, demand and utilization of RH-services within the frame of FHM are important for situation analysis stage related to SWOC. There are important issues that could be depicted from the study:

Strategic planning

The MOHP-strategic plan 2006-2010 is focusing on universal coverage with BBP through FHF-health insurance. The redefinition of MOHP role in regulatory functions related to "consolidation of multiple vertical public health programs" is not associated with clear strategies for the role of the currently working vertical programs, especially in the transition phase 2006-2011.

Consequently, the FHM facilities and the family health services providers are exposed to double system (integrated family medicine and vertical programs) as demonstrated in the following examples:

- FHM facilities in all pilot governorates (except Menofia), have FP clinics in addition to family health clinics. This could indicate that the strategy of integration through family physician is not valid at the operation level.
- Having double MIS for FHM and vertical programs at the FHM facilities.
- Introducing the service of mobile clinics beside FHM facilities results in shifting clients to use free service by female physician in the mobile clinics.

RH-programs goals and targets

RH-programs goals and targets mentioned in the MOHP-HSRP documents are not updated according to the concepts of health sector reform which focus on the BBP. For example, the set targets do not include any items related to RTIs, and youth RH-problems. The MIS of both the FHM and the vertical programs does not include monitoring and evaluation indicators for those items. The performance indicators for the FHM facilities' service providers lack those items. Therefore, service providers do not pay any interest for case finding or marketing for RTIs services, and youth services. Consequently, those two services had shown underutilization in the FHM facilities. For example (chapter 6): Only 2% of the families in the community have demands for the service of "management of male RTIs" and the FHM facilities contribution in this demand is only 9%.

- **Availability of health facilities**

FHM facilities succeeded in coverage of the population with RH-services in the rural areas but not in the urban areas. The HSRP has three policies for coverage of the urban areas with FHM facilities. Those policies have some limitations.

First: The policy of shifting from the "catchment area-based planning" to population based planning, with allocation of 1000 families per family physician results in shortage in covering the population with RH-services especially in the urban areas. This situation results in reduction in

coverage of the population within the catchment areas with RH-services. For example, in Alexandria ANC coverage in 2007 was 26% in the FHM facilities versus 69% in the PHC facilities. Additionally, the planning for building new FHM facilities has the constraints of limited resources and time as well as the difficulty to find geographically accessible places for new facilities as in case of Alexandria.

Second: contract with private/NGOs facilities has confronted some challenges. For example, experiences of contracting and sustaining the contract between FHF and NGOs/private facilities had shown limited success in Alexandria and Menofia (chapter 4, IDIs with USHA and HDD).

Third: While MOHP-HSRP plan support having FHM facilities that could provide quality RH-services, NPC-population plan 2007-2008 [(57)] includes introduction of mobile clinics into the health service delivery system to provide FP services.

Fourth: HSRP consider renovation /improving the facility infrastructure of PHC facilities is the major dimension in quality services. However, there are other quality issues that should be considered for each community. For example: Souhag ranked the second governorate regarding the quality standard of its FHM-RH-services. However, Souhag FHM facilities had demonstrated severe underutilization of FP services throughout the period 2003-2007 compared to their counterpart PHC facilities.

- **Availability of RH-services**

  The BBP which include RH-services as well as EDL which include RH-drugs had motivated women, men and youth to utilize RH-services in the FHM facilities (FGDs with the community members). However, lack of some RH-drugs (for RTIs) had reduced the utilization of such service (see findings of the FHM facility quality checklist, chapter 4).

- **Availability of service providers**

  The service providers are available and sufficient in the FHM facilities, but the reallocation, training, job description and incentive system could influence the utilization pattern of RH-services. High rate of turnover of the staff is a major problem as expressed by service providers and the served community. The attitude of the community towards the family physician as unspecialized physician reduce seeking care in the FHM facilities (chapter 6).

- **Geographic accessibility of the facilities**

  FHM facilities are geographically accessible, as they represent the already available PHC facilities. However, other health facilities are geographically accessible as well e.g. public hospitals. People prefer to use hospitals, since they are more geographically accessible and due to low cost as well as having specialist at any time (see chapter 4. IDI with HDD and chapter 6 FGD with the community members).

- **Financial accessibility**

  Both the FHM personnel at the governorate, district and service providers in the FHM facilities consider cost-sharing is an obstacle for utilization of RH-services. In some governorates, there is pressure imposed on women to pay for enrollment in the family physician roster. There is no well-defined system for pricing RH-services with variation across the governorates at the implementation level. Example: In Menofia, it is not important to have family folder to get RH-services.

  The FHM has 6 fee schemes (58) : 1-vertical preventive services are free (well-baby care, Maternal care, immunization, FP) with nominal cost for contraceptives, 2-Health insurance for U5 children (LE 5/year, LE 0.5 /visit, 1/3 of the drug cost), 3-Health insurance for employees (free service, 3 drugs, LE 1- or ¼ for the drug cost), 4-Health insurance for widows and pension (completely free service), 5- MD 147 (health insurance annual premium at LE 10 /individual /year with maximum LE 30/ family, LE 3/ visit, 2 drugs maximum, 1/3 of the drug cost, LE

10/individual per year for specialist services) 6- Those who are not joining the FHM-roster pay LE5 per visit and the whole price of the drugs.

There are complete fee exemptions for 15% of families per FHM facility.

At the implementation level there are several shortcomings which could have negative impact on RH-services utilization in the FHM facilities: There are variations across the governorates in applying the fee schemes. Chapter 6 (table 6.14), shows that the community is unaware about prices of the services and women do not know that RH-services are provided freely. During FGD with the community, people mentioned paying LE 6 /visit in the afternoon shifts. For management of RTIs among females, which was part of FP services, women have to pay for the visit LE 3 and 1/3 of the drug cost. To receive RH-services women have to join the FHM-roster.

- **Service accessibility**

Despite service providers consider that the client cycle is very long (eleven steps), the RH-clients consider that they get the service in a very short time. Restricting the number of patient/physician/day at 24 cases, could make the doctors, who receive more than 24 cases per day, select cases who pay for the service rather than RH-clients who receive free services (Chapter 4, RH-advocates). Setting criteria for cases served per month (according to the performance-based incentive system), makes the doctor has control over the number and type of clients to be served. This limits accessibility to some services in the critical time as in case of referral (FGD with girls).

HSRP/RH-related decentralization through DPO

The DPO organogram is not exactly applied in the pilot district as set by the HSRP. Additionally, there are variations across the governorates (chapter 4 IDIs with HDD). This indicates that there is no model DPO organogram. MOHP 2005 document [(58)] affirmed that DPO continue to be challenging situation in the HSRP.

HSRP/RH-related reorganization of the health system

Reorganization of the integrated health system to be FHU, FHC and district hospital is not absolute (being not completely covering the pilot district). Therefore, underutilization of FHM facilities could be due to RH-client shift to low cost PHC facilities in the same district, as observed in Souhag.

Capacity building/training of the staff

As mentioned in chapter 4 most of the service providers are trained in RH-services, either through the package of Family Medicine or through the vertical programs. However, there is a consensus that the training in FP is not satisfactory. About 70% of the interviewed family physicians had no training in family medicine (chapter 4) .

- **Job-description and terms of reference**

According to the job description, the nurse is the service provider to mothers during ANC (Menoufia), and this could result in shift of mothers from the FHM to the private facilities (FGD with women in the community).

The link between the job description and RH-items in the BBP is not clear. For example, postpartum and post-abortion care are included in the BBP but not included in the job-description of the family physician or the nurse. Therefore, it is difficult to find data that describe the utilization pattern of those two services.

There is no specific job description related to FP service delivery to doctors. The job description includes providing FP advice and assistance to women during ANC.

- **Motivation of the staff**

  The FHM depends on performance-based incentive system as a driving and pivotal factor for motivating service providers to achieve the monthly target. However, this situation link the health facility utilization output by the number of physicians per facility, who have fixed output (according to the target). For example in Alexandria pilot district, the average FP client/physician/day is **1.8** clients (2003-2007), at the same time the average number of FP clients/facility/day is 12 clients (2003-2007). This means that the average number of physicians per facility is **7 family physicians**. The counterpart situation in the control district is different. The average number of FP client/physician/day is **3.1** clients (2003-2007), at the same time the average number of FP clients/facility/day is 5 clients (2003-2007). This means that the average number of physicians per PHC facility is **less than 2 FP physicians** /facility (***see chapter 5***).

  Incentive –based performance results in recording false utilization data (chapter 4).

  MOHP-HSRP[58] document stated that "*curative care should become a priority for the management of the program as family medicine is what makes it specific, necessary and responsive"*. Such statement could have its impact on directing the focus towards curative rather than preventive RH-services.

Supervision System

Clinical Supervision system is one of the systems that have severe shortcomings during the transition phase from vertical to integrated FHM system. Currently, there is no clinical supervision to PHC or FHM staff. PHC facilities working according to MD 75 are focusing on fulfillment of checklist, for quantitative indicators, and observation of the health facility infrastructure, with no on-the –job training especially for RH-services.

The weak points in the FHM supervision system are: 1-The supervision system of the FHM done by district staff and FHF is "supervision to control" rather than supervision to help "constructive supervision" 2-exposure of the health facility staff to about 15 types of supervisors from the different levels and vertical programs 3-there is no supervisor who is supervisor who is considered expert in family medicine to transfer experience to the FHM service providers 4- FHM did not build on experience of the MOHP vertical programs of involving district hospital specialists as "clinical supervisors" in the on-the-job training and update clinical skills of the service providers in the FHUs.

Management Information System

The transfer from vertical MIS (with extensive number of indicators and no indicators for other services) to physician- folder-based output data for all the services, still constitute a major **problem in data management for decision making.** The double system of data recording to satisfy the FHF and the vertical programs involve the physicians in **extensive paper work**. Having a fixed target of 24 cases/physician/day and those cases has to fit into special distribution across services: FP, ANC, child immunization, chronic diseases, etc. keeps a constant profile for the physician's output in service delivery. This **planned output** does not reflect any initiative to serve more people or to focus on priority service to be directed for a certain locality/village. (See IDIs with the RH-advocates, USHA, HDD, chapter 4).

Infrastructure of the health facilities

The HSRP-policy of having family medicine clinics, allows for providing RH-services in more than one clinic in the same facility (compared with vertical programs). This approach is coupled with increasing equipment within each clinic to provide quality RH-services.

However, there is no room for counseling in FP. In some clinics there is no gynecology examination bed for IUD insertion (chapter 4). The community perceives providing all services by one doctor as professional incompetence (chapter 6).

There is no room for oral rehydration, and the service has to be delivered in the family medicine clinic. This could result in providers' dissatisfaction (chapter 4).

RH-commodity system

The availability of RH-commodities including equipment, and drugs could contribute in increasing the utilization of some services. For example, SONAR, lab investigations, iron and vitamins for the pregnant women are available in almost of the FHM facilities.

Outreach activities

In FHM facilities there is redistribution of nurses, where extra nurses have to conduct home visits to market for FHM services, and provide health education in RH-services. Those nurses, being technically qualified in RH-services could motivate women to attend the FHM facilities to get RH-services with subsequent increase utilization of FP, immunization and maternal care services.

The role of the community workers remain the same in the outreach program, despite their non-inclusion in the FHM organizational structure.

Community utilization of RH-services in the FHM

Most of families 98.5% in the catchment area of the FHM facilities which were previously PHC facilities had reported the utilization of at least one of 22 types of RH-services delivered in the FHM facilities. However, 66% of families in the catchment area of the FHM are enrolled in FHM roster. Those families are considered the constant utilizers of FHM facilities. FHM-rostered families, compared with the non-rostered families are considered at reproductive risk: mothers are young, less educated, of high parity.

There is a gap between Knowledge, acceptability and utilization of RH-services in the FHM facilities:

The FHM-served community presented by women in the reproductive has adequate knowledge and high acceptability about specific types of RH-services delivered in FHM facilities (81% for family planning services). However, there are less demand (do not seek any care in any health facility) for some services related to men and adolescents. The FHM response to community demands for RH-services is only 54%.

For a health problem as female RTIs, that reported to be prevalent in Egypt at a level of 40% [(59)], the demand (seeking health services) of the studied community was 39%. However, the percent contribution of the FHM facility to deliver this service was 27%.

The geographic accessibility is the main driving force for utilization of the FHM services. The community considers that other types of facilities as hospitals and private facilities provide both quality services and specialized technical services (chapter 6).

Rising demands for family health services

Marketing activities to FHM services depends on internal (within the facility) demonstration of the package of service. The FHM depends on the outreach programs of the traditional PHC-vertical programs.

There are no community participation interventions at the district level through contribution of the local councils in strategic planning. At the facility level the clinic boards are not activated (chapter 4).

7.2 SWOC Analysis of the Political Support to FHM-and RH-Related Programs

Strengths:	Weaknesses:
▪ There is high political support to the FHM, with more governmental financial support to PHC. The Minister of Health and Population announced that, by year 2020, all Egypt health facilities have to achieve the accreditation. ▪ MOHP 5-year plan (2006/2010) illustrates shift of the government's interest towards **integrated family medicine**, rather than the expensive curative services. This reflects an **implicit policy** for the government commitments for **sustainable** support to **RH-services through family medicine**.	▪ There is **no advocacy** for the governmental policy which declares the mechanisms of providing quality integrated family medicine including RH services. The policy does not find any support at the level of MOHP departments concerned with vertical programs. MOHP/PS staff feels that FP program lost its political support.
Opportunities:	**Challenges:**
▪ Egypt President and Prim- Minister declared the rolling out of the FHM. In the National Population Conference, June 2008, the prim-minister expressed support to FHM, being a successful step towards improving health care in Egypt. ▪ The change in the international health policy, from donors' support to partnership indicates cooperation of the donors with Egypt to implement its strategic plan. The GOE new policy of "budget support" indicates that the MOHP strategic plan is the key reference for any donor to support health programs.	▪ HSRP did not consider coordination with other ministries to achieve RH-goals. For example: the Ministry of Social Solidarity policy of providing financial support to pregnant women is interpreted by the public as governmental support to high fertility. ▪ The relation between the STSP and MOHP/ curative care sector as well as MOHP/PHC-vertical programs advocates does not show active cooperation. ▪ There is a gap between policy makers and planners at the MOHP and the served community at all levels. The community is not adequately informed about the FHM.

7.3 SWOC Analysis of the Role of FHM in Strategic Planning for RH Services

Strengths:	Weaknesses:
▪ The adoption of the MOHP- "National Strategic Plan for Population in Egypt 2002-2017" indicates the commitment of the HSRP to achieve the RH-goals, objectives and strategies as set in the plan, at the documentation level.	▪ There is no single document that includes "policies and procedures" of FHM, that links between goals, targets, objectives for each health service and policies and regulations that are related to each service.

Strengths:	Weaknesses:
▪ HSRP follows the principles of planning during assessment of needs for health facilities and manpower. In pilot governorates and districts there are master plans. The master plans demonstrate manpower/facility/families per community.	▪ The plan does not include the role of the MOHP sectors and departments, and the future of the vertical programs. MOHP vertical programs still receive budget to do activities, even in the areas covered by FHM (e.g. supervision). The action plan at the facility level could suffer from being static, as setting targets specific for the served community, could not be matched with fixed number of clients to be served per day e.g. 24 cases/day/physician with total working days per physician per year at 250 days. Additionally, linking the incentives with specific outputs: referral, ANC, CYP, records are fixed to be applied in all the governorates, irrespective to any plans at local levels. This could lead to weakness of the relation between the health facility and the served community.
Opportunities:	**Challenges:**
▪ The Prim-Minister and Peoples Assembly approved the plan, and there is a well-defined budget allocated for implementation of the planned activities.	▪ The strategic plans does not include the relation between the health sector and the other organizations involved in RH-issues as National Council for Motherhood and Childhood, National Population Council, National Council for Women as well as other ministries. The plans at the district level do not include members from Local Population Council (LPC) who represent the channel for community contribution in the FHM. ▪ Getting decisions from the higher level to expand the model and increase the number of accredited facilities had resulted in providing accreditation to some facilities which have no source of clean water or electricity. ▪ The annual population action plan 2007-2008 published by NPC, did not mention any information related to HSRP or FHM.

7.4 SWOC Analysis of the FHM in Achieving Universal Coverage with RH-Services

7.4.1 Availability of RH services through FHM (facilities, services, manpower)

Strengths:	Weaknesses:
▪ There are enough MOHP health facilities to provide RH-services. The decision of changing the role of integrated hospitals to be FHC, adds another 600 FHM facilities. The BBP is provided in all FHM facilities. ▪ Building new FHM facilities and contracting with NGOs and Private sector ensures availability of RH services.	▪ Rebuilding of collapsed facilities has obstacles related to license from local authorities. Establishing new facilities could not fulfill the geographic accessibility requirements (e.g. in Alexandria). ▪ There are difficulties in some governorates to involve private and NGOs sectors.

Opportunities:	Challenges:
▪ There are many facilities related to NGOs/private sector. The presence of enough medical schools and nursing schools distributed in all Egypt regions ensure supply with enough manpower. The introduction of family medicine specialty in medical schools ensure sustainability of FHM.	▪ Time and resources continue to be a challenge for ensuring the availability of accessible facilities and qualified manpower specialized in family medicine. There are no successful mechanisms to involve qualified/accredited NGOs/Private facilities in the FHM. ▪ RH-advocates continue to emphasize the importance of the mobile clinics in RH-services delivery. The national population/RH implementation plan 2007-2008 includes adding new mobile clinics. In Alexandria , mobile clinics provide RH-services nearby the FHM facilities. ▪ The current interventions of using "medical coveys" which provide free services could reduce the utilization of the FHM facilities which have cost-sharing strategy.

7.4.2 Accessibility of RH Services through FHM

Strengths:	Weaknesses:
▪ The served community affirmed that FHM facilities are geographically accessible. The FHM strategy of upgrading the traditional PHC facilities to be FHM facilities has facilitated accessibility and acceptability of the facilities that people used to use to get their essential health services.	▪ Financial accessibility continues to be a problem in RH-services. There is no clear statements in the HSRP documents that mention what specific services should be delivered free of charge among the non-exempted people. For each specific service there is no clear specification of the cost of service: e.g. Is there a cost –sharing for women attending the FHM facility for follow up services of the inserted IUD? ▪ In some communities social accessibility is a problem. The switch of doctors from their original specialty to family medicine specialty (while continue working in the same facility) could reduce their credibility by the community. Preferring male or female physician continue to be a problem in some communities. ▪ Limiting the number of cases per day per physician at 24 cases, limits accessibility to service, especially for free services as FP. Emergency cases that need referral to hospital could be rejected because the doctor had completed his/her quota for referrals.
Opportunities:	**Challenges:**
▪ There are trials in Menofia to involve NGOs sector in the FHM	▪ Building new facilities could not fulfill geographical accessibility

7.5 SWOC Analysis of the FHM in Improving the Organization and Management of the Health System for RH-Services Delivery

7.5.1 Decentralization through DPO

Strengths:	**Weaknesses:**
▪ All studies affirmed that district level-as mid level management- is the best approach for decentralization. FHM-advocates consider that FHF cannot supervise all health facilities at the governorate level without the support of the DPO. Monitoring and evaluation indicators could be easily developed at the district level, due to ability to compile data from different sources including health facilities.	▪ The health district does not have the strong potentials and autonomy to work as DPO. The Health District has no enough authority on health facilities, This due to limited experience and resources to support the health facilities and due to its being not the decision maker regarding the incentives (compared with FHF).There is no demonstration for any success to the HDA regarding autonomy, responsibility, and authority to work as DPO. The organizational structure of the DPO does not include technical staff that could provide specialized on-the-job training. The differences across pilot governorates regarding fulfillment of set policies related to DPO organizational structure indicates difficulty in reaching "universal model for DPO" that could be applied to all governorates. ▪ According to FHM the service providers get performance-based incentives but not the district staff. ▪ The relation between the health district and the district hospital is not clear.
Opportunities:	**Challenges:**
▪ There are potentials that could promote the DHA to improve performance as in Menofia. District approach is the best approach for community mobilization, and optimization of the use of local resources as private and NGOs sectors	▪ Vertical program supervisors are working according to MD 75. In case of submitting report on FHM facilities, the supervisor gets the incentive, but not the service providers. This increases the number of supervisors to the health facilities without fulfillment of the requirements of constructive supervision. ▪ Local Population Councils (LPC) do not show any support to DPO in providing license to build new health facilities. LPC interference in the process of redistribution of the health district staff and health facility staff presents a major challenge for manpower distribution. Therefore, the pressure of the local authorities limits any improvement in the organizational structure of the DHA.

7.5.2 Costing, financing and purchasing of RH-Services

Strengths:	**Weaknesses:**
▪ Service providers consider cost-sharing is necessary to get their incentives, and to have sustainable financial resources to ensure availability of supplies for quality services (e.g. materials for infection control, drugs etc.).	▪ The link between cost-sharing per consult visit and paying to join the family roster, make people feel that they pay a lot per visit. They also consider that the private doctor is more cost-effective. ▪ The concept of health insurance and cost sharing is not properly marketed for at all levels. The ideas as risk-pooling, solidarity in health care are not clear among health personnel at the health directorate level and other levels. ▪ There is no clear announcing about the price policy for RH-services, especially what are the free services and what are the paid services. ▪ There are complicated procedures for exempting the poor to ensure equity. This could limit access of poor women to seek RH-services.
Opportunities:	**Challenges:**
▪ Having two levels of prices per consultation i.e. LE 3 per visit to rostered families and LE 5 to those non-rostered families could motivate people to contribute in the health insurance program.	▪ Applying cost-sharing in FHM facilities and not in other PHC facilities and hospitals could lead to client shift to cost-free facilities. ▪ The culture of risk-pooling, cost-sharing in public facilities is not well developed among the served communities. ▪ The FHF role in controlling the functions of the FHM facilities, with more emphasis on cost-revenue, may restrict the FHM staff to pay attention to some RH- free services.

7.5.3 Human resources development

Strengths:	**Weaknesses:**
▪ Pre-service training in Family Medicine, include integrated RH-services training. ▪ Having well-defined terms of reference for the staff working in FHM. ▪ The facilities have female physicians, who demonstrated less turnover. ▪ Linking performance with incentive system and accreditation, ensures availability of physicians in the facilities and less probability for turn over.	▪ Not all the family physicians are trained in family medicine. ▪ The training in FP is not satisfactory being for one week only, with two days practical training and 30 participants per course. ▪ The selection of physicians, with different background specialty, to be family physicians could result in ineffective performance in RH-services. ▪ Contracting with selected personnel to work in the FHM facilities, while allowing for other staff personnel to be affiliated to the facility-with no access to the incentive system- results in developments of opponents to the FHM at the facility level.

Strengths:	Weaknesses:
	▪ The FHM is depending on community workers during the phase of enlistment of families, development of family folders and marketing for the service. However, community workers are not included in the FHM organizational structure. ▪ The nurses who are prepared to provide health services and become "extra nurses" in the FHM have a new job in health education through home visits. Their role in marketing for FHM is questionable, being out of the facility service providers' team. ▪ The health facility staff suffers from shortage of nurses who are needed for specific services as immunization sessions, at the same time regulations enforce nurses to work as home visitors.
Opportunities:	**Challenges:**
▪ The success in introduction of family medicine as an important medical specialty in Egypt medical schools ensures adequate supply with family medicine specialists. ▪ Doctors are motivated to have postgraduate specialty in family medicine to access to three opportunities: contracting with FHF, having job in Arab countries, and high salaries compared with clinical specialties. ▪ The MD75 prepare health teams in the PHC facilities to improve performance in integrated service delivery and expand the incentive-performance based system. This step prepares the health manpower staff for the coming health reform/FHM. ▪ The MOHP-National Institute of Training in Cairo has the capability for capacity building in TOT in family medicine.	▪ The total number of FM specialists needed to cover FHU in Egypt is about 14000 physicians, which need several generations of medical school graduates. ▪ The concept of family physician that provides all types of services is not accepted by the community, as the community considers specialize physicians are technically competent.

7.5.4 Supervision system

Strengths:	Weaknesses:
▪ Integrated supervision is one of the important characteristics of FHM. Supervision includes all the health facility staff. Findings of supervision visits are linked with performance score and the incentive level.	▪ The concept of "supervision to help" is not there. It is supervision to assess/control performance to decide on incentive level. There is no on-the job training. ▪ Due to the current parallel system, FHM facilities' staff could be supervised by FHF and DPO, in addition to supervisors from the central, governorate and district level according to MD 75. Multiple supervision visits could affect the FHM facilities' staff time allocated for service delivery.

Strengths:	Weaknesses:
	▪ Despite the importance of the role of DPO in supervision, FHF supervision predominates. FHF being an agency located at the health directorate level, with limited staff members' number, they do not have enough staff to cover the governorate health facilities. ▪ The checklist used by FHM supervisors does not include enough items to cover RH-services.
Opportunities:	**Challenges:**
▪ The supervision system which had been developed by the MOHP/PS and includes clinical supervisor e.g. Obstetrics and Gynecology specialist from the district hospital proved to be effective in on-the job training and establish strong channels between the health units and the district hospital.	▪ Due to phasing out of donor support to RH-programs, there is shortage in the fund necessary for training of supervisors on supervision of RH-services, . Therefore, qualified RH-supervisors are decreasing over time. The technical-performance supervision decreases over time for both FHM and other facilities.

7.5.5 Management information system

Strengths:	Weaknesses:
▪ Some FHM facilities have computers to develop data base for service statistics. ▪ FHM –MIS includes data on RH as well as indicators on RH.	▪ fixed target for the physician to get the incentive could influence the quality/accuracy of recorded data. ▪ The data in the family folders are not enough to respond to requirements for development of M&E indicators for RH services. ▪ More paper work could influence the technical/clinical performance of physicians. ▪ Some health facilities do not have electricity or telephone lines for establish MIS network across different levels. ▪ HSRP-MIS links between the health facility and the central level, and bypass the district and governorate level. The health directorates suffer from that unrevised data, and according in case data needed about the health unit, the directorate has to contact the central level. ▪ Each physician has specific output data related to the rostered families. To have data about performance of the health facility, compiling of data from physicians' records has to be done (there is no special logbooks for the different programs). Therefore, vertical programs MIS continue its role to develop M&E indicators, as a parallel system, with more paper workload on the FHM staff. Inaccuracy and incomplete data could be an outcome.

Opportunities:	Challenges:
▪ The enlistment of families and development of family folders provide rich source of data that could help in assessment of RH-services for each family, as well as planning for different health services at the facility, district, and governorate level. Also it could provide material for monitoring and evaluation of the FHM.	▪ Adding more formats to respond to vertical programs' needs to develop M&E indicators increase the paper work for the FHM staff.

7.6 SWOC Analysis of the Role of FHM in Improving the Health Services Provision for Reproductive Health Services

7.6.1 Physical infrastructure of the health facilities

Strengths:	Weaknesses:
▪ Improving the work environment is achieved through renovation, good furniture as well as building new facilities according to specific standards. This situation resulted in satisfaction of both the service providers and the beneficiaries. Care given to physicians' residency motivates doctors to stay longer in the facilities, and not to travel frequently to their home city. ▪ The new design of having family medicine clinics, rather than one clinic for each vertical program, ensures efficient use of the space to serve more RH-clients (as shown from the utilization pattern).	▪ There is no special clinic for FP services delivery. ▪ There is no special room for FP-counseling (Nurse-client interaction). ▪ No waiting area for FP clients. ▪ No special room for oral rehydration. ▪ The location of the lab does not allow for adequate ventilation. ▪ There is no good maintenance system to the equipment (Sonar in Menofia). ▪ The money allocated by FHF is not enough to provide supplies for maintenance of the health facilities especially to satisfy the requirements for infection control.
Opportunities:	**Challenges:**
▪ FHF provides resources for maintenance of the facilities. Those financial resources will increase with expansion in the volume of families enrolled in the model.	▪ Time and resources are needed to expand and maintain the model. The increase in the number of FP clinics which occurred in year 1997 and after (from 2255 FP clinics in 1996 to be 3827 clinics in 1997 and 5047 clinics in 2005, and 5034 clinics in 2008) is due to establishment of FP clinics in the hospitals including fever hospitals, endemic disease hospitals, etc. If the health system is going to depend on FHM facilities for FP service delivery, those clinics have to be excluded from the system and could result in drop in the volume of utilization of FP services. ▪ Maternal care services are delivered to about 11% of females in the child bearing period, but FP services are planned to cover more than 70% of married females in the child bearing period.

7.6.2 RH- health commodity system

Strengths:	**Weaknesses:**
▪ FHM succeeded in ensuring the availability of essential drugs, including those for RTIs for males and females, as well as vitamins and minerals necessary for MCH services. OCs, and Injectables are included in the EDL.	▪ Not all the FHM facilities have enough drugs, and there is shortage in some drugs for management of RTIs for males and females. ▪ The link between having family folder and receiving medications limits access of people to different essential drugs. Patients have to pay for RTIs drugs, which had been dispensed freely in the same health facility before being FHM. Some people, especially women do not receive the treatment.
Opportunities:	**Challenges:**
▪ The governmental role in supporting the supply of the FHM facilities, immunizations and MCH vitamins and minerals and FP methods ensure that RH-services and supplies are accessible and free of charge to all people.	▪ In this transition phase of donors' phasing out, still there is immature experience in maintaining quality FP methods logistics/procurements system. The RH-services delivered in the FHM could be affected by the quality of FP methods made available by the vertical programs, at the MOHP-central level. ▪ The HSRP plan to make DPO responsible for FP methods procurement and logistic system are expected to confront many challenges. ▪ There is a negative culture concerned with rationalization of use of drugs among both the service providers and the community. Patients have to buy extra drugs from private pharmacies.

7.6.3 FHM Facilities' staff performance in RH-services

Strengths:	**Weaknesses:**
▪ HSRP succeeded in development "practice guidelines for family physicians" to be used by all family physicians in all facilities. The guidelines are included in well-designed books that include information about all services including RH services. ▪ There is a job description for each member in the FHM facility.	*Weakness related to "practice guidelines for family physicians":* ▪ The MOHP/vertical program managers consider the guidelines look like the text books (with extensive theoretical background material) and there are no protocols that facilitate practical performance in the clinic. ▪ The FP manual has been available in each facility as "loose leaves", to allow exchange papers and add new papers including updated information. However, the current family medicine guide looks like "textbook". *Weaknesses related to the job description: The job description related to RH-services is not clear* ▪ The term "family planning" was mentioned once in the job description of the family physician: "7 -Cares for the pregnant women during the whole pregnancy period and provides advice and assistance with family planning".

Strengths:	Weaknesses:
	▪ The term "family planning" is mentioned twice in the FHM nurse's job description: "24-Supervise the delivery of care at specialized clinics to clients at unit or center: Maternal and child health, Normal/Sick child clinic, Family health clinic of all age groups, Family Planning Clinic, etc. ▪ "27-Ensure that patients are provided informed choice in relation to the provision of family planning method". ▪ The job description of the social worker include 18 items, out of which 2 items had specified RH-services: (duty No. 8 : identifying the children who missed vaccination by asking mothers coming for ANC) and (duty No. 17: assisting in awareness of women visiting the unit regarding FP and breast feeding). The job description of the social worker has no items related to outreach home visits to cover items related to RH-services. ▪ The service providers are not aware about the job description.
Opportunities:	**Challenges:**
▪ There are opportunities to update the job description and preparing manuals and protocols. The practice guidelines is used now for training the house-officers in Cairo University, and feedback from such training could help in updating.	▪ Before the FHM, there were PHC directors at the district level, who represent experienced personnel due to previous working in the health units. Currently, there are no family medicine directors at the district level who could transfer experience to health unit staff, evaluate the job description, and adjust the standard of practice. Therefore, none of the studied facilities have "well-defined standard of practice" to be applied to all.

7.6.4 Integration of services

Strengths:	Weaknesses:
▪ The availability of all RH-services on daily basis and in or more than me shift (e.g. not according to special schedule) facilitates the opportunity to get more than one service during single visit to FHM. Additionally, the presence of both consultation services, management services including dental care and ancillary services (e.g. lab services, pharmacy services) motivate people to receive more than one service from the same facility. ▪ Exit interview data showed that 26% of the clients in the FHM receive more than one service during a single visit to the FHM. RH services form two thirds of the received services.	▪ To assess integration of RH-services the only source of data is exit interview. There is no special records to identify the number of services received by each client. ▪ The MIS data are available on-vertical basis. No information available whether the doctor talked about FP with the mother coming for ANC. ▪ At the clinic level FP/RH, service statistics showed no differences regarding the number of services received per client during a single visit, where in PHC and FHM facilities the average number of services per client ranges from 1.02-1.06 services per client (e.g. getting FP method and management of RTIs, etc.). There are difficulties to link between the recorded data on child care, maternal care and FP services to assess integration. ▪ Paying for RH-services limits access to some services: follow up of IUD, RTIs, management of co-morbidity with pregnancy, etc.

Opportunities:	Challenges:
▪ According to the incentive system, physicians and the health team have to increase the volume of health services. Therefore, they have to promote for different services to ensure receiving more than one service during single visit.	▪ Despite integration could be a concept that is promoted by health planners, on practical basis it could not be applied. The incentive system that consider the number of visits per pregnant mother, does not consider that the doctor talked to the mother about FP, or children immunization-an activity that has nothing to do with performance score/incentive system. On the other hand, the woman coming to get FP method as a continuing user (free- return visit), the doctor may ask her for gynecological examination (paid service) to be sure that she is free from RTIs. Such doctor's behavior is considered as supporting integration, where the woman received two services. ▪ The concept of integration is not client-behavior. Clients do not plan to get more than one service during single visit. This needs specific approach to raise awareness about integration. The service providers have to contribute in motivating clients to receive more than one service during clinics' visits.

7.6.5 Referral services

Strengths:	Weaknesses:
▪ The FHM included referral services between FHU, FHC and referral hospital (for ambulatory cases and emergency cases only). There are specific services to be delivered at each level within the BBP.	▪ Setting specific target for referral/per physician could have negative effect on the served community due to rejection of emergency cases due to quota completion.
Opportunities:	**Challenges:**
▪ The payment (low price) for specialist services for the rostered families, ensure compliance to referral system. The high medical specialist cost that should be paid by the non-FHM enrolled families, limits the process of by-passing the FHU to get the service in the referral hospital.	▪ There are no special policies in the hospitals to limit their services to referred cases. Consequently, referral services have no benefit so long as patients could go directly to hospitals even for minor conditions that could be treated at the PHC level, and receive comprehensive services including specialized professional services.

7.6.6 Quality of RH services

Strengths:	Weaknesses:
▪ FHM consider total quality management and continuous quality improvement through accreditation and incentive system. FHM model succeeded in having high proportion of clients with characteristics that constitute potential for success of RH-programs. In FHM facilities, there is increase in the proportion of new FP clients, young FP clients, low parity clients and IUD users. Additionally, there is reduction in the percentage of clients suffering from FP methods side effects. FHM facilities could withstand any general-health system-related problems that could negatively affect the service delivery, and keep reasonable pattern of annual increase in the volume of RH-services. ▪ Despite coverage of the served community with ANC services is less in the FHM compared with PHC facilities, almost of the FHM-ANC registered mothers had reported 4 regular ANC visits.	▪ Quality of services is incentive-linked and not associated with development of the culture of quality. The link between accreditation and contract with FHF, and periodic exposure to periodic assessment to maintain the accreditation, keep the staff under stress and job dissatisfaction.
Opportunities:	**Challenges:**
▪ Currently all Egypt health facilities are exposed to integrated supervision (MD 75) that ensure quality services in the PHC facilities. Consequently, the health teams will be prepared to adopt the attitude of continuous quality improvement. ▪ The MOHP goal of achieving accreditation to all Egypt health facilities by year 2020, had motivated the health services managers at the governorate levels to improve quality of health services to achieve accreditation and subsequent contracting with FHF. ▪ The accreditation process is very sharp, and could exclude FHM facilities which achieved accreditation before. This periodic filtration of health facilities ensures quality improvement.	▪ To insure continuous quality improvements, and expand the accreditation process, financial resources are needed.

7.7 SWOC Analysis for the Role of FHM in Demand Creation for Reproductive Health Services

The FHM capitalize on the well-established awareness about RH-services delivered in the PHC facilities, whose role is now FHM facilities. Therefore, demand creation strategy adopted by the FHM is through providing quality services that motivated people to utilize the different RH-services. The following are SWOC analysis of the FHM strategy in marketing for RH-services and its implication on increasing utilization of RH-services.

Strengths:	Weaknesses:
Knowledge about RH-services delivered in the FHM facilities ▪ ***Awareness about FHM-RH services:*** All FHM clients could mention at least 3 out of the total 13 RH-services delivered in the FHM facilities. ▪ ***Perception of specific FHM-RH-services by the clients:*** Clients could recall the package of FHM-RH-services as immunization (75%), FP (68%), ANC (58%). ▪ ***Service providers and community workers*** are the major sources of knowledge about FHM facilities' services to the FHM-rostered families. ▪ ***People utilized the FHM facilities disseminate information about FHM services:*** 40% of the FHM-rostered families know about the FHM from people in the community. ▪ ***Higher proportion of FHM-rostered family has information about all FHM-RH services:*** For all (13 RH services), high proportion of FHM rostered families has knowledge about FHM-RH services than the non-rostered families. .	**Knowledge about RH-services delivered in the FHM facilities** ▪ ***Lack of perception of specific FHM-RH-services by the clients:*** Minority of the clients could recall some reproductive health services where less than 2% of the clients mentioned premarital care and management of: RTIs for men, adolescent health problems and infertility. ▪ ***Community workers are the major source of information about FHM-RH services to the rostered families:*** The community workers are not included in the organizational structure of the FHM, despite their role as channel for communication with the community. ▪ ***No clear price policy:*** There is no universal information about the price of different services in the FHM facilities, even for the free services as immunization. ▪ ***Unsatisfactory approach during introduction of the FHM to the community:*** the process of enlistment and completing family folders are not coupled with proper informing the community about FHM.
Attitude of the Community for RH-services Delivered in the FHM facilities ▪ ***High acceptability to receive RH services in the FHM facilities:*** compared to other health facilities there is high acceptability to receive specific services in the FHM facilities: children immunization (97%), FP (81%), child care/IMCI (70%-77%), ANC (75%). ▪ ***Geographic accessibility:*** (81%) of FHM facilities' clients consider that the facilities are accessible. ▪ ***Capitalizing on already available facilities:*** upgrading the PHC facilities to be FHM, is an investment of people previous experience/knowledge/utilization of the facilities (91% of the clients had previously used the facilities). ▪ ***Generally people consider the FHM facilities provide quality services:*** 91% consider that FHM facilities provide good services.	**Attitude of the Community for RH-services Delivered in the FHM facilities** ▪ ***Low acceptability to receive some RH-services in the FHM facilities:*** people expressed their preference to receive some RH-health services in health facilities other than FHM as management of: infertility (90%) male RTIs (80%), premarital counseling (70%), male and female adolescent health problems (60%). ▪ ***Quality of FHM services is not the driving factor to use RH-services:*** Only 5% and 2% of women prefer the FHM facilities for FP and ANC services respectively due to their quality , versus 50%, 86% who consider that other facilities provide quality FP services, and ANC services respectively. ▪ ***Fewer percentages of FHM-rostered families will do social marketing to FHM services:*** despite the overall satisfaction was expressed by 91% of the rostered families, only 52% will tell others about FHM services. ▪ ***Lack of qualified medical services to deal with male health problems:*** no male physicians in some facilities, shortage of medications for male RTIs.

Strengths:	**Weaknesses:**
▪ ***People feel marked difference due to change from PHC to FHM:*** the community consider that FHM staff become good communicators with the clients, more drugs, more lab services, more equipment, clean environment, follow up services, referral services. ▪ ***Women appreciate the client/patient flow:*** women appreciate the organized service which include : getting folder, clinical examination and receiving treatment in a very short time. ▪ ***Shift from private to FHM facilities:*** The improved quality had motivated women to shift from the private to FHM.	▪ ***Satisfaction index from FHM-services is 23% among roistered families:*** There high compound satisfaction index reflects satisfaction from geographic accessibility (67%), accessibility of the service (4%), Quality of service (11%), integration (2%), Comprehensiveness of services (2%), continuity of care (1%) and overall satisfaction/marketing (72%). ▪ ***Unsatisfactory Technical performance is a major cause of community dissatisfaction from FHM:*** shortage in having specialized physicians in the FHM reduces convenience of community towards the Family Physician performance. Two thirds of the FHM-rostered families consider that unspecialized physicians in the FHM could lead to underutilization. ▪ ***Cost-sharing is an obstacle for utilization of FHM facilities:*** the switch from free service to cost-sharing in the same facility causes dissatisfaction. About one third of the FHM-rostered families consider that the services received from private physicians are more cost-effective. ▪ ***No youth friendly services:*** Adolescent girls consider that FHM facilities' staff is not qualified to communicate and respond to girls' health problems.
Opportunities:	**Challenges:**
Knowledge about RH-services ▪ ***Universal knowledge about children immunization:*** the prevalence of knowledge about children immunization is 100% in all communities. ▪ ***Universal knowledge about FP methods:*** the prevalence of knowledge about FP methods is 99% in all communities. ▪ ***High level of knowledge about ANC:*** The prevalence of knowledge about ANC ranges from 91% to 100%. ▪ ***High level Knowledge about health care to adolescents/youth:*** The prevalence of knowledge about youth health care ranges from 75% to 90%.	**Knowledge about RH-services** ▪ ***Variation in the Socio-economic standards across communities served by FHM facilities:*** the differences across the studied five communities in socioeconomic background indicate variation in the level of knowledge about RH, and the needs for specific interventions for each FHM-community. ▪ ***Lack of knowledge about premarital care***, as observed in FHM-catchment area in Alexandria (93%). ▪ ***Postnatal care,*** as observed in all the studied communities except Quena. ▪ ***Safe delivery,*** as observed in Souhag and Suez. ▪ ***STDs,*** The prevalence of knowledge ranges from 52% (Menofia) to 84% (Suez). ▪ ***Lack of Epidemiological Information about the prevalence of RH-problems of youth:*** the shortage in information about the prevalence of RH problems among male and female youth in each FHM community makes difficulty to assess needs, and unmet needs for youth RH-care.

Opportunities:	Challenges:
Attitude of the FHM community towards RH-services ▪ ***Positive attitude towards child care:*** More than 90% of the FHM communities feel the importance of medical consultation in case of children's diarrhea (95%) and ARI (91%).	**Attitude of the FHM community towards RH-services** ▪ ***Lack of knowledge about importance of health care to male and female youth:*** half of the FHM communities do not know or feel the importance of health care to youth males. ▪ ***Geographic accessibility is not a major concern of clients:*** Private health facilities and public hospitals outside the village/city are the first choice to seek medical care. FHM ranks the fifth choice (7% visited the FHM facility in the last year). ▪ ***The society does not accept seeking RH-services by adolescent girls.*** ▪ ***The culture of risk- pooling and cost-sharing is not well-developed in the community:*** the concept of social insurance and solidarity, paying/cost-recovery to get quality care even in a public facilities are not clear to the public.

KEY FINDINGS AND RECOMMENDATIONS TO INCREASE UTILIZATION OF RH –SERVICES IN THE FHM CLINICS 8

KEY FINDINGS AND RECOMMENDATIONS

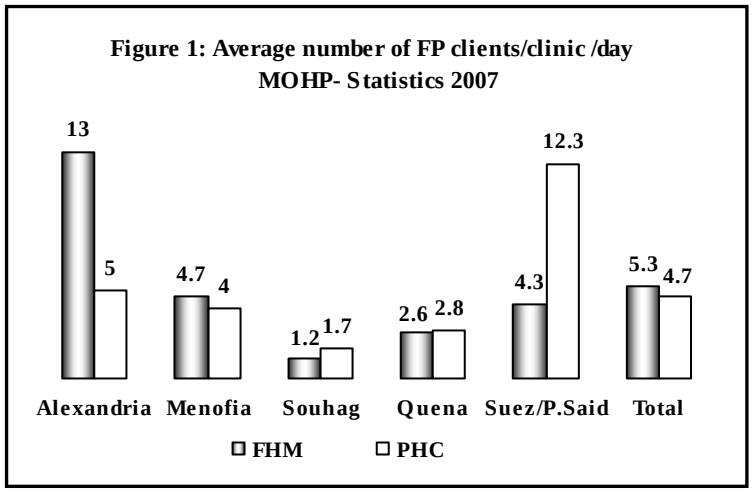
The study findings showed that the FHM compared with PHC has challenges that restrict its role in making substantial positive impact on RH-services utilization at the health facility level or at the community level. This situation is due to the articulation of different factors at the policy, programmatic, operational and community level.

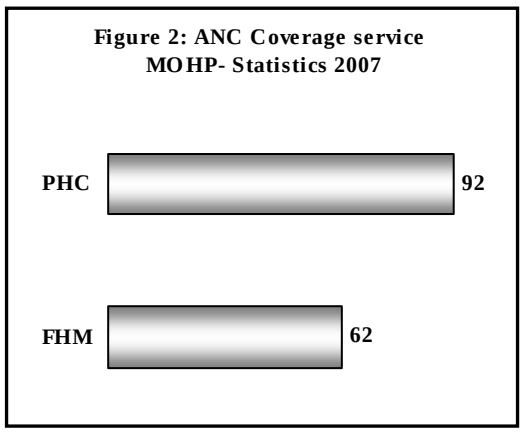
The following are the key findings, suggestions and guidelines to develop interventions at the policy, programmatic and operational level that aim at increasing the utilization of RH-services in the FHM clinics.

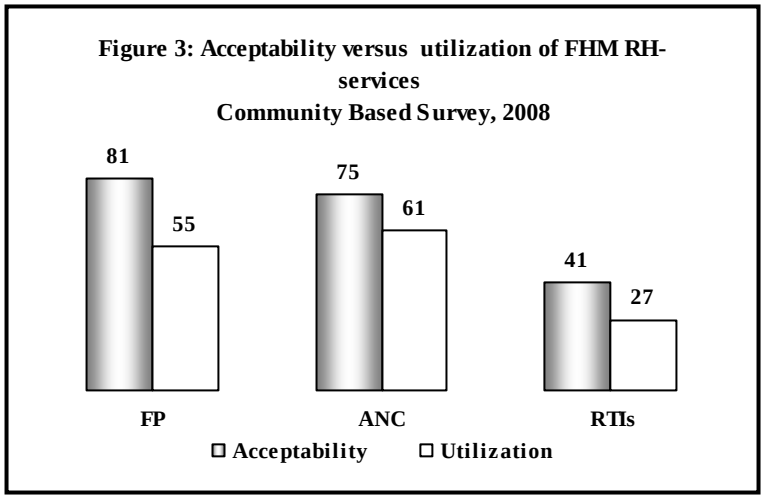
8.1 POLITICAL AND PROGRAMMATIC SUPPORT TO RH-SERVICES PROVISION THROUGH FHM

1- FHM does not offer enough support to improve RH-services utilization during the transition phase from donor-supported to self-reliant programs

- In the current transition phase from the donor-dependent to self-reliant RH-programs, both the FHM and PHC facilities had static profile of low efficiency in RH-service utilization. The current political support to RH programs is included as implicit policy in the FHM. Therefore, RH-issues which were having explicit policy and targets had lost advocacy at both the health facility level and community level.

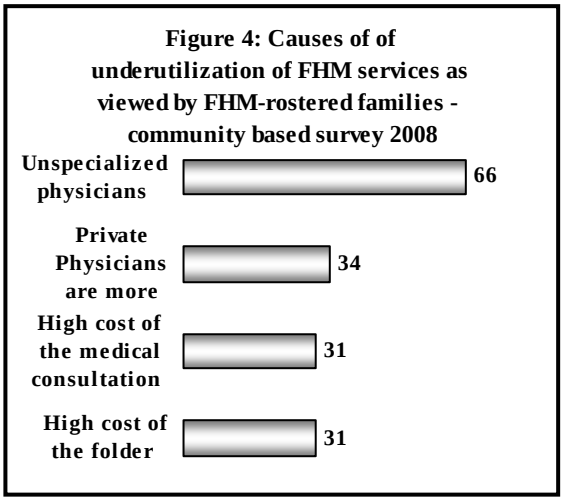






- There is no updated HSRP document that includes all RH-program goals, targets, strategies, after 9 years of experience (1999-2008) in the pilot governorates. The available HSRP documents include compiled MOHP/vertical programs' goals and strategies set in year 2000. Vertical programs' documented strategies which had been set in year 2000 do not consider the principles of HSRP.

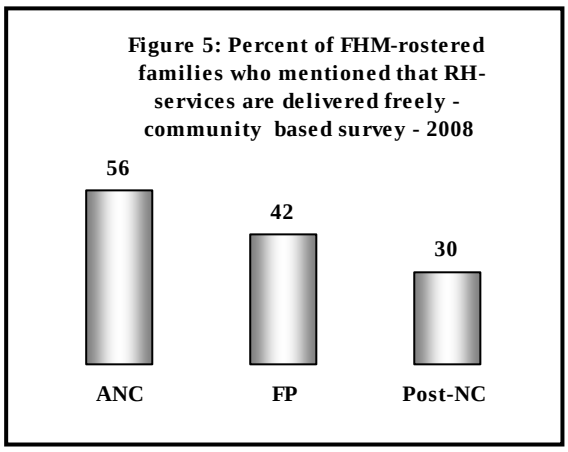
- The Egyptian community believes in specialization in medical practice. The non-acceptance of receiving services from unspecialized physicians (general practitioners of family physician) is one of the major causes of not using the different types of PHC services. The FHM facilities which apparently organize their clinics as: clinic 1, clinic 2, clinic 3 etc., operationally work as specialized clinics for FP, child care, maternal care etc., to be accepted by the community.



- There is no clear role for the MOHP staff working in the vertical RH-programs (at the central, governorate, and district level) in the HSRP.

- It is difficult to find out in any of the 5 HSRP pilot governorates a FHM capable in demonstrating increased efficiency of the health facilities in providing RH-services. The situation is attributed to lack of enough flexibility in operational policies and planning in the FHM facilities as demonstrated in the following examples:

  - FHM consider fixed targets for the family physician according to the system of the "performance based incentives".
  - FHM operational policies do not consider variability across governorates so as to design mechanisms to increase RH-services utilization in priority



governorates that have challenges in implementation of RH-programs as Upper Egypt Governorates.

- The policy of restriction of free-RH services to those included in the FHM- roster, with annual payment system for health insurance, limits accessibility to RH-services.

Recommendations:

DEVELOP AN UPDATED DOCUMENT: "POLICIES, STRATEGIES AND PROCEDURES MANUAL FOR RH-SERVICES PROVISION IN THE FHM FACILITIES"

Suggested contents of the updated FHM-RH services document:

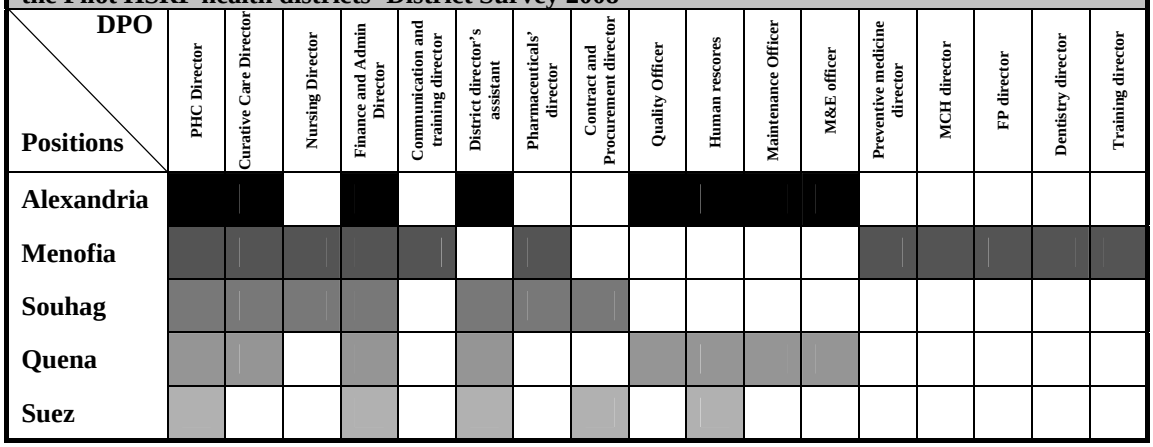
- Importance of FHM in providing integrated health services including RH-services at the three levels: FHU, FHC and District hospital.
- How FHM fulfill the sustainability potentials of RH-services, especially with phasing out of the donors' support to the RH-health vertical programs.
- Goal, mission, objectives, specific health status targets related to RH-services and strategies of the FHM to achieve the targets.
- Role of MOHP at central, governorate and district level, in setting policies, regulation and monitoring and evaluation of RH programs.
- Mechanisms of responding to the regional variations regarding the challenges that confront RH-programs to make FHM more proactive to respond to such challenges.
- Policies and regulations related to manpower management including qualification and clear job description in RH-services.
- Training system and training contents in RH-services according to the national standards.
- The supervision system and on-the job training.
- Pricing policies for the different health services and RH-services.
- The monitoring and evaluation indicators.

MOHP-PHC Department, being responsible for FHM has to manage a **taskforce** to develop this document. This document is necessary to be circulated at all MOHP departments and at the central and local levels.

2- There is no adequate preparation of the environment within the MOHP to support RH-services through the FHM

- There is no enough involvement of the MOHP-staff at all levels, especially those involved in the RH- programs, during setting plans and targets for FHM-RH services.
- The general perception of the MOHP staff that the HSRP program is a new vertical program that merges all MOHP services in the FHM, with subsequent reduction of interest to support the national RH-programs.
- There is inadequate information about the ideology of the FHM and health insurance among health program's managers at all levels including the pilot governorates as well as the served community.
- There is no unified FHM applied in the 5 HSRP pilot governorates regarding the staff pattern (Figure 6), availability of some drugs, equipment, etc. This issue raises the question of what is the profile of the FHM that intended to be rolled out.

Figure 6: The variability in the organizational structure of the DPO (17 DPO job-posts) across the Pilot HSRP health districts- District Survey 2008



- There is incomplete implementation of the FHM to cover one district or a whole governorate to demonstrate a unique model capable in overcoming the challenges related to provision of quality integrated services. At the same time dependence of the FHM facilities on the vertical programs (e.g. supply of FP methods) and exposure of the FHM to vertical program activities (e.g. supervision), had made confusion and conflicts at all levels. This could also result in difficulty in measuring the impact of "pure FHM" on RH-services utilization.

Recommendations:

CONDUCT NATIONAL CONFERENCE TO RAISE AWARENESS OF MOHP STAFF ABOUT FHM AND ITS ROLE IN RH-SERVICE PROVISION

Goal and objectives of the National MOHP Conference:

Goal: Sustainability of RH-services provided in the FHM facilities, through support of all the MOHP departments

Objectives:

- Demonstrate the role FHM in providing sustainable RH services,
- Present and discuss the document prepared in the previous recommendation to come into common understanding of the FHM role in supporting RH-services utilization.

8.2 UNIVERSAL COVERAGE WITH RH- SERVICES THROUGH FHM

1- There is inadequate coverage with RH-services through the FHM

- FHM is population-based planning (i.e. one family physician for each 1000 families) and not catchment areas-based planning (i.e. a PHC facility serves a specific catchment area). Therefore, good proportion of the urban families, who are resident within FHM-catchment areas that have high population density, could not be included in the FHM-roster, with less opportunity to access to RH-services (Figures 2).
- Low demand and underutilization of some RH-services as postnatal care, premarital care, adolescent and men reproductive health problems are attributed to non-inclusion of some services in the BBP, as well as lack of adequate promotion for such services.
- There is low coverage with ANC services especially in the urban governorates (Figures 2).
- Health Insurance (joining the FHM-roster) is a prerequisite to get free RH-services.

- Some families do not know about the FHM-fee exemption system.
- Women in governorates as Souhag and Menofia prefer monthly injectable contraceptives which are not provided at the public sector facilites and not included in the Essential Drug List (EDL). Also, IUD coper not included in the EDL.
- Girls expressed their dissatisfaction from the way they had been treated by service providers in the FHM facilities. Girls conveyed that service providers have not been properly prepared to deal with adolescent's health problems.
- The topic of Adolescents' health problems is included with the adult problems in the BBP.
- Health services as management of RTIs and services provided to adolescents are not included in the performance based indicators. Therefore, service providers pay less interest to such cases and there is no effort to raise demand for those who need the service.
- Cultural factors play a role in restricting access of girls to FHM services. Also cultural factors hamper seeking services for RTIs management among men in a health facility in the same village.
- Females who have RTIs do not seek care due to financial constraints for medical consultations and the cost of the drugs. Management of female RTI had been provided freely in the FP-PHC clinics.
- Despite the needs for active contribution of NGOs and the private sector in the FHM to cover the population with BBP, there are some limitations to build up this partnership in the pilot governorates.

Recommendations:

IMPROVE UNIVERSAL COVERAGE WITH BASIC HEALTH SERVICES INCLUDING RH-SERVICES THROUGH FHM- THROUGH revising and updating the BBP, EDL and national health insurance policies

1- Revised and updated BBP has to consider the following items:

- Supplementation of mothers in the postpartum period with iron preparations and for 3-6 months.
- Premarital check up services (Rh testing, other medical screening).
- Management of adolescents' health problems related to delayed puberty, dysmenorrhea, and menstrual disorders.

2- Revised Essential Drug List has to consider the following items:

- Add monthly Injectables and IUDs to the essential drug list.
- Have clear logistic management system for RH-medications and supplies: e.g. contraceptives, vaccinations, vitamins and minerals to pregnant women, and drugs used for management of RTIs.

3- Updated information related to FHF has to consider the following items:

- All policies and procedures related to enrollment in the FHM-roster should be clear.
- Announce the criteria for exemption of the poor.
- Identification of the RH-services that should be delivered free of charge to the clients.
- Consider providing medications for cases with RTIs free of charge.
- RH-services have to be delivered freely whether the family is joining the FHM-roster or not i.e. providing the service for those insured and non-insured families.

4- Set mechanize to encourage private and NGO sector to participation in family health program.

5- Revised and Updated Performance-Based indicators and targets : suggested targets to be added are the following:

- Average number of newly registered mothers for ANC per month is about 11 women /physician. This is in case of having 100% ANC coverage for 1000 families/physician and a crude birth rate at 25 live births per 1000 population.
- The average number of mothers registered for postnatal care per month is 11 women/ physician. This provides postnatal care coverage at 100%
- The average number of newborn children registered for neonatal care per month is 11 newborn children /physician. This provides neonatal care coverage at 100%
- The average number of FP clients per month/ family physician is 42 clients as current and/or new users (to keep CPR at 60% among MWRA in 1000 families).
- The average number of women seeking management of RTIs per month is 28 women /physician (the prevalence rate for RTIs is 40%).
- The average number of female youth (15-24 years of age) who receive FHM-services is 8 girls: According to the current study, for each 1000 families, about 100 girls (15-24) demand RH-services.

In case of having complete population-based planning, and achieving the above mentioned targets, coverage with RH-services could be ensured. However, performance should not be linked with the incentive system, so as to keep transparency and reliability of the service statistics.

8.3 IMPROVE ORGANIZATION AND MANAGEMENT OF THE HEALTH SYSTEM

1- There is no clear role for the MOHP- technical departments (population/FP and MCH) in the FHM

- MOHP-HSRP documents do not include information about contraceptive security and the role of MOHP-PS in FP methods contraceptive logistic management.
- MOHP-HSRP documents do not include information about the mechanisms of continuous updating the national standard of practice in RH-services.
- MOHP staff members affiliated to FP and MCH departments is working according to MD 75. This restricts their role in supporting RH-programs based on their professional experience.

Recommendations:

REFORM THE ROLE OF THE MOHP –HQ TECHNICAL DEPARTMENTS TO SUPPORT RH-SERVICE DELIVERY IN THE FHM FACILITIES

Suggested roles of the MOHP-HQ technical departments in the HSRP:

*** Role of the MOHP/PS/FP**

- Procurement and logistics management of FP methods.
- MIS for FP services.
- Setting the standards of practice in FP services.
- Setting standards for management of RTIs.
- Setting standards for management of adolescent male and female RH–problems.
- Setting standards for providing premarital care services.
- Periodic review the BBP to ensure the availability of FP methods according to contraceptive technology update.
- Monitoring and evaluation of FP program.
- Manage the conduction of operations research and programmatic research in FP.

*** Role of the MOHP/MCH**

- Ensure the availability vaccines and maintenance of the cold chain.
- Planning, monitoring and evaluating different vaccination cpmpaigns.
- Setting the standards of practice in MCH services.
- MIS for MCH services.
- Ensure the availability of MCH services in the BBP.
- Monitoring and evaluation of MCH program.
- Manage the conduction of operations research and programmatic research in MCH.

2- The District Provider Organization (DPO) has many challenges to support FHM-RH services

- The Health District represents the mid-level management and its involvement in the FHM is pivotal for decentralization of management of health services. However, the profile of this system is not clear in the pilot governorates due to lack of commitment to major principles.
- The DPO organogram varies across the HSRP pilot governorates, which raises the question about "the successful model" to be rolled out in Egypt 260 health districts (Figure 6).
- DPO confront many internal challenges related to the organizational structure and the needs for capacity building and to have new skills in marketing and negotiations,
- DPO confront many external challenges due to less autonomy, exposure to pressure from local authorities in addition to the shortage of the DPO resources.
- The DPO has negligible role in decision-making regarding the allocation of service providers, distribution of drugs and equipment across the health districts' facilities.
- The previous role of the district in supervision, MIS, on-the-job training in RH-vertical programs is no more operating within the FHM regulations.
- About 29% of the family physicians are not trained in family medicine. The service providers are not aware about their job description.

Recommendations:

SUPPORT THE ROLE OF THE DPO IN MANAGEMENT OF FHM SERVICES INCLUDING RH SERVICES

*** Suggested DPO mission:**

Management of strategic planning to improve health status of the population at the district and action plans at the health facility level, Cooperate with the other health-related organizations and other health organizations (e.g. NGOs and the private sector) within the district, Cooperate with other health districts and health directorates in issues related to the national health programs, Preparation of database which include all types of health facilities within the district, and a database which include information about health workforce by specialty and workplace for continuous update of needs assessment, Upgrade the district MIS, Monitoring and evaluation of the FHM facilities performance according to specific indicators, Management of the administrative and clinical supervision system to the FHM facilities, Management of the research projects (operations research and programmatic research) at the district level.

*** Suggested DPO Organogram**

The DPO organogram has to be composed of 9 posts with specific job description:

1- DPO director:

- Management of DPO daily activities according to the set mission.
- Management of strategic planning at the district level.
- Manage the development of action plans by the health facilities.
- Reporting to Health directorate, Family Health Fund (FHF).
- Manage the regularly conducted DPO-staff meetings, review monitoring and evaluation reports and plan proactive interventions.

2- DPO supervision coordinator/officer(Primary Health Care Director):

- Manage the clinical supervision team (curative care supervisor/internal medicine specialist from the district hospital, RH-supervisor/obstetrics and gynecology specialist from the district hospital and nurse supervisor from the health district).
- Prepare the plan/scheduled supervision visits to be conducted by the clinical supervisors.
- Monitor the clinical supervision visits, and review the feedback reports.
- Conduct administrative supervision visits to all the health facilities to ensure fulfillment of the quality standards according to the checklist. He has to help in solving the problems related to drug, equipment and supply shortages etc..
- Communicate with other DPO staff to discuss/solve problems identified during supervision visits e.g. problems related to training, personnel distribution/shortage, marketing, equipment maintenance, commodity supplies etc.,.

3- DPO training officer:

- Conduct training needs assessment of the health facilities' personnel.
- Working with the other DPO training managers at the governorate level to set the training courses contents and the training plan.
- Organize training programs at the district level.

4- DPO manpower officer:

- Ensure that each facility has enough working staff.
- Solve the problems related to allocation of personnel across the health facilities.
- Solve the problems of turnover of the staff.
- Review, orient the health facility staff about job description.
- Communicate decrees and decisions related to manpower management.

5- DPO Marketing and IEC officer:

- Prepare marketing plan to health district facilities to ensure community participation.
- Communicate with official and non-official leaders to orient them about the FHM.
- Communication with NGOs and private physicians to expand FHM at different service delivery points at the district level.
- Prepare the IE&C plan including health education seminars, posters, RR messages and linking of the IEC plans at the district level with the national IE&C plans.
- Manage community–based surveys and facility-based surveys to assess the perception of the community to FHM performance including performance in RH-services, and disseminate recommendations for improving performance.

6- DPO financial manager:

- Review the financial component related to the district and health facilities' plans.
- Set and review the budgeting and accounting system related the district and health facilities.
- Working with the FHF to monitor financial issues related to the health facilities.
- Conduct negotiations with health insurance organizations.
- Set plans for financial sustainability of activities of the DPO and the affiliated health facilities.

7- DPO officer for commodities, supplies, equipment maintenance:

- Review the administrative supervisory reports and take actions accordingly.
- Assess needs of each health facility, and implement interventions for improving the situation.
- Insure having strategic stocks of essential products as contraceptive methods.

8- Nurse Supervisor:

- Conduct supervision visits to the district's health facilities on monthly basis.
- Discuss nurses needs with the manpower officer, and training officer, to ensure job satisfaction of the nurses.
- Discuss different issues identified during supervision visits especially those related to commodities with the DPO officers.
- On-the –job-training of nurses.

9- DPO MIS coordinator:

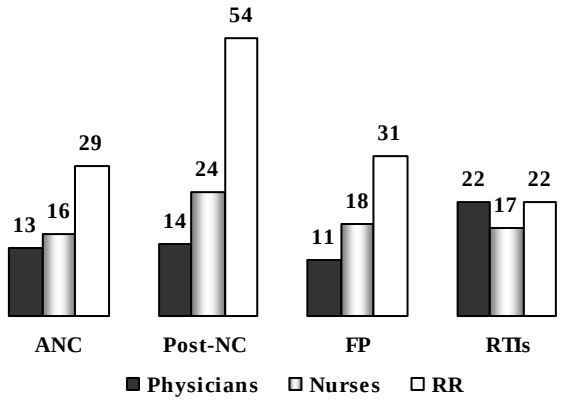
- Compile and verify data received from the health districts' facilities.
- Develop monitoring and evaluation indicators.
- Prepare performance reports.
- Send reports which demonstrate all the health facilities' performance to be reviewed by the directors of each facility to take corrective actions.
- Prepare time-series analysis for different indicators: input, process (quality score, supervision visits), output, and impact indicators (crude birth rate, maternal mortality ratio, infant mortality rate etc.,).
- Prepare synthesis report on key findings and recommendations about all research studies conducted at the district level.

3- There are challenges confronting FHM for efficient management of human resources to improve RH Services utilization

- FHM allows training of physicians from different specialties (e.g. tropical medicine, internal medicine) to be family physicians. Those physicians show interest to provide care to cases related to their original specialty, with minimal care for RH-cases especially FP that needs skills for IUD insertion.
- The FHM pre-service training allocates one week for training in FP, with 2 days for practical training, which are not enough to develop skills in IUD insertion.
- The job description of the family physician in RH-services is not clear for the items related to FP services,
- The community members consider having specialized physician and not family physician, is necessary to receive quality services (Figure 4). In some communities, FHM-rostered families prefer female physician to receive RH-services, and husbands prefer male physicians to deal with men's problems

- The community workers play an active role in informing the people about FHM-RH services. However, they are not included in the organizational structure of the FHM facilities (Figure 7).
- The FHM had selected some nurses to work as team members within the health facilities. The extra nurses had been directed to conduct specific assignments outside the health facilities i.e. conduct home visits for health educators and to provide postnatal care. However, nurses with "new assignments" had proved their ineffectiveness (e.g. only 15% of mothers in the FHM served community had received post-natal care, and 41% of those services were through the FHM facilities' activities.
- Physicians are severely involved in paper work. Therefore, they become unable to keep active interaction with the clients and the time allocated for providing quality clinical services is reduced.
- There is high turnover of the FHM staff.
- The "performance-based payment mechanism" could result in loss of transparency in recording of patients' visits. Additionally, families have been exposed to pressure from the service providers to be FHM-rostered. RH-services clients are directed to use paid curative care services.

Figure 7: Sources of knowlege of the FHM-rostered families about FHM-RH-services - Community -based Survey 2008



Recommendations:

IMPROVE FHM FACILITY STAFF PERFORMANCE IN RH-SERVICES

*** Capacity building of the FHM service providers**

1- Reorganize the service providers to provide services in three types of clinics within the FHU:

- Clinic for reproductive health services to women: ANC, postnatal care, FP, RTIs management (one clinic).
- Clinic for family medicine/Curative care services: curative services to all members of the family included in the family folder (more than one clinic according to the number of the served population).
- Clinic for Child care: well-baby care and immunization (services provided by the nurses) – some facilities have delivery room.
- Specify separate room to provide the following services: Family planning consultation, oral rehydration of the children, some facilities should have a place for delivery.

2- Capacity building/training of the staff:

- Set mechanisms for selection of family physicians: General practitioners are better than specialists who become family physicians after a training course.
- The physicians working in the FHM has to be categorized into two groups:
  - RH-physicians (future obstetrics and gynecology specialists).
  - Curative care providers (future internal medicine specialists, surgeons or other specialties).

- Revise the agenda of the FHM pre-service training (6 weeks): It has to include three types of courses:
    1. General courses to all physicians including principles of PHC, family medicine and FHM.
    2. Condensed courses on RH-services (4 weeks) for physicians who are going to work in the RH-clinics.
    3. Condensed courses on curative care services (4 weeks) for doctors who are going to work in family medicine clinics.
- Training in FP should be for 10 days with 5 days have to be allocated to practical training. The participants in the practical training sessions should not exceed 10 physicians per course.

3- Job description

- Develop special simple manual that includes the standard of practice and protocols. This manual has to be used as a resource material during development of the job description.
- The role of physicians and nurse should be clear in each specific RH-service: FP, ANC, postnatal care, RTIs management and how to integrate different services e.g. postpartum /FP services.
- Revise the job description of the physicians to have specific tasks in FP as well as ANC.
- The role of the nurse in FP counseling should be clear.
- Set a clear role for the nurses who conduct home visits to provide post-partum care and neonatal child care.
- Find other alternatives to reduce involvement of the physician in paper work to ensure focusing on quality clinical services.

4- Motivation and

- Monthly payment should not be linked with quantitative targets.
- Add more sensitive indicators that stimulate the service providers to create demand and increase coverage with RH-services.
- Clinical supervisors from the district hospitals could play a role in motivation for improving performance.
- Replace the performance-based payment mechanism with job promotion and opportunity to register for mater degree after 2 years.
- Motivation has to be liked with the health facility efficiency rather than the physician output.

5- Reallocation of the staff

- Find alternatives to solve the problem of social/cultural acceptability regarding the gender of the family physicians. In conservative communities, having female physician for RH-services and male physician for curative-family medicine services could solve this problem.
- Community workers have to be included in the organizational structure of the FHM.
- Develop strict regulation to have the suitable number of nurses. Addition of one extra nurse to provide immunization services.
- Study the possibility of organizing visits of specialists from the district hospitals to the FHU to conduct supervision/ on-the-job training to physicians and provide specialized services to the patients who need specialists' services (instead of the patients travel from the village to the city to get specialized service in the FHC or the district hospital).

4- The FHM supervision system is inefficient to ensure constructive supervision in RH-services

- There is no clinical supervision to PHC or FHM staff.The current supervision system in MOHP depends on using the checklist for integrated services that consider the whole facility condition (MD 75), with no in-depth supervising the performance of the service providers while delivering services to any type of the clients. The supervision system of the FHM done by district staff and FHF is "supervision to control" rather than supervision to help.
- Exposure of the health facility staff to about 15 types of supervisors from the different levels and from all vertical programs in addition to FHF. There is no supervisor who is considered expert in family medicine to transfer experience to the FHM service providers.
- FHM did not build on experience of the MOHP vertical programs of involving district hospital specialists as "clinical supervisors" in the on-the-job training and updating clinical skills of the service providers.

Recommendations:

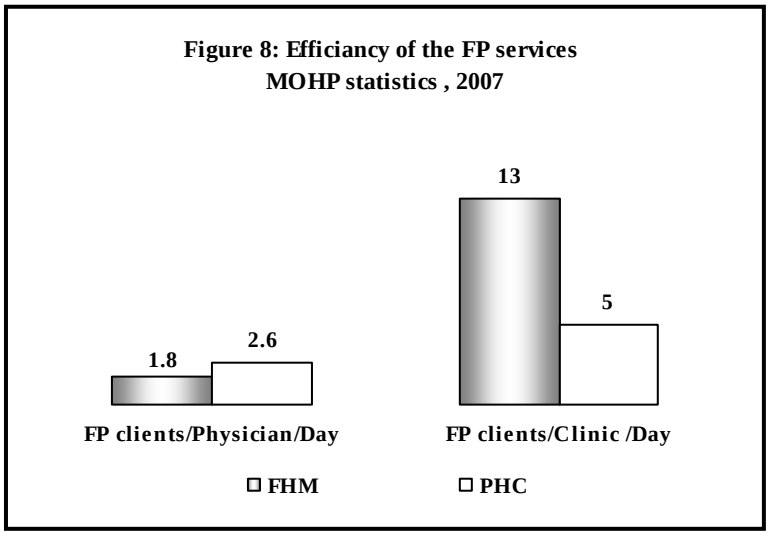
IMPROVE THE SUPERVISION SYSTEM through supporting clinical and administrative supervision

- The DPO should have a major role in management of the supervision system: administrative supervision using integrated quality checklist and clinical supervision by specialists from the district hospital.
- The DPO supervision coordinator has to set the supervision plan and monitor its implementation, so as to ensure that each health facility is visited by 4 supervisors per month:
    1. DPO supervision coordinator for integrated quality services at the facility services.
    2. Obstetrics and gynecology specialist supervisor from the district hospital to the RH-physician.
    3. Internal medicine specialist supervisor from the district hospital to the family medicine physicians.
    4. Nurse supervisors to the health facility nurses.
- Clinical supervisors could provide specialized services to cases needing specialists' services.
- Clinical supervisors should have a role in strengthening the feedback mechanism of the referral process.

5- FHM -Management Information System is not efficient to support RH-services

- There is no MIS specialist in both the DPO or FHM facilities.
- The performance- based-payment mechanism with fixed targets makes the physicians' output to be static at a certain level for RH-services. This reduces the opportunities for increasing service output for the priority service e.g. RH and priority geographic areas e.g. rural Upper Egypt.
- The issue of linking between the incentives and the physicians quantitative output, could influence the reliability of MIS data of FHM facilities.
- Having double MIS (for vertical program indicators and FHM indicators) overloads the MIS system at all levels.
- The heavy involvement of physicians in paper work beside the clinical services, could influence the quality of recoded data.

- There is no published FHM monitoring and evaluation reports which include time series/trend analysis to provide information about the impact of the FHM on RH-services utilization. Therefore, there is always needs to conduct specific studies in this context.



- Unfortunately, there is controversy regarding the role FHM in increasing the utilization of PHC services. Some studies demonstrate improved performance of the FHM and others are not. This is due to sampling techniques and duration covered in the study.

- FHM –MIS indicators are physician-based output indicators, while PHC indicators are facility-based output indicators. Therefore, in case of having fixed target for each family physician, the facility output could not be increase except by increasing the number of physicians. Consequently, FHM facilities' output indicators reflect input (number of physicians) and not the efficiency of the facility staff (process) (Figure 9).

Recommendations:

**** IMPROVE THE FHM-MIS TO SUPPORT DECISION MAKING IN RH-PROGRAMS***

Characteristics of the suggested intervention to improve FHM-MIS

- Identify the essential data and indicators necessary for continuity of care of cases as well as development of monitoring and evaluation indicators for decision making.
- Develop a special unified standard format/logbook that includes the above set essential data. The logbook pages have to allow having original and copy data, with enough spaces between recorded cases.
- The doctor has to record data "once" in the logbook, and during the client visit. Those data should be in a spread sheet that requires just "marks" for the related information.
- The original pages in the logbook represent the document for the service output, and to be used for calculation of all monitoring and evaluation indicators.
- The copy pages (red in color) have to be cut into paper slices, where each slice represents data on one client visit. Those paper slices could be fixed into the corresponding folders by the FHU clerks.
- The MIS specialist at the FHM facility (or the health office clerk in the facility or a nurse) has to record the logbook data (total items) and develop indicators. In case of having computers in the facility, it is easy to do this step.
- To achieve the above steps operations research could be used to test the effectiveness of the intervention (logbook, flow of information and indicators development).

**** RE-EVALUATE THE PERFORMANCE-BASED PAYMENT MECHANISM:***

The fixed daily output at 24cases/day with pre-set profile of cases to be served has to be replaced by other indicators related to quality, patient satisfaction and increase the volume of RH-services overtime etc.,

8.4 IMPROVE HEALTH SERVICES PROVISION

1- Physical infrastructure of the health facility restricts proper provision of some RH-services

- The HSRP-policy of having more than one family medicine clinics allows for providing RH-services in more than one clinic in the same facility. However, having a clinic that provide all services to all members of the family reduces privacy especially for RH-services.
- There is no room for FP counseling.
- No room for oral rehydration of the children.
- The lab is located in an ill-ventilated place in the facility.

Recommendations:

HAVING RH-SERVICES CLINIC IN EACH OF THE FHM FACILITIES IN ADDITION TO FAMILY MEDICINE CLINICS

Suggested criteria of the RH-clinic

- It is a separate clinic, in the FHM facilities, that provides health services to women: maternal, family planning and RTIs management.
- It is better to have special waiting area and room for FP counseling.
- It is better to have female physician to provide services in this clinic especially in the rural areas.
- On-the bases of serving 24 cases per day and 250 working days /physician per year, the RH-physician could serve 6000 married women in the reproductive age/year, or mothers in 6000 families.
- All RH-services in this clinic should be provided freely. There is no need for the clients to pass through 11 FHM steps to get the RH-services.
- Women should be recorded in the logbook as mentioned previously (MIS system). The part in the logbook including the client visit to reproductive health clinic should be cut into paper slices and fixed into the corresponding family folder for the woman.

8.5 RAISING DEMANDS FOR RH-SERVICES IN THE FHM FACILITIES

1- The community is unaware about the concept of the FHM and Health Insurance and the included RH-services

- The concept of health insurance and cost- sharing is not clear to many families. This is because the new system is implemented in MOHP governmental PHC facilities which usually provide free health services,
- Those who join the FHM-roster are those with high "socioeconomic risk". This indicates that middle and high socioeconomic classes do not financially support the FHM. This could negatively affect the financial sustainability of the FHM.
- The High and middle socioeconomic classes utilize the PHC facilities for public health services as immunization and health office services. However, there are no mechanisms to involve them in the health solidarity program of the FHM.
- The topic of adolescent health problems is covered in the "practice guide" for family physicians as part of topic on school health program. However, based on findings of the

current study, the role of mothers is pivotal in informing their daughters about adolescent health.

- Both the community and service providers are not accommodating the concept of drug rationalization. Doctors in the FHM prescribe 2 drugs according to the FHM regulations, but asking the patients to buy more drugs from the private pharmacy. The patients expressed their dissatisfaction from prescribing/dispensing two drugs only.
- Cultural factors reduce the opportunity for access of girls to FHM-RH services
- The mass media does not have any role in preparing the environment to accept the concepts of social health insurance and integrated services through family physicians. HSRP advocates consider that FHM is in its "trial" stage", and involvement of the mass media could increase demand for services which is not available in its final form.
- The mass media does not have any role in informing the people about HSRP-integrated health system "health services pyramid". The people usually prefer to go directly to the hospital and by-pass the PHC level, with subsequent underutilization of PHC-RH services. This is obvious in FHM facilities which do not apply referral system at the district level.

Recommendations:

HSRP HAS TO RAISE THE COMMUNITY AWARNESS ABOUT RECEIVING RH-SERVICES IN THE FHM FACILITIES- : through social marketing in the mass media and other communication channels

Suggested contents of the social marketing messages:

- The concepts of solidarity to keep health for all people are necessary to motivate people to be enrolled in the social health insurance system. Those messages could be included in the mass media-religious programs.
- The concepts of solidarity in health care include the concepts of cost-sharing to improve quality, risk pooling and equity. Therefore, joining the FHM roster is necessary for the rich and poor people to support the health system in Egypt.
- FHM provides integrated services for all the family members. The family folder includes all important information about health of each family member and it is necessary for continuity of care. FHM services include BBP, EDL, referral services, drug use rationalization and the package of RH- services provided freely in all the FHM facilities.
- The community contact with the health system should consider the "health services pyramid" to insure receiving quality services at all levels. The first level (primary) responds to 80% of the community health needs. The Secondary level (specialist services) responds to 15% of health needs. The third level (specialized/university hospitals) responds to 5% of health needs of the community.
- Role of mothers is crucial for guiding their adolescent and youth girls and boys towards health promotion, and receiving RH-services in a proper time. Therefore, mothers should be aware about adolescents' RH-problems. Those messages could be included in the mass media-women focused programs.

2- FHM outreach program is not efficient for raising demands for RH-services

- The majority of the families joining the FHM-roster (66% of the target community) get their information about RH-services from the community worker (RR) (Figure 8). At the same time, FHM depends on RR in implementing the community-related administrative component of the FHM i.e. enlistment of families and informing about the folders. However FHM did not consider adequate preparation of the RR in introducing the concept of FHM/Family Folder to the community. Therefore, the community is not well-prepared

to accept the idea of family folder which is linked with "paying the premium to get health services, which were previously provided freely in the MOHP facilities".

- Involvement of RR in demand raising activities for multiple health programs could have negative effects on all the programs especially RH-program, and reduction of RR credibility by the community.
- The changing role of some nurses in the FHM, who become involved in home-visiting health education activities had resulted in exposure of the families to two different sources of information about FHM-services (i.e. nurses and RR) with subsequent duplication and/or contradiction of information. However, the influential role of RR on the community is usually dominating (Figure 8).

Recommendations:

IMPROVE THE OUTREACH PROGRAM FOR FHM-RH SERVICES: INCLUDING THE COMMUNITY WORKERS (RR) IN THE FHM ORGANIZATIONAL STRUCTURE CAPACITY BUILDING OF COMMUNITY WORKERS

Suggested Contents of the training courses to community workers:

- Importance of integrated services to the family members through FHU.
- Integrated health system through the "health services pyramid".
- Importance of the family folder/health insurance.
- Importance of premarital counseling and medical examination, and components of premarital care.
- Reproductive health problems of adolescent girls and the importance of early detection.
- Reproductive health problems of adolescent boys and the importance of early detection.
- RTIs among women and UTIs and RTIs among males and the importance of seeking care.
- Importance of postnatal care to mothers and the newborn babies.

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Annex

ARAB REPUBLIC OF EGYPT
MINISTRY OF HEALTH AND POPULATION
UNFPA
EL- ZANATY & ASSOCIATES
STUDY ON REPRODUCTIVE HEALTH IMPACT OF
FAMILY HEALTH MODEL PILOT IN EGYPT

Governorate:……
District:……...
During month…….. year……..

MONTHLY REPORT FOR CHILDREN IMMUNIZATIONS

MODEL (1)

Serial NO.	Facility name	Date of entering reform	Date of independence	Number of doctors	Number of nurses	Number of population	Number of births	BCG vaccine		DPT 3		Hepathitis		Polio 3		Measles	
								NO.	%	NO.	%	NO.	%	NO.	%	NO.	%

ARAB REPUBLIC OF EGYPT
MINISTRY OF HEALTH AND POPULATION
UNFPA
EL- ZANATY & ASSOCIATES
STUDY ON REPRODUCTIVE HEALTH IMPACT OF
FAMILY HEALTH MODEL PILOT IN EGYPT

Governorate:……
District:……...
During month……... year……..

MONTHLY REPORT FOR MATERNAL CARE SERVICES

MODEL (2)

Serial NO.	Facility name	NO. of newly pregnant	Total flow of visits	Tetanus vaccine (2 or more)	Place of delivery				Who perform delivery			Data of birth		Total no. of visits for post antenatal care	Referral data			
					Hospital	Same unit	Other	Home	Doctor	Nurse/ midwife	Daya/ other	Alive	Dead		Total reffered births	post antenatal complications	Delivery complications	Abortion

ARAB REPUBLIC OF EGYPT
MINISTRY OF HEALTH AND POPULATION
UNFPA
EL- ZANATY & ASSOCIATES
STUDY ON REPRODUCTIVE HEALTH IMPACT OF
FAMILY HEALTH MODEL PILOT IN EGYPT

Governorate:……
District:……...
During month…….. year……..

MONTHLY REPORT FOR FAMILY PLANNING SERVICES

MODEL (3)

Serial NO.	Facility name	Total No. of clients	Type of client		clients according to Type of method							clients according to age		clients according to no. of children			According to the reason of visit						
			New	Regularly	Pills	Loop	Injectables	Norplant	Emplanon	Condom	Other	Less than 20 years	20- 24 years	Not exist	One child	2 Childs	get 1 method	Changed method	Medical compl-ication	Loop follow up	Loop removel	Capsules removel	Reprod-uctive health

ARAB REPUBLIC OF EGYPT
MINISTRY OF HEALTH AND POPULATION
UNITED NATION POPULATION FUND (UNFPA)
EL-ZANATY & ASSOCIATES

Form Number

STUDY ON REPRODUCTIVE HEALTH IMPACT OF FAMILY HEALTH MODEL PILOTS IN EGYPT

Form for FHM- Health Facility Assessment (2008)

Data Collected from this Study is Confidential and will be used for Scientific Purposes only

Identification Data	
Governorate:…….....	Governorate ☐☐
District :……...	District ☐☐
Shiaka/ village:……..……	Shiaka/ village ☐☐
Kism/ Markaz:…….....	Kism/ Markaz ☐☐
Health Facility Name :……..	Health Facility Name
Health facility code:……..…….	Health facility code ☐☐
Health Facility Address:……	
Health Facility Phone No:……..	
Health Facility Type: Family health unit ……..1 Family health centre …..……..2 Other ……...6 (specify)	Health Facility Type ☐

Visits of the Researchers

Visits of the Researchers		Final Visit
Date:	.....	☐☐ ☐☐☐☐
Team:	.....	☐☐
Researcher:	.....	☐☐
Supervisor:	.....	☐☐

Interviewed Personnel		
Name:……..	Job:……...	Phone:……
Name:……..	Job:……...	Phone:……
Name:……..	Job:……...	Phone:……
Name:……..	Job:……...	Phone:……
Name:……..	Job:……...	Phone:……

Data Management				
	Supervisor	**Office Review**	**Coding**	**Data Entry**
Name: Date: Signature	…… / /2008 ……	…… / /2008 ……	…… / /2008 ……	…… / /2008 ……
	☐☐	☐☐	☐☐	☐☐

Checklist of the Quality PHC Services

A- Demographic Data: Vital Statistics

Items		Data
A1	Total Population within the catchment area 2007	
A2	Crude Birth Rate 2007	
A3	Crude Death Rate 2007	

B- General Resources and Services

B1 - Health Team: Manpower in the health facility

Health Manpower		Number		Currently Working	
		Males	Females	Males	Females
Physicians by Specialty					
B1-1	**Number of Physicians: Total**				
B1-2	Health Facility Director				
B1-3	General Practitioners (GP)				
B1-4	Family Medicine specialists				
B1-5	Physician trained in Family medicine				
B1-6	Ob&Gyne specialists				
B1-7	Pediatricians				
B1-8	Internal Medicine specialists				
Physicians by Type of Health Services					
B1-9	Family Medicine				
B1-10	Family Planning				
B1-11	Maternal Care				
B1-12	Child Care				
B1-13	Outpatient services				
Other specialists					
B1-14	Dentists				
B1-15	Pharmacists				
B1-16	**Total Other Specialties**				
Support Staff					
B1-17	Nurses	**Number**		**Currently Working**	
B1-18	Lab Technicians				
B1-19	Health Office Employees staff				
B1-20	Sanitarians				
B1-21	Community/Outreach Workers				
B1-22	Workers (house keeping)				
B1-23	Others				
B1-24	**Total Support Staff**				

B2- Working hours, Number of Clinics and Places for service delivery:

#	Observation Items	Findings
B2-1	Working Morning Hours: Number	
B2-2	Working Afternoon Hours: Number	
B2-3	Family Health Clinics: Number	
B2-4	Maternal care clinic	(1) yes (2) No
B2-5	Child Care clinic	(1) yes (2) No
B2-6	Family Planning clinic	(1) yes (2) No
B2-7	Outpatient clinic	(1) yes (2) No
B2-8	Delivery Room	(1) yes (2) No
B2-9		(1) yes (2) No
B2-10		(1) yes (2) No
B2-11		(1) yes (2) No

#	Observation Items	Findings
B2-12		(1) yes (2) No
B2-13	Children care for the first months	(1) yes (2) No
B2-14	Mother care	(1) yes (2) No
B2-15	Laboratory	(1) yes (2) No
B2-16	Pharmacy	(1) yes (2) No
B2-17	Education Kitchen	(1) yes (2) No
B2-18	Health office (1) Within facility (2) near (2) far from the facility	
B2-19	Room for Family Folders keeping	(1) yes (2) No
B2-20	Reception office	(1) yes (2) No
B2-21	Waiting areas	(1) yes (2) No
B2-22	Toilets for clients' use	(1) yes (2) No

B3- Special Health Services in addition to Primary Health Care Services: Social / Community Activities:

#	Observation Items	Findings	
B3-1	- Care for the orphans	(1)Present	(2) Not Present
B3-2	- Care for the elderly	(1)Present	(2) Not Present
B3-3	- Women's club	(1)Present	(2) Not Present
B3-4	- Youth friendly services	(1)Present	(2) Not Present
B3-5	- Ambulance care	(1)Present	(2) Not Present
B3-6	-Well-defined hospitals for referral	(1)Present	(2) Not Present
B3-7	-Well-equipped ambulance car	(1)Present	(2) Not Present

B4- accreditation and patient_ satisfaction survey system

#	Accreditation	Findings
B4-1	Date of entering the health reform	Month …… year……
B4-2	Having Accreditation Certificate according to the Health Reform Program	(1) yes (2) No
B4-3	Date of first having the accreditation	Month …… year……
B4-4	Date of last visit for accreditation	Month …… year……
B4-5	Patient satisfaction survey questionnaire form used by the facility (1) Seen by the researcher (2) Available (3) Not available	☐
B4-6	Reports on patients' satisfaction survey findings (1) Seen by the researcher (2) Available (3) Not available	☐

B5 - Health Facility Infrastructure

No Item	Observation Items	Findings (Observation)
B5.1	General condition of the facility building	(1) Sound building/recently renovated (2) Collapsing/needs renovation
B5.2	Identification sign for the PHC facility	(1) The sign is clear (2) No sign/sign is not clear
B5.3	Surrounding environment:	(1) Clean and safe/green areas (2) Unclean/refuse heaps, /sewage overflow/animal sheds/open trench/ exposed electricity wire
B5.4	System for general refuse disposal:	(1) Containers are wide enough, covered, and timely disposed (2)No containers/uncovered containers/ full containers

No Item	Observation Items	Findings (Observation)
The availability of methods specialized for the security		
B5.5	Security fulfillment: Metal bars fixed to windows (pharmacy and stores),	(1) yes (2) No
B5.6	Methods for locking doors	(1) yes (2) No
B5.7	Safety measures for fire	(1) yes (2) No
B5.9	Safety measures for electricity.	(1) yes (2) No
Waiting Area		
B5-10	Presence of a clean waiting area (no bad smell)	(1) yes (2) No
B5-11	Adequate ventilation of the waiting area (open windows)	(1) yes (2) No
B5-12	Adequate lighting of the waiting area	(1) yes (2) No
B5-13	Presence of a table for brochures and leaflets, and stands for the posters for the Information, Education & Communication (IE&C) material	(1) yes (2) No
B5-14	Bathroom, present and clean	(1) yes (2) No
B5-15	Presence of poster presenting the **patients' rights**	

B6- Infection Control Measures

No Item	Observation Items (1)Available & Observed (2) Available (3) Not Available (8)NA	
Equipment and Supplies		
B6-1	Source of clean water for routine hand washing	
B6-2	Soap for routine hand washing	
B6-3	Disposable (non-sterile) gloves to be used during vaginal examination or handling of contaminated material	
B6-4	Sterile gloves (disposable) to be used during dressing the umbilical stump, and during conduction of surgical procedures	
B6-5	Cidex solution (or Betadine or ethyle alcohol 70%) for High Level Disinfection of the instruments	
B6-6	Boiler for high level disinfection of the instruments	
B6-7	Autoclave (or Hot Air Oven) for sterilization of the instruments	
B6-8	Special jar with disinfectant solution to be changed every two hours to keep thermometers after their washing with soap and water after each single use each	
Disposal of the Health Facility's Wastes		
B6-9	Any bags for non-medical waste collection	
B6-10	Colored bags for medical waste collection	
B6-11	Incinerators and disposal of ash every two weeks by the local governmental unit. (or transfer of the waste to the district hospital incinerator)	

B7- Laboratory Services

#	Observation Items	Findings (Observed)	
B7-1	Wall of the Lab	(1)Good condition	(2)Bad
B7-2	Floor of the lab	(1)Good condition	(2)Bad
B7-3	Lightning	(1)Good condition	(2)Bad
B7-4	Ventilation	(1)Good	(2)Bad
B7-5	Protection against insects	(1)Wire mish on the windows	(2)Not present

#	Observation Items	Findings (Observed)	#
B7-6	Permanent source for clean water	(1)Present	(2)Not present
B7-7	Basin for washing the hands	(1)Present	(2)Not present
B7-8	Basin for washing the instruments	(1)Present	(2)Not present
B7-9	Sanitary basin with siphon to dispose the sample remnants	(1)Present	(2)Not present
B7-10	Bathroom for the clients	(1)Present and clean (2) Present & not clean	(3)Not present
Lab Furniture: Observation Items **(1)Available & Observed (2) Available (3) Not Available (8)NA**			
B7-11	Desk and chair		
B7-12	Shelf to keep bottles containing solutions		
B7-13	Metal or plastic basket		
B7-14	Cupboard to keep records and supplies		
B7-15	Source of flame		
Lab Equipment and Supplies			
B7-16	Microscope		
B7-17	Centrifuge		
B7-18	Refrigerator		
B7-19	Electric oven		
B7-20	Incubator		
B7-21	Test tubes and glass cubs		
B7-22	Logbook/formats/case records		
Laboratory Investigations			
B7-23	Urine examinations	(1)Available	(2)Not available
B7-24	Stool examinations	(1)Available	(2)Not available
B7-25	Hemoglobin measurement	(1)Available	(2)Not available
B7-26	Blood picture	(1)Available	(2)Not available
B7-27	Blood sugar	(1)Available	(2)Not available
B7-28	Test for ABO group	(1)Available	(2)Not available
B7-29	Test for Rh	(1)Available	(2)Not available
B7-30	Measurement of the sedimentation rate	(1)Available	(2)Not available
B7-31	Test for VDRL	(1)Available	(2)Not available
B7-32	Tests for HIV/AIDS	(1)Available	(2)Not available
B7-33	Sputum examination for TB	(1)Available	(2)Not available
B7-34	Others (e.g. examination for vaginal discharge)	(1)Available	(2)Not available
B6-35	Discharge examination for the men duct urine	(1)Available	(2)Not available
B7-36	Other Lab Investigations (Mention): (……..)	(1)Available	(2)Not available
Reference Materials for the Standard of Practice (SOP)			
B7-37	Standard procedures: an updated manual/guidelines/posters for each lab test for each: lab test	(1)Available	(2)Not available

B8- Pharmacy Services

#	Service Item	Findings	
Methods of Keeping the Medications			
B8-1	Space area of the pharmacy is suitable for the available drug packets	(1) Enough space	(2) No enough space
B8-2	Protection of the medications from direct sun light	(1)Protected	(2) Not protected
B8-3	Protection of the medications from dampness/water (in a good dry place) (shelving)	(1)Yes, all of them	(2)No, only some of them

#	Service Item	Findings		
Guide for the Standard of Practice				
B8-4	List of Available medications	(1)Updated list for the available medication (2)Not updated		
B8-5	List of Unavailable medications	(1)Updated list for the unavailable medication (2)Not updated		
Availability of the essential drugs (1=Child health, 2=Maternal health, 3=Reproductive tract infections, 4= Parasitic infestations) Observe the list on the wall of the pharmacy				
Oral Medications				
B8-6	Amoxicillin (1,2)	(1)Available	(2)Not Available	
B8-7	Aspirin (1,2,3)	(1)Available	(2)Not Available	
B8-8	Cefloxin (3)	(1)Available	(2)Not Available	
B8-9	Folic Acid (2)	(1)Available	(2)Not Available	
B8-10	Iron (1,2)	(1)Available	(2)Not Available	
B8-11	Iron &Folic Acid (2)	(1)Available	(2)Not Available	
B8-12	Mebendazole (1,2)	(1)Available	(2)Not Available	
B8-13	Metronidazole (2,3)	(1)Available	(2)Not Available	
B8-14	Nystatine tablets (1,2)	(1)Available	(2)Not Available	
B8-15	Paracetamol (1)	(1)Available	(2)Not Available	
B8-16	Penicillin (1,2)	(1)Available	(2)Not Available	
B8-17	Tetracycline (2,3)	(1)Available	(2)Not Available	
B8-18	Vitamin A 200,000 IU(1,2)	(1)Available	(2)Not Available	
B8-19	Vitamin A ≥25,000 IU(1,2)	(1)Available	(2)Not Available	
B8-20	Oral Rehydration salt (1)	(1)Available	(2)Not Available	
Injections				
B8-21	Ampicillin (2)	(1)Available	(2)Not Available	
B8-22	Benzathine benzyle P. (1,3)	(1)Available	(2)Not Available	
B8-23	Ceftriaxone (3)	(1)Available	(2)Not Available	
B8-24	Cefotaxin (2)	(1)Available	(2)Not Available	
B8-25	Ergometrine (2)	(1)Available	(2)Not Available	
B8-26	Gentamycin (1,2)	(1)Available	(2)Not Available	
B8-27	Normal saline (2)	(1)Available	(2)Not Available	
Medications for Parasitic Infestations (4)				
B8-28	Praziquantile for Bilahrziasis (tables and syrup)	(1)Available	(2)Not Available	
B8-29	Lifamisol, Flubendazol, Mindazole (for Ascaris, Ancylestoma, Oxyuris)	(1)Available	(2)Not Available	
B8-30	Niclosamide tablets (for Tape worms)	(1)Available	(2)Not Available	
B8-31	Metrobendazol tablets and syrup (for Ameba and Giardia)	(1)Available	(2)Not Available	
Other Medications				
B8-32	Nystatin vaginal T(3)	(1)Available	(2)Not Available	
B8-33	Antibiotic eye drops ***{Not chloramphenicol)***(1)	(1)Available	(2)Not Available	
B8-34	Iodine, gentian violet, local preparations for skin diseases	(1)Available	(2)Not Available	
B8-35	Other Medications: Mention (……)	(1)Available	(2)Not Available	

B9- Outpatient Services

Item No	Service Item	Findings		
B9-1	Examination bed	(1)Available	(2)Not Available	Available in family health clinic
B9-2	Sphygmomanometer	(1)Available	(2)Not Available	Available in family health clinic

Item No	Service Item	Findings		
B9-3	Stethoscope	(1)Available	(2)Not Available	Available in family health clinic
Health Education Materials and Activities Including the Following Topics:				
B9-4	Prevention and control of parasitic infestations		(1)Present	(2)Not present
B9-5	Prevention and Control of Sexually Transmitted diseases		(1)Present	(2Not present
B9-6	Prevention and control of HIV/AIDS		(1)Present	(2)Not present
B9-7	Prevention and control of non-communicable diseases (Diabetes and Hypertension)		(1)Present	(2)Not present

B10- Referral System:

Item No	Service Item	Findings
►Selection Criteria and Actions for the Referred Cases (discuss the items with the service providers		
B10-1	The referral process Follows a specific protocol	(1) Follows a specific protocol (2) Does not follow a specific protocol
B10-2	Common Reasons for the referral process: Multiple answers are allowed	(A) Unavailability of experienced staff (B) Unavailability of specific equipment (C) Referral to specialized hospital (e.g. fever, chest) (D) Need for surgery (E) No specific cause (X)Others
B10-3	Providing first aid according to the set protocol before referral	(1)Provided (2) Not provided
B10-4	Referral to the appropriate facilities	(1)Referral to the right/relevant facilities (general, fever, chest hospitals) (2) No rules for referring cases to specific facilities
► Communication with the Hospitals for Emergency Cases		
B10-5	Telephone facilities available and works regularly	(1) Available and working regularly (2) Not available/ not working regularly
B10-6	Telephone numbers' list of hospitals, newborn incubators, emergency centers	(1) Available (2)Not available
B10-7	Telephone communication with health facilities to receive the referred cases	(1)Done for each case (2)Not done for each case
►Transportation Facilities for the Emergency Cases		
B10-6	Access to ambulance services or vehicle to transport emergency cases	(1) Available (2)Not available
B10-7	Guidelines to be followed for proper transportation of different emergency cases to the ambulance vehicle	(1) Available (2)Not available
►Providing Ambulance Services during the Transportation Process		
B10-8	Care for the emergency case during the transportation to the hospital	(1)One of the trained personnel from the center join the case in the ambulance vehicle (in case of unavailability of ambulance specialist) (2) Not present
►Referral Documentation Forms and Registry		
B10-9	Logbook to register data about the referred cases	(1)Referral logbook is in the outpatient or the reception room (2) Not present

Item No	Service Item	Findings
B10-10	Enough amount of referral formats (at least for 2 months)	(1)Present (2)Not present
B10-11	File to keep the referral formats including the feedback of information	(1)Present (2)Not present
B10-12	Logbook for follow up the referred cases	(1)Present (2)Not present

C- Primary Health Care Programs

C1: Antenatal Care

#	Service Item	Findings
Equipment and Supplies: Observation Items **(1)Available & Observed (2) Available (3) Not Available (4)available in family health clinic**		
C1-1	Examination spotlight source	
C1-2	Obstetric examination bed	
C1-3	Hand washing facilities	
C1-4	Bin for the waste disposal with competent cover	
C1-5	Sterile gloves	
C1-6	Sphygmomanometer	
C1-7	Stethoscope	
C1-8	Fetal stethoscope	
C1- 9	Ultrasound	
C1-10	Records for each client	
C1-11	Log books to record data about the pregnant women	
C1-12	Scale to measure body weight	
C1-13	Equipment to measure client's height	
Home Visits Bag **(1)Available & Observed (2) Available (3) Not Available (4)available in family health clinic**		
C1-14	Home visits bag	
C1-15	Thermometers, at least two	
C1-16	Scale to measure child weight	
C1-17	Tape to measure child length	
C1-18	Stethoscope	
C1-19	Sphygmomanometer	
C1-20	Tongue depressor	
C1-21	Test strips for albumin and sugar in urine	
C1-22	Artery forceps	
C1-23	Straight forceps (5 inches)	
C1-24	Box containing sterilized dressings	
C1-25	Antiseptic solution	
C1-26	Boric acid solution	
C1-27	Sulfacidamide eye drops (10.0%)	
C1-28	Women health records	

C2: Natal Care Services

No Item	Service Item	Findings
Facilities for delivery Room/ Delivery bag (1)Available & Observed (2) Available (3) Not Available (4)available in family health clinic		
C2-1	Delivery bag (for Home deliveries)	
C2-2	Surgical instruments	
C2-3	Instruments for the newborn care	
C2-4	Special clothes for the service providers	
C2-5	Disposable gloves	
C2-6	Special materials for the newborn (umbilical stump clamps, towels)	
C2-7	Medications (magnesium sulfate ampoules)	
C2-8	Lab supplies to test for blood group, and urine for albumin and sugar	
No Item	**Service Item**	**Findings**
C2-9	Pharmaceutical supplies (cotton, catheters, syringes, cannula, antiseptics)	
C2-10	Other supplies: soap, shaving machine	
C2-11	Fluids/solutions (glucose, saline, Ringer) and facilities for fluid transfusion	
C2-12	Print materials, formats to record data about deliveries	

C3: Family Planning (FP) Services

No Item	Service Item	Findings
Equipment to Provide FP Services: (1)Available & Observed (2) Available (3) Not Available (4)available in family health clinic		
C3-1	Gynecology examination table	
C3-2	Spot light	
C3-3	Instruments for gynecological examinations	
C3-4	Instruments for IUD insertion	
C3-5	Supplies: cotton, antiseptics etc.,	
C3-6	Different FP methods to be dispensed to the clients	
C3-7	Manual/folder for the standard of practice in FP	
C3-8	Logbooks, formats for recording clients' data	
Methods for FP: (1)Available & Observed (2) Available (3) Not Available (5)credit less than 3 months		
C3-9	OCs stock for 3 months	
C3-10	IUDs stock for 3 months	
C3-11	Injectables stock for 3 months	
C3-12	Condoms stock for 3 months	
C3-13	Norplant/implanol stock for 3 months	
C3-14	Posters showing Diagrams for the FP service output	
Information/Education/Communication (IE&C) Materials		
C3-15	Posters demonstrating importance of FP for the mother and child health, birth spacing	
C3-16	Booklets/leaflets demonstrating the FP methods	
C3-17	Box containing models for the different FP methods available in the health unit	
C3-18	Flip chart to demonstrate pictures about FP methods to the clients	

C4: Well-baby Care Services

No Item	Service Item	Findings
Education Kitchen (to demonstrate the preparation of child food/ Conduction of Health Education Seminars)		
C4-1	Space is enough for about 30 persons	(1)Enough space for the participants (2) No enough space
C4-2	Light and ventilation	(1)Adequate light (2) No adequate light (3) Adequate ventilation (4) No adequate ventilation
C4-3	Source for safe potable water	(1)Present (2)Not present
C4-4	Facilities for food preparation	(1)Present (2)Not present
C4-5	Actual preparation of healthy meals from available cheap food stuff	(1)Good demonstration for the steps of preparation of healthy cheap food and active participation of the mothers (2)Not present
Facilities for Monitoring the Growth and Development: **(1)Available & Observed (2) Available (3) Not Available (4)available in family health clinic**		
C4-6	Facilities to measure weight	
C4-7	Facilities to measure Length/height	
C4-8	Records showing the growth curve	
C4-9	Health education material	

C5: Sick-baby Care Services: (Integrated Management of the Childhood Illness: Diarrhea, ARI and malnutrition): Management of Diarrhea

No Item	Service Item	Findings
Facilities for Health Services to Diarrhea Cases		
C5-1	Oral Re-hydration room	(1)Present (2)Not present
Facilities for oral re-hydration		
C5-2	Plastic glasses (200 cm^3)	(1)Present (2)Not present
C5-3	Coleman, Not present	(1)Present (2)Not present
C5-4	salt packets for curing dryness	(1)Present (2)Not present
Posters for the Service Providers in the Examination Room		
C5-5	Poster including guidelines for management of diarrhea and dehydration	(1)Present (2)Not present
C5-6	Prevention of diarrhea: personal and food hygiene, covering food and protection against insects	(1)Present (2)Not present
Management of ARI: Facilities and Supplies		
C5-7	Stop watch to calculate the respiration rate	(1)Present (2) Not present
C5-8	Tongue depressor	(1)Present (2) Not present
C5-9	Otoscope	(1)Present (2) Not present

C6: Immunization Services

Immunizations in the facility.....(1) health office……..(2) ⟶
D ↓

No Item	Service Item	Findings	
Immunization Services: Equipment and Supplies			
C6-1	At least one ice box is available	(1) Available	(2) Not available
C6-2	The ice box is clean with no inside and/or outside crakes	(1)Yes	(2) No

No Item	Service Item	Findings	
C6-3	Refrigerator: is in a good general condition, no crakes or rust	(1)Yes	(2) No
C6-4	Refrigerator's door is firmly closed with good isolation rubber	(1)Yes	(2) No
C6-5	Refrigerator's temperature monitor is in a good working condition	(1) Yes	(2) non working thermometer
C6-6	The refrigerator is clean/no frost no wastes/no bad smell	(1) Yes	(2) No
C6-7	Presence of water balance showing that the refrigerator is kept in a horizontal position	(1) Yes	(2) No/non functioning water balance
C6-8	Supplies: available disposable syringes 2-2.5 cm^3	(1)Yes	(2) No
C6-9	Supplies: available disposable syringes 1 cm^3 (for BCG)	(1)Yes	(2) No
C6-10	Supplies: available health records and temperature tables in a good condition	(1)Yes	(2) No
Availability of Vaccines			
C6-11	Poliomyelitis Vaccine	(1) Available	(2) Not available
C6-12	DPT Vaccine	(1)Available	(2) Not available
C6-13	Measles vaccine	(1)Available	(2) Not available
C6-14	BCG vaccine	(1)Available	(2) Not available
C6-15	Hepatitis B Vaccine	(1)Available	(2) Not available
C6-16	Tetanus Toxoid Vaccine	(1)Available	(2) Not available
C6-17	MMR vaccine	(1)Available	(2) Not available
Cold Chain Procedures: **The Refrigerator and arrangement of the Vaccines:**			
C6-18	The refrigerator is not exposed to direct sun light/ in a good ventilated place	(1)Yes	(2)No
C6-19	The refrigerator: is 20-30 cm distance from the wall to allow air cycle	(1)Yes	(2)No
C6-20	Keeping of Poliomyelitis vaccine in the freezer	(1)Yes	(2)No
C6-21	Keeping of measles vaccines on the first shelf	(1)Yes	(2)No
C6-22	Keeping of other vaccines and solvents on the second shelf	(1)Yes	(2)No
C6-23	No vaccines at all are kept in the refrigerator door	(1)Yes	(2)No
C6-24	The vaccines are arranged according to the expiry date, recent vaccines are kept in the right side of the refrigerator	(1)Yes	(2)No
C6-25	Keeping spaces between vaccine vials to allow cold air cycle	(1)Yes	(2)No
C6-26	Colored water bottles are kept in the last shelf to help maintaining the cooling process	(1)Yes	(2)No
C6-27	Presence of at least 12 ice packs in the freezer	(1)Yes	(2)No
C6-28	Only vaccines and their solvents are kept in the refrigerator	(1)Yes	(2)No
C6-29	Keeping the temperature between +2 and +8 centigrade, but no more	(1)Yes	(2)No
C6-30	Presence of temperature chart fixed on the external wall, with recoding the temperature twice daily	(1)Yes	(2)No
C6-31	Frost does not exceed 0.5 cm thickness	(1)Yes	(2) Frost more than 0.5 cm

No Item	Service Item	Findings
Cooling Box/Vaccine Container		
C6-32	Lining with ice packs	(1) Lined with ice packs (2)Not lined with ice packs
C6-33	Keeping poliomyelitis vaccine	(1)Completely surrounded by the ice packs (2) Not completely surrounded by the ice packs
C6-34	Keeping of measles vaccine	(1)Completely surrounded by the ice packs (2) Not completely surrounded by the ice packs
C6-35	Tetanus Toxoid vaccine is kept away from direct contact with ice packs	(1) Yes (2) No
C6-36	Keeping other vaccines and solvents	(1)Over the ice packs and separated by paper sheet (2) Any place within the cooling box
C6-37	Keeping the vaccination vials	(1)Within plastic bags to keep labels (2)The labels are not protected from wet
C6-38	Thermometer in the cooling box	(1)Present and the cooling box is covered (2)Not present and the cooling box is not covered

D- Services Directed towards the Community

There is health office services..(1) D2 **There isn't health office services...(2)** →

D1- Health Office Services

Item No	Service Item	Findings
D1-1	Birth registry	(1)Birth registry and issuing the birth certificates (2)Not present
D1-2	Death registry	(1)Death registry including the cause of death (2)Not present
Review Documents on Surveillance and Control Measures for the Infectious Diseases:		
D1-3	Surveillance system	(1)Surveillance system for 26 infectious diseases (guideline manuals, and recorded activities) (2) Not present
D1-4	Disinfection procedures	(1)Procedures (guidelines), recorded activities and facilities for disinfection (2) Not present
D1-5	Measures for contacts	(1)List of family contacts (2)Not present
D1-6	Surveillance of contacts	(1)Document showing results of contacts' medical and lab examinations and prophylactic measures (2)Not present
D1-7	Control measures for the community	(1)Documents for implemented procedures to protect the community (insecticides, rodenticides, health education, immunization etc.,) (2)Not present
D1-8	Measures for pilgrims (before traveling)	(1)Immunization against meningococcal meningitis (2)Not present
Review Documents for Planning for Health Unit planning for health services/Monitoring and evaluation		
D1-9	Map for the catchment area	(1)Map is present and updated

		(2) Map is present but not updated (3) No map
Item No	**Service Item**	**Findings**
D1-10	Enlistment for places of people groupings	(1)List for schools, mosques, churches, markets, restaurants etc., (2) Not present
D1-11	Inspection for the places that could be potential sources for environmental pollution	(1)List for factories, refuse disposal, animal and birds breeding, water collections (2)No documentation
D1-12	Sick leaves	(1)Document showing procedures to issue sick leaves (2)No documents
D1-13	Enlistment for water sources	(1)List for water sources (private and public) (2)The list is not present
D1-14	Inspection of water purification plant and water networks	(1)Results of periodic visits to water plants, and reports on water networks (2)Not present
D1-15	Water samples	(1) Documents showing periodic collection of water samples from different sources (2)Not done
D1-16	Actions for unsafe water sources	(1)Documented actions in case of unsatisfactory sample for water (2)No documents
D1-17	Samples from the sewage system	(1)Document showing active procedures of sewage samples taking (2)No documents
D1-18	Actions in case of identification of markers for environmental pollution/contamination	(1)Document showing specific actions in case of unsatisfactory sewage sample (2)No documents
Review documents for food sanitation		
D1-19	Food samples	(1)Document showing data about the samples for food collected from different sources (2)No documents
D1-20	Examination and license for food handlers	(1)List and data about food handlers within the catchment area (2) No documents about food handlers
D1-21	Procedures for control of outbreaks of food poisoning	(1)Report including the procedures followed to control outbreaks of food poisoning (2) No reports
D1-22	Sanitary disposal of spoiled food stuff	(1)Document showing the procedures followed for disposal of spoiled food stuff, including recent data (2)No document

D2: Clinic Board

Clinic Board Members	Job

D3: Meetings of the Clinic Board Members:

1-Monthly, 2- every 2-3 months, 3- every 3-6 months 4- every 6-12 months, 5-every year and more

D4: The last problem discussed by the clinic board

……

D5: Health Facility Plan

D5-1	Having a health facility plan	(1) Yes (2) NO
D5-2	Last plan cover the period from month…..... year.....To month…....year.....	

Researchers' Notes

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Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates

EXIT INTERVIEW FOR FAMILY HEALTH UNITS
2008

EXIT QUESTIONNAIRE

DATA COLLECTED FROM THIS STUDY IS CONFIDENTIAL AND WILL BE USED FOR SCIENTIFIC PURPOSES ONLY

EXIT QUESTIONNAIRE

IDENTIFICATION	
Governorate: …….....…….……	GOVERNORATE ☐☐
Kism/Markaz: ……...……...…..……	KISM/MARKAZ ☐☐
Facility name ...:…….	
Facility address:…….	
Code of the facility:……	CODE OF THE FACILITY ☐☐
INTERVIEWER VISITS	**FINAL VISIT**
Date of interview: ……...	DAY ☐☐ MONTH 0☐ YEAR 0 8
Interviewer's name: ……	INTERVIEWER NUMBER ☐☐
Client number:……	CLIENT NUMBER ☐☐

	Field Editor	Office Editor	Coder	Keyer
NAME	_____	_____	_____	_____
DATE	/ / 2008	/ / 2008	/ / 2008	/ / 2008
SIGNATURE	_____ ☐☐	_____ ☐☐	_____ ☐☐	_____ ☐☐

SECTION 1
CLIENT'S TREATMENT AT THE CLINIC

Good morning (afternoon) My name is …… I am working for MOHP, we are doing this survey in some areas to know the availability of health service. This information will help the government to plan health services. The interview survey usually takes between 10 and 15 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons. Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions.
At this time, do you want to ask me anything about the survey?

RESPONDENT AGREE ☐ **RESPONDENT DIDN'T AGREE** ☐ → 312

NO.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
101	Have you ever come to this unit before?	YES..... 1 NO…… 2	
102	From where did you know about this unit for the first time?	HUSBAND……..…….. 01 RELATIVES…….…….…. 02 FRIENDS/NEIGHBORS……..…..……. 03 NEAR HOUSE/ PARENT'S HOUSE…..…..… 04 NEAR WORK……..…… 05 PEOPLE FROM CLINIC VISITED ME…..…. 06 ANNOUNCEMENT FOR THE CLINIC..... 07 OTHER_____ 96 (SPECIFY)	
103	Do you go from your home and this facility on foot or by transportation?	ON FOOT……..……... 1 BY TRANSPORT……..…….. 2	
104	Could you tell me the name of the nearest place to your home that provides health service?	FACILITY NAME…….. ☐☐ ……	
105	Why did you come to this unit and did not go to another unit?	THE PLACE IS NEAR..... A THERE IS NO OTHER PLACE..... B EASY TRANSPORTATION TO IT..... C COST IS CHEAP/SUITABLE..... D CHEAPEST PLACE..... E RELATED TO HIO..... F ALL PEOPLE SAY THIS PLACE IS THE BEST FOR THIS SERVICE..... G WE WELL KNEW DOCTOR..... H DOCTORS ARE CLEVER..... I FEMALE PHYSICIAN..... J WELL ORGANIZED..... K TIMES ARE SUITABLE..... L MEDICINES ARE AT THE UNIT ALL THE TIME (INCLUDES FAMILY PLANNING METHODS)..... M THE NURSE AND ASSISTANT TEAM ARE GOOD..... N ALL THE SERVICES IS BEING IN THE SAME PLACE (LABORATORY, RAYS,....)... O IF PERSON DID NOT GO THE NURSE VISITS HIM IN HIS HOUSE (ANTENATAL CARE, POSTNATAL CARE, VACCINATION,) P THE SERVICE IS AVAILABLE ALL THE TIME (MORNING, EVENING)..... Q THE SERVICES IS GOOD OVERALL..... R OTHER_____ X (SPECIFY)	
106	Have you ever visited other unit or any other facility that provides health service other than this unit in the past year?	YES..... 1 NO…… 2	→ 108

NO.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
107	Can you list the last unit have you visited during the last year? **WRITE NAME AND ADDRESS OF CLINIC SHE VISITED, THEN IDENTIFY THE ENTITY IT FOLLOWS AND CIRCLE THE APPROPRIATE CODE.** _____ _____	**MINISTRY OF HEALTH FACILITY** **URBAN HOSPITAL…….....…** **01** **URBAN HEALTH UNIT….....…..** **02** **RURAL HOSPITAL …….…..** **03** **RURAL HEALTH UNIT…….....** **04** **MATERNAL & CHILD CARE ……...** **05** **MOBILE CLINIC.....** **06** **OTHER MOH UNITS…….……** **07** **OTHER GOVERNMENTAL FACILITY** **TEACHING HOSPITAL……..……..** **08** **HEALTH INSURANCE ORGANIZATION……** **09** **CURATIVE CARE ORGANIZATION…..** **10** **OTHER GOV. UNIT.....……..** **11** **PRIVATE ORGANIZATION** **EFPA…….…….……** **12** **CSI PROJECT……...…...** **13** **OTHER PRIVATE UNIT ……..….** **14** **MEDICAL PRIVATE SECTOR** **PRIVATE HOSPITAL/CLINIC…….…** **15** **PRIVATE DOCTOR……...….** **16** **OTHER PRIVATE SECTOR** **MOSQUE HEALTH UNIT…….…** **17** **CHURCH HEALTH UNIT……..** **18** **OTHER_____** **96** **(SPECIFY)** **DON'T KNOW…….....……..…...** **98**	
108	When you came to this unit today, why did you come for?	**PREMARITAL EXAMINATION**..... **A** **ANTENATAL CARE**..... **B** **DELIVERY**..... **C** **POSTNATAL CARE**..... **D** **FAMILY PLANNING**..... **E** **CHILDREN VACCINATION**..... **F** **CHECK A CHILD IF HE HAD DIARRHEA**..... **G** **CHECK A CHILD IF HE HAD INFLAMMATION OF RESPIRATORY SYSTEM**..... **H** **OBSERVATION CHILD'S GROWTH**..... **I** **TREATMENT INFLAMMATION OF REPRODUCTIVE SYSTEM FOR WOMAN**..... **J** **TREATMENT INFLAMMATION OF REPRODUCTIVE SYSTEM FOR HUSBAND**..... **K** **TREATMENT STERILITY CASES**..... **L** **TREATMENT PROBLEMS FOR YOUNG WOMEN15-24**..... **M** **TREATMENT PROBLEMS FOR YOUNG MEN 15-25**..... **N** **TREATMENT CHRONIC DISEASES (BLOOD PRESSURE, DIABETES. ASTHMA..)**..... **O** **LABORATORY ANALYSIS**..... **P** **BIRTHS RECORD**..... **Q** **DEATH RECORD**..... **R** **SEMINARS ON FAMILY PLANNING& CHILD'S HEALTH**..... **S** **PERFORMING HEALTH CERTIFICATE**..... **T** **OTHER_____** **X** **(SPECIFY)**	
109	Do you know that your family has a file in this unit?	**YES**…… **1** **NO …….** **2**	

NO.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
110	Can you tell me, what are services provided in this family health unit?	**PREMARITAL EXAMINATION**..... **A** **ANTENATAL CARE**..... **B** **DELIVERY**..... **C** **POSTNATAL CARE**..... **D** **FAMILY PLANNING**..... **E** **CHILDREN VACCINATION**..... **F** **CHECK A CHILD IF HE HAD DIARRHEA**..... **G** **CHECK A CHILD IF HE HAD INFLAMMATION OF RESPIRATORY SYSTEM**..... **H** **OBSERVATION CHILD'S GROWTH**..... **I** **TREATMENT INFLAMMATION OF REPRODUCTIVE SYSTEM FOR WOMAN**..... **J** **TREATMENT INFLAMMATION OF REPRODUCTIVE SYSTEM FOR HUSBAND**..... **K** **TREATMENT STERILITY CASES**..... **L** **TREATMENT PROBLEMS FOR YOUNG WOMEN15-24**..... **M** **TREATMENT PROBLEMS FOR YOUNG MEN 15-25**..... **N** **TREATMENT CHRONIC DISEASES (BLOOD PRESSURE, DIABETES. ASTHMA..)**..... **O** **LABORATORY ANALYSIS**..... **P** **BIRTHS RECORD**..... **Q** **DEATH RECORD**..... **R** **SEMINARS ON FAMILY PLANNING& CHILD'S HEALTH**..... **S** **PERFORMING HEALTH CERTIFICATE**..... **T** **OTHER**_____ **X** **(SPECIFY)**	
111	Did they take any personal data from you and make a file for you?	**I HAVE A FILE BEFORE**……..…….... **1** **YES**……..…… **2** **NO** ……..... **3**	
112	Do you have a card containing the data on your visits to the unit?	**YES**……..…… **1** **NO** ……..... **2**	
113	Generally, do you think the quality of service you have received today is good or bad?	**GOOD**……..……..……... **1** **BAD**……..……..……..……... **2**	→ 115
114	Why do you think that the service is good? _____ _____ **(RECORD ALL MENTIONED)**	**REASONABLE WAITING PERIOD**…… **A** **REASONABLE COST**……..……..……. **B** **STAFF TREATS US WELL**……..…..……... **C** **CLEAN PLACE**……..……..…..…….. **D** **ARRANGED PLACE**……..…….…. **E** **EXAMINATION ACCORDING TO TURN. ..…** **F** **WORKING HOURS ARE SUITABLE**……..... **G** **COMFORTABLE WAITING PLACE**……..…… **H** **DOCTOR IS ALWAYS PRESENT** ……. **I** **PRIVACY WHILE EXAMINING**……..….. **J** **OFFERING SERVICES OTHER THAN FP**….. **K** **PRESENCE OF A FEMALE DOCTOR**…..…….. **L** **AVAILABILITY OF ALL KINDS OF METHODS**……..……..… **M** **AVAILABILITY OF MEDICATIONS**……..….... **N** **PROVIDING SERVICE RAPIDLY & EASILY**.. **O** **EFFICIENCY OF EXAMINATION**……. **P** **DOCTORS/ NURSES ARE HELPFUL & FRIENDLY**…….. **Q** **DOCTOR TREAT US WELL**..... **R** **DOCTOR COMPETENCE**..... **S** **PRESENCE OF A FILE INCLUDED ALL INFORMATION**…….. **T** **OTHER** _____ **X** **(SPECIFY)**	→ 116

NO.	QUESTIONS & FILTERS	CODING CATEGORIES		SKIP TO
115	Why do you think that the service is bad? _____ _____ **(RECORD ANSWER IN DETAIL)**	**LONG WAITING PERIOD…….…..** **EXPENSIVE ……..…..** **STAFF TREATS US BADLY……..…..** **DIRTY PLACE…….……..…..** **PLACE NOT ARRANGED……...…..** **EXAMINATION IS NOT ACCORDING TO TURN** **WORKING HOURS ARE NOT SUITABLE…..** **WAITING PLACE IS NOT COMFORTABLE...** **DOCTOR IS NOT PRESENT MOST OF TIME.** **HIGH TURNOVER OF THE DOCTOR...…..…** **NO PRIVACY WHILE EXAMINING…….....** **NO OTHER SERVICES THAN FP……....** **NO FEMALE DOCTOR……...…….....** **NOT ALL METHODS ARE AVAILABLE…....** **MEDICATIONS ARE NOT AVAILABLE…....** **NURSE/ DOCTOR AREN'T HELPFUL OR FRIENDLY…….……** **OTHER_____** **(SPECIFY)**	**A** **B** **C** **D** **E** **F** **G** **H** **I** **J** **K** **L** **M** **N** **O** **P** **X**	
116	Generally, if you or any member in your household become sick and need to go to a health facility, do you prefer to come for this unit or prefer anther unit?	**YES…….……..……..……....** **NO ……..……..……....**	**1** **2**	
117	When you back to your home today, would you tell your neighbors and relatives are you blissful from this unit?	**YES.....** **NO……**	**1** **2**	→ 119
118	Why?	**REASONABLE WAITING PERIOD……** **REASONABLE COST……..…..…….** **STAFF TREATS US WELL……..…..…….....** **CLEAN PLACE…….……..…..…….** **ARRANGED PLACE……..……..….** **EXAMINATION ACCORDING TO TURN. ...…** **WORKING HOURS ARE SUITABLE……...** **COMFORTABLE WAITING PLACE…….……** **DOCTOR IS ALWAYS PRESENT ……** **PRIVACY WHILE EXAMINING……..…..** **OFFERING SERVICES OTHER THAN FP…...** **PRESENCE OF A FEMALE DOCTOR…….…..** **AVAILABILITY OF ALL KINDS OF METHODS** **AVAILABILITY OF MEDICATIONS……..…...** **PROVIDING SERVICE RAPIDLY&EASILY..** **EFFICIENCY OF EXAMINATION…….** **DOCTORS/ NURSES ARE HELPFUL & FRIENDLY** **DOCTOR TREAT US WELL.....** **DOCTOR COMPETENCE.....** **PRESENCE OF A FILE INCLUDED ALL INFORMATION……..** **OTHER _____** **(SPECIFY)**	**A** **B** **C** **D** **E** **F** **G** **H** **I** **J** **K** **L** **M** **N** **O** **P** **Q** **R** **S** **T** **X**	→ 201
119	Why did you not blissful?	**LONG WAITING PERIOD…….…..** **EXPENSIVE ……..…..** **STAFF TREATS US BADLY……..…..** **DIRTY PLACE…….……..…..** **PLACE NOT ARRANGED……...…..** **EXAMINATION IS NOT ACCORDING TO TURN** **WORKING HOURS ARE NOT SUITABLE…..** **WAITING PLACE IS NOT COMFORTABLE...** **DOCTOR IS NOT PRESENT MOST OF TIME.** **DOCTOR IS CONTINUOUS CHANGE…….** **NO PRIVACY WHILE EXAMINING…….....** **NO OTHER SERVICES THAN FP……....** **NO FEMALE DOCTOR……...…….....** **NOT ALL METHODS ARE AVAILABLE…....** **MEDICATIONS ARE NOT AVAILABLE…....** **NURSE/ DOCTOR AREN'T HELPFUL OR FRIENDLY** **OTHER_____** **(SPECIFY)**	**A** **B** **C** **D** **E** **F** **G** **H** **I** **J** **K** **L** **M** **N** **O** **P** **X**	

SECTION 2
CLIENT SATISFACTION

NO.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
	Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the maternal health services.		
201	How long did you wait between the time you first arrived at this facility and the time a Provider saw you for the consultation?	**MINUTES .....** ☐☐☐ **SAW PROVIDER IMMEDIATELY……000** **DON'T KNOW……...……998**	

202 Often people can identify particular issues that they either don't like or feel are problems that may affect whether they are satisfied with the health services they receive. Can you name any issues that you think were problems with your experience here at this facility today?

- FOR EACH ISSUE THE RESPONDENT IDENTIFIES ASK: Do you consider this a big problem or a small problem?

WHEN THE RESPONDENT CAN NO LONGER NAME ISSUES, PROBE FOR EACH ISSUE LISTED BELOW THAT WAS NOT MENTIONED.

Now I want to ask you about a few other issues that other clients have identified. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems

	SPONTANEOUS		PROMPT			
	BIG	SMALL	BIG	SMALL	NO	DK/NA
1) Time you waited?	1	2	3	4	5	8
2) Time it takes to complete all parts of the consultation once initially seen?	1	2	3	4	5	8
3) Time it takes to receive results from laboratory?	1	2	3	4	5	8
4) Ability to discuss problems or concerns about your health with the health provider?	1	2	3	4	5	8
5) Amount of explanation you were given about the problem or treatment?	1	2	3	4	5	8
6) Quality of the examination and treatment provided?	1	2	3	4	5	8
7) Privacy from others seeing exam?	1	2	3	4	5	8
8) Privacy from others hearing discussion?	1	2	3	4	5	8
9) Availability of medicines at the facility?	1	2	3	4	5	8
10) The hours/days of services?	1	2	3	4	5	8
11) Cleanliness of facility?	1	2	3	4	5	8
12) How staff treated you?	1	2	3	4	5	8
13) Cost of services?	1	2	3	4	5	8
14) Other _____ (SPECIFY)	1	2			5	

No.	QUESTIONS & FILTERS	CODING CLASSIFICATION	SKIP TO
203	Do you participate in any pre-pay plan such as health insurance, or other program or an institutional arrangement that provides some of the payment for services at this facility? This includes if you prepay for a package of services or if you received a discounted price or an exemption from paying. **IF YES,** what type of program do you participate in?	**YES, HEALTH INSURANCE.....A** **YES, OTHER SYSTEM.....B** **YES, PREPAY AT FACILITY FOR PACKAGE OF SERVICES.....C** **YES, DISCOUNT/EXEMPT STATUS.....D** **OTHER _____X** **(SPECIFY)** **NO.....Y** **DON'T KNOW.....Z**	
204	Did you paid for the family file?	**YES..... 1** **NO…… 2** → 206	
205	How much did you pay?	**L.E……** ☐☐	
206	What is the total amount for all staff, services, or treatments which you paid for the consultation today? Please include any money you paid for staff services, laboratory tests, or medicines you received.	**1) LAB** **L.E** ☐☐☐ **Piaster** ☐☐ **PAID NO MONEY ..... 00000** **NOT APPLICABLE..... 99995** **DON'T KNOW..... 99998**	
		2) MEDICINE **L.E** ☐☐☐ **Piaster** ☐☐ **PAID NO MONEY ..... 00000** **NOT APPLICABLE..... 99995** **DON'T KNOW..... 99998**	
		3) CONSULT **L.E** ☐☐☐ **Piaster** ☐☐ **PAID NO MONEY ..... 00000** **NOT APPLICABLE..... 99995** **DON'T KNOW..... 99998**	
		4) OTHER **L.E** ☐☐☐ **Piaster** ☐☐ **PAID NO MONEY ..... 00000** **NOT APPLICABLE..... 99995** **DON'T KNOW..... 99998**	
		5) TOTAL AMOUNT **L.E** ☐☐☐ **Piaster** ☐☐ **PAID NO MONEY ..... 00000** **NOT APPLICABLE..... 99995** **DON'T KNOW..... 99998**	

SECTION 3
PERSONAL CHARACTERISTICS OF CLIENT

No.	QUESTIONS & FILTERS	CODING CLASSIFICATION	SKIP TO
301	Could you tell me how old are you?	AGE IN YEARS..... ☐☐ DON'T KNOW..... 98	
302	Have you ever attended school?	YES.....1 NO.....2	→ 304
303	What is the highest level of school (certificate) you have successfully completed?	NONE.....1 PRIMARY.....2 PREPARATORY.....3 SECONDARY.....4 ABOVE SECONDARY.....5 UNIVERSITY.....6 ABOVE UNIVERSITY.....7	→ 306
304	Have you ever attended any literacy classes?	YES.....1 NO.....2	
305	Can you read or write?	YES, READ ONLY.....1 YES, READ AND WRITE.....2 NO.....3	
306	Are you currently employed?	YES.....1 NO.....2	→ 309
307	Do you work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER.....1 FOR SOMEONE ELSE.....2 FOR HERSELF.....3	
308	Do you earn your wage or salary in the form of cash or kind or both, or you don't take any?	CASH.....1 BOTH.....2 KIND.....3 NOTHING.....4	
309	Do you live in a city or a village?	CITY.....1 VILLAGE.....2	
310	Which governorate do you live in?	GOVERNORATE_____ ☐☐ _____	
311	INTERVIEWER COMMENTS _____ _____ _____ _____		

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates **Focus Group Discussions Guideline**
Study on reproductive health impact of **for health service provider**
family health model pilot in Egypt **Reproductive health Egypt 2008**

Data for the discussion team

Discussion name:
Recorder name: **Number of the recorded tapes: ( )**
tapes
Governorate : **Number of the team:**
Supervisor name: **Date of the discussion: /2/2008**

Identification data

Place of the interview:
Number of participants:
Any other important information that must be specified:
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……

General comments about the focus

Please do small notes about the session in a general image and the how the participants responded, and was it was easy to convince them to attend and participate, the same words that they told, anything you think that is related to the session in addition to the notes written in the session contents.

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates **Focus Group Discussions Guideline**
Study on reproductive health impact of **for health service provider**
family health model pilot in Egypt **Reproductive health Egypt 2008**

Identification card

Focus Group for health service provider

Line NO.	Name	Age	Eligible	Social status
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates **Focus Group Discussions Guideline**
Study on reproductive health impact of **for health service provider**
family health model pilot in Egypt **Reproductive health Egypt 2008**

Focus group

Health service provider

El salm elekoum wa rahmat Allah w barakatoh……..

My name…….. we are conducting a study to identify more on the impact of the family health unit model(family medical) on the health services, by your permission with us Mr. …….. records what we are saying and I would like to know that data of the study would in privacy and also by your permission we will record this session so that we don not miss any information from what we are going to say.

This session is going to take around one hour and half and we want to hear everyone of you, and for that we don't want to interrupt each other and accordingly we want to hear all of you ……. Can we start?

Accept ☐ Reject ☐

And if you approve first could we know your names.

Distribution of the focus group

3.	**4.**	**5.**
2.		**6.**
1.		**7.**

Recorder	**Discussion**

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates **Focus Group Discussions Guideline**
Study on reproductive health impact of **for health service provider**
family health model pilot in Egypt **Reproductive health Egypt 2008**

Focus group discussion

First: Changes in the health unit:

First question: is there is any changes happened in the facility in …

Determents	Before		After	
	Increase	decrease	Increase	decrease
Medicines				
Family planning methods				
Immunizations				
Instruments				

Second: The work and arrangements impact on the flow of clients:

Second question: Did the flow of clients increase on the premarital examination? And why?

……

Third question: Did the flow of clients increase on the antenatal care? And why?

……

Fourth question: Did the flow of clients increase on the post antenatal care services? And why?

……

Fifth question: Did the flow of clients increase on post antenatal care services and abortion care? And why?

……

Sixth question: Did the flow of clients increase on the immunizations? And why?

……

……

Seventh question: Did the flow of clients increase on the immunizations? And why?

……

……

Eighth question: Did the flow of clients increase on the child care? And why?

……

……

Sixth question: Did the flow of clients increase on the inflammation of the sexual system for men services? And why?

……

……

Sixth question: Did the flow of clients increase on the inflammation of the sexual system for women services? And why?

……

……

Fourth: Evaluations for the role of raedat:

Eleventh question: do you find the role of raida el refia in the family health care(family medical)?

……

……

twelfth question: Is there is a decrease in the average flow of on the family planning services(family medical)? what are the reasons?

……

……

Fourth: suggestions for improving the services for the targeted category:

Twelfth question: what are the things that you like to exist in the family health unit(family medical).

……
……
……

Do any of you have another project that is closely related to the focus discussion

We would like to thank you to what you did from effort and participate in this focus discussion hoping that you continue to cooperate in the development of the reproductive health in order to arise with the level of health for the dearest Egypt

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates **Focus Group Discussions Guideline**
Study on reproductive health impact of **for married women**
family health model pilot in Egypt **Reproductive health Egypt 2008**

Data for the discussion team

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Identification data

Place of the interview:
Number of participants:
Any other important information that must be specified:
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……
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General comments about the focus

Please do small notes about the session in a general image and the how the participants responded, and was it was easy to convince them to attend and participate, the same words that they told, anything you think that is related to the session in addition to the notes written in the session contents.

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates
Study on reproductive health impact of family health model pilot in Egypt

Focus Group Discussions Guideline for married women
Reproductive health Egypt 2008

Identification card

Focus Group for married women in the reproductive age

Line NO.	Name	Age	Eligible	Social status	Number of living children	
					Males	Females
1.						
2.						
3.						
4.						
5.						
6.						
7.						

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Study on reproductive health impact of family health model pilot in Egypt

Focus Group Discussions Guideline for married women Reproductive health Egypt 2008

Focus group
Married women
in the reproductive age

El salm elekoum wa rahmat Allah w barakatoh……..

My name…….. we are conducting a study to identify more on the impact of the family health unit model(family medical) on the health services, by your permission with us Miss/ Mrs. …….. records what we are saying and I would like to know that data of the study would in privacy and also by your permission we will record this session so that we don not miss any information from what we are going to say.

This session is going to take around one hour and half and we want to hear everyone of you, and for that we don't want to interrupt each other and accordingly we want to hear all of you ……. Can we start?

Accept ☐ Reject ☐

And if you approve first could we know your names.

Distribution of the focus group

3.	**4.**	**5.**
2.		**6.**
1.		**7.**
Recorder	**Discussion**	

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates
Study on reproductive health impact of family health model pilot in Egypt

Focus Group Discussions Guideline for married women
Reproductive health Egypt 2008

Focus group discussion

First: Transfer from health unit to family health unit and vice versa and going to another places:

First question: Did you used to go to the health unit(mention the name of the unit) before it transferred to be family health unit(family medical)?

……

If the answer no: did you go to another places? Like what?

……

……

Second question: What were the services that you get from the heath unit(mention the name of the unit) before it became family health unit(family medical)?

……

……

Third question: What is your opinion about the service before and after it became family health unit(family medical)?

Determinates	Improved, why	Not improved, why
Purgation and arrangements of the unit		
Family file		
Family medical clinic		
Instruments		
Medicines		
Doctors		
Nurses		

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Study on reproductive health impact of **for married women**
family health model pilot in Egypt **Reproductive health Egypt 2008**

Determinates	Improved, why	Not improved, why
Referral to the hospital		
Follow up for health		
Provided services for mothers, children, youth and husbands		
Labs		
Length of the examination		
Efficiency of the administrative services		

In addition to

…….....

……

Fourth question: What are the differences that exist between family health unit(family medical) and the other places that you can go and take the service?(probe for all of the differences)

1. 2.
3. 4.
5. 6.

Fifth question: Which services did you like more? And why?

Family health service(family medical)	Another medical place
1.	1.
2.	2.
3.	3.
4.	4.

In addition to

…….....

…….

Sixth question: Do you know the services that is presented in the family health clinic(medical health) for free? And who told you about?

……
……
…….

Seventh question: Did the family health clinic give a chance to the females and males that they go and examine and take a medication or not?

……

In your opinion what are these cases?

……

Eighth question: What are the main advantages of the family health clinic(family medical)? And why?

…….
……

Ninth question: What are the main disadvantages of the family health clinic(family medical)? And why?

……
……

Second: The evaluation of the elements of the family health unit(family medical):

Tenth question: Did anyone go to family health clinic(family medical) and found problems or felt uncomfortable in the things I am going to say ? and why?

Determinates	
Family planning services	
Antenatal care	
Help in delivery or referral to a delivery hospital	
Post antenatal care (mother, birth child)	

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Focus Group Discussions Guideline for married women
Reproductive health Egypt 2008

Determinates	
Pregnant immunization (Tetanus vaccine)	
Children immunizations	
Women examination (Discharge, genital sore	
Child examination	
Follow up for the child growth (height and weight measure)	
Attending the seminars (family planning, antenatal care)	
Husband examination in case of illness	
Examining males and females in case of illness/ health problems	
Availability of medicines	
Lab	
Referral to hospital	
Follow up- and medicating the diabetes and the blood pressure	
Other services	

In addition to

…….....

……

Third : How to the people know about the family health project(family medical):

Eleventh question: In your opinion what is the best method to let people know about the services that family health unit (family medical) provides from the family planning services and mother care and ……?

……
……
……

Fourth: suggestions for improving the services for the targeted category:

Twelfth question: what are your suggestions to make family health services (family medical) good and many people as possible benefit form it(husbands, mothers, children, males, females)?

……
……
……

Do any of you have another project that is closely related to the focus discussion

We would like to thank you to what you did from effort and participate in this focus discussion hoping that you continue to cooperate in the development of the reproductive health in order to arise with the level of health for the dearest Egypt

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates **Focus Group Discussions Guideline**
Study on reproductive health impact of **for non married females**
family health model pilot in Egypt **Reproductive health Egypt 2008**

Data for the discussion team

Discussion name:
Recorder name: **Number of the recorded tapes: ( ) tapes**
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Supervisor name: **Date of the discussion: /2/2008**

Identification data

Place of the interview:
Number of participants:
Any other important information that must be specified:
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General comments about the focus

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Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates
Study on reproductive health impact of family health model pilot in Egypt

Focus Group Discussions Guideline for non married females
Reproductive health Egypt 2008

Identification card

Focus Group for non married females

Line NO.	Name	Age	Eligible	Social status
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates **Focus Group Discussions Guideline**
Study on reproductive health impact of **for non married females**
family health model pilot in Egypt **Reproductive health Egypt 2008**

Focus group
Non married females

El salm elekoum wa rahmat Allah w barakatoh……..

My name…….. we are conducting a study to identify more on the impact of the family health unit model(family medical) on the health services, by your permission with us Miss/ Mrs. …….. records what we are saying and I would like to know that data of the study would in privacy and also by your permission we will record this session so that we don not miss any information from what we are going to say.

This session is going to take around one hour and half and we want to hear everyone of you, and for that we don't want to interrupt each other and accordingly we want to hear all of you ……. Can we start?

Accept ☐ Reject ☐

And if you approve first could we know your names.

Distribution of the focus group

3.	**4.**	**5.**
2.		**6.**
1.		**7.**
Recorder	**Discussion**	

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates **Focus Group Discussions Guideline**
Study on reproductive health impact of **for non married females**
family health model pilot in Egypt **Reproductive health Egypt 2008**

Focus group discussion

First: background about the services and how are the beneficial categories from them:

First question: What did you know about the services of the family health method(family medical)?

……

What are these services?

……

Who can benefit from these services?

……

Second question: Do girls at your age can have health problems? Like what?

……

……

Do these problems need a medication? What is the best place to have a medication? And why is this place specifically?

……

……

Third question: some girls may found things that prevents them from going to examine or taking a medication in some cases especially the sensitive ones, what are these things? What are there impacts on the girl and on her health situation?

……

……

Fourth question: For the health problems of the girls it can be medicated in many places, what is the place that the girls usually prefer from the places that I am going to tell you about? And why

1. private doctor Why
2. Ngo clinic Why
3. Health unit Why

Fifth question: When the family had a file, does this encourage the girls to go and examine in case of existing any health problem?

In case of yes
why?.....
…….

In case of no
why?.....
……

<u>Second: The evaluation of the elements of the family health unit(family medical):</u>

Sixth question: does it occur that pretty girls like you go to the family heath unit(family medical) with their small sisters for the children immunizations or to examine the child in case of his illness?
……
……

do you find that the treatment is good from the doctor, nurse which encourage that she herself examine if she had any health problem la kadar Allah?(probe about this treatment)
……
……

Third: how do the people know about the family health(family medical) project:

Eleventh question: is your father and mother or any of your neighbors or relatives talk about the family health unit(family medical) and that it can present health services for the girls?

If the answer is no: is it because that they didn't talk to them about or for another reason?

……

If the answer is yes: what exactly they talked to you about?

……

And is there is encouragement or prevention that you go and participate in seminars or discover in case of exiting of any health problem la kadar Allah to any one of you?

……

Fourth: suggestions for improving the services for the targeted category:

Twelfth question: what are the things that you like to exist in the family health unit(family medical) that can encourage to examine or even go and listen to seminars there

……

……

……

Do any of you have another project that is closely related to the focus discussion

We would like to thank you to what you did from effort and participate in this focus discussion hoping that you continue to cooperate in the development of the reproductive health in order to arise with the level of health for the dearest Egypt

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates **Focus Group Discussions Guideline**
Study on reproductive health impact of **for non married males**
family health model pilot in Egypt **Reproductive health Egypt 2008**

Data for the discussion team

Discussion name:
Recorder name: **Number of the recorded tapes: ( ) tapes**
Governorate : **Number of the team:**
Supervisor name: **Date of the discussion: /2/2008**

Identification data

Place of the interview:
Number of participants:
Any other important information that must be specified:
……
……
……
……
……

General comments about the focus

Please do small notes about the session in a general image and the how the participants responded, and was it was easy to convince them to attend and participate, the same words that they told, anything you think that is related to the session in addition to the notes written in the session contents.

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates
Study on reproductive health impact of family health model pilot in Egypt

Focus Group Discussions Guideline for non married males
Reproductive health Egypt 2008

Identification card

Focus Group for non married males

Line NO.	Name	Age	Eligible	Social status
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Arab Republic of Egypt
Ministry of Health and Population
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El Zanaty & Associates
Study on reproductive health impact of family health model pilot in Egypt

Focus Group Discussions Guideline for non married males
Reproductive health Egypt 2008

Focus group
Non married males

El salm elekoum wa rahmat Allah w barakatoh……..

My name…….. we are conducting a study to identify more on the impact of the family health unit model(family medical) on the health services, by your permission with us Mr. …….. records what we are saying and I would like to know that data of the study would in privacy and also by your permission we will record this session so that we don not miss any information from what we are going to say.

This session is going to take around one hour and half and we want to hear everyone of you, and for that we don't want to interrupt each other and accordingly we want to hear all of you ……. Can we start?

Accept ☐ Reject ☐

And if you approve first could we know your names.

Distribution of the focus group

3.	**4.**	**5.**
2.		**6.**
1.		**7.**
Recorder	**Discussion**	

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates
Study on reproductive health impact of family health model pilot in Egypt

Focus Group Discussions Guideline for non married males
Reproductive health Egypt 2008

Focus group discussion

First: background about the services and how are the beneficial categories from them:

First question: What did you know about the services of the family health method(family medical)?

……

What are these services?

……

Who can benefit from these services?

……

Second question: Do males at your age can have health problems? Like what?

……

……

Do these problems need a medication? What is the best place to have a medication? And why is this place specifically?

……

……

Third question: some males may found things that prevents them from going to examine or taking a medication in some cases especially the sensitive ones, what are these things? What are there impacts on the girl and on her health situation?

……..……

Fourth question: For the health problems of the males it can be medicated in many places, what is the place that the males usually prefer from the places that I am going to tell you about? And why

1. private doctor Why
2. Ngo clinic Why
3. Health unit Why

Fifth question: When the family had a file, does this encourage the males to go and examine in case of existing any health problem?

In case of yes
why?.....
...……

In case of no
why?.....
....……

Second: The evaluation of the elements of the family health unit(family medical):

Sixth question: does it occur that pretty males like you go to the family heath unit(family medical) with their small bothers for the children immunizations or to examine the child in case of his illness?

……
……..……

Do you find that the treatment is good from the doctor, nurse which encourage that he himself examine if he had any health problem la kadar Allah?(probe about this treatment)

……
……..……

Third: how do the people know about the family health(family medical) project:

Eleventh question: Is your father and mother or any of your neighbors or relatives talk about the family health unit(family medical) and that it can present health services for the males?

If the answer is no: is it because that they didn't talk to them about or for another reason?

……

If the answer is yes: what exactly they talked to you about?

……

And is there is encouragement or prevention that you go and participate in seminars or discover in case of exiting of any health problem la kadar Allah to any one of you?

……

Fourth: suggestions for improving the services for the targeted category:

Twelfth question: what are the things that you like to exist in the family health unit(family medical) that can encourage to examine or even go and listen to seminars there

……

…..……

……..……

Do any of you have another project that is closely related to the focus discussion

We would like to thank you to what you did from effort and participate in this focus discussion hoping that you continue to cooperate in the development of the reproductive health in order to arise with the level of health for the dearest Egypt

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates
Study on reproductive health impact of family health model pilot in Egypt

In-depth interview doctors
Reproductive health Egypt 2008

Data for the discussion team

Discussion name:
Recorder name: **Number of the recorded tapes: ( ) tapes**
Governorate : **Number of the team:**
Supervisor name: **Date of the discussion: /2/2008**

Identification data

Place of the interview:
Number of participants:
Any other important information that must be specified:
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……

General comments about the focus

Please do small notes about the session in a general image and the how the participants responded, and was it was easy to convince them to attend and participate, the same words that they told, anything you think that is related to the session in addition to the notes written in the session contents.

In-depth interview

Doctors

El salm elekoum wa rahmat Allah w barakatoh……..

My name…….. we are conducting a study to identify more on the impact of the family health unit model(family medical) on the health services, and I would like to know that data of the study would in privacy and also by your permission we will record this session so that we don not miss any information from what we are going to say.

This session is going to take around half hour ……. Can we start?

Accept ☐ Reject ☐

Arab Republic of Egypt
Ministry of Health and Population
UNFPA
El Zanaty & Associates
Study on reproductive health impact of family health model pilot in Egypt

In-depth interview doctors
Reproductive health Egypt 2008

Focus group discussion

First: Training for the family health project(family medical):

First question: Do you receive sufficient training in the family planning?

……

Mother care?

……

Child care?

……

Inflammation medication?

……

Diseases of the inflammation of the sexual system for men and women?

……

medication for males and females?

……

Second: Provides medical services and its advantages and its disadvantages:

Second question: Does the examination for the reproductive health is in one clinic for the individuals of the family ?

……

Third question: What are the advantages and the disadvantages of the family file?

Advantages:

……

…..……

Disadvantages:

……

……

And what is the effect of the family file on the flow for the reproductive health services?

……

……..……

Third: Evaluation of the supervision and the dependence:

Fourth question: Do you face any problems for the dependence? mention them?

……

……..……

Fifth question: Do you face any problems for the supervision?

……

……..……

Advantages		Disadvantages	
Before	**After**	**Before**	**After**

Fourth: suggestions for improving the services for the targeted category:

Twelfth question: what are the things that you like to exist in the family health unit(family medical).

……

…..……

……..……

Do any of you have another project that is closely related to the focus discussion

We would like to thank you to what you did from effort and participate in this focus discussion hoping that you continue to cooperate in the development of the reproductive health in order to arise with the level of health for the dearest Egypt

ARAB REPUBLIC OF EGYPT
MINISTRY OF HEALTH AND POPULATION
UNFPA
EL- ZANATY & ASSOCIATES

Questionnaire Number

EGYPT DEMOGRAPHIC AND HEALTH SURVEY 2008

HOUSEHOLD QUESTIONNAIRE

DATA COLLECTED FROM THIS STUDY IS CONFIDENTIAL AND WILL BE USED FOR SCIENTIFIC PURPOSES ONLY

IDENTIFICATION

GOVERNORATE _____ KISM/MARKAZ _____

SHIAKHA/VILLAGE _____ BUILDING NO. _____

HEALTH UNIT NO. _____ HOUSING UNIT NO. _____

HOUSEHOLD NUMBER _____

URBAN . . . . . 1 RURAL 2

NAME OF HOUSEHOLD HEAD _____

ADDRESS IN DETAIL _____

TELEPHONE NO. LANDLINE: _____ MOBILE: _____

GOVERNORATE	KISM/MARKAZ

SHIAKHA/VILLAGE	HEALTH UNIT NO.

HOUSEHOLD NO.	URBAN/RURAL

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE				DAY MONTH YEAR: 0 0 8
TEAM				TEAM . . . . .
INTERVIEWER				INT. NUMBER . . .
SUPERVISOR				SUP. NUMBER .
RESULT				RESULT . . . . .
NEXT VISIT: DATE				TOTAL NUMBER OF VISITS
TIME				

RESULT CODES:

1 COMPLETED
2 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME AT TIME OF VISIT
3 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME
4 POSTPONED
5 REFUSED
6 DWELLING VACANT OR ADDRESS NOT A DWELLING
7 DWELLING DESTROYED
8 DWELLING NOT FOUND
9 OTHER _____ (SPECIFY)

TOTAL PERSONS IN HOUSEHOLD

TOTAL ELIGIBLE WOMEN

LINE NO. OF RESPONDENT TO HOUSEHOLD QUESTIONNAIRE

ADDRESSED CHECKED BY: _____

	YES	NO
REINTERVIEW:	1	2

	FIELD EDITOR	OFFICE EDITOR	CODER	KEYER
NAME				
DATE	/ / 2008	/ / 2008	/ / 2008	/ / 2008
SIGNATURE				

HOUSEHOLD SCHEDULE

Now we would like some information about the people who usually live in your household or who are staying with you now.

LINE NO.	USUAL RESIDENTS	RELATIONSHIP	RESIDENCE		SEX	AGE	MARITAL STATUS
							IF AGE 15 OR OLDER
001	002	005	006	007	008	009	010
	Please give me the names of the persons who usually live in your household starting with the head of the household. AFTER LISTING NAMES, ASK QUESTIONS 003-004 TO BE SURE THAT THE LISTING IS COMPLETE. THEN GO ON TO QUESTION 006.	What is the relationship of (NAME) to the head of the household? (SEE CODES BELOW)	Does (NAME) usually live here?	Did (NAME) sleep here last night?	Is (NAME) male or female?	How old was (NAME)? at his/her last birthday? RECORD IN COMPLETED YEARS	What is (NAME'S) current marital status? 1 MARRIED 2 WIDOWED 3 DIVORCED 4 SEPARATED 5 SIGNED CONTRACT 6 NEVER MARRIED
			YES NO	YES NO	M F	IN YEARS	
01		HEAD 0 1	1 2	1 2	1 2		
02			1 2	1 2	1 2		
03			1 2	1 2	1 2		
04			1 2	1 2	1 2		
05			1 2	1 2	1 2		
06			1 2	1 2	1 2		
07			1 2	1 2	1 2		
08			1 2	1 2	1 2		
09			1 2	1 2	1 2		
10			1 2	1 2	1 2		

Just to make sure that I have a complete household listing:

003 Are there any other persons such as small children or infants that we have not listed? YES ☐ → ADD TO 002 NO ☐

004 In addition, are there any other people who may not be members of your family, such as domestic servants, lodgers or friends who usually live here? YES ☐ → ADD TO 002 NO ☐

CODES FOR Q006
RELATIONSHIP TO HEAD OF HOUSEHOLD:

01 = HEAD
02 = WIFE/HUSBAND
03 = SON/DAUGHTER
04 = SON-IN-LAW/ DAUGHTER-IN-LAW
05 = GRANDCHILD
06 = PARENT
07 = PARENT-IN-LAW
08 = BROTHER/SISTER
09 = BROTHER-IN-LAW/ SISTER-IN-LAW
10 = OTHER RELATIVE
11 = ADOPTED/FOSTER CHILD
12 = STEPCHILD
13 = NOT RELATED
98 = DON'T KNOW

LINE NO.	ELIGIBILE FOR WOMAN QUESTIONNAIRE (EVER-MARRIED AGE 15-49)	EDUCATION	
		IF AGE 6 YEARS OR OLDER	
	011	012	013
	CIRCLE LINE NUMBER OF EVER-MARRIED WOMEN AGE 15-49 WHO ARE RESIDENTS	Has (NAME) ever attended school?	What is the highest level of school (NAME) has attended? What is the highest grade (NAME) completed at that level? (SEE CODES BELOW)
		YES NO	LEVEL GRADE
01	01	1 2 → GO TO 023	
02	02	1 2 → GO TO 023	
03	03	1 2 → GO TO 023	
04	04	1 2 → GO TO 023	
05	05	1 2 → GO TO 023	
06	06	1 2 → GO TO 023	
07	07	1 2 → GO TO 023	
08	08	1 2 → GO TO 023	
09	09	1 2 → GO TO 023	
10	10	1 2 → GO TO 023	

CODES FOR Qs. 020, 022, AND 024

EDUCATION LEVEL:

0 = NURSERY SCHOOL
1 = PRIMARY
2 = PREPARATORY
3 = SECONDARY
4 = UPPER INTERMEDIATE
5 = UNIVERSITY
6 = MORE THAN UNIVERSITY

EDUCATION GRADE:

0 = LESS THAN 1 YEAR COMPLETED (FOR Q. 020 ONLY. THIS CODE IS NOT ALLOWED FOR Qs. 022 AND 024.)
8 = DON'T KNOW

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	What type of dwelling does your household live in?	APARTMENT . . . . . 1 FREE STANDING HOUSE . . . . . 2 OTHER _____ 6 (SPECIFY)	
102	Is your dwelling owned or rented by your household? IF OWNED: Is it owned solely by your household or jointly with someone else?	OWNED . . . . . 1 OWNED JOINTLY . . . . . 2 RENTED . . . . . 3 OTHER _____ 6 (SPECIFY)	
103	What is the main source of drinking water for members of your household?	**PIPED WATER** PIPED INTO DWELLING . . . . . 11 PIPED TO YARD/PLOT . . . . . 12 PUBLIC TAP/STANDPIPE . . . . . 13 **TUBE WELL** . . . . . 21 **DUG WELL** PROTECTED WELL . . . . . 31 UNPROTECTED WELL . . . . . 32 **WATER FROM SPRING** PROTECTED SPRING . . . . . 41 UNPROTECTED SPRING . . . . . 42 **TANKER TRUCK** . . . . . 61 **CART WITH SMALL TANK** . . . . . 71 **SURFACE WATER** (RIVER/DAM/ LAKE/POND/STREAM/CANAL/ IRRIGATION CHANNEL) . . . . . 81 **BOTTLED WATER** . . . . . 91 **OTHER** _____ 96 (SPECIFY)	→ 108 → 105 → 108
104	What is the main source of water used by your household for other purposes such as cooking and handwashing?	**PIPED WATER** PIPED INTO DWELLING . . . . . 11 PIPED TO YARD/PLOT . . . . . 12 PUBLIC TAP/STANDPIPE . . . . . 13 **TUBE WELL** . . . . . 21 **DUG WELL** PROTECTED WELL . . . . . 31 UNPROTECTED WELL . . . . . 32 **WATER FROM SPRING** PROTECTED SPRING . . . . . 41 UNPROTECTED SPRING . . . . . 42 **TANKER TRUCK** . . . . . 61 **CART WITH SMALL TANK** . . . . . 71 **SURFACE WATER** (RIVER/DAM/ LAKE/POND/STREAM/CANAL/ IRRIGATION CHANNEL) . . . . . 81 **OTHER** _____ 96 (SPECIFY)	→ 108
105	Where is (SOURCE IN 103 OR 104) located?	IN OWN DWELLING . . . . . 1 IN OWN YARD/PLOT . . . . . 2 ELSEWHERE 3	→ 108
106	How long does it take to go there, get water, and come back?	MINUTES . . . . . [ ][ ][ ] ON/NEXT TO PREMISES . . . . . 996 DON'T KNOW 998	→ 108
107	Who usually goes to this source to fetch the water for your household?	ADULT WOMAN 15+ . . . . . 1 ADULT MAN 15+ . . . . . 2 FEMALE CHILD UNDER 15 YEARS OLD . . . . . 3 MALE CHILD UNDER 15 YEARS OLD . . . . . 4 OTHER _____ 6 (SPECIFY)	
108	During the last two weeks, was there any time when water was not available from (SOURCE IN 103 OR 104)?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 110

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
109	Did this happen on a daily or almost daily basis, only a few times per week, or less frequently?	DAILY/ALMOST DAILY . . . . . 1 FEW TIMES PER WEEK . . . . . 2 LESS FREQUENTLY . . . . . 3 DON'T KNOW 8	
110	Do you treat your water in any way to make it safer to drink?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 112
111	What do you usually do to the water to make it safer to drink? Anything else? RECORD ALL MENTIONED.	BOIL . . . . . A ADD BLEACH/CHLORINE . . . . . B STRAIN THROUGH A CLOTH/COTTON C USE WATER FILTER (CERAMIC/ SAND/COMPOSITE/ETC.) . . . . . D SOLAR DISINFECTION . . . . . E LET IT STAND AND SETTLE . . . . . F OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
112	What kind of toilet facility do members of your household usually use?	MODERN FLUSH TOILET . . . . . 11 TRADITIONAL TANK FLUSH . . . . . 12 TRADITIONAL BUCKET FLUSH . . 13 PIT TOILET/LATRINE TOILET . . . . . 21 BUCKET TOILET . . . . . 41 NO FACILITY/FIELD . . . . . 61 OTHER _____ 96 (SPECIFY)	→ 117
113	Into where does this toilet flush drain?	PIPED SEWER SYSTEM . . . . . 01 VAULT (BAYARA) . . . . . 02 SEPTIC SYSTEM . . . . . 03 PIPED CONNECTED TO CANAL . . . . . 04 PIPED CONNECTED TO GROUND WATER . . . . . 05 EMPTIED (NO CONNECTION) . 06 OTHER _____ 96 (SPECIFY) DON'T KNOW WHERE 98	
114	Are you or your neighbors currently experiencing any problems with this drainage system?	YES . . . . . 1 NO 2	→ 116
115	What problems are you experiencing?	POOLING AROUND OWN DWELLING . A POOLING AROUND NEIGHBOR'S DWELLING . . . . . B COST OF EVACUATION . . . . . C MOSQUITOES/INSECTS . . . . . D OTHER _____ X (SPECIFY)	
116	Including your own household, how many households use this toilet?	NO. OF HOUSEHOLDS IF LESS THAN 10 . . . . . 0 [ ] 10 OR MORE HOUSEHOLDS . . . 95 DON'T KNOW 98	
117	Does your household have: Electricity? A radio with cassette recorder? A color television? A black and white television? A video or DVD player? A mobile? A telephone? A satellite dish? A personal home computer? A sewing machine? An electric fan? An air conditioner?	YES NO ELECTRICITY . . . . . 1 2 RADIO . . . . . 1 2 COLOR TV . . . . . 1 2 BLACK AND WHITE TV . . . . . 1 2 VIDEO/DVD . . . . . 1 2 MOBILE TELEPHONE . . . . . 1 2 NON-MOBILE TELEPHONE . . . 1 2 SATELLITE DISH . . . . . 1 2 COMPUTER . . . . . 1 2 SEWING MACHINE . . . . . 1 2 ELECTRIC FAN . . . . . 1 2 AIR CONDITIONER 1 2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
118	What type of fuel does your household mainly use for cooking?	ELECTRICITY . . . . . 01 LPG . . . . . 02 NATURAL GAS . . . . . 03 BIOGAS . . . . . 04 KEROSENE . . . . . 05 COAL, LIGNITE . . . . . 06 CHARCOAL . . . . . 07 WOOD . . . . . 08 STRAW/SHRUBS/GRASS . . . . . 09 AGRICULTURAL CROP . . . . . 10 ANIMAL DUNG . . . . . 11 OTHER _____ 96 (SPECIFY)	→ 120
119	In your household, is food cooked on a stove or an open fire? PROBE FOR TYPE.	OPEN FIRE OR STOVE WITHOUT CHIMNEY/HOOD . . . . . 1 OPEN FIRE OR STOVE WITH CHIMNEY/HOOD . . . . . 2 CLOSED STOVE WITH CHIMNEY . . . 3 OTHER _____ 6 (SPECIFY)	
120	Is the cooking usually done in the house, in a separate building, or outdoors?	IN THE HOUSE . . . . . 1 IN A SEPARATE BUILDING . . . . . 2 OUTDOORS . . . . . 3 OTHER _____ 6 (SPECIFY)	→ 122
121	Do you have a separate room which is used as a kitchen?	YES . . . . . 1 NO 2	
122	How does your household mainly dispose of kitchen waste and trash? RECORD MAIN METHOD OF DISPOSAL ONLY. IF TWO OR MORE METHODS ARE USED EQUALLY, RECORD THE METHOD HIGHEST ON THE LIST.	COLLECTED FROM HOME . . . . . 11 FROM CONTAINER IN STREET . . . 12 DUMPED INTO STREET/EMPTY PLOT . . . . . 21 INTO CANNAL/DRAINAGE . . . . . 22 BURNED . . . . . 31 FED TO ANIMALS . . . . . 41 OTHER _____ 96 (SPECIFY)	
123	Does your household have: A refrigerator? A freezer? A water heater? A dishwasher? An automatic washing machine? Any other washing machine? A bed? A sofa? A hanging lamp (yellow with no cover)? A table? A "Tablia" (very low round table)? A chair? Kolla/Zeer (a container for reserving water)?	YES NO REFRIGERATOR . . . . . 1 2 FREEZER . . . . . 1 2 WATER HEATER . . . . . 1 2 DISHWASHER . . . . . 1 2 AUTOMATIC WASHER . . . . . 1 2 OTHER WASHER . . . . . 1 2 BED . . . . . 1 2 SOFA . . . . . 1 2 HANGING LAMP . . . . . 1 2 TABLE . . . . . 1 2 TABLIA . . . . . 1 2 CHAIR . . . . . 1 2 KOLLA/ZEER 1 2	
124	How many rooms does your household use for living (excluding the bathrooms, kitchens and stairway areas)?	ROOMS	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
125	MAIN MATERIAL OF THE FLOOR. RECORD OBSERVATION.	NATURAL FLOOR EARTH/SAND . . . . . 11 RUDIMENTARY FLOOR WOOD PLANKS . . . . . 21 FINISHED FLOOR PARQUET OR POLISHED WOOD . . . . . 31 CERAMIC/MARBLE TILES . . . . . 32 CEMENT TILES . . . . . 33 CEMENT . . . . . 34 WALL-TO-WALL CARPET . . . . . 35 VINYL . . . . . 36 OTHER _____ 96 (SPECIFY)	
126	TYPE OF WINDOWS. RECORD OBSERVATION.	ALL WINDOWS WITH GLASS . . . . . 1 SOME WINDOWS WITH GLASS AND SOME WITHOUT GLASS . . . . . 2 ALL WINDOWS WITHOUT GLASS . . . 3 NO WINDOW OPENINGS 4	
127	Does any member of this household own: A watch? A bicycle? A motorcycle or motor scooter? An animal-drawn cart? A car or truck?	YES NO WATCH . . . . . 1 2 BICYCLE . . . . . 1 2 MOTORCYCLE/SCOOTER . . . 1 2 ANIMAL-DRAWN CART . . . . . 1 2 CAR/TRUCK 1 2	
128	Does any member of this household own any land that can be used for agriculture?	YES . . . . . 1 NO 2	→ 130
129	How many feddans or kirates of agricultural land do members of this household own? IF MORE THAN 95 FEDDAN, ENTER '9995'.	FEDDAN KIRATE LAND AREA [ ][ ] . [ ][ ] DON'T KNOW 9998	
130	Does your household own any livestock, herds, or farm animals or any poultry or birds?	YES . . . . . 1 NO 2	→ 132
131	How many of the following does your household own? Cattle (buffalo, calf)? Milk cows or bulls? Horses, donkeys, or mules? Goats? Sheep? Birds (Chickens, geese, ducks, and pigeons)? IF NONE, ENTER '00'. IF MORE THAN 95, ENTER '95'. IF UNKNOWN, ENTER '98'.	CATTLE . . . . . [ ][ ] COWS/BULLS . . . . . [ ][ ] HORSES/DONKEYS/MULES . [ ][ ] GOATS . . . . . [ ][ ] SHEEP . . . . . [ ][ ] BIRDS(CHICKENS/GEESE/ETC) [ ][ ]	
132	Does any member of your household have an account in a bank or any saving institution?	YES . . . . . 1 NO 2	

OBSERVATIONS
TO BE FILLED IN AFTER COMPLETING INTERVIEW

201 INTERVIEWER'S OBSERVATIONS

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

202 SUPERVISOR'S OBSERVATIONS

NAME OF SUPERVISOR: _____ DATE: _____

203 EDITOR'S OBSERVATIONS

NAME OF EDITOR: _____ DATE: _____

ARAB REPUBLIC OF EGYPT
MINISTRY OF HEALTH AND POPULATION
UNFPA
EL- ZANATY & ASSOCIATES

STUDY ON REPRODUCTIVE HEALTH IMPACT OF FAMILY HEALTH MODEL PILOT IN EGYPT 2008

WOMAN QUESTIONNAIRE

DATA COLLECTED FROM THIS STUDY IS CONFIDENTIAL AND WILL BE USED FOR SCIENTIFIC PURPOSES ONLY

WOMAN QUESTIONNAIRE

IDENTIFICATION

GOVERNORATE ..... KISM/MARKAZ .....
SHIAKHA/VILLAGE ..... BUILDING NO. .....
HEALTH UNIT NO. ..... HOUSING UNIT NO. .....
HOUSEHOLD NUMBER .....
URBAN ..... 1 RURAL 2
NAME OF HOUSEHOLD HEAD .....
ADDRESS IN DETAIL .....
NAME OF WOMAN .....
LINE NUMBER OF WOMAN .....

GOVERNORATE ☐☐ KISM/MARKAZ ☐☐
SHIAKHA/VILLAGE ☐☐ HEALTH UNIT NO. ☐☐
HOUSEHOLD NUMBER ☐☐☐ URBAN/RURAL ☐
LINE NUMBER OF WOMAN ☐☐

INTERVIEWER'S VISITS

	1	2	3
DATE	.....	.....	.....
TEAM	.....	.....	.....
INTERVIEWER	.....	.....	.....
SUPERVISOR	.....	.....	.....
RESULT	.....	.....	.....
NEXT VISIT DATE	.....	.....	
TIME	.....	.....	

FINAL VISIT

DAY ☐☐ MONTH ☐☐ YEAR 0 8
TEAM ☐☐
INTERVIEWER ☐☐
SUPERVISOR ☐☐
RESULT ☐

TOTAL NUMBER OF VISITS ☐

RESULT CODES

1 COMPLETED
2 NO COMPETENT RESPONDENT AT HOME AT THE OF VISIT
3 POSTPONED
4 REFUSED
5 PARTLY COMPLETED
6 OTHER _____
(SPECIFY)

HEALTH UNIT NO. .....

	FIELD EDITOR	OFFICE EDITOR	CODER	KEYER
NAME	_____	_____	_____	_____
DATE	/ / 2008	/ / 2008	/ / 2008	/ / 2008
SIGNATURE	_____	_____	_____	_____
	☐☐	☐☐	☐☐	☐☐

SECTION 1: BACKGROUND CHARACTERISTICS

My name is _____ and we are conducting a survey for the ministry of health and population in some regions to see the available health services. This information will help the government in planning health services.

The interview will take between 20 to 45 minutes to be completed. Whatever information you provide will be kept strictly confidential and will not be shown to other persons. Participation in the survey is voluntary and you can choose not to answer any of the questions or all questions. However, we hope that you will participate in the survey since your views are important.

Do you want to ask me anything about the survey? May I begin the interview now?

SIGNATURE OF THE INTERVIEWER: _____

RESPONDENT AGREED TO BE INTERVIEWED ..... 1 ↓ RESPONDENT DID NOT AGREE TO BE INTERVIEWED ..... 2 → 801

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
101	**RECORD THE TIME.**	HOUR ..... [ ][ ] MINUTES ..... [ ][ ]	
102	In what month and year were you born?	MONTH ..... [ ][ ] DON'T KNOW MONTH ..... 98 YEAR ..... [ ][ ][ ][ ] DON'T KNOW YEAR 9998	
103	How old were you at your last birthday? **COMPARE AND CORRECT 102 AND/OR 103 IF INCONSISTENT.**	AGE IN COMPLETED YEARS ..... [ ][ ]	
104	What is your current marital status?	MARRIED ..... 1 WIDOWED ..... 2 DIVORCED ..... 3 SEPARATED 4	
105	Now I would like to ask you some questions about your marriage(s). How many times have you been married?	NUMBER OF TIMES MARRIED ..... [ ]	
106	How old were you when you started living together with your (first) husband?	AGE IN COMPLETED YEARS ..... [ ][ ]	
107	Have you ever given birth?	YES ..... 1 NO ..... 2 → 111	
108	How many sons and daughters have you? **IF NONE, RECORD '00'.**	SONS ..... [ ][ ] DAUGHTERS ..... [ ][ ]	
109 110	How old is your last son/daughter? How old is your first son/daughter?	AGE OF LAST SON/DAUGHTER ..... [ ][ ] AGE OF FIRST SON/DAUGHTER ..... [ ][ ]	
111	Have you ever attended school?	YES ..... 1 NO ..... 2 → 115	
112	What is the highest level of school (certificate) you attended?	PRIMARY ..... 1 PREPARATORY ..... 2 SECONDARY ..... 3 UPPER INTERMEDIATE ..... 4 UNIVERSITY ..... 5 MORE THAN UNIVERSITY 6	
113	What is the highest grade you successfully completed at that level?	GRADE ..... [ ]	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
114	**Check 112:** PRIMARY ☐	PREPARATORY OR HIGHER ☐ →	116
115	Can you read a letter or a newspaper easily, with difficulty or not all?	EASILY ..... 1 WITH DIFFICULTY ..... 2 NOT AT ALL ..... 3 →	117
116	Do you usually read a newspaper or magazine almost every day, at least once a week, less than once a week or not at all?	ALMOST EVERYDAY ..... 1 AT LEAST ONCE A WEEK ..... 2 LESS THAN ONCE A WEEK ..... 3 NOT AT ALL 4	
117	Do you usually listen to the radio almost everyday, at least once a week, less than once a week or not at all?	ALMOST EVERYDAY ..... 1 AT LEAST ONCE A WEEK ..... 2 LESS THAN ONCE A WEEK ..... 3 NOT AT ALL 4	
118	Do you usually listen to watch television almost every day, at least once a week, less than once a week or not at all?	ALMOST EVERYDAY ..... 1 AT LEAST ONCE A WEEK ..... 2 LESS THAN ONCE A WEEK ..... 3 NOT AT ALL 4	

SECTION 2: REPRODUCTION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
201	Have you ever heard (knew) of "premarital examination" that is a consultation with a doctor or any medical staff as part of the preparation for marriage or have you ever heard (knew) of "newly wed examination" that is a consultation with a doctor or any medical staff within one or two months after getting married?	YES, PREMARITAL EXAMINATION ..... A YES, NEWLY WED EXAMINATION ..... B NONE FOR BOTH ..... Y →	207
202	Can you tell me what is the importance of the medical advice and the examination for those who are going to marry?	TO BE SURE OF SAFETY HEALTH ..... A TREATMENT FOR THE PROBLEMS WHICH MAY AFFECT THE RESULTS OF PREGNANCY ..... B PREVENT INHERITED DISEASES ..... C DISCOVERMENT&TREATMENT FOR THE DISEASES WHICH CAN AFFECT THE MARRIAGE&REPRODUCTION LIKE DIABETES ..... D TAKE NECESSARY VACCINATION SPECIALLY FOR FEMALE ..... E OTHER _____ X (SPECIFY) NONE FOR BOTH ..... Y	
203	Have you ever done “premarital examination” or “newly wed examination”?	YES, PREMARITAL EXAMINATION ..... A YES, NEWLY WED EXAMINATION ..... B NONE FOR BOTH ..... Y →	207
204	Where was this examination? **WRITE THE NAME AND THE ADDRESS OF THE PLACE.** _____ _____ _____ _____ **(NAME AND ADDRESS OF PLACE)**	HEALTH UNIT THAT HAS A FAMILY HEALTH IN YOUR AREA/VILLAGE ..... 01 ANOTHER HEALTH CENTRE THAT DOES NOT HAS A FAMILY HEATH (INSIDE YOUR AREA/VILLAGE) 02 PRIVATE CLINIC INSIDE YOUR AREA/VILLAGE .. 03 MOSQUE/CHURCH CLINIC INSIDE YOUR AREA/ VILLAGE ..... 04 PHARMACY INSIDE YOUR AREA/VILLAGE ..... 05 GOVERNMENTAL HOSPITAL INSIDE YOUR AREA/ VILLAGE ..... 06 PRIVATE HOSPITAL INSIDE YOUR AREA/VILLAGE 07 NGOS HOSPITAL INSIDE YOUR AREA/VILLAGE 08 ANOTHER HEALTH CENTRE DOES NOT HAS FAMILY HEATH (OUTSIDE YOUR AREA/VILLAGE) ..... 09 PRIVATE CLINIC OUTSIDE YOUR AREA/VILLAGE 10 MOSQUE/CHURCH CLINIC OUTSIDE YOUR AREA/ VILLAGE ..... 11 PHARMACY OUTSIDE YOUR AREA/VILLAGE ..... 12 GOVERNMENTAL HOSPITAL OUTSIDE YOUR AREA/ VILLAGE ..... 13 PRIVATE HOSPITAL OUTSIDE YOUR AREA/VILLAGE 14 NGOS HOSPITAL OUTSIDE YOUR AREA/VILLAGE 15 OTHER _____ 96 (SPECIFY)	
205	In what year did you do this examination?	YEAR ..... ☐☐☐☐	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
206	What are the reasons for choosing this place?	THE PLACE IS NEAR ..... 01 THERE IS NO OTHER PLACE ..... 02 EASY TRANSPORTATION TO IT ..... 03 COST IS CHEAP/SUITABLE ..... 04 CHEAPEST PLACE ..... 05 RELATED TO HIO ..... 06 ALL PEOPLE SAY THIS PLACE IS THE BEST FOR THIS SERVICE ..... 07 WE WELL KNEW DOCTOR ..... 08 DOCTORS ARE CLEVER ..... 09 FEMALE PHYSICIAN ..... 10 WELL ORGANIZED ..... 11 TIMES ARE SUITABLE ..... 12 MEDICINES ARE AT THE UNIT ALL THE TIME (INCLUDES FAMILY PLANNING METHODS) ..... 13 THE NURSE AND ASSISTANT TEAM ARE GOOD ..... 14 ALL THE SERVICES IS BEING IN THE SAME PLACE (LABORATORY, RAYS,....) ..... 15 IF PERSON DID NOT GO THE NURSE VISITS HIM IN HIS HOUSE (ANTENATAL CARE, POSTNATAL CARE, VACCINATION,...) ..... 16 THE SERVICE IS AVAILABLE ALL THE TIME (MORNING, EVENING) ..... 17 THE SERVICES IS GOOD OVERALL ..... 18 OTHER _____ 96 (SPECIFY)	
207	Is the examination to young man or young woman (age 15-24) important for assuring at their health?	YES ..... 1 NO 2	
208	What are the cases that make young woman should examine to be assure from the thing that may affect the marriage and reproduction?	ADULT DELAYING (MENSTRUAL PERIOD) ..... A NO GROWTH IN BREASTS AND NO APPEARANCE OF HAIR IN THE AXILLA OR PUBES ..... B APPEARANCE OF OUTSIDE INFLAMMATION/ VIRGINITIES/ SECRETIONS/ ITCHES ..... C OTHER _____ X (SPECIFY) DON'T KNOW/NO NEED TO EXAMINE ..... Z	
209	What are the cases that make young man should examine to be assure from the thing that may affect the marriage and reproduction?	ADULT DELAYING (NO APPEARANCE FOR OF MUSTACHE, NO APPEARANCE OF HAIR IN THE AXILLA OR PUBES ..... A IN CASE THERE IS INFLAMMATION SECRETIONS AND PAIN IN URINE ..... B OTHER _____ X (SPECIFY) DON'T KNOW/NO NEED TO EXAMINE ..... Z	
210	Have you any daughters or sons aged 15-24 years (your children or brothers)?	YES, GIRLS ..... A YES, BOYS ..... B NO ..... C →	301

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
211	Did any of your daughters or sisters (15-24 years) need to examine theirself for the things I am going to tell you about? - Influenza/tonsils/nose and ear/ophthalmic ..... - Digestive apparatus problems ..... - Skin problems (acne) ..... - Adult delaying ..... - Menstrual period problems ..... - Burning during urination ..... - OTHER _____ (SPECIFY) **IF ANSWER 2, SKIP TO NEXT ITEM**	YES NO NA 1 2 5 1 2 5 1 2 5 1 2 5 1 2 5 1 2 5 1 2 5 place (SEE CODES BELOW) [ ][ ] reasons of choosing (SEE CODES BELOW) [ ][ ]	
212	Did any of your sons or brothers (15-24 years) need to examine theirself for the things I am going to tell you about? - Influenza/tonsils/nose and ear/ophthalmic ..... - Digestive apparatus problems ..... - Skin problems (acne) ..... - Adult delaying ..... - Burning during urination ..... - OTHER _____ (SPECIFY) **IF ANSWER 2, SKIP TO NEXT ITEM**	YES NO NA 1 2 5 1 2 5 1 2 5 1 2 5 1 2 5 1 2 5 place (SEE CODES BELOW) [ ][ ] reasons of choosing (SEE CODES BELOW) [ ][ ]	

***PLACE CODES**

HEALTH UNIT THAT HAS A FAMILY HEALTH IN YOUR AREA/VILLAGE 01
ANOTHER HEALTH CENTRE THAT DOES NOT HAS A FAMILY HEATH (INSIDE YOUR AREA/VILLAGE) 02
PRIVATE CLINIC INSIDE YOUR AREA/VILLAGE 03
MOSQUE/CHURCH CLINIC INSIDE YOUR AREA/VILLAGE 04
PHARMACY INSIDE YOUR AREA/VILLAGE 05
GOVERNMENTAL HOSPITAL INSIDE YOUR AREA/VILLAGE 06
PRIVATE HOSPITAL INSIDE YOUR AREA/VILLAGE 07
NGOS HOSPITAL INSIDE YOUR AREA/VILLAGE 08
ANOTHER HEALTH CENTRE DOES NOT HAS FAMILY HEATH (OUTSIDE YOUR AREA/VILLAGE) 09
PRIVATE CLINIC OUTSIDE YOUR AREA/VILLAGE 10
MOSQUE/CHURCH CLINIC OUTSIDE YOUR AREA/VILLAGE 11
PHARMACY OUTSIDE YOUR AREA/VILLAGE 12
GOVERNMENTAL HOSPITAL OUTSIDE YOUR AREA/ VILLAGE 13
PRIVATE HOSPITAL OUTSIDE YOUR AREA/VILLAGE 14
NGOS HOSPITAL OUTSIDE YOUR AREA/VILLAGE 15
OTHER _____ 96
(SPECIFY)

****REASON OF CHOOSING CODES**

THE PLACE IS NEAR 1
THERE IS NO OTHER PLACE 2
EASY TRANSPORTATION TO IT 3
COST IS CHEAP/SUITABLE 4
CHEAPEST PLACE 5
RELATED TO HIO 6
ALL PEOPLE SAY THIS PLACE IS THE BEST FOR THIS SERVICE 7
WE WELL KNEW DOCTOR 8
DOCTORS ARE CLEVER 9
FEMALE PHYSICIAN 10
WELL ORGANIZED 11
TIMES ARE SUITABLE 12
MEDICINES ARE AT THE UNIT ALL THE TIME (INCLUDES FAMILY PLANNING METHODS) 13
THE NURSE AND ASSISTANT TEAM ARE GOOD 14
ALL THE SERVICES IS BEING IN THE SAME PLACE (LABORATORY, RAYS,....) 15
IF PERSON DID NOT GO THE NURSE VISITS HIM IN HIS HOUSE (ANTENATAL CARE, POSTNATAL CARE, VACCINATION,...) . 16
THE SERVICE IS AVAILABLE ALL THE TIME (MORNING, EVENING) 17
THE SERVICES IS GOOD OVERALL 18
OTHER _____ 96
(SPECIFY)

SECTION 3. ANTENATAL CARE, POSTNATAL CARE AND BREASTFEEDING

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
301	Have you ever heard about the antenatal care?	YES ..... 1 NO ..... 2 →	304
302	Do you know what are the antenatal care services?	YES ..... 1 NO ..... 2 →	304
303	What are these services?	WEIGHT MEASURE ..... A BLOOD PRESSURE MEASURE ..... B BLOODALYSIS ..... C URINALYSIS ..... D CHEST EXAMINATION ..... E HEART EXAMINATION ..... F BELLY EXAMINATION ..... G OBSERVATION EMBRYO GROWTH ..... H DETERMINATION DATE&PLACE OF DELIVERY .. I GET TETANUS VACCINATION ..... J GET IRON TABLES AND AMINO ACID ..... K TREATMENT OF ANY HEALTH PROBLEM DURING PREGNANCY ..... L THERE IS AN ARCHIVE AT THE UNIT TO ENSURE THAT WOMAN IS REGULAR AT THE ANTENATAL CARE VISITS ..... M DOING HOME VISITS FROM UNIT IF WOMAN IN NOT REGULARLY AT ANTENATAL CARE ..... N HEIGHT MEASURE ..... O OTHER _____ X (SPECIFY)	
304	Have you ever heard about safe delivery?	YES ..... 1 NO ..... 2 →	306
305	What is mean by safe delivery?	DELIVERY AT HOME IF THERE IS A CLEAN PLACE AND WATER ..... A DELIVERY IN A HEALTHY PLACE ..... B THE IMPORTANTANCE OF EXISTING A MEAN OF TRANSPORTATION AT TIME TO THE NEAREST HOSPITAL TO HAVE THE DELIVERY SERVICES/EMERGENCY C THE IMPORTANTANCE OF THE DELIVERY BY DOCTOR OR A TRAINED NURSE ..... D OTHER _____ X (SPECIFY)	
306	Have you ever heard about postnatal care?	YES ..... 1 NO ..... 2 →	308
307	What are the services of the postnatal care (examination during 40 days after delivery) for the mother?	ENSURE THAT THE MOTHER HAS A GOOD HEALTH A DISCOVERY HEMORRHAGE VAGINAL ..... B DISCOVERY CHILDBED FEVER ..... C ENSURE THAT THE BREASTFEEDING STARTED AFTER THE DELIVERY BY 2 HOURS ..... D TAKEN VITAMIN A CAPSULES ..... E OTHER _____ X (SPECIFY)	
307a	What are the services of the postnatal care (examination during 40 days after delivery) for the child?	ANY PROBLEMS IN UMBILICAL CORD ..... A CONGENITAL ANOMALIES ..... B ENSURE THAT THE BABY CAN BREASTFEED ..... C VACCINATION POLIO 0& BCG ..... D DISCOVERY HEALTH PROBLEM LIKE BILE ..... E OTHER _____ X (SPECIFY)	

308 **FOR THE INTERVIEWER:** CHECK 109 AND 110, IN CASE THAT THERE IS NO CHILDREN FROM 2002-2007 GO TO Q409

Now I would like to ask you some questions about the care you took during pregnancy and delivery through the few years before. Can you tell me names of your children who were delivered between 2002 and 2007 and we will begin with the last child. **NO. OF CHILDREN** ☐ IF MORE THAN 5 CHILDREN USE ADDITIONAL QUESTIONNAIRE

Child name	----------	----------	----------	----------	----------
Year of birth	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
A. Antenatal care	YES NO	YES NO	YES NO	YES NO	YES NO
have an antenatal care	1 2 → **SKIP TO B**	1 2 → **SKIP TO B**	1 2 → **SKIP TO B**	1 2 → **SKIP TO B**	1 2 → **SKIP TO B**
place of having this care*	☐☐	☐☐	☐☐	☐☐	☐☐
reasons of choosing place**	☐☐	☐☐	☐☐	☐☐	☐☐
B. Delivery					
who is help in delivery	☐	☐	☐	☐	☐
place of delivery*	☐☐	☐☐	☐☐	☐☐	☐☐
reasons of choosing place**	☐☐	☐☐	☐☐	☐☐	☐☐
C. Postnatal care	YES NO	YES NO	YES NO	YES NO	YES NO
C1.postnatal care for mother	1 2 → **SKIP TO C2**	1 2 → **SKIP TO C2**	1 2 → **SKIP TO C2**	1 2 → **SKIP TO C2**	1 2 → **SKIP TO C2**
place of postnatal care*	☐☐	☐☐	☐☐	☐☐	☐☐
reasons of choosing place**	☐☐	☐☐	☐☐	☐☐	☐☐
C2.postnatal care for child	YES NO 1 2 → **SKIP TO NEXT CHILD OR 401**	YES NO 1 2 → **SKIP TO NEXT CHILD OR 401**	YES NO 1 2 → **SKIP TO NEXT CHILD OR 401**	YES NO 1 2 → **SKIP TO NEXT CHILD OR 401**	YES NO 1 2 → **SKIP TO NEXT CHILD OR 401**
place of postnatal care*	☐☐	☐☐	☐☐	☐☐	☐☐
reasons of choosing place**	☐☐	☐☐	☐☐	☐☐	☐☐

***PLACE CODES**

HEALTH UNIT THAT HAS A FAMILY HEALTH IN YOUR AREA/VILLAGE 01
ANOTHER HEALTH CENTRE THAT DOES NOT HAS A FAMILY HEATH (INSIDE YOUR AREA/VILLAGE) 02
PRIVATE CLINIC INSIDE YOUR AREA/VILLAGE 03
MOSQUE/CHURCH CLINIC INSIDE YOUR AREA/VILLAGE 04
PHARMACY INSIDE YOUR AREA/VILLAGE 05
GOVERNMENTAL HOSPITAL INSIDE YOUR AREA/VILLAGE 06
PRIVATE HOSPITAL INSIDE YOUR AREA/VILLAGE 07
NGOS HOSPITAL INSIDE YOUR AREA/VILLAGE 08
ANOTHER HEALTH CENTRE DOES NOT HAS FAMILY HEATH (OUTSIDE YOUR AREA/VILLAGE) 09
PRIVATE CLINIC OUTSIDE YOUR AREA/VILLAGE 10
MOSQUE/CHURCH CLINIC OUTSIDE YOUR AREA/VILLAGE 11
PHARMACY OUTSIDE YOUR AREA/VILLAGE 12
GOVERNMENTAL HOSPITAL OUTSIDE YOUR AREA/ VILLAGE 13
PRIVATE HOSPITAL OUTSIDE YOUR AREA/VILLAGE 14
NGOS HOSPITAL OUTSIDE YOUR AREA/VILLAGE 15
OTHER _____ 96
(SPECIFY)
HOME 21

****REASON OF CHOOSING CODES**

THE PLACE IS NEAR 01
THERE IS NO OTHER PLACE 02
EASY TRANSPORTATION TO IT 03
COST IS CHEAP/SUITABLE 04
CHEAPEST PLACE 05
RELATED TO HIO 06
ALL PEOPLE SAY THIS PLACE IS THE BEST FOR THIS SERVICE 07
WE WELL KNEW DOCTOR 08
DOCTORS ARE CLEVER 09
FEMALE PHYSICIAN 10
WELL ORGANIZED 11
TIMES ARE SUITABLE 12
MEDICINES ARE AT THE UNIT ALL THE TIME (INCLUDES FAMILY PLANNING METHODS) 13
THE NURSE AND ASSISTANT TEAM ARE GOOD 14
ALL THE SERVICES IS BEING IN THE SAME PLACE (LABORATORY, RAYS,....) 15
IF PERSON DID NOT GO THE NURSE VISITS HIM IN HIS HOUSE (ANTENATAL CARE, POSTNATAL CARE, VACCINATION,...) .. 16
THE SERVICE IS AVAILABLE ALL THE TIME (MORNING, EVENING 17
THE SERVICES IS GOOD OVERALL 18
OTHER _____ 96
(SPECIFY)

CODES OF WHO HELPS IN DELIVERY

DOCTOR 1
NURSE 2
DAYA 3
OTHER --------- 6
(SPECIFY)

SECTION 4: FAMILY PLANNING METHODS AND STI

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
401	What are the methods of family planning that you heard about? **CIRCLE ALL MENTIONED.**	FEMALE STERILIZATION ..... C MALE STERILIZATION ..... D PILL ..... E IUD ..... F INJECTABLES ..... G IMPLANTS ..... H CONDOM ..... I DIAPHRAGM, FOAM, JELLY ..... K RHYTHM METHOD ..... N WITHDRAWAL ..... R PROLONGED BREASTFEEDING ..... T OTHER _____ X (SPECIFY)	
402	What is importance of the family planning?	CONSERVATISM TO HEALTH MOTHER AND CHILD A SPACING BETWEEN BIRTHS ..... B SPECIFIC NUMBER OF BIRTHS ..... C OTHER _____ X (SPECIFY) NOT IMPORTANT ..... Y	
403	Have you ever used anything to delay getting pregnant?	YES ..... 1 NO ..... 2 →	409
404	Are you currently using any method to delay or avoid getting pregnant?	YES ..... 1 NO ..... 2 →	409
405	What is this method? **CIRCLE ALL MENTIONED.**	FEMALE STERILIZATION ..... C MALE STERILIZATION ..... D PILL ..... E IUD ..... F INJECTABLES ..... G IMPLANTS ..... H CONDOM ..... I DIAPHRAGM/FOAM/JELLY ..... K RHYTHM METHOD ..... N WITHDRAWAL ..... R PROLONGED BREASTFEEDING ..... T OTHER _____ X (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
406	Where did you obtain this method? **WRITE THE NAME AND THE ADDRESS OF THE PLACE.** _____ _____ _____ _____ **(NAME AND ADDRESS OF PLACE)**	HEALTH UNIT THAT HAS A FAMILY HEALTH IN YOUR AREA/VILLAGE ..... 01 ANOTHER HEALTH CENTRE THAT DOES NOT HAS A FAMILY HEATH (INSIDE YOUR AREA/VILLAGE) 02 PRIVATE CLINIC INSIDE YOUR AREA/VILLAGE .. 03 MOSQUE/CHURCH CLINIC INSIDE YOUR AREA/ VILLAGE ..... 04 PHARMACY INSIDE YOUR AREA/VILLAGE ..... 05 GOVERNMENTAL HOSPITAL INSIDE YOUR AREA/ VILLAGE ..... 06 PRIVATE HOSPITAL INSIDE YOUR AREA/VILLAGE 07 NGOS HOSPITAL INSIDE YOUR AREA/VILLAGE 08 ANOTHER HEALTH CENTRE DOES NOT HAS FAMILY HEATH (OUTSIDE YOUR AREA/VILLAGE) ..... 09 PRIVATE CLINIC OUTSIDE YOUR AREA/VILLAGE 10 MOSQUE/CHURCH CLINIC OUTSIDE YOUR AREA/ VILLAGE ..... 11 PHARMACY OUTSIDE YOUR AREA/VILLAGE ..... 12 GOVERNMENTAL HOSPITAL OUTSIDE YOUR AREA/ VILLAGE ..... 13 PRIVATE HOSPITAL OUTSIDE YOUR AREA/VILLAGE 14 NGOS HOSPITAL OUTSIDE YOUR AREA/VILLAGE 15 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	
407	Why did you go this place not other?	THE PLACE IS NEAR ..... 01 THERE IS NO OTHER PLACE ..... 02 EASY TRANSPORTATION TO IT ..... 03 COST IS CHEAP/SUITABLE ..... 04 CHEAPEST PLACE ..... 05 RELATED TO HIO ..... 06 ALL PEOPLE SAY THIS PLACE IS THE BEST FOR THIS SERVICE ..... 07 WE WELL KNEW DOCTOR ..... 08 DOCTORS ARE CLEVER ..... 09 FEMALE PHYSICIAN ..... 10 WELL ORGANIZED ..... 11 TIMES ARE SUITABLE ..... 12 MEDICINES ARE AT THE UNIT ALL THE TIME (INCLUDES FAMILY PLANNING METHODS) ..... 13 THE NURSE AND ASSISTANT TEAM ARE GOOD . 14 ALL THE SERVICES IS BEING IN THE SAME PLACE (LABORATORY, RAYS,....) ..... 15 IF PERSON DID NOT GO THE NURSE VISITS HIM IN HIS HOUSE (ANTENATAL CARE, POSTNATAL CARE, VACCINATION,...) ..... 16 THE SERVICE IS AVAILABLE ALL THE TIME (MORNING, EVENING) ..... 17 THE SERVICES IS GOOD OVERALL ..... 18 OTHER _____ 96 (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
408	Inwhat year and month did you begin to use (name of method) continually?	MONTH ..... ☐☐ YEAR ..... ☐☐☐☐	
409	Have you ever heard about infected diseases that can be transmitted through sexual contact?	YES ..... 1 NO 2	
410	What are the cases that make the woman examine gynecology to take a cure?	VAGINAL SECRETIONS ..... A INCHING IN THE OUTSIDE AREA OF THE VAGINA B SECRETIONS AND INFLAMMATION IN URINE .... C PROLABSE ..... D OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
411	Now I would like to ask you some questions about your health, have you had ever a health problem through sexual contact?	YES ..... 1 NO 2	
412	Sometimes women experience a bad smelling abnormal genital have you had a bad smelling abnormal genital discharge?	YES ..... 1 NO 2	
413	Sometimes women have a genital sore or ulcer. have you had a genital sore or ulcer?	YES ..... 1 NO 2	
413a	**CHECK 411, 412, AND 413:** AT LEAST ONE YES ☐ ↓	ALL OF ANSWERS ARE NO ☐ →	416
413b	The last time you had **(PROBLEM FROM 411/412/413).** Did you look for any kind of advice or treatment?	YES ..... 1 NO ..... 2 →	416
414	Where did you go? **WRITE THE NAME AND THE ADDRESS OF THE PLACE.** _____ _____ _____ _____ **(NAME AND ADDRESS OF PLACE)**	HEALTH UNIT THAT HAS A FAMILY HEALTH IN YOUR AREA/VILLAGE ..... 01 ANOTHER HEALTH CENTRE THAT DOES NOT HAS A FAMILY HEATH (INSIDE YOUR AREA/VILLAGE) 02 PRIVATE CLINIC INSIDE YOUR AREA/VILLAGE .. 03 MOSQUE/CHURCH CLINIC INSIDE YOUR AREA/ VILLAGE ..... 04 PHARMACY INSIDE YOUR AREA/VILLAGE ..... 05 GOVERNMENTAL HOSPITAL INSIDE YOUR AREA/ VILLAGE ..... 06 PRIVATE HOSPITAL INSIDE YOUR AREA/VILLAGE 07 NGOS HOSPITAL INSIDE YOUR AREA/VILLAGE 08 ANOTHER HEALTH CENTRE DOES NOT HAS FAMILY HEATH (OUTSIDE YOUR AREA/VILLAGE) ..... 09 PRIVATE CLINIC OUTSIDE YOUR AREA/VILLAGE 10 MOSQUE/CHURCH CLINIC OUTSIDE YOUR AREA/ VILLAGE ..... 11 PHARMACY OUTSIDE YOUR AREA/VILLAGE ..... 12 GOVERNMENTAL HOSPITAL OUTSIDE YOUR AREA/ VILLAGE ..... 13 PRIVATE HOSPITAL OUTSIDE YOUR AREA/VILLAGE 14 NGOS HOSPITAL OUTSIDE YOUR AREA/VILLAGE 15 OTHER _____ 96 (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
415	Why did you go this place not other?	THE PLACE IS NEAR ..... 1 THERE IS NO OTHER PLACE ..... 2 EASY TRANSPORTATION TO IT ..... 3 COST IS CHEAP/SUITABLE ..... 4 CHEAPEST PLACE ..... 5 RELATED TO HIO ..... 6 ALL PEOPLE SAY THIS PLACE IS THE BEST FOR THIS SERVICE ..... 7 WE WELL KNEW DOCTOR ..... 8 DOCTORS ARE CLEVER ..... 9 FEMALE PHYSICIAN ..... 10 WELL ORGANIZED ..... 11 TIMES ARE SUITABLE ..... 12 MEDICINES ARE AT THE UNIT ALL THE TIME (INCLUDES FAMILY PLANNING METHODS) ..... 13 THE NURSE AND ASSISTANT TEAM ARE GOOD . 14 ALL THE SERVICES IS BEING IN THE SAME PLACE (LABORATORY, RAYS,....) ..... 15 IF PERSON DID NOT GO THE NURSE VISITS HIM IN HIS HOUSE (ANTENATAL CARE, POSTNATAL CARE, VACCINATION,...) ..... 16 THE SERVICE IS AVAILABLE ALL THE TIME (MORNING, EVENING) ..... 17 THE SERVICES IS GOOD OVERALL ..... 18 OTHER _____ 96 (SPECIFY)	
416	Have your husband ever had any problem like dischange and burning during urination?	YES ..... 1 NO ..... 2 →	420
417	Did he examine himself or directly go and take medicine form pharmacy?	YES, EXAMINE ..... 1 NO. NOT EXAMINE ..... 2 TAKE MEDICINE FROM PHARMACY WITHOUT AN EXAMINATION ..... 3 →	420
418	Where did he go? **WRITE THE NAME AND THE ADDRESS OF THE PLACE.** _____ _____ _____ _____ **(NAME AND ADDRESS OF PLACE)**	HEALTH UNIT THAT HAS A FAMILY HEALTH IN YOUR AREA/VILLAGE ..... 01 ANOTHER HEALTH CENTRE THAT DOES NOT HAS A FAMILY HEATH (INSIDE YOUR AREA/VILLAGE) 02 PRIVATE CLINIC INSIDE YOUR AREA/VILLAGE .. 03 MOSQUE/CHURCH CLINIC INSIDE YOUR AREA/ VILLAGE ..... 04 PHARMACY INSIDE YOUR AREA/VILLAGE ..... 05 GOVERNMENTAL HOSPITAL INSIDE YOUR AREA/ VILLAGE ..... 06 PRIVATE HOSPITAL INSIDE YOUR AREA/VILLAGE 07 NGOS HOSPITAL INSIDE YOUR AREA/VILLAGE 08 ANOTHER HEALTH CENTRE DOES NOT HAS FAMILY HEATH (OUTSIDE YOUR AREA/VILLAGE) ..... 09 PRIVATE CLINIC OUTSIDE YOUR AREA/VILLAGE 10 MOSQUE/CHURCH CLINIC OUTSIDE YOUR AREA/ VILLAGE ..... 11 PHARMACY OUTSIDE YOUR AREA/VILLAGE ..... 12 GOVERNMENTAL HOSPITAL OUTSIDE YOUR AREA/ VILLAGE ..... 13 PRIVATE HOSPITAL OUTSIDE YOUR AREA/VILLAGE 14 NGOS HOSPITAL OUTSIDE YOUR AREA/VILLAGE 15 OTHER _____ 96 (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
419	Why did he Choose this place?	THE PLACE IS NEAR ..... 01 THERE IS NO OTHER PLACE ..... 02 EASY TRANSPORTATION TO IT ..... 03 COST IS CHEAP/SUITABLE ..... 04 CHEAPEST PLACE ..... 05 RELATED TO HIO ..... 06 ALL PEOPLE SAY THIS PLACE IS THE BEST FOR THIS SERVICE ..... 07 WE WELL KNEW DOCTOR ..... 08 DOCTORS ARE CLEVER ..... 09 FEMALE PHYSICIAN ..... 10 WELL ORGANIZED ..... 11 TIMES ARE SUITABLE ..... 12 MEDICINES ARE AT THE UNIT ALL THE TIME (INCLUDES FAMILY PLANNING METHODS) ..... 13 THE NURSE AND ASSISTANT TEAM ARE GOOD . 14 ALL THE SERVICES IS BEING IN THE SAME PLACE (LABORATORY, RAYS,....) ..... 15 IF PERSON DID NOT GO THE NURSE VISITS HIM IN HIS HOUSE (ANTENATAL CARE, POSTNATAL CARE, VACCINATION,...) ..... 16 THE SERVICE IS AVAILABLE ALL THE TIME (MORNING, EVENING) ..... 17 THE SERVICES IS GOOD OVERALL ..... 18 OTHER _____ 96 (SPECIFY)	
420	**CHECK 401:** A WOMAN DID NOT DELIVER ☐ ↓ A WOMAN DELIVERED ☐ →		423
421	Did you and your husband examine for reproduction? **IF YES:** who go for the examination?	SHE EXAMINED HERSELF ..... 1 HER HUSBAND EXAMINED HIMSELF ..... 2 SHE AND HER HUSBAND ..... 3 SHE AND HER HUSBAND DIDN'T ..... 4 →	423
422	Can you tell me where did you or/and your husband go during previous years for this examination? **WRITE THE NAME AND THE ADDRESS OF THE PLACE.** _____ _____ _____ _____ **(NAME AND ADDRESS OF PLACE)**	HEALTH UNIT THAT HAS A FAMILY HEALTH IN YOUR AREA/VILLAGE ..... A ANOTHER HEALTH CENTRE THAT DOES NOT HAS A FAMILY HEATH (INSIDE YOUR AREA/VILLAGE) B PRIVATE CLINIC INSIDE YOUR AREA/VILLAGE .. C MOSQUE/CHURCH CLINIC INSIDE YOUR AREA/ VILLAGE ..... D PHARMACY INSIDE YOUR AREA/VILLAGE ..... E GOVERNMENTAL HOSPITAL INSIDE YOUR AREA/ VILLAGE ..... F PRIVATE HOSPITAL INSIDE YOUR AREA/VILLAGE G NGOS HOSPITAL INSIDE YOUR AREA/VILLAGE H ANOTHER HEALTH CENTRE DOES NOT HAS FAMILY HEATH (OUTSIDE YOUR AREA/VILLAGE) ..... I PRIVATE CLINIC OUTSIDE YOUR AREA/VILLAGE J MOSQUE/CHURCH CLINIC OUTSIDE YOUR AREA/ VILLAGE ..... K PHARMACY OUTSIDE YOUR AREA/VILLAGE ..... L GOVERNMENTAL HOSPITAL OUTSIDE YOUR AREA/ VILLAGE ..... M PRIVATE HOSPITAL OUTSIDE YOUR AREA/VILLAGE N NGOS HOSPITAL OUTSIDE YOUR AREA/VILLAGE O OTHER _____ X (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
423	Do anyone of your of family have a chronic healthy problem (like: Diabetes, blood pressure, Asthma..)?	YES ..... 1 NO ..... 2 →	500
424	Did he take a cure to these cases?	YES ..... 1 NO ..... 2 →	500
425	Where do he examine/follow up this case? **WRITE THE NAME AND THE ADDRESS OF THE PLACE.** _____ _____ _____ _____ **(NAME AND ADDRESS OF PLACE)**	HEALTH UNIT THAT HAS A FAMILY HEALTH IN YOUR AREA/VILLAGE ..... 01 ANOTHER HEALTH CENTRE THAT DOES NOT HAS A FAMILY HEATH (INSIDE YOUR AREA/VILLAGE) 02 PRIVATE CLINIC INSIDE YOUR AREA/VILLAGE .. 03 MOSQUE/CHURCH CLINIC INSIDE YOUR AREA/ VILLAGE ..... 04 PHARMACY INSIDE YOUR AREA/VILLAGE ..... 05 GOVERNMENTAL HOSPITAL INSIDE YOUR AREA/ VILLAGE ..... 06 PRIVATE HOSPITAL INSIDE YOUR AREA/VILLAGE 07 NGOS HOSPITAL INSIDE YOUR AREA/VILLAGE 08 ANOTHER HEALTH CENTRE DOES NOT HAS FAMILY HEATH (OUTSIDE YOUR AREA/VILLAGE) ..... 09 PRIVATE CLINIC OUTSIDE YOUR AREA/VILLAGE 10 MOSQUE/CHURCH CLINIC OUTSIDE YOUR AREA/ VILLAGE ..... 11 PHARMACY OUTSIDE YOUR AREA/VILLAGE ..... 12 GOVERNMENTAL HOSPITAL OUTSIDE YOUR AREA/ VILLAGE ..... 13 PRIVATE HOSPITAL OUTSIDE YOUR AREA/VILLAGE 14 NGOS HOSPITAL OUTSIDE YOUR AREA/VILLAGE 15 OTHER _____ 96 (SPECIFY)	
426	Why did you Choose this place?	THE PLACE IS NEAR ..... 01 THERE IS NO OTHER PLACE ..... 02 EASY TRANSPORTATION TO IT ..... 03 COST IS CHEAP/SUITABLE ..... 04 CHEAPEST PLACE ..... 05 RELATED TO HIO ..... 06 ALL PEOPLE SAY THIS PLACE IS THE BEST FOR THIS SERVICE ..... 07 WE WELL KNEW DOCTOR ..... 08 DOCTORS ARE CLEVER ..... 09 FEMALE PHYSICIAN ..... 10 WELL ORGANIZED ..... 11 TIMES ARE SUITABLE ..... 12 MEDICINES ARE AT THE UNIT ALL THE TIME (INCLUDES FAMILY PLANNING METHODS) ..... 13 THE NURSE AND ASSISTANT TEAM ARE GOOD . 14 ALL THE SERVICES IS BEING IN THE SAME PLACE (LABORATORY, RAYS,....) ..... 15 IF PERSON DID NOT GO THE NURSE VISITS HIM IN HIS HOUSE (ANTENATAL CARE, POSTNATAL CARE, VACCINATION,...) ..... 16 THE SERVICE IS AVAILABLE ALL THE TIME (MORNING, EVENING) ..... 17 THE SERVICES IS GOOD OVERALL ..... 18 OTHER _____ 96 (SPECIFY)	

SECTION 5: CHILE HEALTH AND BREASTFEEDING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
500	**CHECK Q110 HOUSEHOLD QUESTIONNAIRE:** HAVE CHILDREN FORM 2000-2007 ☐ DIDN'T HAVE CHILDREN FROM 2000-2007 ☐		→ 601
501	Did you ever hared about children vaccination?	YES ..... 1 NO 2	→ 505
	Do you know the vaccination the child must take. IF "YES": can tell me the vaccination, and when it should be taken? CIRCLE CODE 1 IN 502 FOR EACH IMMUNIZE MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN COLUMN 502, READING THE NAME AND DESCRIPTION OF EACH VACCINE DID NOT MENTION SPONTANEOUSLY. CIRCLE CODE 1 IF VACCINE IS RECOGNIZED, AND CODE 2 IF IT IS NOT RECOGNIZED. THEN, FOR EACH VACCINE WITH CODE 1 CIRCLED IN 502, ASK 503.		

THE VACCINE	**502** What are the vaccination that you have heard about? **FOR THE NOT MENTIONED VACCINATION, ASK:** Have you ever heard of **(THE VACCINE)?**	**503** When do this vaccine must be taken?
1. A BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar?	YES ..... 1 NO 2	DURING FIRST THREE MONTHS ..... A OTHER _____ X (SPECIFY)
2. Polio vaccine, that is, drops in the mouth?	YES ..... 1 NO 2	WHEN COMPLETE 2 MONTHS ..... A WHEN COMPLETE 4 MONTHS ..... B WHEN COMPLETE 6 MONTHS ..... C 18-24 MONTHS ..... D OTHER _____ X (SPECIFY)
3. A DPT vaccination, that is, an injection given in the thigh or buttocks, sometimes given at the same time with the polio drops?	YES ..... 1 NO 2	WHEN COMPLETE 2 MONTHS ..... A WHEN COMPLETE 4 MONTHS ..... B WHEN COMPLETE 6 MONTHS ..... C 18-24 MONTHS ..... D OTHER _____ X (SPECIFY)
4. Measles?	YES ..... 1 NO 2	FROM 9 TO 12 MONTHS ..... A OTHER _____ X (SPECIFY)
5. Vaccine against hepathitis?	YES ..... 1 NO 2	WHEN COMPLETE 2 MONTHS ..... A WHEN COMPLETE 4 MONTHS ..... B WHEN COMPLETE 6 MONTHS ..... C 18-24 MONTHS ..... D OTHER _____ X (SPECIFY)
6. MMR vaccine?	YES ..... 1 NO 2	AT 1 YEAR AND HALF ..... A OTHER _____ X (SPECIFY)
7. Vitamin A, it this capsules?	YES ..... 1 NO 2	AT 9 MONTHS ..... A AT 1 YEAR AND HALF ..... B OTHER _____ X (SPECIFY)
8. Have you heard of any other vaccination the child can take?	YES ..... 1 _____ (SPECIFY) _____ (SPECIFY) NO 2	AGE BY MONTHS ..... ☐☐ AGE BY MONTHS ..... ☐☐

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO

504 For the interviewer: check 308 and write the name of the births from 2002-2007.

NO. OF CHILDREN ☐ IF MORE THAN 3 CHILDREN USE ADDITIONAL QUESTIONNAIRE

Now I want you to tell me about the vaccination that your children took, starting by the last child

	LAST BIRTH LINE NO. ☐☐			**NEXT-TO-LAST BIRTH** LINE NO. ☐☐			**SECOND-FROM-LAST BIRTH** LINE NO. ☐☐		
	Take vaccine YES ..... 1 NO 2	place **(FROM Q425)**	reason of choosing **(FROM Q426)**	Take vaccine YES ..... 1 NO 2	place **(FROM Q425)**	reason of choosing **(FROM Q426)**	Take vaccine YES ..... 1 NO 2	place **(FROM Q425)**	reason of choosing **(FROM Q426)**
BCG	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
Polio									
POLIO 1	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
POLIO 2	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
POLIO 3	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
ACTIVATED DOSE	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
DPT									
DPT 1	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
DPT 2	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
DPT 3	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
ACTIVATED DOSE	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
MEASLES	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
HEPATITIS									
HEPATITIS 1	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
HEPATITIS 2	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
HEPATITIS 3	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
VITAMIN A DOSE 1	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
POLIO 0	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
POLIO 4	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
MMR	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
VITAMIN A DOSE 2	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐
OTHER (SPECIFY)	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
505	Is it important or not important that a child breastfeeds form her mother? **IF "YES":** Why?	IMPORTANT ..... 1 PROTECTED HIM FROM DISEASES ..... A FORMATION OF THE IMMUNITY FOR THE CHILD ..... B GOOD NUTRITION ..... C OTHER _____ X (SPECIFY) NOT IMPORTANT ..... 2 →	507
506	For how long does the mother breastfeed her child (without supplement)?	MONTHS ..... ☐☐	
507	If child had diarrhea is it important to examine him or not?	YES ..... 1 NO 2	
508	If child had a diarrhea do his mother should continue breastfeed him or not?	YES ..... 1 NO 2	
509	If a child had diarrhea, is it possible to give him something to drink less than usual, about the same amount, more than usual, or nothing to eat? **IF LESS, PROBE:** Is it possible to give him much less than usual or somewhat less?	MUCH LESS ..... 1 SOMEWHAT LESS ..... 2 ABOUT THE SAME ..... 3 MORE ..... 4 NOT GAVE FOOD ..... 5 DON'T KNOW 8	
510	If a child was ill with a fever and cold and cough is it important to examine him or not?	YES ..... 1 NO 2	

504 For the interviewer: check 308 and write the name of the births from 2002-2007.

NO. OF CHILDREN ☐ IF MORE THAN 3 CHILDREN USE ADDITIONAL QUESTIONNAIRE

511 Did (NAME) has (….) at any time within the last 2 weeks?	**LAST BIRTH** LINE NO. ☐☐				**NEXT-TO-LAST BIRTH** LINE NO. ☐☐				**SECOND-FROM-LAST BIRTH** LINE NO. ☐☐			
	had YES NO	cured YES 1 NO 2	place **(FROM Q.425)**	reason of choosing **(FROM Q426)**	had YES NO	cured YES 1 NC 2	place **(FROM Q425)**	reason of choosing **(FROM Q426)**	had YES NO	cured YES 1 NC 2	place **(FROM Q425)**	reason of choosing **(FROM Q426)**
Diarrhea*	1 2	☐	☐☐	☐☐	1 2	☐	☐☐	☐☐	1 2	☐	☐☐	☐☐
Influenza* (flu, cough, fever)	1 2 next child	☐	☐☐	☐☐	1 2 next child	☐	☐☐	☐☐	1 2 next child	☐	☐☐	☐☐

512 Had you follow up growth a child (weight) during first the five years of age?	**LAST BIRTH** LINE NO. ☐☐			**NEXT-TO-LAST BIRTH** LINE NO. ☐☐			**SECOND-FROM-LAST BIRTH** LINE NO. ☐☐		
	follow up YES 1 NC 2	place **(FROM Q425)**	reason of choosing **(FROM Q426)**	follow up YES 1 NC 2	place **(FROM Q425)**	reason of choosing **(FROM Q426)**	follow up YES 1 NC 2	place **(FROM Q425)**	reason of choosing **(FROM Q426)**
	☐	☐☐	☐☐	☐	☐☐	☐☐	☐	☐☐	☐☐

SECTION 6: KNOWLEDGE OF SOURCES HEALTH PROVIDED SERVICES FROM REPRODUCTIVE HEALTH AND CHILD HEALTH

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
601	Now I shall ask you about the places provided health services and a person can go it. And I want you to tell me the place that the one can go to for this service. I want you tell me the first place that comes to your mind and you can go to for the service I am going to tell you about:		

HEALTH SERVICES	NAME OF PLACE AND ADDRESS	CODE OF PLACE (SEE CODES BELOW)
- Premarital examination	----------	☐
- Antenatal care	----------	☐
- Delivery	----------	☐
- Postnatal care	----------	☐
- Family planning	----------	☐
- Children vaccination	----------	☐
- Examine a child if he had diarrhea	----------	☐
- Examine a child if he had inflammation of Respiratory system	----------	☐
- Observation of the child's growth	----------	☐
- Treatment of the inflammation of reproductive System for woman	----------	☐
- Treatment of the inflammation of reproductive System for husband	----------	☐
- Treatment of the sterility cases	----------	☐
- Treatment of the problems for female youth 15-24	----------	☐
- Treatment of the problems for male youth 15-25	----------	☐
- Treatment of the chronic diseases (blood pressure, Diabetes, Asthma.)	---------- ----------	☐

Code of place

HEALTH UNIT THAT HAS A FAMILY HEALTH IN YOUR AREA/VILLAGE 01
ANOTHER HEALTH CENTRE THAT DOES NOT HAS A FAMILY HEATH (INSIDE YOUR AREA/VILLAGE) 02
PRIVATE CLINIC INSIDE YOUR AREA/VILLAGE 03
MOSQUE/CHURCH CLINIC INSIDE YOUR AREA/VILLAGE 04
PHARMACY INSIDE YOUR AREA/VILLAGE 05
GOVERNMENTAL HOSPITAL INSIDE YOUR AREA/VILLAGE 06
PRIVATE HOSPITAL INSIDE YOUR AREA/VILLAGE 07
NGOS HOSPITAL INSIDE YOUR AREA/VILLAGE 08
ANOTHER HEALTH CENTRE DOES NOT HAS FAMILY HEATH (OUTSIDE YOUR AREA/VILLAGE) 09
PRIVATE CLINIC OUTSIDE YOUR AREA/VILLAGE 10
MOSQUE/CHURCH CLINIC OUTSIDE YOUR AREA/VILLAGE 11
PHARMACY OUTSIDE YOUR AREA/VILLAGE 12
GOVERNMENTAL HOSPITAL OUTSIDE YOUR AREA/ VILLAGE 13
PRIVATE HOSPITAL OUTSIDE YOUR AREA/VILLAGE 14
NGOS HOSPITAL OUTSIDE YOUR AREA/VILLAGE 15
OTHER _____ 96
(SPECIFY)

SECTION 7: SOCIETY KNOWLEDGE OF FAMILY HEALTH UNIT SERVICES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
701	Could you please tell me the name of the nearest place for your home that provides health service?	NAME OF THE FACILITY ..... ☐☐	
702	Did you know the family health unit in (NAME OF PLACE)?	YES ..... 1 NO ..... 2 →	801
703	What are the services provided by this family health unit? **IF "YES":** What is this services?	PREMARITAL EXAMINATION ..... A ANTENATAL CARE ..... B DELIVERY ..... C POSTNATAL CARE ..... D FAMILY PLANNING ..... E CHILDREN VACCINATION ..... F CHECK A CHILD IF HE HAD DIARRHEA ..... G CHECK A CHILD IF HE HAD INFLAMMATION OF RESPIRATORY SYSTEM ..... H OBSERVATION CHILD'S GROWTH ..... I TREATMENT INFLAMMATION OF REPRODUCTIVE SYSTEM FOR WOMAN ..... J TREATMENT INFLAMMATION OF REPRODUCTIVE SYSTEM FOR HUSBAND ..... K TREATMENT STERILITY CASES ..... L TREATMENT PROBLEMS FOR YOUNG WOMEN15-24 M TREATMENT PROBLEMS FOR YOUNG MEN 15-25 N TREATMENT CHRONIC DISEASES (BLOOD PRESSURE, DIABETES. ASTHMA..) ..... O LABORATORY ANALYSIS ..... P BIRTHS RECORD ..... Q DEATH RECORD ..... R SEMINARS ON FAMILY PLANNING&CHILD'S HEALTH ..... S PERFORMING HEALTH CERTIFICATE ..... T OTHER _____ X (SPECIFY) DO NOT KNOW ..... Y	
704	Did any person talk to you about the services provided by the family health unit?	YES ..... 1 NO 2	
705	From whom did you know that the unit became a family health unit?	WE ARE REGULAR WITH THIS UNIT AND WHEN WE WENT THEY TOLD US ABOUT THE FAMILY FILE A DOCTOR GAVE US AN IDEA ..... B NURSE SAID THAT ALL OF THE PERSON IN FAMILY HAVE A CARE IN THE UNIT ..... C OUR RAIDA RIFIA OF FAMILY PLANNING TOLD US THAT THE UNIT BECAME FOR ALL THE MEMBERS OF FAMILY ..... D CHANGED THE NAMEPLATE TO BECOME THE FAMILY HEALTH UNIT ..... E WE FOUND THAT THE UNIT WAS COLORED AND BECAME ORGANIZED AND WHEN WE ASKED THEY TOLD THAT IT BECAME FAMILY HEALTH UNIT .. F WE HEARD FROM PEOPLE WHO WENT TO THE UNIT THAT IT BECAME FOR ALL THE MEMBER OF THE FAMILY ..... G WHEN THEY ASKED FOR 30 L.E FOR THE FILE, 3 L.E FOR THE EXAMINATION (INSTEAD OF 1 L.E) WE ASKED WHY SO THEY ANSWERED THAT IT BECAME FAMILY UNIT ..... H RAIDA&NURSES CAME TO HOUSES AND TOOK OUR DATA AND TOLD US THAT THE UNIT WOULD BE REFORMED AND THERE WILL BE A FAMILY FILE I OTHER _____ X (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
706	I shall ask some questions about the services provided by the family health unit		

HEALTH SERVICES	Did you know that service ..... Presented in the family health unit?	Who talked to you? (SEE CODES BELOW)	PRICE AT THE PROVIDED SERVICE
- Premarital examination	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Antenatal care	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Delivery	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Postnatal care	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Family planning	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Children vaccination	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Examine a child if he had diarrhea	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Examine a child if he had inflammation of Respiratory system	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Observation of the child's growth	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Treatment of the inflammation of reproductive System for woman	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Treatment of the inflammation of reproductive System for husband	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Treatment of the sterility cases	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Treatment of the problems for female youth 15-24	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Treatment of the problems for male youth 15-25	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998
- Treatment of the chronic diseases (blood pressure, Diabetes, Asthma.)	YES 1 / NO 2 ↓	☐	L.E. ..... ☐☐☐ FOR FREE ..... 995 DON'T KNOW 998

CODE OF SOURCE

DOCTOR	A	OTHER _____ (SPECIFY)	X
NURSE	B		
RAIDA	C	NONE	Y
PEOPLE	D	DON'T KNOW	Z

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
707	Did you make a family file in the family health unit?	YES ..... 1 NO ..... 2 →	714a
708	When was your last visit to family health unit?	LAST MONTH ..... 1 MORE THAN 3 MONTH AGO ..... 2 LAST YEAR ..... 3 A YEAR PRELIST YEAR ..... 4 DIDN'T GO SINCE IT BECAME FAMILY HEALTH . 5 →	714b
709	What are the services that you took from the family health unit?	PREMARITAL EXAMINATION ..... A ANTENATAL CARE ..... B DELIVERY ..... C POSTNATAL CARE ..... D FAMILY PLANNING ..... E CHILDREN VACCINATION ..... F EXAMINE A CHILD IF HE HAD DIARRHEA ..... G EXAMINE A CHILD IF HE HAD INFLAMMATION OF RESPIRATORY SYSTEM ..... H OBSERVATION OF THE CHILD'S GROWTH ..... I TREATMENT OF THE INFLAMMATION OF REPRODUCTIVE SYSTEM FOR WOMAN ..... J TREATMENT OF THE INFLAMMATION OF REPRODUCTIVE SYSTEM FOR HUSBAND ..... K TREATMENT STERILITY CASES ..... L TREATMENT OF THE PROBLEMS FOR YOUNG WOMEN 15-24 ..... M TREATMENT OF THE PROBLEMS FOR YOUNG MEN 15-25 ..... N TREATMENT OF THE CHRONIC DISEASES (BLOOD PRESSURE, DIABETES. ASTHMA..) ..... O LABORATORY ANALYSIS ..... P BIRTHS RECORD ..... Q DEATH RECORD ..... R SEMINARS ABOUT FAMILY PLANNING&CHILD'S HEALTH ..... S PERFORMING HEALTH CERTIFICATE ..... T OTHER _____ X (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
710	What did you like about the family health unit?	THE PLACE IS NEAR ..... A THERE IS NO PLACE EXCEPT IT ..... B THE MONEY WE SPENT IS REASONABLE ..... C THE SERVICES IS GOOD ..... D THE UNIT IS CLEAN AND WELL-ORGANIZED ..... E DOCTORS ARE GOOD (HAVE A FRIENDLY MEETING) F DOCTORS ARE CLEVER ..... G FEMALE PHYSICIAN ..... H WE CAN GET A LOT OF SERVICES AT THE SAME TIME FROM FAMILY'S DOCTOR ..... I THER CAN TRANSFER SOME CASES TO THE HOSPITAL AND OBSERVE WHEN THEY COME BACK ..... J MEDICINES ARE AVAILABLE ..... K THEY HAD OUR FILE THAT ENCOURAGE US TO FOLLOW UP WITH THEM ..... L THE SERVICES FOR MOTHER, HUSBAND AND CHILDREN ARE AVAILABLE ALL DAYS ..... M THE CLINIC IS OPENED AT MORNING AND NIGHT N MEDICINES ARE CHEAPER THAN FROM OUTSIDE, AS WE PAY ONLY A PART ..... O WE ARE REGULAR WITH THIS UNIT PAID OR NOT P SERVICES BECOME LIKE PRIVATE UNIT OR BETTER Q THERE ARE SOME FREE SERVICES (VACCINATION, ANTENATAL CARE..) ..... R THE COST FOR EXAMINATION IS ON SICK PERSONS ONLY ..... S EXAMINATION ON CHILDREN UNDER 5 YEARS IS FOR FREE ..... T WHEN THEY ADVICE A MEDICINE THEY TELL US HOW TO USE ..... U THEY TELL US THE DATE OF CONSULTATION .... V OTHER _____ X (SPECIFY) I DIDN'T LIKE ANY THING ..... Y	
711	Do you tell your neighbors and relatives go to the family health unit?	YES ..... 1 NO 2	
712	What did you don't like about the family health unit?	THE PLACE IS FAR AWAY ..... A NO TRANSPORTATION ..... B FILE PRICE IS EXPENSIVE ..... C EXAMINATION PRICE IS EXPENSIVE ..... D DOCTOR IS NOT SPECIALIST ..... E NO PRIVACY, MAN, WOMAN AND CHILDREN ARE EXAMINED IN THE SAME PLACE ..... F THE WAITING PLACE IS FOR MEN AND WOMEN TOGETHER AND WE HATE THIS ..... G WE HAVE TO MAKE A FILE WITH 30 L.E AND IT IS NOT USEFUL AS DOCTOR KNEW US ..... H DOCTOR IS CHANGED AFTER WE GET USED TO HIM I NO FEMALE PHYSICIAN ..... J TIMES ARE UNSUITABLE ..... K THERE ISN'T CARE WHEN WE ARE TRANSFERRED TO THE HOSPITAL ..... L MEDICINE IS INSUFFICIENT (SOMETIMES THEY SAID THERE IS NO MEDICINE) ..... M WE HAVE PAID COST (SOME COST) OF MEDICINE N DOCTOR TAKE A LONG TIME IN EXAMINATION .... O DOCTOR TAKE A SHORT TIME IN EXAMINATION .. P DOCTOR DECIDE ONLY 2 KINDS OF MEDICINE .. Q WE FEEL THAT THIS UNIT FOR POOR ..... R NURSES ARE NOT GOOD ..... S THE CLINICS ARE NOT CLEAN ..... T NO ORGANIZATION ..... U OTHER _____ X (SPECIFY) I LIKED EVERY THING ..... Y	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
713	What did your suggest to improve the services in family health unit?	UNITS MUST BE CLEAN ..... A WC MUST BE CLEAN ..... B REDUCE THE PRICE OF THE FILE (OR PAID BY INSTALLMENTS) ..... C REDUCE THE EXAMINATION PRICE ..... D LABORATORY HAS TO HAVE ALL TYPES OF ANALYSIS BY A LOW PRICE ..... E MEDICINE MUST BE CHEAPER ..... F WELL ORGANIZED ..... G SEPARATED CLINICS FOR MEN, WOMEN AND CHILDREN ..... H SEPARATED WAITING PLACE FOR MEN AND WOMEN I TO MORE CARE ABOUT THOSE WHO WILL BE TRANSFERRED TO THE HOSPITAL ..... J MUST BE DOCTORS IN ALL SPECIALIZE ..... K FEMALE PHYSICIAN ..... L DOCTORS SHOULD BE CLEVER ..... M NURSE DEALS GOOD WITH SICK PEOPLE ..... N MEDICINE ENSURING ..... O WE NEED MORE THAN 2 KIND OF MEDICINE SO THEY SHOULD BE AVAILABLE ..... P ADVISE PEOPLE BY THE SERVICES BY THE RAIDA LIKE FAMILY PLANNING ..... Q MAKE SPOTS IN TV ABOUT SERVICES WHICH THIS UNITS PROVIDE IN THIS NEW SYSTEM ..... R WHEN ANYONE GO TO UNIT THEY TELL HIM ABOUT THE SERVICES TO BRING HIE NEIGHBORS ..... S OTHER _____ X (SPECIFY)	
714 714a 714b	Why didn't you make a family file? Why didn't yougo after it became a family unit? Why do you think that some of your neighbors didn't go to the family health unit?	30 L.E IS EXPENSIVE ..... A WE PAY 30 L.E AND THEN WE ALSO PAY 3 L.E FOR THE EXAMINATION ..... B AS LONG AS WE PAID FOR SERVICES SO PRIVATE DOCTOR IS BETTER ..... C WHY I GO TO THIS UNIT ALL TIMES, I WANT TO GO TO ANOTHER PLACE TOO ..... D THERE IS NO CHANGES ABOUT THE GOVERNMENTAL UNITS ALL THEY WANT IS THE MONEY ..... E WE ARE COVERED WITH HEALTH INSURANCE .... F THERE IS ANOTHER GOVERNMENTAL UNITS BUT FOR FREE ..... G TIMES ARE UNSUITABLE ..... H WE HEAR THAT THEY DON'T HAVE SUFFICIENT MEDICINE ..... I WE PAY THE COST OF TREATMENT ..... J ALSO DOCTORS ARE NOT AVAILABLE ALL THE TIME ..... K THIS IS FOR POOR PEOPLE ..... L NO FEMALE PHYSICIAN ..... M NO PRIVACY, MAN, WOMAN AND CHILDREN ARE EXAMINED IN THE SAME PLACE ..... N DOCTORS ARE NOT SPECIALISTS WHICH MEANES THAT THE DOCTOR IS FOR ALL HE EXAMINE WOMEN, MEN AND CHILDREN ..... O OTHER _____ X (SPECIFY)	

OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

801 INTERVIEWER'S OBSERVATIONS

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

802 SUPERVISOR'S OBSERVATIONS

NAME OF SUPERVISOR: _____ DATE: _____

803 EDITOR'S OBSERVATIONS

NAME OF EDITOR: _____ DATE: _____